



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

Addendum to Release Notes

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1.0 Introduction

This TeamTrack Patch Release includes all patches and executables that have been completed, tested, and packaged for distribution since general availability of EHR v1.1 p13. Generally, these releases contain High, Medium, and Low defect corrections.

1.1 TeamTrack/Artifact Priority Classification

IHS issues are classified by Priority:

- **HIGH.** Could result in incorrect data being documented for a patient or impede the use of a key clinical feature.
- **MEDIUM.** Affects a key clinical feature, but does not impede its safe use.
- **LOW.** A minor or cosmetic disturbance while using the application.

2.0 Enhancements and Changes

This section provides information regarding enhancements and changes made to RPMS as part of this TeamTrack Patch release. The subsections are ordered by TeamTrack/Artifact (TT/A) number.

2.1 TT/A 1138; 1372/12706 – Family History Not Retaining Cause of Death

Description:

Client reports that the cause of death disappears whenever the screen is edited. This is a problem because the user does not always remember what was written there.

If other fields regarding the family members are edited (like updating the type of cancer or correcting a misspelling), the cause of death is lost. So often the screen is just not edited.

The V code and Age of Death also erase when a disease is edited.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on the RPMS-EHR.
2. Select the Patient Chart tab.
3. Click the Patient Not Selected pane.
4. Select a patient (Test, Patient A) from the Patient Selection window.
5. Click OK.
6. Click the Visit Not Selected pane.
7. Create a new visit.
8. Select the CC/PROBS tab.
9. In the Problem List pane, select the Family History tab.
10. Click the Add Relation button.

11. Populate the following data fields:
 - Relation (Natural Father)
 - Name
 - Status (Deceased)
 - Cause of Death (Heart Attack)
 - Age at Death (40-49)
12. Click ADD.
13. Click the Add button to search for a Systematized Nomenclature of Medicine-Clinical Terms (SNOMED CT) for the relative being added to the Family History.
14. On the SNOMED CT Lookup window:
 - a. Click the Synonym option button.
 - b. Enter Heart Attack in the Search field.
 - c. Click the Find button.
15. Select Family History of congestive heart failure from the Pick List.
 - a. Click the Select button. The Family History Condition window displays with the newly selected SNOMED CT displayed in the Description field.
16. Enter the following:
 - Provider Text
 - Age at Diagnosis. If unsure of Age at Diagnosis, click the Approximate check box.
17. Click Save.
18. On the Family History window, click Save.
19. Verify the Cause of Death field and the Condition fields containing the International Classification of Diseases (ICD) code are populated correctly on the grid.
20. Click the new entry in the Family History List and verify the Edit Relation and Delete Relation buttons are now selectable.
21. Select the Integrated Problem List (IPL) tab and enter a Problem (Chest Pains).
 - Set it as today's Purpose of Visit (POV).
22. Click the Patient Selected pane and select a different patient (Test, Patient B).

23. Click the Patient Selected pane and reselect the patient with the newly entered Family History (Test, Patient A).
24. Click the Visit Not Selected pane and select the Visit previously created for this patient.
25. Select the CC/PROBS tab.
26. In the Problem List pane, select the Family History tab.
27. Verify that the Cause of Death field and the Condition fields containing the ICD codes are populated correctly.

Note: The Cause of Death and the Age at Death should be retained.

Expected Results:

Added new lines for the Cause of Death and the Condition fields are saved. The Cause of Death and the Age at Death are retained upon edit.

2.2 TT/A 1056; 1193/12958 – Mandatory Clinical Indication for Copy/New/Renew medication

Long Title:

TT/A 1056; 1193/12958 – Mandatory Medication SNOMED CT Codes, Clinical Indication, and Copy to New or Renew

Description:

If a clinical indication does not exist when the user attempts to Copy to New or Renew, the user is forced to add a SNOMED CT code for each medication.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select an order that does not have a clinical indication.
4. Right-click and select Copy to New.

5. Right-click and select Renew.

Expected Results:

The SNOMED CT Lookup window launches and the user can search for a clinical indication.

2.3 TT/A 1230/13224 – Rx Print Template Fields, ICD-10/SNOMED CT Considerations

Description:

Currently, there are template fields for Indication Code and Indication Text (Ind Code and Ind Text, respectively). The code should be the ICD code that is mapped to the SNOMED CT term the provider chose as the clinical indication, realizing that in some instances this may be .9999.

The indication text may need to be the SNOMED CT description or synonym (whatever was chosen by the provider), since using the ICD text may result in the text Uncoded Diagnosis printing, which is less than helpful.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and an Outpatient visit.
3. Select the IPL.
4. Click Add.
5. Add a SNOMED CT coded problem.
6. Select the Meds tab.
7. Order an Outpatient medication.
8. Click the Clinical Indication list and select the newly added problem.
9. Accept and sign the order.
10. Click the Print Queue button.

11. Select a template and a printer.

Expected Results:

The SNOMED CT code and term display on the prescription.

2.4 TT/A XXXX/13380 – MU2 – Infant Feeding Clinical Quality Measures – Capture and Export

Description:

Client wants the following issues addressed:

- Move ½ breast ½ formula to in-between Exclusive Breastfeeding and Formula Only. Also, would like to adopt the business rule that no Secondary Fluids are selectable. This is consistent with the written requirements.
- Editing an entry of Formula Only defaults to Exclusive Breastfeeding when opened in RPMS-EHR.
- Double-clicking a current entry acts as if the user intends to edit the entry (not sure if this is expected behavior). With most components, users can right-click to edit. Some components use a double-click to view details, and others to edit.

It was noted that users are not able to see the Visit Detail on the right-click menu like other components. Right-click options, including Visit Detail, should be added, but may be done after Patch 13.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select the Patient Chart tab.
3. Click the Patient Not Selected pane.
4. Select a patient who is an infant from the Patient Selection window.
5. Click OK.
6. Click the Visit Not Selected pane.
7. Create a new visit.
8. Select the Wellness tab.

9. Select the Infant Feeding tab.
10. Verify the Infant Feeding Choice window displays.
11. Click Add.
12. Select the Mostly Formula option button.
13. Verify the Secondary Fluids pane is activated.
14. Select multiple Secondary Fluids.
15. Add a comment for each secondary fluid selected.
16. Click Save.
17. Select the Notes tab.
18. Select Option in the Notes header.
19. Select Edit Templates from the Option drop-down menu.
20. Click Action in the Template Edit header.
21. Select Generate Template from the Action drop-down menu.
22. Select the Patient Data (Object) option button.
23. Enter Infant Feeding in the Search field.
24. Click OK and then click OK again.
25. On the Notes tab:
 - a. Click the Templates button.
 - b. Click My Templates.
26. Double-click the Infant Feeding template.
 - a. Select a title for the Note.
 - b. Click OK.
27. Verify the Infant Feeding data just entered is displayed in the new Progress Note.

Expected Results:

Verify the Infant Feeding data just entered is displayed in the new Progress Note.

2.5 TT/A 1279/13381 –MU2 Family History requires capture and storage of SNOMED CT

Long Title:

TT/A 1279/13381 – MU2 Family History Requires Capture and Storage of SNOMED CT or HL7 Pedigree Standard

Description:

The Meaningful Use (MU) 2 Family History requires the capture and storage of a SNOMED CT or HL7 Pedigree Standard. The SNOMED CT Concept/Description ID:

- Will be using Preferred Terms
- Provider narrative will use the same conventions as the Problem List
- Store as Provider Text | Description ID
- Display as Description | Provider Text

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Click the Patient Not Selected button.
 - a. Select a patient from the Patient Pick List.
 - b. Click OK.
3. Click the Visit Not Selected button.
4. Create a new visit for the selected patient.
5. Select the CC/PROBS tab.
6. Click the Add Relation button in the Family History pane.
7. On the Family History window, enter the following data:
 - a. Relation
 - b. Name
 - c. Status

- d. Cause of Death
- e. Age at Death
8. Click the Add button.
9. The SNOMED CT Lookup window displays with the SNOMED CT Lookup subset set to SRCH Family History.
10. On the SNOMED CT Lookup window:
 - a. Click the Synonym option button.
 - b. Enter Heart Attack in the Search field.
 - c. Click the Find button.
11. Select Family History Premature Coronary Heart Disease from the Pick List.
12. Click the Select button.
13. The Family History Condition window displays with the newly selected diagnosis displayed in the Description field.
14. Enter free- text in the Provider Text field.
 - a. Enter the Age at Diagnosis.
 - b. If unsure of the family member's Age at Diagnosis, click the Approximate check box.
 - c. Click the Save button.The Family History window appears.
15. Click the Save button.
16. Verify the new entry is displayed correctly in the Family History and includes the appropriate ICD code.
17. Select the Notes tab.
18. Click the New Note button.
19. On the Progress Note Properties window, select a Note Title.
20. Click OK.
21. Click the Templates button.
22. Double-click the Family HX template in the Templates Pick List.
23. Verify the Family History data just entered is displayed in the new Progress Note.

Expected Results:

The Family History data entered is stored and displayed in the Progress Note when the user selects the Family HX template.

2.6 TT/A 1263/13389 – MU2 BMI Measurement Capture and Storage

Description:

Currently, two measures are calculated using real-time data:

- Body Mass Index (BMI)
- BMI Percentile (BMIP)

The solution avoids additional clicks or user input. The proposed solution is as follows:

- Additional Measurements available:
 - BMIP (calculated and stored)
 - BMI (calculated and stored)

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Vitals tab.
4. Click New Date/Time.
5. Enter the Height and Weight measurements.
6. Click Update.
7. Log on to Terminal Service.
8. Access VA FileMan,
9. Perform INQ to File Entries.
10. At OUTPUT FROM WHAT FILE: V MEASUREMENT//, press Enter.

11. At V Measurement Type, enter BMIP.
12. At OUTPUT FROM WHAT FILE: V MEASUREMENT//, press Enter.
13. At V MEASUREMENT TYPE, enter BMI.

Expected Results:

BMIP for children and BMI are calculated and stored, along with LOINC codes.

2.7 TT/A 1300/13392 – TT/A 1300/13392 –MU2 Add qualifier to IPL

Long Title:

TT/A 1300/13392 – MU2 Adding of Qualifier to Integrated Problem List Requirement (SNOMED CT)

Description:**Workflow – Current Behavior:**

- Descriptions of diagnoses are currently managed a variety of ways.
- Solution needs to avoid impeding workflow, but offer ways to provide detail needed for coders to select more granular ICD-10.

Workflow – Desired Future Behavior:

- Provider text of 60 characters offered to users when selecting SNOMED CT term for diagnosis:

Expected Behavior in RPMS:

- Data entry will not include SNOMED CT entry.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL.
4. Add a problem.

Expected Results:

Qualifiers are searchable and selectable.

2.8 TT/A 1290/13433 – MU2 Update Med List CQM RQMT 26TT

Description:**Justification:**

- Clinical quality measures criteria and requires that EHRs demonstrate capture of each and every data element used in each measure.
- EHR clinical users do not want changes in the front-end User Interface for Chart Review functionality.
- When a Clinical Action is stored in the V Updated/Reviewed #9000010.54 as a result of managing the med list or documenting a Chart Review Clinical Action on the Chart Review component, the SNOMED CT will be stored in the Documentation Meds SCT field, as well as Entered By and Date/Time entered.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Review and Update Meds/Adverse Reaction and Problem List.
4. Sign the review.

Expected Results:

An entry in the V Updated/Reviewed #9000010.54 is created with the SNOMET CT field populated, including the user signed-in, and the Date/Time entered.

2.9 TT/A 1288/13435 – MU2 EHR Stroke Tool Component

Description:

Store CPT J codes for thrombolytic in Acute Myocardial Infarction (AMI) and Stroke, for patient refusals.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Select the Stroke tab.
4. Click Add.
5. Complete the Arrival Date/Time and Onset Date/Time.
6. Click Symptom.
7. Click Witnessed.
8. Enter Witnessed by and Witnessed Date/Time.
9. Enter Comment.
10. Click Save.
11. Click Save in the main Stroke screen.
12. Click the stroke event entered in the above steps.
13. Click Edit.
14. Click the Pencil icon on the added symptom, and then update the comment entered previously.
15. Click Save.

Expected Results:

Stroke component functions as desired.

2.10 TT/A 1287/13436 – MU2 SNOMED CT Search Problem List RQMT

Description:

The SNOMED CT Search dialog box, while similar to the ICD/Lexicon dialog box, will be the default means of adding a new item to the problem list. This dialog box will replace all current dialog boxes where an ICD code is looked up, including the clinical indication for meds and lab.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL.
4. Click Add.
5. Click the Ellipsis button to perform a SNOMED CT search.
6. Search for a term and click Select.

Expected Results:

The user can search for a SNOMED CT term using the SNOMED CT Lookup utility. The user also has the ability to use different subsets for a more specific search.

2.11 TT/A 1286/13437 – MU2 SNOMED CT Search Pick List Selection RQMT 112TT

Description:**Selecting Pick Lists:**

- The user can only access the PL Pick List button from the IPL component if the visit selected is not locked
- The user can use the Pick List button to add a new problem, or edit an existing problem
- The user has the ability to choose SNOMED CT Terms by defined Pick Lists

- The user can see the SNOMED CT Term or Fully Specified Name
- SNOMED CT terms (based on Concept ID) that are already present on the patient's Problem List will not be selectable on the Pick List
- Pick List displays Descriptor, if present
- The user retains the current Pick List functionality found within EHR

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and an unlocked visit.
3. Select the IPL tab.
4. Click the PL Pick List button.
5. Select one or more Pick Lists.

Note: If the Pick List button from the main screen is used, more than one Pick List can be selected. If the Pick List button from the Add or Edit an IPL screen is used, only one Pick List can be selected.

6. Select SNOMED CT Descriptions to apply to the Pick Lists you selected.
7. Click Save.

Expected Results:

User can search for a SNOMED CT code upon Add or Edit of an existing Pick List.

2.12 TT/A 1285/13438 – MU SNOMED CT Search Order Entry RQMT 112TT

Description:

Modify the following Order dialog boxes collecting clinical indication or provisional diagnosis to utilize IPL SNOMED CT codes only, no free-text allowed:

- Consult Order dialog box
- Medication Order dialog box

- Laboratory Order dialog box

Impact:

Medium

Area Affected:

EHR

Steps to Validate:**Scenario 1:**

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Order a Med.
4. Select the Clinical Indication field.
5. Select Other.

Scenario 2:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Order a lab.
4. Select the Clinical Indication field.
5. Select Other.

Scenario 3:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Order a Consult.
4. Select the Clinical Indication field.
5. Select Other.

Expected Results:

The user can use the new search for CT lookup.

2.13 TT/A 1284/13439 – MU SNOMED CT Search Family History RQMT 112TT

Description:

The SNOMED CT search dialog, while similar to the ICD/Lexicon dialog, will be the default means of adding a new item to the problem list. This dialog replaces all current dialogs where an ICD code is looked up, including the clinical indication for meds and lab.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Click Patient Not Selected button.
 - a. Select a patient from the Patient Pick List.
 - b. Click OK.
3. Create a new visit for the patient.
4. Select the CC/PROBS tab.
5. In Family History, add a Relation.
6. On the Family History window, enter the following data:
 - Relative
 - Name
 - Status
 - Cause of Death
 - Age at Death
7. Click the Add button to search for a SNOMED CT for the relative being added to the Family History.
8. On the SNOMED CT Lookup window:
 - a. Click the Synonym option button.
 - b. Enter Heart Attack in the Search field.

- c. Click the Find button.
9. Select Family History Premature Coronary Heart Disease from the Pick List.
 - a. Click the Select button. The Family History Condition window displays with the newly selected diagnosis displayed in the Description field.
10. Enter the following:
 - Provider Text
 - Age at Diagnosis. If unsure of Age at Diagnosis, select the Approximate check box.
11. Click Save.
12. On the Family History window, click Save.
13. Verify the new entry is displayed correctly in the Family History and includes the appropriate ICD code.
14. Select the Notes tab.
15. Click the New Note button.
16. On the Progress Note Properties window:
 - a. Select a Note Title.
 - b. Click OK.
17. Click the Templates button.
18. Double-click the Family HX template in the Templates Pick List.
19. Verify the Family History data just entered is displayed in the new Progress Note.

Expected Results:

Family History data displays correctly.

2.14 TT/A 1283/13440 – MU SNOMED CT Search Patient Education RQMT 112TT

Description:

The SNOMED CT Search dialog box, while similar to the ICD/Lexicon dialog box, will be the default means of adding a new item to the problem list. This dialog box replaces all current dialog boxes where an ICD code is searched, including the clinical indication for Meds and Lab.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Wellness tab.
4. Click Add to add a patient education
5. Click the Disease and Topic Entry option button
6. Click the Ellipses button for Disease/Illness.
7. Search for a SNOMED CT code.
8. Select a topic.
9. Click OK.

Expected Results:

The Apelon tool launches and the user can search for a SNOMED CT code.

2.15 TT/A 1281/13442 – MU2 POV Component Within IPL

Description:

The ability to select a problem and move it to the POV currently exists. However, the ability to directly enter POVs from the POV component and/or to add a POV and move it to the problem list will no longer exist. In this new paradigm, the POV entry only goes one way – from problem list to POV.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to EHR.

2. Select a patient and a visit.
3. Select the IPL.
4. Click the POV button.

Expected Results:

A POV can be added by using the button or right-clicking and selecting POV.

2.16 TT/A 1280/13443 – MU2 Historical Diagnosis Component

Description:

Client reports that the user can no longer add, edit, or delete. The Historical Diagnosis component is read-only. The user can no longer choose an old POV to be added as Today's POV.

All changes will be handled in the Problem List calls.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the POV tab.

Expected Results:

User is able to view Historical Diagnoses linked to previous visits, but can no longer edit or delete a past diagnosis. The diagnosis can no longer be set as today's POV.

2.17 TT/A 1274/13449 – MU2 Reasons Not Done CQM RQMT 26TT

Description:

Clinical quality measures criteria requires that EHRs demonstrate the capture of each and every data element used in each measure. There are several measures where various reasons for a procedure not being done are captured in SNOMED CT.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.

Add an Immunization:

1. Click the Immunizations tab.
2. Click Add.
3. In the Vaccine Selection dialog box, select a vaccine, and then click OK.

Add Vaccination Refusal:

1. In the Add Immunization window, select the Not Done option button.
2. Verify that the Reason field drop-down menu is updated with new refusal reasons.
3. In Reason, select a reason from the list.
4. In Comment, type a note, and then click OK.

Add Contraindication:

1. In Contraindications, click Add.
2. In the Enter Patient Contraindication, click the Ellipsis button to search for a vaccine, and then click OK.
3. In Contraindication Reason, select Patient Refusal or Parent Refusal, click to select a Reason, and then click OK.

Add Skin Test:

1. In Skin Test History, click Add.
2. In Lookup Skin Test, search for a skin test or select one from the list, and then click OK.
3. Select the Not Done option button.
4. Select a Reason from the drop-down menu.
5. Click Save to add the skin test.

Add Personal Health Refusal:

1. Click the Wellness tab.
2. In the Personal Health component, select Refusal from the drop-down menu, and then click Add.
3. Add a Refusal for each Refusal Type that is available, for example, CPT, EKG, Lab, PAP, and so on, and select a different Refusal Reason for each item.
4. Go to Reminders and select a reminder that has refusal reason field configured on the dialog box.
5. Select the Patient Refused check box, and type a comment.
6. Verify that the Refusal Reason drop-down menu is updated for reminders.
7. Select a Refusal Reason from the drop-down menu.
8. Finish the reminder.
9. Validate refusals added using steps above are saved and display the Refusal Reason selected.

Expected Results:

The PATIENT REFUSALS FOR SERVICE/NMI SERVICE TYPE file displays the following fields with SNOMED CT values:

- Concept ID Reason not done
- Desc ID reason not done
- Concept ID RND FSN

2.18 TT/A 1271/13452 – MU2 Principle Dx CQM RQMT 26TT

Description:**Justification:**

Clinical quality measuring criteria require that EHRs demonstrate capture of each and every data element used in each measure.

Workflow – Current Behavior:

- Outpatient:
 - User selects a POV
 - First one stored is Primary or may change to Primary
- Inpatient:

- Discharge diagnosis selected as Primary
- Solution needs to avoid additional clicks or user input

Workflow – Desired Future Behavior:

Store the 63161005 Principal (qualifier) SNOMED CT code for purposes of visit or discharge diagnoses marked as Primary.

Expected Behavior in RPMS:

- Add SNOMED CT Concept ID to V POV file #9000010.07 when Primary/Secondary field #9000010.07,.12 is set to P primary
- If primary is changed to secondary, then the SNOMED CT Concept ID is removed from field #9000010.07,.12

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL.
4. Highlight a problem and click the POV button.
5. Set a primary POV and click Save.
6. Select the POV tab.
7. Log on to RPMS-EHR.
8. Access VA FileMan.
9. Access the V POV file.

Expected Results:

The POV displays on the POV tab as Primary. SNOMED CT Concept ID has been added to the V POV file. When a POV is changed from Primary to Secondary or deleted, the SNOMED CT Concept ID for Primary is removed from the V POV file.

2.19 TT/A 1269/13454 – MU2 Pick List RQMP 112

Description:

Client's request for selecting Pick Lists:

- The user can only access the PL Pick List button from the IPL component if the visit selected is not locked.
- The user can use the Pick List button to add a new problem, or edit an existing problem.
- The user has the ability to choose SNOMED CT Terms by defined Pick Lists.
- The user can see the SNOMED CT Term or Fully Specified Name.
- SNOMED CT terms (based on Concept ID) that are already present on the patient's problem list will not be selectable on the Pick List.
- The Pick List displays Descriptor, if present.
- The user retains the current Pick List functionality found within EHR.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Click the PL Pick List button.

Expected Results:

The Pick List functions as desired.

2.20 TT/A 1267/13456 – MU2 National Pick Lists RQMT TT

Description:

Client wants a nationally defined Pick List created. SME input will be utilized for creation of the Pick List to be deployed within EHR patch release.

The client also wants to add a new parameter, BGO DEFAULT PICKLIST, that will be populated with the name of the default Pick List. This will be returned as the first item on the call for Pick Lists. However, other Pick Lists will be available to use.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL tab.
4. Click the PL Pick List button.
5. Select a code.
6. Click Save.

Expected Results:

The problem is added to the patient's problems.

2.21 TT/A 1265/13458 – MU2 Add to BEH Measurement Control File

Description:

MU2 criteria is added to the BEH Measurement Control file:

- NIH Stroke Scale Total
- Cup to Disc
- Framingham 10-Year
- BMI
- BMIP (age specific)

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.
3. Select the Vitals tab.
4. Click New Date/Time.
5. Enter the following:
 - NIH Score – 30 Qualifier (Baseline)
 - Cup to Disc Ratio – 0 Qualifier (Baseline)
 - Framingham 10-Year Risk – 8
 - Height – 48
 - Weight – 110
6. Click Update. Values are stored.
7. Log on to RPMS-EHR.
8. FM-Inquire.
9. OUTPUT FROM WHAT FILE: V MEASUREMENT//.
10. Select V MEASUREMENT TYPE: NSST.
11. Select V MEASUREMENT TYPE: CDR.
12. Select V MEASUREMENT TYPE: F10R.
13. Select V MEASUREMENT TYPE: BMI.
14. Select V MEASUREMENT TYPE: BMIP.

Expected Results:

Values are stored for BMIP, BMI, F10R, CDR, and NSST. LOINC codes are stored for all but CDR.

2.22 TT/A 1262/13461 – MU2 Immunizations CQM RQMT 26 TT

Description:

Client would like the Patient Contraindications Reasons for specified vaccines to display on the selected patient Official Immunization Record.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient with multiple signed immunizations orders pre-positioned.
3. Create a new visit.
4. Select the Order tab.
5. Verify the pending Immunizations display on the Active Orders pane.
6. Click the Immunization tab.
7. In the Contraindication pane, click the Add button.
8. On the Enter Patient Contraindication window, click the Ellipse button.
9. On the Vaccine Selection window, select a vaccine from the Pick List.
10. Click OK.
11. On the Enter Patient Contraindication window, select a Contraindication Reason.
12. Click Add.
13. Verify the new Contraindication Reason is displayed in the Contraindication pane.
14. Click the Print Record button, on the Immunization tab, in the Vaccinations pane.
15. Verify that the Print Record window displays with the Official Immunization Record displayed and includes the Patient Contraindication just entered under Contraindications.

Expected Results:

The Patient Contraindications Reasons for specified vaccines display on the selected patient Official Immunization Record.

2.23 TT/A 1261/13468 – MU2 Health Factors – Smoking Status RQMT TT

Description:

Clinical Quality Measures criteria requires that EHRs demonstrate capture of each and every data element used in each measure.

For EHR clinical users, no changes will be made in the front-end user interface for entering health factors.

For Patient Care Component (PCC) data entry, no change will be made in the RPMS Data Entry user interface for entering health factors.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Wellness tab.
4. Add a Health Factor.
5. INQ on V Health Factors file in FileMan.

Expected Results:

SNOMED CT codes and LOINC codes store in FileMan.

2.24 TT/A 1260/13469 – MU2 Health Factors CQM RQMT TT 26 TT

Description:

Add the MU2 Health Factors.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Wellness Tab.

4. Click Add to add a health factor.
5. Expand ECOG PERFORMANCE STATUS.
6. Choose ECOG 1- SOME RESTRICTION.
7. Enter a comment in the Comment field.
8. Click Add.

Expected Results:

New ECOG statuses are available in the Health Factor and the Reminder. SNOMED CT codes are being stored in the V Health Factors file in File Manager for new ECOG statuses.

2.25 TT/A 1259/13470 – MU2 Exams CQM RQMT 26 TT

Description:

Client is requesting changes to the Exams Application.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Wellness tab.
4. Add an exam.
5. Save the exam.

Expected Results:

SNOMED CT codes and LOINC codes store.

2.26 TT/A 1257/13472 – MU2 Drug Order Check Decision Support RQMT TT

Description:

Client would like the following changes to the Drug Order Check application:

Workflow – Desired Future Behavior:

- Clinical Users (EHR):
 - Existing workflow is adequate except for the need for citations/sources. This information could be incorporated into the order check dialogues:
 - Certain allergens (reactants) have been added by IHS separately from the VA Standards and Terminology Service.
- Admins and Clinical Application Coordinators (CAC):
 - Existing workflow would seem to be adequate, except for the statement from ONC that a system should record when they are enabled. There is no language exempting drug-drug or drug-allergy checks from this. May need to record in a multiple when turned on or off and by whom.
- Source attributes for Diabetes Reminders

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Order two drugs that create an order check.

Expected Results:

In the dialog caption, the word Source:<name of source> displays.

2.27 TT/A 1258/13473 – MU2 Drug Order Check Drug Allergy RQMT TT

Description:

Client requires the following changes:

File Storage:

May require changes the Order Check parameter files to store the state (enabled or disabled) at each level. Also to the date/time set, and who modified the status.

Clinical Users (EHR):

Existing workflow is adequate except for the need for citations/sources. Because most drug-allergy and drug-drug interaction information is taken from the VA, we may use a global citation and source information. This information could be incorporated into the order check dialogues.

Certain allergens (reactants) have been added by IHS separately from the VA Standards and Terminology Service; it is not clear if we would need to have a separate statement for these or how it might display.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on the RPMS-EHR.
2. Select a patient and a visit.
3. Order two drugs that create an order check.

Expected Results:

The Order Checking Source displays in the dialog caption.

2.28 TT/A 1255/13476 – MU2 Consults GMRC Clinical Indication

Description:

Client requests that the user have the ability to search for a Clinical Indication using Apelon for a SNOMED CT code when adding a new consult. When the Completed Consult notification is processed for a consult resolved by a consult note title, SNOMED CT 371530004 Clinical Consultation Report and 371531000 Report of Clinical Encounter are stored in the Consult Loop Closed SCT field.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

Note: BEHOORPA CLINICAL INDICATOR parameter is set to Yes, Consult Service, Clinical Indicator is set to Mandatory or Optional, and SNOMED CT Consult Type is defined.

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the More tab.
4. Select the Consults tab.
5. Click the New Consult button.
6. Select a Service/Specialty from drop-down list (for example, Dental).
7. Select a provider for Attention field.
8. Click the drop-down arrow in the Clinical Indicator field.

Note: Clinical Indicator was previously named Provisional Diagnosis.

9. Select Other. The SNOWMED CT Lookup window displays.
10. In the Search field, type Diabetes and click Find.
11. Click and expand Diabetes Mellitus Type 2.
12. Click Diabetes Mellitus Type 2.
13. Click Select.
14. Complete the remainder of the Consult Order
15. Accept the order and click Quit.
16. Select the Orders tab.
17. Sign the order.
18. Select the Notifications tab.
19. Process the New Consult notification that is generated.
20. Select Action > Consult Results > Complete/Update results.
21. Select Progress Note Title.

22. Complete and sign the Note.
23. Select the Notifications tab.
24. Select and right-click Completed Consult Notification Generated.
25. Select Process Selected.

Note: User is taken to the Consult Tab to view the completed Consult Order.

26. Log on to RPMS-EHR.
27. Select VA FileMan.
28. INQ on the Request/Consultation file.

Expected Results:

- SNOMED CT Lookup window displays when the user selects Other from the Clinical Indicator drop-down list. Fully Specified Name is defaulted and Subset options display. Search Date defaults to today's date. The user has the ability to search by text and select from returned list.
- Once the Completed Consult notification has been processed, the system stores the Closed Consult SCT 371530004 and 371531000 in the REQUEST/CONSULTATION file (#123).

2.29 TT/A XXXX/13478 – MU2 Consult Notifications

Description:

Change the Consult Completed notification from info only to actionable.

When the consult is completed by either a consult note or administratively completed, the user receives a Consult/Request resolution notification. When the user double-clicks, the notification is actionable. Upon signing the notification, reports and encounters are stored in the Consult Loop Closed SCT field of the Request/Consultation file #123.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.
3. Select the More tab.
4. Select the Consults tab.
5. Click the New Consult button.
6. Select a Service/Specialty from drop-down list (for example, Dental).
7. Select a provider for Attention field.
8. Click the drop-down arrow in the Clinical Indicator field.
9. Select Other. The SNOWMED CT Lookup window displays.
10. In the Search field, type Diabetes and click Find.
11. Click and expand Diabetes Mellitus Type 2.
12. Click Diabetes Mellitus Type 2.
13. Click Select.
14. Complete the remainder of the Consult Order
15. Accept the order and click Quit
16. Select the Orders tab.
17. Sign the order.
18. Select the Notifications tab.
19. Process the New Consult notification that is generated.
20. Select Action > Consult Results > Complete/Update results.
21. Select Progress Note Title.
22. Complete and sign the Note.
23. Select the Notifications tab.
24. Select and right-click Completed Consult Notification Generated.
25. Select Process Selected.
26. Log on to RPMS-EHR.
27. Select VA FileMan.
28. INQ on the Request/Consultation file

29. Select REQUEST/CONSULTATION FILE ENTRY DATE: and enter the appropriate consult order date.

30. At ANOTHER ONE: press Enter.

31. At STANDARD CAPTIONED OUTPUT? Yes//, press Enter.

32. At Include COMPUTED fields: (N/Y/R/B): NO//, press Enter.

Expected Results:

System stores the Closed Consult SCT 371530004 and 371531000 in the REQUEST/CONSULTATION file (#123). Entered by [logged in user] and Date/time entered are also stored.

2.30 TT/A 1235/13490 – MU2 Modify Existing Web Info Button

Description:

Client is requesting the following:

- Rename old Info button to ED, which stands for Education Info button
- Change the Web Info button for Lab results on Lab tab to launch to MedlinePlus
- Connect to MedlinePlus
- Requests for Diagnosis (Problem) Codes

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Meds tab.
4. Select a medication.
5. Click the ED button.
6. Select the Lab tab.

7. Select a Lab.
8. Click the ED button.

Expected Results:

The Info button has been renamed to ED (Education Info). The browser for MedlinePlus launches. The Web Info for Labs now launches MedlinePlus as well.

2.31 TT/A 1247/13495 – MU2 AMI EHR Tool

Description:

Client is requesting the creation of an AMI tracking tool. The following is included:

- Date/time of arrival. Defaults to date/time of admit to ED, user may change.
- Free-text entry of symptoms.
- Date/time of implementation of standing orders/protocols.
- Store CPT J codes for thrombolytic in AMI for patient refusals.
- Fibrinolytic therapy initiated or not initiated.
- EKG done or not done.
- SNOMED CT.
- ICD-9 & ICD-10 mapping.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Click the AMI tab, button, or drop-down menu, depending on site configuration.
4. Click Add to add a new AMI encounter.
5. Complete Arrival Date/Time.

Symptoms:

1. Complete Onset Date/Time.
2. Add Symptoms by clicking Add button.

3. Type free-text comment, if needed.

EKG:

1. Select EKG check box. Fields become active.
2. Complete EKG Done Date/Time.
3. Add Finding by clicking Add button.
4. Select Finding.
5. Type Provider Text.
6. Select Interpreted by from drop-down menu.
7. Type comment if needed.
8. Click Save.
9. Type free-text comment, if needed.

Fibrinolytic:

1. Select Therapy Initiated or Therapy Not Initiated option button. Fields become active.
2. Complete Date/Time.
3. Select Not Initiated Reason, if applicable.
4. Type free-text comment, if needed.

Protocol:

1. Add Protocol by clicking Add button.
2. Select Protocol.
3. Complete Protocol Date/Time.
4. Type Comments, if needed.
5. Click Save.
6. Click Save on the AMI main screen to save the entire AMI event.

Editing an AMI event:

1. Right-click and select Edit, or click the Edit button.

Deleting an AMI event:

1. Right-click and select Delete, or click the Delete button.
2. Select a reason, and then click OK.

Expected Results:

AMI events can be added, edited, and managed as designed.

2.32 TT/A 1248/13496 – MU2 CCDA Clinical Summary RQMT 29TT

Description:

Client's proposal to determine if these changes meet RCIS needs.

- Print RCIS referral number on the Transition of Care (ToC) with the info for the provider/facility referring to that we are already displaying.
- When user chooses to Submit a ToC:
 - A dialog opens with the following if there are referrals entered for the visit
 - A dialog opens with the following if there are NO referrals entered for the visit
 - Ability to search and select from the Vendor file to select Facility/Provider and Direct info/Fax info
 - Option to PRINT a ToC if cannot find one

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient.
3. Rest the mouse over the Consolidated Clinical Document Architecture (CCDA) button.
4. Click the GENERATE CCDA for Visit/Visits pop-up link.
5. Verify that the GENERATE CCDA for Visit/Visits window displays.

6. Verify the selected patient's name and Health Record Number are displayed along with the Clinical Summary and the Transition of Care option buttons.
7. Verify a list of all Visits, linked to the selected patient is displayed, with the most recent Visit displayed at the top of the list.
8. Verify that all the visits can be selected by clicking the Visits check box directly above the list of visits.
9. Click the Transition of Care option button.
10. Verify that the following buttons are activated:
 - Print
 - Save
 - Submit
 - Review/Customize
 - Cancel
11. Click the Review/Customize button.
12. Verify that the CCDA Transition of Care window displays.
13. Click the Expand (+) button next to the Clinical Document check box.
14. Verify the selected sections of the Transition of Care displays.
15. Verify the following patient information is displayed:
 - Patient Name
 - HR #
 - DOB
 - Sex
 - Race
 - Ethnicity
 - Preferred Language
 - Visit Date
 - Visit Location
16. Verify that a Table of Contents is displayed and the user can review the following information, if captured, for the Visit selected:
 - Reason for Visit

- Problems/Encounter Diagnoses
 - Allergies, Adverse Reactions, Alerts
 - Medications
 - Procedures
 - Today's Instructions and Patient Decision Aids
 - Plan of Care
 - Social History (Smoking Status)
 - Recent Lab Results
 - Immunizations
 - Recent Vital Signs
 - Care Team
17. Verify the user can click on any of the items to review the data without having to scroll up and down through the Transition of Care window.
 18. Verify a message is displayed if the data element selected was not captured during the visit (for example, No Plan of Care Information for the report generation criteria).
 19. Verify under Problems/Encounter Diagnoses, active and inactive problems/diagnoses and Reason for Visit, if any, are displayed.
 20. Verify under Allergies, Adverse Reactions, Alerts, active and inactive allergies, adverse reactions and alerts, if any, are displayed.
 21. Verify under Medications, medications given during the visit, outpatient medications, and outside medications, if any, are displayed.
 22. Verify under Procedures, Current Facility procedures and Historical/Other Facilities procedures are displayed.
 23. Verify under Reason for Referral, the reason for a referral, if any, is displayed.
 24. Verify under Plan of Care, the patient's care plan, if any, is displayed.
 25. Verify under Functional/Cognitive Status, Functional/Cognitive data, if any, is displayed.
 26. Verify under Social History (for example, Smoking Status) the patient's social history, if any, is displayed.
 27. Verify under Recent Lab Results, Individual Tests and a specific series of tests (for example, Skin Tests), if any, are displayed.

28. Verify under Immunizations, the patient's immunizations, if any, are displayed.
29. Verify under Recent Vital Signs, the patient's most recent Vital Signs, if any, are displayed.
30. Verify under Care Team, the patient's Care Team is display, if any, and may include:
 - Referring Provider
 - Visit Provider:
 - Primary Care Provider:
 - Women's Health Case Manager:
 - HIV Case Manager:
31. Verify the Document ID and the date/time the Document was created are displayed.
32. Click the Finalized check box.
33. Verify that the following buttons are activated:
 - Print
 - Save
 - Submit
 - Cancel.
34. Click Cancel.
35. The Patient Chart tab is redisplayed.

Expected Results:

The Transition of Care Summary displays the data

2.33 TT/A 1249/13498 – MU CCDA Preview and Display RQMT 29TT

Description:**CCDA list of changes:**

- All options should be enabled on hover and right-click if encounter context is selected.
- Only enable Generate CCDA for a Visit/Visits (rename from multiple visits) if no encounter context is selected.

- Displays all visits by date of service and all visits are listed in tree view.
- User can select all visits for a date of service and then deselect visits, as needed, to generate CCDAs.
- Rename the hover options from For One Visit to Current Selected Visit.
- Rename the hover option from All visits for one date to Current date of service visits.
 - Multiple/Visit selection screen sorts newest to oldest as default.

The EHR must support a functionality that will allow a user to add or remove certain data. (Examples may include, but are not limited to: Excluding an entire data element (all values) such problems, or removing or editing text within certain data elements (editing patient instructions, removal of a single condition from the problem list.

We are only responsible to check that the EHR supports customization for the Common MU data set items.

Common MU Data set includes the following:

- Patient name
- Sex
- Date of birth
- Race
- Ethnicity
- Preferred language
- Smoking status
- Problems
- Medications
- Medication allergies
- Laboratory tests
- Laboratory values/results
- Vital signs – height, weight, blood pressure, BMI
- Care plan fields, including goals and instructions
- Procedures
- Care team members

You will satisfy the test step if you can demonstrate a modification of any of the above listed data elements.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.

Note: Patient must have a CCD or CCDA image.

3. Briefly rest the mouse pointer over the CCDA button. Confirm the following menu shows:

Note: You can also right-click to view the menu.

- DO NOT GENERATE Summary, Patient has active PHR
 - DO NOT GENERATE Summary, Patient Declines
 - GENERATE Clinical Summary for Current selected visit
 - GENERATE Clinical Summary for Current date of service visits
 - GENERATE Transition of Care for Current selected visit
 - GENERATE Transition of Care for Current date of service visits
 - GENERATE CCDA for Visits/Referrals
4. Select or right-click and select CCDA for Visits/Referrals.
 5. Select a visit or referral from the list. The list loads, showing the Common MU Data set.
 6. Select or clear any of the elements in the Table of Contents in the left pane.
 7. When clearing an element, confirm that the right-pane removes it from the document.
 8. When selecting an element to add, confirm that the right-panel shows it in the document.

Expected Results:

CCDA displays and functions as expected.

2.34 TT/A 1250/13499 – MU2 CDS/UpToDate Info Button RQMT 17 TT

Description:

Client would like to have an HL7 context aware Info button linked to the UpToDate Web service. They would like this available for the MEDS, LABS, and IPL tabs. Module is to incorporate sex and age into retrieval of information.

The new Info button must utilize the UpToDate logo.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient.
3. Create a new visit for the selected patient.

Problem List:

1. Select the IPL tab.
2. Highlight a problem.
3. Click the UpToDate info button.

Medications

1. Highlight a medication.
2. Click the UpToDate info button.

LAB Orders:

1. Select a resulted Lab order.
2. Click the UpToDate info button.

Expected Results:

The user is able to access the UpToDate information Web service from the MEDS, LABS, and IPL tabs.

2.35 TT/A 1298/13504 – MU 2014 RQMT Clinical Information Reconciliation RQMT TT

Description:

Client requests usability changes to component as a result of the Usability studies:

- Displays in grid format
- When one entry is selected, all like entries are highlighted
- Ability to sort
- View from Problem, Adverse Reaction, or Medication tabs
- Users may add, merge, or remove individual data
- Users may review and validate the accuracy of a final set of data elements, and upon a user's confirmation, automatically update the patient's medication, problem, and adverse reaction list
- Tool indicates number of reconciled or unreconciled documents for selected patient
- Right-click menu

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient.

Note: Patient must have a CCD or CCDA image.

3. Click the CIR Tool icon.
4. Confirm the icon indicates the number of reconciled or unreconciled documents.
5. In the Generated by CCDA section, select one of the CCD images for the patient.
6. Click the image in the right-pane to ensure image displays.
7. Click a column heading to sort.
8. Compare the right-pane with the left pane. Confirm that the left pane contains three tabs:

- Problems
 - Adverse Reactions
 - Medications
9. Select a medication and click to display further information about that medication. Do this for both the right and left pane.
 10. Confirm like entries highlight in the right and left pane
 11. Select the Adverse Reactions tab.
 12. Select an allergy and click to display further information about that allergy. Do this for both the right and left pane.
 13. Confirm like entries highlight in the right and left pane
 14. Select the Problem tab.
 15. Select a problem and click to display further information about that allergy. Do this for both the right and left pane.
 16. Confirm like entries highlight in the right and left pane.
 17. Select the Meds tab.
 18. Add a Non-VA (outside) medication using either the Clinical Document pane right-click menu, or the Add Outside button in the Reconciled Medications pane.
 19. Add an Outpatient Medication using either the Clinical Document pane right-click menu, or the Add OP Medication button in the Reconciled Medications pane.
 20. Select the Problems tab.
 21. Add a new problem.
 22. Select the Adverse reactions tab.
 23. Add a new allergy.
 24. In the Reconcile pane, click Accept All.
 25. Verify in IPL that the new problems display.
 26. Verify in the Meds tab Chart that new medications display.
 27. Verify in the Cover Sheet in Allergies, that the new allergies display.

Expected Results:

CIR Tool appears and functions as expected. Top pane is the Generated by CCDA section that enables user to view clinical summaries. Left pane consists of three tabs Medications, Problems, and Adverse Reactions where data from RPMS are displayed. Right pane is the Clinical Document where data from CCDA are displayed. The bottom panel displays actions taken to the RPMS data and CCDA data.

2.36 TT/A 1299/13506 – MU2 2014 IPL Problem List

Description:

Main display contains:

- Problem ID
- Status
- Onset
- Flag (Personal History, PIP)
- Provider Narrative (problems not SNOMED CT coded are identified by *)
- Notes
- ICD
- Asthma Classification

Application enables user to remove or add columns from the main display and set as personal settings, sort the main display by any column, and see one, many, or all statuses, including:

- Chronic
- Episodic
- Sub-acute
- Personal History
- Inactive
- Social/Environmental

Application enables user to expand/collapse all problems to view care planning activity.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL tab.
4. Click Add to add a problem.
5. Click the Ellipsis button to select a SNOMED CT code.
6. Search for a SNOMED CT term.
7. Select the Term.
8. Enter a Priority.
9. Enter Provider Text, if applicable.
10. Select a Status.
11. Select a Severity.
12. Select a Clinical Course.
13. Select a Finding site.
14. Select a Date of Onset.
15. Enter any Comments, if applicable.
16. Add any Visit/CarePlan/Goal activities.
17. Click Save.

Deleting a problem:

1. Right-click and select Delete or click the Delete button.
2. Select a reason.
3. Click OK.

Editing a problem:

- Right-click and select Edit or click the Edit button.

Expected Results:

Problems can be added, edited, and managed as designed.

2.37 TT/A 1301/13508 – MU 2014 GETSCT BUTTON IN IPL RQMT 112 Problem List RQMT 395 TT

Description:

The Get SCT button is only active if the user selects a problem that does not have a SNOMED CT code. This button is enabled when editing a problem if there is NO SNOMED CT term.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL tab.
4. Highlight a problem that does not contain a SNOMED CT term, and then click Get SCT.

Note: The problem shows an asterisk (*) before the problem name.

5. Select the problem.
6. Highlight a different problem that does not contain a SNOMED CT term and click Edit.
7. Click Get SCT.
8. Select the problem.
9. Select a different problem, right-click in the problem, and click Get SCT.
10. Select the problem.

Expected Results:

The * is removed from the problem. The Get SCT button is not enabled for a problem with a SNOMED CT code. The button is only available for a problem with a non-SNOMED CT term. The Look Up reverse mapper displays with the parents/children of the target SNOMED CT in problem entries where there is an ICD populated, but not a SNOMED CT for each case.

2.38 TT/A 1322/13551 – Immunizations: Eligibility Field Displays Only Active

Description:

Eligibility field drop-down list should only display those codes that the site has designated as Active (field .03 of the BI TABLE ELIGIBILITY CODES File # 9002084.83), via the Manager Menu. Users are only presented with codes relevant to their site (as opposed to all 400 codes).

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select any patient.
3. Select the Immunizations tab.
4. Click Add.
5. Click Show All Active Vaccines.
6. Select Influenza.
7. Click OK.

Expected Results:

The Eligibility field only displays codes that the site has designated as Active.

2.39 TT/A 1323/13552 – Family History – Age Field

Description:

Client is requesting the following:

- Reactivate the Age field for condition
- Add qualifier to the age of Approximate, which would be offered as a check box in the EHR
- Migration of old age range data:
 - Do not delete old data, suppress display
 - Stuff the beginning data range into the Age range and also store Approximate

For example, 50-59, store Age as 50, and mark as Approximate.

Business Rule: After data migration is done when the patch is installed, if a user enters an Age, the age range is deleted.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Click the Patient Chart tab.
3. Click the Patient Not Selected button.
4. Select a patient from the Patient Pick List.
5. Click OK.
6. Click Visit not selected button and create a new visit for the selected patient.
7. Click the CC/PROBS tab.
8. Double-click Add Relation in the Family History pane.
9. On the Family History window, enter the following information:
 - Relative
 - Name
 - Status
 - Cause of Death
 - Age at Death (for example, Select the appropriate Date Range)
10. Click Add to search for a SNOMED CT for the relative being added to the Family History.
11. On the SNOMED CT Lookup window, click the Synonym option button.
12. Enter Heart Attack in the Search field and press Enter, or click the IHS SNOMED CT button.

13. Select Family History Premature Coronary Heart Disease from the list and click Select. The Family History Condition window displays with the newly selected diagnosis displayed in the Description field.
14. Enter Provider Text and Age at Diagnosis.
15. If not sure of exact age, enter Age at Diagnosis and then select the Approximate check box.
16. Click Save.
17. On the Family History window, click Save.
18. Verify the new entry is displayed correctly in the Family History and includes the appropriate ICD code and the Age at Diagnosis displays (approx) next to the age.

Expected Results:

The Family History is displayed correctly.

2.40 TT/A XXXX/13564 – MU2 Care Planning Component within IPL

Description:

Client is requesting the following list of changes:

- Care Planning Display
- Ability to add Goal, Goal Notes, Patient Instructions/Plan, and Clinical Instructions
- Care planning fields are problem related – documentation is allowed when problem is selected, but all fields are associated with a particular problem
- Goals Notes (MU Goal)
- Plan of Care (Care Plan/Patient Instructions - MU Patient instructions)
- Visit Instructions (Clinical Instructions – MU Clinical Instructions)
- V Referral SCT
- V Consults SCT
- V Treatment/Regimen SCT

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL tab.
4. Click Add to add a problem.
5. Click the Ellipsis button to select a SNOMED CT code.
6. Search for a SNOMED CT term.
7. Select the Term.
8. Enter a Priority
9. Enter Provider text, if applicable.
10. Select a Status.
11. Select a Severity.
12. Select a Clinical Course.
13. Select a Finding Site.
14. Select a Date of Onset.
15. Enter any Comments, if applicable.
16. Add any Visit/CarePlan/Goal activities.

Expected Results:

The user is prompted to sign the Visit/CarePlan/Goal activities. The user has the option of Add/Remove//Delete and Inactivate upon editing the problem.

2.41 TT/A XXXX/13565 – MU2 Visit Diagnosis Component

Description:

Visit Diagnosis component is now read-only.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the POV tab.

Expected Results:

Component is read-only, user can no longer add, edit, or delete. A previously selected POV cannot be added as Today's POV.

2.42 TT/A 1331/13604 – Anti-Coag Component Allows Logical Deletion (Entered in Error)

Description:

If a new component is added, the most recent supersedes the older one. They are visit-related so they exist. Edit is only allowed if the visit is unlocked. This was designed originally as a visit-related event, and multiple-visit entries would create the longitudinal record. It is not a patient-related file (PCC design from way back). It makes sense this way.

On the new component, you can back date the start of anticoagulation. So if the need for anticoag changes from three months to forever, when a new one is added, the user can set the start of anticoag to when it was originally started.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and an active visit.
3. Select the Anticoag tab.
4. Add a new entry if none exists for the current visit.
5. Select the Anticoag entry.
6. Click Delete or right-click and select Delete from the menu.
7. Select one of the following reasons:

- Duplicate
- Entered in Error
- Other: If Other is selected, enter a free-text reason.

8. Click OK.

Expected Results:

The deleted entry no longer displays. The deleted entry is marked as Entered in Error in the V Anticoag File. Additional data stored includes the User who Entered in Error and Reason Entered in Error, D/T MARKED ENTERED IN ERROR, and REASON ENT IN ERR IF OTHER.

2.43 TT/A XXXX/13663 – MU2 CIR CCDA Outbound Notifications Queue

Description:

Client requests notifications to the HIMS Department that electronic submission to external provider is needed. Notification to the user informs them which provider, patient, and CCDA are making the request, and who it is to go to or whether to contact the provider for details.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.

Note: Patient must have a CCD or CCDA image.

3. Select the Referrals tab.
4. Select a referral with an associated fax number.
5. Click the Submit button. An information message appears, stating the notification is being sent to the medical record for a fax.
6. Check the notifications for the logged in user. You will see the notification to fax the CCDA stored in VistA Imaging to the referral vendor.

Expected Results:

A notification informs the user which provider, patient, and CCDA are making the request, and who it is to go to or whether to contact the provider for details.

2.44 TT/A 1344/13955 – BMI Reference Table and BMI Reports and Gender=U

Description:

Patients under the age of 19 whose gender has been defined as Unknown are excluded from BMIP and BMI calculations in Vitals and BMI Reports.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient under the age of 19 with Sex defined as Unknown.
3. Select the Vitals tab.
4. Document the patient's weight.

Expected Results:

For patients under the age of 19 with Sex defined as Unknown, BMI and BMIP is prevented from being calculated.

2.45 TT/A 1368/14307 – MU 2014 CQM Discharge Medications

Description:

Client is requesting a new field to be added above Notes to Pharmacist, and below Pick Up.

Currently the check box labeled Discharge Medication is defaulted to CHECKED if the patient is currently admitted, or if the ordering location has clinic stop code of 30.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit with a clinic stop code of 30.
3. Order a medication.

Expected Results:

The new Discharge Medications displays above Notes to Pharmacist and below Pick Up. The box is checked if a patient is currently admitted, or if the ordering location has a Clinic Stop Code of 30.

2.46 TT/A XXXX/14465 – MU2 SNOMED CT Search for Refusals Within Personal Health Component

Description:

Client would like to add the ability for a user to search SNOMED CT for a preferred term for a reason of refusal for a service.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Personal Health component.
4. Select a Form of Refusal.
5. Click Add.
6. Select a refusal type of SNOMED CT.
7. Click the Ellipsis button.

Expected Results:

The user has the ability to search SNOMED CT for a preferred term for a reason of refusal for a service

2.47 TT/A 1372/14470 – Pressing Enter in Family History Cause of Death Only Stores First Line

Description:

In the Family History component, in Cause of Death and Condition, when Enter is pressed to start a new line, only the first line of text stores. In addition, when a Relation is edited, the Cause of Death is removed, and if stored, the Cause of Death is null.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient.
3. Select the CC/PROBSs tab.
4. Select the Family History tab.
5. Click Add Relation.
6. Type a Cause of Death.

Expected Results:

Pressing Enter is no longer allowed in the Cause of Death field. Only 60 characters are allowed. In the Provider Narrative field, only 160 characters are allowed. Editing a relation no longer removes the cause of death.

2.48 TT/A 1384/14683 – Immunizations – Add Admin Notes Field and Manufacturer – to EHR Display

Description:

Client would like the following added:

- The Manufacture Name added to the Get To display grid in the Lot field entry

- The Admin Note added to the end of the display dialog box from Get Call

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Immunizations Tab.
4. Under Vaccinations, select Add.
5. On the Vaccine Selection window, select any active vaccine with an associated lot number and manufacture name.
6. Click OK. The Add Immunization window displays.
7. At the Lot field, click the drop-down list to verify that the lot number displays along with the Manufacture name. Notice that a new field called Admin Notes displays.
8. Select the lot number.
9. Enter all the required fields to add an immunization and enter Admin Notes.
10. Click OK.

Expected Results:

Manufacturer and Admin Notes columns are added to the vaccinations grid and display the data. Verify Administration Notes are saved and display when the user goes back to Edit Immunization window.

2.49 TT/A 1971/14978 – eRX: Provider Information Clarification

Description:

Phone numbers for an eRX are being pulled from the Location file first, when it should be the New Person file accessed first, and then the Location file.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Order an eRX.
4. Access VA FileMan.
5. Change the phone number in the New Person file for the provider in the eRX.
6. Order an eRX again.

Expected Results:

The phone number is updated in the Summary window. The phone number is pulled from the New Person file, and if it is not found there, it is pulled from the Location file.

2.50 TT/A 1402/14987 – Pharmacy Education: Disable Ability to Add POV

Description:

The entry of POV in Pharmacy Education Screen must be disabled. It will eventually be tied to SNOMED CT. Medsphere will determine how to handle the automatic entry of Chart Review and Telephone Type visit as POV, so they can possibly reuse the solution with this.

The parameters needing review are as follows:

- BEHORXED DEFAULT POV – Select default POV for PharmED component
- BEHORXED POV LIST – Selectable POVs on the PharmED component
- BEHORXED POV NARR TEXT – POV Narrative Text

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.

2. Select a patient.
3. Select the Pharmacy Education button.

Expected Results:

The entry of POV in Pharmacy Education Screen has been disabled. The menu options (Select default POV for PharmED component, Selectable POVs on the PharmED component, and POV Narrative Text) for editing the three parameter values have been placed out of order.

2.51 TT/A XXXX/15015 – Update Lab POC Component to Utilize SNOMED CT Apelon Tool

Description:

Update the Sign and Symptoms field in the Lab POC component to utilize only codified problems to SNOMET and Other, which launches the user to Apelon lookup. It is the same user interaction as a Clinical Indication for a Lab order or Med order entry.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Click the POC Lab Entry button.
4. In the Lab Point of Care Data Entry Form, select the lab Test to be ordered.
5. In the Sign or Symptom field drop-down list, select Others. The SNOMED CT Lookup window opens.
6. In the Search field, enter some valid text and press Enter.
7. Highlight any problem from the search results and click Select.
8. Enter some comment text in Comment/Lab Description field.
9. Enter test results in the Result field.
10. Click Save.

11. Verify the order displayed in the LABS tab – Note the Lab order number.
12. Log on to RPMS-EHR and go to the FileMan Lab Order Entry file to validate the SNOMED CT field populated correctly.

Expected Results:

Lab order should be saved with the associated SNOMED CT.

2.52 TT/A 1406/15168 – MU 2014 CCDA View Section of ToC in CIR Component.

Description:

Able to select and view specified sections of ToC in CCDA.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.

Note: Patient must have a CCD or CCDA image.

3. Hover the mouse pointer over the CCDA button or right-click and select Generate CCDA for Visits/Referrals.
4. In the Table of Contents left pane, select or clear any of the elements listed. The Transition of Care document updates with your selections, only showing the items with a check in the check box in the Table of Contents pane.

Expected Results:

Sections are added and removed as specified by user.

2.53 TT/A 1415/15347 – MU 2014 Gender Unknown

Description:

If patient is male, do not prompt pregnancy questions during Radiology Order Entry.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. At the IHS Kernel Option: prompt, enter Test and press Enter.
3. At the Option entry to test: prompt, enter DG REGISTER PATIENT.
4. At the Select Patient Name: prompt, enter the name of a new patient.
5. At the PATIENT SEX prompt, enter U for Unknown.
6. Log on to RPMS-EHR.
7. Select the newly registered patient and a visit.
8. Select the Orders tab.
9. Order an Imaging order.

Expected Results:

The Pregnancy prompts of Yes, No, and Unknown are enabled when Radiology orders are placed for a patient with an unknown gender.

2.54 TT/A 1272/15367 – MU2 – Modification CCDA/RCIS/TOC User Interactions

Description:

Client is requesting modifications to the CCDA menu options for the TOC document, and the matching of referrals to visits and the ability to submit electronically.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

Note: Patient must have a CCD or CCDA image.

3. Rest the mouse over the CCDA button, or right-click.
4. Select GENERATE CCDA for Visits/Referrals.
5. Select a visit or referral from the list.
6. When CCDA is loaded, select or clear any of the elements in the Table of Contents in the left pane.
7. Select the Finalize check box.
8. Select the Submit button.
9. Confirm the following:
 - If no contact information is provided, the Print dialog box opens.
 - If a fax number is provided, an information message confirms the image was sent to VistA imaging for faxing.
 - Clicking OK system-generates a notification to the defined mail group.
 - If an e-mail address is provided, the DirectEmail dialog box opens.

Note: If both a fax number and e-mail address are provided, the referral is sent by e-mail.

10. Click the Save button on the Generate CCDA for Visits/Referrals dialog box to save the document in .xml format to be available for later use (to give to patient, email, and so on).

Expected Results:

CCDA electronic submission functions as expected.

2.55 TT/A 1422/15406 – EHR Vaccine Eligibility Prompt

Description:

Add a Vaccine Eligibility prompt to Reminder dialog boxes.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR
2. Select a patient and visit with immunization due reminder (for example, Tdap, Hep A Adult Immunization, TD Immunization, and so on).
3. Select the Notes tab.
4. Click New Note.
5. Select Progress Notes Title.
6. Click the Reminders button.
7. Select the Immunization Reminder that is due (for example, Tdap).
8. Select the Check to Document Immunization Information check box.
9. Select Patient received Tdap immunization at this visit.
10. Select the Per Provider Order option button.
11. Select Lot Number if applicable.
12. Select Imm Site.
13. Enter Injection Volume.
14. Leave default of Vacc Info Sheet Date.
15. Select *Vac Eligibility Code.
16. Enter *Admin Notes.
17. Click Finish and Sign the notes.

Note: New fields added in immunization reminders are indicated by a *.

Expected Results:

User is now able to document the Vac Eligibility Code and Admin Code via reminders. Selected VAC Eligibility and Administrative Notes entered are stored in Visit Detail, V Immunization and correct Vaccine Eligibility and Admin Note is stored along with the other data entered in Immunization module.

2.56 TT/A 1424/15411 – MU 2014 SNOMED CT for Chart Review/Telephone

Description:

Client wants SNOMED CT codes used when a user selects a telephone or chart review visit. These currently are coded with an ICD-9 code in the POV section.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient.
3. Select a visit of Chart Review or Telephone.
4. Right-click the visit and select Visit Details.

Expected Results:

When a user selects a Chart Review or Telephone visit type, the application automatically stores SNOMED CT codes.

2.57 TT/A 1119/15412 – Med Order Dialog Box – Add Last Weight in lb (kg) with Date

Description:

A client request has been submitted to display the last weight in pounds/kilograms with the date on the Med Order dialog box for providers. This would be a minor safety enhancement.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.
3. Order an Outpatient Medication.

Expected Results:

In the upper-right corner of the Med Order dialog box is the patient weight in lbs (kg) and the date of the last weight.

2.58 TT/A 1428/15423 – MU 2014 CDS HL7 Reporting

Description:

Update V Measurement Control file with the new vitals MLHFQ total score.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:**Set Up:**

1. Add the MLHFQ vital type in the Vital Data Entry template:
 - a. At Select IHS Kernel Option: EHR, select RPMS-EHR Configuration Master Menu.
 - b. At Select RPMS-EHR Configuration Master Menu Option: VIT, select Vital Measurement Configuration.
 - c. At Select Vital Measurement Configuration Option: TPL, select Data Entry Templates.
 - d. At Enter selection, enter the appropriate level to define. For example, 900 System.
 - e. At Select Sequence, enter the next sequence.
 - f. At Are you adding xxx as a new Sequence?, type Yes.
 - g. At Sequence, press Enter to accept the default.
 - h. At Measurement, enter MLHFQ.
 - i. At Select Sequence, press Enter.
2. Add MLHFQ to the Coversheet.
 - a. At Select Vital Measurement Configuration Option: cvr, select Measurements Listed on Cover Sheet.

- b. At Enter selection, enter the appropriate level to define. For example, 900 System.
- c. At Select Sequence, enter the next sequence.
- d. At Are you adding xxx as a new Sequence?, type Yes.
- e. At Sequence, press Enter to accept the default.
- f. At Vital, enter MLHFQ.
- g. At Select Sequence, press Enter.

Document MLHFQ vital on a patient:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Vitals tab.
4. Click New Date/Time.
5. Select Now.
6. Click OK.
7. Find the MLHFQ Total Score.
8. Enter a value from 0 to 105 (no decimal).
9. Click Update.

Expected Results:

The Vital Measurement Display shows the newly entered MLHFQ. Vitals in the Review tab also show the MLHFQ. Visit Detail stores V Measurement for MLHFQ. The V Measurement Type file also stores the MLHFQ, including the linked LOINC-Code 71938-5.

2.59 TT/A XXXX/15441 – MU2 Skin Tests Patient Refusals CQM RQMT 26 TT

Description:

Update Skin Tests Refusals to SNOMED CT.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Immunizations tab.
4. Select Skin Tests.
5. Click Add.
6. In the Add Skin Tests window, click the Not Done option button.
7. Enter a Reason for Refusal.
8. Click Save.
9. Select the row that was added with the Refusal reason, and then click the Edit button.
10. Verify the Reason field retains and displays the value that was selected.

Expected Results:

The Reason for Refusal saves properly upon Save and Edit.

2.60 TT/A 1444/15478 – EHR Notifications not Processing All Notifications

Description:

EHR Notifications are not processing correctly. User reports that if they move off of the Lab tab, the notifications get stuck. The system stays on the same Lab and does not move in the foreground, and the user is requested to sign off on both.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Order at least two or more labs.

4. Result the labs in the Lab component.
5. Select the Notification tab.
6. Highlight at least two Lab notifications.
7. Click Selected.
8. View the lab result.
9. Select another tab.
10. Click Next.

Note: The first lab result displays again instead of displaying the next lab notification. The user cannot get to the next notification.

Expected Results:

The next lab notification can be processed.

2.61 TT/A 1279/13381 – eRx: Add Comments for Transmission Failure to Notification pop up

Long Title:

TT/A 2080/15527 – eRX: Add the Comments for Transmission Failure into the Transmission Failed Notification Pop-Up

Description:

Add the comments for transmission failure into the Transmission Failed Notification warning message.

Client would like to add the comments Missing NDC (or whatever reason the transmission failed) to the Transmission Failed Notification warning message. Doing so would alert the prescriber to the problem before they try to retransmit.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.
3. Order a medication that will fail in transmission.

Expected Results:

The comments for transmission failure have been added into the Transmission Failed Notification warning message.

2.62 TT/A 1463/2086/15570 – MU 2014 eRx Bug Clinical Indication Ask SNOMED CT

Description:

When the user right-clicks the Change option, the dialog box opens and the user can see the original RX, including the SNOMED CT clinical indication. However, the user is seeing the message Unable to save order when clicking change because the system is expecting the Clinical Indication to be selected again.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Meds tab.
4. Order a medication.
5. Select Outside Pharmacy – eRX.
6. Select a Clinical Indication from the Apelon tool using Other.
7. Accept and sign the order.
8. Print the order.
9. Right-click the order, and select Change.
10. Accept the order.

Expected Results:

The user is able to accept the order without having to select the clinical indication again.

2.63 TT/A 1473/15601 – Complex Orders – User Can No Longer Type a Number in the Duration Field

Description:

For Complex orders, the user is no longer able to type a number in the Duration field.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Order a Medication.
4. Select the Complex tab.
5. Select a dosage.
6. Click the Duration field.

Expected Results:

The user is able to type a number in the Duration field.

2.64 TT/A 1321; 1382/15655 – Unexpected Error When Using the Quick Order Wizard

Description:

After creating new a new Quick Order in a group with a large number of Quick Orders and clicking Save, an error was received in the left column. The group display collapsed after clicking OK on the Error message.

When the user selected the newly created Quick Order, the same error message was received again. And after clicking OK, the generic Med Quick Order dialog box appeared.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select the Quick Order Wizard tab.
3. Right-click and select Create Quick Order.
4. Fill in the fields.
5. Click Save.

Expected Results:

An unexpected error is not received.

2.65 TT/A XXXX/15661 – Education: Last Column on the Grid Does Not Have a Column Name for Code

Description:

In the Education component, the last column on the grid does not have a column title. It displays No Code Selected for most of the educations entered. If there is a code, it does display, but it aligns to far-right side of the column making it hard for the user to view unless they scroll all the way right.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient with several education topics entered.
3. Select the Wellness tab.
4. Go to the Education section and scroll to the far right to view the last column on the grid.

Notice there is no column name and it displays the code aligned to far right.

Expected Results:

- Displays the column name
- Displays the code aligned to left-most or center of the column so it is easy to view the code.

2.66 TT/A XXXX/15680 – Adding Refusal Types for Med to AMI, Stroke, and Storage Changes

Description:

The GUI reason not given for AMI and STROKE must display the Refusal Reasons for a medication, and allow a single selection. The values entered must store the SNOMED CT concept ID to V AMI and V STROKE Reason Not Given field.

In the Patient Refusal File for CPT, the SNOMED CT concept ID is stored.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Stroke tool.
4. Enter an Arrival and an Onset Date/Time.
5. In the Fibrinolytic section, select Therapy Not Initiated.
6. Enter a Date/Time.
7. Select a reason for the treatment not being initiated.
8. Select a drug not available.
9. Click Save.
10. Select the AMI tool.
11. Add an entry.

12. Add an Arrival and Onset Date/Time.
13. In the Fibrinolytic section, select Therapy Not Initiated.
14. Enter a Date/Time.
15. Select a reason for the treatment not being initiated.
16. Select a drug not available.
17. Click Save.

Expected Results:

In V AMI and V Stroke, the following fields are stored:

- DID NOT INITIATE FIBRINOLYTIC: <date/time>
- DID NOT INIT FIB D/T ENTERED: <date/time>
- DID NOT INIT FIB ENTERED BY: <user>
- DID NOT INIT FIB REASON: 10 – EVENT DATE & TIME: <date/time>

In the Patient Refusal File for CPT, the SNOMED CT concept ID is stored.

2.67 TT/A XXXX/15690 – Refusal for Education Topics

Description:

If the Comprehension Level is refused, it should store to Refusal and display in Personal Health. You must add an education, and then select the Comprehension Level of the refused.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Wellness tab.
4. Click Add for Patient Education.
5. Select a comprehension level of Refused.

Expected Results:

If the Comprehension Level is refused, it should store to the PATIENT REFUSALS FOR SERVICE/NMI file, and display in Personal Health.

2.68 TT/A XXXX/15740 – STROKE: Entering Onset of Symptoms

Description:

When entering onset of symptoms, this is supposed to store in V Measurements as Last Known Well (LKW), also for the earliest reported symptom. It is not storing.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Stroke tab.
4. Click Add.
5. Enter an Arrival Date/Time and an Onset Date/Time
6. Click the Plus sign (+) to add a symptom.
7. Click Save.
8. Save the Stroke entry.

Expected Results:

When entering Onset of Symptoms, it stores in V Measurements as LKW, and also for the earliest reported symptom. LKW and date also display in the Vital Signs cover sheet.

2.69 TT/A XXXX/15875 – Error Processing Missing POV Notification

Description:

User receives an error when processing a Missing POV Notification in P13.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select the Notifications tab.
3. Select the Visit is Missing POV notification and click Process.

Expected Results:

An error is not received. The user is taken to the IPL tab to select a POV. Once the POV is selected and saved for the problem, the notification is removed.

2.70 TT/A 1515/15909 – IPL Add/Edit – Not storing User Information Correctly

Description:

User reports an editing problem. Storage of the Recording Provider, Entered By, and Last Modified User is incorrect.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and create a new visit.
3. Add a problem.
4. Assign a SNOMED CT code.
5. Save the entry.
6. Log on as a different user.
7. Edit the added problem from above.

8. Click Save.

Expected Results:

In the PROBLEM LIST file, the field User Last Modified is the logged-on user who last edited the above problem. In the field Recording Provider any new entries capture logged in user but when edited the recording provider does NOT change. In the field Entered by, this is logged in user and will change when the problem is edited.

2.71 TT/A XXXX/15966 – CIR: Problem Added in CIR Does Not Add to IPL

Description:

When adding a problem to CIR, the problem does not get added to IPL.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Click the CIR tool icon.
4. Select the Problems tab.
5. Select CCD.
6. Click Add Problem.
7. Add a new problem.
8. Sign the problem.
9. Click the IPL tab.
10. Verify that the problem saved in IPL.

Expected Results:

Problems added in CIR are saved to IPL.

2.72 TT/A 1527/15991 – IPL Injury Data – Blank Field Editable

Description:

Client requests the blank, un-editable Injury data field to be grayed-out to avoid confusion for the user.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL component.
4. Add a problem of fracture.
5. Click the Use as POV button.

<p>Note: The Is Injury box is automatically checked for an Injury Taxonomy.</p>
--

Expected Results:

The Caused By field, which is un-editable, is grayed-out so as to not confuse the user.

2.73 TT/A 1530/15993 – IPL Pick List – Remaining Functionality to be Delivered

Description:

Remaining functionality to be delivered for IPL Pick List:

- When selected, if the entry was marked Open Edit on Selection, the Add/Edit dialog is exposed to the user.
- The user can choose SNOMED CT descriptions by defined Pick Lists.
- User can see the SNOMED CT preferred term, synonym, or Fully Specified Name.
- Pick List displays Descriptor, if present.

Remaining Pick List Management functions to be delivered for IPL Pick List:

- The user can create new Pick Lists based on SNOMED CT terms.
- User will retain the current Pick List Management functionality found within EHR.
- User can associate Qualifiers with a SNOMED CT entry.
- The user can add a Descriptor, which is used for display only for Pick List display organization when building Pick List (optional field).
- User can flag a Pick List item as Open Edit Problem dialog on selection.
- User can edit the status of a SNOMED CT term.
- User can keep current capabilities of cloning an existing Pick List.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and an unlocked visit.
3. Select the IPL.
4. Select the PL Pick List button.
5. Select one or more Pick Lists.

Note: If the Pick List Button from main screen is used, more than one Pick List can be selected. If the Pick List button from the Add or Edit an IPL screen is used, only one Pick List can be selected.

6. Select SNOMED CT Descriptions to apply to the Pick Lists you selected.
7. Click Save.

The user can also utilize the Manage Pick Lists button.

Expected Results:

Users can search for a SNOMED CT code upon Add or Edit of an existing Pick List. They can also Add/Edit/Delete/Group/Status/Query/Merge/Import/Export in the Manage Pick Lists functionality.

2.74 TT/A 1575/15997 – IPL – Injury Data – Pre-selected if SNOMED CT is Mapped to Injury Code

Description:

The Is Injury check box should be pre-selected if a SNOMED CT code that is mapped to an ICD that is in the Injury Taxonomy is selected as POV.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL component.
4. Add a problem of Fracture of Ankle.
5. Click Use as POV.

Expected Results:

The Is Injury check box is automatically selected if the problem is in the injury taxonomy.

2.75 TT/A CR02506/16008 – POV no longer stored in EHR

Long Title:

TT/A CR02506/16008 – POV Using ICD in Reminders, the EHR RPC to Not Store Any POV Data Entered in a Reminder Dialog, and Another Measure to Prevent Data Storing in Background

Description:

The RPMS-EHR RPC should not store any POV data entered in a Reminder dialog box. And another measure must be taken to prevent data storing in the background.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

Path to verify ICD Data Dictionary has been removed in Finding Item and Additional Finding

1. Log on to Terminal Service.
2. At Select IHS Kernel Option, select Test an option not in your menu.
3. At Option entry to test, select Reminder Managers menu.
4. At Select Reminder Managers Menu Option, select the DM Reminder Dialog Management.
5. At Select Reminder Dialog Management Option, select DI Reminder Dialogs.
6. At Select Item: Next Screen//, select a Reminder dialog box.
7. At Select Item: Next Screen//, select CV Change View.
8. AT Select Item: Next Screen//, select ED Edit/Delete Dialog.
9. At TYPE OF VIEW: R//, select E Dialog Elements.
10. At Select Item, enter the appropriate item number.
11. Press Enter at each prompt to bypass fields and stop at the Finding Item prompt.
12. At FINDING ITEM, press Enter.

Note: ICD DD is no longer available.

13. Press Enter again for each prompt and stop at the Additional Finding prompt.
14. At Select ADDITIONAL FINDINGS, press Enter.
15. At '^' TO STOP, press Enter.

Note: ICD Data Dictionary is no longer available.

Verifying dialogs with ICD in Finding Item and Additional Finding has been deleted. The path below is a sample dialog with ICD in Additional Finding:

1. Log on to Terminal Service.
2. Select IHS Kernel Option: test an option not in your menu.
3. At Option entry to test, select reminder managerRS MENU.
4. At Select Reminder Managers Menu Option, select DM Reminder Dialog Management.

5. At Select Reminder Dialog Management Option, select DI Reminder Dialogs.
6. At Select Item, select Next Screen//, select CV Change View.
7. At TYPE OF VIEW: R//, select e Dialog Elements
8. Select the appropriate element with the ICD in additional finding (for example, IM INFLUENZA DONE).
9. Press Enter at each prompt to bypass fields and stop at Select ADDITIONAL FINDINGS.

Note: ICD has been deleted.

Expected Results:

The ICD option is deleted from Finding Item and Additional Findings in Reminder Dialogs. Also, any ICD in Finding Item and Additional Finding has been removed in the dialogs. Taxonomies with ICD codes have been inactivated.

2.76 TT/A 1618/16256 – Imm – Deleting Contraindications API Not Being Called

Description:

Deleting Contraindications API is not being called. User believes the issue may be that EHR is not using the same PEP that BI uses, which is Contraindications. So the first step is to understand what calls EHR is making with regards Contraindications.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and create a new visit.
3. Go to Immunization/Contraindications.
4. Select a Contraindication if there is an existing one, or add a new one.
5. Click Delete.
6. Click Yes when the confirmation message appears.

7. Go to BI Patient Contraindications Delete file through Terminal Service.
8. Enter the patient name.
9. Select the Contraindication that was deleted from the list.
10. Verify it displays the reason for the contraindication, who it was deleted by, and the date/time for the deletion.

Expected Results:

The BI Patient Contraindications Delete file now contains an entry.

2.77 TT/A XXXX/16269 – Disable use of ICD pick list

Long Title:

TT/A XXXX/16269 – Must Disable the Use of ICD Pick List Component with the Introduction of EHR P13

Description:

Disable the ICD Pick List component, as that functionality was included in the new component build IPL.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the POV tab.

Expected Results:

The ICD Pick List has been disabled.

2.78 TT/A XXXX/16271 – Disable use of Problem Management component

Long Title:

TT/A XXXX/16271 – Must Disable Problem Management Component with the Release of EHR P13

Description:

Problem Management Component is being disabled with the release of EHR P13.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the CC/Probs tab.

Expected Results:

The Problem Management component is disabled with the release of EHR P13.

2.79 TT/A 1634/16309 – Duplicate SNOMED CT Concept Codes in IPL When Using the Get SCT Button

Description:

When using Get SCT button, it allows storage of two identical SNOMED CT codes IF the user adds a concept CT problem and then uses GETSCT for an item that will map to the same CONCEPT CT.

The issue is what should be done with the ICD-9 term that has not been converted IF a user adds that problem using the ADD button.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL.
4. Add a SNOMED CT code (diabetes for example).

5. Find the same problem (with the same SNOMED CT concept code) in IPL that has an asterisk (*).
6. Click the Get SCT button.

Expected Results:

A message displays to the user that duplicate SNOMED CT codes are not allowed to be added.

2.80 TT/A 1641/16313 – CCDA – Add statement that data may be omitted to documents

Long Title:

TT/A 1641/16313 – CCDA – Adding Statement to Top of Document Indicating that There Might Be Some Changes to the CCD

Description:

Currently, if you remove one item under a heading within CCDA, there is no indication of any change or anything being redacted. It is only when you remove a whole section that the CCDA will indicate Redacted. This could be a patient safety or legal issue for any health facility. So IHS would like to incorporate a change to the top of the header when the user clicks Finalize, so the header reads:

Clinical summary from Get Well Clinic – Some information may have been redacted at patients request or legal requirement.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Place the mouse pointer over the CCDA button.
3. Select Generate Clinical Summary for Current Selected Visit > Review/Customize.
4. Modify the generated CCDA by clearing any node in the CCDA tree view.

Expected Results:

Additional text is appended to the Document Title at the top of the CCDA Document (for example, some information may have been redacted at patient's request or legal requirement).

2.81 TT/A 1640/16337 – CCDA Help While In Customization Screen

Description:

The system shall provide online Help for a user who customizes the CCDA. Help is in form of a link to the online Help file section/hover/ or blurb. For information on this subject press F1 for online Help.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Click CCDA.
4. Select Generate CCDA for Visits/Referrals.
5. Once the Generate CCDA for Visits/Referrals window displays to select the visit, place the mouse pointer in the window to view the message about the online Help.
6. Press F1.
7. The IHS BGOCCDA Online Help displays.
8. Click the Close button to close the online Help.
9. Select a visit.
10. Once the CCDA-Clinical Summary window displays, place the mouse pointer in the window to view the message about the online Help.
11. Press F1. The IHS BGOCCDA Online Help Displays

Expected Results:

Context Sensitive Help enabled.

2.82 TT/A 1649/16338 – Display >1 visit instruction entries per visit in POV/IPL

Long Title

TT/A 1649/16338 – Display Multiple Visit Instruction Entries per Provider/Visit Content in POV and IPL

Description:

- Issue: If the provider enters more than one visit instruction to a problem on the same visit, only the most recent displays in POV and edit IPL dialog. All show in expand.
- Mission Impact: Duplicate visit notes will be entered by users because the first note is not viewable. Leads to data integrity and duplication of effort by EHR users of the IPL.
- Impact on other apps: None.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL.
4. Click Add to add a problem.
5. Search for a SNOMED CT code and select it.
6. Click the Use as POV button.
7. Add a visit instruction.
8. Sign the instruction.
9. Now add another visit instruction.
10. Sign the instruction.

Expected Results:

Both visit instructions display in the Add/Edit dialog box before and after saving as well.

2.83 TT/A 1584/16414 – ICD-10 – Quick Orders SNOMED CT with Mappings to ICD as Required

Description:

The system shall populate the Indication with SNOMED CT (current functionality as of EHRp13). Based on the date of the order, the system shall pass the mapped ICD-10 to the Lab and Pharmacy file. IF date of order is on or after 10/1/14, then it shall pass the mapped ICD-10 (if there are more than one then it shall pass the first code). If the date of order is prior to 10/1/14 then it shall pass the mapped ICD-9.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Meds tab.
4. Order a Quick Order on a date after the implementation date of ICD-10.
5. Select the Clinical Indication > Other.
6. Search for a SNOMED CT term.

Expected Results:

IF date of order is on or after the implementation date, then it shall pass the mapped ICD-10 (if there are more than one, then it shall pass the first code). If the date of order is prior to implementation then it shall pass the mapped ICD-9.

2.84 TT/A 1654/16443 – CIR – Reason for DC Displays as WRITTEN

Description:

The Reason for DC displays as WRITTEN no matter which reason for discontinue is selected.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the CIR.
4. Select the Medications tab.
5. Right-click a medication.
6. Select Discontinue.
7. Select a reason.
8. Accept all.
9. View the medication details.

Expected Results:

Verify the discontinued reason matches what was selected.

2.85 TT/A 1688; CR2874/16497 – IPL – Problems Entered on 1st Patient Appears on 2nd Patient POV

Description:

Changed the status of a problem for Patient A, then opened the record for patient B, selected a POV, wrote/signed a visit instruction the problem, edited on patient A, dropped into the problem list display, and even let tester select as POV when it was not really there.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.
3. Select IPL.
4. Highlight a problem.
5. Click Edit.
6. Change from Episodic to Chronic.
7. Select another patient and visit.
8. Highlight a problem.
9. Click the POV button.
10. Add a visit instruction.
11. Click Save.
12. Select a third patient and visit.
13. Highlight a problem.
14. Click the POV button.
15. Add a visit instruction.

Note: A problem from a previous patient's problems that was edited displays on the current patient. The user can set it as POV too erroneously. Once the user refreshes, the problem goes away.

Expected Results:

The problems cache now clears, and problems from another patient do not appear incorrectly.

2.86 TT/A 1695; CR2903/16567 – CCDA – Parameterize MAGUSER

Description:

- Add a parameter to contain the site-specified access and verify codes for MAGUSER,CCDA
- Use this parameter to set the `string aAccess` and `string aVerify`

ISSUE: Currently in order to store CCDA in VI, the system must create a user titled MAGUSER. The user name, access, and verify codes are hard-coded. Because sites could inadvertently set this up with permissions to access EHR, RPMS, and VI, this is not appropriate to be hard-coded.

Warning! This is a show-stopping security risk.

FIX: Change the hard coded access and verify codes to a site-set parameter. Change setup instructions to include minimum access to menus/keys required for CCDA to properly store.

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to Terminal Service.
2. Select Menu Management.
3. Select KEYS.
4. Select Allocation of Security Keys.
5. At Allocate key, type behoccdMAG.
6. At Holder of Key,: enter the user name.
7. Access programmer mode.
8. Type d^XUP.
9. At Select OPTION NAME, type behoccd MAG A_V CODES.
10. At Select CCDA VistA Imaging user, enter the user name.
11. Enter the Access and Verify codes for the user.
12. Log on to RPMS-EHR.
13. Select a patient and a visit.
14. Select CCDA>Generate for current date of service.
15. Print or Review/Customize.

Expected Results:

The hard-coded access and verify codes have been changed to a site-set parameter. Instructions have been set up to include minimum access to menus/keys required for CCDA to properly store.

2.87 TT/A 1697; CR2905/16575 – CIR: Chart Review Not Storing Properly Using CIR**Description:**

When the user does not perform any action, a Chart Review: Reviewed event is triggered for the user to sign. Additionally, a Clinical Action: Reviewed gets stored in the V Updated/Reviewed file once the event is signed.

When any action is performed (for example, add, change, edit, entered in error in Problems, Adverse Reaction, Medication Tab or Chart Review: Reviewed) an Updated Event is generated, and only the reviewed event requires a signature.

In the V Updated/Reviewed file an Updated Clinical Action and an additional Reviewed Clinical Action is stored.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select CIR.
4. Click Accept ALL.
5. Sign the CIR events.
6. Note that the Chart Review button turns green with [R] on it.
7. Repeat a similar scenario, but perform an individual tab Accept in CIR.
8. Repeat the scenario and make a change to a problem/meds/allergies.
9. Then do an Individual Accept for each tab.

10. Repeat the scenario making a change on problem/meds/allergies and do Accept All.

Expected Results:

When the user does not perform any action, a Chart Review: Reviewed event should be triggered for the user to sign. And then a Clinical Action: Reviewed gets stored in V Updated/Reviewed file once the event is signed.

When any action is performed, such as add, change, edit, entered in error in Problems, Adverse Reaction, Medication Tab, Chart Review: Reviewed, an Updated Event is generated, and only the reviewed event requires a signature.

In the V Updated/Reviewed file an Updated Clinical Action and an additional Reviewed Clinical Action is stored.

2.88 TT/A 1193/16610 – Clinical indication prompt exposed on renewal inappropriately

Long Title:

TT/A 1193/16610 – The Clinical Indication Prompt is Exposed for a Renewal for a Client That Has Not Ever Been Set to YES at Site

Description:

The Clinical Indication (CI) prompt is exposed for a renewal for a client that has not ever been set to YES at a site.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to Terminal Service.
2. Enter Test an option not in your menu.
3. Enter Enable Clinical Indicator Prompt.
4. Select 900 System.
5. At Select Package: Enter Outpatient Pharmacy.
6. At the Enabled field: set to NO.

7. Log on to RPMS-EHR.
8. Select a patient and a visit.
9. Order an Outpatient Medication.

Note: The user is not prompted to select a CI as expected.

10. Sign the order.
11. Right-click and select Renew.

Expected Results:

The user is not prompted to select a CI when it is not enabled.

2.89 TT/A 1700/16613 – IPL – Search

Description:

Client is concerned about the where the SRCH* subsets are being passed in. This is going to cause any new SRCH subset to not be displayed unless the user generates a new GUI every time a SRCH* subset is added.

This is still hard-coded and NOT passing the SRCH* subsets. Should not be hardcoded.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL.
4. Select the Add button to add a problem.
5. Search for a SNOMED CT term.

Expected Results:

The default subset is retrieved from the BGOSNLK GETSUB RPC Call.

2.90 TT/A 1699; CR2912/16614 – IPL – Non-Mapped SNOMED CT .9999 POV Error

Description:

When user selects a non-mapped SNOMED CT, it adds .9999. This is not a huge problem, but if the user does select, and then chooses POV, it gives a message that is not found (or something similar).

Click OK and it then adds it to IPL, but does not set as POV. But if the user then highlights it on the IPL, and clicks the POV button, it will set as POV.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the IPL.
4. Select the Add button.
5. Search for a SNOMED CT term that is .9999 and select it.
6. Click Use as POV.
7. Click Save.

Expected Results:

The problem is saved as .9999, and saved as POV.

2.91 TT/A 1784/16845 – SNOMED CT Set in QO Not Storing Properly

The SNOMED CT set in QO is not storing properly.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to Terminal Service.
2. At Select an Option, enter Test.
3. Enter CPRS Configuration (CAC).
4. Select MM Order Menu Management.
5. Select QO Enter/Edit Quick Orders.
6. Add a Quick Order name.
7. At the Indication prompt, search for a SNOMED CT term.
8. Place the order.
9. Add the Quick Order to a menu.
10. Log on to RPMS-EHR.
11. Select a patient and a visit.
12. Select the Meds tab.
13. Select the Quick Order.

Expected Results:

The clinical indication appears and the user can accept the order without issues.

2.92 TT/A 1781/16847 – CCDA Index Out-of-Bounds Error for Pending Visits Without Check-In

The Cherokee facility is receiving the Index Out-of-Bounds errors. Medsphere has researched the issue and discovered that when there is a pending visit, there is not an iEn associated with the visit, therefore an error occurs. A workaround is to use the Clinical Summary (and not the ToC) at this point.

The RPC was changed to accept a new parameter. The GUI now needs to be changed as well to send the whole parameter string. Currently, it is only sending the first parameter (the DFN). The 6th parameter needs a 1 in it if the pending check-ins are to be ignored:

```
VISITLST^BEHOENCX(DATA,DFN,BEG,END,LOC,SCEXC,IGPFLG);EP
```

Impact:

Medium

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS.
2. Navigate to the Scheduling/Appointments menu.
3. Make an appointment for a patient with other existing visits, but do not check the patient in (alternately, may use the WI option, and delete the check-in Date/Time when that prompt appears in the WI process).
4. Log on to RPMS-EHR.
5. Select the patient from above.
6. Select a visit other than the pending, check-in one.
7. Click on the CCDA button.
8. Select Generate Transition of Care for Current Selected Visit.

Expected Results:

No index out-of-bounds error occurs.

2.93 TT/A 1798; CR3099/16918 – Vital Sign Entry Defect

This is a patient safety issue.

If a user has not moved from the Vital Entry tab, it cannot be reproduced. The following is how to reproduce it.

If weight and/or height are entered improperly, this affects medication dosing, body surface area measurements, etc. This can contribute to sentinel events.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to Terminal Service.
2. Enter Test an option not in your menu.

3. Enter XPAR EDIT PARAMETER.
4. Enter BEHOVM DEFAULT UNITS.
5. Select 500 Division.
6. Select the institution.
7. Select the Measurement Type, Weight.
8. Set the Default Units to Metric.
9. Log on to RPMS-EHR.
10. Select a patient and a visit.
11. On the Review tab, right-click under Vitals.
12. Click Enter Vitals.

Note: The user is taken to the Vitals component.

13. Select the default units drop down to be US.
14. Enter a weight.
15. Select the Review Tab.
16. Select a different patient.
17. On the Review tab, right click under Vitals.
18. Click Enter Vitals.

Note: The user is taken to the Vitals component.

19. Enter vitals.

Expected Results:

Vital measurement displays the Default Units, not the units that were selected for the previous patient.

2.94 TT/A 1803; CR3131/16953 – Sign All Function Inoperable/Signature Tool

If a user clicks Don't Sign, the Integrated Signature tool subdues and is not actionable.

If a user clicks Cancel, it remains actionable. It also grays out if the user adds Care Planning, clears the Orders checkbox, and signs Care Planning.

The Integrated Signature button is being invoked when storing the selections from the POV dialog box, even when there is no Care Planning to sign, and this is what is causing the many of the issues here.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Notes tab.
4. Select New Note.
5. Enter some data or select a template.
6. Select the Meds tab.
7. Order a few drugs and sign the order.
8. Select the Orders tab.
9. Order a Lab and accept the order.
10. Click Chart Review for Allergies and mark Reviewed.
11. Select the Sig Tool.
12. Click Cancel.

Note: The note can still be edited

13. Select the IPL component.
14. Highlight a problem and click POV.
15. Do not add any data and click Save.

Note: This process invokes the Sig Tool (Known Issue) and note, and Chart Review is absent in the Sig Tool.

16. Select the Sig Tool.

Note: The note is missing, despite still being editable (so it should be included).

17. Click Cancel.

Expected Results:

The Signature Tool retains all items that need to be signed.

2.95 TT/A CR3388/16975 –Lab tab: Micro few Multiples Inappropriately when Selecting Date Range

Long Title:

TT/A CR3388/16975 – Lab: Micro View on Lab Tab Multiplies the Display When Selecting the Date Range

As client changes the Date Range on the Lab Results for Microbiology, the results that display begin to repeat themselves making it appear there are multiple results, when there is only one.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient who has some Microbiology results on the chart.
3. Select a visit.
4. Go to Labs tab.
5. Select Microbiology under the Lab Results tree view.
6. Notice it displays the Microbiology results.
7. In the Date Range field, select Six Months Back from the tree view.
8. Select One Year Back.

Expected Results:

Lab results should not repeat when displaying by date range.

2.96 TT/A CR3440/17036 –IPL: 2 ICD codes change to same when set as POV

Long Title:

TT/A CR3440/17036 – IPL: Problem with Two ICD Codes Changing to the Same Code When Setting as POV

When setting two ICD codes as POV from the right-click option on IPL, it changes ICD so both store as same POV on the Visit diagnosis.

Note: This does not occur if you use Edit and Save, or EDIT, Change Dialog, and Save.

Impact:

High

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Go to IPL.
4. Enter a problem of Diabetic Renal Disease.
5. Set as POV. The system appropriately stores and displays two different ICD codes on the grid.
6. Now select a problem again and right-click it.
7. Select POV.
8. Save the POV dialog box.
9. Go to Visit Diagnosis.

Expected Results:

Verify the systems displays two different ICD codes on each row, and that it did not change both as same (250.40).

2.97 TT/A 1847; CR3923/17102 – Suicide Form Bringing in Entries for Other Patients

- Client has two examples of patients who were returning multiple suicide forms, and the information did not belong to that patient.
- The problem has been identified as being caused by lines 6 and 7 in the BGU GENLIST call below. Line 6 returns 1029, which is the IEN of the patient displayed. Line 7 shows 1029, which causes it to return anything with a patient IEN of 1029, 1029x, 1029xx, etc.
- It can be seen in the results of the call that the IEN of the first suicide form returned is 1029 (the correct patient), but the second is for IEN 102923 (a different patient). When we look at the patient with IEN 102923, the correct form (and only that form) displays. RPMS correctly displays only one form for this patient.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient.
3. Select the Suicide component.
4. Click New Form
5. Complete all fields
6. Click Save.

Note: The suicide form is saved.

7. Select the Suicide form (Non-Patient Centric).

Expected Results:

All suicides for the time frame display.

2.98 TT/A 1900; CR4051/17418 – Info Button, Clinical Key: Broken UpToDate Link

Long Title:

TT/Artifact 1900; CR4051/17418 – Info Button – Clinical Key – Users Taken to Broken UpToDate Link

Client reports that after the initial fix of Clinical Key from UpToDate, the Clinical Key is still not working in EHRp13 at sites. Working as designed in EHRp14. When highlighting a problem and clicking the “I” button, the user is taken to the Web Reference dialog box, which is pre-populated with the problem highlighted.

Impact:

Low

Area Affected:

EHR

Steps to Validate:

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the Meds tab.
4. Highlight a drug.
5. Click the Info button
6. Select the Labs tab.
7. Highlight a lab.
8. Click the Info button.
9. Select the IPL component.
10. Highlight a problem.
11. Click the Info button.

Expected Results:

The Web Reference search is launched when selecting the Info button.

3.0 EHR Component Versions

Filename	Current Version	New Version
ABCpdf.dll		7.0.3.9
ABCpdf5.dll		5.0.0.8
ABCpdfCE7.dll		7.0.3.9
BEHAlerts.ocx	4.2.3.1	
BEHAllergies.chm		08/02/2012
BEHAllergies.ocx	4.2.4.2	4.2.4.54
BEHAntiCoag.chm		08/24/2012
BEHAntiCoag.dll	1.1.0.10	1.1.4955.23154
BEHARTEntry.chm		08/02/2012
BEHARTEntry.dll	2.0.3.6	2.0.4.14
BEHC32Button.dll	1.0.1.0	1.0.3.16
BEHC32Client.dll	1.0.1.0	1.0.3.8
BEHC32Support.dll	1.0.0.3	1.0.3.11
BEHC32TcpService.dll	1.0.1.0	1.0.3.13
BEHCCDA.chm	11/04/2013	04/28/2014
BEHCCDA.dll	1.0.5211.33494	1.0.5261.18176
BEHCCDA.XmlSerializers.dll		1.0.4970.28265
BEHCCDC32.dll	1.0.1.0	1.0.3.10
BEHChartReview.chm		08/02/2012
BEHChartReview.dll		1.1.0.15
BEHCIR.chm	12/18/2013	01/15/2014
behCIR.dll	1.0.5212.22236	1.0.5296.26118
BEHCommunityInfo.dll	1.0.0.62	1.1.0.63
BEHConsultOrders.ocx	4.2.3.2	
BEHConsults.chm	01/27/2014	04/9/2014
BEHConsults.ocx	20.1.3.3	
BEHContextAdapter.ocx	4.2.3.2	
BEHCPRS20.bpl	1.0.14.54	1.0.14.55
BEHCrises.chm		09/10/2012
BEHCrises.ocx	4.2.3.1	
BEHCWAD.ocx	4.2.5.4	4.2.5.6
BEHDCSumm.chm		08/02/2012
BEHDCSumm.ocx	20.1.3.3	
BEHDictate.ocx	1.2.1.1	
BEHDosingCalc.dll	1.2.0.0	1.3.0.3
BEHEncounterInfo.chm		08/02/2012
BEHEncounterInfo.ocx	4.2.1.1	
BEHESigReview.ocx	20.1.1.3	
BEHESigService.dll	20.1.3.16	
BEHHSReport.ocx	1.0.1.1	
BEHInfoBtnSvc.dll	1.1.4961.22167	1.1.5367.16976

Filename	Current Version	New Version
BEHIntervention.chm		09/04/2012
BEHIntervention.dll		1.1.0.8
BEHIPL.chm	03/19/2014	04/16/2014
BEHIPL.dll	1.1.0.21436	1.1.0.21443
BEHKmrButton.dll	1.0.1.0	1.0.3.11
BEHLab.chm	3/19/2014	04/22/2014
BEHLab.ocx	20.1.3.2	
BEHLabOrders.chm		08/02/2012
BEHLabOrders.ocx	4.2.3.2	
BEHLabPOC.dll	1.0.4028.20775	1.0.5002.21863
BEHMedList.chm		08/02/2012
BEHMedList.ocx	4.2.2.1	4.2.3.20
BEHMeds.chm		4/17/2013
BEHMeds.ocx	20.2.2.2	
BEHNotes.chm		09/05/2012
BEHNotes.ocx	20.1.3.13	
BEHNotifications.chm		08/03/2012
BEHNotifications.ocx	5.1.6.8	5.1.6.11
BEHOptions.dll	1.1.2.4	1.1.3.4
BEHOrders.chm		04/23/2013
BEHOrders.ocx	20.1.2.2	27.1.0.5
BEHPatientGoals.chm		09/04/2012
BEHPatientGoals.dll	1.0.4353.28294	1.0.4636.22384
BEHPatientID.chm		08/03/2012
BEHPatientID.ocx	4.2.1.1	
BEHPharmED.chm		08/27/2013
BEHPharmED.ocx	1.0.2.2	1.0.3.2
BEHPrimaryCare.ocx	4.2.1.4	
BEHProblemList.chm		08/03/2012
BEHProblemList.ocx	4.2.3.2	4.2.4.13
BEHPtDetail.ocx	4.2.3.1	
BEHQOWizard.ocx	1.1.4.20	1.1.4.24
BEHReminders.chm		08/23/2012
BEHReminders.ocx	4.2.3.1	
BEHRemindersView.chm		08/28/2012
BEHRemindersView.ocx	4.2.3.1	4.2.3.2
BEHRemoteData.ocx	4.2.2.1	
BEHRemoteViews.dll	4.2.1.2	
BEHReports.chm		09/10/2012
BEHReports.ocx	20.1.3.1	
BEHRxGenerator.dll		1.0.0.60
BEHSNMDSvc.dll		1.0.5030.31338
BEHSpellCheck.dll	1.0.2.2	
BEHStroke.chm		10/29/2013

Filename	Current Version	New Version
BEHStroke.dll	1.0.5144.36204	1.0.5150.31685
BEHSurgery.ocx	20.1.3.1	
BEHVisits.chm		08/16/12
BEHVisits.ocx	5.0.4.1	
BEHVitalEntry.chm		08/28/2012
BEHVitalEntry.dll	2.0.5.26	2.0.5.28
BEHVitals.chm		08/28/2012
BEHVitals.ocx	5.0.4.1	5.0.4.8
bgoAMI.chm		10/24/2013
BgoAMI.dll	1.0.5144.36209	1.0.5154.21301
bgoFamHx.ocx	1.0.0. 679	1.0.0.684
CCD.xsl		2/2/2011 11:41AM
CMS.dll	1.3.4.5	
CSS.dll	1.7.6.1	1.7.7.1
CSSEncounter.dll	4.3.5.10	4.3.6.1
CSSPatient.chm		08/17/2012
CSSPatient.dll	4.3.5.2	
CSSSite.dll		4.3.0.13
CSSUser.dll	4.3.1.2	
dclofficexp70.bpl		7.0.1.569
EHR_Shortcut_Interactive_3.4.msi	11/23/2009	
EHR_Shortcut_Silent_3.4.msi	11/23/2009	
IHS.ImageViewer.dll	1.0.5149.24899	1.0.5280.15581
IHS_BEH_MDAO_FORMS.dll	1.1.3565.24256	
IhsBgoActivityTime.chm		08/29/2012
IhsBgoAsthmaZones.chm		09/05/2012
IhsBgoAsthmaZones.dll	1.0.0.3	1.1.0.7
IhsBgoChiefComplaint.chm		08/23/2012
ihsBgoE&M.chm		09/05/2012
ihsBgoE&M.ocx	1.1.0.203	
IHSBgoExams.chm	08/01/2013	04/09/2014
IHSBgoExams.ocx		1.1.0.376
IhsBgoEyeExam.chm		09/06/2012
IhsBgoEyeExam.dll		1.1.0.9
IHSbgoFamHX.chm	10/01/2013	04/09/2014
IhsBgoHealthFactors.chm	08/30/2012	01/27/2014
IhsBgoHealthFactors.ocx	1.2.0.1	1.2.0.5
IhsBgolcdPickList.chm		09/05/2012
IhsBgolcdPickList.ocx	1.2.0.79	
IhsBgolmmunization.chm	09/13/2013	03/27/2014
IhsBgolmmunization.ocx	1.2.0.191	1.2.0.193
IhsbgoInfantFeed.chm		8/16/2013
IhsbgoInfantFeed.ocx	1.2.0.161	1.2.0.218
IhsBgoltems.chm		09/05/2012

Filename	Current Version	New Version
IhsBgoItems.ocx	1.2.0.50	
IhsBgoPatientED.chm	10/23/2013	3/27/2014
IhsBgoPatientED.ocx	1.2.0.247	1.2.0.256
IhsBgoPovHistory.chm	09/06/2013	03/19/2014
IhsBgoPovHistory.ocx	1.2.0.49	1.2.0.50
IhsBgoProblem.chm		09/06/2012
IhsBgoProblem.ocx	1.2.0.56	1.2.0.82
IhsBgoProceduresViewer.chm		09/06/2012
IhsBgoProceduresViewer.ocx	1.2.0.58	1.2.0.94
IHSbgoRepFactors.chm		09/07/2012
IHSbgoRepFactors.ocx	1.2.0.56	1.2.0.158
IHSbgoRepHist.chm		09/12/2013
IHSbgoRepHist.ocx	1.2.0.55	1.2.0.83
IhsBgoSkinTest.chm		08/19/2013
IhsBgoSkinTest.ocx	1.2.0.95	1.2.0.140
IhsBgoSkinTest.ocx		1.2.0.140
IhsBgoTriageSummary.chm		09/07/2012
IhsBgoVcDate.ocx		1.1.0.61
IhsBgoVCPT.chm		09/06/2012
IhsBgoVCPT.ocx	1.2.0.44	1.2.0.63
IhsBgoVCPT.ocx	1.2.0.68	1.2.0.73
IhsBgoVPOV.chm	09/06/2013	03/19/2014
IhsBgoVPOV.ocx	1.2.0.46	1.2.0.51
ImageViewer.chm		12/16/2013
IndianHealthService.SNOMEDCTSearch.dll		1.0.0.7
Infragistics2.Excel.v10.3.dll		10.3.20103.1000
Infragistics2.Shared.v10.3.dll		10.3.20103.1000
Infragistics2.Win.Misc.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinDock.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinEditors.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinEditors.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinGrid.ExcelExport.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinGrid.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinListBar.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinListView.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinPrintPreviewDialog.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinStatusBar.v10.3.dll		10.3.20103.1000
Infragistics2.Win.UltraWinToolbars.v10.3.dll		10.3.20103.1000
Infragistics2.Win.v10.3.dll		10.3.20103.1000
Interop.ABCpdf5.dll		1.0.0.0
Interop.BEHESigService.dll		1.1.0.10
Interop.CSS_ Encounter.dll	4.3.0.0	
Interop.CSS_ Patient.dll	4.2.0.0	
Interop.CSS_ Site.dll		4.3.0.13

Filename	Current Version	New Version
Interop.ISI_Fetch_Service.dll		1.0.0.0
ISI_Fetch_Service.dll		1.0.0.1
Lab_POC_Data_Entry.chm	10/01/2013	04/07/2014
MaglImportXControl1.ocx	30.50.135.9	30.1.108.3
Microsoft.Practices.Composite.dll		2.0.1.0
Microsoft.Practices.Composite.Presentation.dll		2.0.1.0
Microsoft.Practices.Composite.UnityExtensions.dll		2.0.1.0
Microsoft.Practices.ObjectBuilder2.dll		2.2.0.0
Microsoft.Practices.ServiceLocation.dll		1.0.0.0
Microsoft.Practices.Unity.dll		1.2.0.0
PG.Infrastructure.dll		1.0.4353.29274
PG.Modules.DataAccess.dll		1.0.4353.29281
PG.Modules.History.dll		1.0.4353.29282
PG.Modules.Task.dll		1.0.4353.29288
PGUserControl.dll		1.0.0.0
PrintHook32.dll		1.0.0.7
PrintHook64.dll		1.0.0.7
RaizeComponentsVcl70.bpl	4.3.2	
RaizeComponentsVclDb70.bpl	4.3.2	
Readme.txt	2/6/2008	
SuicideForm.dll	1.1.3908.22749	1.1.4300.3
System.CoreEx.dll		1.0.2563.0
System.Interactive.dll		1.0.2563.0
System.Observable.dll		1.0.2563.0
System.Reactive.dll		1.0.2563.0
System.Threading.dll		1.0.2563.0
Telerik.Windows.Controls.dll		2011.1.223.35
Telerik.Windows.Controls.Docking.dll		2011.1.223.35
Telerik.Windows.Controls.GridView.dll		2011.1.223.35
Telerik.Windows.Controls.Input.dll		2011.1.223.35
Telerik.Windows.Controls.Navigation.dll		2011.1.223.35
Telerik.Windows.Data.dll		2011.1.223.35
vcActiveForms.bpl	2.1.4.2	
vcActiveForms.dll		1.3.0.1
vcBroadcast.dll	4.2.1.1	
vcChatService.dll	1.0.2.1	
vcChronicPainMU.ocx	1.1.2.1	
vcChronicPainPM.ocx	2.1.2.3	
vcChronicPainRP.ocx	1.1.2.2	
vcCommon.dll	1.1.5100.17412	1.1.5128.27598
vcCommon20.bpl	2.0.6.2	2.0.7.0
vcControls.bpl	2.1.4.2	
vcControls.dll		1.0.0.0
vcDate.dll	1.0.3.1	

Filename	Current Version	New Version
vcFMDC.bpl	1.4.3.2	
vcFMDS.bpl	1.0.2.2	
vcExplorer.ocx	4.3.3.1	
vcImage.ocx	4.1.1.1	
vcImaging70.bpl	1.0.2.39	1.0.2.45
vcImagingSvc.dll	1.0.0.7	
vcIniConfig.exe	1.1.1.38	
vcLauncher.ocx	4.1.4.1	
vcldb70.bpl		7.0.8.1
vcManager.exe	1.5.8.24	
vcManagerApplet.cpl	1.5.8.22	
vcPatPhoto.ocx	4.1.3.2	
vcPrint.dll	1.1.4.4	
vcQuickNote.bpl		1.1.2.8
vcQuickNote.chm		09/06/2012
vcQuickNote.lic		
vcQuickNote.ocx	1.1.2.6	1.1.3.3
vcRPCB_R70.bpl	1.6.5.26	1.6.6.1
vcSafeMed.dll	1.0.2804.16720	
vcTelnet.ocx	1.1.2.1	1.1.2.6
vcUpdaterService.exe	1.2.1.1	
vcUpdaterService_Interactive_1.2.msi	2/7/2008	
vcUpdateService_Silent_1.2.msi	2/7/2008	
vcWHealthMF.ocx	1.1.3.1	
vcWHealthMR.ocx	1.1.3.1	
vcWHealthPM.ocx	1.1.3.1	
VIM.chm		08/09/2012
VIM.exe	1.7.6.1	
VueCentric.exe	3.4.1.2	
xml.xsl		2/2/2011 11:41AM

Acronym List

AMI	Acute Myocardial Infarction
BMI	Body Mass Index
BMIP	Body Mass Index Percentile
CAC	Clinical Application Coordinator
CCDA	Consolidated Clinical Document Architecture
EHR	Electronic Health Record
ICD	International Classification of Diseases
IHS	Indian Health Service
IPL	Integrated Problem List
LKW	Last Known Well
MU	Meaningful Use
PCC	Patient Care Component
POV	Purpose of Visit
RPMS	Resource and Patient Management System
SNOMED CT	Systematized Nomenclature of Medicine-Clinical Terms
ToC	Transition of Care
TT/A	TeamTrack/Artifact

Contact Information

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

Phone: (888) 830-7280 (toll free)

Web: <http://www.ihs.gov/helpdesk/>

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