RESOURCE AND PATIENT MANAGEMENT SYSTEM

Electronic Health Record

(EHR)

Release Notes

Version 1.1 Patch 14
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Office of Information Technology
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Table of Contents

1.0   Introduction

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

TeamTrack/Artifact Priority Classification

Indian Health Service (IHS) issues are classified by priority as follows:

- **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/Changes

The following section provides information regarding enhancements and changes made to the Resource and Patient Management System (RPMS) as part of this TeamTrack Patch release.

2.1   TT/Artifact 1077/12539

Unable to Delete Family Planning Method

2.1.1   Description

The issue of the ability to logically delete the Family Planning Method (FPM) was discussed with the client's Women's Health Group. It was agreed that a Patient Care Component (PCC) change is required, so for now, nothing will change. They would like to include instructions on how to use the same Start and End Dates, and enter the comment of Entered in Error to remove FPMs entered in error from view.

The ability to logically delete in a future patch will be added. Medsphere will schedule the EHR-side fix once we know when this change can be done (can wait for next patch).

In the meantime, sites will be advised to enter the same start and end date for an erroneous entry, and enter a comment Entered in Error.

2.1.2   Impact

Medium

2.1.3   Area Affected

EHR

2.1.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a female, adult patient.

3. Select a visit.

4. Select the **Wellness** tab.

5. Select **Reproductive Factors**.

6. In the **Family Planning** field, click **Review-Update**.

7. In **Review/Update of Family Planning Methods**, click **New**. A **Delete** button is added on that screen.

8. Add a new **FPM**.

9. Click **Save**.

10. Verify the FPM was saved and displays in the **Family Planning** pane.

11. Click **Review/Update** again.

12. Select the row where it was saved.

13. Click **Delete**.

2.1.5   Expected Results

Verify that the FPM was deleted without any issues.

2.2   TT/Artifact 1021/12643

ICD-10: Triage Summary – SNOMED CT Patient Education Capture

2.2.1   Description

Incorporate SNOMED CT®. Change so Patient Education changes display instead of P13 SNOMED CT VALUES.

2.2.2   Impact

Medium

2.2.3   Area Affected

EHR

2.2.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Wellness** tab.

4. Click **Add from Education**.

5. Select the **Disease & Topic Entry** option button.

6. Enter text in the **Disease/Illness** search field.

7. Click the Ellipsis button or select one of the items in **POV** field.

8. Select **Topic**.

9. Click **OK**.

10. Click **Add**.

11. Select the **CC/Probs** tab.

12. View the **Triage Summary**.

2.2.5   Expected Results

The **Triage Summary** displays the Education Description and topic, rather than the SNOMED CT and topic.

2.3   TT/Artifact 1026/12648

ICD-10: Superbill for Associations with ICD-10 Diagnostic and Procedures

2.3.1   Description

Users will not be allowed to store an association with International Classification of Diseases (ICD)-10 if the visit selected is prior to 1 Oct 2014. Both ICD procedure and ICD diagnosis are allowed, so both must be updated to ICD-10 if the visit is on or after 1 Oct 2014.

The ICD procedure must be updated, with the ICD diagnosis option changed to a SNOMED CT option, and also disallow the association of a diagnosis code to a Current Procedural Terminology (CPT).

2.3.2   Impact

Medium

2.3.3   Area Affected

EHR

2.3.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient.

3. Select an open visit prior to 10/1/14.

4. Select the **Superbill** tab.

5. Select the Superbill category.

6. Select an item with ICD-10 diagnosis association. A message displays: **You may not use this diagnosis for this visit date, please assign POV from the IPL.**

7. Uncheck the ICD Diagnosis associated.

8. Click **OK**.

9. Verify other associations are stored.

10. Select another open visit after 10/1/14.

11. Select the Superbill Category.

12. Select an item with an ICD-9 diagnosis association. A message displays: **You may not use this diagnosis for this visit date, please assign POV from the IPL.**

13. Uncheck **ICD Diagnosis associated**.

14. Click **OK**.

15. Verify other associations are stored.

2.3.5   Expected Results

If Visit Date is after 10/1/2014 and the selected Superbill has an ICD-9 diagnosis, or if the Visit Date is prior to 10/1/2014 and the Superbill selected has an ICD-10 associated, the user should be presented with the message: **You may not use this diagnosis for this visit date, please assign POV from the IPL.**

The ICD-9 or ICD-10 diagnosis is not stored, but any other associations should store as appropriate.

2.4   TT/Artifact 1333/14080

eRx: Change Process Icon for Failed eRx

2.4.1   Description

Client would like a new icon to indicate a failed eRx change process.

2.4.2   Impact

Medium

2.4.3   Area Affected

EHR

2.4.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Meds** tab.

4. Search for a drug and select a free-text dose.

5. Select **Outside Pharmacy** – eRX.

6. Select a pharmacy.

7. Select a clinical indication.

8. Accept and sign the order.

> **Note:** A notification is sent that the order fails to complete
> AutoFinish.

2.4.5   Expected Results

Process icon is a clinic icon and not a printer icon.

2.5   TT/Artifact 1334/14083

eRx: Change Name of Queue Print Button

2.5.1   Description

Change the name of the queue print button to Print New Items. Include a specific
indicator regarding the number of prescriptions in the queue in a parenthetical. The
blue of this indicator corresponds to the same blue color of unsigned prescriptions.

2.5.2   Impact

Medium

2.5.3   Area Affected

EHR

2.5.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Order an eRX medication.

4. Sign the order.

2.5.5   Expected Results

The queue print button is now called **Print New Items**, including a specific indicator regarding the number of prescriptions in the queue.

2.6   TT/Artifact 1335/14088

eRx: Selecting Items in Print New Items

2.6.1   Description

Client would like the ability to select items in the Print New Items window by using check marks next to each prescription.

2.6.2   Impact

Medium

2.6.3   Area Affected

EHR

2.6.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Meds** tab.

4. Click **New**.

5. Order an eRX drug.

6. Select a Clinical Indication.

7. Select a pharmacy.

8. Sign the order.

9. Click **Print New Items**.

2.6.5   Expected Results

Check marks display allowing the user to print specific prescriptions.

2.7   TT/Artifact 1374/14433

Anticoag – N/A in INR

2.7.1   Description

Currently in PCC data entry, the user cannot enter No for Warfarin indicated, and N/A is not a choice for an INR goal. So users are entering Other and INR of 1 and 1 is stored.

The system shall enable entry of N/A for INR in the Anticoag component. This requires BJPC P10 v files changes.

2.7.2   Impact

Medium

2.7.3   Area Affected

EHR

2.7.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Anitcoag** tab.

4. Click **Add**.

5. Click **Warfarin indicated: NO**.

6. In the **INR Goal** field, **N/A** is defaulted.

7. Complete the other required fields.

8. Click **Save**.

2.7.5   Expected Results

When Warfarin Indicated is defined as No, the INR Goal field is defined as N/A automatically. Once saved, the INR Goal column shows N/A, and the Min/Max column is null.

2.8   TT/Artifact 1494/15634

Add SNOMED CT to Superbill Association

2.8.1   Description

Add SNOMED CT to Superbill Association. This will require that the system checks the Integrated Problem List (IPL) to see if Concept ID exists on Active Problem List:

- If so, adds **Used as POV** to that problem

- If not stores as **Episodic** and adds **Used as POV**

2.8.2   Impact

Low

2.8.3   Area Affected

EHR

2.8.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Superbill** tab.

4. Select a Superbill Category.

5. Select an item with an associated SNOMED CT Diagnosis.

6. Select the **IPL** tab.

7. View the patient's Active Problem list.

2.8.5   Expected Results

If the Superbill's Associated SNOMED CT exists in IPL, the problem is marked as **Use as POV**. If the problem does not exist, it is added as **Episodic**, and marked as **Use as POV**.

2.9   TT/Artifact 1499/15871

Quick Order Bug in Non-VA and Unit Dose Meds No Longer Marked as Outpatient

2.9.1   Description

If a drug is not marked for Outpatient, Quick Order should not work. MSC commented that not sure how this can be prevented, as it is basically behaving like a free-text order, since no dispense drug for the quick order.

2.9.2   Impact

Medium

2.9.3   Area Affected

EHR

2.9.4   Steps to Validate

1. Log on to Terminal Service.

2. Enter Test an option not in your menu.

3. Enter **CPRS Configuration**. (This is normally done by a Clinical Application Coordinator (CAC)).

4. Create a Quick Order for a drug marked as X and U.

5. Enter **DRUG ENTER/Edit**.

6. Unmark a drug for an outpatient.

7. Log on to RPMS-EHR.

8. Select a patient and a visit.

9. Order the Quick Order.

2.9.5   Expected Results

Outpatient medication order is created with orderable only and no dispense drug.

2.10   TT/Artifact 1509/15887

Anticoag – Error on Entering Maximum Character Limit in the Comment Field

2.10.1   Description

User is receiving an error message when entering an Anticoag comment consisting of the maximum character limit.

2.10.2   Impact

Low

2.10.3   Area Affected

EHR

2.10.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and an active visit.

3. Select the **Anticoag** tab.

4. Click **Add**.

5. Enter data in the required fields.

6. Enter a long text that is up to the character limit in the **Comment** field.

7. Click **Save**.

2.10.5   Expected Results

No error occurs when saving an Anticoag entry with a long comment (up to the max character limit).

2.11   TT/Artifact 1510/15888

Anticoag – INR Goal Min and Max Field Populated with 1 (From EHRp13)

2.11.1   Description

EHRp13 Issue – When saving an INR goal, the Min and Max fields are populated with 1.

2.11.2   Impact

Low

2.11.3   Area Affected

EHR

2.11.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Anticoag** Tab.

4. Click **Add**.

5. Select **Warfarin indicated** as **NO**.

6. Verify the **INR Goal** is **N/A**.

7. Define **Duration of Therapy**.

8. Click **Save**.

2.11.5   Expected Results

When Warfarin Indicated is set to NO, INR Goal is defined as N/A, and Min/Max is null.

2.12   TT/Artifact 1562; CR02242/15926

Stroke – Add Stroke Symptom Dialog – Organization/Navigation (Usability)

2.12.1   Description

Client would like to add a Stroke Symptom dialog to improve organization and navigation. Currently, users must scroll through hundreds of terms. Client prefers ability to see in alpha and in columns, and jump to entries (like the old picklists).

2.12.2   Impact

Low

2.12.3   Area Affected

EHR

2.12.4   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 **Onset Date/Time**.

6. Click + to add a symptom.

2.12.5   Expected Results

The picklists are seen in alpha and in columns, and jumps to entries (like the old picklists).

2.13   TT/Artifact 1580/15951

ICD-10: Adding Fields to Identify ICD-9 versus ICD-10 in GO CPT PREFERENCES FILE Associations Sub-Sub File (90362.3121)

2.13.1   Description

For ICD-10, Medsphere is adding fields to identify ICD-9 vs ICD-10 in the BGO CPT PREFERENCES FILE Associations sub-sub file (90362.3121).

2.13.2   Impact

Medium

2.13.3   Area Affected

EHR

2.13.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select the **Services** tab.

3. Click the **Superbills** button.

4. Select a **Category** from the list.

5. Select a Superbill item.

6. Click **Edit**.

7. Click **ADD** in the **Associations** field.

8. Select SNOMED DX.

9. Search for a SNOMED term (for example, Asthma or Tuberculosis).

10. Select a term with a Mapped ICD.

11. Click **Select**.

12. Select an ICD procedure from the list or search for an ICD procedure.

13. Click **Select**.

14. Click **OK**.

15. Click **Exit**.

16. Log on to Terminal Service.

17. At Select **IHS Kernel Option**, select **VA FileMan**.

18. At the "OUTPUT FROM WHAT FILE" prompt, type **BGO CPT PREFERENCES**.

19. At Select BGO CPT PREFERENCES NAME, enter the name of the Superbill Category used in Step 4 above.

20. View the SNOMED DX Association.

2.13.5   Expected Results

Associated SNOMED CT and SNOMED CT DESCRIPTIVE CODE are stored, as well as the ICD-10 Diagnosis Code.

2.14   TT/Artifact 1582/15952

ICD-10: Modify RPCs to Manage ICD-10 for ICD-10 Injury Codes

2.14.1   Description

This RPC must be changed. The Injury fields in the POV and E-codes may be different and how the V POV file will handle these changes is still unknown. It should probably return whether or not the code is ICD-9 or ICD-10.

BGOVPOV SET

The SET call may need to be changed as far as the injury E-code fields are concerned. This is still unknown at the present time. The visit date can give the date to determine whether or not to store an ICD-9 or ICD-10 code.

2.14.2   Impact

Medium

2.14.3   Area Affected

EHR

2.14.4   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 an injury type problem.

5. Select the **Use as POV**.

6. In the **Caused** field, use the Ellipsis button to search for an injury-type problem.

2.14.5   Expected Results

For an injury code added before 10/1/2014, the code will begin with an E. An injury code after the implementation date of ICD-10 begins with a V.

2.15   TT/Artifact 1585/15955

ICD-10: Update Visit Services Component to Launch Apelon to Retrieve ICD-10 Codes

2.15.1   Description

Services:

• Visit date 1 Oct 2014 ICD procedure will search and retrieve ICD-10 procedure codes

• Visit date prior to 1 Oct 2014 ICD procedure will search and retrieve ICD-9 procedure

Add Procedure dialog needs to launch to Apelon for ICD-10 procedure codes confirming if CPT codes should launch there or not.

2.15.2   Impact

Medium

2.15.3   Area Affected

EHR

2.15.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit with a date prior to 10/1/2014.

3. Select the Superbill tab.

4. Click **Add**.

5. Click **ICD Procedure** code.

6. Search for a code (25 for example).

> **Note:** ICD procedure will search and retrieve ICD-9 procedure
> for visits prior to 10/1/2014 and will retrieve ICD-10 for
> visits after 10/1/2014.

2.15.5   Expected Results

ICD procedure will search and retrieve ICD-9 procedure for visits prior to 10/1/2014. It will search and retrieve ICD-10 for visits after 10/1/2014.

2.16   TT/Artifact 1574/15959

IPL – New PIP Column

2.16.1   Description

RPMS-EHR IPL must be modified to display the PIP column. It appears that this is just a Graphical User Interface (GUI) fix, as it looks like the RPC is already returning the correct information. The prenatal 2.0 application will set/clear that value.

2.16.2   Impact

Low

2.16.3   Area Affected

EHR

2.16.4   Steps to Validate

1. Log on to Terminal Service.

2. Access VA FileMan.

3. At the "INPUT TO WHAT FILE" prompt, type **BGO SNOMED PREFERENCES//**.

4. Mark the **PIP** field as **Yes**.

5. Log on to RPMS-EHR.

6. Select a female patient.

7. Add a Prenatal visit.

8. Select Pregnancy Issues and Problems.

9. Add a Pregnancy Related problem.

10. Click **Save**.

11. Select the **IPL**.

12. Select the **Pregnancy Related** problem and Edit it.

13. **Save** the problem.

2.16.5   Expected Results

The Pregnancy Related field is checked, and a red check mark displays in the PIP column.

2.17   TT/Artifact 1583; 1696/15981

ICD-10: Pharmacy Counseling SNOMED

2.17.1   Description

Pharmacy will eventually be tied to SNOMED. Medsphere must determine how to handle the automatic entry of Chart Review and Telephone Type visit as POV so the solution can possibly be reused for this artifact.

2.17.2   Impact

Medium

2.17.3   Area Affected

EHR

2.17.4   Steps to Validate

1. Log on to Terminal Service.

2. At the "Test an Option Not in your Menu" prompt, type **XPAR EDIT PARAMETER**.

3. Type **BEHORXED POV SNOMED LIST**

4. At Select Sequence, type **1**.

5. At the "Are you Adding 1 as a new Sequence?" prompt, type **Yes**.

6. At the SNOMED field, enter a SNOMED CT code.

7. Log on to RPMS-EHR.

8. Select a patient, DO NOT select a visit.

9. Click the **Pharm Education** button.

2.17.5   Expected Results

The Purpose of Visit (POV) is available to be added to the Pharmacy Education.

2.18   TT/Artifact 1578/15995

Inpatient Meds Not Showing Up as Outpatient on Orders Tab

2.18.1   Description

Inpatient Meds is not showing up as Outpatient on the Orders Tab. This is a GUI issue and not related to RPMS, Pharmacy, Orders, and so on. Orders appear correctly on the Meds Tab.

2.18.2   Impact

Low

2.18.3   Area Affected

EHR

2.18.4   Steps to Validate

1. Log on to Terminal Service.

2. At the "Select IHS Kernel Option" prompt, type **Test an option not in your menu**.

3. At the "Option entry to test" prompt, type **XPAR EDIT PARAMETER**.

4. At the "Select PARAMETER DEFINITION NAME" option, type **BEHOPTCX ADT DISPLAY ACTION**.

5. At Select System:

```
--Setting BEHOPTCX ADT DISPLAY ACTION for System: DEMO.MEDSPHERE.COM--
Display action:
```

6. At the "//" prompt, type **??**. The IsInPatient property is set to True when the ADT Event is an Inpatient, and False when the ADT Event is a discharge. This parameter controls how the Patient Context object reacts when an ADT admission event is received. The options are:

   - **I**. Do not change the Encounter Context

   - **P**. Prompt the user to determine if the Encounter Context will be set to the inpatient encounter

   - **F**. Force the Encounter Context to the inpatient encounter

7. Set the parameter as desired.

2.18.5   Expected Results

When the parameter is set to I, the encounter context does not change. When it is set to prompt, the user receives a dialog asking to Change Encounter Context to Inpatient Encounter. If it is set to Force, the Encounter Context is automatically changed.

2.19   TT/Artifact 1025/16082

ICD-10 Codes on the Problem List – Hover

2.19.1   Description

Expose Map Advice using hover on Add/Edit Problem dialog.

- Client wants Map Advice exposed using the hover tool on the following:

  - Integrated Problem List:
    - Visual cue on ICD field.

- Hover will display Map Advice based on SNOMED concept when hovering over an ICD field, and then disappear when the user moves off the field.
  - Add/Edit problem dialog:
    - Visual cue on SNOMED that appears after selection of SNOMED term – It was suggested that it is placed to the left of the SNOMED term.
    - Hover will display Map Advice based on SNOMED concept when the user hovers over an icon, and disappears when the user moves off the icon.

2.19.2   Impact

Low

2.19.3   Area Affected

EHR

2.19.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Hover over the **ICD** column.

5. Edit a problem.

2.19.5   Expected Results

Map advice is exposed using the hover tool on the Add/Edit Problem dialog and in the Main IPL screen ICD column.

2.20   TT/Artifact 1691/16130

Edit Screen POV Check Box

2.20.1   Description

Client requests that on the edit screen if USE as POV is selected, but the Primary check box is not, if there is no existing Primary POV, it should be a Primary POV, not a secondary POV.

2.20.2   Impact

Low

2.20.3   Area Affected

EHR

2.20.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Add a problem.

4. Search for a SNOMED CT term.

5. Click **Use as POV**.

2.20.5   Expected Results

If there is no existing primary POV, even though the Primary POV check box was not selected, the problem is automatically a primary POV and not a secondary.

2.21   TT/Artifact 1617/16142

Patient Education and No Visit Selected

2.21.1   Description

User should not have the ability to document Patient Education without a visit selected.

- Issue: Without a visit, if user clicks on Lab/Problem/Med and then ED button, the Education dialog is triggered, but the user cannot document education because there is no visit selected. The system is attempting to store it as historical however, it grays out the field. The user can cancel out so there is a workaround.

- Fix: Correct behavior would be: No activation of Education dialog without visit selected

2.21.2   Impact

Low

2.21.3   Area Affected

EHR

2.21.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient, but no visit.

3. Highlight a **Lab**.

4. Click the **Patient ED** button. The following message is displayed:

   An active visit has not been selected. An active visit is required to update patient education records. Do you want to select an active visit?

5. Click **No**. The Web browser is launched for patient education.

6. Close the Web browser.

7. Highlight the **Lab** again.

8. Click the **ED** button. The following message is displayed:

   An active visit has not been selected. An active visit is required to update patient education records. Do you want to select an active visit?

9. Click **Yes**. The encounter field opens to select a visit.

10. Select the visit. The Web browser is launched.

11. Close the window. The **Patient Education** page opens.

12. Click **Add**. Patient Education is added to the **Wellness** tab.

13. Repeat the above steps for the **IPL** and **MEDS** tabs.

2.21.5   Expected Results

The Patient Education dialog does not display if no visit is selected.

2.22   TT/Artifact 1612/16264

IPL – Treatment/Regime – Reorganization of Subsets

2.22.1   Description

Instead of pulling one subset from DTS and then hard-coding the division into the multiple lists, programming has set up multiple lists as subsets in Apelon. IPL will pull in the multiple TREG PickLists and display them.

2.22.2   Impact

Medium

2.22.3   Area Affected

EHR

2.22.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL**.

4. Click **Add**.

5. Search for a SNOMED CT code and select it.

6. Select **Use as POV**.

7. Select **Add Visit Instruction/Care Plans/Goal Activities**.

8. Click the **Treatment/Regimen** button.

2.22.5   Expected Results

The Treatment/Regimens now display based on TREG.

2.23   TT/Artifact 1633/16283

Limit the PickLists the User Can View and Use When Items from the Edit PickList Dialog Are Defined

2.23.1   Description

Limit the picklists that the user can view and use when items from the Edit PickList dialog are defined.

Hospital location – Where the visit is taking place

Clinic – Clinic stop of where the patient is for the visit

Provider – Logged-on user

Provider Class – The logged-on user's assigned class

2.23.2   Impact

Medium

2.23.3   Area Affected

EHR

2.23.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select **IPL**.

4. Click the **IPL** button.

5. Click **Manage PickLists**.

6. Click **Edit PickLists**.

7. Click **Edit**.

8. Add a **Hospital Location**.

9. Add a **Provider**.

10. Click **Save**.

Next Scenario:

1. Add a **Provider**.

2. Add a **Clinic**.

3. Click **Save**.

Next Scenario:

1. Add a **Manager**.

2. Click **Save**.

2.23.5   Expected Results

PickLists are now based on Location, Provider, Clinic, Provider Class, and Manager.

2.24　TT/Artifact 1632/16284

Limit the Superbills the User Can View and Use by Defined Parameters

2.24.1　Description

Limit the Superbills that the user can view and use when items from the Edit Superbill (Category) dialog are defined.

Hospital location – Where the visit is taking place

Clinic – Clinic stop of where the patient is for the visit

Provider – Logged-on user

Provider Discipline – The logged-on user's defined specialty

2.24.2　Impact

Medium

2.24.3　Area Affected

EHR

2.24.4　Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient.

3. Select a visit.

4. Select the **Superbill** tab.

5. View Superbill Category list.

> **Note:** Do not click Show All.

2.24.5　Expected Results

Superbill Category list is based on what is defined in the Hospital location, Clinic, Provider, and Prov Discipline in the Manage Category dialog for each category. If none of the fields are defined, then that category is available for everyone.

2.25   TT/Artifact 1652/16358

CIR Allowing Duplicate SNOMED CT Concept IDs in Patient Problem List

2.25.1   Description

When adding to or editing an existing problem, or a new problem from a CCDA is added, the CIR component does not stop the user if the SNOMED CT concept ID matches an existing entry in the problem file for that patient. Currently IPL does not allow duplicates from add/edit and the Get SCT function.

2.25.2   Impact

Medium

2.25.3   Area Affected

EHR

2.25.4   Steps to Validate

Issue #1:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select **CIR**.

4. Expand **Reconciled Problems** panel.

5. Click **Add Problem**.

6. Click the Ellipsis button.

7. Search for a problem that already exists in the patient's problem list (must have the same SNOMED CT and ICD code).

> **Note:** Another scenario is to select an existing problem and change it to another problem that already exists in the patient's record.

Issue #2:

1. Log on to RPMS-EHR.

2. Select a patient and a visit with a non- SNOMED CT Problem (problems with * in front of the Provider Narrative).

3. Click **CIR**.

4. Select the non- SNOMED CT problem.

5. Right-click and select **Change**.

6. Correct code displays at the bottom under the **Provider** field.

7. Click **GET SCT**.

8. SNOMED CT Look up brings up the correct set of codes.

2.25.5   Expected Results

Issue #1: A duplicate SNOMED CT concept error displays and should not allow the user to add the same problem.

Issue #2: For non-SNOMED CT problems, CIR displays the correct diagnosis code.

2.26   TT/Artifact CR3987

MSC/16377 – CCDA: If All Content from a Heading or Subheading is Removed, Leave Heading and Show Word Redacted

2.26.1   Description

If all content from a heading or subheading is removed, leave heading and show word redacted. If individual items are removed word redacted is not needed. For example:

- When unselecting the Inactive sub-section of Problems/Encounter Diagnoses, it should display Inactive (Personal History), and the word Redacted is displayed. Currently only Redacted displays.

2.26.2   Impact

Low

2.26.3   Area Affected

EHR

2.26.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient.

3. Click **CCDA**.

4. Select **Generate CCDA for Visits/Referrals**.

5. Select a visit.

6. Click **Review/Customize**.

7. Clear the check box for " " Inactive (Personal History) under Problems/Encounter Diagnoses.

> **Note:** it displays Redacted.

2.26.5   Expected Results

Displays Inactive (Personal History).

2.27   TT/Artifact 1680/16459

Quick Orders Menu Option – Find Quick Orders That Have Not Been Converted to SNOMED CT

2.27.1   Description

User is requesting a menu option to search for all Quick Orders that have not been converted to SNOMED CT.

2.27.2   Impact

Medium

2.27.3   Area Affected

EHR

2.27.4   Steps to Validate

1. Log on to Terminal Service.

2. Select **Test an option not in your menu**.

3. Enter BEHOORSY SNOMED CONVERSION (Unconverted Clinical Indication to SNOMED).

4. At the "Device" prompt, type **Home**.

2.27.5   Expected Results

All unconverted Quick Orders display.

2.28   TT/Artifact CR446/16507

eRx – Quantity Behavior Modification for REN Request

2.28.1   Description

User is requesting that the Quantity field on a Refill Request be blocked from user manipulation on a non-provider order number request, or if accidently changed by the electronic eRX mapping. The prescriber should only see Deny New to Follow (DNTF) or Deny (D).

2.28.2   Impact

Low

2.28.3   Area Affected

EHR

2.28.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Click the **Refill Request** queue.

4. Process a refill.

2.28.5   Expected Results

The quantity field on a Refill Request is blocked from user manipulation on a non-prescriber order number request, and if accidently changed by the mapper, the prescriber only sees DNTF or D.

2.29   TT/Artifact 1690/16522

IPL – Display Issue On Expand All

2.29.1   Description

When user enters a patient and clicks Expand All on the problem list, the Existing Care Planning does not display. Only after the user expands and exposes the individual problem's care planning does the info drop in with collapse and display all.

2.29.2   Impact

Low

2.29.3   Area Affected

EHR

2.29.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Add two different problems.

5. Add **Care Planning** and **Visit Instructions** to both problems.

6. Select a new patient, but then change back to the original patient.

7. Click **Expand All**.

> **Note:** The Care Planning instructions do not display on Expand All. You have to select them individually and then expand to see them.

2.29.5   Expected Results

Care Planning displays on Expand All for all problems.

2.30   TT/Artifact 1701/16612

IPL – Priority

2.30.1   Description

Client is requesting that the Priority column be exposed on the Main IPL window in a sortable column. Some clinician's use the field in the IPL Add/Edit window and would also like it to be viewable in a sortable column on the main window.

2.30.2   Impact

Low

2.30.3   Area Affected

EHR

2.30.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient.

3. Select a visit.

4. Select the **IPL**.

2.30.5   Expected Results

The user can sort on the Priority column.

2.31   TT/Artifact CR0752; CR3426/16615

IPL Enhancement – Save PickList Items as POV Option

2.31.1   Description

Client requests that RPMS-EHR have the option to save items selected from a
PickList as POV on selected PickLists (SME input needed). The system shall expose
the option as a button on the PickList titled Set Selected Problem as POV.

When selected by the user, the system shall store the problem and launch the POV
selection dialog.

2.31.2   Impact

Low

2.31.3   Area Affected

EHR

2.31.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient.

3. Select the **IPL** tab.

4. Click the **PickList** button.

5. Click **Manage PickLists**.

6. Click **Edit PickLists**.

7. Click **Edit**.

8. Highlight a PickList and click **Edit**. The **Edit PickList** dialog displays.

9. Click **May Store Selections as POV**.

10. Click **Save**.

11. Click **Exit** twice.

12. Select the PickList.

> **Note:** If you place the mouse cursor over the PickLists on the left, the ones highlighted in blue provide Help text of Enabled to Set Problem to POV.

13. Select a term that displays **May Store Selections as POV**.

14. Click **Save as Problem and POV**.

> **Note:** The Edit problem pane opens for editing.

15. Click **Save**.

2.31.5   Expected Results

A red check mark appears in the POV column on the main window.

2.32   TT/Artifact 1705/16631

PickList Enhancement/Fix – Add Scroll Tool on the Left Inside for the Different PickList

2.32.1   Description

When the user opens the PickList, there is not scroll tool on the left inside for the different picklists. Not everyone sees all the picklists, but the CACs do.

2.32.2   Impact

Medium

2.32.3   Area Affected

EHR

2.32.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL**.

4. Click the **PickList** button.

2.32.5   Expected Results

A scroll bar has been added to the list of PickLists on the left side.

2.33   TT/Artifact 1349/16638

Immunizations GUI – Event Date and Time

2.33.1   Description

Client would like to add a column to the Immunization main display of Admin Date. This corresponds to the Event Date of the immunization.

2.33.2   Impact

Low

2.33.3   Area Affected

Medium

2.33.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Immunizations** tab.

2.33.5   Expected Results

A column has been added to the Immunization main display of Admin Date. This corresponds to the Event Date of the immunization.

2.34   TT/Artifact 1727/16640

Reproductive Factor Screen

2.34.1   Description

Client reports that the Reproductive Factor screen displays when trying to change patients if the old patient is pregnant. This was a previous issue in p12. And Whiteriver is reporting this as an issue in p13.

2.34.2   Impact

Low

2.34.3   Area Affected

Medium

2.34.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a female patient.

3. Select **Reproductive Factors**.

4. Mark the patient pregnant.

5. Enter a value in **EDD Definitive Comments**.

6. Click **Save**.

7. Select another female patient.

2.34.5   Expected Results

The reproductive factor window does not display (for either patient).

2.35   TT/Artifact 1730/16677

Quick Pics [160859] (From EHRp12)

2.35.1   Description

MSC was able to duplicate the Quick Pics issue on an EHR p12 test system:

LOE – Anticipated that this will be low, but we need to confirm with the EHR developer.

Issue – Providers cannot edit Quick Order names or order on the common list that contains their personal Quick Orders.

Impact (# of sites? # of heat tickets/reports) – Two sites, one heat ticket (#160859).

Fix – Fix the problem with the **OK** button for the Edit Common Order List dialog so that changes can be saved.

IS there a workaround- providers can request that regular quick orders be built and placed on a menu?

Patient safety? No.

What patch did you find it in? Why wasn't it found on testing? The problem was found after the sites installed EHR patches 11 and 12. It probably was not included in the testing because it is not recommended for providers to create and use personal quick orders.

2.35.2   Impact

High

2.35.3   Area Affected

EHR

2.35.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Orders** tab.

4. Select **Outpatient Medications** on the left.

5. Select **Options** > **Edit Common List**.

6. Select an order.

7. Edit the order name.

8. Use the Up and Down arrows to move orders up or down on the list.

9. Click **OK** after making edits to the common list.

2.35.5   Expected Results

The **OK** button works, and the order of the items are moved.

2.36   TT/Artifact 1745/16720

Stroke – Cannot Remove Therapy Not Initiated/Therapy Initiated

2.36.1   Description

If a user selects an option button, it cannot be cleared, so there is no way to remove the information if entered prematurely.

2.36.2   Impact

Low

2.36.3   Area Affected

EHR

2.36.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Stroke** component.

4. Add a stroke.

5. Enter an **Arrival Date** and an **Onset Date**.

6. Click the **Therapy Initiated** button.

2.36.5   Expected Results

A None option button has been added so the user can clear the Therapy Initiated or Therapy Not Initiated selection if desired.

2.37   TT/Artifact 1746/16721

AMI – Cannot Remove Therapy Not Initiated/Therapy Initiated

2.37.1   Description

If a user selects an option button, it cannot be cleared, so there is no way to remove the information if entered prematurely.

2.37.2   Impact

Low

2.37.3   Area Affected

EHR

2.37.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **AMI** component.

4. Enter an **Arrival Date** and an **Onset Date**.

5. Click the **Therapy Initiated** button.

2.37.5   Expected Results

A None option button has been added so the user can clear the Therapy Initiated or Therapy Not Initiated selection if desired.

2.38   TT/Artifact 1739/16722

Stroke-Fibrinolytic Therapy Not Initiated Stores as Initiated If the User Does Not Select Reason

2.38.1   Description

Client reports that stroke – Fibrinolytic therapy that is not initiated, stores as if it was initiated if the user does not select a reason.

2.38.2   Impact

Low

2.38.3   Area Affected

EHR

2.38.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Stroke** component.

4. Click **Add** to add a stroke.

5. Select the **Arrival Date/Time** and **Onset Date/Time**.

6. Click the **Therapy Not Initiated** button.

7. Enter a **Date/Time**.

2.38.5   Expected Results

The **Save** button is disabled until the user selects a reason. Once stored, the Therapy Not Initiated button is still retained.

2.39   TT/Artifact 1740/16723

AMI – Fibrinolytic Therapy Not Initiated Can No Longer Be Stored Without Selecting a Reason

2.39.1   Description

Fibrinolytic therapy that is Not Initiated stores as Initiated if the user does not select a reason.

2.39.2   Impact

Low

2.39.3   Area Affected

EHR

2.39.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **AMI** component.

4. Add an AMI.

5. Enter an **Arrival Date** and **Onset Date**.

6. Click the **Therapy NOT Initiated** button (do not select a reason).

2.39.5   Expected Results

The **Save** button is disabled until the user enters a reason and date/time. Once the entry is stored, Therapy Not Initiated is stored as expected.

2.40   TT/Artifact 1744/16724

Stroke – Deleting Stroke Entry Does Not Delete NSST Measurements from V Measurement

2.40.1   Description

Deleting a Stroke entry does not delete the NSST measurements from V Measurement.

2.40.2   Impact

Low

2.40.3   Area Affected

EHR

2.40.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Stroke** component.

4. Enter **Arrival Time** and **Onset Time**.

5. Enter the **Symptom**.

6. Enter the **Stroke Score**.

7. Click **Save**.

8. Highlight the entry and click **Delete**.

9. Click the **Encounter**.

10. Right click and select **Visit Details**.

2.40.5   Expected Results

NSST is removed from the Visit file.

2.41   TT/Artifact 1741/16725

Entering Second Stroke Score Deletes Any Comments from Previously Entered Scores

2.41.1   Description

Client reports that when entering a second Stroke Score, any comments from previously entered scores are deleted.

2.41.2   Impact

Low

2.41.3   Area Affected

EHR

2.41.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Stroke** tool.

4. Click **Add** to add a stroke entry.

5. Select **Arrival Time** and **Onset Time**.

6. Enter some symptoms.

7. Add a **Stroke Score**.

8. Click **UN** and add a comment for at least one entry.

9. Click **Save**.

10. Verify the comment displays in the Visit file in V Stroke.

11. Highlight the entry and click **Edit**.

12. Add another **Stroke Score**.

13. Click **Save**.

14. Select the **Encounter**.

15. Right click and select **Visit Details**.

> **Note:** Both stroke scores are present in V Stroke, but the comments are removed from the initially entered score.

16. Edit the entry again.

> **Note:** The initially entered stroke score no longer contains the comments.

2.41.5 Expected Results

The stroke comments are retained for each Stroke Score.

2.42 TT/Artifact 1742/16727

When Stroke Score is Edited, Stores Second V Measurement

2.42.1 Description

Client reports that when a stroke score is edited, it stores the second V Measurement.

It should mark edited entry as Entered in Error, and store the new one. Entered in Error measurement should not be visible in the Visit file.

2.42.2 Impact

Low

2.42.3 Area Affected

EHR

2.42.4 Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Stroke** component.

4. Click **Add** to add a Stroke Entry.

5. Select **Arrival Time** and **Onset Time**.

6. Enter symptoms.

7. Add a **Stroke Score**.

8. Click **UN** and add a comment for at least one entry.

9. Click **Save**.

10. Highlight the entry.

11. Click **Edit**.

12. Edit the **Stroke Score** to have a different number.

13. Click **Save**.

14. Select the **Encounter**.

15. Right-click and select **Visit Details**.

> **Note:** Two NSST entries should not be saved in the visit file.

2.42.5 Expected Results

The edited entry is marked as Entered in Error, and stores a new one. Entered in Error measurement should not be visible in Visit file. The User can also delete the Stroke Score entirely.

2.43 TT/Artifact 1743; 1748/16729

Stroke – Unable to Delete Stroke Score – REQS NEW BJPC BUILD

2.43.1 Description

Client is unable to delete a Stroke Score. Users would have to delete entire stroke entry and start over.

2.43.2 Impact

Low

2.43.3 Area Affected

EHR

2.43.4 Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Stroke** tool.

4. Click **Add** to Add a stroke entry.

5.   Select **Arrival Time** and **Onset Time**.

6.   Enter symptoms.

7.   Add a **Stroke Score**.

8.   Click **UN** and add comment for at least one entry.

9.   Click **Save**.

10. Highlight the entry.

11. Click **Edit**.

12. Delete the **Stroke Score**.

2.43.5   Expected Results

The user can delete the stroke score.

2.44   TT/Artifact 1749/16741

Anticoag – Mismatch Between Start and End Date in GUI vs. Visit File

2.44.1   Description

Align GUI End Date with the RPMS End Date.

The RPMS application is using 90 days to translate to 3 months, 180 days to translate 6 months, and 365 days to translate to 1 year. The GUI is using 3 months, 6 months, and 1 year to translate the duration. This must be synced up.

2.44.2   Impact

Low

2.44.3   Area Affected

EHR

2.44.4   Steps to Validate

1.   Log on to RPMS-EHR.

2.   Select a patient and a visit.

3.   Select the **Anticoagulation** component.

4.   Click **Add**.

5. At **Select Warfarin Indicated**, type **Yes**.

6. Select an **INR** goal.

7. Select **Duration of Therapy**.

8. Click **Save**.

9. Compare the **End Date** of the visit details in V Anticoagulation to the **GUI End Date**.

2.44.5   Expected Results

The GUI End Date matches the RPMS End Date.

2.45   TT/Artifact 1756/16754

IPL – Duplicate Problem Being Added When Using Pharmacy Education Button

2.45.1   Description

When a user selects a problem that exists on the problem list, it does not just mark the existing SNOMED problem as Used as POV, rather it stores a DUPLICATE.

2.45.2   Impact

Low

2.45.3   Area Affected

EHR

2.45.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL**.

4. Add a problem.

5. Search for the problem of **Dispensing Medication Education** using the **All SNOMED** button.

6. Click **Save**.

7. Click the **Pharmacy Education** button.

8. At Do you want to append to the current encounter, click **NO**.

9. Select **Dispensing Medication Education** on the **Pharm Ed** dialog.

10. Select an **Education** topic.

11. Click **Save**.

> **Note:** The SNOMED correctly stores to POV, but stores a second, duplicate problem erroneously.

2.45.5   Expected Results

A second duplicate problem is not stored, and the problem is stored as POV.

2.46   TT/Artifact 1759/16806

IPL – PickList Management Display to the User Needs Change

2.46.1   Description

When an item is added to a PickList, the values stored should be SNOMED Concept ID and Description ID of the preferred term, if Preferred Term is selected. If a synonym is selected it should store the SNOMED Concept ID of the preferred term, and the Description ID of the synonym. The descriptor field should store the SNOMED CT term preferred or the synonym, depending on what was selected from the Apelon tool.

2.46.2   Impact

Low

2.46.3   Area Affected

EHR

2.46.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Click the **PickList** button.

5. Select **Manage PickLists**.

6. Click **Add**.

7. Search for a SNOMED CT term.

8. Select a Synonym to display in the **PickList**.

2.46.5 Expected Results

The Preferred Term column has been removed. The SNOMED Term column now displays the description of the selected SNOMED (for example, the preferred term or the synonym term).

When an item is added to the PickList, the values stored should be SNOMED Concept ID and Description ID of the preferred term, if the Preferred Term is selected. If a synonym is selected, it should store the SNOMED Concept ID of the preferred term, and the Description ID of the synonym. The Descriptor field should store the SNOMED term preferred or synonym, depending on what was selected from the Apelon tool.

2.47 TT/Artifact 1785/16817

IPL: Error in IPL Template When Entering Any Free-Text in the Add/Edit Dialog

2.47.1 Description

A simple template was placed in Goal Notes and Care plans. When opening one of the notes, when completing it, selecting **OK**, and then attempting to edit it manually, you get an object reference not set to an instance of an object error.

2.47.2 Impact

Medium

2.47.3 Area Affected

EHR

2.47.4 Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Edit an existing problem.

5. Select **Use as POV**.

6. Click the **CVG** button.

7. Select one of the template buttons.

8. Click **OK**.

9. Type text in the field.

10. Click **OK**.

2.47.5   Expected Results

An object reference error is not received and the edits are retained.

2.48   TT/Artifact 1793/16844

APSP: Discharge Medication Field Is Empty in the Order Details

2.48.1   Description

The Discharge Medication field is empty in the Order Details dialog. It should display the information/instructions regarding medication being discharged to a patient.

2.48.2   Impact

Medium

2.48.3   Area Affected

EHR

2.48.4   Steps to Validate

1. Log on to the Pharmacy Package.

2. Select a patient.

3. Enter a **New Order**.

4. Accept the defaults.

5. At **Discharge Medication**, type **Yes**.

6. Accept the order.

7. Edit the order, changing the **Discharge Medication** field to **No**.

8. Accept the order.

9. Log on to RPMS-EHR.

10. Select the patient and a visit.

11. Double-click the order to view the order details.

2.48.5   Expected Results

The Discharge Medication field contains what was entered at the prompt, Yes or No.

2.49   TT/Artifact 1783; CR3401/16856

IPL: Limited Users in Clinic Stops, Managers, Hospital Locations, and Provider Classes

2.49.1   Description

Currently, when doing a search for managers, clinics, hospital locations, and provider classes, it is limited to 250 results. Client wants this limitation removed.

2.49.2   Impact

Low

2.49.3   Area Affected

EHR

2.49.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Click the **PickLists** button.

5. Click **Manage PickLists**.

6. Click **Edit PickLists**.

7. Click **Add**.

2.49.5   Expected Results

The search for managers, clinics, hospital locations, and provider classes is no longer set to a maximum of 250 results.

2.50   TT/Artifact 1025/16883

Add POV Column to Main IPL to Display POV (Red Check Mark) for Selected Encounter Only

2.50.1   Description

New POV Column on IPL:

The system shall display a POV column to the right of the IP column on the IPL.

The system shall display a red check mark in the POV column on the IPL if the problem was selected as the POV for that visit.

2.50.2   Impact

Medium

2.50.3   Area Affected

EHR

2.50.4   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 and click the **POV** button.

5. Click **Save**.

2.50.5   Expected Results

A red check mark appears in the POV column to the right of the IP column in the main IPL display.

2.51   TT/Artifact 1000/16884

Designated Provider Component is Limited to 2000

2.51.1   Description

Client would like the current restriction of the number of users removed.

2.51.2   Impact

Medium

2.51.3   Area Affected

EHR

2.51.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **PCP** component.

4. Click **Add**.

2.51.5   Expected Results

All users can be selected, and the number is not restricted to 2000.

2.52   TT/Artifact 1795/16908

CCDA – Header Redaction Statement (From EHRp13) Needs CCB Approval for EHRp14

2.52.1   Description

Client is requesting that the description appear on all CCDAs.

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

2.52.2   Impact

Low

2.52.3   Area Affected

EHR

2.52.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit containing data.

3. Click the **CCDA** button.

4. Select **GENERATE Clinical Summary** for the current selected visit.

5. Click **Print**. The Print dialog appears.

6. Select a printer.

7. Print the **CCDA** and review the content. The Header Redaction statement is included.

8. Repeat with other CCDA generate options.

2.52.5   Expected Results

The Header Redaction statement appears on each CCDA regardless of customizations.

2.53   TT/Artifact 1799/16925

IPL – Previous Value Narrative Unreadable IPL Detail

2.53.1   Description

Previous value narratives are unreadable IPL detail, as they all run together. In addition, an unexpected error is received when changing the SNOMED CT term, but only for an IP.

The previous value detail is an issue for both IP and OP.

2.53.2   Impact

Medium

2.53.3   Area Affected

EHR

2.53.4   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.

5. Click **Edit**.

6. Click the Ellipsis button to get a different term.

7. Select the term.

8. Click **Save**.

9. Double-click the problem details.

2.53.5   Expected Results

An unexpected error is not received when editing the SNOMED CT term, and the previous value is not all run together making it hard to read.

2.54   TT/Artifact 1584; CR3127/16935

Update Quick Orders ICD Codes

2.54.1   Description

When a Quick Order with a SNOMED CT is selected, the return RPC call will determine the ICD code based on the SNOMED CT. This code will then be stored with the order.

2.54.2   Impact

Low

2.54.3   Area Affected

EHR

2.54.4   Steps to Validate

Precondition: The Quick Order must be mapped to SNOMED Concept ID.

How to map a quick order to SNOMED codes:

1. Log on to Terminal Service.

2. At the "Select IHS Kernel Option" prompt, type **Test an option not in your menu**.

3. At the "Option entry to test" prompt, select the **CPRS Manager Menu**.

4. At the "Select CPRS Manager Menu Option" prompt, type **PE CPRS Configuration** (Clinical Coordinator).

5. At the "Select CPRS Configuration (Clinical Coordinator) Option" prompt, type **MM Order Menu Management**.

6. At the "Select Order Menu Management Option" prompt, type **QO Enter/edit Quick Orders**.

7. At the "Select QUICK ORDER NAME" prompt, enter the Quick Order Name (for example, PSOZ METFORMIN PLAIN 500MG BID).

8. Continue pressing Enter until the "INDICATION" prompt displays.

9. At the "INDICATION" prompt, type a text to search (for example, diabetes).

   > **Note:** System will return a list of SNOMED codes related to diabetes

10. Select the appropriate SNOMED code.

11. At the "(P)lace, (E)dit, or (C)ancel this quick order?" prompt, press Enter to accept the default (Place).

12. At the "Auto-accept this order?" prompt, press Enter to accept the default (No).

13. At the "Select QUICK ORDER NAME' prompt, type a caret (**^**) to exit.

Place the QUICK ORDER on a patient:

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Orders** tab.

4. Select **Output Med Quick Orders** (or the appropriate menu where the Quick Order with SNOMED CT is included).

5. Select **Diabetes Meds** under the **ENDOCRINE** heading.

6. Select **Metformin Plain 500mg BID** under **BIGUANIDES** heading.

7. View the **Clinical Indication** field and make sure it is defined with the correct SNOMED CT concept.

8. Click **Accept Order**.

Verify ICD codes attached to SNOMED CT clinical indication:

1. Log on to Terminal Service.

2. At the "Select IHS Kernel Option" prompt, type **3 VA FileMan**

3. At the "Select VA FileMan Option" prompt, select **inquire to File Entries**

4. At the "OUTPUT FROM WHAT FILE" prompt, type **ORDER**.

5. At the "Select ORDER" prompt, type the **Order Number** (can be seen in Order Details window label in RPMS-EHR).

6. At the "ANOTHER ONE" prompt, press Enter.

7. At the "STANDARD CAPTIONED OUTPUT?" prompt, press Enter to accept the default (Yes).

8. At the "Include COMPUTED fields" prompt, press Enter to accept the default (N0).

9. Search for the Item Entry for OR GTX CLININD2.

2.54.5   Expected Results

Correct ICD code attached to SNOMED CT clinical indication is stored with the order.

2.55   TT/Artifact 1810/16943

V Orders Not Formatting Well in Notes

2.55.1   Description

The V Orders component is not formatting well once placed on Notes, for example, inappropriate line breaks in-between lines.

2.55.2   Impact

High

2.55.3   Area Affected

EHR

2.55.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select your patient and a visit.

3. Go to **Notes**.

4. Select a **Progress Notes** title.

5. Click **Template**.

6. Select the appropriate template with V Orders.

7. Enter any other appropriate required information in the template.

8. Click **OK**.

9. Delete the note.

10. Repeat Steps 4 through 8.

11. Click **Finish**.

12. Sign the Note.

2.55.5   Expected Results

V Orders data should display properly without formatting issue.

2.56   TT/Artifact 1783/17121

Superbill – Limited Users in Clinic Stops, Managers, Hospital Locations, and Provider Classes

2.56.1   Description

Client is requesting that the maximum number of search results (currently set at 250) for managers, clinics, hospital locations, and provider classes be removed.

2.56.2   Impact

Low

2.56.3   Area Affected

EHR

2.56.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Superbill** component.

4. Click the **Superbills** button.

5. Click **Add/Edit Superbills**.

6. Click **Add**.

2.56.5   Expected Results

The search for managers, clinics, hospital locations, and provider classes is no longer set to a maximum of 250 results.

2.57   TT/Artifact 1851; CR3942/17151

IV Dialog Bug

2.57.1   Description

The Duration or Total Volume dialog in the Infusion Order dialog remains grayed out when the schedule for an intermittent infusion is changed from a one-time schedule to a continuous schedule.

The Duration or Total Volume dialog should become available for providers to enter information when an infusion schedule is changed from a one-time type (such as ONCE) to a continuous type (such as Q1H).

There is a work-around, but it is not likely to be acceptable to providers. After editing the schedule, the provider can accept the order, then select Change a second time to make the Duration or Total Volume dialog become available.

This was discovered by a client site when a provider tried to order sequential bolus potassium infusions.

2.57.2   Impact

Low

2.57.3   Area Affected

EHR

2.57.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select an inpatient visit.

3. Select the **Orders** tab.

4. Click **Infusion**.

5. Order the drug with a schedule of now and intermittent.

6. Accept the order.

7. Sign the order.

8. Right-click the order and select **Change**.

9. Set the schedule to be **Q2H**.

2.57.5   Expected Results

The duration or Total Volume remains editable.

2.58   TT/Artifact 1866; CR3983/17232
BMXNet Issue With Well Child Component

2.58.1   Description

Well Child stopped working after they switched to Patient Education. The client has determined that the issue seems to be with some new code introduced with the MU release.

2.58.2   Impact

Low

2.58.3   Area Affected

EHR

2.58.4   Steps to Validate

1. Log on to RPMS-EHR

2. Select a child and a visit.

3. Select **Well Child**. Well Child works normally.

4. Go to **Patient Education**.

5. Enter an education item.

6. Click **Add**.

7. Return to **Well Child**.

8. Click the **Enter Today's Score** button or select **Refresh Data** from the RPMS-EHR main menu.

2.58.5   Expected Results

The Well Child component works without requiring to restart RPMS-EHR.

2.59   TT/Artifact 1874; CR3992/17258

IPL and PIP Allowing Deletion of Problems with Inactive Care Plans

2.59.1   Description

IPL and PIP are allowing deletion of problems with inactive care plans.

2.59.2   Impact

Low

2.59.3   Area Affected

EHR

2.59.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Add a problem and click **Save**.

5. Highlight the problem and click the **POV** button.

6. Enter a care plan and sign it.

7. Clear the **Use for POV** button.

8. Save the problem.

9. Create a new visit.

10. Highlight the same problem and click **POV**.

11. Inactivate the care plan.

> **Note:** If you do not enter a comment indicating that you are inactivating the care plan, an unexpected error is received.

12. Enter a comment to inactivate

13. Uncheck the **Save as POV** button and **Save**

14. Double-click the problem details.

> **Note:** The inactive care plan displays.

15. This creates a problem with an inactive care plan that has not been used as POV.

16. Highlight the problem and delete.

> **Note:** You are able to delete the problem, but should not be able to.

2.59.5 Expected Results

The problem cannot be deleted even if it contains an inactive care plan. The inactive care plan also displays in the problem details.

2.60 TT/Artifact 1878; CR4015/17264

Superbill – CPT Lookup Launching SNOMED Search (From EHRp14 i6)

2.60.1 Description

The Procedure look up for CPT actually launches a SNOMED search. This was found during EHRp14 i6 internal testing. Client is requesting approval for EHRp14 i7.

2.60.2 Impact

Low

2.60.3 Area Affected

EHR

2.60.4   Steps to Validate

1. Log on to RPMS-EHR. Only users holding the BGOZ V PCT EDIT key can Add or Edit CPT codes for visits.

2. Select a patient and a visit.

3. Select the **Superbill** tab.

4. Click the **Superbill** button.

5. Click **Edit**. The **Edit PickList Item** dialog displays.

6. Click **Add**. An **Add Association** dialog displays.

7. Click **Education Topic**. The **Education Topic Selection** dialog displays.

8. Click the **Procedure and Topic Entry** button. A list of CPT codes displays and allows the user to search for a specific CPT code.

9. Search for a word (for example, Hysterectomy) and click the Ellipses button.

2.60.5   Expected Results

The CPT look up window displays with results.

2.61   TT/Artifact 1879; CR4007/17266 –

Superbill – Not Honoring Settings in Manage Categories

2.61.1   Description

Superbill is not honoring settings configured in the Manage Categories dialog.

2.61.2   Impact

Low

2.61.3   Area Affected

EHR

2.61.4   Steps to Validate

Precondition: Set up a Superbill with a Hospital Location = Test Clinic.

1. Log on to RPMS-EHR. Only users holding the BGOZ V PCT EDIT key can add or edit CPT codes for visits.

2. Select a patient.

3. Select an active visit with Visit Location = Test Clinic.

4. Select the **Superbill** tab.

5. View the **Category List**.

2.61.5 Expected Results

Show All is not selected. Category defined with Test Clinic in Hospital Location field in Manage Category is displayed/available. This is true even for users that hold the BGOZ Key. They see that PickList ONLY if the patient is in that hospital location, and the Superbill has a filter of Hospital location = Test Clinic.

2.62 TT/Artifact 1880; CR4008/17267

Superbill – Cannot Add or Delete a Superbill (From EHRp14 i6)

2.62.1 Description

Superbill – Client has a CAC key. They can add to an existing Superbill, however, they cannot add a new Superbill or delete an existing one. Plus, the client cannot edit others.

This is an issue, as someone must have permission to clean out the PickLists if the staff leaves. So the CAC should have access to all (with old business rules, CAC, owners, and managers could access PickLists). Without a CAC key, the client can add a Superbill (expected behavior) and edit their own.

2.62.2 Impact

Low

2.62.3 Area Affected

EHR

2.62.4 Steps to Validate

1. Log on to RPMS-EHR as a user that holds the BGOZ CAC key.

2. Select a patient and a visit.

3. Select the **Superbill** tab.

4. Click the **Superbills** button.

5. Click the **Add/Edit Superbills** button.

2.62.5   Expected Results

The CAC can add a new Superbill, and/or delete a Superbill, even if they are not the Superbill owner. (This was an old business rule – CAC, owners and managers could access PickLists). If a user does not have a CAC key, they can add a Superbill (expected behavior) and edit their own only. The CAC key allows add/edit/delete of ANY PickList or Superbill.

2.63   TT/Artifact 1883; CR4011/17269

Care Planning – Variable Behavior Documenting Care Planning (From EHRp14 i6)

2.63.1   Description

Variable behavior documenting Care Planning from Add/Edit dialog using templates:

- Visit Instructions entered using template – Unsigned
- Visit Instructions entered using template – Signed
- Goals/Care Plans entered using template – Unsigned (This works as expected)
- Goals/Care Plans entered using template – Signed

2.63.2   Impact

Low

2.63.3   Area Affected

EHR

2.63.4   Steps to Validate

1. Log on to RPMS-EHR.
2. Select a patient and a visit.
3. Select the **IPL** tab.
4. Edit an existing problem.
5. Click **Use as POV**.
6. Click the **Add Visit Instruction/Care Plans/Goals** button.

7. Click the template button for Visit Instructions. The template displays for editing.

8. Select desired check boxes and click **OK**.

9. Enter text in the **Visit Instructions** field.

10. Click **OK**. The **Signature Tool** displays for signing.

11. Click **Don't Sign**. The **Add/Edit** dialog is displayed and the content, including the text, is visible before saving.

12. Test **Goals** and **Care Plans** using Steps 7 through 11.

2.63.5   Expected Results

All text is retained, including the free-text, if you sign or do not sign the note.

2.64   TT/Artifact 1884; CR4012/17270

Care Planning – Template Issues

2.64.1   Description

If the template used in Care Planning does not have text before accessing the Template field, the Template field does not work. Found during Internal Testing of EHRp14 i6.

2.64.2   Impact

Low

2.64.3   Area Affected

EHR

2.64.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Notes** tab.

4. Create a Shared Template and insert Template field.

5. Add the Template to BGO IPL CARE TEMPLATE.

6. Select the **IPL** tab.

7. Highlight a problem and click **Edit**.

8. Click **Use as POV**.

9. Add a **Care Plan** using the Template button.

10. Select the Template field created.

2.64.5   Expected Results

The template should display as it does on the Notes tab.

2.65   TT/Artifact 1877; CR4014/17272

Superbill – Clicking Adds Entries to Visit Services (From EHRp14i6)

2.65.1   Description

Each time the client selects or clears a Superbill item, it adds an entry into Visit Services.

2.65.2   Impact

Low

2.65.3   Area Affected

EHR

2.65.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the Superbill.

4. Select and clear a Superbill item that has no associations.

> **Note:** It works fine if there are associations on the item.

2.65.5   Expected Results

An item is added when selected, but removed when cleared.

2.66   TT/Artifact 1893; CR4022/17315
PickList – Import/Export Issues (From EHRp14 i6)

2.66.1   Description

Issue 1: Export is not extracting correct information and is preventing proper importing of PickList.

Issue 2: Potential issue – what happens to existing PickLists when we load EHRp14. Are they hosed because they do not contain the description ID?

This would be disastrous for sites if all of their PickLists are deleted and there is no way to back them up. Do the PickLists have a default – that is, if no description ID then retrieve Preferred term of SNOMED CT (in the ICD-10 version)? This needs analysis ASAP to determine if this is a real issue.

Client believes the Import/Export routines were not properly updated to accommodate for the description ID and descriptor.

It is not parsing the status, concept ID, and description ID correctly – ICD should be blank.

2.66.2   Impact

Low

2.66.3   Area Affected

EHR

2.66.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Click the **PickLists** button.

5. Click **Manage PickLists**.

6. Export a **PickList** and name the file **Test 1**.

7. Import the **PickList**.

2.66.5   Expected Results

Data is stored to BGO SNOMED PREFERENCES file and displays on the PickList.

2.67   TT/Artifact 1894; CR4023/17316

PickLists – Allowing Storage of Duplicate SNOMED (From EHRp14i6)

2.67.1   Description

System storing duplicate SNOMED concepts to IPL if >1 PickList items of same concept are selected at the same time and stored.

2.67.2   Impact

Low

2.67.3   Area Affected

EHR

2.67.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Click the **PickLists** button.

5. Click **Manage PickLists**.

6. Click **Add**.

7. Search for Adenomyosis.

8. Click the drop-down list on Endometriosis of the Uterus, and select the synonym of Adenomyosis.

9. Click **Add**.

10. Search for Endometriosis of the Uterus.

11. Exit the PickList manager.

12. Select both of the newly added terms.

13. Click **Save as Problem**.

2.67.5   Expected Results

Only one term is allowed to be stored.

2.68   TT/Artifact 1891; CR4020/17317

Info Button – Open with Clinical Key instead of UpToDate

2.68.1   Description

Change subscription from UpToDate to Clinical Key. This is a new requirement due to a change in subscription (from UpToDate to Clinical Key). The changeover is 1 Sept 2014. Change the following instances of the"I" button to open Clinical Key instead of UpToDate.

2.68.2   Impact

Low

2.68.3   Area Affected

EHR

2.68.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Meds** tab.

4. Highlight a medication.

5. Click **Open Clinical Key**. The Clinical Key application launches.

6. Select the **IPL** tab.

7. Highlight a problem.

8. Click **Open Clinical Key**. The Clinical Key application launches.

9. Select the **Visit Diagnosis** component.

10. Click **Open Clinical Key**. The Clinical Key application launches.

11. Select the Historical Diagnosis component.

12. Click **Open Clinical Key**. The Clinical Key application launches.

13. Select the **Lab** component.

14. Highlight a Lab.

15. Click **Open Clinical Key**. The Clinical Key application launches.

2.68.5   Expected Results

Clinical Key application launches for the components outlined.

2.69   TT/Artifact 1903; 4053/17366
Get SCT – Index Was Outside the Bounds of the Array

2.69.1   Description

Client is receiving an error from Get SCT, but only on one Inpatient Ward.

2.69.2   Impact

Low

2.69.3   Area Affected

EHR

2.69.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select an Inpatient.

3. Find a problem that has not been converted (contains an asterisk (∗) before the problem).

4. Click **Get SCT**.

2.69.5   Expected Results

User does not receive an error.

2.70   TT/Artifact 1908/17407

Info Button – Redirect CE HL7 Code to Clinical Key

2.70.1   Description

Client would like to redirect the HL7 code from UpToDate to Clinical Key when the Info button is clicked.

2.70.2   Impact

Low

2.70.3   Area Affected

EHR

2.70.4   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** tab.

10. Highlight a problem.

11. Click the **Info** button.

2.70.5   Expected Results

When the user clicks the Info button, a Web reference dialog opens and the user can launch the Clinical Key if desired.

2.71   TT/Artifact 1907/17408

Stroke Tool – Fibrinolytic Comments Retained When None is Selected

2.71.1   Description

Fibrinolytic comments are retained after the user edits the Stroke Tool and changes the Fribrinolytic selection. The user selects Fibrinolytic Therapy Initiated (date/time) and saves it, then adds comments. When the user edits the Stroke Tool, and selects None for Fibrinolytic, comments from the previous selection are retained.

2.71.2   Impact

Low

2.71.3   Area Affected

EHR

2.71.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Stroke** component.

4. Highlight the entry.

5. Click **Edit**.

6. Click the drop-down list under **Details**.

7. Select the **Therapy Initiated** button.

8. Enter a **Date/Time** or enter **now**.

9. Enter a Comment.

10. Click **Save**.

11. Access VA FM, and do an INQ on V STROKE.

12. Highlight the entry.

13. Click **Edit**.

14. Change the **Therapy Initiated** button to **Therapy Not Initiated**.

15. Select a reason.

16. Click **Save**.

17. Access VA FM, and do an INQ on V STROKE.

18. Highlight the entry and right-click **Edit**.

19. Click **None** for **Therapy Initiated**.

2.71.5   Expected Results

The Date/Time, Not Initiated Reason and Comment selections are cleared.

2.72   TT/Artifact 1905; CR4055/17412

IPL – Superbill Association Not Allowing Removal of Diagnoses When Uncheck Superbill

2.72.1   Description

Superbill association is not allowing the removal of diagnoses when the Superbill option is cleared.

2.72.2   Impact

High

2.72.3   Area Affected

EHR

2.72.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **Superbill** component.

4. Click the **Superbills** button.

5. Click **Edit**.

6. Click **Add**.

7. Add an association for the following:

   - Education topic

   - Exam

- Health Factor

- SNOMED Diagnosis

- Icd Procedure

- Imm

- Skin Test

8. Select a Superbill item and process dialogs.

9. Clear the Superbill item.

> **Note:** User is presented with an option to clear all items (with CPT pre-selected and uneditable). DIAGNOSIS is missing – unable to remove diagnosis.

2.72.5   Expected Results

ICD Diagnosis can be removed.

2.73   TT/Artifact 1904; CR4054 /17416

IPL – After Logging On to RPMS-EHR, System is Not Displaying Asthma Classification Choices

2.73.1   Description

After adding an Asthma diagnosis to a patient who does not have a current Asthma diagnosis, the asthma classification choices are not displaying in the drop down list.

2.73.2   Impact

Low

2.73.3   Area Affected

EHR

2.73.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient who does not have asthma on their problem list and a visit.

3. Select the **IPL** tab.

4. Click **ADD problem**.

5. Search for and select **Asthma**.

6. Select the **Classification**.

> **Note:**   There are no selections in the drop down list.

7. **Save** the problem.

8. Edit the Asthma problem. Now choices are there and remain for the rest of the RPMS-EHR session.

9. Log out.

10. Log back in and repeat. Notice that the selections are blank again.

2.73.5   Expected Results

The asthma classifications are not blank.

2.74   TT/Artifact 1909; CR4060/17420

BJPN – Visit Instruction Display on POV dialog different when launched from PIP

2.74.1   Description

Current Prenatal Issues and Problems (PIP) encounter is returning all visit instructions instead of current/today's instructions. PIP is functioning differently than the Integrated Problem list (IPL).

2.74.2   Impact

Low

2.74.3   Area Affected

EHR

2.74.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a female patient who is pregnant.

3. Select a visit.

4. Select **PIP**.

5. Add a pregnancy problem.

6. Set as **POV**.

7. Add a visit instruction.

2.74.5   Expected Results

The visit instruction display matches that of IPL.

2.75   TT/Artifact 1903/17443

Get SCT – Index Was Outside the Bounds of the Array

2.75.1   Description

Client reports that when using Get SCT for one inpatient ward, the following error message is received:

The index appears outside the bounds of the array.

2.75.2   Impact

Low

2.75.3   Area Affected

EHR

2.75.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select an Inpatient.

3. Find a problem that has not been converted (a problem that contains an asterisk (*) before the problem).

4. Click **Get SCT**.

2.75.5   Expected Results

The user does not receive an error when using Get SCT.

2.76   TT/Artifact 1916/17455

Patient's Full Social Security Number (SSN) is Displaying in the Patient Selection Dialog

2.76.1 Description

When the client enters the last initial of a patient's name, and the last 4 numbers of the patient's SSN, the FULL SSN appears in the Patient Selection dialog.

2.76.2 Impact

Low

2.76.3 Area Affected

EHR

2.76.4 Steps to Validate

1. Log on to RPMS-EHR.

2. Select the **Patient Selection** dialog.

3. Enter the last initial of the Patient Name, and the last four numbers of their SSN (for example, t1212).

2.76.5 Expected Results

The full SSN does not display in the patient selection field.

2.77   TT/Artifact 17728

Anticoag – Erroneous Display of This Visit Has An Entry

2.77.1 Description

While on the Anticoag tab, upon selecting a different patient and adding a new visit, the Anticoag screen erroneously displays the message:

This visit has an entry.

At the same time, the Add/Edit/Delete buttons are all dim, even though there are NO entries in the Anticoag screen grid. This effectively disallows entry for the new visit.

2.77.2 Impact

Low

2.77.3   Area Affected

EHR

2.77.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient.

3. Create a new visit.

4. Select the **Anticoag** tab.

5. Enter and save an entry. Normally, the system would display *This visit has an entry*, and the **Add** button would be disabled, and the **Edit** and **Delete** buttons are enabled.

6. While still on the **Anticoag** tab, select a different patient, and create a new visit for that patient.

2.77.5   Expected Results

This visit has an entry should not still display, and the **Add** button should not be disabled to allow for an anticoag entry for this new patient/visit.

2.78   TT/Artifact 17946

Duplicate ICD Codes Are Returned in POV

2.78.1   Description

Duplicate ICD codes are returned in POV in the following condition:

Problem has at least two ICD codes, one of which being .9999. The problem is marked as POV using the POV button. The Provider Alt Text is added to the problem and saved. The code is now duplicated on the POV component.

2.78.2   Impact

High

2.78.3   Area Affected

EHR

2.78.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and a visit.

3. Select the **IPL** tab.

4. Add a problem that contains at least two ICD codes, one of which is .9999.

5. Save the problem.

6. Highlight the problem and click **POV**.

7. Add **Alt Provider Text**.

8. Click **Save**.

9. Select the **POV** component.

2.78.5   Expected Results

The original ICD codes are retained and displayed in POV.

2.79   TT/Artifact 2034/18129

PXRM – Expose Narratives

2.79.1   Description

Expose the narrative instead of numeric choices for vaccine eligibility in the reminder dialogs (need LOE). Client does not know if we can default based on eligibility like IMMS component can. Ask MSC if this is possible, and the LOE.

2.79.2   Impact

Low

2.79.3   Area Affected

EHR

2.79.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and visit.

3. Navigate to Immunizations.

4. Click **Add**.

5. Click **Show All Active Vaccines**.

6. Select an immunization.

7. Click **OK**.

8. Note the Vaccine Eligibility choices.

9. Navigate to **Notes**.

10. Select an **Immunization Reminder** dialog.

2.79.5 Expected Results

Expose the Narratives in the Vaccine Eligibility field for reminder dialogs.

2.80 TT/Artifact 2032; CR4433/18140

Suicide Reporting Forms Issue HT

2.80.1 Description

This is a display issue in RPMS EHR. Client was able to duplicate it in their OIT CMBB database, but could not duplicate the issue in the OIT CMBA. The displays in these databases are different. One has a scroll bar and the other does not. The one without the scroll bar worked.

Client verified that all forms (whether or not they were complete) show in the Behavioral Health System (both roll-n-scroll and GUI). Also the PCC and BHS (AMH) reports show all the forms as well. iCare also displays all the forms in patient view area.

The issue is that the first five suicides entered into the EHR GUI stay static on the EHR GUI. You can enter additional forms with no problem. After the first five are entered regardless of their date, they are the only ones visible on the EHR GUI Suicide tab. This was replicated this on the PRH data base and the GPA DEHR.

2.80.2 Impact

Low

2.80.3 Area Affected

EHR

2.80.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient and visit.

3. Navigate to the Suicide Form.

4. Log on to Terminal Service.

5. Enter Test an option not in your menu.

6. Enter SUICIDE REPORTING FORMS – UPDA AMH SUICIDE FORM UPDATE.

7. Select SFP Update Suicide Reporting Form for a Patient.

8. Enter a patient name.

9. Compare the number of suicides to the EHR GUI Suicide form.

2.80.5   Expected Results

All suicide attempts that were entered display.

2.81   TT/Artifact 2043; 4448/18158

Re-admitting a Patient at Sites With Observation Ward

2.81.1   Description

No beds are available when a patient is admitted into the hospital. With no beds available, the patient is placed in an observation room. The patient is seen and Orders are made. Several hours later a bed becomes available. The patient is discharged from the observation bed, and within one hour, "Readmitted" into the new bed.

Requested Change:

In ADT, the user is prompted "Do you want existing orders to follow the patient?." If the user says, yes then all orders from the existing room carry forward to the new room.

The orders are available real-time (no delay, no confusion, no missed tasks). The orders do not have to be re-entered (no delay, no mistakes in re-entering data).

2.81.2   Impact

Low

2.81.3   Area Affected

EHR

2.81.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select an Inpatient.

3. View all active orders.

4. Discharge the patient using BDG Discharge.

5. At the prompt "Will the patient be re-admitted immediately?" answer **Yes**.

6. In ADT, at the, "Do you want existing orders to follow the patient?" Prompt, answer **Yes**.

2.81.5   Expected Results

All orders from the existing room carry forward to the new room. Go back to the EHR and refresh the patient. Then admit the patient again and view the orders.

2.82   TT/Artifact 2047, 2048, 2049/18176

CCDA Email Modifications When Emailing a CCD from CCDA

2.82.1   Description

The current content will be included in the XML File attachment. DIRECT displays it as plain text, and does not render the message.

While removing the CCD text from the email, the following text should be inserted:

This e-mail, and any attachments thereto, is intended only for use by the addressee(s) named herein, and may contain privileged and/or confidential information. If you are not the intended recipient of this e-mail, any dissemination, distribution, or copying of this e-mail, and any attachments thereto, is strictly prohibited. If you have received this e-mail in error, immediately notify the sender by e-mail or telephone, and permanently delete all copies of this e-mail and any attachments.

2.82.2   Impact

Low

2.82.3   Area Affected

EHR

2.82.4   Steps to Validate

1. Log on to RPMS-EHR.

2. Select a patient.

3. Click the **CCDA** button and select **Generate CCDA for Visits/Referrals**.

4. Select the **Referrals** tab.

5. Select a visit.

6. Click **Submit**.

7. On the **Direct Email Form**, enter a **To** and **From** email address.

8. Click **Send**.

2.82.5   Expected Results

Add an extension to attachments (for example, xml, xsl), add the CCD as an attachment, remove the CCD in the body of the email, make the subject line the exact statement included in the IHS request, and the subject line is not editable.

3.0   EHR Component Versions

Filename	Current Version	New Version
BEHAntiCoag.dll	1.1.5303.17793	1.1.5303.17793
BEHCIR.dll	1.0.5401.14543	1.0.5422.27406
BEHCPRS20.bpl	1.0.15.33	1.0.15.36
BEHAntiCoag.chm	02/11/2014	5/21/2014
BEHCCDA.dll	1.0.5373.20281	1.0.5584.14938
BEHChartReview.dll	1.0.5126.29583	1.0.5483.25703
BEHCIR.chm	03/28/2014	09/15/2014
BEHCommunityInfo.dll	1.0.0.63	1.1.5116.17967
BEHInfoBtnSvc.dll	1.1.5129.24446	1.1.5380.15214
BEHIPL.chm	06/24/2014	11/13/14
BEHIPL.dll	1.1.0.21576	1.1.0.21619
BEHStroke.chm	02/11/2014	05/22/2014
BEHStroke.dll	1.1.5382.27388	1.1.5423.18571
IhsBgoE&M.ocx		1.1.0.236
bgoAMI.dll	1.1.5235.22974	1.1.5514.16557
IhsBgoPovHistory.ocx	1.2.0.23	1.2.0.52
IhsBgoIcdPickList.ocx	1.2.0.79	1.2.0.80
IhsBgoItems.chm	06/4/2014	11/20/2014
IhsBgoItems.ocx	1.2.0.50	1.2.0.52
IhsBgoProblem.ocx	1.2.0.82	1.2.0.104
IhsBgoSuperBill.chm		08/13/2014
IhsBgoVPOV.ocx	1.2.0.48	1.2.0.54
IHSBgoExams.ocx	1.1.0.377	1.1.0.378
IhsBgoImmunization.ocx	1.2.0.195	1.2.0.202
IhsBgoImmunization.chm		09/10/2014
IhsBgoPatientED.ocx	1.2.0.258	1.2.0.261
IhsBgoSkinText.ocx	1.2.0.141	1.2.0.154
IhsBgoVCPT.ocx	1.2.0.72	1.2.0.77
BEHChartReview.chm		08/5/2014
BEHOrders.chm		08/5/2014
BEHLab.chm	08/13/2014	11/24/2014
BEHMeds.chm	09/15/2014	11/25/2014
BEHPharmED.ocx	1.0.4.3	1.0.4.7
BEHPharmED.chm	02/25/2014	05/19/2014
BEHReports.ocx	20.1.3.1	20.1.3.3
BEHRxGenerator.dll	1.0.0.60	1.0.5189.26976
BEHVisits.chm	03/28/2014	06/06/2014
BEHRemoteViews.dll		4.2.1.4
BEHPCP.dll	1.1.5378.13763	1.1.5533.24507
BEHPovCvg.dll		1.0.5416.19448
BEHVitalEntry.dll		2.0.6.3
bgoFamHx.ocx	1.0.0.681	1.0.0.685

Filename	Current Version	New Version
CSSEncounter.dll		4.3.6.2
CSSPatient.dll	4.3.5.2	4.3.5.4
IHSbgoRepFactors.ocx	1.2.0.186	1.2.0.189
IHSbgoRepFactors.chm	03/28/2014	05/22/2014
IHSbgoRepHist.ocx	1.2.0.55	1.2.0.84
IhsBgoSkinTest.ocx		1.2.0.157
IhsBgoSuperBill.dll	1.1.0.38	1.1.0.46
IhsBgoPovHistory.chm		11/24/2014
IhsBgoProceduresViewer.ocx	1.2.0.94	1.2.0.95
ihsbgoinfantfeed.ocx		1.2.0.219
IhsBgoVPOV.chm		11/24/2014
IHS.ImageViewer.dll		1.0.5546.21933
vcCommon.dll	1.1.5256.17231	1.1.5423.18559
vcControls.dll		1.1.5289.25811
vcQuickNote.ocx	1.1.3.3	1.1.3.4
IhsBgoVCPT.chm	03/28/2014	06/06/2014
BEHPatientGoals.dll	1.0.5284.27423	1.0.5284.27423
PG.Infrastructure.dll	1.0.5284.27408	1.0.5284.27408
PG.Modules.DataAccess.dll	1.0.5284.27424	1.0.5284.27424
PG.Modules.History.dll	1.0.5387.17841	1.0.5284.27424
PG.Modules.Task.dll	1.0.5102.25268	1.0.5284.27425
PGUserControl.dll	1.0.5284.27426	1.0.5284.27426
BMXWIN40.dll		4.0.0.1
BMXEHR40.dll		4.0.0.1
BMXNET40.dll		4.0.0.1

Acronym List

Acronym	Meaning
CAC	Clinical Application Coordinator
CPT	Current Procedural Terminology
EHR	Electronic Health Record
FPM	Family Planning Method
GUI	Graphical User Interface
ICD	International Classification of Diseases
IHS	Indian Health Service
IPL	Integrated Problem List
PCC	Patient Care Component
POV	Purpose of Visit
RPMS	Resource and Patient Management System
SNOMED CT	Systematized Nomenclature of Medicine--Clinical Terms
TT	Team Track

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/

Email: support@ihs.gov