



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(RPMS-EHR)

Setup Guide

Version 1.1 Patch 6
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Preface

This document provides a review of the new features for RPMS-EHR, Patch 6.

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1.0 Introduction

This document provides an overview of RPMS EHR 1.1 Patch 6 and assumes that the site has already completed the setup for RPMS EHR 1.1 and has loaded patches up to Patch 5.

PLEASE thoroughly review this manual, patch notes, and requirements

2.0 Problems Identified with Interim Solutions and Timeline for Fixes

The following problems were identified during EHRv1.1 Patch 6 testing. Problems, interim solutions and fixes are listed for your information.

2.1 Medication Reconciliation Lists Using Outside Meds Component

This section provides information about the problem, interim solution, and fix.

2.1.1 Problem

When users omit a dosage OR enter a non-standard dose, the resulting medication entry does not pass to the PCC V Medication file and will not display on the Patient Wellness Handout or Health Summaries.

The medication entry DOES display on the TIU Medication objects and DOES participate correctly in order checking

2.1.2 Interim Solutions

Use Case 1 OR Case 2, as shown below.

Case 1: Print the medication lists from the Medications tab. You will need to print the Outpatient Medications and the Outside Medications separately.

OR

Case 2: Use the PREVIEW/PRINT functionality in TIU to provide a list for your patients. You may use one of several TIU objects for display. See SET UP section 3.1.2.

Examples:

```
[ACTIVE MEDICATIONS |
|MEDS CHR,ACT,HOLD,EXP |
|MEDICATION RECONCILIATION |
```

Figure 2-1: Examples of interim solutions

You do not need a visit created nor do you need a note selected.

On Notes tab, click Template. Then right-click on desired template and select Preview/Print | Print.

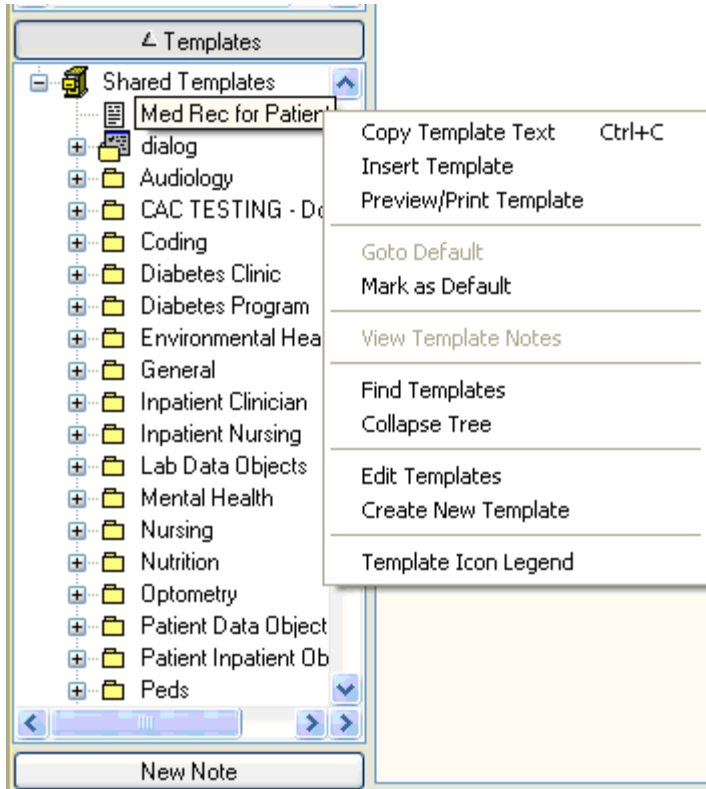


Figure 2-2: Options on right-click menu

After selecting the Print option, the output will occur.

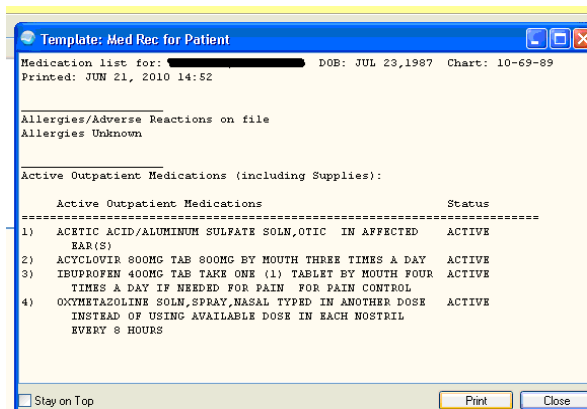


Figure 2-3: Sample output

2.1.3 Fix

PCC will add lookups to include outside med entries that do not cross to V Med. This will be included in BJPC 2.0 patch 5 in development currently. A problem was

identified in the trigger to pass the information to V Medication in the PCC Link of the Pharmacy Patient file. This will be fixed in APSP 7.0 p1009 currently in beta testing.

2.2 Auto-finish of renewed medications does not auto-discontinue the original order

This section provides information about the problem, interim solution, and fix.

Note: This only affects sites that do not have an in-house pharmacy and choose to implement auto-finish via the Print button.

2.2.1 Problem

Renewed medications do not discontinue the original order when auto-finished. Furthermore, the original order that was renewed cannot be discontinued from the EHR Medication or Order tab.

2.2.2 Interim Solution

Discontinue is possible through the RPMS Pharmacy package. Alternately use the “change” function.

Note: Strongly consider delaying implementation of auto-finish until APSP 1009 is released which contains the fix for this problem. This patch will enter beta testing when EHRv1.1p6 is released and should be generally released in two months or less.

2.2.3 Fix

APSP 1009 (anticipated release 2 months or less after EHRv1.1 Patch 6 release) will fix this bug.

2.3 Electronic button

The Electronic button has been enabled on med order dialog when right-click drop-down menu is used for Change or Copy

This section provides information about the problem, interim solution, and fix.

2.3.1 Problem

EHRv1.1 Patch 6 delivers some infrastructure in advance of e-Prescribing which will be delivered in EHRv1.1 Patch 8. The electronic button is visible and not active (subdued) appropriately when the Process function is accessed. A small bug is present in the software that exposes the electronic button when Change and Copy are selected through the right click drop down menu. Users who click “electronic” will see a “pharmacy” selection box. Users cannot utilize this functionality because the system is not yet set up for actual transmission of prescriptions.

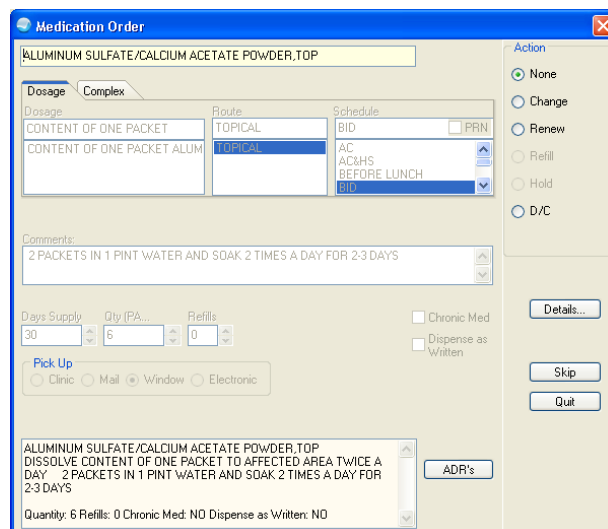


Figure 2-4: Correct display with electronic visible but subdued

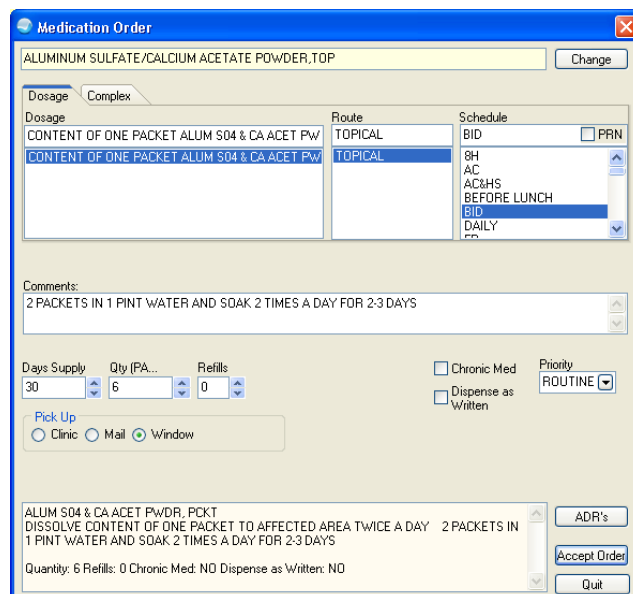


Figure 2-5: Correct display with electronic removed from display when CHANGE selected

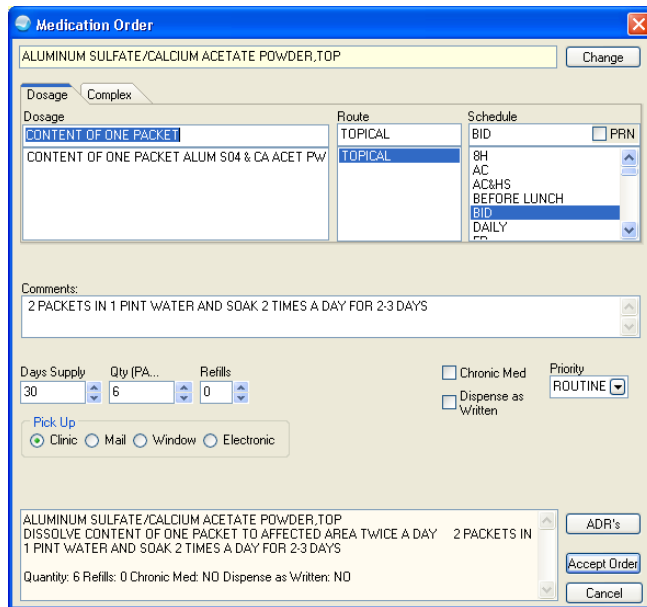


Figure 2-6: Incorrect display with electronic button is active when Change or Copy is selected from right click dropdown menu

2.3.2 Interim Solution

Instruct users to ignore the electronic button. It is not set up for use, so users will be presented with blank pharmacy selection box and will be unable to proceed.

2.3.3 Fix

EHRv1.1 Patch 7 will correct the behavior on the right click dropdown menu. EHRv1.1 Patch 8 is scheduled to deliver e-Prescribing functionality.

2.4 Infant Feeding and Reproductive History

Clear is not working correctly on Infant Feeding and Reproductive History components.

This section provides information about the problem, interim solution, and fix.

2.4.1 Problem

The Clear function leaves the data visible on the Infant Feeding and Reproductive History dialogs. NO patient identifying data is present.

2.4.2 Interim Solution

Use the Clear & Lock function so the display is minimized.

2.4.3 Fix

The fix will come in a future EHR patch. This problem is in the queue and will most likely be corrected in EHR v1.1, patch 7 or 8.

2.5 Historical Services Narrative Display

This section provides information about the problem, interim solution, and fix.

2.5.1 Problem

The narrative on the EHR display does not wrap when the column width is decreased.

2.5.2 Interim Solution

Encourage the use of succinct narratives.

2.5.3 Fix

The fix will be in a future EHR patch. This fix is in the queue but is not scheduled for a specific patch at this time.

2.6 Family History Narrative Display

This section provides information about the problem, interim solution, and fix.

2.6.1 Problem

The narrative on the EHR display does not wrap when the column width is decreased.

2.6.2 Interim Solution

Encourage the use of succinct clinically relevant narratives.

2.6.3 Fix

The fix will be in a future EHR patch that will include wrapping for display and enhanced look-up/selection for conditions. This fix is in the queue but not scheduled for a specific patch at this time.

2.7 Patient Education Outcomes/Standards Display

This section provides information about the problem, interim solution, and fix.

2.7.1 Problem

The narrative does not wrap and impairs readability.

2.7.2 Interim Solution

None.

2.7.3 Fix

The fix will be in a future EHR patch that will include wrapping for display and enhanced look-up/selection for conditions. This fix is in the queue but not scheduled for a specific patch at this time.

2.8 Order Detail and Order Summary on Outside Med Entries

This section provides information about the problem, interim solution, and fix.

2.8.1 Problem

The visit context provider displays as “documented by” or order detail and “requested by” on order summary.

2.8.2 Interim Solution

None. The data stores properly in Order file; the display needs to be adjusted on the order detail. IHS Reports and EHR display fine.

2.8.3 Fix

The fix will be in a future EHR patch that will include an updated order detail display.

2.9 Provider Narrative

The Provider narrative is stored as text instead of a pointer field when entered through the Clinical Reminder dialog.

This section provides information about the problem, interim solution, and fix.

2.9.1 Problem

If the site has added ICD9 codes as FINDINGs or ADDITIONAL FINDINGs in clinical reminders, the provider narrative is being stored as text and not as a pointer field. This is causing data transmission errors for data going to the DATA WAREHOUSE.

2.9.2 Interim Solution

None.

2.9.3 Fix

This will be fixed in patch 7 and a clean-up utility run to change the entries to the correct pointer.

3.0 Setup Checklist

The information in this section shows the requirements prior to loading RPMS-EHR, Patch 6.

- VA Kernel v8.0 or later
- VA FileMan v22.0 or later
- Cache v5.0 or later
- EHR*1.1*5
- APSP*7.0*1008
- IHS PCC SUITE 2.0, patch 1,2, and 4

EHR Patch 6 provides fixes for the issues raised when IHS PCC SUITE 2.0 was installed in the PCC components of the EHR. This patch did not address the same issues in Reminders. Those will be addressed in a later patch.

The checklist provides guidance for preparation and set up – please refer to individual sections for each fix and enhancement for details.

3.1 Preparation for EHR v1.1 p6

The following are to be prepared for patch 6.

3.1.1 Add Users Needed as Signers on TIU Notes

ALL SITES users who will become additional signers on TIU notes must be assigned division sign on permissions for each division another user may select them as additional signers even if you have only 1 division.

- If you have users in Division A who need to be selected as additional signers for note in Division B, then that user needs sign on access to both division A and B.
- If you only have Division A, then the user needs to be assigned Division A to be selectable as an additional signer in Division A.

The provider list on the additional signer dialog currently is limited to active providers within the current division.

This change was needed to support future updates to the RPMS-EHR suite of application.

Description: Prepare list of users and their log on divisions using the General Fileman SEARCH option.

Who Should Perform?: CAC/Site Manager

Instructions:

```

Select FileMan (General) Option: s
  1  Search File Entries
  2  Statistics

CHOOSE 1-2: 1  Search File Entries

OUTPUT FROM WHAT FILE: NEW PERSON//

CHOOSE 1-4: 4  DISUSER
  -A- CONDITION: null

  -B- SEARCH FOR NEW PERSON FIELD:

IF: A//      DISUSER NULL

STORE RESULTS OF SEARCH IN TEMPLATE:

SORT BY: NAME// SERVICE/SECTION
START WITH SERVICE/SECTION: FIRST//
  WITHIN SERVICE/SECTION, SORT BY: NAME
    1  NAME
    2  NAME COMPONENTS
CHOOSE 1-2: 1  NAME
  START WITH NAME: FIRST//
  WITHIN NAME, SORT BY:
FIRST PRINT FIELD: NAME;L15
  1  NAME
  2  NAME COMPONENTS
CHOOSE 1-2: 1  NAME
THEN PRINT FIELD: SERVICE/SECTION;L15
THEN PRINT FIELD: DIVISION      (multiple)
  THEN PRINT DIVISION SUB-FIELD: DIVISION;L30
  THEN PRINT DIVISION SUB-FIELD:
THEN PRINT FIELD:
Heading (S/C): NEW PERSON SEARCH//
STORE PRINT LOGIC IN TEMPLATE:
DEVICE:  Virtual

```

```

NEW PERSON SEARCH              JUL  2,2010  12:15    PAGE 1
NAME                SERVICE/SECTION          DIVISION
-----
TEST,CHRISTINA  ADMINISTRATION  YAKAMA HEALTH CENTER IHS
                                                    WHITE SWAN
                                                    WAPATO
                                                    YAKAMA TRIBAL PROGRAMS
                                                    WHITE SWAN
DENTAL CLINIC
TEST,MARY      ADMINISTRATION  YAKAMA HEALTH CENTER IHS
                                                    WHITE SWAN

```

Figure 3-1: Instructions for process

Add at the Select Division prompt in the Edit a User Menu:

```

Cache TRM:4548 (ENSEMBLE)
File Edit Help
Select NEW PERSON NAME:  RICHARDS,SUSAN  SR
                        Edit an Existing User
NAME: RICHARDS,SUSAN                                     Page 1 of 5
-----
NAME... RICHARDS,SUSAN                                INITIAL: SR
TITLE:                                                NICK NAME:
SSN:                                                  DOB:
DEGREE:                                              MAIL CODE:
DISUSER:                                             TERMINATION DATE:
Termination Reason:

        PRIMARY MENU OPTION: ARMOEVE
Select SECONDARY MENU OPTIONS:
Want to edit ACCESS CODE (Y/N):      FILE MANAGER ACCESS CODE:
Want to edit VERIFY CODE (Y/N):

        Select DIVISION: ██████████
        SERVICE/SECTION: MEDICAL STAFF
-----
Exit      Save      Next Page      Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

```

Figure 3-2: Add at the Select Division prompt

3.1.2 Prepare List of EHR GUI Templates

Description: Prepare list of EHR GUI Templates in use. You will want to perform all the EHR GUI changes at one time after the patch is loaded.

Who Should Perform?: CAC/Site Manager

Instructions:

1. Log into vcManager
2. Click on “Templates” tab.
3. Click on Associations. For better visibility collapse the tree by clicking on each – sign.
4. This provides you a list of which EHR VueCentric templates are currently assigned to users.

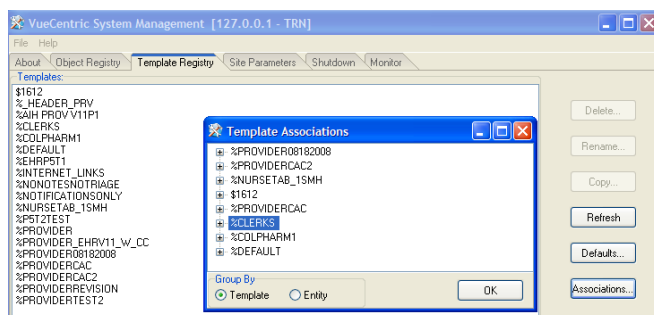


Figure 3-3: Sample templates assigned to user

3.1.3 Prepare Pharmacy Database for Use in Outside Meds Component

Description: Review pharmacy database. Drugs must be marked as “non-VA” to be used. This is done in Drug Enter/Edit and populates field 8 in the Pharmacy Orderable Item file. Many sites have already done this.

Review: Review available “Statements/Explanation” selections delivered at package level and determine if site wants different selection list. Be aware if you override the Package Level parameters, you must recreate the list entirely – the system and division parameters override the package level and are not cumulative (ORDW NONVA REASON parameter).

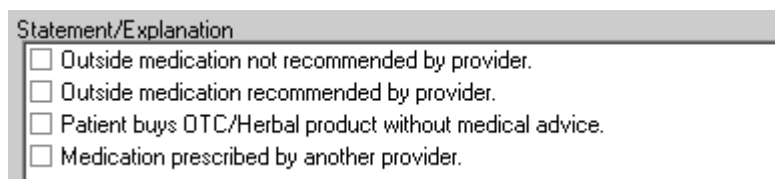


Figure 3-4: Options for reason

Determine if site wants to change the title of the “Outside Medications” component (BEHORX NONVA LABEL parameter).

Who Should Perform?: Pharmacy AdPac.

Instructions:

1. Run the following search in Fileman. This will provide the site a list of Pharmacy Orderable Items that are active but not flagged as “non-VA”.

```
Select FileMan (General) Option: 1 Search File Entries
OUTPUT FROM WHAT FILE: PHARMACY ORDERABLE ITEM//
-A- SEARCH FOR PHARMACY ORDERABLE ITEM FIELD: 8 NON-VA MED
-A- CONDITION: null
-B- SEARCH FOR PHARMACY ORDERABLE ITEM FIELD: .04 INACTIVE DATE
-B- CONDITION: null
```

```

-C- SEARCH FOR PHARMACY ORDERABLE ITEM FIELD:

IF: A&B      NON-VA MED NULL      and INACTIVE DATE NULL
OR:

STORE RESULTS OF SEARCH IN TEMPLATE:

SORT BY: NUMBER// name
START WITH NAME: FIRST//
WITHIN NAME, SORT BY:
FIRST PRINT FIELD: .01;L30  NAME
THEN PRINT FIELD: .02;L15  DOSAGE FORM
THEN PRINT FIELD: 8;L5     NON-VA MED
THEN PRINT FIELD: .04;L12  INACTIVE DATE
THEN PRINT FIELD:
Heading (S/C): PHARMACY ORDERABLE ITEM SEARCH  Replace
STORE PRINT LOGIC IN TEMPLATE:
DEVICE: Virtual

```

Figure 3-5: Beginning Instructions

Your list should like the following – Non-VA blank with NO inactive data

PHARMACY ORDERABLE ITEM SEARCH		MAY 20, 2010 21:49	
NAME	NON-VA DOSAGE FORM	INACTIVE MED	DATE
ACETAMINOPHEN/OXYCODONE N/F	TAB		
ACYCLOVIR N/F	SUSP		
ALBUTEROL/IPRATROPIUM	INHL, ORAL		
ASPIRIN/OXYCODONE N/F	TAB		
BUDESONIDE/FORMOTEROL	INHL, ORAL		
CARBAMAZEPINE N/F	CAP, SA		

Figure 3-6: Sample listing

- Run the following report in Fileman. This will provide the site with a list of Pharmacy Orderable Items and what Generic Drugs are associated with each. The Pharmacy AdPac now has a cross reference to see which drugs the orderable items are tied to so they know which ones to edit.

```

VA FileMan 22.0

Select OPTION: PRINT FILE ENTRIES

OUTPUT FROM WHAT FILE: DRUG//
SORT BY: GENERIC NAME// PHARMACY ORDERABLE ITEM
START WITH PHARMACY ORDERABLE ITEM: FIRST//
WITHIN PHARMACY ORDERABLE ITEM, SORT BY:
FIRST PRINT FIELD: 2.1;L30  PHARMACY ORDERABLE ITEM
THEN PRINT FIELD: .01;30  GENERIC NAME
THEN PRINT FIELD:
Heading (S/C): DRUG LIST//
STORE PRINT LOGIC IN TEMPLATE:
DEVICE:  CONSOLE      Right Margin: 80//you can session log and open in excel

...SORRY, THIS MAY TAKE A FEW MOMENTS...

Your list should look like this

```

DRUG LIST PHARMACY ORDERABLE ITEM	GENERIC NAME	MAY 20,2010 21:56	PAGE 1
70/30 INSULIN	INSULIN 70/30 (HUMAN)		
ABILIFY	ARIPIPRAZOLE 5MG TABS		
ABSORBASE	ABSORBASE OINT,120GM		
ABSORBASE	ABSORBASE OINT,454GM		
ACARBOSE	ACARBOSE 50MG TAB		
ACARBOSE	ACARBOSE 25MG TAB		
ACETAMINOPHEN	ZZACETAMINOPHEN 325MG. TAB. 2		
ACETAMINOPHEN	ACETAMINOPHEN 650MG SUP,RTL		

Figure 3-7: Instructions

- Review and mark active drugs as “Non-VA” that may be entered as Outside Medications. You need to do this for all of the drugs that you want to be selectable in the Outside Medications dialog. Many of the drugs you carry in house may also be ordered and filled outside. Keep this in mind when selecting which medications to mark as “Non-VA!”

```

RMTS Return Medication to Stock
DEE Drug Enter/Edit <- this menu
HS Health Summary ...
MEDP Medication Profile

Select PHARMACY REG TECH Option: dee Drug Enter/Edit

Select DRUG GENERIC NAME: ziprasidone 40
Lookup: DRUG GENERIC NAME
ZIPRASIDONE 40MG CAP CN709 N/F 00049-3970-60
...OK? Yes// (Yes) <<<this med
*****
This entry is marked for the following PHARMACY packages: <- you can see NOT
marked as non VA

Outpatient
Unit Dose
GENERIC NAME: ZIPRASIDONE 40MG CAP Replace
VA CLASSIFICATION: CN709//
DEA, SPECIAL HDLG: 6P//

NATIONAL FORMULARY INDICATOR: YES
LOCAL NON-FORMULARY: N/F//
VISN NON-FORMULARY:
Select DRUG TEXT ENTRY:
Select FORMULARY ALTERNATIVE: QUETIAPINE FUMARATE 200 MG TAB
//
Select SYNONYM: GEODON//
SYNONYM: GEODON//
INTENDED USE: TRADE NAME//
NDC CODE: 00049-3970-60//
Select SYNONYM:
MESSAGE:
RESTRICTION:
FSN:
INACTIVE DATE:
WARNING LABEL:
ORDER UNIT: BT//
DISPENSE UNIT: CAP//
DISPENSE UNITS PER ORDER UNIT: 60//
DISPENSE UNIT NCPDP CODE:
NDC: 00049-3970-60//
PRICE PER ORDER UNIT: 178.50//
    
```

```

LAST PRICE UPDATE: APR 24,2008@15:39:11//
AWP PER ORDER UNIT: 394.3098//
AWP PER DISP UNIT is 00006.571830
SOURCE OF SUPPLY:
DISPENSING LOCATION:
STORAGE LOCATION:
PRICE PER DISPENSE UNIT: 2.975

```

points to ZIPRASIDONE HCL 40MG CAP in the National Drug file.

This drug has already been matched and classified with the National Drug file. In addition, if the dosage form changes as a result of rematching, you will have to match/rematch to Orderable Item.

Do you wish to match/rematch to NATIONAL DRUG file? No// (No)
Just a reminder...you are editing ZIPRASIDONE 40MG CAP.

```

Strength from National Drug File match => 40    MG
Strength currently in the Drug File    => 40    MG

```

Strength => 40 Unit => MG

```

POSSIBLE DOSAGES:
DISPENSE UNITS PER DOSE: 1          DOSE: 40MG          PACKAGE: IO
DISPENSE UNITS PER DOSE: 2          DOSE: 80MG          PACKAGE: IO

```

LOCAL POSSIBLE DOSAGES:

Do you want to edit the dosages? N// O

```

*****
This entry is marked for the following PHARMACY packages:
Outpatient
Unit Dose

```

MARK THIS DRUG AND EDIT IT FOR:

```

- Outpatient
U - Unit Dose
I - IV
W - Ward Stock
D - Drug Accountability
C - Controlled Substances
X - Non-VA Med
A - ALL

```

Enter your choice(s) separated by commas : **X**

X - Non-VA Med

** You are NOW Marking/Unmarking for NON-VA MEDS. **

A Non-VA Med ITEM? No// **Y (Yes)**

** You are NOW in the ORDERABLE ITEM matching for the dispense drug. **

ZIPRASIDONE 40MG CAP is already matched to

ZIPRASIDONE CAP,ORAL

Do you want to match to a different Orderable Item? NO//

Now check

```

Select DRUG GENERIC NAME:      ZIPRASIDONE 40MG CAP          CN709          N/F
00049-3970-60
...OK? Yes// (Yes)
*****
This entry is marked for the following PHARMACY packages:
Outpatient
Unit Dose
Non-VA Med<<<< now it's marked as Non VA
GENERIC NAME: ZIPRASIDONE 40MG CAP Replace

```

Figure 3-8: Further instructions

4. **OPTIONAL:** Create a TIU Template named MED REC FOR PATIENT and place in your Shared template folder – If your users do not select a dose offered, type in a non standard dose or leave the dose blank, the Outside Med entry does not pass to PCC and create a V Medication entry. The Health Summary and Patient Wellness Handouts use V Medications only to compile the medication list. The PCC Link will be fixed in the upcoming Pharmacy patch APSP 7.0p1009 which is in testing now. Until that time the following is recommended:
 - Print patient med lists from the Meds tab (you will have to print Outpatient Medications and Outside Medications separately).
 - Create a TIU Template. The user can then right-click and select: Preview | Print without creating a visit or note.

Site who are 100% EHR:

- Copy/ Paste the following in a TIU template named MED REC FOR PATIENT
- Use one of the following objects:

```

|ACTIVE MEDICATIONS|
|MEDS CHR,ACT,HOLD,EXP|
|MEDICATION RECONCILIATION|

```

Figure 3-9: Object selections

- Place it in the SHARED Template folder
- Train user to:

Open Shared Templates

Right-click and select Preview | Print

This uses TIU objects that non-redundantly aggregate V Medication and Pharmacy entries for a complete medication reconciliation list for your patients.

```

Make a simple TIU TEMPLATE. Name MED REC FOR PREVIEW/PRINT. Place in SHARED TIU
FOLDER. Users can Right Click, Preview and Print.

```

```
OPTION 1: Using |MEDS CHR,ACT,HOLD,EXP-DETAILED| object
```

Figure 3-10: Beginning instructions

Below is a sample print out of the Medication List.

```
Patient: Test Patient T P DOB SEP 27,1982 Chart # 10-10-12
Printed: JUN 17, 2010 16:09

ALLERGIES - It is important to know what allergies and side effects you
have to medicines or foods. Below is a list of allergies that we know of.
Please tell us if there are any that we missed.

ASPIRIN

Active and Outpatient Medications (excluding Supplies):

ATENOLOL 25MG TAB TAKE ONE (1) TABLET BY MOUTH DAILY ACTIVE
CARVEDILOL 12.5 MG TAB TAKE ONE (1) TABLET BY MOUTH TWICE HOLD
A DAY
Reason for HOLD: INSUFFICIENT QTY IN STOCK
RANITIDINE TAB (O) BY MOUTH TWICE A DAY ACTIVE
```

Figure 3-11: Sample print out

Below is a Medication List – Sample Template

```
Patient: |PATIENT NAME| DOB |PATIENT DATE OF BIRTH| Chart # |PATIENT HRCN|
Printed: |NOW|

ALLERGIES - It is important to know what allergies and side effects you
have to medicines or foods. Below is a list of allergies that we know of.
Please tell us if there are any that we missed.

|ALLERGIES/ADR|

|MEDS CHR,ACT,HOLD,EXP|
```

Figure 3-12: Sample template

- Alternately, print Outpatient Meds and Outside Meds from the Meds Tab (you must print each list separately)

Sites that have not completely deployed to EHR (use in Outpatient but ER and Inpatient still using paper)

- Consider holding off deployment of the use of “outside meds” until BJPC 2.0 Patch 5 is released with updated Health Summary and Patient Wellness Handout.

3.1.4 Implementing Clinical Indicator for Medication Orders

Description: Determine if your site will implement Clinical Indicator for Medication Orders.

Who Should Perform?: Clinic Leadership (Clinical Director, Pharmacy Chief or if no pharmacist on staff, consult Area Pharmacy personnel, in collaboration with HIM/BO, Providers, Quality Improvement/Risk Management)

Instructions:

1. CAC should review functionality.
2. Discuss pros/cons with clinical leadership, medical staff, and pharmacy.

3.1.5 Sites with NO In-House Pharmacy

The following applies to sites with NO In-house Pharmacy who plan to use auto-finish functionality (ONLY for use with sites that do not have pharmacies).

Description: If you do not have an in-house pharmacy and plan to use auto-finish, determine list of providers who may auto-finish.

Who Should Perform?: Clinical Director.

Instructions:

1. This will be determined by credentials and workflow.
2. When configured, a pending medication order is auto-finished during the printing process.
3. This functionality is NOT for use at sites that have pharmacy in house.

Description: Determine if your state has specific requirements for prescriptions.

Who Should Perform?: Pharmacy Chief or if no pharmacist on staff, consult Area Pharmacy personnel.

Instructions:

1. If you currently use RPMS print formats for Rx printing from Orders tab, identify the header, footer, and body.
2. If the footer or header uses an field that displays patient address, you will need to edit the address print field for use from the Print Prescription button on the Medication component.

Description: Determine updates needed in pharmacy database and EHR quick orders

Who Should Perform?: Pharmacy package administrator, CAC

Instructions – most common problems below

1. Medications ordered without selecting from the available dosing options will not auto-finish.
 - a. Review pharmacy database to make sure all meds have proper dosages to minimize providers typing in a dose.
2. Mark drugs as Non-VA (X) if not done so already in Outside Medications set up.
3. Review quick orders.
 - a. If you change any doses on the pharmacy side, you **MUST** edit the quick orders and select a proper default dose. If the default dose no longer exists, it behaves like a dose that was manually entered.

Note: If you evaluate your pharmacy database and determine you need to perform significant database clean up to deploy Outside Meds and/or Auto-Finish, consider doing ALL the changes in the drug database necessary for e-Prescribing which will be released later in 2010 or early 2011. Pharmacists working on the e-Prescribing project and pharmacists assisting with database set ups are collaborating to create a guide which will be distributed through area Pharmacy Consultants when available.

3.1.6 Using Imaging Component

Determine if you will use the imaging component – for non-federal sites only who are not or do not plan to use Vista Imaging.

Description: If you do not use Vista Imaging AND are not a federal IHS site, determine if you will use the Imaging component.

Who Should Perform?: Clinical Leadership (non-federal sites only).

Instructions:

1. Review the documentation on the Imaging component.
2. Review security and business rules with HIM and IT security.
3. Develop policies and procedures.

3.2 Preparation for TIU 1.0p1006

Determine the TIU templates that contain the TUI object to replace.

Description: Find templates that contain the old Reproductive History TIU objects. You will need to replace these objects IMMEDIATELY after installing the patch. The new objects are:

REPRODUCTIVE HX2-BRIEF
REPRODUCTIVE HX2-EXPANDED

BMI-UPDATED

Alternately you can remove, or replace with the LMP Brief, LMP Expanded, or Reproductive History All object prior to installation of TIUv1.0p1006. Be aware that Reproductive History All is a large object.

Who Should Perform?: CAC/Site manager.

Instructions:

Run a Fileman search for each of these four objects: This will return the name of the template that contains the object. If the template is part of a TIU Dialog Template, this will not tell you in what dialog it is contained.

```

REPRODUCTIVE HX-BRIEF |
REPRODUCTIVE HX-EXPANDED |
BMI |
BMI WITH CAPTION |

Select VA FileMan Option: search File Entries

OUTPUT FROM WHAT FILE: TIU TEMPLATE//

-A- SEARCH FOR TIU TEMPLATE FIELD: 2 BOILERPLATE TEXT (word-processing)
-A- CONDITION: CONTAINS
-A- CONTAINS: REPRODUCTIVE HX-BRIEF |

-B- SEARCH FOR TIU TEMPLATE FIELD:

IF: A//
TIU TEMPLATE BOILERPLATE TEXT CONTAINS (case-insensitive) "REPRODUCTIVE HX-BRIEF|"

STORE RESULTS OF SEARCH IN TEMPLATE:

SORT BY: NAME//
START WITH NAME: FIRST//
FIRST PRINT FIELD: .01 NAME
THEN PRINT FIELD:
Heading (S/C): TIU TEMPLATE SEARCH//
DEVICE: Console Right Margin: 80//
TIU TEMPLATE SEARCH MAY 17,2010 20:54 PAGE 1
NAME
-----

```

ASTHMA Exacerbation
ASTHMA Follow up1
ASTHMA Initial
Allergy screen
BCHP Results Start

Figure 3-13: Instructions for search

3.3 Post Install Set-up for EHR v1.1 Patch 6

3.3.1 Add New Component to Vuecentric (EHR) Templates

The EHR v1.1 Patch 6 delivers 2 new components that need to be added to the VueCentric (EHR) Templates.

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Infant Feeding component	None	Add to all EHR VueCentric Templates using list generated in the preparation section	Optional: Add infant feeding object to TIT templates INFANT FEEDING	<ul style="list-style-type: none"> Infant Feeding Choices is no longer in Personal Health drop down Captures infant feeding for each visit (V Infant Feeding) and should be updated regularly
Reproductive History	None	Add to all EHR VueCentric Templates using list generated in the preparation section	See TIU configuration	<ul style="list-style-type: none"> Enhanced more intuitive and descriptive fields Now displays the data from the fields in PCC Post install routine migrated any updates to the reproductive factors using EHRv1.1 Patch 5
Family History	None	Add to all EHR VueCentric Templates using list generated in the preparation section Consider adding Health Summary button with report containing "Family Health History" (See APPENDIX C)	None	<ul style="list-style-type: none"> Old family history data imports as a single relation called "UNKNOWN" with multiple conditions. Users need to properly enter family history (using ADD RELATION and assign conditions) for old entries. After this is done, DELETE RELATION for the "Unknown" relation that lists the old data. See screen shots below

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Notifications	None	<p>“Location” column was added and is very wide. To configure:</p> <ul style="list-style-type: none"> • Set column width to desired position • Enter Design Mode • Save the template • Repeat for each VueCentric template in use 		
Allergy/ADR Verifier dialog removed	None	None	None	<ul style="list-style-type: none"> • Remove the EHR dialog until the enhancements for Certification and Meaningful use are incorporated and a new dialog is built. Current dialog does not allow for proper review, verification and documentation by pharmacists • Pharmacists will still get notifications when Allergies are entered and need verification • Notifications will NOT be actionable on the EHR side • Notifications will drop off as the allergies/ADRs are verified in RPMS

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Desktop tools	None	Install on Desktop Properties	None	<ul style="list-style-type: none"> • Review functionality with users • eSig: new or change signature from EHR • Clear and lock: when clicked, clears patient information and locks application • Pharmacokinetic dosing calculator • Community Alerts Splash screen: First log in displays for user. On the fly access using Desktop menu option.

Instructions:

1. To add to Desktop Tools:
2. In Design Mode, go to Design | Layout Manager.
3. The Properties for Desktop dialog will display.

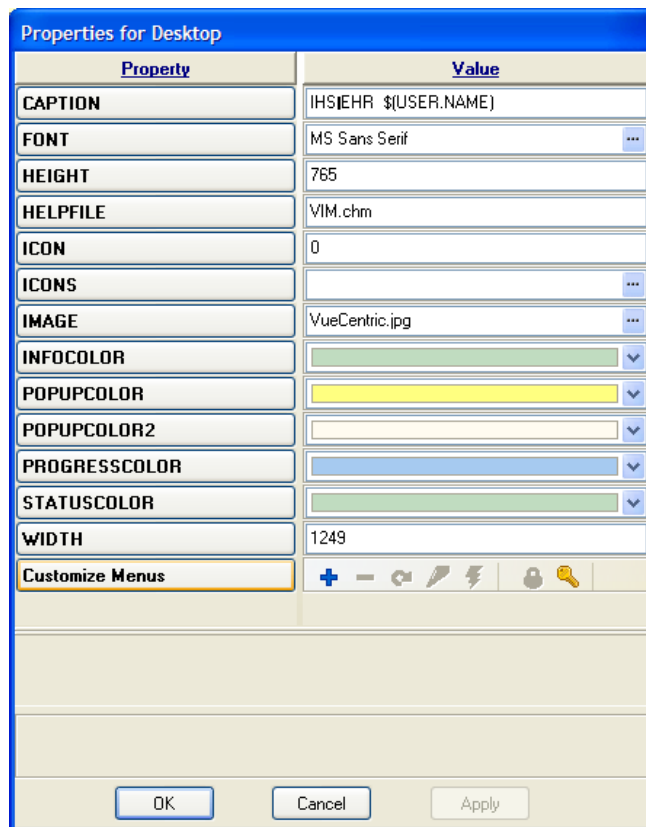


Figure 3-14: Properties for Desktop dialog

4. Click Properties and then use Customize Menus. The Properties for Desktop dialog will display with an expanded area on the far right.
5. To add an item click the + button and type in the name you wish to call the new item (for each of the items below).

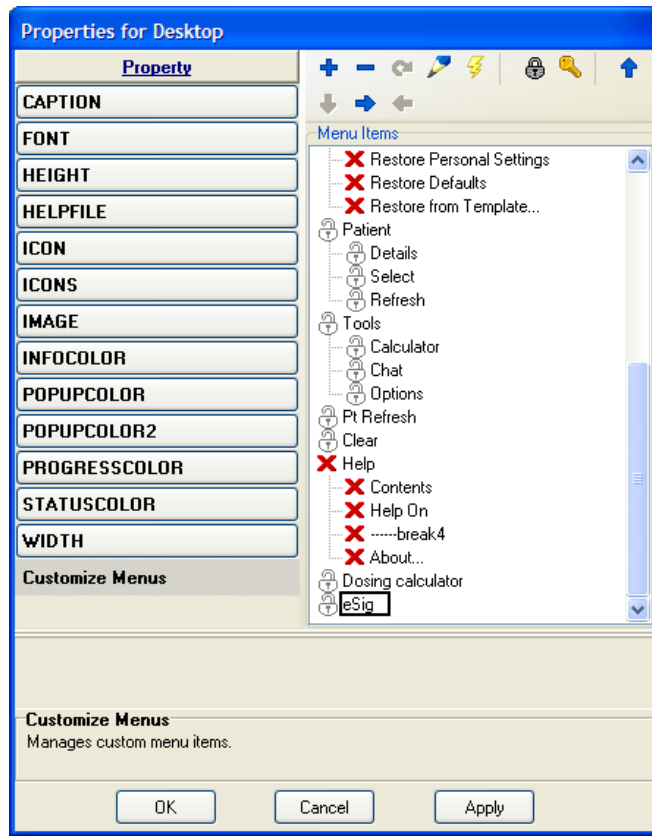


Figure 3-15: Expanded area on far right of dialog

6. Use the Up, Down, Left and Right arrow to move the item to the menu location desired.
7. Click the “lightning bolt” button to set the action for the button. The application displays the eSig dialog. The action should be for the following:

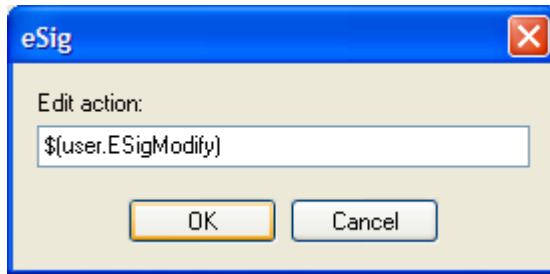


Figure 3-16: Action to use

8. Other actions that you can configure on the Desktop Properties Toolbar Menu:

Action Needed	eSig Action Text
Clear and lock	\$(patient.clear)\$ (vim.lock)
Community alerts	\$(BEHCommunityInfo.CommunityInfo.DisplayAlert)
Dosing calculator	\$(BEHDosingCalc.DosingCalc.Execute)

Once that is done, close all dialogs and then go to Design Mode and select Required Services from the dropdown menu. Check the following Services: Community info, Dosing calculator..

9. Get of out Design Mode.

For Electronic Signature, the application displays the Change your Electronic Signature dialog.

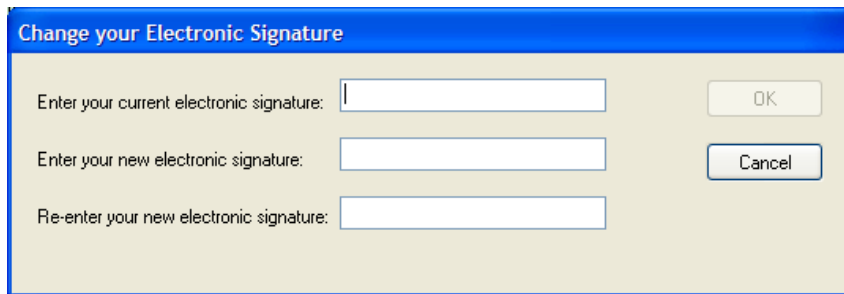


Figure 3-17: Sample Change your Electronic Signature dialog

For Clear and Lock, the application displays the Locked by dialog.



Figure 3-18: Sample Locked by dialog

For Dosing Calculator, the application displays the Pharmacokinetic Dosing Calculator dialog.

Pharmacokinetic Dosing Calculator

Patient **Demo, Fifties Femone** HRN **2757**

Age Sex Male Female Obese No Yes

Weight (kg) HT (inch) CRCL

Scr Calculated Kd

Desired PEAK Calculated Dose

Desired Interv (hr) Calculated CPmin

Dosing

Amikacin Gentamicin Tobramycin Vancomycin

Calculate

Clear

Copy

Close

Figure 3-19: Pharmacokinetic Dosing Calculator dialog

For Community Alerts, the application displays the iCare Community Alerts pop-up window.

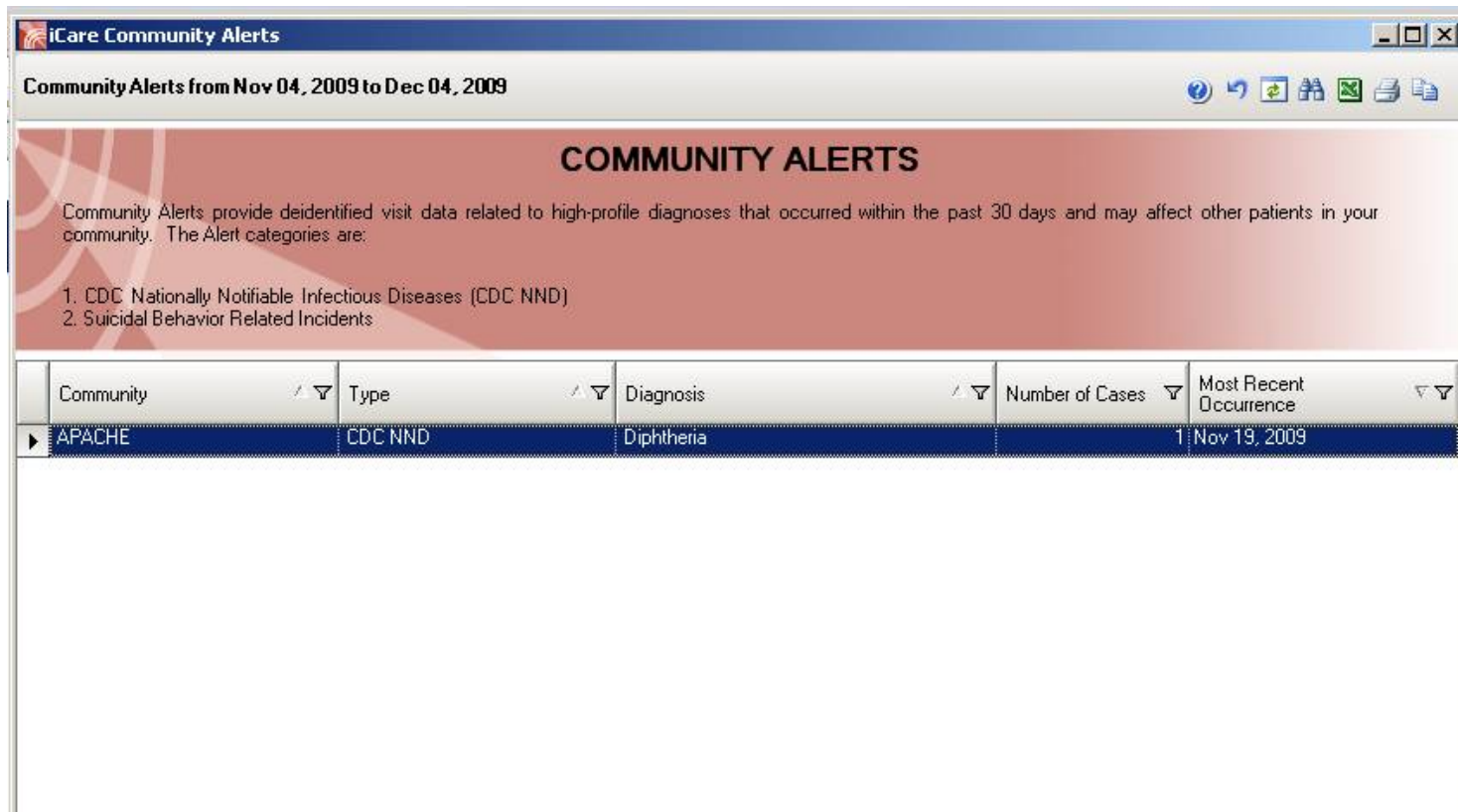


Figure 3-20: Sample iCare Community Alerts dialog

3.3.2 Medication Safety Enhancements

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Medication Management component	<ol style="list-style-type: none"> 1. Add PSH OERR to your write orders list (either ORWDX WRITE ORDERS LIST or ORWOR WRITE ORDERS LIST. 2. Set BEHORX NONVA LABEL to display site chosen label for "Outside Medications." 3. Set ORDW NONVA REASON if site wants different selections for "Statement/Explanations." 	None	Consider uses for TIU Outside medications object	<ul style="list-style-type: none"> • "Outside meds" is not for the medications providers order and patients fill elsewhere • "Outside meds" is to document medications that are ordered and filled outside of your facility AND OTC, herbal, supplements patients procure and take on their own • Documenting outside meds can be done by nursing and pharmacy staff
Printing Med Rec list Interim solution until APSP 7.0p1009 and BJPC 2.0p5 released	Consider REMOVING Medications object from Patient Wellness Handout (see APPENDIX B)		Create TIU Template "MED REC FOR PATIENT"	<ul style="list-style-type: none"> • Outpatient Meds and Outside Meds from the Meds Tab (you must print each list separately) • Alternately, Right Click on MED REC FOR PATIENT template and select Preview; then Print Template (without creating a note)
On demand drug checking	None (in addition to original order checking set up)	None	None	<ul style="list-style-type: none"> • When clicked, presents user with checks against all signed allergies and any meds in the outpatient, inpatient and outside meds components (including unsigned)

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Integrated signature enhancement	None	None	None	<ul style="list-style-type: none"> Train users to apply the integrated signature tool rather than right click to sign med orders Only the integrated signature tool

3.3.3 Clean Up of Old Family History Data

Problems flagged as Family History in the Problem List were migrated to the new Family History file structure. The data structure is significantly changed and offers enhanced capture of relation information.

Because the structure is very different, all problem entries (now called “conditions”) were migrated on a single relation called “unknown.”

- Users will have to use this “unknown” relation as a guide and manually enter the family history properly transcribing the relationship and condition information.
- After entry, the old data can be deleted by removing the entire relation of “unknown.”
- DO NOT remove this relation until all data has been entered properly.

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Condition (ICD9)	Provider Narrative	Age at Diagnosis	Date Modified
UNKNOWN							V18.0	Family Hx Of Diabetes Mellitus - grandparents	Age	08/13/20
UNKNOWN							V17.3	Family Hx Of Heart Disease - grandparents	Age	08/13/20

Figure 3-21: Sample Family History component

Using the “old” data brought in as relation UNKNOWN, enter the relations and the conditions using the Add Relation button. The application will display the Family History dialog.

Family History dialog box showing fields for Relation (GRANDFATHER), Name, Status, Cause of Death, Age at Death, Multiple Birth, and Multiple Birth Type. It includes an 'Add' button and a table of conditions.

Condition (ICD9)	Provider Narrative	Age at Diagnosis
V18.0	Diabetes mellitus	
V17.3	Heart Disease	

Figure 3-22: Sample Family History dialog

Click Save; the application adds the new history to the Family History component.

Updated Family History component showing a table with columns: Relation, Name, Status, Age At Death, Cause of Death, Multiple Birth, Multiple Birth Type, Condition (ICD9), Provider Narrative, Age at Diagnosis, and Date Modified.

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Condition (ICD9)	Provider Narrative	Age at Diagnosis	Date Modified
UNKNOWN							V18.0	Family Hx Of Diabetes Mellitus - grandparents	Age	08/13/2007
UNKNDWN							V17.3	Family Hx Of Heart Disease - grandparents	Age	08/13/2007
GRANDFATHER							V18.0	Diabetes mellitus		05/17/2010
GRANDFATHER							V17.3	Heart Disease		05/17/2010
GRANDMOTHER							V18.0	Diabetes Mellitus		05/17/2010
GRANDMOTHER							V17.3	Heart Disease		05/17/2010

Figure 3-23: Updated Family History component

After you have properly entered the Relations, highlight the old data (UNKNOWN) and click the Delete Relation button.

The application confirms the delete process.

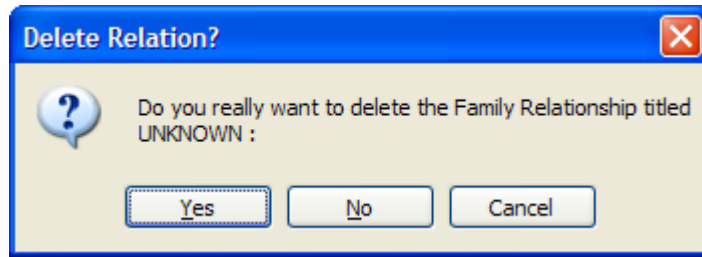


Figure 3-24: Delete Relation confirmation

Click Yes to confirmation the deletion (otherwise, click Cancel).

After using Yes, the correct family history will display.

A screenshot of the "Family History" section in an EHR system. It shows a table with columns: Relation, Name, Status, Age At Death, Cause of Death, Multiple Birth, Multiple Birth Type, Condition (ICD9), Provider Narrative, Age at Diagnosis, and Date Modified. The table contains four rows of data for Grandfather and Grandmother relationships.

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Condition (ICD9)	Provider Narrative	Age at Diagnosis	Date Modified
GRANDFATHER							V18.0	Diabetes mellitus		05/17/2010
GRANDFATHER							V17.3	Heart Disease		05/17/2010
GRANDMOTHER							V18.0	Diabetes Mellitus		05/17/2010
GRANDMOTHER							V17.3	Heart Disease		05/17/2010

Figure 3-25: Correct family history data

Consider adding a Family History Health Summary button on your EHR toolbar to assist users clean up of “family history.”

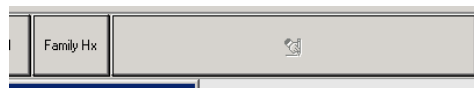


Figure 3-26: Family HX button on toolbar

Once open, the health summary will remain open to use as a guide while updating the Family History component. See APPENDIX C.

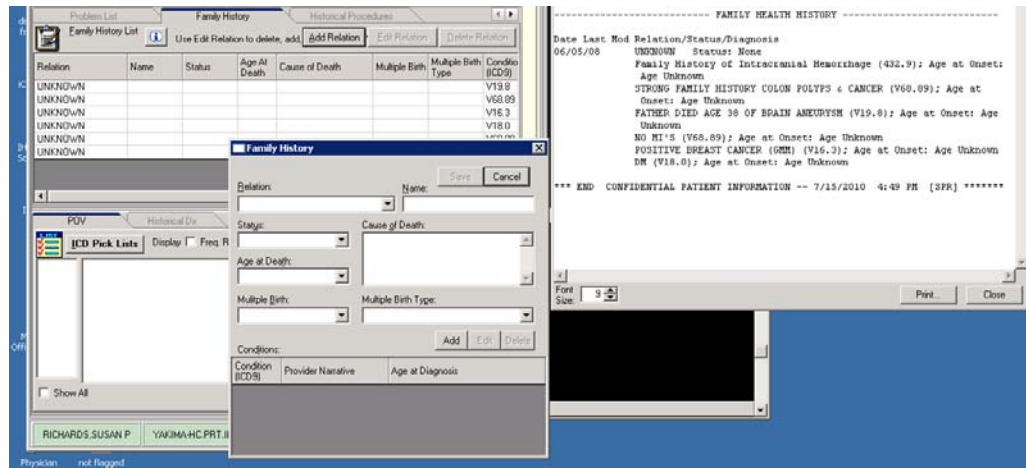


Figure 3-27: Health Summary remaining open

3.3.4 Review Change to Visit Dialog and Problem List components for Asthma Data Capture

EHR v1.1 Patch 6 delivers enhancements to capture Asthma Control (Visit Diagnosis dialog) and Asthma Classification (Problem List dialog).

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Problem List – Asthma Classifications	Review BGP ASTHMA DXS taxonomy (you can use iCare)	None	None	Now available when a Problem of Asthma is entered or edited on the Problem List Also offered if “add to problem list” is selected on the Visit Diagnosis dialog
Visit Diagnosis – Asthma Control	Make sure your BGP ASTHMA DXS taxonomy is populated correctly (you can use iCare)	None	None	Offered when Asthma V POV is added/edited Displays the most recent and if unchanged, stores for today’s visit Should be documented every time patient seen by provider for asthma

3.3.5 Review Changes to Problem List Display of Personal History

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Problem List - Now displays entries from "Personal History" File	None	None	None	<ul style="list-style-type: none"> • Users may not be aware that "personal history" is stored in file called "Personal History and is separate from the Problems flagged as Personal History in the Problem File • These entries can now be Viewed on the problem list and will have Problem number >9000 • May edit the ICD, Narrative, and date of onset • You can delete these entries • Because they are not part of the Problem file, you cannot add notes or use as Visit Diagnoses

Entry from "Personal History file"

Note the entry from "Personal History file with an ID of 9001 is not editable.

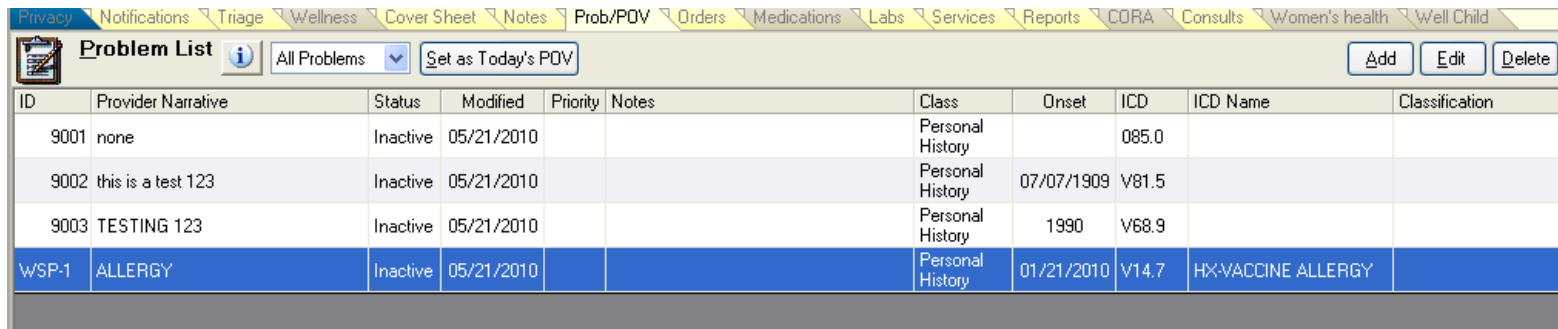


Figure 3-28: First record of ID of 2001 is not editable

The WSP-1 entry in comparison was entered in the Problem List (note the proper Problem list ID of WSP-1) and was flagged as Personal History class.

Site can consider entering old Personal History data as Problems and marking as Personal History class so they will all display together as Inactive History.

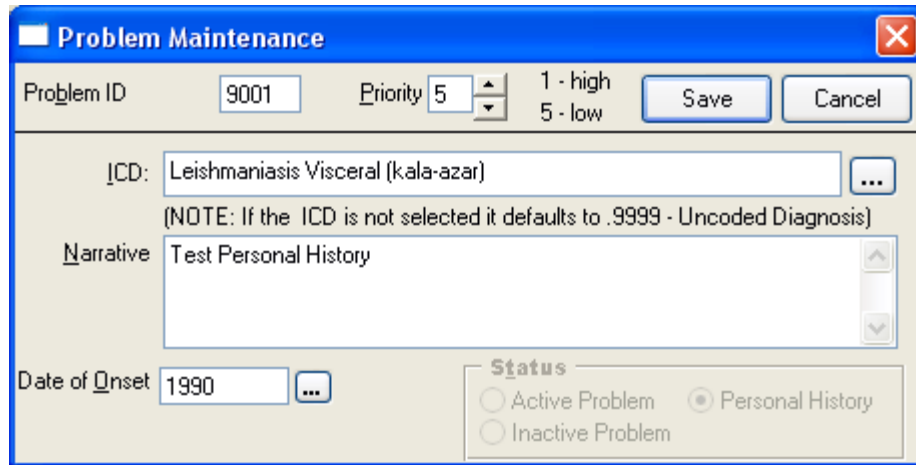


Figure 3-29: Entering old Personal History

3.3.6 Review Changes to Immunizations, Patient Education, Historical Services, TIU, and Reports

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Allergy/ADR Verifier dialog removed	None	None	None	<ul style="list-style-type: none"> Removed the EHR dialog until the enhancements for Certification and Meaningful use are incorporated and a new dialog is built. Current dialog does not allow for proper review, verification and documentation by pharmacists Pharmacists will still get notifications when Allergies are entered and need verification Notifications will NOT be actionable on the EHR side Notifications will drop off as the allergies/ADRs are verified in RPMS

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Immunizations – VFC eligibility	None	None	None	<ul style="list-style-type: none"> Populates based on what is in the registration file for eligibility
Patient Ed - Readiness to learn prompt	None	None	None	<ul style="list-style-type: none"> Readiness to learn is no longer a Health Factor Added prompt on Patient Education dialog
Historical Services - date required before search returns CPT codes	None	None	None	<ul style="list-style-type: none"> A minor change to support Code Set Versioning – a date is required before the search for CPT codes will return a selection list. The date is used to bring forward CPT codes that were active at the time the historical service was provided.
Visit Summary Brief	None	None	None	<ul style="list-style-type: none"> Can view and print a range of Visit Summaries Can view Visit Summary on incomplete, locked visit
Radiology Report Annotation	None	None	None	<ul style="list-style-type: none"> When a radiology report is present (Imaging Local or Imaging), user can right-click and make annotation Visible on report Note titled “Annotation” on Notes tab with Subject referencing date of radiology study
TIU – can now search by Diagnosis	None	None	None	<ul style="list-style-type: none"> In Custom View, users may search by Diagnosis BOLDS the notes that have a POV with the diagnosis in the search
Notifications	None	See below	None	

Below are the instructions for the EHR configuration in the last row of the table above:

The “Location” column was added and is very wide. To configure, do the following:

- Set the column width to the desired position
- Enter Design Mode
- Save the template

- Repeat for each VueCentric template in use

3.4 Post Install Setup for TIU v1.0 Patch 1006

Change or Enhancement	RPMS Configuration	EHR Configuration	TIU Configuration	User Training
Replacement objects	None	None	REPLACE the Reproductive History objects with the new objects REPRODUCTIVE HX2-BRIEF REPRODUCTIVE HX2-EXPANDED REPLACE the BMI objects with the new object BMI-UPDATED	
New objects			Review new objects and include where users wish (see patch notes for list)	New detailed med lists are designed for Pharmacists. New brief med lists are designed for Providers. New Last Med Class/Pharm PT objects will display meds on hold if it is the last one from that class in the system. The Last Med Class object skips hold meds.

4.0 Fixes and Modifications

This section provides information about bug fixes and enhancements.

4.1 Bug Fixes

See Patch notes for a complete list.

4.1.1 Display Brief Visit

This fix allows the user to select incomplete, locked visits and to display a brief visit summary.



Figure 4-1: Visit is locked by summary is still visible

4.1.2 Fractional Quantities for Medication Quick Orders

You could previously enter fractional units but it would not accept a leading zero. This has been fixed.

```
Medication: INSULIN
1  INSULIN 70/30  INSULIN NPH/REG 70/30 INJ
2  INSULIN GLARGINE INJ          (non-formulary)
3  INSULIN LISPRO INJ
4  INSULIN NPH (HUMAN) INJ
5  INSULIN NPH/REG 70/30 INJ
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 3  INSULIN LISPRO INJ
```

```

Complex dose? NO//
Dose: 0.5ML
Route: PER NG // SQ SUBCUTANEOUS SQ
Schedule: QAM QAMEVERY MORNING
Cannot determine dispense drug - some defaults and order checks may not occur!

Patient Instructions: FOR BLOOD SUGAR CONTROL
Include Patient Instructions in Sig? YES//
Chronic Med?// YES
Dispense as Written?// YES
    
```

Figure 4-2: Example of Fractional Quantities for Medication Quick Order

4.1.3 Reminder Dialog for Skin Test

Pending is now included as a result for skin test that have just been placed.

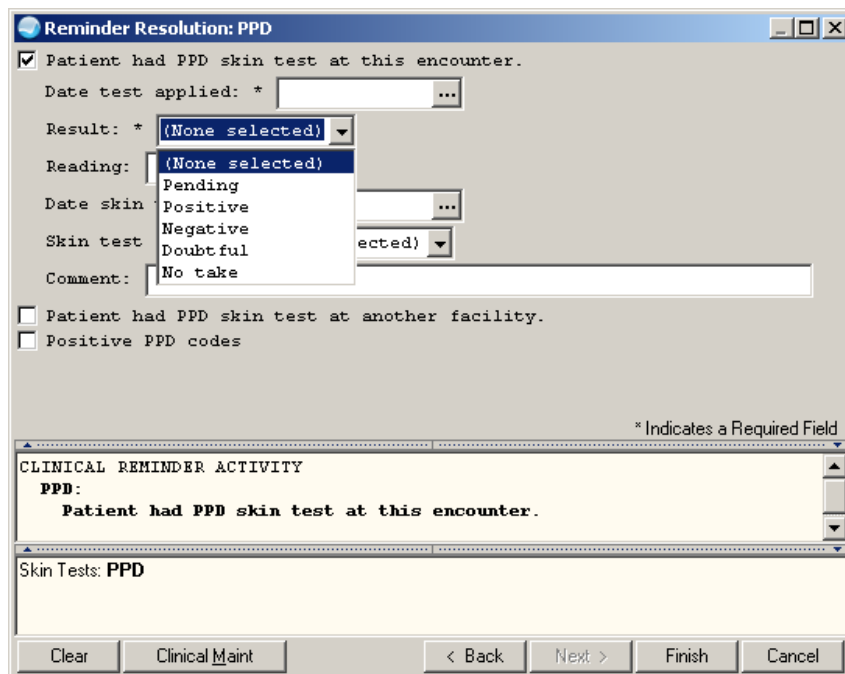


Figure 4-3: Pending is Now Selectable as a Result

Date of entry cannot be in the future.

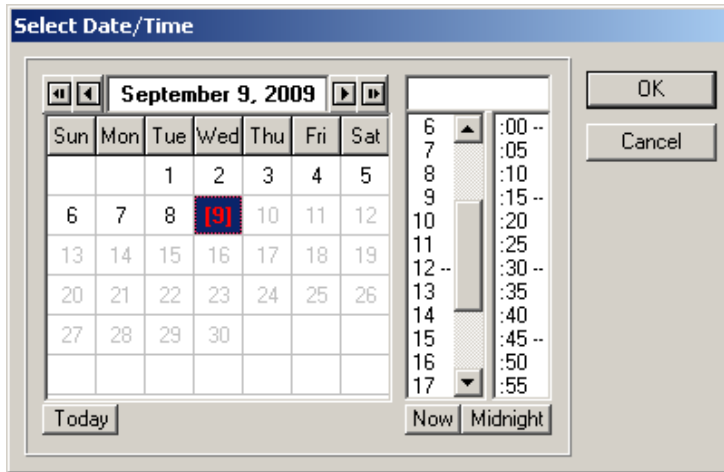


Figure 4-4: Future dates are grayed out

Date of reading will generate an error if a date prior to the date administered is selected.

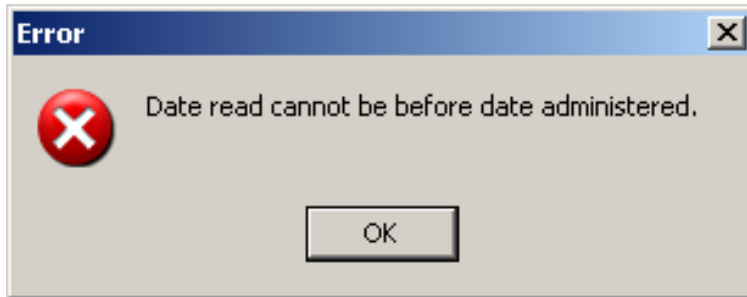


Figure 4-5: Error message when read date is before entry date

4.1.4 Adverse Reaction Parameter

Signing of adverse reactions is now determined by a parameter.

AUT	Automatic Signature of Adverse Reaction Data
ENT	Enable Adverse Reaction Data Entry
VER	Allow Adverse Reaction Verification

Figure 4-6: Adverse Reaction options

When you select the AUT (Automatic Signature of Adverse Reaction Data) option, you get the following:

```
Automatic Signature of Adverse Reaction Data
Force Automatic Signature of ADR entries may be set for the following:
100 User          USR    [choose from NEW PERSON]
200 Class         CLS    [choose from USR CLASS]
800 Division     DIV    [DEMO HOSPITAL]
900 System        SYS    [DEMO.MEDSPHERE.COM]
```

```

Enter selection: 900   System   DEMO.MEDSPHERE.COM

Setting Force automatic signature of ADR entries   for system: DEMO.MEDSPHERE.COM

Automatic signature of ADR entries?: YES//  ??

If yes, signature of any new or edited adverse reaction entries is forced
Upon context change. If no, the user may opt to sign changes at a later
Time.

Automatic signature of ADR entries?: YES//

```

Figure 4-7: Automatic Signature of Reaction Data parameter

Setting this to YES will force allergy signature to work as it did in the past.

4.1.5 Formatting Fix in TIU

TIU had a problem in the EHR with word wrapping at 72 characters. This is now set to 80 characters. This used to cause some unusual wrapping of TIU objects.

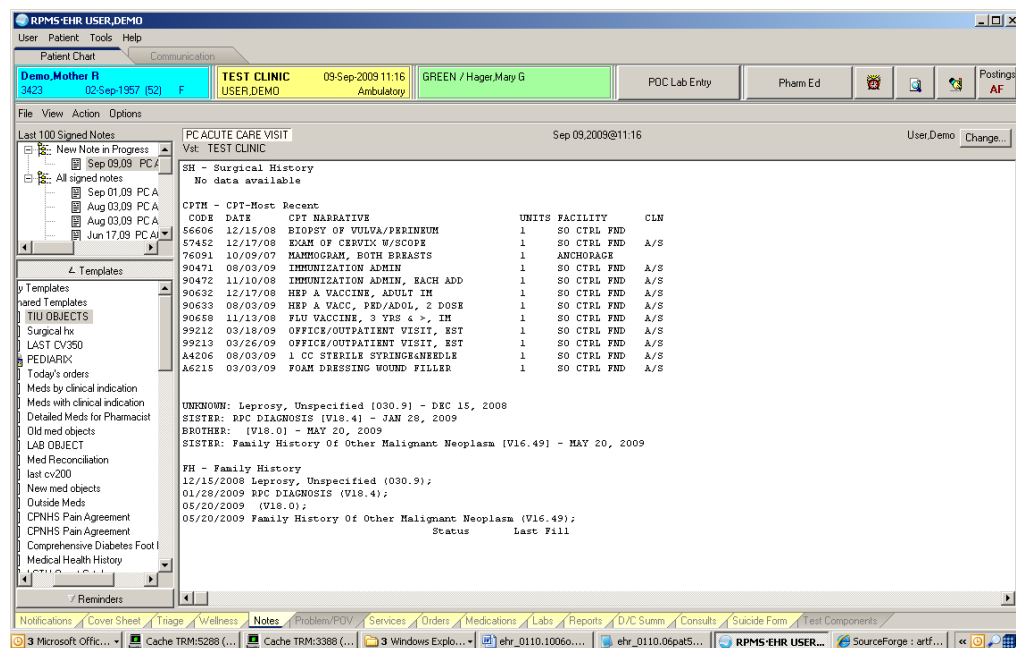


Figure 4-8: New line formatting

4.1.6 Historical Immunization Entry

Historical immunizations used to store the person who documented the immunization as the provider of the immunization. Now the field is marked as DOCUMENTED BY and will be stored as the USER LAST UPDATE.

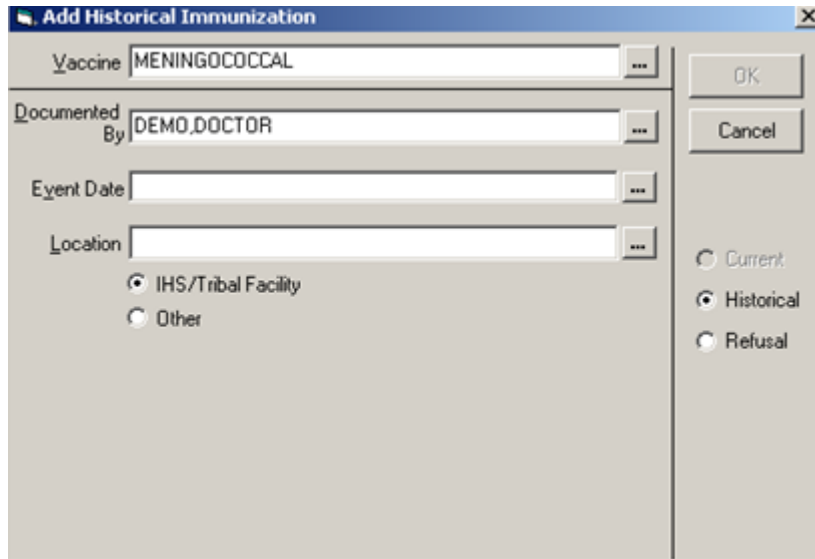


Figure 4-9: Add Historical Immunization dialog

The second field now is Documented by, as shown in the visit detail below.

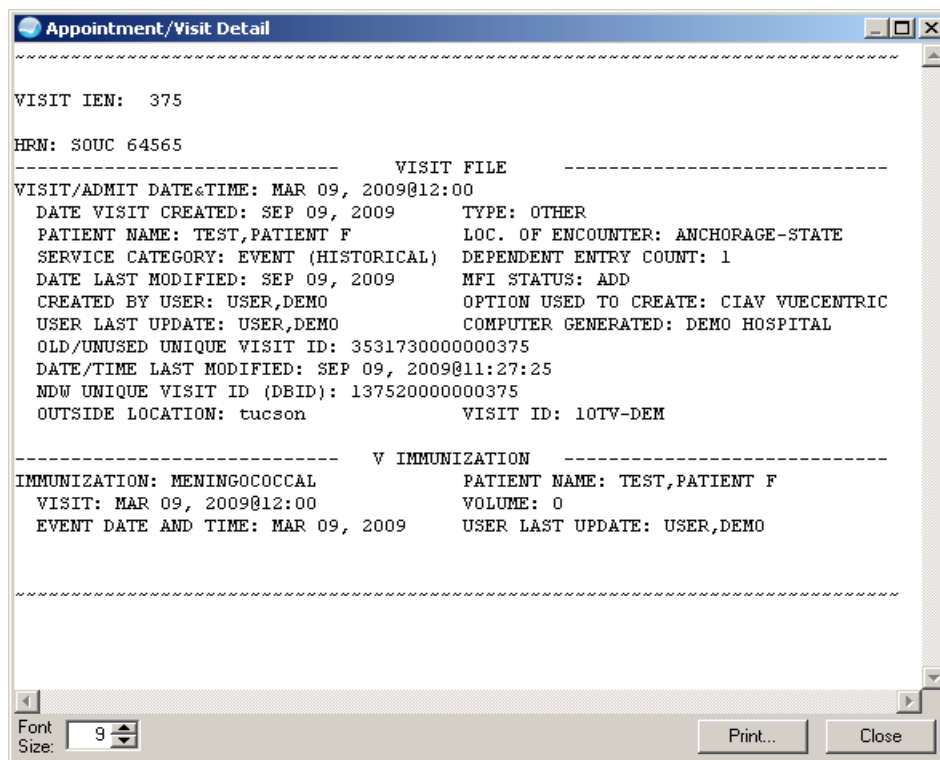


Figure 4-10: Sample Visit Detail

The Visit Detail shows “User Last Updated” as the “Documented By” user.

4.1.7 Reminders Prompts

The Reminders prompts on DX were not working properly. If you added a taxonomy in a reminder dialog, it was not storing properly or adding it to the problem list.

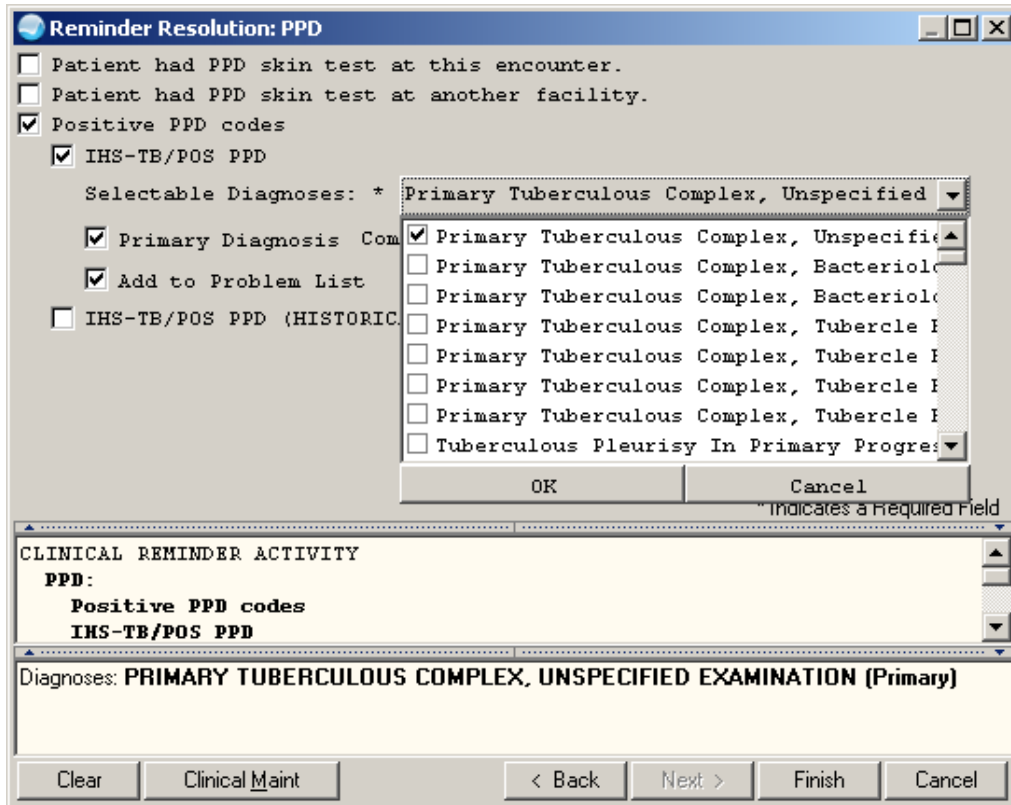


Figure 4-11: Taxonomy Reminder element

The diagnosis is added to the problem list and as the Primary Visit DX.

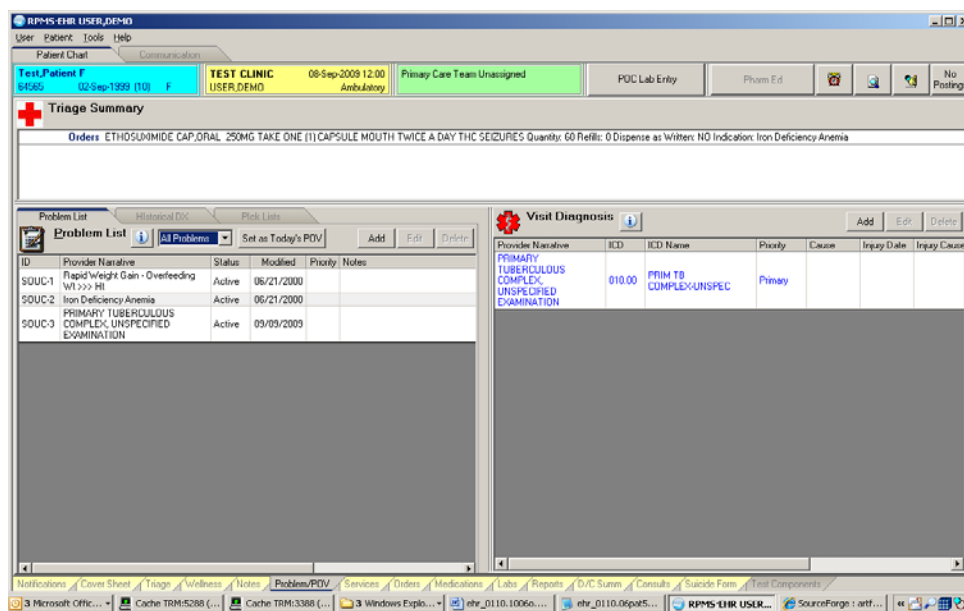


Figure 4-12: Sample Problem List and Visit Diagnosis

4.1.8 Renewing Narcotics

Using the right-click menu allowed narcotics to add refills while using the Medication process button did not. Now they both do not allow refill or renewals.

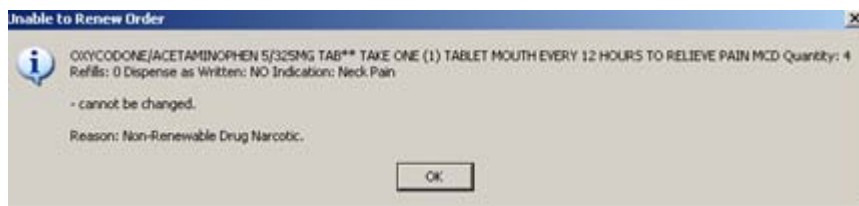


Figure 4-13: Error message on renewing narcotics

4.1.9 Process Button and Chronic Status

The application activates the Chronic status when renewing medications through the Process button.

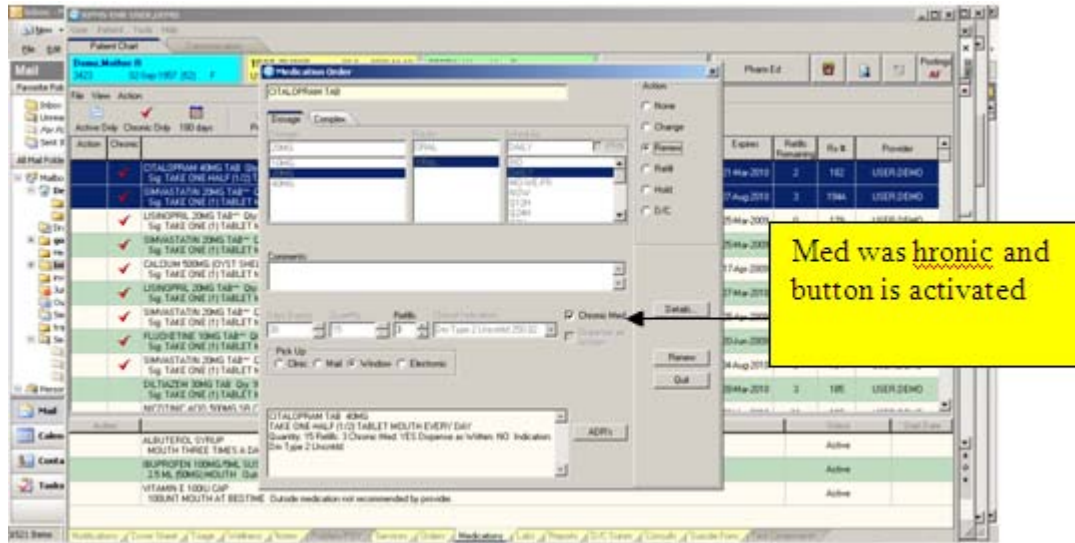


Figure 4-14: Chronic check box activates on renewal of medication

The renewed medication displays with a Chronic status.

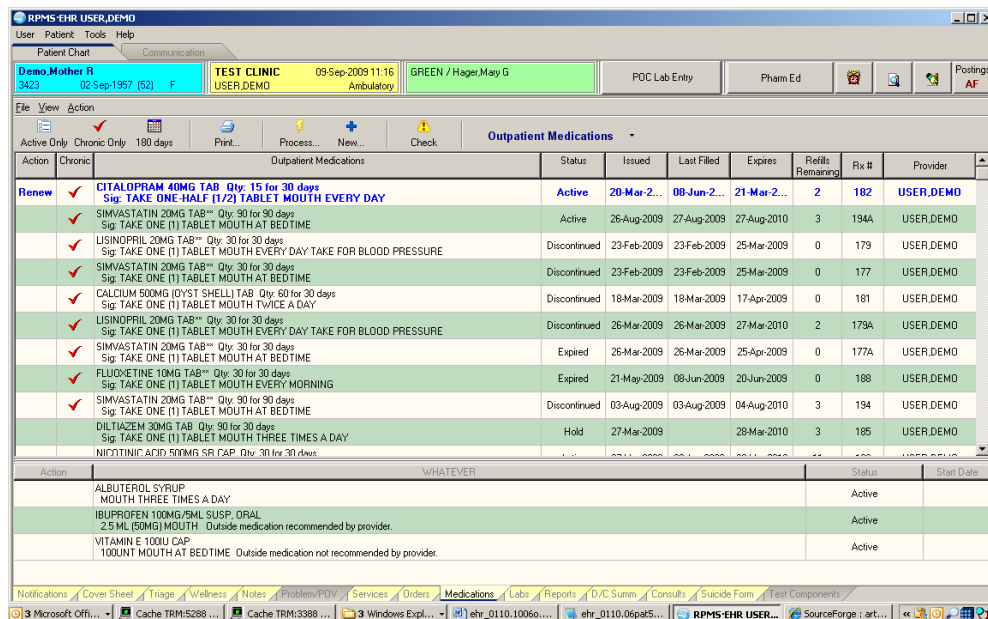


Figure 4-15: Renewed medication

4.1.10 Provider Narratives

Provider narratives are now truncated at 160 characters.

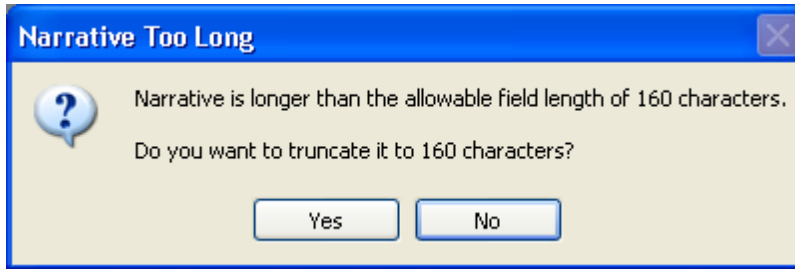


Figure 4-16: Information Message when provider narrative is greater than 160 characters

4.1.11 Record Flags

Inactive record flags should not appear in the popup when POPUPFLAG is TRUE.

A patient has both active and inactive patient record flags as in the example below with an active flag for DRUG STUDY and an inactive PAIN CONTRACT flag.

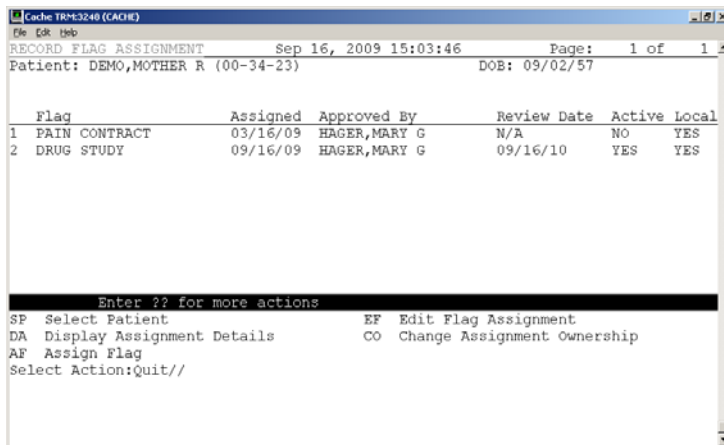


Figure 4-17: Patient with Active and Inactive flags

The pop-up is set to True for this component.

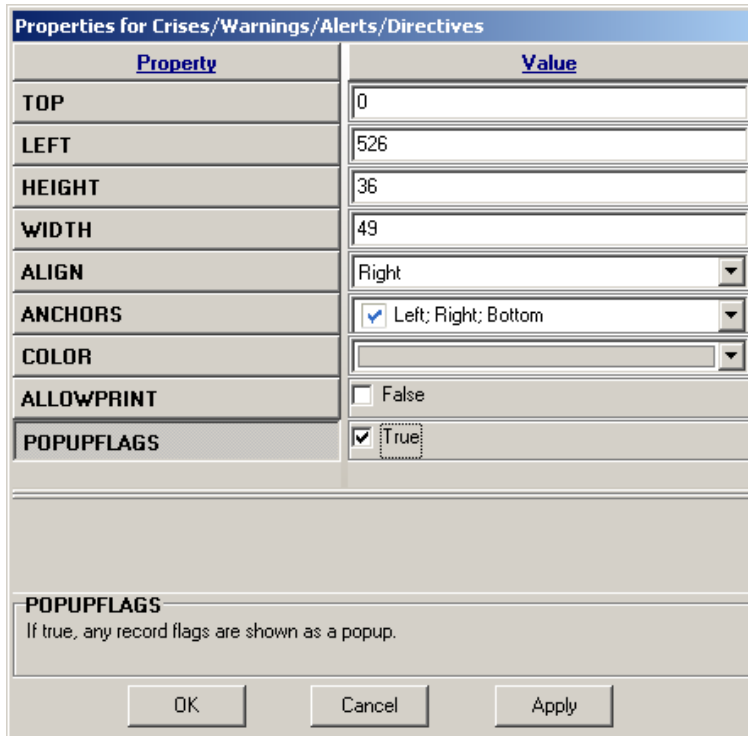


Figure 4-18: Property POPUPFLAGS is set to True

When this patient is selected, only the active flag should appear in the popup.

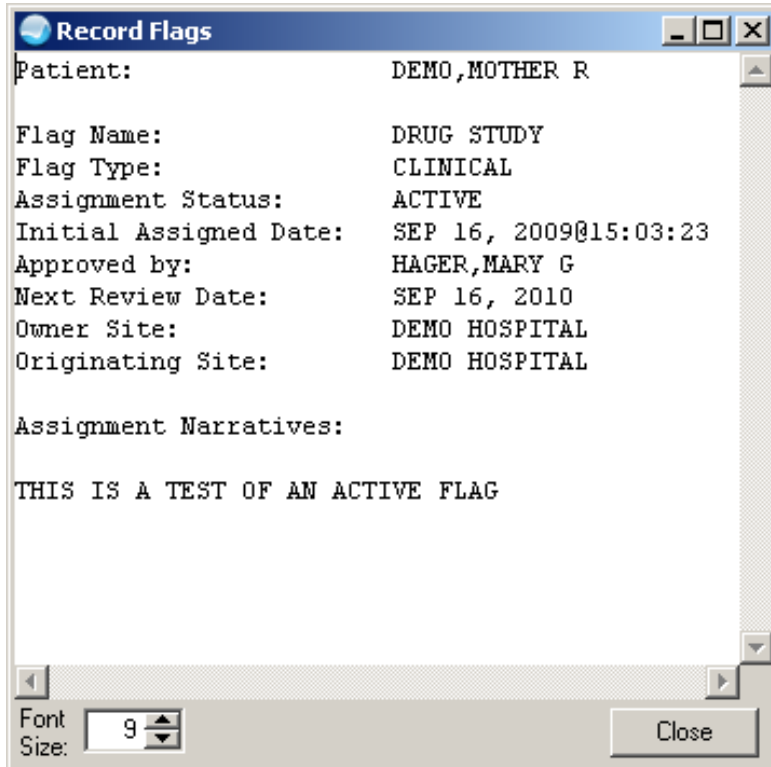


Figure 4-19: Active flag is pop-up

This should match what is seen in the component itself for patient postings

Allergies	Severity	Signs / Symptoms
Penicillin		Hives
Codeine		Nausea, Vomiting

Crisis Notes, Warning Notes, Directives, Record Flags		
F	DRUG STUDY	16-Sep-2009 15:03

Figure 4-20: Active flag in patient postings

4.1.12 Distorted Logon Window

Sites can now set this manually. The user needs to have access to the Server, not the Client. The user needs to log into the bin folder on the SERVER where the EHR files are stored when they are loaded.

The vcIniConfig utility **MUST** be run in the application repository. This means that the VueCentric administrator must log into the Windows Server where the application repository resides and launch the vcIniConfig utility. For patch 6 that means the VC administrator would log into the server (using RDP or sitting at the actual server), navigate to the application repository (c:\ehr\bin) and double-click on vcIniConfig.exe.

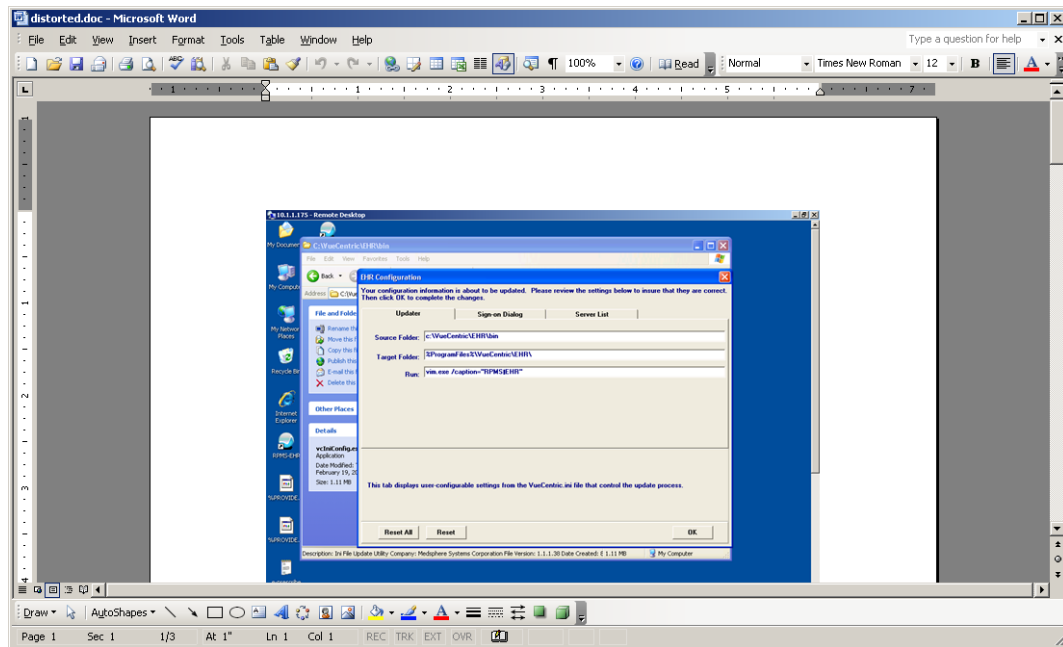


Figure 4-21: vcIniConfig file

After launching vcIniConfig, click on the Sign-on Dialog tab and adjust the settings. Clicking on the Dialog/Size control will display help text on the available values. If you want to resize the dialog, select Reminder and then click on Preview. Resize the dialog to the desired size and then close the dialog by clicking on the X. When your changes are completed click the OK button. This will save your settings to the vcBroker.ini file and update the VueCentric.ini file so that the new broker settings will be brought down to the client machine.

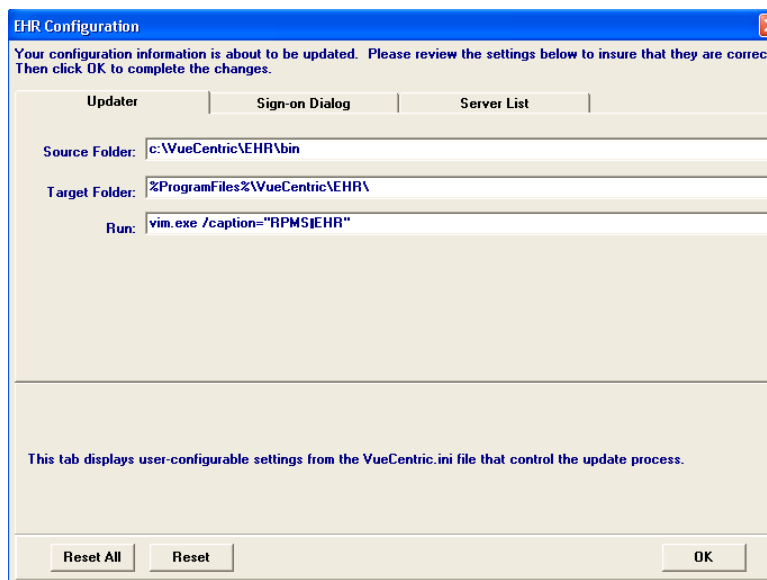


Figure 4-22: VcIniConfig file

Select the sign-on tab and adjust the settings.

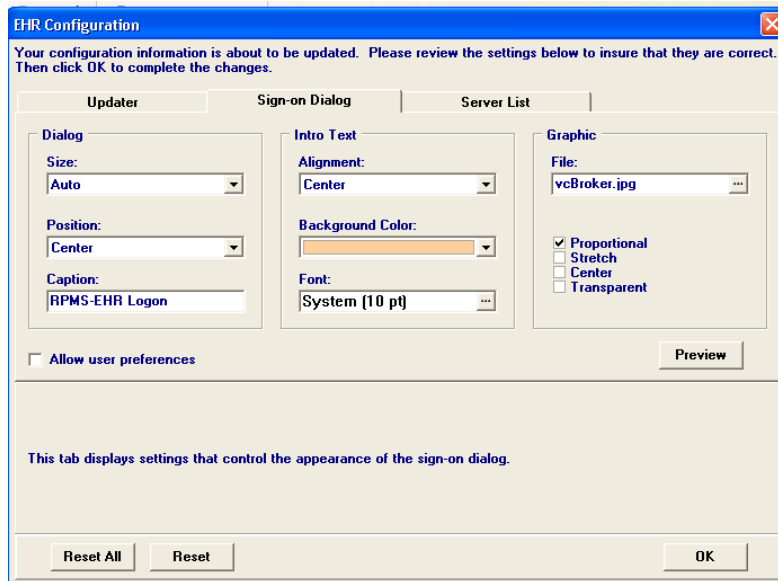


Figure 4-23: Logon Screen Settings

Review the settings and then save them so they will be brought down to all users as they logon.

4.1.13 Relocking Unlocked Visits

The parameter to unlock a visit now has another field so that the visit will again be locked after a time interval.

```

Temporarily Override Visit Lock for User
Select NEW PERSON NAME:   USER,DEMO   DU   DOCTOR

---- Setting Use to override visit lock for a user.  for User: USER,DEMO ----
Select Visit to unlock:  `410  9-23-2009@10:01:00   DEMO,INFANT   DEMO HOSPIT
AL   AMBULATORY   ALCOHOL AND SUBSTANCE
Are you adding 3090923.1001 as a new Visit to unlock? Yes//   YES

Visit to unlock: 3090923.1001//   9-23-2009@10:01:00   DEMO,INFANT   DEMO HO
SPITAL   AMBULATORY   ALCOHOL AND SUBSTANCE   3090923.1001
Date override expires: T+2

```

Figure 4-24: Setting overrides date

4.1.14 Order Comments

The user can no longer add Order Comments from the Action menu.

This is a change in VA software - from VA documentation:

The purpose of the order comments field was ambiguous to End Users and was used for various purposes. Based on the recommendation of the CPRS Clinical

Workgroup, the "Order Comments" function was disabled and the order comments field locked out.

4.1.15 Recurring Lab Order Display

The child pending labs now display on recurring Lab Order display

Previously, only the parent lab was displayed on the Order tab. Once the first child lab in a set of recurring labs was accessioned, the parent lab became active and the pending child labs could only be viewed by clicking on the order to review the order detail resulting in duplicate ordering. Now all child labs are visible.

Active Orders (includes Pending & Recent Activity) - ALL SERVICES							
Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Lab	+ALDOLASE Q227 BLOOD SP DAILY Indication: CEPHALEXIN ALLERGY	Start: 07/22/10 Stop: 08/20/10	Richard...				pending
Lab	ALDOLASE Q227 BLOOD SP LB #2620	Start: 07/22/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #3272	Start: 07/23/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #3415	Start: 07/24/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #4549	Start: 07/25/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #5361	Start: 07/26/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #5362	Start: 07/27/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #5645	Start: 07/28/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #7862	Start: 07/29/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #9978	Start: 07/30/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #10483	Start: 07/31/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #10740	Start: 08/01/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #10844	Start: 08/02/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #12381	Start: 08/03/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #13194	Start: 08/04/10	Richards.S				pending
Lab	ALDOLASE Q227 BLOOD SP LB #13216	Start: 08/05/10	Richards.S				pending

Figure 4-5: Pending child lab display

4.2 Enhancements

Patch 6 has added functionality. Below is information on how to use this new functionality. Prescription faxing and printing is in its own section.

4.2.1 Document Outside Medications

Medications that are not dispensed at the site can now be added. These can include over the counter medications or medications prescribed by an outside physician. The pharmacy data management menu has the options to setup a medication as a non-VA med. Any medication with this designation can be used as an outside med. TIU objects for outside meds are in TIUv1.0 patch 1006 which was released at the same time as EHRv1.1 Patch 6.

CHOOSE 1-3: 1 HYDROCHLOROTHIAZIDE 25MG TAB** CV701 -47975 00172-2083-80 DEMO PHARMACY *****

```

This entry is marked for the following PHARMACY packages:
  Outpatient
  Unit Dose
  Non-VA Med
  GENERIC NAME: HYDROCHLOROTHIAZIDE 25MG TAB**  Replace
  VA CLASSIFICATION: CV701//
  DEA, SPECIAL HDLG: 6//

NATIONAL FORMULARY INDICATOR: YES
LOCAL NON-FORMULARY:
VISN NON-FORMULARY:
Select DRUG TEXT ENTRY:
Select FORMULARY ALTERNATIVE:
Select SYNONYM: 000172208380//
  SYNONYM: 000172208380//
  INTENDED USE: DRUG ACCOUNTABILITY//
  NDC CODE: 000172-2083-80//
Select SYNONYM:
MESSAGE:
RESTRICTION:
FSN:
INACTIVE DATE:
WARNING LABEL: 7,11//
ORDER UNIT: BT//
DISPENSE UNIT: TAB//
DISPENSE UNITS PER ORDER UNIT: 1000//
NDC: 00172-2083-80//
PRICE PER ORDER UNIT: 5.64//
LAST PRICE UPDATE:
AWP PER ORDER UNIT: 79.25//
AWP PER DISP UNIT is 00000.079250
SOURCE OF SUPPLY:

```

Figure 4-25: Beginning Instructions

The instructions continue below.

```

DISPENSING LOCATION:
STORAGE LOCATION:
PRICE PER DISPENSE UNIT: 0.006

      points to HYDROCHLOROTHIAZIDE 25MG TAB in the National Drug file.

This drug has already been matched and classified with the National Drug
file. In addition, if the dosage form changes as a result of rematching,
you will have to match/rematch to Orderable Item.

Do you wish to match/rematch to NATIONAL DRUG file? No//  (No)
Just a reminder...you are editing HYDROCHLOROTHIAZIDE 25MG TAB**.

Strength from National Drug File match => 25      MG
Strength currently in the Drug File    => 25      MG
Strength => 25      Unit => MG

POSSIBLE DOSAGES:
  DISPENSE UNITS PER DOSE: 1          DOSE: 25MG          PACKAGE: IO
  DISPENSE UNITS PER DOSE: 2          DOSE: 50MG          PACKAGE: IO
  DISPENSE UNITS PER DOSE: 0.5        DOSE: 12.5MG        PACKAGE: IO

LOCAL POSSIBLE DOSAGES:

Do you want to edit the dosages? N// 0

```

```

*****
This entry is marked for the following PHARMACY packages:
  Outpatient
  Unit Dose
  Non-VA Med

MARK THIS DRUG AND EDIT IT FOR:
O - Outpatient
U - Unit Dose
I - IV
W - Ward Stock
C - Controlled Substances
X - Non-VA Med

Enter your choice(s) separated by commas : X
                                     X - Non-VA Med
** You are NOW Marking/Unmarking for NON-VA MEDS. **

A Non-VA Med ITEM? Yes// (Yes)

** You are NOW in the ORDERABLE ITEM matching for the dispense drug. **

HYDROCHLOROTHIAZIDE 25MG TAB** is already matched to

      HYDROCHLOROTHIAZIDE TAB

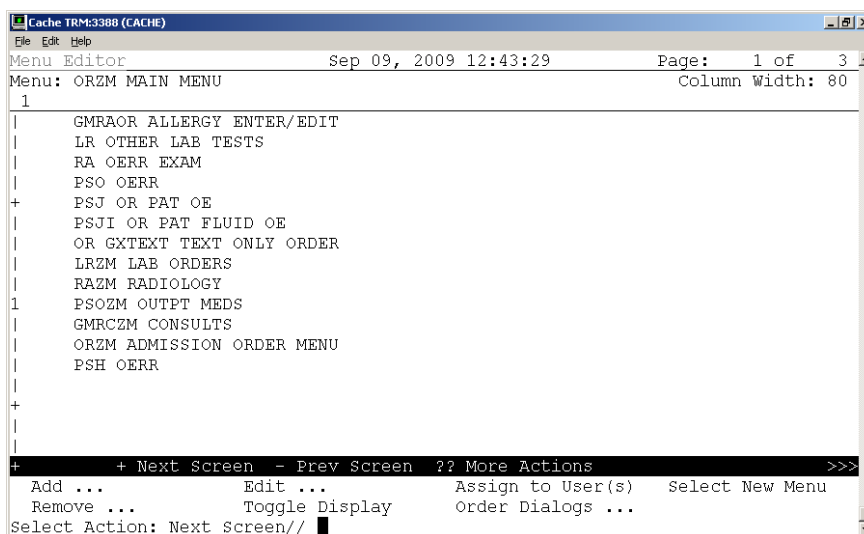
Do you want to match to a different Orderable Item? NO//

```

Figure 4-26: Drug marked as non-VA medication

4.2.1.1 Ordering

This concerns adding Outside meds dialog to the main ordering menu. The generic dialog for outside meds is PSH OERR. Add this to either your main menu if you are using the parameter ORWDX WRITE ORDERS MENU.



```

Cache TRM:3388 (CACHE)
File Edit Help
Menu Editor          sep 09, 2009 12:43:29          Page: 1 of 3
Menu: ORZM MAIN MENU          Column Width: 80
1
| GMRAOR ALLERGY ENTER/EDIT
| LR OTHER LAB TESTS
| RA OERR EXAM
| PSO OERR
+ PSJ OR PAT OE
| PSJI OR PAT FLUID OE
| OR GXTEXT TEXT ONLY ORDER
| LRZM LAB ORDERS
| RAZM RADIOLOGY
1 PSOZM OUTPT MEDS
| GMRCZM CONSULTS
| ORZM ADMISSION ORDER MENU
| PSH OERR
|
+
|
+ + Next Screen - Prev Screen ?? More Actions >>>
Add ...      Edit ...      Assign to User(s)  Select New Menu
Remove ...   Toggle Display    Order Dialogs ...
Select Action: Next Screen//

```

Figure 4-27: Main ordering menu

If the site has setup the ORWOR WRITE ORDERS LIST parameter for its main menu, then add PSH OERR to a sequence number in this list.

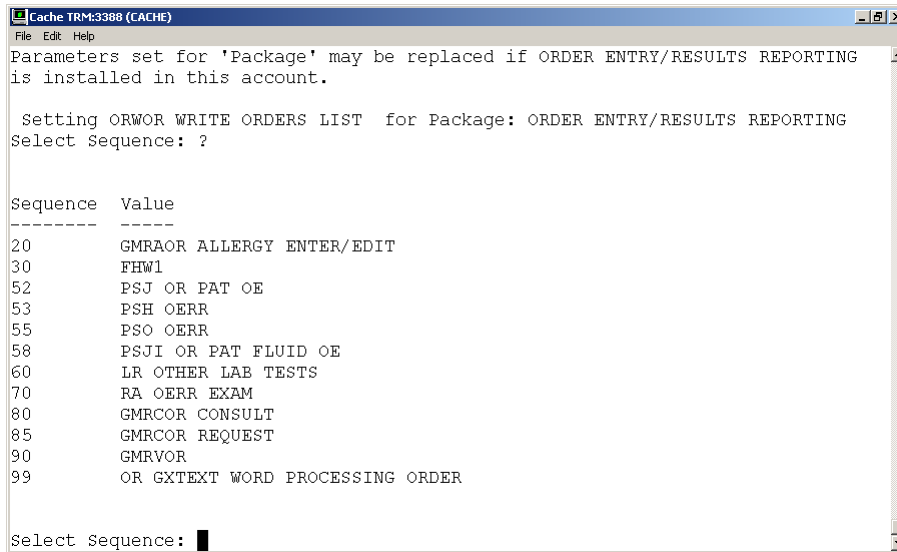


Figure 4-28: ORWOR WRITE ORDERS LIST parameter

This is the outside meds dialog.

If a user does not select a dose from the list, types in a non standard dose OR leaves the dose blank, the medication will not pass to the V Medication file in PCC. This entry WILL order check and WILL appear in med lists in TIU, however these entries will not appear in the Health Summary and the Patient Wellness handout until this is fixed in the BJPC v2.0 Patch 5 currently in development. Recommend either of the 2 methods below to produce a medication reconciliation list:

- Right click, preview and print a TIU template using one of the updated TIU (see set up instructions section 3.1.3)
- Print Outpatient Meds and Outside Meds from the Meds Tab (you must print each list separately)

The explanation field is controlled by a parameter.

Dosage	Route	Schedule
250MG 0.3	ORAL	QID
500MG 0.6	ORAL	QID

Comments:

Statement/Explanation

Outside medication not recommended by provider.

Outside medication recommended by provider.

Patient buys OTC/Herbal product without medical advice.

Medication prescribed by another provider.

Start Date:

ACETAZOLAMIDE TAB
TAKE BY MOUTH 4 TIMES A DAY QID

Accept Order

Quit

Figure 4-29: Outside meds dialog

On the Medications tab you will see two screens and possibly three (if the patient is an inpatient). On the Medications tab, click in the Outside Meds group box to add/edit DC outside medications.

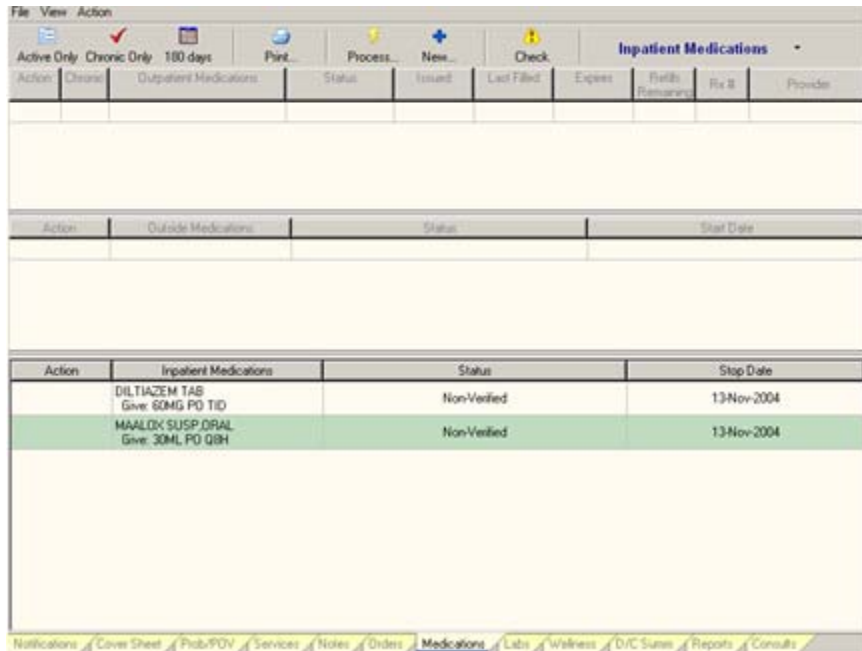


Figure 4-30: Sample Medications window with three group boxes

4.2.1.2 Parameters

Below are various parameters associated with medications.

4.2.1.2.1 BEHORX NONVA LABEL

This parameter is set to Outside Meds for the name of this component.

```

BEHORX NONVA LABEL may be set for the following:

      800 Division      DIV      [DEMO HOSPITAL]
      900 System        SYS      [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting BEHORX NONVA LABEL for System: DEMO.MEDSPHERE.COM -----
Label: Outside Meds//
    
```

Figure 4-31: Setting BEHORX NONVA LABEL to Outside Meds

4.2.1.2.2 ORWD NONVA REASON

Other reasons for giving an outside med can be added.

```

--- Setting ORWD NONVA REASON for Package: ORDER ENTRY/RESULTS REPORTING ---
Select Sequence: ?

Sequence  Value
-----  -----
    
```

- | | |
|---|---|
| 1 | Outside medication not recommended by provider. |
| 2 | Outside medication recommended by provider. |
| 3 | Patient buys OTC/Herbal product without medical advice. |
| 4 | Medication prescribed by another provider. |

Figure 4-32: Adding other reasons for Outside Meds

4.2.1.2.3 ORWDX NEW MED

This sets up what appears in the GUI. If the Outside Med item isn't setup, it will not display in the GUI.

```

----- Setting ORWDX NEW MED for Package: ORDER ENTRY/RESULTS REPORTING -----
Select Patient Status: ?

Patient Status Value
-----
Outside Med      PSH OERR
Inpatient        PSJ OR PAT OE
Outpatient       PSO OERR

Select one of the following:

i      Inpatient
o      Outpatient
h      Outside Med
    
```

Figure 4-33: Set up for Outside Meds

4.2.2 On Demand Drug Interaction Checker

The Medication window contains a Yellow CHECK button. Click this button to invoke the order checker at any time.

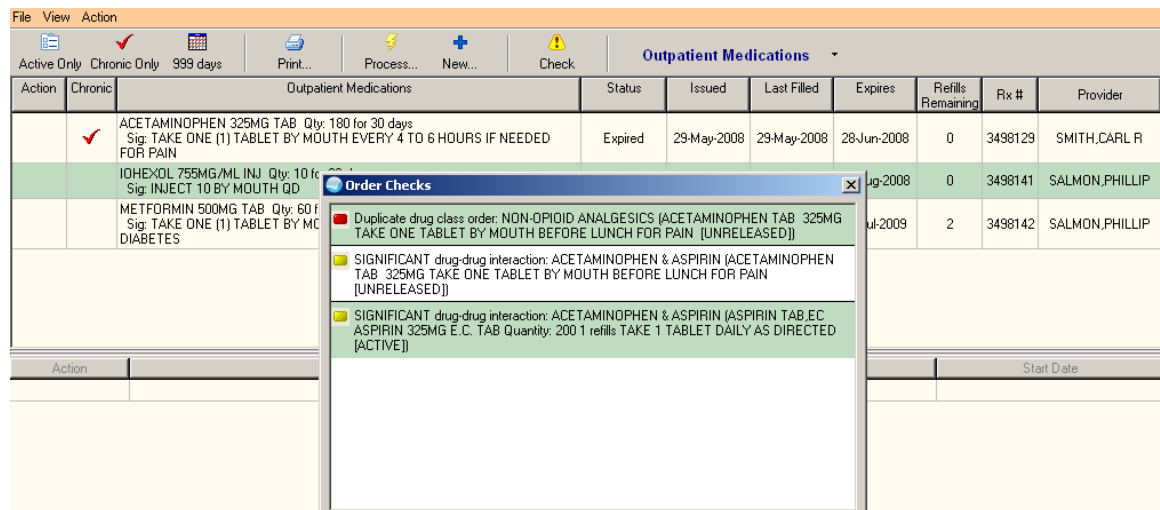


Figure 4-34: Order Checks pop-up on Medications window

4.2.3 Filter, Search, or Order Notes by Associated DX

Notes can now be search on the POV attached to that visit. The notes will appear in **BOLD** text for easy viewing. Select the View drop-down on the Notes tab and select Custom View.

Figure 4-35: Custom search of TIU notes by POV Diagnosis

On the List Selected Documents, select the Diagnosis check box and then enter the DX you want to search for in the lower text box. For example if you specified the DX to be Diabetes and clicked OK, then the particular notes will display.

In the following screen capture, items that are bolded have a POV of diabetes.

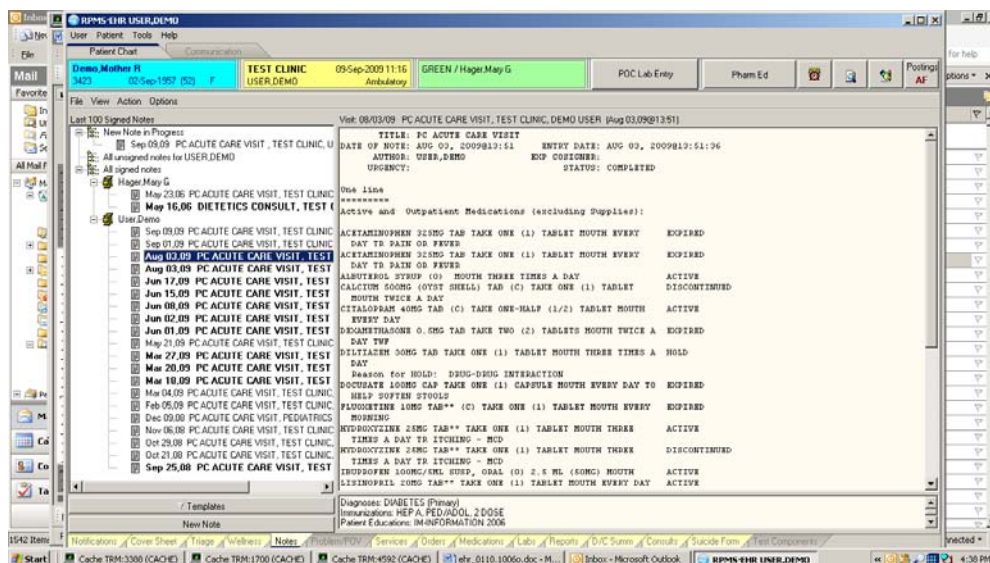


Figure 4-36: Items having a POV of diabetes

4.2.4 Visit Summaries with Date Range

A new report similar to the other visit summaries has been created with the addition of time variables. You may need to add this to your report list parameter.

On the RPMS-EHR Configuration Master Menu, choose the RPT (Report Configuration) option. The application displays another set of options.

FMT	Print Formats
HSM	Health Summary Configuration ...
PAR	Report Parameters ...
SYS	System Display Parameters
USR	User Display Parameters

Figure 4-37: New set of Options

Select SYS (System Display Parameters) option.

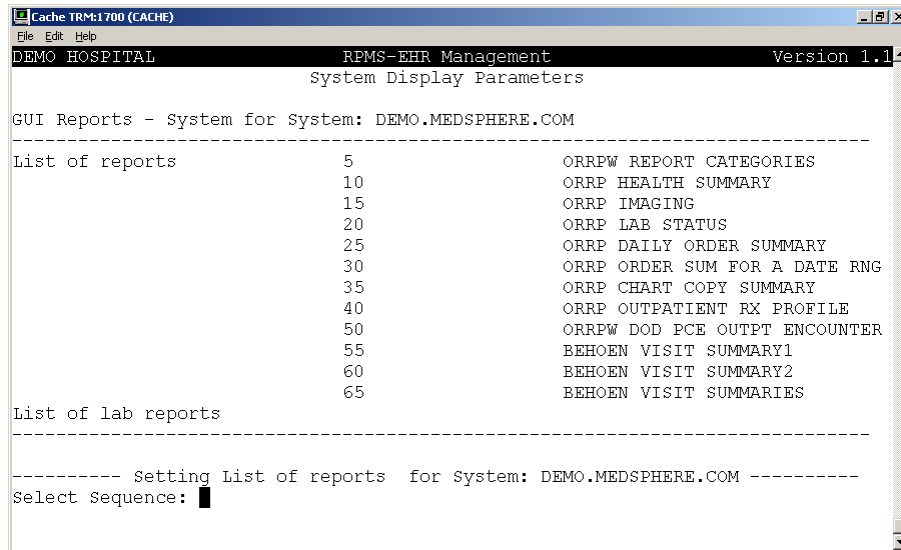


Figure 4-38: List of System Report Parameters

If BEHOEN VISIT SUMMARIES is NOT there, add a new sequence number and then add this report.

There are now 3 reports

- BEHOEN VISIT SUMMARY1
- BEHOEN VISIT SUMMARY2
- BEHOEN VISIT SUMMARIES

Log off the EHR and then logon again.

After selecting the report, select the Date Range.

Reports Page

Available Reports

- Clinical Reports
- Health Summary
 - Imaging (local only)
 - Visit Summaries
 - Visit Summary
 - Visit Summary (Brief)
 - E-Prescribing Receipt

CLINIC: 14 MENTAL HEALTH LOC. OF ENCOUNTER: WWH
VISIT/ADMIT DATE&TIME: 05-Nov-2009 15:23 ENCOUNTER PROVIDER(s): GARCIA,RYAN(P)

----- PROGRESS NOTES -----
----- BH PSYCHIATRIC PROGRESS NOTE -----
AUTHOR: GARCIA,RYAN SIGNED BY: GARCIA,RYAN
STATUS: COMPLETED
Visit Diagnosis
Bipolar I Disorder, Single Manic Episode, Mild:

Functional Status
testing ehr bh notes crossing to the backend

Treatment Plan:

Medication Prescription and Monitoring:

Modality and Frequency of Treatment:

Results of Clinical Tests and Standardized Testing:

HISTORY BH MEASUREMENT
PHQ2 PHQ9 DEP CRAFFT

Symptoms:

Date Range
Date Range...
Today
One Week Back
Two Weeks Back
One Month Back
Six Months Back
One Year Back
03-May-2010 to 10-May-2010

Figure 4-39: Visit Summary by Dates report

4.2.5 Infant Feeding Choice

Infant feeding has been removed from the Personal History component and become stand alone. The dialog will only be active if the child age is 5 or younger.

Infant Feeding Add/Update Delete

Infant Feeding History

Feeding Choice	Entry Date
1/2 & 1/2 BREAST AND FORMULA	05/11/2010 15:12
FORMULA ONLY	12/01/2009 12:06

Figure 4-40: Sample active Infant Feeding component

After you click Add/Update, the Infant Feeding Choice dialog displays.

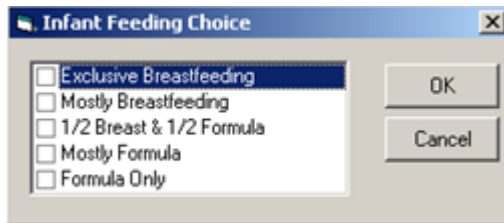


Figure 4-41: Infant Feeding Choice dialog

4.2.6 Reproductive Factors

The Reproductive Factors component only applies to female patients. This window displays the reproductive history of the patient.

Figure 4-42: Sample Reproductive Factors component

Data can be updated as needed.

After clicking Add or Edit, the application displays the Update Reproductive Factors dialog.

Figure 4-43: Sample Update Reproductive Factors dialog

Items divided into categories of every visit questions. Data changed with each pregnancy will reflect the current pregnancy data.

4.2.7 Clinical Indication for Medications

A new Parameter BEHOORPA has been added to control the display of the Clinical Indication for both labs and medications. Right now, LAB and OUTPATIENT PHARMACY are the only packages it is designed to work with.

```
Select PARAMETER DEFINITION NAME: BEHOORPA CLINICAL INDICATOR      Enable Clinical
Indicator Prompt

BEHOORPA CLINICAL INDICATOR may be set for the following:

      800 Division      DIV      [DEMO HOSPITAL]
      900 System        SYS      [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

---- Setting BEHOORPA CLINICAL INDICATOR for System: DEMO.MEDSPHERE.COM ----
Select Package: ?
Package      Value
-----
LAB SERVICE      YES
OUTPATIENT PHARMACY  YES
```

Figure 4-44: Parameter for Clinical Indication

As with the clinical indication for labs, the default list will be the patient's problem list.

The selection of Other will open up a dialog to select any ICD9 code. This code will then be the default for any other meds or labs ordered during this ordering session

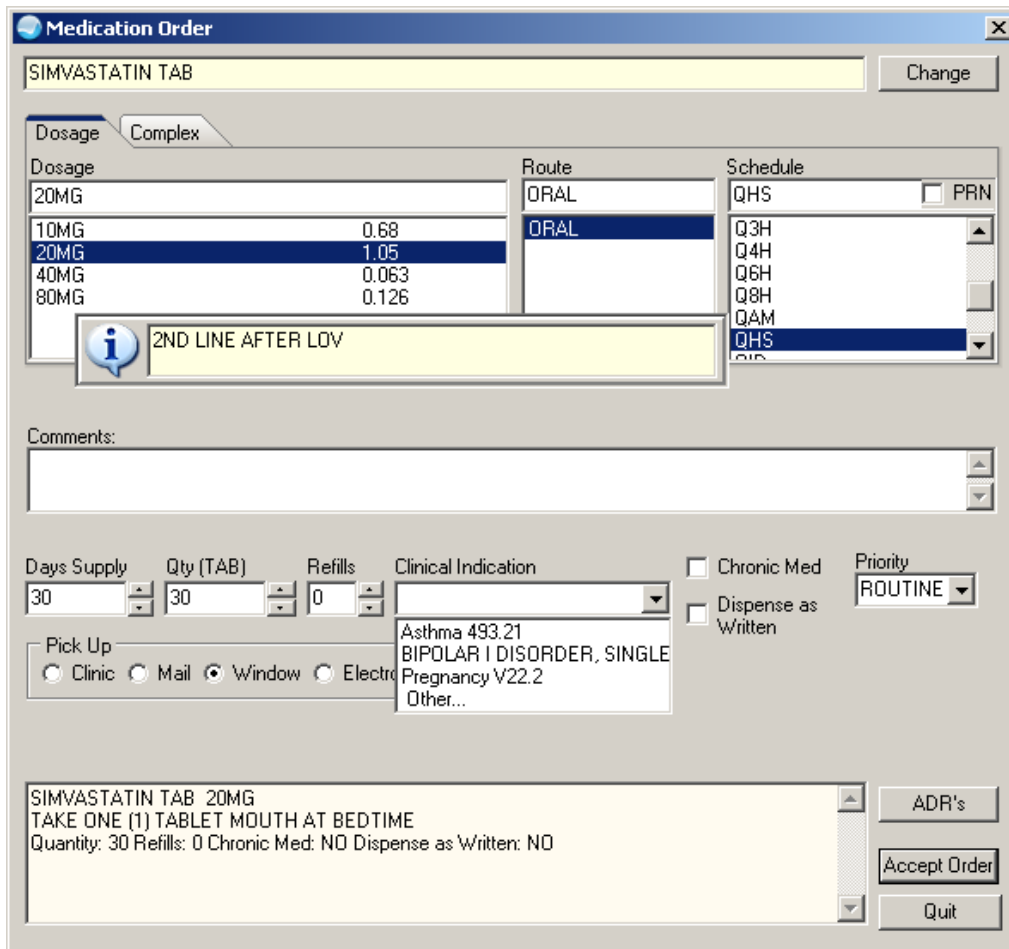


Figure 4-45: Clinical Indication added to outpatient medication dialog

If you select the Other option on the drop-down list, the application displays the Other Clinical Indication dialog.

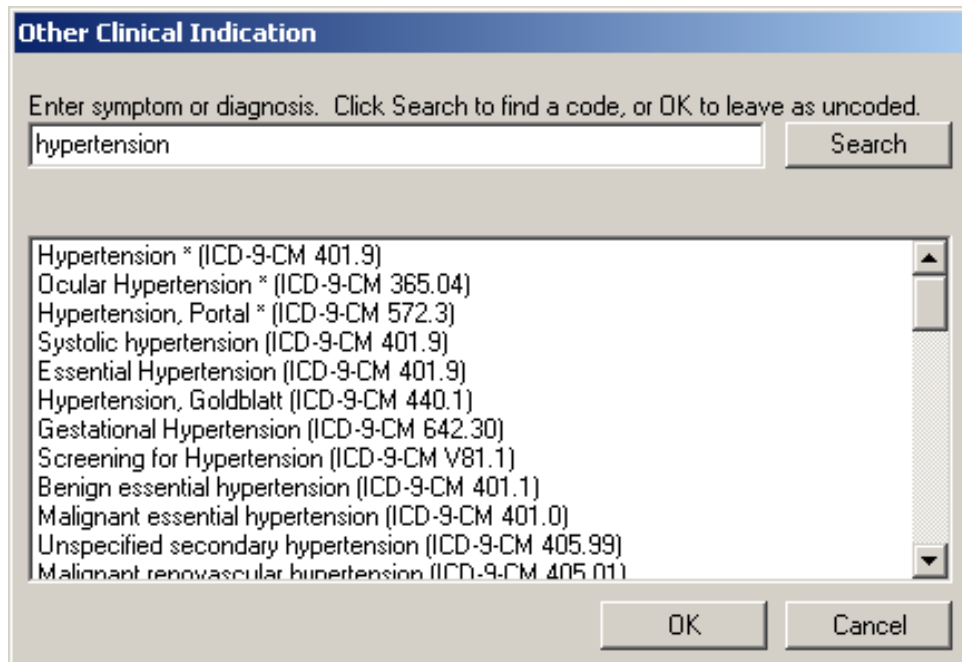


Figure 4-46: Generic ICD9 lookup for clinical indication

4.2.8 Radiology Report Annotation

Radiology reports that appear on the reports tab can now be annotated by a clinician.

When a report is available, right click on the report in the list, not in the text and then select annotate.

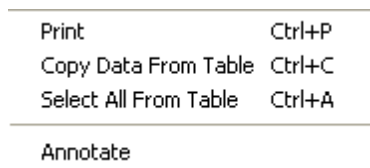


Figure 4-47: Annotate option on right-click menu

The Annotation of dialog displays.

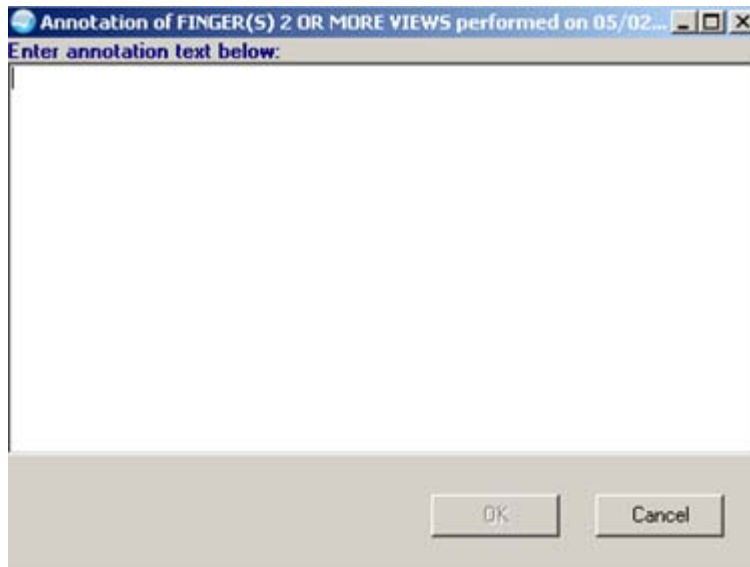


Figure 4-48: Annotation dialog

After saving the annotation, it will appear with the report.

```

PERIOPAL GRANULOMATOUS DISEASE IN THE UPPER AND LOWER CHEST LUNG.
Report
Right peripical pulmonary linear and nodular like calcific densities
consistent with granulomatous residual and minimal focal fibrosis. Mild
ectasia of the thoracic aorta and mild left ventricular diltation are
identified. Osteoporotic thoracic spine with hypertrophic anterior endplate
slipping noted. Otherwise, unremarkable chest.
Annotation
-----
TITLE: ANNOTATION
DATE OF NOTE: JUL 16, 2008@15:20:25  ENTRY DATE: JUL 16, 2008@15:20:42
AUTHOR: TETER,SHIRLEY          EXP COSIGNER:
URGENCY:                        STATUS: UNSIGNED
SUBJECT: Annotation of CHEST 2 VIEWS PA&LAT performed on 10/07/1999 11:51

There was 3 views that took place
Facility: DEMO INDIAN HOSPITAL
-----

```

Figure 4-49: Annotation text in report

It also appears as a note on the notes tab that will need to be signed by the provider. The title of this note is ANNOTATION.

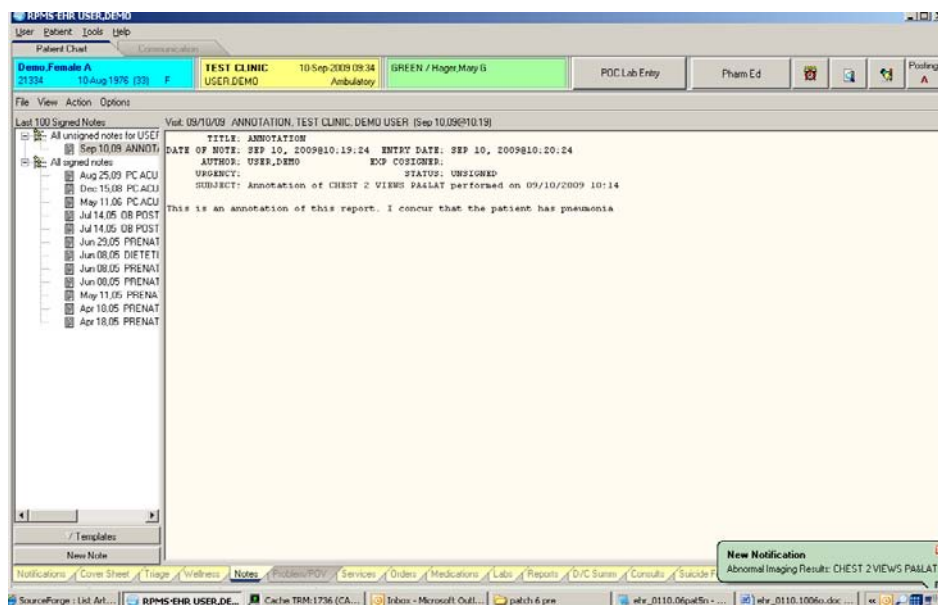


Figure 4-50: Annotation notes

4.2.9 Encounter Detail

Right-clicking on an encounter in the encounter component will now allow you to view the data on the visit.

The visits detail is determined by a parameter.

```

BEHOENCX DETAIL REPORT may be set for the following:

    100 User          USR      [choose from NEW PERSON]
    300 Service       SRV      [choose from SERVICE/SECTION]
    500 Division      DIV      [DEMO HOSPITAL]
    900 System        SYS      [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting BEHOENCX DETAIL REPORT for System: DEMO.MEDSPHERE.COM -----
Value: D REPORT~BEHOENPS(VIEN) Replace

```

Figure 4-51: Setting the parameter

Right-click on the visit and select Visit Detail.

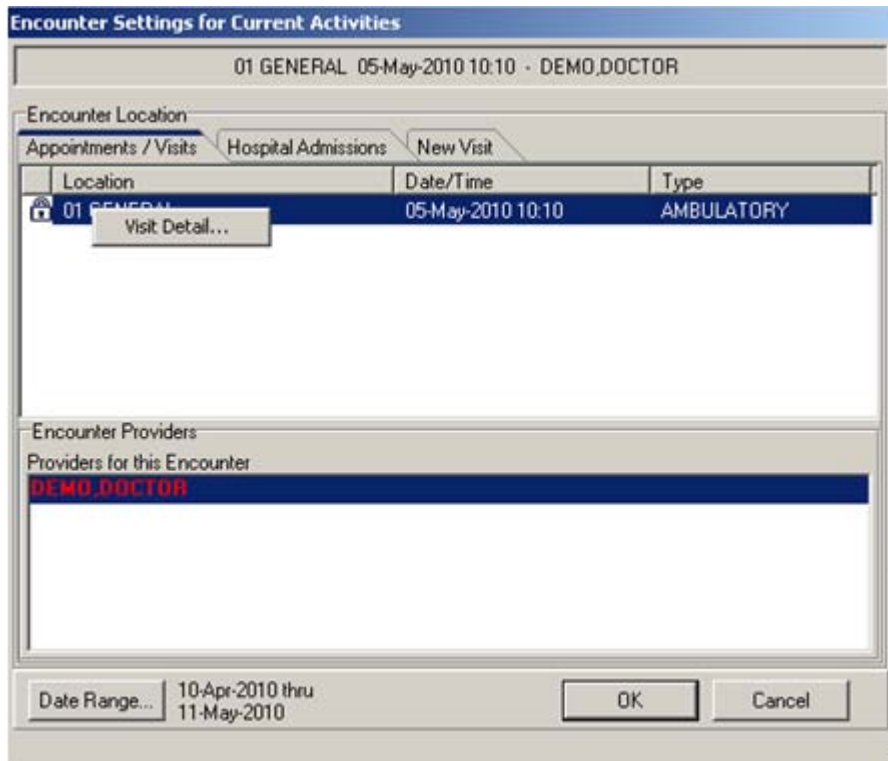


Figure 4-52: Visit Detail option on right-click menu

The application displays the Visit Detail report.

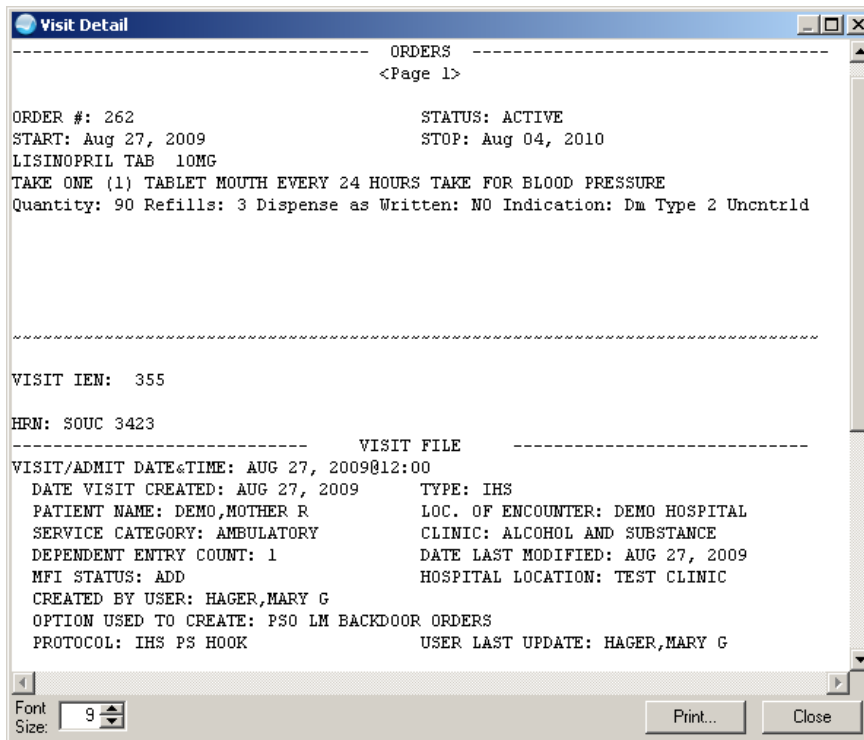


Figure 4-53: Sample Visit Detail report

4.2.10 Contraindications for Reminder Immunizations

There is a prompt that can be added to reminder elements for immunizations that is called PXRМ REACTION. If a site chooses to add this element, they can document any reactions to an immunization. However, IHS stores these in a separate file.

The solution was to also add the prompt PXRМ CONTRAINDICATION.

Then if a reaction is entered, a prompt will appear asking if you wish to enter this reaction as a contraindication.

First, you need to add the prompts to the elements by editing the element and adding both the PXRМ REACTION and PXRМ CONTRAINDICATION prompts.

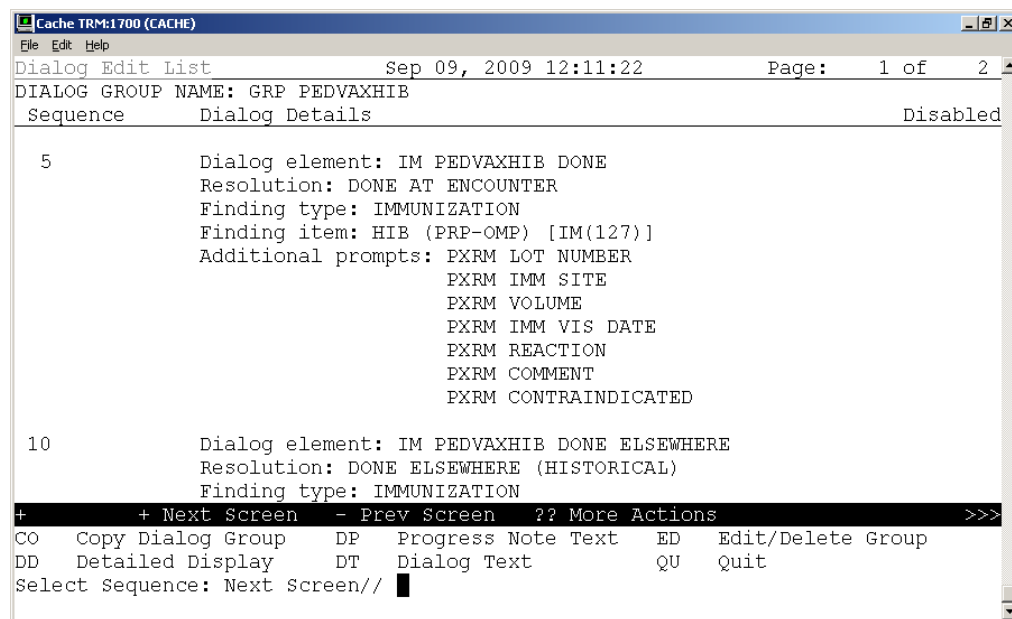


Figure 4-54: Reminder with new prompts

Below is a Reminder Resolution screen.

Reminder Resolution: Pedvaxhib

Immunizations Due: IPV (past due)
 MMR (past due)
 HEP A PED (past due)
 MENING-CV4 (due)

Check to document immunization information

Patient received pedvaxhib immunization at this encounter

Lot Number: * (None selected) ▾

Imm Site: * (None selected) ▾

Injection Volume: 0.50 ▾

Vacc Info Sheet Date: 18-Sep-2008 ...

Reaction: (None selected) ▾

Comment:

Contraindicated:

Patient/family indicated pedvaxhib immunization was received at another facility.

Patient/family refused pedvaxhib immunization at this visit.

Check to document immunization education done at this visit.

* Indicates a Required Field

CLINICAL REMINDER ACTIVITY

Pedvaxhib:

Immunization information

Clear Clinical Maint < Back Next > Finish Cancel

Figure 4-55: Reminder Resolution screen

Reminder with reaction and contraindication prompts is shown below.

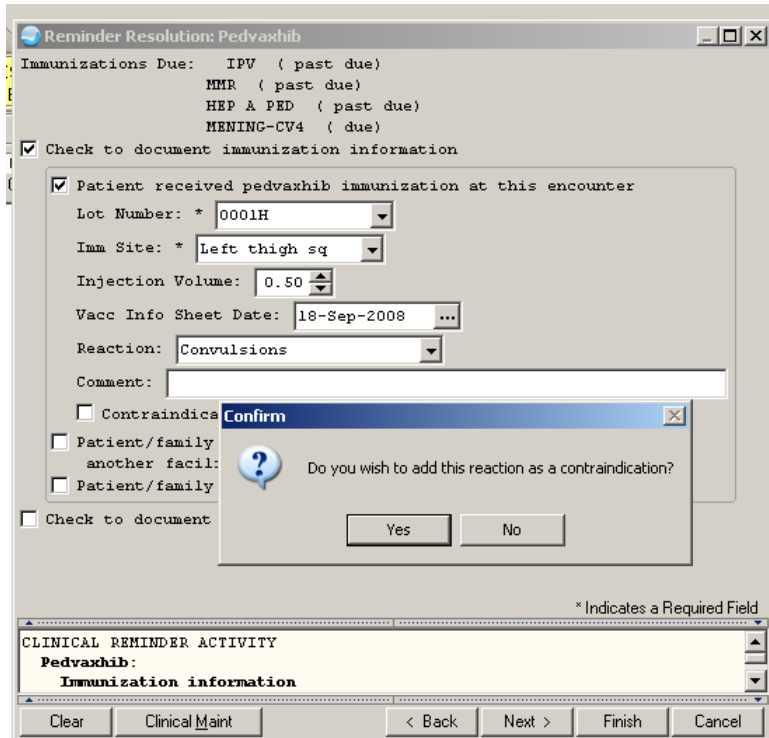


Figure 4-56: Reminder with dialog to add reaction as a contraindication

Below shows where the contraindication is stored and the reaction is listed with the immunizations.

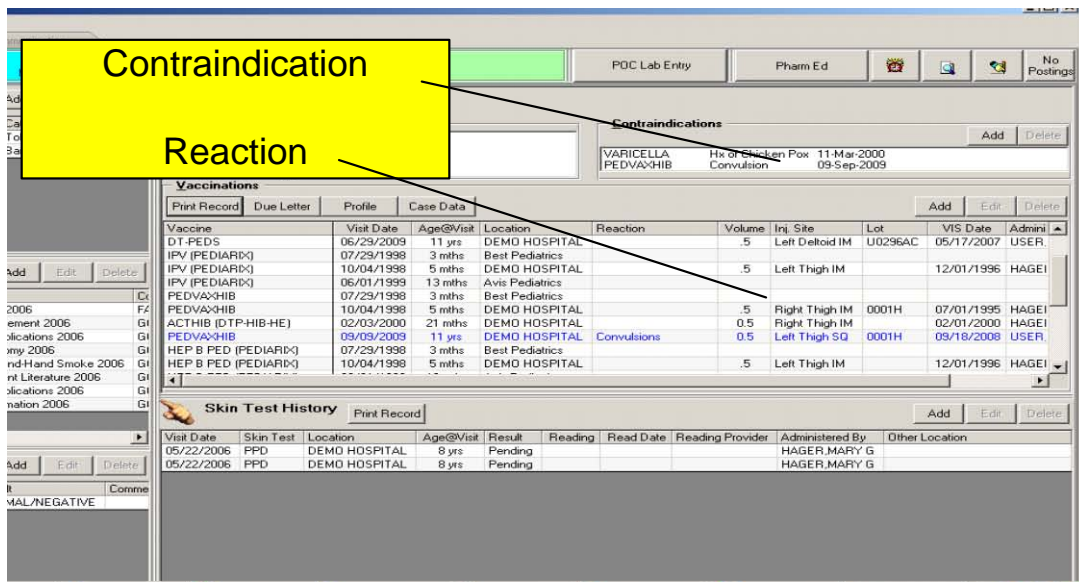


Figure 4-57: Contraindication and Reaction locations

4.2.11 VFC Prompt for Childhood Immunizations

Immunizations for children under the age of 19 will now have an extra prompt to add the VFC eligibility.

Figure 4-58: Add Immunization dialog for child

4.2.12 Readiness to Learn for Education Topics

Readiness to learn has moved to a field in the patient education file.

This prompt is now added to the education component with the list of choices available in the drop-down box.

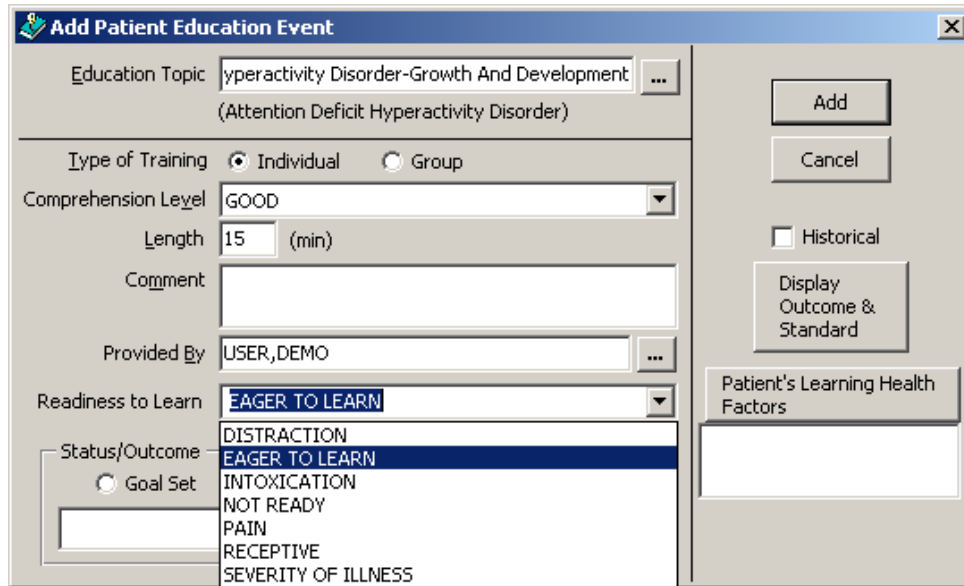


Figure 4-59: Readiness to Learn field on Add Patient Education Event dialog

The Education component now has the Readiness to Learn column in the grid.

Visit Date	Education Topic	Comprehension	Readiness To Learn	Status	Objectives	Comment	Provider
07/28/2008	Diabetes I/juv Not Uncontrol-Anatomy And Physiolog	GOOD					RICHARDS,SUS
07/28/2008	Diabetes I/juv Not Uncontrol-Disease Process 2006	GOOD					RICHARDS,SUS
12/23/1996	Ob/gyn-Postpartum Exam 2005	GROUP/NO ASSESSMENT					FORD,MIKE
09/24/1996	Prenatal-Labor Precautions 2005						CLELAND,RICH-
09/09/1996	W/Diet 2005	GOOD					SMITH,MONICA
09/09/1996	W/E exercise 2005	GOOD					SMITH,MONICA
08/15/1996	W/Diet 2005	GOOD					LEE,AMANDA K

Figure 4-60: Education component

4.2.13 Asthma and Problem List

Asthma classification is now a field in the problem list file for those diagnoses that are asthma related by taxonomy definition. In the EHR a column has been added to the problem list for the asthma classification.

ID	Provider Narrative	Status	Modified	Priority	Notes	Class	Onset	ICD	ICD Name	Classification
Ww-1	Diabetes With Other Specified Manifestations, Type 1 [juvenile Type], Uncontrol	Active	08/28/2008					250.83	DIAB w/OTHER IJUV UNCONT	
Ww-2	Leptospirosis, Unspecified	Active	08/28/2008				08/28/2008	100.9	LEPTOSPIROSIS NOS	

Figure 4-61: Problem List component

When a problem is entered that belongs to the asthma taxonomy, a prompt appears for the user to add the asthma classification.

The screenshot shows a 'Problem Maintenance' window with the following fields and options:

- Problem ID:** WW-3
- Priority:** 1 - high, 5 - low
- ICD:** Extrinsic Asthma, Unspecified
- Narrative:** Extrinsic Asthma, Unspecified
- Date of Onset:** (empty)
- Classification:** (empty dropdown menu)
- Note (3-60 c):** A dropdown menu is open, showing options: INTERMITTENT, MILD PERSISTENT, MODERATE PERSISTENT, and SEVERE PERSISTENT.
- Status:** Radio buttons for Active Problem (selected), Personal History, and Inactive Problem.
- Buttons:** Save and Cancel.

Figure 4-62: New asthma diagnosis with classification field

If the classification needs to be changed, the problem should be edited, and because it is an asthma diagnosis the classification field will appear with the current classification as the default. A different classification can be selected and saved as an update to the problem.

4.2.14 Asthma and POV

When an asthma POV is selected, a field for the asthma control will now appear. The patient's last recorded asthma control will pre-populate the field and can be edited.

When an asthma POV is selected using a pick list or an historical DX, the POV will need to be edited to change or record the asthma control. If the box to add the POV to the problem list is clicked, the asthma classification box will also appear.

Figure 4-63: Asthma POV with the asthma control field

The Visit Diagnosis component has changed.

Provider Narrative	ICD	ICD Name	Priority	Cause	Injury Date	Injury Cause	Injury Place	Modifier	Onset Date	Asthma Control
asthma	433.00	EXTRINSIC ASTHMA, UNSPECIFIED	Primary							WELL CONTROLLED

Figure 4-64: Asthma Control is added to the Visit Diagnosis component

4.2.15 Desktop Tools

This section explains the setup for eSig tool and Dosing calculator.

4.2.15.1 eSig Tool

Follow these steps to setup the eSig Tool. This tool will allow you to change your electronic signature within the RPMS-EHR application.

1. In Design Mode, access Design | Layout Manager.
2. Click Properties and then Customize Menus.
3. To add an item, click the + button and then type in the name you want, such as eSig.

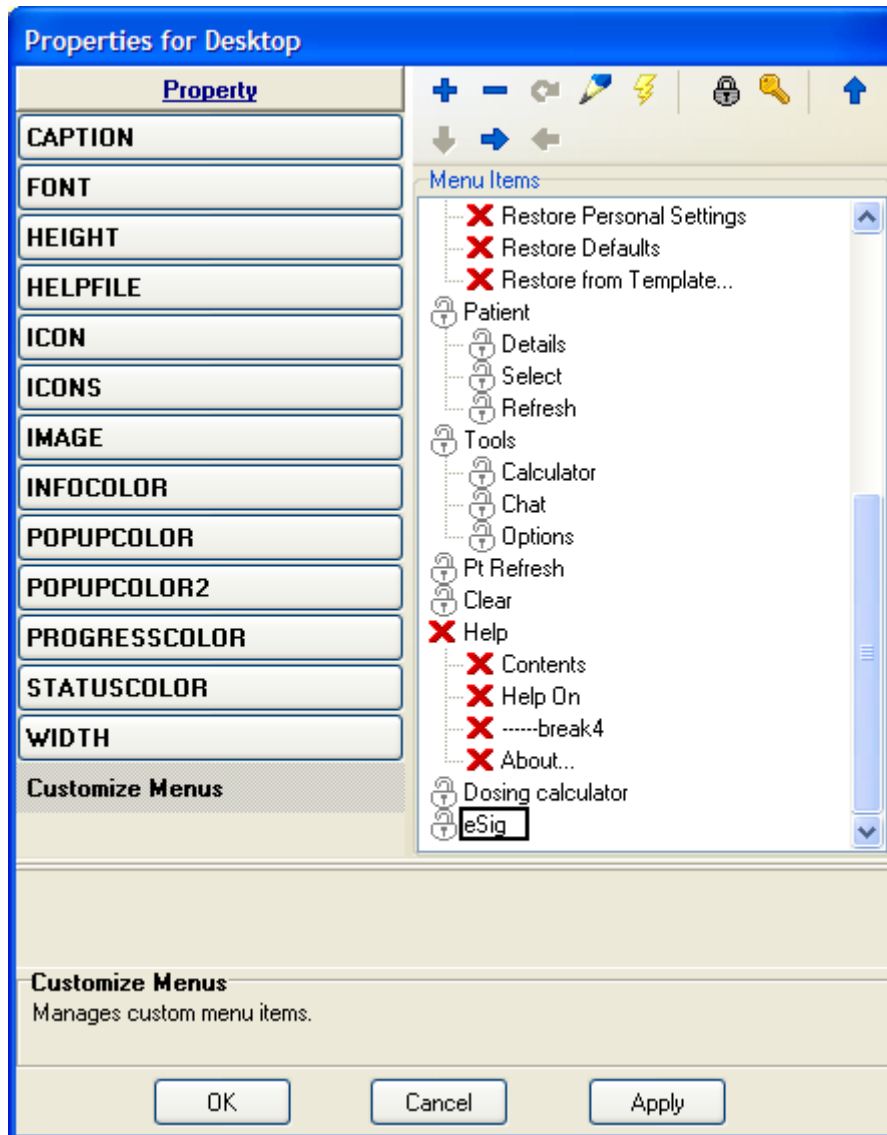


Figure 4-65: Location of the eSig

4. Use the Up, Down, Left, and Right arrow to move the item to the menu location you want.
5. Click the Lightning Bolt button to set the action for the eSig. Enter \$(user.ESigModify) in the Edit action field.

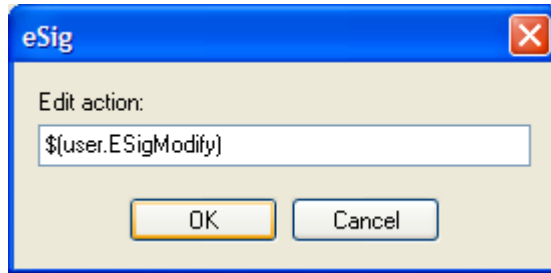


Figure 4-66: Entering data in Edit action field

6. Get out of Design Mode. When you click the eSig item, the application will display the Change your Electronic Signature dialog.

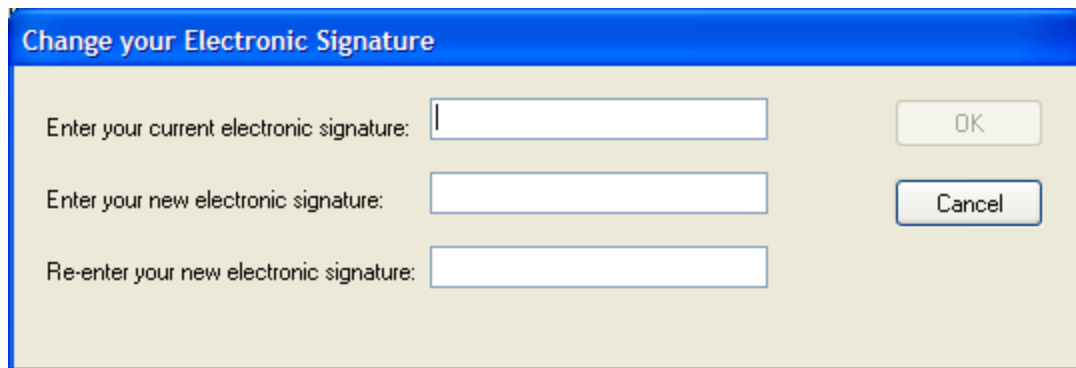


Figure 4-67: Change your Electronic Signature dialog

4.2.15.2 Dosing Calculator

Follow these steps to setup the Dosing Calculator.

1. In Design Mode, access Design | Layout Manager.
2. Click Properties and then Customize Menus.
3. To add an item, click the + button and then type in the name you want, such as Dosing Calculator.
4. Use the Up, Down, Left, and Right arrow to move the item to the menu location you want.
5. Click the Lightning Bolt button to set the action for the Dosing Calculator. The action should be \$(BEHDosingCalc.DosingCalc.Execute).

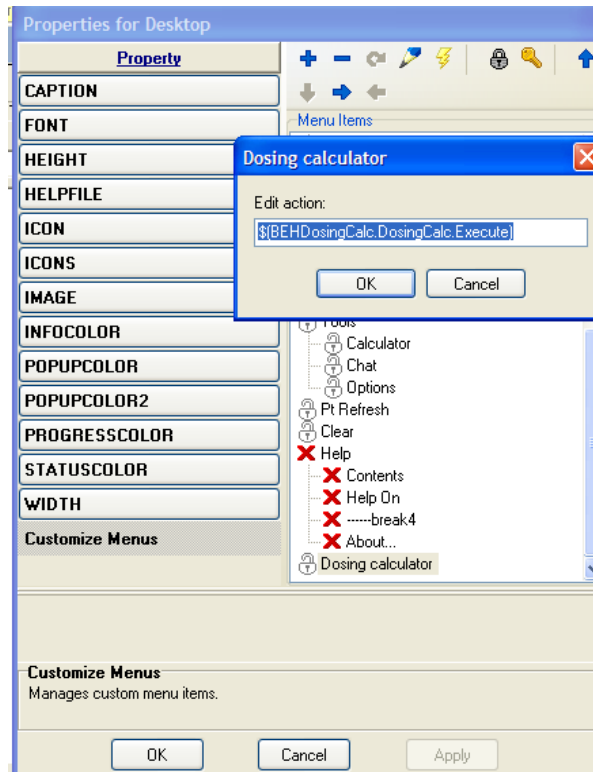


Figure 4-68: Adding the action to the new item

6. After you click OK on the Dosing calculator dialog, close all dialogs and then go to Design | Required Services. Check the Dosing Calc check box.
7. Get out of Design Mode and the Dosing Calculator should work.

The screenshot shows a software window titled "Pharmacokinetic Dosing Calculator". At the top, it displays patient information: "Patient Demo, Fifies Femone" and "HRN 2757". Below this, there are several input fields and radio button options:

- Age:** A text box containing the number "61".
- Sex:** Radio buttons for "Male" and "Female", with "Female" selected.
- Obese:** Radio buttons for "No" and "Yes", with "No" selected.
- Weight (kg):** An empty text box.
- HT (inch):** An empty text box.
- CRCL:** An empty text box.
- Scr:** An empty text box.
- Calculated Kd:** An empty text box.
- Desired PEAK:** An empty text box.
- Calculated Dose:** An empty text box.
- Desired Interv (hr):** An empty text box.
- Calculated CPmin:** An empty text box.

At the bottom left, there is a "Dosing" section with radio buttons for "Amikacin", "Gentamicin", "Tobramycin", and "Vancomycin", with "Amikacin" selected. To the right of this section are three buttons: "Calculate", "Clear", and "Copy". At the very bottom center of the window is a "Close" button.

Figure 4-69: Sample Dosing Calculator

4.2.16 Integrated Signature Tool Enhancement

Electronic Signature Service: Non-order signature items (allergy/adverse reactions) are now processed first in case they affect order checks.

If the user applies a signature using the integrated signature tool, the allergy entry will be processed then order checking run again.

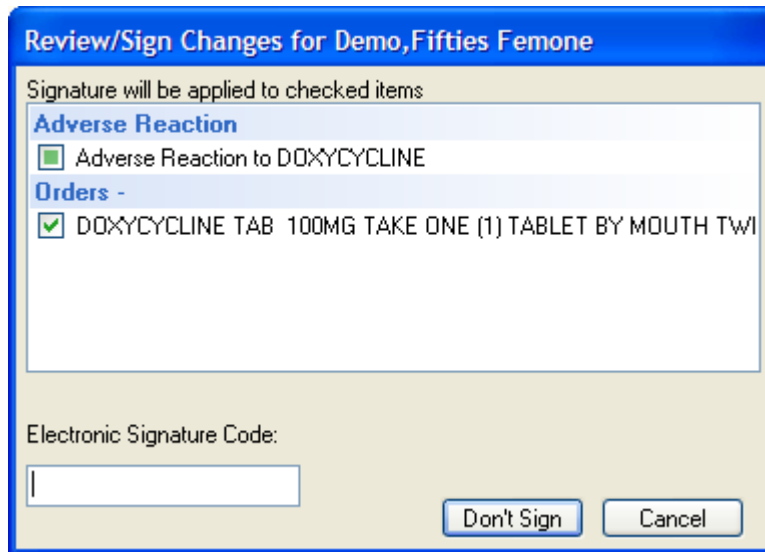


Figure 4-70: Review/Sign Changes dialog

Below is the Order Checks.

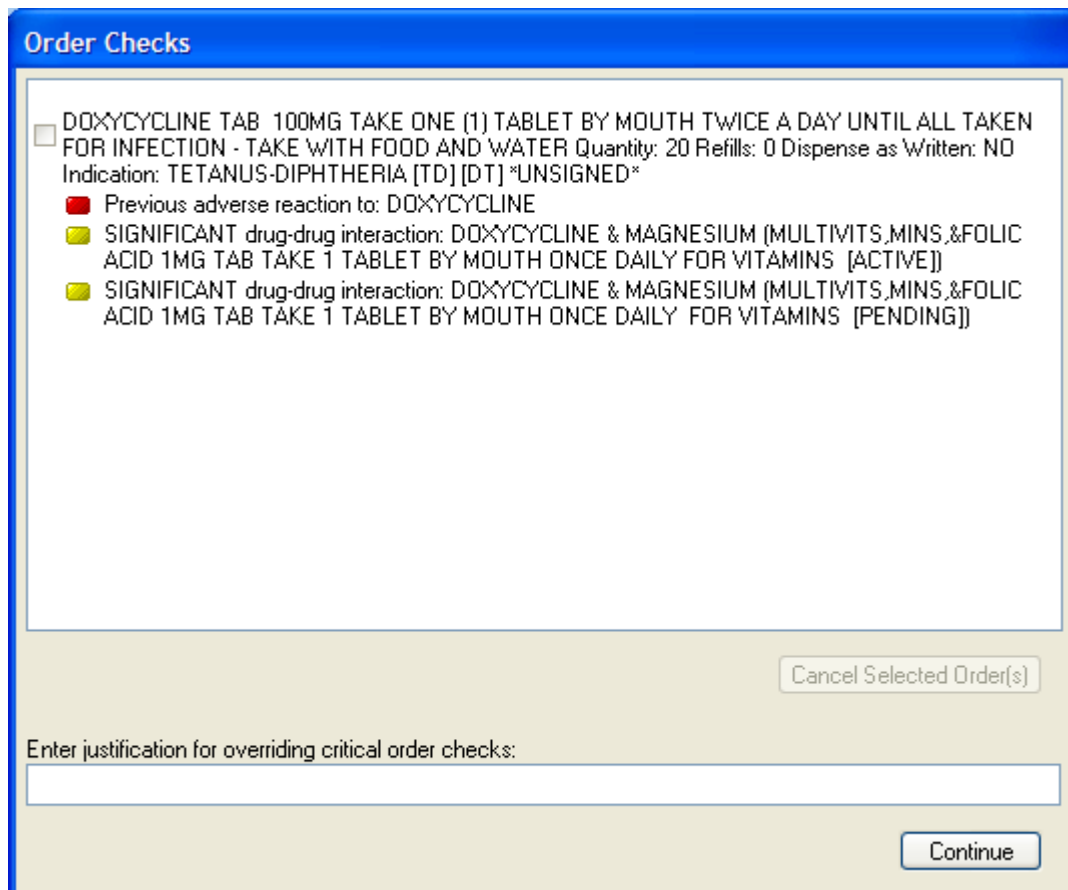


Figure 4-71: Sample order checks

User now has option to discontinue medication by selecting the medication and clicking the Cancel Selected Order(s) button.

4.2.17 Message Logging

This feature allows the Medsphere broker to log all messaging activities for a session in the CIA ACTIVITY LOG file. To activate this feature, use the XPAR EDIT PARAMETER menu option and select the CIANB ACTIVITY LOGGING parameter. You can set this parameter at the system, division, or user level. When prompted for an application, enter CIAV VUECENTRIC. This is the application context for the EHR. Activate activity logging by responding YES to the prompt that follows.

```
Select OPTION NAME: XPAR EDIT PARAMETER

Edit Parameter Values
                --- Edit Parameter Values ---

Select PARAMETER DEFINITION NAME: CIANB ACTIVITY LOGGING      Enable logging of
session activities

CIANB ACTIVITY LOGGING may be set for the following:

    100 User          USR      [choose from NEW PERSON]
    200 Division     DIV      [DEMO HOSPITAL]
    400 System        SYS      [DEMO.CIAINFORMATICS.COM]

Enter selection: 400 System DEMO.CIAINFORMATICS.COM

---- Setting CIANB ACTIVITY LOGGING for System: DEMO.CIAINFORMATICS.COM ----
Select Application: CIAV VUECENTRIC      VueCentric
Are you adding CIAV VUECENTRIC as a new Application? Yes//   YES
Application: CIAV VUECENTRIC//   CIAV VUECENTRIC
Enable activity logging: YES
```

Figure 4-72: Instructions for message logging

Once activated, every session that logs in will have its activity logged in detail. The entries are indexed by session id and several other fields. You can use FileMan to view the contents (don't use ENTER/EDIT or you may cause an active session to hang while trying to write to the log).

```
Select OPTION: INQUIRE TO FILE ENTRIES
OUTPUT FROM WHAT FILE: CIA ACTIVITY LOG//
Select CIA ACTIVITY LOG SESSION ID:      833
ANOTHER ONE:
STANDARD CAPTIONED OUTPUT? Yes//   (Yes)
Include COMPUTED fields: (N/Y/R/B): NO// - No record number (IEN), no Computed
Fields

SESSION ID: 833                                USER: USER,POWER
  WORKSTATION ID: vm-xppro-cchit                LOGIN TIME: JAN 24, 2008@15:06:56
  LOGOUT TIME: JAN 24, 2008@15:07:53           DIVISION: DEMO HOSPITAL

DATE/TIME: JAN 24, 2008@15:06:57              TYPE: EVENT
  NAME: LOGIN
  LOG:
```

```
833^vm-xppro-cchit^CIAV VUECENTRIC^2779^USER,POWER^61019,54416^1820
DATE/TIME: JAN 24, 2008@15:07          TYPE: RPC
  NAME: CIANBRPC DIVGET
  LOG:

Return Data:
3987
3987^DEMO HOSPITAL^808701

DATE/TIME: JAN 24, 2008@15:07          TYPE: RPC
  NAME: CIAVMRPC INIT
  LOG:
P1 = 1.7.5.1

Return Data:
0
1
```

Figure 4-73: Continuation of instruction

Note that this file will get big fast, so it should not be turned on for very long. This file is also purged by the task called CIANB NIGHTLY TASK. The retention period is controlled by the CIANB ACTIVITY RETENTION parameter.

5.0 Pharmacy Auto-finish

Patch 6 allows sites auto-finish prescriptions as they are printed. This functionality is only to be used at facilities that do not have an on-site pharmacy. Auto finish is tied to the BEHORX PRINT SCRIPT parameter and if set to SINGLE or MULTIPAGE will auto-finish any pending prescriptions selected when printed. **DO NOT USE** if you have in house pharmacy!

The OUTPATIENT SITE FILE set up must be reviewed. This file is part of the general pharmacy package set up, so if you are currently using RPMS Pharmacy, the file is already present. Review the fields highlighted.

Use the Outpatient Pharmacy Manager [PSO MANAGER] menu to setup this file.

A sample setup is below. The CPRS ordering institution is required.

```

OUTPUT FROM WHAT FILE: OUTPATIENT SITE//
Select OUTPATIENT SITE NAME: DEMO PHARMACY 1946
ANOTHER ONE:
STANDARD CAPTIONED OUTPUT? Yes// (Yes)
Include COMPUTED fields: (N/Y/R/B): NO// - No record number (IEN), no Computed
Fields

NAME: DEMO PHARMACY
MAILING FRANK STREET ADDRESS: PO BOX 2088
AREA CODE: 317 PHONE NUMBER: 555-1212
MAILING FRANK ZIP+4 CODE: 46240 SITE NUMBER: 1946
MAILING FRANK CITY: INDIANAPOLIS MAILING FRANK STATE: INDIANA
LABEL/PROFILE MONITOR MAX: 1000 BARCODES ON ACTION PROFILES: NO
VERIFICATION: YES EDIT DRUG: NO
RENEWING RX'S ALLOWED: YES PASS MEDS CANCEL: YES
AUTO SUSPEND: NO SHALL COMPUTER ASSIGN RX #S: YES
PROFILE WITH NEW PRESCRIPTIONS: NO CANCEL DRUG IN SAME CLASS: NO
REFILL INACTIVE DRUG RXS: NO ASK METHOD OF PICKUP: YES
PASS MEDS ON PROFILE: YES PROFILE `SORT BY' DEFAULT: DATE
COPIES ON NEW: YES DRUG CHECK FOR CLERK: YES
FEE BASIS SUPPORT: NO MULTI RX REQUEST FORM: NO
BARCODES ON REQUEST FORMS: BOTH SCREEN PROFILES: YES
EDIT PATIENT DATA: YES HOLD FUNCTION?: YES
SUSPENSE FUNCTION?: NO SLAVED LABEL PRINTING: NO
DAYS TO PULL FROM SUSPENSE: 10 NEW LABEL STOCK: NO
NARCOTICS NUMBERED DIFFERENTLY: NO NARCOTIC LOWER BOUND: 100
NARCOTIC UPPER BOUND: 999999999 PRESCRIPTION # LOWER BOUND: 100
PRESCRIPTION # UPPER BOUND: 999999999

Enter RETURN to continue or '^' to exit:
LAST PRESCRIPTION # ISSUED: 206 IB SERVICE/SECTION: PHARMACY SERVICE
RELATED INSTITUTION: DEMO HOSPITAL
CPRS ORDERING INSTITUTION: DEMO HOSPITAL
*SITE DEA NUMBER: BC6112623

```

Figure 5-1: Sample instructions

5.1 APSP CONTROL Pharmacy File

Use the APSP IHS CONTROL (IHS Pharmacy Site Parameters) menu option to REVIEW the setup of this file. A sample is below. The default patient status and pharmacy visit location are the fields that are used for the auto-finishing of prescriptions.

```

Select APSP CONTROL PHARMACY SYSTEM:      DEMO PHARMACY
PHARMACY SYSTEM: DEMO PHARMACY//
DEFAULT PATIENT STATUS:  OUTPATIENT//
LABEL WIDTH:
PRINTABLE LINES:
SKIP LINES BEGINNING:
SKIP LINES END:
MAIL/WINDOW OPTION: ASK MAIL/WINDOW//
NUMBER OF LABELS TO SKIP:
LEFT MARGIN TAB:
EXPIRATION DATE:
SUMMARY LABELS: DON'T PRINT//
COMPRESSED LEFT MARGIN:
COMPRESSED LABEL WIDTH: 48//
PCC RUNNING: YES//
PREPACK PRINTABLE LINES: 9//
PREPACK SKIP LINES BEGINNING: 1//
PREPACK SKIP LINES END: 2//
PREPACK LABELS TO SKIP: 0//
PREPACK LEFT MARGIN:
PREPACK LABEL WIDTH: 34//
UNIT DOSE PRINTABLE LINES:
UNIT DOSE SKIP LINES BEGINNING:
UNIT DOSE SKIP LINES END:
UNIT DOSE LABELS TO SKIP:
UNIT DOSE LEFT MARGIN:
UNIT DOSE LABEL WIDTH:
UNIT DOSE LABELS TWO ACROSS:
UNIT DOSE 2ND LEFT MARGIN:
PREPACK LABEL LINE 1: NAME: _____ CHART# _____
                        Replace
PREPACK LABEL LINE 2: DATE:          MD:          Replace
USING PREPACK SYSTEM: YES//
SUMMARY LABEL COPIES: 1//
MANUFACTURER/LOT#/EXP: DON'T ASK OR DISPLAY MAN DATA
//
DEFAULT OTHER LOCATION: ALASKA NATIVE MEDICAL CENTER
//
SHOW PATIENT STATUS FIELD: YES//
RX BILL DEFAULT STATUS: MANUAL BILL//
SHOW RX BILL & INSURER FIELDS: NO//
SIGNATURE LABEL: N//
PASS DATA TO POS: NO//
SHOW NDC:
SHOW AWP PER DISPENSE UNIT:
SHOW AAC PER DISPENSE UNIT:
DISPLAY NDC ON LABEL:
SHOW TRIPLICATE #:
                        Replace
EXT INTERFACE CALL LOGIC: D EP^BZSPLINK/

SHOW CHRONIC MED PROMPT: SHOW WITHOUT A DEFAULT//
AUTORELEASE RX://
PAPERLESS REFILL:
VA LASER LABEL: YES//

```

```

PHARMACY VISIT LOCATION: PHARMACY//
SHOW DI ON LASER REFILL LABEL:
SHOW CASH DUE PROMPT:
EXT INTERFACE HAS DRUG LOGIC: ;S X=' '$D(^BZSPDRUG($P($G(^PSRX(RX,0)),U,6)))

```

Figure 5-2: Sample Instructions

5.2 Review Addresses

Make sure that the sites address is correct in the Institution file (file 4).

```

Check the INSTITUTION FILE

Select INSTITUTION NAME: DEMO HOSPITAL INDIANA INDIANA 35 IN 1946
NAME: DEMO HOSPITAL STATE: INDIANA
STREET ADDR. 1: 8100 RED BUD CT CITY: NEWBURGH
ZIP: 47630 STATION NUMBER: 1946
CODING SYSTEM: VASTANUM ID: 1946

```

Figure 5-3: Address in Institution file

Check that the sites address is correct in the Location file (file 9999999.06).

```

OUTPUT FROM WHAT FILE: LOCATION//
Select LOCATION NAME: DEMO HOSPITAL INDIANA INDIANA 35
IN 1946
NAME: DEMO HOSPITAL SHORT NAME: SO CTRL FND
AREA: INDIANA SERVICE UNIT: INDIANA
CODE: 35 ABBRV: SOUC
ASUFAC INDEX: 222235 MAILING ADDRESS-STREET: 8100 RED
BUD CT
MAILING ADDRESS-CITY: MAILING ADDRESS-STATE:
NEWBURGH INDIANA

MAILING ADDRESS-ZIP: 47630 FACILITY LOCATION CODE: 134
MODIFIED DATE: DEC 28, 2005 STATE: INDIANA
PSEUDO PREFIX: ALA UNIQUE RPMS DB ID: 13752

```

Figure 5-4: Address in Location file

5.3 APSP AUTO RX DEF PT STATUS

APSP AUTO RX DEF PT STATUS is a back up parameter in case site has not set the RX PATIENT STATUS FILE.

```

Set Enter selection: 80 System YAKIMA-HC.PRT.IHS.GOV

--- Setting APSP AUTO RX DEF PT STATUS for System: YAKIMA-HC.PRT.IHS.GOV ---
Default Patient Status: ?
Answer with RX PATIENT STATUS NUMBER, or NAME, or ABBR
Choose from:
1 OUTPATIENT
2 NON-VA

```

Figure 5-5: Instruction for process

5.4 BEHORX Parameters

These new parameters are part of patch 6. Set them up using the General Parameters Tools menu options.

5.4.1 BEHORX PRINT LABEL

Set this parameter to YES if you want to manually print a label.

```

BEHORX PRINT LABEL may be set for the following:

      800 Division      DIV      [DEMO HOSPITAL]
      900 System        SYS      [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting BEHORX PRINT LABEL for System: DEMO.MEDSPHERE.COM -----
Enable Print Label Feature: YES

```

Figure 5-6: Instructions for process

5.4.2 BEHORX PRINT SCRIPT

Set this parameter to YES if you wish to manually print prescriptions. Any prescriptions printed will auto-finish. ONLY for use at sites that do not have in house pharmacy. This parameter allows you to print multiple prescriptions on the same page or one RX per page. The one per page format works best for faxing. The multiple RX per page creates better formatting for paper prescriptions.

```

BEHORX PRINT SCRIPT may be set for the following:

      800 Division      DIV      [DEMO HOSPITAL]
      900 System        SYS      [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting BEHORX PRINT SCRIPT for System: DEMO.MEDSPHERE.COM -----
Enable Print Script Feature: SINGLE PAGE// ?

Controls the availability of the Print Rx print feature within EHR.

Select one of the following:

      0      DISABLED
      1      MULTIPAGE ← prints widows format
      2      SINGLE PAGE ← prints text format (see BEHORX SCRIPT CUSTOM
FORMAT)

Enable Print Script Feature: SINGLE PAGE//

```

Figure 5-7: Instructions for process

5.4.3 BEHORX PRINT SCRIPT MAX

Set this up with the maximum # of scripts per page. If MULTIPAGE was selected, this parameter allows a site to determine the maximum # of scripts to be on one page.

```

BEHORX PRINT SCRIPT MAX may be set for the following:

    100 User          USR    [choose from NEW PERSON]
    500 Class         CLS    [choose from USR CLASS]
    800 Division     DIV    [DEMO HOSPITAL]
    900 System        SYS    [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting BEHORX PRINT SCRIPT MAX for System: DEMO.MEDSPHERE.COM -----
Value: 5//

```

Figure 5-8: Instructions for process

5.4.4 BEHORX SCRIPT CUSTOM FORMAT

This is a custom prescription format.

```

BEHORX SCRIPT CUSTOM FORMAT may be set for the system level

BEHORX SCRIPT CUSTOM FORMAT Custom Prescription Format

--- Setting BEHORX SCRIPT CUSTOM FORMAT for System: TEST-HC.PRT.IHS.GOV ---
Value: D FAXRX~APSPELRX//

M code to generate a prescription format. Specifying a routine
in this parameter will supersede the use of OE/RR Print Formats

Use @ at the prompt to remove the M code and then set up the BEHORX SCRIPT HEADER,
BEHORX SCRIPT FORMAT, BEHORX SCRIPT FOOTER with the OE/RR Print Formats you wish to
use

```

Figure 5-9: Instruction for process

5.4.5 BEHORX SCRIPT FOOTER

This is the prescription footer. It is the format used to print the footer of the prescription for the hospital.

```

BEHORX SCRIPT FOOTER may be set for the system level

BEHORX SCRIPT FOOTER Prescription Footer

----- Setting BEHORX SCRIPT FOOTER for System: YAKIMA-HC.PRT.IHS.GOV -----
PRESCRIPTION FOOTER: CHART COPY FOOTER//

```

Figure 5-10: Instructions for process

5.4.6 BEHORX SCRIPT FORMAT

This is the prescription format. It is the format used when printing the body of a prescription for the hospital.

```
BEHORX SCRIPT FORMAT    may be set for the system level
BEHORX SCRIPT FORMAT    Prescription Format
----- Setting BEHORX SCRIPT FORMAT for System: YAKIMA-HC.PRT.IHS.GOV -----
PRESCRIPTION FORMAT: PHARM WORK BODY//
```

Figure 5-11: Instructions for process

5.4.7 BEHORX SCRIPT HEADER

This is the prescription header. It is the format used to print the header of the prescription for the hospital.

```
BEHORX SCRIPT HEADER    may be set for the system level
BEHORX SCRIPT HEADER    Prescription Header
----- Setting BEHORX SCRIPT HEADER for System: YAKIMA-HC.PRT.IHS.GOV -----
PRESCRIPTION HEADER: OUTSIDE RX HEADER//
```

Figure 5-12: Instructions for process

5.4.8 BEHORX PRINT DEFAULT

Use this parameter to set up the default printer. Some sites use special paper for printing prescriptions so a default printer can be selected for the printing. A different default printer can be selected for each type of report. Also, this parameter is configurable by location so that individual clinics can have their own printers since one printer per facility would not be practical.

```
Select PARAMETER DEFINITION NAME: behorx print default    Default Printer for M
ed Print Action

BEHORX PRINT DEFAULT may be set for the following:

    700 Location      LOC    [choose from HOSPITAL LOCATION]
    800 Division      DIV    [DEMO HOSPITAL]
    900 System        SYS    [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting BEHORX PRINT DEFAULT for System: DEMO.MEDSPHERE.COM -----
Select Report Type: ?

There are currently no entries for Report Type.

    Select one of the following:
```

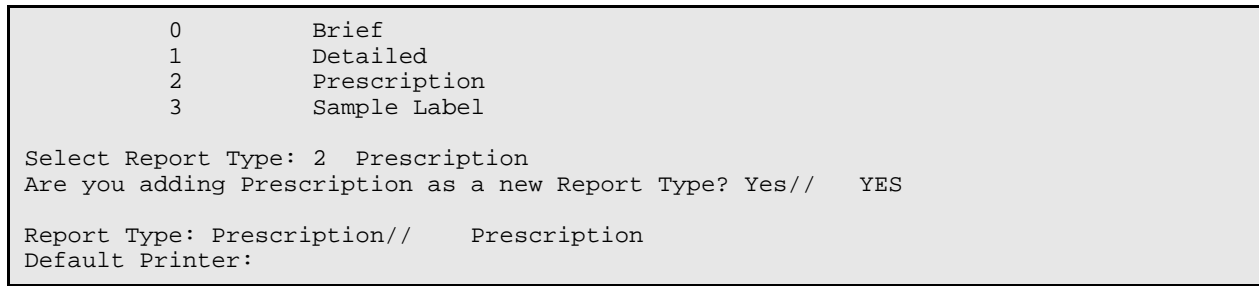


Figure 5-13: Instructions for process

5.5 Ordering an RX

Ordering can be done from either the Orders component or the Medications component.

This is for outpatient meds only.

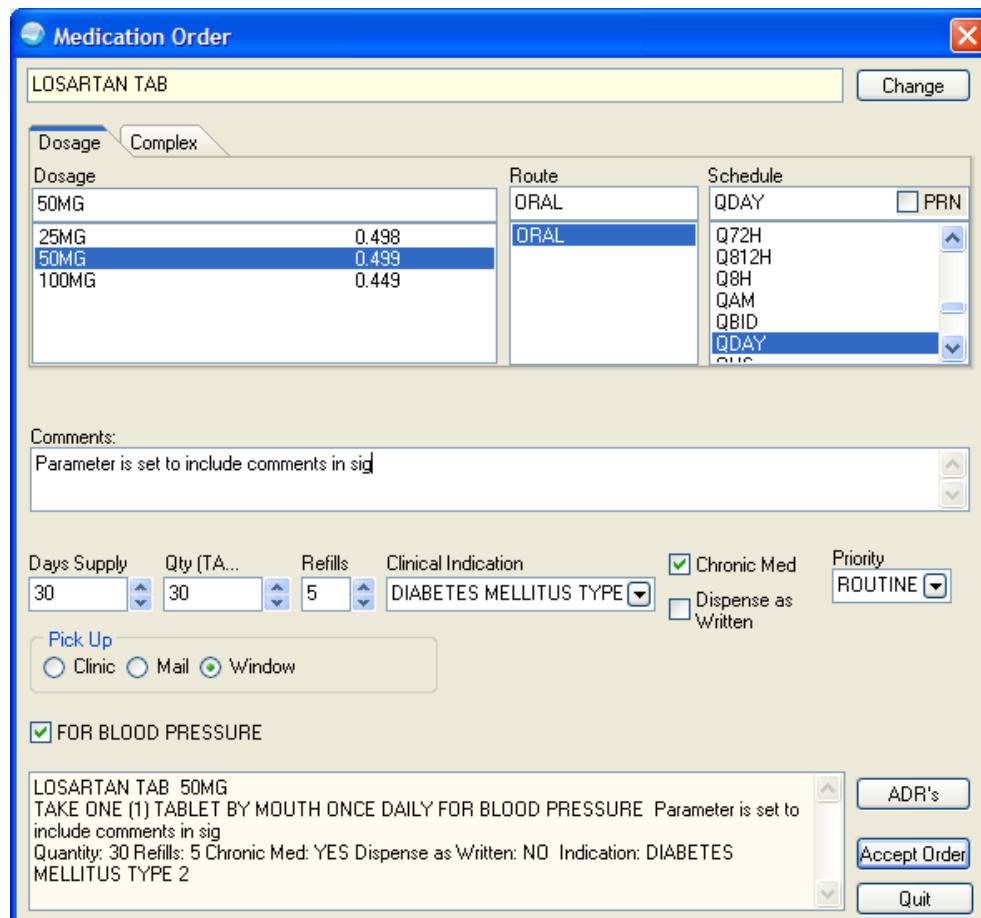


Figure 5-14: Medication Order

After completing and saving, sign the order.

On the Meds tab, select the pending items from the list and then click on the Print button. Depending on the parameters setup, you will see radio buttons for label and prescription. Choose Prescription.



Figure 5-15: Sample pop-up

When you click the Print button, the Print Setup dialog displays.

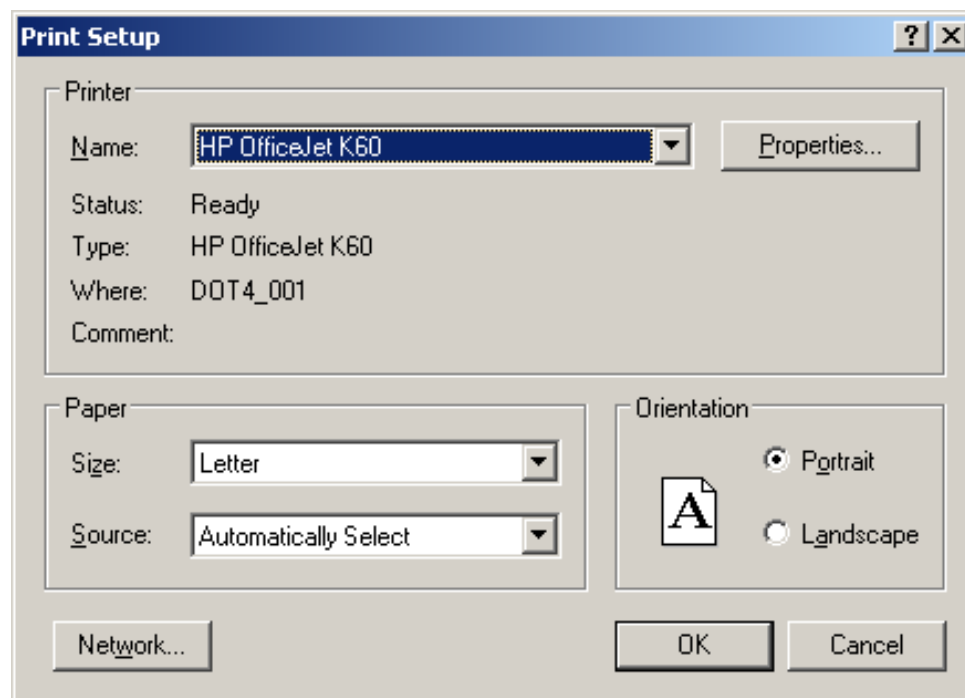


Figure 5-16: Selection of network printer

Select the printer if a default printer has not been defined. This should be a NETWORK printer so that the formatting is more defined. The prescription will now become an active prescription once the printing of the prescription has occurred

Action	Change	180 days	Print	Process	New	Check	Status	Issued	Last Filled	Expires	Subs. Remaining	Rx #	Provider
✓							Pending						
✓							Active	31 Mar 2010	31 Mar 2010			1730740	RICHARDS,SUSAN P
✓							Encountered	07 Oct 2008	07 Oct 2008	08 Oct 2009	5	1380726	RICHARDS,SUSAN P

Figure 5-17: Prescription detail

Below an example of a prescription if BEHORX PRINT SCRIPT is set to SINGLE.
(Notice that the comments are included as MD comments.)

```
DEMO HOSPITAL
8100 RED BUD CT
NEWBURGH, INDIANA 47630

-----

Rx for: SMILEY,FACE 49392
      302 Elm St
      Tuba City, ARIZONA
-----

SIMVASTATIN 20MG TAB**
Also known as: ZOCOR

Pharmacy may choose strength(s) of drug to meet requirements of directions.

TAKE ONE (1) TABLET MOUTH AT BEDTIME TAKE WITH FOOD

Dispense: 30 TAB      Pharmacy to adjust qty for # of days.
Days Supply: 30
Refill(s): 10
Issue Date: AUG 27, 2009
Indicator: ATRIAL FIBRILLATION (427.31)
DOB: OCT 30, 1976
MD Comments: Take with food

Signed: /ES/USER,DEMO 006789
```

Figure 5-18: Output for Single

Below is an example of a prescription if BEHORX PRINT SCRIPT is set to MULTIPAGE.

Demo, Fifties Femone (2757)
DOB: 08-Dec-1948 Sex: F
Phone:

YAKAMA HEALTH CENTER IHS
401 BUSTER ROAD 401 BUSTER ROAD
TOPPENISH, WASHINGTON 98948

Adverse Reactions: PENICILLIN; ACTOS (EDEMA); CITRUS (RASH); FELODIPINE
(EDEMA; AGRANULOCYTOSIS); SIMVASTATIN; CODEINE (RASH); EGGS (AGRANULOCYTOSIS);
IBUPROFEN (AGITATION)

Prescription
SIMVASTATIN 80MG TAB Sig: TAKE ONE TABLET BY MOUTH EVERY EVENING FOR CHOLESTEROL Quantity: 30 Refills: 5 Indication: DIABETES MELLITUS TYPE 2 (250.00)

Phone:
Fax:

Printed 10-Mar-2010 21:51
Page 1

Figure 5-19: Output is multipage

6.0 Family History

The new family history component is designed for the family history redesign that was part of PCC. This component will need to be added to the VueCentric templates that are used at sites.

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Condition (ICD9)	Provider Narrative	Age at Diagnosis	Date Modified

Figure 6-1: Sample Family History component

6.1 Add Relationship

Click the Add Relation button on the Family History component to access the Family History dialog.

Family History dialog form fields:

- Relation: [dropdown]
- Name: [text field]
- Status: [dropdown]
- Cause of Death: [text area]
- Age at Death: [dropdown]
- Multiple Birth: [dropdown]
- Multiple Birth Type: [dropdown]
- Conditions:

Condition (ICD9)	Provider Narrative	Age at Diagnosis

Figure 6-2: Family History form

There is a drop-down list from which to select the type of relationship, a name field, and then data for whether this person is living or deceased, the cause of death and multiple birth information.

6.1.1 Add Problem

When a relationship is added, there is an Add button on this dialog to add a problem. Only one problem can be added at a time.

Code	Description
V16.0	Family History Of Malignant Neoplasm Of Gastrointestinal Tract
V16.1	Family History Of Malignant Neoplasm Of Trachea, Bronchus, And Lung
V16.2	Family History Of Malignant Neoplasm Of Other Respiratory And Intrathoracic Organs
V16.3	Family History Of Malignant Neoplasm Of Breast
V16.40	Family History Of Malignant Neoplasm Of Genital Organ, Unspecified
V16.41	Family History Of Malignant Neoplasm Of Ovary
V16.42	Family History Of Malignant Neoplasm Of Prostate
V16.43	Family History Of Malignant Neoplasm Of Testis
V16.49	Family History Of Other Malignant Neoplasm
V16.51	Family History Of Malignant Neoplasm Of Kidney
V16.52	Family History Of Malignant Neoplasm, Bladder
V16.59	Family History Of Malignant Neoplasm Of Other Urinary Organs
V16.6	Family History Of Leukemia
V16.7	Family History Of Other Lymphatic And Hematopoietic Neoplasms
V16.8	Family History Of Other Specified Malignant Neoplasm
V16.9	Family History Of Unspecified Malignant Neoplasm
V17.0	Family History Of Psychiatric Condition
V17.1	Family History Of Stroke (cerebrovascular)
V17.2	Family History Of Other Neurological Diseases

Copy Description to Narrative

Narrative:

Age at Diagnosis:

Save Cancel

Figure 6-3: Sample Family History (ICD)

On the Family History (ICD) dialog, select the ICD code, enter the Narrative, and enter the Age at Diagnosis. Notice that if you check the Copy Description to Narrative check box, the Description of the ICD code will populate the Narrative field.

After you click Save, below is a populated Family History form.

Family History

Relation: AUNT Name:

Status: DECEASED Cause of Death: Penumonia

Age at Death: At age 50-59

Multiple Birth: NO Multiple Birth Type:

Conditions:

Condition (ICD9)	Provider Narrative	Age at Diagnosis
V16.6	Leukemia	At age 30-39

Figure 6-4: Populated Family History form

6.1.2 Add Second History

To add a second family history diagnosis for a patient, you select the relationship, highlight it, and then click Add. In the example below, Fred was selected and the Add button in the family history button was clicked. The dialog appeared.

You then click Add in the conditions area to add another family history item.

The screenshot shows a 'Family History' form with the following fields and values:

- Relation: AUNT
- Name: Jane
- Status: DECEASED
- Cause of Death: Pneumonia
- Age at Death: At age 40-49
- Multiple Birth: NO
- Multiple Birth Type: (empty)

Buttons: Save, Cancel, Add, Edit, Delete.

Conditions:

Condition (ICD9)	Provider Narrative	Age at Diagnosis
V16.6	Leukemia	At age 20-29
V16.3	Breast Cancer	

Figure 6-5: Updated Family History form

There will be two entries for the Aunt in the Family History List grid.

The screenshot shows the 'Family History List' grid with the following data:

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Condition (ICD9)	Provider Narrative	Age at Diagnosis	Date Modified
AUNT		DECEASED			NO		V16.6	Family History Of	At age 30-39	05/11/2010
AUNT		DECEASED			NO		V16.3	Breast Cancer		05/11/2010

Figure 6-6: Updated Family History List grid

6.1.3 Delete Condition

In the Condition group box, highlight the condition you want to delete and then click the Delete button. The application displays the “Delete Family?” information message asking if you are sure you want to delete the condition. Click Yes to delete (otherwise, click No.)

6.2 Edit Relation

You can edit the relationship on the Family History List grid. Select a record you want to edit and then click the Edit Relation button.

Family History

Relation: AUNT Name: Jane

Status: DECEASED Cause of Death:

Age at Death:

Multiple Birth: NO Multiple Birth Type:

Buttons: Save, Cancel, Add, Edit, Delete

Condition (ICD9)	Provider Narrative	Age at Diagnosis
V16.6	Leukemia	At age 20-29
V16.3	Breast Cancer	

Figure 6-7: Editing a Relationship

The ICD9 code can be edited by highlighting it and clicking Edit. This will edit the family history item for this relationship and overwrite the existing one.

6.3 Delete Relation

Highlight a relation you want to delete and then the Delete Relation button on the Family History List grid. The application displays the “Delete Relation?” information message.

Delete Relation?

Do you really want to delete the Family Relationship titled AUNT : Jane

Buttons: Yes, No, Cancel

Figure 6-8: Delete Relation? information message

7.0 Imaging

While many sites are using Vista Imaging for image storage and retrieval, a low tech imaging component has been added to patch 6. This new capability is NOT intended for any radiology imaging, EKG strips, etc. It is only for notes and/or patient pictures.

Sites that are using Vista Imaging should continue to use that application for storage of images.

The approved imaging solution for Indian Health Service facilities, whether for scanned documents, photographs, radiographs, or other images, is Vista Imaging. However, some non-IHS users of RPMS have requested simplified image viewing capabilities limited to scanned documents and other non-diagnostic images. EHR v1.1. patch 6 delivers a “low tech” image viewer that can be configured to display documents and other images stored in a network folder. This component is not designed for use with radiographs, electrocardiograms, and any other diagnostic image, and it is not been approved by IHS Health Information Management or Information Security for use in Federal IHS facilities.

7.1 File Storage

When a site decides to storage images, one of the concerns is the amount of space needed for images. Images can take a lot of space and so the site managers need to determine if there is enough room for images to be stored and then where the images will be stored. Sites need to keep check on this space to see if more is needed.

The site manager will need the MAG SYSTEM key to setup the network location for the images. The menu MAG SYS MENU has an option on it to Enter/Edit Network Location. This location has to be open for adding new documents.

```

MAG SYS MENU      Imaging System Manager Menu

DS      Define Imaging Site Parameters
IX      Image Index Conversion Menu ...
IW      Edit Image WRITE LOCATION only.
WF      Enter/Edit Background Processor Workstation File
NT      Enter/Edit Network Location
LS      Edit Network Location STATUS
PUR     Edit Imaging Purge Parameters
        Ad hoc Enterprise Site Report
        Copy Routines to DICOM Gateway
        Imaging Database Integrity Checker Menu ...

```

Figure 7-1: MAG SYS MENU options

When you use the NT option, the prompts are:

```

HASH Select Imaging System Manager Menu Option: nt  Enter/Edit Network Location

Select NETWORK LOCATION: ?
  Answer with NETWORK LOCATION, or PHYSICAL REFERENCE, or STORAGE TYPE:
  DEMO          C:\WEBDAV\

      You may enter a new NETWORK LOCATION, if you wish
      Answer must be 3-30 characters in length.

Select NETWORK LOCATION: DEMO          C:\WEBDAV\
NETWORK LOCATION: DEMO//
STORAGE TYPE: MAGNETIC//
OPERATIONAL STATUS: On-Line//
PHYSICAL REFERENCE: C:\WEBDAV\//
HASH SUBDIRECTORY: YES//

Select NETWORK LOCATION:      DEMO      C:\WEBDAV\
NETWORK LOCATION: DEMO//
STORAGE TYPE: MAGNETIC// ??
  This field describes the media type of this network location. It should be
  MAGNETIC for a magnetic disk server. Jukeboxes should be WORM-DG for Data
  General Jukeboxes under Open Netware or WORM-PDT for Pegasus Jukeboxes or
  WORM-OTG for OTG Disk Extender. WORM-DG and WORM-PDT are for backward
  compatibility only. Note: WORM stands for Write Once, Read Many
  The GCC type refers to the Generic Carbon Copy (GCC) utility implemented
  by the Health Eligibility Center application.

  Choose from:
  MAG      MAGNETIC
  WORM-DG  WORM-DG
  WORM-PDT WORM-PDT
  RW       READ/WRITE
  WORM-OTG WORM-OTG
  EKG      MUSE-EKG
  GCC      EXPORT
  DGM      DIAGRAM
STORAGE TYPE: MAGNETIC//
OPERATIONAL STATUS: On-Line//
PHYSICAL REFERENCE: https://demo.medsphere.com/webdav/
SUBDIRECTORY: YES//

  HASH SUBDIRECTORY: YES// ??
      Control whether subdirectory should be hashed.

  Choose from:
  Y      YES
HASH SUBDIRECTORY: YES//
Select NETWORK LOCATION:

```

Figure 7-2: Instructions for NT option

For the Normal PHYSICAL REFERENCE, see below:

<https://demo.medsphere.com/webdav/>

7.2 Parameter Setup

There are several new parameters that must be setup to turn on imaging.

7.2.1 CIAOMAG IMAGING ENABLED

This is the Enable Imaging Support parameter. It controls whether imaging support is activated in the graphical user interface.

This can be setup by individual user if desired. This parameter turns imaging on.

```
CIAOMAG IMAGING ENABLED may be set for the following:

    100 User          USR    [choose from NEW PERSON]
    800 Division     DIV    [DEMO HOSPITAL]
    900 System       SYS    [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting CIAOMAG IMAGING ENABLED for System: DEMO.MEDSPHERE.COM -----
Enable Imaging Support: YES//
```

Figure 7-3: Instructions for parameter

7.2.2 CIAOMAG EXTERNAL VIEWER

This is the Enable Imaging Support parameter. It controls whether imaging support is activated in the graphical interface.

This can be setup by individual user if desired. This parameter turns imaging on.

```
CIAOMAG EXTERNAL VIEWER may be set for the following:

    100 User          USR    [choose from NEW PERSON]
    800 Division     DIV    [DEMO HOSPITAL]
    900 System       SYS    [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM

----- Setting CIAOMAG EXTERNAL VIEWER for System: DEMO.MEDSPHERE.COM -----
Enable external viewer?: YES/
```

Figure 7-4: Instructions for parameter

7.2.3 CIAOMAG CAN CAPTURE

This is the Can Capture Images parameter. If this parameter is set to YES, user can capture and store external images. If set to NO, the ability to capture images is determined by VistA Imaging settings.

```
CIAOMAG CAN CAPTURE may be set for the following:

    100 User          USR    [choose from NEW PERSON]
    800 Division     DIV    [DEMO HOSPITAL]
    900 System       SYS    [DEMO.MEDSPHERE.COM]

Enter selection: 900 System DEMO.MEDSPHERE.COM
```

```
----- Setting CIAOMAG CAN CAPTURE for System: DEMO.MEDSPHERE.COM -----
Can capture external images?: YES// ??
```

Figure 7-5: Instructions for parameter

7.3 Patient Photographs

Add the patient photograph component to the EHR.

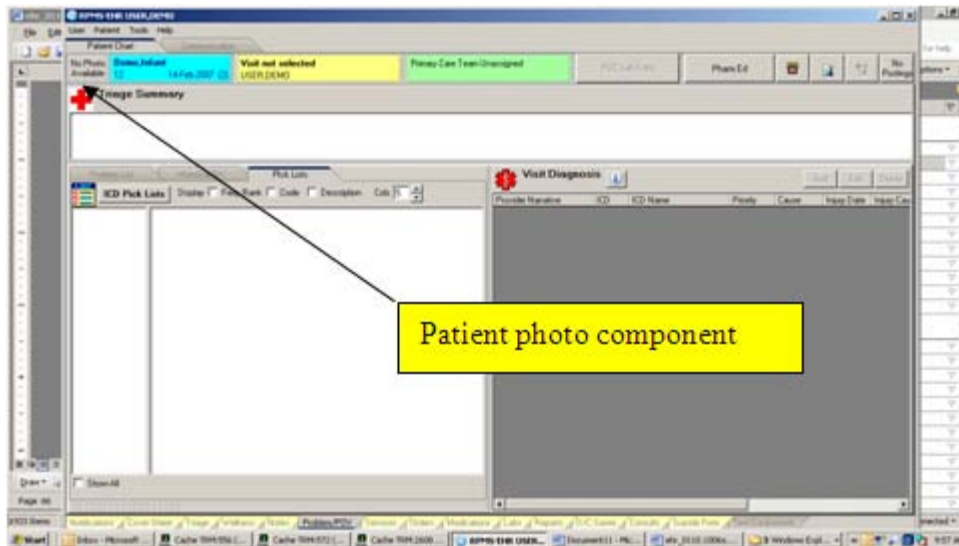


Figure 7-6: EHR with Photograph component added

Right-click on the Patient Photo component and select the Add Image option.

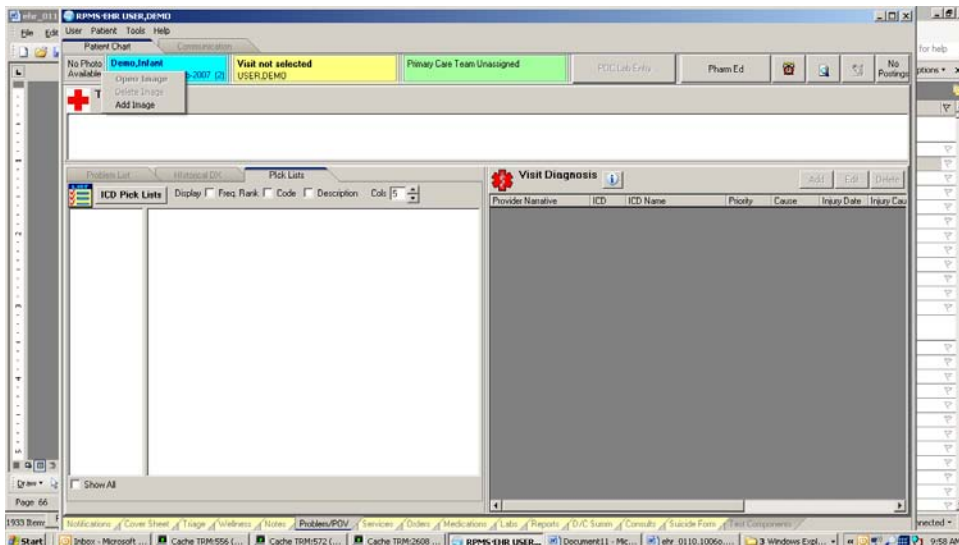


Figure 7-7: Patient Photograph component with Add Image

Add image view appears for user to find the image on the server.

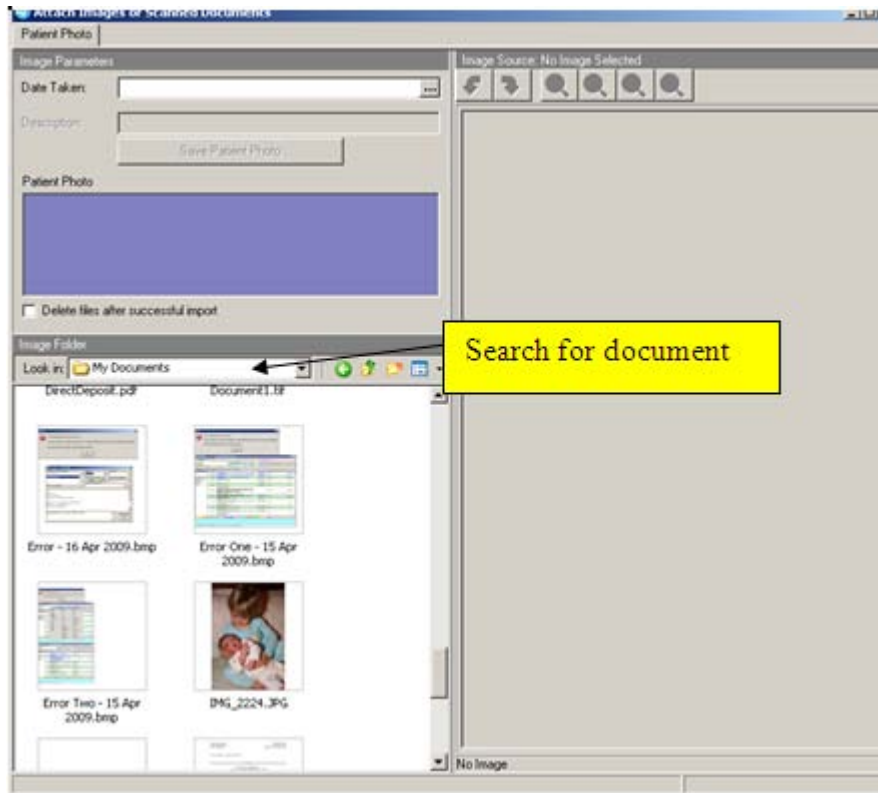


Figure 7-8: Document upload dialog

Double click on the correct photograph and wait until it is uploaded.

If the photographs were first stored in an open folder that anyone can see, you may want to delete the file after a successful upload. That option is a checkbox in the dialog.

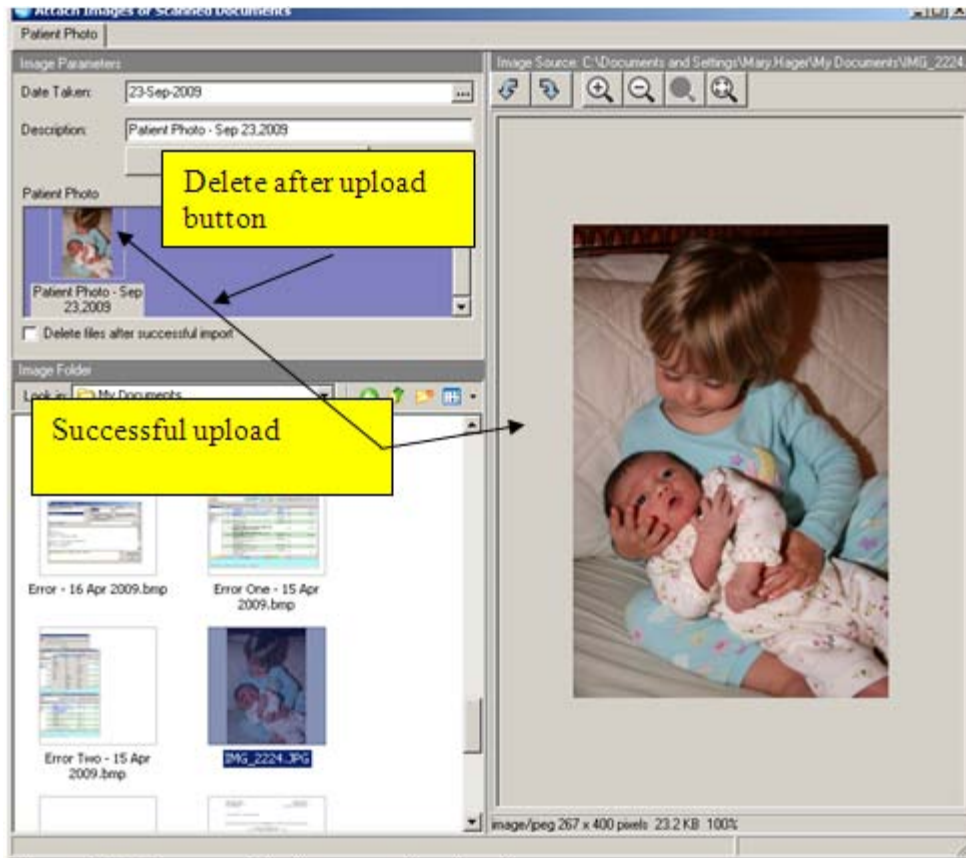


Figure 7-9: Successful photograph upload

Once the photograph is uploaded, you can edit the date taken and then click on the Save Patient Photo. The application displays the Capture Complete information message.



Figure 7-10: Capture Complete information message

Then click Done.

7.4 Adding External Documentation

Documents can also be added to notes. These can be documents that the patient has signed or documents from outside sources. To attach these documents, the user will need to start a new note. Sites may select to create new note titles for these documents or they can use any current titles.

Write the note or have a TIU Template to place some data into the note.

Then right click and the last item on the list is to Attach Image.

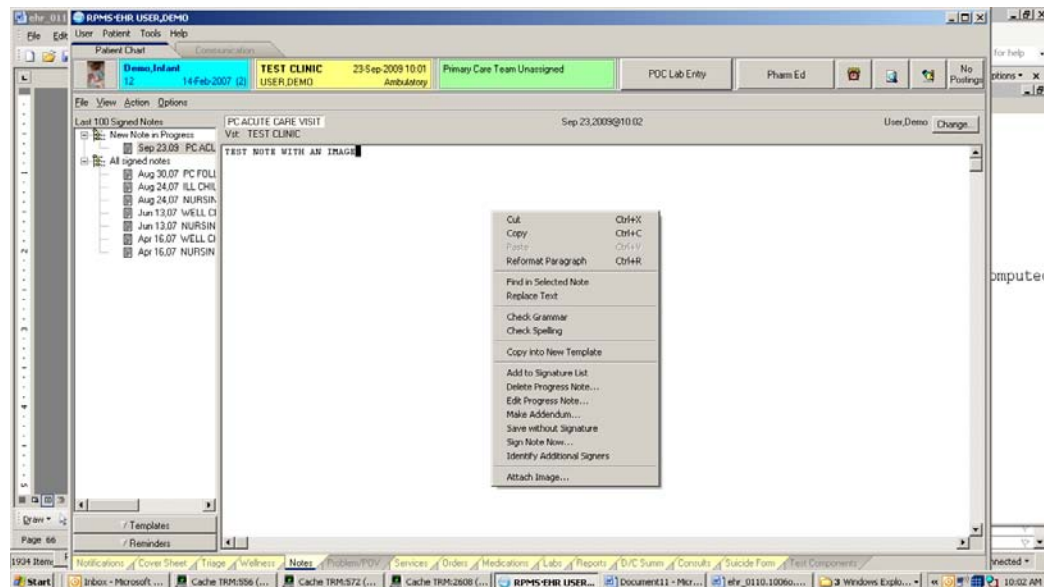


Figure 7-11: Selecting option to add image

The document dialog will appear and will show that it is being attached to a note.

Again, if the document was stored in an open directory, sites can choose to delete the document once it has been uploaded. This dialog will allow the user to search for the document to upload.

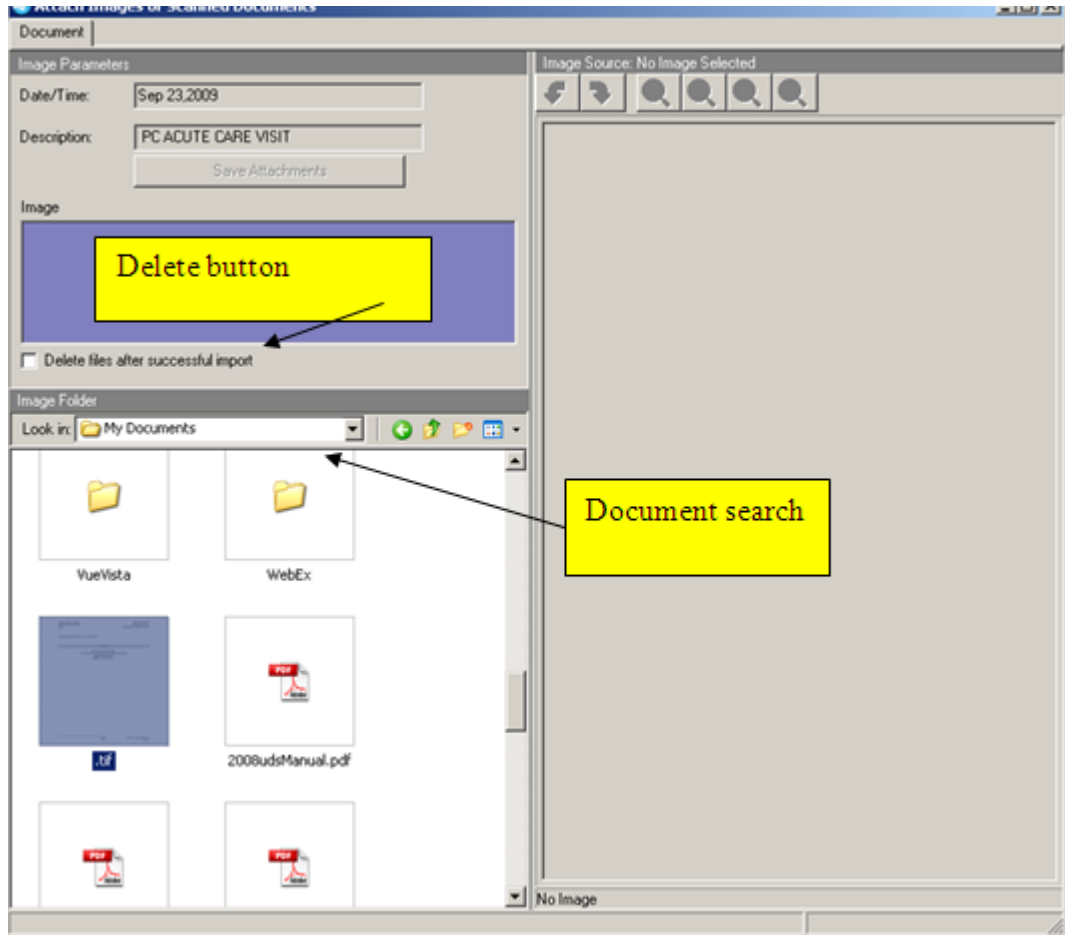


Figure 7-12: Image dialog open for document search

Double click on the document you wish to upload and wait for the upload to finish.

Then select Save Attachments.

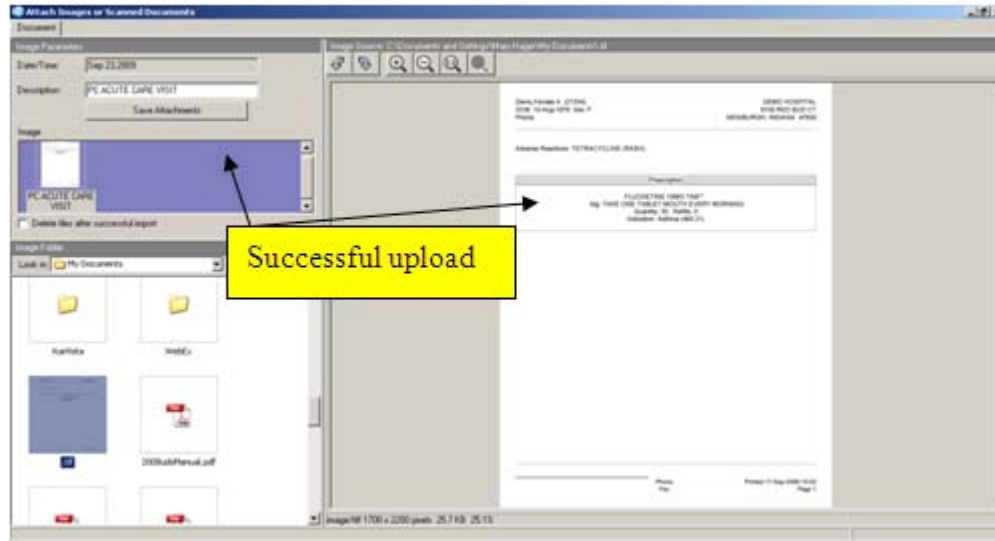


Figure 7-13: Successful upload

If successful the following message will appear. If this is the only document for this note, select Done. Otherwise, other documents can be uploaded to this note.



Figure 7-14: Successful storage message

Sign the note. Once signed, images may no longer be attached unless an addendum is written.

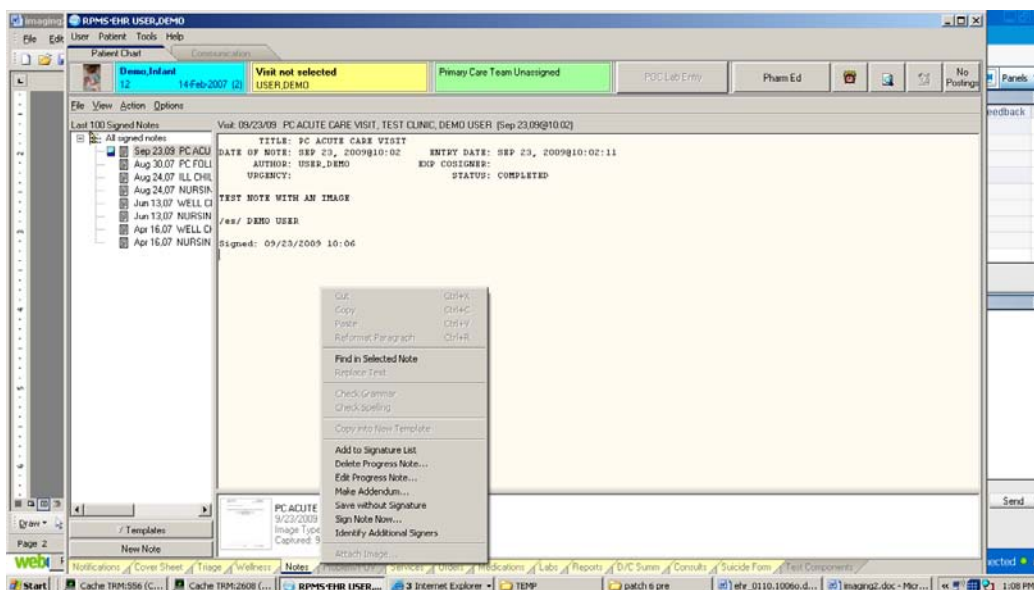


Figure 7-15: Note with image after signature

7.5 Viewing the Images

When a user selects a patient with documents attached to the notes, there will be an additional icon in the document list to alert the user to an attached image.

When the note is selected the image will appear in a thumbnail form at the bottom of the note.

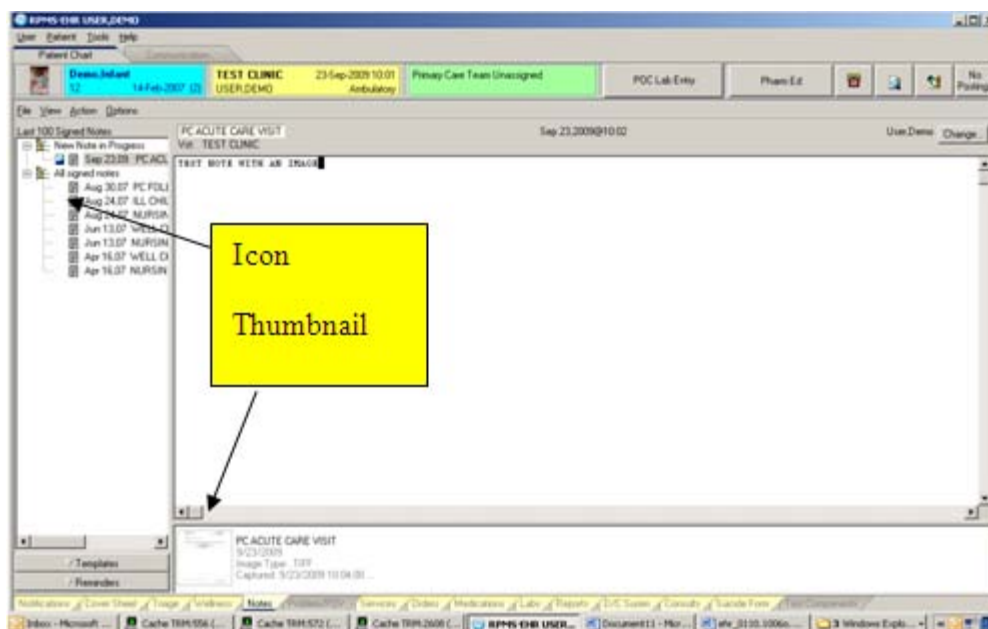


Figure 7-16: Note with image

Click on the thumbnail image and a viewer will appear to read the attached note.

If the external viewer icon was enabled, the user can use that viewer to read the note as well.

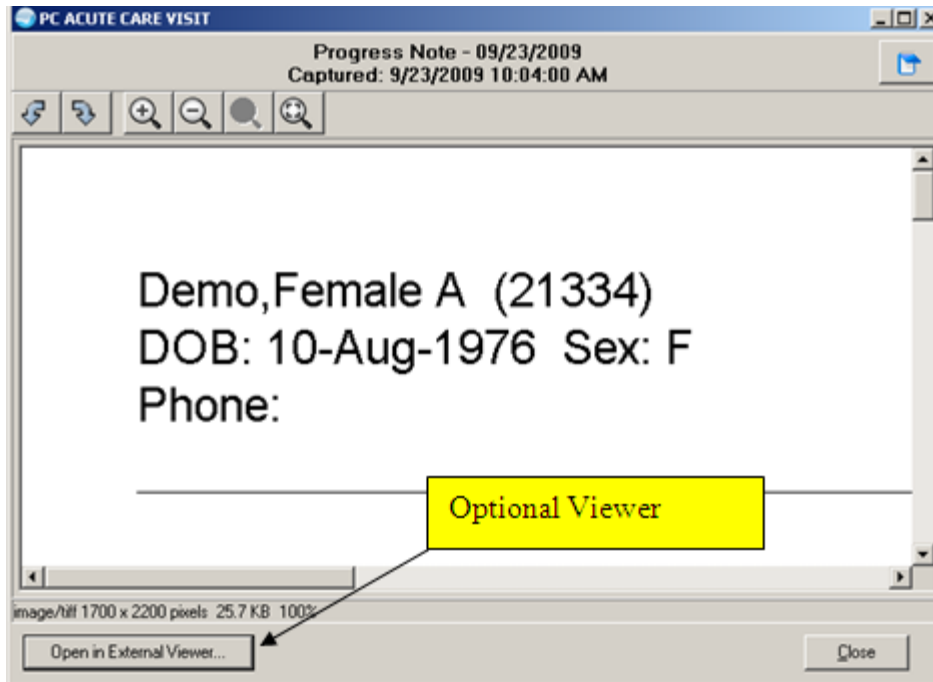


Figure 7-17: Location of Open in External viewer

After you click the optional view, you get the following:

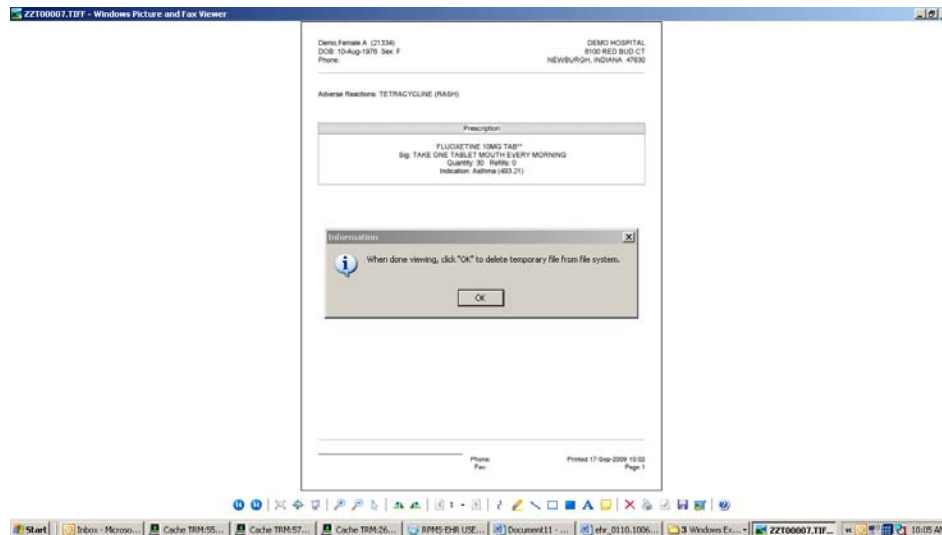


Figure 7-18: Note in external view

8.0 New Parameters

This section addresses new parameters.

8.1 APSP AUTO RX DEF PT STATUS

This parameter is only used at sites with NO in-house pharmacy that use auto-finish. The APSP AUTO RX DEF PT STATUS parameter is a back-up parameter in case the site has not set the RX PATIENT STATUS FILE.

```
Set Enter selection: 80 System YAKIMA-HC.PRT.IHS.GOV
--- Setting APSP AUTO RX DEF PT STATUS for System: YAKIMA-HC.PRT.IHS.GOV ---
Default Patient Status: ?
Answer with RX PATIENT STATUS NUMBER, or NAME, or ABBR
Choose from:
1 OUTPATIENT
2 NON-VA
```

Figure 8-1: Instructions for parameter

8.2 CIANB ACTIVITY LOGGING

This parameter is used to enable logging of session activities.

If activated, results in logging session activities such as remote procedure calls and events to the CIA ACTIVITY LOG file. Activating this feature may have significant adverse impact on application performance and disk usage.

This can be set for User Division and System levels.

8.3 CIANB ACTIVITY RETENTION

This parameter is used to specify the retention periods for logged activities. This controls how long entries in the CIA ACTIVITY LOG file are retained. The Retention Period is in days.

8.4 BEHOART AUTOSIGN

This parameter forces automatic signature for ADR entries.

If set to Yes, the signature of any new or edited adverse reaction entries is forced upon context change. If No, the user can opt to sign changes at a later time. This parameter is set at User, Class, Division and System levels.

8.5 BEHOENCX DETAIL REPORT

This parameter provides the Visit Detail report – the M code to generate a visits detail report. This is attached to visits in the encounter selection component. Right-click on a visit to get the visit details. This parameter is set at User, Service, Division and System levels.

8.6 BEHOORPA CLINICAL INDICATOR

This parameter enables the Clinical Indicator field. It controls which order entry dialogs present a clinical indicator field. At the present time, this is used for Lab and Pharmacy packages. This parameter is set at the Division and System levels.

8.7 BEHOPTCX IGNORE ALIASES

This parameter is used to ignore aliases in the patient lookup. If it is set to Yes, any aliases encountered in the primary index of the patient file are ignored. This parameter is set at the Division and System levels.

8.8 BEHOPTCX REQUIRES HRN

This parameters forces the selected to have an HRN. This parameter controls whether a patient must have an assigned health record number to be selectable within the EHR. This parameter is set at System level.

8.9 BEHORX NONVA LABEL

This parameter is used with the Label to describe NonVA Meds. The value will be used to label the dropdown button and column heading that represent NonVA Meds in the Medication component. This parameter is set at System level.

8.10 BEHORX PRINT DEFAULT

This parameter sets the Default Printer for Med Print Action. The Default printer for the selected report type. Report types: 0:Brief; 1:Detailed; 2:Prescription; 3:Sample Label. This parameter is set at System level.

8.11 BEHORX PRINT LABEL

This parameter sets the Enable Print Label Feature. It controls the availability of the Print Rx print feature within EHR. This parameter is set at Division and System level.

8.12 BEHORX PRINT SCRIPT

This parameter sets the Enable Print Script Feature. It controls the availability of the Print Rx print feature within EHR. This parameter is set at Division and System level. The choices are Disable, Single Page and Multipage.

8.13 BEHORX PRINT SCRIPT MAX

This parameter sets the Maximum # of scripts per page. It controls the maximum number of prescriptions that may be printed on a single page. This parameter is set at the User, Class, Division, and System levels.

8.14 BEHORX SCRIPT CUSTOM FORMAT

This parameters provides the M code to generate a prescription format. Specifying a routine in this parameter will supersede the use of OE/RR Print Formats defined in the other BEHORX SCRIPT parameters.

8.15 BEHORX SCRIPT HEADER

This parameters sets the format used to print the header of the prescription form for the hospital.

8.16 BEHORX SCRIPT FORMAT

This parameter sets the format used when printing the body of a prescription form for the hospital.

8.17 BEHORX SCRIPT FOOTER

This parameter sets the format used to print the footer of the prescription for the hospital.

8.18 BGO POV DEFAULT CHART

This parameter is used to select the default POV for chart reviews. It is set at Division and System levels. The default is V68.9.

8.19 BGO POV DEFAULT TELEPHONE

This parameter is used to select the default POV for telephone visits. It is set at Division and System levels. The default is V65.9.

8.20 CIAOMAG IMAGING ENABLED

This parameter is used to turn on the image viewer and capture of images for photographs and documents.

8.21 CIAOMAG CAN CAPTURE

This parameter is used to turn on the ability to capture and upload images. It can be setup by user if desired

8.22 CIAOMAG EXTERNAL VIEWER

This parameter allows sites to use an external viewer to view the document images.

9.0 Appendix A

Sample Process to capture Outside Meds that are not yet been entered in the Drug Database

This appendix describes how to capture Outside Meds that are not yet been entered in the Drug Database. This is a sample process and set-up.

Until the enhanced Medication Reconciliation functionality is delivered in EHRv1.1p7 which contains a queue for medications entered with incomplete information (no matching in drug database, patient does not know med, etc), sites need to consider a solid process for alerting a responsible individual to ensure that these missing drugs are entered into the database and subsequently in the Outside Meds component so that they will participate in order checking properly.

I thank Tulalip for recommending the process below and offer the process as a viable work around. Sites can consider making multiple “outside med” entries available because duplicates will cause “duplicate order” dialogs when entering/signing meds; however, sites do not want these entries on the chart for a long period of time so creating a single Outside Med Miscellaneous entry may be sufficient.

Entering and reconciling Outside Meds that are not present in the drug selection list when the nurse or provider documents information.

9.1 Overview of the Process

1. Click on Outside Medications
2. Click “Add” button
3. Select “Outside Med Miscellaneous”
4. Enter drug information in Dosage (drug, dose/dosage form) route and schedule if known and Accept Order

because the actual drug is not in the system yet, the drug itself will not participate in order checks
5. Designated pharmacist (or designee at sites without pharmacist) receives notification that and Outside Med Miscellaneous med has been entered
6. Pharmacist (or designee at sites without pharmacist) enters the drug in the database (make sure and mark as non-VA)

7. Pharmacist (or designee at sites without pharmacist) corrects the Outside Medications (uses NEW to enter the drug, then Delete the “Outside Med Miscellaneous” entry marking as “duplicate.”)
8. Delete notification

9.2 Set-up

1. Pharmacy supervisor (or clinical director if no site with no pharmacy): Identify designated “New Drug Pharmacist” or designee of site with no pharmacy. Assign 1 pharmacist (or designee) who is responsible for entering new drugs into the system.
2. New drug pharmacist (or designee): Create the following “drug” using Drug Enter/Edit menu in the pharmacy package.

```
Name: Outside Med Miscellaneous
Mark as "X" Non-VA ONLY
Dosage form: Miscellaneous
Local possible dose: "Enter drug and dose if known in Dosage
```

Figure 9-1: Procedure instructions

3. CAC: Set the FLAGGED OI ORDER – OUTPT notification to mandatory for the designated “New Drug Pharmacist.”

```
RPMS-EHR Master Configuration Menu>NOT>PRC
      Enable/Disable Notifications

Processing Flag may be set for the following:

   1  User           USR      [choose from NEW PERSON]
   2  Team (OE/RR)  OTL      [choose from OE/RR LIST]
   3  Service        SRV      [choose from SERVICE/SECTION]
   4  Location       LOC      [choose from HOSPITAL LOCATION]
   5  Division       DIV      [choose from INSTITUTION]
   6  System         SYS      [DEMO-HO.BEM.IHS.GOV]
   7  Package        PKG      [ORDER ENTRY/RESULTS REPORTING]

Enter selection: 1  User      NEW PERSON
Select NEW PERSON NAME: Richards, Su  RICHARDS,SUSAN      SR

----- Setting Processing Flag for User: RICHARDS,SUSAN -----
Select Notification:      FLAGGED OI ORDER - OUTPT
Are you adding FLAGGED OI ORDER - OUTPT as a new Notification? Yes//  YES

Notification: FLAGGED OI ORDER - OUTPT//  FLAGGED OI ORDER - OUTPT  FLAGGED OI
ORDER - OUTPT
Value: ?

Code indicating processing flag for the entity and notification.

Select one of the following:

   M      Mandatory
   E      Enabled
   D      Disabled
```

Value: Mandatory

Figure 9-2: Procedure instructions

4. CAC: Set the notification for Flag Orderable Item (outpatient, order) at the User level for the designated “New drug pharmacist” or designee.

```
RPMS-EHR Master Configuration Menu>NOT>FLG
      Flag ORDERABLE ITEMS to send Notifications

1.  Flag INPATIENT orders/results/expiring orders.
2.  Flag OUTPATIENT orders/results/expiring orders.
3.  Flag Lab tests for Threshold Exceeded alerts.

Select "1" to flag INPT orders/results, "2" to flag OUTPT orders/results, "3" to
set Lab Thresholds: 2

      Flag OUTPATIENT orderable items to send Notifications

1.  Flag Outpatient ORDERS.
2.  Flag Outpatient RESULTS.
3.  Flag Outpatient EXPIRING orders.

Select "1" to flag outpt ORDERS, "2" to flag outpt RESULTS, "3" to flag outpt EX
PIRING orders: 1

Flag Items to Send OUTPT ORDER Notifs may be set for the following:

      1  User           USR      [choose from NEW PERSON]
      2  Team (OE/RR)  OTL      [choose from OE/RR LIST]
      3  Device         DEV      [choose from DEVICE]

Enter selection: 1  User      NEW PERSON
Select NEW PERSON NAME:      RICHARDS,SUSAN      SR

-- Setting Flag Items to Send OUTPT ORDER Notifs for User: RICHARDS,SUSAN --
Select Orderable Item: OUTSIDE MED MISCELLANEOUS

Are you adding OUTSIDE MED MISCELLANEOUS as a new Orderable Item? Yes// y  YES

Orderable Item: OUTSIDE MED MISCELLANEOUS //      OUTSIDE MED MISCELLANEOUS
Send alert for ALL outpatients?: YES
```

Figure 9-3: Procedure instructions

9.3 Process

Follow these steps:

1. Entry of Outside Medications not currently in database (by nurse or provider).
 - Click on Outside Medications section of Meds tab. Either click NEW button or right click and select NEW MEDICATION.
 - Search for and select OUTSIDE MED MISCELLANEOUS.

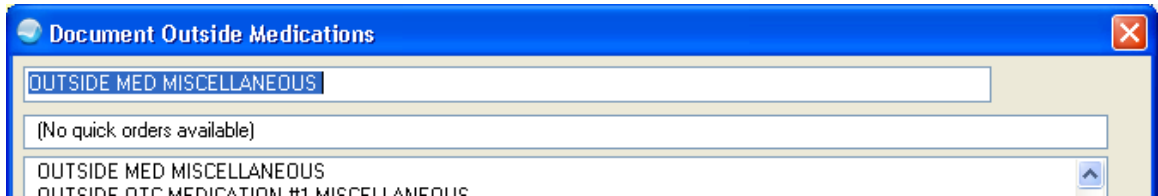


Figure 9-4: Search for Outside Med Miscellaneous

- Enter drug info in DOSAGE along with any other known info, click ACCEPT and click SIGN tool button.

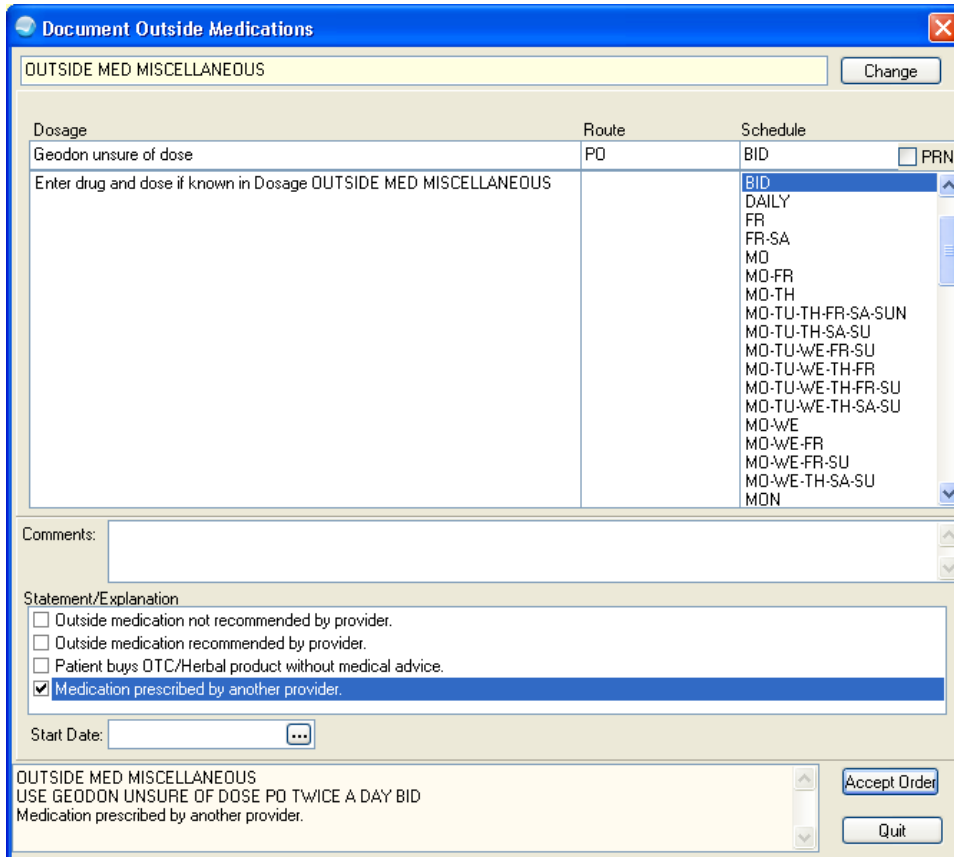


Figure 9-5: Entering drug information

- This is what the Med tab shows – the “medication” is “Outside Med Miscellaneous” – the Geodon won’t order check until the pharmacist (or designee) adds to database and updates the entry

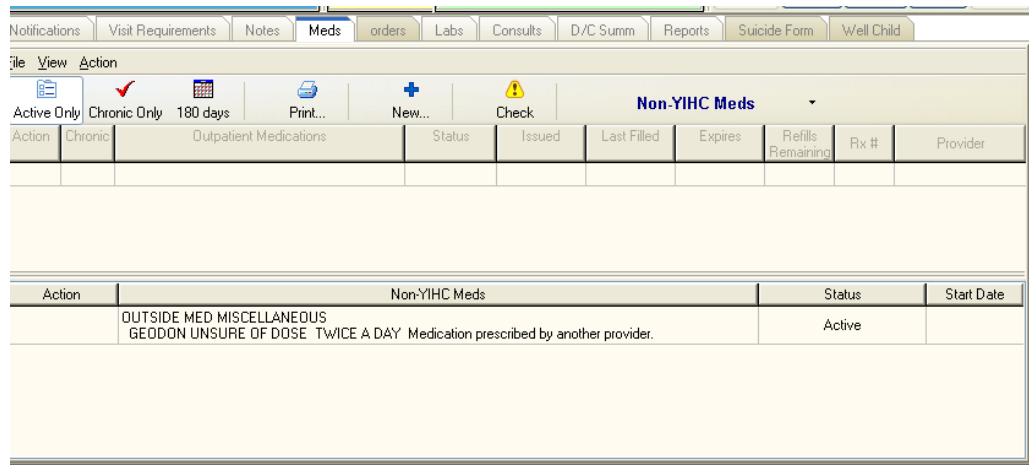


Figure 9-6: Sample Meds tab

- This is what the designated “New Drug Pharmacist” (or designee) receives in Notifications
- Double click on the notification and click the “View Patient” button

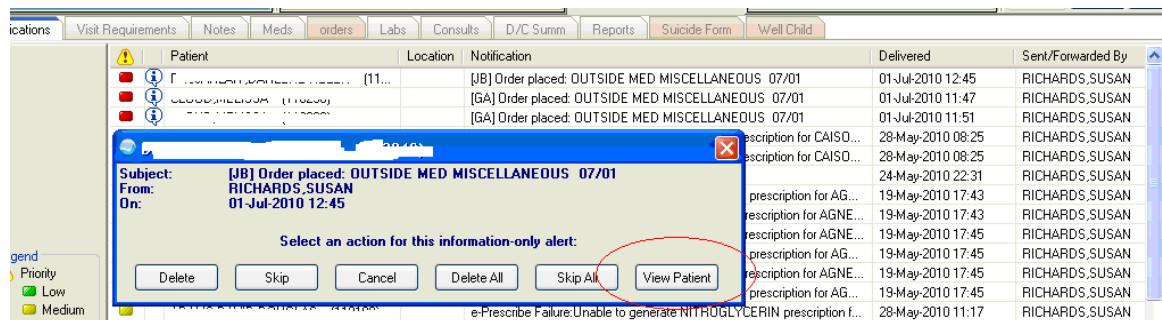


Figure 9-7: Clicking the View Patient button

2. Pharmacist (or designee) notified of new Outside Med Miscellaneous entry and updates Drug Database.
 - Reviews info provided on Outside Medications “Outside Med Miscellaneous” entry
 - Enters new drug in database
3. Pharmacist (or designee) updates “Outside Medications” list.
 - Now enter the Outside Medications into the patient’s med list using NEW

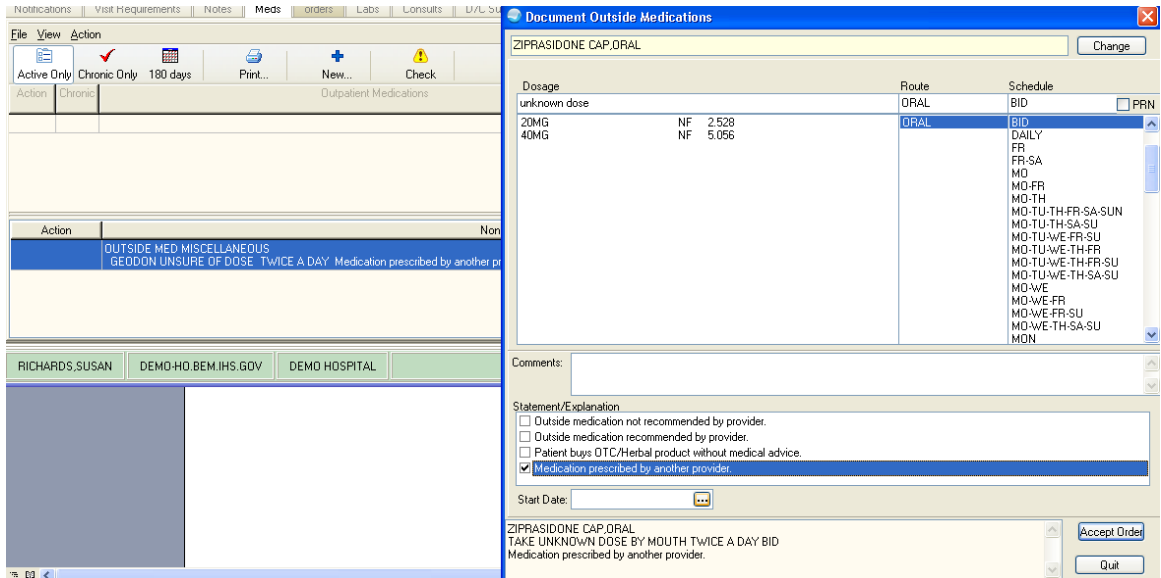


Figure 9-8: Entering Non-Y1HC Med using NEW

- Discontinue the “Outside Med Miscellaneous” and mark as Duplicate entry

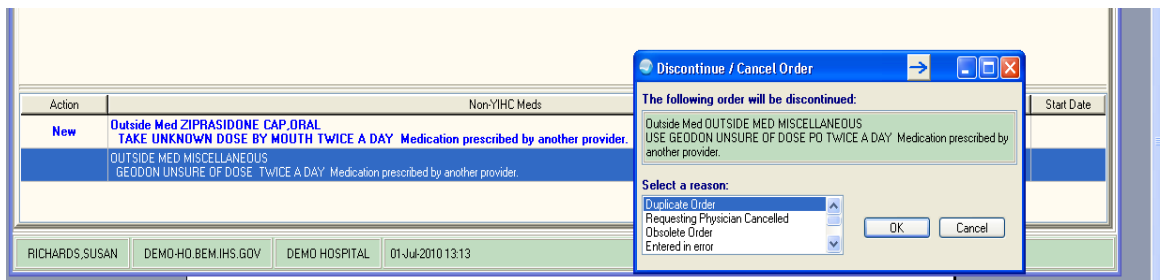


Figure 9-9: Marking as Duplicate Entry

- Click the Signature tool and OK
- Now you have the corrected entry on the med list. This one WILL order check.

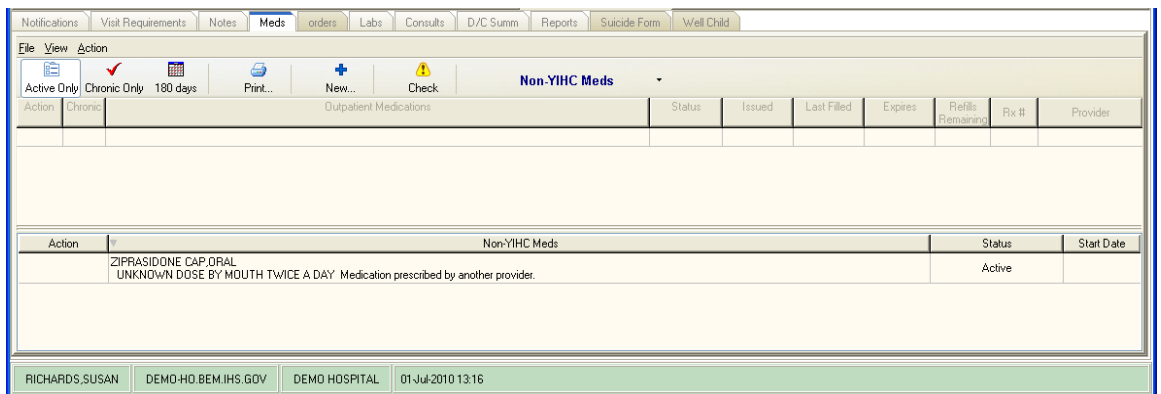


Figure 9-10: This one will order check

10.0 Appendix B

This appendix contains information about the Patient Wellness Handout.

10.1 Removing Medications Object from Patient Wellness Handout

The patient wellness handout is configurable and sites may configure additional handouts as they desire. The menu is available on the IHS Health Summary Maintenance Menu. The APCH PWH Menu also allows sites to set the default PWH for a site.

More info can be found here:

http://www.ihs.gov/RPMS/PackageDocs/bjpc/bjpc0200.02u_apch.pdf

If you want to make additional PWH available on either the reports tab or health summary buttons on the toolbar, create VA Health Summary reports using the PWH Selected component.

Choose the Patient Wellness Handout Menu - Option name: APCH PWH MENU

```

PWH   Generate a Patient Wellness Handout
DEF   Update Default PWH for a Site
AAP   Print Asthma Action Plan
MPWT  Create/Modify Patient Wellness Type
Select Patient Wellness Handout Menu Option: MPWT  Create/Modify Patient Wellness
Type

This option will allow you to create a new or modify an existing
Patient Wellness Handout type.

Select HEALTH SUMMARY PWH TYPE NAME: Adult REGULAR
NAME: ADULT REGULAR//
LOCK: APCHZMGR//

Create/Modify PWH Type          Jul 15, 2010 12:52:41          Page:    1 of    2
Patient Wellness Handout: ADULT REGULAR

STRUCTURE:
Order Component
10  HEIGHT/WEIGHT/BMI
20  MEDICATIONS (ACTIVE AND RECENTLY EXPIRED)
30  BLOOD PRESSURE
40  HIV SCREENING
50  ALLERGIES
Source for Allergy component: FROM BOTH ALLERGY TRACKING AND PROBLEM LIST
60  IMMUNIZATIONS RECEIVED
70  IMMUNIZATIONS DUE
75  CHOLESTEROL
80  DIABETES CARE
85  CANCER SCREENING
90  QUALITY OF CARE TRANSPARENCY REPORT CARD

```



```

+          Enter ?? for more actions
MS  Modify Structure      PH  Print Handout
DH  Display Handout      Q   Quit
Select Action:+//MS Modify Structure

```

Figure 10-1: Procedure instructions

You can add a new component by entering a new order number and component name. To remove a component from this PWH type select the component by name or order and then enter an '@'.

```

Select SUMMARY ORDER: 120// 20          MEDICATIONS (ACTIVE AND RECENTLY EXPIRED)
SUMMARY ORDER: 20// @
SURE YOU WANT TO DELETE THE ENTIRE '20' SUMMARY ORDER? Y (Yes)
Select SUMMARY ORDER:

```

Figure 10-2: Procedure instructions

10.2 Creating Patient Wellness Handout Reports

The following describes how to create Patient Wellness Handout report in the VA Health Summary package for display on the Health Summary buttons in the EHR.

1. Create a VA Health Summary using PWS selecting the Patient Wellness Handout you want.

```

Health Summary Maintenance Menu [GMTS IRM/ADPAC MAINT MENU]
 1  Disable/Enable Health Summary Component
 2  Create/Modify Health Summary Components
 3  Edit Ad Hoc Health Summary Type
 4  Rebuild Ad Hoc Health Summary Type
 5  Resequence a Health Summary Type
 6  Create/Modify Health Summary Type
 7  Edit Health Summary Site Parameters
 8  Health Summary Objects Menu ...
 9  CPRS Reports Tab 'Health Summary Types List' Menu ...
10  CPRS Health Summary Display/Edit Site Defaults ...

Select Health Summary Maintenance Menu Option: PWH Local Name
Are you adding 'PWH Med Rec' as
a new HEALTH SUMMARY TYPE (the 78th)? No// y YES
NAME: PWH Local Name//
TITLE:
SUPPRESS PRINT OF COMPONENTS WITHOUT DATA:

Do you wish to copy COMPONENTS from an existing Health Summary Type? YES// NO
Select COMPONENT: PWS PW HANDOUT SELECTED PWS
SUMMARY ORDER: 5// 5
HEADER NAME: Handout Selected//

No selection items chosen.

Select new items one at a time in the sequence you want them displayed.
You may select any number of items.

Select SELECTION ITEM: Local Name

Searching for a PWH TYPES, (pointed-to by SELECTION ITEM)

```

```

Searching for a PWH TYPES
LOCAL NAME
  ...OK? Yes// y (Yes)
Are you adding 'LOCAL NAME' as a new SELECTION ITEM (the 1ST for this STRUCTURE)?
No// y (Yes)
Select SELECTION ITEM

```

Figure 10-3: Procedure instructions

2. Find record number in Fileman.

```

1 Search File Entries
2 Print File Entries
3 Inquire to File Entries
4 Statistics
5 List File Attributes

Select FileMan (General) Option: inquire to File Entries

OUTPUT FROM WHAT FILE: VA HEALTH SUMMARY TYPE//
Select VA HEALTH SUMMARY TYPE NAME: PWH Local Name
ANOTHER ONE:
STANDARD CAPTIONED OUTPUT? Yes// (Yes)
Include COMPUTED fields: (N/Y/R/B): NO// BOTH Computed Fields and Record Number
(IEN)

NUMBER: 80 NAME: PWH Local Name
OWNER: RICHARDS,SUSAN P
SUMMARY ORDER: 5 COMPONENT NAME: PW HANDOUT SELECTED
HEADER NAME: Handout Selected
SELECTION ITEM: LOCAL NAME
TIMESTAMP: 61759,54656

Select VA HEALTH SUMMARY TYPE NAME:

```

Figure 10-4: Procedure instructions

3. Configure Health Summary button in the EHR in Design Mode.

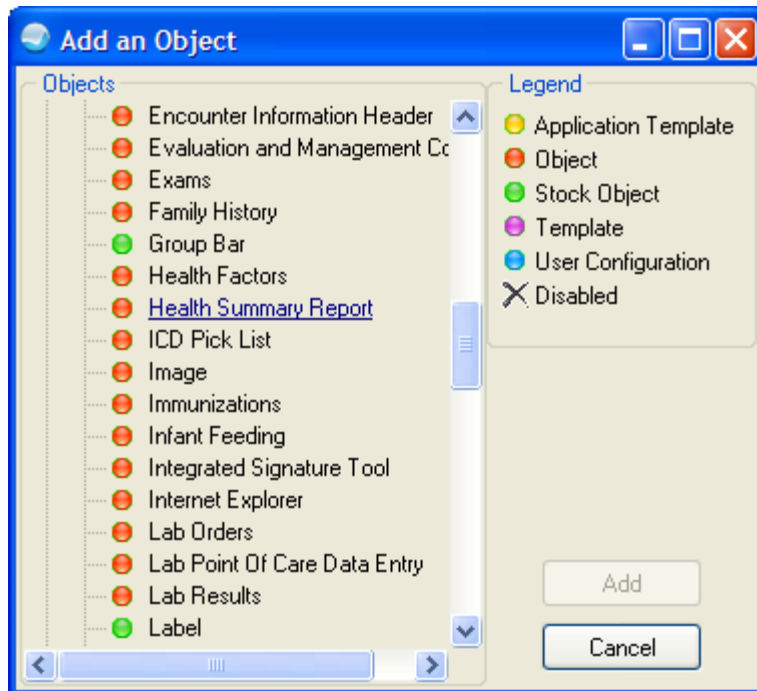


Figure 10-5: Add an Object in Design Mode

Add the Health Summary Report to the toolbar. Right-click and select **PROPERTIES**.

Properties for Health Summary Report	
Property	Value
TOP	0
LEFT	523
HEIGHT	58
WIDTH	259
ALIGN	All
ANCHORS	<input checked="" type="checkbox"/> Top; Left; Right; Bottom
GLYPH	
CAPTION	Local Name
LAYOUT	Image appears on the left.
ASYNCHRONOUS	<input checked="" type="checkbox"/> True
ENCOUNTERREQUIRED	<input type="checkbox"/> False
REFRESHOPTION	If a report is displayed on receipt of a refresh
REPORT	1^80
TITLE	Local Name
REFRESHOPTION	Controls behavior upon receipt of a refresh request.

enter
1^report number

OK Cancel Apply

Figure 10-6: Properties for Health Summary Report dialog

- Enter a Title and Caption
Then enter REPORT using 1^report number (the one you retrieved from the Fileman Inquire look up).
- Save the template
- Now click the PWH Med Rec button to display the selected Patient Wellness Handout you configured. You can do this with more than one PWH. Repeat the instructions and configure separate Health Summary buttons for each.

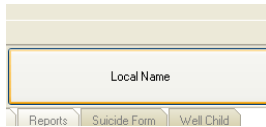


Figure 10-7: New button on toolbar

The following shows a sample output for the process.

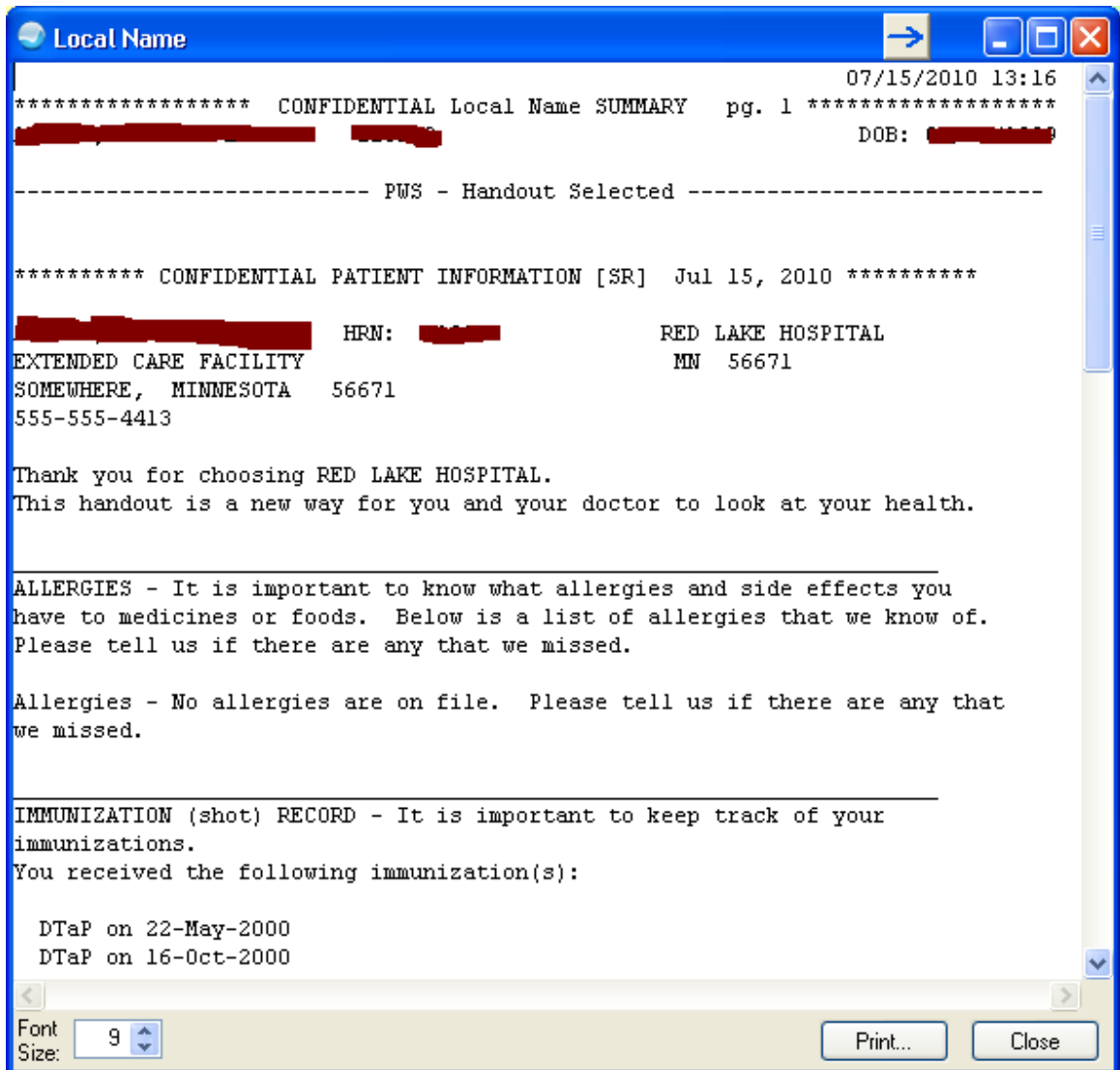


Figure 10-8: Sample output

11.0 Appendix C

This appendix describes adding the Family History Health Summary button.

11.1 Create IHS Health Summary

On the Health Summary Maintenance Menu, using MS – Create/Modify Health Summary Type [APCHSTED].

```
Select HEALTH SUMMARY TYPE NAME: Family History
Are you adding 'Family History' as
a new HEALTH SUMMARY TYPE (the 29TH)? No// Y (Yes)
NAME: Family History//
LOCK:
```

Figure 11-1: Procedure instructions

The instructions continue after this screen capture.

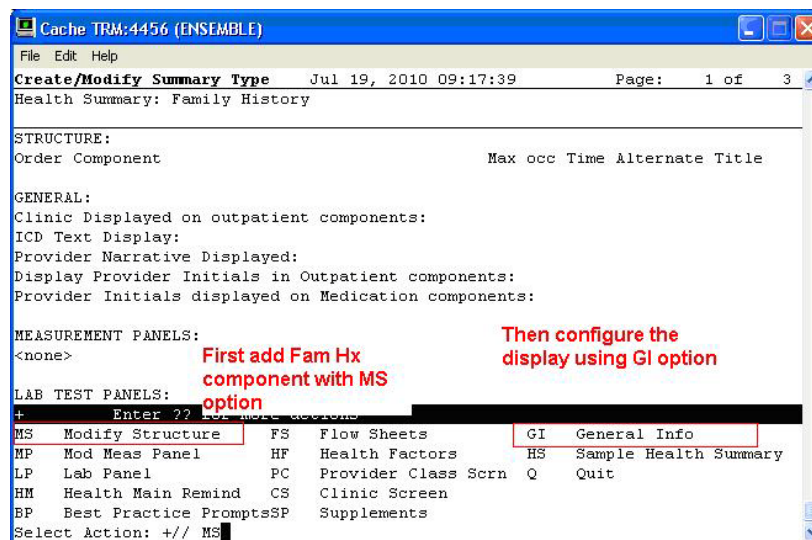


Figure 11-2: Sample instructions

Use the option MS – Modify Structure to add a Family Health History component.

You can add a new component by entering a new order number and component name. To remove a component from this summary type select the component by name or order and then enter an '@'.

```
Select SUMMARY ORDER: 5
STRUCTURE COMPONENT NAME: FAMILY HEALTH HISTORY
COMPONENT NAME: FAMILY HEALTH HISTORY//
ALTERNATE TITLE:
Select SUMMARY ORDER:

CONFIGURE display
```

```

Select Action: +// GI General Info
CLINIC DISPLAYED:
ICD TEXT DISPLAYED: N NONE
PROVIDER NARRATIVE DISPLAYED: Y YES
DISPLAY PROVIDER INITIALS:
DISPLAY PROV INITIALS W/MEDS:
DISPLAY COMMENTS W/LAB:

```

Figure 11-3: Procedure instructions

11.2 Determine Internal Entry Number

Use the following to determine the Internal Entry Number of the newly created report.

```

FileMan (General) [AKMOFMAN]
1 Enter or Edit File Entries
2 Print File Entries
3 Search File Entries
4 Inquire to File Entries

Select FileMan (General) Option: inquire to File Entries

OUTPUT FROM WHAT FILE: VOLUME SET// Health Summary Type
(29 entries)

Select HEALTH SUMMARY TYPE NAME: Family History
ANOTHER ONE:
STANDARD CAPTIONED OUTPUT? Yes// (Yes)
Include COMPUTED fields: (N/Y/R/B): NO// BOTH Computed Fields and Record Number
(IEN)

NUMBER: 40 NAME: Family History
SUMMARY ORDER: 5 COMPONENT NAME: FAMILY HEALTH HISTORY
ICD TEXT DISPLAYED: NONE PROVIDER NARRATIVE DISPLAYED: YES

```

Figure 11-4: Procedure instructions

11.3 Add Family History Health Summary Button

Use the following to add/configure the Family History Health Summary button.

1. In DESIGN MODE, add a HEALTH SUMMARY REPORT.
2. Right click – PROPERTIES.
3. Align LEFT.
4. Anchor TOP, BOTTOM.
5. Caption = Family History
6. Title = Family History
7. Report = IHS^40
8. Click Apply and click OK

- DESIGN – Save Template as [your local template name]
- Repeat for each EHR GUI template you want to add button.

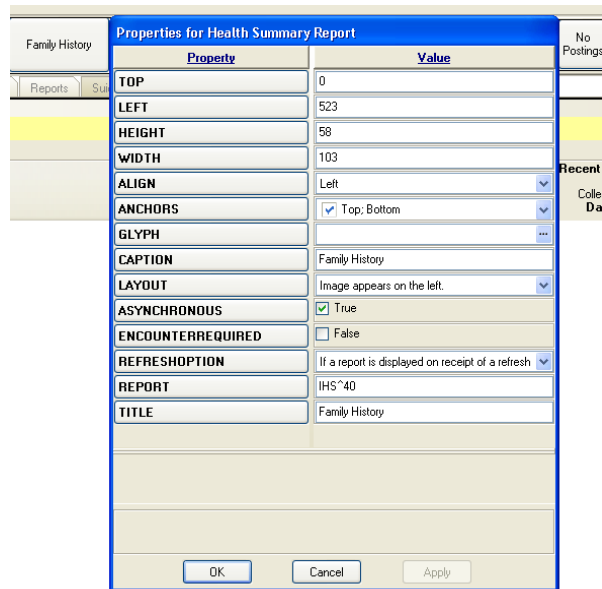


Figure 11-5: Window in Design Mode

Now, users can go to the Family History tab, make EHR small and click on Family History. This sits on top and they can use that as a guide when entering the migrated data. After entering it all, they can then remove the “unknown”

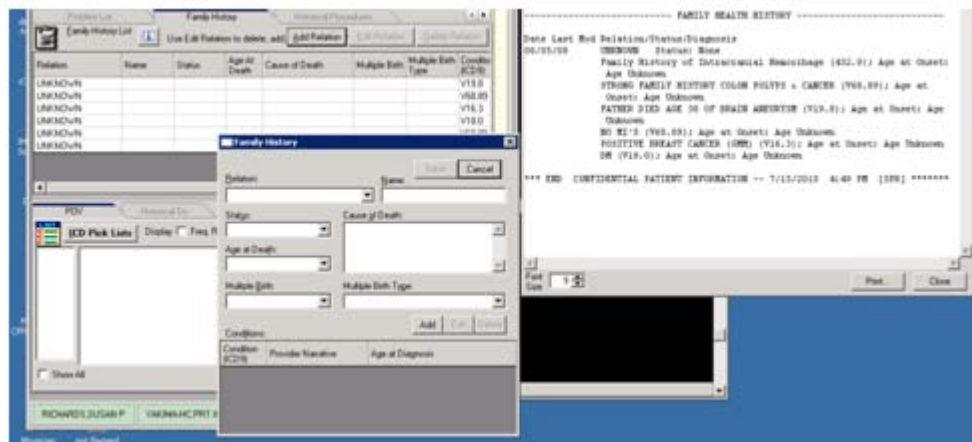


Figure 11-6: Family History that sits on top of the EHR

12.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: support@ihs.gov