Cerner CoPathPlus™

User Guide

Version 3.1

CoPathPlus™

Two University Office Park
51 Sawyer Road
Waltham, MA 02453

Telephone: 781-434-2200
Fax: 781-642-6222

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

CoPathPlus is a trademark of Cerner CoPathPlus. All other products and brand names are trademarks or registered trademarks of their respective companies.

© Copyright 1994-2008 Cerner CoPathPlus. All rights reserved. Due to rapid advancements in technology, specifications are subject to change without notice.

No part of this document may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or any information storage and retrieval system, without permission in writing from Cerner CoPathPlus.

Contents

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Chapter 1: Introduction

Overview of CoPathPlus

In the pathology laboratory setting, you use CoPathPlus to register a patient (or accept registration through an interface), accession a specimen for a patient, enter a final diagnosis, sign out that case, gather statistics, and print out that patient's final report and distribute copies to all concerned (e.g., the submitting physician, the client affiliated with the patient, your Medical Records department).

While in CoPathPlus you can perform several other actions on the specimen. For example, you can order a procedure for the specimen, inquire on the status of the patient/specimen, refer the specimen for further review, send the specimen for Quality Assurance review, etc. Some activities are appropriate before a case is signed out, some after signout, and some during both circumstances.

Once you enter a patient/specimen into the system, CoPathPlus collects data about the case. The system tracks who has dealt with the specimen and when (e.g., who performed and entered the gross description and when, who made the final diagnosis and signed out the case and when), and produces (when instructed) statistical reports, such as the number of cases awaiting pathologist review and turnaround time. CoPathPlus can also produce retrospective and historical reports (e.g., how many Cytology gynecological specimens were accessioned in 2007, how many surgical pathology specimens were diagnosed by Dr. Jane A. Kittamer from 2005 to 2008).

Overview of the CoPathPlus User Guide

This guide tells you how to use CoPathPlus. It shows you how to perform the standard routines that all sites will carry out.

The information contained in this guide is based on the standard export version of CoPathPlus. Because CoPathPlus is tailored during the implementation process to meet the needs of each user site, it is possible that your system will not include fields or items described in the guide or find that these fields/activities have be renamed. Or your system may have additional fields and items that are not documented here. This manual may also contain information on features your site has not implemented or for which you do not have permission to use. The general descriptions and routines (e.g., how to accession a specimen, how to register a patient,etc.) detailed in this guide are relevant and appropriate for the functions available in CoPathPlus,

Requirements

Everyone who uses CoPathPlus should have a good working knowledge of the operation and capabilities of Microsoft Windows so that he or she can effectively and efficiently use the CoPathPlus system. This guide does not teach you how to use Microsoft Windows and assumes that you know how to use it. Users who will be creating ad hoc reports from CoPathPlus data will need to know other software packages, such as PowerBuilder InfoMaker™ or another Sybase® - compatible or MS SQL-compatible report writer.

Technical Information

The ability to use CoPathPlus does not require that you understand the technology mentioned here—though you should know how to use Microsoft Windows. However, we hope that the technical information provided here will give you a better understanding of CoPathPlus. Your CoPathPlus System Manager and Information Systems (IS) department will be more familiar with the technical aspects of CoPathPlus.

CoPathPlus employs a Microsoft Windows graphical user interface and has at its foundation a Sybase relational database engine. What does this mean?

CoPathPlus is based on the architecture of the client/server model, which enables a wide variety of users within an organization to access, share, and distribute information across systems and functional boundaries. This model allows efficient use of the huge amounts of data that are received and produced within an anatomic pathology environment.

CoPathPlus features a graphical user interface consistent with the look and feel of other Microsoft Windows applications. Like Windows, CoPathPlus uses the desktop metaphor. You can run CoPathPlus while other applications (e.g., a word processing package, a spreadsheet, an electronic mail function) are also open in other individual windows on your desktop. You can also easily switch from one application to another, cut (or copy) and paste data between applications, and perform functions using a mouse or other pointing device (besides through a keyboard).

Sybase® and MS SQL are the two database alternatives available to store CoPathPlus data files. CoPathPlus functionality typically does not differ based on the database used. In the rare cases that CoPathPlus features are applicable to just one database or are different based on the type of database, the documentation will indicate this specifically. Finally, because the CoPathPlus server resides on your hospital network, you have an environment that allows other applications to communicate with CoPathPlus and vice versa.

Other Tools Used Within CoPathPlus

Other tools that you can use within CoPathPlus include:

- **Text Editor.** CoPathPlus uses either Microsoft® Word or Visual Writer® as the text editor for entering information in diagnostic text fields (e.g., Gross Description, Final Diagnosis). Your site determines during CoPathPlus implementation which text editor it will use. You have the ability to insert Quick Text into your diagnostic text fields and

check the spelling. CoPathPlus text fields are explained in more detail throughout this guide.

NOTE: Although "TX Text Control" is the new commercial name for Visual Writer, CoPathPlus still uses "Visual Writer" and "VW."

NOTE: For sites using Microsoft Word as the CoPathPlus text editor, patient reports are always displayed using Microsoft Word.

Warning: If both MS Outlook and CoPathPlus are set up to use Word as their text editors, conflicts may occur during simultaneous use. Users doing text entry/editing, report signout or report printing must not have MS Outlook open while running CoPathPlus, or must not use Word as Outlook's editor.

- **Patient Report Painter.** CoPathPlus uses the Patient Report Painter tool to customize patient specimen reports, including Working Drafts, Final reports and Procedure/Addendum reports. Typically, you copy the standard reports provided with CoPathPlus and then modify these as needed for each specimen class or for specific procedures and addenda. The Patient Report Painter tool uses the same text editor (either Microsoft Word or Visual Writer) as the one chosen by your site for editing diagnostic text fields. For more information about this tool, refer to the *Cerner CoPathPlus Tools Training Manual*.

- **Window Painter.** CoPathPlus uses the Window Painter tool to customize specimen and patient registration data entry windows. Typically, you copy the standard windows provided with CoPathPlus and then modify these as needed. For more information about this tool, refer to the *Cerner CoPathPlus Tools Training Manual*.

Third-Party Tools Used Within CoPathPlus

Third party tools that you can use within CoPathPlus include:

- **InfoMaker**®**.** CoPathPlus uses InfoMaker, a reporting tool that lets you create reports through queries to the CoPathPlus database, to produce its standard management reports (i.e., internal-review-only reports, such as statistical, management, and quality assurance reports). Cerner CoPathPlus provides one copy of InfoMaker software with the CoPathPlus system. Therefore, you can create your own InfoMaker reports or revise the ones provided by Cerner CoPathPlus. Note that you can also use other reporting tools that can read the Sybase relational database engine used by CoPathPlus.

  As necessary, you should review or have available to you the documentation provided with InfoMaker and the *Cerner CoPathPlus Management Report Training* manual.

Other CoPathPlus Documentation

This guide deals specifically with how to use CoPathPlus. You may also need to refer to or read the following other documentation:

NOTE: You may also want to review or have available to you the documentation provided with your purchase of Microsoft Windows and PowerSoft InfoMaker or other Sybase-compatible report writer (as applicable).

- Cerner CoPathPlus Dictionary Building Manual

- Cerner CoPathPlus Implementation Manual

- Cerner CoPathPlus System Manager Guide

- Cerner CoPathPlus Fax Agent PC Setup Guide

Cerner CoPathPlus Dictionary Building Manual

The *Cerner CoPathPlus Dictionary Building Manual* describes all of the CoPathPlus dictionaries and how to build them. Use this manual in conjunction with the *Cerner CoPathPlus Implementation Manual* when you implement the system at your site.

Cerner CoPathPlus Implementation Manual

The *Cerner CoPathPlus Implementation Manual* explains how to implement CoPathPlus from understanding the implementation schedule to learning about conference calls to making decisions about the system to going "live." Use this document in conjunction with the *Cerner CoPathPlus Dictionary Building Manual* when you implement the system at your site.

Cerner CoPathPlus System Manager Guide

The *Cerner CoPathPlus System Manager Guide* describes advanced features of CoPathPlus such as Folders and Items, Security, System Settings, and System Documentation and Reports. System managers and the IS Department use this document as needed to make adjustments which affect the functionality and appearance of the CoPathPlus system and to generate system reports.

Cerner CoPathPlus Fax Agent PC Setup Guide

A Fax Agent can be used to fax output for patient reports or InfoMaker/management reports using the standard CoPathPlus Print/Send capabilities. The *Cerner CoPathPlus Fax Agent PC Setup Guide* outlines set-up requirements for the Fax Agent software and the Fax Agent. It also explains how to use the Fax Agent.

Preview of Topics

This guide contains the following sections:

- Introduction introduces you to CoPathPlus, tells you about the prerequisites to using the system, provides some technical background, previews the topics in the guide, and lists other documentation related to the system.

- Getting Started tells you how to sign on to CoPathPlus and details the common elements found throughout the system. It also explains the conventions used in the documentation.

- Security describes how CoPathPlus security features affect your access to the system.

- Specimens explains all the activities you can perform on a specimen. It explains how to accession a specimen and enter diagnoses. It also shows you how to order a procedure, perform a Quality Assurance (QA) review, and sign out a case.

- Worklists explains how to choose a specimen or procedure from a worklist.

- Inquiry explains how to perform an inquiry on a patient and/or specimen. It also shows you how to print a patient report (e.g., Surgical Working Draft, Procedure Report) from the results of the inquiry.

- Patients explains patient registration. It tells you how to enter a new patient or encounter into CoPathPlus and how to edit demographic information for an existing patient or encounter.

- Reports explains how to access and run the standard management reports provided with your CoPathPlus system. It also explains how to print the standard patient reports (Final Report, Working Draft, Procedure/Addendum Report). Also included is a brief description of each report and any regulations pertaining to the report that you may need to know.

- Tasks explains a number of CoPathPlus items that deal with system maintenance and that you must perform on a periodic basis (e.g., daily, monthly, etc.). These items cover areas such as billing, histology, merging and moving patients, moving and deleting specimens, the Schedule Manager, system session utilities, and the Fax/E-Mail Queue/Log.

NOTE: The dictionaries listed under the **Dictionaries** command button are detailed in the *Cerner CoPathPlus Dictionary Building Manual*. In addition, most of the items found under the **Setup** command button are documented in the *Cerner CoPathPlus System Manager Guide*. You will find guide in CoPathPlus for the items found under both of these command buttons.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

This page was intentionally left blank.

Chapter 2: Getting Started

Overview

Getting Started provides an overview of Cerner CoPathPlus. It tells you how to sign on to CoPathPlus and details the common elements found throughout the system. It also explains the conventions used in this guide.

Everyone who uses CoPathPlus should have a good working knowledge of the operation and capabilities of Microsoft Windows. This guide does not teach you how to use Windows and assumes that you know how to use it. Only CoPathPlus-specific items are detailed in this guide. Users who will be creating ad hoc reports from CoPathPlus data will need to know other software packages, such as InfoMaker (a reporting tool) from PowerSoft Corporation.

What Should I Know Before I Start?

This topic points out some things that you should know before you start, including:

- Conventions
- Access Issues
- Navigation in CoPathPlus

Conventions

This guide shows text or a button that you have to type or press, or a representation of previously typed text, in a **boldface** font. If a button or other command can be executed via an access key, the letter of the access key is underlined in the command name (e.g., **S̲pecimens**).

This guide assumes that you are using a two-button mouse with the left mouse button as the primary button. Therefore, when you are instructed to press something (e.g., an icon, a button), you should use the left mouse button unless otherwise noted. See "Navigating with a Mouse" for more information.

This guide also assumes that the CoPathPlus toolbar is visible.

Access Issues

Everyone who uses CoPathPlus must first be identified as a valid user within the system. Once set up, each person receives a user ID and password (which must be entered every time you try to access CoPathPlus). During the new user set-up process, which is performed by the

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

CoPathPlus System Manager, defaults are also put in place for each user (e.g., access to particular CoPathPlus items, toolbar appearance).

NOTE: For information on password expiration and changing passwords, refer to "Security".

Note that as you use CoPathPlus you will likely see selections (e.g., buttons, menu commands) disabled (i.e., they appear "grayed out") or find that the guide mentions a feature that you may not see on your particular workstation. Disabled items mean that the currently signed-on user has not been defined as needing access to those items. Not all users require access to certain items within CoPathPlus. When this is the case, an item may be accessible to one user, but not to another.

NOTE: Some menu commands can switch from enabled to disabled and vice versa, as appropriate. For example, on the Edit menu, Cut and Copy are disabled if you do not have some text highlighted. Once you have highlighted some text, the Cut and Copy commands become available. This is an attribute of the Windows environment.

Navigation in CoPathPlus

You can navigate the windows and fields within CoPathPlus by using a keyboard, a mouse, a light pen, or any combination of these. You will find that the easiest way to navigate from field to field on a CoPathPlus window is to use the Tab key to move forward and Shift+Tab to reverse direction.

Navigating with the Keyboard

You can navigate CoPathPlus by using the keyboard. Most anything that you can do with a mouse, you can do through the keyboard with the use of the menu bar; access keys; shortcut keys; and the arrow, Tab, and Enter keys.

The following keyboard navigation attributes apply within CoPathPlus:

- **To quickly move from field to field:** Press the Tab key to move forward or Shift+Tab to reverse direction. You can keep the key or keys pressed to speed tab through the fields. Release the Tab key when you arrive at the field you want.

- **To quickly move from data group to data group on a tab page:** Press the F7 key to move forward to the first field of a data group or Shift+F7 to reverse direction. As illustrated below, a data group contains a set of logically related and/or arranged fields. Note that F7 only works for data groups that contain fill-in fields; not check box or option button fields.

-

- **To easily move from tab page to tab page**:
  - o Press the F5 key to move forward to the next tab page or Shift+F5 to reverse direction. You can keep the keys pressed to speed tab from tab page to tab page within the window you have open in CoPathPlus. Release the F5 key (and the other keys) when you arrive at the tab page you want.

  - o Click on the Next Tab button ◢ at the bottom, right-hand corner of each tab page, or tab to it and press the spacebar. This will move you forward to the next tab page in the window. On the last tab page, doing this will return you to the first tab page.

  To learn more about a tab and tab page, refer to "Tab".

- **To easily switch from open window to open window:** Press Ctrl+Tab to move forward to the next open window or Shift+Ctrl+Tab to reverse direction. You can keep the keys pressed to speed switch between all your open CoPathPlus windows. Release the Tab key (and the other keys) when you arrive at the window you want.

CoPathPlus provides you with access keys for many of its command buttons and shortcut keys for many of its menu commands.

NOTE: Menu commands are disabled when they are not applicable to what you are currently doing.

Using Access Keys

Many of the buttons in CoPathPlus have access keys. Access keys allow you to use the keyboard instead of the mouse, to execute commands while in a CoPathPlus window.

An access key is a combination of the Alt key and the underlined letter of a button. By holding down the Alt key, and then typing the underlined letter, you select the appropriate command. For example, by pressing Alt+S when you are on the Select Patient window, **Search** is selected.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Using Shortcut Keys

Shortcut keys are associated with menu commands and usually involve the use of the Ctrl key (though the Shift or one of the standard Function keys [e.g., F1, F2] can also be used) along with another key or character from the keyboard. Sample shortcut keys in CoPathPlus include: Ctrl+Tab to move from one open window to another, F5 to go to the next tab page, and Shift+F5 to go back to a previous tab page.

Shortcut keys display to the right of their pull-down menu commands on the menu bar. You can execute shortcut keys without having to display the pull-down menu, as long as the menu command is available (e.g., you cannot use the shortcut key Ctrl+V to paste something when there is nothing to paste [if you were to look, it would be disabled on the menu]).

Navigating with a Mouse

This guide assumes that you are using a two-button mouse with the left mouse button as the primary button. Therefore, when you are instructed to press something (e.g., an icon, a button), you should use the left mouse button unless otherwise noted. It also assumes that the default mouse pointer is an outline of a left-angled arrowhead.

This guide normally tells you how to do something by pressing a button or icon with the mouse. For example, you can use the mouse to access guide by pressing:

 or or

Where appropriate, both mouse and keyboard equivalents may be provided.

The following distinctions apply to the main mouse pointer (which can differ from workstation to workstation depending on how it was set up):

- To use a mouse to activate or "press" something (e.g., a button, an icon), you position the pointer over the item and press and release the left mouse button. Or, you may also have to double-click, in which case you would press and release the left button twice in quick succession over the item.

- To use the drag and drop maneuver to move an item, position the mouse pointer over the item, press the left mouse button and, while holding it down, drag the item (move the mouse pointer) somewhere else on the screen, and then drop the item (release the button) where you want it to appear.

    Within CoPathPlus, during this drag and drop maneuver the mouse pointer will change to reflect an appropriate image. For example, when you use drag and drop to add something to your Personal Menu list, the pointer changes to a hollow rectangular box. See Left Side of the Application Manager (Personal Menu) for information on the Personal Menu list. In another example, when you use the mouse pointer to re-order multi-row fields, the pointer changes to a double arrow, one facing up and the other facing down with the arrows separated by two horizontal lines. See Re-Ordering Rows on a Multi-Row Control for an example of this pointer.

- When you click the mouse pointer within a field, an I-beam cursor appears. This cursor moves as you type.

- The mouse pointer appears as the symbol for "no" when, while performing a drag and drop maneuver, you try to drop on a spot on the screen that will not accept it.

- The mouse pointer turns to an hourglass ⧗ to let you know that the system is working on the task that you instructed it to perform (e.g., Save).

Navigating with a Light Pen

You can also use a light pen to navigate within CoPathPlus. Refer to the documentation provided when you purchased this instrument to learn how to use a light pen as a pointer.

NOTE: The system only accepts light pen activity as a navigating and/or selection tool. You cannot enter text using a light pen.

How Do I Access CoPathPlus?

This topic describes:

- Signing on to CoPathPlus
- Exiting CoPathPlus

Signing on to CoPathPlus

Perform these steps to sign on to CoPathPlus:

1) Power up your workstation and access Windows.

2) Double-click on ▨ on your desktop or in the CoPathPlus program group (or wherever you may have this icon).

3) Enter your user ID and password on the CoPathPlus Sign-On window, and press **Sign On**.

   NOTE: You may also be required to enter a Workstation Group in addition to your ID and password. This is often used with Thin Client environments. After the first time you enter a Workstation Group, the group previously selected will be offered as a default. Select your workstation group from the Workstation Group drop-down list field. For more information, including the appropriate group to select, see your system manager.

The Main CoPathPlus Window and Application Manager appear. If you enter either your user ID or password incorrectly, an error message appears instead. Try again. After five unsuccessful attempts to sign on, CoPathPlus automatically exits you from the CoPathPlus Sign-On window. All failed sign-on attempts appear on the Failed Sign-On Attempts report.

Note: Your system may also be setup to disable a workstation after a specified number of signon attempts. You will receive a notification if this occurs.

See Main CoPathPlus Window and Application Manager to learn more about these CoPathPlus features.

NOTE: Your user ID and password were set up by your site's CoPathPlus System Manager. You should contact your System Manager if you are unable to sign on to CoPathPlus using your designated user ID and password. Your site may also have other security measures in place (e.g., your site may require you to also sign on to the network before you can access Windows).

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Exiting CoPathPlus

Perform these steps to exit CoPathPlus:

1) Press ![exit icon] on the toolbar and the Exit CoPathPlus message box appears.

2) Press **OK**. Note that another message box can appear if you have not already performed a save function on any item that you may still have open.

   NOTE: There are other methods that you can use to exit CoPathPlus (e.g., from the menu bar or standard Windows methods for exiting an application) and you can use any of them as you prefer.

What is the CoPathPlus Environment Like?

This topic gives you an overall introduction to the CoPathPlus environment. If you are familiar with the Windows environment, you will see that CoPathPlus is very much a Windows-based application. Features described include:

- Main CoPathPlus Window

- Application Manager

- CoPathPlus Windows

- CoPathPlus Controls

- CoPathPlus Data-Entry Fields

- Zoom Command

- System Messages

- Windows Features

- Other Features

Main CoPathPlus Window

The Main CoPathPlus Window is the first window that you see after you sign on to the system. It is the window that reads "CoPathPlus" in the title bar and always appears, whether or not it is the active window. The Main CoPathPlus Window has the menu bar and the toolbar, both of which can change to reflect the available menu groups or tools for whichever CoPathPlus item you may have open. All other windows sit on top of the Main CoPathPlus Window.

The following illustration shows the Main CoPathPlus Window with its major components labeled.
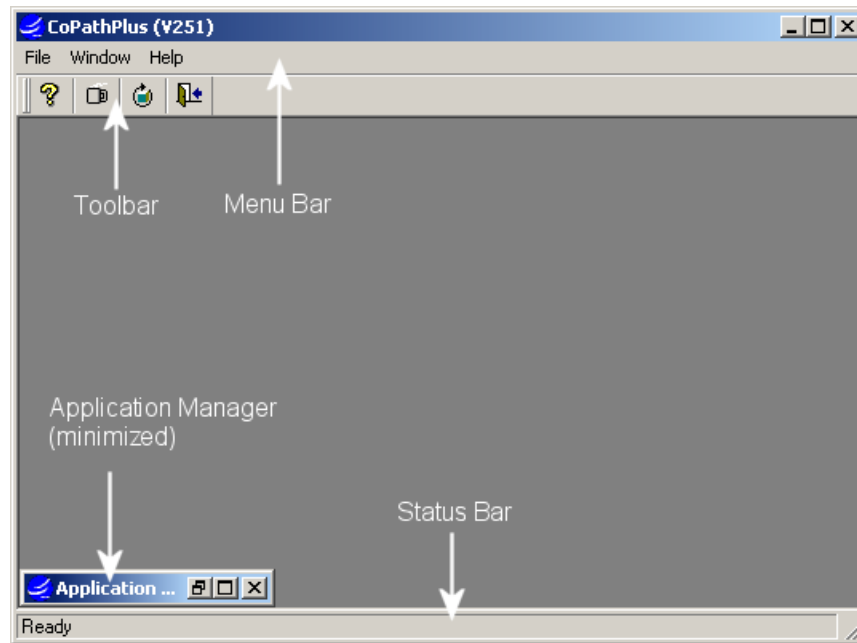
Menu Bar

The menu bar contains logically grouped commands that you can use to access CoPathPlus items and common Windows commands. The menu bar changes to reflect the appropriate menus for the item or command you have chosen.

For example, when you first enter CoPathPlus, the menu bar reads File, Window, and Help. However, once you activate the Specimens command, the menu bar changes to File, Edit, Options, Window, and Help.
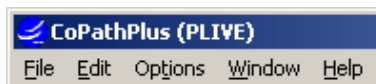
Also, when you open a menu from the menu bar, you will notice that only appropriate commands are available for whichever window you currently have active; inappropriate menu commands are disabled. Commands may be disabled when they are unavailable for the current activity or when the user does not have explicit permission to them. For example, on the Edit menu, the Cut and Copy commands are disabled if you do not have some text highlighted.

Most of the menus and commands should be familiar to anyone accustomed to the Windows environment. However, several menus, such as the Options menu, are unique to CoPathPlus.

NOTE: Other CoPathPlus-specific menus and Menu bar commands are described in the help topic for the feature in which they are utilized.

CoPathPlus File Menu Highlights

When you have only the Application Manager open on top of the Main CoPathPlus window, the File menu has five commands. The following is an example:
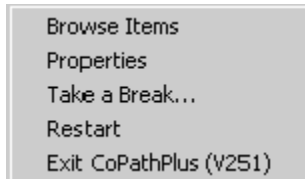
File, Browse Items lets you bring up a list of all the items the person currently signed on to the system can access in CoPathPlus. See Right Side of the Application Manager (Messages) to learn more about File, Browse Items.

File, Properties lets you change certain properties of the items that you list in your Personal Menu (the left side of the CoPathPlus Application Manager). See Left Side of the Application Manager (Personal Menu) to learn more about File, Properties.

File, Take a Break lets you leave your workstation without exiting the item you are currently in and without shutting down CoPathPlus. It also prevents others from accessing CoPathPlus using your user ID when you are away from your workstation. For more information, refer to "Taking Breaks and Time Out".

File, Restart lets you sign out and immediately sign back on to CoPathPlus. This is useful when there is a shift change or several users share one common PC.

NOTE: Using the Restart command does not localize the CoPathPlus application on your workstation.

File, Exit CoPathPlus lets you exit the CoPathPlus application.

The commands available from the File menu vary depending on where you access the menu. The two examples below show the commands available when you access the File menu from a specimen-related activity and from the Registration Entry/Edit item. File menu commands that are unique to an activity or item are described in the guide for that activity/item. Notice that both of the examples below include a command to bring the Application Manager forward (File, Manager or F2).

File Menu for a Specimen Related Activity
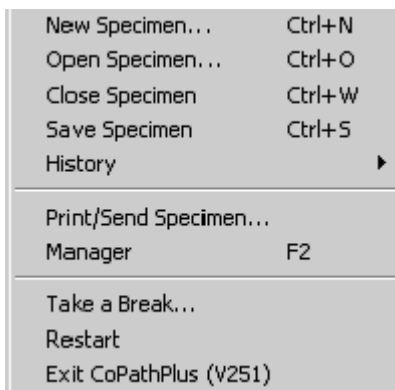
File Menu for the Registration Entry/Edit Window on an existing patient
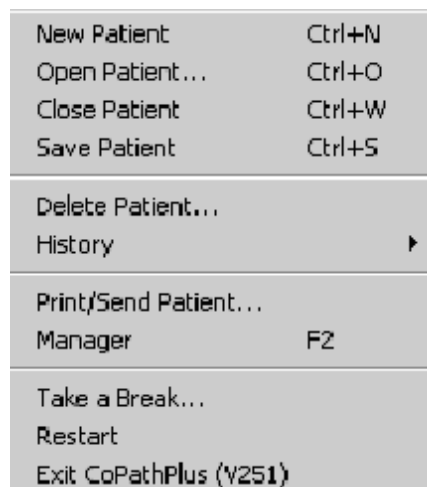
New Specimen/Patient allows you to create a new record in the specimen or demographic file.

Open Specimen/Patient allows you to search for an existing specimen or patient.

Close Specimen/Patient closes the open record currently in focus.

Save Specimen/Patient saves changes made to the current record.

Delete Patient allows the user to delete a patient record if that patient has no active encounters or associated specimens.

History allows you to view the history of data values posted to a specific field in the specimen or demographic as long as that field is activated for audit trailing.

Print/Send Specimen/Patient allows you to print the record.

Take a Break lets you leave your workstation without exiting the item you are currently in and without shutting down CoPathPlus. It also prevents others from accessing CoPathPlus using your user ID.

Restart will shut down and restart CoPathPlus without searching for system updates.

Exit CoPathPlus will shut down the system.

Edit Menu Highlights

The Edit menu contains general editing and CoPathPlus-specific editing commands. When in a CoPathPlus field that allows editing, you can call up the Edit menu by clicking on the menu name, or by pressing Alt+E, or by pressing the **right** mouse button. Once the Edit menu appears, you can select an Edit command by clicking on it. After you click on the command you want, the Edit menu list disappears.

Undo	Ctrl+Z
Cut	Ctrl+X
Copy	Ctrl+C
Paste	Ctrl+V
Clear	Ctrl+Del
Prior Tab	Shift+F5
Next Tab	F5
Prior Group	Shift+F7
Next Group	F7
Delete Fee Code	Ctrl+D
Add Fee Code	Ctrl+A
Move Fee Code Up	Shift+F6
Move Fee Code Down	F6
Date and Time	▶
Lookup...	F8
Zoom...	Shift+F8
Quick Fill...	F9

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

The Edit menu on the menu bar contains the following CoPathPlus-specific commands. (The Edit menu accessed via the right mouse button contains a subset of these commands plus some additional commands.)

Prior Tab, Next Tab, Prior Group, and Next Group. To learn about these commands, refer to "Navigating with the Keyboard".

Delete..., Add..., Move... Up, and Move... Down. To learn about these commands, refer to "Re-Ordering Rows on a Multi-Row Control". Notice that the exact command names depend on what field your cursor is currently on. In the above illustration, the cursor is in the Fee Code(s) field.

Date and Time. To learn about the commands found here, refer to "Date/Time Fields". Note that this menu command is only available when your cursor is currently in a date/time field.

Lookup... To learn about this command, refer to "Lookup Window".

Zoom... To learn about this command, refer to "Zoom Command".

Quick Fill... To learn about this command, refer to "Quick Fill Fields".

Options Menu Highlights

The Options menu is unique to CoPathPlus.

This menu has the following commands:

Activities. . . lists the available activities for the current patient/specimen.

Other Specimens displays a report that lists the other specimens for the current patient, along with relevant specimen information.

Patient Report Single Print prints any of the following reports, if present, for the selected patient and specimen: Final Report, Working Draft, Procedure/Addendum Report. For more information about this activity, refer to "Patient Report Single Print".

Edit Text opens a Microsoft Word document where you can enter and edit diagnostic text (e.g., clinical history) for the text types available in the current specimen activity. This command is enabled only for sites using Microsoft Word as the CoPathPlus text editor. This command is disabled if the current activity is set up to use Edit Report mode (see below) instead.

Edit Report opens a Microsoft Word version of the Final Report for this specimen. You can edit data in the diagnostic text fields that are applicable for the current specimen activity, but you cannot edit non-diagnostic information (e.g., patient name, client). This button is enabled only for sites using Microsoft Word as the CoPathPlus text editor. This command is disabled if the current activity is set up to use Edit Text mode (see above) instead.

For more information about using Microsoft Word to edit diagnostic text fields, refer to "Using Microsoft Word to Edit Diagnostic Text Fields".

Specimen Activities

The Specimen Activities menu (shown) allows you to switch from one activity to another for the same specimen without having to return to the Select Specimen window. The activities you can switch to depend on your security access and also what activities may be relevant for the current patient/specimen. To learn about activities in CoPathPlus, refer to "Accessing Specimen-Related Activities".
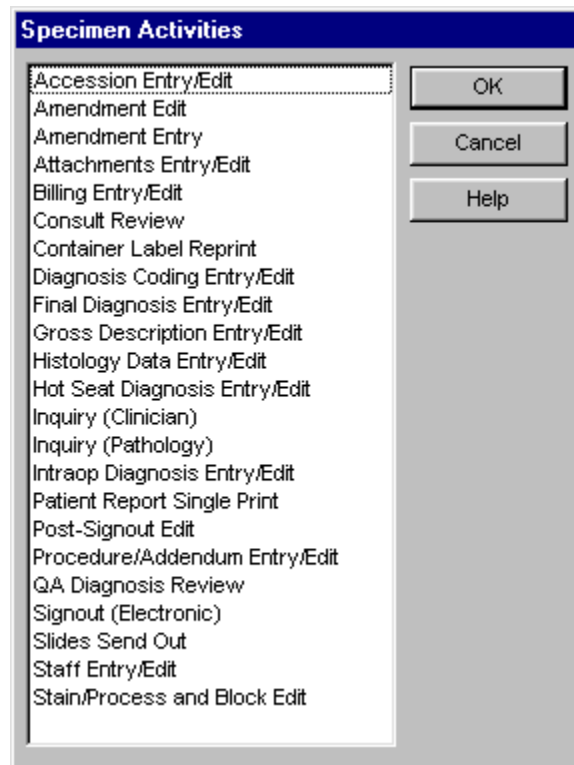
Other Specimens

The **Other Specimens** selection allows you to view a report that lists all of the other specimens for the current patient, if available. This report presents relevant specimen information. To learn about the Other Specimens (OSP) command, refer to "Viewing Other Specimens for a Patient (OSP)".

The following is an example of the Others Specimens window.

You can also press on the toolbar or the F4 key to call up the OSP window. If there are no other specimens for the current patient, this button is disabled.

Window Menu Highlights

Besides the standard Windows commands on the Window menu, you can use this menu to switch to any CoPathPlus window that you may have open. A list of all your open windows appears at the bottom of the Window menu. Because you must return to the Application Manager to open a new CoPathPlus window, the Application Manager command is always in the first position. You can also use the Ctrl+Tab shortcut key to switch between your open windows. See Navigating with the Keyboard to learn about this and other shortcut keys you can use in CoPathPlus.

An example of the Window menu is shown below.

Help Menu Highlights

The Help menu on the menu bar contains these CoPathPlus-specific commands:

- Contents

- Current Window

- Tips

- Context Help

Toolbar

All CoPathPlus windows have a toolbar that contains buttons that allow you quick access to common operations for the window that is currently open. The toolbar also provides a method to get help on your current window. The toolbar must be used with a mouse.

All toolbar options are also available through the menu bar.

As you access CoPathPlus items, the toolbar changes to display buttons for commands and options that are applicable for working in each window. The following illustration shows the full standard CoPathPlus toolbar with each button labeled. You press the appropriate button to:
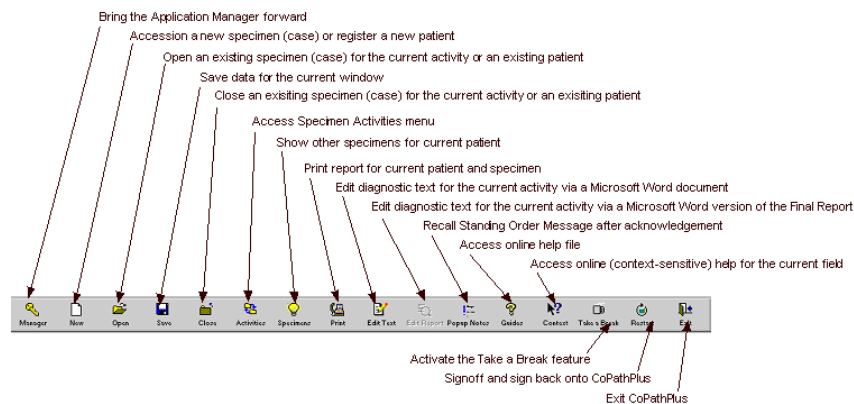
NOTE: The Edit Text and Edit Report buttons do not appear for sites using TxText as the CoPathPlus text editor.

The toolbar can also be displayed as picture only. When in this state, you can hold your mouse pointer over a button (without pressing it) to reveal an identifying label "floating" over each button. Also, a description for each button appears in the status bar area.

To display or hide the text labels on the toolbar:

NOTE: The toolbar appears as picture-only when you first access CoPathPlus.

1) Click once anywhere on the toolbar with the **right** mouse button and a drop-down list box appears.

2) Click on the Show Te<u>x</u>t command (which toggles on or off with each click). A check mark next to this command means that picture and label will appear on the toolbar buttons. No check mark means picture only.

3) The drop-down list also allows you to change the location of your toolbar. Once you set this location, the toolbar will stay there each time you access CoPathPlus until you change it again.

Status Bar

The status bar displays the following information:

- A short description for the toolbar button on which the pointer is currently positioned.

- System messages to keep you informed as to the state of the system (e.g., an appropriate message appears after you activate the Save command, so that you know the system is saving your data).

Application Manager

When you first access CoPathPlus, the Application Manager will be open on top of the Main CoPathPlus Window. The Application Manager serves as the gateway to all the commands and items within CoPathPlus. It contains the command buttons, the Personal Menu list, and an area that serves as a menu for the **Reports**, **Tasks**, **Dictionaries**, and **Setup** command buttons. When you select <u>F</u>ile, <u>B</u>rowse Items from the menu bar, a list of all the items the person currently signed on to the system can access in CoPathPlus appears on the right side of the Application Manager. The right side of the Application Manager also displays system-wide broadcast messages from the Application Manager Message Maintenance function when appropriate. When you first enter CoPathPlus, this area is labeled "Messages".

The combination of the Application Manager open on top of the Main CoPathPlus Window make up the "home base" from which you access the various commands and items within CoPathPlus. The Application Manager can be left open or minimized.

Main CoPathPlus Window

Application Manager
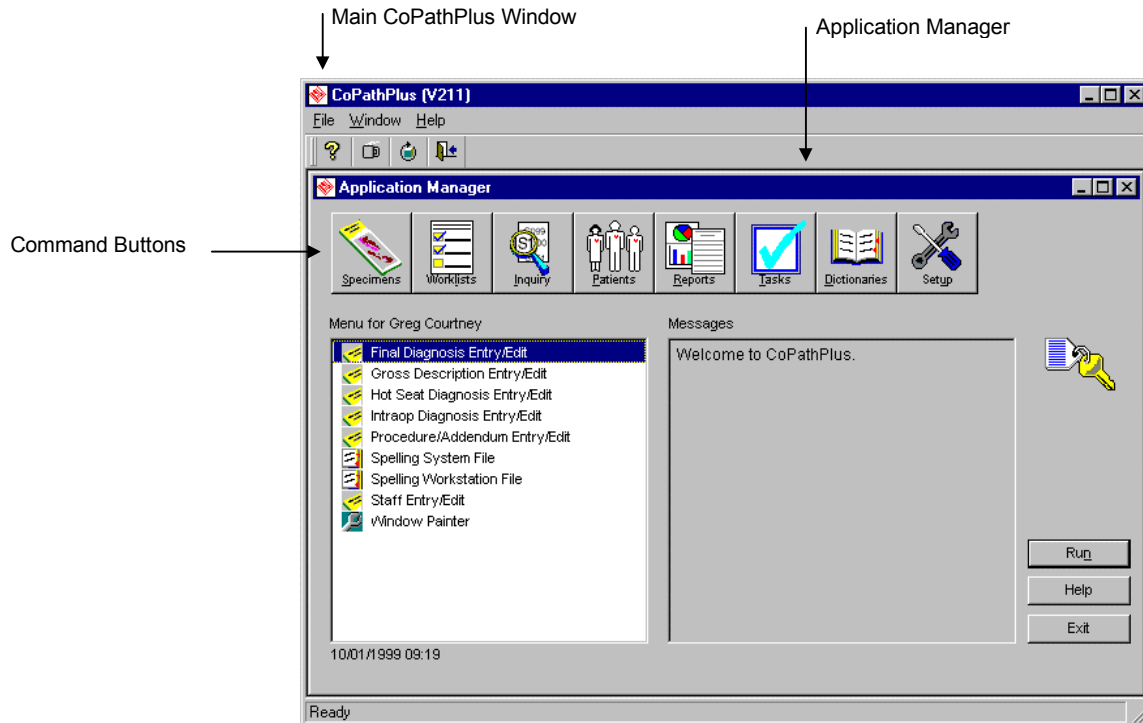
Command Buttons

Press on the toolbar to quickly access the Application Manager from any window.

Command Buttons

The command buttons on the Application Manager allow you to access the items available within CoPathPlus with the quick click of a mouse or other pointing device.

You press the appropriate command button to:

Perform any specimen related activity

Review or update Worklists

Check on a specimen status or print a report

Register a Patient

Access CoPathPlus Management Reports

Access Department-wide or utility functions

Access the CoPathPlus tables that define the system

Access System Manager functions

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

NOTE: Your System Manager is able to restrict your access to the **Specimens**, **Worklists**, **Inquiry**, and **Patients** command buttons. If you do not see one or all of these buttons, you do not have authorization to access the items within them. The **Reports**, **Tasks**, **Dictionaries**, and **Setup** command buttons will always be visible; however, your access to the folders within them may be restricted. If you do not have access to a particular button or item that you need, speak to your System Manager. For more information on security controls in CoPathPlus, refer to "Security" and the "People/Security Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Notice also that you can use access keys to "press" a command button. For example, you can press Alt+S to activate the **Specimens** command button.

Folders and Items

Besides the toolbar and command buttons, the Application Manager also serves as the menu area where you go to view and activate the folders and items found in the CoPathPlus system.

Folders contain logically grouped items, like specimen activities, dictionaries, and tools. Items are the individual CoPathPlus programs that you use to process and manage your anatomic pathology information. Items do not necessarily need to reside within a folder. For example, the Left Side of the Application Manager (Personal Menu) will probably contain many items that you use often, but no folders are allowed here. Some folders can contain additional folders as well as items. CoPathPlus represents each folder with a folder icon to the left of its label. Each item also has a representative icon to the left of its label. Similar items share the same icon. For example, all the CoPathPlus dictionaries use the same dictionary icon.

Like the command buttons, the folders and items you see when you are signed on to the system depends on the system permissions associated with each person. The CoPathPlus System Manager sets up system permissions.

Left Side of the Application Manager (Personal Menu)

The left side of the Application Manager contains your Personal Menu list. Use it as the place to store the CoPathPlus items that you use frequently. You can arrange each item in your Personal Menu list as you want.

Setting Up Your Personal Menu List

Perform these steps to set up your Personal Menu list.

NOTE: The Personal Menu label will be person-specific. For example, when Greg Courtney signs on to the system, the Personal Menu label will read "Menu for Greg Courtney".

1) List the item or items you want on the right side of the Application Manager (i.e., the Messages area).

   You can view a list of all the items in CoPathPlus that you can add to your Personal Menu by selecting File, Browse Items from the menu bar. The list appears on the right side of the Application Manager.

2) Use drag and drop to place each item you want into your Personal Menu list. See Navigating with a Mouse to learn more about drag and drop.

TIP! You can also place the following commands on your Personal Menu by dragging and dropping the command button: **Specimens**, **Worklists**, **Inquiry**, **Patients**.

NOTE: Although the Inquiry activities can be added to your Personal Menu from the **Inquiry** command button, they may not be added from the **Specimen** command button. This is because the Inquiry item accessed via the **Specimen** command button locks a specimen, while the **Inquiry** accessed via the Inquiry command button does not lock the specimen.

You can rearrange the items in your Personal Menu list by using drag and drop within the Personal Menu. You can also take an item off your list by dragging and dropping it outside the Personal Menu list. When you do this, you will be asked to confirm that you want the item removed from the list.

Customizing Your Personal Menu List

You can customize the items that you place in your Personal Menu list. By highlighting an item in your list and then selecting <u>F</u>ile, <u>P</u>roperties from the menu bar (or pressing the right mouse button), you are presented with the following Define Personal Menu Properties pop-up window. The following illustration shows such a window for the Final Diagnosis Entry/Edit activity in CoPathPlus.
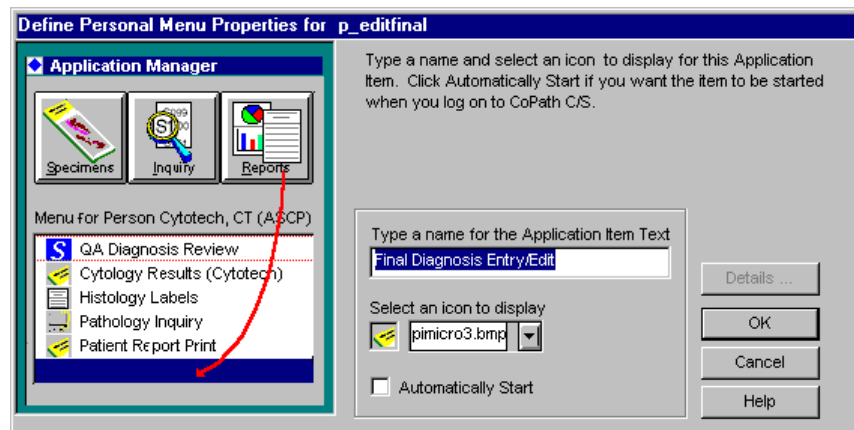
From this window you can:

- Change the standard name of the item in your Personal Menu list by typing in an alternative name in the Type a name for the Application Item Text field and pressing **OK**.

    NOTE: This will change the name of the item in your Personal Menu list only. It will not change its name elsewhere in CoPathPlus.

- Change the icon associated with the item by choosing another one from the drop-down list in the Select an Icon to Display field and pressing **OK**.

- Allow an item to automatically launch when you first enter CoPathPlus by marking the Automatically Start check box.

This window also has a **Details...** button that allows you to identify a specific item within a command which you want to add to your Personal Menu. For example, if you place the Worklists command on your Personal Menu list, you can choose specifically which worklist you would like to access from your Personal Menu.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

To add an item to your personal menu:

1) Click and hold down the left mouse button on the **Worklists** command button and drag it to your Personal Menu. You will then see Worklists on your Personal Menu. If you leave it as is and double-click on it, CoPathPlus presents you with the Select Specimen from Worklist window on which you must specify which worklist you want to access.

2) To customize the Worklists command so that you access a specific worklist, highlight Worklists in your Personal Menu list, select File, Properties from the menu bar, and then press **Details....** The Menu Details pop-up window appears. The following is an example:
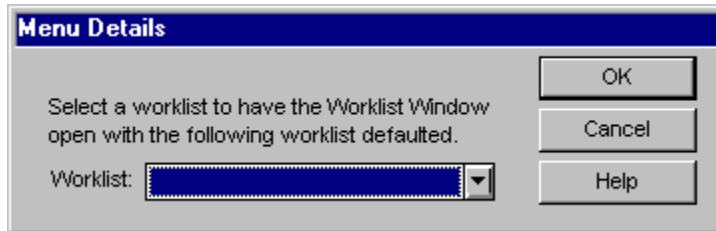
3) Choose the worklist you want to access from your Personal Menu list from the drop-down list and then press **OK**. CoPathPlus changes the name of the item in your Personal Menu list from Worklists to the specific worklist name (e.g., Additional Transcription).

Now when you highlight the worklist in your Personal Menu list and press **Run** (or just double-click on the worklist), CoPathPlus accesses the Select Specimen from Worklist window with the:

- Name of the selected worklist in the Worklist field,

- Name of the associated activity in the Activity field, and

- Specimens in that worklist listed in the Select field.

NOTE: For person-specific worklists (e.g., Pathologist Signout), CoPathPlus initiates the search by entering the person signed on in the Staff field on the Select Specimen from Worklist window. If the user signed on has no specimens to be signed out, a message stating so will appear.

Also the **Details...** button is only available when you have added the **Specimens**, **Worklists**, or **Inquiry** command button to your Personal Menu.

Right Side of the Application Manager (Messages)

The box on the right side of the Application Manager initially serves as a message service. Messages sent to all or specified CoPathPlus users via the App Manager Message Maintenance feature display in this area following signon to CoPathPlus. When the Application Manager options of **Reports**, **Tasks**, **Dictionaries**, or **Setup** are selected, the respective menu items for each of these command buttons will then display in this area. In addition, when you select File, Browse Items from the menu bar, a list of all the CoPathPlus items available to you appear on this side of the Application Manager. You can add items from any list to your Personal Menu by using the drag and drop maneuver.

NOTE: With the list of available items displayed, you can quickly get to a specific item by typing the first letter of that item. CoPathPlus brings you to the first item that starts with that letter. For example, if you press the **Dictionaries** command button, the list of all dictionaries in CoPathPlus will appear on the right side of the Application Manager. To get to the Interpretation dictionary, type the letter **I**. CoPathPlus brings you to the first item that starts with the letter I (in this instance, the ICD-9-CM Code Dictionary), from which you can either arrow

down to the Interpretation dictionary item or keep pressing the letter **I** until you get to the correct item. This feature also works on the left side of the Application Manager (your Personal Menu list).

Note that this area on the right side of the Application Manager is labeled "Messages" when you first enter CoPathPlus. However, the label for this area changes depending on what command button has most recently been selected.

CoPathPlus Windows

CoPathPlus is presented through a series of windows. Your primary means of interaction with CoPathPlus comes about through your use of the keyboard or mouse (or other pointing device) on its various windows. This section explains the two main types of windows in CoPathPlus: primary and pop-up. Primary windows comprise your entire screen, while pop-up windows appear exactly as they sound—they "pop up" on top of a primary window.

Note: Some CoPathPlus window displays may be slightly truncated in Windows XP. To eliminate this display problem, set your workstations to use the Classic Theme display. To do this, from the Control Panel, select Appearances and Themes, and then select Change the computer's theme. A Display Properties window will display. On the Themes tab, select Windows Classic as the Theme.

Primary Windows

Primary windows are your main means of interaction with CoPathPlus. You enter information on these windows while performing the major functions of the system (e.g., registering a patient, entering a Final Diagnosis). Examples of primary windows include the:

- Main CoPathPlus window
- Registration Entry/Edit window
- Final Diagnosis Entry/Edit window
- Accession Entry/Edit window
- Any CoPathPlus dictionary window

The majority of CoPathPlus is comprised of primary windows. Some primary windows are site-tailorable. This means that each site can modify its primary windows to fit its workflow. If sample windows in this guide do not match what you see on your workstation, this means that they were site-tailored during the CoPathPlus implementation process.

Note: If you have a mouse with a scroll wheel, you can press the CTRL key and move the scroll wheel to make the text in some of the windows larger or smaller. This is a standard feature of Microsoft Windows.

Pop-Up Windows

Pop-up windows provide two main functions:

- A means of accessing a primary window (e.g., Select Specimen window)
- A means of providing data that is supplemental to a primary window (e.g., Detail pop-up window)

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

There are three types of pop-up windows in CoPathPlus that are distinguishable by what actions you can or cannot perform while the window is open.

The first type of pop-up window must be addressed before you can continue with your task. When this type of pop-up window is active, you cannot work on another window or access the toolbar. An example of such a pop-up is a message box. Messages must be addressed and cleared from your screen before you can continue with your task.

The second type of pop-up window allows you to continue working on the window behind it while the pop-up window stays on your screen. It need not be addressed and will not prevent you from continuing with your task. An example of such a pop-up is the Detail pop-up window on both the Select Specimen and Select Patient windows. The Detail pop-up window provides you with additional information on either the specimen or patient you have highlighted.

The third type of pop-up window prevents you from continuing work on the window behind it, but does allow you to access the toolbar at the top of your screen to access other items. An example of such a pop-up is the Select Patient window.

To learn more about the specific attributes of a window, refer to the documentation you received when you purchased Microsoft Windows.

CoPathPlus Controls

Each window in CoPathPlus, whether primary or pop-up, contains certain controls (i.e., screen elements), which are illustrated below.

NOTE: The only controls not illustrated below are the drop-down list and combo box fields. These are explained later in this topic.
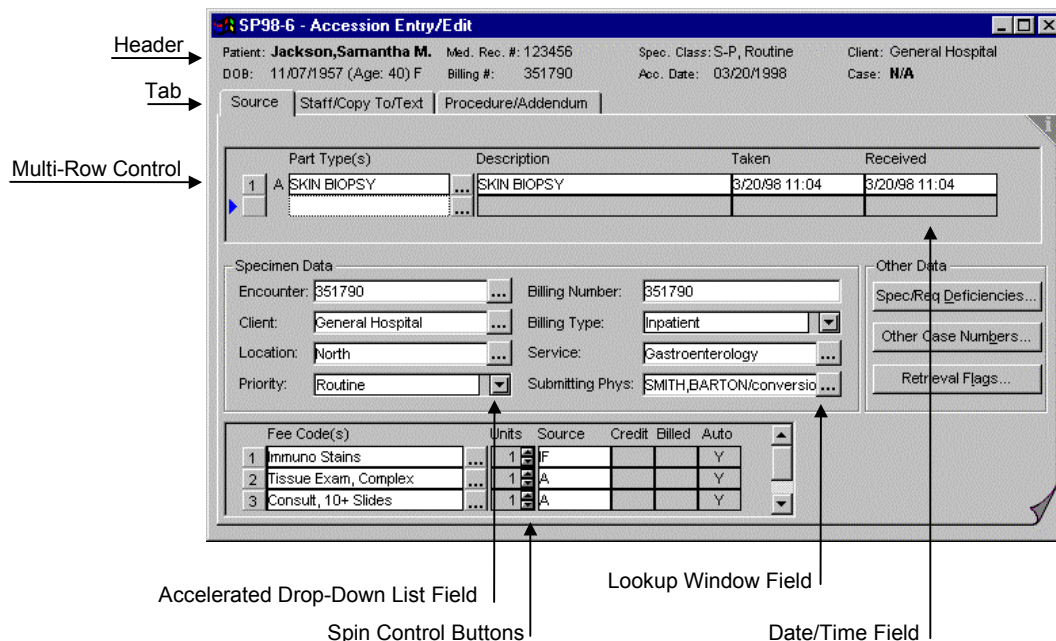
Understanding the attributes for each of these controls will make it easier to understand and navigate through CoPathPlus.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Header

A header displays certain demographic and medical data on a specimen and/or patient. This data, which cannot be edited, is always in view when you are in a CoPathPlus window that has tabs (except when you are registering a new patient or editing registration data for a current patient). A header can display a combination of patient, registration, and specimen information, such as patient name, Medical Record Number, specimen class, specimen number, billing number, etc., during specimen-related activities. Data within a header may (or may not) be updated immediately when you change a field that is linked to a corresponding field in the header area (e.g., you edit the billing number).

Header information will appear between the title bar and the tab row (as illustrated below in the partial view of the Accession Entry/Edit window). The header will also appear across all tabs for the activity. For example, in the Accession Entry/Edit window, the header area will appear regardless of which tab (e.g., Source) is active.
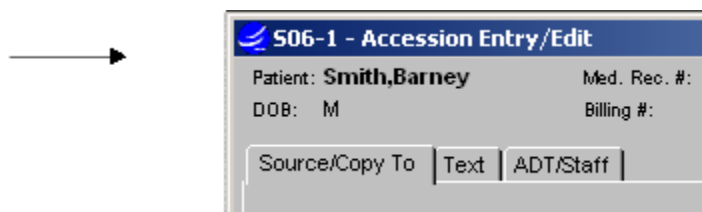
Because of space considerations, the header can contain no more than two lines of data, and data that is longer than allowed for a header field will truncate. When data has not been entered for a header field, the field will be blank.

Tab

A window tab (not the Tab key on a keyboard) presents a set of fields grouped logically and conveniently on a "page". An outline of a CoPathPlus tab page resembles the outline of a tabbed index (or divider) page. You click on the tab to move from page to page. Or you can use these shortcut keys to navigate between tab pages:

- Press F5 to move to the next tab page or press Shift+F5 to move to the previous tab page.

- Click on the Next Tab button at the bottom, right-hand corner of each tab page, or tab to that button and press the spacebar. This will move you forward to the next tab page in the window. On the last tab page, doing this will return you to the first tab page.

For example, the Accession Entry/Edit window for a Surgical Procedure-Only specimen has three tab pages: Source, Staff/Copy To/Text, and Procedure/Addendum. Each tab contains logically grouped fields pertinent to its tab title. The following illustration shows the Accession Entry/Edit window with the Source tab active.

Note the following about navigating with the Tab key while on a tab page:

- You can use a mouse pointer or press the Tab key to move from field to field.

- Typically, the cursor moves from left to right, top to bottom when you press the Tab key. Continuous tabbing will recycle the cursor back to the top of the tab page.

- You can use Shift+Tab to move in the reverse direction. Note that for a boxed group of fields, Shift+Tab brings the cursor to the first field within a group. Therefore, if you want to go to the second field within a boxed group of fields, and you used the Shift+Tab to return to the group, you will then need to tab forward to the field you want within that group.

Accelerated Drop-Down List Field

An accelerated drop-down list is a time- and keystroke-saving feature that is linked to an appropriate dictionary. Accelerated drop-down lists are used for fields in which there will not be a large number of entries to choose from. You can identify an accelerated drop-down list field by the appearance of a downward-facing arrow separated from the far right of the field by a small gray space. To view the dictionary entries available for this type of field, click on the accelerated drop-down list arrow (or, with your cursor within the field, press the Alt+Down Arrow keys).
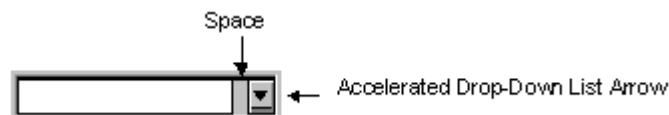
As you type in one of these fields, any dictionary entry that matches what you typed appears in the field. Anything you enter in an accelerated drop-down list field must match an available entry; otherwise, you get an error message when you try to move to another field.

For example, the Country field on the Registration Entry/Edit window is an accelerated drop-down list field. When you type "c", the first country that begins with "c" (e.g., Canada) automatically appears in the field. If "Canada" is what you wanted, you can tab to the next field and continue entering information. If it is not, you can continue typing until there is a match, or you can click the accelerated drop-down list arrow to see the list of available entries.

NOTE: A lookup value for a dictionary entry cannot be used to call up that entry in an accelerated drop-down list field.

Refer to the *Cerner CoPathPlus Dictionary Building Manual* to learn more about dictionaries.

Drop-Down List Field

A drop-down list is a simpler version of an accelerated drop-down list and it is also a time- and keystroke-saving feature. A drop-down list is not linked to a dictionary and can produce one of two types of lists:

Hardcoded List. The choices for this type of drop-down list are hardcoded into the CoPathPlus system and cannot be changed without programmer intervention. The Gender field on the Registration Entry/Edit window is an example of a hardcoded drop-down list field. On the standard CoPathPlus system, it contains the following entries: Female, Male, and Unknown.

Associated List. Choices on an associated list are provided by and linked to another field that must be entered first. For example, (in the standard CoPathPlus system) on the Histology tab of the Histology Data Entry/Edit activity, you normally designate blocks first. Then you select a stain/process, which you also have to associate with a block. The choices for the Blk/Desig (Block/Designation) field that is adjacent to the Stain/Process field appear because you designated the blocks first. If you were to select a stain/process, without having designated the blocks first, the list for the Blk/Desig drop-down list field would be empty.

You can only use choices from the list for a drop-down list field.

You can identify a drop-down list field by the appearance of the downward-facing arrow directly to the far right of the field. Unlike the appearance of the accelerated drop-down list arrow, there is no gray space between the field and the drop-down list arrow. To view the entries available for this type of field, you click on the drop-down list arrow (or, with your cursor within the field, you press the Alt+Down Arrow keys).

1
Blocks designated in this
field (1) produced this list
of drop-down list field
choices (2).

2
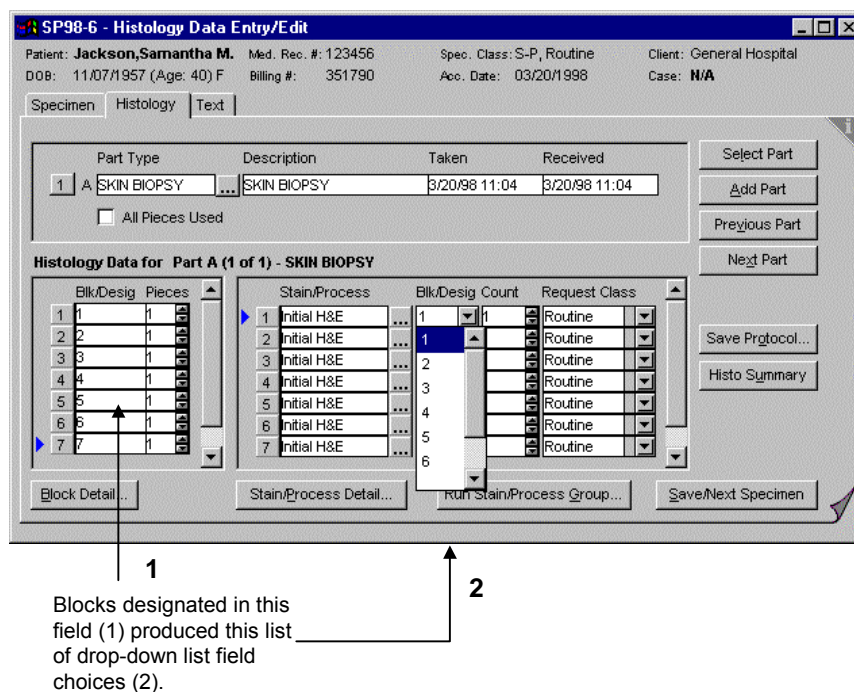
The first letter you type in a drop-down list field brings up the first entry that matches the letter. The second letter you type brings up the next entry that begins with the letter you just typed. For example, if you type "a," the first "a" entry appears. If this is what you want, you can tab to the next field, or you can click the drop-down list arrow to see the list of available entries that begin with "a". If you type "a" twice, it brings up the second "a" entry (if there is one). If you type "a" three times, it brings up the third "a" entry (if there is one), and so forth. Note that if you type "a" and then "t" the system brings up the first "a" entry, then the first "t" entry, it does not bring up the first "at" entry.

NOTE: A lookup value for a dictionary entry cannot be used to call up that entry in a drop-down list field.

Refer to the *Cerner CoPathPlus Dictionary Building Manual* to learn more about dictionaries.

Combo Box Field

Unlike the accelerated drop-down list field (which accepts only dictionary-related entries) and drop-down list fields (which accept only hardcoded or associated lists), the combo box field is the only field in CoPathPlus that accepts either dictionary-related entries or free-text data. Though found infrequently in CoPathPlus, the combo box field is very useful and convenient in the few places where this type of field is acceptable. For example, the Postal Code field in the Registration Entry/Edit window is a combo box field, as is the Requested By field on the Summary tab in the Slides Send Out activity.

In a combo box field, you can insert a dictionary entry (from a dictionary that is linked to the field) or enter a free-text entry that is not found in the associated dictionary. Regardless of whether you enter a dictionary entry or free-text, you can immediately tab to the next field and continue working (unless there is a validation check for entry of a particular data type, such as a numeric value).

You should be careful when using free-text entries since there are no checks for spelling or consistency.

You can identify a combo box field by the appearance of a bent arrow directly to the far right of the field. To view the dictionary entries linked to this type of field, you click the combo box field arrow (or, with your cursor within the field, you press the F8 key).
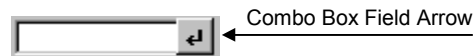
Combo Box Field Arrow

Refer to the *Cerner CoPathPlus Dictionary Building Manual* to learn more about dictionaries.

Lookup Window

A lookup window is a time- and keystroke-saving feature that deals with large amounts of dictionary data. With a lookup window field, you can insert data by:

- Entering the exact name of a lookup value for a dictionary entry.

- Making a selection after you perform a search through the specific dictionary.

Unlike accelerated drop-down and drop-down list fields, a lookup window field can accept a lookup value for a dictionary entry as both a data-entry and a search value. Any entry in this field type must match a selection from the specified dictionary.

You can identify a lookup window field by the appearance of an ellipses button at the far right of the field. To view the dictionary entries linked to this type of field, you click the lookup window ellipses button (or, with your cursor within the field, you press the F8 key).

Lookup Window Ellipses Button
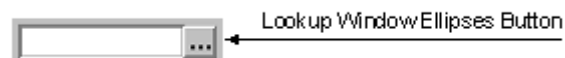
Unlike the accelerated drop-down list, drop-down list, and combo box fields, all of which present a list when you click on its appropriate arrow, when you click on the lookup window ellipses (or while the cursor is within the field, you select Edit, Lookup..., or press the F8 key) you are

presented with a window that lists all the entries that can be used in that field. From this lookup window you can either choose an entry that is listed or perform a search. See "How Data is Gathered for the Lookup Window" for more details.

Refer to the *Cerner CoPathPlus Dictionary Building Manual* to learn more about dictionaries.

How Data is Gathered for the Lookup Window

You can enter data into a lookup window field in one of three ways:

- Enter an Exact Match

- Enter a Partial Value

- Browse

Enter an Exact Match

You enter the exact name or lookup value of a dictionary entry (which is linked to the lookup window field) in the lookup window field.

- If there is one match, the system automatically inserts the appropriate value in the field. Then you can tab to or click on the next field.

- If there are multiple exact matches, the system presents you with a message to this effect. You must press the F8 key to call up a lookup window with a list of all the matches from which you can choose.

- If no match is found, an error message will be presented to this effect. Then you can press the F8 key to call up the lookup window and initiate a search through the linked dictionary.

Enter a Partial Value

If you do not know the exact name of a lookup value, you can enter a partial value to perform a search. Follow these steps (with the cursor inside the lookup window field):

1) Enter at least three characters of the partial value in the field and then select Edit, Lookup… from the menu bar or press the F8 key, to call up the Lookup window.

2) The Lookup window will display, as illustrated below, a list of entries that match the characters you just entered in the lower half of the window.
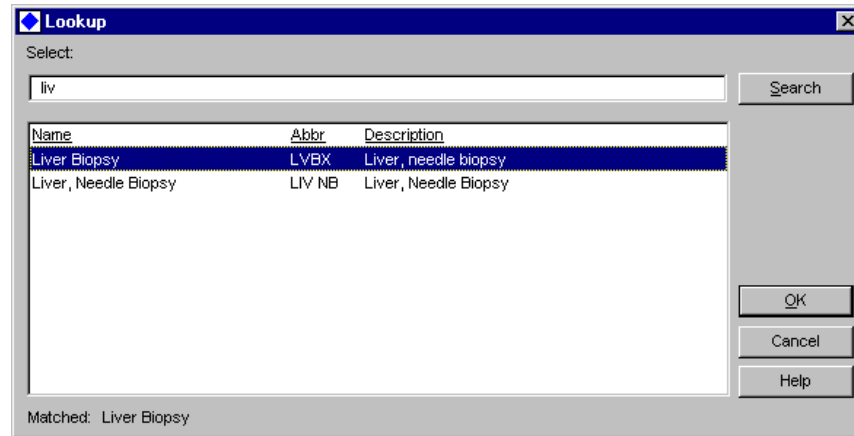
NOTE: Keep in mind that the more characters you use for the search, the faster CoPathPlus searches the database and the more refined the resulting search will be. Although you can enter one character, you will find it faster and more efficient to enter two to three characters or more to perform your search. Also, while most CoPathPlus dictionaries can be searched by entering at least one character, the ICD-9-CM, SNOMED International, SNOMED II, and Person dictionaries, which are quite large, require three characters to start a search. When you have lookup window fields linked to these dictionaries, you press the F8 key to call up the lookup window, enter at least three characters in the Select field on the lookup window, and then press the Enter key or **Search** to start a search.

If no matches are found, you will receive an error message, as illustrated below.
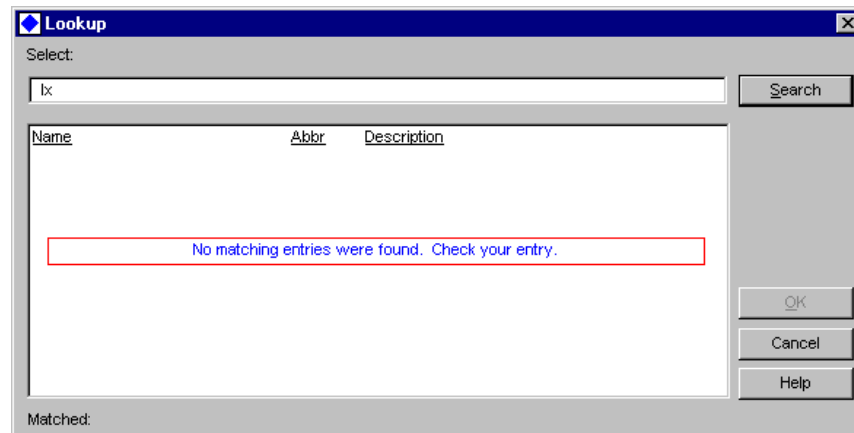
You can press **Cancel** to return to the field and try again, or you can delete the entry in the Select field on the Lookup window and press **Search**. The Lookup window will display a list of all the available active choices for the field in alphabetical order. Inactive choices (those that you cannot choose) will appear at the end surrounded by < and >.

3) Make a selection by highlighting it and pressing **OK** or double-clicking on the one you want.

Note that when you search on a partial value, the first matched (found) entry will appear in the "Matched:" field at the bottom of the window.

Browse

To browse all the entries that can be entered for a specific lookup window field, follow these steps (with the cursor inside the lookup window field):

1) Click the lookup window ellipses or press the F8 key. The Lookup window displays a list of all the available active choices for the field in alphabetical order. Inactive choices (i.e., those that you cannot choose) appear at the end surrounded by < and >.

   NOTE: Remember that the Lookup window fields linked to the ICD-9-CM, SNOMED International, SNOMED II, and Person Dictionaries work a little differently. Because these are very large dictionaries, you cannot perform a browse by just clicking the lookup window arrow or pressing the F8 key. When you have lookup window fields linked to these dictionaries, you press the F8 key to call up the lookup window, enter at least three characters in the Select field on the lookup window, and then press the Enter key or press **Search** to start a search.

2) Browse through the list that appears to find the entry you want. For some dictionaries this list can be very long. Make a selection by highlighting it and double-clicking on the one you want.

Performing a "Wild Card" Search

Perhaps you do not remember the exact dictionary entry name or you want to narrow a partial search. You can invoke two types of "wild card" searches on the Lookup window. Use the:

- Percent sign (%) to try to match any string of characters.
- Underscore character (_) to try to match any single character.

For example, suppose you want to look up all client entries that start with an "m" and have a "c" in their name. You would enter **m%c** in the Client field and press F8 or ⋯. The Lookup window for the client field would display, as illustrated below.
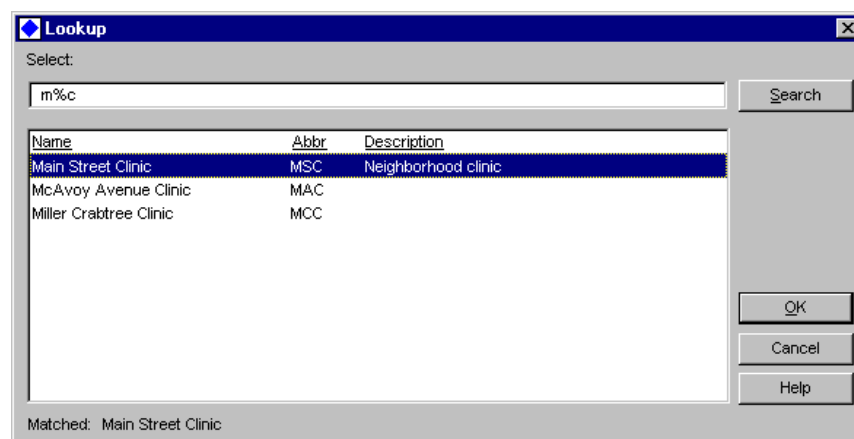
The following can then happen if CoPathPlus finds:

- **Only one match:** The matching entry appears in the list box. You can select it by pressing the Enter key or double-clicking on it.
- **Multiple matches:** The system presents you with a list of matching entries. Highlight the one you want, and then press the Enter key or double-click on your choice.

- **No match:** A message appears stating that no matching entries were found. Press **Cancel** to return to the field or try again by entering another value in the Select field.

Note that if a dictionary entry name contains one of the wild card characters, then to perform a literal search for that character, you must encase it in brackets in the wild card search criteria. For example, suppose you have a client called Davis%McCarthy Clinic. To do a wild card search for this client you could enter a search criteria of **%[%]%** to find any dictionary entry names that literally contain the one percent sign anywhere in the string.

Spin Control Buttons

Where appropriate, a numeric field can have spin control buttons, which increase or decrease the value in a field as you press a button. Spin control buttons appear at the right end of a field as stacked up (top) and down (bottom) arrows.

When you press the up arrow button, a numeric value will increase by one (0 is the default if there is no value already entered) and continue to do so as you click it again. When you press the down arrow button, a numeric value will decrease by one and continue to do so as you press it again. On the keyboard, you can type a greater than character (>) to increase a numeric value by one or a less than character (<) to decrease a numeric value by one.

Multi-Row Control

In CoPathPlus, a multi-row control allows you to list entries for a specified subject and to easily re-arrange the items in that list. A multi-row control typically has:

- A pointer, which is a small triangular arrow that indicates the row that is active or was last edited.

- A sequence number in front of each row. The sequence numbers allow you to easily re-order the rows by using the drag and drop maneuver with a mouse or through the Move Row Up (Shift+F6) and Move Row Down (F6) commands on the Edit menu. See Re-Ordering Rows on a Multi-Row Control for more information about this capability.

    NOTE: The sequence number is blank until the first entry is added.

The following illustration shows the Fee Code(s) data group, which has a multi-row control with a row pointer and sequence numbers.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Re-Ordering Rows on a Multi-Row Control

You can easily re-arrange the sequence of a row within a multi-row control.

In the following illustration, each row on the multi-row control contains a sequence number and a discrete set of data. The row pointer indicates the active row (i.e., the row the cursor is in or was last in).
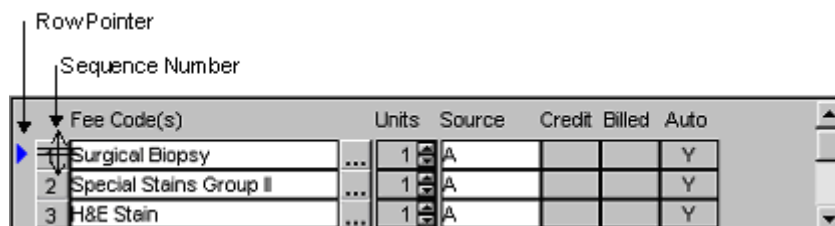
To switch the order of the first fee code (Surgical Biopsy) and the second fee code (Special Stains Group II), follow these steps:

1) Position your mouse pointer over the [1].

2) Click and hold down the left mouse button. Notice that the pointer changes to a double arrow.

3) Drag (move) the mouse pointer over the sequence number where you want to insert the row (e.g., over the [2]).

4) Release the mouse button. Notice that the Surgical Biopsy fee code has now moved to the second position, and the Special Stains Group II has moved up one position
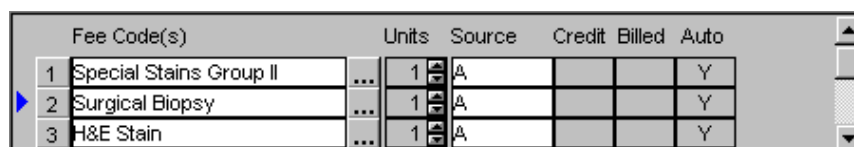
NOTE: Look at the status bar area of the window as you complete this process. The system describes what you are doing or have just done.

The following table specifies the keyboard commands that you can use from the menu bar to edit a series of rows on a multi-row control. Keep in mind that the exact command names depend on what field your cursor is currently in. For the Fee Code(s) field, the commands would read Delete Fee Code, Add Fee Code, Move Fee Code Up, and Move Fee Code Down.

To…	Select…
Remove a row	Edit, Delete ... (Ctrl+D)
Insert a row	Edit, Add ... (Ctrl+A)
Move a row one row up	Edit, Move ... Up (Shift+F6)
Move a row one row down	Edit, Move ... Down (F6)

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Date/Time Fields

CoPathPlus has some shortcut keys you can use when in a date/time field. With your cursor in the field:

For dates, press:

- F11 to decrease the date by one day.

- Shift+F11 to advance the date by one day.

NOTE: If the date/time field is blank, pressing either of the above date-related keys will bring in today's date with the time as 00:00. Remember to adjust the date and time as appropriate.

For time, press:

- F12 to decrease the time by ten-minute intervals.

- Shift+F12 to increase the time by ten-minute intervals.

NOTE: If the date/time field is blank, pressing either of the above time-related keys will bring in today's date with the current time. Remember to adjust the date and time as appropriate.

CoPathPlus Data-Entry Fields

You enter data into CoPathPlus fields through your workstation's keyboard. You can use the Tab key to move quickly forward from field to field or Shift+Tab to move in the reverse direction.

You can use your workstation's mouse (or other pointing device) or the keyboard to navigate CoPathPlus, including: selection of commands on menus, toggling of option boxes, selection of option buttons, and for pressing buttons and icons, etc.

Several types of CoPathPlus fields help you speed the entry of data. These include:

- Dictionary-related fields

- Drop-down list fields

- Related fields

- Quick fill fields

In addition, many CoPathPlus fields have one of the following attributes:

- Required

- Regular default

- Copy-down default

- Display-only

- Multi-select

Dictionary-Related Fields

Many of the data entry fields in CoPathPlus are linked to dictionaries. CoPathPlus dictionaries are repositories for a variety of data that is unique to your site, applicable across patients/specimens, and used frequently. Dictionaries promote faster data entry and ensure consistency within the system.

You can easily identify dictionary-related fields by the accelerated drop-down or lookup ellipsis at the end of the field. See Accelerated Drop-Down List Field to learn about and see what the accelerated drop-down arrow looks like, and Lookup Window to learn about and see what a lookup ellipsis looks like. Refer to the *Cerner CoPathPlus Dictionary Building Manual* to learn more about dictionaries.

Drop-Down List Fields

Like the accelerated drop-down list and the lookup window list, the drop-down list is also a time- and keystroke-saving feature in CoPathPlus. See Drop-Down List Field to learn more about it.

Related Fields

Some data entry fields in CoPathPlus are also logically related and affect each other. For example, when you enter a patient's gender, the system will automatically enter an appropriate title for the patient. Therefore, when a patient's gender is **Male**, the system automatically inserts **Mr.** in the Title field. You can override an entry in this type of field as necessary.

Quick Fill Fields

Quick Fill is a method for rapidly entering text in CoPathPlus free-text, accelerated drop-down, combo box, and lookup window fields. A Quick Fill value is a text string that serves as a shortcut for accessing a predefined value, including dictionary entries. For example, you might use a Quick Fill value of **EE** to pull the text "**Embed on edge**" into the Block Comments field during the Histology Data Entry/Edit activity. A Quick Fill value may be either user-specific or site-wide, and it only applies to the field and window for which it was created. This means that if user Greg Courtney created a user-specific Quick Fill list for the Block Comments field in the Histology Data Entry/Edit window, only he will be able to see the entries on that list for that field in that window. However, if a site-wide Quick Fill list has been created for that field and window, both Greg Courtney and all other users can select from the site-wide list, in addition to their user-specific lists.

NOTE: Quick Fill lists can be utilized only within primary windows; they cannot be utilized within pop-up windows. For more information about CoPathPlus window types, refer to "CoPathPlus Windows".

To create a user-specific Quick Fill list:

1) Place the cursor in an appropriate field and press the F9 key (or select Edit, Quick Fill from the menu bar).

   NOTE: You can also press the right mouse button while in the field and select Quick Fill, <Create this List> from the commands presented. If you have permission to edit site-wide Quick Fill values, a window appears asking whether you want to edit the site-wide values. Press **No**.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

The following Quick Fill Editor window appears.
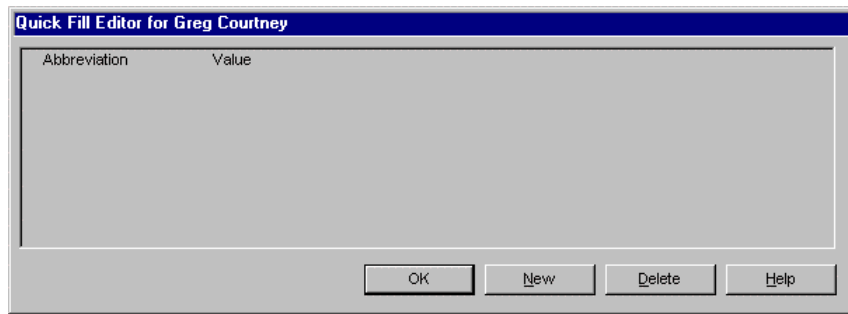
2) Press **New**.

3) Enter an abbreviation for each Quick Fill entry in the Abbreviation field, which accepts up to 25 characters.

4) Enter the appropriate text in the Value field, which accepts up to 255 characters in one continuous text string.

5) To add another entry, press **New** after each entry.

Your window will look similar to that shown below.
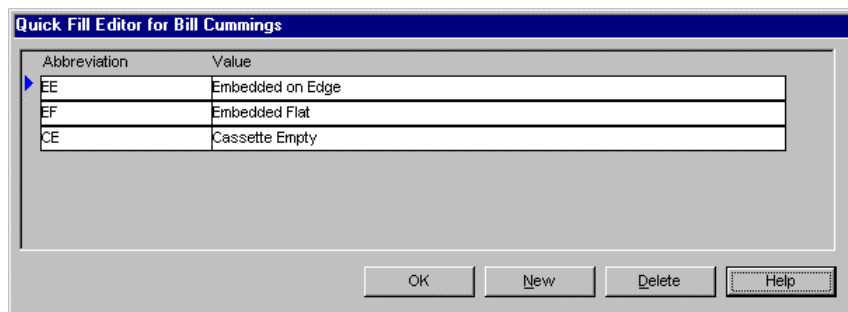
6) Press **OK** to return to the main window.

To select from a Quick Fill list during data entry:

1) Place the cursor in the appropriate field.

2) Do one of the following:

   o Press the F9 key. The Quick Fill list appears. Highlight the appropriate selection and press **OK**.

   o Press the right mouse button, and click on the Quick Fill command. The Quick Fill list appears in a pop-up menu. Click the appropriate selection.

To edit a user-specific Quick Fill list:

1) Place the cursor in an appropriate field and press the F9 key (or select Edit, Quick Fill from the menu bar).

   NOTE: You can also press the right mouse button while in the field and select Quick Fill, <Edit this List> from the commands presented.

The following Quick Fill pop-up window appears.
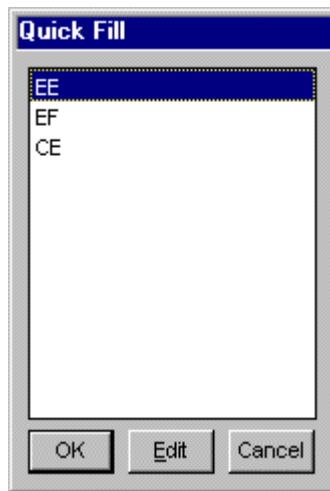
2) Press **Edit**.

    The Quick Fill Editor window appears.

3) Highlight the entry you want and edit it or press **Delete**.

4) Press **OK** to return to the main window.

Keep in mind the following information about Quick Fill:

*   You can add, edit, or delete Quick Fill entries whenever you want, as long as you have permission to access this feature. A separate permission is needed to edit site-wide Quick Fill entries. Your CoPathPlus System Manager sets up system permissions. If you do not have permission to create an individual Quick Fill list, you may still use any site-wide Quick Fill entries.

*   Users with permission to edit site-wide Quick Fill entries will see the following system message when they choose to edit the Quick Fill list:
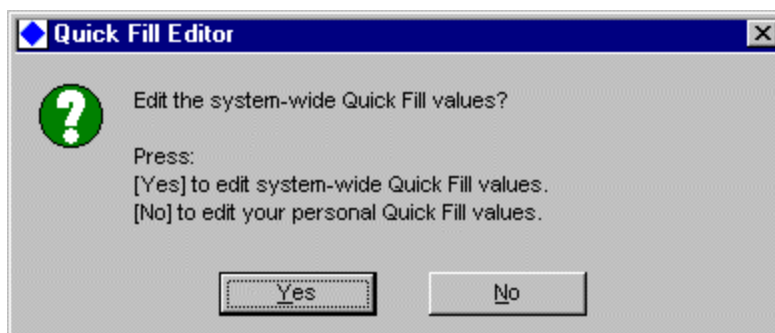
*   When you create a Quick Fill entry for a dictionary-linked field, you must refer to an entry already in the dictionary. For example, if you create a Quick Fill entry of **LIVB** to insert text that reads **Liver Biopsy**, the corresponding dictionary (Part Type, in this example) must have a dictionary entry with this name. If the value is not defined in the dictionary or if the name in the Quick Fill list does not exactly match the name in the

dictionary, a "No Matching Entries Found" message appears when you attempt to select the value during data entry.

- The Quick Fill list for a field appears in the order in which each entry was created. User-specific Quick Fill values appear before site-wide values.

- Quick Fill does not work with certain fields, such as option buttons, drop-down list fields, and multi-line text fields, nor does it work on pop-up windows.

Required Fields

A required field means that data must be entered in it before you can perform a save function. For example, Medical Record Number (MRN) is a required field (for those sites that use MRN). If you try to save data for a newly registered patient without this important piece of data, a pop-up message window will appear that tells you that you need to enter an MRN.

Default Fields

A default field is a field where a default value appears automatically during data entry. Default values reduce data entry time and help ensure that data is consistent and accurate. A default value may or may not be editable. Many default values are retrieved from a CoPathPlus dictionary (e.g., the default histology protocol to use for a specific part type) or system setting. Other default values are based on your response to a previous field.

Copy-Down Default Fields

A copy-down default field can make data entry easier. This type of field can only appear in a multi-row control. A copy-down default field can have one of the following characteristics:

- Copies data from a column on the previous row into the same column of the current row. For example, the SNOMED Codes field on the SNOMED tab of the Final Diagnosis Entry/Edit window under Specimens has a copy-down default for the Source column. After you enter the Source and SNOMED code on the first row, if the Source is the same for the next row, all you have to do is enter the SNOMED code in the second row. Once the system inserts the SNOMED code it automatically copies down the Source data from the previous row. (You can easily change the data in the Source column as necessary.)

- Copies data from the column of the first row into the same column on the current row (e.g., copies **liver biopsy** from column 5 of row 1 to column 5 of row 7).

- For numeric columns, can add 1 to a value in a column and place the higher value into the same column on the next row (e.g., adds 1 to the value **5** in column 2 of row 7 and inserts the value of **6** in column 2 of row 8).

- This type of field can also be implemented without a default characteristic.

Display-Only Fields

A display-only field is a non-interactive field that can only be viewed. This type of field appears as black text on a gray background. For example, after you fill in a date in the Birthdate field on

the Patient tab of the Registration Entry/Edit window, the age of the patient is automatically calculated by the system and inserted in the Age field. The data in this field cannot be changed directly.   (You can change age by changing the date of birth.)

Multi-Select Fields

A multi-select field is a field in which you can select more than one item. Examples of multi-select fields include the Select field in the Final Report List/Print Range item and the Select one or more Block Categories field on the Processing Batch Edit/Compile item. The following keyboard/mouse button combinations are available for selecting items at multi-select fields:

- **Left Click.** Selects an item and de-selects all previously selected items.

- **Ctrl**+**Left Click.** Selects an item without de-selecting any previously selected items.

- **Shift**+**Left Click.** Selects a range of items starting with the last item selected and ending with the current selection. All items selected outside this range are de-selected.

- **Ctrl**+**Left Click.** De-selects a selected item without selecting or de-selecting any other item.

Zoom Command

CoPathPlus has a Zoom command (Edit, Zoom or Shift+F8) that you can use to enlarge a field for viewing purposes. You can edit text in this "zoomed" window, however, it looks and behaves differently depending on the type of field in which you accessed it.

NOTE: The Zoom command is not available for fields on the Select Patient or the Select Specimen windows.

Zoom Command for Data Entry Fields

For data entry fields, you can edit what is in the "zoomed" window but it must match a valid entry for that field. For example, in the following illustration the Zoom Edit window for the Client field contains the entry "General Hospital". This is a valid entry in the Client Dictionary. If you were to change this entry to something that was not in the Client dictionary, you would receive a warning message when you tabbed away from the field.

Zoom Command for Free-Text Fields

For free-text fields, you can do some basic text entry in the "zoomed" window. The Zoom command allows you to do more editing on these types of fields because they potentially can contain a large amount of data.

Using the Zoom command brings up a window that shows more text than would appear in a regular size field window. Within a Zoom window, you can use the arrow keys to scroll the window to see more text (if all the text does not fit the Zoom window). You can use the standard Windows shortcut keys for the Copy, Cut, and Paste commands.

The following illustration shows a partial Zoom Edit window for the Outside Institution field you encounter during accessioning.

Zoom Command for Diagnostic Text Fields

The Zoom command for diagnostic text fields (e.g., Gross Description, Final Diagnosis) provides you the most flexibility. Not only can you perform basic text entry and editing within the "zoomed" window for these types of fields, but you can also enter Quick Text and perform a spell check.

NOTE: For sites using Microsoft Word, the zoom command for diagnostic text fields is used only to view more of the diagnostic text; it is not used to edit text. The TxText formatting fields and buttons do not appear.
".

System Messages

CoPathPlus presents the following types of system messages to alert or inform you of something:

- Critical Message
- Warning Message
- Informational Message
- Multiple Error Message

System messages can appear immediately for a field that is automatically validated after you enter data in that field (e.g., the Medical Record Number field) or when you attempt to save data. When a field fails validation, a message pop-up window will appear to tell you what the problem is and how you can rectify it. If there are system messages when you attempt to save data, a message pop-up window can appear with more than one message and more than one type of message. In these cases, all critical messages appear first, then warning messages, and finally informational messages.

Critical Message

You can easily identify a critical message by the stop sign icon shown in the message window. This type of message alerts you to a serious problem that you must correct before you can proceed with what you are doing.

Warning Message

The warning message informs you of a condition or situation that requires making a decision. This decision may be to:

- Resolve an error that occurred as a result of your action(s).

- Save new data or recently made changes.

In many instances the warning is asked in the form of a question, usually with **Yes** and **No** buttons available. If the warning is a question, the icon is a question mark. If the warning is a statement, then the icon is an exclamation point.

Informational Message

An informational message informs you of the current state of the system when it is not obvious or is the result of a command. Before continuing with your task you must press the **Yes** or **No** button (if the message is phrased in a question) or **Cancel** to clear the message window.

Multiple Error Message

A multiple error message alerts you to one or more problems that you must correct before you can proceed with what you are doing. Press the **Resolve** button to make the required changes.

For an explanation of how to fix each error message, highlight it and read the message explanation that appears below.
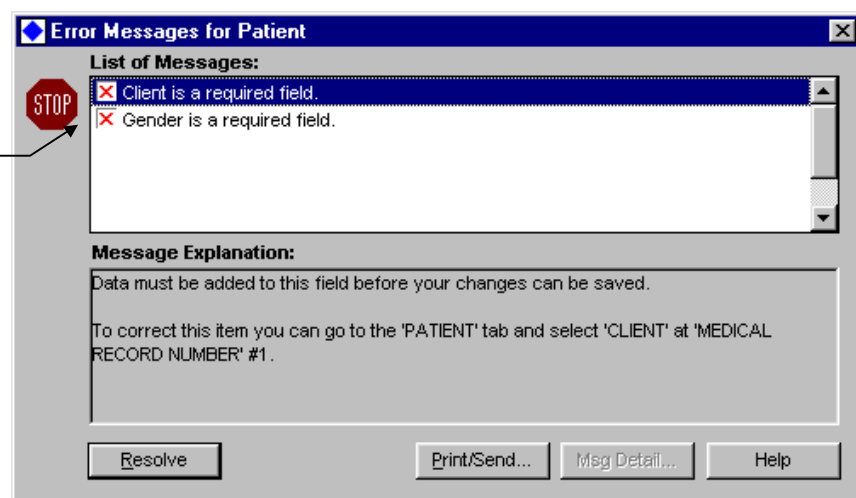
Windows Features

The Microsoft Windows environment has many features that you may find useful within CoPathPlus, such as those listed below. Refer to the documentation you received when you purchased Microsoft Windows to learn more about the features available in Windows. You can:

- Have multiple applications running on the desktop at the same time, on a single workstation, and easily switch between applications.

- View more than one window at a time, and cut (or copy) and paste between applications.

Other Features

The lists that display in some CoPathPlus items (e.g., the Fax/E-Mail Queue/Log, Session Maintenance window, the All Locks pop-up window) have a few of the capabilities found in spreadsheet applications. For example, you can:

- Resize a column by placing your mouse pointer on the line between two column headings (the pointer changes to a two-arrowed pointer), and then clicking and dragging to resize the column.

- Sort column information in either ascending or descending order by double-clicking on the column heading, as illustrated below.

The illustration below shows the display area of the Session Maintenance window as it would normally appear upon your first encounter with it.

Session	Workstation	Last Update	User Name	Msg	
cop86094	SMK@454	19:23 7/2	Courtney,Greg L		
cop34094	mhorn@255	19:23 7/2	Cummings,William L (BLC)		
cop32094	der@266	19:23 7/2	Kittamer,Jane A.		
cop20094	SBJ@786	19:23 7/2	Comed,User		

If you sort the User Name column in ascending order by double-clicking on the column heading, the rows re-order as shown below. Notice that the User Name label is now underlined.

Session	Workstation	Last Update	User Name	Msg	
cop20094	SBJ@786	19:23 7/2	Comed,User		
cop86094	SMK@454	19:23 7/2	Courtney,Greg L		
cop34094	mhorn@255	19:23 7/2	Cummings,William L (BLC)		
cop32094	der@266	19:23 7/2	Kittamer,Jane A.		

If you sort the User Name column in descending order by double-clicking on the column heading again, the rows re-order again as shown below. Notice that the User Name label is now underlined and italicized.

Session	Workstation	Last Update	User Name	Msg	
cop32094	der@266	19:23 7/2	Kittamer,Jane A.		
cop34094	mhorn@255	19:23 7/2	Cummings,William L (BLC)		
cop86094	SMK@454	19:23 7/2	Courtney,Greg L		
cop20094	SBJ@786	19:23 7/2	Comed,User		

What Help is Available?

This topic tells you where you can find help information related to CoPathPlus, including:

- Online Help
- Assistance From Cerner CoPathPlus

Online Help

The CoPathPlus system has a variety of guide available:

- Online CoPathPlus User Guide
- Current Window Help
- Context Help
- Status Bar
- Tips Button

Online CoPathPlus User Guide

The *Cerner CoPathPlus User Guide* is available online as a general reference source for the CoPathPlus system. Perform either of the following actions to access this guide resource:

- Press [?] on the toolbar
- Select <u>H</u>elp, <u>C</u>ontents from the menu bar

NOTE: If you press [?] while using an item found under the **Dictionaries** command button, you access the online *Cerner CoPathPlus Dictionary Building Manual*. Also, if you press [?] while using an item found under the **Set<u>up</u>** command button, you access the online *Cerner CoPathPlus System Manager Guide*.

Review the subject areas on the contents page that appears, or use the <u>S</u>earch command to browse the available guide topics. CoPathPlus Help topics have hypertext links that allow you to easily jump to related topics or other subjects from within your current subject. It also has a Glossary list and a navigation tool. Also, like any Windows help system, you can electronically place bookmarks on and annotate any topic you want.

NOTE: Bookmarks and annotations cannot be shared between users. This means that bookmarks and annotations inserted into a guide by a user at one workstation will not appear when that guide is called up on another user's workstation.

Also keep in mind that while you can insert bookmarks and annotations they will not be available after your next system upgrade. You will have to reinsert bookmarks and annotations if they are still needed.

Current Window Help

Current Window help, accessed by pressing the F1 key or selecting <u>H</u>elp, Current <u>W</u>indow from the menu bar, provides information about the current window or item you are in. A help topic that pertains to your current window or item appears.

You can press [Help] on a pop-up window, if available, for a specific help topic that pertains to the pop-up window you are currently on.

Context Help

Context Help in CoPathPlus provides guide for specific fields on CoPathPlus windows and tabs.

With your cursor positioned at a field, perform any of the following actions to access this guide resource:

- Press [icon] on the toolbar
- Press Shift+F1
- Select <u>H</u>elp, Conte<u>x</u>t Help on the menu bar

Status Bar

Descriptive information on the status bar area of a window is another method to help you familiarize yourself with CoPathPlus. If you float the mouse pointer over a command button on the Application Manager or over a button on the CoPathPlus toolbar, a brief description for that button appears in the lower, left-hand corner of the screen. Note that if the toolbar buttons are picture only (versus picture and text), you will also see a floating label display above the button on which the pointer is currently positioned, as well as descriptive information on the status bar.

To learn how to change the look and location of the CoPathPlus toolbar, refer to "Toolbar".

Tips Button

A site can add its own guide text behind the Tips button [icon] at the corner of CoPathPlus windows. Your System Manager can do this by using the Cerner CoPathPlus tools. If your site adds help text behind a Tips button, the button will appear blue. If there is no help text behind the button, it will appear gray.

Assistance From Cerner CoPathPlus

If you have a question about or problem with CoPathPlus, you should speak with the CoPathPlus System Manager at your site. The System Manager will know the appropriate procedure for contacting the Cerner CoPathPlus Client Service.

Chapter 3: Security

Overview

Security explains how to use the security features available in Cerner CoPathPlus. Because of the highly sensitive and confidential nature of medical information, CoPathPlus requires users to have a unique user identification code and password, and permissions (as authorized by your site's System Manager) to access particular items and data. CoPathPlus also audits unsuccessful attempts to sign on to the system, changes to patient information, and all activities concerning specimens and dictionaries.

For more information, refer to the "People/Security Dictionaries" section in the *Cerner CoPathPlus Dictionary Building Manual*.

Security System Overview

The main security feature within CoPathPlus is the System Manager's ability, through various dictionaries, to restrict a user's access to particular items and data. You may notice that the buttons and windows you see are not always the same as those for your co-workers; or that some buttons are disabled (i.e., they appear "grayed out"). When your System Manager sets up a new user, he or she uses permission groups to set up the defaults that have an effect on that user's access to the system, including the appearance of the windows and toolbar. You cannot give yourself permission to access restricted areas. If you find that you do not have access to the items you need, speak with your System Manager.

For more information about the security setup of CoPathPlus and the Permission Group dictionary, refer to the "People/Security Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

System Philosophy of Protection

CoPathPlus's philosophy of protection is predicated on meeting the most stringent requirements for confidentiality and data integrity appropriate to medical software.

CoPathPlus requires that each user have a unique user identification code and password combination, and special permissions for certain items. A System Manager can associate an unlimited number of permission groups with each user. Permission groups give users access to specific items and data within CoPathPlus.

The integrity of patient data and system tables is rigorously maintained in CoPathPlus. Each user-editing session uses either local memory, or uniquely addressed temporary files, both of which are initialized (cleared) before their use.

To ensure identification of responsible personnel, CoPathPlus audits unsuccessful attempts to sign on to the system. A list of unsuccessful sign-on attempts is available on the Failed Sign-On Attempts report. . Additional general specimen-activity related auditing (who accessioned a specimen and when, who entered the gross on a specimen and when, etc.) is also automatically maintained. Furthermore, CoPathPlus offers the ability to allow auditing of changes to patients, specimens, and dictionaries. The specific audited activities in your CoPathPlus system are determined and configured by your System Manager.

System Manager and User Security Responsibilities

System Managers have overall responsibility for CoPathPlus, including maintaining a secure environment. They serve as the site's primary contact person with Cerner CoPathPlus Healthcare Technologies; they understand, support, and maintain all security features; and, they participate in all training and discussion matters.

Users also share in the responsibility for maintaining a secure, protected environment. Although many CoPathPlus security features are automatic and do not require action, as a responsible user, you should adhere to all the guidelines in this topic, particularly to the following:

- Never leave your workstation unattended for long periods of time while you are signed on to the system. Press the Restart key when finished to safely and efficiently prepare the workstation for others to use. If you have to temporarily leave your workstation but do not want to exit the system, Use the Take a Break feature. Refer to "Taking Breaks and Time Out" for more information.

- Do not share your password with other users, and never send your password to others in e-mail messages or other written communication.

- Follow the guidelines in this topic for creating passwords that are not easily detectable. Refer to "Choosing your Password" for more information.

- Change your password periodically, if you have permission to do so. Your password automatically expires after a pre-determined time. You should change it when the CoPathPlus system notifies you to do so. If you do not have permission to change your password, speak with your System Manager. Refer to "Changing your Password" for more information.

Passwords

Changing your password every few months helps to prevent unauthorized persons from using the system. If you have permission, you should change your password after the first time you sign on to CoPathPlus, especially if your password was created by your System Manager.

IMPORTANT: Never share your password with another co-worker. You should be the only one who knows your password.

Choosing your Password

When you select a password, choose a unique word; one that is not obvious. For example, you can use non-English words, punctuation characters, or numbers. However, you will not be able to use the space in your password. You can even use a combination of numbers and letters. Do not, however, use a version of your name or user ID, and do not reuse a previously used password.

Your System Manager can tell you if your site has special restrictions for passwords, such as length limits and different character type (uppercase letter, lowercase letter, number, symbol) requirements. Your site may also have additional procedural requirements to be followed for password selection.

Changing your Password
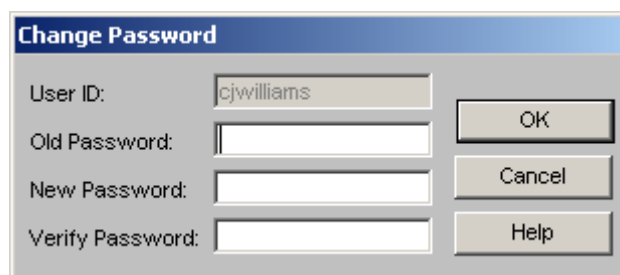
Some sites may use the password expiration feature, meaning that after a pre-determined number of days, your password is no longer valid. Before you are unable to use the password at all, you receive likely expiration warning messages when you sign on to CoPathPlus. You can be locked out of the system if your password expires before you change it. To re-enter the system, see your System Manager.

To change your password, use the Change Password item found in the System Session Utilities folder that is accessed via the **Tasks** command button.

NOTE: If you receive an expired password warning message and you have access to the Change Password item, press **OK** and the Change Password pop-up window automatically appears. In such cases, skip to Step 5 of the following procedure for instructions on entering information on the Change Password pop-up window. If you do not have access to the Change Password item, see your System Manager.

To change your password:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

2) Double-click on the System Session Utilities folder.

   A list of items appears under the System Session Utilities folder.

3) Double-click on **Change Password**.

4) The following Change Password window appears.

5) Enter your old password in the **Old Password** field. To ensure confidentiality, your password is concealed with asterisks (***) as you type.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

> **NOTE:** If you accessed the Change Password pop-up window through the Login tab in the Person dictionary, the Old Password field will be disabled.

6) Enter your new password in the **New Password** field. Your system may have length or character type restrictions on password assignment. If your new password does not have a valid format, CoPathPlus will display an error message and prompt you to select a different password.

7) Re-enter your new password in the **Verify Password** field and press **OK**. If your entries in the New Password and Verify Password fields do not match, CoPathPlus prompts you to re-enter your new password.

You now have a new CoPathPlus password, which you should memorize. If you forget this new password, see your System Manager.

Taking Breaks and Time Out

CoPathPlus has two security-related features that you will likely use or encounter at some point.

- **Take a Break** lets you leave your current work session without exiting the system.

- Time Out automatically closes the current window and displays the CoPathPlus Sign-On window after a pre-determined period of idle time has elapsed (i.e., no one is using the workstation that is signed on).

Taking Breaks

The Take a Break feature lets you leave your current work session without exiting the system. When you are ready to resume working, you re-enter your password and CoPathPlus returns to the point at which you left off.

To take a break from your current work session:

1) Press [icon] on the toolbar (or select <u>F</u>ile, <u>T</u>ake a Break on the menu bar).

   CoPathPlus displays a message asking if you want to take a break.

   > **NOTE:** If you made changes and did not save your work at the time you want to take a break, CoPathPlus identifies the application(s) with unsaved changes and asks if you want to take a break. We recommend that you press **No** and save all changes before you leave your current work session.

2) Press **OK**.

   The CoPathPlus Sign-On window appears.

   > **NOTE:** The sign-on window you see when you first enter CoPathPlus differs from the one you see when CoPathPlus enters the Take a Break state. As shown in the illustration below, the current user's name appears in the User ID field and the button label reads **Return**, instead of **Sign On**.

Because you need your password to return to the system, the Take a Break feature is not intended for use on shared workstations. However, as a precaution you should always save changes before you leave your workstation unattended. If you do not save changes before you take a break, you will lose your changes if a co-worker signs you off the system.

When you return to your workstation, you can do one of the following:

- Enter your password in the Password field and press **Return**. You are returned to the point at which you were before you took a break.

- Press **Exit** to exit the system. If you have made changes that you have not yet saved, CoPathPlus will warn you that your changes will not be saved if you exit the system now. If you:

  o Do not want to save your changes, press **Yes** to exit CoPathPlus.

  o Want to save your changes, press **No**. Then press **Return** and save your changes before exiting CoPathPlus.

Time Out Status

The CoPathPlus system times out after a pre-determined period of idle time has elapsed (i.e., no one is using the workstation that is signed on). When the Time Out feature is applied, CoPathPlus closes the current window and the CoPathPlus sign-on window displays.

NOTE: The time out period (or number of minutes before CoPathPlus times out when the system is idle) is determined by the value set in the Timeout Minutes field on the Login tab in a user's entry in the Person Dictionary. Otherwise, CoPathPlus uses the system default, which was determined during the CoPathPlus implementation process. To learn more about that dictionary, refer to the "Person Dictionary" topic in the "People/Security Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

NOTE: The sign-on window you see when you first enter CoPathPlus differs from the one you see when CoPathPlus enters the Time Out state. As shown in the illustration above, the current user's name appears in the User ID field and the button label **Return**, instead of **Sign On**.

If you minimized CoPathPlus before it entered Time Out status, the Sign-On window re-displays when you maximize CoPathPlus.

When you return to your workstation, you can do one of the following:

- Sign on again by entering your password in the Password field and pressing **Return**. You are returned to the point at which you were before CoPathPlus entered the time out state.

- Exit CoPathPlus by pressing **Exit**. If you have made changes that you have not yet saved, CoPathPlus warns you that your changes will not be saved if you exit the system now. If you:

  o Do not want to save your changes, press **Yes** to exit CoPathPlus.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

     o   Want to save your changes, press <u>**No**</u>. Then press <u>**Return**</u> and save your changes before exiting the system.

Workstation Disabled

An optional security feature is available to halt inappropriate successive CoPathPlus signon attempts by disabling the workstation where the problem occurred. This security feature may or may not be implemented in your CoPathPlus System. If it is implemented, a workstation will become disabled if a user fails to enter a valid signon in a pre-determined number of tries within a pre-determined time frame on that workstation. Both the number of tries and the time frame are determined and configured by your System Manager.

If your workstation has been disbled, you will receive the following message when you double-click on the CoPathPlus shortcut. The user signout screen will not be displayed. Inform your System Manager anytime you see this message.

Chapter 4: Specimens

Overview

Specimens contains descriptions and instructions for the activities you can perform on specimens in Cerner CoPathPlus. It explains how to accession a specimen and enter diagnoses; and it shows you how to order a procedure, perform a Quality Assurance (QA) review, and sign out a case.

The information contained in this guide is based on the standard export version of CoPathPlus. Because CoPathPlus is tailored during the implementation process to meet the needs of each site, it is possible that your system does not include fields or items described here. Or your system can have additional fields and items that are not documented here.

Navigating Through Specimen Activities

Typically, a specimen arrives in a labeled container with a requisition slip or a labeled slide. The label and/or form should have the patient identifying information, as well as the description of the tissue type, the name of the submitting physician, and the patient's clinical history. It may also note if extra copies of the Final Report are needed and where they are to be sent.

In CoPathPlus, you must first accession a specimen before you can do anything else to it in the system. Accession Entry/Edit is the activity through which specimen information is first entered into the computer and a specimen number is assigned.

Once accessioned, there are a number of activities you can perform on the specimen, such as entering the Gross Description and Final Diagnosis, ordering a procedure or creating an addendum, performing a QA review, or signing out the specimen (i.e., case). This topic describes the characteristics of CoPathPlus specimen activities and how to navigate within them.

NOTE: A patient must be registered in CoPathPlus before you can accession a specimen for that patient. However, you can access patient registration via the New Accession process.

Accessing Specimen-Related Activities

An activity in CoPathPlus refers to a specific action that you can perform on a specimen through a set of windows and the fields on them. The activity may relate to:

- Input of specimen-level data (e.g., Gross Description Entry/Edit)
- Output (e.g., Patient Report Single Print)
- Display (e.g., Inquiry [Pathology])

To perform any specimen-related activity, you must first access the Select Specimen window. Through this window, you can begin the specimen accessioning process on new specimens, view all specimens for a particular patient, and choose from many different specimen-related activities.

NOTE: For existing specimens that have been added to a worklist, you can also perform specimen-related activities via the Select Specimen from Worklist window.

To access the Select Specimen window and begin performing specimen-related activities:

1) Press the <u>Specimens</u> command button on the Application Manager.

   The Select Specimen window appears.

2) Continue with "Using the Select Specimen Window".

TIP! You can also access each specimen-related activity by placing that activity in your Personal Menu and double-clicking on it from there.

Switching Between Specimen Activities

After you accession a specimen or select an existing specimen on which to work, you can switch between specimen activities for that particular specimen without having to return to the Select Specimen window.

To switch between specimen activities, press [icon] on the toolbar (or select Op<u>t</u>ions, <u>A</u>ctivities on the menu bar).

As you switch activities, CoPathPlus prompts you to save the changes you made to the specimen during the current activity.

NOTE: The activities users can perform depend on their level of access provided by their System Manager.

You can also continue the current activity for another specimen. To change specimens, choose one of the following icons from the toolbar:

- [icon] to accession a new specimen (or select <u>F</u>ile, <u>N</u>ew Specimen from the menu bar). The New Specimen window appears. Refer to "Accessioning New Specimens".

- [icon] to retrieve an existing specimen (or select <u>F</u>ile, <u>O</u>pen Specimen from the menu bar). The Select Specimen window appears enabling you to choose another specimen or patient. Refer to "Using the Select Specimen Window".

Performing More Than One Specimen Activity at a Time

CoPathPlus allows you to have more than one specimen open at a time. If you are currently performing an activity on a specimen, you can perform the same or a different activity for a different specimen without closing the current activity and specimen.

To open another specimen while you currently have a specimen open:

1) Press [icon] on the toolbar to switch to the CoPathPlus Application Manager window

2) Press the **Specimens** command button. A message will display to let you know that more then one specimen window is open.

CoPathPlus presents you with a message similar to the one below:
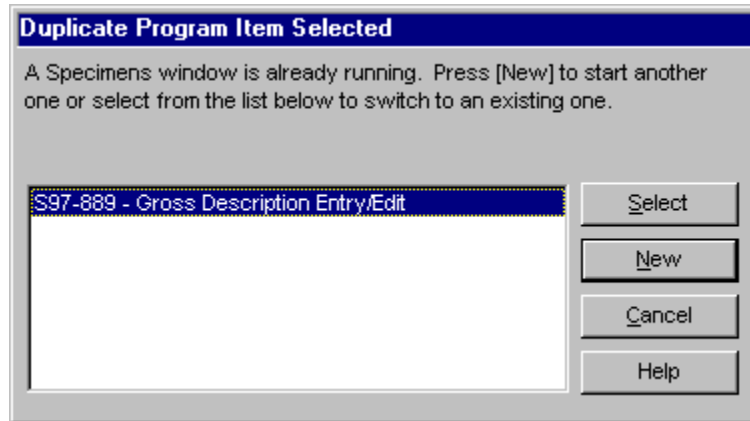
You can then:

o Switch to a specimen and activity already open by highlighting it and pressing **Select**. CoPathPlus returns you to the selected activity.

o Keep the current specimen and activity running and start an activity for a different specimen by pressing **New**. The Select Specimen window appears.

o Close the message window without opening a new specimen by pressing **Cancel**. CoPathPlus returns you to the Application Manager window.

To switch to a different activity for a specimen that is currently open, you must return to that activity and press [icon] on the toolbar.

A specimen can only be open for one user at a time. If you attempt to run an activity for a specimen that is currently in use by another user (or by you on another window), a warning message will appear.
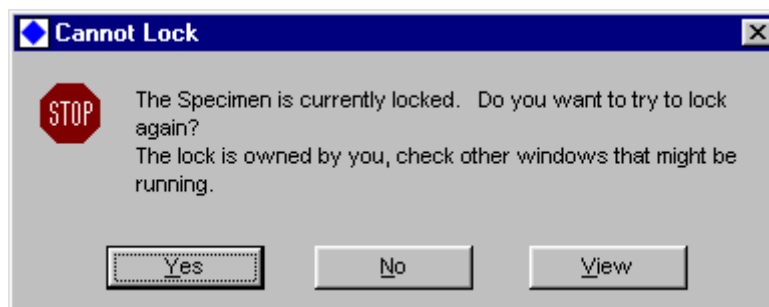
To try to access the specimen again, press **Yes**. If the specimen is still locked (i.e., still in use by another user), this message window reappears. To return to the Select Specimen window, press **No**. To access the specimen in view-only mode (i.e., you cannot edit any specimen information), press **View**.

Using the Select Specimen Window

The Select Specimen window is the means by which you accession a new specimen or select an existing specimen on which to work. To work on an existing specimen, you can either search for the particular specimen you want or you can search for a patient or encounter and then select the specimen.

To access the Select Specimen window, press the **Specimens** command button on the CoPathPlus Application Manager.

If you want to:

- Read a description of each of the fields and buttons on this window, refer to "Select Specimen Window Description".

- Select an existing specimen on which to work, refer to "Selecting an Existing Specimen".

- Select an existing specimen from a worklist, press **Worklists…** and then refer to "Worklists".

- Accession a new specimen, press **New Specimen** and then refer to "Accessioning New Specimens".

Select Specimen Window Description

The Select Specimen window contains the following fields and buttons. For more detailed information on these fields, refer to "Selecting an Existing Specimen" and "Accessioning New Specimens".

- **Specimen # field.** Lets you search for a particular specimen for a patient by specimen number, requisition number, or order number. Requisition numbers must be prefaced with the pound sign character (i.e., #). Order numbers must be prefaced with a period character (i.e., .).If your CoPathPlus system is set up to allow specimen identification using a bar code reader, the cursor must be at this field when the bar code is scanned.

- **Patient Name or MRN field.** Lets you search for a particular patient by name or by medical record number (MRN).

- **Search Criteria button.** Click this button to open the Specimen Search Criteria window. You use this window to specify criteria that CoPathPlus should use to limit the specimen search. For more information, refer to "Specimen Search Criteria".

- **Encounter Number field.** Lets you search for a particular specimen by Encounter or Visit Number. CoPathPlus displays just those specimens associated with the encounter in the Select field.

- **Select field.** Lists all the specimens for this patient organized in reverse chronological order by specimen number, class, accession date, status, and tissue source. If you search by Encounter Number, CoPathPlus displays just those specimens associated with the encounter in this field. If you search by specimen number, CoPathPlus displays just the specimen you accessed, not all the other specimens that the patient may have. Or, if you do not know the specimen number, patient name, or patient identification number(s), you can press **Search Criteria** to limit the specimen search using other criteria. For more

information about the search capability when you click this button, refer to "Specimen Search Criteria".

When multiple specimens are displayed due to the search criteria used, the user may need to open several of the specimens to find the specific specimen of interest or to update several specimens. After the first specimen is opened and updated, the user should use the "Open Specimen" button to return to the Select Specimen search screen. When open specimen is used, the previously invoked specimen list may still be displayed for subsequent selection. A site-definable system setting determines whether:

o The previous search is retained for subsequent selection.

o The previous search is retained for subsequent selection and the previously opened specimens are highlighted in yellow.

o The previous search list is cleared.

- **Activity field.** Contains a drop-down list of all the activities you can perform on the current specimen.

- **Search button.** Activates a search for specimen information by specimen number, requisition number, patient name, or patient medical record number. To activate a search, you must fill in the Specimen #, the Patient Name or MRN, or the Encounter Number field.

- **Same Patient button.** Lets you access the specimens for the same patient on whom you were already working without having to perform another search. This button is only enabled if you previously identified a patient within this same session (i.e., without exiting CoPathPlus).

- **Next Specimen button.** Lets you retrieve the next specimen in this number wheel within the same year. CoPathPlus increments the number by 1. If a specimen number is not used, a message appears stating that the specimen is not found. Press **Next Specimen** again to continue.

- **New Specimen button.** Opens the New Specimen window, enabling you to accession a new specimen. If you entered the patient name or MRN on the Select Specimen window, that information defaults on the New Specimen window.

- **Worklists… button.** Opens the Select Specimen from Worklist window. This window gives you access to a list of specimens or procedures on a worklist. Refer to "Using the Select Specimen from Worklist Window" for more information.

- **Detail… button.** Opens the Detail for Specimen window. This window lists the names of the submitting physician, additional physicians, the client, and any procedures and/or addenda on record (if your site so specifies) for the specimen you have highlighted in the Select field. A system setting allows you to always show detail for the selected specimen.

- **Print Report… button.** Opens the Select Report(s) pop-up window. You use this window to select the patient report you want to print or view. Refer to "Patient Report Single Print" for more information on the Select Report(s) pop-up window.

- **Right-click or use CTRL P** with the focus in the lookup list to invoke the Lookup List Printout. This will produce a printout of just the data within the lookup list. A miscellaneous permission is required for this action.

Selecting an Existing Specimen

From the Select Specimen window, you can search the database for the specimen on which you want to work using the specimen number, requisition number, patient name, patient Medical Record Number, or Encounter Number.

NOTE: During implementation, you can set up your CoPathPlus system to read existing specimen numbers from bar codes printed on slide labels, container labels, and Patient reports. Also, a patient must be registered in CoPathPlus before you can accession a specimen for that patient.

To select an existing specimen on which to work:

1) Decide how you want to search for the patient record:

   o   Specimen Number

   o   Requisition Number

   o   Patient Name or MRN

   o   Encounter Number

   o   Search Criteria button

   A specimen list that meets your search criteria appears. This list shows the specimen number, specimen class, accession date, status, and part or tissue source, listed in reverse chronological order. If you search by Encounter or Visit Number, this list only includes those specimens for that encounter or visit. If you search by specimen number, CoPathPlus displays just the specimen you accessed, not all the other specimens that the patient may have.

   Refer to "Select Specimen List" to see an example of the Select Specimen list.

2) If CoPathPlus has found

   o   **No specimens for this patient**, verify that the information you entered is correct.

   o   **Only one specimen for the patient**, select an activity from the Activity field at the bottom of the window and press **OK**. The corresponding activity window for the specimen and activity you selected appears.

   o   **More than one specimen for the patient**, click on the specimen you want and choose an activity to perform on the specimen in the Activity field at the bottom of the window. Press **OK**. The corresponding activity window for the specimen and activity you selected appears.

NOTE: By pressing **Detail** on the Select Specimen window, you can see physician, client, and procedure/addendum information for the specimen that you highlight. In addition, by pressing **Worklists…**, you can select a specimen from a worklist. For more information about that feature, refer to "Worklists".

Note: If your system is configured for a persistent search display and tracking of accessed specimens during window use, specimens may be highlighted in yellow after they have been accessed during a current search. This enables you to keep track of specimens that you have already viewed.

Selecting a Specimen by Specimen Number

Enter the specimen number in the Specimen # field and press **Search** (or press the Enter or Tab key). You do not have to type the year if the year in which the specimen was accessioned is the current year; you can enter just the prefix and number (e.g., if the current year is 2007 and the specimen number is S07-203, you can enter S203).

NOTE: Also, during implementation, you can set up your CoPathPlus system to read existing specimen numbers from bar codes printed on slide labels, container labels, and Patient reports.

Refer to "Accessioning New Specimens" for more information on specimen numbers.

Selecting a Specimen by Requisition Number

Enter the specimen-level requisition number for the specimen, preceded by a pound sign (e.g., #16532), in the Specimen # field and press **Search** (or press the Enter or Tab key). The requisition number is a hospital, clinic, or other associated system's accession number equivalent.

NOTE: Your site may not be configured to use requisition numbers.

Selecting a Specimen by Order Number

Enter the specimen-level requisition number for the specimen, preceded by a period (e.g., .16532), in the Specimen # field and press **Search** (or press the Enter or Tab key). The order number field is a second field that may be used to record a hospital, clinic, or other associated system's accession number equivalent.

NOTE: Your site may not be configured to use order numbers.

Selecting a Specimen by Patient Name or Medical Record Number

Enter the name or Medical Record Number (MRN) of the patient in the Patient Name or MRN field and press **Search** (or press the Enter or Tab key). You can search by:

- The first few characters of the last name (e.g., **Jack** for Jackson),

- A comma and then the first few characters of the first name (e.g., **Sama** for Samantha), or

- The first few characters of the last name and the first few characters of the first name, separated by a comma (e.g., **Jack,Sama** for Samantha Jackson).

  NOTE: You must enter at least two characters to perform your search. The fewer characters you use, however, the more time it takes for CoPathPlus to search the database.

If you entered the patient's name, the Select Patient window appears. Proceed according to the information in Using the Select Patient Window. Once you have chosen the correct patient, CoPathPlus returns you to the Select Specimen window.

Selecting a Specimen by Encounter Number

In the Encounter Number field, enter the Encounter or Visit Number for which you want to access specimens and press **Search** (or press the Enter or Tab key). If CoPathPlus finds more

than one encounter for the number you entered, the following Select Encounter pop-up window appears.
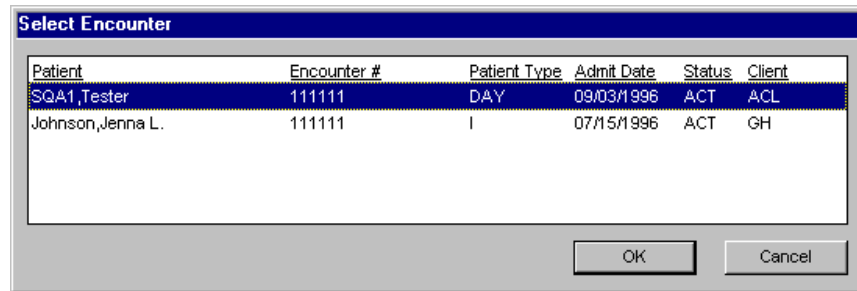
Select the encounter you want and press **OK** (or just double-click on the encounter).

Using the Specimen Search Criteria Window

The Specimen Search Criteria window lets you specify criteria that CoPathPlus should use to limit the specimen search.

Enter the following information on the Specimen Search Criteria window:

NOTE: You need to fill in only those fields you use to conduct your search.

1) **From Accession Date.** Specify the accession date from which you want to begin your search. The standard export version of CoPathPlus has a default of 30 days prior to today and allows a date range maximum of no more than 365 days. Your site's defaults may be different.

2) **To Accession Date.** Specify the accession date through which you want to search. Today's date automatically appears as the default. The standard export version of CoPathPlus allows a date range maximum of no more than 365 days. Your site's default may be different.

3) **Specimen Client.** Select the client associated with the specimen.

4) **Encounter Client.** Select the client associated with the encounter.

5) **Primary Pathologist.** Select the Primary Pathologist associated with this specimen. CoPathPlus searches for the first pathologist entered in the Pathologist(s) field and lists personnel with the pathologist person type only.

6) **Primary Resident.** Select the Primary Resident associated with this specimen. CoPathPlus searches for the first resident entered in the Pathologist(s) field and lists personnel with the resident person type only.

7) **Physician.** Select the physician (submitting or one of the additional physicians) associated with this specimen. CoPathPlus lists personnel with the clinician, pathologist, resident, or fellow person type only.

8) **Retrieval Flag.** Select a retrieval flag to which this specimen has been assigned.

9) **Specimen Classes.** To select more than one specimen class to include in your search criteria, keep the Ctrl key pressed down while clicking the entries you want. Use this

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

same method to de-select a highlighted entry. To select a range of classes, click on the first entry in the range, press and hold down the Shift key, then click on the last entry in the range.

10) **Parts.** To select more than one part type to include in your search criteria, keep the Ctrl key pressed down while clicking the entries you want. Use this same method to de-select a highlighted entry. To select a range of parts, click on the first entry in the range, press and hold down the Shift key, then click on the last entry in the range.

11) <u>Clear</u> **button.** Click this button to remove the search criteria you have already entered on this window. Once you Click this button, CoPathPlus deletes the entries in the fields and enters a default date range in the From Accession Date and To Accession Date fields.

12) Press **OK** to initiate the search.

Viewing Other Specimens for a Patient (OSP)

To access the OSP window while in a specimen activity:

- Press on the toolbar,

- Press the F4 key,

- Select Op<u>t</u>ions, <u>O</u>ther Specimens on the menu bar, or

- Press on the Select Cytology Review window accessed through the Cytology Results (Cytotech or Pathologist) activity.

If a patient has no other specimens to view, the toolbar button is disabled

The Other Specimens for Patient (OSP) window displays a (view-only) chronological list that contains the other specimens associated with the current patient, starting with the most recent specimen. If no other specimens exist for this patient, the OSP button is disabled.

The top portion of the OSP window contains a list of specimens for the current patient, and the bottom portion contains a detailed report for the selected specimen in the top window.

The OSP Window Description

The Other Specimens for Patient (OSP) window contains the following elements:

- **Other Specimens display (top)**, which contains a list of the current specimens for the patient, including specimen class, accession date, status, and part type(s). When you select a specimen, its entire detail is displayed in the bottom portion of the window.

  NOTE: Either use the arrow keys to scroll up and down within the list of current specimens, or use the mouse to select different specimens.

  o The total number of specimens for the current patient appears along the top of the window.

o   An **X** appears in the QA column if QA diagnostic comparison information exists for the specimen, or if this specimen is related to a QA review on another specimen.

o   A **Y** appears in the Abnormal column for any cytology specimen with an abnormal interpretation.

o   **Detail display (bottom)**, which lets you view the details of the selected specimen including the Final Diagnosis, procedure/addendum, and QA information.

> **NOTE:** The report displayed is an InfoMaker report that your site can customize. Your site may have a different report for each specimen class.

- **Navigation buttons**, which let you navigate through the report in the detail portion of the window:

o   ⏮ to move to the first page of the report.

o   ▶ to move to the previous page of the report.

o   ◀ to move to the next page of the report.

o   ⏭ to move to the last page of the report.

Directly underneath these buttons is the page count display. This display shows the page of the report that you are currently on and the total number of pages that the report contains.

- **Print buttons**, which allow you to send the detail portion of the display to a printer:

o   **Print,** which prints the detail for the selected specimen.

o   **Print All,** which prints a summary of other specimens for the current patient.

- **Return button,** which returns you to your previous activity. The OSP window remains open in the background until you access a different specimen or manually close it.

To resize the displays:

1) Move the mouse pointer to the horizontal colored bar that separates the summary of specimens from the detailed specimen information.

2) While holding down the left-mouse button, drag the bar up or down until the display areas are the desired size.

If you drag the bar upwards, the top portion shrinks and the bottom portion becomes larger. Conversely, if you drag the bar downwards, the top portion becomes larger while the bottom portion shrinks.

OSP on Reports

CoPathPlus allows your site to design reports that contain a paragraph on your Working Draft and Final Reports that lists all other specimens (cases) for the current patient. Your site determines how many cases are listed on the reports and sets it up by specimen class in the Specimen Class dictionary. To learn more about patient reports in CoPathPlus, refer to "Patient

Reports". Refer "Specimen Class dictionary" to the *Cerner CoPathPlus Dictionary Building Manual* for more information on the configuration of this dictionary.

Security Levels for the OSP Window

Depending on your level of security access and on the settings in the Specimen Class Dictionary, you may not be able to see the detail for certain specimen classes on the Other Specimens for Patient window.

If you select a specimen to which you do not have access, the following message appears: "Not allowed to view this specimen class. Choose another specimen or see the System Manager". You cannot print the details of a restricted specimen class. You can, however, print summary information for the specimen class by pressing **Print All** on the OSP window.

Note: if your system is set up for stricter security, it may not even display specimens on the lookup list for which you do not have permission to the specimen class. This security is controlled by the User Authorized Specimen Class Lookups System Setting.

Entering Information in Diagnostic Text Fields

CoPathPlus uses either Microsoft Word or TxText as the text editor for diagnostic text fields (e.g., Gross Description, Final Diagnosis). Your site decides during system implementation which text editor it will use. If your site uses Microsoft Word as the text editor, continue with "Using Microsoft Word to Edit Diagnostic Text Fields". If your site uses TxText as the text editor, continue with "Using TxText to Edit Diagnostic Text Fields".

NOTE: TxText is the CoPathPlus Text Editor that was previously referred to as "TxText" or "VW".

Using Microsoft Word to Edit Diagnostic Text Fields

For information about:

- Entering and editing diagnostic text fields using Microsoft Word, continue reading this topic.

- Signout and Consult Review using Microsoft Word, refer to "Using Microsoft Word for Signout and Consult Review".

- Viewing patient reports using Microsoft Word, refer to "Using Microsoft Word to View Patient Reports".

The following illustration shows an example of a diagnostic text field in CoPathPlus for sites using Microsoft Word as the text editor. The Clinical Diagnosis option button is selected, which enables CoPathPlus to display the text for the Clinical Diagnosis field. You cannot see the text's RTF formatting (e.g., bold, italics, table formatting, page breaks). To view text for the next diagnostic text field, press the right arrow key. To proceed to the next field or button after the diagnostic text fields, press Tab.

NOTE: If you are in a display-only text field (e.g., Final Diagnosis in the Diagnosis Coding Entry/Edit activity), you will not see the **Edit Text** button. Also, if you are in view-only mode, a **View Text** button appears instead of the **Edit Text** button.

NOTE: In the standard export version of CoPathPlus, an asterisk (*) after the name of the text field denotes that information has been entered in that field. If you do not see an asterisk, no information has been entered.

TIP! To expand the text area to a larger view, press Shift+F8 while your cursor is in the text field. To learn more about this feature, refer to "Zooming Diagnostic Text Fields".

Warning: If both MS Outlook and CoPathPlus are set up to use Word as their text editors, conflicts may occur during simultaneous use. Users or agents doing text entry/editing, report signout or report printing must not have MS Outlook or PowerBuilder open while running these functions. It may be advisable to not use Word as Outlook's editor if any simultaneous use is anticipated.

To access Microsoft Word from CoPathPlus:

1) Select an activity that includes editable diagnostic text fields (e.g., Accession Entry/Edit).

2) Press 📝 (Edit Text) or 🔍 (Edit Report) from the toolbar (or select Options, Edit Text or Options, Edit Report from the menu bar). If you are on the tab that includes the diagnostic text fields, you can also press **Edit Text**.

   The Microsoft Word window appears.

   NOTE: On the toolbar and the Options menu, only one of the two text editing commands will be enabled, based on the text editing mode set up for the activity. Refer to Edit Text Mode and Edit Report Mode for more information.

   Also, your site may require users to save all specimen changes before they can switch to Microsoft Word.

Most, but not all features available in Microsoft Word are supported by CoPathPlus. For instructions on using Microsoft Word, refer to your Microsoft Word documentation. For a list of features that cannot be used (and are not enabled) when editing diagnostic text using Microsoft Word, refer to "Microsoft Word Features Not Supported in CoPathPlus".

NOTE: When a dialog box appears in Microsoft Word, you should respond to it promptly. If CoPathPlus times out while a dialog box is open in Microsoft Word, changes that have not been saved could be lost. For more information about the CoPathPlus time-out feature, refer to "Time Out Status".

NOTE: For optimal performance when editing specimen-related documents in Microsoft Word, the Update Fields check box should be selected (select Tools, Options… from the menu bar and refer to the Print tab). Also, the Allow Fast Saves check box should **not** be selected (select Tools, Options… from the menu bar and refer to the Save tab). In addition, you should also turn off journaling in the Microsoft Exchange or Microsoft Outlook™ applications. Lastly, if you will be using Word within CoPathPlus throughout the day, you should leave Word open. Because Word takes some time to open from CoPathPlus, you can save yourself this time by keeping Word open. The system setting "Minimize MS Word," located under the Text Entry category, automatically minimizes the Word window when you return to CoPathPlus.

Two CoPathPlus toolbars and a CoPath menu provide additional formatting features that you can use when editing diagnostic text fields using Microsoft Word. These are discussed in CoPathPlus Menu and Toolbars for Microsoft Word.

Your site can specify a default style (i.e., typeface and size) for each diagnostic text field via the Text Type Dictionary. For more information about that dictionary, refer to "Text Type Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

NOTE: When bringing text into Microsoft Word from text that has been converted from another system or TxText, always put the cursor inside the paragraph marker for the text field in which you are inserting the text. This ensures that the new text will have the default style set up for that text field. (If paragraph markers are not visible, you will need to make them visible. For instructions, refer to your Microsoft Word documentation.)

NOTE: The styles you use for diagnostic text should always have the Widow/Orphan control check box selected. That check box is located on the Lines and Page Breaks tab on the Format, Paragraph window.

In Microsoft Word, you can have only one document open for a specimen at any time. For example, if you are in Edit Text mode and you have a diagnostic text field document open in Microsoft Word, you cannot view a patient report for that specimen until you close the first document. A warning message appears informing you that the first document is still open. You can have multiple Microsoft Word documents open for different specimens, and you can also have personal documents (i.e., not related to a specimen) open at the same time as specimen-related documents.

Edit Text Mode and Edit Report Mode

When Microsoft Word is used as the CoPathPlus text editor, each activity can be set up to use one of two text editing modes: Edit Text mode or Edit Report mode.

Note: for clients that also use the Synoptic Reporting Solution, Synoptic Entry only interacts with the Edit Text mode, it does not use the Edit Report mode.

The following is an example of Microsoft Word in Edit Text Mode.
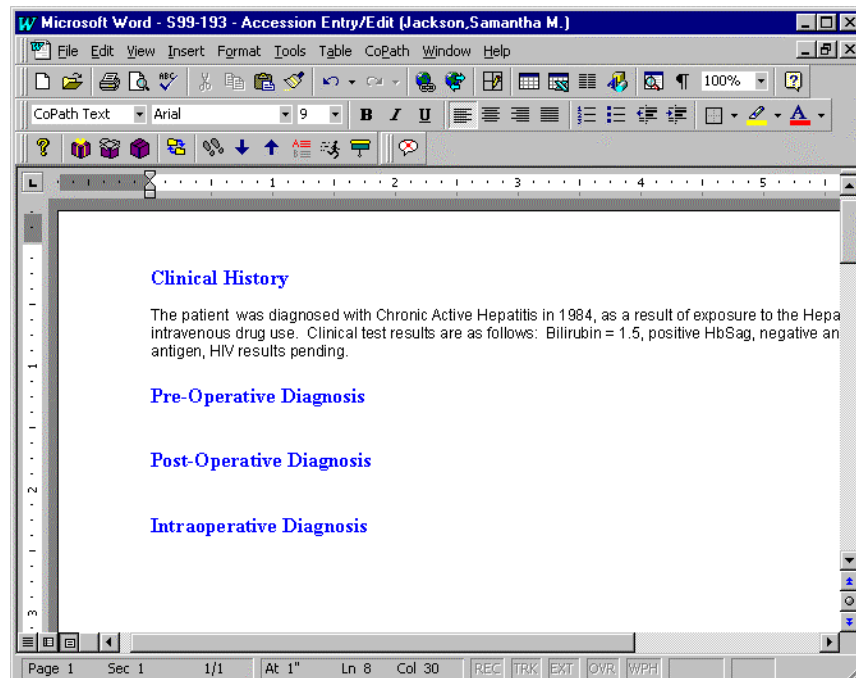
In the standard export version of CoPathPlus, all activities use Edit Text mode. The Consult Review and Signout (Electronic) activities use both Edit Report mode (when you first open the report to review it) and Edit Text mode (when you edit specimen information). The Cytology Results activity uses Edit Text mode when you edit specimen information and Edit Report mode when you choose to sign out the report.

In activities where you can view but not edit diagnostic text fields (e.g., the Accession Entry/Edit activity after a specimen has been signed out, the Inquiry (Pathologist) activity), the **E**d**it Text** button is replaced by a **V**i**ew Text** button. You can view the diagnostic text fields or Final Report in Microsoft Word, but you cannot edit any information.

CoPathPlus Menu and Toolbars for Microsoft Word

When you first access Microsoft Word from CoPathPlus, a CoP̲ath menu and two CoPathPlus toolbars, **CoPathToolbar** and **CoPathToolbar2**, appear at the top of the Microsoft Word window, in addition to the standard menus and toolbars. The menu and toolbars shown below provide additional formatting features that you can use when editing diagnostic text fields using Microsoft Word.
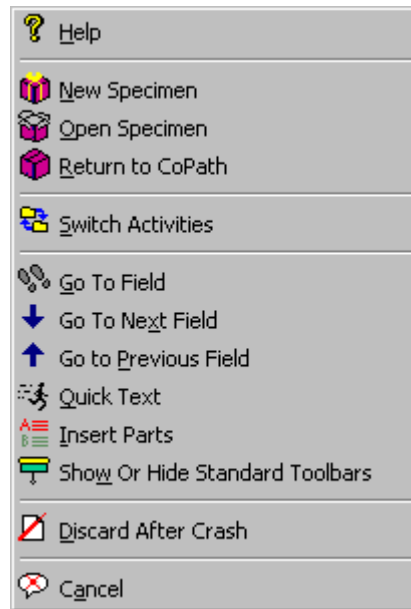
All of the commands on the CoPath menu, except Discard After Crash, are also available on **CoPathToolbar** and are described below. Use the Discard After Crash command to close the specimen-related Microsoft Word document, without closing other Microsoft Word documents, in the event that the CoPathPlus system goes down.

The buttons on CoPath Toolbar will vary depending on which activity you are in and whether you are in view-only mode (e.g., if you access an activity that allows you to view but not edit data once the specimen has been signed out).

NOTE: When editing text in the Quick Text Dictionary (MSWord), the two CoPathPlus toolbars are **CoPathToolbar 1** and **CoPathToolbar 2**. All the buttons on **CoPathToolbar 1** also appear on **CoPathToolbar** and are described below. The second CoPathPlus toolbar is the same in both this dictionary and when you are in a diagnostic text field.

Use the buttons on the CoPathPlus toolbars to do the following:

- (or select CoPath, Help on the menu bar) to access the online *Cerner CoPathPlus User Guide* describing how to use Microsoft Word to edit diagnostic text fields.

- (or select CoPath, New Specimen on the menu bar) to save data for the current specimen, return to CoPathPlus, and accession a new specimen. The New Specimen window appears. For instructions on using that window, refer to "Accessioning New Specimens".

- (or select CoPath, Open Specimen on the menu bar) to save data for the current specimen, return to CoPathPlus, and open an existing specimen. The Select Specimen

window appears. For instructions on using that window, refer to "Using the Select Specimen Window".

- (or select CoPath, Return to CoPath on the menu bar) to return to the current activity window in CoPathPlus. Any changes you made to diagnostic text fields are not saved until you save the specimen.

- (or select CoPath, Switch Activities on the menu bar) to switch to a different specimen activity. For more information, refer to "Switching Between Specimen Activities".

- (or select CoPath, Go To Field on the menu bar) to move to a different diagnostic text field. A list of text fields appears for selection. Select the text field you want to edit and press Go To **Field**.

- (or select CoPath, Go To Next Field on the menu bar) to move to the next diagnostic text field for this activity.

- (or select CoPath, Go To Previous Field on the menu bar) to move to the previous diagnostic text field for this activity.

- (or select CoPath, Insert Parts on the menu bar) to insert part type designators and descriptions, as well as any associated Quick Text. For more information, refer to "Inserting Part Descriptions ".

- (or select CoPath, Quick Text on the menu bar) to insert Quick Text. For more information, refer to "Using Quick Text".

- (or select CoPath, Show or Hide Standard Toolbars on the menu bar) to show or hide the standard Microsoft Word toolbars and ruler.

- (or select CoPath, Cancel on the menu bar) to cancel any changes you made to diagnostic text fields and return to the current activity window in CoPathPlus.

Microsoft Word Features Not Supported in CoPathPlus

The following Microsoft Word features are not supported by CoPathPlus and are disabled when Microsoft Word is used for editing diagnostic text:

- Automatic spell check (manual spell checking is still available)

   NOTE: The inability to use the automatic spell check feature in documents with protected sections, such as specimen-related documents, is a known Microsoft Word defect.

- Save (to save changes to diagnostic text, return to CoPathPlus and press)

- Save As (see previous item)

- Insert section break

- Footnotes

- Captions

- Comments

- Cross-references

- Index, Table of Contents, Table of Figures, Table of Authorities

- Text Boxes

- Bookmarks

- Text Direction

- Autoformat

- Style Gallery (you can select default styles for each text type via the Text Type dictionary)

- Word Count

- Autosummarize

- Merge Documents

- Mail Merge

- Envelopes and Labels

- Letter Wizard

- Access to Web (from within the CoPathPlus-modified version of Microsoft Word only)

- Insert, Picture

- Frames

- Master document commands

- Insert, Hyperlink

- Tools, Templates and Add-Ins

- Headers and Footers (except in the CoPathPlus Report Painter)

- Page Numbers (except in the CoPathPlus Report Painter)

  NOTE: To ensure that page numbers are correct in CoPathPlus patient reports, you must turn on the Microsoft Word "Update Fields" option. To do so, select Tools, Options from the menu bar. Then, go to the Print tab and select the Update Fields check box.

- Columns (i.e., newspaper style columns; columns in tables are supported)

- Page Setup (will be available for troubleshooting purposes only)

- The "Fill-In" field (accessed via Insert, Field…)

For more information, refer to your Microsoft Word documentation.

Using TxText to Edit Diagnostic Text Fields

NOTE: TxText is the CoPathPlus Text Editor that was previously referred to as "Visual Writer" or "VW".

To enter or edit diagnostic text, select the option button for the diagnostic text field and enter information directly into this field. You may also edit previously entered text using the available formatting buttons. The following is an example of a diagnostic text field.

NOTE: If you are in a display-only text field (e.g., Final Diagnosis in the Diagnosis Coding Entry/Edit activity), you will not see any of the formatting buttons. Also, if you are in view-only mode, the formatting buttons will be disabled even though you see them.
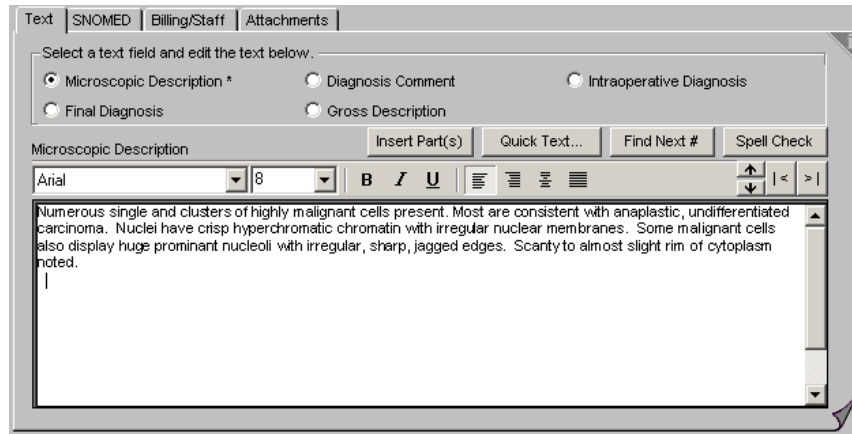
NOTE: In the standard export version of CoPathPlus, an asterisk (*) after the name of the text field denotes that information has been entered in that field. If you do not see an asterisk, no information has been entered.

To expand the text area to a larger view, press Shift+F8 while your cursor is in the text field. To view the text area in Preview mode, press Ctrl+8. To learn more about these capabilities, refer to "Zooming Diagnostic Text Fields".

To switch between diagnostic text fields using the keyboard, press:

- Ctrl+Q to move to the next text field

- Ctrl+Shift+Q to move back to the previous text field.

Your site can specify a default font size for each diagnostic text field via the Text Type Dictionary. For more information about that dictionary, refer to "Text Type Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Formatting Text Using TxText

Each diagnostic text field includes an editor that lets you format and apply attributes to your text by pressing buttons on a toolbar. Each button also has a keyboard equivalent. Refer to "Using Keyboard Equivalents".

NOTE: The default font and size of the text in each text field are determined by your site during implementation and specified in a system setting and in the Text Type dictionary, respectively. Refer to "Text Type Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary. To avoid problems that occur when different workstations have certain fonts available and not others, you should use only Arial or Times Roman font, which are available on all workstations.

Refer to "Zooming Diagnostic Text Fields" for additional features of the text editor that are available when you "zoom" or expand the text field.

Font	Arial	Change the font or character set of the selected text. A default is established via a system setting
Font Size	9	Change the font size of the selected text. A default is established in the Text Type dictionary.
Bold	B	Turn bolding on or off for the selected text or text that you are about to type
Italics	I	Turn italics on or off for the selected text or text that you are about to type
Underline	U	Turn underlining on or off for the selected text or text that you are about to type
Superscript	↑	Make the selected text or text that you are about to type appear as superscript
Subscript	↓	Make the selected text or text that you are about to type appear as subscript
Left Justify	≡	Left-justify the selected paragraph
Right Justify	≡	Right-justify the selected paragraph
Center	≡	Center the selected paragraph
Full Justify	≡	Full-justify the selected paragraph
Remove Indent	|<	Remove an indent from the selected text
Indent	>| {bmct help0134.bmp}	Indent the selected text

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

In addition to the formatting toolbar, you can change text formatting by pressing Ctrl+P or Ctrl+D while the cursor is positioned within a diagnostic text field. Ctrl+P accesses TxText's Paragraph Attribute window. Ctrl+D accesses TxText's Font Attribute window. These windows provide some additional formatting features such as line spacing.

Using Keyboard Equivalents

The following table lists keyboard equivalents for all the buttons on the TxText text editor, as well as other keyboard combinations that can be used within the TxText text editor.

Select/Copy/Cut/Paste Text	
Select all the text in a text field.	Ctrl+A
Select the character to the left of the cursor.	Shift+ ←
Select the character to the right of the cursor.	Shift+ →
Select up to the beginning of the current word.	Ctrl+Shift+ ←
Select up to the end of the current word.	Ctrl+Shift+ →
Copy the selected text to the clipboard.	Ctrl+C or Ctrl+Insert
Cut the selected text to the clipboard.	Ctrl+X or Shift+Delete
Paste the clipboard contents at the cursor location.	Ctrl+V or Shift+Insert
Undo the last edit.	Ctrl+Z
Apply Attributes to Text Press these combinations to turn on or off each attribute for selected text or for text that you are about to type.	
Bold	Ctrl+B
Italics	Ctrl+I
Strikeout	Ctrl+K
Superscript	Ctrl+Shift+=
Subscript	Ctrl+=
Underline	Ctrl+U
Left Justify	Ctrl + L
Right Justify	Ctrl + R
Center	Ctrl + Shift + N
Justify	
Go to the next tab setting.	Tab
Indent the selected paragraph. Any new paragraphs created will keep this same formatting.	Ctrl+>
Remove an indent from the selected paragraph. Any new paragraphs created will keep this same formatting.	Ctrl+<
Move a hanging indent in one tab stop. The first line of text will stay at 0" (or move to 0" if it is not already there) and the remaining lines will move in one tab stop.	Ctrl+T

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Move a hanging indent out one tab stop. The first line of text will stay at 0" (or move to 0" if it is not already there) and the remaining lines will move out one tab stop.	Ctrl+Shift+T
Access/Exit	
Access the Fonts pop-up window.	Ctrl+D
Access the Paragraph Format pop-up window.	Ctrl+P
Access the next text field in a set of option buttons.	Ctrl+Q
Access the previous text field in a set of option buttons.	Ctrl+Shift+Q
Zoom a Text Field/Preview Mode	
Zoom the text field. For more information, refer to "Zooming Diagnostic Text Fields".	Shift+F8
Initiate Preview mode. If you are currently in a text field, using this combination zooms the text field and displays it in Preview mode. If the text field is already zoomed, it displays it in Preview mode. Preview mode displays the text field exactly as it will appear on patient reports and provides horizontal scrolling capabilities, since you may not be able to view all of the text on one window.	Ctrl+8
Close Preview mode.	Ctrl+Shift+8
Navigation/Other	
Find text (Opens the Find pop-up window)	Ctrl + F
Replace text (Opens the Replace pop-up window)	Ctrl + H
Redo	Ctrl + Y
Move to beginning of line.	Home
Move to end of line.	End
Move to beginning of current word.	Ctrl+←
Move to beginning of next word.	Ctrl+→
Move to beginning of text.	Ctrl+Home
Move to end of text.	Ctrl+End
Insert a hard page break.	Ctrl+Enter
Insert a linefeed.	Shift+Enter
Backspace	Backspace
Delete the previous word.	Ctrl+Backspace
Insert a non-breaking space.	Ctrl+Shift+ Spacebar
Insert a File. Access a standard file selection window to insert a file that is in ASCII or rich text format (RTF).	Ctrl+O
Restore oversize text. When you receive a message that you've exceeded the maximum size of the text field, this restores the last saved version of the text.	Ctrl+Shift+R
Table Formatting	
Insert table row	Ctrl+M
Delete table row	Ctrl Shift+M
Gridlines	Ctrl+G

Maximum Size of Diagnostic Text Fields

Individual text fields do have an upper limit of data capacity that occasionally may be reached. An example of a diagnostic text field that could exceed the system limit is the Gross Description text field for an Autopsy specimen.

For client using the Word text editor, a single diagnostic Word text field can contain up to 32,000 (or 32K) of data content. The characters used by the Microsoft Word product, which are considerable in Word XP and 2003, are not subject to this same limitation. Some Windows MS Word products use a very large amount of RTF formatting.

If your text exceeds the limit, a warning message with instructions appears. For sites using Microsoft Word, a message similar to the following appears:
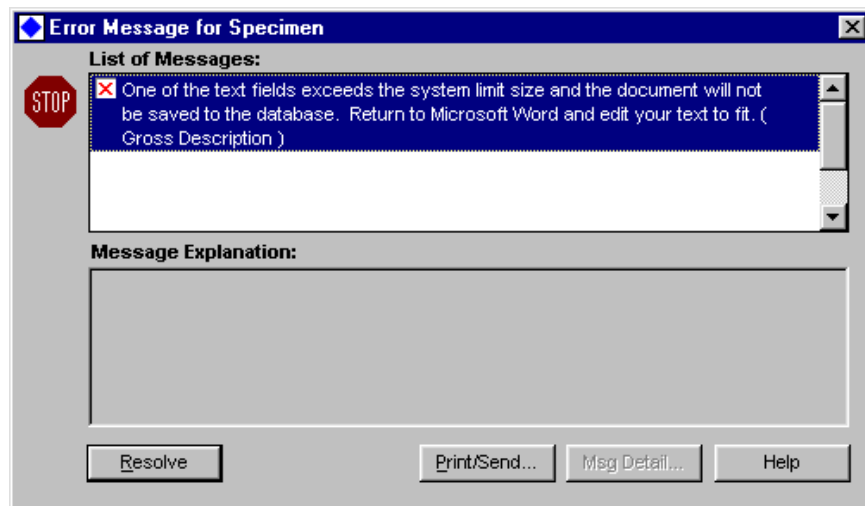
The non-formatted character overhead for sites using TxText as the CoPathPlus text editor is not as large as Word usage, but a single paragraph can still contain up to 22,000 (or 22K) non-formatted characters. The total size of content plus rtf formatting characters allowed in a text field is 32K.

WARNING: For sites using TxText as the CoPathPlus text editor, CoPathPlus may exit you from the system if you use only one paragraph for your text and the text exceeds the limit of 32K. If this happens, new information entered will be lost. To avoid this, diagnostic text should be entered as a series of paragraphs, rather than as one long paragraph.

For sites using TxText, the following message appears when you attempt to leave the text field or save the text:
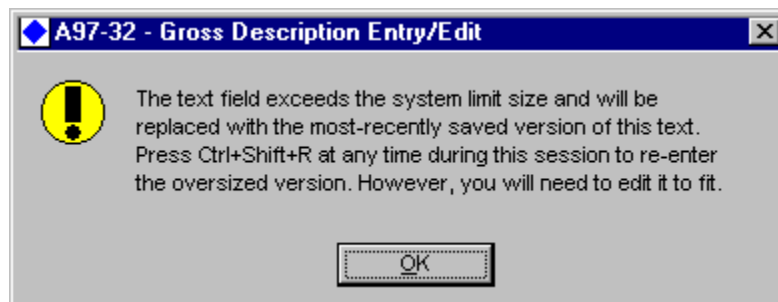
Follow these steps when the diagnostic text exceeds the maximum size:

For Microsoft Word:

1) After you receive a message indicating that the text field exceeds the system limit size, press <u>**Resolve**</u> to clear the message.

2) Press (Edit Text) or (Edit Report) on the toolbar to return to Microsoft Word, and then press (Go to Field) to go to the Gross Description text field.

3) To move the excessive text to a different text field, highlight a few paragraphs of text at the bottom of the text field, and press Ctrl+X to place that text on the Clipboard. Or, you can temporarily paste the text in another Microsoft Word document.

   NOTE: You can also edit the text in the text field so that it does not exceed 32K. In that case, skip to Step 6.

4) Press to go to a diagnostic text field that has room for more text.

5) Press Ctrl+V to paste the text.

6) Press on the toolbar to return to CoPathPlus.

7) Press on the toolbar to save the text.

   o If you are able to save successfully, the text field no longer exceeds the system limit. You can continue entering diagnostic information, as needed.

   o If the warning message re-appears, repeat steps 1 to 7 until it does not appear.

For TxText:

1) After you receive a message indicating that the text field exceeds the system limit size, press <u>**OK**</u> to clear the message. The text changes back to the last saved version.

2) Press Ctrl+Shift+R to restore the most recently entered text (i.e., the text that exceeds the system limit size).

3) To move the excessive text to a different text field, highlight a few paragraphs of text at the bottom of the text field, and press Ctrl+X to place that text on the Clipboard. Or, you can temporarily paste the text in a word processing program that preserves RTF formatting, such as Windows WordPad [but not Notepad] and Microsoft Word.

   NOTE: You can also edit the text in the text field so that it does not exceed 32K. In that case, skip to Step 6.

4) Press Ctrl+Q to move to a diagnostic text field that has room for more text.

5) Press Ctrl+V to paste the text.

6) Press on the toolbar to save the text.

   o If you are able to save successfully, the text field no longer exceeds the system limit. You can continue entering other diagnostic information, as needed.

   o If the warning message re-appears, repeat steps 1 to 6 until it does not appear.

Zooming Diagnostic Text Fields

You can expand any diagnostic text field in CoPathPlus to a larger size than you see on a window. To do this, press Shift+F8 while in the diagnostic text field and CoPathPlus opens a new pop-up window with your expanded diagnostic text field.

TIP! For sites using TxText, if you press Ctrl+8 instead of Shift+F8, CoPathPlus not only expands the diagnostic text field but displays it in Preview mode. Preview mode displays the text exactly as it will appear on patient reports. For sites using Microsoft Word, you use the Patient Report Single Print activity to preview a patient report.

NOTE: For sites using Microsoft Word, the zoom command (Shift+F8) at diagnostic text fields is used only to view more of the diagnostic text; it is not used to edit text. The TxText formatting fields and buttons do not appear.

The following is an example of an expanded text field.
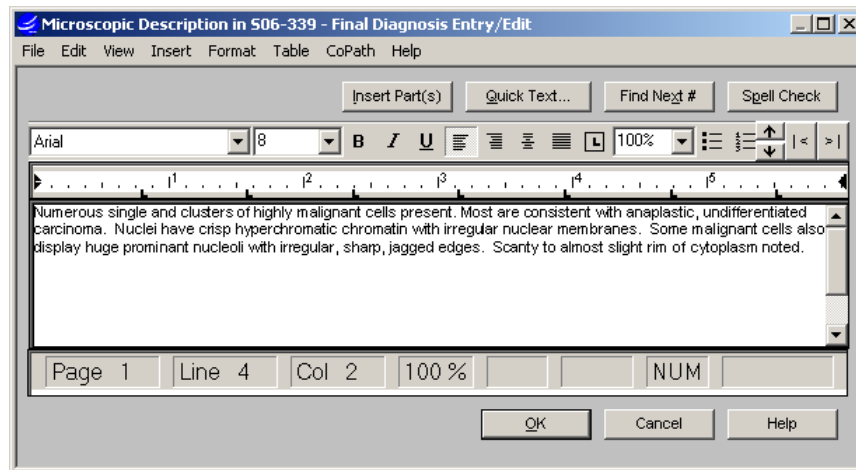
From the Zoom window, you can:

- Use the Zoom Window menu
- Set the tabs
- Insert Part Descriptions
- Use Quick Text
- Use Spell Check

Zoom Window Menu

The Zoom Window menu has the following options:

- File Menu
- Edit Menu
- View Menu
- Insert Menu
- Format Menu

- Table Menu

- CoPath Menu

File Menu

The File menu on the Zoom Window contains the following options:

- **Cancel**. The Cancel option, as well as the Cancel button in the lower right of the Zoom display, will prompt the user regarding whether they wish to save their changes or not before returning to the Specimen Activity screen.

- **Exit**. Use either the Exit option or the X in the upper right corner of the window, will close the Zoom display and return the user to the Specimen Activity without offering a save prompt.

Edit Menu

The Edit Menu on the Zoom Window contains the following options:

Changes from previous keystroke functionality, when existing, are also indicated below.

- **Undo (Ctrl+Z):** Undo was previously only available via a keystroke combination.

- **Redo (Ctrl+Y):** This is a new option used to reverse the previous "undo".

- **Cut (Ctrl+X):** Cut was previously only available via a keystroke combination.

- **Copy (Ctrl+C):** Copy was previously only available via a keystroke combination.

- **Paste (Ctrl+V):** Paste was previously only available via a keystroke combination.

- **Delete (Del):** Previously, both the Del key and Ctrl + H executed a delete. The Del key continues to perform this operation. Ctrl + H has been redirected to the Replace function.

- **Select All (Ctrl+A):** Select All was previously only available via a keystroke combination.

- **Find (Ctrl+F):** Find is an updated feature that invokes a the Find Popup window. This popup allows entry of the text for the search and also provides options for matching case and searching both forwards and backwards. This popup also provides an option to continue to search for the next occurrence of the text string.

- **Replace (Ctrl+H):** Replace is an updated feature that presents a popup window which includes "Find what" and "Replace with" fields as well as buttons to initiate the actions of Find Next, Replace, and Replace All, and Cancel. An option is also provided for the Find action to match based on case.

View Menu

The View menu on the Zoom Window contains the following options:

- **Command Buttons**. Controls the display of the Insert Part(s) button, Quick Text button, Find Next# button and Spell Check button.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- **Button Bar**. Controls the display of the Font name, Font size, Bold button, Italics button, alignment buttons, Zoom drop-down, List button, Bullet button, Sub/Superscript buttons and Indent buttons.

- **Ruler**. Controls the display of the ruler, which is used to set tabs.

- **Status Bar**. Controls the display of the status bar, which displays on the bottom of the Zoom window. It displays the page number, line number, column number and zoom percentage.

- **Zoom**. Zoom text sizing percentages of 50, 75, 100, 150, and 200 percent.

- **Edit Mode** or **Page Preview Mode**. Controls how text is displayed in the Zoom window. Edit mode is the default view and Page Preview Mode displays in the Print version of the text.

Tool bar selection will persist for each CoPathPlus user (person in the Person Dictionary) until it is changed. I.e., the tool bars used for the previous text entry session will be the one(s) presented when the same user returns to a Zoom text entry session.

Size percentages and display modes do not persist for the user. Rather, each session will open up in a 100% Edit Mode display.

Insert Menu

The Insert Menu on the Zoom Window contains the following options:

- **Insert From File**. This feature copies file text into the document; it does not import images or entire files. It does import text from a Text File (.txt), RTF File. (.rtf) or a Word Doc (.doc). Use Ctrl + O or this menu option to perform this action. Navigate to the desired location and select the .txt, .rtf, or .doc file to be inserted. The file location most recently used for file insertion will be the default location presented the next time the Text From File feature is used.

- **Page break**. This feature inserts a page break in the text. Use this menu option Ctrl + Enter.

Format Menu

The Format Menu on the Zoom Window contains the following options:

- **Font Attributes**. Displays the Font Attribute pop-up window, which allows you to change the font type, font size, attributes, position and color. The following is an example of the Font Attribute pop-up window.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
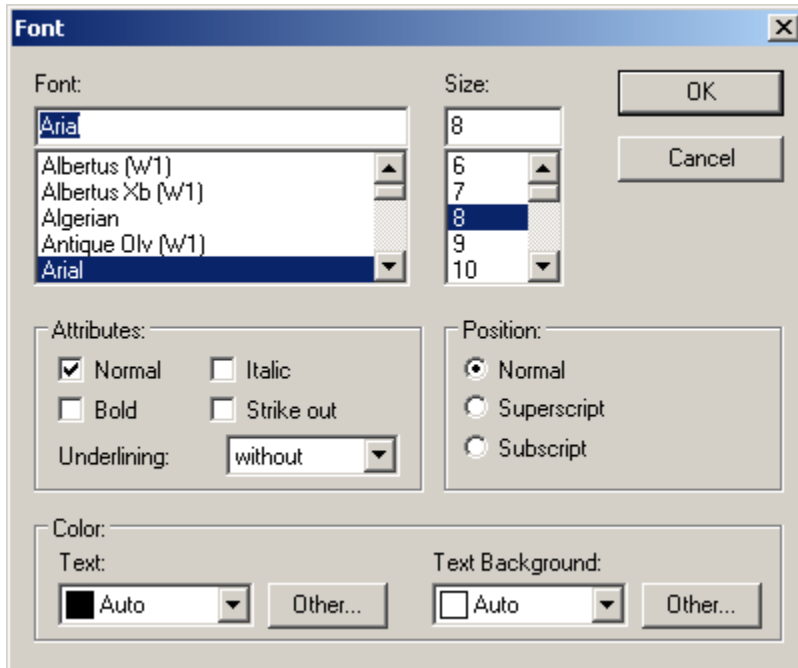
- **Paragraph Attributes**. Displays the Paragraph Attribute pop-up window, which allows you to change the line spacing, alignment, indents and distances. The following is an example of the Paragraph Attribute pop-up window.
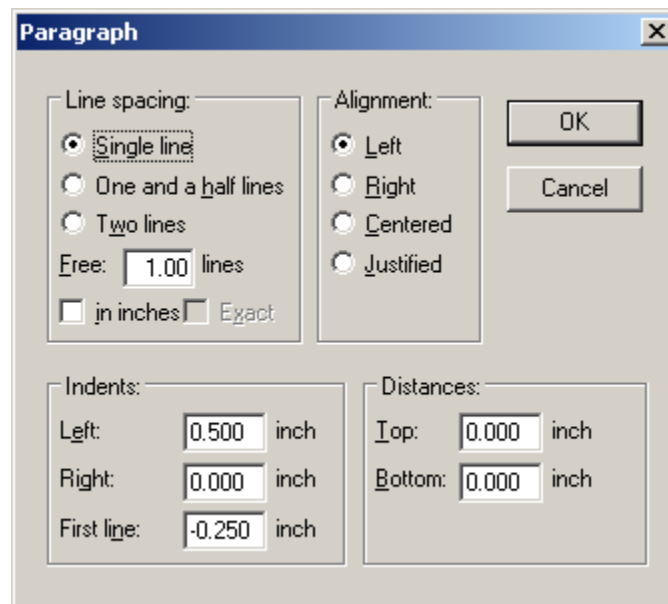
- **Paragraph Indent In** and **Paragraph Indent Out**. Toggles between indenting the text in the paragraph and removing the indent.

- **Tabs**. Displays the Tab pop-up window, which allows you to set or clear tab stop positions.

- **Bullets and Numbering.** The following are sub-menu options from this menu item:

o **Attributes**. Displays the Bullets and Numbering pop-up window, which allows you to configure the attributes for bulleted lists and numbered lists. The following is an example of the Bullets and Numbering Attributes pop-up window.
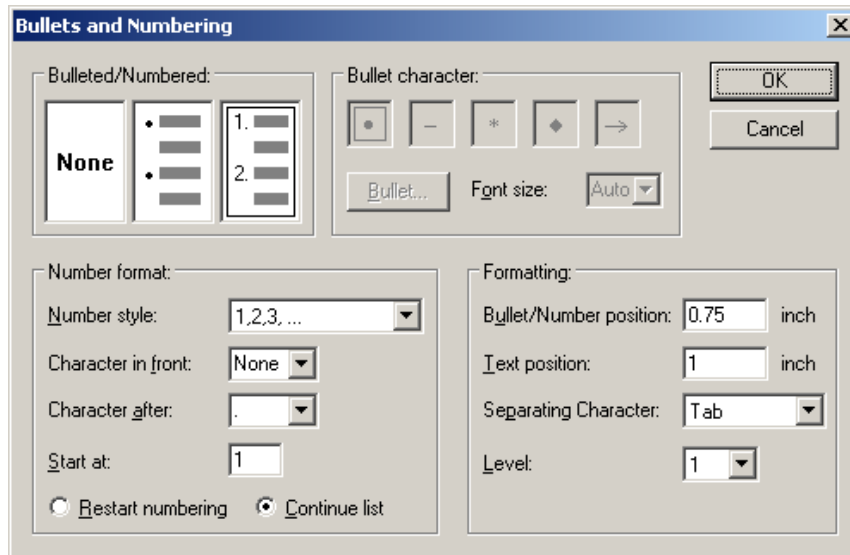
Select the desired bullet format from the displayed options or press the Bullet button for more choices. In the Font Size field, select a predefined font size for the bullets to use, else use the Auto option to have the system match the font size of the bullet to the Font size currently used in the text. Auto is the default selection.

Number Format Group Box:

♦ **Number Style:** Select the desired number style. Options are Standard Numbers, Uppercase Letters, Lowercase Letters, Roman Numerals, or Lowercase Roman Numerals.

♦ **Character in Front:** Select the character that should display in front of the number from the drop-down list. The default selection is no character.

♦ **Character After:** Select the character that should follow the number from the drop-down list. The default selection is a period.

♦ **Start At:** Indicate then character at which numbering should begin. Standard numbering starting points are the default.

♦ **Restart Numbering/Continue List radio Option:** By default, this option will be set to Continue List. Move the option to Restart Numbering when appropriate.

Formatting Group Box:

♦ **Bullet/Number Position:** Identify the starting position within the text field for the first, or left-most, bullet or number

♦ **Text Position:** Identify the starting position within the text field for the text that follows the first or left-most bullet or number

♦ **Separating Character:** Indicates whether the elements should be separated by tabs or spaces.

♦ **Level:** Indicates the bullet or number level of the cursor focus within the text field.

o **Increase Level** and **Decrease Level**. These options toggle the tab indent level for the selected bulleted or numbered list.

Table Menu

The Table menu allows the transcriptionist to add and modify tables within the designated text field. When the cursor is not located within a table in the text field, selection of the Table Menu will only provide the option to insert a new table. When the cursor is located in a table cell, or multiple cells have been highlighted, selection of the Table Menu will offer the appropriate table modification alternatives.

Note: While table use may be optimal in displaying certain type of data in a text field, not all result interfaces can accommodate text formatted into a table. No issues should be encountered if your outgoing result interfaces use PDF report formatting, but other interface types may not be able to accept data formatted in a table. You must test table-formatted text with your interfaces before implementing tables use into your workflow.

The Table Menu on the Zoom Window contains the following options:

• **Insert**. The following are sub-menu options from this menu item:

o **Table**. Displays the Table Size popup window for entry of table specifications. You may stipulate from 1 to 99 rows and from 1 to 9 columns for your table dimensions and then press the **Insert** button to create the table. The table will be placed into your text field according to the cursor location when the Insert Table function was invoked. The default table size is about seven and a quarter inches wide. Cells will be divided equally among the number of columns selected.

o **Insert Column to Left** and **Insert Column to Right.** Adds the designated column to a table. The width of the column will be the same as the width of the column where the cursor was positioned when the command is invoked. A column may not be added to the left of the first column or when column addition would make the table wider than allowed. The system will use the default TxText page width minus the left and right margins to determine maximum table width; which is typically about 7.25 inches. This width is not modifiable by the user and you will not be allowed to set a table to be wider than the allowed page width.

o **Insert Row Above** and **Insert Row Below**. Adds a row above or below the current cursor position. Only one row can be added at a time. A row may also be added to the bottom of the table by positioning the cursor in the last table cell and hitting the tab key. Inserted rows will always be of the standard row height. Row height is only changed by the presence of multiple lines of data within a cell or if the Top or Bottom Text Distance is changed within Table Properties.

• **Delete**. The following are sub-menu options from this menu item:

o **Table**. To delete a table, your cursor may be positioned within any table cell or any number of cells in the table may be highlighted. Select this menu option to delete the

entire table. You may also delete an entire table by highlighting the line above the table plus the entire table and then pressing the **Delete** key.

- o **Columns**. Select the columns you want to delete and then select this menu option to delete the selected columns.

- o **Rows**. Select the rows you want to delete and then select this menu option to delete the selected rows. You may also delete a row from the table by using Ctrl + Shift + M. The row in which the cursor resides will be deleted.

- **Split Table Above** and **Split Table Below**. Splits a table into two separate tables at the designated position. A line will be inserted between the two new tables.

- **Select Table** and **Select Row** and **Select Cell**. Selectis all of the data that exists within a single cell, row, or table. Selection will occur according to the position of the cursor when the Select command is invoked.

  Note: When a table is split, TxText still considers it a single table. As such, if your cursor is placed in the second or subsequent portion of a split table when the Select command is invoked, the resulting focus will be placed onto the cell, row, or table in the associated position in the first portion of the split table, rather than in the selected table portion.

- **Gridlines**. Toggles the display of gridlines to facilitate table entry or to view the data as it will look on a patient report. Alternately, the keystroke combination of Ctrl + G may be used to toggle gridlines off and on. The Gridlines toggle affects all tables within a single text field, including those added after the Gridline display is changed. Toggling off gridlines is a temporary change offered to allow the user to view the text as it would display on a report. When you exit the current text editor, moving to or from the Zoom window, or returning to a previously edited specimen, the gridlines will always redisplay. Gridlines will display when a patient report is viewed online, although they will not display on printed patient reports.

- **Table Properties**. Displays the Table popup window that allows updates to cell line width, background color, cell alignment, and text distances.

  - o **Frame** group box. Allows the line width of designated gridlines to be adjusted. If several cells were highlighted when the Table Properties popup was invoked, the user will be allowed to select gridlines above, below, right, left, vertical center, and/or horizontal center by clicking on them in the Frame graphic. If a single cell was in focus, only the four outside gridlines are indicated. Click on the desired gridlines to be changed and then update the "Line Width" field to make the designated size change.

  - o **Background**. Allows the configuration of a background color for table cells. The default configuration is to not use a background color. To set a background color, select a color from the drop-down list or from under the Other button. The User Defined option button will be automatically selected when a background color is chosen.

  - o **Vertical Alignment**. Allows you to format text placement within cells when there is more than one line of text within a cell. This text may be set to align at the top, bottom, or in the center of the cell.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

o **Text Distance**. The default settings of the distance of the text from the walls of a table cell may be altered if required. Default settings are 1.5 font points (Pt) for the right and left margins, and 0 font points for the top and bottom margins.

CoPath Menu

This menu provides a menu alternate to accessing the following features, which are also located on the Button Bar.

- Insert Parts. Refer to "Inserting Part Descriptions" for more information.

- Quick Text. Refer to "Using Quick Text" for more information.

- Find Next #. Refer to "Using Quick Text Templates" for more information.

- Spell Check. "Refer to "Using the Spell Check" for more information.

Setting Tabs on the Zoom Window

In addition to all of the standard buttons available when using TxText as the CoPathPlus text editor, you also have a tab bar and a ruler bar, shown in the following illustration, on which you can set tabs, indents, and margins.

NOTE: The default tab stops for text fields are determined by your site during implementation and specified in a system setting. The standard version of CoPathPlus has tab stops at every 0.5 inches.

To set tab stops on the tab bar:

1) From the Zoom window, press one of the following buttons on the text editor toolbar:

   o   to set a left tab.

   o   to set a right tab.

   o   to set a decimal tab.

   o   to set a centered tab.

2) Click on the tab bar above the ruler bar at the specific location at which you want to set the tab stop. CoPathPlus inserts a tab stop at that mark.

To remove tab stops from the tab bar:

1) On the tab bar, click on the tab stop you want to remove and hold down the mouse button.

2) Drag the tab stop down and off the tab bar. CoPathPlus removes the tab stop at that mark.

You can also set indents and margins on the tab bar for a text field, as follows:

NOTE: Changes that you make to a given paragraph affect only that paragraph. Attributes for any newly created paragraphs default from the previous paragraph.

To set indents or to change the left margin:

Move the top arrow to indent the first line of text.

Move the bottom arrow to indent (change the left margin for) everything after the first line.

To change the right margin:
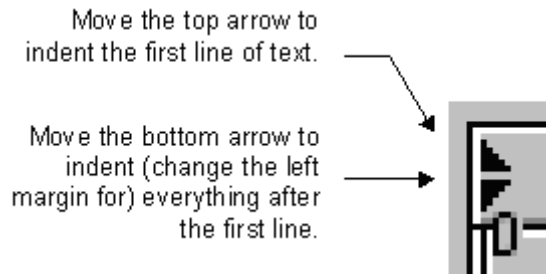
Move this arrow to change the right margin.
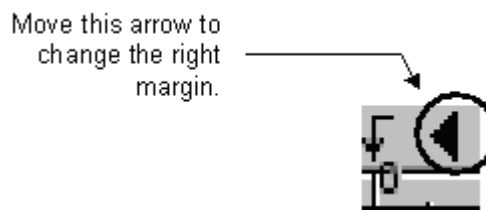
To close the zoom window, press O<u>K</u>.

Inserting Part Descriptions

CoPathPlus can automatically insert the part designation (if there is more than one part for the case) and part description for each part type(s) for this specimen into the text field. Parts are the components of the specimen submitted for diagnosis.

For sites using TxText as the CoPathPlus text editor, press **Insert Part(s)** on the toolbar to insert

the part description(s). For sites using Microsoft Word as the CoPathPlus text editor, press on the toolbar to insert the part description(s).

If you have Quick Text associated with the particular part type(s) you are inserting, CoPathPlus automatically inserts the Quick Text along with the part type(s) in the text field. For more information on Quick Text, refer to "Using Quick Text". For more information on setting up a Quick Text default for a part type, refer to "Part Type Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

NOTE: For sites using TxText as the CoPathPlus text editor, you have the option of using all uppercase letters for part descriptions when those descriptions are automatically inserted into a text field, regardless of how the description was entered in the Part Type dictionary. This feature, which makes the part descriptions easy to locate, is enabled via a system setting during implementation.

Using Quick Text

Quick Text represents text strings (sentences or phrases) stored for repeated use when entering text in a CoPathPlus diagnostic text field, such as Gross Description or Final Diagnosis. Instead of re-typing an entire text string into a text field, you can simply insert the Quick Text. The following are examples of Quick Text:

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- No evidence of carcinoma.

- Fine needle aspirate of thyroid with benign follicular cells and blood.

For sites using TxText as the CoPathPlus text editor, press **Quick Text** or F8 to insert Quick Text.

For sites using Microsoft Word as the CoPathPlus text editor, press on the toolbar to insert Quick Text.

Note that Quick Text behaves like a text accelerator, which means that you can enter the Quick Text abbreviation and then press the applicable button or key to immediately expand the abbreviation into a string of text without having to access the Quick Text window. You can also insert Quick Text templates. Refer to "Using Quick Text Templates" for more information.

A site stores its Quick Text in the CoPathPlus Quick Text dictionary. Refer to "Quick Text Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

To insert Quick Text:

1) Position the cursor in the text editor window at the location where you want to insert text and then press the applicable button or key to access Quick Text. For sites using TxText as the CoPathPlus text editor, press **Quick Text** on the toolbar or F8. For sites using

   Microsoft Word as the CoPathPlus text editor, press on the toolbar.

   The Quick Text Lookup window appears with a list of all available Quick Text for the text field you are in.

   NOTE: To view all available entries for this type of text field, always place the cursor after a blank space or on a blank line before you press **Quick Text**. Otherwise, the Lookup is restricted to entries that start with the text immediately preceding the cursor position.

2) To limit the list of Quick Text that appears, enter the name or name fragment of the Quick Text you want to insert in the Select field, and then press **Search**.

   A list of Quick Text that matches what you entered appears.

3) Select the Quick Text you want by clicking on it (the text appears in the bottom display) and pressing **OK** (or just double-click on the entry you want).

   The Quick Text you selected appears in your text field. Your site determines during implementation whether the text should retain its original text attributes (i.e., font type, font size, etc.), or whether the text will have the text attributes of the paragraph in the text field where it is inserted. Your site also determines whether the text is followed by two blank spaces (i.e., so that you are ready to type your next sentence or insert additional text).

To insert Quick Text by entering a Quick Text code or name:

1) Type the abbreviation, name, or name fragment of the Quick Text entry in the text field.

   NOTE: In order for CoPathPlus to recognize the name of the Quick Text, you must type it at the beginning of a line or make sure that a blank space precedes it.

2) For sites using TxText as the CoPathPlus text editor, press **Quick Text** on the toolbar or

   F8. For sites using Microsoft Word as the CoPathPlus text editor, press on the toolbar.

   If CoPathPlus finds:

   o   An exact match, it automatically inserts the Quick Text in your text field.

   o   More than one match, the Quick Text Lookup window appears with a list of all Quick Text that match your name fragment.

3) If there is more than one match, select the Quick Text you want by clicking on it (the text appears in the bottom display) and pressing **OK** (or just double-click on the entry you want).

   The Quick Text you selected appears in your text field.

Using Quick Text Templates

Your site can set up Quick Text entries that are Quick Text templates. A Quick Text template is the same as a regular Quick Text entry except that it contains *filler characters* where you need to enter case- or diagnosis-specific information once you retrieve the template for a diagnostic text field. In the standard export version of CoPathPlus, the default filler character for sites using TxText as the text editor is a pound sign (#). This means that your site defines the Quick Text entry with a "#" at each location where users need to fill in case-specific information. Your site can select a different filler character, if necessary.

For more information about how Quick Text entries are defined, refer to "Quick Text Dictionary " in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

To fill in a Quick Text template for a diagnostic text field:

NOTE: The process described below only applies to sites using TxText. For sites using Microsoft Word, you need to use either Microsoft Word's Search and Replace feature or create a macro that will find each designated filler character and let you enter the requested data.

1) After inserting a Quick Text template into the text field, press **Find Next #**.

   CoPathPlus goes to the beginning of the text field to begin searching. The first filler character (#) found in the text box appears highlighted.

2) Delete the filler character and enter the appropriate replacement text.

3) Press **Find Next #** to replace the next filler character.

   CoPathPlus continues searching from the point of the cursor onward.

4) Continue to press **Find Next #** until CoPathPlus displays the message "Fill in character not found".

5) Press **OK**.

   CoPathPlus returns to the text field.

You can now continue entering text in the text field.

Using the Spell Check

Both TxText and Microsoft Word include a spell check tool. For information about the Microsoft Word spell check tool, refer to your Microsoft Word documentation. For information about the TxText spell check tool, continue reading this guide.

NOTE: TxText is the CoPathPlus Text Editor that was previously referred to as "Visual Writer" or "VW".

You can perform the following activities with the TxText Spell Check tool:

- Check and correct the spelling of your entries in a text field.

- Add words not found in the standard dictionaries to your own workstation dictionary.

Press **Spell Check** at any CoPathPlus text field to activate the Spell Check tool. If the Spell Check does not recognize a word, the Word Not Found in Dictionary window appears. If it is spelled correctly, consider adding it to your workstation or system file.

When the spell check is complete, you receive a message and CoPathPlus places the cursor at the end of the text. If you cancel the spell check, the cursor remains in the same position where you canceled it.

NOTE: Visual Components® provides the Spell Check tool used in CoPathPlus. For detailed help instructions, press **Help** on the Word Not Found in Dictionary window. *Options* and *Thesaurus*, as outlined in the help system, are not available in the CoPathPlus system.

WARNING: If the spell check replaces words such that the resulting text area exceeds the 32,000 (or 32K) character limit, those characters that exceed the limit are omitted. Edit the text field and initiate the Spell Check again to continue.

Spell Check Dictionaries

The TxText Spell Check references two standard dictionaries:

- **American** (american.vtd), which provides basic English words, and

- **Stedman's** (stedmans.vtd), which provides medical terms.

The TxText Spell Check also references two custom dictionaries:

- **Workstation** (workstat.vtc), which lets you enter words that are available at your workstation only.

- **System** (system.vtc), which provides words that are entered into a system file by the System Manager and are available to all CoPathPlus users at your site.

Adding Words to the Spelling System and Workstation Dictionaries

CoPathPlus lets you build custom dictionaries for words that are not available in the standard dictionaries (American and Stedman's). The Spelling **Workstation** File (workstat.vtc) is a personal list of words that are produced and maintained at individual workstations, and are available to the workstation user only. The Spelling **System** File (system.vtc) is a system-wide list that is built and maintained by the System Manager and is available to all CoPathPlus users.

Note: When CoPathPlus is accessed via thin client (Citrix) workstation, workstation assignments are not static. I.e. the specific workstation id within CoPathPlus varies each time a thin client user signs on depending on available nodes when that sign on occurs. To effectively manage custom dictionaries for thin client connectivity, the Spelling

System File should be used rather than the Spelling Workstation File. Refer to the Troubleshooting Section of the System Managers Guide for additional setup information on the Spelling System File when using a Thin Client server.

You can add words to either spelling file through the Spelling Files folder accessed when you press the **Tasks** command button on the CoPathPlus Application Manager. In addition, you can add words to the Spelling Workstation File during a spell check.

NOTE: You can add single words or hyphenated words (e.g., Astler-Coller) to the custom spelling dictionaries, but you cannot add multiple word phrases (e.g., de novo, Breslow's depth, etc.). Instead, each word in the phrase should be added to the spelling dictionaries as a separate entry.

To add words to the Spelling Workstation File during the spell check:

1) Perform a spell check in your text field by pressing **Spell Check**.

   CoPathPlus performs a spell check and presents you with the Word Not Found in Dictionary pop-up window for any word it does not recognize.

2) On the Word Not Found in Dictionary window, select workstat.vtc (Workstation dictionary) in the field below the **Add to Custom** button.

3) Press **Add to Custom**.

   CoPathPlus adds the word to the dictionary and resumes the spell check.

To add words to the spelling dictionaries from the CoPathPlus Application Manager:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

2) Double-click on the Spelling Files folder.

3) Select the spelling dictionary to which you want to add new words: **Spelling Workstation File** or **Spelling System File** by highlighting it and pressing **Run** (or just double-click on the file).

   NOTE: Words added to the Workstation file are available to that workstation only. Words added to the System file are available to all CoPathPlus users at your site.

   The Spelling File window appears.

4) Add words into the list box, entering each word on a separate line. Do not use delimiters (commas, semicolons, or periods) to separate words.

5) When finished, press .

   CoPathPlus prompts you to save your entries.

6) Press **Yes** to save your entries and exit the current window.

   CoPathPlus saves your entries and closes the window. The words you added are now available each time you perform a spell check.

NOTE: You can also access the spelling files by placing them in your Personal Menu and double-clicking on them from there.

Tracking Clerical Productivity

You can access a CoPathPlus management report, Clerical Productivity by Text Field, that lists all the users that entered information in text fields and a count of how many lines each user entered per text field per day.

The number of characters which constitute a "line" of text is determined by your site at implementation and set via a system setting. The standard CoPathPlus system equates 80 characters to a line of text. Any text with less characters than the "line count" (<80) is rounded up to count as one additional line.

Refer to "Reports" for more information on CoPathPlus management reports.

Accessioning Specimens and Accession Entry/Edit

This section explains the process of accessioning a new specimen in CoPathPlus and editing accession data for an existing specimen. You can edit most accession data after filing the new specimen information, but you cannot edit accession data for specimens that have already been signed out.

New specimens must be accessioned before you can perform activities on them in the CoPathPlus system. When you accession a specimen, you create a new specimen number and record in the CoPathPlus database, and enter information about that specimen. (Specimen numbers often default to the next available number, which can be modified to another number, if necessary. Depending on dictionary configuration, accessioning for certain specimen classes may not offer a default specimen number.)

NOTE: A patient must be registered in CoPathPlus before you can accession a specimen for that patient.

The New Specimen activity lets users accession a new specimen, while the Accession Entry/Edit activity lets users both accession new specimens and edit accession information for existing specimens that have not yet been signed out. Editing accession information for existing specimens is particularly useful to those sites with heavy workflows. Staff can enter minimal patient information during the initial accessioning process, and then later, when time permits, continue entering specimen information using the Accession Entry/Edit activity.

Editing Accession Data for an Existing Specimen

To edit accession data for an existing specimen you need to use the Accession Entry/Edit activity:

1) Press the <u>Specimens</u> command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in "Using the Select Specimen Window".

3) Select **Accession Entry/Edit** in the Activity field on that window.

4) Press **OK**.

   The Accession Entry/Edit window for the specimen class associated with the specimen appears.

TIP! You can also access the Accession Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

In the standard export version of CoPathPlus, the Accession Entry/Edit window you see when editing accession data contains the same tabs you see when you enter accession data for a new specimen. However, when editing an existing specimen, the Accession Entry/Edit window contains the data you originally entered for the specimen.

Accessioning New Specimens

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., [...] and [▼]) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Before you can perform any specimen-related activities on a new specimen, you must first accession the new specimen through the following procedure:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears. Refer to "Using the Select Specimen Window" for more information about this window.

2) Press **New Specimen**.

   The New Specimen window appears.

   TIP! You can also access the New Specimen window by placing the New Specimen item in your Personal Menu and double-clicking on it from there. The New Specimen item is accessed by selecting File, Browse Items on the menu bar on the CoPathPlus Application Manager. The Personal Menu is the recommended access path for anyone who frequently uses the New Specimen activity.

   NOTE: You will see an Order Entry Number field on the New Specimen window if your site has an Order Entry Interface enabled. You use this field to associate an existing order entry number with a new specimen, thereby allowing results sent over a Results Reporting interface to have an associated order entry number. The order entry number selected also provides additional default accessioning information for the specimen. For more information, refer to "Using the Accession Entry/Edit Activity with the Optional Order Entry Interface".

   If you have recently accessioned a specimen for the current patient and you press **New Specimen**, you may receive a message asking if you want to edit the recently accessioned specimen or enter a new specimen. For more information, refer to "Adding Information to Recently Accessioned Specimens".

3) In the New Specimen window, enter data in the following fields:

   a) **Patient Name or MRN.** Identify the patient by entering the last name or medical record number (MRN) and press **Search**. If CoPathPlus presents the Select Patient window with a list (if you entered a patient name), select the name you want and press Enter (or double-click on the name). If you identified the patient on the Select Specimen window, the patient name appears as the default. For more information on this field, refer to "Entering Patient Name or MRN Information".

   NOTE: A patient must be registered in CoPathPlus before you can accession a specimen for that patient. Also, depending on how your site implemented CoPathPlus, the system may check for duplicate patient records when you accession a new specimen. If it does and your site allows it, certain users with permission may be able to merge duplicate patient records at this time. For more information about duplicate patient checking, refer to "Options from the Duplicate Patient Checking Window during New Specimen Entry".

   TIP! You can press the **Same Patient** button to accession a new specimen for the same patient on whom you were already working without having to perform another search. This button is only enabled if you previously identified a patient within the same session (i.e., without exiting CoPathPlus).

b) **Encounter Number.** Enter an encounter number for the patient. (Usually not valid for Card cases.) For more information on this field, refer to "Entering Encounter Number Information".

c) **Order Entry Number.** Identify an order, received through an Order Entry Interface, that you want to link to the new specimen. This field only appears for sites with an Order Entry Interface enabled. For more information, refer to "Using the Accession Entry/Edit Activity with the Optional Order Entry Interface".

d) **Specimen Class.** Identify a specimen class for the current specimen. For more information on this field, refer to "Entering Specimen Class Information".

e) **Specimen Number.** Accept or change the default specimen number. The accessioning process automatically generates a specimen number that identifies a record in the CoPathPlus system. For more information on this field, refer to "Accepting or Changing the Default Specimen Number".

NOTE: If you change the year or number that defaults in the Specimen Number field, you must press **Verify** for CoPathPlus to check the number you entered for conflicts. If conflicts exist, you receive an error message and you must fix the conflict before you can continue.

4) Press **OK**. The Accession Entry/Edit window for the specimen class you selected in Step 3c appears.

NOTE: Following accessioning, your institution may have a clerical staff member search the old manual card file for previous specimens for the patient. If any are found, you can enter them into CoPathPlus using either the Surgical Card or Cytology Card specimen class, if available at your site. To learn more about this, refer to "Accessioning Surgical Card Specimens" or "Accessioning Cytology Card Specimens".

You have completed the first phase of the accessioning process. In the next phase, you must enter information into the specimen class-specific Accession Entry/Edit window.

Entering Patient Name or MRN Information

The first step in accessioning a specimen using the New Specimen window is identifying the patient to which the specimen belongs. If you identified the patient on the Select Specimen window, the patient's name defaults in the Patient Name or MRN field on the New Specimen window.

If you did not identify the patient on the Select Specimen window or if you chose the New Specimen activity from your personal menu, enter the patient's last name in the Patient Name or MRN field and press **Search** (or Enter). The Select Patient window appears with a list of patient(s) that match your entry. From this window you can select an existing patient. Refer to "Using the Select Patient Window" for more information on this window.

NOTE: When you access the Select Patient window through the Select Specimen or New Specimen window, you can edit registration-related information for a patient by choosing **Edit Patient** or register a new patient by choosing **New Patient**.

You can also enter the patient's medical record number (MRN) in the Patient Name or MRN field on the New Specimen window. This type of search finds only exact matches. As a result, if you enter an MRN number that matches an existing patient record, that record is immediately selected.

Once you have identified the patient, CoPathPlus returns you to the New Specimen window. CoPathPlus displays the patient name in the Patient Name or MRN field and the associated encounter number in the Encounter Number field.

Entering Encounter Number Information

The second step in accessioning a specimen using the New Specimen window is entering the Encounter Number. Keep in mind the following rules concerning default Encounter Numbers:

- If a patient is identified by Encounter Number on the Select Specimen window, that number is the default in the Encounter Number field on the New Specimen window.

- If a patient is identified by Medical Record Number (MRN) on the Select Specimen window, the most-recent encounter for the client of that MRN is the default in the Encounter Number field on the New Specimen window.

- If a patient is identified by Medical Record Number (MRN) on the Select Specimen window, but there are no encounters for that client, the most-recent encounter for any client can automatically be the default (depending on a site-specific system setting).

- If a patient is identified in a way other than by Encounter Number or MRN, the most-recent encounter for this patient is the default in the Encounter Number field.

You can change the default encounter number or enter a new encounter through this field. When the Encounter Lookup window appears, press **New Encounter** to enter a new encounter. To learn more about encounters, refer to "Entering/Editing Encounter Information".

Entering Specimen Class Information

The Specimen Class field on the New Accession window lists all the specimen classes to which the user has access. Refer to the "Specimen Class Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

The standard CoPathPlus system currently provides for the following specimen classes:

- Surgical Routine

- Surgical Consult

- Surgical Procedure Only

- Surgical Histology Only

- Surgical Card

- Bone Marrow Routine

- Bone Marrow Card

- Cytology Gynecological (GYN)

- Cytology Non-Gynecological (Non-GYN)

- Cytology Procedure Only

- Cytology Fine Needle Aspirate (FNA)

- Cytology Card

- Autopsy Anatomic/Neuro

- Autopsy Anatomic Only

- Autopsy Neuro Only

- Autopsy Card

Accepting or Changing the Default Specimen Number

If a default number wheel has been entered in the Specimen Class Dictionary, CoPathPlus provides a default specimen number once you identify a specimen class on the New Specimen window. The name or prefix of the specimen number is stored in the Specimen Number Wheel Dictionary, which also contains the mechanism that controls the format of the specimen number. Refer to "Specimen Class dictionary" and "Specimen Number Wheel Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

You can change any portion of the specimen number on the New Specimen window. Whether you accept the default number or assign a different one depends on your department's policy for assigning numbers. Once a specimen number is assigned, you can retrieve the case by this number. If you change the default year or specimen number, you must press <u>Verify</u> for CoPathPlus to check the number you entered for conflicts. If conflicts exist, you receive an error message and you must fix the conflict before you can continue.

The specimen number consists of the following components:

- Number Wheel

- Year

- `Number`

Scanning New Specimen Numbers from Bar Code Labels

Sites that pre-assign specimen numbers for some or all accessioning work (typically by using pre-printed bar code labels) will want to disable the generation of the default numbers in the Specimen Number field on the New Specimen window.

To disable the generation of the default numbers in the Specimen Number field:

1) Your site must be set up for bar code scanning.

2) The *Cerner CoPathPlus*-only system setting "Barcode scan specimen number" must be enabled. See your *Cerner CoPathPlus* Application Analyst for details.

3) The "Preprinted Labels for Accession Number" check box must be selected in the Labels tab of the Specimen Class dictionary for the desired specimen class. Refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information.

NOTE: If your site is not set up to use bar code labels, you can still use this feature if you want to manually type the specimen numbers in the New Specimen window.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

When bar code scanning is enabled for a site and a selected specimen class, the New Specimen window appears.

Note that the **Scan Specimen # from Label** field appears between the Specimen Class and Specimen Number fields, and that a default specimen number does not appear.

With the cursor in the **Scan Specimen # from Label** field, scan in (or type) the full specimen number you wish to assign the current specimen (including number wheel, two-digit year, hyphen, and number portion.

CoPathPlus will then fill in the number portion of the Specimen Number field and enable the **OK** button. Press **OK** to accept the number and open the Accession Entry/Edit window.

Bar Code Label Format:

For bar code specimen number assignment with this feature, CoPathPlus requires a bar code that represents the entire specimen number, including prefix, year, and hyphen before the number portion. This can be accomplished in one of two ways: by printing the bar code of the specimen number as is, or by using *Cerner CoPathPlus*'s encryption global function.

Depending on the format and length of your specimen numbers, and the size of your label stock, a linear bar code version of your accession numbers may not fit onto the labels and still be large enough to be read easily by your bar code readers. To address this issue, *Cerner CoPathPlus* has created an encryption algorithm that turns any allowed specimen number format into a 12-digit number. This is done by taking the number wheel component of the accession number and encrypting it into a number up to three digits in length. Because numbers can be represented in a smaller bar code than letters, this method allows any CoPathPlus specimen number to be represented by an equal-size bar code. Barcode size is not an issue when 2D barcodes are used.

The encrypted numeric version of the specimen number wheel can be viewed in the **Barcode Number** field in the Specimen Number Wheel Dictionary. This can be used to help determine the format of your specimen number bar codes when ordering pre-printed labels. An example is shown below.

- Site will use a new number wheel of TP for liquid based GYN specimens. These will be pre-labeled with pre-printed slide labels. A new entry for TP is created in the Specimen Number Wheel dictionary. Upon saving, the encryption value of 41 is displayed. This means that the encrypted version of specimen numbers for this number wheel for the year 2001 will look like: 04101xxxxxxx, where 041 represents the number wheel (padded to three digits), the 01 represents the current year, and xxxxxxx represents the numeric portion of the year's numbers, starting with 0000001 for TP01-1.

Refer to "Specimen Number Wheel Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information.

NOTE: Should your site wish to use pre-printed labels for bar coded accessioning, *Cerner CoPathPlus* recommends ordering samples of label stock and testing with your TEST system and your site's bar code readers.

Adding Information to Recently Accessioned Specimens

If you choose to accession a new specimen for a patient for whom a specimen has been entered within a site-specified time period (e.g., within the last 24 hours), CoPathPlus asks you whether

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

you really want to accession a new specimen or enter a part for a specimen already accessioned. A message similar to the following example appears:
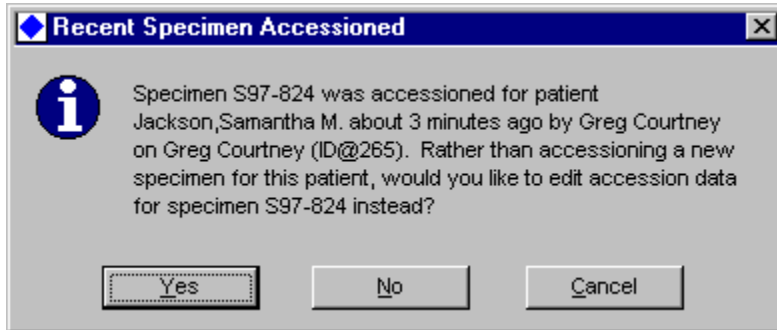
Choose from the following options:

- **Yes** lets you add a new part to the existing specimen.

- **No** lets you accession a new specimen.

- **Cancel** ends the current process.

NOTE: If you want to enter a new part for an existing specimen and this message does not appear (i.e., the defined time period for adding new parts has elapsed), choose the Accession Edit activity on the Select Specimen window.

Number Wheel

Represents the initial alphabetic character(s) of the specimen number and is based on the specimen class you select. You define the number wheel in the Specimen Number Wheel dictionary using a filter by specimen class. Refer to "Specimen Number Wheel Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary and filter. The standard CoPathPlus system provides the following default number wheels:

- **S** for Surgical specimens

- **C** for Cytology specimens

- **A** for Autopsy specimens

You can change the default number wheel by choosing another one from the drop-down list.

Year

Represents the year in which the specimen is accessioned. CoPathPlus enters the current year as a default. You can change the default to a different year. For card cases, an informational message appears if you enter the current year (since card cases typically represent older specimens), and you have the option of continuing or editing the year selected.

If you edit the year to a future year, a warning message appears. If the year is correct, press **Yes**. If the year is incorrect, press **No**.

Number

Represents the sequential number counter. This number appears highlighted in the Recent Specimens for this Number Wheel area as part of a consecutive list of specimens. Until accessioned, this specimen part is referred to as "New Specimen" in the Parts column. CoPathPlus enters a default number, which is the next available number for the number wheel specified. You can increase or decrease this number if you want, but if you choose a number that has already been assigned to a previous specimen, you receive an error message prompting you to choose a new number.

Using the Accession Entry/Edit Activity with the Optional Order Entry Interface

For sites using the optional Order Entry interface, there are some additional fields that appear during the Accession Entry/Edit activity.

Order Entry Number Field on the New Specimen Window

For sites with the Order Entry Interface enabled the New Specimen window includes an additional Order Entry Number field after the Encounter Number field.

The following is an example of the New Specimen window with the Order Entry Interface.

You can select an order, received through an Order Entry interface, that you want to link to the new specimen. An order can be linked to one specimen only. Once you link an order to a new

specimen, that order no longer appears on the Order Lookup window. The Order Entry Number field is disabled for patients with no available orders.

NOTE: Your site determines during implementation whether to have a patient's most recent available order appear as the default at the Order Entry Number field. You can also set up that field so that if there is just one available order for a patient, that order appears as the default.
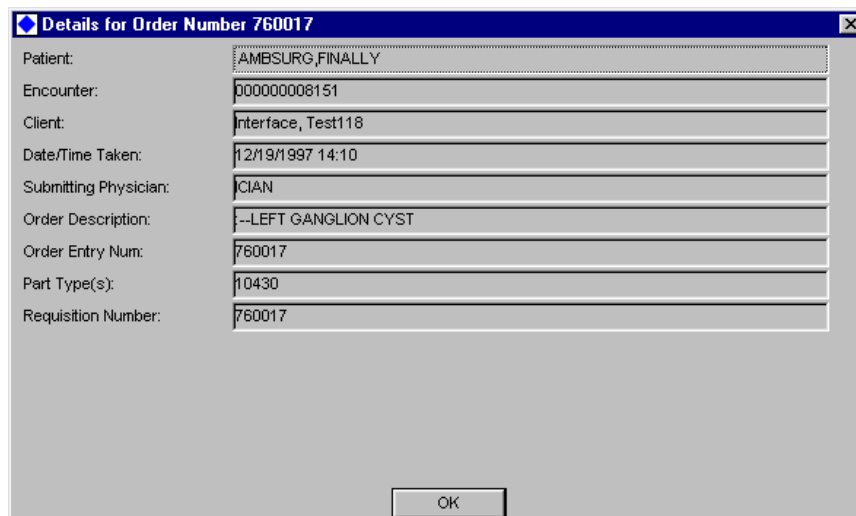
Your site determines, in the Specimen Class Dictionary, whether each specimen class allows linking to orders. If linking is allowed, you can specify whether the specimen class requires a linked order for new cases.

Press ⬚ at the Order Entry Number field to view a lookup of available orders for the selected patient (or a lookup of available orders for all patients, if no patient has been selected). An example of the Order Lookup window is shown below.

The Order Lookup window includes a **Details** button that you can press to view detail for the selected order.

To return to the Order Lookup window, press **OK**. Select the order you want and press **OK**. CoPathPlus fills in the Patient Name or MRN and Encounter fields on the New Specimen window based on the order you select.

Complete the fields on the New Specimen window, and press **OK**. A warning message appears if any of the following is true:

- You edited the default encounter number for the case to a different number (i.e., one that differs from the encounter number associated with the order).

- The specimen class' Department for Accession (specified in the Specimen Class Dictionary) does not match the linked order's department.

- The specimen class requires a linked order, but you have not linked an order to the case.

The Accession Entry/Edit window appears.

Order Entry Fields on the Accession Entry/Edit Window

For sites with the Order Entry Interface enabled, these additional fields appear on the Accession Entry/Edit window:
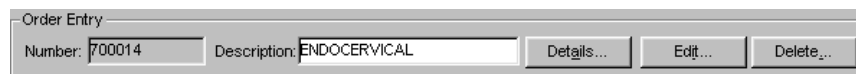
Enter the following information in the Order Entry fields:

Number. Lets you view the order entry number associated with this specimen. You cannot change the order entry number through this field.

Description. Lets you view the order description and edit it if needed.

Det<u>a</u>ils… button. Lets you access the Details for Order window where you can view detail for the order.

Ed<u>i</u>t… button. Lets you change the order linked to the specimen. If you do so on this window, just the order number and description are updated with the new information; any ADT information retrieved from the original order is not updated. The following message appears:
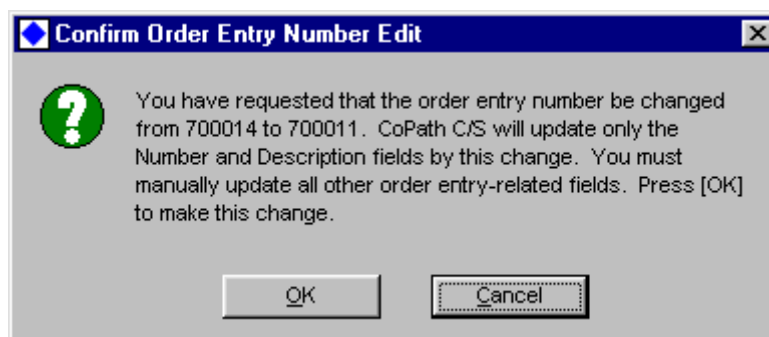
Press **OK** to confirm the edit, or **Cancel** if you do not want to make the change.

Delete<u>.</u>.. button. Lets you delete the link between the order and the specimen. The following message appears:

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
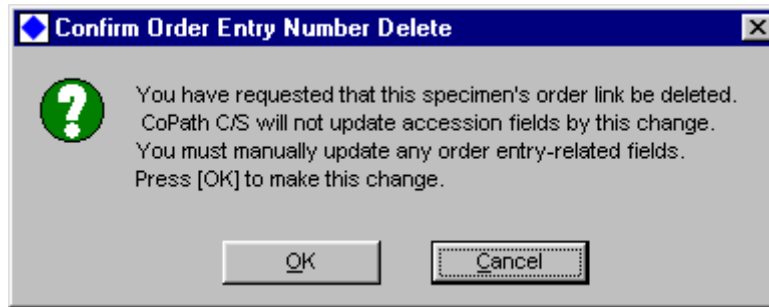
To delete the link, press **OK**. Otherwise, press **Cancel**. Once you delete a link, the order can then be linked to a different specimen.

NOTE: The order linked to the new specimen can provide default values during accessioning for the following fields: encounter number, client, part type, date/time taken, submitting physician. Your site determines during implementation which, if any, of those values you want to retrieve for the new specimen.

Accessioning Surgical Routine Specimens

This procedure begins the next phase of accessioning your Surgical Routine specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen class-specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Surgical Routine specimen contains the following tabs:

- Source/Copy To tab, which lets you enter part type information and lets you specify where additional report copies will go.

- Text tab, which lets you enter diagnostic information such as the Clinical or Intraoperative Consult Diagnosis.

- ADT/Staff tab, which lets you enter specimen data and fee codes and lets you identify pathologists and clinicians associated with the specimen.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. For more information, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., and) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Source/Copy To Tab on the Accession Entry/Edit Window for a Surgical Routine Specimen

NOTE: The Source tab for a Bone Marrow Routine specimen is identical to the Source tab for a Surgical Routine specimen. Your system may look different depending on the modifications made by your site.

Enter the following information on the Source tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

- **Part Type(s).** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

- **Description.** The Part Type Dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

- **Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

- **Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

  NOTE: For certain specimen classes, an additional Label Designator field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Designator field in the Part Type Dictionary. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Client. Select the client associated with the encounter number or change it, if necessary.

NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

Submitting Phys. This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Copy To.

- **Additional Physician(s).** Identify other clinician(s) related to this case. These physicians may default from an interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

- **Outside Institution.** Enter the name and address of a physician or institution to whom you want to send copies of reports. This is a free-text field that works in conjunction with the Outside Institutions Report Chute. Ask your System Administrator if this chute is used at your site.

Other Data. For detailed information about the check box and the pop-up windows accessed through these buttons, refer to "Other Data".

- **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

- **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

- **Order Procedures.** Click this button to open the Procedure/Addendum pop-up window, which lets you order a procedure or create an addendum for the current specimen.

NOTE: For certain specimen classes, an additional Print Container Labels check box can appear in the lower, right portion of this tab. If this check box is selected, container labels will print for new part types when you file this specimen. This check box is disabled if no new part types were added. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Copy/Edit Insurance button. Click this button to open the Encounter Entry/Edit window for the patient, where you can add new insurance information or edit existing information. For a description of the tabs and fields on this window, refer to "Entering/Editing Encounter Information".

NOTE: This button is only visible if the system setting "Multiple Insurance per Encounter" is set to Yes. Also, another system setting determines whether the full Encounter Entry/Edit window opens, or an abbreviated version that contains the insurance-related tabs and fields only.

The number in parentheses on the button represents the number of insurance records for the patient. When first used, this number is always zero. After its initial use, the button text and number are changed to indicate that insurance records exist and may be edited (e.g., from

Copy/Edit Insurance (0) to Edit Insurance (3)).

NOTE: If the patient's encounter was created automatically, the insurance and guarantor information (if any) that appears on the Encounter Entry/Edit window will default from the patient's encounter associated with his or her most recent specimen.

When you close the Encounter Entry/Edit window, you will return to the Accession Entry/Edit window.

Part Type(s)

Parts are the components of the specimen that are submitted for diagnosis. You can have more than one part type for each specimen, but you must enter at least one. You enter the part types in the **Part Type(s)** field, which is a required field.

Any default description defined in the Part Type dictionary appears in the **Description** field. This description is usually what you see on the Requisition Slip for the specimen. You can add to the description or replace the default. The part type description is required and appears in various places within CoPathPlus, including:

- Select Specimen window

- Select Specimen from Worklist window

- Patient reports

- Free-text fields, when the **Insert Parts** button is pressed.

The current date and time appear as the default in the **Taken** field, which represents the date and time at which the specimen was taken from the patient, and in the **Received** field, which represents the date and time at which the first part type for the specimen was received in the lab.

The values you enter in the Taken and Received fields for the first part type appear as default values for any subsequent part types entered. You can change either of these dates, if necessary.

CoPathPlus displays a part designator before the Part Type(s) field as you enter part(s) for this specimen. This designator can be a letter or a number and is determined by your site in the Specimen Class Dictionary.

If you have fee code(s) linked to part type(s) in the Part Type Dictionary, the appropriate default fee code(s) appear on this tab once you enter a part type and then save this specimen. For more information, refer to "Fee Code(s) "and "Billing Entry/Edit".

If you have procedure(s) linked to part type(s) in the Part Type Dictionary, the appropriate procedure is automatically ordered once you enter that part type and then save the specimen. For more information, refer to "Procedures/Addenda" and "Procedure/Addendum Entry/Edit".

Refer to "Part Type Dictionary", "Specimen Class dictionary" and "Billing Fee Code Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

Other Data

In the standard export version of CoPathPlus there are four buttons labeled Other Data.

- Spec/Req Deficiencies
- Other Case Numbers
- Retrieval Flag
- Order Procedures

For certain specimen classes, the following check box may also appear in the Other Data area:

- Print Container Labels

   NOTE: The Print Container Labels check box is available for all specimen classes except Card. The **Order Procedures** button is available for Surgical Routine, Cytology Non-Gynecological, Cytology Fine Needle Aspirate (FNA), Autopsy Anatomic/Neuro, and Autopsy Anatomic-Only specimen classes.

Specimen/Requisition Deficiencies

When you press **Spec/Req Deficiencies…** the following pop-up window, on which you can enter any specimen requisition/deficiencies you encounter, appears.

Specimen/requisition deficiencies involve choosing entries from a CoPathPlus dictionary that allows problems anticipated or encountered with a specimen during the accessioning process to be noted. Each specimen/requisition deficiency entered for a specimen (case) consists of a Specimen/Requisition Deficiency and a potential Specimen/Requisition Resolution, both of which are dictionary fields, with associated comments.

The Deficiency field next to the Specimen/Requisition Resolution Comment field is a free-text field in which you can enter the number of the Specimen/Requisition Deficiency that relates to the Specimen/Requisition Resolution. The number defaults to 1 and copies down to the next line.

Other Case Numbers

When you press **Other Case Numbers…**, the following pop-up window appears, on which you can enter other free-text case (specimen) numbers that are related to this specimen. This information can display on the Other Specimens for Patient window, Working Draft reports, Final reports, and reports you create using InfoMaker. To save changes and exit this window, press **OK**.

Retrieval Flags

When you press **Retrieval Flags…** a pop-up window, on which you can enter flags that you want to place the current specimen, appears.
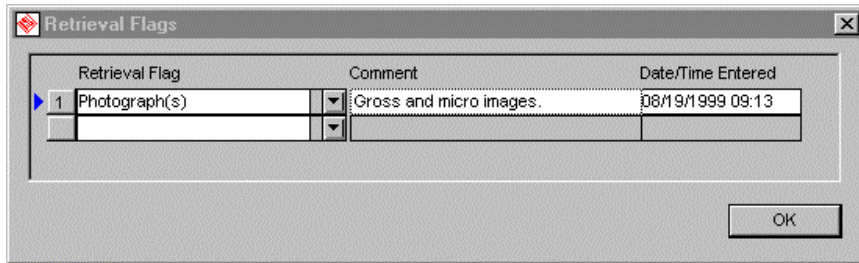
**CoPathPlus provides three standard management reports that you can use to obtain
retrieval flag information:**

- Retrieval Flags by Accession Date

- Retrieval Flags by Entry Date

- Retrieval Flags by Specimen Class

Procedures/Addenda

When you press **Order Procedures…**, a pop-up window appears, on which you can order a
procedure or create an addendum for the current specimen.

NOTE: The **Order Procedures…** button is available for Surgical Routine, Bone Marrow Routine, Cytology Non-
Gynecological, Cytology Fine Needle Aspirate (FNA), Autopsy Anatomic/Neuro, and Autopsy Anatomic-Only
specimen classes.
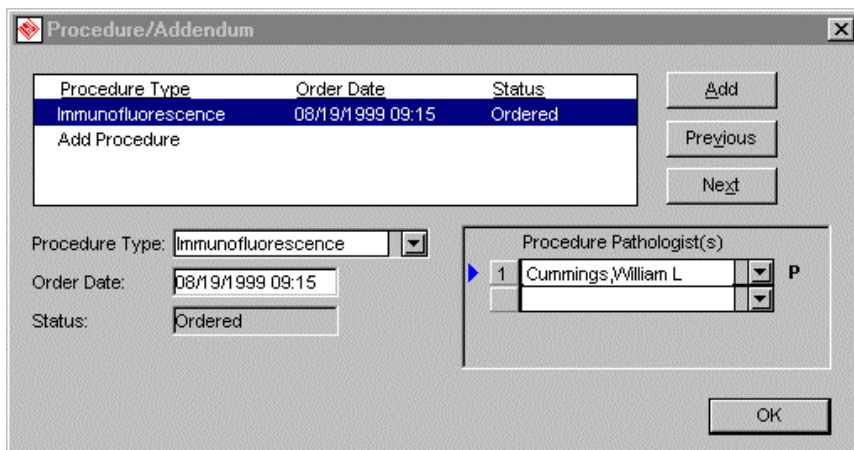
You use the Procedure/Addendum pop-up window to order a procedure and/or create an
addendum. To enter diagnostic information or to mark the procedure or addendum complete,
you must use the Procedure/Addendum Entry/Edit activity.

To enter a new procedure or addendum:

1) **Display field.** The top portion of this window lists all existing procedures or addenda for
   this specimen (case). The information associated with the procedure or addendum
   highlighted in the top portion displays in the bottom portion of the window. You can
   highlight the entry by clicking on it or press **Previous** or **Next** to move up and down the
   list. Press **Add** to enter a new procedure or addendum (or just double-click on the Add
   Procedure row).

2) **Procedure Type field.** Select the type of procedure that you are ordering or specify that this is an addendum. This is a dictionary field for which you can look up an entry in the Procedure dictionary. Refer to "Procedure Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

3) **Order Date.** Enter the date on which the procedure or addendum was ordered (the current date and time defaults). You can enter a past or present date but you cannot enter a future date.

4) **Status.** Specifies the status of this procedure or addendum. Possible statuses you may see include AM (amended), COMP (completed), ORD (ordered), S/O (signed out). You cannot change the information in the Status field.

5) **Procedure Pathologist(s).** Select the primary pathologist and/or resident associated with the procedure or addendum. You can also enter any additional pathologist(s) involved with the procedure or addendum. This is a dictionary field for which you can look up an entry in the Person dictionary. Refer to "Person Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary. Each procedure or addendum gets its own set of pathologists.

Printing Container Labels During Accessioning

The Accession Entry/Edit activity can be configured to print a container label for certain specimen classes. The Specimen Class dictionary determines whether container labels should be printed for each specimen class, and which container label entry in the Label Dictionary to use. For more information, refer to "Specimen Class Dictionary" in the "Accessioning Dictionaries" section and "Label Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

If container labels are set to print for a specimen class, these two additional fields appear on the Source tab in the Accession Entry/Edit activity for that specimen class.

1) **Label Designator.** This field appears after the Part Type Received date field, for all non-Cytology specimen classes. The Label Designator field determines which text prints on a container label for this part type. Default label text can be defined for each part type in the Part Type dictionary in the Label Designator field.

2) **Print Container Labels check box.** This check box appears under "Other Data" on the Source tab. When a new part type is entered for a specimen, this field is selected to indicate that container labels will print for the new part type when the specimen is saved. To prevent container labels from printing for the new part type(s), clear this field. This field is enabled only when you add a new part type to a specimen.

Container labels print to the label chute (i.e., printer) specified in the Label dictionary. For more information about label-related dictionaries, refer to "Label Chute Dictionary" and "Label Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Container and Requisition labels can be reprinted using the Container Label Reprint activity. For instructions on using that activity, refer to "Container Label Reprint".

Printing Requisition Labels During Accessioning

The Accession Entry/Edit activity can be configured to print a requisition label for certain specimen classes. The Specimen Class Dictionary determines whether requisition labels should be printed for each specimen class, how many requisition labels to print, and which requisition label entry from the Label Dictionary to use. For more information, refer to "Specimen Class" in the "Accessioning Dictionaries" section and "Label Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Requisition labels print to the designated label chute after you save the specimen for the first time during the Accession Entry/Edit activity. For information about defining default label chutes for requisition labels, refer to "Label Chute Dictionary" and "Label Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Requisition labels can be reprinted using the Container Label Reprint activity. For instructions on using that activity, refer to "Container Label Reprint".

Copy To

If your site uses multiple addresses, you need to select the appropriate address for the clinician you are entering in the Additional Physician(s) or Submitting Phys fields. If you do a dictionary lookup on this field, you see a list of all people in the CoPathPlus Person Dictionary with a person type of clinician, resident, fellow, or pathologist. To do a lookup if you know the address, you can enter a name fragment, followed by a slash (/), and then the address (e.g., SMK/Cambridge). CoPathPlus enters the clinician's name and address in the field.

The assignment of an additional physician to a specimen ensures that all patient reports for this specimen will be distributed to that physician. A physician's report chute information is defined in the Person dictionary. The report chute used for distribution of patient reports to an outside institution is defined in the Specimen Class dictionary.

For more information, refer to "Person Dictionary" and "Specimen Class Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

Text Tab on the Accession Entry/Edit Window for a Surgical Routine Specimen

NOTE: The Text tab for a Bone Marrow Routine specimen is identical to the Text tab for a Surgical Routine specimen. Your system may look different depending on the modifications made by your site.

For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Mark Intraoperative Diagnosis Complete. Select this check box to mark the Intraoperative Diagnosis complete in CoPathPlus.

S̲ave/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

ADT/Staff Tab on the Accession Entry/Edit Window for a Surgical Routine Specimen

NOTE: The ADT/Staff tab for a Bone Marrow Routine specimen is identical to the ADT/Staff tab for a Surgical Routine specimen. Your system may look different depending on the modifications made by your site.

Enter the following information on the ADT/Staff tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Billing Number.** The billing number may be predefined per client, may use the current encounter number, or may require specific data entry.

3) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters You can change the billing type or accept the default.

5) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

Staff. For detailed information on these fields, refer to "Staff".

1) **Gross Pathologist(s).** Select the name(s) of the gross pathologist(s), if any, associated with this specimen.

   NOTE: During the CoPathPlus implementation process, this field may have been renamed as "Prosector(s)," a common designation.

2) **Intraop Consult Pathologist(s).** Select the name(s) of the intraoperative consult pathologist(s), if any, associated with this specimen.

3) **Pathologist(s).** Select the name(s) of the case pathologist(s) associated with this
specimen.

Fee Codes button. Click this button to access the Fee Codes pop-up window on which you can
enter and edit billing fee code information for this specimen. For detailed information on the fee
code fields, refer to "Fee Codes".
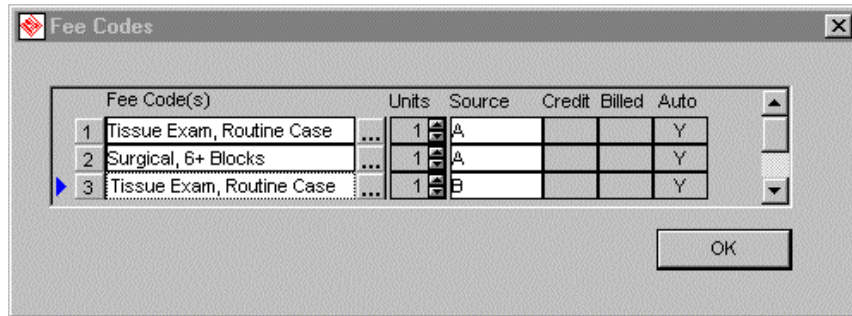
Enter the following information on the Fee Codes pop-up window:

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on
   the specimen. Once you enter a fee code, it generally becomes available for Technical
   and Professional billing when the case is signed out. Note that CoPathPlus automatically
   bills via several triggers (part type, stain/process, procedure, and more) so you can elect
   to defer showing fee codes until later activities when most fee codes would have been
   entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon
   settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen
   Class Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus* Dictionary Building
   Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged.
   The default is 1 or the stain/process slide count. This field is disabled for charges created
   from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually
   entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures
   and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus
   completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a
   charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee
   code has been billed, a **P** if just the professional component of the fee code has been
   billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically
   through a dictionary link, or is blank if it was entered manually.

7) Press **OK** to return to the ADT/Staff tab on the Accession Entry/Edit window.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Specimen Data

You enter specimen data on any tab and activity in CoPathPlus that allows it, including the Source tab on the Accession Entry/Edit window.

The specimen data that displays, with the exception of Priority, can be default information from an Admission/Discharge/Transfer (ADT) interface. You can change the default information. To learn more about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

- The encounter number entered on the New Specimen window displays in the Encounter field. You can change the encounter number displayed in this field to a different patient encounter, or enter a new encounter. When you do so, CoPathPlus presents a message pop-up window asking you if you want to overwrite existing encounter data with data associated with the other number. To learn more about encounters, refer to "Patients".

- The **Billing Number** is a visit-specific number needed by some billing offices that generally corresponds to the Encounter Number. This number will default to the most-recent encounter for the patient.

- CoPathPlus displays the client associated with the encounter in the Client field, which is a required field. In CoPathPlus, you store client information in the Client Dictionary. For more information on clients, refer to "Client Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual.*

  NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

- You can identify a **Billing Type** or category to which specific charges can be assigned. The billing type may be defaulted from data received through the ADT interface, specimen class, and/or client. If it does not or if you need to change the billing type, you can choose one from the drop-down list. Refer to "Billing Type Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on billing types.

- The **Location** field specifies the place where the patient was when the specimen was taken. This information can default from encounter information. This location never changes even if the location of the patient changes through an ADT update.

- The value in the **Service** field defaults from the ADT interface or you can enter a service in this field that is associated with this specimen.

- You can enter the specimen's priority in the Priority field, which is a required field, or accept the default. The default priority and available priorities vary depending on the specimen class. Examples of priorities include: Routine, Cytology Routine, Autopsy Routine, Missing, Stat, Decalcification.

- The physician you enter or that defaults from an ADT interface in the **Submitting Phys** (Physician) field represents the doctor ordering this specimen. You can change the physician that appears or enter a new one. You have the ability to choose the correct

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

address for a clinician. If you do a dictionary lookup on this field, you will see a list of all people in the CoPathPlus Person Dictionary with a person type of clinician, resident, fellow, or pathologist.

If your site uses multiple addresses, you need to select the appropriate address for the clinician you are entering. To do a lookup if you know the address, you can enter a name fragment, followed by a slash (/), and then the address (e.g., SMK/Cambridge). CoPathPlus will enter the clinician's name and address in the field.

Staff

All the staff fields are dictionary fields for which you can look up an entry in the CoPathPlus Person Dictionary. You can enter the name(s) of the physicians associated with this specimen during the accessioning process or you can enter them later during other activities associated with this specimen (e.g., Gross Description Entry/Edit, Final Diagnosis Entry/Edit). Note that which staff fields display and the order of these fields depend on which specimen class and activity you are currently working with.

The first pathologist you enter in each field becomes the Primary Pathologist as denoted by a **P** after the name, and the first resident entered becomes the Primary Resident for that field as denoted by an **R** after the name.

To learn more, refer to "Person Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

TIP! You can rearrange the order of the pathologists listed (refer to "Multi-Row Control").

Fee Code(s)

Enter as many fee codes as are appropriate for the services performed on this specimen in the **Fee Code(s)** field. If you have fee code(s) linked to part type(s) in the Part Type Dictionary, CoPathPlus can automatically default in the appropriate fee code(s) once you enter a part type and then save this specimen. Fee codes can also default from the Stain/Process and Procedure dictionaries. For more information, refer to "Billing Entry/Edit". Refer to the "Part Type Dictionary", "Stain/Process Dictionary" and "Procedure Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

The Fee Code(s) field is a dictionary-linked field for which you can look up an entry in the Billing Fee Code Dictionary.

Corresponding to each fee code are the following fields:

- **Units**, which specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

- **Source**, which designates the part type or procedure/addendum this fee code is linked to. In the case of a part type, you will see a part designator (e.g., A, B, 1, 2). In the case of a procedure/addendum, you will see the corresponding abbreviation (e.g., ADD, EM). For linked codes, CoPathPlus fills in this field automatically and copies down a default from the prior row. You fill in this field for manually entered codes.

- **Credit**, which is a display-only field that contains an **X** if this fee code is a credit rather than a charge. For more information, refer to "Entering a Credit".

- **Billed**, which is a display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

- **Auto**, which is a display-only field that contain an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually

Once you enter a fee code row, it becomes available for billing either immediately or after the case has been signed out, depending on the workflow at your site. Once a fee code is available for billing, it awaits the compilation of your site's billing batches. For more information on billing batches, refer to "Billing Functions".

Refer to "Billing Entry/Edit" for more information on billing terms and concepts. Refer to "Billing Fee Code Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on fee codes.

Accessioning Surgical Consult Specimens

This procedure begins the next phase of accessioning your Surgical Consult specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Surgical Consult specimen contains the following tabs:

- Source, which lets you enter information such as part type, specimen data, and fee codes.

- Staff/Copy To, which lets you enter pathologists and clinicians associated with the specimen and to specify where additional report copies will go.

- Text, which lets you enter text field information such as the Clinical or Intraoperative Diagnosis.

Source Tab on the Accession Entry/Edit Window for a Surgical Consult Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Source tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

2) **Description.** The Part Type Dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

   NOTE: For certain specimen classes, an additional Label Designator field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Designator field in the Part Type Dictionary. For more information about container labels, refer to "Printing Container Labels During Accessioning".

**Specimen Data.** For detailed information on these fields, refer to "Specimen Data".

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Billing Number.** The billing number may be predefined per client, may use the current encounter number, or may require specific data entry.

3) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Keep Slides. Select this check box if any slides sent out for review need not be returned. Otherwise, clear the check box.

Fee Code(s). For detailed information on the fee code fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Staff/Copy To Tab on the Accession Entry/Edit Window for a Surgical Consult Specimen

Enter the following information on the Staff/Copy To tab:

Pathologist(s). Select the name(s) of the case pathologist(s) associated with this specimen. For detailed information on this field, refer to "Staff".

Additional Physician(s). Identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Personal Consult. Select this check box if this specimen was a referral to a particular pathologist in your anatomic pathology department.

Outside Institution. Enter the name and address of a physician or institution to whom you want to send copies of reports. This is a free-text field.

Text Tab on the Accession Entry/Edit Window for a Surgical Consult Specimen

NOTE: For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Save/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. When you finish entering information on the Accession Entry/Edit window for a Surgical Consult specimen and save your changes, the Next Process pop-up window appears.

Specifying the Next Process for the Accession Entry/Edit Activity for a Surgical Consult Specimen

Once you finish entering or editing information on the Accession Entry/Edit window for a Surgical Consult specimen, the Next Process pop-up window appears. You need to specify what action CoPathPlus should take next.
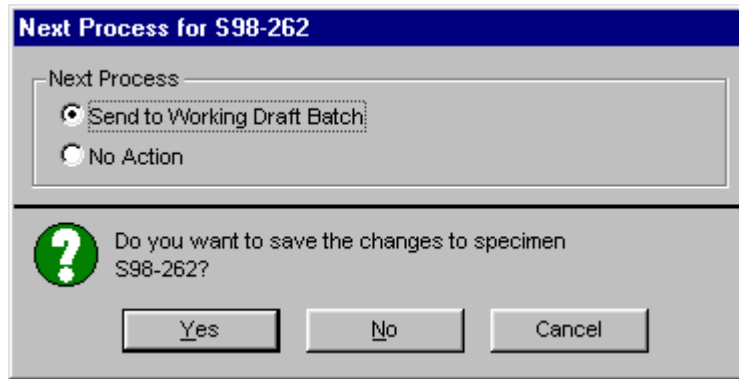
To have CoPathPlus:

- Save your changes and place this specimen on the Working Draft Batch, press **Yes**.

- Save your changes and perform no other action, click on the No Action option button and then press **Yes**.

- Exit this specimen without saving any changes, press **No**.

- Return you to the Accession Entry/Edit window without performing any action, press **Cancel**.

Accessioning Surgical Procedure-Only Specimens

This procedure begins the next phase of accessioning your Surgical Procedure-Only specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Surgical Procedure-Only specimen contains the following tabs:

- Source, which lets you enter information such as part type, specimen data, and fee codes.

- Staff/Copy To/Text, which lets you enter pathologists and clinicians associated with the specimen, to specify where additional report copies will go, and to enter text field information such as the Clinical Diagnosis.

- Procedure/Addendum, which lets you order procedures or create addenda for the current specimen.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. For more information, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ▭ and ▭) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

When you finish entering information on the Accession Entry/Edit window for a Surgical Procedure-Only specimen and save your changes, the Next Process pop-up window appears. Refer to "Specifying the Next Process for the Accession Entry/Edit Activity for a Surgical Procedure-Only Specimen" for more information.

Source Tab on the Accession Entry/Edit Window for a Surgical Procedure-Only Specimen

Enter the following information on the Source tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

   NOTE: For certain specimen classes, an additional Label Designator field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Designator field in the Part Type Dictionary. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Billing Number.** The billing number may be predefined per client, may use the current encounter number, or may require specific data entry.

3) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Fee Code(s). For detailed information on the fee code fields, refer to "Fee Code(s) "

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Staff/Copy To/Text Tab on the Accession Entry/Edit Window for a Surgical Procedure-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Staff/Copy To/Text tab:

Gross Pathologist(s). Select the name(s) of the gross pathologist(s) associated with this specimen. For detailed information on this field, refer to "Staff".

Additional Physician(s). Identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to whom you want to send copies of reports. This is a free-text field.

Diagnostic Text Fields.

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Procedure/Addendum Tab on the Accession Entry/Edit Window for a Surgical Procedure-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

You use the Procedure/Addendum tab to order a procedure and/or create an addendum. To enter text field information or to mark the procedure or addendum complete, you must use the Procedure/Addendum Entry/Edit activity.

Enter the following information on the Procedure/Addendum tab:

1) **Display field.** The top portion of this tab lists all existing procedures or addenda for this specimen (case). The information associated with the procedure or addendum highlighted in the top portion displays in the bottom portion of the tab. You can highlight the entry by clicking on it or press **Previous** or **Next** to move up and down the list. Press

Add to enter a new procedure or addendum (or just double-click on the Add Procedure row).

2) **Procedure Type field.** Select the type of procedure that you are ordering or specify addendum. This is a dictionary field for which you can look up an entry in the Procedure dictionary. Refer to "Procedure Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

3) **Order Date.** Enter the date on which the procedure or addendum was ordered (the current date and time defaults). You can enter a past or present date but you cannot enter a future date.

4) **Status.** Specifies the status of this procedure or addendum. Possible statuses you may see include AM (amended), COMP (completed), ORD (ordered), S/O (signed out). You cannot change the information in the Status field.

5) **Procedure Pathologist(s).** Select the primary pathologist and/or resident associated with the procedure or addendum. You can also enter any additional pathologist(s) involved with the procedure or addendum. This is a dictionary field for which you can look up an entry in the Person dictionary. Refer to "Person Dictionary" the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary. Each procedure or addendum gets its own set of pathologists.

Save/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. When you finish entering information on the Accession Entry/Edit window for a Surgical Procedure-Only specimen and save your changes, the Next Process pop-up window appears

Specifying the Next Process for the Accession Entry/Edit Activity for a Surgical Procedure-Only Specimen

Once you finish entering or editing information on the Accession Entry/Edit window for a Surgical Procedure-Only specimen, the Next Process pop-up window appears. You need to specify what action CoPathPlus should take next.
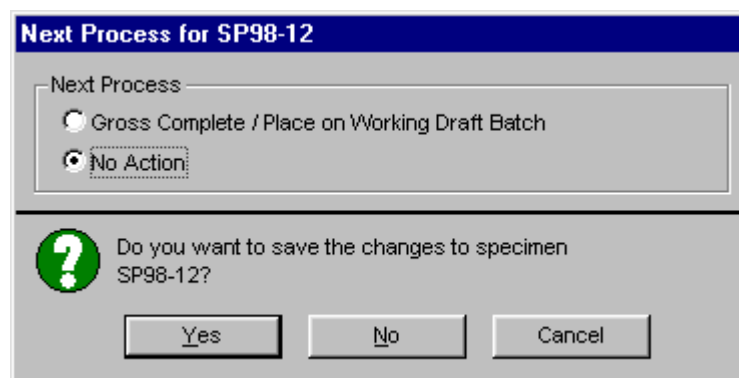
To have CoPathPlus:

- Save your changes and perform no other action, press **Yes**.

- Save your changes, mark the Gross Description complete, and place this specimen on the Working Draft Batch, click on the Gross Complete / Place on Working Draft Batch option button, and then press **Yes**.

- Exit this specimen without saving any changes, press **No**.

- Return you to the Accession Entry/Edit window without performing any action, press **Cancel**.

To continue the accessioning process, refer to "Next Step for the Accession Entry/Edit Activity".

Accessioning Surgical Histology-Only Specimens

This procedure begins the next phase of accessioning your Surgical Histology-Only specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Surgical Histology-Only specimen contains the following tabs:

- Source tab, which lets you enter information such part type, specimen data, and fee codes.

- Histology tab, which lets you enter histology data for part, block, block/designation/sectioning site, stain/process information, and associated dependent information.

- Staff/Copy To/Text Tab, which lets you enter pathologists and clinicians associated with the specimen, to specify where additional report copies will go, and to enter diagnostic information such as the Clinical Diagnosis.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. For more information, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ▦ and ▦) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to CoPathPlus Controls.

NOTE: For certain specimen classes, an additional Print Container Labels check box can appear in the lower, right portion of this tab. If this check box is selected, container labels will print for new part types when you file this specimen. This check box is disabled if no new part types were added. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Source Tab on the Accession Entry/Edit Window for a Surgical Histology-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Source tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

5) **Load check box.** If a default histology protocol has been set up for a part type, this check box is automatically selected. (Once the protocol has been run for the part type, this check box is cleared.) The name of the default histology protocol appears in the **Protocol Name** field. If there is no default protocol for a part type, and you want to use an existing histology protocol to order the blocks and stains/processes for the part type, select this check box and then proceed to the **Protocol Name** field.

6) **Protocol Name.** The name of the default histology protocol for each part type appears, but can be edited to a more applicable protocol, if needed. If no default is specified for a part type, and you want to use an existing protocol to order blocks and stains/processes for that part type, select the histology protocol to use.

    NOTE: CoPathPlus disables the Protocol Name field if the protocol has already been run. It also disables that field if the Load check box has not been selected.

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Billing Number.** The most recent encounter number appears as the default.

3) **Client.** Select the client associated with the encounter number or change it, if necessary.

    NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from an ADT interface and other specimen data. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Fee Code(s). For detailed information on the fee code fields, refer to "Fee Code(s) "

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Histology Tab on the Accession Entry/Edit Window for a Surgical Histology-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site. Also, an activity can be set up to run protocols automatically either when you access a tab page (other than the first tab page) that includes the **Run Protocol(s)** button or when you save the case.

Enter the following information on the Histology tab:

Gross Pathologist(s). Select the name(s) of the gross pathologist(s) associated with this specimen. For detailed information on staff fields, refer to "Staff".

Part Type. For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type.** The first part type defined for the specimen appears as the default. The **Histology Data for** portion of this window displays block and stain/process information for whichever part type is selected at this field. You can select any part type in the specimen or add a new part type.

2) **Description.** The Part Type dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** The current time and date generally appear as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

5) **All Pieces Used check box.** Select this check box if all pieces of tissue have been used for the designated part. Note that after running one or more protocols, CoPathPlus will place you at this field for the first part on which a protocol has been run.

6) **Part buttons.** Press:

   o **Select Part** to access the Select Part pop-up window so you can see a list of the parts available for this specimen (case) and make a selection.

   o **Add Part** to add a new part for this specimen.

   o **Previous Part** to access the previous part for this specimen.

   o **Next Part** to access the next part for this specimen.

Histology Data:

1) **Blk/Desig (Block/Designator).** Enter a unique, short designator for each block. If you run a protocol that includes block designator information, the value specified in the protocol appears as the default. The first character of the designator must either be numeric or alphabetic, depending on the specimen class. (This requirement is based on decisions made by your site during the CoPathPlus implementation process).

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

>   **NOTE:** Block designations can also include sectioning site detail, but must be unique and can be edited in this field (e.g., 1-LUL). Also, deleting a block/designator will automatically delete all associated stains/processes.

2) **Pieces.** Enter the number of pieces of tissue taken for the corresponding block/designator.

3) **Block Detail button.** Click this button to access the Block Detail pop-window, which shows the details for each block for this specimen. Refer to "Block Detail" for more information.

Stain/Process fields. For more information about these fields, refer to "Stain/Process".

1) **Stain/Process.** A default of **H&E, Initial** automatically appears for each block entered. If necessary, select additional stain(s)/process(es) to order for this part type. All available stains and processes are defined in the Stain/Process dictionary. For more information about that dictionary, refer to "Stain/Process Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

   Note: You can turn off the H&E Initial default for selected blocks. Refer to "Block Category Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

2) **Blk/Desig (Block/Designator).** Select the block for which to apply this stain or process. If there is only one block for this part type, that block appears as the default. If the stain or process applies to the entire part type, rather than just the block, leave this field blank.

3) **Count.** Enter the number of stains or processes to be performed on this part. The default count is **1**, or, if using a protocol, the number entered in the Protocol dictionary for the stain/process. You can edit the default if necessary.

4) **Request Class.** Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class dictionary. Request classes are used to categorize histology tests and the reason they were performed.

5) **Save Protocol… button.** Click this button to access the Save Protocol pop-up window. You use this window to either create a new histology protocol consisting of the current block and stain/process information entered for this part type, or to update an existing histology protocol with that information. For more information, refer to "Save Protocol".

6) **Run Protocol(s) button.** Click this button to load the selected histology protocol for each part type. A protocol can only be loaded if the Load check box next to the part type on the Source tab is selected and a histology protocol has been specified. Once you Click this button, CoPathPlus retrieves the block and stain/process information defined for each part type and displays that data on the Histology tab.

   After running one or more protocols, CoPathPlus places you at the Part Type field for the first part. The block and stain/process information displayed is for the first part type in the specimen. Also, if you re-enter histology data, when you re-run a protocol on a part with previously saved block and/or stain/process data, CoPathPlus replaces the previous data with the new data.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

7) **Histo Summary button.** Click this button to access the Histology Summary pop-up window, which presents a summary of all the histology information for this specimen entered to date in one place. Refer to "Histo Summary" for more information.

8) **Stain/Process Detail button.** Click this button to access the Stain/Process Detail pop-up window, which shows the details for each stain/process for this specimen. Refer to "Stain/Process Detail" for more information.

9) **Run Stain/Process Group button.** Click this button to load the selected stain/process group protocol for each part type. Once you Click this button, CoPathPlus displays the Run Stain/Process Group Protocol pop-up window. Select the protocol you want on this window and press **OK**. For more information on the different types of protocols available, refer to "Histology Protocols".

Save/Next Specimen button. Click this button to save the current data and continue entering histology information for another specimen. The Select Specimen window appears.

Staff/Copy To/Text Tab on the Accession Entry/Edit Window for a Surgical Histology-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following staff and copy to information on the Staff/Copy To/Text tab:

Pathologist(s). Select the name(s) of the case pathologist(s) associated with this specimen. For detailed information on this field, refer to "Staff".

Additional Physician(s). Identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Diagnostic Text Fields.

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

<u>S</u>ave/**New Specimen** button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Surgical Card Specimens

This procedure begins the next phase of accessioning your Surgical Card specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Surgical Card specimen contains the following tabs:

- Source/Staff, which lets you enter information such as part specimen data, and the responsible medical staff.

- Text, which lets you enter diagnostic information such as the Final Diagnosis.

- SNOMED, which lets you assign SNOMED codes to a case based on diagnostic information.

Source/Staff Tab on the Accession Entry/Edit Window for a Surgical Card Specimen

NOTE: The Source/Staff tab for a Bone Marrow Card specimen is identical to the Source/Staff tab for a Surgical Card specimen.

Enter the following information on the Source/Staff tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Accession Date.** Enter an accession date for this specimen (i.e., case). There is no default accession date for a Card case.

2) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

3) **Submitting Phys.** Identify the physician who ordered the current specimen or change the value already in the field.

4) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

Pathologist(s). Select the name(s) of the case pathologist(s) associated with this specimen. For detailed information on this field, refer to "Staff".

Additional Physician(s). Identify other clinician(s) related to this case. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Text Tab on the Accession Entry/Edit Window for a Surgical Card Specimen

NOTE: The Text tab for a Bone Marrow Card specimen is identical to the Text tab for a Surgical Card specimen. Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

SNOMED Tab on the Accession Entry/Edit Window for a Surgical Card Specimen

NOTE: The SNOMED tab for a Bone Marrow Card specimen is identical to the SNOMED tab for a Surgical Card specimen.

Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED tab:

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field on the Text tab. To automatically code the Final Diagnosis, press **Autocode**. CoPathPlus will fill in the SNOMED code-related fields on this tab, as described below.

NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you will have to enter your SNOMED codes manually.

Edit Text button. Click this button to edit diagnostic text fields, including the Final Diagnosis. This button does not appear for sites using TxText as the CoPathPlus text editor. For more information about how to use this button, refer to "Using Microsoft Word to Edit Diagnostic Text Fields".

SNOMED. To learn more about the SNOMED code-related fields on this tab and how to use the Automatic SNOMED II Coder, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Codes.** CoPathPlus will automatically fill in the SNOMED Code(s) field. To learn more about SNOMED codes, refer to "SNOMED Codes".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, when users have entered codes manually or edited ones entered by the Automatic SNOMED II Coder or through dictionary links.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display.

   a) Review these words to ensure proper spelling and syntax.

   b) If any words are misspelled, refer to the Text tab and fix the misspelled words.

   c) Then return to the SNOMED tab and press **Autocode** again to re-code the Final Diagnosis.

Mark Coded Diagnosis Complete. Select this check box when you have completed the SNOMED coding process.

Save/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

SNOMED Codes

Because the coding dictionaries (SNOMED II Code, SNOMED International Code, and ICD-9-CM Code) are so large, manual entry of codes uses a special "keyword" lookup capability in order to assist with lookups.

This means that each time you add a new entry to the dictionary or edit an entry's Name field in the dictionary, CoPathPlus automatically makes each significant word in the name of the entry a lookup value. Certain words (e.g., "THE") are ignored. The coding dictionaries are the only ones that have the keyword lookup capability. You can also enter additional "keywords" explicitly.

You must enter at least three characters to initiate a search for the code you want. Because of the large number of entries in each coding dictionary, entering at least three characters helps to narrow the selection pool and speed up the search process. If you do not enter the minimum number of characters needed to initiate a lookup search, CoPathPlus will present you with a reminder message

Each word entered (separated by a space) is treated as a separate search string, and only those entries that match **all** the keywords are displayed. For example, if you enter "squa metap," you will see a short list of codes relating to squamous metaplasia, as opposed to a much longer list that results from entering one keyword. Included in the short list is "Adenocarcinoma with squamous metaplasia" even though the name does not begin with either of the values entered.

Accessioning Bone Marrow Routine Specimens

This procedure begins the next phase of accessioning your Bone Marrow Routine specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Bone Marrow Routine specimen contains the following tabs:

- Source, which lets you enter information such as part type, specimen data, and fee codes.

- Staff/Copy To, which lets you enter pathologists and clinicians associated with the specimen, and to specify where additional reports copies will go.

- Text, which lets you enter diagnostic information such as the Clinical or Intraoperative Diagnosis.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. For more information, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⬚ and ⬚) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Accessioning Bone Marrow Card Specimens

This procedure begins the next phase of accessioning your Bone Marrow Card specimen. Before proceeding, you must first complete the general accessioning steps in Accessioning New Specimens. After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Bone Marrow Card specimen contains the following tabs:

- Source/Staff, which lets you enter information such part type, specimen data, and the responsible medical staff.

- Text, which lets you enter diagnostic information such as the Final Diagnosis.

- SNOMED, which lets you assign SNOMED codes to a case based on diagnostic information.

Accessioning Cytology Gynecological Specimens

This procedure begins the next phase of accessioning your Cytology Gynecological (GYN) specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Cytology GYN specimen contains the following tabs:

- Source, which lets you enter information such as part type and stain/process information.

- Billing/Copy To, which lets you enter information such as specimen data and fee codes, and to specify where additional report copies will go.

- Clinical History, which lets you enter the Clinical Diagnosis for the specimen and medical history for the patient.

Source Tab on the Accession Entry/Edit Window for a Cytology Gynecological Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Source tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Source Detail.** The top portion of this tab lists any existing part type(s) if you are editing accession data. To move through the list, press **Previous** or **Next**. To enter a new part type, press **Add**. The detail for the part type you have highlighted in this portion of the tab displays in the fields below. For a Cytology GYN specimen, "Pap Smear" part type information may automatically default in these fields.

2) **Part Type.** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

3) **Description.** The Part Type Dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

4) **Date/Time Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

5) **Date/Time Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

6) **Load Protocol.** Refer to "Stain/Process" below.

7) **Protocol Name.** Refer to "Stain/Process" below.

8) **Label Designator.** The label designator specified in the Part Type Dictionary for this particular part type, if any, defaults in this field. Otherwise, you can enter the alternative specimen abbreviation you want to appear on the slide labels when they are printed.

   NOTE: If container labels print for this Cytology specimen class, the value entered in this field also prints on the container label. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Stain/Process. For detailed information on the Stain/Process fields, refer to "Stain/Process".

1) **Load Protocol.** If you have a cytology protocol associated with a part type in the Part Type Dictionary, this check box is automatically selected and the protocol name appears in the **Protocol Name** field.

2) **Protocol Name.** Specifies the name of the cytology protocol you have associated with this part type in the Part Type dictionary. Press **Run Protocol** to have CoPathPlus enter the associated stain/process information in the Stain/Process field(s) on this tab.

3) **Stain/Process.** Specify the stain(s) and process(es) associated with the current part type.

   a) **Count.** Enter the number of stains or processes per item to be performed on the current part.

   b) **Slide Label Text.** Specify the text for the stain or process that you want to display (in addition to the part) on the slide labels.

   c) **Date/Time Ordered.** Specifies when the stain/process was ordered. The current time and date defaults, which you cannot change.

4) **Stain/Process Detail button.** Click this button to open the Stain/Process Detail pop-up window, which lets you edit other stain/process information that defaults from the protocol. To save your changes or additions, press **Save Protocol** on this window.

5) **Run Protocol(s) button**. Click this button to have CoPathPlus enter the associated stain/process information in the Stain/Process fields.

> **NOTE:** The Accession Entry/Edit activity can be set up to run protocols automatically either when you access a tab page (other than the first tab page) that includes the **Run Protocol(s)** button or when you save the case. The first time you run a protocol, it runs in "slow" mode so that CoPathPlus can verify that there are no specimen class conflicts or invalid dictionary entries. If conflicts are found, a message appears asking you resolve the conflicts and re-save the protocol. The protocol will continue to run in "slow" mode until the problems are resolved. Once the protocol has been run (or after all problems are resolved), the protocol runs in "fast" mode to reduce data entry time. Subsequent changes to data in the protocol (e.g., the inactivation of a stain/process) will cause the protocol to run in "slow" mode again.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Stain/Process

CoPathPlus provides the ability for you to associate default stain/process information per part type. This default information is known as a protocol. By associating a protocol with a part type in the Part Type Dictionary, you can automatically establish default stain/process information when you use that part type.

Once you enter a part type, the **Load Protocol** check box is automatically selected. If you have associated a protocol with this particular part type, the name of that protocol will display in the **Protocol Name** field. To have CoPathPlus enter the associated stain/process information, press **Run Protocol(s)**. CoPathPlus fills in the corresponding information in the Stain/Process fields on the appropriate tab in the activity you are using and clears the Load Protocol check box.

NOTE: For specimen classes whose histology data is not typically entered during accessioning (e.g., Surgical Routine, Bone Marrow Routine), the Accession Entry/Edit activity can be set up to automatically run the default protocol associated with each part type (if not already run) when you save data during that activity. For specimen classes whose histology data is typically entered during accessioning (e.g., Surgical Histology-Only), the Accession Entry/Edit activity can be set up to run protocols automatically when you access a tab page (other than the first tab page) that includes the **Run Protocol(s)** button.

The **Stain/Process** field specifies the stain(s)/process(es) associated with this part type. This field is a dictionary field for which you can look up an entry in the Stain/Process dictionary. Refer to "Stain/Process Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary. Corresponding to each stain/process is the:

- **Count**, which indicates how many of the stains or processes are to be performed on this part. The default count is 1 or, if using a protocol, the number entered in the Protocol dictionary for the stain/process. You can change the number in this field.

- **Slide Label Text**, which allows you to specify the text for the stain or process that will display in addition to the part that you want to appear on the slide labels. A default is established in the Stain/Process dictionary. You can change the information in this field.

- **Date/Time Ordered**, which is a display-only field that specifies when the stain/process was ordered. The current date and time appear. These values cannot be edited.

You can see additional detail for each stain/process you order by pressing the **Stain/Process Detail** button. The following Stain/Process Detail pop-up window appears.

If you edit any part of the default stain/process information from the protocol or if you enter the information yourself, you can then save the changed information as a new protocol or overwrite the existing protocol by pressing **Save Protocol** on this window. For more information, refer to "Save Protocol".

Billing/Copy To Tab on the Accession Entry/Edit Window for a Cytology Gynecological Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Billing/Copy To tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Billing Number.** The billing number may be predefined per client, may use the current encounter number, or may require specific data entry.

3) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen

billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Fee Code(s). For detailed information on the fee code fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Copy To.

1) **Additional Physician(s).** Identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

2) **Outside Institution.** Enter the name and address of a physician or institution to whom you want to send copies of reports. This is a free-text field.

Clinical History Tab on the Accession Entry/Edit Window for a Cytology Gynecological Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Clinical History tab:

Date of Last Menstruation. Enter the date of this patient's last menstruation. You can use date format (e.g., **5/15/97**) or free-text (e.g., **Middle of May**).

Clinical Category fields. Select the appropriate information in the clinical category fields. You select entries from the drop-down list for each field. Use the free-text Comment field to add additional information, per entry. If no information exists for a particular field, leave it blank.

Clinical Diagnosis button. Click this button to open the following Clinical Diagnosis pop-up window, which lets you enter a Clinical Diagnosis or free-text medical history information for the current patient.

NOTE: For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Clinical Diagnosis pop-up window:

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The Clinical Diagnosis heading and text appear in a Microsoft Word document.

2) Enter or edit the information under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to the Clinical Diagnosis Pop-Up Window in CoPathPlus after you finish entering and editing text.

4) Press **OK** to return to the Clinical History tab.

Save/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Cytology Non-Gynecological Specimens

This procedure begins the next phase of accessioning your Cytology Non-Gynecological (Non-GYN) specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Cytology Non-GYN specimen contains the following tabs:

- Source, which lets you enter information such as part type and stain/process information.

- Billing/Copy To, which lets you enter information such as specimen data and fee codes, and to specify where additional report copies will go.

- Clinical History, which lets you enter the Clinical Diagnosis and Gross Description for the specimen and medical history for the patient.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. For more information, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., [⋯] and [▼]) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

NOTE: For certain specimen classes, an additional Print Container Labels check box can appear in the lower, right portion of this tab. If this check box is selected, container labels will print for new part types when you file this specimen. This check box is disabled if no new part types were added. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Source Tab on the Accession Entry/Edit Window for a Cytology Non-Gynecological Specimen

NOTE: The Source tab for the Cytology Fine Needle Aspirate (FNA) specimen class is identical to the Source tab for the Cytology Non-GYN specimen class. Your system may look different depending on the modifications made by your site.

Enter the following information on the Source tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Source Detail.** The top portion of this tab lists any existing part type(s) if you are editing accession data. To move through the list, press **Pre<u>v</u>ious** or **Ne<u>x</u>t**. To enter a new part type, press **<u>A</u>dd**. The detail for the part type you have highlighted in this portion of the tab displays in the fields below.

2) **Part Type.** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

3) **Description.** The Part Type Dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

4) **Date/Time Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

5) **Date/Time Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

6) **Load Protocol.** Refer to "Stain/Process" below.

7) **Protocol Name.** Refer to "Stain/Process" below.

8) **Label Designator.** The label designator specified in the Part Type Dictionary for this particular part type, if any, defaults in this field. Otherwise, you can enter the alternative specimen abbreviation you want to appear on the slide labels when they are printed.

   NOTE: If container labels print for this Cytology specimen class, the value entered in this field also prints on the container label. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Stain/Process. For detailed information on the Stain/Process fields, see Stain/Process.

1) **Load Protocol.** If you have a cytology protocol associated with a part type in the Part Type dictionary, this check box is automatically selected and the protocol name appears in the **Protocol Name** field.

2) **Protocol Name.** Specifies the name of the cytology protocol you have associated with this part type in the Part Type dictionary. Press **Run Protocol** to have CoPathPlus enter the associated stain/process information in the Stain/Process field(s) on this tab.

3) **Stain/Process.** Specify the stain(s) and process(es) associated with the current part type.

   a) **Count.** Enter the number of stains or processes to be performed on the current part.

   b) **Slide Label Text.** Specify the text for the stain or process that you want to display (in addition to the part) on the slide labels.

   c) **Date/Time Ordered.** Specifies when the stain/process was ordered. The current time and date defaults, which you cannot change.

4) **Stain/Process Detail button.** Click this button to open the Stain/Process Detail pop-up window, which lets you edit the stain/process information that defaults from the protocol. To save your changes or additions, press **Save Protocol** on this window. For more information, refer to "Stain/Process".

5) **Run Protocol(s) button**. Click this button to have CoPathPlus enter the associated stain/process information in the Stain/Process fields.

   NOTE: The Accession Entry/Edit activity can be set up to run protocols automatically either when you access a tab page (other than the first tab page) that includes the **Run Protocol(s)** button or when you save the case. The first time you run a protocol, it runs in "slow" mode so that CoPathPlus can verify that there are no specimen class conflicts or invalid dictionary entries. If conflicts are found, a message appears asking you resolve the conflicts and re-save the protocol. The protocol will continue to run in "slow" mode until the problems are resolved. Once the protocol has been run (or after all problems are resolved), the

protocol runs in "fast" mode to reduce data entry time. Subsequent changes to data in the protocol (e.g., the inactivation of a stain/process) will cause the protocol to run in "slow" mode again.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

4) **Order Procedures.** Click this button to open the Procedure/Addendum pop-up window, which lets you order a procedure or create an addendum for the current specimen.

Billing/Copy To Tab on the Accession Entry/Edit Window for a Cytology Non-Gynecological Specimen

NOTE: The Source tab for the Cytology Fine Needle Aspirate (FNA) specimen class is identical to the Source tab for the Cytology Non-GYN specimen class.

Enter the following information on the Billing/Copy To tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Billing Number.** The billing number may be predefined per client, may use the current encounter number, or may require specific data entry.

3) **Client.** Select the client associated with the encounter number or change it, if necessary.

    NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Fee Code(s). For detailed information on the fee code fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Copy To.

1) **Additional Physician(s).** Identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

2) **Outside Institution.** Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Clinical History Tab on the Accession Entry/Edit Window for a Cytology Non-Gynecological Specimen

NOTE: The Source tab for the Cytology Fine Needle Aspirate (FNA) specimen class is identical to the Source tab for the Cytology Non-GYN specimen class.

Your system may look different depending on the modifications made by your site.

Enter the following information on the Clinical History tab:

Clinical Category fields. Select the appropriate information in the clinical category fields. You select entries from the drop-down list for each field. Use the free-text Comment field to add additional information, per entry. If no information exists for a particular field, leave it blank.

Clinical Diagnosis and Gross button. Click this button to open the following Text Fields pop-up window, which lets you enter a Clinical Diagnosis or Gross Description for the specimen or free-text medical history information for the patient.

NOTE: For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text Fields pop-up window:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The Clinical Diagnosis and Gross Description headings and text appear in a Microsoft Word document.

2) Enter or edit the information under the headings for those fields. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to the Text Fields Pop-Up Window in CoPathPlus after you finish entering and editing text.

4) Press **OK** to return to the Clinical History tab.

Save/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Cytology Procedure-Only Specimens

This procedure begins the next phase of accessioning your Cytology Procedure-Only specimen. Before proceeding, you must first complete the general accessioning steps in Accessioning New Specimens. After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Cytology Procedure-Only specimen contains the following tabs:

- Source, which lets you enter information such as part type and stain/process information.

- Billing/Copy To, which lets you enter information such as specimen data and fee, codes, and to specify where additional report copies will go.

- Clinical History, which lets you enter the Clinical Diagnosis and Gross Description for the specimen and medical history for the patient.

- Procedure/Addendum, which lets you order procedures or create addenda for the current specimen.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. For more information, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⌷ and ⌷) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

NOTE: For certain specimen classes, an additional Print Container Labels check box can appear in the lower, right portion of this tab. If this check box is selected, container labels will print for new part types when you file this specimen. This check box is disabled if no new part types were added. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Source Tab on the Accession Entry/Edit Window for a Cytology Procedure-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Source tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Source Detail.** The top portion of this tab lists any existing part type(s) if you are editing accession data. To move through the list, press **Previous** or **Next**. To enter a new part type, press **Add**. The detail for the part type you have highlighted in this portion of the tab displays in the fields below. There is no default part type for Cytology Procedure-Only specimens.

2) **Part Type.** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

3) **Description.** The Part Type Dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

4) **Date/Time Taken.** The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

5) **Date/Time Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

6) **Load Protocol.** Refer to "Stain/Process" below.

7) **Protocol Name.** Refer to "Stain/Process" below.

8) **Label Designator.** The label designator specified in the Part Type Dictionary for this particular part type, if any, defaults in this field. Otherwise, you can enter the alternative specimen abbreviation you want to appear on the slide labels when they are printed.

   NOTE: If container labels print for this Cytology specimen class, the value entered in this field also prints on the container label. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Stain/Process. For detailed information on the Stain/Process fields, refer to "Stain/Process".

1) **Load Protocol.** If you have a cytology protocol associated with a part type in the Part Type Dictionary, this check box is automatically selected and the protocol name appears in the **Protocol Name** field.

2) **Protocol Name.** Specifies the name of the cytology protocol you have associated with this part type in the Part Type dictionary. Press **Run Protocol** to have CoPathPlus enter the associated stain/process information in the Stain/Process field(s) on this tab.

3) **Stain/Process.** Specify the stain(s) and process(es) associated with the current part type.

   a) **Count.** Enter the number of stains or processes to be performed on the current part.

   b) **Slide Label Text.** Specify the text for the stain or process that you want to display (in addition to the part) on the slide labels.

   c) **Date/Time Ordered.** Specifies when the stain/process was ordered. The current time and date defaults, which you cannot change.

4) **Stain/Process Detail button.** Click this button to open the Stain/Process Detail pop-up window, which lets you edit other stain/process information that defaults from the protocol. To save your changes or additions, press **Save Protocol** on this window. For more information, refer to "Stain/Process".

5) **Run Protocol(s) button**. Click this button to have CoPathPlus enter the associated stain/process information in the Stain/Process fields.

   NOTE: The Accession Entry/Edit activity can be set up to run protocols automatically either when you access a tab page (other than the first tab page) that includes the **Run Protocol(s)** button or when you save the case. The first time you run a protocol, it runs in "slow" mode so that CoPathPlus can verify that there are no specimen class conflicts or invalid dictionary entries. If conflicts are found, a message appears asking you resolve the conflicts and re-save the protocol. The protocol will continue to run in "slow" mode until the problems are resolved. Once the protocol has been run (or after all problems are resolved), the protocol runs in "fast" mode to reduce data entry time. Subsequent changes to data in the protocol (e.g., the inactivation of a stain/process) will cause the protocol to run in "slow" mode again.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The

numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Billing/Copy To Tab on the Accession Entry/Edit Window for a Cytology Procedure-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Billing/Copy To tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Billing Number.** The billing number may be predefined per client, may use the current encounter number, or may require specific data entry.

3) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Fee Code(s). For detailed information on the fee code fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

> **NOTE:** Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Copy To.

1) **Additional Physician(s).** Identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

2) **Outside Institution.** Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Clinical History Tab on the Accession Entry/Edit Window for a Cytology Procedure-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Clinical History Tab:

Cytotech(s). Select the name(s) of the cytotech(s) associated with this specimen. For detailed information on these fields, refer to "Staff".

Clinical Category fields. Select the appropriate information in the clinical category fields. You select entries from the drop-down list for each field. Use the free-text Comment field to add additional information, per entry. If no information exists for a particular field, leave it blank.

Clinical Diagnosis and Gross button. Click this button to open the following Text Fields pop-up window, which lets you enter a Clinical Diagnosis or Gross Description for the specimen or free-text medical history information for the patient.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

NOTE: For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text Fields pop-up window:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Op**t**ions, **E**dit Text on the menu bar). The Clinical Diagnosis and Gross Description headings and text appear in a Microsoft Word document.

2) Enter or edit the information under the headings for those fields. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to the Text Fields Pop-Up Window in CoPathPlus after you finish entering and editing text.

4) Press **OK** to return to the Clinical History tab.

Procedure/Addendum Tab on the Accession Entry/Edit Window for a Cytology Procedure-Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

You use the Procedure/Addendum tab to order a procedure and/or create an addendum. To enter diagnostic information or to mark the procedure or addendum complete, you must use the Procedure/Addendum Entry/Edit activity.

Enter the following information on the Procedure/Addendum tab:

Display field. The top portion of this tab lists all existing procedures or addenda for this specimen (case). The information associated with that procedure or addendum highlighted in the top portion displays in the bottom portion of the tab. You can highlight the entry by clicking on it or press **Previous** or **Next** to move up and down the list. Press **Add** to enter a new procedure or addendum (or just double-click on the Add Procedure row).

Procedure Type field. Enter the type of procedure that you are ordering or specify addendum. This is a dictionary field for which you can look up an entry in the Procedure Dictionary. Refer to "Procedure Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

Order Date. Enter the date on which the procedure or addendum was ordered (the current date and time defaults). You can enter a past or present date but you cannot enter a future date.

Status. Specifies the status of this procedure or addendum. Possible statuses you may see include AM (amended), COMP (completed), ORD (ordered), S/O (signed out). You cannot change the information in the Status field.

Procedure Pathologist(s). Select the primary pathologist and/or resident associated with the procedure or addendum. You can also enter any additional pathologist(s) involved with the procedure or addendum. This is a dictionary field for which you can look up an entry in the Person dictionary. Refer "Person Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary. Each procedure or addendum has its own set of pathologists.

S̲a̲v̲e̲/̲N̲e̲w̲ ̲S̲p̲e̲c̲i̲m̲e̲n̲ button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Cytology FNA Specimens

This procedure begins the next phase of accessioning your Cytology Fine Needle Aspirate (FNA) specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Cytology FNA specimen contains the following tabs:

- Source, which lets you enter part type and stain/process information.

- Billing/Copy To, which lets you enter information such as specimen data and fee codes, and to specify where additional report copies will go.

- Clinical History, which lets you enter the Clinical Diagnosis and Gross Description for the specimen and medical history for the patient.

Accessioning Cytology Card Specimens

This procedure begins the next phase of accessioning your Cytology Card specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen-class specific information.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for a Cytology Card specimen contains the following tabs:

- Source/Staff, which lets you enter information such as part type, specimen data, and the responsible medical staff.

- Text, which lets you enter diagnostic information such as Final Diagnosis.

- SNOMED, which lets you assign SNOMED codes to a case based on diagnostic information.

Source/Staff Tab on the Accession Entry/Edit Window for a Cytology Card Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Source/Staff tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Accession Date.** Enter an accession date for this specimen (i.e., case). There is no default accession date for a Card case.

2) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

3) **Submitting Phys.** Identify the physician who ordered the current specimen or change the value already in the field.

4) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part type. Parts are the components of the specimen submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type dictionary provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** Enter the time and date when the specimen was taken from the patient. Typically, there is no default for this field for card cases.

4) **Received.** Enter the time and date the specimen was received in the lab. The current time and date appears as the default. Typically, there is no default for this field for card cases.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Staff. For detailed information on these fields, refer to "Staff".

1) **Pathologist(s).** Select the name(s) of the case pathologist(s) associated with this specimen.

2) **Cytotech(s).** Select the name(s) of the cytotech(s) associated with this specimen.

For the **Additional Physician(s)** field, identify other clinician(s) related to this case. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Text Tab on the Accession Entry/Edit Window for a Cytology Card Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press   on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press   on the toolbar to return to CoPathPlus after you finish entering and editing text.

SNOMED Tab on the Accession Entry/Edit Window for a Cytology Card Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field on the Text tab. To automatically code the Final Diagnosis, press **Autocode**. CoPathPlus fills in the SNOMED code-related fields on this tab, as described below.

NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you have to enter your SNOMED codes manually.

Edit Text button. Click this button to edit diagnostic text fields, including the Final Diagnosis. This button does not appear for sites using TxText as the CoPathPlus text editor. For more

information about how to use this button, refer to "Using Microsoft Word to Edit Diagnostic Text Fields".

SNOMED. To learn more about the SNOMED code-related fields on this tab and how to use the Automatic SNOMED II Coder, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Codes.** CoPathPlus automatically fills in the SNOMED Code(s) field.

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Automatic SNOMED II Coder generates a default value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, when users have entered codes manually or edited ones entered by the Automatic SNOMED II Coder or through dictionary links.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display.

   a) Review these words to ensure proper spelling and syntax.

   b) If any words are misspelled, refer to the Text tab and fix the misspelled words.

   c) Then return to the SNOMED tab and press <u>Autocode</u> again to re-code the Final Diagnosis.

Mark Coded Diagnosis Complete. Select this check box when you have completed the SNOMED coding process.

<u>Save/New Specimen</u> button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Autopsy Anatomic/Neuro Specimens

This procedure begins the next phase of accessioning your Autopsy Anatomic/Neuro specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen class-specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for an Autopsy Anatomic/Neuro specimen contains the following tabs:

- Autopsy, which lets you enter information such as part or body type and autopsy data (such as the date and time, reason, and person who authorized the autopsy).

- Staff/Copy To, which lets you identify specimen data (such as Encounter Number and client), select pathologists and clinicians associated with the specimen, and specify where additional report copies will go.

- Text, which lets you enter diagnostic information (such as the Clinical Diagnosis and Special Requests).

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. To learn more about this subject, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⬚ and ⬚) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Autopsy Tab on the Accession Entry/Edit Window for an Autopsy Anatomic/Neuro Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Autopsy tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part or body type. Parts are the components of the specimen or case submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type Dictionary provides the default for the Description field. You can add to the description or replace the default.

3) **Taken.** This information is often not used for Autopsy cases. The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** This information is often not used for Autopsy cases. The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

   NOTE: For certain specimen classes, an additional Label Designator field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Designator field in the Part Type Dictionary. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Autopsy Data.

1) **Autopsy Date/Time.** The date and time that the autopsy was performed. The default is the current date and time.

2) **Priority.** Select the priority for this specimen (case) or accept the default of **Autopsy Routine**.

3) **Postmortem Hours.** CoPathPlus calculates this value, which is a display-only field. The number of hours in this field represents the difference between the date and time of expiration (as entered on the Patient Registration window) and the date and time of the autopsy.

4) **Submitting Phys.** A default received through an ADT interface may appear. Otherwise, you can identify the physician who ordered the autopsy or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

5) **Reason for Autopsy.** Select the reason that this autopsy is being conducted. This field points to the Autopsy Reason dictionary. Refer to "Autopsy Reason Dictionary " in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

6) **Gestational Age/Weeks.** Use this field for stillborn or prenatal autopsies only. Enter the age of the deceased in weeks (a number with up to one decimal place; e.g., 28, 3.1, 56.5).

7) **Authorized By.** Enter the name of the person who authorized this autopsy. This is a free-text field.

8) **Relationship to Deceased.** Enter the relationship of the person who authorized the autopsy to the deceased. This is a free-text field.

9) **Autopsy Restrictions.** Select any restriction for this autopsy. For the Autopsy Anatomic Only and Autopsy Anatomic/Neuro specimen classes, a **None** restriction is the default. This field points to the Autopsy Restriction dictionary. Refer to "Autopsy Reason Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

10) **Restrictions Comment.** Enter any additional information concerning the restrictions specified above for this autopsy. This is a free-text field.

11) **Medical Examiner.** Enter the name of the Medical Examiner who examined the deceased. This is a free-text field.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

4) **Order Procedures.** Click this button to open the Procedure/Addendum pop-up window, which lets you order a procedure or create an addendum for the current specimen. Note that CoPathPlus automatically orders a Neuro unique procedure when you accession an Autopsy Anatomic/Neuro specimen.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Staff/Copy To Tab on the Accession Entry/Edit Window for an Autopsy Anatomic/Neuro Specimen

Enter the following information on the Staff/Copy To tab:

Staff Information. Default data received through an ADT interface may appear. Otherwise, you can identify the pathologist(s) related to this case or change the values already in the staff-related fields. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". If information was received through an Admission/Discharge/Transfer (ADT) interface, default data can appear for all fields on this portion of the tab. To learn more about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

3) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

4) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

Text Tab on the Accession Entry/Edit Window for an Autopsy Anatomic/Neuro Specimen

For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **E̲dit Text** (or press on the toolbar, or select Op̲tions, E̲dit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

S̲ave/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Autopsy Anatomic Only Specimens

This procedure begins the next phase of accessioning your Autopsy Anatomic Only specimen. Before proceeding, you must first complete the general accessioning steps outlined in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen class-specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for an Autopsy Anatomic Only specimen contains the following tabs:

- Autopsy, which lets you enter information such as part or body type and autopsy data (such as the date and time, reason, and person who authorized the autopsy).

- Staff/Copy, which lets you identify specimen data (such as Encounter Number and client), select pathologists and clinicians associated with the specimen, and specify where additional report copies will go.

- Text, which lets you enter diagnostic information (such as the Clinical Diagnosis and Special Requests).

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. To learn more about this subject, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., and) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

NOTE: For certain specimen classes, an additional Print Container Labels check box can appear in the lower, right portion of this tab. If this check box is selected, container labels will print for new part types when you file this specimen. This check box is disabled if no new part types were added. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Autopsy Tab on the Accession Entry/Edit Window for an Autopsy Anatomic Only Specimen

Enter the following information on the Autopsy tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part or body type. Parts are the components of the specimen or case submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type dictionary provides the default for the Description field. You can add to the description or replace the default.

3) **Taken.** This information is often not used for Autopsy cases. The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** This information is often not used for Autopsy cases. The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

   NOTE: For certain specimen classes, an additional Label Designator field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Designator field in the Part Type Dictionary. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Autopsy Data.

1) **Autopsy Date/Time.** The date and time that the autopsy was performed. The default is the current date and time.

2) **Priority.** Select the priority for this specimen (case) or accept the default of **Autopsy Routine**.

3) **Postmortem Hours.** CoPathPlus calculates this value, which is a display-only field. The number of hours in this field represents the difference between the date and time of expiration (as entered on the Patient Registration window) and the date and time of the autopsy.

4) **Submitting Phys.** A default received through an ADT interface may appear. Otherwise, you can identify the physician who ordered the autopsy or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

5) **Reason for Autopsy.** Select the reason that this autopsy is being conducted. This field points to the Autopsy Reason dictionary. Refer to "Autopsy Reason Dictionary" the *Cerner CoPathPlus Dictionary Building Manual* for more information.

6) **Gestational Age/Weeks.** Use this field for stillborn or prenatal autopsies only. Enter the age of the deceased in weeks (a number with up to one decimal place; e.g., 28, 3.1, 56.5).

7) **Authorized By.** Enter the name of the person who authorized this autopsy. This is a free-text field.

8) **Relationship to Deceased.** Enter the relationship of the person who authorized the autopsy to the deceased. This is a free-text field.

9) **Autopsy Restrictions.** Select any restriction for this autopsy. For the Autopsy Anatomic Only and Autopsy Anatomic/Neuro specimen classes, a **None** restriction is the default. This field points to the Autopsy Restriction dictionary. Refer to "Autopsy Reason Dictionary" the *Cerner CoPathPlus Dictionary Building Manual* for more information.

10) **Restrictions Comment.** Enter any additional information concerning the restrictions specified above for this autopsy. This is a free-text field.

11) **Medical Examiner.** Enter the name of the Medical Examiner who examined the deceased. This is a free-text field.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

4) **Order Procedures.** Click this button to open the Procedure/Addendum pop-up window, which lets you order a procedure or create an addendum for the current specimen.

Staff/Copy To Tab on the Accession Entry/Edit Window for an Autopsy Anatomic Only Specimen

Enter the following information on the Staff/Copy To tab:

Staff Information. Default data received through an ADT interface may appear. Otherwise, you can identify the pathologist(s) related to this case or change the values already in the staff-related fields. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". If information was received through an Admission/Discharge/Transfer (ADT) interface, default data can appear for all fields on this portion of the tab. To learn more about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Client.** Select the client associated with the encounter number or change it, if necessary.

   NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

3) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

4) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

Text Tab on the Accession Entry/Edit Window for an Autopsy Anatomic Only Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Save/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Autopsy Neuro Only Specimens

This procedure begins the next phase of accessioning your Autopsy Neuro Only specimen. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen class-specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for an Autopsy Neuro Only specimen contains the following tabs:

- Autopsy, which lets you enter information such as part or body type and autopsy data (such as the date and time, reason, and person who authorized the autopsy).

- Staff/Copy To, which lets you identify specimen data (such as Encounter Number and client), select pathologists and clinicians associated with the specimen, and specify where additional report copies will go.

- Text, which lets you enter diagnostic information (such as the Clinical Diagnosis and Special Requests).

- Procedures, which lets you add or edit a procedure/addendum for this specimen.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. To learn more about this subject, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⬚ and ⬚) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

NOTE: For certain specimen classes, an additional Print Container Labels check box can appear in the lower, right portion of this tab. If this check box is selected, container labels will print for new part types when you file this specimen. This check box is disabled if no new part types were added. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Autopsy Tab on the Accession Entry/Edit Window for an Autopsy Neuro Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Autopsy tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part or body type. Parts are the components of the specimen or case submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type dictionary provides the default for the Description field. You can add to the description or replace the default.

3) **Taken.** This information is often not used for Autopsy cases. The current time and date generally appears as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** This information is often not used for Autopsy cases. The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

> **NOTE:** For certain specimen classes, an additional Label Designator field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Designator field in the Part Type Dictionary. For more information about container labels, refer to "Printing Container Labels During Accessioning".

Autopsy Data.

1) **Autopsy Date/Time.** The date and time that the autopsy was performed. The default is the current date and time.

2) **Priority.** Select the priority for this specimen (case) or accept the default of **Autopsy Routine**.

3) **Postmortem Hours.** CoPathPlus calculates this value, which is a display-only field. The number of hours in this field represents the difference between the date and time of expiration (as entered on the Patient Registration window) and the date and time of the autopsy.

4) **Submitting Phys.** A default received through an ADT interface may appear. Otherwise, you can identify the physician who ordered the autopsy or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

5) **Reason for Autopsy.** Select the reason that this autopsy is being conducted. This field points to the Autopsy Reason dictionary. Refer to "Autopsy Reason Dictionary" the *Cerner CoPathPlus Dictionary Building Manual* for more information.

6) **Gestational Age/Weeks.** Use this field for stillborn or prenatal autopsies only. Enter the age of the deceased in weeks (a number with up to one decimal place; e.g., 28, 3.1, 56.5).

7) **Authorized By.** Enter the name of the person who authorized this autopsy. This is a free-text field.

8) **Relationship to Deceased.** Enter the relationship of the person who authorized the autopsy to the deceased. This is a free-text field.

9) **Autopsy Restrictions.** Select any restriction for this autopsy. For the Autopsy Neuro Only specimen class, the default is the **Brain and Spinal Cord Only** restriction. This field points to the Autopsy Restriction dictionary. Refer to "Autopsy Reason Dictionary" the *Cerner CoPathPlus Dictionary Building Manual* for more information.

10) **Restrictions Comment.** Enter any additional information concerning the restrictions specified above for this autopsy. This is a free-text field.

11) **Medical Examiner.** Enter the name of the Medical Examiner who examined the deceased. This is a free-text field.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Staff/Copy To Tab on the Accession Entry/Edit Window for an Autopsy Neuro Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Staff/Copy To tab:

Staff Information. Default data received through an ADT interface may appear. Otherwise, you can identify the pathologist(s) related to this case or change the values already in the staff-related fields. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, identify other clinician(s) related to this case. These physicians may default from an ADT interface. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". If information was received through an Admission/Discharge/Transfer (ADT) interface, default data can appear for all fields on this portion of the tab. To learn more about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** Select an encounter number for this specimen (case) or change it, if necessary. To learn more about encounters, refer to "Patients".

2) **Client.** Select the client associated with the encounter number or change it, if necessary.

    NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

3) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

4) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

Text Tab on the Accession Entry/Edit Window for an Autopsy Neuro Only Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Procedure(s) Tab on the Accession Entry/Edit Window for an Autopsy Neuro Only Specimen

NOTE: Your system may look different depending on the modifications made by your site.

NOTE: CoPathPlus automatically orders a Neuro unique procedure when you accession an Autopsy Neuro Only specimen.

Enter the following information on the Procedure(s) tab:

1) **Display field.** The top portion of this tab lists all existing procedures or addenda for this specimen (case). The information associated with the procedure or addendum highlighted in the top portion displays in the bottom portion of the tab. You can highlight the entry by clicking on it or press **Previous** or **Next** to move up and down the list. Press **Add** to enter a new procedure or addendum (or just double-click on the Add Procedure row).

2) **Procedure Type field.** Select the type of procedure that you are ordering or specify addendum. This is a dictionary field for which you can look up an entry in the Procedure dictionary. Refer to "Procedure Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary. Note that CoPathPlus automatically orders Autopsy-Neuro and Autopsy-Neuro Preliminary procedures, which cannot be changed. The field becomes enabled when you add or edit entries other than these default ones.

3) **Order Date.** Enter the date on which the procedure or addendum was ordered (the current date and time are the default values). You can enter a past or present date but you cannot enter a future date.

4) **Status.** Specifies the status of this procedure or addendum. Possible statuses you may see include AM (amended), COMP (completed), ORD (ordered), S/O (signed out). You cannot change the information in the Status field.

5) **Procedure Pathologist(s).** Select the primary pathologist and/or resident associated with the procedure or addendum. You can also enter any additional pathologist(s) involved with the procedure or addendum. This is a dictionary field for which you can look up an

entry in the Person dictionary. Refer to "Person Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary. Each procedure or addendum gets its own set of pathologists.

<u>S</u>ave/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Accessioning Autopsy Card Specimens

This procedure begins the next phase of accessioning your Autopsy Card specimens. Before proceeding, you must first complete the general accessioning steps in "Accessioning New Specimens". After you have completed the general accessioning steps, the Accession Entry/Edit window appears with specimen class-specific information.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Accession Entry/Edit window for each specimen class may not resemble those present in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels (e.g., you may be asked to enter a Financial Number rather than a Billing Number).

The Accession Entry/Edit window for an Autopsy Card specimen contains the following tabs:

- Source/Staff, which lets you enter information such as part type, specimen data, and pathologists and clinicians associated with the specimen.

- Text, which lets you enter diagnostic information (such as the Clinical Diagnosis and Special Requests).

- SNOMED, which lets you assign SNOMED codes to a case based on diagnostic information.

NOTE: Patients must be registered in CoPathPlus before you can accession a specimen for them. To learn more about this subject, refer to "Registering a New Patient".

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., [...] and [▼]) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Source/Staff Tab on the Accession Entry/Edit Window for an Autopsy Card Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Source/Staff tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Accession Date.** Enter an accession date for this specimen (i.e., case). There is no default accession date for a Card case.

2) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Autopsy Routine**.

3) **Submitting Phys.** Identify the physician who ordered the autopsy or change the value already in the field.

4) **Client.** Select the client associated with the encounter number or change it, if necessary.

> **NOTE:** Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** Enter a part or body type. Parts are the components of the specimen or case submitted for diagnosis. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** The Part Type Dictionary provides the default for the Description field. You can add to the description or replace the default.

3) **Taken.** This information is often not used for Autopsy cases. You can enter the time and date when the specimen was taken from the patient.

4) **Received.** This information is often not used for Autopsy cases. You can enter the time and date the specimen was received in the lab.

Staff Information. Identify the pathologist(s) related to this case or change the values already in the staff-related fields. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, identify other clinician(s) related to this case. You can change the physicians that appear or add new ones. For information about this functionality for this field, refer to "Copy To".

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Text Tab on the Accession Entry/Edit Window for an Autopsy Card Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part

designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

SNOMED Tab on the Accession Entry/Edit Window for an Autopsy Card Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED tab:

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field on the Text tab. To automatically code the Final Diagnosis, press **Autocode**. CoPathPlus fills in the SNOMED code-related fields on this tab, as described below.

NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you have to enter your SNOMED codes manually.

Edit Text button. Click this button to edit diagnostic text fields, including the Final Diagnosis. This button does not appear for sites using TxText as the CoPathPlus text editor. For more information about how to use this button, refer to "Using Microsoft Word to Edit Diagnostic Text Fields".

SNOMED. To learn more about the SNOMED code-related fields on this tab and how to use the Automatic SNOMED II Coder, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Code(s).** CoPathPlus automatically fills in the SNOMED Code(s) field. For more information about SNOMED codes, refer to "SNOMED Codes".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Automatic SNOMED II Coder generates a default value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, for manually entered codes or for those codes entered by the Automatic SNOMED II Coder but then edited.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display.

   a) Review these words to ensure proper spelling and syntax.

   b) If any words are misspelled, refer to the Text tab and fix the misspelled words.

   c) Then return to the SNOMED tab and press **Autocode** again to re-code the Final Diagnosis.

Mark Coded Diagnosis Complete. Select this check box when you have completed the SNOMED coding process.

<u>S</u>ave/New Specimen button. Click this button if you want to save the current data and continue accessioning another specimen. The New Specimen window appears.

Next Step for the Accession Entry/Edit Activity

Now that you have completed the information on the Accession Entry/Edit window, you can perform one of the following actions:

- Save your current entries and begin accessioning a new specimen by pressing **Save/Next Specimen** on one of the tabs in the Accession Entry/Edit window (or select <u>F</u>ile, <u>N</u>ew Specimen on the menu bar). The specimen class you are currently using is the default in the Specimen Class field on the New Specimen window. Press **Yes**, when prompted, to save your edits to the current specimen.

- Retrieve another existing specimen by pressing ![open icon] on the toolbar (or select <u>F</u>ile, <u>O</u>pen Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

    TIP! You can access an existing specimen for the current patient by pressing **Sa<u>m</u>e Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen (e.g., enter the Gross Description or Final Diagnosis or Cytology Results) by pressing ![activities icon] on the toolbar (or select Op<u>t</u>ions, <u>A</u>ctivities on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing ![close icon] on the toolbar (or select <u>F</u>ile, <u>C</u>lose Specimen on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

    NOTE: Pressing ![key icon] on the toolbar (or selecting <u>F</u>ile, <u>M</u>anager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing ![exit icon] on the toolbar (or select <u>F</u>ile, E<u>x</u>it CoPath Client/Server on the menu bar). Press **<u>O</u>K**, when prompted, to sign off of CoPathPlus. Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

The Accession Entry/Edit activity can be set up to automatically run the default protocol associated with each part type (if it has not already been run) when you save data during the activity. You can later view and edit the histology data using either the Histology Data Entry/Edit activity or the Stain/Process and Block Edit activity.

For specimen classes defined to print container and/or requisition labels after a new part type is accessioned, those labels print to the appropriate label chute when you save changes to the specimen. For more information, refer to "Printing Container Labels During Accessioning" and "Printing Requisition Labels During Accessioning".

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

For the Surgical Consult and Surgical Procedure-Only specimen classes, you will see a Next Process pop-up window appear when you choose many of the following actions. For information on this window, refer to "Specifying the Next Process for the Accession Entry/Edit Activity for a Surgical Consult Specimen" and "Specifying the Next Process for the Accession Entry/Edit Activity for a Surgical Procedure-Only Specimen".

Specifying the Next Process for an Activity

For many CoPathPlus specimen activities, after you complete the activity, a Next Process pop-up window appears.

You have to tell CoPathPlus which action to take at this point. The actions available vary depending on the activity. For more information about the implications of selecting an action, refer to the documentation for the activity in the online guide or in the *Cerner CoPathPlus User Guide*.

Once you select the appropriate next process at the top of the Next Process pop-up window, respond to the question at the bottom of the window (i.e., "Do you want to save the changes to specimen") by selecting one of the following:

- **Yes.** CoPathPlus saves any changes and performs the action you specified.

- **No.** CoPathPlus does not save any changes you may have made or perform any action you may have specified.

- **Cancel**. CoPathPlus returns you to the activity window without filing any changes.

Amendment Entry and Amendment Edit

This topic describes the Amendment Entry and Amendment Edit activities in the standard export version of the CoPathPlus system.

Amending a case involves temporarily reversing the sign out of the final report, procedure, or addendum so that diagnostic information can be corrected. One reason for amending a case would be if the diagnosis has changed upon re-review of the case.

Amending a case has important legal implications, because the case or procedure/addendum was already reported to the clinician(s) at the time of sign out. All actions to a signed-out case or procedure/addendum are subject to security restrictions and most specimen- or procedure/addendum-related information is locked from further user access unless an amendment is performed.

The Amendment Entry activity allows you to add a new amendment to a final report, procedure, or addendum. The Amendment Edit activity allows you to edit an amendment previously added to the case.

NOTES:

- In situations where you want to add information to a case, but you do not need to edit the existing diagnostic information, you might want to create an addendum instead of amending the case. "Procedure/Addendum Entry/Edit" for more information on creating an addendum.

- In situations where you need to make modifications to a signed out case which are not of a diagnostic nature and where a corrected report does not need to be issued, you may use Post-Signout Edit. Refer to "*Post-Signout Edit*" for more information on this feature.

Accessing the Amendment Entry Activity

To access the Amendment Entry activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window. You can only amend a signed-out specimen.

3) Select **Amendment Entry** in the Activity field on that window.

4) Press **OK**. The Select a Report pop-up window appears.

TIP! You can also access the Amendment Entry activity by placing it in your Personal Menu and double-clicking on it from there.

Selecting a Report to Amend

The Select a Report window lists all the available specimen reports for the specimen you chose and the status of each report. If a procedure or addendum report is available, this window also shows the procedure/addendum order date.

The possible report statuses are:

- PRE (Preliminary)

- S/O (Signed Out)

- AM (Amended)

- N/A (Not Applicable. This status is assigned to all Working Drafts and to Final Reports for specimen classes that are never signed out [e.g., Card cases])

You can only amend a report with a status of S/O. Select the report you want to amend and press **OK**. The Amendment Entry window appears.

Entering a New Amendment

In the standard export version of CoPathPlus, the only tab on the Amendment Entry window is the Amend tab.

Enter the following information on the Amend tab:

Final/Interpretation/Addendum. Depending on the report selected, the final diagnosis, procedure interpretation, or addendum diagnosis text appears for review. This is a display-only field which cannot be edited on this window.

Amendment Date. Enter the date and time of the amendment. Today's date and the current time appear as the default. You can edit the default to a prior date and time, but not to a future date and time.

Amendment Reason. Enter the reason for this amendment. Amendment reasons are either "major" (e.g., an incorrect diagnosis) or "minor" (e.g., a typographical error), as determined in the Amendment Reason Dictionary. For major amendments, an Amendment banner will print on Final Reports, Inquiries, and other appropriate reports and displays in CoPathPlus. For more information, refer to "Amendment Reason Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

Comment. Enter any free-text comment for this amendment. These comments appear during an Inquiry, Signout, and on patient reports.

Primary Pathologist(s) / Cytotech(s). The pathologist(s) associated with the specimen or procedure/addendum are displayed for reference. If this is a Cytology specimen, the associated cytotech(s) are also displayed. This is a display-only field which cannot be edited on this window.

Save/Switch Activities button. Click this button to save the new amendment, and then switch to the appropriate activity for updating the incorrect diagnostic information. You can also save the amendment ⊞ or switch activities ⊞ through the toolbar.

After you press the **Save/Switch Activities** button, the Next Process pop-up window appears.

Specifying the Next Process for the Amendment Entry Activity

Once you finish entering amendment information, if you choose to switch activities or exit the Amendment Entry activity, the Next Process pop-up window appears. The following illustration shows an example of the Next Process pop-up window for the Amendment Entry activity.

You have to tell CoPathPlus whether to save the amendment. The standard export version of the CoPathPlus system provides for two actions at this point.

- **Amend Case (or Procedure or Addendum)/Send to Primary Pathologist**, which amends the case or procedure/addendum and places it on the Pathologist Signout Worklist. The primary pathologist for the case or procedure/addendum appears as the default in the Send to field. You can enter a special comment in the Memo field and, if necessary, place the case or procedure/addendum on hold (which means that CoPathPlus will place it at the end of a worklist). For more information on worklists, refer to "Worklists".

- **No Action**, which you should only choose if you want to exit the Amendment Entry activity without filing amendment information for this specimen or procedure/addendum.

Once you select the appropriate next process at the top of this window, respond to the question at the bottom of the screen by selecting one of the following:

- **Yes.** CoPathPlus saves any changes and performs the action you specified.

- **No.** CoPathPlus does not save any changes you may have made or perform any action you may have specified.

- **Cancel.** CoPathPlus returns you to the Amendment Entry window without filing any changes.

Next Step for the Amendment Entry Activity

Now that you have completed the information on the Amendment Entry window, you can perform one of the following actions:

- Save your current entry and switch to another activity (e.g., Final Diagnosis Entry/Edit) by pressing **Save/Switch Activities** on the Amend tab, or [icon] on the toolbar (or select Options, Activities on the menu bar). The Next Process pop-up window appears. Refer to "Specifying the Next Process for the Amendment Entry Activity".

  For information on the activity you selected, refer to the appropriate topic in this guide.

- Enter an amendment for another specimen by pressing [icon] on the toolbar (or select File, Open Specimen on the menu bar). The Next Process pop-up window appears.

  1) Select a next process option, as necessary.

  2) Press **Yes** to save your edits to the current specimen.

      The Select Specimen window appears.

  TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Return to the CoPathPlus Application Manager by pressing [icon] on the toolbar (or select File, Close Specimen on the menu bar). The Next Process pop-up window appears. Refer to "Specifying the Next Process for the Amendment Entry Activity".

  NOTE: Pressing [icon] on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing [icon] on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. The Next Process pop-up window appears. Refer to "Specifying the Next Process for the Amendment Entry Activity".

Accessing the Amendment Edit Activity

To access the Amendment Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Amendment Edit** in the Activity field on that window.

4) Press **OK**. The Amendment Edit window appears.

TIP! You can also access the Amendment Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Editing an Amendment

The only tab on the Amendment Edit window is the Amendments tab in the standard export version of the CoPathPlus system, as illustrated below. The Amendment Edit activity allows you to edit the Amendment date, reason, or comments for an existing amendment. Updates may only be made in the Amendment Edit function when the specimen is at the status of Amend. The actual corrections or edits that need to be made must be made in the appropriate activity (e.g., a typographical error in the Final Diagnosis can be made by switching to the Final Diagnosis Entry/Edit activity), before the specimen is signed out again. You can switch to the appropriate activity by pressing **Save/Switch Activities** at the bottom of the Amendments tab.

Enter the following information on the Amendments tab:

Select Amendment. The following information is displayed for all existing amendments for this specimen and its procedures or addenda: amendment date and time, amendment type (case, procedure abbreviation, or "ADD" [addendum]), amendment reason, and person who entered the amendment.

Highlight the amendment you want to edit. The corresponding amendment date, amendment reason, and comments are displayed in the subsequent fields.

Amendment Date. Enter the date and time of the amendment. You can edit the default to a prior date and time, but not to a future date and time.

Amendment Reason. Enter the reason for this amendment. Amendment reasons are either "major" (e.g., an incorrect diagnosis) or "minor" (e.g., a typographical error), as determined in the Amendment Reason Dictionary. For major amendments, an Amendment banner will print on Final Reports, Inquiries, and other appropriate reports and displays in CoPathPlus. For more information, refer to "Amendment Reason Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

Comment. Enter any free-text comment for this amendment. These comments appear during an Inquiry, Signout, and on patient reports.

Save/Switch Activities button. Click this button to save the edits to the amendment, and then switch to the appropriate activity for updating the incorrect diagnostic information. The Specimen Activities pop-up window appears. You can also save the edit or switch activities through the toolbar.

NOTE: The Next Process pop-up window does not appear during the Amendment Edit activity.

Next Step for the Amendment Edit Activity

Now that you have completed the information on the Amendment Edit window, you can perform one of the following actions:

- Save your current edits and switch to another activity by pressing **Save/Switch Activities** on the Amendments tab or on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. The

Specimen Activities pop-up window appears. Either select another activity and press **OK**, or press **Cancel** to return to the Application Manager.

For information on the activity you selected, refer to the appropriate topic in this guide.

- Edit an amendment for another specimen by pressing on the toolbar (or select <u>F</u>ile, <u>O</u>pen Specimen on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Sa<u>m</u>e Patient** on the Select Specimen window.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select <u>F</u>ile, <u>C</u>lose Specimen on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing on the toolbar (or selecting <u>F</u>ile, <u>M</u>anager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select <u>F</u>ile, E<u>x</u>it CoPath Client/Server on the menu bar). Press **<u>O</u>K**, when prompted, to sign off of CoPathPlus. Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

Attachments Entry/Edit

This topic describes the Attachments Entry/Edit activity in the standard export version of CoPathPlus. You can use this activity to attach digital images or other files (e.g., anatomical diagrams, requisitions,) to a case so that those files can be printed on patient reports, archived, or used for teaching purposes.   You also use this activity to select which of the attachments you want to print on patient reports.

Note: With Windows XP, Microsoft removed Imaging for Windows® from its standard offerings. Prior to this version of Windows, Imaging for Windows® was included as part of the standard Windows offerings. The CoPathPlus attachment feature requires this software on each client workstation that will be accessing or attaching images. The software is not required on client workstations that only view attachments. Imaging for Windows can be purchased from its new vendor; see information is in the v2.4 CoPathPlus Release Notes. Cerner CoPathPlus cannot assume any responsibility for changes made to Imaging for Windows®. Alternately, the PICSPlus Solution can be pursued. Contact Cerner CoPathPlus to obtain information on the PICSPlus Solution.

Your site also decides which activities should be set up to allow linking of attachments and selection of attachments for inclusion on patient reports, and which activities should be set up to allow only selection of attachments for inclusion on patient reports. . You can use the Signout (Electronic) and Consult Review activities to select which attachments to print on patient reports.

Once a report is signed out, you cannot edit any attachment selected to print on that report, nor can you link new attachments to that report or delete them from that report. For signed out specimens, you can continue to add attachments to the case, link the new attachments to reports that are not yet signed out, remove attachments from those reports, and edit the new attachments.

Attachment Type Dictionary

During the Attachments Entry/Edit activity, you must select an attachment type for each attachment you want to link to a specimen. The attachment type determines default information for the attachment such as whether this type of attachment can be printed on patient reports, whether to automatically print the attachment on certain types of patient report (e.g., Final Report), the size of the image to display on patient reports, and when to purge the attachment from CoPathPlus.

Each attachment type also has an associated attachment class that determines how the attachment is accessed by CoPathPlus (i.e., which third-party software is used). Attachment types are defined in the Attachment Type dictionary. For more information about that dictionary, refer to "Attachment Type Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Accessing the Attachments Entry/Edit Activity

To access the Attachments Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Attachments Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Attachments Entry/Edit window appears.

TIP! You can also access the Attachments Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Adding and Editing Attachments

In the standard export version of CoPathPlus, the only tab on the Attachments Entry/Edit window is the Attachments tab.

NOTE: Your system may look different depending on the modifications made by your site.

The top portion of this tab displays all attachments currently linked to the specimen (i.e., case). The bottom portion of this tab displays detail for the selected attachment. To select a different attachment, press **Next** or **Previous** (or scroll to the attachment you want and select it). To link a new attachment to this case, press **Add**. To delete the link between this case and an attachment, highlight that attachment, and press **Delete**.

NOTE: A warning appears if you attempt to delete an attachment type for which deletions are not allowed.

The date on which the attachment was linked to the specimen, the user's initials, and the file size are displayed at the top of the Details portion of this tab. If an attachment has been purged, a "***PURGED***" message displays.

Enter the following information on the Attachments tab:

Type. For new attachments, select the attachment type from the Attachment Type dictionary. For existing attachments, you can only change the attachment type to one that has the same attachment class as the original attachment type. Refer to "Attachment Type Dictionary" for more information about attachment types.

Title. Enter a title that describes the attachment. This title will appear under the image when it is printed on a report.

File Name. Enter the directory and file name of the attachment. During implementation, your site can specify a default path for this field. To search the network for the file you want to attach, press **Browse…**. You must enter at least the directory (e.g., F:\) at the File Name field before you can search for a file. **Browse…** is enabled only for attachment types with an attachment class of Image in File, Media Clip File, or Sound File.

Comment. Enter a free-text comment for this attachment.

Reports. The following information is displayed for each patient report available for this case:

- Type of report (e.g., Final)

- Status of the report (e.g., Preliminary)

- Whether the attachment is going to print on that report (as evidenced by a selected Linked check box)

- The procedure/addendum abbreviation, if this is either a procedure or addendum report

- The procedure/addendum order date and time, if this is either a procedure or addendum report

To print the attachment on a report, select the Linked check box for that report. To prevent an attachment from printing on a report, clear that check box. To select which attachments will print on the report, double-click on the report (or highlight it and press **Image Order**).

NOTE: The Reports field is disabled for attachment types that cannot be printed on reports, as specified in the Attachment Type dictionary. The standard export version of CoPathPlus running with TxText as the text editor can print both bitmap (*.bmp) and TIFF (*.tif) images on patient reports. However, since there are many variants of the TIFF format, not all TIFF images will print. The standard export version of CoPathPlus running with Microsoft Word as the text editor can also print JPEG (*.jpg) images.

NOTE: Your site determines what size to print images on patient reports (e.g., 2"x2"), and selects a disclaimer to print at the end of the report to notify users that the printed images may not exactly match the original. In addition, your site selects replacement icons to display instead of the image when the image cannot be printed, is not available, has been purged, or when a user previews a report.

Attachment… button. Lets you view and annotate the attachment using whichever third-party software the attachment type is defined to use. For example, a gross anatomical diagram might appear in the Microsoft Paint application. You can then add callouts, shading, or other indicators to the attachment. If you save the annotations, the attachment is permanently changed and the annotations will print on patient reports (if the attachment is printed on patient reports).

NOTE: You can also select the **Attachment…** button by double-clicking on an attachment on the top portion of this tab. The types of annotations you can make depend on which third-party software is used for this attachment type.

Image Order button. Accesses the Image Order window for the selected patient report. This button is enabled only if one of the patient reports at the Reports field is selected. You use the Image Order window to view the sequence in which attachments will print on the patient report, change the print sequence of attachments within a particular attachment type, and add or remove attachments from the report. For more information, refer to "Image Order".

Image Order

The Image Order window lets you select which printable attachments you want to print on a patient report. You can also change the sequence in which attachments will print within a particular attachment type.

You access the Image Order window by pressing **Image Order** on the Attachments tab. For activities set up to allow just selection of attachments for printing on patient reports (and not linking of new attachments), the image order information appears directly on the Attachments tab.

If you access the Image Order window by pressing the **Image Order** button, the name of the patient report to which this image order applies is displayed in the window header after the specimen number.

Enter the following information on the Image Order Window:

Selected Images for [Name of the Patient Report to Which This Image Order Applies]. Lists, by attachment type, all attachments selected to print on the selected patient report. To remove an attachment from the report, highlight it and press **Remove**. To remove all attachments from the report, press **Remove All**.

To change the print sequence of attachments within an attachment type, use the mouse to click and drag the attachment's sequence number (i.e., the number to the left of the attachment title) to the desired position.

NOTE: You cannot use the Image Order window to change the sequence in which the attachment types print on patient reports. This sequence is determined by how your site's patient reports are set up. For information about how to customize patient reports, refer to "Patient Report Painter" in the *Cerner CoPathPlus Tools Online Guide*.

Available Images. Lists all attachments associated with this specimen that have not been selected to print on the report. To print an attachment on the report, highlight the attachment and press **Add**. To print all the attachments on the report, press **Add All**.

When you finish reviewing and adjusting how attachments will print on the patient report, press **OK** to return to the Attachments tab.

Next Step for the Attachments Entry/Edit Activity

Now that you have completed the information on the Attachments Entry/Edit window, you can perform one of the following actions:

- Save your current edits and switch to another activity by pressing on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. The Specimen Activities pop-up window appears. Either select another activity and press **OK**, or press **Cancel** to return to the Application Manager.

For information on the activity you selected, refer to the appropriate topic in this guide.

- Edit attachment information for another specimen by pressing on the toolbar (or select File, Open Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

   TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

   NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Billing Entry/Edit

This topic details the Billing Entry/Edit activity in the standard export version of CoPathPlus. Billing output (batches and interfaces) is explained in Billing Functions.

In order to be compensated for their services, pathology labs require a method for capturing, storing, and reporting information on the services they provide. Pathology labs also use this information to generate statistical and management reports. CoPathPlus has the ability to establish, capture, and update billing charges for pathology procedures.

Billing data consists of a combination of patient, specimen, encounter, physician, and fee code information. CoPathPlus can report billing data through the use of a paper report or an interface to another system, or the export of data to another medium (e.g., tape).

Within CoPathPlus, two dictionaries are integral to the functioning of the Billing Entry/Edit activity:

- Billing Type
- Billing Fee Code

Billing Type

A billing type defines a particular way that billing data is handled (i.e., what set of billing codes to use, what set of charges to use, how to process the output, and what billing rules apply when determining a default billing type within CoPathPlus). CoPathPlus can determine a default billing type (e.g., Inpatient, Private Outpatient, Medicare, etc.) for a patient/specimen based on a combination of encounter and specimen data entered at the time of accession.

During the CoPathPlus implementation process, your site sets up all of its billing types in the Billing Type Dictionary. For each Billing Type Dictionary entry, you can specify one or more of the following four criteria to use to determine the default billing type for a specimen:

- Client Group
- Patient Type
- Specimen Class
- Financial Class

These criteria make up a rule or set of rules that allow CoPathPlus to determine a default billing type for a patient/specimen which will appear in the Billing Type field during the accessioning process. These rules, while automatically ranked, can be overridden by a manually entered ranking number.

Note that CoPathPlus has one standard overriding billing type. Also, if enabled, any patient who is age 65 or older at the time of specimen accession may automatically receive a "Medicare" billing type, no matter what other billing type rules may apply. Each of these features is governed by a system setting that was determined during the CoPathPlus implementation process. If necessary, you can manually edit the Billing Type field.

Refer to the "Billing Type Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information about billing types, and how their criteria determine the defaulting of a billing type per specimen (case) in CoPathPlus.

Billing Fee Code

A billing fee code (or just "fee code") represents a code associated with a fee charged for pathology services. You can define fee codes for each of the processes performed within the laboratory, such as standard processing, special stains and procedures, and for other items such as Consults. You can associate separate technical and/or professional numbers (e.g., CPT-4 codes) and dollar amounts with each code. You can also assign the provider type (primary pathologist, signing pathologist, gross pathologist, etc.) to which each different fee code should be attributed. All this is done through the Billing Fee Code Dictionary.

For more information, refer to "Billing Fee Code Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

Billing Fee Code Schedule

Fee codes and prices for services performed in a pathology lab can vary for different types of patients and/or clients (i.e., by billing type). To support this variation, CoPathPlus provides a Billing Fee Code Schedule. To build this schedule, your site associates a billing type with a fee code and specifies the codes and charges (Professional and/or Technical) for that particular combination.

The Billing Fee Code Schedule consists of a matrix for all possible fee code/billing type combinations, containing codes and prices for the technical and professional components of each service performed by the lab. For more information on these components, refer to "Viewing/Editing the Detail Portion of the Fee Codes Tab".

Your System Manager builds and maintains the Billing Fee Code Schedule in the Billing Fee Code Schedule item. You can view and update the schedule for one particular fee code through the Billing Fee Code Dictionary. Refer to "Billing Fee Code Schedule" for more information on creating and maintaining this schedule. For more information, refer to "Billing Fee Code Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

NOTE: To successfully send billing to an electronic output (e.g., interfaces), your site is required to associate fee codes with billing types. Each fee code/billing type combination must have at least technical and/or professional codes, or errors will occur when you validate the billing batch.

Dictionary Links

Pathology labs may require automated assistance in capturing fee codes for services performed on specimens. This ensures that all standard services are billed. CoPathPlus provides this automated assistance through a process called "linking". Linking refers to the automatic attachment of one or more standard, site-specified billing charges to a specimen each time a standard service is performed. Linking is accomplished through dictionary entries in CoPathPlus and you can use them for both fee codes and ICD-9-CM codes.
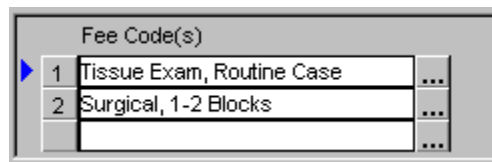
Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

ICD-9-CM codes are diagnosis codes used in standard Medicare or insurance billing. A site can transmit these codes as part of its billing output. For more information about these codes, refer to "ICD-9-CM Code(s)".

Fee Code Linking

CoPathPlus currently provides fee code linking through the following dictionaries:

- Part Type
- Procedure
- Stain/Process

Each of these dictionaries contains the Fee Code(s) field. The following illustration is an example of this field from the Part Type Dictionary in the standard export version of the CoPathPlus system.

Fee code linking eliminates the need for you to manually enter fee codes for standard services performed on specimens. You enter the fee code(s) associated with a part type (or procedure type or stain/process) in the Fee Code(s) field in the appropriate dictionary. Then whenever you use the part type (or procedure or stain/process) on a specimen, CoPathPlus automatically applies these fee code(s) to the specimen once you save the specimen.

In the example shown above, each time the part type of "Appendix" is filed on a specimen, the two fee codes shown would automatically be applied to the specimen's fee code list. Similarly, each time a procedure or stain/process with linked fee codes is ordered for a specimen, those fee codes would automatically be applied to the specimen and added to the fee code list.

CoPathPlus also has a group of system settings that a site can use with Cytology Gynecological specimens that require additional review by a pathologist. These settings allow CoPathPlus to automatically substitute the fee code(s) designated for a cytotech-reviewed specimen with a different fee code(s) when the specimen requires additional review by a pathologist. For more information about editing system settings, refer to "System Settings" in the *CoPathPlus System Manager's Guide*.

For more information, refer to the Part Type, Procedure, and Stain/Process Dictionaries in the *Cerner CoPathPlus Dictionary Building Manual*.

ICD-9-CM Code Linking

CoPathPlus provides linking to ICD-9-CM codes through the following dictionaries:

- Interpretation (for Cytology Results activities)
- Quick Text (for all other activities)

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

NOTE: If your site uses the Cytology Results (Cytotech) and Cytology Results (Pathologist) activities to enter cytology data, then ICD-9-CM code linking happens only through the Interpretation Dictionary. All other CoPathPlus activities, where these codes are applicable, use default ICD-9-CM codes from Quick Text Dictionary links.

Both these dictionaries contain the ICD-9-CM Diagnosis Code(s) field. The following illustration is an example of this field for the "Atypical squamous cells of undetermined significance" entry in the Interpretation Dictionary in the standard export version of the CoPathPlus system.
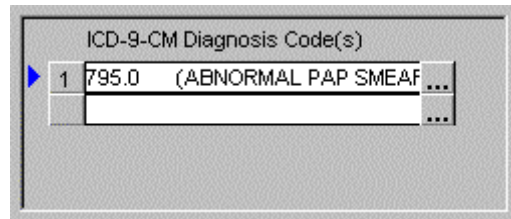
ICD-9-CM code linking reduces the need for you to manually enter ICD-9-CM codes. You enter the ICD-9-CM code(s) associated with an interpretation (or quick text) in the ICD-9-CM Diagnosis Code(s) field in the appropriate dictionary. Then whenever you use the interpretation (or quick text entry) on a specimen, CoPathPlus automatically applies the ICD-9-CM code(s) to the specimen once you save the specimen.

In the example shown above, each time the interpretation of "Atypical squamous cells of undetermined significance" is filed on a specimen, the ICD-9-CM code shown would automatically be applied to the specimen's ICD-9-CM code list.

For more information on the Interpretation and Quick Text Dictionaries, refer to "Quick Text Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

Accessing the Billing Entry/Edit Activity

To access the Billing Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Billing Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Billing Entry/Edit window appears.

NOTE: The Billing Entry/Edit activity is also available within the Billing Functions folder under the **Tasks** command button.

TIP! You can also access the Billing Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Your site may have the ability to enter billing data via other activities or items, depending on the decisions made during the CoPathPlus implementation process. In general, you will want to be able to enter or edit billing data during any CoPathPlus activity used to:

- Order a service that can be billed (e.g., accession; or ordering stains, procedures).

- Make a change to existing data that causes a need to update a fee code (e.g., fee codes for pap smears examined by a pathologist may differ from those screened by a cytotech only).

- Sign out a specimen (case).

However, for most sites it is only within the Billing Entry/Edit activity that you can override the codes or prices for each code and enter credits.

NOTE: It is necessary to have the billing data entry fields present in an activity where automatic billing linking can occur (such as where you order parts, procedures, or stains). However, these billing data entry fields may not be visible to the end user. CoPathPlus applies billing links automatically whether or not the data entry fields are visible. The fields should be visible when end users are assigned to review the linked codes.

Entering/Editing Billing Data

You can enter and edit billing data for all specimen classes in the standard export version of the CoPathPlus system. The two tabs listed below, which you see on the Billing Entry/Edit window when you access this activity, are the same for all specimen classes:

- Fee Codes, which allows you to enter fee code data and specify professional and technical data for the current specimen.

- Billing/ICD-9-CM, which allows you to enter the billing number, billing type, and ICD-9-CM codes for the current specimen.

Fee Codes Tab on the Billing Entry/Edit Window

NOTE: Your system may look different depending on the modifications made by your site.

The top portion of the Fee Codes tab identifies the fee codes for the current specimen. The information you enter in the bottom portion of this tab corresponds to whichever fee code you have selected on the top portion of this tab.

Enter the following information on the Fee Codes tab:

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (e.g., addition of a part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been applied.

    NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Service Date.** Enter the date on which this service was performed. Your site determines during implementation whether the date that defaults in this field is taken from the specimen's accession date or the Date Taken field for either the part type linked to this fee code or the first part type. This field is editable for manually entered fee codes only.

4) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). If your lab uses the Pathology Role for Charges feature, entry of Procedure abbreviations in this field is important so that the proper pathologist role to can be assigned on billing interface transactions. CoPathPlus completes this field automatically for linked fee codes.

5) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge. Refer to "Entering a Credit" for more information.

6) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

7) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Detail for (fee code): Each fee code consists of up to two components: professional and technical. For more information on the Detail portion of the Fee Codes tab, refer to "Viewing/Editing the Detail Portion of the Fee Codes Tab".

NOTE: CoPathPlus disables the Professional and/or Technical fields, along with their associated Code fields, once the corresponding fee codes have been billed (i.e., an **X** displays in the Billed field on the top portion of the Fee Codes tab).

- **Professional Component.** Enter a price for the professional charge for the corresponding fee code. The Professional charge represents the clinician's services to interpret the prepared sample (i.e., examining the slides and issuing an interpretation). The associated **Code** field for the Professional field represents the professional component code for the corresponding fee code. The Code field often contains the CPT-4 code.

- **Technical Component.** Enter a price for the technical charge for the corresponding fee code. The Technical charge represents preparation of a tissue sample for examination (e.g., creating the blocks, staining the slides). The associated **Code** field for the Technical field represents the technical component code for the corresponding fee code. Alternatively, if your site sends a single "combined" or "global" code to another system for processing, enter that code here.

  NOTE: While the charge amount is optional, most electronic billing outputs require codes for all services to be billed.

- **Billed**. A date displays if either component has been billed.

- **Special Billing Number.** If a fee code requires a special billing number (e.g., a doctor's research grant) which is different from the specimen billing number, select a fee code-level billing number from the drop-down list. A default fee code-level billing number may appear based on the histology request class associated with a stain/process ordered for this specimen. The billing type associated with the special billing number may be different from the billing type associated with the specimen's billing number. As a result, a fee code can have different professional and technical billing codes and a different billing chute than other fee codes for a specimen. For more information about setting default special billing numbers, refer to the "Histology Request Class Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

- **Comment.** Enter any comment you may want to record for this fee code for the current specimen.

C̲r̲e̲d̲i̲t̲ **button.** Click this button to add a credit to the selected fee code. Refer to "Entering a Credit" for more information.

Charges Available For Billing: If Professional or Technical charges are available for billing for this specimen, the corresponding check box is selected. Select or deselect as many check boxes as appropriate. Note that these check boxes apply to all fee codes for the current specimen (case). Choose:

- **Professional**, if you want the professional charges to be released so that they can be billed for the current specimen (case).

- **Technical/Global**, if you want the technical or global charges to be released so that they can be billed for the current specimen (case).

- **Billing Reviewed**, if your site uses such an event to trigger "billing made available" to be placed in Billing chutes.

- **No Charge Flag**, if you do not want charges produced for the current specimen (case).

  NOTE: The events that determine whether Professional or Technical charges are available for billing are specified in the Specimen Class dictionary.

Fee Code Modifier(s) for Selected Fee Code: If your site uses billing fee code modifiers to further describe charges, select the appropriate billing fee code modifier. For more information about setting default fee code modifiers, refer to the "Billing Fee Code Modifier Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

Viewing/Editing the Detail Portion of the Fee Codes Tab

When you highlight a fee code in the top portion of the Fee Codes tab on the Billing Entry/Edit window, the detail for that fee code is shown on the bottom portion of the tab. The detail shows both the charge and its associated code for the professional and technical components in the **Charge** and **Code** fields, respectively. CoPathPlus obtains default professional and technical prices and codes from the Billing Fee Code Schedule according to a specimen's billing type. The price that CoPathPlus displays in the Charge field is per unit, not total for the charge. The extended price (units x charge) is not calculated until the billing batch is compiled. For more information on billing batches, refer to "Billing Chute Manager".

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

If a charge has already been billed, you will see the date on which it was billed in the **Billed** field (on the bottom portion of the Fee Codes tab).

You can override both the charge and the code for any fee code that has not yet been billed. If there is a date in the Billed field for either component, you cannot change the code or the charge.

Any further modifications once a charge has been billed must be handled through credits. For more information on credits, refer to "Entering a Credit". You can also enter a free-text comment in the **Comment** field explaining the reason for any modifications made to a particular fee code.

To undo an override on a *manually entered code* that you may have entered incorrectly:

1) Highlight the original fee code row.

2) Perform a dictionary lookup on the fee code.

3) Select the correct fee code.

   CoPathPlus pulls in the original prices and codes from the Billing Fee Code Schedule and sets the fee code back to its original state.

To undo an override on a *linked code*:

1) See the Billing Fee Code Schedule for the particular fee code you want to fix. (Access this item within the Billing Functions folder under the **Tasks** command button.)

2) Make note of the standard prices and codes for the specimen's billing type.

3) Return to the Billing Entry/Edit activity and edit the detail area for the incorrect code.

Entering a Credit

If a charge has not yet been sent for processing (i.e., there is no value in the Billed field in the top portion of the Fee Codes tab on the Billing Entry/Edit window), you can edit a fee code or delete a fee code (using Edit, Delete Row). If a charge has already been sent, you need to enter a credit to rectify the incorrect charge.

To credit any of the fee codes listed that have already been billed:

1) Place the cursor in the fee code row (in the top portion of the Fee Codes tab) that you want to credit.

2) Press **Credit**.

   CoPathPlus automatically creates a new fee code row, copies down all the data from the previously highlighted fee code row into the next available fee code row (except for the Billed and Auto fields), and enters an **X** in the Credit field.

The following illustration shows that row 14 is a credit against the Special Stains Group III fee code in row 11.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

You can change the default number of units in the Units field if you want to apply a partial credit to a billed fee code. You cannot, however, credit more units than were originally billed.

Once entered, CoPathPlus process credits similar to other fee codes and, once available for billing, and will compiled them into the next applicable billing batch. For more information on billing batches, refer to "Billing Chute Manager".

Billing/ICD-9-CM Tab on the Billing Entry/Edit Window

Enter the following information on the Billing/ICD-9-CM tab:

Billing Data:

1) **Billing Number.** Enter a visit-specific number that is required by some billing offices. During accessioning, the billing number defaults from the encounter number. This number corresponds to the encounter number. To learn more about encounters, refer to "Patient Registration". For sites that use institutional/client billing, the billing number can instead be used to relate the client to the case.

2) **Billing Type.** Select the billing category or group to which this specimen (case) is assigned. A default value typically appears based on the "Billing Type" rules defined by selected specimen and encounter data. These groups are charged different fees for pathology procedures, have different codes for the same service, or have a different destination for charges. Refer to "Billing Type" for more information.

   NOTE: If you change the billing type and there are already unbilled fee codes for this specimen, all codes and prices that have not been manually overridden will be changed to match the new billing type when the fee codes are compiled into a batch. However, if you change the billing type after fee codes have been billed, you may need to manually credit old fee codes and enter new ones if any codes or prices are incorrect for the new billing type.

3) **ICD-9-CM Code(s).** For detailed information on the ICD-9-CM Code(s) field and dictionary linking, refer to "ICD-9-CM Code Linking" and the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

4) **ICD-9-CM Code(s).** Select as many ICD-9-CM codes as are appropriate for the services performed on the specimen. ICD-9-CM codes represent diagnosis codes used in standard Medicare or insurance billing.

5) **Source.** Enter the part or procedure to which the ICD-9-CM code is linked if you manually entered ICD-9-CM codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked codes.

   Note: CoPathPlus v3.1 and higher requires the Source field to perform Source field validation.

6) **Auto.** Displays the following:

   o **D** for ICD-9-CM codes entered through Quick Text links.

   o **L** for ICD-9-CM codes entered through Interpretation Dictionary links.

   o Blank, when users have entered codes manually.

Next Step for the Billing Entry/Edit Activity

Now that you have completed the information on the Billing Entry/Edit window, you can perform one of the following actions:

- Save your current entries and continue entering billing data for another specimen by pressing on the toolbar (or select File, Open Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Container Label Reprint

This topic describes the Container Label Reprint activity in the standard export version of the CoPathPlus system.

The Specimen Class Dictionary determines the specimen classes for which it is appropriate to print a container label and/or requisition label, the number of requisition labels to print per specimen, and which label entries from the Label Dictionary to use. For container labels, one label prints per part type. To learn more about the assignment of label formats, refer to the "Specimen Class Dictionary" topic in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

The standard export version of CoPathPlus is set up so that you have the option of printing initial container labels during the Accession Entry/Edit activity. Requisition labels also print automatically during that activity (if the specimen class is set up to print requisition labels.) The label object must be painted onto the desired Accessioning windows to allow automatic label generation during accession.

The Container Label Reprint activity provides you with the ability to reprint container and requisition labels for accessioned specimens. You can also use this activity to print initial container labels if you chose not to print the initial labels during the Accession Entry/Edit activity, or if your system is not set up to print container labels during that activity.

Accessing the Container Label Reprint Activity

To access the Container Label Reprint activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Container Label Reprint** in the Activity field on that window.

4) Press **OK**. The Container Label Reprint window appears.

TIP! You can also access the Container Label Reprint activity by placing it in your Personal Menu and double-clicking on it from there.

Reprinting Container and Requisition Labels

When you select the Container Label Reprint activity in the standard export version of the CoPathPlus system, the following Container Label Reprint window appears:

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
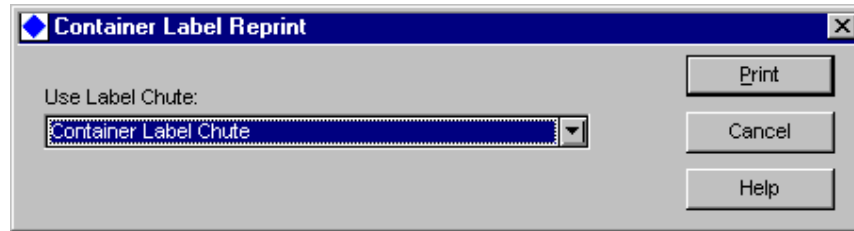
Select the label chute (i.e., printer destination) that CoPathPlus should use to reprint (or print initial) container and requisition labels for this specimen. A default label chute can appear based on two criteria:

- The container label specified for this specimen class in the Specimen Class Dictionary

- The label chute defined for that container label in the Label Dictionary.

Press **Print**. You will receive the message "Container and requisition labels have successfully been printed to the Label Chute selected. Check the printer for your labels". Press **OK** and you return to the Select Specimen window.

For more information about label-related dictionaries, refer to "Label Chute Dictionary" and "Label Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Cytology Results

This topic details the Cytology Results activities (Cytology Results [Cytotech] and Cytology Results [Pathologist]) in the standard export version of the CoPathPlus system.

The Cytology Results (Cytotech) and Cytology Results (Pathologist) activities enable clinical staff to review cases (specimens) and enter diagnoses. The data you enter in these activities constitute a **review**, which contains screening data for each reviewer evaluating a case. Once you have evaluated a particular case, you can edit your review, but you cannot create additional reviews for it. You can also examine and copy other reviews made for a particular case.

All information you enter in the Cytology Results activity windows is based upon Standardized Nomenclature entries that provide for consistent wording of diagnoses.

Within CoPathPlus, the following three dictionaries are integral to the functioning of Standardized Nomenclature:

- Specimen Adequacy

- Interpretation

- Recommendation

Specimen adequacy comments, interpretations, and recommendations are on a per-specimen-part basis. That is, each part will have its own set of codes for each category. In addition, each part may have one set of adequacy, interpretation, and recommendation codes for each cytotechnologist and each pathologist who performed a review. There may also be codes from multiple cytotechnologists or pathologists if your site has a primary, secondary, or resident review process. You can select a single review or set of Standardized Nomenclature entries to form the diagnosis for a case.

For detailed information on these dictionaries, refer to the *Cerner CoPathPlus Dictionary Building Manual*.

Accessing the Cytology Results Activity

To access the Cytology Results activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select either **Cytology Results (Cytotech)** or **Cytology Results (Pathologist)** in the Activity field on that window.

4) Press **OK**.

   If a review has already been entered for this specimen, the Select Cytology Review window appears. Refer to "Select Cytology Review Window".

> **If no review has yet been entered for this specimen**, the Cytology Results window for
> the staff and specimen class associated with the specimen appears. Refer to "Cytology
> Results (Cytotech)or "Cytology Results (Pathologist)

TIP! You can also access the Cytology Results (Cytotech) or Cytology Results (Pathologist) activity by placing it
in your Personal Menu and double-clicking on it from there.

Select Cytology Review Window

If information has already been entered for the current case (i.e., if a review has already been
created) when you access the Cytology Results activities, the following Select Cytology Review
window appears. This window contains a list of all reviews and corresponding diagnoses
entered for the current case.
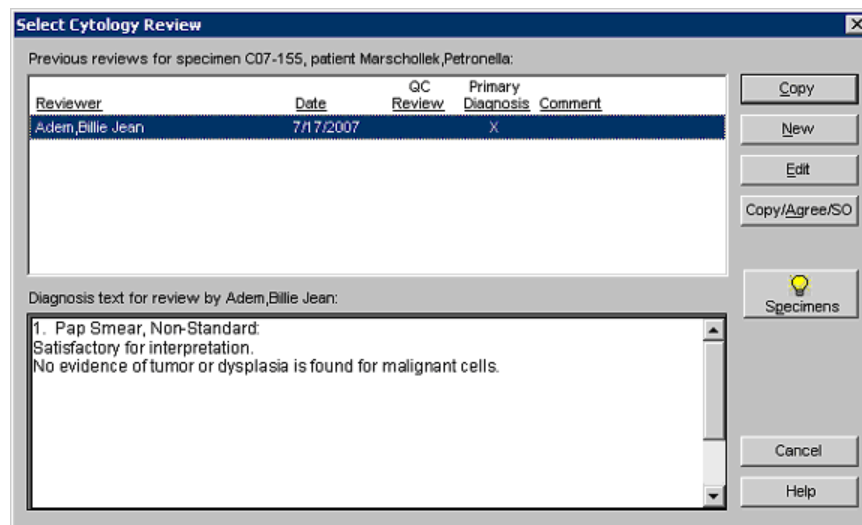
From this window, you can:

- **Copy an existing review** by highlighting the review (in the top display) and pressing
  Copy. This means that you have just created a new review for the current case. The
  Cytology Results window appears with the information from the review you copied
  displayed. You can then edit the review as appropriate and save your changes when you
  are done.

- **Copy an existing review and immediately review the Final Report and sign it out**
  without accessing the Cytology Results window by pressing **Copy/Agree/SO**. This action
  makes the current review the primary review and simultaneously automatically codes it.
  This action can be taken only by a cytotech or a pathologist.

- **Create a new review** by pressing **New**. The Cytology Results window appears on which
  you can enter your review.

- **Edit an existing review** by highlighting the review (in the top display) and pressing **Edit**.
  The Cytology Results window appears with the information that was previously entered
  for the review displayed.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted
without the express written consent of Cerner CoPathPlus.

- **View other specimens for the current patient** by pressing the **Specimens** button. The Other Specimens for Patient window appears. For more information on this window, refer to Viewing Other Specimens for a Patient (OSP).

  NOTE: You cannot copy an existing review or enter a new review if you have previously entered a review. You must edit the existing one. The only exception is for those users who have permission to enter reviews for other staff members. These users can create new reviews even if they already have a review on file. They merely need to change the name in the Reviewer field on the Review tab before filing the review.

Cytology Results (Cytotech)

You can enter/edit results in the Cytology Results (Cytotech) activity for the following Cytology specimen classes in the standard export version of the CoPathPlus system:

- Cytology Gynecological (GYN)

- Cytology Non-Gynecological (Non-GYN)

- Cytology Fine Needle Aspirate (FNA)

The tabs you see on the Cytology Results (Cytotech) window when you access this activity depend on the type of specimen class you are accessing.

When the Enable Cytotech Slide Limits feature is turned on, a Cytotech Slide Workload Entry window will be presented after the cytotechnologist saves the first Cytology result of the day. This window will not display after subsequent Cytology result entry episodes, although a standalone function is available if adjustments need to be made to the data initially entered. This automatic pop-up window includes fields for Reviewer, Date, CoPath Shift Hours, Outside Shift Hours, and Outside Slide Reviews. The reviewer field will default to the Cytotechnologist who reviewed the previous slide. The Date field will default to the current date. Fill in the CoPathPlus shift hours; the system will present an error message if this field is left incomplete. Complete the Outside Shift Hours and Outside Slides Reviewed fields if appropriate.

On subsequent Cytology result entry episodes, the microhelp display at the bottom of the Cytology Results (Cytotech) activity presents the current tally of today's Cytology counts.

If enabled, when the warning threshold indicating the Cytotechnologist is approaching their daily slide limit is reached, the system will display a warning indicating how many slides may still be reviewed that day. This warning, with an updated total of the number of remaining reviews, will display on each subsequent Cytology result entry until the limit is reached.

Once the daily limit is reached, the system will warn "You have exceeded your daily slide review limit of #" each time the reviewer attempts to enter an additional Cytology Result during that day. This message is a warning; the system will allow result entry to exceed the defined limit for that cytotechnologist.

Refer to "Cytotech Slide Workload Entry" for more information.

Entering/Editing Cytology Results (Cytotech) Data for a Cytology GYN Specimen

When you choose the Cytology Results (Cytotech) activity for a Cytology Gynecological (GYN) specimen in the standard export version of the CoPathPlus system, you are presented with the Cytology Results (Cytotech) window with the following tabs:

- Review, which allows you to enter the Standardized Nomenclature information for this specimen (i.e., enter a review). You can access prior reviews from this tab and enter reviewer information.

- History, which lets you enter clinical history for the patient. Most of this information is entered during accessioning and is displayed here for review purposes.

- Staff/Text, which lets you enter the staff associated with the specimen and text field information such as Diagnosis Comment and Clinical Diagnosis.

- SNOMEDEnteringInformationontheSNOMEDTabontheCytologyResults.Cytotech.Window owforaCytologyGYNSpecimen, which lets you assign SNOMED codes to a case based on diagnostic information.

- Billing/Copy To, which lets you enter information such as the clinicians/institutions that should receive report copies, fee codes, ICD-9-CM codes, and to specify where additional report copies will go.

Review Tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site.

The top portion of the Review tab identifies the part types for the current specimen. The information you enter on this tab pertains to the part type you have highlighted in this display. You can move between parts by clicking on the one you want or pressing **Previous** or **Next**. Or you can press **Prior Reviews** to access a pop-up window that will display all the existing reviews for the current specimen (case).

You can also edit the part description for a selected part type. Do this by highlighting the part type for which you want to edit the description and press **Edit Description** on this tab. The Part Description Edit pop-up window appears on which you can change the part description.

Enter the following information on the Review tab on the Cytology Results (Cytotech) window for a Cytology GYN specimen:

Standardized Nomenclature fields: For more detailed information on these fields, refer to the "Standardized Nomenclature Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **Adequacy.** Select the entry that identifies the condition of the slides prior to evaluation (e.g., unsatisfactory; slide contains unidentifiable foreign matter). In the standard export version of CoPathPlus, a value of **Satisfactory for Interpretation** defaults in this field.

2) **Primary Interpretation.** This field is required for all parts on the current case. Select the entry that constitutes the main diagnosis for the part. This interpretation is also used for statistical purposes on management reports. In the standard export version of CoPathPlus, a value of **Within Normal Limits** defaults in this field.

3) **Other Interpretation(s).** Select the secondary or supporting diagnosis information for the part.

4) **Recommendation.** In the standard CoPathPlus export version, this field appears on the Cytology Results (Pathologist) activity only. Select an entry that specifies the suggested future handling of this case (e.g., repeat screen in 6 months).

   NOTE: You can press **Edit/View Text** to access the Edit Review Text pop-up window. This window displays the text corresponding to the information you entered in these Standardized Nomenclature fields in a standard text field.

   NOTE: You can edit and add to the review text directly on this window. Refer to "Entering Information in Diagnostic Text Fields" for more information on using the text editor.

   For sites using TxText as the CoPathPlus text editor, the **Edit Text** button is replaced by several formatting fields and buttons as described in Using TxText to Edit Diagnostic Text Fields,.

   Keep in mind that if you do edit text through the Edit Review Text pop-up window, but then go back and change the Standardized Nomenclature fields on the Review tab, CoPathPlus will present you with a message pop-up window asking you if you want to overwrite what you manually entered through the Edit Review Text pop-up window.

5) **Flag check boxes:** For more detailed information on these check boxes, refer to Flags.

6) **MD Review check box.** This field does not normally appear on the Cytology Results (Pathologist) activity. Select this check box if you want a pathologist to review the current case. CoPathPlus will automatically select this check box if any interpretation for the specimen already requires MD Review, or if your system is set to require all High Risk specimens to be reviewed by a pathologists and the current specimen meets this criteria.

   Both the Primary Interpretation and Other Interpretation fields must be included on your Cytology Results -Cytotech form sequence in order for this check box to be automatically activated.

7) **High Risk check box.** Select this check box if the current specimen is a high risk case (even if it tests within the normal range). CoPathPlus will automatically select this check box if the patient has had abnormal results in the past. The system may also select this check box based on the presence of one or more high risk clinical conditions on the (clinical) History tab, or a previous abnormal specimen for the patient within a period of

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

time (number of months) set by your site (during the CoPathPlus implementation process) to trigger this flag.

Reviewer, Slides, and Agreement fields:

1) **Reviewer.** Select the name of the person associated with this review. If the person who is signed on is a person type of cytotech, resident, fellow, or pathologist, his or her name displays in this field. You can change the name that displays.

2) **Date.** Enter the date on which this review was created. Today's date will default.

3) **QC Reviewer check box.** Select this check box if the current reviewer is performing the Quality Control (QC) review on the case. Refer to "Flags" for more information on QC.

4) **Primary Slides.** For first reviews, CoPathPlus defaults the total number of slides to review in this field. Subsequent reviews default the number of slides remaining to be reviewed in this field while the Secondary Slides field shows the total number already reviewed.

5) **Secondary Slides.** For first reviews, this field is blank. Subsequent reviews default the number of slides remaining to be reviewed in the Primary Slides field while this field shows the total number already reviewed.

   NOTE: The Primary and Secondary Slides fields must be included on your site's Cytology Results (Cytotech) form sequences in order for CoPathPlus to calculate Cytotech Slide Limits.

6) **Agreement option buttons.** Select the option button that reflects your opinion concerning the initial review on this case:

   - Agree
   - Partially Disagree
   - Completely Disagree

   Note that for the initial review, CoPathPlus automatically selects "Agree".

   NOTE: Rather than the above default 3-way Agreement option, your lab may have elected to implement a 5-way Agreement option..

Buttons:

   o See explanations already mentioned above for the **Previous**, **Next**, **Edit Description**, **Prior Reviews**, and **Edit/View Text** buttons.

   o **Copy to Final button.** Press the **Copy to Final** button to have CoPathPlus copy your review text into the Final Diagnosis field for this case. Refer to "Copy to Final Button" for more information.

   o **Save/Sign Out button.** When you have completed Cytology Results entry for this specimen (case), you can press **Save/Sign Out** to save your current entries and to display the Signout for Final Report window. Refer to "Save/Signout Button on the Cytology Results (Cytotech) Window" for more information. Refer to "Next Step for the Cytology Results Activity".

   o **Save/Next Process button.** Click this button to save your current entries and to initiate the next action, other than Signout, for this case. Refer to "Save/Next Process Button on the Cytology Results (Cytotech) Window" for more information. Refer to "Next Step for the Cytology Results Activity".

Refer to "Entering Information on the Histology Tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen" to continue the cytology results process or "Next Step for the Cytology Results Activity" if you are done entering results.

Flags

CoPathPlus allows you to specify whether an interpretation requires MD Review via an option in the Interpretation Dictionary. If you select that interpretation as an entry in either the Primary Interpretation or Other Interpretation(s) field on the Review tab on the Cytology Results (Cytotech) window, CoPathPlus automatically selects the **MD Review check box** on that tab. If this check box is not automatically selected or if a current non-abnormal review is designated the Primary Review or you just want the case to be reviewed by a Pathologist, you can select this check box manually. For Cytology Non-GYN cases, CoPathPlus automatically sets this flag (the check box does not appear on the Review tab for this specimen class).

CoPathPlus automatically selects the **High Risk check box** on the Review tab on the Cytology Results window if:

- Any high-risk clinical categories have been entered on the current case on the History tab; or

- Prior Cytology GYN specimens contain a Primary Review marked as "abnormal" for this patient within a period of time (number of months) set by your site (during the CoPathPlus implementation process) to trigger this flag.

If your site automatically selects high-risk cases as part of your Quality Control (QC) process, CoPathPlus checks each specimen against the following three criteria before the specimen can be considered part of the high-risk pool:

- The High Risk check box is manually selected by the reviewer or automatically checked by CoPathPlus due to a high-risk clinical history entry.

- The MD Review check box is manually selected by the reviewer or automatically checked by CoPathPlus.

- All of the interpretations, if any, are QC eligible based on the settings designated in the Interpretation Dictionary.

The system controls QC selection of cytology specimens through a series of settings that were determined by your site during the CoPathPlus implementation process. For more information about automated cytology QC selection, refer to "GYN Cytology Quality Control Assignment" in the *Cerner CoPathPlus System Manager Guide*. For more information about the cytology QC review process, refer to Cytology QC Worklist.

Other flags include the:

- **Primary Review**, which represents the review copied into the Final Diagnosis.

- **Abnormal**, which considers a case abnormal if any one interpretation on the review has a property of Abnormal/MD Review as specified in the Interpretation Dictionary.

If the Primary Review is flagged as Abnormal, the case is considered on selected Cytology/CLIA'88 "Abnormal" management reports.

Copy to Final Button

The **Copy to Final** button on the Review tab on the Cytology Results (Cytotech) window appears only for the Cytology GYN specimen class. Clicking this button performs the following tasks:

- Copies text from the Standardized Nomenclature entries and any review text edits into the Final Diagnosis field.

- Automatically codes the Final Diagnosis and enters the SNOMED codes for the specimen on the SNOMED tab on the Cytology Results window.

  NOTE: This occurs only if your site is using SNOMED II codes or dictionary linking and is controlled by a specimen class setting. If not, you must enter the SNOMED codes manually.

- Enters any dictionary-linked ICD-9-CM codes from the current review's Standardized Nomenclature entries into the ICD-9-CM Code(s) field on the Billing/Copy To tab on the Cytology Results (Cytotech) window.

- Sets the review-level flag for this review to be the Primary Review (i.e., it is copied into and becomes the Final Diagnosis). You can observe this designation in the Inquiry (Pathologist) activity.

The **Copy to Final** action is not available to a cytotech reviewer when the MD Review check box is selected either manually or by CoPathPlus when an interpretation requiring MD review is entered. It is also not available for use when an abnormal interpretation is entered. CoPathPlus will issue a warning if the **Copy to Final** button is used in either of these cases.
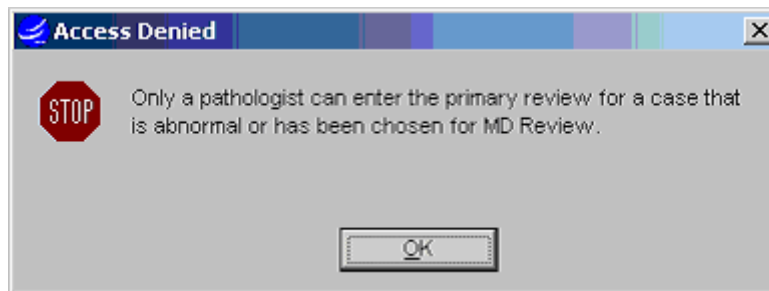
Save/Next Process Button on the Cytology Results (Cytotech) Window

When you are done with entering information on the Cytology Results (Cytotech) window for a Cytology GYN, Non-GYN, or FNA specimen and want to save your current entries and to initiate the next action, other than signing out the specimen (case), you can press **Save/Next Process** on the Review tab and the following Next Process pop-up window appears:

NOTE: If you want to sign out the specimen, press **Save/Sign Out** instead. Refer to "Save/Sign Out Button on the Cytology Results (Cytotech) Window" for more information.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

NOTE: For sites that manually select Cytology Gynecological cases for QC review, the Next Process window includes an additional Screened / Send to QC option that lets you add the case to the Cytology QC Worklist.

To have CoPathPlus:

- Save your changes, specify that this case has been screened, and send it to a pathologist, click on the Screened/Send to Pathologist option button. Accept the default, if applicable, or select the pathologist to which you want to send this case in the Send to field. You can enter a special comment in the Memo field and, if necessary, place the case on hold (which only means that CoPathPlus will place it at the end of a worklist). Then press **Yes**.

- Save your changes, specify that this case has been screened, and send it to another cytotech, click on the Screened/Send to Other Cytotech option button. Select the cytotech to which you want to send this case in the Send to field. You can enter a special comment in the Memo field and, if necessary, place the case on hold (which only means that CoPathPlus will place it at the end of a worklist). Then press **Yes**.

- Save your changes and perform no other action, click on the No Action option button. Then press **Yes**.

- Exit this specimen without saving any changes, press **No**.

- Return you to the Cytology Results (Cytotech) window without performing any action, press **Cancel**.

Save/Sign Out Button on the Cytology Results (Cytotech) Window

When you are done with entering information on the Cytology Results (Cytotech) window for a Cytology GYN, Non-GYN, or FNA specimen and want to save your current entries and sign out the specimen (case), you can press **Save/Sign Out** on the Review tab.

One of the following things happen:

1) The Signout Report window appears. See below for more information.

2) The Quick Signout Window appears. Refer to "Using the Quick Signout Window (Cytology)" for more information.

3) If a cytotech attempts to signout a specimen whose result is abnormal or is marked for MD Review, the system will issue a message that the case must be signed out by a pathologist. The **Save/Next Process** button should be used in this circumstance.

For a detailed explanation of the fields on this window, refer to "Signout (Electronic) and Consult Review".

To have CoPathPlus:

- Sign out the case, press **Sign Out**. The Enter Password pop-up window appears. Enter your user ID (if user ID is required by your site) and password. For sites using TxText as the text editor, you need to first enter your user ID (if user IDs are required by your site) and password on the Signout Report window. Continue with "Next Step for the Cytology Results Activity".

- Sign out the case and send it to the QA (Post-Signout) worklist, press **SO/To QA**. The Sign Out and Send to QA (Post-Signout) Worklist window appears.

1) You can enter a special comment in the Memo field and, if necessary, place the case on hold (which means that CoPathPlus will place it at the end of a worklist). For more information on worklists, refer to "Worklists". Continue with "Next Step for the Cytology Results Activity".

2) After you complete the information on this window, the Enter Password pop-up window appears. Enter your user ID (if user ID is required by your site) and password. For sites using TxText as the text editor, you need to enter your user ID and password on the Signout Report window before the Sign Out and Send to QA (Post-Signout) Worklist window appears.

Upon specimen sign-out, the system may randomly auto-select specimens for QC. Each system manager makes numerous determinations regarding QC eligibility, percentages, and notifications. The technologist may or may not see a QC selection warning message when a specimen is auto-selected for QC. Specimens are eligible for random QC selection as long as all interpretations, if any, are marked as QC eligible in the Interpretation Dictionary. If a specimen is signed out without an interpretation, it is also eligible for random selection for QC.

Using the Quick Signout Window (Cytology)

The Quick Signout window enables users to sign out cases directly from the signout window after entry of a cytology review, without having to access the entire patient report or a data entry window.

The Quick Signout window will only appear if the following occurs:

1) The system setting "Enable Quick Signout" is set to Yes.

2) The user has been assigned the miscellaneous permission "Quick Signout Access".

3) The Save/Signout button has been painted on the window and has the Quick Signout Permission.

Note: Refer to the *CoPathPlus System Manager Guide* and the *CoPathPlus Tools Training Guide* for information on system settings, permissions and window painting.

The following paragraphs describe the fields and buttons on the Quick Signout window.

User ID and **Password.** The User ID field defaults to the user currently logged on to the workstation. To sign out a report, enter your password for each report you select, then press **Sign Out** (see below). User ID and Password are required fields.

NOTE: If the "Require Password for Each Report in ESO" checkbox in the Person dictionary is unchecked, you need only enter your password once and it will then default for each signout.

Sign Out button. Click this button to sign out the report. This marks the case as Final Diagnosis Complete, if not already done so, and changes its status to Signed Out.

To Path/SO button. Click this button to place the specimen on the Pathologist Signout worklist for a pathologist, so that that pathologist can sign it out. After you press **To Path**, the Send to Other Pathologist for Signout pop-up window appears.

If assigned, the specimen's primary pathologist appears as the default in the **Send to** field, but you can select another pathologist. You can enter a special comment in the **Memo** field (e.g., the reason you are forwarding it to the pathologist for signout), and, if necessary, place the case on hold by selecting the **On Hold** check box. Press **OK** to send the report. You are then returned to the Quick Signout window.

Addl Trans button. Click this button to send the specimen to the Additional Transcription worklist. This action also removes the Final Diagnosis Complete status for this case.

SO/To QA button. Click this button to sign out the report and also send it to the QA (Post-Signout Review) worklist.

Print Report… button. Lets you print the selected report. For more information, refer to "Print".

View Report/Edit Report button. For sites using TxText as the CoPathPlus text editor, this button will read **View Report**. Click this button to open the Signout Report window for the selected report. Refer to "Using TxText for Signout and Consult Review" and Consult Review for information.

For sites using Microsoft Word as the CoPathPlus text editor, this button will read **Edit Report**. Click this button to open the Signout Report window for the selected report. Refer to "Using Microsoft Word for Signout and Consult Review" and Consult Review for information.

Staff/Text Tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Staff/Text tab on the Cytology Results (Cytotech) window for a Cytology GYN specimen:

Staff. For detailed information on the staff fields, refer to "Staff".

1) **Pathologist(s).** CoPathPlus will default in this information from the Reviewer field on the Review tab if that person is a Pathologist, Resident, or Fellow person type. Otherwise, you can select the name(s) of the pathologist(s) associated with this specimen. For more on person types, refer to "Person Dictionary" in the "People/Security Dictionaries" section in the *Cerner CoPathPlus Dictionary Building Manual*.

2) **Cytotech(s).** CoPathPlus will default in this information from the Reviewer field on the Review tab if that person is a Cytotech person type. Otherwise, you can select the name(s) of the cytotech(s) associated with this specimen.

Diagnostic text fields.

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

History Tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process.

Enter the following information on the History tab on the Cytology Results (Cytotech) window for a Cytology GYN specimen:

1) **Date of Last Menstruation.** Enter the date of this patient's last menstruation. This is a free-text field.

2) **Clinical History fields.** Select the appropriate information in the clinical history fields from the drop-down list for each field. Use the free-text Comment fields to add additional information. If no information exists for a particular field, leave it blank.

SNOMED Tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED tab:

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field on the Staff/Text tab. When you press **Copy to Final** on the Review tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen, CoPathPlus automatically codes the diagnosis and fills in the following fields on the SNOMED tab:

NOTE: If you want to edit the Final Diagnosis text, make your changes using the Edit Review Text pop-up window (press **Edit/View Text** on the Review tab), and then press **Copy to Final** again.

SNOMED. To learn more about the SNOMED codes-related fields on this tab, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Code(s).** CoPathPlus automatically fills in the SNOMED Code(s) field. For information about SNOMED codes, refer to "SNOMED Codes".

   NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you will have to enter your SNOMED codes manually. To learn more about coding diagnoses, refer to "Using the Automatic SNOMED II Coder".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, when users have entered codes manually or edited ones entered by the Automatic SNOMED II Coder or through dictionary links.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display. Review these words to ensure proper spelling and syntax. If any words are misspelled, go to the Review tab, press **Edit Text** and fix the misspelled words. Then press **Copy To Final** again to re-code your diagnosis.

Billing/Copy To Tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process.

Enter the following information on the Billing/Copy To tab on the Cytology Results (Cytotech) window for a Cytology GYN specimen:

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect

to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class Dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). If your lab uses the Pathology Role for Charges feature, entry of Procedure abbreviations in this field is important so that the proper pathologist role to can be assigned on billing interface transactions. CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Billing Number.** CoPathPlus defaults in the billing number that is associated with the encounter. To learn more about encounters, refer to "Patient Registration".

2) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

ICD-9-CM Code(s). For detailed information on the ICD-9-CM code fields and dictionary linking, refer to "ICD-9-CM Code Linking" and the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **ICD-9-CM Code(s).** Your site may have set it up so that these codes automatically default through a link to the Interpretation Dictionary when you press **Copy to Final** on the Review tab on the Cytology Results (Cytotech) Window for a Cytology GYN Specimen. Otherwise, you can manually select as many ICD-9-CM codes as are appropriate for the services performed on the specimen. ICD-9-CM codes represent diagnosis codes used in standard Medicare or insurance billing.

2) **Source.** Enter the part or procedure to which the ICD-9-CM code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked codes.

3) **Auto.** Displays the following:

      o **L** for ICD-9-CM codes entered through Interpretation Dictionary links.

      o Blank, when users have entered codes manually.

Copy To. For detailed information on the copy to fields, refer to "Copy To"

1) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

2) **Additional Physician(s).** Identify other clinician(s) related to this case. These physicians may have defaulted in from an ADT interface. You can add or edit the physician data here.

Refer to "Next Step for the Cytology Results Activity" to continue the cytology results process.

Entering/Editing Cytology Results (Cytotech) Data for a Cytology Non-GYN Specimen

When you choose the Cytology Results (Cytotech) activity for a Cytology Non-Gynecological (Non-GYN) or Fine Needle Aspirate (FNA) specimen in the standard export version of the CoPathPlus system, you are presented with the Cytology Results (Cytotech) window with the following tabs:

- Review, which allows you to enter the Standardized Nomenclature information for this specimen (i.e., enter a review). You can access prior reviews from this tab and enter reviewer information.

- History/Text, which lets you enter the Clinical Diagnosis and Gross Description for the specimen and clinical history for the patient. Most of this information is entered during accessioning and is displayed here for review purposes.

- Prep, which lets you enter the stains/processes per part for a specimen.

- Staff/Billing, which lets you enter information such as the staff (i.e., pathologist[s], cytotech[s]) responsible for the current case, fee codes, ICD-9-CM codes, and to specify where additional report copies will go.

Review Tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site.

The top portion of the Review tab identifies the part types for the current specimen. The information you enter on this tab pertains to the part type you have highlighted in this display. You can move between parts by clicking on the one you want or pressing **Previous** or **Next**. Or you can press **Prior Reviews** to access a pop-up window that will display all the existing reviews for the current specimen (case).

You can also edit the part description for a selected part type. Do this by highlighting the part type for which you want to edit the description and press **Edit Description** on this tab. The Part Description Edit pop-up window appears on which you can change the part description.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Enter the following information on the Review tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN or FNA specimen:

Standardized Nomenclature fields: For more detailed information on these fields, refer to the "Standardized Nomenclature Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **Adequacy.** Select the entry that identifies the condition of the slides prior to evaluation (e.g., unsatisfactory; slide contains unidentifiable foreign matter). In the standard export version of CoPathPlus, a value of **Satisfactory** defaults in this field.

2) **Primary Interpretation.** This field is required for all parts on the current case. Select the entry that constitutes the main diagnosis for the part. This interpretation is also used for statistical purposes on management reports. In the standard export version of CoPathPlus, a value of **Negative for malignancy** defaults in this field.

3) **Other Interpretation(s).** Select the secondary diagnosis or supporting diagnosis information for the part.

   NOTE: You can press **Edit/View Text** to access the Edit Review Text pop-up window, which displays the information you entered in these Standardized Nomenclature fields in a standard text field. You can edit or add to the review text directly on this window. Refer to "Entering Information in Diagnostic Text Fields" for more information on using the text editor.

   For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

   Keep in mind that if you do edit text through the Edit Review Text pop-up window, but then go back and change the Standardized Nomenclature fields on the Review tab, CoPathPlus will present you with a message pop-up window asking you if you want to overwrite what you manually entered through the Edit Review Text pop-up window.

Reviewer, Slides, and Agreement fields:

1) **Reviewer.** Select the name of the person associated with this review. If the person who is signed on is a person type of cytotech, resident, fellow, or pathologist, his or her name displays in this field. You can change the name that displays.

2) **Date.** Enter the date on which this review was created. Today's date will default.

3) **Primary Slides.** For first reviews, CoPathPlus defaults the total number of slides to review in this field. Subsequent reviews default the number of slides remaining to be reviewed in this field while the Secondary Slides field shows the total number already reviewed.

Secondary Slides. For first reviews, this field is blank. Subsequent reviews default the number of slides remaining to be reviewed in the Primary Slides field while this field shows the total number already reviewed.

   NOTE: The Primary and Secondary Slides fields must be included on your site's Cytology Results (Cytotech) form sequences in order for CoPathPlus to calculate Cytotech Slide Limits.

5) **Agreement option buttons.** Select the option button that reflects your opinion concerning the initial review on this case:

   o Agree

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

      o   Partially Disagree

      o   Completely Disagree

Note that for the initial review, CoPathPlus automatically selects "Agree" (which is the only acceptable choice in this situation).

NOTE: Rather than the above default 3-way Agreement option, your lab may have elected to implement a 5-way Agreement option.

Buttons:

- See explanations already mentioned above for the **Previous**, **Next**, **Edit Description**, **Prior Reviews**, and **Edit/View Text** buttons.

- **Save/Next Process button.** When you have completed Cytology Results entry for this specimen (case), you can press the **Save/Next Process** button to save your current entries and to initiate the next action, other than Signout for it. Refer to "Save/Next Process Button on the Cytology Results (Cytotech) Window", as well as Next Step for the Cytology Results Activity for more information.

Flags:

CoPathPlus automatically sets all Cytology Non-GYN cases for **MD Review**. In addition, the **High Risk flag** available for Cytology GYN cases is not available for Cytology Non-GYN cases. Other flags include:

- **Primary Review**, which represents the review copied into the Final Diagnosis.

- **Abnormal**, which considers a case abnormal if any one interpretation on the review has a property of Abnormal/MD Review as specified in the Interpretation Dictionary.

If the Primary Review is flagged as Abnormal, the case is considered on selected Cytology/CLIA'88 "Abnormal" management reports.

History/Text Tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the History/Text tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN or FNA specimen:

Clinical History fields. Select the appropriate information in the clinical history fields from the drop-down list for each field. Use the free-text Comment fields to add additional information. If no information exists for a particular field, leave it blank.

Diagnostic text fields.

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Prep Tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process.

The top portion of the Prep tab identifies the part types for the current specimen. The information you enter on this tab pertains to the part type you have highlighted in this display. You can move between parts by clicking on the one you want or pressing **Previous** or **Next**.

Enter the following information on the Prep tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN or FNA specimen:

1) **Stain/Process.** For detailed information on the stain/process fields, refer to "Stain/Process". Select the stain(s)/process(es) associated with this part type. This field is a dictionary field for which you can look up an entry in the Stain/Process Dictionary. Refer to "Stain/Process Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

   NOTE: If you edit the total number of stains/processes ordered during the Cytology Results activity, the slide count on the Review tab is automatically updated.

2) **Count.** Enter the number of stains or processes to be performed on this part. It will default to one. You can change the number in this field.

3) **Slide Label Text.** Enter the text that you want to appear on the slide labels when they are printed. If there is slide text associated with this particular part type, it will default in this field. You can change the information in this field.

4) **Date/Time Ordered.** A display-only field that specifies when the stain/process was ordered. The current date and time will default, which you cannot change.

Staff/Billing Tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process.

Enter the following information on the Staff/Billing tab on the Cytology Results (Cytotech) Window for a Cytology Non-GYN or FNA specimen:

Staff. For detailed information on the staff fields, refer to "Staff".

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

1) **Pathologist(s).** CoPathPlus will default in this information from the Reviewer field on the Review tab if that person is a Pathologist, Resident, or Fellow person type. Otherwise, you can select the name(s) of the pathologist(s) associated with this specimen.

To learn more about person types, refer to "Person Dictionary" in the "People/Security Dictionaries" section in the Cerner CoPathPlus Dictionary Building Manual.

2) **Cytotech(s).** CoPathPlus will default in this information from the Reviewer field on the Review tab if that person is a Cytotech person type. Otherwise, you can select the name(s) of the cytotech(s) associated with this specimen.

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). If your lab uses the Pathology Role for Charges feature, entry of Procedure abbreviations in this field is important so that the proper pathologist role to can be assigned on billing interface transactions. CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Billing Number.** CoPathPlus defaults in the billing number that is associated with the encounter. To learn more about encounters, refer to "Patient Registration".

2) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

ICD-9-CM Code(s). For detailed information on the ICD-9-CM code fields and dictionary linking, refer to "ICD-9-CM Code Linking" and the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **ICD-9-CM Code(s).** Your site may have set it up so that these codes automatically default through a link to the Interpretation Dictionary when you initiate a save. Otherwise, you can manually select as many ICD-9-CM codes as are appropriate for the services performed on the specimen. ICD-9-CM codes represent diagnosis codes used in standard Medicare or insurance billing.

2) **Source.** Enter the part or procedure to which the ICD-9-CM code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked codes.

3) **Auto.** Displays the following:

   o **L** for ICD-9-CM codes entered through Interpretation Dictionary links.

   o Blank, when users have entered codes manually.

Copy To. For detailed information on the Copy To fields, refer to "Copy To"

1) **Submitting Physician.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

2) **Additional Physician(s).** Identify other clinician(s) related to this case. These physicians may have defaulted in from an interface. You can add or edit the physician data here.

Refer to "Next Step for the Cytology Results Activity" to continue the cytology results process.

Entering/Editing Cytology Results (Cytotech) Data for a Cytology FNA Specimen

When you choose the Cytology Results (Cytotech) activity for a Cytology Fine Needle Aspirate (FNA) specimen in the standard export version of the CoPathPlus system, you are presented with the same Cytology Results (Cytotech) window as for a Cytology Non-Gynecological specimen. Refer to "Entering/Editing Cytology Results (Cytotech) Data for a Cytology Non-GYN Specimen" for descriptions.

Cytology Results (Pathologist)

You can enter/edit results in the Cytology Results (Pathologist) activity for the following Cytology specimen classes in the standard export version of the CoPathPlus system:

- Cytology Gynecological (GYN)

- Cytology Non-Gynecological (Non-GYN)

- Cytology Fine Needle Aspirate (FNA)

The tabs you see on the Cytology Results (Pathologist) window when you access this activity depend on the type of specimen class you are accessing.

Entering/Editing Cytology Results (Pathologist) Data for a Cytology GYN Specimen

When you choose the Cytology Results (Pathologist) activity for a Cytology Gynecological (GYN) specimen in the standard export version of the CoPathPlus system, you are presented with the Cytology Results (Pathologist) window with the following tabs:

- Review, which allows you to enter the Standardized Nomenclature information for this specimen (i.e., enter a review). You can access prior reviews from this tab and enter reviewer information.

- History, which lets you enter clinical history for the patient. Most of this information is entered during accessioning and is displayed here for review purposes.

- Staff/Text, which lets you enter the staff associated with the specimen and text field information such as Diagnosis Comment and Clinical Diagnosis.

- SNOMED, which lets you assign SNOMED codes to a case based on diagnostic information.

- Billing/Copy To, which lets you enter information such as the clinicians/institutions that should receive report copies, fee codes, and ICD-9-CM codes, and to specify where additional report copies will go.

In the standard export version of CoPathPlus, the Review tab for the Cytology Results (Pathologist) activity for a Cytology GYN specimen is almost identical to the Review tab for the Cytology Result (Cytotech) activity for a Cytology GYN specimen, with the following exceptions. This window:

- Has a Recommendation field. Use this field to enter a suggested future handling of this case (e.g., **Repeat screen in 6 months.**).

- Does not have the MD Review check box.

- Does not have a **Save/Next Process** button.

- Pathologists are qualified to signout specimens with abnormal results or with an active MD Review check box.

Depending on system configuration, the save of specified cytology interpretations be a primary factor in a reflexive ordering action where a procedure is automatically ordered on a specimen. This action is dependent on a number of site-specific configurations plus certain CoPathPlus events. In order for a reflex action to occur, the following parameters must be in place:

- A "preliminary" reflex request is placed on specimen:

  o Via Standing Order process (refer to Standing Order documentation)

  o OR manually set via check box or datawindow

- The specimen's part type is eligible for the reflex as defined in the Reflex Dictionary

- The specimen's interpretation is eligible for the reflex as defined in the Reflex Dictionary

- Copy to Final has been done

- Save has been done

Note: Reflex actions occur on a per specimen basis rather than a per part basis. I.e. if part type A is eligible for the reflex and part type's B's interpretation is eligible, the reflex will still occur.

Entering/Editing Cytology Results (Pathologist) Data for a Cytology Non-GYN Specimen

When you choose the Cytology Results (Pathologist) activity for a Cytology Non-Gynecological (Non-GYN) or Fine Needle Aspirate (FNA) specimen in the standard export version of the CoPathPlus system, you are presented with the Cytology Results (Pathologist) window with the following tabs:

- Review, which allows you to enter the Standardized Nomenclature information for this specimen (i.e., enter a review). You can access prior reviews from this tab and enter reviewer information.

- Staff/Text, which lets you enter the staff associated with the specimen and text field information such as Diagnosis Comment, Clinical Diagnosis, and Gross Description.

- History/Prep, which lets you enter clinical history and the stains/processes per part for a specimen for the patient. Most of this information is entered during accessioning and is displayed here for review purposes.

- SNOMED, which lets you assign SNOMED codes to a case based on diagnostic information.

- Billing/Copy To, which lets you enter information such as the clinicians/institutions that should receive report copies, and ICD-9-CM codes, and to specify where additional report copies will go.

Review Tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site.

The top portion of the Review tab identifies the part types for the current specimen. The information you enter on this tab pertains to the part type you have highlighted in this display. You can move between parts by clicking on the one you want or pressing **Previous** or **Next**. Or you can press **Prior Reviews** to access a pop-up window that will display all the existing reviews for the current specimen (case).

You can also edit the part description for a selected part type. Do this by highlighting the part type for which you want to edit the description and press **Edit Description** on this tab. The Part Description Edit pop-up window appears on which you can change the part description.

Enter the following information on the Review tab on the Cytology Results (Pathologist) window for a Cytology Non-GYN or FNA specimen:

Standardized Nomenclature fields: For more detailed information on these fields, refer to the "Standardized Nomenclature Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **Adequacy.** Select the entry that identifies the condition of the slides prior to evaluation (e.g., unsatisfactory; slide contains unidentifiable foreign matter). In the standard export version of CoPathPlus, a value of **Satisfactory** defaults in this field.

2) **Primary Interpretation.** This field is required for all parts on the current case. Select the entry that constitutes the main diagnosis for the part. This interpretation is also used for statistical purposes on management reports. In the standard export version of CoPathPlus, a value of **Negative for malignancy** defaults in this field.

3) **Other Interpretation(s).** Select the secondary diagnosis or supporting diagnosis information for the part.

4) **Recommendation.** Select an entry that specifies the suggested future handling of this case (e.g., repeat screen in 6 months).

   NOTE: You can press **Edit/View Text** to access the Edit Review Text pop-up window, which displays the information you entered in these Standardized Nomenclature fields in a standard text field. You can edit or add to the review text directly on this window. Refer to "Entering Information in Diagnostic Text Fields" for more information on using the text editor.

   For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

   Keep in mind that if you do edit text through the Edit Review Text pop-up window, but then go back and change the Standardized Nomenclature fields on the Review tab, CoPathPlus will present you with a message pop-up window asking you if you want to overwrite what you manually entered through the Edit Review Text pop-up window.

Reviewer and Agreement fields:

1) **Reviewer.** Select the name of the person associated with this review. If the person who is signed on is a person type of cytotech, resident, fellow, or pathologist, his or her name displays in this field. You can change the name that displays.

2) **Date.** Enter the date on which this review was created. Today's date will default.

3) **Primary Slides.** For first reviews, CoPathPlus defaults the total number of slides to review in this field. Subsequent reviews default the number of slides remaining to be reviewed in this field while the Secondary Slides field shows the total number already reviewed.

4) **Secondary Slides.** For first reviews, this field is blank. Subsequent reviews default the number of slides remaining to be reviewed in the Primary Slides field while this field shows the total number already reviewed.

5) **Agreement option buttons.** Select the option button that reflects your opinion concerning the initial review on this case:

   o   Agree

> o   Partially Disagree
>
> o   Completely Disagree
>
> Note that for the initial review, CoPathPlus automatically selects "Agree".

Buttons:

> o   See explanations already mentioned above for the **Pre<u>v</u>ious**, **Ne<u>x</u>t**, **Edit Description**, **Prior Reviews**, and **Ed<u>i</u>t/View Text** buttons**.**
>
> o   **Copy to Final button.** Press the **Copy to Final** button to have CoPathPlus copy your review text into the Final Diagnosis field for this case. Refer to "Copy to Final Button" for more information.
>
> o   Refer to "Next Step for the Cytology Results Activity" for instructions for the **Save/Sign Out** button.

Staff/Text Tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Ed<u>i</u>t Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Staff/Text tab on the Cytology Results (Pathologist) window for a Cytology Non-GYN or FNA specimen:

Staff. For detailed information on the staff fields, refer to "Staff".

1)   **Pathologist(s).** CoPathPlus will default in this information from the Reviewer field on the Review tab if that person is a Pathologist, Resident, or Fellow person type. Otherwise, you can select the name(s) of the pathologist(s) associated with this specimen.

> To learn more about person types, refer to "Person Dictionary" in the "People/Security Dictionaries" section in the Cerner CoPathPlus Dictionary Building Manual.

2)   **Cytotech(s).** CoPathPlus will default in this information from the Reviewer field on the Review tab if that person is a Cytotech person type. Otherwise, you can select the name(s) of the cytotech(s) associated with this specimen.

Diagnostic text fields.

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Ed<u>i</u>t Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1)   Press **Ed<u>i</u>t Text** (or press on the toolbar, or select Op<u>t</u>ions, <u>E</u>dit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2)   Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

History/Prep Tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process.

Enter the following information on the History/Prep tab on the Cytology Results (Pathologist) window for a Cytology Non-GYN or FNA specimen:

Clinical History fields. Select the appropriate information in the clinical history fields from the drop-down list for each field. Use the free-text Comment fields to add additional information. If no information exists for a particular field, leave it blank.

The middle portion of the History/Prep tab identifies the part types for the current specimen. The information you enter in the stain/process portion of this tab pertains to the part type you have highlighted in this display. You can move between parts by clicking on the one you want or pressing **Pre<u>v</u>ious** or **Ne<u>x</u>t**.

Stain/Process fields:

1) **Stain/Process.** For detailed information on the stain/process fields, refer to "Stain/Process". Select the stain(s)/process(es) associated with this part type. This field is a dictionary field for which you can look up an entry in the Stain/Process Dictionary. Refer to "Stain/Process Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

   NOTE: If you edit the total number of stains/processes ordered during the Cytology Results activity, the slide count on the Review tab is automatically updated.

2) **Count.** Enter the number of stains or processes to be performed on this part. It will default to one. You can change the number in this field.

3) **Slide Label Text.** Enter the text that you want to appear on the slide labels when they are printed. If there is slide text associated with this particular part type, it will default in this field. You can change the information in this field.

4) **Date/Time Ordered.** A display-only field that specifies when the stain/process was ordered. The current date and time will default, which you cannot change.

SNOMED Tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN or FNA specimen:

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field on the Staff/Text tab. When you press **Copy to Final** on the Review tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN Specimen, CoPathPlus automatically codes the diagnosis and fills in the following fields on the SNOMED tab:

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

NOTE: If you want to edit the Final Diagnosis text, make your changes using the Edit Review Text pop-up window (press **Edit/View Text** on the Review tab), and then press **Copy to Final** again.

SNOMED. To learn more about the SNOMED codes-related fields on this tab, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Code(s).** CoPathPlus automatically fills in the SNOMED Code(s) field. For information about SNOMED codes, refer to "SNOMED Codes".

   NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you will have to enter your SNOMED codes manually. To learn more about coding diagnoses, refer to "Using the Automatic SNOMED II Coder".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, when users have entered codes manually or edited ones entered by the Automatic SNOMED II Coder or through dictionary links.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display. Review these words to ensure proper spelling and syntax. If any words are misspelled, go to the Review tab, press **Edit Text** and fix the misspelled words. Then press **Copy To Final** again to re-code your diagnosis.

Billing/Copy To Tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN Specimen

NOTE: Your system may look different depending on the modifications made by your site. The information you see on this tab is usually entered during the accessioning process.

Enter the following information on the Billing/Copy To tab on the Cytology Results (Pathologist) window for a Cytology Non-GYN or FNA specimen:

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

   NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). If your lab uses the Pathology Role for Charges feature, entry of Procedure abbreviations in this field is important so that the proper pathologist role to can be assigned on billing interface transactions. CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Specimen Data. For detailed information on these fields, refer to "Specimen Data".

1) **Billing Number.** CoPathPlus defaults in the billing number that is associated with the encounter. To learn more about encounters, refer to "Patient Registration".

2) **Billing Type.** This information typically defaults in from an ADT interface and other specimen data. You can change the billing type or accept the default.

ICD-9-CM Code(s). For detailed information on the ICD-9-CM code fields and dictionary linking, refer to "ICD-9-CM Code Linking" and the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **ICD-9-CM Code(s).** Your site may have set it up so that these codes automatically default through a link to the Interpretation Dictionary when you press **Copy to Final** on the Review tab on the Cytology Results (Pathologist) Window for a Cytology Non-GYN Specimen. Otherwise, you can manually select as many ICD-9-CM codes as are appropriate for the services performed on the specimen. ICD-9-CM codes represent diagnosis codes used in standard Medicare or insurance billing.

2) **Source.** Enter the part or procedure to which the ICD-9-CM code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked codes.

3) **Auto.** Displays the following:

   o **L** for ICD-9-CM codes entered through Interpretation Dictionary links.

   o Blank, when users have entered codes manually.

Copy To. For detailed information on the copy to fields, refer to "Copy To".

1) **Submitting Physician.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

2) **Additional Physician(s).** Identify other clinician(s) related to this case. These physicians may have defaulted in from an ADT interface. You can add or edit the physician data here.

Entering/Editing Cytology Results (Pathologist) Data for a Cytology FNA Specimen

When you choose the Cytology Results (Pathologist) activity for a Cytology Fine Needle Aspirate (FNA) specimen in the standard export version of the CoPathPlus system, you are presented with the same Cytology Results (Pathologist) window as for a Cytology Non-Gynecological specimen. Refer to "Entering/Editing Cytology Results (Pathologist) Data for a Cytology Non-GYN Specimen" for descriptions.

Next Step for the Cytology Results Activity

Now that you have completed the information on the Cytology Results window, you can perform one of the following actions:

NOTE: For the Cytology Results (Cytotech) activity you will see a Next Process pop-up window appear when you choose one of the following actions rather than signing out the case. To learn more about this window, refer to "Save/Next Process Button on the Cytology Results (Cytotech) Windows" for more information.

Also, when you save Cytology results, a system setting determines whether a message appears if the case has been automatically selected for QC review. For more information, refer to "Cytology QC Worklist".

- Press **Save/Sign Out** on the Review tab to save your current entries. If you are configured for Quick Signout, the Quick Signout window appears. Refer to "Using the Quick Signout Window (Cytology)" for more information. Otherwise, the Signout for Final Report window appears. Here is where you will sign out the case. To learn more about this window, refer to "Save/Signout Button on the Cytology Results (Cytotech) Window" and "Signout (Electronic) and Consult Review". This button is available to cytotechs in the Cytology Results (Cytotech) activity only for a Cytology GYN specimen, and to pathologists in either Cytology Results activity with all appropriate cytology specimen classes.

- Press **Save/Next Process** on the Review tab to save your current entries and to initiate the next action, other than Signout, for this specimen (case). This button appears on the Cytology Results (Cytotech) window, but not the Cytology Results (Pathologist) window. Refer to "Save/Next Process Button on the Cytology Results (Cytotech) Window" for more information.

- Press on the toolbar (or select File, Open Specimen on the menu bar) to retrieve another existing specimen. Press **Yes**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Press ▣ on the toolbar (or select <u>F</u>ile, <u>C</u>lose Specimen on the menu bar) to return to the CoPathPlus Application Manager. Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing ▣ on the toolbar (or selecting <u>F</u>ile, <u>M</u>anager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Press ▣ on the toolbar (or select <u>F</u>ile, E<u>x</u>it CoPath Client/Server on the menu bar) to exit CoPathPlus. Press **<u>OK</u>**, when prompted, to sign off of CoPathPlus. Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

- Press ▣ on the toolbar (or select Op<u>t</u>ions, <u>A</u>ctivities on the menu bar) to choose another activity to perform on the current specimen. Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Diagnosis Coding Entry/Edit

This topic describes the Diagnosis Coding Entry/Edit activity in the standard export version of the CoPathPlus system.

The Diagnosis Coding Entry/Edit activity allows you to easily assign SNOMED II codes to a case based on diagnostic information in the Final Diagnosis field using of the Automatic SNOMED II Coder, or you manually assign codes. You can also use this activity to review and edit codes entered by someone else, perhaps during Final Diagnosis Entry/Edit or Signout.

NOTE: SNOMED II codes may also be assigned to specimens via the following the CoPathPlus activities: Final Diagnosis Entry/Edit, Signout [Electronic], Cytology Results [Cytotech], and Cytology Results [Pathologist].

You can only use the Automatic SNOMED II Coding feature for a specimen if the associated specimen class is defined to allow automatic coding. When you use the Diagnosis Coding Entry/Edit item for a specimen whose class does not allow automatic coding, the **Autocode** button is disabled.

NOTE: The Automatic SNOMED II Coder only works with SNOMED II codes. If your site uses SNOMED International codes, you have to enter those codes manually.

To learn more about the Automatic SNOMED II Coding function in CoPathPlus, refer to "Using the Automatic SNOMED II Coder".

Accessing the Diagnosis Coding Entry/Edit Activity

To access the Diagnosis Coding Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select **Specimen** window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Diagnosis Coding Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Diagnosis Coding Entry/Edit window appears.

TIP! You can also access the Diagnosis Coding Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Entering/Editing Diagnosis Coding Data

You can enter SNOMED II codes for all specimen classes in the standard export version of the CoPathPlus system, except for Surgical Histology Only. This specimen class is not valid for the Diagnosis Coding Entry/Edit activity. Also, while you can use the Diagnosis Coding Entry/Edit activity to assign SNOMED II codes for Cytology specimens, CoPathPlus automatically performs this function when you press the **Copy to Final** button found on the Review tab in either of the two Cytology Results activities.

For the standard export version of CoPathPlus, the tabs you see on the Diagnosis Coding Entry/Edit window when you access this activity are the same for all specimen classes, except for Surgical Procedure-Only and Cytology Procedure-Only.

- SNOMED II, which lets you automatically and manually assign SNOMED II codes to a case based on Final Diagnosis information.

- Procedures, which lets you view (one at a time) each procedure or addendum and its corresponding interpretation or addendum comment for the current specimen.

For the Surgical Procedure-Only and Cytology Procedure-Only specimen classes, the Diagnosis Coding Entry/Edit window only has one tab, the SNOMED II tab. For these specimen classes, the SNOMED II tab contains a combination of fields from the standard SNOMED II and Procedures tabs for the other specimen classes for this activity. Because a Procedure-Only specimen does not normally have Final Diagnosis text, and because the automatic coding feature executes based on Final Diagnosis information, the automatic coding functionality is not relevant for the Diagnosis Coding Entry/Edit activity for the Surgical Procedure-Only and Cytology Procedure-Only specimen classes. The SNOMED II tab for these two specimen classes allow you to manually enter SNOMED II codes and to view (one at a time) each procedure or addendum and its corresponding interpretation or addendum comment for the current specimen.

SNOMED II Tab on the Diagnosis Coding Entry/Edit Window for Specimen Classes Other than Procedure-Only

The first tab on the Diagnosis Coding Entry/Edit window for specimen classes other than Procedure-Only is the SNOMED II tab in the standard export version of the CoPathPlus system.

Enter the following information on the SNOMED II tab:

Final. The top portion of the SNOMED II tab is a display-only field that shows the Final Diagnosis text for the current specimen.

NOTE: If there is no text in the Final field, no coding will occur.

Autocode button. Click this button to automatically assign SNOMED II codes to the Final Diagnosis text shown on the top portion of the SNOMED II tab. After the case has been coded, CoPathPlus displays the codes and any words it did not use during the automatic coding process. You can edit, add, and delete codes.

NOTE: If your site uses SNOMED International codes, you will not refer to **Autocode** or it will be disabled. You must enter SNOMED International codes manually.

SNOMED II Code(s). For more detailed information on the fields on the SNOMED II tab and on using the Automatic SNOMED II Coder, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Code(s).** CoPathPlus automatically fills in the SNOMED Code(s) field. For information about SNOMED codes, refer to "SNOMED Codes".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

      o   **L** for SNOMED codes entered through dictionary links.

      o   Blank, when users have entered codes manually or edited ones entered by the Automatic SNOMED II Coder or through dictionary links.

   4)   **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display field. Review these words to ensure proper spelling and syntax. If any words are misspelled, access an appropriate activity (such as Final Diagnosis Entry/Edit) and fix the misspelled words. Then press **A̲utocode** again to re-code your diagnosis. You should be able to do this within the activity you selected to make the corrections.

Mark Coded Diagnosis Complete. Select this check box when you have completed the SNOMED coding process.

I̲CD-9-CM Code(s)…button. Click this button to open the ICD-9-CM pop-up window, which lets you enter/edit any ICD-9-CM codes for this specimen. For detailed information about this pop-up window, refer to "ICD-9-Code(s)".

Procedures Tab on the Diagnosis Coding Entry/Edit Window for Specimen Classes Other Than Procedure-Only

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Procedures tab:

NOTE: The Automatic SNOMED II Coding feature is not available for procedures/addenda or if you are using SNOMED International codes. You have to enter SNOMED codes for procedures/addenda and SNOMED International codes manually.

Procedure/Addendum Display-Only Area. The top portion of the Procedures tab is a display-only field that lists all the procedures and addenda for the current specimen (case). To review the interpretation (for a procedure) or addendum diagnosis (for an addendum), press **Pre̲vious** or **Ne̲xt** to highlight the item you want on the list.

Interpretation/Addendum Display-Only Area. The bottom portion of the Procedures tab displays the interpretation (for a procedure) or addendum diagnosis (for an addendum) for the item highlighted on the top portion of this tab.

NOTE: An appropriate label for the bottom display-only area appears (i.e., "Interpretation" or "Addendum"). No label appears if the display area at the top portion of this tab is empty.

Save/Next Specimen button. Click this button to save the current data and continue entering diagnosis coding information for another specimen. The Select Specimen window appears.

SNOMED II Tab on the Diagnosis Coding Entry/Edit Window for Procedure-Only Specimen Classes

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED II tab:

Procedure/Addendum Display-Only Area. The top portion of the Procedures tab is a display-only field that lists all the procedures and addenda for the current specimen (case). To review

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

the interpretation (for a procedure) or addendum diagnosis (for an addendum), press **Pre<u>v</u>ious** or **Ne<u>x</u>t** to highlight the item you want on the list.

Interpretation/Addendum Display-Only Area. The middle portion of the Procedures tab displays the interpretation (for a procedure) or addendum diagnosis (for an addendum) for the item highlighted on the top portion of this tab.

NOTE: An appropriate label for the middle display-only area appears (i.e., "Interpretation" or "Addendum"). No label appears if the display area at the top portion of this tab is empty.

1) **SNOMED Code(s).** Enter as many SNOMED code(s) as apply. For information about SNOMED codes, refer to "SNOMED Codes".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** This field is blank to show that the SNOMED codes were manually entered.

Mark Coded Diagnosis Complete. Select this check box when you have completed the SNOMED coding process.

<u>I</u>CD-9-CM Code(s)…button. Click this button to open the ICD-9-CM pop-up window, which lets you enter/edit any ICD-9-CM codes for this specimen. For detailed information about this pop-up window, refer to "ICD-9-Code(s)".

<u>S</u>ave/Next Specimen button. Click this button if you want to save the current data and continue entering diagnosis coding information for another specimen. The Select Specimen window appears.

Next Step for the Diagnosis Coding Entry/Edit Activity

Now that you have completed the information on the Diagnosis Coding Entry/Edit window, you can perform one of the following actions:

- Save your current entries and continue entering diagnosis coding data for another specimen by pressing **<u>S</u>ave/Next Specimen** on the Procedures or SNOMED II tab; or on the toolbar (or select <u>F</u>ile, <u>O</u>pen Specimen on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Sa<u>m</u>e Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Op<u>t</u>ions, <u>A</u>ctivities on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select <u>F</u>ile, <u>C</u>lose Specimen on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Final Diagnosis Entry/Edit

This topic describes the Final Diagnosis Entry/Edit activity in the standard export version of the CoPathPlus system.

As a pathologist examines the slides for a case, he or she determines data relevant to the Microscopic Description findings and the Final Diagnosis result and comment.

The Final Diagnosis Entry/Edit activity is used to enter and/or edit the Microscopic Description, Final Diagnosis, and the Diagnosis Comment for a specimen after the specimen has been accessioned but before the specimen is signed out. You can also use this activity to assign SNOMED, billing, and ICD-9-CM codes to the Final Diagnosis, and to select images and other files to attach to the case.

The Final Diagnosis Entry/Edit activity lets you enter or edit diagnostic information for Surgical, Bone Marrow, and Autopsy specimen classes. To enter diagnostic information for Cytology specimens, use the Cytology Results activity.

Accessing the Final Diagnosis Entry/Edit Activity

To access the Final Diagnosis Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Final Diagnosis Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Final Diagnosis Entry/Edit window for the specimen class associated with the specimen appears.

TIP! You can also access the Final Diagnosis Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Entering/Editing Final Diagnosis Data

You can enter/edit data in the Final Diagnosis Entry/Edit activity for the following types of specimen classes in the standard export version of the CoPathPlus system:

   o Surgical Routine and Bone Marrow Routine

   o Surgical Consult

   o Autopsy Anatomic/Neuro and Autopsy Anatomic Only

The tabs you see on the Final Diagnosis Entry/Edit window when you access this activity depend on the specimen class you are accessing.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., [...] and [▼]) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Entering/Editing Final Diagnosis Data for a Surgical Routine or Bone Marrow Routine Specimen

You can enter/edit Final Diagnosis data for the Surgical Routine and Bone Marrow Routine specimen classes in the Final Diagnosis Entry/Edit activity in the standard export version of the CoPathPlus system. The tabs you see when you access this activity look the same for both of these specimen classes. They include:

- Text, which allows you to enter or edit diagnosis information, including Final Diagnosis, Microscopic Description, and Gross Description.

- SNOMED, which displays the Final Diagnosis for a case and lists the associated SNOMED codes. You can assign SNOMED codes to the Final Diagnosis from this tab.

- Billing/Staff, which allows you to enter billing and specimen data and to specify where additional report copies will go. It also allows you to enter or edit the pathologist(s) associated with the specimen (case).

- **Attachments,** which lets you attach digital images and other files to the case, and select which attachments you want to print on patient reports for this case.

Much of the information presented on these tabs defaults in from data entered during the accessioning and gross processes.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Final Diagnosis Entry/Edit window for each specimen class may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Text Tab on the Final Diagnosis Entry/Edit Window for a Surgical Routine or Bone Marrow Routine Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press [icon] on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part

designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press 📦 on the toolbar to return to CoPathPlus after you finish entering and editing text.

SNOMED Tab on the Final Diagnosis Entry/Edit Window for a Surgical Routine or Bone Marrow Routine Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED tab:

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field on the Text tab. To automatically code the Final Diagnosis, press **Autocode**. CoPathPlus will fill in the SNOMED code-related fields on this tab, as described below.

NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you will have to enter your SNOMED codes manually. If you want to edit the Final Diagnosis text, go to the Text tab.

Edit Text button. Click this button to edit diagnostic text fields, including the Final Diagnosis. This button does not appear for sites using TxText as the CoPathPlus text editor. For more information about how to use this button, refer to "Using Microsoft Word to Edit Diagnostic Text Fields".

SNOMED. To learn more about the SNOMED code-related fields on this tab and how to use the Automatic SNOMED II Coder, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Code(s).** CoPathPlus automatically fills in the SNOMED Code(s) field. For information about SNOMED codes, refer to "SNOMED Codes".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, for manually entered codes or for those codes entered by the Automatic SNOMED II Coder but then edited.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display.

   a) Review these words to ensure proper spelling and syntax.

   b) If any words are misspelled, go to the Text tab and fix the misspelled words.

   c) Then return to the SNOMED tab and press **Autocode** again to re-code the Final Diagnosis.

Mark Coded Diagnosis Complete. Select this check box when you have completed the SNOMED coding process.

For information on installation and maintenance of the Automatic SNOMED II Coder, refer to the *Cerner CoPathPlus System Manager Guide*.

Billing/Staff Tab on the Final Diagnosis Entry/Edit Window for a Surgical Routine or Bone Marrow Routine Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Billing/Staff tab:

NOTE: If specimen, pathologist, additional physician, outside institution, or retrieval flag data for this specimen was entered during the accessioning or gross process, that information automatically displays here. You can enter or change the information on this tab.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". Some of the data that displays on this portion of the tabmay default in from information received through an Admission/Discharge/Transfer (ADT) interface. To learn more interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** This information typically defaults in from data entered during the accessioning process. You can change the current encounter number or accept the default.

2) **Billing Number.** CoPathPlus defaults in the billing number that is associated with the encounter. To learn more about encounters, refer to "Patient Registration".

3) **Client.** This information typically defaults in from data entered during the accessioning process. You can change the client or accept the default that is associated with the encounter number.

   NOTE: Your site may have entered an institutional billing number in the Client dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or

change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Staff Information. Identify the pathologist(s) related to this case or change the values already in the staff-related fields. Note that which staff fields display and the order of these fields depend on which specimen class you are currently working with. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, the physician name(s) may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Buttons.

1) ICD-9-CM Code(s). Click this button to open the ICD-9-CM pop-up window, which lets you enter/edit any ICD-9-CM codes for this specimen. For detailed information about this pop-up window, refer to "ICD-9-Code(s)".

2) Retrieval Flags. Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen. For detailed information about this pop-up window, refer to "Retrieval Flags".

3) Save/Next Specimen button. Click this button if you want to save the current data and continue entering Final Diagnosis information for another specimen. Or you can switch activities or exit CoPathPlus through the toolbar. For all actions, the Next Process pop-up window appears for the Surgical Routine and Bone Marrow Routine specimen classes

ICD-9-CM Code(s)

ICD-9-CM codes are diagnosis codes used in standard Medicare or insurance billing. A site can transmit these codes as part of its billing output. In CoPathPlus, a site stores these codes in the ICD-9-CM Code Dictionary. Once in the dictionary, you can quickly retrieve a code or codes into the ICD-9-CM Code(s) field, which you encounter in activities determined by decisions made during the implementation of your CoPathPlus system (e.g., Final Diagnosis Entry/Edit, Cytology Results, Billing Entry/Edit, Signout).

You can enter ICD-9-CM codes manually or your site can set it up so that the codes automatically default onto a specimen through a link to the Quick Text Dictionary or, in the case of Cytology Results, the Interpretation Dictionary.
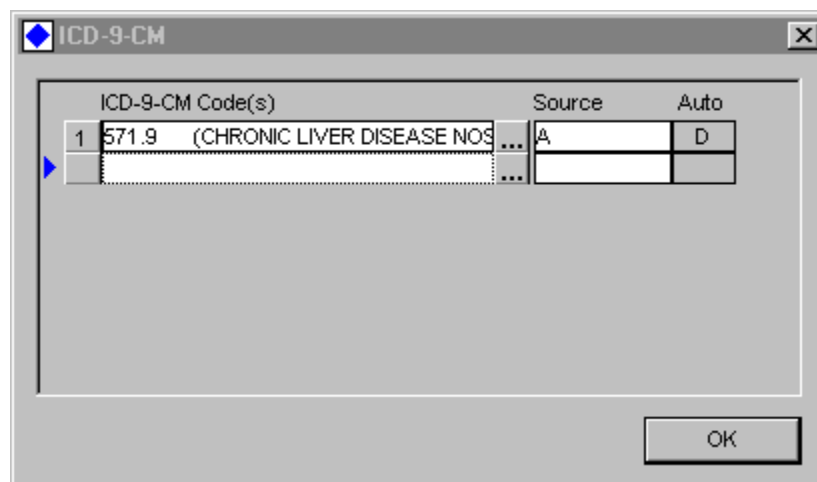
For detailed information on the ICD-9-CM Code(s) field and dictionary linking, refer to "ICD-9-CM Code Linking" and the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **ICD-9-CM Code(s).** Select as many ICD-9-CM codes as are appropriate for the services performed on the specimen.

2) **Source.** Enter the part or procedure to which the ICD-9-CM code is linked if you manually entered ICD-9-CM codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). If your lab uses the Pathology Role for Charges feature, entry of Procedure abbreviations in this field is important so that the proper pathologist role to can be assigned on billing interface transactions. CoPathPlus completes this field automatically for linked codes.

3) **Auto.** Displays the following:

   o **D** for ICD-9-CM codes entered through Quick Text links (for non-Cytology specimen classes only).

   o **L** for ICD-9-CM codes entered through Interpretation Dictionary links (for Cytology specimen classes only).

   o Blank, for manually entered codes.

Attachments Tab on the Final Diagnosis Entry/Edit Window for a Surgical Routine or Bone Marrow Routine Specimen

For detailed instructions on how to complete the fields on the Attachments tab, refer to "Attachments Entry/Edit".

Continue with "Next Step for the Final Diagnosis Entry/Edit Activity".

Entering/Editing Final Diagnosis Data for a Surgical Consult Specimen

You can enter/edit Final Diagnosis data for the Surgical Consult specimen class in the Final Diagnosis Entry/Edit activity in the standard export version of the CoPathPlus system. For this

specimen class, the tabs you see on the Final Diagnosis Entry/Edit window differ from what you would see for a Surgical Routine or Bone Marrow Routine specimen.

- Staff/Text, which allows you to enter or edit the pathologist(s) associated with the specimen (case); as well as its diagnosis information, including Final Diagnosis; its associated SNOMED codes; and slide detail that is only relevant for a Surgical Consult specimen.

- Billing/Copy To, which allows you to enter billing and specimen data and to specify where additional report copies will go.

Much of the information presented on these tabs defaults in from data entered during the accessioning and gross processes.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Final Diagnosis Entry/Edit window for each specimen class may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Staff/Text Tab on the Final Diagnosis Entry/Edit Window for a Surgical Consult Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Staff/Text tab:

NOTE: If staff and/or slide detail data for this specimen was entered during the accessioning or gross process, that information automatically displays here. You can enter or change the information on this tab.

Pathologist(s). Identify the name(s) of the case pathologist(s) associated with this specimen. For detailed information on a staff field, refer to "Staff".

Slide Detail. CoPathPlus displays slide information fields only for the Surgical Consult specimen class for the Final Diagnosis Entry/Edit activity in the standard export version of the CoPathPlus system.

- **Keep Slides.** Select this check box if any slides sent out for review need not be returned. Otherwise, clear the check box.

- **Slides Returned.** Select this check box if slides that were sent out for review have been returned. Otherwise, clear the check box.

SNOMED Code(s) Button. Click this button to open the SNOMED Code(s) pop-up window, which lets you use the Automatic SNOMED II Coder to apply these codes to the Final Diagnosis. For detailed information about this pop-up window, refer to "SNOMED Code(s) Pop-Up Window".

For information about SNOMED codes, refer to "SNOMED Codes". To learn more about using the Automatic SNOMED II Coding function, refer to "Using the Automatic SNOMED II Coder".

Diagnostic Text Fields.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press [icon] on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press [icon] on the toolbar to return to CoPathPlus after you finish entering and editing text.

SNOMED Code(s) Pop-Up Window in the Final Diagnosis Entry/Edit Activity

Enter the following information on the SNOMED Code(s) pop-up window:

NOTE: For information about SNOMED codes, refer to "SNOMED Codes".

1) **SNOMED Code(s).** CoPathPlus automatically fills in the SNOMED code(s) as appropriate for the Final Diagnosis text when you press **Autocode**.

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, for manually entered codes or for those codes entered by the Automatic SNOMED II Coder but then edited.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display field.

   a) Review these words to ensure proper spelling and syntax.

   b) If any words are misspelled, go to the Staff/Text tab and fix the misspelled words.

   c) Press **SNOMED Code(s)…** again to access the SNOMED Code(s) pop-up window.

   d) Press **Autocode** again to re-code your Final Diagnosis.

Billing/Copy To Tab on the Final Diagnosis Entry/Edit Window for a Surgical Consult Routine Specimen

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Billing/Copy To tab:

NOTE: If specimen, additional physician, outside institution, or retrieval flag data for this specimen was entered during the accessioning or gross process, that information automatically displays here. You can enter or change the information on this tab.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". Some of the data that displays on this portion of the tabmay default in from information received through an Admission/Discharge/Transfer (ADT) interface. To learn more interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces"

1) **Encounter.** This information typically defaults in from data entered during the accessioning process. You can change the current encounter number or accept the default.

2) **Billing Number.** CoPathPlus defaults in the billing number that is associated with the encounter. To learn more about encounters, refer to "Patient Registration".

3) **Client.** This information typically defaults in from data entered during the accessioning process. You can change the client or accept the default that is associated with the encounter number.

   NOTE: Your site may have entered an institutional billing number in the Client dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Additional Physician(s). This data may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For detailed information on this field and its functionality, refer to "Staff" and "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Buttons.

1) <u>I</u>CD-9-CM Code(s). Click this button to open the ICD-9-CM pop-up window, which lets you enter/edit any ICD-9-CM codes for this specimen. For detailed information about this pop-up window, refer to "ICD-9-Code(s)".

2) Retrieval F<u>l</u>ags. Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen. For detailed information about this pop-up window, refer to "Retrieval Flags".

<u>S</u>ave/Next Specimen **button.** Click this button if you want to save the current data and continue entering Final Diagnosis information for another specimen. Or you can switch activities or exit CoPathPlus through the toolbar. For all actions, the Next Process pop-up window appears for the Surgical Consult specimen class.

Entering/Editing Final Diagnosis Data for an Autopsy Specimen

You can enter/edit Final Diagnosis data for the Autopsy Anatomic/Neuro and Autopsy Anatomic Only specimen classes in the Final Diagnosis Entry/Edit activity in the standard export version of the CoPathPlus system. The tabs you see when you access this activity look the same for both of these specimen classes.

- Text, which allows you to enter or edit diagnosis information, including Final Diagnosis, Microscopic Description, and Gross Description.

- SNOMED, which displays the Final Diagnosis for a case and lists the associated SNOMED codes. You can assign SNOMED codes to the Final Diagnosis from this tab.

- Staff/Copy To, which allows you to enter or edit the pathologist(s) associated with the specimen (case), specimen data; and to specify where additional report copies will go.

- **Attachments,** which lets you attach digital images and other files to the case, and select which attachments you want to print on patient reports for this case.

Some of the information presented on these tabs defaults in from the data entered during the accessioning and gross processes.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Final Diagnosis Entry/Edit window for each specimen class may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Text Tab on the Final Diagnosis Entry/Edit Window for an Autopsy Anatomic/Neuro or Autopsy Anatomic Only Specimen

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **E**<u>d</u>**it Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **E**<u>d</u>**it Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

SNOMED Tab on the Final Diagnosis Entry/Edit Window for an Autopsy Anatomic/Neuro or Autopsy Anatomic Only Specimen

Enter the following information on the SNOMED tab:

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field on the Text tab. To automatically code the Final Diagnosis, press **Autocode**. CoPathPlus will fill in the SNOMED code-related fields on this tab, as described below.

NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you will have to enter your SNOMED codes manually. If you want to edit the Final Diagnosis text, go to the Text tab.

Edit Text button. Click this button to edit diagnostic text fields, including the Final Diagnosis. This button does not appear for sites using TxText as the CoPathPlus text editor. For more information about how to use this button, refer to "Using Microsoft Word to Edit Diagnostic Text Fields".

SNOMED. To learn more about the SNOMED code-related fields on this tab and how to use the Automatic SNOMED II Coder, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Code(s).** CoPathPlus automatically fills in the SNOMED Code(s) field. For information about SNOMED codes, refer to "SNOMED Codes".

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked. The Coder automatically defaults in the value for this field.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, for manually entered codes or for those codes entered by the Automatic SNOMED II Coder but then edited.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display.

   a) Review these words to ensure proper spelling and syntax.

   b) If any words are misspelled, go to the Text tab and fix the misspelled words.

c) Then return to the SNOMED tab and press **Autocode** again to re-code the Final Diagnosis.

Mark Coded Diagnosis Complete. Select this check box when you have completed the SNOMED coding process.

For information on installation and maintenance of the Automatic SNOMED II Coder, refer to the *Cerner CoPathPlus System Manager Guide*.

Specifying the Next Process for the Final Diagnosis Entry/Edit Activity

Once you finish entering or editing information on the Final Diagnosis Entry/Edit window for the Surgical Routine, Bone Marrow Routine, Surgical Consult, and Autopsy specimen classes and either perform a save function (e.g., press **Save/Next Specimen**) or switch activities, the Next Process pop-up window appears. You need to specify whether the Final Diagnosis is complete and what action CoPathPlus should take next.

In the standard export version of CoPathPlus, there are three actions available for a Surgical Routine specimen:

- **Final Complete/Send to Primary Pathologist**, which marks the Final Diagnosis complete and places a Final Report for the specimen on the Pathologist Signout worklist. At the worklist **Send to** field, the default is the primary pathologist for this case, but can be edited. You can enter a special comment in the **Memo** field and, if necessary, place the case **on hold** (which means that CoPathPlus will place the report at the end of a worklist).

- **Final Complete/Send to Resident or Fellow**, which marks the Final Diagnosis complete and places a Final Report for the specimen on the Resident/Fellow Review worklist. At the worklist **Send to** field, the default is the primary resident or fellow for this case, but can be edited. You can enter a special comment in the **Memo** field and, if necessary, place the case **on hold** (which means that CoPathPlus will place the report at the end of a worklist).

- **No Action**, which is the default, files the information you have entered so far and does not place a Final Report for the case on a worklist nor mark any part of the case complete.

NOTE: Depending on decisions made by your site during the CoPathPlus implementation process, marking the Final Diagnosis complete can trigger the Automatic SNOMED II Coder to code the Final Diagnosis text.

Once you select the appropriate next process at the top of this window, respond to the **Do you want to save the changes to specimen** question at the bottom of the window by selecting one of the following buttons:

- **Yes.** CoPathPlus saves any changes and performs the action you specified.

- **No.** CoPathPlus does not save any changes you may have made or perform any action you may have specified.

- **Cancel.** CoPathPlus returns you to the Final Diagnosis Entry/Edit window without filing any changes.

Next Step for the Final Diagnosis Entry/Edit Activity

Now that you have completed the information on the Final Diagnosis Entry/Edit window, you can perform one of the following actions:

NOTE: For the Final Diagnosis Entry/Edit activity, you will see a Next Process pop-up window appear when you choose the following actions for a Surgical Routine, Bone Marrow Routine, Surgical Consult, or any Autopsy specimen class. To learn more about this window, refer to "Specifying the Next Process for the Final Diagnosis Entry/Edit Activity".

- Save your current entries and continue entering Final Diagnosis data for another specimen by pressing **Save/Next Specimen** on the Billing/Staff tab for a Surgical Routine or Bone Marrow Routine specimen, the Billing/Copy To tab for a Surgical Consult specimen, or the Staff/Copy To tab for an Autopsy specimen; or [icon] on the toolbar (or select File, Open Specimen on the menu bar). The Next Process pop-up window appears.

  1) Select a next process option, as necessary.

  2) Press **Yes** to save your edits to the current specimen.

     The Select Specimen window appears.

     TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing [icon] on the toolbar (or select Options, Activities on the menu bar). The Next Process pop-up window appears.

  For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing [icon] on the toolbar (or select File, Close Specimen on the menu bar). The Next Process pop-up window appears.

  NOTE: Pressing [icon] on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing [icon] on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. The Next Process pop-up window appears.

Using the Automatic SNOMED II Coder

The Automatic SNOMED II Coding feature of CoPathPlus automatically assigns SNOMED II codes to a case based on diagnostic information (i.e., Final Diagnosis). After the case has been coded, CoPathPlus displays the codes it has assigned and any words it did not use during the automatic coding process. You can edit these codes, add codes, or delete codes.

NOTE: This feature currently only assigns SNOMED II codes to a specimen (case). If your site uses SNOMED International codes, you must enter these codes manually.

The Automatic SNOMED II Coding feature applies per specimen class. This means that each site specifies in the Specimen Class Dictionary whether or not the Automatic SNOMED II Coding feature can be used for that particular specimen class. If you have accessed a specimen with a specimen class that does not allow this feature, **Autocode** will be disabled.

You can use the Automatic SNOMED II Coding feature in any specimen-level activity within CoPathPlus that has a SNOMED tab in it, such as Final Diagnosis Entry/Edit, Signout (Electronic), and Diagnosis Coding Entry/Edit.

NOTE: Your system may look different depending on the modifications made by your site.

The SNOMED tab shows the Final Diagnosis to be coded in a display-only field. The tab also lists any SNOMED II or SNOMED International codes associated with the Final Diagnosis, depending on what your site uses, along with the Source, which represents the part (designation) or procedure/addendum (abbreviation) associated with the SNOMED code.

CoPathPlus uses the value in this **Source** field to simulate SNOMED code groups so that:

- Related SNOMED codes appear together on patient reports or other report outputs, and

- Searches of cases using multiple SNOMED codes (i.e., looking for more that one SNOMED code within the same "group" or "source") are accurate.

The Automatic SNOMED II Coder automatically fills in the Source field with "copy-down" functionality to facilitate manual entry of codes. The Coder assumes that each paragraph is synonymous with the part designator, i.e., the first paragraph in the diagnostic text is Part 1 or Part A (depending on the part designation that your site uses), the second paragraph refers to Part 2 or Part B, etc. The Coder re-sorts SNOMED codes by Source, regardless of how they were originally entered, each time you run it.

The **Auto** field will display the following:

- **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

- **L** for SNOMED codes entered through dictionary links.

- Blank, for manually entered codes or for those codes entered by the Automatic SNOMED II Coder but then edited.

Note that if you re-run the Automatic SNOMED II Coder, manually entered and linked codes will not be replaced but previous codes that were automatically coded will be.

The Automatic SNOMED II Coder logic tables associate Final Diagnosis words or phrases with SNOMED II codes. The Words not used by Coder display will show any words not recognized by the logic tables, sorted by source. You need to review these words to see if any of them are misspelled. If any are misspelled, you need to edit the Final Diagnosis text and rerun the Automatic SNOMED II Coder.

Initiating Automatic SNOMED Coding

There are two ways you can initiate the Automatic SNOMED II Coding process:

- Press **Autocode** on a SNOMED tab.

- Press **Copy To Final** while in the Cytology Results activity.

Either of these actions will cause the Automatic SNOMED II Coder to code the text and list the codes in the SNOMED II Code(s) field.

NOTE: Depending on decisions made by your site during the CoPathPlus implementation process, marking the Final Diagnosis complete may also trigger the Automatic SNOMED II Coder to code the Final Diagnosis text.

Codes Added Automatically to the SNOMED II Code Dictionary

Occasionally, the Automatic SNOMED II Coder adds SNOMED II entries to the SNOMED II Code Dictionary. This happens when the Coder assigns to a specimen codes that do not already have entries in the SNOMED II Code Dictionary. Codes can also be automatically added to the SNOMED II Code Dictionary during the conversion process. This feature helps you maintain the dictionary with the codes you use most often at your site.

When the system adds a code to the SNOMED II Code Dictionary automatically, the new entry is incomplete. The system cannot include the code's label text because there is no way for it to determine what the label text should be. In place of the label text, the system inserts the code itself, preceded by a tilde (~), in the Name field of the new dictionary entry. It also inserts a boilerplate phrase in the Description field to explain how the code was added (e.g., **This entry was automatically added by the Automatic SNOMED II Coder** or **Added by conversion**).

Normally, wherever a SNOMED II code is used in CoPathPlus, it is followed by its label text in parentheses. In order for the label text to be displayed on specimen windows and to print on patient reports, the Name field in the SNOMED II Code Dictionary must contain the label text for that code. Because the label text is missing in dictionary entries that were added automatically, the Name fields for these entries must be corrected manually.

To find and update codes that were automatically added to the SNOMED II Code Dictionary, the System Manager should periodically:

1) Print out the SNOMED II Codes Not in Dictionary report found within the Dictionary-Related Printouts folder under the **Dictionaries** command button.

2) Look up these codes in the Numeric Index of the Systematized Nomenclature of Medicine, Second Edition.

3) Edit the entries in the SNOMED II Code Dictionary to replace the ~code in the Name field with the label text found in the *Systematized Nomenclature of Medicine, Second Edition*. For example, if the SNOMED II code ~57030 had been added to the dictionary, you would change the Name field to **Neck of gallbladder**.

   NOTE: The label text is printed immediately to the right of the code itself. Do not enter the synonyms for the label text in the Name field. Synonyms are printed beneath the code and label text and are indented. You may, however, want to enter the synonyms as lookup values.

4) (optional) Delete the boilerplate phrase in the Description field, or replace it with a more meaningful description.

To learn more about SNOMED coding, refer to "Using the Automatic SNOMED II Coder".

NOTE: If you should find that the Automatic SNOMED II Coder incorrectly codes a diagnosis, you should file a support log with Client Service at Cerner CoPathPlus.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Inactive Codes Assigned to Specimens

When an entry in the SNOMED II Code Dictionary is marked "inactive", that code does not appear in lookup windows and cannot be manually assigned to a case. Inactive codes can, however, still be assigned to a case by the Automatic SNOMED II Coder. Inactive codes can also be assigned to a case through dictionary links and by inactivating codes already assigned to a case.

Inactive codes are included, along with the active codes, in the list of SNOMED codes for the case. On windows, inactive codes are indicated by angle brackets, e.g., <T56240 (Hepatic sinusoid)>. Like other inactive dictionary entries, inactive codes are printed without angle brackets on reports.

When inactive codes are assigned to a case, the System Manager should try to determine why the entries were made inactive. The System Manager must then decide whether to remove these codes from the case, or to reactivate them in the dictionary.

To learn more about SNOMED coding, refer to "Using the Automatic SNOMED II Coder".

NOTE: If you should find that the Automatic SNOMED II Coder incorrectly codes a diagnosis, you should file a support log with the Cerner CoPathPlus Client Service Help Desk.

Diagnosis Text Entry Rules

The following diagnosis text entry rules must be followed in order for the CoPathPlus Automatic SNOMED II Coder to code correctly.

- Use Periods
- Space Punctuation Properly
- Do Not Use Arabic Numbers
- Use Only Accepted Abbreviations
- End Negative Phrases with Punctuation
- Use Hyphens Carefully
- Be Explicit About Items
- Use the Spelling Checker
- Organize Text into Meaningful Blocks

Use Periods

Use periods to separate sentences in the text you want to code.

Space Punctuation Properly

Be sure to space your punctuation properly. The Automatic SNOMED II Coder strips out punctuation before reading text.

Do NOT enter this…   **Enter this…**

BIOPSY,LIVER	BIOPSY, LIVER
ATYPIA(SQUAMOUS)	ATYPIA (SQUAMOUS)

Do Not Use Arabic Numbers

Do not use Arabic numbers in phrases to be coded. The Automatic SNOMED II Coder ignores Arabic numbers.

Do NOT enter this…	**Enter this…**
CIN 3	CIN III

Use Only Accepted Abbreviations

The Automatic SNOMED II Coder will recognize only the most common abbreviations, such as POC, CIN, and HPV.

End Negative Phrases with Punctuation

Be sure to end each negative phrase with a punctuation mark; but do not string them together with commas. The Automatic SNOMED II Coder analyzes each negative phrase separately. Negative phrases include NO, NOT, FREE OF, FREE FROM, NEGATIVE, WITHOUT, NEITHER, NOR.

Structure phrases like this: "NEGATIVE WORD THEN WORDS TO NEGATE".

Do NOT enter this…	**Enter this…**
NO EVIDENCE OF CARCINOMA BUT REACTIVE CELLS SEEN.	NO EVIDENCE OF CARCINOMA. REACTIVE CELLS SEEN.
NO EVIDENCE OF CARCINOMA, HYPERPLASIA OR DYSPLASIA.	NO EVIDENCE OF CARCINOMA. NEITHER HYPERPLASIA NOR DYSPLASIA IS PRESENT.
HYPERPLASTIC CELLS, BUT CARCINOMA SUSPICION IS NEGATIVE.	HYPERPLASTIC CELLS, NO EVIDENCE OF CARCINOMA.

Use Hyphens Carefully

The Automatic SNOMED II Coder strips out hyphens before reading text, so be sure to use them carefully. Two hyphens together (a dash) are acceptable. End-of-line hyphenation is also acceptable.

Do NOT enter this…	**Enter this…**
HYPERPLASTIC-APPEARING	HYPERPLASTIC APPEARING
NON SMALL CELL CARCINOMA	NON-SMALL CELL CARCINOMA

Be Explicit About Items

Make sure you are explicit about the items you want coded. The Automatic SNOMED II Coder does not infer sites, morphologies, or procedures from each other.

Do NOT enter this…	**Enter this…**
RIGHT LOBE: ATYPIA.	PROSTATE, RIGHT LOBE: ATYPIA.
LEFT OVARY: CHRONIC	LEFT OVARY: CHRONIC

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

INFLAMMATION.   INFLAMMATION.

RIGHT: SEE ABOVE.   RIGHT OVARY: NO INFLAMMATION.

Use the Spelling Checker

The Automatic SNOMED II Coder recognizes only properly spelled words. Always use the spelling checker on diagnostic text that will be automatically coded. For more information refer to "Using the Spell Check". Review the "Words not used by Coder" display for oversights (e.g., BIOPSYLIVER may appear on this list).

Organize Text into Meaningful Blocks

Organize the text you want coded into meaningful blocks separated by blank lines. Generally, blank lines are used to separate parts that you want coded in separate diagnosis groups.

Do NOT enter this…	Enter this…
PROSTATE, RIGHT LOBE, CHRONIC INFLAMMATION BUT NO EVIDENCE OF CARCINOMA. PROSTATE, LEFT LOBE, CELLULAR ATYPIA.	A. PROSTATE, RIGHT LOBE: CHRONIC INFLAMMATION BUT NO EVIDENCE OF CARCINOMA.
	B. PROSTATE, LEFT LOBE. CELLULAR ATYPIA.

Abbreviations Coded

When used in diagnosis text, the following abbreviations are recognized by the CoPathPlus Automatic SNOMED II Coder, and valid SNOMED codes are assigned as appropriate.

Abbreviation	Translates to…
&	AND
AML	ACUTE MYELOGENOUS LEUKEMIA
AV	ARTERIOVENOUS
BX	BIOPSY
CGL	CHRONIC GRANULOCYTIC LEUKEMIA
CIN	CERVICAL INTRAEPITHELIAL NEOPLASM
CLL	CHRONIC LYMPHOCYTIC LEUKEMIA
CMML	CHRONIC MYELOMONOCYTIC LEUKEMIA
CMV	CYTOMEGALOVIRUS
CNS	CENTRAL NERVOUS SYSTEM
CSF	CEREBROSPINAL FLUID
CVA	CEREBROVASCULAR STROKE
DC	DILATATION AND CURETTAGE
DIC	DISSEMINATED INTRAVASCULAR
DR	DR
DR.	DR
EBV	EPSTEIN BARR VIRUS

FNA	FINE NEEDLE ASPIRATE
GE	GASTROESOPHAGEAL
HPV	HUMAN PAPILLOMA VIRUS
HSV	HERPES SIMPLEX VIRUS
IBS	IMMUNOBLASTIC SARCOMA
IBSB	IMMUNOBLASTIC SARCOMA B
IBST	IMMUNOBLASTIC SARCOMA T
IG	IMMUNOGLOBULIN
IGA	IMMUNOGLOBULIN A
IGE	IMMUNOGLOBULIN E
IGG	IMMUNOGLOBULIN G
IGM	IMMUNOGLOBULIN M
IIIII	II III
LT	LEFT
MPS	MUCOPOLYSACCHARIDOSIS
NAB	NEEDLE ASPIRATION BIOPSY
PCP	PNEUMOCYSTIS CARINII PNEUMONIA
PNET	PRIMATIVE NEUROECTODERMAL TUMOR
PKU	PHENYLKETONURIA
PNS	INFECTIOUS
POC	PRODUCTS OF CONCEPTION
PREP	PREPARATION
RAEB	REFRACTORY ANEMIA EXCESS BLASTS
RBC	ERYTHROCYTE
RT	RIGHT
SIDS	SUDDEN INFANT DEATH SYNDROME
SIL	SQUAMOUS INTRAEPITHELIAL LESION
VS	VERSUS
VS.	VERSUS

Gross Description Entry/Edit

This topic details the Gross Description Entry/Edit activity in the standard export version of the CoPathPlus system.

As the pathologist responsible for the gross performs the preliminary examination of a specimen, he or she usually dictates a Gross Description of the tissue. This description is loaded into CoPathPlus by a transcriptionist, via a dictation interface, or via voice entry.

You can enter and/or edit the Gross Description for a specimen after the specimen has been accessioned but before the specimen is signed out. The Gross Description Entry/Edit activity allows you to not only enter or edit the Gross Description for a particular specimen but also to enter or edit selected information that may or may not have been entered during the accessioning process.

Accessing the Gross Description Entry/Edit Activity

To access the Gross Description Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Gross Description Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Gross Description Entry/Edit window for the specimen class associated with the specimen appears.

TIP! You can also access the Gross Description Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Entering/Editing Gross Description Data

You can enter/edit data in the Gross Description Entry/Edit activity for all of the following types of specimen classes in the standard export version of the CoPathPlus system:

* Surgical and Bone Marrow, except for Surgical Card, Surgical Histology Only, and Bone Marrow Card

* Cytology, except for Gynecological and Card

* Autopsy, except for Autopsy Card

The tabs you see on the Gross Description Entry/Edit window when you access this activity depend on the type of specimen class you are working with.

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., [...] and [▼]) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Entering/Editing Gross Description Data for the Surgical or Bone Marrow Specimen Classes

You can enter/edit Gross Description data for all Surgical and Bone Marrow specimen classes (except as noted) in the Gross Description Entry/Edit activity in the standard export version of the CoPathPlus system. The tabs you see when you access this activity look the same for all these specimen classes.

NOTE: Typically, the Gross Description Entry/Edit activity is not valid for the Surgical Card, Surgical Histology Only, and Bone Marrow Card specimen classes.

- Text, which allows you to enter or edit diagnosis information, such as the Gross Description and Intraoperative Diagnosis.

- Billing/Copy To, which allows you to enter billing and specimen data and to specify where additional report copies will go.

- Source/Staff, which allows you to enter or edit part type and fee code information for the specimen. You can also enter or edit the pathologist(s) associated with the specimen.

- **Attachments,** which lets you attach digital images and other files to the case, and select which attachments you want to print on patient reports for this case.

    NOTE: You will see this tab only for Surgical Routine and Bone Marrow Routine specimen classes.

Much of the information presented on these tabs defaults in from data entered during the accessioning process.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Gross Description Entry/Edit window for each specimen class may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Text Tab on the Gross Description Entry/Edit Window for Surgical or Bone Marrow Specimen Classes

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

NOTE: In some instances, especially for Autopsy cases, the Gross Description text can exceed the maximum number of characters allowed in that field. To learn how to adjust the size of the Gross Description field when it exceeds the maximum size, refer to "Gross Description Text Field".

3) Press ⬢ on the toolbar to return to CoPathPlus after you finish entering and editing text.

Billing/Copy To Tab on the Gross Description Entry/Edit Window for Surgical or Bone Marrow Specimen Classes

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Billing/Copy To tab:

NOTE: If specimen, additional physician, or outside institution data for this specimen was entered during the accessioning process, that information automatically displays here. You can enter or change the information on this tab.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". Some of the data that displays on this portion of the tab may default in from information received through an Admission/Discharge/Transfer (ADT) interface. To learn more interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** This information typically defaults in from data entered during the accessioning process. You can change the current encounter number or accept the default.

2) **Billing Number.** CoPathPlus defaults in the billing number that is associated with the encounter. To learn more about encounters, refer to "Patient Registration".

3) **Client.** This information typically defaults in from data entered during the accessioning process. You can change the client or accept the default that is associated with the encounter number.

   NOTE: Your site may have entered an institutional billing number in the Client dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Additional Physician(s). This data may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For detailed information on this field and its functionality, refer to "Staff" and "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Source/Staff Tab on the Gross Description Entry/Edit Window for Surgical or Bone Marrow Specimen Classes

Enter the following information on the Source/Staff tab:

NOTE: If part type, fee code, staff, specimen/requisition deficiency, other case number, or retrieval flag data for this specimen was entered during the accessioning process, that information automatically displays here. You can enter or change the information on this tab.

Part Type(s). For detailed information on these fields, refer to "Part Type(s)".

1) **Part Type(s).** This information typically defaults in from data entered during the accessioning process. Otherwise, you can select a new or change a part type. You can have more than one part type for the specimen, but you must enter at least one.

2) **Description.** This information typically defaults in from data entered during the accessioning process. If you select a new part type now, then CoPathPlus will default in data for this field from the Part Type dictionary, which normally provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** Enter the time and date when the specimen was taken from the patient. If you have selected a new part type, CoPathPlus copies down this data from the previous date/time taken. If this is the first time you have selected a part type for this specimen (case), the current time and date generally appears as the default. You can change the data as necessary.

4) **Received.** Enter the time and date when the specimen was received in the lab. If you have selected a new part type, CoPathPlus copies down this data from the previous date/time taken. If this is the first time you have selected a part type for this specimen (case), the current time and date generally appears as the default. You can change the data as necessary.

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect

to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

NOTE: Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Slide Information. CoPathPlus displays slide information fields only for the Surgical Consult specimen class for the Gross Description Entry/Edit activity in the standard export version of the CoPathPlus system.

- o **Keep Slides.** Select this check box if any slides sent out for review need not be returned. Otherwise, clear the check box.

- o **Personal Consult.** Select this check box if this specimen was a referral to a particular pathologist in your Anatomic Pathology Department. Otherwise, clear the check box.

Staff Information. This information may default in from data received through an ADT interface. Otherwise, you can identify the pathologist(s) related to this case or change the values already in the staff-related fields. Note that which staff fields display and the order of these fields depend on which specimen class you are currently working with. For detailed information on these fields, refer to "Staff".

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

<u>S</u>ave/**Next Specimen button.** Click this button if you want to save the current data and continue entering Gross Description information for another specimen. Or you can switch activities or exit CoPathPlus through the toolbar. For all actions, the Next Process pop-up window appears for all the Surgical, Bone Marrow, or Autopsy specimen classes that use this activity.

Attachments Tab on the Gross Description Entry/Edit Window for Surgical or Bone Marrow Specimen Classes

NOTE: You will see this tab only for Surgical Routine and Bone Marrow Routine specimen classes.

For detailed instructions on how to complete the fields on the Attachments tab, refer to "Attachments Entry/Edit".

Continue with "Next Step for the Gross Description Entry/Edit Activity".

Entering/Editing Gross Description Data for the Cytology Specimen Classes

You can enter/edit Gross Description data for all Cytology specimen classes (except as noted) in the Gross Description Entry/Edit activity in the standard export version of the CoPathPlus system. The tabs you see when you access this activity look the same for all these specimen classes.

NOTE: Typically, the Gross Description Entry/Edit activity is not valid for the Cytology Gynecological and Cytology Card specimen classes.

- Text, which allows you to enter or edit diagnosis information, such as Clinical Diagnosis and Gross Description.

- Billing/Copy To, which allows you to enter billing and specimen data and to specify where additional report copies will go.

- Source, which allows you to enter or edit part type and stain/process information for the specimen.

- Staff/History, which allows you to enter or edit the pathologist(s) and/or cytotech(s) associated with the specimen. You can also enter clinical history information for the patient, such as Infections History and other clinical conditions.

Much of the information presented on these tabs defaults in from data entered during the accessioning process.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Gross Description Entry/Edit window for each specimen class may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Text Tab on the Gross Description Entry/Edit Window for Cytology Specimen Classes

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **E**d**it Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **E**d**it Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **E**d**it Text** (or press on the toolbar, or select Op**t**ions, **E**d**it** Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

   NOTE: In some instances, especially for Autopsy cases, the Gross Description text can exceed the maximum number of characters allowed in that field. To learn how to adjust the size of the Gross Description field when it exceeds the maximum size, refer to "Gross Description Text Field".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Billing/Copy To Tab on the Gross Description Entry/Edit Window for Cytology Specimen Classes

Enter the following information on the Billing/Copy To tab:

NOTE: If specimen, additional physician, or outside institution data for this specimen was entered during the accessioning process, that information automatically displays here. You can enter or change the information on this tab.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". Some of the data that displays on this portion of the tab may default in from information received through an Admission/Discharge/Transfer (ADT) interface. To learn more about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** This information typically defaults in from data entered during the accessioning process. You can change the current encounter number or accept the default.

2) **Billing Number.** CoPathPlus defaults in the billing number that is associated with the encounter. To learn more about encounters, refer to "Patient Registration".

3) **Client.** This information typically defaults in from data entered during the accessioning process. You can change the client or accept the default that is associated with the encounter number.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

> **NOTE:** Your site may have entered an institutional billing number in the Client dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

4) **Billing Type.** This information typically defaults in from a system setting or a combination of other CoPathPlus specimen data parameters. You can change the billing type or accept the default.

5) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

6) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

7) **Priority.** Select the priority of the specimen's turnaround time or accept the default of **Routine**.

8) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** Select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it generally becomes available for Technical and Professional billing when the case is signed out. Note that CoPathPlus automatically bills via several triggers (part type, stain/process, procedure, and more) so you can elect to defer showing fee codes until later activities when most fee codes would have been entered/defaulted.

> **NOTE:** Technical and Professional billing can become available at different times, dependent upon settings made within the Specimen Class dictionary. To learn about these settings, refer to "Specimen Class Dictionary" in the "Accession Dictionaries" section of the Cerner CoPathPlus Dictionary Building Manual.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Additional Physician(s). This data may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For detailed information on this field and its functionality, refer to "Staff" and "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Source Tab on the Gross Description Entry/Edit Window for Cytology Specimen Classes

NOTE: Your system may look different depending on the modifications made by your site. Also, an activity can be set up to run protocols automatically either when you access a tab page (other than the first tab page) that includes the **Run Protocol(s)** button or when you save the case.

Enter the following information on the Source tab:

NOTE: If part type, stain/process, specimen/requisition deficiency, other case number, or retrieval flag data for this specimen was entered during the accessioning process, that information automatically displays here. You can enter or change the information on this tab.

Part Type(s). For detailed information on these fields, refer to "Part Type(s)".

1) **Source Detail.** The top portion of this tab lists any existing part type(s). To move through the list, press **Previous** or **Next**. To enter a new part type, press **Add**. The detail for the part type you have highlighted in this portion of the tab displays in the fields below.

2) **Part Type.** This information typically defaults in from data entered during the accessioning process. Otherwise, you can select a new or change a part type. You can have more than one part type for the specimen, but you must enter at least one.

3) **Description.** This information typically defaults in from data entered during the accessioning process. If you select a new part type now, then CoPathPlus will default in data for this field from the Part Type dictionary, which normally provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

4) **Date/Time Taken.** Enter the time and date when the specimen was taken from the patient. If you have selected a new part type, CoPathPlus copies down this data from the previous date/time taken. If this is the first time you have selected a part type for this specimen (case), the current time and date generally appears as the default. You can change the data as necessary.

5) **Date/Time Received.** Enter the time and date when the specimen was received in the lab. If you have selected a new part type, CoPathPlus copies down this data from the previous date/time taken. If this is the first time you have selected a part type for this

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

specimen (case), the current time and date generally appears as the default. You can change the data as necessary.

6) **Load Protocol.** Refer to "Stain/Process" below.

7) **Protocol Name.** Refer to "Stain/Process" below.

8) **Label Designator.** The label designator specified in the Part Type dictionary for this particular part type, if any, defaults in this field. Otherwise, you can enter the specimen abbreviation you want to appear on the slide labels when they are printed.

9) **Additional Labels.** The value in this field also defaults in from the Part Type dictionary, if specified there. Otherwise, you can specify or change the number for how many additional labels you want to print—beyond those generated from ordered stains—if any.

Stain/Process. The Stain/Process fields on the Gross Description Entry/Edit window only appear for the Cytology specimen classes that use this activity in the standard export version of the CoPathPlus system. For detailed information on the stain/process fields, refer to "Stain/Process".

1) **Load Protocol.** If you have a cytology protocol associated with a part type in the Part Type dictionary, CoPathPlus automatically selects this check box and the protocol name appears in the **Protocol Name** field.

2) **Protocol Name.** Specifies the name of the cytology protocol you have associated with this part type in the Part Type dictionary. Press **Ru̲n Protocol(s)** to have CoPathPlus enter the associated stain/process information in the Stain/Process field(s) on this tab.

3) **Stain/Process.** Specify the stain(s) and process(es) associated with the current part type.

    a) **Count.** Specify the number of stains or processes to be performed on the current part.

    b) **Slide Label Text.** Enter the text for the stain or process that you want to display (in addition to the part) on the slide labels.

    c) **Date/Time Ordered.** A display-only field that shows when the stain/process was ordered. The current time and date defaults in this field.

4) **Stain/P̲rocess Detail button.** Click this button to open the Stain/Process Detail pop-up window, which lets you edit the stain/process information that defaults from the protocol. To save your changes or additions, press **S̲ave Protocol** on this window. For more information, refer to "Stain/Process".

5) **Ru̲n Protocol(s) button**. Click this button to have CoPathPlus enter the associated stain/process information in the Stain/Process fields.

    NOTE: The Gross Description Entry/Edit activity can be set up to run protocols automatically either when you access a tab page (other than the first tab page) that includes the **Ru̲n Protocol(s)** button or when you save the case. The first time you run a protocol, it runs in "slow" mode so that CoPathPlus can verify that there are no specimen class conflicts or invalid dictionary entries. If conflicts are found, a message appears asking you resolve the conflicts and re-save the protocol. The protocol will continue to run in "slow" mode until the problems are resolved. Once the protocol has been run (or after all problems are resolved), the protocol runs in "fast" mode to reduce data entry time. Subsequent changes to data in the protocol (e.g., the inactivation of a stain/process) will cause the protocol to run in "slow" mode again.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

Staff/History Tab on the Gross Description Entry/Edit Window for Cytology Specimen Classes

Enter the following information on the Staff/History tab:

NOTE: If staff or clinical history data for this specimen was entered during the accessioning process, that information automatically displays here. You can enter or change the information on this tab.

Staff Information. This information may default in from data received through an interface. Otherwise, you can identify the pathologist(s) and cytotech(s) related to this case or change the values already in the staff-related fields. Note that which staff fields display and the order of these fields depend on which specimen class you are currently working with. For detailed information on these fields, refer to "Staff".

Clinical Category Fields. Select or change the data in any of these fields. Use the associated free-text Comment field to add additional information. If no information exists for a particular field, leave it blank.

Save/Next Specimen button. Click this button if you want to save the current data and continue entering Gross Description information for another specimen. If you are done entering Gross Description data for a Cytology specimen, refer to "Next Step for the Gross Description Entry/Edit Activity".

Entering/Editing Gross Description Data for the Autopsy Specimen Classes

You can enter/edit Gross Description data in the Gross Description Entry/Edit activity for all Autopsy specimen classes (except as noted) in the standard export version of the CoPathPlus system. The tabs you see when you access this activity look the same for all these specimen classes.

NOTE: Typically, the Gross Description Entry/Edit activity is not valid for the Autopsy Card specimen classes.

- Text, which allows you to enter or edit diagnosis information, such as Clinical Summary and Gross Description.

- Staff/Copy To, which allows you to enter or edit the pathologist(s) associated with the specimen and to specify where additional report copies will go.

- Autopsy, which allows you to enter or edit part type and autopsy data, such as the date/time of, reason, authorization, and restrictions for the autopsy.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- Attachments, which lets you attach digital images and other files to the case, and select which attachments you want to print on patient reports for this case.

Some of the information presented on these tabs defaults in from data entered during the accessioning process.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Gross Description Entry/Edit window for each specimen class may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Text Tab on the Gross Description Entry/Edit Window for Autopsy Specimen Classes

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

   NOTE: In some instances, especially for Autopsy cases, the Gross Description text can exceed the maximum number of characters allowed in that field. To learn how to adjust the size of the Gross Description field when it exceeds the maximum size, refer to "Gross Description Text Field".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Gross Description Text Field

In some instances, especially for Autopsy cases, the Gross Description text can exceed the maximum number of characters allowed in that field. If that happens, a warning appears either when you attempt to save the changes to the specimen or when you leave the diagnostic text field. You can resolve this problem by moving the excessive text into the Other Gross Description text field. On Patient Reports, the text from both the Gross Description field and the Other Gross Description field print in a single Gross Description section.

For detailed instructions on how to adjust the size of a diagnostic text field that exceeds the maximum size, refer to "Maximum Size of Diagnostic Text Fields".

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Staff/Copy To Tab on the Gross Description Entry/Edit Window for Autopsy Specimen Classes

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Staff/Copy To tab:

NOTE: If specimen, additional physician, or outside institution data for this specimen was entered during the accessioning process, that information automatically displays here. You can enter or change the information on this tab.

Staff Information. Identify the pathologist(s) related to this case or change the values already in the staff-related fields. Note that which staff fields display and the order of these fields depend on which specimen class you are currently working with. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, the physician name(s) may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". Some of the data that displays on this portion of the tab, , may default in from information received through an Admission/Discharge/Transfer (ADT) interface. To learn more interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** This information typically defaults in from data entered during the accessioning process. You can change the current encounter number or accept the default.

2) **Client.** This information typically defaults in from data entered during the accessioning process. You can change the client or accept the default that is associated with the encounter number.

   NOTE: Your site may have entered an institutional billing number in the Client dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

3) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

4) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

Autopsy Tab on the Gross Description Entry/Edit Window for Autopsy Specimen Classes

Enter the following information on the Autopsy tab:

NOTE: If part type and autopsy data for this specimen was entered during the accessioning process, that information automatically displays here. You can enter or change the information on this tab.

Part Type(s). For detailed information on these fields, refer to "Part Type(s)".

1) **Part Type(s).** This information typically defaults in from data entered during the accessioning process. Otherwise, you can select a new or change a part type. You can have more than one part or body type for the specimen, but you must enter at least one.

2) **Description.** This information typically defaults in from data entered during the accessioning process. If you select a new part type now, then CoPathPlus will default in data for this field from the Part Type dictionary, which normally provides the default for the Description field. You usually see description language on the Requisition Slip for the specimen. You can add to the description or replace the default.

3) **Taken.** This information is often not used for Autopsy cases. Enter the time and date when the specimen was taken from the patient. If you have selected a new part type, CoPathPlus copies down this data from the previous date/time taken. If this is the first time you have selected a part type for this specimen (case), the current time and date generally appears as the default. You can change the data as necessary.

4) **Received.** This information is often not used for Autopsy cases. Enter the time and date when the specimen was received in the lab. If you have selected a new part type, CoPathPlus copies down this data from the previous date/time taken. If this is the first time you have selected a part type for this specimen (case), the current time and date generally appears as the default. You can change the data as necessary.

Autopsy Data.

1) **Autopsy Date/Time.** CoPathPlus defaults in the current date and time in this field, which records when the autopsy was performed.

2) **Priority.** Select the priority for this specimen (case) or accept the default of **Autopsy Routine**.

3) **Postmortem Hours.** CoPathPlus calculates this value, which appears in this display-only field. The number of hours in this field represents the difference between the time of expiration (as entered on the Patient Registration window) and the date/time of the autopsy.

4) **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

5) **Reason for Autopsy.** Select the reason that this autopsy is being conducted. This field points to the Autopsy Reason dictionary. Refer to "Autopsy Reason Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

6) **Gestational Age/Weeks.** Use this field for stillborn or prenatal autopsies only. Enter the age of the deceased in weeks (a number with up to one decimal place; e.g., 28, 3.1, 56.5).

7) **Authorized By.** Enter the name of the person who authorized this autopsy. This is a free-text field.

8) **Relationship to Deceased.** Enter the relationship of the person who authorized the autopsy to the deceased. This is a free-text field.

9) **Autopsy Restrictions.** Select any restriction for this autopsy. For the Autopsy Anatomic Only and Autopsy Anatomic/Neuro specimen classes, a **None** restriction will default. For the Autopsy Neuro Only specimen class, a **Brain and Spinal Cord** restriction will default. This field points to the Autopsy Restriction dictionary. Refer to "Autopsy Restriction Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

10) **Restrictions Comment.** Enter any additional information concerning the restrictions specified above for this autopsy. This is a free-text field.

11) **Medical Examiner.** Enter the name of the Medical Examiner who examined the deceased. This is a free-text field.

Other Data.

1) **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

2) **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

3) **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

4) **Order Procedures.** Click this button to open the Procedure/Addendum pop-up window, which lets you order a procedure or create an addendum for the current specimen.

5) **Cultures.** Click this button to open the Cultures pop-up window, which lets you record and note the results of any cultures performed on the current case.
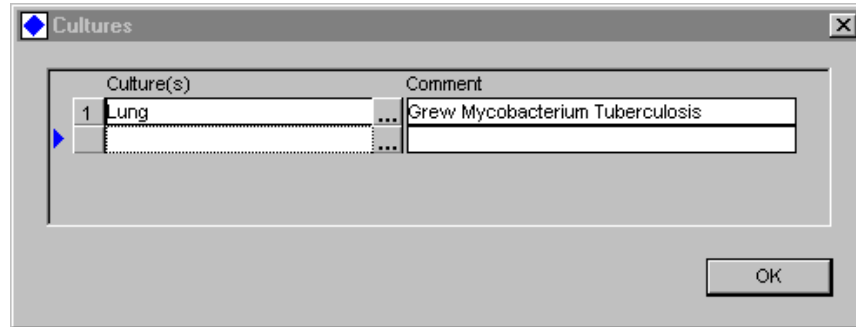
NOTE: If your site is set up to use a cassette labeler or engraver interface, you may also see either an **Engrave Labels** checkbox or a **Save/Engrave…** button on this tab. Selecting the check box causes cassette labels to be automatically requested for all blocks not previously labeled. Pressing the button causes the Request Cassette Labels pop-up window to appear, which lets you select the specific blocks to label. Refer to "Requesting Cassette Labels" for more information on engravers and labels.

Save/Next Specimen button. Click this button if you want to save the current data and continue entering Gross Description information for another specimen. Or you can switch activities ![icon] or exit CoPathPlus ![icon] through the toolbar. For all actions, the Next Process pop-up window appears for all the Autopsy, Surgical, or Bone Marrow specimen classes that use this activity. Continue with "Specifying the Next Process for the Gross Description Entry/Edit Activity".

Cultures

When you press **Cultures…**, the following pop-up window appears on which you can identify (in the **Cultures** field) and record results (in the **Comment** field) of any microbiological cultures performed on the case.

The Culture(s) field is linked to the Culture dictionary. To learn more about it, refer to "Culture Dictionary" in the "Autopsy Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

The Comment field is a free-text field.

Attachments Tab on the Gross Description Entry/Edit Window for Autopsy Specimen Classes

For detailed instructions on how to complete the fields on the Attachments tab, refer to "Attachments Entry/Edit".

Continue with "Next Step for the Gross Description Entry/Edit Activity".

Specifying the Next Process for the Gross Description Entry/Edit Activity

Once you finish entering or editing information on the Gross Description Entry/Edit window for any of the Surgical, Bone Marrow, or Autopsy specimen classes that use this activity and either perform a save function (e.g., press **Save/Next Specimen**) or switch activities, the Next Process pop-up window appears. You need to specify what action CoPathPlus should take next. The following illustration shows an example of a Next Process pop-up window for a Surgical Routine specimen.

NOTE: Your system may have more or fewer or even different actions, depending on the specimen class you have accessed and modifications made by your site.
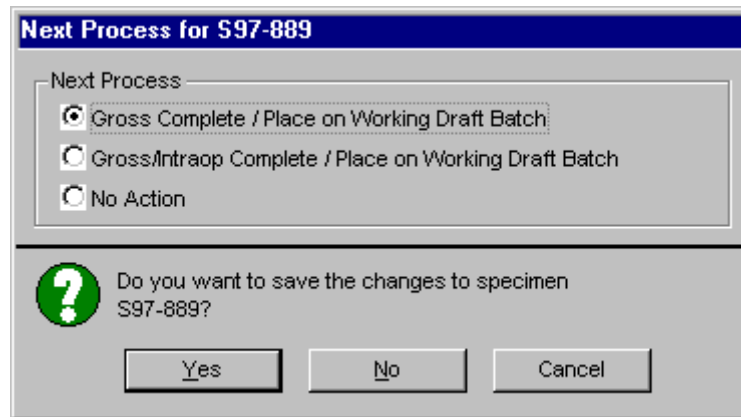
You have to tell CoPathPlus whether the Gross Description and/or Intraoperative Diagnosis, if any, is complete. For a Surgical Routine specimen, the standard export version of the CoPathPlus system provides for three actions at this point:

- **Gross Complete/Place on Working Draft Batch**, which marks the Gross Description complete and places a report for the specimen (case) on the Working Draft Batch.

- **Gross/Intraop Complete/Place on Working Draft Batch**, which marks both the Gross Description and Intraoperative Diagnosis complete and places a report for the specimen (case) on the Working Draft Batch. This action is for a Surgical Routine specimen only in the standard export version of the CoPathPlus system.

- **No Action**, which is the default, would merely file the information you have entered so far and not place a report for the case on a Working Draft Batch or mark any part of it complete.

Once you select the appropriate next process at the top of this window, respond to the question at the bottom of the screen by selecting one of the following:

- **Yes.** CoPathPlus saves any changes and performs the action you specified.

- **No.** CoPathPlus does not save any changes you may have made or perform any action you may have specified.

- **Cancel.** CoPathPlus returns you to the Gross Description Entry/Edit window without filing any changes.

Next Step for the Gross Description Entry/Edit Activity

Now that you have completed the information on the Gross Description Entry/Edit window, you can perform one of the following actions:

NOTE: For the Gross Description Entry/Edit activity you will see a Next Process pop-up window appear when you choose the following actions for the Surgical, Bone Marrow, Cytology, and Autopsy specimen classes. To learn more about this window, refer to "Specifying the Next Process for the Gross Description Entry/Edit Activity".

- Save your current entries and continue entering Gross Description data for another specimen by pressing **Save/Next Specimen** on the Source/Staff tab for a Surgical or Bone Marrow specimen, the Staff/History tab for a Cytology specimen, or the Autopsy tab for

an Autopsy specimen; or on the toolbar (or select File, Open Specimen on the menu bar).

- o For a Cytology specimen, the Select Specimen window appears immediately.

- o For a Surgical, Bone Marrow, or Autopsy specimen, the Next Process pop-up window appears.

   1) Select a next process option, as necessary.

   2) Press **Yes** to save your edits to the current specimen.

   TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Options, Activities on the menu bar).

   - o For a Cytology specimen, press **Yes**, when prompted, to save your edits.

   - o For a Surgical, Bone Marrow, or Autopsy specimen, the Next Process pop-up window appears.

   For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar).

   - o For a Cytology specimen, press **Yes**, when prompted, to save your edits.

   - o For a Surgical, Bone Marrow, or Autopsy specimen, the Next Process pop-up window appears.

   NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus.

   - o For a Cytology specimen, press **Yes**, when prompted, to save your edits.

   - o For a Surgical, Bone Marrow, or Autopsy specimen, the Next Process pop-up window appears.

Group Order Stain Process

This topic details the Group Order Stain Process activity in the standard export version of the CoPathPlus system.

The Group Order Stain Process activity lets you review all histology information currently entered for a specimen (case), and then choose a group of blocks to order additional stains on.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

This activity is similar to the Stain/Process and Block activity, but enables you to select multiple blocks to order stains on in a single step

Accessing the Group Order Stain Process Activity

To access the Group Order Stain Process activity:

1) Press the <u>Specimens</u> command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Group Order Stain Process** in the Activity field on that window.

4) Press **OK**. The Group Order Stain Process window appears.

TIP! You can also access the Group Order Stain Process activity by placing it in your Personal Menu and double-clicking on it from there.

Ordering Group Stains/Processes

You can order stains/processes for all specimen classes (i.e., Surgical, Cytology, Bone Marrow, Autopsy) in the standard export version of the CoPathPlus system, except for Cytology Gynecological. Typically, the Stain/Process and Block Edit activity is not valid for this specimen class.

The tab you see on the Group Order Stain Process window when you access this activity is the same for all specimen classes. This activity has only one tab, Group Order Stain Process , which allows you to enter and edit stain/process and block data for a specimen.

Entering Information on the Histology Tab on the Group Order Stain Process Window

The report display on the Histology tab on the Group Order Stain Process window is similar to the one you see when you access the Stain/Process and Block Edit pop-up window while you are in the Stain/Process and Block Edit activity. However, while the display on the Stain/Process and Block Edit pop-up window enable you to add a stain/process to a single block, the Group Order Stain Process window enables you to select a group of blocks to order stains/processes on.

To select multiple blocks on the Group Order Stain Process window, do one of the following:

- To select consecutive blocks, click the first item, press and hold down SHIFT, and then click the last item.

- To select blocks that are not consecutive, press and hold down CTRL, and then click each item.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Enter the following information on the Histology tab (first clicking on blocks on the display):

Order Stain/Process **button.** Click this button to access the Order Stain/Process pop-up window to order stains/processes for the selected blocks.

Delete Stain/Process button. Click this button to delete any stains/processes that were selected using the Group Order Stain Process pop-up window. Note that this option is only available after you have ordered stains/processes. Pressing this button will delete ALL stains/processes that have been ordered using the Group Order Stain Process pop-up window.

Staff/Billing **button.** Click this button to access the Staff/Billing pop-up window so that you can enter/edit gross pathologist, priority, and fee code data.

Save/Next Specimen **button.** Click this button if you want to save the current data and continue editing/entering stain/process and block information for another specimen. The Select Specimen window appears.

Refer to "Next Step for the Group Order Stain Process Activity" if you are done editing/entering stain/process and block data for a specimen (case).

Order Stain/Process

The Order Stain/Process pop-up window allows you to order stains/process for the selected blocks for the current specimen.

Enter the following information on the Order Stain/Process pop-up window:

Stain/Process. Select additional stain(s)/process(es) to order for this part type. All available stains and processes are defined in the Stain/Process Dictionary. For more information about that dictionary, refer to "Stain/Process Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Blk/Desig (Block/Designator). Leave this field blank.

Count. Enter the number of stains or processes to be performed on the selected blocks. The default count is **1**, or, if using a protocol, the number entered in the Protocol dictionary for the stain/process. You can edit the default if necessary.

Request Class. Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary. Request classes are used to categorize histology tests and the reason they were performed.

Ordered by. Enter the name of the Pathologist, Fellow, Resident, PA/Diener, or Cytotech who ordered this stain/process. In the standard export version of CoPathPlus, the default at this field is the user currently signed on to the system, unless that person has a person type of Unspecified. In that case, the name of the primary pathologist associated with the specimen (case) appears as the default.

Comment. Enter a free-text comment for this stain/process. A default comment can appear based on the histology protocol.

Stain/Process Detail button. Click this button to access the Stain/Process Detail pop-up window, which shows the details for each stain/process for this specimen. Refer to "Stain/Process Detail" for more information.

Run Stain/Process Group button. Click this button to load the selected stain/process group protocol for each part type. Once you Click this button, CoPathPlus displays the Run Stain/Process Group Protocol pop-up window. Select the protocol you want on this window and press **OK**. For more information on the different types of protocols available, refer to "Histology Protocols".

When you are done ordering stains/processes information, press **OK**.

Staff/Billing

The Staff/Billing pop-up window allows you to view the information originally entered in the Histology Data Entry/Edit activity and to edit or enter data, as necessary.

Edit/enter the following information on the Staff/Billing pop-up window:

Gross Pathologist(s). Select the name(s) of the gross pathologist(s) associated with this specimen. For detailed information on staff fields, refer to "Staff".

NOTE: During the CoPathPlus implementation process, this field may have been renamed as "Prosector(s)," a common designation.

Priority. Change or select the turnaround time priority for the specimen, or you can accept the value that may already have been entered.

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** CoPathPlus may have already defaulted in fee code data from stains/processes selected during normal histology data entry. Otherwise, you can change or select as many fee codes as are appropriate for the services performed on the specimen, if applicable.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). If your lab uses the Pathology Role for Charges feature, entry of Procedure abbreviations in this field is important so that the proper pathologist role to can be assigned on billing interface transactions. CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

When you are done entering and editing block information, press **OK**.

Next Step for the Group Order Stain Process Activity

Now that you have completed the information on the Group Order Stain Process window, you can perform one of the following actions:

- Save your current entries and ordering stains/processes by pressing **Save/Next Specimen** on the Histology tab or [icon] on the toolbar (or select File, Open Specimen on the menu bar). If you press the button on the toolbar, you have to press **Yes**, when prompted, to save your edits to the current specimen.

   TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing [icon] on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing [icon] on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

   NOTE: Pressing [icon] on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing [icon] on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Histology Data Entry/Edit

This topic describes the Histology Data Entry/Edit activity in the standard export version of the CoPathPlus system.

While the preliminary examination of the specimen is occurring in the Surgical Laboratory, the Gross Description is being dictated and sections are cut and prepared for submission to the Histology Laboratory. The decisions made while the specimen is being cut, such as which stains and processes to order and whether any special instructions are required for processing, are recorded online using the Histology Data Entry/Edit activity.

The person responsible for entering histology data and the time when it is entered will vary from one institution to another. At some sites, the primary pathologist or pathologist's assistant dictates the Gross Description to a technician, laboratory assistant, or secretary who later enters the data online based on their handwritten log or transcription from an audiotape. At other sites, terminals are provided in the grossing room so that the histology data can be entered as the specimen is being cut.

The histology information captured in CoPathPlus automates the workflow of the Histology Laboratory and provides for the:

- Capture of billing charges and workload information.
- Default ordering of blocks and stain/process information by running (i.e., "loading") protocols for specimens.
- Creation of logs and their corresponding slide labels.

A typical histology specimen has three components:

- Specimen or part type
- Block(s)
- Stains/processes (i.e., slides)

Histology Protocols

CoPathPlus lets you predefine default block and stain/process information for each part type. Default block and stain/process information that is available for selection within the Histology Data Entry/Edit activity is known as a **histology protocol**. A histology protocol saves you time when ordering a long list of blocks and/or stains/processes, or when you typically order the same blocks and/or stains/processes for a part type.

When using the Histology Data Entry/Edit activity, you can order one protocol for each part type for the specimen. If the specimen includes a part type for which a default histology protocol has been specified, that protocol appears as the default. You can change this to a more applicable protocol if needed. After applying the protocol(s), you can edit any of the default block and stain/process information as needed. You can also create new histology protocols as needed.

There is also a **Stain/Process Group protocol** available. Stain/process groups are selections of one or more stains/processes (and dependent information) stored for future use in stain/process entry. The functionality of stain/process group protocols mimics histology protocols except that

stain/process protocols do not contain block and block-level detail, just stain/process and stain/process-level detail.

Histology protocols and stain/process group protocols are defined in the Protocol Dictionary. Default histology protocols are linked to part types in the Part Type Dictionary. Note that only users with the appropriate permission will be able to enter and edit protocols. For more information, refer to the "Protocol Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Histology-Related Activities

The following histology-related activities are also available within CoPathPlus:

- Stain/Process and Block Edit, which lets you order additional blocks, stains, and processes after the initial order has been entered.

- Processing Batch Edit/Compile, which lets you edit or verify the contents of an existing batch or compile a new batch.

- Stain/Process Log Verify/Print, which lets you edit or verify outstanding stains and processes and print a log and labels for pending stains and processes.

All of these activities, including Histology Data Entry/Edit, are found in the Histology Functions folder under the **Tasks** command button. However, Histology Data Entry/Edit and Stain/Process and Block Edit are also specimen activities and are usually accessed via the **Specimens** command button.

Histology-Related Dictionaries

The following dictionaries maintain information that is utilized during the Histology Data Entry/Edit activity:

- Block Category

- Histo Request Class

- Part Type

- Protocol

- Specimen Class

- Stain/Process

- Stain/Process Category

These dictionaries are built during the CoPathPlus implementation process. For information on each of the above dictionaries, refer to the corresponding topic in the *Cerner CoPathPlus Dictionary Building Manual.*

Histology Logs, Labels, and Reports

The following histology-related logs are available:

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- Block/Stain Recut Log

- Histology Stain/Process Log

- Tissue Processing Batch Log

The following histology-related labels are available:

- Histology Labels by Specimen

- Histology Labels by Status

Accessing the Histology Data Entry/Edit Activity

To access the Histology Data Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

    The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Histology Data Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Histology Data Entry/Edit window appears.

TIP! You can also access the Histology Data Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

NOTE: You can also access the Histology Data Entry/Edit activity within the Histology Functions folder under the **Tasks** command button.

Entering/Editing Histology Data

You can enter histology data for all specimen classes in the CoPathPlus system in the standard export version of CoPathPlus, except for Cytology Gynecological. Typically, the Histology Data Entry/Edit activity is not valid for that specimen class.

For the standard export version of CoPathPlus, the tabs you see on the Histology Data Entry/Edit window when you access this activity are the same for all specimen classes. They include:

- Specimen, which lets you enter the Gross Pathologist(s) associated with the specimen, turnaround priority for the specimen, protocol for each part type, and fee codes. You can also run the protocol(s) from this tab.

- Histology, which lets you enter histology data for part, block, block designation/sectioning site, stain/process information, and associated dependent information.

- Text, which lets you optionally enter a Gross Description or other diagnostic text field information as part of the Histology data entry process, and then specify the next process for the specimen.

Specimen Tab on the Histology Data Entry/Edit Window

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Specimen tab:

Gross Pathologist(s). Select the name(s) of the gross pathologist(s) associated with this specimen. For detailed information on staff fields, refer to "Staff ".

NOTE: During the CoPathPlus implementation process, this field may have been renamed "Prosector(s)," a common designation.

Priority. Enter the turnaround time priority for the specimen, or accept the default entered during the accessioning process. Specimens are tracked to assess the lab's ability to complete specimens within the expected turnaround time.

Protocol Check(s):

1) **Part Type(s).** This information typically defaults in from data entered during the accessioning process. Parts are the components of the specimen submitted for diagnosis.

   NOTE: While CoPathPlus allows you to delete or change the data in this field, it also presents you with a warning message if the specimen has any procedure(s) associated with the part type that you are deleting or changing.

2) **Load check box**. If a default histology protocol has been set up for a part type, this check box is automatically selected. (Once the protocol has been run for the part type, this check box is cleared.) The name of the default histology protocol appears in the **Protocol Name** field. If there is no default protocol for a part type, and you want to use an existing histology protocol to order the blocks and stains/processes for the part type, select this check box and then proceed to the **Protocol Name** field.

3) **Protocol Name.** The name of the default histology protocol for each part type appears, but can be edited to a more applicable protocol, if needed. If no default is specified for a part type, and you want to use an existing protocol to order blocks and stains/processes for that part type, select the histology protocol to use.

   NOTE: CoPathPlus disables the Protocol Name field if the protocol has already been run. It also disables that field if the Load check box has not been selected.

4) **Run Protocol(s) button.** Click this button to load the selected histology protocol for each part type. A protocol can be loaded only if the Load check box next to the part type is selected and a histology protocol has been specified. Once you click this button, CoPathPlus retrieves the block and stain/process information defined for each part type and displays that data on the Histology tab.

   NOTE: The Histology Data Entry/Edit activity can be set up to run protocols automatically either when you access a tab page (other than the first tab page) that includes the **Run Protocol(s)** button or when you save the case. The first time you run a protocol, it runs in "slow" mode so that CoPathPlus can verify that there are no specimen class conflicts or invalid dictionary entries. If conflicts are found, a message appears asking you to resolve the conflicts and re-save the protocol. The protocol will continue to run in "slow" mode until the problems are resolved. Once the protocol has been run (or after all problems are resolved), the protocol runs in "fast" mode to reduce data entry time. Subsequent changes to data in the protocol (e.g., the inactivation of a stain/process) will cause the protocol to run in "slow" mode again.

   After running one or more protocols, CoPathPlus places you at the Part Type field for the first part. The block and stain/process information displayed is for the first part type in the specimen. Also, if you re-enter

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

histology data, when you re-run a protocol on a part with previously saved block and/or stain/process data, CoPathPlus replaces the previous data with the new data.

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** CoPathPlus may default in this data from stains/processes once you save this histology entry. Otherwise, you can select as many fee codes as are appropriate for the services performed on the specimen. Once you enter a fee code, it becomes available for billing when the case is signed out.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

NOTE: If your site is set up to use a cassette labeler or engraver, you may also see either an **Engrave Labels** check box or a **Save/Engrave…** button on this tab. Selecting the check box causes cassette labels to be automatically requested for all blocks not previously labeled. Pressing the button causes the Request Cassette Labels pop-up window to appear, which lets you select the specific blocks to label. Refer to "Requesting Cassette Labels" for more information on engravers and labels.

Histology Tab on the Histology Data Entry/Edit Window

Enter the following information on the Histology tab:

Part Type. For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type.** The first part type defined for the specimen appears as the default. The **Histology Data for** portion of this window displays block and stain/process information for whichever part type is selected at this field. You can select any part type in the specimen or add a new part type.

2) **Description.** The Part Type Dictionary provides the default for the Description field. You usually see description language on the requisition slip for the specimen. You can add to the description or replace the default.

3) **Taken.** The current time and date generally appear as the default. Otherwise, you can enter the time and date when the specimen was taken from the patient.

4) **Received.** The current time and date generally appears as the default. Otherwise, you can enter the time and date the specimen was received in the lab.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

5) **All Pieces Used check box.** Select this check box if all pieces of tissue have been used for the designated part. Note that after running one or more protocols, CoPathPlus will place you at this field for the first part on which a protocol has been run.

6) **Part buttons.** Press:

   o **Select Part** to access the Select Part pop-up window so you can see a list of the parts available for this specimen (case) and make a selection.

   o **Add Part** to add a new part for this specimen.

   o **Previous Part** to access the previous part for this specimen.

   o **Next Part** to access the next part for this specimen.

Histology Data:

1) **Blk/Desig (Block/Designator).** Enter a unique, short designator for each block. If you run a protocol which includes block designator information, the value specified in the protocol appears as the default. The first character of the designator must either be numeric or alphabetic, depending on the specimen class. (This requirement is based on decisions made by your site during the CoPathPlus implementation process).

   NOTE: Block designations can also include sectioning site detail, but must be unique and can be edited in this field (e.g., 1-LUL). Also, deleting a block/designator will automatically delete all associated stains/processes.

2) **Pieces.** Enter the number of pieces of tissue taken for the corresponding block/designator.

3) **Block Detail button.** Click this button to access the Block Detail pop-window, which shows the details for each block for this specimen. Refer to "Block Detail" for more information.

Stain/Process fields. For more information about these fields, refer to "Stain/Process".

1) **Stain/Process.** A default of **H&E,Initial** automatically appears for each block entered. If necessary, select additional stain(s)/process(es) to order for this part type. All available stains and processes are defined in the Stain/Process dictionary. For more information about that dictionary, refer to "Stain/Process Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual.*

2) **Blk/Desig (Block/Designator).** Select the block for which to apply this stain or process. If there is only one block for this part type, that block appears as the default. If the stain or process applies to the entire part type, rather than just the block, leave this field blank.

3) **Count.** Enter the number of stains or processes to be performed on this part. The default count is **1**, or, if using a protocol, the number entered in the Protocol Dictionary for the stain/process. You can edit the default if necessary.

4) **Request Class.** Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary. Request classes are used to categorize histology tests and the reason they were performed.

5) **Stain/Process Detail button.** Click this button to access the Stain/Process Detail pop-up window, which shows the details for each stain/process for this specimen. Refer to "Stain/Process Detail" for more information.

6) **Run Stain/Process Group button.** Click this button to load the selected stain/process group protocol for each part type. Once you click this button, CoPathPlus displays the Run Stain/Process Group Protocol pop-up window. Select the protocol you want on this window and press **OK**. For more information on the different types of protocols available, refer to "Histology Protocols".

7) **Save Protocol… button.** Click this button to access the Save Protocol pop-up window. You use this window to either create a new histology protocol consisting of the current block and stain/process information entered for this part type, or to update an existing histology protocol with that information. Refer to "Save Protocol "for more information.

8) **Histo Summary button.** Click this button to access the Histology Summary pop-up window, which presents a summary of all the histology information for this specimen entered to date in one place.

Save/Next Specimen button. Click this button to save the current data and continue entering histology information for another specimen. The Select Specimen window appears.

Block Detail

The Block Detail pop-up window, accessed from the **Block Detail** button on the Histology tab on the Histology Data Entry/Edit window, allows you to view and edit additional block information for a specimen. Note, however, that this pop-up window is not typically used to edit data.

Enter the following information on the Block Detail pop-up window:

NOTE: The **Blk/Desig** and **Pieces** fields on this window are the same as the **Blk/Desig** and **Pieces** fields on the Histology tab. Any changes you make on this pop-up window will be reflected on that tab when you close this pop-up window.

Blk/Desig (Block/Designator). Enter a unique, short designator for each block. If you run a protocol which includes block designator information, the value specified in the protocol appears as the default. The first character of the designator is generally either numeric or alphabetic, depending on the specimen class and the decisions made by your site during the CoPathPlus implementation process).

Pieces. Enter the number of pieces of tissue taken for the corresponding block/designator.

Block Category. Select a block category for this block. A block category identifies a certain group of blocks that are usually processed in a specific run of the tissue processor. A default block category may be defined for the histology protocol (in the Protocol Dictionary), for the part type (in the Part Type Dictionary), or for the specimen class (in the Specimen Class Dictionary).

Request Class. Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary. Request classes are used to categorize histology tests and the reason they were performed, and also to toggle billing for associated stains/processes.

Department. Identify the department where the block is processed. A default department, defined in the Specimen Class Dictionary, can appear, but may be edited.

Status. Select a status for this block. The default status is **Ordered.** Other possible statuses automatically added by the system include: **Missing**, **On Batch**, and **Verified**.

NOTE: Blocks with a status of Verified can only be deleted by users with the miscellaneous permission "Histology Status Change for Block and/or Stain/Process". See your CoPathPlus System Manager for details.

Other Block Number. Enter a number you want to print on the slide label in place of the specimen number for this block. This field is typically used for QC and Research slides.

Comment. Enter a free-text comment for this block. A default comment can appear based on the histology protocol run.

NOTE: If your site is set up to use a cassette labeler or engraver, you may also see an **Engraver Label Type** field on this window. This field lets you view a block's cassette label type, change the label type, or enter a label type if none is assigned. Refer to "Requesting Cassette Labels" for information on engravers and labels. Refer to "Engraver Label Type Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for information on defining label types.

Part buttons. Press:

- **Select Part** to access the Select Part pop-up window so you can see a list of the parts available for this specimen (case) and make a selection.

- **Previous Part** to access the previous part for this specimen.

- **Next Part** to access the next part for this specimen.

Press **OK** to exit this pop-up window.

Stain/Process Detail

The Stain/Process Detail pop-up window allows you to view and edit additional stain/process information for a specimen. Note, however, that this pop-up window is not typically used to edit data. You can access this window from the **Stain/Process Detail** button on the Histology tab on either the Histology Data Entry/Edit window, the Accession Entry/Edit window for a Surgical-Histology Only specimen or from the Edit Stain/Process pop-up window.

Enter the following information on the Stain/Process pop-up window:

NOTE: The **Stain/Process**, **Blk/Desig**, **Count**, and **Request Class** fields on this window are the same as the fields with the same names on the Histology tab. Any changes you make on this pop-up window will be reflected on that tab when you close this pop-up window.

Stain/Process. A default of **Initial H&E** automatically appears for each block entered. If necessary, select additional stain(s)/process(es) to order for this part type. All available stains and processes are defined in the Stain/Process Dictionary. For more information about that dictionary, refer to "Stain/Process Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Blk/Desig (Block/Designator). Select the block for which to apply this stain or process. If there is only one block for this part type, that block appears as the default. If the stain or process applies to the entire part type, rather than just the block, leave this field blank.

Count. Enter the number of stains or processes to be performed on this part. The default count is **1**, or, if using a protocol, the number entered in the Protocol Dictionary for the stain/process. You can edit the default if necessary.

Label Text. Enter the text to print on the slide label to identify this stain or process. If default label text is defined in the Stain/Process dictionary, it appears here and may be edited.

Request Class. Enter the request class for this stain or process. A default request class can appear, based on either the protocol, or if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary. Request classes are used to categorize histology tests and the reason they were performed.

Department. The department responsible for processing the stain/process, as defined in the Specimen Class dictionary, appears. You cannot edit this data on this pop-up window in the standard export version of CoPathPlus.

Order Date. The date and time the stain/process was ordered is displayed for referenced. For new histology stains/processes, the default order date is today and now. You cannot edit the order date via this pop-up window.

Ordered by. Enter the name of the Pathologist, Fellow, Resident, PA/Diener, or Cytotech who ordered this stain/process. In the standard export version of CoPathPlus, the default at this field is the user currently signed on to the system, unless that person has a person type of Unspecified. In that case, the name of the primary pathologist associated with the specimen (case) appears as the default.

Comment. Enter a free-text comment for this stain/process. A default comment can appear based on the histology protocol.

Status. Select a status for this stain/process. The default status is **Ordered**, but it can be edited to **Canceled**, **Missing**, **Printed**, or **Verified**, as applicable.

NOTE: Stains with a status of Verified can only be deleted by users with the miscellaneous permission "Histology Status Change for Block and/or Stain/Process". See your CoPathPlus System Manager for details.

Order Date (for Status field). The effective date and time of the current status is displayed for reference. When you update the status, this date changes to today and now. You cannot edit this data via this pop-up window.

NOTE: If your site is set up to use a slide labeler or engraver, you may also see a **Slide Label Type** field on this window. This field lets you view a stain's slide label type, change the label type, or enter a label type if none is assigned. Refer to "Requesting Slide Labels" for information on engravers and labels. Refer to "Engraver Label Type Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for information on defining label types.

Part buttons. Press:

- **Se<u>l</u>ect Part** to access the Select Part pop-up window so you can see a list of the parts available for this specimen (case) and make a selection.

- **Pre<u>v</u>ious Part** to access the previous part for this specimen.

- **Ne<u>x</u>t Part** to access the next part for this specimen.

<u>**Save**</u> **Stain/Process Group button.** Click this button to access the Save Protocol pop-up window. You use this window to create a new stain/process group protocol based on the current stains/processes ordered for this part type or to update an existing stain/process group protocol with that information.

For detailed information on the stain/process fields, refer to "Stain/Process".

Save Protocol

CoPathPlus allows you to save new protocols from both the Histology Data Entry/Edit activity and the Accession Entry/Edit activity (for a Surgical Histology-Only or Cytology specimen).

Once you save a new protocol, you can select it when ordering blocks and stains/processes (in the case of histology protocols) or stain/processes (in the case of stain/process group protocols and cytology protocols) in the future.

Enter the following information on the Save Protocol pop-up window:

Save Protocol. If the block and/or stain/process information was initially loaded using a protocol, that protocol appears as the default in this field. To update that protocol with the current block and/or stain/process information entered for this part type, press <u>**Search.**</u> Select the protocol from the resulting list and press **OK** to update it. To create a new protocol, enter the new protocol name at this field and then press <u>**A**</u>**dd Protocol**.

<u>**Search**</u> **button**. Initiates a search of existing protocols based on what you enter at the Save Protocol field. A list of entries that meet the search criteria appear.

<u>**V**</u>**iew Protocol button.** Accesses the Protocol Summary window where you can view information for an existing protocol. This is useful when you want to review the data saved in an existing protocol before updating it with the current block and/or stain/process information.

The following is an example of the Protocol Summary Window.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

For each block, this window displays the block designator, number of pieces, request class, workload department, block category, other block number, status, and comment. For each stain/process, this window displays the stain/process name, request class, block designator, workload department, slide label text, status, comment, and count. Use the scroll bar at the bottom of the window to view all of the information. To return to the Save Protocol window, press **OK**.

<u>A</u>dd **Protocol button.** Accesses the Protocol dictionary where you can define a new histology or stain/process group protocol. For instructions on how to add a new entry to that dictionary, refer to "Protocol Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus*

Dictionary Building Manual. After you save the new entry in that dictionary, press to return to the Save Protocol pop-up window. Then, press **OK** to save the current block and/or stain/process information to the new protocol.

Histology Summary

The Histology Summary pop-up window allows you to review the histology information for a specimen (i.e., case) in one place within the Histology Data Entry/Edit activity. You access this window from the **Histo S<u>u</u>mmary** button on the Histology tab on either the Histology Data Entry/Edit window or the Accession Entry/Edit window for a Surgical Histology-Only specimen.
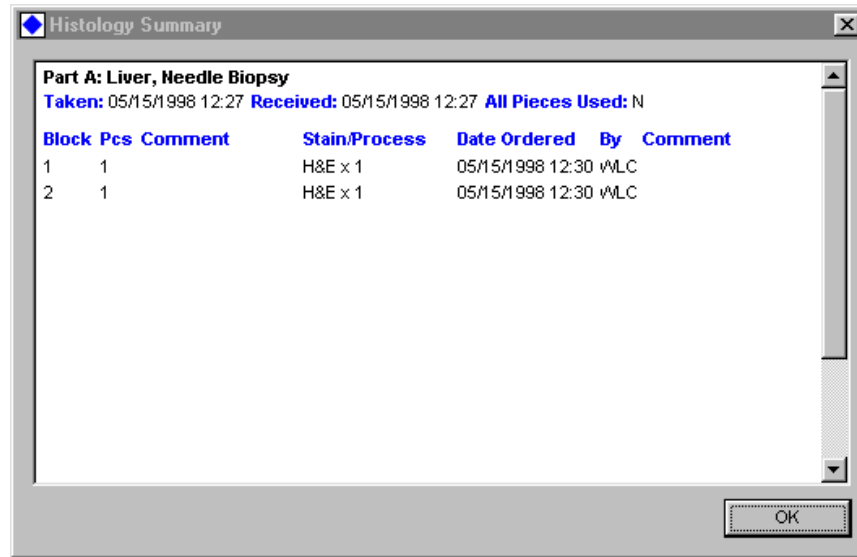
Text Tab on the Histology Data Entry/Edit Window

This tab is optional within the Histology Data Entry/Edit activity, as it provides the same functionality as the Gross Description Entry/Edit activity.

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press [icon] on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press [icon] on the toolbar to return to CoPathPlus after you finish entering and editing text.

4) **Next Process.** Select the next process option for this specimen. Options include:

   o **Gross Complete / Place on Working Draft Batch.** This marks the Gross Description complete and places a report for the specimen on the Working Draft Batch.

   o **Gross/Intraop Complete / Place on Working Draft Batch.** This marks both the Gross Description and Intraoperative Diagnosis complete and places a report for the

specimen on the Working Draft Batch. In the standard export version of CoPathPlus, this action is only utilized for Surgical Routine specimens.

o **No Action.** This is the default. This files the text information entered, but does not place a report for the specimen on a Working Draft Batch or mark any part of it complete.

Save/Next Specimen button. Click this button to save the current data and continue entering histology information for another specimen. The Select Specimen window appears.

Next Step for the Histology Data Entry/Edit Activity

Now that you have completed the information on the Histology Data Entry/Edit window, you can perform one of the following actions:

- Save your current entries and continue entering Histology data for another specimen by pressing **Save/Next Specimen** on the Histology tab; or on the toolbar (or select File, Open Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Hot Seat Diagnosis Entry/Edit

Hot Seat information is part of an academic pathology laboratory's residency program. The fellow or resident sitting "on the hot seat" evaluates all pathology cases before the primary resident or responsible pathologist reviews them. Hot seat data is mainly internal to the laboratory and is generally used for Surgical Routine specimens only. The Hot Seat Diagnosis Entry/Edit activity allows a resident or fellow to record the results of the Hot Seat Diagnosis and for a responsible pathologist to enter the results of his or her Quality Assurance (QA) review.

Accessing the Hot Seat Diagnosis Entry/Edit Activity

To access the Hot Seat Diagnosis Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Hot Seat Diagnosis Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Hot Seat Diagnosis Entry/Edit window appears.

TIP! You can also access the Hot Seat Diagnosis Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Entering a Hot Seat Diagnosis

When you select the Hot Seat Diagnosis Entry/Edit activity in the standard export version of the CoPathPlus system, the Hot Seat Diagnosis Entry/Edit window appears with the Hot Seat Diagnosis tab.

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Hot Seat Diagnosis tab:

Diagnostic text fields.

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part

designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

Hot Seat Pathologist. Select the name(s) of the pathologist(s) who conducted the Hot Seat Diagnosis.

Mark Hot Seat Diagnosis Complete check box. Select this check box to mark the Hot Seat Diagnosis complete in CoPathPlus.

Hot Seat vs Final Diagnosis. After reviewing the Hot Seat Diagnosis, the responsible pathologist can enter his or her QA Review results quickly by choosing an option button on this tab:

- **None.** No diagnosis available.

- **Agree.** The responsible pathologist agrees with the resident's diagnosis.

- **Partial Disagreement.** The responsible pathologist partially disagrees with the resident's diagnosis.

- **Complete Disagreement.** The responsible pathologist completely disagrees with the resident's diagnosis.

The review status is set to "Complete" and the review date is also set to the current date. Once you have chosen a result and saved this specimen, result information can be changed only through the QA Diagnosis Review activity in CoPathPlus. .

Next Step for the Hot Seat Diagnosis Entry/Edit Activity

Now that you have completed the information on the Hot Seat Diagnosis Entry/Edit window, you can perform one of the following actions:

- Save your current entries and continue entering Hot Seat data for another specimen by pressing **Save/Next Specimen** on the Hot Seat Diagnosis tab; or on the toolbar (or select File, Open Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

    TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Intraoperative Diagnosis Entry/Edit

The Intraoperative Diagnosis Entry/Edit activity allows you to record the diagnosis for an Intraoperative Consult, which is also known as a Frozen Section. Some sites may decide to allow users to enter Intraoperative Diagnosis information during the accessioning process and/or Gross Description Entry/Edit activity, rather than using a separate activity to record this information.

Accessing the Intraoperative Diagnosis Entry/Edit Activity

To access the Intraoperative Diagnosis Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

    The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Intraoperative Diagnosis Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Intraoperative Diagnosis Entry/Edit window appears.

TIP! You can also access the Intraoperative Diagnosis Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Entering an Intraoperative Diagnosis

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Intraop Diagnosis tab:

Intraop Consult Pathologist. Select the name(s) of the pathologist(s) who conducted the Intraoperative Consult.

Diagnostic text fields.

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press ![icon] on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press ![icon] on the toolbar to return to CoPathPlus after you finish entering and editing text.

Mark Intraoperative Diagnosis Complete check box. Select this check box to mark the Intraoperative Diagnosis complete in CoPathPlus.

View or Enter the following information of the Received/Called tab:

1) **Part Type(s).** The part type(s) specified during the accessioning process is displayed but cannot be edited. For detailed information on the part type fields, refer to "Part Type(s)".

2) **Description.** The part type description specified during the accessioning process displayed but cannot be edited.

   Use the up and down arrow keys or click in the area just to the left of the Part Type sequence numbers to specify the part type on which to enter intraoperative diagnosis date and comments.

3) **Received Date.** Select the part type and then enter the date and time when the individual intraoperative parts were received into the laboratory.

4) **Called Date.** Enter the date and time when the results for the selected part type were called.

5) **Frozen Comments.** Enter any comments for the selected part type.

Insert Row button. Click this button to add additional rows for the selected part type.

Delete Row button. Select the row you want to delete and then click this button.

Turnaround times captured on this tab will be reported in the Turnaround (mins) Intraoperative Diagnosis InfoMaker Report, which is also known as the Intraop Diagnosis Turnaround Time Report". This report is located in the Case Statistical Reports folder.

Next Step for the Intraoperative Diagnosis Entry/Edit Activity

Now that you have completed the information on the Intraoperative Diagnosis Entry/Edit window, you can perform one of the following actions:

- Save your current entries and continue entering Intraoperative data for another specimen by pressing **Save/Next Specimen** on the Intraop Diagnosis tab; or on the toolbar (or select File, Open Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Order Stain/Process on Outside Block

The Order Stain/Process on Outside Block enables you to associate stains with outside block information without having to go through the process of entering a real block. Instead, you can add additional fields, such as Outside Block ID, directly to the stain level; there is no actual block created. All of the data is available for standard histology areas such as log and label procedures, and histology summary. This activity is useful for your consulting cases.

This feature allows the user to enter information about one or more Outside Blocks, then enter a set of stains/processes which will be ordered for each of the entered Outside Blocks. Thus initially entering multiple blocks together provides a quick way to populate the same stains to all the blocks. If you want different stains on the blocks, you just enter the specific block, its associated stain and then the next specific blocks

Note: This activity needs to be enabled by your site's System Manager. For more information, contact your system manager or Cerner CoPathPlus.

Accessing the Order Stain/Process on Outside Block Activity

To access the Order Stain/Process on Outside Block activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Order Stain/Process on Outside Block** in the Activity field on that window.

4) Press **OK**. The Stain/Process and Block Edit window appears.

TIP! You can also access the Order Stain/Process on Outside Block by selecting File > Browse Items or by placing it in your Personal Menu and double-clicking on it from there.

Ordering Stain(s)/Process(es) on Outside Blocks

You can order stains/processes on outside blocks for all specimen classes (i.e., Surgical, Cytology, Bone Marrow, Autopsy) in the standard export version of the CoPathPlus system, except for Cytology Gynecological. Typically, the Order Stain/Process on Outside Block activity is not valid for this specimen class.

The tab you see on the Order Stain/Process on Outside Block window when you access this activity is the same for all specimen classes. This activity has only one tab, Histology, which allows you to order stains/processes on outside blocks for a specimen.

Histology tab on the Order Stain/Process on Outside Block Window

The report display on the Histology tab on the Order Stain/Process on Outside Block window is similar to the Histology Summary pop-up window accessed from the Histology Data Entry/Edit activity. However, while the display on the Histology Summary pop-up window shows a static report, on the Histology tab on the Order Stain/Process on Outside Block window has interactive

properties. When you click on a block, you enable the Add Outside Block(s) button that allows you to add outside blocks for a specimen. When you click on a block on the display on the Histology tab, you enable the Edit Stain/Process button on this tab that allows you to then edit stain/process information for a specimen.
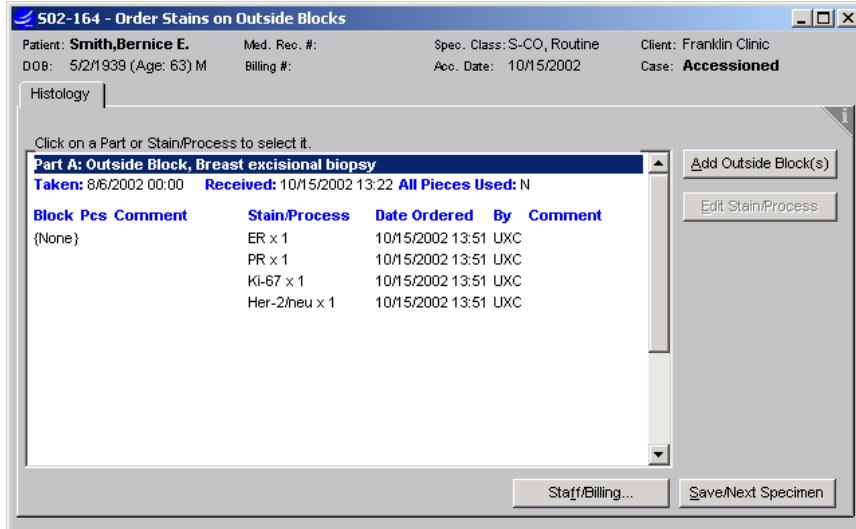
Enter the following information on the Histology tab (first click on a part or block on the display):

Add Outside Block button. Click this button to access the Sectioning Site Wizard to add one or more outside blocks for the selected part.

Edit Stain/Process button. Click this button to access the Edit Stain/Process pop-up window to edit one or more existing stains/processes for the selected block.

Staff/Billing button. Click this button to access the Staff/Billing pop-up window so that you can enter/edit gross pathologist, priority, and fee code data.

Save/Next Specimen button. Click this button if you want to save the current data and order stain/process of outside blocks for another specimen. The Select Specimen window appears.

Add Outside Blocks

The Sectioning Site Wizard pop-up window allows you to add outside blocks for the current specimen.

- **Block ID.** Enter the Block ID supplied by the outside institution.

- **Part.** Enter the part of the specimen from which the block was taken.

- **Date.** Enter the date on which the specimen was accessioned.

- **Patient ID**. Enter patient identification number.

- **Patient Name.** Enter the name of the Patient.

Press **OK** to exit this pop-up window. The Order Stain Process pop-up window will appear.

Order Stain Process

After you add an outside block on the site sectioning wizard and then click OK, the Order Stain Process pop-up window appears.

Enter the following information on the Order Stain Process pop-up window.

1) **Stain/Process.** A default of **H&E,Initial** automatically appears for each block entered. If necessary, select additional stain(s)/process(es) to order for this part type. All available stains and processes are defined in the Stain/Process dictionary. For more information about that dictionary, refer to "Stain/Process Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

2) **Blk/Desig (Block/Designator).** Select the block for which to apply this stain or process. If there is only one block for this part type, that block appears as the default. If the stain or process applies to the entire part type, rather than just the block, leave this field blank.

3) **Count.** Enter the number of stains or processes to be performed on this part. The default count is **1**, or, if using a protocol, the number entered in the Protocol dictionary for the stain/process. You can edit the default if necessary.

4) **Request Class.** Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary.

Request classes are used to categorize histology tests and the reason they were performed.

5) **Stain/Process Detail button.** Click this button to access the Stain/Process Detail pop-up window, which shows the details for each stain/process for this specimen. Refer to Stain/Process Detail for more information.

6) **Run Stain/Process Group button.** Click this button to load the selected stain/process group protocol for each part type. Once you Click this button, CoPathPlus displays the Run Stain/Process Group Protocol pop-up window. Select the protocol you want on this window and press **OK**. For more information on the different types of protocols available, refer to "Histology Protocols".

7) **Save Protocol… button.** Click this button to access the Save Protocol pop-up window. You use this window to either create a new histology protocol consisting of the current block and stain/process information entered for this part type, or to update an existing histology protocol with that information. Refer to "Save Protocol "for more information.

8) **Histo Summary button.** Click this button to access the Histology Summary pop-up window, which presents a summary of all the histology information for this specimen entered to date in one place.

When you are done entering stain/process information, press **OK**.

Edit Stain/Process

The Edit Stain/Process pop-up window allows you to view the information originally entered through the Histology Data Entry/Edit activity for the current specimen and to edit the data or enter a new stain/process, as necessary. When you press **Edit Stain/Process** on the Histology tab of the Order Stain/Process on Outside block window, CoPathPlus places your cursor in the row for the stain/process you highlighted on the Histology tab.
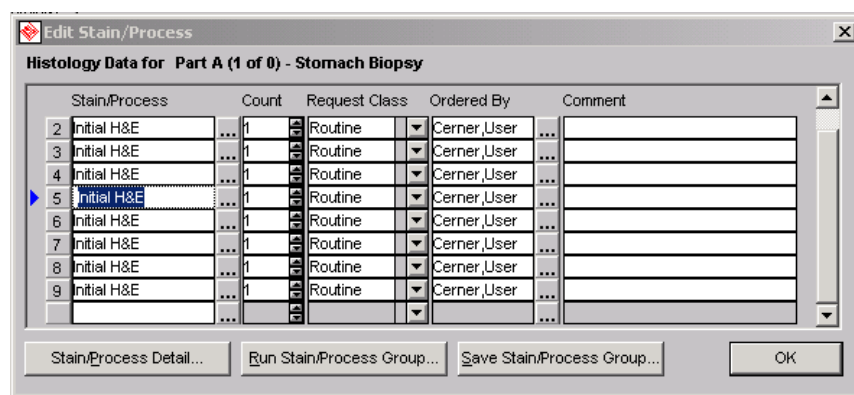
Enter the following information on the Edit Stain/Process pop-up window:

Stain/Process. If necessary, select additional stain(s)/process(es) to order for this part type. All available stains and processes are defined in the Stain/Process Dictionary. For more information about that dictionary, refer to "Stain/Process Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Count. Enter the number of stains or processes to be performed on this part. The default count is **1**, or, if using a protocol, the number entered in the Protocol dictionary for the stain/process. You can edit the default if necessary.

Request Class. Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary. Request classes are used to categorize histology tests and the reason they were performed.

Ordered by. Enter the name of the Pathologist, Fellow, Resident, PA/Diener, or Cytotech who ordered this stain/process. In the standard export version of CoPathPlus, the default at this field is the user currently signed on to the system, unless that person has a person type of Unspecified. In that case, the name of the primary pathologist associated with the specimen (case) appears as the default.

Comment. Enter a free-text comment for this stain/process. A default comment can appear based on the histology protocol.

Stain/Process Detail button. Click this button to access the Stain/Process Detail pop-up window, which shows the details for each stain/process for this specimen. Refer to "Stain/Process Detail" for more information.

Run Stain/Process Group button. Click this button to load the selected stain/process group protocol for each part type. Once you Click this button, CoPathPlus displays the Run Stain/Process Group Protocol pop-up window. Select the protocol you want on this window and press **OK**. For more information on the different types of protocols available, refer to "Histology Protocols".

Save Stain/Process Group… button. Click this button to access the Save Protocol pop-up window. You use this window to enter the stain/process group protocol name and to save the stain/process group protocol information for this specimen. Refer to "Save Protocol "for more information.

NOTE: Only users with the appropriate permission will be able to enter and save protocols. If you do not have permission, the **Save Stain/Process Group…** button is disabled.

When you are done entering and editing stain/process information, press **OK**.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Patient Report Single Print

You can print and view the available reports for a selected specimen using the Patient Report Single Print activity. You can print the following reports for a particular specimen:

- Final Report
- Working Draft
- Procedure/Addendum Report

To print a group of patient reports, refer to "Final Report List/Range Print". To print a previously assembled batch of patient reports, refer to "Report Chute Manager".

Accessing the Patient Report Single Print Activity

To access the Patient Report Single Print activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Patient Report Single Print** in the Activity field on that window.

4) Press **OK**. The Select Report(s) pop-up window appears.

TIP! You can also access the Patient Report Single Print activity by placing it in your Personal Menu and double-clicking on it from there. This activity is also available under Patient Reports when you press the **Reports** command button on the CoPathPlus Application Manager.

Selecting a Report to View or Print

The Select Report(s) window lists all the reports available for the specimen you chose and the status of each. If a procedure or addendum report is listed, this window also shows the procedure/addendum order date.

The possible statuses are:

- PRE (Preliminary)
- S/O (Signed Out)
- AM (Amended)
- N/A (Not Applicable, for all Working Drafts and for Final reports on specimen classes that are never signed out [e.g., Card cases])

You can either view or print the report from the Select Report(s) window. If viewing a report, you can select only one report at a time. If printing a report, you can select one or more of the available reports.

TIP! On the Select Report(s) window, you can use Ctrl+Click to select more than one report that you want to print. When you have more than one report selected, you can use Ctrl+Click to deselect an individual report. Note that this attribute does not apply to the View functionality (i.e., you cannot select more than one report at a time to view).

Viewing the Report

You have the option of viewing an online version of the report you choose before printing it. Select the report you want to view on the Select Report(s) window by highlighting it, and then press **View**. Note that you can view only one report at a time. The **View** button is disabled if more than one report is selected.

Using Microsoft Word to View Patient Reports

An example of a Final Report viewed using Microsoft Word is shown below.
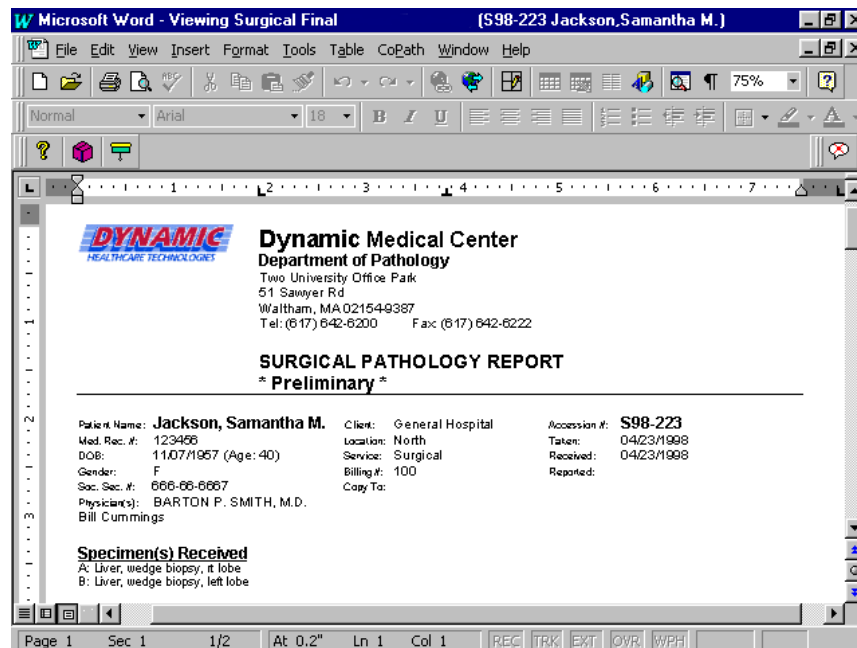
Use the scroll bars at the right and bottom of the screen to view report information. Notice that there are just three buttons available on the CoPathPlus toolbar when viewing a report. That is because you cannot edit any information on the report while in view-only mode. You can, however, print the report from Microsoft Word. Refer to your Microsoft Word documentation for more information about printing.

Press to return to CoPathPlus when finished reviewing report information. For more information about CoPathPlus toolbars, refer to "CoPathPlus Menu and Toolbars for Microsoft Word".

Using TxText to View Patient Reports

NOTE: TxText is the CoPathPlus Text Editor that was previously referred to as "Visual Writer" or "VW".

An example of a Working Draft viewed using TxText is shown below.

You can move from page to page in the report by using the arrow buttons to the right of the display. You can press:

- ⏮ to move to the first page of the report.

- ▶ to move to the previous page of the report.

- ◀ to move to the next page of the report.

- ⏭ to move to the last page of the report.

From this window you can:

- View related and sometimes critical information for the specimen (case) that may not appear on the patient report by pressing **More…**. Another window appears, that shows additional information not normally printed on the patient report, such as SNOMED, ICD-9-CM, and fee codes, and stain/processes.

- Print the report by pressing **Print**. Continue with "Printing the Report".

- Return to the Select Reports window to select a different report to view or print by pressing **Return**.

If you decide that you do not want to print the report, press **Cancel** and CoPathPlus returns you to the Select Report(s) window. From here you can choose another report to view or print or press **Cancel** to return to the specimen activity you were in or the CoPathPlus Application Manager, depending on how you accessed the Patient Report Single Print activity.

Printing the Report

Perform the following steps to print one or more reports:

1) Select the report or reports you want to print on the Select Report(s) window by highlighting it and pressing **Print** (if you are printing only one, just double-click on the report). CoPathPlus brings up the Report Print Manager with the Print/Send Setup window on top. This window lists the printers to which all users have access.

2) Select <u>P</u>rinter or <u>F</u>ax in the Use field on the Print/Send Setup window. For more information about this pop-up, refer to "Print".

> **TIP!** If printing a report with attachments to a printer, select the <u>N</u>o Images check box to suppress printing of the attachments. This is useful if a particular printer is incapable of printing graphic images, or if you want to save time during printing. Also, if you send a very large print job to a network printer, you may want to select the Background check box. This allows you to continue working on the system while CoPathPlus prepares your job for printing.

3) Press **Print**.

> CoPathPlus shows you the status of the print job on the Report Print Manager window and then returns you to the Select Report(s) window when the printing is complete. Refer to "Report Chute Manager" for more information on the Report Print Manager window.

CoPathPlus prints your report and returns you to the Select Specimen window or the specimen activity you were in, depending on how you accessed the Patient Report Single Print activity.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Post-Signout Edit

This topic details the Post-Signout Edit activity in the standard export version of the CoPathPlus system.

The Post-Signout Edit activity provides the ability for you to edit non-diagnostic information on a specimen (case) **after** it has been signed out. This data includes such things as selected accession and statistical information (e.g., encounter and billing numbers; specimen/requisition deficiencies; staff, such as pathologist and cytotech).

If you need to edit diagnostic data for a signed-out case, then you must first amend the case.

Accessing the Post-Signout Edit Activity

To access the Post-Signout Edit activity:

1) Press the Specimens command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Post-Signout Edit** in the Activity field on that window.

4) Press **OK**. The Post-Signout Edit window for the specimen class associated with the specimen appears.

TIP! You can also access the Post-Signout Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Editing Post-Signout Data

You can edit post-signout data for the following specimen classes in the standard export version of the CoPathPlus system:

- Surgical Routine
- Surgical Consult
- Bone Marrow Routine
- Cytology Gynecological
- Cytology Non-Gynecological
- Cytology Fine Needle Aspirate
- Autopsy Anatomic
- Autopsy Anatomic/Neuro
- Autopsy Neuro Only

The following tabs appear when you access the Post-Signout Edit window for the Surgical Routine, Surgical Consult, Bone Marrow Routine, Cytology Gynecological, Cytology Non-Gynecological, and Cytology Fine Needle Aspirate specimen classes:

- Specimen Data, which allows you to edit specimen data (e.g., encounter number, client, billing number, etc.) and specimen/requisition deficiencies.

- Stain/Process (for Cytology specimen classes only), which allows you to edit stain/process information, including protocol data.

- Text, which allows you to edit non-diagnostic text field information such as Clinical Diagnosis, Pre-Operative Diagnosis, Post-Operative Diagnosis, and Physician Notification (where appropriate). Note that this tab basically looks the same for all specimen classes for this activity, except for the choices of which text field option buttons appear on it.

- Staff/Retrieval Flag, which allows you to edit the staff and any retrieval flags associated with the specimen.

The following tabs appear when you access the Post-Signout Edit window for the Autopsy specimen classes:

- Autopsy, which allows you to edit autopsy data, such as the date/time of, reason, authorization, and restrictions for the autopsy.

- Staff/Copy To, which allows you to edit the pathologist(s) associated with the specimen (case), specimen data; and to specify where additional report copies will go.

- Text, which allows you to edit the text field information for the Clinical Diagnosis and Special Request fields. Note that this tab basically looks the same for all specimen classes for this activity, except for the choices of which text field option buttons appear on it.

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⬚ and ⬚) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the Post-Signout Edit window for each specimen class may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Specimen Data Tab on the Post-Signout Edit Window

NOTE: Your system may look different depending on the modifications made by your site.

Edit the following information on the Specimen Data tab:

Specimen Data. For detailed information on these fields, refer to "Specimen Data". Some of the data that displays on this portion of the tab may default in from information received through an Admission/Discharge/Transfer (ADT) interface. To learn more about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Slide Information. CoPathPlus displays this field only for the Surgical Consult specimen class for the Post-Signout Edit activity in the standard export version of the CoPathPlus system.

1) **Keep Slides.** Select this check box if any slides sent out for review need not be returned. Otherwise, clear the check box.

2) **Slides Returned.** Select this check box if slides that were sent out for review have been returned. Otherwise, clear the check box.

Specimen/Requisition Deficiencies. For detailed information on these fields, refer to "Specimen/Requisition Deficiencies".

1) **Deficiency.** Change or select a specimen deficiency (problem encountered) when this specimen (case) was received in the lab and edit or enter the corresponding comment to the deficiency, as needed.

2) **Resolution.** Change or select the resolution to the corresponding specimen deficiency and edit or enter the corresponding comment to the resolution, as needed.

To continue with the post-signout edit process, if you are:

- Working with a Surgical specimen, refer to "Entering Information on the Text Tab on the Post-Signout Edit Window".

- Working with a Cytology specimen, refer to "Entering Information on the Stain/Process Tab on the Post-Signout Edit Window".

- Done editing post-signout data, refer to "Next Step for the Post-Signout Edit Activity".

Stain/Process Tab on the Post-Signout Edit Window

NOTE: Your system may look different depending on the modifications made by your site.

The top portion of the Stain/Process tab identifies the part type(s) for the current specimen. The information you edit on this tab pertains to the part type you have highlighted in the top display. You can move between parts by clicking on the one you want.

Edit the following information on the Stain/Process tab:

Cytology Protocol. For more information about protocols, refer to "Histology Protocols".

1) **Protocol.** Change the protocol that is associated with the part type or accept the value that may already have been entered.

2) **Load.** Select this check box if you want to load a protocol for this part.

3) **Run Protocol(s) button.** Click this button to run the protocol specified in the Protocol field for the associated part. Note that you must select the Load check box first if you want to run a protocol for a part.

Stain/Process. For detailed information on the stain/process fields, refer to "Stain/Process".

1) **Stain/Process.** Change, if necessary, a stain/process or accept the value that may already have been entered.

2) **Count.** Change, if necessary, the count (the number of stains or processes to be performed on this part) for the associated stain/process or accept the value that may already have been entered.

3) **Label Text.** Change, if necessary, the text (that appears on the slide labels) for the associated stain/process or accept the value that may already have been entered.

4) **Date/Time Ordered.** A display-only field that specifies when the stain/process was ordered.

5) **Stain/Process Detail button.** Click this button to open the Stain/Process Detail pop-up window, which lets you edit additional stain/process information. To save your changes or additions, press **Save Protocol** on this window. For detailed information about this pop-up window, refer to "Stain/Process".

Text Tab on the Post-Signout Edit Window

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Edit the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press ![icon] on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press ![icon] on the toolbar to return to CoPathPlus after you finish entering and editing text.

Staff/Retrieval Flag Tab on the Post-Signout Edit Window

NOTE: Your system may look different depending on the modifications made by your site.

Edit the following information on the Staff/Retrieval Flag tab:

Staff Information. Identify the pathologist(s) and cytotech(s) related to this case or change the values already in the staff-related fields. Note that which staff fields display and the order of these fields depend on which specimen class you are currently working with. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, the physician name(s) may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Personal Consult. CoPathPlus only displays this check box for the Surgical Consult specimen class for the Post-Signout Edit activity in the standard export version of the CoPathPlus system. Select this check box if this specimen was a referral to a particular pathologist in your Anatomic Pathology department.

Date of Last Menstruation. CoPathPlus only displays this field for the Cytology Gynecological specimen class for the Post-Signout Edit activity in the standard export version of the CoPathPlus system. Edit the date for the first day of the patient's last menstruation period. You can use date format (e.g., 5/15/07) or free-text (e.g., middle of May)

Other Case Numbers… button. Click this button to open the Other Case Number(s) pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker. For detailed information about this pop-up window, refer to "Other Case Numbers".

Retrieval Flag. Change, if necessary, a retrieval flag and its corresponding comment and date/time information for the current specimen (case). For detailed information on the Retrieval Flag field, refer to "Retrieval Flags".

Save/Next Specimen button. Click this button if you want to save the current data and continue editing post-signout information for another specimen. The Select Specimen window appears.

Autopsy Tab on the Post-Signout Edit Window

Edit the following information on the Autopsy tab:

Autopsy Data.

- **Autopsy Date/Time.** The current date and time defaults in this field, which records when the autopsy was performed.

- **Priority.** Select the priority for this specimen (case) from the drop-down list, or you can accept the default.

- **Postmortem Hours.** CoPathPlus calculates this value, which appears in this display-only field. The number of hours in this field represents the difference between the time of expiration (as entered on the Patient Registration window) and the date/time of the autopsy.

- **Submitting Phys.** This information may default in from data received through an interface. Otherwise, you can identify the physician who ordered the current specimen or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

- **Reason for Autopsy.** Select the reason that this autopsy is being conducted. This dictionary-linked field points to the Autopsy Reason dictionary. Refer to "Autopsy Reason Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on the Autopsy Reason dictionary.

- **Gestational Age/Weeks.** Use this field for stillborn or prenatal autopsies only. Enter the age of the deceased in weeks (a number with up to one decimal place; e.g., 28, 3.1, 56.5).

- **Authorized By.** Enter the name of the person who authorized this autopsy. This is a free-text field.

- **Relationship to Deceased.** Enter the relationship of the person who authorized the autopsy to the deceased. This is a free-text field.

- **Autopsy Restrictions.** Select any restriction for this autopsy. For the Autopsy Anatomic Only and Autopsy Anatomic/Neuro specimen classes, a **None** restriction will default. For the Autopsy Neuro Only specimen class, a **Brain and Spinal Cord** restriction will default. This dictionary-linked field points to the Autopsy Restriction dictionary. Refer to "Autopsy Restriction Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information.

- **Restrictions Comment.** Enter any additional information concerning the restrictions specified above for this autopsy. This is a free-text field.

- **Medical Examiner.** Enter the name of the Medical Examiner who examined the deceased. This is a free-text field.

Other Data.

- **Spec/Req Deficiencies.** Click this button to open the Specimen/Requisition Deficiencies pop-up window, which lets you enter any problems encountered with a specimen.

- **Other Case Numbers.** Click this button to open the Other Case Numbers pop-up window, which lets you enter free-text case numbers that are related to the current specimen. The numbers you enter can display on the Inquiry window, Working Draft reports, Final Reports, and other reports you create using InfoMaker.

- **Retrieval Flags.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

- **Cultures.** Click this button to open the Cultures pop-up window, which lets you record and note the results of any cultures performed on the current case.

Staff/Copy To Tab on the Post-Signout Edit Window

NOTE: This tab appears for Autopsy specimens only.

Edit the following information on the Staff/Copy To tab:

Staff Information. Identify the pathologist(s) related to this case or change the values already in the staff-related fields. Note that which staff fields display and the order of these fields depend on which specimen class you are currently working with. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, the physician name(s) may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Specimen Data. For detailed information on these fields, refer to "Specimen Data". The data that displays on this portion of the tab, with the exception of Priority, may default in from information received through an Admission/Discharge/Transfer (ADT) interface. To learn more about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

1) **Encounter.** This information typically defaults in from data entered during the accessioning process. You can change the current encounter number or accept the default.

2) **Client.** This information typically defaults in from data entered during the accessioning process. You can change the client or accept the default that is associated with the encounter number.

    NOTE: Your site may have entered an institutional billing number in the Client Dictionary for each client. If that is the case, then that institutional billing number may overwrite the encounter-defaulted specimen billing number (in the Billing Number field) when you identify a client in the Client field. Depending on how your site decided to set up this institutional billing functionality during your site's CoPathPlus implementation process, CoPathPlus may or may not ask you if you want the institutional billing number inserted in the Billing Number field.

3) **Service.** This information may default in from data received through an ADT interface. Otherwise, you can identify the section of the hospital where the patient receives treatment as related to the current specimen or change the value already in the field.

4) **Location.** This information may default in from data received through an ADT interface. Otherwise, you can identify the place where the patient was when the specimen was taken or change the value already in the field.

Next Step for the Post-Signout Edit Activity

Now that you have completed editing the information on the Post-Signout Edit window, you can perform one of the following actions:

- Save your current entries and continue entering post-signout data for another specimen by pressing **Save/Next Specimen** on the Staff/Retrieval Flag tab for a specimen other than Autopsy and on the Text tab for an Autopsy specimen; or [icon] on the toolbar (or select File, Open Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

    TIP! You can access an existing specimen for the current patient by pressing **Sa̲me Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing [icon] on the toolbar (or select Op̲tions, A̲ctivities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Procedure/Addendum Entry/Edit

This topic describes the Procedure/Addendum Entry/Edit activity in the standard export version of the CoPathPlus system.

You use this activity to order a procedure or addendum for a specimen, either before or after sign out. This activity also allows you to enter diagnostic information for the procedure/addendum, edit a procedure/addendum, mark a procedure/addendum diagnosis complete, or delete a procedure/addendum.

For several specimen classes, a procedure or addendum can also be ordered during the accessioning process, via the **O_rder Procedures…** button. However, the Order Procedures pop-up window does not allow you to enter diagnostic information or mark a diagnosis complete, as you can during the Procedure/Addendum Entry/Edit activity. For more information on ordering a procedure or addendum during accessioning, refer to "Other Data".

Default Procedures/Addenda

You can associate a part type in CoPathPlus with one or more default procedures and addenda. A part type's default procedures/addenda are defined in the Part Type Dictionary. During the accessioning process, the first time you save the new specimen, any default procedures/addenda associated with a part type included in that specimen are automatically ordered for the specimen. For more information about setting up default procedures/addenda for part types, refer to "Part Type Dictionary" in the "Accession Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*. Procedures can also be automatically order via Reflex testing. Refer to the "Reflex Configuration" section in the *Cerner CoPathPlus System Manager's Guide* for more information about reflex testing.

Procedure/Addendum Entry/Edit Permissions

Users must always have the Procedure Result Entry/Edit permission to enter results for a procedure, regardless of what other permissions the person has, or which are assigned to the procedure. Beyond that,

- When a specific procedure has an explicit Enter Results permission assigned to it:
  - Users possessing the procedure-specific permissions CAN result the procedure, regardless of whether the person also possesses the Edit Limited permission.
  - Users without the special permission are NOT eligible to result the procedure, regardless of whether the person also possesses the Edit Limited permission.
- When a specific procedure does NOT have an explicit Enter Results permission assigned to it:
  - Users without the Edit Limit restriction CAN result the procedure.
  - Users possessing the Edit Limit restriction are NOT eligible to result the procedure.

- Although it is appears on the list of permissions, the Edit Limited Permission does NOT act as a restriction specifically on the System Managers permission group. The System Managers permission group is authorized to all system features.

Permissions to Signout a specific procedure, either via the electronic or manual signout process follow the same general permission mechanism. In this case, the special permission checked will be the one defined in the Permission to Sign Out field of the Procedure Dictionary, and the restrictive permission is "Signout Limited". Refer to the "Miscellaneous Permission Dictionary" in the Cerner CoPathPlus Dictionary Building Guide for more information.

Procedure/Addendum Reports and Signout

The procedure/addendum diagnostic information can appear on two reports in CoPathPlus. Both reports need to be signed out just like any other report associated with a patient.

- **Individual Procedure/Addendum Report.** This report contains procedure/addendum diagnostic and status information.

- **Final Report.** This report does not have procedure or addendum information as part of the body of the report, but includes an Individual Procedure/Addendum Report at the end. The Final Report indicates that an Individual Procedure/Addendum Report will follow.

For more information on signout, refer to "Signout (Electronic) and Consult Review". For more information on CoPathPlus patient reports, refer to "Patient Reports and Patient Report Single Print"

Accessing the Procedure/Addendum Entry/Edit Activity

To access the Procedure/Addendum Entry/Edit activity:

1) Press the <small>**Specimens**</small> command button on the CoPathPlus Application Manager.

    The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Procedure/Addendum Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Select Procedure/Addendum pop-up window appears.

TIP! You can also access the Procedure/Addendum Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Select Procedure/Addendum Window

This window lists all existing procedures and addenda for this specimen, as well as the status of each, the date on which each was ordered, and the primary pathologist assigned to the individual procedure or addendum. The possible statuses are:

- Ordered (**ORD**), which indicates that the procedure/addendum has been ordered, but not yet completed or signed out.

- Completed (**COMP**), which indicates that the diagnosis associated with the procedure or addendum has been marked as complete.

- Signed Out (**S/O**), which indicates that the completed procedure/addendum has been signed out. Procedures and addenda, like specimens, are signed out using one of the available sign-out activities.

- Amended (**AM**), which indicates that the procedure or addendum was signed out and then amended, but has not been signed out again.

If the specimen does not have any existing procedures/addenda, you will see a message stating so.

From this window you can:

- **Order a new procedure or addendum** by pressing **New**. The Order New Procedure/Addendum pop-up window appears. This window is explained in "Ordering a New Procedure/Addendum".

- **Edit information for a previously ordered procedure or addendum** that has a status other than S/O (signed out) by double-clicking on the entry. The Procedure/Addendum Entry/Edit window appears. A warning message appears if you attempt to edit a procedure/addendum with a status of **COMP**; however, you are not prevented from doing so. For instructions on how to proceed, refer to "Entering/Editing Procedure and Addendum Data".

- **Delete a previously ordered procedure or addendum** by selecting the entry and then pressing **Delete**. You can delete a procedure/addendum only if your permission group is defined to allow that. An additional permission is required to delete signed-out procedures/addenda. Note that deleting a procedure/addendum will also remove the procedure's or addendum's associated report from any worklists or report chute it may be on, and it will generate an event of the type "Procedure Deleted".

- **View information for a procedure or addendum that your site has specified can be viewed only and not edited** by double-clicking on the entry. You will receive a message that states "This procedure/addendum has a status of '[status].' Do you want to continue?" Press **Yes** and the Procedure/Addendum Entry/Edit window appears. You cannot change any of the information on this window.

  NOTE: During system implementation, your site has the ability to specify which procedure statuses can only be viewed by a user and not edited.

Ordering a New Procedure/Addendum

Enter the following information on this window:

Specimen. The specimen number of the selected specimen appears for reference and cannot be edited.

Name. The name and medical record number of the patient associated with the selected specimen appears for reference and cannot be edited.

Procedure/Addendum. Select the type of procedure to order or specify that this is an addendum. All available procedures are defined in the Procedure dictionary. For more

information about the Procedure dictionary, refer to "Procedure Dictionary" in the "Reporting Dictionaries" section of *Cerner CoPathPlus Dictionary Building Manual*.

Press **OK** to proceed after you select the procedure/addendum to order. The Procedure/Addendum Entry/Edit window appears.

Entering/Editing Procedure and Addendum Data

You can order a procedure or addendum for all specimen classes. In the standard export version of CoPathPlus, the Procedure/Addendum Entry/Edit window includes the following tabs:

- **Status/Staff,** which lets you view the procedure/addendum status and current worklists, and to enter the order date and time, billing type, procedure primary pathologist, and ICD-9-CM code information.

- **Text,** which lets you enter diagnostic information associated with this procedure/addendum, such as an interpretation or comment, and SNOMED codes(s).

- **Attachments,** which lets you attach digital images and other files to the case, and select which attachments you want to print on patient reports for this case.

    NOTE: You will see this tab only for Surgical Routine, Bone Marrow Routine, and Autopsy specimen classes (except Autopsy Card cases).

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., [...] and [▼]) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Status/Staff Tab on the Procedure/Addendum Entry/Edit Window

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Status/Staff tab:

Procedure. The name of the ordered procedure or addendum is displayed for reference; it cannot be edited on this window.

Status. The status of the ordered procedure/addendum is displayed for reference; it cannot be edited on this window. Possible statuses are: Ordered, Completed, Signed out, and Amended.

Date Ordered. Enter the date and time that the procedure or addendum was ordered. For new entries, the default is the current date and time. Future times cannot be entered.

Billing Type. Enter a billing type for this procedure or addendum. The default is the specimen's billing type. For detailed information on this field, refer to "Specimen Data".

Current Worklist. This field lists any worklists on which the procedure or addendum is currently included, and the name of the person to which the procedure or addendum is assigned. For more information on worklists, refer to Worklists".

Procedure Pathologist(s). Enter the primary pathologist for the procedure or addendum. You can also enter any additional pathologist(s) involved with the procedure or addendum.

CoPathPlus assumes that the first pathologist in the list is the primary pathologist for this procedure or addendum.

Case Pathologist(s). If a Primary and any consulting pathologist(s) have been assigned to the case as a whole, their names are displayed for reference. This information cannot be edited on this window.

ICD-9-CM Code(s)…button. Click this button to open the ICD-9-CM pop-up window, which lets you enter/edit any ICD-9-CM codes for this procedure/addendum. For detailed information about this pop-up window, refer to "ICD-9-Code(s)".

Text Tab on the Procedure/Addendum Entry/Edit Window

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in "Using TxText to Edit Diagnostic Text Fields".

Enter the following information on the Text tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

4) **SNOMED Code(s) button.** Click this button to open the SNOMED Code(s) pop-up window, which allows you to manually enter and edit the SNOMED Code(s) associated with this specimen. For more information about this pop-up window, refer to "SNOMED Code(s) Pop-Up Window".

Save/Next Specimen button. Click this button if you want to save the current data and order a procedure or addendum for another specimen. Or you can switch activities or exit CoPathPlus through the toolbar. For all actions, the Next Process pop-up window appears.

SNOMED Code(s) Pop-Up Window in the Procedure/Addendum Entry/Edit Activity

Enter the following information on the SNOMED Code(s) pop-up window:

SNOMED Code(s). The SNOMED Code(s) associated with the specimen appear as the default. Use this field to manually enter any additional SNOMED Code(s) that are applicable for this procedure/addendum diagnosis, or to edit existing SNOMED code information.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Source. Enter the part designator (i.e., a letter or digit) or procedure/addendum abbreviation for which this SNOMED code is applicable. CoPathPlus uses the value in this field to simulate SNOMED code groups so that:

- Related SNOMED codes appear together on patient reports or other report outputs.

- Searches of cases using multiple SNOMED codes (i.e., looking for more that one SNOMED code within the same "group" or "source") are accurate.

Auto. For manually entered codes, this field is always blank. An **A** appears for codes entered through the Automatic SNOMED II Coder and an **L** appears for codes entered through dictionary links.

Press **OK** to exit this window when you finish entering and editing codes.

For more information about the manual entry of SNOMED codes, refer to "SNOMED Codes".

Attachments Tab on the Procedure/Addendum Entry/Edit Window

For detailed instructions on how to complete the fields on the Attachments tab, refer to "Attachments Entry/Edit".

Continue with "Next Step for the Procedure/Addendum Entry/Edit Activity".

Specifying the Next Process for the Procedure/Addendum Entry/Edit Activity

Once you finish entering or editing information on the Procedure/Addendum Entry/Edit window and you either perform a save function (e.g., press **Save/Next Specimen**) or switch activities, the Next Process pop-up window appears. You need to specify whether the Procedure Interpretation or Addendum Diagnosis is complete and what action CoPathPlus should take next.

In the standard export version of CoPathPlus, there are three actions available for a Surgical Routine specimen:

- **Complete/Send to Pathologist**, which marks the procedure or addendum diagnosis information complete and places a report for the procedure/addendum on the Pathologist Signout worklist. At the worklist **Send to** field, the default is the primary pathologist for the procedure/addendum, but can be edited. You can enter a special comment in the **Memo** field and, if necessary, place the case **on hold** (which means that CoPathPlus will place the report at the end of a worklist).

- **Remove From All Worklists**, which removes the procedure or addendum from any worklists that it is currently on. (The top of this pop-up window lists the worklists on which the procedure/addendum is currently included.) Use this action in cases where a procedure or addendum was mistakenly marked complete and placed on a worklist.

- **No Action**, which is the default, files the information you have entered so far but does not place a report for the procedure/addendum on a worklist nor mark any part of procedure/addendum complete.

Once you select the appropriate next process at the top of this window, respond to the **Do you want to save the changes to specimen** question at the bottom of the window by selecting one of the following buttons:

- **Yes.** CoPathPlus saves any changes and performs the next process action you specified.

- **No.** CoPathPlus does not save any changes you may have made or perform any next process action you may have specified.

- **Cancel.** CoPathPlus returns you to the Procedure/Addendum Entry/Edit window without filing any changes.

Next Step for the Procedure/Addendum Entry/Edit Activity

Now that you have completed the information on the Procedure/Addendum Entry/Edit window, you can perform one of the following actions:

NOTE: For the Procedure/Addendum Entry/Edit activity, you will see a Next Process pop-up window appear when you choose any of the actions described below. To learn more about this window, refer to "Specifying the Next Process for the Procedure/Addendum Entry/Edit Activity".

- Save your current entries and order a procedure or addendum for another specimen by pressing **Save/Next Specimen** on the Text tab or ![icon] on the toolbar (or select File, Open Specimen on the menu bar).

   The Next Process pop-up window appears. Once you specify the next process for this specimen and save your changes, the Select Specimen window appears.

   TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing ![icon] on the toolbar (or select Options, Activities on the menu bar). The Next Process pop-up window appears.

   For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing ![icon] on the toolbar (or select File, Close Specimen on the menu bar). The Next Process pop-up window appears.

   NOTE: Pressing ![icon] on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing ![icon] on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. The Next Process pop-up window appears.

QA Diagnosis Review

CoPathPlus provides many types of quality assurance tools, including Case Turnaround and Overdue Case reports, productivity reports, specimen/requisition deficiencies and resolutions, and diagnosis comparison reviews.

QA diagnosis comparison reviews help you to monitor specific Quality Assurance efforts on a specimen-by-specimen basis. They also help you to track related actions taken to improve the overall quality of the department's work.

You can enter one or more QA diagnosis comparison reviews during selected CoPathPlus activities. The standard export version of the CoPathPlus system provides for entry of a QA review during Signout, as well as through the QA Diagnosis Review activity. It requires an additional miscellaneous permission to delete a QA Review or to edit an already entered, but pending QA Review Result. A separate miscellaneous permission is required to edit a completed QA Review.

Any number of related diagnoses on a specimen (case)/patient can be compared for agreement or disagreement level information as part of the QA Diagnosis Review activity. One or more reviewers compare their diagnoses with the primary reviewer's/pathologist's diagnosis on either the specimen (case) in question or on previous cases related to the current case. In addition, one department's diagnosis may be compared with another department's diagnosis (e.g., Surgical Pathology versus Cytology) on a related or similar source case for the patient.

Accessing the QA Diagnosis Review Activity

To access the QA Diagnosis Review activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **QA Diagnosis Review** in the Activity field on that window.

4) Press **OK**. The Select QA Diagnosis Review pop-up window Select QA Diagnosis Review Window appears.

TIP! You can also access the QA Diagnosis Review activity by placing it in your Personal Menu and double-clicking on it from there.

Select QA Diagnosis Review Window

The Select QA Diagnosis Review window lists any existing reviews for the selected specimen. If the specimen does not have any existing reviews, a message appears stating that.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
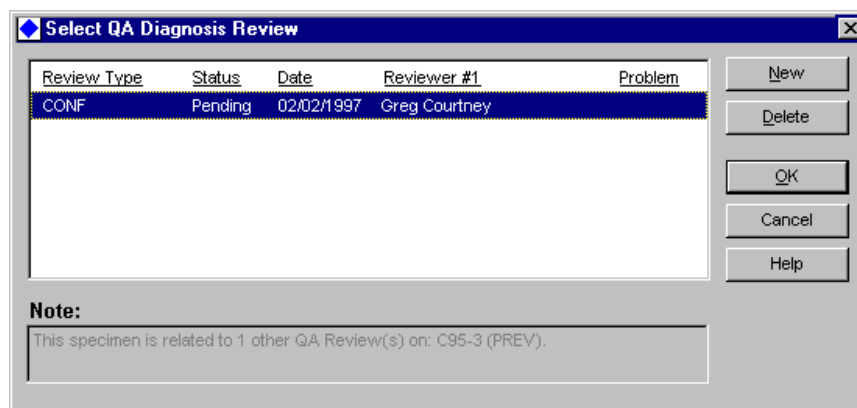
This window displays the following information for each review: Review Type abbreviation, review status (i.e., **Pending** or **Complete**) the date on which the review was entered, the person who entered the review, and whether the review has been flagged as a problem review.

In addition, if this case is related to another case that has a QA review, that information will display at the bottom of this window.

NOTE: A specimen's related cases are identified during the Accessioning process by pressing the **Other Case Numbers…** button from the Accession Entry/Edit window. For more information, refer to "Other Data".

From the Select QA Diagnosis Review window, you can:

- **Order a new QA review** by pressing **New**. The QA Diagnosis Review window appears on which you can enter a new review. Continue with "Entering Information for a QA Review".

- **Delete an existing QA review** by selecting the entry and then pressing **Delete**. Press **OK** when informed that you are about to delete the entire QA review. If you do not want to delete this review, press **Cancel** instead. The Delete function will only be available to users with explicit permission to do this.

- **Edit information for an existing QA review** by selecting the entry and then pressing **OK** (or just double-clicking on the entry). The QA Diagnosis Review window appears with the information that was previously entered for the review defaulted. Users may only edit pending or completed reviews if they have explicit permissions allowing this.

Entering Information for a QA Review

When you enter a new QA review or edit an existing QA review in the standard export version of the CoPathPlus system, the QA Diagnosis Review window appears with the following tabs:

- Diagnosis Review, which specifies the Review Type and associated results(s), resolution(s), and reason(s). You also specify the reviewer(s) on this tab.

- Related Specimens, which lists all the other specimens for the current patient from which you select those that should be a part of this QA review.

NOTE: Because each site can customize its CoPathPlus system to meet its specifications, the fields shown on the QA Diagnosis Review window may not be exactly like the ones you see in your system. You may not see all of the fields, you may see additional fields not specified here, or your fields may have different labels.

Diagnosis Review Tab on the QA Diagnosis Review Window

Enter the following information on the Diagnosis Review tab:

Review Type and Status fields. For a brief explanation of the QA Review Type dictionary used in the Review Type fields, refer to "Dictionaries in QA". For a more detailed explanation, refer to "QA Review Type Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual*.

1) **Review Type.** Select the type of review you are performing.

2) **Date.** Enter the date on which the QA review was entered. The current date defaults.

3) **Status.** The status of the review defaults to Pending. You can change it to Complete if this review has been completed.

4) **Problem check box.** Select this check box to flag this review as a problem. This flag is used for management reporting purposes.

5) **Reviewer(s).** The reviewer defaults to the user that is signed on if:

   o The Review Type you enter specifies that it should default to the user signed on (this is specified in the QA Review dictionary), and

   o That user is a person type of cytotech, pathologist, resident, or fellow.

   Only cytotechs, pathologists, residents, and fellows can be QA reviewers.

6) **Remove from QA PostSignout** or **No Action** options. The "Remove from QA PostSignout" option can be used to clear a completed QA Review from the Post Signout Worklist. Simply select this option on the appropriate QA Review and save the form sequence. "No Action" is the default position for this button box. These radio buttons have been added to the end of the tab sequence and there are no other workflow changes invoked by this window change when the "No Action" position is left enabled.

7) **QA Fields.** For a brief explanation of dictionaries used in these fields, refer to "Dictionaries in QA". For a more detailed explanation of each, refer to the *Cerner CoPathPlus Dictionary Building Manual*.

8) **Result(s).** Select the outcome of this QA Review. A default result may be entered on some QA Review Types.

9) **Resolution(s).** Select the activity that your site will perform to prevent recurrence of this type of problem in the future.

10) **Reason(s).** Select this reason why this QA Review was performed.

You can also enter a free-text comment in the **Comment** field for each Result(s), Resolution(s), and Reason(s) fields. These comments can appear on QA-related management reports.

Dictionaries in QA

To initiate a QA diagnosis comparison review for a specimen in CoPathPlus, the specimen must first be associated with at least one entry from the "primary dictionary" (i.e., QA Review Type). Then, as the review proceeds, you select entries from the "subsidiary dictionaries" (i.e., QA Reason, QA Resolution/Action, QA Result, QA Reviewer [Person]) to indicate how the review progressed and any actions that may be taken.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Primary QA Dictionary

QA activities can be tracked for a specimen only after an entry from the primary dictionary (i.e., QA Review Type) has been assigned to a specimen. The QA Review Dictionary contains classes or categories of QA diagnosis comparison reviews conducted by your site. An example of an entry in this dictionary would be "Intraoperative vs. Final Diagnosis".

Subsidiary QA Dictionaries

Questions about the progress and resolution of QA reviews are answered by selecting entries from the subsidiary dictionaries. These dictionaries are called "subsidiary" because you cannot assign entries from them to a specimen until you assign an entry from one of the primary dictionaries.

The four subsidiary QA dictionaries in CoPathPlus are:

- QA Reason. Indicates why a certain type of review is performed. For example, a specimen may have been reviewed because it was selected randomly, or because the Submitting Physician requested that it be reviewed. Autopsy QA reviews are also done for a specific reason (e.g., the patient dies within 48 hours of surgery).

- QA Resolution/Action. Specifies activities that your site performs to prevent recurrence of a type of problem in the future. An entry of "In-Service Training Provided" is an activity that will hopefully prevent the problem from arising again.

- QA Result. Contains entries that comprise the decisions, judgments, or conclusions of someone who performs a QA Diagnosis Comparison Review. For example, if more than one person reviews the same specimen and the reviewers disagree in their findings, that disagreement can be reflected by an entry of "Complete Disagreement" in the QA Result dictionary.

- QA Reviewer (Person). The name of the person who performs the review. This name actually comes from the Person Dictionary.

For more information on any of these dictionaries, refer to the *Cerner CoPathPlus Dictionary Building Manual*.

Related Specimens Tab on the QA Diagnosis Review Window

NOTE: Your system may look different depending on the modifications made by your site.

You specify other specimens for the current patient that will be a part of this QA review on this tab. The top portion of this tab lists all the specimens for the current patient, as well as the specimen class of each, the date on which the specimen was accessioned, its current status, and the associated part type(s). In addition, if a specimen has a current QA review or is listed as a related specimen on another QA review, that is indicated by an **X** in the QA column. The bottom portion of this tab lists all the specimens you choose as QA-related.

To select a specimen as a QA-related case:

1) Click on the specimen in the top portion of this window.

2) Press **Select**.

CoPathPlus will then:

- o Remove the specimen from the top portion of the window, and

- o List the specimen in the bottom portion of the window.

TIP! You can double-click on the specimen or drag-and-drop the specimen from the top portion of this window to the bottom portion.

NOTE: You can specify all the specimens as QA-related by clicking anywhere in the top portion of the window and pressing **Select All**.

To de-select a specimen as a QA-related case:

1) Click on the specimen in the bottom portion of this window.

2) Press **De-select**.

CoPathPlus then:

- o Removes the specimen from the bottom portion of the window, and

- o Lists the specimen in the top portion of the window.

TIP! You can double-click on the specimen or drag-and-drop the specimen from the bottom portion of this window to the top portion.

You can also enter a free-text comment in the **Comment** field to specify associated information (e.g., why you chose selected specimens for QA if not indicated elsewhere).

Next Step for the QA Diagnosis Review Activity

Now that you have completed the information on the QA Diagnosis Review window, you can perform any of the following actions:

- Save your current entries and continue entering QA data for another specimen by pressing on the toolbar (or select File, Open Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select <u>F</u>ile, E<u>x</u>it CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Signout (Electronic) and Consult Review

This topic explains both the Signout (Electronic) and Consult Review activities. Signout in CoPathPlus involves selecting a report (e.g., Final Report, Procedure Report), reviewing and updating related information (if necessary), signing out the report, and then sending the report along to final report batches, results or billing interfaces, post-signout worklist(s), etc.

The signout of a report signifies that the case or procedure/addendum can now be reported to the clinician (i.e., submitting or additional physician[s]). This action has important legal implications. Subsequent actions on the specimen or procedure/addendum are thereafter subject to security restrictions and most specimen- or procedure/addendum-related information is locked from further user access unless an amendment is performed. For more information on Amendments, refer to "Amendment Entry and Amendment Edit ".

Signout should not occur unless pertinent diagnostic information has been entered for the specimen or procedure/addendum, (e.g., Final Diagnosis, Interpretation) and that information has been marked complete. Signing out a case's Final Report changes the status of the entire case to S/O (Signed Out). Therefore, for each procedure/addendum, your site can specify (in the Procedure Dictionary) whether the Final Report for a specimen must be signed out before you can sign out associated Procedure/Addendum reports, and whether to display a warning during the signout of a Final Report if any associated Procedure/Addendum reports have not yet been signed out. For more information, refer to the "Procedure Dictionary" topic in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Card cases and Surgical Histology-Only specimens are not typically signed out.

The Consult Review activity involves the review of specimen and/or procedure/addendum reports by a resident, fellow, or consulting pathologist before they are signed out. Once reviewed, they are sent to another pathologist for signout. Using the Consult Review activity involves the same steps as using the Signout (Electronic) activity except that reports cannot be signed out.

NOTE: Your site determines during the implementation process whether to use Electronic Signout or Manual Signout. In the standard export version of CoPathPlus, Electronic Signout is utilized.

Accessing the Signout (Electronic) and Consult Review Activities

You can access the Signout (Electronic) or Consult Review activities in two ways:

Pressing the Specimens command button:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select the **Signout (Electronic)** or **Consult Review** activity in the Activity field on that window.

4) Press **OK**.

Pressing the Worklists command button:

1) Press the **Worklists** command button on the CoPathPlus Application Manager.

   The Select Specimen from Worklist window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen from Worklist Window.

If you accessed the activity via the **Specimens** command button, the Select a Report pop-up window appears.

NOTE: You will not see the Select a Report pop-up window if you are using the **Worklists** command button because you will access the appropriate report directly.

TIP! You can also access the Signout (Electronic) and Consult Review activities by placing them in your Personal Menu and double-clicking on them from there. In addition, you can place a specific worklist that uses the Signout (Electronic) or Consult Review activity in your Personal Menu.

Selecting a Report to Sign Out or Review

The Select a Report pop-up window lists all the reports available for the specimen you chose and the status of each. If a procedure or addendum report is listed, this window also shows the procedure/addendum order date.

The possible statuses are:

- PRE (Preliminary)

- S/O (Signed Out)

- AM (Amended)

- N/A (Not Applicable, for all Working Drafts and for Final reports on specimen classes that are never signed out [e.g., Card cases])

The reports on this window appear in the order entered in CoPathPlus (e.g., the Final Report when a specimen is accessioned, a Procedure/Addendum Report when a procedure is ordered or an addendum is created).

Select the report you want to sign out or review by double-clicking on it or by highlighting it and pressing **OK**.

A warning can appear if either of the following is true:

- You have selected a Procedure or Addendum report to sign out for a specimen whose Final Report is not yet signed out.

- You have selected a Final Report to sign out for a specimen with a Procedure or Addendum report that is not yet signed out.

Press **OK** to proceed or **Cancel** to stop.

Using Microsoft Word for Signout and Consult Review

After you select a report to sign out or review, the Signout Report window appears. The cursor is positioned at the first editable diagnostic text field on the Final Report or Procedure/Addendum report.

NOTE: Your system may look different depending on the modifications made by your site. Also, your site determines during implementation if it wants to have the Signout (Electronic) activity access the Edit Specimen window prior to the Signout Report window. For more information, refer to "Editing Report Information".

When accessed via the Consult Review activity, this window does not include the following: **To Path** button **, Sign Out** button. An additional **To Primary** button will appear.

Navigating Within the Signout Report Window (Microsoft Word)

Use the scroll bars at the right and bottom of the window to view report information. You can edit all diagnostic text fields, insert page breaks, and print the report from Microsoft Word. You cannot edit non-diagnostic text fields (e.g., patient name, client) directly on the report, nor can you edit or delete the names of diagnostic text fields.

For instructions on editing diagnostic text using Microsoft Word, refer to "Using Microsoft Word to Edit Diagnostic Text Fields". For more information about Microsoft Word text editing features, including printing, refer to your Microsoft Word documentation.

NOTE: If you delete all of the text in a text field that has been set up to be suppressed from the report when no text is entered for that field (i.e., "skip logic"), the heading continues to display on the Microsoft Word version of the report. However, if you preview the report (e.g., using the Microsoft Word File, Print Preview command), you can see that the heading is also suppressed from the report when no text is entered. Similarly, if a text field is set up to display a message on the report such as "{Not Entered}" when no text is entered for that field (i.e., "replacement logic"), you will not see that message when you are in Edit Report mode. You must preview the report to see the replacement message. For more information about skip logic, replacement logic, and other features of the Patient Report Painter, refer to "Patient Report Painter" in the *Cerner CoPathPlus Tools Training Manual*.

During Signout and Consult Review, two CoPathPlus toolbars, **CoPathToolbar** and **CoPathToolbar2**, are available. These provide additional buttons which you can use to edit diagnostic text, sign out the report, and specify the next process for the report. An example of these toolbars appears below:

Many of these buttons also appear on the CoPath menu in Microsoft Word. For more information about the CoPath menu and CoPathPlus toolbars, refer to "CoPathPlus Menu and Toolbars for Microsoft Word".

Signout Using the Worklists Command Button (Microsoft Word)

If you accessed the Signout Report window through the **Worklists** command button, you can sign out the report by pressing **Sign Out**. The Enter Password window appears.

NOTE: The **Sign Out** button is not available for the Consult Review activity.

To sign out the report, CoPathPlus automatically displays your user ID. Beneath it, enter your w password and then press **OK**. This action will mark the case Final Complete, if not already done so, and change its status to S/O (Signed Out). To cancel this action, press **Cancel**. The Signout pop-up window appears.

Your site determines during implementation whether the report for the next specimen on the worklist automatically appears for review and sign out. If it does, you can quickly sign out subsequent cases without having to return to the Select Specimen from Worklist window and select the next report. If you come to a case that you do not want to sign out, press the **Skip to Next** button. If your site is not set up so that the report for the next specimen appears automatically, you the Select Specimen from Worklist window appears so that you can select the next report you want to sign out.

NOTE: When signing out multiple reports, your entry in the Person Dictionary determines whether you are required to enter your password to sign out each report or whether you need to only enter your password for the first report you sign out.

Skip to Next is unavailable once you edit specimen information during signout. Cytology cases cannot utilize the **Skip to Next** button or the automatic selection of the next report on the worklist because of Cytology's unique signout process.

Signout Using the Specimens Command Button (Microsoft Word)

If you accessed the Signout Report window through the **Specimens** command button, you can sign out the report by pressing **Sign Out**. The Enter Password window appears.

NOTE: This action is not available for the Consult Review activity.

To sign out the report, CoPathPlus will display your user ID. Beneath it, enter your password and press **OK**. This action will mark the case Final Complete, if not already done so, and change

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

its status to S/O (Signed Out). To cancel this action, press **Cancel**. The Signout pop-up window appears.

After you sign out a report, you return to the Select Specimen window from which you can choose another case or procedure/addendum to sign out.

Other Actions From the Signout Report Window (Microsoft Word)

In addition to signing out a report and editing diagnostic text, you can perform the following actions from Microsoft Word during Signout by pressing the corresponding button on the toolbar:

- ❓ (or select Co**P**ath, **H**elp on the menu bar) accesses guide on using Microsoft Word for Signout and Consult Review.

- 🔷 (or select Co**P**ath, **R**eturn to CoPath on the menu bar) prompts you to save any changes you made to the diagnostic text and returns you to the CoPathPlus window from which you accessed the report.

- 👣 (or select Co**P**ath, **G**o To Field on the menu bar) moves you to a different diagnostic text field. A list of text fields appears for selection.

  Select the text field you want to edit and press **Go to Field**. A text field is flagged as ***hidden*** if the report is set up to suppress that field and its heading when no text has been entered for that field. (This feature, known as "skip logic," is discussed in more detail in the "Patient Report Painting" section of the *Cerner CoPathPlus Tools Training Manual.*) To enter text for a hidden field, select that field and press **Enable**. A heading for that text field appears on the report so that you can enter text.

- ⬇ (or select Co**P**ath, Go To Ne**x**t Field on the menu bar) moves you to the next editable diagnostic text field.

- ⬆ (or select Co**P**ath, Go To **P**revious Field on the menu bar) moves you to the previous editable diagnostic text field.

- 📋 (or select Co**P**ath, **I**nsert Parts on the menu bar) inserts part type designators and descriptions, as well as any associated Quick Text. For more information, refer to "Inserting Part Descriptions".

- 🏃 (or select Co**P**ath, **Q**uick Text on the menu bar) inserts Quick Text. For more information, refer to "Using Quick Text".

- 🔲 (or select Co**P**ath, Sho**w** or Hide Standard Toolbars on the menu bar) shows or hides the standard Microsoft Word toolbars and ruler.

- **E**d**it Specimen button.** Click this button to edit specimen information. For more information, refer to "Editing Report Information".

- **More… button.** Click this button to view related and sometimes critical information for the specimen that may not appear on the patient report. The More window appears. This window displays additional information not normally printed on the patient report, such as SNOMED, ICD-9-CM, and fee codes, and stain/processes.

The More window is a TxText-based window. Use the arrow keys at the lower, right of the window to move from page to page and the scroll bars to move within each page. The current page number and total number of pages are displayed at the bottom, right of the window. You can use the Zoom field to make the display larger or smaller.

To return to the Signout Report window, press **Report**. To edit specimen information, press **Edit Specimen**. For more information, refer to "Editing Report Information". To print this information, press **Print/Send**. For more information about printing, refer to "Print". Press **View Text** to view the text fields of the report (see description below).

- **Skip to Next button.** Use this button to skip a case that you do not want to sign out or review. This button is only available if the activity was accessed via the **Worklists** command button.

  NOTE: Cytology cases cannot utilize the **Skip to Next** button functionality because of Cytology's unique sign out process.

- **View Text button.** Click this button to view (as read-only) the various text fields of the patient report (e.g., Clinical History, Gross Description, Final Diagnosis).

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
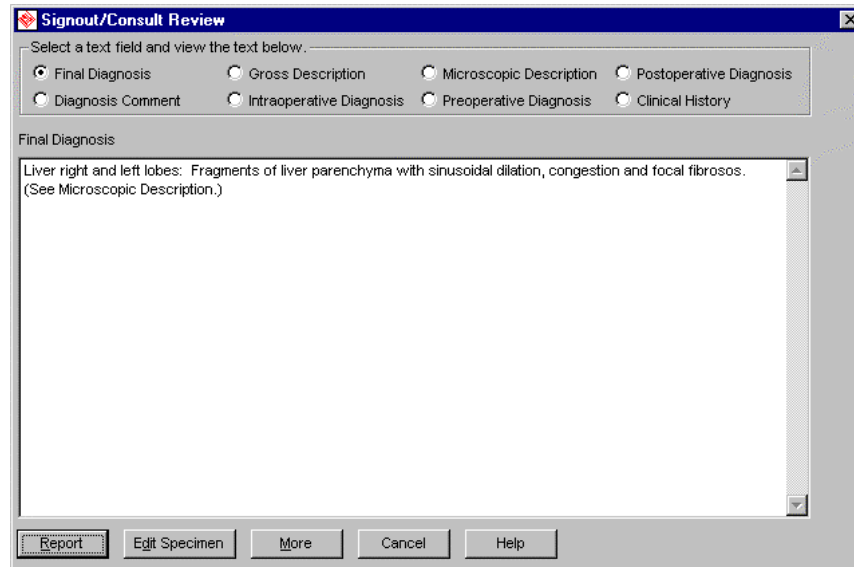
Select the desired field at the top of the window, and the text of that field will appear in the display area. To return to the Signout Report window, press **Report**. To edit specimen information, press **Edit Specimen**. To view related information for the specimen that may not appear on the patient report, press **More**.

- **Addl Trans button.** Click this button to take the specimen off the current worklist and send it to the Additional Transcription worklist. This action also removes the Final Complete status for this specimen or procedure/addendum. For more information, refer to "Additional Transcription Worklist".

  After you press **Addl Trans**, the Additional Transcription Required pop-up window appears.

  The **Send to** field is disabled. You can enter a special comment in the **Memo** field (e.g., the reason why additional transcription is needed) and, if necessary, place the case or procedure/addendum on hold by selecting the **On Hold** check box. Press **OK** to send the report.

  After you complete the information on this pop-up window, either the report for the next specimen on the worklist appears, or the Select Specimen or Select Specimen from Worklist window appears.

  If you press **Cancel** on the Additional Transcription Required pop-up window, the Signout pop-up window appears.

- **To Path button.** Click this button to remove the specimen or procedure/addendum from its current worklist, and then place it on the Pathologist Signout worklist for another pathologist so that it can be signed out by another pathologist instead. After you press **To Path**, the Send To Other Pathologist for Signout pop-up window appears.

  NOTE: In the Consult Review activity, this button is named **To Primary**, and the pop-up window which appears is labeled **Send To Primary Pathologist**.

  The specimen or procedure/addendum's primary pathologist appears as the default in the **Send to** field, but can be edited. You can enter a special comment in the **Memo** field (e.g., the reason you are forwarding it to another pathologist for signout), and, if necessary, place the case or procedure/addendum on hold by selecting the **On Hold** check box. Press **OK** to send the report.

  After you complete the information on this pop-up window, either the report for the next specimen on the worklist appears, or the Select Specimen or Select Specimen from Worklist window appears.

  If you press **Cancel** on the Send to Other Pathologist for Signout pop-up window, the Signout pop-up window appears.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- (or select CoPath, Cancel on the menu bar) cancels any changes you made to diagnostic text fields and returns you to the CoPathPlus window from which you accessed the report.

Signout Pop-Up Window

During the Signout (Electronic) and Consult Review activities, pressing **Cancel** from the Enter Password, Additional Transcription, Send to Other Pathologist for Signout, or Send to Primary Pathologist pop-up windows accesses the Signout pop-up window.
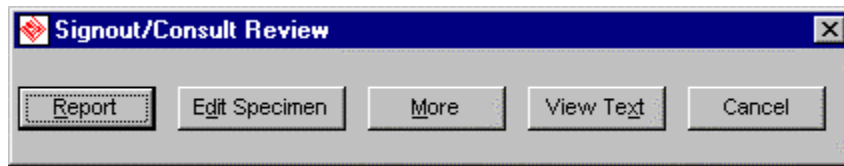
Select your next action by pressing one of the following buttons:

- **Report button.** Returns you to Microsoft Word in Edit Report mode for the Final or Procedure/Addendum report. You can sign out the report from this window. For more information, refer to "Navigating Within the Signout Report Window (Microsoft Word)".

- **Edit Specimen button.** Lets you edit specimen data. For more information, refer to "Editing Report Information".

- **More button.** Lets you view related and sometimes critical information for the specimen that may not appear on the patient report.

- **View Text button.** Lets you view (as read-only) the various text fields of the patient report.

    NOTE: The **More** and **View Text** windows are described in Other Actions From the Signout Report Window (Microsoft Word).

- **Cancel button.** Lets you exit this pop-up window and return to the CoPathPlus window from which you accessed the report.

Using TxText for Signout and Consult Review

NOTE: If you are viewing a Patient report via the Patient Report Single Print activity (using TxText as the CoPathPlus text editor), refer to "Using TxText to View Patient Reports".

NOTE: TxText is the CoPathPlus Text Editor that was previously referred to as "Visual Writer" or "VW".

After you select a report to sign out, the Signout Report window for the report you selected appears.

NOTE: Your system may look different depending on the modifications made by your site. Your site determines during implementation if it wants to have the Signout (Electronic) activity access the Edit Specimen window prior to the Signout Report window. For more information, refer to "Editing Report Information".

When accessed via the Consult Review activity, this window does not include the following: User ID and Password fields, **Sign Out** button, **To Path** button. An additional **To Primary** button will appear.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Navigating Within the Signout Report Window (TxText)

There are a number of actions you can perform while on the Signout Report window. You can move from page to page in the report by using the arrow buttons to the lower, right of the display. You can press:

- ⏮ to move to the first page of the report.

- ◀ to move to the previous page of the report.

- ▶ to move to the next page of the report.

- ⏭ to move to the last page of the report.

Signout Using the Worklists Command Button (TxText)

If you accessed the Signout Report window through the **Worklists** command button, you can sign out the report by typing or verifying your ID in the User ID field and your password in the Password field and then pressing **Sign Out**. This action will mark the case Final Complete, if not already done so, and change its status to S/O (Signed Out).

NOTE: This action is not available for the Consult Review activity.

For a specimen or procedure/addendum, if you have:

- Selected the AutoNext check box, the next specimen or procedure/addendum from the selected worklist appears so you can continue signing out cases. From this point on, you can quickly sign out subsequent cases without having to return to the Select Specimen from Worklist window and select the next report. If you come to a case that you do not want to sign out, press the **Skip to Next** button.

   NOTE: Your site determines during implementation whether the AutoNext check box is selected by default. Also, **Skip to Next** is unavailable once you edit specimen information during signout.

   Cytology cases cannot utilize the **Skip to Next** button/AutoNext check box functionality because of Cytology's unique signout process.

- Not selected the AutoNext check box, the Select Specimen from Worklist window appears, from which you can choose another specimen (case) or procedure/addendum.

NOTE: When signing out multiple reports, your entry in the Person Dictionary determines whether you are required to enter your password to sign out each report or whether you need to only enter your password for the first report you sign out.

Signout Using the Specimens Command Button (TxText)

If you accessed the Signout Report window through the **Specimens** command button, you can sign out the report by typing your ID in the User ID field (if User ID is required by your site) and your password in the Password field and then pressing **Sign Out**. This action will mark the case Final Complete, if not already done so, and change its status to S/O (Signed Out). You then return to the Select Specimen window, from which you can choose another specimen (case) or procedure/addendum.

NOTE: This action is not available for the Consult Review activity.

Other Actions From the Signout Report Window (TxText)

In addition to signing out a report, you can perform the following actions from the Signout Report window by pressing the corresponding button.

- **More… button.** Click this button to view related and sometimes critical information for the specimen that may not appear on the patient report. The More window appears. This window displays additional information not normally printed on the patient report, such as SNOMED, ICD-9-CM, and fee codes, and stain/processes.

  From the More window, you can perform all of the same actions as from the Signout Report window. To return to the Signout Report window, press **Report**.

- **Edit button.** Click this button to edit specimen information. For more information, refer to "Editing Report Information".

- **To Path button.** Click this button to remove the specimen or procedure/addendum from its current worklist, and then place it on the Pathologist Signout worklist for another pathologist so that it can be signed out by another pathologist instead. After you press **To Path**, the Send To Other Pathologist for Signout pop-up window appears.

  NOTE: In the Consult Review activity, this button is named **To Primary**, and the pop-up window which appears is labeled **Send To Primary Pathologist**.

  The specimen or procedure/addendum's primary pathologist appears as the default in the **Send to** field, but can be edited. You can enter a special comment in the **Memo** field (e.g., the reason you are forwarding it to another pathologist for signout), and, if necessary, place the case or procedure/addendum on hold by selecting the **On Hold** check box. Press **OK** to send the report.

  After you complete the information on this pop-up window, either the report for the next specimen on the worklist appears, or the Select Specimen or Select Specimen from Worklist window appears.

- **Addl Trans button.** Click this button to take the specimen off the current worklist and send it to the Additional Transcription worklist. This action also removes the Final Complete status for this specimen or procedure/addendum. For more information, refer to "Additional Transcription Worklist".

  After you press **Addl Trans**, the Additional Transcription Required pop-up window appears.

  The **Send to** field is disabled. You can enter a special comment in the **Memo** field (e.g., the reason why additional transcription is needed) and, if necessary, place the case or procedure/addendum on hold by selecting the **On Hold** check box. Press **OK** to send the report.

  After you complete the information on this pop-up window, either the report for the next specimen on the worklist appears, or the Select Specimen or Select Specimen from Worklist window appears.

- **Skip to Next button.** Use this button to skip a case that you do not want to sign out or review. This button is only available if the activity was accessed via the **Worklists** command button.

  NOTE: Cytology cases cannot utilize the **Skip to Next** button because of Cytology's unique sign out process.

- **AutoNext check box**. This field only appears when the Signout (Electronic) activity is accessed from the **Worklists** command button. Select this check box if you want to automatically select the next case or procedure/addendum on the worklists for signout or review.

  NOTE: Cytology cases cannot utilize the AutoNext check box because of Cytology's unique signout process. Also, your site determines during implementation whether this check box is selected by default.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- **Print/Send button.** Click this button to print the report or transmit it to a site via fax. For more information, refer to "Print".

Editing Report Information

You can press **Edit Specimen** (Microsoft Word) or **Edit** (TxText) on the Signout Report window to edit specimen information on the Final report or Procedure/Addendum report. The Signout (Electronic) window appears. In the standard export version of CoPathPlus, the tabs and fields that appear on the Signout (Electronic) window vary depending on the report type and the specimen class.

- To edit information for a Final report, refer to "Editing Final Report Data".

- To edit information for a Procedure/Addendum report, refer to "Editing Procedure/Addendum Report Data". Note that you should also use these instructions to edit data for a procedure-only specimen classes.

Editing Final Report Data

In the standard export version of CoPathPlus, the Signout (Electronic) window for a Final Report contains the following tabs:

- Diagnosis, which lets you to view and edit diagnostic text field information, and view events and amendments associated with the specimen.

- Billing/Misc, lets you edit part type and billing data, including ICD-9-CM codes and fee codes.

  NOTE: You will not see this tab for Autopsy specimens.

- Autopsy, lets you edit part type and autopsy data, including culture information.

  NOTE: You will see this tab only for Autopsy specimens.

- SNOMED, displays the Final Diagnosis and associated SNOMED codes for this case, and lets you automatically code the case using the Automatic SNOMED II Coder.

- QA, lets you to enter QA diagnosis comparison information for this specimen and identify the QA Reviewer(s).

- Staff, lets you edit the pathologist(s) and additional physicians associated with the case, and view the current worklist information.

- **Attachments,** lets you select which specimen attachments will print on the Final Report and change the print sequence of attachments within an attachment type.

  NOTE: You will see this tab only for Surgical Routine, Bone Marrow Routine, and Autopsy specimen classes.

NOTE: Your system may look different depending on the modifications made by your site. Also, if you accessed the Signout (Electronic) activity from the **Worklists** command button with TxText as the CoPathPlus text editor, the **Skip to Next** button and AutoNext check box will no longer be displayed when you return to the Signout Report window after editing data.

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⬛ and ⬛) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Diagnosis Tab on the Signout (Electronic) Window for a Final Report

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Diagnosis tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press 🖎 on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press 📦 on the toolbar to return to CoPathPlus after you finish entering and editing text.

4) **Events button.** Select this button to view a detailed list of all events performed on the specimen, including: the event name, any report generated, the date/time of the occurrence, the initials of the staff who performed the action, and the affected report chute or worklist.

5) **Amendments button.** Select this button to view the Amendment List pop-up window that lists any amendments associated with the specimen or procedure/addendum. This button is disabled if no amendments exist.

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing ⊞ on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a **Save/View Report** button appears instead of a **Save/Sign Out** button. The **Save/View Report** button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

Billing/Misc Tab on the Signout (Electronic) Window for a Final Report

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Billing/Misc tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** The part type(s) specified during the accessioning process appear but can be edited.

2) **Description.** The part type description specified during the accessioning process appears but can be edited.

3) **Taken.** The date and time when the specimen was taken from the patient, as recorded during the accessioning process, appear but can be edited.

4) **Received.** The date and time when the specimen was received in the lab, as recorded during the accessioning process, appear but can be edited.

    NOTE: For certain specimen classes, an additional Label Text field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Text field in the Part Type Dictionary.

ICD-9-CM Code(s). For detailed information on the ICD-9-CM Code(s) field and dictionary linking, refer to "ICD-9-CM Code Linking" and the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **ICD-9-CM Code(s).** Any ICD-9-CM codes previously entered for this specimen appear but can be edited. ICD-9-CM codes represent diagnosis codes used in standard Medicare or insurance billing.

2) **Source.** The part or procedure to which the ICD-9-CM code is linked appears but can be edited. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM).

3) **Auto.** Displays the following:

   o **D** for ICD-9-CM codes entered through Quick Text links.

   o **L** for ICD-9-CM codes entered through Interpretation dictionary links.

   o Blank, when users have entered codes manually.

Specimen Data.

1) **Billing Number.** The billing number specified during the accessioning process appears but can be edited. This visit-specific number is required by some billing offices and corresponds to the patient's encounter number.

2) **Billing Type.** The billing type specified during the accessioning process appears but can be edited. For more information, refer to "Billing Type".

   NOTE: If you change the billing type and there are already unbilled fee codes for this specimen, all codes and prices that have not been manually overridden will be changed to match the new billing type when the fee codes are compiled into a batch. However, if you change the billing type after fee codes have been billed, you may need to manually credit old fee codes and enter new ones if any codes or prices are incorrect for the new billing type.

3) **Submitting Physician.** This field identifies the physician who ordered the current specimen. If you edit this value, you have the ability to choose the correct address for a clinician. For more information about this field, refer to "Copy To".

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** The fee code(s) entered for this specimen appear but can be edited.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** The part or procedure to which the fee code is linked appears but can be edited. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM).

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge. For more information, refer to "Entering a Credit".

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a <u>**Save/View Report**</u> button appears instead of a <u>**Save/Sign Out**</u> button. The <u>**Save/View Report**</u> button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

Autopsy Tab on the Signout (Electronic) Window for a Final Report

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Autopsy tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** The part type(s) specified during the accessioning process appear but can be edited.

2) **Description.** The part type description specified during the accessioning process appears but can be edited.

3) **Taken.** The date and time when the specimen was taken from the patient, as recorded during the accessioning process, appear but can be edited. This field is often not used for autopsy cases.

4) **Received.** The date and time when the specimen was received in the lab, as recorded during the accessioning process, appear but can be edited. This field is often not used for autopsy cases.

   NOTE: For certain specimen classes, an additional Label Text field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Text field in the Part Type Dictionary.

Autopsy Data. For detailed information on these fields, refer to "Entering Information on the Autopsy Tab on the Accession Entry/Edit Window for an Autopsy Anatomic/Neuro Specimen".

1) **Autopsy Date/Time.** Enter the date and time that the autopsy was performed.

2) **Priority.** Enter the priority for this specimen.

3) **Postmortem Hours.** The number of hours in this field represents the difference between the date and time of expiration (as entered on the Patient Registration window) and the date and time of the autopsy. This automatically calculated field cannot be edited.

4) **Submitting Phys.** Enter the physician who ordered the autopsy.

5) **Reason for Autopsy.** Enter the reason that this autopsy is being conducted.

6) **Gestational Age/Weeks.** Use this field for stillborn or prenatal autopsies only. Enter the age of the deceased in weeks (a number with up to one decimal place; e.g., 28, 3.1, 56.5).

7) **Authorized By.** Enter the name of the person who authorized this autopsy. This is a free-text field.

8) **Relationship to Deceased.** Enter the relationship of the person who authorized the autopsy to the deceased. This is a free-text field.

9) **Autopsy Restrictions.** Select any restriction for this autopsy.

10) **Restrictions Comment.** Enter any additional information concerning the restrictions specified above for this autopsy. This is a free-text field.

11) **Medical Examiner.** Enter the name of the Medical Examiner who examined the deceased. This is a free-text field.

Other Data.

1) **Retrieval Flags button.** Click this button to open the Retrieval Flags pop-up window, which lets you identify the retrieval flag or flags in which you want to place the current specimen.

2) **Cultures button.** Click this button to open the Cultures pop-up window, which lets you record and note the results of any cultures performed on the current case.

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing [icon] on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a **Save/View Report** button appears instead of a **Save/Sign Out** button. The **Save/View Report** button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

SNOMED Tab on the Signout (Electronic) Window for a Final Report

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED tab:

Final Display. The SNOMED tab shows a display-only field that contains the Final Diagnosis entered in that text field. To automatically code the Final Diagnosis, press **Autocode**. CoPathPlus will fill in the SNOMED code-related fields on this tab, as described below.

NOTE: The Automatic SNOMED II Coder is available for SNOMED II codes only. If your site is using SNOMED International codes, you will have to enter your SNOMED codes manually.

Edit Text button. Click this button to edit diagnostic text fields, including the Final Diagnosis. This button does not appear for sites using TxText as the CoPathPlus text editor. For more information about how to use this button, refer to "Using Microsoft Word to Edit Diagnostic Text Fields".

SNOMED. To learn more about the SNOMED code-related fields on this tab and how to use the Automatic SNOMED II Coder, refer to "Using the Automatic SNOMED II Coder".

1) **SNOMED Codes.** Any SNOMED codes that were entered manually or using the Automatic SNOMED II Coder appear but can be edited. To learn more about SNOMED codes, refer to "SNOMED Codes "

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

o Blank, when users have entered codes manually or edited ones entered by the Automatic SNOMED II Coder or through dictionary links.

4) **Words not used by Coder.** If the Automatic SNOMED II Coder found words that it did not recognize, they appear in this display.

a) Review these words to ensure proper spelling and syntax.

b) If any words are misspelled, go to the Diagnosis tab and fix the misspelled words.

c) Then return to the SNOMED tab and press **Autocode** again to re-code the Final Diagnosis.

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing ▣ on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a **Save/View Report** button appears instead of a **Save/Sign Out** button. The **Save/View Report** button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

QA Tab on the Signout (Electronic) Window for a Final Report

Enter the following information on the QA tab:

QA Data. A summary of all scheduled reviews for this specimen appears. Press **Next** or **Previous** to change the selected review. The fields at the bottom of the screen display data associated with the selected review. To add a new review, press **Add**. For more information about QA reviews and the fields on this tab, refer to "QA Diagnosis Review".

QA Review Type. Enter the QA review type. All available QA review types are defined in the QA Review Type dictionary. For more information, refer to "QA Review Type Dictionary" in the "Quality Assurance Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Review Date. Enter the QA review date. For new reviews, today's date and time appear as the default.

Status. Enter the status of the QA review. The default is **Pending**.

Problem check box. To flag the review as a problem, select the Problem check box. This flag is used for management reporting purposes.

Reviewer(s). Enter the reviewer for this QA review. If your user ID and password identify you as a cytotech, pathologist, resident, or fellow, and this type of QA review is defined to pull in the current user as the default reviewer, your name appears as the default in this field.

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing ▣ on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a <u>Save/View Report</u> button appears instead of a <u>Save/Sign Out</u> button. The <u>Save/View Report</u> button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

Staff Tab on the Signout (Electronic) Window for a Final Report

Enter the following information on the Staff tab:

For more information about the fields on this tab, refer to "Staff".

Pathologists. Select the name(s) of the case pathologist(s) associated with this specimen.

Intraoperative Consult Pathologist(s). Select the name(s) of the intraoperative consult pathologist(s), if any, associated with this specimen.

NOTE: The Intraoperative Consult Pathologist(s) field does not display for Autopsy specimens.

Gross Pathologist(s). Select the name(s) of the gross pathologist(s), if any, associated with this specimen.

NOTE: During the CoPathPlus implementation process, the Gross Pathologist(s) field may have been renamed "Prosector(s)," a common designation.

Additional Physician(s). Identify other clinician(s) related to this case. You can change the physicians that appear or add new ones. For more information about this field, refer to "Copy To".

Current Worklist. If the specimen is on a worklist, the name of the worklist and the person responsible for the case are displayed.

<u>Save/Sign Out</u> **button.** Click this button to save the current data and sign out the report. You can also save the current data by pressing 🖫 on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a <u>Save/View Report</u> button appears instead of a <u>Save/Sign Out</u> button. The <u>Save/View Report</u> button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

Attachments Tab on the Signout (Electronic) Window for a Final Report

NOTE: You will see this tab only for Surgical Routine, Bone Marrow Routine, and Autopsy specimen classes.

Enter the following information on the Attachments tab:

For more information about linking attachments to a specimen and printing attachments on patient reports, refer to "Attachments Entry/Edit".

Selected Images for Final Report. Lists, by attachment type, all attachments selected to print on the Final Report. To remove an attachment from the report, highlight the attachment and press <u>Remove</u>. To remove all attachments from the report, press <u>Remove All</u>.

To change the print sequence of attachments within an attachment type, use the mouse to click and drag the attachment's sequence number (i.e., the number to the left of the attachment title) to the desired position.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

NOTE: You cannot use this tab to change the sequence in which the attachment types print on the Final Report. This sequence is based on how your site's patient reports are set up. For information about how to customize patient reports, refer to "Patient Report Painter" in the *Cerner CoPathPlus Tools Online Guide*.

Available Images. Lists all attachments associated with this specimen that have not been selected to print on the Final Report. To print an attachment on the Final Report, highlight it and press **Add**. To print all attachments on the Final Report, press **Add All**.

To save your edits to the specimen and return to the Signout Report window, go to any other tab on this window and press **Save/Sign Out.** You can also save the current data by pressing ![save] on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

Editing Procedure/Addendum Report Data

In the standard export version of CoPathPlus, the Signout (Electronic) window for a Procedure/Addendum report contains the following tabs:

- Diagnosis, lets you to view and edit diagnostic text field information for the procedure, addendum or specimen, view events for the case, and view amendments associated with the procedure, addendum, or specimen. For procedures and addenda, and you can also view Final Diagnosis data for the entire case.

- Billing/Misc, lets you edit part type and billing data, including ICD-9-CM codes and fee codes.

- SNOMED, displays the Procedure Interpretation, Addendum Diagnosis, or specimen Final Diagnosis, and lets you manually edit the SNOMED codes associated with the case.

- QA, lets you to enter QA diagnosis comparison information for this procedure, addendum, or specimen and identify the QA Reviewer(s).

- Staff, lets you edit the procedure pathologist(s) and additional physicians associated with the case, and view the case pathologists and current worklist information.

- **Attachments,** lets you select which specimen attachments will print on the Procedure/Addendum Report and change the print sequence of attachments within an attachment type.

  NOTE: You will see this tab only for Surgical Routine, Bone Marrow Routine, and Autopsy specimen classes.

NOTE: Your system may look different depending on the modifications made by your site. Also, if you accessed the Signout (Electronic) activity from the **Worklists** command button with TxText as the CoPathPlus text editor, the **Skip to Next** button and AutoNext check box will no longer be displayed when you return to the Signout Report window after editing data.

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ![button] and ![dropdown]) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Diagnosis Tab on the Signout (Electronic) Window for Procedures/Addenda

NOTE: Your system may look different depending on the modifications made by your site. For sites using TxText as the CoPathPlus text editor, you will see several formatting fields and buttons instead of the **Edit Text** button. These fields and buttons are described in Using TxText to Edit Diagnostic Text Fields,.

Enter the following information on the Diagnosis tab:

NOTE: An asterisk (*) after the name of the text field indicates that information has been entered in that field. If you do not see an asterisk, no information has been entered for that field. The area below the **Edit Text** button displays diagnostic text (without RTF formatting) for whichever text field is currently selected.

1) Press **Edit Text** (or press on the toolbar, or select Options, Edit Text on the menu bar). The diagnostic text field headings and text appear in a Microsoft Word document. The text fields vary depending on the specimen class you are working with.

2) Enter or edit the information for each diagnostic text field under the heading for that field. To learn about entering text in CoPathPlus text fields, including inserting part designations and descriptions, and Quick Text, refer to "Entering Information in Diagnostic Text Fields".

3) Press on the toolbar to return to CoPathPlus after you finish entering and editing text.

4) **Events button.** Select this button to view a detailed list of all events performed on the specimen, including: the event name, any report generated, the date/time of the occurrence, the initials of the staff who performed the action, and the affected report chute or worklist.

   Refer to "Editing Information on the Diagnosis Tab on the Signout (Electronic) Window for a Final Report" to see an example of the Events pop-up window.

5) **Amendments button.** Select this button to view the Amendment List pop-up window, that lists any amendments associated with the specimen or procedure/addendum. This button is disabled if no amendments exist.

   Refer to "Editing Information on the Diagnosis Tab on the Signout (Electronic) Window for a Final Report" to see an example of the Amendment List pop-up window.

6) **Final Diagnosis button.** Select this button to view the final diagnosis, if present, for the entire case. The Final Diagnosis pop-up window is for display only and cannot be edited. For sites using TxText as the CoPathPlus text editor, this button is disabled when a Final Diagnosis has not been entered for the case and when the case is for a Procedure-Only specimen.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a **Save/View Report** button appears instead of a **Save/Sign Out** button. The **Save/View Report** button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

Billing/Misc Tab on the Signout (Electronic) Window for Procedures/Addenda

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Billing/Misc tab:

Part Type(s). For detailed information on the part type fields, refer to "Part Type(s)".

1) **Part Type(s).** The part type(s) specified during the accessioning process appear but can be edited.

2) **Description.** The part type description specified during the accessioning process appears but can be edited.

3) **Taken.** The date and time when the specimen was taken from the patient, as recorded during the accessioning process, appear but can be edited.

4) **Received.** The date and time when the specimen was received in the lab, as recorded during the accessioning process, appear but can be edited.

   NOTE: For certain specimen classes, an additional Label Text field may appear after the Part's Date/Time Received field. Enter the text to print on a container label for this part type. A default can appear based on the Label Text field in the Part Type Dictionary.

ICD-9-CM Code(s). For detailed information on the ICD-9-CM Code(s) field and dictionary linking, refer to "ICD-9-CM Code Linking" and the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

1) **ICD-9-CM Code(s).** Any ICD-9-CM codes previously entered for this specimen appear but can be edited. ICD-9-CM codes represent diagnosis codes used in standard Medicare or insurance billing.

2) **Source.** The part or procedure to which the ICD-9-CM code is linked appears but can be edited. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM).

3) **Auto.** Displays the following:

   o **D** for ICD-9-CM codes entered through Quick Text links.

   o **L** for ICD-9-CM codes entered through Interpretation dictionary links.

   o Blank, when users have entered codes manually.

Specimen Data.

1) **Billing Number.** The billing number specified during the accessioning process appears but can be edited. This visit-specific number is required by some billing offices and corresponds to the patient's encounter number.

2) **Billing Type.** The billing type specified during the accessioning process appears but can be edited. For more information, refer to "Billing Type".

   NOTE: If you change the billing type and there are already unbilled fee codes for this specimen, all codes and prices that have not been manually overridden will be changed to match the new billing type when the fee codes are compiled into a batch. However, if you change the billing type after fee codes have been billed, you may need to manually credit old fee codes and enter new ones if any codes or prices are incorrect for the new billing type.

3) **Submitting Physician.** This field identifies the physician who ordered the current specimen. If you edit this value, you have the ability to choose the correct address for a clinician. For more information about this field, refer to "Copy To".

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** The fee code(s) entered for this specimen appear but can be edited.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** The part or procedure to which the fee code is linked appears but can be edited. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). If your lab uses the Pathology Role for Charges feature, entry of Procedure abbreviations in this field is important so that the proper pathologist role to can be assigned on billing interface transactions.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge. For more information, refer to "Entering a Credit".

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing on the toolbar. For more information about signing

out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a **Save/View Report** button appears instead of a **Save/Sign Out** button. The **Save/View Report** button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

SNOMED Tab on the Signout (Electronic) Window for Procedures/Addenda

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the SNOMED tab:

Interpretation/Addendum Diagnosis. A display-only field that shows the procedure interpretation or addendum diagnosis.

SNOMED. To learn more about SNOMED codes, refer to "SNOMED Codes".

1) **SNOMED Codes.** All SNOMED codes previously entered for this specimen appear and can be edited.

2) **Source.** Represents the part designator or procedure/addendum abbreviation to which the SNOMED code is linked.

3) **Auto.** Displays the following:

   o **A** for SNOMED codes entered through the Automatic SNOMED II Coder.

   o **L** for SNOMED codes entered through dictionary links.

   o Blank, when users have entered codes manually or edited ones entered by the Automatic SNOMED II Coder or through dictionary links.

Save/Sign Out button. Click this button to save the current data and sign out the report. You can also save the current data by pressing ![save icon] on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a **Save/View Report** button appears instead of a **Save/Sign Out** button. The **Save/View Report** button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

QA Tab on the Signout (Electronic) Window for Procedures/Addenda

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the QA tab:

QA Data. A summary of all scheduled reviews for this procedure/addendum appears. Press **Next** or **Previous** to change the selected review. The fields at the bottom of the screen display data associated with the selected review. To add a new review, press **Add**. For more information about QA reviews and the fields on this tab, refer to "QA Diagnosis Review".

QA Review Type. Enter the QA review type. All available QA review types are defined in the QA Review Type Dictionary. For more information, refer to "QA Review Type Dictionary" in

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

the "Quality Assurance Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Review Date. Enter the QA review date. For new reviews, today's date and time appear as the default.

Status. Enter the status of the QA review. The default is **Pending**.

Problem check box. To flag the review as a problem, select the Problem check box. This flag is used for management reporting purposes.

Reviewer(s). Enter the reviewer for this QA review. If your user ID and password identify you as a cytotech, pathologist, resident, or fellow, and this type of QA review is defined to pull in the current user as the default reviewer, your name appears as the default in this field.

<u>Save</u>/<u>Sign Out</u> button. Click this button to save the current data and sign out the report. You can also save the current data by pressing ⊞ on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a <u>Save</u>/<u>View Report</u> button appears instead of a <u>Save</u>/<u>Sign Out</u> button. The <u>Save</u>/<u>View Report</u> button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

Staff Tab on the Signout (Electronic) Window for Procedures/Addenda

Enter the following information on the Staff tab:

Procedure Pathologists. Enter the primary pathologist for the procedure or addendum and any additional pathologist(s) involved with the procedure or addendum. CoPathPlus assumes that the first pathologist in the list is the primary pathologist for this procedure or addendum.

Additional Physician(s). Identify other clinician(s) related to this case. You can change the physicians that appear or add new ones. For more information about this field, refer to "Copy To".

Case Pathologist(s). If a Primary and any consulting pathologist(s) have been assigned to the case as a whole, their names are displayed for reference. This information cannot be edited on this window.

Current Worklist. If the specimen is on a worklist, the name of the worklist and the person responsible for the case are displayed.

<u>Save</u>/<u>Sign Out</u> button. Click this button to save the current data and sign out the report. You can also save the current data by pressing ⊞ on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

NOTE: In the Consult Review activity, a <u>Save</u>/<u>View Report</u> button appears instead of a <u>Save</u>/<u>Sign Out</u> button. The <u>Save</u>/<u>View Report</u> button returns you to the Signout Report window where you can perform all the same actions as in the Signout (Electronic) activity, except for signing out the report.

AttachmentsTab on the Signout (Electronic) Window for Procedures/Addenda

NOTE: You will see this tab only for Surgical Routine, Surgical Bone Marrow, and Autopsy specimen classes.

Enter the following information on the Attachments tab:

For more information about linking attachments to a specimen and printing attachments on patient reports, refer to "Attachments Entry/Edit".

Selected Images for Final Report. Lists, by attachment type, all attachments selected to print on the Procedure/Addendum report. To remove an attachment from the report, highlight the attachment and press **Remove**. To remove all attachments from the report, press **Remove All**.

To change the print sequence of attachments within an attachment type, use the mouse to click and drag the attachment's sequence number (i.e., the number to the left of the attachment title) to the desired position.

NOTE: You cannot use this tab to change the sequence in which the attachment types print on the Procedure/Addendum Report. This sequence is based on how your site's patient reports are set up. For information about how to customize patient reports, refer to "Patient Report Painter" in the *Cerner CoPathPlus Tools Training Manual*.

Available Images. Lists all attachments associated with this specimen that have not been selected to print on the Procedure/Addendum report. To print an attachment on the Procedure/Addendum report, highlight it and press **Add**. To print all attachments on the Procedure/Addendum report, press **Add All**.

To save your edits to the specimen and return to the Signout Report window, go to any other tab on this window and press **Save/Sign Out.** You can also save the current data by pressing on the toolbar. For more information about signing out reports, refer to either "Using Microsoft Word for Signout and Consult Review" or "Using TxText for Signout and Consult Review".

Slides Send Out

This topic describes the Slides Send Out activity. You use Slides Send Out to record and track the sending out of slides and other materials for outside pathological consultation to confirm questionable diagnoses. Items sent out often include other cases for the patient as well as materials from the patient's current case in question.

The Slides Send Out activity gives you a way of keeping a record of all slides and materials sent off to other labs or offices and the return status of each. It also lets you enter additional relevant information about the current case, print a form letter to accompany the materials to be sent out (individually), and produce associated management reports (e.g., Slides Sent Out and Slides Sent Out/Not Returned).

NOTES:

- Slides can be sent out more than once.
- Specimens that have undergone Slides Send Out are not eligible to be moved via the Specimen Move function.

Accessing the Slides Send Out Activity

To access the Slides Send Out activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Slides Send Out** in the Activity field on that window.

4) Press **OK**. The Select Slides Send Out Item pop-up window appears.

TIP! You can also access the Slides Send Out activity by placing it in your Personal Menu and double-clicking on it from there.

Select Slides Send Out Item Window

The Select Slides Send Out Item pop-up window lists any existing Slides Send Out items (i.e., slides or other materials have already been sent out for this specimen) for the selected specimen. If the specimen does not have any existing items, you will see a message stating so.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.
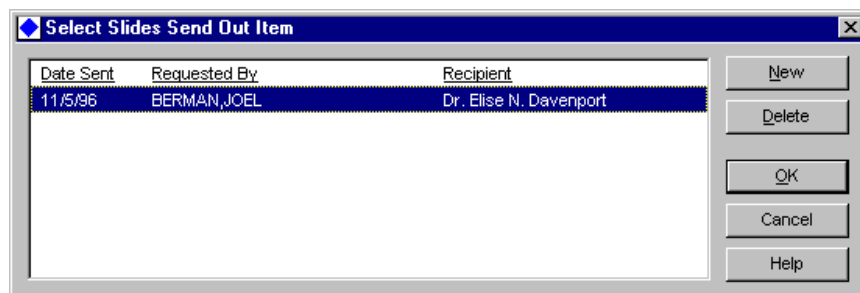
For all specimens sent off site, this window lists the date the slide(s) were sent, the person who authorized the send, and the person who received the materials. If the specimen is associated with another specimen that has already been sent out, a message appears at the bottom of the screen indicating that.

From this window, you can:

- **Order a new Slides Send Out Item** by pressing **New**. The Slides Send Out window appears on which you can specify the slides or materials being sent out. Continue with "Entering Information for a Slides Send Out Item".

- **Delete an existing Slides Send Out Item** by selecting the entry and pressing **Delete**. Refer to "Deleting or Removing Specimens".

  NOTE: You must have the proper access to delete a Slides Send Out Item. If you do not have the proper access, **Delete** will be disabled.

- **Edit information for an existing Slides Send Out Item** by selecting the entry and then pressing **OK** (or just double-clicking on the entry). The Slides Send Out window appears with the information that was previously entered for the item defaulted. Continue with "Entering Information for a Slides Send Out Item".

Deleting or Removing Specimens

You cannot delete or remove specimens from CoPathPlus if they have been selected for the Slides Send Out activity as a "master" or "other" specimen. You must delete the Slides Send Out Item before you can delete the specimen. For more information on deleting specimens, refer to "Specimen Move/Delete".

Entering Information for a Slides Send Out Item

When you choose to enter a new Slides Send Out Item or edit an existing one in the standard export version of CoPathPlus, the Slides Send Out window appears with the following tabs:

- Summary, which lets you enter the date on which the slide(s) were sent, the person who authorized the send, and the person who received the materials. You can also specify whether the materials need to be returned.

- Specimens, which lets you enter a description of the materials sent out.

- Returns, which lets you specify the return status of the item.

Summary Tab on the Slides Send Out Window

Enter the following information on the Summary tab:

Date Sent Out. Enter the date on which the materials were sent from your site. CoPathPlus uses this date to identify this item when performing a search for particular slides sent off site.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Requested By. Enter the name of the person who requested the current slide be sent out. You can enter a person's name in this field or select a person from a list of available choices in the Person dictionary.

Recipient Information. Enter the name, address, and telephone number of the person to which the material is going.

Return Status fields. Select from the slide return status options: Return is pending; Return is complete; or Material will not be returned. If you select "Return is pending," the Return by Date field becomes active so you can enter the date you expect the slides to be returned. The information you enter here is reflected in the Return Status fields on the Returns tab on this window and vice versa.

Reason. Select the reason that this slide is being sent out. This dictionary-linked field points to the Autopsy Reason dictionary. Refer to "Slide Send Out Reason Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on the Slide Send Out Reason dictionary.

Comment. Enter an optional free-text comment for this item.

To continue with the Slides Send Out process, refer to "Entering Information on the Specimens Tab on the Slides Send Out Window". If you are done entering Slides Send Out information, refer to "Next Step for the Slides Send Out Activity".

To learn about the other tab on this window, refer to "Entering Information on the Returns Tab on the Slides Send Out Window".

Specimens Tab on the Slides Send Out Window

Enter the following information on the Specimens tab:

 # specimen(s) selected for Send Out. This field lists the total number specimens selected for this Slides Send Out Item and each specimen number. When you create a new Slides Send Out Item, the current specimen is automatically shown as "selected for Send Out" and is designated the "Master Specimen".

1) **Material Description.** Enter a description of the material sent out for this case.

    If related slides or other material for the same patient is to be sent along with the Master Specimen, press **Add Specimen(s)**.

2) **Add Specimen(s) button.** Lets you enter additional specimens for the patient to the send out list using the Select Additional Specimen(s) for this Patient for Send Out window.

3) **Remove Specimen button.** Removes the highlighted specimen Slide Send Out Item.

Print Form Letter check box. Select this check box if you want to automatically generate a form letter to be sent along with the specimens. (If you are creating a new Slides Send Out Item, this box appears selected by default.) To view an example of this form letter, refer to "Sample Form Letter".

Save/Next Specimen button. Saves the information you have entered so far, prints a form letter for the current Slides Sent Out item if the Print Form Letter check box is selected, and presents you with the Select Specimen window on which you can access a new specimen for this activity.

Select Additional Specimen(s) for This Patient for Send Out Window

The Select Additional Specimen(s) for This Patient for Send Out pop-up window, which you access by pressing **Add Specimens** on the Specimens tab in the Slides Send Out window, lets you select additional specimens associated with the current case to send out. This window lists all the specimens for the current patient that have not already been selected for send out.
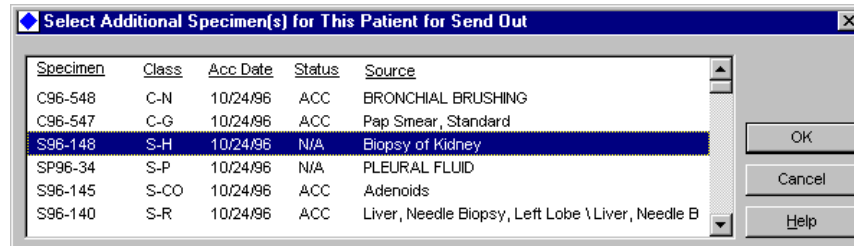
To select specimens for sending out, select each specimen and press **OK**. The selected specimens appear in the Specimen tab in the **# specimen(s) selected for Send Out** fields.

TIP! To select more than one specimen, hold down the Ctrl key and use the mouse to select each item in the list. When finished, press **OK**. All selected specimens appear on the Specimens tab.

Sample Form Letter

The following letter is an example of the form letter automatically generated by CoPathPlus if the Print Form Letter check box, on the Specimens tab on the Slides Send Out Activity window, is selected:

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

February 16, 2007

Dr. Elise Whitman
Biotech Pathology Labs
21100 Technology Way
Framingham, MA 01720

Dear Dr. Elise Whitman:
Enclosed are the pathology report(s) you have requested as well as the following:

    Patient Name: **Jackson,Samantha M.**

    S96-196   3 blocks part 1: right lung

    S96-210   1 block part 2: adenoids

A copy of your interpretation would be appreciated in order that we might complete our files.

If additional information is requested, please contact one of the secretaries at the Department of Pathology.

    Expected Date of Return: **03/30/2007**

Sincerely,

Department of Pathology
Dynamic Development Hospital
51 Sawyer Road
Waltham, MA 02154

Returns Tab on the Slides Send Out Window

Enter the following information on the Returns tab:

Return Status fields. Select from the slide return status options: Return is pending; Return is complete; or Material will not be returned. If you select "Return is pending," the Return by Date field becomes active so you can enter the date you expect the slides to be returned. The information you enter here is reflected in the Return Status fields on the Summary tab on this window and vice versa.

 # specimen(s) selected for Send Out. As on the Specimens tab, this field lists the specimens selected for this Slides Send Out item. "Master Specimen" indicates the current specimen (case).

1) **Material Description.** The description of the material send out displays on this field. Review this information to verify that all material has been returned. Then enter a date in the Return Date field.

2) **Return Date.** Enter the date the material was returned. You need to enter a return date for each entry in the Slides Send Out item.

A̲ll Materials Returned button. Lets you indicate that all specimens sent out are now returned. When you click this button, you are prompted to enter a return date that will apply to all specimens listed on this tab that do not already have return dates entered.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

<u>S</u>ave/Next Specimen **button.** Saves the information you have entered so far, prints a form letter for the current Slides Sent Out item if the Print Form Letter check box is selected, and presents you with the Select Specimen window on which you can access a new specimen for this activity. If you try to save a Slides Send Out item when the Return Status is marked complete and Return dates are not entered for all specimens sent, you receive a warning message prompting you to enter the return dates.

<u>Next Step for the Slides Send Out Activity</u>

Now that you have completed the information on the Slides Send Out window, you can perform any of the following actions:

- Save your current entries and continue entering slides send out data for another specimen by pressing <u>S</u>ave/Next Specimen on either the Specimens or Returns tab or on the toolbar (or select <u>F</u>ile, <u>O</u>pen Specimen on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Sa<u>m</u>e Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Op<u>t</u>ions, <u>A</u>ctivities on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select <u>F</u>ile, <u>C</u>lose Specimen on the menu bar). Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing on the toolbar (or selecting <u>F</u>ile, <u>M</u>anager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select <u>F</u>ile, E<u>x</u>it CoPath Client/Server on the menu bar). Press **<u>O</u>K**, when prompted, to sign off of CoPathPlus. Press **<u>Y</u>es**, when prompted, to save your edits to the current specimen.

Staff Entry/Edit

This topic details the Staff Entry/Edit activity in the standard export version of the CoPathPlus system.

The Staff Entry/Edit activity lets enter and edit the staff data associated with a specimen before it is signed out. You can also use this activity to send a case to or remove it from a worklist.

Accessing the Staff Entry/Edit Activity

To access the Staff Entry/Edit activity:

1) Press the **Specimens** command button on the CoPathPlus Application Manager.

    The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Staff Entry/Edit** in the Activity field on that window.

4) Press **OK**. The Staff Entry/Edit window for the specimen class associated with the specimen appears.

TIP! You can also access the Staff Entry/Edit activity by placing it in your Personal Menu and double-clicking on it from there.

Entering/Editing Staff Data

You can enter and edit staff data for all (Surgical, Cytology, Bone Marrow, Autopsy) specimen classes in the standard export version of the CoPathPlus system except for the Surgical Histology specimen class. To enter/edit staff data for a Surgical Histology specimen, you should use the Accession Entry/Edit or Histology Data Entry/Edit activity.

In the standard export version of CoPathPlus, the Staff Entry/Edit window contains one tab, the Staff tab, for all specimen classes.

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⬚ and ⬚) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Staff Tab on the Staff Entry/Edit Window

NOTE: Your site may look different depending on the modifications made by your site.

Enter the following information on the Staff tab:

Staff Information. Identify the pathologist(s) and cytotech(s) related to this case or change the values already in the staff-related fields. Note that which staff fields display and the order of these fields depend on which specimen class you are currently working with. For detailed information on these fields, refer to "Staff".

For the **Additional Physician(s)** field, the physician name(s) may default in from an ADT interface. Otherwise, you can identify other physician(s) related to this case or change the value already in the field. You have the ability to choose the correct address for a clinician. For information about this functionality for this field, refer to "Copy To".

Outside Institution. Enter the name and address of a physician or institution to which you want to send copies of reports. This is a free-text field.

Current Worklist. This area of the Staff Entry/Edit window shows you if a particular case is currently on a worklist. If it is, you will see the name of the worklist and to which the case is assigned, if anyone. If it is not, a "Not on a worklist" statement will appear. To learn more about worklists, refer to "Worklists".

Next Process. CoPathPlus displays these fields only for the Routine, Consult, Gynecological, Non-Gynecological, Fine Needle Aspirate, and all Autopsy specimen classes for the Staff Entry/Edit activity in the standard export version of the CoPathPlus system. The option button choices vary depending on the most appropriate next steps for the individual specimen class. Once you finish entering/editing information on the Staff Entry/Edit window, you can specify what action CoPathPlus should take next.

- **Option Buttons.** Select the appropriate option button for the current specimen. The buttons that appear at the top of the list allow you to send the case to a pathologist for signout or review, or to a resident or fellow, or to a cytotech, whichever may be appropriate for a particular specimen class. The following two buttons appear on all windows for Staff Entry/Edit window for all specimen classes:

  o **Remove Specimen From All Worklists.** Select this option button if you want to remove this specimen from all worklists that it might currently be on (shown in the Current Worklist field). For example, you would select this option button for a case that was mistakenly placed on a worklist.

  o **No Action.** Select this option button when you merely want to file the information you have entered so far and do not want to make any worklist changes.

- **Send to.** When you select an option button that will send a specimen to someone's worklist, you enable the Send to field. You can select or change the name in this field or accept the default, if any.

- **Memo.** If necessary, enter a special comment in this field (e.g., the reason why you may be placing a case on hold). This comment will appear with the case on the appropriate worklist.

- **On Hold.** If necessary, select this check box to place the specimen on hold, which only means that CoPathPlus will place it at the end of a worklist.

<u>Save/Next Specimen</u> **button.** Click this button if you want to save the current data and continue entering/editing staff information for another specimen. The Select Specimen window appears.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Next Step for the Staff Entry/Edit Activity

Now that you have completed the information on the Staff Entry/Edit window, you can perform one of the following actions:

- Save your current entries and continue entering/editing staff data for another specimen by pressing **Save/Next Specimen** on the Staff tab or on the toolbar (or select File, Open Specimen on the menu bar). If you press the button on the toolbar, you have to press **Yes**, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Same Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Options, Activities on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select File, Close Specimen on the menu bar). Press **Yes**, when prompted, to save your edits to the current specimen.

  NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Stain/Process and Block Edit

This topic details the Stain/Process and Block Edit activity in the standard export version of the CoPathPlus system.

The Stain/Process and Block Edit activity lets you review all histology information currently entered for a specimen (case), and then choose a part or block to order additional stains on. You can also use this activity to edit/add to other existing histology information (e.g., add new blocks, edit/delete/cancel existing blocks and stains).

This activity differs from the Histology Data Entry/Edit activity in that the first thing you see when you access the Stain/Process and Block activity is a summary of the stains/processes for the current specimen, from which you can then enter additional tests or edit histology block or stain/process information.

Accessing the Stain/Process and Block Edit Activity

To access the Stain/Process and Block Edit activity:

1) Press the _{Specimens} command button on the CoPathPlus Application Manager.

    The Select Specimen window appears.

2) Choose a specimen according to the procedure in Using the Select Specimen Window.

3) Select **Stain/Process and Block Edit** in the Activity field on that window.

4) Press **OK**. The Stain/Process and Block Edit window appears.

TIP! You can also access the Stain/Process and Block Edit activity within the Histology Functions folder found under the _{Tasks} command button or by placing it in your Personal Menu and double-clicking on it from there.

Entering/Editing Stain/Process and Block Data

You can edit/edit stain/process and block data for all specimen classes (i.e., Surgical, Cytology, Bone Marrow, Autopsy) in the standard export version of the CoPathPlus system, except for Cytology Gynecological. Typically, the Stain/Process and Block Edit activity is not valid for this specimen class.

The tab you see on the Stain/Process and Block Edit window when you access this activity is the same for all specimen classes. This activity has only one tab, Histology, which allows you to enter and edit stain/process and block data for a specimen.

Histology Tab on the Stain/Process and Block Edit Window

The report display on the Histology tab on the Stain/Process and Block Edit window is the same one you see when you access the Histology Summary pop-up window while you are in the Histology Data Entry/Edit activity. However, while the display on the Histology Summary pop-up window shows a static report, its counterpart on the Histology tab on the Stain/Process and

Block Edit window has interactive properties. When you click on a part, block, or stain/process on the display on the Histology tab, you enable the corresponding buttons on this tab that allow you to then enter or edit stain/process and block information for a specimen.

Enter the following information on the Histology tab (first click on a part, block, or stain/process on the display):

Add Stain/Process button and Edit Stain/Process button. Press either button to access the Stain/Process Entry/Edit pop-up window. Press the first button if you want to add or the second button if you want to edit one or more existing stains/processes for the selected part, block, or stain/process. Note that if you have selected a block, that block's designation will default into the Blk/Desig field for a new stain. If you have selected a part, the Blk/Desig field default is blank.

Add Block button and Edit Block button. Press either button to access the Block Entry/Edit pop-up window. Press the first button if you want to add or the second button if you want to edit one or more existing blocks for the selected part or block.

Staff/Billing button. Click this button to access the Staff/Billing pop-up window so that you can enter/edit gross pathologist, priority, and fee code data.

Save/Next Specimen button. Click this button if you want to save the current data and continue editing/entering stain/process and block information for another specimen. The Select Specimen window appears.

NOTE: If your site is set up to use the a cassette labeler or engraver, you may also see a **Save/Engrave…** button on this tab. Pressing the button causes the Request Cassette Labels pop-up window to appear, which lets you select the specific blocks to label. Refer to Requesting Cassette Labels for more information on engravers and labels.

Stain/Process Entry/Edit

The Stain/Process Entry/Edit pop-up window allows you to view the information originally entered through the Histology Data Entry/Edit activity for the current specimen and to edit the data or enter a new stain/process, as necessary. When you press **Add Stain/Process** on the Histology tab, CoPathPlus places your cursor in the next available empty row on the Stain/Process Entry/Edit pop-up window, ready for you to add a new item. When you press **Edit Stain/Process**, CoPathPlus places your cursor in the row for the stain/process you highlighted on the Histology tab.

Enter the following information on the Stain/Process Entry/Edit pop-up window:

Stain/Process. A default of **H&E,Initial** automatically appears for each block entered. If necessary, select additional stain(s)/process(es) to order for this part type. All available stains and processes are defined in the Stain/Process Dictionary. For more information about that dictionary, refer to "Stain/Process Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Blk/Desig (Block/Designator). Select the block for which to apply this stain or process. If there is only one block for this part type, that block appears as the default. If the stain or process applies to the entire part type, rather than just the block, leave this field blank.

Count. Enter the number of stains or processes to be performed on this part. The default count is **1**, or, if using a protocol, the number entered in the Protocol dictionary for the stain/process. You can edit the default if necessary.

Request Class. Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary. Request classes are used to categorize histology tests and the reason they were performed.

Ordered by. Enter the name of the Pathologist, Fellow, Resident, PA/Diener, or Cytotech who ordered this stain/process. In the standard export version of CoPathPlus, the default at this field is the user currently signed on to the system, unless that person has a person type of Unspecified. In that case, the name of the primary pathologist associated with the specimen (case) appears as the default.

Comment. Enter a free-text comment for this stain/process. A default comment can appear based on the histology protocol.

Stain/Process Detail button. Click this button to access the Stain/Process Detail pop-up window, which shows the details for each stain/process for this specimen. Refer to Stain/Process Detail for more information.

Run Stain/Process Group button. Click this button to load the selected stain/process group protocol for each part type. Once you Click this button, CoPathPlus displays the Run Stain/Process Group Protocol pop-up window. Select the protocol you want on this window and press **OK**. For more information on the different types of protocols available, refer to "Histology Protocols".

Save Stain/Process Group… button. Click this button to access the Save Protocol pop-up window. You use this window to enter the stain/process group protocol name and to save the stain/process group protocol information for this specimen. Refer to Save Protocol for more information.

NOTE: Only users with the appropriate permission will be able to enter and save protocols. If you do not have permission, the **Save Stain/Process Group…** button is disabled.

When you are done entering and editing stain/process information, press **OK**.

Block Entry/Edit

The Block Entry/Edit pop-up window allows you to view the information originally entered through the Histology Data Entry/Edit activity and to edit the data or enter a new block, as

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

necessary. When you press **Add Block** on the Histology tab, CoPathPlus places your cursor in the next available empty row on the Block Entry/Edit pop-up window, ready for you to add a new item. When you press **Edit Block**, CoPathPlus places your cursor in the row for the block you highlighted on the Histology tab.

Edit/enter the following information on the Block Entry/Edit pop-up window:

Blk/Desig (Block/Designator). Enter a unique, short designator for each block. If you run a protocol which includes block designator information, the value specified in the protocol appears as the default. The first character of the designator is generally either numeric or alphabetic, depending on the specimen class and the decisions made by your site during the CoPathPlus implementation process).

Pieces. Enter the number of pieces of tissue taken for the corresponding block/designator.

Block Category. Select a block category for this block. A block category identifies a certain group of blocks that are usually processed in a specific run of the tissue processor. A default block category may be defined for the histology protocol (in the Protocol Dictionary), for the part type (in the Part Type Dictionary), or for the specimen class (in the Specimen Class Dictionary).

Request Class. Identify the request class for this stain or process. A default request class can appear, based on either the protocol, or, if no protocol is specified, the specimen class. All possible request classes are defined in the Histo Request Class Dictionary. Request classes are used to categorize histology tests and the reason they were performed, and also to toggle billing for associated stains/processes.

Comment. Enter a free-text comment for this block. A default comment can appear based on the histology protocol run.

All Pieces Used check box. Select this check box if all pieces of tissue have been used for the selected part.

Block Detail button. Click this button to access the Block Detail pop-window, which shows the details for each block for this specimen. Refer to Block Detail for more information.

When you are done entering and editing block information, press **OK**.

Staff/Billing

The Staff/Billing pop-up window allows you to view the information originally entered in the Histology Data Entry/Edit activity and to edit or enter data, as necessary.

Edit/enter the following information on the Staff/Billing pop-up window:

Gross Pathologist(s). Select the name(s) of the gross pathologist(s) associated with this specimen. For detailed information on staff fields, refer to "Staff".

NOTE: During the CoPathPlus implementation process, this field may have been renamed as "Prosector(s)," a common designation.

Priority. Change or select the turnaround time priority for the specimen, or you can accept the value that may already have been entered.

Fee Code(s). For detailed information on these fields, refer to "Fee Code(s)".

1) **Fee Code(s).** CoPathPlus may have already defaulted in fee code data from stains/processes selected during normal histology data entry. Otherwise, you can change or select as many fee codes as are appropriate for the services performed on the specimen, if applicable.

2) **Units.** Enter a number that specifies how many times this fee code should be charged. The default is 1 or the stain/process slide count. This field is disabled for charges created from stain/process-derived dictionary links, or after a fee code has been billed or credited.

3) **Source.** Enter the part or procedure to which the fee code is linked if you manually entered fee codes. Parts are denoted by part designators (e.g., A, B, 1, 2). Procedures and addenda are denoted by corresponding abbreviations (e.g., ADD, EM). CoPathPlus completes this field automatically for linked fee codes.

4) **Credit.** A display-only field that contains an **X** if the fee code is a credit rather than a charge.

5) **Billed.** A display-only field that contains a **T** if just the technical component of the fee code has been billed, a **P** if just the professional component of the fee code has been billed, or an **X** if both components of the fee code have been billed.

6) **Auto.** A display-only field that contains an **X** if the fee code was entered automatically through a dictionary link, or is blank if it was entered manually.

When you are done entering and editing block information, press **OK**.

Next Step for the Stain/Process and Block Edit Activity

Now that you have completed the information on the Stain/Process and Block Edit window, you can perform one of the following actions:

- Save your current entries and continue editing/entering stain/process and block data for another specimen by pressing <u>**Save/Next Specimen**</u> on the Histology tab or on the toolbar (or select <u>F</u>ile, <u>O</u>pen Specimen on the menu bar). If you press the button on the toolbar, you have to press <u>**Yes**</u>, when prompted, to save your edits to the current specimen.

  TIP! You can access an existing specimen for the current patient by pressing **Sa<u>m</u>e Patient** on the Select Specimen window.

- Choose another activity to perform on the current specimen by pressing on the toolbar (or select Op<u>t</u>ions, <u>A</u>ctivities on the menu bar). Press <u>**Yes**</u>, when prompted, to save your edits to the current specimen. For information on the activity you selected, refer to the appropriate topic in this guide.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select <u>F</u>ile, <u>C</u>lose Specimen on the menu bar). Press <u>**Yes**</u>, when prompted, to save your edits to the current specimen.

NOTE: Pressing on the toolbar (or selecting File, Manager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPath Client/Server on the menu bar). Press **OK**, when prompted, to sign off of CoPathPlus. Press **Yes**, when prompted, to save your edits to the current specimen.

Standing Orders Feature

Standing Orders Module

Standing orders are used to define an action the system should automatically take based upon a pre-defined set of circumstances. This configuration is set up in the Standing Orders Dictionary. Two types of actions are available; they may be activated separately or both actions can be invoked together:

- An informational message can display in a modal pop-up window.

    o This message may or may not be defined to request user acknowledgment.

    o The Standing Order Message will continue to display either until the user acknowledges it via pressing the OK button, or when the activity associated to the message is exited.

    o If the message has already been acknowledged, it can be retrieved via the Popup Notes button in the CoPathPlus Toolbar.

    o If there is more than one message appropriate to the specimen and activity, all messages will be compiled into the same pop-up window.

    o When a specimen possessing both an identified physician and an identified client from the same Standing Order record occurs, just one message will be presented. This message can either start as "Based on the rule for xxx Clinic:" or "Based on the rule for xxx, xxxx", the message will reflect either the first condition to be made true (such as when a user enters data to the specimen), or the first condition recognized as true (when the already existing specimen is opened in an activity activated for message display.

    o Duplicate messages can be seen if they come from two different records in the Standing Order Dictionary.

    o The modal pop-up window will also display a warning when conflicting reflex rules are in effect. When this occurs, the client should determine if the reflex check should be activated and manually mark it.

- A specific reflex order can be set up to occur if later result interpretations warrant it. Reflex orders can be defined to either allow or disallow system users from being able to edit this reflex request designation once it is assigned.

It will be necessary to customize windows via the CoPathPlus Window Painter to enable Reflex Ordering functionality. Refer to the Customizer Manual for more information.

In addition to defining the type of action, the Standing Order Dictionary also serves to stipulate:

- CoPathPlus activities where the action (either the message or preliminary reflex order) takes place.

- Eligible specimen classes.

- Physicians eligible for this action.

- Clients eligible for this action.

- Reflex Ordering details including: whether the order is placed or not, if the user may manually modify the order designation, and the specific Reflex Testing record that is referenced. When the Order, Disable Field option is used, the system "grays out" the reflex check box once it has been selected for a specimen.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Chapter 5: Worklists

Overview

Worklists explains how to choose a specimen or procedure from a worklist so that you can perform a Cerner CoPathPlus activity.

The information contained in this guide is based on the standard export version of CoPathPlus. Because CoPathPlus is tailored during the implementation process to meet the needs of each site, it is possible that your system will not include fields or items described here. Your system may also have additional custom worklists that are not documented here.

Selecting a Specimen from a Worklist

CoPathPlus provides the ability for the System Manager to implement named lists of specimens or procedures that need a common activity performed on them, such as Signout (Electronic) or Cytology Results. These lists are called "Worklists".   CoPathPlus offers a variety of different worklists.

For an explanation of each worklist, refer to "Available Worklists".

Worklist Characteristics

Worklists can be generic (e.g., Cytology QC worklist) or they can be filtered to be person-specific (e.g., Dr. George Smith's surgical specimens to be signed out would be placed on the Primary Pathologist Signout worklist). A worklist in CoPathPlus is tied to a default activity, e.g., Signout (Electronic). However, if the reviewer has access to other specimen-related activities, he or she can switch activities. Refer to "Accessing Specimen-Related Activities" for more information. To learn about each CoPathPlus activity, e.g., Signout (Electronic), Cytology Results (Pathologist), Cytology Results (Cytotech), Final Diagnosis Entry/Edit), etc., refer to the correspondingly named topics in the "Specimens" section of this guide.

Note that if a specimen on a worklist is not appropriate for the defaulted or chosen activity, CoPathPlus will present an applicable error message. For example, if you are on the Pathologist Signout worklist (for which the default activity is Signout [Electronic]) but the first specimen (e.g., a Cytology Gynecological specimen) on the worklist is not appropriate for the activity, if you press **OK** CoPathPlus will present a "This activity is not valid for Cytology Gynecological specimens". In this case (after CoPathPlus returns you to the Select Specimen from Worklist window), select the appropriate activity for the specimen or select a specimen on the worklist that is appropriate for the activity chosen.

Accessing Worklists

To access worklists:

1) Press the **Worklists** command button on the CoPathPlus Application Manager.

   The Select Specimen from Worklist window appears and the Worklist Summary displays in this window.

2) Choose a worklist by highlighting the one you want from the Worklist Summary and double-clicking on it. Refer to "Using the Select Specimen from Worklist Window" for more information.

3) Press **OK**.

   NOTE: You can also access the Select Specimen from Worklist window in two other ways:

   By pressing Worklists… on the Select Specimen window. You access this window by pressing the Specimens command button on the CoPathPlus Application Manager.

By placing a specific worklist(s) in your Personal Menu and double-clicking on it from there. Placing a worklist on your personal menu will also allow you to stipulate a default worklist. I.e. when the personal menu item is selected, it can automatically retrieve a specific worklist rather than having the user select the desired worklist from the Worklist drop-down list. Refer to "Left Side of the Application Manager (Personal Menu) for more information on how to place activities and items in your Personal Menu.

Using the Select Specimen from Worklist Window

Besides presenting the Worklist Summary, CoPathPlus uses the Select Specimen from Worklist window to display the contents of a particular worklist from which you select an existing specimen or procedure/addendum on which to work.

If you want to:

- Refer to a description of each of the fields and buttons on this window, refer to "Select Specimen from Worklist Window Description".

- Obtain a list of specimens or procedures on a particular worklist, refer to "Selecting a Worklist and Specimen".

- Learn more about worklists, refer to "Worklists".

- Exit worklists to search for a particular specimen or to accession a new specimen, press **Spec. Lookup**. The Select Specimen window appears.

Select Specimen from Worklist Window Description

The Select Specimen from Worklist window contains the following fields and buttons:

- **Worklist field.** Contains a drop-down list of all the current worklists available in CoPathPlus. It also presents two other options: Worklist Summary and Pending Work.

- **Staff field.** Contains a drop-down list of all persons that currently have pending work on a worklist. When applicable, you can narrow down the list of specimens on a particular worklist by specifying the staff. This field is only available for person-specific worklists (e.g., Pathologist Signout) and will default to the name of the person logged on.

- **Select field.** Lists all the specimens or procedures on the worklist you chose. Report items from the same specimen number appear together based on priority (High Priority first), specimen number order, report instance order (with Final Report first). Information displayed includes specimen number, accession date, status, type of report, tissue source, staff, and patient name. The list also specifies any comments and whether the specimen is on hold (which only means that CoPathPlus places it at the end of a worklist).

  Unless you have customized your view, when you first access the Select Specimen from Worklist window you will see the Worklist Summary.

- **Activity field.** Contains a drop-down list of all the activities you can perform on the current specimen. The default activity for the worklist chosen appears here. To switch activities, tab to this field and press the Down Arrow key. For detailed information about each activity, refer to "Specimens".

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- **Search button.** Activates a search for worklist information. To activate a search, you must fill in the Worklist field.

- **Print button.** Lets you print the worklist that is presented on the window. For more information, refer to "Print".

- **Spec. Lookup button.** Lets you access the Select Specimen window to search for a particular specimen.

- **Filter… button**. Lets you define an additional set of search criteria to limit the number of choices presented to you. Refer to "Limiting Your Search" for more information.

- **Clear Filter button.** Removes any filter information for the current search. Note that pressing this button does not delete the data entered via the **Filter…** button; it just removes it for the current search. You can quickly turn on those filters on again by pressing the **Filter…** button and then pressing **OK**.

- **Sort... button.** Lets you change the way the specimens are sorted within the worklist display. The sort defaults to the standard sort order, per worklist, upon exiting the worklist and returning to the worklist option.

- **Quick S/O button.** Opens the Quick Signout window, which lets you view key diagnostic information on a patient report and sign out cases directly from that window without having to access the entire report or a data entry window (unless desired). Refer to "Using the Quick Signout Window" for more information.

  NOTE: The Quick S/O button is only visible if the system setting Enable Quick Signout is set to Yes and you have the "Quick Signout Access" miscellaneous permission. Also, the Pathologist Signout worklist is the only worklist that can access Quick Signout.

- **Remove button**. Allows users who have been granted Worklist Removal permission to remove inappropriate cases from the worklist. If an inappropriate case appears on the worklist, select the case and click this button. The system will prompt for verification. Press the Yes option to confirm case removal. An event of "Removed from Worklist" will be written to Event Details in Inquiry. This event will indicate the worklist, date/time of the removal, and the initials of the person who performed the removal.

Note: If a case gets inappropriately removed from a worklist, use the Staff Entry/Edit or other appropriate specimen activity to add it back.

Worklist Summary

When you first access the Select Specimen from Worklist window, the Worklist Summary automatically appears (unless you have customized your Worklist function).

This report shows a summary of items in all worklists that are assigned to the person currently signed on. If the person currently signed on is not of the appropriate person type or if he or she has no items on worklists, the summary displays for all users that currently have items on worklists. Notice also that the summary shows the number of high priority items and the number of items on hold per worklist. An asterisk (*) also appears to the left of the worklist name if the worklist contains any high priority items.

You can access the worklist you want from this summary by highlighting it and double-clicking on the worklist. The worklist you chose displays. You access the case or procedure/addendum you want by highlighting it on the worklist and double-clicking on it.

NOTE: You can access this Worklist Summary directly from the CoPathPlus Application Manager by placing it in your Personal Menu and even setting it to automatically launch every time you enter CoPathPlus. Refer to "Left Side of the Application Manager (Personal Menu) and "Customizing Your Personal Menu List" for more information on these capabilities.

Pending Work

You access the Pending Work report by selecting it in the Worklist field on the Select Specimen from Worklist window, making a selection in the Staff field, and pressing <u>Search</u>. This report displays all items in all worklists:

- That are assigned to the person selected in the Staff field (the user currently signed on will default if he or she is the appropriate person type), or

- Where the person selected in the Staff field is the Primary Pathologist on the case or procedure/addendum.

You access the case or procedure/addendum you want by highlighting it on the Pending Work report and double-clicking on it.

The order in which the worklists display on the Pending Work report is determined by your site and specified in the Worklist dictionary.

Selecting a Worklist and Specimen

To obtain a list of specimens or procedures currently on a specific worklist:

1) Select the name of the worklist in the Worklist field. Refer to "Available Worklists" for a description of the worklists provided with the standard CoPathPlus system.

   NOTE: If you chose a worklist from your Personal Menu, that worklist will default in this field.

2) If you choose a person-specific worklist, select the person (e.g., cytotech, pathologist, etc.) associated with the specimen or procedure you want in the Staff field. For more information, refer to "Limiting Your Search".

3) Press <u>Search</u> (or press Enter).

   A specimen or procedure or list of specimens or procedures that are on the specified worklist appears. An activity associated with the worklist you chose defaults in the Activity field. Refer to "Worklist Description" for an explanation of the information you see on this worklist.

   NOTE: You can override the default activity by selecting a different activity in the Activity field.

4) If CoPathPlus has found:

   o No specimens on the worklist, verify the information you entered is correct. You can press **Spec.** <u>Lookup</u> to search for the particular specimen you are interested in. The Select Specimen window appears.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

o **Only one specimen on the worklist**, press **OK**. The appropriate window for the activity that either defaulted in or that you entered in the Activity field on the Select Specimen from Worklist appears.

o **More than one specimen on the worklist,** select the specimen you want and press **OK**. The appropriate window for the activity that either defaulted in or that you entered in the Activity field on the Select Specimen from Worklist appears.

5) Press <u>**OK**</u>.

NOTE: If a specimen on a worklist is not appropriate for the defaulted or chosen activity, CoPathPlus will present an applicable error message. For example, if you are on the Pathologist Signout worklist (for which the default activity is Signout (Electronic)) but the first specimen (e.g., a Cytology Gynecological specimen) on the worklist is not appropriate for the activity, if you press OK CoPathPlus will present a "This activity is not valid for Cytology Gynecological specimens". In this case (after CoPathPlus returns you to the Select Specimen from Worklist window), select the appropriate activity for the specimen or select a specimen on the worklist that is appropriate for the activity chosen.

After you review a specimen or procedure on the worklist and complete the associated activity, you return to the Select Specimen from Worklist window. CoPathPlus:

- Checks off the item you reviewed, and

- Automatically highlights the next item for you to review.

NOTE: If you access the Signout (Electronic) activity through a worklist and select the AutoNext check box on the Signout Report window, you will automatically go to the next specimen on the worklist after completing your action (e.g., signing out the report) rather than returning to the Select Specimen from Worklist window. For more information about this activity, refer to "Signout (Electronic) and Consult Review".

NOTE: If you use the **Skip to <u>Next</u>** button on the Signout Report window of the Signout (Electronic) activity and the next specimen on the worklist is not appropriate for the this activity, CoPathPlus will present an applicable error message. For example, if a Cytology Gynecological specimen appears on a Pathologist Signout worklist while you are in the Signout (Electronic) activity, CoPathPlus will present "This activity is not valid for Cytology Gynecological specimens". In this case (after CoPathPlus returns you to the Select Specimen from Worklist window), select the appropriate activity for the specimen or select a specimen on the worklist that is appropriate for the activity chosen.

You can refresh (update) the list at any point by pressing <u>**Search**</u> again.

NOTE: Be aware that if you refresh the list, CoPathPlus removes any check marks that appeared on the list.

Limiting Your Search

You can limit the number of choices presented to you when you perform search for worklists. If you are looking at person-specific worklists, you can specify the staff whose specimens you want to see. You can also filter your search by specimen class, priority, those items on hold, or by assigned staff in worklist (the last filter possibility is for Pending Work only).
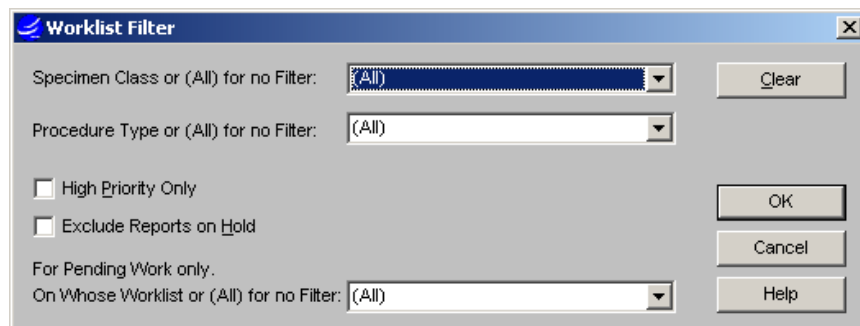
Specifying the Staff

When you access Worklists, the Staff field defaults to the user signed on. If a user has no items on the list, a message stating so appears on the worklist. You can then access another staff if he or she has items on a worklist. Once you access another staff person, you need to press <u>**Search**</u> again. If the worklist is generic, the Staff field is disabled.

If you choose a person-specific worklist (e.g., Pathologist Signout), you can narrow the list of specimens on the worklist that CoPathPlus presents to you. By specifying in the Staff field the person (e.g., cytotech, pathologist, etc.) associated with the specimen or procedure you want, only that person's specimen/procedures appears on the list.

Filtering Your Search

If you want to further limit a database search to the most likely candidates, use filters by pressing **Filter...** on the Select Specimen from Worklist window. When you press **Filter…**, the Worklist Filter pop-up window appears.

NOTE: You will only see the last field (For Pending Work Only) if you accessed this window while you had the Pending Work report displayed on the Select Specimen from Worklist window.

Select a single specimen class to filter the worklist to just that specimen class or select (All) to see specimens from all eligible specimen classes. The Specimen Class filter drop-down list will show only those specimen classes that are currently included on the selected worksheet.

Select a single procedure type to filter the worklist to just that type of procedure or select (All) to see all eligible procedure types. The Procedure Type filter drop-down list will include only those procedures that are currently listed on the selected worksheet.

Enter the filter information you want and press **OK** to accept the filter information. You can press **Clear** on this window to clear the information you have just entered. Once you press **OK**, you need to press **Clear Filter** on the Select Specimen from Worklist window to remove any filter information defined in the search.

Worklist Description

The worklist shown in the Select field on the Select Specimen from Worklist window shows specimens in the following sort order:
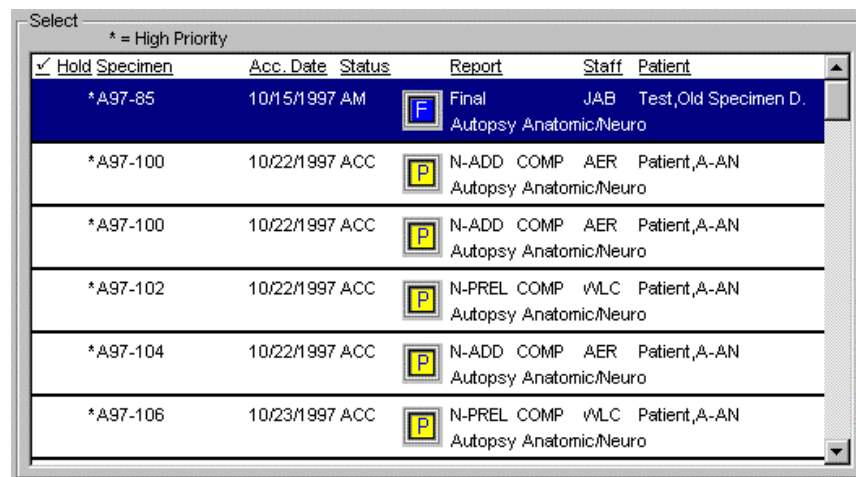
1) High-priority specimens, in chronological order (whether or not they have a Hold status).

2) Specimens that are not high priority and not on hold, in chronological order.

3) Specimens that are not high priority and are on hold, in chronological order.

> **NOTE:** The Hold status for a specimen only means that it will appear at the end of a worklist.

NOTE: You can print the worklist you have accessed by pressing **Print** on this window.

The following topics explain the information you see on this list:

Check Mark	A check mark appears in the first column if you have already accessed the specimen or procedure and have returned to the Select Specimen from Worklist window.
Hold	An **X** appears in the Hold column if the specimen or procedure is on hold. The user specifies this hold status at the time he or she places the specimen or procedure on the worklist and can change it at any time thereafter. The Hold status only means that a specimen will appear at the end of a worklist.
Specimen	The specimen number appears in the Specimen column (an asterisk [*] will appear to the left of the specimen number if this specimen is high priority).
Acc Date	The date on which the specimen was accessioned appears in the Acc Date column.
Status	The status of the specimen appears in the Status column. Possible statuses are: ACC (Accessioned), GR (Gross Complete), F (Final Diagnosis Complete), SO (Signed Out), or AM (Amended).
Report	An icon displays under the Report column to distinguish between the types of reports: • • Final 🔷F (blue) • • Procedure 🟨P (yellow) • • Addendum 🟩A (green)
Procedure Status	If the worklist item refers to a procedure or addendum, the status of the procedure will appear next to the Report column. Possible statuses are: ORD (Ordered), COMP (Complete), SO (Signed Out), or AM (Amended).
Staff	The Staff column specifies the staff (e.g., pathologist, cytotechnologist) associated with the specimen or procedure if this worklist is person-specific. If it is not person-specific or the specimen or procedure was not assigned to someone, the Staff column will be blank.
Worklist Memo	A worklist memo, if any, will print on the first part of the second line. The user can enter this memo at the time he or she places the specimen or procedure on the worklist and can change it at any time.
Parts	The first three part types for this specimen will show on the second part of the second line. If there are additional parts for this specimen, you will see ellipses (...).

Using the Quick Signout Window

The Quick Signout activity provides a fast way to sign out cases, especially simple reports with normal and/or short diagnoses (such as dermatopathology cases). You can view minimal

information on the patient report and then sign out these cases directly from the Quick Signout window, without having to access the entire report or a data entry window unless desired. For additional information on the report signout process in CoPathPlus, refer to "Signout (Electronic) and Consult Review".

The Pathologist Signout worklist is currently the *only* worklist that can access Quick Signout because the Final (or Procedure/Addendum) diagnosis is already present. Other worklists (particularly cytology worklists such as Cytology QC and Pathologist Cytology Review) assume that the user/pathologist will enter the final/cytology review as part of cytology results entry and concurrent signout. Refer to "Pathologist Signout Worklist" for more information.

Specimens are locked during Quick Signout when any of the buttons on the Quick Signout window (except **Print Report…**) are selected. Also, the specimen (or procedure/addendum) cannot be edited following Quick Signout unless it is done through an amendment. Refer to "Amendment Entry and Amendment Edit".

To open the Quick Signout window, press **Quick S/O** on the Select Specimen From Worklist window. The Quick Signout window appears.

NOTE: The **Quick S/O** button is only visible if the system setting "Enable Quick Signout" is set to Yes and you have the "Quick Signout Access" miscellaneous permission. This latter security feature accommodates multiple performing labs where different Pathology groups (with different sets of pathologists) can decide whether Quick Signout should be used or not. Your CoPathPlus System Manager sets these permissions.

TIP! You can also access the Quick Signout item by placing it in your Personal Menu and double-clicking on it from there. Drag the **Worklists** command button to your Personal Menu, then right-click to access the Properties window. Under Details, select Pathologist Signout and select the Quick Signout check box.

The following paragraphs describe the fields and buttons on the Quick Signout window.

Select field. When it opens, the Quick Signout window defaults to the Pathologist Signout worklist for the user logged on to the workstation. The Select field lists all the specimens currently on that worklist. For a description of how the specimen and report information is displayed, refer to "Worklist Description".

To sign out a report, you must first select it from the list. If the Details check box is selected (see below), the Select field splits and the bottom portion displays the InfoMaker report for the specimen selected in the top portion of the field. You can drag the bar that separates the specimen list from the report details up or down to show more of either portion of the Select field.

User ID and **Password.** The User ID field defaults to the user currently logged on to the workstation. To sign out a report, enter your password for each report you select, then press **Sign Out** (see below). User ID and Password are required fields.

NOTE: If the "Require Password for Each Report in ESO" check box in the Person Dictionary is unchecked, you need only enter your password once and it will then default for each signout.

Sign Out button. Press this button to sign out the selected report. This marks the case as Final Diagnosis Complete, if not already done so, and changes its status to Signed Out.

SO/To QA button. Press this button to sign out the report and also send it to the QA (Post-Signout Review) worklist.

Addl Trans button. Press this button to remove the specimen from the Pathologist Signout worklist and send it to the Additional Transcription worklist. This action also removes the Final Diagnosis Complete status for this case.

After you press **Addl Trans**, the Additional Transcription Required pop-up window appears.

The **Send to** field is disabled. You can enter a special comment in the **Memo** field (e.g., the reason why additional transcription is needed) and, if necessary, place the case on hold by selecting the **On Hold** check box. Press **OK** to send the report. You are then returned to the Quick Signout window.

To Path button. Press this button to remove the specimen from its current Pathologist Signout worklist and place it on the Pathologist Signout worklist for another pathologist, so that it can be signed out by that pathologist instead. After you press **To Path**, the Send to Other Pathologist for Signout pop-up window appears.

The specimen's primary pathologist appears as the default in the **Send to** field, but you can select another pathologist. You can enter a special comment in the **Memo** field (e.g., the reason you are forwarding it to another pathologist for signout), and, if necessary, place the case on hold by selecting the **On Hold** check box. Press **OK** to send the report. You are then returned to the Quick Signout window.

Worklist Staff button. Press this button to access the Pathologist Signout worklist for other pathologists so that you can review or sign out other reports. After you press **Worklist Staff**, the Worklist Staff pop-up window appears.

In the **Staff** field, select another pathologist, or "(All)" for all pathologists. Press **OK** to close this pop-up window and return to the Quick Signout window, where the Pathologist Signout worklist for the selected pathologist now appears in the Select field.

Details check box. When checked, displays details of the InfoMaker report for the specimen selected in the Select field. This check box is checked by default so that you can verify the diagnosis before signing out the report, but you may want to uncheck it to save time if you are simply looking through the specimens on a worklist.

If you try to sign out a report without viewing the details, you will receive a warning message. If you confirm that you want to proceed, CoPathPlus will continue signing out the report.

NOTE: The InfoMaker information displayed in the details portion of the Select field is site-configurable. See your CoPathPlus System Manager for details.

Print Report… button. Lets you print the selected report. For more information, refer to "Print".

View Report/Edit Report button. For sites using TxText as the CoPathPlus text editor, this button will read **View Report**. Press this button to open the Signout Report window for the selected report. Refer to "Using TxText for Signout and Consult Review" for more information.

For sites using Microsoft Word as the CoPathPlus text editor, this button will read **Edit Report**. Press this button to open the Signout Report window for the selected report. Refer to "Using Microsoft Word for Signout and Consult Review" and Consult Review for information.

Edit Specimen button. Press this button to open the Electronic Signout window and edit the specimen information on the case or procedure. For more information, refer to "Editing Report Information" and "Consult Review".

Available Worklists

The standard CoPathPlus system provides the following worklists: Your site will probably use a subset of these worklists.

- Additional Transcription

- Consult Review

- Cytology QC

- Cytotechnologist Review

- Pathologist Cytology Review

- Pathologist Signout

- Procedure Entry

- QA (Post-Signout Review)

- Resident/Fellow Review

Additional Transcription Worklist

The specimens (or procedure/addendum) listed on the **Additional Transcription** worklist, which is a generic worklist, are those that have been sent back for additional transcription. They may need such things as additional dictation, typographical corrections, or an updated diagnosis based on the opinion of a consulting pathologist.

Specimens are placed on this worklist by a pathologist during Signout or other reviews. Specimens are removed from this worklist when they are placed onto another worklist.

Note that transcriptionists can use this worklist to access specimens (by specimen number) that need additional corrections. Pathologists may use this worklist as a reminder of those reports that were sent back for additional work.

The Final Diagnosis Entry/Edit activity defaults for this worklist.

Consult Review Worklist

The specimens listed on the **Consult Review** worklist, which is person-specific and may have a default reviewer in various activities.

Specimens are placed on this worklist by the primary pathologist who would like the case reviewed by another pathologist, but then returned to him or her for final signout. Specimens are removed from this worklist by explicit reviewer actions (e.g., "Additional Transcription Needed," "Send to Primary Pathologist").

The Consult Review activity defaults for this worklist. Refer to "Signout (Electronic) and Consult Review" for more information on this activity.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Cytology QC Worklist

The specimens listed on the **Cytology QC** worklist, which is a generic worklist, are those cytology specimens selected for QC review either manually by a cytotechnologist or automatically by CoPathPlus.

NOTE: When automatic QC selection is used, system settings determine: 1) whether high risk cases are selected for review, 2) the percentage of high risk and normal cases to select for review, and 3) whether to include high risk cases in the total count of cases when selecting normal cases for review.

If a cytotechnologist deems a specimen on this worklist to be abnormal during QC review, the specimen can be signed out only after review by the responsible primary pathologist. Therefore, some cases are moved from this worklist to the Pathologist Cytology Review worklist.

Specimens are removed from this worklist by explicit reviewer actions (e.g., "Screened/Send to Pathologist" or signed out).

The Cytology Results (Cytotech) activity defaults for this worklist. Refer to "Cytology Results" for more information on this activity.

Cytotechnologist Review Worklist

The specimens listed on the **Cytotechnologist Review** worklist, which is a person-specific worklist, are those that are to be re-reviewed by the original cytotechnologist or placed on another cytotechnologist's worklist for review and or follow-up.

Specimens are explicitly placed on this worklist by a cytotechnologist at the completion of the Cytology Results by Cytotech activity. The specimens on this worklist may be questionable normal gynecological (GYN) specimens, abnormal GYNs, or non-GYNs. These specimens represent any that the reviewer would like reviewed by another (e.g., senior) cytotechnologist before being passed on to their next stage.

Specimens are removed from this worklist by explicit reviewer actions (e.g., marked as "Screened/Send to Pathologist" or signed out).

The Cytology Results (Cytotech) activity defaults for this worklist. Refer to "Cytology Results" for more information on this activity.

Pathologist Cytology Review Worklist

The specimens listed on the **Pathologist Cytology Review** worklist, which is a person-specific worklist, are abnormal gynecological (GYN) specimens or non-GYNs. These types of specimens must always be passed from the cytotechnologist to the responsible primary pathologist for review before the case can be signed out. In addition, you can manually select certain negative GYNs (e.g., those that may be questionable or high risk) for pathologist review and place them on this worklist.

Specimens that are later amended, if originally signed out by a responsible primary pathologist, can be placed back onto this worklist.

Specimens are removed from this worklist by explicit reviewer actions (e.g., marked as "Additional Transcription Needed" or signed out).

The Cytology Results (Pathologist) activity defaults for this worklist. Refer to "Cytology Results" for more information on this activity.

Pathologist Signout Worklist

The specimens listed on the **Pathologist Signout** worklist, which is a person-specific worklist, are those waiting to be reviewed by the specimen's primary pathologist (for a Final Report) or by the primary pathologist for a particular procedure/addendum (for a Procedure/Addendum Report). These specimens could also have been initially reviewed by the primary pathologist and then assigned to a new reviewer during Signout, they could have been initially reviewed by a Resident, Fellow, or Consulting Pathologist and then assigned to the primary pathologist during Consult Review.

Specimens are placed on this worklist when the Final Diagnosis or Procedure/Addendum is either marked as complete or is amended. Specimens are removed from this worklist by explicit reviewer actions (e.g., marked as "Additional Transcription Needed," marked as "Send to Other Pathologist," or signed out).

The Signout (Electronic) activity defaults for this worklist. For more information about this activity, refer to "Signout (Electronic) and Consult Review".

Procedure Entry

The Procedure Entry worklist displays a list of all ordered procedures that are denoted eligible for this worklist in the Procedure Dictionary. The procedure must be activated for the worklist in the dictionary before it is ordered on the case, i.e., procedures will not be pulled retrospectively onto the worklist. Only ordered procedures appear on the worklist. Once a procedure is marked complete, it will be removed from the worklist.

For information on how to configure the Procedure Dictionary, refer to "Procedure Dictionary" in the *Cerner CoPathPlus Dictionary Building Guide*.

QA (Post-Signout Review) Worklist

The specimens listed on the QA (Post Signout Review) worklist have already been signed out and need QA review.

The QA Diagnosis Review activity defaults for this worklist.

Resident/Fellow Review Worklist

The specimens listed on the **Resident/Fellow Review** worklist, which is a person-specific worklist, are those that a transcriptionist deems to warrant review by the resident or fellow assigned to the case prior to primary pathologist review and signout.

Specimens are placed on this worklist by a transcriptionist during the Final Diagnosis Entry/Edit activity. Specimens are removed from this worklist by explicit reviewer actions (e.g., marked as "Additional Transcription Needed" or marked as "Send to Primary Pathologist").

The Signout (Electronic) activity defaults for this worklist. For more information about this activity, refer to "Signout (Electronic) and Consult Review".

Chapter 6: Inquiry

Overview

Inquiry explains how to perform an inquiry on a patient and/or specimen in Cerner CoPathPlus. The inquiry feature allows you to view, but not change, patient and specimen information.

This topic explains two of the three options available under the **Inquiry** command button. For information on the Patient Report Single Print activity, refer to "Patient Report Single Print".

The information contained in this section is based on the standard export version of CoPathPlus. Because CoPathPlus is tailored during installation to meet the needs of each user site, it is possible that your system will not include fields or applications described in this section. Your system may also have additional fields and applications that are not documented here.

Inquiry Process

At any time during the normal flow of events for a case, a pathologist or attending physician may contact the department staff to inquire about the status of a case or results information.

The Inquiry option allows you to review the status of a particular case and to view some or all of the information entered to date. Depending on what type of Inquiry (Pathology Inquiry or Clinician Inquiry) or the specimen class you access, you may see the following information for a particular case:

- Summary information for the case

- Autopsy information

- A dated event log, including the "events" designated by your institution

- Source information

- Associated physicians or cytotechs and a list of physicians who should receive a copy of the final report

- Any procedures ordered on or addenda created for the specimen

- Neurology information for an autopsy case

- Billing data

- Demographic information for the patient associated with the specimen

- Clinical history information for cytology specimens

- Diagnoses information

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- Miscellaneous information, such as specimen/requisition deficiencies and reporting categories

Use the Inquiry option when your primary aim is to review the status of a particular specimen in the department and/or review descriptive and diagnosis information entered to date. For example, you would use the Inquiry option when a physician calls the lab to ascertain the status of a case.

Accessing Inquiry

To access an Inquiry activity:

1) Press the **Inquiry** command button ⬚ on the CoPathPlus Application Manager.

   The Select Specimen window appears.

2) Choose a specimen according to the procedure in "Using the Select Specimen Window".

3) Select Pathology Inquiry, Clinician Inquiry, or Patient Report Single Print in the Activity field on that window.

4) Press **OK**.

   The Specimen Inquiry window or the Select Report window appears, depending on the activity you chose.

Proceed as follows:

- If you chose **Pathology Inquiry**, refer to "Pathology Inquiry".

- If you chose **Clinician Inquiry**, refer to "Clinician Inquiry".

- If you chose **Patient Report Single Print**, refer to "Patient Report Single Print".

You can also access Inquiry in two other ways:

- By placing the Inquiry activities (i.e., Pathology Inquiry, Clinician Inquiry, and Patient Report Single Print) in your Personal Menu and double-clicking on them from there.

- This activity is also available as a specimen activity when you press the **Specimens** command button on the CoPathPlus Application Manager.

Keeping Inquiry Open

You may find it useful to access Inquiry at the start of your workday and to keep it open throughout the day while you are in CoPathPlus performing other activities.

To open Inquiry and keep it running, perform these steps:

1) Press the **Inquiry** command button on the CoPathPlus Application Manager.

2) Choose a specimen according to the procedure in "Using the Select Specimen Window".

3) Select **Pathology Inquiry** or **Clinician Inquiry** in the Activity field on that window.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

4) Press **OK**.

   The Specimen Inquiry window appears.

5) Once you access the Specimen Inquiry window, minimize it and proceed with your next activity from the Application Manager.

Minimizing the Specimen Inquiry window will reduce the Specimen Inquiry window to an icon, which you can return to throughout the day as needed simply by clicking on the icon at the bottom of your window and accessing a new specimen or patient.

You can also have Inquiry automatically open when you access CoPathPlus.

To have Inquiry automatically open upon CoPathPlus startup, perform these steps:

1) Place Inquiry in your Personal Menu.

2) Select the Inquiry option in your Personal Menu and press the right mouse button.

3) Select Properties.

4) Select the Automatically Start check box.

5) Press **OK**.

Now Inquiry will automatically start up when you access CoPathPlus.

Editing Versus Viewing the Inquiry Windows

The information presented to you when you perform an Inquiry is for viewing purposes only. You cannot edit it. If you want to edit any of the information presented, you must access the appropriate activity to perform the edit. For example, if you find that any of the patient demographic information is incorrect, you need to access Patient Registration in order to change that data.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Pathology Inquiry

The Specimen Inquiry window for a Pathology Inquiry contains ten tabs, which will vary based on the specimen class of the selected case.

Summary Tab

The Summary tab is visible for all specimen classes in Pathology Inquiry.
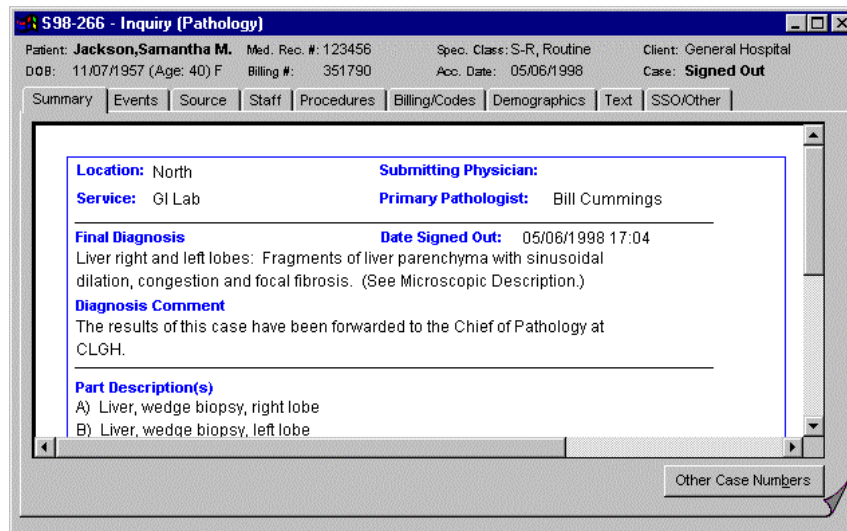
This tab contains basic summary information about the specimen. It presents the following types of information for the specimen you selected:

- Location and service at time of inquiry

- Submitting physician and primary pathologist.

- Final Diagnosis and any Diagnosis Comments

- Generated Diagnostic Synoptic text.

  Note: This will only appear for clients who have purchased the Cerner CoPathPlus Synoptic Reporting solution.

- Parts and any procedure/addendum associated with the specimen, along with its status. (Refer to "Source Tab" and "Procedures Tab" for more detailed information.)

- Worklist information including the name of the worklist, the staff to whom the specimen is assigned, any memo, and whether the specimen is on hold.

- Whether any attachments or PICSPlus images exist for the specimen. (The following message appears at the bottom of this tab if either type of attachments exist: **Attachments exist on this case**.)

The Summary tab also specifies whether the specimen was amended and, if it was, the date on which it was amended, the staff that entered the amendment, and the reason it was amended.

In addition, at the bottom of the Summary Tab is the **Other Case Numbers** button. When you press this button, the following pop-up window appears, which specifies other case (specimen) numbers that are related to this specimen. This information can display on the Other Specimens for Patient window, Working Draft reports, Final reports, and reports you create using InfoMaker. To exit this window, press **OK**.
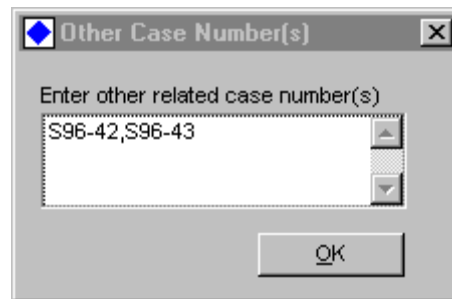
Autopsy Tab

The Autopsy tab is visible for only Autopsy specimen classes in Pathology Inquiry.
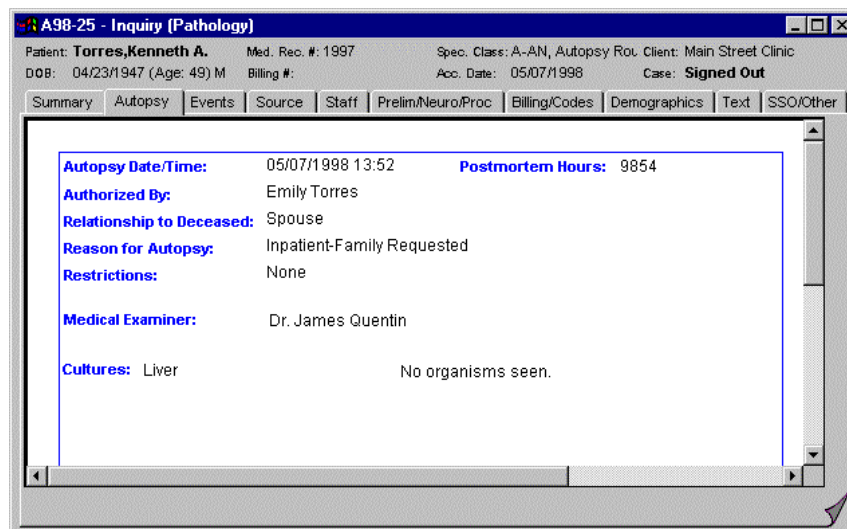
This tab contains basic autopsy information about the specimen. It presents the following types of information for the specimen you selected:
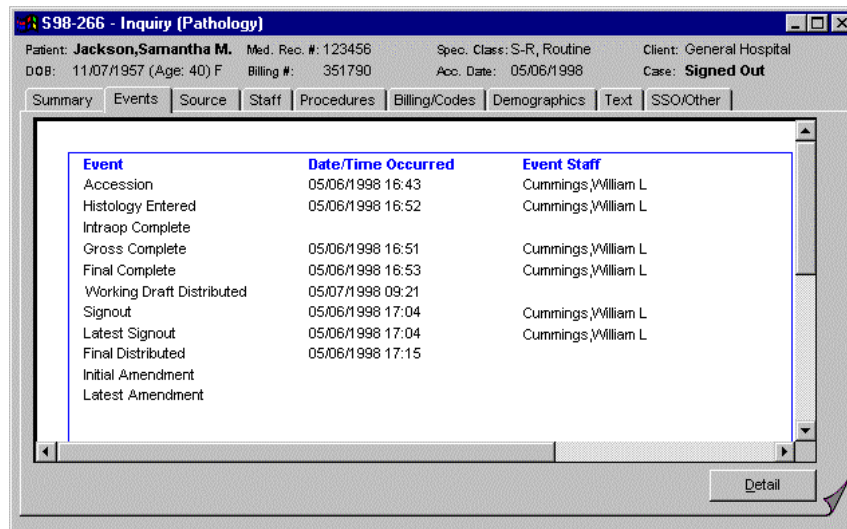
- Autopsy date and time

- Postmortem Hours

- Who authorized the autopsy and his/her relationship to the deceased

- The reason for the autopsy

- Any restrictions that may apply

- Gestational age, if applicable

For more information on or to change any of the autopsy data for a specimen, refer to "Accessioning Specimens and Accession Entry/Edit".

Events Tab

The Events tab is visible for all specimen classes in Pathology Inquiry.

This tab shows the current processing stage for a particular specimen. You can also view the chronological record of activity on a specimen from this tab.

Events can relate to the specimen as a whole (e.g., accessioned or signed out) or pertain to a component of the accessioning process (e.g., a text field marked complete, a report signed out, or a report printed to a particular report destination).

The actions listed on the Events tab are those that were defined by Cerner CoPathPlus and by your site's System Manager. All events are included on the Audit Trail. The Events tab lists the event, the date and time it was performed or completed, and who performed the action.

You can press **Detail** on the Events tab to obtain more detailed information about the events listed on the Events tab.
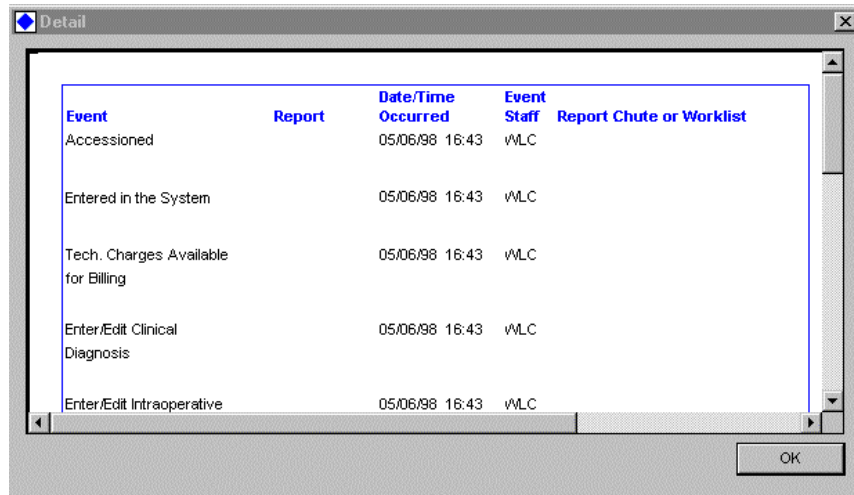
You cannot edit the information shown on the Events tab and the Detail window.

Continue with the Source tab or go to Next Step for the Pathology Inquiry if you are finished viewing information for this specimen/patient.

Source Tab

The Source tab is visible for all specimen classes in Pathology Inquiry.
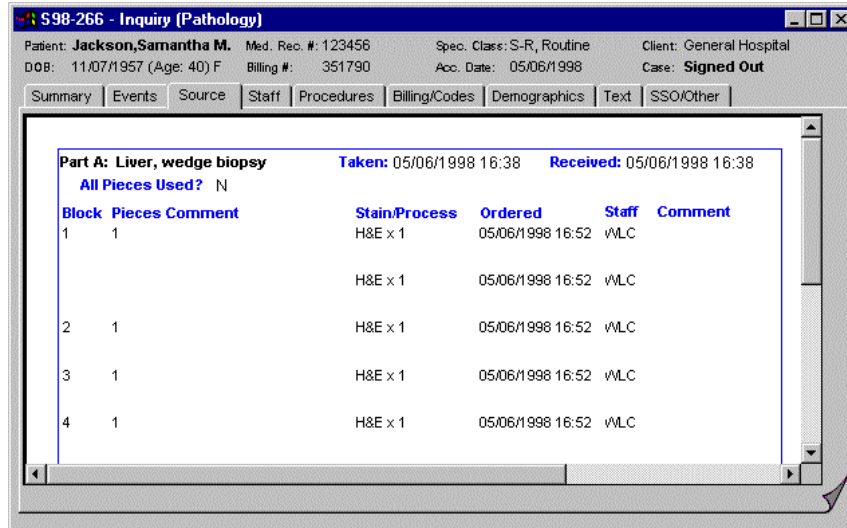
This tab lists part types, their descriptions, and the date on which each was taken and received in the lab. This tab also displays a histology stain and block summary, including the:

- Block, number of pieces, and any comment

- Stain abbreviation, number of stains, date on which it was ordered, staff responsible for the order, and any comment.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

For more information on or to change the part information you see on the Source tab for a specimen, refer to "Accessioning Specimens and Accession Entry/Edit" or "Histology Data Entry/Edit".

Staff Tab

The Staff tab is visible for all specimen classes in Pathology Inquiry.

This tab lists the pathologist(s), gross pathologist(s), intraoperative consult pathologist(s), and any other physicians and/or institutions associated with the specimen that should receive report copies. For cytology specimens, any Cytotechnologist(s) associated with the specimen are also listed. For autopsy specimens, the gross pathologist field may be labeled prosector.

For more information on or to change any of the information you see on the Staff tab for a specimen, refer to "Accessioning Specimens and Accession Entry/Edit" or "Staff Entry/Edit"".

Procedures Tab

The Procedures tab is visible for the Surgical and Cytology specimen classes in Pathology Inquiry.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
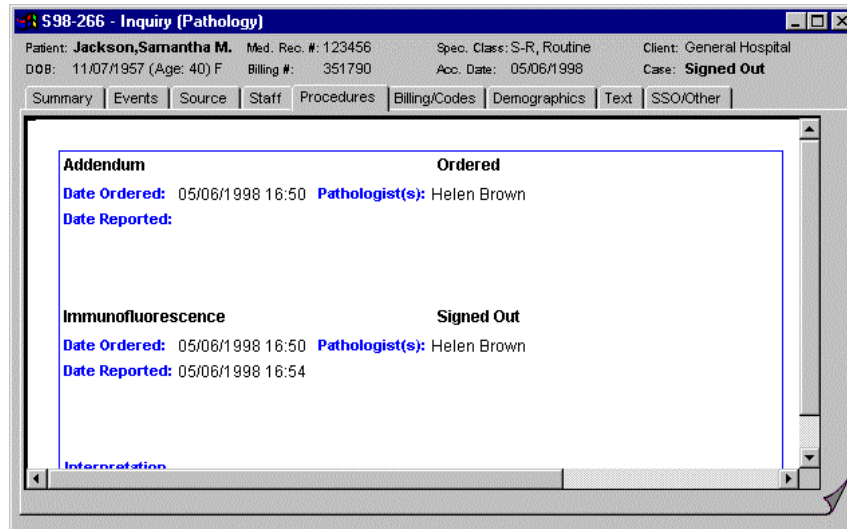
The tab lists the procedure or addendum, its status (Ordered, Completed, Signed Out, Amended), the date on which it was ordered, the pathologist responsible for the procedure, and the date on which it was reported. Also shown is the diagnostic information for both procedures and/or addenda, if entered.

This tab also specifies whether or not the procedure/addendum is currently on a worklist. If it is, the worklist, the staff to whom the specimen is assigned, and any worklist memo are displayed. If this procedure or addendum was amended, it will be noted on this tab.

For more information on or to change any of the information you see on the Procedures tab for a specimen, refer to "Procedure/Addendum Entry/Edit".

Continue with the "Billing/Codes tab" or go to "Next Step for the Pathology Inquiry" if you are finished viewing information for this specimen/patient.

Prelim/Neuro/Proc Tab

The Prelim/Neuro/Proc tab is visible for only the Autopsy specimen classes in Pathology Inquiry.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
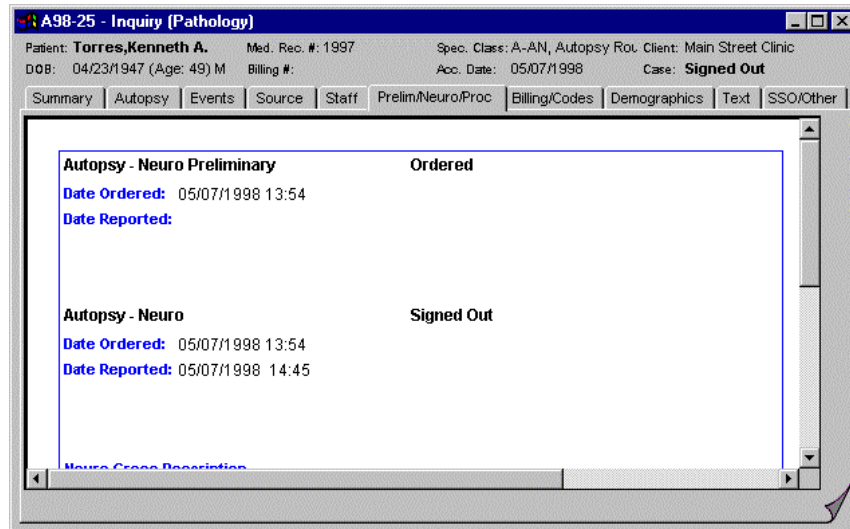
This tab lists the Anatomic Preliminary, the Neuro, and the Neuro Preliminary, the status of each, the date on which each was ordered, the date on which each was reported, and any preliminary diagnosis or interpretation.

For more information on or to change any of the information you see on the Prelim/Neuro/Proc tab for a specimen, refer to "Accessioning Specimens and Accession Entry/Edit"" and "Procedure/Addendum Entry/Edit".

Continue with the "Billing/Codes tab" or go to "Next Step for the Pathology Inquiry" if you are finished viewing information for this specimen/patient.

Billing/Codes Tab

The Billing/Codes tab is visible for all specimen classes in Pathology Inquiry.
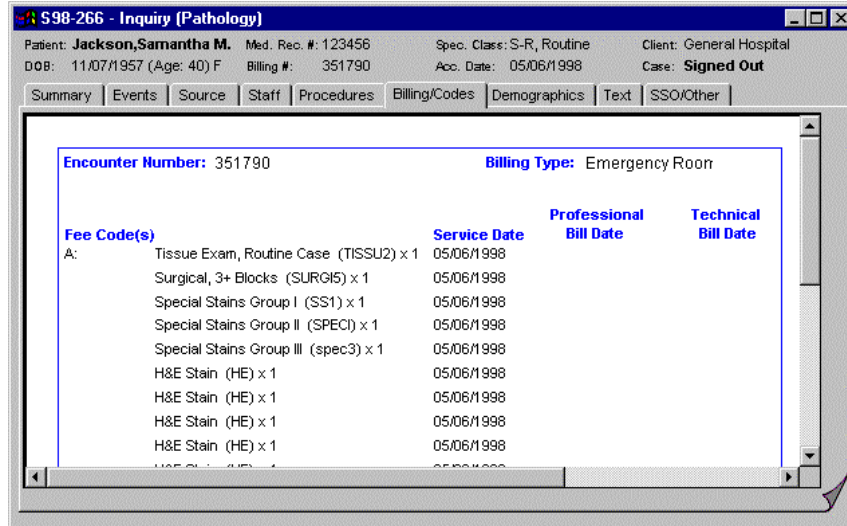
This tab lists any fee codes associated with the billing type, along with the abbreviation, numbers of units, source, and service date. Professional Bill Date and Technical Bill Date will display if the fee codes have been billed. This tab also specifies whether or not the fee code is a credit.

The Billing/Codes tab also lists any ICD-9-CM and SNOMED codes entered for the specimen.

For more information on or to change any of the information you see on the Billing/Codes tab for a specimen, refer to "Billing Entry/Edit".

NOTE: For sites with an Order Entry interface, the linked order number appears below the encounter number. For more information, refer to "Using the Accession Entry/Edit Activity with the Optional Order Entry Interface".

Demographics Tab

The Demographics tab is visible for all specimen classes in Pathology Inquiry.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
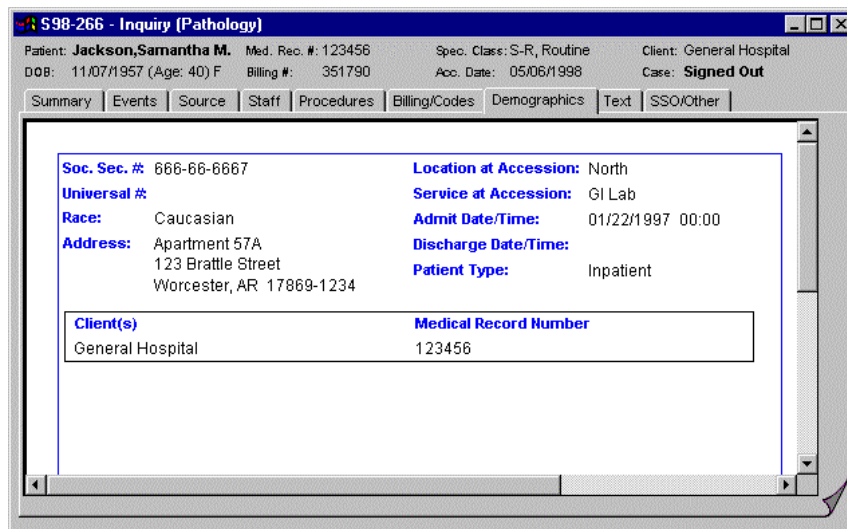
This tab shows registration information for the patient, such as demographics, admission and discharge dates, and the client(s) and Medical Record Number(s) associated with the specimen.

For more information on or to change any data that you see on the Demographics tab, refer to "Editing Information for an Existing Patient".

Text Tab

The Text tab is visible for all specimen classes in Pathology Inquiry.
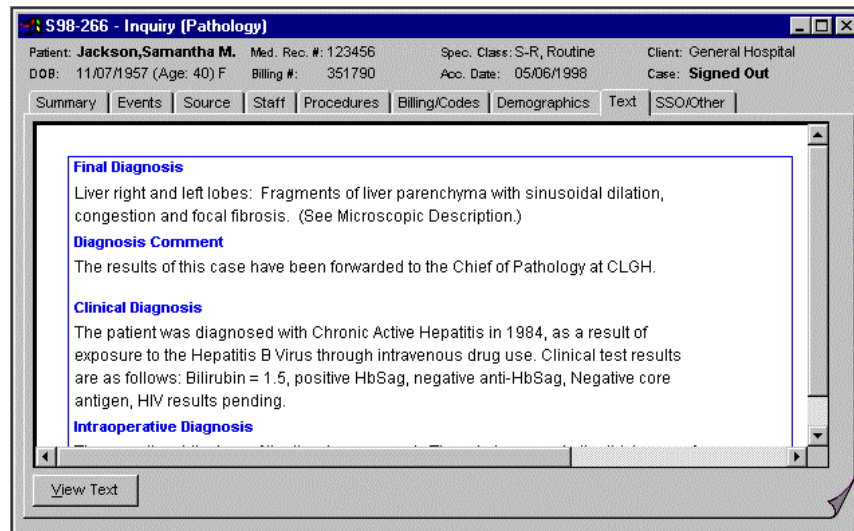
This tab shows all the text fields associated with this specimen that contain data, such as the Clinical Diagnosis, Diagnosis Comment, Final Diagnosis, Microscopic Description, etc. The display does not show text field information related to procedures/addenda. For text field information related to procedures/addenda, refer to "Procedures Tab".

The text shown on this tab does not display any special formatting (e.g., bold, font changes, indents, etc.) that may have been made. For sites using Microsoft Word as the CoPathPlus text editor, you see a **View Text** button on this window. For sites using TxText as the CoPathPlus text editor, you will see an **RTF Text** button on this window. Either button accesses another window that shows the text with all special formatting that may have been applied.

NOTE: TxText is the CoPathPlus text editor that was previously referred to as "Visual Writer" and "VW".

The Microsoft Word pop-up window displays showing the text with any formatting that may have been applied. Press on the toolbar to close the window.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
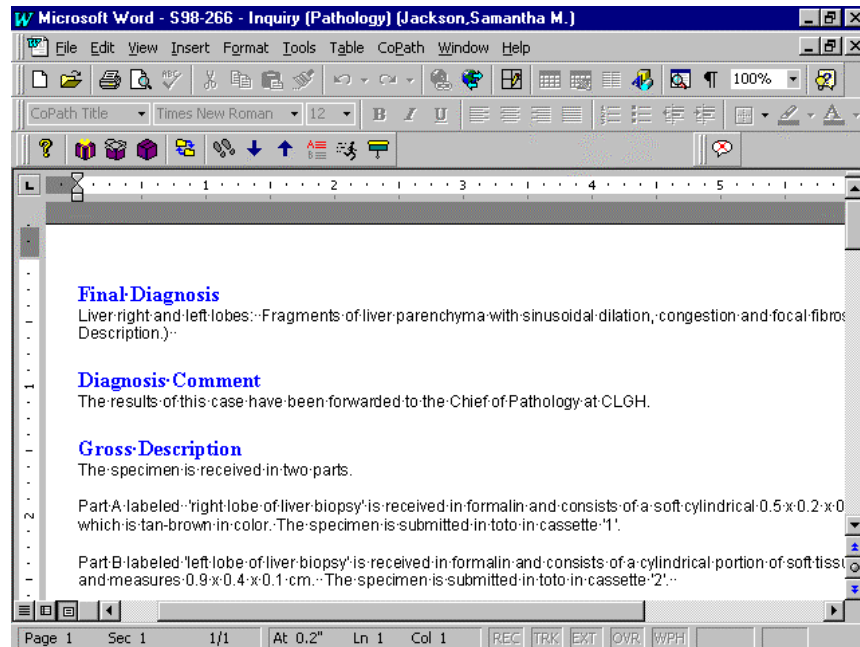
NOTE: For sites using TxText as the CoPathPlus text editor, you will see an **RTF Text** button instead of a **View Text** button. Pressing **RTF Text** lets you view the rich text formatting for the diagnostic text fields. To exit the RTF Text window and return to the Text tab, press **OK**. For more information on text editors in CoPathPlus, refer to "Entering Information in Diagnostic Text Fields" in the "Specimens" section of this user guide.

If you are working with a Cytology specimen, you will also see the **Cytology Review(s)** button on the Text tab. Press this button to access the Cytology Review(s) pop-up window that lists all the reviews that have been entered on this case (specimen) to date, when each was entered, and the reviewer associated with each. Press **OK** to close the window.
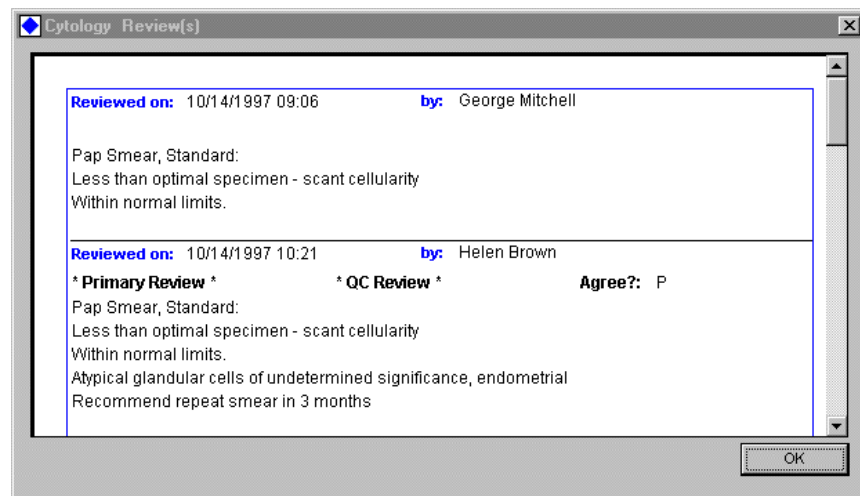
To enter or change:

- **The Diagnosis Comment and/or Final Diagnosis** text for a specimen, refer to "Final Diagnosis Entry/Edit".

- **The Gross Description or Microscopic Description** text for a specimen, refer to "Gross Description Entry/Edit".

- **The Clinical, Pre-Operative, or Post-Operative Diagnosis** text for a specimen, refer to "Accessioning Specimens and Accession Entry/Edit".

- **The Intraoperative Consult Diagnosis** text for a specimen, refer to "Intraoperative Diagnosis Entry/Edit".

- **The Hot Seat Diagnosis** text for a specimen, refer to "Hot Seat Diagnosis Entry/Edit".

- **Cytology review** information, refer to "Cytology Results".

- Any other free-text field that your site has included in your CoPathPlus system, refer to the appropriate topic in this guide.

History Tab

The Text tab is visible for only Cytology specimen classes in Pathology Inquiry.
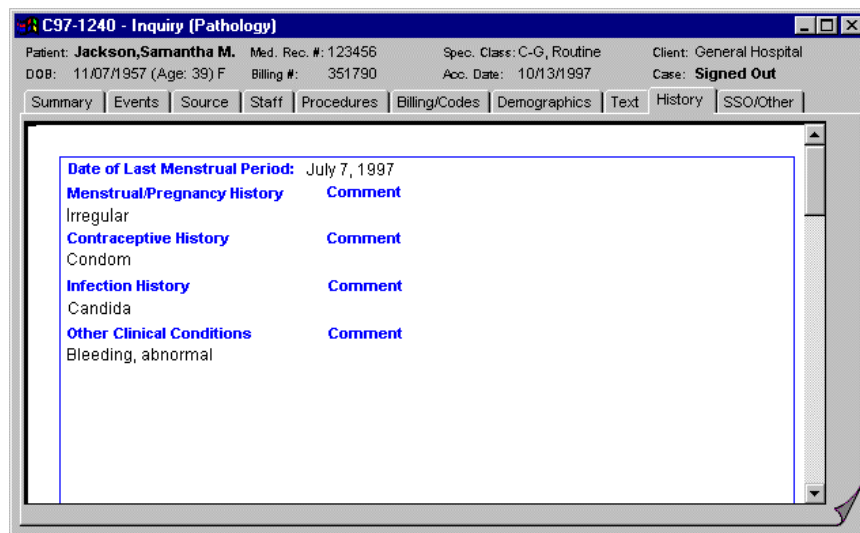
This tab shows clinical history associated with the patient. It lists the patient's history and any comment for:

- Menstrual/Pregnancy
- Cancer
- Treatment
- Contraceptive
- Infections
- Other Clinical Conditions

For more information on or to change any of the information you see on the History tab for a specimen, refer to "Accessioning Specimens and Accession Entry/Edit".

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

SSO/Other Tab

The SSO/Other tab is visible for all specimen classes in Pathology Inquiry.
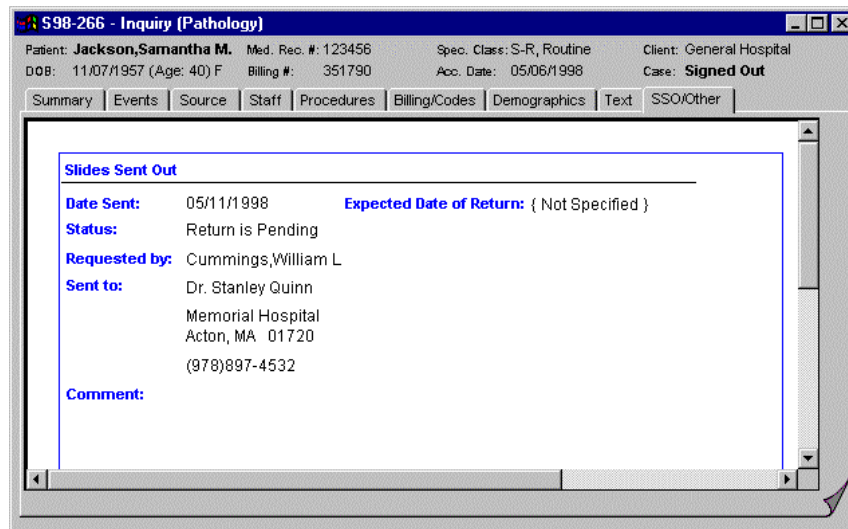
This tab shows miscellaneous information related to the specimen, such as Specimen/Requisition Deficiencies, Resolutions and Retrieval Flags. The SSO/Other tab also contains Slides Send Out information such as the date on which the slides were sent, the status of the slides, who requested the slides, the address to which they were sent, an expected date of return, and any comments.

For more information on or to change any of the information you see on the SSO/Other tab for a specimen, refer to "Accessioning Specimens and Accession Entry/Edit".

Next Step for the Pathology Inquiry

Once you have accessed the Pathology Inquiry for a specimen, you can perform any of the following actions. If you:

- **Want to perform a Clinician Inquiry for this specimen**, then press on the toolbar (or Options, Activities on the menu bar) and select **Clinician Inquiry**. Refer to "Clinician Inquiry".

- **Want to print a patient report for this specimen**, then press on the toolbar (or Options, Activities on the menu bar) and select **Patient Report Single Print**. Refer to "Patient Report Single Print".

- Are finished with Inquiry for this specimen and you:

  o **Want to keep Inquiry running**, then minimize the Specimen Inquiry window and proceed with your next function.

  o **Do not want to keep Inquiry running**, then press:

    ▪ (or File, Close Specimen) to return to the CoPathPlus Application Manager.

■ (or <u>F</u>ile, E<u>x</u>it CoPath Client/Server) to exit CoPathPlus. Press **OK** when asked if you want to log off of CoPathPlus.

o **Want to inquire on another specimen**, then press (or <u>F</u>ile, <u>O</u>pen Specimen) to load another existing specimen. The Select Specimen window appears. Select a specimen as explained in Using the Select Specimen Window.

   NOTE: If you want to access an existing specimen for the current patient, press <u>S</u>ame Patient on the Select Specimen window and CoPathPlus will list the existing specimens for this patient.

Clinician Inquiry

Clinician Inquiry may be used when a limited amount of information should be made available to the inquiring user.   This activity does not filter result retrieval according to physician, therefore use by an outside institution is not recommended. Besides the display of a limited amount of information, this activity will display the Final Diagnosis only if the specimen has been signed out.

The Clinician Inquiry tab lists the most pertinent information related to the specimen on which you chose to perform an inquiry. The information is condensed and shown on one tab for easy access and display.

Refer to the individual tabs documented in "Pathology Inquiry" for information on how to enter or change information for a specimen.

Next Step for the Clinician Inquiry

Once you have accessed the Clinician Inquiry for a specimen, you can perform any of the following actions. If you:

- **Want to perform a Pathology Inquiry for this specimen**, then press on the toolbar (or Options, Activities on the menu bar) and select **Pathology Inquiry**. Refer to "Pathology Inquiry".

- **Want to print a patient report for this specimen**, then press on the toolbar (or Options, Activities on the menu bar) and select **Patient Report Single Print**. Refer to "Patient Report Single Print".

- Are finished with Inquiry for this specimen and you:

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- o **Want to keep Inquiry running**, then minimize the Specimen Inquiry window and proceed with your next function.

- o Do not want to keep Inquiry running, then press:

  - ■ (or File, Close Specimen) to return to the CoPathPlus Application Manager.

  - ■ (or File, Exit CoPath Client/Server) to exit CoPathPlus. Press **OK** when asked if you want to log off of CoPathPlus.

- o **Want to inquire on another specimen**, then press (or File, Open Specimen) to load another existing specimen. The Select Specimen window appears. Select a specimen as explained in Using the Select Specimen Window.

  NOTE: If you want to access an existing specimen for the current patient, press **Same Patient** on the Select Specimen window and CoPathPlus will list the existing specimens for this patient.

Chapter 7: Patients

Overview

Patients explains the Patient Registration feature in Cerner CoPathPlus. It describes how to:

- Manually register a new patient.

- Edit data for existing patient records.

- Delete a patient record.

- Use the Select Patient window to search for a patient to perform an action on (e.g., accession a specimen).

- Enter and edit patient visit (i.e., encounter) information.

The information contained in this guide is based on the standard export version of CoPathPlus. Because CoPathPlus is tailored during the implementation process to meet the needs of each site, it is possible that your system will not include fields or items described here. Or your system may display additional fields that are not documented here.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Patient Registration

Patient Registration is the process by which you initially enter demographic information for a patient into the CoPathPlus database. If a patient is new to the database, registration data for the patient can either be entered manually or through an Admission/Discharge/Transfer (ADT) interface.

When you register a patient in CoPathPlus, you create a patient record. You can also create an encounter record for the patient each time he or she visits the hospital. An encounter represents an "admission", "visit", or "episode of care". Each encounter has a corresponding number, which identifies an encounter record in the CoPathPlus database.

Encounters are normally created via an ADT interface. However, since insurance information is held on the encounter level, sometime encounters are manually created in CoPathPlus when the site does not have use an ADT interface for some or all patients but it is still necessary to output insurance information on these patients.

For more information on interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *Cerner CoPathPlus Implementation Manual*.

You can manually register a patient by using the **Patients** command button on the CoPathPlus Application Manager or during the first part of the accessioning process. While a patient must be registered in CoPathPlus before you can accession a specimen for that patient, you can also access the demographic entry feature directly from the New Accessioning screen for efficient patient entry when that patient did not previously exist in CoPathPlus.

Accessing Patient Registration

You can access Patient Registration by either:

- Pressing the **Patients** command button on the CoPathPlus Application Manager,

- Performing a patient lookup from the Select Specimen window or the New Specimen window when accessioning a specimen.

In either case, the Select Patient window appears.

TIP! You can also access the Patient Registration item by placing it in your Personal Menu and double-clicking on it from there.

Using the Select Patient Window

The Select Patient window is the means by which you register a new patient or select an existing patient for whom you want to perform a task (e.g., accession a specimen). To select an existing patient record, you can either search for the patient by name or by one of several numbers associated with the patient record (e.g., Medical Record Number, Social Security Number, etc.). You can also utilize "filters" to limit the search to a particular set of patients (e.g., all male

patients). To access the Select Patient window press the **Patients** command button on the CoPathPlus Application Manager.

NOTE: You can also access this window when you do a patient lookup from the New Specimen or Select Specimen window while accessioning. When accessed through the New Specimen window, you will see both a **New Patient** button and an **Edit Patient** button on the Select Patient window. When accessed through the Select Specimen window, you will see the **Edit Patient** button only.

Select Patient Window Description

The Select Patient window contains the following fields and buttons.

Patient. Enter the first few letters of the patient's last name or an appropriate patient number, based on which Search By option is selected.

Search By. Select how you want to search for the patient. You can search by:

- Name (Last,First Middle)
- Medical Record Number
- Social Security Number
- Encounter Number
- Universal Number
- HIS Other Number

For more information about patient searches by name, refer to "Patient Search by Name". For more information about each patient number and how to use them to perform a patient search, refer to "Patient Search by Number".

NOTE: A system setting determines the default Search By option.

Exact Match check box. Select this check box if you want to do an exact match search. In that case, the search will only show patients whose name or number exactly match the value entered in the Patient field. If this check box is selected and you enter a partial name or number (e.g., JON), the search will not show patients whose names or patient numbers start with those characters; rather it will only show patients whose last name or patient number exactly match those characters. The default for this check box for the Patient name search os off. This check box defaults to "on" for all the number search options. For some number Search By options (e.g., Social Security Number), this check box cannot be cleared, i.e., the exact match must be searched on.

Select. After you enter search criteria and press **Search**, this window lists all the patients that match your search criteria in alphabetical order by patient name. In the standard export version of CoPathPlus, the following information is displayed on the Select Patient list for each patient: name (Last, First Middle), patient suffix, any aliases, gender, birth date, current age, and any associated Medical Record Numbers and clients. If you searched on a patient's alias, this list will still be sorted by the patient's real name.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Search button. Activates a search for a patient either by patient name or patient number. To activate a search, you must fill in the Patient field with either a patient name or number and specify how you are searching in the Search By field.

New Patient button. Opens the Registration Entry/Edit window, enabling you to register a new patient. For more information, refer to "Registering a New Patient".

Filter... button. Lets you define an additional set of search criteria, such as patient age or sex, to limit the number of choices presented to you. For more information, refer to "Filtering Patient Searches".

Clear Filter button. Removes any filter information for the current search. For example, if a filter is set up to only include 29 year old females, and your search is for patients whose last name begins with "SMI", pressing **Clear Filter** will modify the search so that it shows all patients whose last name begins with "SMI", and not just 29 year old females. Note that pressing this button does not delete the data entered via the **Filter...** button; it just removes it for the current search. You can quickly turn those filters on again by pressing the **Filter...** button, and then pressing **OK**.

Edit Patient... button. Opens the Registration Entry/Edit window for an existing patient record. This button appears on the Select Patient window only when a patient search is initiated from the New Specimen window.

Detail button. Opens the Detail for Patient window. In the standard export version of CoPathPlus, this window lists the Social Security Number and address for the patient you have highlighted in the Select field. Once you select this button, this window remains open until you close it.

NOTE: A system setting determines whether this window appears automatically when a patient search finds one or more records.

Selecting an Existing Patient

If the patient demographic information already exists in CoPathPlus (i.e., the patient has been registered either manually or through an interface with another hospital computer system), you can edit the existing demographic data. For example, you may want to change the address for someone who has moved, add a missing birth date, correct a misspelling, or edit the name or create an alias name if the patient has changed his/her name.

From the Select Patient window (accessed by pressing the **Patients** command button), you can search the database for the correct patient using either the patient name or patient number.

To select an existing patient:

1) Decide how you want to search for the patient record:

   o **Patient Name.** Enter the name of the patient in the Patient field. For more information, refer to "Patient Search by Name".

   o **Patient Number**. Enter the number for the patient in the Patient field and then select one of the identification number options in the Search <u>B</u>y field. For more information, refer to "Patient Search by Number".

2) If you want to further limit a database search to the most likely candidates, such as only male patients, use filters by pressing **Filte<u>r</u>…** on the Select Patient window. For more information, refer to "Filtering Patient Searches".

3) Press **<u>S</u>earch**.

   A patient or list of patients that meet your search criteria appears **on** the Select field.

   NOTE: By pressing **<u>D</u>etail**… on the Select Patient window, you can view additional patient information such as social security number and address.

4) Determine what CoPathPlus has found and then refer to the appropriate topic:

   o No matches for the name you entered.

   o Only one match for the name you entered.

   o More than one match for the name you entered.

Patient Search by Name

To search by patient name, enter the name of the patient in the Patient field (on the Select Patient window), select the **Name (Last,First Middle)** option in the Search <u>B</u>y field and press **<u>S</u>earch**.

NOTE: In the standard export version of CoPathPlus, the **Name (Last,First Middle)** option is selected by default, but a system setting allows your site to choose a different default Search <u>B</u>y option if you want.

If you want CoPathPlus to search for an exact match of the name you enter, select the E<u>x</u>act Match check box. This will ensure that you only see the most likely candidates. If you are not sure of the correct spelling, you can enter a name fragment and press **<u>S</u>earch.** For example, you could enter:

- The first few characters of the last name (e.g., **Jack** for Jackson),

- A comma and then the first few characters of the first name (e.g., Sama for Samantha), or

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- The first few characters of the last name and the first few characters of the first name, separated by a comma (e.g., **Jack,Sama** for Samantha Jackson).

     NOTE: You must enter at least two characters to perform your search. The fewer characters you use, the more time it takes for CoPathPlus to search the database.

You can also search by the patient's alias(es). Refer to "Entering Patient Aliases".

Patient Search by Number

To search by a patient number, enter the number of the patient in the Patient field and then select one of the following items in the Search <u>B</u>y field:

- Medical Record Number
- Social Security Number
- Encounter Number
- Universal Number
- HIS Other Number

NOTE: If you look up a patient's specimens by Medical Record Number on the Select Specimen window, that number is displayed in parentheses after the patient's name in the Patient Name or MRN field on that window.

Filtering Patient Searches

If you want to further limit a database search to the most likely candidates, use filters by pressing **Filter...** on the Select Patient window. When you press **Filter...** the following Patient Filters pop-up window appears.

Enter the following information on the Patient Filters pop-up window:

Birth Date or <u>A</u>ge. Limits the search to patients with a specific birthdate or to patients of a specified age. You can enter either a birthdate or age, but not both.

<u>G</u>ender. Limits the search to patients of a specific gender. Enter **Female** or **Male**.

Client. Limits the search to patients associated with a particular client.

<u>M</u>iddle Name or Initial. Limits the search to patients with a specific middle name or initial.

C<u>l</u>ear button. Removes all filter information entered on this window.

Once you finish entering filter information, press **OK** to return to the Select Patient window. A summary of filter information appears at the top of the Select Patient window.

Deleting a Patient Record

You can delete a patient from CoPathPlus if that patient does not have any associated specimens or encounters. This would normally only be done if the patient was entered in error and it was causing confusion in CoPathPlus. Encounters can be canceled or moved if necessary to allow a deletion. Specimens that are not yet signed out can be deleted or moved if necessary to allow a deletion.

Note: The CoPathPlus Patient Purge mechanism can be used to automatically purge patients in CoPathPlus that have no pathology specimen activity after a designated amount of time. Most ADT interfaces send all patients to CoPathPlus regardless of whether they have pathology activity or not. For example, CoPathPlus would normally receive demographic transactions on patients admitted to a hospital but only had clinical laboratory or radiology orders.

To delete a patient:

1) Access the patient record using the procedure described in "Selecting an Existing Patient".

    The Registration Entry/Edit window appears.

2) Select File, Delete Patient from the menu bar.

    CoPathPlus deletes the patient and returns you to the Select Patient window.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Registering a New Patient

This topic describes how to manually register a new patient in CoPathPlus and how to manually enter and edit encounter information for a patient. A patient must be registered before you can accession specimens for that patient.

Accessing the Registration Entry/Edit Window for a New Patient

To access the Registration Entry/Edit window for a new patient:

1) Press the **Patients** command button on the CoPathPlus Application Manager. The Select Patient window appears.

2) Search for an existing record for the patient using the methods described in "Selecting an Existing Patient". If an existing record is found, you do not need to enter a new patient record. If no existing record is found, proceed to Step 3.

    NOTE: During Patient Registration, when you save a new patient record, CoPathPlus automatically checks for duplicate patient records based the name, age, and social security number. However, you can save time by checking if a record already exists for the patient before entering all the information for the new record. For more information about duplicate patient checking, refer to "Duplicate Patient Checking".

3) Press **New Patient**. The Registration Entry/Edit window appears. For a detailed description of the fields on this window, refer to "Entering/Editing Patient Registration Information".

    NOTE: You will also see the **New Patient** button on the Select Patient window when you access that window from the New Specimen window during accessioning.

To enter or edit encounter data for an existing patient, go to "Entering/Editing Encounter Information".

Duplicate Patient Checking

It is very important to avoid registering duplicate patients in CoPathPlus. When duplicate records exist for a patient, you will be unable to easily review a complete history for the patient to see trends in diagnoses.

Before entering a new patient record, you should check whether a record already exists for the patient using the methods described in "Selecting an Existing Patient". Although CoPathPlus will perform a check for duplicate records when you save a new patient record (as described below), you can save time by checking if a record already exists for the patient before entering all the information for the new record.

When you save a new patient record, CoPathPlus will automatically check for duplicate patient records based on the patient's name, birth information, and social security number. This check does not occur when you edit information for an existing patient record.

NOTE: Depending on how your site implemented CoPathPlus, the system may also check for duplicate patient records when you accession a new specimen.

Conditions for Duplicate Patient Flagging

CoPathPlus will flag a patient record as a potential duplicate in the following situations:

- The name or alias of the new patient record exactly matches the name or alias of an existing patient record (same last name and same or partial match on the first name) **AND**

  Any of the following are true:

  o The new patient record birth date is the same as the existing patient record birth date, **OR**

  o The new patient record birth date is within a site-specified number of days before or after the existing patient's estimated birth date, based on the existing patient's age.

  o For example, suppose you are entering a new patient record on 01/01/98. The new patient birth date is 01/25/70. An existing record has the same patient name and is for a 28 year old patient, indicating that the patient was born between 01/02/70 and 01/01/71. Since the new patient birth date (01/25/70) is within one year of the existing patient's possible birth dates, a warning will appear., **OR**

  o The existing patient record birth date is within a site-specified number of days before or after the new patient's estimated birth date, based on the new patient's age.

  NOTE: If both patient records have non-matching birth dates entered, CoPathPlus does not consider the records to be duplicates even if the names are the same. Also, your site determines during implementation what number of days between one patient record's actual birth date and the other patient record's estimated birth date should cause the records to be flagged as possible duplicates. The default is one year (i.e., 366 days).

  WARNING If a new patient record does not have an age or birth date specified, CoPathPlus will not check for duplicate records based on name and age when you save that record.

- The social security number of the new patient record exactly matches the social security number of an existing patient record.

  NOTE: This condition only applies to sites that have been modified to accept duplicate social security numbers.

CoPathPlus will not display the Duplicate Patient Warning window for two patient records that have been marked as not being duplicates via either the Duplicate Patient Processing or Patient Merge/Encounter Move items.

Options from the Duplicate Patient Warning Window During Patient Registration

If CoPathPlus detects a possible duplicate record during Patient Registration, the Duplicate Patient Warning window appears.
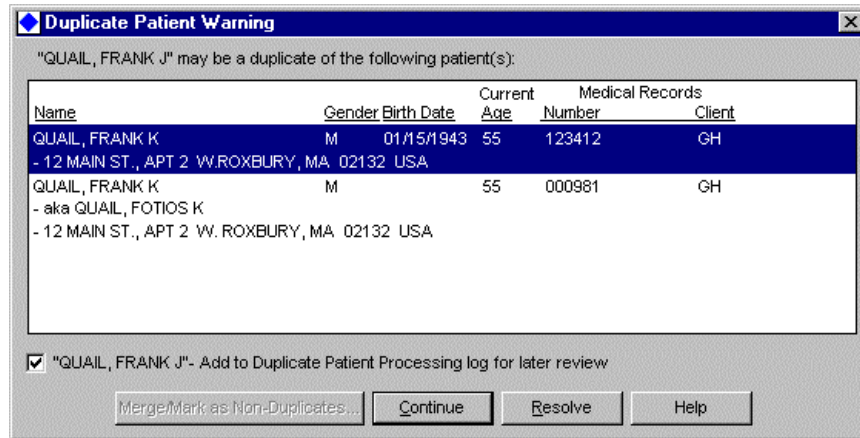
Your options from the Duplicate Patient Warning window include:

- **Save the new patient record and add the records to the Duplicate Patient Log.** To do so, press **Continue**. Afterwards, you can use the Duplicate Patient Processing item to review records in the Duplicate Patient Log and either merge them or mark them as not duplicates.

- **Save the new patient record without adding the records to the Duplicate Patient Log.** To do so, clear the Add to Duplicate Patient Processing Log for later review check box and then press **Continue**.

- **Return to the Registration Entry/Edit window without saving the new patient record.** To do so, press **Edit New Patient**. You can then close the Patient Registration item without saving the new record.

- **Delete the new patient record.** To do so, press **Delete New Patient**. CoPathPlus deletes the patient record and returns you to the CoPathPlus Application Manager window.

Options from the Duplicate Patient Warning Window During New Specimen Entry

If CoPathPlus detects a possible duplicate record when you are accessioning a new patient, the Duplicate Patient Warning window appears.
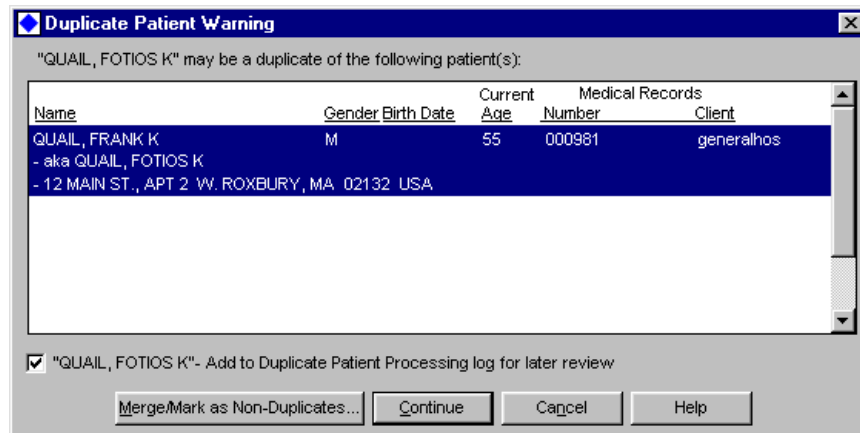
Your options from the Duplicate Patient Warning window include:

- **Merge the duplicate patient records.** To do so, press <u>Merge/Mark as Non-Duplicates…</u>. The Patient Merge/Encounter Move window appears.

  After you complete the merge, CoPathPlus returns you to either the New Specimen window (if just one possible duplicate record was found) or the Duplicate Patient Warning window (if more than one possible duplicate record was found). If the New Specimen window appears, the merged patient record is selected at the <u>P</u>atient Name or MRN field. If the Duplicate Patient Warning window appears, continue to process the remaining possible duplicate records as described in this topic.

- Mark the patient records as not duplicates. To do so, press <u>M</u>erge/Mark as Non-Duplicates…. The Patient Merge/Encounter Move window appears.

  After you mark a record as not a duplicate, you return to the Select Patient window with your original search criteria selected.

- **Accession the new specimen and add the records to the Duplicate Patient Log.** To do so, press <u>C</u>ontinue. Afterwards, you can use the Duplicate Patient Processing item to review records in the Duplicate Patient Log and either merge them or mark them as not duplicates.

- **Continue to accession the new specimen without adding the records to the Duplicate Patient Log.** To do so, clear the Add to Duplicate Patient Processing Log for later review check box and then press <u>C</u>ontinue.

- **Cancel the accessioning and return to the Select Patient window.** To do so, press Ca<u>n</u>cel.

NOTE: Depending on how your site implemented CoPathPlus, duplicate patient records may be merged from the Duplicate Patient Warning window during New Specimen entry. If your site allows this, certain users with permission may be able to merge duplicate patient records at that time. For those users, the **Merge/Mark as Non-Duplicates…** button is enabled on the Duplicate Patient Warning window during New Specimen entry. That button is disabled during Patient Registration.

Merge on the Fly During Accessioning

Merge on the Fly is a feature to speed duplicate patient merges during accessioning. For this feature to work, you must have the "Merge on the Fly" permission (Contact your system administrator for more information). This permission, labeled "Merge on the Fly", works in conjunction with the two system settings *Show Duplicate Patients During Accessioning* and *Merge on the Fly During Accessioning* to determine the exact functionality of the real-time merge feature during accession. Refer to the chart below for the expected outcome of combinations of the two settings and whether or not the permission is granted.

Show Duplicate Patients During Accessioning System Setting	Merge on the Fly During Accessioning System Setting	Merge on the Fly Misc. Permission	Outcome
Y	Y	Granted	Duplicate Pt Window displays and user may select to merge or mark as non-duplicates
Y	Y	Not granted	Duplicate Pt window displays but merge or mark as non-duplicates is not available
Y	N	Either granted or not	Duplicate Pt window displays but merge or mark as non-duplicates is not available
N	Y or N	Either granted or not	Duplicate Patient window does not display
M	Y	Granted	Duplicate Pt Window displays and user may select to merge or mark as non-duplicates
M	Y	Not granted	Duplicate Pt Window does not display
M	N	Granted	Duplicate Pt window displays but merge or mark as non-duplicates duplicates is not available
M	N	Not granted	Duplicate Pt Window does not display

Entering/Editing Patient Registration Information

Once you access Patient Registration, the Registration Entry/Edit window appears. In the standard export version of CoPathPlus, the Registration Entry/Edit window contains these two tabs:

- Patient, which lets you enter and edit patient-related registration information such as name, patient numbers, age, and address.

- Encounters, which lets you view, add, or edit patient encounter information such as admission date and discharge date. . Since multiple encounters can be associated to the same patient, this tab links to all assigned encounter records.

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., ⌶ and ⌶) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Patient Tab on the Registration Entry/Edit Window

In the standard export version of CoPathPlus, the first tab on the Registration Entry/Edit window is the Patient tab.

NOTE: Your system may look different depending on the modifications made by your site.

Enter the following information on the Patient tab:

Patient Name.

1) **Last Name.** Enter the patient's last name.

2) **First Name.** Enter the patient's first name.

3) **Middle Name.** Enter the patient's middle name or initial, if any.

4) **Suffix.** Enter any suffix this patient may have (e.g., Jr., III).

5) **Aliases.** Press this button to open the Patient Aliases pop-up window on which you can enter any alternative names or aliases for this patient.   For additional information about how to enter a patient's "other" names, such as a maiden name or nickname, refer to "Entering Patient Aliases".

Medical Record Information. For more detailed information about these fields, refer to "Medical Record Number and Client Information".

1) Medical Record Number**.** Enter this patient's Medical Record Number(s). Although a patient can have multiple MRNs, each must be unique per client.

2) **Client.** Enter the client associated with the Medical Record Number. A client must be associated to every Medical Record Number entered for the patient.

Other Number Information. For detailed information on these fields, refer to "Other Number Information".

1) **Universal #.** Enter your site's Universal Number for this patient if your site maintains this data.

2) **HIS Internal #.** Enter your site's HIS Internal Number for this patient, if any. This number may be sent in an Admissions/Discharge/Transfer (ADT) record.

Demographics. For detailed information on these fields, refer to "Demographic Information".

1) **Soc. Sec. #.** Enter this patient's Social Security Number. You do not have to use delimiters (e.g., -) to separate the numbers.

2) **Gender.** Select the gender of this patient. Select "Unknown" if you do not know.

3) **Title.** Specify the title for this patient (e.g., Mr., Mrs., Ms., Dr.).

4) **Birth Date.** Enter the date on which this patient was born. If you fill in a birth date, CoPathPlus automatically enters the patient's age in the Age field.

5) **Age.** If you do not know the patient's birth date but know the patient's age, enter it in this field. Enter the numeric value in the first field and then select the units (e.g. years, days) from the drop-down list in the adjacent field.

6) **Race.** Select the race of this patient, if your site collects this data.

7) **Expired.** Select this check box if this patient has died.

8) **Date/Time Expired.**   If you selected the Expired check box (i.e., this patient has died), enter the date and time at which this patient died.

Address. For detailed information on these fields, refer to "Address Information".

1) **Street.** Enter the street address for this patient. Press Enter at the end of each line.

2) **City.** Enter the city in which this patient lives.

3) **State.** Specify the state in which this patient lives.

4) **Postal Code.** Specify the ZIP or postal code for this patient's address. You can look up an entry already entered in the ZIP/Postal Code Dictionary or you can enter up to 12 characters of free text in this field.

5) **Country.** Specify the country in which this patient lives.

Save/Close **button.** Press this button to save the information you have entered and return to the CoPathPlus Application Manager.

If you are done registering this patient and do not want to enter encounter information, go to "Next Step for the Registration Entry/Edit Window".

To view and edit encounter information, continue with "Entering Information on the Encounters Tab on the Registration Entry/Edit Window".

Entering Patient Aliases

In addition to entering the patient's full name on the Patient tab on the Registration Entry/Edit window, you can enter any number of alternative names or aliases for this patient. This could represent a maiden name or a nickname. In CoPathPlus, patients can be identified either by the name entered on the Patient tab or by any of their aliases. When you press Aliases on the Patient tab, the Patient Aliases pop-up window appears.

You can enter as many aliases as you need for this patient. Press **OK** (or press Enter) when you are done adding aliases.

Medical Record Number and Client Information

You can associate a unique Medical Record Number(s) with the patient on the Patient tab on the Registration Entry/Edit window by entering both the:

- Medical Record Number (MRN) in the **Medical Record Number** field, and
- The associated client in the Client field.

You can enter multiple MRNs for the patient, each with a different client. A Medical Record Number must be unique for a client. A patient can only have one MRN for a given client. You can enter this information manually or through an ADT interface.

For more information on interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *Cerner CoPathPlus Implementation Manual*.

Other Number Information

You can enter two other unique numbers for this patient on the Patient tab on the Registration Entry/Edit window.

- **Universal #.** Represents a free-text corporation patient identification number used at your institution. This number is not the same as the Medical Record Number. You can use the Universal Number to look up a patient on the Select Patient window.

- **HIS Internal #.** Represents a free-text "hospital information system" internal identification number used at your institution. This number is sometimes sent in an Admissions/Discharge/Transfer (ADT) record. You can use the HIS Other Number to look up a patient on the Select Patient window.

Demographic Information

You can enter demographic information for the patient on the Patient tab on the Registration Entry/Edit window. It is also on this tab where you would specify if a patient had died.

- Enter the patient's social security number in the **Soc Sec #** field. You can use this number to identify the patient on the Select Patient window. You do not need to enter delimiters (e.g., - or /) to separate the numbers.

- If you enter **F** (for "Female") in the **Gender** field, CoPathPlus provides a default title of Ms. in the **Title** field. If you enter **M** (for "Male") in the Gender field, CoPathPlus provides a default title of Mr. Title is a free-text field. You can edit it to change the default value. You can also enter a value of **U** in the Gender field if the gender of the patient is unknown.

- If you know the patient's date of birth, enter it in the **Birth Date** field. If you enter a date of birth, CoPathPlus automatically enters the patient's age in the **Age** field and then disables the field. If you do not know the birth date, enter a number in the first part of the Age field and choose one of the following entries for the second part of the field: Days, Weeks, Months, or Years (default).

Address Information

Enter the patient's street address in the **Street** field. This is a multi-line field in which you press Enter at the end of each line to start typing on the next line. Enter the full name of the city in which the patient lives in the **City** field. If this is a foreign address, enter the city and any other information needed before the country. The following features apply to the City, State, Postal Code, and Country fields.

If…	Then...
The city you enter is in the ZIP/Postal Code Dictionary and is associated with one state	The correct state and postal code will default in the State and Postal Code fields, respectively.
The city you enter is in the ZIP/Postal Code Dictionary and is associated with two states	Enter the state in the State field and the correct postal code will default.
NOTE: If the city you enter is associated with more than one postal code in the Zip/Postal Code Dictionary, you will have to enter the correct postal code.	
You enter the postal code first and it is in the ZIP/Postal Code Dictionary	The correct city and state will default in the City and State fields, respectively.

You can enter the state or province in which the patient lives in the **State** field by selecting from the available state abbreviations in the drop-down list. The value in the **Country** field defaults when you enter a state if the country is associated with the state in the State Dictionary.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

If the patient lives in the United States, you can enter a five- or nine-digit ZIP or postal code in the **Postal Code** field. Otherwise, you can enter 12 characters of free text in this field.

NOTE: Entering free text in this field will not automatically load that data into the ZIP/Postal Code Dictionary. If you want this information in the dictionary, you must manually add an entry to that dictionary. For more information, refer to "ZIP/Postal Code Dictionary" in the "Registration Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Also, if your site has included the County field, the county associated with the ZIP/Postal Code will default, if defined in the ZIP/Postal Code Dictionary.

Encounters Tab on the Registration Entry/Edit Window

In the standard export version of CoPathPlus, the second tab on the Registration Entry/Edit window is the Encounters tab. When entering information for a new patient, no encounters would be listed on this tab. A patient must already exist in CoPathPlus in order for there to be existing encounter information or for you to enter a new encounter for that patient.

NOTE: Your system may look different depending on the modifications made by your site.

The following information is displayed for each of this patient's encounter records: encounter number, patient type, admit date, status, client, and location. If you are creating a new patient record, no encounters will exist.

To enter a new encounter, press **New Encounter**. To edit information for an existing encounter, highlight that encounter and press **Edit Encounter**. In both cases, the Encounter Entry/Edit window appears. For a detailed description of that window, go to "Entering/Editing Encounter Information".

NOTE: If this is a new record or if you made any edits to an existing record, you must press on the toolbar (or select File, Save Patient on the menu bar) to save the entry before you can enter an encounter for the patient.

Entering/Editing Encounter Information

In the standard export version of CoPathPlus, the Encounter Entry/Edit window contains three tabs:

- Admission, which lets you enter encounter type and location information, and admission and discharge data.

- Staff/ICD9/Guarantor, which lets you enter the admitting and attending physicians, ICD-9-CM code(s), and guarantor information.

- **Insurances,** which lets you enter patient insurance information, including multiple insurance coverage.

Remember that many CoPathPlus fields contain a control located to the far right of the field (e.g., and) that you can click to access a list from which you can select an entry for the field. For information about controls, refer to "CoPathPlus Controls".

Admission Tab on the Encounter Entry/Edit Window

In the standard export version of CoPathPlus, the first tab on the Encounter Entry/Edit window is the Admission tab.

Enter the following information on the Admission tab:

Type and Location Information. For more detailed information on these fields, refer to "Type and Location Information".

1) Encounter Number**.** Enter a number for this encounter if you do not have an ADT interface. A system setting determines whether a patient's latest encounter number appears as the default at the Encounter field during accessioning.

2) **Status.** Select the status of this encounter: **Active** (the default), **Discharged**, **Canceled**.

3) **Client.** Select a client from the drop-down list, or accept the default client, which is associated with the encounter number. Clients are entities, often institutions that send specimens to the pathology laboratory, and they usually collect the specimen and receive the report of diagnosis results. CoPathPlus requires a client entry in this field.

   NOTE: CoPathPlus Clients are configured to require, allow, or disallow encounter records. If you attempt to save an encounter with a Client code that disallows encounters, the system will post an error message. Either correct the client type or delete the encounter.
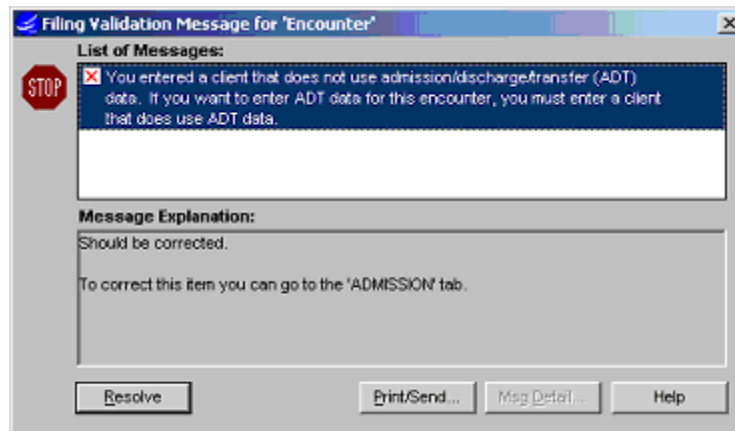
4) **Location.** Select the place where the patient was when the specimen was taken.

5) Patient Type**.** Select the patient type or admission class.

6) **Room/Bed.** Enter the specific room or bed in which this patient is located.

7) Service**.** Select the section of the hospital where the patient receives treatment as related to the current visit.

8) **Financial Class.** Select the party responsible for the billing for this encounter.

Admission and Discharge Information. For detailed information on these fields, refer to "Admission and Discharge Information".

1) **Admit Date/Time.** Enter the date and time the patient was admitted or visited the institution.

2) **Admitting Diagnosis.** Specify the reason the patient was admitted or why he or she visited the hospital.

3) **Discharge Date/Time.** Enter the date and time the patient left the institution. This field may only be completed when the Status field is set to Discharged.

4) **Encounter Patient Status.** When the patient is discharged, select the method of the patient's discharge (e.g., Ambulatory, Deceased). All possible statuses are defined in the Discharge Disposition Dictionary. For more information, refer to "Discharge Disposition Dictionary" in the "Registration Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

5) **Discharge Diagnosis.** Enter the outcome of the patient's encounter.

Type and Location Information

You can enter certain type and location information on the Admissions tab on the Encounter Entry/Edit window:

- You can enter a number for this encounter in the Encounter Number field if you do not have an Admissions/Discharge/Transfer (ADT) interface. The Encounter Number represents an "admission", "visit", or "episode of care". Each encounter has a corresponding number, which is usually passed to CoPathPlus via an ADT interface and used for billing purposes. It will identify an admission record in the CoPathPlus database.

  If your site does not have an ADT interface, you may choose not to record encounters at all. Encounters assist with specimen accession by providing default values and for tracking additional information not captured with the specimen. However, encounters are not required.

- The value in the **Status** field represents the status of the encounter and defaults to Active. There are three possible statuses: Active, Canceled, and Discharged. You can change the value in this field. An encounter cannot have a status of Canceled if specimens have already been assigned to the encounter.

  If you have an ADT interface, an Encounter Number can be reused if the original Encounter Number has a status of Canceled. In addition, you can reactivate a Canceled Encounter Number if that Encounter Number has not been reassigned to another patient.

- You can enter a client associated with this encounter in the Client field. For those sites with only one client, the system can be configured to allow that client to default into the Client field.

- In the Location Dictionary you can associate a location to the patient.

- You can enter a Patient Type on the Admission tab.

- **Room/Bed** is a free-text field.

- You can enter a service in the Service field that is associated with this encounter.

- "**Financial Class**" is the party or institution that will be billed for the encounter. It is also sometimes referred to as Insurance Class.

Admission and Discharge Information

The Admission tab on the Encounter Entry/Edit window provides a place for you to enter admission and discharge information for the encounter. This information is usually passed to CoPathPlus via an ADT interface. You can manually enter this information. Enter the date and time the patient was admitted or visited the institution in the **Admit Date/Time** field and the date and time he or she was discharged in the **Discharge Date/Time** field.

NOTE: The Discharge Date cannot be earlier than the Admit Date.

You can also enter the reason that the patient was admitted in the **Admitting Diagnosis** field and the outcome of the patient's encounter in the **Discharge Diagnosis** field. Both of these are free-text fields that can contain up to 60 characters. You can use the **Encounter Patient Status** field to note the method of discharge (e.g., Ambulatory, Deceased, etc.). Encounter patient statuses are defined in the Discharge Disposition Dictionary. For more information, refer to "Discharge Disposition Dictionary" in the "Registration Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Staff/ICD9/Guarantor Tab on the Encounter Entry/Edit Window

In the standard export version of CoPathPlus, the second tab on the Encounter Entry/Edit window is the Staff/ICD9/Guarantor tab. **NOTE:** Your system may look different depending on the modifications made by your site.

Enter the following information on the Staff/ICD9/Guarantor tab:

Admitting Physician. Select the name of the physician who admitted this patient.

Attending Physician(s). Enter the names of all physicians attending this patient. These physicians will copy down to specimens when new accessions are entered. The physicians maintained at the specimen level will receive a copy of the patient's report. A system setting determines whether the first attending physician entered for a patient appears as the default at the Submitting Physician field during accessioning.

Role Id. Select the role for each attending physician (e.g., attending, consulting, resident). Roles are defined in the Person Role Dictionary. Refer to "Person Role Dictionary" in the "People/Security Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual.*

Encounter-Level ICD-9-CM Code(s). Enter the ICD-9-CM code(s) to associate with this encounter. These codes are often sent through an ADT interface and appear as defaults in this field. If the ICD-9-CM code(s) received from an ADT interface do not match a code in the CoPathPlus ICD-9-CM Code dictionary, the code from the ADT interface does not appear as a default in this field, and the code will appear on the Interface Error Log.

For information on the ICD-9-CM Code dictionary, refer to "ICD-9-CM Code Dictionary" in the "Billing Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*. For information about the Interface Error Log, refer to "View Errors" in the "Interface Functions" section of the *Cerner CoPathPlus System Manager Guide*.

Guarantor. The guarantor is the person responsible for payment of charges related to the encounter.

NOTE: A system setting determines whether the patient name/address/phone information defaults as the guarantor name/address/phone information.

1) **Last Name.** Enter the guarantor's last name.

2) **First Name.** Enter the guarantor's first name.

3) **Middle Name.** Enter the guarantor's middle name or initial, if any.

4) **Phone.** Enter the guarantor's telephone number.

5) **Street.** Enter the street address for the guarantor. Press the Enter key at the end of each line.

6) **City.** Enter the city in which the guarantor lives.

7) **State.** Select the state in which the guarantor lives.

8) **Postal Code.** Specify the ZIP or postal code for the guarantor's address. You can look up an entry already entered in the ZIP/Postal Code Dictionary or you can enter up to 12 characters of free text in this field.

9) **Country.** Select the country in which the guarantor lives.

> **NOTE:** The guarantor address fields operate in much the same way as the patient address fields on the Patient tab on the Registration Entry/Edit window. For detailed information on these fields, refer to "Address Information".

Insurances Tab on the Encounter Entry/Edit Window

In the standard export version of CoPathPlus, the last tab on the Encounter Entry/Edit window is the Insurances tab.

NOTE: Your system may look different depending on the modifications made by your site.

The Insurances tab includes an insurance list, with insurance detail fields below. The values in the detail fields depend on which insurance you select on the insurance list.

NOTE: In order to use multiple insurances for a patient, a conversion must be run on your site's existing encounter data. Contact your Cerner CoPathPlus Implementation Project Manager for more information.

The following fields and buttons appear on the Insurances tab:

Select Insurance display field. The top portion of this tab lists all the insurance policies for the patient, arranged by insurance type, policy number, and subscriber. The information associated with the insurance policy highlighted in the top portion displays in the Edit Insurance detail fields on the bottom portion of the tab. You can highlight the entry by clicking on it or press **Pre<u>v</u>ious** or **Ne<u>x</u>t** to move up and down the list. Press **<u>A</u>dd** to enter a new insurance policy.

NOTE: In the standard export version of CoPathPlus, you can enter unlimited insurances on this tab. However, if your site uses site-specific version of the Encounter Entry/Edit window, you can enter no more than three insurance values. Contact your Cerner CoPathPlus Implementation Project Manager for more information.

Edit Insurance detail fields.

1) **Insurance Type.** Select the name of the specific insurance company or type of insurance for this encounter. This field is a lookup into the Insurance dictionary. For more information on this dictionary, refer to "Insurance Dictionary" in the "Registration Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual.*

You can also select "Wild Card Insurance" to enter an insurance type that does not reside in the Insurance dictionary. Press the **Insurance Detail** button to open the Insurance Details window (see below) and enter the insurance name and address.

2) **Policy Number.** Depending on your selection in the Insurance Type field, use this field to enter the insurance policy number of the person or party responsible for the billing.

3) **Group Number.** Depending on your selection in the Insurance Type field, use this field to enter the insurance group number of the person or party responsible for the billing.

4) **Subscriber Last Name.** Enter the last name of the insured. This entry may or may not be the current patient.

   NOTE: A system setting determines whether the patient or guarantor name/address/phone information defaults as the subscriber name/address/phone information.

5) **First Name.** Enter the first name of the subscriber.

6) **Middle Name.** Enter the middle name of the subscriber, if known.

7) **Rel. to Patient.** Select the relationship of the person or party identified in the Subscriber Last Name field to the patient (e.g., Self, Child, Spouse). This field is a lookup into the Relationship dictionary. For more information on this dictionary, refer to "Relationship Dictionary" in the "Registration Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual.*

8) **Street.** Enter the street address for the subscriber. Press the Enter key at the end of each line.

9) **Phone.** Enter the subscriber's telephone number.

10) **City.** Enter the city in which the subscriber lives.

11) **State.** Select the state in which the subscriber lives.

12) **Postal Code.** Specify the ZIP or postal code for the subscriber's address. You can look up an entry already entered in the ZIP/Postal Code Dictionary or you can enter up to 12 characters of free text in this field.

13) **Country.** Select the country in which the subscriber lives.

   NOTE: The subscriber address fields operate in much the same way as the patient address fields on the Patient tab on the Registration Entry/Edit window. For detailed information on these fields, refer to "Address Information".

Insurance Detail button. Press this button to open the Insurance Details window. Use this display-only window to view the name, telephone number, and address of the insurance organization selected on the Insurances tab. This default address information is contained in the Insurance dictionary. Press **OK** to close the window and return to the Insurances tab.

NOTE: This data fields in the Insurance Details window are editable (not display-only) when you select Wild Card Insurance as the **Insurance Type**. In this case, you can enter the insurance organization's name, phone, and address in the window fields. Press **OK** to save the details and return to the Insurances tab.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Creating Encounters Automatically

For sites that do not have an Admissions/Discharge/Transfer (ADT) interface, or that use a combination of specimens associated with ADT encounter and reference-type specimens, but still require saving data normally stored at the encounter level, CoPathPlus provides the option of creating encounters automatically upon specimen accession. This is most often used by clients who do not have an ADT interface but who need to maintain patient insurance information for billing purposes since insurance information is stored at the encounter level.

The system setting "Automatic Encounter Generation" must be turned on in one of two ways:

- If the setting is 'Y,' an encounter will be automatically created for each newly-accessioned specimen. However, this setting prevents users from manually entering encounters. This is mainly used by reference labs that do not have ADT encounters.

- If the setting is 'C,' then automatic encounter generation will depend upon the specimen client. The 'C' value enables the "Automatically add encounter on specimen accession" checkbox in the Client dictionary, so you can choose which clients will have automatic encounters for their specimens. This setting is mainly used by hospital labs that have a mixture of specimens associated with ADT encounters, and reference-type specimens. For more information on this dictionary, refer to "Client Dictionary" in the "Registration Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

The Accessioning form sequence must include the Copy/Edit Insurance application user object. This object appears to be a button on the Accession Entry/Edit window. It is not included on the standard, exported form sequences. Refer to the Customizer Manual for information on Window Painting.

Press the Copy/Edit Insurance button in Accession Entry/Edit to create a new encounter or to update the encounter currently linked to the specimen. When a new encounter is created, the encounter number will be the specimen number including the 4 digit year value, the encounter status will be Active, and the encounter client will be the client entered for the specimen. Data entry for the remaining encounter fields should proceed for the encounter as per normal conventions.

NOTE: If the "Automatic Encounter Generation" setting is 'C' and a specimen is deleted for Patient A and that same specimen number is reassigned to a new specimen for Patient B, you will receive a warning message that the encounter already exists for Patient A, and that a new encounter must be created manually for Patient B.

Next Step for the Encounter Entry/Edit Window

Now that you have completed the information on the Encounter Entry/Edit window, you can perform one of the following actions:

- Return to the Encounters tab on the Registration Entry/Edit window by pressing on the toolbar (or select File, Close Encounter and Return on the menu bar). Press **Yes**, when prompted, to save your edits to the current encounter.

- Exit CoPathPlus by pressing on the toolbar (or select File, Exit CoPathPlus on the menu bar). Press **OK**, when prompted, to sign-off CoPathPlus. Press **Yes**, when prompted, to save your edits to the current encounter.

Next Step for the Registration Entry/Edit Window

Now that you have completed the information on the Registration Entry/Edit window, you can perform one of the following actions:

- Save your current entry and begin registering a new patient by pressing on the toolbar (or select <u>F</u>ile, <u>N</u>ew Patient on the menu bar). Press **Yes**, when prompted, to save your edits to the current patient.

- Choose an existing patient record to edit by pressing on the toolbar (or select <u>F</u>ile, <u>O</u>pen Patient on the menu bar). Press **Yes**, when prompted, to save your edits to the current patient.

- Return to the CoPathPlus Application Manager by pressing on the toolbar (or select <u>F</u>ile, <u>C</u>lose Patient on the menu bar). Press **Yes**, when prompted, to save your edits to the current patient.

   NOTE: Pressing on the toolbar (or selecting <u>F</u>ile, <u>M</u>anager on the menu bar) will also return you to the CoPathPlus Application Manager. However, this button will merely bring the Manager forward, where you can access another function, but will not close and file your current activity.

- Exit CoPathPlus by pressing on the toolbar (or select <u>F</u>ile, E<u>x</u>it CoPathPlus on the menu bar). Press **OK**, when prompted, to sign-off CoPathPlus. Press **Yes**, when prompted, to save your edits to the current patient.

Editing Information for an Existing Patient

This topic describes how to edit patient registration and encounter data for an existing patient.

To edit registration data for an existing patient, you must first identify the patient to CoPathPlus. Refer to "Selecting an Existing Patient" for more information on selecting an existing specimen.

After you identify the patient, the Registration Entry/Edit window appears with the current patient information. From the Registration Entry/Edit window, you can edit both patient demographic information and encounter information.

NOTE: You can also access Patient Registration by performing a patient lookup from the New Specimen or Select Specimen window when accessioning a specimen. However, you cannot register a new patient when you do a lookup from the Select Specimen window. To register a new patient, you must either press the **Patients** command button or do a lookup from the New Specimen window and press **New Patient**. For more information on the New Specimen and Select Specimen windows, refer to "Accessioning Specimens and Accession Entry/Edit".

Entering/Editing Patient Registration Information for an Existing Patient

In the standard export version of CoPathPlus, the first tab on the Registration Entry/Edit window is the Patients tab. This tab contains the same fields you see when registering a new patient. For existing patients, however, the fields contain the data you originally entered for the patient. Refer to "Entering Information on the Patient Tab on the Registration Entry/Edit Window" for more information.

Entering/Editing Encounter Information for an Existing Patient

In the standard export version of CoPathPlus, the second tab on the Registration Entry/Edit window is the Encounters tab. This tab contains the same fields you see when registering a new patient. For existing patients, you can either enter a new encounter for the patient or edit existing encounter information. For information on how to enter a new encounter for this patient, refer to "Entering/Editing Encounter Information".

If there is an existing encounter for this patient, you will see the encounter or encounters listed on the Encounters tab.

Remember that a patient must already exist in CoPathPlus in order for there to be encounter information for that patient.

NOTE: Encounters can also be entered into CoPathPlus through an Admissions/Discharge/Transfer (ADT) interface. For more information on interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *Cerner CoPathPlus Implementation Manual*.

To edit encounter information for a patient in CoPathPlus:

1) Press (or File, Save Patient) to file any patient information you entered/edited so far, if necessary.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

2) Select the encounter you want to edit and press **Edit Encounter** on the Encounters tab. The Encounter Entry/Edit window appears.

You can now enter/edit insurance, admission, and physician information for the patient in the Encounter Entry/Edit window.

Entering Information on the Admission Tab on the Encounter Entry/Edit Window for an Existing Patient

In the standard export version of CoPathPlus, the first tab on the Encounter Entry/Edit window is the Admission tab. This tab contains the same fields you see when entering an encounter for a new patient. For existing encounters, these fields contain the data you originally entered for the encounter. For more information about this tab, refer to "Entering Information on the Admission Tab on the Encounter Entry/Edit Window".

You can enter/edit most of the information on this tab. Note, however, that you will receive a warning message if you change the encounter number if specimens are already associated with the original encounter number. If you change the encounter number anyway, all specimens associated with that encounter will be updated with the new encounter number. CoPathPlus also updates the associated specimen's billing numbers if you have not manually overridden them with a different number.

Entering Information on the Staff/ICD9/Guarantor Tab on the Encounter Entry/Edit Window for an Existing Patient

In the standard export version of CoPathPlus, the second tab on the Encounter Entry/Edit window is the Staff/ICD9/Guarantor tab. This tab contains the same fields you see when entering an encounter for a new patient. For existing encounters, these fields contain data you originally entered for the encounter. For more information about this tab, refer to "Entering Information on the Staff/ICD9/Guarantor Tab on the Encounter Entry/Edit Window".

You can use this tab to enter/edit the physicians or insurance information associated with this patient.

Entering Information on the Insurances Tab on the Encounter Entry/Edit Window for an Existing Patient

In the standard export version of CoPathPlus, the last tab on the Encounter Entry/Edit window is the Insurances tab. This tab contains the same fields you see when entering an encounter for a new patient. For existing encounters, these fields contain data you originally entered for the encounter. For more information about this tab, refer to "Entering Information on the Insurances Tab on the Encounter Entry/Edit Window".

You can use this tab to enter/edit the physicians or insurance information associated with this patient.

This page was intentionally left blank.

Chapter 8: Reports

Overview

Reports explains how to access and generate patient reports plus use of the Report Chute Manager. It also covers running management reports and includes a brief description of each standard management report in CoPathPlus.

NOTE: Security is defined per report. You may not be able to access some of the reports mentioned in this guide if you do not have permission to do so.

Sites can also copy and modify management reports and then link them to CoPathPlus where appropriate. Cerner CoPathPlus recommends that custom site reports be saved within the Site Specific Reports folder.

NOTE: You can also obtain a printout of all the entries most CoPathPlus dictionaries. This Dictionary Printouts option is available to you when you press the **Dictionaries** command button on the CoPathPlus Application Manager. Refer to "Printing Dictionaries" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this option.

The information contained in this guide is based on the reports provided with the standard export version of CoPathPlus. Your system may have additional, custom reports that are not documented here.

Management Reports

This section explains how to access, run, and print the standard management reports provided with your CoPathPlus system. CoPathPlus uses InfoMaker to produce these reports. To learn how to duplicate and modify these reports or to create new InfoMaker reports of your own, refer to the *Cerner CoPathPlus Management Report Training* manual.

NOTE: You can run your site-created InfoMaker reports through the CoPathPlus InfoMaker Wizard. The InfoMaker Wizard is a CoPathPlus application feature that lets you easily specify different types of selection criteria for all reports using InfoMaker. People with permission can link site-created InfoMaker reports to the InfoMaker Wizard through the InfoMaker Item Entry/Edit item found within the Folders and Items folder under the **Setup** command button. Consult your System Manager for more information about this capability. To learn about this item, refer to "InfoMaker Item Entry/Edit" in the "Setup" section of the *Cerner CoPathPlus System Manager Guide*.

Accessing the Management Reports

To access the standard management reports in CoPathPlus:

1) Press the **Reports** command button on the CoPathPlus Application Manager. A list of folders (categories of reports) appears on the right side of the Application Manager:

   - Audit Trail Reports

   - Billing Reports

   - Case Diagnostic Reports

   - Case Statistical Reports

   - CLIA '88/Cytology Reports

   - Dictionary Related Printouts

   - Download Reports

   - Labels

   - Logs

   - Patient Reports

   - QA Reports

   - Site-Specific Reports (this is the folder that you may use to store your site-created reports)

2) Double-click on the folder you want.

   A list of available reports or items available within that folder appears. If the folder appears empty, you do not have permission to any reports assigned in this folder.

3) Double-click on the report or item you want.

TIP! You can also access each individual report by placing the report in your Personal Menu and double-clicking on it from there.

If you choose:

- **All other folders containing management reports,** when you select any management report, the InfoMaker Wizard appears. Continue with the "Running the Management Reports" section for additional information.

- **Patient Reports folder**, a list of items associated to patient diagnostic reports is displayed.   Continue with the "Patient Reports" section for more information.

Running the Management Reports

Once you choose the management report you want to run, as specified in Accessing the Management Reports, the InfoMaker Wizard for the report you chose appears. The InfoMaker Wizard is a CoPathPlus application feature that lets you easily specify different types of selection criteria for all reports using InfoMaker.

NOTE: You can schedule reports to run using the CoPathPlus Schedule Manager.

For a description of each management report currently available in CoPathPlus, refer to "Report Descriptions".

Data Fields and Selection Criteria

The top portion of the InfoMaker Wizard lists the data fields that are set up in your report to be asked at runtime (i.e., when you try to produce a report). For example, the Accession Log contains two data fields: Accession Date and Specimen Class.

The front end for the CoPathPlus management reports currently can be set up with the following different types of data fields:

- Age
- Choices
- Date/Time
- Dictionary
- Free-Text
- Number
- Pop-Up
- Query Lists
- SNOMED II Code
- SNOMED II Collection Code
- Text Search for Natural Language Search

Each data field has a corresponding set of selection criteria, which is how you specify report generation parameters.   To define or change the selection criteria associated with a data field, you highlight the data field you want to update in the top portion of the InfoMaker Wizard. The
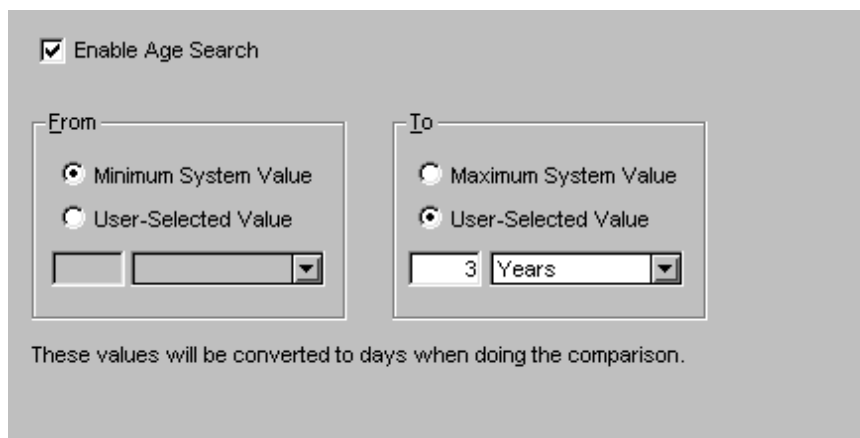
associated selection criteria appears in the display in the bottom portion of the window, known as the Selection Method field. What displays in the Selection Method field depends on the data field type you have chosen and the variant for the data field. As you change items in the bottom portion of the window, the top display is automatically updated with the defined criteria. The criteria displayed here is what prints on the header of your report for the standard reports provided within CoPathPlus.

You can move from data field to data field in the top display by clicking on the data field you want or by pressing **Previous** and **Next** beside the display. If more than four data fields are defined, a scroll bar appears so that you can navigate to the other data fields.

Age Data Field Type

The Age data field type lets you filter specimens on a CoPathPlus report based on patient age at the time of accessioning. The default search criteria at this field is **Not Used**, indicating that there is no specimen filtering based on patient age. An example of the Age data field type is shown below.

NOTE: For patients who were deceased at the time of accessioning, this search criteria will apply to the patient's age at the time of their expiration. Also, if a patient record does not have a value entered in the Birth Date field, specimens for that patient will not appear on a report when the age data field type is used.
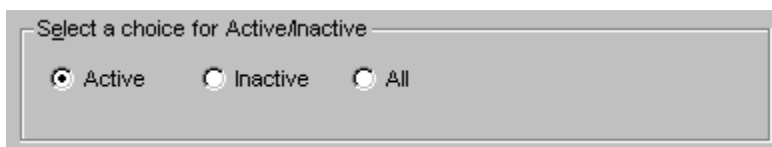
Enable Age Search. Select this checkbox to filter specimens based on patient age. Doing so causes the From and To fields to become enabled.

From field. To start your age range with the lowest age in the CoPathPlus database, select the Minimum System Value option. This is the default. To start your age range with a specific age, select the User-Selected Value option. Then, enter the minimum age in years, months, weeks, or days. As the message at the bottom of this data field indicates, CoPathPlus converts all ages to days when filtering specimens on a report. For example, an age of 52 weeks will convert to 365 days, and an age of 1 month will convert to 30 days.

To field. To end your age range with the highest age in the CoPathPlus database, select the Maximum System Value option. This is the default. To end your age range with a specific age, select the User-Selected Value option. Then, enter the maximum age in years, months, weeks, or days.

Choices Data Field Type

The Choices data field type allows you to select one choice from whatever the selection criteria may be to run on your CoPathPlus reports. The most common Choices data field type is the Active/Inactive data field (which is on all dictionary printouts), as shown in the following illustration:

Refer to "Printing Dictionaries" in the *Cerner CoPathPlus Dictionary Building Manual* for information on dictionary printouts.

Date/Time Data Field Type
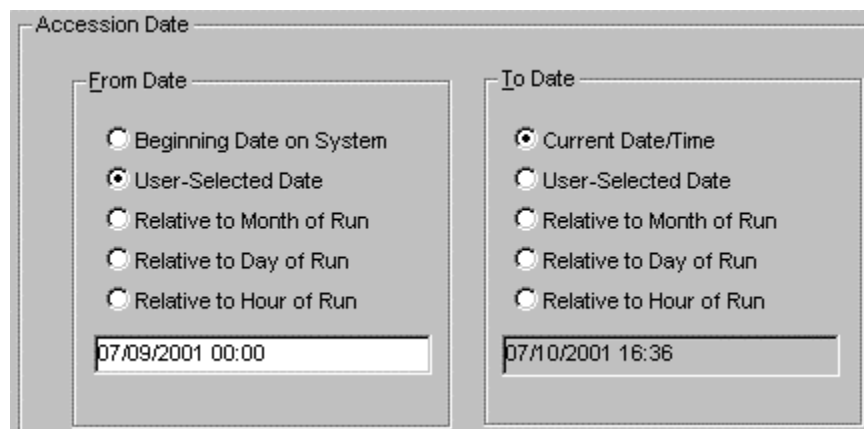
The Date/Time data field type allows you to define the date and time for which you want run your CoPathPlus reports. This data field type has variants that allow you two different ways to specify date and time selection criteria:

- From Date/To Date
- Single-Instance Date

The variant you use depends on the report you are running. Within these variants, you specify the choice you want by choosing the appropriate option button(s) or field(s) in the Selection Method field.

From Date/To Date Variant for the Date/Time Data Field Type

From Date/To Date is the most commonly seen variant for a date/time data field type. The Selection Method field for the From Date/To Date variant allows you to choose from a range of options. The following illustration shows a sample From Date/To Date variant for the Date/Time data field type.

Beginning Date on System (From Date). This choice runs the report from the date on which the first specimen was accessioned in your system (including Card cases). This date displays in the field below the From Date options, and prints in the header of your report.

Current Date/Time (To Date). This choice runs the report to the current date/time. This date and time displays in the field below the To Date options and prints in the header of your report.

User-Selected Date (From Date and To Date). This choice runs your report from the date and time you specify to the date and time you specify. The system defaults in yesterday's date with a time of midnight on the From Date side and today's date and current time on the To Date side on all reports with date retrieval criteria. You do not have to choose both options. For example, you can choose Beginning Date on System for the From Date and choose User-Selected Date for the To Date or vice versa. When you choose these options, the display on the bottom becomes enabled so that you can enter the date/time that you want. If this report is not scheduled to run in the Schedule Manager, the date/time of yesterday/midnight defaults as the scheduled date/time.

Relative to Month of Run (From Date and To Date). This choice is often used in reports run via the Schedule Manager.

Therefore, this choice, which has four selections, runs relative to the month in which this report was scheduled to run (or the current month, if not scheduled):

- Beginning of Month
- End of Month
- Beginning of Previous Month
- End of Previous Month

In CoPathPlus, the beginning of the month is the first of the month at a time of 00:00. The end of the month is the last day of the month at 23:59.

Relative to Day of Run (From Date and To Date). This choice is often used in reports run via the Schedule Manager. This choice runs relative to the day in which this report was scheduled to run (or the current day, if not scheduled). When you choose this option, you specify a number of days (positive or negative) in the field below the option buttons.
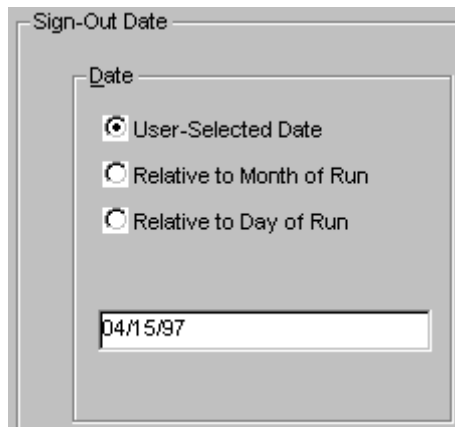
For example, if you enter **-1** for the From Date, CoPathPlus would run the report from the day before the scheduled run date at 00:00 (or yesterday at 00:00, if there was no scheduled run date). If you enter **0** for the To Date, CoPathPlus would run the report to the current day of the scheduled run at runtime (e.g., up to 23:59 of the current day).

Relative to Hour of Run (From Date and To Date). This choice is also often used in reports run via the Schedule Manager. This choice runs relative to the hour in which this report was scheduled to run (or the current hour, if not scheduled). When you choose this option, you specify a number of hours (positive or negative) in the field below the option buttons.

For example, for a shift report of all special stains ordered from 7am to 3pm that is run each day at 3:30pm, the entry would be **-8** for the From Date, and **0** for the To Date.

Single-Instance Date Variant for the Date/Time Data Field Type

As the name for it implies, you use the Single-Instance date variant to specify one date for which to run your report. The following illustration shows a sample Single-Instance Date variant for the Date/Time data field type.

User-Selected Date. This option runs your report for the date and time you specify.

Relative to Month of Run. This option is often used in reports run via the Schedule Manager. Therefore, this choice, which has four selections, runs relative to the month in which this report was scheduled to run (or the current month, if not scheduled):

- Beginning of Month
- End of Month
- Beginning of Previous Month
- End of Previous Month

In CoPathPlus, the beginning of the month is the first of the month at the time of 00:00. The end of the month is the last day of the month at 23:59.

Relative to Day of Run. This option is often used in reports run via the Schedule Manager. This choice runs relative to the day in which this report was scheduled to run (or the current day, if not scheduled). When you choose this option, you specify a number of days (positive or negative) in the field below the option buttons.

Dictionary Data Field Type

The Dictionary data field type allows you to specify dictionary-linked selection criteria to use in your CoPathPlus reports. This data field type has variants that allow you three different ways to specify dictionary-linked selection criteria:

- Array
- Single-Instance
- Required Single-Instance

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

The variant you use depends on the type of report you are running. Within these variants, you specify the choice you want by choosing the appropriate option button(s) or field(s) in the Selection Method field.

NOTE: Data fields linked to the Query List dictionary are described in Query List Data Field Type. Data fields linked to the SNOMED II Code dictionary are described in SNOMED II Code Data Field Type.

Array Variant for the Dictionary Data Field Type

Array is the most commonly seen variant for the Dictionary data field type. The Selection Method field for the Array variant has three options from which you can choose:

- All Values
- Individual Items
- Lists of Items

All Values Option (Dictionary Data Field Type)

The **All Values** option for a Dictionary data field type allows you to run the report for all entries in a specified CoPathPlus dictionary. The following illustration shows the All Values option for the Specimen Class dictionary. When this option is selected, all specimen classes in the Specimen Class dictionary will be included when you run this report.

Notice that the information below the Selection Method field is disabled when you choose the All Values format because you do not need to make any choices.
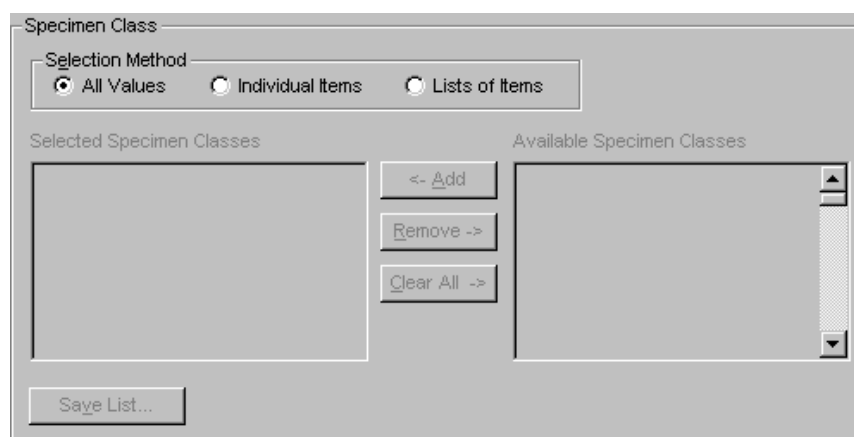
NOTE: Some reports are set up so as to not allow All Values as a choice because it does not make sense to run the report on all entries. For example, the Cytology/Surgical Correlation report asks for a target and related specimen class, which you would always want to be different. If All Values is not allowed, the option is disabled and Individual Items is the default.

Individual Items Option (Dictionary Data Field Type)

The **Individual Items** option for a Dictionary data field type allows you to run the report for selected entries in the specified CoPathPlus dictionary. The following illustration shows the Individual Items option for the Specimen Class dictionary.
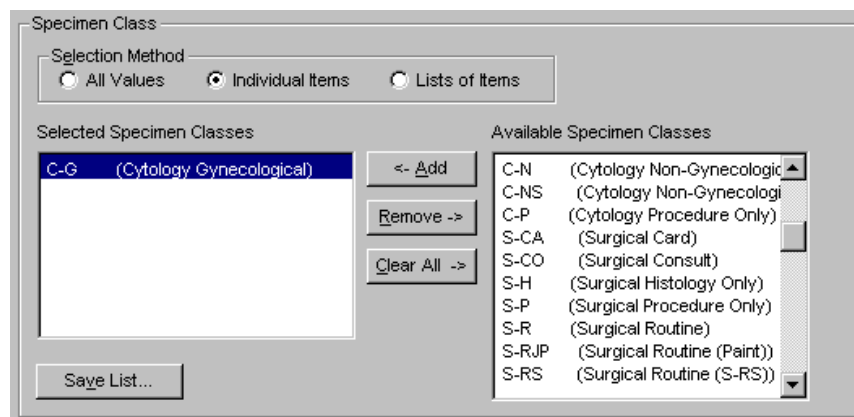
When you choose this option, the information below the Selection Method field is enabled. The right side of the window shows **all** the entries in the specified dictionary from which you can choose an individual entry.

NOTE: All specimen classes (or other dictionary items) will list when you select the Individual Items choice, whether or not they are relevant to the report. It is up to you to know what specimen classes make sense to select for each report.

To choose an entry to include in your report, do one of the following:

- Drag and drop the entry with the mouse from the right side of the window to the left side

- Highlight the entry and press **Add**

- Double-click on the entry

Your choice(s) appear on the left side of the window.

Each time you select an entry to include, the top portion of the InfoMaker Wizard is updated; the total number of selected entries appears in parentheses, followed by a list of the selected entries. The list of entries will truncate once it becomes too long for the display area. Refer to the following illustration for an example.

NOTE: AND and OR operators are limited to a maximum of 250.
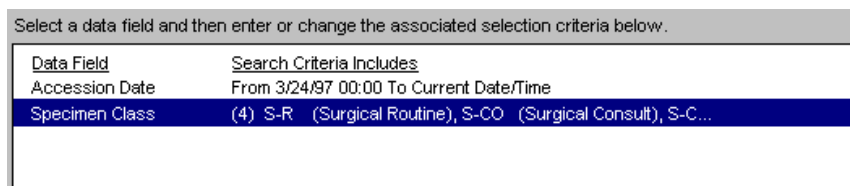
Once you have selected at least one entry to include on the report, **Save List...** becomes enabled. This button lets you create a new query list that consists of all the entries you currently have selected for inclusion on the report. For more information, refer to "Saving New Query Lists from the InfoMaker Wizard".

To remove an entry that you have selected:

You can use the same methods as when you choose an entry to include, except that you would use the **Remove** button instead of the **Add** button. Your choice disappears from the left side of the window and reappears on the right side. To remove all selected entries, press **Clear All**.

Lists of Items Option (Dictionary Data Field Type)

The **Lists of Items** option for a Dictionary data field type allows you to run the report for entries in a query list. The following illustration shows the Lists of Items option for the Specimen Class dictionary.
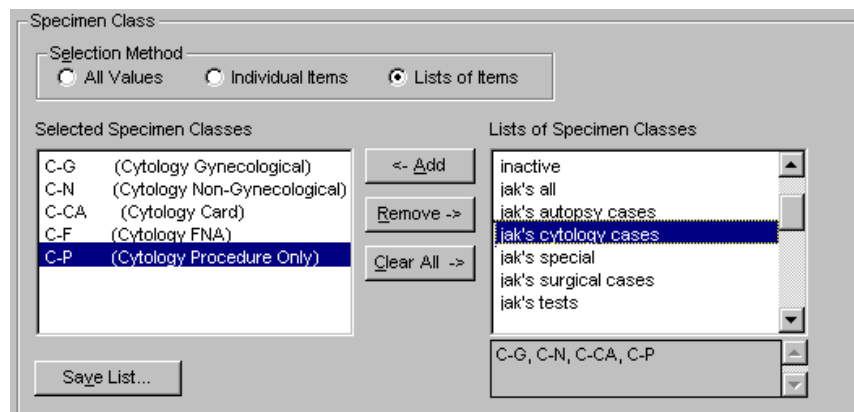
NOTE: In the above example, "jak" refers to Dr. Jane A. Kittamer.

The right side of the window displays all existing query lists for this data field. When you highlight a list, any comment that was saved with the list appears below the display. In the example above, "jak's cytology cases" comment shows that the list contains the Cytology Gynecological (C-G), Cytology Non-Gynecological (C-N), Cytology Card (C-CA), and Cytology Procedure Only (C-P) specimen classes. Once you select a list, its contents (i.e., the individual entries) appear in the left side of the window. You can remove individual entries if you want. Refer to "Individual Items Option for information on removing and selecting individual items.

You can choose as many query lists as you like. Each time you select a query list to include, the top portion of the InfoMaker Wizard window is updated; the total number of query lists appears in parenthesis, followed by the names of the selected query lists. The list of selected query lists will truncate once it becomes too long for the display area. CoPathPlus ignores duplicate entries (i.e., an entry that is included on more than one of the query lists that you chose).

NOTE: If you remove one or more individual entries from the left side of the window, the query list name is removed from the top portion of the InfoMaker Wizard and from the selection criteria in the header of the report, and individual dictionary entry names are displayed instead. That is because your selection criteria no longer matches the entries in the query list.
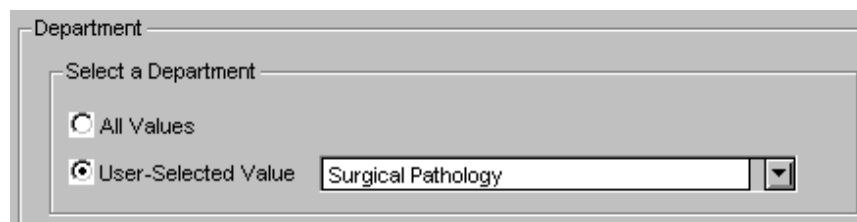
Once you have selected at least one query list to include on the report, you can save all the entries that you currently have selected as a new query list by pressing **Save List...**. For more information, refer to "Saving New Query Lists from the InfoMaker Wizard".

NOTE: AND and OR operators are limited to a maximum of 250.

If there are no available query lists for a particular data field, a message stating so appears when you choose the Lists of Items option.

Single-Instance Variant for the Dictionary Data Field Type

As the name for it implies, the Single-Instance variant allows you to you specify one dictionary-linked value for which to run your report. Notice, however, that this variant also allows you to specify all the values available. The following illustration shows a sample Single-Instance variant for the Dictionary data field type.

All Values. Select this option if you want to run the current report for all the possible values allowed. (In the above example, it would be all the departments at your site referred to in CoPathPlus.) CoPathPlus disables the User-Selected Value field when you choose the All Values option.

User-Selected Value. Select this option and then choose a value in the drop-down list if you want to specify only one selection criteria value.

Required Single-Instance Variant for the Dictionary Data Field Type

As the name for it implies, the Required Single-Instance Dictionary variant allows you to specify only one dictionary-linked value for which to run your report. The following illustration shows a sample Required Single-Instance variant for the Dictionary data field type.

Single-Instance Field. Select a choice in the drop-down list to specify a selection criteria value.

Free-Text Data Field Type

The Free-Text data field type allows you to specify free-text selection criteria to use in your CoPathPlus reports. This data field type has variants that allow you two different ways to specify free-text selection criteria:

- Array
- Single-Instance

The variant you use depends on the type of report you are running. Within these variants, you specify the choice you want by choosing the appropriate option button(s) or field(s) in the Selection Method field.

Array Variant for the Free-Text Data Field Type
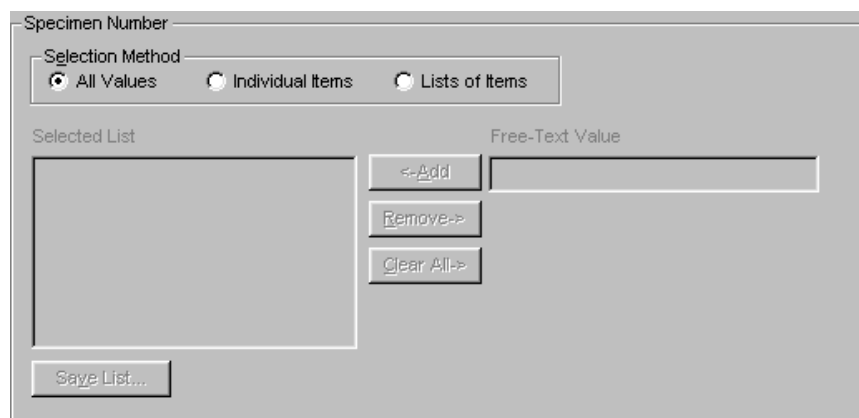
Array is the most commonly seen variant for the Free-Text data field type. The Selection Method field for the Array variant has three options from which you can choose:

- All Values

- Individual Items

- Lists of Items

All Values Option (Free-Text Data Field Type)

The **All Values** option for a Free-Text data field type allows you to run the report for all values that exist for a data field. The following illustration shows the All Values option for a Specimen data field. When this option is selected, all specimens in the CoPathPlus database will be included when you run this report.

Notice that the information below the Selection Method field is disabled when you choose the All Values format because you do not need to make any choices.

Individual Items Option (Free-Text Data Field Type)

The **Individual Items** option for a Free-Text data field type lets you enter a free-text description of each individual item you want to include on the report. The following illustration shows the Individual Items option for a Specimen data field.
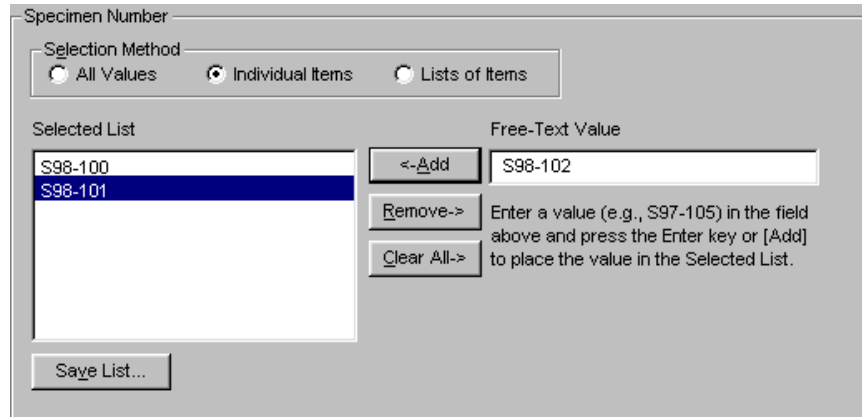
When you choose this option, the information below the Selection Method field is enabled.

To choose an item to include in your report, enter it in the Free-Text Value field and press **Add**

Your choice(s) appear on the left side of the window.

Each time you select an item to include, the top portion of the InfoMaker Wizard is updated; the total number of selected items appears in parentheses, followed by a list of the selected items. The list of items will truncate once it becomes too long for the display area. See the following illustration for an example.

NOTE: AND and OR operators are limited to a maximum of 250.

Once you have selected at least one item to include on the report, **Save List...** becomes enabled. This button lets you create a new free-text query list that consists of all the entries you currently have selected for inclusion on the report. For more information, refer to "Saving New Query Lists from the InfoMaker Wizard".

To remove an entry that you have selected, highlight it on the left side of the window and press **Remove**. To remove all selected entries, press **Clear All**.

Lists of Items Option (Free-Text Data Field Type)

The **Lists of Items** option for a Free-Text data field type lets you run the report for entries in a Free-Text query list. The following illustration shows the Lists of Items option for a Specimen data field. Because a Free-Text data field type can be used for many different data fields, the query lists that appear will not always apply to the current data field.
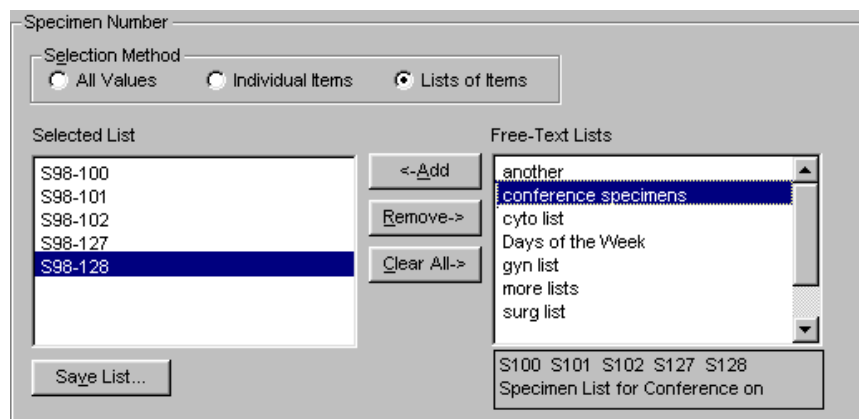
The right side of the window displays all existing Free-Text query lists. When you highlight a list, any comment that was saved with the list appears below the display. In the example above, the list of specimen numbers included in the list also appear in the comment field. Once you select a list, its contents (i.e., the individual entries) appear in the left side of the window. You can remove individual entries if you want. Refer to "Individual Items Option for information on removing and selecting individual items.

You can choose as many query lists as you like. Each time you select a query list to include, the top portion of the InfoMaker Wizard window is updated; the total number of query lists appears in parenthesis, followed by the names of the selected query lists. The list of selected query lists will truncate once it becomes too long for the display area. CoPathPlus ignores duplicate entries (i.e., an entry that is included on more than one of the query lists that you chose).

NOTE: If you remove one or more individual entries from the left side of the window, the query list name is removed from the top portion of the InfoMaker Wizard and from the selection criteria in the header of the report, and individual free-text items are displayed instead. That is because your selection criteria no longer matches the items in the query list.
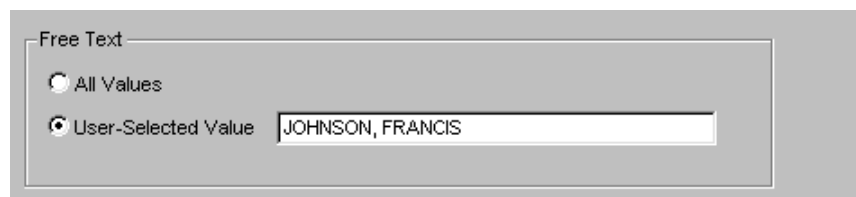
Once you have selected at least one query list to include on the report, you can save all the entries that you currently have selected as a new query list by pressing **Save List...**. For more information, refer to "Saving New Query Lists from the InfoMaker Wizard".

NOTE: AND and OR operators are limited to a maximum of 250.

If there are no available Free-Text query lists for a particular data field, a message stating so appears when you choose the Lists of Items option.

Single-Instance Variant for the Free-Text Data Field Type

As the name for it implies, the Single-Instance variant allows you to you specify one free-text value for which to run your report. Notice, however, that this variant also allows you to specify all the values available. The following illustration shows a sample Single-Instance variant for the free-text data field type.

All Values. Select this option if you want to run the current report for all the possible values allowed. (In the above example, it would be all the patients at your site.) CoPathPlus disables the User-Selected Value field when you choose the All Values option.

User-Selected Value. Select this option and then enter one free-text value.

Number Data Field Type
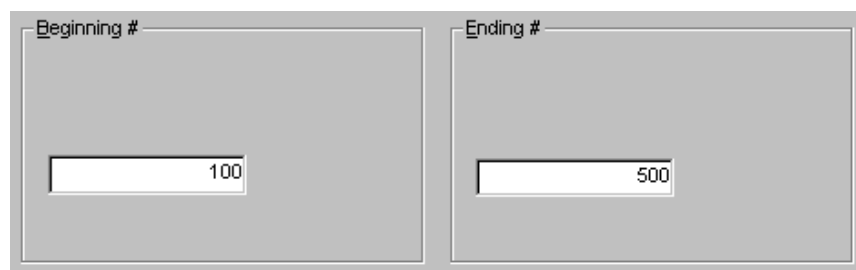
The Number data field type allows you to specify a specific number for certain selection criteria to include in your CoPathPlus reports. The Number data field type has variants that allow you two different ways to specify Number data field selection criteria:

- Beginning #/Ending #
- Single-Instance

The variant you use depends on the report are running. Within these variants, you specify the choice you want by entering values in the Selection Method field.

Beginning #/Ending # Variant for the Number Data Field Type

As the name for it implies, you use the Beginning #/Ending # variant to specify a number range to define your number selection criteria. The following illustration shows a sample Beginning #/Ending # variant for the Number data field type.
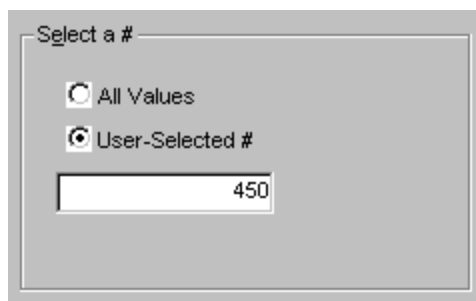
Beginning #. Beginning # runs the report from the number specified. In this example, the selection criteria starts with the number **100**. This selection criteria prints in the header of your report.

Ending #. Ending # runs the report to the number specified. In this example, the selection criteria ends with the number **500**. This selection criteria prints in the header of your report.

Single-Instance Variant for the Number Data Field Type

As the name for it implies, you can only specify one number (instead of a range) to define your number selection criteria on the Single-Instance variant for the Number data field type. However, you can also select to run your report using all the values available. The following illustration shows a sample Single-Instance variant for the Number data field type.

All Values. Select this option if you want to run the current report for all the possible values allowed. CoPathPlus disables the User-Selected # field when you choose the All Values option.

User-Selected Value. Select this option and enter a value if you want to specify only one selection criteria value. In this example, the only selection criteria is **450** for the Number data field type.

Pop-Up Data Field Type

The Pop-Up data field type allows you to select one or more choices from a database-linked pop-up window to include on your CoPathPlus reports. Examples of pop-up data fields are specimen number and patient.

The Pop-Up data field type uses the Array variant for selection of items. The Selection Method field for the Array variant has three options from which you can choose:

- All Values
- Individual Items
- Lists of Items

All Values Option (Pop-Up Data Field Type)

The **All Values** option for a Pop-Up data field type allows you to run the report for all values in a specified CoPathPlus database. The following illustration shows the All Values option for the Specimen database. When this option is selected, all specimens in the CoPathPlus database will be included when you run this report.

Notice that the information below the Selection Method field is disabled when you choose the All Values format because you do not need to make any choices.

This variant resembles the All Values option for the Array variant for the Dictionary data field type, except for the Select field on the right side of the Selection Method field.
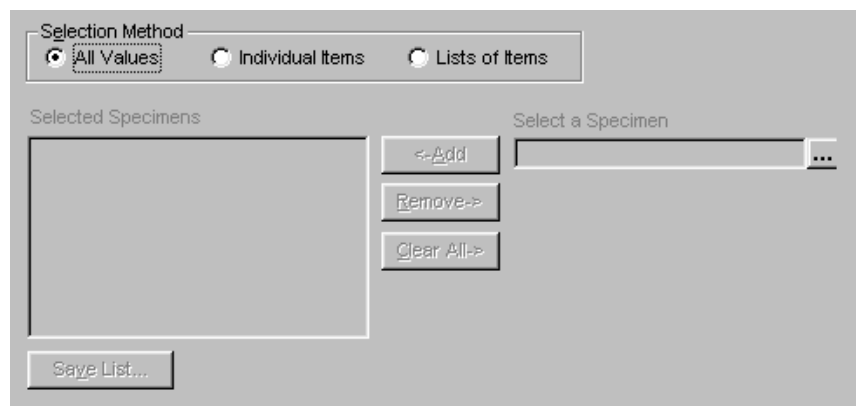
NOTE: Some reports are set up so as to not allow All Values as a choice because it does not make sense to run the report on all values. For example, the Histology Labels by Specimen Number report asks you to identify specimens for which you want to print histology labels, since it does not make sense to print histology labels for all specimens in CoPathPlus.

Individual Items Option (Pop-Up Data Field Type)

The **Individual Items** option for a Pop-Up data field type allows you to run the report for selected values in the specified CoPathPlus database. The following illustration shows the Individual Items option for the Specimen database.
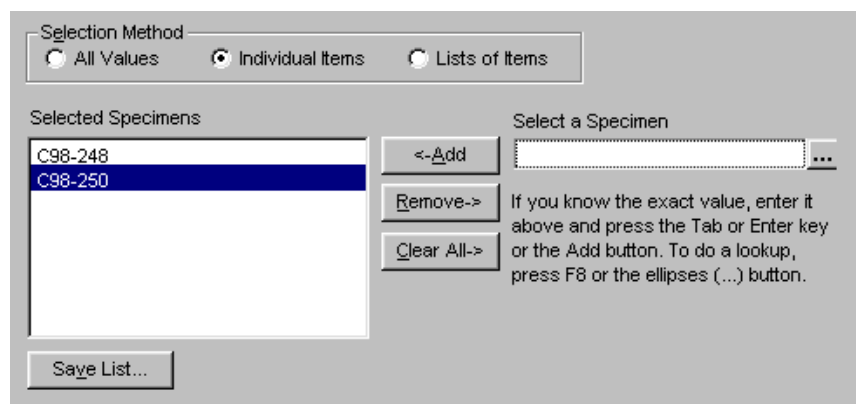
When you choose this option, the information below the Selection Method field is enabled.

To choose a value to include on your report, do one of the following:

- Enter an exact value at the Select field and then press **Add**. Your selection appears on the left side of the window.

- Press **...** to access a pop-up selection window for the database linked to the data field. For example, if this is the Specimen data field, you will access the Select Specimen window. Once you select a value from the pop-up window, the value appears on the left side of the InfoMaker Wizard window and the cursor returns to the Select field.

Each time you select a value to include, the top portion of the InfoMaker Wizard is updated; the total number of selected entries appears in parentheses, followed by a list of the selected values.

The list of values will truncate once it becomes too long for the display area. See the following illustration for an example.

Once you have selected at least one value to include on the report, **Save List...** becomes enabled. This button lets you create a new query list that consists of all the entries you currently have selected for inclusion on the report. For more information, refer to "Saving New Query Lists from the InfoMaker Wizard".

To remove an value that you have selected:

Select the value on the left side of the window and press **Remove**. Your choice disappears from the left side of the window and reappears on the right side. To remove all selected values, press **Clear All**.

Lists of Items Option (Pop-Up Data Field Type)

The **Lists of Items** option for a pop-up data field type allows you to run the report for values in a query list. The following illustration shows the Lists of Items option for the Specimen database.
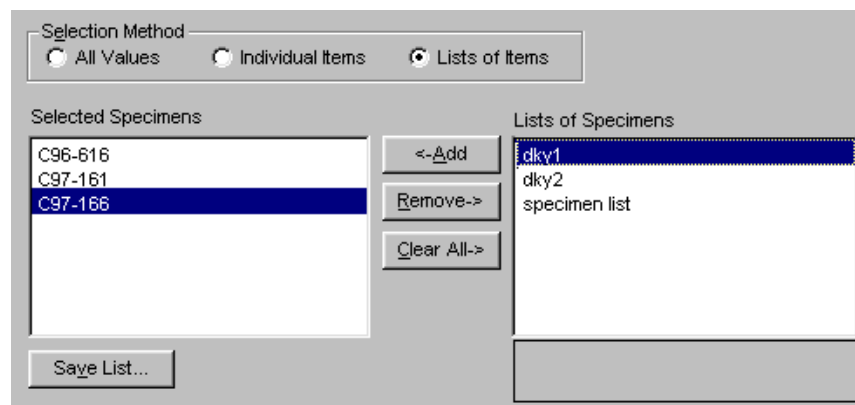
The right side of the window displays all existing query lists for this database. When you highlight a list, any comment that was saved with the query list appears below the display. Once you select a query list, the values in that list appear on the left side of the window. You can then remove individual values from the report if you want. Refer to "Individual Items Option for information on removing and selecting individual values.

You can choose as many query lists as you like. Each time you select a query list to include, the top portion of the InfoMaker Wizard window is updated; the total number of query lists appears in parenthesis, followed by the names of the selected query lists. The list of selected query lists will truncate once the list becomes to long for the display area. CoPathPlus ignores duplicate entries (i.e., a value that is included on more than one of the query lists that you chose).

NOTE: If you remove one or more individual values from the left side of the window, the query list name is removed from the top portion of the InfoMaker Wizard and from the selection criteria in the header of the report, and individual values are displayed instead. That is because your selection criteria no longer matches the values in the query list.

NOTE: AND and OR operators are limited to a maximum of 250.

Once you have selected at least one query list to include on the report, you can save all the values that you currently have selected as a new query list by pressing **Save List...**. For more information, refer to "Saving New Query Lists from the InfoMaker Wizard".

If there are no available query lists for a particular data field, a message stating so appears when you choose the Lists of Items option.

Query List Data Field Type

The Query List data field type lets you select a predefined list of items to include on a CoPathPlus management report. Each list of items, known as a query list, is defined either in the Query List dictionary or while using the InfoMaker Wizard. For more information about how to define query lists, refer to "Saving New Query Lists from the InfoMaker Wizard" or refer to "Query List Dictionary" in the "Report Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

The type of query lists you can select for a report depends on how the report is defined. For example, the Counts of Stains/Processes by Request Class and Query List report has a Stain/Process Query List data field that lets you select either all available Stain/Process query lists or individual Stain/Process query lists to include on the report.

The Selection Method field for a Query List data field type has two options:

- All Values
- Individual List

All Values (Query List Data Field Type)

The All Values option for a Query List data field type lets you run the report for all query lists of the specified type. The following illustration shows the All Values option for the Stain/Process Query List data field. When this option is selected, the report will include information for stains/processes on all available Stain/Process Query Lists.

Notice that the information below the Selection Method field is disabled when this option is selected.

Individual List (Query List Data Field Type)

The Individual List option for a Query List data field type lets you run the report for items on query lists of the specified type. The following illustration shows the Individual List option for a Stain/Process Query List data field.

When you choose the Individual List option, the information below the Selection Method field becomes enabled. The right side of the window displays all query lists of the specified type. When you highlight a list, any comment that was saved with the list appears below the display.

To choose a query list to include in your report, do one of the following:

- Drag and drop the entry with the mouse from the right side of the window to the left side.

- Highlight the entry and press **Add**.

- Double-click on the entry.

Your choice(s) appear on the left side of the window.

You can choose as many query lists as you like. Each time you select a query list to include, the top portion of the InfoMaker Wizard window is updated; the total number of query lists appears in parenthesis, followed by the names of the selected query lists. The list of selected query lists

will truncate once it becomes too long for the display area. CoPathPlus ignores duplicate entries (i.e., an entry that is included on more than one of the query lists that you chose).

NOTE: AND and OR operators are limited to a maximum of 250.

If there are no available query lists of the required type, a message stating so appears when you choose the Individual List option.

To remove an entry that you have selected, you can use the same methods as when you choose an entry to include, except that you use the **Remove** button instead of the **Add** button. Your choice disappears from the left side of the window and reappears on the right side. To remove all selected entries, press **Clear All**.

Details button. Lets you view the items included in the selected (i.e., highlighted) query list. Refer to "Details Window for the Query List Data Field Type" for more information.

Details Window for the Query List Data Field Type

When you choose the Individual List option as the selection method for a Query List data field, you can view all of the items in a query list by selecting the query list and then pressing **Details**. This is useful if you want to review the contents of a query list before selecting it for inclusion on a CoPathPlus management report. The Items of List window, shown below, appears.

NOTE: When query lists appear on both the left and right side of the InfoMaker Wizard window (i.e., when some query lists have been selected for inclusion on the report and some have not), one query list will be highlighted on each side. In that case, pressing **Details** will display data for the highlighted query list that has "focus", as indicated by a dashed line around the item.
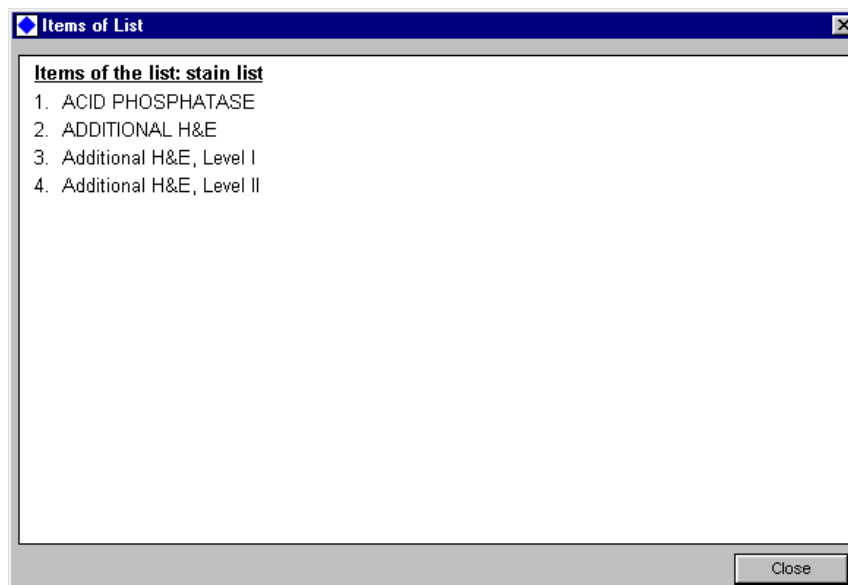
The list name is displayed in bold at the top of the list. If there is more than one page of items, a scroll bar appears at the right side of the window.

When you finish viewing items in the query list, press **Close** to return to the InfoMaker Wizard window.

SNOMED II Code Data Field Type

The SNOMED II Code data field type lets you select SNOMED II codes to include on a report. This type of data field provides four ways of selecting SNOMED II codes:

- Single value

- Range of values

- Leading code

- SNOMED II Collection

    NOTE: SNOMED II Collections are defined in the SNOMED II Collection dictionary. Each entry in that dictionary consists of one or more SNOMED II codes grouped together for reporting purposes. For more information about SNOMED II Collections, refer to the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

You can use multiple selection criteria in a single search (e.g., both a single value and a range), and you can apply logic to the search. For example, if you enter two selection criteria, you can specify whether both conditions need to be true, or just one.

An example of a SNOMED II Code data field type is shown below. The default Search Criteria for this data field type is **Not Used**, indicating that all SNOMED II codes will be included on the report.

Entry Type. Lets you specify how you want to select SNOMED II codes to include on the report. Options are:

- **Single.** Lets you select a single value from the SNOMED II Code dictionary to include on the report.

- **Range.** Lets you enter a free-text range of SNOMED II codes (or leading codes) to include on the report. Enter the first value followed by a hyphen(-), and then enter a second value. Each value must consist of at least two characters.

- **Leading Code.** Lets you select all SNOMED II codes that start with a specific leading code. At least 2 characters must be entered.

- **Collection.** Lets you select an entry from the SNOMED II Collection dictionary.

NOTE: After you select a SNOMED II collection, the **Details…** button becomes enabled. Refer to "Details Window for the SNOMED II Code Data Field Type" for more information.

An example of each option is shown in the figure above.

Row Logic. If you have entered more than one row of selection criteria, lets you specify the relationship one row and the next. Options are:

- **Same.** Include a specimen on the report if one of its part types meets the criteria in both the current row AND the next row. For example, suppose you enter two rows of selection criteria for this data field; each row identifies a single SNOMED II code, and the row logic selected is **Same**. In order for a specimen to be included on the report, the specimen must be coded with both of the specified SNOMED II codes, and the Source (i.e., part type designator) specified for those codes must be the SAME.

- **And.** Include a specimen on the report if it meets the selection criteria in both the current row AND the next row, regardless of what Source is specified for the codes.

- **Or.** Include a specimen on the report if it meets the selection criteria in either the current row OR the next row, regardless of what Source is specified for the codes.

Edit Logic Statement: Select this check box to override the simple logic that was built while you entered text search specifications. You can then use the Logic Statement field below to modify the input. You can use parentheses, ANDs (or the & character), and ORs (or the ! character) to specify search logic.   This check box is only accessible if you have entered more than two rows of selection criteria.

Note the following rules:

- InfoMaker evaluates AND logic (if present) first, then applies OR logic. For example, it reads the statement "a and b or c" as "(a and b) or c". Therefore, if you want a statement evaluated as "a and (b or c)," then you must select the Edit Logic Statement check box and enter the parentheses in the appropriate places.

- Do not use the keywords "NOT" or "NEAR" in the Logic Statement field.

A̲dd Row button. Lets you add a new row of selection criteria for the data field.

De̲lete Row button. Lets you delete the current row of selection criteria for the data field.

Details Window for the SNOMED II Code Data Field Type

When you choose **Collection** as the entry list type for a SNOMED II code data field, you can view all items in the SNOMED II collection by pressing **Details…**. This is useful when you want to review the contents of the collection before running the report. An example of the Details window for a SNOMED II collection is shown below.
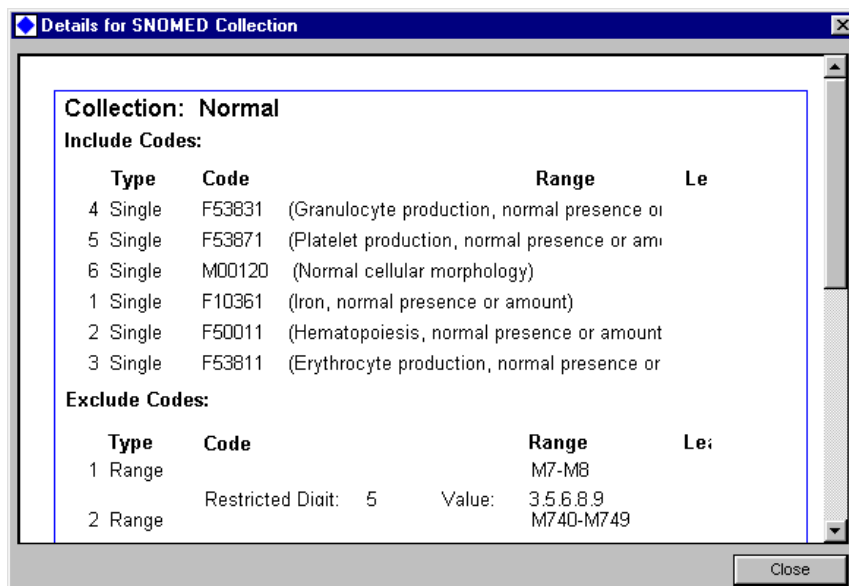
NOTE: If a specimen has a code that matches both the **Include Codes** criteria (e.g., an individual code) and the **Exclude Codes** criteria (e.g., a range that includes the same code), the specimen will still appear on the report being run.

Press **Close** to return to the InfoMaker Wizard window.

SNOMED II Collection Code Data Field Type

The SNOMED II Collection Code data field type lets you select all SNOMED codes in a specific SNOMED II collection. In the standard export version of CoPathPlus, this data field type is only found on the old version of the SNOMED II Search report.

NOTE: SNOMED II Collections are defined in the SNOMED II Collection dictionary. Each entry in that dictionary consists of one or more SNOMED II codes grouped together for reporting purposes. For more information about SNOMED II Collections, refer to the "Coding Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

An example of the SNOMED II collection code data type field is shown below.

Not Used. Select this option if you want to run the report for all possible SNOMED II codes.

User-Selected Value. Select this option and then choose a value from the drop-down list if you want to run the report for just SNOMED II codes that belong to a specific SNOMED II collection.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Specimen Block Retrieval Data Field Type

The Specimen Block Retrieval argument allows a user to select multiple specimen/block combinations to be posted to a. The intent, and most efficient means of using this InfoMaker Wizard, is by scanning a 2D barcode used that contains the specimen number, delimiter, and block identifier in the standard format. However, you may also manually post entries into this retrieval argument by typing the full specimen number (capitalized prefix, year included) followed by ";B" followed by the INST number of a block, and pressing Enter.

The Specimen/Block Retrieval argument is currently only included on custom InfoMaker Reports.

Text Search Data Field Type for Natural Language Search

The Text Search data field type allows you to specify certain text that you want to include or exclude when running your CoPathPlus reports. This data field type is used with the Natural Language Search report provided within CoPathPlus. This report utilizes a free-text search capability that allows you to enter the text you want to search for within the free-text fields in CoPathPlus. The following illustration shows a sample Text Search data field type.

NOTE: The Include If Contains and Exclude if Contains fields do not search for phrases; they only search for individual words. Therefore, if you enter a phrase at one of those fields (e.g., Lymph Node), each word is searched for separately.

Include if Contains: If you want your search to contain any of the words you specify in the Include if Contains field, then select the Any option button. If all of the words you specify must be present, then select the All option button.

If you want your search to contain any of the words you specify in the Include if Contains field, then select the Any option button. If all of the words you specify must be present, then select the All option button.

Exclude if Contains: Select either the Any or All option button to exclude a word or words in the search. Then specify the word or words that you do not want present in the same context as those you specified in Include if Contains (e.g., to find specimens with evidence of carcinoma, you would enter NO and EVIDENCE in the Exclude if Contains field with CARCINOMA in the Include if Contains field).

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

In Text Type: Select the text field in which you want to perform your search (e.g., Gross Description, Interpretation, Final Diagnosis). If you want to search all text fields in CoPathPlus, select **(ALL)**.

Within Same Paragraph: Select this check box to narrow the search for multiple words to within an individual paragraph (e.g., if you specify **CARCINOMA** and **LIVER** in the Include if Contains field and CARCINOMA appears in paragraph one LIVER and in paragraph two, that specimen will not be included in the results of the search).

NOTE: Not selecting the Within Same Paragraph check box will broaden the search to the entire text field (if you chose one) or to all the specimen's text data (if you choose **(ALL)** in the In Text Type field).

And or Or Option Buttons: These option buttons specify a logical connection between the current row and the next. Select the And option button if both rows should apply. Select the Or option button if either row should apply.

Edit Logic Statement: Select this check box to override the simple logic that was built while you entered text search specifications. You can then use the Logic Statement field below to modify the input. You can use parentheses, ANDs (or the & character), and ORs (or the ! character) to specify search logic.

Note the following rules:

- InfoMaker evaluates AND logic (if present) first, then applies OR logic. For example, it reads the statement "a and b or c" as "(a and b) or c". Therefore, if you want a statement evaluated as "a and (b or c)," then you must select the Edit Logic Statement check box and enter the parentheses in the appropriate places.

- Do not use the keywords "NOT" or "NEAR" in the Logic Statement field.

- Do not try to search for a phrase in the Natural Language Search report, as it currently cannot perform this type of search. Use the Within Same Paragraph check box when necessary to most closely approximate "phrase" searchers.

A̲dd Row Button: Press this button if you want to include another text search criteria row.

De̲lete Row Button: With the cursor in the appropriate row, press this button if you want to delete a text search criteria row.

For more information about the Natural Language Search report, refer to "Natural Language Search Report".

Saving New Query Lists from the InfoMaker Wizard

When selecting criteria for Management Reports using the InfoMaker Wizard, you can use the **Sav̲e List…** button to create a new query list. The new query list will consist of all items currently chosen for inclusion on the report for the selected data field. By creating a new query list, you can quickly select the same items at this data field when you run this report (or another report with the same data field) in the future. Query lists can also be added directly to the Query List dictionary. Refer to "Query List dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information.

NOTE: Only dictionary-based query lists can be accessed through the Query List dictionary. Other types of query lists (e.g., Specimen, Patient, Free-Text) can be added, edited, and deleted via the InfoMaker Wizard.

To select an existing query list when running a management report, select the Lists of Items option at the Selection Method field on the InfoMaker Wizard window. This option is described in both Lists of Items Option (Dictionary Data Field Type) and Lists of Items Option (Pop-Up Data Field Type).

The **Save List…** button is only enabled when all of the following are true:

- The data field is an array variant for either a dictionary data field type or a pop-up data field type

- You have selected either the Individual Items option or the Lists of Items option

- You have chosen at least one item or query list to include on the report

- You have permission to save query lists. If you do not have permission, **Save List...** will always be disabled.

When you press **Save List…** , the Save List pop-up window appears.

NOTE: In the above example, "jak" refers to Dr. Jane A. Kittamer.

Enter a name for your list in the List Name field and, if you want, a comment about the list in the Comment field. Then press **Save**.

The Save List window displays existing query lists for this data field. The list type (i.e., Specimen Class in the above example) is displayed for reference below the existing query lists. You can select an existing query list and replace it with the currently selected items (i.e., highlight the query list and then press **Save**), or you can delete existing lists from the (i.e., highlight the query list and then press **Delete**).

Loading and Saving Criteria and SQL

On the right side of the InfoMaker Wizard are three buttons:

- Load Criteria. . .
- Save Criteria. . .
- SQL. . .

Load Criteria… and **Save Criteria…** have to do with the choices you made for your selection criteria when running your report and are also used for scheduling reports to run. Refer to "Data Fields and Selection Criteria" for information on choosing selection criteria.

SQL… displays the SQL definition of the report that you would use to troubleshoot report definition problems.

Load Criteria

This window lists all the criteria that have been saved for the specific report you are running. If you select the Show All Criteria Sets check box, the windows expands to include all criteria saved for all reports. You can either type in a portion of the name of the criteria you want and press **Search** to search for your selection, or highlight your criteria selection from the list. Once you have selected the criteria you want, press **OK** and CoPathPlus loads your criteria on the InfoMaker Wizard. If you chose criteria from a different report that is not valid for the current

report, a message appears indicating that the set of criteria is not compatible and it will not be loaded into the InfoMaker Wizard. The Load Report Criteria window also lists the name of the report as the Report Type and any comments associated with the criteria you chose.

If no saved criteria exists for the report you are currently running, CoPathPlus displays a message stating so when the Load Criteria pop-up window appears.

Save Criteria

Once you specify all the selection criteria you want for your report, you can save the criteria so that you can use it again on the same report, or on a different report that uses **exactly the same** selection criteria, without having to make your selections again. Refer to "Load Criteria" for more information on using criteria that has already been saved.

To save the criteria you have selected, press <u>S</u>ave Criteria… on the InfoMaker Wizard. You are presented with the Save Report Criteria pop-up window.

NOTE: You must have permission to save criteria. If you do not have permission, <u>S</u>ave Criteria... will always be disabled.

Type the name you want to give your criteria in the Name for Report Criteria field. Enter any comments you want associated with your named criteria in the Comment field, and press <u>S</u>ave. CoPathPlus saves the criteria and allows you to load it when you run the report again (by pressing <u>L</u>oad Criteria...). The Save Report Criteria window also lists all the criteria that have been saved so far for the specific report you are running. Type the name of the report as the Report Type and any comments associated with the criteria you chose. You can also delete one of the saved criteria from the window by highlighting it and pressing <u>D</u>elete.

IMPORTANT: As stated above, CoPathPlus allows you to modify report criteria and save those changes. If you attempt to change the report criteria for a report scheduled to run via the Schedule Manager, CoPathPlus will present a warning message stating that changes will have an effect on a scheduled report. You will want to be careful as to how you respond to the warning message. If you save changes to report criteria for a report already on the Schedule Manager, you may be altering the original purpose for running the report.

SQL

You can access the internal criteria the report is set up to retrieve by pressing **SQL...** on the InfoMaker Wizard. You are presented with the Show WHERE Clause pop-up window.

This window displays the SQL definition of the report. **This is used primarily for support purposes.** Once you become familiar with CoPathPlus internal field names and SQL syntax, and receive InfoMaker training, this window will help you understand the report criteria. If **SQL...** is disabled, this means the report is running from a stored procedure.

Viewing and Printing the Management Reports

Once you have specified your report selection criteria on the InfoMaker Wizard, press <u>O</u>K. CoPathPlus runs your report and displays it on the Report window for the report you are running. The report header displays the report selection criteria.

NOTE: The report header prints the maximum number of selected items and then truncates what cannot fit. The number of entries selected appears at the beginning of the list in parentheses. Instead of the truncated display, you can create a list to display selected entries. Refer to "Individual Items Option" for more information.

NOTE: While your report is running, the Wait window shows you how many rows are being retrieved. You can press **Cancel** to stop the retrieval. If you do, a warning message appears telling you that the data will be incomplete.

For a description of each report currently available in CoPathPlus, refer to "Report Descriptions".

Navigation Buttons

You can move from page to page in the report by using the Navigation buttons at the top, left of the window. You can press:

- $\blacksquare$ to move to the first page of the report.
- $\blacksquare$ to move to the previous page of the report.
- $\blacktriangleright$ to move to the next page of the report.
- $\blacktriangleright$ to move to the last page of the report.

Directly underneath these buttons is the page count display. This display shows the page of the report that you are currently on and the total number of pages that the report contains.

Zoom

The Zoom field specifies the size of the report display as a percentage of the report's normal size. In the standard CoPathPlus system, all reports default to 75% of their normal size for viewing purposes. Labels default to 100%. Custom reports or labels could default to different zoom percentages. You can increase or decrease the size on the report display. However, reports and labels always print out at 100%.

Select Criteria

You can press **Select Criteria...** to return to the InfoMaker Wizard. From this window you can rerun the report on the same criteria or change the criteria and run the same report again. Refer to "Running the Management Reports" for more information on the InfoMaker Wizard.

Print

You can press **Print...** to send your report to a printer or facsimile machine (fax). CoPathPlus brings up the standard Print/Send Setup window, similar to the one shown below. This window lists all active printers installed on your user workstation.

NOTE: The Print/Send Setup Defaults window, accessed via the Label Chute and Report Chute dictionaries, has the same appearance as the Print/Send Setup window. Use the Print/Send Setup Defaults window to specify default printing or fax instructions for each label chute or report chute. For report chutes, you can later change the Print/Send Setup information for individual batches using the Report Chute Manager item.
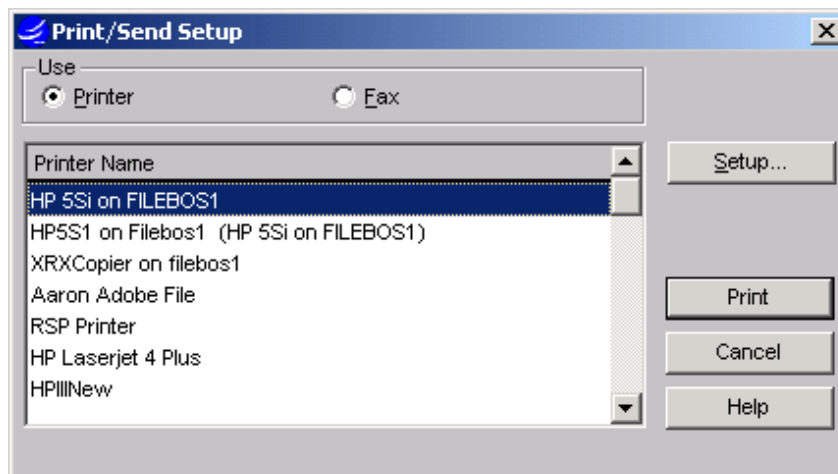
For Patient Reports, the Print/Send Setup window includes an additional option button (No Images), as shown below.
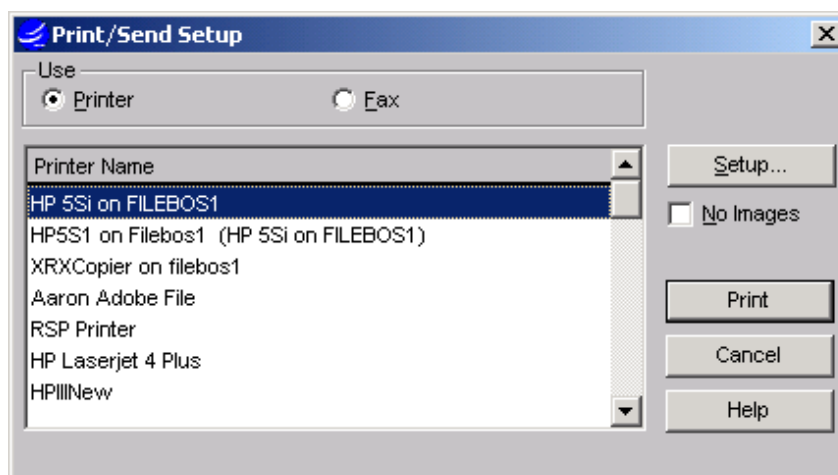
For Patient Reports, you can select the No Images check box to suppress printing of the report's attachments. This is useful if a particular printer is incapable of printing graphic images, or if you want to save time during printing.

Select either the Printer or Fax option button in the Use field on this window.

The InfoMaker Report Print button uses persistence to determine a default print type method during a workstation signon session. For example, a user presses the Print button for a specific InfoMaker report and selects Fax as the output method. The next InfoMaker report they attempt to print will already have the Print/Send Setup window radio button defaulted to Fax. This will be the case whether it is the same or a different InfoMaker report that was selected for generation. If the Print radio button is selected next, the persistence default will revert to the Print option. The Print/Send Setup window radio button default choice will return to the Printer option each time CoPathPlus is restarted.

Printing to a Printer

To print your report to a printer:

1) Select the <u>P</u>rinter option button in the Use field on the Print/Send Setup window.

2) Proceed as follows:

- **If the printer to which you want to print is listed**, select it and press Print.

    CoPathPlus prints your report to the printer you specified and then returns you to the Report window when the printing is complete.

- **To select a printer other than one of those listed**, select (Select Windows Printer) at the bottom of the printer list and press Print.

    NOTE: If there are no other printers available to you, the (Select Windows Printer) choice will not appear.

    Another list of printers should appear, as shown in the following illustration, on the Printer Setup window.
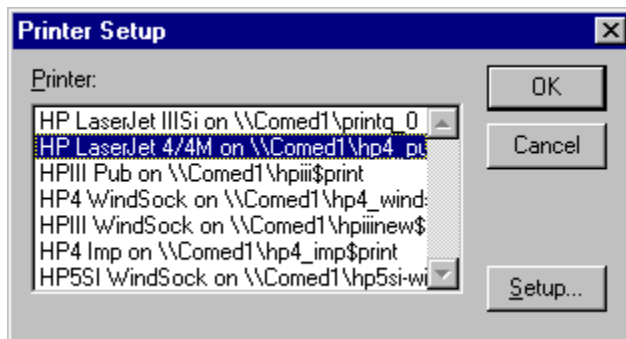
Select the printer you want and press **OK**.

CoPathPlus prints your report to the printer you specified and then returns you to the Report window when the printing is complete.

To specify printing details for your report, such as the number of copies:

1) Press **Setup...** on the Print/Send Setup window.

    The Setup window, shown below, appears.
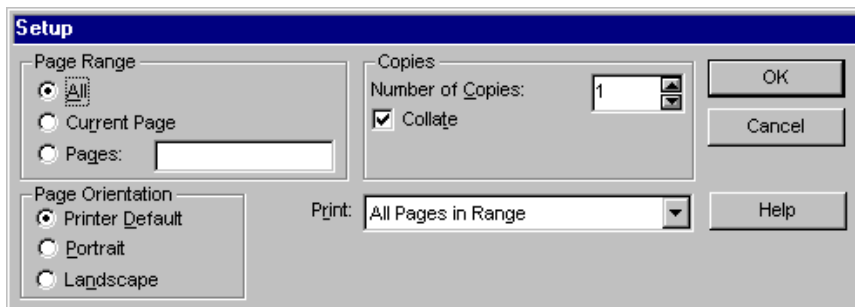
2) Specify any of the following settings:

- **Page Range**, which lets you print the entire report, the current page of the report, or specific pages of the report.

- **Page Orientation**, which lets you print the report in different length/width directions: Portrait for 8.5 x 11-inch positions; Landscape for 11 x 8.5-inch positions; and Printer Default, which could be either portrait or landscape. (Check with your System Manager to determine your printer's default print orientation.)

- **Copies**, which lets you determine the number of copies you want printed. Use the spinner box to increase or decrease the default number displayed. To organize pages when you print multiple copies, select the Collate check box. The InfoMaker Wizard prints a complete copy of the first document before it begins to print the first page of the second document.

- **Print**, which lets you select the pages to print within the range you specified in the Page Range area: all pages, all even pages, or all odd pages.

Printing to a Fax Machine

To print a report to a fax machine:

1) Select the Fax option button in the Use field on the Print/Send Setup window.

2) The Print/Send Setup window changes to display fax-related fields.

3) Enter the following information on the Print/Send Setup window:

   - **To Name, Institution, Fax.** Enter the name of the recipient to which this fax will be sent, and the fax number of the recipient. To select an entry from the Person dictionary, press **Lookup …**. To select an entry from the Client dictionary, press **Client Lookup …**.

   NOTE: Depending on which report printing item you are using, a default recipient may appear. For example, the Gross Pathologist can appear as the default recipient for a Working Draft when you are using the Patient Report Single Print activity.

   - **From Name, Institution, Phone, Fax, E-Mail.** Enter the name of the person sending the fax, the institution from which it is being sent, and the phone number, fax number, and e-mail address of the report sender. If you (i.e., the current user) are the sender, press **From Me**. Doing so fills in the From fields with default data defined for you in the Person dictionary.

   NOTE: Depending on which report printing item you are using, default values may appear in one or more of the From fields.

   - **Subject.** For specimen-related reports, a system-generated description of the fax is displayed and cannot be edited. For all other reports, enter a description of the report being sent. The subject makes it easier to identify the fax when tracking it.

   - **Cover Page Text.** Enter a free-text comment to appear on the cover page for this fax.

   - **Priority**. Select a priority for this fax.

     - **Regular** places the fax at the end of the fax queue, to be processed on a first-come, first-served basis.

     - **Background** places the entire processing of the report to be faxed into the background, thereby routing it to a scheduling agent and freeing up your

workstation. When the report is passed to the fax queue, it has a priority of Regular. Therefore, for on-demand faxes (i.e., faxes you request to be sent now), if you select Background, you cannot select High Priority. Typically, you would not want to slow down a High Priority fax by routing it to a scheduling agent.

- **High Priority** forces the fax to the front of the RPI fax queue to be faxed first.

NOTE: If there is a fax currently being processed, this high priority fax will not be sent until the current fax has completed.

4) Press **Send**.

You can use the Fax/E-Mail Queue/Log item to view information about the status of a sent fax.

Printing to a File Using Adobe® Acrobat

The following provides instructions to print reports to a PDF file. PDF is a universal file format that will print your CoPathPlus reports to a file in the exact same way if you printed them. Adobe® PDF files can be shared, viewed, and printed by anyone with Adobe Reader® software, which is available as freeware at the following location:

http://www.adobe.com/products/acrobat/main.html

To print a report to a PDF file:

1) If you have not already done so, install Adobe Acrobat 5.0.5 or higher. Follow the instructions for a typical installation provided with the software.

   You must purchase the full version of Adobe Acrobat, which allows you to create PDF files. Adobe Acrobat Reader, which is available as freeware, only enables you to read Adobe PDF documents.

2) From CoPathPlus, select a report that you would like to print to a PDF file.

3) After selecting your criteria, run the report and click **Print**.

   The Print/Send Setup window appears.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.
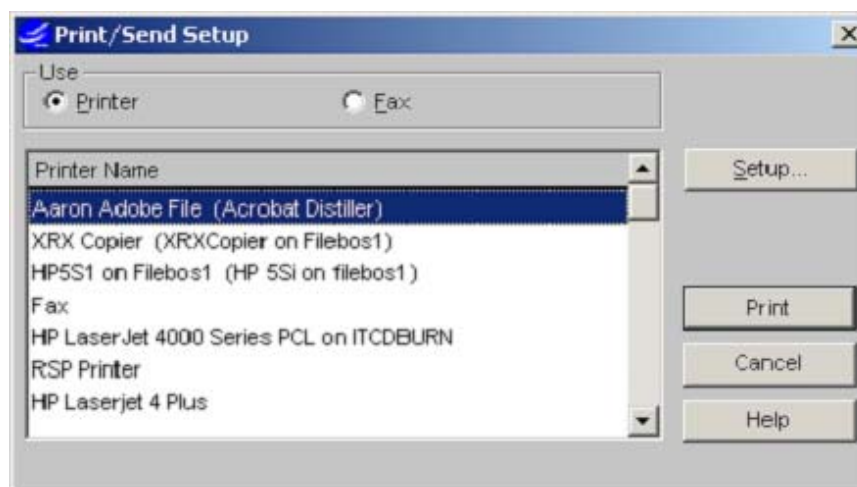
4) Select Acrobat Distiller from the list of printers. If an Acrobat Distiller printer is not listed, follow these instructions:

   a) Select **(Select Windows Printer)** at the bottom of the printer list and press **Print**.
   NOTE: If there are no other printers available to you, the (Select Windows Printer) choice will not appear.

   Another list of printers should appear, as shown in the following illustration, on the Printer Setup window.
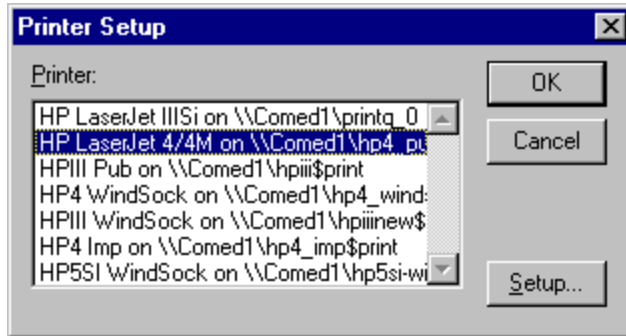
   Select the Acrobat Distiller printer you want and press **OK**.

   Refer to "Printing to a Printer" for information on specifying printing details for your report, such as the number of copies.

5) Click **Print**.

   The Save PDF As window appears.
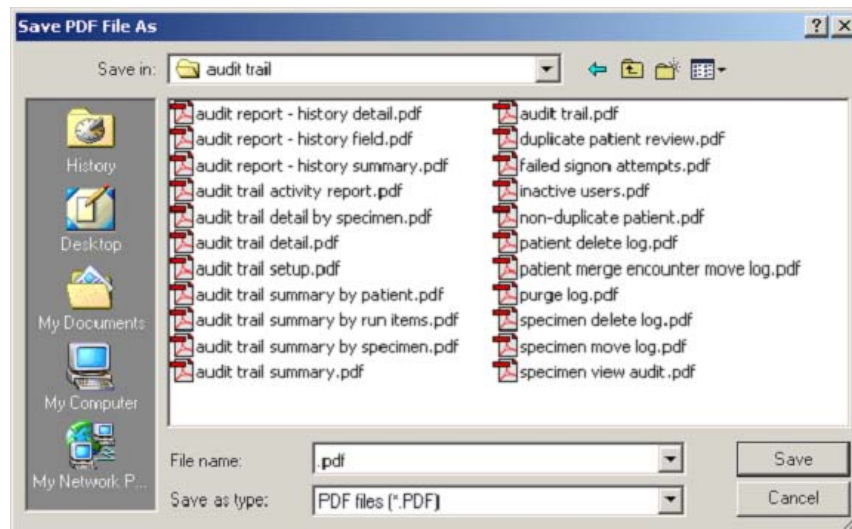
6) Select the destination location of the Adobe PDF file and enter a name for the file. Press **Save**.

   Adobe will launch with the report, you can close the window and go to the location of the file for distribution at a later time.

Data Menu Commands

In CoPathPlus, the <u>D</u>ata menu appears only on the Report window. The <u>D</u>ata menu is shown below.

```
Filter...
Sort...
Select Criteria...

First Page
Prior Page
Next Page
Last Page

Refresh

Show Syntax...
Save Raw Data...
Save Specimen List
Print Patient Reports...
```
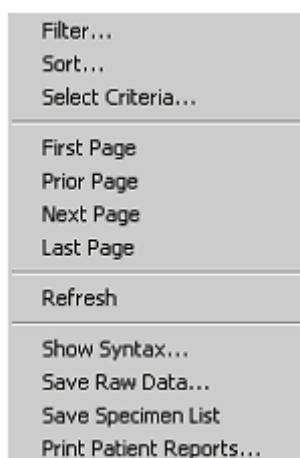
The commands available from the <u>D</u>ata menu include:

- Filter. . . further limits the data included on the report.

- Sort. . . changes the sort order of fields.

- Select Criteria. . . changes the report search criteria.

- **<u>F</u>irst Page** moves to Page 1 of the report.

- **<u>P</u>rior Page** moves to the previous page of the report.

- **<u>N</u>ext Page** moves to the next page of the report.

- **<u>L</u>ast Page** moves to the last page of the report.

- Refresh updates the data on the report.

- **Show Syntax. . .** displays the report syntax.

- Save Raw Data. . . saves the current result set from this data search.

- Save Specimen List saves a list of specimens to a table.

- Print Patient Reports. . . prints Final reports for specimens included on the report.

Filter

When you press 🖺 on the toolbar (or select <u>D</u>ata, F<u>i</u>lter on the menu bar), you are presented with the Specify Filter pop-up window.

Filters represent an additional set of selection criteria you can define to limit the number of choices presented to you in a CoPathPlus database search for the current run of the report only. It does not change the report definition, which may already have a pre-specified filter criteria for a report.

NOTE: While your report is running, the Wait window shows you how many rows are being retrieved. The "Rows retrieved" statement that appears on the Wait window does not count any rows that have been filtered out.

The available fields to filter by depend on the fields you initially defined for printing and sorting on the report.

NOTE: If there is already a filter for a report, it will display on the Specify Filter pop-up window for that report.

This window is part of the InfoMaker product. For more on the Specify Filter pop-up window, refer to your InfoMaker documentation.

NOTE: If you filter data out of your report and then print it, the header of your report will **not** reflect what you filtered out.

Sort

When you press on the toolbar (or select <u>D</u>ata, <u>S</u>ort on the menu bar) you are presented with the Specify Sort Columns pop-up window.

The Specify Sort Columns window lets you change the sort order of the fields on your report for the current run of the report only. It does not change the report definition, which may already have a pre-specified sort criteria for a report. It specifies how the report is currently sorted, which you can change. The available fields to sort by depend on the fields you initially defined for printing and sorting on the report.

This window is part of the InfoMaker product. For more information on the Specify Sort Columns pop-up window, refer to your InfoMaker documentation.

Refresh

You can press on the toolbar (or select <u>D</u>ata, <u>R</u>efresh on the menu bar) to rerun the report using the same criteria. You might want to use this option if you had canceled the report retrieval and do not see what you want on the report. Access this option to rerun the report and let it run for a longer period of time.

The report definition for each CoPathPlus management report may have its own set of filter/sort specifications. While these specifications will always be part of a report's report definition, you can temporarily specify filter/sort criteria for a report. For more information about these report selection capabilities, refer to "Filter" and "Sort".

Keep the following characteristics in mind when you press on the toolbar:

- After running a report for the first time during the current session, if you modify the filter/sort criteria for a report and you run it with your new specifications, then if you press the Refresh button, this means that you are regenerating the report with the filter/sort criteria that you have specified (not what is in a report's original report definition).

- After you have run a report with your own set of filter/sort specifications, if you return to the InfoMaker Wizard window (press **Select <u>C</u>riteria** on the Report window), run the same report (whether or not you make any Selection Criteria changes) by pressing **<u>OK</u>** on the

InfoMaker Wizard, the filter/sort specifications revert back to what is in the report's original report definition.

Show Syntax

When you select <u>D</u>ata, Show S<u>y</u>ntax on the menu bar you are presented with the Report Syntax pop-up window.

The Report Syntax window is used for support purposes.

If you are having problems with a report that you have modified from our standard or that you created on your own, perform these steps from this window:

1) Press **Select <u>A</u>ll**.

2) Press **<u>C</u>opy**.

3) Open Notepad in Windows.

4) Paste the selection in Notepad.

5) Select WordWrap from the Edit menu.

6) Send the selection to a printer.

7) Fax the printout and a copy of the report, with the name of the folder and application item of the report, plus an explanation of the problem to the Cerner CoPathPlus Client Service Help Desk.

Save Raw Data

Select this command to download the "raw data" retrieved for a management report to either another file or the clipboard. Raw data consists of the column headers, specimen numbers, and other data retrieved for display on the report. This command is useful when you want to manipulate the stored data (e.g., in a spreadsheet, database, SQL, or HTML file) or send it to tape.

The raw data can be very different from the data displayed on the management report, since the report can include extensive grouping, formatting, and subtotaling. Also, not all data retrieved for the report can be downloaded using this command.

Types of data that do not download include:

- Result sets in nested reports, such as most CoPathPlus text fields.

- InfoMaker calculations.

You have the option of converting the RTF data to plain text. If you choose not to, the RTF fields are downloaded in their raw form with all the formatting commands included but not executed. Some calculations programmed in SQL will download, but a user requires an understanding of SQL to work with the results. Users should have knowledge of SQL when working with raw data. You can also save and print the raw data report via the InfoMaker Wizard, instead of having to manually process the SQL.

When you select **Data**, **Save Raw Data**… from the Report window menu bar, the following pop-up window appears.
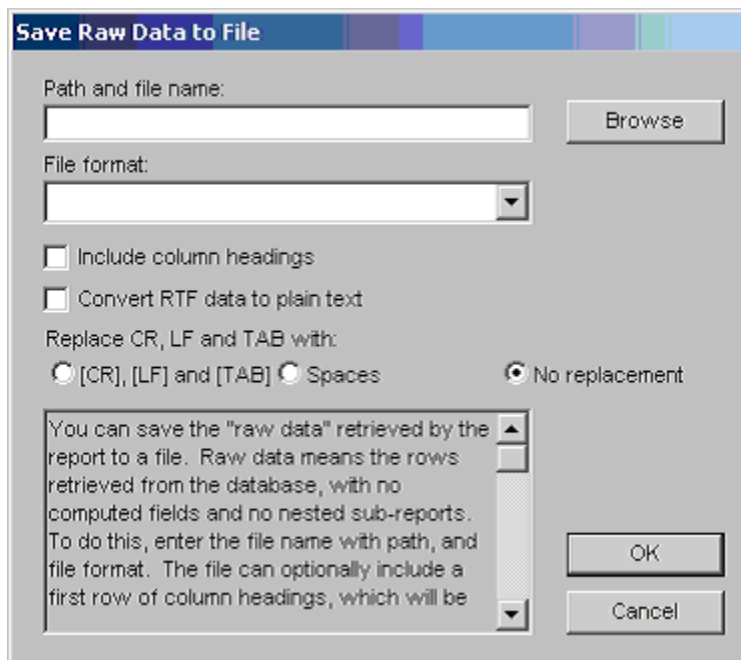
Enter the following information:

File name. Specify a name for the file in which you want to save the raw data and the path.

Note: If a job is scheduled to run on the Agent, make sure the file path entered to save data is correct. If the path involves a local call to the C drive, the file will save to the Agent, not the PC where you may have entered the job, for example, the System Manager's computer. To save the file to the System Manager's computer, make sure you enter the correct network file path.

File format. Select one of the following formats in which to save the raw data:

- Tab-delimited text
- Comma-separated values
- Excel
- HTML table
- Powerbuilder Report (PSR)
- SQL inserts

   Note: When you select to save raw data in Excel (.xls) format, the raw data truncates at 256 characters. If you want to view the file in Excel without having the data truncated, you should save the data in Tab-delimited text (.txt) format and import the text file into Excel. Refer to your Microsoft Excel documentation for more information on importing text files.

Include column headings. Select the check box if you want to include the report's column heading in the raw data file.

Convert RTF data to plain text. Select the check box if you want to remove the RTF formatting commands from the text.

Replace CR, LF and TAB with. When the raw data includes carriage return, line feed, and tab characters, you may decide how you want to treat these characters since these characters may cause problems in some file formats. Three radio button options exist allowing you to define this configuration. Options are to:

- Replace these control characters with the labels of [CR], [LF], and [TAB], respectively.

- Replace each of these control characters with a tab.

- Do not perform a replacement.

Save Specimen List

Select this command to store a specimen list in the z_population and z_population_detail tables. The stored information can be used in custom reports or custom functions. Contact your Cerner CoPathPlus Client Manager for more information about custom functions.

Note: This command is only available when viewing reports that display a list of specimens.

When you select Data, Save Specimen List from the Report window menu bar, CoPathPlus brings up the following window:

Enter a name to identify this specimen list and any comments about the list. Press **Save** to store the information in the tables.

Print Patient Reports from InfoMaker

Select this command to print Final reports for specimens on a management report. A system setting determines whether associated individual Procedure/Addendum reports also print. If a management report does not include specimen data (e.g., Failed Sign-On Attempts report), this command is disabled.

NOTE: You must have the proper CoPathPlus miscellaneous permission (i.e., InfoMaker – Patient Reports) to access this command. Also, this command prints Final reports for all specimen classes, regardless of your specimen class permissions.

When you select Data, Print Patient Reports… from the Report window menu bar, CoPathPlus brings up the standard Print/Send Setup window on top of the Report Print Manager window. The Print/Send Setup window lists the printers to which all users have access. Select the printer you want to use and press **Print**. For more information on the Print/Send Setup window, refer to "Print".

Once you press **Print**, CoPathPlus shows you the status of the print job on the Report Print Manager window and then returns you to the Report window when the printing is complete. For more information about the Report Print Manager window, refer to "Report Chute Manager". To

see examples of the patient Final Reports available in CoPathPlus, refer to the *Cerner CoPathPlus Reports Guide*.

Your site specifies (in a system setting) the maximum number of patient reports that can be printed from InfoMaker. If the management report includes more specimens than the maximum number allowed for printing, the following warning appears.
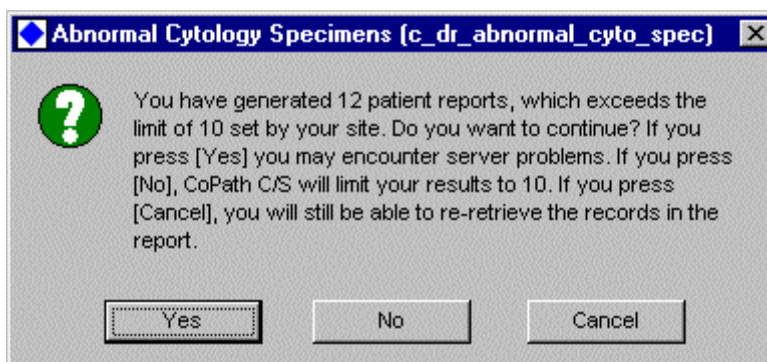
To attempt to print all reports, press **Yes**. To limit printing to the maximum number allowed, press **No**. To cancel printing, press **Cancel**.

Report Descriptions

This topic describes each of the standard management reports available in the standard export version of CoPathPlus, which are organized by the following categories:

- Audit Trail Reports

- Billing Reports

- Case Diagnostic Reports

- Case Statistical Reports

- CLIA '88/Cytology Reports

- Dictionary-Related Printouts (no report-specific documentation available)

- Download Report

- Labels

- Logs

- QA Reports

- Site-Specific Reports

In addition, there are a number of management reports that you can find under the Setup command button on the CoPathPlus Application Manager.

TIP! You can access any of the reports described here by placing the report in your Personal Menu and double-clicking on it from there.

Rules Concerning InfoMaker Management Reports

- **User-specified** means that the user will be prompted to enter the necessary values when the report is run. The values entered when the report is run are shown in the header of the report.

- All reports that sort by specimen number sort as follows: number wheel prefix, year, and number.

- All reports that print part types will only print the part designator if there is more than one part. Parts sort by part designator.

- All reports specifying cytology specimens assume the user will select the appropriate specimens by a list of specimen classes.

- Unless otherwise specified:

  - All sorts are ascending.

  - All sorts on names are last, first, middle initial.

  - All patient names are last, first, middle initial.

  - All reports print in portrait format.

- Text in reports is black, and the background color is white.

- Dates print with this format: [short date]:hh:mm.

- Margins should be set to the following:

  - Left: 0.75 inches

  - Right: 0.25 inches

  - Top: 0.50 inches

  - Bottom: 0.25 inches

Reports with Graphs

A few of the standard CoPathPlus reports include a as a means of illustrating the general outcome of a report. However, a graph is neither practical nor useful for all potential outcomes of this report. In situations where the result is comprised of a large number of different data elements, such as numerous different part types, the graph display may appear skewed due to InfoMaker formatting limitations. This graphical display will not affect the report's statistical information display.

Patient Reports

The following items are available to you in the standard export version of the CoPathPlus system when you access the Patient Reports folder under the **Reports** command button:

- Report Chute Manager, which allows you to select and print report batches.

- Queue of Report Jobs, which lets you view both the print schedule for report chute-related print jobs and the background jobs currently processing.

- Final Report List/Range Print, which allows you to print a group of patient Final Reports (or Working Drafts) at one time.

- Patient Report Single Print, which allows you to print an individual patient report.

- Print Reports for Patient, which allows you to print all final reports for all of a patient's specimens.

- Working Draft List/Range Print, which allows you to print a group of patient Working Drafts at one time.

Report Chute Manager

The Report Chute Manager is the main window for selecting and printing report batches. It also lets you view details of a particular batch from a report chute.

The main area of the window contains a list of report chutes, as denoted by the letter icon on the left side of the window, the batch number and status for each report chute, and the potential number of specimen reports within the batch (the actual number of reports printed may vary based on the number of copies printed for each specimen and any printing exclusions). Batches are displayed in reverse chronological order based on the report chute type specified.

NOTE: You can close and automatically print or fax report chute batches using the Schedule Manager.

TIP! You can view all batches, opened and closed, for a particular report chute by double-clicking on its letter icon (or on the report chute name itself). Double-clicking on it again will display only current batches once again. Double-clicking on a batch takes you to the Batch Detail view of the Report Chute Manager.

For information on security features concerning Report Chutes, refer to "Security and Report Chutes". In addition, there are a number of CoPathPlus dictionaries related to report chutes, such as the Report Chute, Specimen Class, and Person dictionaries. Refer to the *Cerner CoPathPlus Dictionary Building Manual* for more information on these dictionaries.

The following topics explain the fields and buttons on this window.

Display Chute Types

The Display Chute Types area lets you select the report chute types to display in the Report Chute Manager window: Departmental, Physician, Location, and Client. (The Departmental chute is the default.) All report chutes for each selected chute type are displayed in alphabetical order. You can display one or several chute types at once.

NOTE: You must have specific permission to see individual departmental report chutes. When you choose this chute type, you will only see those departments to which you have permission. A single Miscellaneous Permission (Report Chutes – Access Dictionary Based Entries) is used to make all Physician, Location, and Client report chutes available to the user.

Print Batch

Once you select (highlight) a batch in the Report Chute Manager, **Print Batch** becomes active, letting you open the Report Print Manager and the Print/Send Setup window.

In the background, the Report Print Manager displays the reports from the report chute you selected in the Report Chute Manager. All the reports appear highlighted (because they are ready to be printed). The Print/Send Setup window appears in front, prompting you to select the output device to which you want to print the reports. Press **Print** to print the current batch.

Warning: Do not make modifications to the report template while reports are generating. Reports will not be able to generate properly if the template is changed during generation.

Once you press **Print**, the Report Print Manager automatically closes the batch and begins printing. The batch will temporarily have the status of "Closed" while it is preparing to generate and generating. Once printing is complete, the Report Print Manager closes and the Report Chute Manager appears. The report will then have the status of "Printed". Note that if you press **Cancel** instead of **Print,** the batch status changes to Closed and the Report Chute Manager window appears.

If errors occur during printing, the Report Print Manager remains open and specifies that an error occurred. You can then view the Error Log for details by pressing **Error Log**. To close the Report Print Manager, press **Done**. Report batches that have errored out may show either the status of "Error" or "Closed". Note that closed is also a temporary normal status. For a batch with the status of Closed, you may check to see if the Status Date/Time is within a few minutes of the current time. If so, the batch is likely proceeding along the normal printing mechanism. If this date and time is older, the batch has likely failed to print.

NOTE: CoPathPlus may or may not also attempt to include unprinted reports from the previous batch (same Report Chute name with the immediate previous batch number). If the previous batch has a status of Closed, Error, or Printed with Errors, those reports that were previously unprinted may then "roll over" into the present batch at the time of batch generation. Your system manager controls this occurrence via the system setting of *Report Chute Manager Checks Previous Batch for Unsent Reports*.

You can also print reports that have already been printed, or those that are closed. In the Report Chute Manager, display all batches for a chute by double-clicking on the Display Chute Type letter to the left of the chute description. Then, select a closed batch for printing. **Print Batch** changes to **Reprint Batch**. Press **Reprint Batch** to access the Report Print Manager.

NOTE: The Print/Send Setup window does not appear until you press **Print** because you can select a range of reports to reprint instead of reprinting the entire batch. By default, the entire batch is selected for reprinting.

Printing Report Batches

You can print individual, multiple, or all reports within a chute from the Report Chute Manager window or when in Batch Detail view. If you want to print a batch that has already been printed, you can search for a particular print starting point within that batch.

To print or fax report batches from the Report Chute Manager:

1) Select the chute(s) that contains the reports you want to print or fax.

   TIP! To select individual chutes, hold down the Ctrl key and use the mouse to select each chute. To select a range of chutes, hold down the Shift key and use the mouse to mark the first and last chute of the range.

2) Press <u>P</u>rint Batch.

   The Report Print Manager and the Print/Send Setup windows appear. If the current batch is open, the Report Print Manager closes the batch, sorts it, shows the sort detail, and prepares for printing.

3) The Print/Send Setup window appears. To learn more about this pop-up window, refer to "Print".

   NOTE: If you are not sure of the printer location or name, ask your System Manager for information.

4) Once all batch printing finishes, the Report Print Manager closes and returns you to the Report Chute Manager.

   Refer to "Report Batch Printing Attributes".

To print or fax individual reports from within the current chute:

1) Select a single chute(s) that contains the reports you want to print or fax.

2) Press <u>B</u>atch Detail.

   The reports from the selected chute appear in Batch Detail view.

3) Select the reports you want to print or fax.

   TIP! To select individual reports, hold down the Ctrl key and use the mouse to select each report. To select a range of reports, hold down the Shift key and use the mouse to mark the first and last report of the range.

4) Press <u>P</u>rint Report.

   The Report Print Manager and the Print/Send Setup windows appear.

5) The Print/Send Setup window appears. To learn more about this pop-up window, refer to "Print".

   NOTE: If you are not sure of the printer location or name, ask your System Manager for information.

6) Once all batch printing finishes, the Report Print Manager closes and returns you to the Report Chute Manager.

Report Batch Printing Attributes

Keep the following attributes in mind when you print a batch:

- At the beginning of a batch, CoPathPlus will print out a cover page that tells you the name and number of the batch, and the date and time of printing.

- At the end of a batch, CoPathPlus will print out a summary list of what was printed and an error list if any errors were encountered (in this order). For an example of an error list, refer to "Viewing Print Errors".

- Batches can be defined to include sort pages. If this is configured, CoPathPlus will sort the batch in the designated sort sequence and insert a divider page between the logical report batch "sets". For example, for the Surgical Department Final Reports batch in the Departmental Chute, the reports are sorted by ordering physician and defined to use a sort page. CoPathPlus will insert a divider page prior to the reports for doctor Adams which will indicate "Deliver To: Andrea Adams, M.D." on it at the beginning of this group.

Reprinting Report Batches

You can print batches that have already been printed. If you want to start printing at a particular point within the batch, use the "Search for Sort Values" field in the Report Print Manager Reprint Batch display. Based on the values you enter, CoPathPlus searches for the first matching report and starts reprinting from that point.

To reprint report batches:

1) Double-click on the Display Chute Type letter that appears to the left of the chute description to show all batches for the current chute.

2) Select the chute(s) or batches that contains the reports you want to reprint.

   TIP! To select individual chutes or batches, hold down the Ctrl key and use the mouse to select each. To select a range of chutes or batches, hold down the Shift key and use the mouse to mark the first and last chute/batch of the range.

3) Press Reprint Batch.

   The Report Print Manager appears. The entire report batch appears selected (highlighted), ready for reprinting.

4) If you want to start printing (or faxing) the batch at a particular point, either click on that point in the batch or enter values in the Search for Sort Values field.

5) Press **Print**.

   The hand icon (☞) appears to indicate the starting point of the print job, and the Print/Send Setup window appears.

6) The Print/Send Setup window appears. To learn more about this pop-up window, refer to "Print".

   NOTE: If you are not sure of the printer location or name, ask your System Manager for information.

   TIP! To set page range, number of copies, and page orientation, press **Setup** on the Print/Send Setup window.

7) Once all batch printing finishes, the Report Print Manager closes and returns you to the Report Chute Manager.

Viewing Print Errors

Errors that occur during the printing process are captured on the Report Print Manager Error Log window.

In this window, the details of the print error(s) are identified. The print job finishes and then the Error Log is shown. The Error Log is printed at the end of the batch, prior to the batch summary sheet. Reports that had errors when printed are marked by two asterisks (**) on both the Batch Detail window and the batch summary sheet. Also, **Error Log** on the Report Print Manager, which lets you view and print a summary of the errors, is enabled.

NOTE: When you exit the Report Print Manager, all print errors are deleted.

Remove

Once in Batch Detail view, you can remove selected reports from the current (open) batch by pressing **Remove**.

NOTE: You must have permission to be able to remove a report from a batch on the Batch Detail window. If you do not have permission, **Remove** will be disabled.

To remove reports from the current batch:

1) On the Report Chute Manager, select the batch of the report you want to remove and press **Batch Detail**, or double-click on the batch to access the Batch Detail view.

2) In Batch Detail view, select the report you want to remove by highlighting it.

   TIP! To select individual reports to remove, hold down the Ctrl key and use the mouse to select individual reports. To select a range, hold down the Shift key and use the mouse to mark the first and last report of the range.

3) Press **Remove**.

   A warning message appears. The reports are removed from the current batch. You can continue with other Report Chute Manager tasks.

4) If you want to exit to the Report Chute Manager, press **Done**.

Batch Detail

From the Report Chute Manager, press **Batch Detail** to view the details of a particular batch: specimen number, patient, type of patient report (for each specimen associated with the batch), and the report status.

To view the detail of a particular batch:

1) On the Report Chute Manager, select a batch by double-clicking on it, or by highlighting it and pressing **Batch Detail**.

   The selected batch appears in Batch Detail view.

   NOTE: If no reports exist in the current report chute, you cannot switch to Batch Detail view.

2) To close the Batch Detail view, press **Close Detail** (or double-click on the chute name or icon).

   TIP! If you want to view the detail of a report batch that has already been closed or printed, double-click on the letter icon of the particular report chute to view all batches or highlight it and press **Batch Detail**.

Late Reports

When you press **Late Reports** on the Report Chute Manager, the Report Chute Unprocessed Reports window appears, displaying the report chute batches at a closed or error status for the date range selected.

From this window, you can perform the following tasks:

- Update the display with the most recent changes by updating the Batch Date time frame and pressing **Refresh**.

- Reprint any problem reports from within this function by highlighting the report(s) of interest and pressing **RePrint Reports**. The control and shift keys may be used in standard window fashion to select multiple reports for reprinting purposes.

- Print the current display (the summary screen shown in the Report Chute Unprocessed Reports window) by pressing **Print Summary**.

- Exit this window by pressing **Done**.

Double-click on the report chute of interest to view a list of the patients, specimen numbers, report types, report statuses, status dates/times, batch numbers, most recent print attempts, and the number of printout retries.

Once a report has been successfully printed, it will be removed from the Late Report list. If all reports within the same chute have been reprinted, the entire chute will be removed from the Late Report List. However, that report chute itself as seen in the Report Chute Manager will maintain its original status of Closed or Error.

Cerner recommends that the Late Report be used in conjunction with other daily monitoring tools to insure all reports are successfully sent. This includes the Schedule Manager Log , Report Chute Distribution Error Report, and the Distributed Report Process Status Log

When using the Late Reports function, the Report Chute Unprocessed Reports feature is active (rather that the Report Chute Manager itself). If reports are reprinted from here, the status of the batch in the Report Chute Manager is not updated. Batch statuses are updated in the Report Chute Manager only when batches are processed through the Report Chute Manager. You may want to use these features in conjunction with one another. I.e., use Late Reports for it's ease of errored report batch identification, and use the Report Chute Manager to process those identified batches to completion. Steps would be:

1) Use the Late Report Print Summary button to obtain a list of the chutes that need to be reprinted.

2) Return to the Report Chute Manager to reprint the batches identified.

Schedule

When you press **Schedule** on the Report Chute Manager, the Queue of Report Jobs Currently Scheduled for Distributed Processing window appears, displaying the print schedule for report chute-related print jobs. This report also lists any background jobs currently processing.

From this window, you can perform the following tasks:

- Update the display with the most recent changes by pressing **Refresh**.

- Print the current display (the queue shown in the Queue of Report Jobs Currently Scheduled for Distributed Processing window) by pressing **Print**.

- Check the status, including the error report, of report jobs that were processed by pressing **Status Log…**, explained below.

- Exit this window by pressing **Done**.

When you press **Status Log** on the Queue of Report Jobs Currently Scheduled for Distributed Processing window, the Distributed Report Process Status Log window appears. This window lets you view the status log of a particular batch print job that has been scheduled for processing or that has been processed. Background job errors and status also display on this log.
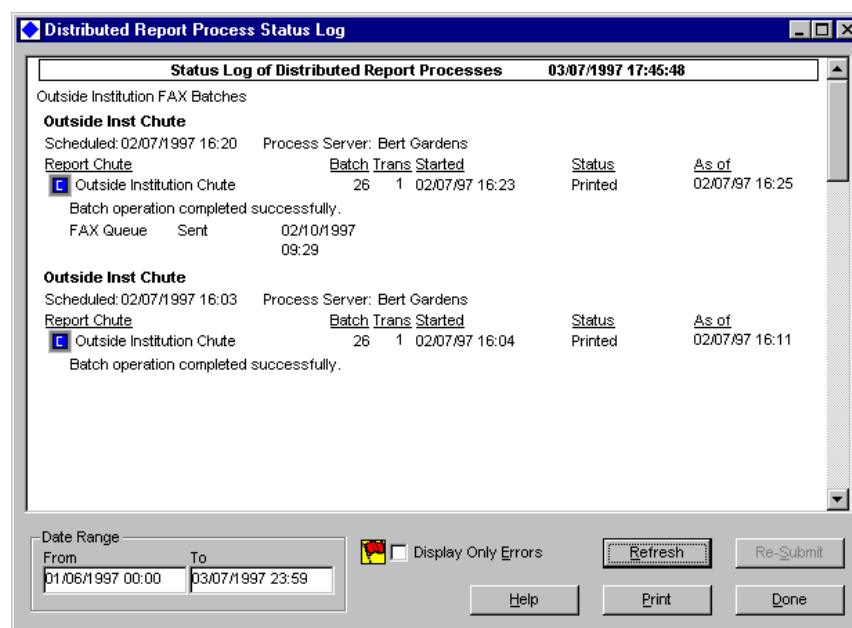
You can view the status, including the error report, of a particular job by entering a range in the Date Range area, and you can print the current status log by pressing **Print**. If the Display Only Errors check box is selected, only batches with errors appear (this is the default setting). If the batch sent for processing received errors and did not print, you can re-submit that batch by selecting it from the status list and pressing **Re-Submit**. To exit this window, press **Done**.

Report Chute Site Settings

You can set up the way you want CoPathPlus to sort the fields (Client, Location, Physician, and Department) for new report chutes and recompile procedures for the report chutes by pressing **Settings** on the Report Chute Manager. "The sorts and missing data replacement values as well as the sort page designators identified on this window will be copied into the Report Chute Dictionary for all new report chutes created. However, changes to the Report Chute Site Settings will not alter these configurations in existing report chutes. In addition, CoPathPlus uses also uses sort and replacement values defined here if the specific report chute does not have pre-

determined sort criteria. Configurations are set up separately for the four different types of report chutes (Client, Location, Physician, and Department).

The Report Chute Site Settings window appears.

Enter the following information on the Report Chute Site Settings window:

Sort Field. Specify a sort method for each chute by selecting one or more sort values from the drop-down lists, in order of your site's sorting requirements for a particular chute type. These sorts are used when the individual report chute does not have other sorts defined. For example, if you did not enter sort criteria for the Main Street Clinic entry (a location) in the Report Chute dictionary; when CoPathPlus processes report batches for this location, it will use the Location sort criteria found on the Report Chute Site Settings window. Refer to "Report Chute Sorts" for more information.

Missing Data Replacement. Enter the text that CoPathPlus will substitute for a sort-level data value if the item has no value. The number of allowable characters varies according to the Sort used. It is suggested this you limit your entry to 24 characters or less.

Print Sort Page. Select this check box if you want to print a sort page before the reports for this sort level. A clear check box means that no sort page will print.

Usually, a sort page displays the value by which the reports are sorted, along with any additional data relating to that sort value that may be needed for routing the reports.

Sort Page Template. Select the InfoMaker report template (datawindow) to use for the sort page for the corresponding sort level.

NOTE: The Sort Page Template field is disabled if the corresponding Print Sort Page check box is not selected. If you clear the Print Sort Page check box after selecting a Sort Page Template, the template name is retained, but the sort page will not print.

Report Batch Purging. This display area provides you with information on the last time CoPathPlus purge report batches, as determined by how you set up the Report Chute Batch Purge entry in the Purge dictionary.

Recompile Procedures for ALL Report Chutes. Typically, you would only need to press the <u>Sorting</u> and/or <u>Distribution</u> buttons when instructed by personnel from Cerner CoPathPlus (most often after your CoPathPlus system has been upgraded). Pressing these buttons recompiles sort or distribution criteria, respectively, for your site's chutes.

To learn more about the two dictionaries mentioned above, refer to "Report Chute Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* and "Purge Dictionary" in the "Setup" section of the *Cerner CoPathPlus System Manager Guide*.

NOTE: You must have permission to edit report chute settings such as defaults. If you do not have permission, <u>Se</u>ttings is disabled once a Report Chute is selected.

Report Chute Sorts

Report chute sorts will be applied to a report batch when the batch is first printed. Reprints of the same batch will use the original batch sort even if the report chute has been assigned a different sort in the Report Chute Dictionary.

Name of Sort	Description
Accession Number	This sort organizes the batch by the formatted specimen number. Accession number is also the default sort used when a sort has not been specified.
Billing Type	This sort organizes the batch alphabetically by the specimen's Billing Type Name.
Client (Dept Copy Suppressed)	A Department Copy Suppressed sort can only be used on departmental report chutes. When this sort is used, CoPathPlus will look to see the specific reports within this batch have already printed to any Client Report Chutes PLUS look at the value for the Suppress Departmental Copy check box found in the Client Dictionary. If the Suppress Departmental check box is enabled and the report has printed in a Client Chute, CoPathPlus will suppress the report from also printing in the Departmental batch using this sort.
Client (Specimen Level)	This sort organizes the batch by specimen-level client name.
Copy To Person	This sort organizes the batch alphabetically by the names of each Copy To Person. The batch can generate multiple copies of the same report as it will print one report for each assigned Copy To Person. One report will still be generated for each specimen in the batch even if there are no assigned Copy To Persons.
Courier Route	This sort organizes the batch alphabetically by the text in the Courier Route field from the Client Dictionary. It is used for Client Report Chutes only.
Courier Route and Client Name	This sort organizes the batch by the Client's courier route and then the client name, so all clients for 1 courier route print together (without using up 2 of the 3 possible sorts). It is used for Client Report Chutes only.
Cytotech	This sort will organize the batch alphabetically by the name of each associated Cytotechnologist. It will produce multiple copies of the same report within the batch when there is more than one Cytotechnologist associated to the case. At least one copy will print even if there are no associated Cytotechnologists (such as the specimen being reviewed only by a pathologist).
Date Taken of the First Specimen Part	This sort will organize the batch by the Date Taken field of the first part.
Department	This sort will organize the batch by the Department for Accession assigned to the specimen.
Final Transcriptionist	This sort is used only for Departmental Reports. It will sort according to the "lastname, firstname" of the transcriptionist or other person who entered the text into the Final text field. This sort may be useful for Final Review Reports.
Gross Pathologist	This sort will organize the batch alphabetically by the name of each associated gross pathologist. It will produce multiple copies of the same report within the batch when there is more than one gross pathologist associated to the case. At least one copy will print even if a gross pathologist has not been identified in CoPathPlus. In that case, the report will be positioned according to the defined Missing Data Replacement data. This sort is used only for Departmental chutes and may be useful for Working Draft Batches.
Gross Resident	This sort will organize the batch according to the gross pathologist assigned the Resident rank. Even if there is more than one resident assigned as a gross pathologist, only the first will be assigned a "R" adjacent to the resident name. Only that resident will be issued a copy of the report from a report chutes using this sort. This sort is used only for Departmental chutes and may be useful for Working Draft Batches.
Location	This sort will organize the batch according to the patient's current location. It will initially attempt to sort by the location assigned in the patient's encounter record. If that location field is empty, it will then use the location assigned in the specimen record.
Location (Dept Copy Suppressed)	A Department Copy Suppressed sort can be used on departmental report chutes. When this sort is used, CoPathPlus will look to see the specific reports within this batch have already printed to any Location Report Chutes PLUS look at the value for the Suppress Departmental Copy check box found in the Location Dictionary. If the Suppress Departmental check box is enabled and the report has printed in a Location Chute, CoPathPlus will suppress the report from also printing in the Departmental batch using this sort. When the report prints within this chute, it will attempt to sort by the location assigned in the patient's encounter record. If that location field is empty, it will then

	attempt to sort by the location assigned in the specimen record.
MedRec Number	This sort organizes the batch numerically according to the patient's medical record number for the client used oin the specimen.
MRN Terminal Digit Sort	This sort is not used.
Number of Copies (based on client and specimen class)	This sort is used in conjunction with the # of copies tab in the Client Dictionary. Enter the desired number of copies for each specimen class for the client into this table. You may leave the table empty to generate just one copy as long as you stipulate "1" as the Missing Data Replacement value for any report chute that uses this sort. Batches using this sort will print all reports one time. It will then reprint all reports that require two or more copies. It will then reprint the reports that require three or more copies and continue with this pattern. This sort can only be used individually. Sorts defined prior to it will be ignored. Sorts defined after it will be deleted. It can be used for Client and Departmental Report Chutes.
Ordering Physician	This chute organizes the batch alphabetically by ordering physician name.
Outside Institution	This chute organizes the batch alphabetically by the free form address entered to the Outside Institution field. It may be useful for sorting the Outside Institution Chute.
Pathologist	This sort will organize the batch alphabetically by the name of each associated pathologist. It will produce multiple copies of the same report within the batch when there is more than one pathologist associated to the case in the multi-instance (final) Pathologist field. At least one copy will print even if a pathologist has not been identified in CoPathPlus. In that case, the report will be positioned according to the defined Missing Data Replacement data. This sort is used only for Departmental chutes and may be useful for Working Draft Batches.
Patient Name	This chute organizes the batch alphabetically by patient last name, then first name.
Patient Name and Number of Copies (based on client & specimen class)	This sort will organize batches by patient name and will generate the number of report copies defined for each Specimen Class in the Client Dictionary on the # of copies tab. Enter the desired number of copies for each specimen class for the client into this table. You may leave the table empty to generate just one copy as long as you stipulate "1" as the Missing Data Replacement value for any report chute that uses this sort. This sort should only be used alone. Other report chutes sorts defined before or after this sort will be ignored. This sort can be used for Client and Departmental Report Chutes.
Physicians	This sort will organize the batch alphabetically by the name of each associated physician, including the Submitting Physician and all Additional Physicians. It will produce multiple copies of the same report within the batch when there is more than one physician associated to the case. At least one copy will print even if physicians have not been identified in CoPathPlus. In that case, the report will be positioned according to the defined Missing Data Replacement data. This sort is used only for Departmental chutes and may be useful for Working Draft Batches.
Physicians (Dept Copy Suppressed)	A Department Copy Suppressed sort can only be used on departmental report chutes. When this sort is used, CoPathPlus will look to see the specific reports within this batch have already printed to any Physician Report Chutes PLUS look at the value for the Suppress Departmental Copy check box found in the Physician Dictionary. If the Suppress Departmental Copy check box is enabled and the report has printed in a Physician Chute, CoPathPlus will suppress the report from also printing in the Departmental batch using this sort. This sort can also produce multiple copies when there are multiple physicians associated to the specimen.
Physicians (No Image Dept Copy Suppressed)	This sort is similar to Physicians (Department Copy Suppressed) chute, but is used in conjunction with PICSPlus images. This sort organizes the batches by physicians, but the departmental copy suppression will be for physicians with linked physician chutes unless the report has images. If the report has images, it will not be suppressed in the Department batch using this sort.
Physicians by Client	This sort will organize the batch by physicians (submitting or additional) as long as that physician has an association to the specimen's client in the Person Dictionary. Multiple copies of the report will print if more than one physician on the case is compatible with the client assignment. If none of the physicians on the case are associated to the

	specimen's client, one report copy will still print for each case; that copy will be sort according to the missing data replacement value.
Physicians by Client (Dept Copy Suppressed)	This sort is similar to the Physicians by Client report chute but it also includes the departmental copy suppression feature for Physician reports. If the Suppress Departmental Copy check box is enabled and the report has printed in a Physician Chute, CoPathPlus will suppress the report from also printing in the Departmental batch using this sort. This sort can also produce multiple copies when there are multiple physicians associated to the specimen.
Physicians by Client (Phys & Client Dept Copy Suppressed)	This sort is similar to the Physicians by Client report chute but it also includes the departmental copy suppression feature for both Physician and Client reports. This sort is valid for only Departmental Reports.
Primary Pathologist	This sort will organize the batch according to the staff pathologist assigned as primary in the (final) Pathologist field. Even if there is more than one pathologist assigned in the Pathologist multi-instance field, only one will be assigned a "P" adjacent to his/her name. Only that pathologist will be issued a copy of the report from a report chutes using this sort. This sort is used only for Departmental chutes and may be useful for Working Draft Batches
Primary Resident	This sort will organize the batch according to the assigned Resident. Even if there is more than one resident assigned in the Pathologist multi-instance field, only one will be assigned a "R" adjacent to the resident name. Only that resident will be issued a copy of the report from a report chutes using this sort. This sort is used only for Departmental chutes and may be useful for Working Draft Batches.
Service	This sort will organize the batch alphabetically by the specimen's service.
Specimen Priority	This sort will organize the batch alphabetically by the priority of the specimen.

Refresh

You can update the Report Chute Manager with the latest batch modifications by pressing **Refresh**. This feature lets you view the most current information during your work session.

Security and Report Chutes

System Managers can control the security of their report chutes. The goal is to prevent problems such as having a user from one department, for example Surgical, accessing (and accidentally closing) a report chute that has been set up for another department such as Cytology. If a site combines both Surgical and Cytology reports into one chute, then departmental security is unnecessary between these departments. If reports are included in a report chute for a particular physician or location, they can be suppressed from the departmental report chute.

Report chute security is set up by the System Manager through entries in a number of dictionaries. For more information on these dictionaries, refer to the "Person Dictionary" in the "People/Security Dictionaries" section and the "Report Chute Dictionary" in the "Reporting Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Queue of Report Jobs

The Queue of Report Jobs item allows you to directly access the Queue of Report Jobs Currently Scheduled for Distributed Processing window. This is the same window that appears when you press **Schedule** from the Report Chute Manager item. For instructions on how to use the Queue of Report Jobs Currently Scheduled for Distributed Processing window, refer to "Schedule".

Final Report List/Range Print

The Final Report List/Range Print item gives you a way of printing a group of patient Final reports (or Working Drafts) at one time. You can enter a list or a range of specimens for which you want to print a Final Report. Refer to "Report Chute Manager" for information on printing batches of reports.

When you access the Final Report List/Range Print item, you are presented with the Final Report List/Range Print window.

NOTE: This window looks exactly the same as the Working Draft List/Range Print window, except for the title bar.

If you want to enter a:

- **List of specimens**, enter a single specimen in the From Specimen field, press **Add List/Range** to list as many specimens as you want, and press **Search**.

- **Range of specimens**, enter the beginning specimen in the range in the From Specimen field and the ending specimen in the range in the To Specimen field. If you want to add another range, press **Add List/Range**. Finally, press **Search**.

When entering a range of specimens, keep the following points in mind:

- **Specimens Must Have the Same Number Wheel**. The specimens in a range must have the same number wheel prefix. For example, you can enter S05-2 to S05-5 but you cannot enter S05-2 to C05-5.

- **Specimens Must Have the Same Year**. The specimens in a range must have the same year. For example, you can enter S05-2 to S05-5, but you cannot enter S04-2 to S06-5.

- **Ranges Cannot Overlap**. You cannot overlap ranges. For example, you can enter S05-2 to S05-5 as the first range and S05-7 to S05-10 as the second range, but you cannot enter S05-2 to S05-5 for the first range and S05-4 to S05-10 as the second range.

- **Ranges Cannot Exceed a Site-Specified Limit**. You cannot enter ranges that contain more than 500 specimens. If you enter a range that exceeds 500 specimens, CoPathPlus

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

> will automatically adjust the value in the To Specimen field to fit within the 500-specimen limit. To retrieve any additional specimens, just enter a new range that includes those specimens.

- **You Cannot Edit a Range**. Once you enter a range of specimens and search on it, you cannot edit it. You must delete the range by highlighting it and pressing **Delete List/Range**. CoPathPlus automatically updates the specimen list to remove the specimens in the deleted range. You can then add the range you want by pressing **Add List/Range** and entering the appropriate specimen numbers in the From Specimen and To Specimen fields.

CoPathPlus presents the list of specimens that you specified in the Select field. The system sorts the list by the order in which you requested the cases. All the specimens appear highlighted. If there is a specimen(s) in the list for which you do not want to print the Final Report or Working Draft, use Shift+Down Arrow or Shift+Up Arrow to move to the specimen, and then press **De-select**. To re-select a specimen that you have de-selected, use Shift+Down Arrow or Shift+Up Arrow to move to it, and then press **Select**. For more information about selecting items in multi-select fields, refer to "Multi-Select Fields".

NOTE: When multiple specimens are selected and you want to select or de-select additional specimens, use Shift+Down Arrow or Shift+Up Arrow to move to those specimens. If you just use the Up/Down Arrows keys to move to the specimen or if you click on a specimen with the left mouse button, all other specimens except the selected one will become de-selected.

Also, if there are any specimens in the resulting list to which you do not have access, those specimens will not be selected and the following message will appear.
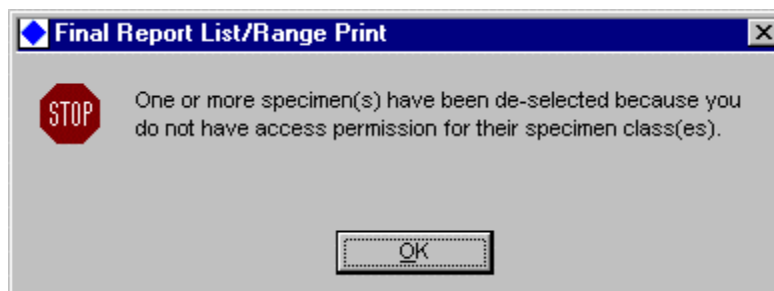
Once you have all the specimens highlighted for which you want to print a Final Report or Working Draft, press **Print/Send**. Note that you must select the Print Procedure/Addendum Report check box to include procedure/addendum reports when printing. If this check box is selected, reports are sorted by type (i.e., Final, then Addenda, then Procedure) and, within type, by report instance.

NOTE: A system setting determines whether the Print Procedure/Addendum Report check box is selected by default.

CoPathPlus brings up the standard Print/Send Setup window on top of the Report Print Manager window. The Print/Send Setup window lists the available printers.
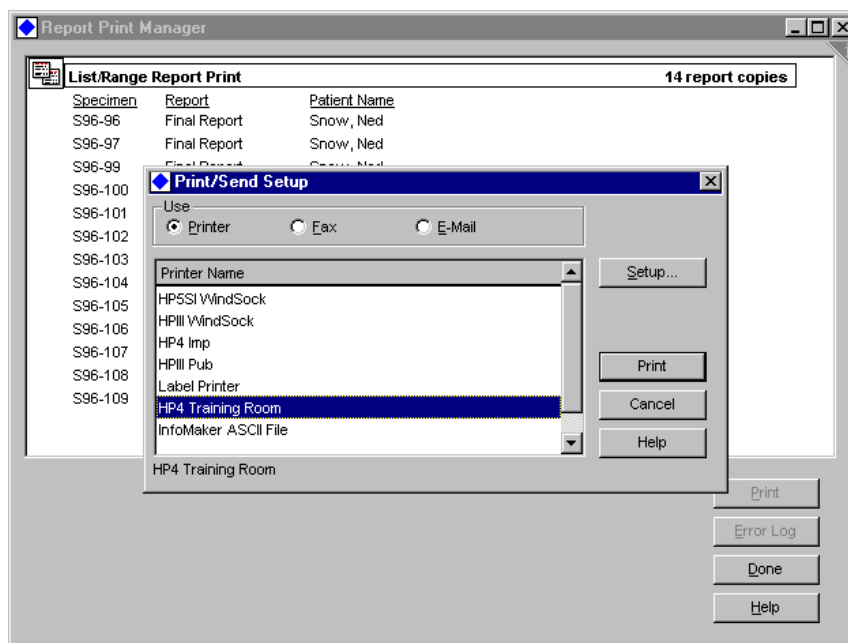
Select the printer you want to use and press **Print/Send**. For more information on the Print/Send Setup window, refer to "Print".

Once you press **Print/Send**, CoPathPlus shows you the status of the print job on the Report Print Manager window and then returns you to the Final Report List/Range or Working Draft Print window when the printing is complete. The previously selected list/range will still be in the Select field. Refer to "Report Chute Manager" for more information on the Report Print Manager window.

You can now enter additional specimens for which to print a Final Report or Working Draft, or press **Close** to return to the CoPathPlus Application Manager.

Print Reports for Patient

The Print Reports for Patient item lets you print all Final reports for all of a selected patient's specimens, with the option of printing associated individual Procedure/Addendum reports.

The fields on this window are the same as those on the Final Report List/Range Print window, except that you select a single patient at the Patient Name or MRN field, instead of selecting a range of specimens. To select a patient, enter a name or name fragment, or the patient's medical record number in the Patient Name or MRN field and press Enter.

For information about the other fields on this window, refer to "Final Report List/Range Print".

Working Draft List/Range Print

The Working Draft List/Range Print item gives you a way of printing a group of patient Working Drafts at one time. Users can enter a list or a range of specimens for which they want to print a Working Draft. This item works in the same way as the Final Report List/Range Print item, with

the exception that Procedure/Addendum reports can only be printed using the Final Report List/Range Print item.

Label Chute Manager

The Label Chute Manager is the main window for selecting and printing label queues. It also lets you view details of a particular queue from a label chute. This feature is used in conjunction with Requisition and Container labels.

The main area of the window displays each label chute, the current open queue for each chute, the number of labels, the status date/time for each label chute. Double-clicking on the chute name will expand the display to show all the queues on file for that chute, in reverse chronological order so that the most recent queues are at the top of the list. A double-click on the chute name that is already displaying all the details will close the details and display only the current open queue. You can scroll through the list and double-click on as many chutes as desired.

NOTE: You can close and automatically send queues associated with label chutes using the Schedule Manager, in which case you would not have to use the Label Chute Manager.

Two CoPathPlus dictionaries directly related to label chutes; they are the Label Chute and Label dictionaries. Other dictionaries may be used for label routing purposes. Refer to the *Cerner CoPathPlus Dictionary Building Manual* for more information on these dictionaries.

Print Labels

You can print a queue within a chute from the Label Chute Manager window

To print or fax label queues from the Label Chute Manager:

1) Select the chute(s) that contains the labels you want to print or fax. Double-clicking on a queue row will open the detail display.

   TIP! To select individual chutes, hold down the Ctrl key and use the mouse to select each chute. To select a range of chutes, hold down the Shift key and use the mouse to mark the first and last chute of the range.

2) Press <u>P</u>rint Labels.

   The Label Print Agent window appears and shows the label rendered. You can then select a printer or output device.

3) The Print/Send Setup window appears. To learn more about this pop-up window, refer to "Print". The default is the printer defined in the Label Chute Dictionary for that Chute. Refer to the "Label Chute Dictionary" topic in the *CoPathPlus Dictionary Building Manual* for more information.

   NOTE: When printing labels from within the Label Chute Manager you will be directing the labels specifically to printers, rather than to label chutes (which are associated to printers).

4) After printing, the Label Print Agent remains open to allow you to reprint the queue. To close the Print Agent and return to the Label Chute Manager screen, press **Done**. .

Label Details

From the Label Chute Manager, press **Details** to view the list of specimens or procedures in that queue and the type of label for each.

To view the detail of a particular queue:

1) On the Label Chute Manager, select a queue by double-clicking on it, or by highlighting it and pressing **Details**.

   The selected queue appears in Label Detail view.

   When the detail display is open, you can click on a label the click Remove to delete selected labels from the queue. Double-clicking in detail mode will also delete the label after prompting you for confirmation.

   NOTE: If no labels exist in the current label chute, you cannot switch to Detail view.

2) To close the Detail view, press **Close Detail**.

Remove Labels

To remove labels from a queue on the Label Chute Manager:

1) On the Label Chute Manager, select a queue by double-clicking on it, or by highlighting it and pressing **Details**.

   The selected queue appears in Queue Detail view.

2) Click on the label you want to remove and press **Remove**. You can also double-click on the label and confirm you want to remove the label.

3) To close the Detail view, press **Close Details**.

Statistics

From the Label Chute Manager, press **Statistics** to view the label printing statistics. The statistics are available on an hourly or per minute basis so your site can monitor and evaluate the volume and timing of label processing.

The statistics show the number of labels printed on an hourly or per-minute basis, plus the average number of minutes those labels had to wait in the queue before being processed.

Note: The statistics do not make distinctions between how many Label Print Managers or Agent PCs were involved in the processing - only the total number of labels processed across all print Managers.

To view label printing statistics, press **Statistics** on the Label Chute Manager.

The Label Chute Print Statistics window appears.

The default statistics are displayed by counts per hour and the past 30 days are displayed.

To view counts per minute, click the **Minute** option button on the bottom of the window.

To change the number of days displayed, click on the up or down arrows ⬍ next to **Number of days to include** at the bottom of the window. Then press **Refresh** to see the selected number of days.

Label Chute Print Managers

From the Label Chute Manager, press **Print Mgrs** to view the active/scheduled label print managers.

The Label Chute Print Manager processes all label print jobs. This reduces the startup overhead of each print job and allows more throughput in terms of number of labels being printed per hour. A Label Print Manager is started automatically (if not already running) whenever a label gets placed into the queues. The Print Manager will shut itself down after ½ hour of no label activity. If a Label Chute Manager is running continuously for 8 hours or more, it will shut itself down and restart as another scheduled job. This prevents memory errors in the system.

Note: If you have permission, you can also manually start a Print Manager by pressing Start Managers on the Print Manager Status window

Refresh

You can update the Label Chute Manager with the latest queue modifications by pressing **Refresh**. This feature lets you view the most current information during your work session.

Label Routing Manager

The Label Routing Manager is a utility feature that performs a recompile of the stored procedure that handles the routing logic for all active label chutes. While label routing recompilation is needed only infrequently, it may be necessary to run this utility after a major system change such as an operating system upgrade. Normally this recompile is only performed per the direction of a Cerner CoPathPlus representative.

To run the Label Routing Manager:

1) Select the Label Routing Manager from File > Browse Items. The following pop-up window will appear:
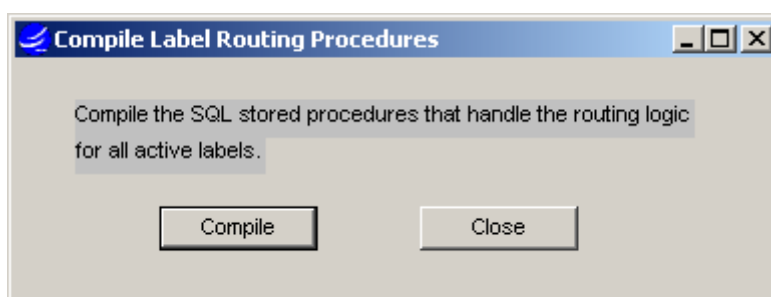
2) Press the Compile button to initiate this recompile. When the process has completed, the system will advise "Label Routing Rules stored procedures have been compiled for all ## active labels". The following is an example of the message window:

3) Press OK to acknowledge this message and then press the Close button to exit the Label Routing Manager.

Audit Trail Reports

CoPathPlus provides the following standard Audit Trail reports:

- Audit Report - History Detail Report   (not accessed from Audit Trail Reports folder)
- Audit Report - History Field Report   (not accessed from Audit Trail Reports folder)
- Audit Report - History Summary Report   (not accessed from Audit Trail Reports folder)
- Amended Final Reports by Accession Number

- Audit Setting Activity Report

- Audit Trail Detail Report

- Audit Trail Detail by Specimen Report

- Audit Trail Setup Report

- Audit Trail Summary Report

- Audit Trail Summary/Patient Report

- Audit Trail Summary of Run Items Report

- Audit Trail Summary by Specimen Report

- Duplicate Patient Review Report

- Failed Sign-On Attempts

- Inactive Users Report

- Inactive Workstations

- Non-Duplicate Patient Report

- Patient Delete Log

- Patient Demographic Audit Trail

- Patient Merge/Move Log

- Purge Log

- Specimen Delete Log

- Specimen Move Log

- Specimen View Audit

- User Sign-on Report

Audit Report- History Detail

The Audit Report- History Detail report displays audit trail information on every change to the specimen: user name, workstation ID, date/time filed, navigation (part no.), old value, new value, and new text. The report prints the table name and the column name where data is sorted.

Note: You need to have permission to run the history report. The system also must have Detail Audit trails turned on for detailed data records. If there is not any data there will be no information in the report. Refer to "Audit Trail Maintenance" in the *CoPathPlus System Manager Guide* for more information.

To access the Audit Report History Detail report:

When you are in a field in an application item, click **File > History** and select Record (Detail). The report will open in a new window.

Audit Report- History Field

The Audit Report- History Field report is similar to the Audit Report - History Detail report except it does not include table name and column name. This report displays audit trail information on every change to the specimen: user name, workstation ID, date/time filed, navigation (part no.), old value, new value, and new text.

Note: You need to have permission to run the history report. The system also must have Detail Audit trails turned on for detailed data records. If there is not any data there will be no information in the report. Refer to "Audit Trail Maintenance" in the *CoPathPlus System Manager Guide* for more information.

To access the Audit Report History Field report:

When you are in a field in an application item, click **File > History** and select Field. The report will open in a new window.

Audit Report- History Summary

This report is similar to the Audit Report - History Detail report except it only includes three columns. This report displays audit trail information on every change to the specimen: user name, workstation ID, and date/time filed.

Note: You need to have permission to run the history report. The system also must have Audit trails turned on for data records. If there is not any data there will be no information in the report. Refer to "Audit Trail Maintenance" in the *CoPathPlus System Manager Guide* for more information.

To access the Audit Report History Field report:

When you are in a field in an application item, click **File > History** and select Record (Summary). The report will open in a new window.

Amended Final Reports by Acc

The Amended Final Report by Accession Number provides the system manager with an efficient means of retrieving the previous and current Final Diagnosis Text fields for a specific specimen. Specimen Number is the sole retrieval argument.   The report will display the previous and current final Diagnosis for each amendment performed on the specimen.   Additional information presented on the report includes accession number, patient name, accession date/time, last sign out date/time, status, amendment date/time, amendment performed by person, amendment reason and comment. It also indicates the amendment type; either Major or Minor.

Audit Trail Detail Report

The Audit Trail Detail Report provides the same information as the Audit Trail Summary Report, and: table and columns changed, who made the change (i.e., user or system), and the old value (for edits). In addition, if the change is in a sub-table of the top table, path information from the top table to the sub-table is displayed.

Audit Trail Detail/Specimen

The Audit Trail Detail by Specimen Report provides the same information as the Audit Trail Summary by Specimen Report, and: table and columns changed, who made the change (i.e., user or system), and the old value (for edits). In addition, if the change is in a sub-table of the top table, path information from the top table to the sub-table is displayed.

Audit Trail Setup Report

The Audit Trail Setup Report displays two sections, one for header setup (**Header Audit Trail Records)** and one for detail setup (**Detail Audit Trail Records**). The Header Audit Trail Records section of this report displays the external and SQL names of each top table that is audited at the header level. The Detail Audit Trail Records section of this report displays the external and SQL names of each table that is audited at the detail level, the SQL column name, and the type of user to be audited.

This report sorts both sections alphabetically by external table names.

NOTE: System settings may override these values.

Audit Trail Summary Report

The Audit Trail Summary Report provides a summary of user modifications to data within CoPathPlus. Selection criteria include table name, date range, actions performed (i.e., additions, deletions, edits), and users. This report prints the audit date, audited entity, time, item changed, action performed, user, and comment (i.e., a brief description of the change).

This report sorts in alphabetical order by audited entity, and then in descending order by audit date within each entity.

Audit Trail Summary/Patient

The Audit Trail Patient Report provides audit trail information for a patient and related entities (encounters and specimens). Retrieval arguments are patient, audit date range, and action performed. Detail information includes time, action, user, and comment.

Note: Currently this report supports only one patient at a time (you will get no data if you enter multiple patients), but this will be changed in a subsequent patch.

This report sorts in alphabetical order by audited entity, and then in descending order by audit date within each entity.

Audit Trail Summary/Run Items

The Audit Trail Summary of Run Items Report provides a summary of each time a user opened a window within CoPathPlus. Selection criteria include table name, date range, actions performed (i.e., additions, deletions, edits), and users. This report prints the audit date, audited entity (which is always a run item), time, item opened, action performed, user, and a comment (i.e., a brief description of the action).

This report sorts in descending order by audit date, and then in descending order by time.

NOTE: This report is only displayed when the following Audit Trail category system settings are set to Yes: "Audit Header Option" and "Audit trail all run items". We recommend that this latter setting <u>not</u> be turned on, as it generates a large file of highly detailed data and may cause other audit trail reports to run slowly.

Audit Trail Summary/Specimen

The Audit Trail Summary by Specimen Report provides a summary of user modifications to specimens within CoPathPlus. Selection criteria include specimens to include, date range, actions performed (i.e., additions, deletions, edits), and users. This report prints the audit date, audited entity (which is always a specimen number on this report), time the specimen was changed, action performed, user, comment (i.e., a brief description of the change).

This report sorts in descending order by audit date, and then in ascending order by specimen number within each date.

Duplicate Patient Review Report

The Duplicate Patient Review Report lists patient records that have been added to the Duplicate Patient Log. A patient record is added to that log if CoPathPlus finds a potential duplicate record during Patient Registration or New Specimen entry. For information about how CoPathPlus checks for duplicate patient records, refer to "Duplicate Patient Checking".

Selection criteria include date range (i.e., the date on which the records were flagged as possible duplicates), users, and workstations. The report prints the "base" patient record followed by all possible duplicate records. The "base" patient record is the record that was being accessed when CoPathPlus found a possible duplicate. The following information prints for each patient record: whether the record is the base patient record (Y/N), name, aliases, address, gender, birth date, current age, medical record number(s), and client abbreviation.

The report sorts alphabetically by base patient.

After you review this report, you can use either the Duplicate Patient Processing or Patient Merge/Encounter Move items to merge the duplicate records or to mark records that are not duplicates. Once you merge the records or mark them as not duplicates, they no longer appear on this report. Patient records marked as not duplicates appear on the Non-Duplicate Patient Report.

Failed Sign-On Attempts

The Failed Sign-On Attempts report lists all unsuccessful attempts to sign on to CoPathPlus. A signon is considered unsuccessful if the user enters an incorrect user ID/password combination and then exits the CoPath Client/Server Sign-On window without successfully signing on. If a user enters an incorrect user ID/password combination, but then signs on successfully, the signon is not considered a failure and will not appear on this report. CoPathPlus automatically exits a user from the CoPath Client/Server Sign-On window after five failed attempts to enter a valid user ID/password combination. A user should contact their System Manager if unable to sign on to CoPathPlus using their designated user ID and password.

The only selection criteria for this report is failure date/time range. The report prints the failed signon date and time, workstation ID, and number of failed sign-on attempts. Data is sorted in descending order by date/time, starting with the most recent failed signon.

Inactive Users Report

The Inactive Users report lists all users who have not signed on since the date you enter in the selection criteria. The report only includes users who are marked as active in the Person dictionary and who have password expiration dates in the future. The intention of this report is to provide a list of users who you may want to change to inactivate.

The report sorts alphabetically by user name.

Inactive Workstations

The Inactive Workstations report searches all active workstations that have had not activity since a selected date. Retrieval arguments are not_used_since_date and workstation.

The report is sorted by workstation name and includes workstation id, workstation domain, and workstation description.

Non-Duplicate Patient Report

The Non-Duplicate Patient Report lists patient records that have been marked as not duplicates through the Duplicate Patient Processing or Patient Merge/Encounter Move items. Selection criteria include date range (i.e., the date on which the records were marked as not duplicates), users, and workstations.

This report displays the patient records side by side and provides the patient names, aliases, addresses, gender, birth dates, current ages, medical record numbers, and client abbreviations.

The report sorts alphabetically by base patient.

Refer to "Duplicate Patient Review Report ".

Pat. Demographic Audit Trail

The Patient Demographic Audit Trail Report tracks edits or deletions to the patient table. Retrieval arguments are audit date, patient, who edited. Detail is grouped by Audit Date and includes time audited, item (this will be the patient's last name), action (either deleted or edited), user (who make edit/deletion), comment (where it was changed), old and new values.

For this report to work, Audit Trails for patients must be enabled.

To turn audit trails in CoPathPlus:

Press the **Setup** command button on the CoPathPlus Application Manager. A list of folders (categories of reports) appears on the right side of the Application Manager.

2) Double-click on the Security Items folder.

A list of items appears under the Security Items folder.

3) Double-click on the Audit Trail Maintenance folder.

A list of items appears under the Audit Trail Maintenance folder.

4) Select the Table Audit Settings item.

Enter the following settings:

- Global Settings should be set to:

  ■ Yes (audit normally)

  ■ Yes (selected columns)

  ■ Store new values also

- Top Tables should be set to:

- Patient. Add a check in Hdr and Det.

- For who, add u ("u" indicates user changes).

The following illustration displays the settings on the Audit Trail by Table window.
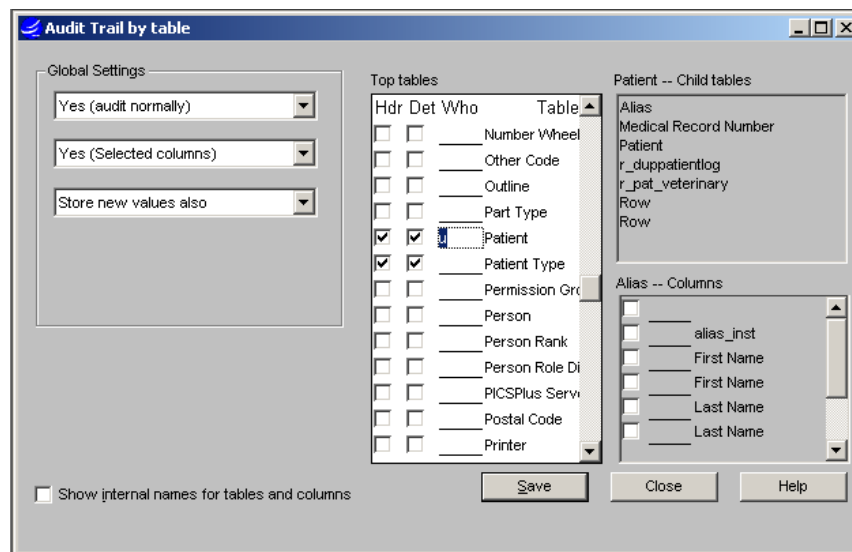
Patient Delete Log

The Patient Delete Log provides a list of all patient records that were deleted using the Patient Registration item, including the total number of records deleted. Selection criteria include patient names and date/time deleted.

This report prints the patient name, user ID, date/time of deletion, and medical record numbers associated with the deleted record.

This report sorts the records by deletion date/time, starting with the oldest record in the selected date range.

You can access this report by pressing either the:

- **Tasks** command button and selecting the Patient/Specimen Merge/Move/Delete folder, or

- **Reports** command button and selecting the Audit Trail Reports folder.

Patient Merge/Move Log

The Patient Merge/Move Log lists all patient records that were either merged into another patient record or that had a patient encounter moved to a different patient record, using the Patient Merge/Encounter Move item. Selection criteria include the patient(s) to include and the date/time of the merge/move. The standard report is divided into two sections: **Patients Merged** and **Encounters Moved**, in that order.

This report prints the patient name associated with the record from which data was merged/moved, patient name associated with the record into which data was merged/moved, user ID, date/time merged/moved, merge comment, medical record numbers associated with the merge/move from record, and medical record numbers associated with the merge/move to record (including those added to the record by the merge).

This report sorts the records by merge date/time, starting with the oldest record in the selected date range.

You can access this report by pressing either the:

- **Tasks** command button and selecting the Patient/Specimen Merge/Move/Delete folder, or

- **Reports** command button and selecting the Audit Trail Reports folder.

Purge Log

The Purge Log provides a list of all audit trail data that is purged during the Nightly Purge. The Nightly Purge is scheduled in the Schedule Group dictionary. The only selection criteria is purge date/time.

This report prints the purge start date/time, purge item, user ID, purge end date/time, and comment (i.e., brief description of the purge). This report sorts in descending order by purge date/time.

Specimen Delete Log

The Specimen Delete Log lists all patient records that were deleted using the Specimen Move/Delete item, including the total number of specimens deleted. Selection criteria include the specimens to include and the date/time deleted.

This report prints the specimen number, user id, date/time deleted, accession date/time, specimen class abbreviation and description, associated patient, associated encounter, associated medical record numbers, and total number of specimens deleted.

This report sorts the records by deletion date/time, starting with the oldest record in the selected date range.

You can access this report by pressing either the:

- **T**asks command button and selecting the Patient/Specimen Merge/Move/Delete folder, or

- **R**eports command button and selecting the Audit Trail Reports folder.

Specimen Move Log

The Specimen Move Log lists all specimens that were moved to a different patient record using the Specimen Move/Delete item, including the total number of specimens moved. Selection criteria include the specimens to include and the date/time moved. The standard report displays the specimen number, user id, date/time deleted, accession date/time, specimen class abbreviation and description, old patient name (i.e., the name associated with the record from which the specimen was moved), old encounter number, old medical record numbers, new patient name (i.e., the name associated with the record to which the specimen was moved), new encounter number, new medical record numbers, total number of specimens moved.

The report sorts the records by move date/time, starting with the oldest record in the selected date range.

You can access this report either by pressing the:

- **T**asks command button and selecting the Patient/Specimen Merge/Move/Delete folder, or

- **R**eports command button and selecting the Audit Trail Reports folder.

Specimen View Audit

The Specimen View Audit report can be run for one specimen at a time. The header displays specimen number and patient name, and is grouped by the person who viewed/edited the specimen. Detail information shows the date/time, type (edit, view, delete, or new), and the application item (application item refers to the name of the item that the user ran to edit or view the specimen).

Note: Application audit trails must be turned on for data to be collected and displayed.

User Sign-on Report

This report captures the user sign-on information including date/time signed on and signed off, sign-off status, and sign-on person name. The retrieval arguments are sign-on date and sign-on person name. Scheduled sessions are not included. Sign-off statuses include:

- **F** - Finished (without error)

- **C** - Crashed (closed due to an error, but that error couldn't be logged to the database)

- **S** - Shut down (another Plus process sent a message to the process to shut down)

- **E** - Error (logged error)

Billing Reports

The following standard Billing reports are provided with your CoPathPlus system:

- Billing Batch Error Report
- Billing Batch Internal Report
- Billing Batch Output Report
- Billing Batch Output with Final
- Billing Report Procedures Not Available
- Billing Report Specimens Not Available
- Count of Fee Codes by Accession Date
- Count of Fee Codes by Accession Date and Client
- Fee Code Amounts by Submitting MD
- Fee Code Totals by Signout Person
- No-Charge Specimens Report
- Patient Billing Report
- Professional Billing Report on Signed Out Cases
- Professional Billing by Accession Date
- Professional Billing by Client
- Specimens With No Billing Type
- Specimens Without Fee Codes
- Technical Billing Report on Signed Out Cases

Billing Batch Error Report

The Billing Batch Error Report searches the billing batch(es) for specimens that may have errors that would exclude them from being finalized on the batch. It displays the billing batch name and batch number, date/time compiled, validated (if applicable), sent (if applicable), batch status, number of errors, the specimen number, patient name, billing number, billing fee code name, billing fee code modifiers and the validation comment indicating the fields causing the billing fee to have errors (e.g., no billing number or incorrect billing type for the charge).

This report sorts by billing chute name, billing batch number, patient name, specimen number, and billing fee code name.

Billing Batch Internal Report

The Billing Batch Internal Report searches for internal billing information on all specimens (both successfully compiled and not successfully compiled) included on a compiled/validated billing batch. Selection criteria includes the particular billing chute and batch number. It displays the formatted output that are specified from the interface/output service used by the site.

The standard internal report displays the following elements: billing chute name and batch number, date/time compiled, validated (if applicable), sent (if applicable), batch status, number of errors (if applicable), specimen number, patient name, and billing (encounter) number, each item in the batch in the order in which it is compiled, the service date, Prof/CPT Code, Tech/Comb Code, fee code billing override number, fee code credit indicator, billing fee code modifiers and grand total number of units.

Billing Batch Output Report

The Billing Batch Output report searches for external billing information on successfully compiled specimens that are in a compiled/validated billing batch. Selection criteria includes the particular billing chute and batch number.

The report prints the following elements: billing chute name and batch number, the date/time compiled, validated, and sent (if applicable), batch status, number of errors (if applicable), billing type, total items for the billing type, total fee code units for the billing type, specimen number , patient name, encounter (billing) number, medical record number, client name, service date, billing fee code name, Prof/CPT fee code and number of charges, Tech/Comb fee and number of charges, fee code billing override number, fee code credit indicator (if applicable), billing fee code modifiers and the grand total number of units for all billing types combined.

This report sorts by billing chute name, batch number, billing type name, patient name, specimen number, and fee code service date.

Billing Batch Output w Final

The Billing Batch Output Report With Final report is similar to Billing Batch Output Report except that the fee codes are now applied as a nested report. Detail information includes fee codes and final diagnosis.

Billing Rpt. Procs. Not Avail.

The Billing Report Procedures Not Available report is similar to the Billing Report Specimens Not Available report, except this report searches for procedures that have fee codes, but that have not been checked as available for billing, and therefore not billed. For procedure sign out date range, it prints the billing type, patient name, specimen number, specimen status, encounter (billing) number, medical record number, and client name. It also prints Technical, Professional, or Technical/Professional to indicate which kind of billing is not available.

This report sorts by billing type name, patient ID, and specimen number.

Billing Rpt. Specs. Not Avail.

The Billing Report Specimens Not Available report searches for specimens that have fee codes, but that have not been checked as available for billing, and therefore not billed. For sign-out date range, it prints the billing type, patient name, specimen number, specimen status, encounter (billing) number, medical record number, and client name.   It also prints Technical, Professional, or Technical/Professional to indicate which kind of billing is not available.

This report sorts by billing type name, patient ID, and specimen number.

Count of Fee Codes by Acc. Date

The Fee Code Counts by Date Range report searches for a count of fee codes of each type (billed or not) that were on cases during a specified accession date range. The report counts the Units field, so if you have a fee code with 2 units, it will count appropriately. The report prints the fee code and the total number of units for each. It sorts by fee code.

Count of Fee Codes by Acc/Cli

The Fee Code Counts by Date Range and Client report searches for a count of fee codes of each type (billed or not) that were on cases during a specified accession date range per client. The report counts the Units field, so if you have a fee code with 2 units, it will count appropriately. The report prints the client, the fee codes for each, and the total number of units for each fee code. It sorts by client.

Fee Code Amts by Submit

The Fee Code Amounts by Submitting MD Report s similar to Fee Code Totals by Signout Person except grouping is by Submitting MD. Detail includes units, tech code, technical charges (tech code x units), professional code, professional charges (prof charge x units), with totals for each submitting and for all. Retrieval arguments are accession date, client, specimen class, feecode, Submitting MD, and location.

Note: A case must be signed out for it to appear on this report.

Fee Code Totals by Signout Per

The Fee Code Totals by Signout Person report shows the total amount of fee code charges (in dollars) for each signout person. Each fee code is listed by fee code name, technical component code and charge, and professional component code and charge. For each signout person, the total technical and professional charges are calculated. In addition, the report calculates the total technical and professional charges for the fee codes found for *all* signout persons.

The selection criteria for this report are accession date/time, specimen class, and fee code. The report sorts alphabetically by signout person.

No-Charge Specimens Report

The No-Charge Specimens report shows all specimens that have the No Charge check box selected on the Fee Codes tab in the Billing Entry/Edit activity. Setting this check box for a case prevents the patient from being billed for service by including a 'no-charge' marker with these charges on billing reports. Examples of when you might select the No Charge check box for a case include charity work or research.

The only selection criteria for this report is the accession date/time range. This report prints the billing type, total number of No Charge fee codes per billing type, patient name, specimen number, accession date, billing number, medical record number, client, fee code name, fee code override number (if entered), professional and technical billing codes, normal charge per professional or technical code, total charges per professional or technical code that were not billed to the patient, fee code comment (if entered), and total number of no-charge billing fee code units.

The report sorts by billing type, patient, and specimen.

Patient Billing Report

The Patient Billing Report is a billing report that displays patient demographic information, guarantor information, insurance (multiple up to three providers), charge entry information, fee codes, ICD-9-CM codes, and number of blocks per part. The retrieval arguments are sign out date (first sign out date) and specimen class.

This report prints one page per specimen number.

Note: Amended cases are excluded from this report.

Prof Bill Code Report

The Professional Billing Report on Signed Out Cases report is a billing report on signed out cases for the professional code component. With retrieval arguments of accession date range and specimen class, this report contains specimen information: accession number, patient name, SS #, location, DOB, submitting physician, and final diagnosis. The billing information is reported in the detail band, with one line per fee code entry: Date of service, professional billing code, number of units, and billing fee code comment. A credit will be indicated with a "Cr". This report collects only signed out cases.

Prof Billing by Acc Date

The Professional Billing by Accession Date report groups by accession date, with detail including accession number, patient name, MRN, pathologist (if available), billing type, location (if available), date taken, ICD-9 codes (if available), fee code name, units, professional code, and professional charge. Charges are summed at the group (accession date) level as well as in the summary. The case must be signed out to appear on this report.

Prof Billing by Client

The Professional Billing by Client report prints a billing statement for each client for professional codes. Retrieval arguments are accession date, specimen class, client name, and billing type. The case must be signed out. Detail information includes client name and address, specimen number, patient name, fee code name, professional code, units, professional charge, and total charges (per specimen) and total per client. This report will page break for each new client. If a client's cases exceed one page, the client name and address will not print on subsequent pages.

Specimens without Billing Type

The Specimens with no Billing Type report captures specimens that do not have a billing type assigned. Retrieval argument is accession date range. Patient demographic and specimen information are included. The detail includes professional and technical codes, and charges sorted by fee code name.

Specimens Without Fee Codes

The Specimens Without Fee Codes report shows all specimens that have no assigned fee codes. For each billing type, the report lists patient name, specimen number, MRN, and client. The report also shows the total number of specimens found without fee codes.

The only selection criteria for this report is the specimen sign-out date/time. The report sorts by billing type, then alphabetically by patient.

Tech Bill Codes

The Technical Billing Report on Signed Out Cases report displays technical charges. Retrieval arguments are accession date range, location, specimen class, and client. The report groups by location, with detail information: specimen number, patient name, billing number, submitting physician, and MRN. Technical billing data includes date of service, technical code, and number of units. Credits are indicated by "Cr" preceding technical code.

Cases are included on this report only if they are signed out.

Case Diagnostic Reports

The following Case Diagnostic Reports are available in your CoPathPlus system:

- Amended Reports by Reason
- Amended Reports List
- Cases With No SNOMED Codes
- Cases With No SNOMED M Codes
- Consulting Pathologist Report
- Finals Not Marked Complete

- Natural Language Search Report

- Natural Language II Search Report

- Natural Language II Search No Race

- Patient Summary

- Physicians without Fax number

- Proc Search by Proc Pathologist

- Procedures Ordered/Not Complete

- Reports Signed Out by Other

- Retrieval Flags by Accession Date

- Retrieval Flags by Entry Date

- Retrieval Flags by Signout Date

- Retrieval Flags by Specimen Class

- SNOMED II Search

- SNOMED II Search No Race

- Specimen Search

- Specimen Search/Person

- Specimen Search With Final

- Specimens with Procedure/Adden

- Specimens Without Final Text

- Specimens without Gross Text

- Unsigned Cases by Pathologist

Amended Reports by Reason

The Amended Reports by Reason report groups all amended cases by Amended Reason and includes accession number, patient name, and D.O.B.; and dates accessioned, signed out, and amended. Primary Pathologist and Amended By persons are included. Also displayed is the previous final diagnosis and current final diagnosis. Retrieval arguments are amended date range and amendment reason.

Amended Reports List

The Amended Reports List report is a listing of all amended patient reports. Retrieval arguments are amended date range and specimen class. Detail information includes specimen number, patient name, amended date, amend instance, and amend type. The total count appears in the summary band.

Cases With No SNOMED Codes

The Cases With No SNOMED Codes report provides a list of specimens with no associated SNOMED II codes. Selection criteria include sign-out date and specimen class.

This report prints the specimen number, accession date, sign-out date, final diagnosis, and total number of cases with no SNOMED codes assigned.

The report sorts in ascending order by specimen class and number.

Cases With No SNOMED M Codes

The Cases With No SMOMED M Codes report provides a list of specimens with no associated SNOMED II M codes. Selection criteria include sign-out date and specimen class.

This report prints the specimen number, accession date, sign-out date, primary pathologist, primary cytotech (if present), SNOMED II codes (if present), final diagnosis, and total number of cases with no SNOMED M codes assigned.

The report sorts in ascending order by specimen class and number.

Consulting Pathologist Report

The Consulting Pathologist Report collects cases that have more than one pathologist other than the primary pathologist. Retrieval arguments are accession date (case does not have to be signed out), specimen class, and consulting pathologist. The detail is grouped by consulting pathologist and lists specimen number, parts, primary pathologist name and final diagnosis.

Finals Not Marked Complete

The Finals Not Marked Complete report looks for cases where final text is entered but is not marked complete. Retrieval arguments are accession date and specimen class. Detail information includes accession number, patient name, accession date, specimen priority, primary pathologist (if assigned) and name of person who entered final diagnosis text.

Natural Language Search Report

The Natural Language Search report allows you to search for cases based on words included in diagnostic free-text field types. For example, you can search for all cases whose final diagnosis includes the words "malignant" and/or "melanoma". The resulting report provides the specimen number and complete text for each diagnostic text field, which includes the selected word(s). Selection criteria for the report include accession date/time range, specimen classes, text search, and text field types (e.g., final diagnosis, gross description, etc.).

This report prints the specimen number, accession date/time, complete text for each of the text field types requested with inclusions/exclusions based on the text search data specified, primary pathologist (if present), primary cytotech (if present), patient name, and medical record number (MRN).

The report sorts in ascending order by specimen number.

For more information about using text searches, refer to "Text Search Data Field Type for Natural Language Search".

NOTE: All words that can be searched for in a natural language search are indexed. The natural language search process excludes "noise" words, such as "a" and "the" which are not indexed and cannot be searched for in a natural language search. To review the list of noise words for your site, refer to "Natural Language Noise Words".

TIP! While natural language searches are relatively fast, if you are searching through more than a few months' worth of data, you should use the Schedule Manager to automatically run these searches during off-hours.

Natural Language II Search Report

This is an enhanced version of the Natural Language Search report (c_dr_natlang). Additional retrieval arguments include: signout date, age, gender, race, and part type. Additional objects on the report include age, gender, race, and date signed out. The Natural Language Search II Report allows you to search for cases based on words included in diagnostic free-text field types. For example, you can search for all cases whose final diagnosis includes the words "malignant" and/or "melanoma".

Natural Language II Search No Race

This report is a modification of the Natural Language II Search report that does not include the race retrieval argument or column. Retrieval arguments include: signout date, age, gender, and part type. Additional objects on the report include age, gender, and date signed out. The Natural Language Search II Report allows you to search for cases based on words included in diagnostic free-text field types. For example, you can search for all cases whose final diagnosis includes the words "malignant" and/or "melanoma".

Patient Summary

This report is a listing of a patient's specimens. The retrieval arguments are patient name and specimen class. Included on this report are patient demographic information, dates accessioned and signed out, and submitting physician, primary pathologist, and cytotech. Diagnostic information includes specimen source, final diagnosis, diagnosis comment, amendments, and addendum. This report sorts by patient name and descending accession date (most recent to oldest). A count of specimens per patient follows each patient listing. When more than one patient is selected, a new page will begin for each patient change.

Physicians without Fax number

The Physicians without Fax numbers report looks for specimens who have a physician (submitting or other MD) that does not have a fax number. Retrieval arguments are accession date, specimen class and person. The person is any physician (submitting or other MDs) associated with a specimen. Detail information includes the physician name and will print any address information (street, city, state, zip, phone) that has been entered. A line will appear if there is no data entered. For the physician fax number, a line will appear.

The intent of this report is to run this daily on current accessioned cases to collect those cases whose associated MD does not have a fax number. A blank line will appear for fax number so it can be looked up and written down before entering into the Person Dictionary.

Proc Search by Proc Pathologist

The Procedure Search by Procedure Pathologist report returns specimens with procedures. Retrieval arguments are specimen accession date, specimen class, procedure, procedure status, procedure pathologist, and procedure resident. Data is grouped by specimen number. Detail information includes patient demographics, specimen status, procedure name, order date, signout date, procedure text and the specimen's final diagnosis. Individual values can be chosen from either the Procedure Pathologist OR the Procedure Resident arguments, but not both. One of these options must be set to All pathologists or residents.

Procedures Ordered/Not Compl.

This Procedures Ordered/Not Complete report lists the procedures ordered but not complete. Retrieval arguments are procedure order date range and specimen class. The report is grouped by procedure order date and includes specimen number, procedure name, and order date/time. Calculations include number of cases by accession date and total cases.

Reports Signed Out by Other

The Reports Signed Out by Other report retrieves cases signed out by a pathologist who was NOT the primary pathologist. The selection criteria include accession date, specimen class, and pathologist (sign out pathologist). The report prints the patient name, accession number, MRN, submitting physician, date accessioned, date signed out, sign out pathologist, and primary pathologist. Only signed out cases will appear.

Retrieval Flags by Acc. Date

The Specimens by Retrieval Flag and Accession Datereport lists specimens associated with retrieval flags. Selection criteria include accession date/time and retrieval flag names.

This report prints the retrieval flag name, specimen number, specimen class, specimen status, accession date/time, sign-out date/time, retrieval flag comment and a total of all specimens found.

This report sorts by retrieval flag name and specimen number.

Retrieval Flags by Entry Date

The Specimens by Retrieval Flag and Entry Date report lists specimens associated with retrieval flags. This report is similar to the Retrieval Flags by Accession Date report except that this report searches for data based on the retrieval flag entry date, rather than on the specimen accession date. Selection criteria include retrieval flag entry date/time and retrieval flag names.

This report prints the retrieval flag name, specimen number, specimen class, specimen status, accession date/time, sign-out date/time, entered date/time, retrieval flag comment, and a total of all specimens found.

This report sorts by retrieval flag name and specimen number.

Retrieval Flags by SO Date

The Specimens by Retrieval Flag and Sign Out Date Report lists specimens associated with retrieval flags. Selection criteria include signout date/time and retrieval flag names. This report prints the retrieval flag name, specimen number, specimen class, specimen status, accession date/time, signout date/time, retrieval flag comment and a total of all specimens found. This report sorts by retrieval flag name and specimen number.

Retrieval Flags by Spec Class

The Retrieval Flags by Specimen Class report searches an accession date/time range, specimen classes, and retrieval flags (such as Cytology Conference) for all cytology specimens.

This report prints the retrieval flag name, specimen number, final diagnosis text, all review text, review date/time, reviewer, and the primary review flag. It also prints the number of specimens per retrieval flag and the total number of specimens found. It sorts by retrieval flag and specimen number.

SNOMED II Search

The SNOMED II Search report searches accession date range, sign-out date range, specimen classes, and part types for specimens that have been signed out based on entries from the SNOMED II Collection dictionary. It prints the specimen number, accession date, final diagnosis text, primary pathologist, primary cytotech (if present), patient name, medical record number, and SNOMEDs (name/codes) per SNOMED source/group designator. This report sorts by accession number.

NOTE: This report will not include any patient without an assigned race. Therefore, if your site does not consistently capture data in the race field, use the SNOMED ll Search No Race report rather than this report.

NOTE: If the selection criteria value for SNOMED Code is "Not Used," then this report can also return specimens without any associated SNOMED codes.

Refer to "SNOMED II Code Data Field Type" for information on using the SNOMED Code retrieval arguments.

SNOMED II Search No Race

The SNOMED II Search No Race report is a modification of the SNOMED II Search report that does not include the race retrieval argument or column. The report searches accession date range, sign-out date range, specimen classes, and part types for specimens that have been signed out based on entries from the SNOMED II Collection dictionary. It prints the specimen number, accession date, final diagnosis text, primary pathologist, primary cytotech (if present), patient

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

name, medical record number, and SNOMEDs (name/codes) per SNOMED source/group designator. This report sorts by accession number.

NOTE: If the selection criteria value for SNOMED Code is "Not Used," then this report can also return specimens without any associated SNOMED codes.

Refer to "SNOMED II Code Data Field Type" for information on using the SNOMED Code retrieval arguments.

Specimen Search

The Specimen Search report prints patient name, gender, date of birth, specimen number and accession date using the following retrieval arguments: accession date range, patient lookup, specimen class, pathologist, part type, physician, client.

The report sorts by accession number.

The case does not have to be signed out, but it must have an assigned pathologist in order to be included on this report.

Specimen Search/Person

The Specimen Search/Person report is a modification of the standard Specimen Search Report. Retrieval arguments are accession date range, patient, specimen class, pathologist, part type, and person. The Person retrieval argument pulls from either the submitting physician or other attending physician assigned to a case. Detail information includes patient name, gender, accession number, accession date, date of birth. The case does not have to be signed out, but it must have an assigned pathologist in order to be included on this report.

Specimen Search With Final

The Specimen Search With Final report has retrieval arguments for sign out date, specimen class, part type, submitting physician, and client. Detail information includes accession number, patient name, client name, final diagnosis, and sign out person (primary pathologist and/or primary cytotech).

The report sorts by accession number.

Note: If your site does not use the Client field, cases will not appear.

Specimens with Procedure/Adden

The Specimens with Procedure/Addendum Report sorts/prints by specimen number and prints the accession date, specimen class, specimen status and final diagnosis if the specimen has at least one procedure or addendum on it. The procedure/addenda data includes the name, current status and associated diagnosis text field. Retrieval arguments are accession date range, procedure and specimen class.

Specimens Without Final Text

This Specimen Search With Final Text report sorts by specimen status and lists the total number of specimens, then lists the specimen number and accession date. The overall total number of specimens appears on the last page. Retrieval arguments are accession date, specimen class and specimen status. Specimens that are not signed out, such as card cases, do not display.

Specimens without Gross Text

The Specimens without Gross Text Report looks for cases without gross description up to X number of days after accession. The report groups by specimen status, with detail listing specimen number, patient name, accession date and part(s).

Unsigned Cases by Pathologist

The Unsigned Cases by Pathologist Report collects cases that are pending (not signed out). Grouping is by pathologist (with a new page for each new pathologist), the detail displays specimen information, patient demographics, status, submitting as well as clinical history (if present) and parts.

Case Statistical Reports

The following Case Statistical Reports are available in your CoPathPlus system:

- Autopsy Turnaround
- Clerical Productivity With Specimen Count
- Clerical Productivity by Text Field
- Count by Pathologist and Sign Out Date
- Count of Blocks by Request Class
- /ProceCount of Stainssses and Blocks
- Count of Stains/Processes by Request Class
- Count of Stains/Processes by Request Class, Query List
- Daily Specimen Count by Submitting MD
- ICD-9 Code Counts
- ICD-9 Codes Per Specimen
- Intradepartmental Consult
- Monthly Counts by Specimen Class
- One vs. Two Slide Gynecological Cases
- Overdue Reports by Cytotech
- Overdue Reports by Pathologist

- Overdue Reports by Pathologist with Accession Date Range

- Procedure/Addendum Turnaround Time (%) by Cytotech

- Procedure/Addendum Turnaround Time (%) by Pathologist

- Procedure/Addendum Turnaround Time (%) by Signout Person

- Procedure/Addendum Turnaround Time (Days) by Cytotech

- Procedure/Addendum Turnaround Time (Days) by Pathologist

- Procedure/Addendum Turnaround Time (Days) by Signout Person

- Procedure Count

- Professional Charges by Client

- Slides and Blocks by Client/Specimen Class

- Slide Count by Pathologist

- Specimen Count by Client and Specimen Class

- Specimen Count by Part Type/Client

- Specimen Status by Pathologist with Aging

- Specimen Count by Cytotech

- Specimen Count by Specimen Class

- Specimen Count by Patient Type

- Specimen Count by Primary Pathologist

- Specimen Count by Submitting Physician/Cross Tabulation

- Specimen Count by Submitting Physician

- Specimen Count for Pathologist/Resident by Specimen Class

- Specimen Turnaround With Detail

- Specimen Distribution by Client/Graph

- Specimen Volume by Department/Graph

- Specimens by Stain/Process

- Specimens by Pathologist/Resident

- Specimens by Submitting Physician by Status

- Stain Search by Specimen

- Technical Processing Data by Part Type

- Specimen Turnaround Time (%) by Cytotech

- Turnaround by Specimen Number

- Specimen Turnaround Time (%) by Pathologist

- Specimen Turnaround Time (%) by Signout Person

- Specimen Turnaround Time (Days) by Client and Specimen Priority

- Specimen Turnaround Time (Days) by Client and Specimen Class

- Specimen Turnaround Time (Days) by Cytotech

- Specimen Turnaround Time (Days) by Pathologist and Specimen Priority

- Specimen Turnaround Time (Days) by Pathologist

- Specimen Turnaround Time (Days) by Specimen Priority and Pathologist

- Specimen Turnaround Time (Days) by Signout Person

- Turnaround Time % by Submitting MD

Autopsy Turnaround

The Autopsy Turnaround Report shows autopsy turnaround for autopsies having a PAD. Retrieval arguments are accession date, number wheel, and specimen class. Detail data is grouped by accession date and includes accession number, patient name, primary pathologist (if available), and turnaround days for Acc-PAD and Acc-FAD

Clerical Prod w Spec Count

The Clerical Productivity With Specimen Count report is a modification of the standard Clerical Productivity by Text report. Instead of displaying the line counts for each text type, this report displays the total lines per person without detail. Also included is the total number of cases for each person.

Clerical Productivity by Text

The Clerical Productivity by Text Field report searches a user-specified text entry date range, user-specified "user(s)," and user-specified text field(s) for a count of text lines per:

- Text entry date

- User

- Text field

This report calculates the number of lines entered based upon lines entered per text field. The number of characters per line is determined by a site-specific system setting (generally 80). Any additional lines with characters less than the "line count" (<80) is rounded up to count as an additional line. The report sorts by user, then date/time.

Count by Path. S/O Date

The Count by Pathologist and Sign Out Date report searches sign out date, specimen classes, and pathologists for a total count of the number of cases by primary pathologist. The report is grouped by pathologist, with listing by sign out date and with count for each date and total by pathologist. Summary total is included. The total includes only signed out cases.

Count of Blocks by Request Class

The Blocks by Request Class report searches a date range, department(s), specimen classes, and block categories for a total count of specimens and blocks sorted by histology request class.

Count of Stain/Process/Blocks

The Count of Stains/Processes and Blocks report searches a date range, department(s), specimen classes, and stain/process categories for a total count of specimens and stains/processes by stain/process category. The report also calculates the total number of specimens, stains/processes, and blocks included on the report.

Count of Stain/Process by Req Cl

The Count of Stains/Processes by Request Class report searches a date range, department(s), specimen classes, and stain/process categories for a total count of specimens and stains/processes sorted by histology request class.

Count Stains/Procs by Req, Ql

The Count of Stains/Processes by Request Class, Query List report is identical to the Count of Stains/Processes by Request Class report (refer to "Count of Stains/Processes by Request Class") except that it prints/sorts by the stain/process query list name instead of the individual stain/process name. Stains not in any stain/process query lists print out together under **Not on a list**.

Daily Spec Count by Submit

The Daily Specimen Count by Submitting MD Report displays the number of cases received each day for each submitting MD. Retrieval arguments are accession date, specimen class and submitting MD.

The only submitting MDs appearing will be those with at least ONE case in the selected date range.

The report is in landscape format. If run for more than one month, the data will print on subsequent pages, indicated as horizontal pages

Note: Since the results are grouped by month, this report is intended to be run within a calendar year. This report will also count cases that do not have a submitting MD assigned. These will appear in the blank line directly above the first submitting MD in the list.

ICD-9 Code Counts

The ICD-9 Code Counts report searches an accession date/time range, specimen classes, and ICD-9-CM codes for a total count of the number of ICD-9-CM codes. The report displays ICD-9-CM code and name, and total count for that entry. The report sorts by ICD-9 code.

ICD-9 Codes Per Specimen

The ICD-9 Codes Per Specimen report lists searches an accession date/time range, specimen classes, and ICD-9-CM codes for the ICD-9-CM codes assigned per specimen. The report displays the specimen number, ICD-9-CM code number, and name assigned for that specimen. The report sorts by specimen number and then ICD-9 code.

Intradepartmental Consult

The Intradepartmental Consult report searches an accession date/time range and specimen classes for specimens that have consulting pathologists (more than one pathologist who is not a resident) assigned to the specimen.

It prints the primary pathologist, specimen number and other (consulting) pathologists, and sorts by primary pathologist (pretty print name), specimen number, and consulting pathologist (pretty print name).

Each primary pathologist set of reports prints on a new page.

Abnormal Cytology Slides

The Abnormal Cytology Slides report searches accession date/time range, specimen classes, a primary pathologists, part types (e.g., urine or sputum), and stain/processes (e.g., silver) for all cytology specimens with abnormal primary reviews.

This report prints specimen number, specimen class, patient name, accession date/time, primary pathologist, part designator, part type description, stain/processes, and final diagnosis text. It sorts by specimen class and specimen number.

Monthly Counts by SpecClass

The Monthly Counts by Specimen Class report displays the number of cases by specimen class and month. Retrieval arguments are accession date and specimen class. A bar graph represents the statistical data.

One vs. Two Slide Gyn Cases

The One vs. Two Slide Gynecological Cases report uses an accession date range, specimen classes, and part types to give a count of the number of gynecological cases having one slide received, and the number of gynecological cases having two slides received.

Overdue Reports by Cytotech

The Overdue Reports by Cytotech and Specimen Class report searches for overdue reports for specimen classes (where the specimen class requires signout and report status does not equal N/A), and the primary cytotech, based on the priority assigned to the specimen or the procedure/addenda turnaround time.

This report prints the primary cytotech, total overdue reports per cytotech, specimen number, patient name, accession date/time, priority, report type, report status, report status date/time, hours overdue (based on a Monday through Friday workweek), days overdue (based on a Monday through Friday workweek), and a total count of all specimens found.

This report sorts by primary cytotech, days overdue descending and specimen number. Each primary cytotech prints on a new page.

Overdue Rpts. By Pathologist

The Overdue Reports by Pathologist and Specimen Class report searches for overdue reports for specimen classes (where the specimen class requires signout and report status does not equal N/A), and the primary pathologist, based on the priority assigned to the specimen or the procedure/addenda turnaround time.

This report prints the primary pathologist, total overdue reports per pathologist, specimen number, patient name, accession date/time, priority, report type, report status, report status date/time, hours overdue (based on a Monday through Friday workweek), days overdue (based on a Monday through Friday workweek), and a total count of all specimens found.

This report sorts by primary pathologist, and days overdue descending and specimen number. Each primary pathologist prints on a new page.

Odue Rpts by Path w/Date Range

The Overdue Reports by Pathologist with Accession Date Range report is identical to the Overdue Reports by Pathologist report, but includes the additional search criteria of accession date and time.

Proc Turnaround (%)/Cyto

The Procedure/Addendum Turnaround Time (%) by Cytotech Report is a modification of the standard specimen turnaround report except this looks for turnaround of Procedures/Addenda. Retrieval arguments are order date range, specimen class, and cytotech.

Proc Turnaround (%)/Path

The Procedure/Addendum Turnaround Time (%) by Pathologist Report is a modification of the standard specimen turnaround report except this looks for turnaround of Procedures/Addenda. Retrieval arguments are order date range, specimen class, and pathologist.

Proc Turnaround (%)/Sign out

The Procedure/Addendum Turnaround Time (%) by Signout Person Report is a modification of the standard specimen turnaround report except this looks for turnaround of Procedures/Addenda. Retrieval arguments are order date range, specimen class, and CoPathPlus user.

Proc Turnaround (Days)/Cyto

The Procedure/Addendum Turnaround Time (Days) by Cytotech Report is a modification of the standard specimen turnaround report except this looks for turnaround of Procedures/Addenda. Retrieval arguments are order date range, specimen class, and cytotech.

Proc Turnaround (Days)/Path

The Procedure/Addendum Turnaround Time (Days) by Pathologist Report is a modification of the standard specimen turnaround report except this looks for turnaround of Procedures/Addenda. Retrieval arguments are order date range, specimen class, and pathologist.

Proc Turnaround (Days)/Signout

The Procedure/Addendum Turnaround Time (Days) by Signout Person Report is a modification of the standard specimen turnaround report except this looks for turnaround of Procedures/Addenda. Retrieval arguments are order date range, specimen class, and CoPathPlus user.

Procedure Count

The Procedure Count report counts the number of procedures. Procedure must be completed to appear on this report. Retrieval arguments are accession date, specimen class, and procedure name.

Prof. Charges by Client

The Professional Charges by Client report searches an accession date/time range, client name, and specimen classes. It prints the total professional charges per client. The summary includes a bar graph representing this data, plus total professional charges for all clients. Only signed out cases will appear.

Retrospective Review by %

The Retrospective Review by %" Report was designed to be used as a means of asking CoPathPlus to select a "random" percentage of signed out cases from the database.   Retrieval arguments are signout date, specimen class, pathologist, and percentage.

Note: Searching for 10% of the cases and then 5% of cases using the same values for the other retrieval arguments will yield *about* half as many cases, it may not return exactly half the number of cases.

Slides and Blocks Client/Specc

The Slides and Blocks by Client/Specimen Class report displays the histology workload by client, then specimen class. The total number of slides, total blocks, and total cases (that have blocks/slides) appear at each group level. Retrieval arguments are accession date, specimen class, client, request class, and stain name. A case does not have to be signed out to be included in this report.

Slide Count by Pathologist

The Slide Count by Pathologist report can be used for pathologist workload. Retrieval arguments are accession date, specimen class, pathologist, and client. Cases do not have to be signed out to appear on the report. The report detail information is grouped by primary pathologist and then specimen class. For each group, there are calculations for total cases (all cases assigned to a primary pathologist) and total slides (sum of all slides from cases assigned to the primary pathologist.)

Spec Count by Client/Spec. Class

The Specimen Count by Client and Specimen Class report searches an accession date/time range, client name, part type and specimen classes. It prints client name, specimen class name, and a count of specimens for each specimen class, and it sorts by client and specimen class.

Spec. Count by Parttype/Client

The Specimen Count by Client and Part Type report searches an accession date/time range, client name, and specimen classes. The report prints the part types by client. It also counts the number of part types and specimens per client. The summary includes total part types and specimens, plus a pie graph representing percentages of part types. Only signed out cases will appear.

Spec Status by Path w Aging

The Specimen Status by Pathologist with Aging report searches an accession date/time range, pathologists, specimen statuses, and specimen classes. The report prints the accession date, accession number, patient name, days lapsed, and pathologist. Results are sorted descending by accession date.

Note: This SQL uses a UNION in order to retrieve cases with or without an assigned pathologist. The report uses the "datediff" function (date difference between accession date and today) to display the "Days Lapsed", which is simply the difference between the accession date and now. This <u>does not</u> exclude weekends. To exclude weekends, delete the datediff from the SQL and use the turnaround global function in design mode.

Specimen Count by Cytotech

The Specimen Count by Cytotech report searches an accession date/time range and specimen classes. It prints primary cytotech name, specimen class, a count of specimens for each specimen class, and a total for each primary cytotech.

This report sorts by primary cytotech and specimen class. It also allows for post-run resorting by specimen number.

Specimen Count by Spec. Class

The Specimen Count by Specimen Class report searches an accession date/time range and specimen classes. It prints specimen class name and a count of specimens for each specimen class, and it sorts by specimen class. It also allows for post-run resorting by specimen number.

Specimen Count by Patient Type

The Specimen Count by Patient Type report is grouped by patient type and sub-grouped by specimen class and number of cases.   Retrieval arguments are accession date, specimen class, and patient type. Cases must have an encounter to appear on this report.

Specimen Count by Prim Path

The Specimen Count by Primary Pathologist report counts the number of cases for each pathologist. Retrieval arguments are accession date, specimen class, and pathologist. Cases do not have to be signed out to appear but must have a pathologist. Along with the number of cases per pathologist, the percent of total cases is calculated and presented on the report.

Specimen Count by Sub-crosstab

The Specimen Count by Submitting Physician/Cross Tabulation report uses the cross tab presentation style. Retrieval arguments include accession date range and submitting physician. This summary style report is grouped by submitting physician (active entries only) and lists total specimens received per month (1 is Jan., 2 is Feb., etc.), with grand totals per month.

Specimen Count by Submitting

The Specimen Count by Submitting Physician report provides a count of accessioned specimens sorted alphabetically by submitting physician and then alphabetically by specimen class. Selection criteria include accession date range, specimen classes, Location, Client and submitting physicians.

This report prints the submitting physician name, total specimens accessioned by that submitting physician, count of accessioned specimens by specimen class for each submitting physician, and total number of specimens.

Specimen Count Path/Res Spc Cl

The Specimen Count for Pathologist/Resident by Specimen Class report searches an accession date/time range and specimen classes.It prints the number of specimens per specimen class for each pathologist and resident, and it sorts by pathologist, resident, and specimen class.

Specimens by Client Graph

The Specimen Distribution by Client/Graph report searches an accession date/time range and specimen classes. It prints a bar graph depicting the number of specimens per client, and it sorts by client and specimen class.

Specimens by Dept Graph

The Specimen Volume by Department/Graph report searches an accession date/time range and specimen classes. It prints a pie chart depicting the number of specimens per department, and it sorts by department and specimen class.

Specimens by Stain/Process

The Specimens by Stain/Process report searches an accession date/time range, specimen classes, and stain/processes for all specimens. It prints the stain/process name, number of specimens per stain/process, number of stain/processes per stain/process type, a total of all specimens found, and a total of all stain/processes found.

This report sorts by stain/process and accession date/time.

Specimens by Pathologist/Resident

The Specimens by Pathologist/Resident report looks for Primary or Resident in pathologist and gross pathologist tables. Retrieval arguments are accession date, specimen class, and person. Person retrieval argument is used to capture both residents and pathologists that are the first entry in pathologist and gross pathologist fields, these pathologists are respectively labeled as 'P' and 'R'. The report is grouped by Resident or Pathologist and detail includes specimen number, patient name, MRN, priority, status, specimen class, and parts.

Specimens by Submit - Status

The Specimens by Submitting Physician by Status report is a listing of all specimens from a submitting physician. Retrieval arguments include accession date range, specimen class, and submitting physician. The report is grouped by submitting physician and further grouped into specimen class and report status of either Not Signed Out or Signed Out. Detail information includes patient name, D.O.B., and client name.

Stain Search by Specimen

The Stain Search by Specimen report allows clients to retrieve list of ordered stains by the stain/process. Retrieval arguments are accession date, specimen class, part type, billing type, and stain process. This report presents accession number, patient name, billing type, count and type of stain on each specimen. The total number of cases on the report will be tallied.

Tech Process Data by Part Type

The Technical Processing Data by Part Type report searches an accession date range for a count of all instances in which a given part type was used and calculates the total and average number of blocks and stains ordered on parts of that part type. You use this report to generate "cost analysis" type data to see how "expensive" it is to do one type of specimen processing versus another type.

Turnaround (Days)/Client/Spcl

The Specimen Turnaround Time (Days) by Client and Specimen Class Report is a modification of our standard specimen turnaround report that groups by client then specimen class. Retrieval arguments are accession date range, specimen class, pathologist, specimen priority, part type, and client name.

Turnaround (%)/Cytotech

The Specimen Turnaround Time (%) by Cytotech report searches from an accession date to first sign-out date (ignoring amendments), primary cytotech, and specimen class (where the specimen class requires signout, the report type equals final, and the report status does not equal N/A), and calculates a turnaround time from accession to signout based on a Monday to Friday workweek.

It prints the primary cytotech name; percent of specimens signed out for (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11-15, 16-20, >20) day(s); number of specimens; number of specimens signed out, average days and totals for each of these columns, and sorts by primary cytotech.

Turnaround by Spec Num

The Turnaround by Specimen Number report is a turnaround report at a specimen number level. Detail includes dates (taken, received, accessioned, and signed out) as well as turnaround days (taken-rcv, rcv-acc, acc-so, taken-so, rcv-so). This report uses the turnaround global function, workweek M-F. Workweek can be changed to S-F for a 7 day week or M-S for Mon-Sat. Retrieval arguments are accession date range and specimen class. The summary band includes total cases and average turnaround days for each date combination. Turnaround of less than 24 hours will be indicated as "1" day.

Turnaround (%)/Pathologist

The Specimen Turnaround Time (%) by Pathologist report searches from an accession date to first sign-out date (ignoring amendments), primary pathologist, and specimen class (where the specimen class requires signout, the report type equals final, and the report status does not equal N/A), and calculates a turnaround time from accession to sign out based on a Monday to Friday workweek.

This report prints the primary pathologist name; percent of specimens signed out for (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11-15, 16-20, >20) day(s); number of specimens; number of specimens signed out, average days and totals for each of these columns, and sorts by primary pathologist.

Turnaround (%)/Sign Out

The Specimen Turnaround Time (%) by Sign Out Person report searches from an accession date to first sign-out date (ignoring amendments), signout person, and specimen class (where the specimen class requires signout, the report type equals final, and the report status does not equal N/A), and calculates a turnaround time from accession to sign out based on a Monday to Friday workweek.

This report prints the signout person name; percent of specimens signed out for (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11-15, 16-20, >20) day(s); number of specimens; number of specimens signed out, average days and totals for each of these columns, and sorts by signout person.

Turnaround (Days)/Client/Pri

The Specimen Turnaround Time (Days) by Client and Specimen Priority report is a modification of our standard turnaround report, with retrieval arguments for accession date range, specimen class, pathologist, specimen priority, part type, and client. The turnaround time is first grouped by client, second by specimen class.

Turnaround (Days)/Cytotech

The Specimen Turnaround Time (Days) by Cytotech report searches from an accession date to first sign-out date (ignoring amendments), primary cytotech, and specimen class (where the specimen class requires signout, the report type equals final, and report status does not equal N/A), and calculates a turnaround time from accession to sign out based on a Monday to Friday workweek.

This report prints the primary cytotech name; number of specimens signed out for (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11-15, 16-20, >20) day(s); number of specimens; number of specimens signed out, average days; % of specimens signed out in <=1 day and totals for each of these columns, and sorts by primary cytotech.

Turnaround (Days)/Path/Pri

The Specimen Turnaround Time (Days) by Pathologist and Specimen Priority report is a modification of our standard specimen turnaround report that groups by pathologist and then specimen priority. Retrieval arguments are accession date range, specimen class, pathologist, specimen priority, part type, and client name.

Turnaround (Days)/Pathologist

The Specimen Turnaround Time (Days) by Pathologist report searches from an accession date to first sign-out date (ignoring amendments), primary pathologist, and specimen class (where the specimen class requires signout, the report type equals final, and the report status does not equal N/A), and calculates a turnaround time from accession to sign out based on a Monday to Friday workweek.

The report prints the primary pathologist name; number of specimens signed out for (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11-15, 16-20, >20) day(s); number of specimens; number of specimens signed out, average days; % of specimens signed out in <=1 day and totals for each of these columns, and sorts by primary pathologist.

Turnaround (Days)/Pri/Path

The Specimen Turnaround Time (Days) by Specimen Priority and Pathologist report is a modification of our standard specimen turnaround report that groups by specimen priority and then pathologist. Retrieval arguments are accession date range, specimen class, pathologist, specimen priority, part type, and client name.

Turnaround (Days)/Sign Out

The Specimen Turnaround Time (Days) by Sign Out Person report searches from an accession date to first sign-out date (ignoring amendments), sign out person, and specimen class (where the specimen class requires sign out, the report type equals final, and the report status does not equal N/A), and calculates a turnaround time from accession to sign out based on a Monday to Friday workweek.

The report prints the sign out person name; number of specimens signed out for (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11-15, 16-20, >20) day(s); number of specimens; number of specimens signed out, average days; % of specimens signed out in <=1 day and totals for each of these columns, and sorts by sign out person.

Turnaround Time % by Submitting MD

In the Turnaround Time % by Submitting MD report, results are grouped by submitting physician and include data for total cases, the average turnaround time, and the percentage of cases signed out within 1, 2, 3 days as well as those signed out more than 3 days ago. Overall totals are included in the summary. Retrieval arguments are accession date, specimen, class, submitting MD, client, and location. Unlike other turnaround time reports, this report does not use a stored procedure.

CLIA '88/Cytology Reports

The following standard CLIA '88 and Cytology-specific reports are provided with your CoPathPlus system:

- Abnormal Cytology Slides
- Abnormal Cytology Specimens
- Abnormal Gynecological Cases by Cytotech
- Abnormal Gynecological Cases by Pathologist
- Abnormal Gynecological Review by Interpretation(s)
- Abnormal Gynecological with Related Surgical Review
- Abnormals by Submit/Client
- Abnormals by Submit/ Interpretations Letter
- Adequacies/Interpretations by Part Type

- Adequacies/Interpretations by Part Type and Cytotech

- Adequacies/Interpretations by Part Type and Pathologist

- Adequacies/Interpretations by Part Type and Query List

- Adequacies/Interpretations by Specimen Class

- Adequacies/Interpretations by Specimen Class and Cytotech

- Adequacies/Interpretations by Specimen Class and Pathologist

- Adequacies/Interpretations by Specimen Class and Query List

- Adequacy Percentage by Client

- All Interpretation Count By Submitting MD

- All Slides Reviewed by Cytotech as Primary/Secondary Reviewer

- All Slides Reviewed by Pathologist

- All Slides Reviewed by One Pathologist Reviewer/QC Reviewer

- Amended Reports by Specimen Class

- Cytology Abnormals without Proximals

- Cytology Abnormals without Proximals Letter

- Cytology Abnormals without Proximals Letter by Specimen Number

- Cytology Abnormals without Proximals Letter with Interpretation

- Cytology Adequacy by Submitting

- Cytology Cases by Primary Cytotech/ Interpretation %

- Cytology Cases by Department/ Interpretation %

- Cytology Cases by Primary Pathologist/ Interpretation %

- Cytology Discrepant Case Review

- Cytology Discrepant Case Review Summary

- Cytology Discrepant QC Case Review

- Cytology Interpretation by Submitting

- Cytology Interpretation Specimen List

- Cytology Interpretation Review

- Cytology Primary Interpretations by Part/Specimen

- Cytology Primary Interpretations, Query List

- Cytology Slides by Part Type/Specimen

- Cytology Specimens by Part Type and Interpretation

- Cytology Specimen Count by Adequacy

- Cytotech/Pathologist Agreement (3 way) Rev

- Cytology/Surgical Correlation

- Cytology/Surgical Correlation (Abnormals Only)

- Cytology/Surgical Correlation, Ask Part Type

- Descriptive Diagnoses (DXs) By Cytotech

- Descriptive Diagnoses (DXs) By Primary Pathologist

- Descriptive Diagnoses (DXs)- Department

- Cytology Abnormal Report List

- Cytology Negative Report List

- Cytotech/MD Review Percentage with Detail

- Five Year Negative Gynecological Review

- Gynecological Statistics by Client

- Negative Paps Followup by Client Form Letter

- Non-Gynecological Cytology Review by Interpretation

- Number of Parts per Part Type

- Number of QA Slides

- Number of Unsatisfactory Specimens by Submitting Physician

- One vs. Two Slide Gynecological Cases

- (Primary) Interpretation Percentage by Client

- QC % of QC-Eligible Gynecological Cases

- QC % of QC-Eligible Gynecological Cases When High Risk Not Selected for QC

- QC % of QC-Eligible Gynecological Cases Including High Risk QC Statistics

- QC Review Information

- Specimens with Recommendation or Physician Notification

- Unsatisfactory By Specimen Detail

- Unsatisfactory Parts by Submitting Physician Summary

- Unsatisfactory by Submitting Physician by Specimen Summary

- Unsatisfactory Cytology Gynecological Follow-up

Abnormal Cytology Slides

The Abnormal Cytology Slides report searches accession date/time range, specimen classes, a primary pathologists, part types (e.g., urine or sputum), and stain/processes (e.g., silver) for all cytology specimens with abnormal primary reviews.

This report prints specimen number, specimen class, patient name, accession date/time, primary pathologist, part designator, part type description, stain/processes, and final diagnosis text. It sorts by specimen class and specimen number.

Abnormal Cytology Specimens

The Abnormal Cytology Specimens report searches an accession date/time range, specimen classes, and interpretations for all cytology specimens with abnormal primary reviews.

This report prints specimen number, accession date/time, specimen class, review date, reviewed by, if QC reviewer, if primary review, agreement y/n, review text (all review information **per** review) final diagnosis text, and a total count of all specimens found. It sorts by specimen number and primary interpretation. It also allows for post-run resorting by specimen number.

Abnormal Gyn Cases by Cytotech

The Abnormal Gynecological Cases by Cytotech report searches an accession date range and generates a count (and percentage) of abnormal cytology gynecological cases from the total number of gynecological cases.

This report sorts by primary cytotech. It also allows for post-run resorting by specimen number.

Abnormal Gyn Cases by Path

The Abnormal Gynecological Cases by Pathologist report searches an accession date range and generates a count (and percentage) of abnormal cytology gynecological cases from the total number of gynecological cases.

This report sorts by primary pathologist. It also allows for post-run resorting by specimen number.

Abnormal Gyn Review by Interp

The Abnormal Gynecological Review by Interpretation(s) report searches a sign-out date range or accession date range, specimen classes and interpretations for cases with an abnormal primary review. It prints specimen number, accession date, specimen class abbreviation, cytology review information, final diagnosis, and primary pathologist.

NOTE: You must select the appropriate gynecological specimen classes.

This report sorts by Primary Cytotech, agreement data for the primary review, and specimen number.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: All gynecologic smears interpreted as reactive, reparative, atypical pre-malignant or malignant must be confirmed by the technical supervisor in cytology.

Abnormal Gyn with Related Surg

The Abnormal Gynecological with Related Surgical Review report searches an accession date range (for target specimens), specimen classes, abnormal specimen classes, and related days (when related cases were accessioned in relationship to the target case). The target case must be abnormal.

This report prints the patient name, accession date, specimen number, final diagnosis text, primary pathologist, and primary cytotech (if applicable). It sorts first by patient name, then by target/abnormal specimen number, then by related/negative specimen numbers.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: Laboratories must compare pre-malignant and malignant gynecology reports with histopathology (Surgical) reports, if available in the lab.

Abnormals by Submit/Client

The Abnormals by Submit/Client report searches for "abnormal" cases from the interpretations chosen at run time by the user. The search criteria is: accession date, specimen class, client, submitting, and interpretation. The report is grouped by client name. The report prints submitting physician, accession date, surgical number, part source, and final diagnosis. This report page breaks for each client change

Abnormals by Submit/ Interpretations Letter

This report is a modification of the standard report Abnormals by Submit/Client. This report does not have client information. Retrieval arguments are accession date range, specimen class, submitting physician, and interpretation. Cases must be signed out to be included on the report. Detail information includes today's date, submitting physician's name and address, text stating that these are abnormal cases. Abnormal cases for this report are determined by the specific interpretations defined in the retrieval argument. This is not determined by a setting in the Interpretation Dictionary.

Cases are grouped by primary interpretation. The report lists patient name, DOB, accession number and the date the specimen was taken.

Adeq/Interp by Part Type

The Adequacies/Interpretations by Part Type report searches an accession date/time range, part types (e.g., sputum), adequacy names, and interpretation names for cytology specimens with a primary review entered.

This report prints part type, number of parts, number of adequacies, adequacy name, percent of adequacies per part type, number of interpretations, interpretation name, percent of interpretations per part type, and a total of all parts. It sorts by part type, adequacy name and interpretation name.

Adeq/Interp by Part Type/Cyto

The Adequacies/Interpretations by Part Type and Cytotech report searches an accession date/time range, cytotech, part types (e.g., sputum), adequacy name, and interpretation name for cytology specimens with a primary review entered.

This report prints primary cytotech name, part type, number of parts, number of adequacies, adequacy name, percent of adequacies per part type, number of interpretations, interpretation name, percent of interpretations per part type, and a total of all parts. It sorts by primary cytotech, part type, adequacy name, and interpretation name.

Adeq/Interp by Part Type/Path

The Adequacies/Interpretations by Part Type and Pathologist report searches an accession date/time range, pathologist, part types (e.g., sputum), adequacy name, and interpretation name for cytology specimens with a primary review entered.

This report prints primary pathologist name, part type, number of parts, number of adequacies, adequacy name, percent of adequacies per part type, number of interpretations, interpretation name, percent of interpretations per part type, and a total of all parts. It sorts by primary pathologist, part type, adequacy name, and interpretation name.

Adeq/Interp by Part Type/QL

The Adequacies/Interpretations by Part Type and Query List report searches an accession date/time range, adequacy or interpretation query list, part types (e.g., sputum), adequacy name, and interpretation name for cytology specimens with a primary review entered.

This report prints adequacy or interpretation query list name, part type, number of parts, number of adequacies, adequacy name, percent of adequacies per part type, number of interpretations, interpretation name, percent of interpretations per part type, and a total of all parts. It sorts by adequacy or interpretation query list, part type, adequacy name, and interpretation name.

Adeq/Interp by Specimen Class

The Adequacies/Interpretations by Specimen Class report provides a count of Cytology results by adequacy and interpretation and calculates what percentage of Cytology cases were assessed with each adequacy/interpretation. The report includes only statistics for the case's primary review. Selection criteria include accession date/time range, specimen classes, specimen adequacies, and interpretations.

This report prints the specimen class, total number of specimen results entered for that class, quantity of specimens diagnosed with each adequacy/interpretation, adequacy/interpretation name, percent of total specimens diagnosed with each adequacy/ interpretation, and total number of specimens included on the report.

The report sorts alphabetically by Cytology class.

Adeq/Interp by Spec Class/Cyto

The Adequacies/Interpretations by Specimen Class and Cytotech report provides statistical information for Cytology results entered by primary cytotechs only. For all primary reviews, the report provides a count of Cytology results by adequacy/interpretation and calculates what percentage of Cytology cases were assessed with each adequacy/interpretation.

Selection criteria include accession date/time range, specimen classes, specimen adequacies, interpretations, and cytotechs. This report prints the cytotech name, total number of Cytology specimen results entered by that cytotech, Cytology specimen class, total number of specimen results entered for that specimen class by that cytotech, quantity of specimens diagnosed with each adequacy/interpretation, adequacy/interpretation name, % of total specimens diagnosed with each adequacy/interpretation, total number of specimens included on the report.

The report sorts alphabetically by cytotech and then alphabetically by Cytology specimen class.

Adeq/Interp by Spec Class/Path

The Adequacies/Interpretations by Specimen Class and Pathologist report provides statistical information for Cytology results entered by primary pathologists only. For all primary reviews, the report provides a count of Cytology results by adequacy/interpretation and calculates what percentage of Cytology cases were assessed with each adequacy/interpretation.

Selection criteria include accession date/time range, specimen classes, specimen adequacies, interpretations, and pathologists. The standard report prints the following information: pathologist name, total number of Cytology specimen results entered by that pathologist, Cytology specimen class, total number of specimen results entered for that specimen class by that pathologist, quantity of specimens diagnosed with each adequacy/interpretation, adequacy/interpretation name, % of total specimens diagnosed with each adequacy/interpretation, total number of specimens included on the report.

The report sorts alphabetically by pathologist and then alphabetically by Cytology class.

Adeq/Interp by Spec Class/Qlis

The Adequacies/Interpretations by Specimen Class and Query List report provides statistical information for Cytology results entered by adequacy or interpretation query list only. For all primary reviews, the report provides a count of Cytology results by adequacy/interpretation and calculates what percentage of Cytology cases were assessed with each adequacy/interpretation.

Selection criteria include accession date/time range, specimen classes, specimen adequacies, interpretations, and adequacy or interpretation query list name. The standard report prints the following information: adequacy or interpretation query list name, total number of Cytology specimen results entered by that query list, Cytology specimen class, total number of specimen results entered for that specimen class by that query list, quantity of specimens diagnosed with each adequacy/interpretation, adequacy/interpretation name, % of total specimens diagnosed with each adequacy/interpretation, total number of specimens included on the report.

The report sorts alphabetically by Cytology class, then alphabetically by adequacy or interpretation query list name.

Adequacy % by Client

The Adequacy Percentage by Client report is a summary report provides summary information by adequacy percentage by client. The selection criteria includes accession date/time range and client names. The report is sorted by client and prints the adequacy, number of cases and percentage of the total.

This report page breaks for each new client.

All Interp Count by Submit

The All Interpretation Count By Submitting MD Report looks at all interpretations (key and secondary) from the cytotech review reviewed copied to the final (signed out cases only). The report groups by submitting MD, then interpretation, with a count of each interpretation and then percentage of # of interpretation/total interpretations. Retrieval arguments include accession date, specimen class, submitting MD and interpretation.

All Slides Rev. Cyto Prim/Sec

The CLIA '88 All Slides Reviewed by Cytotech as Primary/Secondary Reviewer report searches a date/time reviewed range and cytotechs for all cytology specimens reviewed by a cytotech.

This report prints and sorts by cytotech name, review date (giving a count of primary, secondary and total slides per cytotech reviewer per review date), and total slides per cytotech reviewer per review date. The Maximum Daily Slides print per cytotech, but only if different from the common daily maximums used: 80 or 100.

Regulation Addressed: This report satisfies the CLIA '88 final rule 493.1257 Standard; Cytology; Level II Tests: The laboratory is responsible for ensuring that each individual engaged in non-automated microscopic evaluation of cytology preparations examines no more than 100 slides (including non-gynecological preparations) in any 24-hour period.

All Slides Rev/Pathologist

The CLIA '88 All Slides Reviewed by Pathologist report searches a date/time reviewed range and pathologists for all cytology specimens reviewed by a pathologist.

This report prints and sorts by pathologist name, review date (giving a count of primary, secondary and total slides per pathologist reviewer per review date), and total slides per pathologist reviewer per review date. The Maximum Daily Slides print per reviewer, but only if different from the common daily maximums used: 80 or 100.

Regulation Addressed: This report satisfies the CLIA '88 final rule 493.1257 Standard; Cytology; Level II Tests: The laboratory is responsible for ensuring that each individual engaged in non-automated microscopic evaluation of cytology preparations examines no more than 100 slides (including non-gynecological preparations) in any 24-hour period.

All Slides Rev/1Path/QC

The CLIA '88 All Slides Reviewed by 1 Pathologist Reviewer/QC Reviewer report provides a count of slides for which a pathologist is the only reviewer on the case (shown in the **Primary** column) and/or the QC reviewer for the case (shown in the **Secondary** column). Note that "pathologist" in this context refers to a person who is defined (in the Person dictionary) with a person type of pathologist, fellow, or resident.

Regulation Addressed: This report satisfies the CLIA '88 final rule 493.1257 Standard; Cytology; Level II Tests: The laboratory is responsible for ensuring that each individual engaged in non-automated microscopic evaluation of cytology preparations examines no more than 100 slides (including non-gynecological preparations) in any 24-hour period.

Amended Reports by Spec. Class

The Amended Reports by Specimen Class report searches user-defined date/time range and a user-defined specimen class for final, procedure, or addendum reports that have been amended.

This report prints the specimen class, total number of reports amended for the specimen class, specimen number, patient name, number of times the report has been amended, report type (final or specific procedure or addendum report, accession date/time, last signed out date/time, specimen status, part type, part type description, amended date/time, who amended the report, reason for amendment, amendment comment if it is a major or minor amendment, previous diagnostic text, previous pathologist(s), original signout date/time, current diagnostic text, primary pathologist(s), cytotechs (if it is a cytology specimen class) and a total number of reports amended for all specimen classes.

This reports sorts by specimen class, specimen number, category descending, procedure/addendum name, and amend date/time descending.

Regulation Addressed: This report, if run on Cytology gynecological specimen classes, satisfies the CLIA '88 final rule 493.1257 Standard; Cytology; Level II Tests: The laboratory must establish and document an annual statistical evaluation of the number of gynecological cases in which any re-screen of a normal or negative specimen results in re-classification as malignant or pre-malignant.

mended Rep. Spec Class/graph

The CLIA '88 Amended Final/Procedure/Addendum Reports by Specimen Class with Graph Summary report is the same as the existing CLIA'88 Amended Final/Procedure Addendum Report by Specimen Class, except it includes a summary bar graph on the last page.

Cyto Abn. w/o Proximals

The Cytology Abnormals without Proximals report searches an accession date/time range, target specimen classes, and related specimen classes for all abnormal cytology gynecological specimens with no follow-up surgical specimens. Provides for the related days retrieval argument and interpretation retrieval argument for target specimens.

This report prints the patient name, specimen number, accession date/time, part designator, part type description, final diagnosis text, primary pathologist, and a total count of all specimens found. It also prints medical record number (MRN) according to the following logic: prints patient MRN for encounter client, then patient MRN for specimen client, else patient MRN for default client. This report sorts by patient name and accession date.

Regulation Addressed: This report, if run with a cytology target specimen class, satisfies the CLIA '88 final rule requirement of the number of gynecological cases for which histology (i.e., Surgical Pathology) was unavailable to compare with malignant or pre-malignant cytology.

Cyto Abn. w/o Proximals Ltr.

This report searches an accession date/time range, target specimen classes, and related specimen classes for all abnormal cytology gynecological specimens with no follow-up specimens. Provides for the related days retrieval argument and interpretation retrieval argument for target specimens.

This report prints the following elements in letter format: today's date, the submitting physician name, submitting physician address, submitting physician salutation, text of the letter, patient name, specimen number, accession date/time, and signature line with the site name. It also prints medical record number (MRN) according to the following logic: prints patient MRN for encounter client, then patient MRN for specimen client, else patient MRN for default client. It prints all specimens per submitting physician on one letter.

Cyto Abn w/o Prox Ltr by Spec

This is a modification of the standard report, Cytology Abnormals without Proximals Letter, except this report prints one page (letter) per Case and includes a request for follow-up information. Detail includes submitting name and address, patient name, patient DOB, specimen number, date taken, and final diagnosis.

Cyto Abn w/o Prox Ltr w Intrp

The Cytology Abnormals without Proximals Letter with Interpretation report is similar to the standard report. Cyto Abn w/o Proximals Ltr" except it also includes the patient DOB and the primary interpretation. Retrieval arguments are target date, target and related specimen class, interpretation name, and related days.

The "Before Related Days" retrieval argument allows users to find cases without proximals to the target cases or using a selected number of days (e.g. 7) prior to the target case. Note that there is no "From Related Days" retrieval argument since the report searches for the absence of a related case at any point after the target date.

Cytology Adequacy by Submit

The Cytology Adequacy by Submitting report searches by an accession date/time range, patient names, accession numbers, and adequacy(s). This report only retrieves signed out cases.

This report groups by submitting physician, with a page break after each group change.

Cyto Cases by Cytotech/Interp %

The Cytology Cases by Primary Cytotech/Interpretation % report provides the quantity and percentage of all interpretations assigned to cytology specimens, sorted by primary Cytotech. Selection criteria include accession date/time range, specimen classes, and interpretations.

This report prints cytotech name, total number of specimens reviewed by each cytotech, quantity of parts assigned to each interpretation, % of parts assigned to each interpretation, and the total number of parts and specimens included on the report.

The report sorts alphabetically by primary cytotech.

Cyto Cases by Dept/Interp %

The Cytology Cases by Department/Interpretation % report provides the quantity and percentage of all interpretations assigned to cytology specimens by your entire department. Selection criteria include accession date/time range, specimen classes, and interpretations.

This report prints the quantity of parts assigned to each interpretation, % of parts assigned to each interpretation, quantity of specimens assigned to each interpretation, and the total number of parts and specimens included on the report.

The report sorts alphabetically by interpretation.

Cyto Cases by Path/Interp %

The Cytology Cases by Primary Pathologist/Interpretation % report provides the quantity and percentage of all interpretations assigned to cytology specimens, sorted by primary Pathologist. Selection criteria include accession date/time range, specimen classes, and interpretations.

This report prints pathologist name, total number of specimens reviewed by each pathologist, quantity of parts assigned to each interpretation, % of parts assigned to each interpretation, total number of parts and specimens included on the report.

The report sorts alphabetically by primary pathologist.

Cyto Discrepant Case Review

The Cytology Discrepant Case Review report searches a sign-out date range or accession date range for all cytology specimens accessioned in the last month where the primary reviewer (often a pathologist) disagreed with the cytotech diagnosis.

This report prints the cytotech, primary pathologist, specimen number, accession date, patient name, specimen part, cytotech comment text and final diagnosis text. It sorts by cytotech and specimen number.

Regulation Addressed: The report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory must follow a program designed to detect errors in the cytological examinations and the reporting of results that includes: 1) a review of slides examined by each individual, and 2) a review of at least 10 percent of all gynecologic cases interpreted to be negative.

Cyto Discrepant Case Rvw Sum

The Cytology Discrepant Case Review Summary report is a summary version of the Cytology Discrepant Case Review report.

This report searches a sign-out date range for all cytology specimens accessioned in the last month where the primary reviewer (often a pathologist) disagreed with the cytotech diagnosis.

This summary report prints the cytotech, primary pathologist, specimen number, patient name and MRN, an indication of the primary review and the reviewer's initials, agreement level, whether the review was for QC, and adequacy and interpretation abbreviations. (The report omits the cytotech comment text and final diagnosis text.) It sorts by cytotech and specimen number.

Cyto Discrepant QC Case Review

The Cytology Discrepant QC Case Review report searches a signout date range for cytology specimens accessioned last month that were chosen for QC review where the primary reviewer (often a pathologist) disagreed with the cytotech diagnosis.

This report prints the cytotech, primary pathologist, specimen number, accession date, patient name, specimen part, cytotech comment text and final diagnosis text. It sorts by cytotech and specimen number.

Regulation Addressed: The report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory must follow a program designed to detect errors in the cytological examinations and the reporting of results that includes: 1) a review of slides examined by each individual, and 2) a review of at least 10 percent of all gynecologic cases interpreted to be negative.

Cyto Interp by Submitting

The Cytology Interpretation by Submitting report searches by accession date, patient name, specimen class, submitting physician, and primary cytology interpretation. The report prints the patient name, accession date, accession number, and primary cytology interpretation. This report retrieves signed out cases only.

The report page breaks after each group change.

Cyto Interp Specimen List

The Cytology Interpretation Specimen List looks at the cytology primary review (the one copied as the final dx). This summarizes ALL interpretations associated with the primary review. The report is grouped by interpretation and lists specimen number, patient name, MRN, and accession date. Retrieval arguments are: accession date, specimen class, interpretation (primary or secondary), person (reviewer), submitting physician, client, location and parttype.

Cyto Interpretation Review

The Cytology Interpretation Review report searches a user-specified accession date/time range, user-specified specimen class(es), user-specified cytotech(s) and user-specified interpretation(s) (primary or other) for all cytology specimens with a primary review entered.

This report prints the primary interpretation, specimen number, accession date/time, cytotechs, all review text, review date/time and reviewers, Final Diagnosis text, and primary pathologist, if present. It sorts by interpretation name and specimen number.

Cyto Prim. Interp by Part/Spec

The Cytology Primary Interpretations by Part/Specimen report searches accession date ranges and specimen classes to give a count of primary interpretations sorted by part type, for cytology specimens with a primary review entered.

Cytotech/Pathologist Agreement (3 way) Rev

This reports looks for cytology cases seen by both a cytotech and pathologist. This report is for sites using 3-way agreement. Retrieval arguments are sign out date, cytotech and specimen class. The report is grouped by cytotech and then pathologist agreement (Agree, Partially Disagree, Completely Disagree). Detail information includes specimen number, patient name, cytotech diagnosis abbreviation, pathologist diagnosis abbreviation, and pathologist initials. Counts are included at each group level and the summary.

Cyto/Path Agreement (5way) Rev

This reports looks for cytology cases seen by both a cytotech and pathologist. This report is for sites using 5-way agreement. Retrieval arguments are sign out date, cytotech and specimen class. The report is grouped by cytotech and then pathologist agreement (Agree, 1+ Disagreement, 2+ Disagreement, 1- Disagreement, 2- Disagreement). Detail information includes specimen number, patient name, cytotech diagnosis abbreviation, pathologist diagnosis abbreviation, and pathologist initials. Counts are included at each group level and the summary.

Cyto Prim. Interp (Query List)

The Cytology Primary Interpretations, Query List report is identical to the Cytology Primary Interpretations by Part/Specimen report (refer to "Cytology Primary Interpretations by Part/Specimen") except that it prints/sorts by the interpretation query list name instead of the individual interpretation.

Cyto Slides by Part Type/Spec.

The Cytology Slides by Part Type/Specimen report provides a count of the number of specimens and slides by part type. Selection criteria include accession date/time range and specimen classes.

This report prints the part type, number of specimens that include that part type, number of slides for that part type, and the total number of specimens and slides included on the report.

The report sorts alphabetically by part type. It also allows for post-run resorting by specimen number.

Cyto Spec. by Part Type/Interp

The Cytology Specimens by Part Type and Interpretation report searches an accession date/time range, specimen classes, part types (e.g., breast FNA) and interpretations (e.g., Susp/Pos) for cytology specimens with a primary review entered.

This report prints patient name, specimen number, part type description, and final diagnosis text, and sorts by patient name and specimen number.

Cyto Spec. Count by Adequacy

The Cytology Specimen Count by Adequacy report searches an accession date/time range and specimen adequacies (e.g., LTO) for cytology specimens with a primary review entered.

This report prints the submitting physician, the count of specimens per adequacy, the total for each submitting physician, and a total for all submitting physicians. It sorts by submitting physician and adequacy name.

Cyto/Surg Correlation

The Cytology/Surgical Correlation report searches a user-specified accession date/time range, user-specified target specimen class(es), user-specified related specimen class(es), and user-specified related from/to days (days where the related specimen is accessioned in reference to the target specimen).

This report prints patient name, specimen number, accession date/time, date of birth, medical record number, a target or related specimen designation for each specimen included on the report. It sorts by patient name, specimen accession date, Department, and specimen number.

Note: The medical record number on this report will only display if the patient has a medical record number for a client that is linked to any of the specimens.

Cyto/Surg Correlation-abn

The Cytology/Surgical Correlation report searches a user-specified accession date/time range, user-specified target specimen class(es), user-specified related specimen class(es), and user-specified related from/to days (days where the related specimen is accessioned in reference to the target specimen). This report prints patient name, specimen number, date of birth, medical record number, a target or related specimen designation for each specimen included on the report and final diagnosis text. It sorts by patient name, specimen accession date, department, and specimen number.

Note: The medical record number on this report will only display if the patient has a medical record number for a client that is linked to any of the specimens included on the report.

Cyto/Surg Correlation-part

The Cyto/Surg Correlation, Ask Part Type report is similar to the existing Cytology/Surg Correlation report except that it allows you to select the target part types and related part types using two new retrieval arguments. This report will return specimens if one or more part types selected is associated with the specimen.

Cytotech/MD Review % w detail

The Cytotech/MD Review Percentage with Detail report searches cytotech name and cyto review date. This report counts all cases reviewed by a cytotech, and counts those cases also reviewed by a pathologist. This report does not use the MD review column. This report is a UNION report, with one query looking for all cases reviewed by that cytotech (T - total reviewed), and the other SQL looking for those cases also reviewed by a pathologist (C - combination of cytotech and pathologist).

This report is grouped by cytotech, with total counts of cases also reviewed by a pathologist, total reviewed by that cytotech, and percentage of cases with MD review.

Cytology Abnormal Report List

This report is useful for sites using only a few different primary interpretations with more detailed interpretation in the "other" interpretation field. For a case to appear on this report, it must have a primary interpretation and at least one "other" interpretation. Retrieval arguments are accession date, specimen class, submitting physician, client, query list name, and interpretation. A query list must be created for the primary interpretation(s). A new page will print for each client/submitting physician. This report is grouped by submitting physician, query list name (primary interpretation), and then "other" interpretations. The report is limited to the first other interpretation only. For a case to appear, it must have a submitting physician and be signed out. Detail includes accession number, date taken, patient name, DOB, address, and phone number

Some system managers may wish to further customize this report to include more description displays. Since the query list name has limited characters, display of the query name itself may be limiting. An option is to delete the query list name in design view and replace with an expression such as:

if(c_query_list_values_list_name = 'Epithelial Abn', 'EPITHELIAL CELL ABNORMALITY', c_query_list_values_list_name)

Cytology Negative Report List

This report is for reporting negative cytology interpretations. Retrieval arguments are accession date, specimen class, client, submitting, and interpretation. A new page will print for each client/submitting. Detail groups first by submitting physician name, next interpretation name, with detail including accession number, patient name, patient DOB, date taken, patient address and phone.

Descriptive DXs By Cytotech

The Descriptive Diagnoses (DXs) By Cytotech report is similar to the standard Cytology Cases by Primary Cytotech/Interpretation % report that looks at the primary interpretations from all reviews. Descriptive Diagnoses (DXs) By Cytotech report returns the descriptive diagnoses (other interpretations) based on a query list of primary interpretations. The selection criteria are: accession date (but case must be signed out), specimen class, interpretation ("other" interpretation), and interpretation (primary interpretation) query list. This report groups by cytotech and lists the descriptive diagnoses for a particular group of primary interpretations.

Descriptive Diagnoses (DXs) By Primary Pathologist

The Descriptive Diagnoses (DXs) By Primary Pathologist report is similar to the standard Cytology Cases by Primary Pathologist/ Interpretation % that looks at the primary interpretations from all reviews. The Descriptive Diagnoses (DXs) By Primary Pathologist report returns the descriptive diagnoses (other interpretations) based on a query list of primary interpretations. The selection criteria are accession date (but case must be signed out), specimen class, interpretation ("other" interpretation), and interpretation (primary interpretation) query list.

This report groups by pathologist and lists the descriptive diagnoses for a particular group of primary interpretations.

Descriptive DXs - Depart.

The Descriptive Diagnoses (DXs)- Department report is similar to the standard Cytology Cases by Department/ Interpretation % report that looks at the primary interpretations from all reviews. The Descriptive Diagnoses (DXs)- Department report returns the descriptive diagnoses (other interpretations) based on a query list of primary interpretations. The selection criteria is accession date (but case must be signed out), specimen class, interpretation ("other" interpretation), and interpretation (primary interpretation) query list.

This report groups by descriptive diagnosis for a particular group of primary interpretations.

Five Year Neg. Gyn Review

The Five Year Negative Gynecological Review report searches (abnormal) target specimen classes, and interpretation for target specimens. The target specimen is a first-time abnormal gynecological case.

This report prints the patient name, abnormal specimen number, accession date, final diagnosis text, primary pathologist, and primary cytotech for each abnormal case. The report then lists <u>all</u> previous gynecological specimens for that patient, with each case including the same data as for the abnormal specimen. The report prints only those specimens with a specimen class that has the Cytology Gynecological check box selected on the Properties tab in the Specimen Class dictionary.

It sorts first by patient name, then by target/abnormal specimen number, then by related gynecological specimen numbers.

Regulation Addressed: This report satisfies CLIA '88 final rule 493.1257 Standard; Cytology; Level II Tests: For each patient with a current high grade or above intraepithelial lesion (moderate dysplasia or CIN-2 or above), the laboratory must review all normal or negative gynecologic specimens received within the previous five years.

Gyn Statistics by Client

The Gynecological Statistics By Client report is a summary report based on Interpretation Query Lists. Four specific query lists need to be created by the System Manager in order to use this report. The interpretations chosen for each query list should be interpretations available for the Key (aka Primary) cytology interpretation.

To create the required Query Lists:

1) Access the Query List Dictionary and select the List Type of Interpretation.

2) Press the New button and enter "g-abnormal" for the first Query List name. Select the interpretation values that are considered abnormal at your site. When completed, Save and close the query list.

3) Add a second Interpretation Query List using the specific name of "g-negative". Select the interpretation values that are considered negative at your site. When completed, Save and close the query list.

4) Add a third Interpretation Query List using the specific name of "g-unsat". Select the interpretation values that are considered unsatisfactory at your site. When completed, Save and close the query list.

5) Add a fourth Interpretation Query List using the specific name of "g-other". Select the interpretation values that are not included in the other three query lists. When completed, Save and close the query list.

This report looks at Primary interpretations only. The selection criteria are accession date, specimen class, and client. Only signed out cases are included on this report. The report is grouped by client name, then by submitting physician. "Totals" will display for each client and submitting. The total number of specimens (cases) appears in the client name trailer.

Negative Paps Followup by Client Form Letter

The Negative Paps Followup by Client form letter finds all negative pap smears for a client in a given accession date range and lists them on the letter. It includes the hospital name and phone number and sorts and page breaks by client.

Non-Gyn Review by Interp

The CLIA '88 Non-Gyn Cytology Review by Interpretation(s) report searches a sign out date range, specimen classes, and interpretations. It prints specimen number, accession date, specimen class abbreviation, cytology review information, final diagnosis, and primary pathologist; and it sorts by primary cytotech, agreement data for the primary review, and specimen number.

NOTE: You must select the appropriate non-gynecological specimen classes.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: All non-gynecologic cytologic preparations must be reviewed by the technical supervisor in cytology.

Number of Parts per Part Type

The Number of Parts per Part Type report searches an accession date/time range, a specimen class, and a part type, and counts the number of parts accessioned between the given date/time range for each part type.

This report prints the specimen class, part type, a count for each part type, and a total count of all part types per specimen class and for all specimen classes. It sorts by specimen class and part type name.

Regulation Addressed: This report, if run on Cytology specimen classes, satisfies CLIA '88 final rule requirement 493.1257: Cytology: Level II Tests: The laboratory must examine and document an annual statistical evaluation of the number of cytology cases examined and the number of specimens processed by specimen type.

Number of QA Slides

The Number of QA Slides report searches a QA review date range for selected QA reviews (five-year negative reviews, surgical vs. cytology, etc.). It finds the related cases' total slides on those reviews (stain/processes where slide labels equals **yes**), and provides a count of QA slides reviewed per QA reviewer and QA date reviewed.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory is responsible for ensuring that each individual engaged in non-automated microscopic evaluation of cytology preparations examines no more than 120 slides (including non-gynecological preparations) in any 24-hour period.

Number of Unsat. By Submitting

The Number of Unsatisfactory Specimens by Submitting Physician report searches a sign-out date/time range and counts the number of signed out cytology specimens received by the lab that are unsatisfactory for evaluation.

This report prints the submitting physician's name, the number of unsatisfactory specimens per submitting physician, specimen number, patient name, accession date/time, part designator, part description, adequacy name, and a total count of all specimens found. It sorts by specimen number, submitting physician, and part designator.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory must establish and document an annual statistical evaluation of the number of cases examined, including the number of unsatisfactory specimens submitted by physician.

One vs. Two Slide Gynecological Cases

The One vs. Two Slide Gynecological Cases report counts the number of gynecological cases having one slide received and those having two slides received based on accession date ranges, specimen classes, and part types.

Regulation Addressed: This report satisfies New York State Cytopathology regulations.

Prim Interp % by Client

The Interpretation Percentage by Client report is a summary report that groups by client. The selection criteria are accession date and client name. The report prints the Primary Interpretation Name, number of cases, and percentage of total for that client.

This report page breaks for each new client.

QC % of QC-Eligible Gyn. Cases

The QC % of QC-Eligible Gynecological Cases report shows the number and percentage of QC-eligible Cytology Gynecological cases that were selected for QC review. A case is considered QC-eligible if the interpretations(s), if any, entered for the case during the Cytology Results activity are defined to allow selection for QC review (as evidenced by a selected Allow Section for QC check box on the Name tab in the Interpretation Dictionary.)In addition, if your CoPathPlus system is set up to automatically select cases for QC review, your site determines whether or not high-risk cases are considered QC-eligible.

Selection criteria include review date/time range and specimen class.

For each reviewer, the report prints the cytotech/first reviewer name, review date, number of QC-eligible specimens, number of QC-eligible specimens selected for QC review, and percentage of QC-eligible specimens selected for QC review. The report also prints totals for each reviewer and combined totals for all reviewers.

The report sorts alphabetically by reviewer and then in ascending order by review date.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory must follow a program designed to detect errors in the cytological examinations and the reporting of results that includes: 1) a review of slides examined by each individual, and 2) a review of at least 10 percent of all gynecological cases interpreted to be negative.

QC % of QC-Eligible Gyn. Cases / High Risk

The QC % of QC-Eligible Gynecological Cases When High Risk Not Selected for QC report is similar to the QC % of QC-Eligible Gynecological Cases report, except that this report:

- Excludes high-risk cases from QC-eligible statistics (regardless of whether high risk cases are QC-eligible for your site). Typically, you would use this report only if your site does not automatically select high-risk cases for QC review.

- Provides a separate count of high risk cases

- Calculates two QC percentages: 1) the number of cases selected for QC review, excluding high risk cases, and 2) the overall percentage of cases selected for QC review, including high risk cases

Selection criteria include review date/time and specimen class.

For each reviewer, the report prints the cytotech/first reviewer name, review date, number of QC-eligible specimens (excluding high risk QC-eligible specimens), number of QC-eligible cases selected for QC review (excluding high risk QC-eligible specimens), percentage of QC-eligible cases selected for QC review (excluding high risk QC-eligible specimens), number of high risk cases, and percentage of both QC-eligible and high risk cases selected for QC review. The report also prints totals for each reviewer and combined totals for all reviewers.

The report sorts alphabetically by reviewer and then in ascending order by review date.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory must follow a program designed to detect errors in the cytological examinations and the reporting of results that includes: 1) a review of slides examined by each individual, and 2) a review of at least 10 percent of all gynecological cases interpreted to be negative.

QC% of QC-Eligible/HR/All

The QC % of QC-Eligible Gynecological Cases Including High Risk QC Statistics report provides the same information as the QC % of QC-Eligible Gynecological Cases report, except that this report separates the statistics into non-high risk and high-risk categories. You use this report to compare non-high risk and high-risk cases chosen, if your site automatically selects high-risk cases for QC review.

Selection criteria include review date/time range and specimen class.

For each reviewer, the report prints the cytotech/first reviewer name, review date, number of QC-eligible specimens, number of non-high risk QC-eligible cases, number of non-high risk QC-eligible cases selected for QC review, percentage of non-high risk QC-eligible cases selected for QC review, number of high risk QC-eligible cases, number of high risk QC-eligible cases selected for QC review, percentage of high risk QC-eligible cases selected for QC review, and percentage of both non-high risk and high risk QC-eligible cases selected for QC review. The report also prints totals for each reviewer and combined totals for all reviewers.

The report sorts alphabetically by reviewer and then in ascending order by review date.

Regulation Addressed: This report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory must follow a program designed to detect errors in the cytological examinations and the reporting of results that includes: 1) a review of slides examined by each individual, and 2) a review of at least 10 percent of all gynecological cases interpreted to be negative.

QC Review Information

The QC Review Information report searches an accession date/time range for specimens scheduled for QC review.

This report prints the primary cytotech, primary pathologist, specimen number, patient name, primary pathologist, part type, part description, final diagnosis text, all review text, review date/time, reviewer, primary review flag, and agreement level.

This report sorts by primary cytotech and specimen number.

Regulation Addressed: The report satisfies CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: The laboratory must follow a program designed to detect errors in the cytological examinations and the reporting of results that includes: 1) a review of slides examined by each individual, and 2) a review of at least 10 percent of all gynecologic cases interpreted to be negative.

Spec. w/Recom. Or Phys. Notif

The Specimens with Recommendation or Physician Notification report searches a signout date range and specimen classes where a recommendation or physician notification has been entered.

This report prints cytotech, specimen number, accession date, patient name, final diagnosis text, recommendation, physician notification, and primary pathologist. It sorts by specimen number.

Regulation Addressed: The report satisfies the CLIA '88 final rule requirement 493.1257 Standard; Cytology: Level II Tests: Laboratory reports must include several new information items, including physician notification if specimens are unsatisfactory for examination and appropriate provisions for follow-up recommendations.

Unsat. By Specimen Detail

The Unsatisfactory By Specimen Detail report displays specimen information when the primary review has at least one unsatisfactory adequacy associated with it. This report sorts/prints by specimen number and prints the accession date, submitting physician, part descriptions and adequacies. A total number of specimens appear on the last page. Retrieval arguments are sign out date range, specimen class and submitting physician.

Unsat. By Submit Parts Sum

The Unsatisfactory Parts by Submitting Physician report sort/prints by submitting physician and lists the total number of unsatisfactory parts with a percentage of that physician's total number of parts. A summary total of parts and percentage unsatisfactory appears on the last page. Retrieval arguments are sign out date range, specimen class and submitting physician.

Unsat. By Submit Spec Sum

This report is the same as the Unsatisfactory Parts by Submitting Physician report except it prints the number of specimens with related percentages instead of parts. This report sort/prints by submitting physician and lists the total number of unsatisfactory specimens with a percentage of that physician's total number of specimens. A summary total of specimens and percentage

unsatisfactory appears on the last page. Retrieval arguments are sign out date range, specimen class and submitting physician.

Unsat. Cyto Gyn Followup

The Unsatisfactory Cytology Gynecological Follow-up report searches an accession date/time range and target specimen classes for unsatisfactory cytology gynecological specimens for patients who have no other specimens accessioned after the accession date/time on the unsatisfactory specimen.

This report prints submitting physician, specimen number, patient name, accession date/time, and a total count of all specimens found. It sorts by submitting physician and specimen number.

Download Reports

The following standard Download reports are provided with your CoPathPlus system:

- Billing Fee Code Dictionary Download
- Nat Language Download
- Person Dictionary Download
- Professional Billing Codes Download
- Tumor Registry Download
- Tumor Registry Download - Nat Lang

Billing Fee Code Dictionary Download

This report is a downloadable version of the Billing Fee Code Dictionary and includes columns: fee code abbreviation, fee code name, fee code description, active flag, professional code, professional charge, technical code, technical charge, billing type.

Retrieval arguments are Active/Inactive, Fee code, Billing Type.

This report is designed to be run by using the "Save Raw Data" feature or to be scheduled. Refer to "Save Raw Data " in this section or "Schedule Manager " in the Tasks section for more information.

Nat Language Download

The Natural Language Download report is a downloadable version of the Natural Language Search report. Retrieval arguments are accession date, specimen class, text search, and text type.

Columns downloaded:

- Patient last name
- Patient first name
- Patient date of birth

- Medical Records Number

- Specimen Number

- Accession date

- Submitting physician

- Text data

- Text type

This report is designed to be run by using the "Save Raw Data" feature or to be scheduled. Refer to "Save Raw Data" in this section or "Schedule Manager " in the Tasks section for more information.

Person Dictionary Download

The Person Dictionary Download is a downloadable version of the Person Dictionary. Retrieval arguments are Active/Inactive, Person Type and Person.

This report is designed to be run by using the "Save Raw Data" feature or to be scheduled. Refer to "Save Raw Data" in this section or "Schedule Manager" in the Tasks section for more information.

Prof Billing Codes - Download

The Professional Billing Codes Download report is a download report for professional billing. Retrieval arguments include specimen class, accession date range, professional billing code, and pathologist. Download columns include medical record number, patient last name, patient first name, location, encounter number, specimen number, professional billing code, units, credit fee code instance, and accession date. All cases appear, regardless of specimen status (i.e., specimen does not have to be signed out).

This report is designed to be run by using the "Save Raw Data" feature or to be scheduled. Refer to "Save Raw Data" in this section or "Schedule Manager" in the Tasks section for more information.

Tumor Registry Download

The Tumor Registry Download report is written to be a download report.   The report is not formatted for printing. Retrieval arguments are accession date, specimen class and SNOMED code. With download reports, the following columns from the Select statement are presented:

- r_pat_demograph.lastname as "pt_lastname"

- r_pat_demograph.firstname as "pt_firstname"

- r_pat_demograph.date_of_birth as "pt_dob"

- r_pat_demograph.govt_num as "pt_ss_num"

- c_specimen.specnum_formatted as "spec_number"

- submitting.lastname as "phy_lastname"

- submitting.firstname as "phy_firstname"

- c_d_person_a.street as "phy_street"

- c_d_person_a.city as "phy_city"

- c_d_person_a.state_ID as "phy_state"

- c_d_person_a.zip as "phy_zip"

- p_part.datetime_taken as "date_collected"

- clinhx.text_data as "clinhx"

- gross.text_data as "gross"

- micro.text_data as "micro"

- final.text_data as "final"

- dxcom.text_data as "dxcom"

- adddx.text_data as "addendum"

This report is designed to be run by using the "Save Raw Data" feature or to be scheduled. Refer to "Save Raw Data" in this section or "Schedule Manager" in the Tasks section for more information.

Tumor Registry Download - Nat Lang

The Tumor Registry Download by Natural Language report is designed to be downloaded via the Save Raw Data option. Retrieval arguments are accession date, specimen class and Text search (Natural Language). With download reports, the columns from the SELECT are downloaded (see below). Prior to using this report, you MUST CUSTOMIZE it to specifically include site-appropriate information in the first 4 columns.

- "Your laboratory or hospital name"

- "Your address (Street, City, State, and Zip)"

- "Your site phone number"

- "Your CLIA Number"

- Patient last name

- Patient first name

- Patient date of birth

- Social Security Number

- Specimen Number

- Physician last name

- Physician first name

- Physician street address

- Physician city

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- Physician state

- Physician zip code

- Date collected

- Clinical History

- Gross description

- Microscopic description

- Final diagnosis

- Diagnosis comment

- Addendum

Note: Since the report includes several text fields, it will be very long. Please note that Excel will truncate data fields downloaded from an InfoMaker Report at about 256 characters. It is recommended you save this file to a Tab-Delimited format. You should then be able to import the tab delimited file into Excel if desired.

This report is designed to be run by using the "Save Raw Data" feature or to be scheduled. Refer to "Save Raw Data " in this section or "Schedule Manager " in the Tasks section for more information.

Labels

The following standard labels are provided with your CoPathPlus system.

- Cytology Labels by Order Date

- Cytology Engrave Labels by Date

- Cytology Labels by Specimen Number

- Cytology Engrave Labels by Specimen Number

- Histology Labels by Specimen Number

- Histology Engrave Labels by Specimen Number

- Histology Labels by Specimen Number/Part/Block

- Histology Engrave Labels by Specimen Number/Part/Block

- Histology Labels by Status

- Histology Engrave Labels by Status

Cytology Labels by Order Date

The Cytology Labels by Order Date report searches an order date/time range, specimen classes, and stain/process department(s) for stain/processes that indicated **Y** to generate labels in the Stain/Process dictionary.

Cytology labels print a label for each stain/process and a label for each additional label identified per part with the following information: specimen number, part designator, part label designator,

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

stain/process label text (does not print on additional labels), patient name (patient name function is not used), and a blank line for a pre-printed site name.

Standard label stock is 6 across, 15/16" x 15/16" each (with 1/16" in between). Cytology labels sorts by specimen number and part sequence. Additional labels without stain/process text print at the end of each specimen number.

Cytology Labels by Specimen

The Cytology Labels by Specimen Number report is the same as the Cytology Labels by Order Date report, except the search performed is on a specimen number.

Cyto Engrave Labels by Date

The Cytology Engrave Labels by Date report is similar to the Cytology Labels by Order Date. However, this report is used to generate engraved slide label requests for a slide engraver. The format of this report simply gives you a list of what will be sent to the engraver: specimen number, part/block, stain/process, and label type.

To send the data to the engraver, select **Data** from the menu bar and then select **Engrave Labels** from its drop down menu.

The Engrave Labels option is only enabled if the system setting "Enable Slide Engravers" is set to Yes and there is at least one active slide engraver defined in the Engraver dictionary.

Label requests representing each stain on the report will be sent to the slide engraver. The Engraver Label Format associated with the Engraver Label Type associated with each stain determines the actual format of what is engraved on the slide.

Cyto Engrave Labels by Specimen

The Cytology Engrave Labels by Date report is similar to the Cytology Labels by Specimen Number. However, this report is used to generate engraved slide label requests for a slide engraver. The format of this report simply gives you a list of what will be sent to the engraver: specimen number, part/block, stain/process, and label type.

To send the data to the engraver, select **Data** from the menu bar and then select **Engrave Labels** from its drop down menu.

The Engrave Labels option is only enabled if the system setting "Enable Slide Engravers" is set to Yes and there is at least one active slide engraver defined in the Engraver dictionary.

Label requests representing each stain on the report will be sent to the slide engraver. The Engraver Label Format associated with the Engraver Label Type associated with each stain determines the actual format of what is engraved on the slide.

Histology Labels by Specimen

The Histology Labels by Specimen Number report searches by specimen number for histology stain/processes (that indicated **Y** to generate labels in the Stain/Process dictionary), specimen classes, block logs, stain/process logs, and stain/process department(s).

This report prints a label for each stain/process and a label for each additional label identified per part with the following information: specimen number, part designator, space, block designator ({No Block} if no block designator exists), stain/process label text (does not print on additional labels), ordering MD initials, patient name (patient name function is not used), and a blank line for a pre-printed site name.

Standard label stock is 6 across, 15/16" x 15/16" each (with 1/16" in between). Histology labels sort by specimen number and part designator. Additional labels with no stain/process text print at the end of each specimen number.

Histology Labels by Status

The Histology Labels by Status report searches an order date/time range for stain/processes (that indicated **Y** to generate labels in the Stain/Process dictionary), stain/process statuses, stain/process categories, and stain/process departments.

This report prints a label for each stain/process and a label for each additional label identified per part with the following information: specimen number, part designator, space, block designator ({No Block} if no block designator exists), stain/process label text (does not print on additional labels), ordering MD initials, patient name (patient name function is not used), and a blank line for a pre-printed site name.

Standard label stock is 6 across, 15/16" x 15/16" each (with 1/16" in between). Stain/process labels sort by specimen number and part designator. Additional labels with no stain/process text print at the end of each specimen number.

Histo Labels by Spec#/Part/Blk

The Histology Labels by Specimen Number/Part/Block report is similar to the Histology Labels by Specimen Number report, except this report includes additional retrieval arguments (Part Designator, Block Designator and Stain/Process) that let you identify a specific part and block so that a subset of labels on the specimen can be printed.

NOTE: This report cannot be used for specimens that do not have blocks (i.e., those with specimen-level stains). Use the Histology Labels by Specimen Number report instead.

Histo Engrave Labels by Spec

The Histology Engrave Labels by Specimen Number report is similar to the Histology Labels by Specimen Number. However, this report is used to generate engraved slide label requests for a slide engraver. The format of this report simply gives you a list of what will be sent to the engraver: specimen number, part/block, stain/process, and label type.

To send the data to the engraver, select **Data** from the menu bar and then select **Engrave Labels** from its drop down menu.

The Engrave Labels option is only enabled if the system setting "Enable Slide Engravers" is set to Yes and there is at least one active slide engraver defined in the Engraver dictionary.

Label requests representing each stain on the report will be sent to the slide engraver. The Engraver Label Format associated with the Engraver Label Type associated with each stain determines the actual format of what is engraved on the slide.

Histology Engrave Labels by Status

The Histology Engrave Labels by Status report is similar to the Histology Labels by Status. However, this report is used to generate engraved slide label requests for a slide engraver. The format of this report simply gives you a list of what will be sent to the engraver: specimen number, part/block, stain/process, and label type.

To send the data to the engraver, select **Data** from the menu bar and then select **Engrave Labels** from its drop down menu.

The Engrave Labels option is only enabled if the system setting "Enable Slide Engravers" is set to Yes and there is at least one active slide engraver defined in the Engraver dictionary.

Label requests representing each stain on the report will be sent to the slide engraver. The Engraver Label Format associated with the Engraver Label Type associated with each stain determines the actual format of what is engraved on the slide.

Histo Engrv Lbls by Spec#/P/B

The Histology Engrave Labels by Specimen Number/Part/Block report is similar to the Histology Labels by Specimen Number/Part/Block. However, this report is used to generate engraved slide label requests for a slide engraver. The format of this report simply gives you a list of what will be sent to the engraver: specimen number, part/block, stain/process, and label type.

To send the data to the engraver, select **Data** from the menu bar and then select **Engrave Labels** from its drop down menu.

The Engrave Labels option is only enabled if the system setting "Enable Slide Engravers" is set to Yes and there is at least one active slide engraver defined in the Engraver dictionary.

Label requests representing each stain on the report will be sent to the slide engraver. The Engraver Label Format associated with the Engraver Label Type associated with each stain determines the actual format of what is engraved on the slide.

NOTE: This report cannot be used for specimens that do not have blocks (i.e., those with specimen-level stains). Use the Histology Engrave Labels by Specimen Number report instead.

Logs

CoPathPlus provides the following standard management logs.

- Accession Log

- Accession Log ll

- Accession Log with Histology Summary

- Block/Stain Recut Log

- Cases with no Previous Specimens

- Client Dictionary Lookup

- Client Requisition with Barcode

- Tables from CoPathPlus

- Cytology Stain/Process Log

- Cytotech Daily Log

- Embedding Log

- Fax Log

- Histology Stain/Process Log

- Person Dictionary Lookup

- Proc Worklist by Proc

- Procedures Ordered by Reflex

- Report Chute Batch Errors

- Report Template

- Reports Awaiting Signout by Cytotech

- Reports Awaiting Signout by Pathologist

- Reports on Worklists by Pathologist/Cytotech

- Slides Sent Out

- Slides Sent Out/Not Returned

- Slide Sent Out/Not Returned Letter

- Specimen Status by Pathologist

- Tissue Discard Log

- Tissue Processing Batch Log

- Who Accessioned

- Who Accessioned Summary

Accession Log

The Accession Log searches an accession date/time range, and specimen class. It prints the specimen number, patient name, accession date/time, specimen class abbreviation, priority, client, medical record number, part designator, part type description, date/time taken, date/time received, and a total count of all specimens found.

This log sorts by specimen number.

Accession Log II

The Accession Log searches an accession date/time range, and specimen class. This report is identical to the Accession Log but it also includes Additional retrieval arguments have been added for submitting physician, client, location, and parttype.

Submitting physician, client and location are not required for the case to be returned when using all values at run time.

 This log sorts by specimen number.

Accession Log with Histo Sum

The Accession Log with Histology Summary searches an accession date/time range and specimen class. It prints the specimen number, patient name, submitting physician, part designator, and part type description. If blocks and slides exist, the total number of blocks and slides PER PART will appear next to each part. This log sorts by accession date.

Block/Stain Recut Log

The Block/Stain Recut Log is the same as the Tissue Processing Batch Log except that the former filters out all blocks or stains that do not have a request class of "recut".

The Block/Stain Recut Log searches by processing batch number and block status. It prints specimen number, block category, block and status, stain by numbered ordered, request class abbreviation, ordering MD and date/time, stain/process and status, specimen priority, block designator, prosector, part designator, part description, all pieces used, additional labels, number of pieces stain comment, and stain/process comment. It sorts by batch number, specimen number, part designator, block designator, and stain ID.

Cases with no Prev Specimens

The Cases with no Previous Specimens report searches for specimens by accession date and specimen class. It displays detail information by patient last name including patient DOB, MRN, and parts for the case. It could be used by sites that use a patient history card file or don't print working drafts and want to search the file only if the current case does not have any previous specimens in CoPathPlus

Client Dictionary Lookup

This report is a modification of the standard Client Dictionary that can be used as an online client lookup. Retrieval arguments are client name and status (active/inactive). The report sorts by client name. It includes client group, address, status, phone, fax, email, and notes.

Client Req. with Barcode

This untitled report is used for preprinted specimen requisitions that are distributed to clients submitting specimens. Client information such as client code, name, address, phone, and bar code are included. The retrieval argument is client name. The two nested reports will pull the first 10 physicians that are associated with the client.

CoPath Tables Listing

The Tables from CoPathPlus Listing displays database tables and columns from the current version of CoPathPlus. Tables are listed alphabetically along with column information - column name, edit/entry date, and indication of primary key(s). This report has no retrieval arguments and will retrieve all tables in the database.

Cytology Stain/Process Log

The Cytology Stain/Process Log searches a date/time ordered of blocks and stain/processes, specimen classes, block categories, stain/process categories, and Block/Stain/Process departments.

This log prints specimen number, block category, specimen priority, source, additional labels, number of pieces, block comment, stain/process label text, number ordered/slide count, request class abbreviation, ordering MD initials, and stain/process comment. It sorts by specimen number, source, and stain label text.

Cytotech Daily Log

The Cytotech Daily Log provides detailed information about the Cytology specimens reviewed by each cytotech. Selection criteria include review date/time range, cytotechs, and specimen classes.

This report prints a new page for each cytotech, with the cytotech name, patient name, review date, patient medical record number, slide label text, specimen number (and an asterisk [*] if there is more than one part type), total slides, reviewer ID, a "P" if the reviewing Pathologist agrees with the interpretation, primary interpretation, whether the case was discussed with a technician, a "Q" if the case was selected for QC, and the total slides per cytotech.

The report sorts alphabetically by cytotech, then alphabetically by patient, and then in ascending order by review date.

Embedding Log

The Embedding Log is a simple embedding log without stain information. Retrieval arguments are block category (log) and batch number. Detail information includes specimen number, block number, number of pieces, block comment, part designator, part type name and primary pathologist initials.

Fax Log

The Fax Log documents fax activity. Retrieval arguments are date faxed and fax status. Detail information includes date sent, to whom, by whom, description, and fax status. When a fax has errored, this report displays the reason for the error.

Since the retrieval argument "fax status" is not standard, free text values will need to be entered. Enter a the following single letter for each status:

- s for sent
- c for cancelled
- e for error
- q for queued
- p for processing

Histology Stain/Process Log

The Histology Stain/Process Log searches a status date/time ordered of stain/process statuses, stain/process categories, and block/stain/process departments.

This log prints specimen number, block and status, stain by numbered ordered, request class abbreviation, ordering MD and date/time, stain/process and status, specimen priority, block designator, prosector, part designator, part description, all pieces used, additional labels, number of pieces block comment, stain/process label text, and stain/process comment. It sorts by stain/process category, specimen number, part designator, block designator, and stain ID.

Person Dictionary Lookup

This report is an online lookup for the person dictionary. Retrieval arguments are person (name), person type, and active flag. Detail sorts by name and includes person-level contact information (email address, pager, cell phone), as well as address-level information (associated client, address, phone, and fax).

Proc Worklist by Proc

The Worklist by Procedure report searches by procedure order date, specimen class, and procedure. The result is grouped by procedure (with a count). The detail displays specimen number, patient name, MRN, and collect date (date taken). This report looks at procedures with a status of Ordered.

Procedures Ordered by Reflex

The Procedures Ordered by Reflex report will list specimens that have procedures ordered by Reflex Testing. Retrieval arguments are accession date, specimen class, procedure, client, and submitting physician. Detail will display specimen number, patient name, accession date, MRN, submitting MD, client, part type, primary interpretation, and final diagnosis.

Report Chute Batch Errors

This report is a quick reference to identify all report chute batches in a "closed" or other error status. Retrieval argument is status date/time. The report display includes report chute name and number, problem status, and the status date/time.

Report Template

This is a report template that can be used when writing an InfoMaker report from scratch.   To use, open and select File; Save As with a custom name (y_). Change Text box "Report Title" to new report title. The template includes footer and header set up and a retrieval argument for accession date. The only table attached is c_specimen and column specnum_formatted, but this can be deleted if not needed.

Rpts. Awaiting S/O by Cyto.

The Reports Awaiting Sign Out by Cytotech log searches for specimens that have a status of cytology reviewed, pathologist reviewed, or that have been amended for a primary cytotech and specimen class (where the specimen class requires signout, and the report status does not equal N/A).

This log prints the primary cytotech, report type, specimen number, specimen class, accession date/time, report status, report status date/time, pathologists, total reports awaiting signout per cytologist, and a total count of all specimens found. It sorts by primary cytotech and specimen number.

Rpts. Awaiting S/O by Path.

The Reports Awaiting Sign Out by Pathologist log searches for specimens that have a status of final complete, cytology reviewed, pathologist reviewed or amended for a primary pathologist and specimen class (where the specimen class requires signout and report status does not equal N/A), and primary pathologist.

This log prints the primary pathologist, specimen number, specimen class, accession date/time, ordered date/time (if this is a Procedure/Addendum report), report type, report status, report status date/time, total reports awaiting signout per pathologist and a total count of all specimens found. It sorts by primary pathologist and specimen number.

Rpts. On Worklists by Path/Cyt

The Reports on Worklists by Pathologist/Cytotech log searches a user-specified person name. It prints the person name, worklist name, count of reports per worklist, specimen number, accession date/time, specimen status, specimen class abbreviation, specimen priority, final report or procedure addendum name, specimen status or procedure/addendum status, procedure/addendum order date/time, specimen or procedure/addendum worklist comment, specimen or procedure/addendum hold status and a total count of all reports on all worklists.

This log groups by and page breaks by person name and worklist. It sorts by person name, worklist name, and hours overdue in descending order. This report also prints those specimens not assigned to a worklist in a group called **Unassigned**.

Slides Sent Out

The Slides Sent Out log searches a "from date sent out/to date sent out" range. It prints patient name and per SSO (Slides Sent Out) item: date sent, status, expected date of return, requested by, recipient name, recipient specimen, and return date per master/other specimen.

This log sorts by date sent, patient name, SSO item, and SSO master/other specimens in sequence order.

Slides Sent Out/Not Returned

The Slides Sent Out/Not Returned log searches a "from date sent out/to date sent out" range for Slides Sent Out (SSO) items that have the pending status **only**. It prints patient name and per SSO item, date sent, expected date of return, requested by, recipient name, recipient address, recipient phone number, comment, other specimens, description of material per master/other specimen, and return date per master/other specimen.

This log sorts by date sent, patient name, SSO item, and SSO master/other specimens in sequence order.

Slide Sent Out/Not Returned Letter

This report produces a letter for each specimen which had slides sent out, but not yet returned via as recorded via the Slide Send Out activity. The retrieval argument is the Slide Send Out Date (range). Detail includes today's date and information from the original slide send out activity consisting of name, address, details on material sent, and return by date.

This report includes a global function for the "user signed on" name as well as the nested report that pulls the site name. This information appears at the end of the report.

Specimen Status by Path.

The Specimen Status by Pathologist log shows the current status of all specimens assigned to each pathologist. The log includes only those specimens that are not signed out and that do not have a status of **N/A** (i.e., specimen classes that are never signed out). Selection criteria include accession date/time range and pathologists.

This log prints the pathologist name, specimen status, specimen number, status date, total specimens for each pathologist.

The log sorts alphabetically by pathologist name.

Tissue Discard Log

The Tissue Discard Log report searches by accession date, specimen class, and days after sign out. The "days after sign out" retrieval argument expects a number to be used in this function: date difference in days between the sign out date and today. The report includes:

- **Discard Up To**: This displays the accession number for the most recently signed out case over "n days after sign out" as input in the retrieval argument.

- **DO NOT DISCARD**: This lists the cases that are not signed out or are signed out less than "n days after sign out" as input in the retrieval argument.

Tissue Processing Batch Log

The Tissue Processing Batch Log report searches by processing batch number.

This log prints specimen number, block category, block and status, stain by numbered ordered, request class abbreviation, ordering MD and date/time, stain/process and status, specimen priority, block designator, prosector, part designator, part description, all pieces used, additional labels, number of pieces stain comment, and stain/process comment. It sorts by specimen number, part designator, block designator, and stain ID.

This log displays data in the same format as the report generated by the Processing Batch Compile Edit item found within the Histology functions folder accessed through the **Tasks** command button.

Who Accessioned

This report is grouped by the name of the person who accessioned the specimen and below the name is a list of specimen numbers. The system credits the person who is logged into CoPathPlus as the person who accessioned the specimen. Each group includes a count. Retrieval arguments are accession date, specimen class, and who accessioned.

Who Accessioned Summary

This report is grouped by the name of the person who accessioned the specimen and displays a count of the number of cases accessioned as well as the percentage of cases accessioned/total cases. Retrieval arguments are accession date, specimen class, and person (who is logged on when accessioning)

QA Reports

The following standard Quality Assurance (QA) reports are provided with your CoPathPlus system:

- FS QA Review

- Intraoperative Diagnosis by Location

- Intraoperative Diagnosis vs. Final Diagnosis

- Interoperation vs. Final by Frozen Section Pathologist

- QA Deficiencies And Resolutions Summary

- QA Review Percent by Client

- QA Review Report by Client

- QA Review Report by Reviewer

- QA Review Search

- QA Reviews with No Results

- QA Specimen/Requisition Deficiency by Submitting Physician

- QA Statistics By Pathologist And Review Type

- Tissue Committee Report

FS QA Review

The FS QA Review searches for cases that have a FS (Intraoperative) pathologist and most likely will be run for a QA Review Type for FS Agreement. Retrieval arguments are QA Review Date, Specimen Class, QA Review Type, FS Pathologist, QA Result. The report groups by FS Pathologist, includes number of cases, then QA Review type. Detail groups by result name, with detail including accession number, pathologist (if available), number of cases with result and percentage (# cases with result/total QA cases) for FS pathologist group.

Intraoperative vs. Final

The Intraoperative Diagnosis vs. Final Diagnosis report searches an accession date/time range and specimen classes for specimens where an intraoperative (i.e., frozen section) consult diagnosis exists.

This report prints the specimen number, accession date/time, intraoperative consult diagnosis text, intraoperative consult primary pathologist, final diagnosis text, and primary pathologist. It also prints the total number of specimens found. It sorts by specimen number.

Intraop Dx by Location

The Intraoperative Diagnosis by Location Report searches by accession date, specimen class, submitting physician, and location. Detail displays accession number, patient demographics, submitting physician and location. Includes all cases with an intraoperative diagnosis and displays case parts, intraoperative text, and intraoperative pathologist

Intraop vs. Final by FS Path

The Interoperation versus Final by Frozen Section Pathologist report is a modification of the standard Intraoperative vs. Final Diagnosis report except this report includes a retrieval argument for Intraoperative Pathologist. The report groups by intraoperative pathologist. It lists intraoperative diagnosis, intraoperative pathologist, final diagnosis and final primary pathologist.

A case must have an intraoperative pathologist assigned to be eligible for this report.

QA Defic/Resolution Summary

The QA Deficiencies And Resolutions Summary report is a summary report displaying the specimen requisition deficiency name, count of deficiencies and how many had a resolution. The selection criteria are accession date, client name, specimen class, and requisition deficiency name.

QA Percent by Client

The QA Review Percent by Client is a summary report with retrieval arguments for accession date range and client. The report groups by client with calculations for number of cases with a QA Review, total cases per client, and percentage of cases with a QA review.

QA Review by Client

The QA Review Report by Client Report is a modification of the standard QA Review report with the addition of a retrieval argument for Client. In addition, this report groups the QA review information by Client Name.

QA Review by Reviewer

The QA Review Report by Reviewer report is similar to the QA Search report except that the detail is grouped by QA reviewer (with count) and QA review type (with count). Retrieval arguments are QA review date, QA result, QA reviewer, QA review type, and specimen class.

QA Review Search Report

The QA Review Search report searches an accession date range, QA Reviews, QA Results, and QA Reviewer . It prints the following data on cases with QA reviews specified that have a QA reviewer and QA result: specimen number, patient name, accession date, QA review type name, QA Review Date, QA review status, if it is a problem QA, QA Reviewers, QA result names (and comments), QA Reasons (and comments), QA resolutions (and comments), QA-related cases, Primary pathologist, and a total count of all specimens found.

This report sorts by QA review type name, then specimen number.

QA Reviews with No Results

The QA Reviews with No Results report provides a list of specimens scheduled for QA reviews for which no results have yet been entered. Selection criteria include starting QA review date and QA review type.

This report prints the specimen number, patient name, accession date/time, QA review type, review date/time, status, whether this is a problem QA (Y or N), and total number of QA reviews with no results.

The report sorts in ascending order (alphabetically, then numerically) by specimen number.

QA Spec/Req Def by Submitting

The QA Specimen/Requisition Deficiency by Submitting Physician report searches an accession date/time range, specimen/requisition deficiencies (e.g., unlabeled container), and a submitting physician for specimens that have QA specimen/requisition deficiencies.

This report prints the submitting physician, patient name, specimen number, accession date/time, floor/location, QA specimen/requisition deficiency name, QA specimen/requisition deficiency comment, QA specimen/requisition resolution, QA specimen/requisition resolution comment, and a total count of all specimens found. This report sorts by submitting physician and accession date/time, deficiency number and resolution number.

QA Stats Pathologist/Rev Type

The QA Statistics By Pathologist And Review Type report is a summary report for QA reviews by pathologist. Grouped by primary pathologist, it displays QA review type name and number of cases with that review type. The selection criteria are accession date, specimen class, client name, QA review name, and pathologist.

Tissue Committee Rpt.

The Tissue Committee report contains patient demographic information and two text fields: Preop Dx and Final Dx. The report sorts by accession date.

Setup Reports

CoPathPlus provides several system management reports that are accessed through the **Setup** command button on the CoPathPlus Application Manager. These reports are located in the following folders:

- Cerner Customizer > Folders and Items
  - InfoMaker Wizard Retrieval Arguments
  - Menu Tree Report
  - Personal Menu Report
- Interface Items > Interface Reports
  - Conversion Test Report
  - Failed Interface Merges
  - Parse Rule Edits Report
  - Order List
  - Requests on Hold

- Security Items

  - Person Printout

  - Miscellaneous Permission Printout

  - Permission Group Printout

  - Permission Groups and Users

  - Permissions by User

- System Documents and Reports

  - LTW by Procedure/Activity

  - LTW by Registration Windows

  - LTW by Specimen Class/Activity

  - Table Specification (Detail)

  - Table Specification (Summary)

- System Settings and Tables

  - Natural Language Noise Words

  - Printer Printout

  - Purge Dictionary Printout

  - Purge Log

  - System Settings Detail

  - System Settings Summary

  - Workstation Printout

InfoMaker Wizard Retrieval Arguments

The InfoMaker Wizard Retrieval Argument report lists all the retrieval arguments (i.e., data fields) available for running InfoMaker reports through the InfoMaker Wizard. Retrieval arguments are statements that let you define the search criteria used when an InfoMaker report runs. By allowing retrieval arguments to be defined by users, they are given the ability to select just the criteria they need from a larger report. Retrieval arguments are seen and defined while creating an InfoMaker report.

In relation to retrieval arguments, prompt names are also shown in the InfoMaker Wizard Retrieval Argument report. The prompt, when selected, initiates a particular retrieval argument and causes specific criteria to be shown. Prompts, which have been defined by retrieval arguments, are seen when accessing a report through the InfoMaker Wizard.

This report also acts as an information resource if you need to find the particular table location of a given prompt, or what the particular retrieval arguments are as well as their table location. This is also useful when creating new reports and setting up retrieval arguments.

Menu Tree Report

The Menu Tree report provides a complete picture of the folder and item setup at a site, including any site-specific folders or items. The names and internal IDs of all folders and items, and the icon each uses, are displayed on this report. You can use this report to find the internal ID of a folder you want to override and to view the contents of all folders in CoPathPlus. The report gives a detailed inventory list of all the folders and items present in the menus of CoPathPlus.

Personal Menu Report

The Personal Menu Report lists the contents of the Personal Menu for each user in CoPathPlus. It lists each item name, the icon associated with each, and the internal item or folder name. You can run this report for an individual user, a number of users, or all users of CoPathPlus.

Because changes or deletions made to folders and items are not reflected in the Personal Menu of users, this report provides a way for System Managers to find those users who might not have up-to-date folders or items in their Personal Menus.

Conversion Test Report

The Conversion Test report lists all the information that has been successfully converted into the CoPathPlus database. A conversion transfers information from a legacy system into CoPathPlus. You can use this report to keep track of successful conversions and monitor, by their absence, unsuccessful conversions.

Failed Interface Merges

This report provides an account of the data from intentionally unprocessed merge transactions. For each respective incoming ADT interface, the site may stipulate when they would like to have interface merge transactions processed:

- Always, Unless both patients have specimens,
- Always, Unless the "from" patient has specimens
- Never.

This determination is set in the Interface Format Dictionary on the Filer tab.

Interface merge transactions that intentionally "fail" due to this dictionary definition will be included on the Failed Interface Merges InfoMaker report.

This report is retrieved by Error Date and displays the date the error occurred as well as the specific merge interface message. An example message is 'Merging 1234567 into 7654321 not performed, as the "from" patient has cases'.   Since this report is retrieved from the interface error log, it may be retrieved only until the interface error log is purged.

Order List

The Order List contains specific information about orders received by CoPathPlus through the Order Entry interface, including the name of the patient, the processing date, order number, encounter number, etc. The report prints the description of the order in an Order Description field. You can use the Order List to keep track of specimen orders used in CoPathPlus, as well as monitor orders received by CoPathPlus, but not yet associated with a specimen.

Parse Rule Edits Report

This report displays changes made to interface parsing rules.   The report indicates the items that have been changed; it does not show old or new values. Changes are audited only beginning with CoPathPlus version 2.5, so any history before your upgrade to this version will not be available. The auditing is turned on automatically for all users, regardless of your site's audit trail configuration.

Requests on Hold

The Requests on Hold report identifies specimen results or status messages that are waiting for the assignment of an Order Entry Number before they can be processed by the output interface. The Order Entry Number requests are on the hold queue (i_request_hold).

Person Printout

The Person Printout provides a list of all persons currently set up in the Person Dictionary in CoPathPlus. The report details all the information about a particular person (relevant to CoPathPlus), as well as permission group(s) with which that person has been associated. You can use this report to identify everyone (except patients) who uses and is associated with the CoPathPlus system, as well as what permission groups they currently have.

Miscellaneous Permission Printout

The Miscellaneous Permission Printout provides a description of each miscellaneous permission available in the Miscellaneous Permission dictionary in CoPathPlus. It details what a user will have access to if assigned the permission. Miscellaneous permissions comprise one type of permission that you can include in a permission group; the others being application items, specimen classes, and report chutes. You can use this report to determine which permission groups should include this permission.

NOTE: The Miscellaneous Permission dictionary is accessible by Cerner CoPathPlus staff only.

Permission Group Printout

The Permission Group Printout provides a list of all permission groups currently set up in the Permission Group Dictionary in CoPathPlus and details the permission types (i.e., application items, specimen classes, report chutes, miscellaneous permissions) included in each. You can use this report to determine which permission group(s) to assign to a user.

Permission Groups and Users

The Permission Groups and Users report provides a list of all permission groups currently set up in CoPathPlus and details the users of CoPathPlus that have been assigned to each group. These groups are assigned to a user through that user's Person Dictionary entry. You can use this report to easily see who is included in each permission group.

Permissions by User

The Permissions by User report provides a list of all users of CoPathPlus and details which permission groups each user has been assigned. In addition, it lists the components of each permission type (i.e., application items, specimen classes, report chutes, or miscellaneous permissions) to which a user has access. You can use this report to easily see the permissions to which each CoPathPlus user has access.

LTW by Procedure/Activity

The LTW by Procedure/Activity report provides a complete reference of windows linked by procedure/activity. The Default Procedure type lists the windows currently linked to all the Procedure/Addendum activities for each procedure/addendum. If a procedure/addendum has customized (tailored) windows, those windows are listed in the Procedure/Activity report as well. The report provides detailed information concerning procedure type, activity, the activity internal name, and the linked window. Using this report as a reference helps you to follow the guidelines for linking tailored procedure/activity windows during window painting.

LTW by Registration Windows

The LTW by Registration Windows report lists the main registration and encounter windows as well as the window internal name that links to each. Using this report as a reference helps you to follow the guidelines for linking tailored registration windows during window painting.

LTW by Specimen Class/Activity

The LTW by Specimen Class/Activity report provides a complete reference of windows linked by specimen class/activity. The report provides detailed information concerning activity, the activity internal name, and the linked window. Using this report as a reference helps you to follow the guidelines for linking tailored specimen class/activity windows during window painting.

Table Specification (Detail)

The Table Specifications (Detail) report lists specific information concerning the tables and columns you can paint on windows and patient reports in CoPathPlus. It presents detailed information concerning entry style, default values, variants/headers, and whether or not the item is display only. In addition, this report contains the name of the associated Parent Table. This allows you to see the original table, from which more specifically detailed data was separated to make up the table you are currently referencing (e.g., the Specimen Adequacy Filter

[c_d_adequacy_f] is derived from Specimen Adequacy [c_d_adequacy], which is its parent table).

Table Specification (Summary)

The Table Specifications (Summary) report lists more general information concerning the tables and columns you can paint on windows and patient reports in CoPathPlus. It lists data type, entry type, and the maximum number of characters that can be entered in a field. For more detailed information concerning entry style, default values, variants/headers, and whether or not the item is display only, refer to "Table Specification (Detail)".

Natural Language Noise Words

The reporting function in CoPathPlus allows you to perform natural language searches by identifying cases based on words found in various CoPathPlus text fields. To do so, CoPathPlus indexes each word that is entered into one of these text fields. However, not every word should be indexed. CoPathPlus considers some words "noise words". Noise words are common words like "a" and "the" that are not indexed and therefore cannot be searched for in natural language searches.

The Natural Language Noise Words item, found within the System Settings and Tables folder under the **Setup** command button, accesses an InfoMaker report that shows you a list of words that CoPathPlus considers noise words. These words are ignored by CoPathPlus when you perform natural language searches.

CoPathPlus contains a standard noise words list. During the implementation of the CoPathPlus system, your site might have added and/or deleted entries from the standard list. You should use the Natural Language Noise Words item to print out the list of noise words for your site.

NOTE: Once this list is determined by your site during implementation, it cannot be edited.

Printer Printout

The Printer printout provides a list of all printers currently set up in CoPathPlus – both active and inactive.

Purge Dictionary Printout

The Purge Dictionary printout provides a list of all entries currently set up in the Purge dictionary – both active and inactive.

Purge Log

The Purge Log lists all the information purged from the CoPathPlus system (i.e., report chute batches, audit trails, and billing sent batches) during a specified period of time. This log includes the name of the purged item, the name of the person who purged the item (initials only), and a comment field. Each time you access the Purge Log it displays all purges that took place from the last date on which you accessed the log.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

System Settings Detail

The System Settings Detail report lists the same information defined in the System Settings Summary report. In addition, if anyone edits the System Settings Detail report, it will show the name of the person who edited it as well as the edit date. The report will also detail the Setting Description and Site Comments (if any have been entered).

System Settings Summary

The System Settings Summary report lists all the System Settings that are currently available in CoPathPlus. The report also details the current values that are selected for each system setting and whether or not they are editable by the user.

Workstation Printout

The Workstation Printout provides a list of all printers currently set up in CoPathPlus – both active and inactive.

This page was intentionally left blank.

Chapter 9: Tasks

Overview

Tasks explains a number of Cerner CoPathPlus items that deal with system maintenance and that you must perform on a periodic basis (e.g., daily, monthly, etc.). These items cover areas such as billing, cassette and slide engraving, histology, merging patients, and moving encounters, moving and deleting specimens, quick entry functions, the Schedule Manager, System Session Utilities, and the Fax Queue/Log.

This guide explains most of the items found under the **Tasks** command button in CoPathPlus. The following items are explained in other sections:

- ·Billing Entry/Edit (Billing Functions folder)
- Spelling Files
- Change Password(System Session Utilities folder)
- Failed Sign-On Attempts Report (System Session Utilities folder)
- Report Chute Manager

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Billing Functions

This topic details the Billing Chute Manager and Billing Fee Code Schedule. It explains how to use both functions in CoPathPlus.

The Billing Chute Manager allows your site to manually compile new billing batches, validate billing batches prior to sending them to output, and send batches to output. It also allows you to recompile, revalidate, and resend billing batches when needed.

The Billing Fee Code Schedule, which is built by each site, contains a matrix for all the possible billing type/fee code combinations for a site.

Notice that while you can access the Billing Entry/Edit activity within the Billing Functions folder, it is also one of the activities accessed under the **Specimens** command button. Refer to the Specimens chapter for information on this activity.

Billing Chute Manager

A billing chute acts as a destination or output method for billing data captured by the CoPathPlus system. A billing batch contains all the charges and/or credits for a particular billing chute for a given period of time (i.e., all charges/credits made available for billing since the previous billing batch was compiled). Each billing chute can have a series of billing batches. Each billing batch has its own unique identifying number and contents. For example, billing charges/credits in Batch 15 of the Professional Output File billing chute are not found in any other batch.

You identify your site's available billing chutes (e.g. the Inpatient Technical chute, which routes billing data to your hospital interface; the Professional Output File chute, which routes billing data to a paper printout for mailing to a private billing service) in the Billing Chute Dictionary. To learn about this dictionary, refer to "Billing Chute Dictionary" in the "Billing Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

Accessing the Billing Chute Manager

To access the Billing Chute Manager:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Billing Functions folder.

   A list of items appears under the Billing Functions folder.

3) Double-click on the Billing Chute Manager item.

   The Billing Chute Manager appears.

TIP! You can also access the Billing Chute Manager item by placing it in your Personal Menu and double-clicking on it from there.

Using the Billing Chute Manager

The Billing Chute Manager is the main window you use to manually compile, validate, and send batches of billing charges. The compile process collates all the charges eligible for this batch. The validate process identifies problems within the compiled batches such as when specific charge codes are missing. The Send process queues up the billing batch for the associated interface. The Send process can identify additional problems in the batch as related to interface required fields. For example, the Billing Chute Manager would not normally require that insurance be assigned to the patient in order for billing to occur. However, if insurance is a required field in the associated billing interface, then the Send process will add any charges where the patient has no assigned insurance companies to the list of billing errors for the batch. The Billing Chute Manger also lets you select in-house management report print options and preview these reports. In addition, you can delete a Compiled or Validated billing batch through the Billing Chute Manager when that is required. When this is done, the charges assigned to that batch are released to be collated by the subsequent batch. A billing batch in a Sent status cannot be deleted.

The main area of the Billing Chute Manager window contains a list of billing batches per billing chute, along with the status for each billing batch (Compiled, Validated or Sent) and the number of errors within the batch. The Billing Chute Manager displays billing batches in reverse chronological order within each billing chute. The Billing Chute Manager allows selection of one batch at a time for processing.

The following paragraphs describe the fields and buttons on the Billing Chute Manager.

Sent Batches Filter. For each billing chute, this field determines the number of previously sent batches to display. The default is **1.** Multiple batches will display unless they all have a status of sent. You can change the number in this field to specify how many previously sent batches CoPathPlus should display per billing chute on the Billing Chute Manager window. For example, you can increase the number to see additional sent batches.

Batch Options. Either select the "new" row or a specific billing batch. CoPathPlus will enable the appropriate options (i.e., check boxes). The following batch operations are available on the Billing Chute Manager window:

NOTE: CoPathPlus enables the **OK** button only after you have selected at least one of the check boxes under Batch Options or Report Print Options.

- **Compile.** Select this check box to compile a batch. It is enabled only when you have highlighted the "(new)" row for a billing chute. Keep in mind that you cannot compile batches that have already been compiled. However, you can delete an unsent batch and then recompile the batch, or you can revalidate a batch to re-include charges. Deleting and recompiling a batch can include additional charges that have become eligible for billing since the first time the batch was compiled.

- **Validate.** Select this check box when you want to validate a batch. CoPathPlus enables this check box only if a batch is already compiled (or about to be compiled) and not yet sent. The validation process excludes charges with errors and can re-include those charges once they no longer have errors. Typically, you would select the Validate and Compile check boxes when you want to resolve batch errors prior to sending.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- **Send.** Select this check box to mark a compiled batch (or about to be compiled batch) as sent. If a batch goes to an interface, then CoPathPlus places the batch on an interface request queue. For a batch not going to an interface, the send may eventually trigger an automatic printout of the site-specified InfoMaker report for that billing chute (as defined in the entry for the chute in the Billing Chute Dictionary). Once a batch is marked as "sent," it becomes available to be purged from the system.

    NOTE: Only those persons at a site with permission will be able to select an already sent batch and resend that batch. If you have permission to resend a billing batch, CoPathPlus enables the Send check box for a batch that has already been sent. For more information, refer to "Security Issue for Resend Capability in the Billing Chute Manager".

    Also note that if a batch is resent, the send date for the batch is updated with the most recent sent date.

Report Print Options. First you should select a specific billing batch, then select a report print option, and press **OK**. The following report print options are available on the Billing Chute Manager window:

- **Output.** Select this check box to print the Billing Batch Output report, which shows all the billing charges that successfully compiled. Note that this check box is enabled only if a report is compiled (or about to be compiled) and if an output report is defined for the billing chute in the Billing Chute Dictionary.

- **Internal.** Select this check box to print the Billing Batch Internal report, which shows all the billing charges for a batch whether or not they were successfully compiled. Note that this check box is enabled only if a report is compiled (or about to be compiled) and if an internal report is defined for the billing chute in the Billing Chute Dictionary.

- **Error.** Select this check box to print the Billing Batch Error report, which shows all the billing charges that did not successfully compile. Personnel at your site would use this report to determine which billing charges need attention so that any missing or invalid data can be corrected. Corrected charges will be compiled in the next batch if the original batch has already been sent. Note that this check box is enabled only if a report is compiled (or about to be compiled) and if an error report is defined for the billing chute in the Billing Chute Dictionary.

To learn about the Billing Chute Dictionary, refer to "Billing Chute Dictionary" in the "Billing Dictionaries" section of *the Cerner CoPathPlus Dictionary Building Manual*.

Report button. Press this button to access the Billing Batch Report window. This window allows you to preview the reports (i.e., Billing Batch Output, Billing Batch Input, and Billing Batch Error) for the batch you have highlighted on the Billing Chute Manager.

Delete button. Press this button to delete the billing batch you have highlighted on the Billing Chute Manager window. CoPathPlus enables this button only if the batch is compiled or validated but not sent. After deletion, you can compile a new batch that will contain the charges from the deleted batch plus any new charges that have become available.

Close button. Press this button to close the Billing Chute Manager window.

Billing Batch Report Window

The Billing Batch Report window allows you to preview a report before you print it.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Navigation buttons. You can move from page to page in the report by using the navigation buttons at the bottom, left of the window.

Directly underneath these buttons is the page count display. This display shows the page of the report that you are currently on and the total number of pages that the report contains.

Zoom. This field specifies the size of the report display as a percentage of the report's normal size. In the standard CoPathPlus system, all standard reports default to 75% of their normal size for viewing purposes. You can increase or decrease the size on the report display. However, reports and labels always print out at 100%.

Report Option buttons. Select one of the following options for reports:

- **Output** to display the Billing Batch Output report. This report shows all the billing charges that successfully compiled.

- **Internal** to display the Billing Batch Internal report. This report shows all the billing charges for a batch, whether or not they were successfully compiled.

- **Error** to display the Billing Batch Error report. This report shows all the billing charges that did not successfully compile. Personnel at your site would use this report to determine which billing charges need attention so that any missing or invalid data can be corrected. Corrected charges will be compiled in the next batch if the original batch has already been sent.

Print button. Press this button if you want to print out the report that is currently displaying on the Billing Batch Report window. The Print/Send Setup pop-up window appears.

Close button. Press this button to close the Billing Batch Report window.

Security Issue for Resend Capability in the Billing Chute Manager

All of the check boxes and option buttons will be available to any user who can access the Billing Chute Manager, with the exception of the Resend capability. To avoid accidentally resending batches that have already been sent (which would lead to double billing), only those persons with an explicit permission to resend a batch will be able to do so. If you have permission to resend a billing batch, **OK** will be enabled when you select the Send check box for a batch that has already been sent. CoPathPlus will also present the following warning message, which you should respond to as appropriate:
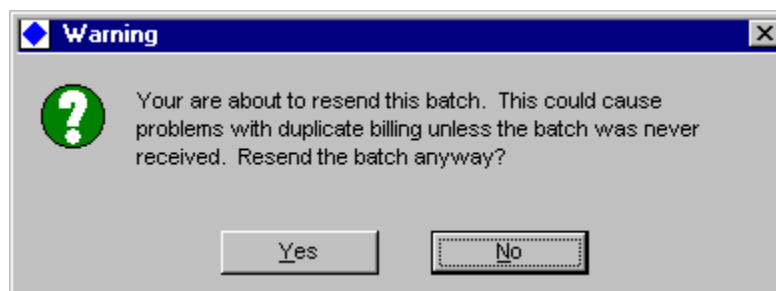
Billing Fee Code Schedule

Fee codes and prices for services performed in a pathology lab can vary for different types of patients and/or clients (i.e., by billing type). To support this variation, CoPathPlus provides a Billing Fee Code Schedule that is built by each site and that contains all the billing type/fee code combinations possible for a site. To build this schedule, you associate a billing type with a fee code and specify the codes and charges (professional and/or technical) for that particular combination.

To learn about the CoPathPlus billing activity, refer to "Billing Entry/Edit" in the Specimens chapter.

Accessing the Billing Fee Code Schedule

To access the Billing Fee Code Schedule:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Billing Functions folder.

   A list of items appears under the Billing Functions folder.

3) Double-click on the Billing Fee Code Schedule item.

   The Billing Fee Code Schedule appears.

TIP! You can also access the Billing Fee Code Schedule item by placing it in your Personal Menu and double-clicking on it from there.

Fee Code Components

The Billing Fee Code Schedule consists of a matrix for all possible fee code/billing type combinations, containing codes and prices for the technical and professional components of each service performed by the pathology lab. Each fee code consists of two components:

- **Professional**, which represents the charge and code for the clinician's services to interpret the prepared sample (i.e., examining the slides and issuing an interpretation).

- **Technical**, which represents the charge and code for the preparation of a tissue sample for examination (e.g., creating the blocks, staining the slides). You can also use the Technical field to designate combined or global codes and charges.

Before Building the Billing Fee Code Schedule

You should be aware of the following information before you start building the Billing Fee Code Schedule:

- Because the Billing Fee Code Schedule contains billing types and billing fee codes, a site must build the Billing Type and identify the fee codes in the Billing Fee Code Dictionaries before it can build the Billing Fee Code Schedule.

- Your site's System Manager builds and maintains the Billing Fee Code Schedule through the Billing Fee Code Schedule item or through the Billing Fee Code Dictionary. It is most efficient to use the Billing Fee Code Schedule for the initial setup of the billing type/fee code combinations data for all your site's billing type/fee code combinations. You can use the Schedule tab in the Billing Fee Code Dictionary to view and update the schedule for one particular fee code.

  ```
  NOTE:  To successfully send billing to an electronic output (e.g.,
  interfaces), your site is required to associate fee codes with billing
  types.  Each fee code/billing type combination must have both technical
  and professional codes.   If either the professional or technical code
  is not valid for a particular charge type, "N/A" must be posted to that
  field to indicate this.
  ```

- When you access it, the Billing Fee Code Schedule appears with a list of all the billing type/fee code combinations already in your system. This data comes from the Billing Type and Billing Fee Code Dictionaries. You can only enter professional codes and charges and technical codes and charges for the billing type/fee code combinations that appear on the Billing Fee Code Schedule. If you want to add another billing type/fee code combination, you must add new entries in the respective dictionaries first.

- Inactive Billing Type and Billing Fee Code Dictionary entries will still appear in the Billing Fee Code Schedule. They will appear at the end of the schedule enclosed in angle brackets (e.g., <Test Billing Type>).

  ```
  TIP!  This gives your site the ability to build a new fee code schedule
  (e.g., in anticipation of its future use), then activate it by clearing
  the Inactive check boxes in the appropriate entries in the Billing Type
  and Billing Fee Code Dictionaries.
  ```

- If your site wants to have charges that are professional or technical only, users must enter "**N/A**" (you **must** enter the slash [/]) in the code that is not applicable. If either the Prof Code or the Tech Code column is left blank, the batch validate function will kick the charge out of the batch and the charge will remain at least partially unbilled.   Note that when the interface sees the **N/A** charges, they are marked as billed but are ignored in the batching process and are not sent to the billing system.

- Your site must compile and send all technical and professional charges − even if they are marked N/A and even if the specimen is marked "No Charge". If it does not, the batch compiler will run slower and slower as it looks at more and more unbilled charges when generating a batch.

Refer to "Billing Type Dictionary" and "Billing Fee Code Dictionary" in the "Billing Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* to learn about these dictionaries.

Security Issues

Keep the following security-related issues in mind:

- The Billing Fee Code Schedule and the Billing Fee Code Dictionary both allow you to edit professional and technical codes and charges for each billing type, although the

Billing Fee Code Dictionary only allows you to edit one fee code at a time. Because of this editing capability, your site may want to limit access to both those items.

- If someone has the Billing Fee Code Schedule open, no one can access the Billing Fee Code Dictionary, and vice versa.

Entering/Editing the Billing Fee Code Schedule

Fill in the fields on the Billing Fee Code Schedule as follows:

1) **Prof. Code.**   Enter a professional component code for each relevant billing type/fee code combination (row). This is often the CPT-4 code (which refers to the [clinicians'] Current Procedural Terminology code that relates to pathology work). You can enter up to 20 alphanumeric characters. This field must have a value to process properly. If there is not a valid code, enter "N/A".

2) **Prof. Charge.** Enter a charge (price) for the corresponding professional code. You can enter a number up to 999,999.99. This field is optional; it is only required if you choose to send prices to your interfaced billing system.

3) **Tech. Code.**   Enter a technical component code for each relevant billing type/fee code combination (row). You can enter up to 20 alphanumeric characters. This field must have a value to process properly. If there is not a valid code, enter "N/A".

4) **Tech. Charge.** Enter a charge (price) for the corresponding technical code. You can enter a number up to 999,999.99. This field is optional; it is only required if you choose to send prices to your interfaced billing system.

5) Press <u>S</u>ave to file your data.

   Note: You must enter N/A in any Tech. Code or Prof. Code fields that are not applicable when any particular Fee Code is used only for professional or technical charge purposes.   When the Combined (Global) billing scheme is used, charge codes are taken from the Tech. Code field.   It is necessary to enter the N/A into all Prof. Code fields when using this scheme.

View By

You can view and/or edit the Billing Fee Code Schedule either by billing type (i.e., the default view) or by fee code.

Perform the following steps in the View By area of the Billing Fee Code Schedule:

1) Select either the Billing Type or Fee Code option button, depending on how you want to view the Fee Code Schedule.

2) Select a billing type or fee code in the field below the option buttons, depending on what you choose above.

For example, if you select the view by Billing Type and then you select the billing type **Blue Cross** at the subsequent field, this billing type will appear in the Billing Type column of the Billing Fee Code Schedule and all its fee codes will appear in the Fee Codes column in alphabetic order.

Or, if you decide to view the schedule by Fee Code and you select the fee code **Electron Microscopy**, then this fee code will appear in the Fee Code column and all its billing types will appear in the Billing Type column in alphabetic order.

Copy Codes and Charges

The Billing Fee Code Schedule has a Copy Codes and Charges feature that allows you to copy fee code entries (codes and charges) from one billing type to another. For example, you may have a billing type that contains your site's standard set of billing fee codes and charges. Suppose you add a new billing type called Main Street Clinic that has most of the same billing fee codes and charges as the standard billing type. You could copy all codes and charges from the standard billing type to the Main Street Clinic billing type through the Billing Fee Code Schedule. Then you can edit any individual charges that may be necessary for Main Street Clinic.

You can also copy just the professional codes, professional charges, technical codes, or technical charges.

To copy fee code entries from one billing type to another:

1) Select the billing type into which you want to copy codes and/or charges in the View By area.

2) Select the billing type from which you want to copy codes and charges in the From Billing Type field in the Copy Codes and Charges area. When you view by billing type, all rows visible in the schedule are overwritten when you press **Copy**.

   NOTE: If you were to view by fee code, only the row in which your cursor is placed would be overwritten.

3) Notice that the To Billing Type field is already filled in for you, with what you selected in Step 1 above.

4) Select one of the following choices in the Columns to Copy field:

   o **All,** copies all the codes and charges from the "From Billing Type" field to the "To Billing Type" field.

   o **Technical Code,** copies just the technical codes.

   o **Technical Charge,** copies just the technical charges.

   o **Professional Code,** copies just the professional codes

   o **Professional Charge,** copies just the professional charges.

5) Respond as appropriate to the message box that asks if you want to update all the rows (one row constitutes one billing type/fee code codes and charge combination) or columns for the affected billing type.

6) Press **Save** to save your changes.

Engraver Functions

NOTE: This section of the documentation applies only to clients with interfaced cassette or slide labeler devices.

This topic describes the interface between CoPathPlus and three different types of labelers (aka engravers). All three of these labeler types may support slide as well cassette labelers.

- SM-Compatible serial connection labeling devices.

- Windows Printer type labelers where the labeler is attached to the Engraver Manager similar to the technology used for Windows printers.

- File Format type labelers where the labeling device picks up a file left in a specific directory by the CoPathPlus Engraver Manager.

Numerous different Labeler devices are available in the marketplace and manufacturers frequently introduce new models that may utilize different connection technologies or have different data stream expectations. Refer to cerner.com for a list of supported labeler devices. Contact Cerner CoPathPlus for specific compatibility questions or if you want to purchase a new Labeler Interface.

One or two engravers may be linked to one CoPathPlus Engraver Manager workstation, assuming the workstation has two available communication ports.

When a block or stain is ordered, an Engraver Label Type is automatically assigned to it based on rules defined in the Engraver Label Type Dictionary. When a request for cassette or slide labels is made, the group of blocks or stains is added to the engraver label queue as one request. The **Engraver Manager** will try to process together all the cassettes or slides in a single label request so that they do not get intermingled with other label requests.

The Engraver Manager runs continuously on each workstation that is linked to one or more labelers, and provides a user interface for managing a labeler's hopper contents. The label type assigned to a hopper (e.g., red cassettes, blue slides) should match what is physically loaded in the hopper. The Engraver Manager lists all the labelers linked to its workstation, and each labeler's hopper(s) with their current label type assignments.

The Engraver Manager searches the label queue for label requests that can be processed on its labelers. It processes label requests that match a department an engraver services, and that match a label type that is currently set up for a hopper. A label request (or a portion of a label request) will remain in the engraver label queue until an Engraver Manager can process it. For example, a label request for red cassettes will remain in the queue until a hopper is set up for red cassettes. For another example, if a label request consists of three pink cassettes and two white cassettes and only white cassettes are loaded, then the two white cassettes will be engraved and the three pink cassette requests will remain in the queue.

An **Engraver Inquiry** item is available from any workstation to view the label queue for all engravers on all workstations.

In case a workstation crashes while running an Engraver Manager and cannot be restarted, an **Engraver Workstation Reset** item is available from any workstation to reroute the labeling jobs to another workstation's engraver.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

In addition to the Engraver Manager, Engraver Inquiry, and Engraver Workstation Reset items, the following CoPathPlus dictionaries are used to set up the interface:

- Engraver Dictionary, which defines all the labelers at your site, their host workstations, and the histology department(s) that use them.

- Engraver Label Type Dictionary, which defines the various types of labels, which typically depend upon departments, cassette colors, types of slides, and variations in label formats. A user-specified matrix of rules defines which label type to assign to any given block or slide.

- Engraver Label Format Dictionary, which defines the text format and layout of engraved labels.

Refer to the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information on each of these dictionaries.

Accessing the Session Maintenance Item

To access Session Maintenance:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the System Session Utilities folder.

   A list of items appears under the System Session Utilities folder.

3) Double-click on the Session Maintenance item.

   The Session Maintenance Window appears.

Requesting Cassette Labels

NOTE: A block must have an assigned label type in order to request a cassette label for it. Refer to "Engraver Label Type Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for information on defining cassette label types for blocks.

Cassette labels may be requested when histology protocols and blocks are ordered or edited in any of the following windows:

- Accession Entry/Edit

- Histology Data Entry/Edit

- Stain/Process and Block Edit

- Gross Description Entry/Edit

Depending on how your site sets up its windows, one or both of the following methods may be used:

1) **Engrave Labels check box**. When selected, at the time the specimen is saved, labels will automatically be requested for all blocks that have an assigned label type and have not yet been labeled.

This method may be preferable to the button described below if a site is running protocols during accession and wants to get a cassette labeled for each block in the protocol. This requires little, if any, user intervention.

2) **Save/Engrave… button.** <kbd>Save/Engrave...</kbd> When pressed, the specimen is saved and the Request Cassette Labels window appears.
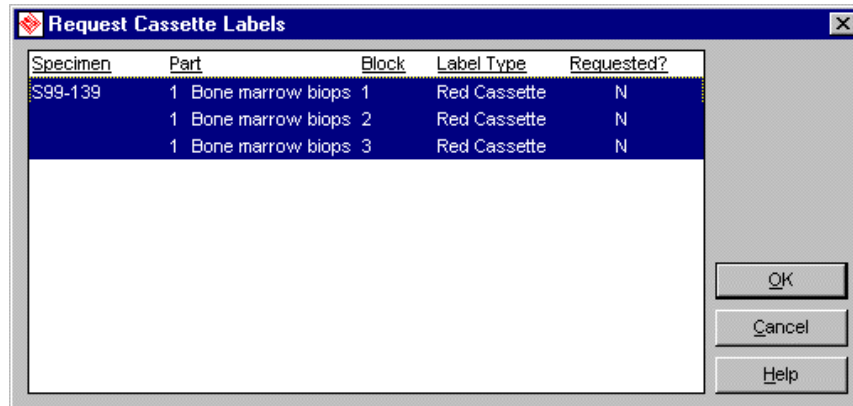
The Request Cassette Labels window displays a row for each block on the specimen. The columns are part no., block no., label type, and requested status (Yes or No). When the window opens, CoPathPlus selects by default all blocks that have an assigned label type and have not yet been labeled. You can override this default and select specific blocks by:

o   Clicking on any entry to deselect or select it.

o   Ctrl-click to select or deselect multiple blocks.

o   Shift-click to select or deselect consecutive rows of blocks.

Once the correct blocks are selected, press **OK** to send the label request to the engraver. A block is marked as labeled once a label request is made. (CoPathPlus receives no information about whether or not the block's cassette was physically labeled.)

NOTE: Blocks with no assigned label type cannot be selected. Also, if there are no blocks on the specimen, the **OK** button is disabled.

When a request for cassette labels is made, the group of blocks is added to the engraver label queue as one label request. The Engraver Manager will try to process together all the cassettes in a single label request, so that they do not get intermingled with other label requests. However, any block with an assigned label type that is not loaded in an active hopper will remain in the queue until the hopper is reassigned to that label type.

Assigning a Label Type to a Block

A block may be created either by running a protocol or by a user adding an individual block. When a block is ordered, a cassette label type is automatically assigned to it based upon the rules you set in the Engraver Label Type dictionary.

An **Engraver Label Type** field may also appear on the Block Detail pop-up window in Histology Data Entry/Edit or Stain/Process and Block Edit. You can use this field to view or change the assigned label type.

CoPathPlus uses whatever label type is associated with a block when a label is requested for it. Changes to the block's label type after the request will have no effect on the original request. Blocks with no label type are ignored if a label is requested.

Recalculating a Label Type for a Block

If any of the following window fields are changed, the cassette label type *may* be recalculated based upon that change.

Changed Field…	Recalculates Label Type for…
Specimen Priority	All blocks.
Part Type	All blocks on that part.
Block Category	That block

These are fields that might be referenced in the Label Type rules in the Engraver Label Type Dictionary. For example, in Histology Data Entry/Edit, as soon as you add a block, a label type is assigned. If you then decide to change the Block Category that defaults in for that block, the label type will be reassigned based on this new information, but only if you have specified the Block Category field in the label type rules.

Refer to "Engraver Label Type Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information on specifying label type rules.

How to Reprint Cassette Labels

Access any specimen activity window that has the **Save/Engrave…** button. Press this button to open the Request Cassette Labels window, then select the blocks that need a new cassette labeled. Press **OK** to reprint the cassette labels.

NOTE: If a cassette was already engraved, it should be discarded.

How Editing or Deleting Blocks Affects Requesting Cassette Labels

Typically, cassette labels will be requested before any tissue is cut. The number of cassettes is usually based upon a protocol definition or a user's best guess at how many cassettes will be needed. When the tissue is being cut and the cassettes are being filled, the person doing this may determine that additional blocks (and therefore, cassettes) are needed. How the user adds the blocks into CoPathPlus will affect how the additional cassette labels are requested.

The user may add the additional blocks in the following ways:

1) Add individual blocks.

   The Request Cassette Labels window will select by default only the new blocks (assuming labels were previously requested for the other blocks).

2) Delete the old protocol and run a new protocol.

The Request Cassette Labels window will select by default all the blocks from the new protocol because CoPathPlus effectively deletes all the blocks associated with the old protocol along with their labeled flag. The blocks from the new protocol are considered all new blocks.

For example, suppose you use protocols that are generic to a specific number of blocks, such as "9 Blocks", "10 Blocks", "11 Blocks," etc. Suppose a biopsy normally is nine blocks so you run the "9 Blocks" protocol for it. You request labels for those nine blocks. But, as you are filling the cassettes, you find that you need two more cassettes. If you edit the protocol from "9 Blocks" to "11 Blocks," you will have effectively deleted the nine blocks associated with the "9 Blocks" protocol and their labeled flag while adding 11 new blocks. If you press the **Save/Engrave…** button, the Request Cassette Labels window shows all 11 blocks as selected. You can deselect the first nine blocks leaving the last two blocks (the ones you know are new) selected.

If a part or a block is deleted, all cassette label requests for that part or block will automatically be removed from the label queue and Audit Trail Log.

Requesting Slide Labels

NOTE: A stain must have an assigned label type in order to request a slide label for it. Refer to "Engraver Label Type Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for information on defining slide label types for stains.

Slide labels may be requested when stains are ordered or edited through any of the following CoPathPlus activities:

- Stain/Process Log Verify/Print window
- Details for Scheduling Stain/Process Log Print window
- Various label-related InfoMaker reports

A site may choose to only print paper labels, only engrave slides, or use a combination of both. CoPathPlus supports both types of labels. For example, a site may have a histology lab that services surgical and cytology, and also an autopsy lab that does its own slides. There may be a slide engraver in the histology lab but none in the autopsy lab, so the autopsy lab would still need to use paper labels.

When a request for slide labels is made, the group of stains is added to the engraver label queue as one label request. The Engraver Manager will process together all the slides in a single label request, so that they do not get intermingled with other label requests.

Assigning a Label Type to a Stain

A stain may be created by running a protocol, running stain/process groups, or by a user adding an individual stain. When a stain is ordered, an Engraver Label Type is automatically assigned to it based upon the rules you set in the Engraver Label Type Dictionary.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

A **Label Type** field may also appear on the Stain/Process Detail pop-up window in Histology Data Entry/Edit or Stain/Process and Block Edit. You can use this field to view or change the assigned label type.

CoPathPlus uses whatever label type is associated with a stain when a label is requested for it. Changes to the stain's label type after the request will have no effect on the original request. Stains with no label type are ignored if a label is requested.

NOTE: Stain/Process Dictionary entries that do not have the **Generate Labels** field selected will not be included in any stain/process label request.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Recalculating a Label Type for a Stain

If any of the following window fields are changed, the slide label type *may* be recalculated based upon that change.

Changed Field…	Recalculates Label Type for…
Specimen Priority	All stains.
Part Type	All stains on that part.
Block Category for block assignment	All stains on that block.
Block Assignment	That stain.
Stain Department	That stain.

These are fields that might be referenced in the Label Type rules in the Engraver Label Type Dictionary. For example, in Histology Data Entry/Edit, as soon as you add a stain a label type is assigned. If you then link it to a Block, the label type will be reassigned based on that block's Block Category, but only if you have specified the Block Category field in the label type rules.

Refer to "Engraver Label Type Dictionary" in the "Histology Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual* for more information on specifying label type rules.
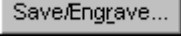
Using the Stain/Process Log Verify/Print Window to Request Slide Labels

NOTE: Cytology departments may not use the Stain/Process Log Verify/Print activity to track completed slides. In this case, InfoMaker reports will have to be used to request labels. Refer to "Using InfoMaker Reports to Request Slide Labels".

The Stain/Process Log Verify/Print window has two buttons for requesting labels.

- **Save/Labels.** Press this button to print **paper labels**. The Print/Send window pops up for selection of a printer. After a printer is selected, a progress message box appears confirming that output is being sent. This button is always visible.

- **Save/Engrave.** Press this button to send requests to an engraver for **engraved slide labels**. A progress message is displayed in the status area at the bottom of the window. This button is only visible if the system setting Enable Slide Engravers is set to Yes.

  NOTE: The **Printed Stains/Processes check box** on the Select Stain/Process Log window refers to the Printed status of a stain/process. The status of a stain/process is changed to Printed when you use the **Save/Engrave, Save/Labels,** and **Save/Print** buttons.

Using the Details for Scheduling Stain/Process Log Print Window to Request Slide Labels

NOTE: Using the Schedule Group Dictionary, you can schedule the Schedule Stain/Process Log Print activity. The window for this activity contains a **Detail** button. Press this button to open the Details for Scheduling Stain/Process Log Print window.

The Details for Scheduling Stain/Process Log Print window includes the option buttons **Engrave Labels** and **Paper Labels**. These let you choose either engraved slide labels or paper slide labels. Selecting **Engrave Labels** causes engraved slide labels to be automatically requested for all stains on the log, and the **Label Output** button will not be enabled. Selecting **Paper Labels**

causes paper slide labels to be automatically requested for all stains on the log, and the **Label Output** button will be enabled and must be selected to identify the printer.

For example, you could schedule the engraving request for all surgical routine stain slides to be daily at 1:00PM. Another department that does not have an engraver may set up a different Schedule Group and request all their routine stain slides to have paper labels printed at 2:00 PM.

For more information, refer to "Schedule Group Dictionary" and "Details for Scheduling Stain/Process Log Print".

NOTE: This feature is only available if the system setting Enable Slide Engraver is set to Yes. If it is turned off, paper labels only are assumed and only the **Label Output** button is visible.

Using InfoMaker Reports to Request Slide Labels

NOTE: All the InfoMaker reports listed below may be accessed by pressing the **Reports** button on the Application Manager, then double-clicking on the Labels folder. The histology reports may also be accessed under the **Tasks** button and Histology Functions folder.

The following InfoMaker reports are used to generate **paper slide labels**:

- Cytology Labels by Order Date
- Cytology Labels by Specimen Number
- Histology Labels by Specimen Number
- Histology Labels by Specimen Number/Part/Block
- Histology Labels by Status

The following InfoMaker reports are used to generate **engraved slide label requests** for a slide engraver (note that they are counterparts to the paper label reports listed above):

- Cytology Engrave Labels by Order Date
- Cytology Engrave Labels by Specimen Number
- Histology Engrave Labels by Specimen Number
- Histology Engrave Labels by Specimen Number/Part/Block
- Histology Engrave Labels by Status

The engraved labels reports have the same selection parameters as those for the paper labels. Here is how they differ:

- The format of the report simply gives you a list of what will be sent to the engraver: specimen number, part/block, stain/process, and label type.
- To send the data to the engraver, select Data from the menu bar and then select Engrave Labels from its drop down menu.
- The Engrave Labels option is only enabled if the system setting Enable Slide Engravers is set to Yes and there is at least one active slide engraver defined in the Engraver dictionary.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- Label requests representing each stain on the report will be sent to the slide engraver. The actual format of what is engraved on the slide is determined by the Engraver Label Format associated with the Engraver Label Type associated with each stain.

NOTE: Cytology departments may not use the Stain/Process Log Verify/Print options to track completed slides. In this case, the InfoMaker reports will have to be used to request labels.

How to Reprint Slide Labels

You may reprint slide labels by using the Stain/Process Log Verify/Print item and selecting Printed Stains/Processes in the Select Stain/Process Log window.

If you want to reprint slide labels for one specimen, use the InfoMaker report called Histology Engraved Labels by Specimen Number or Cytology Engraved Labels by Specimen Number.

How Deleting Parts and/or Blocks, and Canceling Stains Affects Requesting Slide Labels

If a part or block is deleted, or if a stain is canceled, all slide label requests for that part, block, or stain will automatically be removed from the label queue and Audit Trail Log.

Engraver Manager

The Engraver Manager serves two main purposes:

1) It processes label requests for the label types currently linked to the hoppers on the engravers on its workstation.

2) It provides a GUI for users to view the label queue and to change the hopper contents.

The Engraver Manager processing does the following:

- Services multiple engravers simultaneously.

- Processes label requests on a first come, first served basis.

- Processes all the labels in one label request together. Only one label request at a time is processed per engraver, and a label request must finish before another can begin for an engraver. Any block or stain with a label type that is not loaded will remain in the queue.

The Engraver Manager continuously cycles through all the engravers on its workstation, processing a label request for one engraver, then moving on to the next engraver.

For each engraver, the Engraver Manager searches the label queue in the order that the labels were requested. It starts with the first label request where the label type matches a hopper's contents. Any label requests or portions of label requests that cannot be processed (i.e., that don't match) will remain in the queue until a hopper is assigned a matching label type.

The Engraver Manager should run continuously, while the engravers are in operation, on each workstation that hosts one or more engravers. Your site may choose to start it up each morning and close it down each night, or you may choose to keep it running indefinitely, even during periods when nothing is being processed.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

How to Start the Engraver Manager

Follow these steps to start the Engraver Manager:

1) Go to the workstation on which you want to run the Engraver Manager (i.e., make sure you use the workstation that is connected to the correct engravers).

   NOTE: If you start the Engraver Manager on a workstation that has no engravers connected, the Engraver Manager window will simply show no engravers.

2) Make sure the Schedule Manager is running on the workstation. If it is not, start it up. Refer to "Schedule Manager" for instructions.

3) Press **Tasks**, double-click on the Engraver Functions folder, then double-click on the Engraver Manager Startup item. This starts up the Engraver Manager as its own task and then returns you to the Application Manager window. You may continue to do other activities in CoPathPlus or exit out of CoPathPlus. The Engraver Manager will continue to run until it is stopped by you or another user.

4) Press **Tasks**, double-click on the Engraver Functions folder, then double-click on the Engraver Manager item. This opens the Engraver Manager window.

5) Assign label types to the hoppers based on what is physically loaded in the hoppers. The hopper queue statuses will show Hopper Not Started. You will then need to start the queues. Press **Start All** to start all the queues, or select individual hoppers and press **Start**. Refer to "Using the Engraver Manager" for instructions on how to use the fields and buttons on the Engraver Manager window.

Using the Engraver Manager

The Engraver Manager window is the main window you use to process cassette and slide label requests.

The top half of the window lists all the engravers linked to the workstation and the hoppers for each engraver. The bottom half shows the number of each label type in the queue and any label requests currently in progress.

The following paragraphs describe the fields and buttons on the Engraver Manager window.

Engraver column. Lists each engraver connected to the workstation.

Hopper column. Lists each hopper position for each engraver. Hoppers are numbered consecutively 1, 2, etc., starting with the uppermost hopper on the engraver.

Label Type column. Indicates which label type is assigned to each hopper. The value in this column should always reflect the physical setup of the engraver's hopper (i.e., cassettes should only be assigned to cassette hoppers, slides only to slide hoppers). If the label type is Unassigned, the processor will ignore it. This field is disabled when the hopper's status is Running or Stop Requested, or if more than one hopper has been selected.

To edit this field, select the row associated with the hopper and use the **Assign Label Type** field (see below) to select a different label type.

 # Queued column. This number represents the total individual labels waiting to be processed for this hopper's label type and this engraver's department(s).

This number is updated: approximately every two minutes, when a Label Type is assigned to a hopper, and when a label is completed. Or, you can press the **Re_f_resh Stats** button to update it on demand.

Status column. Indicates the current processing status of the hopper's queue:

- **Manager Not Running.** Engraver Manager is not running and needs to be started. Therefore, all hoppers for engravers associated with this Engraver Manager will have this status.

- **Hopper Not Started.** Engraver Manager is running, but processing for this hopper has not been started. When the Engraver Manager is first open, every hopper's status is set to Hopper Not Started. A user must press **Start** or **Start All** to start processing the hoppers.

- **Running.** Processing for this hopper is running.

- **Stop Requested.** A user has requested that processing be stopped on this hopper. The status is set to Stop Requested until CoPathPlus finishes processing the labels that were in progress at the time of the stop request.

- **Stopped by Request.** Processing has been stopped for this hopper at the request of a user.

- **Stopped with Error.** Processing has been stopped for this hopper by CoPathPlus because an error was detected. This shuts down processing on all the hoppers for that engraver because the engraver itself stops processing entirely when an error is detected.

Assign Label Type. Use this field to change the label type that appears in the Label Type column. Highlight the row associated with the hopper above, then select a label type from the drop-down list. If you try to assign a cassette label type to a slide hopper, or a slide label type to a cassette hopper, you will receive an error message. You will also receive an error message if you try to assign the same label type to two different hoppers servicing the same department, regardless of the engraver.

Start button. Select one or more hoppers, then press this button to start processing the hopper queues on the selected hoppers. Use **Ctrl-Click** to add another hopper, and **Shift-Click** to select a range of hoppers.

Start All button. Press this button to start processing hopper queues for all the engravers on this workstation.

Stop button. Select one or more hoppers, then press this button to stop processing the hopper queues on the selected hoppers. Use **Ctrl-Click** to add another hopper, and **Shift-Click** to select a range of hoppers.

Stop All button. Press this button to stop processing hopper queues for all the engravers on this workstation.

NOTE: Pressing either stop button opens the Stop Processing Engraver Hoppers window, which gives you the option to stop processing immediately or let the remaining labels in the request finish printing. Refer to "How to Stop the Engraver Manager" for additional information.

Queue Stats. This window lists all the label types with pending label requests that have a department that matches one of the departments that one of the engravers services. Label Types

with no pending requests will not be listed. (See **# Queued** column above for an explanation of the number.)

In Progress. This window lists which label request is currently being processed on which engraver. Only one label per engraver is processed as any given time.

View Queue… button. Press this button to open the Engraver Manager Queue/Log. Refer to "Viewing the Engraver Manager Queue/Log" for details.

Refresh Stats button. Press this button to immediately update the number of labels in the **# Queued** column with the latest label requests.

How to Reload or Change the Contents of an Engraver Hopper

If you need to stop a hopper to reload it or change its contents, you must first stop processing on that hopper. Follow these steps:

1) Go to the workstation on which the Engraver Manager is running.

2) On the Engraver Manager window, select the hopper and press Stop. Wait until the hopper's status becomes Stopped by Request.

3) Load the hopper with the appropriate cassettes or slides.

4) If the cassette type or slide type was changed, select the hopper on the Engraver Manager window and edit the Assign Label Type field accordingly.

5) Press Start.

Refer to "Using the Engraver Manager" for more information.

Engraver Manager Error Handling

The most common engraver errors are jams and empty hoppers. When such errors occur, some engravers goes off-line and its error light goes on. Unfortunately, some engravers currently do not supply specific error information in its interface communication. Therefore, CoPathPlus must make its best interpretation of an error situation. Here is how it works and what to expect:

- When CoPathPlus sends a label request to the engraver, it waits for a response from the engraver before continuing on to the next label request for that same engraver.

- The engraver's response mirrors back the same communication string that CoPathPlus sent. All this means is that the engraver received the string. There is no feedback relative to the integrity of the communication, or to whether or not the engraver will be able to process the string.

- CoPathPlus will continue to wait for a response for a period of time. If this time period expires without a response, CoPathPlus assumes that an error has occurred and does the following:

  ♦ Stops the processing on all of that engraver's hoppers.

  ♦ Paints the background of the Engraver Manager red so that the user is alerted visually.

  ♦ Marks the requested label's status as Error.

What happens next depends upon how quickly the engraver is cleared of the error and put back online, and/or how soon the next label request is sent by CoPathPlus.

Example 1: The engraver error is cleared immediately:

1) CoPathPlus sends a label request for block A to the engraver.

2) The engraver returns a response that it received the request, so CoPathPlus sends its next label request for block B.

3) The engraver determines that there is a jam or an empty hopper, goes off-line and turns on its error light.

4) Meanwhile, CoPathPlus is waiting for a response to its label request for block B.

5) The user fixes the engraver and puts it back online before CoPathPlus times out.

6) The engraver engraves block A's cassette.

7) The engraver returns a response about block B to CoPathPlus.

8) The engraver engraves block B's cassette.

9) CoPathPlus moves on to the next request.

Example 2: The user does not fix the engraver error immediately:

1) CoPathPlus sends a label request for block A to the engraver.

2) The engraver returns a response that it received the request, so CoPathPlus sends its next label request for block B.

3) The engraver determines that there is a jam or an empty hopper, goes off-line and turns on its error light.

4) Meanwhile, CoPathPlus is waiting for a response to its label request for block B.

5) CoPathPlus continues to wait and finally times out. It marks the label request for block B as Errored and stops all the hoppers.

6) The user fixes the engraver and puts it back online after CoPathPlus times out.

7) The engraver engraves block A's cassette.

8) The engraver engraves block B's cassette (because the request is still in the queue).

9) Using CoPathPlus, the user starts up the processing on the engraver's hoppers.

10) The first label request that CoPathPlus will try to send is the one it errored out on, block B. It sends this request to the engraver.

11) The engraver returns a response that it received the request (for block B).

12) The engraver engraves the cassette (again) for block B.

Note that in this example, there were two cassettes engraved for the same block.

Guidelines for Error Recovery:

1) The user determines that there is an error either by seeing the red error light on the engraver, or by seeing the red window on the Engraver Manager.

2) The user determines which engraver has the problem either by seeing the red error light on the engraver, or by looking on the Engraver Manager for an engraver with hopper status(es) of Stopped with Error.

3) The user clears the problem and sets the engraver back online.

4) The user uses the Engraver Manager to select the engraver's hoppers, then presses **Start**.

5) The user watches while the next few cassettes or slides are labeled and discards any that are redundantly labeled.

Viewing the Engraver Manager Queue/Log

The Engraver Manager Queue/Log is accessed by pressing the **View Queue…** button from either the Engraver Manager window or the Engraver Inquiry window. Refer to "Using the Engraver Manager" and "Using the Engraver Inquiry Window".

The Engraver Manager Queue/Log shows the label queue for all engravers attached to a workstation. The upper left portion of the window shows the queue, arranged in column format. Each row represents one label. The lower left portion shows read-only details for the specific label you select in the top portion of the window. The right portion of the window contains selection criteria you use to determine which labels are shown in the queue.

The following paragraphs describe the fields and buttons on the Engraver Manager Queue/Log window.

Selection criteria. Use the following check boxes and fields to refine the list of labels that appear in the queue:

- **Include.** Select the label status(es) you want displayed in the queue (the defaults are Queued and Error).

  o **Queued.** Label is in the label queue, but has not been sent to the engraver yet.

  o **Labeled.** Label was successfully sent to the engraver. (Whether or not the label was actually printed by the engraver is *not* communicated back to CoPathPlus.)

  o **Error.** Engraver Manager detected an error message from the engraver for the label.

  o **Canceled.** User canceled the label.

- **Queued From/Queued To.** These dates refer to the date and time the label was put into the label queue. Defaults are from 24 hours ago to now.

Queue display area. These columns show information about each label in the queue.

- **Status.** The first character of the label status (see **Include** above for a description of each status).

- **Date Queued.** The date and time the label was put in the queue.

- **Dept.** For blocks, this is the specimen's accession date. For stains, this is the processing department.

- **Label Type.** The label type (e.g., Red Cassette, Green Slide).

- **Specimen #.** The specimen number.

- **Part.** Part designator (e.g., number).

- **Block.** Block designator (e.g., letter).

- **Stain.** Stain abbreviation.

- **Engraver.** The engraver the label was processed on.

- **Req #.** The number given to the label request.

- **Req Inst.** The sequential number assigned to the label within the request.

NOTE: To change the order of the columns, the order in which they are sorted, or the width of the columns, refer to "What is the CoPathPlus Environment Like?".

Status display area. These display-only fields show status information about the label selected in the queue display area.

- **Status.** The status of the label.

- **Status Date/Time.** The date and time the label was put in the queue.

- **Status Info:.** Error information supplied by the engraver (when available).

- **Requested By.** The user who requested the label.

Refresh button. Press this button to update the queue/log display. If you change any of the **Include** statuses, or the **Queued From/Queued To** dates, you must press this button for the changes to take effect.

Cancel Label button. Select one or more labels, then press this button to stop processing the labels. Use **Ctrl**-**Click** to add another label, and **Shift**-**Click** to select a range of labels.

How to Stop the Engraver Manager

There are two ways to stop the Engraver Manager:

1) Remotely, using the Session Maintenance activity. Refer to "Session Maintenance" for instructions on how to shut down a session. The Engraver Manager will close after all hopper queues have stopped.

2) Directly, using the Engraver Manager window. On the window, press **Stop All** to stop all the hopper queues, or select individual hopper queues and press **Stop**.

   Regardless of which stop button you press, the Stop Processing Engraver Hoppers window opens, as shown below.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

If you press **Stop** <u>Now</u>, processing will stop immediately for all the queues you selected on the Engraver Manager window. Any remaining labels will not be printed.

If you press **Stop**, processing will stop after the last label in the current request has been printed for all the queues you selected on the Engraver Manager window. A "Shutdown in Progress" message will appear in the data window while the remaining labels are completed.

As an example, if the current label request had 10 labels and three have already been processed, then there are seven labels remaining. Typically, if something is wrong with the engraver or the hopper is empty, you want to use **Stop** <u>Now</u>. If you want to stop because you are getting ready to take a break, use **Stop** and let the remaining seven labels finish printing.

Refer to "Using the Engraver Manager" for additional information.

NOTE: Once the Engraver Manager has stopped, each engraver's hopper(s) will be listed in the Engraver Inquiry window with a status of Manager Not Running.

Engraver Inquiry

The Engraver Inquiry window lets you view the current processing status for all engravers at your site. You can access the Engraver Inquiry window from any workstation.

Accessing the Engraver Inquiry Window

To access the Engraver Inquiry window:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Engraver Functions folder.

   A list of items appears under the Engraver Functions folder.

3) Double-click on the Engraver Inquiry item.

   The Engraver Inquiry window appears.

TIP! You can also access the Engraver Inquiry window by placing it in your Personal Menu and double-clicking on it from there.

Using the Engraver Inquiry Window

Use the Engraver Inquiry window to view status information about all the engravers used at your site.

The Engraver Inquiry window displays the same information as the Engraver Manager, but with the following exceptions:

- You can access the Engraver Inquiry window from any workstation, even one that does not have an attached engraver.

- The window shows *all* engravers, regardless of which workstation they are connected to.

- The window shows all label requests, regardless of their department.

- The window does not show the In Progress data.

- The window is read-only.

- The **View Queue…** and **Refresh Stats** buttons work the same as on the Engraver Manager. This means that you *can* cancel labels from the Engraver Inquiry activity. Press **View Queue…** to open the Engraver Manager Queue/Log window, then use that window's **Cancel Label** button. Refer to "Viewing the Engraver Manager Queue/Log" for details.

For a description of the columns and buttons on the Engraver Inquiry window, refer to "Using the Engraver Manager".

Engraver Workstation Reset

The Engraver Workstation Reset window should be used when a workstation running an Engraver Manager has crashed and cannot be used to restart the Engraver Manager and labeling needs to be rerouted to another workstation's engraver.

NOTE: We recommend that only your system manager be given permission to perform this activity.

Accessing the Engraver Workstation Reset Window

To access the Engraver Workstation Reset window:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Engraver Functions folder.

   A list of items appears under the Engraver Functions folder.

3) Double-click on the Engraver Workstation Reset item.

   The Engraver Workstation Reset window appears.

TIP! You can also access the Engraver Workstation Reset window by placing it in your Personal Menu and double-clicking on it from there.

Using the Engraver Workstation Reset Window

Use the Engraver Workstation Reset window to reroute labeling from a crashed workstation's engraver to another workstation's engraver.

You must select the workstation to be reset. CoPathPlus will prompt you for confirmation of your selection. It will then reset the following fields for all hoppers on all engravers linked to the crashed workstation:

1) Resets the status to Engraver Not Running.

2) Resets the label type to Unassigned. This allows you to assign the label types to another engraver for the same department.

Do *not* reset a workstation that is actively running an Engraver Manager.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Histology Functions

This topic details the Processing Batch Edit/Compile and Stain/Process Log Print/Verify items in CoPathPlus. It explains how to use both items to keep track of blocks and stains as they are being processed in the Histology Lab (or wherever histology is performed at your site).

Processing Batch Edit/Compile allows you to edit and verify the contents of an existing tissue processing batch or compile and print a new batch/log.

Stain/Process Log Verify/Print allows you to print a log and/or labels for pending stains/processes or verify and edit outstanding stains/processes.

Your site can schedule the generation of histology tissue batches and stain/process logs through the Schedule Manager. For example, for histology tissues batches, your site might find it useful to schedule a tissue batch compilation to coincide with the normal start time for your lab's tissue processor. The next day, your lab staff can compare the blocks and make any additions and/or deletions to the logs. For stain/process logs, your site may schedule a compilation of a list of new stain orders and associated labels for printing first thing in the morning for all items ordered since the last compile after the tissue processing batch for the day would have been edited and verified. To help your lab staff keep track of new work during the day, you can schedule another compilation for later in the day that would print logs and labels of only new (and not previously printed) stains.

Notice that while you can access the Histology Data Entry/Edit and Stain/Process and Block Edit activities within the Histology Functions folder, you can also access them under the **Specimens** command button.

The following logs and labels are also found within the Histology Functions folder.

- Block/Stain Recut Log
- Histology Labels by Specimen Number
- Histology Labels by Spec#/Part/Block
- Histology Labels by Status
- Histology Engraver Labels by Specimen Number
- Histology Engraver Labels by Spec#/Part/Block
- Histology Engraver Labels by Status
- Histology Stain/Process Log
- Tissue Processing Batch Log

Processing Batch Edit/Compile

Processing Batch Edit/Compile allows you to edit, verify, compile, and print tissue processing batch logs. When you compile a tissue processing batch log you are simply creating a list of

blocks that are scheduled to be processed in a given run of the tissue processor. Tissue processing batch logs are used to:

- Make sure all the necessary blocks are included in a given run of the tissue processor.
- Verify which blocks have been successfully desiccated in the tissue processor.
- Make appropriate adjustments for blocks that were not successfully processed.

Processing Batch Edit/Compile consists of several different windows, depending on the option you choose to perform.

Accessing the Processing Batch Edit/Compile Item

To access Processing Batch Edit/Compile:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Histology Functions folder.

   A list of items appears under the Histology Functions folder.

3) Double-click on the Processing Batch Compile/Edit item.

   The Select Tissue Processing Batch window appears.

Select Tissue Processing Batch Window

Unlike most CoPathPlus activities and items that present one Select window when you access an activity or item, Processing Batch Edit/Compile consists of two distinctly different Select Tissue Processing Batch windows depending on the option you choose to perform.

In the initial appearance of the Select Tissue Processing Batch window (i.e., when you first access Processing Batch Edit/Compile), CoPathPlus presents the window with the Edit an Existing Tissue Processing Batch option selected. As it implies, this option allows you to edit an existing tissue processing batch.

Perform the following steps on the Select Tissue Processing Batch window if you want to edit an existing tissue processing batch:

1) Select an existing tissue processing batch from the list presented.

2) Press **OK**.

   The Edit Tissue Processing Batch window appears.

To complete this option, refer to "Using the Edit Tissue Processing Batch Window".

However, if you select the Compile a New Tissue Processing Batch option instead, a different Select Tissue Processing Batch window appears.

Perform the following steps on the Select Tissue Processing Batch window if you want to compile a new tissue processing batch:

1) Select one department for which you want to compile a tissue processing batch from the Select a Department field. Note that if more than one department appears, the list appears in alphabetical order.

2) Select a block category for the chosen department from the Select one or more Block Categories field. In combination with the mouse and the keyboard, you can use Shift+Click to select more than one block category at a time.

3) Enter any comment that you want to describe this tissue processing batch log in the Comment field.

   `NOTE:  After you compile this batch (by using the Compile a New Tissue Processing Batch Window), this comment will appear on the Select Tissue Processing Batch window when you select the Edit an Existing Tissue Processing Batch option.`

4) Press **OK**.

   The Compile a New Tissue Processing Batch window appears.

Using the Compile a New Tissue Processing Batch Window

The Compile a New Tissue Processing Batch window allows you to compile a new tissue processing batch for the department/block category (or categories) you chose on the Select Tissue Processing Batch window.

The data on the Compile a New Tissue Processing Batch window sorts by block status, block category, specimen number, part, and block.

Use the Compile a New Tissue Processing Batch window as follows:

NOTE: CoPathPlus does not enable the **Verify**, **Add Block(s)**, **Move Block(s)**, and **Mark Missing** buttons because they are not relevant to the compile option for the Processing Batch Edit/Compile item.

List on the display area. Select a batch (or batches) by clicking on a block category, a specimen, a part, or a block to select the associated blocks. This list displays the blocks for this tissue processing log by specimen number. You may click on individual blocks for selection or use Control-click or Shift-click according to standard window conventions. This feature also offers several buttons across the bottom of the screen to facilitate movement as well as batch item selection within the Tissue Processing display.

Use the **Next Category** button to quickly move to the first block of each subsequent category in the retrieved batch. When the focus is on the last category in the batch, pressing the Next Category button will return the focus to the first category in the batch. CoPathPlus will highlight the first block in each category when this button is used.

If you press the:

- **Select All** button, CoPathPlus will highlight all blocks retrieved in the Tissue Processing Batch.

- **Select Category** button, CoPathPlus highlights all the blocks for the category currently under focus.

- **Select Specimen** button**,** CoPathPlus highlights all blocks for the specimen currently under focus.

- **Select Part** button**,** CoPathPlus highlights only the blocks for that part currently under focus.

- These buttons work in conjunction with the Control and Shift keys to select individual blocks as well as to select multiple categories, specimens, and/or parts.

- To select:

- **A single Block**, click on that block individually.

- **Multiple, specific Blocks,** hold down the control key while clicking on each desired block in turn.

- **Multiple, sequential Blocks**, click either the first block and then hold down the shift key while clicking on the last block. Alternately, click on the last block and then hold down the shift key while clicking on the last block.

- **Multiple Parts**, select the first part and then hold down on the control key while selecting any block of the next desired part. Use the Select Parts button to have CoPathPlus select the rest of the blocks assigned to that part for you.

- **Multiple Specimens**, select the first specimen and then hold down on the control key while selecting any block of the next desired specimen. Use the Select Specimens button to have CoPathPlus select the rest of the blocks assigned to that specimen for you.

- **Multiple Categories**, select the first category and then hold down on the control key while selecting any block of the next desired category. Use the Select Category button to have CoPathPlus select the rest of the blocks assigned to that category for you.

  Note: You may "mix and match" your selections. For example, even if you already selected a category, you may then use Control plus Select Specimens to also select all block from a specific specimen from a different category.

TIP! Anytime you individually click on any element within the Tissue Processing Batch display without holding down the control key, you will deselect all previous selections.

Unselecting rows may be accomplished via:

- Selecting an individual row unselects all others unless the Control key is held down.

- Using any of the group selection buttons (Select Category, Select Specimen, or Select Part) without holding down the Control key will unselect everything else.

Select Batch button. Press this button if you want to select another tissue processing batch. CoPathPlus returns you to the Select Tissue Processing Batch window.

Using the Edit Tissue Processing Batch Window

The data on the Edit Tissue Processing Batch window sorts by block status, block category, specimen number, part, and block.

Use the Edit Tissue Processing Batch window as follows:

List on the display area. Select a batch (or batches) by clicking on a block category, a specimen, a part, or a block to select the associated blocks. This list displays the blocks for this tissue processing log by specimen number. If you select a:

- **Block category**, CoPathPlus highlights all the blocks for that category.

- **Specimen**, CoPathPlus highlights only the blocks for that specimen.

- **Part**, CoPathPlus highlights only the blocks for that part.

- **Block**, CoPathPlus highlights only the chosen part.

TIP! You can use Ctrl+Click to deselect individual blocks as needed.

Select Batch button. Press this button if you want to select another tissue processing batch. CoPathPlus returns you to the Select Tissue Processing Batch window.

Remove button. Press this button to remove the selected block(s) from the current tissue processing batch. CoPathPlus does this immediately, though you must still press **Save** to keep your changes. Removed blocks become eligible for inclusion on batch logs compiled at a later time.

Verify button. Press this button to mark the selected block(s) as verified. CoPathPlus then changes their status from "On Batch" to "Verified". CoPathPlus does this immediately, though you must still press **Save** to keep your changes.

Add Block(s) button. Press this button to open the Add Block(s) pop-up window, which lets you select the block(s) to add to this tissue processing batch.

Move Block(s) button. Press this button to open the Move Block(s) pop-up window, which lets you select another tissue processing batch to move the selected block(s) from this tissue processing batch to.

Mark Missing button. Press this button to mark the selected blocks as missing. CoPathPlus then lists them separately at the end of the current tissue processing batch log. CoPathPlus does this immediately, though you must still press **Save** to keep your changes.

Save/Print button. Press this button to save your changes to this tissue processing batch and then print the Tissue Processing Batch log for this batch. The Print/Send Setup pop-up window appears.

TIP! You can also print out this log (for one or more batches) when you are not on the Edit Tissue Processing Batch window by accessing the Tissue Processing Batch Log item within the Histology Functions folder found under the **Tasks** command button or within the Logs folder found under the **Reports** command button.

Save button. Press this button to save your changes to this tissue processing batch.

Close button. Press this button to close the Edit Tissue Processing Batch window. Respond as appropriate when CoPathPlus asks if you want to save your changes.

Add Block(s)

When you press **Add Block(s)…**, the following pop-up window appears. It allows you to select blocks from cases that were accessioned without histology details yet entered or blocks that were previously removed from the current tissue processing batch. These blocks may be added to the current tissue processing batch log.
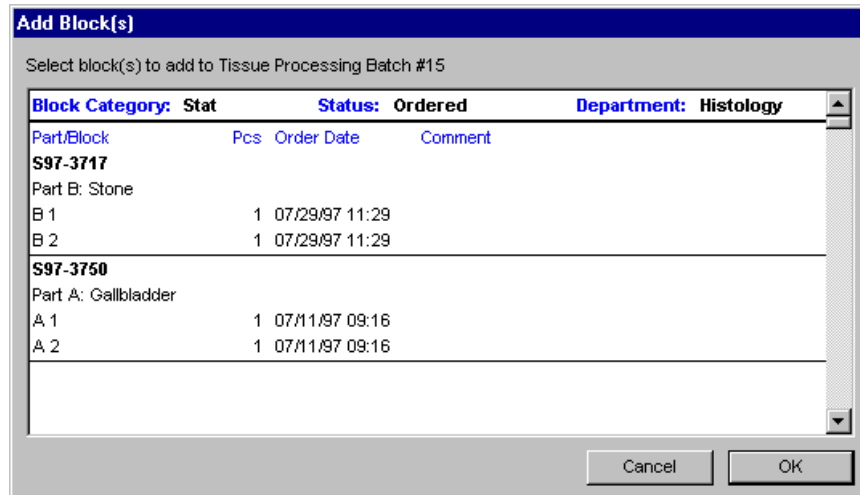
For example, you would perform the following steps if you wanted to add blocks from the Add Block(s) pop-up window for Tissue Processing Batch #29 back onto the Edit Tissue Processing Batch #29 window:

1) Press **Add Block(s)** on the Edit Tissue Processing Batch #29 window.

   The Add Block(s) pop-up window appears, which lists the blocks you can add back to Batch #29.

2) Select the blocks you want to add to Edit Tissue Processing Batch #29.

3) Press **OK**. CoPathPlus automatically removes the selected blocks from the Add Block(s) pop-up window and returns you to the Edit Tissue Processing Batch #29 window, at the point on which it added the blocks you selected.

4) Press **Save** (or **Save/Print**) on the Tissue Processing Batch #29 window to save your changes.

NOTE: To be able to add blocks, they have to be eligible for the current tissue processing batch (i.e., they must contain a block category or categories of the blocks being added). Ineligible blocks do not appear in the Add Block(s) pop-up window.

Move Block(s)

When you press **Move Block(s)…**, the following pop-up window appears. It allows you to select which tissue processing batch you want to deposit the block(s) you select to move.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
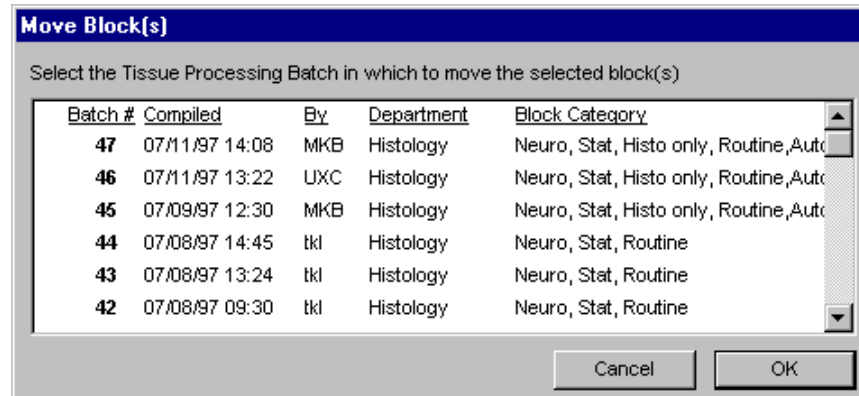
For example, you would perform the following steps if you wanted to move all of the blocks for S97-1168 from Tissue Processing Batch #16 to Tissue Processing Batch #15:

1) Select the blocks for S97-1168 on the Edit Tissue Processing Batch #16 window.

2) Press <u>M</u>ove Block(s)….

   The Move Block(s) pop-up window appears.

3) Select the Batch #15 row on the Move Block(s) pop-up window.

4) Press **OK**. CoPathPlus automatically removes the blocks and returns you to the Edit Tissue Processing Batch #16 window.

5) Press **<u>S</u>ave** (or **Save/<u>P</u>rint**) on the Tissue Processing Batch #16 window to save your changes.

NOTE: To be able to move blocks, they have to be eligible for the current tissue processing batch (i.e., they must contain a block category or categories of the blocks being moved). You will only see eligible batch numbers in the Move Block(s) pop-up window.

Stain/Process Log Verify/Print

Stain/Process Log Print/Verify allows you to edit and/or verify outstanding stains/processes and print a log and/or labels for pending stains/processes. Stain/process logs differ from tissue processing batch logs in that they are "rolling" logs. This means that stain/process logs include all outstanding work to be done. They are not "batched" and therefore will not have a batch number.

You can print stain/process logs at any time and include any stain/processes ordered to date. You should print these logs just after editing tissue processing batch logs to see current block status information.

Accessing the Stain/Process Log Print/Verify Item

To access Stain/Process Log Print/Verify:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

2) Double-click on the Histology Functions folder.

A list of items appears under the Histology Functions folder.

3) Double-click on the Stain/Process Log Print/Verify item.

The Select Stain/Process Log window appears.

Note: If the Stain/Process Log Verify/Print activity is already open, an error message will appear displaying the information for the user who has the activity open. The error message also offers a retry option.

Select Stain/Process Log Window

CoPathPlus presents the Select Stain/Process Log window when you select the Stain/Process Log Verify/Print item. From this window you can select a particular portion of the stain/process log for which you want to edit, verify, or print.

Perform the following steps to use the Stain/Process Log Verify/Print window:

1) Select the:

o **Printed Stains/Processes** checkbox if you want to verify and print stains/processes that have already been printed. CoPathPlus will display a list of blocks and their associated specimen numbers on which stains and processed have been ordered. Items on this log were previously viewed or printed. By selecting Printed Stains/Processes you can view or print the log again and verify histology work that has been completed.

o **New Stains/Processes** checkbox if you want to verify and print new stains/processes. CoPathPlus will display a list of blocks and their associated specimen numbers on which stains and processes have recently been ordered. You can use this list to identify pending staining and processing work. Once you save this list or any changes made to it, the stain/process orders listed on it are no longer considered new and will not appear on a subsequent log of new stains/processes.

o Both check boxes if you want both types.

2) Enter an optional status date search in the From and To Status date fields. The date and time needs to be entered in the following format: x/x/xxxx x:xx, for example 1/1/2000 00:00. If you leave this blank the system will search for all dates.

3) Select one department for which you want to select a stain/process log from the Select a Department field. Note that if more than one department appears, the list appears in alphabetical order.

4) Select a stain/process category for the chosen department by highlighting it on the Select one or more Stain/Process Categories field. In combination with the mouse and the keyboard, you can use Shift+Click to select more than one block category at a time.

The Stain/Process Log Verify/Print window appears.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Using the Stain/Process Log Verify/Print Window

Once you have selected a particular stain/process log to work with in the Select Stain/Process Log window, that log appears in the Stain/Process Log Verify/Print window. Usually you will first print your logs and/or labels (by pressing **Save/La<u>b</u>els** or **Save/<u>P</u>rint**). Then you would select one or more stain/process orders that you want to edit and verify.

The data on the Stain/Process Log Verify/Print window sorts by stain status, stain/process category, specimen number, part, and stain/process.

Use the Stain/Process Log Verify/Print window as follows:

List on the display area. This list displays the stains/processes for this stain/process log by specimen number. The top of this list displays the stain/process category, status of "Printed" (i.e., what it will be after the stains/processes are printed), and the department. Since the log print/verify activity is designed to be a "take action" activity, the status is displayed as it will become upon the logical completion of the activity. Thus the status "Printed" displays at the top of the log although the stains/processes included on the log are not necessarily printed yet.

You may click on an individual stain/processes for selection or use Control-click or Shift-click according to standard window conventions. This feature also offers several buttons across the bottom of the screen to facilitate movement as well as batch item selection within the Stain/Process Log Verify/Print display.

Use the **Next Category** button to quickly move to the first stain or process of each subsequent category in the retrieved batch. When the focus is on the last category in the batch, pressing the Next Category button will return the focus to the first category in the batch. CoPathPlus will highlight the first stain or process in each category when this button is used.

If you press the:

- **Select All** button, CoPathPlus will highlight all stain/processes retrieved in the Stain Process Log batch.

- **Select Category** button**,** CoPathPlus highlights all the stain/processes for the category currently under focus.

- **Select Specimen** button**,** CoPathPlus highlights all the stain/processes for the specimen currently under focus.

- **Select Part** button**,** CoPathPlus highlights only the stain/processes for that part currently under focus.

- These buttons work in conjunction with the Control and Shift keys to select individual stains or processes as well as to select multiple categories, specimens, and/or parts.

- To select:

- **A single Stain or Process**, click on that item individually.

- **Multiple, specific Stain or Process,** hold down the control key while clicking on each desired item in turn.

- **Multiple, sequential Stain or Process**, click either the first item and then hold down the shift key while clicking on the last item. Alternately, click on the last item and then hold down the shift key while clicking on the last item.

- **Multiple Parts**, select the first part and then hold down on the control key while selecting any block of the next desired part. Use the Select Parts button to have CoPathPlus select the rest of the blocks assigned to that part for you.

- **Multiple Specimens**, select the first specimen and then hold down on the control key while selecting any stain or process of the next desired specimen. Use the Select Specimens button to have CoPathPlus select the rest of the stain/processes assigned to that specimen for you.

- **Multiple Categories**, select the first category and then hold down on the control key while selecting any stain or process of the next desired category. Use the Select Category button to have CoPathPlus select the rest of the stain/processes assigned to that category for you.

    Note: You may "mix and match" your selections. For example, even if you already selected a category, you may then use Control plus Select Specimens to also select all stain/processes in a specific specimen from a different category.

TIP! Anytime you individually click on any element within the Stain/Process Log Verify/Print display without holding down the control key, you will deselect all previous selections.

Unselecting rows may be accomplished via:

- Selecting an individual row unselects all others unless the Control key is held down.

- Using any of the group selection buttons (Select Category, Select Specimen, or Select Part) without holding down the Control key will unselect everything else.

TIP! You can use Ctrl+Click to deselect individual blocks as needed. If the list is blank, make sure you have selected both a department and at least one stain/process category on the Select Stain/Process Log window.

Select Log button. Press this button if you want to select another stain/process log. CoPathPlus returns you to Select Stain/Process Log window.

Remove button. Press this button to remove the selected stain(s)/process(es) from this stain/process log. CoPathPlus then changes their status from "Printed" to "Ordered". CoPathPlus does this immediately, though you must still press **Save** to keep your changes.

Verify button. Press this button to mark the selected stain(s)/process(es) as verified. CoPathPlus then changes their status from "Ordered" to "Verified". CoPathPlus does this immediately, though you must still press **Save** to keep your changes.

Mark Canceled button. Press this button to mark the selected stain(s)/process(es) as canceled. CoPathPlus then changes their status from "Ordered" to "Canceled". CoPathPlus does this immediately, though you must still press **Save** to keep your changes.

Save/Labels button. Press this button to save this stain/process log and then print all paper slide labels for new stains/processes. The Print/Send Setup pop-up window appears.

TIP! You can also print labels for both new and previously printed stains/processes by accessing the Histology Labels by Status item within the Histology Functions folder found under the **Tasks** command button or within the Labels folder found under the **Reports** command button.

NOTE: If your site is set up to use a labeler, you will also see a **Save/Engrave…** button on this window. Pressing the button causes engraved slide labels (i.e., labels etched onto the glass of the slide itself) to be automatically requested for all stains on the log. Refer to "Requesting Slide Labels" for more information on engravers and labels.

Save/<u>P</u>rint button. Press this button to save this stain/process log and then print the associated Histology Stain/Process Log for this log. The Print/Send Setup pop-up window appears.

TIP! You can also print out this log (for one or more batches) when you are not on the Stain/Process Log Verify/Print window by accessing the Histology Stain/Process Log item within the Histology Functions folder found under the <u>**Tasks**</u> command button or within the Logs folder found under the <u>**Reports**</u> command button.

S<u>a</u>ve button. Press this button to save any changes you may have made to this stain/process log.

Close button. Press this button to close the Stain/Process Log Verify/Print window. Respond as appropriate when CoPathPlus asks if you want to save your changes.

Patient/Specimen Merge/Move/Delete

This topic describes the Patient Merge/Encounter Move and Specimen Move/Delete items in CoPathPlus.

- Duplicate Patient Processing lets you review all patient records that CoPathPlus has flagged as possible duplicates, and then either merge the records or mark them as not duplicates.

- Patient Merge/Encounter Move lets you combine information from two patient records into a single patient record if both records contain information for the same patient, move encounter information and all of the encounter's associated specimens to a different patient record, and mark two patient records as not duplicates.

- Specimen Move/Delete lets you move a specimen from one patient record to another or delete specimens when necessary.

The following reports are also found within the Patient/Specimen Merge/Move/Delete folder.

- Duplicate Patient Review Report

- Non-Duplicate Patient Report

- Patient Delete Log

- Patient Merge/Move Log

- Specimen Delete Log

- Specimen Move Log

Duplicate Patient Processing

During Patient Registration and New Specimen entry, CoPathPlus checks for the existence of duplicate patient records. This occurrence is automatic in the Patient Registration function and is enabled via a site-defined system setting for the New Specimen Entry process. Each suspected duplicate record can be saved in the Duplicate Patient Log so that you can later review the records and determine those that are duplicates and should be merged and those that are not duplicates. The Duplicate Patient Processing item lets you merge duplicate patient records or indicate that a patient record is not a duplicate.

For more information about how CoPathPlus checks for duplicate patient records, refer to "Duplicate Patient Checking".

Duplicate Patient Reports

Two reports are available for reviewing and managing duplicate patient record information:

- Duplicate Patient Review Report. Lists patient records that have been added to the Duplicate Patient Log.

- Non-Duplicate Patient Report. Lists patient records marked as not duplicates via the Duplicate Patient Processing or Patient Merge/Encounter Move items.

Accessing Duplicate Patient Processing

To access Duplicate Patient Processing:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Patient/Specimen Move/Merge/Delete folder.

A list of items appears under the Patient/Specimen Move/Merge/Delete folder.

3) Double-click on the Duplicate Patient Processing item.

The InfoMaker Wizard for Duplicate Patient Processing window appears.

4) Select the date range, user(s), and workstation(s) for which you want to process duplicate patient records. Instructions for using this window appear in Running the Management Reports.

5) Press **OK**. The Duplicate Patient Processing window appears.

TIP! You can also access the Duplicate Patient Processing item by placing it in your Personal Menu and double-clicking on it from there.

Entering Information on the Duplicate Patient Processing Window

If there are no duplicate patient records for the selection criteria you entered, a message appears informing you of that. Otherwise, the Duplicate Patient Processing window lists all "base" patients (i.e., the patient record being accessed when CoPathPlus found a possible duplicate record), followed by all possible duplicate records for that base patient.
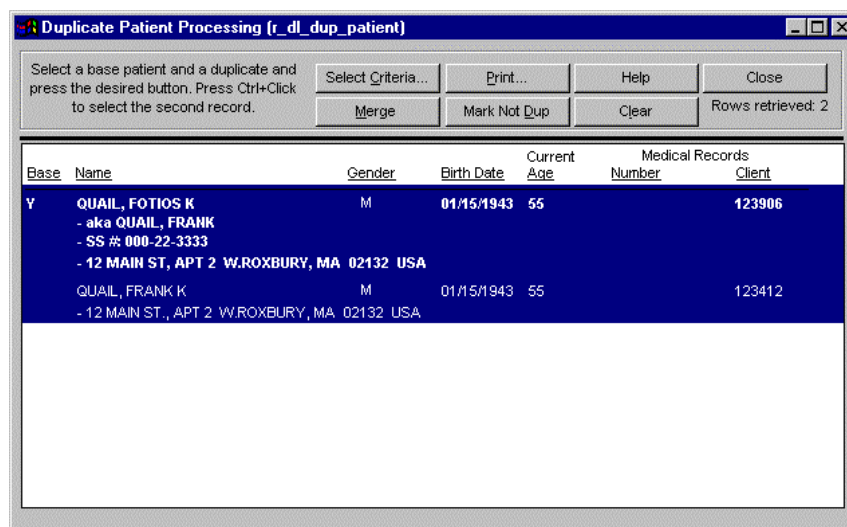
Enter the following information on the Duplicate Patient Processing window:

1) Select the two patient records that you want to process. To select the first record, highlight it. To select the second record, hold down Ctrl and left-click on the record. One of the records selected must be a base patient record, and the other record must be a possible duplicate for that base patient.

   After a base patient record and possible duplicate record are selected, the **Merge** and **Mark Not Dup** buttons become enabled.

2) **Merge button**. Accesses the Patient Merge/Encounter Move window. Use that window to view more information about the patient records such as related encounters and cases, and then either merge the records or mark them as not duplicates. For instructions on how to use this window, refer to "Entering Information on the Patient Merge/Encounter Move Window".

3) **Mark Not Dup button**. Lets you confirm that the patient records are not duplicates.

4) To mark the patient records as not duplicates, press **OK**. To cancel this action, press **Cancel**. Once you mark patient records as not duplicates, they are removed from this window and no longer flagged as possible duplicates within this item.

5) **Clear button**. Lets you deselect all highlighted records.

NOTE: The remaining buttons on this window (i.e., **Select Criteria…**, **Print…**, **Help**, and **Close**) are standard for all InfoMaker Wizard reports. For information about these buttons, refer to "Viewing and Printing the Management Reports".

After you merge two records or mark them as not duplicates, they are removed from the Duplicate Patient Log. Records in the Duplicate Patient Log that are not processed within a set number of days (as specified in the Purge Dictionary) are purged from the log. For more information about setting the number of days after which to purge unprocessed records from the Duplicate Patient Log, refer to the "Purge Dictionary" in the "Setup" section of the *Cerner CoPathPlus System Manager Guide*.

NOTE: The Data Menu and the toolbar for the Duplicate Patient Processing item contain some commands and buttons that are only available for items that utilize the InfoMaker Wizard. For instructions on how to use these commands and buttons, refer to "Data Menu Commands".

Patient Merge/Encounter Move

Sometimes a specimen is incorrectly assigned to the wrong patient and encounter, or the same patient is mistakenly registered twice in CoPathPlus. You can use the Patient Merge/Encounter Move item to straighten out mistakes of this kind. This item allows you to merge two patient records or to move encounters (and all their associated specimens) from one patient record to another. It also lets you mark suspected duplicate patient records as not duplicates so that the Duplicate Patient Warning window will not appear for those records during future activities.

To move or delete individual specimens, refer to "Specimen Move/Delete". To delete a patient record, refer to "Deleting a Patient Record".

NOTE: You can delete a patient record from CoPathPlus only if that record does not have any associated specimens or encounters.

You can also run and print these InfoMaker reports that summarize all the patient merges, moves, deletions, and non-duplicate designations that were performed within a user-specified date range or for a single patient or specimen:

- Patient Merge/Move Log

- Patient Delete Log

- Non-Duplicate Patient Report

Restrictions on Merging Patients or Moving Encounters

There are a number of requirements that must be met before you can merge patients or move encounters:

- **Security Access.** You must have permission set up in the Person Dictionary to move or delete specimens. Refer to "Person Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

- **Encounter Does Not Contain QA-Related Specimens.** The encounter that you are moving cannot contain any specimens that are QA-related to any other specimen in CoPathPlus.

- **Specimen or Patient is Locked.** No other user in CoPathPlus can be working on either a patient you are merging or any of his or her specimens while you are doing the merge.

- **Conversion is in Process.** You cannot merge a converted patient while a conversion is in process, unless you have permission set up in the Procedure Group Dictionary. Refer to "Procedure Group Dictionary in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

Accessing the Patient Merge/Encounter Move Item

To access the Patient Merge/Encounter Move item:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

    A list of folders and items appears on the right side of the **Application** Manager.

2) Double-click on the Patient/Specimen Move/Merge/Delete folder.

    A list of items appears under the Patient/Specimen Move/Merge/Delete folder.

3) Double-click on the Patient Merge/Encounter Move item.

    The Patient Merge/Encounter Move window appears.

    TIP! You can also access the Patient Merge/Encounter Move item by placing it in your Personal Menu and double-clicking on it from there.

Entering Information on the Patient Merge/Encounter Move Window

You must first identify the patients you want to include in the move or merge you are about to perform on the Patient Merge/Encounter Move window.

NOTE: If you accessed this window via the Duplicate Patient Warning or Duplicate Patient Processing windows, the patients are already identified and may not be edited.

There are two buttons on the toolbar on this window that you do not see anywhere else in CoPathPlus.

- ![edit icon] (or <u>E</u>dit, <u>U</u>ndo All on the menu bar) reverses all your actions since the last time you saved (e.g., if you moved an encounter from one patient to another, pressing this button will move it back).

- ![clear icon] (or <u>E</u>dit, C<u>l</u>ear All on the menu bar) clears both patients you have selected from the window. You can then select other patients. If you have made any changes and you then press this button, CoPathPlus first asks you if you want to save the changes.

The following topics explain the fields on the Patient Merge/Encounter Move window.

Patient Identifying Information

The top of the Patient Merge/Encounter Move window contains the Patient fields. Enter a patient name in the **Patient 1** field. The patient must already be registered in CoPathPlus. Once you select a patient, that patient's demographic information (i.e., social security number, gender, birth date, and age, universal number, HIS internal number and race) display below the field. This information is for display only and cannot be edited.

You can then enter a second patient in the **Patient 2** field. The same type of information for Patient 2 displays below the field.

Aliases and Medical Record Number Information

Below the patient identifying information on the Patient Merge/Encounter Move window, you will see any aliases that the patient may have. In addition, this window will list any Medical Record Numbers for the patient and the associated client, as shown below. The aliases and Medical Record Number information is for display only and cannot be edited.

Encounter Information

Below the aliases and Medical Record Number information on the Patient Merge/Encounter Move window you will see all the encounter information for each patient you selected, as shown below.

This information includes the Encounter Number, the patient type, the encounter status, the patient's admit date for that encounter, the associated client, and the number of cases (specimens) associated with that encounter. Below this display you will see a message specifying whether this patient has any specimens that have no associated encounter.

If you want to see the detail (individual specimens) for the encounters listed and for any specimens that do not have an associated encounter, press **Show All Cases** below the display. You will see the Show All Cases pop-up window. The information on this window is for display only and cannot be edited.
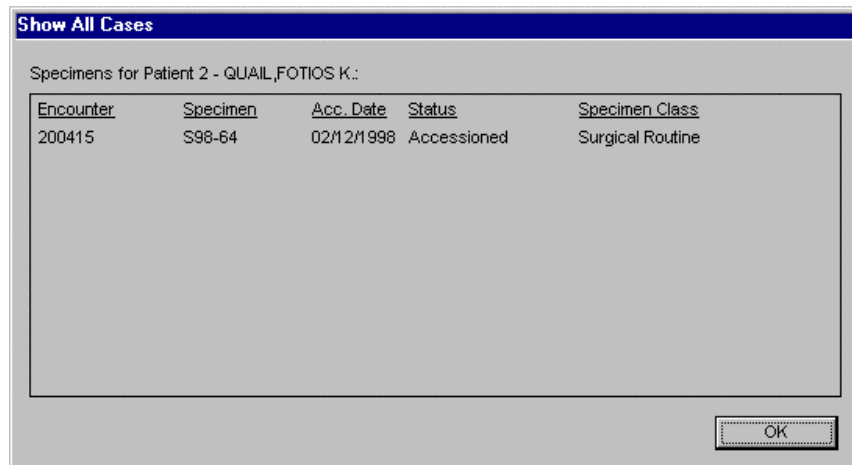
Moving and Merging Patients and Encounters

You can merge entire patient records from one patient to another, or you can move individual encounters (and all associated specimens) or all encounter information from one patient to another.

Merging Two Patient Records

You can merge two patient records, which moves all case information from one patient to another. You would use this function when a patient had mistakenly been registered twice in CoPathPlus. Once you merge patients, CoPathPlus makes one patient the "owner" of all the specimens and deletes the other patient (and his or her associated demographic data). However, when the *Move Info at Patient Merge* System Setting is enabled, selected patient information can be moved from the secondary, or "merge away from", patient to the primary patient when the primary patient previously had no entry for the selected patient data field(s).

You will see two **Patient** buttons on the Patient Merge/Encounter Move window. If you press the:

- First button, **Patient 1-->**, CoPathPlus moves selected patient information (i.e., aliases, Medical Record Number, encounters, specimens, etc.) from the first patient (the patient on the left side of the Patient Merge/Encounter Move window) to the second patient (the patient on the right side of the Patient Merge/Encounter Move window). CoPathPlus keeps the second patient as the "owner" of the information and deletes the first patient once you save your change.

- Second button, **<--Patient 2**, CoPathPlus moves selected patient information (i.e., aliases, Medical Record Number, encounters, specimens, etc.) from the second patient (the patient on the right side of the Patient Merge/Encounter Move window) to the first patient (the patient on the left side of the Patient Merge/Encounter Move window). CoPathPlus keeps the first patient as the "owner" of the information and deletes the second patient once you save your change.

CoPathPlus transfers any alias(es) for the patient to be deleted to the patient that will now own the information, unless it is a duplicate. It will also list the deleted patient's name as an alias for the patient that is retained.

If you merge patients and each of the patients has a Medical Record Number associated with the same client, a warning message will appear.
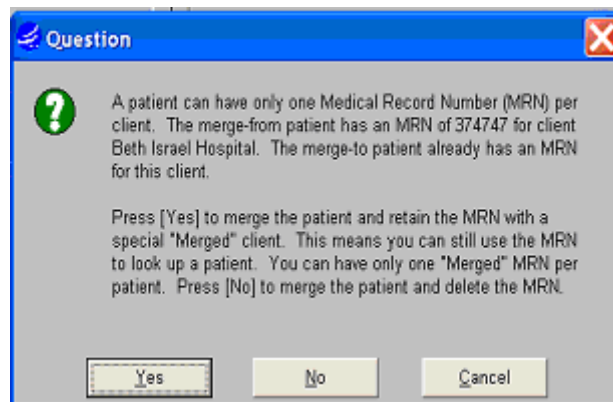
Click one of the following buttons on the message:

- **Yes**, CoPathPlus moves the Medical Record Number of the patient to be deleted to the "owner" of the information. This MRN will appear with a client of "Merged" and can still be used to look up the patient. (The "merged" client is an inactive dictionary entry used only for this purpose.)

- **No**, CoPathPlus merely deletes the Medical Record Number of the patient to be deleted and does not transfer it to the "owner" of the information.

- **Cancel**, CoPathPlus aborts the merge and returns you to the Patient Merge/Encounter Move window.

Once you save your changes (one way to do this is by pressing **Save/Clear All** at the bottom of the Patient Merge/Encounter Move window), the Confirm Move pop-up window appears.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information
© Cerner CoPathPlus. All rights reserved. This document contains confidential information which may not be reproduced or transmitted without the express written consent of Cerner CoPathPlus.

This window merely gives you a last chance to review the actions that are about to take place and gives you the opportunity to cancel what you have done if it is not what you want. Once you press **OK**, CoPathPlus merges the patients.

Note: When merging patient records, it is a good practice to review the demographic fields before performing the merge. When patient records are merged, only one set of demographics is retained. Therefore, it may be necessary to manually edit the demographics before or after performing the merge.

To merge several patients into one:

1) Select the patient that you want to retain in the Patient 1 field and the first patient to be merged in the Patient 2 field.

2) Press **<--Patient 2**. Answer any messages you may receive. CoPathPlus merges Patient 2 into Patient 1.

3) Press on the toolbar (or select File, Save from the menu bar).

4) Press **OK** (or press Enter) at the Confirm Move pop-up window. CoPathPlus saves your changes, deletes Patient 2, and the Patient Merge/Encounter Move window appears.

5) Select the second patient to be merged in the Patient 2 field.

6) Continue with Step 2 above. Repeat this procedure until all the patients you want are merged.

7) Press **Save/Clear All** at the last merge to save your changes and clear the window.

Moving an Encounter from One Patient to Another

You can move individual encounters (and all associated specimens) or all encounter information from one patient to another. You would use this function when encounter and associated specimen information had been accessioned against the wrong patient. When you move the information, CoPathPlus makes one patient the "owner" of all the encounters (or just the ones you selected) but does not delete the other patient.

You will see two **Encounter** buttons on the Patient Merge/Encounter Move window. If you press the:

- First button, **Encounter-->**, CoPathPlus moves the encounter you have selected in the encounter information display for the first patient (the patient on the left side of the Patient Merge/Encounter Move window) to the second patient (the patient on the right side of the Patient Merge/Encounter Move window). The second patient is now the "owner" of that encounter and all associated specimens (cases).

- Second button, **<--Encounter**, CoPathPlus moves the encounter you have selected in the encounter information display for the second patient (the patient on the right side of the Patient Merge/Encounter Move window) to the first patient (the patient on the left side of the Patient Merge/Encounter Move window). The first patient is now the "owner" of that encounter and all associated specimens (cases).

You can also just double-click on the encounter you want to move or use drag-and-drop to move it from one patient to another. To move another encounter, repeat what you did for the first one.

Once you save your changes (one way to do this is by pressing **Save/Clear All** at the bottom of the window), the following Confirm Move pop-up window appears.

This window merely gives you a last chance to review the actions that are about to take place and gives you the opportunity to cancel what you have done if it is not what you want. Once you press **OK**, CoPathPlus moves the encounters between patients.

Marking Non-Duplicate Patient Records

To use the Patient Merge/Encounter Move window to mark patient records as not duplicates:

1) Identify the two patient records that you want to mark as not duplicates.

    NOTE: If you accessed this window via the Duplicate Patient Warning or Duplicate Patient Processing windows, the patients are already identified and cannot be edited.

2) Press **Mark as Non-Duplicates**. A message will appear indicating that the patient records will be marked as duplicates.

3) Press **OK** to mark the patient records as not duplicates or press **Cancel** to stop this action and return to the Patient Merge/Encounter Move window.

If you erroneously marked a patient record as not a duplicate, you can reverse the marking by doing the following:

1) Identify the two patient records that you previously marked as not duplicates.

2) Press **Remove Mark as Non-Duplicates**. The Non-Duplicate marking is removed so that CoPathPlus can flag these records as potential duplicates in the future. This button is enabled only if both patient records selected were previously marked as not duplicates.

Specimen Move/Delete

Sometimes a specimen is inadvertently assigned to the wrong patient, or one patient is mistakenly assigned specimens under two similar names. You can use the Specimen Move/Delete item to straighten out mistakes of this kind. The Specimen Move/Delete item allows you to delete a specimen or to move a specimen from one patient to another. You must have the proper authorization to move or delete specimens.

To move encounters or to merge duplicate patients, refer to "Patient Merge/Encounter Move".

You can also run and print two InfoMaker reports that summarize all the moves and deletes that were performed within a user-specified date range or for a single patient or specimen:

- Specimen Delete Log
- Specimen Move Log

Restrictions on Moving or Deleting Specimens

There are a number of requirements that must be met before you can move or delete a specimen:

- **Security Access.** You must have permission set up in the Person Dictionary to move or delete specimens. Refer to "Person Dictionary" in the *Cerner CoPathPlus Dictionary Building Manual* for more information on this dictionary.

- **Specimen Is Not Signed Out.** The specimen you are moving or deleting cannot be signed out (i.e., it does not have a status of S/O [signed out]).

- **Specimen Has Never Been Signed Out.** The specimen you are moving or deleting cannot have been signed out in the past (i.e., it does not have a status of AM [amended]).

- **Related Procedures/Addenda Are Not Signed Out.** The specimen you are moving or deleting cannot have any related procedures or addenda that are signed out (i.e., they do not have a status of S/O [signed out]).

- **Related Procedures/Addenda Have Never Been Signed Out.** The specimen you are moving or deleting cannot have any related procedures or addenda that have been signed out in the past (i.e., they do not have a status of AM [amended]).

- **Specimen has not undergone Slide Send Out.** Specimens for which slides have been sent out are not eligible for Specimen Move. This is the case if it was the primary specimen that was sent out or an add-on specimen. This is also true regardless of whether the Slides Send Out process is completed or still in progress. If it is necessary to move a specimen that has undergone Slide Send Out, you may delete that Send Out episode and re-enter it later for the proper patient.

- **Specimen Is Not a QA-Related Specimen.** The specimen cannot be QA-related to any other specimen in CoPathPlus.

Accessing the Specimen Move/Delete Item

To access the Specimen Move/Delete item:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Patient/Specimen Move/Merge/Delete folder.

A list of items appears under the Patient/Specimen Move/Merge/Delete folder.

3) Double-click on the Specimen Move/Delete item.

The Select Specimen to Move or Delete window appears. This window is almost identical to the Select Specimen window except that you do not see an Activity field and the following buttons are not available: **Search Criteria…**, **Next Specimen**, **New Specimen**, **Worklists…**, and **Print Report…**.

TIP! You can also access the Specimen Move/Delete item by placing it in your Personal Menu and double-clicking on it from there.

Entering Information on the Specimen Move/Delete Window

Once you identify the specimen you want to move or delete, you are presented with the Specimen Move/Delete window.

This window displays the patient currently associated with the specimen. It also shows specimen-related information that defaults from the encounter to which this specimen is assigned. It also displays the physician(s) associated with the specimen (case). From this window you can either move the specimen from one patient to another or delete the specimen.

Deleting a Specimen

To delete the specimen displayed on the Specimen Move/Delete window:

1) Press **Delete Specimen** at the top of the Move/Delete tab.

CoPathPlus asks you if you want to delete the specimen.

2) Press **OK**.

CoPathPlus asks you a second time to make sure that the specimen you have identified is the one you want to delete.

3) Press **Yes**.

CoPathPlus presents an informational message that the specimen has been deleted.

4) Press **OK**.

The Select Specimen to Move or Delete window appears.

5) You can then select another specimen or, if you are done, press **Cancel** to return to the CoPathPlus Application Manager.

Moving a Specimen

Note: It is not possible to move a specimen that has been signed out to another patient unless you amend the specimen. Refer to "Amendment Entry and Amendment Edit" for more information on amending specimens.

To move the specimen displayed on the Specimen Move/Delete window:

1) Identify the patient to whom you are moving this specimen by selecting a patient in the To Patient field.

If the specimen had been assigned to an encounter, a message appears to indicate that it has been assigned.
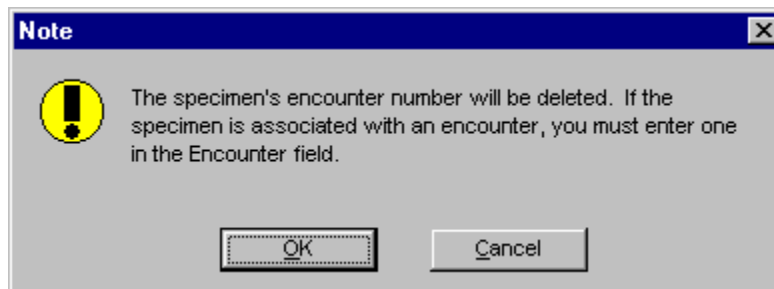
2) Press **OK**.

CoPathPlus removes the "old" encounter number associated with the specimen. This old encounter number refers to the "old" patient. If the client of the specimen requires an encounter number, you will need to enter a new one. If you enter a new encounter number, a message will display asking to overwrite the specimen data with the new encounter number.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
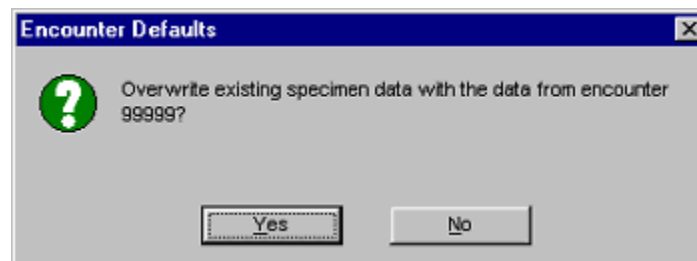
3) Press <u>Y</u>es.

CoPathPlus moves the specimen to the new patient and displays the specimen-related information associated with the new encounter.

4) Press <u>S</u>ave/Next Specimen.

CoPathPlus asks you if you want to save your changes.

5) Press <u>Y</u>es.

CoPathPlus saves your changes and the Select Specimen to Move or Delete window appears.

6) You can then select another specimen or, if you are done, press **Cancel** to return to the CoPathPlus Application Manager.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Quick Entry Functions

Quick Entry functions enable the addition of identical information to multiple specimens at once. The following Quick Entry functions are available:

- Add Pathologist to Specimen(s)
- QA Quick Entry

Accessing Quick Entry Functions

To access Quick Entry functions:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Quick Entry Functions folder.

   A list of items appears under the Quick Entry Functions folder.

3) Double-click on the item that you want:

   o Add Pathologist to Specimen(s)
   o QA Quick Entry

Add Pathologist to Specimen(s)

The Add Pathologist to Specimen(s) item provides a way to quickly add a primary pathologist to a list of specimens.

To add a pathologist to a list of specimens:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

2) Double-click on the Quick Entry Functions folder.

   A list of items appears under the Quick Entry Functions folder.

3) Double-click on Add Pathologist to Specimen(s).

   The following Add Pathologist to Specimen(s) window appears.
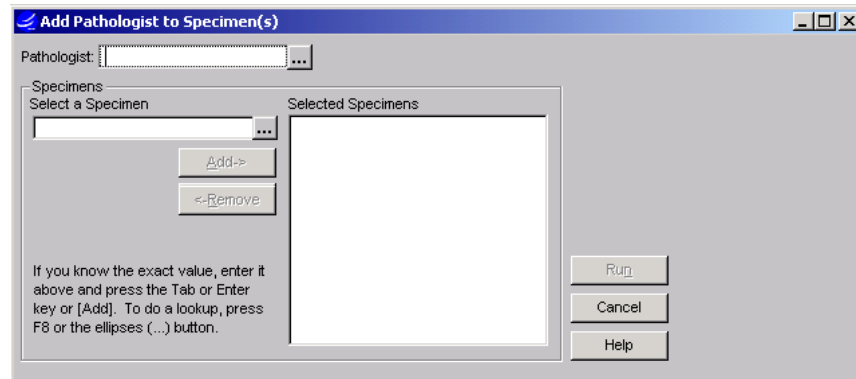
5) Enter the following information on the Add Pathologist to Specimen(s) window:

    o **Pathologist.** Select a pathologist from the pop-up window lookup.

    o **Select a Specimen**. If you know the exact value of the specimen number, enter it and then press the Tab or Enter key or . To search for a specimen, press F8 or the ![...] button. The specimens will display in the Selected Specimens box. You can remove any specimens from the list by highlighting the specimen and clicking ![<-Remove].

6) Once the list is complete, press ![Run] to start the addition of the pathologist. The pathologist is then added to the selected specimens.

Once completed, you can select another pathologist and list of specimens or close the window.

Note: You must have both application permissions of "Staff Entry/Edit" and "Add Pathologist to Specimen(s)" in order to use the Add Pathologist to Specimen(s) function.

QA Quick Entry
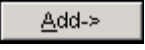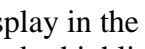
The QA Quick Entry item provides the ability to quickly enter basic QA review data on a list of specimens.
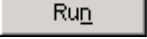
To enter QA review data on a list of specimens:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

2) Double-click on the Quick Entry Functions folder.

    A list of items appears under the Quick Entry Functions folder.

3) Double-click on QA Quick Entry.

Enter the following information on the QA Quick Entry window:

    o **QA Review.** Select a QA Review type from the pop-up window lookup.

    o **Date.** Enter the review date or leave the default current date.

    o **Result(s)**. Select the QA results from the pop-up window lookup. You can also enter an optional comment after you have entered the results.

    o **Reviewer(s)**. Select the QA reviewer(s) from the pop-up window lookup.

o **Select a Specimen**. If you know the exact value of the specimen number, enter it and then press the Tab or Enter key or [Add->]. To search for a specimen, press F8 or the button. The specimens will display in the Selected Specimens box. You can remove any specimens from the list by highlighting the specimen and clicking [<-Remove].

Once the list is complete, press [Run] to begin the automatic data entry process on the selected specimens.

Once the entry is complete, the user can enter new QA review and specimen information, or close the window.

Note: You must have both application permissions of "QA Diagnosis Review" and "QA Quick Entry" in order to use the Add Pathologist to Specimen(s) function.

Schedule Manager

This topic explains the Schedule Manager, which is a CoPathPlus utility that manages the scheduling of jobs (e.g., batch print and background) that run unattended on an agent server. "Schedule Manager" is a general term we use for this entire component that consists of the following items that are detailed within this topic:

- Schedule Group Dictionary, which allows you to create a schedule group that may contain one or more schedule items to run at a specified date and time. The Schedule Group Dictionary provides a way to schedule tasks, such as printing management reports and running interfaces, for production/execution in a timely manner.

- Schedule Group Printout, which lists all the different schedule groups and their associated schedule items that were entered through the Schedule Group Dictionary.

- Schedule Manager Log, which reports the status of every schedule item that was on the schedule queue.

- Schedule Manager Queue, which displays the current schedule queue.

As well, CoPathPlus contains settings in other components that have an effect on the Schedule Manager. They are mentioned in this topic where appropriate.

This topic also explains how to:

- Start up and shut down a scheduling agent .

- Shut down a scheduled job (i.e., a job currently running as scheduled versus a schedule item, which is something waiting to run).

- Prevent a schedule group from starting.

- Monitor scheduling agents and schedule items.

Generally, you will install and configure any required agent and scheduling agents during the CoPathPlus implementation process. Thereafter, you can make adjustments depending on the needs of your site.

Refer to the *CoPathPlus Implementation Manual* if you want to learn more about the implementation process.

How Scheduling Works

The CoPathPlus system maintains one schedule queue that contains a list of schedule items for all agents. One or more scheduling agents constantly searches the schedule queue in order to determine which schedule items to start up. The scheduling agent can also activate any job set for a restart or which has been rescheduled. Note that only one scheduling agent can be running on a single agent server at one time.

One or more schedule items resides in a schedule group, which is entered in the Schedule Group dictionary. For each schedule group, the scheduling agent starts up one schedule item at a time, in the order that they were entered for the schedule group in the Schedule Group Dictionary.

Note that a schedule item can also be placed on the schedule queue (and therefore started up by a scheduling agent) for processing in the background, without having been entered in the Schedule Group Dictionary. For example, your site may be able to place in the background the printing of patient reports. This is possible when the In Background check box appears on the Print/Send Setup pop-up window for those printing activities that allow background printing.

NOTE: Before trying to start up a schedule item, the scheduling agent compares how many scheduled jobs are currently running on the specified agent server against the maximum number of processes allowed to run concurrently on it. If starting up a schedule item would exceed the maximum processes allowed on the specified agent server, the scheduling agent holds off starting a new job until one of the already-running processes completes. You determine the maximum processes for each agent server in Workstation Setup. To learn how to do this, refer to "How to Edit a Workstation Setup" in the "Setup" section of the *Cerner CoPathPlus System Manager Guide*.

Throughout this scheduling process, the system maintains a Schedule Manager Log to keep track of what happens to schedule items in the schedule queue.

Once a scheduling agent performs its task (i.e., starts up a schedule item), the scheduling agent is done with that schedule item. The job is then in the hands of whichever CoPathPlus application item that you chose to perform the scheduled job (e.g., print a batch of patient reports).

Note that the scheduling agent also runs the Updater for its agent server. CoPathPlus uses the Updater to update files on the local workstation based upon changes that have been made to the system (e.g., patch versions of the system, edits to windows). When CoPathPlus requires it, the scheduling agent will stop all jobs to run the Updater. Once the Updater completes successfully, the scheduling agent puts back on the schedule queue the items it stopped and restarts them—for those application items that allow a restart after an abnormal ending.

Accessing the Schedule Manager

To access the items that make up the Schedule Manager:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Schedule Manager folder.

   A list of items appears under the Schedule Manager folder.

3) Double-click on the item that you want:

   o Schedule Group Dictionary

   o Schedule Group Printout

   o Schedule Manager Queue

   o Schedule Manager Log

Schedule Group Dictionary

The CoPathPlus Schedule Group Dictionary provides a way to schedule tasks, such as printing patient or management reports and running interfaces, for production/execution in a timely

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

manner. You can place a job with the Schedule Manager either indirectly or directly. For example, when a user tells CoPathPlus to print a batch of patient reports in the background, the system will indirectly place the job with the Schedule Manager for printing. This is possible when the In Background check box appears on the Print/Send Setup pop-up window for those printing activities that allow background printing. However, a user with permission to access the Schedule Group Dictionary can directly add a job to the Schedule Manager by making an entry in this dictionary.

The Schedule Group Dictionary has the following unique features that distinguish it from the typical CoPathPlus Dictionary, it is actually a Tool, rather than a dictionary:

- If you set a Schedule Group Dictionary entry for "One Time Run," after it has successfully run, CoPathPlus automatically deletes the entry from the dictionary.

- You may directly delete a record in this table. Select the File menu and then Delete Schedule Group.

- This dictionary does not look like the dictionaries accessed under the **Dictionaries** command button in that it des not contain the standard fields.

- This dictionary does not reside under the **Dictionaries** command button, instead you would normally find it in the Schedule Manager folder found under the **Tasks** command button.

How to Add an Entry to the Schedule Group Dictionary

When you add an entry to the Schedule Group dictionary, you are scheduling a job for the Schedule Manager. To learn how to access the Schedule Group Dictionary, refer to "Accessing the Schedule Manager".

On the Open Schedule Group window:

- Press **New** to add an entry to the Schedule Group Dictionary, or

- If you want to create a new entry by using an existing entry:

  o Press **Search** to produce a list of all the entries currently in the dictionary.

  o Highlight the entry you want to use and press **Copy From**.

  o Change the data on the duplicate version—especially the Group Name field—to make a new entry for the Schedule Group Dictionary. Be careful to also delete data in fields from the original entry that may not be appropriate for your new entry.

  o Save your new entry.

Enter the following information on the Group tab:

1) **Group Name.** Enter a schedule group name (e.g., Working Drafts, Physician Reports, Nightly Billing Batches). A schedule group can contain a list of schedule items for the Schedule Manager.

2) **View Status button.** Press this button to access the View Status pop-up window, which shows you the most recent schedule activity for this group. The use of this button is practical only when you are editing a Schedule Group Dictionary entry.

3) **Schedule Type.** Select any one of the option buttons:

   o **One-Time Run**, allows you set this schedule group to run only once. Enter the date you want it to run on in the Next Scheduled Run field.

   o **Manual Reschedule**, allows you the opportunity to manually reset the next date and time the Schedule Manager runs this schedule group.

   o **Automatic Reschedule**, allows you to have CoPathPlus automatically reschedule the next run of this schedule group (per your entry in the Run Every field).

4) **Next Scheduled Run.** Enter a valid date and time to start up this schedule group. If you selected the:

   o One Time Run option button, remember that after this job has run successfully, the dictionary entry is automatically deleted from the dictionary.

   o Manual Reschedule option button, you have to access this schedule group and re-enter the reschedule date in this field yourself.

   o Automatic Reschedule option button, CoPathPlus will automatically update this field for you (per your decision in the Run Every field).

   NOTE: Leaving the Next Scheduled Run field blank or deleting the value in it effectively unschedules this schedule group.

5) **Run Every.** These fields are used only with the Automatic Reschedule option. Enter a whole number up to three characters in the first (or left) field and then select the criteria in the second (or right) field (i.e., Minutes, Hours, Workdays (M-F), Days, Weeks, Months). If you select **Month**, the number in the first field must be **28** or smaller.

6) Schedule Group Items.

   o **Name.** Enter as many schedule items as you want to include in this schedule group. This is a free text field in which you can enter up to 60 characters. If there is only one item to include, you can name this item the same name as the schedule group.

   NOTE: The scheduling agent will start up the schedule items for a schedule group in the order that you have them listed in the Schedule Group Dictionary. In other words, while you may specify that a schedule group should start at 10:00, the first schedule item for the group will start at the time specified. The next schedule item in the same schedule group will not start until the first item has completed, and so on.

   o **Type.** Select the application item type you want to run when a scheduling agent starts up this schedule item and it becomes a scheduled job. Some application item types may need more information (e.g., InfoMaker Reports) for which you need to press **Details…** and/or **Print/Send…** to be able to enter the required information.

   Refer to "Purge Manager" to learn about the automatic purging of certain types of old information from the CoPathPlus system.

   NOTE: You will see listed only those application items that can be scheduled and for which you have permission to use.

   As well, whether or not details are required for the selected type was determined during the CoPathPlus implementation process.

      o **Dist Processing Agent PC.** Select the agent server on which to run this schedule item. Note that besides being an agent server, a scheduling agent must be running on it before the Schedule Manager can work.

7) <u>Details</u> **button.** Press this button to open the Details pop-up window for the schedule item you currently have highlighted. When appropriate, this pop-up window, which varies according to the application item type you have selected for a schedule item, lets you enter details for those application item types that use a wizard window (e.g., InfoMaker Reports).

8) <u>Print/Send</u> **button.** Press this button to open up the Print/Send Setup pop-up window for the schedule item you currently have highlighted. When appropriate, this pop-up window lets you enter output information for those application item types that need output specifications (e.g., InfoMaker Reports).

   ```
   NOTE:  When you set print/send parameters in the Schedule Group
   Dictionary for a schedule item that has a type that calls up the
   Details for Scheduling Chutes by Type or Details for Scheduling Chutes
   by List pop-up window, you will have the opportunity to override any
   print/send specifications set in the Report Chute dictionary for a
   chute.  CoPathPlus will present a warning message when this happens.
   The warning message details your possible actions.
   ```

View Status

The View Status pop-up window presents a report that is formatted just like the Schedule Manager Log, except that the entries on this report are sorted in reverse chronological order, and the report is only for the current schedule group.

Details Pop-Up Windows

Certain applications item types (e.g., InfoMaker Reports, Report Chutes Lists) for schedule items require you to enter more specific details. For these types you will need to press **Details…** on the Schedule Group window.

The Details pop-up window that appears varies according to the application item type you have selected for this schedule item. Currently, when you press **Details…**, one of the following pop-up windows may appear:

Details for Scheduling Audit Trail Archive/Restore

- Details for Scheduling Billing Batches

- Details for Scheduling Chutes by List

- Details for Scheduling Chutes by Type

- Details for Scheduling InfoMaker Reports

- Details for Scheduling I/O Handler

- Details for Scheduling Interface Input/Conversion Server

- Details for Scheduling Interface Output Server

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- Details for Scheduling Stain/Process Log Print

- Details for Scheduling Tissue Processing Batch Compile

- Details for Scheduling Label Chutes

- Details for Scheduling Text Search Index Filer

- Details for Report File (PDF) Processor

- Details for PICSPlus Image Format Conversion

Details for Scheduling Audit Trail Archive/Restore

The Details for Scheduling Audit Trail Archive/Restore pop-up window allows you to specify the minimum age for data archive that CoPathPlus should compile when the currently selected schedule item becomes a scheduled job. It also allows you to specify the path name where the system should place the newly archived file and the name the system should assign to the new archive file.

To learn about Audit Trail archiving, refer to "Audit Trail Archive/Restore" in the *Cerner CoPathPlus System Manager Guide*.

Note: While this Schedule Group Item Type is entitled "Audit Trail Archive/Restore", this feature only serves to schedule archives. Archive restores cannot be scheduled. Manual Audit Trail Archives and Restores are invoked from the same CoPathPlus activity.

Enter the following information on the Details for Scheduling Audit Trail Archive/Restore pop-up window:

Folder. Enter the path name where the system should place the newly archived file. If you use a mapped drive, ensure the Agent that is assigned to process the schedule request is appropriately mapped and has authority to access that drive. If the drive is external, such as to a CD, ensure that procedures are in place to load the proper media before the archive is scheduled to occur.

Filename. Enter the name the system should assign to the new archive file. Use a # symbol to have the system use its incrementing sequential number to uniquely identify the filename. CoPathPlus maintains a counter of the number of archives performed. For example, a system manager previously performed 11 manual archives. After the update to CoPathPlus v2.5, the archive was scheduled to be done using the filename of "Archive#". CoPathPlus would name this latest archive episode "Archive12".

Days. Enter the minimum age for data archive. Data older than this will be archived. For example, if 30 was entered, audit trails 31 days and older will be sent to the archive. As with the manual archive process, the scheduled archive will automatically exclude any already archived, but not yet purged data. This convention ensures that archive media is not wasted storing the exact same data more than once.

Details for Scheduling Billing Batches

The Details for Scheduling Billing Batches pop-up window allows you to specify which billing chute CoPathPlus should compile when the currently selected schedule item becomes a

scheduled job. You can also set whether the compiled job should be sent to an interface, to a printout, or both.

To learn about billing chutes, refer to "Billing Chute Manager". To learn about interfaces, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

Enter the following information on the Details for Scheduling Billing Batches pop-up window:

1) **Billing Chute to Compile.** Select the billing chute to compile for the currently selected schedule item when it becomes a scheduled job. Billing chutes are defined in the Billing Chute Dictionary. To learn about this dictionary, refer to "Billing Chute Dictionary" in the "Billing Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

2) Batch Options.

   o **Validate Batch.** Select this check box if you to want to compile and validate a batch. Typically, you would want to select this check box if you are sending to a printout.

   o **Send Batch.** Select this check box if you want the batch to be sent immediately to the interface, or marked as sent if your site is not using an interface. Typically, you would select this check box to ensure that billing charges are automatically sent to the interface.

3) Report Options.

   o **Print Output Report.** Select this check box to print a report of all the billing charges that successfully compiled.

   o **Print Internal Report.** Select this check box to print a report of all the billing charges for a batch, showing all charges whether or not they were successfully compiled.

   o **Print Error Report.** Select this check box to print a report of all the billing charges that did not successfully compile. Personnel at your site would use this report to determine which billing charges need attention so that any missing or invalid data can be corrected. Corrected charges will be compiled in the next batch if the original batch has already been sent.

   If any of the report options are used, configure the Print/Send button on the Group tab of the Schedule Manager Dictionary to identify where the printout will be sent.

Details for Scheduling Report Chutes by List

The Details for Scheduling Chutes by List pop-up window allows you to select one or more specific report chutes (not chute type) CoPathPlus should include in this run when the currently selected schedule item becomes a scheduled job. For example, you may only want to designate three chutes from your list of 10 chutes within your Client chute type. So instead of using the Details for Schedule Chutes by Type pop-up window to select all the chutes within the Client chute type, you would use the Details for Scheduling Chutes by List pop-up window to select the specific client chutes you want for the current schedule item.

Enter the following information on the Details for Scheduling Chutes by List pop-up window:

1) **Print Current Open Batch for.** Select one or more chutes for the currently selected schedule item. If you want to remove an entry, highlight it and press <u>**Delete**</u>.

   NOTE: You can select up to 20 entries.

2) **Minimum number of reports that must be in a batch.** Enter a number for the minimum number of reports that must be in a batch before the schedule item can become a scheduled job.

To learn about report chutes, refer to "Report Chute Manager".

Details for Scheduling Report Chutes by Type

The Details for Scheduling Chutes by Type pop-up window allows you to select the one report chute type CoPathPlus should include in this run when the currently selected schedule item becomes a scheduled job. For example, if you selected the Client chute type, this means that you have selected all the chutes that fall within this chute type. Therefore, if you have 10 chutes within the Client chute type, when the Schedule Manager runs the schedule item that has Client selected on the Details for Schedule Chutes by Type pop-up window, all 10 chutes will, in this case, print out whatever open batches they contain.

To learn about report chutes, refer to "Report Chute Manager".

Enter the following information on the Details for Scheduling Chutes by Type pop-up window:

1) **Print Current Batch for Chutes of Type.** Select one type of report chute for the currently selected schedule item.

2) **Minimum number of reports that must be in a batch.** Enter a number for the minimum number of reports that must be in a batch before the schedule item can become a scheduled job.

Details for Scheduling InfoMaker Reports

The Details for Scheduling InfoMaker Reports pop-up window allows you to specify which InfoMaker report (along with its corresponding selection criteria) CoPathPlus should print when the currently selected schedule item becomes a scheduled job.

To learn about the management reports available with the standard export version of the CoPathPlus system, refer to "Report Descriptions".

Enter the following information on the Details for Scheduling InfoMaker Reports pop-up window:

1) **Select a Report.** Select the InfoMaker report for which you want to specify selection criteria.

2) **Select a Criteria.** Select the selection criteria that you want to use to run this report.

   TIP! You can create and save selection criteria for the specified report here, or you can use selection criteria that was created through the InfoMaker Wizard window for the report. No matter where the selection criteria was created, as long as it was saved, it can be used with the report in either place.

   o   To specify a new set of selection criteria, press <u>**New**</u>.

TIP! Use the relative date options for the Date fields when you specify your selection criteria for a report that will be run by the Schedule Manager.

   o To change an existing set of selection criteria, select the one you want to change and press **Edit**.

In both cases, the InfoMaker Wizard appears. To learn about the InfoMaker Wizard, refer to "Running the Management Reports".

3) **Comment.** This display-only field shows any comment entered for the selection criteria when the criteria was originally entered on the InfoMaker Wizard.

4) **Use Report Server.** This check box is only enabled if your site maintains a separate copy of the main CoPathPlus database on its own server (typically named the Report Server). When checked, the InfoMaker report will be run on the Report Server against this second database. This lets you run the report on a separate database without affecting (i.e., slowing down) other system users on the main database.

   NOTE: This second CoPathPlus database option requires additional hardware purchase and configuration. Contact your Cerner CoPathPlus Customer Sales Representative for details.

   Also, the site must determine how often the main database will be backed up (copied) to the Report Server. Reports will only be as current as the last back up.

5) **Save Data as a Specimen Population.** This check box and its associated fields of Population Name and App Flag (Optional) are reserved for future use.

6) **Save Data to an Interface Output Queue.** Enable this check box when the designated InfoMaker Report is run as a means to gather data for transmission to a batch output interface. This interface mechanism is used for caBIG and selected RPP2 (Reporting Pathology Protocols) interfaces.

7) **Interface Request.** Identify the record in the Interface Request Dictionary appropriate to interface use.

8) **Print Patient Reports from InfoMaker Report**. Enable this check box to generate both the management report and associated patient reports. Patient reports use the Final Report template whether or not the reports are signed out. Procedure and/or Addendum reports may also print if indicated by a system setting. Only a single report, or single set of final/procedure /addendum reports, will print, even if the specimen is listed on the management report multiple times.

   Note: System settings considered by this feature are:

   ▪ **Number of Patient Reports in InfoMaker**: Reports are divided into multiple print jobs with each job printing the number patient reports stipulated in this setting.

   ▪ **Print Procedure/Addendum Reports With Final**: When this is set to a Yes"; Procedure and Addendum reports will also print.

   Note: In order for a management report to be used for patient report generation, it must include the specimen_id or specnum_formatted field. If one of these fields is not included in the result set of the InfoMaker report, a comment will be written to the Schedule Manager log indicating: "Cannot print patient report from IM. No specimen ID found".

If you want to save the InfoMaker report as raw data, click **Save Data to File**.

Scheduling Saving Raw Data to File

The Save Raw Data to File button opens a pop-up window allows you to save an InfoMaker report as raw data when the currently selected schedule item becomes a scheduled job.

Types of data that do not download include:

- Result sets in nested reports, such as:

  o Most CoPathPlus text fields

  o Most multi-instance occurrences (such as a list of additional physicians, a list of ICD-9 codes, a list of SNOMED codes, etc.)

- InfoMaker calculations.

Other considerations that must be taken into account when you save raw data include:

- Saving raw data directly in XLS format appears to truncate at around 256 characters.

- Saving in TXT format saves long text okay (tested approximately up to our 32K limit for plain text).

- In Excel you can import the TXT file and still get the long text.

To schedule saving an InfoMaker Report as Raw Data, follow the procedure for scheduling InfoMaker reports. On the Details for Scheduling InfoMaker Reports pop-up window, click **Save Data to File**. The Save Raw Data to File pop-up window will appear.

Enter the following information:

File name. Specify a name for the file in which you want to save the raw data and the path. You can define the last 6 characters of the file as YYMMDD to indicate to the system to include the date of report generation as the last 6 characters of the file name. For example, if you named the report "billingYYMMDD" and the report printed on 9/6/2002, the system would name the report "billing020906".

Note: If a job is scheduled to run on the Agent, make sure the file path entered to save data is correct. If the path involves a local call to the C drive, the file will save to the Agent, not the PC where you may have entered the job, for example, the System Manager's computer. To save the file to the System Manager's computer, make sure you enter the correct network file path.

Note: If a file of the stipulated name already exists with the defined path, CoPathPlus will append the letter a - z to the end of the file name to make the name unique. The "z" file will be overwritten if subsequent generations of the report with the same name continue.

File format. Select one of the following formats in which to save the raw data:

- Tab-delimited text

- Comma-separated values

- Excel

- HTML table

- Powerbuilder Report (PSR)

- SQL inserts

> **Note:** When you select to save raw data in Excel (.xls) format, the raw data truncates at 256 characters. If you want to view the file in Excel without having the data truncated, you should save the data in Tab-delimited text (.txt) format and import the text file into Excel. Refer to your Microsoft Excel documentation for more information on importing text files.

Include column headings. Select the check box if you want to include the report's column heading in the raw data file.

Convert RTF data to plain text. Select the check box if you want to remove the RTF formatting commands from the text.

Replace CR, LF and TAB with. When the raw data includes carriage return, line feed, and tab characters, you may decide how you want to treat these characters since these characters may cause problems in some file formats. Three radio button options exist allowing you to define this configuration. Options are to:

- Replace these control characters with the labels of [CR], [LF], and [TAB], respectively.

- Replace each of these control characters with a tab.

- Do not perform a replacement.

Details for Scheduling I/O Handler

The Details for Scheduling I/O Handler pop-up window allows you to specify which I/O handler CoPathPlus should run when the currently selected schedule item becomes a scheduled job.

Enter the following information on the Details for Scheduling I/O Handler pop-up window:

I/O Handler. Select the I/O handler you want to run when this schedule group item becomes a scheduled job. This field is linked to the I/O Handler Dictionary. To learn about interfaces and the I/O Handler Dictionary, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

Details for Scheduling Interface Input/Conversion Server

The Details for Scheduling Interface Input/Conversion Server pop-up window allows you to specify which interface input or conversion server CoPathPlus should run when the currently selected schedule item becomes a scheduled job.

Enter the following information on the Details for Scheduling Interface Input/Conversion Server pop-up window:

1) **Interface Processor.** Select the interface processor you want to run when this schedule item becomes a scheduled job. This field is linked to the Interface Processor dictionary. To learn about interfaces and the Interface Processor dictionary, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *CoPathPlus Implementation Manual*.

2) **Mode.** Select:

   o **Interface**, if interface messages are to be processed (i.e., creating new data and updating existing data).

       o **Conversion**, if conversion messages are to be processed (i.e., creating new data, not updating existing data as well).

       o **Both**, if both interface and conversion messages are to be processed. Note that you would normally use this option for testing purposes only, and seldom use it in live operations.

Details for Scheduling Interface Output Server

The Details for Scheduling Interface Output Server pop-up window allows you to specify which interface output server CoPathPlus should run when the currently selected schedule item becomes a scheduled job.

Enter the following information on the Details for Scheduling Interface Output Server pop-up window:

Interface Processor. Select the interface processor you want to run when this schedule item becomes a scheduled job. This field is linked to the Interface Processor dictionary. To learn about interfaces and the Interface Processor dictionary, refer to the "Interfaces" section and "Implementation Packet #7: Setting Up and Testing Interfaces" in the "Implementation Packets" section of the *Cerner CoPathPlus Implementation Manual*.

Details for Scheduling Label Chutes

The Details for Label Chutes pop-up window allows you to select one or more specific label chutes CoPathPlus should include in this run when the currently selected schedule item becomes a scheduled job.

Enter the following information on the Details for Scheduling Label Chutes pop-up window:

1) **Print Current Open Batch or Queue for.** Select one or more chutes for the currently selected schedule item. If you want to remove an entry, highlight it and press **Delete**.

    NOTE: You can select up to 20 entries.

2) **Minimum labels that must be in the batch or queue.** Enter a number for the minimum number of labels that must be in a batch or queue before the schedule item can become a scheduled job.

Details for Scheduling Stain/Process Log Print

The Details for Scheduling Stain/Process Log Print pop-up window allows you to specify for which department and for which stain/process category (or categories) CoPathPlus should run this log when the currently selected schedule item becomes a scheduled job.

Enter the following information on the Details for Scheduling Stain/Process Log Print pop-up window:

1) **Check boxes.** Select:

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

       o **Printed Stains/Processes** and **New Stains/Processes** to see all outstanding stains/processes, or just

       o **New Stains/Processes** to see stains/processes ordered since the last log run.

         NOTE: CoPathPlus always prints just the "new" labels (i.e., labels not previously printed).

2) **Select a Department.** Select a department for which you want to schedule this log by clicking on it.

3) **Select one or more Stain/Process Categories.** Select one or more stain/process categories to include in the log. To select more than one category, hold down the Ctrl key as you click on another choice.

4) <u>L</u>abel Output **button.** Press this button to enter the printer specifications for the associated stain/process log labels.

NOTE: If your site is set up to use a labeler, you may also see the **Engrave Labels** and **Paper Labels** option buttons on this window. These let you choose either engraved slide labels (i.e., labels etched onto the glass of the slide itself) or paper slide labels. Selecting **Engrave Labels** causes engraved slide labels to be automatically requested for all stains on the log, and the <u>Label Output</u> button will not be enabled. Selecting **Paper Labels** causes paper slide labels to be requested for all stains on the log, and the <u>Label Output</u> button will be enabled and must be selected to identify the printer. Refer to "Requesting Slide Labels" for more information on engravers and labels.

This feature is only available if the system setting Enable Slide Engraver is set to Yes. Otherwise, paper labels are assumed and only the <u>Label Output</u> button is visible.

To learn more about this pop-up window, refer to "Stain/Process Log Verify/Print".

Details for Scheduling Tissue Processing Batch Compile

The Details for Scheduling Tissue Processing Batch Compile pop-up window allows you to specify for which department and for which block category (or categories) CoPathPlus should compile the batch when the currently selected schedule item becomes a scheduled job.

Enter the following information on the Details for Scheduling Tissue Processing Batch Compile pop-up window:

NOTE: The only option allowed on this pop-up window is the **Compile a New Tissue Processing Batch** option.

1) **Select a Department.** Select a department for which you want to compile the batch by clicking on it.

2) **Select one or more Block Categories.** Select one or more block categories that you want to include in the compile. To select more than one category, hold down the Ctrl key as you click on another choice.

To learn more about this pop-up window, refer to "Processing Batch Compile/Edit".

Details for Scheduling Text Search Index Filer

The Details for Scheduling Text Search Index Filer pop-up window allows you to configure the way the Text Search Filer works in CoPathPlus when the currently selected schedule item becomes a scheduled job. The Text Search Index Filer is a CoPathPlus program that looks at newly entered text and breaks it down by word and puts each word in a table to make Natural Language Search reports run quickly.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

To learn about Natural Language Search, refer to "Natural Language Search Report".

Enter the following information on the Details for Scheduling Text Search Index Filer pop-up window:

1) **Process Text From.** Select one of the following options:

   o **Production Data** to configure text collected as a result of the normal day-to-day operations at your site. Typically, you would have a schedule item with this criteria run on a consistent (e.g., daily) basis.

   o **Conversion Data** to configure text collected through a conversion. Typically, you would have multiple schedule items with this criteria and it may run for a extended period of time. After the conversion has completed, you would not usually use this criteria again.

2) **Stop Job if Running at This Time.** Enter the time at which this schedule item should stop running. To allow an item to run longer than 24 hours, leave the field blank. To stop this job, you would have to manually shut down the scheduled job. To learn how to do this, refer to "How to Shut Down a Scheduled Job".

3) **Maximum Number of Text Fields.** Specify the maximum number of text fields that CoPathPlus should review/process during one run of this scheduled item. This field is optional. You may want to enter a number in this field if you are just getting started with natural language search or if you are testing the capacity of your system.

Periodically Run Update Statistics. Select this check box if you want the program to update the statistics the relational database management system (e.g., Sybase) keeps to optimize processing. This will be done only when processing text from conversion data.

Details for Report File (PDF) Queue Processor

The Details for Report File (PDF) Queue Processor pop-up window allows you to configure background creation of report files for the PDF repository.

Enter the following information on the Details for Report File (PDF) Queue Processor:

1) **Process Reports From.** Select one of the following options:

   o **Production Data** to generate PDF Reports when a case, procedure, or addendum is signed out in the production (live) system.

   o **Conversion Data** to generate PDF Reports when a case, procedure, or addendum is signed out in the test environment.

Report File Server. Select the PDF Report repository that will store the PDF generated by this Schedule Agent job.

Stop Job if Running at This Time. Enter the time at which this schedule item should stop running. To allow an item to run longer than 24 hours, leave the field blank. To stop this job, you would have to manually shut down the scheduled job. To learn how to do this, refer to "How to Shut Down a Scheduled Job". This field is optional.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

4) **Maximum Number of Text Fields.** Specify the maximum number of PDF reports that CoPathPlus should review/process during one run of this scheduled item. This field is optional.

Details for PICSPlus Image Format Conversion

This activity is only used for PICSPlus sites are upgrading from CoPathPlus version 2.4 or before to CoPathPlus version 2.5 or above. The format used for PICSPlus image storage changed from a proprietary format to a JPEG 200 format. Refer to the version 2.5 PICSPlus Release Notes for additional information on this conversion.

1) **Time to Stop the Job if still Running.** Enter the time at which this schedule item should stop running. To allow an item to run longer than 24 hours, leave the field blank. To stop this job, you would have to manually shut down the scheduled job. To learn how to do this, refer to "How to Shut Down a Scheduled Job". This field is optional.

Stop Job if number of errors Equals. Specify the maximum number of errors (non converted images) that will halt the image conversion process. This field is optional.

Run Minimized. Denotes whether the image conversion process will run minimized on the agent or the conversion status window will be displayed.

Purge Manager

Periodically, data (such as old billing batches, patient report chutes, audit trail information, and inactive patient and/or encounter data) must be purged from the CoPathPlus system. Otherwise as your system contains less and less available storage space, it may run slower and ultimately run out of space. The Purge Manager gives CoPathPlus an automatic purge capability. The Purge Manager comprises a combination of the Purge Manager type in the Schedule Manager, the Purge Dictionary, and the Patient Type dictionary.

Schedule Manager and Dictionaries

The entry that you have in the Schedule Manager that uses the Purge Manager type allows the automatic purging of data from the CoPathPlus system. When the Schedule Manager activates the Purge Manager on CoPathPlus, the Purge Manager then systematically activates all of the purge jobs as identified in the Purge Dictionary.

System Managers use the Purge Dictionary to change selected fields that may affect the purge capability in CoPathPlus for all purging options, except for encounter data, which is controlled through the Patient Type Dictionary. To learn about the dictionaries, refer to "Purge Dictionary" in the "Setup" section of the *Cerner CoPathPlus System Manager Guide* and "Patient Type Dictionary" in the "Registration Dictionaries" section of the *Cerner CoPathPlus Dictionary Building Manual*.

How to Set Up the Purge Manager

While an on-demand Purge may be run via the Purge Manager activity, typically, the Purge Manager is scheduled in the Schedule Manager.

- Usually, the Cerner CoPathPlus Implementer updates the Schedule Type information on the standard Purge entry in the Schedule Group Dictionary. This record uses the Purge Manager type in the Type field, as illustrated below.

- The System Manager reviews the entries in the Purge Dictionary (which come pre-built) and, if necessary, changes the purging parameters or inactivates Purge Dictionary entries if such data should not be purged. Consult with Cerner CoPathPlus personnel as needed. To learn about this dictionary, refer to "Purge Dictionary" in the "Setup" section of the *Cerner CoPathPlus System Manager Guide*.

- The System Manager may also review the Encounter Record Settings fields on the Details tab for any or all entries in the Patient Type Dictionary and, if necessary, change the values in the fields on how long to keep discharged and undischarged encounter records. Consult with Cerner CoPathPlus personnel as needed.

Editing a Schedule Group Dictionary Entry

Use caution when you edit a Schedule Group dictionary entry.

Do not edit a Schedule Group Dictionary entry if it is currently running. If you attempt to edit a schedule group and save your changes while it is running, you may affect the correct running of all the schedule items in the schedule group (i.e., you may cause an item to not run). CoPathPlus will present a warning message if you attempt to save changes to a schedule group that is currently running. For example, if you have a schedule group of Accession Log Daily that is set to run every day at 1 p.m., do not edit this schedule group entry in the Schedule Group Dictionary until you are sure that the schedule group has completed processing.

If you attempt to change the report criteria for a management (i.e., InfoMaker) report scheduled to run via the Schedule Manager, CoPathPlus will present a warning message stating that changes will have an effect on a scheduled report. You will want to be careful as to how you respond to the warning message. If you save changes to report criteria for a report already on the Schedule Manager, you may be altering the original purpose for running the report as it was intended.

Schedule Group Printout

The Schedule Group Printout item accesses the Schedule Group Dictionary report that allows you to view on the screen the schedule groups and their associated schedule items that have been entered in the Schedule Group Dictionary. You can also print out the report.

To learn how to access, run, and print the standard management reports provided with your CoPathPlus system, refer to "Management Reports".

Schedule Manager Queue

The Schedule Manager Queue item automatically accesses the Schedule Manager Queue report, as shown below, that displays the current schedule queue. You can also print out this report. This report prints the date and time when each job is scheduled to run, the name of the job (if submitted through the Schedule Group dictionary) or descriptive name of the job (if submitted as a background job), the group item that the job is related to, the specific printer to which the log generated (if there is a single printer assignment) and the agent server that the job will run on.

To learn about the buttons and fields available for this report, refer to "Viewing and Printing the Management Reports".

Schedule Manager Log

The Schedule Manager Log item accesses an InfoMaker report by the same name that reports the status of every schedule item that was on the schedule queue. This report prints the name of the job (if submitted through the Schedule Group Dictionary) or descriptive name of the job (if submitted as a background job), the group item that the job is related to, the agent server that the job will be run from, the date and time when the job is scheduled to run, the status of the job, and the date, the specific printer to which the log generated (if there is a single printer assignment) and time the status was last updated.

This report does not show schedule jobs that have not yet started.

To learn how to access, run, and print the standard management reports provided with your CoPathPlus system, refer to "Management Reports".

Managing Scheduling Agents

Managing scheduling agents consists of the following tasks:

- Start up a scheduling agent
- Shut down a scheduling agent
- Shut down a scheduled job
- Prevent a schedule group from starting
- Monitor scheduling agents and scheduled jobs

How to Start Up a Scheduling Agent

Only one scheduling agent per database can be running on a single agent server at one time. I.e., a CoPathPlus agent machine may run a schedule agent job for the production database and another schedule agent job for the test environment at the same time. However, two schedule agent jobs may not simultaneously run for the same database on the same agent machine.   If you try to start up a scheduling agent on an agent server that already has a scheduling agent running, the system will present an error message and abort the start up.

However, more than one agent machine can be run the scheduling agent job at the same time.

For a scheduling agent to run on its assigned agent server, you must make sure the workstation is listed in Workstation Setup with the Distributed Processing Agent PC check box selected. Otherwise, the scheduling agent will not start up. To learn about the Workstation Setup item, refer to "Workstation Setup" in the "Setup" section of the *Cerner CoPathPlus System Manager Guide*.

Perform any of the following actions to start up a scheduling agent.

- To **automatically** start up a scheduling agent, include coagent.exe in the Windows' Startup folder. Thereafter, when you start up Windows, the scheduling agent will launch.

- To **manually** start up a scheduling agent, go to the agent server that is associated with the schedule agent you want to run and launch coagent.exe.

  NOTE: You can also remotely start up the scheduling agent if both PCs are running pcAnywhere and the following conditions exist:

How to Shut Down a Scheduling Agent

Note that any scheduled job that was already started by the scheduling agent will continue to run to completion, even if you shut down its scheduling agent. The scheduling agent has no effect on jobs that are already in process.

Perform any of the following actions to shut down a scheduling agent.

- To **directly** shut down a scheduling agent, go to the agent server, access the Update Agent activity in the Windows tool bar and close it. Then, access the Scheduling Agent application and close it.

- To **indirectly** shut down a scheduling agent from any CoPathPlus workstation:

   1) Sign on to CoPathPlus.
   2) Access the Session Maintenance item (found within the System Session Utilities folder under the **Tasks** command button).
   3) Select the row for the scheduling agent.
   4) Press **Shut Down Session(s)**.
   5) Access the Agent to shut independently shut down the Update Agent job.

How to Shut Down a Scheduled Job

There are two options you can use when you want to shut down a scheduled job that is already running:

- **Shut Down Individual Session**, from any CoPathPlus workstation:

   1) Sign on to CoPathPlus.
   2) Access the Session Maintenance item (found within the System Session Utilities folder under the **Tasks** command button).
   3) Select the row for the scheduled job you want to shut down.

   TIP! Look for the workstation ID for the agent server that should be running the job. Be careful, as you can inadvertently shut down a person's session should you select the wrong session.

   4) Press **Shut Down Session(s)…**.
   5) Press **Session Only** on the Shut Done One or All Sessions pop-up window.

   NOTE: If the application item associated with the scheduled job can restart a scheduled job that was abnormally ended, CoPathPlus will present a warning message: "This job would normally restart after it has been stopped. Do you want to override this and NOT restart the job?"
   You can:

   ♦ Click **Yes** to not restart the job

   ♦ Click **No** to restart the job.

   ♦ Click **Cancel** to ignore the shut down directive.

- **Shut Down All Sessions.** To shut down all sessions, perform the same steps as for an individual session, but press **All Sessions** on the Shut Down One or All Sessions pop-up window instead.

   IMPORTANT: Use this option with discretion.

   For this shut down, CoPathPlus will not present the warning message mentioned above. These jobs will be put back on the queue as a restart (which will happen once you start up the scheduling agent again).

   TIP! If the scheduled jobs you shut down do not restart after you restart the scheduling agent and if the scheduled jobs come from a schedule group, you can edit the schedule group entry in the Schedule Group Dictionary and delete the data in the Next Schedule Run field and then use Session Maintenance to stop the scheduled job. To restart, edit the schedule group entry again and enter a Next Schedule Run date and time.

How to Prevent a Schedule Group from Starting

To prevent a schedule group from starting, access the appropriate schedule group entry in the Schedule Group Dictionary and delete the Next Schedule Run date and time, or reset it to a future date and time.

How to Monitor Scheduling Agents and Schedule Items

To monitor scheduling agents and schedule items, you will need to:

1) See which schedule items are active.

2) Confirm that the scheduling agent is running.

3) View the status of schedule items/scheduled jobs.

Which Schedule Items are Active

To see which schedule items are active, go to the agent server and click on the Scheduling Agent icon on the taskbar. As illustrated below, the Scheduling Agent pop-up window appears and displays the following information regarding the current agent:

Scheduled jobs that are scheduled to run within the next 15 (or other) minutes

Scheduled jobs that are currently active

Scheduled jobs that have completed in the past 15 (or other) minutes

General data about the agent processing including the assigned application (CoPathPlus live versus CoPathPlus test), the name of the workstation, the maximum number of jobs that can run simultaneously on that workstation.

Interactive features allow:

Alteration of the default 15 minute display time frame

Shutdown of the Scheduling Agent

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information
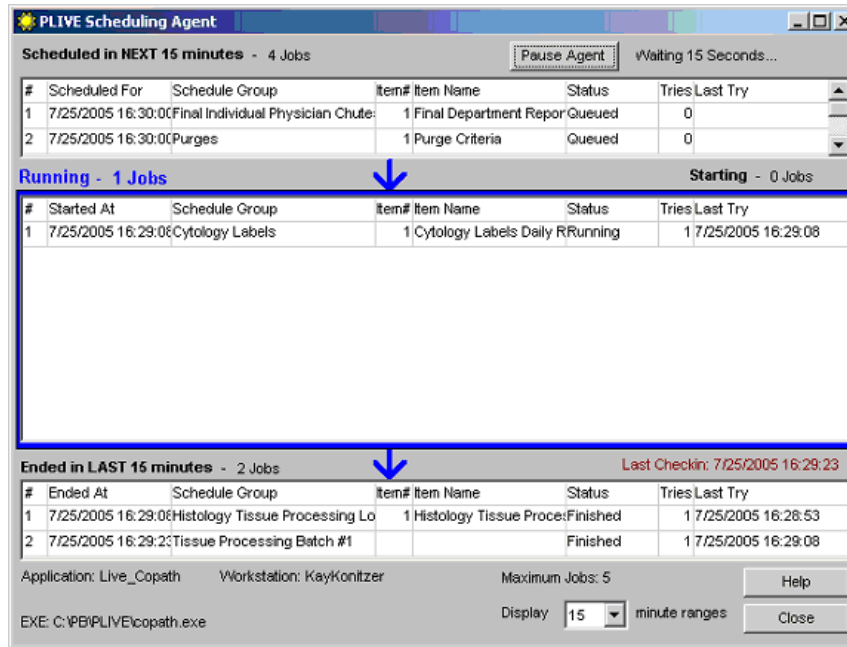
NOTE: The list appears and disappears very quickly, depending on how many jobs are on the list (versus maximum number of jobs allowed to run concurrently) and how quickly they are started.

Confirm Scheduling Agent Running

To confirm that the scheduling agent is running, access Session Maintenance (found within the System Session Utilities folder under the **Tasks** command button). Because a scheduling agent does not have its own session number (it is still tracked by Session Maintenance), look for entries where the user name is "Schedule Agent" and where no Session ID is assigned and/or look for the appropriate agent server's workstation ID.
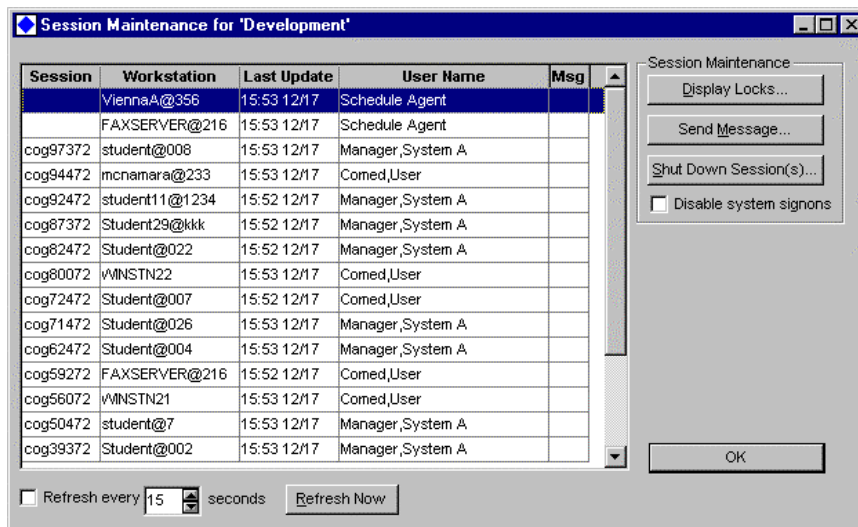
Check Status of Scheduled Jobs that have been Started Up by a Scheduling Agent

To view scheduled jobs that have been started up by all of the scheduling agents, access the Schedule Manager Log, as illustrated below, for a selected date and time range.
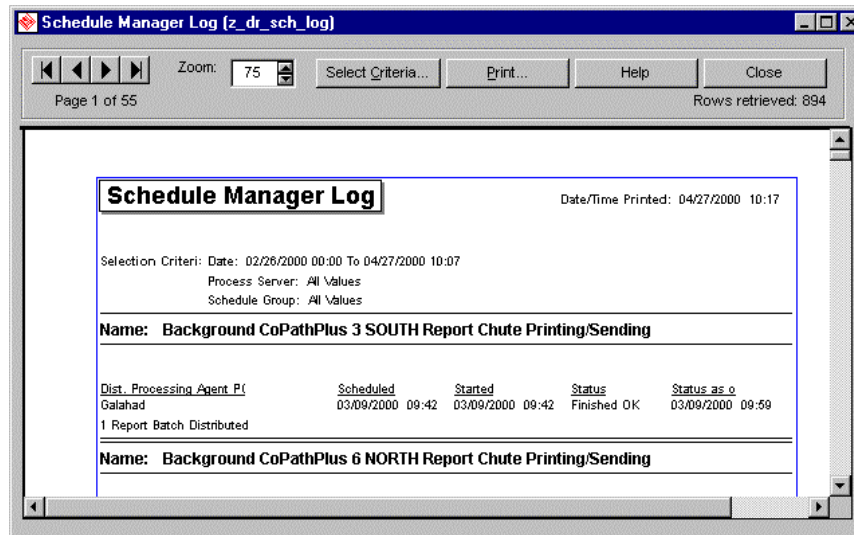
Timely Acceptance of CoPathPlus Updates

CoPathPlus provides a mechanism to facilitate timely acceptance of CoPathPlus Updates via two system settings and an associated Workstation Setup check box. CoPathPlus may be configured to ensure that agent and thin client servers accept all CoPathPlus updates as soon as they are issued, or configured such that these updates are processed at a later time at the convenience of the System Manager. This feature is applicable only to thin client server and agent updates, it does not affect updates to standard fat client workstations. The system settings utilized by this mechanism, "Update Required By (Date/Time)" and "Urgency of Last System Update", are both found under the System Setting Installation Category. The associated Workstation Setup check box is "Do Not Shut Down this Workstation to Load Medium-Priority System Updates". As the description implies, this check box is only applicable only when the "Urgency of Last System Update" is set to Medium.

Note: The CoPathPlus Update process is initiated by the System Manager each time you Accept and Rebuild a window painting change or when you perform the Rebuild Custom Report Library function to add or update a custom InfoMaker Report. It may also be triggered by the addition of words to the System Spell Dictionary or changes that use the Update Flag Trigger feature. The application of a software patch, Maintenance Release, or Version update by Cerner CoPathPlus will also initiate the Update process.

System Setting of Update Required By (Date/Time)

If the date and time in the setting is in the future, no automated updates will be made to any workstations or thin client servers. However, an update reminder will be displayed on each agent requiring an update. An example of this Agent reminder message is displayed below.
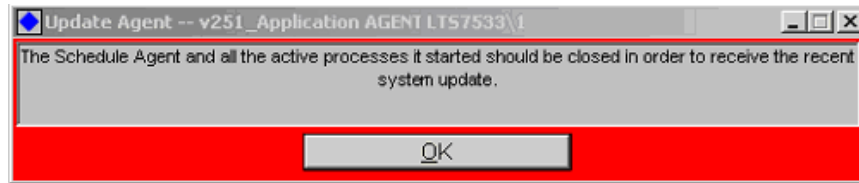
If the date and time in the Update Required By (Date/Time) setting is in the past, CoPathPlus will provide additional reminders or automatically process the update depending on the configuration of the Urgency of Last System Update system setting.

System Setting of Urgency of Last System Update

This setting has the three possible values of Low, Medium, or High.

- **Low-priority updates**: When this setting is set to Low and the "Update Required By (Date/Time)" value is in the past, CoPathPlus will first check to see if anyone is signed onto agents or a thin client server. If not, CoPathPlus will automatically process these updates. If users are active, CoPathPlus will disable signons and send a message to request signoff of all thin client and agent users currently signed on. The reminder message displayed on the CoPathPlus Agents is the same as seen when the Update Required By (Date/Time) System Setting value is in the future. (See above for an example.)

  System Managers signed on to regular fat client workstations will also receive a message reminding them that agents require Update processing. This mechanism provides a useful reminder to promptly accept CoPathPlus updates on agent machines that might otherwise be overlooked. An example of this message is displayed below.
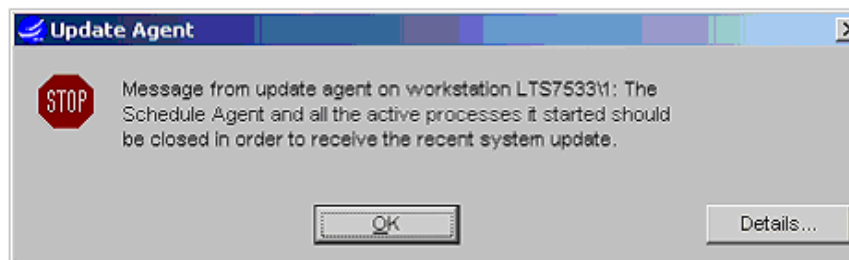
- **Medium-priority updates**: When this setting is set to Medium and the "Update Required By (Date/Time)" value is in the past, the "Do Not Shut Down this Workstation to Load Medium-Priority System Updates" check box in Workstation Setup will be evaluated to determine how to proceed for each agent. If the check box is clear, CoPathPlus will proceed with Agent Processing as if a Low-priority update is assigned. If this check box is enabled, CoPathPlus will proceed with Agent Processing as if a High-priority update is assigned. For Thin Client Servers, CoPathPlus will automatically shut down all users signed into this server and process the update.

- **High-priority updates:** When this setting is set to High and the "Update Required By (Date/Time)" value is in the past, CoPathPlus will force ALL agents and thin clients to be

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

shut down (if necessary) at the time specified in the Update Required By system setting to get the update, if they have not processed the Update already.

Tip! If you update the system setting date and time just before any CoPathPlus Update is initiated, you can assign an update date and time that is both convenient and will cause a minimum of disruption in your daily process. For example, all thin client users are usually finished with their daily work by 5 PM. If you plan to initiate an Update Process at noon, set your date/time to the current date with the time of 17:00, or shortly afterwards. Updates will proceed at this time ensuring timely update completion with a minimum of user disruption.

Tip! If System Managers do not wish to use this feature, set date in the "Update Required By (Date/Time)" System Setting to a distant future date such as 50 years in the future. If this is done, the value of the "Urgency of Last System Update" System Setting will not matter.

System Session Utilities

This topic details the following system session utilities that you may have permission to use depending on your security level.

- Display Current Users, which allows you to quickly see who is signed on to the CoPathPlus system.

- Display Session Maintenance, which provides a InfoMaker report of the data displayed on the Session Maintenance window.

- Display Error Log, which quickly shows you any SQL errors that may have occurred during the current session.

- Session Maintenance, which allows you to view a list of all the currently locked entities in CoPathPlus, send a message to a signed on user, and shut down an active session.

- System Performance Auto-Run, which allows you to run standard system performance tests.

- System Performance Graph, which allows you to graph two system test runs for comparison, and print a report that lists the numerical results for both tests.

NOTE: The Change Password and Failed Sign-On Attempts items are also found within the System Session Utilities folder.

Display Current Users

The Display Current Users item accesses a management (InfoMaker) report, which you can print out if you want, that quickly shows you who is signed on to the CoPathPlus system.

To access Display Current Users:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the System Session Utilities folder.

   A list of items appears under the System Session Utilities folder.

3) Double-click on the Display Current Users item.

   The Current Users report appears.

   The Current Users report displays the following information:

   o **User Name** shows, alphabetically by last name, who is signed on to CoPathPlus. To help differentiate people with identical names, the list also includes (when available) a person's code as entered in the Person dictionary entry for each person.

   o **Workstation ID** shows the unique identification for a workstation. The System Manager assigned this identification when he or she installed CoPathPlus on a workstation. Typically this data encompasses two identifiers: user and port number

the workstation is connected to (e.g., gks@202 identifies the user George K. Smith who is using the workstation connected to port 202).

- o **Start Date/Time** shows the date and time a user signed on to CoPathPlus.

- o **Session ID** shows the session identification number CoPathPlus assigned, as available. If a user has a problem on a site's CoPathPlus system, personnel from Cerner CoPathPlus may ask for this number.

- o **Status** shows **A** for each active session.

To learn about the controls on this report window, refer to "Viewing and Printing the Management Reports".

Display Session Maintenance

The Display Session Maintenance item displays the same data as the Session Maintenance screen, serving as a hardcopy printout for Session Maintenance when desired. The report is grouped to separate out jobs based on the user type computed column: fat client users, thin client users, interfaces, schedule agents, conversions, background jobs, and web users.

To access Display Session Maintenance:

1) Press the **T**ask**s** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the System Session Utilities folder.

   A list of items appears under the System Session Utilities folder.

3) Double-click on the Display Session Maintenance item.

   The Display Session Maintenance pop-up window appears.

Display Error Log

The Display Error Log item accesses a pop-up window that quickly shows you any SQL errors that may have occurred during the current session. **This information is used primarily for support purposes.**

To access Display Error Log:

1) Press the **T**ask**s** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the System Session Utilities folder.

   A list of items appears under the System Session Utilities folder.

3) Double-click on the Display Error Log item.

   The SQL Errors pop-up window appears.

   The SQL Errors pop-up window displays the following information:

o **Session** shows the session identification number CoPathPlus assigned, as available. If a user has a problem on a site's CoPathPlus system, personnel from Cerner CoPathPlus may ask for this number.

o **Error** shows the SQL error that occurred. It also specifies the exact location of the error.

Session Maintenance

The Session Maintenance item accesses the Session Maintenance window, which allows you to:

- View a list of users currently signed on to CoPathPlus, including information about each user's session.

- View other details about a session.

- View a list of all the currently locked entities in CoPathPlus.

- Shut down a session.

- View a list of all application servers on the system, along with any workstations on each.

- Troubleshoot and debug a session.

- Prevent users from signing on to CoPathPlus.

Session Maintenance Window

The Session Maintenance window displays the following information:

- **Display Area.** Review the list on the display area and select a specific user/session, depending on what you want to do. To learn about the resizing and resorting capabilities on this list, refer to "Other Features". For detailed information on the fields in this area, refer to "Display Area".

- **Refresh Now button.** Press this button to refresh (update) the display list now instead of waiting for the next automatic refresh time.

- **(Refresh) or every check box.** Select this check box and enter a number in the field to the right to specify how often (in seconds) you want the list to be automatically refreshed. If you do not select the check box, CoPathPlus will not automatically refresh the list even if there is a number in the Seconds field.

- **Details button.** Press this button to access the Other Details for Session pop-up window, which shows a list of application items currently running for the selected session.

- **Locks… button.** Press this button to access the All Locks pop-up window, which displays all users currently on the CoPathPlus system with a locked specimen, patient, or dictionary entry.

- **Message… button.** Press this button to access the Send Message to One or All Sessions pop-up window.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- **Shut Down… button.** Press this button to access the Shut Down One or All Sessions pop-up window, which lets you shut down one or all currently active sessions.

- **Thin Client Server(s) button.** Press this button to access the Thin Client Server Maintenance pop-up window, which lets you view a list of all application servers on CoPathPlus along with any workstations on each, including workstations not currently in use.

- **Troubleshooting button.** Press this button to access the Troubleshooting Session pop-up window, which lets authorized users analyze a selected session's interaction with the server, user key/mouse presses, and other data.

- **Disable Signons or Enable Signons button.** This lets you block or unblock all users from signing onto CoPathPlus. Depending on the current state of the system (as specified in the message at the lower left of the Session Maintenance window), this button will either say Disable Signons or Enable Signons.

Display Area

The Display Area of the Session Maintenance window shows the information listed below. The display includes a horizontal scroll bar and is shown in grid format, which allows column resizing, if needed. The total number of active sessions will be displayed in the lower left corner of the display area.

- **Session** shows the session identification number CoPathPlus assigned, as available. If a user has a problem on a site's CoPathPlus system, personnel from Cerner CoPathPlus may ask for this value.

- **Workstation** shows the unique identification for a workstation. The System Manager assigned this identification when he or she installed CoPathPlus on a workstation. Typically this data encompasses two identifiers: user and port number the workstation is connected to (e.g., gks@202 identifies the user George K. Smith who is using the workstation connected to port 202).

- **Last Checkin** shows the last time that session did a system check in. Normally a system check in is done every minute. However, certain things may prevent the session from being updated (e.g., after a system crash occurs, or during the running of long reports).

- **User Name** shows who is signed on to CoPathPlus, alphabetically by last name. To help differentiate people with identical names, the list also includes (when available) a person's code as entered in the Person dictionary entry for each person.

- **Type** shows a flag denoting the session type. The following flags are used: F= fat client, T= thin client, A = agent, I = interface job, B= background job, C = conversion process, and W = web (CoMed for Results) user.

- **Msg** shows a flag that indicates one of three things has been done to the session by someone using Session Maintenance:

  o <blank>: Nothing was done to this session.

  o **M**: A message has been sent to this workstation and it has not yet been displayed. This will normally happen once every minute.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

- o **S**: This workstation is marked to be shut down and should shut down within a minute. If the session experienced a system crash, you may have to manually shut down the system by pressing **Shut Down…**.

- **WS Group** shows the Workstation Group for the workstation.

- **PID** shows the process id assigned to this process under Microsoft Windows for that workstation, as seen in the Task Manager.

- **SPid** is the Sybase Server Process id, as seen on several Sybase maintenance displays (e.g., the output of the sp_who command).

- **ThinCli Id** is the workstation ID as seen in Citrix Server utilities that identify Thin Client processes on one Thin Client Server.

- **Sched Log Id** is the CoPathPlus-assigned session identifier for scheduled jobs or background print jobs running on an Agent.

These fields provide technical information that can be used by Cerner CoPathPlus personnel or site staff to troubleshoot sessions, check the status of individual jobs on agents or remote workstations, or investigate other system issues.

All Locks

The All Locks pop-up window allows you to see what entities on the CoPathPlus system are locked and by whom.

Use the All Locks window as follows:

Display Area. Review the list on the display area and select a specific session, as appropriate for what you want to do. Look at the grayed out field just below the display area to determine specifically which entity is locked. The following columns appears on the list on the All Locks window.

- **Hierarchy** shows you whether the session concerns a specimen, patient, or dictionary entity.

- **Type** currently only shows **write**.

- **Lock Key(s)** shows the internal identifier for what item is locked by this user in CoPathPlus. When you have a row highlighted, look at the grayed out field just below the display area to see which item the lock key is referring to (e.g., S97-889).

- **User Name** shows, alphabetically by last name, who is currently signed on to CoPathPlus. To help differentiate people with identical names, the list also includes (when available) a person's code as entered in the Person dictionary entry for each person. For example, see the **Courtney,Greg L.** entries on the above illustration.

- **Workstation** shows the unique identification for a workstation. The System Manager assigned this identification when he or she installed CoPathPlus on a workstation. Typically this data encompasses two identifiers: location and port number the workstation is connected to (e.g., blc@252 would identify the location for William L. Cummings who is using the workstation connect to port 252).

- **Session** shows the session identification number CoPathPlus assigned, as available. If a user has a problem on a site's CoPathPlus system, personnel from Cerner CoPathPlus may ask for this value.

To learn about the resizing and resorting capabilities on this table, refer to "Other Features".

NOTE: Whichever row you have highlighted on the All Locks window, when you return to the Session Maintenance window (by pressing **Done** on the All Locks window), the corresponding item will be highlighted on the Session Maintenance window.

Refresh every check box. Select this check box and enter a value in the field to the right of the check box to specific how often (in seconds) you want to automatically refresh the list. If you do not select the check box, CoPathPlus will not automatically refresh the list (even if there is a number in the second field).

Refresh Now button. Press this button to refresh the display area now instead of waiting for the next refresh time.

Session check box. Select this check box if you want to see only the locked objects for yourself.

Done button. Press this button when you are done working on this pop-up window.

Send Message to One or All Sessions

The Send Message pop-up window allows you to send an informative message to a single workstation or to all workstations.

Use the Send Message pop-up window as follows:

Message to Send to Session(s). Enter your message. This is a free-text field.

Send Buttons. Press either button as appropriate. You may not send a message to your own session.

- **Session Only.** Press this button to send the message to only the person/workstation you highlighted on the Session Maintenance window. CoPathPlus inserts an M in the Msg column on the Session Maintenance window when the message is distributed.

All Sessions. Press this button to send your message to all the active sessions as shown on the Session Maintenance window.

Shut Down One or All Sessions

The Shut Down Session(s) pop-up window allows you to shut down a currently active session or sessions when necessary.

Use the Shut Down One or All Sessions pop-up window as follows:

Message to Display when Session is Shut Down. Enter your message. This is a free-text field.

Shut Down. Press either button as appropriate. In both cases, CoPathPlus asks you to confirm your shut down request. Respond as appropriate. CoPathPlus will confirm the shut down request if that is what you told it to do.

- **Session Only.** Press this button to shut down the session of the person/session you highlighted on the Session Maintenance window. CoPathPlus inserts an **S** in the Msg column on the Session Maintenance window when a shutdown has occurred.

- **All Sessions.** Press this button to shut down all the active sessions as shown on the Session Maintenance window.

Use this option with caution. Once you select this option, CoPathPlus queues a shutdown message for the selected or all sessions. Every session checks this message queue when it is not busy. If a session encounters a shutdown message for it while it is not busy, then the shutdown message displays and the session shuts down. At that point, all changes in progress are ignored. (A session is considered busy when it, for example, is in the process of calling up a report, sending a report to a printer, saving data, etc.)

Troubleshooting a Session

NOTE: The Troubleshooting Session window should only be used when Cerner CoPathPlus personnel require authorized site users to assist them with debugging.

The Troubleshooting Session pop-up window lets authorized users perform PowerBuilder debugging and logging tasks, and also trace focus and input changes (i.e., record user mouse clicks and key presses).

Use the Troubleshooting Session pop-up window as follows:

Logging/Debugging Method. Select one of two methods to build the debugger log:

- **Regular:** Check this to specify the logging flags in the Code Execution Logging/Debugging area below that will be in effect once this window is closed.

- **Dynamic:** Check this to specify the actual conditions that will turn on and off the logger and debugger flags.

<u>Specify button</u>. This button is only enabled when the Logging/Debugging Method is **Dynamic**. Press this button to open the Dynamic Log/Debug Conditions pop-up window, which lets you specify the log and debug details.

Code Execution Logging/Debugging. These flags are only enabled when the Logging/Debugging Method is **Regular**. Use them to specify the information that will be stored in the debugger log.

- **<u>A</u>pplication Scripts.** Check this to include application-level PowerBuilder script calls in the log.

- **<u>T</u>ool Scripts.** Check this to include tool-level PowerBuilder script invocations in the log.

- **<u>S</u>QL Sent to Server.** Check this to include invocations of SQL code in the log.

- **<u>V</u>isible Log Window.** Check this to display a pop-up window containing all debugger log information.

- **Include <u>M</u>emory Use.** Check this to include RAM usage information in the log.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

- **Log to File:.** Enter the full path name of the text file (.txt) into which the debugging log will be saved. Or, press the ⋯ button to browse and select a file. This .txt file should be located on a local drive of the workstation.

- **Reset File on Close.** Check this to make sure that the debugger log file is initialized. If not checked, new information will be appended to the file.

Focus and Input Change Trace. Use this area to specify how the system will trace focus and input changes (i.e., record user mouse clicks and key presses).

- **Remember Last (number) focus and input changes.** Enter the number of focus and input changes the system will record.

- **Trace to File:.** Enter the full path name of the text file (.txt) into which the focus and input change information will be saved. Or, press the ⋯ button to browse and select a file. This .txt file should be located on a local drive of the workstation.

- **Reset Trace Flag on Close.** Check this to make sure that the trace file is initialized. If not checked, new information will be appended to the file.

Disable or Enable Signons

The current signon enabled/disabled status message is displayed in the lower left of the Session Maintenance window. If signons are currently enabled (i.e., users are allowed to sign on to CoPathPlus), press **Disable Signons** to prevent users from signing on to CoPathPlus. You must enter a message into the message box for distribution to all signed on users. For example, you would use this feature when you upgrade your CoPathPlus software because no users can be signed on to the system at that time.

If signons are currently disabled (i.e., users are prevented from signing on to CoPathPlus), press **Enable Signons** to allow users to sign back on.

System Performance Auto-Run

The System Performance Auto-Run item allows you to test the performance of certain aspects of the CoPathPlus database, individual workstations and their network connection, and network resources. A typical use of this item is to track down which aspects of a system are running slow.

NOTE: This item automatically runs all the tests set up in the System Performance Tester tool, which is accessed only by Cerner CoPathPlus personnel. The System Performance Auto-Run item is generally used by a user at a site to run a standard system performance test at any time, or when instructed to do so by Cerner CoPathPlus.

Accessing the System Performance Auto-Run Item

To access the System Performance Auto-Run item:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the System Session Utilities folder.

   A list of items appears under the System Session Utilities folder.

3) Double-click on the System Performance Auto-Run item.

   The System Performance Tester windows appear.

Running the System Performance Auto-Run Item

When you select the System Performance Auto-Run item, an explanatory text window and the System Performance Tester window appear.

Each time you use this item, CoPathPlus generates a new test run. It identifies each run by the workstation on which the run was performed and the date and time of the run.

In the Test Run Comment field, you can enter an optional free-text comment further describing the run. (You might want to enter your name, the workstation location, or other helpful information.) Press **OK** to continue. A Test in Progress window opens and fills the screen.

As the test is run, the name of each test and any associated graphics display (these usually flash by very quickly). To stop the run, press **Stop Testing**. You receive a message that the tests were stopped and no results were saved in the database. When the run has completed, the Test in Progress window closes and you receive a message that the tests are completed and saved in the database. To view the test run results and compare them against other runs, open the System Performance Graph item.

NOTE: Other tasks running on the workstations and servers being tested will affect test results. Shut down other applications on the system while the tests are run. Also, running the tests several times at different times of the day will gather results that will better estimate the "average" conditions.

System Performance Graph

Each time you use the System Performance Auto-Run item, CoPathPlus stores the completed test run in the database. The System Performance Graph item lets you graphically compare two stored test runs and print a report that lists the numerical results for both runs. Here are examples of potentially useful comparisons:

- **Compare one workstation to another**. If you think your PC is slower than another user's, compare a test run performed on each PC (preferably done at similar times of day so that the network and database loads will be similar). Some differences may be due to obvious factors such as different CPU speeds or different amounts of memory. But some factors are subtler, such as different video drivers. Or, if the network tests are consistently slower on one PC after numerous tests, it might indicate that one network segment is slower than another.

- **Generate two test runs on the same workstation**, one when the system is fast and the other when the system is slow. If nothing was changed on the PC between tests, the workstation-related test results should be about the same. However, the network and database results might vary widely depending on overall system load.

Database performance can vary greatly depending on the number of users, what they are doing, and what background jobs are running (especially printing patient reports and running management reports).

Database performance also decreases somewhat as the database size grows. If two test runs show a decrease in database performance at times when the server load is about the same, you may want to consult Cerner CoPathPlus support staff to see if the database needs tuning. Remember that database performance depends more on the kinds of activities and queries executing than it does on the size of the database. A large database takes longer to scan when running reports, but may not impact data entry. Yet a very small database performs worse during data entry due to contention among users because the active data is not spread out yet.

Accessing the System Performance Graph Item

To access the System Performance Graph item:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the System Session Utilities folder.

   A list of items appears under the System Session Utilities folder.

3) Double-click on the System Performance Graph item.

   The System Performance Test Graph window appears.

Accessing the Test Results

Use the System Performance Test Graph window as follows:

Run1… and Run2… buttons. Use these buttons to open the System Performance Test Lookup window and select the two test runs you want to compare.

Filter Tests with field. Use this field to refine the comparison that will be shown in the display area by including or excluding individual tests.

- To display all tests from the run, leave the field blank.

- To select specific tests to display, enter the leading characters of the test ID. For example, **z_cpu** will cause only the CPU tests to be displayed.

- To select specific tests to exclude from the display, enter the leading characters of the test ID preceded by the word **not** and a space. For example, **not z_cpu** means all tests except the CPU tests will be displayed.

Zoom field. This field specifies the size of the System Performance Comparison display as a percentage of the comparison's normal size. The default is 100%. You can increase or decrease the size of the display.

System Performance Comparison display area. This area shows the results of the comparison, and is divided into two sections:

- **System Performance Graph.** A color-coded bar graph shows individual test times (in milliseconds) for each run. Use the scroll arrows to move down the graph to see the test details.

- **System Performance Test Details.** This section lists the numerical test results for both runs, and a description of each test. Use the scroll arrows to move up or down the comparison.

Print/Send… button. When the comparison appears in the display area, you can send it to a printer or facsimile (fax) machine. Press this button and the Print/Send Setup pop-window appears.

Close button. Press this button to close the System Performance Test Graph window.

System Performance Test Lookup

The System Performance Test Lookup window allows you to select which two test runs will be compared by the System Performance Graph item. This window appears when you press the **Run1…** or **Run2…** buttons on the System Performance Test Graph window.

Use the System Performance Test Lookup window as follows:

Run on This Workstation check box. This box is selected by default when the window opens, and limits the search to only those test runs performed on this workstation. To open the search to include other workstations upon which system tests have been run, clear this box.

Run by Me check box. This box is selected by default when the window opens, and limits the search to only those test runs performed by you (i.e., the current user). To open the search to include other users who have performed system tests, clear this box.

From/To Run Date fields. Use these fields to limit the search to only those tests run during a certain time period. The **To Run Date** field is set by default to the current system date. To change a date, highlight the field and enter the desired date as MMDDYYYY.

Search button. After you have entered the desired values in the check boxes and date fields, press <u>Search</u> and a list of test runs will appear in the display area.

Display Area. Review the list of test runs in the display area and select the run you want for comparison. Highlight the run, then press **OK**.

Delete button. If you want to remove a test run from the list on the display area (and from the database), highlight it and press **Delete**.

Edit button. To edit the comment for a test run, highlight the run and press **Edit**. The System Performance Tester window will appear containing the existing comment, and you can make changes as needed.

Benchmark button. To mark a test run as a benchmark, highlight the run and press **Benchmark**. Benchmark tests are the standard against which other runs should be compared. Benchmark test runs are identified in the display area by a ****Benchmark**** designator, and will appear as the default **Run2…** on the System Performance Test Graph window.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

OK button. Highlight the desired test run in the display area, then press **OK.** The System Performance Test Lookup window will close and the run will appear on the System Performance Graph window.

Cancel button. Press this button to close the System Performance Test Lookup window at any time without saving your selections.

Cytotech Slide Workload Entry/Edit

The Cytotech Slide Workload activity enables sites to track Cytotech slide review workloads, tally hours and slide workloads entered using CoPathPlus. If the cytologist enters slides at other sites, that information may also be entered.

This activity helps sites to comply with Federal Register 493.1257 Cytology regulations regarding daily limits, weighted values of slide reviews based on automation or other factors.

Note: This activity is limited to Cytology.

Within CoPathPlus, the following dictionaries are integral to the functioning of Cytotech Slide Workload:

- Stain Process Dictionary
- Person Dictionary

Refer to the *Cerner CoPathPlus Dictionary Building Guide* for information about the above dictionaries.

In addition, the following system settings need to be configured:

- Enable Cytotech Slide Limits
- Warn when cyto is n slides from limit

Refer to "System Settings" in the *Cerner CoPathPlus System Manager Guide* for information on accessing and configuring system settings.

Accessing the Cytotech Slide Workload Task

To access the Cytotech Slide Workload Task:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on Cytotech Slide Workload Entry/Edit

   The Cytotech Slide Workload Entry/Edit window appears.

TIP! You can also access the Cytotech Slide Workload task by placing it in your Personal Menu and double-clicking on it from there.

Using the Cytotech Slide Workload Task

This window allows you to edit the Cytotech Slide Workload information. The Cytotech can also enter this information daily when first entering cytology results for a specimen. Refer to "Cytology Results (Cytotech)" for more information.

Use the Cytotech Slide Workload task as follows:

Cyto Reviewer. Select the cytology reviewer from the drop-down list.

Search Criteria. Enter the following criteria to search for dates for the reviewer.

- **Start Date.** Enter the earliest date for which you want to search.

- **End Date.** Enter the latest date for which you want to search.

- **Refresh button.** Press this button to refresh the information in the entry area when you enter values or to get the most current information (for example, if you leave your workstation for a few minutes, you may want to press this button to see if the information on this window has changed).

Cytotech Slide Workload entry Area. Enter the date of review, the number of hours that the Cytotech worked Inside (at your site) and Outside (at another site, if applicable) and the number of slides examined at the Outside site, if applicable.

Delete button. Select the row in the Cytotech Slide Workload entry area that you want to delete and click this button.

Insert button. Select the row in the Cytotech Slide Workload entry area that you want to insert a row above and then click this button.

Save button. Click this button to save your changes

Close button. Press this button to close the Cytotech Slide Workload window.

Fax Queue/Log

The Fax Queue/Log allows you to find out what happened to the faxes you requested CoPathPlus to send. The Print/Send functionality in CoPathPlus allows you to output patient reports or management (i.e., InfoMaker) reports to a network printer or through facsimile transmission (fax).

CoPathPlus has two options for sending faxes:

- **Automatic.** By using the Schedule Manager, you can have CoPathPlus automatically send faxes on a timely basis.

- **On demand.** You can send faxes on demand within those CoPathPlus activities that allow you to access the Print/Send Setup window. This window is used to designate the output device for printing out reports.

NOTE: If you requested a fax be sent as a background job or as a scheduled job, the Schedule Manager Queue and Schedule Manager Log indicate only what happened to the printing portion of a job and do not indicate what happened to the faxing portion. To learn about the Schedule Manager, refer to "Schedule Manager".

For detailed information on setting up the Fax Agent Server and installing the Fax Agent software in CoPathPlus, refer to the *CoPathPlus Fax Agent Setup Guide*.

Accessing the Fax Queue/Log

To access the Fax Queue/Log:

1) Press the **Tasks** command button on the CoPathPlus Application Manager.

   A list of folders and items appears on the right side of the Application Manager.

2) Double-click on the Fax Queue/Log item.

   The Fax Queue/Log window appears.

Printing the Fax Queue/Log

To print a copy of the Fax Queue/Log:

1) Access the Fax Queue/Log.

2) Select File > Print/Send Fax Queue/Log

You can also print from the Fax Queue/Log activity by pressing CTRL+P or by right-clicking anywhere in the fax datawindow and selecting "Lookup List Printout".

Using the Fax Queue/Log

The Fax Queue/Log is the main window you use to check on the status of the faxes you requested sent by CoPathPlus.
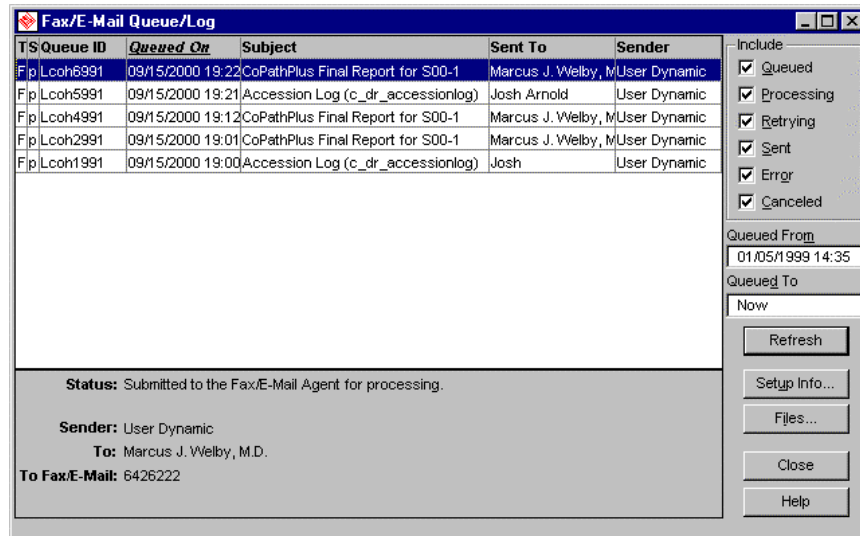
The main area of the Fax Queue/Log window contains a table that shows the requested faxes to be sent and their statuses. When you select a row, CoPathPlus provides more information in the lower (gray) portion of the window. To learn about the information in the columns on the table in the display area, refer to "Table Columns on the Fax Queue/Log Window". To learn about the information provided at the bottom of the window, refer to "Detailed Information Per Fax Entry".

NOTE: To learn about the resizing and resorting capabilities on this table, refer to "Other Features".

Use the Fax Queue/Log as follows:

Include. Select one or more fax statuses for CoPathPlus to display on the **Fax Queue/Log**. For more information about these fax statuses, refer to "Table Columns on the Fax Queue/Log Window". Select:

- **Queued** to show faxes that have been queued for processing.

- **Processing** to show faxes that are in the processing state.

- **Retrying** to show faxes that have failed on the first attempt and are still trying to transmit.

- **Sent** to show faxes that have been successfully sent.

- **Error** to show faxes that attempted to be transmitted but failed and when the failure occurred between the fax agent and the receiving fax machine. Examples are busy fax numbers or attempted transmission to a number that does not answer.

- **Canceled** to show faxes that were manually canceled.

- **Submit Errors** to show faxes where there was an error in the submission of the fax to the fax agent, such as inadequate information was passed to the fax server or there was a network failure or other system problem.

Queued fields. Use:

- **Queued From** to enter a standard date/time format (e.g., 7/1/07 13:45). CoPathPlus defaults in the date/time of 24 hours from the time you accessed the Fax Queue/Log.

- **Queued To** enter a standard date/time format or accept the default of **Now**.

Refresh button. Press this button to refresh the information in the display area when you enter values in the Include and Queued fields or to get the most current information (for example, if you leave your workstation for a few minutes, you may want to press this button to see if the information on the Fax Queue/Log has changed).

Setup Info… button. Press this button to access the Print/Send Setup pop-up window, which allows you to enter your print/send parameters. This button is only enabled if your assigned permission group allows access to this feature.

NOTE: Faxes that failed to be sent can be edited and resent through the Print/Send Setup pop-up window. For these faxes, the **Resend** button appears. Otherwise, the information on the window is for display purposes only, without the **Resend** button.

Files… button. Press this button to access the Files of [name of subject highlighted on the display area on the Fax Queue/Log window pop-up window], which allows you to see the list of files included as part of the selected entry. This button is only enabled if your assigned permission group allows access to this feature. For more information about this pop-up window, refer to "Files of [Subject]".

NOTE: Some time after a fax has been successfully sent, it is automatically purged from the system. Once purged, its information is not available on this pop-up window. The length of time between a successfully sent fax and when it is purged from the system was decided by your site during its implementation of the CoPathPlus system.

Close button. Press this button to close the Fax Queue/Log window.

Table Columns on the Fax Queue/Log Window

CoPathPlus displays the following information on the table columns on the Fax Queue/Log window:

- **Type (T).** The following types may appear:
  - **F** for fax.
  - **E** for e-mail. Currently CoPathPlus only supports fax.
- **Status (S).** The following statuses may appear:
  - **c** for canceled-a user manually canceled the fax at the Fax Agent server.
  - **e** for error-after a certain number of attempts, the CoPathPlus Fax Agent was unable to send the fax successfully. The number of times the Fax Agent attempts to send a fax was determined during the installation of your Fax Agent. Typically, it is two to four tries.
  - **p** for processing-the Fax Agent has started processing. This means that the fax agent may have it in the internal queue to send it through the next available modem, or it may be going through a modem now, or that it just completed sending and you are able to get confirmation.
  - **q** for queued-the Fax/E-Mail scheduling agent has queued the fax and is ready to "hand it over" to the Fax Agent server.

      o **r** for retrying-the Fax Agent is processing the fax entry again after a failed attempt. The Fax/E-Mail scheduling agent tries a set number of times before giving up and changing the status of this fax to **e**.

      o **s** for sent-the fax was sent successfully.

- **Queue ID.** This is the queue identification number that the Fax/E-Mail scheduling agent assigns to the fax. This ID can be used to find the fax job in the faxing software on the Fax Agent.

- **Queued On.** This tells you the date and time when the Print/Send Setup function originally put the fax on the queue.

- **Subject.** The Subject field from Print/Send Setup window provides the information for this column.

- **Sent To.** CoPathPlus shows you the name of the person to whom the fax was sent. If a To Institution had been specified, it appears in parentheses.

- **Sender.** For on-demand faxes, this is the user who requested the fax. For automatic faxing, it is either the user associated with the schedule group item type's application item, or if no one is associated, then it is the last user who edited the schedule group. (The latter only being the case if the user did the editing before the fax entry was generated.)

Detailed Information Per Fax Entry

Below the list of fax entries on the Fax Queue/Log window is a portion of the window reserved to display more information about whichever entry is highlighted in the top portion of the window.

Status. Spells out the status that is abbreviated in the table in the top portion of the window. To learn more about fax statuses, refer to "Table Columns on the Fax Queue/Log Window". Note the following:

- For the "Sent" status, CoPathPlus shows the time when the system confirmed the fax was sent, the transmission time in seconds, and the number of pages (including the cover page) sent. For example, **Sent on Sent on 5/12/05 at 16:38, transmission time 492 seconds, with 12 pages sent.**

- For the "Error" status, a diagnostic error message appears via the fax software you are using. For example, **Error: no answer (12).**

Sender. Shows the same information as the same named column mentioned in Table Columns on the Fax Queue/Log Window, though you will probably see more of the information in the Sender field below.

To. Shows the same information as the Sent To column mentioned in Table Columns on the Fax Queue/Log Window, though you will probably see more of the information in the To field below.

To Fax. Shows the fax number used.

Document Title: Cerner CoPathPlus User Guide v3.1   Document #: 30TRGEXT013022 Rev: 002
Eff. Date: June 12, 2009   Owner: CoPathPlus Lab Operations
Cerner Corporation   Confidential Information

Resend on. Shows the date and time that a resend fax request was made, and who made it. This information is included only if a request to resend this fax was made. (This can be done for an errored fax using the **Setup Info** button.)

The Details portion of the Fax Queue/Log will also indicate if a fax was requested with a high priority. For more information on high priority faxing, refer to "Print" in the "Reports" section of this user guide.

Files of [Subject]

The Files of [Subject] pop-up window allows you to see the list of files included as part of the fax you highlighted on the Fax Queue/Log window. When you highlight a row on the Files of [Subject] pop-up window and press **View**, CoPathPlus opens a fax file viewer application that shows you to view an image of the actual fax output of that part of the fax. Notice that the total size of all the files in this subject is noted at the bottom of the pop-up window. Press **Close** to exit this pop-up window.

NOTE: Some time after a fax has been successfully sent, it is automatically purged from the system. Once purged, its information is not available on this pop-up window. A message box appears to indicate this if this is the case. The length of time between a successfully sent fax and when it is purged from the system was decided by your site during its installation of the Fax Agent.

This page was intentionally left blank.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Glossary Of Terms

Accession

Represents the routine through which specimen information is first entered into the computer. A specimen must be accessioned before anything else can be done to it in the system. Accession provides the ability to automatically generate a specimen number for a specimen upon user request. It includes the ability to enter a new specimen record into the database.

Addendum

Represents a diagnosis or other information that supplements the original principal diagnosis for a specimen. One or more addenda can be added to any case through the Procedure/Addendum Entry/Edit activity. Addenda are generally added after signout, although they can be added before signout. You can use addenda when you do not want to amend a case. (An amendment reverses the signout.) For example, you would create an addendum for a signed-out specimen to:

- Describe the results of a consult that confirms the Final Diagnosis.

- Note the results of a procedure.

- Add a comment.

- Note a minor correction in one of the diagnosis text fields.

Adequacy

See Specimen Adequacy.

Admission/Discharge/Transfer (ADT) Interface

Constitutes the configuration of hardware and software that allows CoPathPlus to receive admission/discharge/transfer (ADT) data for patients from a hospital information system.

ADT Interface

See Admission/Discharge/Transfer (ADT) Interface.

Amendment

Reverses the signout of a case or of a procedure/addendum to permit editing of key diagnostic information such as the Gross Description, Part Types, or Final Diagnosis. When you reprint a report for an amended case or procedure, an "amended" banner is printed on the report (unless the amendment is designated a minor amendment in the Amendment Reason dictionary).

To edit non-diagnostic information for a signed-out case without reversing the signout, use the Post Signout Edit feature. To add supplementary diagnostic information without reversing the signout, add an addendum.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Application Manager

Serves as the gateway to all the functions and activities within CoPathPlus. It contains the command buttons, the Personal Menu list, and an area to the right of the Personal Menu that serves as a menu for the **Reports**, **Tasks**, **Dictionaries**, **Setup** command button functions, and (from the menu bar) the File, Browse Items choices. This area also displays system-wide broadcast messages when appropriate and is labeled "Messages" when you first enter CoPathPlus.

The combination of the Application Manager open on top of the Main CoPathPlus Window make up the "home base" from which you access the various functions and activities within CoPathPlus.

Attachment

Represents information (e.g., image, sound file, media clip) that originated from and is manipulated by an application external to CoPathPlus but is accessible through CoPathPlus. How CoPathPlus accesses the attachment depends upon the attachment class and technical implementation.

Attachment Class

Represents the mode of acquisition of an attachment. Each attachment class is associated with a application that your site uses to acquire, review, edit, and, in some cases, delete attachments belonging to that attachment class.

Audit Trail

Represents a record of changes made to the database or to the system configuration. CoPathPlus keeps track of what action or event occurred, when (date and time) it took place, and who executed it . Audit trails exist for dictionaries, patients, and specimen records.

Axes

Represent categories of nomenclature for SNOMED codes. The axes (or categories) are Topography (T), Morphology (M), Etiology (E), Function (F), Procedure (P), Occupation (O), and Disease (D).

Billing Chute

Represents an automatic destination or output method for sending billing data captured by the CoPathPlus system over a hospital interface. Billing chutes are defined in the Billing Chute dictionary.

Billing Number

Used in third-party billing to identify the clinician who performed a service.

Billing Type

Identifies a billing category or group to which specific charges can be assigned. These "groups" can be charged different fees for pathology procedures.

Card Case

Contains historical data from old cases that were originally recorded on cards. Card cases generally contain less detailed information than regular cases and cannot be signed out in the

CoPathPlus system. Because of these characteristics, card cases are assigned to specimen classes created specifically for card cases, such as Cytology Card or Surgical Card.

Client

Constitutes an institution or other entity that sends specimens to the pathology laboratory. Examples of clients include your site where the pathology laboratory is based, other hospitals, physician groups, and clinics. Typically, it is the client that collects the specimen and that receives the report of the diagnosis results.

Client Report Chute

Represents an automatic distribution channel for delivering patient reports to clients via print, fax, or e- mail . Client report chutes are controlled by settings in the Client dictionary, the Report Chute dictionary, and the Specimen Class dictionary.

Data Field

Represents a field in the CoPathPlus database that you want included in your report and is answered when you run the report.

Department

Identifies the area of a pathology laboratory where the specimen is processed and diagnosed.

Departmental Report Chute

Represents an automatic distribution channel for delivering patient report batches to a single destination via print, fax, or e- mail. Departmental chutes include printed hardcopy (such as Physician Hardcopy or Client Hardcopy chutes), departments (such as Medical Records), and non-client institutions (such as the Outside Institution chute). Departmental report chutes are created directly in the Report Chute dictionary and are controlled by settings in the Specimen Class dictionary.

Dictionary Worksheet

A blank form that lists all the fields for a specific dictionary. You fill out a dictionary worksheet for each entry in a specific dictionary (e.g., the liver biopsy entry in the Part Type dictionary), and then use the forms to guide you as you build the dictionary.

Distributed Processing Agent PC

Identifies a dedicated workstation in the client/server environment that is set up with software that handles the processing requests from multiple clients (i.e., user PCs) for a specific process, such as scheduling batch print jobs or handling fax jobs. A site with heavy reporting demands can have more than one distributed processing agent PC on its system.

Electronic Signout

Allows a pathologist or cytotechnologist to sign out a report or procedure electronically, instead of manually signing the printed copy of the Final Report. Electronic Signout, or ESO, provides pathologists and cytotechnologists with access to reports as soon as they are ready to be signed out. You can view reports on the computer screen, edit them as needed, and sign them out— without having to handle stacks of paper to get the work done. Electronic Signout streamlines the administrative effort required to produce reports and improves turnaround time.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation
Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Encounter

Represents a patient "admission," or "visit," or "episode of care." Each encounter has a corresponding number, which is usually passed to CoPathPlus via an ADT interface and used for billing purposes. The encounter number identifies an admission record in the Cerner DHT database.

If your site does not have an ADT interface, you may choose not to record encounters at all. Encounters assist with specimen accession by providing default values and for tracking additional information not captured with the specimen. However, encounters are not required.

Encounter Number

Represents the number associated with a patient encounter.

Event

Represents any operation performed on a specimen or any milestone achieved that is included in the Audit Trail. These operations and milestones are defined as events in the Events dictionary. CoPathPlus keeps track of what the action or milestone was, who performed it, and when (date and time) it took place. Examples of events include accessioning, ordering special procedures, and signout.

ESO

See Electronic Signout.

Fee Code

Represents a code associated with a fee charged for pathology services. You can define fee codes for each of the processes performed within the department, such as standard processing, special stains and procedures, and for other items such as Consults. You can associate separate technical and/or professional numbers and dollar amounts with each fee code.

Fee Code Schedule

Consists of a matrix for all possible fee code/billing type combinations, containing codes and prices for the technical and professional components of each service performed by the lab. Supports the variation in fee codes and prices for services performed in a pathology lab for different types of patients and/or clients (i.e., billing type). To build this schedule, your site associates a billing type with a particular fee code and specifies the charge for that particular combination.

Filters

Represent an additional set of search criteria to limit the number of choices presented to you in a CoPathPlus database search.

Financial Class

Identifies a financial status (e.g., Bill to Medicare, Bill to Patient) that your site can associate with a patient. Financial class has important billing implications because it determines how your laboratory's billing provider will handle billing for a particular patient encounter.

Gregorian Dates

Are represented by expressions that specify the month, day, and (optionally) year. January 1, 2000 and 13 May are both examples of Gregorian dates. Gregorian dates are awkward to use in calculations, so most computer applications store dates as Julian dates.

HIS

Acronym for Hospital Information System, a general term for computer systems that handle patient registration, financial information, and other data used in a hospital setting.

HL7 Interface

Is a widely used standard data format for transferring medical records between hospital information systems.

ICD-9-CM Code

Represents a diagnosis code used in standard insurance billing. ICD- 9- CM refers to *International Classification of Diseases, 9th Edition, Clinical Modification*, published by the U.S. Department of Health and Human Services. The United States Congress/HCFA mandates the use of ICD- 9- CM codes in order to standardize coding practices for proper reimbursement of procedures on Medicare and other patients. ICD- 9- CM is based on the *International Classification of Diseases, 9th Edition*, published by the World Health Organization.

Implementation

Is the process of installing and customizing CoPathPlus at your site. Building dictionaries is one of the key activities in the implementation process. Refer to the *CoPathPlus Implementation Manual* for more information about implementation.

Interface

Is required if your site plans to convert specimen data from another database into CoPathPlus.

Interface Link

Is a unique identifier that is used to match dictionary entries in CoPathPlus with the corresponding data in other databases. You must fill in the Interface Link field for each entry in a CoPathPlus dictionary if your site plans to convert data from another database into CoPathPlus.

Interpretations

Represent the "diagnosis" portion of the specimen review. Interpretations are the cytotechnologist's and pathologist's judgments about what is seen in a specimen. Interpretations also help determine whether a specimen must be submitted for MD Review, and whether the specimen is considered "within normal limits." CoPathPlus uses Interpretations to account for the Standardized Nomenclature notions of "General Categorization" and "Descriptive Diagnoses."

Julian Dates

Are expressed as a number that represents the number of dates since January 1, 1900. Because date calculations are easier with Julian dates than with Gregorian dates, spreadsheet and database applications stores dates as Julian dates.

Document Title: Cerner CoPathPlus User Guide v3.1
Eff. Date: June 12, 2009
Cerner Corporation

Document #: 30TRGEXT013022 Rev: 002
Owner: CoPathPlus Lab Operations
Confidential Information

Keyword Lookup

Large dictionaries such as the coding dictionaries (SNOMED II Code, SNOMED International Code, and ICD- 9- CM Code) use a special "keyword" lookup capability to assist with lookups. Each significant word in the name of the dictionary entry is automatically made a lookup value for that entry. You can also enter additional keywords explicitly.

To search for an entry in a keyword dictionary, you must enter at least three characters. You may enter multiple words, separated by spaces. Each word entered is treated as a separate search string, and only those entries that match all the keywords are displayed. For example, if you enter "squa metap," you will see a short list of codes relating to squamous metaplasia, as opposed to a much longer list that results from entering one keyword. Included in the short list is "Adenocarcinoma with squamous metaplasia" even though the name does not begin with either of the values entered.

Label Chute

Represents an automatic means of printing container and requisition labels as needed for new specimens. Label chutes are controlled by settings in the Label Chutes dictionary. Each label in the Label dictionary has a default label chute. You can also set up routing rule/label chute associations for labels in the Label dictionary.

Location Report Chute

Represents an automatic distribution channel for delivering patient reports to patient locations via print, fax, or e- mail . Location report chutes are controlled by settings in the Location dictionary, the Report Chute dictionary, and the Specimen Class dictionary.

Logic Tables

Used by the Automatic SNOMED II Coder to associate SNOMED II codes with words or phrases used in diagnostic text fields.

Lookup Values

Enable you to quickly select a dictionary entry from a list in a lookup window. (Lookup values are not used with dropdown lists.) The system automatically creates at least two lookup values from the text in the Name and Abbr. fields. You can also add lookup values to a dictionary entry manually.

Manual Signout

Is based on printed reports and involves several steps: a review of a hard-copy report by the pathologist, entering or editing results by a transcriptionist, and later transcriptionist/clerical signout in lieu of the pathologist or cytotechnologist. See Electronic Signout.

Multi-Instance Fields

Allow you to enter as many values as necessary. The Lookup Values field on a dictionary Name tab is an example of a multi- instance field.

Natural Language Search

Is a technique for searching for specimens in the database by analyzing the language in diagnostic text fields such as the Final Diagnosis field. Natural Language Search is used in the Natural Language Search Report, found in the Case Diagnostic Reports folder under Reports.

NOS

Abbreviation for Not Otherwise Specified, often used as in the label text and as a lookup value for SNOMED II, SNOMED International, and ICD-9-CM codes.

OSP

See Other Specimens for Patient.

Other Specimens for Patient

Allows you to view or include in a printed report other specimen data for the same patient. The number of specimens to include and the number of months to search for specimens as well as the permission group required to print them are set individually for each specimen class in the Specimen Class dictionary.

Outside Institution

Is a destination entered as free text in the Outside Institution field on the Staff/Copy To or the Billing/Copy To tab on the Accession Entry/Edit activity. You can enter the name and address of any physician or institution for which you want to print copies of the report for that specimen. If an Outside Institution destination is filled in for particular specimen and if an Outside Institution Chute is defined for that specimen class, a copy of the report will be printed for that destination.

Outside Institution Chute

A special departmental report chute that makes it possible to automatically print copies of reports for destinations for which there is no corresponding entry in the Report Chute dictionary. Outside Institution Chutes are set up for each report type for each specimen class in the Specimen Class dictionary.

Part Type

Represents the component of the specimen that is submitted for diagnosis. In Surgical Pathology and Autopsy, every specimen comes from a part of the body. Each part may have one or more sectioning sites. Each sectioning site may have one or more blocks.

Patient Type

Indicates a classification of the patient with a specific encounter/ admission record (e.g., Inpatient, Outpatient). It is sometimes referred to as the Admission Class.

Permission Group

Sets permissions for access to application items (e.g., accessioning, editing dictionaries, or running reports), specimen classes on which a user can view or edit data, report chutes, and miscellaneous functions, such as signout or QC review.

Person Type

Identifies a CoPathPlus user as part of one of the categories of persons recognized by CoPathPlus, so that it will display as a choice in appropriate fields (e.g., the Gross Pathologist field will accept the pathologist, resident, fellow, and PA/diener person types, but not cytotech or unspecified user ones). It also helps identify different setup requirements. For example,

transcriptionists require sign- on privileges but not demographics or clinical settings; while a cytotech and pathologist would require the three items mentioned above.

Physician Report Chute

Represents an automatic distribution channel for delivering patient reports to physicians via print, fax, or e-mail . Physician report chutes are controlled by settings in the Person dictionary, the Report Chute dictionary, and the Specimen Class dictionary.

Post-Signout Edit

The Post-Signout Edit activity allows you to edit non-diagnostic information on a specimen (case) after it has been signed out. You can edit data such as the encounter and billing numbers; specimen/requisition deficiencies; names of the staff, such as pathologist and cytotech, associated with the case.

If you need to edit diagnostic data for a signed-out case, then you must use the Amendment Entry activity to amend the case. To add new diagnostic information to a signed-out case without amending it, used the Procedure/Addendum Edit/Entry feature to add an addendum.

Priority

Specifies the expected turnaround time for specimen results. Specimens are tracked to assess the lab's ability to complete specimens within the expected turnaround time.

Procedure

Is considered an addendum with unique features. Like addenda, procedures generally provide a diagnosis or set of information that is supplemental to the original diagnosis on a case. But in contrast to addenda, procedures:

- Come from the review of test or slide results that pertain to a unique or non-routine diagnostic procedure or process rather than light microscopic review of standard histologic stains/slides.

- May be the only process performed on a specimen. This is why CoPathPlus provides a Surgical Procedure Only and Cytology Procedure Only specimen class.

- Often capture additional data as compared to addenda, such as which procedure is performed and test results (e.g., procedure "comment").

Project Manager

A Cerner DHT associate who is your site's primary contact person throughout the CoPathPlus implementation process.

Protocol

Represents a script for a series of steps (ordering blocks and stains/processes) that are performed together on a specimen. Once you create and save a protocol, you can run that protocol whenever you need to perform the same steps on a specimen. You can associate a default protocol with a part type in the Part Type dictionary. CoPathPlus will then automatically load the default stain/process information when you use that part type.

QA

Abbreviation for Quality Assurance. Quality Assurance refers to any program done by a lab to examine the quality of its work. QA programs include peer review, comparing Intraoperative and final diagnoses, or randomly re-screening specimens.

QC

Abbreviation for Quality Control. In a pathology lab, QC refers specifically to the re-screening of cytology gynecological specimens done to meet the CLIA '88 regulations.

Quick Text

Represents text and formatting stored for repeated use when entering text in a CoPathPlus diagnostic text field, such as Gross Description or Final Diagnosis. Instead of retyping a long text passage into a text field, you can simply insert the Quick Text. Examples of Quick Text include:

- "Pap smear, no abnormalities identified. No endocervical component present."
- "No evidence of carcinoma."
- "Fine needle aspirate of thyroid with benign follicular cells and blood."

Recommendations

Represent suggestions a cytotechnologist or pathologist might make regarding future handling of a cytology case (e.g., repeat screen in 6 months). Recommendations usually apply only to parts that have a specimen adequacy of "unsatisfactory" and for which additional samples and/or preparations are warranted.

Registration

Registration is the process by which you initially enter demographic information for a patient into the CoPathPlus database. If the patient is new to the database, you can either enter registration data manually or receive it through an Admission/Discharge/Transfer (ADT) interface.

Report Chute

Represents an automatic distribution channel for delivering patient reports via print, fax, or e-mail to departments, locations, physicians, or clients. Report chutes are defined and enabled in dictionaries.

Report chutes are maintained in the Report Chute dictionary, or in one of the three dictionaries linked to it (Location, Person, and Client dictionaries). Report chute delivery rules are defined for each specimen class in the Specimen Class dictionary, which is also where report chutes are enabled or disabled for each specimen class.

Some report chutes, such as the Medical Records chute, are simple chutes where all reports are delivered to the same destination. Other chutes, such as the Location, Physician, and Client chutes, are compound chutes where each location, physician, client, etc., can have its own report delivery destination.

Report Types

Are predefined classes of patient reports that can be automatically generated for specimens in a particular specimen class. The six predefined report types include Final Report, Procedure Report, Working Draft, Preliminary Final Report, Addendum Report, and Other Specimens.

You can enable or disable each report type for a specimen class and define the distribution rules for that report type in the Specimen Class dictionary. Distribution rules control which report chutes are enabled for that report type, whether any condition must be true for reports of that type to be sent to a particular report chute, and what event triggers reports of that type to be distributed.

Retrieval Flags

Allow you to create your own site-specific categories or lists of specimens for management reports or later retrieval. You can use these flags to mark cases for cases for conferences, research projects, a tissue committee, or a special disposition of the tissue. You create retrieval flags in the Retrieval Flags dictionary and assign one or more retrieval flags to a specimen in the Accession Entry/Edit activity.

Routing Rules

Are optional rules associated with label chutes that allow you to use conditional logic to send container and requisition labels to different label chutes. A routing rule consists of a label chute, a statement with one or more rule clauses, and an optional comment. Routing rules are defined in the Label dictionary.

Service

Indicates the section of the hospital where a patient receives treatment, such as Oncology, OB/Gyn, Emergency, or Surgery. In CoPathPlus, the Service dictionary stores the list of service areas available for a client.

SNOMED Codes

Refers to coded diagnostic terms from the *Systematized Nomenclature of Medicine, Second Edition*, known as SNOMED II, and the *Systematized Nomenclature of Human and Veterinary Medicine, Third Edition*, known as SNOMED International, both published by the College of American Pathologists. SNOMED codes categorize pathology cases by a series of alphanumeric codes for easy searching and retrieval purposes. The SNOMED coding system consists of several modules that begin with a different letter of the alphabet. Most CoPathPlus sites are primarily concerned with the M (morphology) and T (topography) axes, as these identify a specimen by its body site and diagnostic condition. CoPathPlus provides separate dictionaries for SNOMED II and SNOMED International codes.

Specimen Adequacy

Indicates a judgment about the extent to which a given cytology specimen is acceptable for diagnostic evaluation.

Specimen Class

Provides a way to define or categorize cases. A specimen class represents a category assigned to the specimen, which defines or controls the workflow of the specimen. It determines such things

as which windows you see during accessing, choices for report templates, the specimen number prefix, and choices for dictionary entries in various fields.

Standardized Nomenclature

Represents a widely accepted method of reporting diagnostic information for cytology specimens using standardized wording. Standardized Nomenclature describes specimens both according to their adequacy for interpretation and their diagnostic interpretation, so that all cases with the same conditions analyzed by the same laboratory will be reported with consistent wording. Standardized Nomenclature is sanctioned by the Clinical Laboratory Improvement Act (CLIA) and is documented in the 1988 Final Rule, known as CLIA '88.

System Setting

Represents a site-specific constant or switch. These settings are determined by your site at implementation time and vary by site. An example of a system setting would be your site's decision to use Arial font for all text fields in CoPathPlus.

Text Type

Refers to a category of free-text field, such as Final Diagnosis, Gross Description, or Physician Notification that can appear on a CoPathPlus window or in a report. The system uses text type to determine which text fields to index for searching, which Quick Text entries should be available in a particular text field, and which Quick Text entry to use as the default for a part type. Text Types are defined in the Text Type dictionary.

User-Assigned Key

Represents the unique code or abbreviation that you are required to enter before creating a new entry in any of the following dictionaries: ICD-9-CM Code, SNOMED II Code, SNOMED International Code, Specimen Class, Specimen Number Wheel, and State. This code or abbreviation serves as the key for that dictionary entry.

User ID

See User Identification Code.

User Identification Code

Represents a string of characters, distinct from a password, that is required for logging on to CoPathPlus. All authorized users have a user ID.

UPIN

Acronym for Universal Provider Identification Number. UPINs are required for third-party billing. A physician's UPIN can be used as a lookup value when you search for a physician in a lookup window.

Validation Rule

Represents an expression that describes the number format for a Medical Record Number or an Encounter Number for a client in the Client Dictionary. If a validation rule exists, the system uses it to ensure that users enter numbers in an appropriate format for that client.

Worksheet

See Dictionary Worksheet.

Worklist

Contains an online list of specimens, procedures, and reports ready for batch processing through a single activity, such as Signout (Electronic) or Cytology Results. In other words, all the items in have the same next step. Your site defined the worklists that will be available to your site during the CoPathPlus implementation process.