



CLINICAL PROCEDURES

Version 1.0

TECHNICAL MANUAL AND PACKAGE SECURITY GUIDE

April 2004

Revised January 2011

Department of Veterans Affairs
Office of Information & Technology
Office of Enterprise Development

Revision History

Description	Date	
Originally released.	April 2004	
¹ Patch MD*1.0*1 released.	July 2004	
Patch MD*1.0*2 released.	August 2006	
² Patch MD*1.0*5 released August 2006. Updated File List, Package Default Definition, Parameter Definitions, and menu options.	Documented February 2008	Shirley Ackerman, Alfred Bustamante
³ Patch MD*1.0*14 released. Updated Routine Descriptions, File List, Parameter Definitions, Protocols, menu options, and Cross References. Deleted bad references to Sample Reports in Ch. 15.	March 2008	Shirley Ackerman, Alfred Bustamante
⁴ Patch MD*1.0*6 released. Added description of Hemodialysis module and 508 Compliance to Introduction; updated Routine Descriptions, File List, Package Default Definition, Remote Procedure Calls, Parameter Definitions, menu options, Cross References, Callable Routines, External Relations, Internal Relations, and Glossary. Removed individual vendor contact information from Ch.15.	May 2008	Shirley Ackerman, Alfred Bustamante
⁵ Patch MD*1.0*11 released. Updated Routine Description, File and Field Description, Parameter Definition, and Menu Options By Name.	March 2009	Shirley Ackerman, Alfred Bustamante
⁶ Patch MD*1.0*21 released. Updated Routine Description, Parameter Definition, and Menu Options By Name.	May 2010	Shirley Ackerman, Rachel Wilder

¹ Patch MD*1.0*1 and MD*1.0*2 July 2004 Patch 2 release added.

² Patch MD*1.0*5 August 2006 Patch 5 release added.

³ Patch MD*1.0*14 March 2008 Patch 14 release added.

⁴ Patch MD*1.0*6 May 2008 Patch 6 release added.

⁵ Patch MD*1.0*11 March 2009 Patch 11 release added.

⁶ Patch MD*1.0*21 May 2010 Patch 21 release added.

<p>¹Patch MD*1.0*20 released. Added new Exported Options and Updated the Routine Descriptions. Added new Parameter Definitions.</p>	<p>November 2010</p>	<p>Shirley Ackerman, Rachel Wilder</p>
<p>²Patch MD*1.0*16 released. Added 508 compliance statement. Added new and updated Exported Options and Routine Descriptions. Added Dialogs and Security Keys. Updated File Security. Corrected link to the Clinical Flowsheets website. Added new file entries to the existing Package Default Definition list. Updated the Electronic Signatures section. Updated Cross References. Removed Kardex references. Added file and field descriptions. Added terms to the Glossary. Corrected figure captions. Removed two routines from Routine Descriptions section. Added MDCLI01 and MDTERM to Section 9, Callable Routines. Removed terminology dictionaries for Aware and Spacelabs from Section 15.</p>	<p>January 2011</p>	<p>Rachel Wilder</p>

¹ Patch MD*1.0*20 November 2010 Patch 20 release added

² Patch MD*1.0*16 January 2011 Patch 16 release added

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1. Introduction

¹CP (Clinical Procedures) is a conduit for passing final patient results, using Health Level 7 (HL7) messaging, between vendor clinical information systems (CIS) and Veterans Health Information Systems and Technology Architecture (VistA). The patient's test result or report is displayed through the Computerized Patient Record System (CPRS). The report data is stored on the Imaging Redundant Array of Inexpensive Disks (RAID) and in some instances, discrete data is stored in the Medicine database.

CP provides features that can be used across clinical departments such as general medicine, cardiology, pulmonary, women's health, neurology, and rehabilitation medicine.

²Hemodialysis is a new module of the Clinical Procedures (CP) package that provides features specific to hemodialysis treatment. The Hemodialysis module allows you to collect hemodialysis treatment information from the medical device, and manually enter treatment data into the application.

Pre-dialysis vitals, information obtained during treatment, and post-dialysis vitals can be entered into the Hemodialysis data entry screens. A Treatment Summary is created and used to fill out Centers for Medicare & Medicaid Services (CMS)/End Stage Renal Disease (ESRD) forms.

Benefits

a. Standardized and Common User Interface

Clinicians can go through the same program, CPRS, to enter, review, interpret, and sign CP orders. CP documents in TIU obey Authorization Subscription Utility (ASU) Business Rules. The update users functionality currently used by Consults determines which users are allowed to access or edit CP documents.

b. Integration

The ordering process of a CP procedure is initiated by CPRS and processed through the Consult/Request Tracking Package (Consults). The interpretation of the data is entered and displayed through TIU. The final result of the CP procedure is displayed by VistA Imaging. The ordering, viewing, reviewing, interpreting, and signing of the CP medical record is accessed through one location, the Consults tab in CPRS.

c. Variety of Accepted File Types

CP is able to accept data/final result report files from automated instruments in .txt, .rtf, .jpg, .jpeg, .bmp, .tiff, .pdf, and .html file types. CP allows additional automated instruments and file types to be added to interface with CP in the future.

¹ Patch MD*1.0*16 January 2011 Spelled out CP acronym on first use.

² Patch MD*1.0*6 May 2008 Hemodialysis introduction added.

d. Links to Other Packages

CP interfaces with packages such as Computerized Patient Record System (CPRS), Consult/Request Tracking Package, Text Integration Utility Package (TIU), and VistA Imaging. New Health Summary components shall be available in the future.

e. Interface Between CP and Imaging

Certain images such as consent forms and report objects are acquired, processed, stored, transmitted, and displayed by the VistA Imaging package. This interface will replace existing capture interface between Medicine 2.3 and VistA Imaging.

f. Inpatient and Outpatient Workloads

CP Definition file (#702.01) allows for defining the Hospital Location where the procedure is performed. This determines which Encounter Form is presented to the end user. CPRS and TIU parameters allow for the configuration of TIU software to prompt users to enter workload data which is then passed to the Patient Care Encounter software (PCE) for both inpatients and outpatients.

1508 Compliance

²The Department of Veterans Affairs, Office of Enterprise Development (OED), and New Editions have completed the Section 508 compliance testing of MD*1.0*16.

- CPFlowsheets (MD*1.0*16) is assigned a Section 508 status of compliant.
- CPCConsole Manager (MD*1.0*16) is assigned a Section 508 status of compliant.

Note: The following notice applies only to Patch MD*1.0*6.

The Clinical Procedures Hemodialysis Software is exempt from coverage under the Section 508 standards. The definition of "electronic and information technology" in the Section 508 standards specifically excludes "medical equipment where information technology is integral to its operation." 36 C.F.R. Section 1194.4. VHA's use of the Clinical Procedures Hemodialysis Software also does not violate Section 508 because it will not affect access to the data or information provided by that software. 29 U.S.C. Section 794d(a). The data or information collected by the software is immediately made available through the CPRS system, which is accessible to people with disabilities.

¹ Patch MD*1.0*6 May 2008 508 Compliance notice added.

² Patch MD*1.0*16 January 2011 Added 508 compliance statement.

¹Clinical Flowsheets Patch

The Clinical Flowsheets patch provides an interface to collect patient information from Intensive Care Unit (ICU) monitoring devices, and the subsequent entry and storage of the data in VistA. A large and varied set of patient data is generated in the ICU setting, and it is a challenge for Department of Veterans Affairs (VA) medical providers to easily and consistently collect and analyze patient data without standardization.

The Clinical Flowsheets patch provides the ICU connectivity that makes the required data available to the Clinical Reminders Index. This functionality is provided by the Clinical Observation database (CliO) Service. The application provides user-friendly, customizable, graphical user interfaces (GUI) with flowsheets to view, edit, and enter patient ICU Vitals, Renal Dialysis, and Intake & Output (I&O). Vendor products include monitors and other instruments, as well as CIS.

The Clinical Flowsheets patch (MD*1.0*16) distributes HL7 links designed to receive clinical observations from ICU monitors and other clinical systems that meet the published CP ORU Conformance Profile. The patch also allows users to enter data manually collected from monitors that cannot electronically send the information. The incoming vendor data is made available concurrently with the manually entered information in the Clinical Flowsheets patch.

The Clinical Flowsheets patch consists of three executables through which the ICU and VistA communicate: CP Gateway, CP Console, and CP Flowsheets.

- The CP Gateway system allows third party vendor devices to send observational data to a VistA CP system for display and reporting. HL7 messaging is the broadcaster (generator) of the text passed between the devices and VistA. For more information about the CP Gateway, refer to the *Clinical Flowsheets Installation Guide*.
- The CP Console application provides the tools to build the flowsheets that you use in the ICU for patient care, recording vital statistics as necessary. For more information on the CP Console application, refer to *Clinical Procedures (CP) Console Implementation Guide*.
- The CP Flowsheets patch provides CIS functions, such as data entry and validation, patient management, and system administration. For more information on the CP Flowsheets application, refer to *Clinical Procedures V.1.0 CP Flowsheets User Manual*.

Kardex

Kardex functionality was removed from this application version and will be included in a future release. Some back-end Kardex files remain in place and will not adversely affect application functionality.

¹ Patch MD*1.0*16 January 2011 Added information about the Clinical Flowsheets package. Added Kardex section.

|

2. Implementation and Maintenance

For implementation and maintenance issues, refer to “Chapter 1 – Introduction” of the *Clinical Procedures Implementation Guide*. For implementation and maintenance of Clinical Flowsheets, refer to the *Clinical Procedures (CP) Console Implementation Guide*.¹

¹ Patch MD*1.0*16 January 2011 Added document reference.

3. Clinical Instrument Interface Specifications

Refer to Chapter 10 of the Clinical Procedures Implementation Guide for information on Setting up HL7 Parameters.

¹Refer to the Clinical Instrument Bi-Directional Interface Specifications document for information on Clinical Procedures instrument interface specifications. Directions for locating the document follow:

1. Access the Clinical Procedures website:
<http://vista.med.va.gov/clinicalspecialties/clinproc/>
2. On the navigation bar found on the left-hand side of the page, hover your mouse pointer over **Clinical Procedures Project**, then click **Documentation**.
3. Click **Clinical Procedures Documents**.
4. ²Click the **Clinical Procedures Bi-Directional Communication Specification** link to view the document or save a copy.

Click the **Clinical Procedures Bi-Directional Communication Specification** link to view the document or save a copy.

¹ Patch MD*1.0*14 March 2008 Outdated link removed and replaced with directions to document.

² Patch MD*1.0*16 January 2011 Added step number to fourth step.

4. Routine Descriptions

```
MDAPI ; HOIFO/DP/NCA - CP API Calls ; [05-05-2003 10:28]
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDAPI1 ; HOIFO/NCA - Electrocardiogram Data Extraction ;12/4/02 12:32
; ;1.0;CLINICAL PROCEDURES;**1**;Apr 01, 2004;Build 4
MDAR7M ; HOIFO/NCA - Get Text Impression ;2/27/09 12:38
; ;1.0;Clinical Procedures;**21**;Apr 01, 2004;Build 24
MDARP3 ; HOIFO/NCA - Get Procedures for Medicine ;1/13/04 14:35
; ;1.0;CLINICAL PROCEDURES;**10,13**;Apr 01, 2004;Build 22
MDARSET ; HOIFO/NCA - High Volume Check-In Setup ;6/30/09 10:00
; ;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDCLN ; HOIFO/NCA - Cleanup Disabled Studies ;4/19/01 11:52
; ;1.0;Clinical Procedures;**21**;Apr 01, 2004;Build 24
MDCVT ; HOIFO/DP/NCA - Medicine Package Conversion ;10/20/04 12:49
; ;1.0;CLINICAL PROCEDURES;**5**;Apr 01, 2004;Build 4
MDCVT1 ; HOIFO/NCA - Medicine Package Conversion (Cont.) ;1/6/05 15:12
; ;1.0;CLINICAL PROCEDURES;**5**;Apr 01, 2004;Build 4
MDCVTU ; HOIFO/NCA - Medicine Conversion Verification Utility ; [08-28-2003
11:34]
; ;1.0;CLINICAL PROCEDURES;**5**;Apr 01, 2004;Build 4
MDESPRT ; HOIFO/NCA - ELECTRONIC SIGNATURE PRINT ;12/21/04 09:24
; ;1.0;CLINICAL PROCEDURES;**5**;Apr 01, 2004;Build 4
MDDEVCL ; HOIFO/NCA - Collect Device Data ;8:34 AM 9 Jun 2005
; ;1.0;CLINICAL PROCEDURES;**20**;Apr 01, 2004
MDHL7A ; HOIFO/WAA - Routine to Decode HL7 for CP ;05/21/09 15:57
; ;1.0;CLINICAL PROCEDURES;**6,11,21**;Apr 01, 2004;Build 24
MDHL7B ; HOIFO/WAA -Bi-directional interface routine ;7/23/01 11:41
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7BH ; HOIFO/WAA -Bi-directional interface (HL7) routine ;10/26/09 09:21
; ;1.0;CLINICAL PROCEDURES;**11,21,20**;Apr 01, 2004;Build 30
MDHL7D ; HOIFO/WAA -B-Braun, Fresenius Dialysis ; 06/08/00
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDHL7E ; HOIFO/WAA -Olympus/CMore/Pentax Endoscopy ; 06/08/00
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7K1 ; HOIFO/WAA-KenitDx Interface ; 06/08/00
; ;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDHL7K2 ; HOIFO/WAA -HP EnConcert Echo ; 06/08/00
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7M1 ; HOIFO/WAA - Muse EKG ; [02-06-2002 16:13]
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7MCA ; HOIFO/REL-Routine to Decode HL7 for MEDICINE ; [05-07-2001 10:38]
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDHL7MCMX ; HIRFMO/WAA - Generate HL7 Error Message for MEDICINE ; [05-07-2001
10:38]
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7P1 ; HOIFO/WAA-Sensormedics,Jaeger Pulmonary ; 06/08/00
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7R1 ; HOIFO/WAA -Clinivision Respiratory ; 06/13/02
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7U ; HOIFO/WAA -Routine utilities for CP ;7/23/01 11:41
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7U1 ; HOIFO/WAA -Routine utilities for CP PROCESSING OBX ; 7/26/00
; ;1.0;CLINICAL PROCEDURES;**11**;Apr 01, 2004;Build 68
MDHL7U2 ; HOIFO/WAA -Utilities for CP PROCESSING OBX text ; 7/26/00
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDHL7U3 ; HOIFO/WAA -Utilities for CP to process HL7 messages ;02/17/10 15
:59
; ;1.0;CLINICAL PROCEDURES;**6,21**;Apr 01, 2004;Build 24
MDHL7X ; HOIFO/WAA -Generate HL7 Error Message ; 06/08/00
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDHL7XXX ; HOIFO/DP - Loopback device for CP ;4/10/09 09:20
; ;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDKRPC1 ; HOIFO/FT-RPC to return patient data ;2/19/08 13:13
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDKRPC2 ; HOIFO/DP - RPC Calls (Cont.) ;11/27/07 09:42
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDKUTL ; HOIFO/DP - Renal Utilities ;11/29/07 14:45
; ;1.0;CLINICAL PROCEDURES;**14**;Apr 01, 2004;Build 22
MDKUTLR ; HOIFO/DP - Renal Utilities RPC;11/29/07 14:45
```

¹ Patch MD*1.0*20 November 2010 Update routine list with new routines and patch history changes.

Routine Descriptions

```

MDNCHK      ;;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
            ; HOIFO/NCA - CP Multiple Result Check ;4/26/05 15:17
            ;;1.0;CLINICAL PROCEDURES;**11,21,20**;Apr 01, 2004;Build 68
MDOUTOR     ; HOIFO/NCA - Post Conversion Routine ; [04-14-2003 10:51]
            ;;1.0;CLINICAL PROCEDURES;**5**;Apr 01, 2004;Build 4
MDPCE       ; HIRMF/NCA - Routine For Data Extract ;6/9/08 13:29
            ;;1.0;CLINICAL PROCEDURES;**5,21**;Apr 01, 2004;Build 24
MDPCE1      ; HOIFO/NCA - Updated Routine For Data Extract ; [05-28-2002 12:55]
            ;;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDPCE2      ; HOIFO/NCA - Routine For Data Extract For Hemo Dialysis;9/10/04 11
            :23 ;1/20/10 10:00
            ;;1.0;CLINICAL PROCEDURES;**6,21**;Apr 01, 2004;Build 24
MDPFTP1     ; HOIFO/NCA - PFT REPORT-DEMO INFO ;3/15/04 11:55
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004;Build 4
MDPFTP2     ; HOIFO/NCA - PFT REPORT-VOLUMES ;3/15/04 10:00
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004;Build 4
MDPFTP2A    ; HOIFO/NCA - PFT REPORT-FLOWS ;3/17/04 08:22
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004;Build 4
MDPFTP3     ; HOIFO/NCA - PFT REPORT-SPECIAL STUDIES (PT 2) ;3/17/04 12:48
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004;Build 4
MDPOST      ; HOIFO/DP - Post Init ;2/18/04 11:39
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDPOST04    ; HOIFO/DP - Post Init ; 2/18/04 11:39
            ;;1.0;CLINICAL PROCEDURES;**4**;Apr 01, 2004;Build 6
MDPOST06    ; HOIFO/DP - Post Init ;2/7/07 16:15
            ;;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDPOST1     ; HOIFO/NCA/DP - Build CP DEFINITION file (#702.01) - Optional Post
            Init ; [12-04-2002 13:06]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDPOST21    ; HOIFO/NCA - Post Init ;2/7/07 16:15
            ;;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDPOST6A    ; HOIFO/NCA-Convert Existing Notes to New File ;11/28/07 14:31
            ;;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDPS1       ; HOIFO/NCA - CP/Medicine Report Generator ;5/18/04 09:48
            ;;1.0;CLINICAL PROCEDURES;**2,10,13,21**;Apr 01, 2004;Build 24
MDPS2       ; HOIFO/NCA - CP/Medicine Report Generator (Cont.) ;5/18/04 09:41
            ;;1.0;CLINICAL PROCEDURES;**2**;Apr 01, 2004;Build 4
MDPS3       ; HOIFO/NCA - Remote Data View Data Retriever for CP ;8/26/05 14:37
            ;;1.0;CLINICAL PROCEDURES;**2,5,13**;Apr 01, 2004;Build 22
MDPS4       ; HOIFO/NCA - Retrieve List of Consult Procedures ;1/26/06 12:45
            ;;1.0;CLINICAL PROCEDURES;**13**;Apr 01, 2004;Build 22
MDPS5       ; HOIFO/NCA - Retrieve List of Consult Procedures for RDV ;3/4/05 1
            3:29
            ;;1.0;CLINICAL PROCEDURES;**13**;Apr 01, 2004;Build 22
MDPSU       ; HOIFO/NCA - CP/Medicine Report Generator Utility;5/18/04 09:48
            ;;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDPSUL      ; HOIFO/NCA - HS Component Utility;5/18/04 09:48 ;10/5/09 09:33
            ;;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDPURGE     ; HOIFO/NCA - Study Clean-Up process ;6/18/08 10:15
            ;;1.0;CLINICAL PROCEDURES;**11**;Apr 01, 2004;Build 68
MDRPCNT     ; HOIFO/NCA - Document Handler Object (TMDNOTE) ;5/23/05 15:50
            ;;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDRPCNT1    ; HOIFO/NCA - Object RPCs (TMDNOTE) Continued 2;10/29/04 12:20 ;2/2
            5/09 16:08
            ;;1.0;CLINICAL PROCEDURES;**6,21**;Apr 01, 2004;Build 24
MDRPCOD     ; HOIFO/DP - Object RPCs (TMDProcedureDef) ; [01-09-2003 15:20]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDRPCOG     ; HOIFO/DP - CP Gateway ; [01-09-2003 15:20]
            ;;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDRPCOL     ; HOIFO/DP - Object RPCs (Logfile) ; [02-11-2002 13:41]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDRPCOO     ; HOIFO/DP - Object RPCs (TMDOutput) ; [03-24-2003 15:44]
            ;;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDRPCOP     ; HOIFO/DP - Object RPCs (TMDPatient) ;8/3/09 10:39
            ;;1.0;CLINICAL PROCEDURES;**4,6,11,20**;Apr 01, 2004;Build 85
MDRPCOP1    ; HOIFO/DP - Object RPCs (TMDPatient) - Cont. ; 01-09-2003 15:21
            ;;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDRPCOR     ; HOIFO/DP - Object RPCs (TMDRecordId) ; [01-10-2003 09:14]
            ;;1.0;CLINICAL PROCEDURES;**17,20**;Apr 01, 2004
MDRPCOT     ; HOIFO/DP/NCA - Object RPCs (TMDTransaction) ;10/26/09 10:23
            ;;1.0;CLINICAL PROCEDURES;**5,6,11,21**;Apr 01, 2004;Build 24
MDRPCOT1    ; HOIFO/NCA/DP - Object RPCs (TMDTransaction) - Continued ;3/13/09
            11:18
            ;;1.0;CLINICAL PROCEDURES;**5,11,21**;Apr 01, 2004;Build 24
MDRPCOT2    ; HOIFO/NCA - Object RPCs (TMDTransaction) Continued 2;10/29/04 12:
            20 ;3/12/08 09:18

```

```

MDRPCOTA ; ;1.0;CLINICAL PROCEDURES;**6,21,20**;Apr 01, 2004;Build 24
; HOIFO/NCA - Object RPCs (TMDTransaction) Continued 2;10/29/04 12:
20 ;3/12/08 09:18
; ;1.0;CLINICAL PROCEDURES;**20**;Apr 01, 2004;Build 85
MDRPCOTH ; HOIFO/NCA - Process High Volume Procedure Results ;2/27/09 10:08
; ;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDRPCOU ; HOIFO/DP - Object RPCs (TMDUser) ; [01-09-2003 15:21]
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDRPCOV ; HOIFO/DP - Object RPCs (TMDParameter) ; [04-15-2003 12:42]
; ;1.0;CLINICAL PROCEDURES;;Apr 01, 2004;Build 4
MDRPCOW ; HOIFO/DP/NCA - Billing Widget ;10/3/05 12:17
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDRPCU ; HOIFO/DP - Object RPC Utilities ; [05-23-2003 10:16]
; ;1.0;CLINICAL PROCEDURES;**4**;Apr 01, 2004;Build 6
MDRPCW ; HOIFO/NCA - Calls to AICS;04/01/2003 ;01/21/10 11:51
; ;1.0;CLINICAL PROCEDURES;**6,21,20**;Apr 01, 2004;Build 24
MDRPCW1 ; HOIFO/NCA - MD TMDENCOUNTER Object; [05-28-2002 12:55] ;2/16/10 1
6:17
; ;1.0;CLINICAL PROCEDURES;**6,21,20**;Apr 01, 2004;Build 24
MDRPCWU ; HOIFO/NCA - CPT Code Query; [05-28-2002 12:55] ;2/16/10 16:17
; ;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDSTATU ; HOIFO/NCA - Print List of Document Titles Needed ;10/21/04 13:44
; ;1.0;CLINICAL PROCEDURES;**5**;Apr 01, 2004;Build 4
MDSTUDL ; HOIFO/NCA - Clinical Procedures Studies List ;10/26/05 11:46
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDSTUDW ; HOIFO/NCA - Print a List of Procedures With Incomplete Workload ;3
/2/09 10:00
; ;1.0;CLINICAL PROCEDURES;**21**;Apr 01, 2004;Build 24
MDUXML ; HOIFO/WAA -Utilities for XML text ; 7/26/00
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDUXMLM ; HOIFO/WAA -Utilities for XML text ; 7/26/00
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDUXMLOX ; HOIFO/WAA -OBX converter XML text ; 7/26/00
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDUXMLU1 ; HOIFO/WAA -Utilities for XML text ; 7/26/00
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDWCAN ; HOIFO/NCA - Process No-Shows and Cancels ;7/29/08 09:50
; ;1.0;CLINICAL PROCEDURES;**11,21**;Apr 01, 2004;Build 24
MDWCHK ; HOIFO/NCA - Create CP Studies for Existing Procedures ;12/13/07 1
5:52
; ;1.0;CLINICAL PROCEDURES;**14**;Apr 01,2004;Build 22
MDWOR ; HOIFO/NCA - Main Routine to Decode HL7 ;9/8/08 15:20
; ;1.0;CLINICAL PROCEDURES;**14,11,21,20**;Apr 01,2004;Build 24
MDWORC ; HOIFO/NCA - Main Routine to Decode HL7 from Consult ;1/8/08 15:00
; ;1.0;CLINICAL PROCEDURES;**14**;Apr 01,2004;Build 22
MDWORSR ; HOIFO/NCA - Daily Schedule Studies;7/2/04 12:39 ;10/15/08 13:39
; ;1.0;CLINICAL PROCEDURES;**14,11,21,20**;Apr 01,2004;Build 24
MDWSETUP ; HOIFO/NCA - Auto Study Check-In Setup ;3/18/08 14:14
; ;1.0;CLINICAL PROCEDURES;**14,11**;Apr 01, 2004;Build 68
MDXMLFM ; HOIFO/DP - Fileman -> XML Utilities ; [01-10-2003 09:14]
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103
MDXMLFM1 ; HOIFO/DP/NCA - Data -> XML Utilities ; [01-10-2003 09:14]
; ;1.0;CLINICAL PROCEDURES;**6**;Apr 01, 2004;Build 103

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5. File List and Related Information

File and Field Descriptions

CP Transaction File - #702

This file contains the studies between the instruments and user generated data as it is matched to a consult order and a TIU document is created for the results. It also manages the interface between the images and the Imaging RAID.

Field Name	Field Number	Format	Description
Patient	702,.01	Pointer to Patient (#2) file	This field contains a pointer to the Patient (#2) file for this study.
SSN	702,.011	Computed	This field contains the computed value of the patient's SSN from the Patient (#2) file.
DOB	702,.012	Computed	This field contains the computed value of the patient's date of birth from the Patient (#2) file.
Created Date/Time	702,.02	Date	This field contains the date/time the study was created within the CP User executable.
Created By	702,.03	Pointer to New Person (#200) file	This field contains the DUZ of the user that created this study.
CP Definition	702,.04	Pointer to CP Definition (#702.01) file	This field contains a pointer to the CP Definition (#702.01) file of the procedure definition that this study represents.
Consult Number	702,.05	Free Text 1-20 characters in length	This field contains an IEN of the Consult (#123) file representing the Consult order that is matched up to this study.

Field Name	Field Number	Format	Description
TIU Note	702,.06	Pointer to TIU Document (#8925) file	This field contains a pointer to the TIU Document (#8925) file representing the note that contains the interpretation of this study as well as the links to the associated images.
Vstring	702,.07	Free Text 1-50 characters in length	¹ This field contains the vstring. The vstring is in the following format: Visit Type_”;”_Visit Date/Time_”;”_Hospital Location (internal entry number of the visit).
Transaction Message	702,.08	Free Text 1-80 characters in length	Contains the message returned from the VistA Imaging API’s for storing the images on the server.
Transaction Status	702,.09	Set: 0 - New 1 - Submitted 2 - Error 3 - Complete	This field contains the status of this study.
Error Messages (multiple)	702.091,.01	Number between 1-9999, 0 decimal digits	Error message number.
Date Received	702.091,.02	Date	Date and time this error message was generated.
Received From	702.091,.03	Free Text 1-30 characters in length	Where the error was generated.
Message	702.091,.09	Free Text 1-150 characters in length	Text of the error message.
Image (multiple)	702.1,.01	Number between 1-999, 0 decimal digits	Index of attached image for this study.
Type	702.1,.02	Set: I - Instrument data U - User supplied file	Type of attachment to be processed.
Result Report	702.1,.03	Pointer to CP Result Report (#703.1) file	Pointer to the CP Result Report (#703.1) file containing the attachment from the instrument.

¹ Patch MD*1.0*16 January 2011 Erroneous words removed from description.

Field Name	Field Number	Format	Description
Status	702.1,.09	Set: 0 - Submitted to server 1 - Error in submission 2 - Error in filing 3 - Copied to server	Status of this image.
UNC	702.1,.1	Free Text 1-245 characters in length	Contains the Universal naming Convention (UNC) for this attachment.
Submitted to Instrument	702,.11	Pointer to CP Instrument (#702.09) file	Points to the instrument definition that this study was submitted to at the time of check-in.
Instrument Order Number	702,.12	Free Text 1-22 characters in length	Contains the unique order number for this study that is sent to the bi-directional instrument.
¹ Visit	702,.13	Pointer to Visit (#9000010) file	This is the Visit number returned from PCE. Reference IA# 1902.
² Scheduled Date/Time	702,.14	Date	This field contains the date/time when the HL7 message should be sent by CP to the device for this CP transaction.
³ Conversion ID Reference	702,.3	Free text 1-30 characters in length.	This field is the Reference Conversion ID. It is a variable Pointer to the Medicine files. It indicates which converted Medicine report record is associated with the CP Transaction study. This field helps to keep track which CP Transaction study was created for the Medicine report conversion.
Image Count	702,.991	Computed	Computed field to return the number of images associated with this study.

¹ Patch MD*1.0*6 May 2008 Field added to support the storing of the Clinical Indicator questions, CPT and ICD9 codes in the CP Transaction file.

² Patch MD*1.0*14 March 2008 Field added to support the auto study check-in with scheduled appointment date/time.

³ Patch MD*1.0*5 August 2006 Field added.

¹CP_Transaction_TIU_History File - #702.001

This CP Transaction TIU History file stores all TIU notes that is associated with the CP Transaction study. This will keep track of multiple notes associated with one CP study.

Field Name	Field Number	Format	Description
Study_ID	702.001,.01	Pointer To CP Transaction File (#702)	This field contains a pointer to the CP Transaction file (#702).
TIU_Note_ID	702.001,.02	Pointer To TIU Document File (#8925)	This field contains a pointer to the TIU Document file (#8925) representing the note that contains the interpretation of this CP Transaction. (Reference IA #3376)
Date_Assigned	702.001,.03	Date	This field contains the date/time when the TIU note was assigned to this transaction.

¹ Patch MD*1.0*6 May 2008 File 702.001 added.

CP Definition File - #702.01

This file defines all the procedures used by the Clinical Procedures package. All elements that define a procedure are in this file. This file is exported with data, but entries may be added by the site.

Field Name	Field Number	Format	Description
Name	702.01,.01	Free Text 3-30 characters in length	This field contains the name of the procedure. It should be descriptive of the procedure and contain 3-30 alphanumeric characters. The first character MUST be a letter. To maintain consistency it is recommended that all procedures be entered in UPPERCASE letters as well.
Treating Specialty	702.01,.02	Pointer to Facility Treating Specialty (#45.7) file	This field defines the specialty that this procedure falls under.
Require External Data	702.01,.03	Set: 0 - No 1 - Yes	Setting this field to Yes will force a consult for this procedure to be processed via the CP User executable for matching whether or not there are instruments associated with it.
Default TIU Note	702.01,.04	Pointer to TIU Document Definition (#8925.1) file	This field contains a TIU Note Title to use as the default when CP creates a note for interpretation for this procedure.
Hospital Location	702.01,.05	Pointer to Hospital Location (#44) file	This is the location that will be used when creating the TIU Note for interpretation.
¹ Processing Application	702.01,.06	Set: 1 - Default 2 – Hemodialysis	This field is used to indicate if this is a Hemodialysis procedure or not. The field is a set of codes, 1=DEFAULT so it will be processed by Clinical Procedures or 2=HEMODIALYSIS and the procedure will be processed by the Hemodialysis application.

¹ Patch MD*1.0*6 May 2008 Field added to the CP Definition file.

Field Name	Field Number	Format	Description
Auto Submit	702.01,.07	Set: 0 - No 1 - Yes	This field only applies to bi-directional instruments. It is used to indicate whether or not the image attachment should be automatically submitted to VistA Imaging once the procedure is performed and the result is passed to CP.
External Data Directory	702.01,.08	Free Text 3-150 characters in length	This field contains a reference to a network share where user supplied attachments are located for this procedure.
Active	702.01,.09	Set: 0 - No 1 - Yes	Yes/No to indicate active procedures that can be linked to Consults.
Instrument (multiple)	702.011,.01	Pointer to CP Instrument (#702.09) file	Contains a pointer to an instrument that generates results for this procedure.
¹ High Volume	702.01,.11	Set: 0 FOR No; 1 FOR Yes	This field is used as a flag indicator to specify if this procedure is high volume or not.
² Processed Result	702.01,.12	Set: 0 - Final Result 1 - Multiple Results 2 - Cumulative Result	This field is a flag which indicates whether a final result, multiple results, or cumulative result is associated with this procedure.
ID	702.01,.13	Free Text (Required) (Key field)	This is a Globally Unique Identifier (GUID) for this procedure. This is maintained nationally so it is the same throughout the enterprise. A sample ID could be "{69DBD11E-9A8C-4ECE-AFA4-73947218807D}".
DESCRIPTION	702.01,.9	Free Text	This is a detailed DESCRIPTION of this procedure. A sample DESCRIPTION could be "ABD Paracentesis followup".

¹ Patch MD*1.0*16 January 2011 Field descriptions added.

² Patch MD*1.0*11 June 2009 New field added.

CP Instrument File - #702.09

This file contains the list of instruments used by the Clinical Procedures package. This file is exported with data.

Field Name	Field Number	Format	Description
Name	702.09,.01	Free Text 3-30 characters in length	Name or mnemonic of instrument. Used by vendor in HL7 message header.
Notification Mailgroup	702.09,.02	Pointer to Mail Group (#3.8) file	Mail group that will receive error messages and other notifications dealing with this device from the interface routines.
Description	702.09,.03	Free Text 1-50 characters in length	This field contains a short informational description for the instrument.
Delete when Submitted	702.09,.05	Set: 0 - No 1 - Yes	Select Yes if you want files created by this instrument deleted once they are successfully copied to the VistA Imaging RAID. Deletion will be performed by the VistA Imaging application.
Printable Name	702.09,.06	Free Text 3-30 characters in length	Name of instrument that is printed on the reports, etc.
Default File Ext	702.09,.07	Free Text (e.g., .txt)	Default file extension for vendor instrument reports (e.g., .doc, .pdf).
Serial Number	702.09,.08	Free Text 1-50 characters in length	Vendor serial number of the instrument (for reference only).
Active	702.09,.09	Set: 0 - No 1 - Yes	Whether or not the instrument is active on the network.
¹ ID	702.09,.1	Free Text (Required) (Key field)	This is a Globally Unique Identifier (GUID) for this instrument. This is maintained nationally so it is the same throughout the enterprise. A sample ID could be "{69DBD11E-9A8C-4ECE-AFA4-73947218807D}".
Processing Routine	702.09,.11	Free Text 1-8 characters in length	MUMPS routine used to process interface information.

¹ Patch MD*1.0*16 January 2011 Field description added.

Field Name	Field Number	Format	Description
Processing Code	702.09,.12	Set: M - Medicine C - CP V. 1.0 B - Both	Where data is to be processed: M - Medicine C - Clinical Procedures B - Both
Bi-directional	702.09,.13	Set: 0 - No 1 - Yes	This field indicates whether or not this device can accept HL7 messages from VistA.
IP Address	702.09,.14	Free Text 7-15 characters in length	This field contains the IP address of this instrument.
Port	702.09,.15	Number between 1000-99999, 0 decimal digits	This field contains the port number for this instrument.
HL7 Instrument ID	702.09,.16	Free Text 3-30 characters in length	This is the name of the actual device where the device name can be "SMC St Louis".
HL7 Universal Service ID	702.09,.17	Free Text 1-48 characters in length	This field defines what type of procedure the device can perform if the device can perform multiple types of procedures.
HL7 Logical Link	702.09,.18	Pointer to the HL Logical Link (#870) file	This field contains the HL7 logical link.
Server Name	702.09,.21	Free Text 1-30 characters in length	Network name of instrument server where the report is stored.
Server Share	702.09,.22	Free Text 1-30 characters in length	Share folder/driver of the instrument server where the report is stored.
Server Path	702.09,.23	Free Text 1-150 characters in length	Path on the network where the report is stored.
Server Executable	702.09,.24	Free Text 1-30 characters in length	Name of server program that is run to create the report for the interface.
Process UNC	702.09,.301	Set: 0 - No 1 - Yes	Enter Yes if this instrument produces UNC type data.
Process Text	702.09,.302	Set: 0 - No 1 - Yes	Enter Yes if this instrument produces text type data.
Process URL	702.09,.303	Set: 0 - No 1 - Yes	Enter Yes if this instrument produces URL type data.
Process DLL	702.09,.304	Set: 0 - No 1 - Yes	Enter Yes if this instrument produces DLL type data.

Field Name	Field Number	Format	Description
Process UUEncode	702.09,.305	Set: 0 - No 1 - Yes	Enter Yes if this instrument produces UUEncode type data.
Process XML	702.09,.306	Set: 0 - No 1 - Yes	Enter Yes if this instrument produces XML type data.
Process XMS	702.09,.307	Set: 0 - No 1 - Yes	Enter Yes if this instrument produces XMS type data.

CP Result Report File - #703.1

This file contains the information for the results uploaded from the medical instruments used by Clinical Procedures. It is distributed without any data. All fields are automatically stuffed by Clinical Procedures. There is no user input.

Field Name	Field Number	Format	Description
Upload ID	703.1,.01	Free Text 1-30 characters in length	Unique identifier assigned for each upload.
Patient	703.1,.02	Pointer to Patient (#2) file	Pointer to the Patient (#2) file of the patient uploaded from the result of the instrument.
Date/Time Performed	703.1,.03	Date	Date/time the procedure was performed on the instrument.
Instrument	703.1,.04	Pointer to CP Instrument (#702.09) file	Pointer to the CP Instrument (#702.09) file of the instrument that produced these reports.
Study Reference Number	703.1,.05	Pointer to CP Transaction file (#702)	This field is used as a reference to the transaction.
HL7 Reference Number	703.1,.06	Free Text 1-30 characters in length	This field is used to keep the IEN of the HL7 message. It serves as a reference to the message that will be purged once the data has been successfully moved to the VistA Imaging server.
Status	703.1,.09	Set: U - Unmatched M - Matched	Status of the results: U - Unmatched M - Matched
Upload Item (multiple)	703.11,.01	Set: 1 - Impression Text 2 - Report Text 3 - Attachment UNC 4 - Attachment URL 5 - UUEncoded Data 6 - DLL 7 - XML Data 8 - XML Style Sheet	This field contains the type of data element that was uploaded from the instrument.
Attachment UNC	703.11,.02	Free Text 1-240 characters in length	This field contains the Universal Naming Convention (UNC) for this attachment. This indicates where the attachment is located.

Field Name	Field Number	Format	Description
Item Value	703.11,.1	Free Text 1-245 characters in length	If the uploaded item is a single string value, it is stored here.
Item Text	703.11,.2	Word-Processing	If the uploaded data is multi-lined, it is stored here.

¹CP Conversion File- #703.9

This file is used for storing the site parameters needed and used to convert Medicine reports to CP Text reports. This file also stores the status of the conversion process for each converted Medicine report.

Field Name	Field Number	Format	Description
Name	703.9,.01	Free Text (Required)	This field contains the name of the CP conversion. It is only accessible by the CP conversion routine. It is exported with one "DEFAULT" entry.
Mode	703.9,.02	Set: 0 - test 1 - real	This field indicates if the CP conversion is in test or real mode.
Administrative Closure User	703.9,.03	Pointer to new person file (#200)	This field points to the New Person file (#200). It is used to indicate the Administrative Closure person used to close the TIU documents for the CP conversion.
Scratch HFS Directory	703.9,.1	Free Text	This field stores the scratch HFS directory used for the CP conversion. CP conversion program will use this directory to convert Medicine reports.
Medicine File Parameters ² (multiple)	703.91,.01	Pointer to File file (#1)	This field points to the File file (#1). It is used to store the Medicine file number that this parameter is pertaining to. (Reference IA #4507)
CP Definition	703.91,.02	Point to CP Definition File (#702.01)	This field contains the CP Definition to which the Medicine Report will be mapped.
Convert Y/N	703.91,.03	Set: 0 - No 1 - Yes	This field is used as a flag to mark the Medicine Report. Enter 0 for 'to not convert' or 1 for 'to convert'.
Convert if No Status	703.91,.04	Set: 0 - No 1 - Yes	This field is used as a flag to indicate whether the Medicine report should be converted or not be converted, if there is no status for the report. The field is 0 for 'not to convert' or 1 for 'to convert'.

¹ Patch MD*1.0*5 August 2006 CP Conversion File #703.9 added.

² Patch MD*1.0*16 January 2011 Added "(multiple)" to Field Name.

Field Name	Field Number	Format	Description
Use TIU Note Title	703.91,.05	Pointer to TIU Document Definition File (#8925.1)	This field stores the Historical TIU note title used for the conversion of the Medicine reports to CP reports. (Reference IA #3377 and 3568)
Conversion ID ¹ (multiple)	703.92,.01	Free Text	This field is the Conversion ID. It is a variable pointer to the Medicine files. This field will store an entry for each Medicine file record converted. This field is a variable pointer to the following files: 691 ECHO 691.1 CARDIAC CATHETERIZATION 691.5 ELECTROCARDIOGRAM (EKG) 691.6 HOLTER 691.7 EXERCISE TOLERANCE TEST 691.8 ELECTROPHYSIOLOGY (EP) 694 HEMATOLOGY 694.5 CARDIAC SURGERY RISK ASSESSMENT 698 GENERATOR IMPLANT 698.1 V LEAD IMPLANT 698.2 A LEAD IMPLANT 698.3 PACEMAKER SURVEILLANCE 699 ENDOSCOPY/CONSULT 699.5 GENERALIZED PROCEDURE/CONSULT 700 PULMONARY FUNCTION TESTS 701 RHEUMATOLOGY
Status	703.92,.02	Set: CR - Converted Real Mode CT - Converted Test Mode E - Error S - Skipped R - Ready to Convert	This is the status field of the conversion log. There are five set of codes: CR - Converted Real Mode CT - Converted Test Mode E - Error S - Skipped R - Ready to Convert

¹ Patch MD*1.0*16 January 2011 Added "(multiple)" to Field Name.

Field Name	Field Number	Format	Description
New TIU Document IEN	703.92,.03	Free Text	This field contains a pointer to the TIU Document file (#8925). (Reference IA #4796). This will hold the internal entry number of the document of the converted medicine report.
Lines	703.92,.04	Number	This field contains the line count of the Medicine report that was converted.
Bytes	703.92,.05	Number	This field contains the number of bytes of the Medicine report that was converted.
Error Msg	703.92,.1	Free Text	This field stores the error message during the conversion of the Medicine report.

¹Hemodialysis Access Points File - #704.201

This new file contains information on access points used by the Hemodialysis application.

Field Name	Field Number	Format	Description
Patient_ID	704.201,.01	Pointer to patient file (#2)	This field contains the patient DFN. (Required)
Access Points	704.201,.1	Word Processing	This field holds the XML in UUEncoded format for this patient's access points for dialysis treatments.
Access History	704.201,.2	Word Processing	This field holds the XML in UUEncoded format for this patient's access history for dialysis treatments.
Infection History	704.201,.3	Word Processing	This field holds the XML in UUEncoded format for this patient's infection history for dialysis treatments.

¹ Patch MD*1.0*6 May 2008 File 704.201 added.

¹Hemodialysis Study File - #704.202

This new file contains information on hemodialysis studies used by the Hemodialysis application.

Field Name	Field Number	Format	Description
ID	704.202,.01	Pointer to CP Transaction file (#702)	This field contains the IEN of the CP STUDY (File #702) for this dialysis treatment. (Required)
Patient	704.202,.02	Pointer to Patient file (#2)	Pointer to the PATIENT (File #2) of the patient for this dialysis treatment.
Study_DateTime	704.202,.03	Computed date	Computed field used to allow automated XML creation with appropriate tag/value pairs.
Study_Location	704.202,.04	Computed	Computed field used to allow automated XML creation with appropriate tag/value pairs.
² User	704.202,.05	0;3 Pointer to NEW PERSON FILE (#200)	This field contains the user who accessed the Hemodialysis study.
Date/Time Accessed	704.202,.06	0;4 Date	This field displays the date/time when the hemodialysis study was accessed by the user.
Workstation	704.202,.07	0;5 Free text	This field contains the workstation that was used by the user to access the hemodialysis study.
Status	704.202,.09	Set: 0 - Closed 1 - Active	Contains the status of this procedure.
Study Data	704.202,.1	Word Processing	Contains the study data XML document in UUEncoded format.
Summary	704.202,.2	Word Processing	Contains the summary data XML document in UUEncoded format.
Flowsheet	704.202,.3	Word Processing	Contains the flowsheet data XML document in UUEncoded format.
Med Log	704.202,.4	Word Processing	Contains the med log data XML document in UUEncoded format.
Note List	704.202,.5	Word Processing	This field contains the Note List data XML document in

¹ Patch MD*1.0*6 May 2008 File 704.202 added.

² Patch MD*1.0*16 January 2011 Fields added.

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			UUEncoded format.
Event Log	704.202,.6	Word Processing	This field contains the Event Log data XML document in UUEncoded format.

¹**Hemodialysis Setting File - #704.209**

This new file contains information on hemodialysis settings used by the Hemodialysis application.

Field Name	Field Number	Format	Description
Setting Name	704.209,.01	Free Text 3-30 characters in length. Not numeric or starting with punctuation.	Contains the descriptive name of the data contained in this setting.
Owner	704.209,.02	Pointer to new person file (#200)	If this setting is user specific, this field will contain that user's DUZ.
User	704.209,.03	Pointer to new person file (#200)	This field displays the user name that is locking the Hemodialysis setting option.
Date/Time of Lock	704.209,.04	Input transform: S %DT="ET" D ^%DT S X=Y K:Y<1 X	This field will store the date and time of when the Hemodialysis setting option was locked for use.
Process ID	704.209,.05	Free text 3-40 characters in length. Input transform: K:\$L(X)>40!(\$L(X)<3) X	This field will store the JOB ID of the process that is locking the Hemodialysis setting option.
XML Document	704.209,.1	Word Processing	Contains the XML document for this setting in UUEncoded format.

¹ Patch MD*1.0*6 May 2008 File 704.209 added.

¹CP_CONSOLE_ACL File (704.001)

This file maintains the Access Control List (ACL) for items in the console by that item's ID.

Field Name	Field Number	Format	Description
ITEM_ID	704.001,.01	Free text (38 char)	This ITEM_ID represents the Global Unique Identifier (GUID) of a console item and Clinical Observation (CliO) record. An appropriate GUID is alphanumeric and 38 characters in length.
USER_ID	704.001,.02	Pointer to NEW PERSON file (#200)	This is the end-user given access permission to the item (ITEM_ID).
ACCESS_LEVEL	704.001,.03	SET (Required) 0 FOR Read Only 1 FOR Read+Write 2 FOR Read+Write+Delete 3 FOR Full Control	This is the level of edit access to the item (ITEM_ID) the end-user (USER_ID) has been permitted. In addition, "Full Control" will grant the user full edit privileges as well as the ability to grant access of this item to another user. This access permission is granted via the Access Control List Manager, a function within the CP Console application.

¹ Patch MD*1.0*16 January 2011 File description added.

¹CP_HL7_LOG File (#704.002)

This file maintains a log of HL7 Messages processed by Clinical Flowsheets.

Field Name	Field Number	Format	Description
MESSAGE_ID	704.002,.01	FREE TEXT (38 CHAR)	This field identifies the Clinical Flowsheets HL7 message. This MESSAGE_ID is generated by the Clinical Flowsheets system.
STATUS	704.002,.02	'1' FOR ENTERED; 2' FOR AWAITING PROCESSING; 3' FOR ERROR; 4' FOR PROCESSED;	This field indicates the status of this Clinical Flowsheets HL7 message (MESSAGE_ID field (#.01)). This status is maintained by Clinical Flowsheets and HL7 message processing.
MAPPING_TABLE	704.002,.03	FREE TEXT (1-50 CHAR)	This field contains a copy of the ID field (#.01) in the TERM_MAPPING_TABLE file (#704.108). It is used to determine which mapping table to use when translating the HL7 message (MESSAGE_ID field (#.01)) into observations.
HL7_MESSAGE_ADMINISTRATION	704.002,.04	POINTER TO HL7 MESSAGE ADMINISTRATION FILE (#773)	This field identifies this Clinical Flowsheets HL7 message (MESSAGE_ID field (#.01)) with an entry in the HL7 Message Administration File (#773).
HL7_MESSAGE_TEXT	704.002,.05	POINTER TO HL7 MESSAGE TEXT FILE (#772)	This field identifies this Clinical Flowsheets HL7 message (MESSAGE_ID field (#.01)) text with an entry in the HL7 MESSAGE TEXT File (#772).
PATIENT	704.002,.06	POINTER TO PATIENT FILE (#2)	This is the patient supported by the Clinical Flowsheets HL7 message (MESSAGE_ID field (#.01)).
STUDY_REFERENCE_NBR	704.002,.07	POINTER TO CP TRANSACTION FILE (#702)	This field identifies the Clinical Flowsheets HL7 message (MESSAGE_ID field (#.01)) with a CP TRANSACTION File (#702) entry.
MESSAGE_DATE_TIME	704.002,.08	DATE	This is the date/time the HL7 message (MESSAGE_ID field (#.01)) was created as reported by the HL7 system.
PROCESSED_TIMESTAMP	704.002,.09	DATE	This is the date/time the HL7 message (MESSAGE_ID field (#.01)) was processed as reported by the HL7 system.
REPORTED_LOCATION	704.002,.11	FREE TEXT (1-250 CHAR)	This is raw-data as extracted from the HL7 message (MESSAGE_ID field (#.01)). This should be location identifying data that can be used to locate the source of the HL7 message (MESSAGE_ID field (#.01)).

¹ Patch MD*1.0*16 January 2011 File description added.

File List and Related Information

Field Name	Field Number	Format	Description
REPORTED_PATIENT	704.002,.21	FREE TEXT (1-250 CHAR)	This is raw-data extracted from the HL7 message (MESSAGE_ID field (#.01)). This should be patient identifying data used to determine which patient the HL7 message (MESSAGE_ID field (#.01)) supports.
REPORTED_INSTRUMENT	704.002,.31	FREE TEXT (1-250 CHAR)	This is raw-data extracted from the HL7 message (MESSAGE_ID field (#.01)). This should be instrument identifying data used to determine the source-device of the HL7 message (MESSAGE_ID field (#.01)).

¹CP_HL7_LOG_REASON (#704.004)

This file monitors Clinical Flowsheets HL7 message processing anomalies. These Clinical Flowsheets HL7 messages are referenced via the CP_HL7_LOG file (#704.002).

Field Name	Field Number	Format	Description
CLIO_HL7_LOG	704.004,.01	POINTER TO CP_HL7_LOG FILE (#704.002)	This field indentifies this entry with an entry in the CP_HL7_LOG file (#704.002).
DATE_TIME_EN TERED	704.004,.02	DATE	This is the date/time the file entry was created.
REASON	704.004,.1	FREE TEXT (1- 250 CHAR)	This is the reason this file entry was created.

¹ Patch MD*1.0*16 January 2011 File description added.

¹CP_MOVEMENT_AUDIT File (#704.005)

This file will hold a subset of patient movement data. This must be done rather than using a direct reference to the PATIENT MOVEMENT file (#405) because, in the instance of cancellations, the internal entry number (IEN) of a patient movement disappears before there is the chance to work with it. This file will coalesce all of a movement's data to send to 3rd party users. That data is sent to 3rd party users via the VistA Interface Engine (VIE) and Health Level Seven (HL7) messaging. To ensure that message is available to 3rd party users, the ACCEPTED BY VDEF field (#.09) is set to '1' to confirm the message is in the VIE outbound queue; that CP MOVEMENT AUDIT file (#704.005) entry will then need to be purged.

Field Name	Field Number	Format	Description
PATIENT	704.005,.01	POINTER TO PATIENT FILE (#2)	This field is the identifier of the patient involved in the patient movement event.
DATE_TIME_OF_EVENT	704.005,.02	DATE	This field stores the date/time of the patient movement event.
DIVISION	704.005,.03	POINTER TO MEDICAL CENTER DIVISION FILE (#40.8)	This field identifies the DIVISION per the patient movement event.
WARD	704.005,.04	POINTER TO WARD LOCATION FILE (#42)	This field identifies the WARD per the patient movement event.
BED	704.005,.05	POINTER TO ROOM-BED FILE (#405.4)	This field identifies the room-BED per the patient movement event.
MESSAGE_TYPE	704.005,.06	FREE TEXT (3 CHAR)	This indicates the HL7 MESSAGE TYPE. The value here can be 'ADT' to indicate an admission/discharge/transfer type message.
EVENT_TYPE	704.005,.07	FREE TEXT (3 CHAR)	This indicates the HL7 message EVENT TYPE. The value here can be 'A01' to indicate an Admit/visit notification EVENT TYPE.
PIMS_EVENT_ID	704.005,.08	FREE TEXT (1-20 CHAR)	This is a copy of the internal entry number (IEN) of the PATIENT MOVEMENT file (#405) entry which correlates to this CP_MOVEMENT_AUDIT file (#704.005) entry. If a movement is deleted, the corresponding entry from the patient movement file is deleted as well. This prevents this field from being an actual pointer. This IEN is used only for troubleshooting purposes.

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
ACCEPTED_BY_VDEF	704.005,.09	SET '0' FOR NO; '1' FOR YES;	This indicates whether the VistA Data Extraction Framework (VDEF) has processed and accepted the HL7 message.
VDEF_ERROR_MSG	704.005,.1	FREE TEXT (1-250 CHAR)	This field stores the error message, if an error message is returned by the VistA Data Extraction Framework (VDEF).

¹CP_PROTOCOL_LOCATION File (#704.006)

This file will be used by the Clinical Flowsheets application to determine the target for an outbound admission, discharge, and transfer (ADT) message. Messages are sent to a target via Health Level 7 messaging (HL7).

A target is defined here as a receiving CIS or other COTS product that has expressed a desire to be notified when a patient admission, transfer or discharge has occurred for a specific hospital location.

Field Name	Field Number	Format	Description
SUBSCRIBER	704.006,.01	POINTER TO PROTOCOL FILE (#101)	This field identifies the subscriber protocol to be used to send the message.
DIVISION	704.006,.02	POINTER TO MEDICAL CENTER DIVISION FILE (#40.8)	This field identifies the target MEDICAL CENTER DIVISION for the message.
WARD	704.006,.03	POINTER TO WARD LOCATION FILE (#42)	This field identifies the target WARD location for the message.
MESSAGE_TYPE	704.006,.04	FREE TEXT (3 CHAR)	This field is the type of message to be sent. A sample MESSAGE TYPE could be "ADT".
EVENT_TYPE	704.006,.05	FREE TEXT (3 CHAR)	This is the message's EVENT TYPE. A sample EVENT TYPE could be "A01".
ID	704.006,.06	FREE TEXT (32 CHAR)	This field will be the alpha-numeric portion of the message's Global Unique Identifier (GUID), if the message is generated. A sample ID could be "C42AC54282B642F4950E179A3D43AA85".
NAME	704.006,.07	FREE TEXT (1-30 CHAR)	This field is the assigned name for the message. A sample NAME could be "ADMIT2DEVICEX".

¹ Patch MD*1.0*16 January 2011 File description added.

| **¹CP_SHIFT File (#704.007)**

| This file is used to store the site configurable shift definitions.

Field Name	Field Number	Format	Description
ID	704.007,.01	FREE TEXT (38 CHAR)	This field contains the work-shift identifier. A sample ID could be "{1A5A417B-3F04-23ED-B044-4102B19D66E4}"
NAME	704.007,.02	FREE TEXT (1-30 CHAR)	HELP-PROMPT: Answer must be 1-30 characters in length. This is the NAME of the work-shift. A sample could be "DAY".
START_TIME	704.007,.03	FREE TEXT (4 CHAR)	This is the START TIME of the work-shift. An example is "0800" representing the time 8:00 AM.
STOP_TIME	704.007,.04	FREE TEXT (4 CHAR)	This is the STOP TIME of the work-shift. An example is "1830" representing the time 6:30 PM.
MULTI_DAY	704.007,.05	SET '0' FOR NO; '1' FOR YES;	This field indicates whether a work-shift extends over multiple days or not.
DISPLAY_NAME	704.007,.06	FREE TEXT (1-50 CHAR)	HELP-PROMPT: Answer must be 1-50 characters in length. This field is the text displayed within Clinical Flowsheets for the work-shift. A sample DISPLAY NAME could be "Nights (Midnight - 8:00a)".
ACTIVE	704.007,.09	SET '0' FOR NO; '1' FOR YES;	This field determines whether the work-shift entry is active or not.
COMMENT	704.007,.1	FREE TEXT (1-250 CHAR)	This is a comment about the work-shift.

¹ Patch MD*1.0*16 January 2011 File description added.

¹CP_SCHEDULE File (#704.008)

This file is used to store the site configurable schedules for the Kardex.

Field Name	Field Number	Format	Description
ID	704.008,.01	FREE TEXT (38 CHAR)	This field contains the schedule identifier. A sample ID could be "{E24290F6-31F4-C6F6-B310-E37C563FBD64}".
NAME	704.008,.02	FREE TEXT (1-30 CHAR)	This is the NAME of the schedule. A sample could be "TID/MEALS".
SCHEDULE_TYP E	704.008,.03	SET '0' FOR Continuous; '1' FOR PRN; '2' FOR One-Time; '3' FOR Stat;	This is the type of schedule indicator.
INTERVAL	704.008,.04	NUMBER (0-525600)	This field is the schedule INTERVAL in minutes. An example is "120" to present a schedule INTERVAL of 2 hours.
DISPLAY_NAME	704.008,.05	FREE TEXT (1-50 CHAR)	This field is the text displayed within Clinical Flowsheets for the schedule. A sample DISPLAY NAME could be "3 times daily with meals".
ACTIVE	704.008,.09	SET '0' FOR NO; '1' FOR YES;	This field determines whether the schedule entry is active or not.
COMMENT	704.008,.1	FREE TEXT (1-250 CHAR)	This is a COMMENT about the schedule.
CUSTOM_SCHED ULE	704.008,.2	FREE TEXT (4-250 CHAR)	This field contains actual times a scheduled event is to occur. This data is to be utilized when the schedule intervals are not equal. A sample CUSTOM SCHEDULE could be "0600,1100,1700" for schedule events to occur at 6 AM, 11 AM, and 5 PM.

¹ Patch MD*1.0*16 January 2011 File description added.

¹TERM File (#704.101)

NOTICE: This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the CliO data store if this file is changed.

This file stores all terminology elements for the Clinical Flowsheets application. The entries in this file are called "terms". These terms along with CP files #704.102 -#704.109 constitute the Clinical Data Model.

Field Name	Field Number	Format	Description
ID	704.101,.01	FREE TEXT (Required) (38 CHAR)	This field is the unique identifier for this entry or term. This data is maintained nationally and will be the identifier for this term enterprise-wide. A sample ID could be "{D9FF5CA8-09AF-4318-B784-DEB3A8F819D8}".
TERM	704.101,.02	FREE TEXT (1-7 CHAR)	This field is the name of this TERM entry, in accordance with enterprise-wide terminology standards. A sample TERM could be "PICC LINE".
ABBREVIATION	704.101,.03	FREE TEXT (1-10 CHAR)	This is the enterprise wide ABBREVIATION for this term. This value will be used throughout the Clinical Flowsheets system in dropdowns and list boxes where screen real estate is tight. A sample ABBREVIATION could be "PICC LINE".
DISPLAY_NAME	704.101,.04	FREE TEXT (1-75 CHAR)	This field is a case sensitive, user friendly, DISPLAY NAME for this term. This is the full name for this term for display in the Clinical Flowsheets application. A sample DISPLAY NAME could be "PICC Line".
TERM_TYPE	704.101,.05	POINTER TO TERM_TYPE FILE (#704.102)	This field correlates this term with an entry in the TERM TYPE File (#704.102). This field should define the "purpose" of this term in the Clinical Data Model. CROSS-REFERENCE: 704.101^ATYPE 1)= S ^MDC(704.101,"ATYPE",\$(X,1,30),DA)="" 2)= K ^MDC(704.101,"ATYPE",\$(X,1,30),DA)
DATA_TYPE	704.101,.06	SET '0' FOR Qualifier; '1' FOR Complex; '2' FOR Numeric; '3' FOR PickList; '4' FOR Boolean; '5' FOR String; '6' FOR Range;	This field is to specify the type of data this term represents.

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
VALUE_TYPE	704.101,.07	SET '0' FOR Unspecified; 1' FOR Temperature; 2' FOR Length; 3' FOR Volume; 4' FOR Rate; 5' FOR Time; 6' FOR Mass; 7' FOR Scale;	This field is to specify the VALUE TYPE this term represents. This data will be used for more reliable conversion utilities.
ACTIVE	704.101,.09	SET '0' FOR No; 1' FOR Yes;	This field is to indicate whether a term is ACTIVE or not. Only an ACTIVE term can be used in new clinical observations.
DESCRIPTION	704.101,.1	FREE TEXT (1-250 CHAR)	This field is a full DESCRIPTION of this term. A sample DESCRIPTION could be: "Peripherally Inserted Central Catheter Line".
HELP_TEXT	704.101,.2	FREE TEXT (1-250 CHAR)	This is the text that will display as help for the term, within the Clinical Flowsheets application. A sample HELP TEXT could be: "Peripherally Ins Cen Cath Line".
BOOLEAN_VALUE_TRUE	704.101,.31	FREE TEXT (1-100 CHAR)	This field is the text that will display for Boolean DATA TYPE (field #.06) observations that are "true". A sample BOOLEAN VALUE TRUE could be "TRUE".
BOOLEAN_VALUE_FALSE	704.101,.32	.3;2 FREE TEXT (1-100 CHAR)	This field is the text that will display for Boolean DATA TYPE (field #.06) observations that are "false". A sample BOOLEAN VALUE FALSE could be "FALSE".
MULTI_SELECT_PICKLIST	704.101,.33	SET '0' FOR No; 1' FOR Yes;	This field determines if more than one value may be selected from a "picklist" for an observation.
SCHEDULE	704.101,.34	NUMBER	This field is the minutes of interval per SCHEDULE. A sample SCHEDULE could be "120".
SCHEDULE_TYPE	704.101,.35	SET '0' FOR Continuous; 1' FOR PRN; 2' FOR Stat; 3' FOR One-Time;	This field is the type of schedule.
VOID	704.101,99.99	FREE TEXT (1-20 CHAR)	This field is the VHA Unique Identifier (VOID) for this term.
ID	704.102,.001	NUMBER	This is the ordinal position of this term-type entry.

¹TERM_TYPE File (#704.102)

This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the CliO data store if this file is changed.

Field Name	Field Number	Format	Description
TYPE	704.102,.01	FREE TEXT (1-30 CHAR)	This is the name for this term TYPE. A sample TYPE could be "OBSERVATION".
XML_TAG	704.102,.02	FREE TEXT (1-30 CHAR)	This is the XML TAG this data element is to be stored on when an appropriate XML document is built. A sample XML TAG could be "TERM_ID".
VUID	704.102,.03	FREE TEXT (1-20 CHAR)	This field is the VHA Unique Identifier (VUID) for this term type. A sample VUID could be "4688703".

¹ Patch MD*1.0*16 January 2011 File description added.

¹TERM_QUALIFIER_PAIR File (#704.103)

This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the Clio data store if this file is changed.

This file is a join table for the Clinical Data Model that matches observations to their allowable qualifiers. A sample could be the observation equating to "weight" and the paired qualifier equating to "lift scale".

Field Name	Field Number	Format	Description
TERM_ID	704.103,.01	POINTER TO TERM FILE (#704.101) (Required) (Key field)	This field identifies the primary TERM file (#704.101) entry in the Clinical Data Model for this pairing.
QUALIFIER_ORDER	704.103,.02	NUMBER (Between 0-9999)	This represents the order that this qualifier will be displayed with the term as well as the order of interpretation for complex terms.
QUALIFIER_ID	704.103,.03	POINTER TO TERM FILE (#704.101)	This field identifies the qualifier term or subcomponent for this pair.
RANKING	704.103,.04	NUMBER (Between - 999999999 and 999999999, 9 decimal digits)	This value will be used in calculations for this pairing as well as future graphing capabilities for pick-list values.

¹ Patch MD*1.0*16 January 2011 File description added.

¹TERM_UNIT_CONVERSION File (#704.104)

NOTICE: This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the CliO data store if this file is changed.

This file links like units of measure together with required conversion logic to change the value from one unit to another.

NOTE: Units are presented as entries in the TERM file (#704.101). For example the unit "CENTIMETER" could be identified by the TERM file (#704.101), TERM ID (field #.01)"{EF700458-8C2D-16E8-02DC-9E1711584C53}".

Field Name	Field Number	Format	Description
UNIT_ID_PRE	704.104,.01	POINTER TO TERM FILE (#704.101)	This field is the identifier of the unit that a value will be converted from.
UNIT_ID_POST	704.104,.02	POINTER TO TERM FILE (#704.101)	This field is the identifier of the unit that a value will be converted to.
CONVERSION_OF FSET_PRE	704.104,.03	NUMBER (Between -99999999 and 99999999, 6 decimal digits)	This field will be used to offset a value prior to executing the conversion logic. A sample CONVERSION OFFSET PRE could be "0".
CONVERSION_OF FSET_POST	704.104,.04	NUMBER (Between -99999999 and 99999999, 6 decimal digits)	This is used to offset a value post execution of the conversion logic. A sample CONVERSION OFFSET POST could be "32".
CONVERSION_FACTOR	704.104,.05	NUMBER (Between -99999999 and 99999999, 9 decimal digits)	This value is used by the conversion logic as a multiplier of the original value. A sample CONVERSION FACTOR could be "1.8".
DECIMAL_PRECISION	704.104,.06	NUMBER (Between -99999999 and 99999999, 0 decimal digits)	This field is the decimal precision for rounding the resulting conversion value. A sample DECIMAL PRECISION could be "2".
DESCRIPTION	704.104,.09	FREE TEXT (1-150 CHAR)	This is a DESCRIPTION of the conversion logic. A sample DESCRIPTION could be "DEGREES C -> DEGREES F".

¹ Patch MD*1.0*16 January 2011 File description added.

¹TERM_UNIT_PAIR File (#704.105)

NOTICE: This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the CliO data store if this file is changed. This file matches observation(s) with available units for the observation, and the range settings for each pair.

Observations are presented as entries in the TERM file (#704.101). For example the observation "TRACTION WEIGHT" could be identified by the TERM file (#704.101), TERM ID (field#.01) "{0C913807-C678-4E94-BD20-B8B2EBE697BE}".

Field Name	Field Number	Format	Description
TERM_ID	704.105,.01	POINTER TO TERM FILE (#704.101)	This field identifies the Observation in this "observation/unit" pair.
UNIT_ID	704.105,.02	POINTER TO TERM FILE (#704.101)	This field identifies the Unit in this "observation/unit" pair.
MIN_VALUE	704.105,.03	NUMBER Between -999999999 and 999999999, 7 decimal digits)	This field contains the minimum value that can be entered for this observation/unit pair. A sample could be "-1".
MAX_VALUE	704.105,.04	NUMBER Between -999999999 and 999999999, 7 decimal digits)	This field contains the maximum value that can be entered for this observation/unit pair. A sample could be "31".
DEC_PRECISION	704.105,.05	NUMBER (0-7) INPUT TRANSFORM: K:+X'=X!(X>7)!(X<0)!(X?.E1"."1.N) X LAST EDITED: APR 02, 2009 HELP-PROMPT: Type a number between 0 and 7, 0 Decimal Digits	This is the maximum decimal precision that can be entered for this observation/unit pair. A sample could be "0".
REFERENCE_LO W	704.105,.06	NUMBER Between -999999999 and 999999999, 9 decimal digits)	This is the value for this observation/unit pair that will cause Clinical Flowsheets to interpret the observed value as "low". A sample REFERENCE LOW could be "0".
REFERENCE_HIG H	704.105,.07	NUMBER Between -999999999 and 999999999, 9 decimal digits)	This is the value for this observation/unit pair that will cause Clinical Flowsheets to interpret the observed value as "high". A sample REFERENCE HIGH could be "30".

¹ Patch MD*1.0*16 January 2011 Added file description.

¹TERM_CHILD_PAIR File (#704.106)

NOTICE: This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the CliO data store if this file is changed.

This file holds the structure for complex observations by pairing the parent observation to the child observation with an ordinal position as well. Observations are entries in the TERM file (#704.101).

Field Name	Field Number	Format	Description
TERM_ID	704.106,.01	POINTER TO TERM FILE (#704.101)	This identifies the primary observation/term for complex term pairs. A sample TERM_ID could identify "blood pressure" as a primary term.
CHILD_ORDER	704.106,.02	NUMBER (between 1 and 999)	This represents the order of the child pair in association with a complex term.
CHILD_ID	704.106,.03	POINTER TO TERM FILE (#704.101)	This identifies the child term for a complex term pair. A sample CHILD_ID could identify "systolic" as a child term of "blood pressure".
CHILD_UNIT_ID	704.106,.04	POINTER TO TERM FILE (#704.101)	This is the unit(s) to present this child term. A sample CHILD_UNIT_ID could identify "MILLIMETERS OF MERCURY".
VALUE_TYPE	704.106,.05	SET '0' FOR Extract; '1' FOR Delimited;	This field will indicate whether the observation values are delimited or not.
VALUE_DELIMITER	704.106,.06	NUMBER (ASCII 32-126)	This is the number between 32 and 126 (0 Decimal Digits) of the ASCII value for the character to be used as the delimiter per delimited values. A sample VALUE_DELIMITER could be "47" to signify the use of the character "/" as delimiter.
VALUE_START_POSITION	704.106,.07	NUMBER (Between 1 and 250)	The "child values" may be presented in a string of data. This field is either the position or the delimited piece, of the data to begin extracting child values.
VALUE_STOP_POSITION	704.106,.08	NUMBER (Between 1 and 250)	The "child values" may be presented in a string of data. This field is either the last position or the last delimited piece of the data. This is where extracting of child values is to stop.
DESCRIPTION	704.106,.09	FREE TEXT (1-50 char)	This is a DESCRIPTION of this observation/child term pair. A sample DESCRIPTION could be "Systolic pressure".

¹ Patch MD*1.0*16 January 2011 File description added.

¹TERM_RANGE_CHECK File (#704.107)

This file maintains value ranges for related observations/terms.

An example could be a TERM RANGE CHECK entry that would result in an observed TEMPERATURE of 80 DEGREES FAHRENHEIT for a MALE between 55-150 years of AGE, triggering a "CRITICAL LOW" response by the Clinical Flowsheets application.

Field Name	Field Number	Format	Description
TERM_ID	704.107,.01	POINTER TO TERM FILE (#704.101)	This field identifies the term to which a term range check is applicable. A sample TERM ID could identify the term "TEMPERATURE".
UNIT_ID	704.107,.02	POINTER TO TERM FILE (#704.101)	This identifies the unit of measurement related to the TERM_ID (field #.01). A sample UNIT ID could identify "DEGREES F".
SEX	704.107,.03	SET M' FOR Male; F' FOR Female; N' FOR Non-Specific;	This field indicates the gender to which a term range check is applicable. A sample SEX could be "Male".
AGE_MINIMUM	704.107,.04	NUMBER (Between 0 and 150)	This is the minimum age which the term range check is applicable. A sample AGE MINIMUM could be "55".
AGE_MAXIMUM	704.107,.05	NUMBER (Between 0 and 150)	This is the maximum age which the term range check is applicable. A sample AGE MAXIMUM could be "150".
PATIENT_ID	704.107,.08	POINTER TO PATIENT FILE (#2)	This field identifies a patient for which the term range check is applicable. A sample PATIENT ID could identify "CP FLOWSHEETS,PATIENT1".
DESCRIPTION	704.107,.09	FREE TEXT (1-250 char)	This field is a DESCRIPTION of the term range check entry. A sample DESCRIPTION could be "Senior male temperature".
CRITICAL_LOW	704.107,.11	NUMBER (Between -9999999 and 9999999, 7 decimal digits)	This value will cause a "CRITICAL LOW" result when the term range check is applied. A sample CRITICAL LOW could be "80".
ABNORMAL_LO W	704.107,.12	NUMBER (Between -9999999 and 9999999, 7 decimal digits)	This value will cause an "ABNORMAL LOW" result when the term range check is applied. A sample ABNORMAL LOW could be "85".
NORMAL_LOW	704.107,.13	NUMBER (Between -9999999 and 9999999, 7 decimal digits)	This value will cause a "NORMAL LOW" result when the term range check is applied. A sample NORMAL LOW could be "90".

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
NORMAL_HIGH	704.107,.14	NUMBER (Between -9999999 and 9999999, 7 decimal digits)	This value will cause a "NORMAL HIGH" result when the term range check is applied. A sample NORMAL HIGH could be "100".
ABNORMAL_HIG H	704.107,.15	NUMBER (Between -9999999 and 9999999, 7 decimal digits)	This value will cause an "ABNORMAL HIGH" result when the term range check is applied. A sample ABNORMAL HIGH could be "103".
CRITICAL_HIGH	704.107,.16	NUMBER (Between -9999999 and 9999999, 7 decimal digits)	This is the value that will cause a CRITICAL HIGH"" result when the term range check is applied. A sample CRITICAL HIGH could be "106".

¹TERM_MAPPING_TABLE File (# 704.108)

NOTICE: This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the CliO data store if this file is changed.

This file is the anchor for the mapping table structure for the CP Gateway. Each mapping table is called up by elements in the HL7 message. The entries are used to translate the HL7 data into appropriate CP terminology.

Field Name	Field Number	Format	Description
ID	704.108,.01	FREE TEXT (38 char)	This field is the Global Unique Identifier (GUID) that identifies the mapping table. A sample ID could be "{4E41823C-CB5B-499F-BAAC-13626A6CD0D2}".
NAME	704.108,.02	FREE TEXT (Between 1-50 char)	This field is the NAME of the mapping table. A sample could be "DeviceX ServiceZ".
HL7_SENDING_APPLICATION	704.108,.03	FREE TEXT (1 to 50 char)	This field is the application sending the HL7 message. This will be used for matching purposes. A sample HL7 SENDING APPLICATION could be "ServiceZ".
ACTIVE	704.108,.09	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this mapping-table is ACTIVE or not.
COMMENT	704.108,.1	FREE TEXT (1-250 char)	This field is a comment about the mapping-table. A sample COMMENT could be "Default DeviceX ServiceZ mapping table".
SOURCE_ID	704.108,.21	FREE TEXT (1-50 char)	This field identifies the source of the HL7 message. A sample SOURCE ID could be "DeviceX".
SOURCE_APPLICATION	704.108,.22	FREE TEXT (1-50 char)	This field is the application regarded as the source of the HL7 message. A sample SOURCE APPLICATION could be "ServiceZ".
SOURCE_VERSION	704.108,.23	FREE TEXT (1-50 char)	This field is the version of the source of the HL7 message. A sample SOURCE VERSION could be "VerN-ReleaseN.NN".
SOURCE_TRUSTED	704.108,.24	SET '0' FOR No; '1' FOR Yes;	This field indicates whether data processed via this source/mapping-table is "trusted" or not. Only verified data will be filed. Verification may be done with user intervention or it may be automatic. Trusted mapping-tables will have their data filed as "verified" without user intervention.

¹ Patch MD*1.0*16 January 2011 File description added.

¹TERM_MAPPING_PAIR File (#704.109)

NOTICE: This file is maintained exclusively by the CP Terminology group and must not be modified or edited in any way. Subsequent releases of CP Terminology may create lasting errors in the CliO data store if this file is changed.

This file correlates a vendor (VENDOR KEY field #.1) with a mapping-table (MAPPING TABLE ID field #.01) and an HL7 message segment (TERM TYPE field #.03). A sample entry could be interpreted as follows: Mapping-TableXX is used for processing when VendorX has sent an XType message.

Field Name	Field Number	Format	Description
MAPPING_TABLE_ID	704.109,.01	POINTER TO TERM_MAPPING_TABLE FILE (#704.108)	This identifies the mapping-table of this TERM MAPPING PAIR entry. A sample could identify "Mapping-TableXX".
RECORD INDEXES:		PK (#772)	
TERM_TYPE	704.109,.03	POINTER TO TERM_TYPE FILE (#704.102)	This field will determine the HL7 message segment relating to this term mapping pair; and identifies a term-type in the TERM TYPE File (#704.102). A sample could be a TERM TYPE identifying the HL7 message segment with "XType" data to be related to this term mapping pair.
TERM	704.109,.04	POINTER TO TERM FILE (#704.101)	This field identifies the TERM relating to this term mapping pair. A sample TERM could identify "TEMPERATURE".
VENDOR_KEY	704.109,.1	FREE TEXT (1-240 char)	This field indicates the vendor related to this term mapping pair. A sample VENDOR KEY could be "111X213".

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS_VIEW File (#704.111)

This file maintains the views displayed within a flowsheet via the Clinical Flowsheets application. A view is a group of terms displayed together. A sample view could display "ICU VITALS, INPUTS, OUTPUTS, and ICU HEMODYNAMICS" information together in a section of a flowsheet displayed via the Clinical Flowsheets application.

Field Name	Field Number	Format	Description
VIEW_ID	704.111,.01	FREE TEXT (38 char)	This is the view's Global Unique Identifier (GUID). This value is maintained nationally and represents this view throughout the enterprise. A sample VIEW ID could be "{11AA9949-B1FA-40A5-A208-5BB8255BE961}".
NAME	704.111,.02	FREE TEXT (1-50 char)	This is the NAME of this view. A sample NAME could be "ICU HEMODYNAMICS".
TIME_INTERVAL	704.111,.03	NUMBER (1-1440)	A view is displayed to the user as part of a "page" on the screen. That page is divided into TIME INTERVALs. This field is the number of minutes within an interval when the page is initially displayed to the user. The maximum is 1440 (1 day). A sample TIME INTERVAL could be "60".
X_AXIS	704.111,.04	SET '0' FOR Terminology; '1' FOR Date/Time;	This field indicates whether the initial layout of the view's horizontal axis shows terminology information or date/time information. The information not indicated to display horizontally will initially display vertically.
DISPLAY_NAME	704.111,.05	FREE TEXT (1-50 char)	This is the name of this view to display to the user when this view is being used. A sample DISPLAY NAME could be "ICU Hemodynamics".
ALLOW_PIVOT	704.111,.06	SET '0' FOR No; '1' FOR Yes;	This field indicates whether the user is allowed to "pivot" how information is displayed. For example: If initially this view's terminology information displays horizontally and date/time information displays vertically, a '1' value ("YES") in this field gives the user the option to display this view's terminology information vertically and the date/time information horizontally.
NATIONAL_TITLE	704.111,.08	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this view is a NATIONAL TITLE, maintained nationally, and cannot be modified at/by a site.
ACTIVE	704.111,.09	SET '0' FOR No; '1' FOR Yes;	This field indicates whether this view is ACTIVE or not. An ACTIVE view can be incorporated into a flowsheet.

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
COMMENT	704.111,.1	FREE TEXT (1-250 char)	This field is free-text comment to describe the use and purpose of this view. A sample COMMENT could be "National ICU Flowsheet View".

¹OBS_VIEW_TERMINOLOGY File (#704.1111)

This file maintains the relationships between views of OBS_VIEW File (#704.111) and terms of TERM file (#704.001).

Some field descriptions are directed to a programming and development audience.

Field Name	Field Number	Format	Description
VIEW_ID	704.1111,.01	POINTER TO OBS_VIEW FILE (#704.111)	This field identifies an entry in the OBS VIEW File (#704.111); correlates this file entry with a view.
TERM_ORDER	704.1111,.02	NUMBER (1-999)	This field indicates the order this term will display in that view identified by VIEW ID (field #.01).
TERM_ID	704.1111,.03	POINTER TO TERM FILE (#704.101)	This field identifies an entry in the TERM File (#704.001); correlates this file entry with a term.
DISPLAY_NAME	704.1111,.04	FREE TEXT (1-50 char)	This name will display to the user when the Clinical Flowsheets application shows this term (TERM ID field #.03). A sample DISPLAY NAME could be "IV - Platelets".
DISPLAY_WIDTH	704.1111,.05	NUMBER (80-9999)	This field is the number of pixels this term (TERM ID field #.03) will require to be displayed in the Clinical Flowsheets application. A sample could be "120".
DISPLAY_TOTAL	704.1111,.06	SET '0' FOR NO; '1' FOR YES;	This field indicates whether a summation of term (TERM ID field #.03) measurements will display at the bottom of a grid shown via the Clinical Flowsheets application.
DISPLAY_COUNT	704.1111,.07	SET '0' FOR NO; '1' FOR YES;	This field indicates whether or not a count of terms (TERM ID field#.03) related to the view (VIEW ID field #.01) will display at the bottom of the grid shown via the Clinical Flowsheets application.
DISPLAY_AVERAGE	704.1111,.08	SET '0' FOR NO; '1' FOR YES;	This field indicates whether an average of term (TERM ID field #.03) measurements will display at the bottom of the grid shown via the Clinical Flowsheets application.
DISPLAY_ONLY	704.1111,.09	SET '0' FOR NO; '1' FOR YES;	This indicates whether this term (TERM ID field#.03) in this view (VIEW ID field#.01) is only for display and reporting purposes and cannot be modified.
DISPLAY_COLUMNS	704.1111,.1	NUMBER (0-9)	When a "picklist" value is displayed for input in a radio group box this value is used to indicate how many columns this term-value will be displayed in.

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
DISPLAY_IN_CEL L_TOTAL	704.1111,.11	SET '0' FOR NO; '1' FOR YES;	This field indicates whether a sub-totals of indicated totals (e.g., total(#.06), count(#.07), average(#.08) etc.) display within each TIME INTERVAL (file #704.111 field #.03) of this view (VIEW ID #.01).
DISPLAY_MINIM UM	704.1111,.12	SET '0' FOR NO; '1' FOR YES;	This field indicates whether the least of a list of term measurements will display at the bottom of the grid shown via the Clinical Flowsheets application.
DISPLAY_MAXI MUM	704.1111,.13	SET '0' FOR NO; '1' FOR YES;	This field indicates whether the greatest of a list of term measurements will display at the bottom of the grid shown via the Clinical Flowsheets application.
REQUIRED_TER M	704.1111,.14	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this term (TERM ID #.03) must be given a value when using this view (VIEW ID #.01) for input.
USE_DROPDOWN	704.1111,.15	SET '0' FOR NO; '1' FOR YES;	This field indicates whether a value for this term will necessitate the use of a "drop down" instead of a "radio group". With long "picklists" it is sometimes necessary to display items in a drop down instead of a radio group.

¹OBS_VIEW_FILTER File (#704.1112)

This file maintains relationships between view entries in the OBS VIEW file (#704.1111) and qualifiers/filters.

Field Name	Field Number	Format	Description
VIEW_ID	704.1112,.01	POINTER TO OBS_VIEW FILE (#704.111)	This field identifies an entry in the OBS VIEW File (#704.111); correlates this file entry with a view.
TERM_ORDER	704.1112,.02	NUMBER (1-9999)	This is the order of the filter in this file entry.
RECORD INDEXES:		PK (#730)	
FILTER_TYPE	704.1112,.03	POINTER TO TERM_TYPE FILE (#704.102)	This is the type of term this filter uses.
FILTER_TERM	704.1112,.04	POINTER TO TERM FILE (#704.101)	This field identifies the term this filter relates to; correlates this file entry to a TERM File (#704.101) entry. This is the term/qualifier by which to filter.
FILTER_USAGE	704.1112,.05	SET '0' FOR DEFAULT VALUE; '1' FOR MANDATORY VALUE;	This field is to indicate whether this filter is mandatory or a default when entering new data.

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS_FLOWSHEET File (#704.112)

This file maintains the flowsheets used by the Clinical Flowsheets application.

Field Name	Field Number	Format	Description
FLowsHEET_ID	704.112,.01	FREE TEXT (38 char)	HELP-PROMPT: Answer with the Global Unique Identifier (GUID) for this flowsheet. This value is the Global Unique Identifier for this flowsheet. This value is system generated, maintained nationally, so this value represents the same flowsheet throughout the enterprise. A sample FLOWSHEET ID could be "{E2237CB1-7706-4B43-A96C-D08B812D2A2E}".
NAME	704.112,.02	FREE TEXT (1-50 char)	This is the official NAME for this flowsheet (#.01). A sample NAME could be "ICU MONITORING".
DISPLAY_NAME	704.112,.03	FREE TEXT (1-50 char)	This is the name displayed via the Clinical Flowsheets application for this flowsheet. A sample DISPLAY NAME could be "ICU Monitoring".
COMMENT	704.112,.04	FREE TEXT (1-50 char)	This is a free-text COMMENT to document the purpose for this flowsheet (#.01). A sample COMMENT could be "Primary flowsheet for ICU patients".
ACTIVE	704.112,.05	SET '0' FOR No; '1' FOR Yes;	This field indicates whether this flowsheet (#.01) can be used in the Clinical Flowsheets application.
DEFAULT_TIU_NOTE	704.112,.06	POINTER TO TIU DOCUMENT DEFINITION FILE (#8925.1)	This field correlates this entry to an entry in the TIU DOCUMENT File (#8925).
DISPLAY_KARDEX	704.112,.07	SET '0' FOR NO; '1' FOR YES;	This field indicates whether the "Kardex grid" will be displayed when this flowsheet (#.01) is opened.

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS_FLOWSHEET_PAGE File (#704.1121)

This file maintains the relationships between OBS_FLOWSHEET file (#704.112) entries and pages/view (OBS_VIEW file #704.111) entries.

Field Name	Field Number	Format	Description
FLowsheet_ID	704.1121,.01	POINTER TO OBS_FLOWSHEET FILE (#704.112) (Key field)	This field identifies the flowsheet that correlates to this file entry.
PAGE_ORDER	704.1121,.02	NUMBER (1-99)	This field is the order of display for this view in the flowsheet (#.01).
VIEW_ID	704.1121,.03	POINTER TO OBS_VIEW FILE (#704.111) (Key field)	This field identifies a page/view displayed via this flowsheet (#.01).
PAGE_TYPE	704.1121,.04	SET '0' FOR Mandatory; '1' FOR Optional; '2' FOR Supplemental;	This field indicates how this view (#.03) will be utilized in this flowsheet (#.01).
DISPLAY_NAME	704.1121,.05	FREE TEXT (1-200 char)	This is a name to override the default DISPLAY NAME (file #704.112, field #.03). This name will display when this page/view (#.03) is shown with this flowsheet (#.01). A sample DISPLAY NAME could be "NurseX ICU Monitoring".
SPECIAL_INSTRUCTIONS	704.1121,.1	FREE TEXT (1-250 char)	This is free-text to provide a way to give additional instruction, comment, or note about the use of this view (#.03) with this flowsheet (#.01). A sample SPECIAL INSTRUCTIONS value could be "Pivot the page when possible".

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS_FLOWSHEET_SUPP_PAGE File (#704.1122)

This file maintains supplemental pages/views. The supplemental page is a variation of a page as supported via the OBS_FLOWSHEET_PAGE file (#704.1121).

Field Name	Field Number	Format	Description
ID	704.1122,.01	FREE TEXT (38 char)	This is the Global Unique Identifier (GUID) for this entry. This value is maintained nationally, so this value identifies this supplemental page throughout the enterprise.
VIEW_ID	704.1122,.02	POINTER TO OBS_VIEW FILE (#704.111)	This identifies the view for this supplemental page (#.01); correlates this entry with an entry in the OBS_VIEW File (#704.111).
PATIENT_ID	704.1122,.03	POINTER TO PATIENT FILE (#2)	This identifies the patient assigned to this supplemental page (#.01); correlates this entry with a PATIENT File (#2) entry.
DEFAULT_METHOD_ID	704.1122,.04	POINTER TO TERM FILE (#704.101)	This identifies the default method to use with this supplemental page (#.01). This method is a TERM File (#704.101) entry. A sample DEFAULT METHOD ID could be an identifier for the term "ARTERIAL LINE".
DEFAULT_POSITION_ID	704.1122,.05	POINTER TO TERM FILE (#704.101)	This identifies the default position to use with this supplemental page (#.01). This position is a TERM File (#704.101) entry. A sample DEFAULT POSITION ID could be an identifier for the term "LYING".
DEFAULT_LOCATION_ID	704.1122,.06	POINTER TO TERM FILE (#704.101)	This identifies the default location to use with this supplemental page (#.01). This location is a TERM File (#704.101) entry. A sample DEFAULT LOCATION ID could be an identifier for the term "ANKLE".
DEFAULT_PRODUCT_ID	704.1122,.07	POINTER TO TERM FILE (#704.101)	This identifies the default product to use with this supplemental page (#.01). This product is a TERM File (#704.101) entry. A sample DEFAULT PRODUCT ID could be an identifier for the term "5% PRODUCT X".
DISPLAY_NAME	704.1122,.08	FREE TEXT (1-100 char)	This is the DISPLAY NAME to override the view display name (file #704.111, field #.05) when activated. A sample DISPLAY NAME could be "IV Input Blood Products".
STATUS	704.1122,.09	SET '0' FOR INACTIVE; '1' FOR ACTIVE;	This indicates whether this supplemental page (#.01) is active or inactive for this patient's (#.03) treatment.

¹ Patch MD*1.0*16 January 2011 File description added.

File List and Related Information

Field Name	Field Number	Format	Description
SET_ID	704.1122,.1	POINTER TO OBS_SET FILE (#704.116)	This field identifies the OBSERVATION SET file (#704.116) entry that correlates with this entry.
ACTIVATED_DATE_TIME	704.1122,.11	DATE	This is the date/time this supplemental page (#.01) is activated.
ACTIVATED_BY_ID	704.1122,.12	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) to activate this supplemental page (#.01).
ACTIVATED_COMMENT	704.1122,.13	FREE TEXT (1-200 char)	This is the user supplied comment stored when the page is activated. A sample ACTIVATED COMMENT could be "supplemental page X activated by request".
ACTIVATED_AS_TYPE	704.1122,.14	SET '0' FOR Mandatory; '1' FOR Optional; '2' FOR Supplemental;	This indicates a purpose for the activation of this supplemental page (#.01).
DEACTIVATED_DATE_TIME	704.1122,.21	DATE	This is the date/time this supplemental page (#.01) was deactivated.
DEACTIVATED_BY_ID	704.1122,.22	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) that deactivated this supplemental page (#.01).
DEACTIVATED_COMMENT	704.1122,.23	FREE TEXT (1-200 char)	This is a user supplied comment stored when this supplemental page (#.01) is deactivated. A sample DEACTIVATED COMMENT could be "patient/treatment is no longer applicable".

¹OBS_FLOWSHEET_TOTAL File (#704.1123)

This file maintains flowsheets (file #704.112) and observation totals (file #704.113) relationships.

Field Name	Field Number	Format	Description
FLowsheet_ID	704.1123,.01	POINTER TO OBS_FLOWSHEET FILE (#704.112) (Key field)	This identifies the flowsheet file entry for this flowsheet total entry.
TOTAL_ID	704.1123,.02	POINTER TO OBS_TOTAL FILE (#704.113)	This identifies an observation total file entry to correlate with this flowsheet total entry.
TOTAL_ORDER	704.1123,.03	NUMBER (Between 1 and 99)	This field determines the order in which this flowsheet total will be executed and displayed.

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS_TOTAL File (#704.113)

This file maintains observation totals.

Field Name	Field Number	Format	Description
ID	704.113,.01	FREE TEXT (38 char)	This field is a unique IDentifier for this TOTAL. This ID is maintained nationally so it identifies this TOTAL throughout the enterprise. A sample ID could be "{217D131C-13C3-4B9E-A401-D1345766182B}".
NAME	704.113,.02	FREE TEXT (1-50 char)	This is a descriptive NAME for this total (#.01). A sample name could be "OUTTAKE TOTALS".
DISPLAY_NAME	704.113,.03	FREE TEXT (1-50 char)	This is a user friendly name. This is used when displaying this total via the Clinical Flowsheets application. A sample DISPLAY NAME could be "New Flowsheet Outtake Total".
DEFAULT_UNIT	704.113,.04	POINTER TO TERM FILE (#704.101)	This identifies the measurement-unit to be used with the observation total (#.01). The DEFAULT UNIT is an entry in the TERM (#704.101) file. A sample DEFAULT UNIT could identify the term "lbs" or "pounds".
DECIMAL_PRECISION	704.113,.05	NUMBER (1-8 Number Precision)	This is the decimal precision to round the total values to.
ACTIVE	704.113,.09	SET '0' FOR NO; '1' FOR YES;	This indicates whether this total (#.01) can be used by the Clinical Flowsheets application.
COMMENT	704.113,.1	FREE TEXT (1-250 char)	This is a descriptive COMMENT about this total (#.01) entry. A sample COMMENT could be "New totaling apparatus for OUTTAKE totals - default lbs ".
DISPLAY_TOTAL	704.113,.201	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this total (#.01) will display a total of all observations.
DISPLAY_COUNT	704.113,.202	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this total (#.01) will display a count of observations.
DISPLAY_AVERAGE	704.113,.203	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this total (#.01) will display the average of all observations.
DISPLAY_DIFFERENCE	704.113,.204	SET '0' FOR NO; '1' FOR YES;	(Future Use.)

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
DISPLAY_RATIO	704.113,.205	SET '0' FOR NO; '1' FOR YES;	(Future Use.)
DISPLAY_MINIMUM	704.113,.206	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this total (#.01) will display the least value registered of all observations.
DISPLAY_MAXIMUM	704.113,.207	SET '0' FOR NO; '1' FOR YES;	This field indicates whether this total (#.01) will display the greatest value registered of all observations.

¹OBS_TOTAL_TERMINOLOGY File (#704.1131)

This maintains relationships between OBS TOTAL file (#704.113) entries and TERM file (#704.101) entries.

Field Name	Field Number	Format	Description
TOTAL_ID	704.1131,.01	POINTER TO OBS_TOTAL FILE (#704.113)	This identifies the observation total portion of this total-terminology entry.
TERM_ID	704.1131,.02	POINTER TO TERM FILE (#704.101)	This identifies the term portion of this total-terminology entry.
TERM_ORDER	704.1131,.03	NUMBER (Key field)	This field indicates the display order of this term (#.02) within this observation total (#.01).
TERM_DISPLAY_ NAME	704.1131,.04	FREE TEXT (1-50 char)	This is the name to display within the Clinical Flowsheets application for this total terminology entry. A sample TERM DISPLAY NAME could be "TOTs IntakeX".

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS_ALARM File (#704.115)

This file supports the Clinical Flowsheets application "alarm" functionality. And the file maintains the relationships between alarms and patients.

Field Name	Field Number	Format	Description
ID	704.115,.01	FREE TEXT (38 char)	This value is a Global Unique Identifier (GUID) for this alarm. The GUID is maintained nationally so this value represents this item throughout the enterprise.
PATIENT_ID	704.115,.02	POINTER TO PATIENT FILE (#2)	This identifies the patient for which this alarm (#.01) is applicable.
TERM_ID	704.115,.03	POINTER TO TERM FILE (#704.101)	This is the term to be monitored when the Clinical Flowsheets application determines whether to signal an alarm.
UNIT_ID	704.115,.04	POINTER TO TERM FILE (#704.101)	This identifies the unit of measurement to use when Clinical Flowsheets compares observed and "alarm" values.
ALARM_TYPE	704.115,.05	SET 0' FOR Value in range; 1' FOR Value not in range; 2' FOR Value greater than; 3' FOR Value less than; 4' FOR Value in Picklist; 5' FOR Value is True; 6' FOR Value is False;	This indicates the case, when satisfied by an observed value, for the assigned patient and term that may cause the Clinical Flowsheets application to trigger the alarm (#01).
MIN_VALUE	704.115,.06	NUMBER (Number between -999999999 and 999999999)	This field is the minimum value for this term (#.03) and unit (#.04) that will not trigger the alarm (#.01).
MAX_VALUE	704.115,.07	NUMBER (Number between -999999999 and 999999999)	This field is the maximum value for this term (#.03) and unit (#.04) that will not trigger alarm.
ALARM_SET	704.115,.08	SET '0' FOR No; '1' FOR Yes;	This indicates whether this alarm's (#.01) conditions are satisfied.

¹ Patch MD*1.0*16 February 2010 File description added.

Field Name	Field Number	Format	Description
ACTIVE	704.115,.09	SET '0' FOR No; '1' FOR Yes;	This indicates if this alarm (#.01) logic is to be executed on new values (reset).
ACTIVATED_DATE_TIME	704.115,.11	DATE	This field is the date/time this alarm (#.01) is to be activated.
ACTIVATED_BY_ID	704.115,.12	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) that activated this alarm (#.01).
DEACTIVATED_DATE_TIME	704.115,.13	DATE	This is the date/time this alarm (#.01) is to be deactivated.
DEACTIVATED_BY_ID	704.115,.14	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) that deactivated this alarm (#.01).
ACTIVATED_COMMENT	704.115,.2	FREE TEXT (1 – 250 char)	This is the comment entered when this alarm (.01) was activated. A sample ACTIVATED COMMENT could be "Alarm activated for automated monitoring".
DEACTIVATED_COMMENT	704.115,.3	FREE TEXT (1 – 250 char)	This is the comment entered when this alarm (.01) was deactivated. A sample DEACTIVATED COMMENT could be "Alarm deactivated for staff monitoring".
PICKLIST_IDS	704.115,.4	FREE TEXT (1 – 250 char)	This field is a list of VA Unique IDentifiers for a "picklist-type" observation. A sample PICKLIST IDS could be: "{65069804-39BF-41ED-9EA3-BF2C41389F10},{715091C 2-9668-4678-900E-6D55D3335A30},{D5B3E135-4D68-4528-BBC9-6E8A7A997104}"

¹OBS_SET File (#704.116)

This file maintains sets of observations used by the Clinical Flowsheets application.

Field Name	Field Number	Format	Description
SET_ID	704.116,.01	FREE TEXT (38 char)	This value is the Global Unique IDentifier (GUID) for this entry. This value is maintained nationally and is the same throughout the enterprise. A sample SET ID could be "{2E0C516D-3858-4A1F-A2F3-BF0AB9E3A7FC}".
ENTERED_DATE_TIME	704.116,.02	DATE	This field is the date/time this set (#.01) was created.
ENTERED_BY_ID	704.116,.03	POINTER TO NEW PERSON FILE (#200)	This field identifies the person (file #200) that created this set (#.01).
PUBLIC	704.116,.04	SET '0' FOR No; '1' FOR Yes;	(Future use - indicate whether this is used by other applications / public.)
COMMENT	704.116,.1	FREE TEXT (1 – 250 char)	This is the user supplied COMMENT about the purpose of this set (.01). A sample COMMENT could be "Auto-Generated Set".
COUNT	704.116,.911	COMPUTED	This is the number of observations assigned to this set (#.01).

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS_SET_OBS_PAIR File (#704.1161)

This file maintains the relationships between observations and observation sets.

Field Name	Field Number	Format	Description
SET_ID	704.1161,.01	POINTER TO OBS_SET FILE (#704.116)	This identifies the set file (#704.116) entry part of this set-observation pair.
OBS_ID	704.1161,.02	POINTER TO OBS FILE (#704.117)	This identifies the observation file (#704.117) entry part of this set-observation pair.

¹ Patch MD*1.0*16 January 2011 File description added.

¹OBS File (#704.117)

This file maintains observations for use with the Clinical Flowsheets application.

Field Name	Field Number	Format	Description
OBS_ID	704.117,.01	FREE TEXT (38 char)	This is a Globally Unique Identifier (GUID) for this entry. This is maintained nationally so it is the same throughout the enterprise. A sample OBS ID could be "{69DBD11E-9A8C-4ECE-AFA4-73947218807D}".
PARENT_ID	704.117,.02	POINTER TO OBS FILE (#704.117)	This identifies the parent observation in the case of a complex observation.
FACILITY_ID	704.117,.03	POINTER TO DOMAIN FILE (#4.2)	This identifies the domain (file #4.2) relevant to this observation (#.01).
HOSPITAL_LOCATION_ID	704.117,.04	POINTER TO HOSPITAL LOCATION FILE (#44)	This identifies the hospital location (file #44) relevant to this observation (#.01).
OBSERVED_DATE_TIME	704.117,.05	DATE	This is the date/time this observation (#.01) took place.
OBSERVED_BY_ID	704.117,.06	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) that made this observation.
TERM_ID	704.117,.07	POINTER TO TERM FILE (#704.101)	This identifies the type of observation. This "type" is an entry in the TERM File (#704.101). A sample TERM ID here could reference the term "SYSTOLIC PRESSURE".
PATIENT_ID	704.117,.08	POINTER TO PATIENT FILE (#2)	This identifies the PATIENT (file #2) for whom this observation (#.01) was taken.
STATUS	704.117,.09	SET '0' FOR Unverified; '1' FOR Verified; '2' FOR Archived; '3' FOR Purged; '4' FOR Corrected; '5' FOR Removed;	This field indicates the current status of this observation (#.01).
SVALUE	704.117,.1	FREE TEXT (1 – 250 char)	This field represents the value of the observation (#.01). A sample SVALUE could be "122/55".
SOURCE	704.117,.21	FREE TEXT (1 – 50 char)	This field is the source of the SVALUE (#.1). A sample SOURCE could be "instrument" or "CP Flowsheets".

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
SOURCE_COMMENTS	704.117,.22	FREE TEXT (1 – 50 char)	This is any comment type information generated by the source about this observation (#.01). A sample SOURCE COMMENTS could be "Routine MDZCLIO Tag BUILD".
SOURCE_DATA_ITEM_ID	704.117,.23	FREE TEXT (1 – 50 char)	This field contains source (#.21) generated information for later tagging. A sample SOURCE DATA ITEM ID could be "CPFLOWSHEETS.EXE:C13A6427".
SOURCE_VERSION	704.117,.24	FREE TEXT (1 – 50 char)	This is the version of the source (#.21) that generated this observation (#.01). A sample SOURCE VERSION could be "1.0".
ENTERED_DATE_TIME	704.117,.25	DATE	This is the date and time this entry was placed into this observation file.
ENTERED_BY_ID	704.117,.26	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) who entered the data for this observation (#.01).
CHILD_ORDER	704.117,.27	NUMBER (Number 1 - 999)	This is the order that this observation is placed into its parent observation (#.02).
RANGE	704.117,.28	SET '0' FOR Unknown; '1' FOR Normal; '2' FOR Out Of Bounds Low; '3' FOR Out Of Bounds High; '4' FOR Low; '5' FOR High;	This indicates the condition of the observation value (#.1).
COMMENT	704.117,.4	FREE TEXT (1 – 250 char)	This is free-text for additional clinical COMMENT. A sample COMMENT could be "test O2 saturation".
AUDIT_EXISTS	704.117,.911	COMPUTED	This indicates whether or not any record exists in the audit log for this observation.
CORRECTION_FO R_ID	704.117,.912	COMPUTED	This identifies the record this observation was entered to correct.

| ¹OBS_QUALIFIER File (#704.118)

This file maintains relationships between observations and qualifiers.

Field Name	Field Number	Format	Description
OBS_ID	704.118,.01	POINTER TO OBS FILE (#704.117)	This identifies the observation part of this observation/qualifier pair.
QUALIFIER_ID	704.118,.02	POINTER TO TERM FILE (#704.101)	This identifies the qualifier part of this observation/qualifier pair.

¹ Patch MD*1.0*16 January 2011 File description added.

| ¹OBS_AUDIT File (#704.119)

This file maintains the chains of observation audits for Clinical Flowsheets observations. An audit is defined here as a change in an observation's status, state, or condition.

Field Name	Field Number	Format	Description
AUDIT_ID	704.119,.01	FREE TEXT (38 char)	This value is the Global Unique Identifier (GUID) for this entry. This value is maintained nationally and is the same throughout the enterprise. A sample AUDIT ID could be "{2E0C516D-3858-4A1F-A2F3-BF0AB9E3A7FC}".
AUDIT_TYPE	704.119,.02	SET '0' FOR Record Status Update; '1' FOR Record Verified; '2' FOR Record Marked For Purging; '3' FOR Record Marked For Archiving; '4' FOR Record Corrected; '5' FOR Record Rescinded;	This indicates the type of audit; the reason for the audit.
AUDIT_OBSERVATION	704.119,.03	POINTER TO OBS FILE (#704.117)	This identifies the observation that has been audited via this entry.
AUDIT_DATE_TIME	704.119,.04	DATE	This is the date/time this audit occurred.
AUDIT_AUTHOR	704.119,.05	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) that created this audit entry.
STATUS_ORIGINAL	704.119,.06	SET '0' FOR Unverified; '1' FOR Verified; '2' FOR Archived; '3' FOR Purged; '4' FOR Corrected; '5' FOR Rescinded;	This indicates the status/condition of the observation (#.03) before this audit entry (#.01) was created.
STATUS_NEW	704.119,.07	SET '0' FOR Unverified; '1' FOR Verified; '2' FOR Archived; '3' FOR Purged; '4' FOR Corrected; '5' FOR Rescinded;	This indicates the status/condition of the observation (#.03) after this audit entry (#.01) was created.

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
REPLACEMENT_ OBSERVATION	704.119,.08	POINTER TO OBS FILE (#704.117)	This identifies the observation that was replaced by a new observation via this audit.
COMMENT	704.119,.1	FREE TEXT (1 – 250 char)	This is a COMMENT provided by the person as documentation per this observation audit (#.01). A sample COMMENT could be "Verified with Clinical Flowsheets".

¹CP_KARDEX_ACTION File (#704.121)

This file supports Clinical Flowsheets scheduled tasks and actions functionality.

Field Name	Field Number	Format	Description
ID	704.121,.01	FREE TEXT (38 char)	This value is the Global Unique Identifier (GUID) for this entry. This value is maintained nationally and is the same throughout the enterprise. A sample ID could be "{2E0C516D-3858-4A1F-A2F3-BF0AB9E3A7FC}".
TASK_ID	704.121,.02	POINTER TO TERM FILE (#704.101)	This identifies a task in the TERM File (#704.101).
SCHEDULE_ID	704.121,.03	POINTER TO CP_SCHEDULE FILE (#704.008)	This identifies the schedule (#704.008) to use with the task (#.02).
PATIENT_ID	704.121,.04	POINTER TO PATIENT FILE (#2)	This field identifies the patient (file #2) assigned to this task.
START_DATE_TIME	704.121,.05	DATE	This is the date/time the execution of this task is permitted.
STOP_DATE_TIME	704.121,.06	DATE	This is the date/time the execution of this task is no longer permitted.
SCHEDULE_TYPE	704.121,.07	SET '0' FOR Continuous; '1' FOR PRN; '2' FOR One-Time; '3' FOR Stat; '4' FOR Now;	This field indicates the type of schedule used for this task.
PRN_TYPE	704.121,.08	SET '0' FOR No PRN; '1' FOR PRN-And; '2' FOR PRN-AndNTE; '3' FOR PRN-Or;	This field indicates the Pro Re Nata (PRN) option for task.
STATUS	704.121,.09	SET '0' FOR Active; '1' FOR Expired; '2' FOR Discontinued; '3' FOR Held;	This field indicates the status of the task.
SPECIAL_INSTRUCTIONS	704.121,.1	FREE TEXT (1 – 250 char)	This is free-text for instructions for this particular task. A sample SPECIAL INSTRUCTIONS could be "Turn patient 90 degrees".

¹ Patch MD*1.0*16 January 2011 File description added.

Field Name	Field Number	Format	Description
PRN_NTE_AMOUNT	704.121,,21	NUMBER (Number 1 - 999)	This field the maximum number of times this task should executed. This field is used in the case of tasks with a PRN option.
FIRST_SCHEDULED_TIME	704.121,,22	FREE TEXT (1 – 4 char)	This is the military time of the first time that this item should be executed once the start date/time has been reached. A sample FIRST SCHEDULED TIME could be "1330" to represent "01:30 PM" as the first time this task should be executed.
CUSTOM_SCHEDULED_TIMES	704.121,,3	FREE TEXT (1 – 250 char)	This field is a custom schedule. If the user wished to modify the schedule for this task (#.02), the schedule here in a military times. A sample CUSTOM SCHEDULED TIMES could be "0400,0800,1200,1600,2000".

| ¹CP_KARDEX_EVENTS File (#704.1211)

This file supports Clinical Flowsheets scheduled events/actions functionality.

Field Name	Field Number	Format	Description
EVENT_ID	704.1211,.01	FREE TEXT (38 char)	This is a Globally Unique Identifier (GUID) for this entry. This is maintained nationally so it is the same throughout the enterprise. A sample EVENT ID could be "{69DBD11E-9A8C-4ECE-AFA4-73947218807D}".
CARE_ACTION_ID	704.1211,.02	POINTER TO CP_KARDEX_ACTION FILE (#704.121)	This identifies the action (#704.121) to which this event will be assigned.
DUE_DATE_TIME	704.1211,.03	DATE	This is the date/time this event is scheduled to be executed.
COMPLETED_DATE_TIME	704.1211,.04	DATE	This is the date/time this event was actually done.
COMPLETED_BY_ID	704.1211,.05	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) who marked this event as completed.
STATUS	704.1211,.09	SET '0' FOR PENDING; '1' FOR COMPLETED; '2' FOR HELD; '3' FOR REFUSED;	This indicates the status, condition, or state of this event.
COMMENT	704.1211,.1	FREE TEXT (1 – 250 char)	This is a free-text, user entered COMMENT for this event. A sample COMMENT could be "This event was completed on time. It was entered late".
AUDIT_COUNT	704.1211,.991	COMPUTED	This is a calculated count of the number of audits for this event.

¹ Patch MD*1.0*16 January 2011 File description added.

| ¹CP_KARDEX_AUDIT File (#704.1212)

This file maintains audits of scheduled event/tasks via the Clinical Flowsheets application.

Field Name	Field Number	Format	Description
ACTION_ID	704.1212,.01	POINTER TO CP_KARDEX_ACTION FILE (#704.121)	This identifies the audited scheduled task.
EVENT_ID	704.1212,.02	POINTER TO CP_KARDEX_EVENTS FILE (#704.1211)	This identifies the audited event.
AUDIT_DATE_TIME	704.1212,.03	DATE	This is the date/time that the audit record is created.
AUDIT_BY_ID	704.1212,.04	POINTER TO NEW PERSON FILE (#200)	This identifies the person (file #200) that created this audit.
AUDIT_DESCRIPTION	704.1212,.1	FREE TEXT (1 – 250 char)	This is free-text automatically generated by the Clinical Flowsheets application when an audit is created. A sample could be AUDIT DESCRIPTION "Event placed in Hold Status".
AUDIT_COMMENT	704.1212,.2	FREE TEXT (1 – 250 char)	This is free-text generated by the user (#.04) when creating this audit. A sample AUDIT COMMENT could be "Provider action required a hold".

¹ Patch MD*1.0*16 January 2011 File description added.

Package Default Definition

FILE #	NAME	UP DATE DD	SEND SEC. CODE	DATA COMES W/FILE	SITE DATA	RSLV PTS	USER OVER RIDE
702	CP TRANSACTION	YES	YES	NO			
¹ 702.001	CP_TRANSACTION_TIU_HISTORY	YES	YES	NO			
702.01	CP DEFINITION	YES	YES	NO			
702.09	CP INSTRUMENT	YES	YES	YES	ADD	NO	NO
703.1	CP RESULT REPORT	YES	YES	NO			
² 703.9	CP CONVERSION	YES	YES	NO			
³ 704.001	CP_CONSOLE_ACL	YES	YES	NO			
704.002	CP_HL7_LOG	YES	YES	NO			
704.004	CP_HL7_LOG_REASON	YES	YES	NO			
704.005	CP_MOVEMENT_AUDIT	YES	YES	NO			
704.006	CP_PROTOCOL_LOCATION	YES	YES	NO			
704.007	CP_SHIFT	YES	YES	NO			
704.008	CP_SCHEDULE	YES	YES	NO			
704.101	TERM	YES	YES	NO			
704.102	TERM_TYPE	YES	YES	YES	REPL	NO	NO
704.103	TERM_QUALIFIER_PAIR	YES	YES	NO			
704.104	TERM_UNIT_CONVERSION	YES	YES	NO			
704.105	TERM_UNIT_PAIR	YES	YES	NO			
704.106	TERM_CHILD_PAIR	YES	YES	NO			
704.107	TERM_RANGE_CHECK	YES	YES	NO			
704.108	TERM_MAPPING_TABLE	YES	YES	NO			
704.109	TERM_MAPPING_PAIR	YES	YES	NO			
704.111	OBS_VIEW	YES	YES	NO			
704.1111	OBS_VIEW_TERMINOLOGY	YES	YES	NO			
704.1112	OBS_VIEW_FILTER	YES	YES	NO			
704.112	OBS_FLOWSHEET	YES	YES	NO			
704.1121	OBS_FLOWSHEET_PAGE	YES	YES	NO			
704.1122	OBS_FLOWSHEET_SUPP_PAGE	YES	YES	NO			
704.1123	OBS_FLOWSHEET_TOTAL	YES	YES	NO			
704.113	OBS_TOTAL	YES	YES	NO			
704.1131	OBS_TOTAL_TERMINOLOGY	YES	YES	NO			
704.115	OBS_ALARM	YES	YES	NO			
704.116	OBS_SET	YES	YES	NO			
704.1161	OBS_SET_OBS_PAIR	YES	YES	NO			
704.117	OBS	YES	YES	NO			
704.118	OBS_QUALIFIER	YES	YES	NO			
704.119	OBS_AUDIT	YES	YES	NO			
704.121	CP_KARDEX_ACTION	YES	YES	NO			
704.1211	CP_KARDEX_EVENTS	YES	YES	NO			
704.1212	CP_KARDEX_AUDIT	YES	YES	NO			
704.201	HEMODIALYSIS ACCESS POINTS	YES	YES	NO			
704.202	HEMODIALYSIS STUDY	YES	YES	NO			
704.209	HEMODIALYSIS SETTINGS	YES	YES	NO			

¹Patch MD*1.0*6 May 2008 Default definitions added for 702.001, 704.201, 704.202, and 704.209.

²Patch MD*1.0*5 August 2006 Default definitions added for 703.9.

³ Patch MD*1.0*16 January 2011 Default definitions added for 704,001 - 704.1212.

6. Exported Options

Delphi Components

Clinical Procedures uses RPC Broker and custom Delphi Components in the display and navigation of screens. Below is a list of the Delphi components this application currently uses along with a short description.

TMDRecordSource = class(TComponent)

This is the primary component that all others interact with. This component represents a record within FileMan via the Data Dictionary Number and the IEN. In the event that the record is a sub-file then this component will point to another TMDRecordSource that represents the parent record of the sub-record. There is no limit to the number of sub-records that can be linked together.

TMDEdit = Class(TEdit)

This component is designed to manage FileMan Free-Text and Numeric type fields. Other types may be used here with the exception of word-processing but they will require exact data input (i.e. non-ambiguous entries must be entered in the case of pointers or set of codes types). All input and output transforms are applied to the field on validation.

TMDEditPointer = Class(TComboBox)

This component is designed to manage FileMan Pointer types. This component currently handles screens via hard coded screens on the server side in routine MDRPCOR.

TMDLabel = Class(TLabel)

This component is a static component that can display one of three data elements for a FileMan field. These are 1) Data value 2) Field Title or 3) Field Help Text. There is no server update associated with this component.

TMDMemo = Class(TMemo)

This component manages FileMan word-processing data types only. It will validate the data upon leaving the component.

TMDComboBox = Class(TComboBox)

This component was designed for either set of codes or pointer type fields. If using a pointer type field the developer must be aware that the entire pointed to file will be retrieved so large files such as the Patient file (#2) is not possible to represent with this component. Files such as the State file (#5) are handled quite well if there are approximately 100 or less entries and the pointed to file does not have complex output transforms on the .01 field.

TMDRadioGroup = Class(TRadioGroup)

This field was designed specifically for the FileMan set of codes field. It loads the appropriate codes into the radio group and displays the 'Stands For' portion of the codes while storing to the database the internal value of the code.

TMDCheckBox = Class(TCheckBox)

This component was designed for a set of codes that are restricted to only two codes (i.e. Yes/No, True/False, On/Off).

Remote Procedure Calls (RPC)

NAME: MD GATEWAY TAG: RPC
 ROUTINE: MDRPCOG RETURN VALUE TYPE: GLOBAL ARRAY
 AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE
 VERSION: 1

NAME: MD TMDOUTPUT TAG: RPC
 ROUTINE: MDRPCOG RETURN VALUE TYPE: GLOBAL ARRAY
 AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE
 DESCRIPTION:
 Manages the output of VistA data to the client via the default HFS device.
 INPUT PARAMETER: OPTION PARAMETER TYPE: LITERAL
 MAXIMUM DATA LENGTH: 30 REQUIRED: YES
 SEQUENCE NUMBER: 1
 DESCRIPTION:
 Currently set to EXECUTE as the only option.
 INPUT PARAMETER: RTN PARAMETER TYPE: LITERAL
 MAXIMUM DATA LENGTH: 30 REQUIRED: YES
 SEQUENCE NUMBER: 2
 DESCRIPTION:
 Contains the routine to produce the output. Currently to client produces
 this parameter in the form of TAG^ROUTINE(needed parameters) to simplify
 the calling process.
 RETURN PARAMETER DESCRIPTION:
 Text of the requested report.

NAME: MD TMDPARAMETER TAG: RPC
 ROUTINE: MDRPCOV RETURN VALUE TYPE: GLOBAL ARRAY
 AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE
 DESCRIPTION:
 Used to set/retrieve/modify parameters in the Kernel ToolKit PARAMETERS
 (XPAR) files.

RPC is called as follows:

Param[0] := OPTION
 Param[1] := Entity
 Param[2] := Parameter name
 Param[3] := Instance
 Param[4] := Value

INPUT PARAMETER: OPTION PARAMETER TYPE: LITERAL
 MAXIMUM DATA LENGTH: 10 REQUIRED: YES
 SEQUENCE NUMBER: 1
 DESCRIPTION:
 Contains the option for the RPC. RPC is called as shown:

Options and other required parameters include:

ENTVAL ENT
 GETPAR ENT, PAR, INST
 GETLST ENT, PAR
 GETWP ENT, PAR, INST
 SETPAR ENT, PAR, INST, VAL
 SETLST ENT, PAR, , .VAL (Uses instance 0-n)
 SETWP ENT, PAR, INST, .VAL

Exported Options

```
DELPAR      ENT,PAR,INST
DELLST      ENT,PAR
INPUT PARAMETER: ENTITY          PARAMETER TYPE: LITERAL
  MAXIMUM DATA LENGTH: 20      REQUIRED: NO
  SEQUENCE NUMBER: 2
```

DESCRIPTION:

An entity is a level at which you can define a parameter. The entities allowed are stored in the Parameter Entity file (#8989.518). The list of allowable entities at the time this utility was released were:

Prefix	Message	Points to File
PKG	Package	Package (9.4)
SYS	System	Domain (4.2)
DIV	Division	Institution (4)
SRV	Service	Service/Section (49)
LOC	Location	Hospital Location (44)
TEA	Team	Team (404.51)
CLS	Class	Usr Class (8930)
USR	User	New Person (200)
BED	Room-Bed	Room-Bed (405.4)
OTL	Team (OE/RR)	OE/RR List (101.21)

The entity may be referenced as follows:

- 1) The internal variable pointer (nnn;GLO(123,))
- 2) The external format of the variable pointer using the 3 character prefix (prefix.entryname)
- 3) The prefix alone to set the parameter based on current entity selected. (prefix)

Method 3 uses the following values for the following entities:

```
USR      Current value of DUZ
DIV      Current value of DUZ(2)
SYS      System (domain)
PKG      Package to which the parameter belongs
INPUT PARAMETER: PAR          PARAMETER TYPE: LITERAL
  MAXIMUM DATA LENGTH: 30    REQUIRED: NO
  SEQUENCE NUMBER: 3
```

DESCRIPTION:

A parameter is the actual name which values are stored under. The name of the parameter must be namespaced and it must be unique. Parameters can be defined to store the typical package parameter data (e.g. the default add order screen), but they can also be used to store GUI application screen settings a user has selected (e.g. font or window width). When a parameter is defined, the entities, which may set that parameter, are also defined. The definition of parameters is stored in the PARAMETER DEFINITION file (#8989.51).

NOTE: This utility restricts the parameter name to those in the Clinical Procedures namespace (MD*).

```
INPUT PARAMETER: INST          PARAMETER TYPE: LITERAL
  MAXIMUM DATA LENGTH: 30    REQUIRED: NO
  SEQUENCE NUMBER: 4
```

DESCRIPTION:

Most parameters will set instance to 1. Instances are used when more than one value may be assigned to a given entity/parameter combination. An example of this would be lab collection times at a division. A single division may have multiple collection times. Each collection time would be assigned a unique instance.

```
INPUT PARAMETER: VAL          PARAMETER TYPE: LITERAL
  MAXIMUM DATA LENGTH: 80    REQUIRED: NO
```

SEQUENCE NUMBER: 5
 DESCRIPTION:
 A value may be assigned to every parameter for the entities allowed in the parameter definition. Values are stored in the PARAMETERS file (#8989.5). VAL may be passed in external or internal format. If using internal format for a pointer type parameter, VAL must be preceded with the grave (`) character. If VAL is being assigned to a word processing parameter, the text is passed in the subordinate nodes of VAL (e.g. VAL(0-n)=Text).
 RETURN PARAMETER DESCRIPTION:
 Returns requested data from the specified option.

NAME: **MD TMDPATIENT** TAG: RPC
 ROUTINE: MDRPCOP RETURN VALUE TYPE: GLOBAL ARRAY
 AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE

NAME: **MD TMDPROCEDURE** TAG: RPC
 ROUTINE: MDRPCOD RETURN VALUE TYPE: GLOBAL ARRAY
 AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE

NAME: **MD TMDRECORDID** TAG: RPC
 ROUTINE: MDRPCOR RETURN VALUE TYPE: GLOBAL ARRAY
 AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE
 DESCRIPTION:
 General RPC for VA Fileman functions.

Param 1 is passed in as the function to perform and includes the following:

LOOKUP: Performs very generic file lookup functionality
 VALIDATE: Validates input to a fileman field and saves to FDA
 DELREC: Validates ability to delete and if able deletes a record
 SETFDA: Validates input and stores in FDA
 SAVEFDA: Saves any data stored in FDA
 CLEARFDA: Clears any data in the FDA without saving
 GETDATA: Retrieves a single field value
 GETCODES: Retrieves the set of codes for a field
 GETLABEL: Retrieves a fields TITLE or LABEL if no Title
 GETIDS: Returns required identifiers for a DD Number
 GETHELP: Returns Fileman help for a field
 RENAME: Validates and renames .01 field if valid
 NEWREC: Creates a new record
 CHANGES: Returns 0/1 if changes exist in FDA
 CHKVER: Version check Client <-> Server
 LOCK: Locks a record by DD and IENS
 UNLOCK: Unlocks record locked by LOCK option

INPUT PARAMETER: OPTION PARAMETER TYPE: LITERAL
 MAXIMUM DATA LENGTH: 30 REQUIRED: YES
 SEQUENCE NUMBER: 1
 DESCRIPTION:
 See description of RPC.

INPUT PARAMETER: DDNUM PARAMETER TYPE: LITERAL
 MAXIMUM DATA LENGTH: 10 REQUIRED: NO
 SEQUENCE NUMBER: 2
 DESCRIPTION:
 Contains the Data Dictionary number of the item being manipulated.

INPUT PARAMETER: IENS PARAMETER TYPE: LITERAL
 MAXIMUM DATA LENGTH: 20 REQUIRED: NO


```

Input Parameter: RESULTS - (Both Input/Output) Passed in as the array to
                    return the results.
                    OPTION - (Input) PROC - obtain a list of Procedures
                                defined for a clinic.
                                DIAG - obtain a list of diagnosis
                                defined for a clinic.
                                SCDISP - Obtain the patient's service
                                connection and rated
disability.
                    DFN - (Input) Patient internal entry number
                    MDSTUD - (Input) CP Study internal entry number
RETURN PARAMETER DESCRIPTION:
> D RPC^MDRPCW(.RESULTS, "PROC", 162, 212)

> ZW RESULTS
RESULTS=^TMP("MDRPCW", 539023945)

@RESULTS@(0)=count of array element (0 if nothing found)
@RESULTS@(1)=^group header
@RESULTS@(2) = P1 := cpt or icd code / ien of other items
                P2 := user defined text
                P6 := user defined expanded text to send to PCE
                P7 := second code or item defined for line item
                P8 := third code or item defined for line item
                P9 := associated clinical lexicon term

> D ^%G

Global ^TMP("MDRPCW", $J
        TMP("MDRPCW", $J

^TMP("MDRPCW", 539023945, 0) = 7
^TMP("MDRPCW", 539023945, 1) = ^PFT PROCEDURES
^TMP("MDRPCW", 539023945, 2) = G0125^Lung image (PET) ^^^^^^^
^TMP("MDRPCW", 539023945, 3) = S9473^Pulmonary rehabilitation pro^^^^^^
^TMP("MDRPCW", 539023945, 4) = S2060^Lobar lung transplantation ^^^^^^^
^TMP("MDRPCW", 539023945, 5) = S2060^Lobar lung transplantation ^^^^^^^
^TMP("MDRPCW", 539023945, 6) = A4480^Vabra aspirator ^^^^^^^
^TMP("MDRPCW", 539023945, 7) = 43450^DILAT ESOPH-SOUND/BOUGIE-1/M^^^^^^
Global ^

> D RPC^MDRPCW(.RESULTS, "DIAG", 162, 212)

> D ^%G

Global ^TMP("MDRPCW", $J
        TMP("MDRPCW", $J

^TMP("MDRPCW", 539023945, 0) = 31
^TMP("MDRPCW", 539023945, 1) = ^PFT
^TMP("MDRPCW", 539023945, 2) = 397.1^RHEUM PULMON VALVE DIS^^^^^^269587
^TMP("MDRPCW", 539023945, 3) = 417.1^PULMON ARTERY ANEURYSM^^^^^^269688
^TMP("MDRPCW", 539023945, 4) = 417.8^PULMON CIRCULAT DIS NEC^^^^^^269690
^TMP("MDRPCW", 539023945, 5) = 417.9^PULMON CIRCULAT DIS NOS^^^^^^269691
^TMP("MDRPCW", 539023945, 6) = 424.3^PULMONARY VALVE DISORDER^^^^^^101164
^TMP("MDRPCW", 539023945, 7) = 516.1^IDIO PULM HEMOSIDEROSIS^^^^^^61083
^TMP("MDRPCW", 539023945, 8) = 746.01^CONG PULMON VALV ATRESIA^^^^^^265805
^TMP("MDRPCW", 539023945, 9) = 673.82^PULM EMBOL NEC-DEL W P/P^^^^^^271756
^TMP("MDRPCW", 539023945, 10) = 747.3^PULMONARY ARTERY ANOM^^^^^^27406
^TMP("MDRPCW", 539023945, 11) = 770.3^NB PULMONARY HEMORRHAGE^^^^^^273240
^TMP("MDRPCW", 539023945, 12) = 794.2^ABN PULMONARY FUNC STUDY^^^^^^273442

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Exported Options

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^TMP ("MDRPCW", 539023945, 13) = 901.41^INJURY PULMONARY
ARTERY^^^^^901.42^^275136
^TMP ("MDRPCW", 539023945, 14) = 162.3^MAL NEO UPPER LOBE
LUNG^^^^^162.4^162.5^73534
^TMP ("MDRPCW", 539023945, 15) = 235.7^UNC BEHAV NEO LUNG^^^^^^267754
^TMP ("MDRPCW", 539023945, 16) = 875.0^OPEN WOUND OF CHEST^^^^^^274991
^TMP ("MDRPCW", 539023945, 17) = 162.9^MAL NEO BRONCH/LUNG NOS^^^^^^73521
^TMP ("MDRPCW", 539023945, 18) = 786.6^CHEST SWELLING/MASS/LUMP^^^^^^273380
^TMP ("MDRPCW", 539023945, 19) = 518.89^OTHER DISEASE OF LUNG, NEC^^^^^^87486
^TMP ("MDRPCW", 539023945, 20) = ^BRONCHOSCOPY
^TMP ("MDRPCW", 539023945, 21) = 012.20^ISOL TRACHEAL TB-
UNSPEC^^^^^012.21^^266107
^TMP ("MDRPCW", 539023945, 22) = 012.22^ISOL TRACH TB-EXAM UNKN^^^^^^266109
^TMP ("MDRPCW", 539023945, 23) = 012.23^ISOLAT TRACH TB-MICRO DX^^^^^^266110
^TMP ("MDRPCW", 539023945, 24) = 012.24^ISOL TRACHEAL TB-CULT DX^^^^^^266111
^TMP ("MDRPCW", 539023945, 25) = 748.61^CONGEN BRONCHIECTASIS^^^^^^265478
^TMP ("MDRPCW", 539023945, 26) = 011.50^TB BRONCHIECTASIS-
UNSPEC^^^^^011.51^^266056
^TMP ("MDRPCW", 539023945, 27) = 784.1^THROAT PAIN^^^^^^276881
^TMP ("MDRPCW", 539023945, 28) = 784.8^HEMORRHAGE FROM THROAT^^^^^^273371
^TMP ("MDRPCW", 539023945, 29) = 034.0^STREP SORE THROAT^^^^^^114610
^TMP ("MDRPCW", 539023945, 30) = 466.11^AC. BRONCH/RESP SYNCYT V
(RSV)^^^^^466.19^
^304309
^TMP ("MDRPCW", 539023945, 31) = 530.10^ESOPHAGITIS, UNSP.^^^^^^295809
Global ^

> D RPC^MDRPCW(.RESULTS, "SCDISP", 17, 212)

    @RESULTS@(n)="Lines of text"

> D ^%G

Global ^TMP ("MDRPCW", $J
    TMP ("MDRPCW", $J
^TMP ("MDRPCW", 539023945, 1) = Service Connected: 50%
^TMP ("MDRPCW", 539023945, 2) = Rated Disabilities: NONE STATED
Global ^

NAME: MD TMDENCOUNTER                                TAG: GETENC
ROUTINE: MDRPCW1                                        RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: RESTRICTED                               WORD WRAP ON: TRUE
VERSION: 1
DESCRIPTION:
This remote procedure will return the existing data in an encounter.
INPUT PARAMETER: STUDY                                PARAMETER TYPE: REFERENCE
REQUIRED: YES                                         SEQUENCE NUMBER: 1
DESCRIPTION:
This is the CP Study internal entry number.
RETURN PARAMETER DESCRIPTION:
The result is returned in ^TMP("MDENC", $J) global.

^TMP ("MDENC", $J, 1) = "SC"; 0/1^0/1; "AO"; 0/1^0/1; "IR"; 0/1^0/1; "EC"; 0/1^0/
1; "MST"; 0/1^0/1; "HNC"; 0/1^0/1; "CV"; 0/1^0/1
P1 = "SC" - Service Connected
P2 = first "^" piece 1 if the condition can be answered
    0 if the condition should be null not asked
    second "^" piece - If Scheduling has the answer, 1 = yes 0 = no
P3 = "AO" - Agent Orange Exposure

```


P4 = first "^" piece 1 if the condition can be answered
 0 if the condition should be null not asked
 second "^" piece - If Scheduling has the answer, 1 = yes 0 = no
 P5 = "IR" - Ionizing Radiation Exposure
 P6 = first "^" piece 1 if the condition can be answered
 0 if the condition should be null not asked
 second "^" piece - If Scheduling has the answer, 1 = yes 0 = no
 P7 = "EC" - Environmental Contaminants
 P8 = first "^" piece 1 if the condition can be answered
 0 if the condition should be null not asked
 second "^" piece - If Scheduling has the answer, 1 = yes 0 = no
 P9 = "HNC" - Head and/or Neck Cancer
 P10 = first "^" piece 1 if the condition can be answered
 0 if the condition should be null not asked
 second "^" piece - If Scheduling has the answer, 1 = yes 0 = no
 P11 = "MST" - Military Sexual Trauma
 P12 = first "^" piece 1 if the condition can be answered
 0 if the condition should be null not asked
 second "^" piece - If Scheduling has the answer, 1 = yes 0 = no
 P13 = "CV" - Combat Veteran
 P14 = first "^" piece 1 if the condition can be answered
 0 if the condition should be null not asked
 second "^" piece - If Scheduling has the answer, 1 = yes 0 = no

^TMP("MDENC",\$J,n)="PRV"^CODE^^NARR^^Primary (1=Yes,0=No)

P1 = "PRV"- Provider segment
 P2 = CODE - New Person internal Entry Number
 P3 = Null
 P4 = NARR - Provider name
 P5 = Null
 P6 = Primary - 1/0/null (1=Yes,0/Null=No)

 ="POV"^ICD9 IEN^ICD9 CODE^provider narrative category^
 provider narrative (Short Description)^Primary (1=Yes,0/Null=No)

P1 = "POV" - ICD segment
 P2 = ICD internal entry number
 P3 = ICD9 Code
 P4 = Provider Narrative Category
 P5 = Short Description
 P6 = Primary - 1/0/null (1=Yes,0/Null=No)

 ="CPT"^CPT IEN^CPT CODE^provider narrative category^
 provider narrative (Short Description)^^Quantity

P1 = "CPT" - CPT segment
 P2 = CPT internal entry number
 P3 = CPT Code
 P4 = Provider Narrative Category (CPT Category Grouping)
 P5 = Short Description
 P6 = null
 P7 = Quantity

NAME: **MD TMDLEX**

TAG: LEX

ROUTINE: MDRPCW1

RETURN VALUE TYPE: GLOBAL ARRAY

AVAILABILITY: RESTRICTED

WORD WRAP ON: TRUE

VERSION: 1

DESCRIPTION:

This RPC will return a list of CPT or ICD for a search typed in.

INPUT PARAMETER: MDSRCH

PARAMETER TYPE: REFERENCE

Exported Options

```
    REQUIRED: YES                               SEQUENCE NUMBER: 1
DESCRIPTION:
This is the text typed in for the look-up.
INPUT PARAMETER: MDAPP                         PARAMETER TYPE: REFERENCE
    REQUIRED: YES                               SEQUENCE NUMBER: 2
DESCRIPTION:
This is the application indicator.  It is either "CPT" or "ICD".
RETURN PARAMETER DESCRIPTION:

^TMP("MDLEX", $J, #)=P1 - CPT/ICD Code
                        P2 - Internal Entry Number
                        P3 - Lexicon text

>D LEX^MDRPCW1(.RESULTS, "BORE", "CPT")

>ZW RESULTS
RESULTS="^TMP("MDLEX", 539152953) "

>D ^%G

Global ^TMP("MDLEX", $J -- NOTE: translation in effect
^TMP("MDLEX", 539152953, 1)=86618^302213^Borella Burgdorferi (Lyme Disease)
Antibody (CP T-4 86618)

NAME: MD TMDNOTE                            TAG: RPC
ROUTINE: MDRPCNT                               RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: RESTRICTED                       INACTIVE: ACTIVE
WORD WRAP ON: TRUE                             VERSION: 1
DESCRIPTION:
This remote procedure call does the following:
Accepts the following Inputs:
    RESULTS - Both (Input and Output) - Passed in as the array to return
              results in.

    OPTION - NEWDOC = Add additional new document to the Hemodialysis
              study.

    NOTELIST = Returns a list of documents associated with the
              study.  The pieces returned are: Note IEN, Note
              title, Date/Time Creation, Author, and Hospital
              Location.

    VIEWTIU = Return the text lines of a document from NOTELST.

MDSID - Study internal Entry Number.
MDTIU - TIU Document Internal Entry Number.
MDDTE - Date/Time of Document Creation.
MDAUTH - Author of document.
MDESIG - Encrypted Electronic Signature.
MDTXT - Text of the new document in an array.

Return Results are the following:
```

```

OPTION = NEWDOC

> D RPC^MDRPCNT(.RESULTS,"NEWDOC",904,"",3050524.0915,679,74RHLld;flk,MDTXT)

> D ^%G

Global ^TMP("MDKUTL",$J
      TMP("MDKUTL",$J
^TMP("MDKUTL",538992716,0) = Note internal entry number    or -1^Error Message

OPTION = NOTELIST

> D RPC^MDRPCNT(.RESULTS,"NOTELST",476)

> D ^%G

Global ^TMP("MDKUTL",$J
      TMP("MDKUTL",$J
^TMP("MDKUTL",538992716,1) = 968^PROCEDURE NOTE^OCT 10, 2001@17:08:36
^MDPROVIDER,ONE ^PROSTHETICS
^TMP("MDKUTL",538992716,2) = 969^PROCEDURE NOTE^OCT 10,
2001@17:10:44^^PROSTHET
I
CS
^TMP("MDKUTL",538992716,3) = 970^PROCEDURE NOTE^OCT 10,
2001@17:11:50^^PROSTHET
I
CS
^TMP("MDKUTL",538992716,4) = 971^PROCEDURE NOTE^OCT 10,
2001@17:15:45^^PROSTHET
I
CS
^TMP("MDKUTL",538992716,5) = 972^PROCEDURE NOTE^OCT 10,
2001@17:16:34^^PROSTHET
I
CS
^TMP("MDKUTL",538992716,6) = 974^PROCEDURE NOTE^OCT 11,
2001@10:56:03^^PROSTHET
I
CS
^TMP("MDKUTL",538992716,7) = 975^PROCEDURE NOTE^OCT 11,
2001@12:50:29^^PROSTHET
I
CS
Global ^

OPTION = VIEWTIU

> D RPC^MDRPCNT(.RESULTS,"VIEWTIU",476,968)

> D ^%G

Global ^TMP("TIUVIEW",$J
      TMP("TIUVIEW",$J
^TMP("TIUVIEW",538992716,1) =          TITLE: PROCEDURE NOTE

^TMP("TIUVIEW",538992716,2) = DATE OF NOTE: OCT 10, 2001@17:08:36  ENTRY
DATE:
O

```

Exported Options

```
CT 10, 2001@17:08:36
^TMP("TIUVIEW",538992716,3) =          AUTHOR: MDPROVIDER,ONE   EXP COSIGNER:
^TMP("TIUVIEW",538992716,4) =          URGENCY:
STATUS:
```

COMPLETED

```
^TMP("TIUVIEW",538992716,5) =
^TMP("TIUVIEW",538992716,6) = PROCEDURE SUMMARY CODE: Abnormal

^TMP("TIUVIEW",538992716,7) = DATE/TIME PERFORMED: OCT 15, 2001
^TMP("TIUVIEW",538992716,8) =
^TMP("TIUVIEW",538992716,9) =          *** PROCEDURE NOTE Has ADDENDA ***
^TMP("TIUVIEW",538992716,10) =
^TMP("TIUVIEW",538992716,11) = Complete consult 1104. 6 attached images.
^TMP("TIUVIEW",538992716,12) =
^TMP("TIUVIEW",538992716,13) = /es/ MDPROVIDER,ONE
^TMP("TIUVIEW",538992716,14) =
^TMP("TIUVIEW",538992716,15) = Signed: 10/15/2001 13:02
^TMP("TIUVIEW",538992716,16) =
^TMP("TIUVIEW",538992716,17) = 10/15/2001 ADDENDUM
STATUS:
```

COMPLETED

```
^TMP("TIUVIEW",538992716,18) = aDDENDUM LA LA LA
^TMP("TIUVIEW",538992716,19) = LA LA LA
^TMP("TIUVIEW",538992716,20) =
^TMP("TIUVIEW",538992716,21) = /es/ MDPROVIDER,ONE
^TMP("TIUVIEW",538992716,22) =
^TMP("TIUVIEW",538992716,23) = Signed: 10/15/2001 13:04
```

```
NAME: MD TMDSUBMITU          TAG: RPC
ROUTINE: MDRPCOWU           RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: RESTRICTED   WORD WRAP ON: TRUE
VERSION: 1
```

```
NAME: MD TMDWIDGET         TAG: RPC
ROUTINE: MDRPCOW           RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: RESTRICTED   WORD WRAP ON: TRUE
VERSION: 1
```

```
NAME: MDK GET VISTA DATA   TAG: RPC
ROUTINE: MDKRPC1          RETURN VALUE TYPE: ARRAY
AVAILABILITY: RESTRICTED  INACTIVE: ACTIVE
INPUT PARAMETER: OPTION   PARAMETER TYPE: LITERAL
MAXIMUM DATA LENGTH: 8   REQUIRED: YES
SEQUENCE NUMBER: 1
DESCRIPTION:
This is the routine tag that will be called to retrieve the data.
INPUT PARAMETER: DATA    PARAMETER TYPE: LITERAL
MAXIMUM DATA LENGTH: 50  REQUIRED: YES
SEQUENCE NUMBER: 2
DESCRIPTION:
This is whatever data is needed by the subroutine to process the request
for data. In many cases it will be a single value (e.g., patient id -
DFN).
```

RETURN PARAMETER DESCRIPTION:
Returns an array.

RESULT(0)=number or
RESULT(0)=-1^error message
RESULT(1)=data
RESULT(n)=data

If data is not found, RESULT(0) will be contain a "-1" in the first piece and an error message in the second piece.

If data is found, RESULT(0) will contain a number that indicates how many entries are returned.

RESULT(1) through RESULT(n) will contain the data that is found.

NAME: **MDK GET/SET RENAL DATA** TAG: RPC
ROUTINE: MDKRPC2 RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE

NAME: **MDK UTILITY** TAG: RPC
ROUTINE: MDKUTLR RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: RESTRICTED WORD WRAP ON: TRUE

¹NAME: **MDCLIO** TAG: RPC
ROUTINE: MDCLIO RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: PUBLIC WORD WRAP ON: TRUE
DESCRIPTION:
This is the primary RPC called by the CliO engine for normal command processing.

NAME: **MDCP CORRECTIONS BY IEN** TAG: GETCORR
ROUTINE: MDCPHL7B RETURN VALUE TYPE: ARRAY
AVAILABILITY: SUBSCRIPTION INACTIVE: ACTIVE
WORD WRAP ON: TRUE
DESCRIPTION:
Gets a list of corrections for a given HL7 message.
INPUT PARAMETER: MDCPMSG PARAMETER TYPE: LITERAL
REQUIRED: YES SEQUENCE NUMBER: 1
DESCRIPTION:
The IEN of the message in file 703.1 (the CP REPORT RESULTS file).
RETURN PARAMETER DESCRIPTION:
Returns a global array in the format:

Correction Type IEN^Uncorrected Value^Corrected Value

NAME: **MDCP MESSAGE BY IEN** TAG: GETMSG
ROUTINE: MDCPHL7B RETURN VALUE TYPE: GLOBAL ARRAY
AVAILABILITY: SUBSCRIPTION WORD WRAP ON: TRUE
VERSION: 1
DESCRIPTION:
This RPC returns an HL7 message based on its IEN.
INPUT PARAMETER: MDCPMSG PARAMETER TYPE: LITERAL

¹ Patch MD*1.0*16 January 2011 Added new remote procedure calls (RPCs).

INPUT PARAMETER: MDCPSTAT	PARAMETER TYPE: LITERAL
MAXIMUM DATA LENGTH: 1	REQUIRED: YES
SEQUENCE NUMBER: 2	
DESCRIPTION:	
The status to which to change the file entry referenced by the first parameter. Check the data dictionary for field .09 to get a list of valid codes. This parameter must be in internal format.	
INPUT PARAMETER: MDCPDFN	PARAMETER TYPE: LITERAL
REQUIRED: NO	SEQUENCE NUMBER: 3
DESCRIPTION:	
This is the IFN of the patient in file 2, if available.	
INPUT PARAMETER: MDCPISCR	PARAMETER TYPE: LITERAL
REQUIRED: NO	SEQUENCE NUMBER: 4
DESCRIPTION:	
If MDCPDFN is set, this tells the linetag that MDCPDFN is a correction, not the original DFN.	
RETURN PARAMETER DESCRIPTION:	
Returns a local variable containing the results of the status update in DIALOG format.	

Parameter Definitions

NAME: MD ALLOW EXTERNAL ATTACHMENTS

DISPLAY TEXT: Allow non-instrument attachments

MULTIPLE VALUED: No

VALUE TERM: Allowed

VALUE DATA TYPE: yes/no

DESCRIPTION:

Set this value to Yes to allow users of CUser.exe to attach documents to the transaction that are not created by an instrument.

PRECEDENCE: 1

ENTITY FILE: SYSTEM

¹**NAME: MD APPOINT END DATE**

DISPLAY TEXT: End Date for Encounter Appointments

MULTIPLE VALUED: No

VALUE TERM: Days

VALUE DATA TYPE: numeric

VALUE DOMAIN: 0:365

VALUE HELP: Enter a number from 0 to 365.

DESCRIPTION:

Enter a number from 0 to 365 for the number of days that will be used to add to today as the end date range of the Encounter Appointments. If no value is entered, the default value used will be 0.

PRECEDENCE: 1

ENTITY FILE: SYSTEM

NAME: MD APPOINT START DATE

DISPLAY TEXT: Start Date for Encounter Appointments

MULTIPLE VALUED: No

VALUE TERM: Days

VALUE DATA TYPE: numeric

VALUE DOMAIN: 0:365

VALUE HELP: Enter a number from 0 to 365.

DESCRIPTION:

Enter a number from 0 to 365 for the number of days that will be used to subtract from today as the start date range of the Encounter Appointments. If no value is entered, the default value used will be 200.

PRECEDENCE: 1

ENTITY FILE: SYSTEM

NAME: MD COMPL PROC DISPLAY DAYS

DISPLAY TEXT: Completed Proc Display Days

MULTIPLE VALUED: No

VALUE TERM: Days

VALUE DATA TYPE: numeric

VALUE DOMAIN: 1:365

VALUE HELP: Enter the number of days from 1 to 365

DESCRIPTION:

The number of days the completed procedure requests will be displayed in the CP Check-in screen.

PRECEDENCE: 1

ENTITY FILE: SYSTEM

²**NAME: MD CHECK-IN PROCEDURE LIST**

DISPLAY TEXT: Check-in Procedure List

MULTIPLE VALUED: Yes

INSTANCE TERM: Procedure

VALUE TERM: Schedule Appointment?

VALUE DATA TYPE: set of codes

VALUE DOMAIN: 0:None;1:Outpatient;2:Inpatient;3:Both

VALUE HELP: Enter 0 for None, 1 for Outpatient, 2 for Inpatient, or 3 for both.

¹ Patch MD*1.0*6 May 2008 Parameter Definitions added.

² Patch MD*1.0*14 March 2008 Parameter Definitions added.

INSTANCE DATA TYPE: pointer
 INSTANCE DOMAIN: 702.01
 INSTANCE HELP: Enter procedures that needs the study to be auto checked-in.
 INSTANCE SCREEN CODE: I +\$P(^MDS(702.01,+Y,0),"^",9)>0
 DESCRIPTION:
 This parameter contains a list of procedures that will be used
 to auto check-in the CP studies during the procedures request in CPRS
 and whether appointments are scheduled for the procedure.
 PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: MD CLINIC QUICK LIST DISPLAY TEXT: Clinic Quick List For CP
 MULTIPLE VALUED: Yes INSTANCE TERM: Clinic
 VALUE TERM: Procedure VALUE DATA TYPE: pointer
 VALUE DOMAIN: 702.01
 VALUE HELP: Select a procedure for the clinic.
 INSTANCE DATA TYPE: pointer INSTANCE DOMAIN: 44
 INSTANCE HELP: Enter clinics that need CP studies to be checked-in.
 DESCRIPTION:
 List of clinics used as a source to get a list of patients
 that need to have CP studies checked-in. This only applies
 to studies with procedures that have multiple results such
 as Hemodialysis, Respiratory Therapy, and sleep studies.
 PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: MD CLINICS WITH MULT PROC
 DISPLAY TEXT: Clinics With Multiple Procedures
 MULTIPLE VALUED: Yes INSTANCE TERM: Procedure
 VALUE TERM: Clinic VALUE DATA TYPE: pointer
 VALUE DOMAIN: 44
 VALUE HELP: Enter a clinic for the procedure.
 INSTANCE DATA TYPE: pointer INSTANCE DOMAIN: 702.01
 INSTANCE HELP: Enter a procedure.
 INSTANCE SCREEN CODE: I +\$P(^MDS(702.01,+Y,0),"^",9)>0
 DESCRIPTION:
 If you have a clinic for multiple procedures, populate this
 parameter with the procedure and associate it to a clinic.
 PRECEDENCE: 1 ENTITY FILE: SYSTEM

¹**NAME: MD CLINIC ASSOCIATION** DISPLAY TEXT: MD Clinic Association
 MULTIPLE VALUED: Yes INSTANCE TERM: Sequence
 VALUE TERM: Clinic;Procedure Association Value
 PROHIBIT EDITING: No VALUE DATA TYPE: free text
 INSTANCE DATA TYPE: numeric INSTANCE DOMAIN: 1:9999
 INSTANCE HELP: Enter the sequence to associate a clinic and procedure.
 DESCRIPTION:
 This parameter is used to identify the clinic and procedure
 association. Each item should be entered with the following format

 Clinic internal entry number_";"_Procedure internal entry number
 PRECEDENCE: 1 ENTITY FILE: SYSTEM

²**NAME: MD COMMANDS** DISPLAY TEXT: CliO Commands
 MULTIPLE VALUED: Yes INSTANCE TERM: Command Name

¹ Patch MD*1.0*11 March 2009 Parameter Definition added

² Patch MD*1.0*16 January 2011 Parameter Definition added.

Exported Options

VALUE TERM: Command Text VALUE DATA TYPE: word processing
INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 1:250
DESCRIPTION:
This parameter holds all command scripts for the CliO DB engine to
process.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

¹NAME: **MD PARAMETERS** DISPLAY TEXT: CP Parameter settings
MULTIPLE VALUED: Yes INSTANCE TERM: Parameter Name
VALUE TERM: Parameter Value PROHIBIT EDITING: No
VALUE DATA TYPE: free text VALUE DOMAIN: 1:250
INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 1:250
DESCRIPTION:
This parameter holds all name value pairs for the configuration of
the CP/CliO system.
PRECEDENCE: 1 ENTITY FILE: SYSTEM
PRECEDENCE: 2 ENTITY FILE: DIVISION
PRECEDENCE: 3 ENTITY FILE: LOCATION
PRECEDENCE: 4 ENTITY FILE: USER

NAME: **MD CRC BYPASS** DISPLAY TEXT: Bypass CRC Checking
MULTIPLE VALUED: No VALUE TERM: Bypass CRC Checking
VALUE DATA TYPE: yes/no
DESCRIPTION:
Set this value to 'Yes' to prevent the client application from verifying
its CRC Value at startup.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: **MD CRC VALUES**
DISPLAY TEXT: Clinical Procedures CRC Values
MULTIPLE VALUED: Yes
INSTANCE TERM: Executable or Library Name
VALUE TERM: CRC Value PROHIBIT EDITING: No
VALUE DATA TYPE: free text VALUE DOMAIN: 1:15
INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 1:30
DESCRIPTION:
This parameter is used to store the CRC values for the most recent
versions of executable and libraries. Use the Tools menu on the CPManager
program to calculate the needed CRC Values of the current versions.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: **MD DAYS FOR INSTRUMENT DATA**
DISPLAY TEXT: Temporary instrument data life (Days)
MULTIPLE VALUED: No VALUE TERM: Days
PROHIBIT EDITING: No VALUE DATA TYPE: numeric
VALUE DOMAIN: 0:365
DESCRIPTION:
The number of days to keep data from the auto-instruments after
the data has been associated with a Clinical Procedures report.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

²NAME: **MD DAYS TO RETAIN COM STUDY**

¹ Patch MD*1.0*16 January 2011 Parameter Definition added.

² Patch MD*1.0*6 May 2008 Parameter Definition added.

DISPLAY TEXT: Days to Retain Completed Study
 MULTIPLE VALUED: No VALUE TERM: Days
 PROHIBIT EDITING: No VALUE DATA TYPE: numeric
 VALUE DOMAIN: 1:365
 VALUE HELP: Enter the number of days from 1 to 365

DESCRIPTION:

The number of days after check-in date/time to display the study that has been complete in the CPUser application. Studies that have procedures with multiple or cumulative results are NOT included. Cumulative and multiple results studies will have a default value of 365.

PRECEDENCE: 1 ENTITY FILE: SYSTEM

¹NAME: **MD DAYS TO RET COM MULT**

DISPLAY TEXT: Days to Retain Completed Multiple Study
 MULTIPLE VALUED: No VALUE TERM: Days
 VALUE DATA TYPE: numeric VALUE DOMAIN: 1:365
 VALUE HELP: Enter the number of days from 1 to 365

DESCRIPTION:

The number of days after check-in date/time to display the study that has been completed in the CPUser application. This only pertains to studies that have procedures with multiple studies.

PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: **MD DEVICE SURVEY TRANSMISSION** DISPLAY TEXT: Device Survey
 Transmission

MULTIPLE VALUED: No VALUE TERM: Yes/No
 PROHIBIT EDITING: No VALUE DATA TYPE: yes/no
 VALUE HELP: Enter 'Y' for 'YES' or 'N' for 'NO'.

DESCRIPTION:

Used to determine if the site wants to transmit the device survey to Hines. Enter 'Y' for 'YES' to send the survey or 'N' for 'NO' to suppress the transmission.

PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: **MD FILE EXTENSIONS** DISPLAY TEXT: Imaging File Types
 MULTIPLE VALUED: Yes INSTANCE TERM: Extension
 VALUE TERM: File type PROHIBIT EDITING: No
 VALUE DATA TYPE: free text VALUE DOMAIN: 1:80
 VALUE HELP: Enter a description of this file type
 INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 2:10
 INSTANCE HELP: Enter the extension of the file type with a '.'
 INSTANCE VALIDATION CODE: K:X'?1".".9ULN X

DESCRIPTION:

This parameter stores a list of valid file types and the associated extensions of these files.

PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: **MD GATEWAY** DISPLAY TEXT: CP Gateway Parameters
 MULTIPLE VALUED: Yes INSTANCE TERM: Parameter Name
 VALUE TERM: Parameter Value VALUE DATA TYPE: free text
 VALUE DOMAIN: 1:255 INSTANCE DATA TYPE: free text
 INSTANCE DOMAIN: 1:255
 PRECEDENCE: 1 ENTITY FILE: SYSTEM

¹ Patch MD*1.0*20 November 2010 Parameter Definitions Added.

Exported Options

¹NAME: **MD GET HIGH VOLUME** DISPLAY TEXT: Get High Volume
MULTIPLE VALUED: Yes INSTANCE TERM: Procedure
VALUE TERM: Get String VALUE DATA TYPE: free text
INSTANCE DATA TYPE: pointer INSTANCE DOMAIN: 702.01
INSTANCE HELP: Enter a high volume procedure.
INSTANCE SCREEN CODE: I
+\$P(^MDS(702.01,+Y,0),"^",6)'=2&(+\$P(^MDS(702.01,+Y,0)
, "^",11)'=2)&(\$P(^MDS(702.01,+Y,0),"^",9)>0)
DESCRIPTION:
This parameter will contain a free text string that contains two pieces
of data delimited by a semicolon ';'. The two pieces of data are: 1)
1/0 (Yes/No) to indicate whether or not the text of the result should be
added to the note, 2) 1/0 (Yes/No) to enter the text of the result as the
significant finding of the Consult. (If you enter a 0, the note will be
auto closed with the text inside.)
Example string: 1;0
PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: **MD HFS SCRATCH**
DISPLAY TEXT: Vista Scratch HFS Directory
MULTIPLE VALUED: No VALUE TERM: Directory name
VALUE DATA TYPE: free text VALUE DOMAIN: 1:250
VALUE HELP: Enter in an OS level directory
DESCRIPTION:
Contains the directory specification for the Kernel OPEN^%ZISH call. This
directory should be accessible for read/write operations by all CP users.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: **MD IMAGING XFER** DISPLAY TEXT: Imaging Network Share
MULTIPLE VALUED: No VALUE TERM: Imaging Network Share
VALUE DATA TYPE: free text VALUE DOMAIN: 1:250
DESCRIPTION:
This parameter contains the name of a network server, share, and path
(UNC) to a location where Clinical Procedures can put files for pick-up by
the Imaging background processor for archiving.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

² NAME: **MDK APPLICATION INSTALL** DISPLAY TEXT: MDK Application
Install
MULTIPLE VALUED: Yes
INSTANCE TERM: Installation Distribution Info
VALUE TERM: Distribution Info Value PROHIBIT EDITING: No
VALUE DATA TYPE: free text VALUE DOMAIN: 1:250
INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 1:250
DESCRIPTION:
This parameter is used to store the Hemodialysis application
distribution information. The information includes the following:
1) Date/Time when application first launched.
2) User Name
3) System Option Loaded (Y/N)
4) Workstation of where the application was launched.

¹ Patch MD*1.0*21 May 2010 Parameter Definition added.

² Patch MD*1.0*6 May 2008 Parameter Definition added.

PRECEDENCE: 1

ENTITY FILE: SYSTEM

NAME: MDK GUI VERSION

DISPLAY TEXT: Hemodialysis Version Compatibility

MULTIPLE VALUED: Yes INSTANCE TERM: Application:Version

VALUE TERM: Compatible with current server version

PROHIBIT EDITING: No VALUE DATA TYPE: yes/no

INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 1:40

DESCRIPTION:

This parameter is used to store the application:versions that are compatible with the current server version of Hemodialysis. Instance format of APPLICATION:VERSION (example: HEMODIALYSIS.EXE:0.0.0.0).

PRECEDENCE: 1

ENTITY FILE: SYSTEM

¹NAME: **MD MEDICINE CONVERTED**

DISPLAY TEXT: Medicine Package

Converted

MULTIPLE VALUED: No VALUE TERM: Yes/No

PROHIBIT EDITING: No VALUE DATA TYPE: yes/no

DESCRIPTION:

Used to determine if the Medicine Package has been converted.

PRECEDENCE: 1

ENTITY FILE: SYSTEM

²NAME: **MD NOT ADMN CLOSE MUSE NOTE**

DISPLAY TEXT: NOT ADMN Close Muse

Note

MULTIPLE VALUED: No VALUE TERM: Yes/No

PROHIBIT EDITING: No VALUE DATA TYPE: yes/no

DESCRIPTION:

This parameter is used to indicate the note should not be administratively closed with the proxy user CLINICAL, DEVICE PROXY SERVICE but the interpreter of the procedure for the MUSE device. The default is "No".

PRECEDENCE: 1

ENTITY FILE: SYSTEM

NAME: **MD OFFLINE MESSAGE**

DISPLAY TEXT: Offline message

MULTIPLE VALUED: No VALUE TERM: Offline Message

VALUE DATA TYPE: word processing

DESCRIPTION:

This parameter contains a message to display to the users when the Clinical Procedures application is offline.

PRECEDENCE: 1

ENTITY FILE: SYSTEM

³NAME: **MD OLYMPUS 7**

DISPLAY TEXT: MD OLYMPUS 7

MULTIPLE VALUED: No VALUE TERM: Yes/No

PROHIBIT EDITING: No VALUE DATA TYPE: yes/no

VALUE HELP: Enter Yes/No whether you have Olympus version 7.3.7.

DESCRIPTION:

This parameter definition indicates whether the Olympus device is version 7.3.7. The value is Yes/No. The default value is "No".

PRECEDENCE: 1

ENTITY FILE: SYSTEM

¹ Patch MD*1.0*5 August 2006 Parameter Definition added.² Patch MD*1.0*21 May 2010 Parameter Definition added.³ Patch MD*1.0*11 March 2009 Parameter Definitions added.

Exported Options

NAME: MD ONLINE

DISPLAY TEXT: Clinical Procedure Online/Offline
MULTIPLE VALUED: No
VALUE TERM: Is Clinical Procedures Online
PROHIBIT EDITING: No VALUE DATA TYPE: yes/no
VALUE HELP: Enter 'Yes' to allow access to CP
DESCRIPTION:
This parameter controls access to the Clinical Procedures package.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: MD USE APPOINTMENT

DISPLAY TEXT: Use Appointment Location
MULTIPLE VALUED: No VALUE TERM: Use Appointment location
VALUE DATA TYPE: yes/no
DESCRIPTION:
Set this value to Yes to allow CPUser to use the location of the appointment selected during CP study check-in for the workload. Otherwise, the hospital location of the CP Definition will be used.

Enter RETURN to continue or '^' to exit:

If no value is entered, the default value is No.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

¹NAME: MD USE APPT WITH PROCEDURE

DISPLAY TEXT: Use Appointment With Procedure
MULTIPLE VALUED: No
VALUE TERM: Use appointment with procedure
PROHIBIT EDITING: No VALUE DATA TYPE: yes/no
DESCRIPTION:
Enter "Y" or "N" for Yes/No on whether your site selects the appointment scheduled for outpatients during the procedure request in CPRS.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

²NAME: MD USE NOTE

DISPLAY TEXT: Use Note
VALUE TERM: Yes/No VALUE DATA TYPE: yes/no
DESCRIPTION:
This parameter indicates that Clinical Procedures will use the note for the text of the result instead of the Significant Finding field in Consult.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: MD USER DEFAULTS

DISPLAY TEXT: CP User Defaults
MULTIPLE VALUED: Yes INSTANCE TERM: Parameter setting
VALUE TERM: Parameter value PROHIBIT EDITING: No
VALUE DATA TYPE: free text VALUE DOMAIN: 1:250
INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 1:250
DESCRIPTION:
This parameter is used to store a users default parameter settings. Each setting is defined on the client.
PRECEDENCE: 1 ENTITY FILE: USER

NAME: MD VERSION CHK

DISPLAY TEXT: Version Compatibility
MULTIPLE VALUED: Yes INSTANCE TERM: Application:Version

¹ Patch MD*1.0*14 March 2008 Parameter Definition added.

² Patch MD*1.0*21 May 2010 Parameter Definition Added.

VALUE TERM: Compatible with current server version
PROHIBIT EDITING: No VALUE DATA TYPE: yes/no
INSTANCE DATA TYPE: free text INSTANCE DOMAIN: 1:30
DESCRIPTION:
This parameter is used to store the application:versions that are compatible with the current server version of Clinical Procedures. Instance format of APPLICATION:VERSION (example: CPMANAGER.EXE:0.0.0.0).
PRECEDENCE: 1 ENTITY FILE: SYSTEM

NAME: MD WEBLINK

DISPLAY TEXT: Clinical Procedures Home Page
MULTIPLE VALUED: No VALUE TERM: Web Address
VALUE DATA TYPE: free text VALUE DOMAIN: 1:250
DESCRIPTION:
This parameter contains the web address for the Clinical Procedures home page. This can be modified to a local address in the event that the pages are downloaded to be displayed from a local server location.
PRECEDENCE: 1 ENTITY FILE: SYSTEM

ENTRY ACTION: D EN^MDWORC(.XQORMSG) TIMESTAMP: 60934,38793

NAME: MD RECEIVE OR

ITEM TEXT: Clinical Procedures receives order msgs from CPRS
 TYPE: action CREATOR: ACKERMAN,NIEN-CHIN
 PACKAGE: CLINICAL PROCEDURES
 DESCRIPTION: This protocol receives order messages from CPRS. (IA 3135)
 ENTRY ACTION: D EN^MDWOR(.XQORMSG) TIMESTAMP: 60934,38793

¹**NAME: MDC ADT_A01 OUTBOUND**

ITEM TEXT: Outbound ADT A01 Routing Protocol
 TYPE: subscriber CREATOR: CLIOPROGRAMMER,ONE
 DESCRIPTION: This is the outbound routing protocol for all ADT A01 messages
 sent by the CP/Clio system.
 TIMESTAMP: 60943,49051
 RECEIVING APPLICATION: MDC ADT OUTBOUND SPL
 EVENT TYPE: A01 RESPONSE MESSAGE TYPE: ADT
 ROUTING LOGIC: D GENDESTS^MDCPVDEF

NAME: MDC ADT_A02 OUTBOUND

ITEM TEXT: Outbound ADT A02 Routing Protocol
 TYPE: subscriber CREATOR: CLIOPROGRAMMER,ONE
 DESCRIPTION: This is the outbound routing protocol for all ADT A02 messages
 send by the CP/Clio system.
 TIMESTAMP: 60943,49051
 RECEIVING APPLICATION: MDC ADT OUTBOUND SPL
 EVENT TYPE: A02 RESPONSE MESSAGE TYPE: ADT
 PROCESSING ROUTINE: Q ROUTING LOGIC: D GENDESTS^MDCPVDEF

NAME: MDC ADT_A03 OUTBOUND

ITEM TEXT: Outbound ADT A03 Routing Protocol
 TYPE: subscriber CREATOR: CLIOPROGRAMMER,ONE
 DESCRIPTION: This is the outbound routing protocol for all ADT A03 messages
 sent by the CP/Clio system.
 TIMESTAMP: 60943,49051
 RECEIVING APPLICATION: MDC ADT OUTBOUND SPL
 EVENT TYPE: A03 RESPONSE MESSAGE TYPE: ADT
 PROCESSING ROUTINE: Q ROUTING LOGIC: D GENDESTS^MDCPVDEF

NAME: MDC ADT_A11 OUTBOUND

ITEM TEXT: Outbound ADT A11 Routing Protocol
 TYPE: subscriber CREATOR: CLIOPROGRAMMER,ONE
 DESCRIPTION: This is the outbound routing protocol for all ADT A11
 messages.
 TIMESTAMP: 60943,49051
 RECEIVING APPLICATION: MDC ADT OUTBOUND SPL
 EVENT TYPE: A11 RESPONSE MESSAGE TYPE: ADT
 PROCESSING ROUTINE: Q

NAME: MDC ADT_A12 OUTBOUND

ITEM TEXT: Outbound ADT A12 Routing Protocol
 TYPE: subscriber CREATOR: CLIOPROGRAMMER,ONE
 DESCRIPTION: This is the outbound routing protocol for all ADT A12 messages

¹ Patch MD*1.0*16 January 2011 Added new protocols.

Exported Options

sent by the CP/CLIO system.

TIMESTAMP: 60943,49051
RECEIVING APPLICATION: MDC ADT OUTBOUND SPL
EVENT TYPE: A13 RESPONSE MESSAGE TYPE: ADT
PROCESSING ROUTINE: Q ROUTING LOGIC: D GENDESTS^MDCPVDEF

NAME: MDC ADT_A13 OUTBOUND

ITEM TEXT: Outbound ADT A13 Routing Protocol
TYPE: subscriber CREATOR: CLIOPROGRAMMER,ONE
DESCRIPTION: This is the outbound routing protocol for all ADT A13 messages sent by the CP/CLIO system.
TIMESTAMP: 60943,49051
RECEIVING APPLICATION: MDC ADT OUTBOUND SPL
EVENT TYPE: A13 RESPONSE MESSAGE TYPE: ADT
PROCESSING ROUTINE: Q ROUTING LOGIC: D GENDESTS^MDCPVDEF

NAME: MDC CPAN VS

ITEM TEXT: Outbound for CLIO ADT A01 from MDC
TYPE: event driver CREATOR: CLIOPROGRAMMER,ONE
DESCRIPTION: Outbound for CLIO ADT A01 from MDC
TIMESTAMP: 60943,49051 SENDING APPLICATION: MDC CPAN
TRANSACTION MESSAGE TYPE: ADT EVENT TYPE: A01
ACCEPT ACK CODE: AL VERSION ID: 2.4
SUBSCRIBERS: MDC ADT_A01 OUTBOUND

NAME: MDC CPCAN VS

ITEM TEXT: Outbound CLIO ADT A11 from MDC
TYPE: event driver CREATOR: CLIOPROGRAMMER,ONE
DESCRIPTION: CLIO Outbound ADT A11 Cancel Admit from MDC
TIMESTAMP: 60943,49051 SENDING APPLICATION: MDC CPCAN
TRANSACTION MESSAGE TYPE: ADT EVENT TYPE: A11
ACCEPT ACK CODE: AL VERSION ID: 2.4
SUBSCRIBERS: MDC ADT_A02 OUTBOUND

NAME: MDC CPDE VS

ITEM TEXT: Outbound CLIO ADT A03 from MDC
TYPE: event driver CREATOR: CLIOPROGRAMMER,ONE
DESCRIPTION: CLIO Outbound ADT A03 Discharge from MDC
TIMESTAMP: 60943,49051 SENDING APPLICATION: MDC CPDE
TRANSACTION MESSAGE TYPE: ADT EVENT TYPE: A03
ACCEPT ACK CODE: AL VERSION ID: 2.4
SUBSCRIBERS: MDC ADT_A03 OUTBOUND

NAME: MDC CPCT VS

ITEM TEXT: Outbound CLIO ADT A12 from MDC
TYPE: event driver CREATOR: CLIOPROGRAMMER,ONE
DESCRIPTION: CLIO Outbound ADT A12 Cancel Transfer from MDC
TIMESTAMP: 60943,49051 SENDING APPLICATION: MDC CPCT
TRANSACTION MESSAGE TYPE: ADT EVENT TYPE: A12
ACCEPT ACK CODE: AL VERSION ID: 2.4
SUBSCRIBERS: MDC ADT_A12 OUTBOUND

NAME: MDC CPCDE VS

ITEM TEXT: Outbound CLIO ADT A13 from MDC
TYPE: event driver
DESCRIPTION: CLIO Outbound ADT A13 Cancel Discharge from MDC

TIMESTAMP: 61257,40262
 TRANSACTION MESSAGE TYPE: ADT
 ACCEPT ACK CODE: AL
 SUBSCRIBERS: MDC ADT_A13 OUTBOUND

SENDING APPLICATION: MDC CPCDE
 EVENT TYPE: A13
 VERSION ID: 2.4

NAME: **MDC CPTP VS**
 (A02)

ITEM TEXT: CLIO Transfer a Patient

TYPE: event driver
 DESCRIPTION: Outbound for CLIO ADT A02 from MDC
 TIMESTAMP: 60943,49051
 TRANSACTION MESSAGE TYPE: ADT
 ACCEPT ACK CODE: AL
 SUBSCRIBERS: MDC ADT_A02 OUTBOUND

CREATOR: CLIOPROGRAMMER,ONE
 SENDING APPLICATION: MDC CPTP
 EVENT TYPE: A02
 VERSION ID: 2.4

NAME: **MDC CPUPI VS**

ITEM TEXT: Outbound CLIO ADT A08 from MDC

TYPE: event driver
 DESCRIPTION: CLIO Outbound ADT A08 Patient Update from MDC
 TIMESTAMP: 60943,49051
 TRANSACTION MESSAGE TYPE: ADT
 ACCEPT ACK CODE: AL

CREATOR: CLIOPROGRAMMER,ONE
 SENDING APPLICATION: MDC CPUPI
 EVENT TYPE: A08
 VERSION ID: 2.4

NAME: **MDHL Device Client**

ITEM TEXT: Instrument Device Client

TYPE: subscriber
 PACKAGE: CLINICAL PROCEDURES
 DESCRIPTION: Clinical Procedures CliO Client Protocol for UCI Devices
 TIMESTAMP: 60943,49051
 TRANSACTION MESSAGE TYPE: ORU
 PROCESSING ID: P
 RESPONSE MESSAGE TYPE: ACK
 SENDING FACILITY REQUIRED?: NO

CREATOR: CLIOPROGRAMMER,ONE
 RECEIVING APPLICATION: MDHL-OUT
 EVENT TYPE: R01
 LOGICAL LINK: MDHL IN
 PROCESSING ROUTINE: D EN^MDCPHL7A
 RECEIVING FACILITY REQUIRED?: NO

NAME: **MDHL Device Server**

ITEM TEXT: Instrument HL7 Event Driver

TYPE: event driver
 DESCRIPTION: CLinical Procedures CliO Server Protocol for ICU Devices.
 TIMESTAMP: 60943,49051
 TRANSACTION MESSAGE TYPE: ORU
 PROCESSING ID: debug
 SENDING FACILITY REQUIRED?: NO
 SUBSCRIBERS: MDHL Device Client

CREATOR: CLIOPROGRAMMER,ONE
 SENDING APPLICATION: MDHL-IN
 EVENT TYPE: R01
 VERSION ID: 2.4
 RECEIVING FACILITY REQUIRED?: NO

HL7 Application Parameters

NAME: **INST-MCAR** ACTIVE/INACTIVE: ACTIVE
 COUNTRY CODE: USA HL7 ENCODING CHARACTERS: ^~\&
 HL7 FIELD SEPARATOR: |

NAME: **MCAR-INST** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: VISTA MAIL GROUP: POSTMASTER
 COUNTRY CODE: USA HL7 ENCODING CHARACTERS: ^~\&
 HL7 FIELD SEPARATOR: |

¹ NAME: **MDC ADT OUTBOUND** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: VISTA COUNTRY CODE: USA
 HL7 ENCODING CHARACTERS: ~\& HL7 FIELD SEPARATOR: |

NAME: **MDC ADT OUTBOUND GE** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: GE COUNTRY CODE: USA
 HL7 ENCODING CHARACTERS: ~\& HL7 FIELD SEPARATOR: |

NAME: **MDC ADT OUTBOUND PHL** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: PHILIPS COUNTRY CODE: USA
 HL7 ENCODING CHARACTERS: ~\& HL7 FIELD SEPARATOR: |

NAME: **MDC ADT OUTBOUND PIC** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: PICIS COUNTRY CODE: USA
 HL7 ENCODING CHARACTERS: ~\& HL7 FIELD SEPARATOR: |

NAME: **MDC ADT OUTBOUND SPL** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: MDC COUNTRY CODE: USA
 HL7 ENCODING CHARACTERS: ^~\& HL7 FIELD SEPARATOR: |

NAME: **MDC CPAN** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: HINES_OIFO COUNTRY CODE: USA
 HL7 ENCODING CHARACTERS: ^~\& HL7 FIELD SEPARATOR: |

NAME: **MDC CPCAN** ACTIVE/INACTIVE: ACTIVE
 FACILITY NAME: HINES_OIFO COUNTRY CODE: USA
 HL7 ENCODING CHARACTERS: ^~\& HL7 FIELD SEPARATOR: |

NAME: **MDC CPCDE** ACTIVE/INACTIVE: ACTIVE
 COUNTRY CODE: USA HL7 ENCODING CHARACTERS: ^~\&
 HL7 FIELD SEPARATOR: |

NAME: **MDC CPCT** ACTIVE/INACTIVE: ACTIVE
 COUNTRY CODE: USA HL7 ENCODING CHARACTERS: ^~\&
 HL7 FIELD SEPARATOR: |

¹ Patch MD*1.0*16 January 2011 Added new HL7 application parameters.

NAME: MDC CPDE	ACTIVE/INACTIVE: ACTIVE
COUNTRY CODE: USA	HL7 ENCODING CHARACTERS: ^~\&
HL7 FIELD SEPARATOR:	
NAME: MDC CPTP	ACTIVE/INACTIVE: ACTIVE
COUNTRY CODE: USA	HL7 ENCODING CHARACTERS: ^~\&
HL7 FIELD SEPARATOR:	
NAME: MDC CPUPI	ACTIVE/INACTIVE: ACTIVE
COUNTRY CODE: USA	HL7 ENCODING CHARACTERS: ^~\&
HL7 FIELD SEPARATOR:	
NAME: MDHL-IN	ACTIVE/INACTIVE: ACTIVE
FACILITY NAME: VISTA	MAIL GROUP: POSTMASTER
HL7 ENCODING CHARACTERS: ^~\&	HL7 FIELD SEPARATOR:
NAME: MDHL-OUT	ACTIVE/INACTIVE: ACTIVE
FACILITY NAME: VISTA	MAIL GROUP: POSTMASTER
HL7 ENCODING CHARACTERS: ^~\&	HL7 FIELD SEPARATOR:

HL Logical Links

NODE: MCAR INST
DEVICE TYPE: Single-threaded Server
AUTOSTART: Enabled
TASK NUMBER: 526320
QUEUE SIZE: 100
RE-TRANSMISSION ATTEMPTS: 3
ACK TIMEOUT: 60
TCP/IP PORT: 9026
PERSISTENT: NO
IN QUEUE BACK POINTER: 331
OUT QUEUE BACK POINTER: 220

LLP TYPE: TCP
STATE: Reading
TIME STARTED: MAR 04, 2004@06:46:17
SHUTDOWN LLP?: NO
READ TIMEOUT: 60
EXCEED RE-TRANSMIT ACTION: ignore
TCP/IP SERVICE TYPE: SINGLE LISTENER
STARTUP NODE: DEV:ISC4A1
IN QUEUE FRONT POINTER: 331
OUT QUEUE FRONT POINTER: 210

NODE: MCAR OUT
DEVICE TYPE: Non-Persistent Client
AUTOSTART: Enabled
TASK NUMBER: 529066
QUEUE SIZE: 100
READ TIMEOUT: 60
EXCEED RE-TRANSMIT ACTION: ignore
TCP/IP PORT: 9028
PERSISTENT: NO
IN QUEUE BACK POINTER: 202
OUT QUEUE BACK POINTER: 206

LLP TYPE: TCP
STATE: Openfail
TIME STARTED: MAR 04, 2004@06:45:47
SHUTDOWN LLP?: NO
RE-TRANSMISSION ATTEMPTS: 3
ACK TIMEOUT: 60
TCP/IP ADDRESS: 10.3.17.157
TCP/IP SERVICE TYPE: CLIENT (SENDER)
STARTUP NODE: DEV:ISC4A1
IN QUEUE FRONT POINTER: 202
OUT QUEUE FRONT POINTER: 202

¹**NODE: MDHL IN**
DEVICE TYPE: Single-threaded Server
AUTOSTART: Enabled
TASK NUMBER: 3393328
QUEUE SIZE: 100
READ TIMEOUT: 3
TCP/IP PORT: 11660
PERSISTENT: NO
IN QUEUE BACK POINTER: 17905
OUT QUEUE BACK POINTER: 17598

LLP TYPE: TCP
STATE: Listen
TIME STARTED: JUL 31, 2008@07:42:51
SHUTDOWN LLP?: NO
RE-TRANSMISSION ATTEMPTS: 3
ACK TIMEOUT: 3
TCP/IP SERVICE TYPE: SINGLE LISTENER
RETENTION: 60
IN QUEUE FRONT POINTER: 17905
OUT QUEUE FRONT POINTER: 17598

¹ Patch MD*1.0*16 January 2011 Added a new HL logical link.

Menu Options by Name

NAME: MD GUI USER MENU TEXT: MD GUI USER
 TYPE: Broker (Client/Server) CREATOR: ACKERMAN,NIEN-CHIN
 TIMESTAMP OF PRIMARY MENU: 59331,44145
 RPC: MD TMDOUTPUT
 RPC: MD TMDPARAMETER
 RPC: MD TMDPATIENT
 RPC: MD TMDPROCEDURE
 RPC: MD TMDRECORDID
 RPC: MD TMDTRANSACTION
 RPC: MD TMDUSER
 RPC: MD UTILITIES
 UPPERCASE MENU TEXT: MD GUI USER

NAME: MD GUI MANAGER MENU TEXT: MD GUI MANAGER
 TYPE: Broker (Client/Server) CREATOR: ACKERMAN,NIEN-CHIN
 TIMESTAMP OF PRIMARY MENU: 59385,45622
 RPC: MD TMDOUTPUT
 RPC: MD TMDPARAMETER
 RPC: MD TMDPATIENT
 RPC: MD TMDPROCEDURE
 RPC: MD TMDRECORDID
 RPC: MD TMDTRANSACTION
 RPC: MD TMDUSER
 RPC: MD UTILITIES
 RPC: MD GATEWAY
 UPPERCASE MENU TEXT: MD GUI MANAGER

¹**NAME: MD AUTO CHECK-IN SETUP** MENU TEXT: Auto Study Check-In Setup
 TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
 PACKAGE: CLINICAL PROCEDURES
 DESCRIPTION: This option is used to populate the XPAR parameters MD USE
 APPT WITH PROCEDURE, MD CHECK-IN PROCEDURE LIST, MD CLINIC QUICK LIST, and MD
 CLINICS WITH MULT PROC. The four XPAR parameters are used for the auto study
 check-in. Users can use the option to indicate whether their site use and
 schedule appointments. They can populate a list of procedures and associated
 clinics that need a CP study checked-in.
 ROUTINE: EN1^MDWSETUP
 UPPERCASE MENU TEXT: AUTO STUDY CHECK-IN SETUP

NAME: MD SCHEDULED STUDIES MENU TEXT: Scheduled Studies
 TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
 PACKAGE: CLINICAL PROCEDURES
 DESCRIPTION: This option is tasked to run daily. It will process the HL7
 messages that need to be sent to the device on a daily basis for CP studies.
 ROUTINE: EN1^MDWORSR SCHEDULING RECOMMENDED: YES
 UPPERCASE MENU TEXT: SCHEDULED STUDIES

NAME: MD STUDY CHECK-IN MENU TEXT: Study Check-in
 TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
 PACKAGE: CLINICAL PROCEDURES
 DESCRIPTION: This option is tasked to run daily. It checks-in CP studies
 for procedures that require multiple encounters such as Hemodialysis,

¹ Patch MD*1.0*14 March 2008 Options added to support the auto study check-in.

Exported Options

Respiratory Therapy, and Sleep Studies.

ROUTINE: CLINICPT^MDWORSR SCHEDULING RECOMMENDED: YES
UPPERCASE MENU TEXT: STUDY CHECK-IN

¹ NAME: **MD HIGH VOLUME PROCEDURE SETUP** MENU TEXT: High Volume Procedure Setup
TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option will populate the XPAR Parameters MD GET HIGH
VOLUME and MD NOT ADMN CLOSE MUSE NOTE. It will let the user populate a list
of Clinical Procedures procedures set it up for high volume procedure process.
ROUTINE: EN1^MDARSET
UPPERCASE MENU TEXT: HIGH VOLUME PROCEDURE SETUP

NAME: **MD PROC W/INCOMPLETE WORKLOAD**
MENU TEXT: Print list of Procedure with incomplete workload
TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option prints a list of procedures that has incomplete
workload for the visit.
ROUTINE: E1^MDSTUDW
UPPERCASE MENU TEXT: PRINT LIST OF PROCEDURE WITH I

NAME: **MD PROCESS RESULTS** MENU TEXT: MD Process Results
TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES E ACTION PRESENT: YES
DESCRIPTION: This task is ran daily for every hour to process results
and update Consults package.
ENTRY ACTION: N ZTSAVE S ZTSAVE("DUZ")=DUZ,ZTSAVE("DUZ")=""
ROUTINE: PROCESS^MDHL7XXX UPPERCASE MENU TEXT: MD PROCESS
RESULTS

² NAME: **MD HEMODIALYSIS USER** MENU TEXT: HEMODIALYSIS USER
TYPE: Broker (Client/Server) CREATOR: ACKERMAN,NIEN-CHIN
TIMESTAMP OF PRIMARY MENU: 60387,39853
RPC: MDK GET VISTA DATA
RPC: MDK GET/SET RENAL DATA
RPC: MDK UTILITY
RPC: VAFCTFU CONVERT DFN TO ICN
RPC: VAFCTFU CONVERT ICN TO DFN
RPC: MD TMDWIDGET
RPC: MD TMDNOTE
RPC: MD TMDCIDC
RPC: MD TMDLEX
RPC: MD TMDENCOUNTER
RPC: GMV MANAGER
RPC: MD GATEWAY
RPC: MD TMDSUBMITU
RPC: ORWPT PTINQ
RPC: GMV PTSELECT
RPC: DG SENSITIVE RECORD ACCESS
RPC: DG SENSITIVE RECORD BULLETIN
RPC: MD TMDRECORDID
UPPERCASE MENU TEXT: HEMODIALYSIS USER

¹ Patch MD*1.0*21 May 2010 Options added to support high volume procedures enhancement.

² Patch MD*1.0*6 May 2008 Hemodialysis User menu option added.

Exported Options

ROUTINE: EN^MDCVT
UPPERCASE MENU TEXT: RUN THE CONVERSION PROCESS

NAME: **MDCVT SUMMARY** MENU TEXT: Summary of Conversion Process
TYPE: print CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option will generate a Medicine Report Conversion report. This report consists of a listing of all Medicine records that were processed in the conversion in variable pointer format and the status of the conversion whether the record was converted, skipped, or errored. If the record was converted, the total number of lines and bytes that the record was converted to in a TIU document will be displayed. If the record errored, the reason why it errored will be displayed. If the record was skipped, the reason why it was skipped will be displayed.
DIC {DIP}: MDD(703.9, L.: 0
FLDS: [MD CONVERSION SUMMARY] BY: [MD CONVERSION SUMMARY]
UPPERCASE MENU TEXT: SUMMARY OF CONVERSION PROCESS

NAME: **MDCVT DISK SPACE** MENU TEXT: Disk Space Requirements
TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option will generate a summary of the Medicine report conversion. This summary consists of a list of the files converted to Clinical Procedures, the count of records converted, the total lines and Bytes the records were converted in each file.
ROUTINE: SUMMARY^MDCVT
UPPERCASE MENU TEXT: DISK SPACE REQUIREMENTS

NAME: **MDCVT LIST OF TIU TITLES** MENU TEXT: List of TIU Titles Needed
TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option will allow the user to generate a list of Medicine procedures and the TIU titles needed to be created for the procedures that will be used for the Medicine report conversion. The PRINT NAME of the procedures in the PROCEDURE/SUBSPECIALTY file (#697.2) will be used in the display. This list will list the procedures and titles for a Medicine Package Procedure, if the "Convert Y/N" parameter is set to "Yes" and the "Use TIU Note Title" parameter is blank in the Conversion Setup option.
ROUTINE: DISP^MDSTATU
UPPERCASE MENU TEXT: LIST OF TIU TITLES NEEDED

NAME: **MDCVT TOTALS** MENU TEXT: Conversion Totals By Status
TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option will verify that the Medicine reports conversion is complete and are in appropriate statuses.
ROUTINE: TOTALS^MDCVT
UPPERCASE MENU TEXT: CONVERSION TOTALS BY STATUS

NAME: **MDCVT ERROR LOG** MENU TEXT: Error Log

```

TYPE: print                                CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option generates a log of all the errors that occurred
with each Medicine report during the conversion. The listing consists of the
CONVERSION ID and ERROR MESSAGE. The CONVERSION ID consists of the record #
concatenated with a ";" and the global location (e.g., "345;MCAR(699,)").
DIC {DIP}: MDD(703.9,                      L.: 0
FLDS: [MD CONVERSION ERRORS]              BY: [MD CONVERSION ERRORS]
UPPERCASE MENU TEXT: ERROR LOG

```

NAME: MDCVT CONVERSION LOCKOUT MENU TEXT: Conversion Lockout
TYPE: run routine CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES
DESCRIPTION: This option will let the user place a specialty/procedure or
ALL specialty/procedures Enter/Edit and Report options 'OUT OF SERVICE' in
the
Medicine package. It will also set Kernel site parameter MD MEDICINE
CONVERTED to "YES" when all specialties/procedures enter/edit and report
options are disabled or when the user indicated that all Medicine reports has
been converted.
ROUTINE: LOCKOUT^MDCVT UPPERCASE MENU TEXT: CONVERSION
LOCKOUT

NAME: MDCVT BUILD CONVERSION LIST MENU TEXT: Build Conversion List
TYPE: action CREATOR: ACKERMAN,NIEN-CHIN
PACKAGE: CLINICAL PROCEDURES E ACTION PRESENT: YES
X ACTION PRESENT: YES
DESCRIPTION: The user will need to run this option before using the [MDCVT
RUN], Run the Conversion Process, option. This option will let the user
build
the conversion list of the Medicine file records for the CP CONVERSION file
(#703.9). It will populate the CONVERSION LOG sub-file (#703.92) with all
entries in the "AC" cross reference in the MEDICAL PATIENT file (#690) and
set
the STATUS field as "Ready to Convert" for each entry. This option can be
queued. Once the conversion list is built, this option can also be used to
add new additional entries in the Medicine file into the conversion list.
This option will not overwrite the existing entries in the CONVERSION LOG but
add to the list.
EXIT ACTION: K MDS ENTRY ACTION: S MDS=\$\$BLD^MDCVT1()
UPPERCASE MENU TEXT: BUILD CONVERSION LIST

¹Dialogs

Missing Required HL7 Element

```
DIALOG NUMBER: 7040020.001                TYPE: ERROR
INTERNAL PARAMETERS NEEDED: YES           PACKAGE: CLINICAL PROCEDURES
SHORT DESCRIPTION: Missing required HL7 element.
DESCRIPTION:  An element that is required according to the HL7 message
profile is missing in the FileMan data for the current record.
TEXT:
Required element |1| is missing for record |2| in File #|3|.
PARAMETER SUBSCRIPT: 3
PARAMETER DESCRIPTION: FileMan file number that is the source of the missing d
PARAMETER SUBSCRIPT: 1
PARAMETER DESCRIPTION: Missing HL7 element identified by SEGMENT.FIELD[.COMPON
ENT[.SUBCOMPONENT]].
PARAMETER SUBSCRIPT: 2
PARAMETER DESCRIPTION: IEN or IENS (comma delimited) of the FileMan record mis
sing that is the source of the missing data. A sub-file IEN would be represented
as sub-file IEN,file IEN (e.g., 2,121. Where the sub-file IEN=2 and the file IEN
=121.).
```

Invalid Key Passed

```
DIALOG NUMBER: 7040020.002                TYPE: ERROR
INTERNAL PARAMETERS NEEDED: YES           PACKAGE: CLINICAL PROCEDURES
SHORT DESCRIPTION: Invalid key passed.
DESCRIPTION:  The passed key has no corresponding entry in the Patient
Movement File (#405).
TEXT:
No entry in ^DGPM() for IEN |1|.
PARAMETER SUBSCRIPT: 1
PARAMETER DESCRIPTION: IEN of Patient Movement File.
```

No Record in Patient File for DFN Passed

```
DIALOG NUMBER: 7040020.003                TYPE: ERROR
INTERNAL PARAMETERS NEEDED: YES           PACKAGE: CLINICAL PROCEDURES
SHORT DESCRIPTION: No record in Patient File for DFN passed.
DESCRIPTION:  There is no entry in ^DPT (file #2) for the DFN extracted from
the Patient Movement File (#405).
TEXT:
There is no entry in ^DPT for DFN |1|.
PARAMETER SUBSCRIPT: 1
PARAMETER DESCRIPTION: DFN from Patient Movement File(#405)
```

Required Segment Missing

```
DIALOG NUMBER: 7040020.004                TYPE: ERROR
INTERNAL PARAMETERS NEEDED: YES           PACKAGE: CLINICAL PROCEDURES
SHORT DESCRIPTION: Required segment missing
DESCRIPTION:  This error occurs when a segment that is required for a
particular message has no data in the database.
TEXT:
Required segment |1| is not returned for IEN |2| in File #|3|.
PARAMETER SUBSCRIPT: 1                    PARAMETER DESCRIPTION: HL7 Segment name.
PARAMETER SUBSCRIPT: 2
PARAMETER DESCRIPTION: IEN of record returning no segment.
PARAMETER SUBSCRIPT: 3
PARAMETER DESCRIPTION: File in which there is no data for the IEN.
```

¹ Patch MD*1.0*16 January 2011 Added Dialogs section.

7. Cross-References

Included in this section is the information about the cross-references of the application.

FILE NUMBER	FIELD NUMBER	CROSS REFERENCE	DESCRIPTION
¹ 702	.05	ACON	Used for searches when the user knows the Consult order number.
	.3	ACONV	This cross reference is used to keep track of which CP transaction study was created during the Medicine report conversion and which Medicine record it is associated with.
	.06	ATIU	Used for searches when the user knows the TIU Note title.
	.01	B	Regular B Cross Reference of the .01 field, the patient name.
	.04	ACP	Used for searches when the user knows the CP definition.
	.11	AINST	Used for searches when the user knows if the study was submitted to Imaging.
	.12	AION	Used to quickly retrieve the study ien from the instrument order number.
	.09	AS	It is a cross reference on the status of the CP study and it is used for quick look up.
	.13	AVISIT	This cross reference is used to make sure that a Visit file entry is not deleted as long as there is an entry.

¹ Patch MD*1.0*6 May 2008 Cross References added.

FILE NUMBER	FIELD NUMBER	CROSS REFERENCE	DESCRIPTION
	.13	AUPNV	This cross reference tells Visit Tracking how many file entries are using (point to) a Visit file entry.
Subfile 702.091	.01	B	Regular B Cross Reference of the .01 field, error messages.
Subfile 702.1	.01	B	Regular B Cross Reference of the .01 field, image.
702.01	.02	ASPEC	Used for searches when the user knows the Treating Specialty.
	.01	B	Regular B Cross Reference of the .01 field, name of the procedure.
	.01	UC	Used to validate a new entry as unique without case sensitivity.
Subfile 702.011	.01	AINST	Used for searches when the user knows the name of the instrument.
	.01	B	Regular B Cross Reference of the .01 field, instrument.

FILE NUMBER	FIELD NUMBER	CROSS REFERENCE	DESCRIPTION
¹ 702.09	.01	B	Regular B Cross Reference of the .01 field, name of the instrument.
	.01	UC	Used to validate a new entry as unique without case sensitivity.
703.1	.02	ADFN	Used for searches when the user knows the patient name.
	.03	ADTP	Used for searches when the user knows the date/time performed.
	.04	AINST	Used for searches when the user knows the name of the instrument.
	.09	ASTATUS	Sets the status for the Gateway to find studies to process.
	.05	ASTUDYID	This cross reference provide a quick look up by the study reference ID.
	.01	B	Regular B Cross Reference of the .01 field, the upload ID.
Subfile 703.11	.01	B	Regular B Cross Reference of the .01 field, upload item.
703.9	.01	B	Regular B Cross Reference of the .01 field, Name.
Subfile 703.91	.01	B	Regular B Cross Reference of the .01 field, Medicine File Parameters.
Subfile 703.92	.01	B	Regular B Cross Reference of the .01 field, Conversion ID.

¹ Patch MD*1.0*6 May 2008 Cross References added.

FILE NUMBER	FIELD NUMBER	CROSS REFERENCE	DESCRIPTION
	.02	AS	Used for lookup by conversion status.
¹ 704.004		B	Regular B Index of file. This cross reference correlates entries in the CP_HL7_LOG FILE (#704.002) with entries in this file. A sample cross reference entry would be : ^MDC(704.004,"B",CP_HL7_LOG_IEN,CP_HL7_LOG_REASON_IEN)=""
704.005		B	Regular B Index of file. This will make it easy to find and sort the PATIENT(s) involved per patient movement data within this file.
704.006	.01	B	Regular B Index of file. This index quickly sorts file entries based on subscriber protocol identification.
704.101	.02	C	Regular C Index of file. This will support a quick view of entries by name.
	.05	ATYPE	Regular ATYPE Index of file. This supports a quick correlation with TERM TYPE File (#704.102) entries and entries in this file.
	.07	ACTIVE	Regular ACTIVE Index of file. This supports quick sorting of entries by VALUE TYPE.

¹ Patch MD*1.0*16 January 2011 Cross References added.

FILE NUMBER	FIELD NUMBER	CROSS REFERENCE	DESCRIPTION
¹ 704.102		B	Regular B Index of file. This supports a quick sort of entries by the TYPE name.
704.201	.01	B	Regular B Cross Reference of the .01 field, PATIENT ID.
704.202	.09	AS	Used for lookup of active hemodialysis studies.
	.01	B	Regular B Cross Reference of the .01 field, the hemodialysis ID.
	.02	C	C Cross Reference of the .02 field, PATIENT record number.
704.209	.01	B	Regular B Cross Reference of the .01 field, SETTING NAME.

¹ Patch MD*1.0*16 January 2011 Cross Reference added.

8. Archiving and Purging

There is no archiving capability at this time. Purging is available in the CPGateway through the Set Maximum Log Entries option. See description below.

Set Maximum Log Entries allows the user to adjust the number of entries that are displayed in the log file. Once this value is reached, entries will be purged from the beginning of the log to keep the log file from growing too large. This value will take effect after the next polling operation so if the current poll value is 300 seconds it may take up to 5 minutes for the new value to be used. Allowable values are 100 to 10000 entries. When the CP Gateway is shut down, all entries are purged from the log file.

Note: Purging is also done daily while the CP Gateway is running. This purge deletes the raw data that comes across from the instrument. The CP Gateway keeps data for a specified number of days based on the entry in the system parameter “Days to keep Instrument Data”. Data older than this will be purged. The data to be deleted is already matched with a study. The fields purged are the Item Value field (#.1) and Item Text field (#.2) of the Upload Item multiple in the ¹CP RESULTS file (#703.1).

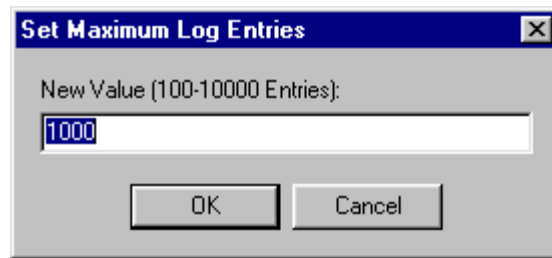


Figure 1, Set Maximum Log Entries

Cleanup

A CP Legacy background task cleans up observations (uuencoded or XML data) from instruments (monitors) that are not in a verified state and are older than the parameter setting (system parameter “Days to Keep Instrument Data”) for unverified observations in the CP Console. This cleanup is designed to run after data is processed, and deletes the unused data. It runs through the UPLOAD ITEM field in the CP RESULT REPORT file (#703.1) and purges unnecessary data from previous uploads.

¹ Patch MD*1.0*16 January 2011 File reference updated to national documentation standards. Added caption to figure. Added new Cleanup task.

9. Callable Routines

¹Entry points provided by the Clinical Procedures V. 1.0 package to other packages are listed below.

Routine: MDAPI (Controlled Subscription)

COMPONENT: \$\$EXTDATA(MDPROC)

VARIABLES: MDPROC

Type: Input

The CP Definition IEN from CP DEFINITION file (702.01)

Type: Output

This is an extrinsic function and it returns: 1/0 for Yes/No.

Entry Point to check if a medical device is associated with the CP Definition.

COMPONENT: \$\$TIUCOMP(MDNOTE)

VARIABLES: MDNOTE Type: Input

The TIU Document IEN from TIU DOCUMENT file (#8925).

\$\$TIUCOMP Type: Output

This is an Extrinsic Function and it returns: 0/1 for fail/success of transaction completion.

Entry Point to complete a CP transaction.

COMPONENT: \$\$TIUDEL(MDNOTE)

VARIABLES: MDNOTE Type: Input

The TIU Document IEN from TIU DOCUMENT file (#8925).

Entry Point to clean up the CP Transaction file entry of the TIU Note that was deleted.

COMPONENT: ISTAT(MDARR)

VARIABLES: MDARR Type: Input

An array of the following:

MDARR(0)="0^error message" or "1^success message"

MDARR(1)=TrackID (CP;Transaction IEN)

¹ Patch MD*1.0*6 May 2008 Description modified and callable routines added.

MDARR(2)=Image(s) Queue Number

MDARR(3..N)=Warnings, if error(s) exist.

Entry Point to update Clinical Procedures of the result of the image(s) that was copied to the Imaging Server.

COMPONENT: ITIU(RESULTS,DFN,CONSULT,VSTRING)

VARIABLES: RESULTS Type: Output

RESULTS(0) will equal one of the following (Required)

- ; IEN of the TIU note if successful
- ; or on failure one of the following status messages
- ; -1^No patient DFN
- ; -1^No Consult IEN
- ; -1^No VString
- ; -1^Error in CP transaction
- ; -1^Unable to create CP transaction
- ; -1^Unable to create the TIU document
- ; -1^No such consult for this patient.

DFN Type: Input

Patient IEN. (Required)

CONSULT Type: Input

Consult IEN. (Required)

VSTRING Type: Input

VString data for TIU Note. (Required)

This entry point enables VistA Imaging to retrieve/create a TIU note for a consult for attaching images to.

COMPONENT:

\$\$TIUREAS(MDFN,MDOLDC,MDANOTE,MDNDFN,MDNEWC,MDNEWV,MDNTIU)

VARIABLES: MDFN Type: Input

Patient DFN in Patient File (#2).

MDOLDC Type: Input

The old consult number that the TIU note is being re-assigned from.

MDANOTE Type: Input

The TIU Note internal Entry Number that is being re-assigned.

MDNDFN Type: Input

The patient DFN who will be re-assigned to the TIU document.

MDNEWC Type: Input

The new consult number that will be

re-assigned to the TIU document.

MDNEWV Type: Input
The new visit for the TIU document assignment.

MDNTIU Type: Input
The new re-assigned TIU document internal entry number.

\$\$TIUREAS Type: Output
This is an extrinsic function and it returns: 1 for Success or 0^Error Message.

This entry point enables TIU to notify CP that a TIU note was reassigned and CP needs to clean up and update the TIU note re-assignment.

ROUTINE: MDRPCOP (Private Subscription)

COMPONENT: GETVST

VARIABLES: DFN Type: Input
Patient's dfn.

RESULTS Type: Output
A subscripted array that contains a list of visits:
1st piece has 3 pieces delimited by an ";"
Patient DFN in Patient File (#2).
- type of visit ("A","I","V")
- date and time
- hospital location ien
2nd piece - date/time of visit
(internal format)
3rd & 4 piece - (external format)
hospital location and status.

This sub-module returns a list of visits for a given patient.

ROUTINE: MDAPI1 (Private Subscription)

COMPONENT: GET(RESULTS,MDARDFN,MDSDT,MDEDI,MDFLDS)

VARIABLES: RESULTS Type: Both
Input: The global ^TMP array in which to return results. (Required)

Output: Passed by Reference
Global array returned in the FM DIQ call
format:

- MDARDFN Type: Input
The patient DFN (Required).
- MDSDT Type: Input
The start date of the date range to return the data in. This must be in FM internal format. (Required).
- MDEDT Type: Input
The end date of the date range to return the data in. This must be in FM internal format. (Required).
- MDFLDS Type: Input
A list of fields from file #691.5 to be returned in RESULTS. MDFLDS should contain a list of fields delimited by ";" (Required).
example: MDFLDS=".01;11;20..."

Example API call:

```
S RESULTS="^TMP("NAMESPACE",$J)"
D
GET^MDAPI1(.RESULTS,162,2900101,3021001,
".01;11")
```

return:

```
^TMP("NAMESPACE",$J,file #,record
ien_,"
,field #,"E")=Data
^TMP("NAMESPACE",$J,subfile #,entry
#_,"_
record ien field of the
multiple,"E")=data
```

^TMP("NAMESPACE",\$J,0) will equal one of the following,

If the call failed:

- 1^No Patient DFN.
- 1^No Start Date Range
- 1^No End Date Range.
- 1^Start Date greater than

End Date.

- 1^No fields defined.

If a local variable is defined
in RESULTS,
^TMP("MDAPI",\$J,0) equals
-1^Global TMP array only.

If no return array defined,
^TMP("MDAPI",\$J,0) equals
-1^No return array global.

If no data,
^TMP("NAMESPACE",\$J,0) equals
-1^No data for patient.

ROUTINE: MDPS1 (Controlled Subscription)

COMPONENT: CPA~MDPS1

VARIABLES: DFN Type: Input

Patient Internal Entry Number. (Required)

GMTS1 Type: Input

The ending date in inverse date format
(9999999-date/time). (Required)

GMTS2 Type: Input

The beginning date in inverse date format
(9999999-date/time). (Required)

GMTSNDM Type: Input

The maximum number of entries to return.
(Optional)

GMTSNPG Type: Input

The Page Number. (Optional)

GMTSQIT Type: Input

Quit indicator. (Optional)

This entry point will display Clinical Procedures result
report that have the Procedure Summary Code of ABNORMAL.
The result consists of the Display Result of the Consult
procedure request, if it exists, and the TIU document text.

COMPONENT: CPB~MDPS1

VARIABLES: DFN Type: Input

Patient Internal Entry Number. (Required)

GMTS1 Type: Input

The ending date in inverse date format
(9999999-date/time). (Required)

GMTS2 Type: Input

The beginning date in inverse date format
(9999999-date/time). (Required)

GMTSNDM Type: Input

The maximum number of entries to return.
(Optional)

GMTSNPG Type: Input
The Page Number. (Optional)

GMTSQIT Type: Input
Quit indicator. (Optional)

This entry point will display a brief summary of the Clinical Procedures result Report. It displays the Consults # (if it exists), Procedure Name, Date/Time Performed, and the Procedure Summary Code.

COMPONENT: CPF~MDPS1

VARIABLES: DFN Type: Input
Patient Internal Entry Number. (Required)

GMTS1 Type: Input
The ending date in inverse date format
(9999999-date/time). (Required)

GMTS2 Type: Input
The beginning date in inverse date format
(9999999-date/time). (Required)

GMTSNDM Type: Input
The maximum number of entries to return.
(Optional)

GMTSNPG Type: Input
The Page Number. (Optional)

GMTSQIT Type: Input
Quit indicator. (Optional)
This entry point displays the full Clinical Procedures result report. The full report consists of the Display Result of the Consult procedure, if it exists, and the TIU document text.

COMPONENT: CPS~MDPS1

VARIABLES: DFN Type: Input
Patient Internal Entry Number. (Required)

GMTS1 Type: Input
The ending date in inverse date format
(9999999-date/time). (Required)

GMTS2 Type: Input
The beginning date in inverse date format
(9999999-date/time). (Required)

GMTSNDM Type: Input
The maximum number of entries to return.
(Optional)

GMTSNPG Type: Input

The Page Number. (Optional)

GMTSQIT Type: Input

Quit indicator. (Optional)

This entry point displays a one line summary of the Clinical Procedures result report. The one line summary consists of the Consult Number, if it exists, Procedure Name, Date/Time Performed, and the Procedure Summary Code.

COMPONENT:

EN1~MDPS1(MDGLO,MDDFN,MDSDT,MDEDT,MDMAX,MDPSC,MDALL)

VARIABLES: MDGLO Type: Both

Return Global Array (Required)

MDDFN Type: Input

Patient DFN (Internal Entry Number)
(Required)

MDSDT Type: Input

Start Date in FM Internal Format
(Optional)

MDEDT Type: Input

End Date in FM Internal Format (Optional)

MDMAX Type: Input

Number of studies to return (Optional)

MDPSC Type: Input

Procedure Summary Code to return. The four Procedure Summary Code are NORMAL, ABNORMAL, BRODERLINE, and INCOMPLETE. By passing this parameter, the entry point will pass studies with this Procedure Summary Code. (Optional)

MDALL Type: Input

MDALL is flag. If MDALL =1, it identifies that all text reports with the procedures list should be returned.

This entry point returns a global Array.

COMPONENT: PR690~MDPS1

VARIABLES: MCARGDA Type: Input

The internal entry number of the Medicine report record.

MCPRO Type: Input

The free text of the Medicine procedure name in the Procedure/Subspecialty file (#697.2).

DFN Type: Input

Patient internal entry number.

ORHFS Type: Input
Order Entry Host File.
Prints the free text of the Medicine report.

COMPONENT: PR702~MDPS1

VARIABLES: MCARGDA Type: Input
The internal entry number of the CP
Transaction record in file (#702).

MCPRO Type: Input
The free text of the CP Definition name
in file (#702.01).

DFN Type: Input
Patient internal entry number.

ORHFS Type: Input
The Order Entry Host File.
Prints the free text of the Clinical Procedures result
interpretation.

COMPONENT: CPC~MDPS1

VARIABLES: DFN Type: Input
Patient Internal Entry Number. (Required)

GMTS1 Type: Input
The ending date in inverse date format
(9999999-date/time). (Required)

GMTS2 Type: Input
The beginning date in inverse date format
(9999999-date/time). (Required)

GMTSNDM Type: Input
The maximum number of entries to return.
(Optional)

GMTSNPG Type: Input
The Page Number. (Optional)

GMTSQIT Type: Input
Quit indicator. (Optional)
This entry point displays the Captioned Clinical Procedures
result report. The captioned report displays the Display
Result of the Consult procedure, if it exists, and the TIU
document text.

¹**ROUTINE:** MDCLIO1

COMPONENT: QRYDATE(ARRAY,START,END)

This entry point provides a list of OBS record IDs (FILE

¹ Patch MD*1.0*16 May 2010 Added MDCLIO1 to Callable Routines

704.117, Field .01) for the date range specified.

Output format:

ARRAY(0)=number of records returned
 ARRAY(n)=record ID (FILE 704.117, Field .01)

n = sequential number starting with 1

Example:

```
>K RESULT
>D QRYDATE^MDCLIO1("RESULT",3070301,3070401)
>ZW RESULT
RESULT(0)=3
RESULT(1)="{FD0FEBBC-8EC1-42E4-9483-4BDBE6370728}"
RESULT(2)="{A7C7FFEB-0CD5-4D55-BB34-35B9620F4ECC}"
RESULT(3)="{D0CEA9D2-A519-41C2-A4AE-9C24C7498E56}"
VARIABLES: Both  ARRAY
```

This is the name of the array to return the data in. It is a closed array and surrounded in quotes (e.g., "RESULT" or "^TMP(\$J)"). (required)

VARIABLES: Input START

This is the date/time to begin the search. It is in FileMan internal date/time format. If it is not defined, all records before the END date/time are returned.

VARIABLES: Input END

This is the end date of the search. It is in FileMan internal date/time format. If it is not defined, no records will be returned.

COMPONENT: QRYOBS(ARRAY,GUID)

This entry point returns the OBS (704.117) file data for the specified record.

Output format:

```
ARRAY("AUDIT_EXISTS","E")=Field .911 (external)
ARRAY("AUDIT_EXISTS","I")=Field .911 (internal)
ARRAY("CHILD_ORDER","E")=Field .27 (external)
ARRAY("CHILD_ORDER","I")=Field .27 (internal)
ARRAY("COMMENT","E")=Field .4 (external)
ARRAY("COMMENT","I")=Field .4 (internal)
ARRAY("CONTEXT",0)=Number of "CONTEXT" records (in this
example: 2)
ARRAY("CONTEXT",1,"METHOD_ID","E")="CONTEXT" nodes are
```

returned when the

ARRAY("CONTEXT",1,"METHOD_ID","I")=node

'ARRAY("TERM_ID","E")="SpO2%".

ARRAY("CONTEXT",1,"OBS_ID","E")=These "CONTEXT" nodes will contain any

ARRAY("CONTEXT",1,"OBS_ID","I")=records about SUPPLEMENTATL OXYGEN

ARRAY("CONTEXT",1,"SVALUE","E")=FLOW RATE and SUPPLEMENTAL OXYGEN

ARRAY("CONTEXT",1,"SVALUE","I")=CONCENTRATION which are related to the

ARRAY("CONTEXT",1,"TERM_ID","E")=SpO2% reading.

ARRAY("CONTEXT",1,"TERM_ID","I")=

ARRAY("CONTEXT",1,"UNIT_ID","E")=

ARRAY("CONTEXT",1,"UNIT_ID","I")=

ARRAY("CONTEXT",2,"OBS_ID","E")=

ARRAY("CONTEXT",2,"OBS_ID","I")=

ARRAY("CONTEXT",2,"SVALUE","E")=

ARRAY("CONTEXT",2,"SVALUE","I")=

ARRAY("CONTEXT",2,"TERM_ID","E")=

ARRAY("CONTEXT",2,"TERM_ID","I")=

ARRAY("CONTEXT",2,"UNIT_ID","E")=

ARRAY("CONTEXT",2,"UNIT_ID","I")=

ARRAY("CORRECTION_FOR_ID","E")=Field .912 (external)

ARRAY("CORRECTION_FOR_ID","I")=Field .912 (internal)

ARRAY("ENTERED_BY_ID","E")=Field .26 (external)

ARRAY("ENTERED_BY_ID","I")=Field .26 (internal)

ARRAY("ENTERED_DATE_TIME","E")=Field .25 (external)

ARRAY("ENTERED_DATE_TIME","I")=Field .25 (internal)

ARRAY("FACILITY_ID","E")=Field .03 (external)

ARRAY("FACILITY_ID","I")=Field .03 (internal)

ARRAY("HOSPITAL_LOCATION_ID","E")=Field .04 (external)

ARRAY("HOSPITAL_LOCATION_ID","I")=Field .04 (internal)

ARRAY("LOCATION_ID","E")=FILE 704.118, Field .02 (external)

ARRAY("LOCATION_ID","I")=FILE 704.118, Field .02 (internal)

ARRAY("METHOD_ID","E")=FILE 704.118, Field .02 (external)

ARRAY("METHOD_ID","I")=FILE 704.118, Field .02 (internal)

ARRAY("OBSERVED_BY_ID","E")=Field .06 (external)

ARRAY("OBSERVED_BY_ID","I")=Field .06 (internal)

ARRAY("OBSERVED_DATE_TIME","E")=Field .05 (external)

ARRAY("OBSERVED_DATE_TIME","I")=Field .05 (internal)

ARRAY("OBS_ID","E")=Field .01 (external)

ARRAY("OBS_ID","I")=Field .01 (internal)

ARRAY("PARENT_ID","E")=Field .02 (external)

ARRAY("PARENT_ID","I")=Field .02 (internal)

ARRAY("PATIENT_ID","E")=Field .08 (external)
 ARRAY("PATIENT_ID","I")=Field .08 (internal)
 ARRAY("POSITION_ID","E")=FILE 704.118, Field .02 (external)
 ARRAY("POSITION_ID","I")=FILE 704.118, Field .02 (internal)
 ARRAY("RANGE","E")=Field .28 (external)
 ARRAY("RANGE","I")=Field .28 (internal)
 ARRAY("SOURCE","E")=Field .21 (external)
 ARRAY("SOURCE","I")=Field .21 (internal)
 ARRAY("SOURCE_COMMENTS","E")=Field .22 (external)
 ARRAY("SOURCE_COMMENTS","I")=Field .22 (internal)
 ARRAY("SOURCE_DATA_ITEM_ID","E")=Field .23 (external)
 ARRAY("SOURCE_DATA_ITEM_ID","I")=Field .23 (internal)
 ARRAY("SOURCE_VERSION","E")=Field .24 (external)
 ARRAY("SOURCE_VERSION","I")=Field .24 (internal)
 ARRAY("STATUS","E")=Field .09 (external)
 ARRAY("STATUS","I")=Field .09 (internal)
 ARRAY("SVALUE","E")=Field .1 (external)
 ARRAY("SVALUE","I")=Field .1 (internal)
 ARRAY("TERM_ID","E")=Field .07 (external)
 ARRAY("TERM_ID","I")=Field .07 (internal)
 ARRAY("UNIT_ID","E")=FILE 704.118, Field .02 (external)
 ARRAY("UNIT_ID","I")=FILE 704.118, Field .02 (internal)

Example:

```

>D
QRYOBS^MDCLIO1("ARRAY",{E24715DE-3DCC-4A04-9F8B-
0A7C6E8E64F4})
>ZW ARRAY
ARRAY("AUDIT_EXISTS","E")=0
ARRAY("AUDIT_EXISTS","I")=0
ARRAY("CHILD_ORDER","E")=""
ARRAY("CHILD_ORDER","I")=""
ARRAY("COMMENT","E")=""
ARRAY("COMMENT","I")=""
ARRAY("CONTEXT",0)=2
ARRAY("CONTEXT",1,"METHOD_ID","E")="NASAL CANNULA"
ARRAY("CONTEXT",1,"METHOD_ID","I")=4688666
ARRAY("CONTEXT",1,"OBS_ID","E")="{792FD976-2C7B-4BC0-8B6F-E62A520
ED9AA}"
      ARRAY("CONTEXT",1,"OBS_ID","I")="{792FD976-2C7B-4BC0-8B6F-
E62A520
ED9AA}"
ARRAY("CONTEXT",1,"SVALUE","E")=1
ARRAY("CONTEXT",1,"SVALUE","I")=1
ARRAY("CONTEXT",1,"TERM_ID","E")="SUPPLEMENTAL OXYGEN FLOW
  
```

```

RATE"
  ARRAY("CONTEXT",1,"TERM_ID","I")=""
  ARRAY("CONTEXT",1,"UNIT_ID","E")="LITERS PER MINUTE"
  ARRAY("CONTEXT",1,"UNIT_ID","I")=""
  ARRAY("CONTEXT",2,"OBS_ID","E")="{BED624B4-A519-4928-B6EB-65C9265
3938E}"
      ARRAY("CONTEXT",2,"OBS_ID","I")="{BED624B4-A519-4928-B6EB-
65C9265
3938E}"
  ARRAY("CONTEXT",2,"SVALUE","E")=100
  ARRAY("CONTEXT",2,"SVALUE","I")=100
  ARRAY("CONTEXT",2,"TERM_ID","E")="SUPPLEMENTAL OXYGEN
CONCENTRATION"
  ARRAY("CONTEXT",2,"TERM_ID","I")=""
  ARRAY("CONTEXT",2,"UNIT_ID","E")="PERCENTAGE"
  ARRAY("CONTEXT",2,"UNIT_ID","I")=""
  ARRAY("CORRECTION_FOR_ID","E")=""
  ARRAY("CORRECTION_FOR_ID","I")=""
  ARRAY("ENTERED_BY_ID","E")="CPPROVIDER,ONE"
  ARRAY("ENTERED_BY_ID","I")=547
  ARRAY("ENTERED_DATE_TIME","E")="AUG 13, 2009@10:23:50"
  ARRAY("ENTERED_DATE_TIME","I")=3090813.10235
  ARRAY("FACILITY_ID","E")=""
  ARRAY("FACILITY_ID","I")=""
  ARRAY("HOSPITAL_LOCATION_ID","E")="2-AS"
  ARRAY("HOSPITAL_LOCATION_ID","I")=1
  ARRAY("METHOD_ID","E")="MONITOR"
  ARRAY("METHOD_ID","I")=4688665
  ARRAY("OBSERVED_BY_ID","E")="CPPROVIDER,ONE"
  ARRAY("OBSERVED_BY_ID","I")=547
  ARRAY("OBSERVED_DATE_TIME","E")="AUG 13, 2009@10:20"
  ARRAY("OBSERVED_DATE_TIME","I")=3090813.102
  ARRAY("OBS_ID","E")="{E24715DE-3DCC-4A04-9F8B-0A7C6E8E64F4}"
  ARRAY("OBS_ID","I")="{E24715DE-3DCC-4A04-9F8B-0A7C6E8E64F4}"
  ARRAY("PARENT_ID","E")=""
  ARRAY("PARENT_ID","I")=""
  ARRAY("PATIENT_ID","E")="CPPATIENT,ONE"
  ARRAY("PATIENT_ID","I")=136
  ARRAY("RANGE","E")="Normal"
  ARRAY("RANGE","I")=1
  ARRAY("SOURCE","E")="CP Flowsheets"
  ARRAY("SOURCE","I")="CP Flowsheets"
  ARRAY("SOURCE_COMMENTS","E")=""
  ARRAY("SOURCE_COMMENTS","I")=""
  ARRAY("SOURCE_DATA_ITEM_ID","E")="CPFLOWSHEETS.EXE:6C6B9A01"

```

```

ARRAY("SOURCE_DATA_ITEM_ID","I")="CPFLOWSHEETS.EXE:6C6B9A01"
ARRAY("SOURCE_VERSION","E")="1.0.16.276"
ARRAY("SOURCE_VERSION","I")="1.0.16.276"
ARRAY("STATUS","E")="Verified"
ARRAY("STATUS","I")=1
ARRAY("SVALUE","E")=100
ARRAY("SVALUE","I")=100
ARRAY("TERM_ID","E")="SpO2%"
ARRAY("TERM_ID","I")=4500637
ARRAY("UNIT_ID","E")="PERCENTAGE"
ARRAY("UNIT_ID","I")=""

```

Example of record not found:

```

>D QRYOBS^MDCLIO1("ARRAY", "")
>ZW ARRAY
ARRAY(0)="-1^No such observation ""

```

VARIABLES: Both ARRAY

This is the name of the array to return the data in. It is a closed array and surrounded in quotes (e.g., "RESULT" or "^TMP(\$J)"). (required)

VARIABLES: Input GUID

This is the Global Unique ID (aka GUID - FILE 704.117, Field .01) value that identifies a record. (required)

KEYWORDS: CLINICAL OBSERVATIONS

¹**ROUTINE: MDTERM**

COMPONENT: CVTVAL(MDVAL,MDFR,MDTO,MDROUND)

This function converts a value from one unit of measurement to another.

Example:

```

>S MDVAL=99,MDFR="DEGREES F",MDTO="DEGREES C",MDROUND=1
>W $$CVTVAL^MDTERM(MDVAL,MDFR,MDTO,MDROUND)
>37.2

```

VARIABLES: Input MDVAL

Value to convert (Required)

VARIABLES: Input MDFR

UUID or Name of unit to convert from (Must be exact match). (Required)

VARIABLES: Input MDTO

UUID or Name of unit to convert to (Must be exact)

¹ Patch MD*1.0*16 May 2010 Added MD to Callable Routines

match) (Required)
VARIABLES: Input MDROUND
Decimal precision (optional to override conversion
logic)
KEYWORDS: CVTVAL

10. External Relations

1. The following describes the installation environment for Version 1.0 of the Clinical Procedures package on the VistA server:
 1. VA FileMan V. 22 or greater
 2. Kernel V. 8.0 or greater
 3. Kernel Toolkit V. 7.3 or greater
 4. Kernel RPC Broker V. 1.1 or greater
 5. PIMS (Patient Information Management System) V. 5.3 or greater (including):
 - a. Registration V. 5.3
 - b. Scheduling V. 5.3
 6. Health Summary V. 2.7 or greater
 7. HL7 (Health Level 7) V. 1.6 or greater
 8. Consults/Request Tracking V. 3.0
 9. TIU (Text Integration Utility) V. 1.0
 10. Order Entry V. 3.0 (CPRS (Computerized Patient Record System) V. 1.0 (GUI V. 18.8)) or greater
 11. PCE (Patient Care Encounter) V. 1.0 or greater
 12. VistA Imaging V. 3.0 or greater (includes installation of background processor and jukebox)
 13. Medicine V. 2.3 (optional)
 14. ¹VDEF (VistA Data Extraction Framework) version 1.0 or greater
 15. Vitals V 5.0 - Patches 25 and 23 must be installed

These packages must be patched up through and including the following patches before Clinical Procedures is installed:

1. Patch 17 of Consults/Request Tracking V. 3.0 (GMRC*3.0*17)
2. Patch 112 of Order Entry V. 3.0 (OR*3.0*112)
3. Patch 109 of Text Integration Utility V. 1.0 (TIU*1.0*109)
4. Patch 7 of Imaging V. 3.0 (MAG*3.0*7)
5. Patch 93 of HL7 V. 1.6 (HL*1.6*93)
6. Patch 98 of HL7 V. 1.6 (HL*1.6*98)
7. If Medicine V. 2.3 is installed, you must install Patch 24 of Medicine (MC*2.3*24), and Patch 146 of Kernel (XU*8.0*146).

2. ²Interface Control Registrations (formerly known as Integration Agreements) between the Clinical Procedures software and other VistA applications exist. Database Interface Control Registrations (DICR) are available on the DBA menu on Forum. For complete information regarding the DICRs for Clinical Procedures V. 1.0, please refer to the *Integration Control*

¹ Patch MD*1.0*16 January 2011 Added VDEF reference. Updated Vitals line.

² Patch MD*1.0*14 March 2008 External Relations list removed. Integration Agreements renamed Interface Control Registrations.

Registrations (Agreements) Menu [DBA IA ISC] option under the *DBA* [DBA] option on FORUM.

¹The following screen capture shows one way to access the DBA option in FORUM:

```
Select Software Services Primary Menu Option: DBA

Select DBA Option: IA  Integration Control Registrations (Agreements)

Select Integration Control Registrations (Agreements) Option: CUST
Custodial Pa
ckage Menu

Select Custodial Package Menu Option: ?

  1      ACTIVE ICRs by Custodial Package
  2      Print ALL ICRs by Custodial Package
  3      Supported References Print All

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help
text.

Select Custodial Package Menu Option: 1  ACTIVE ICRs by Custodial Package
Select PACKAGE NAME: MD  CLINICAL PROCEDURES      MD
DEVICE: HOME//
```

¹ Patch MD*1.0*14 March 2008 Screen capture added.

11. Internal Relations

¹The following are the Clinical Procedures GUI Application menu option, the Clinical Procedures Site Files menu option, and the CP Hemodialysis menu option. Only the MD GUI MANAGER can be invoked independently. The MD GUI USER and MD HEMODIALYSIS USER menu option cannot be invoked independently. They are dependent upon each other. In order to use each module, please refer to the Clinical Procedures Implementation Guide to set up Clinical Procedures.

NAME: **MD GUI USER** MENU TEXT: MD GUI USER
TYPE: Broker (Client/Server) CREATOR: ACKERMAN,NIEN-CHIN
TIMESTAMP OF PRIMARY MENU: 59331,44145
RPC: MD TMDOUTPUT
RPC: MD TMDPARAMETER
RPC: MD TMDPATIENT
RPC: MD TMDPROCEDURE
RPC: MD TMDRECORDID
RPC: MD TMDTRANSACTION
RPC: MD TMDUSER
RPC: MD UTILITIES
UPPERCASE MENU TEXT: MD GUI USER

NAME: **MD GUI MANAGER** MENU TEXT: MD GUI MANAGER
TYPE: Broker (Client/Server) CREATOR: ACKERMAN,NIEN-CHIN
TIMESTAMP OF PRIMARY MENU: 59385,45622
RPC: MD TMDOUTPUT
RPC: MD TMDPARAMETER
RPC: MD TMDPATIENT
RPC: MD TMDPROCEDURE
RPC: MD TMDRECORDID
RPC: MD TMDTRANSACTION
RPC: MD TMDUSER
RPC: MD UTILITIES
RPC: MD GATEWAY
UPPERCASE MENU TEXT: MD GUI MANAGER

NAME: **MD HEMODIALYSIS USER** MENU TEXT: HEMODIALYSIS USER
TYPE: Broker (Client/Server) CREATOR: ACKERMAN,NIEN-CHIN
TIMESTAMP OF PRIMARY MENU: 60387,39853
RPC: MDK GET VISTA DATA
RPC: MDK GET/SET RENAL DATA
RPC: MDK UTILITY
RPC: VAFCTFU CONVERT DFN TO ICN
RPC: VAFCTFU CONVERT ICN TO DFN
RPC: MD TMDWIDGET
RPC: MD TMDNOTE
RPC: MD TMDCIDC
RPC: MD TMDLEX
RPC: MD TMDENCOUNTER
RPC: GMV MANAGER
RPC: MD GATEWAY
RPC: MD TMDSUBMITU
RPC: ORWPT PTINQ

¹ Patch MD*1.0*6 May 2008 Description modified. Hemodialysis User menu option added.

Internal Relations

RPC: GMV PTSELECT
RPC: DG SENSITIVE RECORD ACCESS
RPC: DG SENSITIVE RECORD BULLETIN
RPC: MD TMDRECORDID
UPPERCASE MENU TEXT: HEMODIALYSIS USER

12. Package-wide Variables

No package-wide variables are used in this application.

13. SAC Exemptions

There is one SAC exemption for Clinical Procedures.

1. STANDARD SECTION: 3A Namespacing

DATE GRANTED: APR 25,2002

Since the Medicine package has become a child of the Clinical Procedures package, the Clinical Procedures package is exempt from being required to export the Medicine package as part of the Clinical Procedures package.

14. Software Product Security

Security Management

No additional security measures are to be applied other than those implemented through Menu Manager and the package routines. Clinical Procedures uses the standard RPC broker log-in procedure to validate the user and allow access to the system.

No additional licenses are necessary to run the software.

Confidentiality of staff and patient data and the monitoring of this confidentiality is no different than with any other paper reference.

Security Features

1. Mail groups and alerts.

There is one mailgroup associated with this software. This mailgroup is called MD DEVICE ERRORS. The purpose of this mailgroup is to store a list of people who will be notified if a problem arises with an automated instrument. There is one alert in the software that occurs on the VistA server if the package installation does not finish. This alert is sent to the IRMS staff member who ran the installation.

2. Remote systems.

The application does not transmit data to any remote system/facility database.

3. Archiving/Purging.

¹Refer to the chapter on [Archiving and Purging](#) in this manual. Purging is available in the CP Gateway. Refer to the “CP Gateway Configuration” chapter in the *Clinical Procedures Console Implementation Guide*.

4. Contingency Planning.

It is the responsibility of the using service to develop a local contingency plan to be used in the event of application problems. It is recommended that the CP Gateway be installed on a second machine as a backup in case the initial workstation containing the CP Gateway fails.

¹ Patch MD*1.0*16 January 2011 Updated document reference.

5. Interfacing.

¹CP Flowsheets requires VDEF (VistA Data Extraction Framework) version 1.0 or greater.

6. Electronic signatures.

CP Flowsheets uses E-sign for notes.

7. Menus.

There are no options of special note for the Information Security Officers (ISO's) to view.

8. Security Keys.

The MD MANAGER key controls access to the 'Update Study Status' and the 'Delete Study' options. A user holding this key will be able to use the 'Update Study Status' option on any study currently displayed on the screen. Holders of this key will also be taken directly to the 'Update Study Status' option when opening a study marked in status 'Error'. The 'Update Study Status' option does not do any validation on the new status assigned to the study. The 'Delete Study' option will attempt to delete the study after checking the business rules on the VistA server for the study given its current status and state on the server. This key should be given only with extreme care and only to those users that fully understand the status structure, and the ramifications of changing the status or deletion of a study.

The MD ADMINISTRATOR key is the highest level key in CP. This key controls overall maintenance functions such as downloading and installing updates from the web as well as imports of items from other sites.

The MD HL7 MANAGER key is used to restrict the HL7 management functions.

The MD READ-ONLY key will prevent a user from being able to file data into the CP system. A user with the MD READ-ONLY key may **NOT** log on to CP Console and will have **limited functionality** in CP Flowsheets.

DO NOT assign MD READ-ONLY to a user concurrently with any flowsheet key **other than** MD HL7 MANAGER. Doing so will lead to unpredictable results.

The MD TRAINEE key is used to signify that the signed on user is in trainee status so entries by that person can be flagged for review and approval when appropriate. Entries by a user with a MD TRAINEE key are unverified until verified by a user who is not a trainee.

¹Patch MD*1.0*16 January 2011 Added VDEF reference. Added reference to E-sign. Key descriptions added.

9. ¹File Security.

NUMBER	NAME	DD ACCESS	RD ACCESS	WR ACCESS	DEL ACCESS	LAYGO ACCESS
702	CP TRANSACTION	@			@	
702.001	CP_TRANSACTION_TIU_HISTORY	@	@	@	@	@
702.01	CP DEFINITION	@		#	#	#
702.09	CP INSTRUMENT	@		#	#	#
703.1	CP RESULT REPORT	@		@	@	@
703.9	CP CONVERSION	@	#	#	#	#
704.001	CP_CONSOLE_ACL	@	@	@	@	@
704.002	CP_HL7_LOG	@	@	@	@	@
704.004	CP_HL7_LOG_REASON	@	@	@	@	@
704.005	CP_MOVEMENT_AUDIT	@	@	@	@	@
704.006	CP_PROTOCOL_LOCATION	@	@	@	@	@
704.007	CP_SHIFT	@	@	@	@	@
704.008	CP_SCHEDULE	@	@	@	@	@
704.101	TERM	@			@	@
704.102	TERM_TYPE	@	@	@	@	@
704.103	TERM_QUALIFIER_PAIR	@	@	@	@	@
704.104	TERM_UNIT_CONVERSION	@	@	@	@	@
704.105	TERM_UNIT_PAIR	@	@	@	@	@
704.106	TERM_CHILD_PAIR	@	@	@	@	@
704.107	TERM_RANGE_CHECK	@	@	@	@	@
704.108	TERM_MAPPING_TABLE	@	@	@	@	@
704.109	TERM_MAPPING_PAIR	@	@	@	@	@
704.111	OBS_VIEW	@	@	@	@	@
704.1111	OBS_VIEW_TERMINOLOGY	@	@	@	@	@
704.1112	OBS_VIEW_FILTER	@	@	@	@	@
704.112	OBS_FLOWSHEET	@	@	@	@	@
704.1121	OBS_FLOWSHEET_PAGE	@	@	@	@	@
704.1122	OBS_FLOWSHEET_SUPP_PAGE	@	@	@	@	@
704.1123	OBS_FLOWSHEET_TOTAL	@	@	@	@	@
704.113	OBS_TOTAL	@	@	@	@	@
704.1131	OBS_TOTAL_TERMINOLOGY	@	@	@	@	@
704.115	OBS_ALARM	@	@	@	@	@
704.116	OBS_SET	@			@	@
704.1161	OBS_SET_OBS_PAIR	@	@	@	@	@
704.117	OBS	@			@	@
704.118	OBS_QUALIFIER	@	@	@	@	@
704.119	OBS_AUDIT	@	@	@	@	@
704.121	CP_KARDEX_ACTION	@	@	@	@	@
704.1211	CP_KARDEX_EVENTS	@	@	@	@	@
704.1212	CP_KARDEX_AUDIT	@	@	@	@	@
704.201	HEMODIALYSIS ACCESS POINTS	@			@	
704.202	HEMODIALYSIS STUDY	@			@	
704.209	HEMODIALYSIS SETTINGS	@			@	

10. References.

There are no special reference materials for this package.

11. Official Policies.

¹ Patch MD*1.0*16 January 2011 Updated list.

There are no special official policies for this package.

15. ¹Vendor Interfaces

²The original CP Manager/CP Gateway did not receive discrete data and did not map terminology. Terminology mapping as introduced in Patch 16 allows us to take vendor terminology from a vendor and translate it into VA standard terminology.

List of Vendor Interfaces

The Puritan Bennett Clinivision, Olympus Endoworks, GE Healthcare Muse and Cardinal Health Sensormedics V-max automated device interfaces are exported with CP. Many other device interfaces are also available and you can view the complete list by visiting the [Clinical Procedures website \(http://vista.med.va.gov/ClinicalSpecialties/clinproc\)](http://vista.med.va.gov/ClinicalSpecialties/clinproc). From the Home page, select **Find a Device** and then search for devices by manufacturer, by type, or by name. Also refer to the ICU web site (<http://vista.med.va.gov/clinicalspecialties/icu/>) for more information.

Visit the Clinical Procedures website to view specific information for a particular device. Click the **vendor** name to view the web page. You can find links to the ICU interfaces at the ICU web site (<http://vista.med.va.gov/clinicalspecialties/icu/findDevice.asp?by=TYPE>).

Device	Vendor	Type of Procedure Performed	Type of report with Discrete data included
Aware Gateway	GE Healthcare	Intensive Care Unit	XML
Clinivision	Puritan Bennett	Respiratory	Text
Endoworks	Olympus	Bronchoscopy, Colonoscopy, EGD, EGDPEG, Endoscopy, ERCP, Endo Ultrasound, Enteroscopy, Liver Biopsy, Paracentesis, Sigmoidoscopy	Text, GIF, JPG
Muse	GE Healthcare	ECG, Exercise, Holter, Pacemaker ECG	PDF
PC1,PC2	Intesys	Clinical Suite	XML
Sensormedics V-max	Cardinal Health (formerly Viasys/Sensormedics)	PFT	PDF

¹ Patch MD*1.0*14 March 2008 Deleted vendor contact information for individual contacts. Updated vendor name list. Directions for finding a device on the CP website changed. Unlinked device names due to unavailable links.

²Patch MD*1.0*16 January 2011 Added paragraph about terminology mapping. Added reference to ICU web site. Added link to the vendor interfaces on the ICU web site. Added vendor.

¹ Exalis	Gambro	Dialysis	XML
² Ultraview series	Spacelabs	Intensive Care Unit	XML
UPF Hemodialysis	B.Braun Melsungen AG	Dialysis	XML
Hypercare	Fresenius Medical Care	Dialysis	XML

For the latest vendor information, please see the [Clinical Procedures website \(http://vista.med.va.gov/ClinicalSpecialties/clinproc\)](http://vista.med.va.gov/ClinicalSpecialties/clinproc).

The Mapping Tables will change as new terms are requested and approved. Refer to the ICU website (<http://vista.med.va.gov/clinicalspecialties/icu/showMapping.asp?ID=56>) for the latest table.

Device Setup Instructions

Here are the setup instructions and vendor contact for each device.

Clinivision

Vendor: Puritan Bennett **Type:** Respiratory

Description:

The uni-directional interface for this instrument is currently available.

Requirements:

This instrument requires a Clinivision vendor interface.

Setup Instructions:

This section describes the installation setup for the Clinivision system. Note that a new Protocol and HL Logical Link will need to be created for this device since it is a Persistent connected device. Clinivision is not a bi-directional device. **Note:** Bi-Directional Capabilities checkbox is **not** checked. Therefore, no outbound HL Logical Link is needed and you do not need to enter any bi-directional information.

¹ Patch MD*1.0*6 May 2008 Hemodialysis exported new device entries.

² Patch MD*1.0*16 January 2011 Added Vendor. Added reference to ICU mapping tables.

1

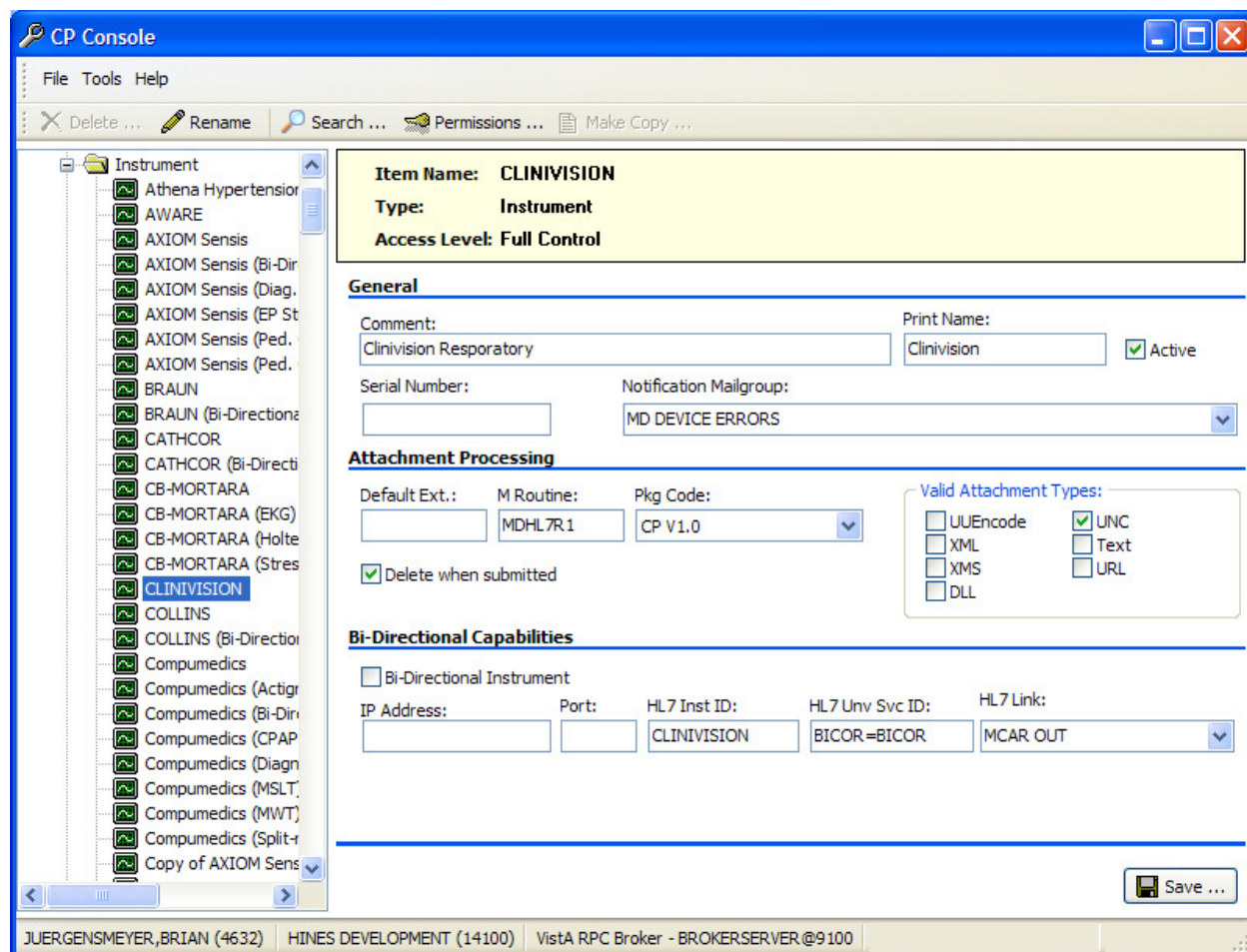


Figure 2, Clinical Procedures Manager

Figure 2, Clinical Procedures Manager displays the settings for the Clinivision device in CP Manager.

¹ Patch MD*1.0*16 January 2011 Name removed from graphic. Added caption to figure.

```

NODE: MCAR3 INST          LLP TYPE: TCP

DEVICE TYPE: Single-threaded Server  STATE: Reading

TIME STARTED: SEP 18, 2002@11:45:27  TASK NUMBER: 321004

SHUTDOWN LLP ?: NO          QUEUE SIZE: 100

RE-TRANSMISSION ATTEMPTS: 3    READ TIMEOUT: 60

ACK TIMEOUT: 60            EXCEED RE-TRANSMIT ACTION: ignore

TCP/IP PORT: 1030          TCP/IP SERVICE TYPE: SINGLE LISTENER

PERSISTENT: YES            STARTUP NODE: ROU:614A01

IN QUEUE BACK POINTER: 1790    IN QUEUE FRONT POINTER: 1790

OUT QUEUE BACK POINTER: 1789    OUT QUEUE FRONT POINTER: 1789
    
```

¹Figure 3, Clinivision Entry in the HL Logical Link File

Figure 3, Clinivision Entry in the HL Logical Link File

3 shows an entry in the HL Logical Link file for the Clinivision device.

```

NAME: MCAR3 Device Client    ITEM TEXT: Instrument HL7 Event Driver

TYPE: subscriber            CREATOR: ACKERMAN,BILL

PACKAGE: CLINICAL PROCEDURES

DESCRIPTION:  This Protocol is used by the HL7 Package to send results to Vista from the Clinivision
Instrument.

IDENTIFIER: E                TIMESTAMP: 59039,32152

SENDING APPLICATION: INST-MCAR    RECEIVING APPLICATION: MCAR-INST

TRANSACTION MESSAGE TYPE: ORU    EVENT TYPE: R01

PROCESSING ID: P              LOGICAL LINK: MCAR3 INST

VERSION ID: 2.3              RESPONSE MESSAGE TYPE: ACK

PROCESSING ROUTINE: D ^MDHL7A    SENDING FACILITY REQUIRED?: NO

RECEIVING FACILITY REQUIRED?: NO
    
```

¹Figure 4, Link Protocol

¹ Patch MD*1.0*16 January 2011 Added caption to figure.

Figure 4 shows the new Protocol that will need to be entered for the Link.

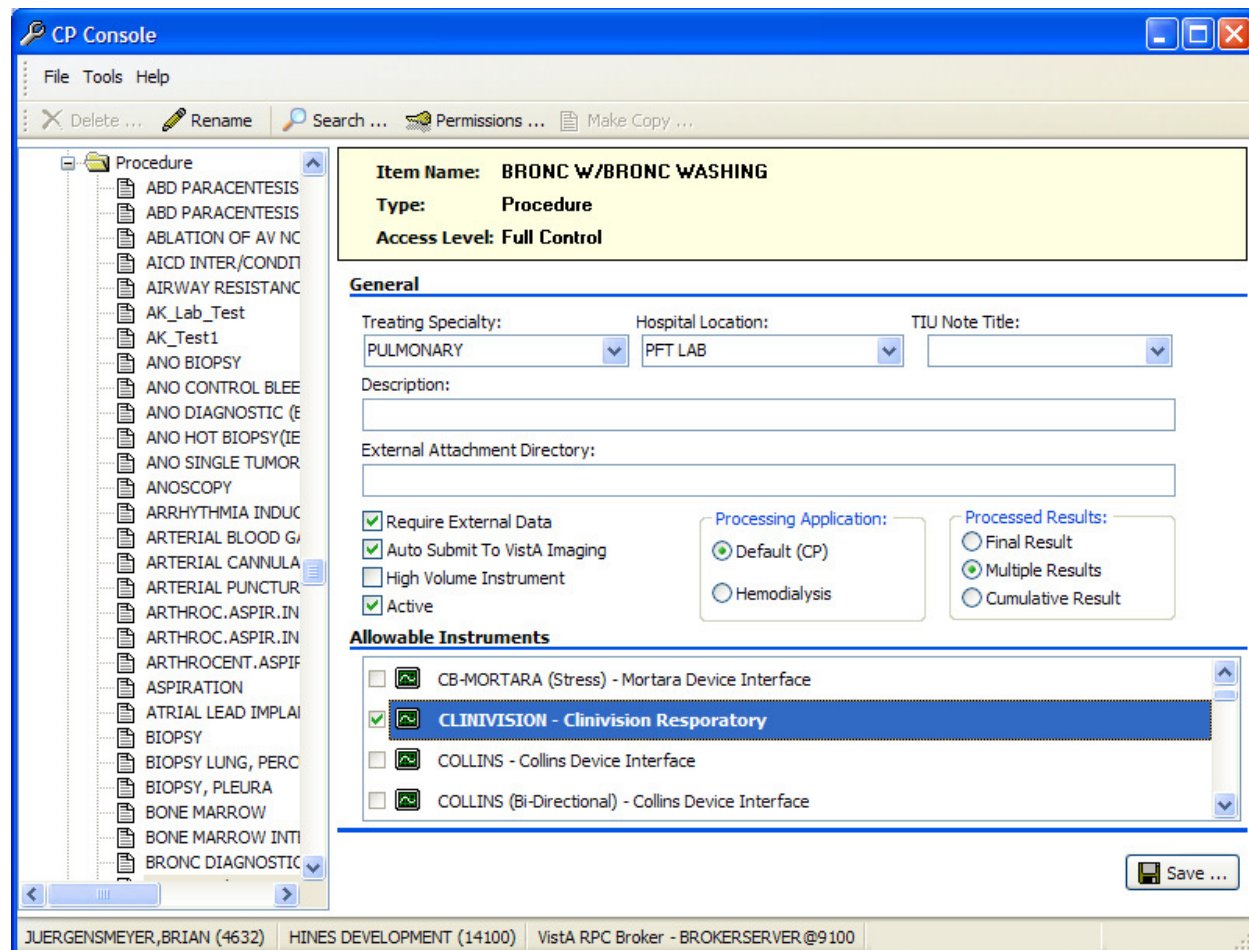


Figure 5, Clinical Procedures Manager

² Figure 5 shows that the device will need to be linked to a procedure in CP Manager.

Contact Clinivision and ask the contact to report the device to the production account, port 1030.

Transmission Instructions:

No information available at this time.

Manuals:

No information available at this time.

Vendor Contacts:

<http://www.clinivision.com/contact/>

¹ Patch MD*1.0*16 January 2011 Removed name from graphic.

² Patch MD*1.0*6 May 2008 Screen capture updated to show new Processing Application field.

Trouble Shooting:

- Is the machine plugged in?
- Is the machine on?
- Are all cables connected correctly?

Endoworks

Vendor: Olympus **Type:** Bronchoscopy, Colonoscopy, EGD, EGDPEG, Endoscopy, ERCP, Endo Ultrasound, Enteroscopy, Liver Biopsy, Paracentesis, Sigmoidoscopy

Description:

The bi-directional interface for this instrument is currently available.

Requirements:

This instrument requires an Advanced Gateway vendor interface.

Setup Instructions:

The Olympus Interface is a non-persistent interface and can share its TCP/IP port address with other non-persistent devices. To configure the Olympus (Endoworks) software, it is recommended that you consult Olympus. Olympus has the correct setting for the Endoworks software that is needed to interface with CP.

¹ The site will need to set up an Olympus type in CPManager.exe for each type of procedure, (such as Olympus (Bronchoscopy), Olympus (Colonoscopy), etc.). Please refer to the Clinical Procedures web site for the device settings for each type of procedure.

```
NODE: MCAR INST          LLP TYPE: TCP
DEVICE TYPE: Single-threaded Server  STATE: Reading
TIME STARTED: SEP 18, 2002@11:45:27  TASK NUMBER: 321004
SHUTDOWN LLP ?: NO          QUEUE SIZE: 100
RE-TRANSMISSION ATTEMPTS: 3      READ TIMEOUT: 60
ACK TIMEOUT: 60             EXCEED RE-TRANSMIT ACTION: ignore
TCP/IP PORT: 1030          TCP/IP SERVICE TYPE: SINGLE LISTENER
PERSISTENT: NO             STARTUP NODE: ROU:614A01
IN QUEUE BACK POINTER: 1790     IN QUEUE FRONT POINTER: 1790
```

¹ Patch MD*1.0*6 May 2008 Added information about setting up a type for each procedure.

OUT QUEUE BACK POINTER: 1789	OUT QUEUE FRONT POINTER: 1789
------------------------------	-------------------------------

¹Figure 6, Inbound HL Logical Link Settings

Figure 6 displays the settings for the standard non-persistent inbound HL Logical Link.

NODE: M CAR OUT	LLP TYPE: TCP
DEVICE TYPE: Non-Persistent Client	STATE: Idle
AUTOSTART: Enabled	TIME STARTED: FEB 25, 2008@08:57:54
TASK NUMBER: 3231951	SHUTDOWN LLP ?: NO
QUEUE SIZE: 100	
RE-TRANSMISSION ATTEMPTS: 3	READ TIMEOUT: 60
ACK TIMEOUT: 60	EXCEED RE-TRANSMIT ACTION: ignore
TCP/IP ADDRESS: 10.3.17.141	TCP/IP PORT: 9027
TCP/IP SERVICE TYPE: CLIENT (SENDER)	PERSISTENT: NO
STARTUP NODE: DEV:DEVISC4A1	IN QUEUE BACK POINTER: 244
IN QUEUE FRONT POINTER: 244	OUT QUEUE BACK POINTER: 251
OUT QUEUE FRONT POINTER: 244	

Figure 7, Outbound HL Logical Link Settings

Error! Reference source not found.7 displays the settings for the standard non-persistent outbound HL Logical Link.

Transmission Instructions:

No information available at this time

Manuals:

No information available at this time.

Costs:

¹ Patch MD*1.0*16 January 2011 Added caption to figure.

No information available at this time.

Trouble Shooting:

- Is the machine plugged in?
- Is the machine on?
- Are all cables connected correctly?

Muse

Vendor: GE Healthcare **Type:** ECG

Description:

The bi-directional interface for this instrument is currently available.

Requirements:

This instrument requires a Muse HL7 vendor interface.

Setup Instructions:

The Muse Interface is a Persistent Interface and must have its own TCP/IP Port address. For configuring the Muse software, it is recommended that you consult with GE Healthcare. GE Healthcare has the correct setting for the Muse software that is needed to interface with CP.

¹The Muse can be set up for different Cardiology procedures such as Holter and Exercise Tolerance Test. Please refer to the Clinical Procedures web page for the setup of the device in CPManager.exe for each type of procedure.

Transmission Instructions:

To send data to Clinical Procedures once the results have been sent from the Cart to the MUSE server, follow these steps:

1. The MUSE generated hard copy is assigned to a cardiologist for over-reading (reviewing).
2. Changes are made on the interpretation, signed by the doctor and returned to the EKG Department.
3. EKG Tech logs on to the MUSE. (All users of the MUSE are assigned a number and password with certain levels of NECESSARY access.)
4. EKG Tech selects over reader (reviewing Cardiologist).
5. EKG Tech selects the patient.
6. EKG Tech selects and then edits the interpretation.
7. EKG Tech selects either Confirm and Print, or Confirm. If Confirm and Print is selected, the HL7 result is sent, and the report is printed. If only Confirm is selected, just the HL7 result is sent.

¹ Patch MD*1.0*6 May 2008 Added information about setting up different procedures.

Manuals:

No information available at this time.

Costs:

No information available at this time.

Trouble Shooting:

1. Is the machine plugged in?
2. Is the machine on?
3. Are all cables connected correctly?

Sensormedics V-MAX

Vendor: Cardinal Health **Type:** PFT

Description:

The bi-directional interface for this instrument is currently available.

Requirements:

This instrument requires a Netlink vendor interface.

¹Configuration Files:

This file contains the configuration parameters for the Vmax software. The vendor should already have a copy of this file.

Setup Instructions:

The Sensormedics Interface is a Non-Persistent Interface and can share TCP/IP ports with other Non-Persistent device interfaces. The Sensormedics V-MAX software must have a shared directory to hold the report document that is created. The directory might be on the PC or on a network share. The key point is that the directory must be accessible from the Sensormedics V-MAX software.

1. Start the Sensormedics V-MAX software.
2. Click on the Reports Button.
3. Select the Netlinks/IS menu from the menu bar.
4. Select TCP/IP from the File Menu on the menu bar.
5. Enter the TCP/IP and Port address to the listener that will be receiving the data from the Sensormedics V-MAX software.
6. Exit back to the Reports Screen.

¹ Patch MD*1.0*14 March 2008 References to Vmaxconfigfile.zip and sample reports were removed because they are no longer hosted on the Clinical Procedures website.

7. Select Setup from the File Menu and enter the Full NETWORK path to the Share directory where you want the PDF document to be stored.

Transmission Instructions:

A path must be setup where the PDF report will be stored prior to being transmitted to VISTA Imaging. This path is usually preset to C:\PDFFiles\ and should be changed to \\(PC Network name)\PDFFiles\. Also, the directory C:\PDFFiles should have Share enabled with Read, Write, Delete permissions for both Imaging and the PC on which the share directory exists.

The following instructions are for transmitting the final patient report to Clinical Procedures.

Note: If the patient whose results you wish to send is already being displayed on the monitor, you can start at step 5.

1. From the Vmax Program Manager screen click the Find Patient Button.



The Find Patient window opens. No patients are displayed.

2. Set search criteria (Last Name, ID, etc.) if any, and click on F1. A list of patients matching your search criteria appears.
3. Select the patient whose results you wish to send by clicking on their name. The selected patient's name is highlighted.
4. Click the F3 button to load the selected patients results data. The Vmax Program Manager screen reappears.
5. From the Vmax Program Manager screen click the Reports Button.



The Reports screen appears.

6. Select the report to process for this patient from the Reports selection box on the left side of the screen. The selected report appears in the upper left box as the Default Patient Report.
7. From the Menu bar click the PrintPDF button to compile the PDF report. A dialog box appears momentarily, indicating the progress of the PDF file creation.
8. From the Menu bar click Netlink/IS® to open the Netlink Transmission Manager.



¹ The Transmission Manager screen appears

Files to be backed up:

¹ Patch MD*1.0*16 January 2011 Name removed from graphic.

You need to backup these files to preserve the operation of Vmax. These files should be backed up after the Vmax is working in production. This list was last updated on May 13, 2003.

Vision folder files used in Netlink communications.

(Depending on software version and configuration, not all files may be present) All files are located in the C:\Vision folder

The following files **always exist** and have **user-modifiable** content

• Id_text.dbf	• Invalid.dbf
• Text_cfg.dbf	• Xmit_cfg.dbf
• Xmitcom.dbf	• Xmithdft.dbf
• Xmithost.dbf	• Xmitparm.dbf
• Xmitpath.dbf	• Xmitxref.dbf

The following files **sometimes exist** and have **user-modifiable** content: They should be manually copied if needed.

• Except	• Replace
• User_1.dbf	• User_2.dbf
• User_3.dbf	• User_4.dbf
• User_5.dbf	• User_6.dbf
• User_7.dbf	•

The following files are shipped **standard** with the software and are **NOT user-modifiable**. They should only be loaded from the software install disk.

• Batchesnd.dbf	• Ctrl_str.dbf
• Received.txt	• Response.txt
• Smascii.dbf	• Smhl7def.dbf
• Smvadeb.dbf	• Xexcept.dbf
• Xmiticon.dbf	• Xmitprm.dbf

• Xreplace	
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The following files are **modified by the software** during operation and **should NOT be user-modified**: They should only be generated by running the software.

• Batchesnd.dbf	• Fileout1.txt
• Fileout2.txt	• Text_rpt.dbf
• Text_rpt.fpt	• Usehost

¹Please refer to the Clinical Procedures web page for the device setup in CPManager.exe.

Manuals:

No information available at this time.

Costs:

No information available at this time.

Trouble Shooting:

Is the machine plugged in?

Is the machine on?

Are all cables connected correctly?

B. Braun

Vendor: B. Braun Melsungen AG **Type:** Hemodialysis

Description:

Both uni-directional and bi-directional interfaces for this instrument are currently available.

Requirements:

This device uses B. Braun's UPF Hemodialysis software.

¹ Patch MD*1.0*6 May 2008 Added reference to CP web page for device setup. Added Hemodialysis vendor B. Braun.

Setup Instructions (B. Braun Device Settings for CP Manager)

Setting For:	Clinical Procedures Device Manager
Procedure Type (HL7 Universal Service ID)	BRAUN (Bi-Directional)
Settings:	Device Setup for the BRAUN (Bi-Directional) ----- NAME: BRAUN (Bi-Directional) PRINT NAME: BBRAUN DESCRIPTION: BBraun Dialysis Device Interface M ROUTINE: MDHL7D PACKAGE CODE: CP V1.0 ATTACH: UNC BI-DIRECTIONAL: YES HL7 INST: BRAUN HL7 UNIVERSAL SERVICE ID: ----- Verified at Hines By: W. A. Ackerman

¹Fresenius Medical Care

Vendor: Fresenius Medical Care **Type:** Hemodialysis

Description:

Both uni-directional and bi-directional interfaces for this instrument are currently available.

Requirements:

This device uses Fresenius's Hypercare software.

¹ Patch MD*1.0*6 May 2008 Added Hemodialysis vendor Fresenius.

Setup Instructions (Hypercare Device Settings for CP Manager)

Setting For:	Clinical Procedures Device Manager
Procedure Type (HL7 Universal Service ID)	Fresenius (Bi-directional)
Settings:	Device Setup for the Fresenius (Bi-directional) ----- NAME: Fresenius (Bi-directional) PRINT NAME: Fresenius DESCRIPTION: Fresenius Dialysis Device Interface M ROUTINE: MDHL7D PACKAGE CODE: CP V1.0 ATTACH: UNC BI-DIRECTIONAL: YES HL7 INST: Fresenius HL7 UNIVERSAL SERVICE ID: ----- Verified at Hines By: W. A. Ackerman

¹Gambro

Vendor: Gambro **Type:** Hemodialysis

Description:

Both uni-directional and bi-directional interfaces for this instrument are currently available.

Requirements:

This device uses Gambro's Exalis software.

Setup Instructions:**Interface Notes for Exalis to Hemodialysis**

- Exalis runs on a PC. VA-Exalis_Interface runs on the same PC as Exalis. The PC must be networked so that there can be a TCP/IP connection between VistA and VA-Exalis_Interface. The Exalis software runs as a standard application (not a service), thus requiring that the PC has been logged on with some user account rather than simply

¹ Patch MD*1.0*6 May 2008 Added Hemodialysis vendor Gambro.

turned on. At this time VA-Exalis_Interface, is a standard application. It may become a service if design and resource constraints allow.

- VA-Exalis_Interface is a .NET application and so requires the .NET Framework 1.1 Redistributable which is freely downloadable from Microsoft and will be included on the VA-Exalis_Interface CDROM.

¹B. Braun Device Settings for CP Manager

Setting For:	Clinical Procedures Device Manager
Procedure Type (HL7 Universal Service ID)	GAMBRO_EXALIS
Settings:	Device Setup for the GAMBRO_EXALIS ----- NAME: GAMBRO_EXALIS PRINT NAME: Gambro Exalis DESCRIPTION: Cobe Dialysis Device Interface M ROUTINE: MDHL7D PACKAGE CODE: CP V1.0 ATTACH: UNC BI-DIRECTIONAL: NO HL7 INST: GAMBRO_EXALIS HL7 UNIVERSAL SERVICE ID: ----- Verified at Hines By: W. A. Ackerman

¹ Patch MD*1*16 May 2010 Removed terminology dictionaries for Aware and Spacelabs.

16. Glossary

Access Code A unique sequence of characters known by and assigned only to the user, the system manager and/or designated alternate(s). The access code (in conjunction with the verify code) is used by the computer to identify authorized users.

Action A functional process that a clinician or clerk uses in the TIU computer program. For example, “Edit” and “Search” are actions. Protocol is another name for Action.

¹**ADP** Automated Data Processing

ADP Coordinator/ADPAC/Application Coordinator Automated Data Processing Application Coordinator. The person responsible for implementing a set of computer programs (application package) developed to support a specific functional area such as clinical procedures, PIMS, etc.

ADT Advanced Data Type (InterSystems Cache). Also Admissions, Discharges, Transfers.

AP Arterial pressure

²**API** Application programming interface, an interface that a computer system, library or application provides in order to accept requests for services from other programs, and/or to allow data to be exchanged between them.

Application A system of computer programs and files that have been specifically developed to meet the requirements of a user or group of users.

Archive The process of moving data to some other storage medium, usually a magnetic tape, and deleting the information from active storage in order to free-up disk space on the system.

Assessment Assessment is the documentation of a clinician’s observations and interpretation of a patient’s clinical state based on a particular set of observations. The documentation is in the form of name-value pairs with values selected from a predetermined set, of name-value pairs in which the value is a number or set of numbers, or of free text.

ASU Authorization/Subscription Utility, an application that allows sites to associate users with user classes, allowing them to specify the level of authorization needed to sign or order specific document types and orderables. ASU is distributed with TIU in this version; eventually it will probably become independent, to be used by many VistA packages.

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

² Patch MD*1.0*6 May 2008 Glossary term added.

Attachments Attachments are files or images stored on a network share that can be linked to the CP study. CP is able to accept data/final result report files from automated instruments. The file types that can be used as attachments are the following:

.txt	Text files
.rtf	Rich text files
.jpg	JPEG Images
.jpeg	JPEG Images
.bmp	Bitmap Images
.tiff	TIFF Graphics (group 3 and group 4 compressed and uncompressed types)
.pdf	Portable Document Format
.html	Hypertext Markup Language

.DOC (Microsoft Word files) are not supported. Be sure to convert .doc files to .rtf or to .pdf format.

Background Processing Simultaneous running of a "job" on a computer while working on another job. Examples would be printing of a document while working on another, or the software might do automatic saves while you are working on something else.

Backup Procedures The provisions made for the recovery of data files and program libraries and for restart or replacement of ADP equipment after the occurrence of a system failure.

Boilerplate Text A pre-defined TIU template that can be filled in for Titles, Speeding up the entry process. TIU exports several Titles with boilerplate text which can be modified to meet specific needs; sites can also create their own.

¹**BP** Blood pressure

²**Broker** Software which mediates between two objects, such as a client and a server or a repository and a requestor.

Browse Lookup the file folder for a file that you would like to select and attach to the study. (e.g., clicking the "...” button to start a lookup).

Bulletin A canned message that is automatically sent by MailMan to a user when something happens to the database.

¹ Patch MD*1.0*16 January 2011 Glossary term added.

² Patch MD*1.0*6 May 2008 Glossary term added.

Business Rule Part of ASU, Business Rules authorize specific users or groups of users to perform specified actions on documents in particular statuses (e.g., an unsigned CP note may be edited by a provider who is also the expected signer of the note).

¹**CAC** Clinical Application Coordinator

Care Action Care action is an intervention scheduled on a patient that may or may not be ordered.

CCB Change Control Board

CCDSS Clinical Care Delivery Support System

CCOW Clinical Context Object Workgroup. An HL7 standard protocol through which applications can synchronize in real-time, enabling Single Sign On and Context Management.

CDR Clinical Data Repository

CGI CliO Generic Interface

CIS Clinical Information System. An ICU Clinical Information System is any hardware/software system that works in concert to collect, store, display, and/or enable manipulation of potential, clinically relevant information. A CIS also acts as an HL7 Gateway. Vendors of monitors and other instruments used in an ICU provide the CIS. The primary distinguishing feature of this CIS is its ability to manually select a subset of all available data and send it to the EMR.

Class Part of Document Definitions, Classes group documents. For example, “CLINICAL PROCEDURES” is a class with many kinds of Clinical Procedures notes under it. Classes may be subdivided into other Classes or Document Classes. Besides grouping documents, Classes also store behavior which is then inherited by lower level entries.

Clinical Flowsheets A patch to the Clinical Procedures package that allows the collection of discrete data from medical devices or a Clinical Information System. It is a complete HL7 standardized instrument interface developed and owned by the Department of Veterans

Clinical Reminders A system which allows caregivers to track and improve preventive healthcare and disease treatment for patients and to ensure timely clinical interventions.

CliO Clinical Observations database

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

¹CM Configuration Management

Consult Referral of a patient by the primary care physician to another hospital service/ specialty, to obtain a medical opinion based on patient evaluation and completion of any procedures, modalities, or treatments the consulting specialist deems necessary to render a medical opinion.

Contingency Plan A plan that assigns responsibility and defines procedures for use of the backup/restart/recovery and emergency preparedness procedures selected for the computer system based on risk analysis for that system.

CP Clinical Procedures.

CP Console An application used by Administrators to configure the CP Flowsheets application and its interface settings.

CP Definition CP Definitions are procedures within Clinical Procedures.

CP Flowsheets A GUI component of the Clinical Flowsheets package. Its primary functions are to provide a means to display data collected from a medical device and to allow manual entry of data. Additional functionality is provided to display and print reports, verify incoming observational data, add comments, correct erroneous information, and submit TIU Notes to CPRS.

²CP Gateway The service application that prepares the data contents of HL7 messages for use in CP Hemodialysis. It requires no direct user interaction.

CP Study A CP study is a process created to link the procedure result from the medical device or/and to link the attachments browsed from a network share to the procedure order.

CPRS Computerized Patient Record System. A comprehensive VistA program, which allows clinicians and others to enter and view orders, Progress Notes and Discharge Summaries (through a link with TIU), Problem List, view results, reports (including health summaries), etc.

Data Dictionary A description of file structure and data elements within a file.

DBIA Database integration agreement.

Delphi A programming language, also known as Object Pascal.

Device A hardware input/output component of a computer system (e.g., CRT, printer).

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

² Patch MD*1.0*6 May 2008 Glossary terms added.

¹Display Interval The amount of time that displays in each column of a flowsheet view. Display interval is configurable from 1 minute to 24 hours. Shorter interval settings can improve readability when a large amount of data is received over a short period of time. Longer interval settings allow you to view longer periods of time while reducing the amount of horizontal scrolling necessary to view all columns.

²DLL Dynamically-Linked Library – provides the benefit of shared libraries.

DOB Date of Birth

Document Class Document Classes are categories that group documents (Titles) with similar characteristics together. For example, Cardiology notes might be a Document Class, with Echo notes, ECG notes, etc. as Titles under it. Or maybe the Document Class would be Endoscopy Notes, with Colonoscopy notes, etc. under that Document Class.

Document Definition Document Definition is a subset of TIU that provides the building blocks for TIU, by organizing the elements of documents into a hierarchy structure. This structure allows documents (Titles) to inherit characteristics (such as signature requirements and print characteristics) of the higher levels, Class and Document Class. It also allows the creation and use of boilerplate text and embedded objects.

DUZ The internal entry number inside FileMan for a particular user.

Edit Used to change/modify data typically stored in a file.

EMR Electronic Medical Record, the HealthVet, is the permanent medical record for a patient in VistA

Field A data element in a file.

File The M construct in which data is stored for retrieval at a later time. A computer record of related information.

File Manager or FileMan Within this manual, FileManager or FileMan is a reference to VA FileMan. FileMan is a set of M routines used to enter, edit, print, and sort/search related data in a file, a database.

File Server A machine where shared software is stored.

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

² Patch MD*1.0*6 May 2008 Glossary terms added.

¹Flowsheet A flowsheet is a table, chart, spreadsheet, or other method of displaying data on two axes. One axis represents time intervals and the other axis represents the readings from an ICU monitor documented at the various time intervals.

Flowsheet view A customizable subsection (or page) of a flowsheet. Flowsheet views are created by adding and arranging terms and choosing their default qualifiers. Flowsheet views can be set up to display observations, provide a way to manually enter observations, and display reports.

Fluid off Cumulative volume of fluid removed from patient.

Gateway The software that performs background processing for Clinical Procedures.

Global An M term used when referring to a file stored on a storage medium, usually a magnetic disk.

GUI Graphical User Interface - a Windows-like screen that uses pull-down menus, icons, pointer devices, and other metaphor-type elements that can make a computer program more understandable, easier to use, allow multi-processing (more than one window or process available at once), etc.

HDR Health Data Repository

HEP (CUM) Cumulative heparin infusion

HFS Host File System

HIPAA Health Insurance Portability and Accountability Act

²HL7 Health Level 7 messaging, a language which various healthcare systems use to interface with one another.

HL7 Gateway Hardware or software provided by a vendor that is able to receive information in a vendor's proprietary format from one or more ICU monitors and other instruments, to translate the data into standardized HL7 message format, and to pass the messages to other systems.

HR Heart rate

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

² Patch MD*1.0*6 May 2008 Glossary terms added.

HSD&D Office of Information (OI), Health Systems Design & Development

HSITES Health Systems Implementation, Training, Education and Support

ICU Intensive Care Unit

IEN Internal Entry Number

IJ Internal jugular

Instrument An instrument is a device used to perform a medical function on a patient. In Clinical Flowsheets instrument refers to ICU monitors, which are electronic devices that collect and/or display information concerning the physical state of a patient. Usually, the monitor attaches to a patient and takes readings over time without requiring intervention for each reading.

Interpreter Interpreter is a user role exported with USR*1*19 to support the Clinical Procedures Class. The role of the Interpreter is to interpret the results of a clinical procedure. Users who are authorized to interpret the results of a clinical procedure are sent a notification when an instrument report and/or images for a CP request are available for interpretation. Business rules are used to determine what actions an interpreter can perform on a document of a specified class, but the interpreter themselves are defined by the Consults application. These individuals are 'clinical update users' for a given consult service.

IRM Information Resource Management.

IRMS Information Resource Management Service.

JCAHO Joint Commission on Accreditation of Healthcare Organizations

Kernel A set of software utilities. These utilities provide data processing support for the application packages developed within the VA. They are also tools used in configuring the local computer site to meet the particular needs of the hospital. The components of this operating system include: MenuMan, TaskMan, Device Handler, Log-on/Security, and other specialized routines.

LAYGO An acronym for Learn As You Go. A technique used by VA FileMan to acquire new information as it goes about its normal procedure. It permits a user to add new data to a file.

LPES/CPS Legacy Product Enterprise Support/Clinical Product Support. Enterprise Product Support (formerly Enterprise VistA Support).

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

Log A list that provides the time and description of events as they occur

M Formerly known as MUMPS or the Massachusetts (General Hospital) Utility Multi-Programming System. This is the programming language used to write all VistA applications.

MailMan An electronic mail, teleconferencing, and networking system.

Menu A set of options or functions available to users for editing, formatting, generating reports, etc.

Module A component of a software application that covers a single topic or a small section of a broad topic.

MUMPS Massachusetts General Hospital Utility Multi-Programming System. Obsolete; now known as "M" programming language.

Namespace A naming convention followed in the VA to identify various applications and to avoid duplication. It is used as a prefix for all routines and globals used by the application.

Network Server Share A machine that is located on the network where shared files are stored.

Notebook This term refers to a GUI screen containing several tabs or pages.

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

¹NTE Not to exceed

OI Office of Information, formerly known as Chief Information Office Field Office, Information Resource Management Field Office, and Information Systems Center.

Option A functionality that is invoked by the user. The information defined in the option is used to drive the menu system. Options are created, associated with others on menus, or given entry/exit actions.

Optional page One of two special types of flowsheet views which provides a way to track a specific condition (e.g., a pacemaker) on its own flowsheet view. An Optional Page can display only once in a given flowsheet. If an optional page is closed and then redisplayed, any data previously entered still displays.

Package Otherwise known as an application. A set of M routines, files, documentation and installation procedures that support a specific function within VistA.

Page This term refers to a tab on a GUI screen or notebook.

Password A protected word or string of characters that identifies or authenticates a user, a specific resource, or an access type (synonymous with Verify Code).

PCE Patient Care Encounter

PIMS Patient Information Management System

Pivot Swap the axes of a table or chart. This causes the values that were displayed along the vertical axis to be displayed along the horizontal axis and the values that were displayed along the horizontal axis to be displayed along the vertical axis.

PM Project Manager

Pointer A special data type of VA FileMan that takes its value from another file. This is a method of joining files together and avoiding duplication of information.

PRN As needed

Procedure Request Any procedure (EKG, Stress Test, etc.) which may be ordered from another service/specialty without first requiring formal consultation.

Program A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

¹Protocol A set of rules governing communication within and between computing endpoints.

²PS Provider Systems

PV Pulmonary Vascular

QG Quality Gate

Qualifiers A word or phrase that provides specific information about an observation. For example, an observation could have qualifiers such as Unit (f=degrees Fahrenheit, c=degrees Celsius, bpm=beats per minute, rpm=respirations per minute, etc.), Method (Cu=cuff BP, Dop=Doppler BP, etc.), Position (Ly=lying, Si=sitting, St=standing, etc.), Location (La=left arm, LL=left leg, RA=right arm, RL=right leg, etc.), Quality (A=accurate, E=Estimated), etc.

Queuing The scheduling of a process/task to occur at a later time. Queuing is normally done if a task uses up a lot of computer resources.

RAID Redundant array of inexpensive disks, a data storage scheme using multiple hard drives to share or replicate data among the drives.

Result A consequence of an order. Refers to evaluation or status results. When you use the Complete Request (CT) action on a consult or request, you are transferred to TIU to enter the results.

<RET> Carriage return.

Routine A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

RPC Remote Procedure Call, a protocol that allows a computer program running on one host to cause code to be executed on another host.

Rx Prescription

SAC Standards and Conventions.

Security Key A function which unlocks specific options and makes them accessible to an authorized user.

Sensitive Information Any information which requires a degree of protection and which should be made available only to authorized users.

¹ Patch MD*1.0*6 May 2008 Glossary terms added.

² Patch MD*1.0*16 January 2011 Glossary terms added.

¹Service A long-running executable designed to perform specific functions without user intervention. Windows services can be configured to restart automatically when the operating system is rebooted.

SGML Standard Generalized Markup Language

Shift A period of time that can be defined in CP Flowsheets. This often corresponds to the time an individual an individual works.

Site Configurable A term used to refer to features in the system that can be modified to meet the needs of each site.

Software A generic term referring to a related set of computer programs. Generally, this refers to an operating system that enables user programs to run.

SQA Software Quality Assurance

SRS Software Requirements Specification

SSN Social Security Number

Status Symbols Codes used in order entry and Consults displays to designate the status of the order.

STS Standards and Terminology Services. An initiative to create and maintain standardized terminology throughout the VA by assigning a code to every term.

Supplemental page One of two special types of flowsheet views which provides a way to track a specific condition (e.g., a pressure wound) on its own flowsheet view. Multiple supplemental pages can be added to a single flowsheet in order to track numerous specific

Tab One of the five primary GUI screens of the CP Flowsheets application: Flowsheet, Alarms, Reports, Log Files, and HL7 Monitor.

Task Manager or TaskMan A part of Kernel which allows programs or functions to begin at specified times or when devices become available. See Queuing.

Terminology Standardization of words and terms used in Flowsheets.

Title Titles are definitions for documents. They store the behavior of the documents which use them.

TIU Text Integration Utilities.

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

¹**TMP** Trans membrane pressure

UFR Ultrafiltration rate

UI User Interface

²**UNC** Universal naming Convention.

Untrusted device A medical instrument which has not been mapped for use with the Clinical Flowsheets package. Data sent from an untrusted device will not display in a flowsheet view until someone reviews it (on the CP Flowsheets Log Files tab) and marks it as verified.

URL Uniform Resource Locator – a means of finding a resource (such as a web page or a device) on the Internet.

URR Urea reduction ratio - The reduction in urea as a result of dialysis

UNC Universal naming Convention.

URL Uniform Resource Locator – a means of finding a resource (such as a web page or a device) on the Internet.

User A person who enters and/or retrieves data in a system, usually utilizing a CRT.

User Class User Classes are the basic components of the User Class hierarchy of ASU (Authorization/Subscription Utility) which allows sites to designate who is authorized to do what to documents or other clinical entities.

User Role User Role identifies the role of the user with respect to the document in question (e.g., Author/Dictator, Expected Signer, Expected Cosigner, Attending Physician, etc.).

Utility An M program that assists in the development and/or maintenance of a computer system.

UUEncoded format A form of binary to text encoding whose name derives from "Unix-to-Unix encoding."

VA Department of Veterans Affairs; formerly the Veterans Administration.

VAMC Department of Veterans Affairs Medical Center

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

² Patch MD*1.0*6 May 2008 Glossary terms added.

¹VDEF VistA Data Extraction Framework.

Verify Code A unique security code which serves as a second level of security access. Use of this code is site specific; sometimes used interchangeably with a password.

VHA Veterans Health Administration

VistA Veterans Health Information Systems and Technology Architecture.

VP Venous pressure

VUID Veterans Health Administration (VHA) Unique Identifier. A unique identifier that specifies individual data elements or observations. In Clinical Flowsheets, each term is assigned a VUID.

Workstation A personal computer running the Windows 9x or NT operating system.

²XML Extensible Markup Language – A simplified subset of Standard Generalized Markup Language (SGML). Its primary purpose is to facilitate the sharing of data across different information systems.

XMS Extended Memory Specification – The specification describing the use of extended memory in real mode for storing data.

¹ Patch MD*1.0*16 January 2011 Glossary terms added.

² Patch MD*1.0*6 May 2008 Glossary terms added.