Medsphere Systems Corporation

# OpenVista 2017.2.0 Release Notes

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# **Release 2017.2.0 Enhancements**

# CareVue

# New icon for Clinical Information Reconciliation

The icon in CareVue for Clinical Information Reconciliation is updated for easier identification.

Old Icon: New Icon:



Clinical Recon

Figure 1: Old and new Clinical Information Reconciliation icons

**Required action:** Identify the new icon in CareVue. Click on the Clinical Information Reconciliation icon to ensure accessibility. Test in your normal Clinical Information Reconciliation workflow.

Related artifact: 20975

# **Flowsheets**

# Font Changes for Intake, Output, and Fluid Balance Volume Totals

Font changes in Flowsheets for Intake, Output, and Fluid Balance Volume Totals facilitate improved reading and interpretation. The Volume Total fields for Intake, Output, and Fluid Balance now display a larger, bold black font; rows are shaded a darker blue. Intake and Output entries have a smaller, non-bold font; the rows are a lighter shade of blue.

**Required action:** Test by entering **Intake** and **Output** values on Flowsheets and viewing the **Volume Totals** and **Fluid Balance**.

Related artifact: 20797

# **Multi-Disciplinary Treatment Plan**

### MDTP enhancement enables site configuration of MDTP frequency choices

A new menu has been created in OpenVista PuTTY called **MDTP MANAGEMENT**. (Find this menu under **MSC CSA Clinical System Analyst**.) The **MDTP ENTER/EDIT REASSESSEMENT FREQUENCY** option in this new menu enables new reassessment frequency for **INTERVENTIONS** and **MEETINGS**.

**Note:** Sign out of CareVue and reload MDTP GlassFish after making changes. Sign back into CareVue to see changes.

**Suggested additional testing:** Enter a new reassessment frequency, edit a reassessment frequency and inactivate a reassessment frequency. Reload MDTP in GlassFish, then sign into CareVue. Test in your normal MDTP workflows.

**Example:** Adding a new reassessment frequency for INTERVENTIONS:

- 1. Sign in to OpenVista PuTTY.
- 2. Select MDTP Management from the MSC CSA Clinical System Analyst menu.



AM ART ARTC CM CPRS DASH DD FM CD	Alert Management Adverse Reaction Tracking Adverse Reaction Tracking Clinician Menu Consult Management CPRS Configuration (Clin Coord) Patient Dashboard Management Document Definitions (Manager) VA FileMan
GP	General Parameter 10015
	MDTP Management
MDTF	Text Integration Utilities (MIS Manager)
MM	Menu Management
RM	Reminder Managers Menu
SECL	SECLUSION/RESTRAINT Management Menu
TEST	Test an option not in your menu
TIU	TIU Maintenance Menu
UM	User Management

Figure 2: The MSC CSA Clinical System Analyst menu

3. Select Enter/Edit Reassessment Frequency.

FREQ Enter/edit reassessment frequency

Figure 3: The FREQ menu option

4. Complete the following fields:



Figure 4: FREQ menu option fields

- 5. Restart the MDTP GlassFish service.
- 6. Sign into CareVue and to see changes in MDTP.

>	Templates Previous Plan Details Tasks	
	Edit Intervention [ENT Disorders - BURN Describe and document move	•
	Description: BURN Describe and document movement of affected	Â
	Start Date: 8/3/2017	
lan	Discipline:	
ous P	Frequency: EVERY 6 MONTHS	
s/Previ	Care Action EVERY 10 BUSINESS DAYS EVERY 12 HOURS	
plate	Associated EVERY 15 MINUTES	
em	EVERY 2 HOURS	
	EVERY 30 MINUTES	
	EVERY 4 HOURS	
	EVERY 5 BUSINESS DAYS	
	EVERY 6 MONTHS	

Figure 5: MDTP changes displayed in CareVue

### Related artifact: 20649



# MDTP includes incorrect signature dialog

An incorrect signature dialog now displays when users attempt to sign an MDTP note if the user enters an incorrect signature code.

**Required action:** Test in your normal MDTP workflow.

Related artifact: 20785

# Immunizations

### Default volumes for immunizations

New functionality enables sites to set default volume values for immunizations.

Note: Default values may be overwritten by loading CDC files. If this occurs, reset the default values.

### **Required action:**

- 1. Log in to PuTTY. Select **Test an Option** not in your menu.
- 2. Enter MSC Immunization Def Vol.



Figure 6: MSC IMMUNIZATION DEF VOL menu option

3. Enter the **BI IMMUNIZATION TABLE HL7/CVX STANDARD NAME**.

The current volume default displays. Enter the desired new default volume.

Select	BI IMMU	NIZATION	TABLE	HL7/CVX	STANDARD	NAME:	MMR
1	MMR	MMR	3				
2	MMRV	MM	٩V	94			
CHOOSE	1-2: 1	MMR	MMR	3			
DEFAUL	T VOLUME	: .75//	. 50				

Figure 7: Updating default volumes

4. Run **BI MENU-MANAGER** > **Restandardize Vaccine Table**.



Select Option 1 2 3 CHOOSE	Systems Manager Menu QA710(GTM02) Option: test an option not in your me entry to test: BI MENU BI MENU-MANAGER Manager Menu BI MENU-PATIENT Patient Menu BI MENU-REPORTS Reports Menu 1-3: 1 BI MENU-MANAGER Manager Menu	enu
IMMI	JNIZATION v8.2 * MANAGER MENU * Site: GENERAL HOSPITAL ====================================	
ERR CMG CMT SCN	Edit Patient Errors Add/Edit Case Manager Transfer a Case Manager's Patients Scan For Patients	
ESP PKG LET LOT VAC	Site Parameters Edit Package Setup Information Form Letters Add/Edit Lot Number Add/Edit Vaccine Table Edit Restandardize Vaccine Table	
EXP KEY	Export Immunizations Allocate/Deallocate Imm Menu Keys	

Figure 8: The Restandardize Vaccine Table menu option

5. Verify that the new default volume is reflected in CareVue.

Related artifact: 20723

# MU 2015 CEHRT- Immunization Registry Query

A new system component, **Immunization Registry Query**, can be added to the **Immunizations** tab. This component allows selected users to submit queries to immunization registries and view results returned from the registry. Note that an interface with the state immunization registry is required. The **Immunization Registry Query** is controlled by the **MSC IMMUNIZATION QUERY ACTIVE** XPAR and **MSCIMMQRY** security key. Contact your enterprise account executive for more information on establishing an interface to a state immunization registry.

PRIVACY NOTIFICATIONS PATIENT CHART RESOURCES ED DA	SHBOARD SURGERY TRACKER	SURGERY SCHEDULING eRX RENEWALS		
TEST.NICKI 544877599 12-Mar-1982 (35) F	ICU	13-Oct-2014 16:20 Inpatient 655411233	Primary Care Team Unassigned Attending: Holman,Joy	
No Photo Available Visit Summary	Clinical Recon	CWAD AF	POC Lab Entry	* Problem Lis Advs Reart Medications
COVERSHEET PROBLEM LIST VITALS ORDERS MEDS LABS	WELLNESS IMMUNIZATIONS	NOTES CONSULTS MDTP FLOWSH	IEETS DC SUMMARY SUPER	BILL REPORTS
Immunization Record				
 Forecast		<u>Contraindications and Refusals</u>		
Immunization Forecasting disabled (see Site Parameters). #314				Add Delete
Vaccinations				
Print Record Due Letter Profile Case Data Registry Query				Add Edit Delete
Vaccine Date Given Age@Visit Location Reaction Heason Volume [ml]	Inj. Site Lot Manuf By VIS Docs A	Admin By Vaccine Elig Counseled Admin Note	s Info Source	
<u>Print Record</u>				Add Edit Delete
Visit Date Skin Test Location Age@Visit Result Reading Re	ad Date Reading Provider Administer	red By Other Location Refusal Comment	Site Volume	

Figure 9: New Immunization Registry Query Button





Figure 10: Registry Query Menu Options

# Submitting an Immunization Registry Query

There are two options in the **Registry Query** menu for submitting a registry query request: **Request History Only** OR **Request Evaluated History and Forecast**.

- 1. Request History Only requests the immunization history of the patient.
- 2. **Request Evaluated History and Forecast** requests both the immunization history for a patient and the projected forecast of dates for upcoming immunizations.

Once the request is sent, the user receives a message confirming that the request was sent successfully. The **Registry Query** button also turns yellow as a visual indicator that a request was sent.



Figure 11: Request History and Forecast sent message



Figure 12: Registry Query button indicating sent message

If a query is submitted but the patient is not found in the registry, the user receives an **Error** warning stating **No Match Found**. If a query is submitted for a patient but there are multiple possible matching patients, the user receives an **Error** stating **Too Many Patients**. In both instances, information from the Immunization Registry cannot be retrieved.



Figure 13: NO MATCH FOUND error window





Figure 14: TOO MANY PATIENTS error window

# Viewing Immunization Registry Query Results

Once results have returned—this may take time—the user who submitted the query receives a notification on their **Notifications** tab. In addition, the **Registry Query** button on the **Immunizations** tab turns green to indicate that results have returned. Clicking on the **Registry Query** button and select **View Response** to see results. Printed if needed. Once the **Results** dialog box is closed, the **Registry Query** button changes from green back to the original gray color.



### Figure 15: Registry Query button indicating results

Name: FAIRCHILD, CAMERON A			DOB:	02/14/2009		MBN	1: 171122			
Address: 105 Laurel Run Rd P			Phone: (760) 325-3258 Gend			Gende	nder: M			
_										
Boz	eman	MONTAN	A							
nmunization	History	06/26/201	7							
/accine Group	Vaccine Ac	dministered	Date Adm	inistered	Valid Dose	Validity Reason	Comple	etion Status	Immuniza	ion So
Hep B Unspec	Hep B NOS	6	04/15/20	09	Y		Comple	ste	ACIP	
HIB PRP-T	HIB NOS		03/14/20	19	N	Too Young	Comple	ete	ACIP	
DTAP-Hep B-IPV	Hep B NOS	6	10/11/20	19	Y		Comple	ate	ACIP	
DTAP-Hep B-IPV	IPV		10/11/20	19	Y		Comple	ete	ACIP	
DTAP-Hep B-IPV	DTAP		10/11/20	19	Y		Comple	ete	ACIP	
Hep BPEDS	Hep B NOS	6	04/11/20	10	Y		Comple	ste	ACIP	
MMR	MMB		04/15/201	10	Y		Comple	ete	ACIP	
4								_		
٠ [				,III						•
nmunization	Forecas	t	_	III	_					•
munization	Forecast	t Earliest Da	ate to Give	, III Latest D	)ate to Give	Immunization Sch	nedule	-	1	•
< mmunization Vaccine Group MMR	Forecast	t Earliest Da	ate to Give	III Latest D	)ate to Give	Immunization Sch ACIP	nedule	F		•
<ul> <li>mmunization</li> <li>Vaccine Group</li> <li>MMR</li> <li>PV</li> </ul>	Forecast Due Date 02/14/2015 02/14/2010	t Earliest Da 06/14/201	ate to Give 10	.m Latest D	)ate to Give	Immunization Sch ACIP ACIP	nedule	F		•
Amunization Vaccine Group MMR PV DTAP	Forecast Due Date 02/14/2015 02/14/2010 02/14/2010	t Earliest Da 06/14/201	ate to Give	.m Latest D	)ate to Give	Immunization Sch ACIP ACIP ACIP	nedule	F F F		F
Mmunization /accine Group MMR PV DTAP	Forecast Due Date 02/14/2015 02/14/2010 02/14/2010	t Earliest Da 06/14/201	ate to Give 10	III Latest D	)ate to Give	Immunization Sch ACIP ACIP ACIP	nedule	F F F		•
Accine Group MMR PV DTAP	Forecast Due Date 02/14/2015 02/14/2010 02/14/2010	t Earliest Da 06/14/201	ate to Give 10	III Latest D	Date to Give	Immunization Sch ACIP ACIP ACIP ACIP	nedule	F F F		•
A Cine Group MMR PV DTAP	Forecast Due Date 02/14/2015 02/14/2010 02/14/2010	t Earliest Da 06/14/201	ate to Give 10	III	Date to Give	Immunization Sch ACIP ACIP ACIP	nedule	F F F		•

Figure 16: Immunization Registry Results Example

**Required Action:** Test by submitting queries to your state's immunization registry when your facility has an interface with that registry established.

Related artifact: 21123



# **Nutrition and Food Service**

# Auto-Print Diet Labels

Schedule diet labels to print automatically using TaskMan instead of manually printing them using OpenVista Dietary menus.

**Required action:** Test by setting up the TaskMan schedule to print. Enter the day/time for the initial print, as well as the **DEVICE FOR QUEUED JOB OUTPUT**, and **RESCHEDULING FREQUENCY** (see example below). To set up subsequent prints by adding another schedule with the same name, type the option quotes **MSCFHORD14** and add new.

Edit Option Schedule Option Name: MSCFHORD14 Menu Text: Auto print diet labels TASK	( ID:	390678
QUEUED TO RUN AT WHAT TIME: MAY 10,2017@13:50		
DEVICE FOR QUEUED JOB OUTPUT: MSCLASER100;P-HPLASER-P10;80;6		
QUEUED TO RUN ON VOLUME SET:		
RESCHEDULING FREQUENCY: 1D		
TASK PARAMETERS:		
SPECIAL QUEUEING:		
Exit Save Next Page Refresh Quit		
Click on one of the above COMMANDs, or on a FIELD		
COMMAND: E		HELP Insert

Figure 17: The Edit Option Schedule window with MSCFHORD14 option

**Suggested additional testing:** Schedule subsequent **MSCFHORD14** options in TaskMan to run several different times throughout the day. Check the printer to verify that the task completes each time entered.

### Related artifact: 20490

# **ED Dashboard**

# **Emergency Department Reporting Enhancements**

This release includes nine new emergency department reports and enhancements to several existing ED reports; two reports—**Overall LOS for Inpatient Admissions** and **Overall Length of Stay for Patients Discharged to Home**—have been removed. The workflow for accessing ED reports has not changed; however, the reports include some new options: customized display orders for each new report, the ability to run a report with today as a start and stop date, as well as the ability to search specific time ranges.

**Note:** The functionality of several new reports depends on ED dashboard changes/customized ED dashboard dispositions included in this release. Familiarize yourself with these changes; the customized dispositions supply data for many new reports.



### Accessing Emergency Department Reports

- 1. Log in to PuTTY and select Test an Option > MSCD DASHBOARD REPORTS.
- 2. Enter the reporting period start date.
- 3. Enter the reporting period end date.
- 4. Enter the start time (optional).
- 5. Enter the stop time (applicable only if a start time is entered).
- 6. Choose either All Dashboard Reports or Selected Dashboard reports

The ability to display patient lists remains an option, as well as the choice of a Full or Summary report.

Each report has options that allow the user to decide how the reported information displays; options are unique for each report. Screenshots for these options showing default values are included for each new report in the New Emergency Department Reports section below.

Print options display next and include the ability to create a delimited file output for use in Excel.

### New Emergency Department Reports

ED Registration: This report provides a total count of ED registrations during the selected date/time range. It also provides a patient list from those ED registrations and includes key data: Name, MRN, Acct #, Age, Arrival date and time, Disposition time and Disposition Type if they are entered on the ED dashboard at the time the report is run. The initial registration time is determined by the DATE/TIME field of the VISIT file entry. The Disposition time is captured when the disposition order is signed. The Disposition Type is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file.

Select Registrat	ion Report Pt Listing O	rder
Select one of	of the following:	
A R D	Alphabetically by Na Registration Time Disposition Time	ame
Enter Selection:	R//	

Figure 18: ED Registration report options

ED Registrations							
MEASURE DESCRIPTION:							
This measure will	l provide a	total count of	ED	registrations			
during the report	ing period(	s):					
DATE /TIME field	f the VISIT	e is determine	a by n +h	TOOKING at the			
DATE/TIME THETO (	I LIE VISII	The entry to	r un	e eb encouncer.			
DATA:							
Number of Registe	ered ED Pati	ents: 20					
PATIENT LIST:							
Name	MRN	Acct #	Age	Arrival	Dispo	Dispo Type	
OHDE, REPORTFIVE	1000000404	200000605	<u>3</u> 0	07/10/17@1430		EX	
OHDE, REPORTSIX A	1000000405	2000000606	72	07/12/17@1258		DISCHARGE	
OHDE, REPORTSEVEN	1000000406	2000000607	40	0//12/1/@1318		DISCHARGE	
OUDE REPORTNINE	1000000408	20000000009	36	07/12/17@1215		DISCHARGE	
OHDE, REPORTTEN M	1000000409	2000000614	37	07/18/17@0910	1011	DISCHARGE	
OHDE, REPORTELEVE	1000000410	2000000615	36	07/18/17@0915	1033	DISCHARGE	
OHDE, REPORTTWELV	1000000411	2000000616	37	07/18/17@1131	1213	EX	
OHDE, REPORTTHIRT	1000000412	2000000617	77	07/18/17@1238	1411	ELOPED	
OHDE, REPORTFOURT	1000000413	2000000618	37	0//18/17@1242	1458	AMA	
OHDE, REPORTE OUR	1000000414	2000000019	10	07/19/1/@0810	1209	TRANSFER	
UNDE - NEFURIEUURI						I DENNITE F R	

Figure 19: ED Registrations listings



Length of Stay: This report provides a breakdown of the length of stay for patients who were dispositioned during the selected reporting period. The report details the total number of dispositioned ED patients, the average length of stay, as well as the total length of stay minutes for the reporting period. Each length of stay is then broken down by Disposition Type and lists the average length of stay in minutes and hours, as well as the number of patients with that disposition assigned. The shortest and longest length of stay is also detailed, along with the patient name and MRN. The patient list displays the Patient Name, MRN, Account #, Age, Arrival Date and Time, Disposition time, and LOS Minutes for that patient. The Disposition Time is captured when the disposition order is signed.

Select LOS Report	t Pt Listing Order
Select one o	of the following:
A S L	Alphabetically by Name Shortest to Longest LOS Longest to Shortest LOS
Enter Selection:	s// 📕

Figure 20: Length of Stay reporting options

LOS						
MEASURE DESCRIPTION: This measure will provide a breakdown of the LOS for any patient who was dispositioned during the reporting period(s). The initial registration time is determined by looking at the DATE/TIME field of the VISIT file entry for the ED encounter. The discharge disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file. If there is no value stored in the DISPOSITION TYPE field the patient will display with a type of UNDEFINED						
DATA:						
Total Number of Average Overall Total LOS Minute	Disposition LOS: 341.9 es: 4103	ned ED Pa 2	atients: 12			
Average LOS for Average LOS for	DISCHARGE ADMIT TRANSFER LWOBS AMA EXPIRED ELOPED UNDEFINED			Minutes 317.60 0.00 231.00 122.00 181.00 0.00 159.00 0.00	Hours 5.3 0.0 3.9 2.0 3.0 0.0 2.7 0.0	Total Pts 5.0 0.0 1.0 2.0 0.0 2.0 0.0
Shortest LOS Longest LOS	Minutes 61 1482	Hours 1.0 24.7	Patient Na OHDE,REPOR OHDE,REPOR	me TTEN M TTWELVE A	MRN 1000 A 1000	0000409 0000411

Figure 21: Length of Stay report summary

PATIENT LIST: Name	MRN	Acct #	Age	Arrival	Disp	LOS Mins
TEST,DISCHARGE TEST,PUFFER OHDE,REPORTSEVEN TEST,TEDDY H TEST,RANDY Y TEST,VANCE C TEST,KINDRA H	100000062 100000239 1000000417 1000000091 1000000019 1000000112 100000096	2000000671 2000000672 2000000686 2000000664 2000000663 2000000670 2000000669	61 43 75 30 19 48 32	08/07/17@0919 08/07/17@0921 08/11/17@0806 08/04/17@1352 08/04/17@1348 08/07/17@0829 08/07/17@0826	0937 0939 0829 1425 1422 0903 0902	18 23 33 34 34 36

Figure 22: Length of Stay report with patient details

 Discharge: This report provides a total count of ED patients with a disposition type of Discharge. The discharge disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file. The report displays the total number of ED patients with a disposition of Discharge.



The disposition is broken down and displayed by each customized discharge disposition unique to each facility, which includes the number of patients for each type of discharge disposition, as well as a percentage of the total discharges. The patient list displays the **Patient Name**, **MRN**, **Account #, Age**, **Arrival Time**, **Disposition**, and **Discharge Time** for that patient. The **Discharge Time** is captured when the disposition order is signed.



Figure 23: Discharge reporting options

Discharge						
MEASURE DESCRIPTION: This measure will provide a total count of ED patients with a disposition type of DISCHARGE. The discharge disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file.						
DATA						
DATA:						
Number of ED Patients with d	isposition DIS	CHAR	GE: 5			
Disposition HOME		N	umber of 5	Pts %	of Total 100.00%	
PATIENT LIST:						
Name MRN	Acct #	Age	Arrival	Dispos	ition	DISCH Time
OHDE, REPORTTEN M 1000000409	2000000614	37	0910	HOME		1011
OHDE, REPORTELEVE 1000000410	2000000615	36	0915	HOME		1033
OHDE, REPORTFIFTE 1000000414	2000000619	18	0816	HOME		1209
OHDE, REPORTEIGHT 1000000418	2000000624	63	1341	HOME		0850
OHDE, REPORTTWENT 1000000420	2000000626	37	0826	HOME		0933



• Admit: This Report provides a total count of ED patients with a disposition type of Admit. The admit disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file. The report displays a total number of ED patients with a disposition of Admit. The disposition is broken down and displayed by each customized Admit disposition unique to each facility, which includes the number of patients for each type of admit disposition, as well as a percentage of the total admits. The patient list displays the Patient Name, MRN, Account #, Age, Arrival Time, Disposition, and Admit Time for that patient. The Admit Time is captured when the disposition order is signed.

Select ADMIT Report	: Pt Listing Order
Select one of	the following:
A D P T	Arrival Time Disposition Time Patient Name Type of Disposition
Enter Selection: P/	//

Figure 25: Admit reporting options



Admit						
MEASURE DESCRIPTION: This measure will provide a total count of ED patients with a disposition type of ADMIT The discharge disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file.						
DATA:						
Number of ED Patients with d	isposition ADM	IT: 2	2			
Disposition MED/SURG NEUROLOGY		N	umber of 1 1	Pts %	of Tota 50.00% 50.00%	1
PATIENT LIST: Name MRN OHDE,REPORTEIGHT 1000000407 OHDE,REPORTSEVEN 1000000417	Acct # 2000000687 2000000686	Age 36 75	Arrival 0808 0806	Dispos NEUROLO MED/SUR	ition DGY RG	ADMIT Time 0947 0829

Figure 26: Admit report with patient detail

• **Transfer:** This report provides a total count of ED patients with a disposition type of **Transfer**. The transfer disposition is determined by looking at the **DISPOSITION TYPE** field of the **MSCD EVENT** file. The report displays a total number of ED patients with a disposition of **Transfer**. The disposition is then broken down and displayed by each customized **Transfer** disposition unique to each facility, which includes the number of patients for each type of transfer disposition, as well as a percentage of the total transfers. The patient list displays the **Patient Name**, **MRN**, **Account #**, **Age**, **Arrival Time**, **Disposition**, and **Transfer Time** for that patient. The **Transfer Time** is captured when the disposition order is signed.



Figure 27: Transfer reporting options

Transfer						
MEASURE DESCRIPTJ This measure will with a dispositio The discharge dis DISPOSITION TYPE	CON: l provide a on type of T sposition is field of th	total count of RANSFER determined by e MSCD EVENT f	f ED   / lool file.	patients king at	the	
DATA:						
Number of ED Pati	ients with d	isposition TRA	ANSFEI	R: 7		
Disposition MERCY MEDICA ST JOSEPH'S UNIVERSITY H	Disposition MERCY MEDICAL CENTER ST JOSEPH'S HOSPITAL UNIVERSITY HOSPITAL			umber of 2 2 3	Pts % of Total 28.57% 28.57% 42.86%	
PATIENT LIST:						
Name	MRN	Acct #	Age	Arrival	Disposition	TRANS Time
OHDE, REPORTEIGHT	100000407	200000642	36	1349	UNIVERSITY HOSP	P 0852
OHDE, REPORTEIGHT	1000000407	2000000651	36	0900	UNIVERSITY HOSP	P 1041
OHDE, REPORTFOURT	1000000415	2000000620	45	0820	MERCY MEDICAL C	
OHDE, REPORTNINE	1000000408	2000000052	22	1102	UNIVERSITY HUSP	11/12
TEST, EKIN	1000000017	20000000000	31	1106	ST INSEPU'S HOS	1140
TEST PEARI	1000000056	200000000556	10	1108	ST JOSEPH'S HOS	1146

Figure 28: Transfter report with patient detail



LWOBS (Left Without Being Seen): This report provides a total count of ED patients with a disposition type of Left Without Being Seen (LWOBS). The LWOBS disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file. The report displays a total number of ED patients with a disposition of LWOBS. The disposition is then broken down and displayed by each customized LWOBS disposition unique to each facility, which includes the number of patients for each type of transfer disposition, as well as a percentage of the total transfers. The patient list displays the Patient Name, Medical Record Number, Account #, Age, Arrival Time, Disposition, and LWOBS Time for that patient. The LWOBS Time is captured when the disposition order is signed.

Select LWOBS Repo	ort Pt Listing Order
Select one o	of the following:
A D P T	Arrival Time Disposition Time Patient Name Type of Disposition
Enter Selection:	P//

Figure 29: Left Without Being Seen reporting options

LWOBS							
MEASURE DESCRIPTION: This measure will provide a total count of ED patients with a disposition type of Left Without Being Seen. The discharge disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file.							
DATA:							
Number of ED Pat	ients with d	isposition LWO	BS:	7			
Disposition PRIOR TO PRO PRIOR TO TR	DVIDER IAGE		N	umber of 5 2	Pts % o	of Total 71.43% 28.57%	
PATIENT LIST:							
Name OHDE,REPORTNINET TEST,FRIDAY TEST,JAMBERRY TEST,KINDRA H TEST,MARY TEST,RANDY Y TEST,TEDDY H	MRN 1000000419 100000087 100000099 100000096 100000097 1000000019 1000000091	Acct # 2000000625 2000000666 2000000669 2000000669 2000000663 2000000663 2000000664	Age 22 62 50 31 61 18 30	Arrival 0821 0803 1346 0826 0800 1348 1352	Disposit PRIOR TC PRIOR TC PRIOR TC PRIOR TC PRIOR TC PRIOR TC PRIOR TC	Tion LW PROVID PROVID TRIAGE TRIAGE PROVID PROVID PROVID	DBS Time 1023 0905 1424 0902 0901 1422 1425

Figure 30: Left Without Being Seen report with patient detail

AMA (Against Medical Advice): This report provides a total count of ED patients with a disposition type of Against Medical Advice (AMA). The AMA disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file. The report displays a total number of ED patients with a disposition of AMA. The disposition is then broken down and displayed by each customized AMA disposition unique to each facility, which includes the number of patients for each type of AMA disposition, as well as a percentage of the total AMA patients. The patient list displays the Patient Name, Medical Record Number, Account #, Age, Arrival Time, Disposition, and AMA Time for that patient. The AMA Time is captured when the disposition order is signed.



Select AMA Report H	Pt Listing Order
Select one of	the following:
A D P T	Arrival Time Disposition Time Patient Name Type of Disposition
Enter Selection: P,	//

Figure 31: Against Medical Advice reporting options

АМА						
MEASURE DESCRIPTION: This measure will provide a total count of ED patients with a disposition type of Against Medical Advice The discharge disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file.						
DATA:						
Number of ED Patients with disposition AMA	.: 4					
Disposition AMA FORM NOT SIGNED AMA FORM SIGNED	Number of Pts % of Total 1 25.00% 3 75.00%					
PATIENT LIST: Name OHDE,REPORTFOURT 1000000413 200000618 OHDE,REPORTFOURT 100000413 200000650 OHDE,REPORTSIXTE 100000416 2000000621 OHDE,REPORTSIXTE 100000416 2000000649	Age Arrival Disposition AMA Time 37 1242 AMA FORM SIGNED 1458 37 0859 AMA FORM SIGNED 1235 28 0824 AMA FORM SIGNED 1210 28 0856 AMA FORM NOT SI 1231					

Figure 32: Against Medical Advice report with patient detail

• Eloped: This report provides a total count of ED patients with a disposition type of Eloped. The Eloped disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file. The report displays a total number of ED patients with a disposition of Eloped. The disposition is then broken down and displayed by each customized Eloped disposition unique to each facility, which includes the number of patients for each type of Eloped disposition, as well as a percentage of the total eloped patients. The patient list displays the Patient Name, Medical Record Number, Account #, Age, Arrival Time, Disposition, and Eloped Time for that patient. The Eloped Time is captured when the disposition order is signed.



Figure 33: Eloped reporting options



Eloped					
MEASURE DESCRIPTION: This measure will provide a total count of ED patients with a disposition type of ELOPED The discharge disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file.					
DATA:	DATA:				
Number of ED Patients with dispo	ition ELOPED:	4			
Disposition UNWITNESSED WITNESSED	Nu	umber of 3 1	Pts % of Tota 75.00% 25.00%	1	
PATIENT LIST: Name MRN Acc OHDE,REPORTSEVEN 1000000417 2000 OHDE,REPORTTHIRT 1000000412 2000 TEST,DISCHARGE 1000000062 2000 TEST,PUFFER 1000000239 2000	z# Age 0000622 75 0000617 77 0000671 61 0000672 43	Arrival 0829 1238 0919 0921	Disposition UNWITNESSED UNWITNESSED WITNESSED UNWITNESSED	ELOPE Time 1214 1411 0937 0939	

Figure 34: Eloped report with patient detail

Expired: This report provides a total count of ED patients with a disposition type of Expired. The expired disposition is determined by looking at the DISPOSITION TYPE field of the MSCD EVENT file. The report displays a total number of ED patients with a disposition of Expired. The disposition is then broken down and displayed by each customized Expired disposition unique to each facility, which includes the number of patients for each type of expired disposition, as well as a percentage of the total expired patients. The patient list displays the Patient Name, MRN, Account #, Age, Arrival Time, Disposition, and Expired Time for that patient. The Expired Time is captured when the disposition order is signed.



Figure 35: Expired reporting options

Expired							
MEASURE DESCRIPTI This measure wil with a dispositio The discharge dis DISPOSITION TYPE	TON: l provide a provide a provide a formation type of E sposition is field of the	total count of XPIRED determined by e MSCD EVENT f	ED p look ile.	oatients cing at	the		
DATA:							
Number of ED Pati	ients with d	isposition EXP	IRED	6			
Disposition MEDICAL TRAUMA			N	umber of 5 1	Pts %	of Total 83.33% 16.67%	
PATIENT LIST:							
Name	MRN	Acct #	Age	Arrival	Dispos	ition	EXPIR Time
ALPHA, PAILENI	1022	2000000630	21	1027	MEDICAL		1011
OHDE, REPORTTWELV	1000000409	2000000616	37	1131	MEDICAL	-	1213
TEST, JOY A	100000278	2000000668	47	0824	MEDICAL		0904
TEST, STONE M	1000000079	2000000667	31	0810	TRAUMA		0906
TEST, VANCE C	1000000112	2000000070	40	0029	MEDICAL		0903

Figure 36: Expired report with patient detail



# Existing Emergency Department Report Enhancements

**Note:** The existing **Registration to Triage Start** ED report was enhanced in the 2016.2.0 release. No changes were made to this report in this release; however, a screenshot is included for comparison with the other enhanced reports.

Registration to	Triage Start		
MEASURE DESCRIP This measure wi of the patient	TION: ll evaluate the time betwee until the time that the tri	n the initial regis age process was beg	tration un.
The initial reg DATE/TIME field triage begin ti for this visit matches one of MSCD TRIAGE TIU look to the ENT determine the t	istration time is determine of the VISIT file entry fo me is determined by looking time and finding the first the TIU Note titles defined DOCUMENT. Once the triage RY DATE/TIME field of the T riage start time.	d by looking at the r the ED encounter. through the Notes note with a title w by the parameter: note is found the r IU DOCUMENT file en	The on file hose name eport will try to
DATA:	Minutes from Reg to Triage	No. of Pts.	Total Percentage
Reg to Triage	2 3 4 6 7 9 16 25 27 34 35 45	2 2 3 2 1 3 2 1 1 1 2 1	$\begin{array}{c} 9.52\%\\ 9.52\%\\ 14.29\%\\ 9.52\%\\ 4.76\%\\ 14.29\%\\ 9.52\%\\ 4.76\%\\ 4.76\%\\ 4.76\%\\ 4.76\%\\ 4.76\%\\ 4.76\%\\ 4.76\%\\ 4.76\%\\ 4.76\%\end{array}$
Number of Patie	nts Registered: 27		
Number of Patie	nts from Registration to Tr	iage Start: 21	
Average Registr	ation to Triage time per pa	tient: 14.33	

Figure 37: Enhanced Registration to Triage Start report

• **Triage Start to Triage End:** The measure of **Triage Start to Triage End** was changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients triaged, number of patients with a signed triage note, and the average minutes from triage start to triage end displays. The minutes from triage start to triage end is also added to the patient list for each patient. No changes were made in the way data is captured for this report.



Triage Start to Triage	e End				
MEASURE DESCRIPTION: This measure will eva triage process until	luate the tin the time the	me between the triage note w	e beginning of t vas signed.	he	
The triage begin time file for this visit t name matches one of t MSCD TRIAGE TIU DOCUME look to the ENTRY DATT determine the triage s will look to the SIGNA note has not yet been	is determin ime and find ne TIU Note ENT. Once the /TIME field start time. ATURE DATE/T signed it w	ed by looking ing the first titles defined e triage note of the TIU DO For the triage IME field for ill display th	through the Not note with a tit l by the paramet is found the re CUMENT file ent end time the r the triage note word UNSIGNED	es on le whose er: port will ry to eport . If a	
DATA:	Tota	al Minutes No	o. of Pts. To	tal Perce	ntage
Triage Start to Triage	End	1 2 6 7	9 6 2 1	50.00 33.33 11.11 5.56	
Number of Patients Reg Number of Patients Tr Number of Patients wi Average minutes from T	gistered: 20 iaged: 18 th SIGNED Tr Friage Start	iage Note: 18 to Triage End	l: 2.22		
PATIENT LIST: Name OHDE,REPORTTEN M OHDE,REPORTELEVEN A OHDE,REPORTTWELVE A	MRN 1000000409 1000000410 1000000411	Acct # 2000000614 2000000615 2000000616	Triage Start 07/18/17@0916 07/18/17@0918 07/18/17@1135	End 0918 0920 1136	Minutes 1 1 1

Figure 38: Enhanced Triage Start to Triage End report

Triage End to Exam Room Assignment: The measure of Triage End to Exam Room
 Assignment was changed from time groupings to exact minutes and displays along with the total
 number of patients and percentages for each minute marker. The number of patients registered,
 number of patients triaged, number of patients with an exam room assignment, and the average
 minutes from triage end to room assignment displays. The minutes from triage end to room
 assignment is also added to the patient list for each patient. No changes were made in the way
 data is captured for this report.

Triage End to Exam Room Assign	nment		
MEASURE DESCRIPTION: This measure will evaluate the signed and when the exam room	e time between was assigned t	when the triag o the patient.	je note was
The triage end time is determi file for this visit time and f name matches one of the TIU No MSCD TRIAGE TIU DOCUMENT. Once look to the SIGNATURE DATE/TIM determine the triage end time. will look through the change l date/time when the initial exa	ined by looking inding the fir ote titles defi the triage no IE field of the For the room log for the MSC um room assignm	through the N st note with a ned by the par te is found th TIU DOCUMENT assignment tim D EVENT record ent occurred.	Notes on title whose rameter: ne report will file entry to le the report and find the
Negative numbers indicate the room prior to triage end.	patient was as	signed to a	
DATA:	Total Minutes	No. of Pts.	Total Percentage
Triage End to Room Assignment	0 1 2 3 4 8 9 23 1087	7 3 2 1 1 1 1 1 1	$\begin{array}{c} 38.89\\ 16.67\\ 11.11\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\\ 5.56\end{array}$
Number of Patients Registered: Number of Patients Triaged: 18 Number of Patients with Exam R Average minutes from Triage Er	20 Room Assign: 11 nd to Room Assi	gn: 103.73	

Figure 39: Enhanced Triage End to Exam Room Assignment report



PATTENT LTST:					
Name	MRN	Acct #	Triage End	Room Assigned	Minutes
OHDE, REPORTTEN M OHDE, REPORTNINET	$\begin{array}{c} 1000000409 \\ 1000000419 \end{array}$	2000000614 2000000625	07/18/17@0918 07/25/17@0835	07/18/17@0920 07/25/17@0837	2 2
OHDE, REPORTFOURT OHDE, REPORTSIXTE	1000000415 1000000416	2000000620 2000000649	07/19/17@0848 08/04/17@0906	07/19/17@0851 08/04/17@0909	3 3
OHDE, REPORTTHIRT OHDE, REPORTNINE	1000000412 1000000408	2000000617 2000000652	07/18/17@1315 08/04/17@0913	07/18/17@1320 08/04/17@0917	4 4
OHDE, REPORTSEVEN	1000000417	2000000622	07/19/17@0916	07/19/17@0925	8
OHDE, REPORTSEVEN	1000000406	2000000607	07/12/17@1333	07/12/17@1343	9

Figure 40: Triage End to Exam Room Assignment report with patient detail

• Registration to Provider Assignment: The measure of Registration to Provider Assignment was changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients with a provider assignment, and the average minutes from registration to provider assignment displays. The minutes from registration to provider assignment is also added to the patient list for each patient. No changes were made in the way data is captured for this report.

Registration to Provider Assign	nment		
MEASURE DESCRIPTION: This measure will evaluate the of the patient until the time	time between that the provi	the initial re der was assign	egistration ned.
The initial registration time DATE/TIME field of the VISIT f provider assignment time the r for the MSCD EVENT record and provider assignment occurred.	is determined ile entry for eport will loo find the date/	by looking at the ED encount k through the time when the	the cer. For the change log initial
DATA:	Total Minutes	No. of Pts.	Total Percentage
Registration to Provider Assig	n 5 6 7 8 12 14 17 32 33 36 40 40 44 52 129 196 1109 6882 UNASSIGNED	1121111111112	$\begin{array}{c} 5.00\\ 5.00\\ 10.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 5.00\\ 10.00\\ \end{array}$
Number of Patients Registered: Number of Patients with Provid Average minutes from Registrat	20 er assignment: ion to Provide	18 r assignment:	479.39

Figure 41: Enhanced Registration to Provider Assignment report



PATIENT LIST: Name	MRN	Acct #	Registration	Provider Assign	Minutes
OHDE,REPORTTEN M	1000000409	2000000630	07/31/17@1027	07/31/17@1032	5
OHDE,REPORTTWELV TEST,PUFFER	1000000411 1000000239	2000000616 2000000672	07/18/17@1131 08/07/17@0921	07/18/17@1137 08/07/17@0927	6 6
OHDE, REPORTFIVE OHDE, REPORTELEVE	1000000404 1000000410	2000000605 2000000615	07/10/17@1430 07/18/17@0915	07/10/17@1437 07/18/17@0922	7 7
OHDE,REPORTSIX A OHDE,REPORTEIGHT TEST,DISCHARGE	1000000405 1000000407 1000000062	2000000606 2000000642 2000000671	07/12/17@1258 08/02/17@1349 08/07/17@0919	07/12/17@1306 08/02/17@1357 08/07/17@0927	8 8 8
OHDE,REPORTSIX A	1000000405	2000000653	08/04/17@0903	08/04/17@0913	10
TEST,LAUREN	100000018	2000000655	08/04/17@1106	08/04/17@1117	11

Figure 42: Registration to Provider Assign with patient detail

• Exam Room Assignment to Provider Assignment: The measure of Exam Room Assignment to Provider Assignment was changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients with a room and a provider assigned, and the average minutes from room assignment to provider assignment displays. The minutes from room assignment to provider assignment is also added to the patient list for each patient. No changes were made in the way data is captured for this report.

Exam Room Assignm	ment to Provi	ider Assignm	ent		
MEASURE DESCRIPT This measure will room and the time	CON:   evaluate th e that the pr	ne time betwo rovider was a	een the assignm assigned.	ent of the exam	
For the exam room change log for the initial exam room report will look and find the date	n assignment ne MSCD EVEN n was assigne through the e/time when t	time the rep record and ed. For the p change log the initial p	port will look find the date/ provider assign for the MSCD EV provider assign	through the time when the ment time the ENT record ment occurred.	
DATA:		Tatal Mission		Tatal Davas	<b>.</b>
		Total Minu	tes No. of Pts	. Total Percen	tage
Room Assign to Pr	rovider Assig	gn 1 2 7 16	8 2 1 1	53.33 13.33 6.67 6.67	
		91 140 6865	1 1 1	6.67 6.67 6.67	
Number of Patient Number of Patient Average minutes f	ts Registered ts with Room From Room Ass	d: 20 and Provide sign to Prov	r Assigned: 15 ider Assign: 47	5.40	
PATIENT LIST: Name	MRN	Acct #	Room Assign	Provider Assign	Minute
OHDE, REPORTFIVE OHDE, REPORTSIX A OHDE, REPORTTEN M OHDE, REPORTELEVE	$\begin{array}{c} 1000000404\\ 1000000405\\ 1000000409\\ 1000000410 \end{array}$	2000000605 2000000606 2000000614 2000000615	07/10/17@1436 07/12/17@1305 07/18/17@0920 07/18/17@0921	07/10/17@1437 07/12/17@1306 07/18/17@0922 07/18/17@0922	1 1 1 1

Figure 43: Enhanced Exam Room Assignment to Provider Assignment report

• Provider Assignment to Inpatient Admission: The measure of Provider Assignment to Inpatient Admission was changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients with a provider assigned and an inpatient admission, and the average minutes from provider assignment to inpatient admission displays. The minutes from provider assignment to inpatient admission is also added to the patient list for each patient. No changes were made in the way data is captured for this report.



Provider Assignme	ent to Inpat	ient Admissio	on			
MEASURE DESCRIPT This measure will assigned and wher will only conside	CON:   evaluate th n the IP adm <sup>-</sup> er those pat <sup>-</sup>	ne time betwe ission order ients who wer	een when the pro was written. Th re admitted as I	ovider was his measure Inpatients.		
For the provider assignment time the report will look through the change log for the MSCD EVENT record and find the date/time when the initial provider assignment occurred. For the admission order date/time the report will search through the ORDER file to find an order for one of the ORDERABLE ITEM's defined by the parameter: MSCD ADMIT ORD ITEMS. Once the admission order is found the report will use the DATE/TIME ORDERED field of the initial order creation order action subfile entry.						
DATA:		Total Minut	tes No. of Pts	. Total Perce	ntage	
Provider Assign t	to IP Adm	52	1	100.00		
Number of Patients Registered: 20 Number of Patients with Provider Assigned and IP Admission: 1 Average minutes from Provider Assign to IP Adm: 52.00						
PATIENT LIST: Name	MRN	Acct #	Prov Assign	IP Admit	Minutes	
OHDE, REPORTTWENT	1000000420	2000000626	07/25/17@0840	07/25/17@0933	52	

Figure 44: Enhanced Provider Assignment to Inpatient Admission report

• ED Disposition to Ward/Bed Assignment: The measure of ED Disposition to Ward/Bed Assignment has changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients with an ED disposition and an inpatient bed, and the average minutes from ED disposition to inpatient bed displays. The minutes from ED disposition to inpatient bed assignment is also added to the patient list for each patient. No changes were made in the way data is captured for this report.

MEASURE DESCRIPTION: This measure will evaluate the time between the when the admission order was written and when the patient was transferred to the IP location
location.
For the admission order date/time the report will search through the ORDER file to find an order for one of the ORDERABLE ITEM's defined by the parameter: MSCD ADMIT ORD ITEMS. Once the admission order is found the report will use the DATE/TIME ORDERED field of the initial order creation order action subfile entry. To determine the IP location transfer time the report will search the PATIENT MOVEMENT file to look for an ADMISSION entry that occurs after the date/time of the ED visit.
DATA:
Total Minutes No. of Pts. Total Percentage
Total Minutes No. of Pts. Total Percentage ED Disposition to IP Bed 286 1 100.00
Total Minutes No. of Pts. Total Percentage ED Disposition to IP Bed 286 1 100.00 Number of Patients Registered: 20 Number of Patients with ED Disposition and IP Bed 1 Average minutes from ED Disposition to IP Bed: 286.00
Total MinutesNo. of Pts.Total PercentageED Disposition to IP Bed2861100.00Number of Patients Registered: 20 Number of Patients with ED Disposition and IP Bed 1 Average minutes from ED Disposition to IP Bed: 286.00286.00PATIENT LIST: NameMRNAcct #ED Disposition Bed Assignment Minutes

Figure 45: Enhanced ED Disposition to Ward/Bed Assignment report



• **Registration to Inpatient Admission:** The measure of **Registration to Inpatient Admission** is changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients with an inpatient admission, and the average minutes from registration to inpatient admission display. The minutes from registration to inpatient admission is also added to the patient list for each patient. No changes were made in the way data is captured for this report.

Registration to Inpatient	Admission			
MEASURE DESCRIPTION: This measure will evaluat of the patient until the	e the time betw time that the a	een the initial dmission order	registration was written.	
The initial registration DATE/TIME field of the VI admission date/time the r find an order for one of MSCD ADMIT ORD ITEMS. Onc will use the DATE/TIME OR order action subfile entr	time is determi SIT file entry eport will sear the ORDERABLE I e the admission DERED field of y.	ned by looking for the ED enco ch through the TEM's defined b order is found the initial ord	at the Dunter. For the ORDER file to y the parameter the report ler creation	
DATA:	Total Minu	tes No. of Pts	. Total Perc	entage
Reg to IP Admission	6 67	1 1	50.0 50.0	) )
Number of Patients Regist Number of Patients with I Average minutes from Regi	ered: 20 P Admission: 2 stration to IP	Adm: 36.50		
PATIENT LIST: Name MRN	Acct #	Registration	IP Admission	Minutes

Figure 46: Enhanced Registration to Inpatient Admission report

• **Registration to Discharge:** The measure of **Registration to Discharge** is changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients with a discharge disposition, and the average minutes from registration to discharge display. The minutes from registration to discharge is also added to the patient list for each patient. No changes were made in the way data is captured for this report.

Registration to Discharge (fo	r pts discharge	ed to home)	
MEASURE DESCRIPTION: This measure will evaluate th of the patient until the time This measure only considers t from the ED. It will not cons	e time between that the disch hose patient wh ider Inpatient	the initial re barge order was bo were dischar admissions.	gistration written. ged to Home
The initial registration time DATE/TIME field of the VISIT DISCHARGE time, the report wi an order for one of the ORDER MSCD DISCHARGE ORD ITEMS. Onc will use the DATE/TIME ORDERE order action subfile entry.	is determined file entry for 11 search throu ABLE ITEM's def e the discharge D field of the	by looking at the ED encount igh the ORDER f ined by the pa order is foun initial order	the er. For the ile to find rameter: d the report creation
DATA:	Total Minutes	No. of Pts.	Total Percentage
Registration to Discharge	61 78 93 122 136 225 226 231 233 1149 1482		$\begin{array}{c} 9.09\\ 9.09\end{array}$
Number of Patients Registered Number of Patients with Disch Average minutes from Registra	: 20 arge: 11 tion to Dischar	ge: 366.91	

Figure 47: Enhanced Registration to Discharge report



### **Removed Emergency Department Reports**

These emergency department reports have been removed.

- Overall LOS for Inpatient Admissions
- Overall Length of Stay for Patients Discharged to Home

The new Length of Stay ED report now incorporates all the data previously captured by these reports.

**Required action:** Test each new report after configuring customized **ED Disposition Types** (see the release notes below for Customizing ED Dashboard Dispositions) and adding new dispositions to test patients. Run new ED reports and analyze the data. Test existing report enhancements by utilizing your normal ED report workflow.

**Suggested additional testing:** Test by running each new and existing ED report utilizing several dates and date/time range combinations.

### Related artifacts: 20132; 20693

### ED Dashboard Changes

- 1. **Disposition column:** The new customized disposition selections will display on the ED dashboard in the Disposition column.
- 2. **Comments column:** Comments entered on the Encounter tab will display on the ED dashboard in the Comments column.

### Encounter Tab

1. **Disposition field:** The disposition field is changed from a free-text field to a drop-down field that displays customized dispositions, which are mapped to new ED reports and allow for greater reporting capabilities.

**Notes:** See the Customizing ED Dashboard Disposition section below for instructions on customizing the dispositions for your facility. See the ED Dashboard Reports Enhancements section for details on the new ED Dashboard reports and reporting enhancements.

- 2. **Comments field:** A free text **Comments** field is added, allowing users to add short comments on the patient. These comments display in the new **Comments** column on the ED Dashboard.
- 3. Room Assignment field: Room Assignment is relabeled Room.
- Notes/Comments field: The Notes/Comments field is relabeled Notes. Information entered in the Notes field remains in the Encounter tab and is not viewable on the ED Dashboard Comments column.



# Making ED Dashboard Changes

User Patient	Ref	resh Data Tools Help	Add/Edit	eSig C	iear Clear and Lock	Dosing	g Calculat	or Grap	hing Ir	nbox													
PRIVACY	тои	IFICATIONS PATIEN	IT CHART	RES	OURCES ED DASH	IBOAR	D SU	RGERY T	RACKER	R SUI	RGERY S	CHEDU	LING	eRx R	.ENEW	ALS							
Exa FILTERS: [AL	n Ar L]	ea Nurse		F	Physician	Mic [Al	l-Level		Pati	ent/Roc	om	▼ Pr	int Cens	ius Re	port				Unit Sta Unassi Fast Tr Traum ALL: 10	atistics gned: 9 ack: 1 a: 2 )9	16 Triage: 3 Cr Main ED: 3 Ol Waiting: 0	itical Care oservatior	Wait Time < 1 HR 1 - 3 HRS > 3 HRS
ED Room		Name	Age	PMD	Chief Complaint	ESI	Time	NUR	PHY	MLP	MED	LAB	U/A	XR	СТ	US	NSG	CLX	CST	PRC	Disposition	Room	Comments
Critical Care :	0	JONAS, DASHVISITGG	38y (F)		Pneumonia	3	18:59	JN	EL												DISCHARGE- HOME		wants blanket 📩
Critical Care	2	TEST, ANDREW	36y (M	)	Chest Pain	2	22:53	MGH	SM												DISCHARGE- HOME		blue alert
Critical Care	2 0	KESSLER, DAVID	45y (M	)	Chest Pain		22:29	NZ	SR												TRANSFER- ST JOSEP		NPO
Fast Track 2	0	JONAS, EDDASHREGA	A 52y (M	)	Persistent nausea/	3	01:04	JN	EL			_									ADMIT- ICU	114	Awaiting Dr J
Main ED 1	-	TEST, FAN S	45y (F)		Cough	-	20:09	RON	КК	<u> </u>		_			-			-	-				
Main ED 2	0	OHDE, REPORTTHREE	66y (F)	PJ	Persistent nausea/	2	01:13	RON	SM									-	-		ADMIT- OPERATING	OR-3	Pre-Op
Main ED 3		JONAS, DASHVISITJJ	59y (F)	-	Weakness	3	22:05	JN N	EL	-		-	-					-	-		ADMIT- NEUROLOGY		Na familu
Trauma 1	0	OPDAED EPONE	21 J (M	1014	Couch	2	01.55	LIDNI	76	-			-					-	+				No family
Trauma 2	5	TEST DOVE	32v (F)	1	Cough	-	20:12	NU										-			AMA- AMA FORM SL.		Pt is not to h
Triage 1		PRODUCT, EDDASH	52y (M	)	Injury	-	18:31	LC	SM									1			ADMIT- L&D	314	
Account #: 5	5443	36789 MR# Patient Tracking	: 1209		Name: KES	ISLER, I	DAVID			1	Or	ders —	Or	ders	Pro	ogress	Notes	Lab	Results	Integ	rated Problem List	Vitals	Allergies
Chief Canada						ECT.									M	IED L	AB U/	A XR	CT	US	NSG CLX CST PRC		
Chier Compia	sinc		Exam Koo	am o		E 31					⊐∐⊻	erificati	on Statu	s It	em Or	dered	Whe	en Ente	red	Order	Status Additional N	lotes	
Cnest Pain			critical Ca	are 2							<u> </u>												
Nurse Assign	ed		Physician	Assigned		Mid-	Level As	signed			-11												
ZAVALA,NUF	SE.	<u> </u>	REMPEL,S	AM	-						-    -												
Disposition			Room	Note	5		□ Cr	itical No	te 🗆 Se	epsis Ale	ert												
TRANSFER- S	DI T	SEPH'S HOSPITAL		test	note 1						-11												
Comments	NPO	)								Save													

### Figure 48: Customizing ED Dashboard Dispositions

A new option, **MSCD Disposition**, is added in PuTTY to enable sites to create a customized list of ED dispositions that are selectable on the Encounter tab and display on the ED Dashboard. These dispositions feed the new emergency department reports.

### Creating dispositions:

- 1. Log in to PuTTY
- 2. FileMan
- 3. Enter or Edit File Entries
- 4. MSCD DISPOSITION
- 5. Enter the MCSD DISPOSITION NAME
- 6. Enter the **DISPOSITION TYPE** using the following options: Admit, Discharge, Transfer, LWOBS, AMA, Expired, or Eloped
- 7. Enter the Division. Type Yes when asked if you are adding your hospital as a new division. You will be asked this question for every new disposition created.

**Note:** The **Disposition Type** automatically displays first, then the name in the **Disposition** drop-down menu. Therefore, the **MSCD DISPOSITION NAME** should not contain the **Disposition Type** or the name, e.g., do not enter **Admit-ICU** as the name. Only enter **ICU**.

### Examples:

MSCD DISPOSITION NAME	DISPOSITION TYPE
Med-Surg	Admit
Labor & Delivery	Admit
Trauma ICU	Admit



Home	Discharge
Skilled Nursing Facility	Discharge
Jail	Discharge
Form Signed	AMA
Form Not Signed	AMA
Witnessed	Eloped
Unwitnessed	Eloped
Medical Pt	Expired
Trauma Pt	Expired
Mercy Medical Center	Transfer
University Hospitals & Clinics	Transfer
Other	Transfer
Prior to Triage	LWOBS
Prior to Provider	LWOBS

### Related artifact: 21098

# Autofax

# Autofaxing laboratory and radiology results to the patient PCP

A new **Autofax Primary Care Physician** file (**MSC AUTO FAX PCP**) enables primary care physicians (PCPs) to receive radiology and/or laboratory results via Autofax.

Populate the PCP information in this file one of two ways:

- Manually by a system user
- Automatically via certain ADT messages containing the PCP's ID number (assigned by the ADT system) and name in the HL7 fields **PD1 4.1** and **PD1 4.2**, respectively.

Both elements must be available in the ADT HL7 message for this information to populate the file automatically. These primary care fields are supported by the following ADT HL7 message types: A01, A04, A05, A06, A07 and A08.

### FileMan

Use FileMan to edit or add to the new **MSC AUTO FAX PCP** file and configure the **MSC AUTO FAX PCP** settings manually. Note that provider ID is determined by the ADT system when setting up a PCP manually. Once the provider is entered, configure the **MSC AUTO FAX PCP** settings for Autofax based on the provider's needs. The provider can receive faxes for only laboratory results, only radiology results or both by using the **MODULE** setting. The provider can also receive faxes for inpatient, outpatient or both for each module using the **LAB PATIENT LOCATION** and **RAD PATIENT LOCATION** settings.



Select VA FileMan PMPHARM(GTM) Option: ENTER or Edit File Entries
Input to what File: MSC AUTO FAX PCP// (3 entries) EDIT WHICH FIELD: ALL//
Select MSC AUTO FAX PCP PCP ID: 4 Are you adding '4' as a new MSC AUTO FAX PCP (the 4TH)? No// Y (Yes) PCP NAME: AUTOFAX,PCP3 FAX NUMBER: 6787586542 MODULE: 2
Enter module to send faxes for (IR=IAB, RA=RAD, B=Both)
Choose from:
LR LABORATORY
RA RADIOLOGY
в вотн
MODULE: B BOTH
LAB PATIENT LOCATION: ?
Enter Lab Location to send faxes for (I=Inpatient, O=Out, B=Both).
Choose from:
I INPATIENT_
O OUTPATIENT
B BOIH
LAB PALLENT LOCATION: B BOTH
RAD PAILENI LOCATION: /
Chapter from to send faxes for (I=Inpatient, U=Out, B=BOLH).
RAD FALLENT LOCATION. B BOTH
TNACTIVATED
$\mu_{\text{DATED}} + \mu_{10} $ (oct 27 2017010.00)
Select PATIENT: MEDREC, DEMO MEDREC, DEMO 1-24-54 1-24-54 DOWN1650
Are you adding 'MEDREC, DEMO' as a new PATIENT? No// N (No) ??

Figure 49: Population of the MSC AUTO FAX MAIN MENU via FileMan

# MSC AUTO FAX MAIN MENU

Use the new **MSC AUTO FAX PCP EDIT** option in the **MSC AUTO FAX MAIN MENU** to populate or edit the Autofax configuration.

MSC	AUTO	FAX MAIN MENU
R	RSND	RESEND FAX
E	DTL	AUTOFAX Log File Edit
E	DTU	AUTO FAX USER EDIT
I	[NAU	INACTIVATE AUTO FAX PROVIDER
R	REAU	REACTIVATE AUTO FAX USER
E	DTP	AUTO FAX PCP EDIT
I	[PCP	INACTIVATE AUTO FAX PCP
R	RACD	REACTIVATE AUTO FAX PCP

Figure 50: MSC AUTO FAX MAIN MENU

MSC AUTO FAX PCP EDIT Select MSC AUTO FAX PCP PCP ID: 1 FAX NUMBER: 6787147055// MODULE: BOTH// LAB PATIENT LOCATION: BOTH// RAD PATIENT LOCATION: BOTH// OFFICE PHONE: 678555741// Select MSC AUTO FAX PCP PCP ID:

### Figure 51: MSC AUTO FAX PCP EDIT

Maintain the PCP file using the Inactivate Auto Fax PCP and Reactivate Auto Fax PCP options.



#### MSC AUTO FAX MAIN MENU

RSND EDTL	RESEND FAX AUTOFAX Log File Edit AUTO FAX USER EDIT
INAU	INACTIVATE AUTO FAX PROVIDER REACTIVATE AUTO FAX USER
EDTP IPCP	AUTO FAX PCP EDIT INACTIVATE AUTO FAX PCP

Figure 52: The MSC AUTO FAX MAIN MENU

	GENERAL HOSPITAL	
Date:10/27/17	MSC AUTO FAX PCP Reactivate PCP	Time:10:21 A
Select one of the PCPs	5 below to activate:	
<ol> <li>LANGLEY, AUTOFA</li> </ol>	AX [1]	
Enter Number: 🗧		
Figure 53: Reactivate PCP o	options	
-	GENERAL HOSPITAL	
Date:10/27/17	MSC AUTO FAX PCP Deactivate PCP	Time:10:22 AM

Select one of the PCPs below to deactivate:

1) AUTOFAX,PCP2 [3] 2) AUTOFAX,PCP3 [4] 3) Autofax,PCP [2]		
Enter Number: 🗧		

Figure 54: Deactivate PCP options

**Required action:** Work with your ADT vendor to populate **PD1 4.1** and **PD1 4.2** fields for message types A01, A04, A05, A06, A07 and A08. Test by sending the appropriate ADT messages with these fields populated in OpenVista. Ensure that the PCP and associated patient information populates the file as expected. Configure the PCP to receive radiology and/or lab results. Enter lab and radiology tests for the test patient and result them to ensure a fax is generated. Repeat this test by manually configuring the PCP on a test patient without utilizing an ADT message.

### Related artifact: 20450

# Enabled Autofax configuration based on Inpatient/Outpatient Status

Users can now configure OpenVista' Autofax to send lab and radiology results to the ordering physician based on patient inpatient and outpatient location. Configure this new option in the **MSC Auto Fax Name** 



file via FileMan or by using the MSC AUTO FAX USER EDIT function shown below. This setting can be applied to either or both radiology and lab results.

Sel Opt	ect Syste ion entry	ems Manager Mer / to test: msc	u PMPHA auto f	RM (GTM)	Option:	test an	option	not in yo	our menu
	1 MSC 2 MSC	AUTO FAX CONS AUTO FAX EDIT	OLE LOG FI	AUTO	FAX CON AUTOFA	SOLE X Log Fi	le Edit		
	3 MSC	AUTO FAX INAC	TIVATE	USER	INAC	TIVATE A	UTO FAX	PROVIDER	
	4 MSC 5 MSC	L AUTO FAX REAC	EDIT	AU	TO FAX U	SER EDIT	UTO FAX	USER	
CHO	DSE 1-5:	5 MSC AUTO FA	X USER	EDIT	AUTO F	AX USER	EDIT		
Sel	ect MSC /	AUTO FAX NAME: .OK? Yes// (Y	user,p ′es)	USER,P	HYSICIAN	Р	U	M.D.	
PRO	VIDER: US	SER, PHYSICIAN //							
FAX	NUMBER:	6787145623//							
MOD	ULE: BOTH								
MSC	H MESSAGE	E CONFIGURATION	I: IESI/						
PRO	TUCUL:								
	DATTENT								
LAD	Choose	from:							
	T	TNPATTENT							
	õ	OUTPATIENT							
	B	BOTH							
LAB	PATIENT	LOCATION:							
RAD	PATIENT	LOCATION: ?							
	Choose	from:							
	I	INPATIENT							
	O	OUTPATIENT							
	B	BOTH							
RAD	PATIENT	LOCATION:							

Figure 55: Autofax configuration options

**Required action:** Test in your normal workflow when setting up and sending radiology and lab results via Autofax for inpatients and outpatients.

Related artifact: 21124

# CCDA

### Added account numbers to CCDA

CCDAs generated by CareVue now have the patient account number as the **Encounter ID**. Previously, the internal entry number (IEN) for the **VISIT** was displayed as the **Encounter ID**.

Contact info	Work Place: 1903 Wright P Carlsbad, CAI Work Place: 9	Place LIFORNIA 949-999-99	92008, 949-999 999	9-9999
Encounter Id	654654654		Encounter Type	Decreased level of consciousness
E 1				00 0047 40 00 40

Figure 56: CareVue CCDA with encounter ID

**Required action:** Test in your normal CCDA generation workflow.

Related artifact: 21160



# **New Audit Report Features**

A new option in OpenVista called **MSCR AUDIT REPORT** makes it easier to view changes to the records of a single patient or all patients over a given period. Previously, viewing audits required looking at each file one by one. For audit reporting, it is still necessary to enable auditing for specific files and fields. But the new report provides a consolidated view of changes made across multiple audited files. In addition to displaying audits tracked by FileMan audit logging, this report also can display entries from the Output from the **MSCV AUDIT ITEM** file. The **MSCV AUDIT ITEM** tracks user access to different parts of the patient record such as viewing tabs, printing notes and saving CCDA files.

New parameters associated with MSCR AUDIT REPORT:
---

Use the XPAR	To specify		
MSC AUDIT DEFAULT SORT FIELD	The default field on which to sort the results of the report. 1 DATE/TIME		
	2 PATIENT NAME (COMPUTED)		
	3 USER		
	4 ACTION		
	5 FIELD ACTED UPON		
MSC AUDIT DEFAULT SORT ORDER	Whether default sort is ascending or descending		
MSC AUDIT REPORT DEFAULT FILES	Default list of audited files to display		

The **MSCR AUDIT REPORT** can print the results using a template for each entry, or can export a tabular version of the data as a CSV (Comma Separated Values) file.

**Caution:** Detailed auditing of many files can be resource intensive. Audit reports can also be very long. Some entries have been deleted from the example below.

```
Option entry to test: MSCR AUDIT REPORT
                                             MSC Audit Report
Enter starting date/time: 8/11/17 (AUG 11, 2017)
Enter ending date/time: 8/11/17023:59 (AUG 11, 2017023:59)
Currently Defined Files to be Displayed:
    PATIENT
    ORDER
    PROBLEM
    V HEALTH FACTORS
    V IMMUNIZATION
    V PATIENT ED
Do you want to accept this list? Y// ES
Select only access or changes by a particular user? N// O
     Select one of the following:
         S
                   Single patient
         А
                  All patients
Select edits to a single patient, or all patients during the time frame: A// All patients
     Select one of the following:
         1
                  DATE/TIME
         2
                   PATIENT NAME (COMPUTED)
                   USER
         3
         4
                  ACTION
                  FIELD ACTED UPON
         5
Select item to sort by: 1// DATE/TIME
```



Select one of the following: Α Ascending order D Descending order Select sort order: D// escending order Select one of the following: P Standard Printed Output Delimited Output D Select report output type: P// Standard Printed Output DEVICE: HOME// TELNET Audit Report Selected Date Range : 8/11/17 to 8/11/17@23:59 User Selection : ALL Patient Selection : ALL Sort Selection : DATE/TIME Sort Order : DESCENDING Files with AUDIT entries: MSCV AUDIT ITEM, PATIENT, ORDER, PROBLEM V HEALTH FACTORS, V IMMUNIZATION, V PATIENT ED Files w/o AUDIT entries: DG SECURITY LOG AUDIT FILE ENTRY from PATIENT: NUMBER: 101075 INTERNAL ENTRY NUMBER: 800 DATE/TIME RECORDED: AUG 11,2017@17:36:43 FIELD NUMBER: .01 USER: MANAGER, SYSTEM ACCESSED: INQUIRED TO ENTRY MENU OPTION USED: MSCR AUDIT REPORT ENTRY NAME (c): TEST, WHILES PATIENT (c): TEST, WHILES MSCV AUDIT ITEM ENTRY: USER: LITELLA, EMILY TIME: AUG 11,2017@17:08:23 PATIENT: 0 🗲 View of "Patient O" is when no patient is ACTION: OUERY displayed. NOTE: Viewed patient in selector MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017017:08:11 USER: LITELLA.EMILY ACTION: PRINT PATIENT: TEST, WHILES DEVICE: Device: Brother HL-2170W (redirected 48) INFORMATION TYPE: MEDICAL RECORD Progress Notes MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017@17:07:45 USER: LITELLA, EMILY ACTION: QUERY PATIENT: TEST, WHILES NOTE: Viewed 'Notes' tab in CareVue MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017@17:07:36 USER: LITELLA, EMILY ACTION: QUERY PATIENT: TEST, WHILES NOTE: Viewed patient chart MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017@17:07:36 USER: LITELLA, EMILY ACTION: QUERY PATIENT: TEST, WHILES NOTE: Viewed patient in selector < ... similar entries deleted ... > MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017016:56:09 USER: LITELLA, EMILY ACTION: QUERY PATIENT: 0 NOTE: Viewed patient in selector MSCV AUDIT ITEM ENTRY:



TIME: AUG 11,2017016:56 USER: LITELLA, EMILY ACTION: COPY PATIENT: TEST, WHILES INFORMATION TYPE: VIEW DOWNLOAD TRANSMIT MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017016:55:35 USER: LITELLA, EMILY ACTION: QUERY PATTENT: TEST, WHILES NOTE: Viewed 'Orders' tab in CareVue AUDIT FILE ENTRY from PROBLEM: NUMBER: 53 INTERNAL ENTRY NUMBER: 1061 DATE/TIME RECORDED: AUG 11,2017@16:55:07 FIELD NUMBER: 80002 USER: LITELLA, EMILY MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): R69. FIELD NAME (c): SNOMED CT DESIGNATION CODE OLD VALUE (c): 20652013 PATIENT (c): TEST, WHILES NEW VALUE (c): 25292015 < ... similar entries deleted ... > AUDIT FILE ENTRY from PROBLEM: NUMBER: 49 INTERNAL ENTRY NUMBER: 1061 DATE/TIME RECORDED: AUG 11,2017016:54:02 FIELD NUMBER: 1.03 USER: LITELLA, EMILY NEW INTERNAL VALUE: 175 DATATYPE OF NEW VALUE: P200'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): R69. FIELD NAME (c): ENTERED BY OLD VALUE (c): OLD VALUE (c): TEST,WHILES NEW VALUE (c): LITELLA, EMILY AUDIT FILE ENTRY from PROBLEM: NUMBER: 48 INTERNAL ENTRY NUMBER: 1061 DATE/TIME RECORDED: AUG 11,2017@16:54:02 FIELD NUMBER: .08 USER: LITELLA, EMILY NEW INTERNAL VALUE: 3170811 DATATYPE OF NEW VALUE: RDIa MENU OPTION USED: CIAV VUECENTRIC FIELD NAME (c): DATE ENTERED ENTRY NAME (c): R69. OLD VALUE (c): OLD VALUE (c): TEST,WHILES NEW VALUE (c): AUG 11,2017 AUDIT FILE ENTRY from PROBLEM: NUMBER: 47 INTERNAL ENTRY NUMBER: 1061 DATE/TIME RECORDED: AUG 11,2017016:54:02 FIELD NUMBER: .02 USER: LITELLA, EMILY NEW INTERNAL VALUE: 800 DATATYPE OF NEW VALUE: RP9000001'Ia MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): R69. FIELD NAME (c): PATIENT NAME NEW VALUE (c): TEST, WHILES AUDIT FILE ENTRY from PROBLEM: NUMBER: 46 INTERNAL ENTRY NUMBER: 1061 DATE/TIME RECORDED: AUG 11,2017016:54:02 FIELD NUMBER: .01 USER: LITELLA, EMILY RECORD ADDED: Added Record NEW INTERNAL VALUE: 569632 DATATYPE OF NEW VALUE: R\*P80'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): R69. FIELD NAME (c): DIAGNOSIS OLD VALUE (c): <<u>no previous value></u> PATIENT (c): TEST,WHILES NEW VALUE (c): <u>Z89.439</u> AUDIT FILE ENTRY from ORDER: NUMBER: 679 INTERNAL ENTRY NUMBER: 12266,1 DATE/TIME RECORDED: AUG 11,2017016:53:10 FIELD NUMBER: .1,.01 USER: LITELLA, EMILY RECORD ADDED: Added Record NEW INTERNAL VALUE: 1964 DATATYPE OF NEW VALUE: MP101.43'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): 12266 FIELD NAME (c): ORDERABLE ITEMS, ORDERABLE ITEM



PATIENT (c): TEST, WHILES

OLD VALUE (c): <no previous value>

NEW VALUE (c): ASPIRIN TAB, CHEWABLE AUDIT FILE ENTRY from ORDER: NUMBER: 678 INTERNAL ENTRY NUMBER: 12266 DATE/TIME RECORDED: AUG 11,2017@16:53:10 FIELD NUMBER: 4 USER: LITELLA, EMILY NEW INTERNAL VALUE: 3170811.1653 DATATYPE OF NEW VALUE: Da MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): 12266 FIELD NAME (c): WHEN ENTERED OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): AUG 11,2017016:53 AUDIT FILE ENTRY from ORDER: NUMBER: 677 INTERNAL ENTRY NUMBER: 12266 DATE/TIME RECORDED: AUG 11,2017@16:53:10 FIELD NUMBER: 3 USER: LITELLA, EMILY NEW INTERNAL VALUE: 175 DATATYPE OF NEW VALUE: P200'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): 12266 FIELD NAME (c): WHO ENTERED OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): LITELLA, EMILY AUDIT FILE ENTRY from ORDER: NUMBER: 676 INTERNAL ENTRY NUMBER: 12266 DATE/TIME RECORDED: AUG 11,2017016:53:10 FIELD NUMBER: .02 USER: LITELLA, EMILY NEW INTERNAL VALUE: 800;DPT( DATATYPE OF NEW VALUE: RVa MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): 12266 FIELD NAME (c): OBJECT OF ORDER OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): TEST, WHILES MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017016:52:20 USER: LITELLA, EMILY ACTION: QUERY PATIENT: TEST, WHILES NOTE: Viewed 'Orders' tab in CareVue MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017016:51:17 USER: LITELLA, EMILY ACTION: OUERY PATTENT: TEST, WHILES NOTE: Viewed 'Notes' tab in CareVue AUDIT FILE ENTRY from V IMMUNIZATION: INTERNAL ENTRY NUMBER: 323 NUMBER: 9 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: .05 USER: LITELLA, EMILY OLD INTERNAL VALUE: 8 DATATYPE OF OLD VALUE: \*P9999999.41'a MENU OPTION USED: CIAV VUECENTRIC FIELD NAME (c): LOT OLD VALUE (c): ABC234 NEW VALUE (c): <deleted> AUDIT FILE ENTRY from V IMMUNIZATION: INTERNAL ENTRY NUMBER: 323 NUMBER: 8 DATE/TIME RECORDED: AUG 11,2017@16:51:08 FIELD NUMBER: .03 USER: LITELLA, EMILY OLD INTERNAL VALUE: 2271 DATATYPE OF OLD VALUE: R\*P9000010'Ia MENU OPTION USED: CIAV VUECENTRIC FIELD NAME (c): VISIT OLD VALUE (c): JAN 20,2016@13:03:43 NEW VALUE (c): <deleted> AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 7 INTERNAL ENTRY NUMBER: 323 DATE/TIME RECORDED: AUG 11,2017@16:51:08 FIELD NUMBER: .02 USER: LITELLA, EMILY OLD INTERNAL VALUE: 800 DATATYPE OF OLD VALUE: RP9000001'Ia MENU OPTION USED: CIAV VUECENTRIC FIELD NAME (c): PATIENT NAME OLD VALUE (c): TEST, WHILES NEW VALUE (c): <deleted>



AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 6 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: 1216 USER: LITELLA, EMILY NEW INTERNAL VALUE: 3170811.165108 DATATYPE OF NEW VALUE: Da MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): DATE/TIME ENTERED OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): AUG 11,2017016:51:08 AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 5 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: 1217 USER: LITELLA, EMILY NEW INTERNAL VALUE: 175 DATATYPE OF NEW VALUE: P200'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): ENTERED BY OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): LITELLA, EMILY AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 4 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: .05 USER: LITELLA, EMILY NEW INTERNAL VALUE: 12 DATATYPE OF NEW VALUE: \*P9999999.41'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): LOT OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): D5551T AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 3 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017@16:51:08 FIELD NUMBER: .03 USER: LITELLA, EMILY NEW INTERNAL VALUE: 2271 DATATYPE OF NEW VALUE: R\*P9000010'Ia MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): VISIT OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): JAN 20,2016@13:03:43 AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 2 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: .02 USER: LITELLA, EMILY NEW INTERNAL VALUE: 800 DATATYPE OF NEW VALUE: RP9000001'Ia MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): PATIENT NAME OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): TEST, WHILES AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 1 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017@16:51:08 FIELD NUMBER: .01 USER: LITELLA, EMILY RECORD ADDED: Added Record NEW INTERNAL VALUE: 227 DATATYPE OF NEW VALUE: RP9999999.14'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): IMMUNIZATION OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): ZOSTER AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 15 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: 1217 USER: LITELLA, EMILY DATATYPE OF OLD VALUE: P200'a OLD INTERNAL VALUE: 175 NEW INTERNAL VALUE: 173 DATATYPE OF NEW VALUE: P200'a MENU OPTION USED: CIAV VUECENTRIC



ENTRY NAME (c): ZOSTER FIELD NAME (c): ENTERED BY OLD VALUE (c): LITELLA, EMILY PATIENT (c): TEST, WHILES NEW VALUE (c): NICKLAS, FLOYD M AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 14 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: 1216 USER: LITELLA, EMILY OLD INTERNAL VALUE: 3170811.165108 DATATYPE OF OLD VALUE: Da NEW INTERNAL VALUE: 3160210.070949 DATATYPE OF NEW VALUE: Da MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): DATE/TIME ENTERED OLD VALUE (c): AUG 11,2017016:51:08 PATIENT (c): TEST, WHILES NEW VALUE (c): FEB 10,2016@07:09:49 AUDIT FILE ENTRY from V IMMUNIZATION: NUMBER: 13 INTERNAL ENTRY NUMBER: 382 DATE/TIME RECORDED: AUG 11,2017016:51:08 FIELD NUMBER: 1217 USER: LITELLA, EMILY OLD INTERNAL VALUE: 175 DATATYPE OF OLD VALUE: P200'a DATATYPE OF NEW VALUE: P200'a NEW INTERNAL VALUE: 175 MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): ZOSTER FIELD NAME (c): ENTERED BY OLD VALUE (c): LITELLA, EMILY PATIENT (c): TEST, WHILES NEW VALUE (c): LITELLA, EMILY < ... similar entries deleted ... > AUDIT FILE ENTRY from V HEALTH FACTORS: NUMBER: 4 INTERNAL ENTRY NUMBER: 432 DATE/TIME RECORDED: AUG 11,2017016:50:29 FIELD NUMBER: 1218 USER: LITELLA, EMILY NEW INTERNAL VALUE: 3170811.165029 DATATYPE OF NEW VALUE: Da MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): CURRENT EVERY DAY SMOKER FIELD NAME (c): DATE/TIME LAST MODIFIED PATIENT (c): TEST, WHILES OLD VALUE (c): <no previous value> NEW VALUE (c): AUG 11,2017016:50:29 AUDIT FILE ENTRY from V HEALTH FACTORS: NUMBER: 3 INTERNAL ENTRY NUMBER: 432 DATE/TIME RECORDED: AUG 11,2017016:50:29 FIELD NUMBER: 1217 USER: LITELLA, EMILY NEW INTERNAL VALUE: 175 DATATYPE OF NEW VALUE: P200'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): CURRENT EVERY DAY SMOKER <mark>OLD VALUE (c): <no previous value></mark> FIELD NAME (c): ENTERED BY PATIENT (c): TEST, WHILES NEW VALUE (c): LITELLA, EMILY AUDIT FILE ENTRY from V HEALTH FACTORS: NUMBER: 2 INTERNAL ENTRY NUMBER: 432 DATE/TIME RECORDED: AUG 11,2017@16:50:28 FIELD NUMBER: .02 USER: LITELLA, EMILY NEW INTERNAL VALUE: 800 DATATYPE OF NEW VALUE: RP9000001'Ia MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): CURRENT EVERY DAY SMOKER FIELD NAME (c): PATIENT NAME OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): TEST, WHILES AUDIT FILE ENTRY from V HEALTH FACTORS: NUMBER: 1 INTERNAL ENTRY NUMBER: 432 DATE/TIME RECORDED: AUG 11,2017@16:50:28 FIELD NUMBER: .01 USER: LITELLA, EMILY RECORD ADDED: Added Record NEW INTERNAL VALUE: 58050 DATATYPE OF NEW VALUE: R\*P9999999.64'a MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): CURRENT EVERY DAY SMOKER FIELD NAME (c): HEALTH FACTOR OLD VALUE (c): <no previous value> PATIENT (c): TEST, WHILES NEW VALUE (c): CURRENT EVERY DAY SMOKER



AUDIT FILE ENTRY from V PATIENT ED: NUMBER: 4 INTERNAL ENTRY NUMBER: 362 DATE/TIME RECORDED: AUG 11,2017016:50:14 FIELD NUMBER: .01 USER: LITELLA, EMILY OLD INTERNAL VALUE: 50052 DATATYPE OF OLD VALUE: R\*P9999999.09'Oa MENU OPTION USED: CIAV VUECENTRIC OLD VALUE (c): STRK-LITERATURE FIELD NAME (c): TOPIC NEW VALUE (c): <deleted> AUDIT FILE ENTRY from V PATIENT ED: NUMBER: 3 INTERNAL ENTRY NUMBER: 362 DATE/TIME RECORDED: AUG 11,2017016:50:14 FIELD NUMBER: 1217 USER: LITELLA, EMILY OLD INTERNAL VALUE: 173 DATATYPE OF OLD VALUE: P200'a MENU OPTION USED: CIAV VUECENTRIC FIELD NAME (c): ENTERED BY OLD VALUE (c): NICKLAS,FLOYD M NEW VALUE (c): <deleted> AUDIT FILE ENTRY from V PATIENT ED: NUMBER: 2 INTERNAL ENTRY NUMBER: 362 DATE/TIME RECORDED: AUG 11,2017@16:50:14 FIELD NUMBER: 1216 USER: LITELLA, EMILY MENU OPTION USED: CIAV VUECENTRIC FIELD NAME (c): DATE/TIME ENTERED OLD VALUE (c): MAR 2,2016@09:24:24 NEW VALUE (c): <deleted> AUDIT FILE ENTRY from V PATIENT ED: NUMBER: 1 INTERNAL ENTRY NUMBER: 362 DATE/TIME RECORDED: AUG 11,2017016:50:14 FIELD NUMBER: .02 USER: LITELLA, EMILY OLD INTERNAL VALUE: 800 DATATYPE OF OLD VALUE: RP9000001'Ia MENU OPTION USED: CIAV VUECENTRIC FIELD NAME (c): PATIENT NAME OLD VALUE (c): TEST, WHILES NEW VALUE (c): <deleted> MSCV AUDIT ITEM ENTRY: TIME: AUG 11,2017@16:49:14 USER: LITELLA, EMILY ACTION: QUERY PATIENT: TEST, WHILES NOTE: Viewed patient chart AUDIT FILE ENTRY from PATIENT: NUMBER: 101071 INTERNAL ENTRY NUMBER: 800 DATE/TIME RECORDED: AUG 11,2017016:49:14 FIELD NUMBER: .01 USER: LITELLA, EMILY ACCESSED: INQUIRED TO ENTRY MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): TEST, WHILES PATIENT (c): TEST, WHILES AUDIT FILE ENTRY from PATIENT: NUMBER: 101070 INTERNAL ENTRY NUMBER: 800 DATE/TIME RECORDED: AUG 11,2017@16:49:14 FIELD NUMBER: .01 USER: LITELLA, EMILY MENU OPTION USED: CIAV VUECENTRIC ACCESSED: INQUIRED TO ENTRY ENTRY NAME (c): TEST, WHILES PATIENT (c): TEST, WHILES AUDIT FILE ENTRY from PATIENT: NUMBER: 101069 INTERNAL ENTRY NUMBER: 800 DATE/TIME RECORDED: AUG 11,2017016:49:14 FIELD NUMBER: .01 USER: LITELLA, EMILY ACCESSED: INQUIRED TO ENTRY MENU OPTION USED: CIAV VUECENTRIC ENTRY NAME (c): TEST, WHILES PATIENT (c): TEST, WHILES

#### Related artifact: 20887



# Release 2017.1.1 Fixes

# CareVue

### Corrected Visit Date for Patient Education and Event Dates for Health Factors

Visit Dates for Health Factors and Event Dates (date of entry) for Patient Education are now correct when entered by a nurse from a note.

**Required action:** Logged in as a nurse, add a new patient note using Reminder Dialogs that include Health Factors and Patient Education. Confirm that Health Factors displays the Visit Date correctly and Patient Education displays the correct Event Date (date of entry).

### Related artifact: 20645

### Fix for issue with TIU Template Editor

An issue with the TIU Template Editor in which text did not display when selecting Preview/Print Template or editing Template fields has been corrected.

Suggesting testing: Test in your normal TIU template creation and editing workflows.

Related artifact: 20912

### Search for lab tests using numeric synonym beginning with number other than 0 (zero)

Users can now search for a lab test that has a numeric synonym when entering lab orders in CareVue.

**Required action:** Test in your normal workflow when ordering a lab test; use the **Order a Lab Test** dialog in CareVue.

Related artifact: 20971

### Print Active Meds from Meds tab are legible

Active medications of longer than one page on the CareVue **Meds** tab now print without the footer overwriting or overlapping the last line of the report.

Required action: Test in your normal workflow when printing active meds from the Meds tab in CareVue.

Related artifact: 20936

### Right/Left Deltoid Subcutaneous added injection sites

On the **Immunization** tab in CareVue, the **Injection Site** menu now has options for **Left Deltoid Subcutaneous** and **Right Deltoid Subcutaneous**.



🖏 Add Imm	unization	×
⊻accine	DTAP-HIB-IPV	OK
<u>A</u> dministered By	LITELLA,EMILY	Cancel
<u>L</u> ot		
Injection Site	<b>•</b>	Ourrent
Vol <u>u</u> me Vac. Infø. Sh <u>e</u> ets	Left Thigh Intramuscular Left Thigh Subcutaneous Right Thigh Intramuscular Right Thigh Subcutaneous Left Deltoid Intramuscular Right Deltoid Subcutaneous Right Deltoid Subcutaneous Left Arm Subcutaneous Right Arm Subcutaneous Oral Intranasal Left Arm Intradermal Right Arm Intradermal	Historical
Admin Notes		

Figure 57: CareVue Immunization tab with new options

Required action: Test in your normal immunization order process.

Related artifact: 21064

# Restrict user to an administrator configured patient list

The restricted patient list functionality uses the existing patient list files as a source, restricting a user to a defined list of patients. The patient list is defined by a configuration user through the **Patient List Mgmt** menu in OpenVista PuTTY. The restriction to a patient list is configured by setting the **RESTRICT PATIENT SELECTION** field to **YES** and entering the patient list name in the **OE/RR LIST** field in the **EDIT AN EXISTING USER OPTION**.



🔗 qalinuxgtm02.medsphere.com - PuTTY	- • •
Edit an Existing User	Dage 4 of 5
NAME: MCPHERSON, JULIE SM	Page 4 or 5
RESTRICT PATIENT SELECTION: YES OE/RR LIST: JULIE TEAM OUTPT	
CPRS TAB ACCESS: Name Description Effective Date Expirat COR CPRS GUI "core" tabs. JUL 24,2015	tion Date
Exit Save Next Page Previous Page Refresh Quit Enter a COMMAND, or "^" followed by the CAPTION of a FIELD to jump f	to.
COMMAND: q Press <f1>H for he</f1>	elp Insert
Add a New User to the System Grant Access by Profile Edit an Existing User Deactivate a User List users User Inquiry Switch Identities Clear Electronic signature code Electronic Signature Block Edit List Inactive Person Class Users Manage User File OAA Trainee Registration Menu	

Figure 58: Restrict Patient Selection updates

A user with a restricted patient list only sees patients assigned to the list configured for them. CareVue is fully functional for those patients on the list and respects the user's CareVue profile limitations with regard to security keys, user classes, etc. Access to the CareVue patient list edit is removed for the user.

G OpenVista CareVue - QA710 - qalinuxgtm02.medsphere.com -	MCPHERSON, JULIE SM		3.0.0
User Patient Refresh Data Tools Help Add/EditeSig Clea	r Clear and Lock Dosing Calculator	Graphing Inbox	
PRIVACY NOTIFICATIONS PATIENT CHART RESOURCES Patient not selected	Visit not selected	SURGERY SCHEDULING eRCRENEWALS	Primary Care Team Unassigned
Visit Summary	Patient Selection	ou - 1	Entry  Problem Lis Advs Reart Medications
COVERSHEET PROBLEM LIST VITALS ORDERS MEDS	Patients	Demographics	UMMARY SUPERBILL REPORTS
Active Problem List	1		Alerts
Problem Date	CM350_STROKEADULTNB MUNDL2NNAA MUNDL2OFYZOE STUCK/PA STUCK/PA STUCK/PA STUCK/PA STUCK/PE STUCK/PE STUCK/PE STUCK/PE STUCK/PE STUCK/PE STUCK/PE JONAS,ERVRENDD PROBLEMUST,INPATENT OPDEREPORTFREA	<no available="" photo=""></no>	Date      Date      Vitals      Qualifier
Status Inpatient/Outpatient			
All CActive All Out In			
Lab Orders		Patient Detail	Appointments/Visits
Lab Order A Status Date			ent Date 🔻 Status
		- OK Cancel	
MCPHERSON, JULIE SM VISTA, GOLD. MEDSPHERE. COM G	ENERAL HOSPITAL 24-Jul-2017 15:25		generat Medspher

Figure 59: CareVue Patient Chart tab with Patient Selection window

**Required action:** Configure a patient list using the **Patient List Mgmt** menu option in OpenVista PuTTY. Set the **RESTRICT PATIENT SELECTION** field to **YES** and enter the patient list name in the **OE/RR LIST** field in the **EDIT AN EXISTING USER OPTION** on page 4 of OpenVista PuTTY.

Suggested testing: Configure a test user with a restricted patient list. Test all CareVue workflows.



### Related artifact: 21135

### Problem List resets scroll position on a new search

Previously, when searching for a **SNOMED CT** term in the **Search Snomed** dialog, users sometimes scrolled through a long list of results without finding what they needed. This issue is corrected so that a search always resets the scroll position and the most relevant items appear at the top of the list.

Required action: Test in your normal SNOMED term search workflow.

### Related artifact: 21171

### Active, Pending, Discontinued/Expired Meds correct on Meds tab

Active and pending medications always display on the **Meds** tab for three years from the date of last activity. This date range covers clinical reasonable viability of any active or pending medication order. For all other medication order statuses, the range is set by the **Restrict Medication Activity** function on the Meds tab, which is based on the date of last activity for the order. The filtering of statuses other than active and pending through the number of days in the **Restrict Medication Activity** button helps providers filter the number of medications shown in the **Meds** tab. The **Active Only** button also be filters the **Meds** tab to display active and pending medications only.

**Required action:** From the **Meds** tab in CareVue, change the number of days in the **Restrict Medication** Activity dialog; confirm that the change updates all medication order statuses except active and pending. Active and pending medication orders should remain in the **Meds** tab display up to three years from the date of last activity.

**Suggested additional testing:** Use the **Active Only** button to confirm that only active and pending medications display. Use the **Chronic Only** button to confirm that only outpatient medications flagged as Chronic display.

Related artifact: 21391

# **Pharmacy**

### Charge on Administration XPAR respected regardless of patient location

The **Charge on Administration (COA)** location level XPAR value is now honored for any medication dispense or administration regardless of the location of the patient when the order was entered.

**Required action:** Set the **Charge on Administration (COA)** XPAR to **YES** for a location. Enter a medication order for a patient in that location and dispense and administer a dose of that order. Transfer the patient to a location where the **Charge on Administration (COA)** XPAR is set to **NO** so medications are charged on dispense (COD), then dispense and administer another dose of that order. Verify that charges are correctly generated based on the **Charge on Administration** XPAR setting for the current location of the patient.

### Related artifact: 20557

### Red "Less Than Age 19" alert shows correctly in Pharmacy

The red-text warning for patients younger than 19 now shows correctly in the Pharmacy application for all users.



**Required action:** Test by copying an existing pharmacist user to create a new pharmacist user. Confirm the red warning text displays as expected.

### Related artifact: 20771

### Order Check Override Reason report runs correctly

A Stack error is no longer generated when running the Order Check Override Reason report in PuTTY.

**Required action:** Log into CareVue to generate order check warnings and override the order checks. Log into PuTTY and run the **Order Check Override Reason** report (**ORK ORD OVERRIDE REPORT**). Confirm that the report runs successfully with overrides listed.

### Related artifact: 20783

### DEA numbers print correctly on outpatient prescriptions

Provider DEA# now prints on outpatient medication prescriptions appropriately as configured in the **MSCPSO DEA** parameter regardless of whether users enter a free text dose as an outpatient order.

**Required action:** Set the **MSCPSO DEA** parameter to **YES** to ensure that all outpatient prescriptions (controlled and non-controlled) display the provider's DEA#. Set the **MSCPSO DEA** parameter to **NO** to ensure that only controlled substance outpatient prescriptions display the provider DEA#.

Related artifact: 21228

# Laboratory

### Auto verification option does not edit lab results

Sites can now use the MSC REF LAB AUTO VERIFY option without inadvertently editing lab results.

Required action: Test in your normal lab resulting workflow.

Related artifact: 21183

# **Flowsheets**

### Lab reference range hover data matches Lab tab reference range

The abnormal values reference ranges displayed in the hover-over feature on Flowsheets are adjusted to reflect the lab reference ranges displayed on the **Lab** tab.

**Required action:** Test by locating a patient with abnormal laboratory results that display on the Flowsheet. Hover over the results on the Flowsheet and view the test reference range. View the test reference range on the **Lab** tab and ensure the ranges match.

**Suggested additional testing:** Enter at least one lab result that is abnormally high, one that is abnormally low, and one normal result for a test patient. View the values on Flowsheets. Using the hover feature, verify the abnormal lab reference ranges in the hover match the lab reference ranges on the **Lab** tab.

### Related Artifact: 20579



# Seclusion/Restraint Flowsheet drop-down arrows widened for cloud clients

Drop-down arrows within the **Seclusion/Restraint** documentation on Flowsheets have been widened to create easier viewing and accessibility for cloud clients.

**Required action:** Access Flowsheets. Click on a time field on the **Seclusion/Restraint** Flowsheet row. View and click on the drop-down arrows within the **Edit Values** tab for documentation options; ensure all drop-down menus are accessible.

**Suggested additional testing:** Enter documentation within the **Seclusion/Restraint** Flowsheet per your hospital and departmental guidelines.

Related artifact: 20710

# **BCMA**

### Incorrect Units per Dose shows for Fractional Doses

Units per Dose information now displays correctly for Fractional Doses orders placed using the CPRS Med Order button in BCMA.

**Required action:** Order/Administer a fractional dose using the **CPRS Med Order** button in BCMA. Make sure to select the dosage from the dropdown in BCMA. Run the **BCMA Medication Log** report; confirm that fractional doses appear correctly in the **Units Ordered** and **Units Given** columns (U/Ord and U/Gvn).

**Configuration information:** Configure doses for a drug in the **Pharmacy Drug Enter/Edit** menu option so the order dose matches one of the **POSSIBLE DOSEs** for the drug.

Related artifact: 20287

# Patient lookup with ACCOUNT ID enabled

When patient lookup with **ACCOUNT ID** is turned on in the **MSC PSB PATIENT LOOKUP** XPAR, there is no longer an error when users look up a patient by name in the **BCMA Unable to Scan** function.

**Required action:** A BCMA fix addresses this issue, but a configuration change is also required. To allow patient lookup by both name and account number, set the parameter as shown below with the lookups for **PATIENT NAME**, **ACCOUNT ID**, and **HRN** turned **ON**:

### Set MSC PSB PATIENT LOOKUP as follows:

PATIENT	LOOKUP	Value
PATIENT	NAME	ON
HRN		ON
ACCOUNT	ID	ON

Using the **Unable to Scan** function in BMCA, type in a patient name and then select the patient from the list of results. Confirm that the patient loads in BCMA without error.

#### Related artifact: 21278



# Interfaces

# FT1.4 transaction date correct for pharmacy credit message

Pharmacy credit messages triggered by the **PSJU RET**, **Report Returns** menu option now contain the **FT1.4** transaction date equal to the date of the earliest uncredited charge for the medication order. In addition, users are notified if units entered in the **Returns** field are greater than total dispensed doses.

**Required action:** Document a Pharmacy charge by dispensing two pre-exchange doses for a unit dose medication. Wait a day and charge for two more doses of the same medication using the **Extra Units Dispensed** menu option. Using the **Report Returns, PSJU RET** menu option, credit four doses of the same medication order. Check the **Charge Event and Charge Billed** file to confirm that two credits were generated and that the service date for the first credit is equal to the original dispense date; also, check that the service date of the second credit is equal to the date the second charge was generated. Review the HL7 charge messages to confirm that two messages were generated and that the **FT1.4** segment of the first message is equal to the first service (charge) date and the **FT1.4** segment of the second message is equal to the second service (charge) date. Attempt to credit more doses to confirm that you cannot credit more doses than was dispensed.

Suggested additional testing: Test various charge and credit scenarios across different dates.

Related artifact: 20888

# **Group Notes**

### Inactive section of group notes display is legible

Inactive section shading of **Group Notes** is no longer so dark on cloud hosted and Aero theme machines.

Required action: Test in your normal Group Notes workflow.

Related artifact: 20664

# **Autofax**

### Autofaxed lab results complete when partial results were sent previously

Autofaxes of complete results now send, even though partial results may have sent earlier.

**Required action:** Test in your normal Autofax workflow.

**Related artifact: 21108** 

# Orders

### Completed Complex Medication Orders show correct order text in Meds tab

Order text from previously selected patients no longer shows on **Completed Complex Medication Orders** in the **Meds** tab.

**Required action:** View multiple patients in succession who have **Completed Complex Medication Orders** showing on the **Meds** tab.

Related artifact: 20849