MED2020
Health Care Software Inc.

User Guide

WinRecs User Guide

User Guide

Version 298.1

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MED2020 Health Care Software Inc.

MED2020 Health Care Software Inc. (MED2020) is a leading provider of modular health information management solutions for the health care industry.

MED2020 provides solutions to assist capturing, reporting and analyzing health data to:

- Enable enhanced information sharing
- Encourage informed decision making, and
- Streamline facility operations.

MED2020's flagship product, WinRecs™, is the foundation for a complementary suite of modules designed to assist health information management departments with their operational needs.

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About This Document

The information contained in this document is intended as a User Guide to system functionality in the MED2020 WinRecs suite of applications.

To learn more about installing and managing WinRecs at the system level please refer to the WinRecs Server Administration Guide, also available as a download from the MED2020 Client site, located at ftp://web.med2020.ca.

Note: For All Paths that reference Program Files – if your system is 64-bit the path will be Program Files (x86)

Note: The images contained in this document are for illustrative purposes only.

Document Conventions

Throughout this User Guide, text formatting is used to complement the information provided.

Function keys and key sequences are distinguished by large bold text.

Example: **CTRL + M**

Module and function names used in the application are distinguished by italic text.

Example: *WinRecs Application Menu*

Cross-references to other sections of the User Guide are distinguished by bold text.

Example: **Introduction to the CPI Layout**

Important notes and hints are distinguished by text with a gray background.

Example: **Note: This is an important note**

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Pop-ups and Hyperlinks in WinRecs

- If you see a word that is underlined, it is either a hyperlink or a pop-up.
- Clicking a hyperlink moves you to another topic within the help system.
- Clicking on a pop-up generates a new window containing important information relative to the underlined word clicked. Hyperlinks can also take you to a website.
  If you want to return to the topic that you were previously on, click the **Back** button.
- You can also choose to print a pop-up topic by right clicking within the pop-up window and selecting **Print**.

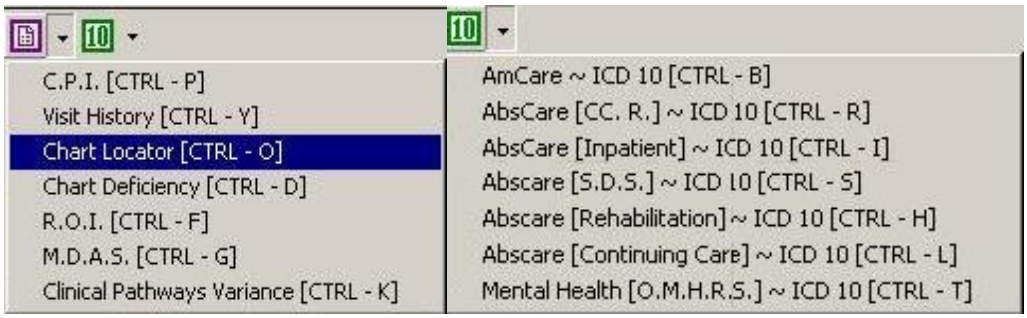
Hotspots and Hot Links

- Hot links will open up websites. You must be connected to the Internet for them to work.
- Hotspots are areas on images that contain pop-ups or hyperlinks. If you move your mouse over an area in the image, notice when the cursor changes from an arrow to a hand. Once it turns into a hand, click to see more information regarding that area.

Hot Linking Between Modules

- To hot-link to other WinRecs modules, select either the Chart Maintenance or Abstracting Hot Link from the icon bar.

Hot-linking generates a NEW record in the receiving module. The drop-down arrow is used to select a different module.



Note: Only modules licensed by your institution will be available.

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About WinRecs

First introduced to the Canadian market in 1996, MED2020's flagship product, WinRecs™, has evolved to become one of the most comprehensive Health Information Management software solutions on the Canadian market. WinRecs is a customizable abstracting and reporting system that is currently being used by hospitals to support decision-making at corporate, regional and provincial levels. The WinRecs Suite of Products provides solutions for Inpatient, Clinical and Ambulatory Care Services, including modules for DAD, NACRS, CJRR, Cancer Care, OHMRS, NRS and CCRS. Furthermore, WinRecs offers a new Computerized Assisted Coding tool for diagnosis and intervention coding, in addition to the complementary modules, Concurrent Review and Chart Maintenance.

WinRecs Features

- User customization without vendor intervention
- Sort ordering of fields to individual user's preference
- Enabling/disabling of fields
- User defined edit checks
- Report selection/distribution
- Default values for faster input
- 20 free user-defined fields customized by the user
- Contains provincial and national fields and edit requirements
- Integrated reports library
- Interface capabilities – HL7, Batch

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1 Introducing WinRecs

1.1 Overview

The WinRecs Suite of Modules is a state-of-the-art coding and abstracting system designed to increase productivity while assisting with quality assurance for Health Information Management departments. This document provides a guide for using various modules of this application.

Note: WinRecs must be installed using a local installation with the WinRecs.exe running from individual PCs.

1.2 Logging on to the WinRecs Application

To open the application, begin by double-clicking the WinRecs icon located on your computer desktop.

The following log on dialog displays.

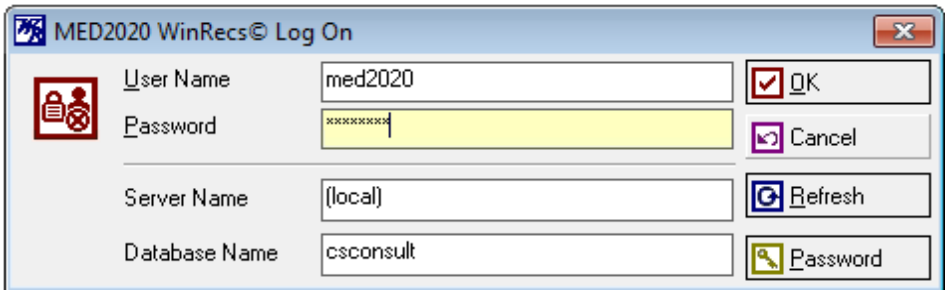

Figure 1: *WinRecs Log-on Dialog Box*

The following table describes the buttons displayed in the above Log On dialog:

	OK	Click this button to log on to WinRecs once all fields have been populated.
	Cancel	Click to close the log on dialog and return to your Windows desktop.
	Refresh	Click to refresh the list of available servers and databases attached to the server.
	Password	Click to initiate a password change.

To log onto the WinRecs, enter the required information then click **OK** (once) or click **ENTER** twice to refocus on the **OK** key (default is on **Cancel**):

- **User Name:** This is assigned in User Profile and is individualized for each user.
- **Password:** This is initially assigned in User Profile. For information regarding Change of Password see the **Changing your Password** section in the document.

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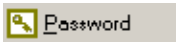
- **Server Name / Database Name**: The Server/Database is set when your system is set up. After you have logged on successfully to WinRecs the first time, your server name and database name will be remembered by the application.

Note: For security reasons, the password is masked. WinRecs tracks all user activity. For new installations it is recommended you change your password as soon as possible. Do not share this password. Passwords are case sensitive.

1.3 Changing your Password

- On the Log On dialog, enter your existing password
- Click the 

button.
- Type a new password, and confirm in the boxes provided.
- Click **OK** to save your new password.

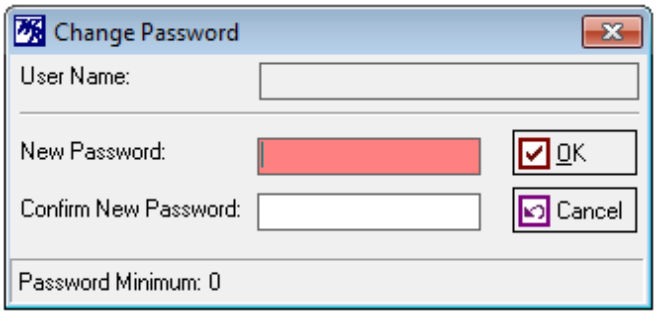


Figure 2: WinRecs Change Password Dialog Box

Note: If your account has been locked out due to repeated failed login attempts, contact your facility's WinRecs system administrator to have your account unlocked.

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Once you have successfully entered your password, the MED2020 WinRecs® 'Splash' screen displays. Bypass it by pressing the **ESC** key on your keyboard.

Figure 3: MED2020 WinRecs® 'Splash' Screen

1.4 Custom Privacy Message

You can customize a Privacy Message at the Regional or Hospital Level, allowing users to accept or decline after login into the WinRecs. By default, this feature is disable and only available if there is text in the Privacy Message field in either Regional Profile or Hospital Profile.

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To configure

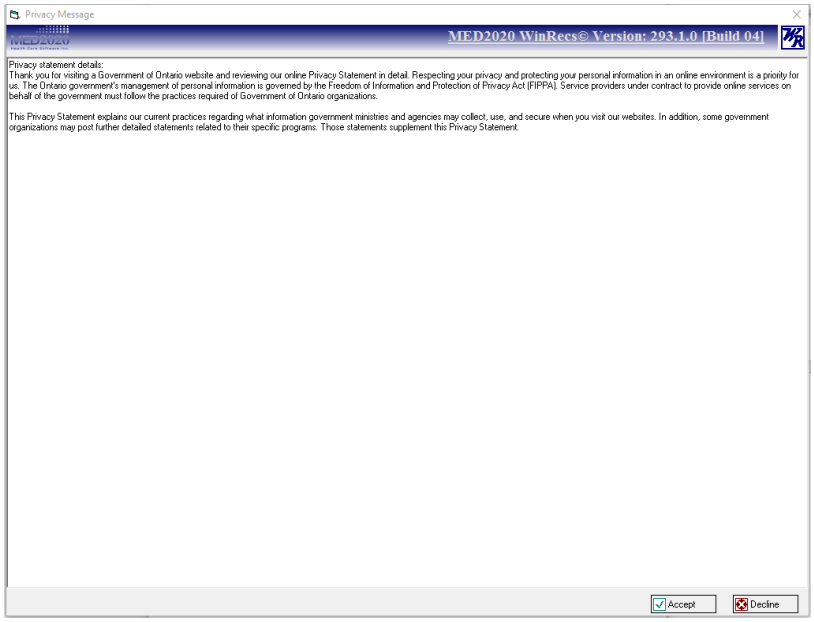
The field Privacy Message in Regional Profile and Hospital Profile allow plain text to be pasted into it (to a maximum length of 4000 characters if SQL2000 and unlimited for later SQL versions).

At the Regional Level: Enter text in the “Privacy Message” field in Regional Profile settings. The privacy message will be the same for all the Region (all the Hospitals in that Region).

At the Hospital Level: Enter text in the “Privacy Message” field in Hospital Profile settings. The privacy message will only display for that specific hospital. Notice that Hospital Privacy Message will override the Regional Privacy Message.

Note: If privacy message is not set, then the pop-up privacy window will not be displayed. If the privacy message field is blank in both Regional and Hospital profile, then no pop up message will display.

If Privacy Message is entered, then users of WR application will see a pop-up Privacy Message right after the MED2020 copyright splash screen.



If user Accept, then a normal WinRecs operation will follow.

If user Decline or close this window (click on an X on the top right of the pop-up), then the system will log off the user from WinRecs Application.

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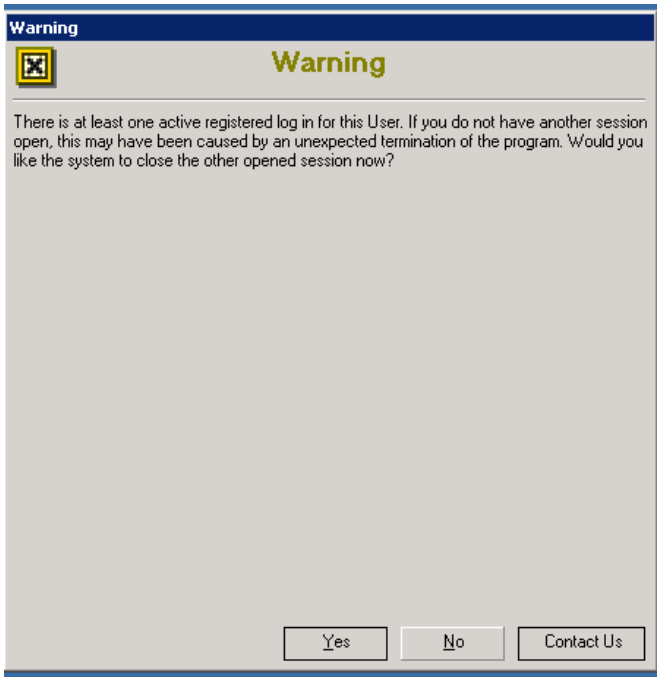
1.5 Terminating Multiple Log in Sessions By User

When a user logs in with other sessions open in the same database a warning generates during login that there is at least one registered login for this user and is prompted to close other sessions:



If the user chooses Yes, the following prompt to terminate will show as follows:

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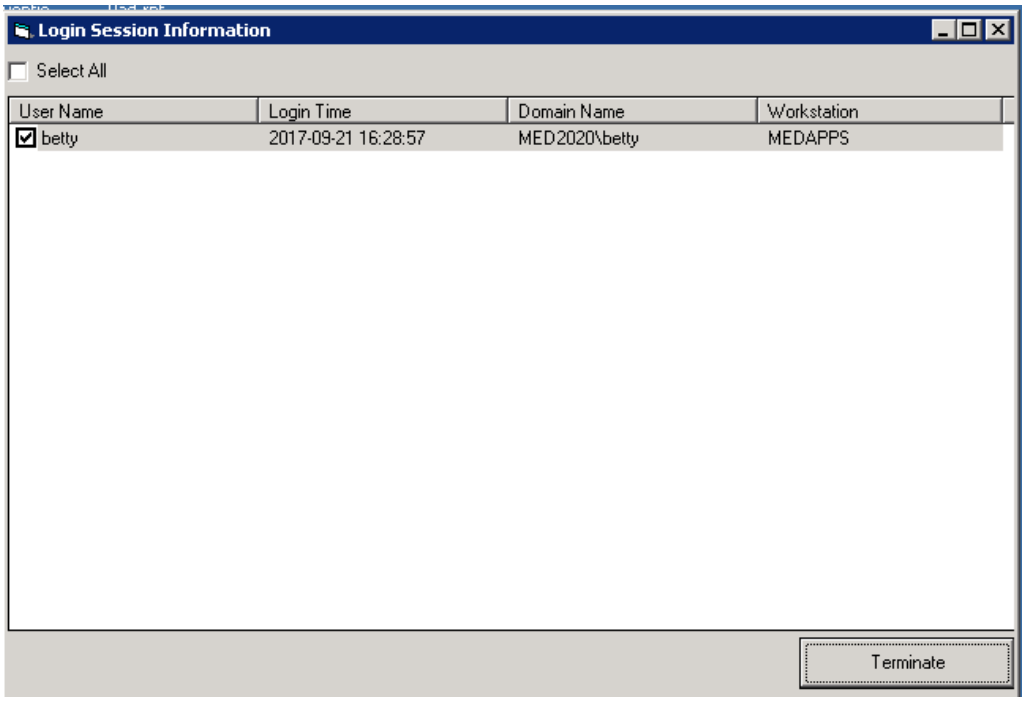
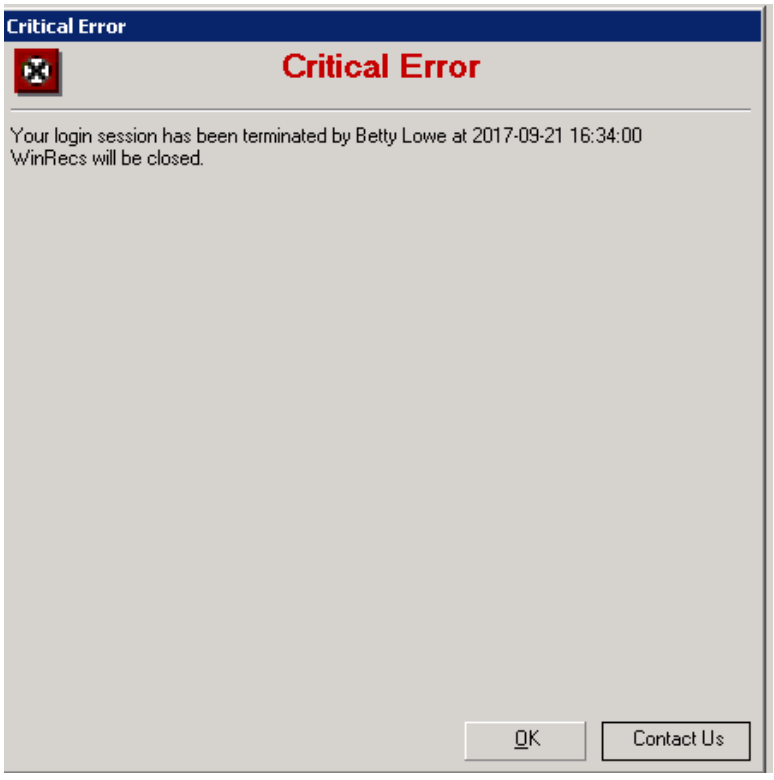


When the user attempts to open a visit with the older log in session this session the following error will display:



Click Ok and the session is then terminated.

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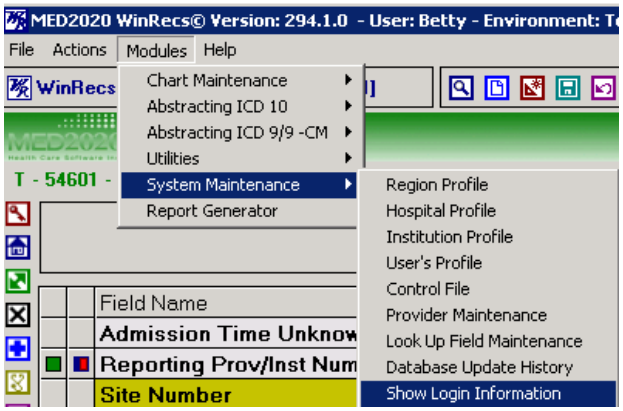
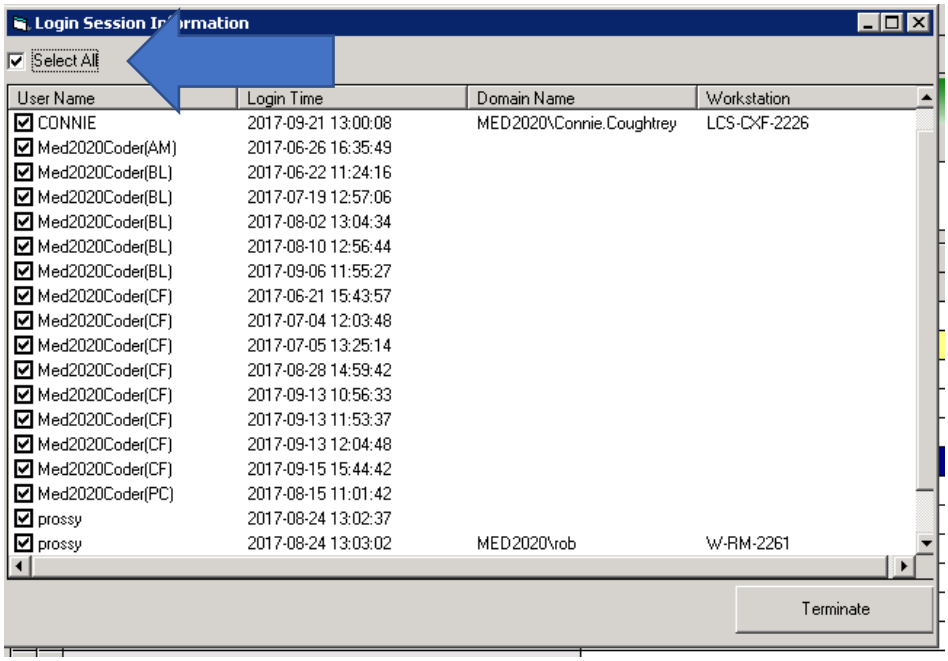
Terminating WinRecs Logins

The WinRecs System Administrator can terminal WinRecs Log in sessions as follows:

Go to Modules > System Maintenance > Show Login Information:



A Login Session Information Box will display showing all users logged into WinRecs:



If Select All Box is checked all users are selected to terminate WinRecs Log in Session.

To select only specified sessions, remove the Select all check and check off the users to terminate

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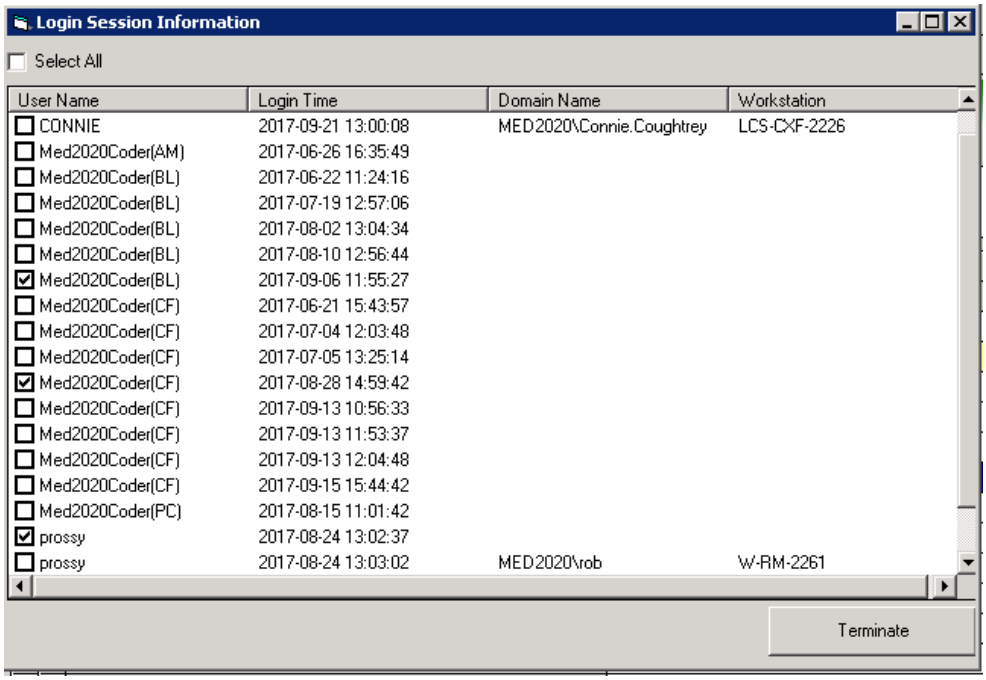
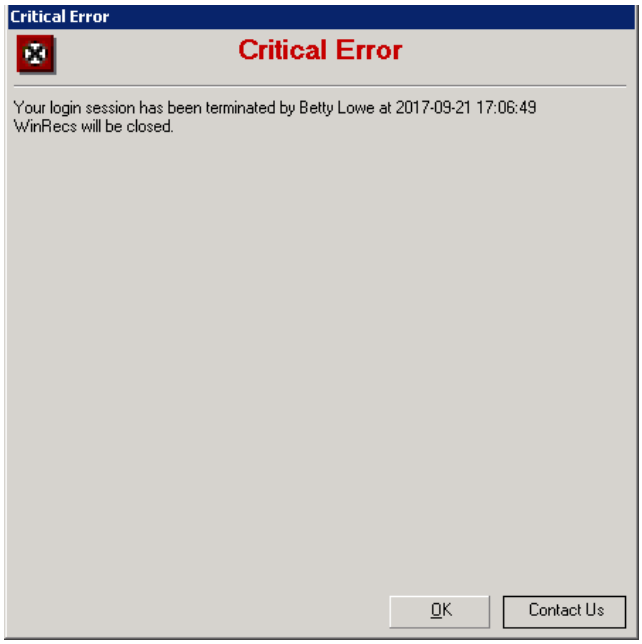


Once the users have been selected click on the Terminate Button. After the user is terminated by the administrator, the user cannot add or load new abstracts but WinRecs will allow coder to finish and save the record being worked on before forcing the login session to terminate with the following error:



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2 WinRecs Layout

2.1 Overview

WinRecs application is the foundation for a variety of modules developed and designed to assist Health Records departments within various facilities. Some of the WinRecs functionalities and features are customizable to an individual facility's requirements; however, there are common functionalities and Graphical User Interfaces (GUI) that apply throughout the application. This chapter describes these common aspects in three sections: WinRecs GUI, Color indicators and Information Panes.

Note: When a menu item has an equivalent function key or key sequence assigned to it, the key/sequence will be displayed between square brackets. For example: *WinRecs Application Menu* [CTRL + M].

2.2 Common WinRecs GUI – Main Grid

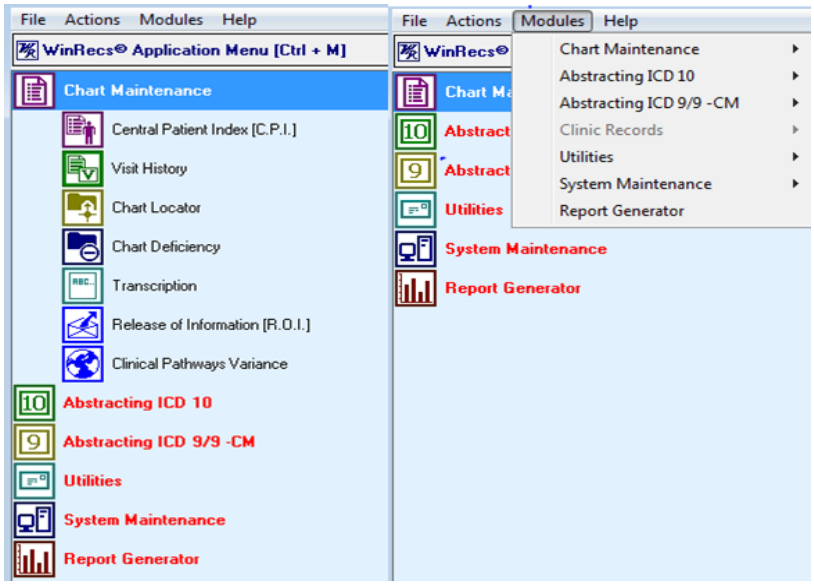
Application Menu

The WinRecs Application Menu [**Ctrl + M**] is displayed under the File menu on the left side of the window when you first log on. The Application Menu will show the same modules that are in the Modules drop down on the top Menu Bar. You will only see the modules you have access to.

To select a Module, single-click on the category and it will expand or collapse accordingly.

To open a module, click on the module you want to open or use the arrow keys on the keyboard to navigate up/down, highlight the module and press **ENTER**.

The following image displays the Category and Module folder structure accessed through the WinRecs Application Menu and the File Menu Bar.



Note: Use the mouse or the keyboard arrow keys and Enter to navigate the WinRecs application Menu.

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The following is the list of Modules contained within each Category and their related modules; category and modules that are greyed out are no longer in use:

Chart Maintenance
- Central Patient Index (C.P.I.)
- Visit History
- Chart Locator
- Chart Deficiency
- Transcription
- Release of Information (R.O.I)
- Clinical Pathways Variance

Abstracting ICD 10
- AmCare (N.A.C.R.S.)
- Concurrent Review (CC.R.)
- Inpatient (D.A.D)
- Same Day Surgery (SDS)
- Rehabilitation (N.R.S.)
- Minimum Data Set 2.0 (MDS 2.0)
- Mental Health (O.M.H.R.S.)
- Cancer Care (CCM)
- Canadian Joint Replacement registry (CJRR)

Abstracting ICD 9 – ICD 9 CM (no longer supported)

Utilities
- CIHI Submission
- CIHI Corrections
- Incoming Batch Interface
- Outgoing Batch Interface
- Reciprocal Billing Submission
- AdaptCS Outgoing Interface
- Batch Grouper
- Purge/Undelete

System Maintenance
- Regional Profile
- Hospital Profile
- Institution Profile
- User's Profile
- Control File
- Provider Maintenance
- Look Up Field Maintenance

Report Generator

Note: The Abstracting ICD 9/9–CM is no longer used in WinRecs

The table below this image displays a description of the reference numbers seen in this image.

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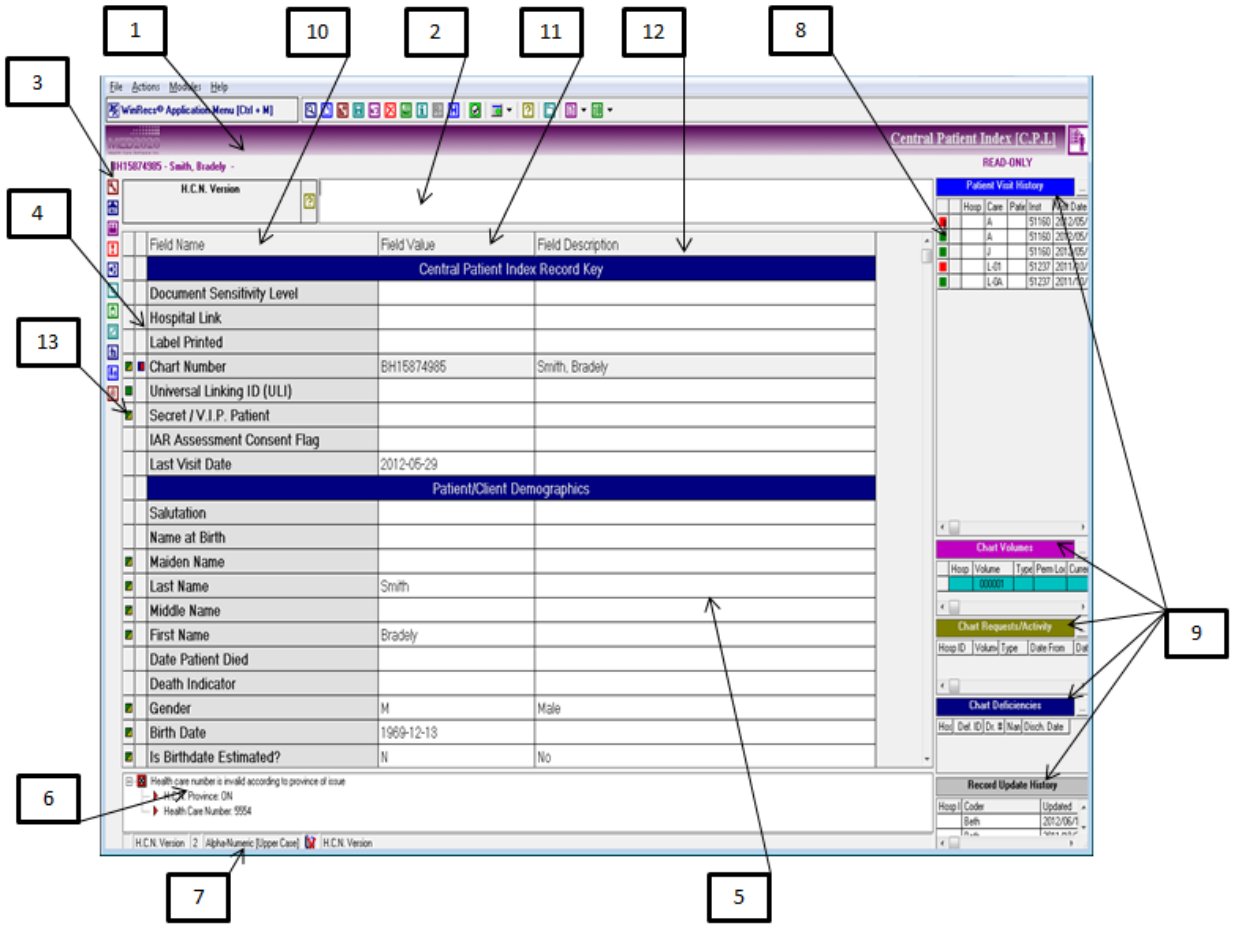

Figure 4: *Central Patient Index (C.P.I.) Window*

The reference numbers refer to the labeled numbers in the image above.

Ref #	Window Control	Description
1.	Module Banner	Each Module has a color-coded banner used as a means to identify it quickly. The same color is displayed on the icon for the module found under the category. The banner displays the module name, record information, and the record status (for example, READ-ONLY, NEW, EDIT), depending on the module and current function. The colours and icons are listed in **Appendix B.**
2.	Data Entry Box	This is where data is entered or updated. The field name selected will be displayed in the box to the left.
3.	Bookmarks Bar	Used to navigate to other sections of the section or to a multiform by clicking on a bookmark icon.
4.	Field Requirements Bar	Displays a colour flag that defines if the field is system, provincial or hospital mandated.

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Ref #	Window Control	Description
5.	Main Grid	Displays the record data grouped into bookmarked data categories. To quickly locate a specific field press (**F3**) and start typing the name of the field you are looking for. Keyboard arrows move the focus up and down through the grid. Pressing **Enter** confirms the text typed in the Data Entry Box, and moves to the next enabled field. Disabled fields are greyed out. These fields do not require data entry and will be skipped over while navigating through the display grid.
6.	Message Pane	Warnings and error messages are displayed in this area. Double-clicking on a message automatically moves focus to the field that is causing the error. See the section on color indicators.
7.	Status Bar	From left to right, the following information is displayed: - CIHI field reference - Users Field Description - Data Length - Maximum Data Length - Lookup table status - Default Name associated with the current field
8.	Calculation Note Bar/Shared Field Status Bar	Displays a module-specific colour flag, defining if the field will affect information in the Patient History, or CMG™, DPG™ or CACS Calculations. For System Maintenance modules, this is used to identify the modules in which a field is used.
9.	Information Sidebars	Display additional information relevant to the current record and module.
10.	Field Name	Provides different fields by which a user can search the database for records. When pressing the (**F3**) button a drop-down list of these fields display.
11.	Field Value	Displays data recorded in the field. To access the Lookup Table for valid field responses, press **F2**.
12.	Field Description	Displays the meaning of the Field Value code letter or number.
13.	Calculation Bar	In D.A.D., the calculation bar shows which fields affect the CMG calculation. For other modules, the calculation bar reflects a reference to the fields necessary to calculate the scores relevant to the module, such as CACS, FIM, etc.

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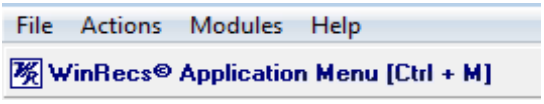
Menu Bar

On the main page of WinRecs, the Menu bar contains four main dropdown menu items: ***File, Actions, Modules,*** and ***Help; e***ach having further options as follows:



The following table lists the content of each menu item in the above Menu bar:

Menu	Options
File	Contains a list of the last 6 entries accessed by the user. Exit Other Logged In Users (Who) Log Off *(your personal log on name)*
Actions	Find [F4] New [F5] Edit [F6] Save [F7] Select Hospital Link Show All Regional Data Show Message Pop-up Auto Show Look Up List Enable Quick Search Cancel [F8] Delete [F9] Print [F10] Verify [F11] Show Multiple User Messages Show Chart Linkages Clear CPI Lock Font **NOTE: The above list is the core default Actions List for all Modules. Other Module specific Actions will be available as you navigate each Module.**
Modules	Chart Maintenance > *Central Patient Index, Visit History, Chart Locator, Chart Deficiency, Release of Information, Clinical Pathways Variance* Abstracting ICD 10 > *AmCare, Concurrent Review, Inpatient, Same Day Surgery, Rehabilitation, Minimum Data Set, Mental Health. Cancer Care, Canadian Joint Replacement Registry* Utilities > *CIHI Submission, CIHI Corrections, Incoming Batch Interface, Outgoing Batch Interface, Reciprocal Billing Submissions, Batch Grouper, Purge/Undelete* System Maintenance > *Regional Profile, Hospital Profile, Institution Profile, User's Profile, Control File, Provider Maintenance, Look Up Field Maintenance* Report Generator

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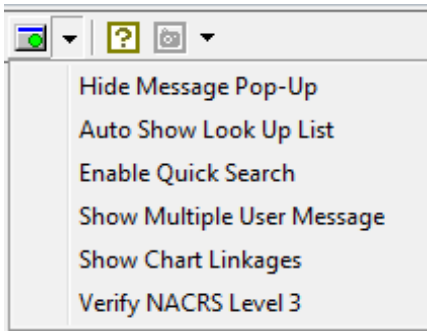
Menu	Options
Help	WinRecs User Guide Download PDF Viewer About License Agreements Contact Us

Tool Bar Area

Each module contains a set of icons, some standard and some module specific. A list of these icons, their shortcut keys and the description of functions can be found in **Appendix A.** Only drop-down menu items are described in this section as follows:

Note: When Quick Search option is enabled, the AutoExecute (save) option from the Report Selection List is not applicable.

Table 1: Show Message Pop-Ups



Message	Description
Show/Hide Message Pop-Up	When the cursor lands on a field with warnings or errors a prompt immediately displays. These prompts require a response prior to moving to the next field. If not activated, warnings and hard errors will display in the message box only. On login, the setting for this field will revert to the permanent setting in User Profile – Show Messages field.

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Message	Description
Auto/Manually Show Look Up List	Auto Show Look Up List automatically displays the look up table associated with the field. If this feature is activated the cursor must be pointed over the data entry box. When the cursor lands on a field that has a lookup table, it will automatically display. Double-click on the value to select it, placing it in the field. The up and down arrow can also be used to move through the selection list. Select **ENTER**. The program will move to the next available field. To deactivate Auto Show Look Up List, click on the down arrow of the Message Selection icon and select Manually Show Look Up List. On login, the setting for this field will revert to the permanent setting in User Profile – Show Messages field will revert to the permanent setting in User Profile – Show Messages field.
Enable/Disable Quick Search	• This option is only available in the Abstracting modules. After an abstract is saved, a Visit Date and Chart Number search window displays. This window displays the previous visit date search. Modify the visit date if required. In the Record Search only records with the recorded visit date displays. If desired, enter the chart number. The chart number search displays and refines with each entry. When the exact match for the record is determined, the program automatically opens the abstract. This function is particularly useful for abstracting many records for the same day such as Ambulatory care abstracting. To deactivate Quick Search, click on the down arrow of the Message Selection icon and select 'Disable Quick Search'.
Show/Hide Multiple User Message	• When this feature is turned on and a user accesses a record when another user is in it, a message displays. The following warning message also displays in the Message Pane: 'At least one other User is currently accessing this record'.
Show/Hide Chart Linkages	• This option is only available from the Central Patient Index module. When 'Show Chart Linkages' is selected, if the chart number is linked to another chart number, the information pane will display Potential Duplicates or Chart Ancestry. When 'Hide Chart Linkages' the Patient Visit History displays.
Verify NACRS Level 3 (Verify NACRS Level 1)	• This option is only available from the Amcare module. Can verify the Emergency abstract at the Level ½ or Level 3. The Message Pane displays the edits based on the Level selected.

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2.3 Information Sidebars

Additional information pertaining to the record and module is provided in the information sidebars, displayed vertically on the right of the main grid. The type of information displayed will depend on the module being accessed.

Below is an example of the Central Patient Index (C.P.I.) window which shows the Information Sidebars with five sections:

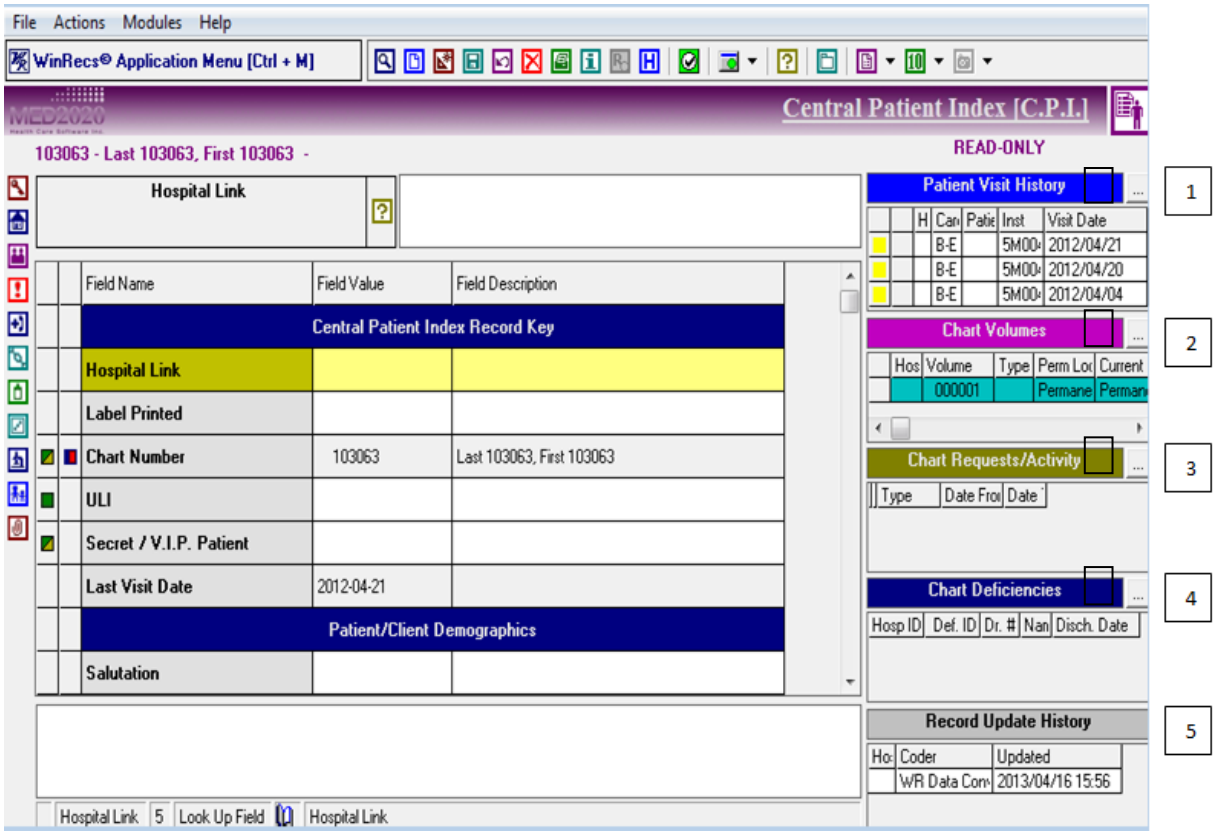

Figure 5: Information Sidebar in CPI

Note: The ellipsis button ... the information sidebar can be used to maximize each section to provide expanded information.

Patient Visit History

In Central Patient Index (CPI), double-click on an entry to open the corresponding chart volume maintenance grid or from the ellipsis window, highlight a volume and press **F7** Select.

Chart Volume

In Central Patient Index (CPI), double-click on an entry to open the corresponding chart volume maintenance grid or from the ellipsis window, highlight a volume and press **F7** Select.

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Chart Volume tells you what Hospital the patient has a chart at, where the chart is currently located within each Hospital, the volume type, volume number, the date the chart starts (Date From) and ends (Date To), the link volume number of charts that have been linked together.

Chart Requests/Activity

Displays all chart request activity.

Chart Deficiencies

The Chart Deficiency module is used to track charts that have incomplete or required information.

Record Update History

Displays an audit trail of all transactions, and includes the WinRecs user ID of the person who made the change.

For detailed information on the contents of these different sidebars, see the Information Sidebars sections in each module.

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2.4 Common WinRecs GUI - Multiforms

Multiforms are embedded in a module's main grid (for example, CPI and Abstracting modules) when more than one entry is required per record. For example, multiple Patient Services, Providers, Diagnoses, Interventions, Special Care Units, and Project Information are often required for a given chart or abstract.

Navigating a multiform is similar to that of the main grid.

Multiform Screens

The Multiform screens show fields where the information/data entered can have more than one occurrence. The fields are grouped in the same occurrence type as required by CIHI. All modules have one or more multiform associated with them.

Multiform GUI

The multiform is divided into two panels. The left panel displays a data entry form, similar to the main grid. The right panel displays information such as the other multiform entries attached to the current record are displayed on the right.

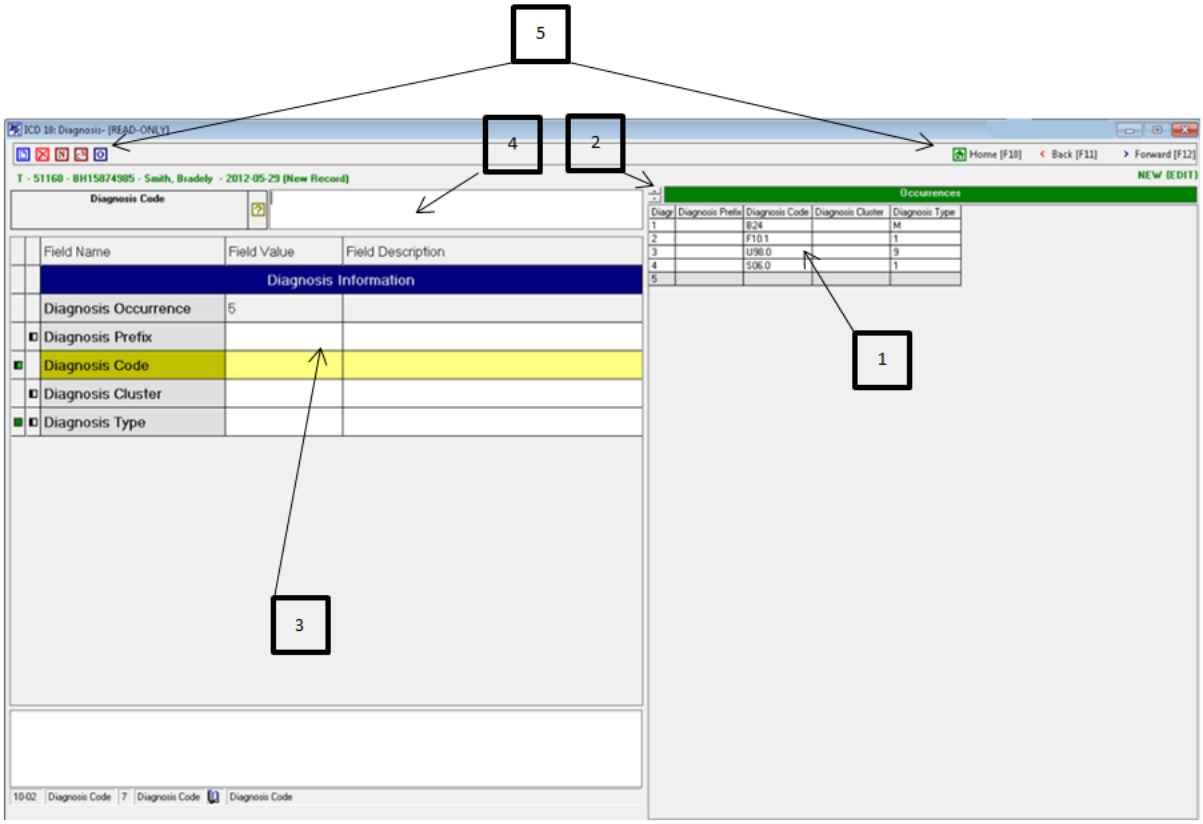

Figure 6: Multiform GUI

The following describes the part of the multiform in detail.

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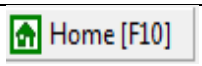
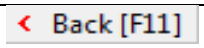
Ref No	Description	
1	Occurrence Grid: Displays the data entered in the main grid for each occurrence.	
2	Re-sequence buttons: Moves occurrence up or down on the occurrence list.	
3	Data Entry Grid: Displays the occurrence data is being entered	
4	Data Entry Box: This is where data is entered. The field the cursor is focused on will display in the box to the left.	
5	Function Icons/Keys (as displayed on Menu Bar)	
	F5	New occurrence: Allow additional data entry for a new occurrence. This will be added at the end of the occurrence list. Re-sequence the occurrence if necessary
	F9	Delete Occurrence: Double-click on the occurrence and ensure the occurrence is in the Data Entry Grid.
	F7	Other N-Coder Diagnosis and Intervention Multiform
		Opens the CIHI Folio (only available in Diagnosis and Intervention multiforms). The File/Folder Paths/Folio paths need to be entered in the User Profile.
	**F10**	Home: Return to the Main Grid
	**F11**	Back: Move back one field. This will move to the previous field or multiform
	F12	Forward: Move forward one field. This will move to the next field or multiform
	F6	Quick Hint – Intervention Multiform. Will display all interventions recorded in the database based on the diagnosis entered.

Table 2: Multiform common elements

Note: Keyboard function to recall an occurrence in a multiform: Hold the CNTRL key down and select the occurrence number on the keyboard above the letter keys (not number pad). This will work with occurrences 1-9 only.

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2.5 Color Indicators

WinRecs uses Icons and color indicators throughout the application to help the user recognize at a glance an error or detail that require attention. This includes graphics displayed in:

Message Pane
Field Requirements Bar
Status on abstract through patient visit history information pane
Calculations Note Bar

Graphics in Message List Box

The following graphics are warning and error messages displayed in Message Pane. Double-clicking on a message will automatically move focus to the field that is causing the error. See color indicators below:

Critical Error: Record will not save. (Dark Red)

Error: Record will save, but will not submit. (Red)

Warning: Record will save and will submit. (Yellow)

Valid: Verified and Valid. (Green)

Information: This displays if there is a message for the User.

Question: This displays if there is a question for the User.

Graphics in Field's Requirements Bar

These colour flags indicate if the field is mandatory by the system, province, CIHI or the hospital.

System Required: WinRecs required field. Must have data entered to save.

CIHI Required: Mandatory data element for submission to CIHI.

CIHI Submitted: Optional data element for submission. However, if a value is entered in the field it will be submitted to CIHI.

Provincial or Module Required. Mandatory data element for Provincial or Module

Hospital Required: Required field. Must have data entered to save. (Dark Red)

Hospital Error: Mandatory data element for submission to CIHI (Red)

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Hospital Warning: Hospital warning. Record will save and submit. (Yellow)

Toolbar Icons

Icon	Menu Item	Keyboard	Function
	WinRecs Application Menu	**[Ctrl + M]**	Displays a drop-down menu of all the modules.
	Find	**F4**	Search for a record
	New	**F5**	Creates a new record
	Edit	**F6**	Makes changes to a record.
	Save	**F7**	Saves changes to the current record.
	Cancel	**F8**	Cancels changes made to record since the previous save. Warning prompt will display. In Chart Deficiency module, **F8** Creates a New Provider to attach deficiencies to the Visit.
	Delete	**F9**	Deletes the current record. A message prompt will appear "You are about to delete this record? Do you wish to proceed?" If you delete an abstract, the record will be found in the Utilities\Purge module. It must be deleted from this module for it to be permanently deleted from the database. If you delete an occurrence in a multiform, this will not go to the Purge module.
	Print	**F10**	Prints a module dedicated report. This is configured using the Report Selection List.
	PDF viewer	**N/A**	Opens the Windows Explorer folder allowing you to view PDF files stored on the PC or Server (see Accessory File Directory)
Red	Suppress Regional Data	**N/A**	View data for your Hospital only. *(Clicking this icon changes the colour of the dot from green to red)*
Green	Show Regional Data	**N/A**	View data from all of Regional Sites *(Clicking this icon changes the colour of the red dot to green.)*
	Select Hospital Link	**N/A**	Select a specific Hospital so only records from the Hospital selected display.
	Verify	**F11**	Verifies the current record. This is applicable for abstracting modules.
	Show Message Pop-Up	**F12**	When selected, the error messages appropriate for the entry will show immediately on the screen, rather than showing only in the Error Message Box at the bottom of the grid after saving. Once selected, the button description will be 'Hide Error Messages' Click/toggle to turn the messages off and on. See 'Show Error

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Icon	Menu Item	Keyboard	Function
			Message' section below for more information (see detail below).
	Help	**F1**	Opens the WinRecs User Guide.
	Abstract Auto Coding		It is a drop down box with two options: Copy Abstract Profile Clone Abstract

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3 WinRecs Basic Functionality

3.1 Overview

The following provides an overview of some of the basic functionality within WinRecs, including searching for records, creating records, editing records, saving records and more.

3.2 Search

Record Search

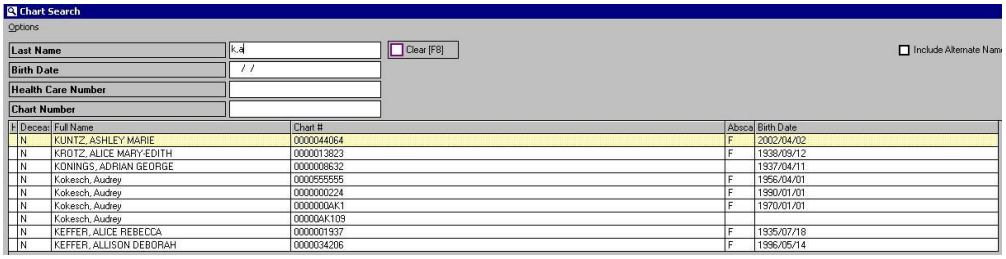
To search for a patient/chart number/abstract click on the Find icon
- or - Press ***F4***.

Type the data that corresponds to the field that the search is focused on (e.g. Chart number) and then press Enter

- ***Options*** allow you to search for a record using up to 4 search fields.

Click on the drop-down column to display the **Field Names**
- or - Press **(F3)**.

Select a **Field Name** that you want to use for a search option.



Note: Once a search has been completed, the settings will retain until the options are changed.

Note: You can sort any of the columns in the search window by clicking on heading of the column. They will sort ascending and descending. To select a patient, highlight the entry and press Enter or double-click.

Note: Right click on the patient's name, select 'Show Patient Visit History'. A report will show all visits for the patient selected.

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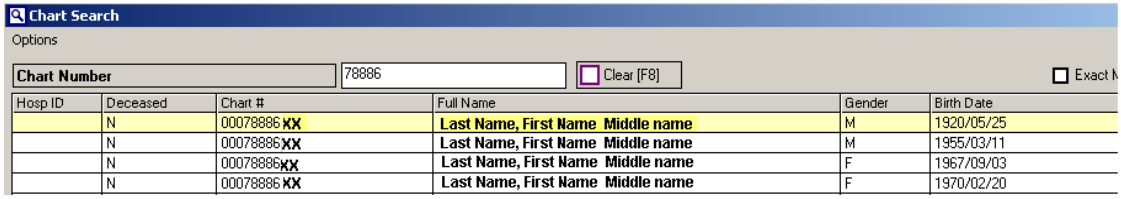

To close the Chart Search dialog and go to the main grid press the **Esc** key.

3.3 Field Search (F3)

This search is a field search. The main grid of any of the abstracting modules has many fields. To find a field on the grid without scrolling through hundreds of fields, press **F3**. This displays the fields in alphabetical order. Select the field on the list and press **ENTER**, or double-click on the field in the list and the program will go directly to the field. Type the first letter of the field to bring you down to the fields that begin with that letter.

Search Techniques

Chart Number	Exact match: Searches for only data in data entry box. If 'exact match Search' is selected on the far-right hand side, the program only searches on the exact values entered.
Chart Number	No Exact Match: Searches for values within the chart number. If 'Exact Match Search' is not checked, then the program searches for any chart that has 123 somewhere in the field. E.g. If you key in 123, the program will return all chart numbers that have 123, 1234, 12345, etc. in the string.
Last Name	Used as first option, will search partial last name and first name if separated by ',' (i.e.: SM,A)
Last Name	Include Alternate name – Will search for other records that have used that data entered as an alternate name.
Last Name	Search anything entered in the data entry box. 'AND' will return records that start with AND in the last name.
Any field except Chart Number Exact Match	Returns anything that starts with the data entered in the data entry box. (i.e.: AHC 123 will return all records that have a Health Care Number starting with 123)
Multiple Searches	If there is more than one option search, the hierarchy will be from the first search, then second etc. (i.e.: Option 1 Discharge Date 2007/04/00, Option 2 Last Name 'SM' returns all records that were discharged in April 2007 that had a last name starting with SM.)
Quick Search	Available on All Abstracting modules. From the Show Messages icon, select Enable Quick Search.

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	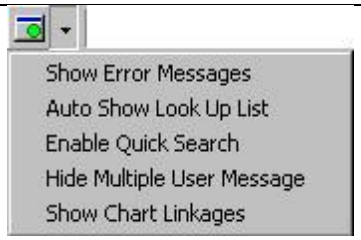 When a save is executed on an abstract the program will go immediately to a modified search screen. The search will retain the previous discharge/registration date, and the data entered in the chart number will modify as it is entered. When there is only one possible match, the program will automatically display the abstract matching the date/chart number. To deactivate From the Show Messages icon, select Disable Quick Search.

3.4 New

To create a new record press **F5** or click

Module	Description
Abstracting – DAD/NACRS/SDS/CCR	Creates a new abstract
MDS 2.0	Creates a new abstract or new assessment. Please refer to the MDS 2.0 section for details.
NRS – Rehab	Creates a new abstract or new assessment. Please refer to the NRS-Rehab section for details.
OMHRS	Creates a new abstract or new assessment. Please refer to the OMHRS section for details.
CCO	Creates a new abstract or new assessment. Please refer to the CCO section for details.
CJRR	Creates a new abstract. Please refer to the CJRR section for details.
Chart Locator	Please refer to the Chart Locator section for details.
Chart Deficiency	Please refer to the Chart Deficiency section for details.
Release of Information	Please refer to the Release of Information section for details.
Regional Profile	This function is not available in this profile
Profiles – Institution, User's	Creates a new Institution or User profile
Provider Maintenance	Creates a new provider
Look Up Maintenance	Creates a new variable for the look up field. It is not possible to create a new look up field.

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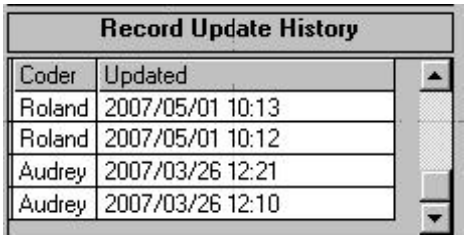
3.5 Save

To 'Save' a record press **F7** or the click

This function saves any data recorded on the record.

A record of the date/time and User who saved the record is maintained in the Record Update History in the bottom left corner.



3.6 Delete

To 'Delete' a record, press F9 or click

This function deletes the entire abstract, occurrence, or item on which the program is focused. If the entire abstract or CPI entry is deleted it will be stored in the PURGE module until it is completely purged from the system.

All abstracts and CPI entries that are held in the PURGE module will show on reports as they are still held in the database. Ensure you have incorporated a PURGE procedure with deletions to ensure your reports are accurate.

There is also a procedure that will send a deletion to CIHI if the abstract has already been submitted to CIHI. All deletions must be dealt with appropriately prior to closing a NACRS period.

3.7 Bookmarks

The bookmarks icons will navigate directly to Sections on the main grid.

3.8 User Fields

In each abstracting module, there are fields available that the user can define for their own data collection purposes. These fields have been preformatted to correspond with the type of data collected in each field.

Each field type has 4 of these fields. These fields are located at the end of the abstracting grid. They can be renamed and resorted as any other field in WinRecs.

Type of field	Description
Date	Default Date format YYYY/MM/DD
Time	Default Time format HH:MM
Look Up	**F2** (Lookup) 12 characters. The Look Up values are set up in Look Up Field Maintenance, with the field names by the module the field is in. EG User Inpatient Look Up 1, User AmCare Look Up 1, User Rehab Look Up 1, etc.

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Numeric	10 characters numeric only.
Text	50 characters free text. When reporting in Crystal this is considered a string field.
Note	255 characters

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3.9 Terminal Digit

Terminal Digit is used to re-arrange the chart number in order to produce reports sorted in a way that leads to a randomized distribution. Terminal Digit functionality has been added to the following module searches: CPI, AbsCare/AmCare, Deficiency, ROI, Visit History, MDS 2.0, Rehab, and OMHRS.

In the Hospital and Regional Profiles, if the Terminal Digit field is configured, the value must be 10 characters long using all digits between 0 and 9. Each number represents the new position of the corresponding chart number.

Example:

Chart No. = 0000123456

Terminal Digit mask = 9012345678

Terminal Digit value = 5600001234

When a chart is saved its Terminal Digit value will populate in the database. If the Terminal Digit field is changed, or needs to be run against converted data, open Set Terminal Digit from the Modules/Utilities menu to Update all Charts or Update only charts that have a blank Terminal digit

Note: If your site uses a Regional database configuration and is interested in using this utility, please contact Client Services at MED2020 to discuss as this feature is presently only available for non-regional databases.

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4 Chart Maintenance and Abstracting Modules

4.1 Central Patient Index [C.P.I.]

Central Patient Index Overview

The Central Patient Index (C.P.I.) stores patient demographic information. Within the C.P.I users are able to capture information such as the record key, patient demographics and user field information.

Available Reports

The following reports are available for the Central Patient Index:

Central Patient Index Visit History
CPI Visit History Report
CPI Report On Load
Embosser Card

Central Patient Index Setup

The following setup must be completed before using the Central Patient Index module. For a complete description of the setup required and the steps to complete please refer to "**Section 5 - System Maintenance**" in the WinRecs User Guide.

User Profile: Set "Display Multiple User Messages" in User Preferences to "Y" to ensure notifications display if accessing a record that another user is currently accessing. The notifications display in the Message Pane. This prevents the second user from modifying the record until the first user exits the record.

Look Up Field Maintenance: The following should be set up for efficient field selection:

- Hospital Link
- Secret / V.I.P. Patient
- Death Indicator
- Gender
- Living Arrangement
- Language
- Primary Province
- Primary Country
- Residence Code
- Residence Type
- H.C.N. Province
- Allergy/Alert Codes

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Accessing the Central Patient Index Module

The Central Patient Index module is one of the modules within Chart Maintenance. Please refer to **Chapter 2 "WinRecs Layout"** for more information on the modules available within WinRecs.

The Central Patient Index is accessed from the WinRecs Application Menu.

To access the Central Patient Index module using the WinRecs Application Menu:

From the WinRecs Application Menu, select **Chart Maintenance** – **Central Patient Index (C.P.I.)**. The Central Patient Index window displays with no information populating fields.

If the Chart Search dialog displays, use the Chart search to select the chart to display, or click to close the search.

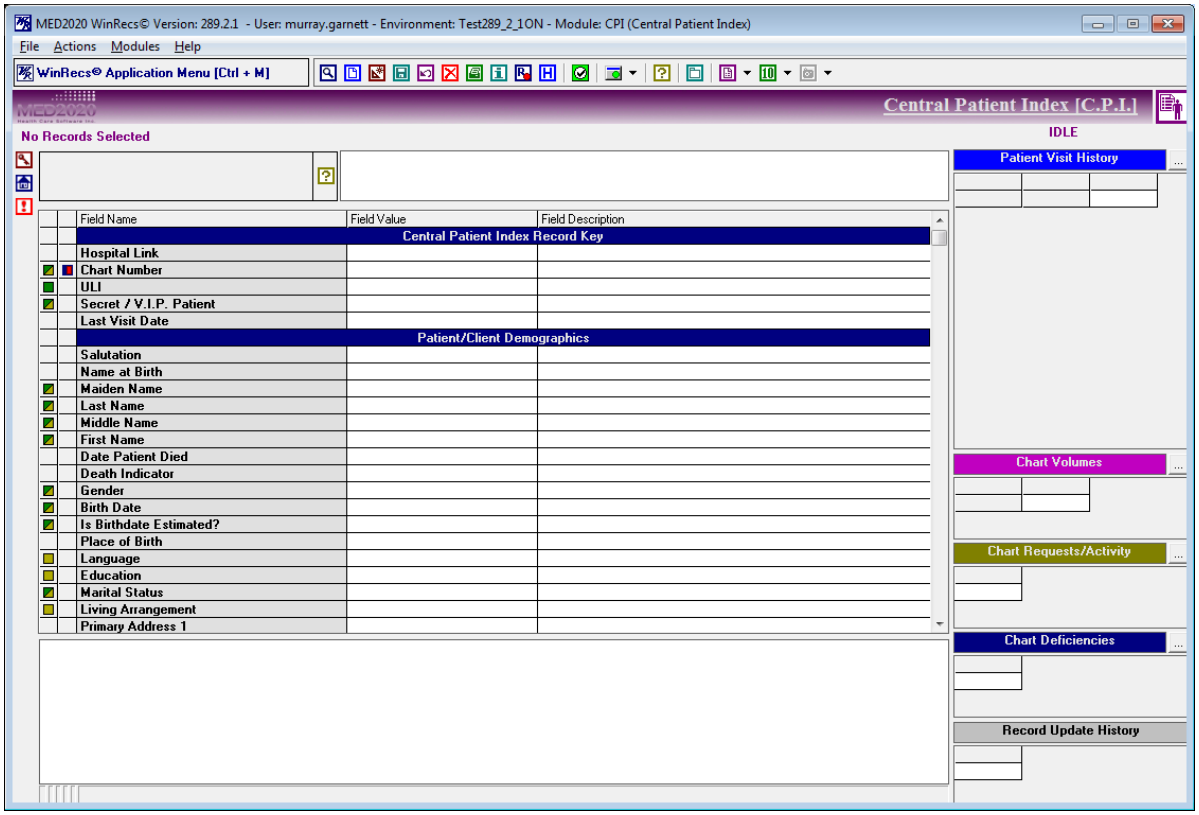

Figure 1

Use the relevant options as described in this chapter to maintain the Central Patient Index information.

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Using the Central Patient Index Module

The Central Patient Index (C.P.I.) stores patient demographic information.

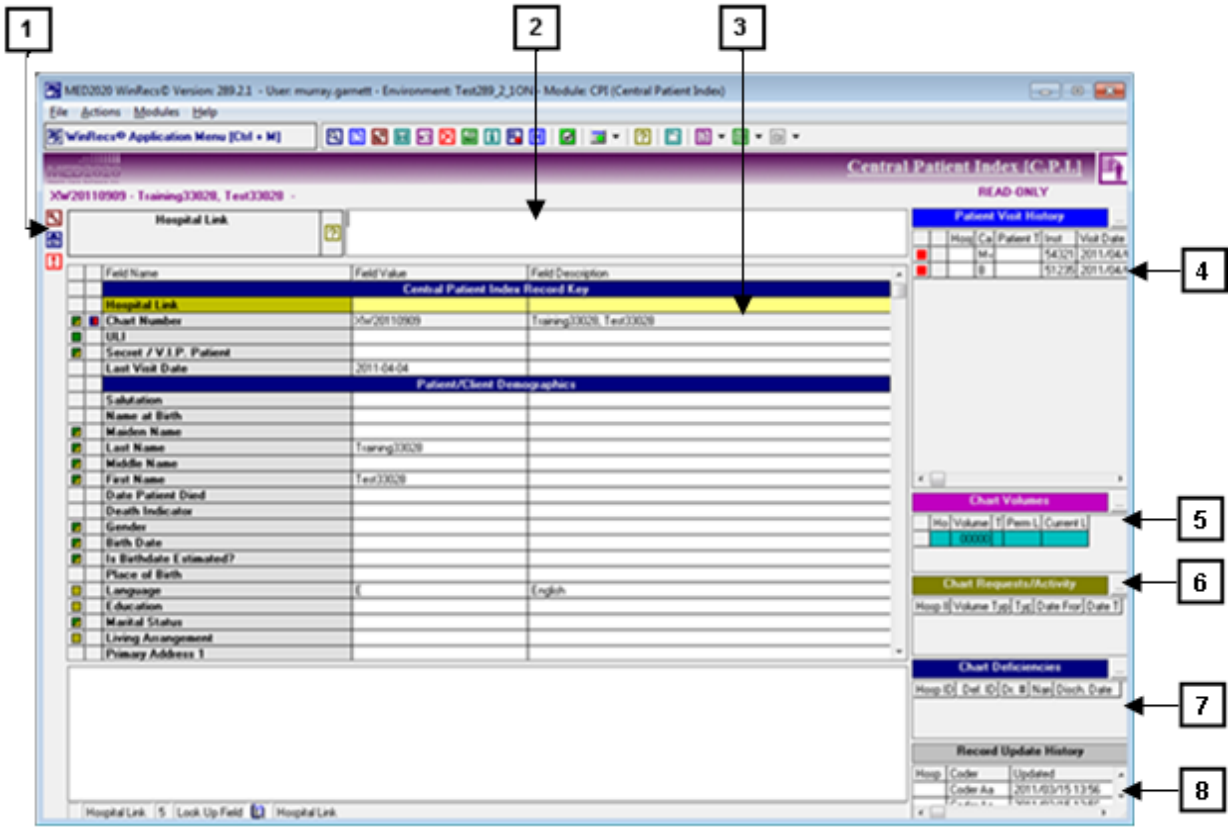

Figure 2

The main components of the Central Patient Index window are the Bookmarks, Main Grid, Data Entry Box and 5 sidebars. The main parts of the Central Patient Index window are described in the table below. The REF# field for each row relates to the callouts shown in the above image.

REF#	Description
1	**Bookmarks**: Bookmarks allow for fast access to categories of information within the Main Grid. Click a bookmark to display the section in the Main Grid. This may be basic data entry, or multiforms (for entering multiple occurrences of information, such as multiple allergies). There are 3 bookmarks (and corresponding sections) in the Main Grid as described below: **Central Patient Index Record Key**. This includes information for uniquely identifying the patient record and last visit. Information is entered in the Central Patient Index Record Key fields using the Data Entry Box. Please refer to **Chapter 2: " WinRecs Layout"** for additional information. **Patient/Client Demographics**. This includes the detailed demographic information for identifying the patient, such as first and last name, birth date, address, etc. Patient demographic information may come from the ADT system or via an HL7 interface. **Alerts/Allergies**. Provides details of any patient alerts or allergies using a multiform.

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2	**Data Entry Box**: The Data Entry Box is used to enter or edit information displaying in the Main Grid. Click on a field in the Main Grid and the field name displays on the left and the cursor is positioned in the box ready for entry.
3	**Main Grid**: The Main Grid shows the information for the currently selected chart. To add or modify information in the Main Grid, select the row and the field name displays beside the Data Entry Box and the data may be changed by typing in the Data Entry Box. The information in the Main Grid is organized under headings and can be accessed by scrolling through the grid, or by clicking on a bookmark to move the grid to the section within the associated heading.
4	**Patient Visit History Sidebar**: Displays a one-line summary of each patient visit for the selected patient. Detailed information may be viewed by double-clicking the visit.
5	**Chart Volumes**: Displays the chart volumes associated with the selected patient. Double-click on the volume in the Chart Volumes sidebar to display the volume detail. Please refer to "**Central Patient Index Information Sidebars**" in this chapter for more information.
6	**Chart Requests/Activity**: Displays all chart requests and associated activity for the selected chart. Double-clicking an entry displays the detailed information for the chart.
7	**Chart Deficiencies**: Displays all chart deficiencies for the selected chart. Double-clicking a deficiency displays the chart deficiency report.
8	**Record Update History Sidebar**: Displays an audit trail showing the history of any changes made. This includes the WinRecs user ID of the user who made the change.

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Creating Central Patient Index Entries

Use the Central Patient Index (C.P.I.) to enter and maintain patient demographic information. The information entered here is used by other modules within WinRecs.

To create Central Patient Index entries:

1. From the Central Patient Index click
   The Central Patient Index fields are available for entry.

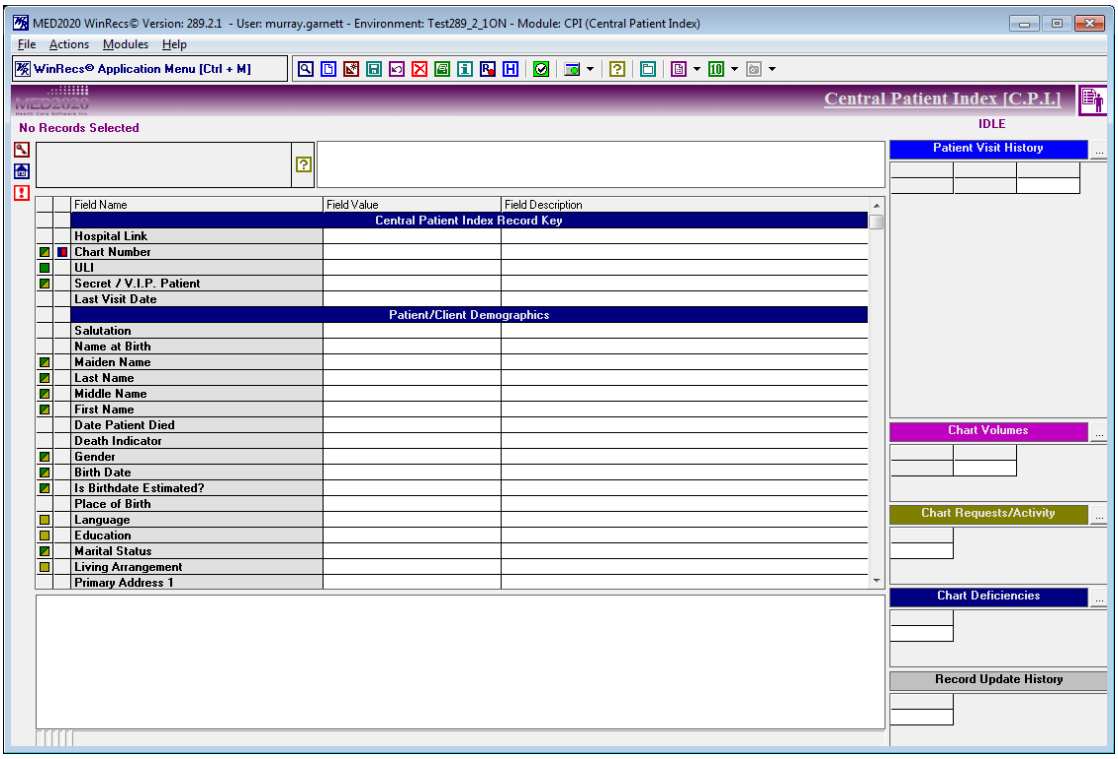
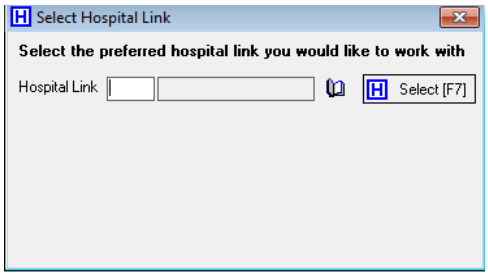


Figure 3

Enter information in all required fields. Press **Enter** after each field to move to the next field. The following are the fields accessed by pressing **Enter**.

Hospital Link:	Select a specific Hospital so only records from the Hospital selected display. When adding a record, (is clicked) the "Select Hospital Link" dialog displays.  If the hospital number is not known, press **F2** to display a list of hospitals in the

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	Lookup from which the hospital may be selected.
Chart Number:	Enter the unique chart number identifying the patient. Use the Chart Lookup (**F2**) to select the chart from the list of available charts. Once the chart number is selected, the patient name and birth date populates the Patient/Client Demographics.
ULI:	The Unique Lifetime Identifier (ULI) is a unique and permanent number assigned to all persons who receive health services in Alberta.
Secret / V.I.P. Patient:	Indicates if the patient is a V.I.P. or if the identity of the patient should be kept confidential. Use the Secret / V.I.P. Lookup (**F2**) to select the required indicator.
Last Visit Date:	The date of the patient's last visit. Dates are entered in "YYYY-MM-DD" format.

Press **Enter** in the Last Visit Date field to move to the Patient/Client Demographics section. Enter the Patient Demographic information.

Salutation:	Enter the salutation to use when addressing the patient, such as Mr., Miss, Mrs., etc.
Name at Birth:	Enter the patient's birth name.
Maiden Name:	Enter the patient's name before marriage, if applicable.
Last Name:	Enter the patient's surname.
Middle Name:	Enter the patient's middle name.
First Name:	Enter the patient's first name.
Date Patient Died:	Enter the date the patient died, if applicable. Dates are entered in "YYYY-MM-DD" format.
Death Indicator:	Enter the death indicator, if applicable. Use the Lookup (**F2**) to select the death indicator.
Gender:	Enter the patient's gender. Use the Lookup (**F2**) to select the gender.
Birth Date:	Enter the date of birth of the patient. Dates are entered in "YYYY-MM-DD" format.
Is Birthdate Estimated?:	Indicate whether or not the birth date is an estimate.
Place of Birth:	Enter the place of birth (city, town, etc).
Language:	Enter the patient's language. Use the Lookup (**F2**) to select the language.
Marital Status:	Enter the marital status of the patient. Use the Lookup (**F2**) to select the status.
Living Arrangement:	Enter the patient's living arrangement, such as "Lives with spouse", etc. Use the Lookup (**F2**) to select the living arrangement.
Primary Address 1:	Enter the patient's primary address.
Primary Address 2:	Enter the patient's additional address information if necessary.
Primary City:	Enter the patient's primary city of residence.
Primary Province:	Enter the patient's primary province of residence. Use the Lookup (**F2**) to select the province.
Primary Country:	Enter the patient's primary country of residence. Use the Lookup (**F2**) to select the country.
Postal Code:	Enter the patient's postal code.

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Residence Code:	Enter the patient's residence code. Use the Lookup (**F2**) to select the residence code.
Residence Type:	Enter the patient's residence type. Use the Lookup (**F2**) to select the residence type.
Primary Phone Number:	Enter the patient's primary phone number.
Cell Phone Number:	Enter the patient's cell phone number.
Fax Number:	Enter the patient's fax number, if applicable.
E-Mail:	Enter the patient's email address, if applicable.
H.C.N. Province:	Enter the H.C.N. Province code. Use the Lookup (**F2**) to select the province code.
Health Care Number:	Enter the number from the patient's health card. The format of the number varies from province to province.
H.C.N. Version:	
C.P.I. Notes:	Enter the freeform notes for additional information.

After pressing **Enter** in the last field, the Alerts/Allergy multiform displays. This multiform records information by recording every "Alert" or "Allergy" relating to the patient.

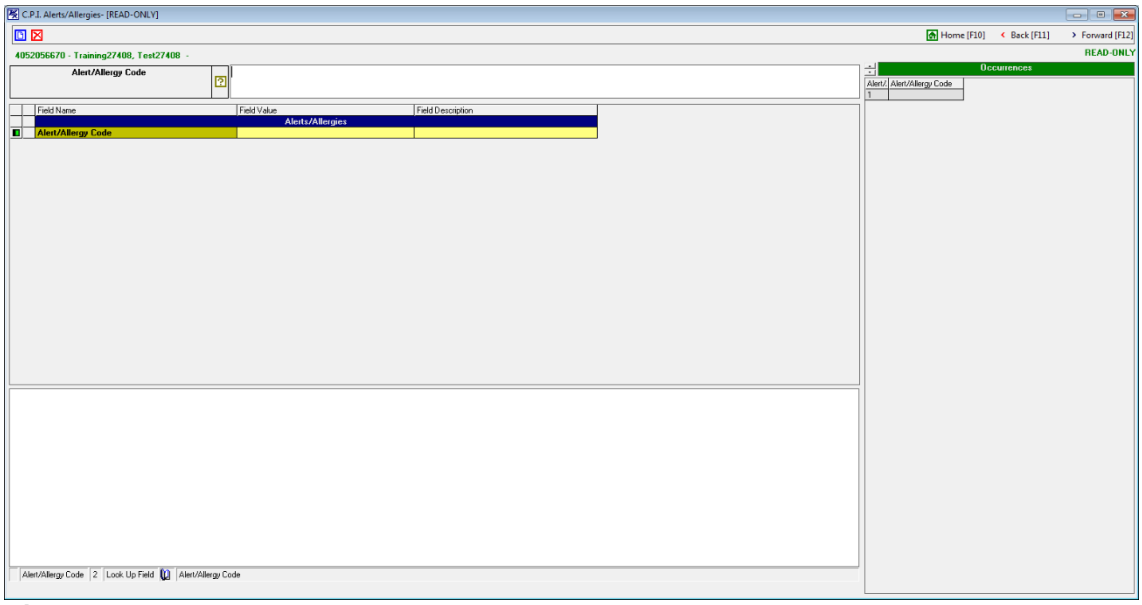
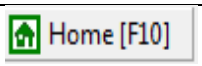


Figure 4

Enter the required information in the Alerts/Allergy multiform.

Alert/Allergy Code:	The Alerts/Allergy uses a multiform, allowing multiple alerts and/or allergies to be entered for the patient. As each is entered, it displays in the Occurrences sidebar.

If there are no more alerts/allergies to enter for the patient, click 

Enter the duplicate chart indicator.

Duplicate Chart:	Enter the duplicate chart indicator.

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When complete click
- or Press **F7**.
The information is saved and displays in the Main Grid.

Modifying Central Patient Index Entries

Central Patient Index (C.P.I.) information may be modified at any time.

To modify Central Patient Index (C.P.I.) information:

From the Central Patient Index click
- or - Press F4.
The Chart Search dialog displays.

Use the search fields in the Chart Search to display central patient index entries.

Double-click in the Chart Search on the entry containing the information to update.
- or - Select the required entry and press **Enter**.
The Central Patient Index (C.P.I.) window displays the information for the selected entry.

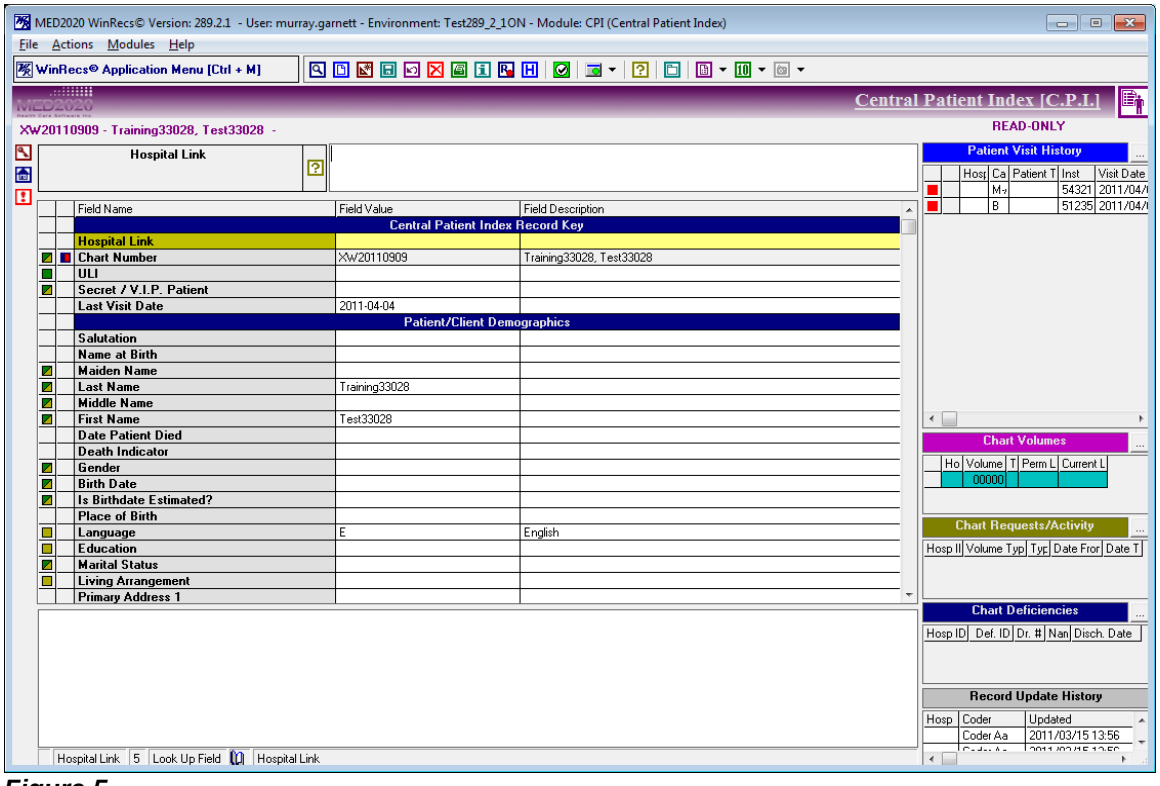

Figure 5

Enter information in all required fields. Press **Enter** after each field to move to the next field. The following are the fields accessed by pressing **Enter**.

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Hospital Link:	Select a specific Hospital so only records from the Hospital selected display. If the hospital number is not known, press **F2** to display a list of hospitals in the Lookup from which the hospital may be selected.
Chart Number:	The unique number identifying the patient. Enter the Chart Number. Use the Chart Lookup (**F2**) to select the chart from the list of available charts. Once the chart number is selected, the patient name and birth date populates the Patient/Client Demographics.
ULI:	Universal Linking ID
Secret / V.I.P. Patient:	Indicates if the patient is a V.I.P. or if the identity of the patient should be kept confidential. Use the Secret / V.I.P. Lookup (**F2**) to select the required indicator.
Last Visit Date:	The date of the patient's last visit. Dates are entered in "YYYY-MM-DD" format.

Enter the Patient Demographic information.

Salutation:	Enter the salutation to use when addressing the patient, such as Mr., Miss, Mrs., etc.
Name at Birth:	Enter the patient's birth name.
Maiden Name:	Enter the patient's name before marriage, if applicable.
Last Name:	Enter the patient's surname.
Middle Name:	Enter the patient's middle name.
First Name:	Enter the patient's first name.
Date Patient Died:	Enter the date the patient died. Dates are entered in "YYYY-MM-DD" format.
Death Indicator:	Enter the death indicator. Use the Lookup (**F2**) to select the death indicator.
Gender:	The patient's gender. Use the Lookup (**F2**) to select the gender.
Birth Date:	The date of birth of the patient. Dates are entered in "YYYY-MM-DD" format.
Is Birthdate Estimated?:	Indicate whether or not the birth date is an estimate.
Place of Birth:	Enter the place of birth (city, town, etc).
Language:	Enter the patient's language. Use the Lookup (**F2**) to select the language.
Marital Status:	Enter the marital status of the patient. Use the Lookup (**F2**) to select the status.
Living Arrangement:	Enter the patient's living arrangement, such as "Lives with spouse", etc. Use the Lookup (**F2**) to select the living arrangement.
Primary Address 1:	Enter the patient's primary address.
Primary Address 2:	Enter the patient's additional address information if necessary.
Primary City:	Enter the patient's primary city of residence.
Primary Province:	Enter the patient's primary province of residence. Use the Lookup (**F2**) to select the province.
Primary Country:	Enter the patient's primary country of residence. Use the Lookup (**F2**) to select the country.
Postal Code:	Enter the patient's postal code.

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Residence Code:	Enter the patient's residence code. Use the Lookup (**F2**) to select the residence code.
Residence Type:	Enter the patient's residence type. Use the Lookup (**F2**) to select the residence type.
Primary Phone Number:	Enter the patient's primary phone number.
Cell Phone Number:	Enter the patient's cell phone number.
Fax Number:	Enter the patient's fax number, if applicable.
E-Mail:	Enter the patient's email address, if applicable.
H.C.N. Province:	Enter the H.C.N. Province code. Use the Lookup (**F2**) to select the province code.
Health Care Number:	The number from the patient's health card. The format of the number varies from province to province.
H.C.N. Version:	
C.P.I. Notes:	Enter the freeform notes for additional information.

After pressing **Enter** in the last field, the Alerts/Allergy multiform displays. This multiform records information by recording every "Alert" or "Allergy" relating to the patient.

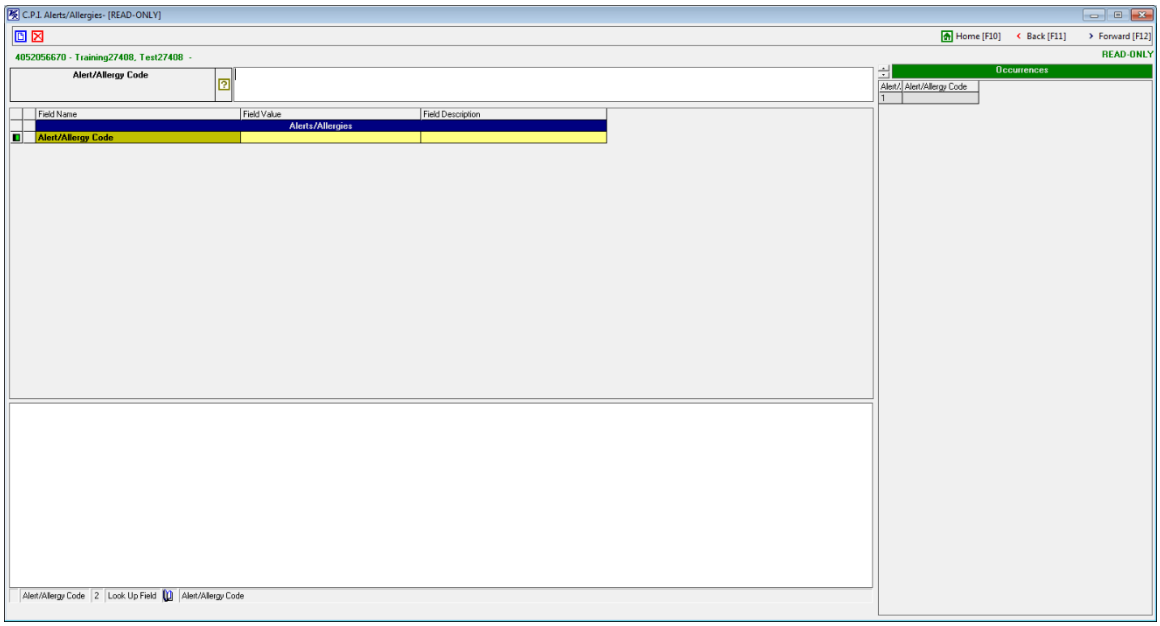
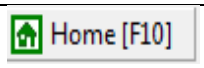


Figure 6

Enter the required information in the Alerts/Allergy multiform.

Alert/Allergy Code:	The Alerts/Allergy uses a multiform, allowing multiple alerts and/or allergies to be entered for the patient. As each is entered, it displays in the Occurrences sidebar.

If there are no more alerts/allergies to enter for the patient, click 

Enter the duplicate chart indicator.

Duplicate Chart:	Enter the duplicate chart indicator.

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When complete click
- or – Press **F7**.
The information is saved and displays in the Main Grid.

Deleting Central Patient Index Information

Central Patient Index (C.P.I.) information may be deleted at any time.

Note: If there are existing abstracts that are currently using the chart, the information cannot be deleted.

To delete Central Patient Index (C.P.I.) information:

1. From the Central Patient Index (C.P.I.) click
   - or - Press **F4**.
   The Chart Search dialog displays.
2. Use the search fields in the Chart Search to display Central Patient Index (C.P.I.) information.
3. Double-click in the Chart Search on the entry containing the Central Patient Index (C.P.I.) information to delete.
   - or - Select the required entry and press **Enter**.
   The Central Patient Index (C.P.I.) window displays the information for the selected entry.

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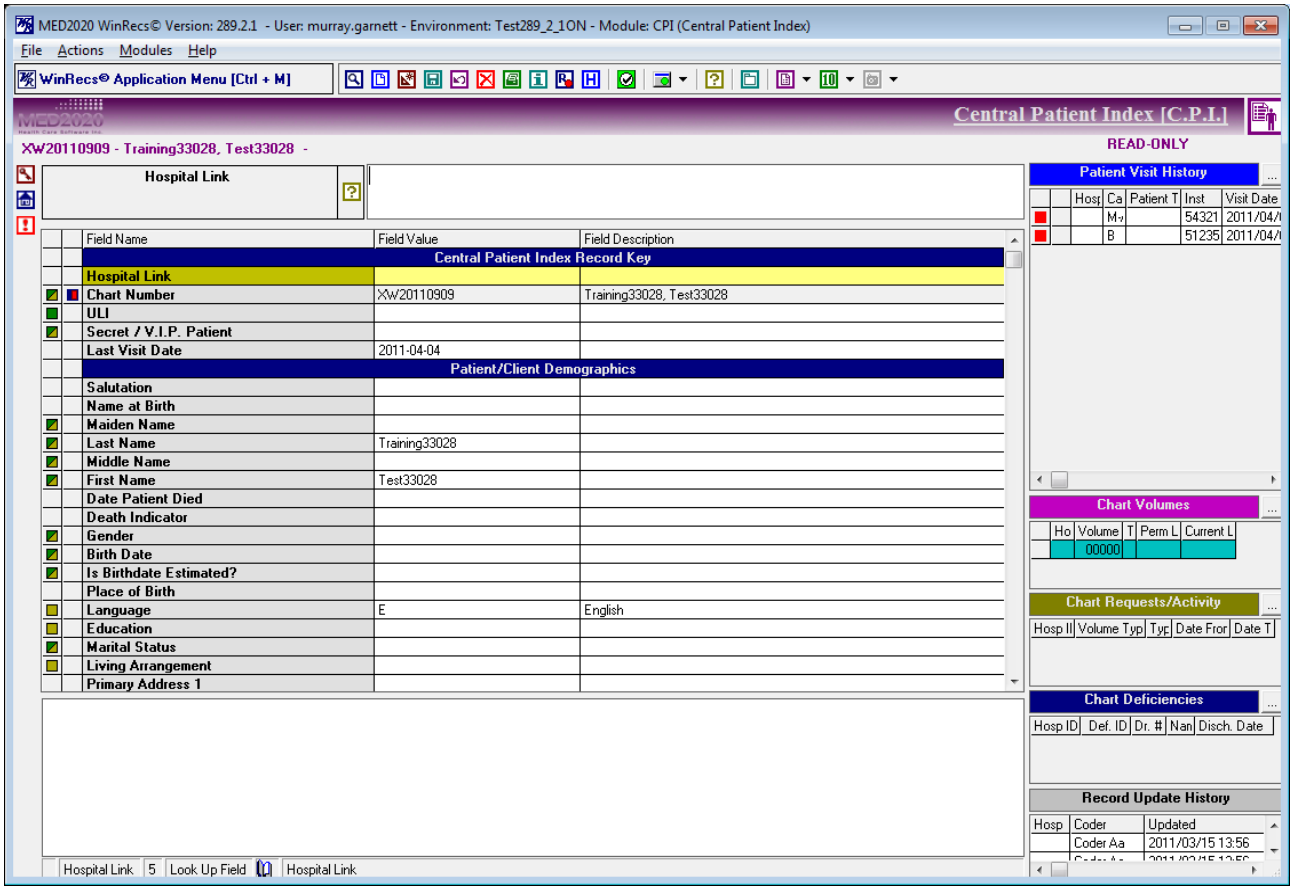

Figure 7

4. Ensure the correct record displays.

Click ☒
The Delete confirmation dialog displays.

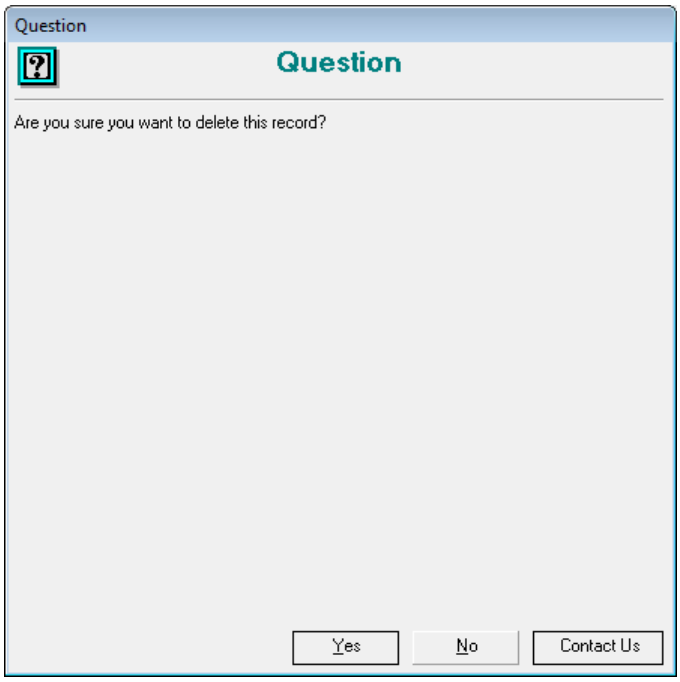

Figure 8

5. Click **Yes**.
   The patient information is removed from the Central Patient Index (C.P.I.) module.

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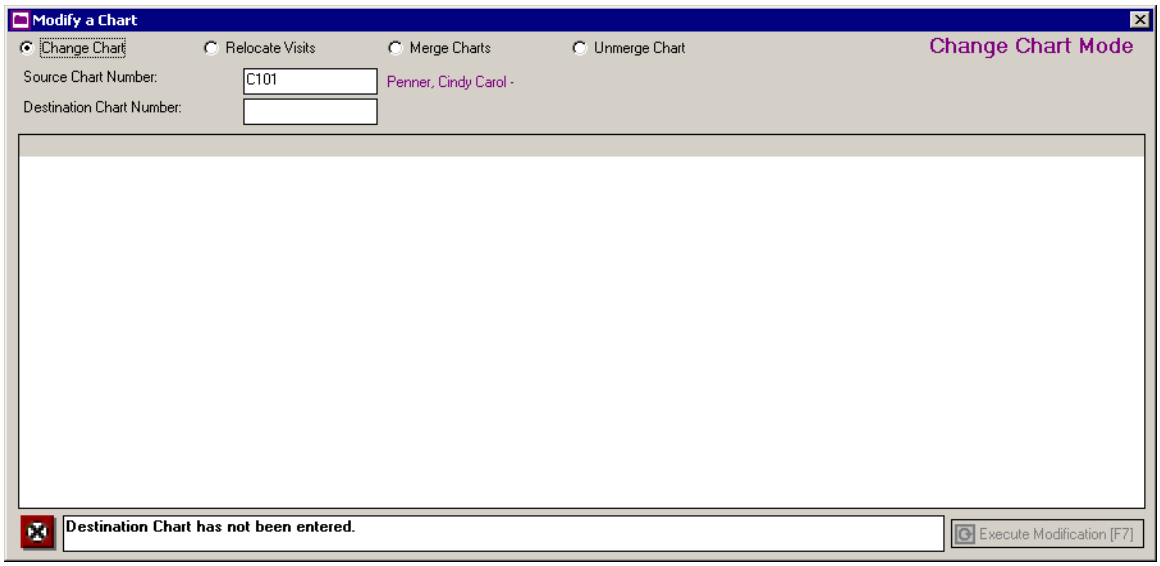
Modifying a Chart

Definitions:
Source Chart – Chart to be merged/child
Destination Chart – Chart to be retained/parent/Master Chart Number

In the **CPI** module, select the chart number you want to change.

Select *Modify a Chart* from the *Actions* menu.

Note: If Modify a Chart is not displayed in the Actions menu, you do not have the necessary permissions. Contact your local WinRecs system administrator.



The Source Chart Number will be the chart number that was accessed in the CPI module.

Function Descriptions

Change Chart
Use this option to change one chart number to another, e.g. change chart # 1234 (Source) to # 4567 (Destination). All visits for the patient will be moved to Chart # 4567. This is only possible if the destination chart number does not already exist in C.P.I. See *Submitted Records* at the end of this section for information on how WinRecs handles records that have already been submitted.

Relocate Visits
Use this option to move only selected visits from one chart to another. The Source Chart Number will display all visits for the chart. Select the Destination Chart Number and the visits to move to the Destination Chart Number. This cannot be 'undone'. See *Submitted Records* at the end of this section for information on how WinRecs handles records that have already been submitted.

Merge Charts
Use this option to move all visits from the Source Chart Number to the Destination Chart Number. See *Submitted Records* at the end of this section for information on how WinRecs handles records that have

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already been submitted.

Unmerge Chart
This option will unmerge previously merged records. The Hospital Profile field 'Charts can be Re-Issued' MUST be set to 'N'.

IMPORTANT! Review the field 'Chart Numbers can be Re-Issued?' in Hospital Profile. If this field is set to 'N' then the Source Chart Numbers cannot be reused – this setting allows Un-Merging. If this field is set to 'Y' you will NOT be able to Un-merge records as this causes a CPI Chart Lock.

Note: Before any of the Modify a Chart options are actually executed, the user will be prompted with the relevant "would you like to continue?" dialogue to manually confirm the action.

Submitted Records

When performing any of the Modify a Chart functions (Change/Relocate Visits/Merge), it is important to consider whether the visits being moved to the new chart number are going to require re-submission to CIHI. **Read this section in its entirety before proceeding!**

Once you click "yes" to confirm proceeding with the selected Modify a Chart function, the screen below will appear if there are abstracts/assessments related to the Source Chart Number. These are records that have been submitted to CIHI and require a correction/deletion file and a new submission file for the period submitted to update the CIHI database.

When selecting records to delete/re-submit, consider whether the relevant CIHI database is still "open" for receipt of updates. (e.g. Corrections for DAD and NACRS may not be allowed for prior fiscal years)

To select specific abstracts, hold down the **Ctrl** key and using the mouse pointer select the abstracts you want to process for deletion/re-submission. In this example the batch year you want to select is 2006.

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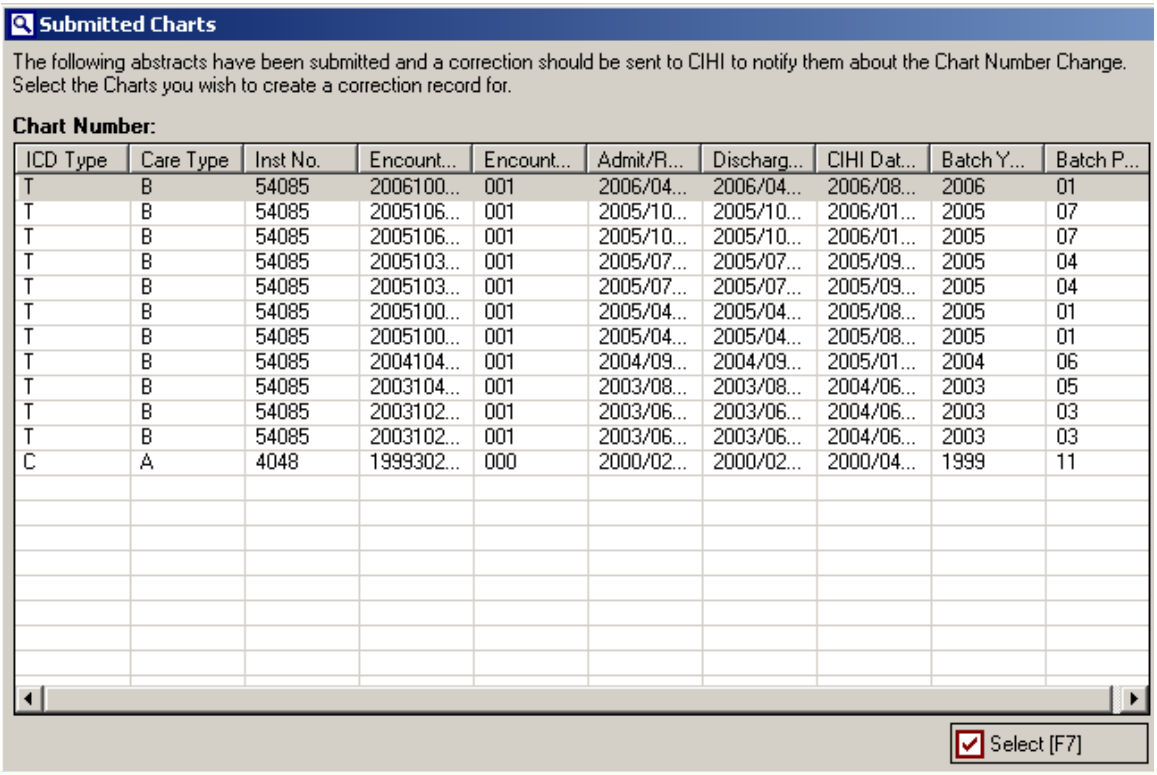
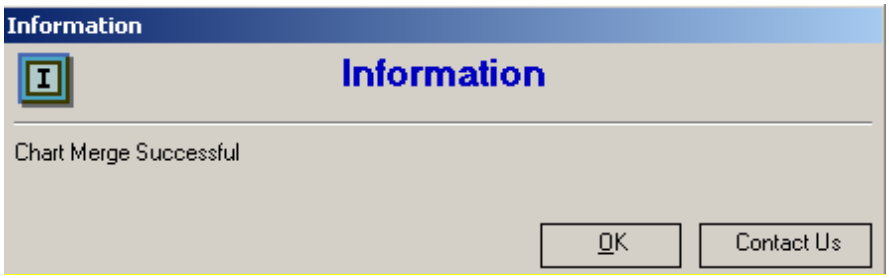


ICD Type	Care Type	Inst No.	Encount...	Encount...	Admit/R...	Discharg...	CIHI Dat...	Batch Y...	Batch P...
T	B	54085	2006100...	001	2006/04...	2006/04...	2006/08...	2006	01
T	B	54085	2005106...	001	2005/10...	2005/10...	2006/01...	2005	07
T	B	54085	2005106...	001	2005/10...	2005/10...	2006/01...	2005	07
T	B	54085	2005103...	001	2005/07...	2005/07...	2005/09...	2005	04
T	B	54085	2005103...	001	2005/07...	2005/07...	2005/09...	2005	04
T	B	54085	2005100...	001	2005/04...	2005/04...	2005/08...	2005	01
T	B	54085	2005100...	001	2005/04...	2005/04...	2005/08...	2005	01
T	B	54085	2004104...	001	2004/09...	2004/09...	2005/01...	2004	06
T	B	54085	2003104...	001	2003/08...	2003/08...	2004/06...	2003	05
T	B	54085	2003102...	001	2003/06...	2003/06...	2004/06...	2003	03
T	B	54085	2003102...	001	2003/06...	2003/06...	2004/06...	2003	03
C	A	4048	1999302...	000	2000/02...	2000/02...	2000/04...	1999	11

Once the selected visits are highlighted, click on the **Select (F7)** button at the bottom right hand corner of the screen. The screens displayed in the image below will pop-up.

Select the **Ok** button to confirm the Modify a Chart function you are using – in this example it is a Chart Merge.



What is the result of this action of selecting submitted records?

Amcare/NACRS records: Visits under the old/source chart number will be flagged as a deletion in the Purge/Undelete module and the "new" abstract created under the new number will be flagged as not submitted. A correction file must be processed for the deleted record to be included in a submission file. The subsequent submission file will then pick up the abstract with the revised chart number.

Abscare/DAD/SDS records: Visits under the old/source chart number will be flagged as a deletion in the Purge/Undelete module and the "new" abstract under the new number will be flagged as not submitted. A

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correction file must be processed, at which time the separate deletion file will be created. A subsequent submission for that batch year/period will include the 'new' abstract.

NRS records: Assessments under the old/source chart number will be flagged as a deletion in the Purge/Undelete module and the "new" assessments under the new number will be flagged as not submitted. A submission file will require creation for that Batch Year/quarter for both the deletion of the old, and insertion of the new assessment to be included. **Note**: an admission assessment cannot have a changed chart number or merge without a linked discharge assessment also being changed/flagged for deletion/resubmission, if that discharge assessment has also been submitted.

If the discharge has not been submitted, it requires deletion (in order for WinRecs to process the delete of the admission) and re-entry but not re-submission until you are ready to submit the period that contains that discharge.

OMHRS records: Assessments under the old/source chart number will be flagged as deletion in the Purge/Undelete module and the "new" assessment under the new number will be flagged as not submitted. A submission file will require creation for that Batch Year/quarter for both the deletion of the old, and insertion of the new assessment to be included. Note: an admission cannot have a changed chart number or merge without any linked quarterly and/or discharge assessments also being changed/flagged for deletion/resubmission.

Changing Chart Numbers

After loading your source chart and selecting 'Modify a Chart' from the Actions menu, ensure the Change Chart radio button is selected.

Type in the *Destination Chart Number* and click ***Execute Modification*** *or* ***[F7]*****.**

Selected any visits as described in the **Submitted Records** section above.

The new *Destination Chart Number* will be saved with the CPI record and future searches for *Source Chart Number* will return the CPI record associated with the *Destination Chart Number*.

The "NEW" number assigned will automatically recreate any selected, submitted abstracts with the new chart number, however the submission control elements will show as Date Sent to CIHI 1900/01/01.

Create and send (if the fiscal year is still open) the appropriate submission files if submitted records were selected.

Merging / Unmerging Charts

IMPORTANT! Review the field 'Chart Numbers can be Re-Issued?' in Hospital Profile If this field is set to 'N' then the Source Chart Numbers cannot be reused – this setting allows Un-Merging. If this field is set to 'Y' you will **NOT** be able to Un-merge records.

Anytime a baby or a mother's chart number changes you will need to manually update the C.P.I. module to reflect these changes. In the C.P.I. module there are fields called 'Mother's Chart' and multiform with fields called 'Baby Chart Number'. **Search Field (F3)** will show the fields on the grid in alphabetical order.

In the case of unmerge the user will need to delete the volume that was created by the merge.

Merging Charts

After loading your source chart and selecting 'Modify a Chart' from the Actions menu, ensure the Merge Charts radio button is selected.

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Type in the *Destination Chart Number* and click *Execute Modification or [F7]*.

Selected any visits as described in the **Submitted Records** section above, if applicable.

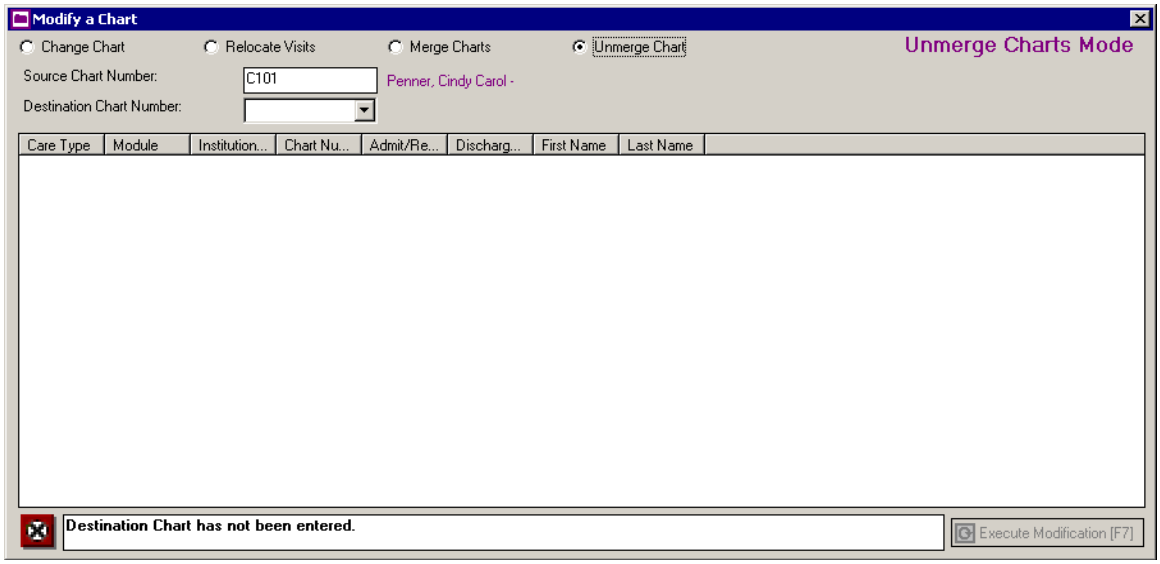
The new *Destination Chart Number* will be saved with the CPI record and future searches for *Source Chart Number* will return the CPI record associated with the *Destination Chart Number*. All visits from the Source Chart Number will now be found under the Destination Chart Number.

The "NEW" number assigned will automatically recreate any selected, submitted abstracts with the new chart number, however the submission control elements will show as Date Sent to CIHI 1900/01/01.

Create and send (if the fiscal year is still open) the appropriate submission files if submitted records were selected.

Un-Merging Charts

Search in CPI for the Source Chart Number (the number the chart was merged to). From the ***Action*** drop-down column select **Modify a Chart**. If **Modify a Chart** is not displayed then you do not have permission to do this.



The Modify a Chart screen will appear.

The Source Chart Number and the patients' name will display.

Select the Unmerge Charts radio-button.

The Destination Chart Number will populate (the Destination Chart is the number the data was originally) and click *Execute Modification or [F7]*.

<u>CLEARING CHART LOCKS</u>: When chart numbers are merged and the "Chart numbers can be reissued" field is set to Y in Hospital Profile this causes a lock and will not allow an unmerge. There is a now new field in users profile called "Can Clear CPI Lock". When a lock happens after a merge, change the "Chart numbers can be reissued" setting in Hospital profile to N. Users that have rights can clear the CPI Lock by going to CPI > Actions > Clear CPI lock. Once this is done

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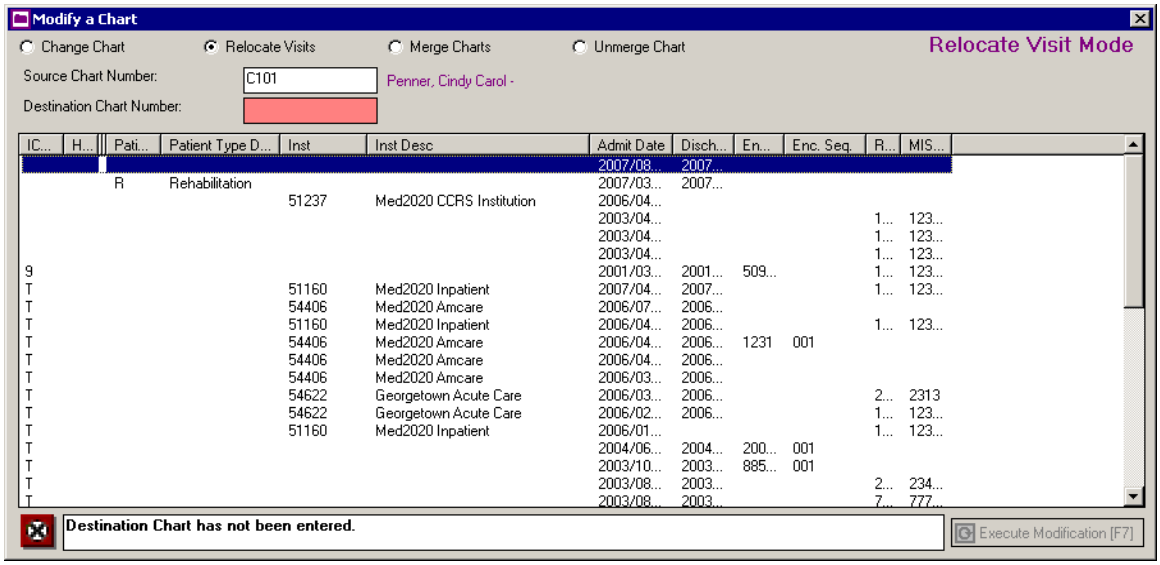
the unmerge button will become enabled and will allow the unmerge of the chart numbers.

Relocating Visits

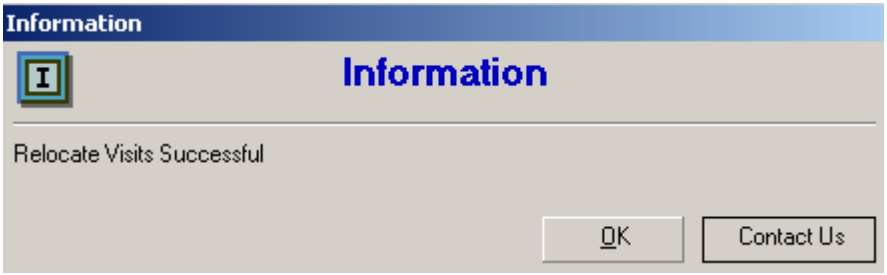
After loading your source chart and selecting 'Modify a Chart' from the Actions menu, ensure the Relocate Visits radio button is selected.

Type in the *Destination Chart Number* and ENTER. The Source Chart Number visits appear in the grid below.



Select the visits you wish to relocate to the Destination Chart Number by holding Ctrl key and click the applicable visits.

Click **Execute Modification (F7)** button. The message below indicates successful relocation of a visit (s).



To change the location of a merge, use the **Transaction Type** 'M' in the **Chart Locator** module. If you change the **Permanent** and **Current Location** of a chart using 1 transaction instead of 2 it will be visible in the **Chart Request/Activity** section of the **C.P.I.** module.

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Electronic Merges via Interface

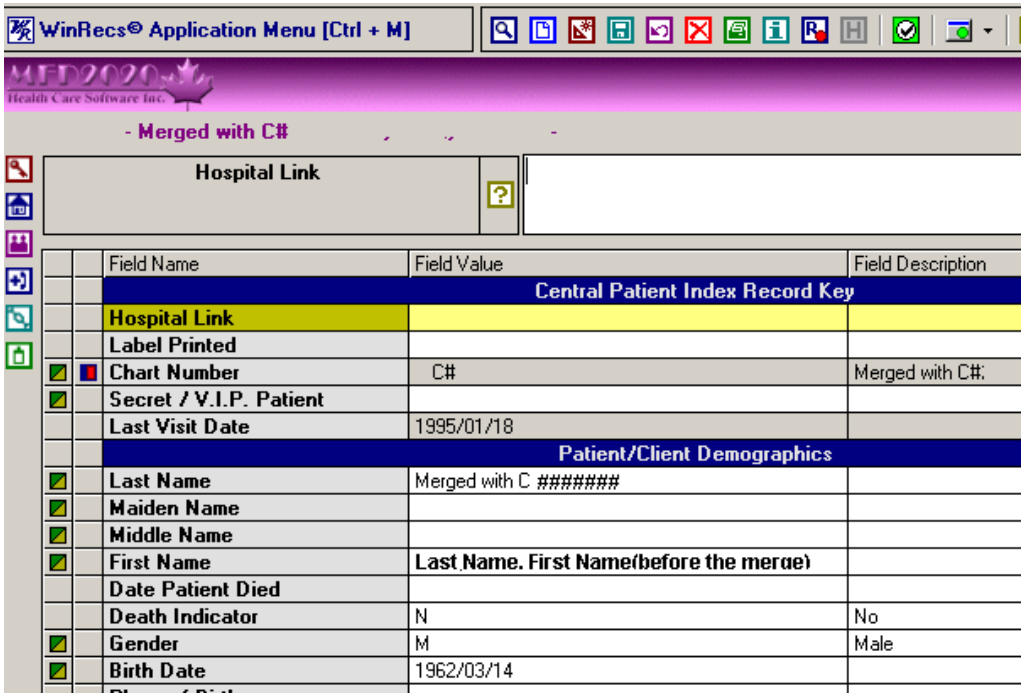
Note: **Merge transactions via an interface have limited functionality. Typically these automated merge transactions are done shortly after the duplicate number has been assigned i.e. before any abstracts/assessments are submitted to CIHI.**

Therefore, MED2020 recommends these transactions be used with caution. None of the automatically flagging or selection of visits to delete/resubmit is incorporated as part of the electronic merge transactions.

Use the CPI Merged Records Report.rpt from the WR2Reports\CPI folder to assess regularly if any charts electronically merged require manual intervention.

1. **Source Chart** number visits are merged into the **Destination Chart** number.

2. Last name of the patient of the source chart gets replaced with "**Merged with Destination Chart Number**", and the first name field of the patient now contains the last name, first name of the patient prior to the merge.



3. All previous **Source Chart** Deficiencies, R.O.I. requests, and visits will appear on the **Destination Chart** screen.
4. Volumes of the **Source Chart** remain with the **Source Chart** number and are **NOT** moved to the **Destination Chart**.
5. Chart Locator Activities associated with the **Source Chart** volume(s) remain with the **Source Chart**

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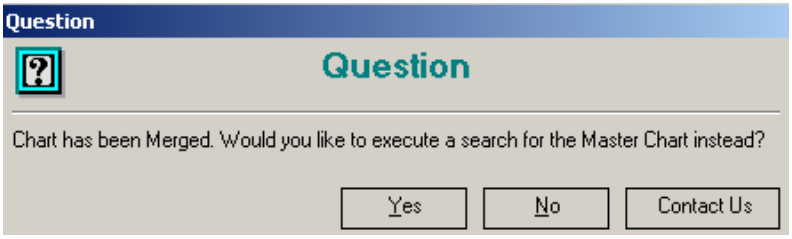
volume(s) and **DO NOT** move to the **Destination Chart** Number.

6. The Master Chart Number field on the **Source Chart** would be updated with the **Destination Chart** number as part of the merge routine.

7. Access and use of the **Source Chart** Number will no longer be available (unless you have been granted permissions to access locked source charts in the User Profile).

When a merged chart number is entered into a search the Question box displayed in the image below will appear. Selecting 'Yes' will direct the user to the **Destination Chart** number (The Master Chart Number).



Note: On a Pull List any Chart Request will NOT be updated to reflect the destination chart number, however, the Lastname field for the merged chart will contain the destination chart number e.g. indicating "Merged with # 1234567"

Printing Reports

The following reports are available for the Central Patient Index:

Central Patient Index Visit History
CP I Visit History Report
CP I Report On Load
Embosser Card

.

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Central Patient Index Sidebars

The following sidebars are available within the Central Patient Index.

Patient Visit History

Displays a one line summary of all patient visits for the selected patient. Detailed information may be viewed by double-clicking the visit.

Chart Volumes

Displays the chart volumes associated with the selected patient. Double-click the Volume Number within the Chart Volume sidebar to display the Chart Volume dialog.

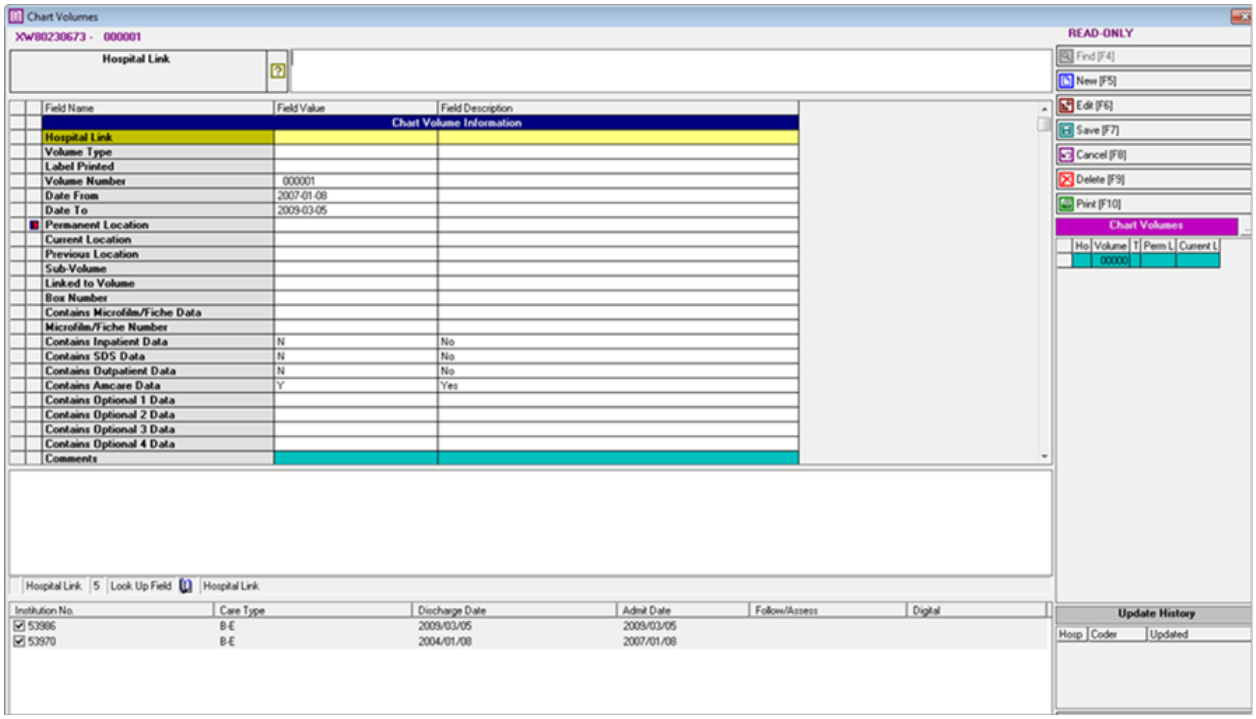

Figure 9

From the Chart Volume dialog, the chart volume information may be maintained using the options on the right. New volumes may be added, existing volumes edited, deleted or printed.

At the bottom of the screen there is a list of all the institutions and the dates for each visit. When finished click

Destruction Date for Chart Volumes:

In the Chart Volumes Module there is a Destruction Date Field:

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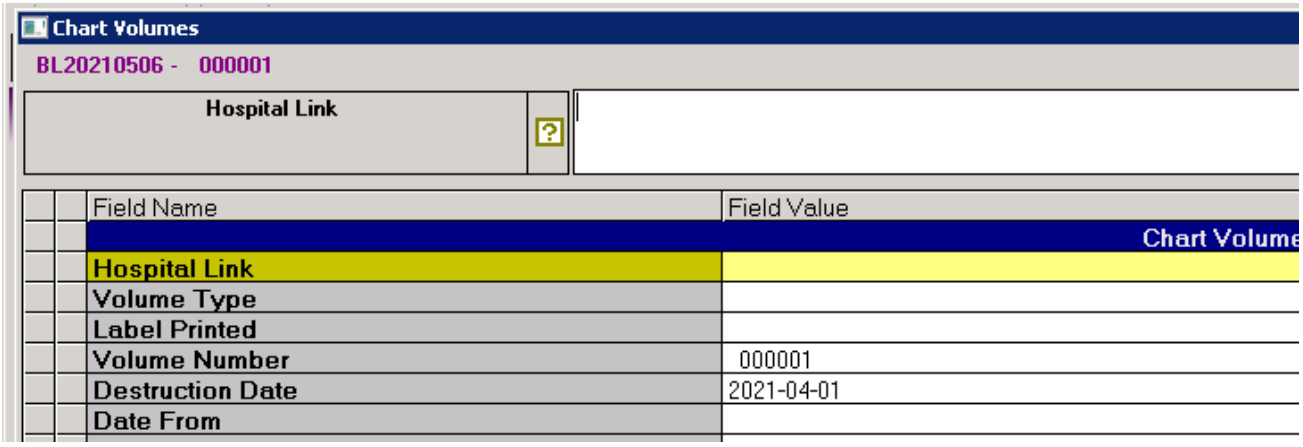

Figure 10

When a date is entered in the Destruction Date field the date now displays in the Chart Volumes area and the destructed volume/s will display in red.

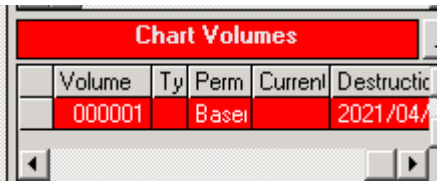

Figure 11

Chart Requests/Activity

Displays all chart requests and associated activity for the selected chart. Double-clicking an entry displays the detailed information for the chart.

Chart Deficiencies

Displays all chart deficiencies for the selected chart. Double-clicking a deficiency displays the Chart Deficiency report.

Record Update History

Displays an audit trail showing the history of any changes made. This includes the WinRecs user ID of the user who made the change.

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4.2 Visit History Overview

The Visit History module is used mainly for chart management within a hospital or facility. Visit history captures both abstracted records and non-abstracted (paper) records.

The Visit History module contains patient / client demographics, admission / discharge information, visit information, and record information.

Note: This is a READ-ONLY module. Changes that need to be made to a patient record should be made in the C.P.I. or the appropriate module.

Available Reports

There are no reports available for Visit History.

Visit History Setup

The following setup must be completed before using the Visit History module. For a complete description of the setup required and the steps to complete please refer to "**Section 6 - System Maintenance**" in the WinRecs User Guide.

Regional Profile: The Regional Profile is used to specify default values which are used in individual facility profiles. The information entered here is required for lookups.

Hospital Profile: The Hospital Profile is used to specify values accessed using lookups when working with Visit History.

Look Up Field Maintenance: The following tables must have entries in them before creating a Visit History entry.

- Gender
- Patient Type
- M.I.S. Code
- Clinic/Nursing Unit
- Attending Provider
- Referring Provider
- Main Diagnosis Code
- Main Intervention Code

User Profile: Users must have rights to access the Visit History module.

Control File Settings: The Control File specifies default settings for fields, determining if fields are visible or enabled within the Visit History module.

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Accessing the Visit History Module

The Visit History module is one of the modules within Chart Maintenance. Please refer to **Chapter 2 "WinRecs Layout"** for more information on the modules available within WinRecs. There are two options for accessing the Visit History module. The option to use can depend on what is to be performed within the module. The options are:

Option 1: From the Central Patient Index (CPI)

This option always opens the Visit History module in "**New**" mode, ready for data entry. When accessed using this option, the chart number and any other relevant fields are populated from the CPI. Therefore, if adding visit history information, this method is recommended. For information on using the CPI, please refer to "Central Patient Index (CPI)" on page 40 within this user guide.

To access the Visit History module from the CPI:

1. From the WinRecs Application Menu, select Central Patient Index (CPI).
2. Search for the patient in the CPI.
   If the CPI does not open in Search mode, press **F4** to display the search dialog then search for the required chart.
3. Double-click on the required chart to display it in the CPI.
4. When the chart displays, hot-link to the Visit History module using the Hot Link ( ) button on the toolbar. The Visit History window displays.

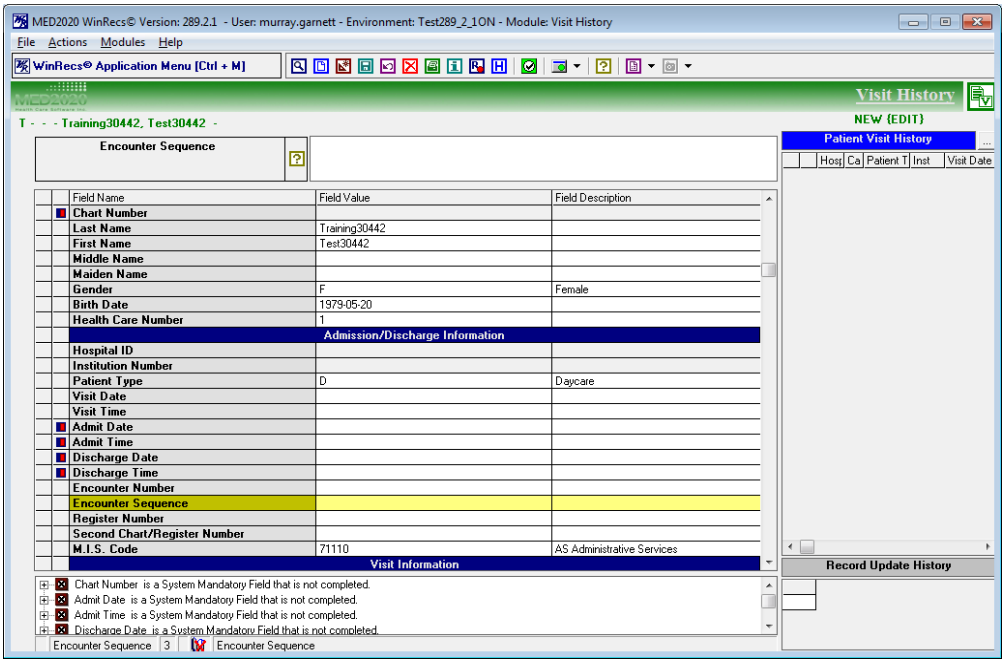

Figure 10

5. With this method, all available information from the CPI populates all relevant fields.

Option 2: From the WinRecs Application Menu

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With this method there is no auto-populating of fields so the Visit History window does not contain any information.

To access the Visit History module using the WinRecs Application Menu:

1. From the WinRecs Application Menu, select **Chart Maintenance – Visit History**. The Visit History window displays with no information populating fields.

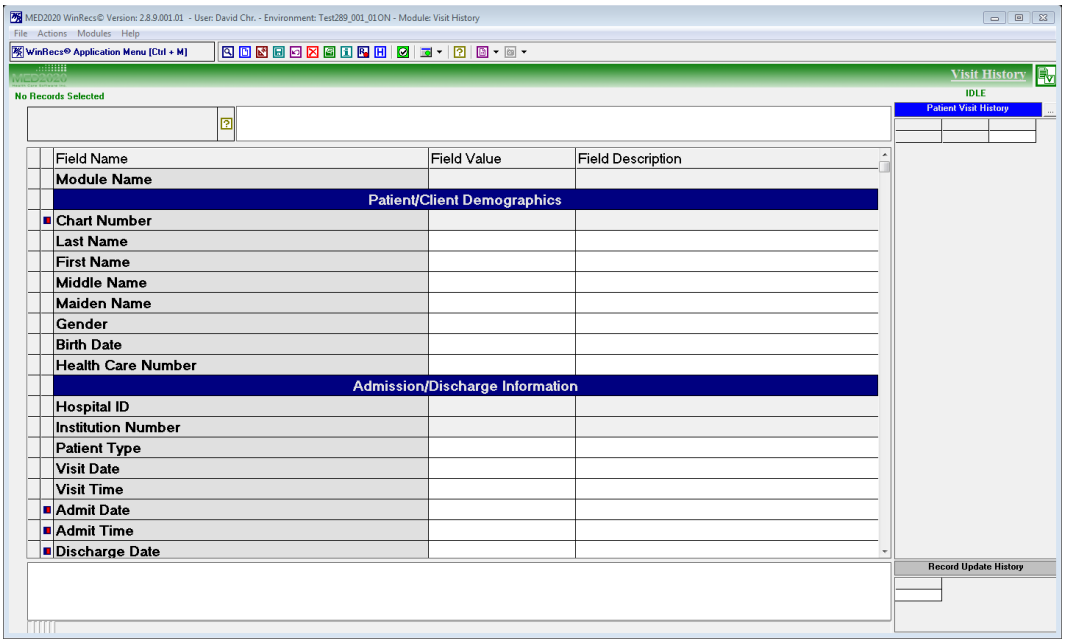

Figure 11

2. Use the relevant options as described in this chapter to maintain visit history and related information.

Note: *For Regional Database users*, this module is linked to your User Profile setting for Hospital Link. You can only view the *Visit History* of patients with the same Hospital Link.

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Using the Visit History Module

The Visit History module is used mainly for chart management within a hospital or facility. Visit history captures both abstracted records and non-abstracted (paper) records.

The Visit History module contains patient / client demographics, admission / discharge information, visit information, and record information.

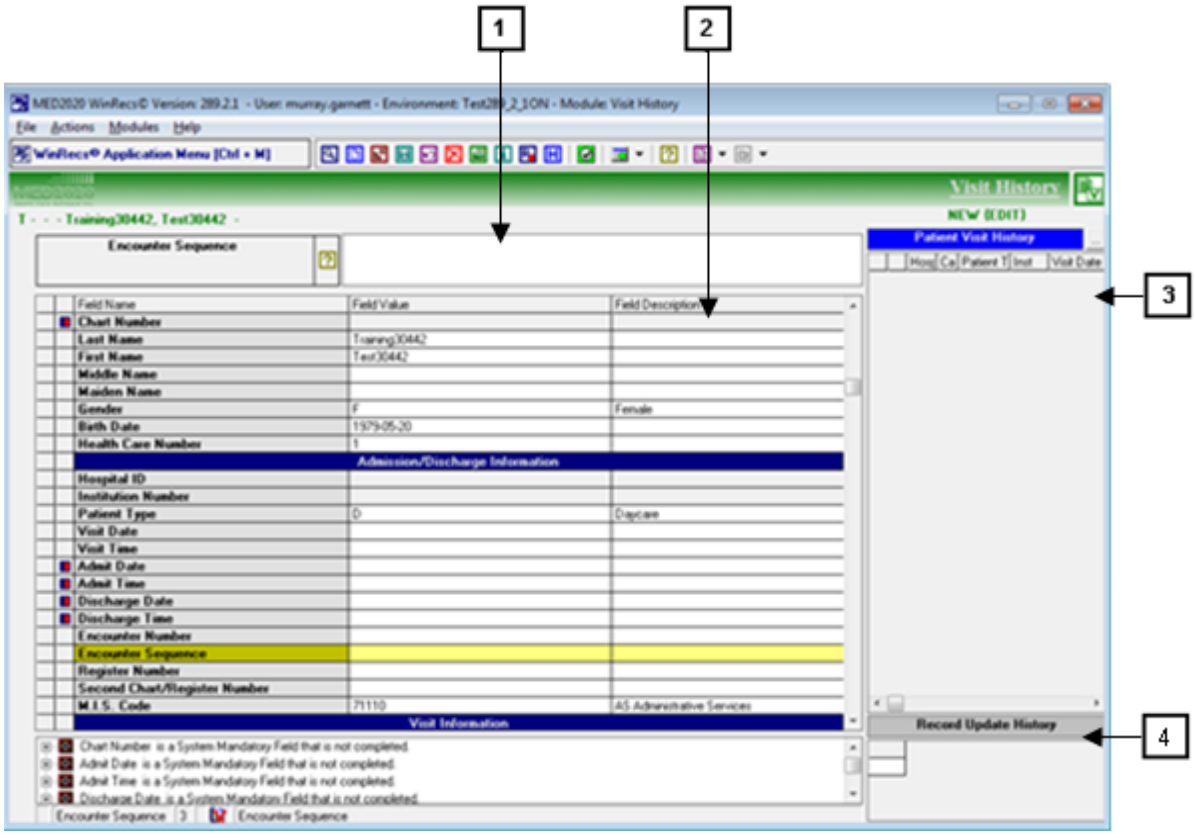

Figure 12

The main components of the Visit History window are the Main Grid, Data Entry Box and 2 sidebars. The main parts of the Visit History window are described in the table below. The REF# field for each row relates to the callouts shown in the above image.

Note that there are no bookmarks in Visit History.

REF#	Description
1	**Data Entry Box**: The Data Entry Box is used to enter or edit information displaying in the Main Grid. Click on a field in the Main Grid and the field name displays on the left and the cursor is positioned in the box ready for entry.
2	**Main Grid**: The Main Grid shows the information for the currently selected visit history entry (or is empty when first creating entries). To add or modify information in the Main Grid, select the row and the field name displays beside the Data Entry Box and the data may be changed by typing in the Data Entry Box. The information in the Main Grid is organized under headings and can be accessed by scrolling

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	through the grid to move the grid to the section within the associated heading.
3	**Patient Visit History**: Displays a summary of patient visits. Clicking the ellipsis displays the detail view of patient visits.
4	**Record Update History Sidebar**: Displays an audit trail showing the history of changes made. This includes the WinRecs user ID of the user who made the change.

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Creating Visit History Entries

Before creating visit history entries, the patient should first exist within WinRecs as the patient data can be used to populate information within the Visit History module. If the patient exists, the Visit History Search may be used to locate the required patient chart and related demographics.

To create visit history entries:

From Visit History click
The Visit History fields are available for entry.

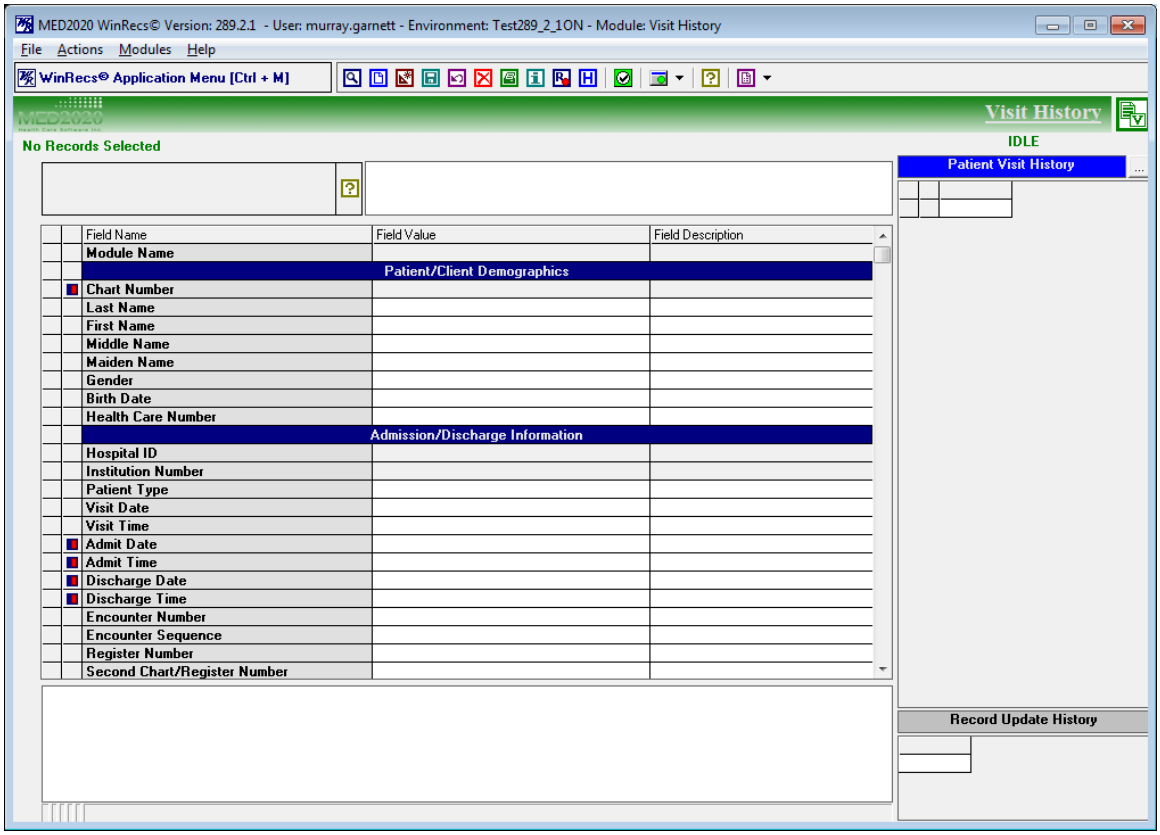

Figure 13

Enter information in all required fields. Press **Enter** after each field to move to the next field. The following are the fields accessed by pressing **Enter**.

Module Name:	If an existing visit is pulled up in Visit History module, the module name auto populates in this field. If new visit is being created for the Visit History only a value of Non Abs (non-abstracted) will display.

Enter the Patient/Client Demographics information.

Chart Number:	Enter the unique chart number identifying the patient. Use the Chart Lookup (F2) to select the chart for the list of all available charts. Once the chart is selected, the patient name and birth date populates the Patient/Client

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	Demographics from the Central Patient Index.
Last Name:	The patient's surname.
First Name:	The patient's first name.
Middle Name:	The patient's middle name.
Maiden Name:	The patient's maiden name (if applicable).
Gender:	The patient's gender.
Birth Date:	The date of birth of the patient. Dates are entered in "YYYY-MM-DD" format.
Health Care Number:	The number from the patient's health card. The format of the number varies from province to province.

Enter the Admission/Discharge information for the patient.

Patient Type:	The type of patient. Use the Lookup (**F2**) to select the patient type.
Visit Date:	The date of the patient visit.
Visit Time:	The time of the patient visit.
Admit Date:	The date the patient was admitted. Dates are entered in "YYYY-MM-DD" format.
Admit Time:	The time the patient was admitted.
Discharge Date:	The date the patient was discharged. Dates are entered in "YYYY-MM-DD" format.
Discharge Time:	The time the patient was discharged.
Encounter Number:	Hospital assigned number.
Encounter Sequence:	Hospital assigned.
Register Number:	Hospital assigned.
Second Chart/Register Number:	Optional hospital assigned.
M.I.S. Code:	Visit M.I.S. functional center code. National values.
Clinic/Nursing Unit:	Optional. Non-CIHI defined field.
Attending Provider:	Optional. Non-CIHI defined field.
Referring Provider:	Optional. Non-CIHI defined field.

When complete click
- or – Press **F7**.
The information is saved and displays in the Main Grid.

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Modifying Visit History

Visit History information may be modified as required.

To modify visit history:

From Visit History click
- or - Press F4.
The Visit History Search dialog displays.

Use the search fields in the Visit History Search to display all charts.

Double-click in the Visit History Search on the entry containing the information to update.
- or - Select the required entry and press **Enter**.
The Visit History window displays the visit history information for the selected entry.

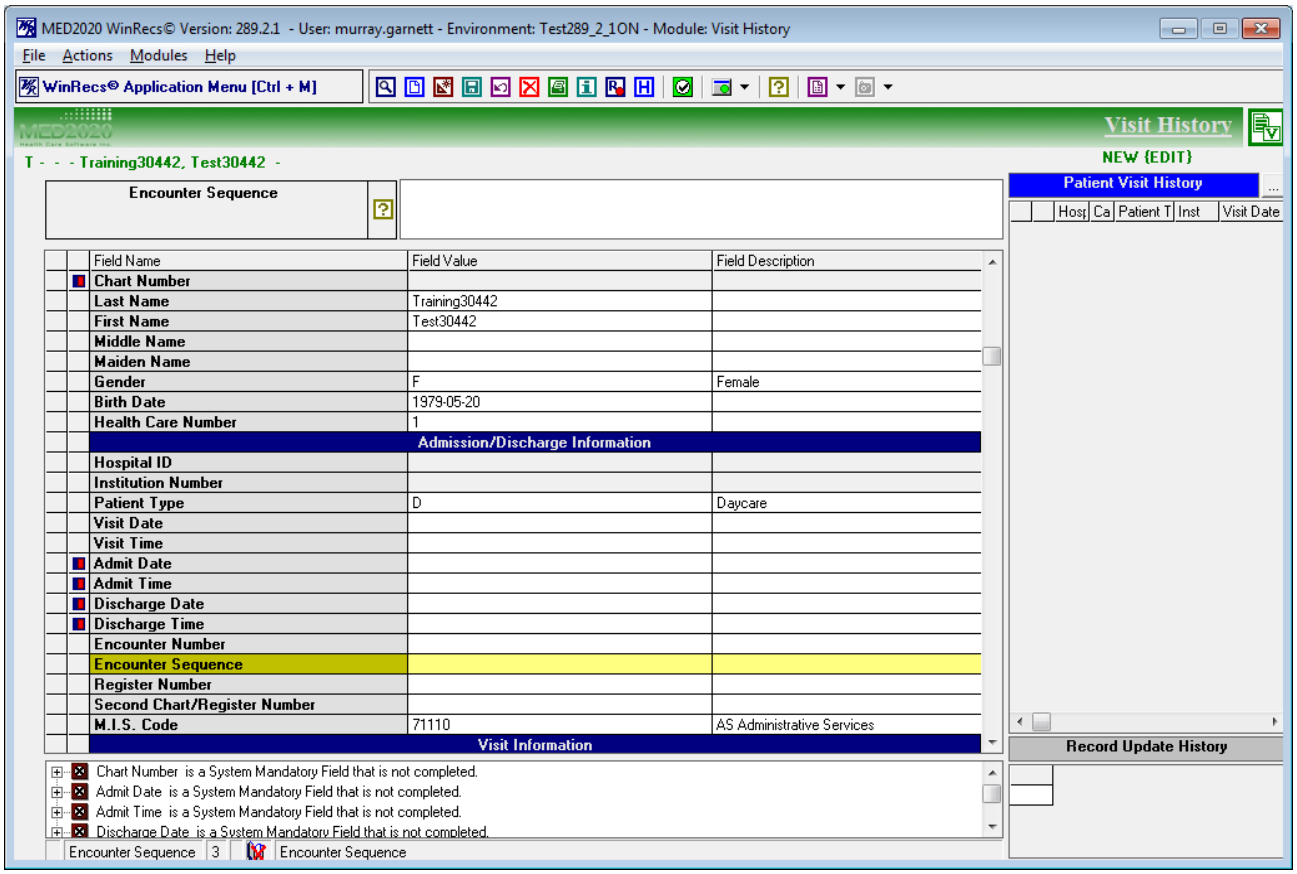

Figure 14

Make the required changes.

When complete click
- or Press **F7**.
The information is saved and displays in the main grid.

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Deleting Visit History

Visit History information may be deleted as required.

Note: **Records can only be deleted from this module if the visit is not linked to any other modules; in other words, the module name value must have a value of Non Abs (Non Abstracted).**

To delete visit history information:

1. From Visit History click
   - or - Press **F4**.
   The Visit History Search dialog displays.
2. Use the search fields in the Visit History Search to display Visit History information.
3. Double-click in the Visit History Search on the entry containing the visit history information to remove.
   - or - Select the required entry and press **Enter**.
   The Visit History window displays the visit history information for the selected entry.

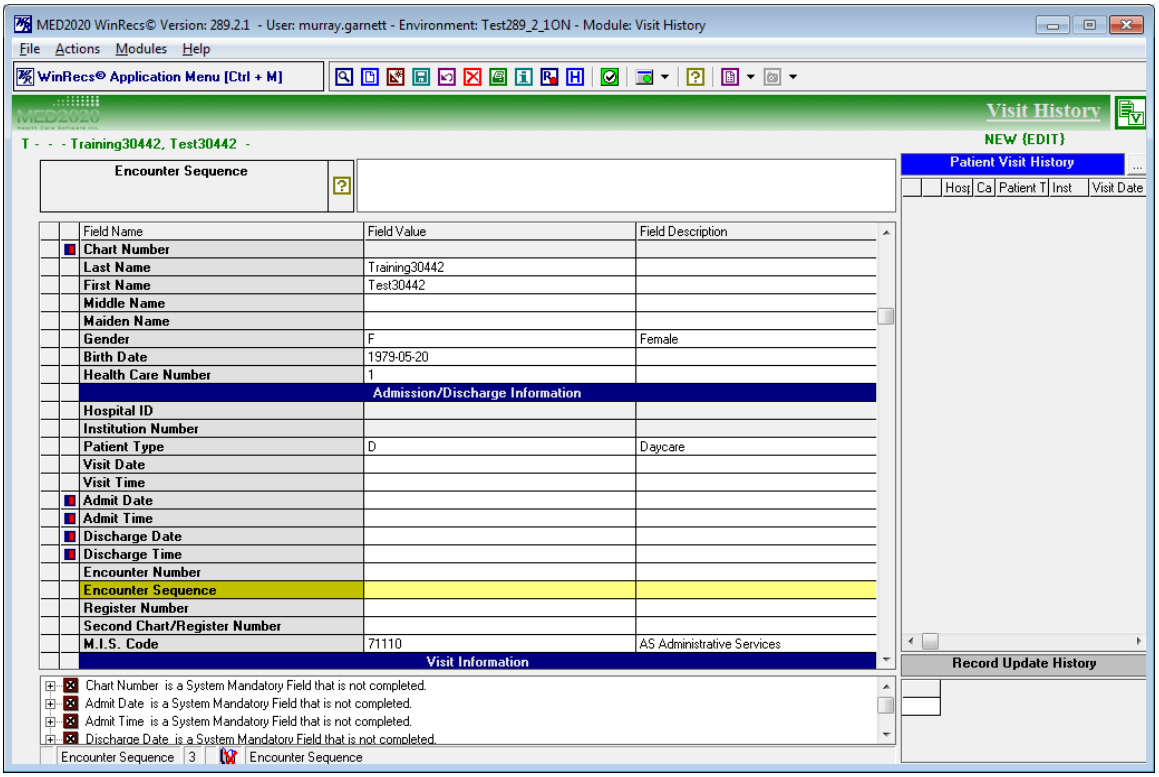

Figure 15

4. Ensure the correct visit history displays.

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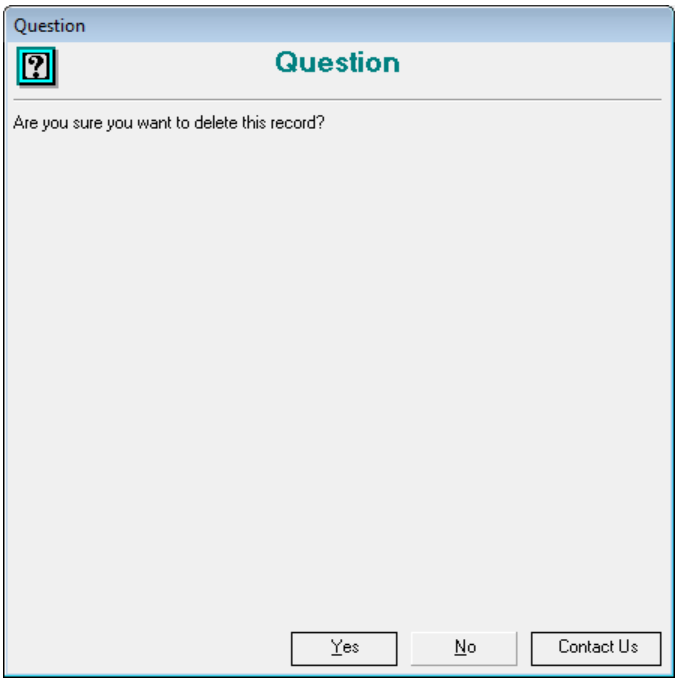
5. Click ☒

The Delete confirmation dialog displays.



6. Click **Yes**.
The selected visit history is removed from the Visit History module.

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Visit History Sidebars

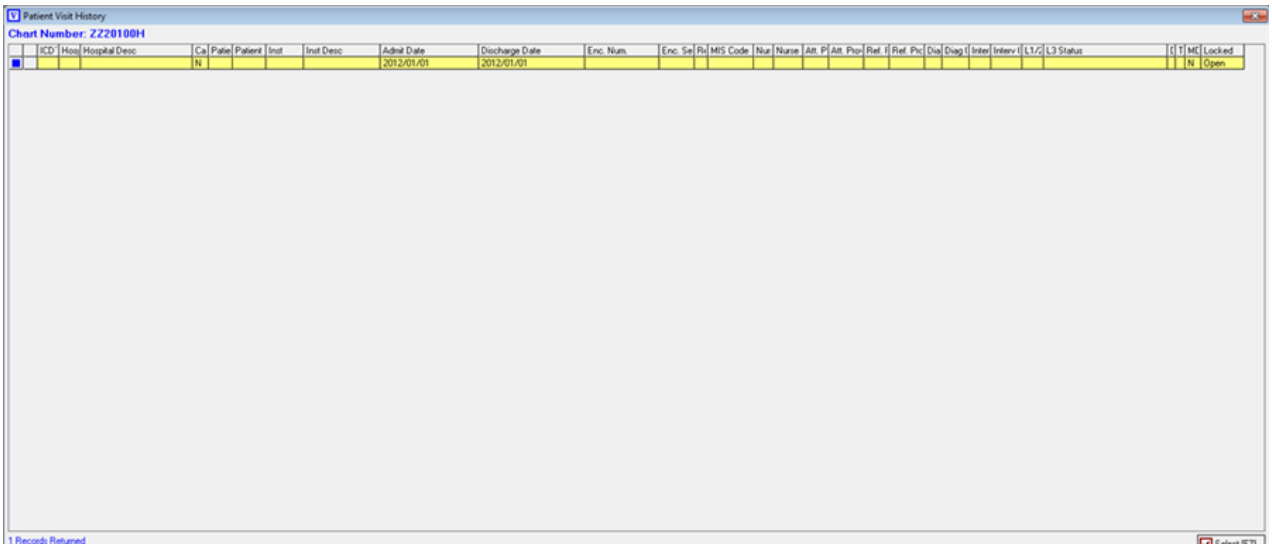
The following sidebars are available.

Patient Visit History

If the patient has had multiple visits on their chart, the Patient Visit History sidebar displays previous visits. These other visits can be accessed by clicking on the ellipsis to displays a detail view of patient visits.

To view other visits:

1. Select the visit in the Patient Visit History Sidebar.
2. Click ...
   The Patient Visit History dialog displays.



3. Double-click a visit to view detailed visit information in the Visit History window.

Record Update History

Displays an audit trail of all requests, and includes the WinRecs user ID of the person who made the change.

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4.3 Chart Locator

Chart Locator Overview

The chart locator module is used for tracking and locating the paper copy of the patient record. Using the key identifier fields entered into the patient record in other modules the chart locater can provide an up to date report on the chart's location within the facility.

There are a number of different locator transaction types that are used to identify and process transactions within the Chart Locator. These transaction types are identified below:

Table 4.1

Transaction Types	
C- Chart Request: Allows you to establish a request for a chart that is currently out on loan. On the chart's return a follow up process identifies the next requester for the chart.	**T- Transfer:** Used for charts transferred from one area to another within the health records department. The difference is that the charts are tracked internally to allow quick access for a provider to complete their charts and/or for patient care.
L- Loan: Used for charts loaned externally from the department. However, charts can be loaned internally also, such as to a R.O.I., Research Area or a Secure File Cabinet etc. in cases where you may need to track an 'expected date of return' for the chart.	**R- Return to Permanent/Previous Location:** This process allows a loaned chart to be returned to either the previous location or the chart's designated permanent location.
M- Mass Change of Location: Used if you want to mass move charts to a new location. Usually used to change one permanent location to another. A field 'New Permanent Location' applies to this Transaction Type.	**X- Cancel:** This allows you to cancel transactions that were made in error and returns the chart to its previous 'current location'.
P- Pull List: Used to create pull lists for clinics etc. These can be created manually or with a Batch Interface.	

Examples of each of these transaction types are included within this chapter.

The chart numbers will be color coded and populate the Chart Volumes pane.

Chart number in Blue: Indicates that there is an outstanding request for the chart.
Chart number in Red : Indicates that the chart is currently out on Loan
Chart number in Purple: Indicates that the current location of the chart is the same as the location you are about to send it to.

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Chart Locator Setup

The following setup must be completed before using the Chart Locator module. For a complete description of the setup required and the steps to complete please refer to "**Section 6 - System Maintenance**" in the WinRecs User Guide.

- System Maintenance modules must be configured before the Chart Locator can be used.
- Regional Profile/Hospital Profiles: Verify that the configured Chart Mask and Terminal Digit formats are correct.
- User Profile Settings: Most Locator transactions (loads, transfers, returns) are performed in this module. Setting the permissions also enables interaction between Chart Locator and Abstracting, and Chart Locator and Chart Deficiency.
- Control File Settings: Set default values for individual fields as well as disable and/or enable fields as required
- Look Up Field Maintenance: All lookup tables for the Chart Locator module are prefixed with "Loan". The following fields must be set up for lookups:

  Hospital Link
  Transaction Type
  Borrower
  Transaction Location
  Location Type
  New Permanent Location
  Request Priority

Note: For each user some changes may need to be applied to the User Profile to give access and permissions.

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Accessing the Chart Locator Module

The Chart Locator module is one of the modules within Chart Maintenance. Please refer to **Chapter 2 "WinRecs Layout"** for more information on the modules available within WinRecs. There are two options for accessing the Chart Locator module. The option to use can depend on what is to be performed within the module. The options are:

Option 1: From the Central Patient Index (CPI)

This option always opens the Chart Locator module in "New" mode, ready for data entry. When accessed using this option, the chart number and any other relevant fields are populated from the CPI. Therefore, if adding charts, this method is recommended. For information on using the CPI, please refer to section 4.2 "Central Patient Index (CPI)" on page 40 within this document.

To access the Chart Locator module from the CPI:

From the WinRecs Application Menu, select Central Patient Index (CPI).

Search for the patient in the CPI.
If the CPI does not open in Search mode, press **F4** to display the search dialog then search for the required chart.

When the patient is located, Hot-link to the Chart Locator module using the Hot Link ( ) button on the toolbar.
The Chart Locator window displays, with available information from the CPI populating all relevant fields.

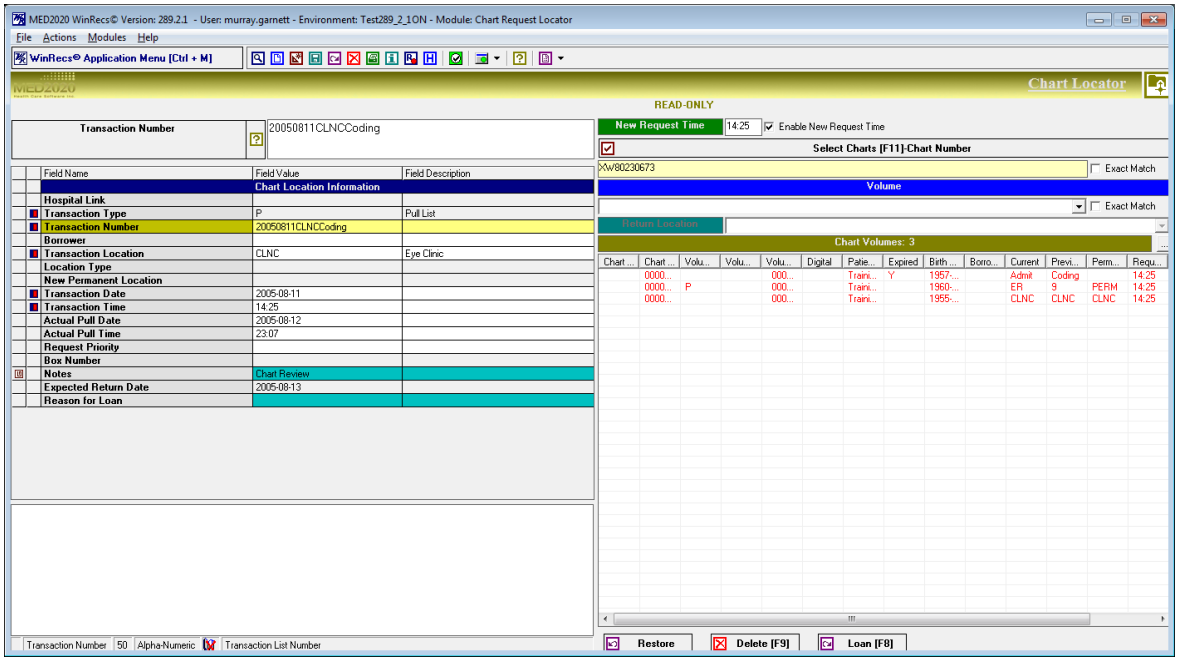

Figure 16

For more information on searching in the Central Patient Index (CPI), please review section 3.2 **"**Search" in Chapter 3 of this document.

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Option 2: From the WinRecs Application Menu

With this method there is no auto-populating of fields.

To access the Chart Locator module using the WinRecs Application Menu:

From the **WinRecs Application Menu**, select **Chart Maintenance - Chart Locator**.
The Chart Locator window displays with no information populating fields.

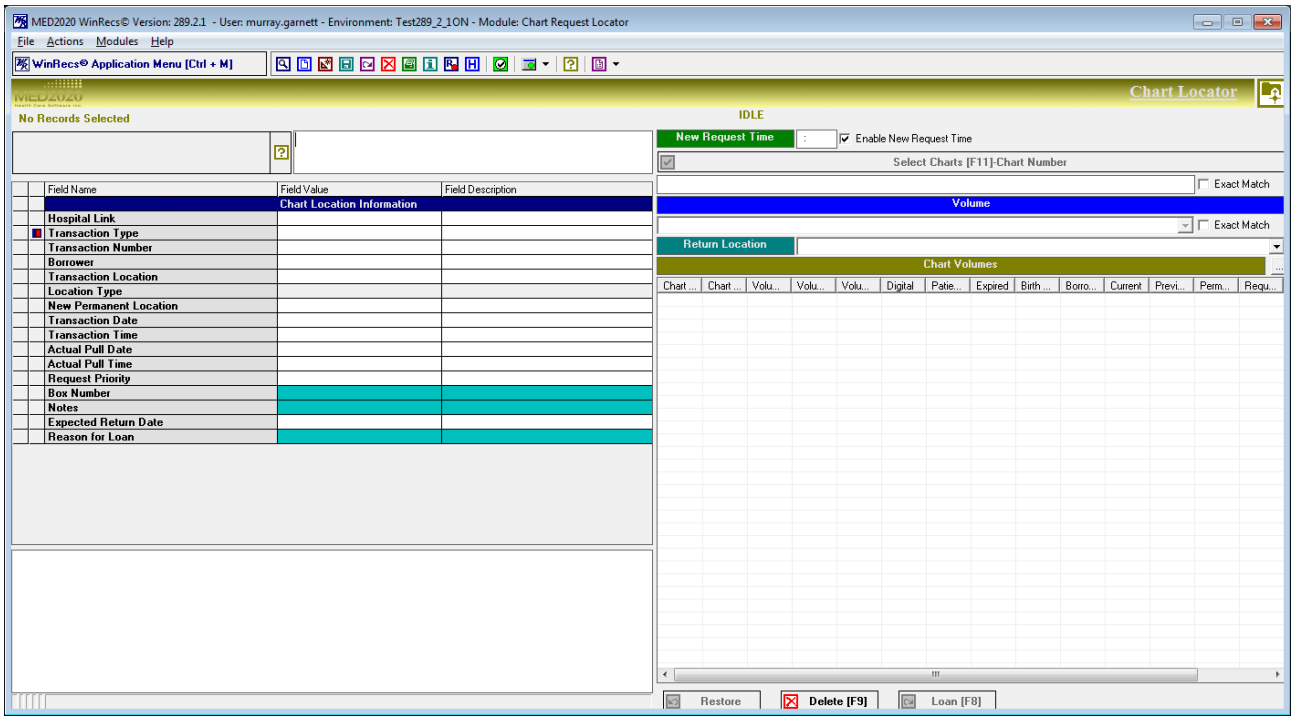

Figure 17

Use the relevant options as described in this chapter to work with charts and related information.

Using the Chart Locator Module

When the Chart Locator module is accessed the Chart Locator window displays. The chart locator module is used for tracking and locating the paper copy of the patient record. Using the key identifier fields entered into the patient record in other modules the chart locater can provide an up to date report on the chart locations within the facility.

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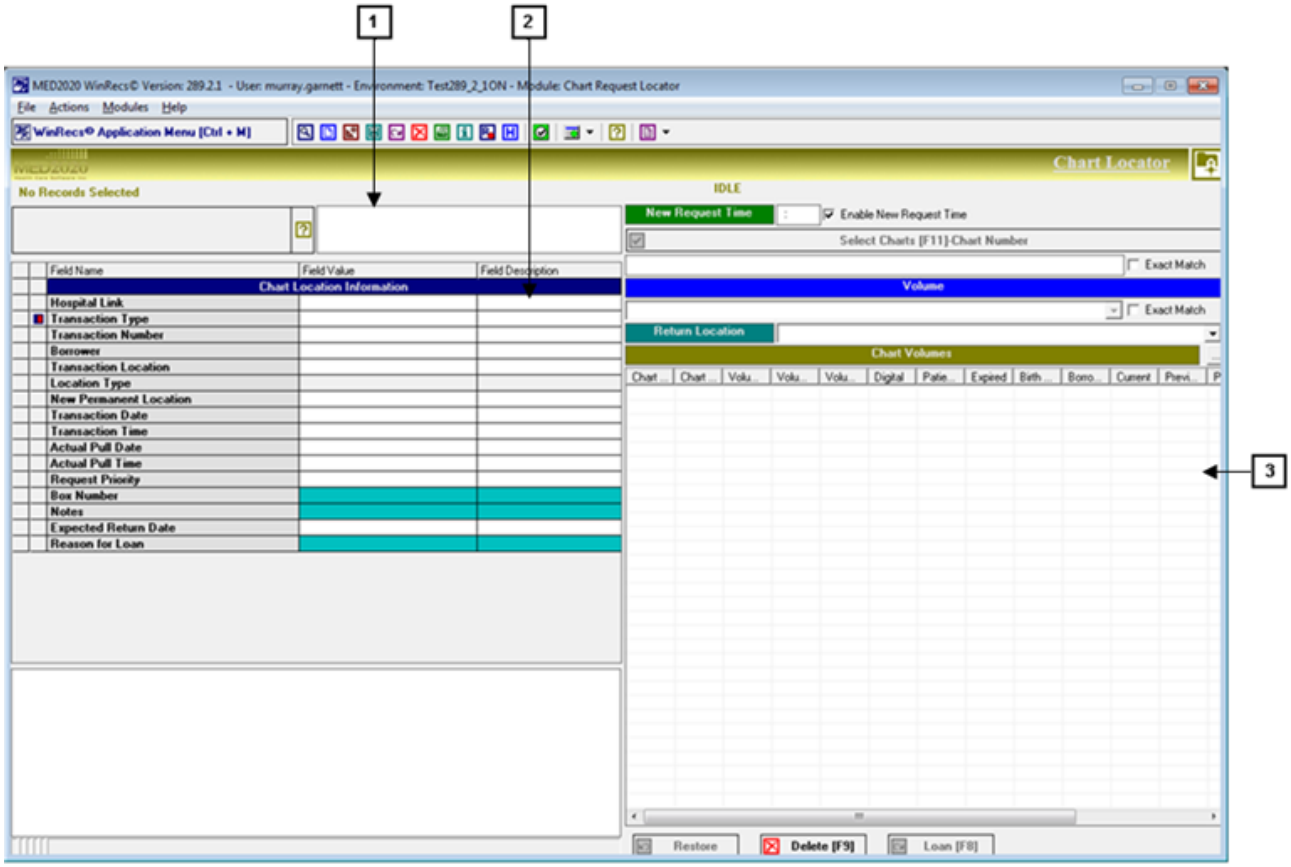

Figure 18

The main components of the Chart Locator window are the Main Grid (there are no Bookmarks), Data Entry Box and sidebar. The main parts of the Chart Locator window are described in the table below. The REF# field for each row relates to the callouts shown in the above image.

REF#	Description
1	**Data Entry Box**: The Data Entry Box is used to enter or edit information displaying in the Main Grid. Click on a field in the Main Grid and the field name displays on the left and the cursor is positioned in the box ready for entry.
2	**Main Grid**: The Main Grid shows the information for the currently selected chart. To add or modify information in the Main Grid, select the row and the field name displays beside the Data Entry Box and the data may be changed by typing in the Data Entry Box.
3	When locating charts for transactions (loaning, returning, transferring, etc.), the charts are selected using the Chart Volumes pane. When first creating a Locator transaction, there are no charts assigned. Existing transactions may or may not have charts already assigned. To locate charts to assign to a Locator transaction, a search may be done to locate the charts. Searches may be done on several fields as listed below.

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Creating Transactions

Transactions are created from the Chart Locator. The type of transaction created depends on the Transaction Type entered. Please refer to Transaction Types earlier within this chapter in Table 4.1. The example within this section should be used as a generic guide only. For a complete description of creating transactions for each transaction type, please refer to the relevant section within this chapter.

To create transactions:

1. From the Chart Locator, click
- or - Press **F5**.
The Chart Locator fields are available for entry.

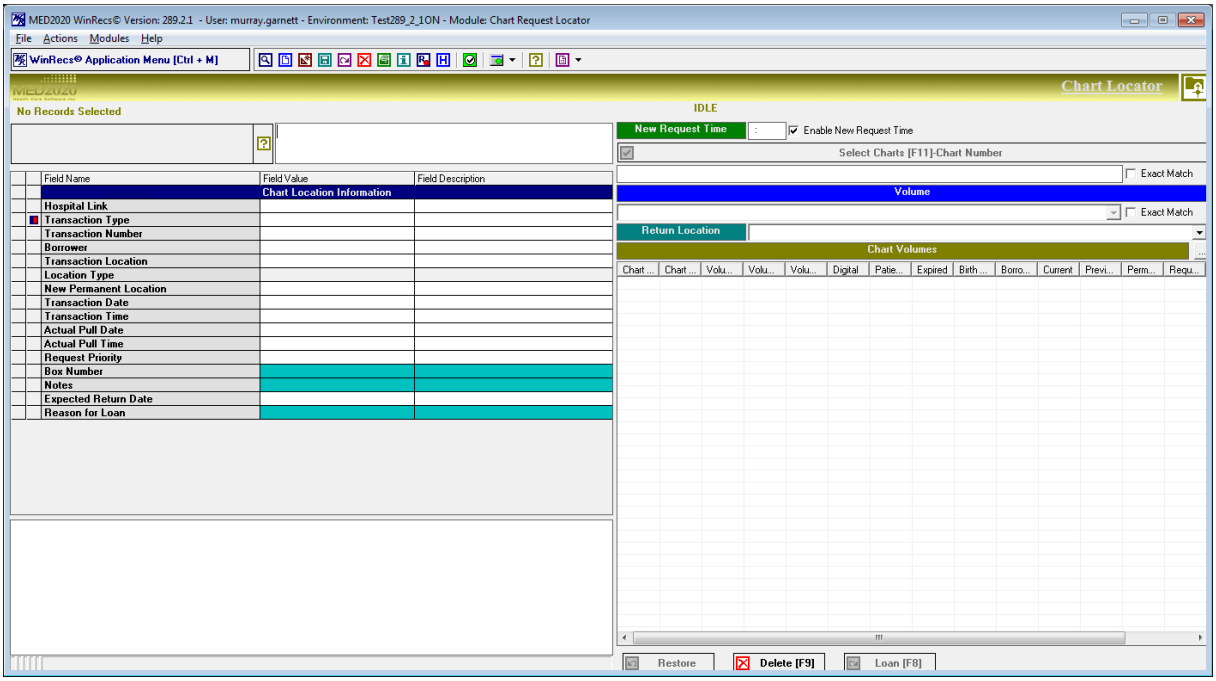

Figure 19

2. Enter information in all required fields. Press **Enter** after each field to move to the next field. The following are the fields that are accessed by pressing **Enter**.

Field Name	Description
Hospital Link:	Select a specific Hospital so only records from the Hospital selected display. If the hospital number is not known, press F2 to display a list of hospitals in the Lookup from which the hospital may be selected.
Transaction Type:	The type of transaction. See Table 4.1 for a complete description of transaction types.
Transaction Number:	This applies to Pull Lists only. The Transaction Number is populated automatically, or can be entered.
Borrower:	This identifies the borrower (a specific person of a location) for the location type.

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Transaction Location:	The location to where the chart is going. Press **F2** to select a location.
Location Type:	The type of location. Press **F2** to select a location type.
New Permanent Location:	This applies to mass moves only. Press **F2** to select a new permanent location.
Transaction Date:	The date that the transaction was created.
Transaction Time:	The time that the transaction was created. To enter the current date, when the Transaction Time field is highlighted, press the **Space Bar**, then **Enter**.
Actual Pull Date:	This applies to Pull Lists only. The date the chart was pulled.
Actual Pull Time:	This applies to Pull Lists only. The time the chart was pulled. To enter the current date, when the Actual Pull Time field is highlighted, press the **Space Bar**, then **Enter**.
Request Priority:	If priorities have been set up in Look Up Field Maintenance, press **F2** to select a priority.
Box Number:	If the location is permanent, enter the box number.
Notes:	Free form text.
Expected Return Date:	This is the date on which the chart is expected to be returned. This is based on the number of loan days indicated on the Transaction Location lookup.
Reason for Loan:	The reason for the loan.

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Selecting Charts

When locating charts for transactions (loaning, returning, transferring, etc), the charts are selected using the Chart Volumes pane. When first creating a Locator transaction, there are no charts assigned. Existing transactions may or may not have charts already assigned.

To locate charts to assign to a Locator transaction, a search may be done to locate the charts. Searches may be done on several fields as listed below.

Pull List: The pull list number.
Chart Number: The chart number.
Last Name: The last name of the patient associated with the chart.
Birth Date: The date of birth of the patient associated with the chart.
Volume Bar Code: When using bar codes for scanning for chart numbers, Exact Match must be selected.
Last Visit Date: The date on which the patient was last seen.

Use the following steps to select a chart for a transaction.

To select charts:

Once the Locator transaction is added or selected in the Main Grid, select the search type (Press **F3** to select the search type and select the type).

Enter the value on which to se**ar**ch.

Note: When searching for charts, the Exact Match option may be more efficient in locating the chart. Exact Match will list only those charts that match exactly. If this is not selected, all charts beginning with the entered value will display.

When using Bar Code scanning, it is important that Exact Match is selected.

Press **Enter**.

The Chart Volumes pane displays. To expand the grid, click ... . To collapse the grid, click ›

Chart Hospital Link	Chart No.	Volume Type	Volume Hospital...	Volume No.	Digital	Patient Name	Expired	Birth Date	Borrower	Current	Previous	Permanent
	000BH44748			000001		Training18373, ...		1969-12-14		CLNC	AMC	PERM
	000BH55474			000001		Training18421, ...		1972-08-11				
	0000022412			000001		Training892, Te...		1917/12/20		Assembly	CLNC	

There are 4 indicators for the charts that display.

Blue:	There is an outstanding request for the chart.
Red:	The chart is currently on loan.
Purple:	The current location of the chart is the same as to where it is to be sent.
Black:	No outstanding requests or loans.

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Requesting Charts

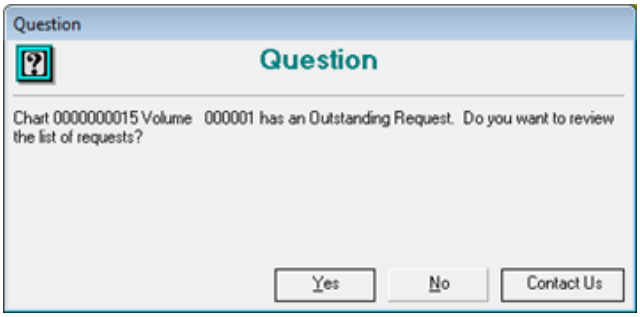
Chart Requests are defined by entering “C” in the Transaction Type field when creating the transaction.

To create chart requests:

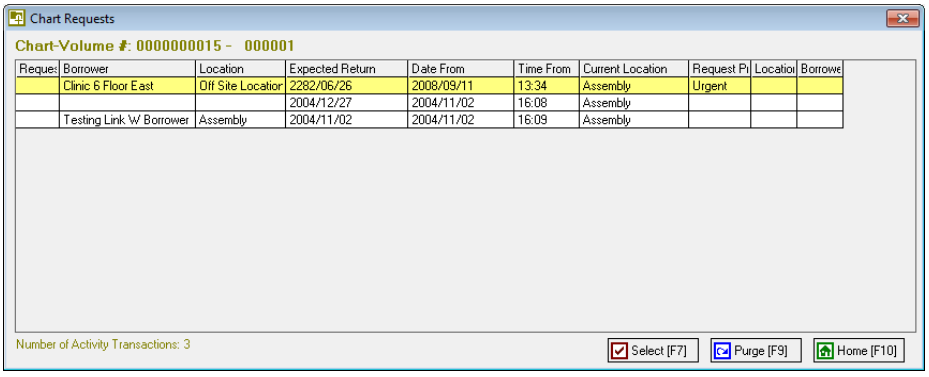
1. From the Chart Locator, click
   - or - Press **F5**.
2. Enter “C” in the Transaction Type field. Press **Enter** after each field to move to the next field. Refer to Creating Transactions on page 79 for a detailed description of each field. The following fields require entry for chart requests:

   Borrower (if applicable)
   Transaction Location
   Transaction Date
   Transaction Time

   The expected Return Date field is populated automatically based on the Transaction Location specified.
3. Select a chart as described in Selecting Charts. If the selected chart already has an outstanding request, the following message displays:



4. To view all outstanding requests, click **Yes**.
   The Chart Requests dialog displays.



5. When complete click
   - or – Press **F7**.
   The chart request is processed.

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Return to Previous or Permanent Location

The return process (R - Return to Permanent/Previous Location) allows a loaned chart to be returned to either the previous location or the chart's designated permanent location.

Charts must be returned when loaned to their previous or permanent location before a new loan may be processed. If Chart Deficiency is used, the loan will stop the day count for a physician and the return starts it again.

The following error message may display if attempting to return a record to a Permanent Location that has an active deficiency:

> "You are attempting to place an active deficiency chart in your permanent location area. Do you want to continue."

To return charts:

1. From the Chart Locator, click
   - or - Press **F5**.
2. Enter "R" in the Transaction Type field. Press **Enter** after each field to move to the next field. Refer to Creating Transactions on page 79 for a detailed description of each field.
3. Enter information in all required fields.
4. The Chart Volumes pane is populated automatically.
5. The following messages may display:

   "Do you want to return Chart Volume 00001 back to its previous location (Awaiting Transcription) or permanent location (ACTIVE-ACTIVE FILE)? Yes – Previous. No – Permanent. Cancel – Select from return location list."

   "Chart Volume 00001 has an Outstanding Request, Do you want to review the list of requests?"

   If the record is selected incorrectly, highlight the record and press

6. When all messages have been answered as required, click
   - or Press **F7**.
   The chart is returned.

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Loaning Charts

The Loan process **(L- Loan)** is used for charts loaned externally from the department. However, charts can be loaned internally also, such as to a R.O.I., Research Area or a Secure File Cabinet etc. in cases where you may need to track an 'expected date of return' for the chart.

To loan charts:

1. From the Chart Locator, click
   - or - Press **F5**.
2. Enter information in all required fields.
3. Enter "L" in the Transaction Type field. Press **Enter** after each field to move to the next field. Refer to Creating Transactions on page 79 for a detailed description of each field. The following fields require entry for chart requests:

   Borrower (if applicable)
   Transaction Location
4. The Location Type, Transaction Date, Transaction Time and Expected Return Date fields are populated automatically.
5. Select a chart volume in the Chart Volumes pane.
6. Click
   The chart loan is processed.

Mass Moving Charts (Change of Location)

The Mass Move process (M – Mass Move) is used for sending charts offsite or to change the location of merged charts. This changes the permanent and the current location in the same transaction for multiple charts.

To mass move charts:

1. From the Chart Locator click
   - or – Press **F5**.
2. Enter information is all required fields.
3. Enter "M" in the Transaction Type field. Press Enter after each field to move to the next field. Refer to Creating Transactions on page 79 for a detailed description of each field. The following field is required for mass moves:

   Transaction Location
4. The New Permanent Location field defaults to the same location as the Transaction Location. The Transaction Date and Transaction Time default to the current date and time.
5. Select a Chart Volume in the Chart Volumes pane as described in **Selecting Charts**.
6. Click
   - or – Press **F7**.
   The Mass Move is processed.

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Pull Lists

Pull lists are used for clinics etc. These can be created manually or with a Batch Interface. There are several types of pull lists, as described in the following sections.

Creating Manual Pull Lists

Manual pull lists are created as required.

To create manual pull lists:

1. From the Chart Locator, click
   - or - Press **F5**.
2. Enter information in all required fields.
3. Enter “P” in the Transaction Type field. Press **Enter** after each field to move to the next field. Refer to Creating Transactions for a detailed description of each field. The following fields are required for mass moves:

   Transaction Date
   Transaction Time
4. The Transaction Number can be set from the Hospital Profile information. A Pull ID can be defined in the Hospital Profile (See section 6.2). If the default is not set in the Hospital Profile, the Transaction Number can be entered automatically.
5. The Actual Pull Date and Time also default to the current date and time, and can also be changed. The Expected Return Date defaults to the date indicated on the Loan Location for number of load days in the Lookup table.
6. Select a Chart Volume in the Chart Volumes pane as described in Selecting Charts.
7. Click
   - or – Press **F7**.
   The Pull List is created. The bottom on the volume grid in the pull list displays the options “Restore”,
   “Purge”, and “Loan”.

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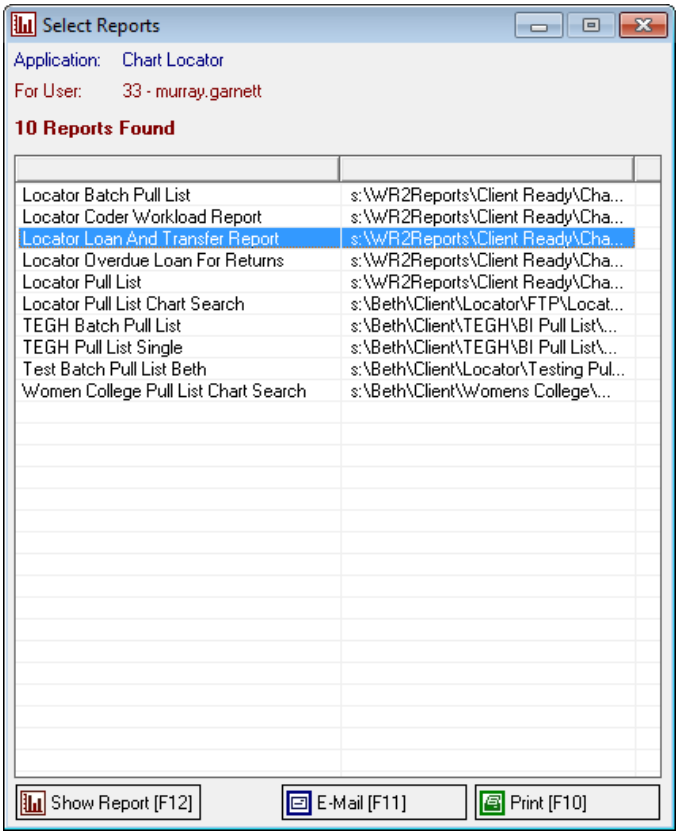
Printing Pull Lists

The Pull List should be printed before loaning charts. Once all charts have been loaned, the Pull List is no longer available. The reports are set up in Look Up Field Maintenance\Report Selection List. For more information on the setting up the reports, please refer to "**Report Selection List**" in Look Up Field Maintenance.

To print Pull Lists:

1. Click
- or – Press **F10**.
The Select Report dialog displays.



2. Select the Pull List that has been developed for your institution or site.

3. Click

- or – Press **F12**.
The report displays.

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Loaning Charts From Pull Lists

Charts may be loaned from a Pull List.

To loan charts from Pull Lists:

From the Chart Locator, click to display the Pull List Search dialog.
- or - Press **F4**.

Use the search fields in the Pull List Search dialog to display charts. The available search fields are:

Actual Pull Date
Actual Pull Time
Transaction Date
Transaction Number
Transaction Time

Double-click in the Pull List Search on the entry containing the pull list to select.
- or - Select the required entry and press **Enter**.
The Chart Locator window displays the chart information.

If the Transaction Date or Time and or Actual Date or Time are different than what was originally entered for this Pull List, it can be changed.

Click
- or Press **F7**.

Select the records to loan.

Click
- or – Press **F8**.
The selected records are loaned.

> Once all records on a pull list have been loaned, the Pull List is no longer available.

Adding Charts to Pull Lists

Charts may be added to Pull Lists when required.

To add charts to Pull Lists:

From the Chart Locator, click to display the Pull List Search dialog.
- or - Press F4.

Use the search fields in the Pull List Search dialog to display charts. The available search fields are:

Actual Pull Date
Actual Pull Time
Transaction Date
Transaction Number
Transaction Time

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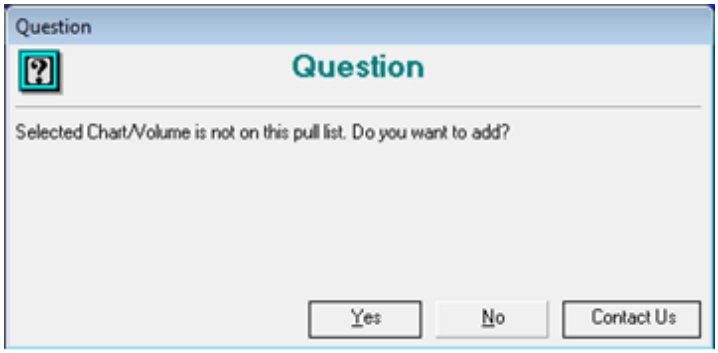
Double-click in the Pull List Search on the entry containing the pull list to select.
- or - Select the required entry and press Enter.
The Chart Locator window displays the chart information.

Press F11 to select a Chart Number on the right side of the window.

Enter the chart number(s) and volumes to add to the list.

The following message may display:



Click **Yes**.

Click
- or Press **F7**.
The records are added to the pull list.

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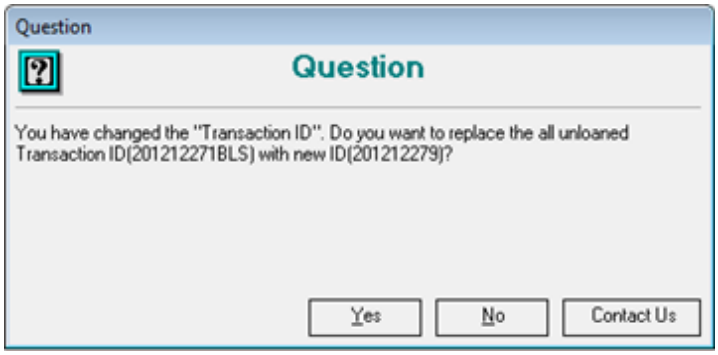
Changing Transaction Details on a Pull List

The Transaction details may be changed as required. This is used to update the Require Time, Notes, Borrower, or Reason for Loan. If changing this information for the main record, use the Main Grid to select the item and make the change in the Data Entry Grid. If making changes to the individual records, use the steps outlined here.

To change the Transaction Details:

1. From the Chart Locator, click to display the Pull List Search dialog.
   - or - Press **F4**.
2. Use the search fields in the Pull List Search dialog to display transactions.
3. Double-click in the Pull List Search on the entry containing the pull list to select.
   - or - Select the required entry and press **Enter**.
   The Chart Locator window displays the chart information.
4. Click the Transaction Date field and enter the new transaction date in the Data Entry Box.
5. The following message may display:



Note: Double-click the ellipse on the right side of the Chart Volume banner to display the detail information.

4. Right-click on the record to modify and make the required selection. The options are:

   Input New Require Time: A dialog displays where the new require time is entered.
   Input Notes: A dialog displays where the new note is entered.
   Update Borrower: This option is used to change the borrower for individual records.
   Update Reason for Loan: This option is used to change the reason for loan for individual records.

Enter the required information.

5. Click
- or Press **F7**.

The transaction details are saved.

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Creating Pull Lists From Another Pull List

There may be charts in various locations: box numbers, Inactive, perm, loaned out to other hospital departments. WinRecs allows for a copy of part of the Pull List to make another Pull List.

To create Pull Lists from other Pull Lists:

1. From the Chart Locator, click
   - or - Press **F5**.
2. Enter the Transaction Type (“P”).
3. Select the Transaction Location for the new Pull List.
4. Change the Transaction Time to be the same as the Pull List that is being copied (if appropriate).
5. Enter the Reason for Loan, if required. This could be used to note the Pull List that is being copied.
6. From the Chart Volumes pane select “Pull List”.
7. Enter the Transaction Number from the original Pull List.
8. Press **Enter**.
9. Select the charts that are to be included in the new Pull List. Select multiple charts by holding down the **Ctrl** key and clicking the required charts.

Press **Enter**.
The new list displays the charts selected.

Click
- or Press **F7**.
The transaction details are saved.

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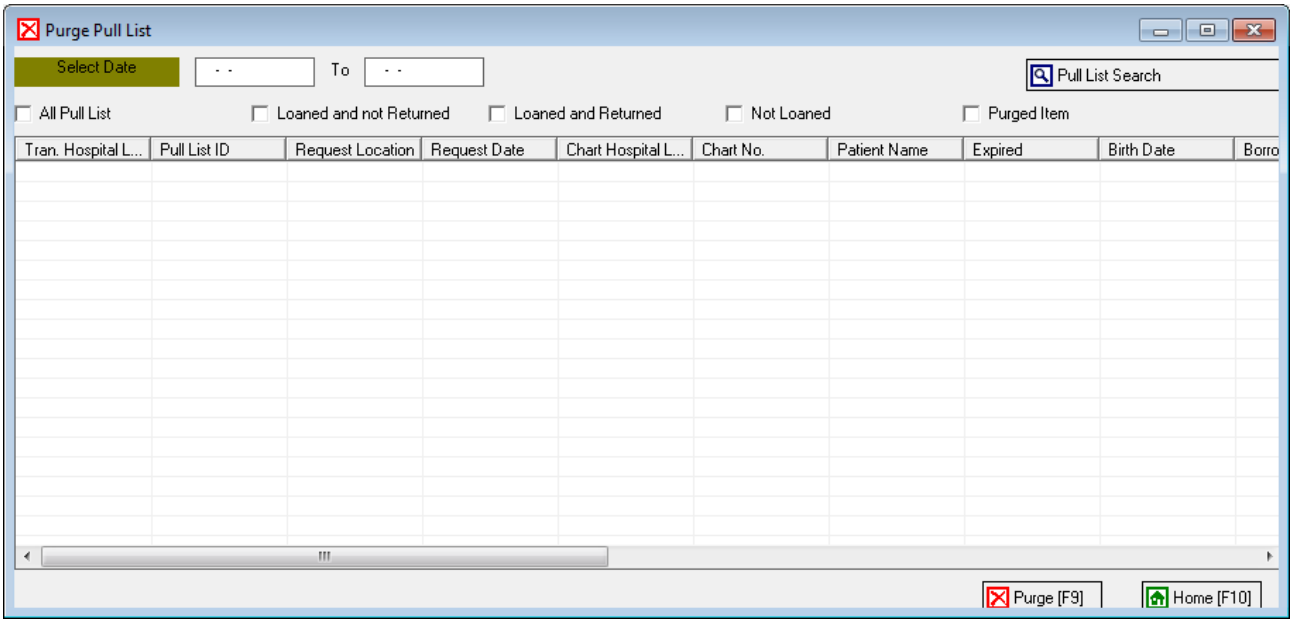
Purging Pull Lists

When a user searches for an existing Pull List, depending on the search method, sometimes a large number of lists are returned. These may be old Pull Lists that have been used previously and may no longer be required.

To access the Purge Pull Lists window:

Select **Chart Maintenance – Chart Locator**.

Select the Actions drop down menu and select **Purge Pull Lists**.
The Purge Pull Lists window displays.



Select the criteria to display the Pull Lists to Purge:

- **Select Date**: Select a date range for selecting Pull Lists. All Pull Lists created within the range entered will display.
- **All Pull List**: Select to display all Pull Lists.
- **Loaned and not Returned**: Select to display all Pull Lists that were loaned, but have not yet been returned.
- **Loaned and Returned**: Select to display all Pull Lists that were loaned, and have been returned.
- **Not Loaned**: Select to display all Pull Lists that were not loaned.
- **Purged Item**: Select to display charts that have been deleted from a pull list.

Select the Pull Lists to purge by clicking with the mouse.

Click Purge [F9]
- or – Press **F9**.

The selected Pull Lists are permanently removed.

Click to return to the Chart Locator Main Grid.

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Transferring Charts

This is used to transfer charts to a new location within the department. These locations are designated in the Transaction Location Table. Please refer to **System Maintenance – Look Up Field Maintenance** for more information.

To transfer charts:

From the Chart Locator click
- or – Press **F5**.

Enter “T” in the Transaction Type field.

Enter the borrower, if applicable. Press **F2** to display a list of Borrowers.

Enter the Transaction Location fields. Press **F2** to display a list of Transaction Locations.

The Transaction Date and Transaction Time fields default to the current date and time.

Press **F11**.

Note: Charts may only be returned if they have been returned to their permanent location.

The Following message may display:

“This chart is currently on loan. Would you like to have the system automatically create a request?”

Click
- or Press **F7**.
The selected charts are transferred.

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Cancelling Transactions

The Cancel process **(X – Cancel)** allows transactions to be cancelled that were made in error and returns the chart to its previous 'current location'. For example, transactions may be cancelled if:

- A chart is accidentally loaned out to the wrong borrower/location.
- A chart has been transferred to the wrong borrower/location.
- A chart has been returned to the wrong location.
- A chart request was made, but the request is no longer needed.

To cancel transactions:

1. From the Chart Locator click
   - or – Press **F5**.
1. Enter the required information as described in Adding Transactions.
2. Enter "X" in the Transaction Type field.
3. The time and date fields are populated automatically.
4. Press **F11** to go to the right side of the window or click on the Chart Volumes pane box.
5. Enter the chart numbers and volume numbers to cancel.
6. Click
   - or Press **F7**.
   The transaction is cancelled.

After the cancel transaction has been processed, the CPI module shows that a new activity has been added titled "Activity Type Cancel" and an activity note is added to the previous activity stating that the transaction has been cancelled.

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Chart Locator Reports

After selecting a patient record the user can generate and view a Crystal report on chart locations by selecting or by pressing (F10). (See chapter 9),

Available Reports

The following reports are available for Chart Locator:

Chart Activity: This report displays in CPI and Chart Locator. This report must be put where the

Locator Loan and Transfer Report: This report can be set up in the Report Selection List. It displays all current Loans and Transfers.

Locator Overdue Loan for Returns: This report can be set up in the Report Selection List. It will display all overdue loans for each location.

Locator Pull List: This report can be set up in the Report Selection List. It is used when to display the Pull List.

CPI Bar Code Label Template: If your site has Bar Code scanning, this report is set up in the Report Selection in the Central Patient Index (CPI) module.

Note: All reports are available for download from ftp://web.med2020.ca/WR2Reports/Chart_Locator/. All reports will be downloaded to the server on which you are working.

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4.4 Chart Deficiency Module

Chart Deficiency Overview

The Chart Deficiency module provides Health Information Management (HIM) departments the ability to track all activity required to complete a patient's chart.

Once a chart is returned to the HIM department, it is collated, sorted and analyzed to determine if any deficiencies exist. These can be entered quickly and easily via the Chart Deficiency module - either manually or using bar code technology. WinRecs generates a deficiency letter per delinquent visit.

As the physician(s) completes the deficient items, the chart can be updated in one of several ways:

If only some of the deficiencies are complete, those individual items can be entered and a new deficiency letter printed, showing only the outstanding items.

If a physician has completed all deficient charts, the physician number can be entered, and all charts will be updated to a status of “C” (Complete). If the physician has completed all items, only one reference number must be entered.

Main Features of the Chart Deficiency module

Deficiency codes are profile driven (Please refer to Lookup Field Maintenance in the WinRecs User Guide for more information).

Bar Code Technology allows for quick and accurate entry of key information, as well as quick removal of completed deficiencies. This is not covered in this document.

Delinquent count is done electronically (first person to sign onto WinRecs activates the count).

Printing of the Deficiency Letter by Provider / Visit Date once the entry has been completed and saved.

Deficiency Color code tabs can be assigned to each provider for easy identification of where deficiencies are noted within the chart. These colors are also printed on the Deficiency Letter for reference. Each provider will have a different colored tab to denote their deficiencies.

Note: To simply view if a chart has any deficiencies, select the chart from the Central Patient Index (C.P.I.) and view the Chart Deficiencies sidebar.

Available Reports

The following reports are available for Chart Deficiencies:

Chart Deficiency Report (Chart Deficiency.rpt): This must be put in the “Reporting” folder where Winrecs.exe is located. This report is run from the Central Patient Index when the Chart Deficiency sidebar is double-clicked.

Deficiency Single Slip (Deficiency Single Slip.rpt): This is used to print a single deficiency letter for a provider.

Deficiency Slip Batch Print (Deficiency Slip Batch Print.rpt): This is used to print a single or multiple providers on a single letter.

Deficiency Providers Pull List (Deficiency Providers Pull List.rpt): This is used to print all deficiencies for a provider.

Note: All reports are available for download from ftp://web.med2020.ca/WR2Reports/Chart_Deficiency/. All deficiency reports and all canned reports will be downloaded to the server on which you are working.

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Chart Deficiency Setup

The following setup must be completed before using the Chart Deficiencies module. For a complete description of the setup required and the steps to complete the setup, please refer to “Section 6 – System Maintenance” in the WinRecs User Guide:

Regional Profile: The Regional Profile is used to specify default values which are used in individual Hospital Profiles. The information entered here is required for lookups.

Hospital Profile: The Hospital Profile is used to specify values accessed using lookups when working with chart deficiencies.

Control File Settings: The Control File specifies default settings for fields, determining if fields are visible or enabled with Chart Deficiencies. This information is mainly used within Chart Deficiencies when access to the Provider Maintenance module is required.

Provider Maintenance: Provider Maintenance must be set up with language and address information.

Look Up Field Maintenance: All deficiency codes must be set up.

Deficiency Letters: Deficiency Letters are created using the Report Generator module.

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Accessing the Chart Deficiency Module

The Chart Deficiency module is one of the modules within Chart Maintenance. Please refer to **Chapter 2 "WinRecs Layout"** for more information on the modules available within WinRecs. There are two options for accessing the Chart Deficiency module. The option to use can depend on what is to be performed within the module. The options are:

Option 1: From the Central Patient Index (CPI):

This option always opens the Chart Deficiency module in "New" mode, ready for data entry. When accessed using this option, the Chart number and any other relevant fields are populated from the CPI. Therefore, if adding charts, this method is recommended. For information on using the CPI, please refer to section 4.2 "Central Patient Index (CPI)" within this document.

To access the Chart Deficiency module from the CPI:

From the WinRecs Application Menu, select Central Patient Index (CPI).

Search for the patient in the CPI.
If the CPI does not open in Search mode, press F4 to display the search dialog, then search for the required chart.

When the patient is located, Hot-link to the Chart Deficiency module using the Hot Link ( ) button on the toolbar.
The Chart Deficiency window displays, with available information from the CPI populating all relevant fields.

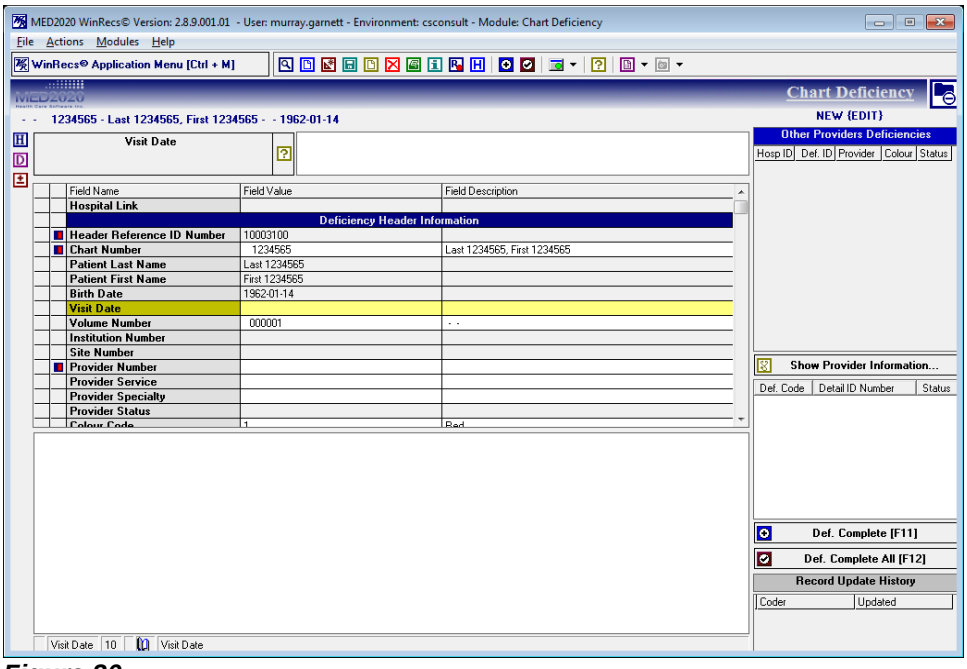

Figure 20

For more information on searching in the Central Patient Index (CPI), please review section 3.2 **"**Search" in Chapter 3 of this document.

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Option 2: From the WinRecs Application Menu:

With this method there is no auto-populating of fields. With this option, the Deficiency List Search dialog displays automatically, and the required chart may be located using the search dialog.

To access the Chart Deficiency module using the WinRecs Application Menu:

From the WinRecs Application Menu, select **Chart Maintenance - Chart Deficiency**.
The Deficiency List Search dialog displays. Please refer "**Searching in WinRecs**" for information on using the Deficiency List Search.

Use the Deficiency List Search dialog to search for an existing chart deficiency.
When a deficiency is located, the information displays in the Chart Deficiency window.

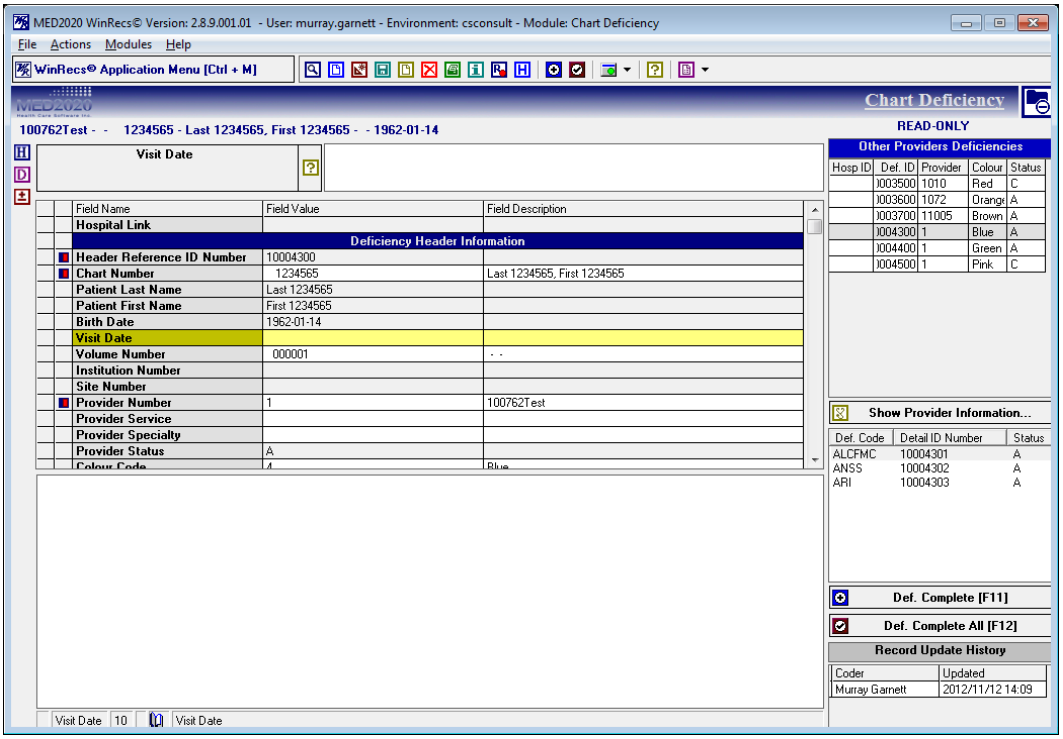

Figure 21

Use the relevant options as described in this chapter to maintain deficiencies and related information.

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Using the Chart Deficiency Module

When the Chart Deficiency module is accessed the Chart Deficiency window displays. The Chart Deficiency window is used to manage chart deficiencies, allowing users to create chart deficiencies, update and remove chart deficiencies, print deficiency letters, transfer deficiencies and enter provider unavailability and other information.

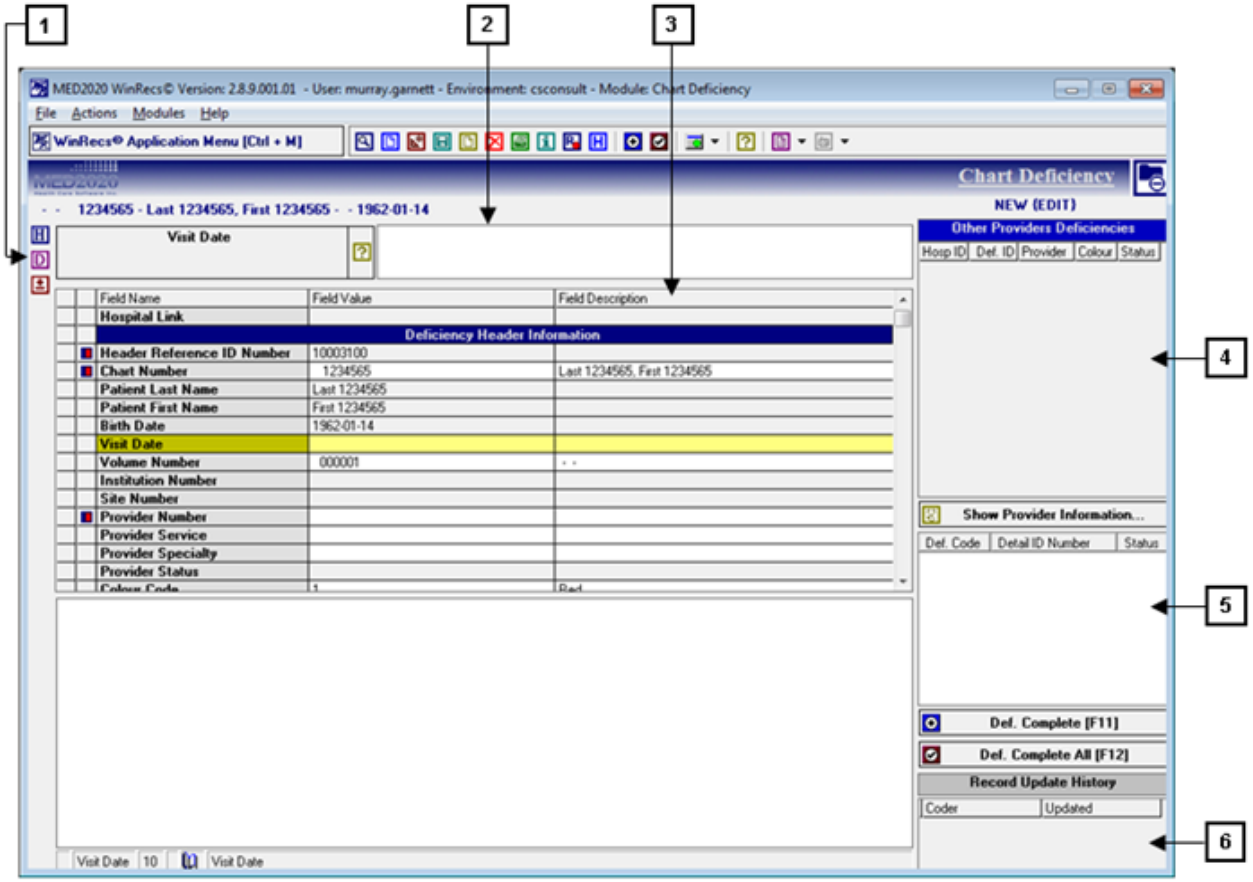

Figure 22

The main components of the Chart Deficiency window are the Bookmarks, Main Grid, Data Entry Box and 3 sidebars. The main parts of the Chart Deficiency window are described in the table below. The REF# field for each row relates to the callouts shown in the above image.

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REF#	Description
1	**Bookmarks**: Bookmarks allow for fast access to categories of information within the Main Grid. Click a bookmark to display the section in the Main Grid. This may be basic data entry, or multiforms (for entering multiple occurrences of information, such as multiple deficiencies for a chart). There are 3 bookmarks (and corresponding sections) in the Main Grid as described below: **Deficiency Header Information**. This includes information for uniquely identifying the patient, hospital, provider, etc. Information is entered in the Deficiency Header Information fields using the Data Entry Box. Please refer to Chapter 2: "TOC - WinRecs Layout" for additional information. **Deficiency Detail Information**. This includes the details for each deficiency. There may be multiple deficiencies for each chart. Deficiency Detail Information uses multiforms for entering information to allow multiple deficiencies for each chart. **Deficiency Calculations**. Only the Deficiency Start and End dates, Manual Days and Header Notes may be entered using the Data Entry Box. The rest of the fields are calculated.
2	**Data Entry Box**: The Data Entry Box is used to enter or edit information displaying in the Main Grid. Click on a field in the Main Grid and the field name displays on the left and the cursor is positioned in the box ready for entry.
3	**Main Grid**: The Main Grid shows the information for the currently selected chart. To add or modify information in the Main Grid, select the row and the field name displays beside the Data Entry Box and the data may be changed by typing in the Data Entry Box. The information in the Main Grid is organized under headings and can be accessed by scrolling through the grid, or by clicking on a bookmark to move the grid to the section within the associated heading.
4	**Other Providers Deficiencies Sidebar**: Displays all providers associated with the selected chart. Deficiency information may be viewed for providers by clicking the provider and the deficiencies for the provider display in the Deficiencies sidebar below. From this sidebar, the Provider Maintenance module is accessed to update provider information such as unavailability.
5	**Deficiencies Sidebar**: Displays deficiency information on the provider selected in the Other Providers Deficiencies sidebar.
6	**Record Update History Sidebar**: Displays an audit trail showing the history of any changes made. This includes the WinRecs user ID of the user who made the change.

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Creating Chart Deficiencies

If it is determined that deficiencies exist in a chart, they can be entered quickly and easily using the steps outlined here. Deficiencies may be entered manually or using a bar code scanner. WinRecs generates a deficiency letter per delinquent visit. As physicians complete deficient items, the chart can be updated.

To create chart deficiencies:

From Chart Deficiencies click
- or - Press **F5**.
A Header Reference ID number is generated by WinRecs and displays in the Header Reference ID Number field.

Enter information in all required fields. Press **Enter** after each field to move to the next field. The following are the fields that are accessed by pressing **Enter**.

Field Name	Description
Header Reference ID Number:	(Required) The Header Reference ID Number is a unique identifier for each deficiency. This is entered automatically and cannot be changed.
Chart Number:	(Required) Enter the Chart Number. Use the Chart Lookup (F2) to select the chart for the list of all available charts. When the chart number is entered, the patient demographics from the Central Patient Index populates the chart deficiency.
Visit Date:	The date of the pati ent visit. Ensure the visit date is correct. To select a different visit date, press F2 to display the Visit History Lookup and select a visit date.
Volume Number:	The Volume Number provides a link to all charts for a patient. The volume indicates the hospital where the patient has a chart, where the chart is currently located at each hospital, the volume type, and the date the chart starts and ends. To select a different volume number, press F2 to display the Volume Lookup and select a volume. If a volume does not display, the Central Patient Index should be updated with the required volume number.
Provider Number:	(Required) Enter the Provider Number. The Provider Number is the unique identifier for each provider. If the Provider Number is not known, press F2 to display a list of providers in the Provider Lookup from which a provider may be selected. If the first few letters of the provider name or number are entered, F2 displays only those providers matching what has been entered.
Provider Service:	The service from the provider. This is entered automatically when the provider number is selected.
Provider Specialty:	The specialty of the provider. This is entered automatically when the provider number is selected.
Colour Code:	Enter the colour code for this provider. Press F2 to display the Colour Code Lookup to select a colour. If the first few letters of the colour are entered, F2 displays only those colours matching what has been entered.

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After pressing **Enter** in the Colour Code field, the Deficiency Detail Information multiform displays.

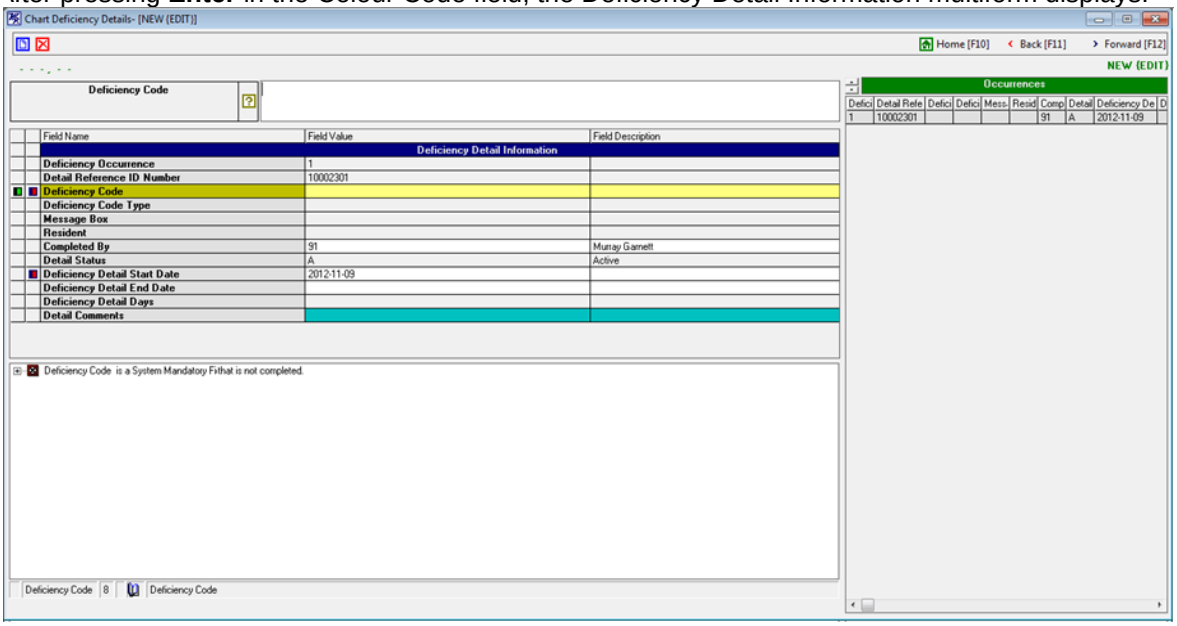

Figure 23

Enter the required information in the Deficiency Detail Information multiform.

Field Name	Description
Deficiency Code:	(Required) Enter the deficiency code, or press F2 for the Deficiency Code Lookup. Type in the first few characters of the deficiency code, then press F2, and the lookup displays all codes matching what was entered. If there is a linked deficiency code, the following message displays: *"There is a deficiency code linked to this one. Would you like to create the link? Yes/No"* These messages are generated from the Lookup Maintenance /Deficiency Code table. There may be deficiency codes such as a signature that are linked to a dictation. Refer to the Deficiency Code table in Lookup Field Maintenance in the WinRecs User Guide for details.
Completed By:	The user ID of the current user is automatically entered.
Deficiency Detail Start Date:	Enter the starting date for the deficiency detail.
Deficiency Detail End Date:	Enter the ending date for the deficiency detail.
Detail Comments:	Enter any required comments.

When the detail for the current deficiency is complete, press **Enter**.
- or - Press **F5**.
The Occurrences sidebar in the multiform is updated to display the deficiency and the Deficiency Code field is selected in the multiform for the next deficiency to be entered.

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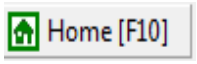
If there are no more deficiencies to enter for the provider, click 

To save the deficiency entered, click , then
If the user has access to the Chart Locator module, the following prompt displays:

"Would you like to change the Chart Location now? Yes/No"

If there are additional providers to enter deficiencies for on this chart, click **No**.

If any required fields are missing, an error message displays in the Message pane. Click **OK**, then view the Message pane to identify the field that required entry. Make any required changes then repeat step 6 to save the information.

Updating Chart Deficiencies

Updating information on the main grid is not recommended. This will update the reference to the physician and provider, and may cause problems with any other provider that may be linked to the visit previously displayed in the grid.

It is recommended that the deficiency that is to be updated be cleared, rather than updating information in the grid.

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Completing Deficiencies

WinRecs allows for single deficiencies to be completed, one at a time, multiple deficiencies to be completed at one time, or for batches of deficiencies to be completed. Use the method that best suits your circumstances.

Completing Single Deficiency Items

Single deficiencies are completed by selecting the deficiency to complete, and following the instructions below.

To complete single deficiencies:

1. From the Chart Deficiencies window click to display the Deficiency List Search dialog.
   - or - Press **F4**.
2. Use the search fields in the Deficiency List Search dialog to display charts.
3. Double-click in the Deficiency List Search on the entry containing the deficiency to complete.
   - or - Select the required entry and press **Enter**.
   The Chart Deficiencies window displays the deficiency information for the selected chart.
4. Double-click the appropriate physician from the Other Providers Deficiencies sidebar.
   The Deficiencies sidebar displays deficiency items for the provider.
5. Select the deficiency item to complete and click

   The Status of the deficiency in the Deficiencies sidebar changes to “C” (Complete). If there are no more deficiencies at “A” (Active) status for the provider, the Status for the provider in the Other Providers Deficiencies sidebar also changes to “C” (Complete).
6. At this point the deficiency is complete at the information is saved.

   If all deficiencies are completed for this chart, and the user has access to the Chart Locator, the following message displays:

   “Would you like to change the Chart Location now? Yes/No
7. If the chart location is to be set to the next location, click “Yes”.

When the last deficiency is set to “C” (Complete), it is not possible to undo the complete status of deficiencies. It will be necessary to reenter the deficiencies. However, if this is not the last deficiency, to change the deficiency back to “A” (Active):

1. Select the deficiency.
2. Select **Actions** – **Def. Incomplete**.
   This sets the item status back to “A” (Active).
3. Click
   The deficiency status information is saved.

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Completing Multiple Deficiency Items

Multiple deficiencies are completed by selecting the deficiencies for a selected provider, and following the instructions below.

To complete multiple deficiencies:

1. From the Chart Deficiencies window, press to display the click Deficiency List Search dialog.
   - or – Press **F4**.
2. Use the search fields in the Deficiency List Search dialog to display charts.
3. Double-click in the Deficiency List Search on the entry containing the deficiencies to complete.
   - or - Select the required entry and press **Enter**.
   The Chart Deficiencies window displays the deficiency information for the selected chart.
4. Double-click the appropriate physician from the Other Providers Deficiency sidebar.
   The Deficiencies sidebar displays the deficiency items for that provider.
5. Click

   The Status of the provider in the Other Providers Deficiencies sidebar and the status for the deficiencies in the Deficiencies sidebar change to “C” (Complete).

   At this point the deficiency is complete and the information is saved.

Completing Batches of Deficiencies for Providers

Completing batches of deficiencies allows all deficiencies for a provider to be completed at once, without having to select deficiencies to complete. This is useful if a provider has completed all deficiencies assigned.

To complete batches of deficiencies:

1. From the Chart Deficiency window select the chart containing the deficiencies to complete.
2. Select **Actions – Def. Batch Complete**.
   The Deficiency Batch Complete window displays.

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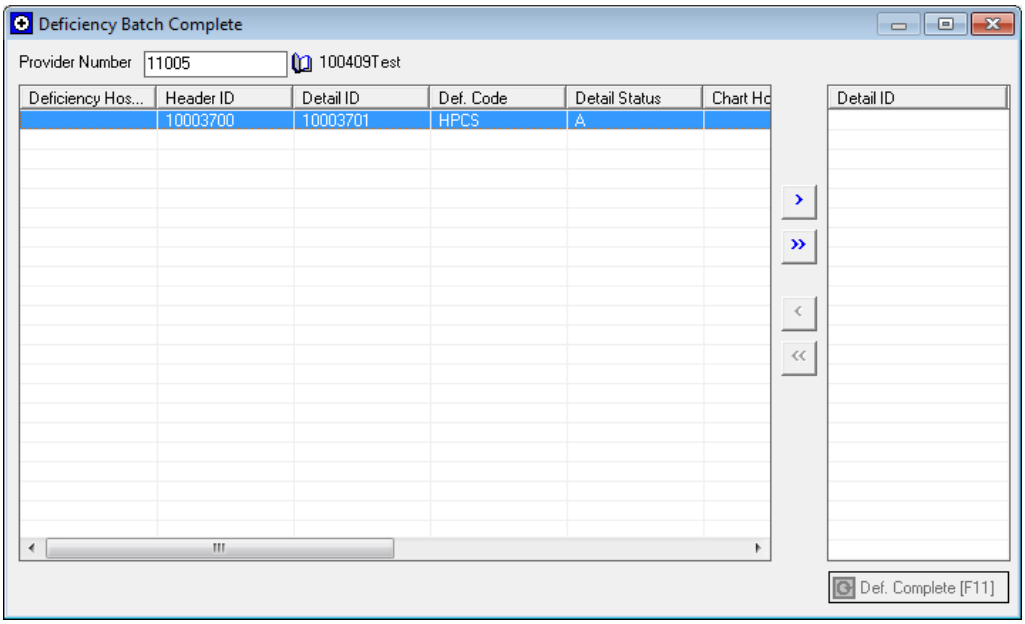

Figure 24

3. In the Provider Number field, enter the Provider Number for whom all deficiencies are to be completed and press **Enter**.
   The deficiencies for the selected provider display.

Note: If only the first character(s) of the provider number are entered, the window first displays all matching providers. Double-click the provider containing the required deficiencies to display the deficiencies for selection.

4. Select the deficiencies to complete.

   To select contiguous deficiencies to complete, hold the **Shift** key down and click the first deficiency and then click the last deficiency. The first and last deficiencies, along with all deficiencies in between are selected. To select non-contiguous deficiencies to complete, hold the **Ctrl** key down and click the deficiencies to select.

5. Click › to move the selected deficiencies to the Detail ID column.
   - or - click » to move all deficiencies.

6. Click **Def. Complete [F11]**
   All deficiencies in the Detail ID column are set to “C” (Complete).

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Printing Deficiency Letters

The Chart Deficiency module can auto-generate deficiency letters to physicians to notify them for chart completion. There can be up to five deficiency levels which are defined by the hospital. Each level represents the number of days the chart is deficient.

Manual Printing of Deficiency Letters

Deficiency letters may be printed on demand, such as when deficiencies have been entered, and the deficiency letter is required.

To print deficiency letters:

1. Select the deficiency letter. Note that if a deficiency was just entered and still displays on-screen, these same instruction apply.
2. Click
   - or – Press **F10**.
   The Select Reports window displays.

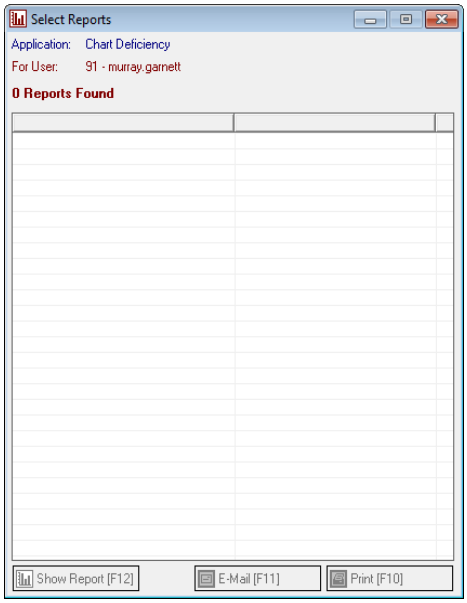

Figure 25

3. Select the report to print. In this case, select one of the deficiency letters.
4. Click

   The letter is printed.

Note that the letter may also be viewed in the Crystal Report viewer or emailed.

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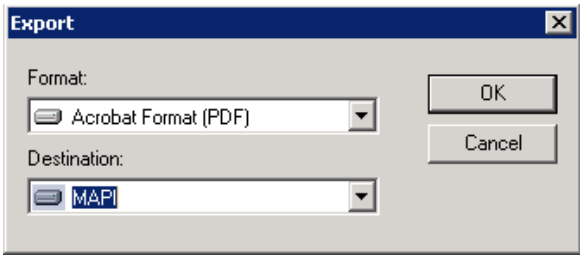
Emailing Deficiency Letters

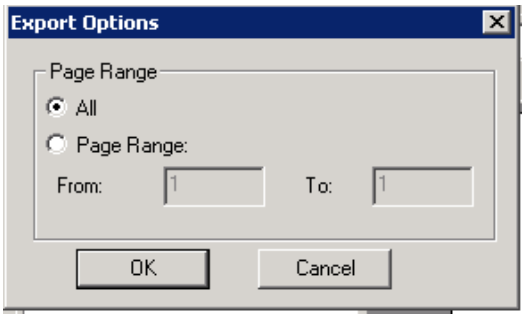
To email deficiency letters:

After report is generated click on Export Report Button

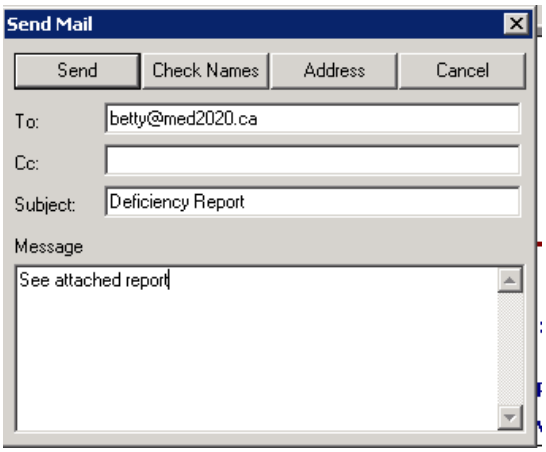
In the Export Box choose document format you wish to email and choose **MAPI** for Destination:



Select **Export Options** and select **OK.**



In the send mail box enter email address/s, subject, message, etc. and select **Send**.



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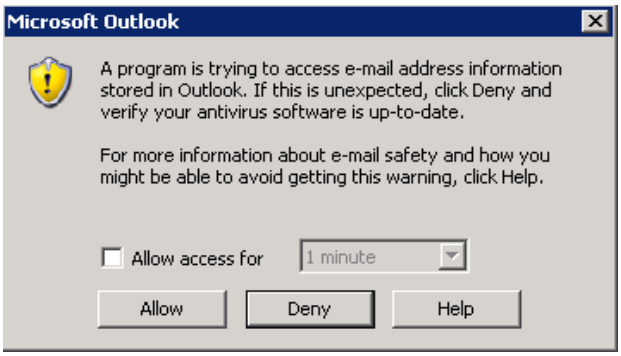
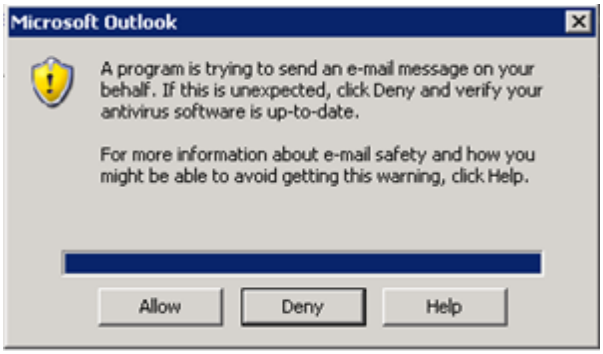
The following Microsoft Outlook message displays.



Select **Allow**.
The following Microsoft Outlook warning will display.



Select **Allow**.
The email will now be sent.

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Transferring Deficiencies to Other Physicians

Deficiencies are transferred as required to different providers. A new start date for the deficiency may also be entered.

To transfer deficiencies:

From Chart Deficiencies select the chart containing the deficiencies to transfer.

From the Menu select **Action – Def Transfer**.
The Deficiency Provider Transfer window displays. Placing the cursor in between the column/field titles until the double-sided arrow appears, hold and drag to expand.

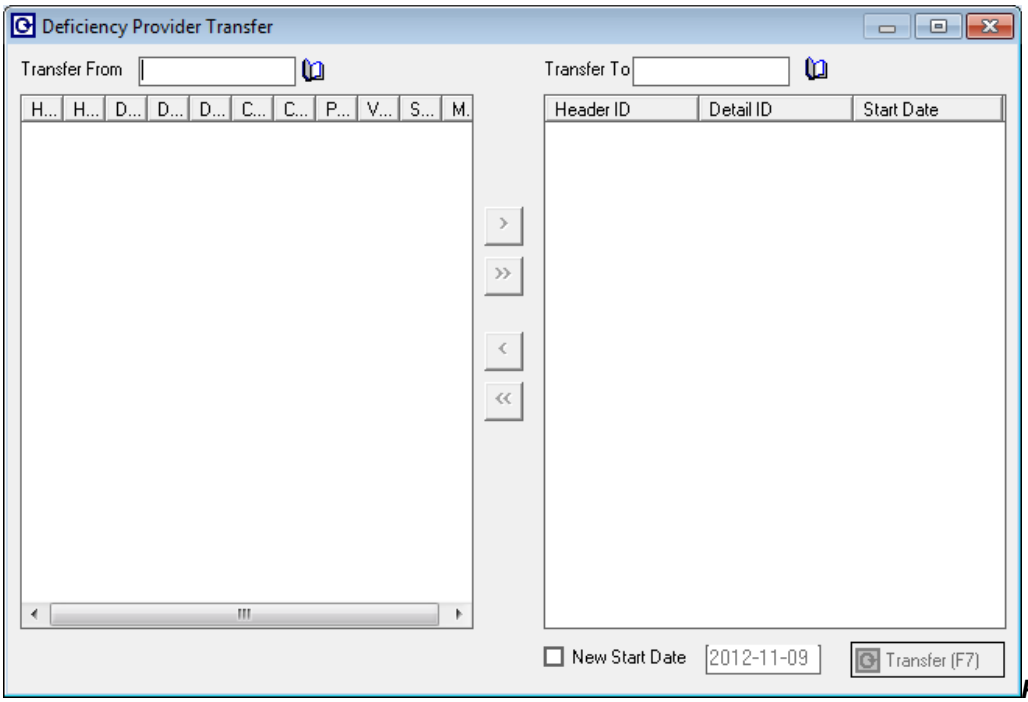

Figure 26

To complete the transfer, enter the “Transfer From” provider. Use the lookup if required.
All deficiencies for the “Transfer From” provider display in the pane on the left.

Enter the “Transfer To” provider. Use the lookup if required. All current deficiencies for the “Transfer To” provider display in the pane on the right.

Note: If only the first character(s) of the provider number are entered in either the Transfer From or Transfer To providers, the pane first displays all matching providers. Double-click the provider containing the required deficiencies to display the deficiencies for selection.

Select the deficiencies to transfer in the left pane. To select contiguous deficiencies to move, hold the **Shift** key down and click the first deficiency and then click the last deficiency. The first and last deficiencies, along with all deficiencies in between are selected. To select non-contiguous deficiencies to transfer, hold the **Ctrl** key down and click the deficiencies to select.

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Click
The selected deficiencies are moved to the right pane.

To move all deficiencies, click

To select a new date, select the New Start Date field, then enter the new start date.

When complete click

The deficiencies are assigned as shown in the panes. If a new start date was entered, the date is assigned to the deficiencies.

Adding Providers for the Same Visit

When additional providers need to be added to a deficiency, the steps here should be used. Using this option, the chart and demographics remain, and new provider information may be entered, along with additional deficiencies.

To add providers for the same visit:

1. From Chart Deficiencies, click
   - or – Press **F8**.
   The Header Reference ID Number is incremented and all fields in Chart Deficiencies are ready for entry. The Chart Number, Visit Date and demographics remain.
2. Enter the information as described in “Creating Chart Deficiencies” in this chapter.

To save the deficiency entered, click , then
If the user has access to the Chart Locator module, the following prompt displays:

“Would you like to change the Chart Location now? Yes/No”

To change the location, click **Yes**.
The Chart Locator displays with the chart number and Volume number already entered. Click **F7** to return to the Chart Deficiencies module.

When the deficiencies for the current provider are entered and saved, the Other Providers Deficiencies sidebar is updated with the additional providers. This sidebar shows all providers with deficiencies for the current chart.

To view deficiency information in the Deficiencies sidebar, double-click on the provider in the Other Providers Deficiencies sidebar. As you toggle between providers, the provider’s chart completion items display in the Deficiency Detail window.

Entering Provider Unavailability

Updating provider unavailability is done using the Other Providers Deficiencies sidebar.

To enter provider unavailability:

1. From the Chart Deficiencies module, select the chart containing the required provider.

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2. In the Other Providers Deficiencies sidebar, click the **Show Provider Information** button. The Provider Maintenance window displays.

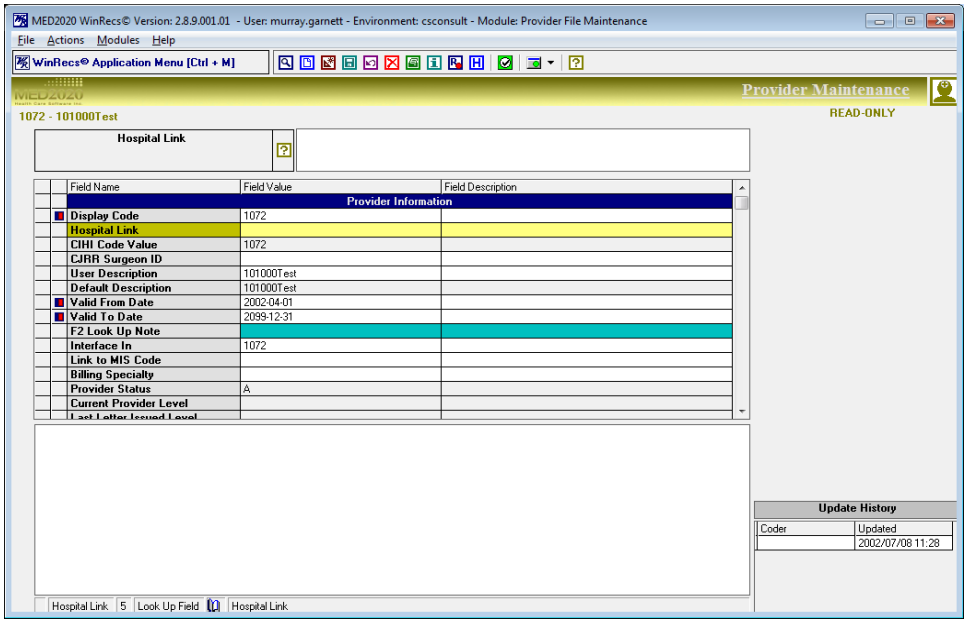


Figure 27

3. Double-click the Provider Unavailability header in the Main Grid. The Provider Unavailability multiform displays.

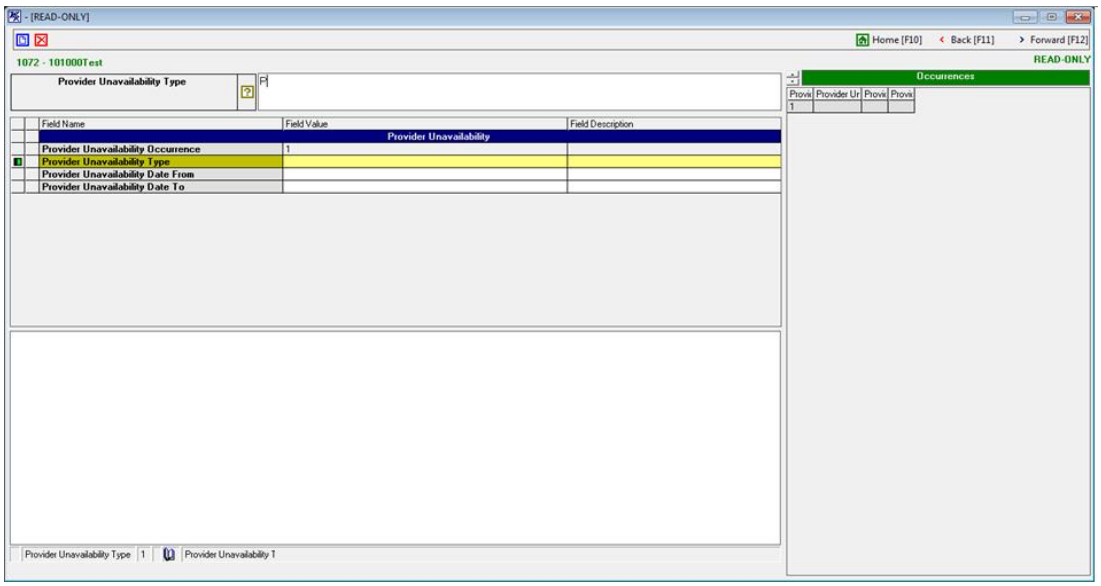
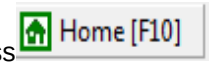


Figure 28

4. Enter the provider unavailability information. Press **Enter** after entering data in each field to move to the next field.

Field Name	Description
Provider Unavailability Occurrence:	This field identifies the unique occurrence of the provider unavailability record. This field is generated and cannot be changed.
Provider Unavailability Type:	(Required) Enter the unavailability type. Press F2 to display the lookup if required to select the type.
Provider Unavailability Date From:	Enter the starting date for unavailability. Dates are entered in the format “YYYY-MM-DD”.
Provider Unavailability Date To:	Enter the ending date for unavailability. Dates are entered in the format “YYYY-MM-DD”.

5. After pressing Enter after the last field, the cursor increments the Provider Unavailability Occurrence field and another unavailability can be entered.
6. If there are no more availabilities to enter, press 

The Provider Maintenance window displays.
7. Press
The information is saved and the Chart Deficiency window displays.

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Entering Provider Logs

When a provider has completed their deficiency chart(s), a Physician's Log entry should be completed.

To complete physician's logs:

1. From the Chart Deficiency module, click
   - or Press **F4.**
   The Deficiency List Search dialog displays.
2. Click **F3** (Search Field) to display the fields on which to search.
3. Select either Provider Number or Provider Name.
4. Press **Enter**.
   The Provider Name or Provider Number prompt displays.
5. Enter the Provider Name or Number, depending on the selection above.
6. Press **Enter**.
   A list of providers displays.
7. Double-click the required provider.
   The Chart Deficiency window displays with the provider highlighted in the Other Providers Deficiencies sidebar.
8. Click Show Provider Information...
   The Provider Maintenance window displays.
9. Double-click the Provider Log field in the Data Grid.
   The Provider Log window displays.

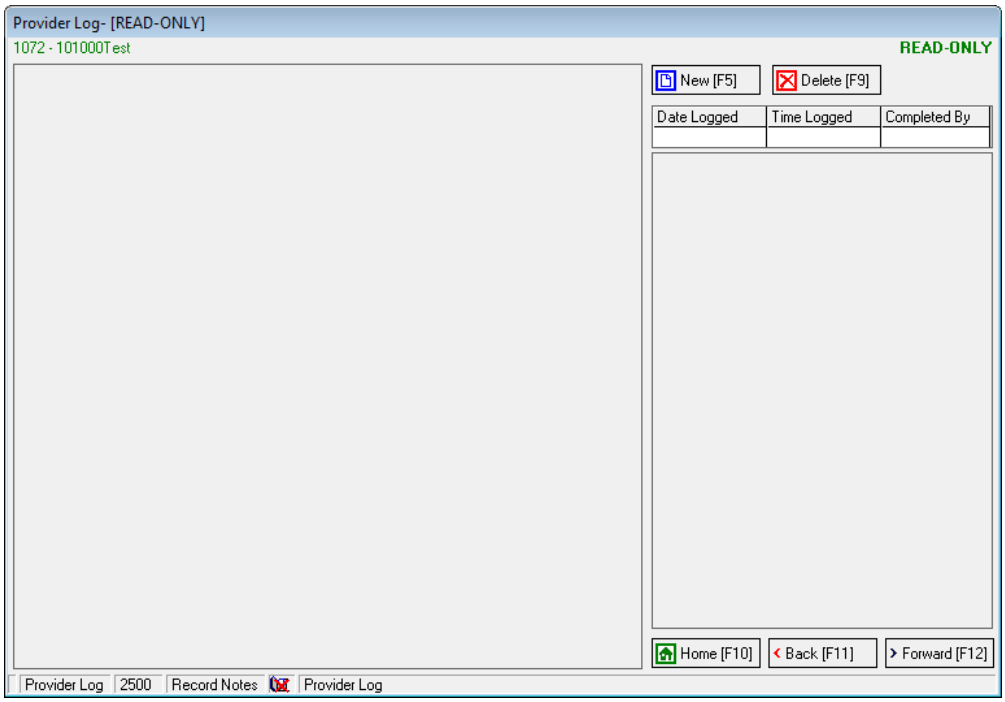
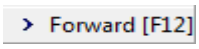


Figure 29

10. Enter the required information. For example, indicate the physicians/residents completion of the deficient charts, such as:

    Physician/resident completed all charts.
    Physician/resident completed all available charts.
    Physician/resident completed dictation only.
    Physician left chart for resident to complete.
    Physician/resident did some charts but was paged.
    Physician/resident requested only certain charts.
    Physician/resident left without indicating what had been done, etc.

11. When complete, click 

    The Provider Maintenance window displays.

12. Click
    The entry is saved and the Chart Deficiency window displays.

Printing Physician Logs

A report must be set up in the System Maintenance - Lookup Field Maintenance - Report Selection List field prior to attempting to run a report using the steps below. For details on running these reports, please refer to “Running Reports Through WinRecs” section.

To print physician logs:

Click
- or – Press **F10**
The Select Reports window displays.

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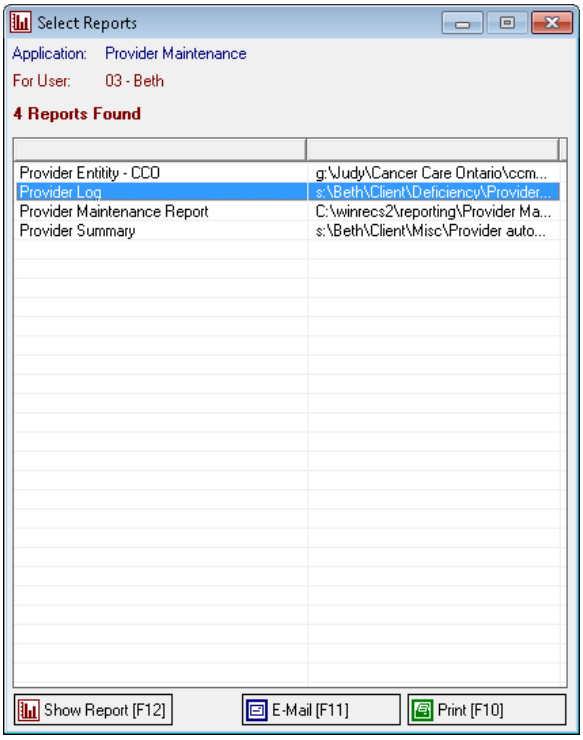

Figure 30

Select Physicians Log report (note that the name may vary).

Click

Enter any required parameters.

Click **OK**.

Click

to print the Physician Log.

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Chart Deficiency Sidebars

The following sidebars are available.

Other Providers Deficiencies

Displays all providers associated with the current chart who are currently deficient. Click on the provider in the Other Providers Deficiencies sidebar to view the provider's deficiency in the Deficiencies sidebar below.

Deficiencies

This provides access to the Provider Maintenance table. To display deficiencies for a provider, click on the provider in the Other Providers Deficiencies sidebar. The deficiencies for the provider display in the Deficiencies sidebar.

Clicking

at the top of this sidebar displays the Provider Maintenance window, where Provider Unavailability and other information for the provider is maintained.

Record Update History

Displays an audit trail of all transactions, and includes the WinRecs user ID of the person who made the change.

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4.5 Release of Information Module (ROI)

Release of Information Overview

The Release of Information module is used to maintain and store all Release of Information requests received by a facility. It can be used to track turn-around time, authorizations, workload measurement as well as invoicing and payments, if desired.

The requests are chart-based, so a request must relate to an existing record in the Central Patient Index.

Available Reports

The following reports are available for Release of Information:

Chart Deficiency Report (Chart Deficiency.rpt): This report is accessed by double-clicking a deficiency in the Chart Deficiencies sidebar.
ROI Invoice.rpt:
ROI Outstanding Transactions.rpt:
ROI Productivity.rpt:
ROI Request Summary.rpt:
ROI Revenue Transactions.rpt:
ROI Standard ConsentTemplate.rpt:

Note: All reports are available for download from ftp://web.med2020.ca/WR2Reports/ROI/. All reports and all canned reports will be downloaded to the server on which you are working.

Release of Information Setup

The following setup must be completed before using the Release of Information module. For a complete description of the setup required and the steps to complete the setup please refer to **"Section 6 - System Maintenance"** in the WinRecs User Guide:

Regional Profile: The Regional Profile is used to specify default values which are used in individual facility profiles. The information entered here is required for lookups.

Hospital Profile: The Hospital Profile is used to specify values accessed using lookups when working with Release of Information requests.

Control File Settings: The Control File specifies default settings for fields, determining if fields are visible or enabled within the Release of Information module.

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Lookup Maintenance: The following tables must have entries in them before creating a Release of Information request.

Note: The valid to/from dates for all ROI Look up values are linked to the Request Received Date in the ROI Module.

ROI Action Types
ROI Authorization Type
ROI Couriers
ROI Item Types
ROI Payment Method
ROI Request Method
ROI Request Type
ROI Requesters
ROI Requester Types
ROI Signed By
ROI Status
Report Generator

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Accessing the Release of Information Module

The Release of Information module is one of the modules within Chart Maintenance. Please refer to **Chapter 2 "WinRecs Layout**" for more information on the modules available within WinRecs.

There are two options for accessing the Release of Information module. The option to use can depend on what is to be performed within the module. The options are:

Option 1: From the Central Patient Index (CPI):

This option always opens the Release of Information module in "New" mode, ready for data entry. When accessed using this option, the chart number and any other relevant fields are populated from the CPI. Therefore, if adding release of information requests, this method is recommended. For information on using the CPI, please refer to section "**Central Patient Index (CPI)"** within this user guide.

To access the Release of Information module from the CPI:

From the WinRecs Application Menu, select **Central Patient Index (CPI)**.

Search for the patient in the CPI.
If the CPI does not open in Search mode, press F4 to display the search dialog then search for the required chart.

Double-click on the required chart to display it in the CPI.

When the chart displays, hot-link to the Release of Information module using the Hot Link ( ) button on the toolbar.
The Release of Information window displays, with available information from the CPI populating all relevant fields.

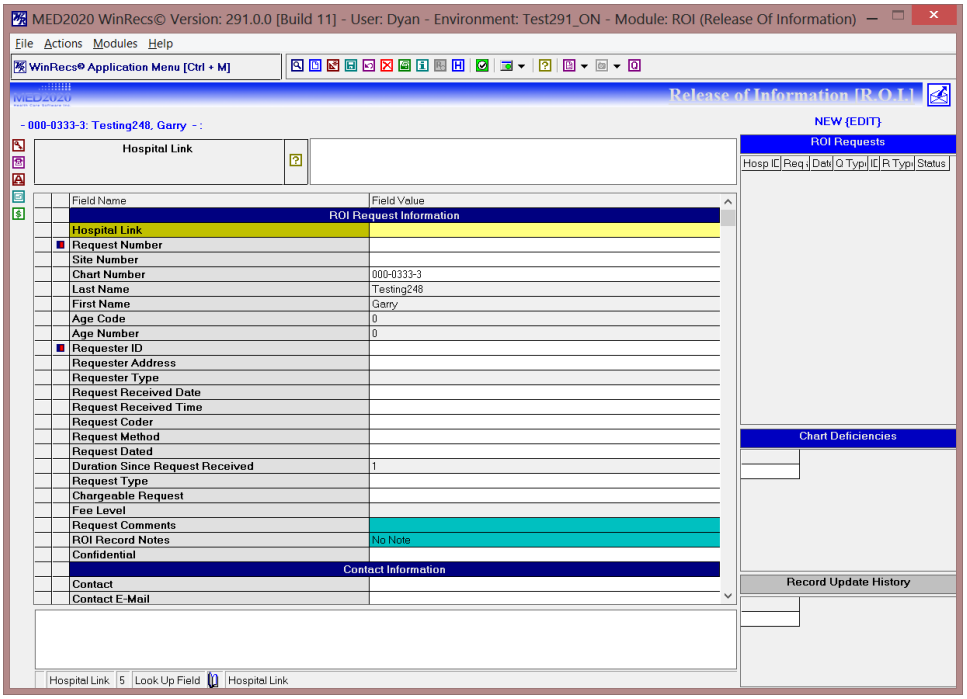

Figure 31

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For more information on searching in the Central Patient Index (CPI), please review **section 3.2 "Search" in Chapter 3** of this document.

Option 2: From the WinRecs Application Menu:

With this method there is no auto-populating of fields so the Release of Information window does not contain any information.

To access the Release of Information module using the WinRecs Application Menu:

From the WinRecs Application Menu, select Chart Maintenance - Release of Information (R.O.I.). The Release of Information (R.O.I.) window displays with no information populating fields.

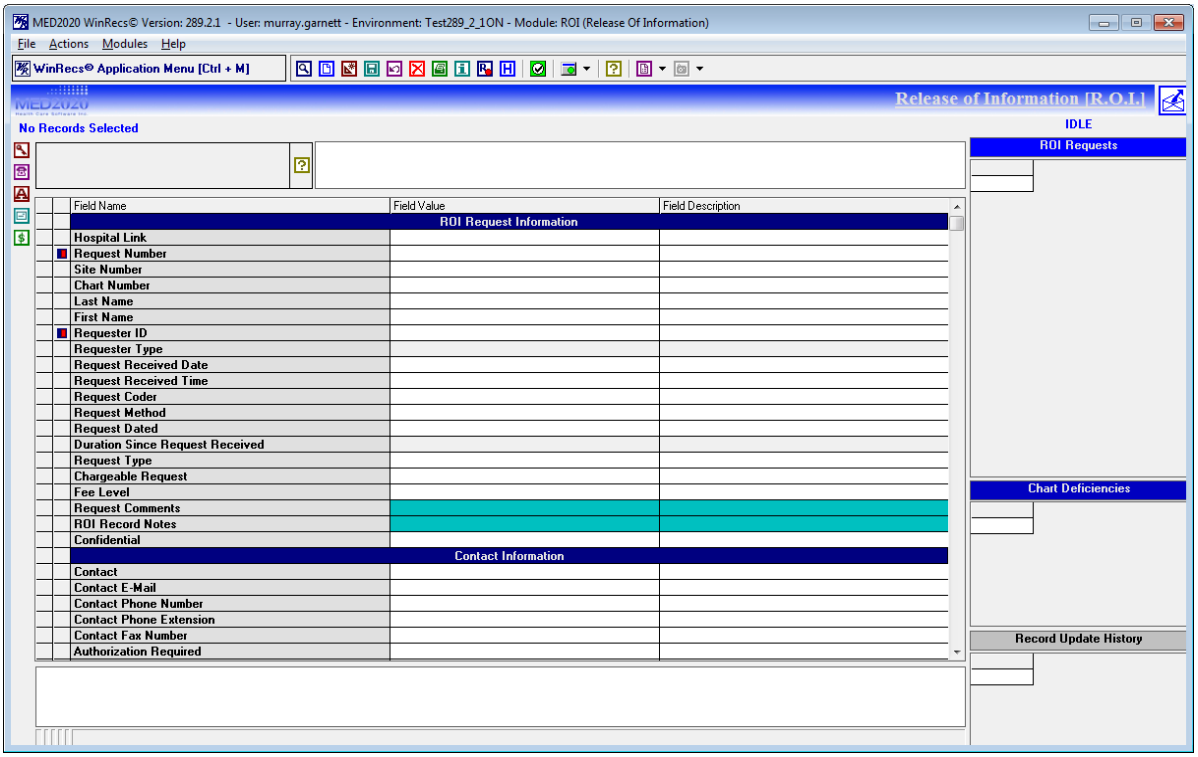

Figure 32

Use the relevant options as described in this chapter to maintain release of information requests and related information.

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Using the Release of Information Module

When the Release of Information module is accessed the Release of Information (R.O.I.) window displays. The Release of Information module is used to maintain and store all release of information requests received by a facility. It can be used to track turn-around time, authorizations, workload measurement as well as invoicing and payments, if desired.

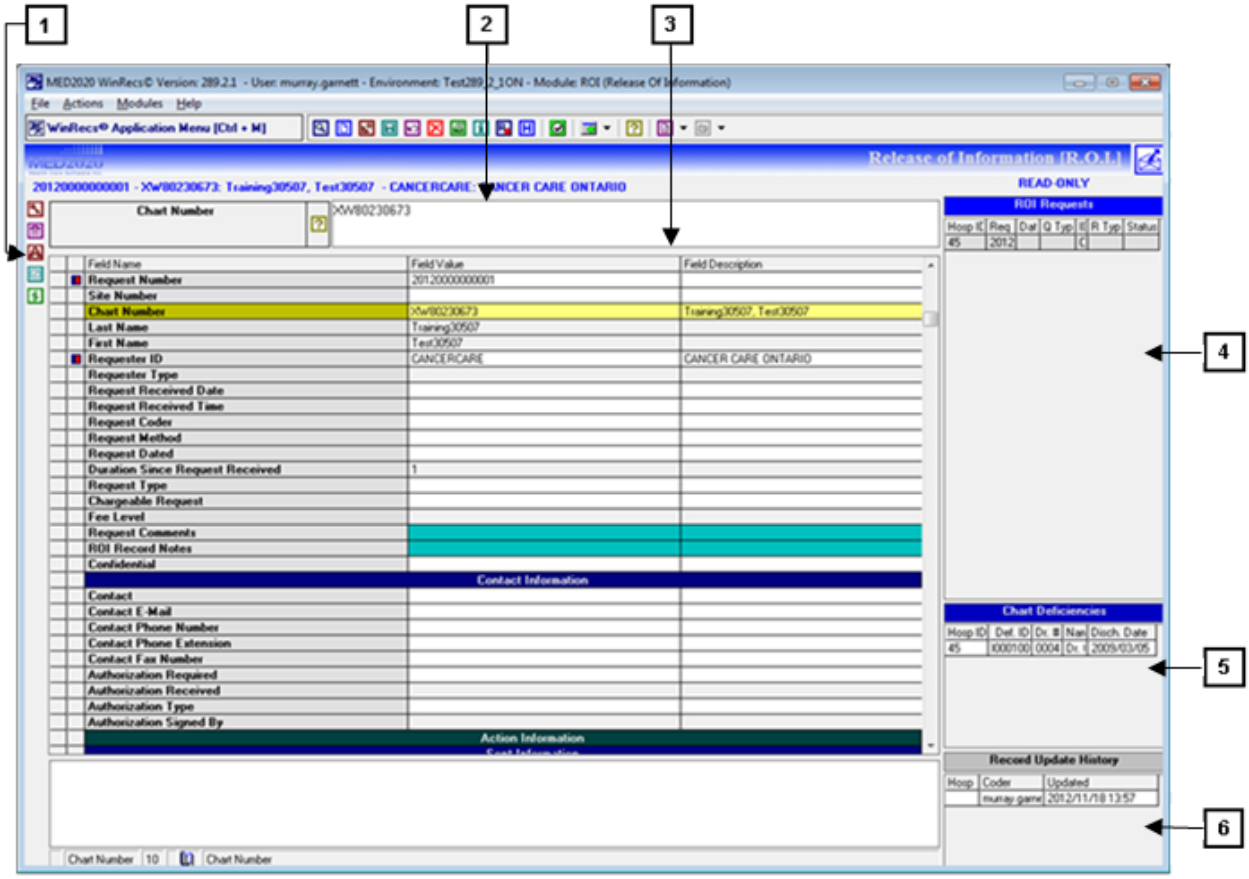

Figure 33

The main components of the Release of Information window are the Bookmarks, Main Grid, Data Entry Box and 3 sidebars. The main parts of the Release of Information window are described in the table below. The REF# field for each row relates to the callouts shown in the above image.

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REF#	Description
1	**Bookmarks**: Bookmarks allow for fast access to categories of information within the Main Grid. Click a bookmark to display the section in the Main Grid. This may be basic data entry, or multiforms (for entering multiple occurrences of information, such as multiple actions performed). There are 5 bookmarks (and corresponding sections) in the Main Grid as described below: **ROI Request Information**. This includes information for uniquely identifying the release of information request, including the facility link, chart, etc. Information is entered in the ROI Request Information fields using the Data Entry Box. Please refer to Chapter 2: “TOC - WinRecs Layout” for additional information. **Contact Information**. This includes the contact information for the person or organization making the information request. **Action Information**. This multiform is used to record every “Action” performed while fulfilling the request for information. Task lists can be designed to run as a canned report, which clerks can print off daily to determine what ROI activities are due to be completed each day. Action Information uses a multiform for entering information to allow multiple actions for each request. **Sent Information.** This section provides information on how the response to the release of information request was sent to the requester. **Invoice Information.** Information in this section is calculated and updated based on information entered in the Invoice and Payments multiforms. Note that there are no bookmarks for Items Sent and Payments in the Main Grid.
2	**Data Entry Box**: The Data Entry Box is used to enter or edit information displaying in the Main Grid. Click on a field in the Main Grid and the field name displays on the left and the cursor is positioned in the box ready for entry.
3	**Main Grid**: The Main Grid shows the information for the currently selected request (or is empty when first creating requests). To add or modify information in the Main Grid, select the row and the field name displays beside the Data Entry Box and the data may be changed by typing in the Data Entry Box. The information in the Main Grid is organized under headings and can be accessed by scrolling through the grid, or by clicking on a bookmark to move the grid to the section within the associated heading.
4	**ROI Requests Sidebar**: Displays all release of information requests for the chart associated with the current request. Release of information request detail may be viewed by double-clicking the request in the sidebar. The associated request detail displays in the Main Grid.
5	**Chart Deficiencies Sidebar**: Displays deficiency information on the chart associated with the current request. Double-click a deficiency to display the Chart Deficiencies Report.
6	**Record Update History Sidebar**: Displays an audit trail showing the history of

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	changes made. This includes the WinRecs user ID of the user who made the change.

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Creating Release of Information Requests

Before creating release of information requests, the patient should first exist within WinRecs as the patient data can be used to populate information within the Release of Information (ROI) module. If the patient exists, the Chart Search function may be used to locate the required patient chart and related demographics. The two system mandatory fields are Request Number and Requester ID. Other fields may be made mandatory for your facility.

For further instructions to make fields mandatory please refer to the Control File section in the WinRecs User Guide.

To create release of information requests:

From Release of Information (R.O.I.) click
The Release of Information fields are available for entry.

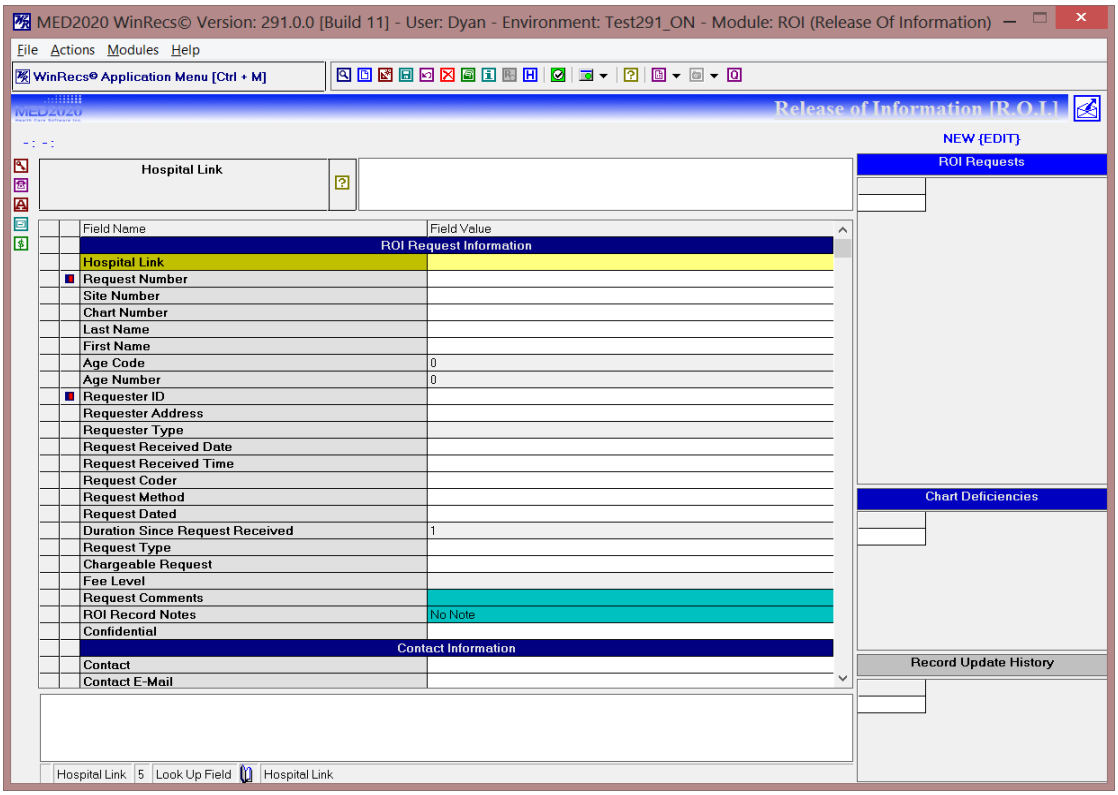

Figure 34

Enter information in all required fields. Press **Enter** after each field to move to the next field. The following are the fields accessed by pressing **Enter**.

Hospital Link:	The hospital link. If the hospital number is not known, press **F2** to display a list of hospitals in the Lookup from which the hospital may be selected.
Request Number:	(Required) Enter the unique alphanumeric identifier for the request. The first digit must be numeric. This can be entered manually or automatically, depending on setup.
Site Number:	Enter the site. If the Site Number is not known, press **F2** to display a list of sites in the Lookup from which a site may be selected.

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Chart Number:	Enter the chart number of the patient. Type in the first part of the chart number and press **Enter** to access the Chart Number Lookup.
Requester ID:	(Required) The ID of the person or organization requesting the information. If the Requester ID is not known, press **F2** to display a list of requesters in the Lookup from which a requester may be selected.
Request Received Date:	The date the request was received. Dates are entered in "YYYY-MM-DD" format.
Request Received Time:	The time the request was received.
Request Coder:	The user ID of the person entering the request. If the user ID is not known, press **F2** to display a list of users in the Lookup from which a user may be selected.
Request Method:	The way in which the request was received. If the method is not known, press **F2** to display a list of methods in the Lookup from which a method may be selected.
Request Dated:	The actual date of the request. Dates are entered in "YYYY-MM-DD" format. The number of days between the Request Received Date and the Request Dated are used to calculate the Duration Since Request Received.
Request Type:	The type of information requested. If the type is not known, press **F2** to display a list of types in the Lookup from which a type may be selected.
Chargeable Request:	Indicates if the request is chargeable ("Y" or "N"). If Chargeable Request is "N", the Fee Level field and Payment multiform are disabled.
Fee Level:	This is connected to the Requester ID. If the requester has a fee level assigned, the Fee Level is entered automatically.
Request Comments:	Enter any required comments.
ROI Record Notes:	This is used to enter notes related to the request.

Press **Enter** in the ROI Record Notes field to move to the Contact Information section where the required contact detail is entered. The fields in Contact Information can be linked to the Requester ID. If the information is entered in the linked Requester ID, when the Requester is selected, the Contact information fields are updated automatically.

Contact:	The code for the contact. This is linked to the Requester ID.
Contact Email:	The email address of the contact.
Contact Phone Number:	The phone number of the contact.
Contact Phone Extension:	The phone number extension of the contact.
Contact Fax Number:	The fax number of the contact.
Authorization Required:	Indicates if authorization is required ("Y" or "N"). If "N" is entered then Authorization Received and Authorization Signed By are disabled.

After pressing **Enter** in the last field, the Action Information multiform displays. This multiform records workload information by recording every "Action" performed while fulfilling the request for information.

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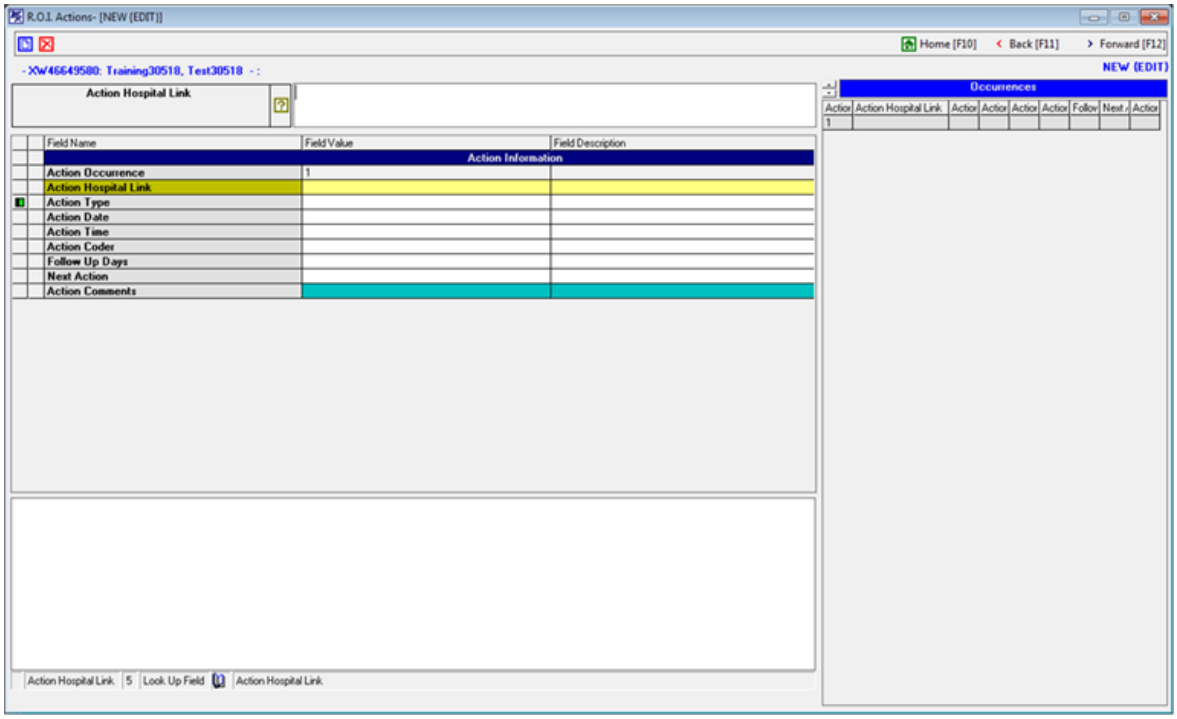

Figure 35

Enter the required information in the Action Information multiform. Using the multiform, multiple actions may be performed for each release of information request.

Field Name	Description
Action Occurrence:	The unique occurrence number of the action done. This is incremented automatically.
Action Hospital Link:	Clients who have regional databases can set this to their specific hospital.
Action Type:	This field indicates the action taken. As the table containing this information is user-defined, actions can be customized to fit your own departmental workflow and procedures. If the Action Type is not known, press **F2** to display a list of actions in the Lookup from which an action may be selected.
Action Date:	The date the action occurred. Dates are entered in "YYYY-MM-DD" format.
Action Time:	The time the action occurred.
Action Coder:	The user who performed the action. If the User ID is not known, press **F2** to display a list of users in the Lookup from which a user may be selected.
Follow Up Days:	The number of days in which the action needs to be completed. In combination with a report, this can produce workload information.
Next Action:	Indicates what the next action (if any) is to be.

When all actions are entered, click Back [F11] to return to the Main Grid.

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Enter the required information in the Sent Information fields.

ROI Status:	The status of the request. If the status is not known, press **F2** to display a list of statuses in the Lookup from which a status may be selected.
Sent Date:	The date the information was sent. Dates are entered in "YYYY-MM-DD" format.
Sent Time:	The time the information was sent.
Sent Coder:	The ID of the coder who sent the information. If the coder is not known, press **F2** to display a list of coders in the Lookup from which a coder may be selected.
Sent By (Couriers):	Indicates how the information was sent. This is normally a courier name. If the Sent By is not known, press **F2** to display a list from which a sent by method may be selected.
Tracking Number:	The tracking number assigned by the courier for following the information sent.
Extension Notice Required?:	Indicates if extension notice is required. Enter "Y" or "N".
Special Handling Instructions:	Enter comments for any special instructions for handling the item.

After pressing **Enter** in the Special Handling Instructions field, the Items Sent multiform displays. This multiform records the details of each item sent, including the item price. The Item Total Amount is calculated by multiplying Item Quantity*Item Price.

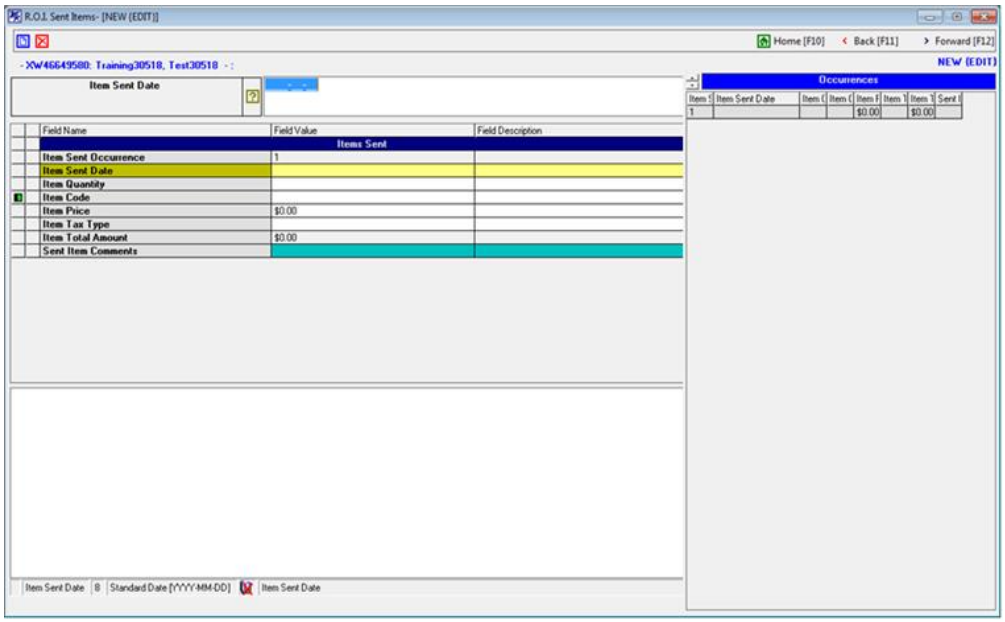

Figure 36

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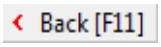
Enter the Items Sent information.

Item Sent Occurrence:	Multiple items sent may be entered for the same request. This is a unique number, generated automatically to identify the occurrence of the item sent.
Item Sent Date:	The date of the information sent request. A date is required. Dates are entered in “YYYY-MM-DD“ format.
Item Quantity:	The number of items sent with this occurrence, such as the number of photocopied pages, etc.
Item Code:	(Required) The code identifying the item, based on tables set up by your facility. If the item code is not known, press **F2** to display a list of item codes in the Lookup from which an item code may be selected.
Item Price:	The item price. This defaults from the Item Code, if applicable, but can be changed.
Item Tax Type:	The tax type (GST, PST, etc) of the item. The value in this field defaults from the Item Code, if applicable. If the tax type is not known, press **F2** to display a list of tax types from which a tax type may be selected. The Item Total Amount is calculated based on the fields entered above.
Sent Item Comments:	Any specific comments relating to the items sent can be entered.

When all items sent are entered, click 

to return to the Main Grid.

Double-click the Payments section heading.
The Payments multiform displays.

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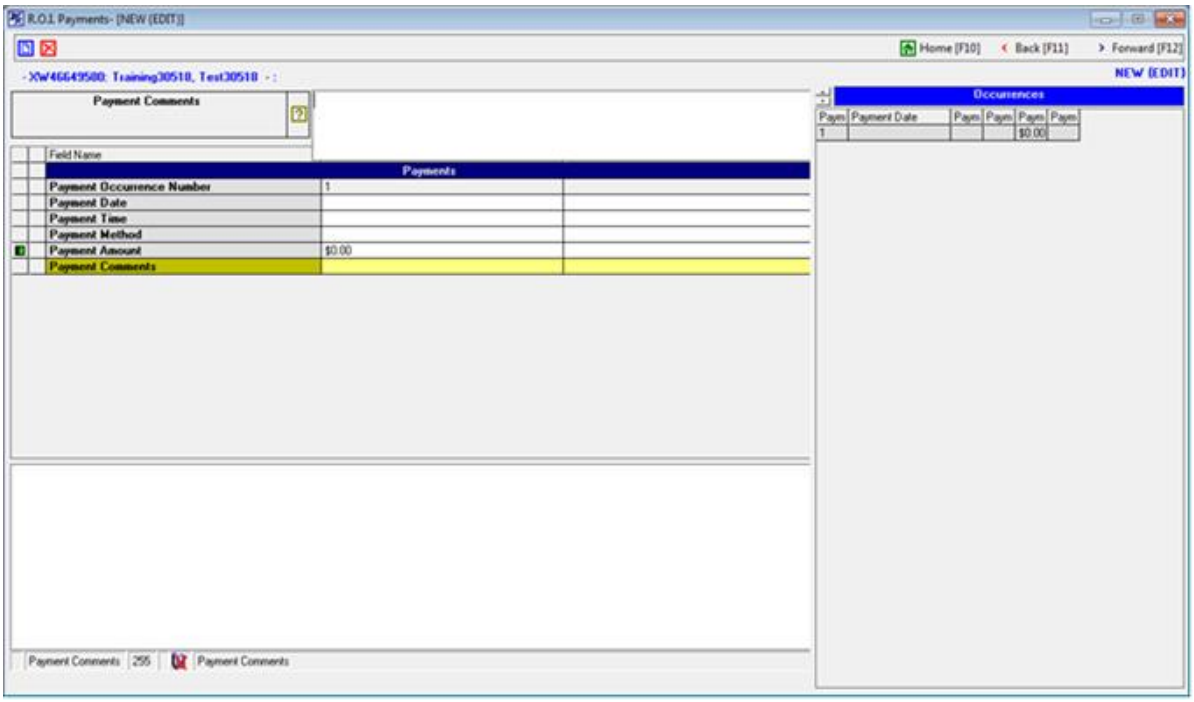

Figure 37

Enter the required information in the Payments multiform. Using the multiform, multiple payments may be entered for each release of information request. This allows for installment payments to be recorded and fields to record information for invoicing purposes. This entire section is enabled if the "Chargeable Request" field is "Y".

Payment Occurrence Number:	This is a unique number, generated automatically to identify the occurrence of the payment.
Payment Date:	The date the payment was received. Dates are entered in "YYYY-MM-DD" format.
Payment Time:	The time the payment was received.
Payment Method:	The method used to make the payment, such as cheque, cash etc.
Payment Amount:	The amount of this payment occurrence.
Payment Comments:	Any additional comments.

When all payments are entered, click Back [F11] to return to the Main Grid.

Enter the required fields in the Invoice Information section.

GST Number:	The hospital's GST number can be entered here. The Control File default can be set up to eliminate repetitive entry.
Invoice Number:	The invoice number.
Invoice Date:	The date the invoice was created. Dates are entered in "YYYY-MM-DD" format.
Invoice Time:	The time the invoice was created.
Invoice Total:	The total amount of the invoice including applicable taxes.

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Amount Paid To Date:	The amount paid to date. Amounts recorded in the Payments multiform will accumulate in this field.
Total Amount Due:	The total due, as adjusted by payments received and recorded in the Payments multiform.
Due Date:	The date by which the Total Amount Due must be paid.

When complete click **Save** **(F7)**.
The information is saved and displays in the main grid.

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Modifying Release of Information Requests

Release of Information requests may be modified as required.

To modify release of information requests:

From Release of Information (R.O.I.) click
- or - Press F4.
The Release of Information (ROI) Search dialog displays.

Use the search fields in the Release of Information (ROI) Search to display all Release of Information requests.

Double-click in the Release of Information (ROI) Search on the entry containing the release of information request to update.
- or - Select the required entry and press Enter.
The Release of Information (R.O.I.) window displays the release of information request for the selected entry.

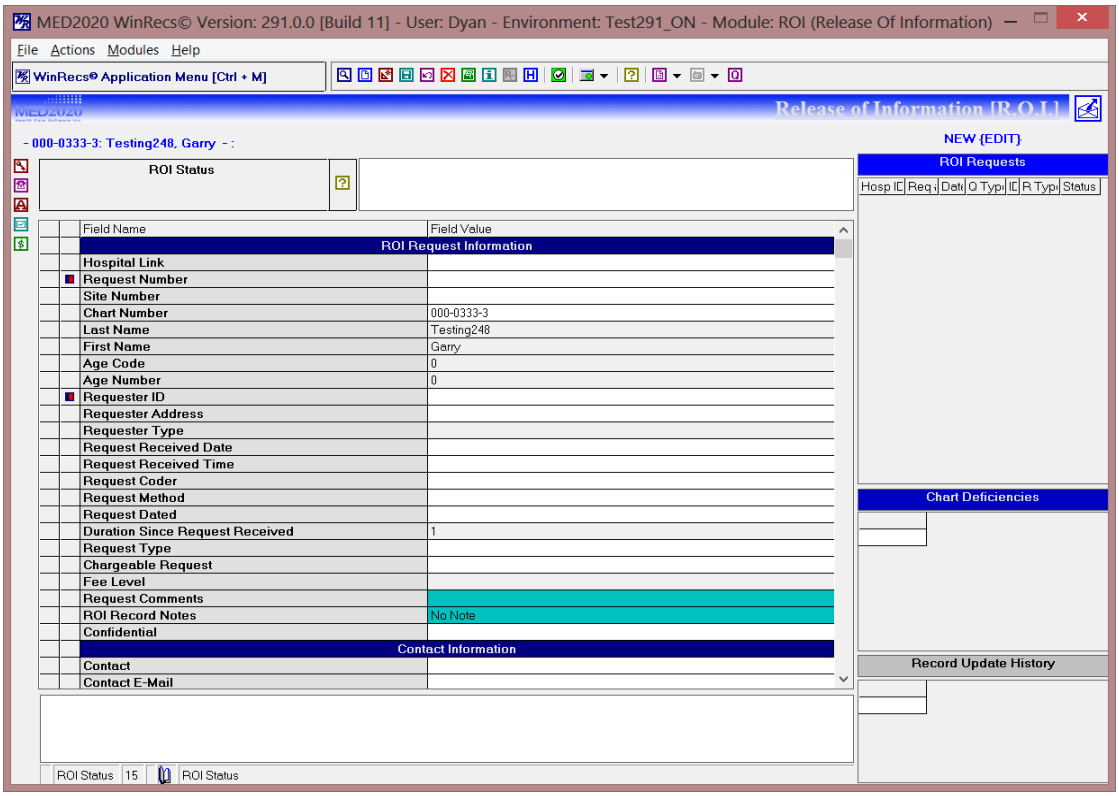

Figure 38

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Make the required changes.

Hospital Link:	The hospital link. If the hospital number is not known, press **F2** to display a list of hospitals in the Lookup from which a hospital may be selected.
Request Number:	(Required) Enter the unique alphanumeric identifier for the request. The first digit must be numeric. This can be entered manually or automatically, depending on setup.
Site Number:	Enter the site. If the Site Number is not known, press **F2** to display a list of sites in the Lookup from which a site may be selected.
Chart Number:	Enter the chart number of the patient. Type in the first part of the chart number and press **Enter** to access to Chart Number Lookup.
Requester ID:	(Required) The ID of the person or organization requesting the information. If the Requester ID is not known, press **F2** to display a list of requesters in the Lookup from which a requester may be selected.
Request Received Date:	The date the request was received. Dates are entered in "YYYY-MM-DD" format.
Request Received Time:	The time the request was received.
Request Coder:	The User ID of the person entering the request. If the User ID is not known, press **F2** to display a list of users in the Lookup from which a user may be selected.
Request Method:	The way in which the request was received. If the method is not known, press **F2** to display a list of methods in the Lookup from which a method may be selected.
Request Dated:	The actual date of the request. Dates are entered in "YYYY-MM-DD" format. The number of days between the Request Received Date and the Request Dated are used to calculate the Duration Since Request Received.
Request Type:	The type of information requested. If the type is not known, press **F2** to display a list of types in the Lookup from which a type may be selected.
Chargeable Request:	Indicates if the request is chargeable ("Y" or "N"). If Chargeable Request is "N" then the Fee Level field and Payment multiform are disabled.
Fee Level:	This is connected to the Requester ID. If the requester has a fee level assigned, the Fee Level is entered automatically. Otherwise the field remains blank and disabled. Use the lookup if necessary.
Request Comments:	Enter any required comments.
ROI Record Notes:	This is used to enter notes related to the request.

Press **Enter** in the ROI Record Notes field to move to the Contact Information section where the required contact detail is entered. The fields in Contact Information can be linked to the Requester ID. If the information is entered in the linked Requester ID, when the Requester is selected, the Contact information fields are updated automatically.

Contact:	The code for the contact. This is linked to the Requester ID.
Contact Email:	The email address of the contact.

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Contact Phone Number:	The phone number of the contact.
Contact Phone Extension:	The phone number extension of the contact.
Contact Fax Number:	The fax number of the contact.
Authorization Required:	Indicates if authorization is required (“Y” or “N”). If “N” is entered then Authorization Received and Authorization Signed By are disabled.

After pressing **Enter** in the last field, the Action Information multiform displays. This multiform records workload information by recording every “Action” performed while fulfilling the request for information.

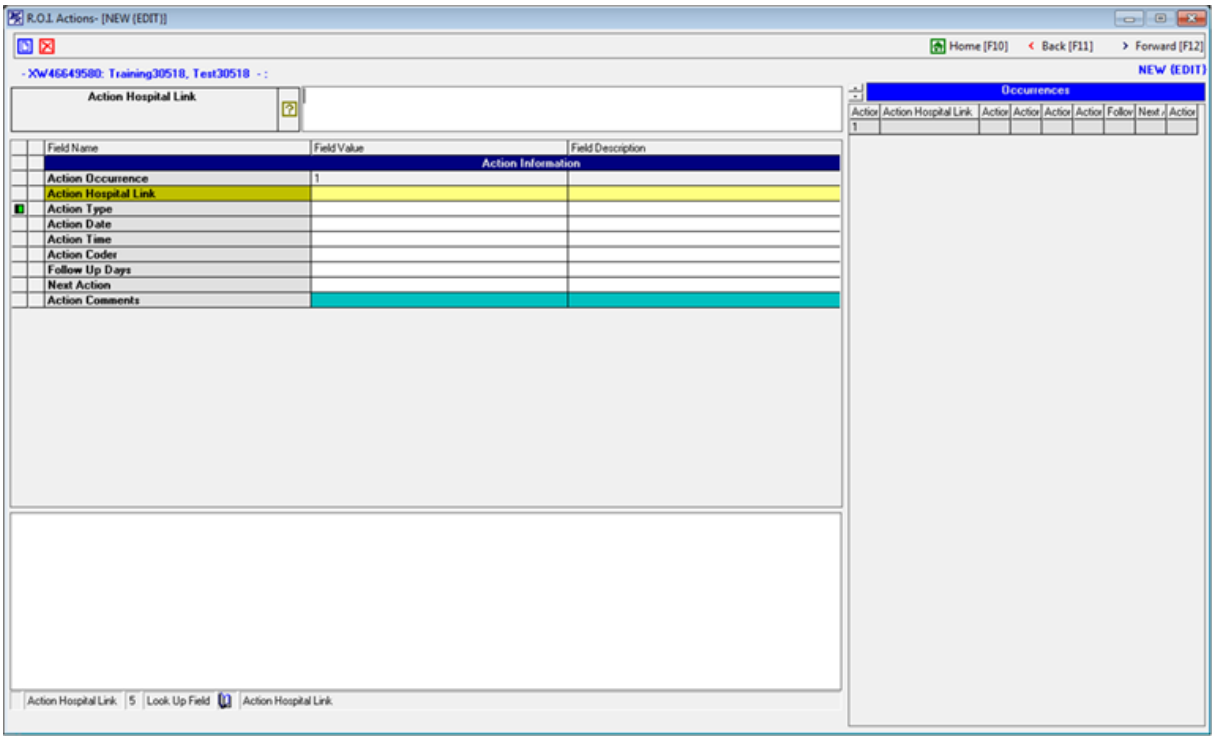

Figure 39

Enter the required information in the Action Information multiform. Using the multiform, multiple actions may be performed for each release of information request.

Field Name	Description
Action Occurrence:	(Required) The unique occurrence number of the action done. This is incremented automatically.
Action Hospital Link:	Clients who have regional databases can set this to their specific hospital.
Action Type:	This field indicates the action taken. As the tables are user-defined, actions can be customized to fit your own departmental workflow and procedures. If the Action Type is not known, press **F2** to display a list of actions in the Lookup from which an action may be selected.
Action Date:	The date the action occurred. Dates are entered in “YYYY-MM-DD“ format.

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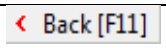
Action Time:	The time the action occurred.
Action Coder:	The user who performed the action. If the User ID is not known, press **F2** to display a list of users in the Lookup from which a user may be selected.
Follow Up Days:	The number of days in which the action needs to be completed. In combination with a report, this can produce workload information.
Next Action:	Indicates what the next action (if any) is to be.

When all actions are entered, click 

to return to the Main Grid.

Enter the required information in the Sent Information fields.

ROI Status:	The status of the request. If the status is not known, press **F2** to display a list of statuses in the Lookup from which a status may be selected.
Sent Date:	The date the information was sent. Dates are entered in “YYYY-MM-DD“ format.
Sent Time:	The time the information was sent.
Sent Coder:	The ID of the coder who sent the information. If the coder is not known, press **F2** to display a list of coders in the Lookup from which a coder may be selected.
Sent By (Couriers):	Indicates how information was sent. This is normally a courier. If the Sent By is not known, press **F2** to display a list from which a sent by method may be selected.
Tracking Number:	The tracking number assigned by the courier for following the information sent.
Extension Notice Required?:	Indicates if extension notice is required. Enter “Y” or “N”.
Special Handling Instructions:	Enter comments for any special instructions for handling the item.

After pressing **Enter** in the Special Handling Instructions field, the Items Sent multiform displays. The multiform records the details of each item sent, including the item price. The Item Total Amount is calculated by multiplying Item Quantity*Item Price.

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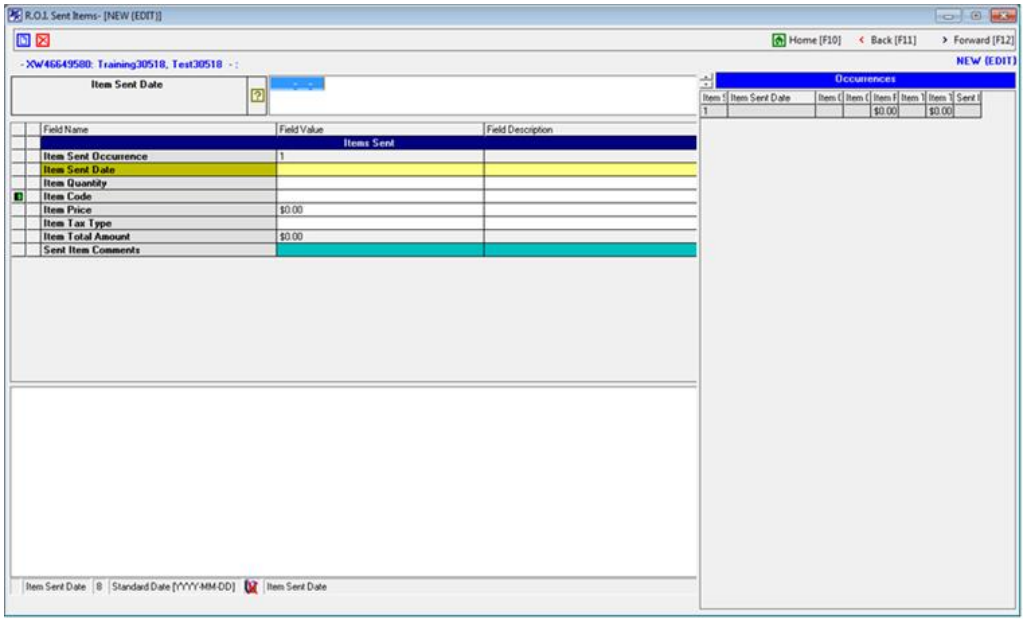

Figure 40

Enter the Items Sent information.

Item Sent Occurrence:	Multiple items sent may be entered for the same request. This is a unique number, generated automatically to identify the occurrence of the item sent.
Item Sent Date:	The date of the information sent request. A date is required. Dates are entered in “YYYY-MM-DD“ format.
Item Quantity:	The number of items sent with this occurrence, such as the number of photocopied pages, etc.
Item Code:	(Required) The code identifying the item, based on tables set up by your facility. If the item code is not known, press **F2** to display a list of item codes in the Lookup from which an item code may be selected.
Item Price:	The item price. This defaults from the Item Code, if applicable, but can be changed.
Item Tax Type:	The tax type (GST, PST, etc) of the item. The value in this field defaults from the Item Code, if applicable. If the tax type is not known, press **F2** to display a list of tax types from which a tax type may be selected. The Item Total Amount is calculated based on the fields entered above.
Sent Item Comments:	Any specific comments relating to the items sent can be entered.

When all items sent are entered, click Back [F11] to return to the Main Grid.

Double-click the Payments section heading.
The Payments multiform displays.

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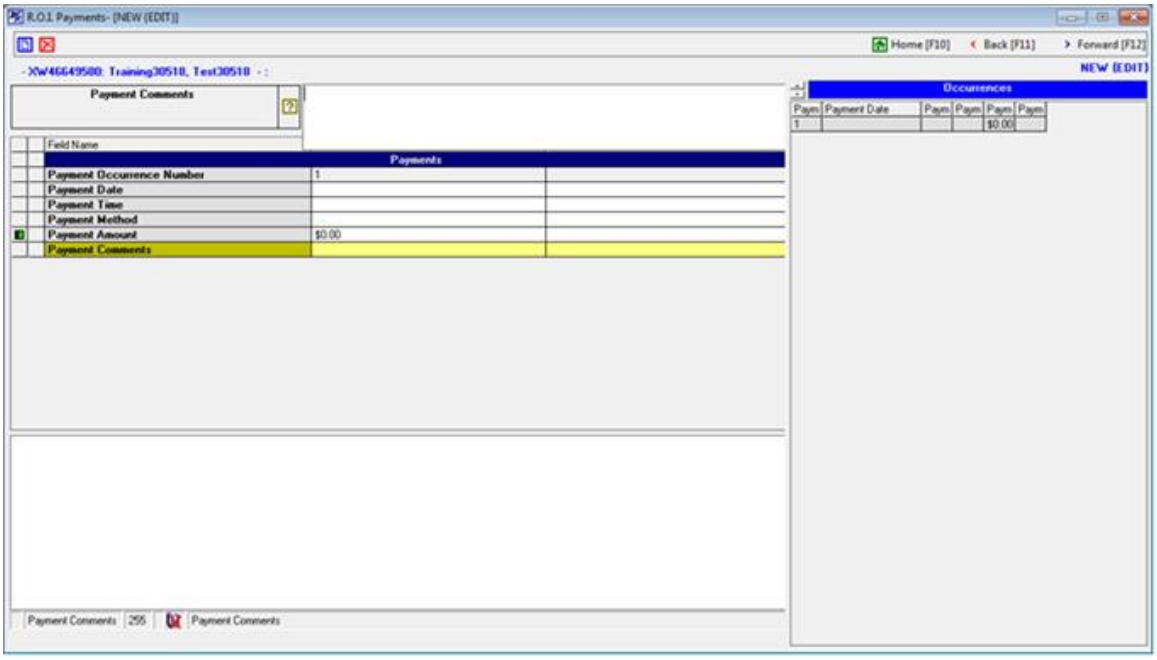

Figure 41

Enter the required information in the Payments multiform. Using the multiform, multiple payments may be entered for each release of information request. This allows for installment payments to be recorded and fields to record information for invoicing purposes. This entire section is enabled if the "Chargeable Request" field is "Y".

Payment Occurrence Number:	Payments uses a multiform, allowing multiple payments for the same request. This is a unique number, generated automatically to identify the occurrence of the payment.
Payment Date:	The date the payment was received. Dates are entered in "YYYY-MM-DD" format.
Payment Time:	The time the payment was received.
Payment Method:	The method used to make the payment, such as cheque, cash etc.
Payment Amount:	The amount of this payment occurrence.
Payment Comments:	Any additional comments.

When all items sent are entered, click Back [F11] to return to the Main Grid.

Enter the required fields in the Invoice Information section.

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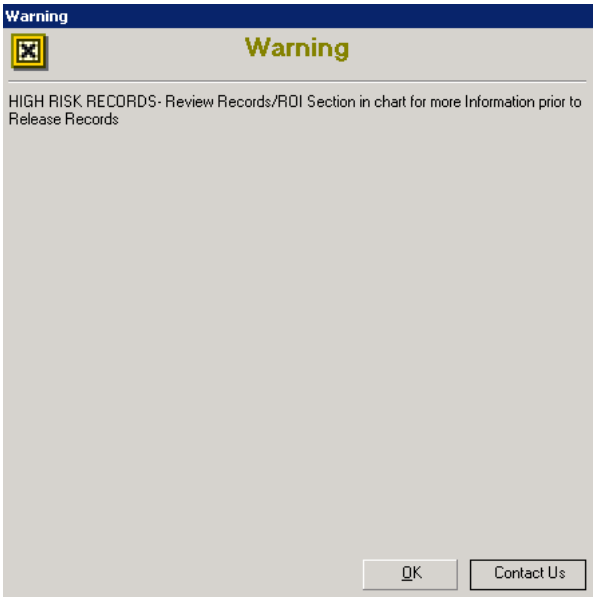
GST Number:	The hospital's GST number can be entered here. The Control File default can be set up to eliminate repetitive entry.
Invoice Number:	The invoice number.
Invoice Date:	The date the invoice was created. Dates are entered in "YYYY-MM-DD" format.
Invoice Time:	The time the invoice was created.
Invoice Total:	The total amount of the invoice including applicable taxes.
Amount Paid To Date:	The amount paid to date. Amounts recorded in the Payments multiform will accumulate in this field.
Total Amount Due:	The total amount due, as adjusted by payments received and recorded in the Payments multiform.
Due Date:	The date by which the Total Amount Due must be paid.

When complete click **Save** **(F7)**.
The information is saved and displays in the main grid.

High Risk Cases

To flag High Risk cases, enter a Y in the High Risk field in the Central Patient Index module. Once a chart number has been flagged as a High Risk case whenever the following warning displays when the chart number is used in the Release of Information Module (ROI):



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Deleting Release of Information Requests

Release of information requests may be deleted as required.

To delete release of information requests:

From Release of Information (R.O.I.) click
- or - Press F4.
The Release of Information (ROI) Search dialog displays.

Use the search fields in the Release of Information (ROI) Search to display Release of Information requests.

Double-click in the Release of Information (ROI) Search on the entry containing the release of information request to remove.
- or - Select the required entry and press **Enter**.
The Release of Information (R.O.I.) window displays the release of information for the selected entry.

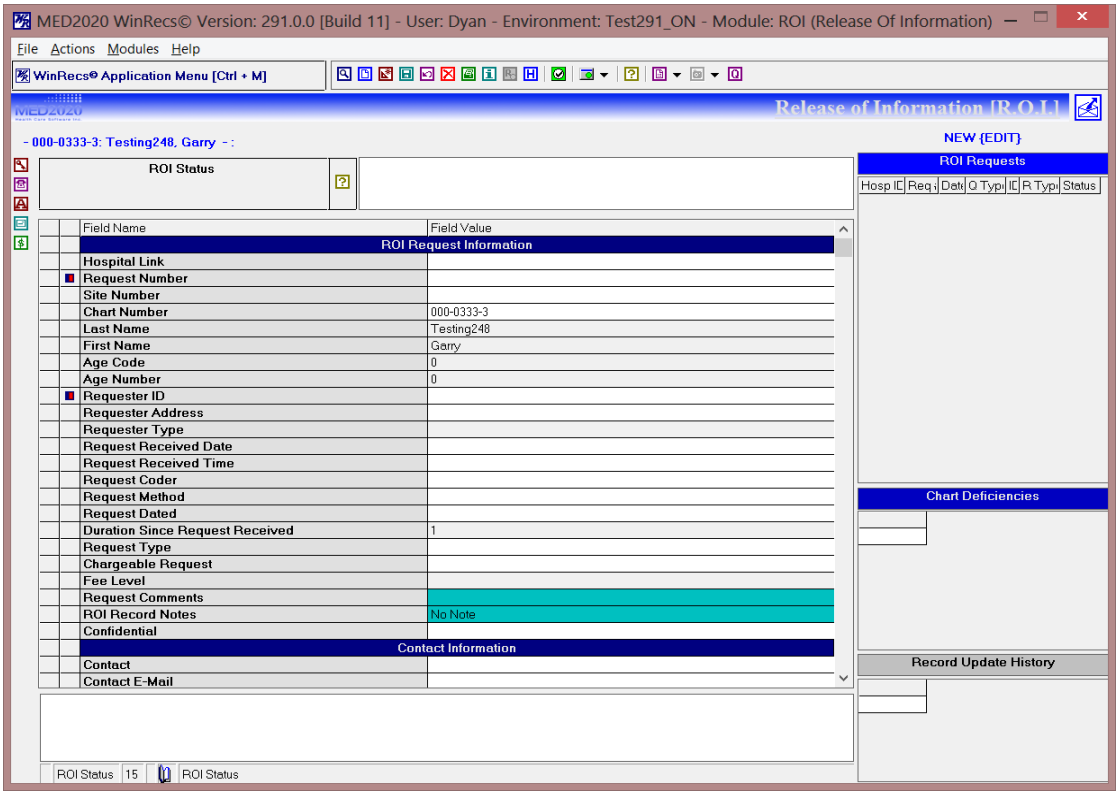

Figure 42

Ensure the correct release of information request displays.

Click

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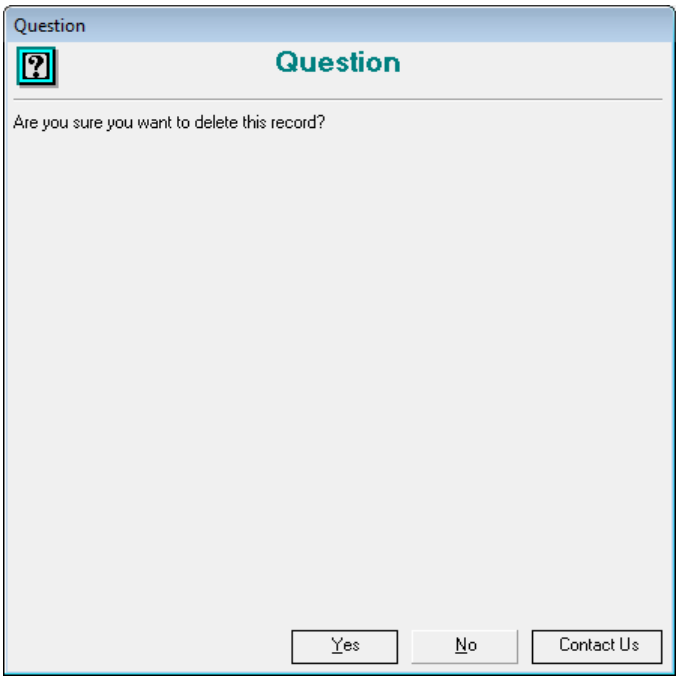
The Delete confirmation dialog displays.



Click **Yes**.
The selected Release of Information request is removed from the Release of Information (R.O.I.) module.

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Printing Reports

The following reports are available from the Release of Information (R.O.I.) module:

Chart Deficiency Report (Chart Deficiency.rpt): This report is accessed by double-clicking a deficiency in the Chart Deficiencies sidebar.

ROI Invoice.rpt:

ROI Outstanding Transactions.rpt:

ROI Productivity.rpt:

ROI Request Summary.rpt:

ROI Revenue Transactions.rpt:

ROI Standard ConsentTemplate.rpt:

Note: All reports are available for download from ftp://web.med2020.ca/WR2Reports/ROI/. All reports and all canned reports will be downloaded to the server on which you are working.

The following example shows how to print the ROI Request Summary report.

To run the ROI Request Summary report:

From the Request of Information (R.O.I.) module, click
The Select Reports window displays.

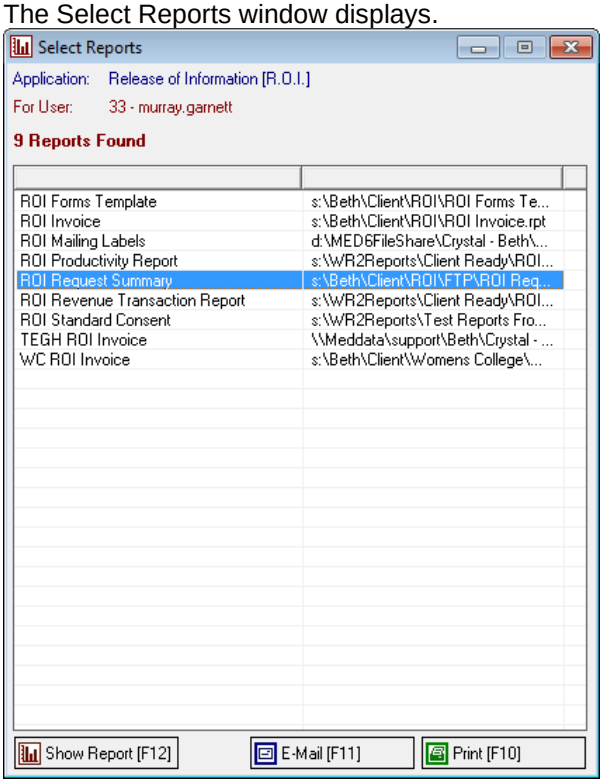

Figure 43

Select ROI Request Summary.

Click

Click **OK**.

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To print the report click

The ROI Request Summary report prints.

Release of Information Sidebars

The following sidebars are available.

ROI Requests

If the patient has had multiple Release of Information requests on their chart, the Release of Information sidebar displays previous requests. These other requests can be accessed by double-clicking on the request entry. The request record will automatically display in the Main Grid section.

Chart Deficiencies

The Chart Deficiencies sidebar displays deficiency information on the selected chart. Double-click a deficiency to display the Chart Deficiencies Report.

Record Update History

Displays an audit trail of all requests, and includes the WinRecs user ID of the person who made the change.

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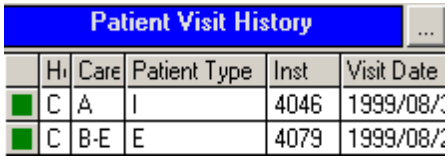
4.6 Abstracting Modules

Abstracting modules are used to store patient care data. The modules can be loaded directly from the *WinRecs Application Menu*, or launched from the Abstracting hot link button on the CPI toolbar.

Note: Function keys can perform different functions, depending on the active module or window.

Sidebar (Information Pane)

Patient Visit History



Double-click on a visit in the list to open the record.

CPI, Visit History, NACRS, CCR, CC, DAD, SDS, NRS, OMHRS

Field	Description
Flag	Red icon – hard errors Dark Red - hard error in which the record will not be saved Green - no errors Yellow - warnings Blue - The record has not been saved by a coder (from HL7 or Batch-In interface)
Hospital ID	Identifies the hospital CPI record is linked.
Care	Letter code for the care type, as defined in the Care Type lookup table. For AmCare (Care type starting with 'B', this is designated by the MIS code recorded on the record. A = Acute B = Ambulatory Care (undefined / incomplete) B-E = Emergency B-D = Day Surgery B–C = Clinic CC = Cancer Care Registration M-A = Mental Health – Admission M-D = Mental Health – Discharge M-S = Mental Health – Short Stay R-1 = Rehabilitation – Admission

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	R2 = Rehabilitation – Discharge R3 = Rehabilitation – Follow up N = Non- abstracted visit (outpatient)
Patient Type	'I' = Inpatient visit 'O' = Outpatient visit 'E' = Emergency visit
Institution	The unique identifier for the institution. If data is submitted to CIHI, this is issued by CIHI.
Visit Date	The date of the patient visit.

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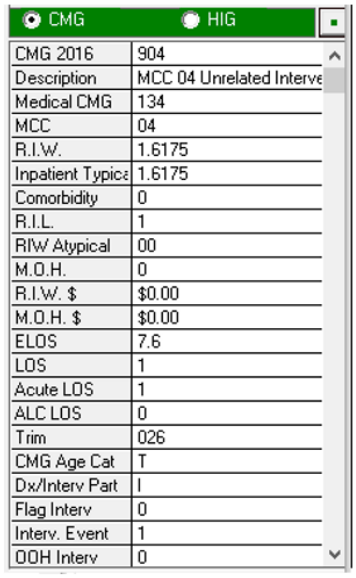
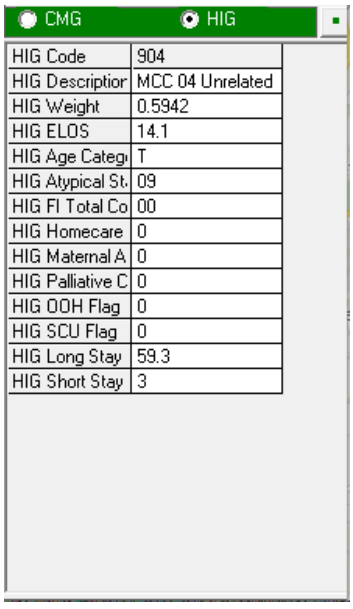
CMG Calculation



Click on this button to expand or compress the CMG Calculation sidebar

Users can select which grouper assignments they prefer to display in the visit by clicking on either the CMG or HIG Radio Button.

Double-click on any of the fields in this information pane to open the CMG Batch/optimizer. CCR, DAD (concurrent review and Discharge Abstract Database



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CMG (Year)	Case Mix Grouper value for the year displayed
Description	Description of the CMG group
MCC	Major Clinical Category code
Cpx	Complexity value (prior to 2007)
Qrtl	Acute Quartile value
MOH	Ministry of Health Resource Intensity Weighted value
RIW $	Resource Intensity Weight (in dollars)
MOH $	Ministry of Health value (in dollars)
ELOS	Estimated Length of Stay
LOS	Length of Stay (Total Days stay)
Acute LOS	Acute Length of Stay (Total LOS minus ALC LOS)
ALC LOS	Alternate Level of Care Length of Stay
Trim	The LOS point in time where the case becomes an outlier should the LOS exceed this # of days.
CMG Age Cat	As outlined by CIHI for CMG+
Diagnosis 2	2007 - Diagnosis in second occurrence is type 6 affects CMG Assignment.
Interv. Dx/Interv Part	2007 - Cases with significant interventions that are considered Appropriate to each MCC are assigned to the intervention partitioning (CMG + Tool Kit, page 36)
Gest. Age	2007 – Recorded in Reproductive Care field
Admit Weight	2007 – Recorded for Newborn
Comorbidity	Comorbidity Level (2007)
Flag Interv.	CMG + Flagged Intervention (2007 – Not used for CMG assignment)
OOH Interv.	Out of Hospital Intervention
R.I.L.	Resource Intensity Level (2007 - Will replace Plx in many CIHI reports for 2007
Interv Used	The CCI code that was used for CMG assignment to the intervention partition If there is more than one related intervention, the grouper loops through and uses the highest-ranked intervention
FI (Intervs)	List of 16 Flagged Intervention categories used in CMG+ methodology
Inpatient RI total	the total number of flagged interventions per case up to a maximum value of 16
Comorbidity Total Fact.	The total multiplicative effect on cost/LOS of the combinations of comorbidities appearing in a case
Intev Episode	Based on Intervention date (trips to OR)
Interv Attributes	Not used for CMG+
Date Batch Grouped	Displays date/time the visit was batch grouped

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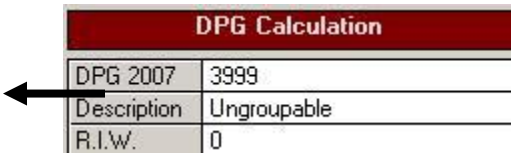
DPG Calculation

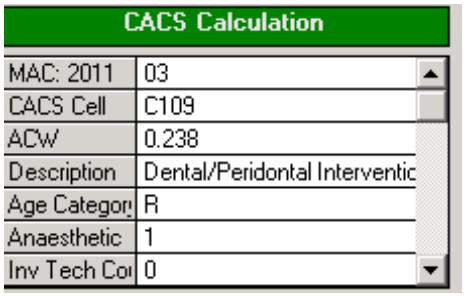
SDS (Same Day Surgery – Only Valid to 2011/03/31))



Double-click on any of the fields in this information pane to open the DPG Batch/Optimizer.

DPG	Day Procedure Group
Description	Description of the Day Procedure Group assigned.
RIW	Resource Intensity Weight for the DPG

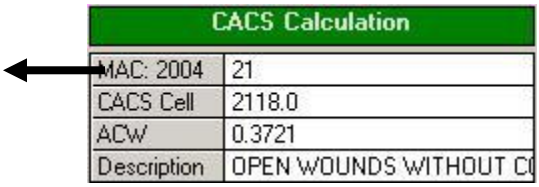
Acute CACS DAD (Same Day Surgery – Effective 2011/04/01)



Double-click on any of the fields in this information pane to open the CACS Batch/Optimizer.

MAC	Number representing Major Ambulatory Cluster
CACS Cell	Comprehensive Ambulatory Classification System Cell Code Value
ACW	Comprehensive Ambulatory Classification System Resource Intensity WT
Description	Description of CACS Group
Age CategoryAcute	CACS Age Grouping
Inv Tech Count	A distinct count of the number of investigative technology categories found on each abstract

CACS Calculation



Double-click on any of the fields in this information pane to open the CACS Batch/Optimizer.
NACRS (National Ambulatory Care Reporting System)

MAC	Number representing Major Ambulatory Cluster
CACS Cell	Comprehensive Ambulatory Classification System Cell Code Value
ACW	Comprehensive Ambulatory Classification System Resource Intensity

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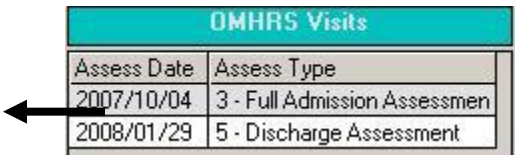
Multiple Contact Information

Only applies to NACRS abstracts prior to April 1, 2006. Entries listed are the multiple care providers that were consulted during the visit. Registrations after April 1, 2006 will only have one entry.

Double-click on the contact information listed to show the contact's abstract information.

Sequence	Unique ID used to patient encounters/visits
MIS Code	The MIS code assigned for the visit

OMHRS Visits



Double-click on the contact information listed to show the assessment information

Assessment Date	The date of the OMHRS assessment.
Assessment Type	Type and Description of the OMHRS assessment.

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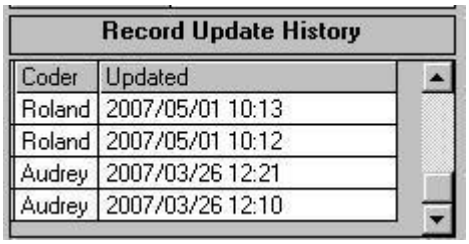
Record Update History

Displays the coders who have saved the record.

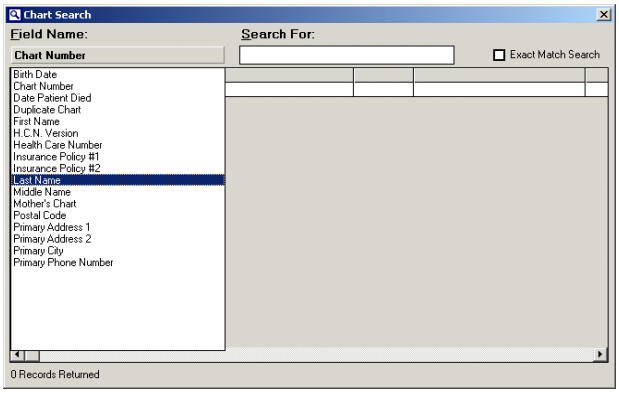


Searching for a Record

Generally speaking, facilities that have a batch or HL7 (real-time) interface transferring records into the WinRecs program will use **Find** **(F4)** to locate records they need to code and abstract.

A facility that does not have an interface to transfer the patient visit information into WinRecs, will generally use **New** **(F5)** to create a new abstract. In this case, the chart search method is Chart Number.

Field Search (F3) displays different fields to search for.



To change the search field, press **F3** and select the new field name from the list. WinRecs will retain this search the next time the search window is opened.

Chart Number search allows an *Exact Match Search*. Check the box to search for the exact chart number entered.

Type the search criteria in the *Data Entry Box P*ress **ENTER**.

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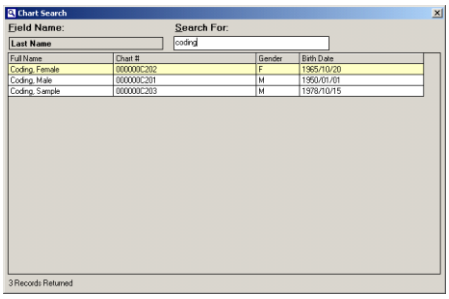

A list of records matching the data entered is displayed. The currently selected record is highlighted in yellow.

To open one of the records in the list, double-click on an entry, or navigate to it using the arrow keys and press **ENTER**.

When no records are found, the data entry box will turn pink.

Change the search criteria and rerun the search, or press **ESC** to close the search window and return to the main module screen.

Creating a New Record

To create a new record, press **New** **(F5)**

If the Chart Number entered does not exist in the CPI a message box appears “Chart cannot be found. Do you wish to create a new one?”

Answer ‘No’ to return to the ‘Select a Chart’ search window.

Answer ‘Yes” to create a new CPI record. Or select the **F5** button in the ‘Select a Chart’ window to create a new chart. The program will go to the CPI module for demographic data entry. At this point, all that is needed is the Chart Number. Press **Save** **(F7)** to return to the abstracting module.

NEW (EDIT) will be displayed on the right, under the module banner.

When creating a new record, the program will automatically go to the first empty data field.

Note: If your facility is using the *Auto-Generate Chart Number* option, the chart number will be provided for you (See Hospital Profile for more information).

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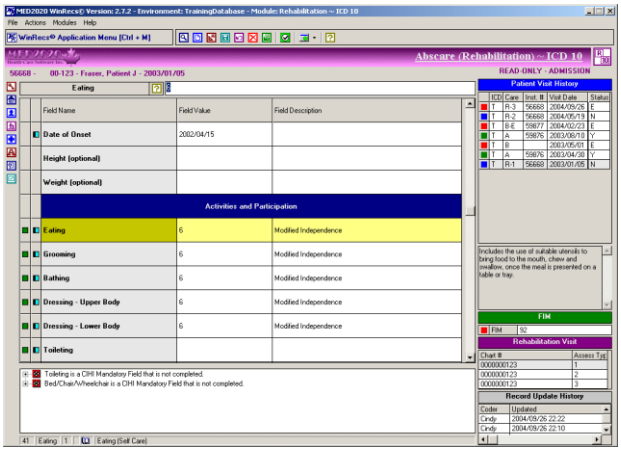
Completing a Record



Typically, a user will navigate through a record from top to bottom, completing the fields as required.

When a field has focus, it is highlighted and the field name is displayed above the main grid.

To facilitate data entry data can be typed without having to put the focus on a text box. Pressing **ENTER** will advance the focus to the next available field (**ALT+ENTER** moves the focus to the previous available field).

To enter the current date or time, when the field is highlighted, press the Space Bar, then **ENTER**.

Note: Fields that have been disabled are grayed out and are skipped when navigating through the main grid.

When a book icon is displayed in the status bar, the current field has an associated lookup table. Press **F2** to view the available values.

Warning and error messages for any fields requiring attention will be displayed below the main grid in the errors/warning messages area.

Note: Even though records can be saved with hard (red) errors, they cannot be submitted to CIHI until the errors have been cleared.

Note: All WinRecs modules are customized in the System Maintenance modules.

When working with modules and records, some fields might not be displayed or might be disabled. Refer to the System Maintenance \Control File for details.

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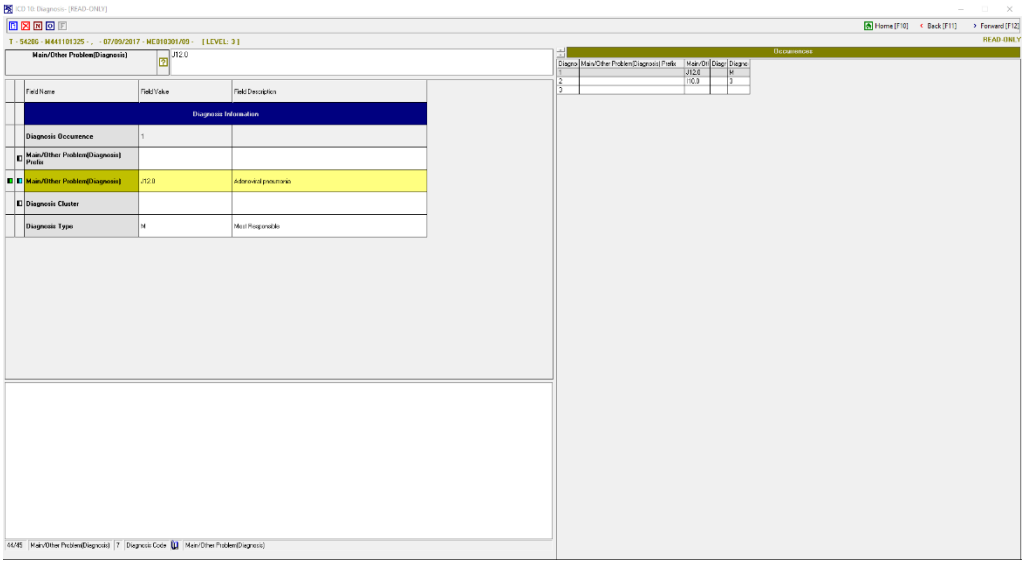
Multiforms



Multiforms are embedded in a module's main grid (for example, CPI & Abstracting modules) when more than one entry is required per record. For example, multiple Patient Services, Providers, Diagnoses, Interventions, Special Care Units, and Project Information are often required for a given chart or abstract.

The multiform is divided into two sections. The left displays a data entry form, similar to the main grid. Information areas displaying information such as the other multiform entries attached to the current record are displayed on the right.

Double-click on an entry to display its contents. Navigating a multiform is similar to that of the main grid. An overview of the available functions is provided below:

Button	Description	Keyboard
New [F5]	Create a new occurrence for data entry. An alternate method is to continue pressing **ENTER** until the cursor goes to the next occurrence	**F5**
Delete [F9]	Deletes the selected occurrence.	**F9**
Home [F10]	Returns to the beginning of the abstract or record in the main grid.	**F10**
Back [F11]	Returns to the previous field.	**F11**
Forward [F12]	Move forward to the next field or multiform in the grid.	**F12**

Note: When creating or modifying a multiform entry, changes are automatically saved.

Once all data has been entered in the multiform screens, return to the main grid by selecting F10 or F12.

Save (F7)

The new record will be stored in the database.

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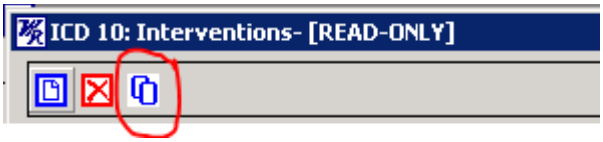
Note: Remember that certain fields are flagged as mandatory, and certain fields require specifically formatted values. If you encounter difficulties saving a record, check to see if any warnings and/or errors are displayed at the bottom of the screen

Copy Function – Intervention Multiform

This function gives you the ability to copy the intervention information from the previous occurrence Inpatient and Amcare records.

- Fill in occurrence 1 with required information
- With occurrence 2 open the copy function will enable



- Pressing this function will populate all fields except the Intervention Code.
- If you need to make any changes you can do this manually.
- If you copy on occurrence 3 it will copy all fields from occurrence 2.

Saving Records

A record can only be saved in **EDIT** or **NEW** mode.

Press **Edit** **(F6)** switch to edit mode. If a user saves a READ-ONLY record, the following message is displayed:

'You are not currently in edit mode. Would you like to save this record anyway?'
'Yes' saves the abstract.
'*No'* returns to the same abstract without saving.

Use **F11/Verify** to Verify the record, then hit **Edit** and **Save**, that way the record is saved right away without any errors.

Note: A record will revert to READ-ONLY after a save.

HINT: Data can be entered in READ-ONLY mode. One technique commonly used when saving a complete abstract is to press F6 F7 one right after another. This will bypass the message requiring a Yes/No answer.

Hot-Linking Between Modules

To hot-link to other WinRecs modules select either the Chart Maintenance or Abstracting Hot Link from the icon bar. Hot-linking generates a NEW record in the receiving module. The drop-down arrow is used to select a different module.

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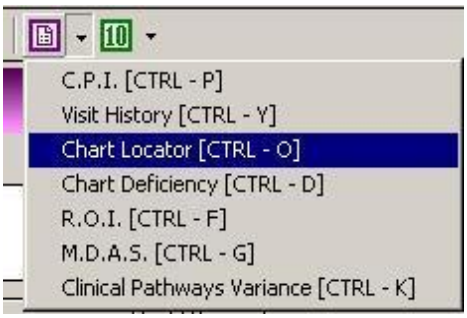

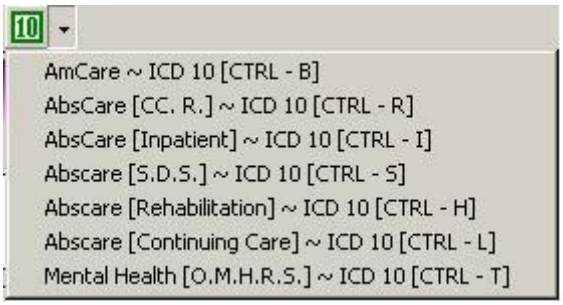

Note: **Only modules licensed by your institution will be available.**

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Locating an Existing Abstract

Select an abstracting module from the *WinRecs Application Menu\Abstracting*, or from the *Modules* menu. For example: *Abstracting ICD 10-> Inpatient [DAD]*.

Find **(F4)**

To change the fields to be used in the search, click in the text box next to the field or press **F3**

Check/uncheck the *Exact Match Search* check box as required.

Type the search text Data Entry Box and press **ENTER**.

If records are displayed, there a three ways to select a record:

Double-click on the record

Select the record with one click and hit **ENTER**

Using the up and down arrows, highlight the record and hit **ENTER**

Note: There can be up to 4 search fields. The number of search fields used can be customized. Click Options in the Abstract Search window to view the options.

Hint: To search for abstracts for an entire month, type 00 for the day (DD).

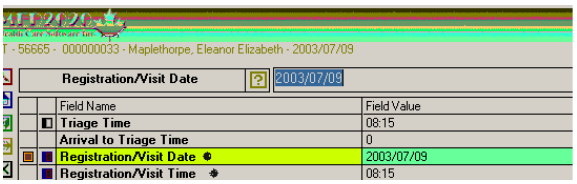
Cloning Abstracts

Cloning an abstract accelerates the data entry process when working with a patient with many visits for the same reason. For example, the information for a patient receiving regular chemotherapy or radiation treatment is the same for the majority of the abstract.

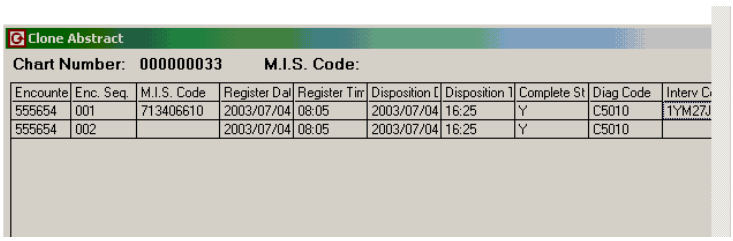
In AmCare, Inpatient or Same-Day Surgery modules, the Clone button is in the Autocoding icon on the toolbar

Select the abstract. This may be an abstract opened by an interface, or manually enter the abstract.

Enter data in system required fields:
Registration/Visit Date and *Registration/Visit Time*.



Click the *Clone* selection.



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From the list, select the visit to be used for the cloned abstract.

For AmCare only records matching the MIS code, or blank for ER records will display. If the MIS code is 7134025, when viewing records to clone from, only matching MIS records will be displayed.

WinRecs will copy data from the selected abstract to the new abstract. Date and Time fields will not be populated. The remainder of fields that are blank will be populated.

Review the record and change any data that requires updating.

Note: Incomplete fields that require data entry will be displayed in the warning/errors message box.

Profile Abstract

Profile is used to create generic abstracts in AmCare, Inpatient, Same-Day Surgery or Mental Health modules. Profiles are used for many patients with the same type of admission/procedure/diagnosis etc.

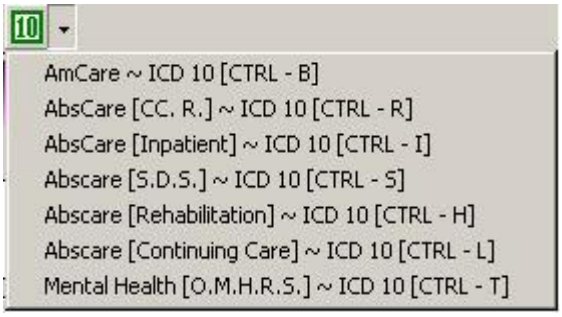
To Create a Profile

Go to the CPI module

New (F5)

Create a new chart in CPI, **maximum 10 characters only using alpha characters (A-Z, a-z)**
Example: PRDialysis or PRNNewborn or PRTURPs

Save (F7)
Using the Abstracting Hot Link icon, go to the module that the Profile is used.



Note: An error indicating the chart number is not a valid number will display. This is expected behavior.

Create an abstract in the module of your choice using this alpha chart number. Complete all fields that would be the same for all abstracts. *Institution Number* must be left blank.

- *Institution Number* must be left blank.
- *Birthdate* – if a diagnosis code has an age range **not** 0 to 130, a birthdate needs to be entered for the diagnosis codes show in Diagnosis multiform. For example: Dx Code 070.001 has an age range of 10 to 65, the birthdate needs to be in that age range. If no birthdate is populated, then the codes will not appear in the Diagnosis multiform.

Save (F7)

The record will be saved in the CPI and Abstracting module.

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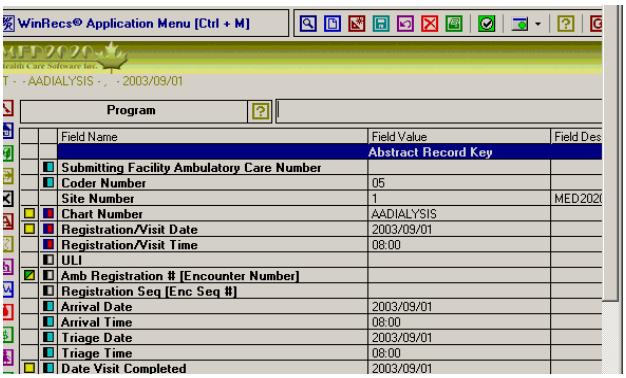
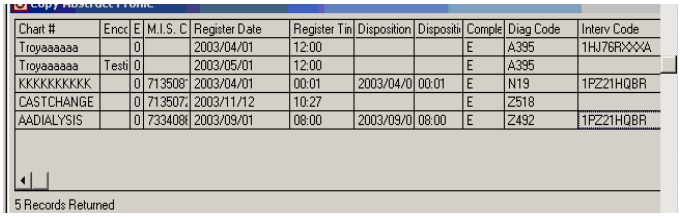


Load the interfaced abstract, or create a new abstract with the registration date and time. Default values will be applied.

Click the *Abstract Auto Coding* drop-down on the toolbar and select *Copy Abstract Profile*.

A new window showing all profiles wil be displayed. Select the profile. Review the record and Complete the remaining required fields, or update fields as required.



Note: You cannot view or load profiles by searching in the abstracting module. This is to prevent abstracts from interfering with abstract record counts. Profiles can be accessed using Patient Visit History from CPI.

Modifying Abstract Profiles

Note: At the beginning of every fiscal year existing Abstract Profiles should be reviewed to ensure the data in the profile is still valid such as the diagnosis code/s, MIS code/s, interventions, etc.

Go to CPI and search Find (F4) by Abstract Profile Chart Number –select the profile:

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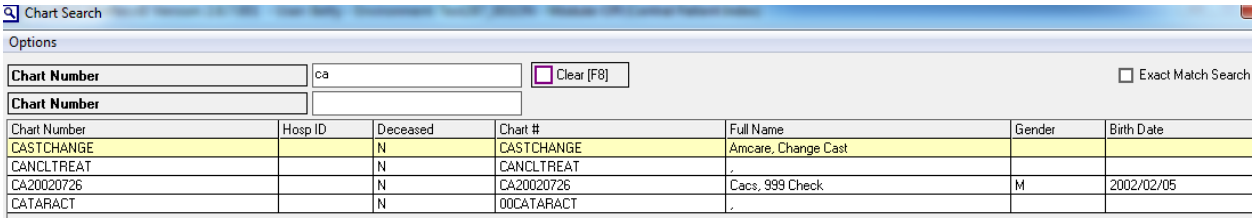
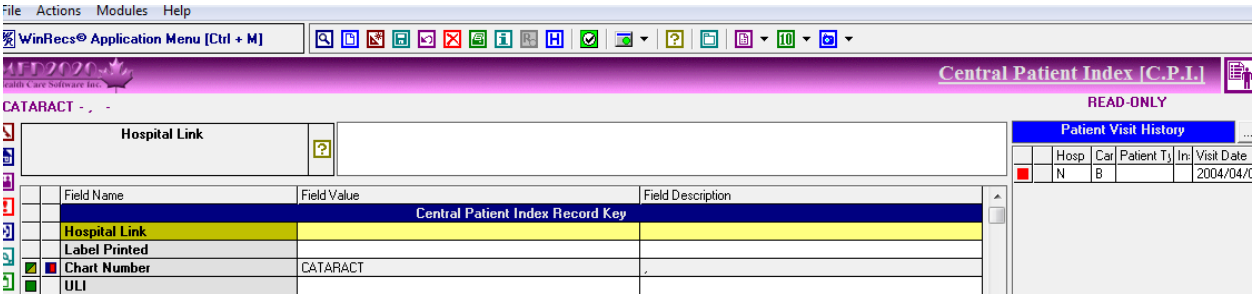


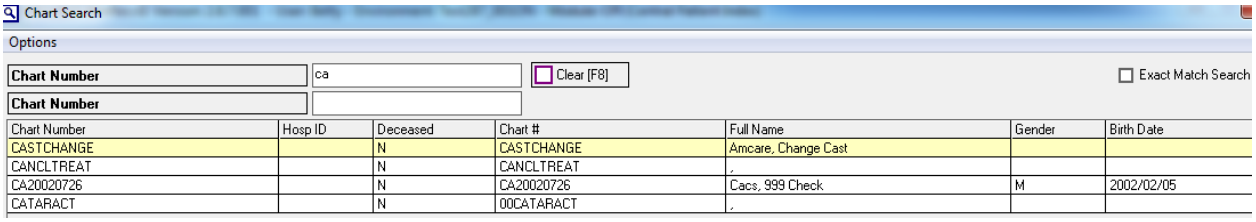
Pull up the Abstract Profile by clicking on Patient Visit history:



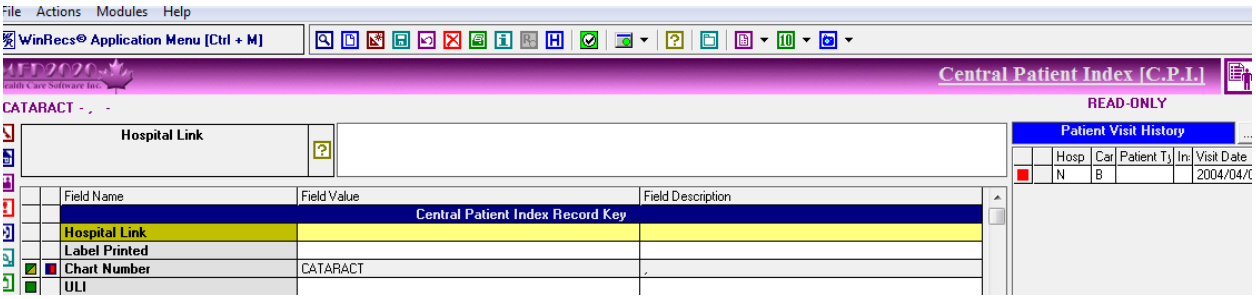
Modify the Profile to ensure all codes (diagnoses, intervention, MIS, etc) are still valid for the current fiscal year. Save any changes using Edit and Save (F6 & F7)

Deleting Abstract Profiles

Go to CPI and search Find (F4) by Abstract Profile Chart Number –select the profile:



Pull up the Abstract Profile by clicking on Patient Visit history:



Click on Delete or (F9)

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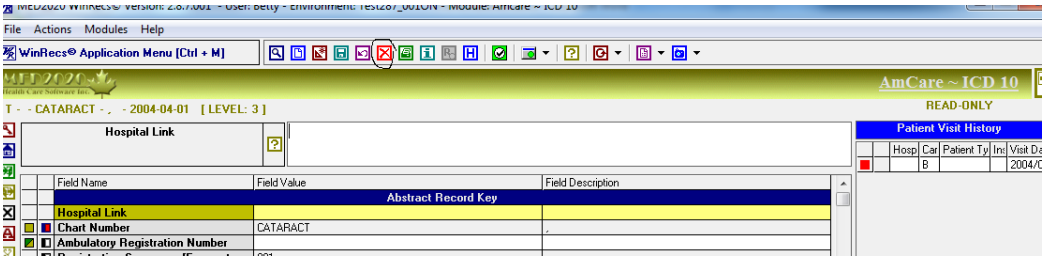
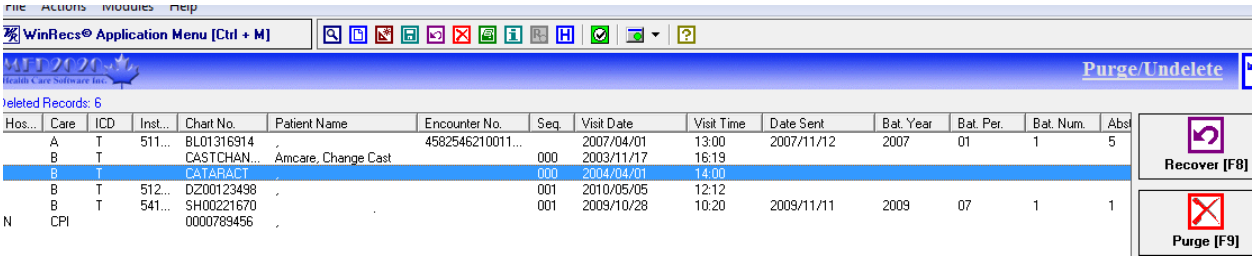


Go to Utilities > Purge/Undelete Module

Highlight the Purged Profile by highlighting and click on purge button

(F9):



Note: The Abstract Profile Chart Number can only be deleted and purged from CPI when there are no profiles attached to it in the patient visit history.

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Concurrent Review

Overview

The Concurrent Review Module (CCR) is used to abstract patient data during a patient's hospitalization.

This module can be used in conjunction with the CMG™ grouping methodology to determine expected lengths of stay (ELOS) and predict expected dates of discharge. Data entered in the Concurrent Review Module can be used in the Report Generator to prepare statistical reports on current inpatients. The more data collected during hospitalization, the more complete the abstract will be on discharge.

Note: System mandatory fields for Concurrent Review differ from Inpatient (D.A.D.). *Chart Number*, *Admit Date*, *Admit Time* and *Institution Number* are mandatory fields.

Data entry in Concurrent Review fields is the same as other abstracting modules.

Once the *Discharge Date* field is populated, the chart will automatically move from Concurrent Review to the appropriate AbsCare module.

Reporting LOS in Concurrent Review

The LOS displayed in the abstract grid is calculated after a save or verify function. Therefore, if you require a report that shows the LOS for CCR Abstracts, do not use the LOS from the Abstracting view. CCR does not have a discharge date and does not automatically update the LOS. For reporting purposes in Crystal Reports, use a custom formula to calculate the LOS, calculated against the Admit Date and Current Date.

A sample formula is provided below:

If {I10_Abstracting.AdmissionDate} = CurrentDate then 1 else DateDiff ('d',{I10_Abstracting.AdmissionDate} , CurrentDate)

Develop the formula. For example: LOS Calculation.

Then use this formula in your report in place of the LOS field in the Abstracting View.

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Abstracting ICD10 –Abstracting DAD\SDS\NACRS

Create a **New** **(F5) or** select **Find** **(F4)** a patient in the system.

Completing the Abstract

As you move through the abstract, fields can be entered with data. The field you are currently viewing is highlighted in yellow and the field name displays at the top of the window, next to the data entry box.

All data entry is done in the Data Entry box, once the information is 'entered'; the information will display in the field on the main grid.

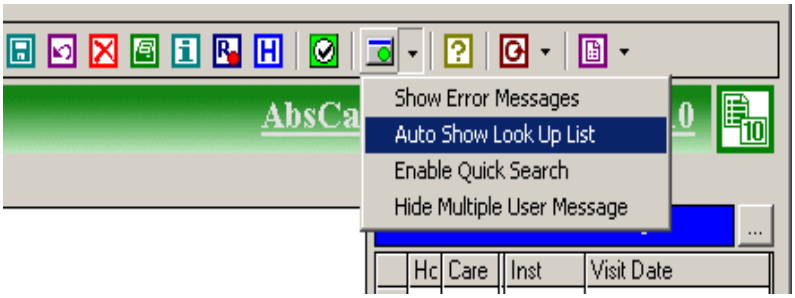
An error message will be displayed at the bottom of the window in the Message List box for fields that are mandatory and not completed.

An abstract can be saved with mandatory fields missing. It cannot be submitted though. The errors will be displayed again when that record is accessed later.

Look Up Fields

F2 Look-Up displays data options for fields that have a look up table (blue book open).

"Auto Show Look Up List" feature automatically displays the look up table associated with the field. This is a feature can be turned off and on using the selection indicated below.



Please refer to Basic WinRecs Functionality for details on the **Show Error Messages** icon.

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Saving the Abstract

Save **(F7)** to save the record.
If it is the first time the record has been saved there will be no other messages.

If the record was previously saved, the program will require it to be in **EDIT** mode from **READ ONLY.**
Select **Edit** (**F6),** and then **Save** **(F7).**

Any changes made in **READ ONLY** mode will not be retained until the record is saved. If you select **Save** **(F7)** while in **READ ONLY**, a message displays: **"You are not currently in edit mode. Would you like to save this record anyway?"** Select 'Yes' to save the abstract. Select 'No' to return to the abstract without saving it. This allows the opportunity to not save any changes made on the record.

To save the abstract at any point in the abstracting process, select **F6** (edit) then **F7** (save). These 2 functions keys are beside each other for ease of use.

When the save is processed, the program changes back to **READ ONLY** mode.

If 'Show Complete…' in User Profile is set to 'Y' for this abstracting module, and there are no hard (red) errors for the record, a message will display "Is the abstract complete?" The response of Y/N to this question will be saved in the "Is Abstract Completed" field on the abstract. See **User's Profile** section for more information on setting this field.

Patient Visit History

	H	Care	Inst	Visit Date
		B-E	54679	2007/12/17
		B		2007/12/05
		B		2007/11/08
		B-E	54679	2007/05/30
		A	54675	2007/05/30

If the colour in the Patient Visit History is yellow, there are warning messages on the abstract that may need to be reviewed. Abstracts can be submitted to CIHI with warnings.

If the colour is red, there are hard errors on the abstract that need to be corrected. If the errors are not corrected, the abstract cannot be submitted to CIHI.

Searching for an Abstract

In the abstracting module the record has been saved:

Find **(F4)**

In the Abstract Search screen, find the record by using one of the search options. For details on searching, see **Basic WinRecs Functionality** section.

Select the record. All data entered previously will display on the grid.

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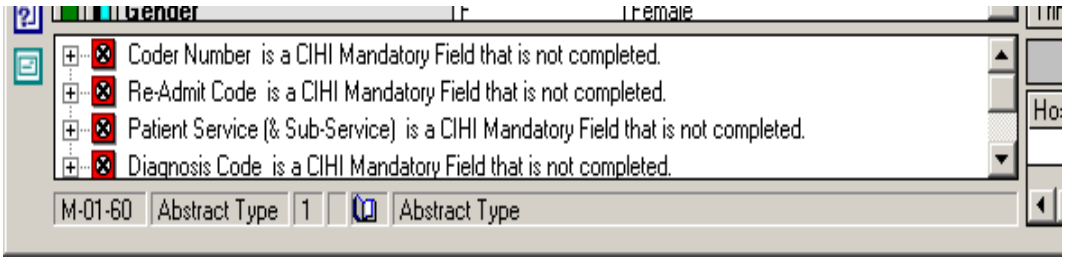
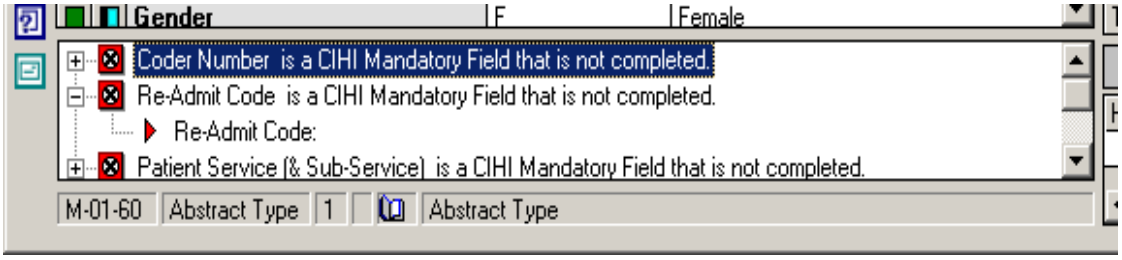
Correcting Errors

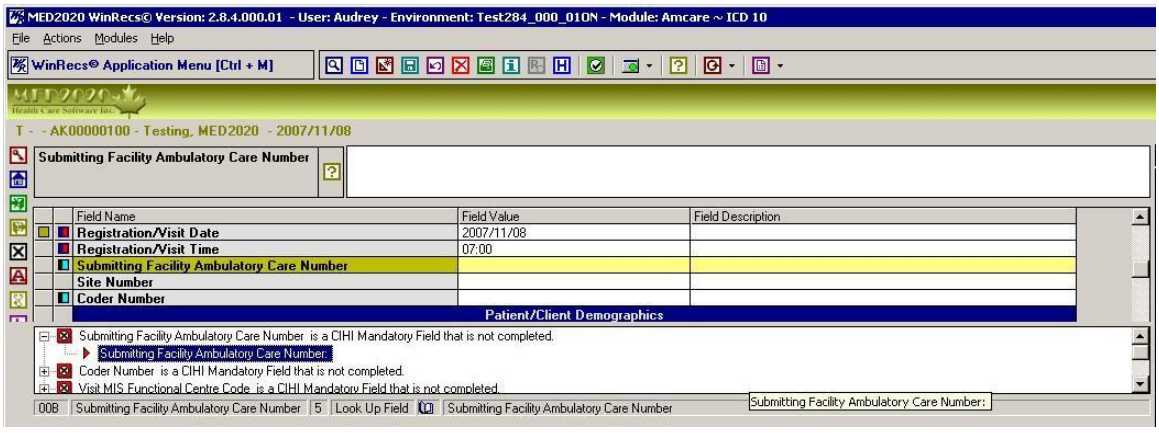
Errors are displayed in the Error Message Box, below the grid. As data is entered that corrects the error the error automatically disappears.



To review a field with an error, open up the error message by clicking the plus (+) sign. This will display the field name and field value (if recorded) that is causing the error.



Double click on the field to select and go to the field in the grid. Complete the data and hit ENTER to move to the next field. When accessing fields from the Error Message Box, the cursor will go back to the top of the main grid, not to the next field in the grid.



Verify (F11) to validate the data with all edits applicable for the module. Verifying the data does not update the 'Record Update History' or any fields in the Record Information section on the grid.

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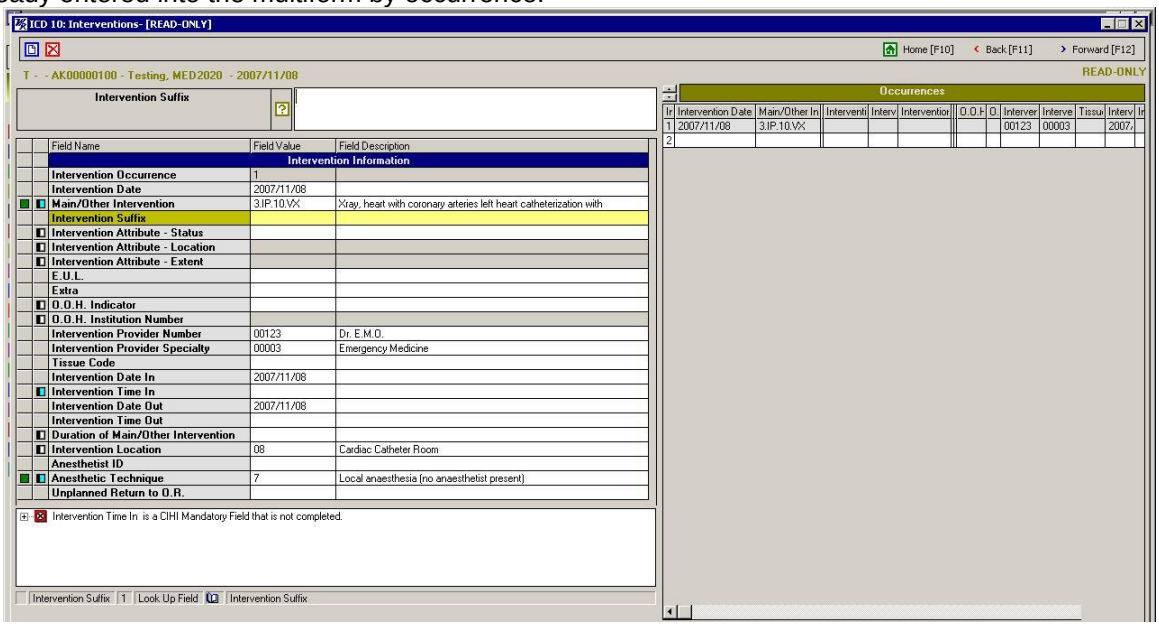
Multiforms

The Multiple Form is used to collect data in sections that may require more than one entry per field. This form has 2 main sections. The left side is the data entry section. The right-side displays information already entered into the multiform by occurrence.



There are specific function keys available to process a multiform. They are:

New **(F5) -** Creates a new occurrence.
As soon as you finish one occurrence press **Enter** and the system will automatically move to the next occurrence.

Delete **(F9) -** This button will delete the occurrence you have selected. The system will display a message “Are you sure you want to delete this occurrence?” to validate the deletion.

Home/Back/Forward move the cursor out of the Multiform.

Home – Returns to the first active field in the Main Grid.
Back - Goes back one field on the grid. This may be another multiform.
Forward – Goes forward to the next field on the grid.. This may be another mutiform.

DAD CJRR

To enable the DAD CJRR Form:

1) In the DAD **Institution Profile** enter a value of Y in the “Submit CJRR in DAD/SDS Submission” field.

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Submit CJRR in DAD/SDS Submission	Y	Yes

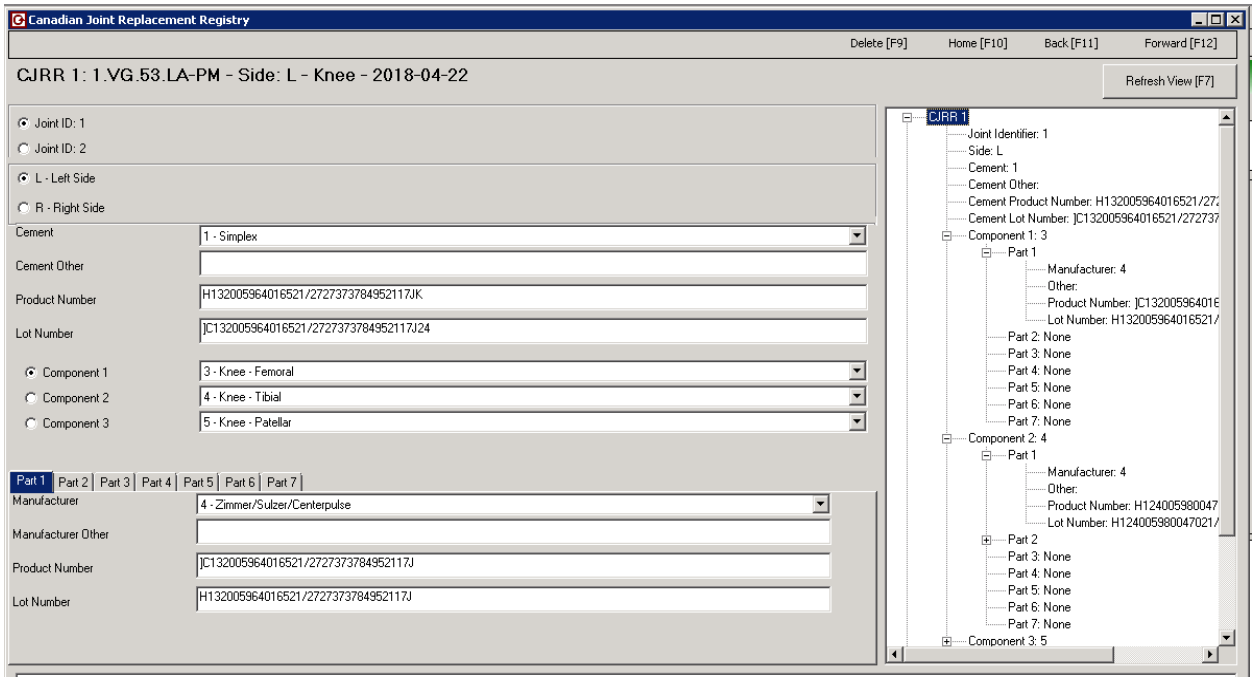
2) Element 11-22 Intervention Joint Identifier (intervention multi-form) must have a value of 1 or 2 to enable the CJRR form. Click forward(F12) and the CJRR Form will open.

Intervention Joint Identifier	1	1

Note: Values 1 and 2 cannot be entered more than once and if recorded, the first entry must be 1 in the Intervention Joint Identifier field (occurrences 1 – 20)

In the DAD CJRR Form Joint ID -1 and Joint ID-2 correspond with the Intervention Joint ID. Joint ID can be repeated for Bilateral procedures. (intervention attribute = B).

Product and Lot Number fields should be completed as per CIHI Guidelines:



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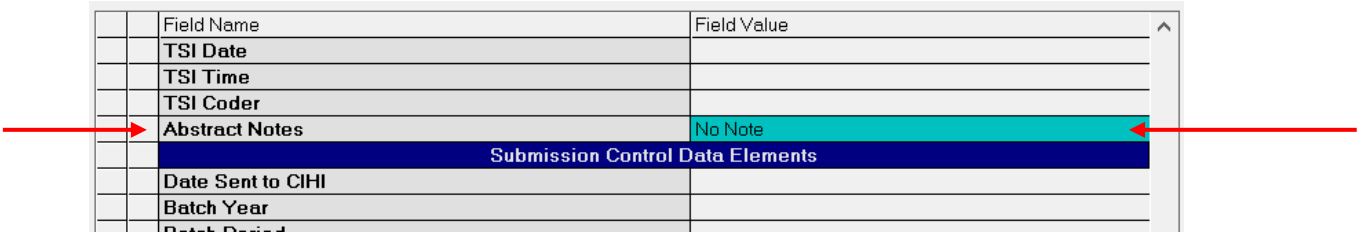
Adding Notes in the Abstract

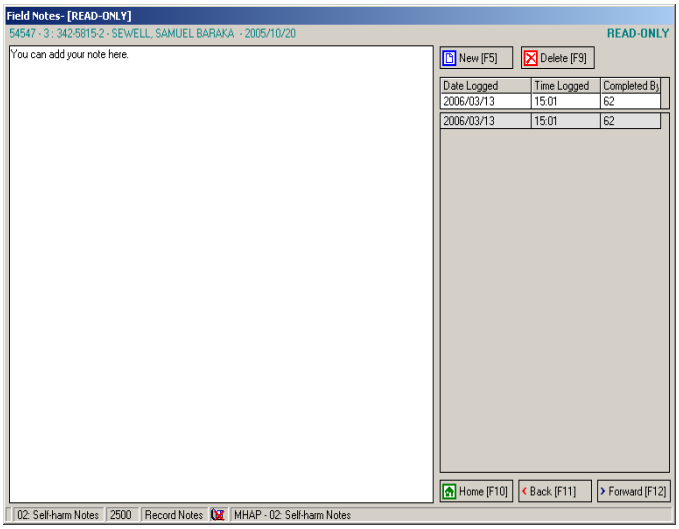
To be able to add a note, select the Abstract Notes field. These are found on the main grid.



The Abstract Notes field functions like a multiform. You can add and delete one or more occurrences of abstract notes.

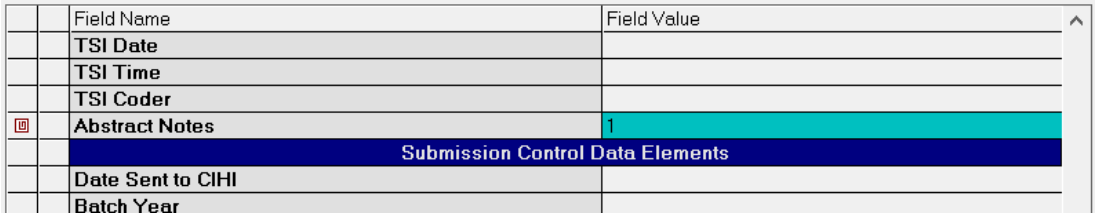
To create a note, click on the abstract notes field. This will take you to a Notes multiform.

New **(F5)**
This will open up the text field on the left hand side (turns it from grey to white).



Make sure the cursor is in the text box and type your note here. Note that as soon as you hit F5/New button, it will automatically create a new occurrence. The list of notes added as occurrences will display on the right-hand side. To view any of the notes, double click on the occurrence. The note will automatically be saved as soon as you leave the form.

When a note has been added, the Abstract Notes field will be updated to reflect this, showing a count of the number of notes for this abstract.



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Printing Reports

Reports set up in the Report Selection list for the module can be accessed. To print a DAD dedicated report, the program must be in the module the report was set up from.

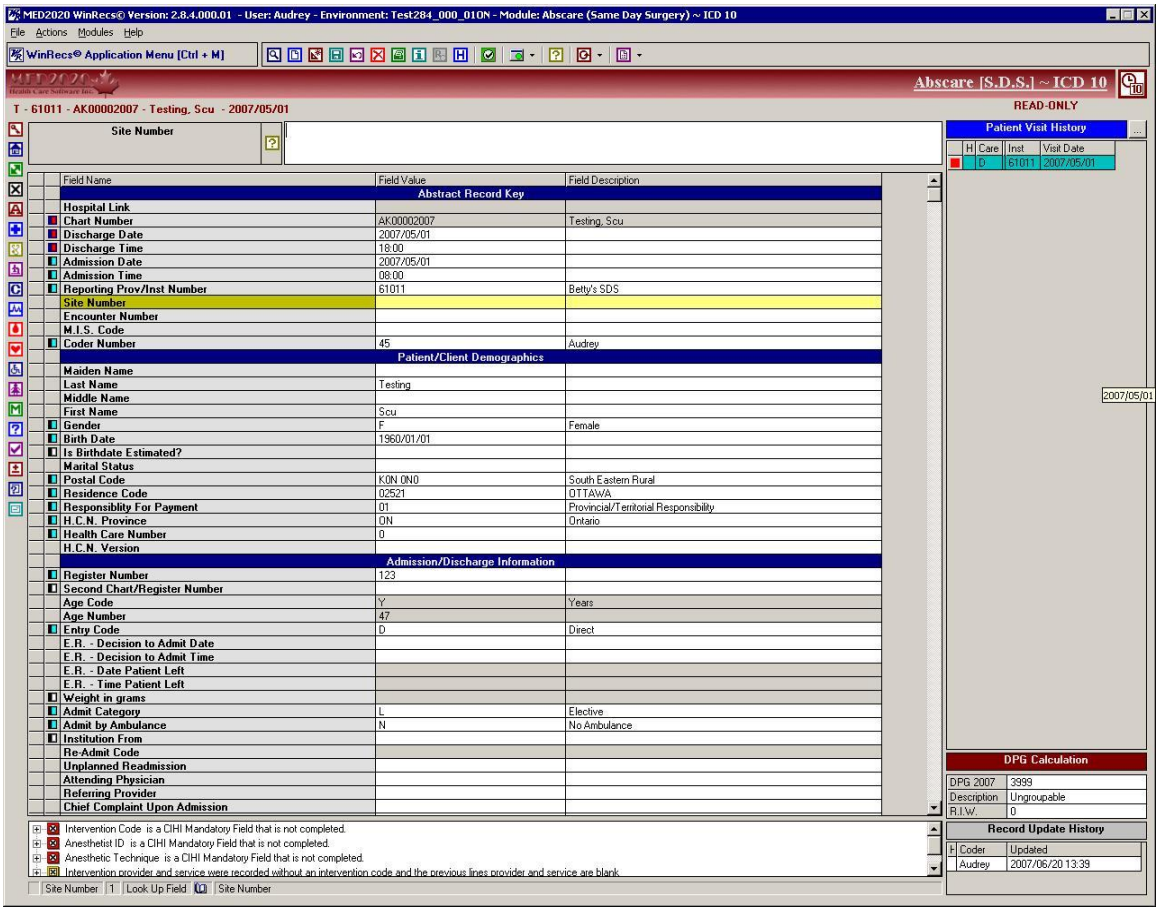
Press **(F10) Select** the report you would like to run.

Press

Complete any parameters and press **OK.**

For complete details, see Running Reports through WinRecs section.

Abstracting ICD10 – SDS



Same Day Surgery Abstracting is completed in a separate module for all clients other than Ontario from Fiscal 2003. Same Day Surgery for Ontario Clients from Fiscal 2003 is completed in the AmCare (NACRS) module.

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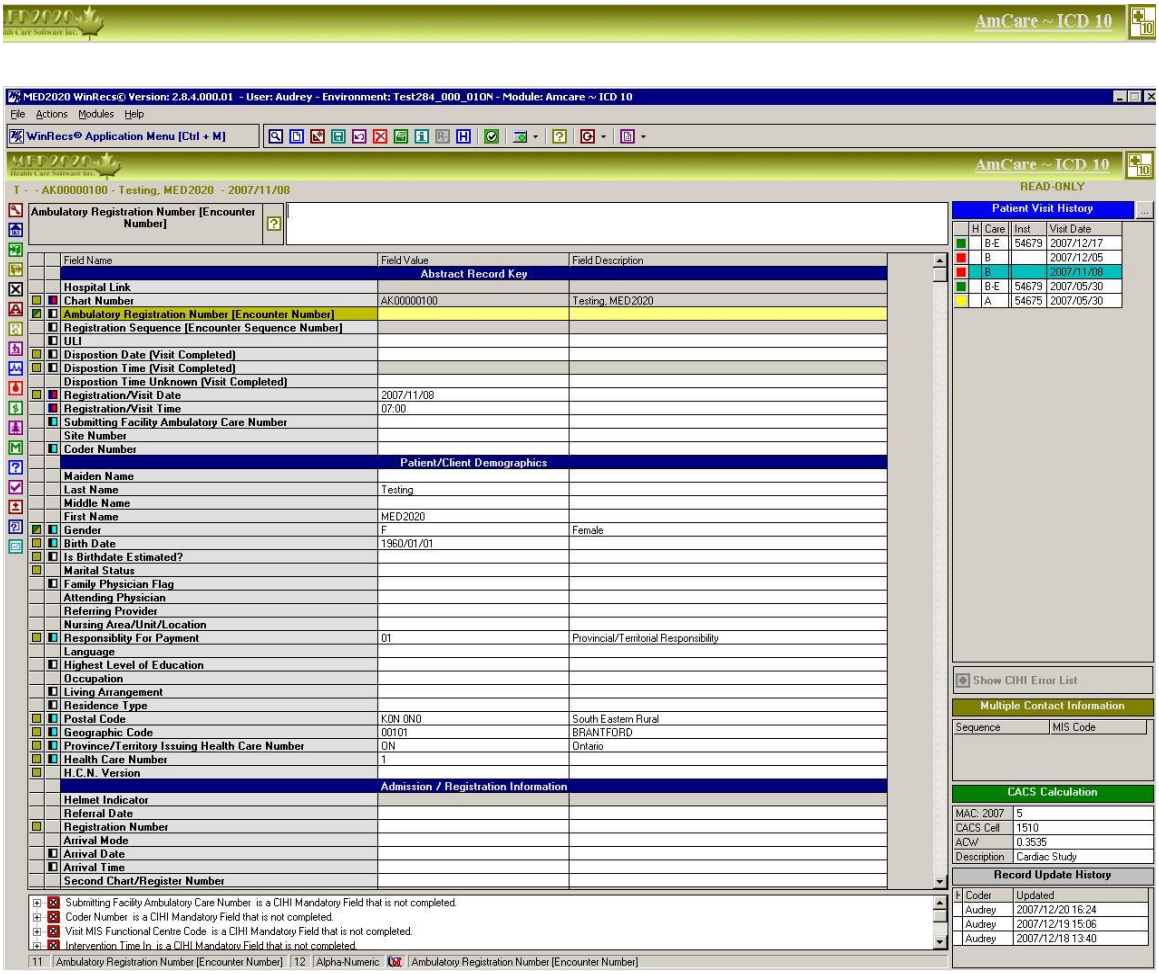
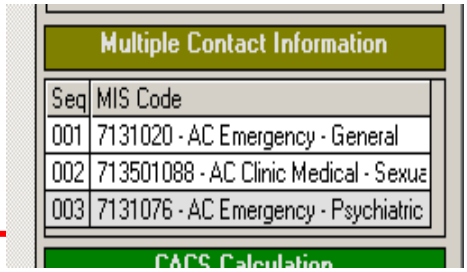
To abstract a SDS case, follow instructions in ICD-10 Abstracting section. Refer to the current CIHI SDS manual for field requirements and details.

Abstracting ICD10 – NACRS



Multiple Contact Information Box



For all visits prior to Fiscal 2006 displays multiple contacts attached to the visit. To display a multiple contact on the grid, double click on the visit in the Multiple Contact Information Sidebar.

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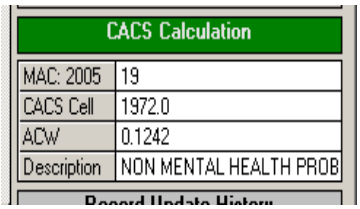
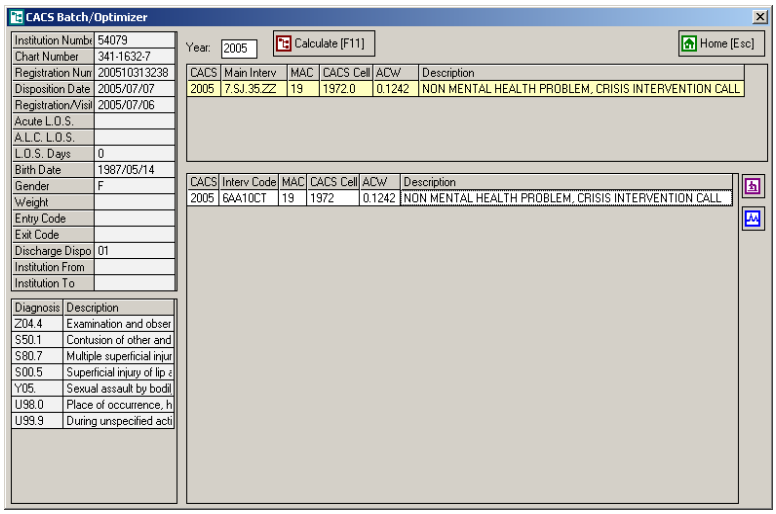
CACS Calculations Box

Displays the CACS cell the case is grouped to. To view details or optimize the case double click below the CAC Calculation bar. For details on CACS Grouping see Section 8 - Groupers





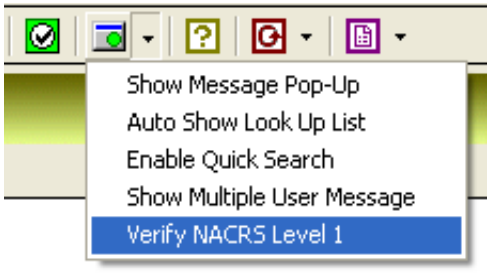
Abstracting a NACRS case

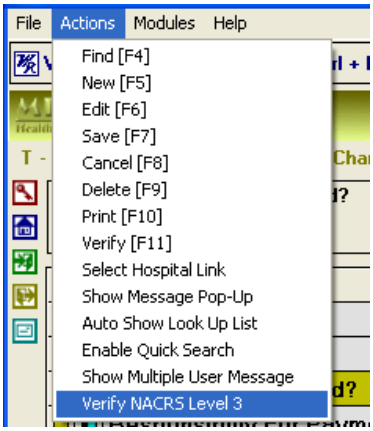
To abstract a NACRS (AmCare) case, follow instructions in ICD-10 Abstracting section. Refer to the current CIHI NACRS manual for field requirements and details.

Edit Validation for Level 1-3

In the Amcare Module, there is the option to display edits at a site's potentially differing submission levels. For those sites submitting strictly at Level 1 NACRS, only the level 1 edits will display on screen within the abstract.

For sites with a combination of Level 1 and 3, or Level 2 and 3, the Show Messages icon on the WinRecs toolbar, plus the Actions drop-down menu, will provide an option to select the alternate edit validation. The default setting upon opening the abstract is the highest level of edits.





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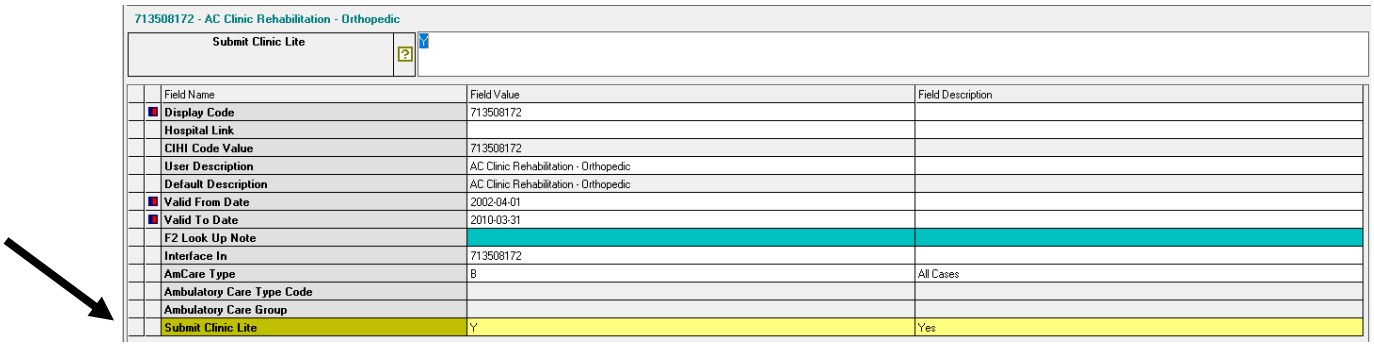
Abstracting Clinic Lite Records

NACRS Lite records are abstracted within the NACRS Module and include Ambulatory Care Groups CL, DI and OT.

A record is identified as Clinic Lite via the MIS Code.

In the Look Up Field Maintenance, in the MIS Code Look Up table, the field called: **Submit Clinic Lite** is used to flag records as NACRS Clinic Lite.

Add a Y to this field for all MIS Codes used for NACRS Clinic Lite visits.


713508172 - AC Clinic Rehabilitation - Orthopedic

Submit Clinic Lite

Field Name	Field Value	Field Description
Display Code	713508172	
Hospital Link		
CIHI Code Value	713508172	
User Description	AC Clinic Rehabilitation - Orthopedic	
Default Description	AC Clinic Rehabilitation - Orthopedic	
Valid From Date	2002-04-01	
Valid To Date	2010-03-31	
F2 Look Up Note		
Interface In	713508172	
AmCare Type	B	All Cases
Ambulatory Care Type Code		
Ambulatory Care Group		
Submit Clinic Lite	Y	Yes

Visits that use MIS Codes that have been flagged as “Submit Clinic Lite” will be submitted as Level 0.

Visits that use MIS Codes that have not been flagged as “Submit Clinic Lite” will be submitted as Level 3.

Note: Once a visit has been submitted the MIS code cannot be changed to a different submission code level (level 0 to level 3 or level 3 to level 0). The existing visit must be sent as a deletion and new record submitted with the new MIS Code.

Institution Profile

NACRS Submission Level Code must be set to include Level 0 which is the reporting Level for Clinic Lite. MED2020 provides the site with a patch to set the level in this field.

NACRS Lite Submission

In the Submissions and Corrections Module Choose Care Type: B-C-Lite: Clinic Lite (CL, DI, OT).

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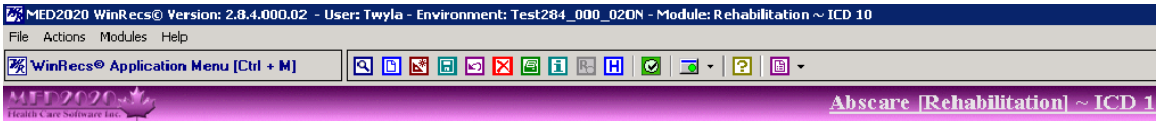
When this Care Type is chosen the submission level will default to 0 (NACRS Clinic Lite).

Abstracting ICD10 - Rehabilitation (NRS)



Overview

The Rehabilitation module is a diagnostic tool to keep track of individual patients and their progress once transferred to a specialized rehabilitation facility.

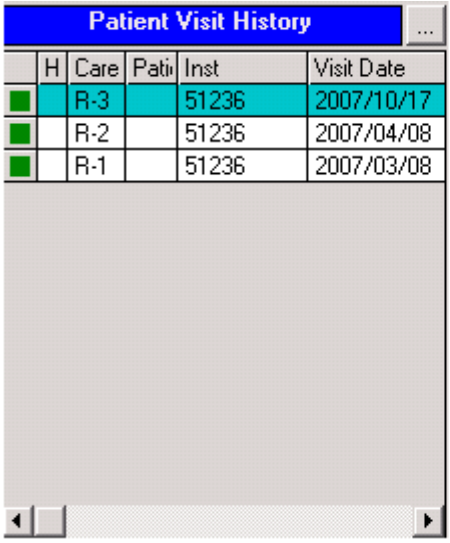
Please refer to the **WinRecs Basic Functionality** Section for details on the abstract layout and functionality.

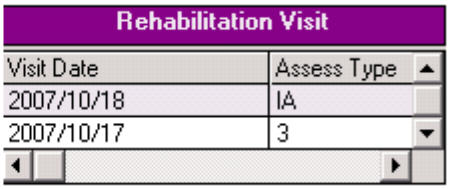
Assessment Types

The following codes are used to distinguish between the different assessments available in the Rehabilitation module.

Care	Description
R1	Admission Assessment
R2	Discharge Assessment
R3	Follow-up Assessment
IA	Interim Assessment
PD	Post Discharge Assessment

All of the assessment types will display in the Patient Visit History and Rehabilitation Visit boxes except for the Interim Assessment and Post Discharge Assessment which will display only in the Rehabilitation Visit Section on the Side Bar of the abstract.





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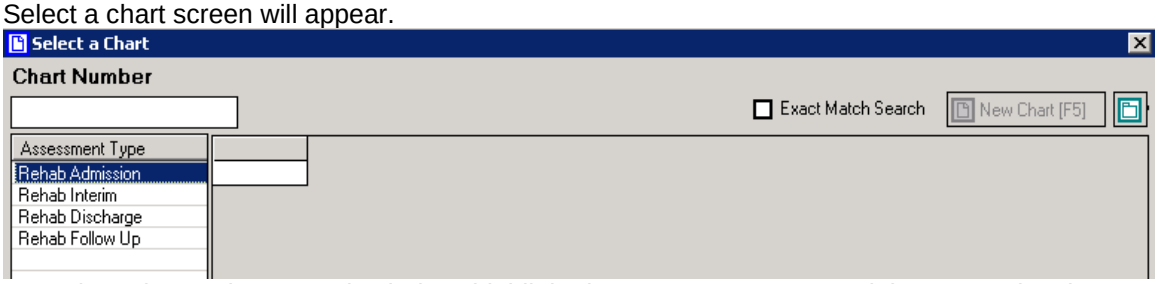
Creating an Assessment

To create a new assessment, ensure that you are in the Rehabilitation Module.

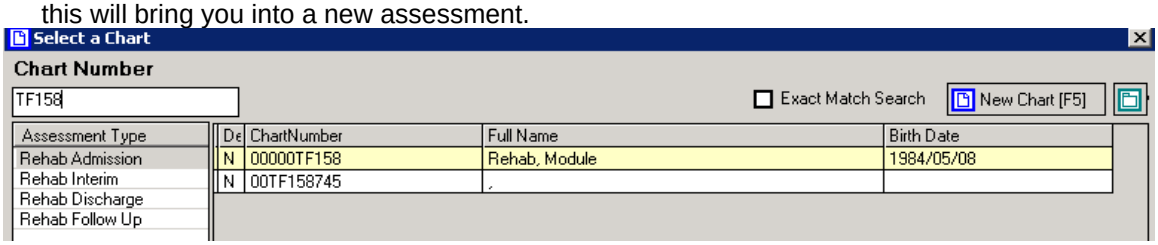
New (F5)

Select a chart screen will appear.



In the select a chart search window, highlight the assessment type and then enter the chart number.

If the chart exists in CPI the chart number will populate. Double click or enter on the chart number and this will bring you into a new assessment.



If the chart number entered in the select a chart window does not exist in CPI, you will receive the following message.

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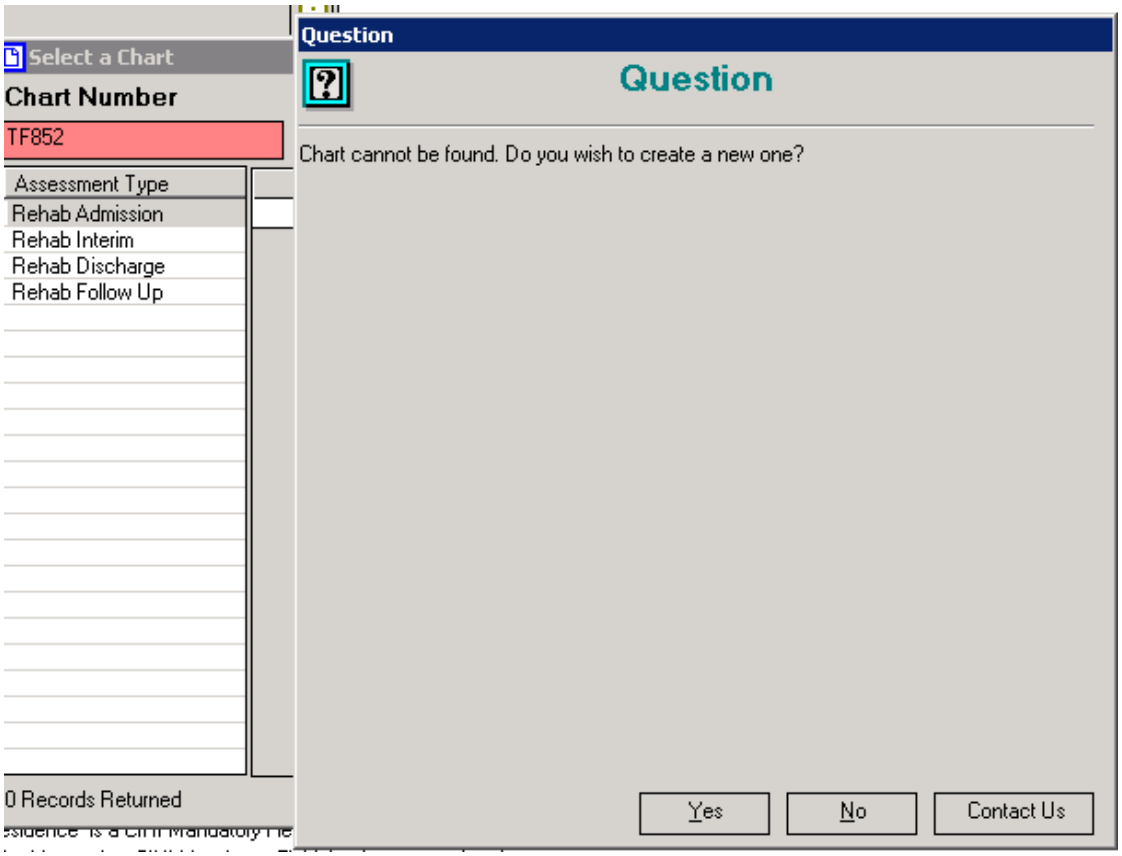

Select YES which will to go to the Central Patient Index Module to register the client. For details on registering clients, refer to the **WinRecs Basic Functionality** Section.

Note: When creating a Discharge Assessment some assessment values (as per CIHI Guidelines) are carried over from the Admission Assessment.

To enter values, highlight the field and enter the data in the Data Entry Box and press **ENTER** to populate the field.

Note: When working with a discharge assessment, several fields will be disabled (grayed out) with data in the fields. These fields contain data provided in the Admission Assessment and must not be changed.

An Admission Assessment must be completed before a Discharge Assessment. It is optional to record a Follow-Up Assessment once the Discharge Assessment has been completed.

A Discharge Assessment must not be deleted without first deleting its associated Follow-Up Assessment (if applicable). Likewise, an Admission Assessment must not be deleted without deleting its associated Discharge Assessment.

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A Post Discharge Assessment can only be created if there is an existing Discharge Assessment. The Post Discharge Assessment is not submitted to CIHI

If an Admission Class field 4 (unplanned discharge without assessment) is used in the Admission Assessment the system will not allow you to create a Discharge Assessment.

The diagnostic codes can be chosen from either pre-existing table (diagnosis multiform) or written in free text in the Diagnostic Health Condition fields. **Both areas cannot be used.**

Defaulting of Diagnosis Condition Type

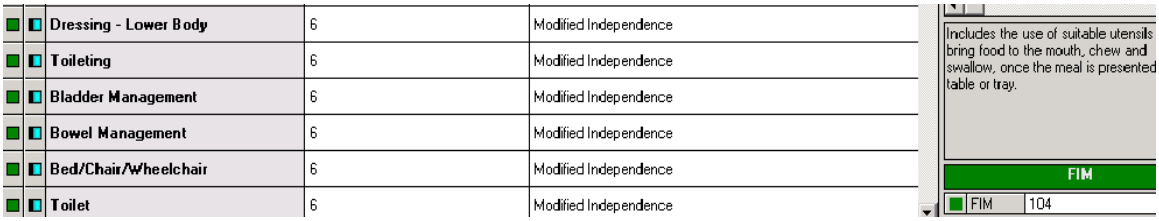
The Main Health Condition type (occurrence 1) currently defaults to M.
Diagnosis condition types for pre-admit and post-admit conditions will now default as follows:

- Admission Assessments - For any diagnosis occurrence greater than 1, the diagnosis condition type will always default to 1 (to represent Pre-admit Health Conditions).
- Discharge Assessments - For any diagnosis occurrence greater than 1, the diagnosis condition type will always default to 2 (to represent Post-Admit Health Conditions).
- Note that Transfer or Death Health Conditions (diagnosis condition type of W) will still need to be manually assigned.

FIM – Functional Independence Measure

Functional Independence Measure is the sum of all scores/values entered on fields 41 – 58 which denotes a GREEN COLOUR Icon in the Field Requirements Bar.
The FIM instrument includes the following data elements:
41. Eating
42. Grooming
43. Bathing
44. Dressing – Upper Body
45. Dressing – Lower Body
46. Toileting
47. Bladder Management
48. Bowel Management
49. Transfers: bed, chair, wheelchair
50. Transfers: toilet
51. Transfers: tub or shower
52. Locomotion: walk/wheelchair
53. Locomotion: stairs
54. Comprehension
55. Expression
56. Social Interaction
57. Problem Solving
58. Memory

Note: FIM calculates as each field is entered. FIM values are not carried over to the Discharge Assessment.



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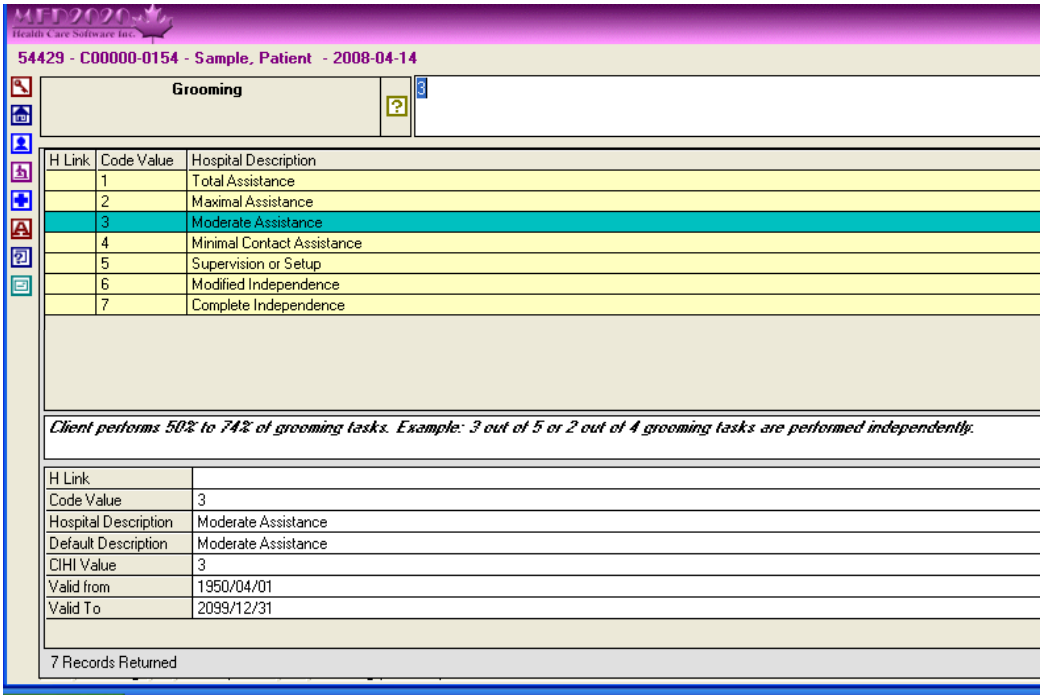
When completing the FIM value fields (**Activities and Participation**) there is an additional text information box that is available when using the **F2** Lookup function.

On the Assessment grid, once a FIM field is highlighted, press the **F2** function key or double-click. The usual look-up table will then display.

Highlight/select the specific value you wish to view the criteria for. The relevant information for that value displays below the list of results.



Error Messages within the Assessments

CIHI mandates that as of their annually-specified date, any assessments not already submitted that fall into the previous fiscal year, MUST be submitted under the new fiscal year edits/requirements.

To accommodate this requirement, WinRecs has a setting in the Rehab institution profile where this annual date can be entered. This field is the “Record Validation and Submission Date.” (Please see the section on ***NRS Submissions*** for more information).

When an assessment is being completed in WinRecs, if it belongs to the previous fiscal year’s data, and the current system date is AFTER the Record Validation and Submission Date, the most current fiscal year edits/requirements will be applied to the assessment.

This may result in some unexpected error messages appearing at the bottom of the screen – but these will be relevant to the current fiscal year’s edit requirements and must be completed correctly.

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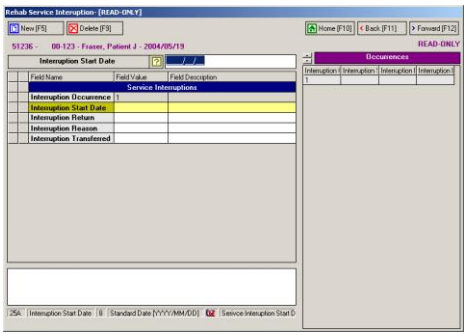
Service Interruptions Multiform



This optional multiform is only available on the Discharge Assessment and is used to record any interruptions of service encountered by a patient.

Note: Consult your facility's guidelines to learn when and how to record any service interruptions.

Rehabilitation Client Group (RCG)/ASIA:
The ASIA Impairment Scale field will only open if traumatic special cord injury is chosen on the RCG field.

Note:
Defaults: Please refer to the Control File section of the User Guide Manual for setting defaults for fields.

Changing Field Sort Order: Please refer to the Control File section of the User Guide Manual on changing field sort order.

Searching for an Assessment

In the NRS module **Find** **(F4)**

In the Abstract Search screen, find the record by using one of the search options. For details on searching, see **Basic WinRecs Functionality** section.

There are specific fields for NRS in the **Field Search F3** selection.

Select the record. All data entered previously will display on the grid. In the Patient Visit History, all Assessment types that have been opened are displayed. To display a different assessment in the main grid, double click on the assessment in the Patient Visit History box.

Update fields as appropriate and **Save** **(F7)**

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NRS RPG Grouper

To provide an integrated grouper and weighting methodology for adult inpatient rehabilitation care within the MED2020 National Rehabilitation Reporting System (NRS) module.

The embedded grouper and weighting methodology will allow MED2020 Clients to account for adult rehabilitation care data into their funding formula which is then reported to Canadian Institute for Health Information (CIHI) and eventually their Provincial counterparts. Of note, currently, Ontario is the sole province where adult rehabilitation reporting is mandated.

Data calculated by the rehabilitation grouper will be stored within the WinRecs database, allowing users to report on the data by use of accompanying pre-designed reports or ad-hoc reports created by the user facility by means of Crystal Reports™.

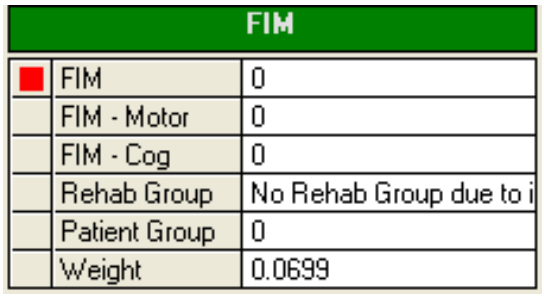
The Rehabilitation Cost Weight (RCW) represents an average relative resource use for patients in an RPG. The data used to develop cost weights for the RPG was drawn from two sources of Ontario data: the National Rehabilitation System (NRS) and the Ontario Cost Distribution Methodology (OCDM).

At discharge, each patient episode is assigned an RCW. The RCW depends on the assigned RPG and the length of stay (LOS) of the episode of care.

Using the NRS RPG Grouper

Once the facility has purchased the NRS Grouper and the WinRecs Update has been applied to their WinRecs database, any user with permissions to the NRS Module will be able to view the NRS Grouper information in the FIM/RPG grid of admission and/or discharge assessments.

The red field indicator next to the FIM value indicates that the Activities and Participation fields required to calculate the FIM have not been fully completed.



When the Admission assessment has had adequate data entered to complete the calculation, the grouper data will display in the relevant cells in the FIM table.

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FIM	
FIM	52
FIM - Motor	32
FIM - Cog	18
Rehab Group	Stroke
Patient Group	1100
Weight	0.0699

Initial values are displayed at completion of the Admission Assessment however the full calculation is applied to the FIM grid once the Discharge Assessment has been completed.

FIM	
FIM	107
FIM - Motor	32
FIM - Cog	18
Rehab Group	Stroke
Patient Group	1100
Weight	2.5148

Batch Grouping

Batch Grouping of NRS RPG data is available using the Batch Grouping functionality in the Utilities menu. Please see ***Using the Batch Grouper*** section in this User Guide for detailed information on the steps required.

Access to RPG information via report writing

The following six data elements are stored in the RH_FIM_RPG table and can be accessed by Crystal Reports ™.

- FIM
- FIM Motor
- FIM Cognitive
- Rehab Group
- Patient Group
- Weight

Rehabilitation Cost Weight (RCW) represents an average relative resource use for patients in an RPG excluding short stay and long stay outliers.

At Discharge, each patient episode is assigned an RCW. The RCW depends on the assigned RPG and the Length of Stay (LOS) of the episode of care.

Episodes with LOS equal to or less than 3 days are assigned the same short stay RCW.

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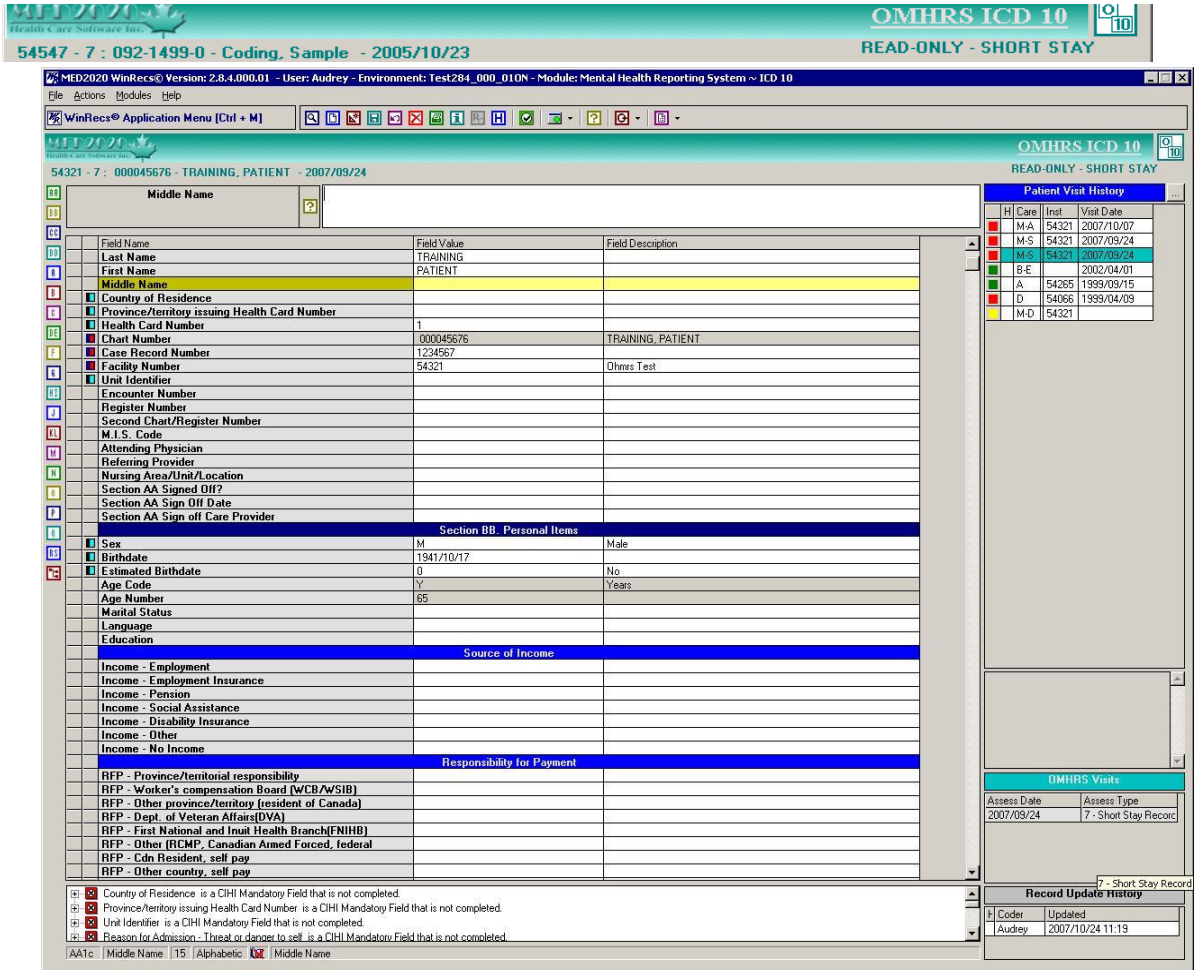
Each RPG has a unique LOS trim point.

Long stay outliers are assigned a RCW which is the sum of the RCW and a per diem weight for the number of days beyond the trim point.

Abstracting ICD10 – Mental Health (OMHRS)



Search for a OMHRS Visit

In the OMHRS module **Find** **(F4)**

In the Abstract Search screen, find the record by using one of the search options. For details on searching, see **Basic WinRecs Functionality** section.

There are specific fields for OMHRS in the **Field Search F3** selection.

If searching by Chart Number or Patient Name all Assessment Types for the patient will be listed.

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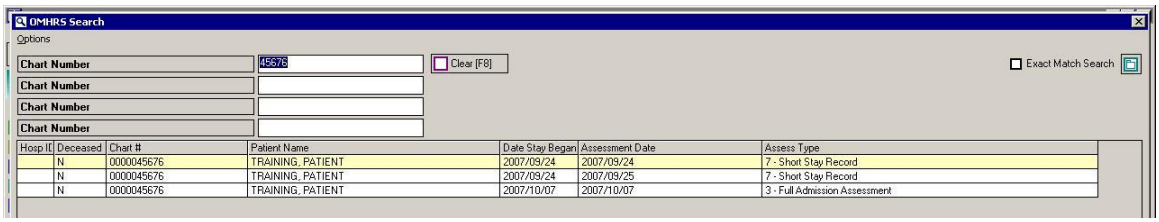


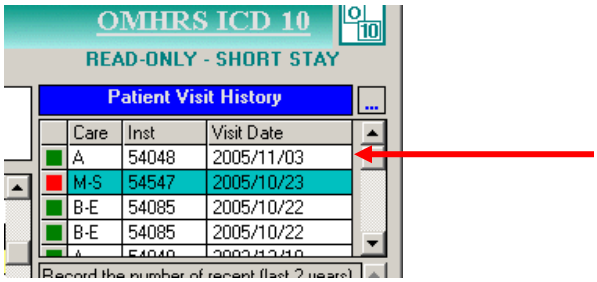
Select the assessment. All data entered previously will display on the grid. In the Patient

Visit History, all Assessment types that have been opened are displayed.

Update fields as appropriate and **Save** **(F7)**

OMHRS Specific Visits

To view other assessments for the patient double click on the visit in the Patient Visit History and the OMHRS visit will display on the main grid.



Adding Notes in the Assessment

To add a note, go to the note field on the main grid. You can find these easily as they are highlighted in green and the field name will include the word “Notes”.

There are Notes fields available for each of the MHAP (Mental Health Assessment Protocols), as well as Assessment Notes.

The Note fields functions like a multiform.

To create a note, click on the note field. This will take you to a Notes multiform.

For details on entering new notes, deleting and editing, refer to Abstracting Notes in the Abstracting Section.

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Assessment Types

Admission Assessment - Through the interface process from ADT SYSTEM, all Admission assessments will be created for you. All you need to do is complete them and ensure they are error free.

Discharge Assessment – Through the interface process from ADT SYSTEM, all Discharge assessments will be created for you. All you need to do is complete them and ensure they are error free.

Short Stay Assessment – Through the interface process from ADT SYSTEM, if the Length of Stay is less than 3 days, the interface process will create the Short Stay assessment for you as well as delete the Admission and Discharge Assessments it has created. All you will need to do is complete the assessment and ensure it is error free.

Quarterly Assessment – These will not be created through the interface process. You will need to manually create these assessments. Please see the notes under the heading “Creating Assessments”.

Change In Status Assessment – These will not be created through the interface process. You will need to manually create these assessments. Please see the notes under the heading “Creating Assessments”.

Creating Assessments

There will be 2 occasions when an assessment will need to be manually created within WinRecs. One is the **Quarterly** assessment, the other is the **Change in Status** assessment.

Both assessments are created the same way and follow the same steps.

A Quarterly assessment is required when a patient has stayed more than 92 days since the last assessment was done.

A Change In Status assessment is required when “a patient has had a major physical, mental, or social change/event that would render the current assessment and care plan invalid” (CIHI 2006).

To create a new assessment type, you must be in the OMHRS module itself.

New **(F5)**

Select the type of Assessment to create.

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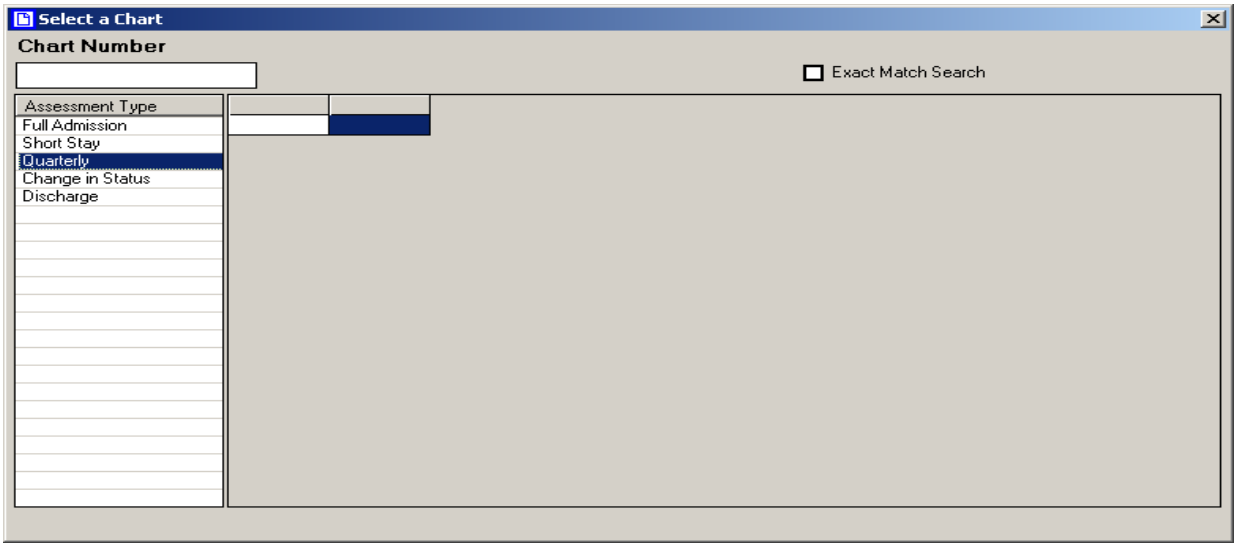
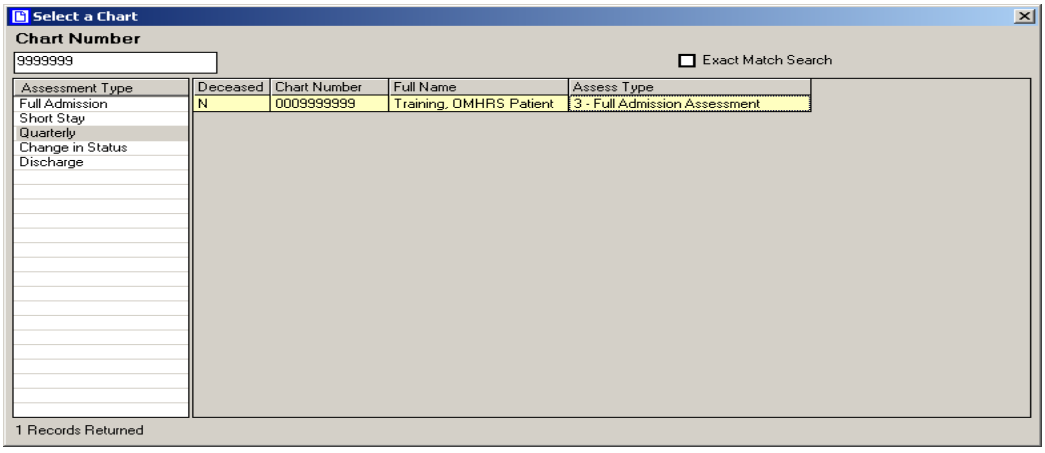


Type the chart number of the patient you wish to create the assessment for.

The system will show you a list of OMHRS visits for that patient. You will need to create the new assessment by selecting the corresponding visit from the list.



By double clicking on the selected case from the list, the system will create the requested assessment the assessment type will change and is displayed just below the Module banner.

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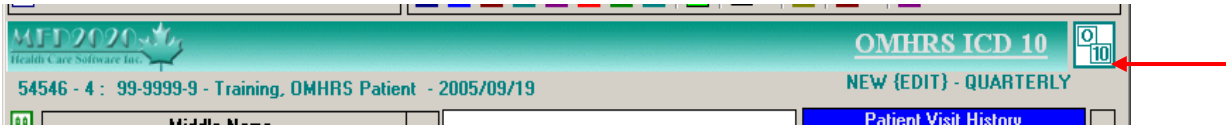


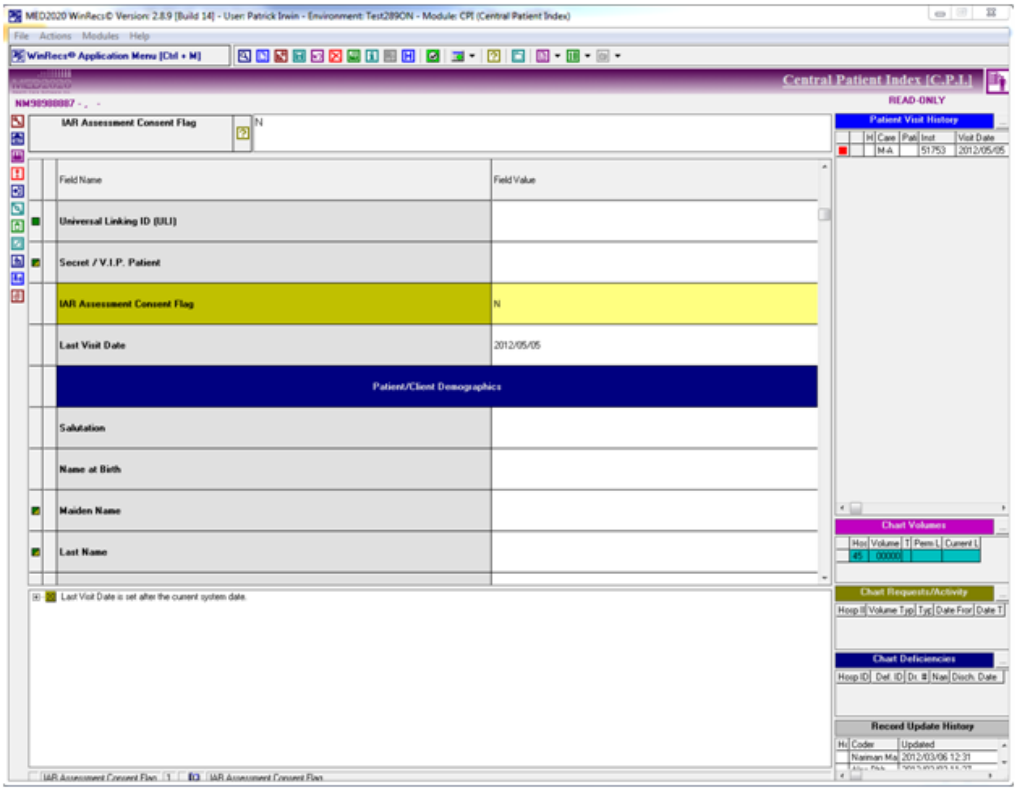
Integrated Assessment Record (IAR)

The Integrated Assessment Record (IAR) was mandated for OMHRS as of April 1, 2012.

The IAR Assessment Consent Flag is located in the Central Patient Index (CPI) to allow the client to set the flag to:

Y= The patient has agreed to allow the sharing of their visit within the IAR

N=The patient has requested that this visit not be shared within the IAR



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This field will be visible and mandatory if the client has purchased the IAR sub module. If the client has not purchased the IAR module then the field will not display and the field will not be mandatory. If the field is visible then the default should be blank to force the client to enter Y=yes or N=no. By selecting Y=Yes the patient is confirming that all visit assessments will default to "Y". If the patient enters N=No then all visit assessments will have no default and the visit assessment will be mandatory to enter either Y=Yes or N=No before an assessment save can happen. If the client changes this field from a Y=Yes to a N=No then all of the visits will change and they will be prompted as a reminder.

Please note that this is not the flag that is sent to Community Care Information Management (CCIM). That flag will be set for each assessment.

Ontario Mental Health Reporting System (OMHRS) -> Integrated Assessment Record (IAR)

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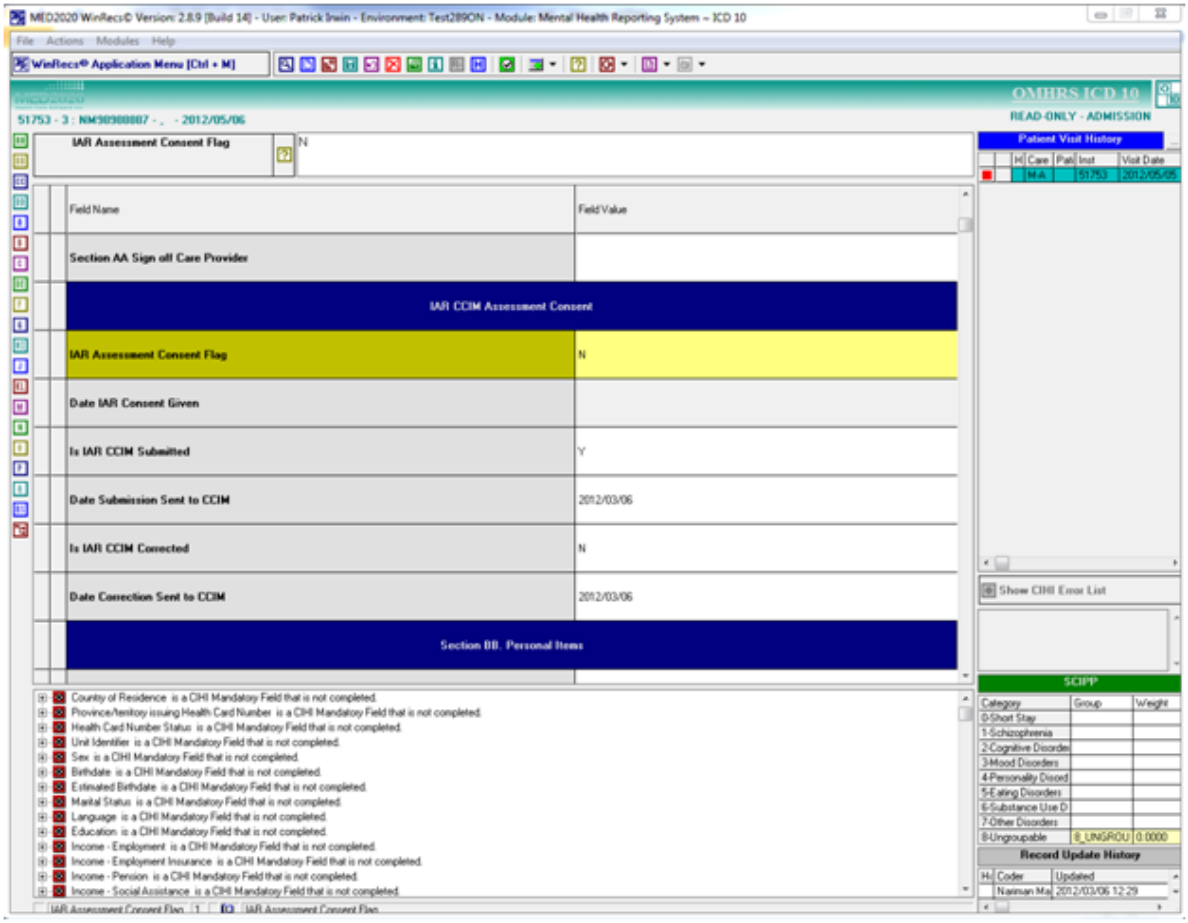

The IAR CCIM Assessment Consent section will only be shown if the client has purchased IAR subsystem. The following fields have been added to the OMHRS assessment module:

IAR Assessment Consent Flag **(mandatory)**

Y= The patient has agreed to allow the sharing of their visit within the IAR

N=The patient has requested that this visit not be shared within the IAR

U=this means the selection is unsupported

Does the Patient/Client consent to the sharing of their assessment?

This is a mandatory field to allow Health Service Providers (HSP's) access to your visit assessment.

This field will be visible and mandatory if the client has purchased the IAR submodule. If the client has not purchased the IAR submodule then the field will not display and the field will not be mandatory. This field will be submitted to the IAR along with the same fields submitted to CIHI for OMHRS. If the CPI:IAR_Assessment_Consent_Flag element is set to N=No then the OMHRS:IAR_Assessment_Consent_Flag does not default and the patient will need to provide

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consent. If the client has entered Y=Yes for the CPI:IAR_Assessment_Consent_Flag then the OMHRS:IAR_Assessment_Consent_Flag will default to Y=Yes.

Date IAR Consent Given **(mandatory):**

This is the date the patient gave consent for either yes they want their assessment to be visible in the portal or no they do want it

Is IAR CCIM Submitted

N=Not Submitted to CCIM,

Y=Submitted to CCIM

This flag determines whether or not the submission to CCIM has occurred

Date Submission Sent to CCIM:

This date field indicates the first time the assessment was sent to CCIM

Is IAR CCIM Corrected:

C=Correction, **D**=Deletion, **N**=New

This flag determines the type of submission to CCIM

Date Corrections Sent to CCIM:

This field identifies the date that the corrections to the assessment have been sent

SCIPP Grouper

(System for the Classification of In-Patient Psychiatry)

The System for the Classification of In-Patient Psychiatry grouper is available to clients to purchase in addition to the OHMRS module. The SCIPP grouper data can be found in the right-hand display panel of the OMHRS module, above the Record Update History. An associated "auto-calculate SCIPP Grouper" option has been added to the User Profile.

SCIPP Grouper pre-designed reports have been made available.

The SCIPP Grouper is only available to clients who have purchased this functionality in addition to the OHMRS module.

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SCIPP		
Category	Group	Weight
0-Short Stay		
1-Schizophrenia		
2-Cognitive Disorder	2_ODC1	1.2236
3-Mood Disorders		
4-Personality Disord		
5-Eating Disorders		
6-Substance Use D		
7-Other Disorders		
8-Ungroupable		

Batch Grouping

Batch Grouping of SCIPP data is available using the Batch Grouping functionality in the Utilities menu. Please see ***Using the Batch Grouper*** section in this User Guide for detailed information on the steps required.

Printing Reports

All OMHRS reports will be set up to run in the OMHRS module. See System Maintenance\Look Up Field Maintenance\Report Selection List for detailed instructions to set up reports.

To print a report set up to run in OMHRS press **Print** **(F10)**
Select the report you would like to view.

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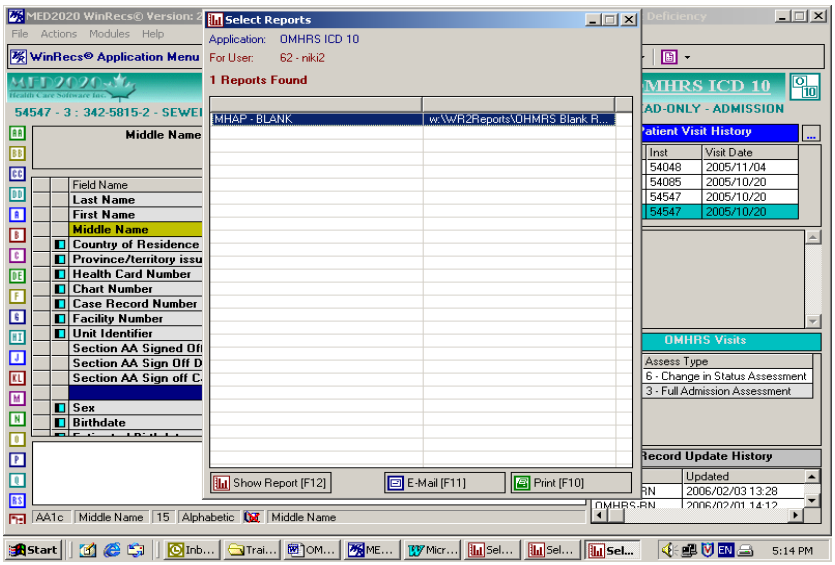

If you wish to view the report on the screen press **Show Report** **(F12.)**

SCIPP CMI weights for case groups may change from year to year. Unlike the CMG or CACS Grouper, there is no methodology year to report on for the SCIPP Grouper. As a result, to report on a given methodology year you will need to set the date range in your report to match the fiscal year of reporting. For example, to report the SCIPP Grouper values for Fiscal 2013 set the date range of your report to 2013/04/01-2014-03-31.

MDS2.0 Assessments (CCRS)

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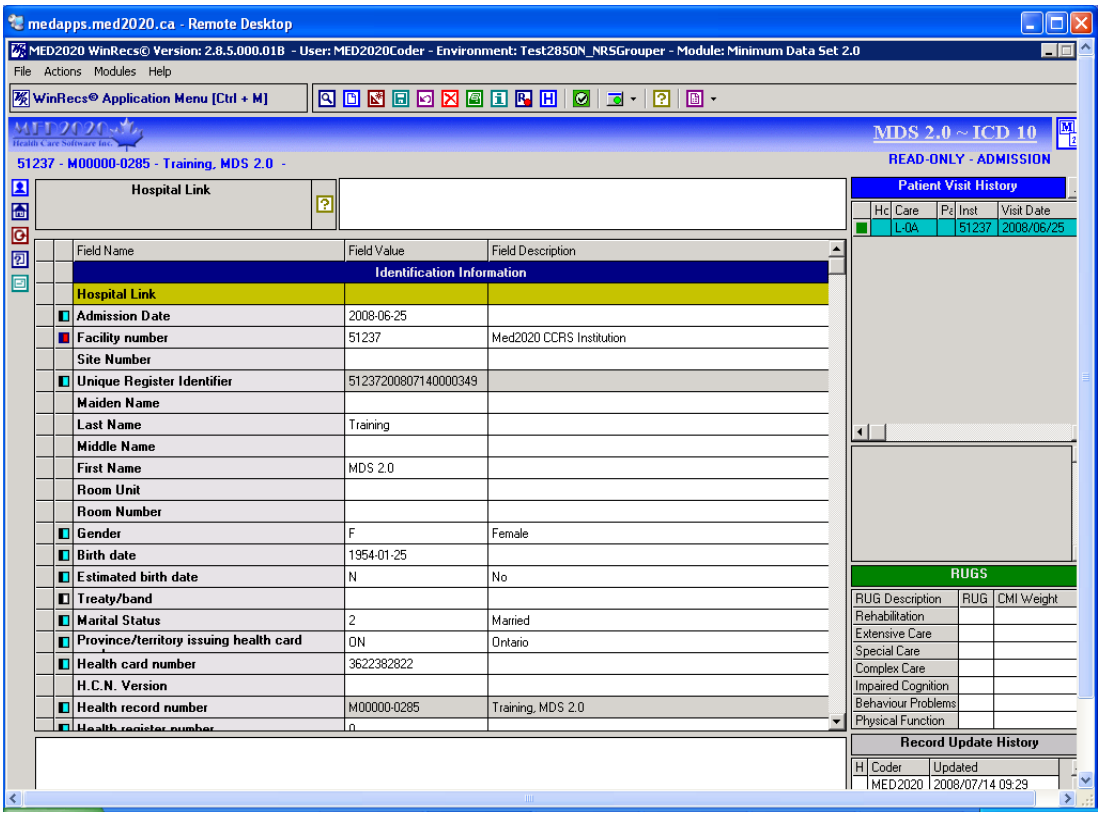


Search for a MDS2.0 Visit

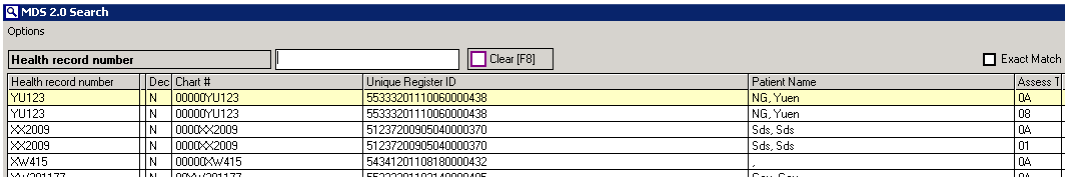
In the MDS2.0 module to search for existing/interfaced assessments use **Find** **(F4).**

To create new assessments manually use New **(F5)**

In the Abstract Search screen, find the record by using one of the search options. For details on searching, see **Basic WinRecs Functionality** section.

There are specific fields for MDS2.0 in the **Field Search F3** selection.

If searching by Chart Number or Patient Name all Assessment Types for the patient will be listed.



Select the assessment. All data entered previously will display on the grid. In the Patient Visit History, all Assessment types that have been opened are displayed.

Select assessment by highlighting and double click or press enter.

All data entered previously/interfaced will display on the grid. In the Patient Visit History, all

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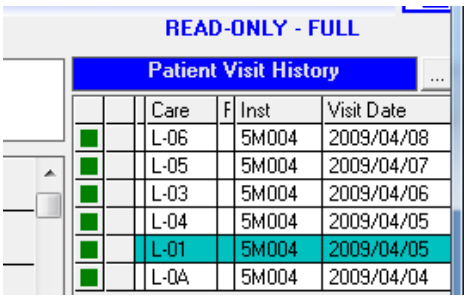
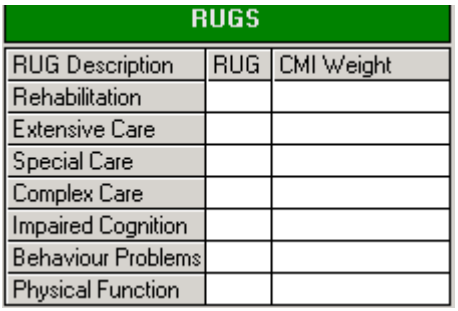
Assessment types that have been opened are displayed.



Update fields as appropriate and **Save** **(F7)**

Sidebar (Information Pane)



RUGS

Field	Description
Rehabilitation	Identifies Rehab RUG-III group the client has been assigned to. The table displays the RUG-III code and level as well as the Case Mix Index Value.
Extensive Care	Identifies Rehab RUG-III group the client has been assigned to. The table displays the RUG-III code and level as well as the Case Mix Index Value.
Special Care	Identifies Rehab RUG-III group the client has been assigned to. The table displays the RUG-III code and level as well as the Case Mix Index Value.
Complex Care	Identifies the Clinically Complex Care RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.
Impaired Cognition	Identifies the Impaired Cognition RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.
Behaviour Problems	Identifies the Behaviour Problems RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.
Physical Function	Identifies the Reduced Physical Function RUG-III group the client has been assigned to. The table will display the RUG-III code and level as well as the Case Mix Index Value.

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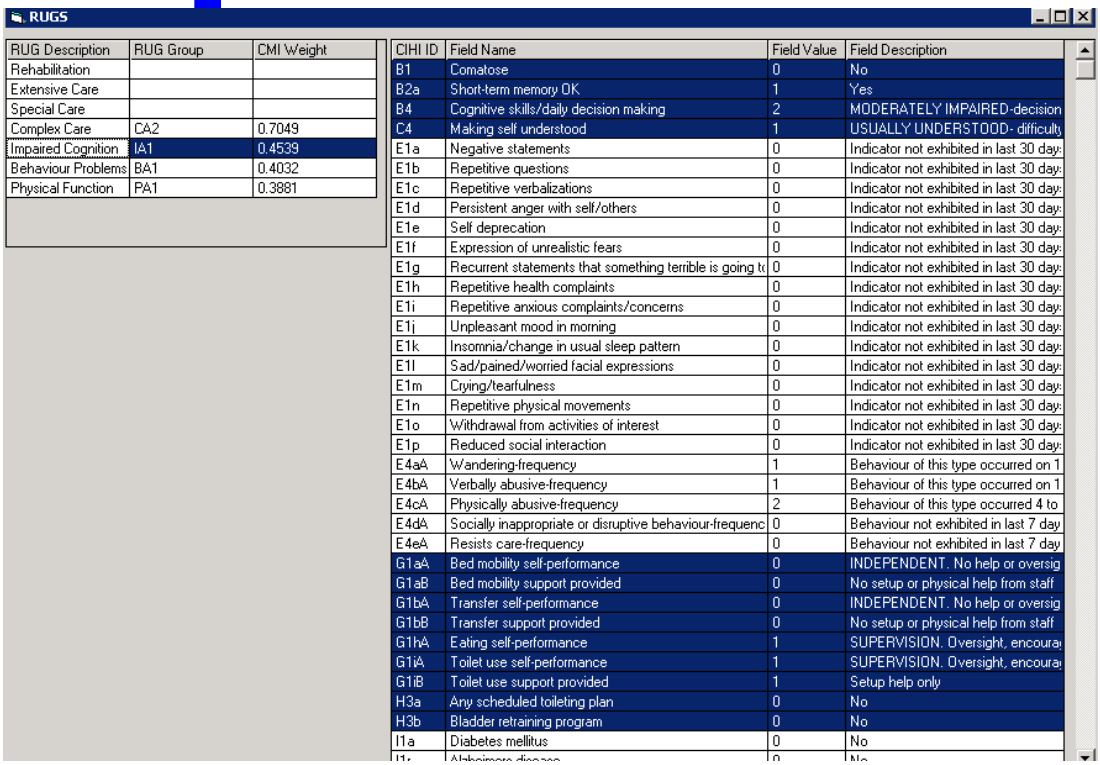
RUG-III Grouping Methodology within WinRecs® for MDS 2.0 Reporting

As information is collected within the WinRecs® application, the RUG-III grouping methodology will begin to assign the RUG-III code and the associated Case Mix Index Value:

RUGS

RUG Description	RUG	CMI Weight
Rehabilitation		
Extensive Care		
Special Care		
Complex Care	CA2	0.7049
Impaired Cognition	IA1	0.4539
Behaviour Problems	BA1	0.4032
Physical Function	PA1	0.3881

Double-clicking within this smaller table will open up the table seen below. This further detail when clicking once within any of the RUGs with values will automatically let you see what data elements were applicable in the RUG-III code assignment, what values within those data elements triggered the RUG-III code and will show the corresponding CMI Weight. To exit out of this table, simply click the 'X' on the top right corner.



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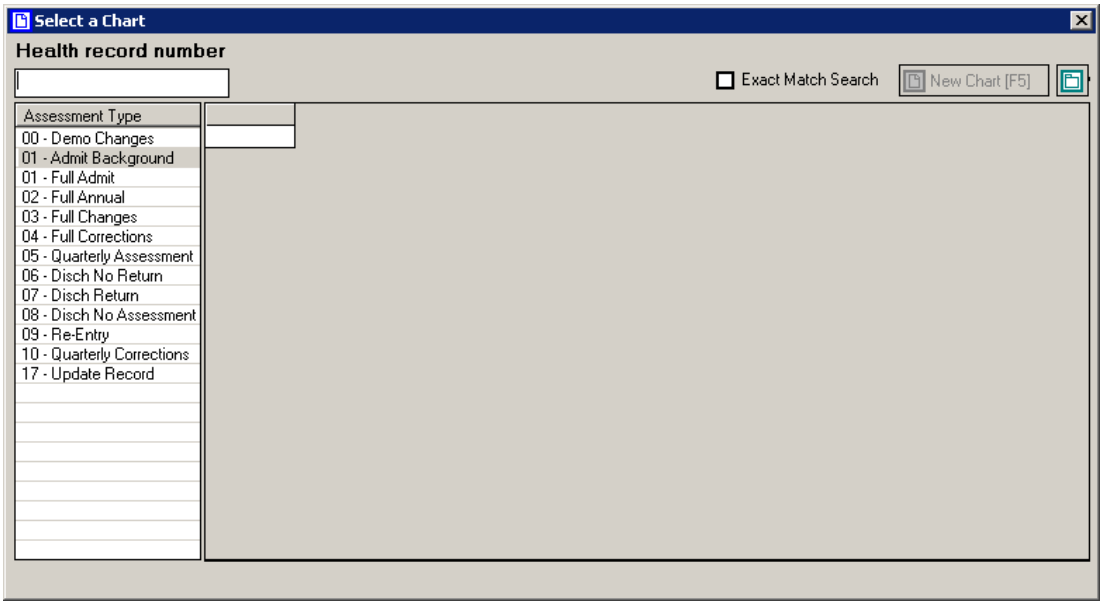
Assessment Types

Note: The below assessments types are effective to March 31, 2012

The following assessment types are available when abstracting in MDS 2.0:



Assessment Type	Description
00 Demographic Changes	To be completed at any stage if changes or corrections to demographic information are required.
01 Admit Background (OA)	To be completed for each resident upon admission. This is submitted with the Admission Full Assessment Record if the Full Assessment is required.
01 Full admit	To be completed by the 14th calendar day of the resident's admission to the facility if this is the resident's first stay in the facility or if the resident returns to the facility after being discharged and the conditions for use of the Re-entry Form do not apply. The 1st calendar day of admission = 0, i.e. If patient was admitted on January 1st, then the full admit should be completed by January 15th.
02 Full Annual	To be completed within 366 days of the Assessment Reference Date (Element A3) from the last Full Assessment.
03 Full Changes	Required if there is a significant change in Resident's status. Complete a Full Assessment within 14 days of the day determination of a significant change has occurred.

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04 Full Corrections	After the Full Assessment has been submitted, the facility might realize that some items are in error. Should be completed following the determination that corrections are required.
05 Quarterly Assessment	Used to track resident status between Full Assessments, and to facilitate monitoring of critical indicators relating to changes in the resident's status. The Quarterly Assessment must be completed within 92 days of the last Full or Quarterly Assessment.
06 Discharge - No Return	Required whenever a resident dies or is discharged from the facility. This is the only record that must be completed at the time of any discharge or death. Complete the No Return (06) if no return to the facility is anticipated.
07 Discharge Return	Required whenever a resident dies or is discharged from the facility. This is the only record that must be completed at the time of any discharge or death. Complete the Return Anticipated (07) if a return to the facility is anticipated.
08 Discharge No Assessment	Discharged prior to completing initial assessment.
09 Re-Entry	Used when a resident is readmitted following a previous discharge from the facility. Certain conditions must be met.
10 Quarterly Corrections	After the Quarterly Assessment has been submitted, the facility might realize that some items are in error. Should be completed following the determination that corrections are required.

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11 Update Record	Assessment type added Fiscal 2010; May be completed at any stage after the resident has been admitted. The data, where completed, will capture the date when the Private Pay Flag (AD1), Bed Type (AD2) and/or MIS Functional centre changed (AD3). Must be submitted within 60 days following the end of the quarter in which the change or error was identified.

Record Types Effective 2012 Fiscal Year:

CR	Control Record
AD	Admission/Re-entry
FA	Full Assessment
QA	Quarterly Assessment
MD	Medication
DC	Discharge
UP	Update
SP	Special Project
CI	Contact Information

Selecting an Existing Assessment

Select the assessment you want to work in by either selecting the abstract from the *Patient Visit History* in the CPI, or:

Open *Minimum Data Set 2.0* (located under *Abstracting ICD-10*) from the *WinRecs ® Application Menu* or the *Modules*

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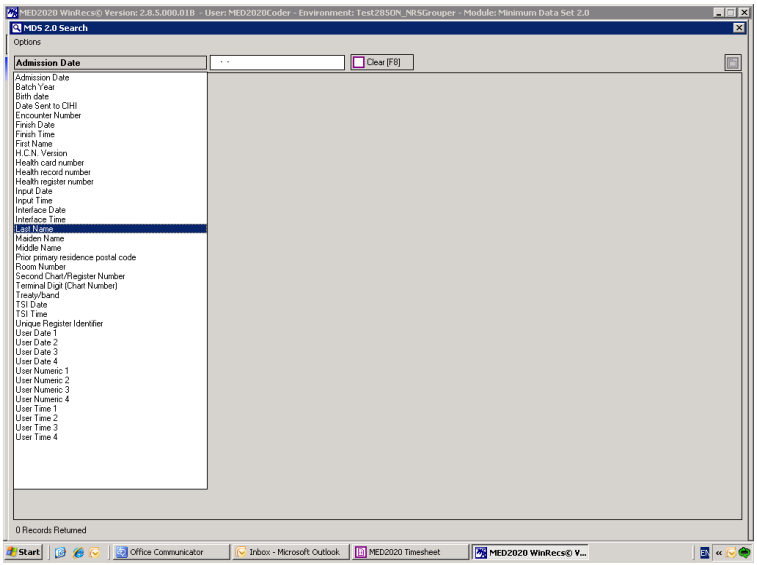
menu.

Press **F4** or click the *Search* button to open the MDS 2.0 Search window.

Press **F3** to change the search criteria.

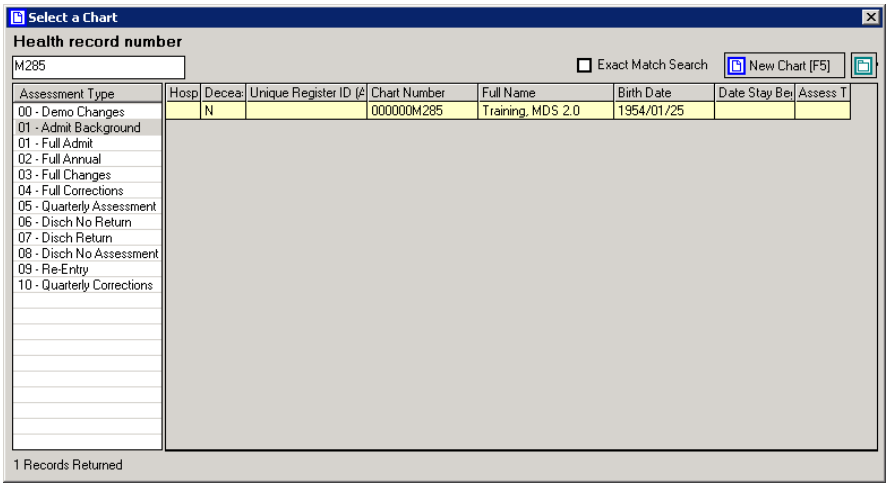


Specify the search criteria and text, and press **ENTER**.

Select the record from the list.

Note: Facilities that have a batch or HL7 (real-time) interface transferring records into the WinRecs program will use the F4 search function to locate the assessment records they need to complete.

Creating a New Assessment



Click the *New* button or press **F5**.

Type the patient Chart Number.

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Highlight the Assessment Type from the list.

Press **ENTER** to display the patient details.

Once the patient is selected, the MDS 2.0 module opens to the selected Assessment Type, bringing forward any demographic details contained in the *Central Patient Index*.

Note: A facility that does not have an interface to transfer the patient visit information into WinRecs ® will use the F5 (*new*) function to create a new assessment record.

Auto-Completion of Fields

Depending on the assessment section, some fields will auto-populate with values based on a key question. A good example of this is the Responsibility/Legal Guardian section of the Full Admission Assessment. (see picture below)

If Y is typed in the *None of the below* field, the remaining fields' values default to No.

This assists with the completion of assessment fields where the section does not apply to that patient, yet must be completed based on data submission requirements. This requires less key-stroking for data entry and consistency in the quality of data entered into the abstract.

Responsibility/Legal Guardian		
None of the below	Y	Yes
Legal guardian	0	No
Durable power of attorney/financial	0	No
Other legal oversight	0	No
Family member responsible	0	No
Endurable power of attorney/health care	0	No
Resident responsible for self	0	No

Field Descriptions

For each data element, the description of the field is displayed on the right-hand of the WinRecs ® abstract in MDS 2.0 for assisting the data entry. The description assists in providing the additional information about the field so that the correct data is entered for each data element. See the following example within a Full Admission Assessment for "Eating Self-Performance":

How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).

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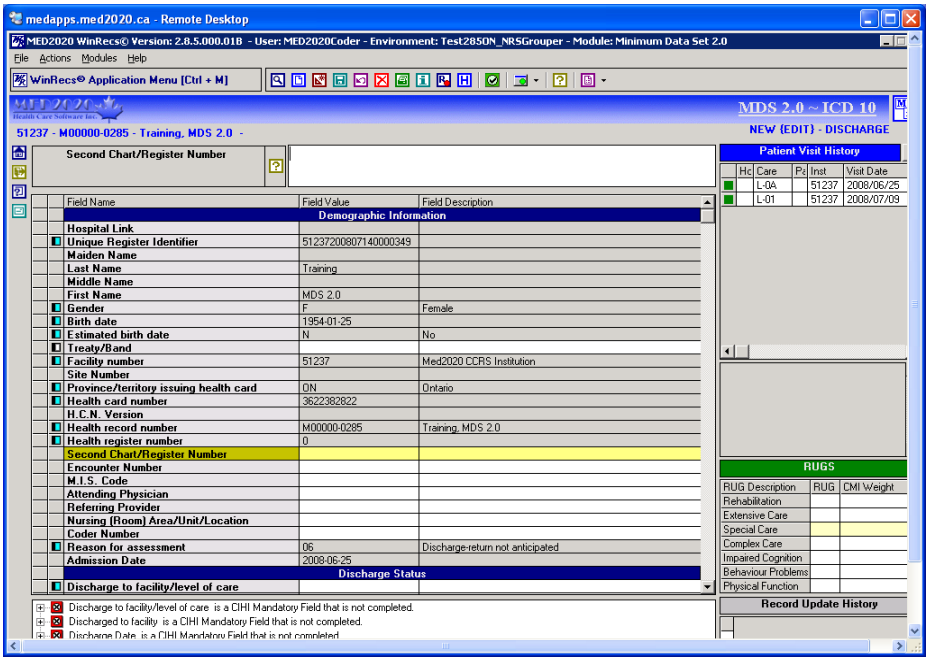
Completing the Discharge Assessment



When completing the Discharge Assessment, you will notice that several fields are grayed out with the data displayed in the field. These are fields that have had the data entered in the Admission, Full or Quarterly Assessments and must not be changed.

Most assessment values are carried over from the earlier Assessments to the Discharge Assessment so that there is consistency in the collection of common data elements for the same individual for that particular encounter for care.

Update the information by highlighting a field and typing the new value, then press **ENTER**.

Deleted Records in CCRS

To delete a CCRS record that has been submitted to CIHI, open the record that needs deletion. Please note that assessments must be deleted in reverse order of submission (Quarterly Assessment needs to be deleted before Admission assessment). When deleting the record the following warning will show for CIHI Submitted records.

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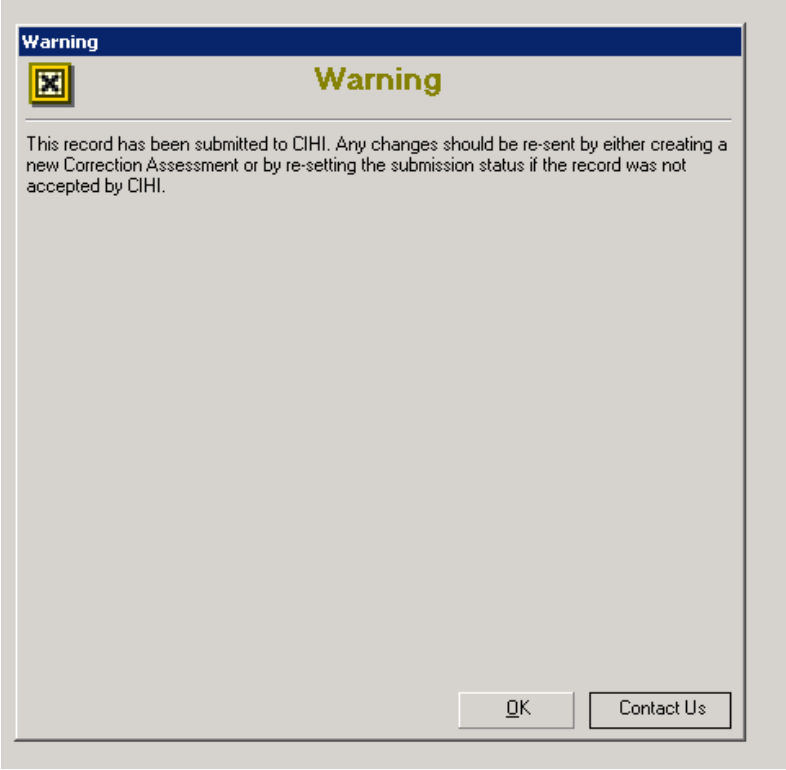

Press Delete (F9) and the following message below will appear. Press **Yes**.

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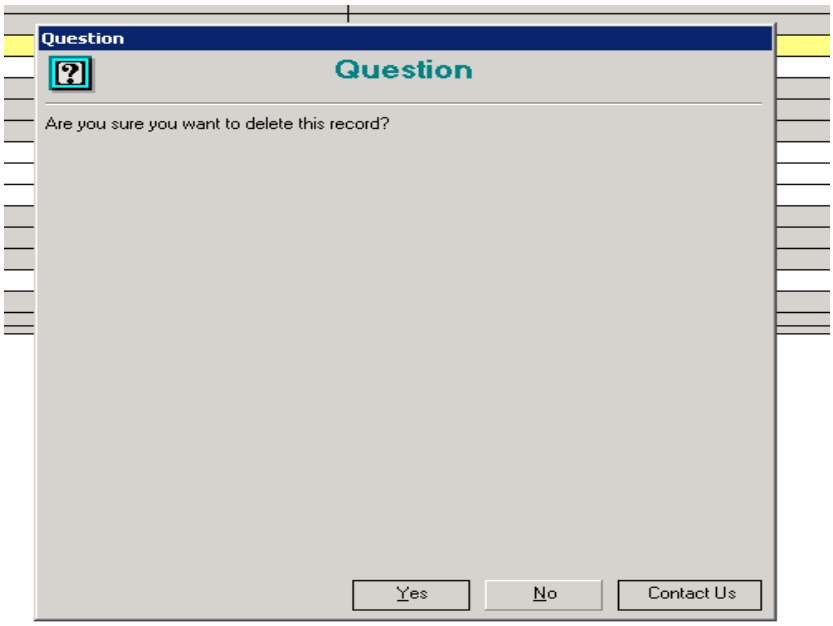
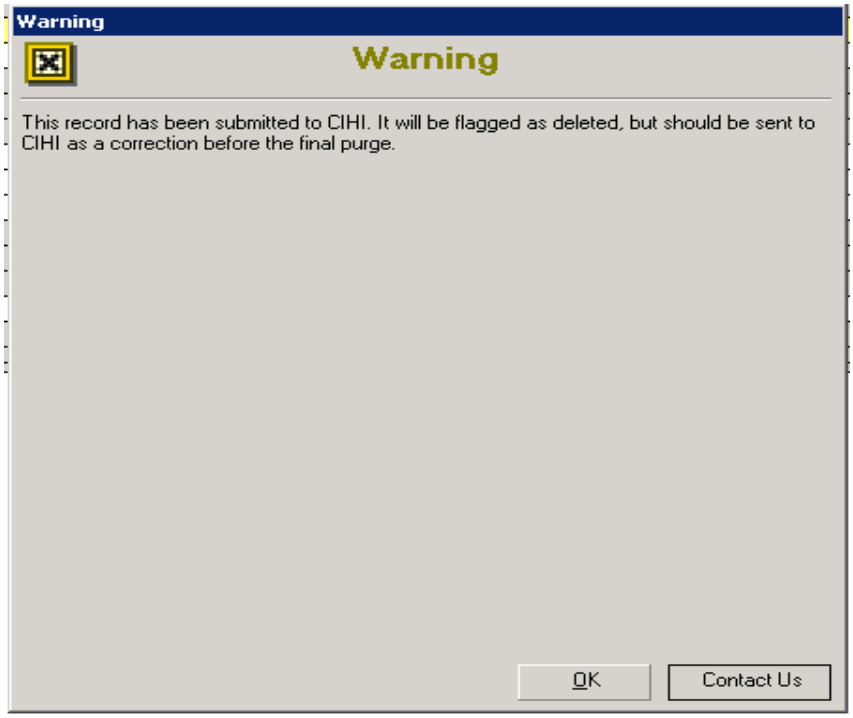


The following Warning message will display and the chart will move to the Purge/Undelete Module:



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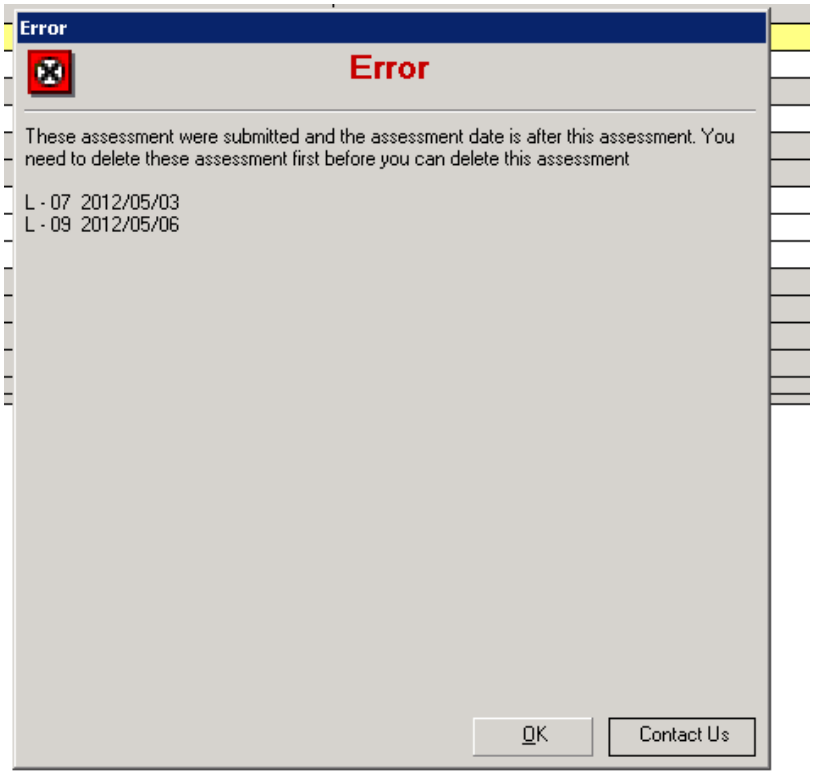
After pressing ‘Yes’ to ‘Are you sure you want to delete this record?’, if you get the following error message then any assessments created after this one need to be deleted as well. These assessments must be deleted in reverse order of submission.



A submission file for the fiscal quarter applicable to the deleted assessments will then need to be created. See Create a CIHI Submission File for details.

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Cancer Care Module – (CCM)

Overview

The Cancer Care module is a data collection tool within the WinRecs suite of modules, sharing a common Central Patient Index and allowing the collection of cancer care data specific to the Disease Registration and New Drug Funding Program - NDFP Enrollment.

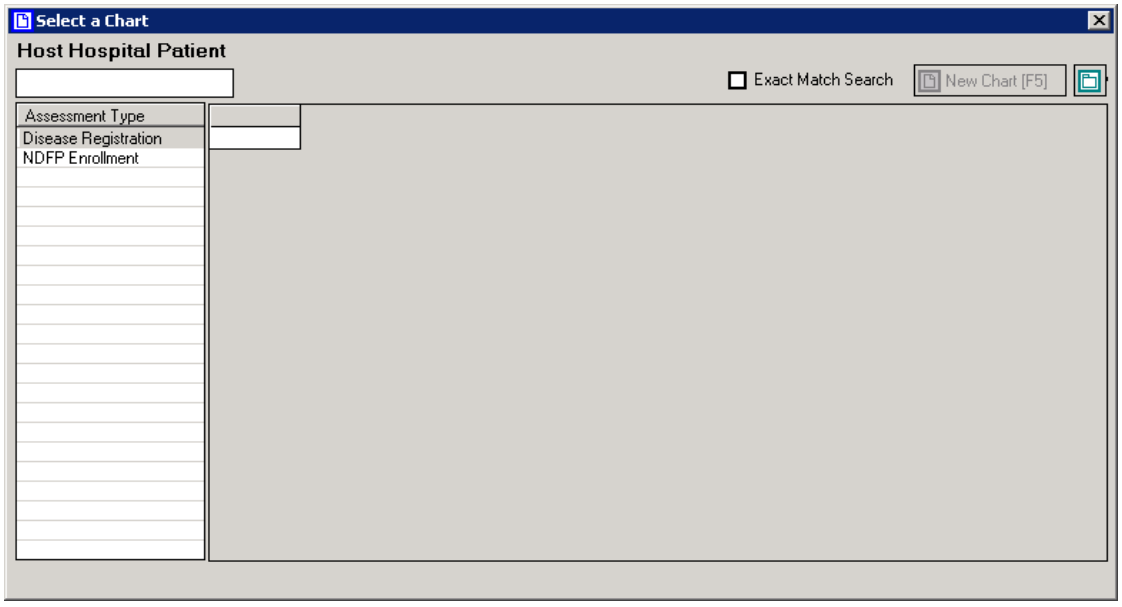
Please refer to the **Basic WinRecs Functionality** section of the User Guide for details on the record layout and functionality.

Creating a Disease Registration / NDFP Enrollment

Select the Cancer Care module from the *WinRecs Application Menu\Abstracting*, or from the *Modules* menu. For example: *Abstracting ICD 10-> Cancer Care [CCM]*.

New **(F5)**

Select a chart screen will appear.



In the select a chart window, the option of creating a new Disease Registration or an NDFP Enrollment is provided. Highlight the option you wish.

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Note: An NDFP enrollment can only be created once a Disease Registration has been completed for a patient.

Enter the chart number of the patient in the data entry box, located below the *Host Hospital Patient* heading.

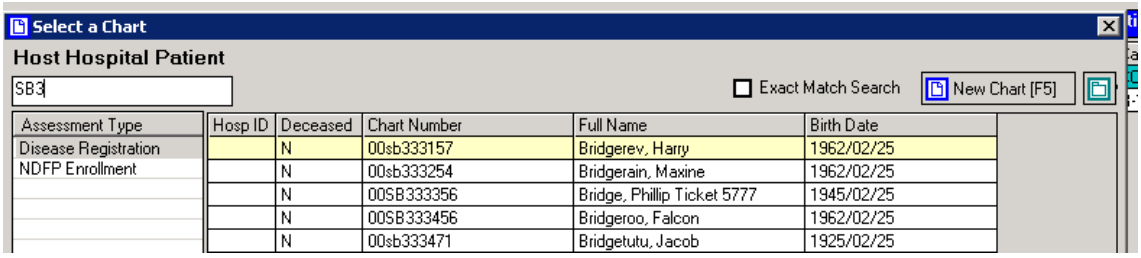
If the chart exists in CPI the chart number will populate.

If records are displayed, there a three ways to select a record:

Double-click on the record

Select the record with one click and press **ENTER**

Using the up and down arrows, highlight the record and press **ENTER**



Selecting a record will bring you into a new disease registration or NDFP Enrollment.

Any common data elements between the CPI record and the Disease Registration and/or NDFP Enrollment will populate in your new record.

If the chart number entered in the select a chart window does not exist in CPI, you will receive the following message (see screen shot below).

Selecting “Yes” will load the Central Patient Index (C.P.I.) window and the user can enter a new C.P.I. record. (See ***Creating a C.P.I Record*** section of the WinRecs User Guide)

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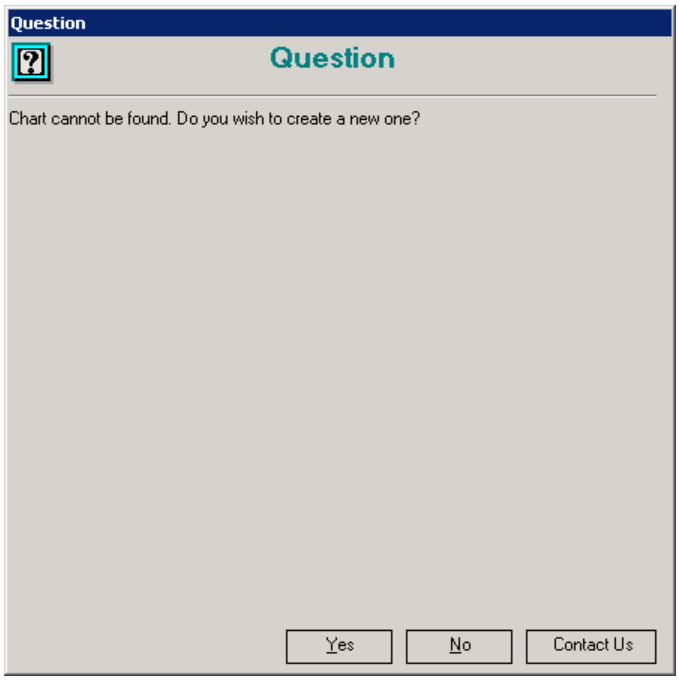

Completing the Record

As you move through the record, fields can be entered with data. The field you are currently viewing is highlighted in yellow and the field name displays at the top of the window, next to the data entry box.

All data entry is done in the Data Entry box, once the information is ‘entered’; the information will display in the field on the main grid.

An error message will be displayed at the bottom of the window in the Message List box for fields that are mandatory or suggested and not completed.

A record can be saved with mandatory fields missing. Any remaining errors will be displayed again when that record is accessed later.

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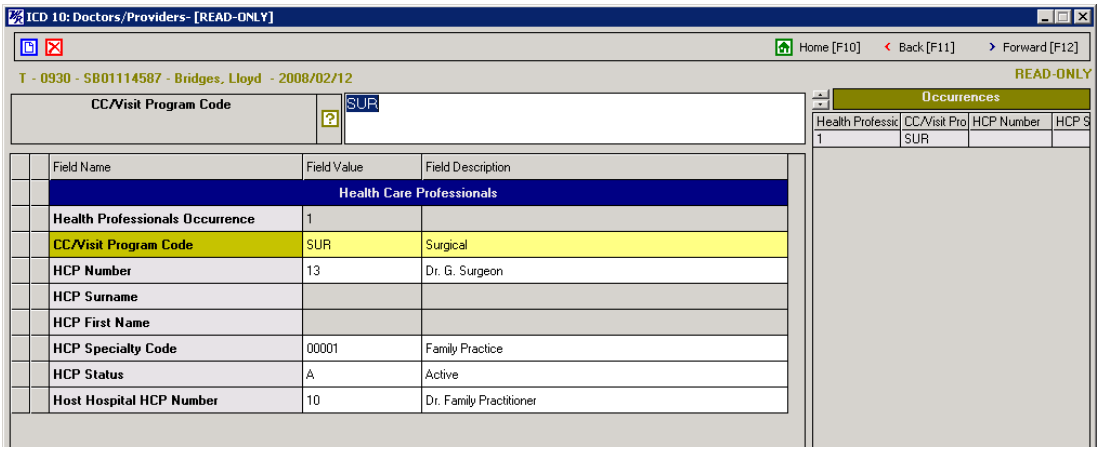
Health Care Professionals Multiform



This optional multiform is used to record any health care providers involved in the patient's care.

There are specific function keys available to process a multiform. They are:

New **(F5) -** Creates a new occurrence.
As soon as you finish one occurrence press **Enter** and the system will automatically move to the next occurrence.

Delete **(F9) -** This button will delete the occurrence you have selected. The system will display a message "Are you sure you want to delete this occurrence?" to validate the deletion.

Home/Back/Forward move the cursor out of the Multiform.

Home – Returns to the first active field in the Main Grid.

Note:	**Consult your facility's guidelines to learn when and how to record any Health Care Professionals**

Saving the Record

Save **(F7)** to save the record.
If it is the first time the record has been saved there will be no other messages.

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If the record was previously saved, the program will require it to be in **EDIT** mode from **READ ONLY.** Select **Edit** (**F6),** and then **Save** **(F7).**

Any changes made in **READ ONLY** mode will not be retained until the record is saved. If you select **Save** **(F7)** while in **READ ONLY**, a message displays: **"You are not currently in edit mode. Would you like to save this record anyway?"** Select 'Yes' to save the record. Select 'No' to return to the record without saving it. This allows the opportunity to not save any changes made on the record.

Patient registered for treatment – Amcare basis (NACRS)

As the patient attends your facility for treatment on an inpatient or outpatient basis you want to ensure that these visits do in fact get processed through from your ADT system to WinRecs.
Some visits of a clinic nature may not currently be processed as they are not required by CIHI (ie. are non-mandated MISCodes).
For these cases, confirm with your CIHI representative that the submission of any additional MISCode abstracts to CIHI will not be problematic and inform them that they can expect these new clinic type records effective April 1st.
Update / modify your current interface to also send those visits to WinRecs and then the MED2020 interface needs to be updated to accept them.
Visits will be populated in the NACRS module.
Additional Cancer Care fields have been added to the standard NACRS module to allow you to enter the Chemo and Radiation Treatment fields required for visit level reporting.
Please ensure that these fields are open via the Control File, for access for the coders that will be coding the cancer care patient information for you.
MISCodes should drive the opening of these fields.

Below you will find a screen shot of these new fields:

Locating an Existing Disease Registration / NDFP Enrollment

Select the Cancer Care module from the *WinRecs Application Menu/Abstracting*, or from the *Modules* menu. For example: *Abstracting ICD 10-> Cancer Care [CCM]*.

For details on searching, see **Basic WinRecs Functionality** section.

Facilities using batch or real-time interfaces to open records in a WinRecs database will use **Find** **(F4)** to locate existing chart numbers for data entry.

Facilities not using interfaces to open records in WinRecs will manually create new disease registrations or NDFP Enrollments using **New** **(F5)**

Find (F4)

To change the fields used in the search, click in the text box next to the field or press **F3**

Check/uncheck the *Exact Match Search* check box as required (if searching by *Host Hospital Patient*

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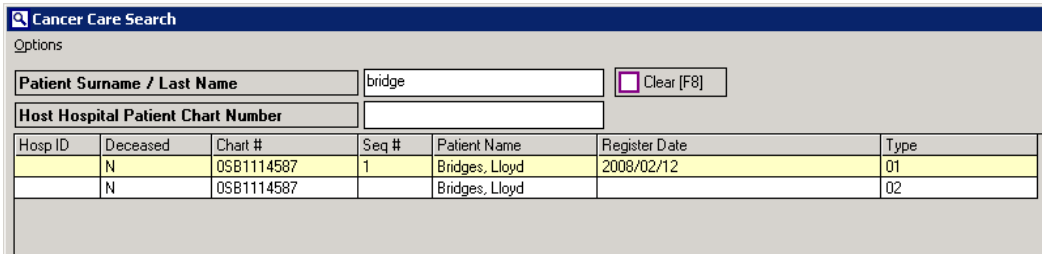
Chart Number).

Type the search text in the Data Entry Box and press **ENTER**.



Note: There can be up to 4 search fields. The number of search fields used can be customized. Click Options in the Cancer Care Search window to view the options.

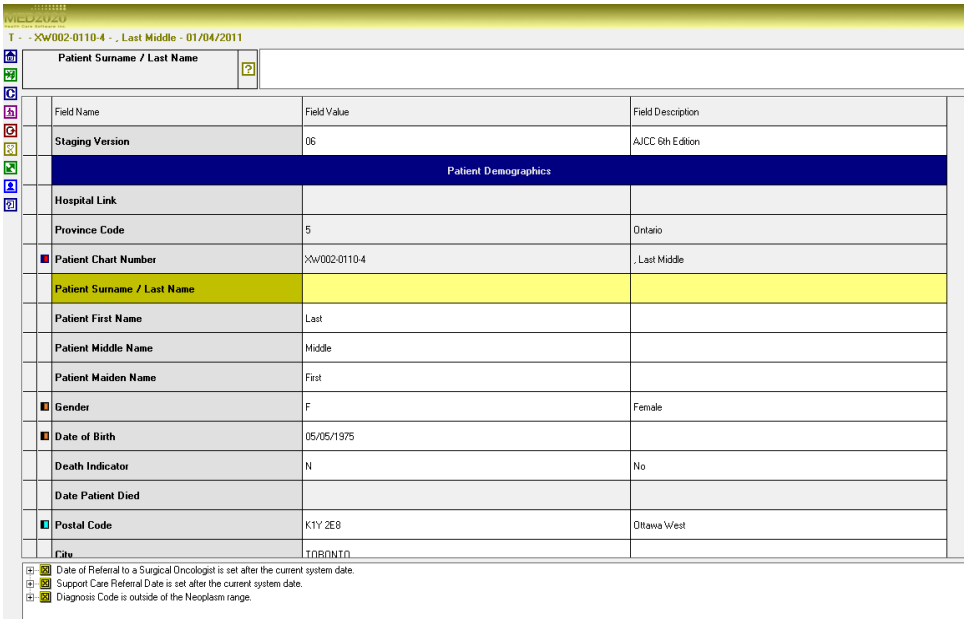
Hint: To search for records for an entire month, type 00 for the day (DD).

Record Types

The Cancer Care Search results window will display a number of columns with data elements displayed to assist the user in selecting the appropriate record.

The Type column will indicate:

- 01 for a Disease Registry or
- 02 for an NDFP Enrollment record



Disease Registry entry form

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Adding an NDFP Enrollment Record

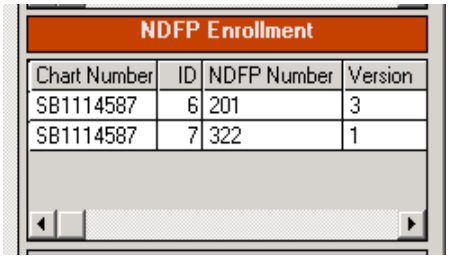
As documented earlier in this section, the NDFP record can only be created based on an existing Disease Registration. More than one NDFP enrollment can be added per disease registration.

Viewing an NDFP Enrollment

A side-bar information pane on the disease registration record will indicate any NDFP Enrollments for this registration.

The individual NDFP Enrollment records can be viewed simply by double-clicking on the selected record, from within the information pane.

The selected record will load, and details can then be reviewed/updated.



Defaulting Field Values / Changing Field Sort Order

Several fields in the Disease Registration and/or the NDFP Enrollment may be practical for defaulting values. Please refer to the **Control File** section of the User Guide for setting defaults for fields and customizing the sort order of fields in either of these record types.

Providers

Specific fields have been added to the Provider Maintenance module in WinRecs (found under System Maintenance) to allow entry of the HCP Program Code and HCP Status for the Health Care Professionals related to the Cancer Care module. Please see **Provider Maintenance** in the WinRecs User Guide for details on editing the provider records.

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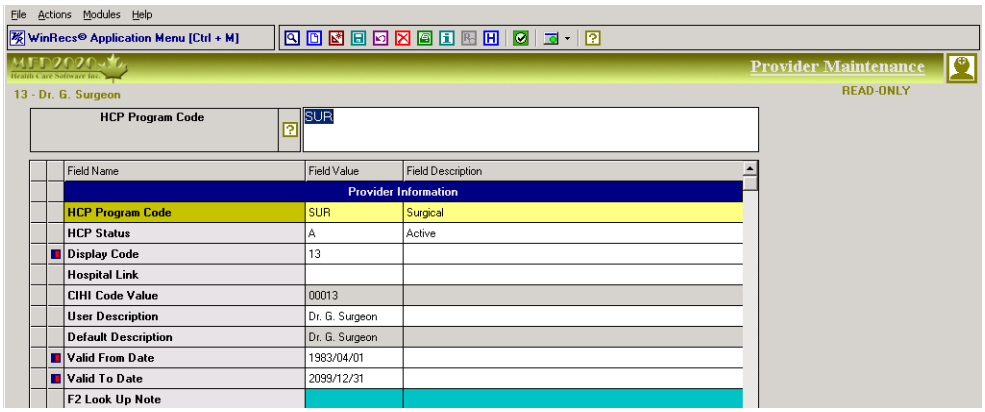

Submitting Data

Creation of submission files is performed via the WinRecs Report Generator. Data is extracted based on the parameter values presented and entered.

Specific submission reports for:

1) Disease Entity
2) NDFP Enrollment
3) Provider's Entity
4) Patient Entity

…are available to run and export to the desired application, such as Microsoft Excel.

See the **Report Generator** section of the WinRecs User Guide for details on how to generate reports.

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Canadian Joint Replacement Registry – (CJRR)

Overview

The Canadian Joint Replacement Registry (CJRR) module is a data collection tool within the WinRecs suite of modules that allows for the specific collection of joint replacement data as set out by the Canadian Institute for Health Information for their CJRR Registry. This registry focuses exclusively on gathering data related to knee and hip interventions as captured by the following CCI codes:

1.VA.53.XX
1.SQ.53.XX
1.VG.53.XX
1.VP.53.XX

CJRR records can be created in 3 ways; directly in the CJRR module (manual creation), through a DAD or NACRS discharge abstract or through a batch in interface from an OR system.

Each facility will need to supply CIHI a list of their orthopedic surgeons prior to using the CJRR system. CIHI will send back assigned unique CJRR Surgeon ID's. This will identify each Surgeon regardless of where they perform their surgeries.

The version of the CJRR module in 2.8.9 provides data collection functionality. Submission functionality will be provided following MED2020's completion of vendor testing with CIHI in April 2012.

Creating a CJRR Record (Manual Creation)

Select the Canadian Joint Replacement Registry (CJRR) module from the *WinRecs Application Menu\Abstracting ICD 10*, or from the *Modules/Abstracting ICD 10* menu. For example: *Abstracting ICD 10->Canadian Joint Replacement Registry (CJRR)*.

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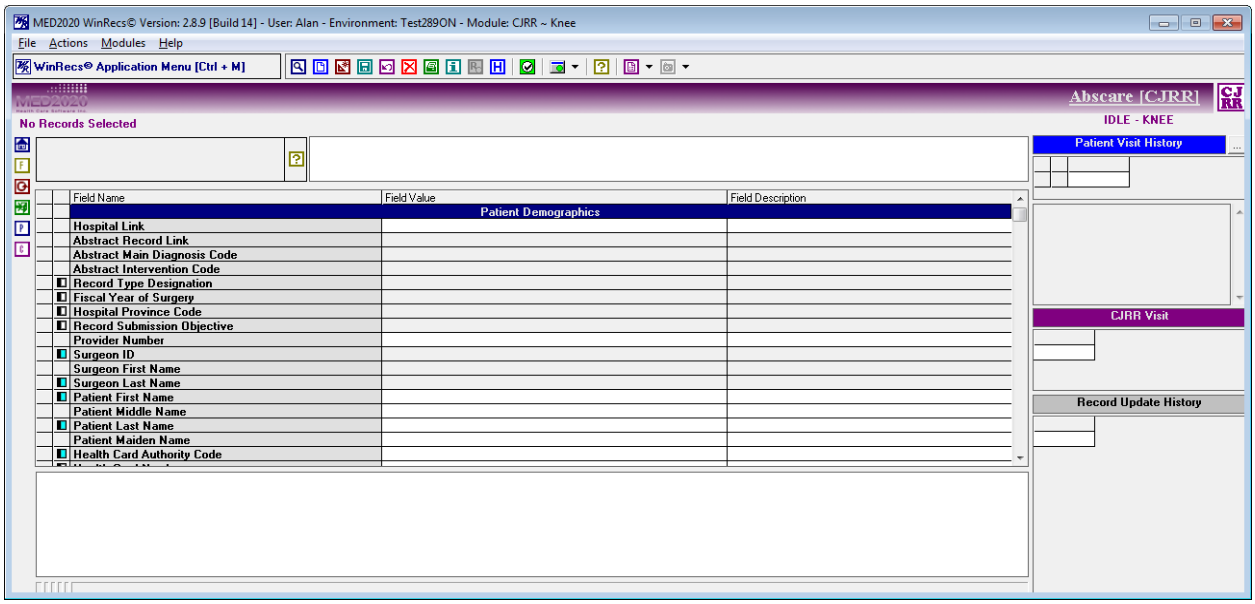
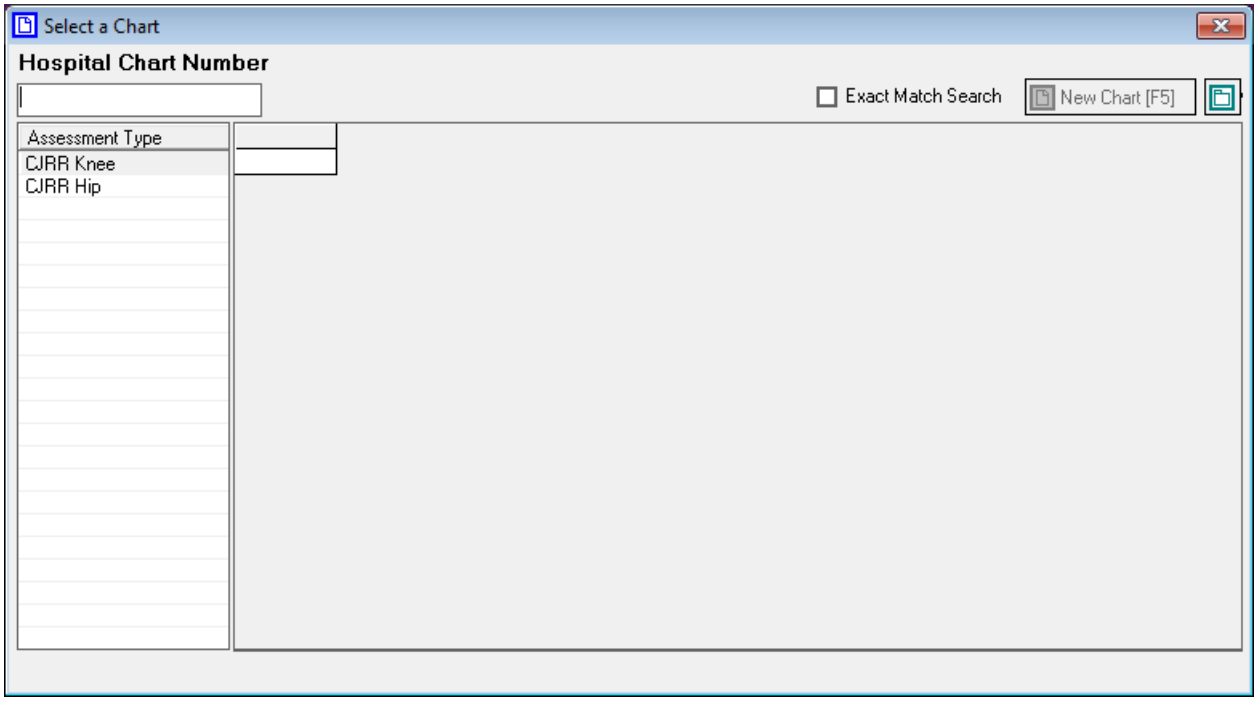


To create a new record: **(F5)**

The Select a chart screen will appear.



In the select a chart window, the option of creating a new CJRR Knee or Hip record is provided. Highlight the option you wish.

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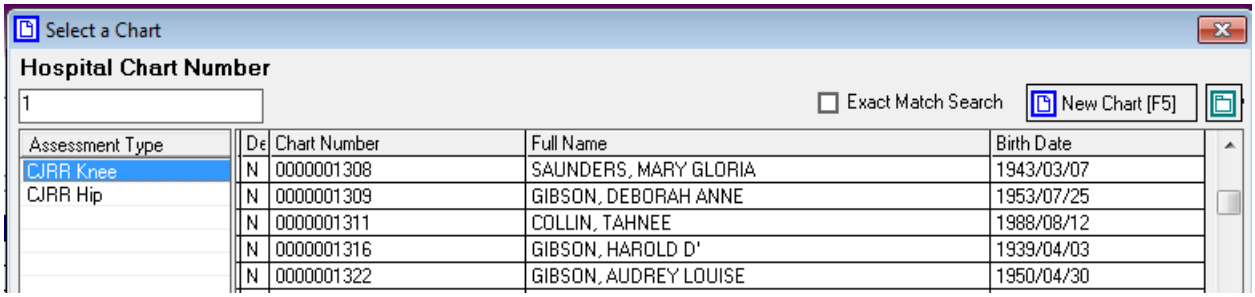
Note: Each knee or hip replacement in the CJRR is a unique record. Therefore a bilateral knee replacement will need to have two records created – one for the left knee and one for the right knee.

Enter the chart number of the patient in the data entry box, located below the *Hospital Chart Number* heading.

If records are displayed, there a three ways to select a record:

- Double-click on the record
- Select the record with one click and press **ENTER**
- Using the up and down arrows, highlight the record and press **ENTER**



Selecting a record will bring you into a new CJRR form. Any common data elements between the CPI record and the CJRR form will populate in your new record.

If the chart number entered in the select a chart window does not exist in CPI, you will receive the following message (see screen shot below).

Selecting “Yes” will load the Central Patient Index (C.P.I.) window and the user can create a new C.P.I. record. (See *Creating a C.P.I Record* section of the WinRecs User Guide)

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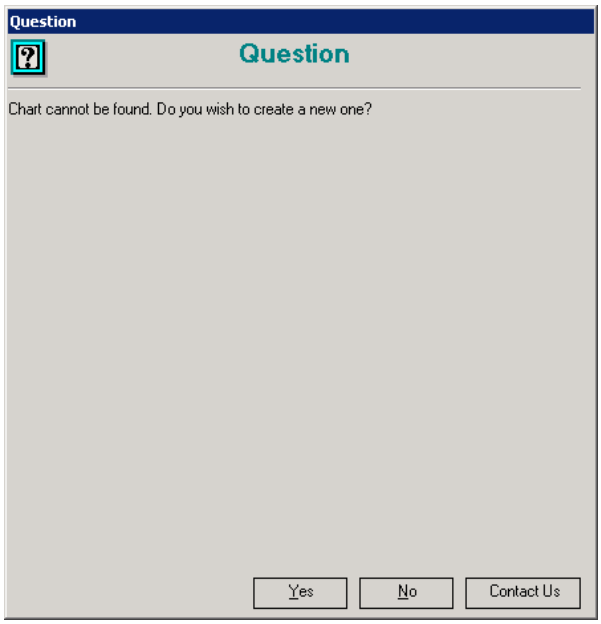

Completing the Record

As you move through the record, fields can be entered with data. The field you are currently viewing is highlighted in yellow and the field name displays at the top of the window, next to the data entry box.

All data entry is done in the Data Entry box, once the information is ‘entered’; the information will display in the field on the main grid.

An error message will be displayed at the bottom of the window in the Message List box for fields that are mandatory or suggested and not completed.

A record can be saved with mandatory fields missing. Any remaining errors will be displayed again when that record is accessed later.

Prosthesis Multiforms

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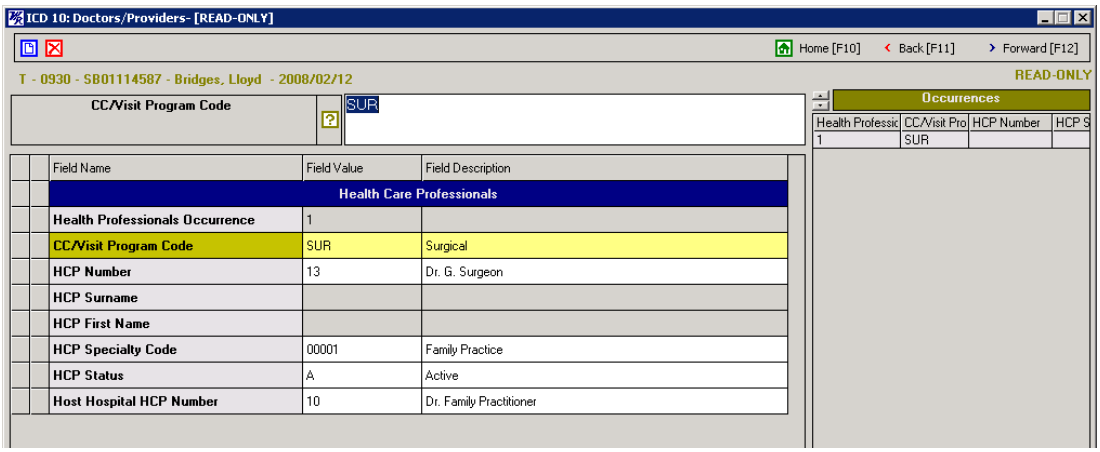

This optional multiform is used to record any health care providers involved in the patient's care.

There are specific function keys available to process a multiform. They are:

New **(F5) -** Creates a new occurrence.
As soon as you finish one occurrence press **Enter** and the system will automatically move to the next occurrence.

Delete **(F9) -** This button will delete the occurrence you have selected. The system will display a message "Are you sure you want to delete this occurrence?" to validate the deletion.

Home/Back/Forward move the cursor out of the Multiform.

Home – Returns to the first active field in the Main Grid.

Note:	**Consult your facility's guidelines to learn when and how to record any Health Care Professionals**

Saving the Record

Save **(F7)** to save the record.
If it is the first time the record has been saved there will be no other messages.

If the record was previously saved, the program will require it to be in **EDIT** mode from **READ ONLY.**
Select **Edit** **(F6),** and then **Save** **(F7).**

Any changes made in **READ ONLY** mode will not be retained until the record is saved. If you select **Save** **(F7)** while in **READ ONLY**, a message displays: **"You are not currently in edit mode. Would you**

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like to save this record anyway?" Select 'Yes' to save the record. Select 'No' to return to the record without saving it. This allows the opportunity to not save any changes made on the record.

Creating a CJRR Record (Through DAD or NACRS)

**** Refer to the Abstracting ICD10 – Abstracting DAD\SDS\NACRS section of this user guide for creating or retrieving a patient's chart.

The following criteria will need to be met in order for the CJRR form to be triggered from DAD or NACRS:

If the intervention is one of the following codes:

- 1.VA.53.^^ - Implantation of internal device, hip joint
- 1.SQ.53.^^ - Implantation of device, pelvis
- 1.VG.53.^^ - Implantation of internal device, knee joint
- 1.VP.53.^^ - Implantation of internal device, patella

This includes knee and hip replacements that are:

- Emergency or elective
- Total or partial
- Primary or revision

The Intervention date must be greater than or equal to April 1, 2012.

Intervention Attribute Status not equal to (<>) "A"=Abandon after onset.

If the above criteria are met then the following pop-up screen will appear:

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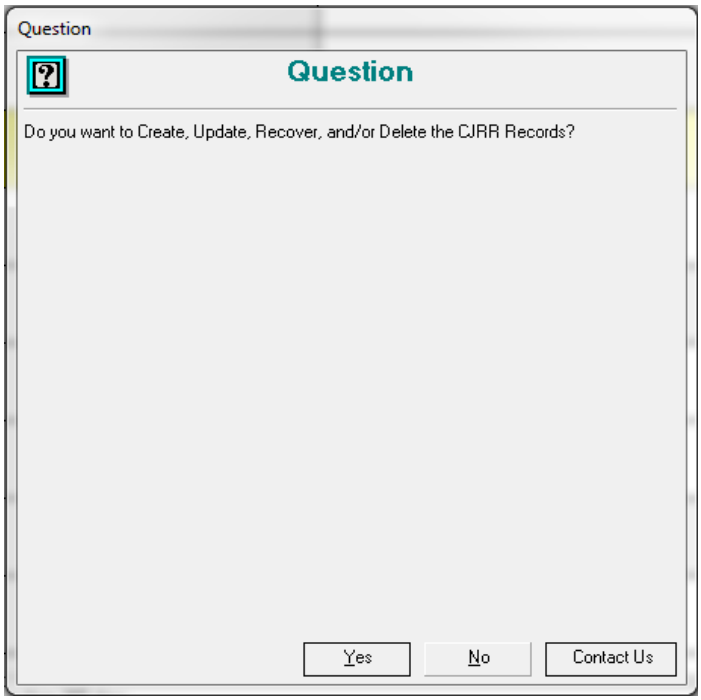
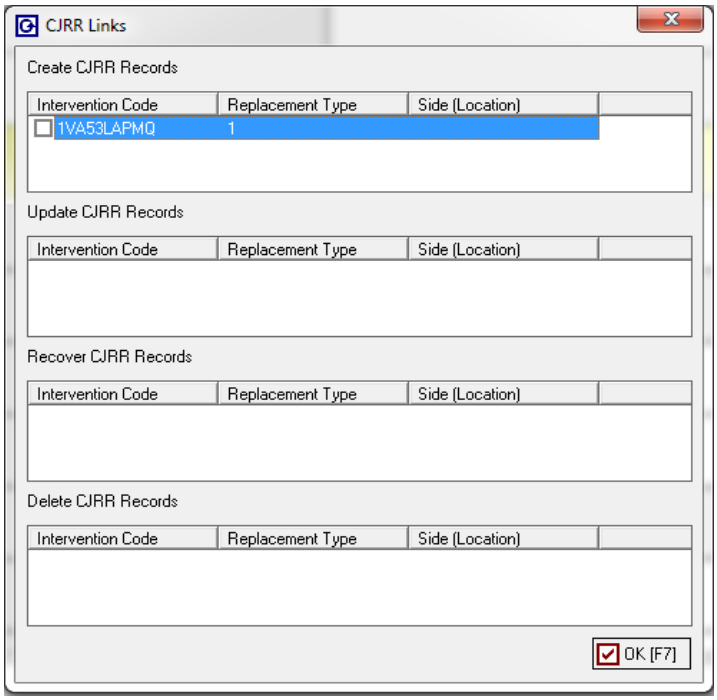


If you click NO the record will be flagged and appear on the Incomplete Report. You will be able to run this report at any time to determine what records are considered CJRR and need to be updated or deleted.

If you click YES then the following pop-up screen will appear:



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When a Health Record Professional accesses a visit it will create a CJRR record if one doesn't already exist, updated if there is a discrepancy, recovered if needs to be brought back or deleted if the criteria does not meet the requirements.

Create:

The CREATE section is asking you if you would like to create a new CJRR record. You must click the checkbox in order for the CJRR form to open. If you do not check the box then the record will be flagged and placed on the Incomplete Report which you will be able to print and decided what to do with the record information. Press the OK button to confirm your response.

Update:

The UPDATE section is if a CJRR record exists and there has been a change on the Abstract (eg. Surgery Date, Intervention). You must click the checkbox in order for the CJRR form to open. If you did not check any boxes then the record will be flagged on the Incomplete Report and you will be able to print or view the report later and decide what to do with the CJRR record. Press the OK button to confirm your response.

Recover:

The RECOVER section is used when you have DELETED a CJRR record and wish to recover it from the purge file. This is useful for when you have accidentally deleted a CJRR record and wish to RECOVER it instead of re-typing all the information in again.

Delete:

The DELETE section is used for moving records to the PURGE file.

Once you click the OK button the CJRR form will open with all the DAD or NACRS patient demographic information being passed through. You will need to enter all the Operation Room (OR) information as this information will not be passed. A record can be saved with mandatory fields missing. Any remaining errors will be displayed again when that record is accessed later.

Note: This Record has been submitted to CIHI. Users must notify their CIHI liaison via email and include: Record ID, Surgery Date, Joint Type and Side (location).

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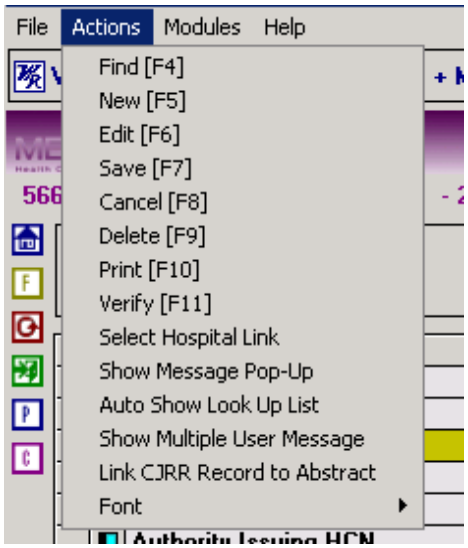
Link CJRR Record to Abstract

- Go to WinRecs Application Menu
- Abstracting ICD 10
- Canadian Joint Replacemnt Registry (CJRR)
    - If the CJRR record is already created press F4 (Search) and enter the If the CJRR record is already created press F4 (Search) and enter the Hospital Chart Number
    - If this is a new CJRR record press F5 (New) (see section on how to create a CJRR record)
- To link the CJRR record to the Abstract go to:
    - Actions
    - Link CJRR Record to Abstract



    - A pop up screen will have the abstract visits for that record, choose the appropriate visit by click on the blank square and press OK(F7)
    -

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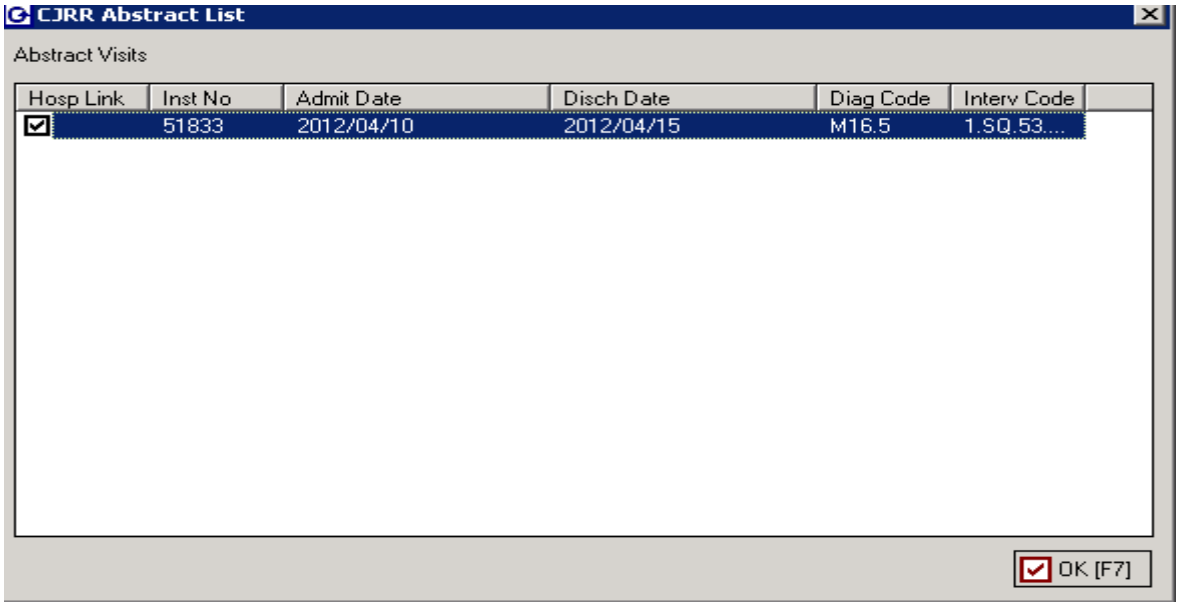
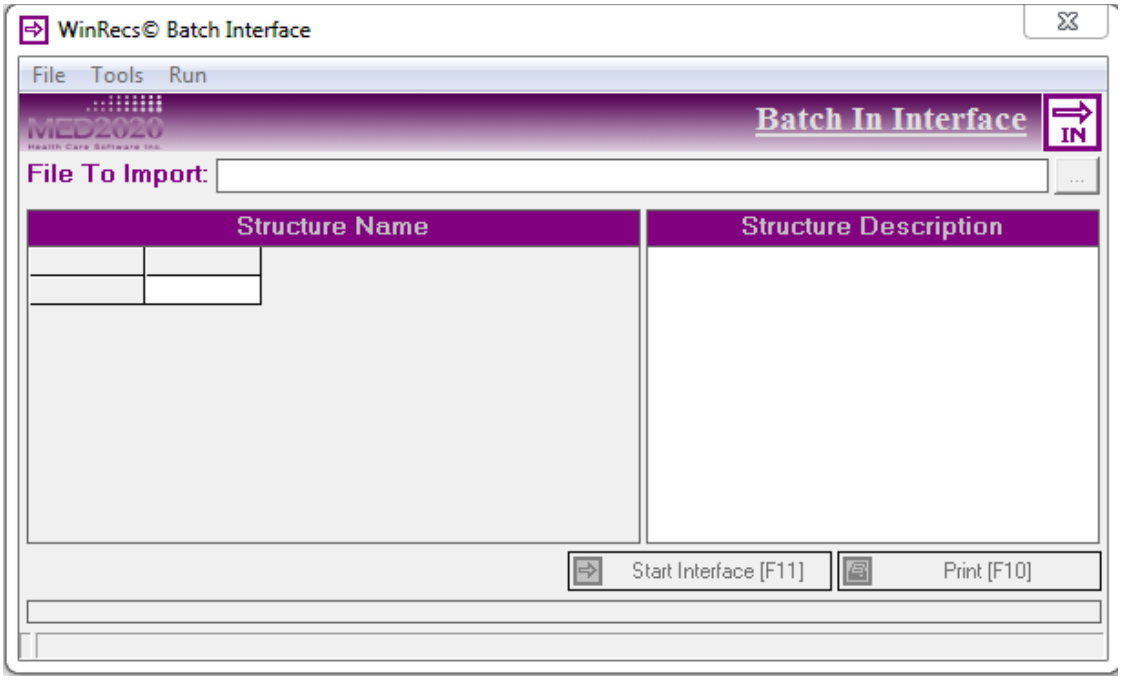


- F6 & F7 to save the record

Physician Provider and CJRR

- Go to: WinRecs Application Menu
- System Maintenance
- Provider Maintenance
- Go to 'CJRR Surgeon ID' field and enter the 'CJRR Surgeon ID' that is assigned by CIHI.
- Go to 'Provider Surname' field and enter the provider surname (this field become mandatory when the 'CJRR Surgeon' field has a value).



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Creating a CJRR Record from a Batch Interface (BI)

MED2020 will provide a standardized file layout of the flat file to be followed
The clients Operating Room (OR) system will generate a file based on the specifications provided by MED2020 and load the file into a centralized location accessible to the WinRecs application
The client will then login to MED2020's and select Utility->Incoming Batch Interface (CJRR)
Refer to the running a BI section within this user guide for more detailed instructions

Creating a CJRR Record from an ADT HL7 feed

The ADT HL7 feed will send across demographic only information as well as the record type entered into ZZ-Segment
Med2020 will work with the organization to determine which ZZ-Segment will need to be populated in order for the record type to be populated correctly
Med2020 will provide the record type values in an Excel Spreadsheet (e.g. with LK=Left Knee)

This process to send a CJRR record from the ADT (Registration) system to the WR CJRR module will be triggered each time the record type is entered in the ZZ-Segment field.

Inputting of Bar Codes

WinRecs will allow the scanning of Bar Codes as long as the Bar Code Scanner that is being used has been installed with all the proper drivers. A bar code font must also be installed on the computer running WinRecs (eg. "3 of 9"). To view a listing or install new font on the computer, go to Control Panel → Fonts.

This will be part of the Med2020 training.

Submitting CJRR Data

Select CIHI Submissions under Utilities from WinRecs Application Menu:

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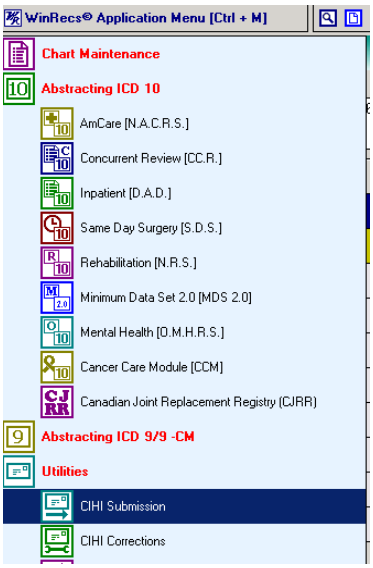

Enter Institution number for CJRR submission

- Enter the Batch Year
- Enter the Batch Period
- Enter Y for Is CJRR Submission
- Complete Re-Verify – enter **yes** if you wish to carry out a complete re-verify or No if one has already been done.

Click F11 - (Start Submission) Process.

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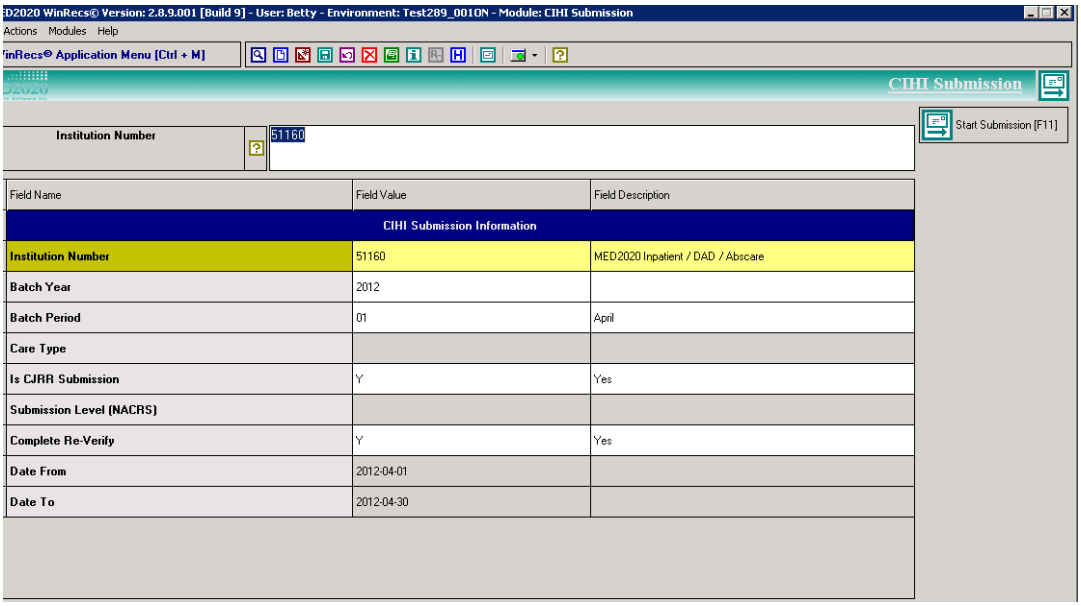
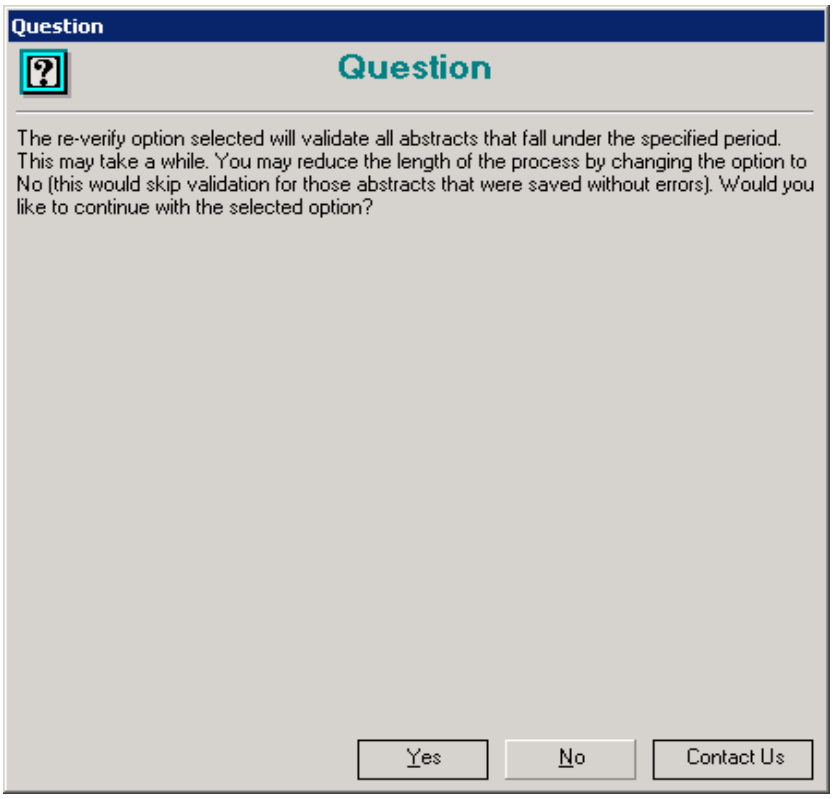


The following message box will appear. Click Yes to proceed or No to cancel action.



The records will be verified and displayed to the right where there are any errors or warnings.

At the top of the screen, the number of records processed will be recorded.

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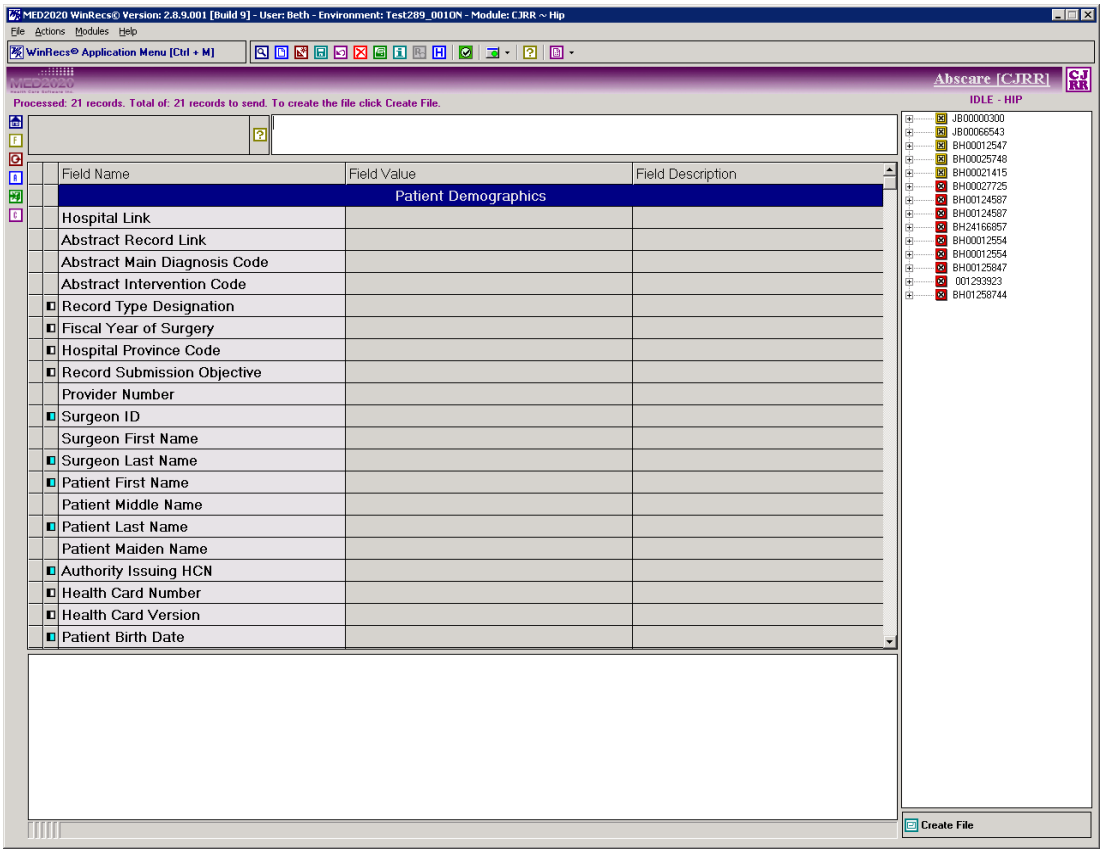

Correct your errors and warnings and then re-run the submissions process.

Note: If you attempt to 'Create File' and there are outstanding errors, the following Error Message Box will appear.

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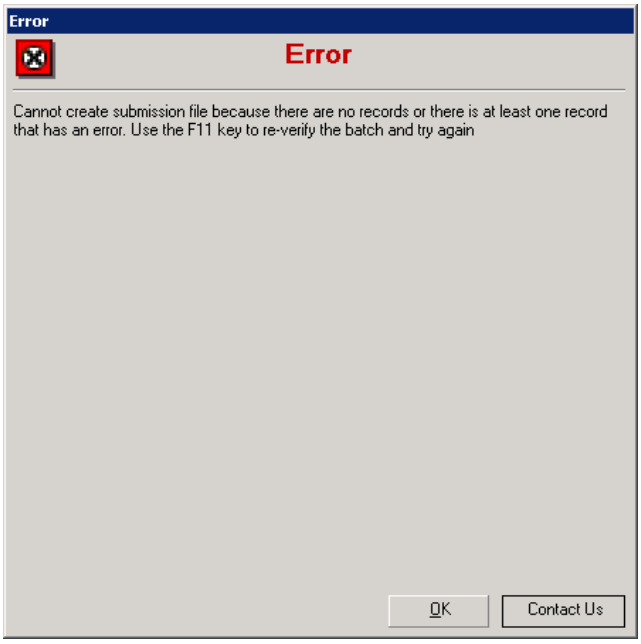

Re-run your re-verify (F11) once all errors are cleared.

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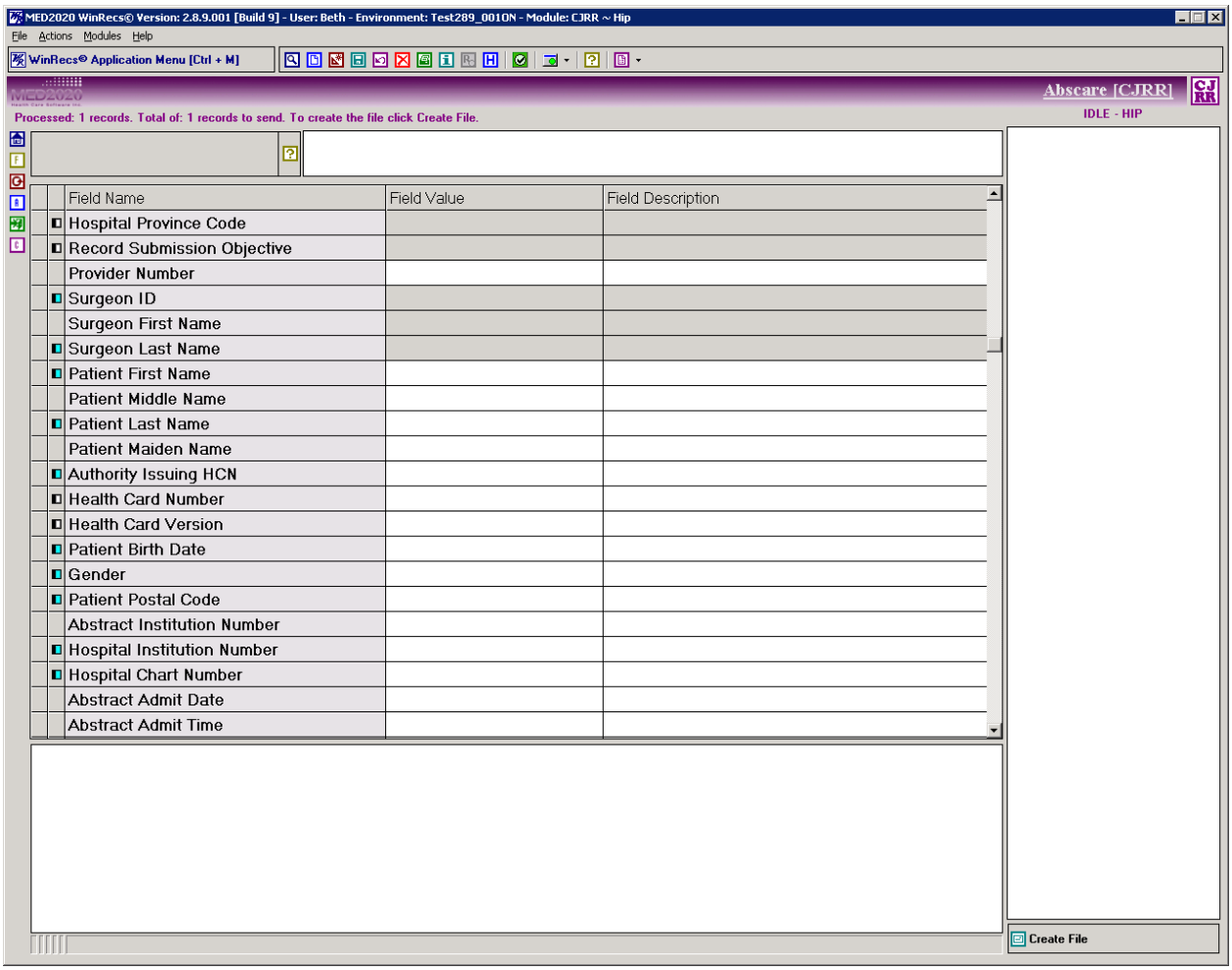
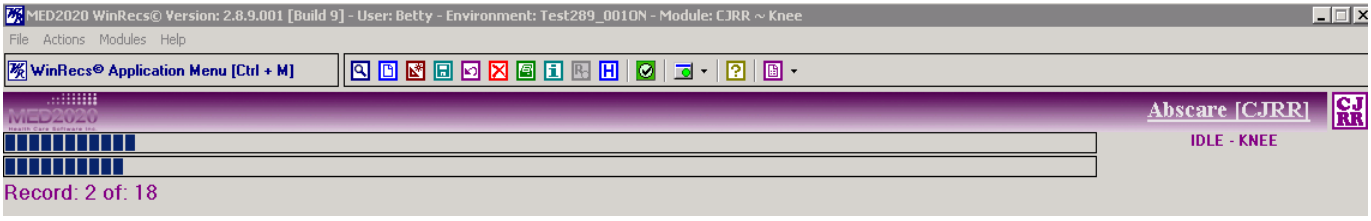


Click Create File.

Submissions progress bar will display.



File location will display at the top of your screen.

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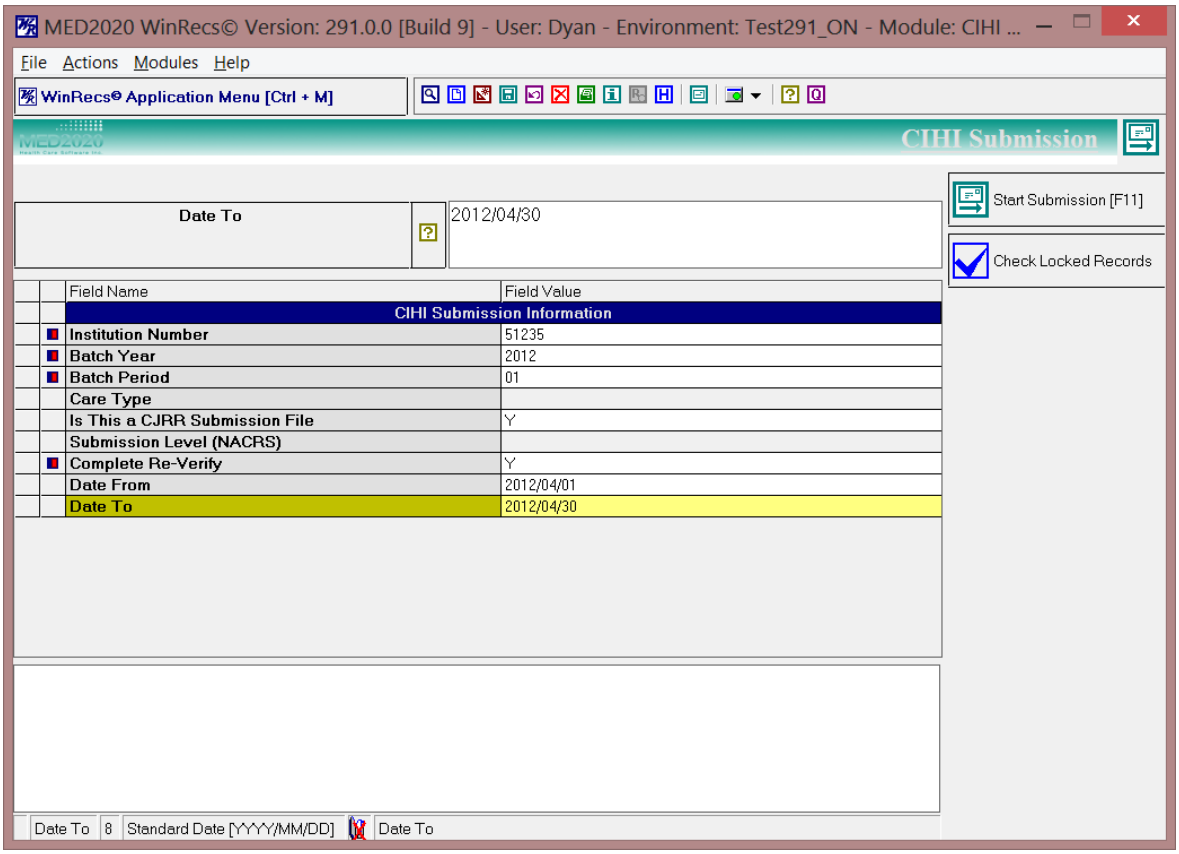

Note: Knee and hip data files must be submitted separately and therefore two separate files will be created at the same time with the following naming convention.

CJR20120151235101.TXT

CJR – denotes the module data comes from

2012 – Denotes the fiscal year

01 – Denotes the period

51235 – Denotes the institution number

1 - Denotes type of record (1-Knee, 2-hip)

01 – Denotes the sequence number

TXT – Denotes the file extension

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Abstract Queue

Overview

The Abstract Queue module is integrated with MED2020's chart abstracting software, WinRecs. The Abstract Queue:

1. Is available for AmCare (NACRS) and Inpatient (DAD) modules.
2. Lists visits that have not been accessed, that contain errors or that have been created by a user.
3. Provides assign capability by the Coder to themselves or by an Administrator to a Coder.

Opening the Abstract Queue

To access the Abstract Queue, the icon is available in the icon bar in WinRecs. The Abstract Queue can be used to search for AmCare or Inpatient records.

Note: To enable the Abstract Queue Icon go to the Hospital Profile and update field "User Abstract Queue" to Yes. Save this value and then users must log out of WinRecs and back in for the change. Notice that If the above field is not shown in the Hospital Profile you must enable the field via the Control File.

Click on the Abstract Queue icon to open the Abstract Queue window.

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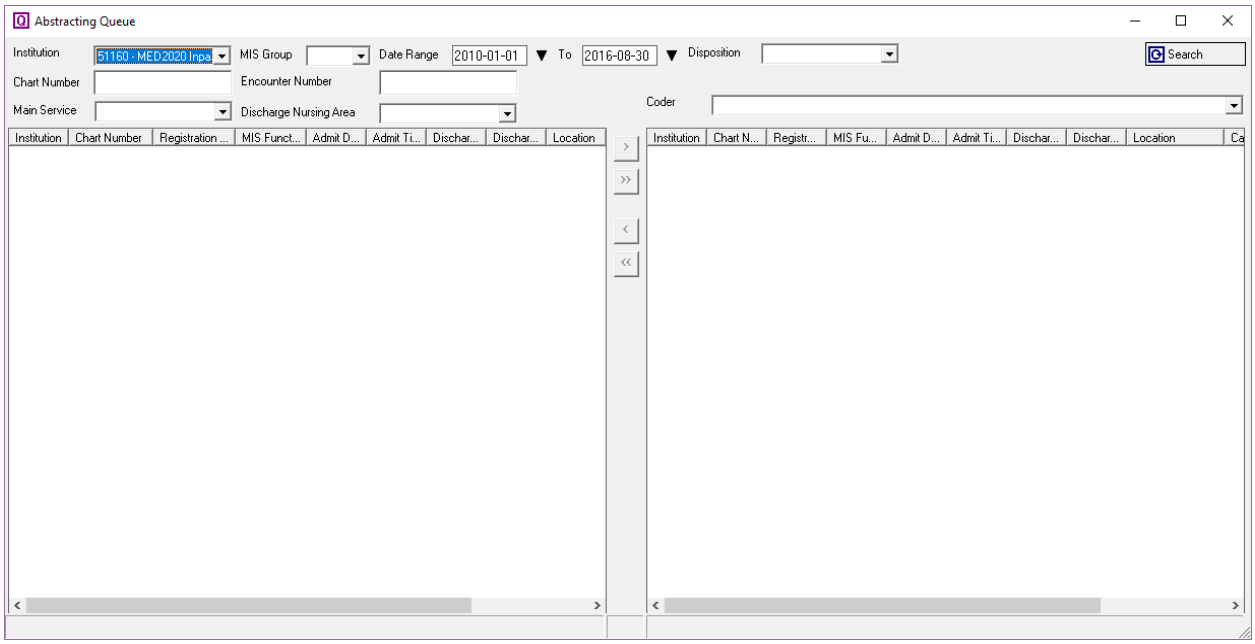
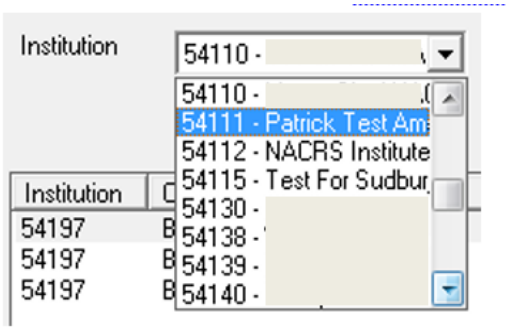


Searching for Records

The Abstract Queue allows filtering by Institution Number, Ambulatory Care Group, Date Range and Chart Number. Click the **Search** button once you've entered the parameters in the fields to run the search.

Search by Institution Number

All Institution Numbers are available to search on and are presented in a drop down list. Use the mouse to highlight the desired Institution Number or the arrow keys to select it from the list.



Search by MIS Group

AmCare Institution Numbers can be further filtered by selecting the Ambulatory Care Group – Emergency Department (ED), Day Surgery (DS), Clinic (CL), Other (OT), or Diagnostic Imaging (DI).

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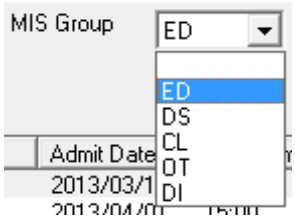
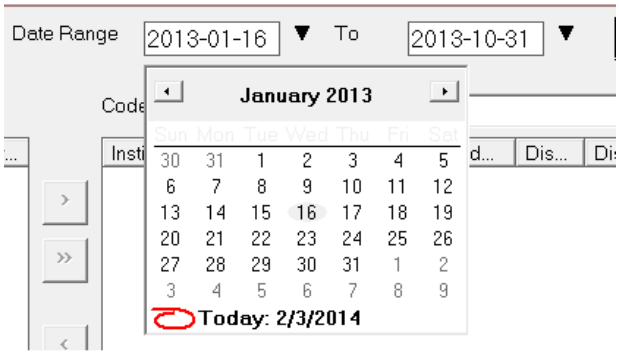


Search by Date Range

The date format is presented as YYYY-MM-DD. The first date field indicates the start date for the search; the second field the end date for the search.

Type a date directly into the Date Range fields or use the arrow ▼ to open the calendar and select a date. Forward and back arrows shown on either side of the name of the month let you move forward and back through the calendar one month at a time.

Click on '**Today'** at the bottom of the calendar to quickly fill today's date into the Date Range fields.



Search by Chart Number

Enter a chart number into the **Chart Number** field. Chart Numbers must be an exact match to locate the record; records with a partial match to the chart number will not be returned.

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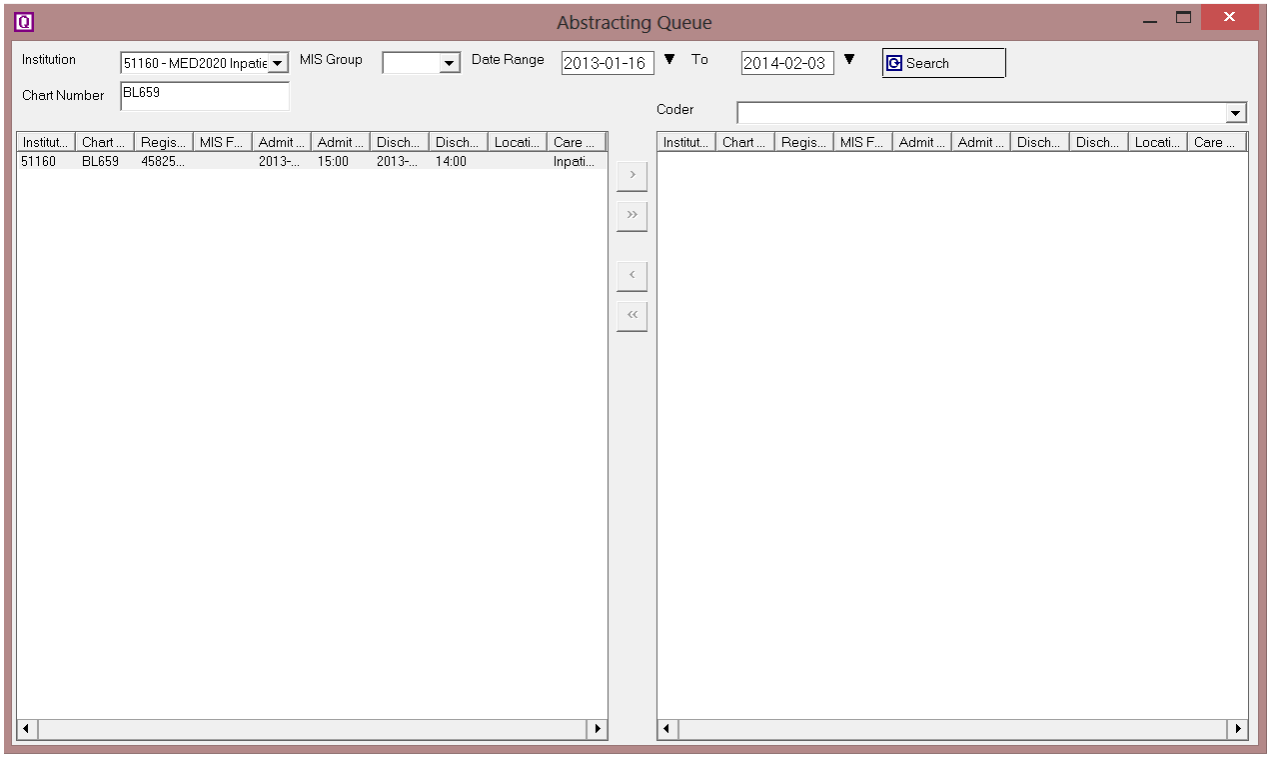
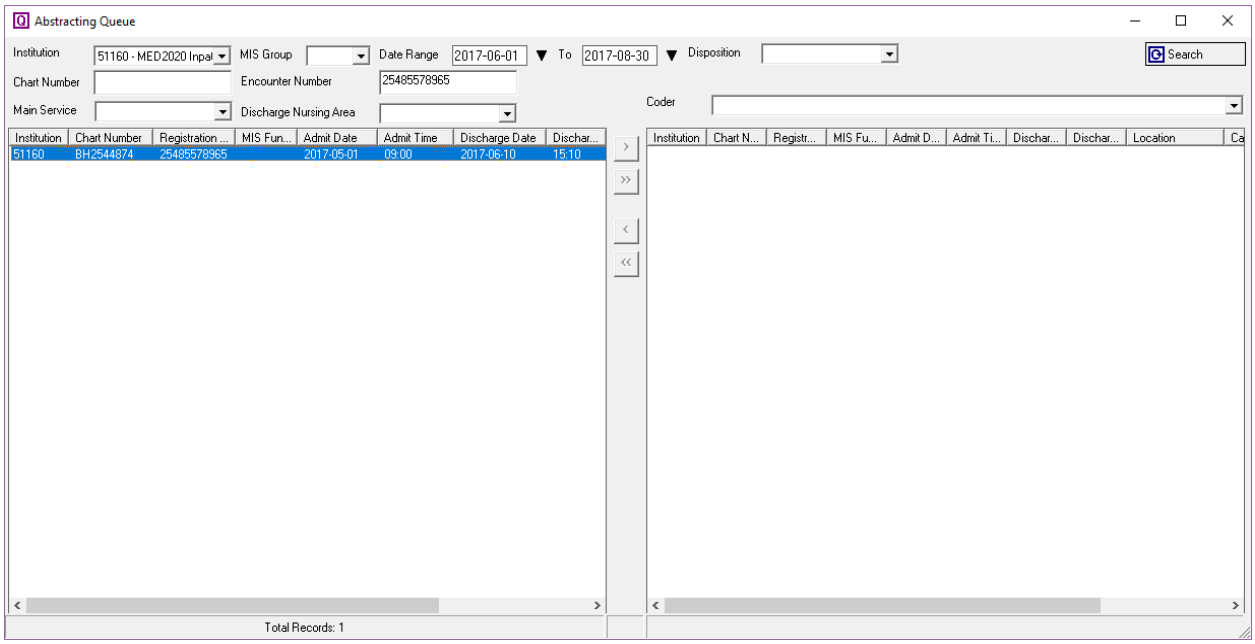


Click the **Search** button to search based on the parameters entered in the search fields.
The search parameters entered are saved from one session to the next.

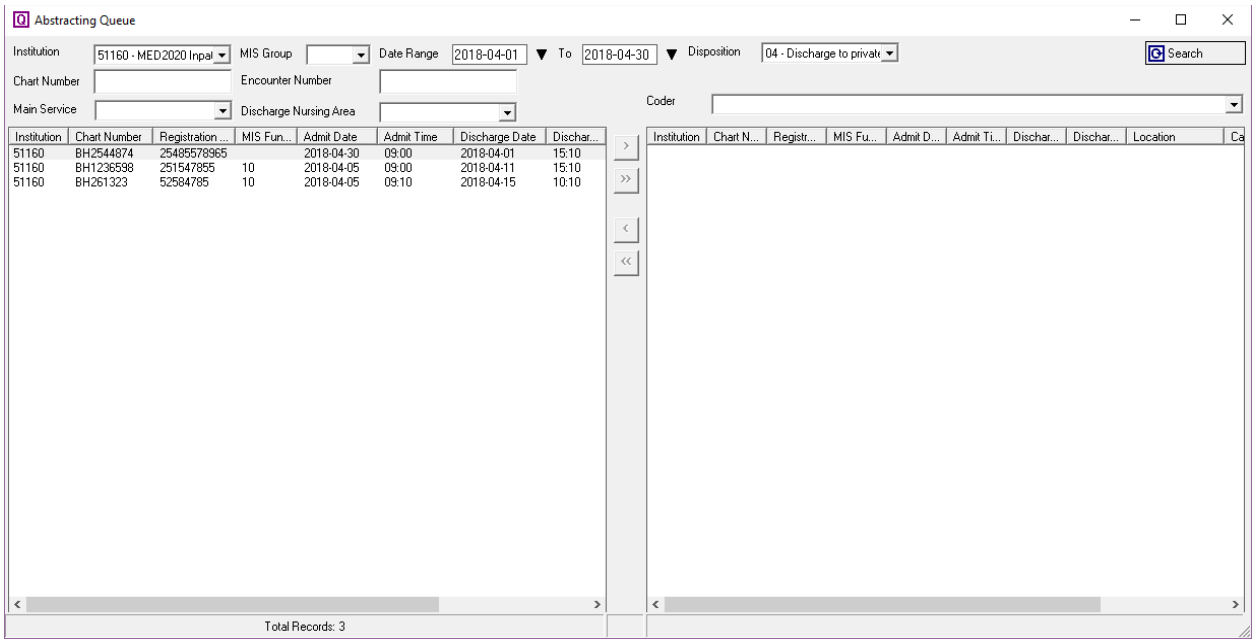
Search by Encounter Number

Enter an encounter number into the **Encounter Number** field. Encounter Numbers must be an exact match to locate the record; records with a partial match to the chart number will not be returned.



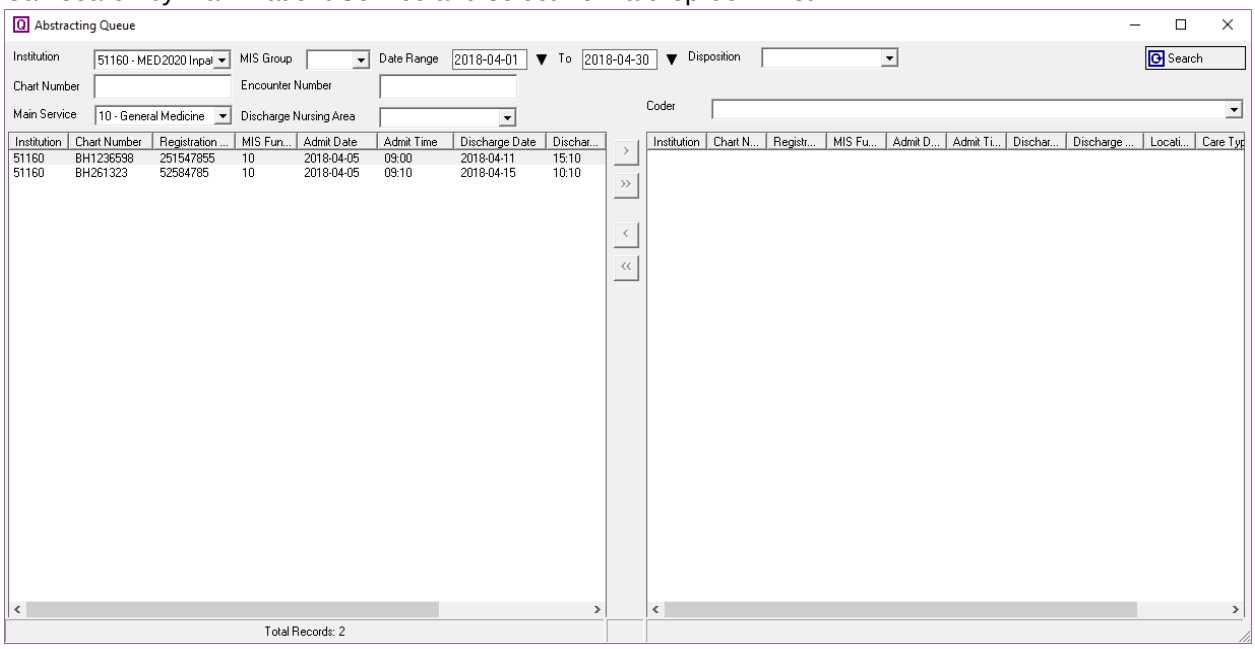
Search by Disposition Code

Can search by Disposition and select from a drop-down list



Search by Main Patient Service

Can search by Main Patient Service and select from a drop-down list



Search by Discharge Nursing Area

Can search by Discharge Nursing Area and select from a drop-down list

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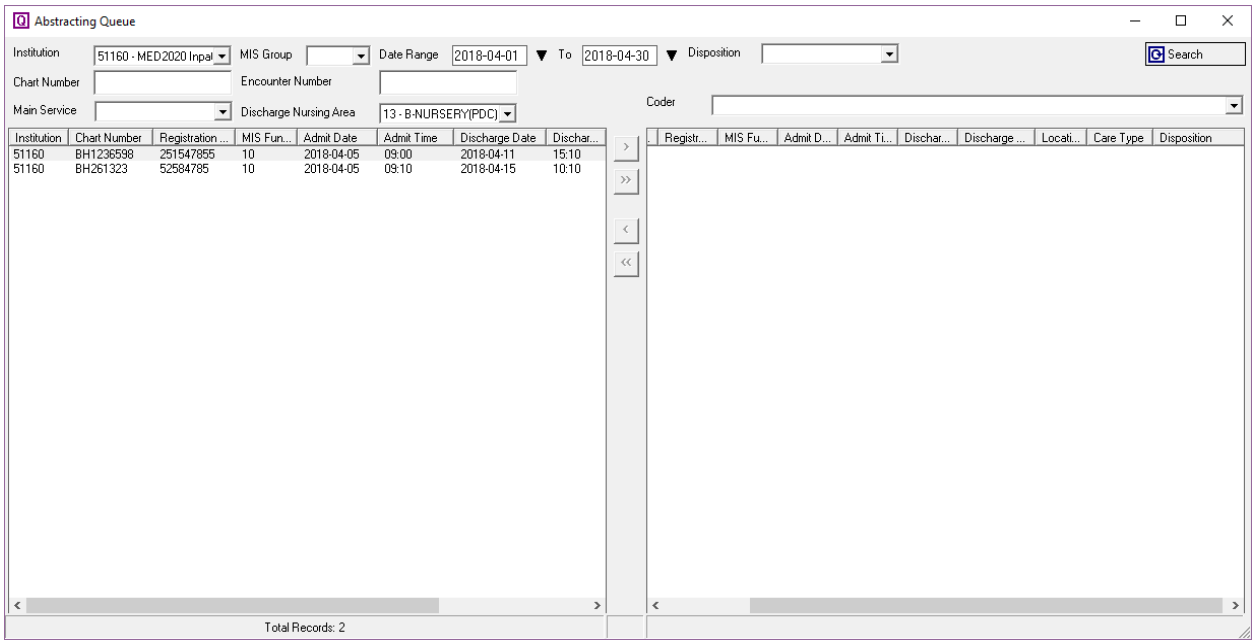
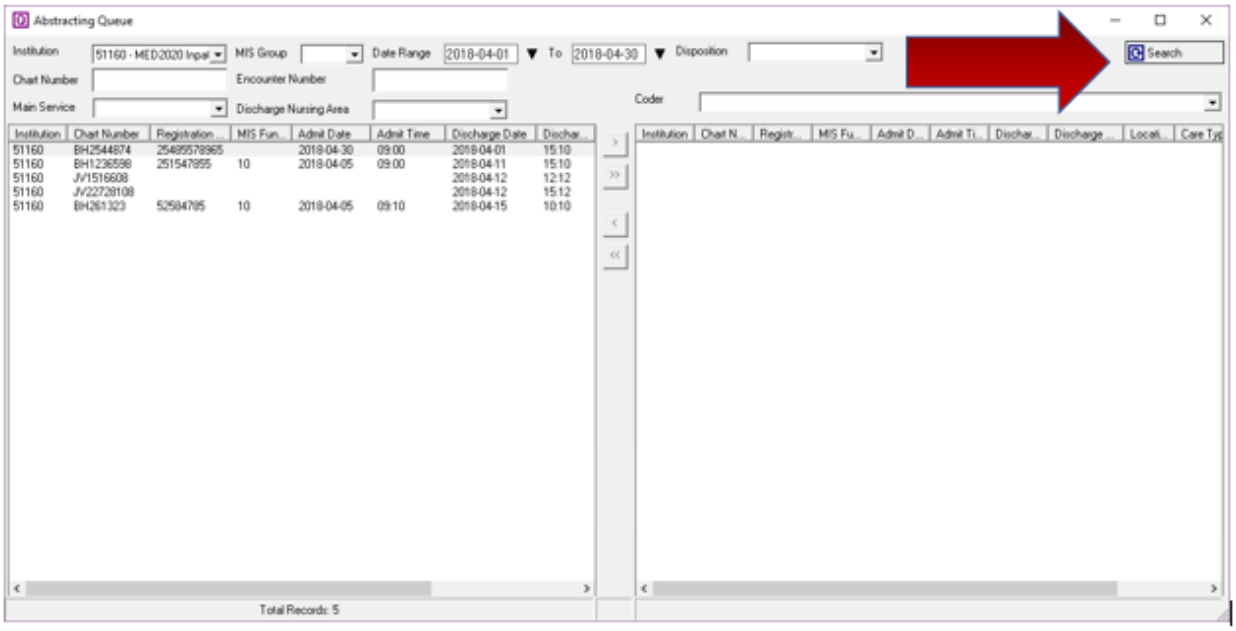


Click the **Search** button to search based on the parameters entered in the search fields.
The search parameters entered are saved from one session to the next.



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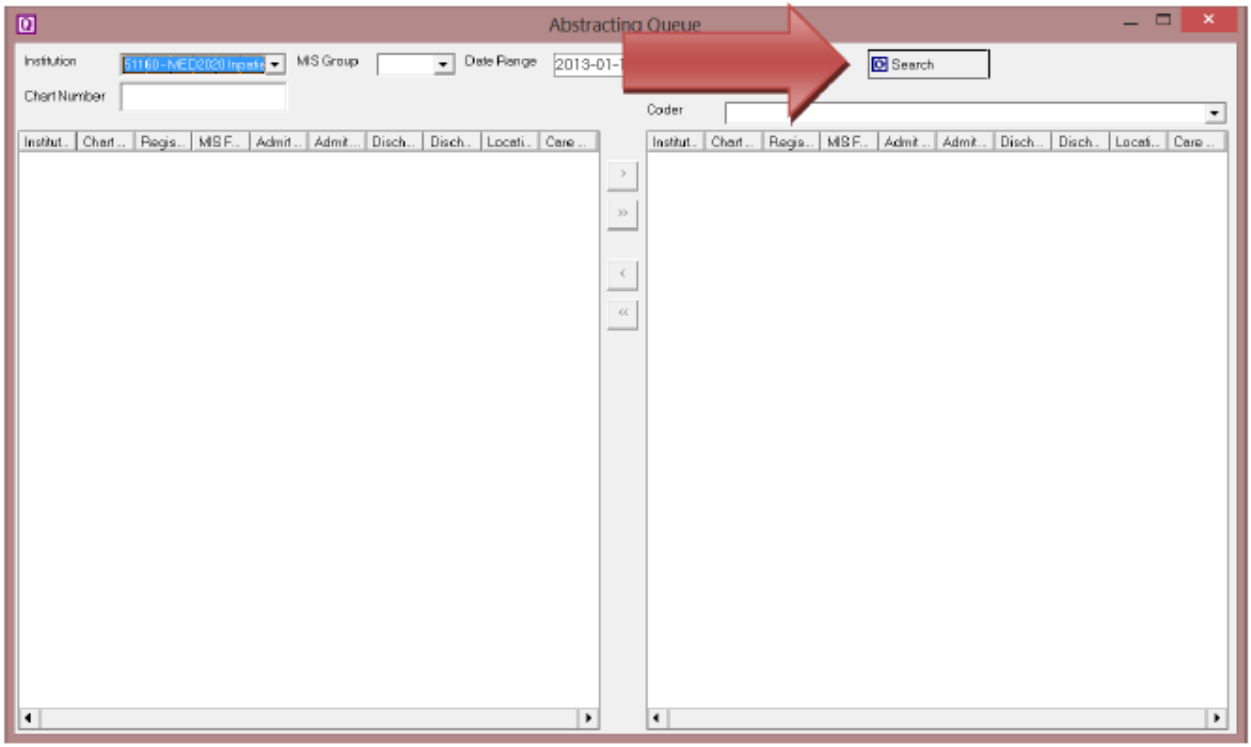

Search Results

Charts returned by the Search will be shown in the search results panel on the left side of the Abstract Queue window. The search will return incomplete records for the date range entered. The following information is given for each result:

Institution Number

Chart Number

Registration Number

MIS Functional Centre

Admit Date

Admit Time

Discharge Date

Discharge Time

Location – Current Location for Chart Locator module

Care Type

Disposition Code

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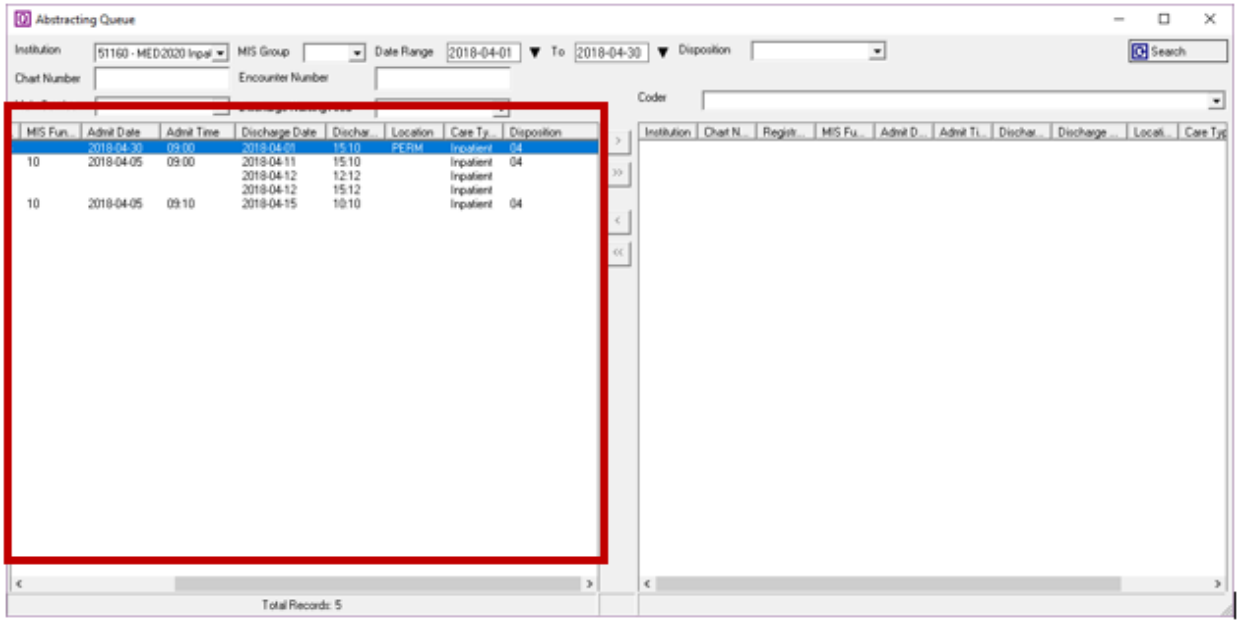
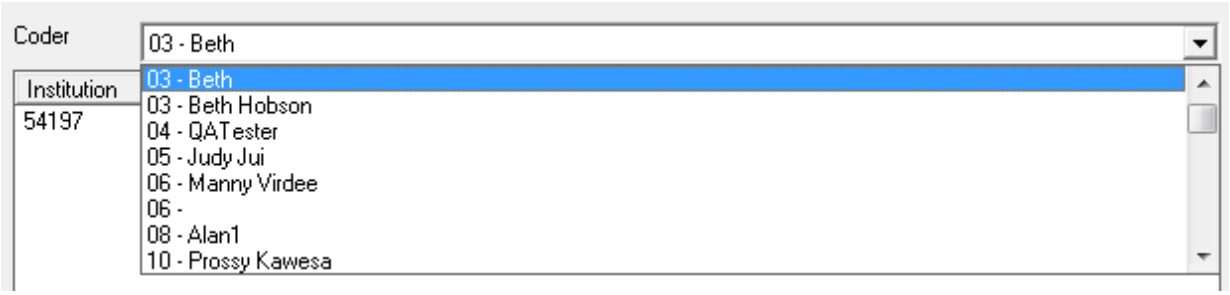


Assigning Records to Coders

Charts can be assigned by a Coder to themselves or can be assigned to other Coders by an Administrator. Users must have proper permissions for to assign visits.

Selecting a Coder

If a User is ***not*** an Administrator, the Coder field will allow the user to select only their own profile (User number) and name from the drop down list in order to assign records to themselves for completion.
If a User is an Administrator, all Users will be shown in the Coder list. The Administrator can then click the dropdown arrow next to the Coder list and use the mouse to select a Coder to assign records. The arrow keys can also be used to move through the Coder list.



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Note: A coder must be selected from the Coder list before records can be assigned to them. This also applies for users who are not Administrators; a user must select their own user number and name from the Coder list before they can begin assigning records to themselves.

When a user is selected from the Coder list, the Abstract Queue window will show any incomplete records that are currently assigned to that Coder.

Assigning a Record to a Coder

To assign a record to a Coder, select the record or records returned by the Search from the left side of the Abstract Queue window and use the arrow to move the selected record(s) under the Coder name on the right side of the Abstract Queue window.

The arrow can be used to assign all records showing in the search results to the selected Coder at once.

Once abstracts are assigned to a Coder, the information for that record no longer appears in the left side of the Abstract Queue window and now only appears on the right under the Coder's name. The Abstract Queue will automatically save this information to the database.

Any abstracts that have been assigned to a Coder will remain assigned to them until the abstract is complete (i.e. verified and saved).

Note: Selecting a Coder from the Coder list will show any previously assigned records that are not complete.

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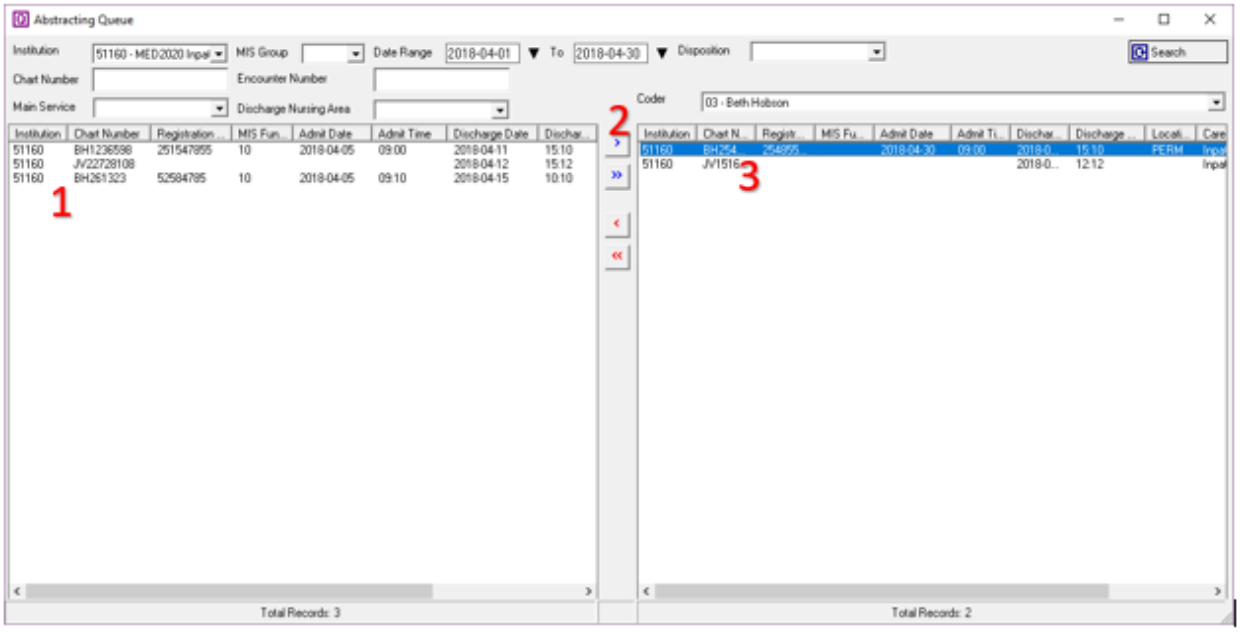
Steps to Assign a Record to a Coder:



1	Select the record from the search results in the left panel of the Abstract Queue.
2	Click the single arrow ›to move only the selected record(s) or the double arrow »to move all records over to the Coder's assigned list.
3	The selected records now appear on the right panel under the selected Coder's name.

In the event more than one User tries to assign the same abstract to themselves at the same time, the second user who is attempting to assign the record will be presented with a message that the selected record will be removed from their list.

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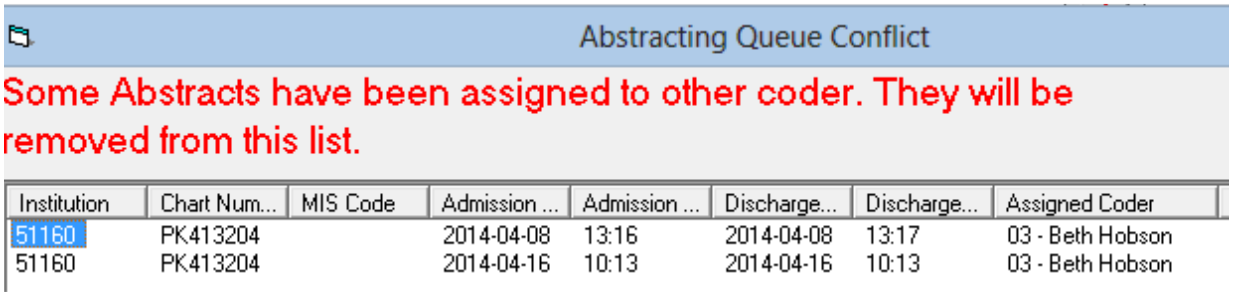

Opening an Assigned Record

Records that have been assigned to a Coder can be quickly opened in the appropriate module by double-clicking on the record in the assigned area of the Abstract Queue window. The Coder can now begin completing the record.

Once the abstract is complete (i.e. verified and saved), it will be removed it from the Coder's assigned list in the Abstract Queue window.

Removing an Assigned Record

Similar to the process for assigning records, a Coder can remove an incomplete record from their assigned list in the Abstract Queue window by using the . arrow All records assigned to a coder can be removed using the arrow.

Records that are removed from a Coder's assigned list on the right panel are returned to the left search results panel.

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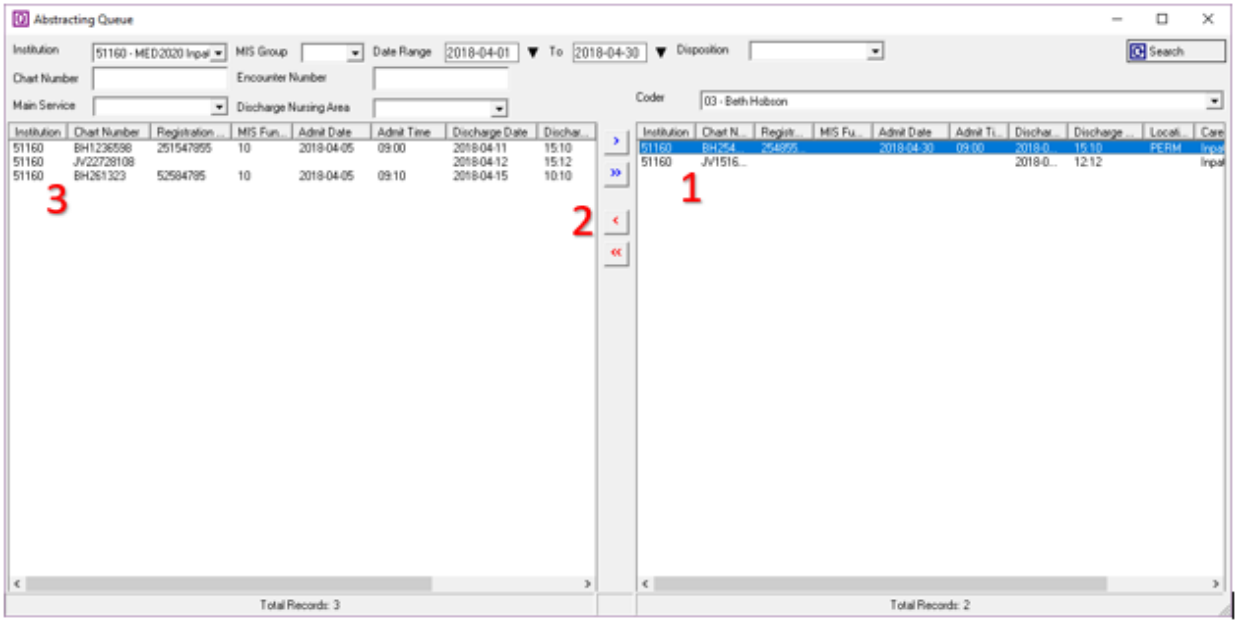
Steps to Remove an Assigned Record from a Coder:



1	Select the record to be removed from the Coder's assigned record list in the right panel of the Abstract Queue.
2	Click the single arrow ‹ to remove only the selected record(s) or the double arrow « to move all records back to the search panel.
3	The records are returned to the left panel.

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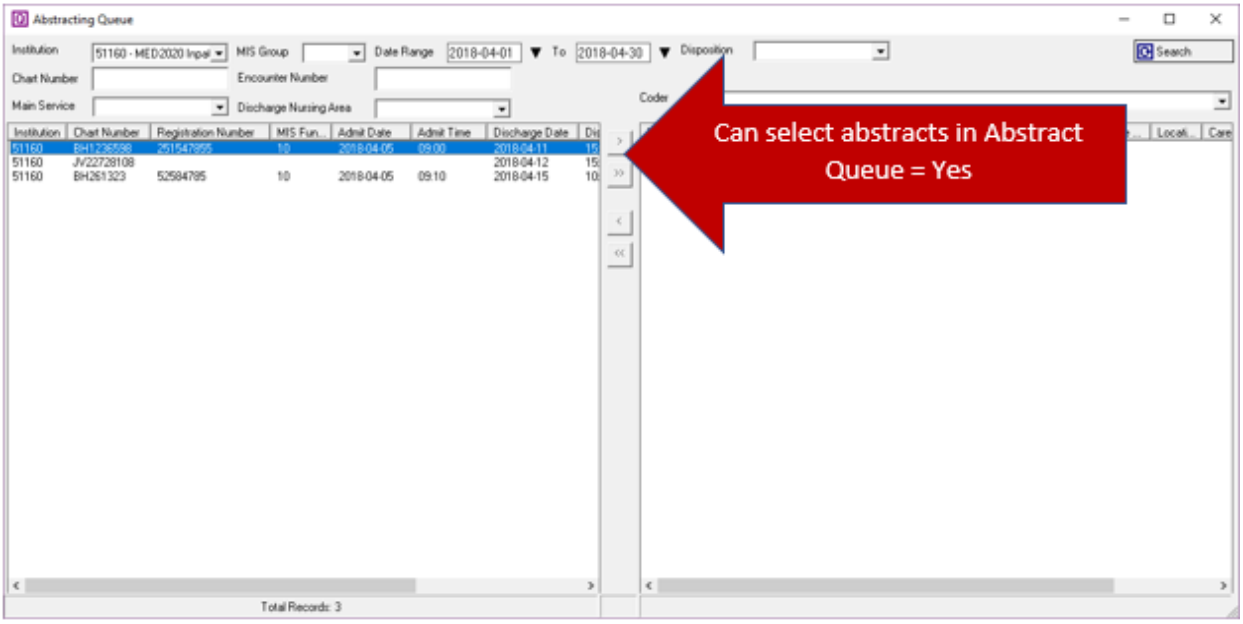
Assigning Next Available Abstract

An Admin user can define whether a Coder will be able to choose any abstract on the queue or only the next available by assigning Yes or No value in the field Can Select abstracts in Abstract Queue? in their User Profile. A Coder will be allowed to select abstracts from the queue if the field is set to Yes. If the user's permission is set to "No" coder can only select next available abstracts in the Queue. All other abstracts will be disabled.

Scenario 1: *Is Administrator* = Yes and *Can Select abstracts in Abstract Queue?* = Yes
Allows the User to see ALL Coder and assign abstracts from Queue to Coder task list.



Scenario 2: *Is Administrator* = No and *Can Select abstracts in Abstract Queue?* = No
User can only see the next available abstract in the Queue and transfer abstract to their task list. All other abstracts in the Queue will not display.

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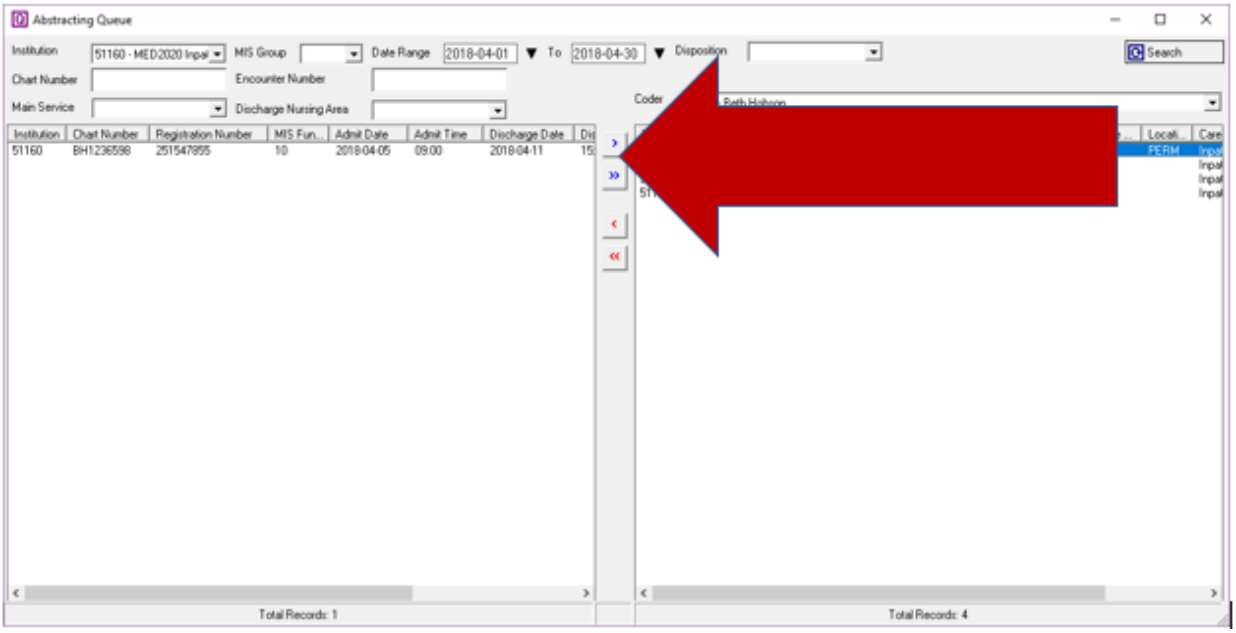
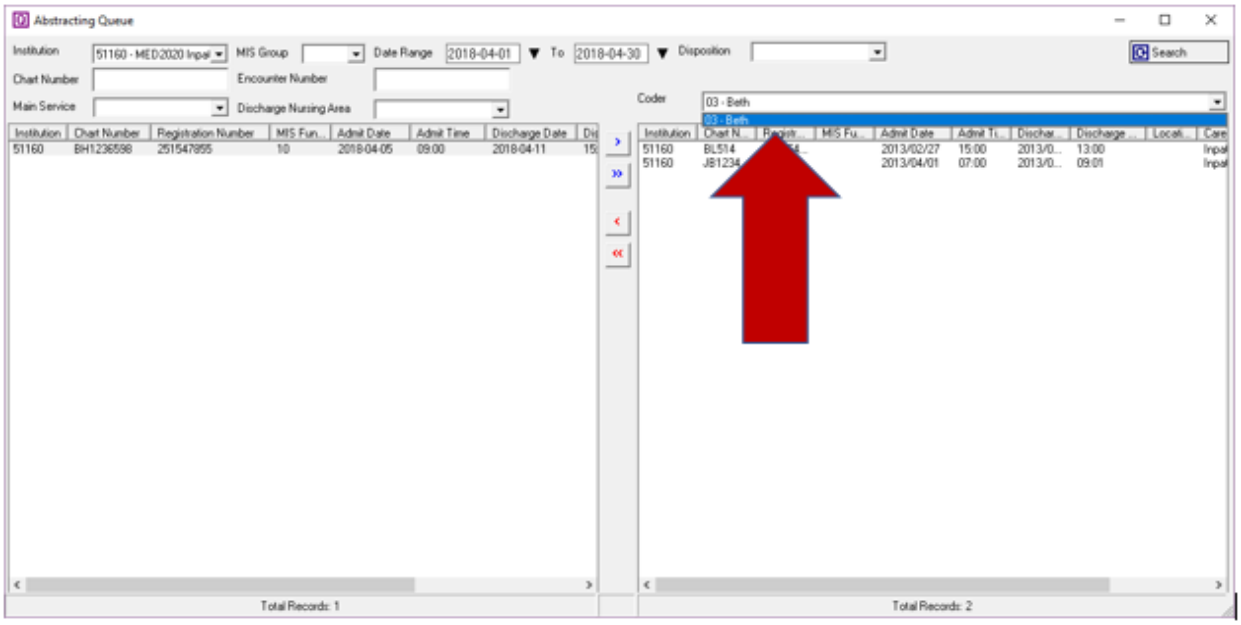


Scenario 3: *Is Administrator* = No and *Can Select abstracts in Abstract Queue?* = Yes
User can only select abstract for their own coder number.



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Interfacing with Folio Views Code Basket

WinRecs has incorporated the ability to interface with the Folio Views application software through the Code basket functionality.

For information of how to use Code Basket functionality please contact CIHI.

Set Up

The Folio file paths need to be set up in the User Profile for the folio basket feature.

Note: Need to ensure the paths point to the latest folio versions on your workstation.

To set the folio file paths:

Options → User Profile → Select User

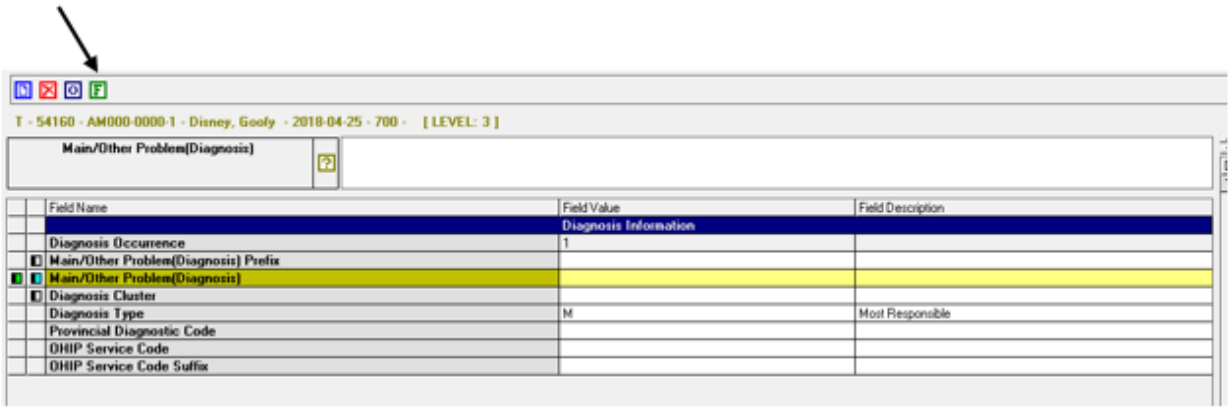
There are two fields, **Folio ICD10 CA File & Folio ICD10 CCI File**

Example:

Folio ICD10 CA File	C:\CIHI\CIHI_PUB_2018\NFO\icd_2018_eng.nfo
Folio ICD10 CCI File	C:\CIHI\CIHI_PUB_2018\NFO\cci_2018_eng.nfo

Importing from Folio Code Basket into WinRecs

From within the Diagnosis or Intervention screen select the Folio button on the tool bar.



Note: Users need to be on the Diagnosis Code or Intervention Code fields to launch Folio

- In Folio, load codes into Folio code basket, as per instructions from CIHI.
- When the code basket has the codes needed, you can close folio.
- In WinRecs, there will be a dialog box that will allow you to trigger the import by selecting Yes, or to cancel the import by selecting No:

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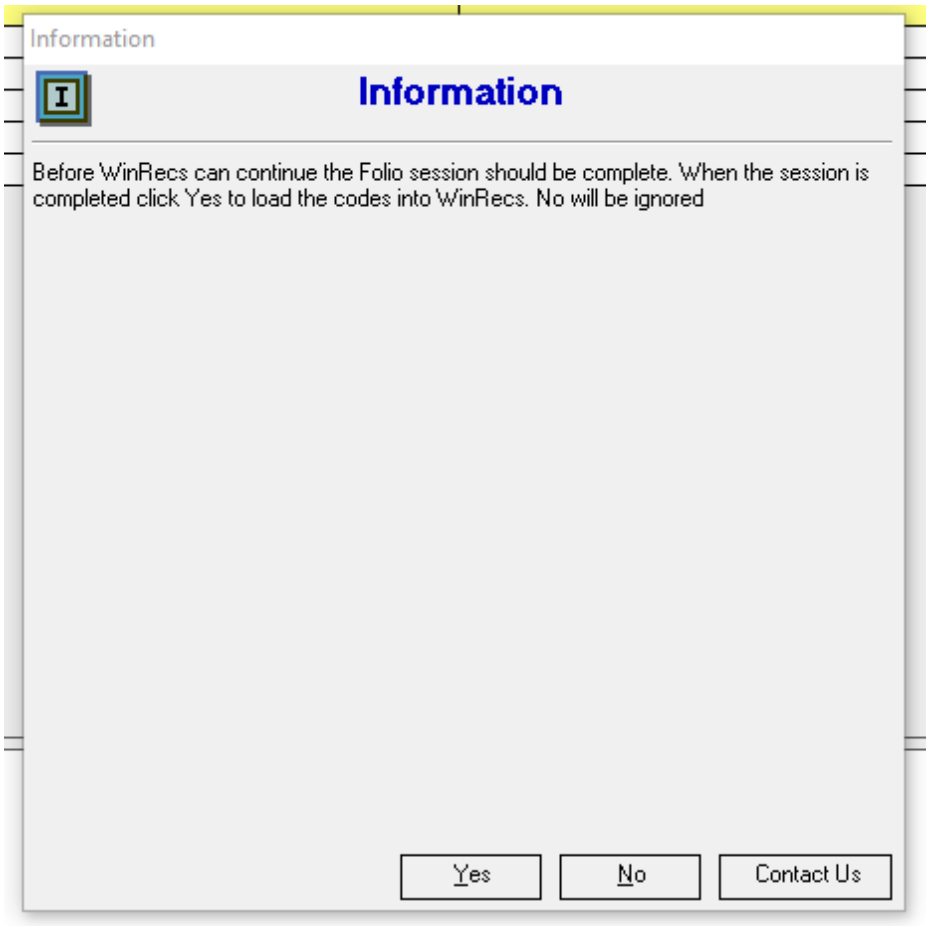
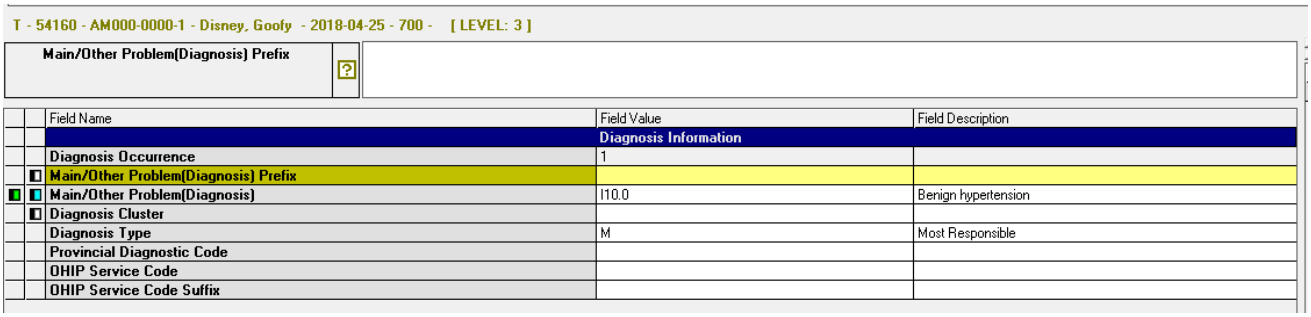


- Click on Yes, to trigger the import of the codes into WinRecs
- All codes that were in the code basket will now display in the abstract:



It's also possible to remove previously selected codes from WinRecs, via Folio, if they are no longer needed.

- Go to Code basket as you would to import a code.
- Delete code from Folio Code Basket (as per instructions from CIHI). Once you've deleted any codes you'd like to, you can close folio.
- Once back in WinRecs, select Yes on the dialog box.

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5 Utilities

5.1 CIHI Submissions

Overview

The CIHI Submissions and Corrections modules are designed to meet current CIHI specifications for data validation and submission file creation. Based on the type of abstracts you are completing the applicable file format will be used. The type of abstracts and relevant edits are determined by the Institution Profile (Care Type).

If an update to any of the groupers (i.e. CMG, DPG and CACS) has been applied while the records for that reporting period were being coded, you will need to batch group your data prior to creating your submission file. This ensures that the most up to date calculations will be submitted with your records.

There are four basic processes involved in the submission of data to CIHI:

Month-end audit reports (balance with Finance or Registration as to number of records to submit).

Create and send the Facility Information File (only at the start of the fiscal year and when information needs to be updated).

Create and submit monthly (or quarterly, as applicable) data files.

Receive and import rejection files for correction and resubmission of abstracts.

Note: Consult the relevant CIHI user manual for detailed information on data submission requirements.

The submission process will:

Verify options.
Assign CIHI Record Types, Batch Numbers and CIHI Abstract Number to each record.
Verify that all records are complete.
Verify that all records are error free.
Create the CIHI file so that it conforms to specifications.
Save the file to a predetermined location as set in the CIHI Files Directory path.

Submission Setup Requirements

- CIHI Files Directory Path
  Set the path in WinRecs to where the CIHI file (both submission and facility profile) will save. This can be done at the Regional, Hospital or Institution level. Please see the System Maintenance section of this User Guide for specific instructions on how to set the CIHI Files Directory Path.

  If the CIHI Files Directory path is left blank, the default file location is “C:\Program Files\WinRecs2\”.

Note: Users must have ‘write’ permissions to the folder where the submission file is created.

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Create the Facility Profile/Facility Information File
Facility profiles or information files are used to identify the facility to CIHI and provide specific information such as demographics, contacts and their vendor. A separate file is set up for each institution number, even if they belong to the same facility.

The facility file must be sent to CIHI before submitting records, and must be updated and resent if the information changes:

- At the start of each fiscal year.
- After a change in the facility (for example, primary contact or facility merger).
- After changing vendors.

Creating the Facility Profile/information File

WinRecs allows you to create a facility profile/information file electronically as required by CIHI.

Ambulatory Care (NACRS)

The information required for each varies slightly, so no examples are provided here. If you have any questions regarding the creation of the facility profile/information file, please refer to the relevant sections below or contact MED2020. The following sections provide the detail for each type of submission. Each section includes a screen shot.

Note: The "Date Sent to CIHI" reflects the date the submission file was created. The WinRecs application has no control over when the user elects to process the upload of the file to the CIHI eDSS Site.

To create a facility file:

Set the CIHI Facility File Sequence to 001 or 01 (depending on the CIHI requirement) in the Institution profile.
Select the appropriate Create Facility File (located under Utilities) from the Module menu.

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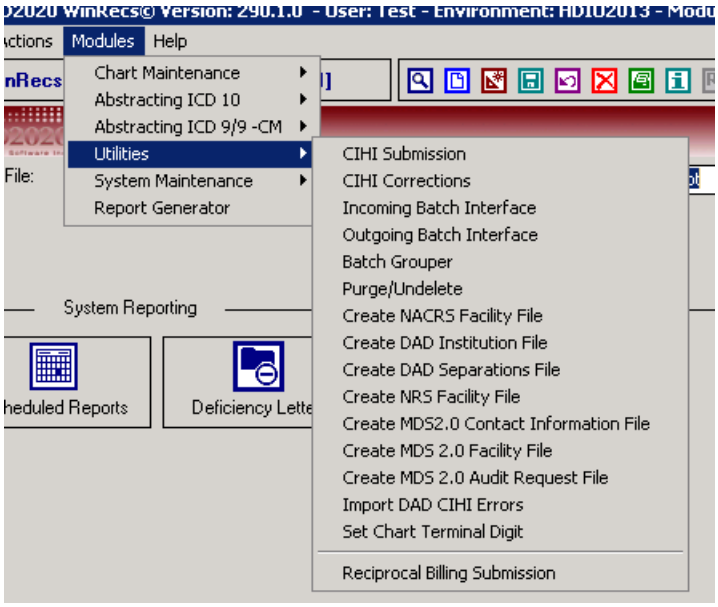

Complete all fields as required. Fields with a book icon denote the presence of a lookup table.

When all information is complete, click Create File [F11]
- or - press **F11**.

A file path/name displays at the top of the window. Your newly created file is saved at this location.

Note: At change of fiscal year, a new WinRecs update will be issued that allows for the creation of the new fiscal year's file format. Users must be on the new fiscal year version of WInRecs in order to create the Facility Information file for that fiscal year.

Creating CIHI Submission Files

Entering required information varies for each module. The following is a general guide. Please refer to the specific modules, starting on page 255.

To create CIHI Submission Files:

Select **Utilities - CIHI Submission**.

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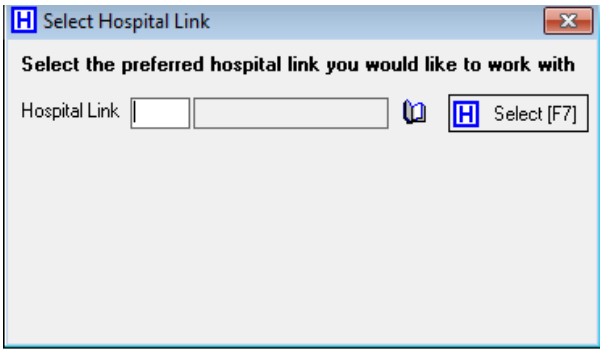
The Select Hospital Link dialog displays.



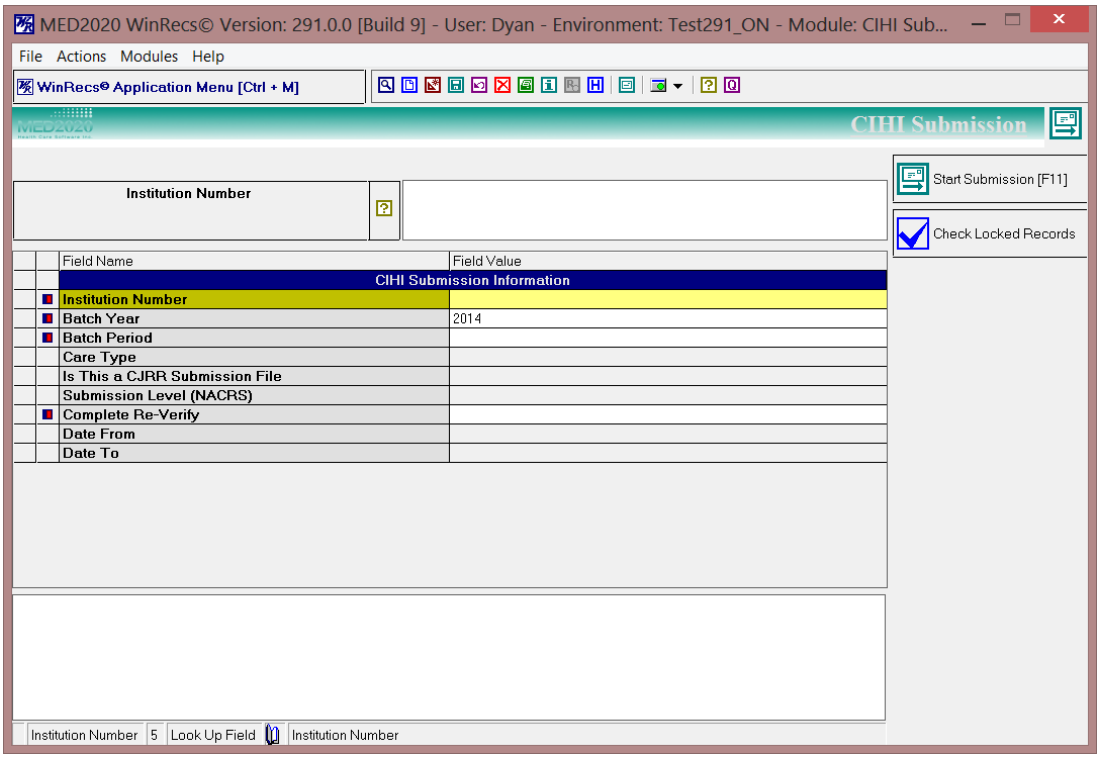
Enter the Hospital code or Press F2 to display a list of Hospitals.

Select the required hospital.

Select [F7]

- or - Press **F7**.

The CIHI Submission window displays.



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Provide the required information in the following fields. Press **Enter** after entering information to move to the next field.

Status	Field	Description
	Institution Number:	Identifies the facility submitting the file to CIHI.
	Batch Year:	A four digit numeric field entered as "YYYY". This will generally default once the Institution Number has been entered. The current batch year is pulled from the Institution Profile.
	Batch Period:	A two character field that represents the CIHI period to be sent. This corresponds with the Date From and Date To fields. This value is the CIHI fiscal period designation 01 – 12 (or in BC. 01 – 13); M-20 through <-12; Q1, Q2, Q3 or Q4.
	Care Type:	The Care Type field will enable when the Institution Number is a Care Type B (Amcare). Press F2 to display the Amcare Care Type Lookup to select. B – All Care Types B-C – Clinic B-D – Day Surgery B-E – Emergency B-E-O – ED Opioid Cases B-C-Lite – Clinic Lite (CL, DI, OT)
	Is This a CJRR Submission File:	
	Submission Level (NACRS):	This field is used only if the Care Type is set to "B".

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	Complete Re-verify:	Select a value as described here: **Y**: Re-verify every record for the selected period. **N**: Only re-verify records that do not have a validated flag or records saved with errors. **C**: Verify and clean will re-verify every record for the selected period, as well as "clean" any extraneous data that may be saved with the abstract due to interfaces populating data that does not meet the CIHI data validation criteria. **S**: Only re-verify records that have previously been submitted to CIHI. Use this option only to provide a list of required corrections, as no submission file will be created. **Note**: If "Y" is selected, an edit/error displays if a disabled field is found to have a value and the submission will not complete. The record must be reloaded add resaved to clear the unwanted value. Selecting "N" will also display an error if a disabled field has a value; however only if the record is already being flagged for other errors/not complete. Selecting "C" will update the data automatically, clearing any invalid values. Multiforms however, cannot have values cleared by this method.
	Date From:	The starting date of the period to be submitted. Valid format is YYYMMDD. This field is automatically completed when the Batch Period is entered above.
	Date To:	The starting date of the period to be submitted. Valid format is YYYMMDD. This field is automatically completed when the Batch Period is entered above.

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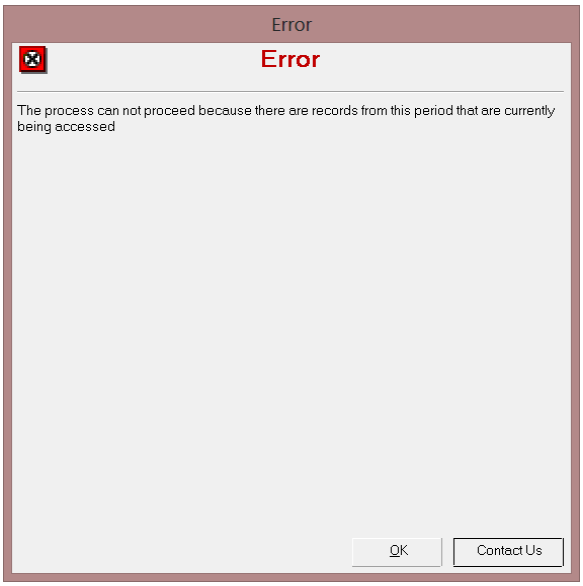
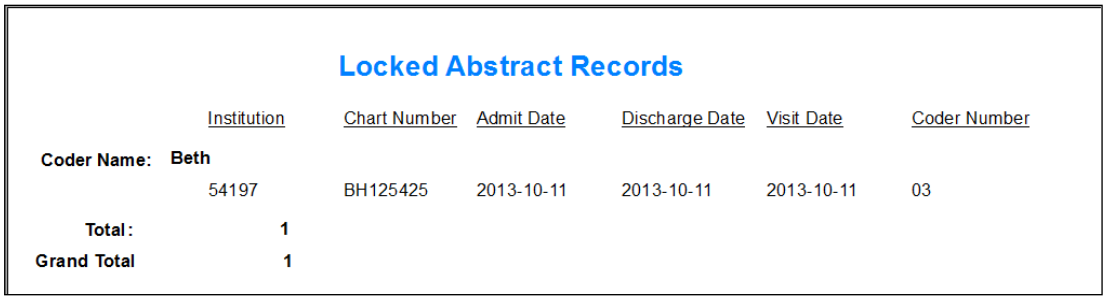
The **Checked Locked Records** button on the Submission screen allows you to see if any records that will be part of your submission are currently open by a User on the system. If a WinRecs User on your network has a file open that will be included in your submission, the following error window will display.



Click the Check Locked Records button

This will generate a Report showing the information of the chart or charts open along with the Coder Name and Coder Number of who is accessing the record(s).



Locked Abstract Records

	Institution	Chart Number	Admit Date	Discharge Date	Visit Date	Coder Number
Coder Name:	**Beth**					
	54197	BH125425	2013-10-11	2013-10-11	2013-10-11	03
Total:	**1**					
Grand Total	**1**					

To start the submission process, click

- or – Press **F11**.
WinRecs opens the abstracting module corresponding to the care type of the institution number entered. A count of all the records within the batch year and period specified will then begin, and records will be validated.

Any records with errors or warning will be listed on the right in the Main Grid.

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Note: Pressing F10 prints the error report displays on the right side. The report provides a detailed list of all charts with a breakdown of errors.

If necessary, records can be edited/corrected from within the Submissions module using the following steps:

- Double-click the Chart Number and then double-click the error message.
- The record opens on the left of the error/warning list. Make any changes required.
- Save the changes to the record.
- Continue editing records containing errors or warnings.
- When editing is complete, records must be re-verified.
- Press **F11**.
  - or – Click the Verify button on the toolbar.

Note: Records with warnings do not always require corrections. If you believe the record to be accurate, the message may be ignored. However, records with errors must be corrected before creating the submission file.

Once all error messages are removed from the list on the right of the Main Display, the submission file may be created.

To create the submission file, click

, located at the bottom right if the window. When the submission file has been created, the path to the created file displays. Make a note of the file location.

Submission Information

Once your abstracts have been included in the submission file, the abstract will be updated with the submission control elements.

Each abstract will be updated with several pieces of information that are available on-screen.

The “Is Abstract Submitted” field value, under the Record Information area of the grid, changes from “N” to “Y” once the record has been included on a submission file.

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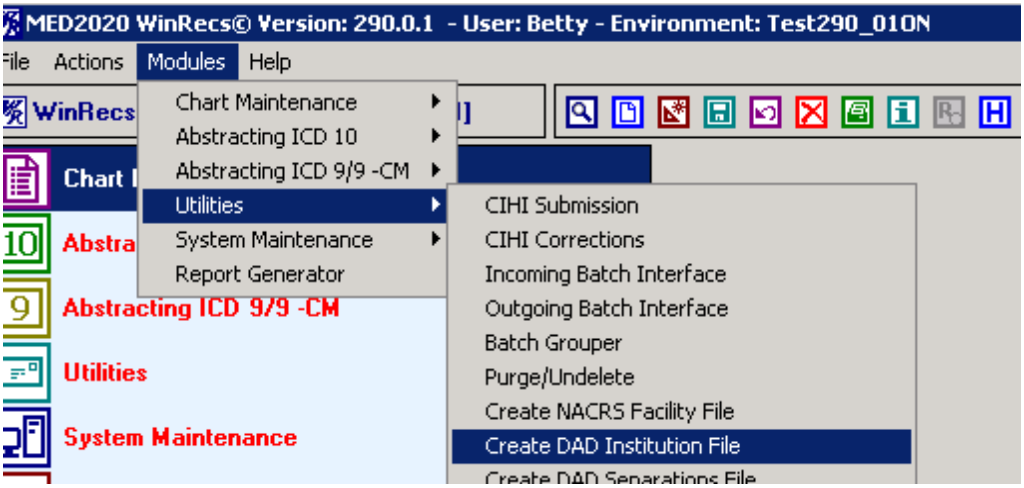
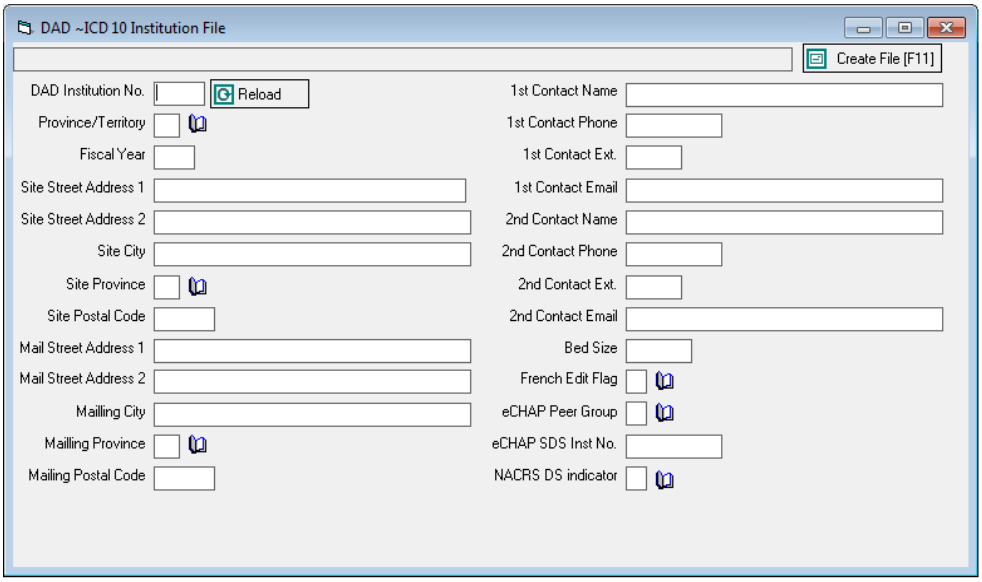
Creating Facility/Institution Files

Select **Modules – Utilities – Create DAD Institution File**.



The Facility/Institution File window displays.



Make the required entries. For additional information please refer to the relevant CIHI user manual for detailed information on data submission requirements, or contact MED2020.

Click Create File [F11]
- or Press **F11**.
The Facility/Institution file is created. The file path will display at the top of the Facility/Institution window

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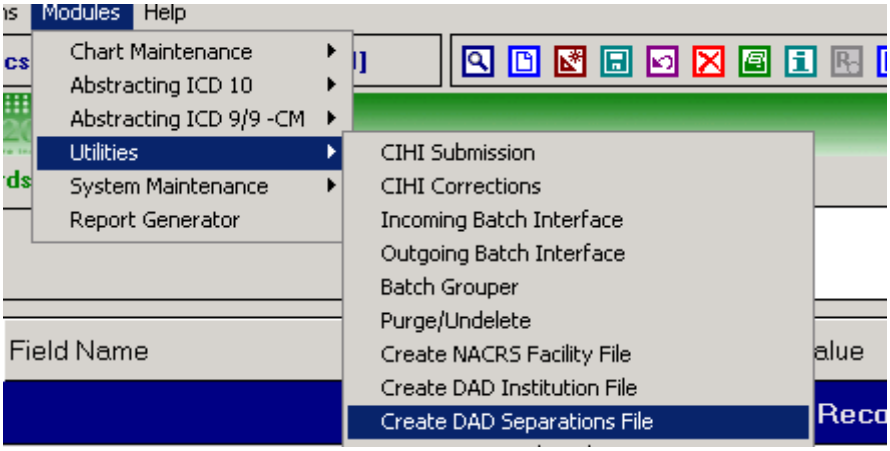
No Separations

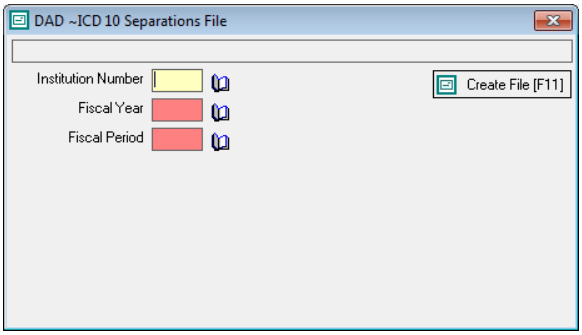
If an institution has no discharges for a specific period, CIHI requires that a “no separation” file be submitted to advise that no abstracts apply to that reporting period.

To create the Separation file:

Select **Modules – Utilities - Create DAD Separations File**.



The DAD – ICD 10 Separations File dialog displays.



Make the required entries.

Click Create File [F11]
- or Press **F11**.
The DAD Separations file is created. The file path will display at the top of the Separations File window.

DAD Error File

This function is used to flag CIHI-submitted records as pending corrections. Importing the DAD error file allows users to print the errors for corrections.

Note: DAD records are not rejected by CIHI if they contain errors.

To import the DAD error file:

Select **Modules – Utilities - Import DAD CIHI Errors**.

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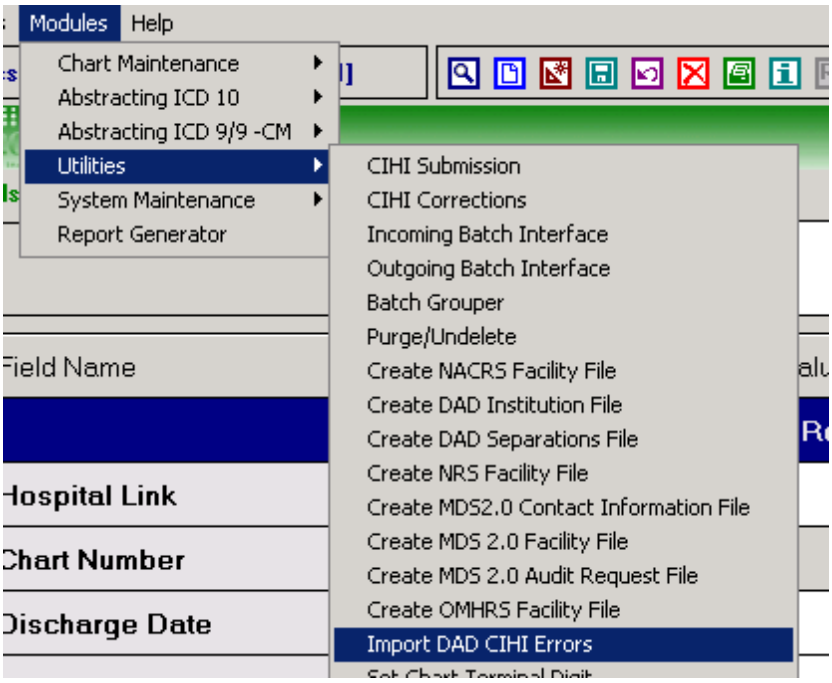
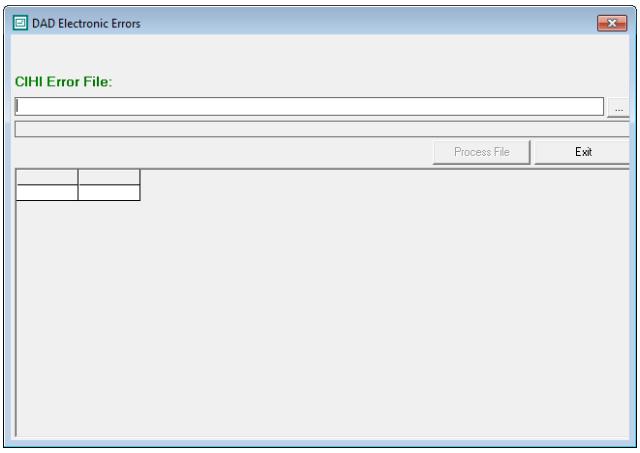


Choose the CIHI Error file to import.



Click **Process File**.
The DAD CIHI Errors are imported.
Once the file is processed, the errors display in the import window for review. You may want to then run the I10 DAD CIHI Error Report.rpt (a WinRecs predesigned report) for a report on which records were flagged as errors or warnings.

If no records are found to match the errors, the errors display in red.

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AmCare (NACRS) Submissions

When an AmCare institution (Care Type “B”) is selected in the CIHI Submissions module, the Care Type field allows a selection from a look up table to select all cases, or one of Emergency, Day Surgery, or Clinic.

If a Care Type other than “B” is selected, only those records with the relevant MIS Codes will be validated/included in the submission file.

To create the NACRS Facility Information File see, Creating Facility/Institution Files.

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NACRS Rejection File Import

The NACRS rejection file flags records that have been submitted to CIHI but have been subsequently rejected due to errors. For detailed information on the Incoming Batch Interface, please refer to Incoming Batch Interface on page 275.

To import the NACRS rejection file:

Select **Utilities - Incoming Batch Interface**.

Select the NACRS Error Import structure file.

Click the Ellipsis and browse for the File to Import.

Click Open when the file is found.

Click

- or – press **F11**.
The import begins.

If any records were not able to be imported, a message displays indicating that the BI Records Processed report may be run to see which records were submitted. Records successfully processed via the import will have the “Is Submitted” flag reset to “N” in the Record Information area of the abstracting grid.

Once the import is complete, the I10 AmCare CIHI Error Report.rpt (a WinRecs predesigned report) can be run for details on which records were imported. After rejected records are corrected and saved, they can be submitted via the usual Create a CIHI Submission File process.

Note: If the NACRS Rejection File is not imported, the submission flag will remain as “Y” and if the record is saved, will subsequently be sent as a correction. This will be rejected by CIHI.

Manual Reset of Submission Status

When correcting rejected NACRS records without having imported the NACRS Rejection file from CIHI, the user will have to reset the submission stats on each abstract as they are corrected.

To manually reset the submission status:

Open the rejected abstract.

Correct the error(s).

Select **Actions – Re-Set Submission Status**.
A prompt displays asking if the user wants to proceed.

Note: Users must have Can Reset Submissions for Amcare set to Yes to see this option.

Click **Yes**.

Save the abstract.
The “Is Abstract Submitted” flag changes to “N” and the record can be resubmitted via the “Create a CIHI Submission File” process.

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Period Closure Requirements

CIHI requires that when all NACRS data has been submitted and accepted for a period, a period closure notification be sent in the form of a “Ready for Reports” flag in the submission control record.

To create the “Close File”:

Select **Utilities - CIHI Submissions**.

Populate the fields with the appropriate values for the institution and period.

Click

- or – Press **F11**.

If there are no errors for the selected period, the AmCare Main Display Grid opens. Below the MED2020 logo (top left), a message “No Records Selected” may display.

At the bottom right the click **Create Close File** to create the file.
The message “There are no records found. Do you wish to close the period” displays.

Click **Yes**.
WinRecs returns to the CIHI submissions module and the message “File Created” displays under the MED2020 logo.

Outstanding Corrections

If you choose No for “Complete Re-verify” when entering your institution information as above, you may not notice records with outstanding errors or that have been flagged for correction. You may, upon clicking the “Create Close File” button, receive the following message:

“Unable to close the period. Some records are flagged as a correction or have errors. The Submission process will terminate.”

If this occurs, it is recommended that you run a Corrections file (using the CIHI Corrections module) for this institution/period first, before attempting to close the period. This ensures any abstracts that may have been opened/saved by coders, which flags a record for correction, will not impede the creation of the close period file.

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Rehabilitation (NRS) Submissions

Review the CIHI Submissions – Overview section through to “Create a CIHI Submission File” for basic information on how to prepare and process an NRS submission file.

When selecting a Rehab institution number in the Institution Number field, the Batch Period look up table displays the list of reporting periods by quarter.

Q1: April – June
Q2: July – September
Q3: October – December
Q4: January – March

Note: Reporting periods can also be set by month.

Data Processing Rules

An admission assessment must be submitted before a discharge assessment.
An admission and discharge assessment must be submitted before a follow-up assessment (optional to record).
If an encounter requires deletion, the assessments must be deleted in the reverse order (ie: follow-up, discharge, admission).

The following fields have significant impact on the processing of NRS Submissions:

Record Validation and Submission Date
Process NRS Admit/Discharge Together?

Record Validation and Submission Date

This date will be updated annually by MED2020 via the annual fiscal year update.

All assessments submitted after the record validation date must follow the new fiscal year edits.

Any submission file created after the Record Validation and Submission Date, regardless of the fiscal year being processed, will have the current fiscal year file specifications applied.

Additional detail on the following fields is available here:

- Process NRS Admit/Discharge Together?: A value of Y allows the admission assessment and the related discharge assessment to be processed at the same time for submission.

Note: If a value of N is entered in this field the assessments will be included in the quarterly submission.

Note: If the Process Together option is chosen this may result in more than one submission file. The naming convention will reflect the fiscal year and quarter applicable to that assessment.

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Note: After clicking OK on the Information dialog, the first file listed is displayed at the top of the WinRecs CIHI Submission window. It is important to note the files created on the Information dialog so you are aware of which files have been saved to you REHAB folder.

Correction/Deleting NRS Assessments

Corrections: Once an assessment has been submitted to and accepted by CIHI, any corrections to the data can be processed by:

Opening the assessment to correct.
Edit the record and save.
Click **OK** on the information message indicating “This record has been submitted to CIHI. Any changes will be part of the current fiscal year correction.
A submission file for the fiscal quarter applicable to the corrected assessments will then need to be created if the corrections are to be submitted to CIHI.

Deletions: Once an assessment(s) has been submitted to and accepted by CIHI, deletions can be processed in a specific order.

If an admission and discharge assessment have been submitted and accepted, the discharge must be deleted first.

Open the discharge abstract.
Click Delete
- or – Press **F9**.
A warning message displays: “The record has been submitted to CIHI. It will be flagged as deleted but should be sent to CIHI as part of a submission before the final purge.”

A submission file for the fiscal quarter applicable to the deleted assessments will then need to be created if the deletions are to be submitted to CIHI.

Resetting Submission Status for Rejected NRS Records

CIHI does not provide an electronic file of rejected records for the NRS database. However, if after submission of data you receive a report of assessments that were rejected, they will not have to be corrected and resubmitted.

Once a record has been successfully validated in WinRecs, and included in a submission file, the “Is Abstract Submitted” flag is set to “Y”. For a rejected record, the user will need to set this field manually by following the “Manual Reset of Submission Status” instructions located within this user guide.

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5.2 CIHI Corrections

The CIHI Submission Corrections module tracks, stores and submits corrections, and/or deletions for abstracts previously submitted to CIHI. Due to CIHI requirements, the Corrections module is only used with the:

- Abscare (DAD) module
- AmCare (NACRS) module

Based on CIHI requirements, corrections for the Inpatient (DAD) abstracts are submitted cumulatively over the fiscal year (ie: correction files are not period specific but fiscal year specific). AmCare (NACRS) abstracts are to be submitted period by period – they are not cumulative. Other WinRecs abstracting modules submit corrections along with the submission file.

The individual abstract that has been sent for correction will display a value of “R” (Resubmitted) in the “Is Abstract Corrected” field.

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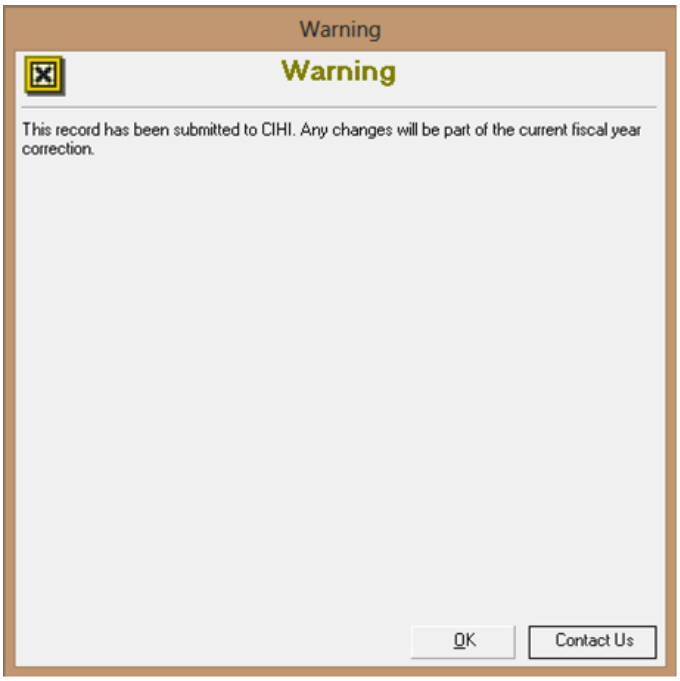
Creating CIHI Correction Files

These requirements are reflected in the “Date To” and “Date From” fields in the CIHI Corrections module when entering an institution number that is either an acute or ambulatory care type.

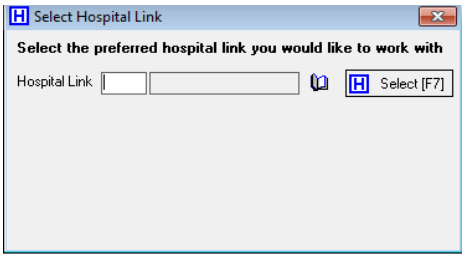
When accessing a submitted record, a warning message displays:



IF a change is made then the Record Information flag “Is Abstract Corrected” changes to “P” indicating a pending correction.

To create a Corrections File:

Select **Utilities – CIHI Corrections**.
The Select Hospital Link dialogue displays only for Regional databases.



Enter the Hospital code or press **F2** to display a list of Hospitals.

Double-click the required hospital.

Click Select [F7]
- or - Press **F7**.
The CIHI Corrections window displays.

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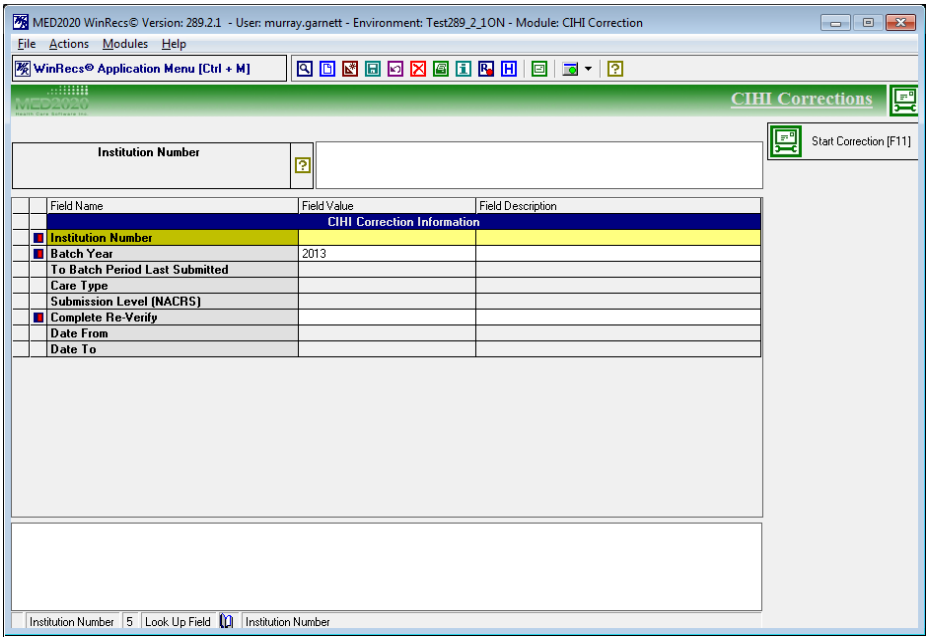

Select the required information. Press **Enter** after each field to move to the next field.

Field	Description
Institution Number:	Identifies the facility submitting the file to CIHI.
Batch Year:	A four digit numeric field entered as “YYYY”. This will generally default once the Institution Number has been entered. The current batch year is pulled from the Institution Profile.
To Batch Period Last Submitted:	A two character field that represents the CIHI period to be sent. This corresponds with the Date From and Date To fields. This value is the CIHI fiscal period designation 01 – 12 (or in BC 01 – 13), Q1, Q2, Q3 or Q4.
Care Type	Care defaults are based on Institution number. A – DAD: Discharge Abstract Database B – NACRS: National Ambulatory Care Reporting System D – DAD: Discharge Abstract Database (Same Day Surgery for all provinces except Ontario) L – MDS 2.0: Minimum Data Set M – OMHRS: Ontario Mental Health Reporting System R – NRS: National Rehabilitation Reporting System
Submission Level (NACRS):	This field is only applicable for NACRS (if the Care Type is set to “B”). Submission levels are 0, 1, 2 or 3.

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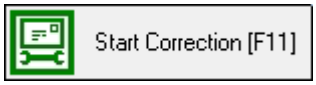
Complete Re-verify:	Select a value as described here: **Y**: Re-verify every record for the selected period. **N**: Only re-verify records that do not have a validated flag or records saved with errors.
Date From:	The starting date of the period to be submitted. This field is automatically completed when the Batch Period is entered above.
Date To:	The starting date of the period to be submitted. This field is automatically completed when the Batch Period is entered above.

Click 

- or – Press **F11**.
The abstracting module that corresponds to the Institution Number provided displays. A count of all records within the specified batch year/period begins and the records are verified for errors.

Any records with errors or warnings will display on the right in the Main Grid. The same process is used for correcting errors and/or viewing warnings as in the Create a CIHI Submission File section of this user guide.

Once finished correcting the errors/warnings, all records must be re-verified by pressing **F11**.
The correction file can be created once the list of errors has been cleared,

Click **Create File** in the bottom right corner of the window.
Once the file has been created, the file path will display.

Deleted Records

A deleted record remains in the Purge/Undelete module until the Submission or Correction file process is performed. If the period(s) processed include a record that has been previously submitted and then subsequently deleted, the following message displays when processing the corrections file:

> "There are 1 records flagged for deletion.
> The corrections will now process to create a
> DAD ICD 10 deletion file for these records."

In this case, both the Correction and Deletion file will be created based on the CIHI file specifications. The file path displays both file names.

Note: For DAD the deletion file is a unique file and for AmCare the deleted record is included in the correction file.

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5.3 Ontario Mental Health (OMHRS) Submissions

Review the CIHI Submissions – Overview section through to Create a CIHI Submission File for basic information on how to prepare and process an OMHRS submission file. Your CIHI OMHRS User Manual will also provide specific information on requirements to submit data to the Ontario Mental Health Reporting System.

OMHRS submissions are done on a quarterly basis.

When selecting an OMHRS institution number in the Institution Number field, the Batch Period lookup table displays the list of reporting periods by quarter.

Q1: April – June
Q2: July – September
Q3: October – December
Q4: January – March

Data Processing Rules

All record types must be submitted chronologically and in order of occurrence for each patient per episode. This avoids possible errors and rejections (ie: an admission assessment must be submitted prior to a quarterly or discharge assessment for the same patient encounter.
The Case Record Number and Chart Number are key identifiers in linking the various assessment types during an episode of care.
If assessments must be deleted, they must be done so in the reverse order of submission (ie: a discharge assessment deleted prior to an admission assessment.
For subsequent admissions for the same patient, the first episode must have the discharge assessment submitted prior to a next admission assessment being submitted (ie: a patient cannot have multiple “open episodes” of care.

Record Validation and Submission Date

CIHI mandates that as of their annually specified date, any assessments not already submitted that fall in the previous fiscal year, must be submitted under the new fiscal year edits/requirements. This date is communicated by CIHI to both their facility clients and the licensed vendors.
When an assessment is being completed in WinRecs, if it belongs to the previous fiscal year’s data, and the current system date is after the Record Validation and Submission Date, the most current fiscal year edits/requirements will be applied to the assessment.
Further, any submission file created after the Record Validation and Submission Date, regardless of the fiscal year being processed, will have the current fiscal year file specifications applied.
This date will be updated annually by MED2020 via the annual fiscal year update, usually released around April 1.

OMHRS Rejection File Import

To import the OMHRS Rejection file:

Select Modules - Utilities - Import OMHRS CIHI Errors.

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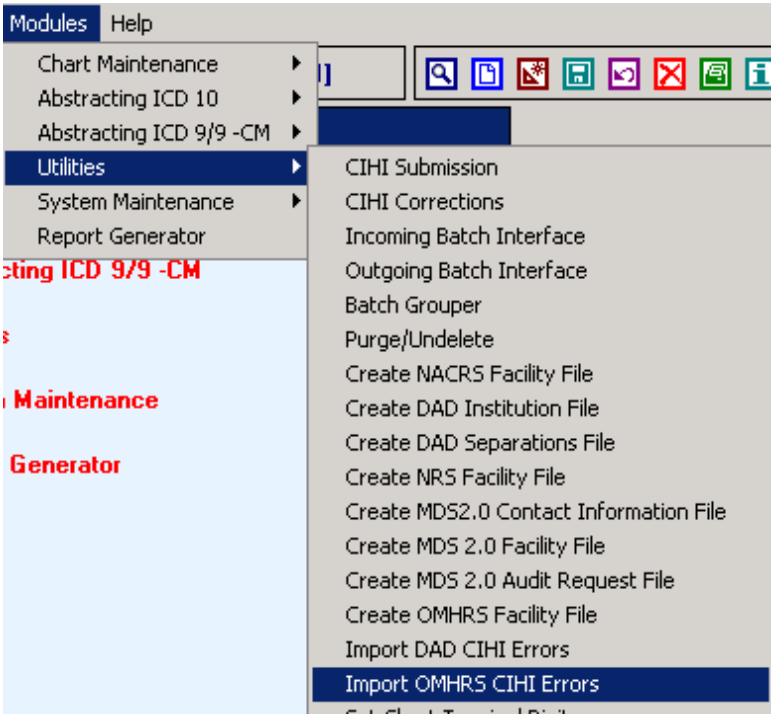

Browse for the previously saved file, received from CIHI.

Click **Open**.

Click **Process File**.
Once the file is processed, the errors display in the import window for review. You may want to then run the OMHRS Error Import.rpt (WinRecs predesigned report) on which records were flagged as errors or warnings.

If any records were not able to be imported, a red background displays on the affected records lines in the import grid.

Records successfully processed via the import will have the “Is Submitted” flag reset to “N” in the Record Information area of the abstracting grid.

Once the import is complete, and after rejected records are corrected and saved, they can be submitted via the Create a CIHI Submission File process.

Note: If the OMHRS rejection File is not imported, the submission flag will remain as “Y” and if the record is saved, will subsequently be sent as a correction. This will be rejected again by CIHI.

Manual Reset of Submission Status

When correcting rejected OMHRS records without having imported the OMHRS Rejection file from CIHI, the user will have to reset the submission status on each abstract as they are corrected.

To reset the submission status:

Open the rejected abstract.

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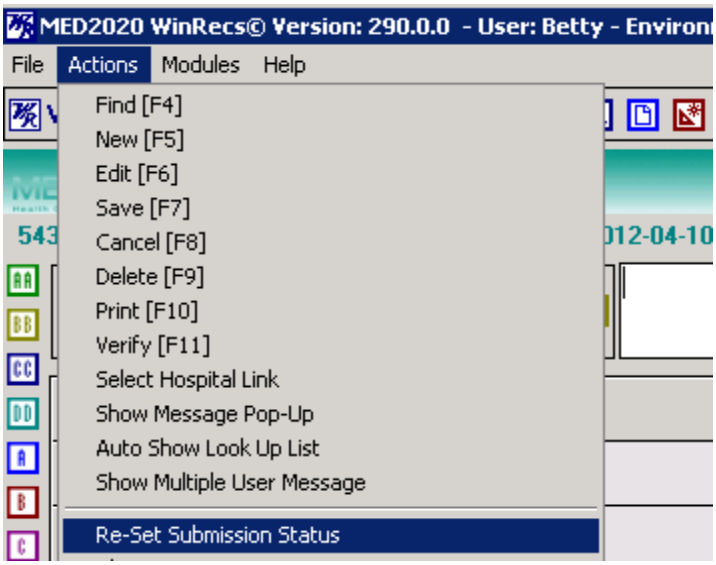
Correct the error(s).

Select Actions – Reset Submission Status.



A prompt displays asking if you want to proceed. Click “Yes”.

Save the abstract.
The “Is Abstract Submitted” flag is changed to “N” and the record can be submitted via the Create a CIHI Submission File process.

Correcting/Deleting OMHRS Assessments

Corrections: Once an assessment has been submitted to and accepted by CIHI, any corrections to the data can be processed by:

Open the assessment to correct.
Edit the record and save.
Click OK on the information message indicating “This record has been submitted to CIHI – Any changes will be part of the current fiscal year correction
A submission file for the fiscal quarter applicable to the corrected assessments will then need to be created if the corrections are to be submitted to CIHI.

Note: If any of the elements used to identify a unique record require correction after the record has been accepted into the CIHI database, the record must be deleted and resubmitted. The applicable data elements are:

Z1: Record Type
X1: Record ID
X30: Chart Number
AA3: Case Record Number
A1: Assessment Reference Date

Deletions: Once an assessment(s) has been submitted to and accepted by CIHI, deletions can be processed in a specific order.

If admission, quarterly and discharge assessments have been submitted and accepted, the discharge must be deleted first, then the quarterly, then the admission.

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Open the discharge abstract.
Click **Delete**.
- or – Press **F9**.

A warning message displays: “The record has been submitted to CIHI. It will be flagged as deleted but should be sent to CIHI as part of the submission before the final purge.”
Repeat this function until the appropriate assessments have been deleted.
A submission file for the fiscal quarter applicable to the deleted assessments will then need to be created if the deletions are to be submitted to CIHI. See Create a CIHI Submission File for details.

Medication Records: Medication records that have been submitted along with the assessment and then the required deletion can be processed as follows:

Open the assessment that contains the erroneous medication record.
Select the medication occurrence that requires deletion.
Click **Delete**.
- or – Press **F9**.
Exit the Medication Records multiform and save the assessment.
Repeat this function until the appropriate assessments have been deleted.
A submission file for the fiscal quarter applicable to the deleted medication record(s) will then need to be created if the deletions are to be submitted to CIHI. The specific Medication Records deleted will be flagged appropriately in the submission file. See Create a CIHI Submission File for details.

If a Medication Record needs to be added after the assessment has already been submitted:

Open the assessment that requires the medication record(s).
Enter the medication record(s).
Exit the Medication Records multiform and save the assessment.

A submission file for the fiscal quarter applicable to the assessment the medication record(s) were recorded in will then need to be created if the medication records are to be submitted to CIHI. A correction record type will process for “parent” assessment and a new record type specific to the medication information will be included in the file.

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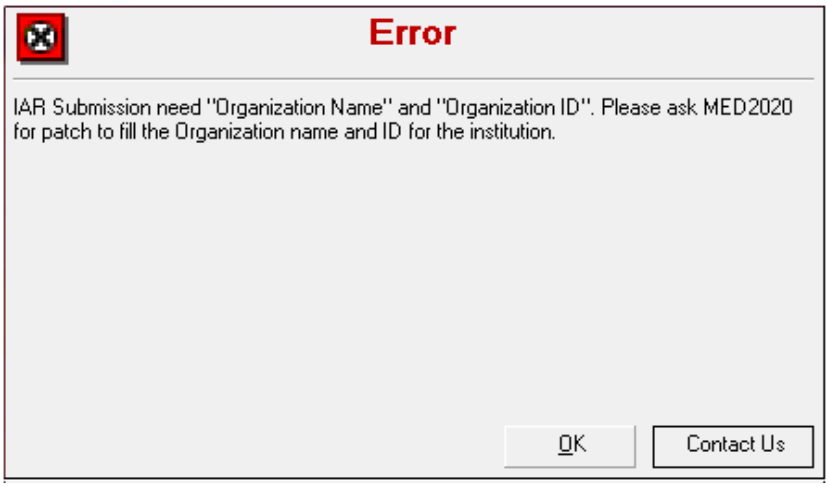
5.4 Integrated Assessment Record (IAR) Submission to Community Care Information Management (CCIM)

The IAR contains common assessment information that is submitted to CCIM. It allows assessment information to be viewed by Health Care providers involved in the care of the patient. Please see documentation from Community Care Information Management for more details.

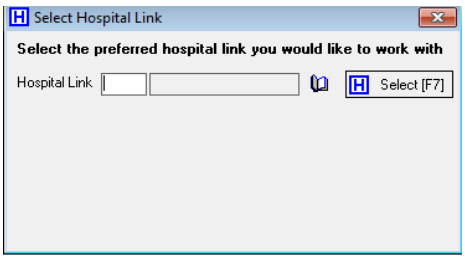
Note: Before creating the IAR Submission file, clients must contact MED2020 to provide their Organization ID and Name. A patch will be provided that inserts the Organization ID and Name into the Institution Profile and the IAR Consent fields in the Central Patient Index (CPI) and Mental Health module. If the Organization ID is not inserted, if 'Start Submission' is clicked, the following error message displays.



Once the Orgaization ID is inserted into the Institution Profile proceed to IAR Submission.

To create an IAR submission file to CCIM:

Select **Utilities – CIHI Submission**.
The Select Hospital Link dialog displays.



Enter the Hospital code or Press F2 to display a list of Hospitals.

Double-click the required hospital.

Press **F7**.

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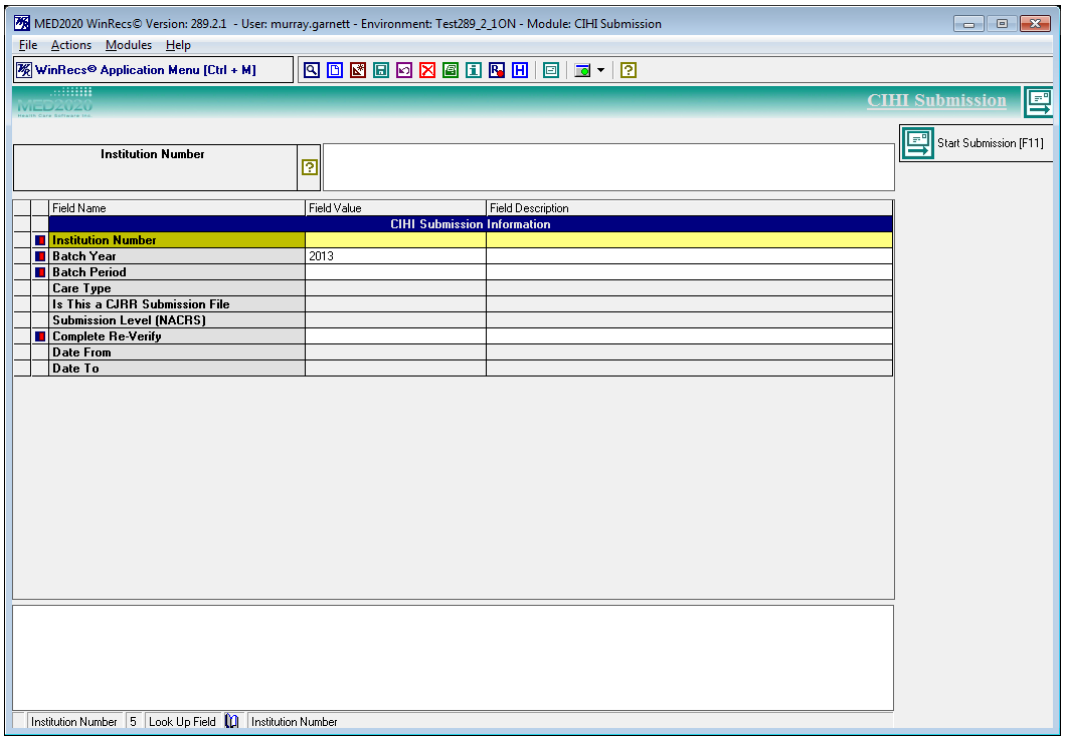
The CIHI Submission window displays.



Provide the required information in the following fields. Press **Enter** after entering information to move to the next field.

Field	Description
Institution Number:	Identifies the facility submitting the file to CIHI.
Batch Year:	A four digit numeric field entered as “YYYY”. This will generally default once the Institution Number has been entered. The current batch year is pulled from the Institution Profile.
Batch Period:	A two character field that represents the CIHI period to be sent. This corresponds with the Date From and Date To fields. This value is the CIHI fiscal period designation 01 – 12 (or in BC. 01 – 13); M-20 through <-12; Q1, Q2, Q3 or Q4.

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<table>
<tr><td>Care Type:</td><td>Enter the required care type. Press F2 to display the Care Type Lookup to select the required care type, i.e. OHMRS.
<table>
<tr><td>A</td><td>DAD: Discharge Abstract Database</td></tr>
<tr><td>B</td><td>NACRS: National Ambulatory Care Reporting System</td></tr>
<tr><td>D</td><td>DAD: Discharge Abstract Database (Same Day Surgery for all provinces except Ontario)</td></tr>
<tr><td>L</td><td>MDS 2.0: Minimum Data Set</td></tr>
<tr><td>M</td><td>OMHRS: Ontario Mental Health Reporting System</td></tr>
<tr><td>R</td><td>NRS: National Rehabilitation Reporting System</td></tr>
</table></td></tr>
<tr><td>Is This an IAR Submission File:</td><td>Enter “Y”. “Y” (Yes) must be entered in this field in order to create the IAR Submission File.</td></tr>
<tr><td>Submission Level (NACRS):</td><td>This is disabled for IAR.</td></tr>
<tr><td>Complete Re-verify:</td><td>Select a value as described here:
Y: Re-verify every record for the selected period. If a disabled field is found to have a:
N: Only re-verify records that do not have a validated flag or records saved with errors.
C: Verify and clean will re-verify every record for the selected period, as well as “clean” any extraneous data that may be saved with the abstract due to interfaces populating data that does not meet the CIHI data validation criteria.
S: Only re-verify records that have previously been submitted to CIHI. Use this option only to provide a list of required corrections, as no submission file will be created.
Note: If “Y” is selected, an edit/error displays if a disabled field is found to have a value and the submission will not complete. The record must be reloaded and resaved to clear the unwanted value. Selecting “N” will also display an error if a disabled field has a value; however only if the record is already being flagged for other errors/not complete. Selecting “C” will update the data automatically, clearing any invalid values. Multiforms, however, cannot have values cleared by this method.</td></tr>
</table>

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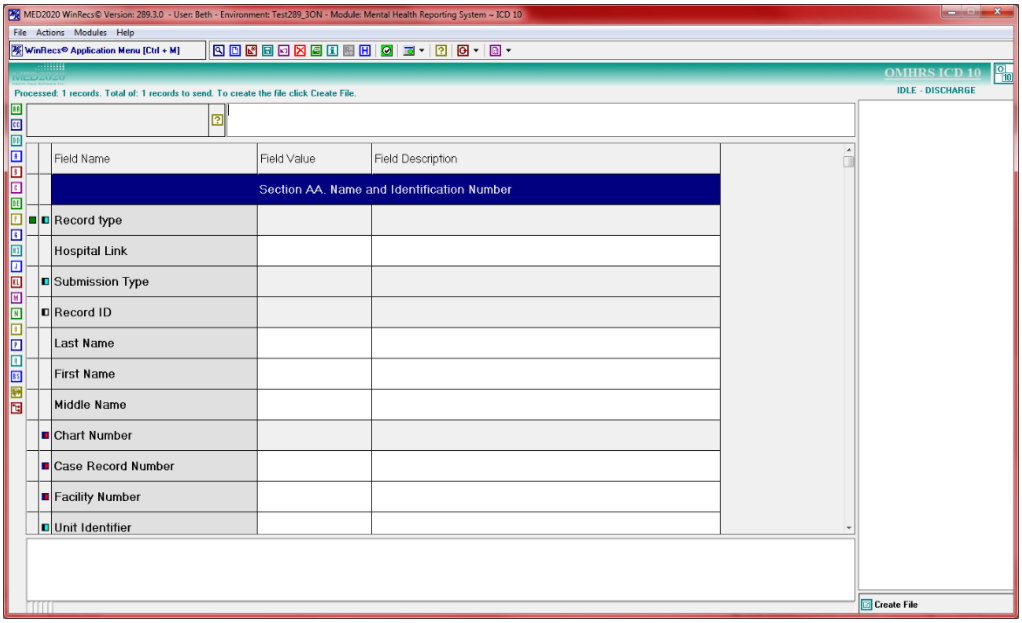
Date From:	The starting date of the period to be submitted. This field is automatically completed when the Batch Period is entered above.
Date To:	The starting date of the period to be submitted. This field is automatically completed when the Batch Period is entered above.

To start the submission process, click

– or –
Press **F11**.
WinRecs opens the abstracting module corresponding to the care type of the institution number entered. A count of all the records within the batch year and period specified will then begin, and records will be examined for errors.



Click Create File
The CIHI Submission File window displays.

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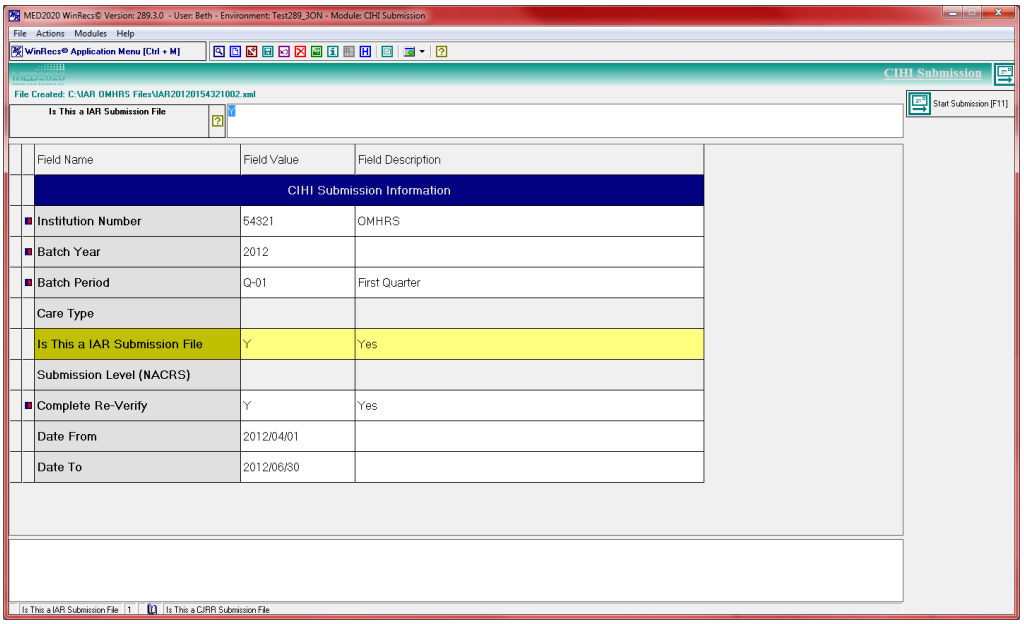

Two files will be created to the path defined in the Institution Profile:

- IARyyyypphhhhhsss.txt
- IARyyyypphhhhhsss.xml

In the Assessment, the Submission Fields are:

- Is IAR CCIM Submitted
- Date Submission Sent to CCIM
- Is IAR CCIM Corrected
- Date Correction Sent to CCIM

Creating the IAR Correction File to CCIM

The process to creating an IAR Correction file is the same as creating an IAR Submission file.

To create an IAR Correction File to CCIM:

If an assessment has been submitted to CCIM and changes have been made to the IAR fields, WinRecs will look at the Update History date and the updated assessment will be picked during the Submission process.

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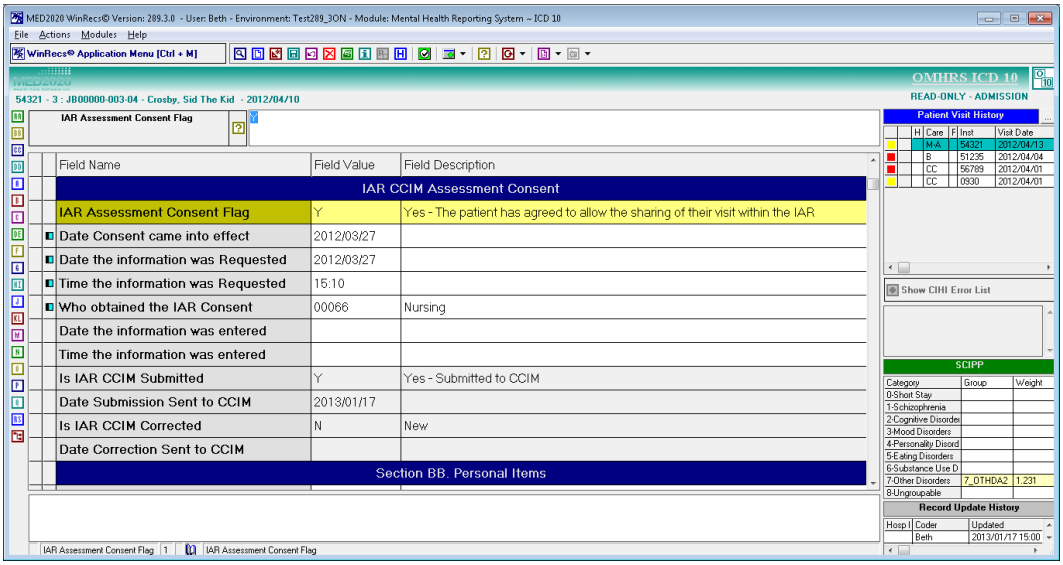
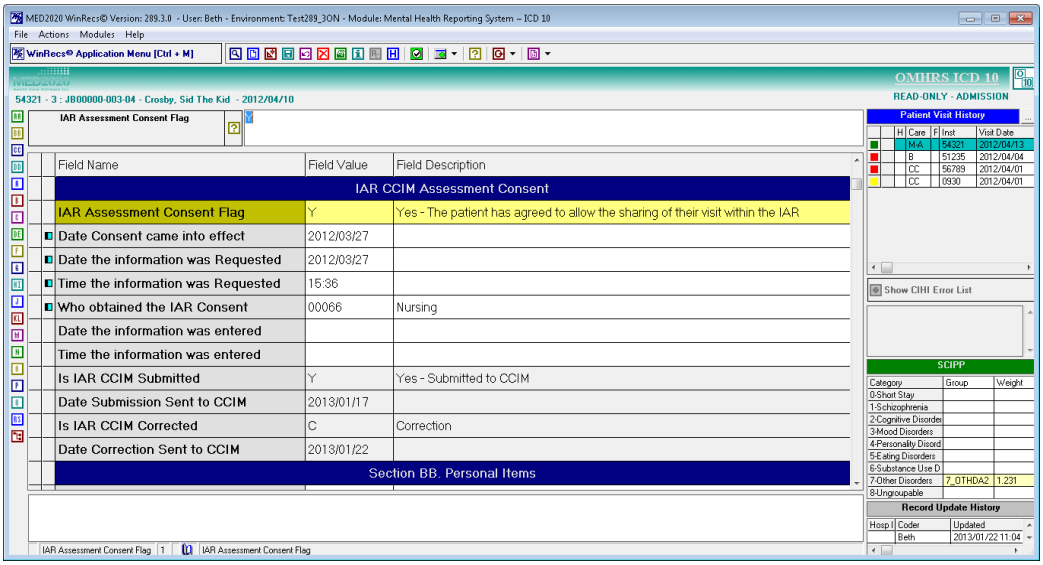


After the file has been created, the 'Is IAR CCIM Corrected' will be "C" (Correction) and the Date Correction Sent to CCIM will be populated.



Two files for the Batch Year and Period will be created with a different sequence number.

- IARyyyypphhhhhsss.txt
- IARyyyypphhhhhsss.xml

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5.5 Summary Table of Submission Functions

Function	DAD	NACRS	NRS	OMHRS	MDS 2.0	CJRR
Facility Information File	Create electronically in WinRecs	Create electronically in WinRecs	Create electronically in WinRecs	Create electronically in WinRecs	Create electronically in WinRecs	Uses DAD/ NACRS institution number
New Records	Submit using CIHI Submission module – submit by batch period.	Submit using CIHI Submission module submit by batch period	CIHI Submission module – submit by quarter	Submit using CIHI Submission module submit by quarter *IAR- Set "Is this a IAR Submission File to "Y"*	Submit using CIHI Submission module submit by quarter	Submit using CIHI Submission module submit by batch period.
Records with errors	Accepted to the CIHI database, DAD error file sent to client	Rejected by CIHI, NACRS Rejection file sent to client	Rejected by CIHI, rejected records report sent to client	Rejected by CIHI, OMHRS Rejection file sent to client *IAR- CCIM notifies rejected records*	Rejected by CIHI, rejected records report sent to client	Rejected by CIHI, rejected records report sent to client
Error file	Can be imported to WinRecs via Modules/Utilities /Import DAD CIHI Errors option	Can be imported via the Incoming Batch Interface module, select the NACRS Error Import structure file	No electronic error file provided	Can be imported to WinRecs via Modules/Utilities/Import OMHRS CIHI Errors option *IAR- N/A*	No electronic error file provided	No electronic error file provided

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Corrections	Update records with correct information and save – record flags as 'pending' for inclusion in next Corrections file.	-Rejected records are corrected and saved in WinRecs. If NACRS rejection file is not imported, use the "Reset Submission Status" function for each corrected abstract. -Importing the NACRS rejection file re-sets submit status to "not submitted" -Process 'corrected' records initially rejected, as a regular submission (CIHI Submission module) -Submitted and accepted records in NACRS can be corrected. Open, edit and save record. -Process CIHI Correction file for the applicable period.	Rejected records are corrected and saved in WinRecs. Use 'Reset Submission Status' function for each rejected abstract. Submitted and accepted records in NRS can be corrected. Open, edit and save the record. Process CIHI Submission file for the applicable quarter.	Rejected records are corrected and saved in WinRecs. If OMHRS rejection file is not imported, use the "Reset Submission Status" function for each corrected abstract. -Importing the OMHRS rejection file re-sets submit status to "not submitted" -Process 'corrected' records initially rejected, as a regular submission (CIHI Submission module) -Submitted and accepted records in OMHRS can be corrected. Open, edit and save record. -Process CIHI Submission file. *-IAR Corrections and deletions processed the same way. Rejected records must be reset manually.*	Rejected records are corrected and saved in WinRecs. Use 'Reset Submission Status' function for each rejected abstract. Submitted and accepted records in MDS 2.0 are updated using specific Change/Correction assessment types.	Rejected records are corrected and saved in WinRecs and re-sent as an insert. Use the "Reset Submission Status" function for each corrected abstract. Submitted and accepted records can be corrected. Open, edit and save record and it will be sent as an update. Both inserts and updates are sent through the submission module.
Deletions	When submitted abstract is deleted, it is flagged in the Purge/Undelete area and will be included in a deletion file next time the CIHI Corrections are processed.	When submitted, accepted, record is deleted, it is flagged in the Purge/Undelete module and will be processed using the CIHI Correction module.	Submitted, accepted, record is deleted, it is flagged in the Purge/Undelete module and will be processed using the CIHI Submission module.	When submitted, accepted, record is deleted, it is flagged in the Purge/Undelete module and will be processed using the CIHI Submission module. Same Process for IAR	Deleted assessments that have been submitted to CIHI are flagged in the Purge/Undelete module and will be picked up as a record type deletion when a submission file for that quarter is created.	Email CIHI Liason and include Record ID, Surgeon ID, Patient's Name, Joint Type, Date of Surgery and Procedure for deletion.

5.6 Incoming Batch Interface

An incoming Batch Interface is a custom module used to import text files containing specifically formatted patient data into WinRecs. This data is produced by an external patient records system, such as an ADT system.

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Note: Batch Interfaces are custom modules that are developed on a per-client basis. Contact your MED2020 representative for more information.

Incoming Batch Interface Setup

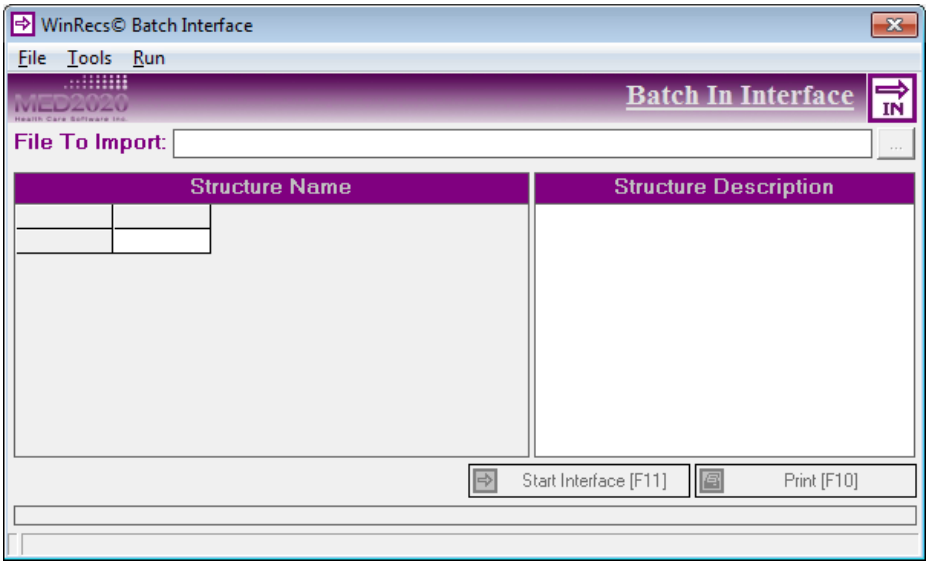
Note: Before WinRecs can be configured to use the Batch Interface module, custom files and instructions must be provided by MED2020. These instructions are not provided in this guide as they are custom for each customer. Do not proceed with the following instructions until you have contacted a MED2020 Client Services representative.

The following steps may be done once the BI database has been attached as per the instructions provided by MED2020.

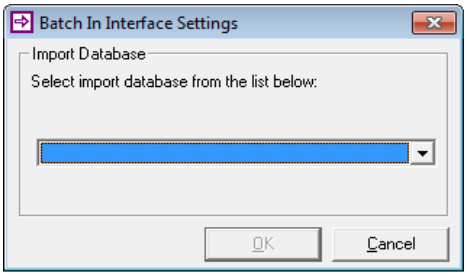
Configuring the Batch-In Interface module

To configure the Batch-In Interface:

Select **Utilities – Incoming Batch Interface**.
The WinRecs Batch Interface dialog displays.



Select **Tools - Settings**.
The Batch In Interface Settings dialog displays.



Select the Batch-In database from the drop down.

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Click **OK**.

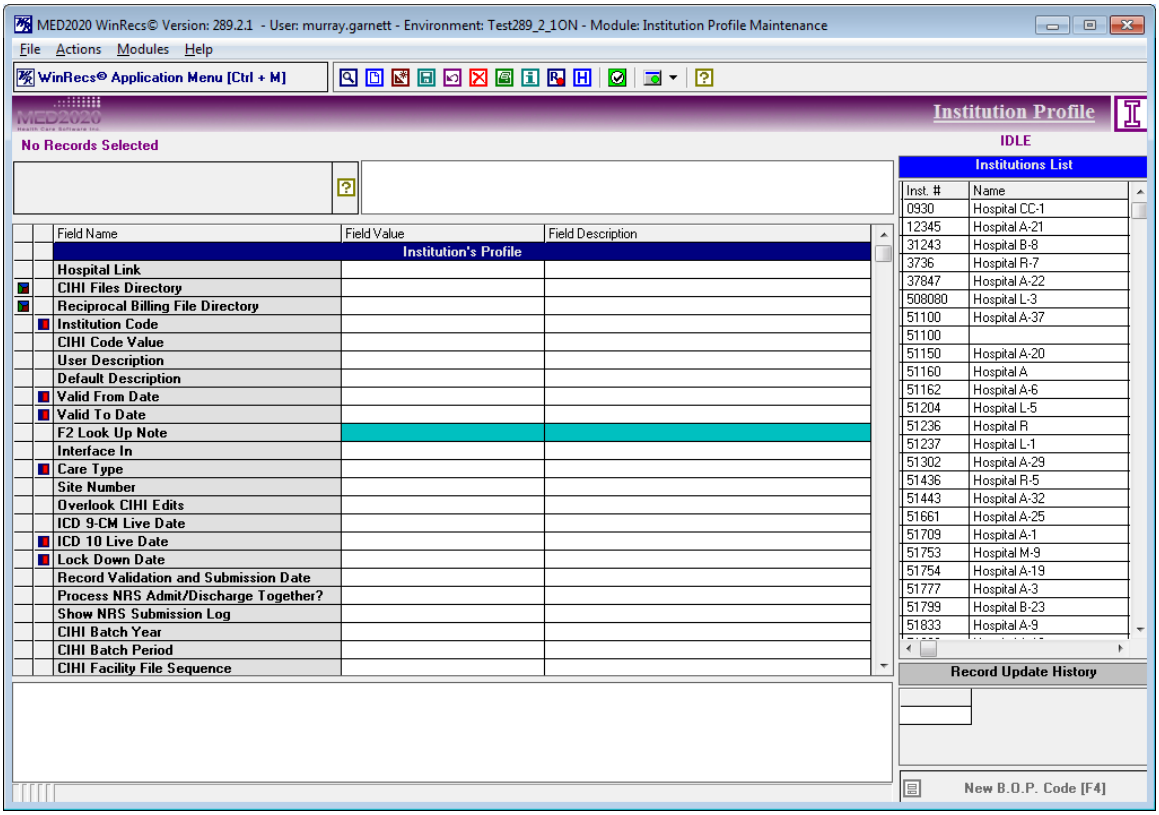
Close the WinRecs Batch Interface dialog.

Configuring the Institution Profile

Use the following steps to configure the Institution Profile for the Batch In process.

To configure the Institution Profile:

Select **System Maintenance – Institution Profile**.
The Institution Profile window displays.



Each institution in the Institution List sidebar that will be updated using the Batch Interface must be configured.

Double-click on the institution in the Institution List to configure.
The institution information displays in the Main Grid.

For each institution, update the “Interface In” field with the corresponding value found in the batch interface data file.

Click
- or Press **F7**.
The information is saved.

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Configuring Look Up Field Maintenance

Every lookup table that corresponds to data in the batch text file must be updated with the corresponding Interface In value. Example lookup tables could be:

- Disposition Code
- Entry Code
- Gender
- H.C.N. Province

Follow the steps outlined in **System Maintenance – Lookup Field Maintenance** to complete any required Lookup Field Maintenance. Update the “Interface In” field with the corresponding value found in the batch interface data file for all required tables.

Once the interface setup is complete, it is recommended that the batch interface first be run in the test environment to ensure that the expected fields are being applied to WinRecs correctly, and therefore no impacting patient data in the live environment.

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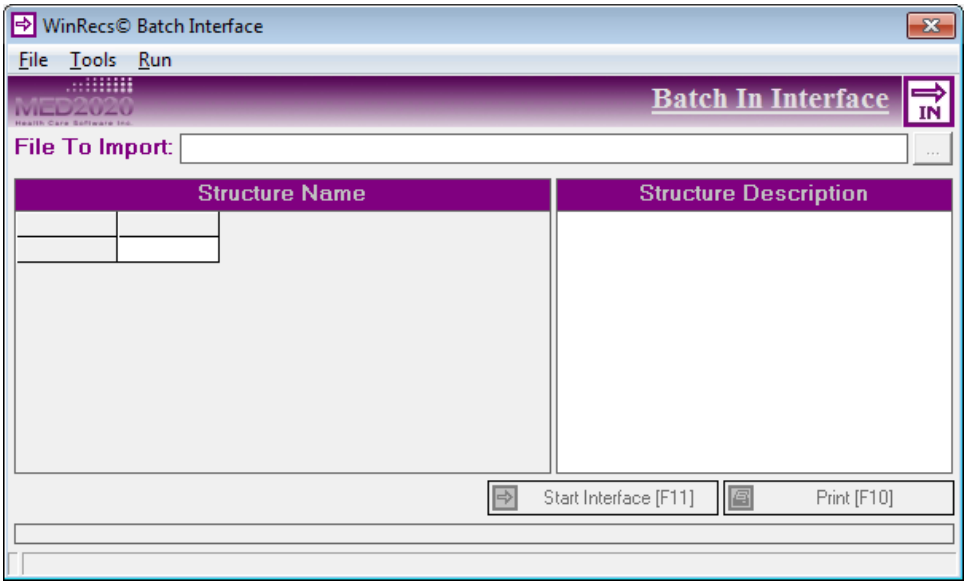
Running the Batch-In Interface

Once the setup is complete, the batch interface may be run. It is recommended that the batch interface first be run in the test environment to ensure that the expected fields are being applied to WinRecs correctly, and therefore not impacting patient data in the live environment.

Note: Data received from the Batch-In Interface may override configured system defaults.

To run the batch-in interface:

Select **Utilities – Incoming Batch Interface**.
The WinRecs Batch Interface dialog displays.



Select the appropriate Structure Name from the list. The available structures are specific to each customer, and are determined by the nature of the record to import, so no structures display in the example above.

The “File To Import” field displays the name and location of the last import file used.

Click ... to locate the import file.

Note: Contact the MED2020 Administrator if you do not know the location of the import files for your setup.

Click Start Interface [F11]
The progress of the import displays at the bottom of the window.

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Batch-In Interface Reports

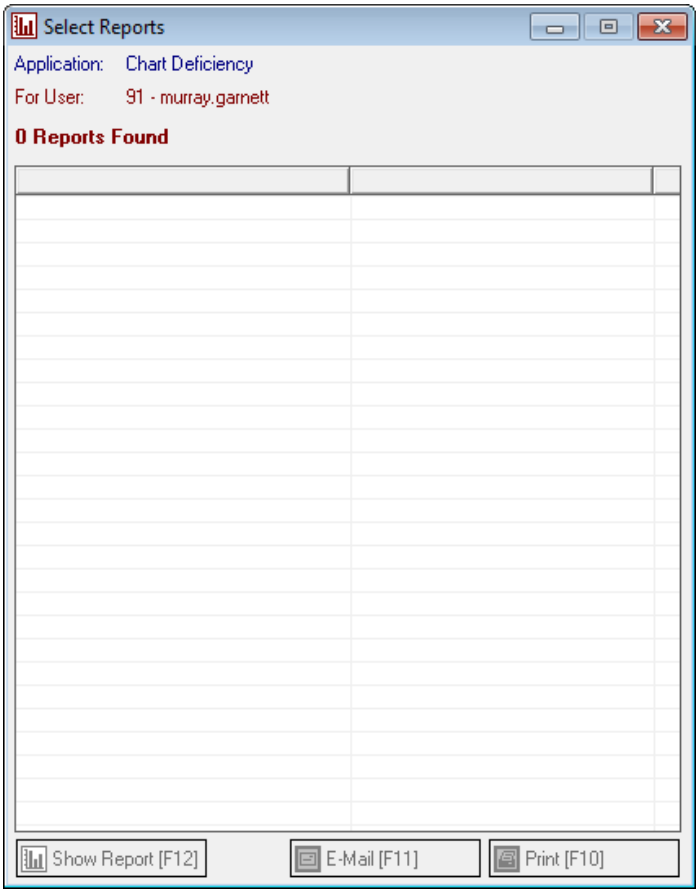
Reports such as those used to identify discrepancies noted during interface processing can be run. These reports must be configured in the Lookup Maintenance Report Section list table.

Note: All reports are available for download from ftp://web.med2020.ca/WR2Reports/. All reports will be downloaded to the server on which you are working.

Note: BI Date Range Errors.rpt must be located in the reporting folder under the main WinRecs program folder.

To run reports:

Click
- or – Press **F10**.
The Select Reports window displays.



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Highlight the required report.

To print the report, click

- or - press **F10**.

To display the report, click

- or - press **F12**.

To close the window, click
The window closes.

Note: It is recommended that the reports are run to confirm accuracy of batch imports, as well as for potential problems, such as a chart number having all demographics changed.

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5.7 Batch-Out Interface

The Batch-Out Interface is a custom module used to export text files.

Note: Batch Interfaces are custom modules that are developed on a per-client basis. Contact your MED2020 representative for more information.

Outgoing Batch Interface Setup

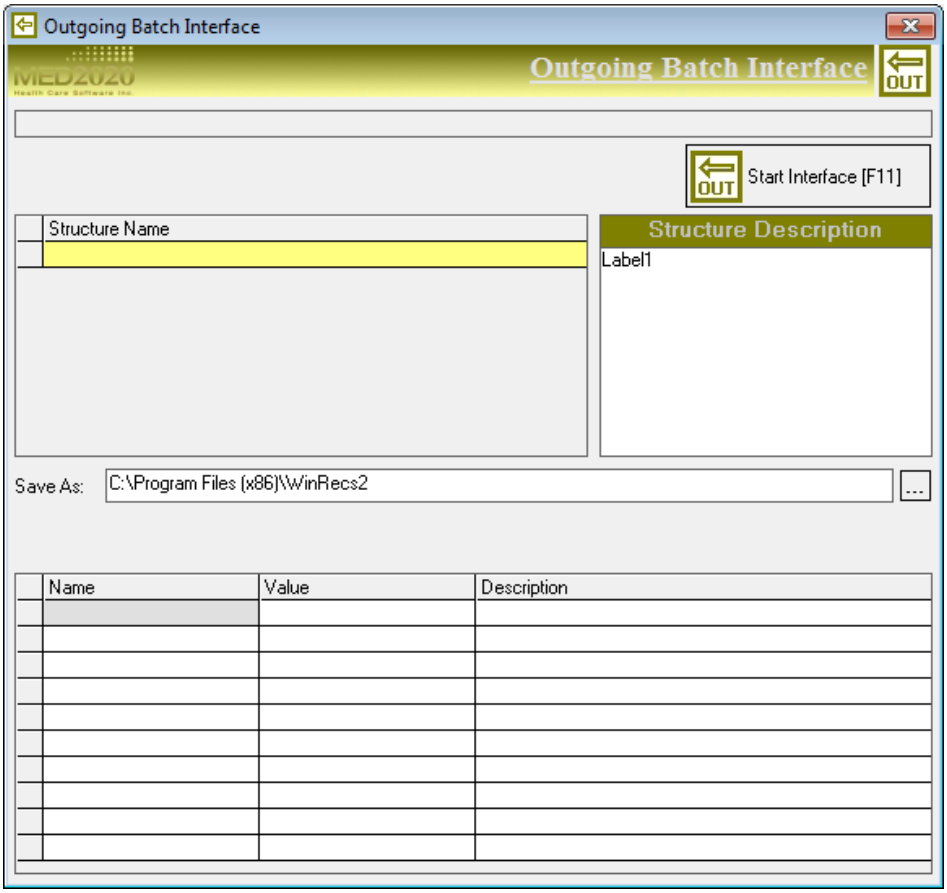
Note: Before WinRecs can be configured to use the Batch Interface module, custom files and instructions must be provided by MED2020. These instructions are not provided in this guide as they are custom for each customer. Do not proceed with the following instructions until you have contacted a MED2020 Client Services representative.

Running the Batch-Out Interface

Follow the steps below to run the batch-out interface.

To run the Batch-Out Interface:

Select **Utilities – Outgoing Batch Interface**.
The Outgoing Batch Interface dialog displays.



Select the Structure Name. The available structures are specific to each customer, and are determined by the nature of the record to export.

Provide a valid Institution Number by clicking on the Institution Number field and pressing **F2**.

Select the required institution from the list.

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Enter the Start Date.

Enter the End Date.

Click ... to locate the file to export.

Click

- or - Press **F11**.
The progress of the export displays at the bottom of the module header. When the batch out is complete, the message “Finished batch out” displays.

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5.8 Reciprocal Billing Submission

The submission process will gather records where Project 998 Question Number 1 = “Y” for the submission period entered.

Note: This process does not expect 100% CIHI record status completion before executing this submission file and can be run for the same period more than once. The file will create with an .rcb file name extension.

File Path Location: The Reciprocal Billing File Directory path should be set in the Hospital Profile to direct WinRecs where to save the .rcb file.

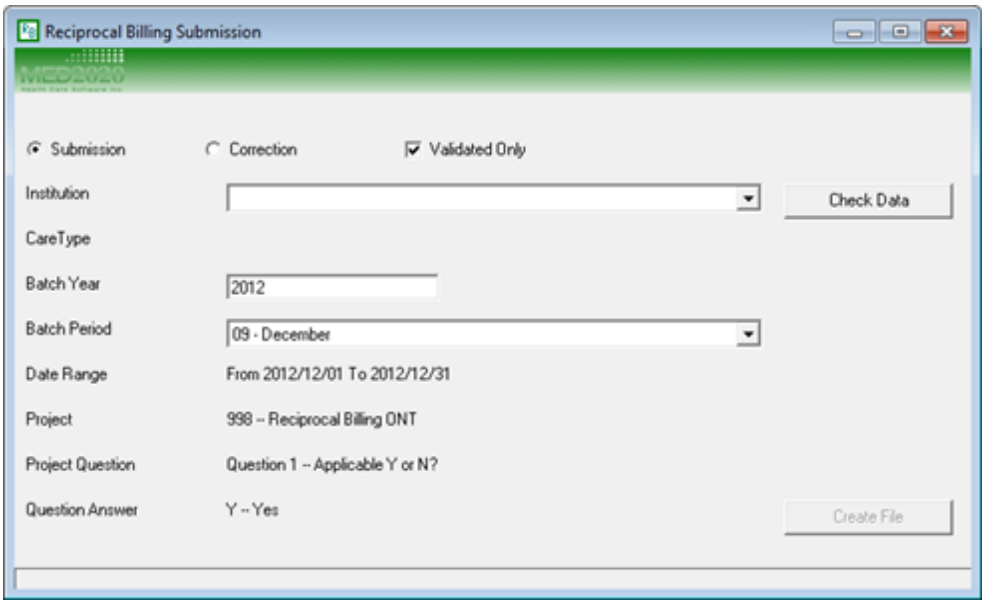
If the specified path is not physically created before processing and RCB file, a “Write File Failed” error displays.

Creating the Reciprocal Billing Submission File

Use the following steps to create the reciprocal billing submission file.

To create the Reciprocal Billing Submission File:

Select Utilities - Reciprocal Billing Submission.
The Reciprocal Billing Submission window displays.



Make the required selections.

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Field Name	Description
Type:	Select either Submission or Correction.
Validated Only:	Select or clear the Validated Only field. If you want records that are not error free to be included, clear this field.
Institution:	
Care Type:	
Batch Year:	
Batch Period:	

Select “Check Data”.
This function verifies that Project 998 data exists for that period.

If the data meets the criteria, the Create File button is activated. The file path/name displays at the top of the window upon completion.

Add to/ Correct Previous Reciprocal Billing Submissions

To add to or correct previous Reciprocal Billing Submissions:

Select Reciprocal Billing Submission from the Utilities menu.

Select the Correction radio button.

Complete the Institution, Batch Year and Batch Period fields.

Select “Check Data”.
This function verifies that Project 998 data exists for that period.

If the data meets the criteria, the Create File button is activated. The file path/name displays at the top of the window upon completion.

Reciprocal Billing Status

A field has been added to the Record Information area of the Inpatient and Ambulatory Care abstracts to record the Reciprocal Billing Status:

Blank: This record has not been submitted in a reciprocal billing file.
“Y” (Yes): This record has been submitted in a reciprocal billing file.
“P” (Pending): The record has been updated since it was submitted in a reciprocal billing file.
“C” (Corrected): The record has had a correction included a reciprocal billing file.

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5.9 Batch Grouper

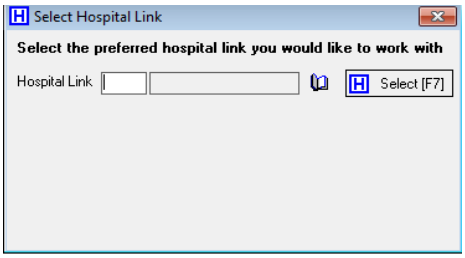
Running the Batch Grouper will ensure the Grouper values are assigned to the visit.

Users should group data prior to creating Submission Files.

Using the Batch Grouper

To access the Batch Grouper:

Select **Utilities - Batch Grouper**.
The Select Hospital Link dialog displays.



Enter the Hospital code or Press **F2** to display a list of Hospitals.

Double-click the required hospital.

Press **F7**.

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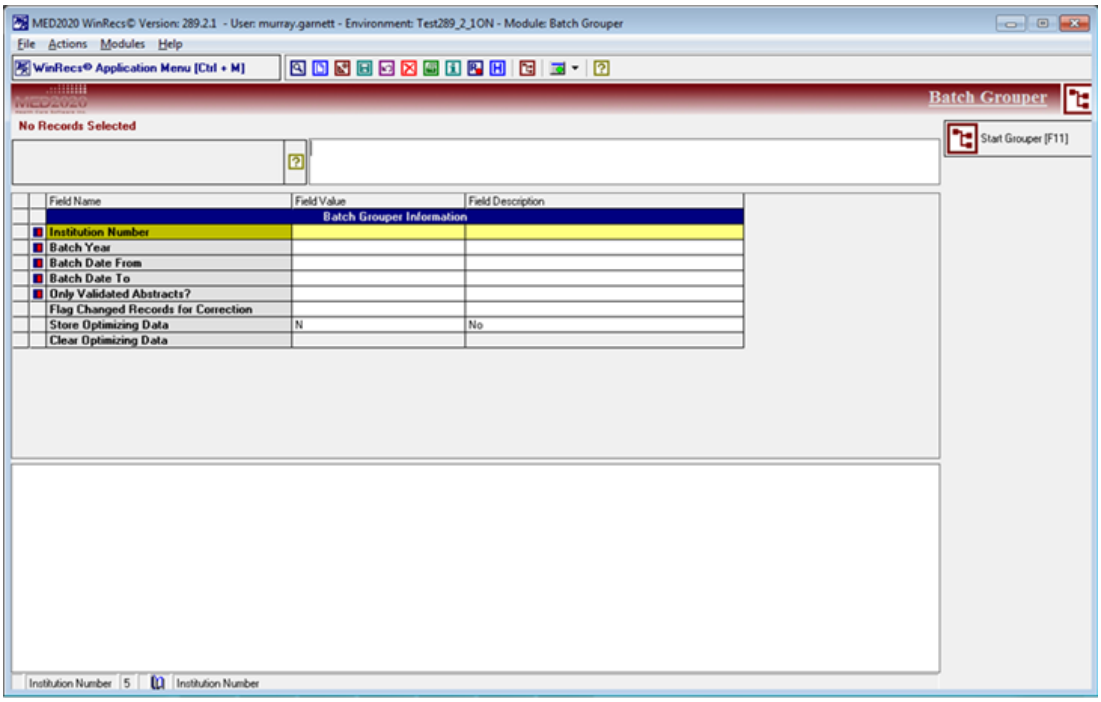
The Batch Grouper window displays.



Complete the required fields. Press **Enter** after each field to move to the next field.

Field Name	Description
Institution Number:	
Batch Year:	
Batch Date From:	"Batch Date From" and "Batch Date To" fields will default the batch year allowed for grouping.
Batch Date To:	"Batch Date From" and "Batch Date To" fields will default the batch year allowed for grouping.
Only Validated Abstracts?:	Will only group those cases where Is Validated = Yes.
Flag Changed Records For Correction:	If grouper value has changed after submitted to CIHI the record will get flagged as a correction if a Yes value is entered in this field. See below section on Flag Changed Records For Correction.
Store Optimizing Data:	Defines if the Batch Grouper will store grouper data for other diagnoses. See below section on Store Optimizing Data.
Clear Optimizing Data:	If Store Optimizing Data is set to "Y", optimizing data will automatically be purged after the specified period. Press F2 when in the Clear Optimizing Data field to see a list of the available options. See below section on Store Optimizing Data.

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Once you have provided the required information, click

- or Press F11.

Once processing is complete, the number of processed records will be noted below the module banner.

Flag Changed Records for Correction

An option to “Flag Changed Records for Correction” is available in the Batch Grouper window to allow for submitted records to be flagged as corrections. This is an optional function and if the site wants to resubmit their grouper data after initial submission, this option can be set to “Y”. Only those records found to have changed grouper data would be flagged (see Batch Grouper Audit above).

Storing Optimized Data

By default, the Batch Grouper only stores data pertinent to the Most Responsible Diagnosis. The fields Store Optimizing Date and Clear Optimizing Date can be configured in Batch Grouper to provide more reporting options.

Note: Effective versions 2.8.6 WinRecs, CIHI licensing now prohibits the batch grouping (or optimization) outside of the fiscal year for which the record belongs. Completing the “Batch To Date” and “Batch From Date” will default the year allowed for grouping.

Batch Grouper Audit

The Batch Grouper uses an audit function to track abstracts that have changed since the Batch Grouper was last run for a given period. The following reports are available for download from the MED2020 web site at ftp://web.med2020.ca/WR2ReportsMisc, and are used to report on abstract changes:

“CACS Batch Grouper Audit.rpt.”
“CMG Batch Grouper Audit.rpt.”
“DPG Batch Grouper Audity.rpt.”

Note: It is recommended that these reports be run after rerunning the Batch Grouper for a given period. Occasionally, MED2020 will advise customers to rerun the batch grouper after a service release. Consult the release notes to determine if Batch Grouper must be rerun.

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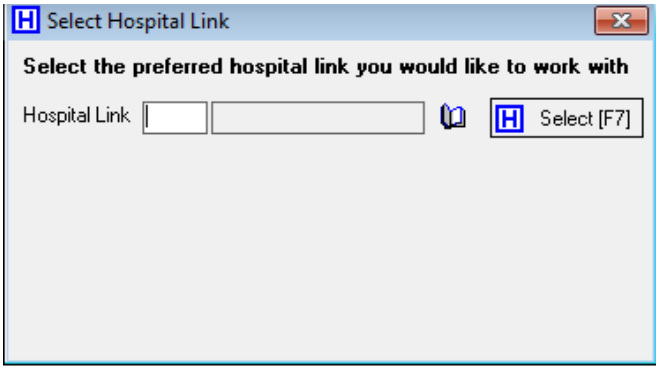
5.10 Using Purge/Undelete

The Purge/Undelete module is used to completely remove or restore deleted data.

To delete data:

Select **Utilities –Purge/Undelete**.
The Select Hospital Link dialog displays.



Enter the Hospital code or Press F2 to display a list of Hospitals.

Double-click the required hospital.

Press **F7**.
The Purge/Undelete window displays.

Select the entries to remove by clicking on the entry. To select multiple noncontiguous entries, hold the Ctrl Key down when clicking. To select multiple contiguous entries, hold the Shift Key down and click the first entry, and keeping the Shift key down click the last entry. All entries in between will be selected.

To completely remove the chart(s) from the system, press **Purge F9.**

To restore the charts to the system, press **Recover F8**.

To close the window, click

Note: If a deleted abstract has been sent to CIHI, you must create a corrections file first. (See CIHI Submissions). Once the corrections file has been created, the deleted abstract will automatically be purged from the Purge/Undelete.

You must also purge abstracts for a period before running CIH Submissions, CIHI Corrections or reports.

Note: CJRR deletions cannot be done electronically. See the section on CJRR.

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5.11 Edits Management Tool (EMT)

The Edits Management Tool give the user the ability to create edits on all fields within a module and are included in the validation process when an abstract is verified (F11) and saved (F7). The edits are created by using the Edit Engine: Edit Editor module. The EMT DO NOT execute actions to fix the abstract.

Conditions can be set on Multiple occurrences and the Expression Condition Rule can check:

- First occurrence
- All occurrences
- All but the first occurrence
- One specific occurrence
- Same occurrence

The User will have the ability to create edits using CMG, HIG and CACS on fields.

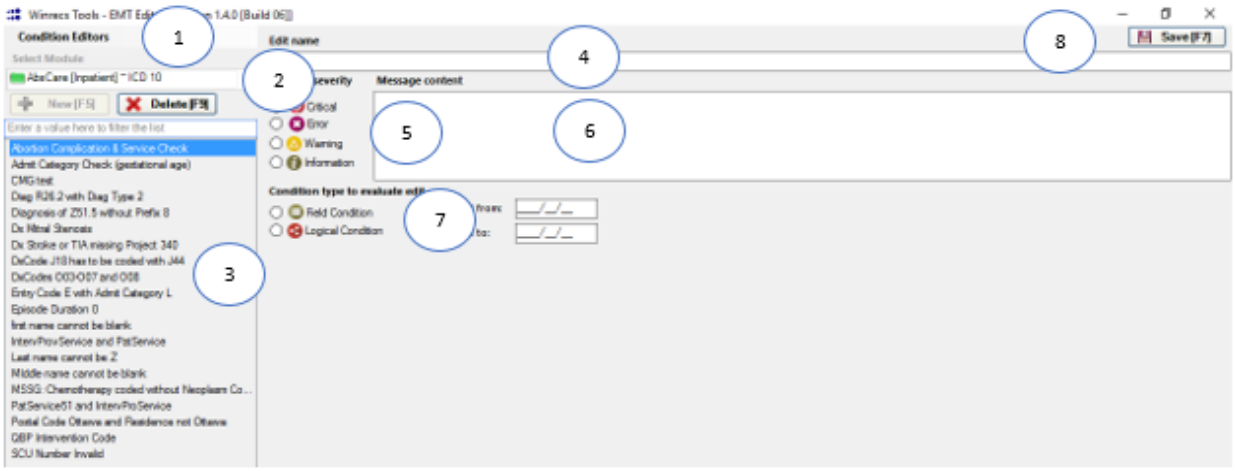
To gain access to this module go to System Maintenance/User's Profile and populate the following fields:

- Can Modify Edit Engine – select 'Y' to allow access
- Edit Engine File – F2 file path to link to the Edit Engine

Edit Engine: Edit Editor

To access the Edit Editor:

Select Utilities - Edits Management Tool, EMT Editor window will display



1. **Condition Editors -** clicking on either of these will open a window for each of below editors. This is where the user will define the conditions of the edit.

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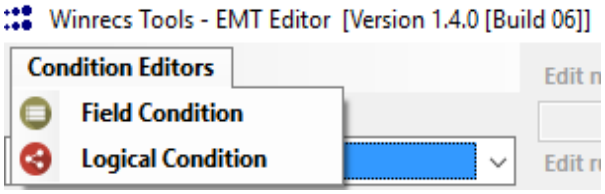

a. **Field Condition Editor** – compares an abstract field against a value (or group of values) or another field based on the Comparison Operator

b. **Logical Condition Editor** – gives the user the ability to compare field conditions to each other

2. **Select Module** – Choose the module the edit is being applied to.

In order to enable the editor, must first select the module. The edit will only display in the module you select.

3. **List of Edits per Module Information** – When a module is selected, the list of available edits displays in the box.

   - New Condition - clicking on this icon will create a new edit and open up the fields on the right hand side of the screen
   - Delete Edit – by clicking on any of the edits in the box below you can delete the edits
   - By clicking on any of the edit it will open the edit up for editing.

4. **Edit Name** – The name usually reflects the fields and conditions involved.

5. **Edit Rule Severity** – When the record is verified, the EMT edits will be included in the Verification Process. All EMT edit icons will have a turquoise frame with the following messages:

   - **Critical (Dark red)** –the abstract cannot be saved
   - **Error (Red)** –the record can be saved but not submitted
   - **Warning (Yellow)** –the record can be saved but not submitted
   - **Information (Blue)** – the record can be saved and submitted

6. **Condition Type and Validation dates** – This shows the conditions (Field and Logical) that have been created in step 1 to use for this edit.

7. **Save Edit** – Press this to save the edit.

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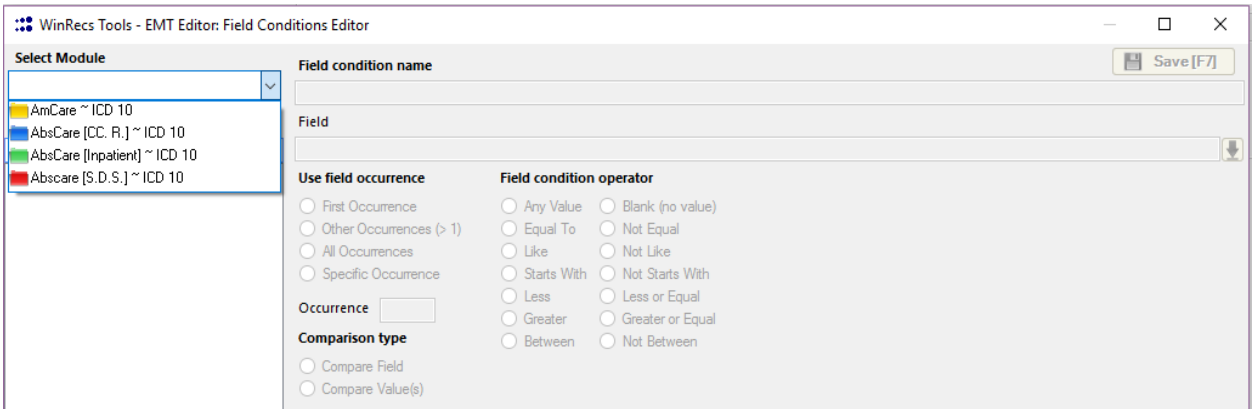
Field Condition Editor:



- Select the Module the edit will be created for
- The list of available conditions for that module will display on the left hand side:
    - double click on any of the conditions and it will display on the right hand side for editing
    - Click once on a condition and press Del. Condition to delete any conditions
    - Press New Condition and the right hand side will populate
- On the right hand side of the screen the following will be populated for the condition:
    - Field Condition Name
    - Field – Click on the drop down to choose the field to build the condition on
    - Use Field Occurrence – Can specify the occurrence if using a multiform

      First Occurrence:
        - For fields in main grid, first occurrence will always be selected
        - In a multiform this first occurrence refers to the MAIN occurrence

      Other Occurrences (>1):
        - In a multiform this refers to other occurrences in a multi form EXCEPT firs occurrence

      All Occurrences:
        - In a multiform this refers to all occurrences from fist occurrence and greater

      Specific Occurrences:
        - In a multiform this refers to a specific occurrence number
    - Field condition operator – Specify the operator available for the condition
        - *Any Value/Blank (no value)*- When selecting a field, this operator refers to a value or no value.

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- *Equal To/Not Equal*- When selecting a field, this operator refers to an EXACT value or NOT EXACT value. The value in condition can be more than one value. Examples: Admit Category = L; Admit Category = L, E, N
- *Like/Not Like*- When selecting a field, this operator refers to a field that contains the value or not like the value. There are two wildcards used in conjunction with the Like/Not Like operator:

  ? – The question mark represents a single character in a specific position for a value

  ***** – The asterisk sign represents zero, one, or multiple characters at that end of the value

Like/Not Like Operator	Description
WHERE PatientName LIKE 'a*'	Finds any values that starts with "a"
WHERE PatientName LIKE '*a'	Finds any values that ends with "a"
WHERE PatientName LIKE '*or*'	Finds any values that have "or" in any position
WHERE PatientName LIKE '?r*'	Finds any values that have "r" in the second position
WHERE PatientName LIKE 'a?*?*'	Finds any values that starts with "a" and are at least 3 characters in length
WHERE PatientName LIKE 'a*o'	Finds any values that starts with "a" and ends with "o"

- *Start With/Not Starts With*- When selecting a field, this operator refers to a field that begins not not begins with this value.Example:Diagnosis Code starts with K29
- *Less/Less or Equal*- When selecting a field, this operator refers to a NUMBER data type field. Example:LOS Days <20, LOS <=20
- *Greater /Greater or Equal*- When selecting a field, this operator refers to a NUMBER data type field. Example: LOS Days >20, LOS>=20

- Comparison Type:
  - *Compare Field* – A specific field and its value compared to another specific field and its value. Examples:
    - Admission Date = Discharge Date
    - Triage Date > Registration Date
  - *Compare Value(s)* – A specific field that refers to values. Examples:
    - Admit Category = L
    - Diagnosis Code like K29
    - Patient Service =10

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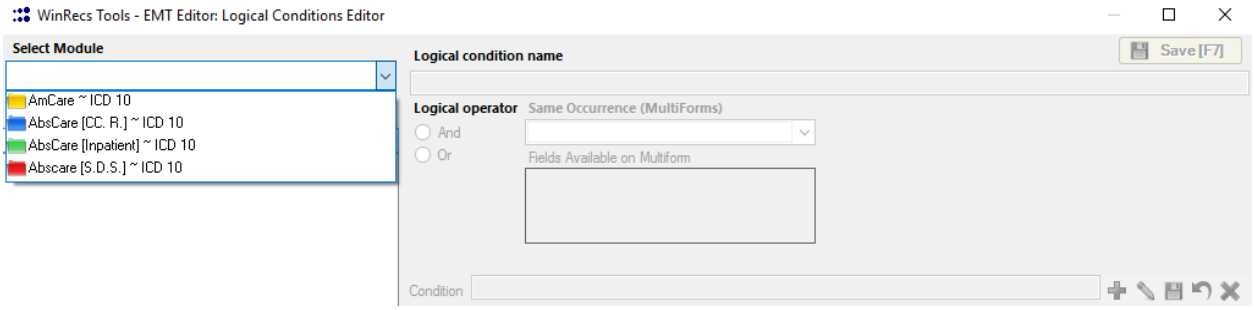
- Once the condition is complete, press Save Condition in the upper right hand corner.

Logical Conditions Editor



- Select Module and a list of availble logical conditions will display
    - Double click on any of the conditions to edit
    - Click on any of the condtions and press Del. Condition to delete
    - Click on New Condtion to create a new condition
- Logical Condition Name – the name of the condition
- Logical Condition Operator – contains *And/Or*. It is used to connect field conditions or to connect field conditions with Logical Conditions
    - FIELD condition AND FIELD condition
    - LOGICAL condition AND FIELD condition
    - LOGICAL condition AND FIELD condition OR FIELD condition
    - LOGICAL condition AND LOGICAL condition
    - LOGICAL condition OR LOGICAL condition
- Save Condition – press to save the logical condition

Creating an Edit

Scenario: When the ER visit has a Death Disposition Code and the Triage Level is not Resuscitation generate a message.

MESSAGE: “Death Disposition must have a Triage Level 1”

Step 1: Select the Module

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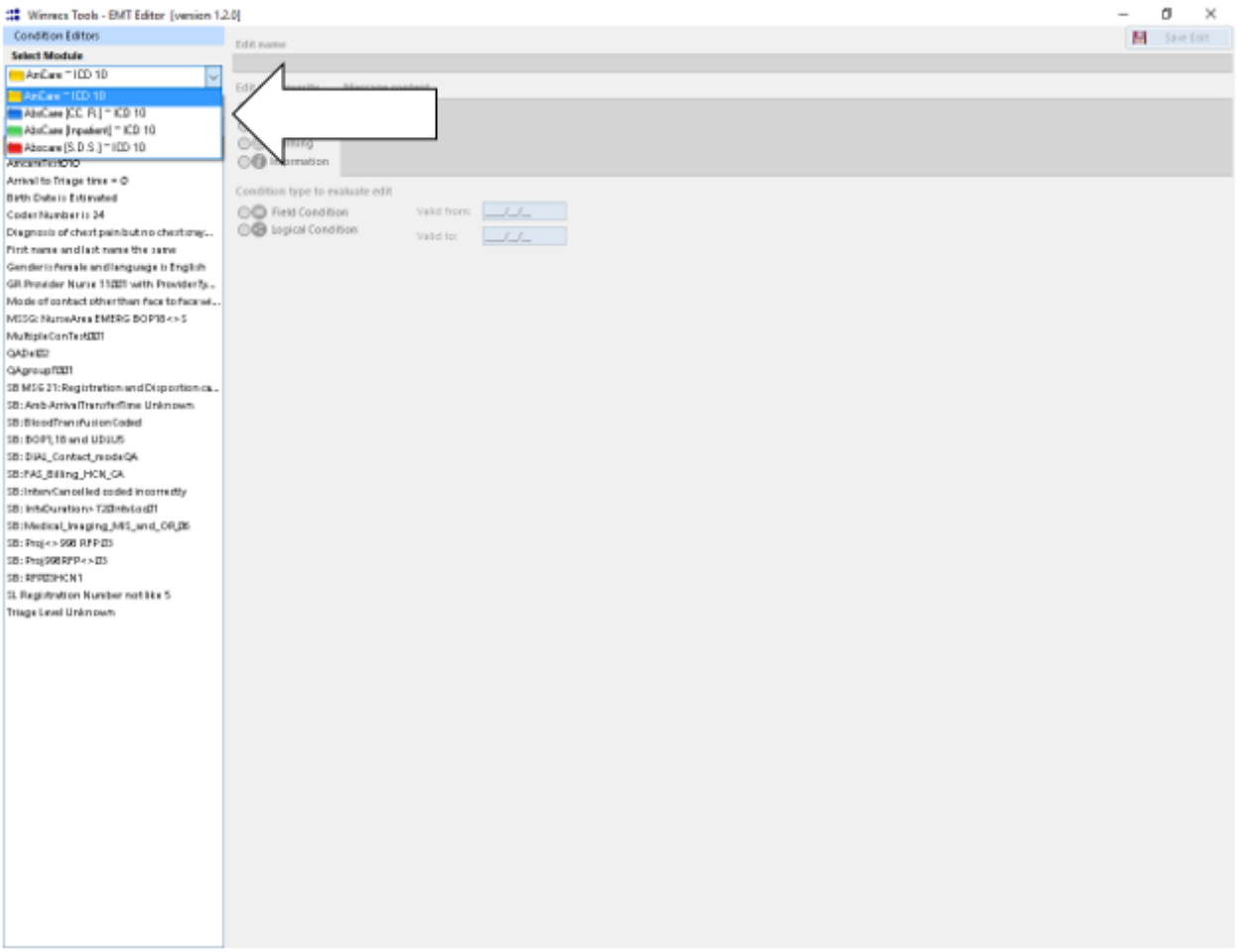

Step 2: Define the message severity and create the message content

a) New [F5]

b) Edit Name

c) Edit Rule Severity

d) Message Content

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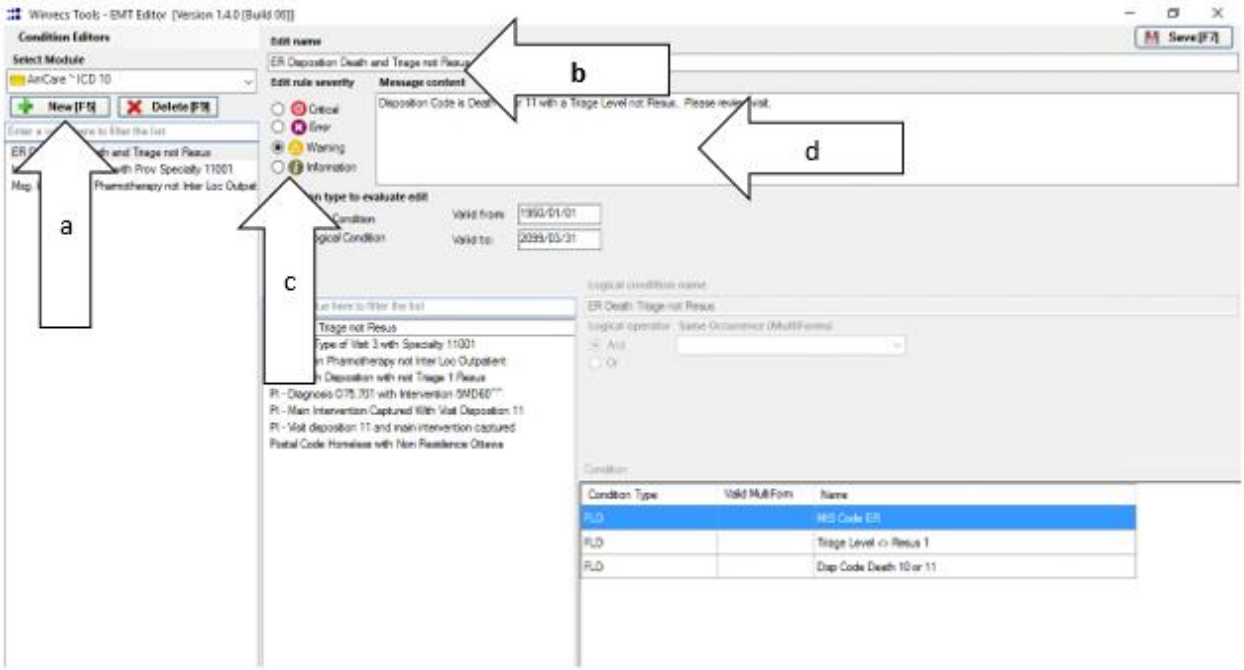
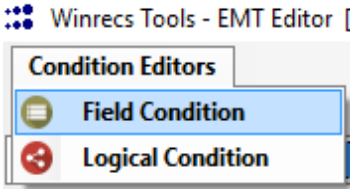


Step 3: Create Field Condition(s)



1. Field Condition
2. New [F5]
3. Field Condition Name
4. Select Field in Drop Down
5. User Field Occurrence
6. Field Condition Operator
7. Comparison type - Compare field / Compare value(s)
8. Click Plus Icon to add value(s) - Valid Values will be returned

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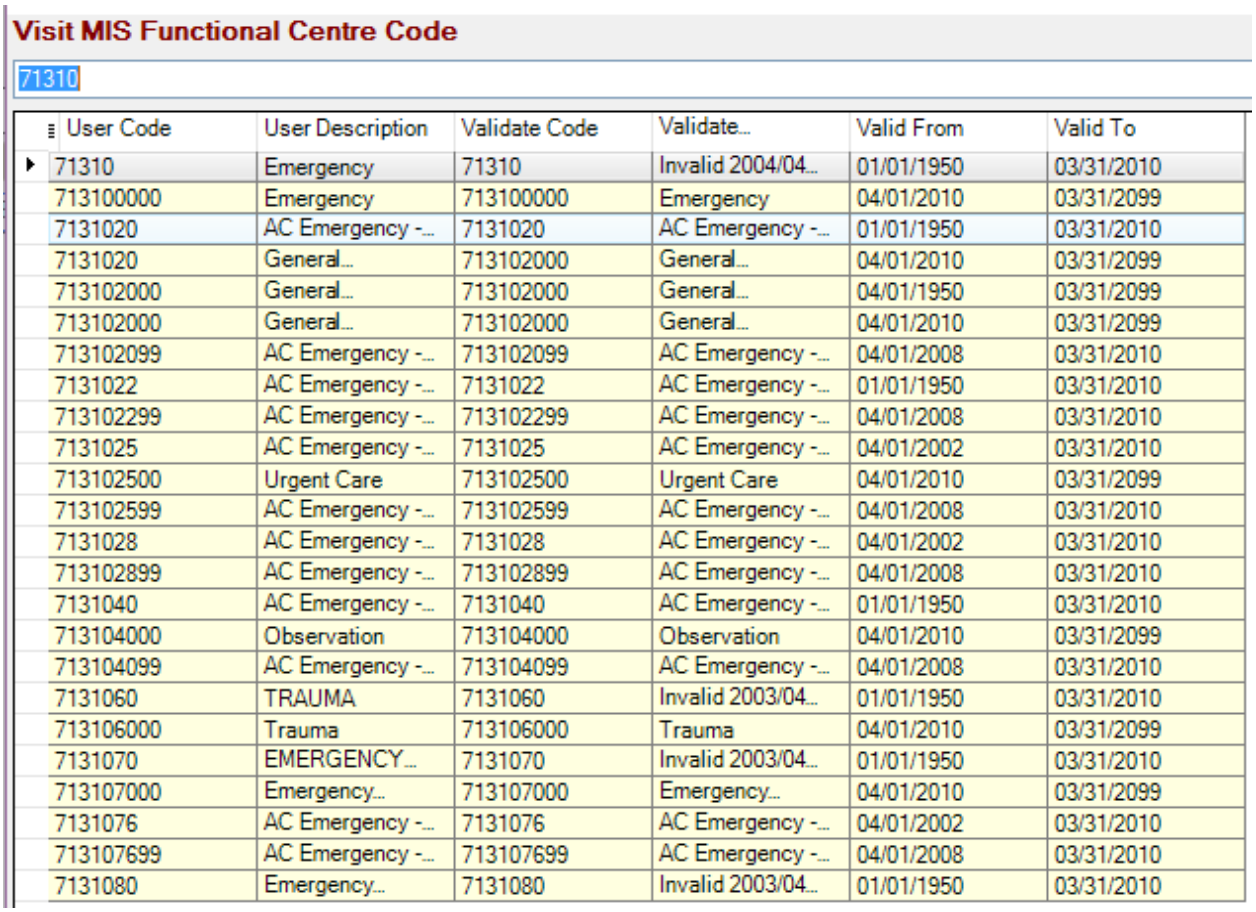

User Code	User Description	Validate Code	Validate...	Valid From	Valid To
71310	Emergency	71310	Invalid 2004/04...	01/01/1950	03/31/2010
713100000	Emergency	713100000	Emergency	04/01/2010	03/31/2099
7131020	AC Emergency -...	7131020	AC Emergency -...	01/01/1950	03/31/2010
7131020	General...	713102000	General...	04/01/2010	03/31/2099
713102000	General...	713102000	General...	04/01/1950	03/31/2099
713102000	General...	713102000	General...	04/01/2010	03/31/2099
713102099	AC Emergency -...	713102099	AC Emergency -...	04/01/2008	03/31/2010
7131022	AC Emergency -...	7131022	AC Emergency -...	01/01/1950	03/31/2010
713102299	AC Emergency -...	713102299	AC Emergency -...	04/01/2008	03/31/2010
7131025	AC Emergency -...	7131025	AC Emergency -...	04/01/2002	03/31/2010
713102500	Urgent Care	713102500	Urgent Care	04/01/2010	03/31/2099
713102599	AC Emergency -...	713102599	AC Emergency -...	04/01/2008	03/31/2010
7131028	AC Emergency -...	7131028	AC Emergency -...	04/01/2002	03/31/2010
713102899	AC Emergency -...	713102899	AC Emergency -...	04/01/2008	03/31/2010
7131040	AC Emergency -...	7131040	AC Emergency -...	01/01/1950	03/31/2010
713104000	Observation	713104000	Observation	04/01/2010	03/31/2099
713104099	AC Emergency -...	713104099	AC Emergency -...	04/01/2008	03/31/2010
7131060	TRAUMA	7131060	Invalid 2003/04...	01/01/1950	03/31/2010
713106000	Trauma	713106000	Trauma	04/01/2010	03/31/2099
7131070	EMERGENCY...	7131070	Invalid 2003/04...	01/01/1950	03/31/2010
713107000	Emergency...	713107000	Emergency...	04/01/2010	03/31/2099
7131076	AC Emergency -...	7131076	AC Emergency -...	04/01/2002	03/31/2010
713107699	AC Emergency -...	713107699	AC Emergency -...	04/01/2008	03/31/2010
7131080	Emergency...	7131080	Invalid 2003/04...	01/01/1950	03/31/2010

9. Click Save Icon to save value(s)
10. Save Condition
11. Repeat 1-10 for each Field Condition

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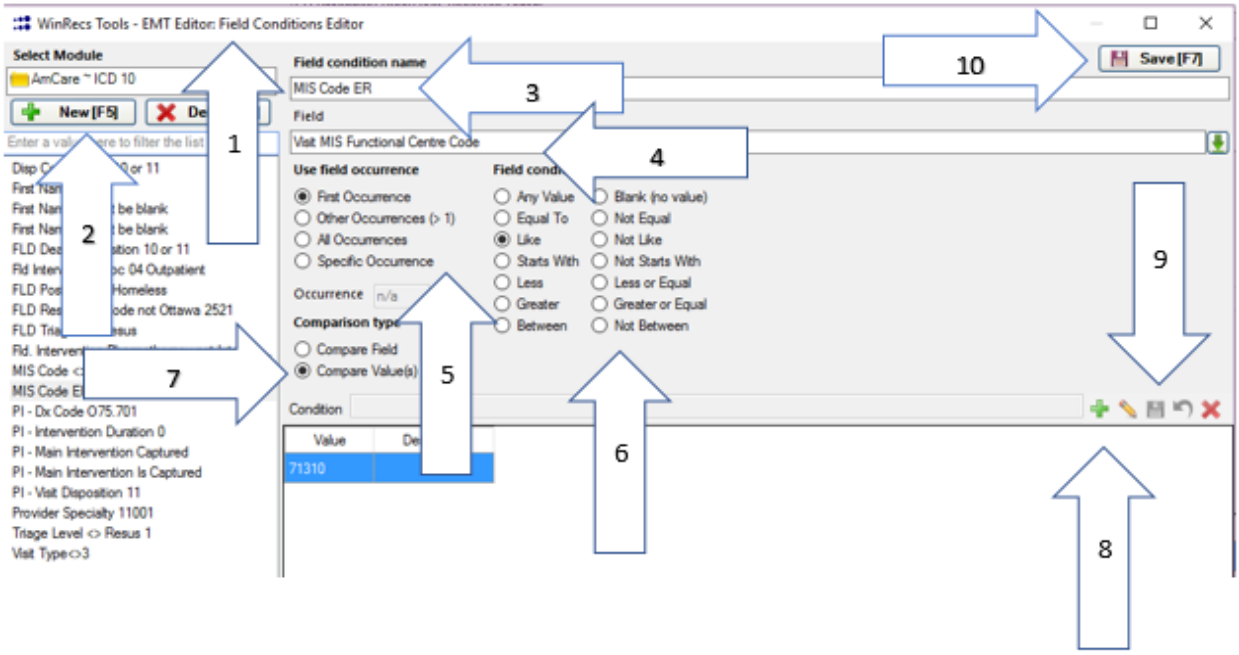
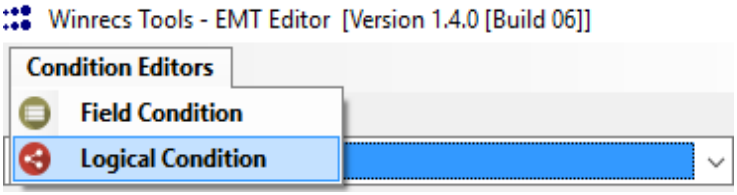


Step 4: Create Logical Condition(s)



1. Logical Condition
2. New [F5]
3. Logical condition name
4. Logical Condition operator - And /Or
5. Click Plus Icon to add value(s)
6. F2 on Condition Field to see drop down list of Field Conditions and Logical Conditions

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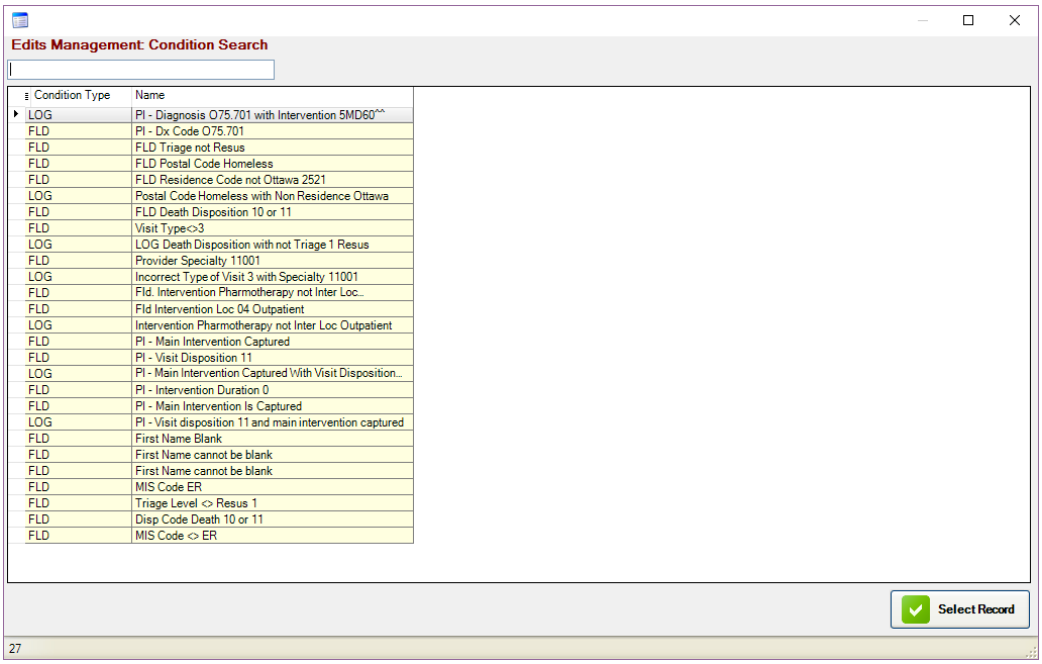

7. Click Save Icon to save
8. Save Condition
9. Save Edit
10. Message will display in Message Window

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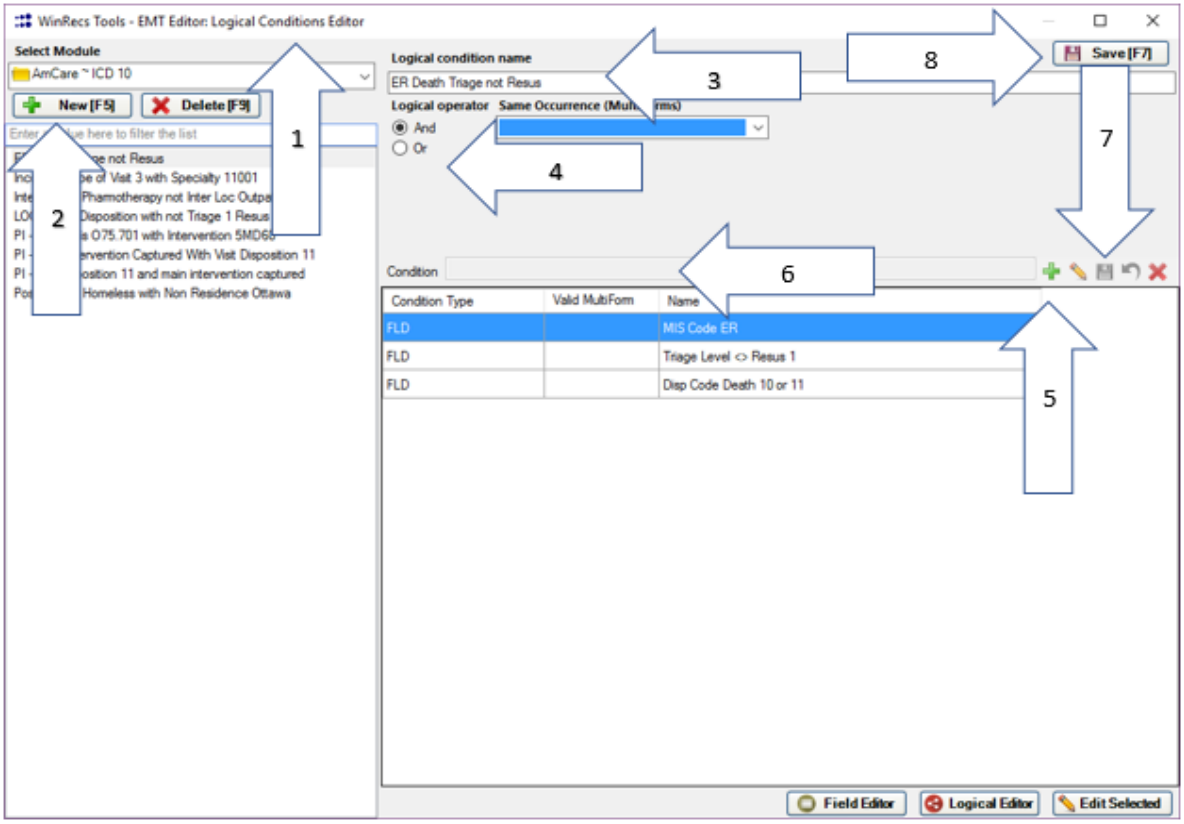
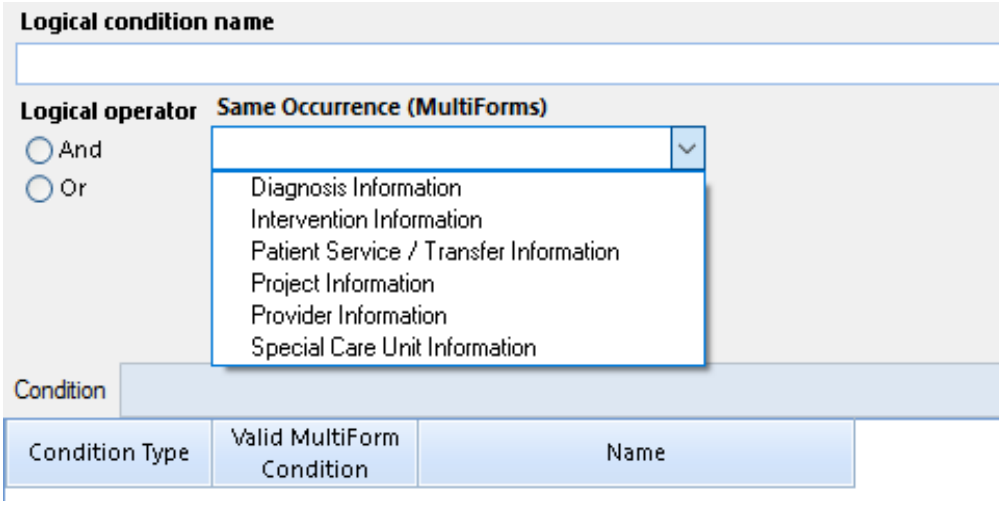


Same Occurrence (Multiforms)

When combining two or more conditions (Field and/or Logical Condition) together, it is possible to create a Logical Condition that refers to fields in a multiform. The edit may refer to fields from the SAME Occurrence.

When click on Same Occurrence (Multiforms), a drop-down list will display all the multiform sections.



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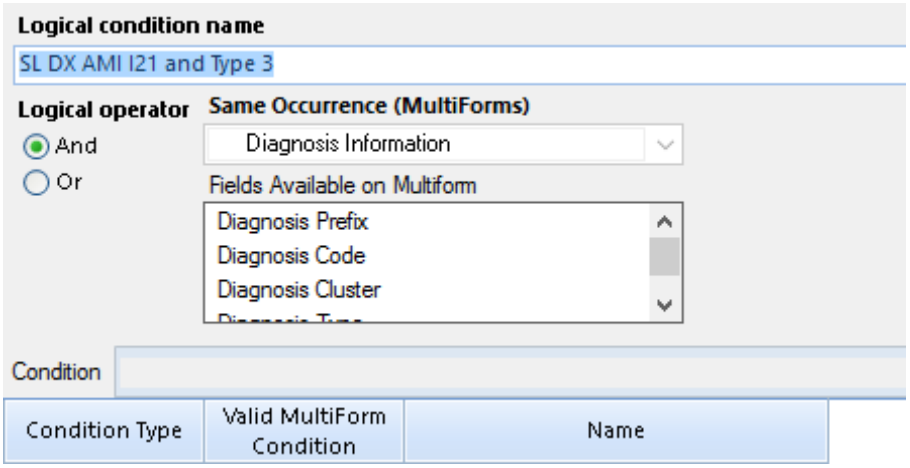
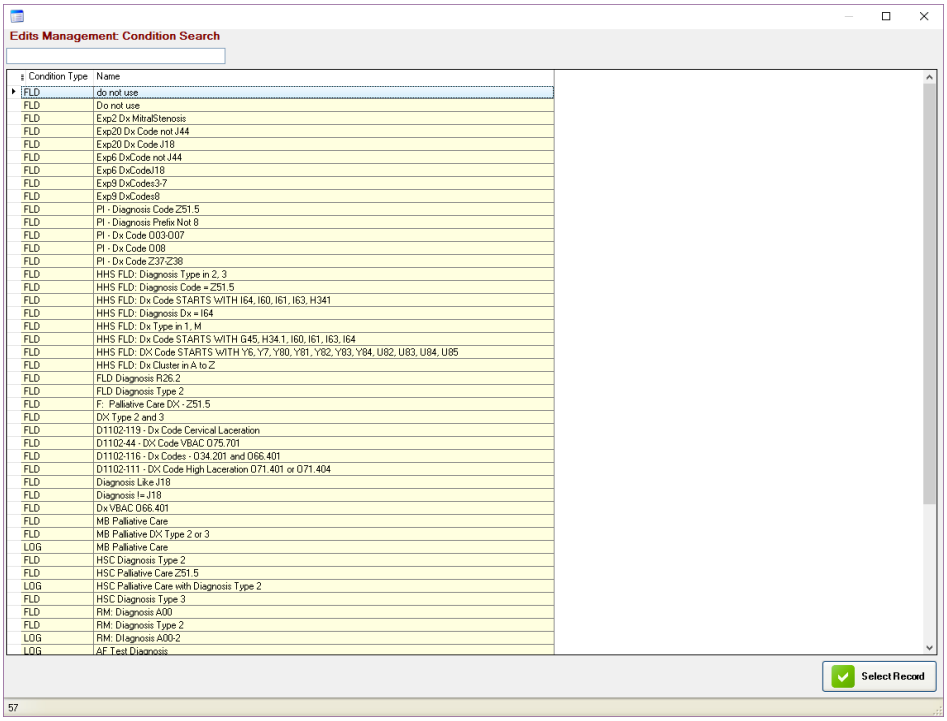
As reference, when you select a multiform, it will display the fields that are available in the multiform. This will ensure the user that the conditions selected must refer to the fields displayed from the list.



To select a condition, click the to enable the Condition field.

Click F2 to display the list of Conditions to select from.



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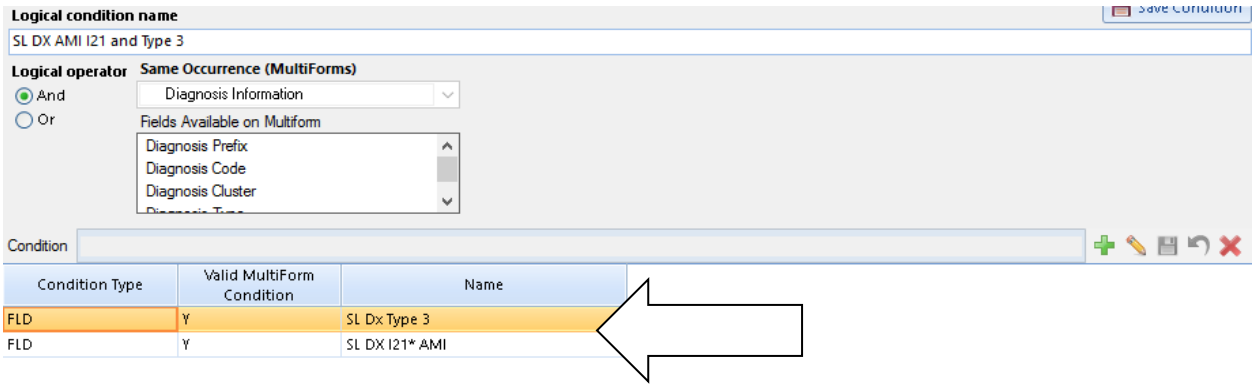
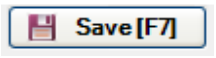
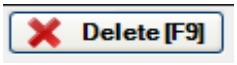
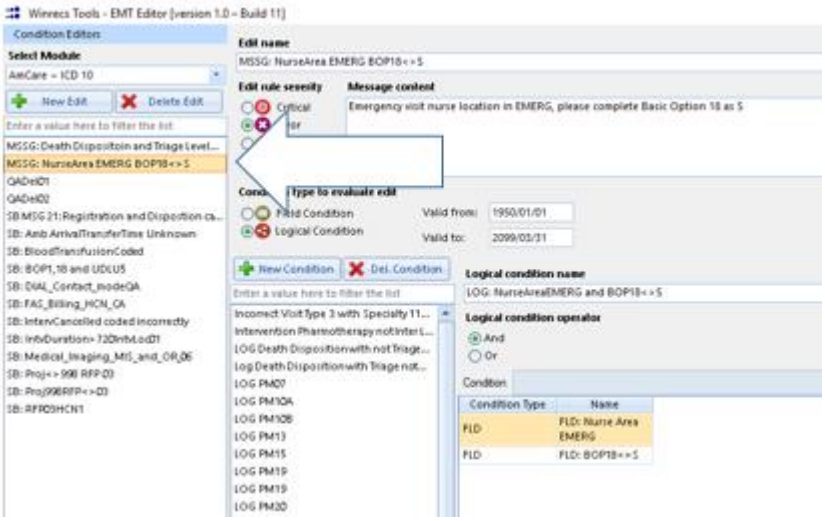
When select the Field and/or Logical Conditons, they will display in a list.





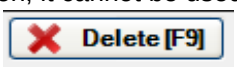
Deleting an Edit

In order to delete an edit so it no longer displays in the abstract, click 



Delete Logical Condition

In order to delete a Logical Condition, it cannot be used in another edit or another Logical Condition.

To delete a Logical Condition click 

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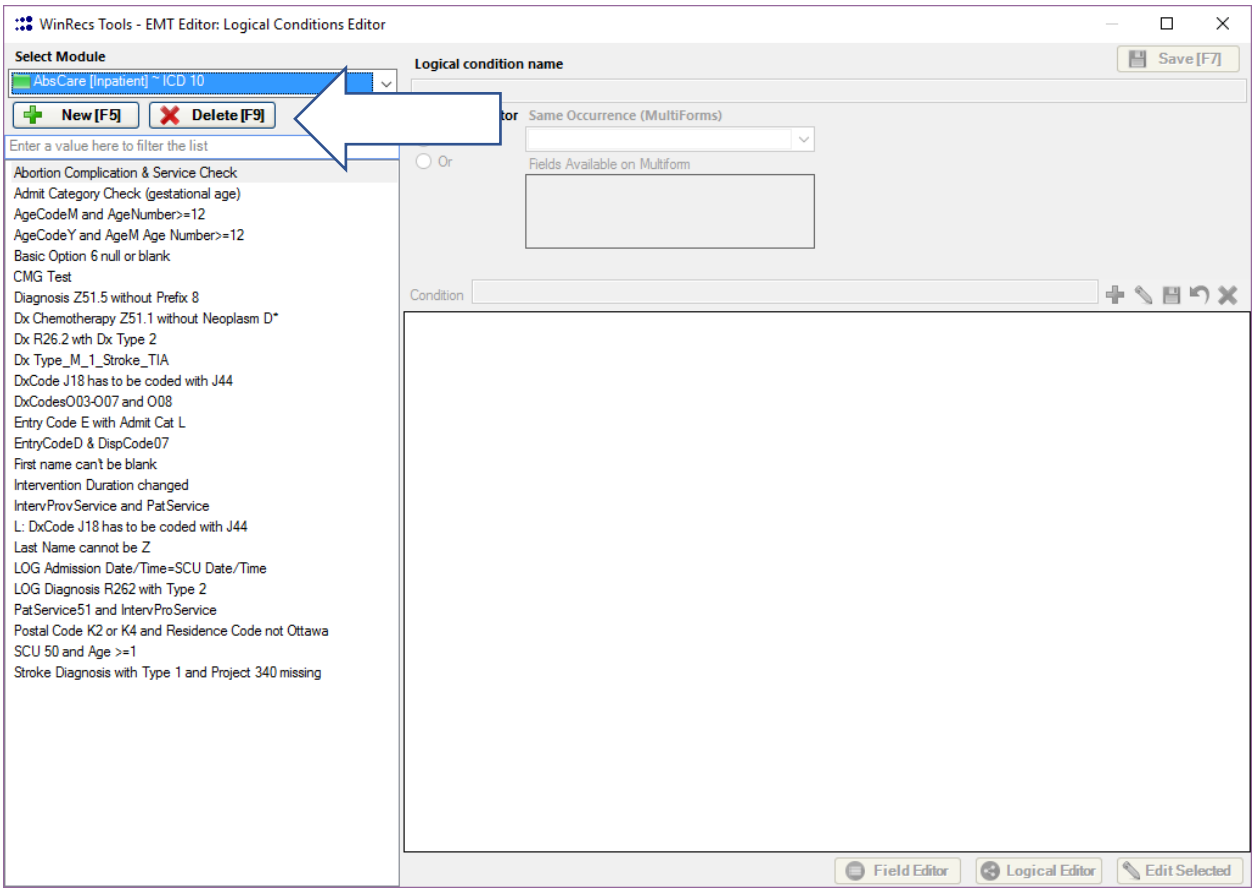
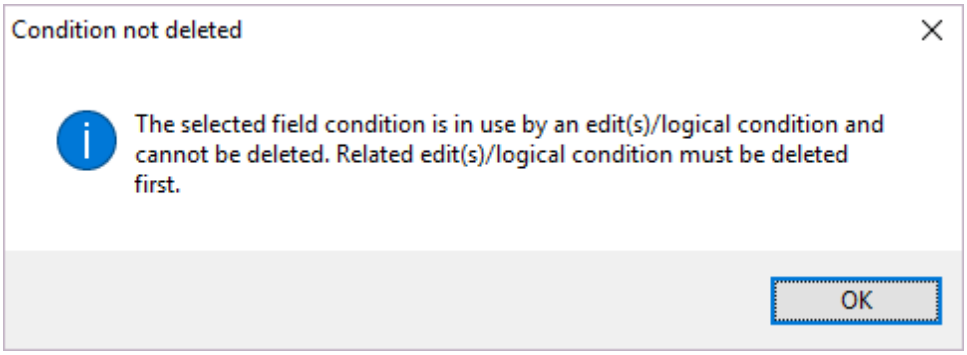
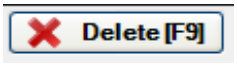


If a Logical Condition is used in another edit, a prompt will display.



Delete Field Condition

Field Conditions can only be deleted if not used in a Logical Condition or another edit. In order to delete a Field Condition click 

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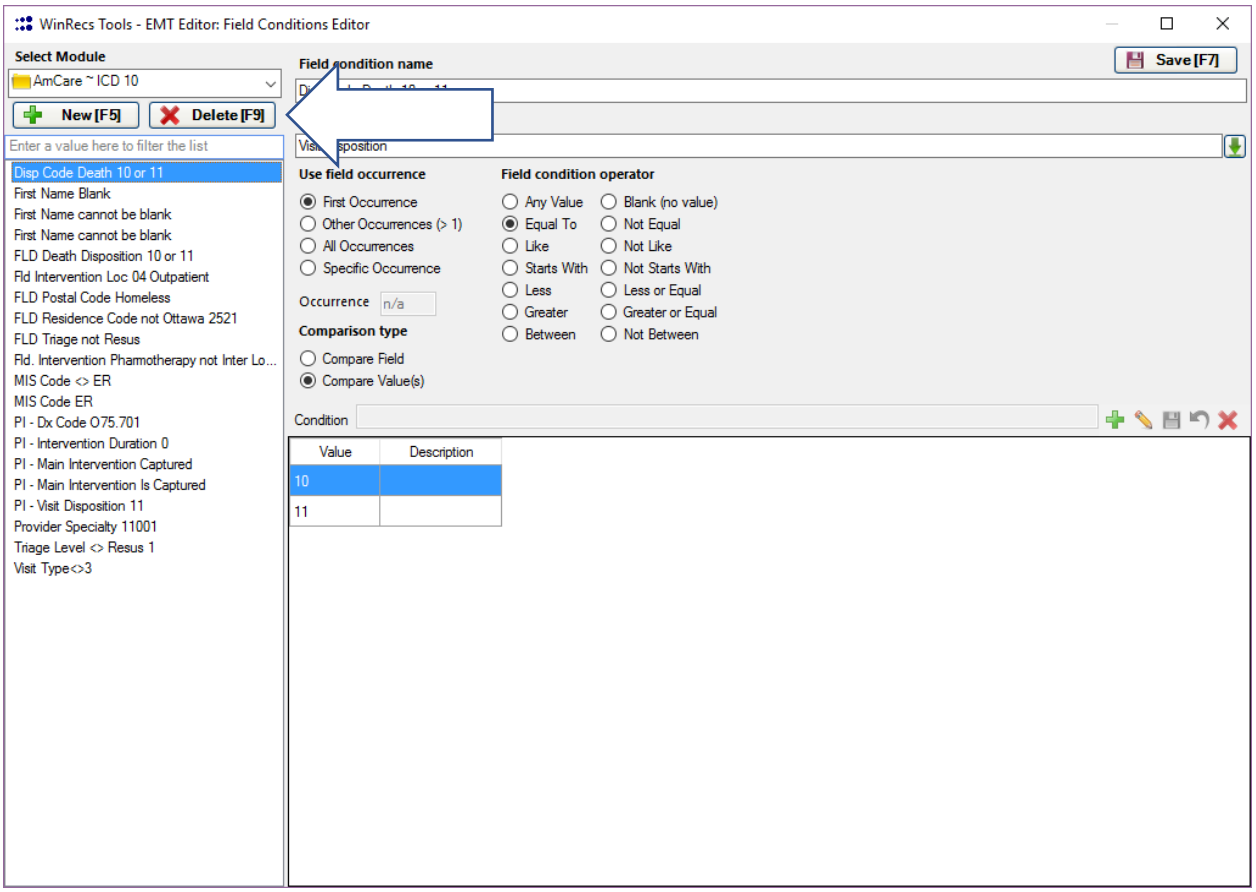
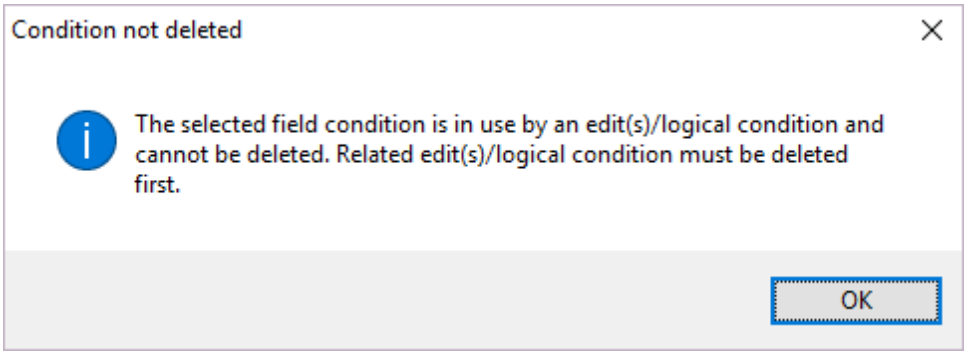


If a Field Condition is used in another edit, a prompt will display.



Access Visit and Verify Abstract

Amcare Abstract

Message should generate in message list box. If message does not generate upon load, F11 Verify.

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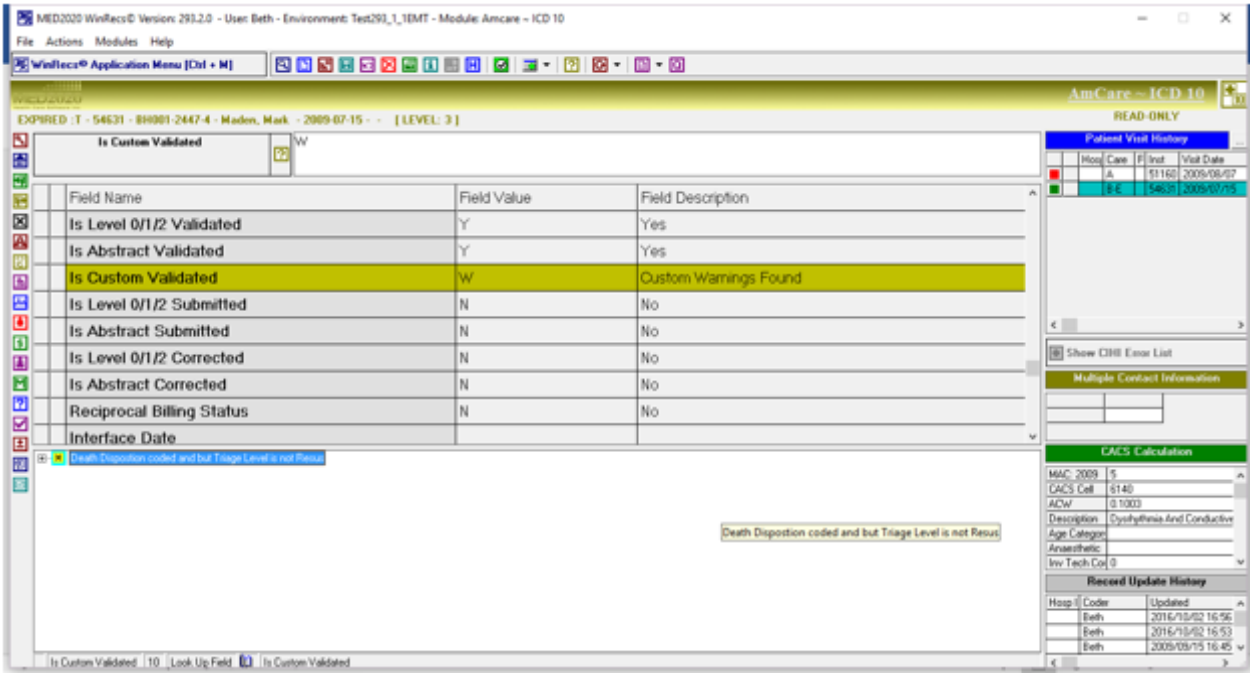

Is Custom Validated field

In the abstract, there is a field called ‘Is Custom Validated’. The Valid Values are:
Yes
When there are no EMT messages generated when abstract is verified, the field will populate a Y.

Custom Errors Found
When there are EMT messages that contain errors, the field will populate an E.

Custom Warnings Found
When there are EMT messages that contain warnings, the field will populate a W.

Custom Information Found
When there are EMT message that contains information, the field will populate an I.

No
When EMT message are not yet verified in the abstract, this field will populate an N.

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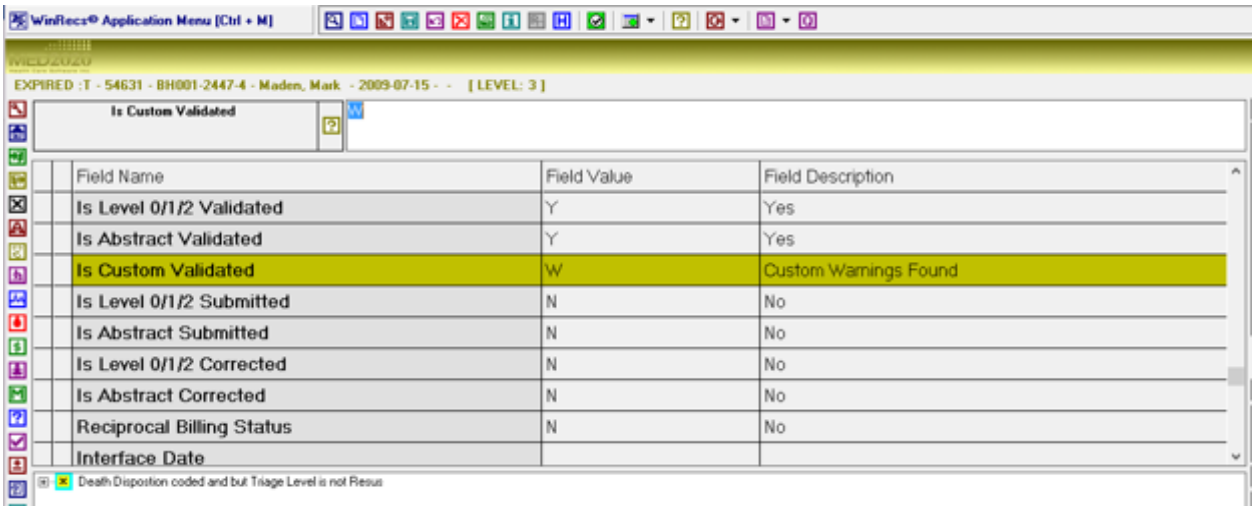

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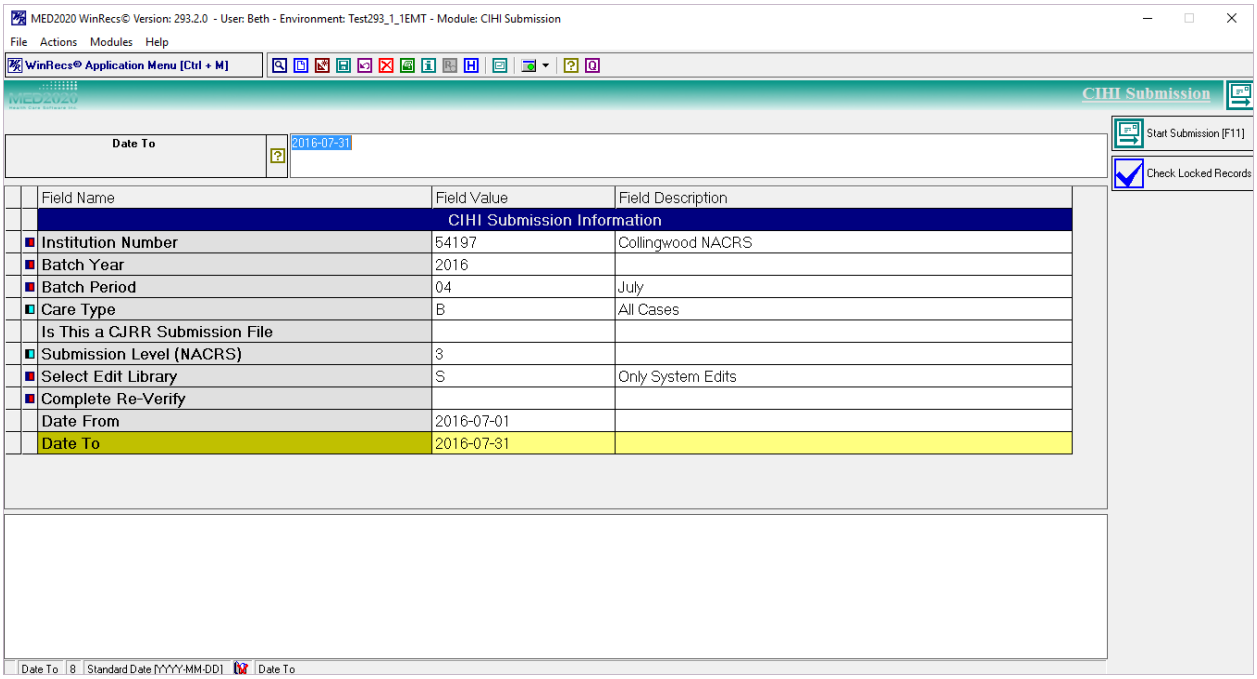
Batch Verify

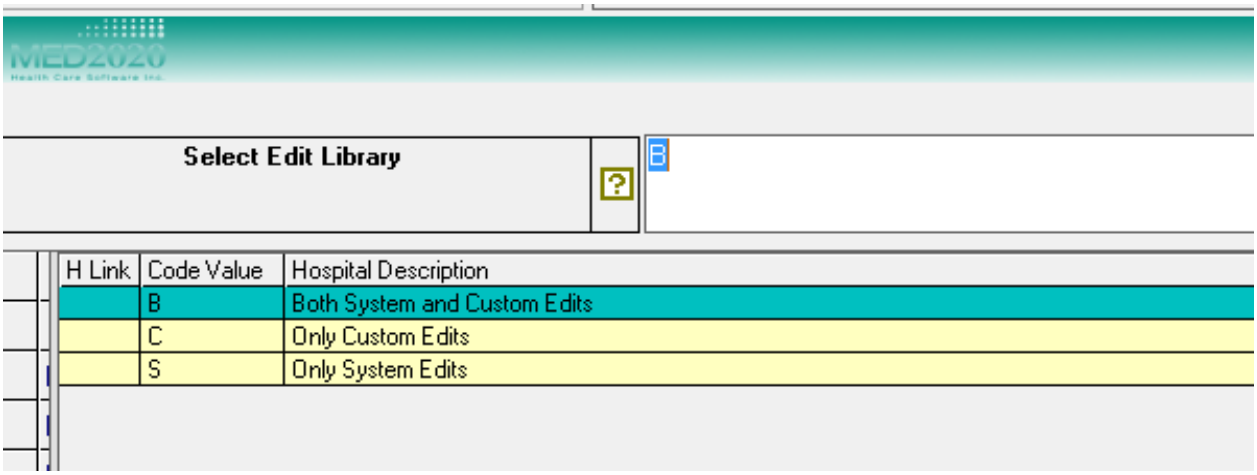
An option to verify all visits to see if EMT edits apply.

Utilities>CIHI Submission



Please Note: For Amare ensure Submission Level (NACRS)= 3

Select Edit Library



Both System and Custom Edits

This will perform the verify on the CIHI or provincial edits along with EMT edits at the same time.

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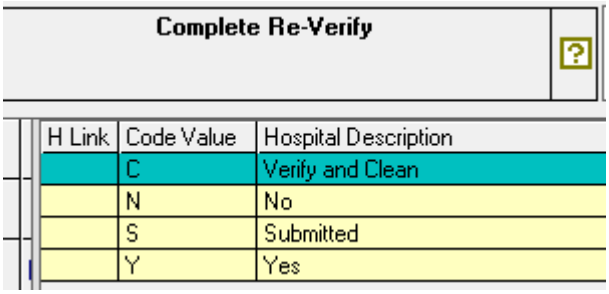
Only Custom Edits
This will perform the verify on the EMT edits only.

Only System Edits
This will perform the verify on the CIHI and provincial edits only.

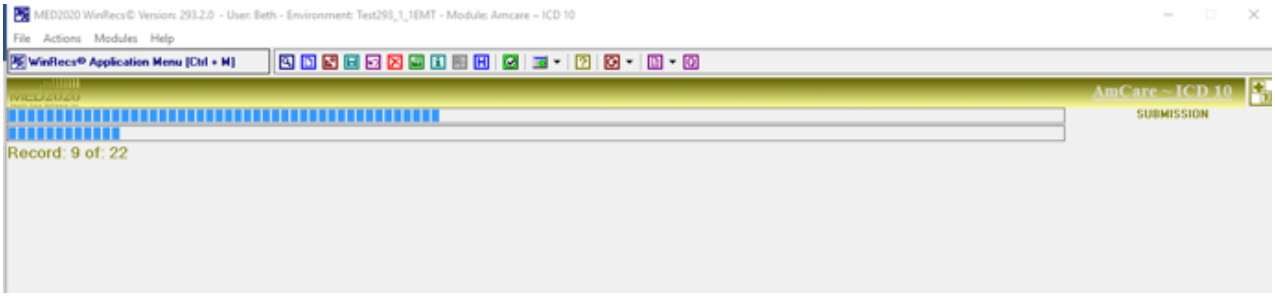
Complete Re-Verify



Yes
Select if period has not been submitted to verify EMT edits

Submitted
Select if period has been submitted to verify EMT edits

When click Start Submission



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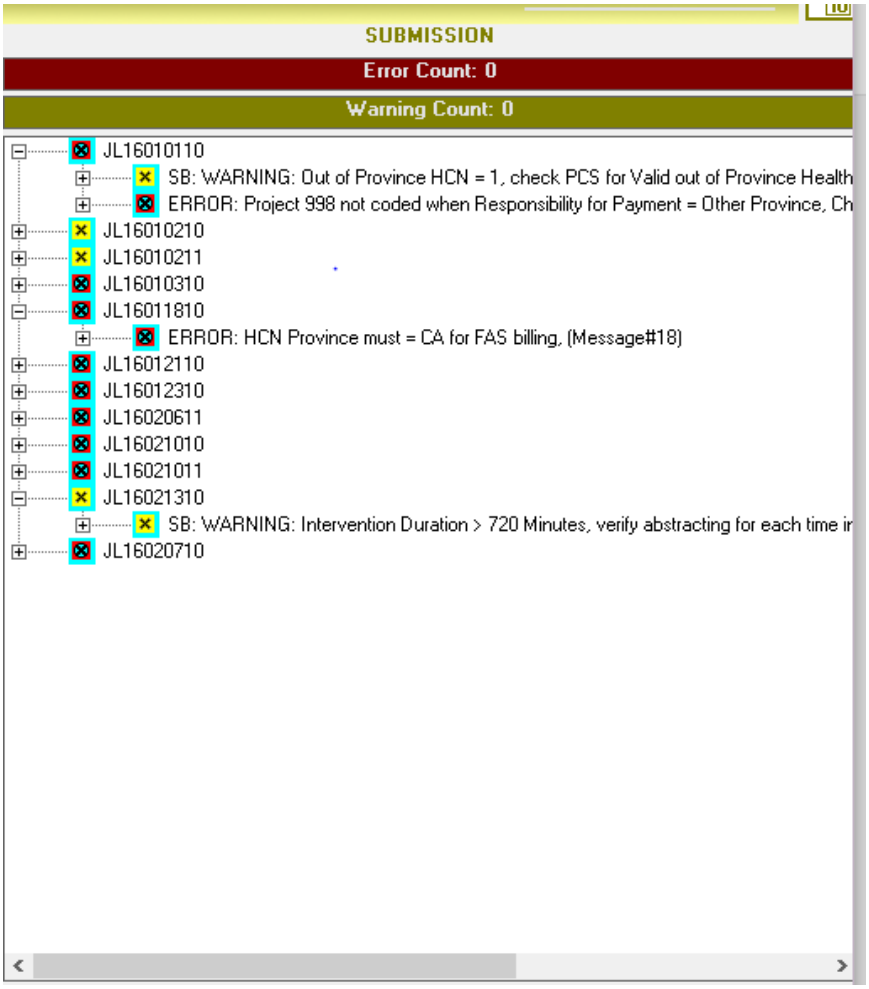

Report Generator

Existing views have been modified:

AbstractingErrorsWarnings_VR

Message Level:

Custom Errors
Custom Warnings
Custom Information

I10 views - The 'Is Custom Validated' field has been added to all the I10 views.

A report called EMT Incomplete Abstract List has been developed.

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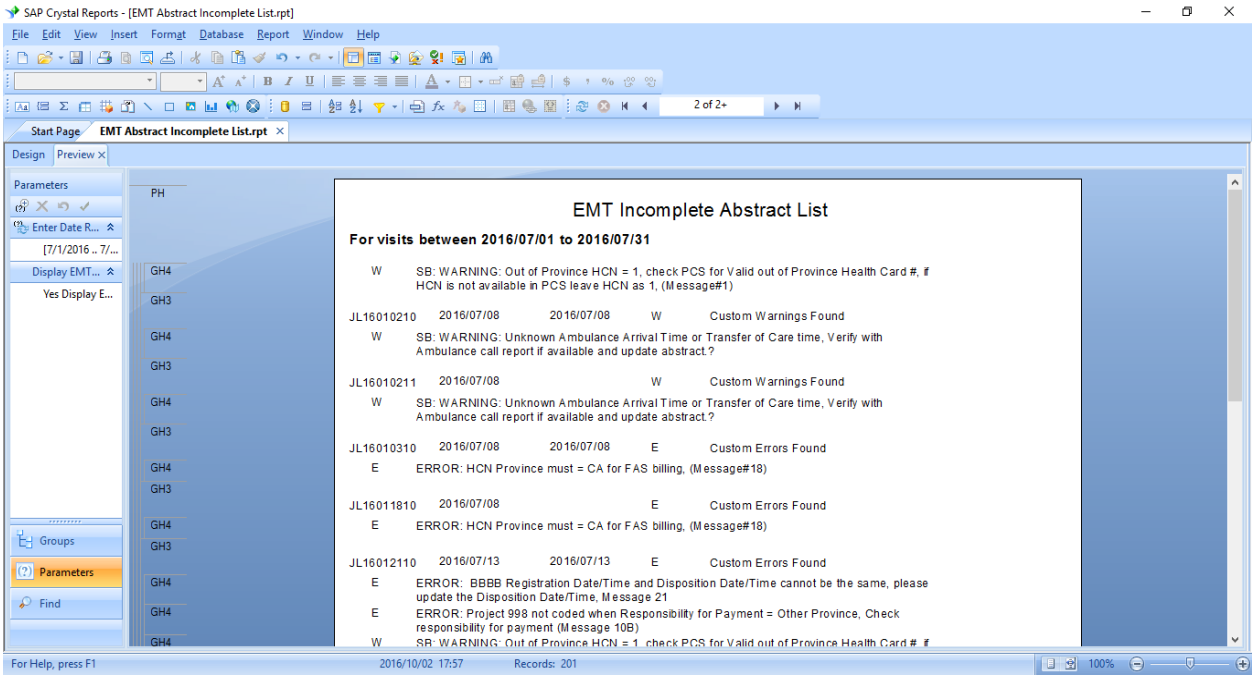

5.12 Batch Clone Utility

The WR_BatchClone.exe needs to be saved locally, as the user will need to run this file to run the Batch Clone Utility.

Prior to running the WR_BatchClone.exe, ensure the abstracts that will be cloned are interfaced to the database. The initial visits, that will be used as a profile abstract for that patient, should be completed and saved with no errors.

Double click on the WR_BatchClone.exe to launch the utility.

Enter the Server and Database names, the start and end dates, and the applicable MIS Code(s):

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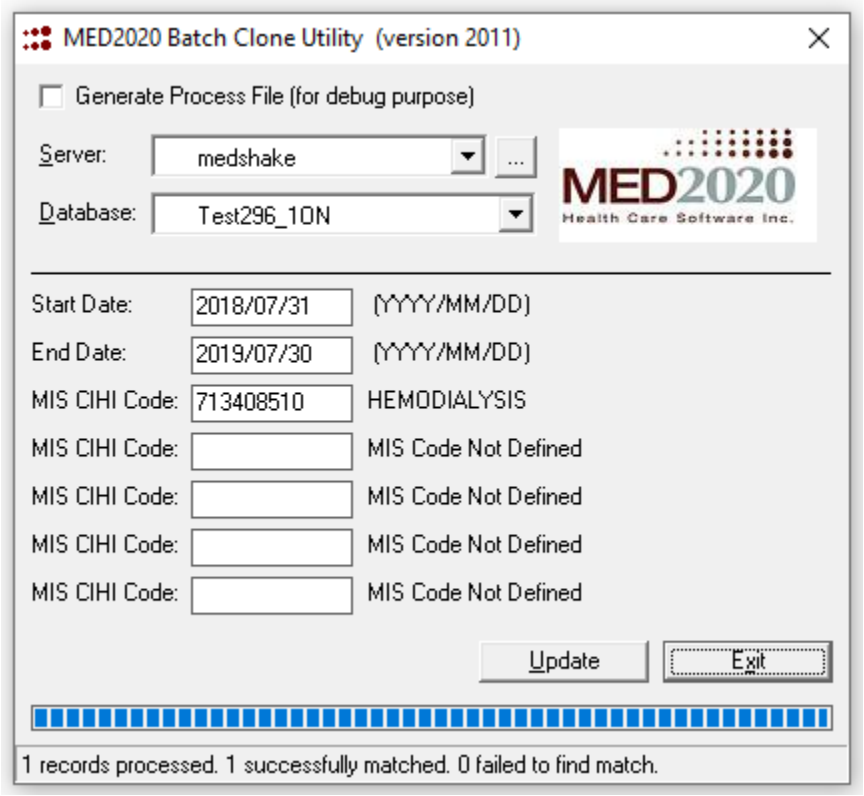

Note: When entering the MIS CIHI Code, be sure to enter the CIHI Code Value, not the Display Code, if there is a discrepancy between the two for the MIS Code you are using.

When all applicable information is entered, click Update.

Once executed, the status bar will indicate how many records were processed, and of those processed records, how many successfully matched and how many failed to find match.

The Batch Clone Utility will select interfaced records that fall within the criteria set in the parameters, and:

- Is Validated is **not** = Yes
- The Record has not been by a user

When the records that match the criteria are selected, it will select the profile abstract from the most recent abstract that has:

- Deleted Flag is = N-No.
- Validated Flag is = Y-Yes or W-Warning (Error Free)

If a previously entered match is found, then it will update the entire interfaced record with the values from the profile except:

- It will not update interface values
- If the visit contains multiform information - it will not be overwritten. If the multiform in the visit has no occurrences, then it will import from the profile.

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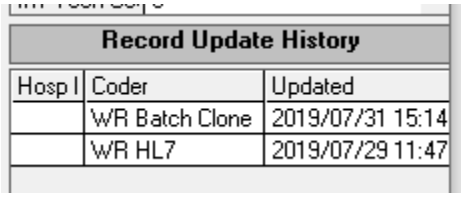
When an abstract has been completed by the Batch Clone utility, it will show “WR Batch Clone” in the Record Update History:



Record Update History

Hosp I	Coder	Updated
	WR Batch Clone	2019/07/31 15:14
	WR HL7	2019/07/29 11:47

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6 System Maintenance

6.1 Regional Profile

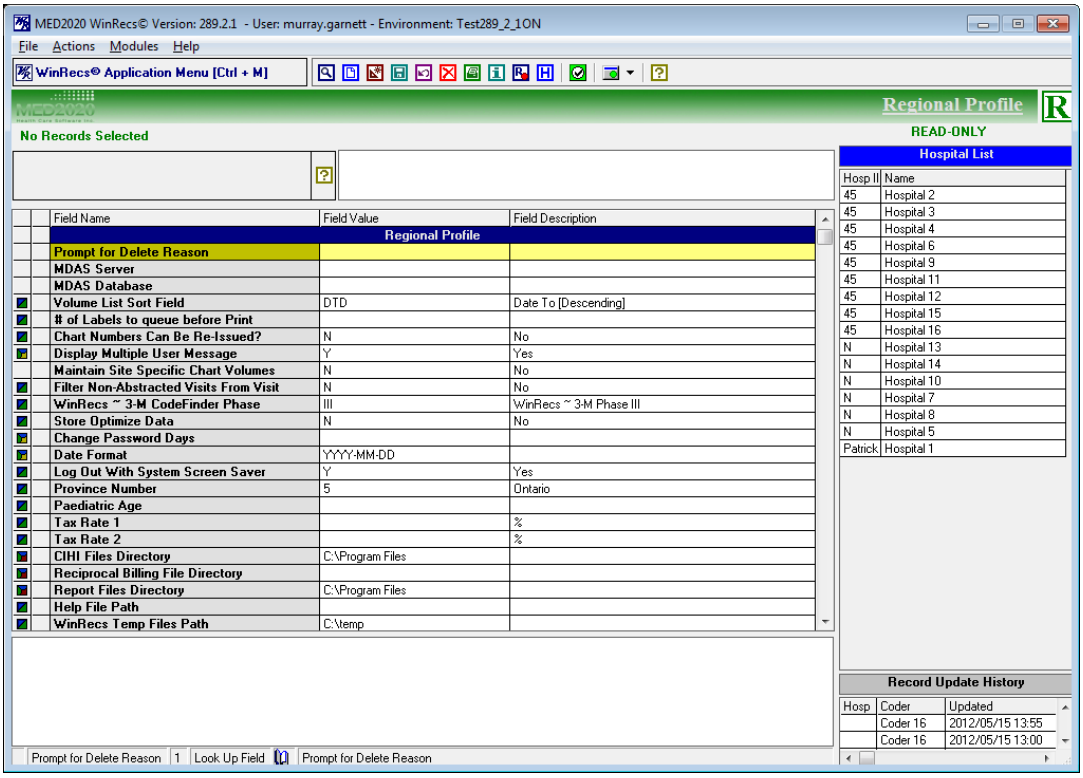
Overview

The Regional Profile is used to specify default values to be inherited by individual Hospital Profiles. If a field is configured in Regional Profile, it will only be inherited by the Hospital Profile if the corresponding field in the Hospital Profile is not defined (blank).

Administrators can use this feature to manage multiple hospitals that use the same WinRecs database.

To access the Regional Profile module:

Select System **Maintenance – Regional Profile**.
The Regional Profile window displays.



Make the required entries.

Prompt for Delete Reason:	If Y is entered, you will be prompted with a Reason Text Box for deleting a visit.
Create CCM Abstract by Health Care Number:	

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Volume List Sort Field:	
# of Labels to queue before Print:	Users who interface chart volumes can define the number of labels to print.
Chart Numbers Can Be Re-issued?:	"Y" = Yes, "N" = No If the users wants to use the Unmerge function in Chart Maintenance/Modify a Chart, this must be set to "N".
Display Multiple User Message:	"Y" = Yes, "N" = No If set to "Y", and a record is accessed that someone is already working in, a popup message displays advising who is currently working in a visit and an error displays in the Message pane. If set to "N", only the popup message displays and it will not be possible to save the information.
Maintain Site Specific Chart Volumes:	"Y" = Yes, "N" = No
Filter Non-Abstracted Visits From Visit History:	"Y" = Yes, "N" = No
WinRecs – 3-M CodeFinder Phase:	Choose applicable Phase by using F2 Look Up.
Store Optimize Data:	"Y" = Yes, "N" = No
Change Password Days:	Enter the number of days within which the password must be changed.
Date Format:	The date format used by WinRecs.
Log Out With System Screen Saver:	"Y" = Yes, "N" = No If set to "Y", and the screen saver is activated, WinRecs will log out of the program. The program will terminate without saving, thus any data entered without being saved will not be retained.
Display Code:	The code that displays for the hospital.
CIHI Code Value:	Enter Facility number or Facility Name.

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User Description:	The identifying description for the hospital.
Valid From Date:	The date from which the institution number is valid.
Valid To Date:	The date on which the institution number is no longer valid.
F2 Lookup Note	Defines the note text viewed when performing lookups.
Interface In:	The value coming from the interface.
Province Number:	0-NL, 1-PE, 3-NB, 4-QC, 6-ON, 6-MB, 8-AB, 9-BC, I-International ,N-Northwest Territories, V-Nunavut, Y-Yukon
Paediactric Age:	This defines the Paediatric Age for Pediatric Services. This value may be defined by your institution or province, and must be entered. For example, “14” defines paediatric as patients 14 years old or under.
G.S.T. Number:	This is for billing purposes in the ROI module. If not configured, the value in the Hospital Profile is used.
Tax Rate 1:	Used in the Release of Information module to calculate the GST.
Tax Rate 2:	Used in the Release of Information module to calculate the PST.
CIHI Files Directory:	This defines the path for the CIHI Submission and Correction processes. Press F2 (or double-click) in the text box to select the path when the submission files are stored. Select the folder and click OK. If this field is left blank, the files and folders default to C:\Program Files\WinRecs\CIHIDATA on the PC the user is working with when running the submission.
Reciprocal Billing File Directory:	It is recommended that UNC standard naming is used.

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Report Files Directory:	The Directory Path for report. Press F2 to open the folder browser. It is recommended that UNC standard naming is used.
Help File Path:	The Directory Path for the Help file. Press F2 to open the folder browser. It is recommended that UNC standard naming is used.
WinRecs Temp File Path:	This field specifies the location of the batch interface temporary folder. WinRecs checks this location in the Regional Profile, unless there is a value in the field in the Hospital Profile. If there is a value in the Hospital Profile, that value is used. If left blank, the default application path (C:\Program Files\WinRecs2\BatchIn\Bin folder is used.
Accessory File Directory:	The Directory Path for accessory files. Press F2 to open the folder browser. It is recommended that UNC standard naming is used.
Multiple User Save:	Y" = Yes, "N" = No This is used to prevent changes from being saved if another user is currently accessing the same record. If set to "Y" then a warning message displays. If set to "N" an error message displays, and the user will not be able to save the record.
Minimum Password Length:	This is used to set the minimum length of the password for users.
# of Password Attempts:	The maximum number of log on attempts before the user is logged out.
Max # of Records To Return On Search:	Defines the maximum number of records returned in a search. The default is 999.
Enable Search Audit:	"Y" = Yes, "N" = No When set to "Y", a record of all searches plus all the abstracts appearing in the searches is stored in the database. The default is "N".
Report Audit Level:	1-None, 2- Basic, 3-Binary

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Auto-Generate Chart No.?:	Y" = Yes, "N" = No If enabled, WinRecs uses the Start with Chart Number field to assign new chart numbers. The Start with Chart Number field will automatically increment as the numbers are used. If attempting to create a new chart number using a number other than the number outlined in the Start with Chart number field, the program will still try to assign the "Start with Chart Number" value. Going back to the Chart Number field in CPI before proceeding will ensure the Chart Number value is the appropriate one.
Start with Chart Number:	This defines the starting point for number of charts. For example, if the value 123 is entered, the next patient chart created that does not have a chart assigned will be assigned chart number 124.
Chart Number Mask:	Alphanumeric (10 Characters). This defines how to view chart numbers on the system – without the leading zeros, or with characters. Examples: ##########: (10 digits) This displays a chart number without any leading zeros, unless "0" is part of the number (ie: 309). #####00-000: This displays the chart number, such as 00-309. ####000-00: This displays the chart, such as 003-09.
Terminal Digit:	For details on Terminal Digit settings, please see Terminal Digit in the Basic WinRecs Functionality Section.
Unique Volume Number:	"Y" = Yes, "N" = No If set to "Y", all volume numbers must be unique.
Unique Deficiency Number:	"Y" = Yes, "N" = No If set to "Y", all deficiency numbers must be unique.

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Days To Add For Deficiency Date:	This indicates when to start counting the day that the chart is deficient. If you do not want to count the day the deficiency is put in the Provider's chart completion area, enter "1" in this field and the count will begin one day after the deficiency is entered.
Days To Add For Next OMHRS Assessment Date:	This is used to automatically calculate the next assessment date in OMHRS abstracts.
Manual Default Return Location:	Yes": When the Transaction Type is "R", users are prompted to select the Return Location. They can then proceed to enter all charts going to that location. "No": When the Transaction Type = "R", users are prompted to select the return location for each chart.
Pull List ID Format:	This is used by the Chart Locator and defines the format used for pull lists. **BorrowerDate**: Borrower + Date (YYMMDD) **DateBorrower**: Date(YYMMDD) + Borrower **DateLocation**: Date(YYMMDD + Location **DateLocBorr**: Date(YYMMDD) + Location + Borrower **Date-Seq**: Date + Sequence No. **LocationDate**:Location + Date(YYMMDD) LocBorrDate: Location + Borrower + Date(YYMMDD) Caution: Changes made to this field will impact the future pull lists already stored in the table. Contact MED2020 before making changes to this field.
Privacy Message	This is used to display a Custom Privacy Message at the Hospital discretion. It can be used at the Regional Level or at the Hospital Level (See Hospital Profile Section). This a free form text box that has unlimited field length for newer SQL versions however for SQL2000 there is a maximum length limit of 4000 characters.

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	The Privacy Message can be standard for all the Region or at the Hospital level. If defined, users of WR application will see a pop-up Privacy Message right after the MED2020 copyright splash screen. Hospital Privacy Message will override the Regional Privacy Message If both fields are blank, then no pop up message will display.

Click
- or – Press **F7**.
The information is saved.

Using Regional Profile Data in other Profile Modules

The following table defines how to use Regional Profile in other profile modules:

Module	Description
Users Profile:	Hospital Link or Default Hospital Link must be defined. Hospital Link restricts the user to view records for the hospital indentified. No restriction is imposed when using the Default Hospital Link field. This is used in other modules that require a default hospital for a user.
Provider Maintenance:	Hospital Link can be defined for a provider to limit the provider's location to the hospital. In cases where a Provider is available to multiple hospitals. Then it is recommended this provider have a blank hospital link (Regional).
Lookup Field Maintenance:	Hospital Link is used to create lookup tables that are specific to one Hospital (ie: Nursing Area).
CPI:	Hospital Link can only be viewed by users that have been linked to the hospital indicated (see Users Profile).
Chart Locator:	Charts can only be accessed when the logged in user has access to the corresponding hospital (see Users Profile).

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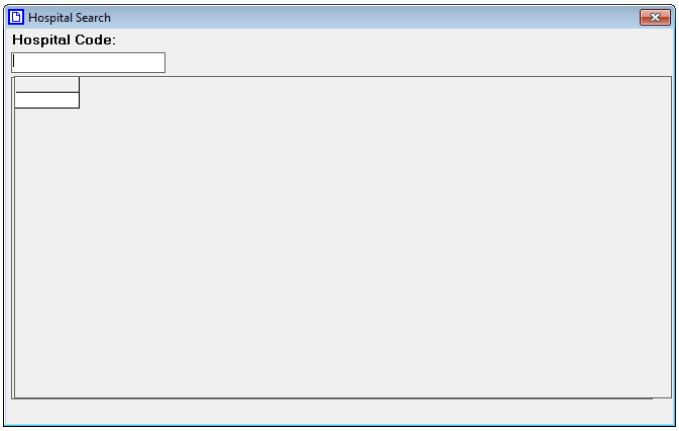
6.2 Hospital Profile

The Hospital Profile is used to specify default values for hospitals. If any field listed below is defined in the Regional Profile the value from the Regional profile is automatically assigned to the corresponding field in the Hospital Profile.

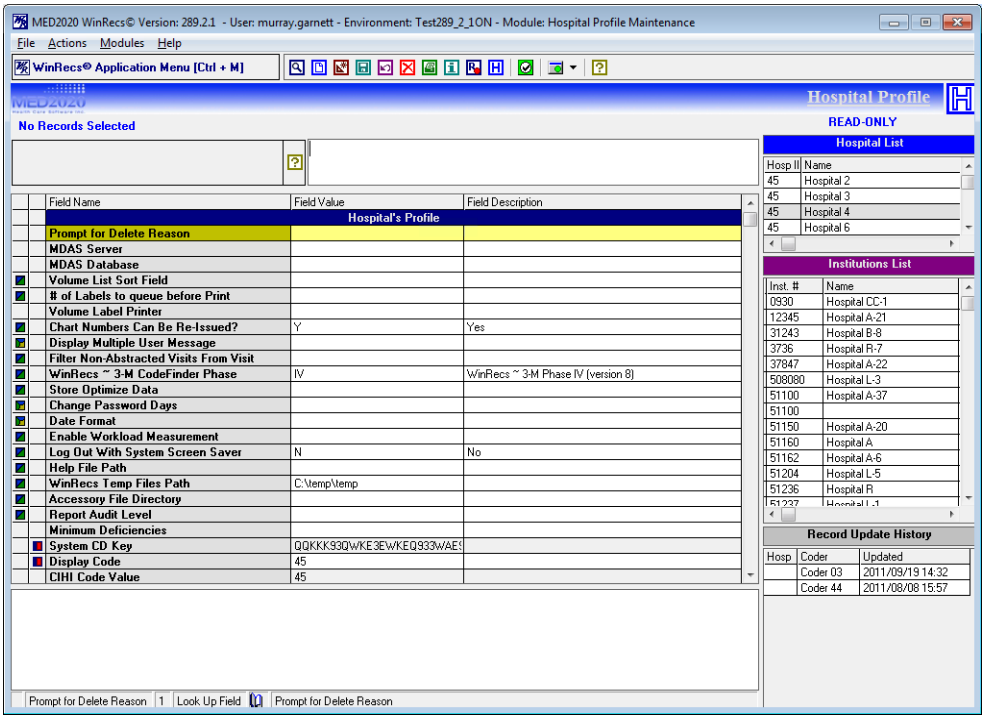
To access the Hospital Profile:

Select **System Maintenance – Hospital Profile**.
The Hospital Search dialog displays.



To display all hospitals, press **Enter**.
All hospitals display in the dialog.

Double-click the hospital to select.
The Hospital Profile window displays.



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Enter the required information. Press Enter to move from field to field. Note that fields in this module affect searches and access to modules (CD Key). Descriptions of the Hospital Profile fields are provided below:

Field	Description
Select Provider Service	"Y" = Yes, "N' = No "Y" – When a provider is selected with multiple services, a popup message will appear to ask you what service you want to choose "N" – the message will not appear for providers with more than one service or specialty.
Prompt for Delete Reason :	If Y is entered, you will be prompted with a Reason Text Box for deleting a visit.
Volume List Sort Field:	
# of labels to queue Before Print:	Users who interface chart volumes can define the number of labels to print.
Volume Label Printer:	Provides the path when the labels are to print. For example: \\medcorp2\SHARP_Copier
Chart Numbers Can Be Re-issued?:	"Y" = Yes, "N" = No If a user wants to use the Unmerge function in Chart Maintenance/Modify Charts, this must be set to "N" (No).
Display Multiple User Message:	"Y" = Yes, "N" = No If set to "Y", and a record is accessed that someone is already working in, a popup message displays advising who is currently working in the window and an error displays in the Message pane. If set to "N", only the popup message displays and it will not be possible to save the information.
Filter Non-Abstracted Visits From Visit:	"Y" = Yes, "N" = No
WinRecs – 3-M CodeFinder Phase:	"Y" = Yes, "N" = No
Store Optimize Data:	"Y" = Yes, "N" = No
Change Password Days:	Enter the number of days within which the password must be changed.
Date Format:	The date format used within WinRecs.

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Log Out with System Screen Saver:	"Y" = Yes, "N" = No If set to "Y", and the screen saver is activated, WinRecs will log out of the program. The program will terminate without saving, thus any data entered without being saved will not be retained.
Help File Path:	The directory path for the WinRecsUserGuide.pdf. Press F2 to open the folder browser.
WinRecs Temp File Path:	This field specifies the location of the batch interface temporary folder. WinRecs checks this location in the Regional Profile, unless there is a value in the field in the Hospital Profile. If there is a value in the Hospital Profile, that value is used. If left blank, the default application path (C:\Program Files\WinRecs2\BatchIn\Bin folder is used.
Accessory File Directory:	The directory path for accessory files. Press F2 to open the folder browser.
Minimum Deficiencies:	The minimum number of deficiencies for a Letter to be generated.
Max Activity Number:	Define the maximum number of chart activities to retain in the database. If 10 is entered in this field and there are 11 activities the earliest will be purged from the database. If this field is blank, all activities will be saved to the database. This also affects how many chart activities will be displayed on the Chart Activity report.
System CD Key:	MED2020 provided CD Key (Read-only, System Mandatory)
Display Code:	The code that displays for the hospital.
CIHI Code Value:	Enter Facility number or Facility Name.
User Description:	The identifying description for the hospital.
Valid From Date:	The date from which the institution number is valid.
Valid To Date:	The date on which the institution number is no longer valid.
F2 Lookup Note:	Defines the note text viewed when performing lookups.
Interface In:	The value coming from the interface.
# of Password Attempts:	The maximum number of log on attempts before the user is logged out.
Max # of Records to Return On Search:	Defines the maximum number of records returned in a search. The default is 999.

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Enable Search Audit:	"Y" = Yes, "N" = No When set to "Y", a record of all searches plus all the abstracts appearing in the searches is stored in the database. The default is "N".
Province Number:	The facility's provincial number, as assigned by CIHI (system mandatory).
Chart Number Mask:	This defines how to view chart numbers on the system – without the leading zeros, or with characters. Examples: ##########: (10 digits) This displays a chart number without any leading zeros, unless "0" is part of the number (ie: 309). #####00-000: This displays the chart number, such as 00-309. ####000-00: This displays the chart, such as 003-09.
Terminal Digit:	For details, please refer to Terminal Digit in Basic WinRecs Functionality section.
Auto-Generate Chart No?:	"Y" = Yes, "N" = No If enabled, WinRecs uses the Start with Chart Number field to assign new chart numbers. The Start with Chart Number field will automatically increment as the numbers are used. If attempting to create a new chart number using a number other than the number outlined in the Start with Chart number field, the program will still try to assign the "Start with Chart Number" value. Going back to the Chart Number field in CPI before proceeding will ensure the Chart Number value is the appropriate one.
Start with Chart Number:	This defines the starting point for number of charts. For example, if the value 123 is entered, the next patient chart created that does not have a chart assigned will be assigned chart number 124.
CIHI Files Directory:	This defines the path for the CIHI Submission and Correction processes. Press F2 (or double-click) in the text box to select the path when the submission files are stored. Select the folder and click OK. If this field is left blank, the files and folders default to C:\Program Files\WinRecs\CIHIDATA on the PC the user is working with when running the submission. **Note**: This option is available in Institution Profile to create separate submission folders for each Institution number.
Reciprocal Billing File	This defines the path for the Reciprocal Billing File. It is recommended that UNC standard naming is used.

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Directory:	
Report Files Directory:	The Directory Path for report. Press F2 to open the folder browser. It is recommended that UNC standard naming is used.
Paediatric Age:	This defines the Paediatric Age for Pediatric Services. This value may be defined by your institution or province, and must be entered. For example, “14” defines paediatric as patients 14 years old or under.
Tax Rate 1:	This is used in the Release of Information module. This would be GST or PST.
Tax Rate 2:	This is used in the Release of Information module. This would be PST or GST.
Days to Add for Deficiency Date:	This indicates when to start counting the day that the chart is deficient. If you do not want to count the day the deficiency is put in the Provider’s chart completion area, enter “1” in this field and the count will begin one day after the deficiency is entered.
Days to Add for Next OMHRS Assessment Date:	This is used to automatically calculate the next assessment date in OMHRS abstracts.
Filter Morphology Codes:	“Y” = Yes, “N” = No If morphology codes are to be included (“Y”) or excluded (“N”) when using other 3rd party encoding software.
Manual Default Return Location:	“Yes”: When the Transaction Type is “R”, users are prompted to select the Return Location. They can then proceed to enter all charts going to that location. “No”: When the Transaction Type = “R”, users are prompted to select the return location for each chart.
Pull List ID Format:	This is used by the Chart Locator and defines the format used for pull lists. **BorrowerDate**: Borrower + Date (YYMMDD) **DateBorrower**: Date(YYMMDD) + Borrower **DateLocation**: Date(YYMMDD + Location **DateLocBorr**: Date(YYMMDD) + Location + Borrower **Date-Seq**: Date + Sequence No. **LocationDate**:Location + Date(YYMMDD) LocBorrDate: Location + Borrower + Date(YYMMDD)

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	Caution: Changes made to this field will impact the future pull lists already stored in the table. Contact MED2020 before making changes to this field.
Privacy Message	This is used to display a Custom Privacy Message at the Hospital discretion. It can be used also at the Regional Level (See Regional Profile Section). This a free form text box that has unlimited field length for newer SQL versions however for SQL2000 there is a maximum length limit of 4000 characters. The Privacy Message can be standard for all the Region or at the Hospital level. If defined, users of WR application will see a pop-up Privacy Message right after the MED2020 copyright splash screen. Hospital Privacy Message will override the Regional Privacy Message If both fields are blank, then no pop up message will display.
Use Abstract Queue	"Y" = Yes, "N" = No When set to "Y", Abstract Queue will be enabled. The default is "N".

Note: If any changes are made to your Hospital Profile, you must log out and then log back on to WinRecs for the changes to take place.

Click
- or - Press F7.
The Hospital Profile information is saved.

Sidebars

Hospital List

Field	Description
Hospital	The unique ID to identify the hospital.
Name	The name of the hospital.

Institutions List

Field	Description

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Institution Number	The unique ID of the institution number set in the profile.
Name	The name of the institution.
Care	The type of care code

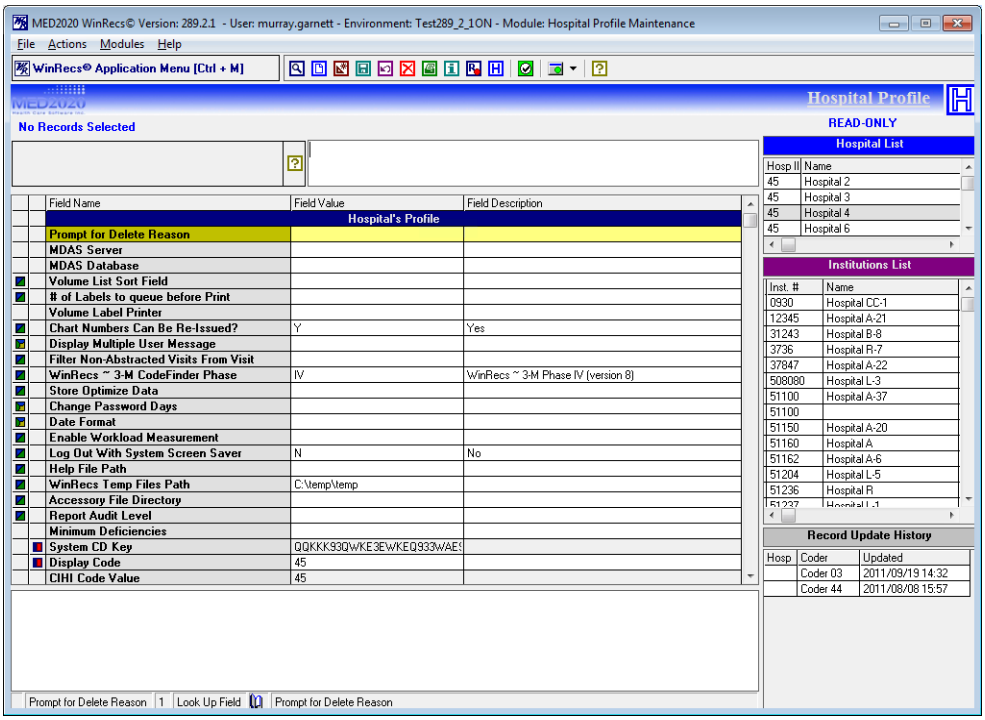
6.3 Institution Profile

The Institution Profile is where institution specific information is entered. More than one institution profile can be defined per hospital profile.

To access the Institution Profile:

Select **System Maintenance – Institution Profile**.
All institutions display in the Institutions Sidebar.

Double-click in the Institutions Sidebar on the institution to select.
The Institution Profile window displays.



Enter the required information. Press Enter to move from field to field. Descriptions of the Hospital Profile fields are provided below:

Field	Description
Hospital Link:	This defines the hospital to which the institution belongs. The institution must belong to the same Hospital Link to have access to this institution's records and functions.
CIHI Files Directory:	This defines the path for the CIHI Submission and Correction processes. Press F2 (or double-click) in the text box to select the path when the submission files are stored. Select the folder and click OK. If this field is left blank, the files and folders default to C:\Program Files\WinRecs\CIHIDATA on the PC the user is working with when running the submission.
Reciprocal Billing File Directory:	This defines the path for the Reciprocal Billing File.
Institution Code:	The institution Number. This is a four or five digit code issued by CIHI or a unique number defined by the hospital (System Mandatory).
CIHI Code Value:	The CIHI value for the institution.
User Description:	A user defined institution name.
Default Description:	Same as User Description.
Valid From Date:	The date from which the institution is valid (System Mandatory).
Valid To Date:	The date to which the institution is valid (System Mandatory).
F2 Lookup Note:	This defines the F2 note that is displayed.
Interface In:	This value is used as the institution number in batch and HL7 interfaces.
Care Type:	The type of institution (System Mandatory).
Site Number:	This is used to distinguish multiple sites of the same care type within a facility.

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Overlook CIHI Edits:	“Y” = Yes, “N” = No If set to “Y”, CIHI edits are ignored. Consult MED2020 Client Services before enabling this option.
ICD 9-CM Live Date:	This defines the starting date for abstracting using ICD 9-CM. If no date is entered, WinRecs assumes the ICD 9 is used.
ICD 10 Live Date:	This defines the starting date for abstracting using ICD 10 (System Mandatory).
Lock Down Date:	This defines the date records will be locked down and accessible in a “View” mode only. For example, once all corrections are made for fiscal 2012, you can use a lockdown date of 2013/04/01 to have read-only access to all data prior to this date (System Mandatory).
Copy Data From Latest Assessment:	This feature is for clinical modules to choose if they wish to copy values from one clinical assessment to another: M - Yes only for new assessment created by user N - No Y - Yes - new assessments created by user and interface
Record Validation and Submission Date:	This is enabled only for Care Type = “R” and “M”. This is used to enter the annual date provided by CIHI for deadline of data submission under previous fiscal year specifications. Data submitted after this date will be validated on the current fiscal year specifications.
Process NRS Admit/Discharge Together?:	This is enabled only for Care Type = “R”. Enter “!” or greater for the number of fiscal quarters to search back to retrieve admission assessments. A value greater than “0” (zero) will only submit “pairs” of admission/discharge assessments. A value of “0” (zero) will process any assessments found within the period selected, regardless of assessment type.
Show NRS Submission Log:	
CIHI Batch Year:	The current fiscal batch year.
CIHI Batch Period:	The current fiscal batch period.

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CIHI Facility File Sequence:	This number should be set to 1 at the beginning of each fiscal year.
Cost Per R.I.W. :	The institution's cost per resources intensity weight.
New Chart Prefix	This defines the alphabetic prefix used when creating a new chart. This can be used to limit the user's access (as defined in User Profile).
Auto-Generate Encounter No.?:	"Y" = Yes, "N" = No This defines if WinRecs automatically generates encounter numbers. If defined, the Start with Encounter Number field (below) will automatically increment as the numbers are used. When a new Encounter Number is created using a number other than the number outlined in the Start with Encounter Number field, WinRecs will still try to assign the Start with Encounter Number value.
Start with Encounter Number:	This is the starting number of auto-generated encounter numbers.
User Mental Health Data:	This field is obsolete as of 2018-04-01. Mental Health fields are driven by Institution Type and Patient Service
NACRS Submission Level Code:	Set by system CD Key.
Preferred Default NACRS Level:	This option allows you to choose which NACRS level of edits to generate on loading a visit.
NACRS Level 3 Live Date:	Set by system CD Key.
MOH Office Code:	This is a single alphabetic code as assigned by the Ministry of Health (no longer used).
Group Number:	The physician group number (no longer used).
Location Code:	The four digit numeric field (no longer used).

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Referring Lab License Number:	The four digit numeric field (no longer used).
GST Number:	This is for billing purposes in the ROI module. If not configured, the value in the Hospital Profile is used.
PST Number:	This is for billing purposes in the ROI module. If not configured, the value in the Hospital Profile is used.
Contact Name:	A contact name within the facility.
Street:	The street on which the facility is location.
City:	The city in which the facility is location.
Province:	The two letter province code.
Postal Code:	The postal code in ANA NAN format where “A” = alphabetic and “N” = numeric.
Web Address:	The URL (web address) of the facility, if available (ie: http://www/med2020.ca).
E-Mail:	The email address of the contact within the facility.
Phone Number:	The contact phone number within the facility.
Basic Option 1 – 19 Text:	See Basic Options in the following section for more information.
Basic Option 1 – 19 State	See Basic Options in the following section for more information.
Basic Option 1 – 19 Lookup	See Basic Options in the following section for more information.

Note: If any changes are made to your Institution Profile, you must log off and then log back on to have the changes take effect.

Click
- or – Press **F7**.
The changes are saved are available to display on the abstract.

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Basic Options

Overview

Basic Options are entered in the Institution Profile for each institution.

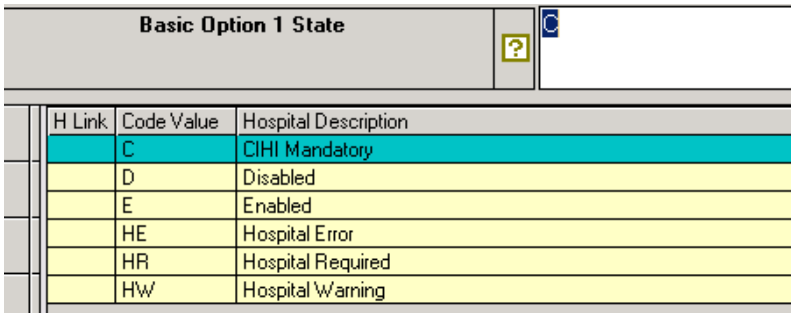
To access Basic Options:

Select the appropriate institution from the Institution List, located to the right of the grid.

Navigate to the area where Basic Options are listed.

For each Basic Option, enter the following:

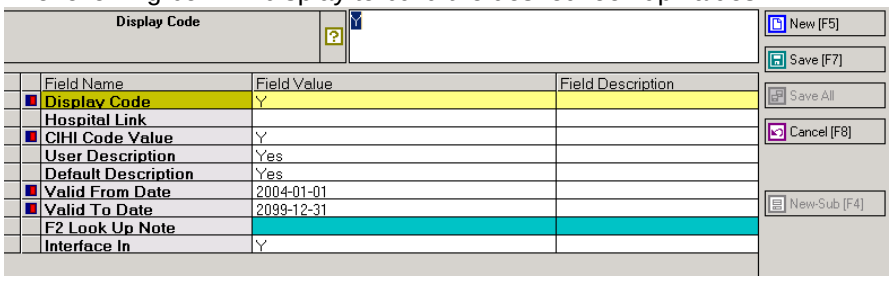
Basic Option Text: Enter the text for this Basic Option.
Basic Option State: Press F2 to for options:



To create new look up values, click on New B.O.P. Code button

- or – Press **F4**.

The following box will display to build the desired look up values:



Click
- or – Press **F7**.
The changes are saved are available to display on the abstract.

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To view the Look Up values, press **F2.**

Institutions List Sidebar

Field	Description
Hospital ID	The Hospital Identifier linked to the institution number set in the profile.
Institution Number	The unique ID of the institution number set in the profile.
Name	The name of the institution.
Care	The type of care code.

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6.4 User's Profile

Sidebar

User's List

The following are the fields displayed under the User list.

Field	Description
Hospital ID	Identifies the Hospital the user account is bound to. If this is not defined, the user can access all records in the database.
Role ID	Identifies the user account the user is linked to.
Coder	The unique identifier of the coder.
User Name	The user ID used to access WinRecs.
Full Name	The user's complete name.

User Profile Overview

A coder number is required for each person using WinRecs. It is not specifically for "coders", but is used to uniquely identify every user. It is used in the system to log entries and to track modifications to WinRecs patient and system records.

The Users Profile also controls access to the WinRecs system by assigning user IDs and passwords, the access of each user and individual modules.

Descriptions of the available fields are provided below. To assign permissions, **F2** will show permission values for each field.

Field	Description
Can Modify Edit Engine:	Setting this to 'Y' will give users permission to the Edits Management Tool
Edit Engine File	By pressing 'F2' will allow you to assign the path to the Edits Management Tool. This path gives user access to a file called MED2020.Winrecs.EMT.exe.
Can Purge Logs:	A user with permission to this Utility can purge the HL7 transactions "prior to" a specific start date.
Can Select abstracts in Abstract Queue:	If the field value is Yes, it will allow the User to select abstracts from the Queue. If the user's permission is set to "No" users can only select next available abstracts in the Queue. All other abstracts will be disabled.

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Can Clear CPI Lock:	Gives Users permission rights to clear the CPI Lock by going to CPI > Actions > Clear CPI Lock and to allow an unmerge of records.
Set NACRS Level 1 Correction:	Gives the User different options on how to set NACRS Level 1 corrections.
Show Confidential Request:	If a user does not have rights to see these requests, the cases flagged as confidential will not be accessible in the ROI module.
Can View Other Logged In Users (Who):	Allows access to a list of other users logged into WInRecs.
Access Locked Source Charts:	If the field value is Yes, it will allow the User to search all chart numbers including merged chart numbers. If the field value is No, it does not allow the User to search on merged charts.
Abstracts Prompt For Chart Locator:	If Yes users will get prompted to go to chart locator module after saving in abstracting modules.
Abstracts Prompt For Chart Deficiency:	If Yes users will get prompted to go to chart deficiency module after saving in abstracting modules. **NOTE:** The prompt will not work for chart deficiency if users have the prompt set up for chart locator.
Can Create NACRS Facility File:	Gives User permission to create NACRS Facility Information File.
Can Create MDS 2.0 Facility File:	Gives User permission to create MDS 2.0 Contact Information File.
Can Create NRS Facility File:	Gives User permission to create NRS Facility Information File.
Can Create OMHRS Facility File:	Gives User permission to create OMHRS Facility Information File.
Can Create DAD	Gives User permission to create DAD Institution File.

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Institution File:	

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Can Create DAD Separation File:	Gives User permission to create DAD No Separations File.
Can Create MDS 2.0 Audit File:	Retired for 2012 Fiscal year.
Can Import DAD CIHI Error File:	Gives User permission to import the DAD CIHI Error File.
Can Import OMHRS CIHI Error File:	Gives User permission to import the OMHRS CIHI Error File.
Can Set Chart Terminal Digit:	Gives User permission to use the Set Chart Terminal Digit Utility.
Can Show All Regional Data:	Allows user to view all regional data.
Can Purge Volume Printing Queue:	Allows a User to purge any volumes in the print queue that they don't need.
Can Re-Set Submissions for AmCare:	Gives the user permission to manually reset the submission status from Yes to No on an Amcare visit. This would be used when an Amcare visit is rejected from CIHI and the record needs to be resubmitted.
Can Re-Set Submissions for Rehab (NRS):	Gives the user permission to manually reset the submission status from Yes to No on a NRS visit. This would be used when a NRS visit is rejected from CIHI and the record needs to be resubmitted.
Can Re-Set Submissions for CJRR:	Gives the user permission to manually reset the submission status from Yes to No on a CJRR visit. This would be used when a CJRR visit is rejected from CIHI and the record needs to be resubmitted.
Hospital Link:	Determines hospital settings used when creating new abstracts (ie: auto-incrementing chart number), but if defined, the user is restricted to viewing records from the specified hospital.

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Role ID:	Use to link the User Profile to another Profile/template. When linked to a Role ID, all User Profile permissions and Control Files settings will be identical to this of the user profile to which it is linked. This is used to maintain groups of users. If a change is made to the Role ID user profile, then all users linked to the Role ID will have the same changes.
Coder Number:	A unique number assigned to each WinRecs user.
CIHI Code Value:	This is the value submitted to CIHI where applicable. This defaults to the coder number.
User Description:	The custom description of the user.
Default Description:	This defaults to the value entered in User Description.
Valid From Date:	This is the date defining the start date of when this user is valid (mandatory). The user account cannot be used before this date.
Valid To Date:	This is the date defining the end date of when this user is valid (mandatory). The user account cannot be used after this date.
F2 Lookup Note:	This defines the note used in F2 Lookup.
Interface In:	This is used for incoming or outgoing interfaces, and defaults to the coder number.
Domain User Name:	This is used for Active Directory authentication. Enter the full path of the network and user in the user field. If this is filled in, the password used for network login for the user will also be used for WinRecs.
Skip Login Screen:	The Skip Login Screen is to be used with the Domain User Name field. Once you enter the Domain User Name the Skip Login Screen field becomes enabled. If you put a Y in this field when the user clicks on the WinRecs exe login they are logged directly into WinRecs and do not have to enter a username or password.
User Name:	The name used to log on to WinRecs. This must be between 5 and 15 characters and must be unique.
Password:	The password used by this user to log on to WinRecs. The value entered in this field is masked (asterisks display as you type). A maximum number of 15 characters is allowed for the password. The minimum password length is 6 characters.
Date Password	The date the password was last changed.

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Changed:	
Change Password Days:	This is the number of days until the password must be changed. If blank or “0” (zero), the password change prompt will never display.
Date Password Expires:	This is the date on which the password will expire. After this date, contract the WinRecs administrator to regain access to WinRecs.
Last Name:	The last name of the user.
Middle Name:	The middle name of the user.
First Name:	The first name of the user.
Transcription Initials:	The initials of the transcriptionist, used by the Transcription module to identify the user.
Folio ICD 10 CA File:	Allows users to launch FOLIO from the Diagnosis multiform. Enter path as follows: C:\CIHI\CIHI_PUB_2012\NFO\icd_2012_eng.nfo
Folio ICD 10 CCI File:	Allows users to launch FOLIO from the Intervention multiform. Enter path as follows: C:\CIHI\CIHI_PUB_2012\NFO\cci_2012_eng.nfo
Search Chart Prefix:	The alphabetic prefix of the chart numbers the user can access. If blank, the user can access all records in the database. For example, if a site uses “M” as their chart number prefix, and “M” is typed in this field, the user will only see charts with a prefix of “M”. This is useful for regions that are using a shared database.
Show VIP Charts:	This determines if the user has access to patients identified as VIPs.
Can Modify Chart #s:	Determines if users can modify/merge chart numbers.
Is Administrator:	“Y” = Yes, “N” = No If set to “Y”, the user has administrative privileges, allowing the user to view all other users in the profile and make changes. If set to “N”, the user can only view their own profile.

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Show Complete for Inpatient – ICD 10:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Show Complete for SDS – ICD 10:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Show Complete for AmCare – ICD 10:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Show Complete for MDS 2.0 – ICD 10:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Show Complete for Rehab – ICD 10:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Show Complete for OMHRS – ICD 10:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.

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Show Complete for Inpatient – ICD 9:	Not used.
Show Complete for SDS – ICD 9:	Not used.
Show Complete for AmCare – ICD 9:	Not used.
Show Complete for Cancer Care Module:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Show Complete for CJRR Module:	"Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Show Complete for Inpatient/SDS/Amcare:	Y" = Yes, "N" = No If set to "Y", if there are no hard (red) errors, a message displays after each save abstract in this module, prompting if the abstract is complete. "Y" or "N" is used to respond to the prompt. If set to "N", no prompt displays.
Auto-calculate CACS Grouper:	"Y" = Yes, "N" = No If set to "Y", the grouper automatically calculates values when relevant grouper data is provided. If set to "N", calculations for this grouper are manual, required the user of the verify (F11) or save (F7) functions.

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Auto-calculate DPG Grouper:	"Y" = Yes, "N" = No If set to "Y", the grouper automatically calculates values when relevant grouper data is provided. If set to "N", calculations for this grouper are manual, required the user of the verify (F11) or save (F7) functions.
Auto-calculate FIM Grouper:	"Y" = Yes, "N" = No If set to "Y", the grouper automatically calculates values when relevant grouper data is provided. If set to "N", calculations for this grouper are manual, required the user of the verify (F11) or save (F7) functions.
Auto-calculate RUGS Grouper:	"Y" = Yes, "N" = No If set to "Y", the grouper automatically calculates values when relevant grouper data is provided. If set to "N", calculations for this grouper are manual, required the user of the verify (F11) or save (F7) functions.
Auto-calculate SCIPP Grouper:	"Y" = Yes, "N" = No If set to "Y", the grouper automatically calculates values when relevant grouper data is provided. If set to "N", calculations for this grouper are manual, requiring the user to use the verify (F11) or save (F7) functions.
Font Size:	Allows user defined font size. **Note**: Can also set font size using the Actions Menu.
Date Format:	Specify the date format used to display on abstracts, such as "YYYY/DD/MM". Press F2 to display the available formats.
Language Code:	Reserved for future use.
Show Messages:	"Y" = Yes, "N" = No If set to "Y", error or warning messages display interactively when moving from field to field. If set to "N", errors or warning display only in the message pane.
Show Chart Linkages:	In the Actions Menu allows the user to see chart ancestry.

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Auto Show Lookup Lists:	"Y" = Yes, "N" = No If set to "Y", the lookup table displays automatically when the mouse pointer is on the current data. If set to "N", all table lookups are accessed manually by pressing F2.
Auto Calculate CMG Grouper:	"Y" = Yes, "N" = No If set to "Y", the grouper calculates values automatically when relevant grouper data is provided. If set to "N", calculations for this grouper are manual, required the use of the verify (F11) or save (F7) functions.
Enable Quick Search:	"Y" = Yes, "N" = No If set to "Y", the Quick Search window is enabled. Quick Search will be activated automatically after saving an abstract so users can quickly access the next chart. If set to "N", searching is manual. The user must press F4 every time to perform a search.

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User Permissions

There are 6 levels of access (permissions) for each module listed under the Users Permissions header in the Users' Profile. These are:

Value	Description
N	No access.
R	Read access.
W	Read and Write access.
A	Read, Write and Add access.
D	Read, Write, Add and Delete access.
P	Read, Write, Add, Delete and Purge access.

Creating Users

To create a user:

Open the Users Profile (WinRecs - Application Menu - System Maintenance - User's Profile).

Click New
- or – Press F5.

Enter a few letters of the user name the new profile is based on.

Press Enter.

Note: When copying a User Profile, all Control File setting for that User are also copied.

All the fields unique to the new user will be blank and require values to be entered.

Note: Create a template user for each level of access required, such as "Administrator", "Analyst", "Clerical" or "View Only". This can speed up the process of creating users.

Note: If any changes are made to your User Profile, you should log off and then log back on again to confirm the changes.

The MED2020 user profile is reserved for authorized MED2020 users only.

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Using the Role ID

Links users to a common profile/template. When a user is linked to a Role ID, all User Profile and Control Files settings will be identical to those of the Role ID User Profile it is linked to. This feature is used to maintain groups of users. If a change is made in the Role ID user profile, all users linked to the Role ID will have the same change.

To use the Role ID:

From the list of users on the right, select the user the Role ID will be applied to.

In the Role ID field, press F2 to select the user to be used as the Role ID.

Save the user profile.

Click “Yes”
The Role Id is linked.

Note: Once a user if linked to another user’s settings (using the Role ID), individual profile settings cannot be modified until the Role ID is removed.

All user permission fields for the User are now disabled. Additionally, this user’s Control File will not be available in the user list.

All user permissions and Control File settings will be identical to the Role ID this profile is linked to.

Note: Any time changes are made to the source Role ID (in the Users Profile or Control File), all users linked to the source profile will be affected.

Hint: If you want to have most of the same settings as another user, but would like different settings such as a different sort of fields, link your user to the Role ID and save the record. Then remove the Role ID and save again. Now all of your settings will be identical to the user (Role ID) that you were temporarily linked to, but no you can make your own personal changes.

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6.5 Control File

Sidebar

Users List

Field	Description
Hospital ID	This identifies the hospital the user is bound to. If this is not defined, the user can access all records in the database.
Role ID	This identifies the user account the user is linked to.
Coder	The unique identifier for the user.
User Name	The user ID used to access WinRecs.
Full Name	The user's complete name.

Modules List

Field	Description
Module Name	These are the modules the selected user has access to Double-click on a module to open the grid for the module.

Control Properties

Mandatory Status	Identifies the mandatory status of the field.
User Def. Header	The name of the currently selected field.
Enabled	Identifies if the currently selected field is enabled or disabled.
Visible	Identifies if the currently selected field is visible or invisible.
Default Value	The default value for the currently selected field.

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Overview

The Control File is used to specify default values for fields, change Field name, restore fields on the Main Grid, make fields visible/invisible or enable/disable for each module in WinRecs.

Note: If you do not have administrative rights, you will only be able to modify your own settings. If you are linked to a Role ID, you will not be able to change the Control File settings.

Copying Existing Control File Settings

When using an existing user profile as a template for a new user, all settings from the template will be copied to the source profile. There are two ways to change the values for a module within the Control File – changing the values of each field individually, or, basing the module preferences on another profile.

For example, if a profile was created based on the Administrator User Profile, all Control File settings are the same as the Administrator settings. To use the same settings as another User please use the following steps:

Open the Control File module (System Maintenance –from the WinRecs Application menu).

Select an existing User from the User List and Module from the Modules List.

Press F5.

Press Enter.

Select the user you want to copy the profile from

Press Enter.

The settings have been copied to the Source User.

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6.6 Changing Field Settings

Select the field to edit.

Control Properties display the current properties for the selected field.

Click Edit.
- or – Press F6.
The current values for the selected field display.

This function can also be done on the Resort Edit window.

To change the value for a field:

Highlight the field in the Destination Box.
This is on the right hand side.

Press F6
- or - click Edit.
Change the properties for the field:

Mandatory Status F2 to view variables	HE	Hospital Error: This will produce a hard red error if not completed.
	HR	Hospital Required: The record cannot be saved if not completed.
	HW	Hospital Warning: This will produce a warning message if not completed.
	N	Not a CIHI field.
	S	Submitted: The value in the field will be submitted to CIHI.
	C	CIHI Mandatory
	W	WinRecs Required: The record cannot be saved if not completed.
User Defined Header	The name of the field can be changed.	
Enabled: F2 to view variables	”Y” (Yes): The user can modify the field. ”N” (No): The field value cannot be modified, but is visible.	
Visible: F2 to view variables	”Y” (Yes): The field is visible in the field list and in the grid. ”N” (No): The field value is not displayed in the field list and is not visible in the grid.	

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Default: F2 to view variables	Define the Default Value to use as the field's default when creating a record. Press F2 to view variables. **Note**: Default values will display on load of abstract but are not stored in the database until the abstract is saved.

Press **F7** to Save.
"Save All" prompts with an advisory window that indicates the change will be applied to all users, not just the one selected.

Press **F10** Done.

Note: You can make a section heading invisible by clicking on the heading, selecting Edit (F6) and make the heading visible "N". You will not see the heading in the Main Grid.

You can also make a whole multiform invisible by making the header invisible. There is no need to make each field invisible if the heading is invisible. To make the multiform visible again, go to the header and set the field "Is Field Visible" to "Y".

WinRecs Default	Description
F2	Search this field to list the Look Up field values for this field. You can select a value to populate every abstract in the module.
00	Will set the coder number field to the coder number to the log on user.
0000	Will set the time field selected to: AmCare (NACRS): Registration Time SDS: Admission Time IP (DAD): Discharge Time
1920/01/01	Will set the date field selected to: AmCare (NACRS): Registration Date SDS: Admission Date IP (DAD): Discharge Date
1921/01/01	Will set the date field selected to: AmCare (NACRS): Disposition Date

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0001	Will set the time field selected to: AmCare (NACRS): Disposition Time If the Discharge Time Unknown field is “Y” then the Time fields which were defaulted to the Disposition Time field are blank, unless there had been a disposition time recorded and then it was removed. Ie: The Default works like any other default in that it only does it once, such as changing the value after it has been accepted will not update the defaulted field value.

Note: Default values will not populate on previously saved abstracts.
Batch-In and HL7 interface values take precedence over any default values in the Control File.

- Click **F7** or Save All.
- Done **F10** to return to the main field list.
- The Control Properties displays the new properties.

Note: The Mandatory Status value cannot be changed if it is CIHI Mandatory or System Mandatory.

Hint: To populate any date and time field with the current date and time, press the Space bar on each field.

Changing Sort Order

To access the field resort function, go to System Maintenance → Control File.

Select the User and Module that you want to work on.

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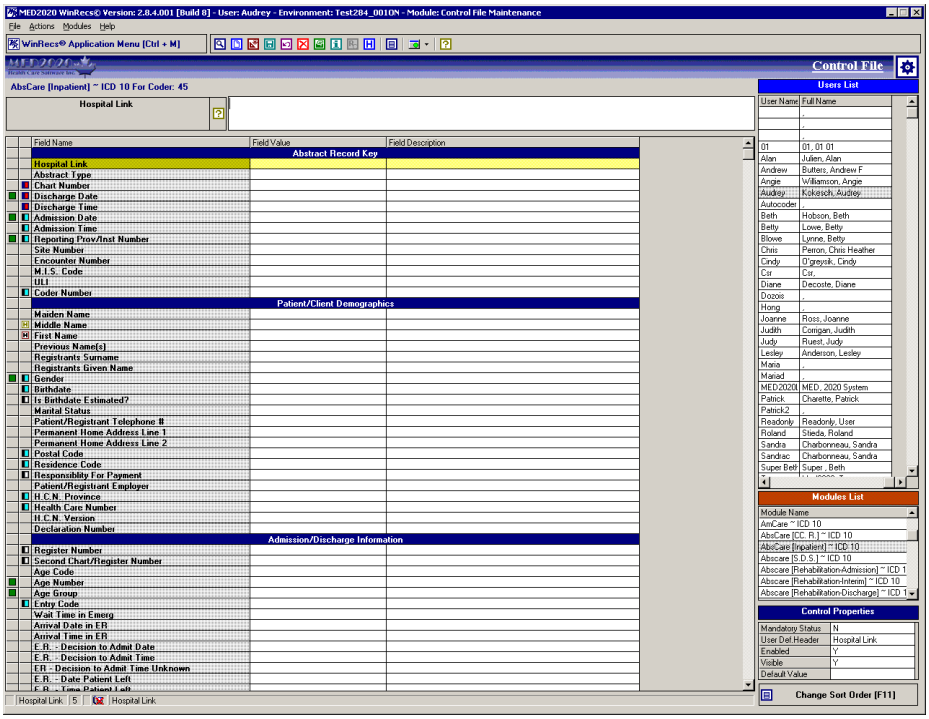

Click on Change Sort Order [F11] on the bottom right corner of the screen.

The table below describes the buttons and functions available in this module.

	Edit (F6). Highlighted field can be edited.
	View Multiform Groups.
	View Group Headers.
	Preview the Revised Sort Order.
	Save changes (F7).
	In Multiform and Preview pain, validates and saves changes.

When the screen loads it may be “idle”. You will see a blank screen after you Save. The first step is to select the group you want to edit. A group corresponds with the section banners on any of modules.

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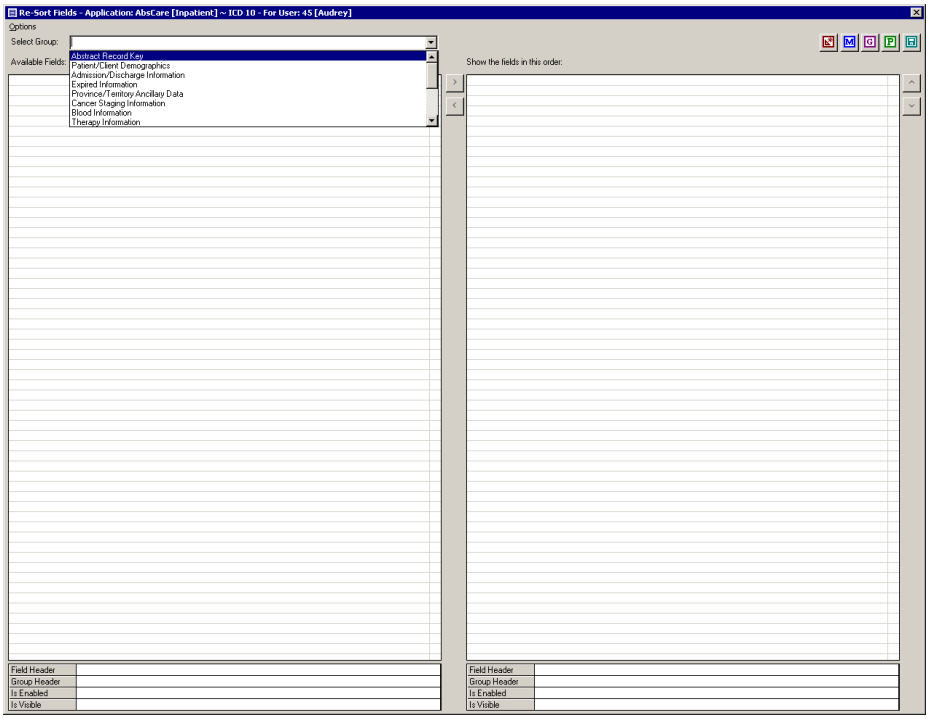

Only the single entry groups will be shown when you view the drop down on the left side.

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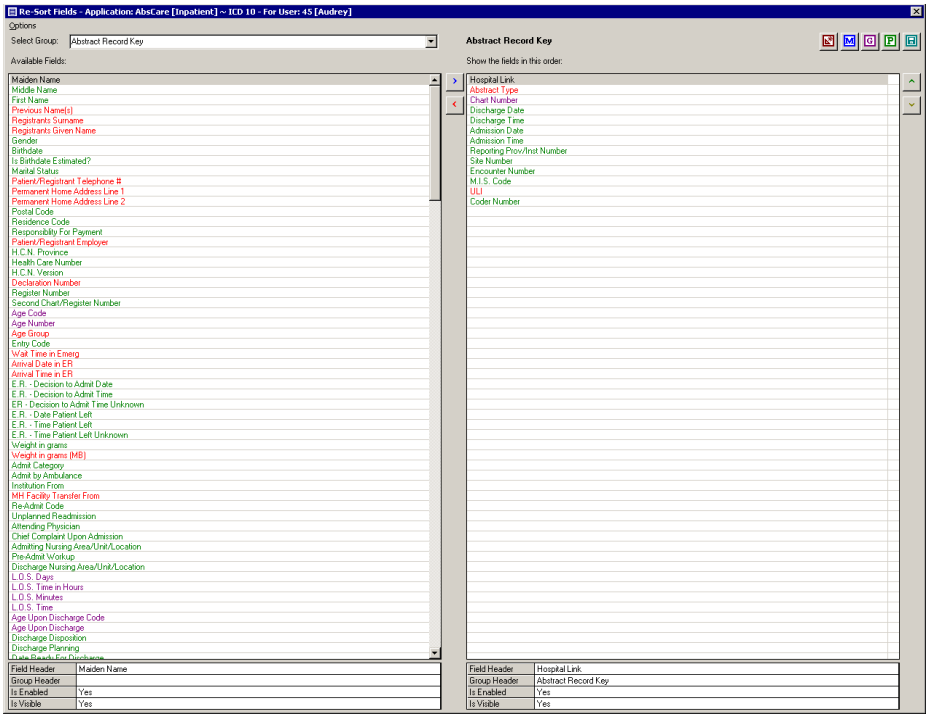

On the left are all of the other single-entry fields. The selected groups fields are loaded on the right side of the screen (i.e. Destination Box).

Color Coding for fields are as follows:

Green - Regular Grid Field - visible & enabled

Blue - Multiform Field - visible & enabled

Purple - Disabled Field

Red - Invisible Field

The bottom part of the screen shows the details for the field that is highlighted. This includes:

- Field Header – Field Name. This can be changed by selecting EDIT or F6 on a field.
- Group Header – Group Name.
- Is Multiform Field – Yes or No.
- Is Enabled – Yes or No. This can be changed by selecting Edit or F6 on a field.
- Is Visible – Yes or No. Can be changed by selecting Edit or F6 on a field.

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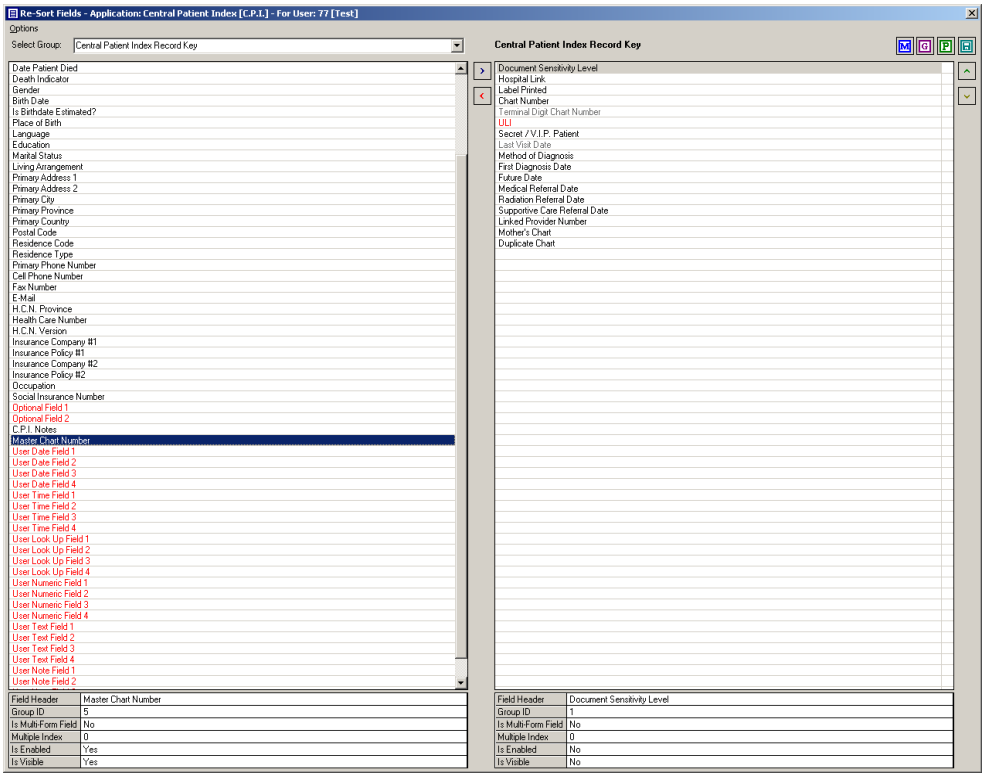

To move a field into the group, find it on the left pane and select it. Either double-click or use the top arrow button visible between the two panes.

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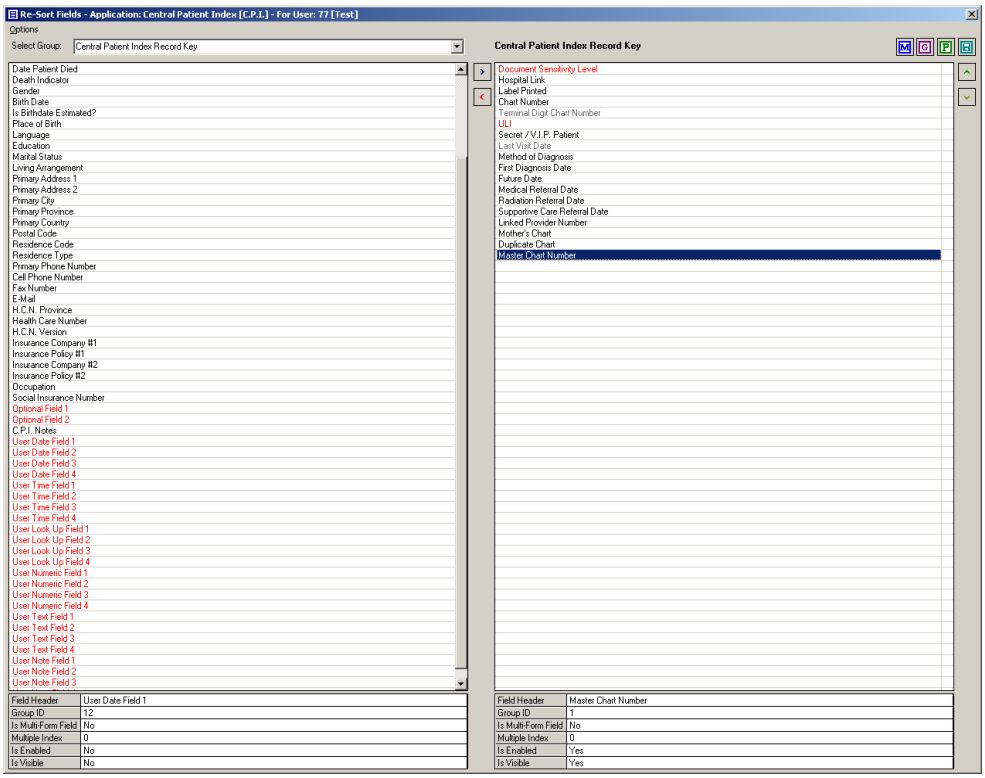
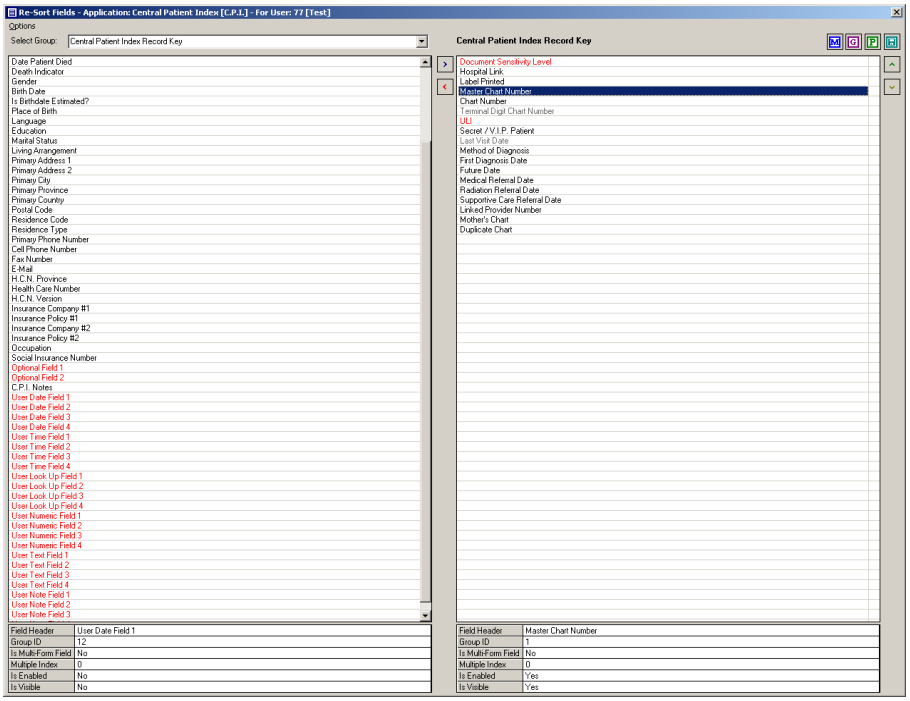


Once moved, the field is now part of the selected group and is placed at the bottom of the list. To move the field into a different sort position within the group, select it and use the arrow buttons (up or down) located to the right of the right pane.



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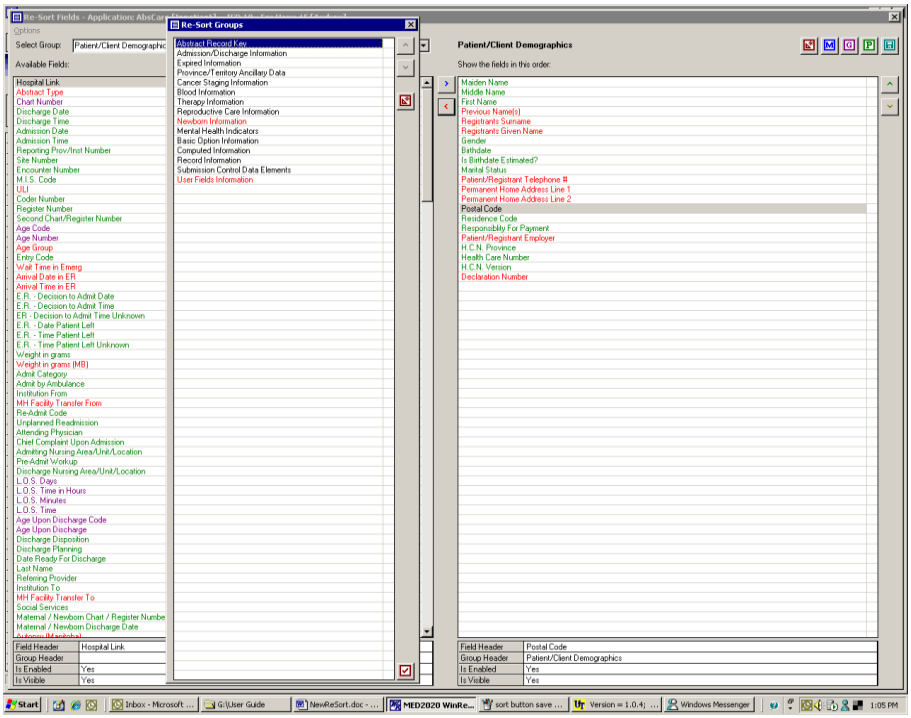
The field has been moved up several positions.

Once the work is complete for the current group, select the next group and the lists will refresh.



You can move a field out of a group, by selecting it in the Destination Box on the right side, and selecting the < arrow. Every field must be in a group. A selection box will show all the groups available to which a field can be moved.

Select the group where you want to move the field. Click to save and close the box.

To alter Multiform fields, click the button located on the top-right of the screen. A secondary window will open that will work much like the single-field version. The exception is that fields cannot be transferred between groups, e.g. a field in the Diagnosis Multiform must stay in this Multiform. The left pane will remain clear when a Multiform group is selected.

The field positions can be re-sorted by selecting the target field and using the up and down arrow buttons (to the right of the pane).

When the changes to the Multiform fields are complete, click the button (on the top-right of the screen), or use the escape key (ESC) on the keyboard.

- To change the order that groups appear, click the button (on the top-right of the screen). This opens the groups sort window.
- Select the target group and change its position using the up and down arrow buttons (on the top-right of the screen).
- When the changes to the groups are complete, exit using the button or the escape key (ESC) on the keyboard.

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To see a preview of the entire field list sorted use the button (on the top-right of the screen). This will load a screen that displays the sorted list. This screen is read-only.

When the preview of the field re-sort is complete, exit using the button or the escape key (ESC) on the key board.

To save the changes use the Save button (on the top-right of screen) or F7.

To undo the changes to the re-sort, use the menu Options -> Undo Recent Changes. Using this option will re-load the field list with what is currently stored in the database. Any changes made after the last save will be cleared.

To restore the sort order to the default MED2020 settings, use the menu Options -> Re-Set to System Default Sort Order. This will re-load the field list with the values used by the MED2020 Coder.

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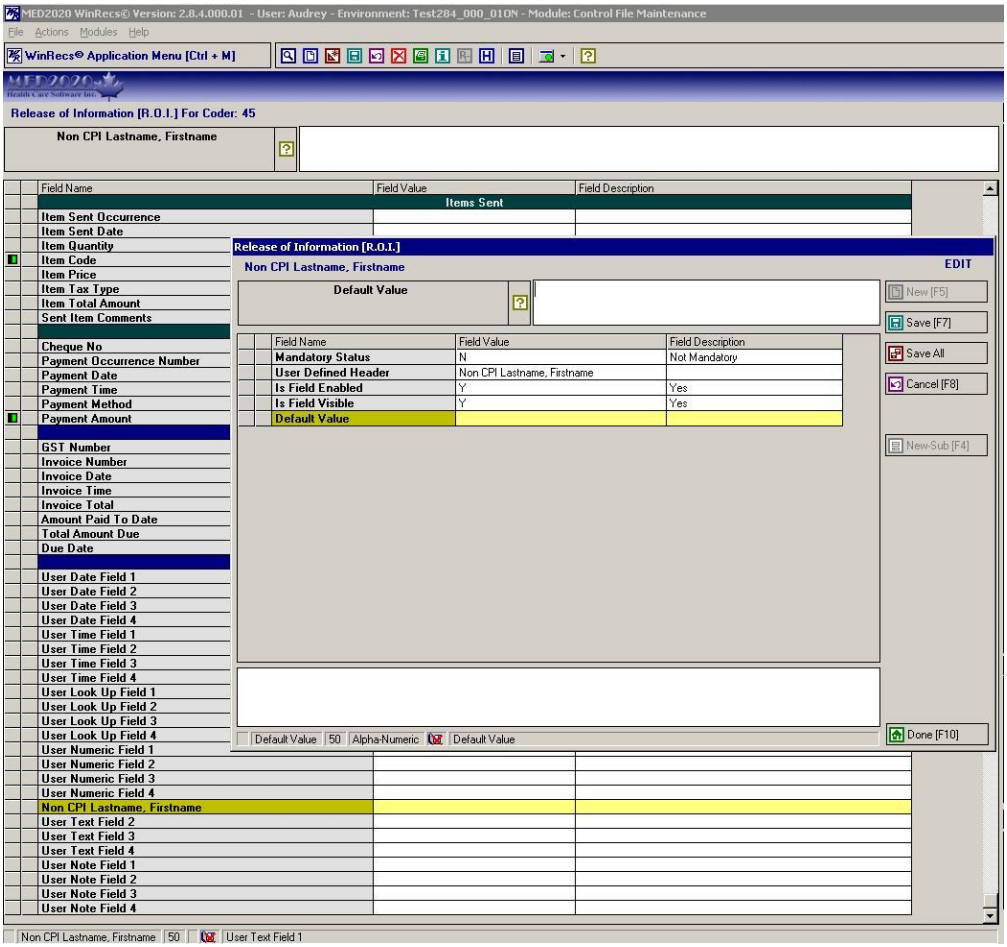
User Defined Fields

WinRecs provides 25 user defined fields (UD) for each of the following: 25 UD Date fields, 25 UD Time fields, 25 UD Numeric fields, 25 UD Look up fields, 25 UD Note fields, 25 UD Text fields. The user defined fields are available in all modules.

These fields are set up in the Control File. WinRecs places these fields at the end of the fields list by default. They can be resorted to display anywhere on the Main Grid of the abstract. They are single data entry fields, and therefore cannot be resorted on multiforms.



In the example above, the Release of Information Module User Text Field 1 has been renamed “Non CPI Lastname, Firstname”. It is enabled and visible. This field could be used in requests on people who are not in the CPI within WinRecs. Other User Defined Fields can be used in the same way to collect demographic information.

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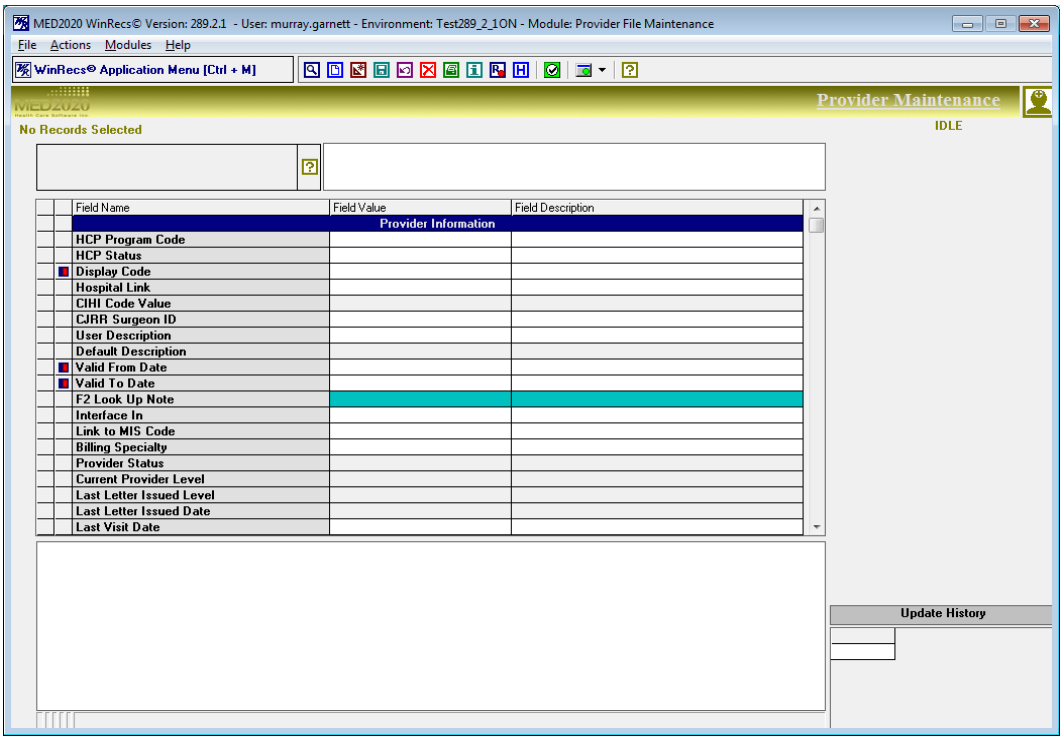
6.7 Provider Maintenance

Overview

The Provider Maintenance module is used to add or edit information for a facility's physicians and other providers. Providers may be added, modified and deleted, we required.

To access Provider Maintenance:

From the WinRecs Application Menu select **System Maintenance – Provider Maintenance**.
The Provider Maintenance window displays.



When the Provider Maintenance window first displays, no provider information displays.

To view Provider detail, click
- or – Press **F4**.
The Provider Search displays.

Use the Provider Search to display the required provider information. Providers may be added, modified and deleted from Provider Maintenance.

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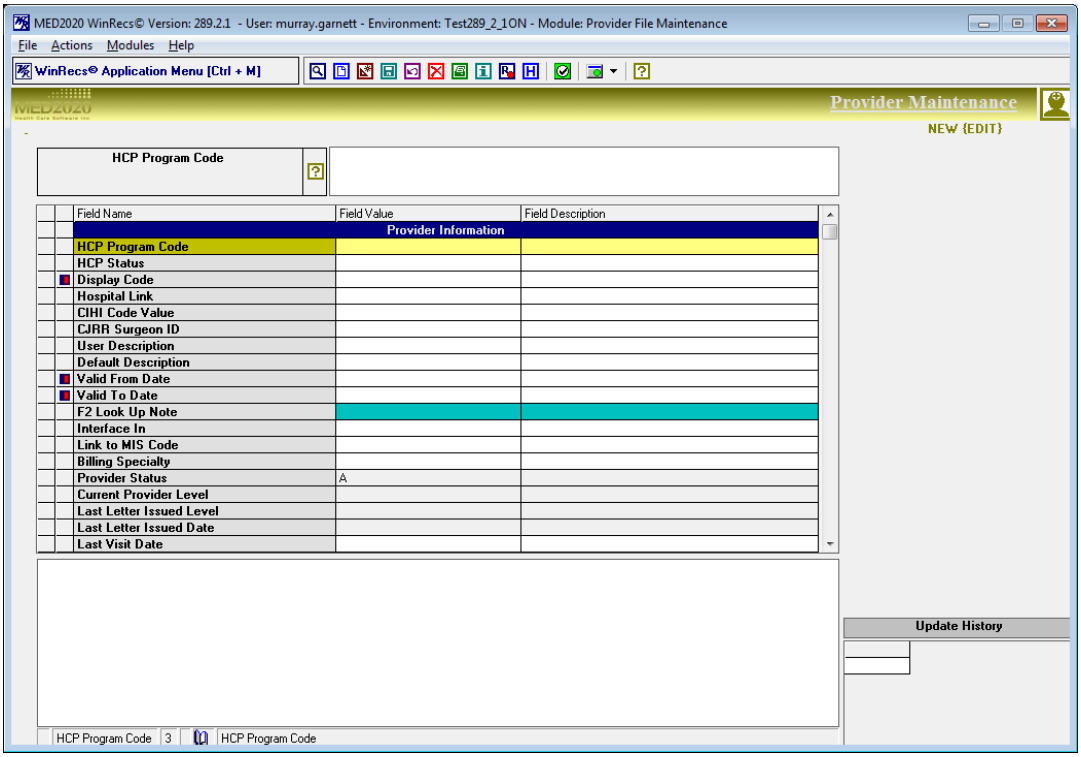
Adding Providers

Providers may be added as required.

To add providers:

From the Provider Maintenance window click
- or – Press **F5**.
The fields in the main grid are available for entry.



Enter information in all required fields. Press **Enter** after each field to move to the next field.

Field	Description
HCP Program Code:	Health Care Provider Program Code.
HCP Status:	Status of Health Care Provider; Active or Inactive.

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Minimum Deficiencies:	Chart Deficiency. Indicates the minimum deficiencies the provider can have before they begin to show in the deficiency levels.
Display Code:	The displayed value for the lookup.
Hospital Link:	This defines the hospital to which the provider belongs. A provider must belong to the same Hospital Link to have access to this institution's records and functions.
CIHI Code Value:	Provider number value that gets submitted to CIHI.
CJRR Surgeon ID:	CJRR surgeon number value. CIHI provides CJRR Surgeon ID numbers to those sites submitting to CJRR.
User Description:	The custom description of the provider such as first and last name.
Default Description:	This defaults to the value entered in User Description.
Valid From Date:	This is the date defining the start date of when this provider is valid (mandatory). The Provider account cannot be used before this date.
Valid To Date:	This is the date defining the end date of when this provider is valid (mandatory). The provider account cannot be used after this date.
F2 Look Up Note:	This defines the note used in F2 Lookup.
Interface In:	Enter the exact value that is sent via HL7 interface or Batch interface to populate provider number in the abstract. If this value does not match what is sent in the interface file the value will not populate in the abstract.

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Link to MIS Code	If a provider is linked to only one specific MIS code, the default MIS code may be entered in this field.
Billing Specialty:	Not used
Provider Status:	Chart Deficiency Module: This field is automatically populated from the Provider Unavailability field.
Current Provider Level:	
Last Letter Issued Level:	Chart Deficiency. This automatically populates the last letter level the provider was sent.
Last Letter Issued Date	Chart Deficiency. This automatically populates the date the last letter was generated.
Last Visit Date	Chart Deficiency. This is an internal log for the last time the provider was in the department to complete records.
Resident:	Chart Deficiency.
Chief Of Staff:	Chart Deficiency.
Transcription Initials:	Obsolete.
Borrower Code:	Chart Locator – allows a borrower to be linked to this Provider.
Max Deficiency:	Chart Deficiency. Indicates the maximum letter level the provider will receive.
Credentials:	Optional.
Title:	Optional.

After pressing **Enter** in the Title field, the Provider Services multiform displays. Service specialty/specialties for this provider are entered here and will populate in the DAD abstract.

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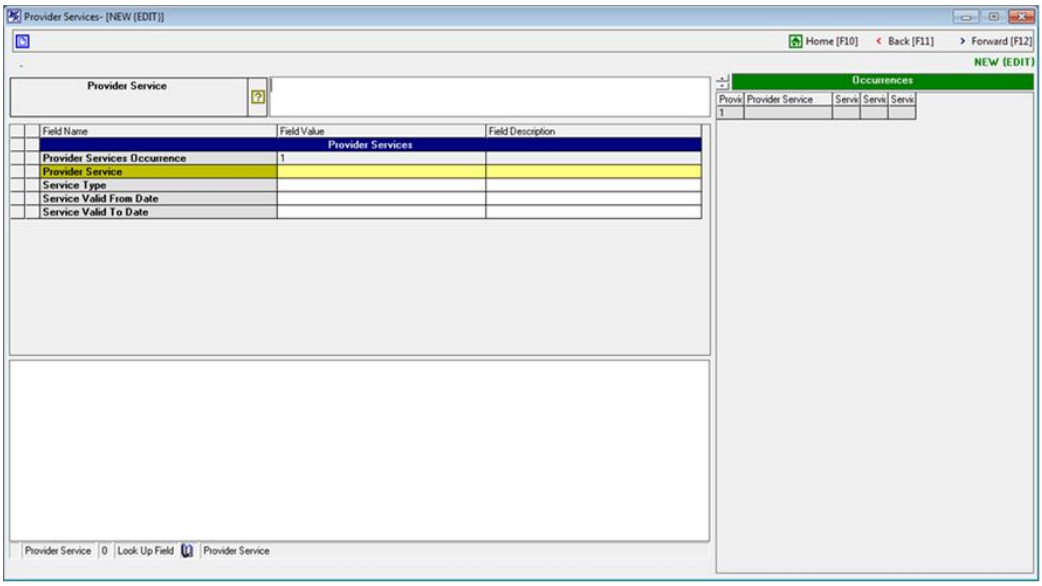

Enter the required information in the Provider Services multiform.

Provider Services Occurrence:	This is a unique number, generated automatically to identify the occurrence of the provider services.
Provider Service:	Provider Service is for DAD Abstracts.
Service Type:	A maximum of 3 services can be entered in this multiform. **Note**: If more than one occurrence is entered the first occurrence must have a service type of M and M can only be assigned once.
Service Valid From Date:	This is the date defining the start date of when this provider service is valid (mandatory). The Provider service for this provider cannot be used before this date.
Service Valid To Date:	This is the date defining the end date of when this provider service is valid (mandatory). The Provider service for this provider cannot be used before after this date.

When the detail for the current provider service is complete, press **Enter**.
- or - Press **F5**.

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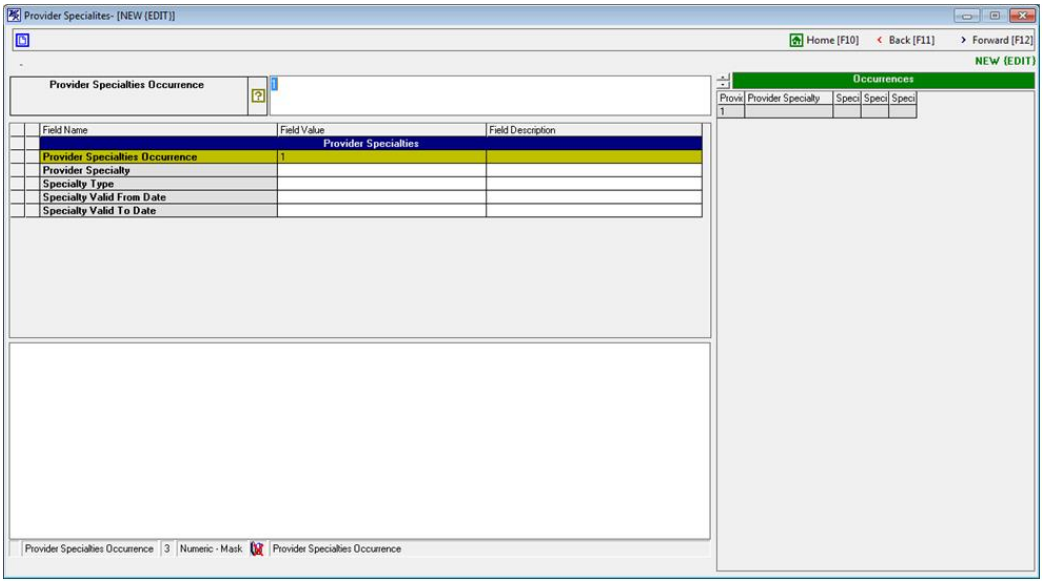
The Occurrences sidebar in the multiform is updated to display the service and the Provider Service field is selected in the multiform for the next service to be entered.

When all items are entered, click the Home button **[F10]** to return to the Main Grid.

Double-click the Provider Specialties section heading.
The Provider Specialties multiform displays. This multiform records each provider Specialty" offered by the provider.



Enter the required information in the Provider Specialties multiform. Using the multiform, multiple specialties may be entered for each provider.

	Provider Specialties Occurrence:	This is a unique number, generated automatically to identify the occurrence of the provider specialties.
	Provider Specialty:	Provider Specialty is a NACRS (AmCare) field.
	Specialty Type:	A maximum of 3 services can be entered in this multiform. **Note**: If more than one occurrence is entered the first occurrence must have a service type of M and M can only be assigned once.
	Specialty Valid From Date:	This is the date defining the start date of when this provider service is valid (mandatory). The Provider specialty for this provider cannot be used before this date.

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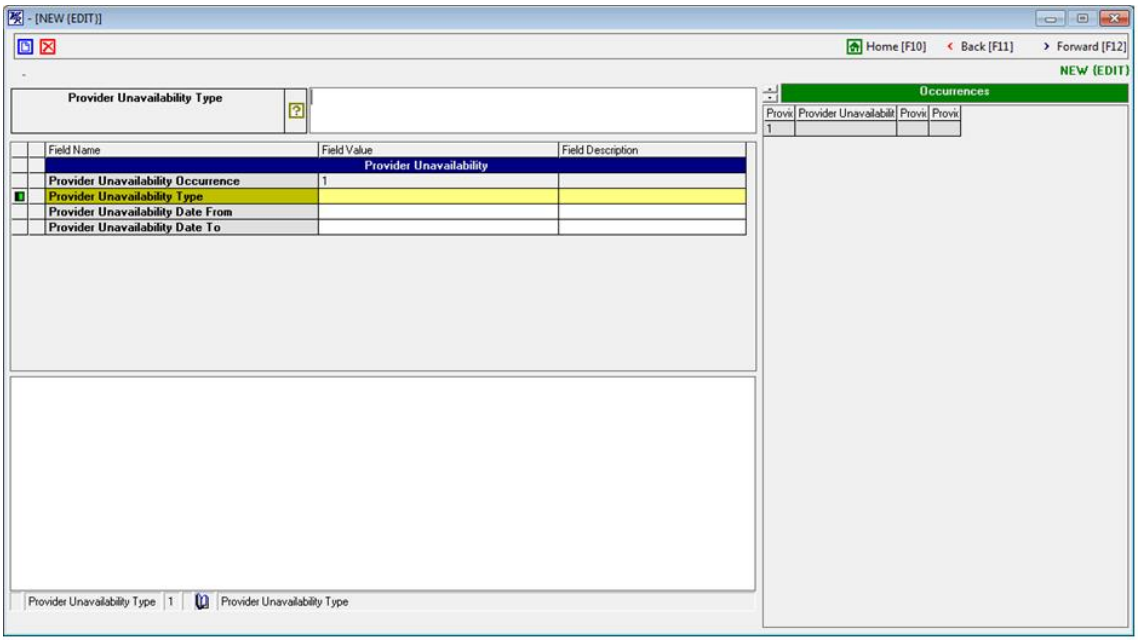
When the detail for the current provider specialty is complete, press **Enter**.
- or - Press **F5**.
The Occurrences sidebar in the multiform is updated to display the specialty and the Provider Specialty field is selected in the multiform for the next specialty to be entered.

When all items are entered, click the Home button **[F10]** to return to the Main Grid.

Double-click the Provider Unavailability section heading. The Provider Unavailability multiform displays. This multiform records each “Unavailability” for the provider.



Enter the required information in the Provider Unavailability multiform. Using the multiform, multiple unavailability entries may be entered for each provider.

	Provider Unavailability Occurrence:	This is a unique number, generated automatically to identify the occurrence of the provider unavailability.
	Provider Unavailability Type:	Site Specific Look up Values built in Look Up Maintenance.
	Provider Unavailability From Date:	Start date which Provider is unavailable.
	Provider Unavailability To Date:	End date which Provider is unavailable.

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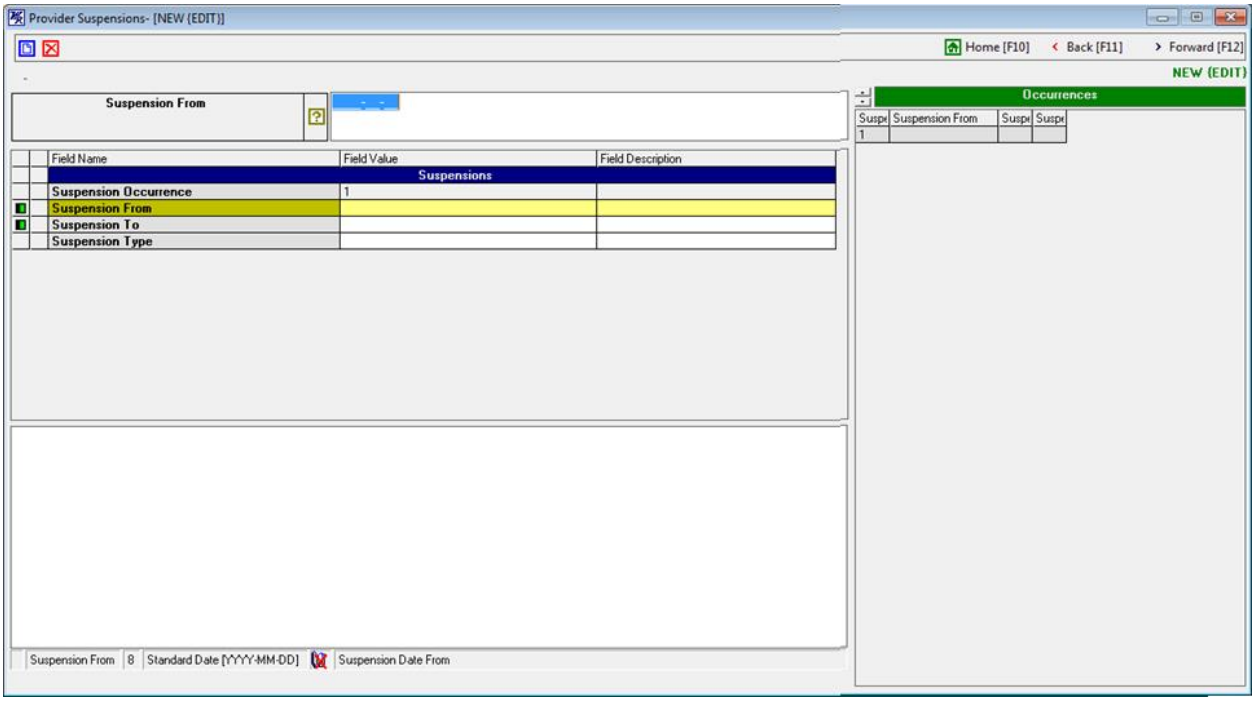
When the detail for the current provider unavailability is complete, press **Enter**.
- or - Press **F5**.
The Occurrences sidebar in the multiform is updated to display the unavailability and the Provider Unavailability field is selected in the multiform for the next unavailability to be entered.

When all items are entered, click the Home button **[F10]** to return to the Main Grid.

Double-click the Provider Suspensions section heading. The Provider Suspensions multiform displays. This multiform records each “Suspension” for the provider.



Enter the suspension information.

	Suspension Occurrence:	This is a unique number, generated automatically to identify the occurrence of the provider suspensions.
	Suspension From:	Date Provider suspension begins.
	Suspension To:	Date Provider suspension ends.

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	Suspension Type:	Type of suspension; site specific Look up values built in Look Up Maintenance

When the detail for the current provider suspension information is complete, press **Enter**.

- or - Press **F5**.
The Occurrences sidebar in the multiform is updated to display the unavailability and the Provider Suspension field is selected in the multiform for the next suspension to be entered.

When all items are entered, click the Home button **[F10]** to return to the Main Grid.

Enter the Demographic information.

Provider Surname:	The last name of the provider.
Provider First Name:	The first name of the provider.
Provider Middle Name	The middle name of the provider.
Language:	The language used by the provider.
Preferred Mode of Information Receipt:	The preferred mode for sending information to the provider.
Address:	The address of the provider.
City:	The city of the provider.
Province:	The province of the provider.
Postal Code:	The postal code of the provider.
Home Phone:	The home phone number of the provider.
Cell Phone:	The cell phone number of the provider.
Office Phone:	The office phone number of the provider.
Hospital Phone:	The hospital phone number of the provider.
Fax Number:	The fax number of the provider.

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E-mail:	The email address of the provider.
Provider Log:	Record Provider specific notes.

Click
- or - press **F7**.
The information is saved.

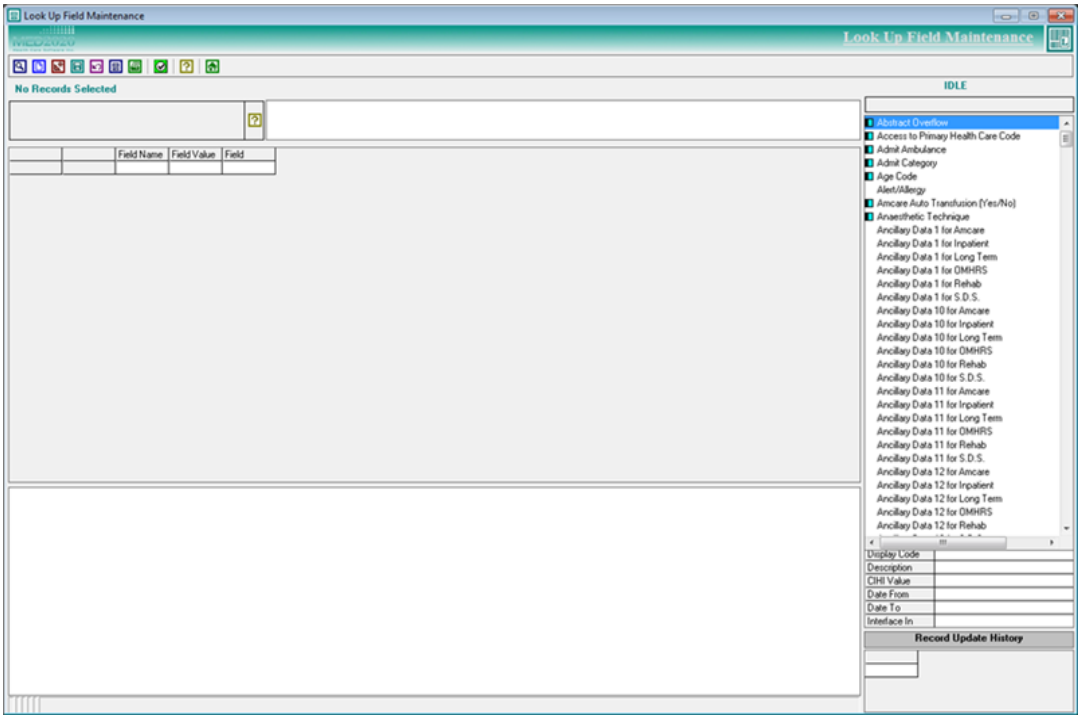
6.8 Look Up Field Maintenance

The Look Up Field Maintenance module is used to maintain WinRecs system Look up tables. These tables contain values defined by CIHI or other provincial authorities, and specific values used by your facility.

In WinRecs, the book icon displays in the status bar when a lookup table is available for the active field. In any WinRecs module, F2 will access the Look Ups for any field that has an associated Look Up table.

To access Look Up Fields Maintenance:

From the WinRecs Application Menu select **System Maintenance – Look Up Field Maintenance**.
The Look Up Field Maintenance window displays.



When the Look Up Field Maintenance window displays, the list of tables on the right may not display.

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Click the button tab below “IDLE” to display the tables or click **F4**. The Look Up tables are defined by MED2020 and it is not possible to add, modify or delete these tables. If you require a Look Up table that is not in the list, please contact MED2020 Client Support.

To display the Look Up table values, click the table on the right. The value detail displays in the Main Grid.

The data within the Look Up tables (in the Main Grid) may be added, modified and deleted. However, do not make changes without contacting MED2020.

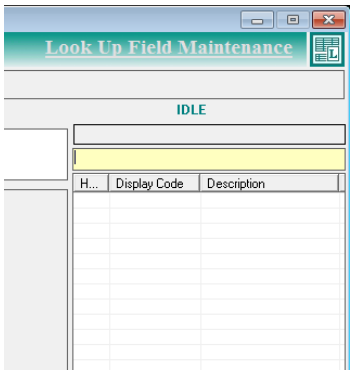
NOTE: Dates to CIHI Mandatory or Provincial mandatory fields should not be changed.

6.9 View Lookup Table Value Detail

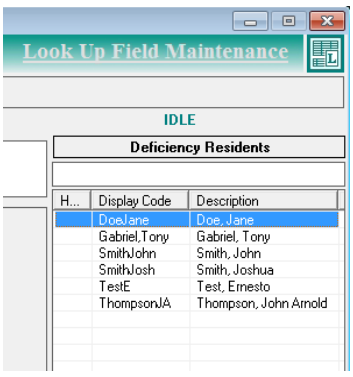
For each Look Up table the detail may be viewed in the Main Grid.

To view Look Up Table detail:

Doube-click the Look Up Table containing the detail to View. The field in the Look Up Field Maintenance table changes to yellow.



Press **Enter**.
The detail displays in the pane.



To display the detail in the Main Grid double-click the entry in the sidebar.
The Look Up Table Value detail displays in the Main Grid.

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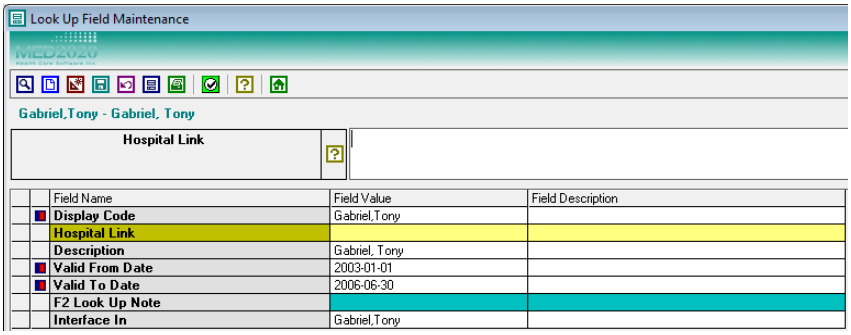

At this point, the information may be modified or invalidated and values added.

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6.10 Adding Look Up Table Values

The Values for each Look Up Table that display in the Main Grid may be maintained. Additional values may be added as required.

To add Look Up Table values:

From Look Up Field Maintenance select the Look Up table in the right pane.

Click
- or – Press **F5**.
The fields in the Main Grid are available for entry.

Make the required entries. The following are typical value fields available. Other fields may be available for different Look Up tables.

Field	Description
Display Code:	The displayed value for the lookup.
Hospital ID:	The hospital ID to which this lookup is associated. If blank, then all hospitals can use the lookup.
Description:	The description of the lookup.
Default Description:	Defaults to the user description. If the description is different, it must be changed when the New code is created. It is not possible to change this description once the record has been saved.
CIHI Value	If applicable, the value assigned by CIHI or the value to be sent to CIHI. This defaults to the display code. If this code must be different, it must be changed when the new code is created. It is not possible to change this value once the record has been saved.
Valid From Date:	The date when the display code becomes active. This is the WinRecs mandatory date for the module, not the calendar date.
Valid To Date:	The date when the display code becomes inactive. This is the WinRecs mandatory date for the module, not the calendar date.
Interface In:	The value used by any HL7 interfaces. This is the value that incoming interface would send, and WinRecs would translate to the Display Code above.
F2 Look Up Note:	Additional description of the value or rules for use.

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Click
- or – Press **F7**.

6.11 Modifying Look Up Table Values

The Values for each Look Up Table that display in the Main Grid may be maintained. Values may be modified as required.

To modify Look Up Table values:

From Look Up Field Maintenance select the Look Up table in the right pane.

Make the required changes. The following are typical value fields available. Other fields may be available for different Look Up tables.

Field	Description
Display Code:	The displayed value for the lookup.
Hospital ID:	The hospital ID to which this lookup is associated. If blank, then all hospitals can use the lookup.
Description:	The description of the lookup
Default Description:	Defaults to the user description. If the description is different, it must be changed when the New code is created. It is not possible to change this description once the record has been saved.
CIHI Value	If applicable, the value assigned by CIHI or the value to be sent to CIHI. This defaults to the display code. If this code must be different, it must be changed when the new code is created. It is not possible to change this value once the record has been saved.
Valid From Date:	The date when the display code becomes active. This is the WinRecs mandatory date for the module, not the calendar date.
Valid To Date:	The date when the display code becomes inactive. This is the WinRecs mandatory date for the module, not the calendar date.
Interface In:	The value used by any HL7 interfaces. This is the value that incoming interface would send, and WinRecs would translate to the Display Code above.
F2 Look Up Note:	Additional description of the value or rules for use.

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Click
- or – Press **F7**.
The information is saved.

Note: You cannot change a value that is grayed out. These fields can be found throughout the Look Up field tables and are either WinRecs default fields and descriptions, or fields that have been submitted to CIHI.

Note: You cannot change the CIHI Value or the Default Description of an existing table entry. If these values need to be changed, you must deactivate the current table entry by resetting the "Valid To" date and creating a new table entry with new values and a current "Valid From" date.

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6.12 ICD-10 Diagnosis and CCI Intervention Code Lookups

There are limited fields that can be updated in the ICD-10 and CCI tables. These are named Diagnosis Codes – ICD 10 and Intervention Codes-ICD 10 in the Look Up list. The CIHI values are visible but not enabled. Disabled fields cannot be changed. The user can change the fields that are visible and enabled.

Edits for Diagnosis and Interventions can be viewed in the Look Up for the code. For example, the Most Responsible Diagnosis codes, age and gender specific diagnosis and intervention codes.

There are also fields that can link the diagnosis and/or intervention to a Project, and Intervention or Diagnosis, etc. These are Look Up fields (F2). At the time of abstracting, if data recorded in the field matches what is in the link field, the abstractor will be prompted with a warning message that data entry is required in the other field.

Modifying Projects

To modify a project:

Find the Look Up table called Project from the list of tables.

Press Enter
- or – double-click the entry.

Press Enter again for a list of projects.

Select the project to modify.

Press Enter
- or double-click the entry.
The project fields will display in the Main Grid.

Select the field to modify. There are many different types of fields in this grid.

Single data element fields such as Display Codes, Valid From/To, User Description.

Look Up fields: Your own look ups for each of the Questions for a project may be created. There is an icon on the icon bar, or press F4 to access the New Look Up.

F2 will allow you to see the Look Up values that have already been set for this question.

Default: Allows you to set a default for the question. This default displays for every occurrence of the project number/question combination.
This is different than some other defaults set in the Control File that would apply to every abstract.

State Fields: Indicates whether the field (question for the project) is enabled or disabled. CIHI Mandatory, Hospital Error/Required/Warning.
If you select F2 on this type of field, the variables can be selected from the message box.

Adding Projects

To add a project:

Find the Look Up table call Project from the list of tables and press Enter.
- or – double-click on the entry.

Click New.
- or – press F5.

Complete the Project Information as shown.

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Display Code	Project Number (ie: 901)
CIHI Value	The value that is submitted to CIHI (ie: 901)
User Description	The title of the project (ie: Diabetes Patients)
Valid From	The date the project starts. This date is the WinRecs date for the module (discharge date for DAD) not the calendar date.
Valid To	The date the project ends. This date is the WinRecs date for the module (discharge date for DAD) not the calendar date.
Interface In	The field values used in batch and HL7 interfaces.
Question 1 Text	The text of the question. For example: ”Type I or Type II. This can be a maximum of 255 characters.
Question 1 Field State	(CIHI Mandatory) Enabled Disabled Hospital Mandatory. Press F2 to view the valid values.
Question 1 Look up	Provides access to the Look Up table values as defined in the steps below.
Question 1 Default	The value that would default for every abstract that project is used.

Note: Defaults for project questions should be done here and not in the control file. Project number default can be set in the control file.

To add a Look Up to a Question:
With the cursor on the Look Up field for the question, press **F4**
- or – click New Sub Look Up.

The Look Up Field Maintenance box displays with the fields to complete for each new Look Up for this question.

Press F7

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Press F10 when all Look Ups are entered.

Repeat the steps for other project questions. The last four project questions (14-17) are numeric fields and do not have corresponding Look Up tables.

Once all questions have been created or updated, save the project.

The CIHI Manual for DAD and NACRS has more information on use of the Project field.

Linking Projects to Diagnosis, Interventions or Patient Service

Projects can be linked to a diagnosis code, intervention code, or patient service.

In Look Up Field Maintenance, find the diagnosis, intervention code or patient service you want to link to the project.

Type the project number in the Linked to Project field.

Note: To be able to enter/select the specific Project in the Linked to Project fields, the Project's Valid To Date must match the Valid To Date for the diagnosis code, intervention code or patient service code you are linking. The Project's Valid To Date can be updated when you no longer wish to continue the linkage.

When abstracting a record, a warning message displays, asking if you want to complete the linked project. The edit process displays a warning if the project has not been completed.

Help File Directory

In both the Regional Profile and the Hospital Profile, there is a setting for Help File Directory.

If these fields are left blank, i.e. no specific path set, the default location will be

C:/Program Files/WinRecs2/ (or if you have installed WinRecs in a drive other than C:\, it will be where the WinRecs .exe is found).

The WinRecs install will automatically create a 'Help File' folder at the root of the location where the WinRecs.exe is found. Upon automatic creation of the Help File folder, WinRecs will download the latest Help file from the install that matches the version the user is presently accessing.

Where the Help File folder currently exists with a previous version of the User guide stored there, when Help is launched from within WinRecs, the updated version of the User Guide will be automatically updated in the Help File.

If the site elects to specify a path for the Help File folder, the path need only be set and the "Help File" folder will be automatically created and subsequently updated in that location.

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7 Interfaces

Batch Interface

Overview

A batch interface is a custom module that is used to import text files, containing specifically-formatted patient data, into WinRecs. This data is produced by an external patient records system, such as an ADT system.

Note: Batch Interfaces are custom modules that are developed on a per-client basis. Contact your MED2020 sales representative for more information.

Batch-In Interface

Setup

Note: Before WinRecs can be configured to use the Batch Interface module, custom files and instructions must be supplied by MED2020. These instructions are not provided in this guide as they vary from customer to customer. Do not proceed with the following instructions until you have contacted a Client Services representative for assistance.

Once the BI database has been attached, as per the instructions provided by MED2020 Client Services, some WinRecs modules must be configured.

Selecting the BI in WinRecs

The following steps require access to WinRecs and can be performed by a Health Information Management professional in your facility. If a member of IT Services will be performing these steps a login to WinRecs will be required.

When the BI is used for the first time for each database, the user will need to configure WinRecs to use the BI. This can be done from any WinRecs application.

It is recommended that you initially attach the new BI in your WinRecs test environment. Once you are satisfied with the results of any testing you would follow these same steps to attach the BI in your live environment.

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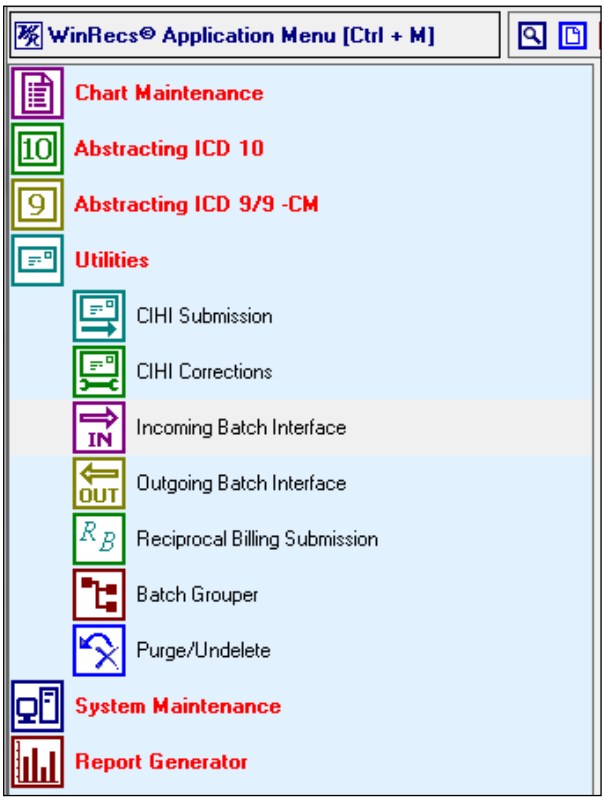
1. From the WinRecs application menu, go to Utilities and open Incoming Batch Interface.



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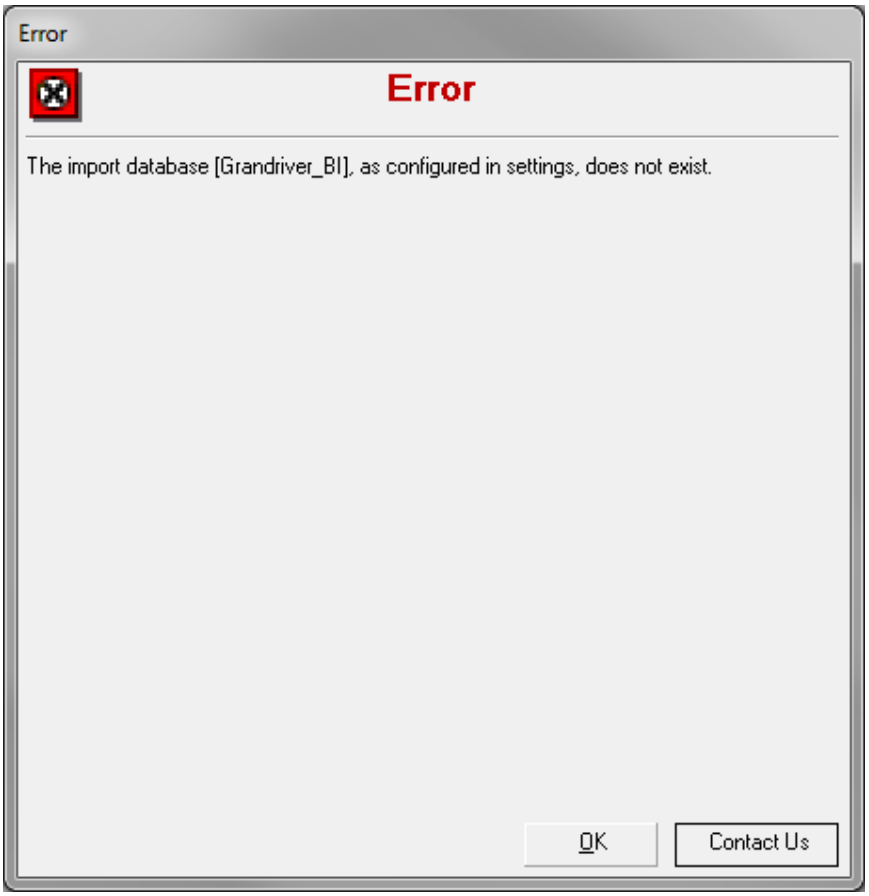
If you receive the following error screen when you first run the BI, click OK and proceed to the WinRecs Batch Interface screen.



Configure the Batch-In Interface module

Open *Incoming Batch* interface from the *WinRecs Application Menu*

In the WinRecs Batch Interface window, click Tools → Settings

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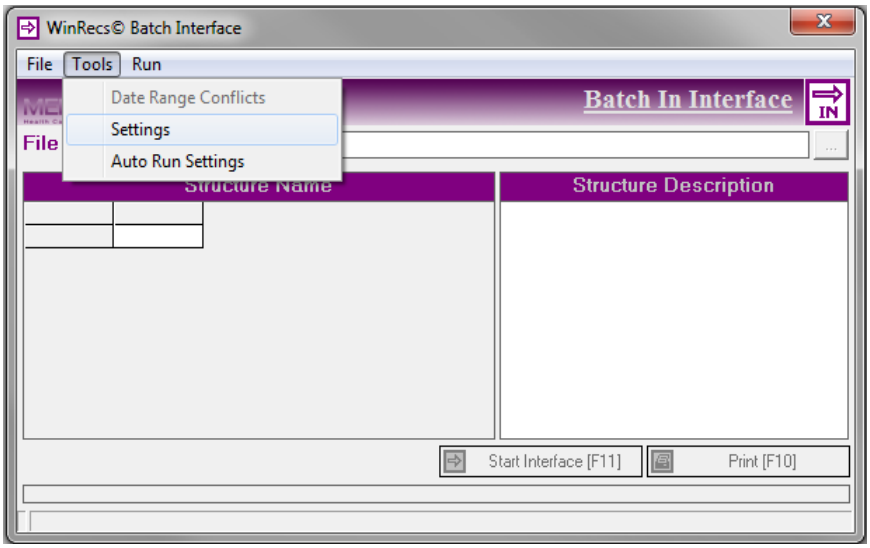
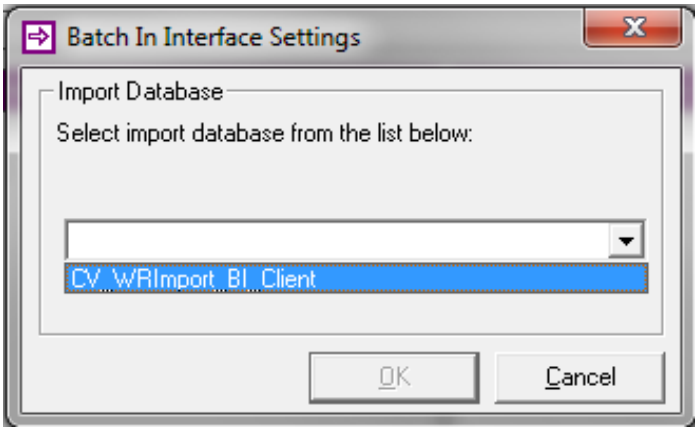


The Batch In Interface Settings dialog box will open. Select the appropriate BI database from the drop down box and click OK.



Close the WinRecs Batch Interface window.

The BI is now available for all users in the environment.

Configure the Institution Profile

Open the *Institution Profile* (located under *System Maintenance*) from the *WinRecs Application Menu* or the *Modules* menu.

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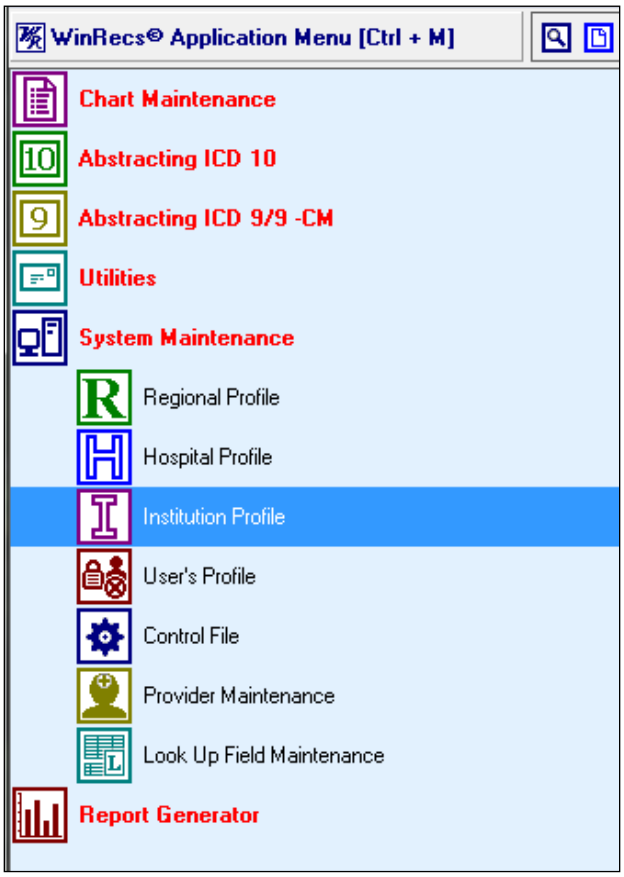

Note the institutions in the Institutions List. Each institution expecting updates via the Batch Interface must be updated as follows:

Double-click on the institution entry in the Institution List.

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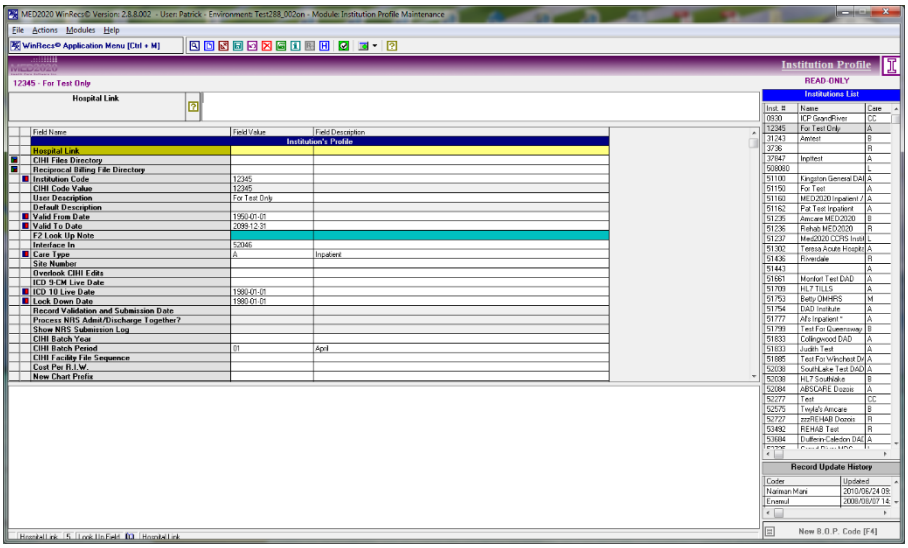
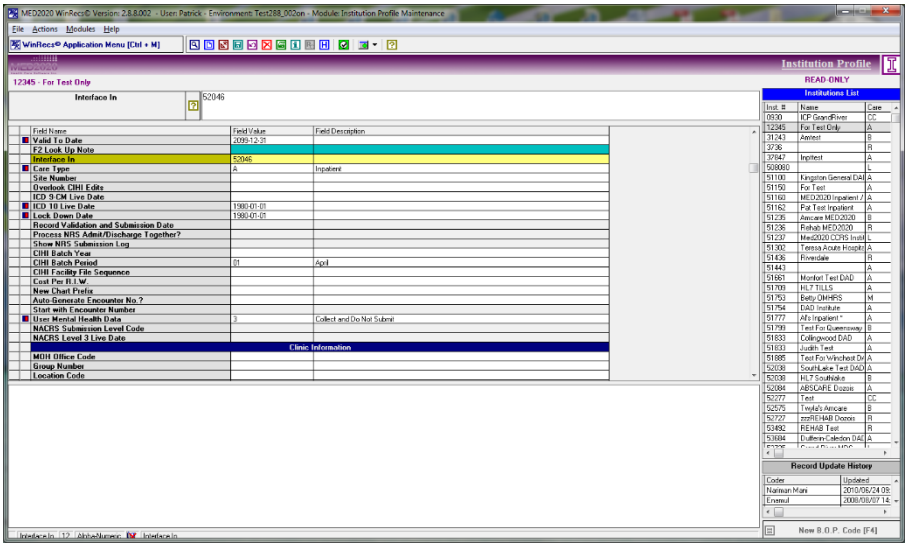


Update the *Interface In* value with the corresponding value found in the batch interface data file.



Save the record.

Configure Lookup Field Maintenance

Every lookup table that corresponds to data in the batch text file must be updated with the corresponding Interface In value. Example lookup tables might include:

Disposition Code

Entry Code

Gender

H.C.N. Province

Open *Lookup Field Maintenance* (located under *System Maintenance*) from the *WinRecs Application Menu* or the *Modules* menu, or press **F4** to display the tables.

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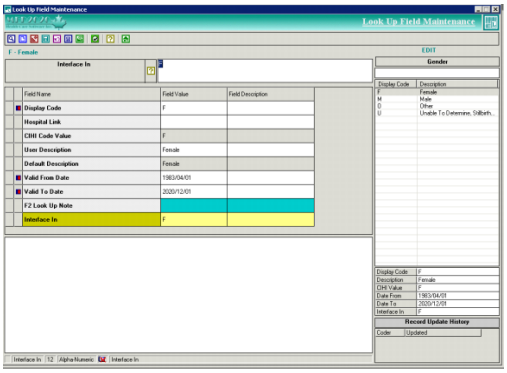
Click on the gray button under the idle label and select the lookup table corresponding to data found in the batch file.

Update the *Interface In* value with the corresponding value found in the batch interface data file.

Save the record.



This process must be repeated for any remaining lookup tables. Refer to *Lookup Field Maintenance* for more information on locating table values).

Once the interface setup has been confirmed, it is recommended that the batch interface first be run in a *test* environment to ensure that the expected fields are being applied to the WinRecs system correctly, thus not impacting patient data in the *live* database.

Running the Batch-In Interface

Open *Incoming Batch Interface* (located under *Utilities*) from the *WinRecs Application Menu* or *Modules* menu.

Select the appropriate Structure Name from the list. The available structures are specific to each customer and are determined by the nature of the records to be imported. The corresponding Structure Description will be displayed on the right.

The *File To Import* will display the name and location of the last import file used.

Click on the ellipsis (…) button to browse for the import file.

Note: Contact your WinRecs administrator to learn where the import files are located in your particular environment.

Click the *Start Interface* button, or press **F11**, to process the import file. The progress will be displayed at the bottom of the window.

Auto Batch Functionality Set Up

The Auto Batch functionality is based on command line parameters. If the L/ parameter is 2 this indicates the system should auto load the batch run based on parameters /B (Batch Name) & /F (path where the file(s) are located).

/B should match (exactly) one of the registered batches that appear in the grid. This is how the system determines which batch to run

/F This is just the path (do not include the file name) and the path should only contain files that can be processed by the batch indicated in /B.

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This is an example of the command line:

C:\Program Files\WinRecs2\WR_WinRecs.exe /L 2 /S DEVSERVER2003 /D

WinRecs_2_8_4 /U test /P test /B 2005 and 2006 NACRS 10 Error Import /F C:\AutoTest

/L - is the log in type (2 is used for auto-batch)

/S - is the server name (this is the equivalent of the server name in the log in screen).

/D - is the database name (same as would be in the log in)

/U - is the User name (like log in)

/P - is the password (log in)

/B - is the batch name (as it appears in the grid in the Batch interface screen)

/F - is the path (only the path) where the file(s) reside

Batch-In Interface Reports

Reports, such as those used to identify discrepancies noted during the interface execution, can be accessed. These reports must be configured in the *Lookup Maintenance* Report Section List table.

Click on the *Print* button or press **F10**. A list of configured reports, and the corresponding location, will be displayed.

Highlight the appropriate report.

To produce a hardcopy of the report, click the *Print* button or press **F10**.

To display the report on the screen, click *Show Report* or press **F12**.

To close this window, click on the Windows *Close* control (the *X* in the top-right corner of the window).

Note: It is recommended that you use reports to confirm the accuracy of batch imports, to check for potential problems, such as a chart number having all demographics changed.

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The primary reports used are:

Report	Description
BI Date Range Errors.rpt	Identifies overlapping dates for lookups.
BI Interface Reporting List.rpt	Lists all abstracts interfaced for a specified Interface Date. When the Batch Interface is run for a given date, the Interface Date and Interface Time fields are updated in the abstract.
BI Lookup Interface IN.rpt	Identifies which lookup table requires manipulation of the Interface In value.
BI Records Processed.rpt	Identifies how many records have been processed and/or dropped.

Note: These reports are available for download from the MED2020 web site, located at ftp://web.med2020.ca/WR2Reports/BatchInterface

Note: The "BI Date Range Errors.rpt" must be located in the reporting folder under the main WinRecs program folder.

Note: Data received from the Batch-In interface may override configured system defaults.

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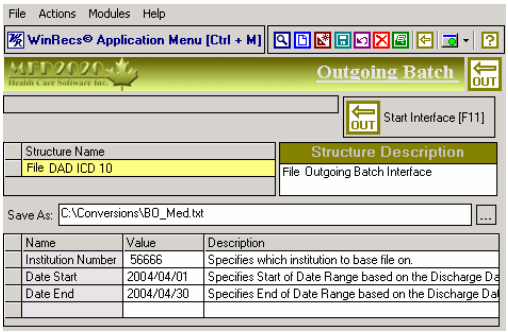
Batch-Out Interface

Setup

Note: Before WinRecs can be configured to use this Batch Interface module, custom files and instructions must be supplied by MED2020. These instructions are not provided in this guide as they vary from customer to customer. Do not proceed with the following instructions until you have contacted a Client Services representative for assistance.

Running the Batch-Out Interface

Select the Structure Name. The corresponding Structure Description will be displayed to the left.



Provide a valid Institution Number by pressing **F2** while focused on the Institution Number field. Select the appropriate institution from the list returned.

Provide the start and end dates in the format of YYYYMMDD.

Click on the ellipsis (…) to browse for the batch file to be exported, then click *Save*.

Press **F11** or click on *Start Interface* to run the batch.

A status bar, located below the module header, will display the progress of the batch out operation. “Finished batch out” will be displayed once finished.

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HL7 Interface

Overview

HL7 is the health industry standard to exchange data between systems over an existing network. The WinRecs HL7 application accepts incoming data from the Client ADT system, interprets the information received, and updates the WinRecs database. WinRecs currently supports HL7 version 2.3.

Note: The WinRecs HL7 interface is a separate executable running outside of the main WinRecs application. MED2020 recommends that the HL7 interface program be installed on the database server. Instructions specific to the WinRecs HL7 interface installation are provided on a per-client basis. Contact your MED2020 sales representative to learn more about acquiring the WinRecs HL7 interface.

Minimum HL7 Segments Required for WinRecs HL7

MSH (Message Header), *EVN* (Event Type), *PID* (Patient Identification) and *PV1* (Patient Visit) are the minimum HL7 segments required for a patient abstract. *PID* and *PV1* segments contain sufficient patient information to create a patient Abstract.

Some of the data elements that may come across for WinRecs HL7:

Institution number *	Admit category
Discharge date	Discharge disposition
Chart number *	Health card number
Patient name	MIS code for Ambulatory Care
Patient address	Marital status
Patient's home phone number	Attending doctor number
Date of birth	Institution from
Gender	Institution to
Postal code	Nursing area
Entry code	Main patient service
Admit date *	Encounter number
Admit time *	Responsibility for payment
Discharge time	Residence code

* Denotes required fields to locate or create an abstract.

Below is a list of HL7 Events currently recognized by the WinRecs HL7 Interface:

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Code	Description
A01	Admit patient (admit Inpatient, applies to CCR only)
A02	Transfer patient (applies to CCR only)
A03	Discharge patient
A04	Register patient (admit SDS or Ambulatory Care patient)
A06	Transfer an outpatient to inpatient
A07	Transfer an inpatient to outpatient
A08	Update patient information
A11	Cancel admit
A13	Cancel discharge
A18	Merge patient
S12	New appointment-create a pull list entry
S14	Appointment modification-modify a pull list entry
S15	Appointment cancellation-deletes a pull list entry
A28	Add person information
A31	Update person information
A34	Merge patient information
A35	Merge patient information - account number only
A36	Merge patient information - patient ID and account number

Note: Data sent by the HL7 interface may override configured system defaults.

The WinRecs HL7 interface logs all processed transactions. There are two types of logs, both stored in the log data folder within the WinRecs HL7folder:

File Name	Description
WRHL7_yyyymmdd.log	Produced daily. It is recommended that daily log files are reviewed and removed regularly.
erroryyyymmdd.log	Produced only when there is a critical error. It is recommended that all critical errors be reported to MED2020.

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Clearing a Critical Error Message

A critical error message might be received when a data element is too big for the database, there is a format mismatch or an internal HL7 application error. In such situations, it is necessary to clear the message.

Pause the external ADT interface (to stop the transmission of HL7 messages).

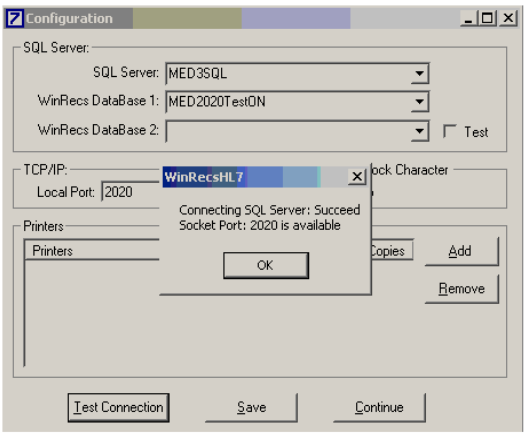
In the WinRecs HL7 interface, select *Clear Critical Error* from the *Edit* menu. (If "clear critical error" is not available, proceed with the next step).

Close and reopen the WinRecs HL7 interface.

Resume the external ADT interface (to resume the transmission of HL7 messages).

Note: If you receive a critical message, contact MED2020 Client Services for assistance. A copy of the critical error log (described above) will be required.

Connecting to the Live Database



Pause the external ADT interface (to stop the transmission of HL7 messages).

In the WinRecs HL7 interface, select *Configuration* from the *Option* menu.

The first database listed will be used as the live database.

Click *Test Connection*.

If the connection is available, click *Continue*, then *Save*.

Resume the external ADT interface (to resume the transmission of HL7 messages).

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Connecting to Live and Test Databases Simultaneously

Pause the external ADT interface (to stop the transmission of HL7 messages).

In the WinRecs HL7 interface, select *Configuration* from the *Option* menu.

The first database listed will be used as the live database.

Specify the test database as the second database connection, and check the *Test* check box.

Click *Test Connection*.

If the connection is available, click *Continue*, then click *Save*.

Resume the external ADT interface (to resume the transmission of HL7 messages).

Updates to your HL7 interface

When MED2020 provides an update to your HL7 interface/script, we internally generate a ticket number to track the changes. Effective as of any changes to your interface after the 2.8.5_002 service release is applied, the ticket number and version of the HL7 will be logged in the Database Update History. Please see **Section 9 – Updates and Patches** for more information.

Maintaining HL7 Transactions within WinRecs

Within the User Profile, a field, Can Purge Logs, is used to set permission to the Purge HL7 Log Utility.

Y - User will see the Menu Item
N - User will not see the Menu Item

A user with permission to this Utility can purge the HL7 transactions "prior to" a specific start date. This will purge any log records before that date and keep any that are on or after it. There is no edit to stop a user from doing a complete purge. However, a warning is generated if the date is a future date, the same as today or less than 90 days from today.

Menu Item Modules -> System Maintenance - > Purge System Tables -> HL7 Log.

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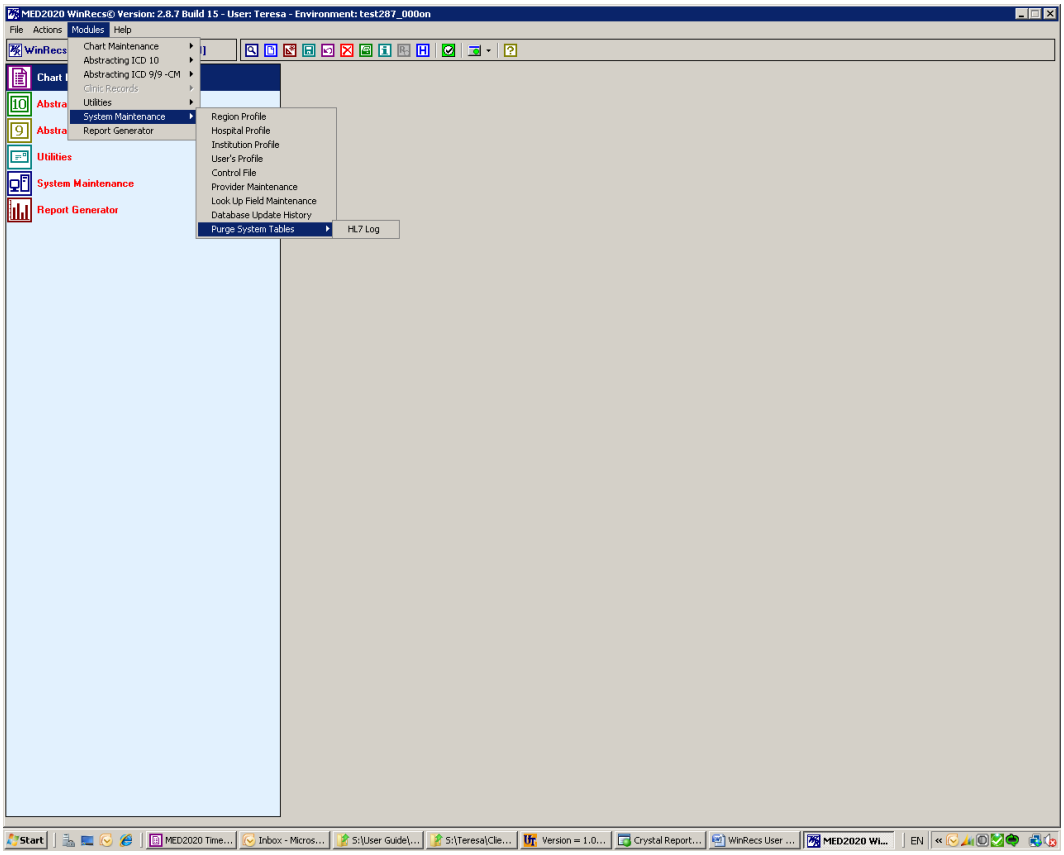

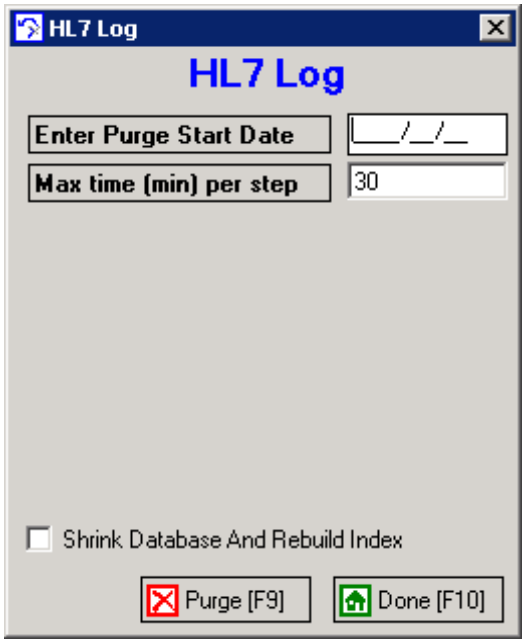

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There are many steps in the purge function.

Enter a start date 90 days or more from today

The text box "Max time(min) per step" defaults value is 30 minutes. The max value is 99 minutes. It allows clients to set the max duration of time in minutes per step. If a timeout occurs a pop up message indicates which step failed.

Note: Please contact MED2020 with the information from the pop up message

Shrink Database and Rebuild Index. This indicates whether you will want to perform a full reindex and shrinking of the database with HL7 log purge function. By default it is unchecked, you need to check the box to initiate the shrinking and re-indexing.

Note: The shrinking and re-indexing of the dataset may be best performed by your SQL database administrator

When client checks the check box, a pop up message warning the client explains: Shrinking the database will slow down WinRecs or will cause a WinRecs runtime error. All WinRecs user should be logged out. Are you sure you want to proceed?

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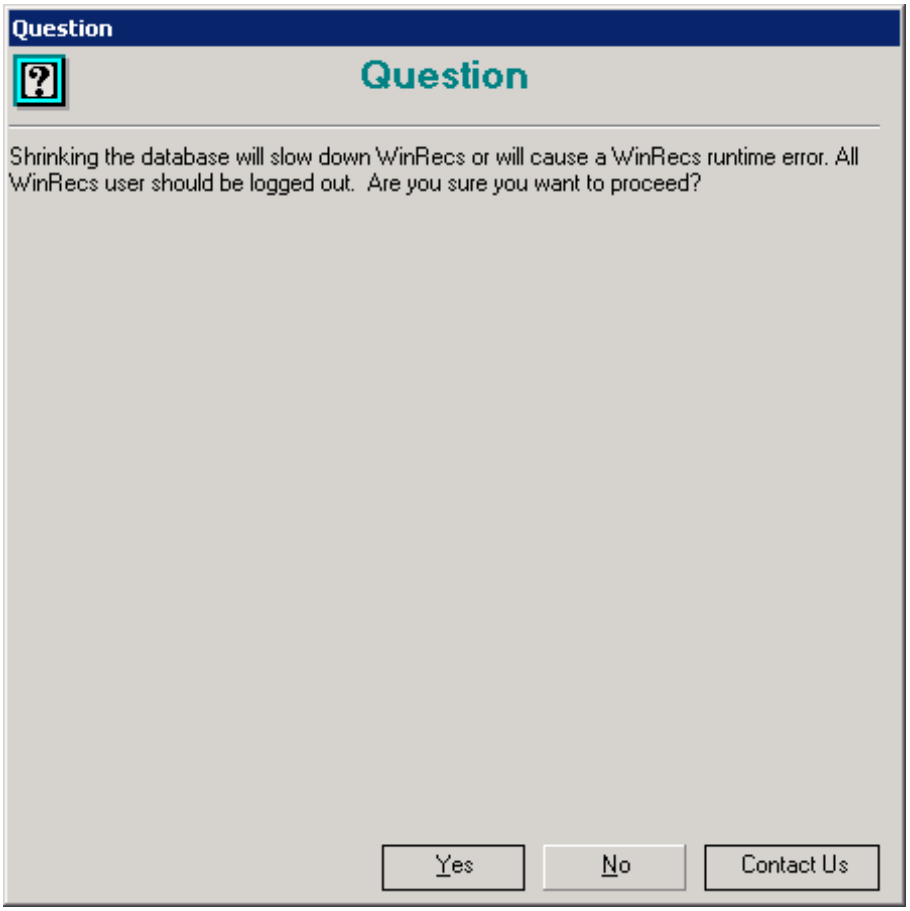

Click Yes

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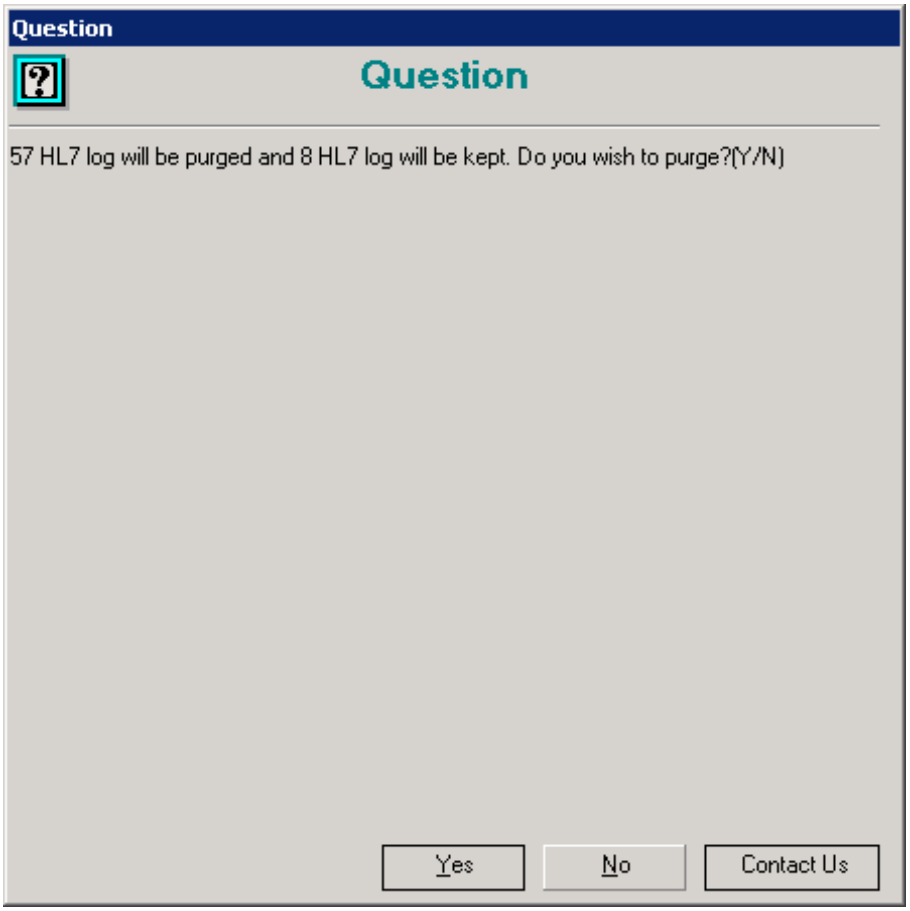

Click Yes

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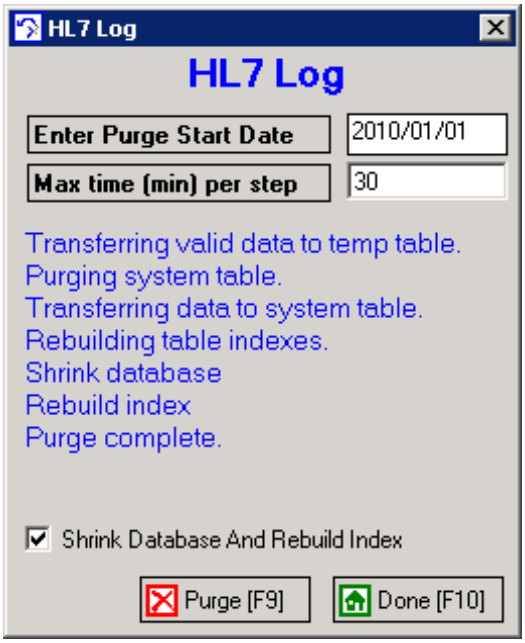

This is the message if you have chosen to check the Shrink Database and Rebuild Index option.

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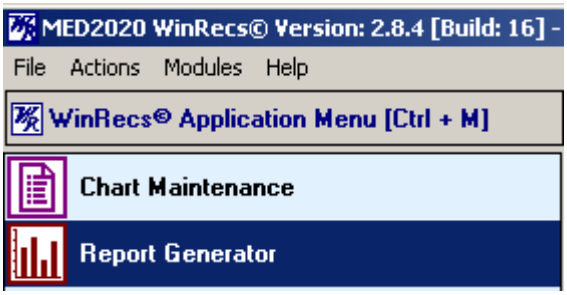
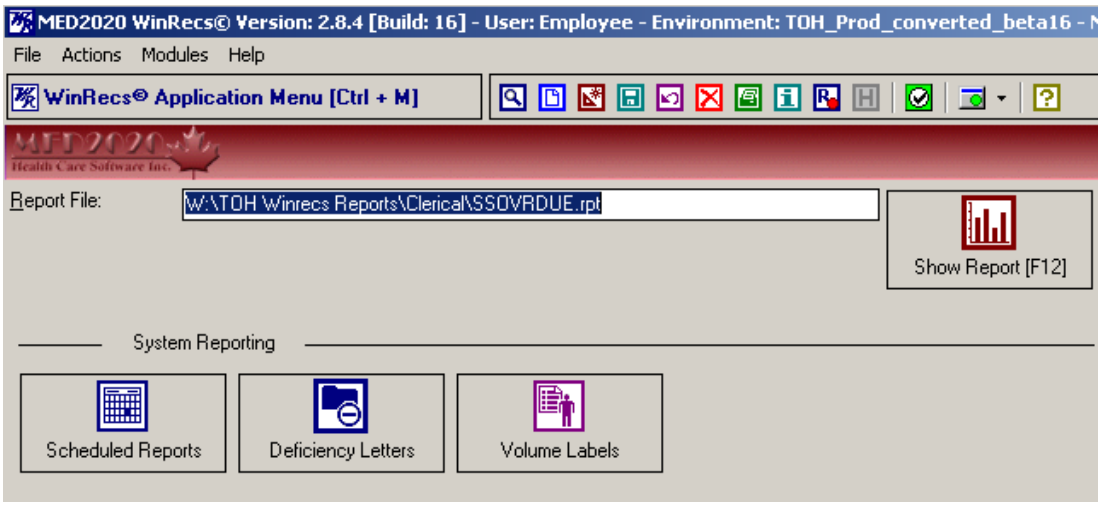
8 Report Generator

All reports developed in Crystal on the WinRecs database can be previewed through WinRecs Report Generator. Once reports are developed, Report Generator allows the report to be generated. It is not possible to update the format of any report through Report Generator. This module allows viewing only. When generated from within WinRecs the program automatically generates the report based on the current server and database which WinRecs is logged on to.

To generate reports click on **Report Generator** from the initial **WinRecs Application Menu** as displayed in the image below.



The image below appears.



In the **Report File** field enter the full path of the report. If you don't know the name of the report double-click on the **Report File** field or press **(F2)** to open the window. It is not necessary to put the reports in a specific folder. It is recommended that 'canned reports' are put in a common folder that is accessible by everyone who will need to run the report.

Once you have successfully run reports through WinRecs, the program remembers the directory where the reports were run from.

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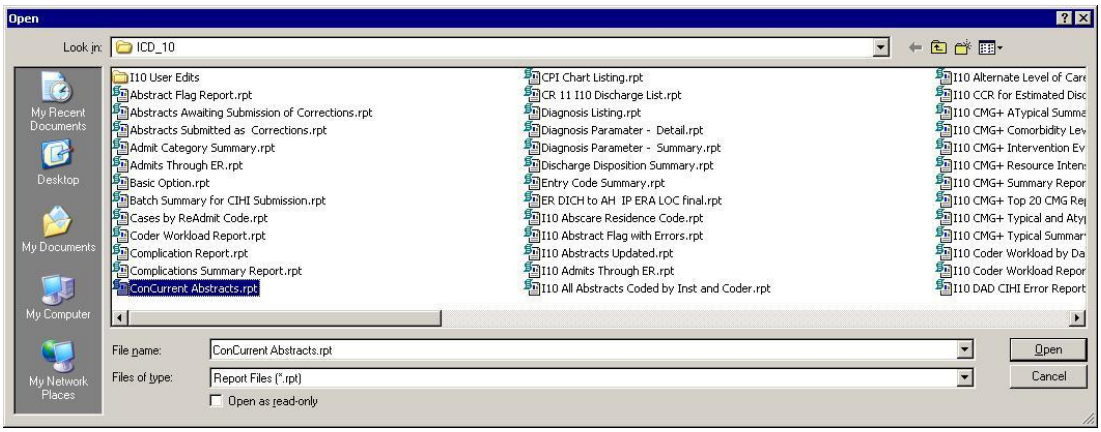
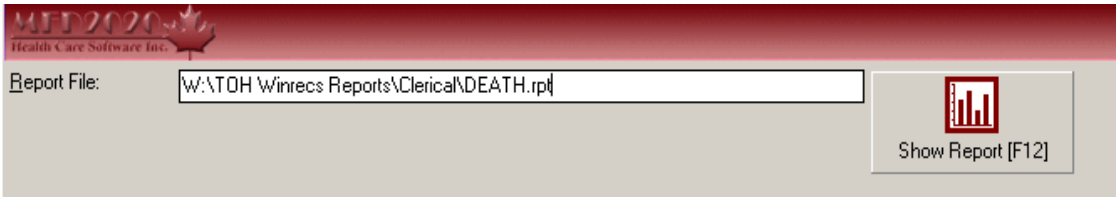


Select the report to generate.

When the file has been selected it will show up in the **Report File** field. If the **Report File** field is correct, press **Show Report (F12)** *(displayed in the image below)* to generate the report.



If there are any parameters built in the report, you must select all the **Parameter Fields** and add the appropriate values.

If there is an add button, once the selection is highlighted, press Add to put the value in the Value display box. If you do not hit 'Add' the value will not be reported.

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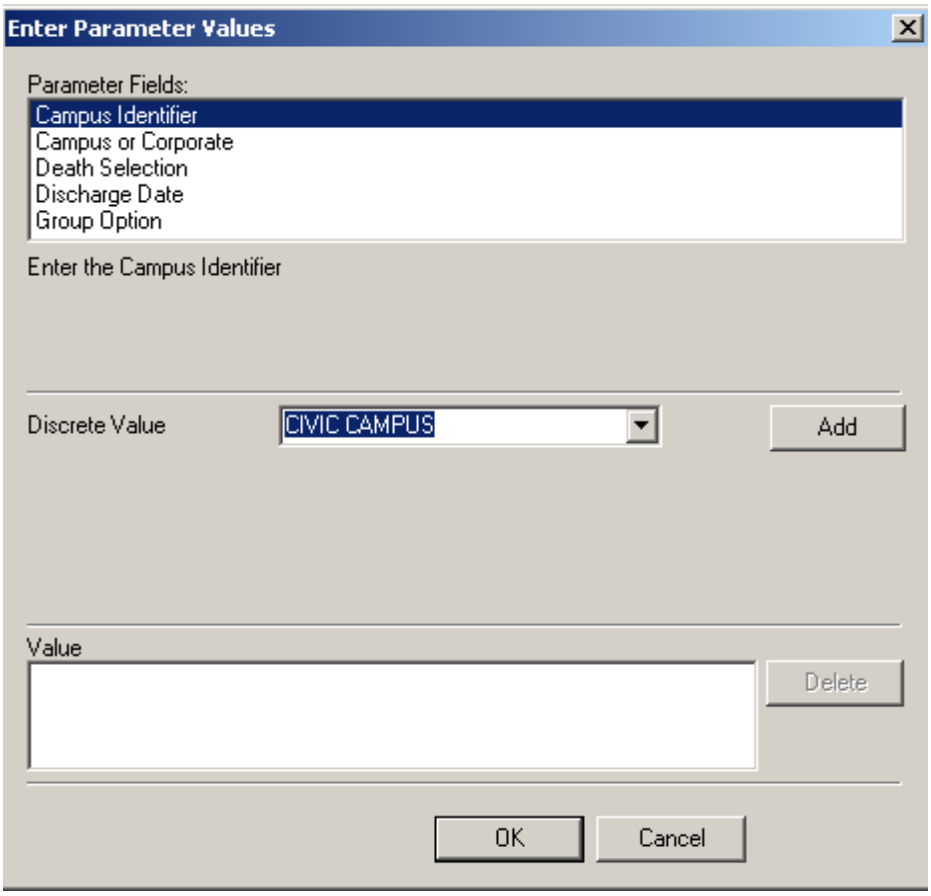

Once all parameters have been answered, press **OK**

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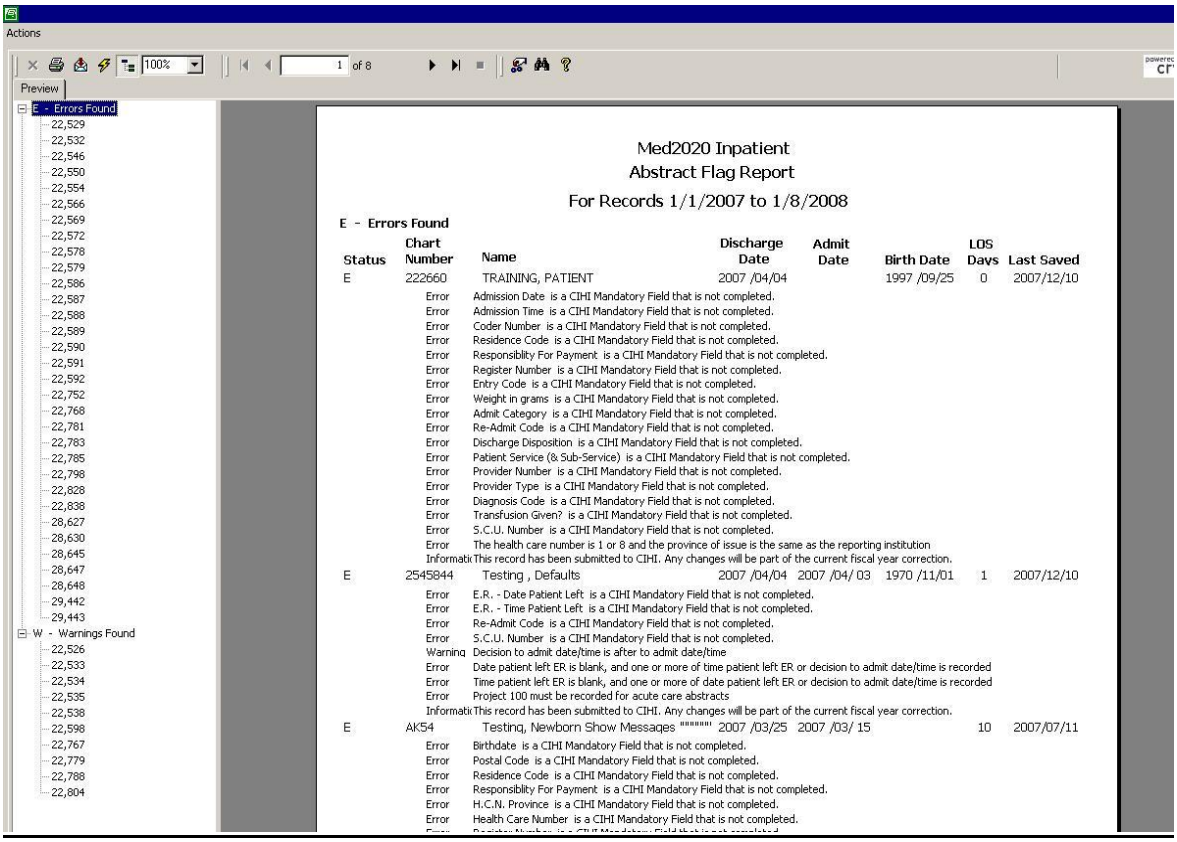

Ref	Description
1	Print icon. Click to print
2	Export Report. E-mail, send report to Disk, etc.
3	Refresh. New parameters can be selected
4	View / Zoom
5	Page indicator
6	Forward one page, or to the end of the report
7	Group reference
8	Body of report

You cannot make any formatting changes to the report, add additional fields or change the sort when

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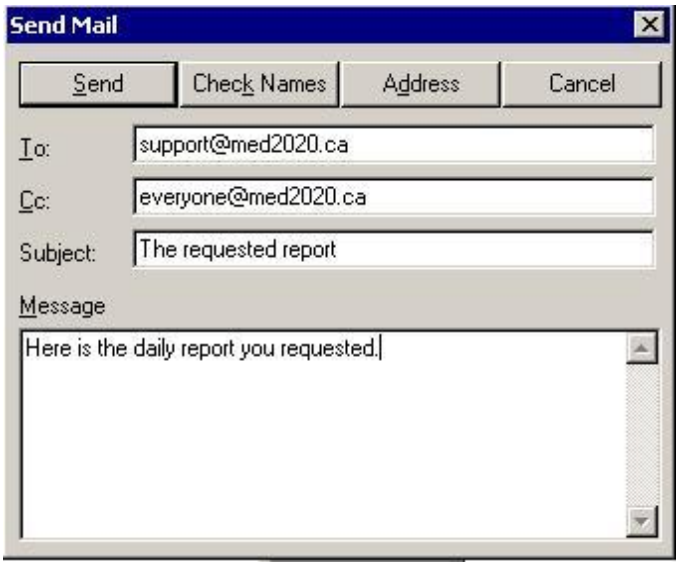
E-mailing Reports

To e-mail a report follow all the steps for generating a report. *(instructions above).*

Click the **Export** icon also on the top left hand corner of the screen.

In the **Export** window, Click the **Format** drop down, and select the type of format the report will be sent.
Then click the **Destination** drop-down and select **MAPI**.
Click **OK**
Select the page range. Click **OK**

Complete the e-mail addresses, subject and message (optional), then click **Send.**



Microsoft Outlook's security will open the following warning message when WinRecs tries to access it to send the report:

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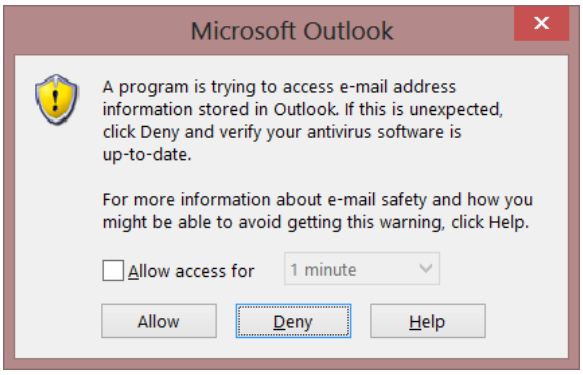

Click the **Allow** button to send your report.

Clicking Deny will return you to WinRecs.

Pre-Designed and System Reports

Pre-Designed Reports:
During installation and training you will have receive “Pre-designed Reports”. These are Crystal Reports ™ developed by Med2020 Support and are available on the ftp site. Updates and/or additional reports are posted to the ftp site at various times and clients notified via the Web Board. The reports are copied where the user can access.

These reports can be used as is or modified in Crystal Reports to extract data from the WinRecs program.

System Reports:
Specific reports, known as System Reports, must be

placed in Reporting folder in the same location as the WinRecs.exe, **or**

placed in the designated path entered in the Report Files Directory located in the Hospital Profile/Regional Profile modules.

The WinRecs Pre-Designed Report Library.xls indicates those reports where this is necessary.

These include:
BI Date Range Errors.rpt
ChartDeficiency.rpt
ChartActivity.rpt
Patient Visit History.rpt
BatchVolumeLabels.rpt
BarCode Label.rpt
Deficiency Letter Level 1.rpt
Deficiency Letter Level 2.rpt
Deficiency Letter Level 3.rpt

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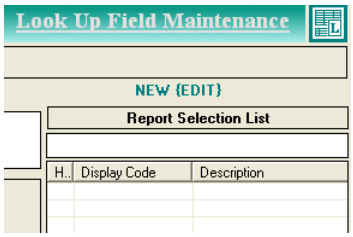
WinRecs Pre-Designed Report Library.xls:
Along with the reports, the WinRecs Pre-Designed Report Library.xls, is maintained on the ftp site and provides a brief description of each of the reports.

Running Reports through WinRecs

Report Selection List

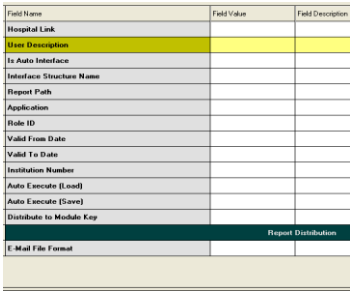
This lookup table is used to define how users access and distribute reports in any of the modules. This allows immediate access to reports for the module without having to go to the Report Generator module.



To create a Report Selection List, follow the steps below:

Go to System Maintenance\Lookup Maintenance.

Press **Find** **(F4)** to display all Look Up Fields
Select Report Selection List from the list of available lookup tables.
Hit ENTER and all the reports set up will display.



To add a new report press **New** **(F5)**
Type the Report Name in the User Description. This is user defined.
Specify the Report Path. Press **(F2)** to browse for the report.
Press **ENTER** once selected.
Specify the application, press (**F2)** and then select the module from the displayed list.
Specify a *Role ID* if required. If a Role ID is entered, only the coder number in this field will see the report on the Report Selection list in the module.
Specify *Valid From* and *Valid To* dates.

WinRecs can be configured to automatically send a report to the workstation's default printer or screen.

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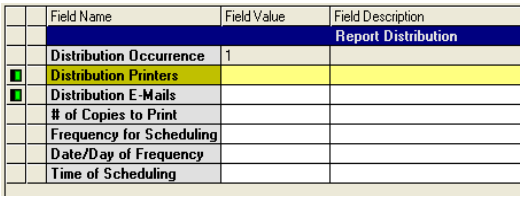
Note: Due to Microsoft Outlook security settings, reports that are scheduled to be automatically emailed will not send until a user manually clicks Allow in the Outlook warning screen to let WinRecs access email.

Modify the AutoExecute (load) or AutoExecute (save) fields to specify how reports will behave:
- N - No action is performed
- S - Send to Screen
- P - Send to the workstation's default printer

Note: When using the Enable Quick Search options, the AutoExecute (save) is not available.

Report Distribution is a multiform where report recipients are defined and scheduling for unattended report generation configuration.



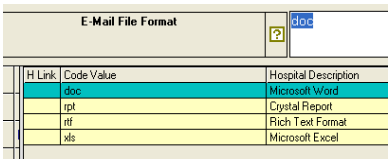
Field Name	Field Value	Field Description
		Report Distribution
Distribution Occurrence	1	
Distribution Printers		
Distribution E-Mails		
# of Copies to Print		
Frequency for Scheduling		
Date/Day of Frequency		
Time of Scheduling		

Specify the printer where the report will be sent.
Type the recipient's email address, if required.
Type a number from 1-99 for the number of copies to be printed.
Press **(F2)** and choose the Frequency for Scheduling from the list:

Daily	Runs every day at the specified time.
Weekly	Runs once a week on the day specified in Date/Day of Frequency, where: 1=Sunday; 7=Saturday
Bi-Weekly	Runs once every two weeks on the day specified in Date/Day of Frequency, where: 1=Sunday; 7=Saturday
Monthly	Runs once a month on the date specified in Date/Day of Frequency. Type 32 to run the report on the last day of every month.

Specify, in Time of Scheduling, the time of day when the report is to be run (**24-hour format**).

Once all the distribution fields have been configured, press (**F12**) to return to the report selection list.



You can set the file format used for emails in the report distribution, press (**F2**) to select the format

Save (F7)

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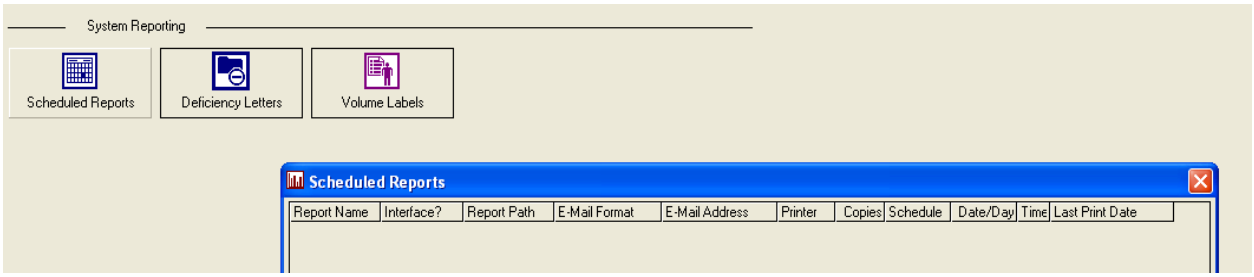
When printing (**F10**) from the specified module, a list of reports will display in the Report Selection List.

Scheduled Reports

Once reports have been set up to run unattended in the Report Selection List the *Report Generator* module **must** be open on a workstation.

Click the *Scheduled Reports* button to display a list of all scheduled reports.

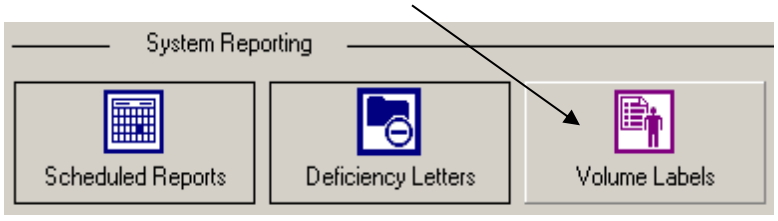


Note: This workstation must remain at this screen in order for the reports to run.

Hint: You may want to set up a dedicated user, with limited WinRecs permissions, to run Scheduled Reports.

Printing Batch Labels

To print a batch of labels, go to WinRecs Application Menu\Report Generator. Click on **Volume Labels** button displayed below.



The following screen will appear displaying the Hospital Link, Chart Number, Volume Number the Patient's Name, Date From/To.

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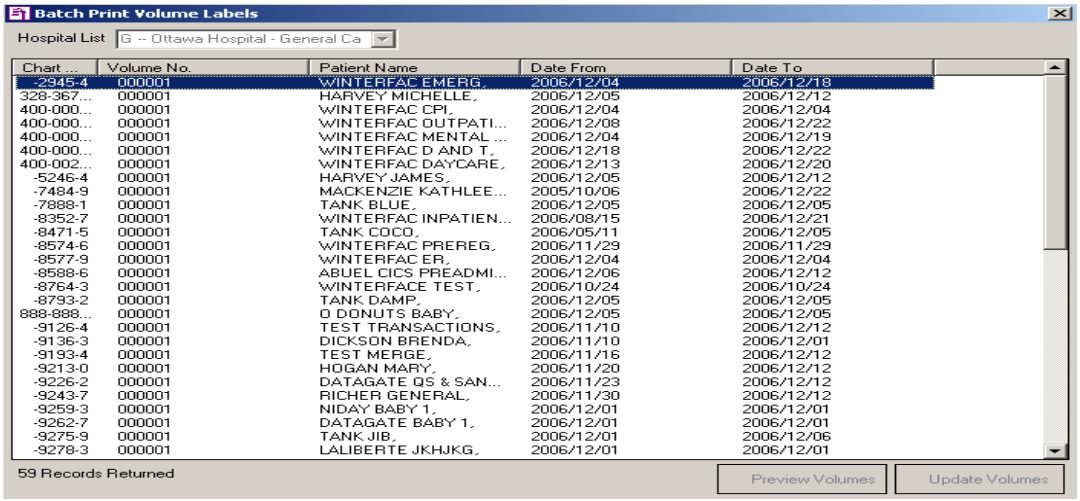
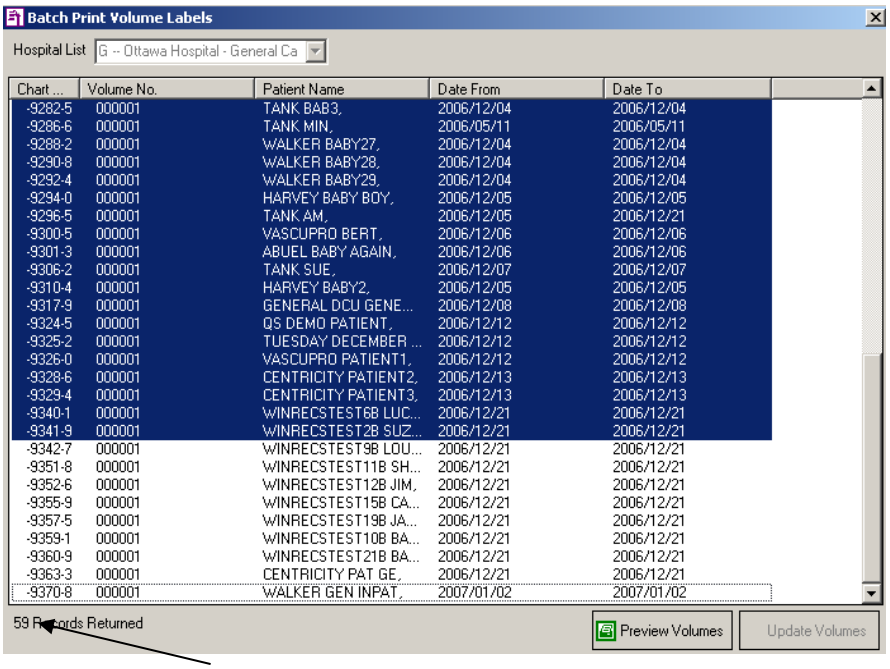


WinRecs allows you to select a maximum of 50 labels at a time. WinRecs will cut you off if you exceed the selection of 50 labels. Select the label (s) to print.



The bottom of the screen identifies how many labels are in the queue to be printed.

Click Preview Volumes button once the 50 labels have been highlighted in **blue**.

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Click Print on the top left hand corner of the screen.
\

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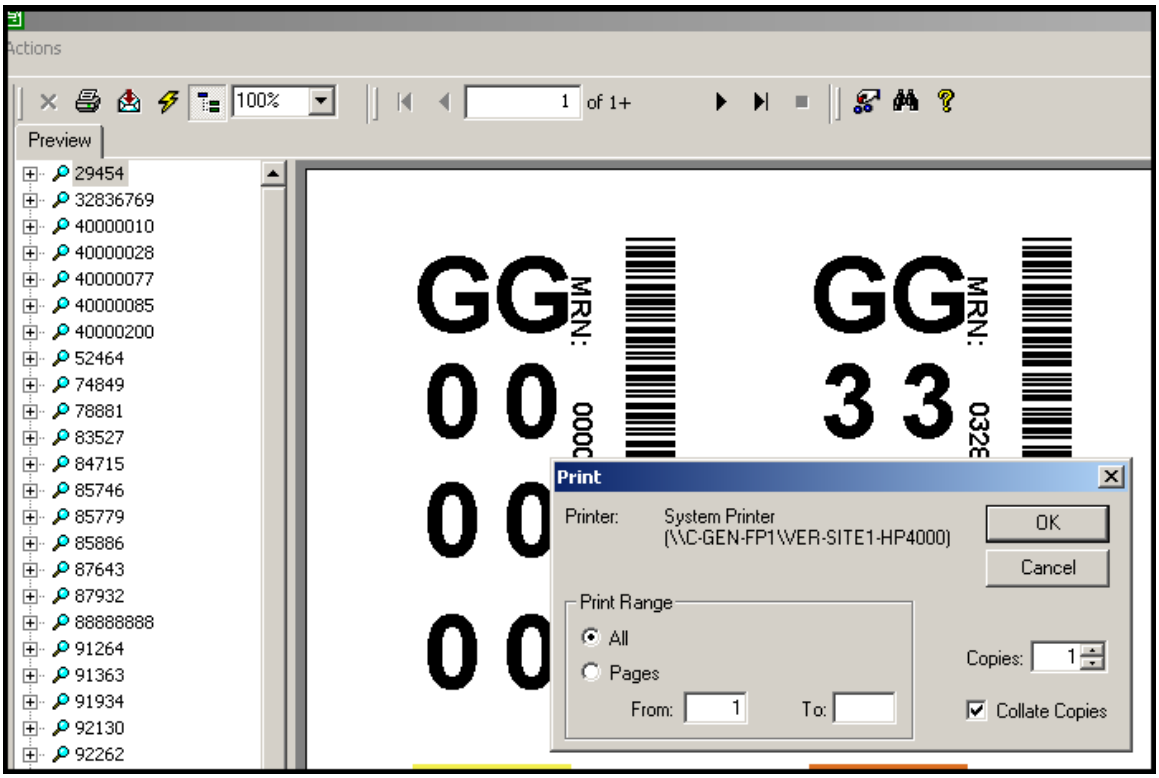

Close the **Batch Print Volume Labels** screen once the labels have successfully printed.

Ensure the label print job is successful before selecting **Update Volumes** button. Once Update Volumes has executed it cannot be reversed. Re-printing of the label in this case would have to be initiated manually (singularly).

If there are more labels to print, Click **Update Volumes** button to display the remainder of the volume labels that need to be printed. (Again, see the Note above re confirming that you have a successful print job first.)

Note: To edit the report data, Crystal Reports must be installed. Refer to your Crystal Reports user guide or online help for more information on working with Crystal Reports.

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9 WinRecs Regional Solution

Introduction

WinRecs version 2.8.4 introduces the implementation of the Regional Solution. Many of the new Regional features must be licensed with MED2020 before they are available for use.

This section of the document provides an overview of the characteristics of the Regional Solution. If applicable it also identifies the impact of licensing on other modules.

A regional solution is defined as a WinRecs implementation for a group of hospitals or sites using a single WinRecs installation. In this environment, each hospital can store and work with patient data independently from other sites in the regional solution. Regional users can be defined for situations where a user, regardless of physical location requires access to records belonging to a different site.

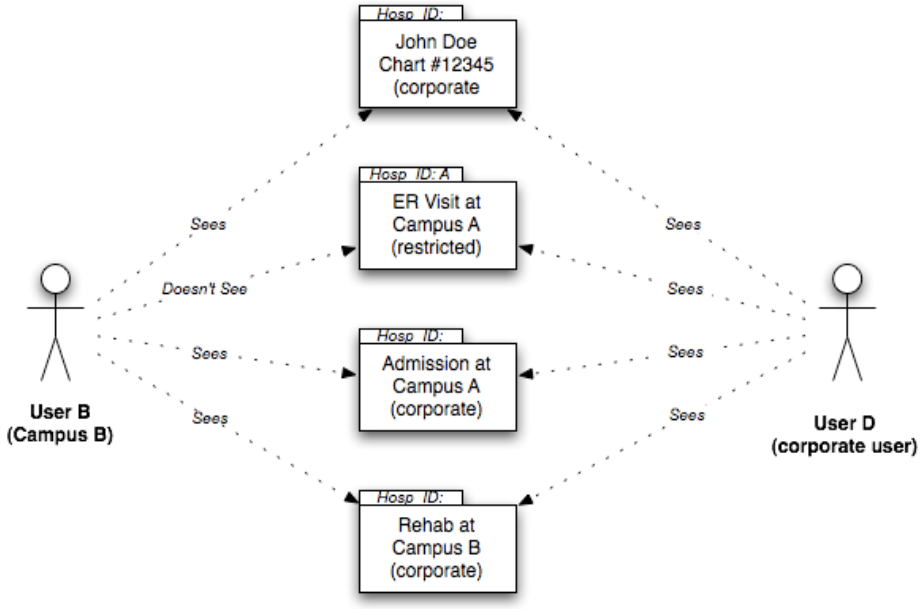
This environment allows global ("Regional") records (for example, CPI records) to be seen at all Hospitals) and permits each Hospital to code abstracts specific to the site.

For example, the group of hospitals named My Group has three different Hospitals (Hospital A, Hospital B and Hospital C).. The WinRecs system has three active users, named User A, User B and User C, each established for the corresponding Hospital. These users shall be referred to as "Site Users " A fourth User D ("Regional User") is also defined.

WinRecs contains records that are Regional and site-specific. When a record is Regional, all WinRecs users, including those established as site-specific, can see these records.

Throughout this document, references to Hospital ID will be made. This field represents the specific site a record is assigned. If *Hospital ID* is not defined (blank) in a record it is a Regional record

User A can see all Regional records and those records restricted to Hospital A. User A cannot see records restricted to Hospital B. User D (Regional user) can see all Regional records and records restricted to Hospital A and Hospital B.



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Using the Regional Solution

The Regional Solution is driven by the the Hospital ID field. This field links a record or user to a specific site. The differences between a standard and a regional implementation are described in the sections below.

Toolbar

Two toolbar buttons are available to Regional WinRecs implementations:

Icon	Description
	This button is used by site users to temporarily escalate the access level to a Regional user By default the button with a red dot is displayed. When the permissions are escalated, the green dot display. (**See 'Escalating Permissions' for more information**).
	This button identifies a user that has escalated permissions. When the permissions are revoked when the user opens a new record or changes modules, the red dot will be displayed. (**See 'Escalating Permissions' for more information**).
	This button is used by Regional users to change the access to a site specific user.

Sidebar (Information Panes)

Sidebar Information Panes such as Patient Visit History and Record Update History display the *Hospital ID* in the first column. This value is used to identify the site the entry is applicable. If blank the record is a Regional entry

Main grid

CPI and abstracting records display the field *Hospital ID*. The field determines if a record is site-specific or Regional (blank).

Searches and Lookups

Search windows and lookup tables include the *Hospital ID* field. When using Look Up (F2) or Search (F4) users will see their site specific as well as those designated as regional

Lookup Tables

Lookup values (**F2**) display the Hospital ID to identify the site the record belongs. If this value is blank the record is Regional. Regional table entries can be viewed by all users.

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Creating New Records

A site user cannot create records for another site.

When a Regional user creates a record, a dialog will be displayed to allow the Regional user to specify which site the record will be created. All settings, searches and lookups for the site the record was created will be active.

The *Hospital ID* field is automatically populated with the site that corresponds to the value configured in the *Institution ID* field.

Modifying Existing Records

To make a record site-specific, and restrict access to Regional users and those of the same site, configure the Hospital ID field of the record with the appropriate value.

Searching for Records

When a user performs a search, the results are limited by the *Hospital ID* configured in the record.

Only those records the current user has access to (records configured with the same *Hospital ID*, or records with no defined *Hospital ID* (Regional)) will be displayed.

Temporarily Changing Permissions

There might be times when a Regional user must code a record that is site-specific or a site user must have escalated permissions.

Escalating Permissions

Users in a regional solution may be configured to be site-specific so that they do not have access to other sites' records. However, there will be occasions when a site-specific user will temporarily require access to records from other sites.

The setting in User Profile – "Can Show All Regional Data" must be set to 'F - Full Access' which would allow the user to modify a record, or 'R – Read-only' which would allow the User to view the data.

Using **Show All Regional Data** (a green dot shows in the icon), a site-specific user can temporarily obtain Regional user permissions.

Temporary Regional status is reset when:

The User logs out

Clicks **Show Regional Information** (a red dot shows in the icon).

A new module is opened

The User opens another record

Note: This button is disabled when a Regional user is logged in.

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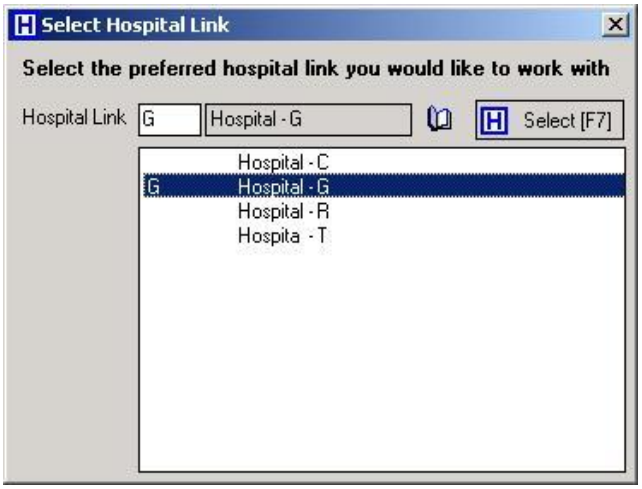
Note:	**The record must be refreshed after escalating permissions.**
Note:	**When you escalate your permissions using this feature, an event is recorded in the Audit Trail module.**

Temporarily accessing another site

Using the *Select Hospital Link* toolbar button, a site-specific user can temporarily obtain Regional user permissions.

Note:	**This button is disabled when a site user is logged in.**

Click the *Select Hospital Link* toolbar button to select a site. The *Select Hospital Link* window will be displayed.



Press **Look Up (F2)** to open the hospital lookup table and select a site from the list.

Press **Select (F7)** or click the button to confirm the selection.

The selected site will now be used as the site for searches, coding and lookups until:

- The user opens a new chart
- The user opens a new module
- The user logs out of WinRecs

Viewing Regional Information

There will be occasions when a site-specific user will temporarily require access to records from other Hospitals.

Clicking on the **Show All Regional Data** toolbar button so that it turns green, allows a site-specific user to temporarily obtain Regional user permissions.

After clicking on the **Show All Regional Data** toolbar button, it is important that you refresh your screen by clicking on the **Find** icon or press **(F4).**

You will remain in Regional status until:

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- You open a new chart
- You open a new module then you log out of WinRecs

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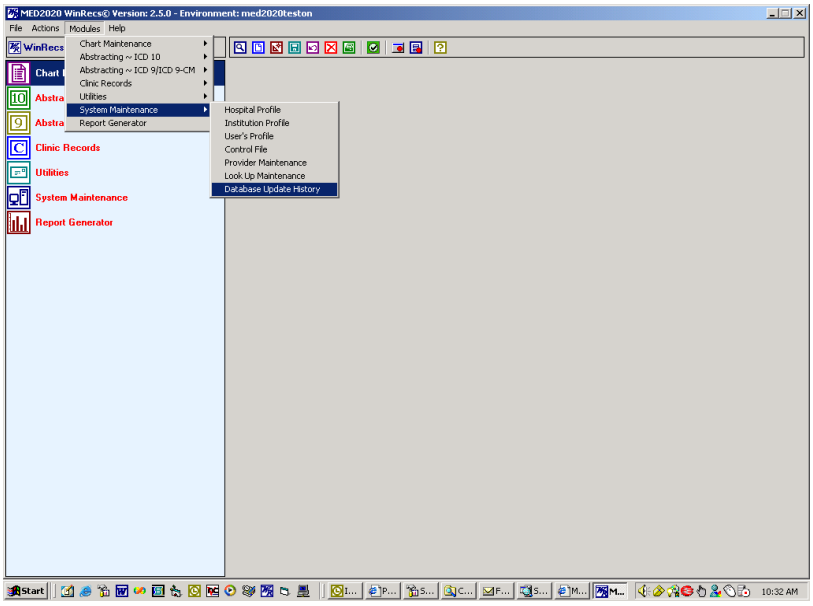
10 Updates and Patches

Running Updates from WinRecs

Download the update to a directory that you have access to.
If the update has a looks like <filename>.zip, unzip it to the directory you downloaded it to.
Log into WinRecs.
Using the Menu Bar, select **Modules \ System Maintenance \ Database Update History**



A list of all previous updates will appear. Click **Run Database Update**
Go to the directory that you downloaded the file to.
Select the file and click **Open**

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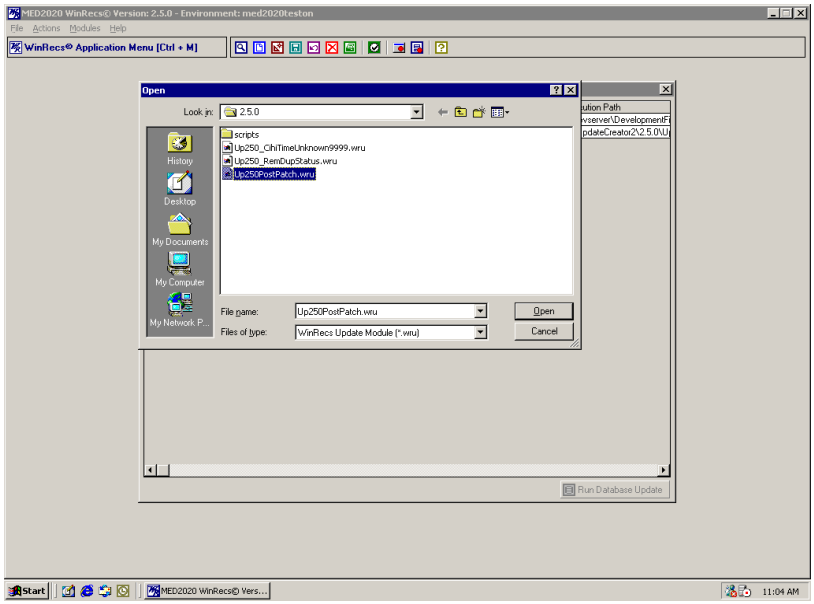
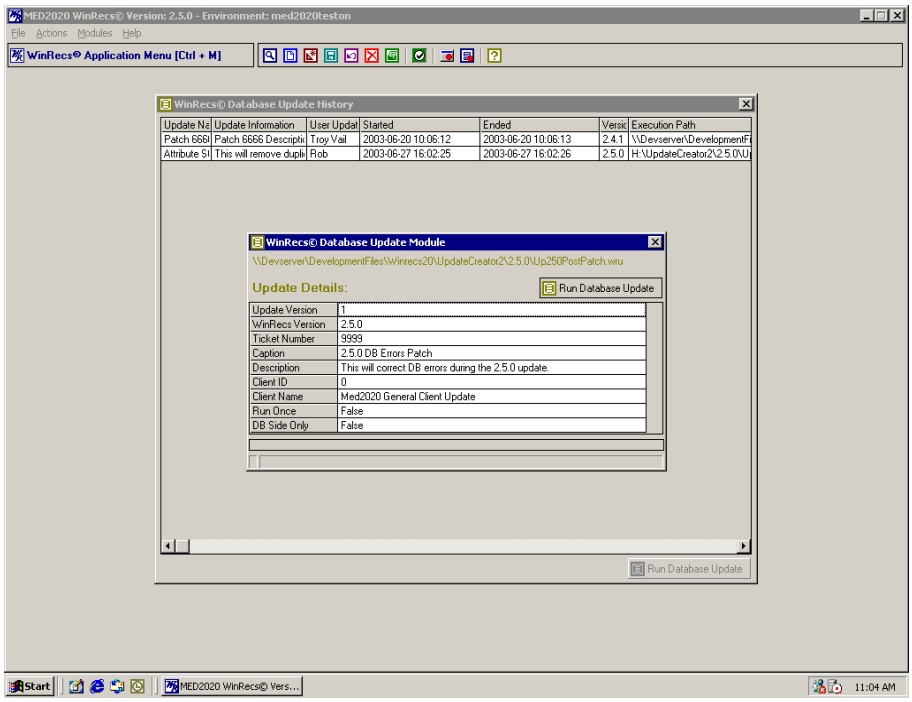


A details window will appear that will let you know about the patch you are running. Click **Run Database Update**.



After the update is complete close the details window and you will see the update you have just run in the list of updates.

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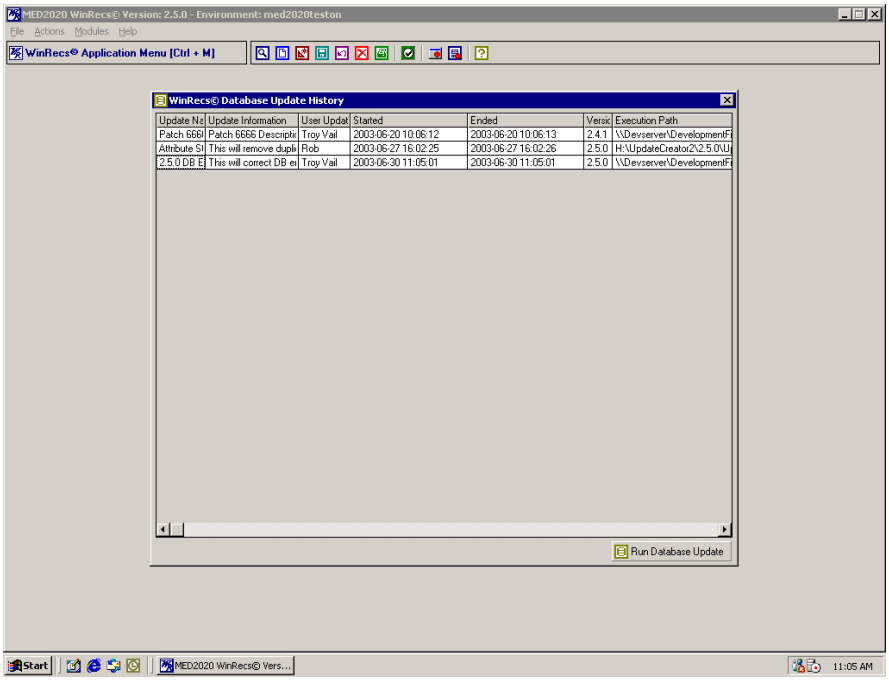

Close the Database Update History Window and log out of WinRecs.

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11 Additional Modules

Audit Trail

Overview

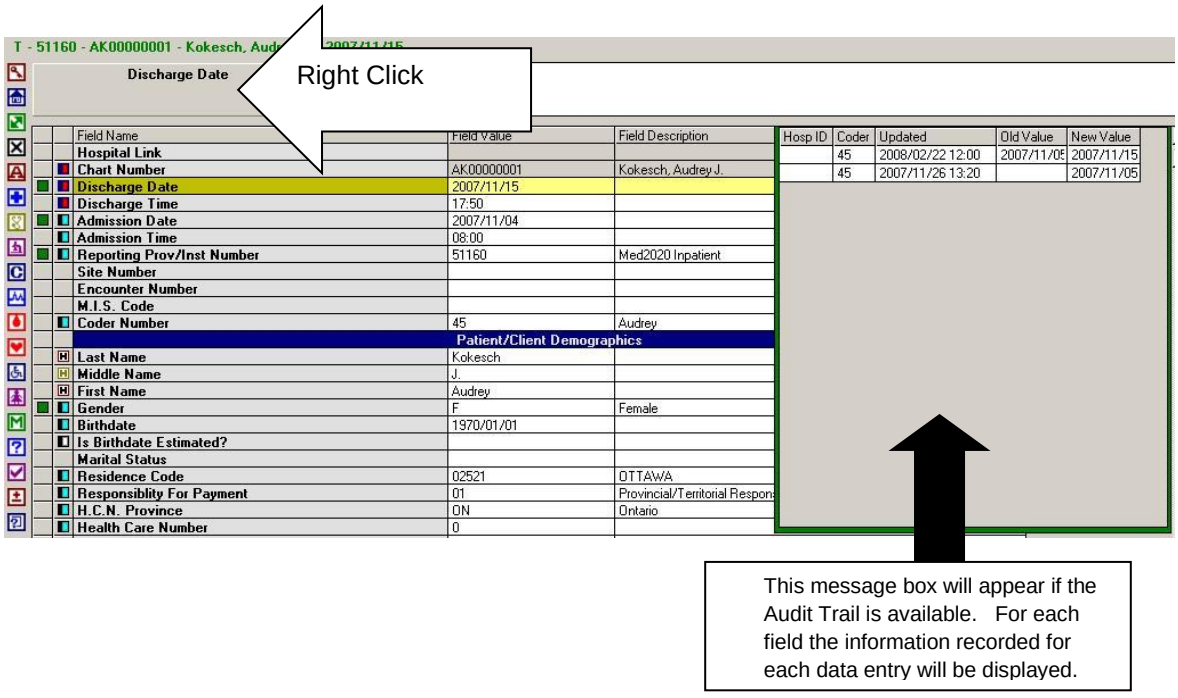
This module will enhance the security features built into the data entry modules. WinRecs tracks all searches, accessed records, changed records and unsuccessful login attempts as required by Provincial and Federal personal health information protection acts.

System Administrators can run audit reports through MED2020 Standard Crystal™ reports or modify them for their own reporting requirements.

A label indicating whether the Audit Trail module is installed on your system can be verified within WinRecs by going to Help and selecting About.

If Audit Trail is enabled it will display - Audit Trail Enabled: Yes
If Audit Trail is not enabled it will dispaly - Audit Trail Enabled: No

Right Click on the Field Name box to the left of the Data Entry box. This will activate the display showing a field audit for every change made to the data in the field. This includes the old and new values saved for each field.



WinRecs Pre-Designed Reports Library - Audit Trail Folder

The advantage to having the Audit Trail module is the ability to report on how the data has been managed in the abstracting module. The Pre-Designed reports allow the user to monitor all searches, accessed records, changes, logins, etc. These reports can be used as developed, or modified to suite individual requirements.

There are additional views required to report on data management.

Note: Sec_LoginAudit_VR and Sec_SubmissionAudit are available to all clients. All other Sec_* views are controlled by CD Key

Report Name
Chart Update Audit by Chart
Chart Update Audit by User
ChartViewSaveHistorybyUser
CPI Search with Chart Number Detail
CPI ViewSave History by User
Database Search Audit Trail
Deleted Abstracts
I10 Abstract Search with Chart Number Detail
Login Audit
Login Audit_No Password Display
Report Execution History
Submission Audit by Application

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PAC10

Executive Summary

Note: PAC10 was discontinued in 2010. Ontario values are now captured using HBAM Inpatient Grouper and CACSON grouper.

The Province of Ontario applies relative cost weights to acute inpatient activity submitted to the Canadian Institute of Health Information's (CIHI) Discharge Abstract Database (DAD) for a variety of purposes. The introduction of the International Statistical Classification of Diseases and Related Health Problems - Tenth Revision, Canada (ICD-10-CA) and the Canadian Classification of Health Interventions (CCI) in Ontario introduces changes in Case Mix Group (CMG™) assignment. Statistical methods are used to identify affected CMG. Relative cost weights are developed for use in Ontario to be applied to 2002/2003 DAD acute inpatient activity. The new relative cost weights are known as PAC-10 to reflect their application to ICD-10-CA and CCI activity. Recommendations regarding their application to weighted cases are provided."

Taken from
http://www.health.gov.on.ca/english/public/pub/ministry_reports/cost_weights_fim/pac10_desc.html

MED2020 provides the PAC10 RIWs to purchase, in conjunction with the CMG and DPGs (using CACS). If the PAC10 is active, the MOH values in the CMG Grouper Sidebar will indicate PAC10 values.

WinRecs Pre-Designed Reports Library PAC10 for CMG and DPG

There are also reports available when this is purchased and installed.

Report Name
ICD10 PAC 10 Full Chart Details CR8
ICD10 PAC 10 Stats Report by Grouping CR8
ICD10 PAC 10 Stats Report Top 50 CMG or MRDX CR8
ICD10 PAC 10 Stats Report Top 50 Interventions CR8

ICD10 PAC 10 DPG Full Chart Details CR8
ICD10 PAC 10 DPG Stats Report by Grouping CR8
ICD10 PAC 10 DPG Stats Report Top 20 DPG CR8
ICD10 PAC 10 DPG Stats Report Top 20 Interventions CR8
ICD10 PAC 10 Day Surgery Full Chart Details CR8.rpt
ICD10 PAC 10 Day Surgery Stats by Top 20 CACS CR8.rpt
ICD10 PAC 10 Day Surgery Stats by Top 20 Interventions CR8.rpt
ICD10 PAC 10 Day Surgery Stats with Group Option CR8.rpt

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Appendix A

CPI Navigation Buttons

Icons	Menu Item	Function
	Central Patient Index Record Key	Displays the patients chart number and the date of their last visit.
	Patient/Client Demographics	Displays demographic information such as; birth date, first and last name, address etc. Patient Demographics information comes from the ADT SYSTEM or by an HL7 interface.
	Alternate Names	Displays any other names the patient may previously have used. Patients Alternate Names comes from the ADT SYSTEM or by the HL7 interface, or may be manually entered.
	Contact/Address Information	Displays contact information for next of kin or family physician. This information comes from the ADT SYSTEM or by the HL7 interface, or may be entered manually
	Chart Links	Displays how many linked charts there are for this patient, the linked chart number and the type of chart that is linked. These are created when charts are merged.
	Baby Charts	Displays baby charts connected to the patient. The baby chart will be populated from the mothers abstract.

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WinRecs Icons

Icon	Menu Item	Keyboard	Function
	WinRecs Application Menu	**[Ctrl + M]**	Displays a drop-down menu of all the modules.
	Find	**F4**	Search for a record
	New	**F5**	Creates a new record
	Edit	**F6**	Makes changes to a record.
	Save	**F7**	Saves changes to the current record.
	Cancel	**F8**	Cancels changes made to record since the previous save. Warning prompt will display. In Chart Deficiency module, F8 Creates a New Provider to attach deficiencies to the Visit.
	Delete	**F9**	Deletes the current record. A message prompt will appear “You are about to delete this record? Do you wish to proceed?” If you delete an abstract, the record will be found in the Utilities\Purge module. It must be deleted from this module for it to be permanently deleted from the database. If you delete an occurrence in a multiform, this will not go to the Purge module.
	Print	**F10**	Prints a module dedicated report. This is configured using the Report Selection List
	PDF viewer	**N/A**	Opens the Windows Explorer folder allowing you to view PDF files stored on the PC or Server (see Accessory File Directory)
Red	Suppress Regional Data	**N/A**	View data for your Hospital only. *(Clicking this icon changes the colour of the dot from green to red)*
Green	Show Regional Data	**N/A**	View data from all of Regional Sites *(Clicking this icon changes the colour of the red dot to green.)*
	Select Hospital Link	**N/A**	Select a specific Hospital so only records from the Hospital selected display.

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Icon	Menu Item	Keyboard	Function
	Verify	**F11**	Verifies the current record. This is applicable for abstracting modules
	Show Message Pop-Up	**F12**	When selected, the error messages appropriate for the entry will show immediately on the screen, rather than showing only in the Error Message Box at the bottom of the grid after saving. Once selected, the button description will be 'Hide Error Messages' Click/toggle to turn the messages off and on. See 'Show Error Message' section below for more information (see detail below)
	Help	**F1**	Opens the WinRecs User Guide.
	Abstract Auto Coding		It is a drop down box with two options: Copy Abstract Profile Clone Abstract. **Note**: *The Auto coding feature can only be used with abstracting modules and not clinical modules.*

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Appendix B

The following table contains a list of icons created for each category and module used in the WinRecs application

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Icons	Category/Module
	Chart Maintenance
	Central Patient Index (C.P.I.)
	Visit History
	Chart Locator
	Chart Deficiency
	Transcription
	Release of Information (R.O.I)
	Clinical Pathways Variance
	Abstracting ICD10
	AmCare ICD10 (N.A.C.R.S.)
	Concurrent Review (CC.R.)
	Inpatient (D.A.D)
	Same Day Surgery (SDS) Rehabilitation (N.R.S.)
	Minimum Data Set 2.0 (MDS 2.0)
	Mental Health (O.M.H.R.S.)
	Cancer Care (CCM)

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	Canadian Joint Replacement registry (CJRR)
	Abstracting ICD 9 – ICD 9 CM (no longer supported)
	Utilities
	•CIHI Submissions
	•CIHI Corrections
	•Incoming Batch Interface
	•Outgoing Batch Interface
	•Reciprocal Billing Submission
	•Batch Grouper
	•Purge / Undelete
	System Maintenance
	•Regional Profile
	•Hospital Profile
	•Institutional Profile
	•User's Profile
	•Control File
	•Provider Maintenance
	•Look-Up Field Maintenance
	Report Generator

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