PCE Standardization 1.0

Release Notes

May 2021

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Revision History

Date	Version	Description	Author
May 2021	1.0	Initial Release	

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1. Introduction

The PCE Standardization 1.0 project addresses the lack of standardized data in PCE which is a barrier to important areas including: interoperability, clinical decision support, and quality reporting.

2. Purpose

To take full advantage of the standardization, changes to VistA applications that use PCE data are required. These applications include Clinical Reminders and Health Summary. To make it easier for sites, the builds for PCE (PX*1.0*211), Clinical Reminders (PXRM*2.0*42), Health Summary (GMTS*2.7*122), Problem List (GMPL*2.0*53), and Order Entry/Results Reporting (OR*3.0*501) are being distributed in a multi-package build named PCE STANDARDIZATION 1.0. These Release Notes describe enhancements and modifications implemented in the PCE Standardization release.

3. Audience

The intended audience for this document is the facility administrative and clinical personnel who are users of Veterans Health Information Systems and Technology Architecture (VistA) PCE, Problem List and CPRS applications.

4. This Release

The following sections provide a summary of the new features and functions added, enhancements and modifications to the existing software, and any known issue for PCE Standardization 1.0.

4.1. New Features Added

None.

4.2. Enhancements and Modifications to Existing

Standardization of immunizations and skin tests was addressed by the VistA Immunization Enhancements (VIMM) project. The goal of this project is, to the extent possible, to standardize the legacy data in Education Topics, Exams, and Health Factors and to introduce a new V file for capturing standardized codes other than International Classification of Diseases (ICD), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS). Systematized Nomenclature of Medicine - Clinical Terms (SNOMED CT) will be the first coding system supported by the new V-file. The ability to use a richer set of standardized codes should reduce the need to create new non-standard data types, especially health factors.

The enhancements and modifications in this document apply to the following builds:

- PCE PX*1.0*211
- Clinical Reminders PXRM*2.0*42
- Health Summary GMTS*2.7*122
- Problem List GMPL*2.0*53
- Order Entry/Results Reporting OR*3.0*501

4.2.1. PCE PX*1.0*211

First, some terminology will facilitate this discussion. If an Education Topic, Exam, or Health Factor is mapped to a standard code, an entry made in the V STANDARD CODES file (#9000010.71) as a result of this mapping will be referred to as a mapped source entry (MSE).

All the V-files have an Event Date and Time field that can be used to record when the action related to the specific V-file entry was done. Although this field has always been present in PCE, it has never really been used. To provide a more accurate patient record, a number of changes have been made to capture Event Date and Time. If, for some reason, Event Date and Time has not been recorded, then Visit/Admit Date &Time will be used instead. But, in any case, we will refer to it as Event Date and Time.

The modifications and enhancements for the following functionalities are described next:

1. PCE Data Element Creation and Editing
2. PCE List Manager Encounter Edit and Display
3. PCE Parameters file #815
4. PCE Reports
5. Mapped Codes
6. PXK Visit Data Event Protocol
7. Clinical Reminders Index
8. V-File APIs

4.2.1.1. PCE Data Element Creation and Editing

The following fields were added to the EDUCATION TOPICS file (#9999999.09), EXAM file (#9999999.15), and the HEALTH FACTORS file (#9999999.64) :

Class is a set of codes that can have a value of National, VISN, or Local. This field replaces the outdated and broken mechanism of designating an entry as national based on its IEN. Data elements whose Class is national cannot be edited by sites.

Sponsor is a pointer to the REMINDER SPONSOR file (#811.6). It provides a way to designate who is responsible for the content of the data element.

Change Log is a multiple that records the user who made changes and when they were made. The user can also add additional information in a word-processing field.

Print Name is used to store a mixed case "user friendly" name for the content. It will be used instead of the Name field in Clinical Reminders maintenance output and Health Summary output. Education Topics already had a Print Name field, but its maximum length was 30 characters. The length was increased to 64 to be consistent with Exams and Health Factors. When PX*1.0*211 is installed, for all data elements that do not already have a Print Name, the post-installation process will generate a Print Name using the .01 field of the data element. These generated Print Names provide a starting place and may not always be optimal, in which case, sites can edit the name if they have a class of Local.

Description is a word-processing field; it is used to describe the use and purpose of the data element.

The **Code Mappings multiple** provides a mechanism to link a data element to standard codes such as a SNOMED CT code. Mapping a data element makes it equivalent to the standard code. If mapping is not done correctly, it will cause data quality problems and possible patient safety issues. Therefore, only national data elements can be mapped and the ability to map is restricted to holders of the key: PX CODE MAPPING.

For data elements that have an associated measurement, the set of fields **Minimum Value**, **Maximum Value**, and **Unified Code for Units of Measure (UCUM) Code** define the allowed range for the magnitude and the unit of the measurement.

To store a measurement **Magnitude** and **UCUM Code**, fields were added to the Education Topic, Exam, and Health Factor V-files.

The **V Standard Codes** file was added. To start with, SNOMED CT codes added to an encounter are stored here. Also, all codes that are added to an encounter as a result of code mapping are stored in this file. This includes CPT and ICD codes.

New management systems were created for Education Topics, Exams, and Health Factors. These are integrated systems that use List Manager to list all the data elements and the actions for managing them. When adding or editing a data element, FileMan's ScreenMan functionality is used.

To make it easier to differentiate between Category and Factor health factors, the .01 field of a category health factor must end with "[C]". If the user does not add the "[C]," it will be appended automatically. When a category is created, only an abbreviated list of health factor fields needs to be populated. Therefore, there is a ScreenMan form for categories and another one for factors. In the past, it was possible to convert a category to a factor, but this created problems if there were any factors in the category. Now it is no longer possible to convert a category to a factor.

4.2.1.2. PCE List Manager Encounter Edit and Display

Many changes were made to this functionality; the largest one was the addition of V Standard Codes. Any V Standard Codes entries that are part of the encounter are now displayed and V Standard Codes entries can be added and edited.

The ability to add/edit Event Date/Time and measurement was added.

The input method for Event Date and Time has been standardized. If the user types "??" at the prompt, descriptive help will be displayed. The help text is the data dictionary description of the Event Date and Time field from the V-file the user is putting data into, for example V Health Factors or V POV. Accordingly, the Descriptions and in some cases Technical Descriptions were updated.

Table 1: Descriptions and Technical Descriptions that got updated

V-file	Fields	Description	Technical Description
Visit	.01	Updated	Not Updated
V CPT	Event Date and Time	Updated	Updated
V Exam	Event Date and Time	Updated	Updated
V Health Factors	Event Date and Time	Updated	Updated
V PATIENT ED	Event Date and Time	Updated	Updated
V POV	Event Date and Time	Updated	Updated
V POV	Date of Injury	Updated	Not Updated
V Provider	Event Date and Time	Updated	Updated
V Standard Codes	Event Date and Time	Updated	Updated

In V POV, there is the concept of an injury code. For ICD-9, these are codes in the range 800-999.9. For ICD-10, a code is an injury code if it starts with the letter S or T. If the code is an injury code, the user is prompted to enter the Date of Injury. Input of the Date of Injury was changed to use the same mechanism as Event Date and Time as described above.

The PCE Workgroup made the determination that editing the .01 of a V-file entry should be treated as a deletion and therefore editing of the .01 is no longer allowed. If the .01 is incorrect, then the entry needs to be deleted. Editing of fields other than the .01 is still allowed.

If an Education Topic, Exam, or Health Factor is added to an encounter and it has a mapped code, the corresponding mapped source entry (MSE) in V Standard Codes will be created and be visible on the encounter. An MSE cannot be edited.

When adding CPT and ICD codes to an encounter, the code lookup is now done through a Lexicon search, consistent with the lookup for V Standard Codes. The user enters a search term, which can be text, such as diabetes, a partial code, or even an exact code. The user is then prompted for the Event Date and Time. If the Event Date and Time is not entered, the Visit/Admit Date &Time will be used in its place. The search term and the Event Date and Time are then passed to Lexicon and a list of codes matching the search term that are active as of the Event Date and Time are returned. If an appropriate code is found on the list and selected by the users, it is added to the encounter.

An existing bug was found where ICD codes were not filing in the List Manager interface. The bug was corrected.

The routine in the List Manager interface that displays the coding system type (ICD-9 or ICD-10) for an ICD diagnosis code was using the Visit Date to determine the coding system type. This was changed to determine the coding system type directly from the code itself.

The PCE Workgroup decided that that capture of Event Date and Time should be allowed for V Provider.

At the direction of the VistA Immunizations Enhancements (VIMM) business owner, adding/editing of ICD diagnosis codes was removed from the List Manager interface for Immunizations and Skin Tests.

For V CPT, V POV, and V Standard Codes, the Event Date and Time is used in the Lexicon search so only codes active as of the Event Date and Time are on the selection list. Because of this, the Event Date and Time cannot be edited for these types of entries. However for Education Topics, Exams, and Health Factors, the Event Date and Time can be edited. If a value has already been stored, it will be used as the default if the field is selected for editing.

4.2.1.3. PCE Parameters file #815

The Management Mail Group field, which is a pointer to the Mail Group file #3.8, was added. Members of this mail group will receive MailMan messages related to the management of PCE. An example is the message that is delivered when linking of a mapped code has completed. This field can be edited using the option PX SITE PARAMETERS EDIT or with FileMan enter/edit.

The Site Support Contacts multiple was also added. When DATA2PCE error messages are displayed to a CPRS user, they may be too technical for the user to understand. The error message will refer them to the contacts on this list. The list can be edited using FileMan enter/edit.

4.2.1.4. PCE Reports

The Reminders Due report change requested in VistA Standardization waiver request #475993 was incorporated. When running the PCE Encounter Summary and Provider Encounter Count reports, this adds the ability to select providers from a CPRS Team (OE/RR List).

4.2.1.5. Mapped Codes

In discussions with representatives from Billing and HIMS, it was determined that we do not want to make any entries into V CPT and V POV as a result of code mapping because this could cause issues with billing. Therefore, all entries generated as a result of code mapping will be stored in the V Standard Codes file.

When MSE codes are stored in V Standard Codes, if any of the following fields are populated in the mapped V-file, they will be stored in the associated V Standard Codes entry: Event Date and Time, Ordering Provider, Encounter Provider, Package, and Data Source.

If the code is not active on the Event Date, the MSE will not be stored in V Standard Codes.

When a code mapping is linked or a code mapping is deleted, a notification MailMan message is sent. It contains the number of entries linked or deleted.

A new data source, PCE CODE MAPPING, to be used when codes are added as a result of code mapping, is added as part of the post-installation process.

The PCE Workgroup decided that there can be duplicate codes on an encounter if they are from different sources. Accordingly, the duplicate check for MSE codes being filed in V Standard Codes checks for an exact match on the code, the date and time associated with the code, and the mapped source. If any of these is different, the code will be stored.

When a Lexicon update is installed, it triggers a protocol event. A PCE protocol was created and attached to the Lexicon protocol. The PCE protocol will produce a report listing mapped codes that are inactive and send it to the PCE mail group.

4.2.1.6. PXK Visit Data Event Protocol

When encounter data is added, edited, or deleted, PCE fires this protocol to notify all subscribing applications of the changes. Firing of the PXK Visit Data Event protocol was added to the mapped code linking and deletion processes.

4.2.1.7. Clinical Reminders Index

The new-style cross-references that set and kill the Clinical Reminders Index for V CPT, V Exam, V Health Factors, V Patient Ed, V POV, V Skin Test, and V Standard Codes were modified to use the Event Date and Time, if it was entered, instead of the Visit/Admit Date &Time. If it is not entered, then Visit/Admit Date &Time will be used. This change had already been made for V Immunization and V Skin Test as part of the VIMM project.

The Clinical Reminders Index rebuilding utility was updated to use Event Date and Time as described above.

V Standard Codes was added to the list of files in the Clinical Reminders Index rebuilding utility.

4.2.1.8. V-File APIs

Event Date and Time and Measurement were added to the data returned by the V-file APIs. This means Event Date and Time and Measurement will be additional Condition Subscript (CSUB) data in Clinical Reminders. CSUB data can be used in Clinical Reminders Condition statements and a few other places. They are defined and described in the Clinical Reminders Manager's Manual.

4.2.2. Clinical Reminders PXRM*2.0*42

The following were modified for PXRM*2.0*42:

1. Clinical Reminders Index
2. Reminder Computed Findings
3. Reminder Definitions
4. Reminder Evaluation
5. Reminder Exchange
6. Reminder Manager Menu
7. Reminder Reports
8. Reminder QUERI Extracts
9. Reminder Taxonomies
10. Reminder Terms
11. Reminder Test
12. Self-Identified Gender

4.2.2.1. Clinical Reminders Index

V Standard Codes was added to the Clinical Reminders Index build/rebuilding utility.

4.2.2.2. Reminder Computed Findings

A test site for PXRM*2.0*47 found they had a number of instances where the Computed Finding Parameter for VA-REMINDER DEFINITION was the name of a definition that no longer existed. This could have been because the reminder definition was renamed or deleted. To handle

this case where it was renamed, a change was made so the Computed Finding Parameter can be either the Internal Entry Number or the Name of the Reminder Definition.

Under certain circumstances, evaluating the national computed finding VA-BSA would produce the following error:

```
<SUBSCRIPT>GHEIGHT+16^PXRMBMI *DIFFL("",0)
While evaluating reminder VA-BODY SURFACE AREA
For patient DFN=13
The time of the error was 11/13/2017@09:42:03
See the error trap for complete details.
```

GHEIGHT tries to find the height measurement made closest to the patient's most recent weight measurement. The situation that generated the above error was that the patient had a height measured before the weight measurement but none after. This has been corrected.

4.2.2.3. Reminder Definitions

A site reported that when running the integrity check on a local reminder definition they were getting a hard error:

```
. I 'FIEVAL(LIST(IND)) Q
   ^
<UNDEFINED>MRD+6^PXRMFF0 *FIEVAL("6")
```

The error was traced to two function findings in the definition that depend on finding 6, which does not exist. The function finding portion of the integrity checker was changed so it can handle non-existent findings.

The integrity checker was only checking for a frequency if resolution logic was defined. In this case, no frequency is a fatal error. A change was made so that if there is no resolution logic, a warning for no frequency is issued. If there is resolution logic, a fatal error is issued.

Puget Sound requested adding the ability to edit the print name for national definitions. The Workgroup concurred with the stipulation that site changes are tracked so when content updates are made, the site can determine what local changes were overwritten.

To meet these criteria, two new options were added to the REMINDER MANAGEMENT MENU:

- DEFINITION PRINT NAME EDIT and
- DEFINITION PRINT NAME REPORT

```
PXRM REMINDER MANAGEMENT      Reminder Definition Management      menu

   RL     List Reminder Definitions
   RI     Inquire about Reminder Definition
   RE     Add/Edit Reminder Definition
   RC     Copy Reminder Definition
   RA     Activate/Inactivate Reminders
   HT     Edit HT PERIODIC Reminder Definition Frequency
   RH     Reminder Edit History
   ICS    Integrity Check Selected
   ICA    Integrity Check All
   PNE    Definition Print Name Edit
   PNR    Definition Print Name Report
```

When the PNE option is selected, the user will be prompted to select a Reminder Definition. After a definition is selected, a ScreenMan form that has Print Name as the only editable field will be opened. The PNR option will run a report that finds all Reminder Definitions whose Print Name was edited using the PNE option. For each definition, it lists who edited the Print Name, when it was edited, the original Print Name, and the new Print Name.

The length of Print Name was increased from 35 to 64 characters.

4.2.2.4. Reminder Evaluation

The ability to use V Standard Codes in reminder evaluation and patient list building was added. Now, whenever Patient Data Source includes encounter data, V Standard Codes will be included in taxonomy evaluation. The Help text was updated to include V Standard Codes. A rebuild of the taxonomy "APDS" index was added to the post-installation routine.

The Clinical Maintenance output for Exams and Health Factors was changed to use the new Print Name field, if it is populated, otherwise the .01 will be used. Print Name was an existing field for Education Topics, so Print Name was already being used in this manner for Education Topics.

If there is no resolution logic, reminder frequency is not required so it will not create an error, but the following warning was added to the Clinical Maintenance output: "There is no reminder frequency!"

If there is resolution logic and no frequency, then the reminder cannot be evaluated, this generates a status of ERROR. Text was added to the Clinical Maintenance output with the error message: "There is resolution logic but no reminder frequency!"

Display of measurement data was added to the Clinical Maintenance output for Education Topics, Exams, Health Factors, and V Standard Codes.

4.2.2.5. Reminder Exchange

When PX*1.0*211 is installed, it adds the Class field to Education Topics, Exams, and Health Factors and it is a required field. Any Reminder Exchange (.prd) files created in an account that does not have PX*1.0*211 will not have these fields and consequently will not install in accounts with PX*1.0*211 installed. Reminder Exchange has been modified to eliminate this problem. If a Reminder Exchange entry that does not contain the Class field is being installed as part of KIDS install, Reminder Exchange will set it automatically to National. If the entry is being manually installed, the Class fields will be set to local. In the future, the Exchange prd file will contain information about the account where the prd file was created, and this will also be used to determine how to set the Class field if it is missing.

Another issue that Reminder Exchange must handle is the requirement that Health Factor Category names end in "[C]." Reminder Exchange tries to determine if an incoming category is new or if it is an existing category but is missing the "[C]." If it is new, it will install it and append the "[C]" to the name. If it already exists, any new incoming health factors in the category will have their category switched to the one with the appended "[C]."

When multiple Reminder Dialogs are included in a single exchange file entry, for each dialog, the Exchange dialog install software was restarting the install from the beginning of the dialog list. Because of this, dialog installation was slow and the display of the dialog was incorrect. This has been fixed. Now only items associated with the dialog selected for installation will be included in the display and installation list; dialogs will install much faster.

A Repack action was added to Reminder Exchange. This new action can be used to select an existing Reminder Exchange file entry and automatically repack it. If the Exchange file entry was originally packed in a different account, the repack may fail because one or more of the components may not exist in the account where the repack is being done.

During an install, if a component was already installed in the account and found to be identical to what is in the Exchange entry, Reminder Exchange was writing out the message: "FILE NAME entry named NAME already exists and the packed component is identical, skipping."

For some Exchange installs, there could be many of these messages and displaying them slowed down the install. Now, these messages will no longer be written out, instead a single period '.' will be written to let the user know Reminder Exchange is processing the entry.

As part of the packing process, the Reminder Integrity Checker will now be run on every definition that is to be included in the Reminder Exchange file entry. If a definition has fatal errors, the packing process will abort.

In the past during an install, if a finding in a definition, term, or dialog did not exist, the user was prompted to input a replacement for every instance of the missing finding in the components being installed. Changes have been made to keep track of finding replacements, so now the user will only have to enter the replacement once. After the replacement has been entered the first time, every subsequent instance of the missing finding will be automatically replaced.

The way dialogs are stored in an Exchange File entry was restructured so that they will install much faster. This means that dialogs packed before this restructuring need to have a conversion run on them. A means to determine if the conversion needs to be done necessitated creating a mechanism for storing and reading packing attributes. The attributes are stored in the Exchange File entry when it is created and read when it is installed. This is all done automatically and does not require any action by the Reminder Exchange user.

4.2.2.6. Reminder Manager Menu

Test site feedback reported: "the manager menu is one line too long – this needs to be shortened."

```
      <TEST ACCOUNT>      Reminder Computed Finding Management ...
      <TEST ACCOUNT>      Reminder Definition Management ...
      <TEST ACCOUNT>      Reminder Sponsor Management ...
      <TEST ACCOUNT>      Reminder Taxonomy Management
      <TEST ACCOUNT>      Reminder Term Management ...
      <TEST ACCOUNT>      Reminder Location List Management ...
      <TEST ACCOUNT>      Reminder Exchange
      <TEST ACCOUNT>      Reminder Test
      <TEST ACCOUNT>      Other Supporting Menus ...
      <TEST ACCOUNT>      Reminder Information Only Menu ...
      <TEST ACCOUNT>      Reminder Dialog Management ...
      <TEST ACCOUNT>      CPRS Reminder Configuration ...
      <TEST ACCOUNT>      Reminder Reports ...
      <TEST ACCOUNT>      Reminders MST Synchronization Management ...
      <TEST ACCOUNT>      Reminder Patient List Menu ...
      <TEST ACCOUNT>      Reminder Parameters ...
      <TEST ACCOUNT>      NLM Value Set Menu
      <TEST ACCOUNT>      Reminder Order Check Menu ...
      <TEST ACCOUNT>      NLM Clinical Quality Measures Menu
      <TEST ACCOUNT>      Reminder Extract Menu ...
      <TEST ACCOUNT>      GEC Referral Report
      <TEST ACCOUNT>      Add/Edit Reminder Categories
```

The GEC Referral Report was already available in the Reminder Reports menu, so it was removed from the Managers Menu.

4.2.2.7. Reminder Reports

When users ran a Reminders Due report at Puget Sound, they got the following error:

```
Reminders Due Report
Select an existing REPORT TEMPLATE or return to continue:
       Select one of the following:

       I      Individual Patient
       R      Reminder Patient List
       L      Location
       O      OE/RR Team
       P      PCMM Provider
       T      PCMM Team

PATIENT SAMPLE: L// o  OE/RR Team

Select TEAM: HCHV Case Mgmt
Select another TEAM:

Enter EFFECTIVE DUE DATE: Jan 07, 2018//   (JAN 07, 2018)

     Select one of the following:

       D      Detailed
       S      Summary

TYPE OF REPORT: S// d  Detailed
Display All Future Appointments: N// O
Sort by Next Appointment date: N// O
Print full SSN: N// O
Print locations with no patients? YES//
Print percentages with the report output? NO//
Select individual REMINDER: ^
Print locations with no patients? YES// ^

RECORDING THAT AN ERROR OCCURRED ---
```

This was occurring because the variable PXRMLCSC was not defined as a result of the "^" input. The code was changed to properly handle the "^" input.

4.2.2.8. Reminder QUERI Extracts

The data from the Ischemic Heart Disease (IHD) and (Mental Health) MH QUERI extracts is no longer being used. Therefore, the monthly run of these extracts is being stopped and all the old QUERI patient lists are being deleted. The following options are deleted, and their scheduling is removed:

- PXRM EXTRACT VA-IHD QUERI
- PXRM EXTRACT VA-MH QUERI

4.2.2.9. Reminder Taxonomies

A user reported that when using the Use In Dialog Edit (UIDE) action, if you quit without saving and selected another taxonomy for UIDE, the codes from the original taxonomy were still displayed. This was corrected.

When using the UIDE action, it was not clear whether or not codes could be marked as Use In Dialog (UID). This display was changed to explicitly state whether or not codes can be marked as UID.

4.2.2.10. Reminder Terms

A Reminder Term Test option was added to the Reminder Term Management menu. The user is prompted for a patient and a term. The term is evaluated and the True or False value and the FIEVAL (Finding Evaluation) array are written out.

4.2.2.11. Reminder Test

The reminder global variables and their values are now displayed in Reminder Test.

4.2.2.12. Self-Identified Gender

Self-identified gender has been added to the Patient file, and consequently it has been added as a new reminder global variable named PXRMSIG. PXRMSIG can be used exactly like any of the already existing reminder global variables such as PXRMSEX or PXRMDOB.

4.2.3. Health Summary GMTS*2.7*122

One of the changes in PX*1.0*211 was to add a Print Name for Education Topics, Exams, and Health Factors. The purpose of the Print Name is to provide a more “user friendly” display. In contrast with the Name (.01) field, which is all upper case, the Print Name is mixed case. The Health Summary components for Education Topics, Exams, and Health Factors were changed to use the Print Name instead of the Name. If, for some reason, the Print Name is not defined, the Name field will be used.

Originally, the output formats for Education Topics, Exams, and Health Factors were not consistent as these examples show:

```
------------------------------ ED - Education ------------------------------

  Date       Facility     Topic - Understanding Level
07/19/2004  ISC-SLC-A4   DIAGNOSIS/DISEASE PROCESS
                         FOOT CARE - GOOD UNDERSTANDING
                          Test GUI Encounter Comments...
05/08/2001  ISC-SLC-A4   PAIN MGMT - ACUTE

---------------------------- EXAM - Exams Latest ----------------------------

     Exam                        Result         Date         Facility
BREAST EXAM                                   02/09/2010  ISC-SLC-A4
CHEST EXAM                       NORMAL       07/17/2000  ISC-SLC-A4
DIABETIC EYE EXAM                             11/26/2003  ISC-SLC-A4

---------------------------- HF - Health Factors ----------------------------

Category
  Health Factor                                    Event/Visit Date
ALCOHOL USE [C]
  DRINKING ALONE                                   09/19/2000
ARCH [C]
  ARCH-NO SERVICE NEEDED THIS VISIT                03/30/2011
  ARCH-SERVICE NEEDED THIS VISIT CONSENTS          03/25/2011
             VISN SERVICE 1, ARCH SERVICE 6
  ARCH-SERVICE NEEDED THIS VISIT CONSENTS          03/09/2011
The formatting was changed to make the output format as consistent as possible.

-------------------- ED - Education (max 3 occurrences) --------------------

  Date      Facility     Topic - Understanding Level
02/03/2000  SALT LAKE    Tobacco Use Screening - GOOD
                         Data Source: TEXT INTEGRATION UTILITIES
01/11/1999  ELY          Tobacco Use Screening - GOOD
                         Data Source: PXCE DATA ENTRY
05/06/1992  ISC-SLC-A4   Tobacco Use Screening - GOOD
                         Data Source: TEXT INTEGRATION UTILITIES

---------------------------- EXAM - Exams Latest ----------------------------

  Date      Facility     Exam - Result
04/05/2001  ISC-SLC-A4   Chest Exam - ABNORMAL
                          Left, Up
                         Data Source: TEXT INTEGRATION UTILITIES
02/02/2000  ISC-SLC-A4   Diabetic Exam
                         Data Source: TEXT INTEGRATION UTILITIES
01/10/2001  No Site      Diabetic Eye Exam
                         Data Source: TEXT INTEGRATION UTILITIES

---------------------------- HF - Health Factors ----------------------------

Event/Visit  Category
   Date        Health Factor
             A A PAIN HX OUTSIDE [C]
08/16/2001     A A Pain Assess Declined
                         Data Source: TEXT INTEGRATION UTILITIES
             ALCOHOL USE [C]
09/20/2004     Binge Drinking
                         Data Source: TEXT INTEGRATION UTILITIES
             DIABETIC HEALTH FACTORS [C]
05/23/2016     Diabetic Eye Exam Done Elsewhere
                         Data Source: PXCE DATA ENTRY
```

The formatting was changed to make the output format as consistent as possible.

```
--------------------- ED - Education (max 3 occurrences) ---------------------

  Date      Facility     Topic - Understanding Level

02/03/2000  SALT LAKE    Tobacco Use Screening - GOOD
                         Data Source: TEXT INTEGRATION UTILITIES
01/11/1999  ELY          Tobacco Use Screening - GOOD
                         Data Source: PXCE DATA ENTRY
05/06/1992  ISC-SLC-A4   Tobacco Use Screening - GOOD
                         Data Source: TEXT INTEGRATION UTILITIES


---------------------------- EXAM - Exams Latest ----------------------------

  Date      Facility     Exam - Result

04/05/2001  ISC-SLC-A4   Chest Exam - ABNORMAL
                          Left, Up
                         Data Source: TEXT INTEGRATION UTILITIES
02/02/2000  ISC-SLC-A4   Diabetic Exam
                         Data Source: TEXT INTEGRATION UTILITIES
01/10/2001  No Site      Diabetic Eye Exam
                         Data Source: TEXT INTEGRATION UTILITIES


---------------------------- HF - Health Factors ----------------------------

Event/Visit  Category
   Date        Health Factor
             A A PAIN HX OUTSIDE [C]
08/16/2001     A A Pain Assess Declined
                         Data Source: TEXT INTEGRATION UTILITIES
             ALCOHOL USE [C]
09/20/2004     Binge Drinking
                         Data Source: TEXT INTEGRATION UTILITIES
             DIABETIC HEALTH FACTORS [C]
05/23/2016     Diabetic Eye Exam Done Elsewhere
                         Data Source: PXCE DATA ENTRY
```

Note that Data Source is now included. The original routines had code to display Data Source, but it was not working. This has been corrected. If an associated measurement is present, it will be displayed also.

4.2.4. Problem List GMPL*2.0*53

One of the changes in PX*1*211 is to change the length of the Provider Narrative “B” index from 30 characters to the full length of the .01 which is 245 characters. This necessitated a change in the API PROVNARR^PXAPI which was written back when the maximum length of the “B” index could only be 30 characters. The Problem List API PROVNARR^GMPLX was also written for a 30-character index and would not function correctly with the new full-length index. PROVNARR^GMPLX provides the same functionality as PROVNARR^PXAPI, so

instead of having two copies of essentially the same code, ICR #6953 was created to allow Problem List to use PROVNARR^PXAPI.

While making the above changes to GMPLX, we noticed that it was making calls to various entry points in ICDXCODE routine which has been deprecated and replaced by ICDEX. These calls were replaced with the corresponding calls in ICDEX.

4.2.5. Order Entry/Results Reporting OR*3.0*501

When Order Entry was calling the DATA2PCE API it was not properly passing the variable PPEDIT. The call to DATA2PCE in the routine ORWPCE1 was corrected so it properly passes PPEDIT.

4.3. Known Issues

None.

5. Product Documentation

Table 2: Documentation

Title	Documentation File name
Installation Guide	px_1_0_211_dibr.docx px_1_0_211_dibr.pdf
Release Notes	px_1_0_211_rn.docx px_1_0_211_rn.pdf
PCE Technical Manual	pxtm.docx pxtm.pdf
PCE User Manual	pxum.docx pxum.pdf
Clinical Reminders Index Technical Manual	pxrm_index_tm.docx pxrm_index_tm.pdf
Clinical Reminders Manager's Manual	pxrm_mm.docx pxrm_mm.pdf

Documentation can be found on the VistA Documentation Library (VDL) at:
https://www.va.gov/vdl/

6. Acronyms

The OIT Master Glossary is available at REDACTED

National Acronym Directory: https://vaww.va.gov/Acronyms/

Term	Definition
CPRS	Computerized Patient Record System
GMPL	Problem List namespace
GMTS	Health Summary namespace (also HSUM)
GUI	Graphic User Interface
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICR	Integration Control Registration
IOC	Initial Operating Capabilities
MH	Mental Health
OHI	Office of Health Information
OI	Office of Information
OIT/OI&T	Office of Information Technology

OMHS	Office of Mental Health Services
ORR	Operational Readiness Review
PCS	Patient Care Services
PD	Product Development
PIMS	Patient Information Management System
PXRM	Clinical Reminder Package namespace
RSD	Requirements Specification Document
SME	Subject Matter Expert
SNOMED CT	Systematic Nomenclature of Medicine of Clinical Terms
SQA	Software Quality Assurance
VA	Department of Veteran Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information System and Technology Architecture