Medsphere Systems Corporation

OpenVista 2017.2.0 Release Notes

November 2017

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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:**

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      Alert Management ...
ART     Adverse Reaction Tracking ...
ARTC    Adverse Reaction Tracking Clinician Menu ...
CM      Consult Management ...
CPRS    CPRS Configuration (Clin Coord) ...
DASH    Patient Dashboard Management ...
DD      Document Definitions (Manager) ...
FM      VA FileMan ...
GP      General Parameter Tools ...
HS      Health Summary Overall Menu ...
MDTP    MDTP Management ...
MIS     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:

```
Select MDTP FREQUENCY NAME: EVERY 6 MONTHS
NAME: EVERY 6 MONTHS//
TASKMAN FREQUENCY: 6M//
TYPE: INTERVENTION//
INACTIVE: NO//
```

Figure 4: FREQ menu option fields

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

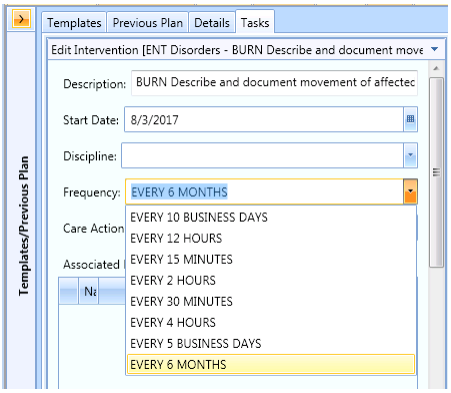


Figure 5: MDTP changes displayed in CareVue

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**.

```
Select Systems Manager Menu QA710(GTM02) Option: test an option not in your menu
Option entry to test: MSC IMMUN
     1   MSC IMMUNIZATION CLEAR CVX       Clear MSC IMMUNIZATION VIS CVX multipl
e
     2   MSC IMMUNIZATION DEF VOL        Edit DEFAULT VOLUME for an Immunization
     3   MSC IMMUNIZATION HL7       Send Immunization HL7 message
     4   MSC IMMUNIZATION LOAD       Update IMMUNIZATION files
     5   MSC IMMUNIZATION MENU       MSC IMMUNIZATION MENU
Press <Enter> to see more, '^' to exit this list,  OR
CHOOSE 1-5: 2  MSC IMMUNIZATION DEF VOL     Edit DEFAULT VOLUME for an Immunizat
ion
```

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 IMMUNIZATION TABLE HL7/CVX STANDARD NAME: MMR
     1   MMR        MMR      3
     2   MMRV       MMRV     94
CHOOSE 1-2: 1  MMR      MMR      3
DEFAULT VOLUME: .75// .50
```

Figure 7: Updating default volumes

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

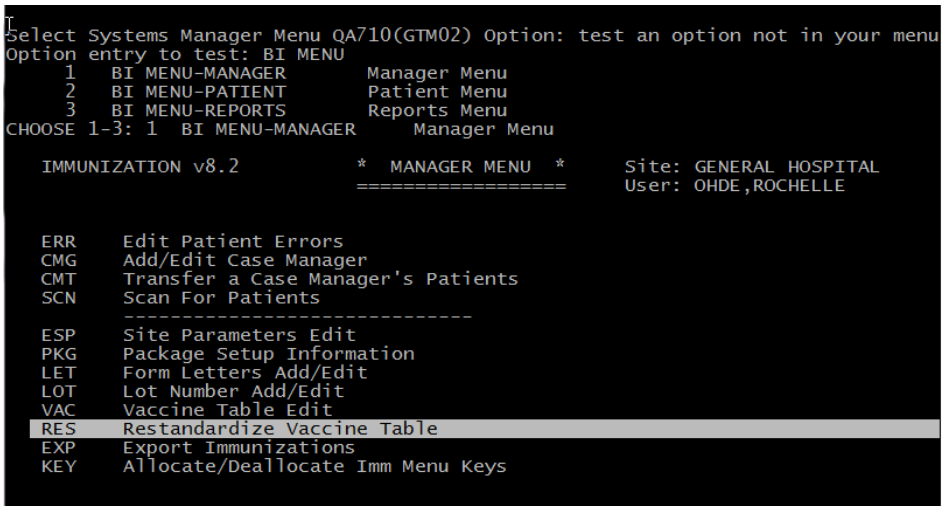


Figure 8: The Restandardize Vaccine Table menu option

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.

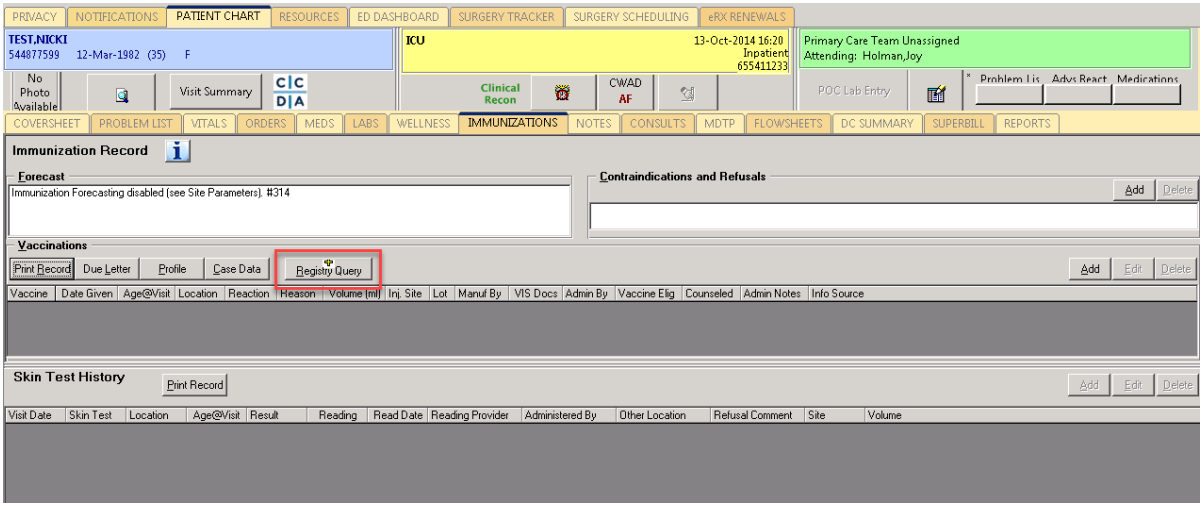


Figure 9: New Immunization Registry Query Button

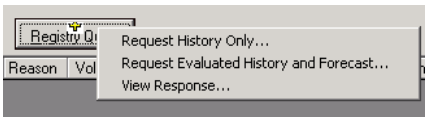


Figure 10: Registry Query Menu Options

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.

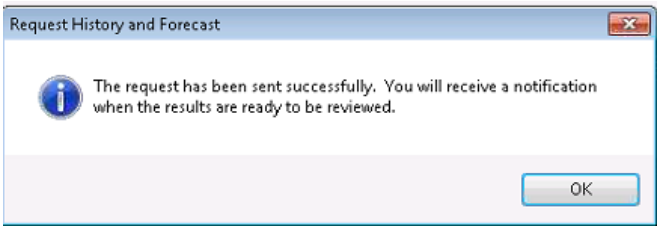


Figure 11: Request History and Forecast sent message

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.

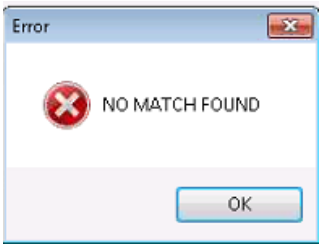


Figure 13: NO MATCH FOUND error window

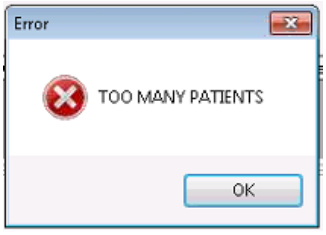


Figure 14: TOO MANY PATIENTS error window

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

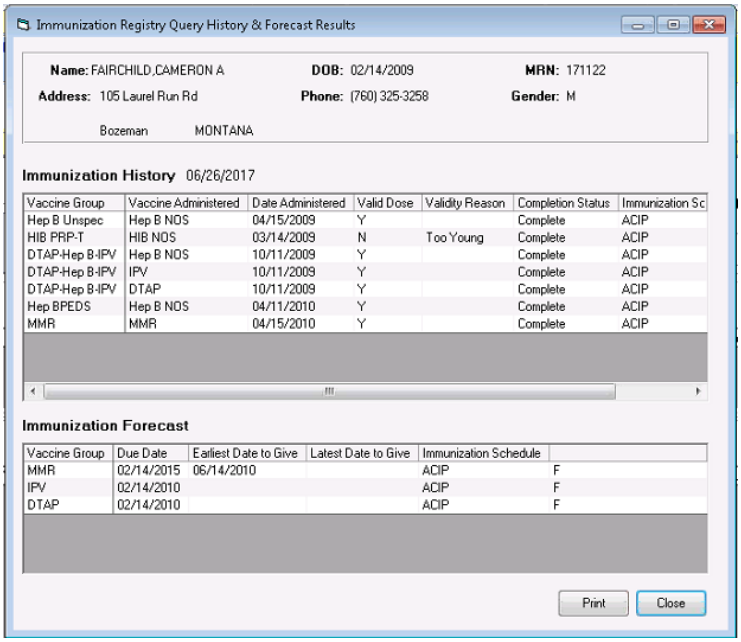


Figure 16: Immunization Registry Results Example

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.

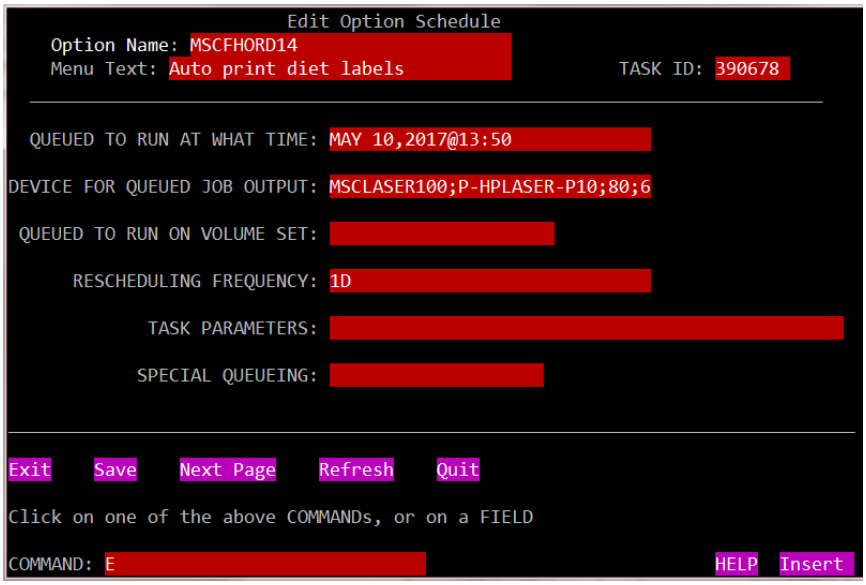


Figure 17: The Edit Option Schedule window with MSCFHORD14 option

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 Registration Report Pt Listing Order

     Select one of the following:

          A         Alphabetically by Name
          R         Registration Time
          D         Disposition Time

Enter Selection: R// 
```

Figure 18: ED Registration report options

```
ED Registrations

MEASURE DESCRIPTION:
This measure will provide a total count of ED registrations
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.


DATA:

Number of Registered ED Patients: 20


PATIENT LIST:
Name             MRN          Acct #       Age Arrival        Dispo Dispo Type
OHDE,REPORTFIVE  1000000404   2000000605    30  07/10/17@1430       EX
OHDE,REPORTSIX A 1000000405   2000000606    72  07/12/17@1258       DISCHARGE
OHDE,REPORTSEVEN 1000000406   2000000607    40  07/12/17@1318       DISCHARGE
OHDE,REPORTNINE  1000000408   2000000609    22  07/12/17@1326       DISCHARGE
OHDE,REPORTEIGHT 1000000407   2000000608    36  07/13/17@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  07/18/17@1242  1458 AMA
OHDE,REPORTFIFTE 1000000414   2000000619    18  07/19/17@0816  1209 DISCHARGE
OHDE,REPORTFOURT 1000000415   2000000620    45  07/19/17@0820  1211 TRANSFER
```

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 Pt Listing Order

     Select one of the following:

          A         Alphabetically by Name
          S         Shortest to Longest LOS
          L         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 Dispositioned ED Patients: 12
Average Overall LOS: 341.92
Total LOS Minutes: 4103

                                        Minutes    Hours      Total Pts
Average LOS for DISCHARGE                317.60      5.3         5.0
Average LOS for ADMIT                      0.00      0.0         0.0
Average LOS for TRANSFER                 231.00      3.9         1.0
Average LOS for LWOBS                    122.00      2.0         1.0
Average LOS for AMA                      181.00      3.0         2.0
Average LOS for EXPIRED                    0.00      0.0         0.0
Average LOS for ELOPED                   159.00      2.7         2.0
Average LOS for UNDEFINED                  0.00      0.0         0.0

                 Minutes    Hours    Patient Name              MRN
Shortest LOS       61        1.0     OHDE,REPORTTEN M          1000000409
Longest LOS      1482       24.7     OHDE,REPORTTWELVE A       1000000411
```

Figure 21: Length of Stay report summary

```
PATIENT LIST:
Name              MRN          Acct #       Age Arrival        Disp     LOS Mins

TEST,DISCHARGE    1000000062   2000000671    61  08/07/17@0919  0937      18
TEST,PUFFER       1000000239   2000000672    43  08/07/17@0921  0939      18
OHDE,REPORTSEVEN  1000000417   2000000686    75  08/11/17@0806  0829      23
TEST,TEDDY H      1000000091   2000000664    30  08/04/17@1352  1425      33
TEST,RANDY Y      1000000019   2000000663    19  08/04/17@1348  1422      34
TEST,VANCE C      1000000112   2000000670    48  08/07/17@0829  0903      34
TEST,KINDRA H     1000000096   2000000669    32  08/07/17@0826  0902      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.

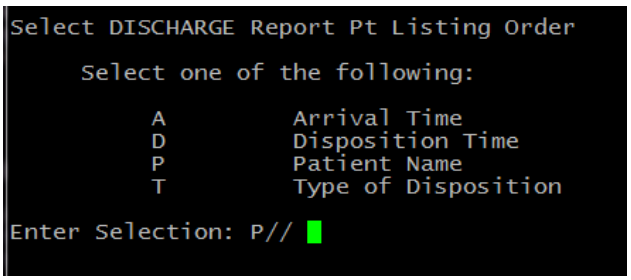


Figure 23: Discharge reporting options

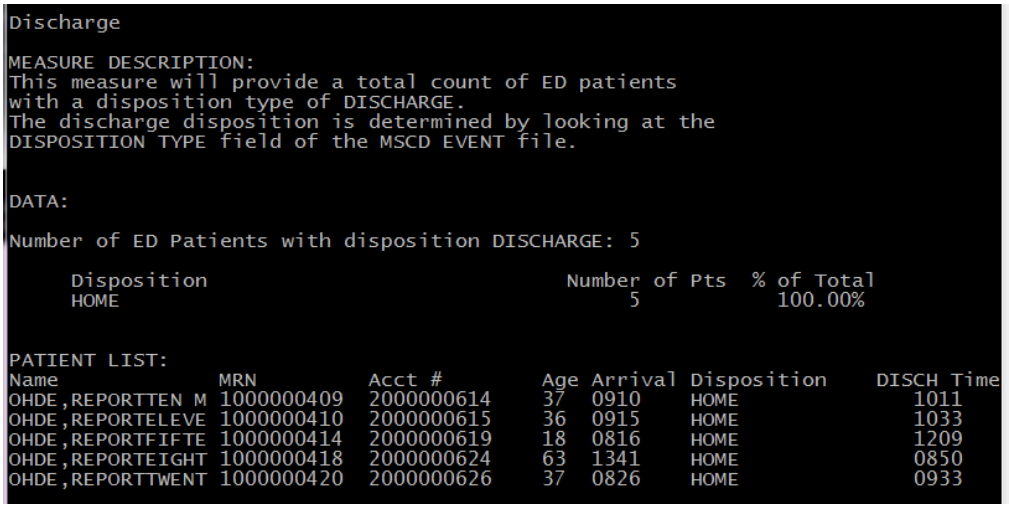


Figure 24: Discharge report with detail

- **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.

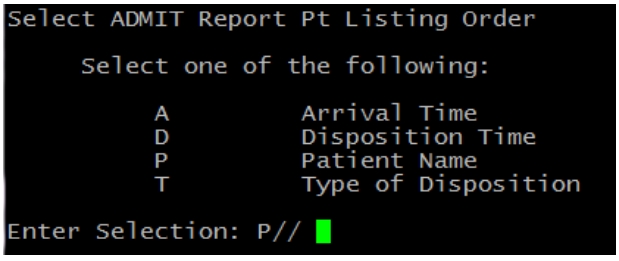


Figure 25: Admit reporting options

```
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 disposition ADMIT: 2

     Disposition                              Number of Pts  % of Total
     MED/SURG                                         1           50.00%
     NEUROLOGY                                        1           50.00%


PATIENT LIST:
Name             MRN         Acct #        Age Arrival Disposition    ADMIT Time
OHDE,REPORTEIGHT 1000000407  2000000687    36  0808    NEUROLOGY          0947
OHDE,REPORTSEVEN 1000000417  2000000686    75  0806    MED/SURG           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.

```
Select TRANSFER Report Pt Listing Order

     Select one of the following:

          A         Arrival Time
          D         Disposition Time
          P         Patient Name
          T         Type of Disposition

Enter Selection: P//
```

Figure 27: Transfer reporting options

```
Transfer

MEASURE DESCRIPTION:
This measure will provide a total count of ED patients
with a disposition type of TRANSFER
The discharge disposition is determined by looking at the
DISPOSITION TYPE field of the MSCD EVENT file.


DATA:

Number of ED Patients with disposition TRANSFER: 7

     Disposition                              Number of Pts  % of Total
     MERCY MEDICAL CENTER                             2           28.57%
     ST JOSEPH'S HOSPITAL                             2           28.57%
     UNIVERSITY HOSPITAL                              3           42.86%


PATIENT LIST:
Name             MRN         Acct #        Age Arrival Disposition    TRANS Time
OHDE,REPORTEIGHT 1000000407  2000000642    36  1349    UNIVERSITY HOSP    0852
OHDE,REPORTEIGHT 1000000407  2000000651    36  0900    UNIVERSITY HOSP    1041
OHDE,REPORTFOURT 1000000415  2000000620    45  0820    MERCY MEDICAL C    1211
OHDE,REPORTNINE  1000000408  2000000652    22  0902    UNIVERSITY HOSP    1021
TEST,ERIN        1000000017  2000000654    39  1102    MERCY MEDICAL C    1148
TEST,LAUREN      1000000018  2000000655    31  1106    ST JOSEPH'S HOS    1149
TEST,PEARL       1000000056  2000000656    49  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 LW**OBS Time** is captured when the disposition order is signed.

```
Select LWOBS Report Pt Listing Order

     Select one of the following:

          A         Arrival Time
          D         Disposition Time
          P         Patient Name
          T         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 Patients with disposition LWOBS: 7

     Disposition                              Number of Pts  % of Total
     PRIOR TO PROVIDER                             5           71.43%
     PRIOR TO TRIAGE                               2           28.57%


PATIENT LIST:
Name            MRN         Acct #       Age Arrival Disposition    LWOBS Time
OHDE,REPORTNINET 1000000419  2000000625   22  0821    PRIOR TO PROVID   1023
TEST,FRIDAY     1000000087  2000000666   62  0803    PRIOR TO PROVID   0905
TEST,JAMBERRY   1000000099  2000000662   50  1346    PRIOR TO TRIAGE   1424
TEST,KINDRA H   1000000096  2000000669   31  0826    PRIOR TO TRIAGE   0902
TEST,MARY       1000000097  2000000665   61  0800    PRIOR TO PROVID   0901
TEST,RANDY Y    1000000019  2000000663   18  1348    PRIOR TO PROVID   1422
TEST,TEDDY H    1000000091  2000000664   30  1352    PRIOR TO PROVID   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.

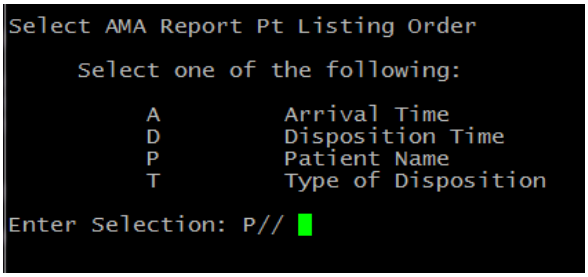


Figure 31: Against Medical Advice reporting options

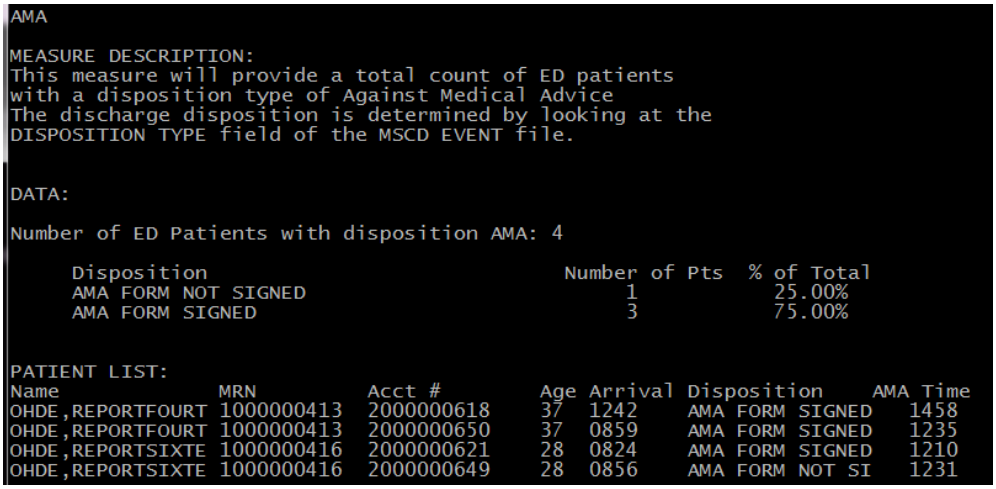


Figure 32: Against Medical Advice report with patient detail

- **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.

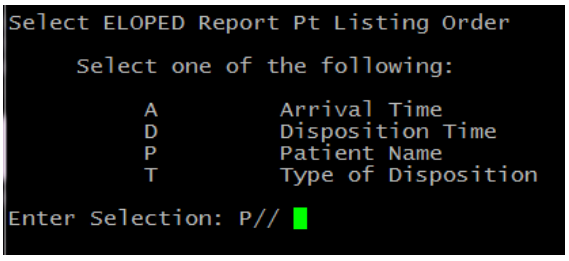
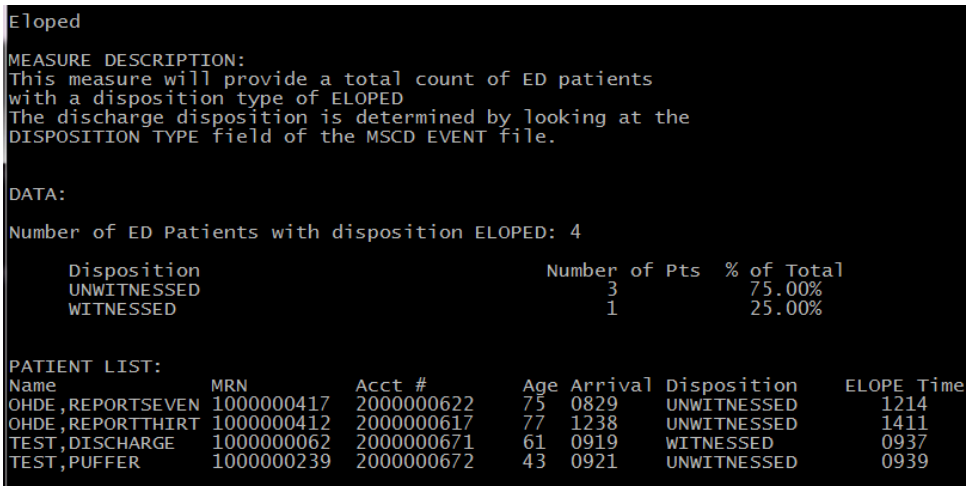


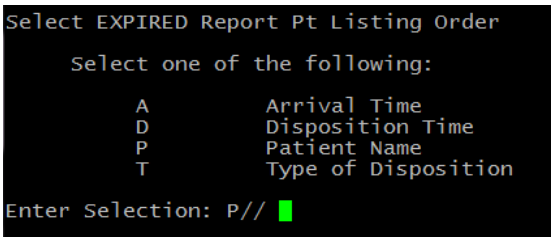
Figure 33: Eloped reporting options



```
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:

Number of ED Patients with disposition ELOPED: 4

     Disposition                              Number of Pts  % of Total
     UNWITNESSED                                      3          75.00%
     WITNESSED                                        1          25.00%


PATIENT LIST:
Name             MRN         Acct #        Age Arrival Disposition    ELOPE Time
OHDE,REPORTSEVEN 1000000417  2000000622    75  0829    UNWITNESSED       1214
OHDE,REPORTTHIRT 1000000412  2000000617    77  1238    UNWITNESSED       1411
TEST,DISCHARGE   1000000062  2000000671    61  0919    WITNESSED         0937
TEST,PUFFER      1000000239  2000000672    43  0921    UNWITNESSED       0939
```

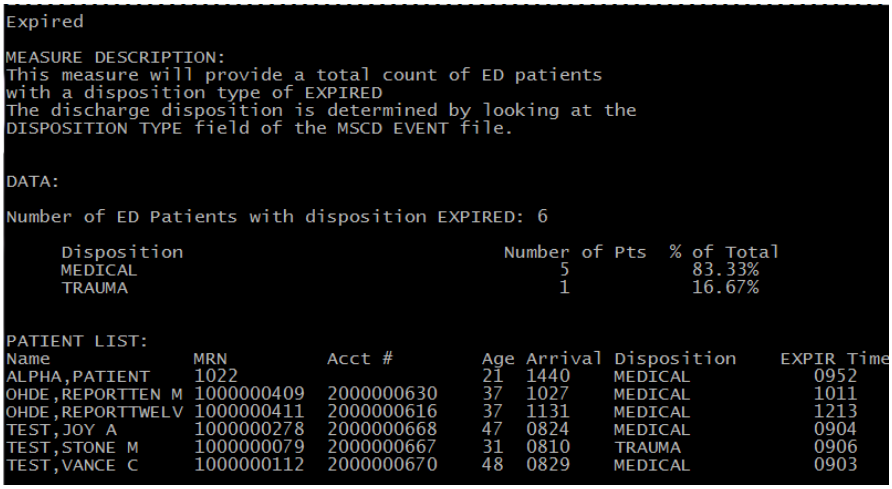
Figure 34: Eloped report with patient detail

- **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.



```
Select EXPIRED Report Pt Listing Order

     Select one of the following:

          A         Arrival Time
          D         Disposition Time
          P         Patient Name
          T         Type of Disposition

Enter Selection: P//
```

Figure 35: Expired reporting options

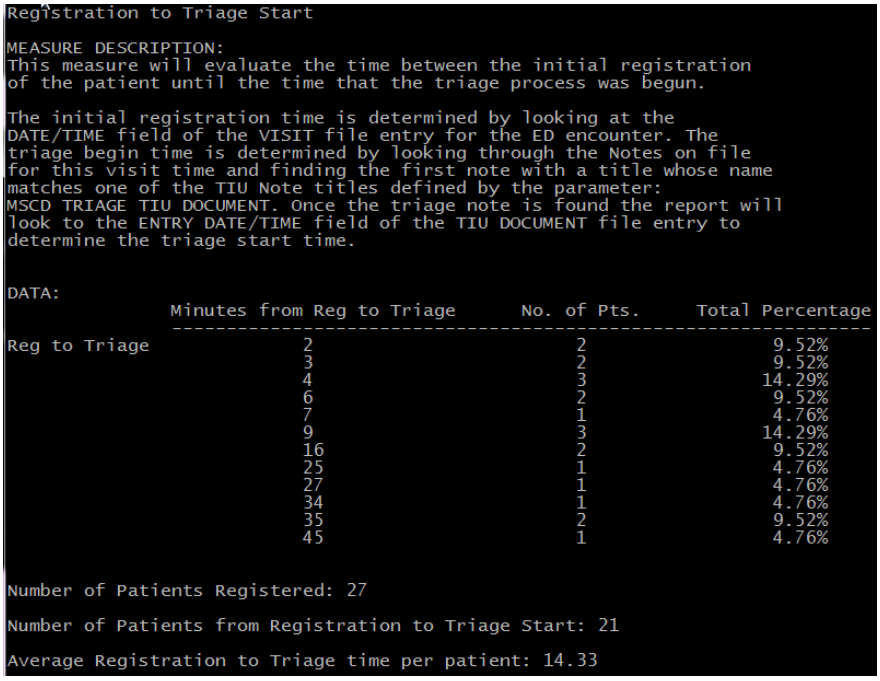


```
Expired

MEASURE DESCRIPTION:
This measure will provide a total count of ED patients
with a disposition type of EXPIRED
The discharge disposition is determined by looking at the
DISPOSITION TYPE field of the MSCD EVENT file.


DATA:

Number of ED Patients with disposition EXPIRED: 6

     Disposition                              Number of Pts  % of Total
     MEDICAL                                          5          83.33%
     TRAUMA                                           1          16.67%


PATIENT LIST:
Name             MRN         Acct #        Age Arrival Disposition    EXPIR Time
ALPHA,PATIENT    1022                      21  1440    MEDICAL           0952
OHDE,REPORTTEN M 1000000409  2000000630    37  1027    MEDICAL           1011
OHDE,REPORTTWELV 1000000411  2000000616    37  1131    MEDICAL           1213
TEST,JOY A       1000000278  2000000668    47  0824    MEDICAL           0904
TEST,STONE M     1000000079  2000000667    31  0810    TRAUMA            0906
TEST,VANCE C     1000000112  2000000670    48  0829    MEDICAL           0903
```

Figure 36: Expired report with patient detail

Existing Emergency Department Report Enhancements

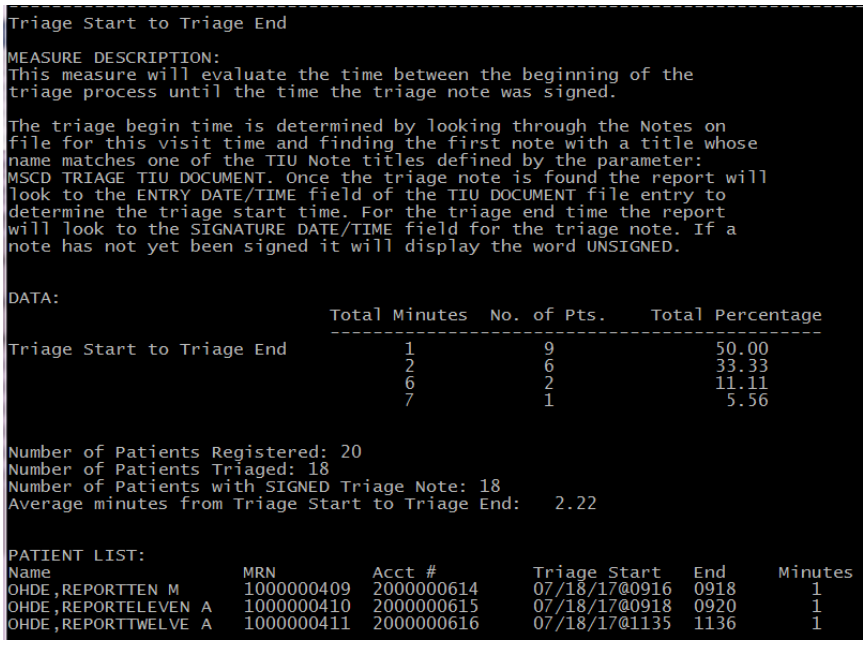
Note: The existing **Registration to Triage Start** ED report was enhanced in the 2016.2.0 release. No changes were made to this report in this release; however, a screenshot is included for comparison with the other enhanced reports.



```
Registration to Triage Start

MEASURE DESCRIPTION:
This measure will evaluate the time between the initial registration
of the patient until the time that the triage process was begun.

The initial registration time is determined by looking at the
DATE/TIME field of the VISIT file entry for the ED encounter. The
triage begin time is determined by looking through the Notes on file
for this visit time and finding the first note with a title whose name
matches one of the TIU Note titles defined by the parameter:
MSCD TRIAGE TIU DOCUMENT. Once the triage note is found the report will
look to the ENTRY DATE/TIME field of the TIU DOCUMENT file entry to
determine the triage start time.


DATA:
              Minutes from Reg to Triage      No. of Pts.     Total Percentage
              ---------------------------------------------------------------
Reg to Triage             2                        2                9.52%
                          3                        2                9.52%
                          4                        3               14.29%
                          6                        2                9.52%
                          7                        1                4.76%
                          9                        3               14.29%
                         16                        2                9.52%
                         25                        1                4.76%
                         27                        1                4.76%
                         34                        1                4.76%
                         35                        2                9.52%
                         45                        1                4.76%


Number of Patients Registered: 27

Number of Patients from Registration to Triage Start: 21

Average Registration to Triage time per patient: 14.33
```

Figure 37: Enhanced Registration to Triage Start report

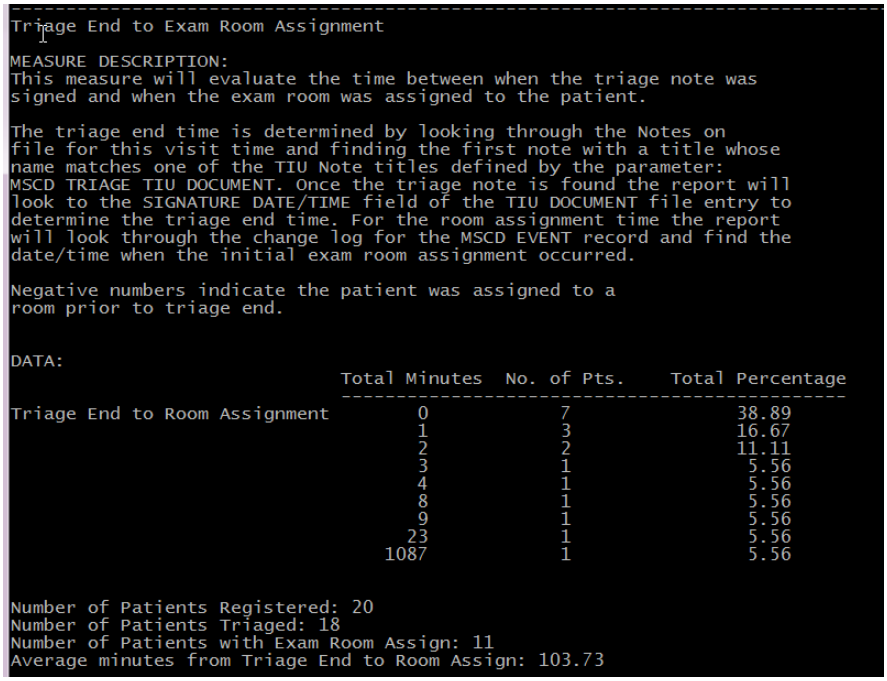
- **Triage Start to Triage End:** The measure of **Triage Start to Triage End** was changed from time groupings to exact minutes and displays along with the total number of patients and percentages for each minute marker. The number of patients registered, number of patients triaged, number of patients 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 End

MEASURE DESCRIPTION:
This measure will evaluate the time between the beginning of the
triage process until the time the triage note was signed.

The triage begin time is determined by looking through the Notes on
file for this visit time and finding the first note with a title whose
name matches one of the TIU Note titles defined by the parameter:
MSCD TRIAGE TIU DOCUMENT. Once the triage note is found the report will
look to the ENTRY DATE/TIME field of the TIU DOCUMENT file entry to
determine the triage start time. For the triage end time the report
will look to the SIGNATURE DATE/TIME field for the triage note. If a
note has not yet been signed it will display the word UNSIGNED.


DATA:
                            Total Minutes  No. of Pts.    Total Percentage
                            -------------------------------------------
Triage Start to Triage End          1            9              50.00
                                    2            6              33.33
                                    6            2              11.11
                                    7            1               5.56


Number of Patients Registered: 20
Number of Patients Triaged: 18
Number of Patients with SIGNED Triage Note: 18
Average minutes from Triage Start to Triage End:   2.22


PATIENT LIST:
Name                 MRN         Acct #         Triage Start   End     Minutes
OHDE,REPORTTEN M     1000000409  2000000614     07/18/17@0916  0918       1
OHDE,REPORTELEVEN A  1000000410  2000000615     07/18/17@0918  0920       1
OHDE,REPORTTWELVE A  1000000411  2000000616     07/18/17@1135  1136       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 Assignment

MEASURE DESCRIPTION:
This measure will evaluate the time between when the triage note was
signed and when the exam room was assigned to the patient.

The triage end time is determined by looking through the Notes on
file for this visit time and finding the first note with a title whose
name matches one of the TIU Note titles defined by the parameter:
MSCD TRIAGE TIU DOCUMENT. Once the triage note is found the report will
look to the SIGNATURE DATE/TIME field of the TIU DOCUMENT file entry to
determine the triage end time. For the room assignment time the report
will look through the change log for the MSCD EVENT record and find the
date/time when the initial exam room assignment occurred.

Negative numbers indicate the patient was assigned to a
room prior to triage end.


DATA:
                            Total Minutes  No. of Pts.    Total Percentage
                            -------------------------------------------
Triage End to Room Assignment       0            7              38.89
                                    1            3              16.67
                                    2            2              11.11
                                    3            1               5.56
                                    4            1               5.56
                                    8            1               5.56
                                    9            1               5.56
                                   23            1               5.56
                                 1087            1               5.56


Number of Patients Registered: 20
Number of Patients Triaged: 18
Number of Patients with Exam Room Assign: 11
Average minutes from Triage End to Room Assign: 103.73
```

Figure 39: Enhanced Triage End to Exam Room Assignment report

```
PATIENT LIST:
Name              MRN          Acct #      Triage End      Room Assigned   Minutes
---------------------------
OHDE,REPORTTEN M  1000000409   2000000614  07/18/17@0918   07/18/17@0920   2
OHDE,REPORTNINET  1000000419   2000000625  07/25/17@0835   07/25/17@0837   2
---------------------------
OHDE,REPORTFOURT  1000000415   2000000620  07/19/17@0848   07/19/17@0851   3
OHDE,REPORTSIXTE  1000000416   2000000649  08/04/17@0906   08/04/17@0909   3
---------------------------
OHDE,REPORTTHIRT  1000000412   2000000617  07/18/17@1315   07/18/17@1320   4
OHDE,REPORTNINE   1000000408   2000000652  08/04/17@0913   08/04/17@0917   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 Assignment

MEASURE DESCRIPTION:
This measure will evaluate the time between the initial registration
of the patient until the time that the provider was assigned.

The initial registration time is determined by looking at the
DATE/TIME field of the VISIT file entry for the ED encounter. 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.


DATA:
                              Total Minutes  No. of Pts.    Total Percentage
                              ---------------------------------------------
Registration to Provider Assign       5            1              5.00
                                      6            1              5.00
                                      7            2             10.00
                                      8            1              5.00
                                     12            1              5.00
                                     14            1              5.00
                                     17            1              5.00
                                     32            1              5.00
                                     33            1              5.00
                                     36            1              5.00
                                     40            1              5.00
                                     44            1              5.00
                                     52            1              5.00
                                    129            1              5.00
                                    196            1              5.00
                                   1109            1              5.00
                                   6882            1              5.00
                                 UNASSIGNED        2             10.00


Number of Patients Registered: 20
Number of Patients with Provider assignment: 18
Average minutes from Registration to Provider 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 1000000411   2000000616  07/18/17@1131  07/18/17@1137    6
TEST,PUFFER      1000000239   2000000672  08/07/17@0921  08/07/17@0927    6
-----------------------------
OHDE,REPORTFIVE  1000000404   2000000605  07/10/17@1430  07/10/17@1437    7
OHDE,REPORTELEVE 1000000410   2000000615  07/18/17@0915  07/18/17@0922    7
-----------------------------
OHDE,REPORTSIX A 1000000405   2000000606  07/12/17@1258  07/12/17@1306    8
OHDE,REPORTEIGHT 1000000407   2000000642  08/02/17@1349  08/02/17@1357    8
TEST,DISCHARGE   1000000062   2000000671  08/07/17@0919  08/07/17@0927    8
-----------------------------
OHDE,REPORTSIX A 1000000405   2000000653  08/04/17@0903  08/04/17@0913    10
-----------------------------
TEST,LAUREN      1000000018   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 Assignment to Provider Assignment

MEASURE DESCRIPTION:
This measure will evaluate the time between the assignment of the exam
room and the time that the provider was assigned.

For the exam room assignment time the report will look through the
change log for the MSCD EVENT record and find the date/time when the
initial exam room was assigned. 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.


DATA:
                            Total Minutes  No. of Pts.    Total Percentage
                            ---------------------------------------------
Room Assign to Provider Assign       1            8              53.33
                                     2            2              13.33
                                     7            1               6.67
                                    16            1               6.67
                                    91            1               6.67
                                   140            1               6.67
                                  6865            1               6.67


Number of Patients Registered: 20
Number of Patients with Room and Provider Assigned: 15
Average minutes from Room Assign to Provider Assign: 475.40


PATIENT LIST:
Name             MRN          Acct #      Room Assign    Provider Assign  Minutes
-----------------------------
OHDE,REPORTFIVE  1000000404   2000000605  07/10/17@1436  07/10/17@1437    1
OHDE,REPORTSIX A 1000000405   2000000606  07/12/17@1305  07/12/17@1306    1
OHDE,REPORTTEN M 1000000409   2000000614  07/18/17@0920  07/18/17@0922    1
OHDE,REPORTELEVE 1000000410   2000000615  07/18/17@0921  07/18/17@0922    1
OHDE,REPORTTHIRT 1000000412   2000000617  07/18/17@1320  07/18/17@1322    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 Assignment to Inpatient Admission

MEASURE DESCRIPTION:
This measure will evaluate the time between when the provider was
assigned and when the IP admission order was written. This measure
will only consider those patients who were admitted as 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 Minutes  No. of Pts.    Total Percentage
                          ---------------------------------------------
Provider Assign 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.

```
ED Disposition to Ward/Bed Assignment

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.

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
                          ---------------------------------------------
ED Disposition to IP Bed          286            1              100.00


Number of Patients Registered: 20
Number of Patients with ED Dispostion and IP Bed 1
Average minutes from ED Disposition to IP Bed: 286.00


PATIENT LIST:
Name            MRN         Acct #      ED Disposition  Bed Assignment  Minutes
-----------------------------
OHDE,REPORTTWENT 1000000420  2000000626  07/25/17@0933   07/25/17@1419   286
```

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 evaluate the time between the initial registration
of the patient until the time that the admission order was written.

The initial registration time is determined by looking at the
DATE/TIME field of the VISIT file entry for the ED encounter. For the
admission 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 Minutes  No. of Pts.    Total Percentage
                            ---------------------------------------------
Reg to IP Admission                 6           1              50.00
                                   67           1              50.00


Number of Patients Registered: 20
Number of Patients with IP Admission: 2
Average minutes from Registration to IP Adm:  36.50


PATIENT LIST:
Name             MRN         Acct #      Registration   IP Admission    Minutes
-----------------------------
OHDE,REPORTTWELV 1000000411  2000000616  07/18/17@1131  07/18/17@1137   6
-----------------------------
```

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 (for pts discharged to home)

MEASURE DESCRIPTION:
This measure will evaluate the time between the initial registration
of the patient until the time that the discharge order was written.
This measure only considers those patient who were discharged to Home
from the ED. It will not consider Inpatient admissions.

The initial registration time is determined by looking at the
DATE/TIME field of the VISIT file entry for the ED encounter. For the
DISCHARGE 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 DISCHARGE ORD ITEMS. Once the discharge order is found the report
will use the DATE/TIME ORDERED field of the initial order creation
order action subfile entry.


DATA:
                           Total Minutes  No. of Pts.    Total Percentage
                           ---------------------------------------------
Registration to Discharge        61           1              9.09
                                 78           1              9.09
                                 93           1              9.09
                                122           1              9.09
                                136           1              9.09
                                225           1              9.09
                                226           1              9.09
                                231           1              9.09
                                233           1              9.09
                               1149           1              9.09
                               1482           1              9.09


Number of Patients Registered: 20
Number of Patients with Discharge: 11
Average minutes from Registration to Discharge: 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**.
4. **Notes/Comments field:** The **Notes/Comments** field is relabeled **Notes**. Information entered in the N**otes** field remains in the **Encounter** tab and is not viewable on the ED Dashboard **Comments** column.

Making ED Dashboard Changes

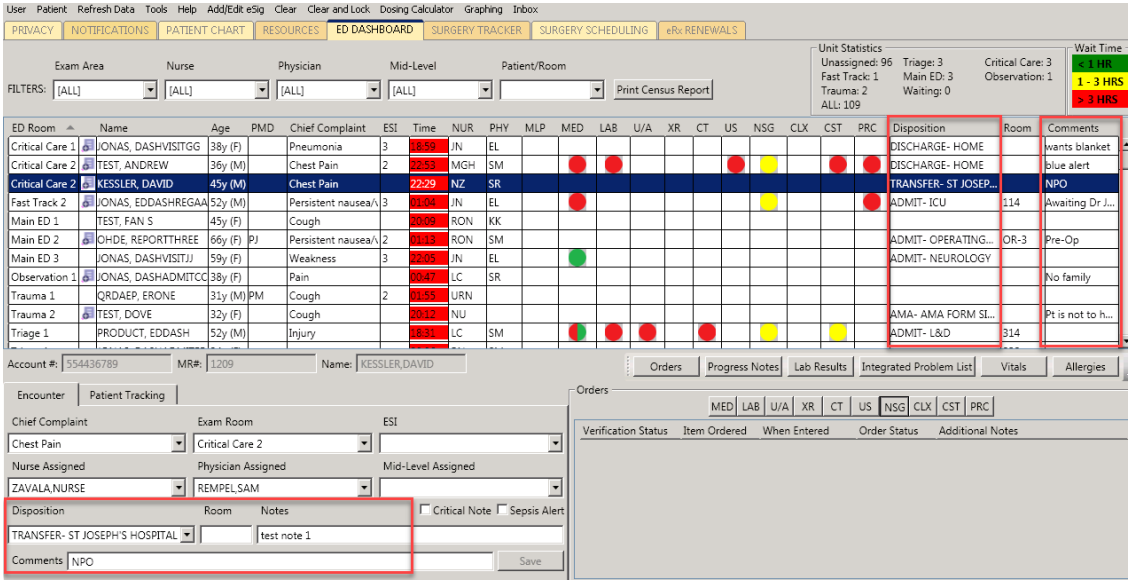


Figure 48: Customizing ED Dashboard Dispositions

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 E**ncounter** 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: ?
     Enter module to send faxes for (LR=LAB, RA=RAD, B=Both).
     Choose from:
       LR        LABORATORY
       RA        RADIOLOGY
       B         BOTH
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         BOTH
LAB PATIENT LOCATION: B  BOTH
RAD PATIENT LOCATION: ?
     Enter Rad Location to send faxes for (I=Inpatient, O=Out, B=Both).
     Choose from:
       I         INPATIENT
       O         OUTPATIENT
       B         BOTH
RAD PATIENT LOCATION: B  BOTH
OFFICE PHONE: 6785236944
INACTIVATED:
UPDATED: t@10  (OCT 27, 2017@10:00)
Select PATIENT: MEDREC,DEMO  MEDREC,DEMO      1-24-54    1-24-54  DOWN1650
                                                         207-2 Female
  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.

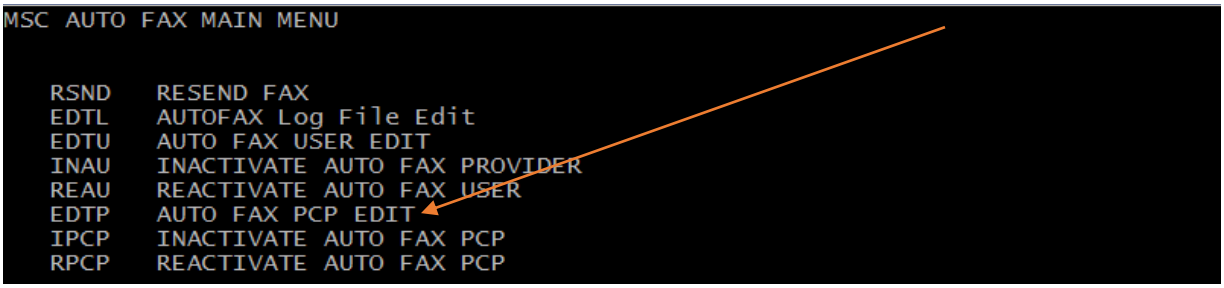


Figure 50: MSC AUTO FAX MAIN MENU

```
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    RESEND FAX
   EDTL    AUTOFAX Log File Edit
   EDTU    AUTO FAX USER EDIT
   INAU    INACTIVATE AUTO FAX PROVIDER
   REAU    REACTIVATE AUTO FAX USER
   EDTP    AUTO FAX PCP EDIT
   IPCP    INACTIVATE AUTO FAX PCP
   RPCP    REACTIVATE AUTO FAX PCP
```

Figure 52: The MSC AUTO FAX MAIN MENU

```
                                GENERAL HOSPITAL

Date:10/27/17                   MSC AUTO FAX PCP                  Time:10:21 AM
                                 Reactivate PCP
--------------------------------------------------------------------------------


Select one of the PCPs below to activate:

     1) LANGLEY,AUTOFAX [1]


Enter Number:
```

Figure 53: Reactivate PCP options

```
                                GENERAL HOSPITAL

Date:10/27/17                   MSC AUTO FAX PCP                  Time:10:22 AM
                                 Deactivate PCP
--------------------------------------------------------------------------------


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 M**SC AUTO FAX USER EDIT** function shown below. This setting can be applied to either or both radiology and lab results.

```
Select Systems Manager Menu PMPHARM(GTM) Option: test an option not in your menu
Option entry to test: msc auto f
     1   MSC AUTO FAX CONSOLE        AUTO FAX CONSOLE
     2   MSC AUTO FAX EDIT LOG FILE       AUTOFAX Log File Edit
     3   MSC AUTO FAX INACTIVATE USER       INACTIVATE AUTO FAX PROVIDER
     4   MSC AUTO FAX REACTIVATE USER       REACTIVATE AUTO FAX USER
     5   MSC AUTO FAX USER EDIT       AUTO FAX USER EDIT
CHOOSE 1-5: 5  MSC AUTO FAX USER EDIT     AUTO FAX USER EDIT

Select MSC AUTO FAX NAME: user,p  USER,PHYSICIAN       PU          M.D.
         ...OK? Yes//   (Yes)

PROVIDER: USER,PHYSICIAN//
FAX NUMBER: 6787145623//
MODULE: BOTH//
MSCH MESSAGE CONFIGURATION: TEST//
PROTOCOL:
INACTIVATED:
LAB PATIENT LOCATION: ?
     Choose from:
       I        INPATIENT
       O        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 (I**EN**) for the **VISIT** was displayed as the **Encounter ID**.

Contact info	Work Place: 1903 Wright Place Carlsbad, CALIFORNIA 92008, 949-999-9999 Work Place: 949-999-9999		
Encounter Id	654654654	**Encounter Type**	Decreased level of consciousness

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: 8/11/17@23:59  (AUG 11, 2017@23:59)
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
          A         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)
          3         USER
          4         ACTION
          5         FIELD ACTED UPON

Select item to sort by: 1//   DATE/TIME
```

```
     Select one of the following:

          A         Ascending order
          D         Descending order

Select sort order: D// escending order

     Select one of the following:

          P         Standard Printed Output
          D         Delimited Output

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:
TIME: AUG 11,2017@17:08:23              USER: LITELLA,EMILY
  ACTION: QUERY                         PATIENT: 0 ← View of "Patient 0" is when no patient is
displayed.
  NOTE: Viewed patient in selector

MSCV AUDIT ITEM ENTRY:
TIME: AUG 11,2017@17:08:11              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 11,2017@16:56:09              USER: LITELLA,EMILY
  ACTION: QUERY                         PATIENT: 0
  NOTE: Viewed patient in selector

MSCV AUDIT ITEM ENTRY:
```

```
TIME: AUG 11,2017@16:56                 USER: LITELLA,EMILY
  ACTION: COPY                          PATIENT: TEST,WHILES
  INFORMATION TYPE: VIEW DOWNLOAD TRANSMIT

MSCV AUDIT ITEM ENTRY:
TIME: AUG 11,2017@16:55:35              USER: LITELLA,EMILY
  ACTION: QUERY                         PATIENT: 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 11,2017@16:54:02
  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): <no previous value>    PATIENT (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
  ENTRY NAME (c): R69.                  FIELD NAME (c): DATE ENTERED
  OLD VALUE (c): <no previous value>    PATIENT (c): TEST,WHILES
  NEW VALUE (c): AUG 11,2017

AUDIT FILE ENTRY from PROBLEM:
NUMBER: 47                              INTERNAL ENTRY NUMBER: 1061
  DATE/TIME RECORDED: AUG 11,2017@16:54:02
  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
  OLD VALUE (c): <no previous value>    PATIENT (c): TEST,WHILES
  NEW VALUE (c): TEST,WHILES

AUDIT FILE ENTRY from PROBLEM:
NUMBER: 46                              INTERNAL ENTRY NUMBER: 1061
  DATE/TIME RECORDED: AUG 11,2017@16:54:02
  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): <no previous value>    PATIENT (c): TEST,WHILES
  NEW VALUE (c): Z89.439

AUDIT FILE ENTRY from ORDER:
NUMBER: 679                             INTERNAL ENTRY NUMBER: 12266,1
  DATE/TIME RECORDED: AUG 11,2017@16:53:10
  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
```

```
  OLD VALUE (c): <no previous value>    PATIENT (c): TEST,WHILES
  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 11,2017@16:53

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 11,2017@16:53:10
  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 11,2017@16:52:20            USER: LITELLA,EMILY
  ACTION: QUERY                       PATIENT: TEST,WHILES
  NOTE: Viewed 'Orders' tab in CareVue

MSCV AUDIT ITEM ENTRY:
TIME: AUG 11,2017@16:51:17            USER: LITELLA,EMILY
  ACTION: QUERY                       PATIENT: TEST,WHILES
  NOTE: Viewed 'Notes' tab in CareVue

AUDIT FILE ENTRY from V IMMUNIZATION:
NUMBER: 9                             INTERNAL ENTRY NUMBER: 323
  DATE/TIME RECORDED: AUG 11,2017@16:51:08
  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:
NUMBER: 8                             INTERNAL ENTRY NUMBER: 323
  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 11,2017@16:51:08
  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 11,2017@16:51:08

AUDIT FILE ENTRY from V IMMUNIZATION:
NUMBER: 5                              INTERNAL ENTRY NUMBER: 382
  DATE/TIME RECORDED: AUG 11,2017@16:51:08
  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 11,2017@16:51:08
  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 11,2017@16:51:08
  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 11,2017@16:51:08
  FIELD NUMBER: 1217                   USER: LITELLA,EMILY
  OLD INTERNAL VALUE: 175              DATATYPE OF OLD VALUE: P200'a
  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 11,2017@16:51:08
  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 11,2017@16:51:08   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 11,2017@16:51:08
  FIELD NUMBER: 1217                    USER: LITELLA,EMILY
  OLD INTERNAL VALUE: 175               DATATYPE OF OLD VALUE: P200'a
  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): 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 11,2017@16:50:29
  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
  OLD VALUE (c): <no previous value>    PATIENT (c): TEST,WHILES
  NEW VALUE (c): AUG 11,2017@16:50:29

AUDIT FILE ENTRY from V HEALTH FACTORS:
NUMBER: 3                               INTERNAL ENTRY NUMBER: 432
  DATE/TIME RECORDED: AUG 11,2017@16:50:29
  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
  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 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 11,2017@16:50:14
  FIELD NUMBER: .01                    USER: LITELLA,EMILY
  OLD INTERNAL VALUE: 50052            DATATYPE OF OLD VALUE: R*P9999999.09'Oa
  MENU OPTION USED: CIAV VUECENTRIC
  FIELD NAME (c): TOPIC                OLD VALUE (c): STRK-LITERATURE
  NEW VALUE (c): <deleted>

AUDIT FILE ENTRY from V PATIENT ED:
NUMBER: 3                              INTERNAL ENTRY NUMBER: 362
  DATE/TIME RECORDED: AUG 11,2017@16:50:14
  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 11,2017@16:50:14
  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 11,2017@16:49:14
  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
  ACCESSED: INQUIRED TO ENTRY          MENU OPTION USED: CIAV VUECENTRIC
  ENTRY NAME (c): TEST,WHILES          PATIENT (c): TEST,WHILES

AUDIT FILE ENTRY from PATIENT:
NUMBER: 101069                         INTERNAL ENTRY NUMBER: 800
  DATE/TIME RECORDED: AUG 11,2017@16:49:14
  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**.

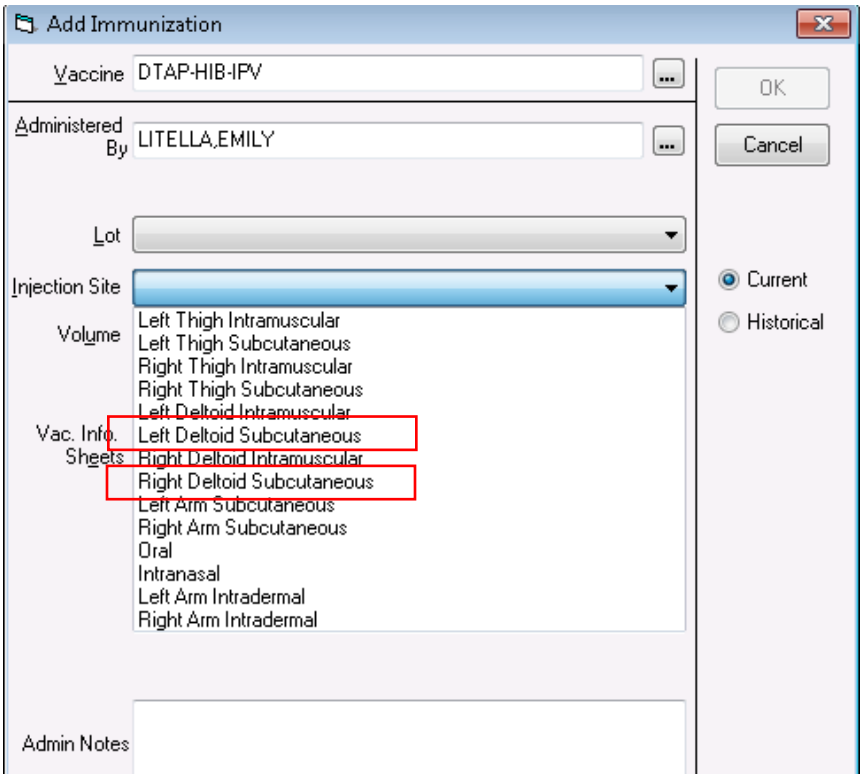


Figure 57: CareVue Immunization tab with new options

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**.

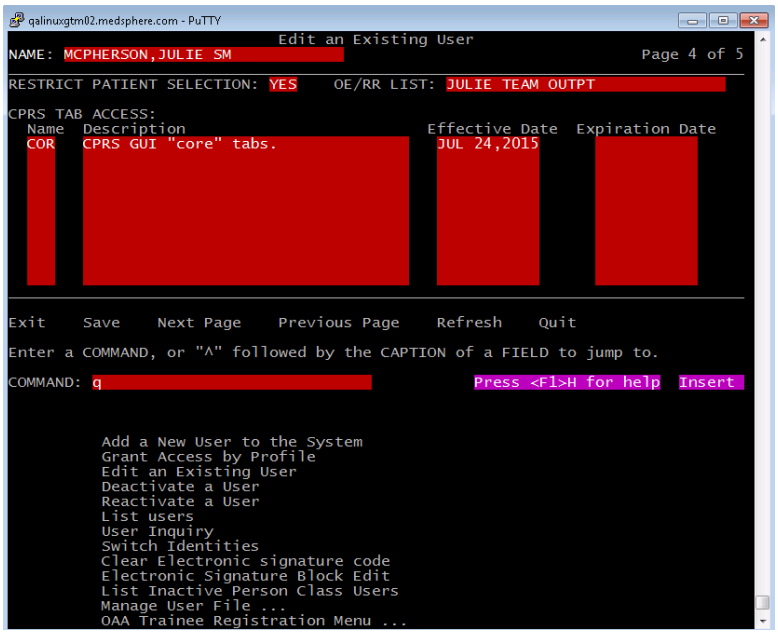


Figure 58: Restrict Patient Selection updates

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.

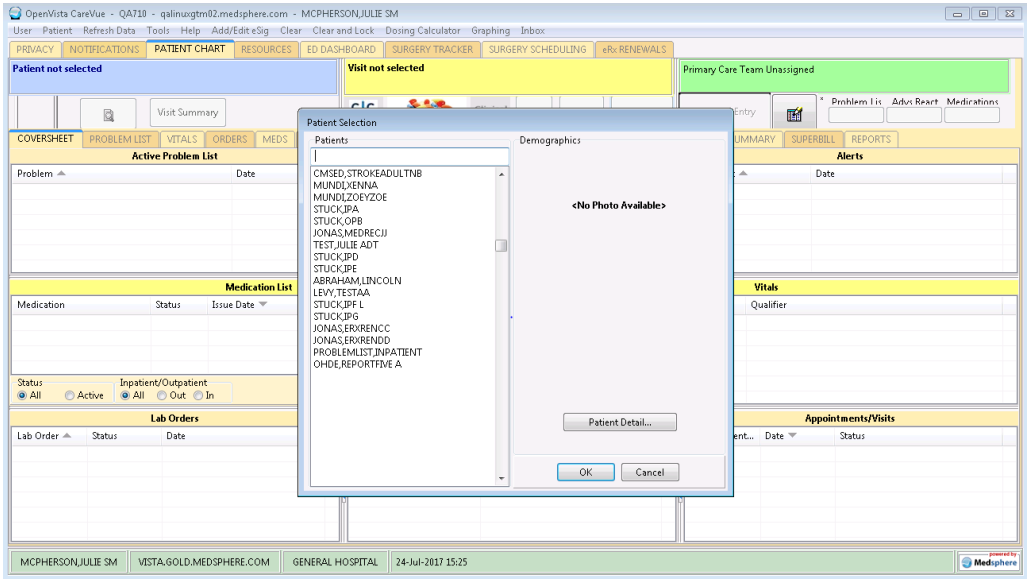


Figure 59: CareVue Patient Chart tab with Patient Selection window

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 M**eds** tab.

Related artifact: 20849