RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record
(RPMS-EHR)

Release Notes

Version 1.1 Patch 7
February 2011

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

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1.0 Introduction

This document provides an overview of the Resource and Patient Management System (RPMS) Electronic Health Record (EHR) 1.1 patch 7 and assumes that the site has already completed the setup for RPMS-EHR 1.1 and has loaded patches up through Patch 6.

Note that sites who use the Well Child Module (VEN) and its components in EHR need to also install VEN 26 patch 2 (which updates the retrieval and display on the Well Child growth charts and graphs).

Please thoroughly review this manual, patch notes, and requirements.

2.0 Issues Identified and/or Planned Enhancements to Delivered Fixes

The following provides information about the identified problems and/or the planned enhancement to delivered fixes for Patch 7.

2.1 BEHOPTCX REQUIRES HRN Parameter

The BEHOPTCX REQUIRES HRN parameter is only honored when selecting the patient from the Patient context box (Patient Identification Header component).

2.1.1 Issue

Users can enter the record from the **Notifications** tab if they receive a notification on that patient. Providers can process notification per usual; however, acting on information from the notification, the provider could inadvertently create a visit on a patient in a division in which the patient is not registered.

2.1.2 Interim Solution

This is unchanged from EHR 1.1 patch 5 behavior. EHR 1.1 patch 6 restricted display of notifications to those patients with registered in the logged on division. This was returned to EHR 1.1 patch 5 behavior because of concerns this configuration might delay provider notification of important patient events.

We recommend that you train providers to ensure they are in the proper division before creating a visit when entering chart from **Notifications** tab. If the patient is not registered, the Health Record Number (HRN) is replaced with the XXX-XX-1234 format of the Social Security Number (SSN).

2.1.3 Fix

A future patch (EHR patch 9 or 10) will add a check of this parameter when entering a chart from notifications and honor that parameter.

2.2 Vital Entry Dialog

2.2.1 Issue

The **New Date/Time** button now launches a dialog with three radio buttons: **Current Visit**, **Historical Visit**, and **Now**. The default is Now. This might not be the preferred default for all users.

2.2.2 Interim Solution

Train users to review Date/Time Done when they activate the **New Date/Time** button. The inpatient users are accustomed to changing the time at the top of the vital entry column. With the enhanced dialog the default Date/Time Done will still be Now, but users can change the date/time here by launching the date/time calendar (clicking the **Ellipsis** button ). Users will still have the option of changing the date/time at the top of the column.

For users who routinely perform asynchronous documentation (home visit and offsite encounters done by Home Health, Public Health Nursing (PHN), Maternal Child Health (MCH), and others) they can quickly change the Date/Time Done to the Current Visit.

2.2.3 Scheduled Enhancement

EHR patch 8 will deliver the ability to set the default as Now or Visit Date/Time as a parameter and will be available on the **Vital Configuration** menu in the **RPMS EHR Configuration Master Menu**.

2.3 Historical Measurements Entered Through Reminder Dialogs

Historical Measurements entered through Reminder Dialogs are not yet available.

2.3.1 Issue

Now that historical measurement documentation is available in the EHR Vital Entry, sites would like the same functionality in Reminder Dialogs. This has never been available and currently stores Now if you try to set up a measurement dialog element using resolution type Done Elsewhere.

2.3.2 Interim Solution

Use the new **Historical Measurement** feature in the EHR Vital Entry component to enter measurements done at other facilities, such as cardiac ejection fractions done during an echo cardiogram or a birth measurement from the newborn hospital record.

2.3.3 Scheduled Enhancement

EHR patch 8 will deliver the ability to enter historical measurements through Reminder Dialogs.

2.4 Immunization Component Auto-Population of CPT and ICD-9 Codes

2.4.1 Issue

Due to the frequency of updates/changes to codes included in immunization, Current Procedural Terminology (CPT), and International Classification of Diseases (ICD) patches, the hard-coded autopopulating from the Immunizations component is extremely difficult to synchronize. Functionality exists that is more efficient.

2.4.2 Interim Solution

Sites are encouraged to stop the autopopulation of the CPT and either set up superbill associations or use EHR Reminders to document immunizations. Strongly consider also stopping autopopulation of ICD Ninth Revision (ICD-9) codes.

1. RPMS EHR Configuration Master Menu | Immunization Configuration (IMM) | Stop Immunizations from Adding CPT codes (CPT).

   Stop Immunizations from Adding CPT Codes can be set for the following:

```
     10  User          USR    [choose from NEW PERSON]
     80  Division      DIV    [choose from INSTITUTION]
     90  Package       PKG    [BGO COMPONENTS]
```

Figure 2-1: Setting for Adding CPT Codes

   Set this to Yes for your divisions.

```
Enter selection: 80  Division   INSTITUTION
Select INSTITUTION NAME:    DEMO HOSPITAL     HEADQUARTERS WEST       NON
SERVICE UNIT       01               MN  IHS       497

 Setting Stop Immunizations from Adding CPT Codes  for Division: DEMO
HOSPITAL
Value: YES
```

Figure 2-2: Setting your divisions to Yes

2. RPMS EHR Configuration Master Menu | Immunization Configuration (IMM) | Stop Immunizations from Adding ICD codes (ICD).

   Stop Immunizations from Adding ICD Codes can be set for the following:

```
     10  User          USR    [choose from NEW PERSON]
     80  Division      DIV    [choose from INSTITUTION]
     90  Package       PKG    [BGO COMPONENTS]
```

Figure 2-3: Settings for Adding ICD codes

Set this to Yes for your divisions.

```
Enter selection: 80  Division   INSTITUTION
Select INSTITUTION NAME:    DEMO HOSPITAL     HEADQUARTERS WEST       NON
SERVICE UNIT       01               MN  IHS       497

 Setting Stop Immunizations from Adding ICD Codes  for Division: DEMO
HOSPITAL
Value: YES
```

Figure 2-4: Setting your divisions to Yes

3. Superbill Associations. Review with your coders the appropriate CPT (and ICD-9 codes if you set the parameter in Step 2 to Yes) and Patient Education codes. You can create a superbill association for each vaccine specific CPT codes and associate the appropriate administration CPT codes, ICD-9 code, patient education code, and Immunization. The Immunization dialog and patient education are presented to the user when selecting the CPT code for each immunization.

- Instructions for set up of superbill associations are found in Section 28.1.1.3 of the EHR v1.1 CAC Guide. ftp://ftp.ihs.gov/pubs/EHR/Training/Guides/EHR%20v1.1/EHR%20CAC%20Setup%20Guide%20v1.1.doc#_Toc211131738
- Immunization coding references (please review with your coder/HIM) are found in the American Academy of Pediatrics Practice Management Online (effective 1/1/11). http://practice.aap.org/content.aspx?aid=2334
- CDC Codes Mapped to CVX Codes: http://www2a.cdc.gov/nip/IIS/IISStandards/vaccines.asp?rpt=cpt
- Medicare Prevention Services Quick Reference Information: Medicare Immunization Billing. https://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf

4. EHR Reminder Dialogs can be enhanced to include vaccine-specific CPT codes and unique ICD-9 codes as additional findings on the Immunization dialog element. Administration codes can be added to dialogs as a separate dialog element, and the diagnosis code used for Hepatitis A and B should also be added to dialogs as separate dialog element. Additional findings must be absolutely unique and not shared with any other reminder dialogs being processed at the same time or the data does not store correctly.

   Alternately, use basic reminder dialogs that store only Immunization data and build superbill associations for each vaccine that include the vaccine-specific CPT, vaccine administration code, ICD-9 code, and education (make sure you do not associate the immunization or you will create a duplicate entry).

2.4.3 Scheduled Enhancement

EHR v1.1 patch 9 will default package level setting of “Stop Immunizations from Adding CPT codes (CPT)” to Yes. This will provide time for sites to select and implement a solution.

3.0 Fixes and Enhancements

The following provides information about the fixes and enhancements for Patch 7.

3.1 Fixes

Item	What It Does
Design Mode	Clear now clears repro history and infant feeding dialogs.
Med List (Cover Sheet)	V Med entries are not duplicated for Outside Medications.
Med Management	APSP 7.0 patch 1009 fixes the problem with autofinishing renewed meds. The original order is now autodiscontinued when autofinished. The fix was verified during EHR and APSP patch testing.
Med Management	Disallowing pending orders from being changed is restored.
Med Management	The component is modified in Patch 7 to fetch the medication orders prior to determining the visible state of the inpatient panel.
Notes	Sortable window is restored in the notes component.
Notifications	EHR patch 6 changed the way notifications were displayed. This code was from the Veterans Administration (VA) software. Only notifications for patients registered in the logged-in division appeared. Although this is "working as designed," with feedback from the field, the EHR team decided to restore the display so that all patients, even those patients not registered in the current logged-in division, would be displayed for the user. Although a user may need to log into a different division to resolve the notification, the user will always be able to see all notifications intended for him or her.
Orders	Copy to new order (med order dialog) now defaults to the correct pick-up location.
Orders	Electronic button now honors the APSP parameters on *all* med order dialogs. This fixes a bug where the electronic button was appearing on the med dialog when copy or change was selected.
Orders	Message field (if configured in drug file) now appears on med order dialog when first selecting order, change or copy from right-click menu and the opening dialog when process is clicked.
Orders (Inpatient)	Error when displaying orders auto-DC'd has been corrected
Patient Ed	Patient education topic may be stored more than once per visit.
Patient ID Header	Patient ID Header now displays XXX-XX-1234 format for SSN if there is no HRN.
Pharm Ed	Provider Narrative text was storing as text instead of a pointer to the Provider Narrative file in the V POV File. This has been corrected. A utility will run to cleanup incorrect values.

Item	What It Does
Printing	The bug forcing the chart copy parameter to be set to prompt post patch 6 has been corrected
Reminder Dialog Prompts	Provider Narrative text was storing as text instead of a pointer to the Provider Narrative file in the V POV File. This has been corrected. A utility will run to cleanup incorrect values
Skin Test	Administration codes no longer are added when entering skin tests.
Skin Test	Fixed display of historical purified protein derivatives (PPDs) entered in Immunizations package. Now reading of Zero displays correctly in EHR.
Skin Test	Fixed error that occurred when entering time for skin test.
Visit Diagnosis	Entering Diabetes as a Purpose of Visit (POV) through EHR now triggers the bulletin for New DM.
Visit Services	CPT modifiers are now returned when EDIT V CPT selected with Code Set Versioning.
Vital Entry	Edema now allows entry of 0 (zero).
Vital Entry	Entering Diastolic blood pressure > Systolic blood pressure no longer allowed.
Suicide Reporting Form	Suicide reporting forms have been updated to the most recent Behavioral Health version.

3.2 Enhancements

Item	What It Does
Historical Services	Can now enter Historical Service for same day
Lab POC	BEHOLR SET DEFAULT PROVIDER parameter added
Med Management (Outside Meds)	Adds an action of Validate for Outside meds entered as miscellaneous medications. Once the drug info is obtained, the user can change the order. This enhancement provides an important visible cue that the entry is not associated with a drug that enters into order checking. See Medication Reconciliation (Enhanced Outside Medications) for more information.
OE/RR Print Fields	Requesting Division has been added.
Patient Detail Report	Other Phone Contact info has been added.
Quick Notes	New functionality. See Quick Notes for more information.
Reminder Dialog Prompts	The following Reminder Dialog Prompts for the following measurements are now available for use in building dialogs: AG, ADM, AKBP, ASFD, AUDC, AUDT, BPF, CEF, CRFT, ED, FEF, FVFC, PF, PHQ2, PHQ9, TON, WC
Skin Test	New skin test fields for administration site and volume.
Vital Entry	Cardiac Ejection Fraction may now be entered through vital entry.

Item	What It Does
Vital Entry	May now enter historical measurements (done elsewhere). See Vital Measurements Enhancements for more information.

4.0 Medication Reconciliation (Enhanced Outside Medications)

The following illustrations show various enhanced Outside Medications.

4.1 Unknown Outside Medication

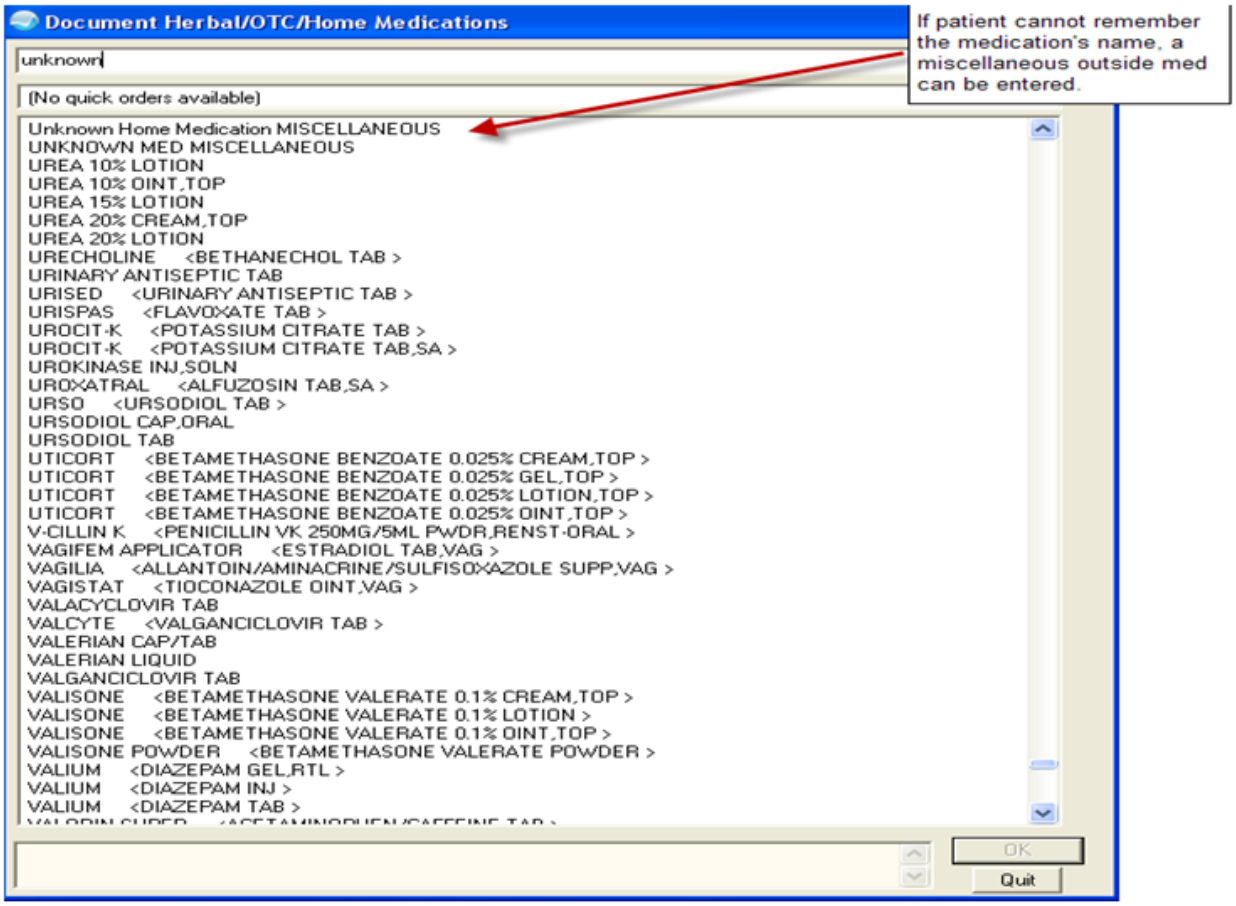

Figure 4-1: Entering a miscellaneous outside medication

4.2 Miscellaneous Medication

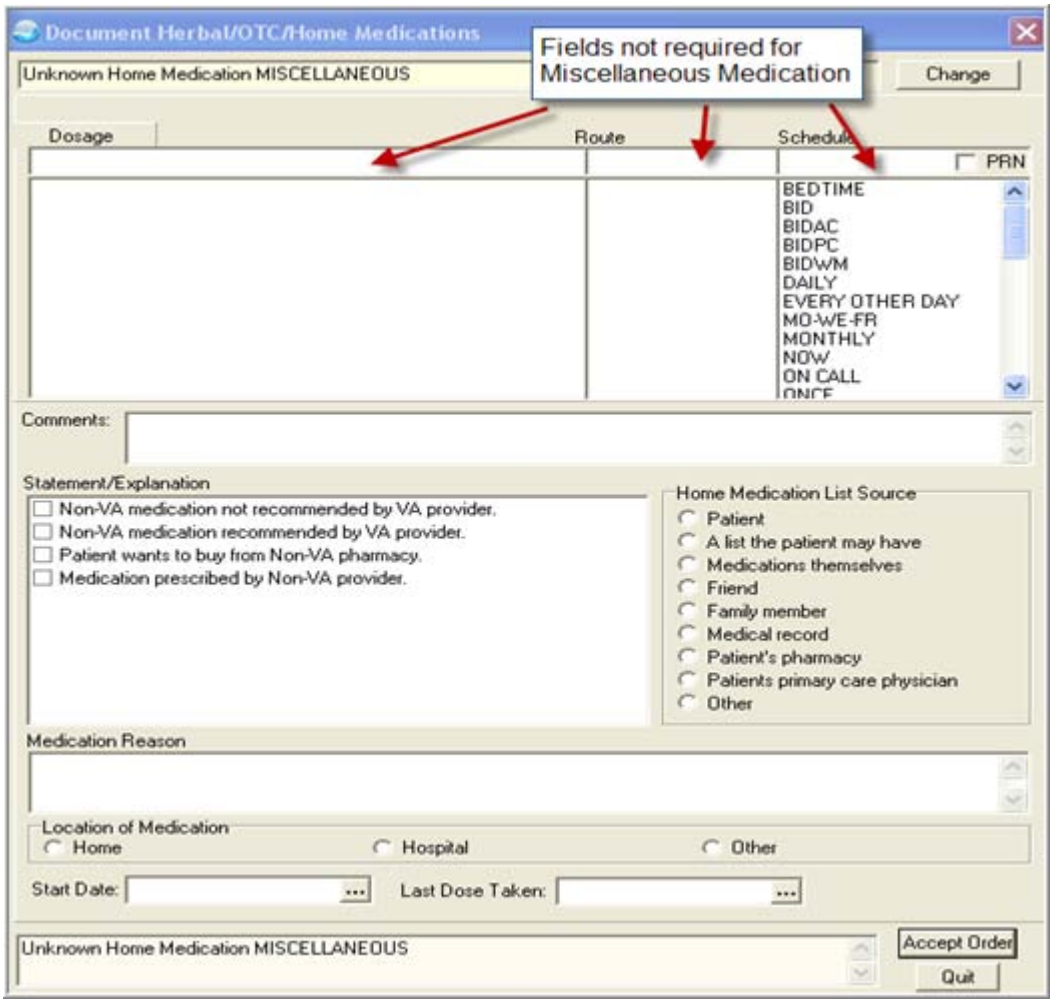

Figure 4-2: Entering miscellaneous medication

4.3 New Fields for Outside Medication

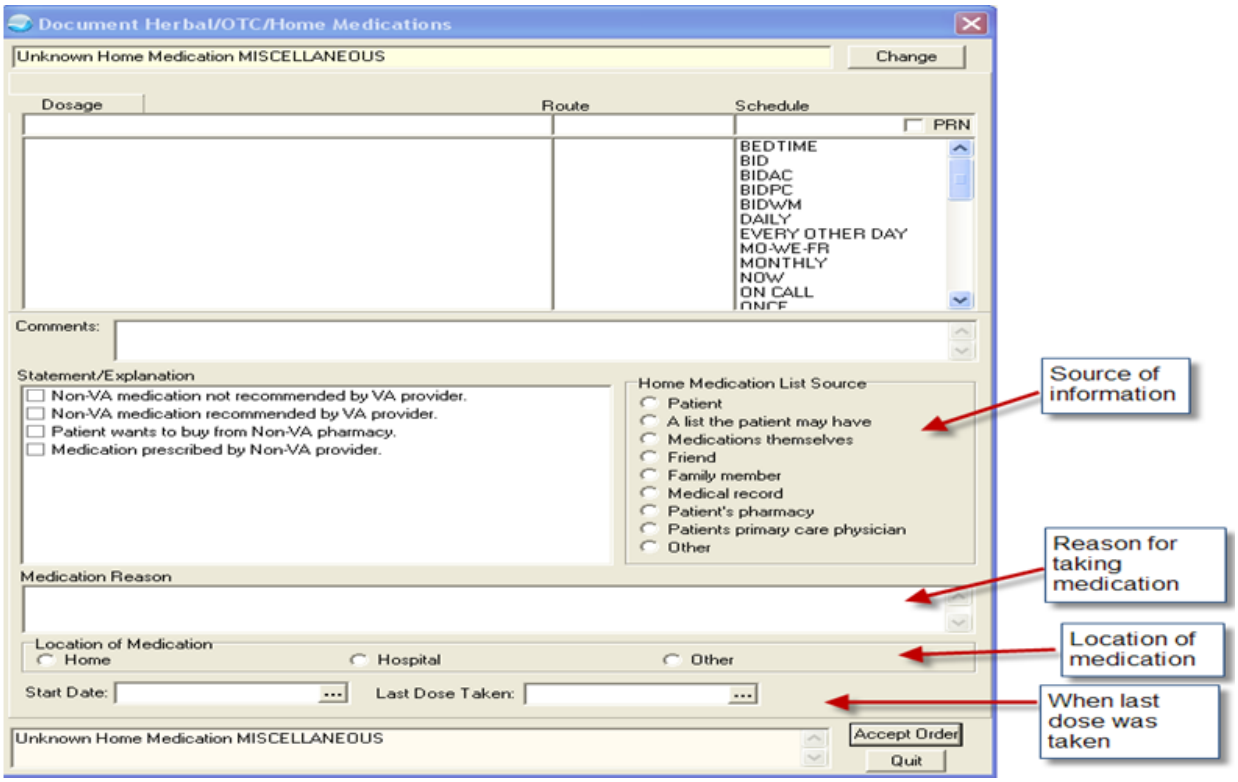

Figure 4-3: Outside medication fields

4.4 New Action for Miscellaneous Medication

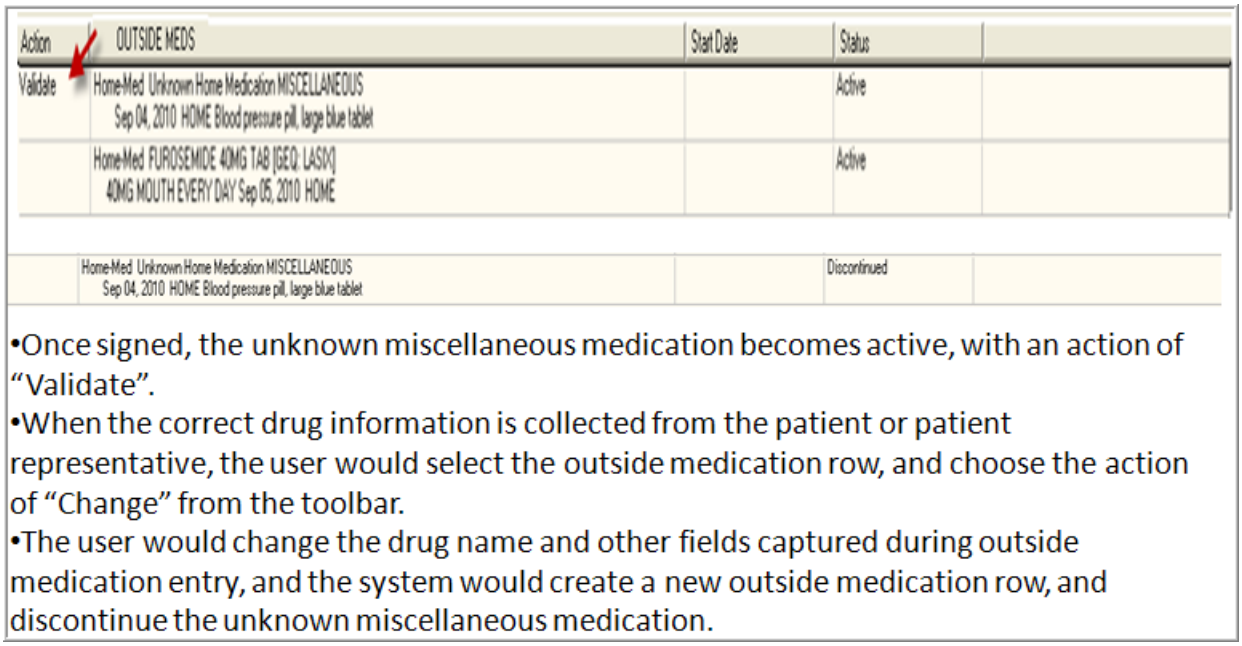

Figure 4-4: Actions for miscellaneous medications

4.5 New Order Statuses

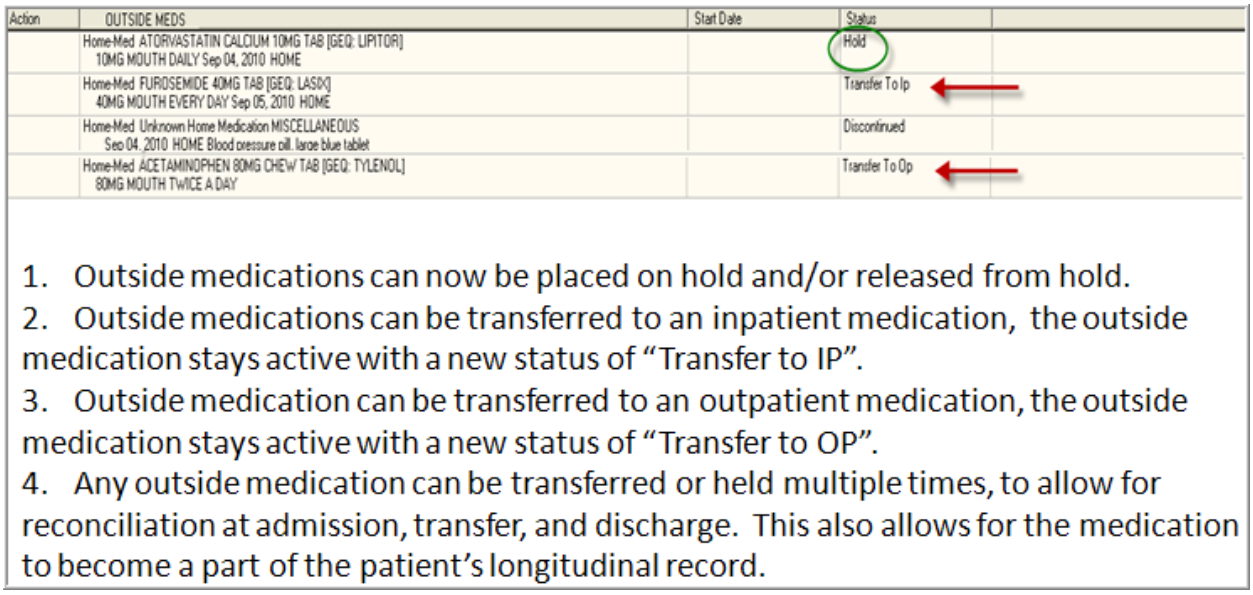

Figure 4-5: Status of new orders

4.6 Unknown Medication Setup

The following is the unknown medication setup information.

```
At ORDERABLE ITEM UNKNOWN HOME MEDICATION navigate to PHARMACY DATA
MANAGEMENT>DRUG ENTER/EDIT.
Select DRUG GENERIC NAME: MISCELLANEOUS DRUG.
At Are you adding MISCELLANEOUS DRUG as a new DRUG (the 5655TH)? No//, type
Y (Yes).
At DRUG NUMBER: 5656//
DRUG VA CLASSIFICATION:
DRUG FSN:
DRUG NATIONAL DRUG CLASS:
DRUG LOCAL NON-FORMULARY:
DRUG INACTIVE DATE:
DRUG MESSAGE:
DRUG RESTRICTION:
GENERIC NAME: MISCELLANEOUS DRUG//
VA CLASSIFICATION:
DEA, SPECIAL HDLG:
DAW CODE:
NATIONAL FORMULARY INDICATOR: Not Matched To NDF
LOCAL NON-FORMULARY:
VISN NON-FORMULARY:
Select DRUG TEXT ENTRY:
Select FORMULARY ALTERNATIVE:
Select SYNONYM:
MESSAGE:
RESTRICTION:
FSN:
NDC:
INACTIVE DATE:
WARNING LABEL SOURCE is not 'NEW'.
WARNING LABEL will be used until the WARNING LABEL SOURCE is set to 'NEW'.
WARNING LABEL:
Current Warning labels for MISCELLANEOUS DRUG
No warnings from the new data source exist for this drug.
Verify that the drug is matched to the National Drug File.
Would you like to edit this list of warnings? N// O
ORDER UNIT:
PRICE PER ORDER UNIT:
DISPENSE UNIT:
DISPENSE UNITS PER ORDER UNIT:
PRICE PER DISPENSE UNIT:
Do you wish to match/rematch to NATIONAL DRUG file? Yes// N (No)
Just a reminder...you are editing MISCELLANEOUS DRUG.
LOCAL POSSIBLE DOSAGES:
Do you want to edit Local Possible Dosages? N// YES
Strength: Unit:
Select LOCAL POSSIBLE DOSAGE:
MARK THIS DRUG AND EDIT IT FOR:
O - Outpatient
U - Unit Dose
I – IV
W - Ward Stock
D - Drug Accountability
C - Controlled Substances
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X - Home Med
A – ALL
Enter your choice(s) separated by commas : O,U,X
```

```
O – Outpatient
U - Unit Dose
X - Home Med
** You are NOW editing OUTPATIENT fields. **
AN Outpatient Pharmacy ITEM? No// Y (Yes)
CORRESPONDING INPATIENT DRUG:
MAXIMUM DOSE PER DAY:
LOCAL NON-FORMULARY:
NORMAL AMOUNT TO ORDER:
SOURCE OF SUPPLY:
CURRENT INVENTORY:
ACTION PROFILE MESSAGE (OP):
MESSAGE:
QUANTITY DISPENSE MESSAGE:
Do you wish to mark to transmit to CMOP?
Enter Yes or No: NO
Do you wish to mark/unmark as a LAB MONITOR or CLOZAPINE DRUG?
Enter Yes or No: NO
** You are NOW editing UNIT DOSE fields. **
AN Unit Dose ITEM? No// Y (Yes)
CORRESPONDING OUTPATIENT DRUG:
ATC MNEMONIC:
Select WARD GROUP FOR ATC CANISTER:
** 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. **
Choose Dosage Form: MISCELLANEOUS
Dose Form -> MISCELLANEOUS
Match to another Orderable Item with same Dosage Form? NO//
Dosage Form -> MISCELLANEOUS
Dispense Drug -> MISCELLANEOUS DRUG
Orderable Item Name: UNKNOWN DRUG
Matching MISCELLANEOUS DRUG to UNKNOWN DRUG MISCELLANEOUS
Is this OK? YES//
Match Complete!
Now editing Orderable Item:
UNKNOWN DRUG MISCELLANEOUS
FORMULARY STATUS:
Select OI-DRUG TEXT ENTRY:
INACTIVE DATE:
DAY (nD) or DOSE (nL) LIMIT:
MED ROUTE:
SCHEDULE TYPE:
SCHEDULE:
PATIENT INSTRUCTIONS:
Select SYNONYM:
Select DRUG GENERIC NAME:
```

Figure 4-6: Unknown Medication Setup instructions

5.0 Vital Measurements Enhancements

The Vital Measurements component has changed with Patch 7. The key features are described below.

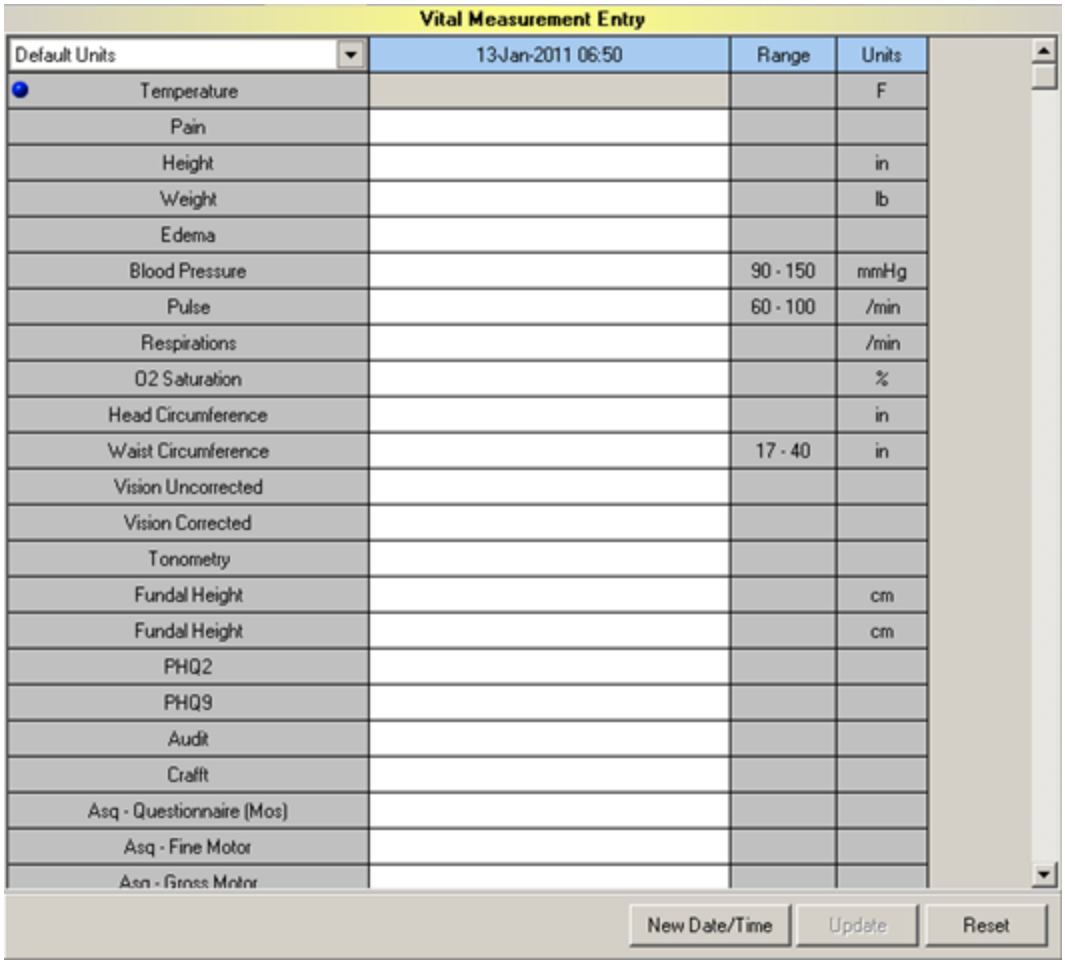

Figure 5-1: Sample **Vital Measurement Entry** component

5.1 New Date/Time Button

Click **New Date/Time** to access the **Select New Date/Time** window.

Figure 5-2: Sample **Select New Date/Time** window

Date/Time Done: The application populates this dialog with the default date and time of Now. You can change the date and time by: (1) clicking the **Current Visit** radio button or (2) clicking the **Ellipsis** button ... to access the calendar, where you can select another date and time.

5.2 Historical Entry

Historical entry is designed to capture measurements transcribed from outside records, such as birth weight or cardiac ejection fraction from Echocardiogram report.

********** This is NOT late entry! **********

This creates a historical event!!

****

When you select the **Historical** radio button, the application displays the **Select Location for Historical Entry** window.

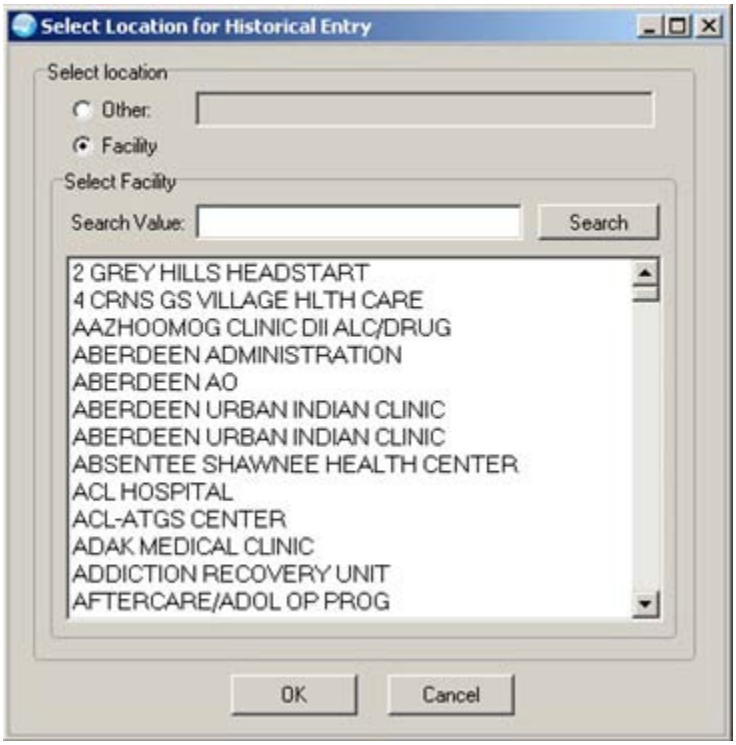

Figure 5-3: **Sample Select Location for Historical Entry** window

After selecting a facility, the **Select New Date/Time** window displays (again) with the date/time empty.

Figure 5-4: **Select New Date/Time** window for Historical

Date Time Done: For the Historical visit, the application leaves this field blank. You can add the date and time by clicking the **Ellipsis** button ... to access the calendar, where you select the date and time of the Historical Visit.

When this window is complete, click **OK** (otherwise, click **Cancel**). After clicking **OK**, you can enter the measurement data on the column created by the historical visit. After completing the data entry, this creates a Historical Event type visit.

6.0 Quick Notes

The primary function of quick notes is for those occasions where the same note and template is used over and over in a particular clinic. For example, a provider who sees both children and adults, sick and well, would probably use several different note titles and templates and therefore would not be a good candidate for a Quick Note. By contrast, a provider who only does telephone triage could create the visit, and start up the note and template all with one click.

6.1 System Setup

1. In RPMS, use the XX General Parameters menu to set the following parameters.
2. At the "PARAMETER" prompt, enter the following one at a time and complete the needed configuration for each parameter.

   a. CIAOQN QNOTES MODIFY–used to assign access to the modify function.

   Keep in mind that this allows the user to modify both personal and public quick notes. Consider restricting modify access to the Clinical Application Coordinator (CAC) and/or Information Technology (IT). You will need to provide temporary modify access for users to set up their personal Quick Notes. It is recommended that the CAC provide assistance to general user in setting up any personal Quick Notes. After the users have created their Quick Notes, the CAC can remove access and the users can still use the Quick Notes.

   b. CIAOQN PROMPT COSIGNER–used to prompt user for cosigner.

   This parameter controls whether or not a user will see the cosigner dialog when TIU reports that a cosigner is required. If set to Yes and the user requires a cosigner, then the user will see the dialog to prompt for a cosigner. If set to No and the user has a default cosigner, the user will not see the dialog.

   c. CIAOQN FORCE VISIT–allows sites to force visit created for a given Service Category.

   d. CIAOQN QNOTES–this parameter holds the information related to a particular Quick Note created by the Quick Note component.

Note: The CIAOQN QNOTES parameter should *not* be edited using the XPAR menu structure.

6.1.1 Adding Quick Note to EHR

The Quick Note component can be added to an EHR template in the tool bar for access at any time. The component is called TIU Quick Note.

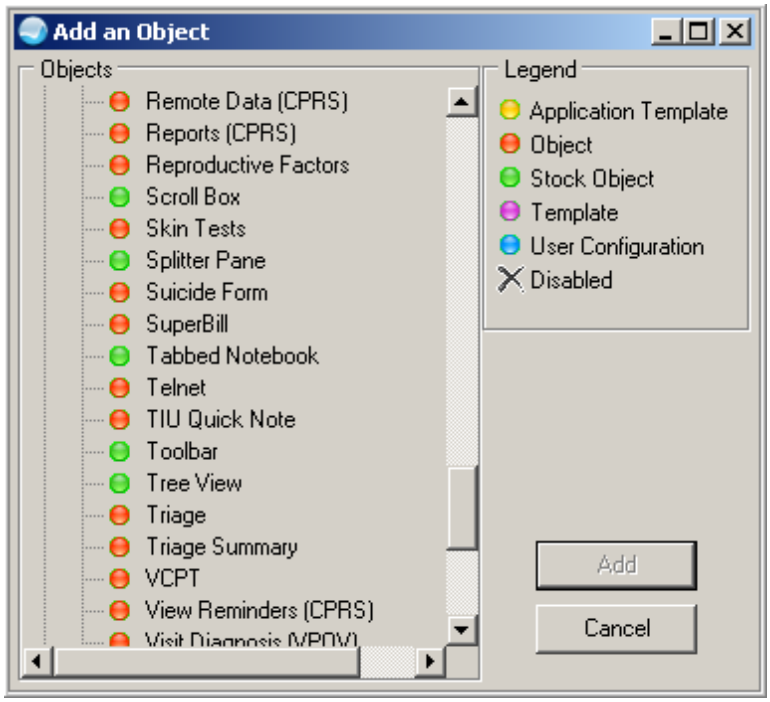

Figure 6-1: **Add an Object** window–TIU Quick Note

6.1.2 Adding the TIU Quick Note Object on the EHR Template

1. In **Design Mode**, go to the **Layout Manager**.

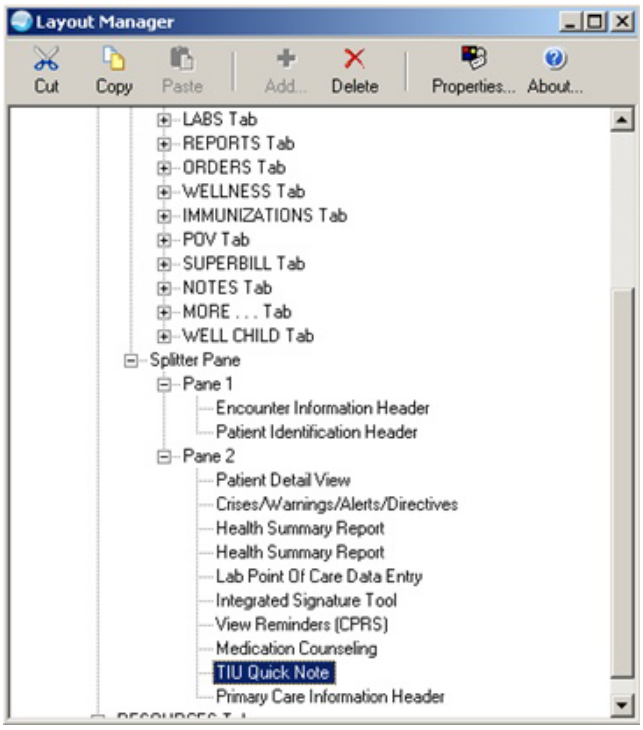

Figure 6-2: **Layout Manager** when in **Design Mode**

2. Adjust the **Quick Notes** properties if needed on the **Properties** dialog.

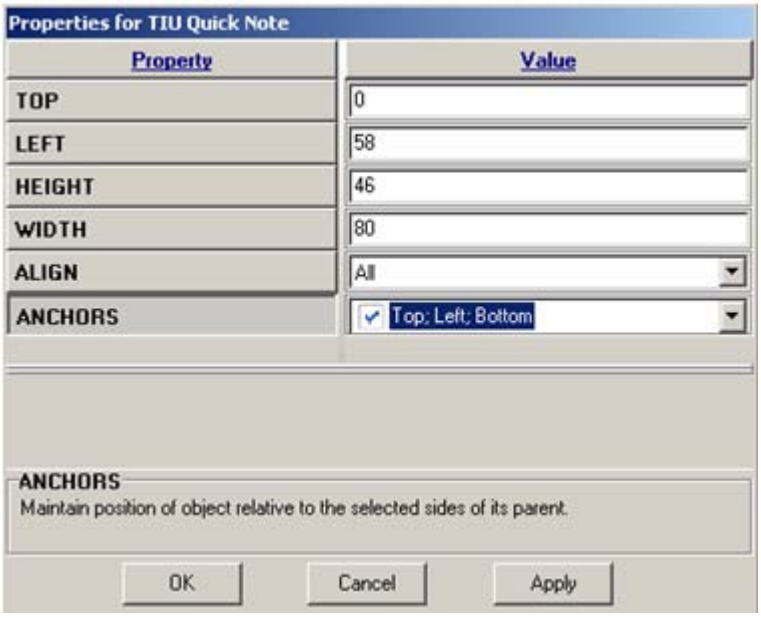

Figure 6-3: **Properties for TIU Quick Note** component

After exiting **Design Mode**, you will see the **Quick Note** button on your desktop. See Figure 6-4.

6.2 Creating a Quick Note Title

The CIAOQN QNOTES MODIFY parameter controls who can create or modify Quick Notes.

1. In the EHR, select a patient and visit.
2. Click **Quick Note**.

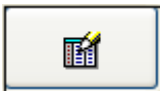

Figure 6-4: **Quick Note** button

3. The application displays the **Quick Note Selector** dialog box.

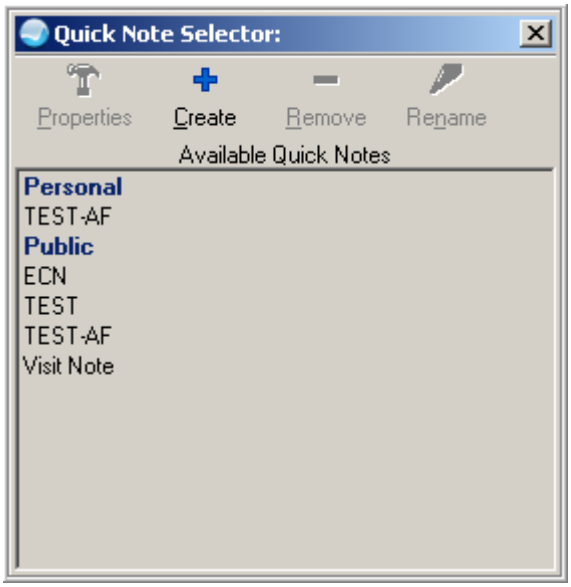

Figure 6-5: Sample **Quick Note Selector** dialog box

4. Click **Create** to access the **Create a New Quick Note** dialog box.

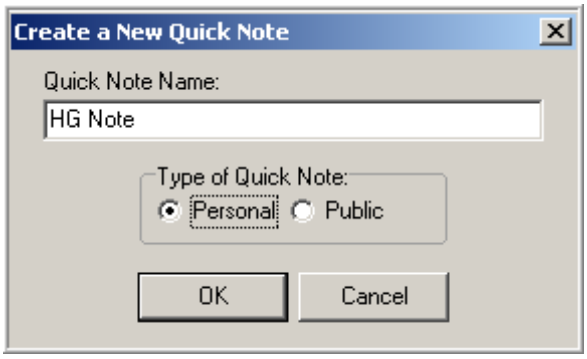

Figure 6-6: **Create a New Quick Note** dialog box

5. Type a name for the note in the **Quick Note Name** text box.
6. Determine the type of Quick Note by selecting one of the radio buttons in the **Type of Quick Note** group box.
   - **Personal**–can only be viewed by the person creating the note.
   - **Public**–open to everyone having access to the Quick Note component.
7. Click **OK** (otherwise, click **Cancel**).
8. After clicking **OK**, the application displays the **Quick Note Properties** dialog box.

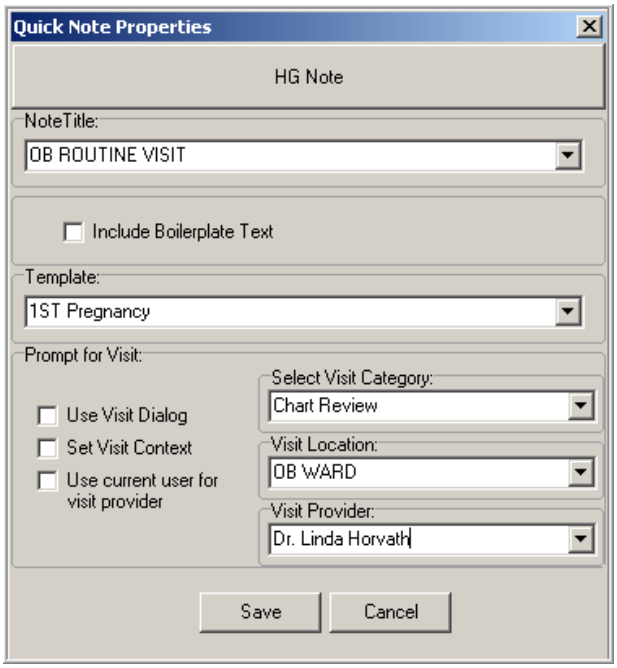

Figure 6-7: Sample **Quick Note Properties** dialog box

9. Do the following on the **Quick Note Properties** dialog box:
   a. In the **Note Title** group box, select the applicable title from the drop-down list. For example, OB Routine Visit.
   b. Select the **Include Boilerplate Text** check box, if applicable. This applies to the applicable fields to the template.
   c. In the **Template** group box, select the applicable template from the drop-down list (for example, 1st Pregnancy). Be aware that all templates appear in this search, so have ready a list of templates you plan to use and type in (case sensitive) the name to reduce the search list.
   d. In the **Prompt for Visit** group box, select the **Application** check box:

- **Use Visit Dialog**: If selected, the **Select Visit Category**, **Visit Location**, and **Visit Provider** drop-down fields become disabled and the **Visit** dialog box is used.
- Select the checkbox to force the Visit Context dialog to be used. Otherwise, a visit is created for Now using the specified criteria. The **Use Current User for Visit Provider** check box remains active.

Note:	The **Use Visit Dialog** check box is best suited to Quick Notes used after visits are created such as ambulatory encounters in a scheduled clinic after check in. The Predefined Visit Category and Visit Locations are best suited for "on the fly" documentation and eliminates several keystrokes for the user. Examples would include Telephone Triage, which would save the user several keystrokes creating a visit in EHR through the **Visit Context** dialog.

- **Set Visit Context**: When selected, the content in this dialog box will automatically make a visit of this type, this location, and this provider every time you start a Quick Note of this type.

  If it is not selected, the visit is created in the background and does not change the visit context; so if the user will also be documenting any visit-related data or entering orders based on the visit created through the Quick Notes, select this check box.

- **Use Current User for Visit Provider**: When selected, the visit is created with the current user as the provider.

e. In **Select Visit Category**, select the visit category from the drop-down list. Chart Review, for example.

f. In **Visit Location**, select the visit location from the drop-down list. OB Ward, for example.

g. In **Visit Provider**, type a name or select it from the drop-down list (Dr. Linda Horvath, for example), or select the **Use Current User for Visit Provider** check box.

10. When the dialog box is complete, click **Save** (otherwise, click **Cancel**).

11. After clicking **OK**, the note appears in the **Quick Note Selector** window.

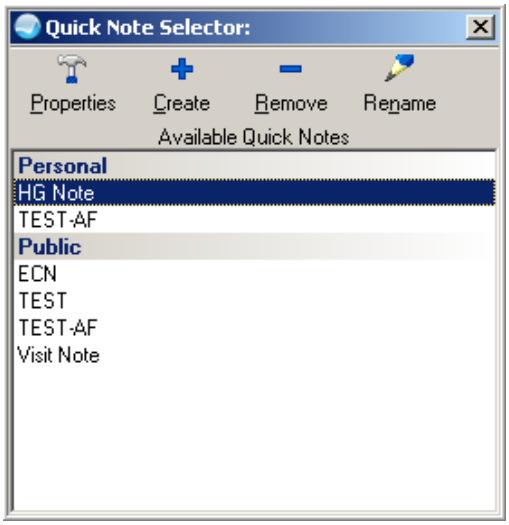

Figure 6-8: **Quick Note Selector** dialog box with new quick note

> **Note**: The **Error** dialog box displays if one or more fields are not defined.

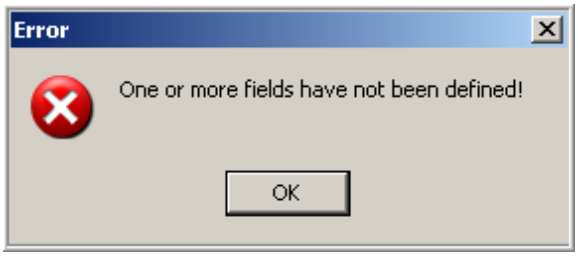

Figure 6-9: Error message indicating that one or more were not defined

6.3 Using a Quick Note

1. After selecting a patient, click **Quick Note**.
2. Double-click the note title you want to use.
   - If the Visit context was set in the Quick Note, the Visit is created, the note is opened, and the template is ready to be used.

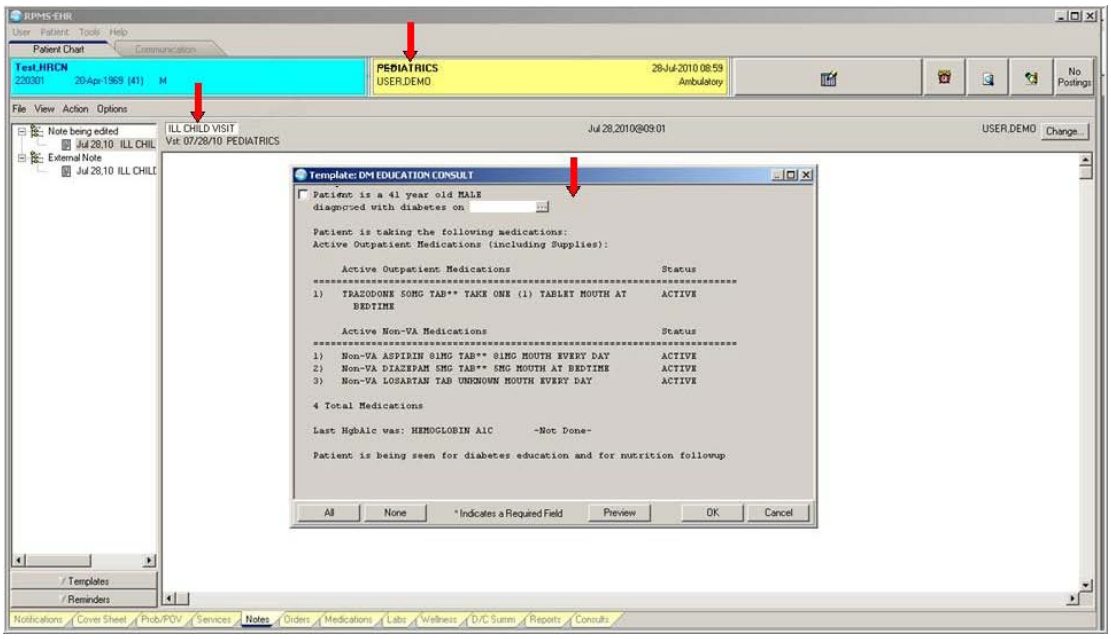

Figure 6-10: Sample **Note** template

- If the Visit context was not set, the application prompts you to select the Visit at this time, if it has not yet been created.

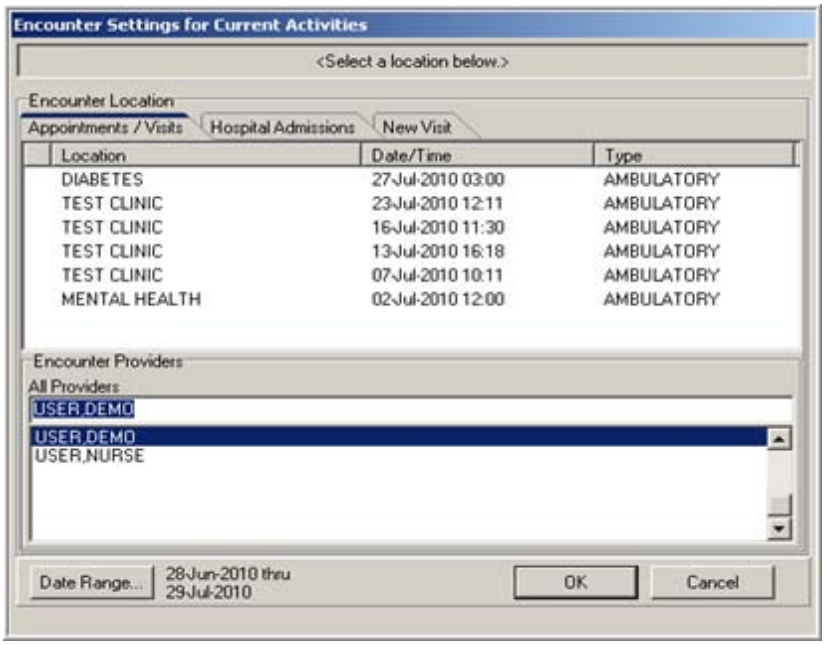

Figure 6-11: Sample **Encounter Settings for Current Activities** dialog box

After completing this dialog box and clicking **OK**, the user is returned to the **Note** component. The note is started, and the template is opened.

3. Process the template as any TIU template.
4. The **Notes** component opens with the **Template** window for the visit. Select the check box.

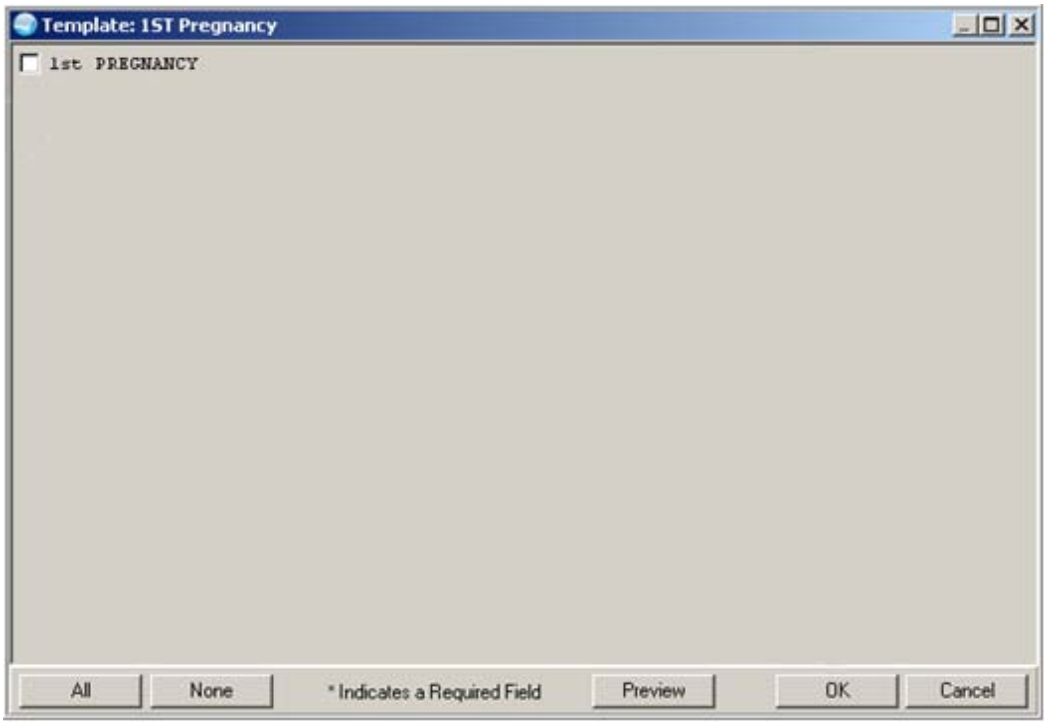

Figure 6-12: Sample **Template** window

The **All**, **None**, and **Preview** buttons are optional:

- Use **All** to expand all of the fields.
- Use **None** to suppress all of the fields.
- Use **Preview** to preview the dialog text. The font size of the text can be changed using this window.

The **Template** window refreshes with the applicable open fields for data entry.

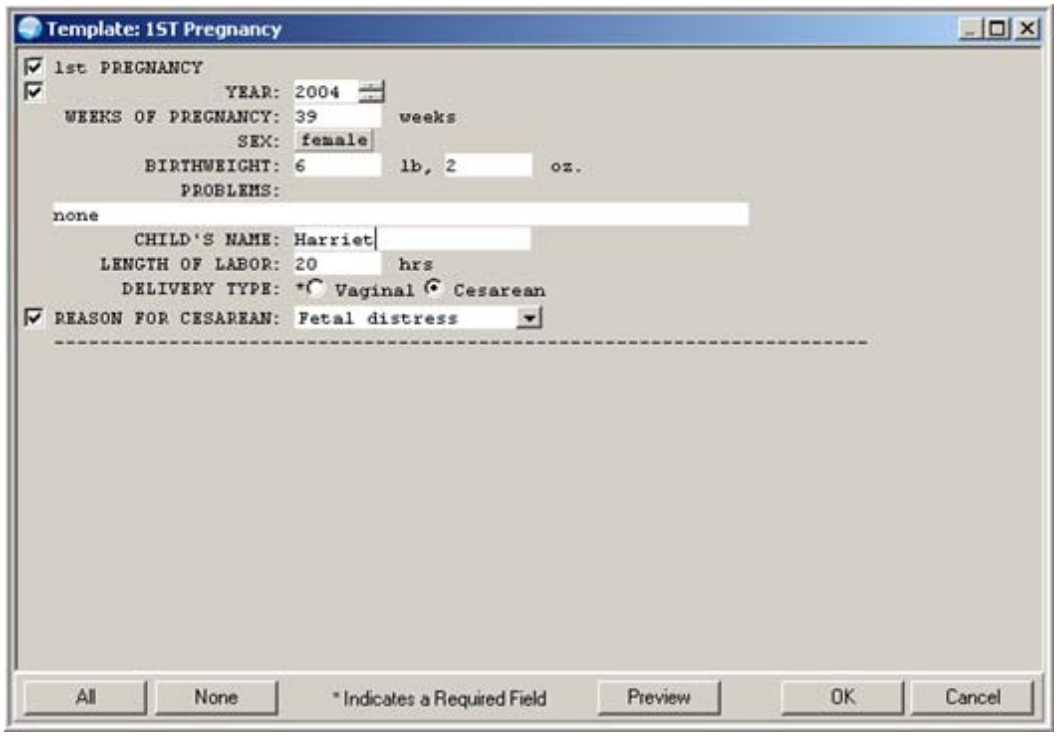

Figure 6-13: Sample fields on the template

5. Complete the text boxes in the **Template** dialog box. For example, in the 1st Pregnancy template, complete the following fields:

   - **Year and Weeks of Pregnancy**
   - **Sex**
   - **Birth Weight**
   - **Problems**
   - **Child's Name**
   - **Length of Labor**
   - **Delivery Type**: Select **Vaginal** or **Cesarean**

   If you used Cesarean, select the **Reason for Cesarean** check box, and select the applicable reason from the drop-down list.

6. When the dialog box is complete, click **OK** (otherwise, click **Cancel**).

7. After clicking **OK**, the note appears on the **Notes** component.

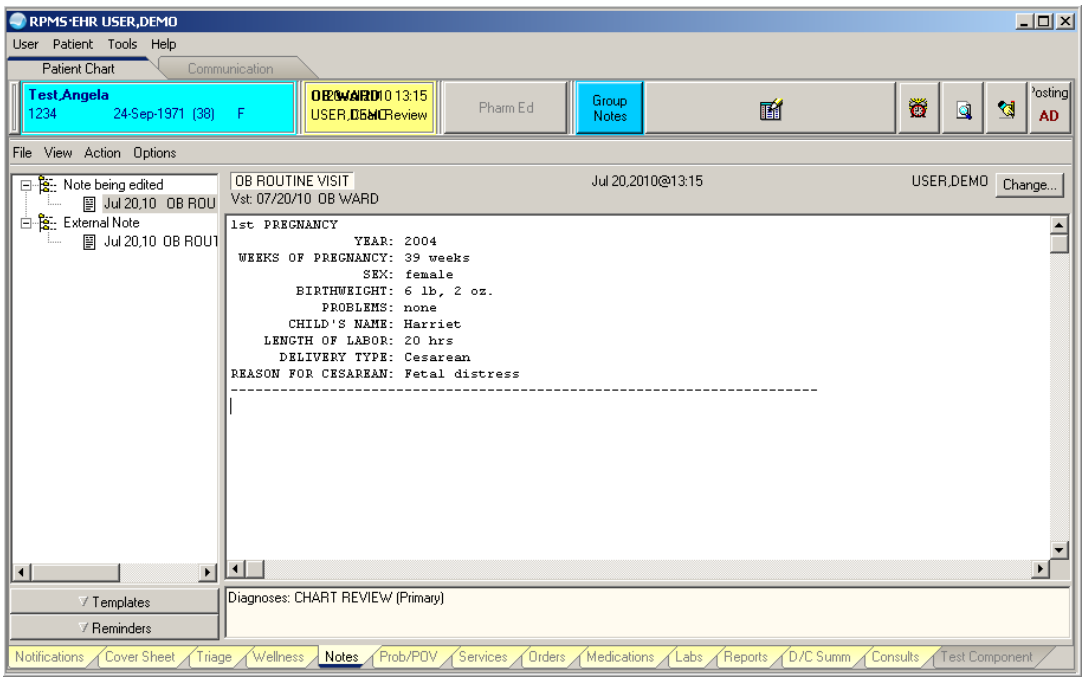

Figure 6-14: Quick Note appearing on **Notes** component

6.3.1 Status Change

When starting a TIU note using the normal functions, the status of a note in progress is New Note in Progress.

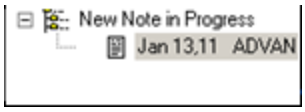

Figure 6-15: New TIU note on **Notes** component

With Quick Notes, you will notice a TUI note is called an External Note and it creates two entries in the status until it is saved. It then appears in **Progress Notes** as any normally entered Note.

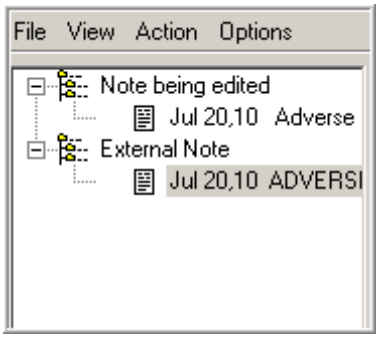

Figure 6-16: External Note on **Notes** tree structure

6.3.2 Editing a Quick Note

1. Click **Quick Note**.

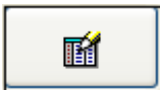

Figure 6-17: **Quick Note** button

2. The application displays the **Quick Note Selector** dialog box. If your CIAOQN MODIFY QUICK NOTES parameter is set to Yes, the **Create** and **Properties** buttons will be active when you select a Quick Note.

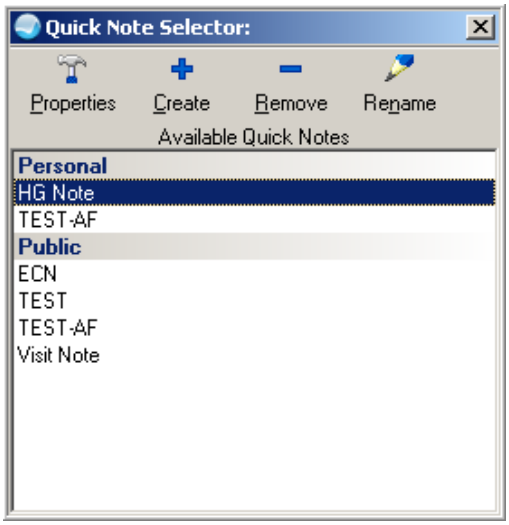

Figure 6-18: Sample **Quick Note Selector** dialog box

3. Click the Quick Note title and then **Properties**. The **Quick Note Properties** dialog box opens.
4. Make your changes to the Quick Note. Save your changes before exiting the note.
5. Click **Remove** to remove an existing Quick Note.
6. Click **Rename** to rename an existing Quick Note.

7.0 New Parameters

Below are the new parameters:

- BEHOLR SET DEFAULT PROVIDER–used to set whether ordering provider defaults as visit context provider or is left blank for user selection.
- CIAOQN QNOTES MODIFY–used to assign access to modify function.

  Keep in mind that this allows the user to modify both personal and public Quick Notes. Consider restricting modify access to the CAC and/or IT. You will need to provide temporary modify access if users want to set up their personal Quick Notes. We recommend that the CAC provide assistance to general users in setting up any personal Quick Notes. After the users have created their personal Quick Notes, the CAC can remove access and the users can still use the Quick Notes.

- CIAOQN PROMPT COSIGNER–used to prompt user for cosigner.

  This parameter controls whether or not a user will see the cosigner dialog when TIU reports that a cosigner is required. If set to No and the user has a default cosigner, the user will not see the dialog.

- CIAOQN FORCE VISIT–allows the site to force visit created for a given Service Category.
- CIAOQN QNOTES–this parameter holds the information related to a particular Quick Note created by the **Quick Note** component. This parameter should *not* be edited using the XPAR menu structure.

Appendix A: Fix/Enhancement Detail with Validation Test from Developer

This is Medsphere Internal Testing.

The following provide information as additional information only about the fixes and enhancements made to the Resource and Patient Management System (RPMS) as part of this TeamTrack Patch release.

A.1 TT/625

This concerns error bug on displaying Orders Auto-DC'd.

Description

When client selects the auto-DC action, and then attempts to view the orders that were auto-DC'd, the grid displays an error on each line.

Data does come back from the RPC call, but none of it is being displayed.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

Electronic Health Record (EHR)

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient.
3. Go to the Progress Note Management component.
4. Select Delayed Orders.
5. Select an Open Visit.
6. Select Admit to Ward.
7. Fill in the fields as appropriate.

8. Accept the Order.
9. Sign the Order.
10. Admit the patient in Terminal Service.
11. Log back on to RPMS-EHR.
12. Place a few Inpatient Medications orders.
13. Sign the orders.
14. Finish and verify in Terminal Service so that the status is Active.
15. Discharge the patient in Terminal Service.
16. Log back on to RPMS-EHR.
17. Select the patient.
18. Go to the **Orders** component.
19. Select the **View** Menu.
20. Select **Auto DC/Release Event Orders**.
21. Select Discharge from the list, and click **OK**.

Expected Results

DC patient and verify orders were discontinued without errors.

A.2 TT/422

This concerns Suicide Form Revisions–Update Fields.

Description

Client owners of the RPMS Suicide Reporting Form (SRF) are requesting two changes to the following fields:

- **Lethality** (inactivate)
- **Behavioral Act** (inactivate two values and add four others)

They are also requesting that all fields on the SRF be mandatory, but not forced.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the **Suicide Form** (HIS BEH SUICIDE FORM EHR).
4. Enter a new suicide entry and validate the fields.

Expected Results

Lethality field is removed from the form, and Behavioral Health entries were added and removed as requested. All fields are mandatory, but not forced so it can be saved and then edited.

A.3 TT/386

This concerns "Measurement" prompts not working in **Reminder** dialogs.

Description

The following measurement prompts are not working in reminders for Patch 6:

Name	Description
AG	Abdominal Girth
ADM	Asthma Work/School Days Missed
AKBP	Ankle Blood Pressure
ASFD	Asthma Symptom Free Days
AUDC	Audit-C
AUDT	Audit
BPF	Best Peak Flow
CEF	Cardiac Ejection Fraction
CRFT	CRAFFT
ED	Edema

Name	Description
FEF	FEF 25-75
FVFC	FEV1/FVC Ratio
PF	Peak Flow
PHQ2	Patient Health Questionnaire2
PHQ9	Patient Health Questionnaire9
TON	Tonometry
WC	Waist Circumference

Problem 1: No data entry field opens for user.

Problem 2: If prompt is selected in a dialog, whole dialog errors.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

Important: The measurements listed above have to be set up as appropriate either through reminders or Text Integration Utility (TIU) if they have not been already set up.

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Click the **Progress Note Management** component.
4. Select **New Note**.
5. Select a title for the note.
6. Click **Reminders**
7. Select **All Evaluated**.
8. Select the appropriate reminder (the reminder that was set up with a corrected measurement above).

9. Select the appropriate measurement (for example, AG, ADM, AKBP, and so on) to document.

10. Click **Finish**.

Expected Results

Each Measurement has the associated text box and entered value is filled with no errors.

A.4 TT/346

Message field does not pop-up on Medication Quick Order.

Description

For medication quick orders, if the pharmacy enters information in the **MESSAGE** field (drug enter/edit in the Pharmacy Application), it is supposed to pop up when the provider selects the quick order. However, the message only appears if the provider EDITS the quick order.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Click the **Orders** tab.

4. Click the **Outpatient Med Quick Orders** on the left.

5. Click **Respiratory Meds**.

6. Select **Triamcinolone MDI 2 Puffs BID**.

Expected Results

The message box should display the message from the DRUG ENTER/EDIT file.

A.5 TT/438

This concerns the removal of the Administration Code for Skin Tests.

Description

Client wants administration code for skin tests removed.

Impact

High – Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Go to the **Skin Test History** component.
4. Add a PPD Skin Test.
5. Select a Skin Test, and click **OK**.
6. Document the fields and click **Save**.
7. Go to the **Visit Services** component.
8. View the code generated under **Visit Services**.

Expected Results

Administrative Code 90772 should not be posted when a skin test is added.

A.6 TT/446

This concerns historical purified protein derivative (PPD) entered in RPMS IMMS. Reading of 0 does not display in EHR.

Description

A Historical Skin Test (for example, PPD) entered in IMMS with a reading of zero (0) does not display in the EHR Skin Test History Component.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to Terminal Service.
2. Access **IMM** > **PAT** > **SGL**.
3. Identify the patient.
4. Accept the default forecast date.
5. Select **S** (Skin Test Add).
6. Enter the following:
   - **Date**–Date in the past
   - **Category**–Historical Event
   - **Skin Test**–PPD or any of the other option
   - **Result**–Negative
   - **Reading**–0 mm
   - **Reading Date**–**Date** field + two days
7. Click **Save** and **Exit**.

8. Log on to the RPMS-EHR.
9. Go to the **Skin Test History** component.
10. Under **Skin Test History**, note the Reading column.

Expected Results

Zero should be displayed in the Reading column.

A.7 TT/455

This concerns that entering Diabetes as a Purpose of Visit (POV) though EHR does not trigger the Bulletin for New DM.

Description

Entering Diabetes as a POV through the EHR does not trigger the bulletin for a New DM Case in the Diabetes Management System (BDM) package.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient who has had no prior diabetes diagnosis.
3. Go to **Visit Diagnosis** and enter the new diagnosis.
4. Enter **(250:00)** and save it
5. Log on to Terminal Service.
6. Go to Mailman and check for the NML.
7. Verify there is a Mailman message for the new diabetes diagnosis on the patient.

Expected Results

Entering Diabetes as a POV through EHR should trigger the bulletin for New DM Case in BDM.

A.8 TT/463

This concerns the parameter for Default Provider in Laboratory POC.

Description

Currently the provider for the Point of Care (POC) laboratory defaults to the Visit Context provider (this is correct behavior). Client would like a parameter so a site can choose to set No Default Provider for the **POC Laboratory** dialog box.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. In RPMS, set the new parameter BEHOLR SET DEFAULT PROVIDER value to No by User, Division, or System.
2. Log on to RPMS-EHR.
3. Selected a patient and a visit.
4. Click on **Lab POC**. The **Ordering Provider** drop-down list will be blank if set to **No** or left blank. It will default to **Visit Provider** if set to **Yes**.

Expected Results

The default provider drop-down list will be set to blank, and the user must select a provider for the Laboratory Point of Care.

A.9 TT/521

You cannot enter Historical Service for Same Day.

Description

The entry function for Historical Services does not allow client to make an entry to the surgical history on the same day the surgery occurred. For sites that do not have an IHS hospital, this forces the client to put off the entry to the next day.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient and visit.
3. Go to the **Historical Services** component.
4. Click **Add**.
5. Select one of the options from the Pick List, or perform a search from the **Procedure** tab.
6. In the **Date** field, enter current date.
7. Enter the appropriate location.
8. Click **Save**.

Expected Results

User should still be allowed to enter historical services for the current date.

A.10 TT/638

This concerns **Skin Test** new fields.

Description

Skin Test must include:

- Site field (the injection site)
- Volume field (the dosage)

This is already available in RPMS and must be included in the EHR if the intent is for providers to use EHR instead of RPMS.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Go to the **Skin Test History** component.
4. Click **Add**.
5. Select a Skin Test, and click **OK**.
6. Enter the Site (right forearm or left forearm).
7. Enter the Volume or take the defaulted Value.
8. Enter any other information needed.
9. Click **Save**.

Expected Results

Site and Volume entered are displayed properly in the appropriate column.

A.11 TT/543

This concerns entering Historical Measurements through the graphical user interface (GUI).

Description

Client wants to add the ability to enter historical measurements through the EHR.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Go to the **Vitals Measurements** component and click **Enter Vitals**.
4. Click **New Date/Time**.
5. It opens the **Select New Date/Time** dialog box containing three buttons.
6. Select **Historical**. This opens the **Select Location for Historical Entry** dialog box and defaults to Other.
7. Type the location in the field above if **Other** is selected, or pick from the drop-down list if the location is an IHS site.
8. Click **OK**.
9. On the **Select New Date/Time** dialog box, pick the historical date from the **Calendar** and click **OK**. This adds another column with the new historical date/time, and the user can enter the historical vitals there.

Expected Results

New Date/Time dialog box appears when clicking **New Date/Time** on **Vitals** and user can enter the historical vitals from EHR.

A.12 TT/546

This concerns incorporating vQuickNotes Component into Patch 7 release.

Description

The Quick Note application provides clinical personnel with an easy way to create a note and attach it to an EHR. The RPMS Quick Note User Guide provides the information necessary to use the application.

Impact

Medium–Affects a key clinical feature, but does not impede its safe use.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

Refer to the RPMS Quick Note User Guide, distributed with the EHR 1.1 Patch 7 release for detailed information.

Expected Results

N/A

A.13 TT/523

This concerns Medication reconciliation changes for EHR.

Description

Changes that were made to OpenVista, new status, etc., are to be added to RPMS and EHR.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

Transfer to IP, Transfer to OP, and Hold instructions for Home Medication:

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Order an outside medication.
4. Sign the order.
5. Highlight the order and select **Transfer to Inpatient**.
6. Sign the order.
7. Highlight the order and select **Hold**.
8. Sign the Hold order.
9. Highlight the order and select **Release Hold**.
10. Refresh the patient.

Validation of an Unknown Miscellaneous Drug:

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Click **Orders** tab.
4. Click **Home Medications**.
5. Choose **Unknown Home Medication Miscellaneous**.
6. Assign a dose, route, and schedule.
7. Attempt to sign the order. A warning message should display saying it cannot be signed because it must be validated first.

8. Click **OK**. The medication displays on the **Meds** tab with an active status, but no validation.

9. Right-click the order and select **Change**. The **Change** button is enabled.

10. Select the medication that the patient is actually taking (for example, Coreg).

11. Accept and sign the order.

Refer to Section 4.1 for more information.

Expected Results

The **Inpatient** dialog box should display when choosing **Transfer to Inpatient**. The **Outpatient** dialog box should display when choosing **Transfer to Outpatient**. The outside medication can be put on Hold and Released Hold.

A.14 TT/552

The full Social Security Number (SSN) exposed in patient context if there is no Health Record Number (HRN).

Description

If no HRN exists, application should be changed to display the full SSN as follows: xxx-xx-1234.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.

2. Select any patient without an HRN number.

3. Verify the SSN on the patient header in xxx-xx-1234 format, only the last 4 digits exposed.

4. Verify that the SSN for a patient is not being completely exposed.

Expected Results

All patients without an HRN should have the SSN displayed in xxx-xx-1234 format on the patient header.

A.15 TT/582

This concerns infant feeding data not clearing when using the **Clear** button.

Description

When Infant Feeding data is set and the **Clear** button is clicked (and all patient data is cleared), the infant feeding data does not clear.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Verify on the top that **Clear** is a menu item on that temple.
3. Select a patient with Infant Feeding data.
4. Click **Clear Menu Time**.
5. Verify that the Infant Feeding data is cleared along with the other patient data.

Expected Results

Infant Feeding data clears when **Clear** is clicked.

A.16 TT/582

Reproductive Factors do not clear using the **Clear** button.

Description

When Reproductive Factors data is set and **Clear** is clicked (and all patient data is cleared), the Reproductive Factors data does not clear.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Verify on the top that **Clear** is a menu item on that temple.
3. Select a female patient with Reproductive Factors data.
4. Click **Clear** menu time.
5. Verify reproductive data is cleared along with the other patient data.

Expected Results

Reproductive Factors data clears when **Clear** is clicked.

A.17 TT/XXX

This concerns VIM.exe (Version 1.7.5.18) is not handling Resize to the Contained Components correctly.

Description

VIM.exe (Version 1.7.5.18) is not handling resize to the contained components correctly.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Resize the application to be small.
3. Launch the application into normal mode.

Expected Results

The application should resize appropriately.

A.18 TT/596

This concerns the **Electronic** button displaying when suppressed and clicking **Change**.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature

Description

The APSP Auto RX Electronic parameter is set to No. When placing the order for the RX, the **Electronic** button is suppressed as expected. However, upon clicking **Change**, the **Electronic** button displays and should not.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

1. Log on to Terminal Service.
2. Set the APSP Auto RX Electronic parameter to No.
3. Log on to RPMS-EHR.
4. Select the patient and a visit.

5. Click **Outpatient Meds**.
6. Order an outpatient Rx (notice that the **Electronic** button does not display as expected).
7. Sign the order.
8. Right-click and select **Change**.

Expected Results

The **Electronic** button should not display.

A.19 TT/611

This concerts the Post-Init Routine to clean up data transmission errors.

Description

IHS reports that in Patch 6, when filing POV narrative for any ICD-9 Dx in any of the Reminders, it would generate a data transmission error. These must be cleaned up.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

1. Log on to Terminal Service.
2. At the system prompt, type **D ^%G**.
3. At "Device:" prompt, type **0** (zero).
4. At "the right margin: 80 =>" prompt, press Enter.
5. At "screen size for paging (0=nopaging)? 24 =>" prompt, press Enter.
6. Review the data displayed in the fourth node.

```
Global ^AUPNVPOV
```

```
^AUPNVPOV
0
^AUPNVPOV(0)=V POV^9000010.07AP^553^547
^AUPNVPOV(1,0)=90120^2^2^136766^^^^^^^^P
           12)=3041215.15214^^^2
^AUPNVPOV(2,0)=11424^2^2^179091^^^^^^^^S
           12)=3041215.152207^^^2
```

Figure 1: Output in the fourth node

Expected Results

In the AUPNVPOV, the forth node will contain a number and no text.

A.20 TT/621

This concerns Inpatient Medications are disappearing after discharging a patient.

Description

After discharging a patient, all of the inpatient meds disappear from the Cover Sheet and the Meds tab. The problem has been reproduced on EHRD patch 6.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select an inpatient with one of the following:
   a. Several order types, like inpatient meds, outpatient meds, and outside meds.
      or
   b. Create an inpatient with the order types above.
3. Log on to Terminal Services.
4. Discharge the patient using the BDG Discharge option.

5. View the Medication Management and the Cover Sheet.

Expected Results

Inpatient medications should be available for viewing after discharging a patient. The inpatient pane must be visible.

A.21 TT/522

This concerns the inability to Add Reading for a positive Historical Skin test in EHR.

Description

When a historical skin test is entered via EHR, the **Reading** field does not display; user is unable to enter the reading value. Issue is verified in Patch 6 as well.

Impact

Medium–Affects a key clinical feature, but does not impede its safe use.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Logon to EHR.
2. Select a patient.
3. Access the **Skin Test History** component.
4. Click **Add**.
5. Select any skin test, and click **OK**.
6. Click **Historical.**
7. Enter Results: **Positive**.

Note: Reading field is now accessible.

8. Leave the **Reading** field blank, or enter value greater than 0.
9. Click **Save**.

Expected Results

Allows reading entry for positive results for Historical Skin Test.

A.22 TT/636

This concerns Current Procedural Terminology (CPT) modifiers not appearing in edits post-Code Set Versioning (CSV).

Description

While editing a visit service CPT code entered on a site using CSV, when attempting to select the modifiers, none displayed.

The code for an edit should work the same as the code for a new entry, which does work correctly.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Access the **Visit Services** component.
4. Click **Add**.
5. Select **CPT Code**.
6. Enter a Procedure (for example, Colonoscopy) and select the **Ellipsis** button  next to the **Procedure** dialog box.
7. Select one of the items listed from the **Procedure Look-up** window (for example, Code 45384), and click **OK**.
8. Select a 1st Modifier (for example, Actual Item/Service Ordered)

9. Click **Save**.

10. Select the newly added visit service.

11. Click **Edit**. Make sure the **Narrative** field displays the procedure description.

12. Click the **1st Modifier** field. The **Modifiers** options should display.

Expected Results

Editing a CPT should display the same modifiers as a new entry.

A.23 TT/044

This concerns allowing entry/display of Cardiac Ejection Fraction into **Vitals** component.

Description

Allow entry/display of Cardiac Ejection Fraction into the **Vitals** component. CEF to enter Cardiac Ejection Fraction–add to BEH MEASUREMENT CONTROL FILE.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

> **Important**: Cardiac Ejection Fraction must be added on the BEHOVM TEMPLATE and BEHOVM VITAL LIST prior to testing.

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Go to the **Vitals Measurement** component and select **Enter Vitals**.

4. Verify there is a **Cardiac Ejection Fraction** field on the vitals, and that the user can enter data into it.

Expected Results

Allow entry/display of Cardiac Ejection Fraction into **Vitals** component.

A.24 TT/634

This concerns entering erroneous blood pressure in Vital Measurement Entry.

Description

Allows entry of systolic < dialstolic (for example, 60/80).

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Sign on to RPMS-EHR.
2. Select a patient and a visit.
3. Enter an erroneous Vital Entry (for example, 60/80).

Expected Results

This should validate properly in RPMS-EHR.

A.25 TT/622

This concerns the Med Management tab dropping **Inpatient Med** pane on Discharge.

Description

When an Inpatient visit contains Outpatient medications, Inpatient medications, and Outside medications, at the time the patient is discharged, the **Inpatient** pane drops off and the medications disappear. The user can still see the orders in the custom view.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Place Inpatient, Outpatient, and Outside Medication orders on an Inpatient.
2. Discharge the patient.

Expected Results

The Inpatient medications now display as Discontinued, and the **Inpatient** pane still displays.

A.26 TT/591

This concerns the error when entering zero for Edema.

Description

Occurs in EHR patch 5, patch 6, and the Flowsheets databases.

BEH Measurement control file INPUT TRANSFORM:

K:X'?1N1"+"!(X>4)!(X<0) X S:'$G(X) X="-1^

Enter the degree of edema as one of the following: 0, 1+, 2+, 3+ or 4+."

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Sign on to RPMS-EHR.

2. Select a patient and a visit.
3. Go to **Vitals Measurements**.
4. Right-click and select **Enter Vitals**.
5. On **Vitals**, go to Edema.
6. Enter **0** (zero) or **1**. An **Invalid Entry** message should display showing 0+,1+, 2+, 3+ or 4+ or valid entries.

Expected Results

The **Invalid Entry** dialog box should display 0+ (zero +) instead of 0 (zero).

A.27 TT/632

This concerns Outside Medications entered through EHR showing up twice on Cover Sheet.

Description

EHR-entered outside medications that pass to V Med (ones entered with blank or free-text dose do not) display twice on the cover sheet. They should only display once.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Sign on to RPMS-EHR.
2. Select a patient and a visit.
3. Enter an outside medication.
4. View the Cover Sheet.

Expected Results

The outside medications do not display in duplicate on the coversheet, and the medication autorefreshes when added.

A.28 TT/586

This concerns adding Other Phone on Patient Inquiry.

Description

Add *Other Phone* on Patient Inquiry.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

> **Important**: Make sure Other Phone is documented in the patient's registration in Terminal Services.

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select the appropriate patient with Other Phone documented.
3. Click the **Patient Detail** button.
4. Scroll to the bottom of the report. The Other Phone Contact should display the Other Phone documented in the patient's registration.

Expected Results

Other Phone Contact should display the Other Phone documented in the patient's registration.

A.29 TT/620

This concerns Notes no longer displayed in a sortable window.

Description

When all notes or custom sort views are used, the sortable display in the upper-right window no longer displays Notes. If user searches by International Classification of Disease (ICD), title, and so on, then the sortable window does display notes.

Impact

Low–A minor or cosmetic disturbance while using the application.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to EHRD-RPMS.
2. Select a patient with notes.
3. Click the **Notes** tab (Progress Notes Management).
4. Select **View** and **All Signed Notes**.
5. Click **All Signed Notes**. The upper-right should show the list of notes and note detail below.

Expected Results

Notes and details should display on the right side of the **Notes** tab when selecting the **All Signed Notes** view.

A.30 TT/637

This concerns Skin Test Entry–entering Time causes GUI error.

Description

Error occurs when entering time for Date Applied.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Access the **Skin History** component.
4. Click **Add**.
5. Select a skin test and click **OK**.
6. Click the **Ellipsis**  on **Date Applied** field.
7. Click the **Now** option under the **Time** column.
8. Click **OK**.
9. Click **Save**.

Expected Results

Error should not occur when **Now** is selected for **Date Applied**.

A.31 TT/641

This concerns INPT Work/Chart printouts.

Description

An issue was identified on INPT services with their reports when EHR patch 6 was loaded. INPT nursing indicated that their Work/Chart NURSE/DOC ORDERS copies are not automatically printing. Current parameter settings were reviewed and all looks correct. All other INPT reports (MAR, Med Orders, daily order summaries, and chart copy summaries) print on queue just fine with no issues to the INPT device printer.

Impact

Medium–Affects a key clinical feature, but does not impede its safe use.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to Terminal Services.
2. At "Select IHS Kernel Option:" prompt, type **EHR RPMS-EHR Configuration Master Menu**.
3. At "Select RPMS-EHR Configuration Master Menu Option:" prompt, type **ORD Order Entry Configuration**.
4. At "Select Order Entry Configuration Option:" prompt, type **PRN Print/Report Parameters**.
5. At "Select Print/Report Parameters Option:" prompt, type **LOC Print Parameters for Wards/Clinics**.
6. At "Select HOSPITAL LOCATION NAME:" prompt, type the name of the location for print copies.
7. Define fields as the Prompt for Chart copy and Prompt for Work Copy to your printer and don't prompt.
8. At "Select Print/Report Parameters Option:" prompt, type **LOC Print Parameters for Wards/Clinics**.

```
DEMO HOSPITAL RPMS-EHR Management Version 1.1
Print Parameters for Wards/Clinics
Select HOSPITAL LOCATION NAME: TEST CLINIC <--Your location
Print Definition (Loc) for Location: TEST CLINIC
------------------------------------------------------------
Chart Copy Print Device LASER100
Prompt for Chart Copy DON'T PROMPT
Work Copy Print Device LASER100
Prompt for Work Copy DON'T PROMPT
Requisition Print Device
Prompt for Requisitions
Label Print Device
Prompt for Labels
Daily Order Summary Device LASER100
Service Copy Default Device
```

```
Print Chart Copy Summary YES
Print Daily Order Summary YES
```

Figure 2: Output instructions

9. Order a laboratory test in EHRD-RPMS and sign the order.

10. Should automatically print to your printer.

Expected Results

If Prompt for copy is set to "Don't Prompt," a copy will automatically print to your device.

A.32 TT/641

This concerns transaction error Post P6 when using the **Pharm Ed** button.

Description

A coder reported that a large amount of errors started appearing when the EHR 1.1 patch 6 was installed. The errors were noticed when running the transaction error report in PCC data entry.

At this point the coder is deleting the provider narrative entry and reentering it in PCC for the error to go away. Similarly, if someone edits the entry in EHR on the **POV** tab, the error goes away.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to Terminal Services.

2. Go to the **RPMS-EHR Configuration Master Menu**.

3. Select the option **Medication Management Configuration**.

4. At the "Select Medication Management Configuration Option" prompt, select **Medication Counseling Configuration**.

5. At the "Select Medication Counseling Configuration Option" prompt, select **POV Narrative Text**. The POV Narrative Text may be set for the following:

```
      80  Division      DIV    [DEMO HOSPITAL]
      90  System        SYS    [DEMO.MEDSPHERE.COM]

Enter selection: 80  Division   DEMO HOSPITAL

---------- Setting POV Narrative Text  for Division: DEMO HOSPITAL --------
-
Select Sequence: ?


Sequence  Value
--------  -----
1         Medication counseling
2         Medication counseling by proxy


Select Sequence: 1

Sequence: 1//    1
Narrative Text: Medication counseling  Replace *** ??
  Replace ... With *** Medication Counseling ***  Replace
   *** Medication Counseling ***
```

Figure 3: Setting the POV Narrative Text

6. Log on to RPMS-EHR.

7. Select an Outpatient (do not select a visit).

8. Click **Pharm Ed**.

9. Click the ICD that has the *** Medication Counseling *** entry.

10. Click a counseling topic, and click **OK**.

11. Access the programmer prompt in Terminal Service.

12. Access the following global in Programmer Mode: Global ^AUPNVPOV(0.

Expected Results

The global should store an entry in the fourth segment, and not the words *** Medication Counseling ***.

A.33 TT/647

This concerns Copy to New Order (Medications) defaulting to Pick Up Location of Clinic.

Description

When copying a new order and COPY then EDIT are chosen, the pick-up window defaults to Clinic. It should default to the pick-up location in the original order.

Impact

Medium–Affects a key clinical feature, but does not impede its safe use.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.
2. Select a patient.
3. Click the **Orders** tab.
4. Click **Outpatient Medications**.
5. Select a visit.
6. Order a medication.
7. Be sure the pickup method is Window.
8. Sign the order.
9. Highlight the order, and select **Copy to New Order**.
10. Click **Edit**
11. Verify that the pickup method matches what the order started with.

Expected Results

The pickup method should match what was in the original order upon Copy to New Order and Edit.

A.34 TT/648

This concerns duplicate Patient Education topics not allowed in EHR.

Description

Client is unable to enter the same education topic more than once. The Diabetes educator provided education on DM-Exercise (this was entered) and the Wellness provider also educated the patient on the same topic. But when the client tried to enter this, it gave him an error stating that the same topic was already entered for this date.

Impact

Medium–Affects a key clinical feature, but does not impede its safe use.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Sign on to RPMS-EHR.
2. Select a patient and an active visit.
3. Access the Patient Education, and click **Add**.
4. Click + to see the items under a category (for example, Asthma).
5. Select a topic (for example, Exercise under the Asthma category).
6. Click **Select**.
7. Complete the appropriate field.
8. Click **Add**. A new education topic is added for the current visit.
9. Click **Add** (to add a new topic).
10. Select the same topic as selected in Step 5.

11. Click **Select**.

12. Fill in the appropriate field.

13. Click **Add**.

Expected Results

User can add the same education topic for the visit.

A.35 TT/XXX/10699

This concerns some patient-specific data not clearing when selecting **Clear Patient** user menu option.

Description

The following patient-specific data is not clearing when the **Clear Patient** user menu option is selected.

1. Vital Measurement
2. Outside Meds
3. Progress Notes
4. Discharge Summary
5. Consult

Impact

Medium–Affects a key clinical feature, but does not impede its safe use.

Area Affected

EHR

Validation

Follow these steps:

> **Note**: These steps might differ based upon site configuration.
>
> **Important**: The following steps assume that ClearPatient Context has been added to **User Menu** option.

1. Log on to EHR.

2. Select a patient with vitals, outside meds, progress notes, discharge summary, and consult, and a visit.

3. Select the tab where the above patient data is located (for example, Vitals is in **Assessment** tab).

4. Select the **User Menu.**

5. Select **Clear Patient Context**.

Expected Results

Data specific to the patient selected before clicking **Clear Patient Context** should be cleared.

A.36 TT/XXX/10817

This concerns WOCRT–VIM crashes when selecting the DC Summary tab.

Description

After selecting a patient in the WOCRT database, and clicking the **D/C Summ** tab, the VIM shuts down.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Note: These steps might differ based upon site configuration.

Modify the parameter as follows:

1. Log on to Terminal Services.

2. Select **Systems Manager Menu** option, and test an option not in your menu.

3. At "Option entry to test:" prompt, select **XPAR EDIT PARAMETER**.

4. At "Select PARAMETER DEFINITION NAME:" prompt, select **ORCH CONTEXT SUMMRIES**.

5. At "Enter selection:" prompt, type **9** for Package (ORDER ENTRY/RESULTS REPORTING).

6. At "Setting ORCH CONTEXT SUMMRIES for Package:" prompt, select **ORDER ENTRY/RESULTS REPORTING -- Value: ;;1;// Type ;;1;,** and press Enter.

To Test:

1. Open the EHR.

2. Select a patient. Do not create a visit.

3. Click the tab **D/C Summ**.

Expected Results

When selecting the **D/C summary** tab, the application should not close.

A.37 TT/XXX/10910

This concerns not being able to select a row in the **Laboratory** tab grid.

Description

Unable to select a result row in the **Laboratory** tab grid.

Impact

High–Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.

Area Affected

EHR

Validation

Follow these steps:

Note: These steps might differ based upon site configuration.

1. Log on to RPMS-EHR.

2. Select a patient with laboratory results.

3. Click the **Laboratory** tab.

4. Click a laboratory results to highlight.

Expected Results

When clicking a laboratory result, the laboratory results should be highlighted.

Appendix B: EHR Component Versions

Filename	Current Version	New Version
CMS.dll	1.3.4.5	
CSS.dll	1.7.5.4	
CSSUser.dll	4.3.1.2	
RaizeComponentsVcl70.bpl	4.3.2	
RaizeComponentsVclDb70.bpl	4.3.2	
vcActiveForms.bpl	2.1.4.2	
vcCommon20.bpl	2.0.5.17	
vcControls.bpl	2.1.4.2	
vcFMDC.bpl	1.4.3.2	
IHS_BEH_MDAO_FORMS.dll	1.1.3565.24256	
vcFMDS.bpl	1.0.2.2	
vcImaging70.bpl	1.0.2.39	
vcImagingSvc.dll	1.0.0.7	
vcRPCB_R70.bpl	1.6.5.26	
VIM.exe		1.7.6.1
VueCentric.exe	3.4.1.2	
BEHCPRS20.bpl		1.0.8.10
BEHAlerts.ocx	4.2.3.1	
BEHAllergies.ocx	4.2.4.2	
BEHARTEntry.dll	2.0.2.45	
BEHCommunityInfo.dll	1.0.0.62	
BEHConsultOrders.ocx	4.2.3.2	
BEHConsults.ocx	20.1.3.3	
BEHContextAdapter.ocx	4.2.3.2	
BEHCrises.ocx	4.2.3.1	
BEHCWAD.ocx	4.2.4.1	
BEHDCSumm.ocx	20.1.3.3	
IhsBgoPovHistory.ocx	1.2.0.8	
IhsBgoIcdPickList.ocx	1.2.0.79	
IhsBgoItems.ocx	1.2.0.50	
IhsBgoProblem.ocx	1.2.0.56	
IhsBgoVPOV.ocx	1.2.0.20	
IhsBgoImmunization.ocx	1.2.0.77	

Filename	Current Version	New Version
IhsBgoPatientED.ocx	1.2.0.32	
IhsBgoVCPT.ocx		1.2.0.44
BEHDictate.ocx	1.2.1.1	
BEHEncounterInfo.ocx	4.2.1.1	
BEHESigReview.ocx	20.1.1.3	
BEHESigService.dll	20.1.3.16	
BEHHSReport.ocx	1.0.1.1	
BEHLab.ocx	20.1.3.2	
BEHLabOrders.ocx	4.2.3.2	
BEHLabPOC.dll		1.0.3897.17493
BEHMedList.ocx	4.2.2.1	
BEHMeds.ocx	20.2.2.2	
BEHNotes.ocx	20.1.3.13	
BEHNotifications.ocx	5.1.6.8	
BEHOptions.dll	1.1.2.3	
BEHOrders.ocx	20.1.2.2	
BEHPatientID.ocx	4.2.1.1	
BEHPharmED.ocx	1.0.2.1	
BEHPrimaryCare.ocx	4.2.1.4	
BEHProblemList.ocx	4.2.3.2	
BEHPtDetail.ocx	4.2.3.1	
BEHQOWizard.ocx	1.1.4.20	
BEHReminders.ocx	4.2.3.1	
BEHRemindersView.ocx	4.2.3.1	
BEHRemoteData.ocx	4.2.2.1	
BEHRemoteViews.dll	4.2.1.2	
BEHReports.ocx	20.1.3.1	
BEHSpellCheck.dll	1.0.2.2	
BEHVisits.ocx	5.0.4.1	
BEHVitalEntry.dll		2.0.4.49
BEHVitals.ocx	5.0.4.1	
bgoFamHx.ocx	1.0.0.540	
CSSEncounter.dll	4.3.5.10	
CSSPatient.dll	4.3.5.2	
ihsBgoE&M.ocx	1.1.0.203	

Filename	Current Version	New Version
IhsbgoInfantFeed.ocx		1.2.0.161
IHSbgoRepFactors.ocx		1.2.0.56
IHSbgoRepHist.ocx	1.1.0.425	
IhsBgoHealthFactors.ocx	1.2.0.1	
IhsBgoProceduresViewer.ocx	1.2.0.58	
IhsBgoSkinTest.ocx		1.2.0.84
Interop.CSS_Encounter.dll	4.3.0.0	
Interop.CSS_Patient.dll	4.2.0.0	
vcBroadcast.dll	4.2.1.1	
vcChatService.dll	1.0.2.1	
vcDate.dll	1.0.3.1	
vcIExplorer.ocx	4.3.3.1	
vcImage.ocx	4.1.1.1	
SuicideForm.dll		1.1.3908.22749
vcLauncher.ocx	4.1.4.1	
vcPatPhoto.ocx		4.1.3.2
vcPrint.dll	1.1.4.4	
vcTelnet.ocx	1.1.2.1	
EHR_Shortcut_Interactive_3.4.msi	Dated 11/23/2009	
EHR_Shortcut_Silent_3.4.msi	Dated 11/23/2009	
Readme.txt	Dated 2/6/2008	
vcUpdaterService_Interactive_1.2.msi	Dated 2/7/2008	
vcUpdateService_Silent_1.2.msi	Dated 2/7/2008	
BEHSurgery.ocx	20.1.3.1	
vcChronicPainMU.ocx	1.1.2.1	
vcChronicPainPM.ocx	2.1.2.3	
vcChronicPainRP.ocx	1.1.2.2	
vcIniConfig.exe	1.1.1.38	
vcQuickNote.ocx		1.1.2.5
vcQuickNote.lic		
vcSafeMed.dll	1.0.2804.16720	
vcWHealthMF.ocx	1.1.3.1	
vcWHealthMR.ocx	1.1.3.1	
vcWHealthPM.ocx	1.1.3.1	
vcManager.exe	1.5.8.24	

Filename	Current Version	New Version
vcManagerApplet.cpl	1.5.8.22	
vcUpdaterService.exe	1.2.1.1	
BEHDosingCalc.dll	1.2.0.0	
IhsBgoVCPT.ocx	1.2.0.38	

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

E-mail: support@ihs.gov