RESOURCE AND PATIENT MANAGEMENT SYSTEM

iCare Population Management GUI

(BQI)

Patient Record User Manual

Version 2.8
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Office of Information Technology (OIT)
Division of Information Technology

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Preface

The iCare application is a Windows-based, client-server graphical user interface (GUI) to the Indian Health Service (IHS) Resource and Patient Management System (RPMS). The iCare application retrieves key patient information from various components of the RPMS database and brings it together under a single, user-friendly interface. iCare is intended to help providers manage the care of their patients. The ability to create multiple panels of patients with common characteristics (e.g., age, diagnosis, community) allows users to personalize the way they view patient data.

1.0 Introduction

The purpose of this manual is to provide you with the needed information to use the latest enhancements to the Patient Record window in the iCare (BQI) population management application.

This manual contains reference information about iCare views, examples of its processes, and step-by-step procedures to show you how to perform activities related to the Patient Record window in the latest version of the iCare application.

2.0 System Navigation

The patient record window has several tabs and other information that shows patient data information stored in the RPMS database. This window provides a wide range of clinical data, with a focus on providing quick access to needed data.

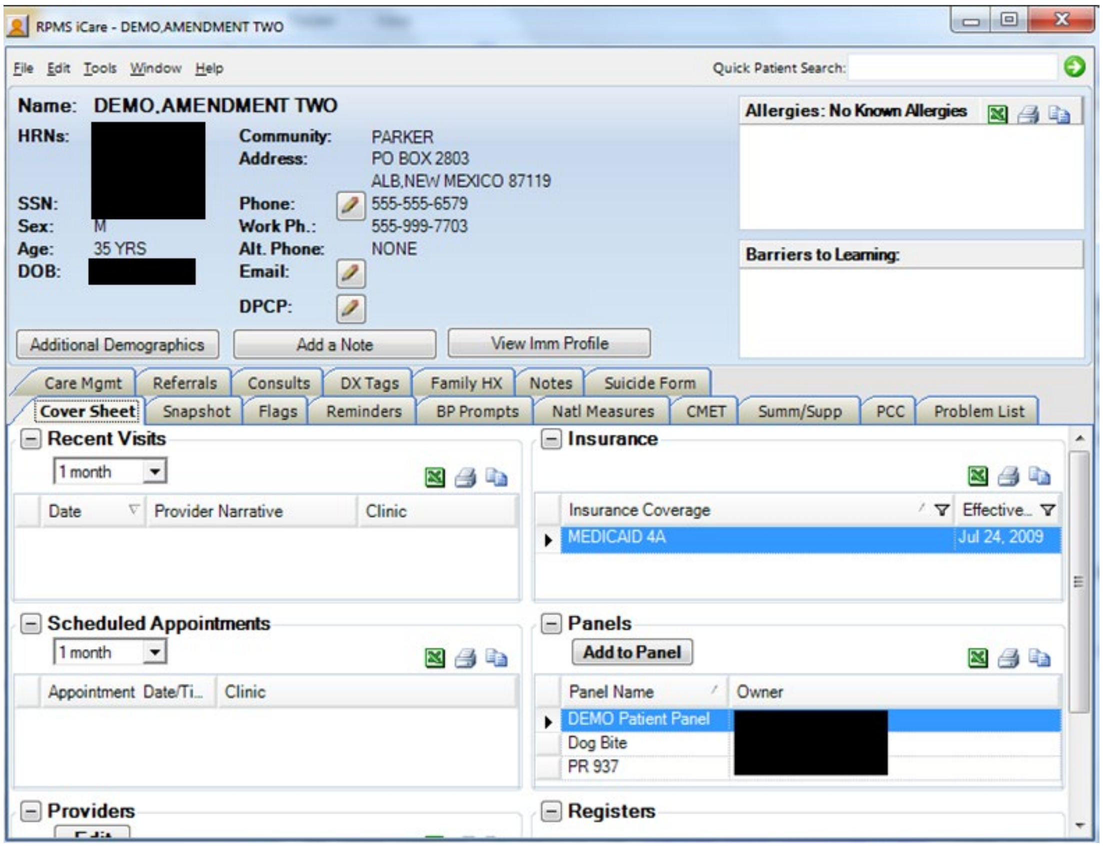


Figure 2-1: Sample Patient Record window

- The patient record window can be accessed either by opening a patient record on a panel or by a direct search for a patient name.
- The Suicide Form tab might not display. This tab displays for those with special keys.
- The **Quick Patient Search** field allows you to search for a particular patient (even one that is not on any of your panels). After a successful search, the data for the indicated patient will display on the Patient Record window.
- As a general rule, when you double-click any date that is underlined (in the Date column), the **Visit File** dialog will display.

2.1 User Preferences

2.1.1 Specifying the Default Tab

You can set which tabs display and the starting tab for the **Patient Record** window by defining it on the Patient View tab of the **User Preferences** window (select **Tools | User Preferences**). This means that when you access the Patient Record window, only the tabs you select will be display and the string tab will be on top. Section 4.1 provides information about User Preferences.

2.2 Security Keys

2.3 Site Parameters

3.0 Package Management

This section describes the steps to be followed to use the Patient Record.

3.1 Patient Demographic Group Box

The top group box shows the patient demographic information. This information remains visible from any tab on the Patient Record window.

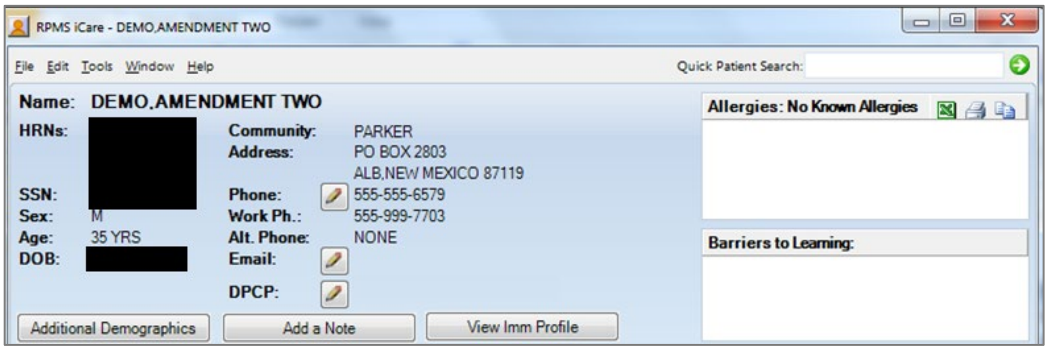


Figure 3-1: Sample Patient demographics group box

3.1.1 Community Field

The Community field shows any alerts about the community in which the patient resides. If the community alert icon ( ) is displayed, click it to display the **Community Alerts for** dialog.

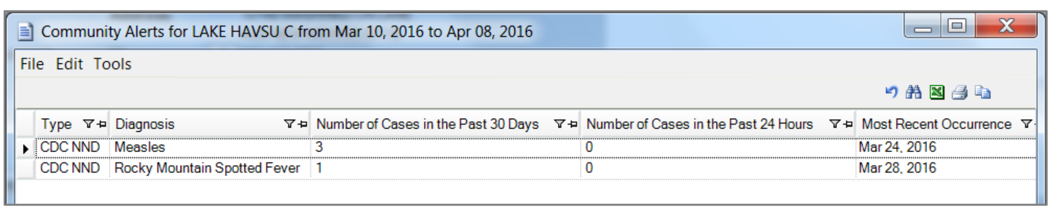


Figure 3-2: Sample **Community Alerts** for Community dialog

3.1.1.1 Community Alerts Layout

The following provides information about the data columns:

- **Type**: The following describes the alert types: (1) CDC Nationally Notifiable Infections Diseases (NND) and (2) Suicidal Behavior: Ideation, Attempt and Completion. For this version, the logic will only display each alert for 30 days from the visit occurrence date.
- **Diagnosis**: The diagnosis category for the alert.
- **Number of Cases Past 30 Days**: The number of cases in the past 30 days.

- **Number of Cases in the Past 24 Hours**: The number of cases in the past 24 hours.
- **Most Recent Occurrence**: The date for the most recent occurrence.

3.1.1.2 Menus on Community Alerts for Community Dialog

The File menu contains the following options:

- **Page Setup**: This option allows you to set Margin, Paper, Layout characteristics (such as landscape or portrait orientation), and the Printer to use.
- **Print Preview**: This option displays the print preview dialog. See Section 4.12 for more information about this dialog.
- **Print**: This option sends the page to the printer using the settings in Page Setup.
- **Close**: The option closes the dialog.

The **Edit** menu contains the **Select All** and **Deselect** options. The **Select All** option will select all of the records in the grid.

The **Tools** menu contains the **Reset View**, **Search**, **Export to Excel**, and **Copy Rows to Clipboard** options that work like the buttons on the right side of the window. Section 4.2 provides information about these buttons.

3.1.1.3 Buttons on Community Alerts for Community Dialog

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.1.2 Allergies Field

The **Allergies** field pulls data (about the patient) directly from the Adverse Reaction Tracking application. Each reaction shows a tooltip (Causative Agent, Reaction, Date of Onset, Historical, or Observed). You can do the following with the selected rows in the grid: Export to Excel, Print, or Copy; Section 4.2 provides information about these buttons.

The allergies message in the iCare Patient view will read, "No Known Allergies" if No Known Allergies is listed in the Electronic Health Record (EHR) for the patient. The allergies message in the view will read as No Allergy Assessment if none have been found in the Adverse Reaction Tracking application.

Section 4.2 provides information about the buttons on the right side of the toolbar of the Allergies.

3.1.3 Barriers to Learning Field

The **Barriers to Learning** field lists the current values for any health factor categorized as Barriers to Learning, e.g., Blind, Deaf, etc.

3.1.4 Phone Fields

The user with appropriate iCare Editor access can edit any of the available phone number fields (Home Alternate, Work) on the Demographic header area.

Click the pencil ( ) button next to the phone number to display the **Edit Patient Demographic Fields** dialog. Section 4.3 provides information about this dialog.

3.1.5 Email Field

You can edit the Email field by clicking the pencil ( ) button next to the Email field to display the **Edit Patient Demographic Fields** dialog. Section 4.3 provides information about this dialog.

3.1.6 DPCP Field

This field displays the Designated Primary Care Provider (DPCP) assigned for the patient. If there is no name in this field, that means that the DPCP has not been assigned; however, other specialty providers might have been assigned. These specialty provider names display in the **Providers** group box on the **Cover Sheet** tab of the patient record.

You can edit the **DPCP** field by clicking the pencil ( ) button to access the **Edit Providers** dialog (for the current patient).

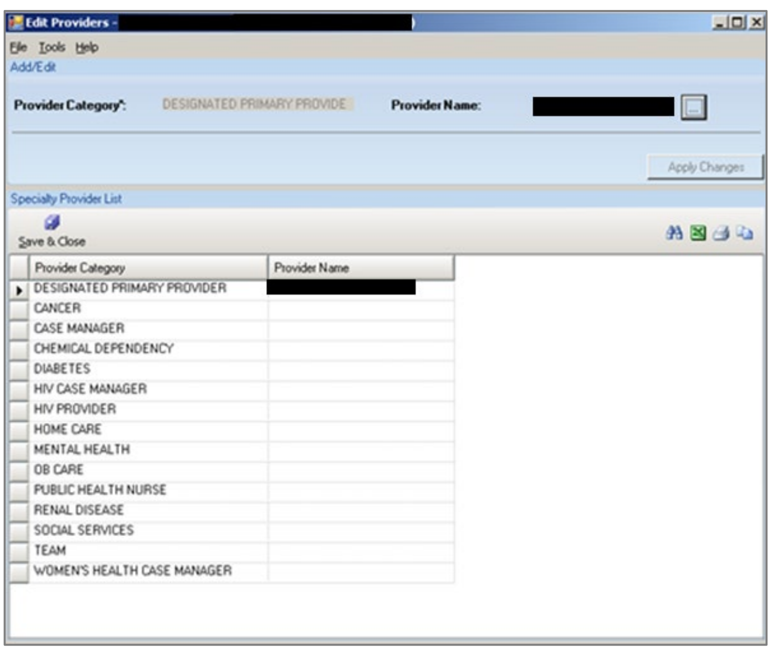


Figure 3-3: Sample **Edit Providers** dialog

Use the **Edit Providers** dialog to add, edit, or remove specialty provider names for the various provider categories. Section 4.7 provides information about this dialog.

3.1.7 Additional Demographics Button

You can view more information about the patient's demographics by clicking the **Additional Demographics** button to access the **Additional Demographics** dialog.

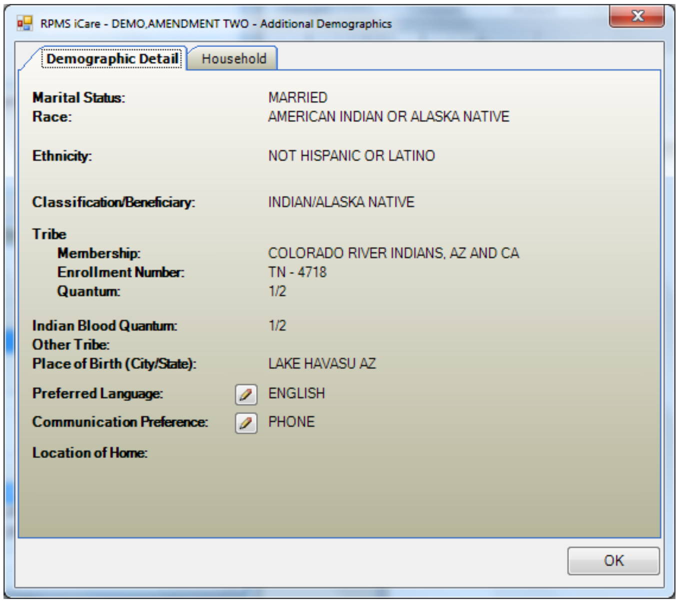


Figure 3-4: Sample **Additional Demographics** dialog

Click **OK** to dismiss this dialog.

- **Demographic Detail** tab: Change the **Race**, **Ethnicity**, **Preferred Language**, and/or **Communication Preferences** fields by clicking the pencil ( ) button next to the field. This action displays the **Edit Patient Demographic Fields** dialog. Section 4.3 provides information about the dialog.
- **Household** tab: You can view additional household information by selecting the **Household** tab. These data values are from the RPMS Patient Registration application (and are view only).

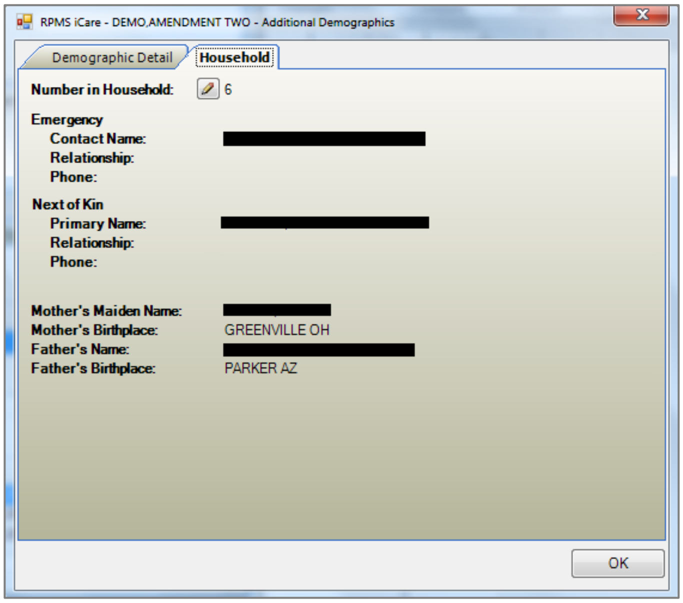


Figure 3-5: Sample Information on **Household** tab

Change the **Number in Household** by clicking the pencil ( ) button to access the **Edit Patient Demographic Fields** dialog. Section 4.3 provides information about the dialog.

3.1.8 Add a Note

Use the **Add a Note** button to add a TIU note for the current patient. This involves a two-step process:

1. Click the **Add a Note** button to access the **Add a Note** dialog and then complete the fields on this dialog. Section 4.4 provides information about the dialog.

2. Click the **Create** button on the **Add a Note** dialog to access the **Add TIU Note** dialog. Section 4.5 provides more information about the dialog.

After clicking the **Add a Note** button, and if no default clinics are defined in user preferences, the application displays the following message: “You must select default clinics in user preferences before being able to enter notes.”

Click **OK** to dismiss the message. Select **Tools** | **User Preferences** to access the **RPMS iCare – User Preferences** dialog. Go to the **Patient View** tab to enter the clinic codes. Section 4.1 provides information about user preferences.

3.1.9 View IMM Profile

Use the **View IMM Profile** button to view the **Immunization Profile** dialog (Figure 3-6).

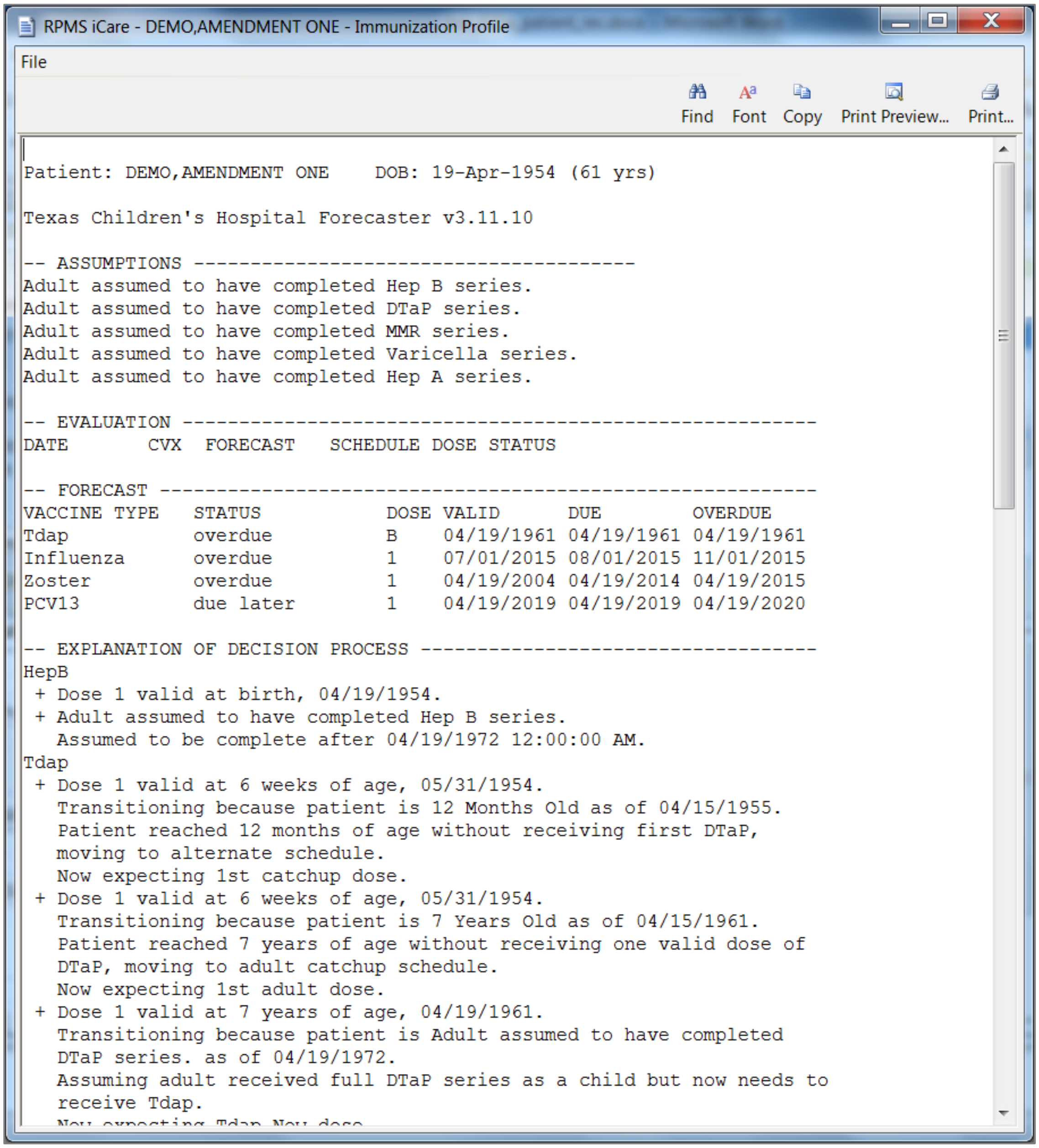


Figure 3-6: Sample **Immunization Profile** dialog

This dialog provides information about the patient's immunization history. Section 4.6 provides information about using the controls on the dialog.

3.2 Cover Sheet Tab

The **Cover Sheet** tab includes several categories of data, such as Providers, Recent Visits, etc.

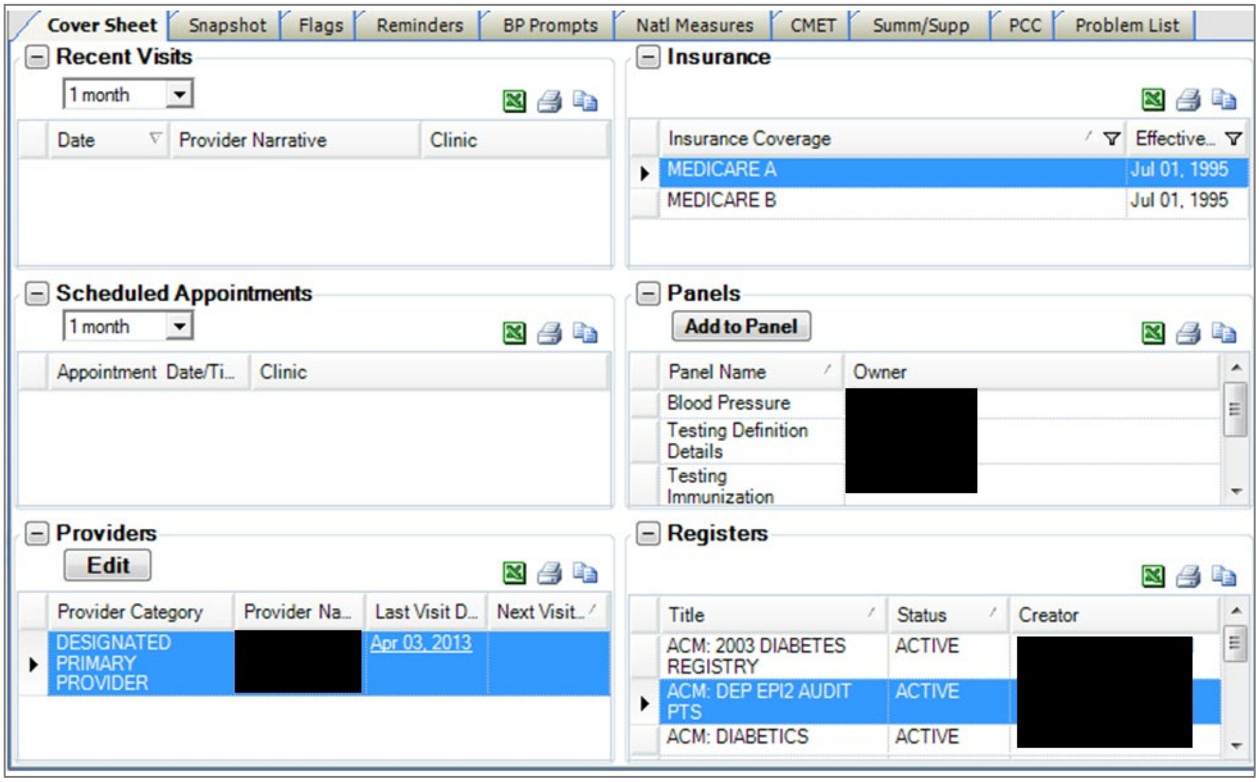


Figure 3-7: Sample Cover Sheet tab

The icon next to each group box name is the expand-collapse symbol. These symbols work like they do in any Windows application:

- Click the expand (⊟) symbol to expand the group box.
- Click the collapse (⊞) symbol to collapse the group box.

Section 4.2 provides information about the buttons on the right side of each group box.

You can sort/filter the columns and perform other functions on the columns in the various group boxes.

3.2.1 Recent Visits Group Box

The **Recent Visits** group box displays the visits in order of most recent visit first, within the selected timeframe. You can determine the time range for the visit display by selecting an option from the list (the default is 1 month).

Hover your mouse over a record to view key visit information (such as diagnosis, provider, etc.) about the visit.

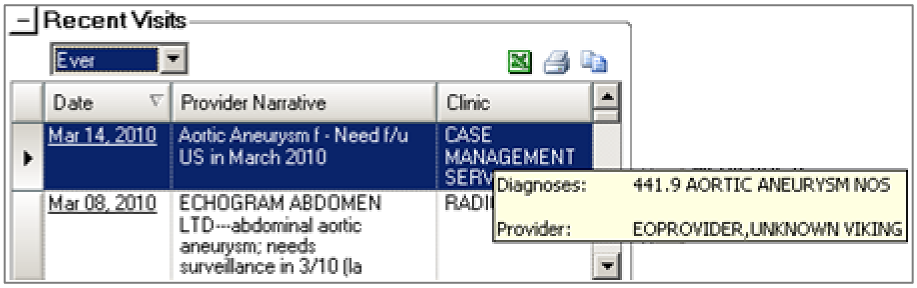


Figure 3-8: Sample **Recent Visits** group box

Double-click any row of the **Recent Visits** group box to display the **Visit Detail** dialog. Section 4.6 provides information about how to use the controls on the dialog.

3.2.2 Scheduled Appointments Group Box

The **Scheduled Appointments** group box displays the patient's scheduled appointments in order of closest upcoming appointment first, within the selected timeframe. Select an option from the list to determine the time interval for the appointments displayed (the default is 1 month).

3.2.3 Providers Group Box

The **Providers** group box displays the list of specialty providers for the patient. This data comes from the RPMS.

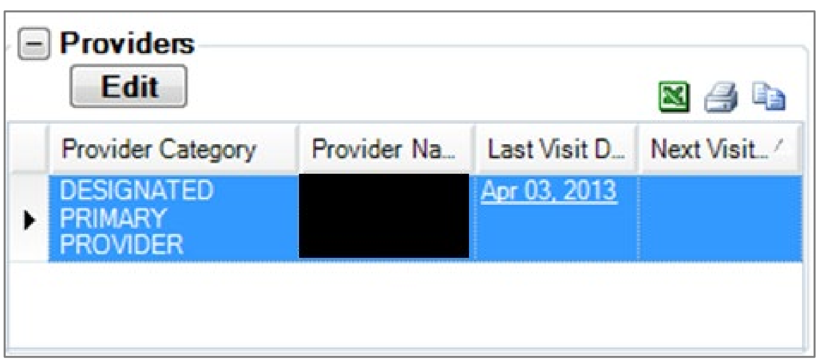


Figure 3-9: Sample **Providers** group box

3.2.4 Link to Last Visit Date

The Last Visit date is linked to the RPMS visit record. Double-click any record to view the **Visit Detail** dialog. Section 4.6 provides information about using the controls on the dialog.

3.2.5 Edit Button

Use the **Edit** button to add and edit specialty provider names. This feature requires either the iCare Editor (BQIZCMED) or iCare Package Manager (BQIZMGR) security key. Choices for new entries will be limited to the existing BDP Category Name list. The user will *not* be able to enter a new BDP Category Name; this function will continue to be performed by an assigned manager within the BDP interface. All additions and changes, including the user name and date the record is edited via the iCare interface will be recorded in BDP (Designated Specialty Provider).

Click the **Edit** button to display the **Edit** Providers window (Figure 3-10).

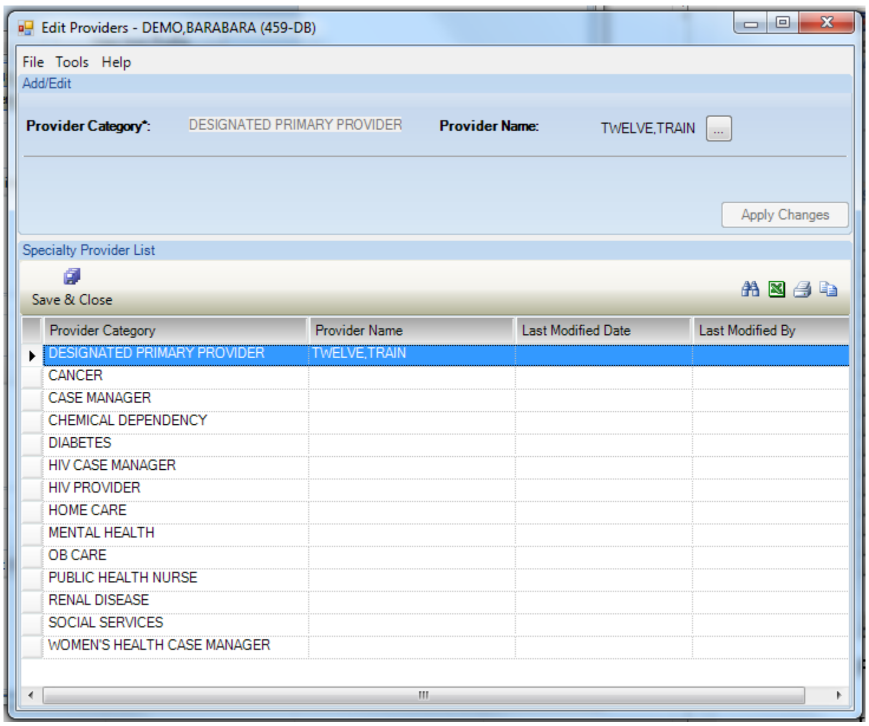


Figure 3-10: Sample **Edit Providers** window

Use this window to add, edit, or remove specialty provider names. Dismiss the **Edit Providers** window by selecting **File** | **Close**. Section 4.7 provides information about this window.

3.2.6 Insurance Group Box

The **Insurance** group box displays all insurances defined as active in Patient Registration and the effective date. There can be multiple active insurances.

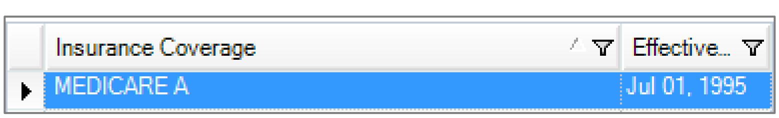


Figure 3-11: Sample **Insurance** group box

3.2.7 Panels Group Box

The **Panels** group box displays the names of all iCare panels available to the user of which the patient is a member.

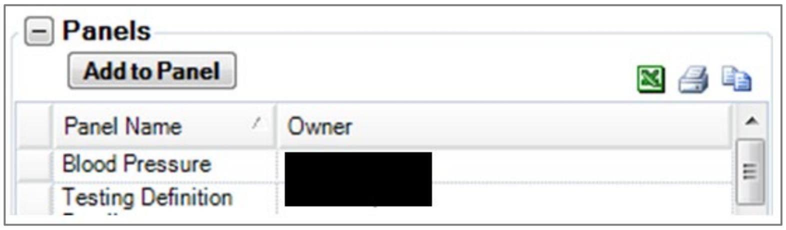


Figure 3-12: Sample **Panels** group box

3.2.8 Tooltip for Panel Description

Hover your mouse over a record to display a description of the panel.

3.2.9 Add to Panel Button

To add the patient to another panel, click the **Add to Panel** button to display the **Add/Remove Panels** dialog.

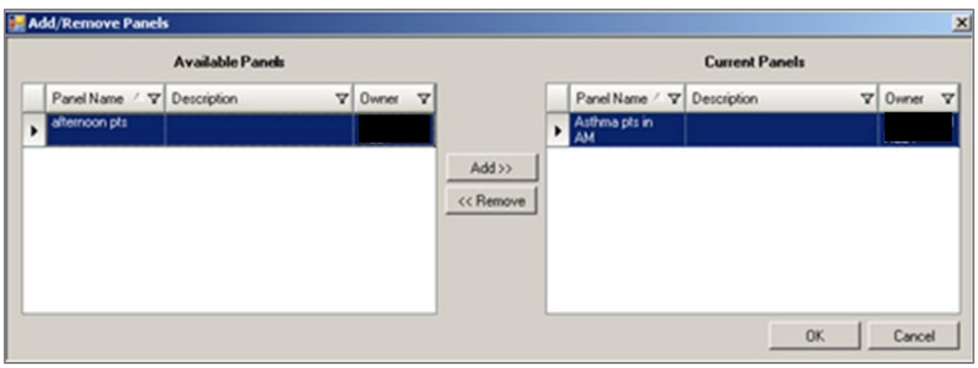


Figure 3-13: Sample **Add/Remove Panels** dialog

The **Available Panels** group box contains the panels of which the patient is *not* a member. The **Current Panels** group box contains the panels of which the patient *is* a member.

Please note that if you select a panel in the **Current Panels** group box and click **Remove**, and if the selected panel is open, the application displays the message that this panel is currently opened in this session and to please try again after you have finished editing the panel or removing the patient from the **Panel View**. (Click **OK** to dismiss the message.)

Click **OK** to add the patient listed in the **Current Panel** group box to the **Panels** group box on the **Cover Sheet** tab. In addition, the patient's name will be added to the "other" panels (on the **Panel View** window). (Otherwise, click **Cancel**.)

3.2.10 Registers Group Box

The **Registers** group box displays the Register names of which the patient is a member. Register names that the user does not have security access to will be inactive. The data shows the patient's register status (in the **Status** column).

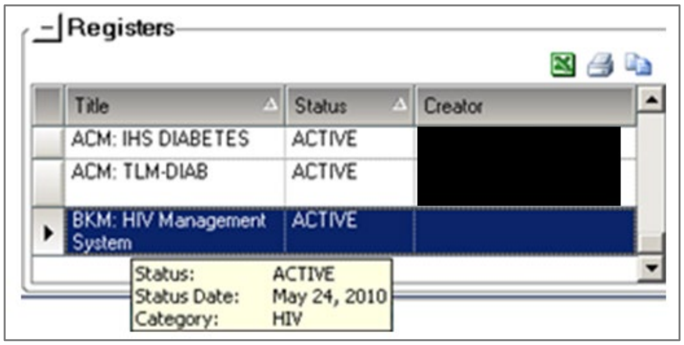


Figure 3-14: Sample **Registers** group box

Hover your mouse over a record to display a tooltip about the status (Status, Status Date, Category).

3.2.11 Cover Sheet Tab Menus

3.2.12 File Menu

The options on the **File** menu for the **Cover Sheet** tab are as follows:

- **New**: This option displays the **Panel Definition** dialog where you create a new panel definition. This is the same as pressing Ctrl-N.
- **Page Setup**: This option is active when you select one or more rows in the grid. This option allows you to set Margin, Paper, and Layout characteristics (like landscape or portrait orientation) for printing. You can select a different printer.
- **Print Preview**: This option is active when you select one or more rows in a grid. This option displays the **Print Preview** dialog. Section 4.12 provides information about this dialog.
- **Print**: This option is active when you select one or more rows in a grid. It uses the most recently selected rows (because there is more than one grid on the tab). This option displays the **Print Preview** dialog for the selected rows in the grid. This is the same as pressing Ctrl-P. Select **File** | **Print** on the dialog to output the data in the rows.

- **Background Jobs**: This option displays a dialog showing background jobs information. Section 4.11 provides information about the dialog.
- **Close**: This option dismisses the current open patient record window.

3.2.13 Tools Menu

The options on the Tools menu for the Cover Sheet tab are as follows:

- **Quick Patient Search**: This option executes a patient search.
- **Export to Excel**, **Print**, and **Copy Rows to Clipboard**: These options work like the buttons on the right side of the window (See Section 4.2). These options will display only if the focus is on one table in the Cover Sheet.
- **User Preferences**: This option opens the **User Preferences** window where you can change your user preferences.
- **Web Links**: This option shows several categories (such as Asthma) that have Web links. When you select a Web link, the Internet browser for the particular category opens.
- **View iCare Log**: This option is primarily a tool for troubleshooting that displays the list of RPC (remote procedure calls) that contacts the server and returns data for display.

3.3 Snapshot Tab

The **Snapshot** tab shows several types of data with a more clinical focus that are useful for case management review. The intention is to highlight more urgent information on this screen when considering various patient conditions.

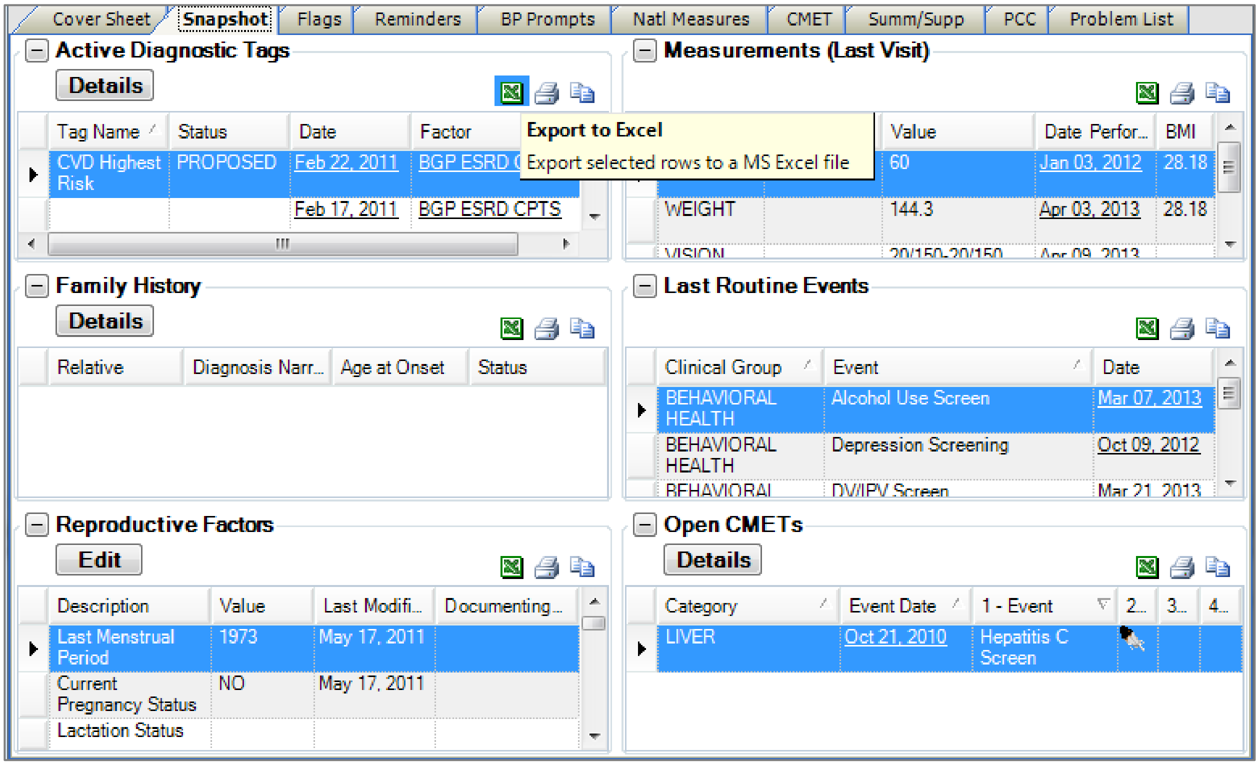


Figure 3-15: Sample **Snapshot** tab

The underlined visit date listed within any of the sections of the Snapshot view will be a link to the underlying RPMS visit record (double-click the underlined date).

You can sort/filter the columns and perform other functions on the columns.

Section 4.2 provides information about the buttons on the right side of the group boxes.

3.3.1 Active Diagnostic Tags Group Box

The **Active Diagnostic Tags** group box displays a list of Predefined Diagnosis definitions ("tags") that iCare has proposed for this patient, based on the tagging function.

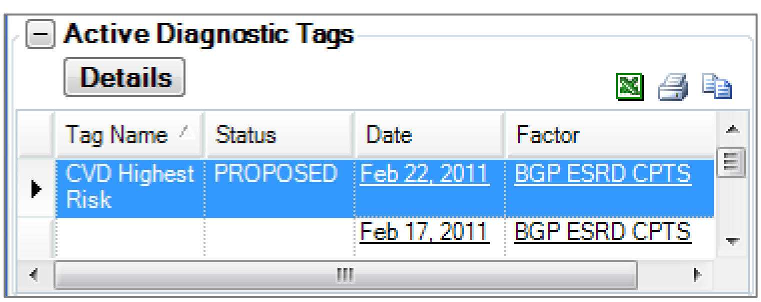


Figure 3-16: Sample **Active Diagnostic Tags** group box

The Diagnostic Tag could have been identified by a visit or by a problem.

3.3.2 Details Button

Select a record and then click the **Details** button to move to the **DX Tags** tab (on the **Patient Record** window) for the particular tag. Here you view the status, date, item, value, and factor about the selected tag.

3.3.3 Tooltip for Active Diagnostic Tags Tab

Hover your mouse over a value in the **Tag Name** column to display the definition of the tag.

Hover your mouse over a value in the **Status** column to display status information (Last Updated, Updated By, Status Change Reason, Status Comment).

Hover your mouse over a value in the **Factor** column to display factor information (Compliance Value, Last Updated).

3.3.4 iCare Taxonomy View/Edit

Double-click any Factor cell in the **Active Diagnostic Tags** group box to display the **iCare Taxonomy View/Edit** dialog.

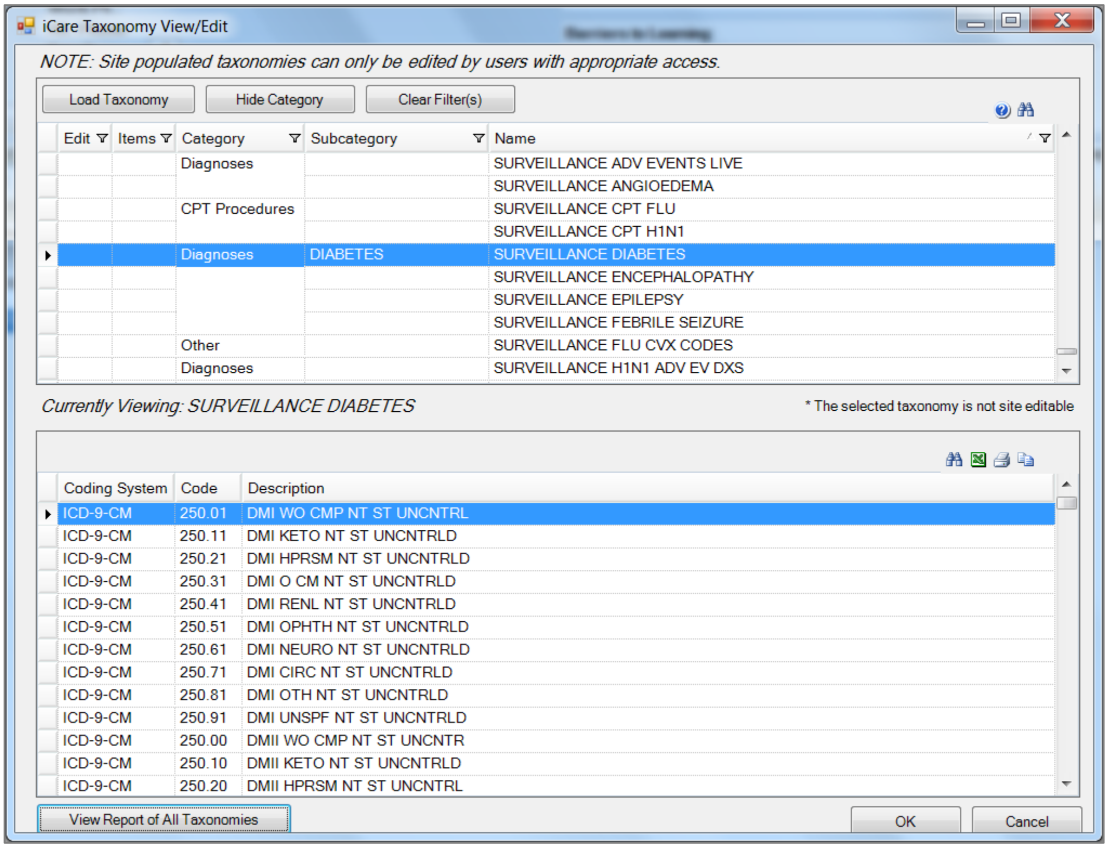


Figure 3-17: Sample **iCare Taxonomy View/Edit** dialog

If you do not have access rights to edit taxonomies, this dialog will display that information.

If you have edit privileges (iCare Taxonomy Editor with security key BQIZTXED), you can add/remove values. Section 4.8 provides information about the iCare Taxonomy Editor Function.

Click **OK** to save any changed data (otherwise, click **Cancel**).

Click the **View Report of All Taxonomies** button to access the **RPMS iCare - Taxonomy Report** dialog. Information about each taxonomy category displays on this dialog. For example, you can view the high and low values for each taxonomy category.

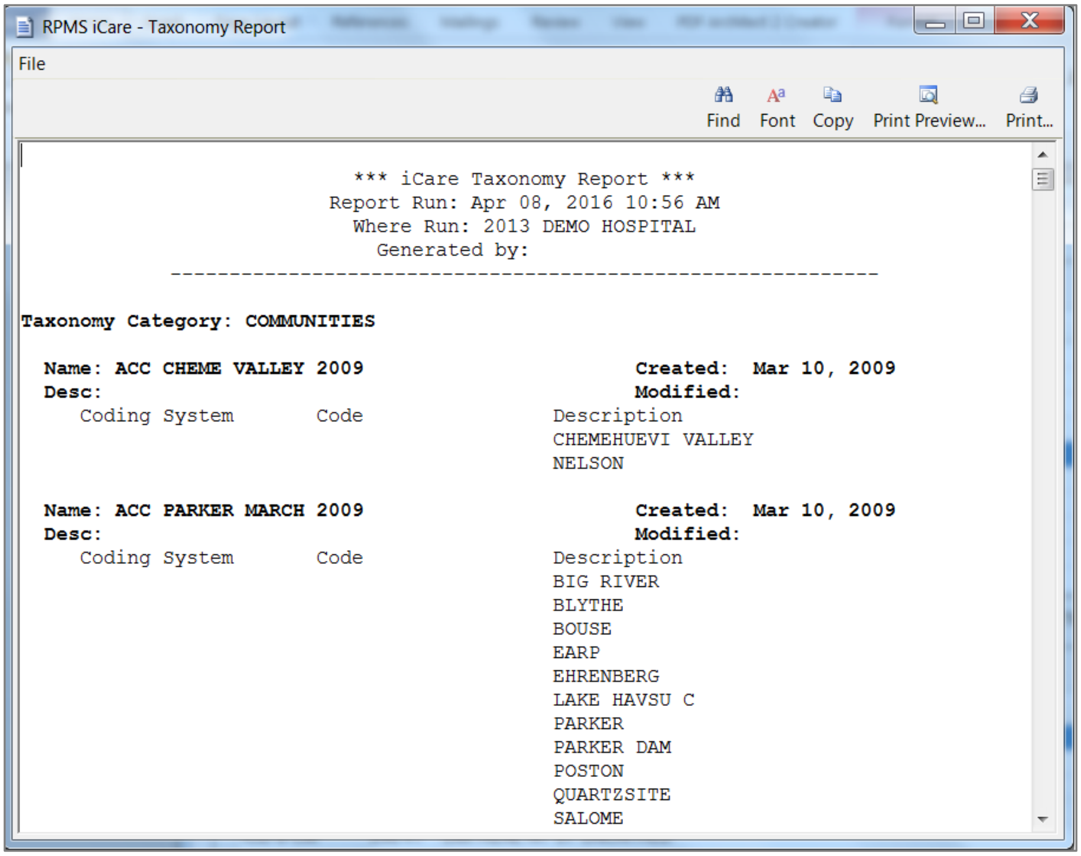
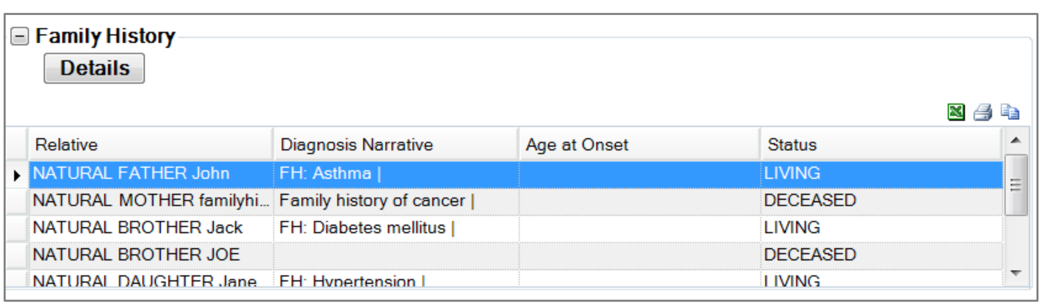


Figure 3-18: Sample **Taxonomy Report** dialog

Section 4.6 provides information about using the controls on the dialog.

3.3.5 Family History Group Box

The **Family History** group box displays the family history information that is relevant to case management. This data is pulled directly from the IHS Dictionaries/Patient: Family History file (9000014).



Relative	Diagnosis Narrative	Age at Onset	Status
NATURAL FATHER John	FH: Asthma |		LIVING
NATURAL MOTHER familyhi...	Family history of cancer |		DECEASED
NATURAL BROTHER Jack	FH: Diabetes mellitus |		LIVING
NATURAL BROTHER JOE			DECEASED
NATURAL DAUGHTER Jane	FH: Hypertension |		LIVING

Figure 3-19: Sample **Family History** group box

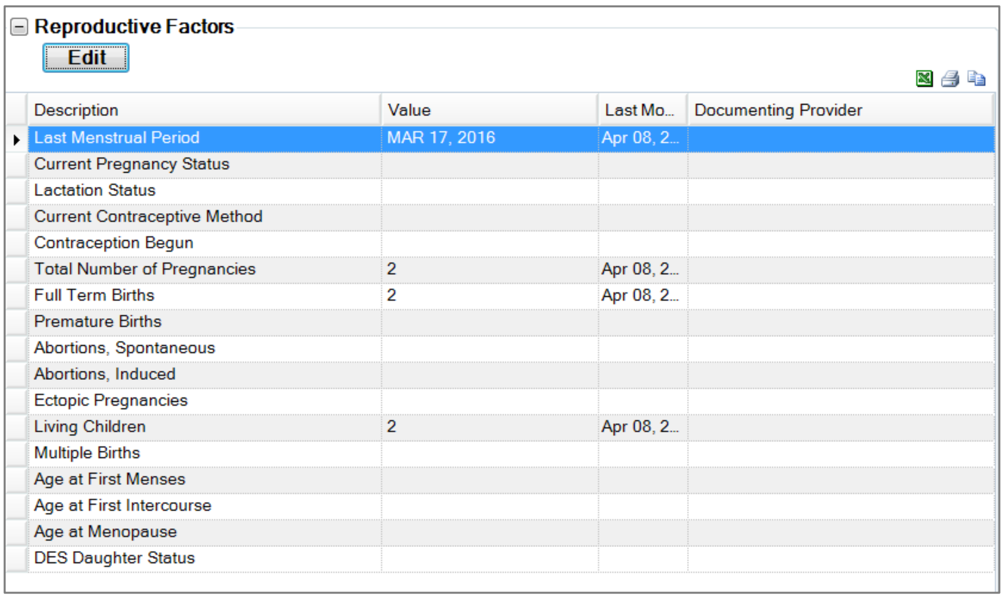
1. The default display will be sorted by Sort Order, then by Relationship.

2. Hover your mouse over any record to view a tooltip (Diagnosis Code, Date Noted).

3. Click the **Details** button to move to the **Family HX** tab of the **Patient Record** window.

3.3.6 Reproductive Factors Group Box

The **Reproductive Factors** group box displays the current patient's reproductive history (from the AUPN IHS Dictionaries/Patient Reproductive Factors file). This applies to female patients only.



Description	Value	Last Mo...	Documenting Provider
Last Menstrual Period	MAR 17, 2016	Apr 08, 2...	
Current Pregnancy Status			
Lactation Status			
Current Contraceptive Method			
Contraception Begun			
Total Number of Pregnancies	2	Apr 08, 2...	
Full Term Births	2	Apr 08, 2...	
Premature Births			
Abortions, Spontaneous			
Abortions, Induced			
Ectopic Pregnancies			
Living Children	2	Apr 08, 2...	
Multiple Births			
Age at First Menses			
Age at First Intercourse			
Age at Menopause			
DES Daughter Status			

Figure 3-20: Sample **Reproductive Factors** group box

3.3.7 Fields on Reproductive Factors Group Box

The fields show the latest values of the current patient's reproductive factors. New reproductive factors can be entered by using the **Edit** button.

3.3.8 Edit Reproductive Factors

Click **Edit** to access the **Edit Reproductive Factors** dialog (where you can add new data).

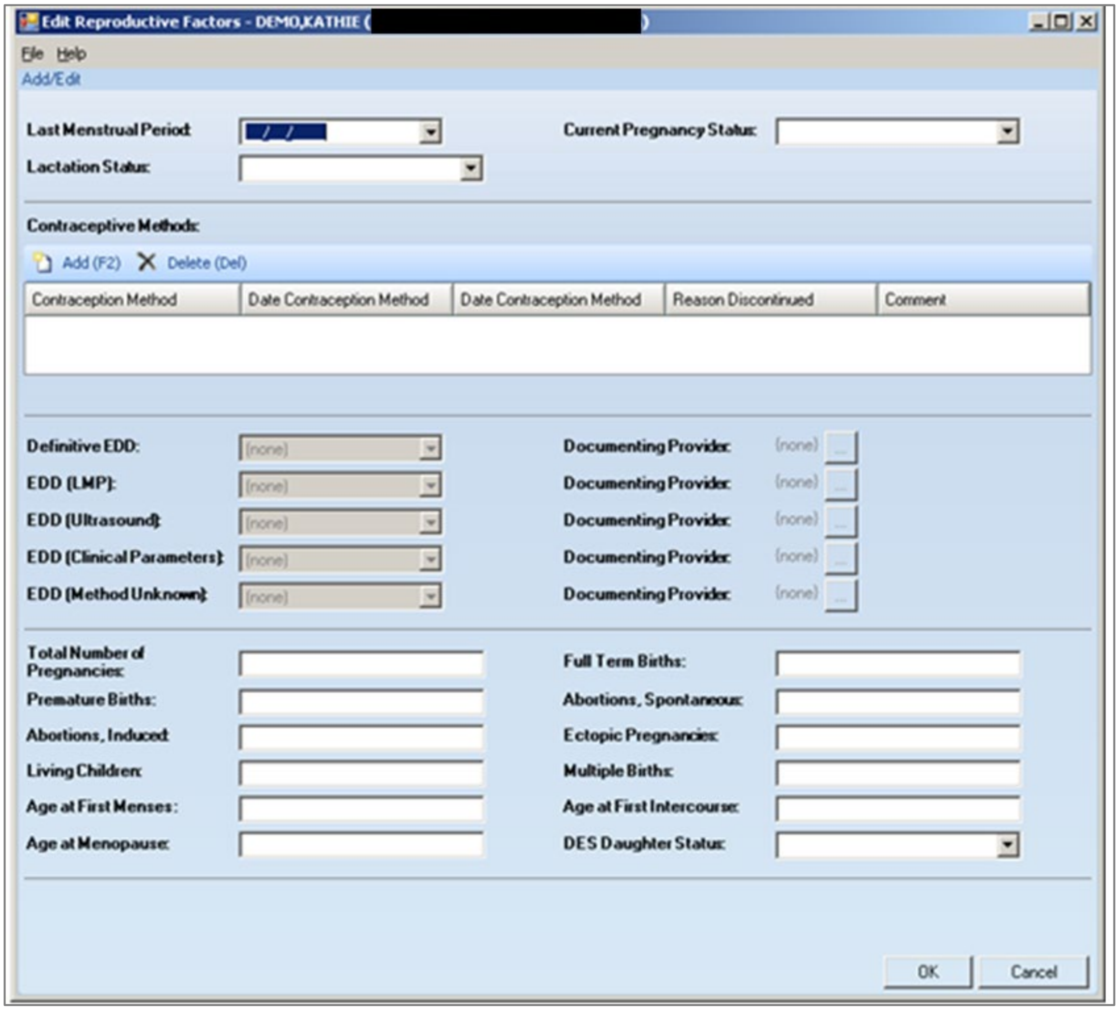


Figure 3-21: Sample **Edit Reproductive Factors** dialog

Section 4.9 provides information about completing this dialog.

3.3.9 Measurements (Last Visit) Group Box

The **Measurements (Last Visit)** group box displays two sets of data:

- The patient's most recent height and weight data.
- All measurement data documented at the patient's last visit.

This will include a calculated BMI only if the height and weight measurements meet the standard Clinical Reporting System (CRS) definition. This information comes from PCC, the V Measurement file.

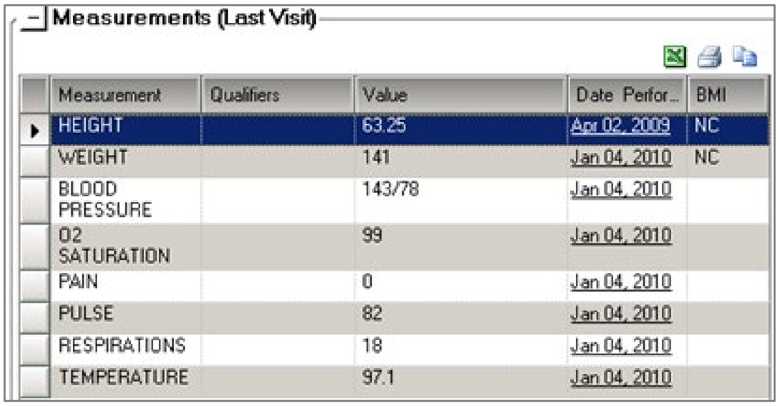


Figure 3-22: Sample Last Measurements group box

There will always be height and weight values. After height and weight, the measurements are displayed in alphabetical order by Measurement name.

The **Qualifiers** field displays any qualifier for the measurement. Qualifiers describe how patient vital signs and measurements were taken. For example, a qualifier for Temperature could be Oral.

Double-click any record in this group box (with a date) to display the **Visit Detail** dialog. Section 4.6 provides information about using the controls on the dialog.

3.3.10 Last Routine Events Group Box

The **Last Routine Events** group box displays a list of the most recent routine screenings, based on Health Summary Reminders logic, that are tailored to the specific patient based on age, sex, etc. This information comes from PCC.

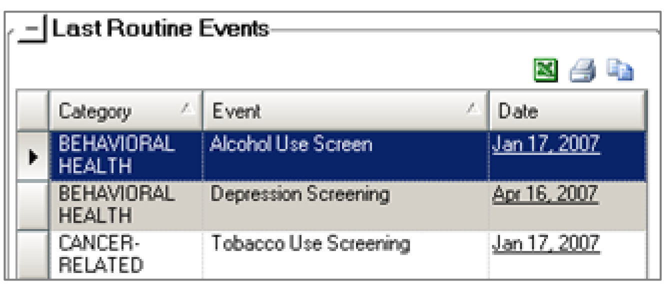


Figure 3-23: Sample **Last Routine Events** group box

Double-click any record in this group box (with a date) to display the **Visit Detail** dialog. Section 4.6 provides information about using the controls on the dialog.

3.3.11 Open CMETs Group Box

The **Open CMETs** group box shows the latest Tracked, Open CMET data for the patient.

Figure 3-24: Sample **Open CMETs** group box

Select a record and then click the **Details** button to move to the event on the **Tracked Events** sub-tab on the **CMET** tab of the **Patient Record** window.

Double-click any underlined event date to display the **Visit Detail** dialog. Section 4.6 provides information about using the controls on the dialog.

There are the following icons in the 2 - Finding(s), 3 - Follow-up(s), and 4 - Patient Notification(s) cells:

- A check mark icon indicates that the step is complete.
  - In the Finding(s) cell, the hover help shows the Finding Date and Finding Value.
  - In the Follow-up(s) cell, the hover help shows the Follow-up Date and Follow-up Value.
  - In the Notifications cell, the hover help shows the Notification Date and the type of Notification.
- A tickler icon indicates that the element is overdue. The element Due Date is prior to Today's date (shown in hover help).
- The cell is blank if it is not completed but is not overdue.

If there are multiple elements for any of the steps (for example, 2 Follow-up(s)), there will a check mark if all of the multiples are completed.

3.3.12 Snapshot Tab Menus

The options on the **File** menu of the **Snapshot** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on the **Tools** menu of the **Snapshot** tab are the same as those on the Tools menu for the **Cover Sheet** tab.

3.4 Flags Tab

The **Flags** tab displays a list of the patient's "flags" identified by the iCare application.

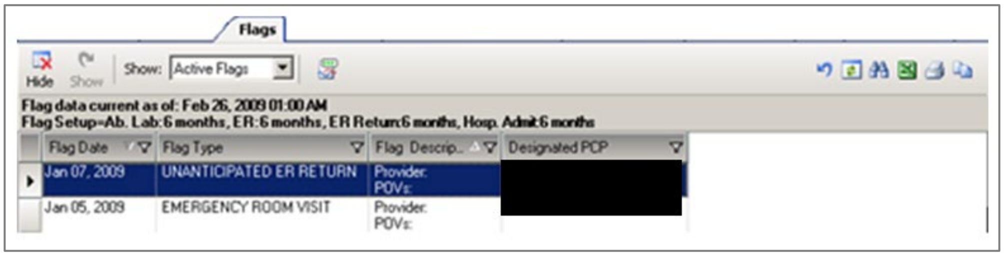


Figure 3-25: Sample **Flags** tab

3.4.1 Flags Tab Layout

The default display has the flag listed alphabetically by flag date (most recent first), by Flag Type, then by flag description. No duplicate values are displayed in the first column. This means if a particular date has more than one flag, the date will be displayed only on the first row.

The iCare application will display an initial list of flags at first login only for the timeframe that is defined in the User Preferences. Likewise, you can change the flag view to display modified flag types and/or timeframes if you change the User Preferences. After changing the flag settings in User Preferences, refresh the flag view.

3.4.2 Flag List Columns

Table 3-1 provides information about the columns.

Table 3-1: Flag list columns and descriptions

Column	Meaning
Flag Date	The date the flag became active, e.g., the date of the hospital admission.
Flag Type	This can be Abnormal Lab Values, ER Visit, Unanticipated ER Return Visit, Hospital Visit. Section 3.4.3 provides information about the flag types.
Flag Description	A brief description of the event that caused the trigger.
Designated PCP	Designated Primary Care Provider, if any. Not all facilities use this field to empanel patients.

You can sort, filter, and perform other functions on the columns.

3.4.3 Flag Types

The Flag Type column contains various flag types, as defined in Table 3-2:

Table 3-2: Flag types and meanings

Flag Type	Meaning
Abnormal Lab Values Alert	This flag type informs the user when a patient has abnormal lab values within a user-defined timeframe, based on the Kernel Alerts component. The Abnormal Lab Values alerts, generated from the RPMS Laboratory application, reside in the Kernel Alerts component. If the ALV alert is closed by the provider in Kernel Alerts, it will no longer display in iCare, regardless of the Flag Display Timeframe selected by the user in the User Preferences.
ER Visit	This flag type informs the user when a patient has an emergency room visit within a user-defined timeframe. This flag is generated directly by iCare. ER visits (clinic code 30) is the trigger for this flag.
Unanticipated ER Return Visit	This flag type informs the user when a patient has an emergency room visit designated as “unanticipated” within a user-defined timeframe. This flag is generated directly by iCare. ER visits (clinic code 30) with Visit Type “Unscheduled Revisit” is the trigger for this flag.
Hospital Admission	This flag type informs the user when a patient has a hospital visit within a user-defined timeframe. This flag is generated directly by iCare. Any visit with service category H where the discharge date is not the same day as the admission date is the trigger for this flag.

3.4.4 Flags Tab Toolbar

The text above the grid shows the flag set-up information and how current the data is.

3.4.5 Show Field

What flags are displayed on this window is determined by the option selected on the Show field. Your choices are:

- **Active Flags:** Active is defined as a flag that has not expired and has not been hidden by the users.
- **Hidden Flags:** Those flags that you specified to be hidden, using the **Hide** button.
- **All Flags:** All flags, hidden as well as active.

3.4.6 Hide

You can hide a highlighted row in the Flag List grid by doing any of the following:

- Click the **Hide** (

) button

- Select **File** | **Flags** | **Hide**
- Select the **Hide** option on the context menu
- Press F3 on your keyboard

You can view the hidden flags by selecting the **Hidden Flags** option on the **Show** field.

3.4.7 Show

If you need to cause a hidden flag to re-appear in the current view, select it from the list on the **Hidden Flags** option (from the **Show** field) and do any of the following:

- Click the **Show** () button
- Select **File** | **Flags** | Show
- Select the **Show** option on the context menu
- Press F4 on your keyboard

3.4.8 Status of Background Jobs

To check on the status of the background jobs, do one of the following:

- Click the **Background Jobs** () button
- Select **File** | **Background Jobs**

The application displays the **RPMS iCare - Background Jobs** window. Section 4.11 provides information about this window.

3.4.9 Flags Tab Menus

The options on the **File** menu are the same as the options on the File menu for the **Cover Sheet** tab.

3.4.10 Tools Menu

The options on the Tools menu are as follows:

- **Quick Patient Search**: This option executes a patient search.
- **Reset View**, **Refresh**, **Search**, **Export to Excel**, **Print**, **Copy Row to Clipboard**: These options operate like those for the buttons on the right side of the window. Section 4.2 provides information about these buttons.
- **User Preferences**: This option takes you to the **User Preferences** window where you can change your user preferences.

- **Web Links**: This option shows several categories (such as Asthma) that have Web links. When you select a Web link, the Internet browser for the particular category opens.

3.4.11 Flags Menu

The options on the **Flags** menu for the **Flags** tab are:

- **Refresh**: This updates any RPMS field values on this view with new data from the server.
- **Hide**: This hides a highlighted row in the Flag List grid.
- **Show**: This causes a hidden flag to re-appear in the current view.

3.5 Reminders Tab

The **Reminders** tab lists the national reminders that are pulled from the same data as the Health Summary report reminders in RPMS (such as lab test, immunization, etc.).

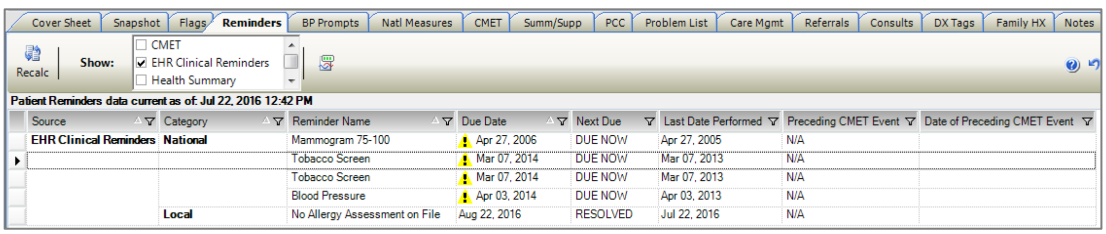


Figure 3-26: Sample **Reminders** tab

You can control what displays on this tab by selecting any one or more of the options in the Show field. After selecting (or de-selecting) any option in the **Show** field, the display will automatically update.

If you select an option that has no reminders for the patient, the application displays a warning message. For example, if the patient does not have any CMET Reminders, after trying to select the CMET option, a message will display that reads: “There are no CMET Reminders for this patient.” Click **OK** to dismiss the warning.

The default sort order is by due date, with the most overdue first, then sorted by Category, Clinical Group, and Reminder Name.

3.5.1 Reminders Tab Layout

The following is an overview of the columns:

- **Source**: The source of the reminder logic. Examples are Health Summary (i.e., Health Maintenance Reminders), HMS (HIV Management System), IZ Forecaster, EHR Clinical Reminders, CMET, etc. When the Source is Care Management and HIV, the denominator for the HMS reminders will be any patient with a proposed or accepted tag for HIV. **Note**: the register status is *not* considered for the denominator definition.
- **Category**: The name of the clinical performance group, for example, Breast.
- **Reminder Name**: The name of the clinical procedure that needs to be completed. View a tooltip by hovering your mouse over any **Reminder Name** cell.
- **Due Date**: The date the reminder procedure is due. This column will display the warning indicator () if any of the patient's reminders are overdue. This date is derived from the Health Summary Reminders Next Due test.
- **Next Due**: The actual text from the Reminders Next Due display on the Health Summary.
- **Last Date Performed**: The date that the reminder procedure was most recently completed.
- **Preceding CMET Event**: This is populated with the tracked Event that initiated this follow-up. If the displayed reminder is not a CMET Reminder, this cell will contain N/A.
- **Date of Preceding CMET Event**: The date of the preceding CMET Event.

You can sort/filter the columns and perform other functions on the columns.

You can view the descriptions of the logic behind each national health summary reminder by accessing the Reminders glossary. Select **Help** | **Reminders Glossary** (or click the **Glossary** button on the toolbar) for more information.

3.5.2 Reminders Tab Toolbar

The Patient Reminders data is current as of the date shown on the toolbar. The reminders are calculated on the fly.

Section 4.2 provides information about using the buttons on the right side of the toolbar.

3.5.3 Recalc

Click the **Recalc** (

) button (or select **Reminders** | **Recalc**) to get the latest data from the server and to run the algorithm.

3.5.4 Background Jobs

Click the **Background Jobs** () button (or select **File** | **Background Jobs**) to display the **Background Jobs** dialog. Section 4.11 provides information about this dialog.

3.5.5 Reminders Tab Menus

The following reviews the **Reminders**, **File**, and **Tools** menus.

3.5.5.1 Reminders Menu

The **Reminder** menu has the **Recalc** option; these perform like the button on the toolbar.

3.5.5.2 File Menu

The options on the **File** menu for the **Reminders** tab are the same as those on the File menu for the **Cover Sheet** tab.

3.5.5.3 Tools Menu

The options on the **Tools** menu are:

- **Quick Patient Search**: This option executes a patient search.
- **Glossary**: This option accesses the glossary information for this tab.
- **Reset View**, **Refresh**, **Search**, **Export to Excel**, **Print**, **Copy Row to Clipboard**: These options operate like those for the buttons on the right side of the window. Section 4.2 provides information about these buttons.
- **User Preferences**: This option takes you to the **User Preferences** window where you can change your user preferences.
- **Web Links**: This option shows several categories (such as Asthma) that have Web links. When you select a Web link, the Internet browser for the particular category opens.

3.6 BP Prompts Tab

The **Best Practice (BP) Prompts** tab displays a list of suggested treatments based on pre-determined prompt logic (including CVD and Asthma reminders). CVD Treatment prompts are callable by the Health Summary or other RPMS applications. The best practice prompts can be turned off via the PCC Health Summary functions.

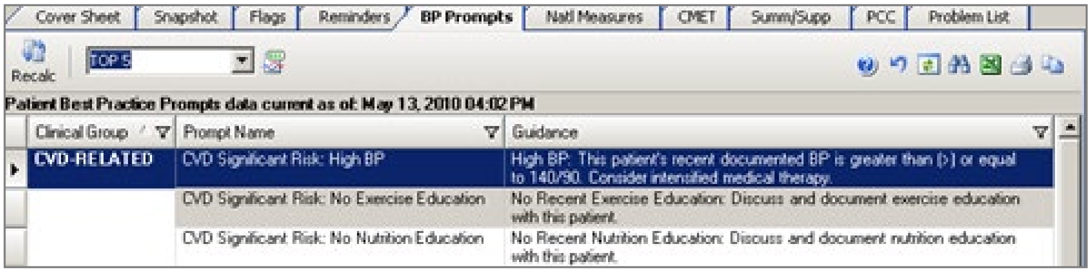


Figure 3-27: Sample **BP Prompts** tab

3.6.1 BP Prompts Tab Layout

The data columns on the Best Practice Prompts tab are:

- **Clinical Group**: The name of the clinical group.
- **Prompt Name**: The name of the best practice prompt.
- **Guidance**: The text that defines the diagnosis.

A tooltip displays by hovering your mouse over the Prompt Name cell. The text is pulled from the Tooltip field in the Treatment Prompt file.

3.6.2 BP Prompts Tab Toolbar

The field with the list determines what data within each clinical group will display: either the TOP 5 or ALL. The default is TOP 5.

The time and date of the last data update displays in the toolbar.

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.6.3 Recalc

Click the **Recalc** (Recalc) button (or select **Best Practice Prompts** | **Recalc**) to get the latest data from the server and to run the algorithm.

3.6.4 Background Jobs

Click the **Background Jobs** ( ) button (or select **File** | **Background** Jobs) to display the **Background Jobs** dialog. Section 4.11 provides information about this dialog.

3.6.5 BP Prompts Tab Menus

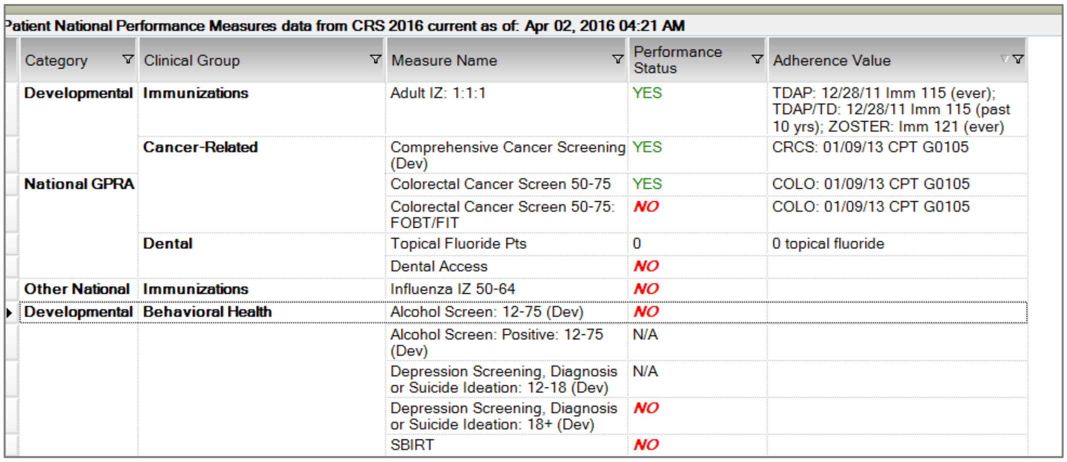
The options on the **File** menu of the **Best Practice Prompts** tab are the same as those on the File Menu for the **Cover Sheet** tab.

The options on the **Tools** Menu on the **Best Practice Prompts** tab are as those of the Tools Menu for the **Reminders** tab.

The **Best Practice Prompts** menu has one option: **Recalc**. This performs like the button on the toolbar.

3.7 Natl Measures Tab

The Natl Measures tab displays the patient's Government Performance and Results Act (GPRA) performance status (based on the CRS national summary report).



Patient National Performance Measures data from CRS 2016 current as of: Apr 02, 2016 04:21 AM

Category	Clinical Group	Measure Name	Performance Status	Adherence Value
Developmental	Immunizations	Adult IZ: 1:1:1	YES	TDAP: 12/28/11 Imm 115 (ever); TDAP/TD: 12/28/11 Imm 115 (past 10 yrs); ZOSTER: Imm 121 (ever)
	Cancer-Related	Comprehensive Cancer Screening (Dev)	YES	CRCS: 01/09/13 CPT G0105
National GPRA		Colorectal Cancer Screen 50-75	YES	COLO: 01/09/13 CPT G0105
		Colorectal Cancer Screen 50-75: FOBT/FIT	NO	COLO: 01/09/13 CPT G0105
	Dental	Topical Fluoride Pts	0	0 topical fluoride
		Dental Access	NO	
Other National	Immunizations	Influenza IZ 50-64	NO	
Developmental	Behavioral Health	Alcohol Screen: 12-75 (Dev)	NO	
		Alcohol Screen: Positive: 12-75 (Dev)	N/A	
		Depression Screening, Diagnosis or Suicide Ideation: 12-18 (Dev)	N/A	
		Depression Screening, Diagnosis or Suicide Ideation: 18+ (Dev)	NO	
		SBIRT	NO	

Figure 3-28: Sample **National Measures** tab

This detailed list shows all national CRS measures broken down by clinical group along with the current patient's status with respect to the measure.

3.8 Natl Measures Tab Layout

- **Category**: The name of the category: Developmental, National GPRA, Non-National, Other, or Other National.
- **Clinical Group**: The name of the clinical performance group.
- **Measure Name**: The measure title derived from the Summary Report. A description of the performance logic (tooltip) will display when you hover the mouse over the name.
- **Performance Status**: Displays the current status (as of the date listed on the toolbar) of this patient's performance to the specific measure.

The **National Measures** tab on the Patient Record is based on CRS logic and the data for each measure is primarily Yes, No, or N/A.

- The font is green if the value is Yes and the measure is traditional in the sense that meeting the measure is positive *or* if the value is No and the measure is such that not meeting the measure is positive.
- The font is red if the value is No and the measure is traditional in the sense that not meeting the measure is negative *or* if the value is Yes and the measure is such that meeting the measure is negative.

Adherence Value: Displays the visit date and clinical procedure that meets the performance numerator definition.

You can view a dialog that defines the detailed logic for each of the national performance measures defined in the Clinical Reporting System by selecting **Help** | **Natl Measures Glossary.**

You can sort/filter the columns and perform other functions on the columns.

3.8.1 Natl Measures Tab Toolbar

The toolbar on this tab displays the date that iCare most recently processed the National Measures logic on your facility's RPMS database. The default setting for the National Measures' logic run is weekly (your Site Manager can select a different time frame).

Section 4.2 provides information about using the buttons on the right side of the toolbar.

3.8.2 Recalc

Click the **Recalc** ( ) button to get the latest data from the server and to run the algorithm.

3.8.3 Background Jobs

Click the **Background Jobs** ( ) button (or select **File** | **Background Jobs**) to display the **Background Jobs** dialog. Section 4.11 provides information about this dialog.

3.8.4 Natl Measures Tab Menus

The options on the **File** menu of the **Natl Measures** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on **Tools** menu for the **Natl Measures** tab are the same as those of the Tools Menu for the **Reminders** tab.

3.9 CMET Tab

The iCare Management Event Tracking (**CMET**) tab displays the CMET data associated with the current patient. The CMET tool is designed to assist users in the electronic tracking and management of their patients' care. CMET is reminiscent of an old fashioned "tickler file."

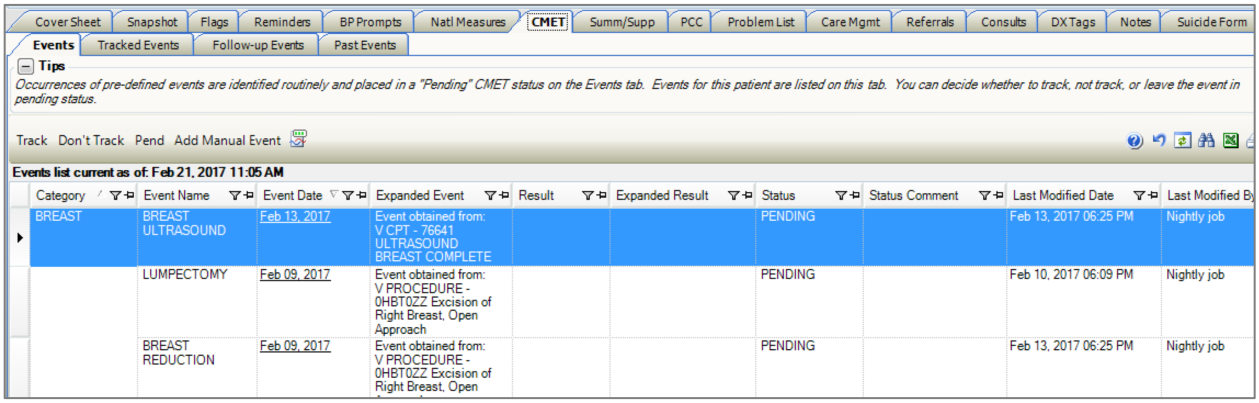


Figure 3-29: Sample **CMET** tab

The **CMET** tab on the patient record window has the information displayed in four sub-tabs: **Events**, **Tracked Events**, **Follow-up Events**, and **Past Events**.

3.9.1 Events Sub-Tab

The patient's events display on the **Events** sub-tab. Events are procedures, screenings and/or exams that have been pre-defined and categorized into Breast, Cervical, Colon, and Skeletal.

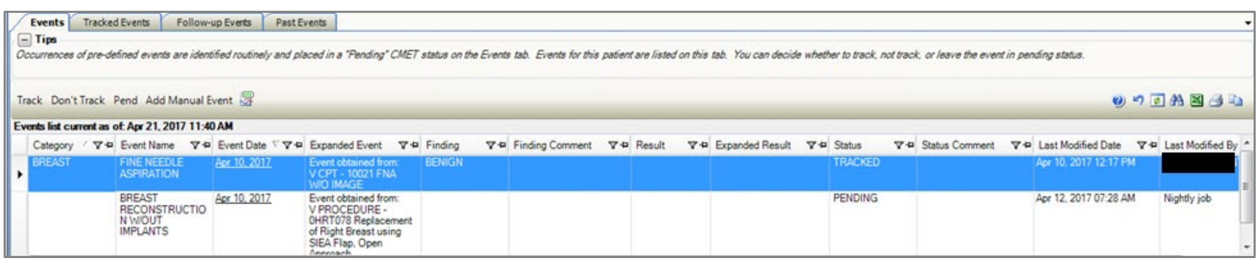


Figure 3-30: Sample **Events** sub-tab

The **Events** sub-tab is divided into three general areas: Tips information, Events toolbar, and Events data.

The Tips information provides an overview of the **Events** sub-tab. You can collapse this area in order to have more room to view the Events data.

3.9.2 Events Sub-Tab Layout

The default sort of the columns is: Category, Date of Event (newest listed first), Patient Name (alphabetical):

- **Category**: The category of the event.
- **Event Name**: The name of the event. Events are procedures, exams, or tests that have been documented in RPMS. Events are predefined. See the CMET Glossary for a list of events by selecting **Help** | **CMET Glossary**.
- **Event Date**: The date the event was performed. Double click any underlined date to view the **Visit Detail** dialog. Section 4.6 provides information about using the controls on the dialog.
- **Expanded Event**: The source of the event such as V CPT, V Lab with value.
- **Finding**: The Finding value associated with the result.
- **Finding Comment**: The comment entered associated with the finding.
- **Result**: The date of the result. Double-click the underlined date to access a particular detail dialog, for example, Women's Health Detail. This cell also has hover help, such as V Radiology.
- **Expanded Result**: The expanded data associated with the result.
- **Status**: The status of the event which can be not tracked, pending, tracked.
- **Status Comment**: Any comments about the status.
- **Last Modified Date**: The date the record was last modified.
- **Last Modified By**: The person who last modified the record. The Initial job name means that this was an initial event.

3.9.3 Events Sub-Tab Toolbar

Section 4.2 provides information about to use the buttons on the right side of the toolbar.

Click the **Background Jobs** ( ) button (or select **File** | **Background Jobs**) to display the **Background Jobs** dialog. Section 4.11 provides information about this dialog.

You can decide whether to track, not track, or leave the event in pending status.

3.9.3.1 Track

The Track function requires the iCare Editor (BQIZCMED) security key. Select one or more events with a status of **Not Tracked** or **Pending** and then click the **Track** button (or select **CMET** | **Events** | **Track**).

Once an event has been Tracked, it cannot be changed to Not Tracked. If the particular event was changed to Tracked and that is not correct, you need to go to the Tracked tab, and then access the CMET worksheet for the event you tracked in error.

If you select events that are not eligible for the Tracked function, the application displays the message: “Events having a status of Tracked can’t be changed to Tracked.” Click **OK** to dismiss the message.

If you select only one eligible event, the application displays the **RPMS iCare - Track - Findings Due Date** dialog.

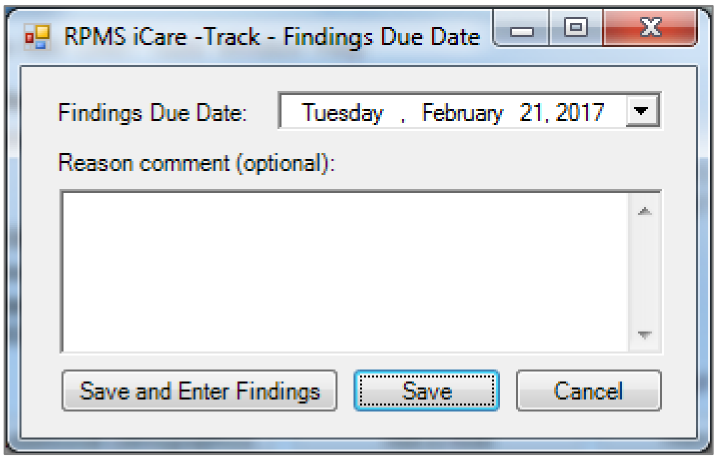


Figure 3-31: Sample **RPMS iCare - Track - Findings Due Date** dialog

If you selected more than one eligible event, the application displays the **RPMS iCare - Track - Findings Due Date** dialog (for multiple events).

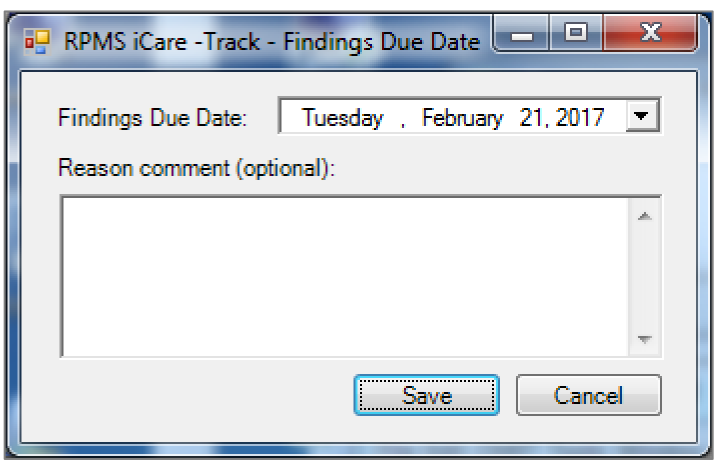


Figure 3-32: Sample **RPMS iCare - Track - Findings Due Date** dialog for multiple events

In either case, do the following:

- Make sure that the correct date is in the **Findings Due Date** field (required). Change the date by clicking the list to access a calendar (where you can select another date). The date cannot be earlier than the current date.
- Type the text of the reason for changing the status to TRACKED in the Free Text **Reason comment** field (not required).
- Click **Save** to save the information and to change the status of the events to Tracked. These events will display on the **Tracked Events** sub-tab of the **Patient Record** window. (Otherwise, click **Cancel**.)

If you use the **Save and Enter Findings** button for a single event, the application displays the CMET Worksheet (where you can add Findings to the event, for example). Section 4.10 provides for information about the worksheet. After saving the worksheet, the focus returns to the **Events** sub-tab.

3.9.3.2 Don't Track

Use the Don't Track function to change the status of a Pending event to Not Tracked. Select the events and click **Don't Track** (or select **CMET** | **Events** | **Don't Track**).

If you select Tracked events and they are not eligible for the Not Tracked function, the application displays the message: Once an event has been Tracked, it cannot be changed to Not Tracked. See the User Manual guidance on how to manage an event that was tracked. Click **OK** to dismiss the message. If the selected Tracked event was erroneously tracked in error, Section 4.15 provides information about how to handle this error.

If you selected eligible events, the application displays the **RPMS iCare – Don't Track Event** dialog.

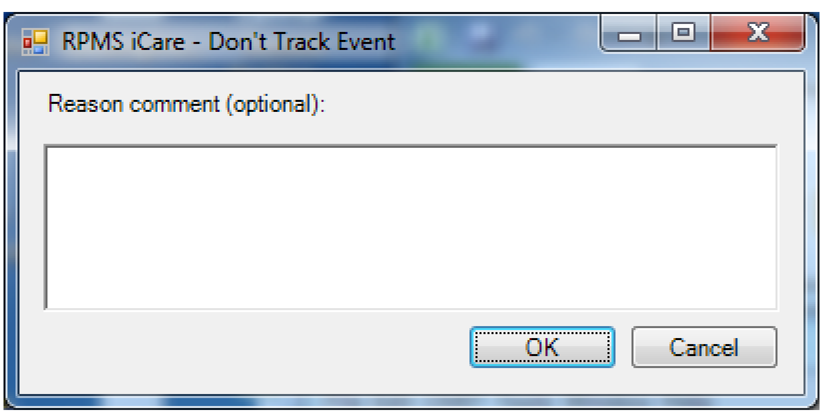


Figure 3-33: Sample **RPMS iCare – Don't Track Event** dialog

Type a reason for the change in the Free Text **Reason comment** field (not required). Click **OK** to save and to change the Status of the events to Don't Track. (Otherwise, click **Cancel**.)

3.9.3.3 Pend

Use the Pend function to change the status of one or more selected Not Tracked event to Pending. Select the events and then click the **Pend** button (or select **CMET** | **Events** | **Pend**).

If you select events that are not eligible for the Pend function, the application displays the message: "Only events with status of Not Tracked can change to Pending." Click **OK** to dismiss the message.

If you selected eligible events, the application displays the **RPMS iCare – Pend Event** dialog.

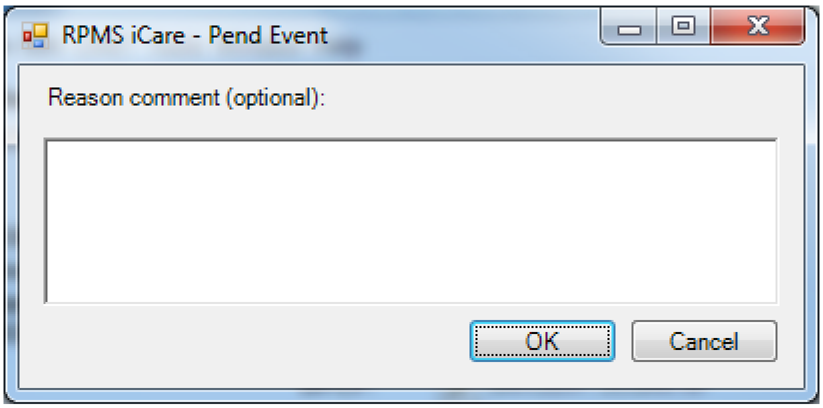


Figure 3-34: Sample **RPMS iCare – Pend Event** dialog

Type a reason for the change in the Free Text **Reason comment** field (not required). Click **OK** to change the Status of the selected events to Pending. (Otherwise, click **Cancel**.)

3.9.3.4 Add Manual Event

Use the Add Manual Event function to add a new manual event. Select the events and then click the **Add Manual Event** button (or select **CMET** | **Events** | **Add Manual Event**).

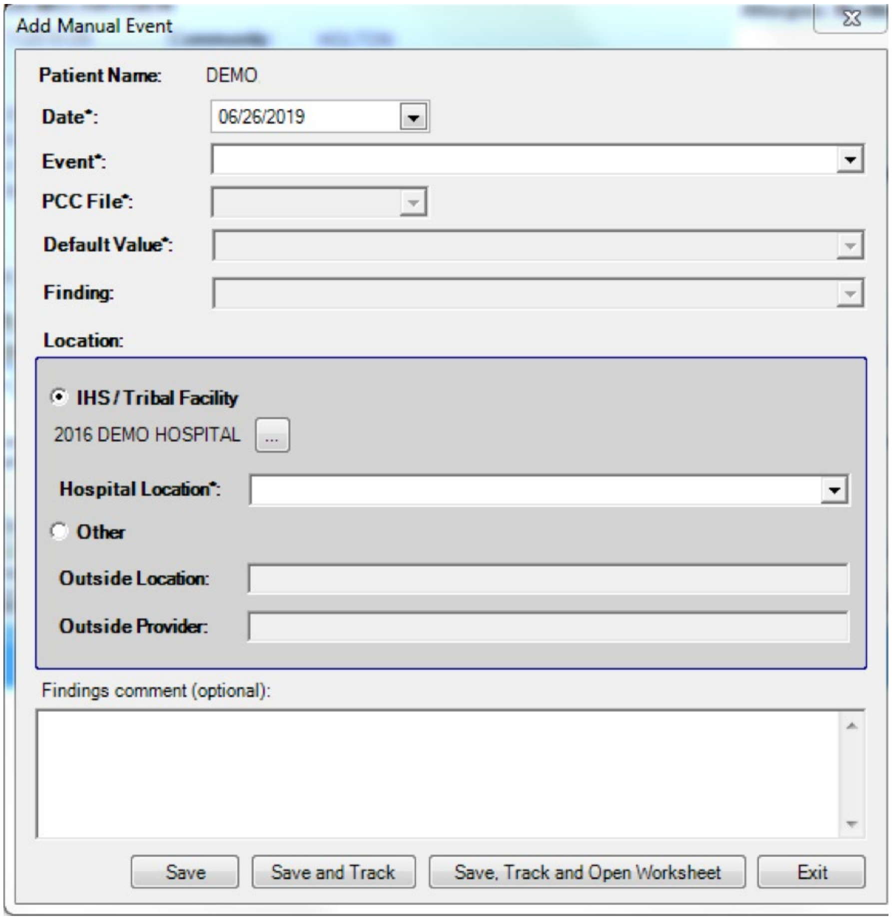


Figure 3-35: Sample **RPMS iCare – Add Manual Event** dialog

The required fields are marked with an asterisk (*) following the name.

- **Date**: Select a date for the event.
- **Event**: Select the event.
- **PCC File**: Select the PCC File.
- **Default Value**: Select a default value for the event.
- **Finding**: Select a finding, if desired for the event.
- Location:
  - **IHS/Tribal Facility:** Select a one of the following:
    - **Hospital Location:** Select a Hospital Location from the list. Required for IHS/Tribal Facility.
    - **Other:** Enter an Outside Location and if desired, an Outside Provider.
- **Finding comment**: Enter a finding comment for the event, as needed.

- Do one of the following:
  - Click **Save** to save a new manual event.
  - Click **Save and Track** to save a new manual event and track. This functions the same as the **Track** button (Section 3.9.3.1).
  - Click **Save, Track and Open Worksheet** to save a new manual event, track, and open a CMET worksheet. This has the same function as the **Open CMET Worksheet** button (Section 3.9.6.3) on the **Tracked Events** tab.

3.9.4 Tracked Events Sub-Tab

The patient's tracked Events display on the **Tracked Events** sub-tab. All events on this view have a CMET status of Tracked and are now considered a CMET.

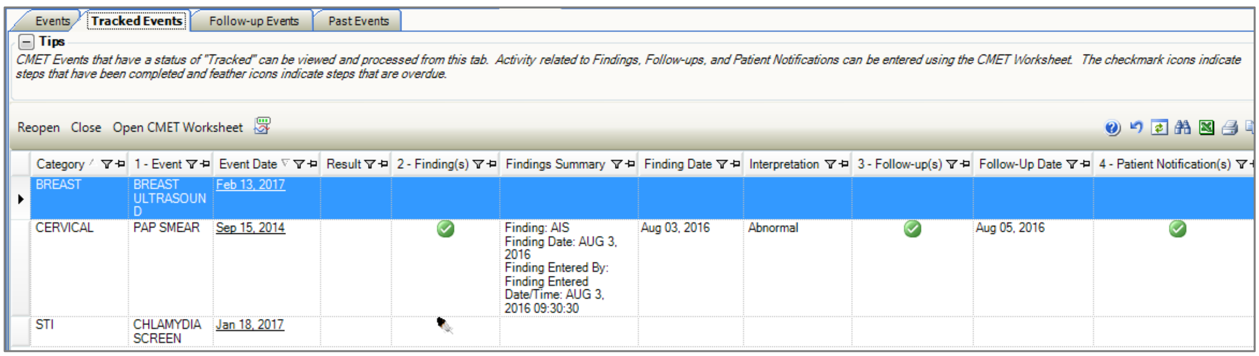


Figure 3-36: Sample **Tracked Events** sub-tab

The **Tracked Events** sub-tab is divided into three general areas: Tips information, Tracked Events toolbar, and Tracked Events data.

The Tips information provides an overview of the **Tracked Events** sub-tab. You can collapse this area in order to have more room to view the Tracked Events data.

3.9.5 Tracked Events Sub-Tab Layout

Table 3-3 provides information about the columns on the **Tracked Events** sub-tab.

Table 3-3: Tracked Events column names and meanings

Column Name	Meaning
Category	The name of the category for the tracked event: Breast, Cervical, Colon, Skeletal, STI.
1 - Event	The name of the event. Events are procedures, exams, or tests that have been documented in RPMS. Events are predefined.
Event Date	The date the event was performed.
Result	The date the result was entered. Hover help will describe where the result came from (V-RADIOLOGY, V-LAB).

Column Name	Meaning
2 - Finding(s)	Icon that indicates if the event has any Findings.
Findings Summary	Summary of the findings
Findings Date	The date of the findings.
Interpretation	The interpretation of the selection in the Result field. There is hover help for this field, e.g., CMET that refers to where the interpretation was obtained.
3 - Follow-up(s)	Icon that indicates if the event has any follow-up data.
Follow-up Date	The date of the follow-up.
4 - Patient Notification(s)	Icon that indicates if the event has any patient notification data.
Patient Notification(s) Date	The notification date of the tracked event.
State	The state of the tracked event (open or closed).
Last Modified Date	The date the record as last modified.
Last Modified By	The name of the person who last modified the record.

Double-click any record to access the CMET Worksheet. Section 4.10 provides information about the worksheet.

3.9.6 Tracked Events Sub-Tab Toolbar

Section 4.2 provides information about the buttons on the right side of the toolbar.

Click the **Background Jobs** ( ) button (or select **File** | **Background Jobs**) to display the **Background Jobs** dialog. Section 4.11 provides information about this dialog.

3.9.6.1 Reopen

Use the Reopen function to change a Closed event to Open. Select only one event with a State of Closed, then click the **Reopen** button (or select **CMET** | **Tracked Events** | **Reopen**) to access the **RPMS iCare – Reopen Tracked Event** dialog.

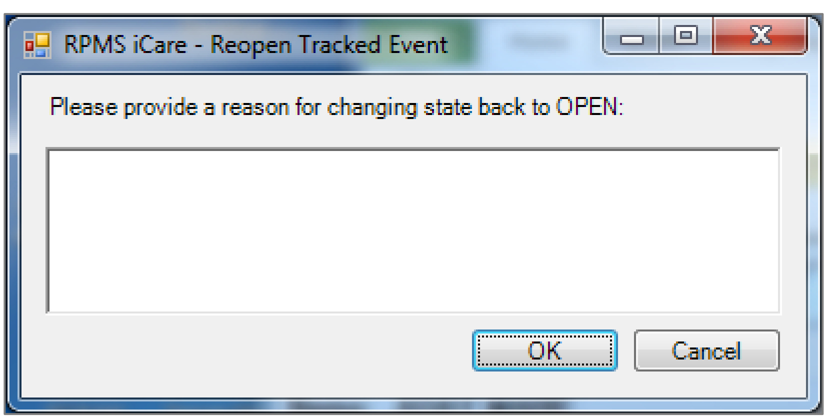


Figure 3-37: **RPMS iCare – Reopen Tracked Event** dialog

Type the reason for changing the state back to Open in the Free Text field (not required). When the dialog is complete, click **OK** to change the State of the tracked event to Open. (Otherwise, click **Cancel**.)

If you select more than one event and use the Reopen function, the application displays a warning message: "Please reselect as only one event can be reopened at one time." Click **OK** to close the warning message and select only one event.

3.9.6.2 Close

Use the Close function to change an Open event to Closed. Select the events with a State of Open, then click the **Close** button (or select **CMET** | **Tracked Events** | **Close**) to access the **RPMS iCare – Reason for Closing** dialog.

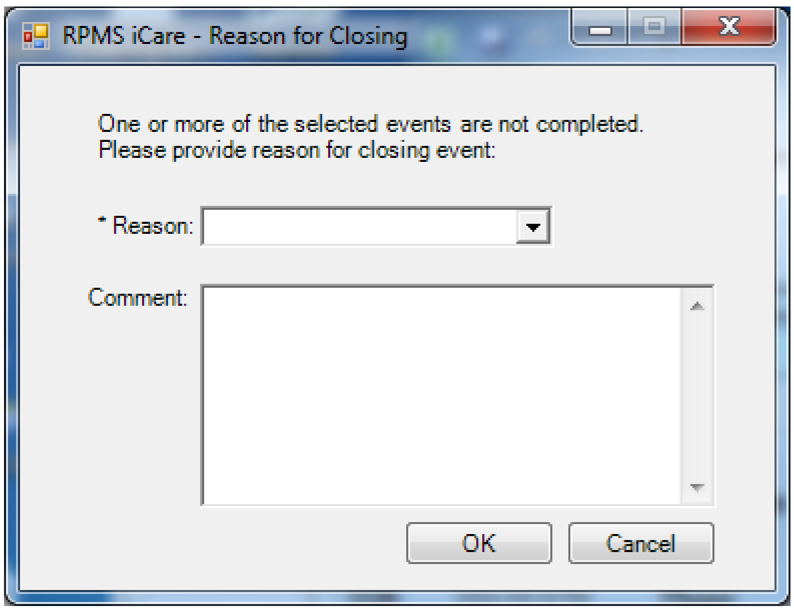


Figure 3-38: **RPMS iCare – Reason for Closing** dialog

Required fields are marked with an asterisk (*) following the name.

Reason: Select an option from the list: Event Complete, Patient Moved, Lost to Follow-up, or Other (this option requires a comment).

Comment: This Free Text field is required when the Reason is Other. Type the text of the reason.

When the dialog is complete, click **OK** to change the State for the selected tracked events to Close. (Otherwise, click **Cancel**.)

3.9.6.3 Open CMET Worksheet

Select an event and then click the **Open CMET Worksheet** button (or select **CMET** | **Tracked Events** | **Open CMET Worksheet**) to access the CMET Worksheet (for the event). Here you can enter Finding(s), Follow-up(s), and Patient Notification(s) for the patient. Section 4.10 provides for more information about the worksheet. **Note**: This function can be applied to only one event.

3.9.7 Follow-up Events Sub-Tab

The **Follow-up Events** sub-tab displays the patient's follow-up events. Follow-up events are generated by the third CMET step. This view lists all those events that have been recommended as follow-up.

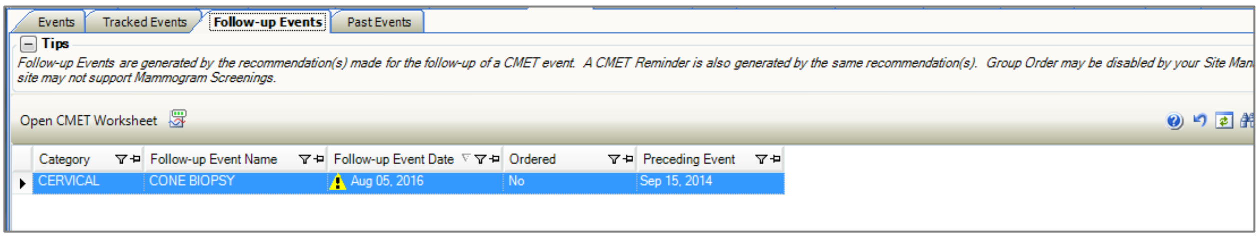


Figure 3-39: Sample **Follow-up Events** sub-tab

The **Follow-up Events** sub-tab is divided into three general areas: Tips information, Follow-up Events toolbar, and Follow-up Events data.

The Tips information provides an overview of the **Follow-up Events** sub-tab. You can collapse this area in order to have more room to view the Follow-up Events data.

Category: The category of the follow-up event.

Follow-up Event Name: The name of the follow-up event.

Follow-up Event Date: The date of the follow-up event.

Ordered: Indicates whether the follow-up has been ordered (Yes or No).

Preceding Event: The date of the preceding event. There is hover help when you move your mouse over the date (for example, PAP SMEAR).

Double-click any record to access the CMET Worksheet. Section 4.10 provides information about the worksheet.

3.9.8 Follow-up Events Sub-Tab Toolbar

Section 4.2 provides information about the buttons on the right side of the toolbar.

Select a record in the grid and click the **Open CMET Worksheet** button (or select **CMET** | **Follow-up Events** | **Open CMET Worksheet**) to access the CMET Worksheet. Section 4.10 provides information about the worksheet.

Click the **Background Jobs** ( ) button (or select **File** | **Background Jobs**) to display the **Background Jobs** dialog. Section 4.11 provides information about this dialog.

3.9.9 Past Events Sub-Tab

The **Past Events** sub-tab displays the patient's past CMET events. Past events come from data mining.

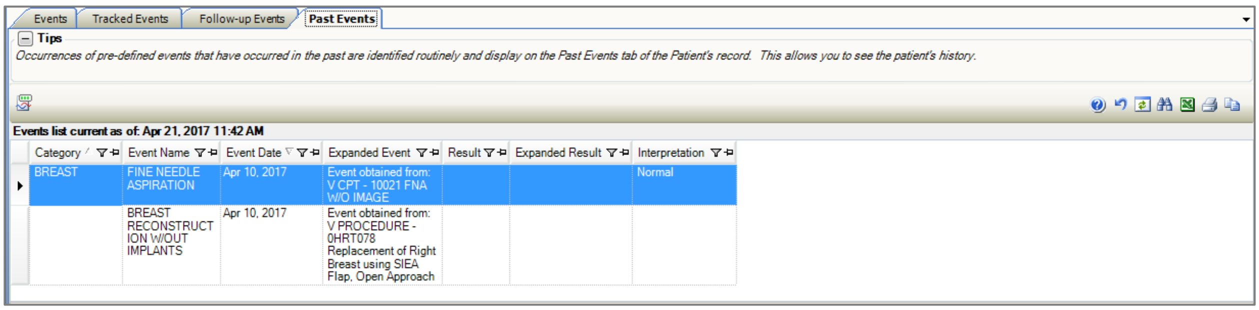


Figure 3-40: Sample **Past Events** sub-tab

The **Past Events** sub-tab is divided into three general areas: Tips information, Past Events toolbar, and Past Events data.

The Tips information provides an overview of the **Past Events** sub-tab. You can collapse this area to have more to view the Past Events data.

3.9.10 Past Events Sub-Tab Layout

Category: The name of the category for the past event.

Event Name: The name of the past event.

Event Date: The date of the past event.

Expanded Event: More detailed information about the past event.

Result: The date of the result of the past event. Double-click a record with an underlined date to access a particular detail dialog, for example, Women's Health Detail.

Expanded Result: More detailed information about the result of the past event.

Interpretation: The interpretation of the selection in the **Result** field. There is hover help for this field, e.g., CMET, that refers to where the interpretation was obtained.

3.9.11 Past Events Sub-Tab Toolbar

Section 4.2 provides information about the buttons on the right side of the toolbar.

To check on the status of the background jobs, do one of the following:

- Click the **Background Jobs** () button
- Select **File** | **Background Jobs**

This displays the **RPMS iCare - Background Jobs** dialog. Section 4.11 provides information about this dialog.

3.9.12 CMET Tab Menus

The options on the **File** menu are the same as those on the File menu for the Cover Sheet.

The options on the **Tools** menu are the same as those on the Tools menu for the **Flags** tab.

The CMET menu varies, according to the sub-tab. Most of the CMET menus reflect the buttons on the toolbar for that sub-tab.

3.10 Summ/Supp Tab

The **Summ/Supp** tab displays a selected type of report (shown in the **Type** field): Asthma Action Plan, Face Sheet, Health Summary, Patient Wellness Summary, Supplement. These reports are from RPMS.

When you first access this tab, it will be blank. You must select an option from the list for the **Type** field.

You can display and print existing condition-specific (i.e., register specific) supplements.

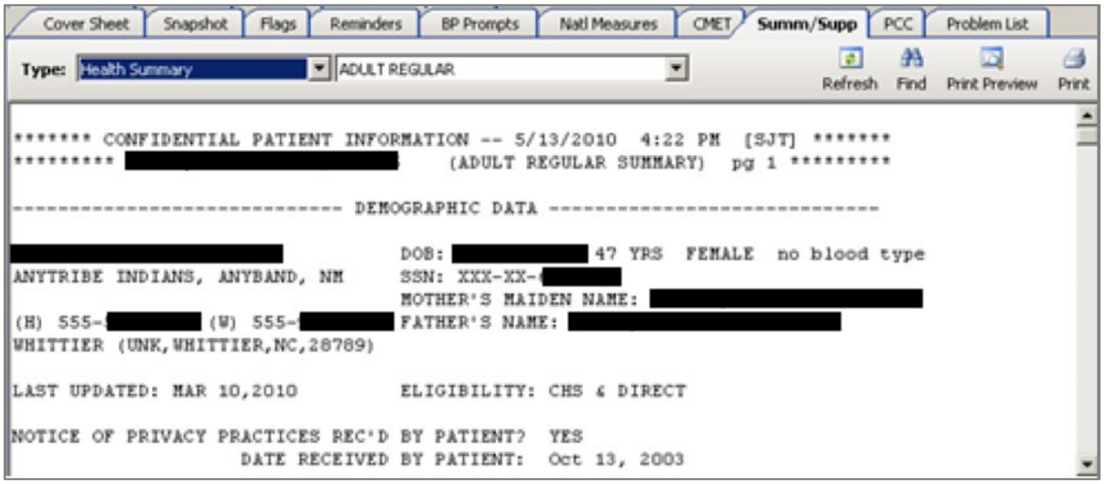


Figure 3-41: Sample **Summ/Supp** tab

When you use the Asthma Patient Care Summary (from the Supplement option), you can review the Asthma Supplement Logic (Section IV) in the Asthma Glossary. This section of the glossary gives the structure of the report and the definitions of the fields. (Select **Help** | **Care Mgmt Glossaries** | **Asthma Glossary** for more information.)

3.10.1 Summ/Supp Tab Toolbar

The **Type** field determines which summary/supplement report to display:

- Asthma Action Plan
- Fact Sheet
- Health Summary (HS) – has a secondary selection; Adult Regular is the default
- Patient Wellness Handout – has a secondary selection
- Supplement – has a secondary selection
- Women's Health Profile – Brief

Refresh button: It is not always intuitive to users that when they select a second HS type and return to the initial HS, they have to click **Refresh** to display updated data, for example, after entering PCC data.

Find button: Searches for a specific text string within the report text. This is especially useful for finding information within long reports.

Print Preview button: Displays a preview of the page layout prior to printing the report on a printer. Section 4.12 provides information about the **Print Preview** dialog.

Print button: Outputs the report. The application displays the **Print** dialog where you select the printer, page range, and number of copies.

3.10.2 Summ/Supp Tab Menus

3.10.3 Tools Menu

The options on the **Tools** menu for the **Summ/Supp** tab are as follows:

- **Quick Patient Search**: This option executes a patient search. This is the same as pressing F8 on your keyboard.
- **Refresh**: Use this option when you select a second HS type, then return to the initial HS to refresh and display the updated data, for example, after entering PCC data. This is the same as pressing F5 on your keyboard or clicking the **Refresh** button.
- **Find**: This option finds data in the current window. The application displays the **Search** dialog. This is same as clicking the **Find** button.
- **User Preferences**: This option takes you to the **User Preferences** window where you can change your user preferences.
- **Web Links**: This option shows several categories (such as Asthma) that have Web links. When you select a Web link, the Internet browser for the particular category opens.

3.10.4 File Menu

The options on the **File** menu of the **Summ/Supp** tab are the same as those the File menu for the **Cover Sheet**.

3.11 PCC Tab

The PCC tab displays various types of PPC data associated with the patient. This data comes the V Lab file from PCC.

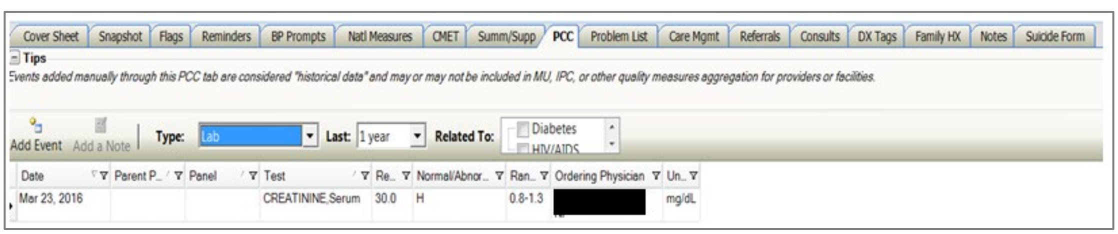


Figure 3-42: Sample **PCC** tab

The PCC data that displays is determined by the selection in the **Type** field on the toolbar. The time interval is controlled by the selections in the Last list.

The PCC tab is divided into two general areas: Tips information and PCC data.

The Tips information provides an overview of the PCC tab. You can collapse this area to have more room to view the PCC data.

3.11.1 PCC Tab Layout

No duplicate values display; for example, if a patient has multiple immunizations on the same day, the date should display only on the first line.

The display can show any of the following PCC data types (shown in the **Type** field):

The **CPT** data has these data elements: Date, CPT Code, Modifier 1, Modifier 2, Quantity.

The **Elder Care** data has these data elements: Date, Toileting, Bathing, Dressing, Transfers, Feeding, Continence, Finances, Cooking, Shopping, Housework/Chores, Medications, Transportation, Functional Status Change, and Is Patient a Caregiver?.

The **Exams** data comes from PCC V Exam files Data Elements: Date, Exam, Result, Encounter Provider, Comments.

The **Health Factors** data comes from PCC V Health Factor files. Data Elements: Date, Health Factor Category, Health Factor, Level/Severity, Quantity, Provider, Comments.

The **Immunizations** data comes from PCC V IMM files. Data Elements: Date (visit), Immunization, Series, Reaction, Encounter Provider.

The **Lab** data comes from the PCC V Lab file. Data Elements: Date, Parent Panel, Panel, Test, Result, Normal/Abnormal, Range, Ordering Physician, Units. When entering historical data, you are limited to lab tests only (you are not allowed entry of lab panels because panels have no result since they are comprised of multiple individual tests with associated results). You can filter Lab data by **Related to** (currently HIV register-related).

The **Measurement** data comes from PCC V Measurements files. Data Elements: Date, Measurement, Value, Qualifiers, Percentile. Qualifiers describe how patient vital signs and measurements were taken (not all measurements have qualifiers).

The **Medication** data comes from PCC V Medications file. Data Elements: Date, Medication (name), Instructions, Quantity, Days, Ordering Physician.

The **Patient Education** data comes from PCC V Patient Ed files. Data Elements: Date, Disease/Topic, Level of Understanding, Time Spent, Provider, Goal Status, Comments.

The **POV** data comes from PCC V POV files. Data Elements: Date, POV Code, POV Description, Provider Narrative, Primary/Secondary, First/Revisit, Encounter Provider.

The **Procedures** data comes from PCC V Procedures files. Data Elements: Date, Operation/Procedure, Provider Narrative.

The **Radiology** data comes from PCC V Radiology file. Data Elements: Date, Procedure, Impression, Result.

The **Skin Test** data comes from PCC V Skin Test files. Data Elements: Date, Skin Test, Results, Reading.

3.11.2 PCC Tab Toolbar

The default date range for all data is one year; you can select different predefined date ranges (3 months, 6 months, 1 year, 2 years, or ever). The default display is in reverse order of date with most recent first.

The **Relate To** field displays for Lab (from the **Type** field). There are other register data that you can select for other data types.

When the Type is Measurement, the **Graph It!** button (see Section 3.11.6) displays on the toolbar.

Section 4.2 provides information about using the buttons on the right side of the window.

3.11.3 Add Event

Use the Add Event feature to record historical PCC data for the current patient. This feature requires either the iCare Editor (BQIZCMED) or iCare Package Manager (BQIZMGR) security key.

The Add Event feature is available for each option in the **Type** field, except Medications.

In PCC, this data is categorized with a Service Category of **Historical Event** and does not enter the normal facility visit billing cycle. Historical data might need to be entered to complete the patient record in the following circumstances:

- The facility uses an off-site reference lab and is not using the RPMS Reference Lab application to send and receive lab data electronically directly into RPMS.
- A test or procedure was documented in the patient's chart but was not entered into RPMS.

- The patient was traveling and received care at another facility that should be documented in their home facility.
- The patient received an immunization or similar public health procedure at an off-site community event.

Click the **Add Event** () button (or select **PCC** | **Add Event**) to display the **Add PCC Event** dialog.

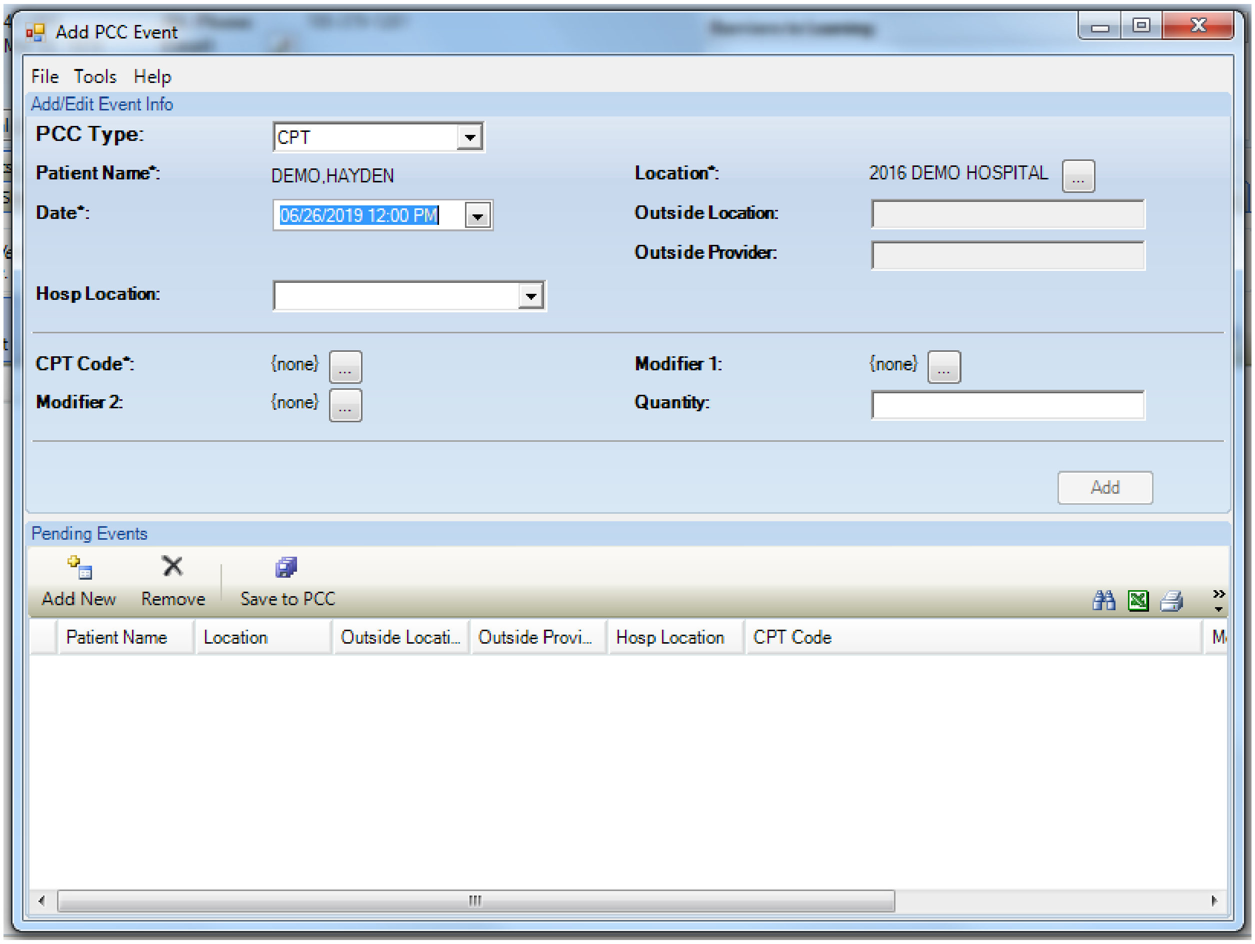


Figure 3-43: Sample **Add PCC Event**

Dismiss the **Add PCC Event** window by selecting **File** | **Close**.

When you click an ellipsis button by a field, the **Table Lookup** dialog displays. Section 4.14 provides information about how to use this dialog.

The Add PCC Event window has two areas: (1) Add/Edit Event Info contains fields to adding or editing PCC data and (2) Pending Events displays the records that are pending events that you can remove, add new ones, and save to PCC.

Any field followed by an asterisk (*) is required.

Please note that a Hospital Location is required for standard locations and not Outside Locations.

3.11.3.1 Add/Edit Event Info Group Box

The default Patient Name is the name of the patient for the Patient Record.

The default location is the service unit associated with the current user. You can change this by clicking the ellipsis button to search for a location name. If the **Location** field is populated with OTHER, then the **Outside Location** and **Outside Provider Name** fields become active; type the appropriate value in each Free Text field.

The fields in this group box vary by the PCC Type. Fields followed by an asterisk (*) are required.

Note:	When using the PCC Type is Measurement, there is a field called Qualifier(s). Not all measurement types have qualifiers. Qualifiers describe how patient vital signs and measurements were taken. But for example, temperature has qualifiers of auxiliary, oral, rectal, core, tympanic, skin.

3.11.3.2 Pending Events Group Box

You can add new records, remove existing records, or save existing records in this group box to PCC.

Section 4.2 provides information about how to use the buttons on the right side of the toolbar of the Pending Events area. These same functions can be found on the Tools menu of the Add PCC Event window.

If you double-click a record in **Pending Events** group box, the **Visit Detail** dialog will display. Section 4.6 provides information about the using the controls on the dialog.

- **Add New:** Click the **Add New** (
) button (or select **File** | **Add New**) to clear the fields in the **Add/Edit Event Info** group box where you can define a new PCC type record. You need to populate the appropriate fields for the selected PCC Type. When all fields are complete, click **Add**. This action adds a new record to the **Pending Events** area.
- **Edit a Record:** Double-click a record in the **Pending Events** area to cause the existing record data to populate the fields in the **Add/Edit Event Info** group box. You can change the fields, as needed. When all fields are complete, click the **Apply Changes** button. This changes the record in the **Pending Events** group box.

- **Remove:** You can remove the highlighted records in the **Pending Events** group box by clicking the **Remove** (

) button (or selecting **File** | **Remove**). The **Confirm remove** window displays, confirming the deletion. Click **Yes** to remove the records. (Otherwise, click **No**.)
- **Save to PCC:** You need to save your changes/additions to PCC (that are listed in the **Pending Events** group box). Click the **Save to PCC** (

) button (or select **File** | **Save to PCC**) to display the **Confirm save to PCC?** information message, confirming that you want to save the PCC data to the patient's PCC visit file.

  Click **Yes** to save the information to PCC. (Otherwise, click **No**.). In either case, the record is removed from the **Pending Events** group box.

After you exit the information message, the application updates the **PCC** tab on the **Patient Record** window and displays the **Add Chart Review?** information message: "Do you wish to add a Chart Review at this time?"

Click **OK** to add a Chart Review record (otherwise, click **Cancel**). If you click **OK**, the application displays the **Add a Note** dialog. Section 4.4 provides information about this dialog.

Please note that for each type of added event, you need to save. When you try to enter a new type, iCare asks if you want to save the existing records to PCC. Do one of the following:

- Click **Yes** to save to PCC. This action removes the record from the **Pending Events** group box.
- Click **No** to not save. This action removes the record from the **Pending Events** group box.
- Click **Cancel** to return to the **Add PCC Event** dialog.

3.11.4 Add a Note

The Add a Note feature is available for each option in the **Type** field. Use this feature to add a note for the patient, such as a chart review, follow-up letter, or telephone call.

Note:	The **Add a Note** button is active *only* if you have your electronic signature on file.

Click the **Add a Note** (

) button (or select **PCC** | **Add a Note**) to access the **Add a Note** dialog. Use this dialog to add a new chart review, follow-up letter, or telephone call note for the patient. Section 4.4 provides information about this dialog.

3.11.5 Related To

When the Type is Lab, the toolbar changes where you can indicate if you want to show labs related to HIV/AIDS or Diabetes.

3.11.6 Graph It Button

The **Graph I**t (

) button only appears when the Type is Measurement. This feature allows you to display, print, and save a graph of particular measurements data.

When the current patient has measurement data, click the **Graph It** button (or select **PCC** | **Graph It**). The application displays the **Charting** window, showing a graph of the various measurement types.

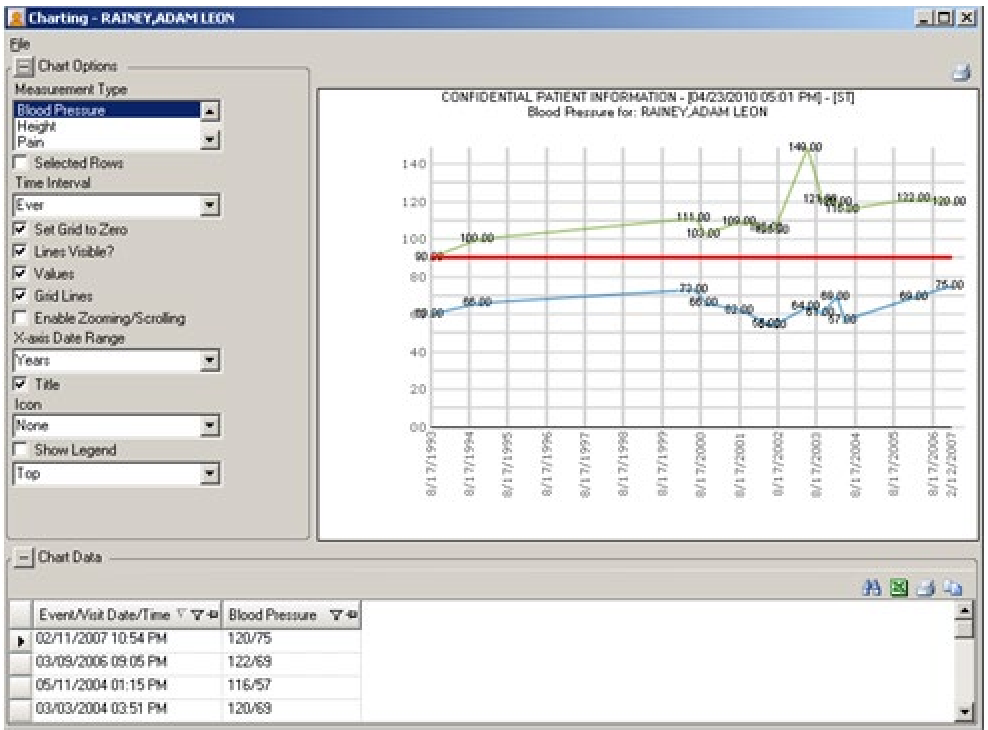


Figure 3-44: Sample **Charting** window

Section 4.13 provides information about the Charting window.

3.11.7 PCC Tab Menus

The options on the **File** menu of the **PCC** tab are the same as those on File Menu for the **Cover Sheet** tab.

The options on **Tools** menu on the **PCC** tab are the same as those on the Tools Menu for the **Flags** tab.

The options on the **PCC** menu operate like the action buttons on the toolbar. Section 3.11.2 provides information about the toolbar.

3.12 Problem List Tab

There are two conditions for this tab: (1) a patient with no problems and (2) a patient with one or more problems. The toolbar to each condition will be different.

Patient with No Problems: The Problem List tab for a patient with no problems is shown in Figure 3-45.

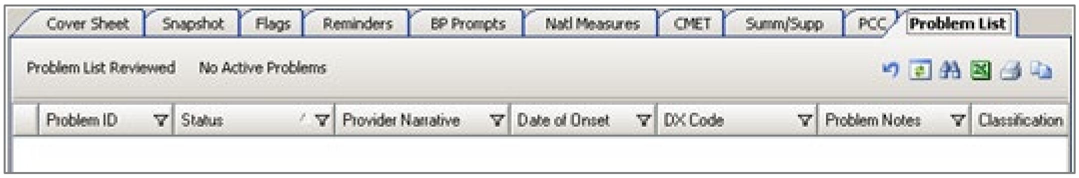
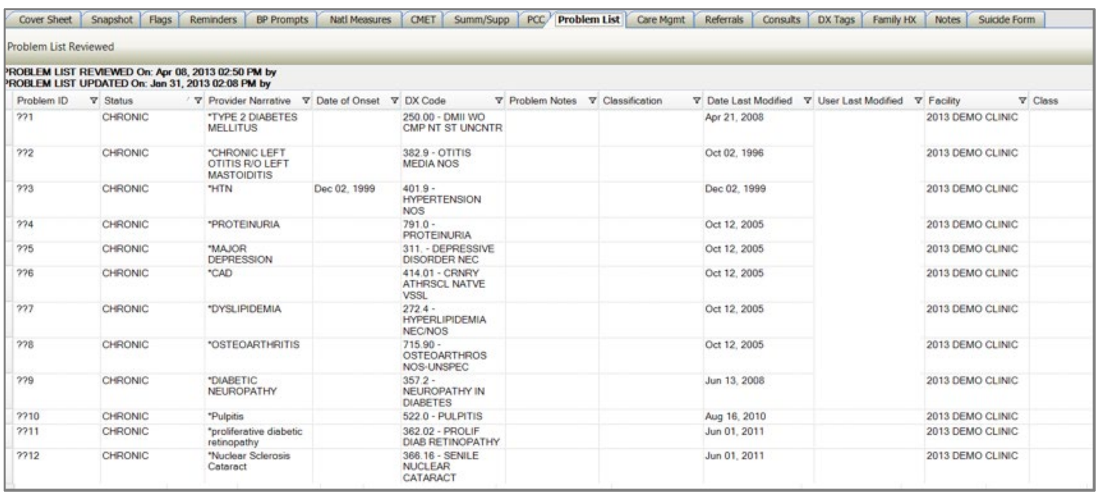


Figure 3-45: **Problem List** tab for patient with no problems

The **No Active Problems** button only displays for a patient with no problems.

Patient with Problems: The Problem List tab shows the patient's current problem list (Figure 3-46). The Problem List data comes from the PCC Problem List.



Problem ID	Status	Provider Narrative	Date of Onset	DX Code	Problem Notes	Classification	Date Last Modified	User Last Modified	Facility	Class
??1	CHRONIC	*TYPE 2 DIABETES MELLITUS		250.00 - DMII WO CMP NT ST UNCNTR			Apr 21, 2008		2013 DEMO CLINIC	
??2	CHRONIC	*CHRONIC LEFT OTITIS R/O LEFT MASTOIDITIS		382.9 - OTITIS MEDIA NOS			Oct 02, 1996		2013 DEMO CLINIC	
??3	CHRONIC	*HTN	Dec 02, 1999	401.9 - HYPERTENSION NOS			Dec 02, 1999		2013 DEMO CLINIC	
??4	CHRONIC	*PROTEINURIA		791.0 - PROTEINURIA			Oct 12, 2005		2013 DEMO CLINIC	
??5	CHRONIC	*MAJOR DEPRESSION		311. - DEPRESSIVE DISORDER NEC			Oct 12, 2005		2013 DEMO CLINIC	
??6	CHRONIC	*CAD		414.01 - CRNRY ATHRSCL NATVE VSSL			Oct 12, 2005		2013 DEMO CLINIC	
??7	CHRONIC	*DYSLIPIDEMIA		272.4 - HYPERLIPIDEMIA NEC/NOS			Oct 12, 2005		2013 DEMO CLINIC	
??8	CHRONIC	*OSTEOARTHRITIS		715.90 - OSTEOARTHROS NOS-UNSPEC			Oct 12, 2005		2013 DEMO CLINIC	
??9	CHRONIC	*DIABETIC NEUROPATHY		357.2 - NEUROPATHY IN DIABETES			Jun 13, 2008		2013 DEMO CLINIC	
??10	CHRONIC	*Pulpitis		522.0 - PULPITIS			Aug 16, 2010		2013 DEMO CLINIC	
??11	CHRONIC	*proliferative diabetic retinopathy		362.02 - PROLIF DIAB RETINOPATHY			Jun 01, 2011		2013 DEMO CLINIC	
??12	CHRONIC	*Nuclear Sclerosis Cataract		366.16 - SENILE NUCLEAR CATARACT			Jun 01, 2011		2013 DEMO CLINIC	

Figure 3-46: Sample **Problem List** tab

The default Problem List display shows the Active Problems first, then the Inactive ones.

3.12.1 Problem List Tab Layout

The data columns are:

- **Problem ID**: The identification label assigned to the problem.

- **Status**: Status of the problem, Active (showing Chronic, Sub-acute, episodic, social) or Inactive.
- **Provider Narrative**: The narrative entered for the International Classification of Diseases (ICD) code for the problem.
- **Date of Onset**: The date the symptoms started.
- **DX Code**: The ICD code for the problem.
- **Problem Notes**: Any notes entered about the problem.
- **Classification**: This shows any staging associated with the problem (for example, in Asthma Severity).
- **Date Last Modified**: The date the problem was last modified.
- **User Last Modified**: The name of the person who last modified the record.
- **Facility**: The name facility where the login user (who entered the problem) resides.
- **Class**: This will be blank or will contain Personal History.

The default display (sort) order will be by Status (Active first), then by Problem ID. You can sort/filter the columns and perform other functions on the columns.

3.12.2 Problem List Tab Toolbar

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.12.3 No Active Problems

Use the **No Active Problems** button to document that the patient has no active problems. Click the **No Active Problems** button to access the **No Active Problems** dialog.

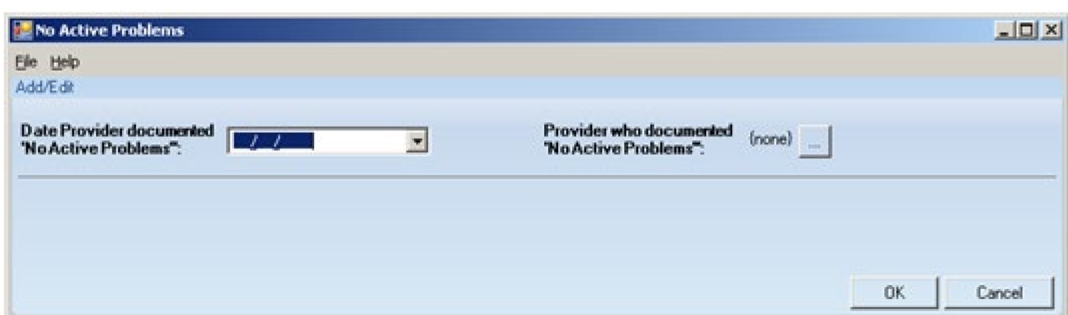


Figure 3-47: **No Active Problems** dialog

Both fields are required.

Date Provider documented "No Active Problems": Either manually populate this field with the date or click the list and pick a date from the calendar.

Provider who documented "No Active Problems": Click the ellipsis button to access the **Table Lookup** dialog. Here you search for a name and select one from the retrieved records to populate the field. Section 4.14 provides information about using the **Table Lookup** dialog.

After the dialog is complete, click **OK** (otherwise, click **Cancel**).

After clicking **OK**, the application displays the **Confirm save to RPMS** information message: "This data will be saved to the RPMS server. Do you want to continue?" Click **Yes** to save the data to the RPMS server. Click **No** to not save the data.

After clicking **Yes**, the **Problem List** tab will change, displaying a message that there are no active problems.

Figure 3-48: Sample **Problem List** tab showing message about no active problems

3.12.4 Problem List Reviewed

Use the **Problem List Reviewed** button to document that the patient's problem list was reviewed.

Click the **Problem List Reviewed** button to access the **Problem List Reviewed** dialog.

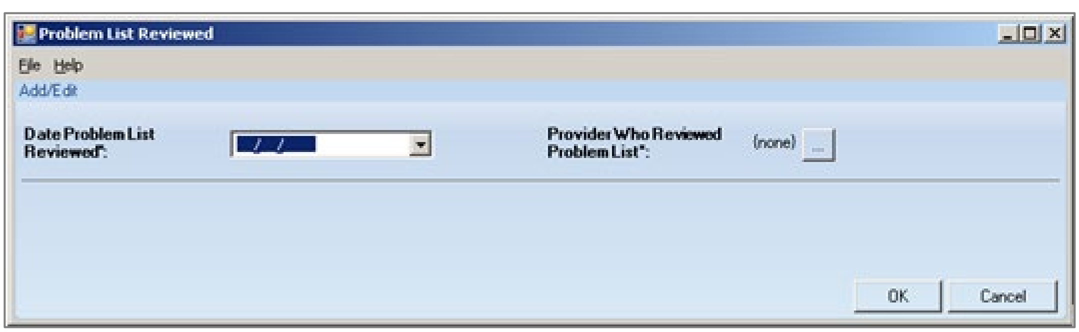


Figure 3-49: **Problem List Reviewed** dialog

Both fields are required.

Date Problem List Reviewed: Select a date by clicking the list to access a calendar.

Provider Who Reviewed Problem List: Click the ellipsis button to access the **Table Lookup** dialog where you search for a provider name. This is the provider who reviewed the problem list. Section 4.14 provides information about using the **Table Lookup** dialog.

When the dialog is complete, click **OK** (otherwise, click **Cancel**). After clicking **OK**, the application displays the **Save to RPMS?** information message: "You have data changes pending. Do you want to save to RPMS now?" Click **Yes** to save the data to RPMS. Click **No** to not save the data to RPMS.

After clicking **OK**, the application updates the toolbar with information about when the problem list was reviewed.

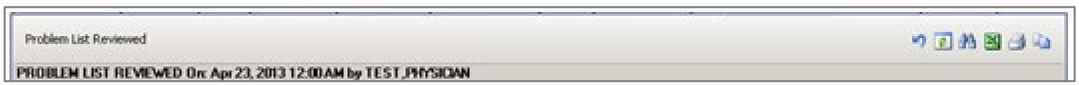


Figure 3-50: Toolbar showing when the problem list was reviewed

3.12.5 Problem List Tab Menus

The options on the **File** menu of the **Problem List** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on **Tools** menu on the **Problem List** tab are the same as those on the Tools Menu on the **Flags** tab.

3.13 Care Mgmt Tab

The Care Management tab displays any related care management data about the current patient. You must select an option from the **Please Select a Group** field to display data. There are two conditions: (1) if the patient does not have any related care management data and (2) if the patient does have related care management data.

3.13.1 Patient with No Tag

Asthma, DM Audit, HIV/AIDS

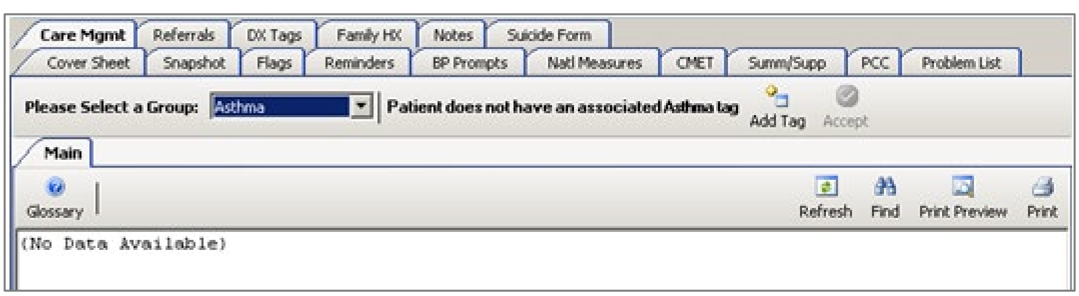


Figure 3-51: Sample Care Management tab for patient with No Tags for Asthma

The Care Management toolbar displays information that the patient does not have an associated Asthma, DM Audit, HIV/AIDS tag.

- Section 3.13.3 provides information about using the **Add Tag** button.
- Section 3.13.6 provides information about using the **Accept** button.

HIV/AIDS

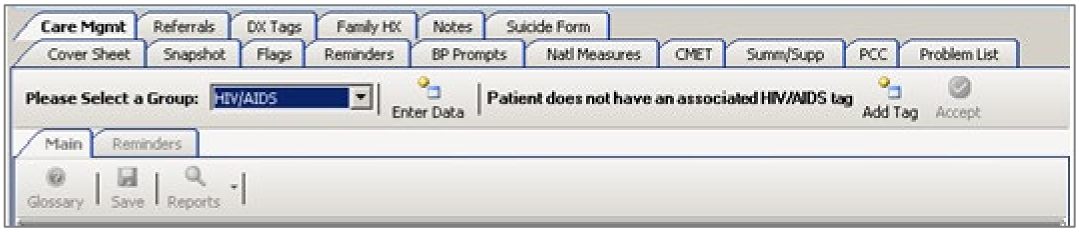


Figure 3-52: Sample Care Management tab for patient with No Tags for HIV/AIDS

The Care Management toolbar displays information that the patient does not have an associated HIV/AIDS tag.

3.13.2 Enter Data

Click the **Enter Data** (

) button (or select **Care Mgmt** | **Enter Data**) to add the patient to a register.

The fields will display in the **Main** sub-tab. This feature requires either the iCare Editor (BQIZCMED) or iCare Package Manager (BQIZMGR) security key. Section 3.13.8 provides more information about the **Main** sub-tab.

3.13.3 Add Tag

Use the Add Tag process to add a diagnostic tab. Click the **Add Tag** (

) button (or select **Care Mgmt** | **Add Tag**) to access the **Add Diagnostic Tag** dialog. This is a manual add.

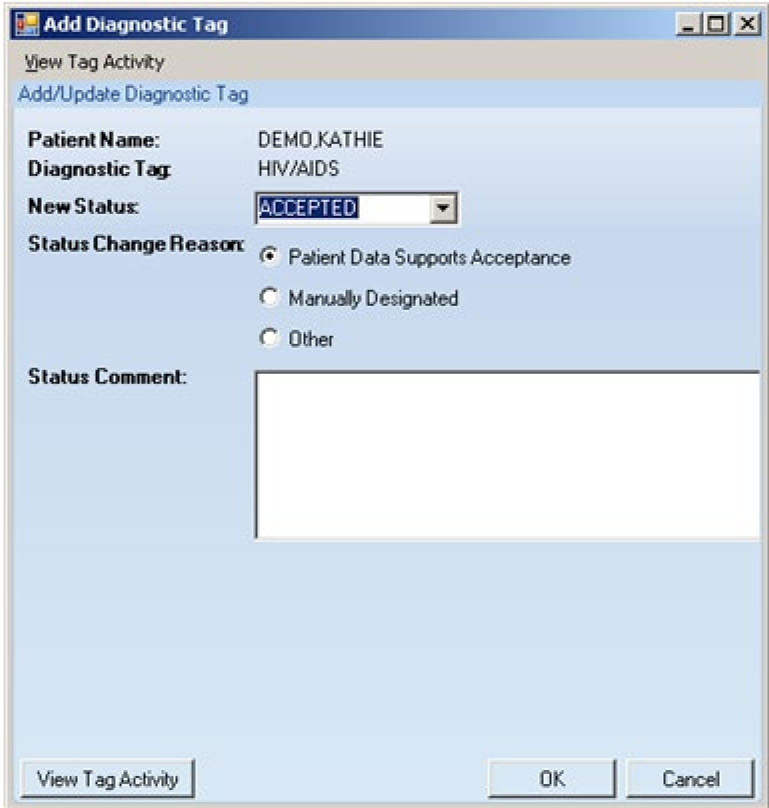


Figure 3-53: Sample **Add Diagnostic Tag** dialog

This manual-add process allows a provider to manually assign one or more of the diagnostic tags to patients that did not meet the tag's criteria for being proposed automatically.

> **Note**: If you are adding the Asthma diagnostic tag, the Diagnostic Tag field will be Asthma. If you are adding for DM Audit, the Diagnostic Tag field will be Diabetes.

3.13.3.1 Fields

New Status: the status of the tag being changed.

- **ACCEPTED**: This option allows you to Accept a proposed tag to provide an affirmation of its validity for a given patient.
- **NOT ACCEPT**: This option allows you to disapprove or Not Accept a diagnostic tag that has been proposed for a patient.
- **PROPOSED**: This option allows you to change the status of a diagnosis tag back to Proposed, so that further review can take place.

Reason: Select the appropriate option button for the reason to change the tag:

- **Patient Data Supports Acceptance**: Use this when the patient data does not support the tag.
- **Manually Designated**: Use this when you manually designate the tag.
- **Other**: Use this when the other reasons do not fit. You must populate the **Status Comment** field to provide the text of the reason.

Status Comment: Type the reason for the change (when the reason is Other) in this Free Text field. This feature provides a rich audit history for reasons for providers' decisions to accept or not accept proposed tag assignments.

Click **OK** to save your changes. (Otherwise, click **Cancel**). If you save, you need to refresh the screen; the message besides the **Care Management Group** field will reflect the change.

3.13.3.2 View Tab Activity Button

Use the **View Tag Activity** button to view the diagnostic tag activities. Click **View Tag Activity** to access the **RPMS iCare – Diagnostic Tag Activity** dialog.

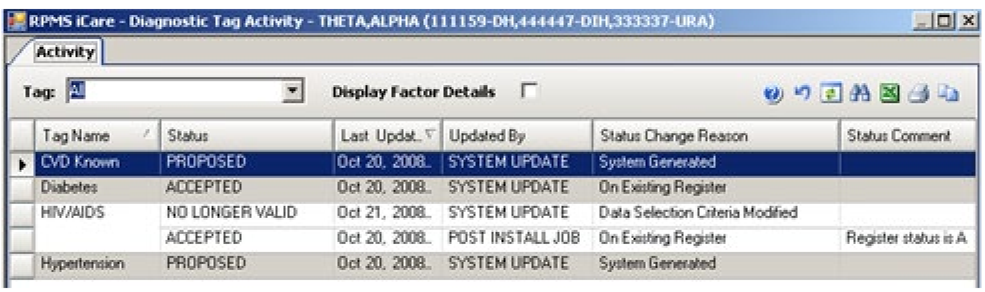


Figure 3-54: Sample Diagnostic Tag **Activity** dialog

You can view various tags by selecting an option from the list for the **Tag** field.

If you select the **Display Factor Details** check box, the following columns will display: Factor, Date, Item, Value. This allows you to view additional details about the tags. The default view is unchecked. You can sort/filter the columns and perform other functions on the columns.

Click the **Glossary** ( ) button to display the Diagnostic Tag Glossary. This dialog provides the detailed logic for each national performance measure defined in the Clinical Reporting System.

You must dismiss the dialog.

3.13.4 Accept Button

When the **Accept** button is active in the toolbar of the Care Management tab, you can change the status of the tag (displayed in the toolbar). The button will be active, for example, when the status of the tag is Proposed.

Section 3.13.6 provides information about using the **Accept** button.

3.13.5 Patient with Active Tags

The data will display on the **Main** sub-tab.

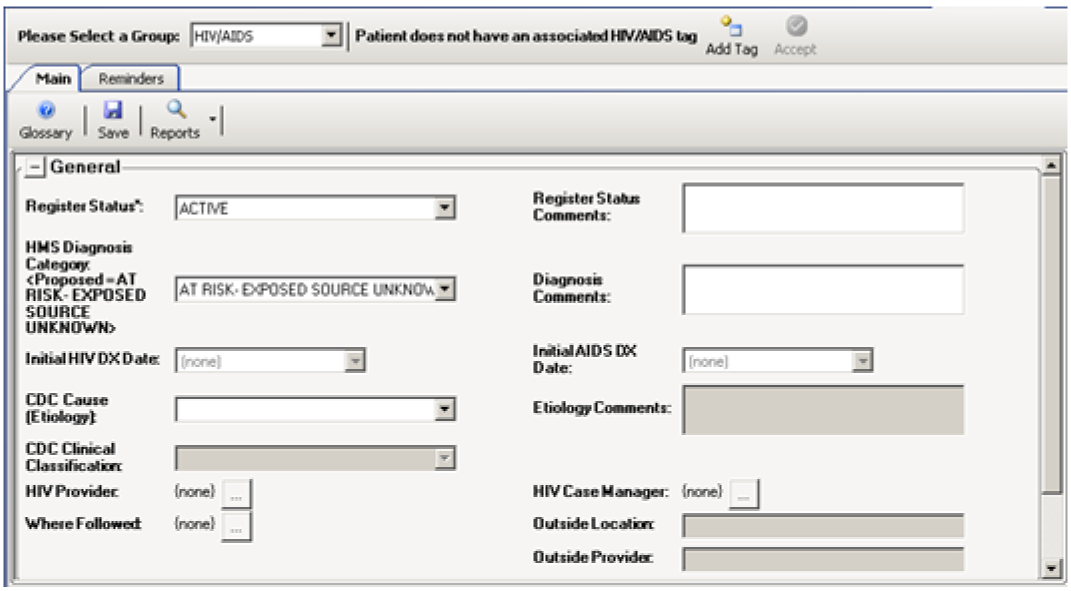


Figure 3-55: Sample Care Management Tab for patient with HIV/AIDS tag

Note: Only the **Main** sub-tab displays for Asthma and DM Audit.

3.13.6 Accept

When the **Accept** button is active in the toolbar of the Care Management tab, you can change the status of the tag (displayed in the toolbar). The button will be active, for example, when the status of the tag is Proposed.

Click the **Accept** button (or select **Care Mgmt | Accept Tag**) to display the **Update Diagnosis Tag** dialog. This dialog displays the patient name, diagnostic tag, and current status.

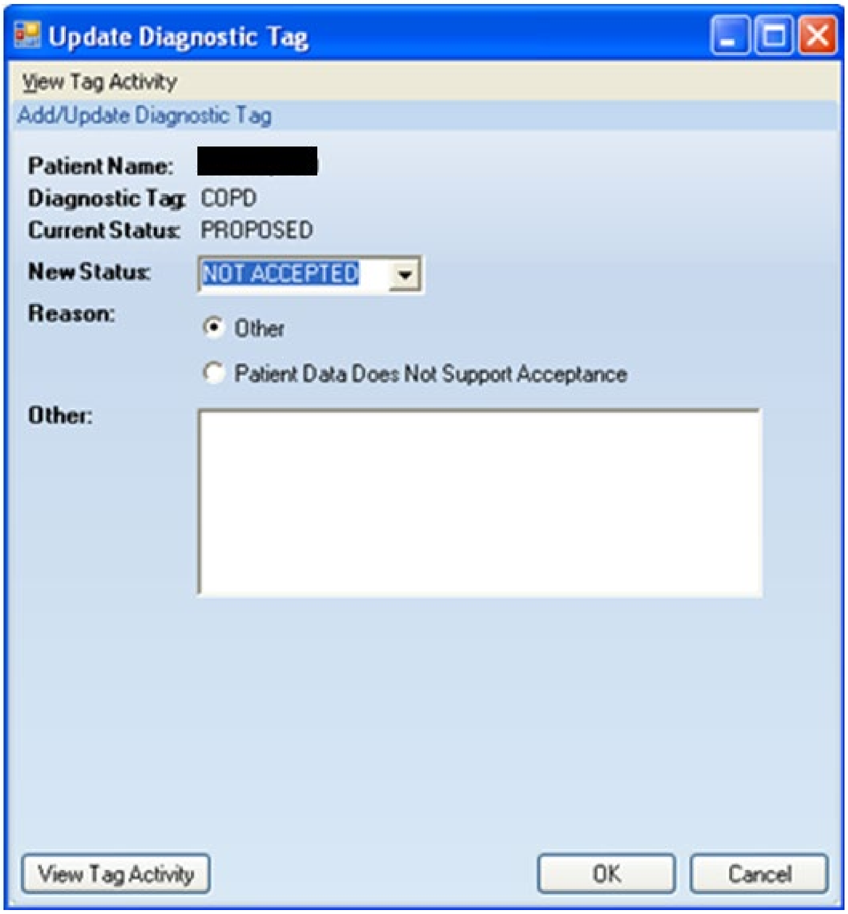


Figure 3-56: Sample **Update Diagnosis Tag** dialog

You can view existing tag activity about the patient by clicking the **View Tag Activity** button. The **Diagnostic Tag Activity** dialog displays. Section 3.13.3.2 provides information about this dialog.

You can edit the following fields:

- **New Status**: The status of the tag being changed.
  - **ACCEPTED**: This option allows you to Accept a proposed tag to provide an affirmation of its validity for a given patient.
  - **NOT ACCEPT**: This option allows you to disapprove or Not Accept a diagnostic tag that has been proposed for a patient.
  - **PROPOSED**: This option allows you to change the status of a diagnosis tag back to Proposed so that further review can take place. In certain cases, this option might not be available.
- **Reason**: Click the appropriate option button for the reason to change the tag.
  - Patient Data Supports Acceptance: Use this when the patient data does not support the tag.

    – Manually Designated: Use this when you manually designate the tag.
    – Other: Use this when the other reasons do not fit. You must populate the Other field to provide the text of the reason.

- **Other**: Type the reason for the change (when using the reason Other) in this Free Text field. This feature provides a rich audit history for the providers' decisions to accept or not accept proposed tag assignments.

Click **OK** to save your changes. (Otherwise, click **Cancel**). If you save, you need to refresh the screen; the message besides the **Care Management Group** field will reflect the change.

3.13.7 Add Tag

Use the Add Tag process to add a diagnostic tab. Click the **Add Tag (****)** button (or select **Care Mgmt | Add Tag**) to access the **Add Diagnostic Tag** dialog. This is a manual add. Section 3.13.3 provides information on using the Add Tag process.

3.13.8 Main Sub-Tab

Use the **Main** sub-tab of Care Management window to add/edit patient register information.

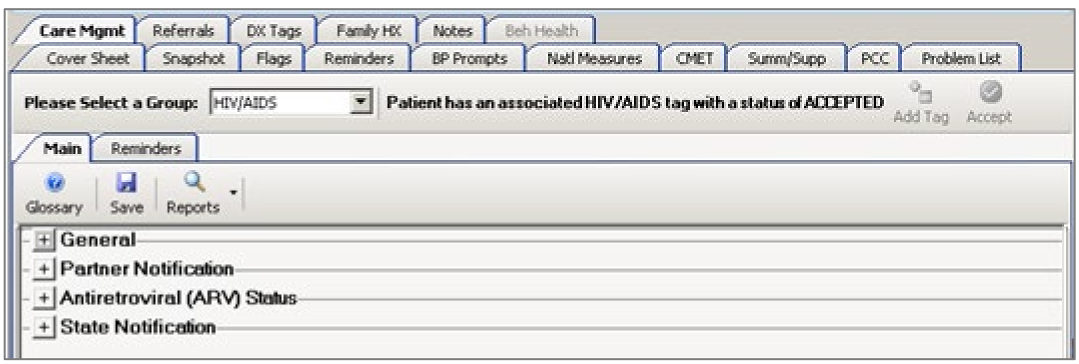


Figure 3-57: Sample Care Management tab after clicking Enter Data

You need to expand any category (listed below the toolbar buttons) that you want to change. After completing your changes, click the **Save** button to save your changes. Section 3.13.12 provides information about the save process.

Many of the field lists include a blank option to use when the particular field has no data. Usually the blank option is the first available on the list.

Note: Only the **Main** sub-tab displays for Asthma and DM Audit.

3.13.9 General

Expand the General category to display the fields on the **General** group box.

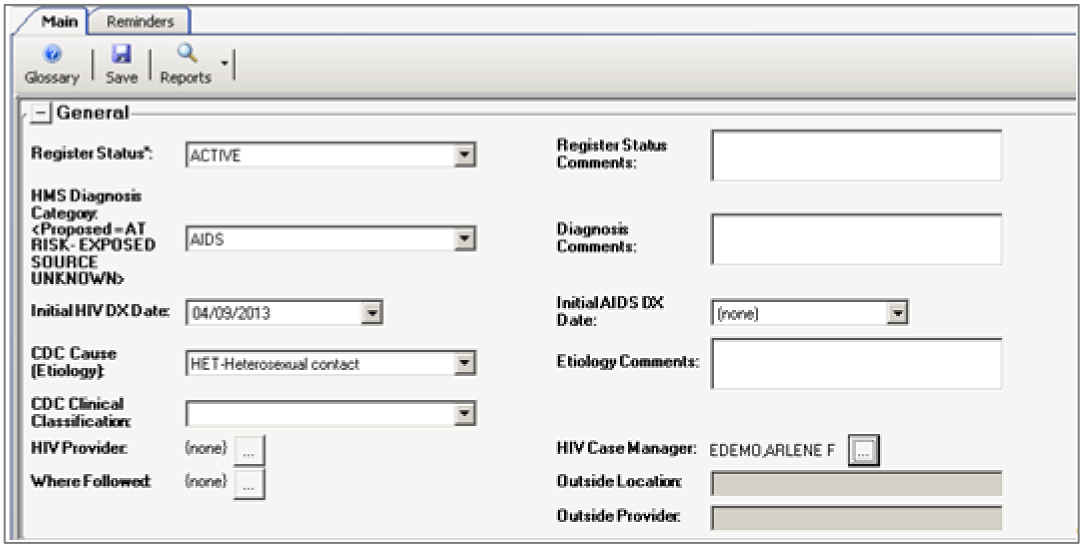


Figure 3-58: Fields for the **General** group box

All fields with an asterisk (*) are required.

- **Register Status**: Select an option from the list that indicates the status of the patient on this register.
- **Register Status Comments**: Type comments about the register status selection in this Free Text field (limited to 50 characters).
- **HMS Diagnosis Category**: Select a specific HIV-related diagnostic category from the list.
- **Diagnosis Comments**: Type comments about the HMS Diagnosis Category selection in this Free Text field (limited to 50 characters).
- **Initial HIV DX Date**: Select the date when this patient was first diagnosed with HIV from the calendar on the list for this field. You can enter a month and year only; in this case the entry will be stored in BKM as MM-01-YYYY. This field is active only when you have populated the **HMS Diagnosis Category** field with HIV.

Note:	A proposed date might display, based on the earliest RPMS data that meets the HIV/AIDS tag definition. You must enter the actual date even if you want to accept the proposed date.

- **Initial AIDS DX Date**: Select the date when this patient was first diagnosed with AIDS from the calendar on the list for this field. You can enter a month and year only; in this case the entry will be stored in BKM as MM-01-YYYY. This field is active only when you have populated the **HMS Diagnosis Categor**y field with AIDS.

> **Note:** A proposed date might display, based on the AIDS logic defined previously in the HMS Diagnosis Category field. You must enter the actual date even if you want to "accept" the proposed date.

- **CDC Cause (Etiology)**: Select an option from the list that indicates the cause (etiology) of the patient's DX. The Centers for Disease Control has categorized the ways in which an individual is exposed to HIV.
- **Etiology Comments**: Type comments about the CDC Cause selection in this Free Text field (limited to 50 characters). (This field is active only when the **CDC Cause (Etiology)** field is populated.) A comment should always be entered if you select **OTH - Other** in the **CDC Cause** field.
- **CDC Clinical Classification**: This field is active when the **HMS Diagnosis Category** field contains AIDS or HIV. Select the clinical classification from the list.

  The current CDC classification system combines three categories of the CD4 count with three symptom categories. The use of both the CD4 cell count and clinical categories provides shorthand for where the patient stands in the course of the HIV/AIDS continuum. While there are guidelines in place, assign the classification only after clinical evaluation. The decision of which category to assign is always made by a clinical person. The CDC proposed that the clinical classification system be used to "guide clinical and therapeutic actions in the management of HIV infected adolescents and adults."

  The **HIV Provider**, **HIV Case Manager**, and **Where Followed** fields are populated by using the **Table Lookup** dialog. Section 4.14 provides more information about using this dialog.

- **HIV Provider**: Click the ellipsis button to search for a HIV provider name at your facility. If this patient is cared for at an outside facility, enter the provider in the **Outside Provider** field. This information is pulled from the RPMS Designated Specialty Provider Management (DSPM) application, if available, and displayed here.
- **HIV Case Manager**: Click the ellipsis button to search for a case manager name at your facility. This information is pulled from the RPMS Designated Specialty Provider Management (DSPM) application, if available, and displayed here.

- **Where Followed**: Click the ellipsis button to search for name of a facility that primarily follows the patient's care related to HIV/AIDS. If this is not your facility, select OTHER from the list; you can identify the specific facility in the outside location field and the provider in the **Outside Provider** field.
- **Outside Location**: Manually type the name of the facility or outside physician's office where the patient is followed. This is a Free Text field limited to 50 characters.
- **Outside Provider**: Manually type the name of the patient's HIV provider at the outside location. This is a Free Text field limited to 50 characters.

3.13.10 Partner Notification

This notification type is to document the notification of a patient's partner of a potential exposure to HIV. The public health recommendation to notify the patient's partner is a practice that is encouraged in all I/T/U facilities.

Figure 3-59: Fields for **Partner Notification** group box

Expand the Partner Notification category to display the following fields on the **Partner Notification** group box:

- **Partner Notification Status**: Select an option from the list that indicates the partner notification status.
- **Partner Notification Date**: This field is active when the Partner Notification Status contains Yes. Enter a date that the partner was notified; you can select from a calendar by using the list.

3.13.10.1 Antiretroviral (ARV) Status

Expand the ARV category to display the fields on the **Antiretroviral ARV (Status)** group box.

Use this group box to enter ARV (antiretroviral) medications data for ARV appropriate, ARV adherence, and ARV Stability. The medications are used to treat HIV/AIDS patients by reducing the viral load and improving the immunological function.

Because the ARV status might change over time, HMS maintains a history of ARV Appropriate and Compliance statuses for the patient. The entire ARV history will be displayed on this screen with the most recent status listed first; this feature allows the provider to easily view the continuum of assessment.

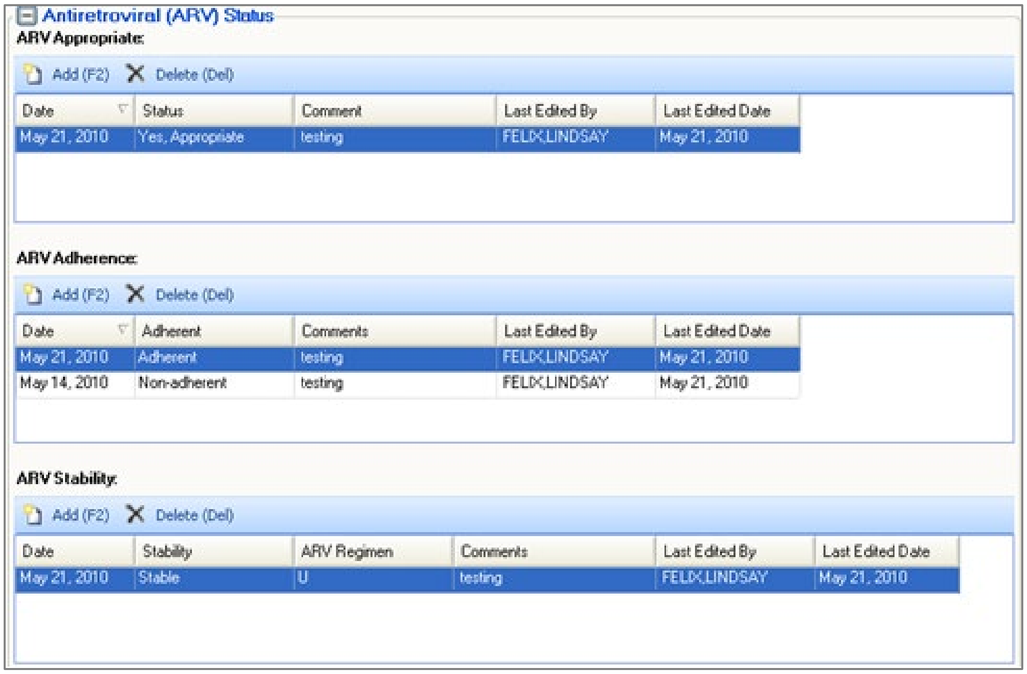


Figure 3-60: Fields on the ARV group boxes

For **ARV Appropriate**, click the **Add** (Add (F2)) button to add data. Each of the fields on the row will have either a list from which to select or a Free Text field where you enter information. Data can be entered at any time and can be done so retrospectively.

- **Date**: Enter the date the patient was assessed for suitability for ARV (required). Click the list to select a date from a calendar.
- **Status**: Select an option from the list that indicates the status of the ARV Appropriate record.
- **Comment**: Type a comment, if appropriate, in this Free Text field, using up to 50 characters.
- **Last Edited By**: The name of the person who last edited the record (system populated).
- **Last Edited Date**: The date the record was last edited (system populated).

After you click **Save**, iCare confirms that you want to add the record. After clicking **Yes**, iCare populates the **Last Edited** By field (name of user who populated the record) and today's date in the Last Edited Date.

For **ARV Appropriate**, you can delete your own selected records by clicking the **Delete** (Delete (Del)) button to display the **Delete Rows** information message. Click **Yes** to remove the records. (Otherwise, click **No**.)

For **ARV Adherent**, click the **Add** (
) button to add data. Each of the fields in the row will have either a list from which to select or a Free Text field where you enter information.

- **Date**: This is the date the patient was assessed for adherence to the prescribed ARV regimen (required). Click the list to select from a calendar.
- **Adherent**: Select an option from the list that indicates the adherent status of the record.
- **Comment**: Type a comment, if appropriate, in this Free Text field, using up to 50 characters.
- **Last Edited By**: The name of the person who last edited the record (system populated).
- **Last Edited Date**: The date the record was last edited (system populated).

After you click **Save**, iCare confirms that you want to add the record. After clicking Yes, iCare populates the **Last Edited By** field (name of user who populated the record) and today's date in the Last Edited Date.

For **ARV Adherent,** you can delete your own selected records by clicking the **Delete** (
) button to display the **Delete Rows** information message. Click **Yes** to remove the records. (Otherwise, click **No**.)

For **ARV Stability**, click the **Add** (
) button to add data. Each of the fields in the row will have either a list from which to select or a Free Text field to enter information.

- **Date**: This is the date the patient was assessed for ARV Stability. Click the list to select from a calendar.
- **Stability**: Select an option from the list that indicates the stability status of the record.
- **ARV Regimen**: Click the list and select one of the options: Changed, Unchanged.
- **Comments**: Add any comments regarding the ARV Stability data in the Free Text field.
- **Last Edited By**: The name of the person who last edited the record (system populated).
- **Last Edited Date**: The date the record was last edited (system populated).

After you click **Save**, iCare confirms that you want to add the record. After clicking Yes, iCare populates the **Last Edited By** field (name of user who populated the record) and today's date in the **Last Edited Date** field.

For **ARV Stability,** you can delete your own selected records by clicking the **Delete** (Delete (Del)) button to display the **Delete Rows** information message. Click **Yes** to remove the records. (Otherwise, click **No**.)

3.13.11 State Notifications

This notification type involves the requirement to notify the appropriate state Health Department of new AIDS diagnoses; most states also required notification of HIV diagnoses as well.

Expand the State Notification category to display the following fields on the **State Notification** group box (Figure 3-61).

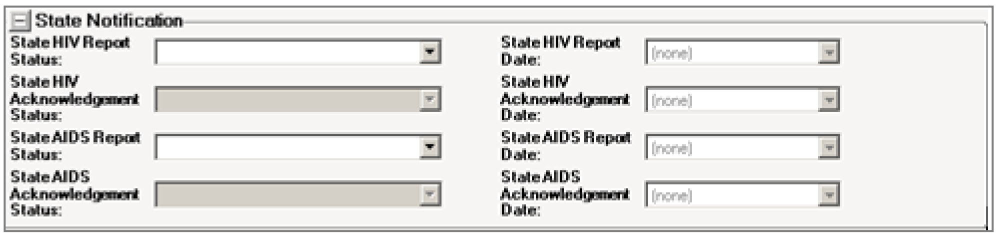


Figure 3-61: Fields on **State Notification** group box

If the HMS Diagnosis is HIV or AIDS, then the fields in this group box are active.

- **State HIV Report Status**: Select the State HIV Report Status from the list: N/A, No, Remind Me Later, Unknown, or Yes. This answers the question: “Has the state health department been notified about this patient’s HIV status?”
- **State HIV Report Date**: This field is active if the **State HIV Report Status** field contains Yes. You can select from a calendar by using the list. This is the date the State HIV status report was submitted to the state health department.
- **State HIV Acknowledgment Status**: Select the State HIV Acknowledgment status from the list: No, Unknown, or Yes. This answers the question: “Has your facility received an acknowledgement from the state health department?”
- **State HIV Acknowledgment Date**: This field is active if the **State HIV Acknowledgment Status** field contains Yes. You can select from a calendar by using the list. This is the date the state acknowledged receipt of HIV report, if any.
- **State AIDS Report Status**: Select the State AIDS Report Status from the list: N/A, No, Remind Me Later, Unknown, or Yes. This answers the question: “Has the state health department been notified about this patient’s AIDS status?”
- **State AIDS Report Date**: This field is active if the **State AIDS Report Status** field contains Yes. You can select from a calendar by using the list. This is the date the AIDS status report was submitted to the state health department.

- **State AIDS Acknowledgment Status**: Select the State AIDS Acknowledgment status from the list: No, Unknown, or Yes. This answers the question: "Has your facility received acknowledgement from the state's health department?" **Note**: Most sites report that they do not receive this acknowledgment.
- **State AIDS Acknowledgment Date**: This field is active if the **State AIDS Acknowledgment Status** field contains Yes. You can select from a calendar by using the list. This is the date the state acknowledged receipt of AIDS report.

3.13.12 Save Button

Use the Save function to save the care management information (entered or changed) in RPMS. Click the **Save** button (or select **Care Mgmt** | **Main** | **Save**) to display the **Confirm save to Care Mgmt** information message where you are asked if you want to save the patient's care management record in RPMS. Click **Yes** to save (otherwise, click **No**.)

The following is one example of what happens after you click **Yes**. What displays after you click **Yes** depends upon if there is a tag status or not.

After clicking **Yes**, you will receive a message asking about changing the tag status.

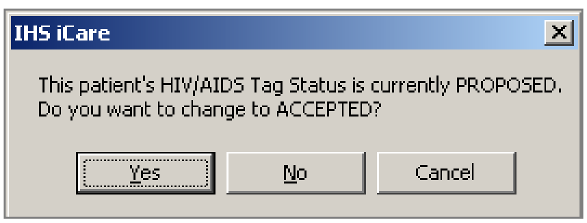


Figure 3-62: Message About Changing Status

If you click **Yes**, you go to the **Update Diagnostic Tag** dialog.

If you click **No**, the system displays the message: HMS Register data has been saved successfully to RPMS. Click **OK** to dismiss the message.

If you click **Cancel**, the system asks if you want to cancel the entire Save process. If you click **Yes**, you exit the save process. If you click **No**, the application displays a message: "Are you sure you want to cancel the entire Save process?" Click **Yes** to cancel the entire Save process. Click **No** and the application displays the message HIV Management System data has been saved successfully to RPMS. Click **OK** to dismiss the message.

3.13.13 Reports

Click the list for the **Reports** button (or select **Care Mgmt** | **Main** | **Reports**) to access any of the following reports (Table 3-4).

Table 3-4: Report selections and descriptions

Report Selection	What You View
Asthma Action Plan	Asthma Action Plan report.
Fact Sheet	Ambulatory Care Record Brief report.
Health Summary	You first select a summary type to view. For example, if you select Lab, you will view the DMS Lab Report Summary.
Patient Wellness Handout	You first select the report parameter that determine the Wellness Handout type. You view the selected patient wellness handout type report.
Supplement	You first select a supplement type to view. For example, if you select Diabetic Care Summary, you will view the Diabetic Patient Care Summary.
Women's Health Profile - Brief	Women's Health Patient Profile that lists the date, procedure, results/diagnosis, and status (for female patients only).
State Surveillance	Adult HIV/AIDS Confidential Case Report to State (State Surveillance report in BKM) about the patient.
HMS Patient Care Supplement	HMS Patient Care Supplement report.
State Surveillance (Blank)	Adult HIV/AIDS Confidential Case Report to State about the patient. This option gets as much data from RPMS that is available. This allows the providers to review this report and manually correct any incorrect or missing data. Then the report is to be sent to the appropriate state agency.

3.13.14 Glossary Button

Click the **Glossary** button to access the **HIV/AIDS / Care Management Glossary** dialog. The glossary provides information about (1) creating a panel, (2) the HIV/AIDS Register specific fields, (3) HMS Patient Care Supplement, (4) Quality of Care Report, and (5) Definitions.

Section 4.6 provides information about using the controls on the dialog.

3.13.15 Reminders Sub-Tab

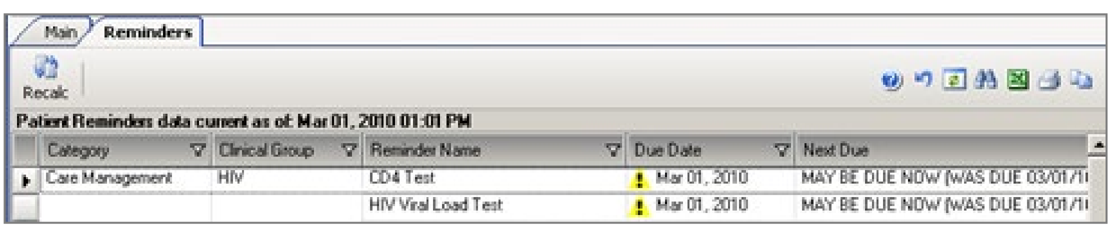


Figure 3-63: Sample **Reminders** sub-tab on Care Management

Note: The **Reminders** sub-tab does ***not*** display for Asthma and DM Audit.

- **Category**: The category of the reminder, for example, Case Management.
- **Clinical Group**: The clinical group of the reminder, for example, HIV.
- **Reminder Name**: The name of the clinical procedure that needs to be done. You can view a tooltip by hovering your mouse over any Reminder Name cell.
- **Due Date**: The date the reminder procedure is due. This column will display the warning indicator ( ) if any of the patient's reminders are overdue. This date is derived from the Health Summary Reminders Next Due test.
- **Next Due**: The actual text from the Reminders Next Due displays on the Health Summary.
- **Last Date Performed**: The date that the reminder procedure was most recently completed.
- **Preceding CMET Event**: This is populated with the tracked Event that initiated this follow-up. If the displayed reminder is not a CMET Reminder, this cell will contain N/A.
- **Date of Preceding CMET Event**: The date of the preceding CMET Event.

You can sort/filter the columns and perform other functions on the columns.

If the patient does not have any HIV reminders, iCare displays the message: "No Reminders Returned." (Click **OK** to dismiss the message.)

3.13.16 Patient with Asthma Tag

The current definition for the Asthma Tag is patients with at least two POVs ever (not on the same date) and one instance on the Active Problem List. Asthma defined with the taxonomy ([BGP ASTHMA DXS]) contains ICD codes 493.00 – 493.92.

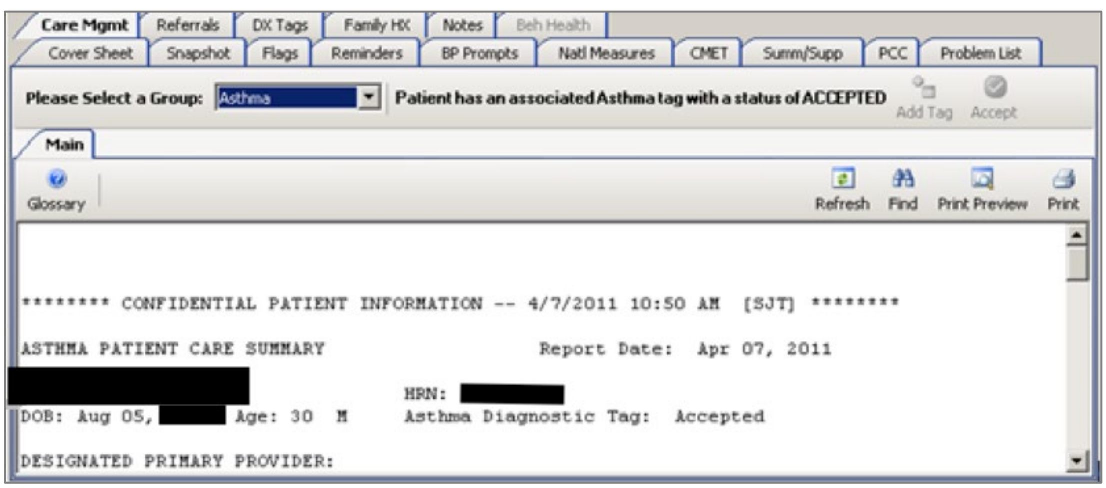


Figure 3-64: Sample Patient with Asthma tag

The **Main** sub-tab displays the existing Asthma Patient Care Summary (Supplement) report. Section 4.6 provides information about using the controls on the dialog. The Asthma Care Management view does not include the **Reminders** sub-tab because there are no asthma-specific reminders.

Click **Glossary** to access the Asthma / Care Management Glossary. This glossary includes (1) Asthma Diagnostic Tab definition, (2) asthma-specific data/patient record, (3) asthma panel layout options/panel view, and (4) asthma supplement logic.

3.13.17 Care Management Tab Menus

The options on the **File** menu of the **Care Management** tab (both **Main** and **Reminders** sub-tabs) are the same as those for the File menu on the **Cover Sheet** tab.

3.13.18 Tools Menu for Main Sub-Tab

The options on the **Tools** menu for the **Main** sub-tab of Care Management are the same as those on the Tools menu for the **Cover Sheet** tab.

3.13.19 Tools Menu for Reminders Sub-Tab

The options on the **Tools** menu for the **Reminders** sub-tab are the same as those for the Tools menu for the **Flags** tab.

3.13.20 Care Mgmt Menu

The options on the Care Management window (both **Main** and **Reminders** sub-tabs) follow. Both sub-tabs have the following options on the Care Mgmt Menu:

- **Add Tag**: This option works like the **Add Tag** button.
- **Accept Tag**: This option works like the **Accept** button.
- **HIV/AIDS Management Guide**: This option displays the iCare Population Management GUI window for online help.

3.13.20.1 Main Sub-Tab

Figure 3-65 shows the **Main** sub-tab for the HIV/AIDS (Group):

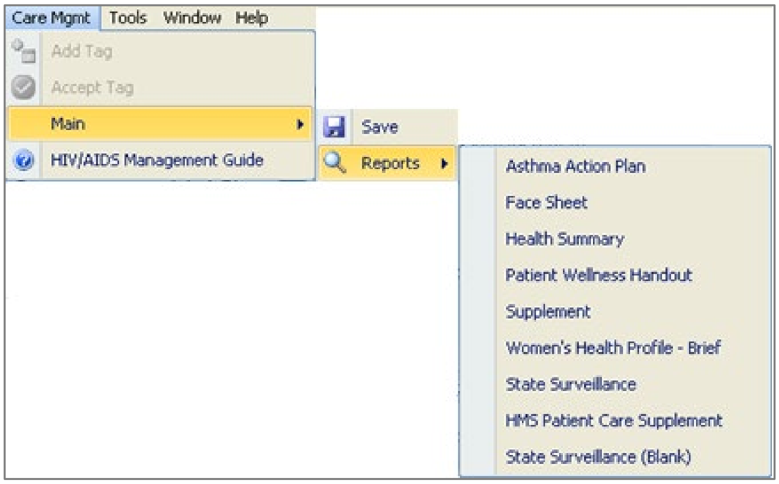


Figure 3-65: **Care Mgmt** menu options for HIV/AIDS

- **Save**: This option has the same function as the **Save** button on the **Main** sub-tab.
- **Reports**: This option lists the available report on the **Main** sub-tab.
- **HIV/AIDS Management Guide**: This option displays the iCare Population Management GUI window for online help.

The following option displays if you are on the **Main** sub-tab for Asthma group:

- **Refresh**: This option refreshes the **Reminders** sub-tab by retrieving the most up-to-date information from the server. This is the same as pressing F5.

3.13.20.2 Reminders Sub-Tab

The Reminders option for the HIV/AIDS (Group):

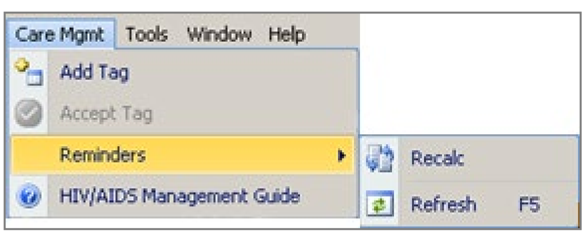


Figure 3-66: **Care Mgmt** menu for the **Reminders** sub-tab

- **Add Tag**: This option works like on the **Action** button on the **Care Mgmt** window.

The following options display if you are on the **Reminders** sub-tab:

- **Recalc**: This option gets the latest data from the server to run the algorithm.

- **Refresh**: This option refreshes the **Reminders** sub-tab by retrieving the most up-to-date information from the server. This is the same as pressing F5.
- **HIV/AIDS Management Guide**: This option displays the iCare Population Management GUI window for online help.

3.14 Referrals Tab

The Referrals tab displays the referrals for the selected patient in the time range shown in the **Last** field. This data comes from the Referral Care Information System (RCIS).

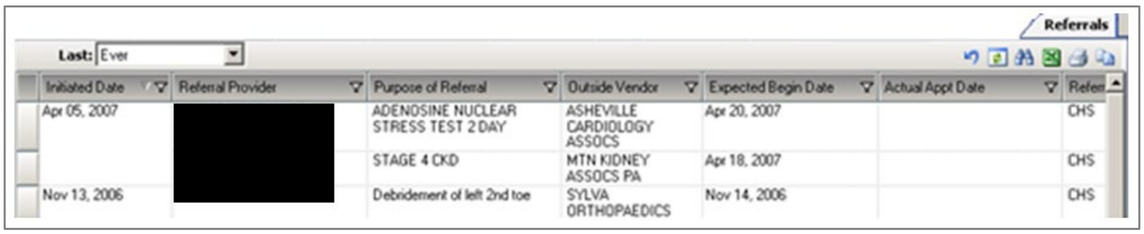


Figure 3-67: Sample **Referrals** tab

The default display is in reverse order of date, with the most recent first.

3.14.1 Referrals Tab Layout

The data comes from the RCIS (Referred Care Information System). You can review the user manual at the following URL:
http://www.ihs.gov/Cio/RPMS/index.cfm?module=home&option=documentschoice

Select **Referred Care Information System** from the list. On the next page, select the User Manual.

You can sort/filter the columns and perform other functions on the columns.

Table 3-5 provides information about the fields.

Table 3-5: Referrals tab fields and descriptions

Field	Meaning
Initiated Date	The date that the referral was initiated.
Referral Provider	The provider who requested the referral for the patient.
Purpose of Referral	This is a narrative that describes the purpose of the referral.
Outside Vender	This is the name of the Outside vendor, such as outside providers, clinics, hospitals, labs etc. This information comes from the RCIS application.
Expected Begin Date	This applies to outpatient visits that is the expected begin date of service.

Field	Meaning
Actual Appt Date	The date that the appointment for the referral was scheduled for this patient.
RCIS Status	The RCIS status of the referral.
Referral Type	The type of referral that was made. This can be any of the following: IHS: A referral to another IHS facility CHS: A referral to an outside facility that will be paid for with CHS funds In-house: A referral to another clinical area within the facility Other: Any other type of referral that will be paid with funds other than CHS (such as Medicaid or private insurance)
Patient Type	This is either inpatient or outpatient.

3.14.2 Referrals Tab Toolbar Options

The **Last** field determines the date range for the data. The default is one year. You can select a different predefined date range.

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.14.3 Referrals Tab Menus

The options on the **File** menu of the **Referrals** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on **Tools** menu on the **Referrals** tab are the same as those on the Tools menu for the **Flags** tab.

3.15 Consults Tab

The **Consults** tab displays the consults for the selected patient in the time range shown in the **Timeframe** field.

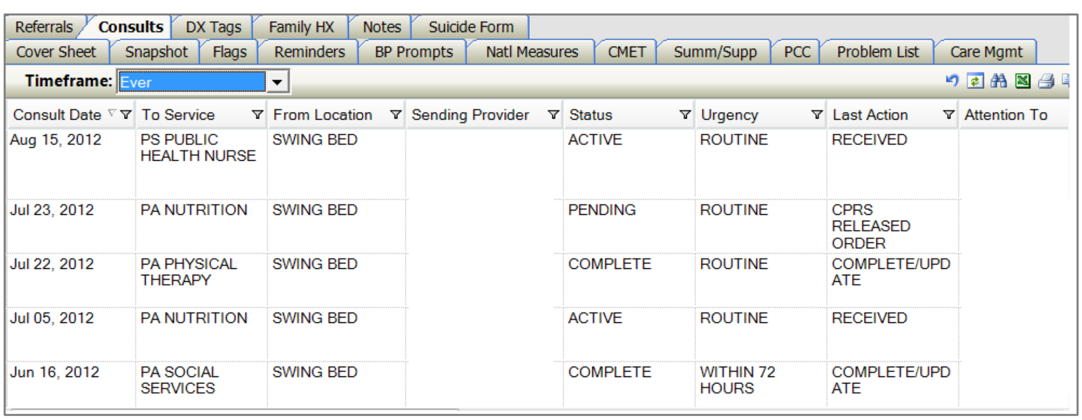


Figure 3-68: Sample **Consults** tab

The default display is in reverse consult date, with the most recent first.

3.15.1 Consults Tab Layout

You can sort, filter, and perform other functions on the columns. Table 3-6 provides information about the fields.

Table 3-6: **Consults** tab fields and description

Field	Meaning
Consult Date	The date of the consult.
To Service	The in-house service the consult is for.
From Location	The location creating the consult.
Sending Provider	Provider who initiated consult.
Status	The status of the consult.
Urgency	What the urgency of the consult is.
Last Action	The last action taken on the consult. Actions are: ADDED COMMENT ADDENDUM ADDED TO ADMIN. CORRECTION CANCELLED COMPLETE/UPDATE CPRS RELEASED ORDER DISASSOCIATE RESULT DISCONTINUED EDIT BEFORE RELEASE EDIT/RESUBMITTED ENTERED IN CPRS FORWARDED FROM FWD TO REMOTE SERVICE INCOMPLETE RPT INITIAL REMOTE REQUEST NEW NOTE ADDED PRINTED TO RECEIVED REMOTE REQUEST RECEIVED SCHEDULED SERVICE ENTERED SIG FINDING UPDATE STATUS CHANGE UNKNOWN ACTION
Attention To	To whom the consult is intended for.
Request Type	The type of request. Can be Procedure or Consult.
Patient Type	This is either inpatient or outpatient.
Consult Number	The unique number assigned to each consult.
Location	The location where consult occurred.
Ordering Facility	The facility from whom the consult is being ordered.
Place of Consultation	This is the place where the consultation will take place.
Provisional Diagnosis	This is the Provisional Diagnosis the ordering clinician would specify on the Consult Form 513.
Associated Results	This is the reason for requesting the Consult or Procedure Request. (Word-processing field).

3.15.2 Consults Tab Toolbar Options

The **Timeframe** field determines the date range for the data. The default is one year. You can select a different predefined date range.

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.15.3 Consults Tab Menus

The options on the **File** menu of the **Consults** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on **Tools** menu on the **Consults** tab are the same as those on the Tools menu for the **Flags** tab.

3.16 DX Tags Tab

The **DX Tags** tab displays the diagnostic tags information for the current patient. Diagnostic Tags are Predefined Diagnosis definitions (“tags”) that iCare has proposed for this patient, based on the tagging function. The display includes the relevant qualifying criteria data.

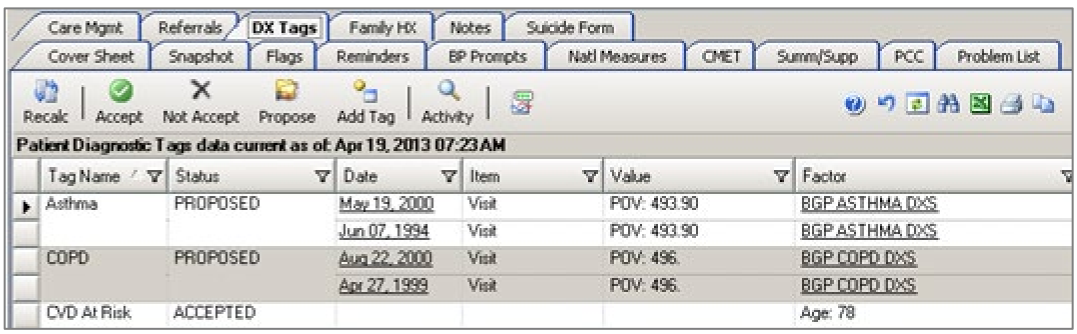


Figure 3-69: Sample **DX Tags** tab

Providers can review tags that were automatically assigned by the system, and then decide whether or not to accept the tags as valid for the patient.

This tab displays the Active tags for the patient, i.e., those tags having the Proposed or Accepted status.

3.16.1 DX Tags Tab Layout

The data columns are described in Table 3-7.

Table 3-7: **DX Tags** tab columns and descriptions

Column	Meaning
Tag Name	The diagnostic tab name. You can view the tooltip by hovering your mouse over this column (shows the definition of the tag).
Status	The status of the tag. You can view the tooltip by hovering your mouse over this column. ACCEPTED: This means the patient is a member of specified formal case management registers with a status of Active, Decease, Transient, Non IHS, Lost to Follow Up, or Noncompliant. PROPOSED: This means the patient has Status Un-reviewed or Inactive in the register. NO LONGER VALID: This means the RPMS data no longer supports the tag.
Date	The date associated with the tag.
Item	This is where the tag was found (Visit or Problem).
Value	The value for the tag. The text that precedes the value determines what that value represent. For example: Problem: 250.00.
Factor	This is defined through the Taxonomy listed or other (like BMI).

Double-click any underlined date to access the **Visit Detail** dialog.

Double-click any underlined Factor to access the **iCare Taxonomy View/Edit** window. Section 4.8 provides information about this window.

3.16.2 DX Tags Tab Toolbar

The patient diagnostic tags are current as of the date shown on the toolbar.

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.16.3 Recalc

Click the **Recalc** () button (or select **Diagnostic Tags** | **Recalc**) to update any values from a logic algorithm by recalculating the logic with new data from the server.

3.16.4 Change the Tag Status

You can change the tag status by clicking the **Accept**, **Not Accept**, or **Propose** button (or selecting the options on the **Diagnostic Tags** menu). This causes the **Update Diagnostic Tag** dialog to display where you can change that tag status, select the reason for the change, and populate the **Other** (Free Text) field. Section 3.13.3 provides information about this dialog.

When you are finished with this dialog, click **OK** to accept the changes. (Otherwise, click **No**.). You can view your changes in the grid of records on the **DX Tags** tab.

3.16.5 Add Tag

Click the **Add Tag** (

) button (or select **Diagnostic Tag** | **Add Tag**) to add a tag to the current patient. The **Add Diagnostic Tag** dialog will display. This is a manual add that allows a provider to manually assign one or more of the diagnosis tags to patients that did not meet the tag's criteria for being proposed automatically. Section 3.13.3 provides information about this dialog.

3.16.6 Activity

You can view existing tag activity about the patient by doing one of the following:

- Click the **Activity** (

) button
- Select **Diagnostic Tags** | **Activity**

The **RPMS iCare - Diagnostic Tag Activity** dialog displays. This is a view-only dialog. Multiple people can enter the tags, so this dialog shows all of the activity. Section 3.13.3.2 provides information about this dialog.

3.16.7 Background Jobs

Click the **Background Jobs** () button to display the **Background Jobs** dialog. Section 4.11 provides information about this dialog.

3.16.8 DX Tags Tab Menus

The options on the **Diagnostic Tags** menu operate like the action buttons on the toolbar.

The options on **File** menu on the **DX Tags** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on **Tools** menu on the **DX Tags** tab are the same as those on the Tools menu for the **Reminders** tab.

3.17 Family HX Tab

The **Family HX** tab displays any family history information about the patient.

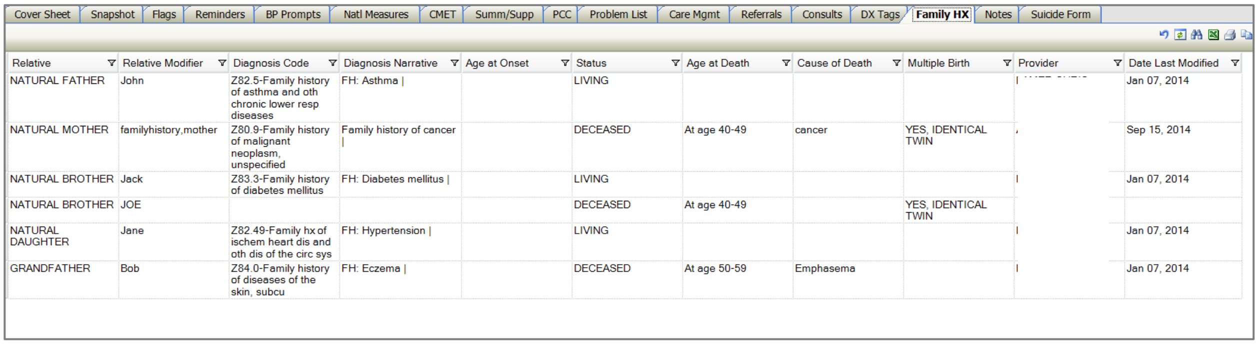


Figure 3-70: Sample **Family HX** tab

This information comes from the Family History of the PCC patient record.

3.17.1 Family HX Tab Layout

You can sort, filter, and perform other functions on the columns. Table 3-8 provides a description of the columns.

Table 3-8: **Family HX** tab columns and descriptions

Column	Meaning
Relative	This is the family history relationship, such as Brother.
Relative Modifier	This is the relative description, if any.
Diagnosis Code	This is the family history ICD code that best describes the diagnosis of the relative.
Diagnosis Narrative	This is the provider narrative that the provider entered.
Age of Onset	This is the age of onset of the condition. This can be In Infancy, Before Age 20, a specific age range (such as 30–39), or Age Unknown.
Status	This is the status of the relative: Living, Deceased, Unknown, Patient Refused To Answer.
Age at Death	If the status is Deceased, this is age of death of the relative.
Cause of Death	If the status is Deceased, this is the cause of death of the relative.
Multiple Birth	This determines is there was a multiple birth: Yes, No, Unknown.
Provider	This is the provider for this record.
Date Last Modified	This displays the date the record was modified (system populated).

3.17.2 Family HX Tab Toolbar

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.17.3 Family HX Tab Menus

The options on the **File** menu of the **Family HX** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on the **Tools** menu of the **Family HX** tab are the same as those on the Tools menu for the **Flags** tab.

3.18 Notes Tab

The **Notes** tab displays the existing TIU notes for the current patient.

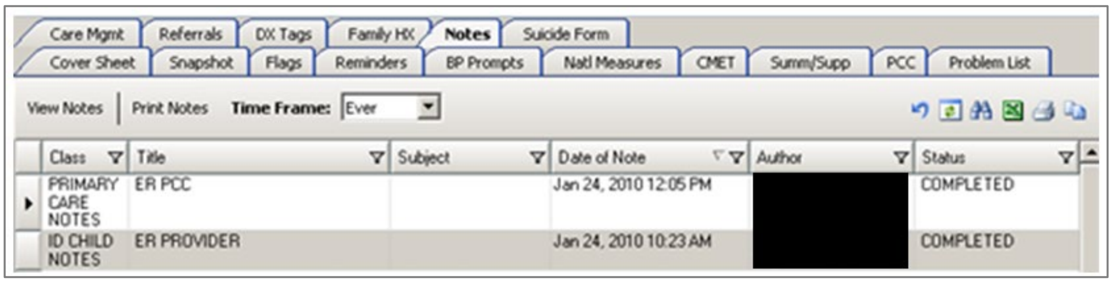


Figure 3-71: Sample **Notes** tab

3.19 Notes Tab Layout

The sort order is only by date, with the most recent date first. Table 3-9 provides information about the fields.

Table 3-9: **Notes** tab fields and descriptions

Field	Meaning
Class	The class of the note.
Title	The title of the note.
Subject	The subject of the note.
Date of Note	The date/time the note was written
Author	The person who wrote the note.
Status	The status of the note.

If you double-click a record in the grid, the application displays a dialog showing information about the particular note.

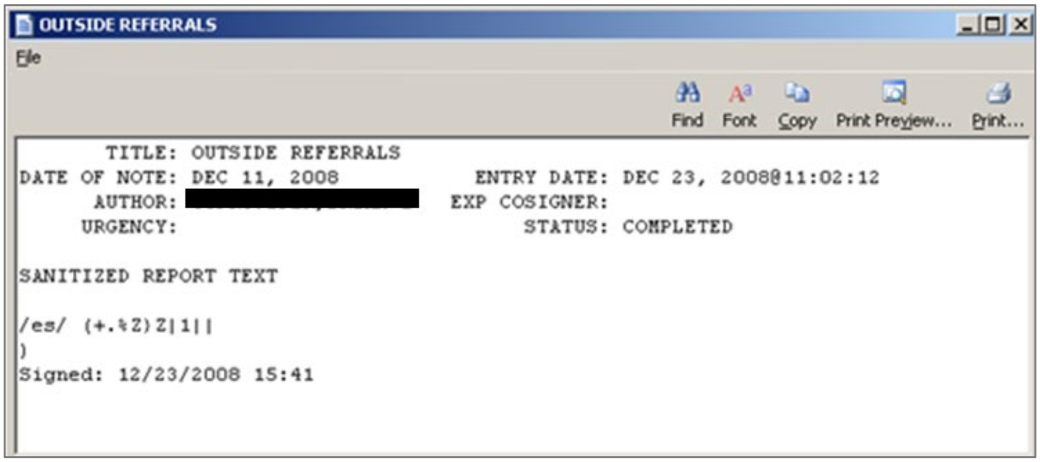


Figure 3-72: Sample note dialog

Section 4.6 provides information about using the controls on the dialog.

3.19.1 Notes Tab Toolbar

Section 4.2 provides information about the buttons on the right side of the toolbar.

You can determine the time range for the notes by selecting an option from the Time Frame list (the default is 1 month).

3.19.2 View Notes

Use the View Notes function view the text of one or more selected notes in the grid. Click **View Note** (or selecting **Notes** | **View Notes**) to access the **View Notes** dialog with TIU headers and footers.

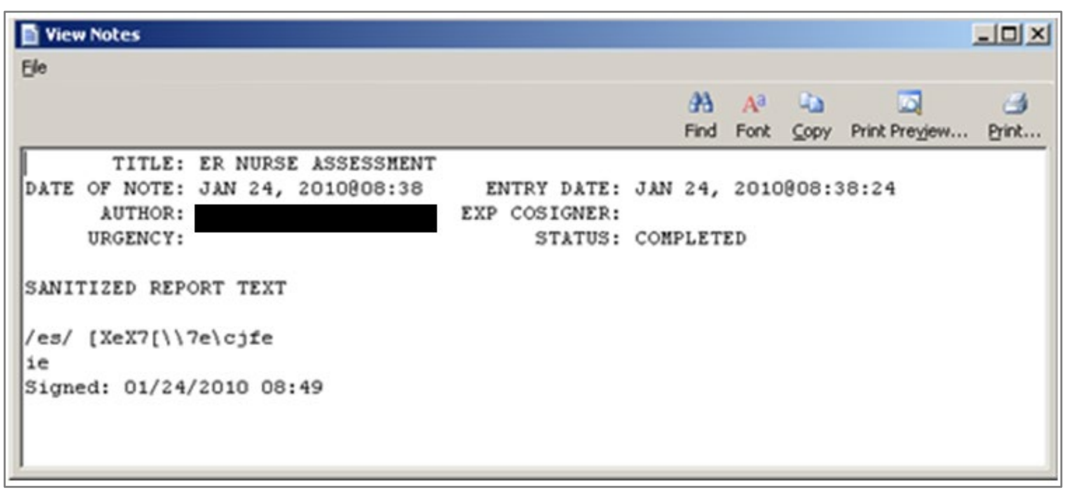


Figure 3-73: Sample **View Notes** dialog

Section 4.6 provides information about using the controls on the dialog.

3.19.3 Print Notes

Use the **Print Notes** button to print the selected notes without TIU headers and footers. Highlight one or more selected notes from the grid and click **Print Notes** (or select **Notes** | **Print Notes**). The application displays the notes in the **Print Preview** dialog. Section 4.12 provides information about this dialog.

Each note (when using more than one note) will start on a new page.

You can print the contents on the **Print Preview** dialog by selecting **File** | **Print**.

The output will contain the date and time it was printed.

3.19.3.1 Notes Tab Menus

The options on the **Notes** menu operates like the **View Notes** and **Print Notes** buttons.

The options on the **File** menu of the **Notes** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on the **Tools** menu of the **Notes** tab are the same as those on the Tools menu for the **Flags** tab.

3.20 Suicide Form Tab

The **Suicide Form** tab only displays for users who been assigned specific Behavioral Health (BH) permission keys. These keys are assigned through BH only, not through iCare User Access Management.

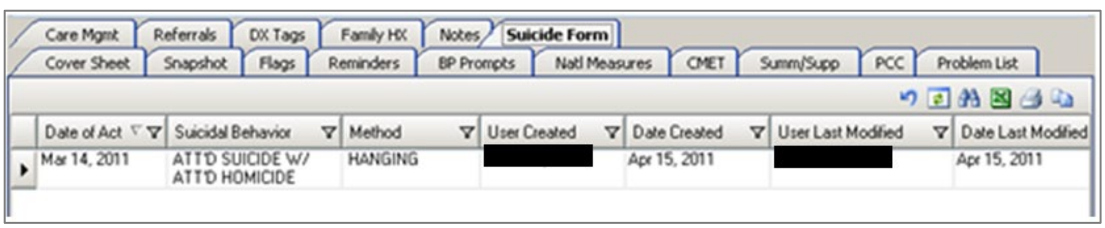


Figure 3-74: Sample **Suicide Form** tab

This tab displays the data from the existing Suicide Reporting Forms (SRF) for the patient.

Double-click any record in the grid to access the Suicide Form Detail.

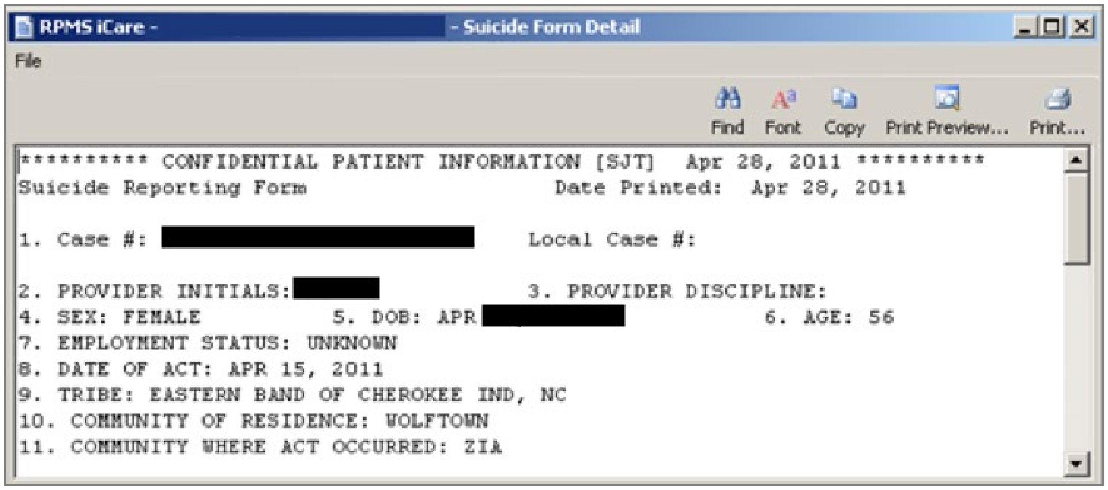


Figure 3-75: Sample **Suicide Form Detail** dialog

Besides the patient demographic information, this dialog displays data in the fields on the SRF. Section 4.6 provides information about using the controls on the dialog.

3.20.1 Suicide Form Tab Layout

You can sort, filter, and perform other functions on the columns.

Date of Act: The date of the suicide act.

Suicidal Behavior: This is the type of suicidal activity for the suicide act.

Method: The method used in the suicide act.

User Created: The name of the provider who created the record.

User Last Modified: The name of the provider who last modified the record.

Date Last Modified: The date the record was last modified.

3.20.2 Suicide Form Tab Toolbar

Section 4.2 provides information about the buttons on the right side of the toolbar.

3.20.3 Suicide Form Tab Menus

The options on the **File** menu of the **Suicide Form** tab are the same as those on the File menu for the **Cover Sheet** tab.

The options on the **Tools** menu of the **Suicide Form** tab are the same as those on the Tools menu for the **Flags** tab.

4.0 iCare Features Used by Patient Record

The following provides information about using the iCare features for the Patient Record.

4.1 User Preferences

This section focuses on the user preferences that are used by the **Patient Record** window.

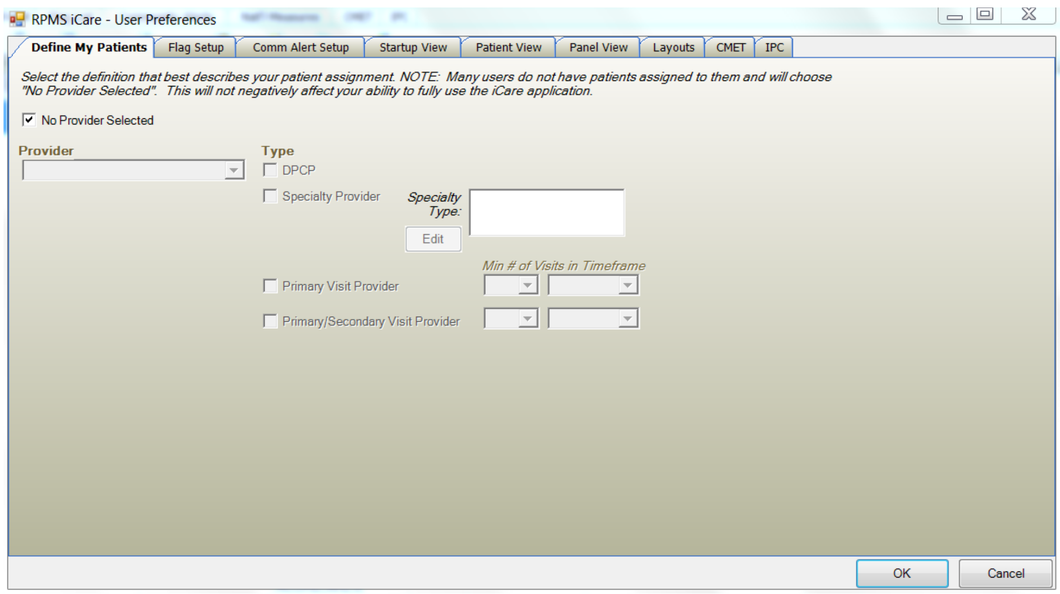


Figure 4-1: Sample **User Preferences** window

After the **User Preferences** window is complete, click **OK** and the user preferences will be in effect for the operation of the iCare application. (Otherwise, click **Cancel**.)

4.1.1 Patient View Tab

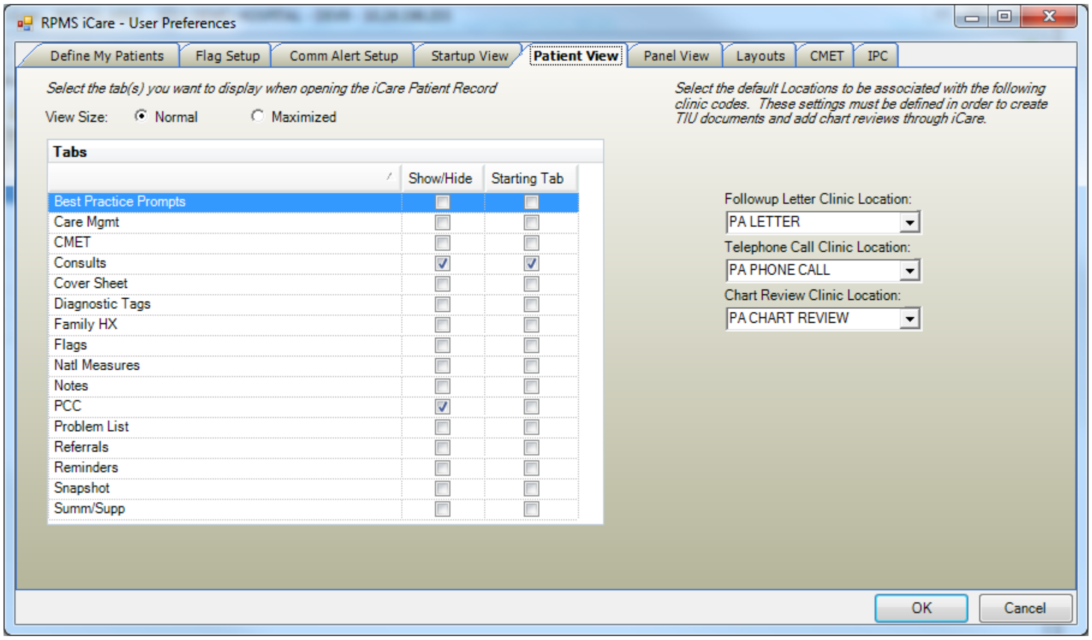


Figure 4-2: Sample **Patient View** tab

The selections on the **Patient View** window determine the following: which tabs display, the startup tab that displays when you first access the Patient View window, the view size, the default location to be associated with various clinic codes.

Tabs: Use the Show/Hide column to determine which tabs display in a panel. Checking will display the selected tab. The Starting Tab column sets which tab is initially displayed when a panel is opened. At a minimum, one tab must be checked as Show and set as the Starting tab.

View Size: Determine the view size and select either the **Normal** or **Maximized** option button (the default is Normal).

> **Note**: The default clinic codes are necessary when you use the **Add a Note** button on the Patient Record window.

Followup Letter Clinic Location: Select a clinic code from the list for TIU documents.

Telephone Call Clinic Location: Select a clinic code from the list for telephone calls.

Chart Review Clinic Location: Select a clinic code from the list for chart reviews.

4.2 Buttons on the Right Side of Window

The buttons on the right side of any iCare window have the same functionality on any window.

Figure 4-3: Buttons on right side of window

These buttons might not be visible; in that case, click the list ( ) button.

The application provides hover help for each button.

Some iCare windows might not have the **Mail Merge** and **Glossary** buttons.

4.2.1 Reset View

Click the **Reset View** ( ) button (or select **Tools** | **Reset View**) to return the current view to the default view. You use this feature when you change the view, such as resize the column width. This is the same as pressing Ctrl-R.

4.2.2 Refresh

Click the **Refresh** ( ) button (or select **Tools** | **Refresh**) to update any RPMS field values on the current window with new data from the server. This is the same as pressing F5.

4.2.3 Search

You can search for data in the current grid by clicking the **Search** ( ) button (or by selecting **Tools** | **Search** or pressing Ctrl-F) to display the **Search** dialog.

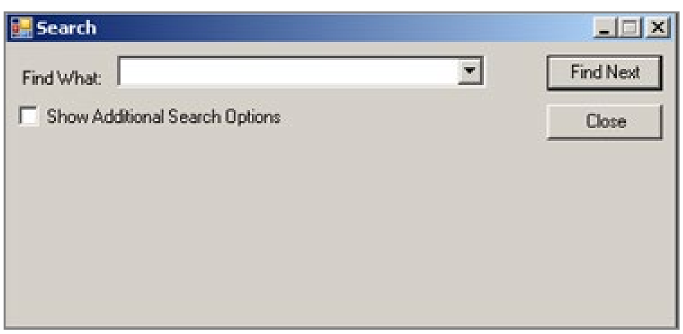


Figure 4-4: **Search** dialog

If you ***do not*** select the **Show Additional Search Options** check box, the search will check in all columns for a match.

If you select the **Show Additional Search Options** check box, the **Search** dialog will display more options for the search.

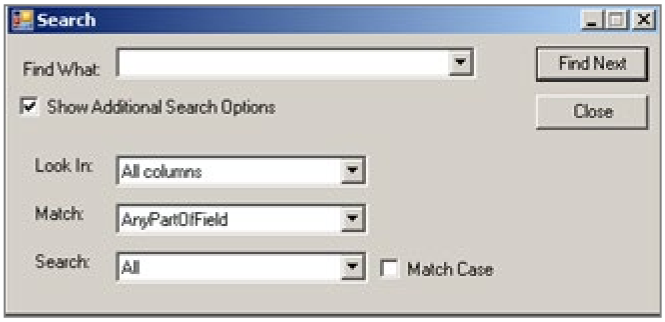


Figure 4-5: **Search** dialog with additional search options

Type what you want to search for in the **Find What** Free Text field. The remaining fields (**Look In**, **Match**, and **Search**) determine the search criteria.

If you check the **Match Case** check box, that will cause the search to match the case of the text in the **Find What** field.

4.2.3.1 Look In Field

Click the list for the **Look In** field to view the options for that field. The highlighted option determines what part of the window to search.

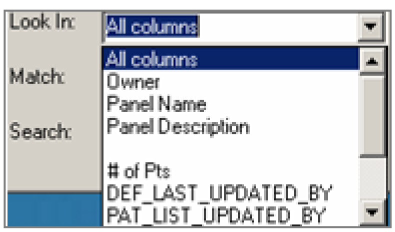


Figure 4-6: Sample list options for **Look In** field

The highlighted selection in the upper part of the list determines the options in the lower part of the list. For example, if the **Look In** field contains **All columns**, the list of the column names will appear in the lower part of the list.

4.2.3.2 Match Field

Click the list for the **Match** field to view the options for that field. The highlighted option determines what part of the **Find What** field will be matched in the search.

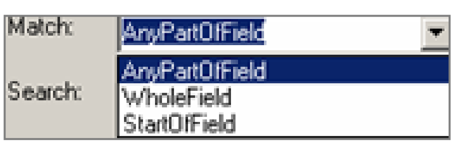


Figure 4-7: Sample **Match** field options

4.2.3.3 Search Field

Click the list for the **Search** field to view the options for that field. The highlighted option determines the direction of the search.

Figure 4-8: Sample **Search** field list options

After all fields are populated with the search criteria, click the **Find Next** button. (Otherwise, click **Cancel**.)

If a match is found, the matching text will be highlighted (in the grid). If you want to continue the same search, click the **Find Next** button again; repeat this process as needed.

If a match is not found, the **Datagrid Search Results** message displays.

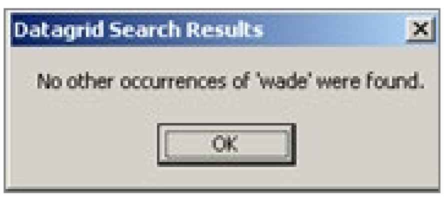


Figure 4-9: Sample **Datagrid Search Results**

Click **OK** to close the message and to return to the **Search** dialog.

4.2.4 Export to Excel

You can export the information in the window to Excel by clicking the **Export to Excel** ( ) button (or by selecting **Tools** | **Export to Excel** or pressing Ctrl-E).

The application displays the warning message about the export.

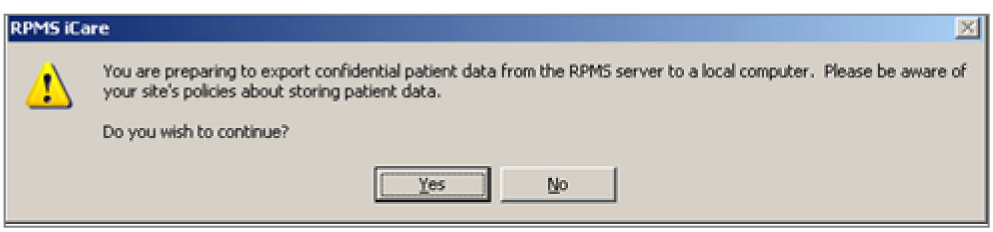


Figure 4-10: Warning message about exporting the patient data

Click **No** to dismiss the warning and exit the export process.

Click **Yes** to continue the export process and to display the **Save As** dialog.

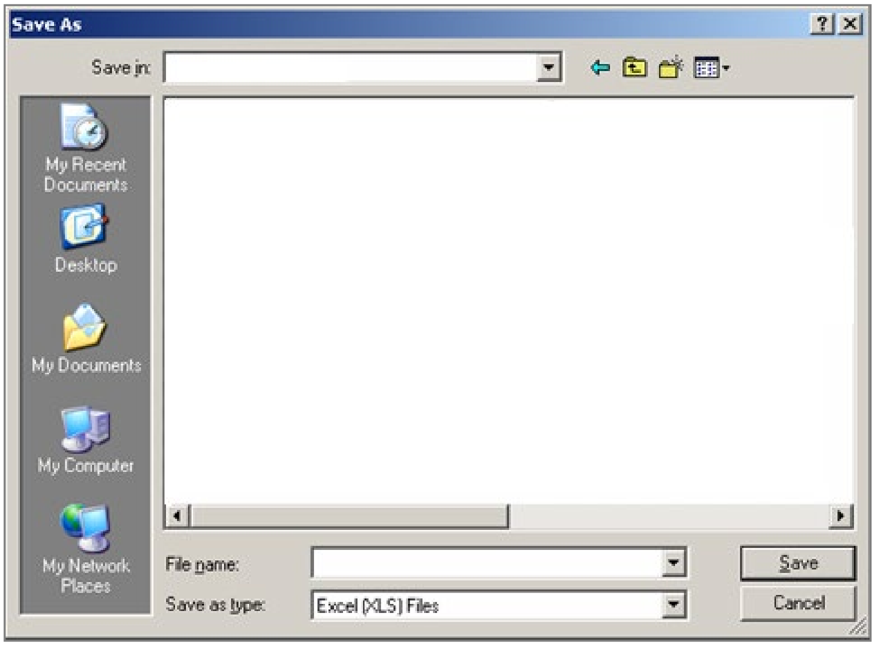


Figure 4-11: Sample **Save As** dialog

Make sure the location where you want to save the file displays in the **Save in** field.

Type the name in the **File name** field. The system will add XLS extension to the field name (automatically).

Click **Save**. (Otherwise, click **Cancel**.) If you click Save, the **Export Panel** message displays: “Excel export has been created.” Click **OK** to dismiss the message.

When you view the Excel document, the application provides a Confidential Patient Information header in the document.

4.2.5 Print

You can print the selected rows in the grid by clicking the **Print** () button (or by selecting **Tools** | **Print** or pressing Ctrl-P) to access the **Print Preview** dialog. Section 4.12 provides information about using this dialog.

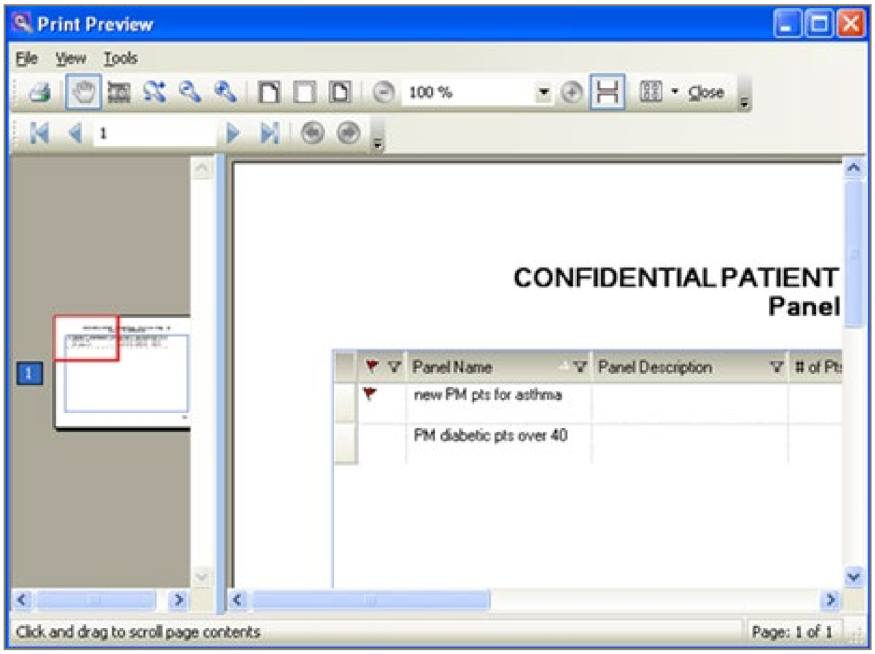


Figure 4-12: Sample **Print Preview** dialog

If you do not select any rows, the application displays a warning message: "You have not selected any rows to print. Do you want to proceed and print all rows in this view or cancel this print?" Click **Yes** to print all the rows. Click **No** to cancel the print function.

4.2.6 Copy to Clipboard

You can copy the selected rows in the grid to the Windows clipboard by clicking the **Copy to Clipboard** ( ) button (or by selecting **Tools** | **Copy Rows to Clipboard** or pressing Ctrl-Shift-C). You can paste the contents of the Windows clipboard to any Windows application.

4.2.7 Mail Merge

The iCare application provides the capability to export patient demographic data in a format that can be used by word processing mail merge files. This is a Demographic Data Export for Letter Generation function. Follow these steps:

1. Select one or more patients that you want to include in the mail-merge process.
2. Click the **Mail Merge Export** ( ) button (or select **Tools** | **Mail Merge**) to display the **Mail Merge Export** dialog.

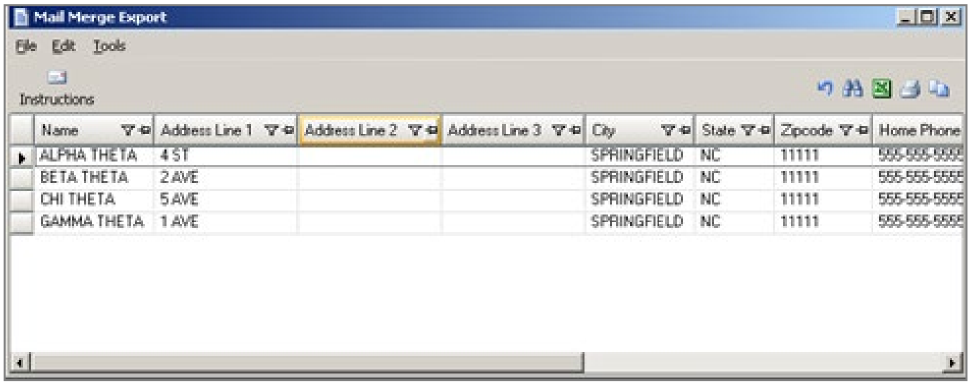


Figure 4-13: Sample **Mail Merge Export** dialog

Section 4.2 provides information about the buttons on the right side of the toolbar.

3. Click the **Mail Merge Instructions** () button to display the **Mail Merge Instructions** dialog. This dialog provides the instructions for completing the mail merge process.

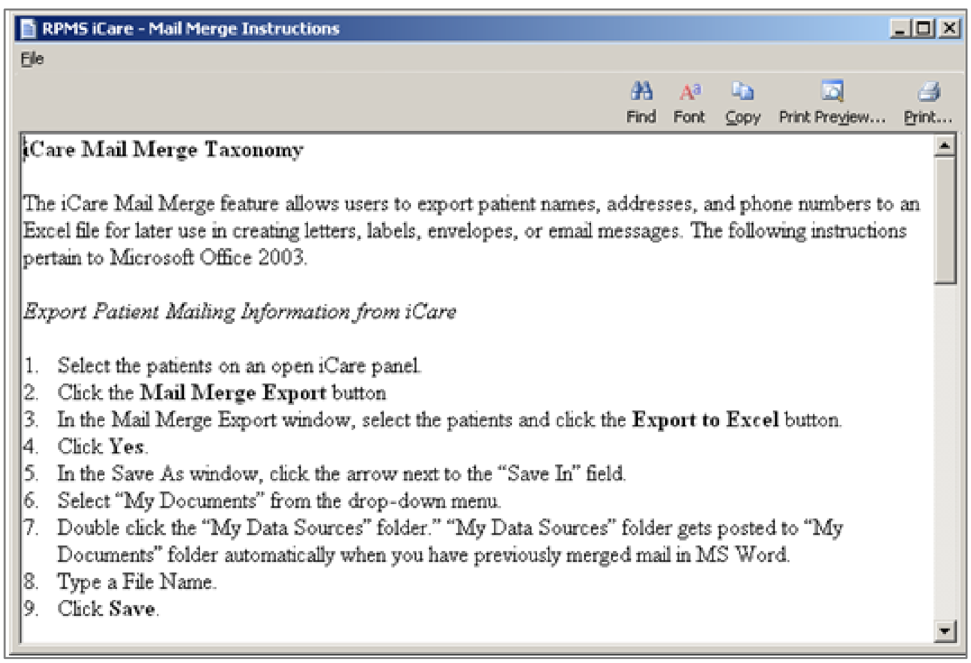


Figure 4-14: **Mail Merge Instructions** dialog

Note that you can print the contents by clicking the **Print** button or by selecting **File** | **Print**.

See Section 4.6 for more information about how to use the controls on the dialog.

4.2.8 Glossary

Click the **Glossary** () button (or select the particular glossary from the Help) to display the particular **Glossary** dialog. The name of the glossary dialog varies according to the part of iCare that you are using. For example, if you are on the Reminders tab, the **Reminders Glossary** dialog will display.

4.3 Edit Patient Demographics Fields

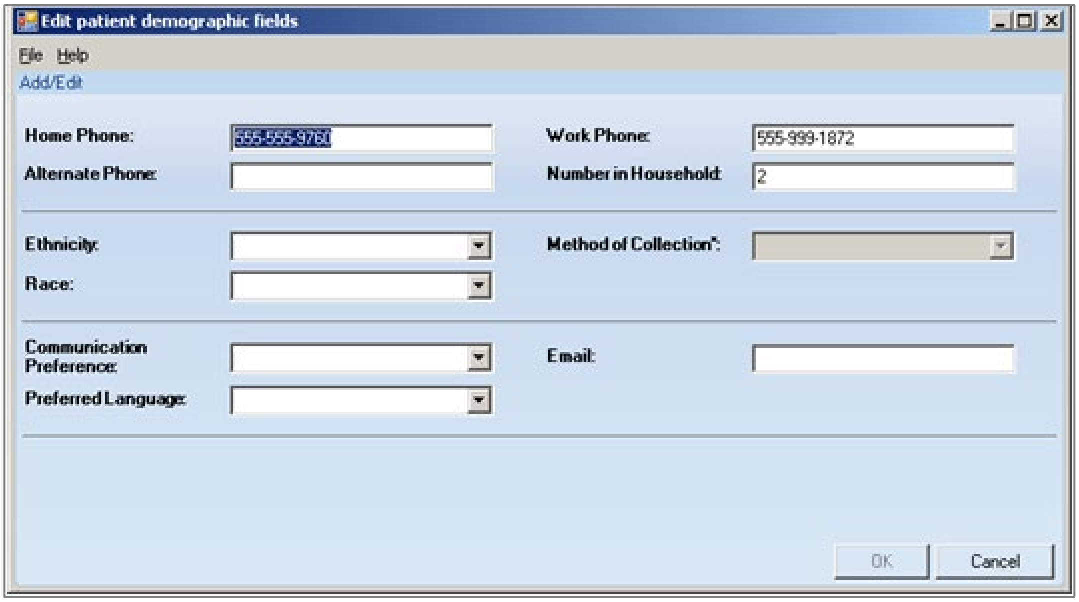


Figure 4-15: Sample **Edit patient demographic fields** dialog

4.3.1 Fields on Edit Patient Demographic Fields Dialog

The field name followed by an asterisk (*) is required. Any field that is inactive on this dialog cannot be changed.

Phone: Populate the phone fields with the appropriate number, using 4–60 characters. This applies to the patient’s **Home Phone**, **Work Phone**, and **Alternate Phone** fields.

Number in Household: Populate with the number of people in the household.

Ethnicity: Use any option on the list to define the patient’s ethnicity. After populating this field, the **Method of Collection** field become active.

Method of Collection: Use any option on the list to define the method of collection for the ethnicity.

Race: Use any option on the list to define the patient’s race.

Communication Preference: Use any option on the list to define the preferred means of communication, for example, email.

Email: Populate with the patient's email address.

Preferred Language: Use any option on the list to define the patient's preferred language.

4.3.2 Menus on Edit Patient Demographic Fields Dialog

Use **File** | **Close** to dismiss this dialog.

The **Help** menu has two options.

- **iCare Help**: Use this option to access the online help for the dialog. This is the same as pressing F1 your keyboard.
- **About iCare**: Use this option to review the iCare version and other information.

4.4 Add a Note Dialog

The following provides information about using the **Add a Note** dialog.

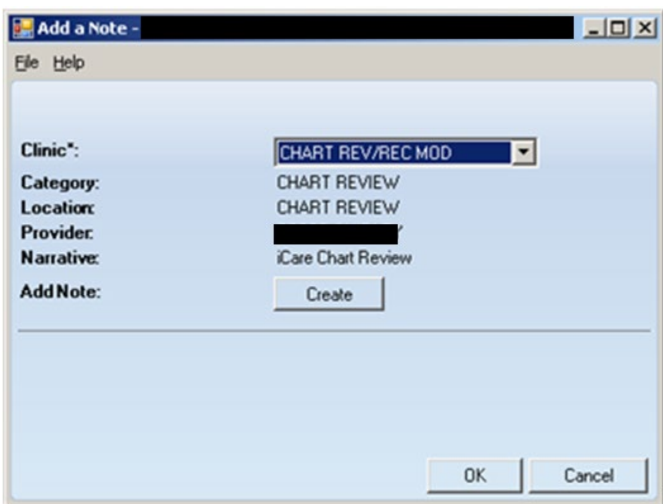


Figure 4-16: Sample **Add a Note** dialog

The application automatically populates the **Location** field, the **Provider** field with the current logged-in user, and the **Narrative** field.

Clinic: Select an option from the list that defines the clinic for the note. The options are Chart Review (or record modification), Follow-Up Letter, or Telephone Call. After populating the **Clinic** field, the application automatically populates the **Category** field.

Add Note: Click the **Create** button to access the **Add TIU Note** dialog. Section 4.5 provides information about this dialog.

The **File** menu (on the **Add a Note** dialog) has one option: **Close**. This closes the dialog (the same action as clicking the **Cancel** button).

The **Help** menu (on the dialog) has two options: (1) iCare help for this dialog (same as pressing the F1 key) and (2) About iCare (displays information about the application, such as the version being used).

4.5 Add TIU Note Dialog

The following information provides information about using the **Add TIU Note** dialog.

When you click the **Add Note** button on the **Patient Record** window, the application displays the **Add a Note** dialog. After clicking the **Create** button on the **Add a Note** dialog, the application displays the **Add TIU Note** dialog.

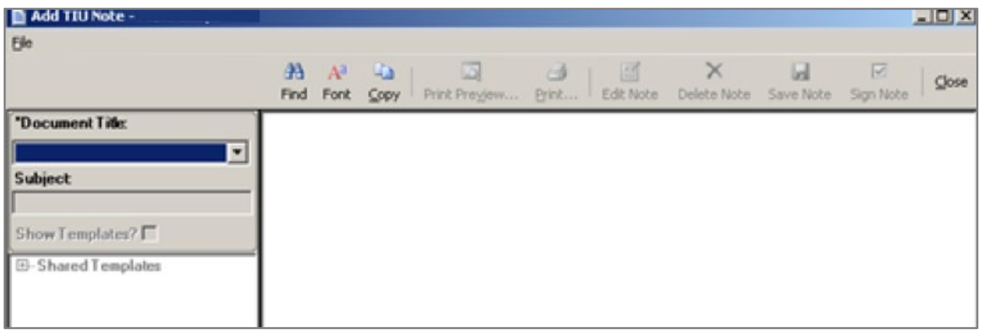


Figure 4-17: Sample **Add TIU Note** dialog

Both fields are required.

Document Title: Select an option from the list to establish the title of the TIU note.

Subject: Use this Free Text field to enter the subject of the TIU note. This field becomes active after populating the **Document Title** field.

At this point, you can do one of the following: not use a template or use a template.

4.5.1 Note with No Template

When you do not want to use a template, and, after you populate the **Document Title** and **Subject** fields, you can type the text of the TIU note in Free Text area on the right side of the dialog.

When the text is complete, the following buttons are active: **Find**, **Font**, **Copy**, **Save Note**, **Sign Note**, and **Close**. Section 4.5.3 provides information about the buttons on the dialog.

The following is an example of what happens after you click the **Save Note** button.

4.5.2 Note with Template

After you populate the **Document Title** and **Subject** fields, select the **Show Template?** check box. This action shows the available templates that you can use. (You will need to expand the **Shared Templates** option.) After you find the template you want to use, double-click its name. The application will display the particular template.

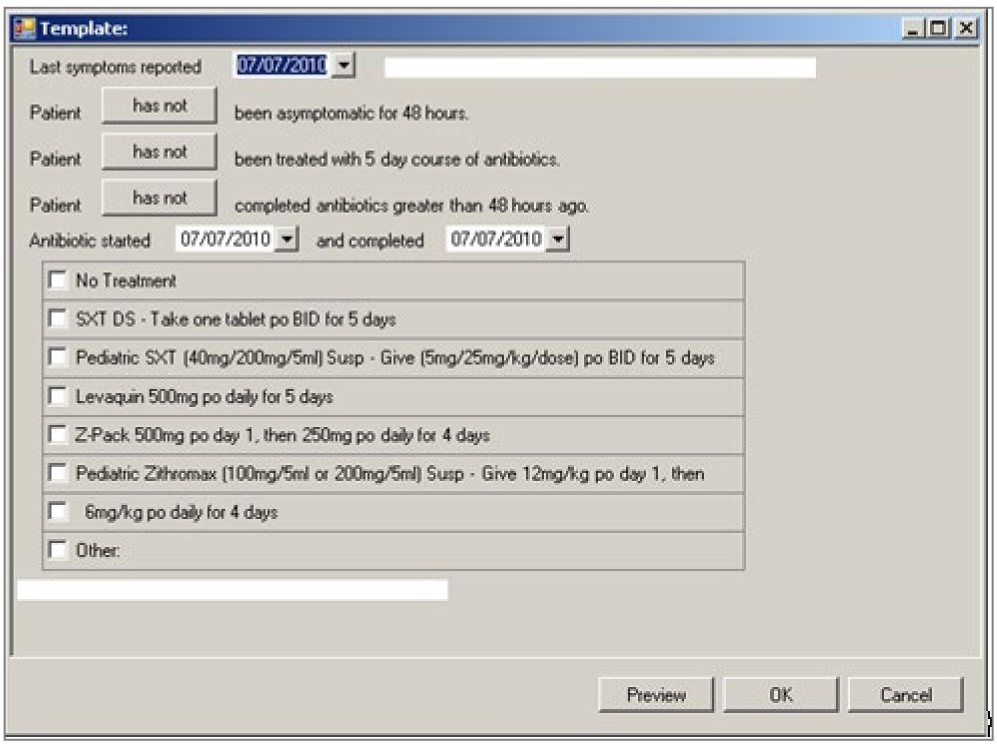


Figure 4-18: Sample Template

You can complete the template by using the buttons and check boxes on the template. What you use on the template determines the text of the TIU note.

Click the **Preview** button (on the Template window) to preview the note in its current state.

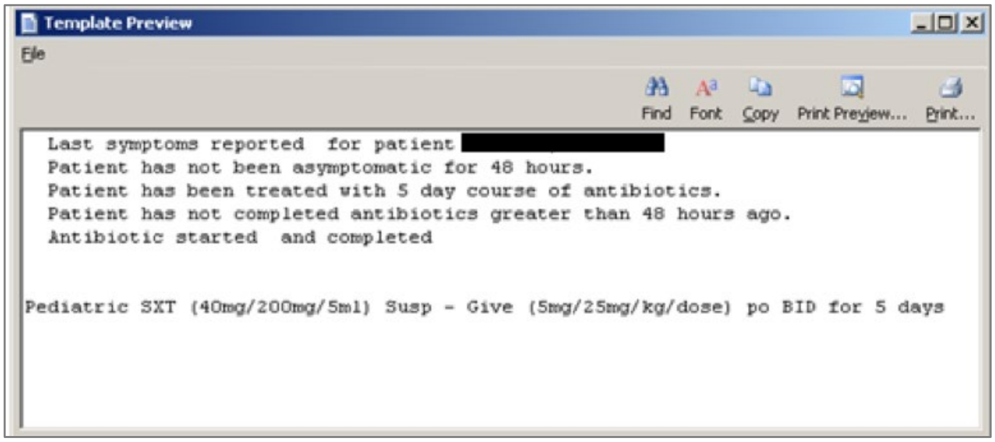


Figure 4-19: Sample **Template Preview** window with TIU note

What displays on the **Template Preview** dialog determines what will be in the text of the TIU note. Section 4.6 for more information about using the controls on the dialog. After you close (**File** | **Close**) the dialog, you return to the Template window.

After you have completed the Template window, click **OK** (otherwise, click **Cancel**). The **OK** option returns you to the **Add TIU** dialog.

4.5.3 Buttons on Add TIU Note Dialog

Please note the following about the text of the TIU note:

- Line lengths should be less than (<) 80 columns (characters), otherwise, the line spacing on the finished TIU note will not format correctly.
- The **Find**, **Font**, **Copy**, **Print Preview**, and **Print** buttons on this dialog work like those on the dialog.
- You should adjust the font size before saving the TIU note, if needed.

Delete Note: Use this button to delete the current unsigned note. (This button does not apply to signed notes.) Click the **Delete Note** button (or select **File | Delete Note**) to access the Delete Note Confirmation: “Do you want to delete the unsigned note?” Click **OK** to delete (otherwise, click **Cancel**). After clicking **OK**, the application displays the message: “Note Deleted successfully.” Click **OK** to dismiss the message.

Save Note: Use this button to save the current note. After clicking this button, the note is saved, and the **Delete Note** and **Edit Note** buttons become active.

Sign Note: Use this button to electronically sign the selected unsigned TIU note. After clicking the **Sign Note** button (or selecting **File | Sign Note**), the application displays the **Enter Electronic Signature** dialog.

Figure 4-20: **Enter Electronic Signature** dialog

Enter your electronic signature in the Free Text field and then click **OK** (otherwise, click **Cancel**). After clicking **OK**, you return to the **Add TIU Note** dialog. The text of the note shows that the note has been electronically signed.

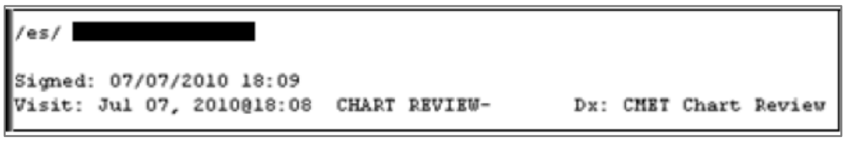


Figure 4-21: Sample electronic signature noted on text of TIU note

Edit Note: Use this function to edit/view the note. Click the **Edit Note** button or select **File** | **Edit Note**) to display the text of the note.

Figure 4-22: Example of text of the note

After you edit the text of the note, you can use the **Save Note** button again.

If you have already signed the TIU note, you cannot change the text; you can only view the text.

Close: Use this button to close the **Add TIU Note** (for patient) dialog. Click the **Close** button (or select **File** | **Close**) to close the dialog.

You return to the **Add a Note** dialog, with the **Preview** button next to the **Add Note** field.

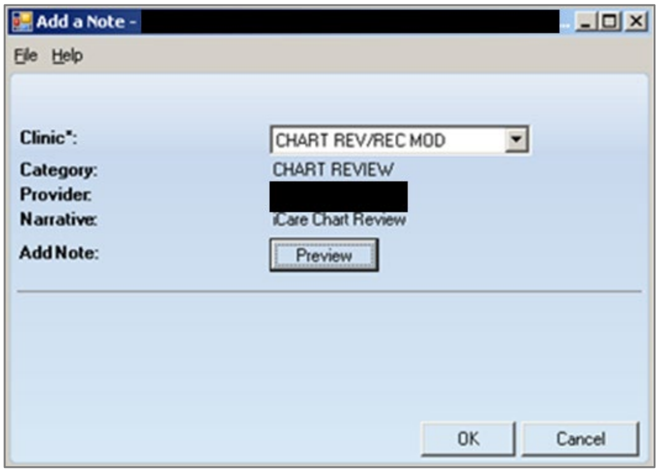


Figure 4-23: Sample **Add a Note** dialog with **Preview** button

Click the **Preview** button to display the text of the note.

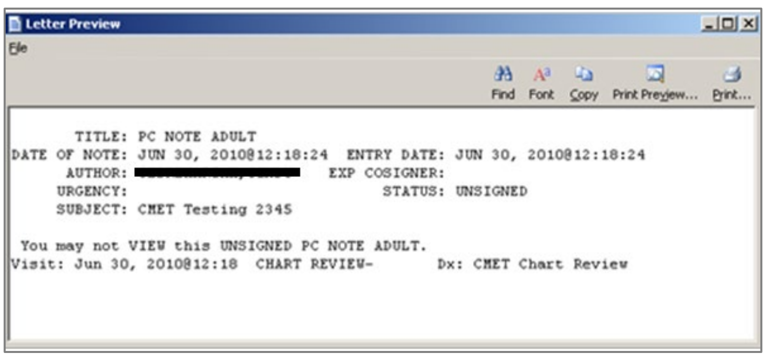


Figure 4-24: Sample **Letter Preview** dialog

Section 4.6 provides information about using the controls on the dialog.

Close the dialog to return to the **Add a Note** dialog (with the **Preview** button on it).

After the **Add a Note** dialog is complete, click **OK** (otherwise, click **Cancel**).

After clicking **OK**, the application displays the **Enter Electronic Signature** dialog.

Figure 4-25: **Enter Electronic Signature** dialog

Enter your electronic signature in the Free Text field. After completing the dialog, click **OK** (otherwise, click **Cancel**).

- If you enter an invalid electronic signature and click **OK**, the application displays the Invalid Attempt information message that states: Invalid electronic signature. Try again? Click **Retry** to return to the Enter Electronic Signature dialog. Click **Cancel** and the application displays the message: "Unable to save with a signed note." Click **OK** to return to the **Add a note** dialog.
- If you enter a valid electronic signature click **OK**, the application displays the information message: "This data will be saved to the RPMS server. Do you want to continue?" Click **Yes** to save and to continue. Click **No** to not save and leave the dialog.

Printing the TIU Note

When you click **OK** (on the **Enter Electronic Signature** dialog), the application displays the **Print TIU Note**s information message.

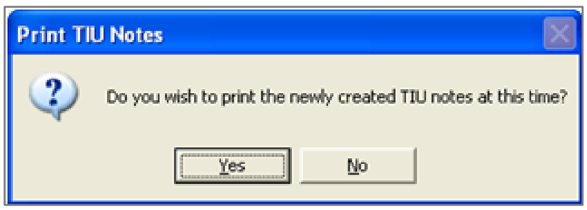


Figure 4-26: **Print TIU Notes** information message

Click **Yes** to print the TUI note. The application displays the **Print Preview** dialog. You can print the TIU note from this dialog. Section 4.12 provides information about the **Print Preview** dialog.

Click **No** to not print the TUI note. The application displays the **Print TIU Notes** information message. This gives you a second time to print the TUI note.

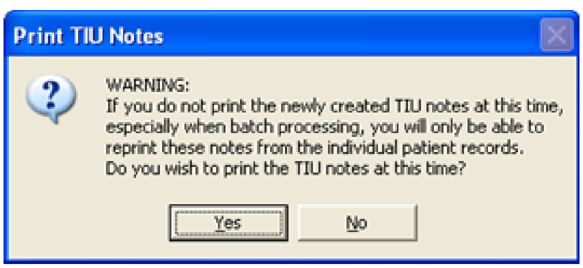


Figure 4-27: **Print TIU Notes** information message

Click **Yes** to print the TIU note at this time when batch processing. Otherwise, you will only be able to reprint this note from the individual patient record.

If you click **Yes**, the application displays the **Print Preview** dialog. You can print the TIU from this dialog. Section 4.12 provides information about the **Print Preview**.

4.6 Dialog Functionality

In several places throughout iCare, you will view dialogs. For example, if you double-click on any row in the **Recent Visits** group box on the **Cover Sheet** of the **Patient Record** window, you will view a dialog.

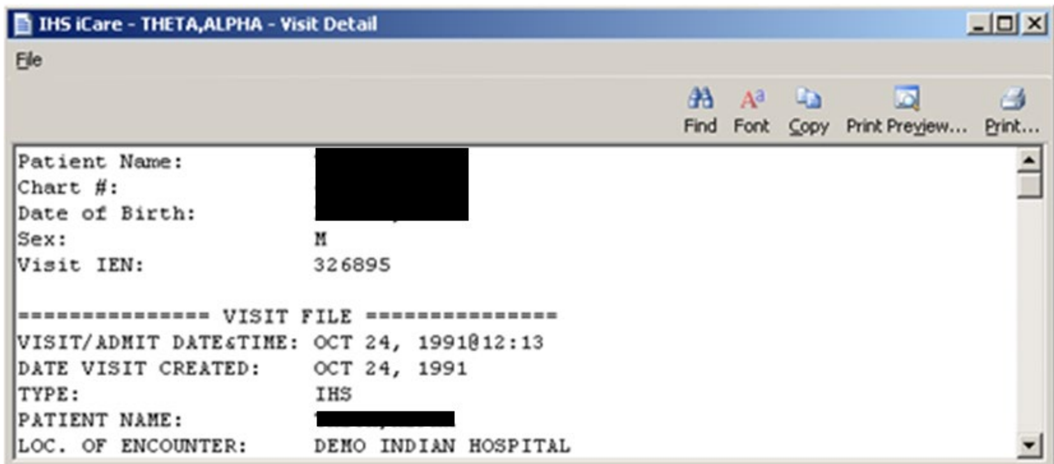


Figure 4-28: Sample **Visit Detail** dialog

You can take the following actions on this dialog:

- Navigate through the information by using the scroll bar.
- Click the **Find** () button (or select **File** | **Find**) to access a search tool to find data in the current window. This button works like the **Search** button.
- Click the **Font** () button (or select **File** | **Font**) to display the **Font** dialog.

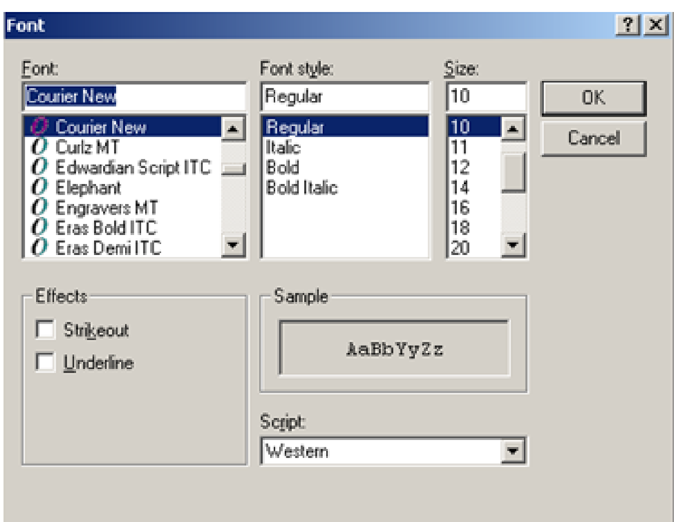


Figure 4-29: **Font** dialog

Here you can change the font name, style, and size of the text in the dialog (applies to all of the text). In addition, you can add effects like Strikeout and Underline — these perform like those effects indicated in MS Word.

Change the Script option if you need to the see the text displayed in another language and that language pack is installed on the machine you are using. If the language pack is not installed on your machine, the display does not change by selecting another script.

Click **OK** to apply your changes to the text in the current dialog. These changes are only effective for the current view of the dialog. (Otherwise, click **Cancel**.)

- Click the **Copy** (Copy) button (or select **Copy** option on the context menu or the **File** menu) to copy the selected text to the Windows clipboard.
- Click the **Print Preview** (Print Preview) button to view the **Print Preview** dialog. You can print the contents of the dialog from this dialog. Section 4.12 provides information about the **Print Preview** dialog.
- Click the **Print** (Print) button to display a print dialog where you specify the printer to output the contents of the dialog, the page range, and number of copies.

The **File** menu contains the print actions (like the **Print Preview** and **Print** buttons), the **Page Setup** function, the find and copy functions, as well as a **Close** function (dismisses the dialog).

4.7 Edit Providers

When you edit the list of specialty providers for the patient, the application displays the **Edit Providers** dialog (for the current patient).

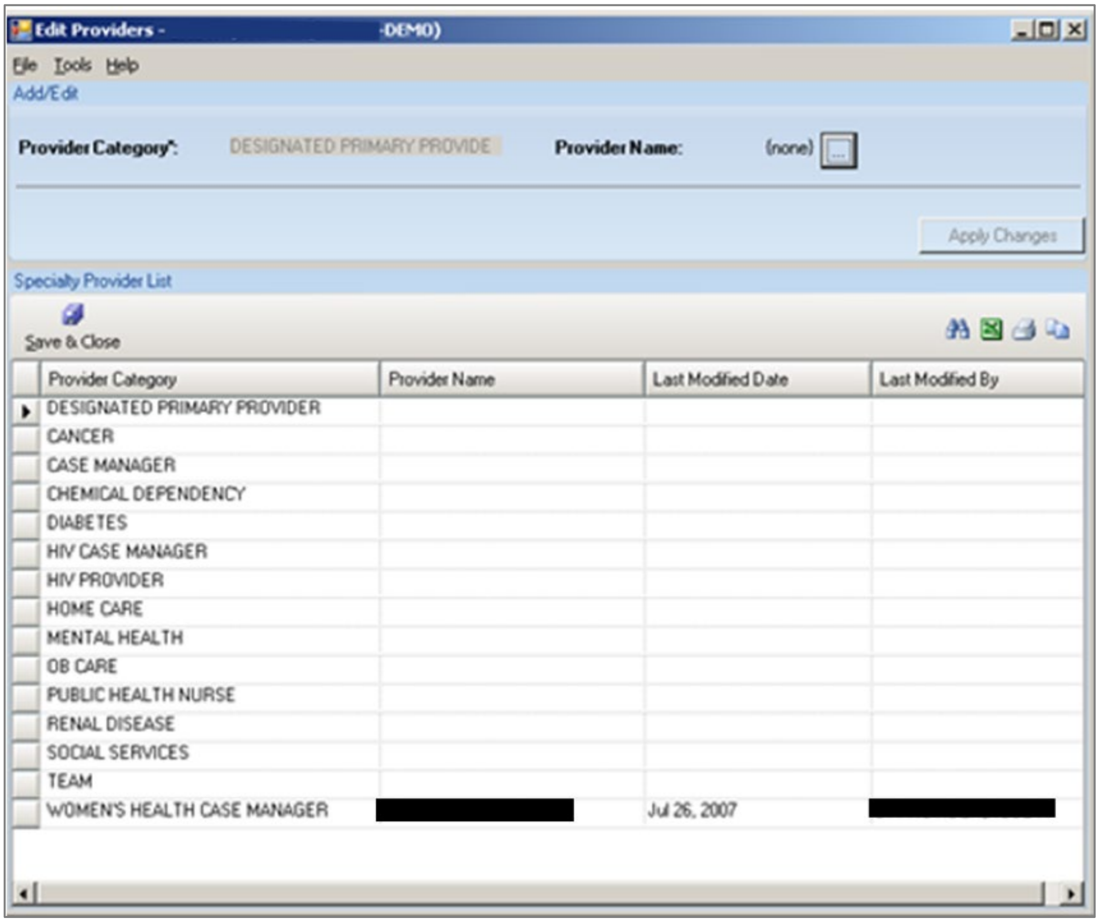


Figure 4-30: Sample **Edit Providers** dialog

The **Edit Providers** window is divided into two areas:

- **Add/Edit** area has fields to add or edit a provider record.
- **Specialty Provider List** area lists the patient's providers.

Section 4.2 provides information about the buttons on the right side of the Specialty Provider List area.

4.7.1 Add/Edit New Provider

Move the cursor to the row of the **Provider Category** (in the **Specialty Provider List** grid) where you want to add or edit the provider.

The **Provider Category** field (in the **Add/Edit** area) will show the provider category that you select, for example, Cancer. This is a view-only field.

You can add the provider for the category and click the ellipsis button to search for the provider name (or initial) on the **Table Lookup** window.

Select the provider name and click **Select**; this name populates the **Provider Name** field (in the **Add/Edit** group box). Then click **Apply Changes** to move the data to the **Specialty Provider List** group box.

4.7.2 Remove Provider Name

You can remove the provider for the category by first selecting the category (in the Specialty Provider List grid). Then, click the ellipsis button by the **Provider Name** field (in the **Add/Edit** area) to access the **Table Lookup** window. Click **Clear** and the focus returns to the **Edit Providers** dialog. Then click **Apply Changes** to remove the provider name from the **Specialty Provider List** group box.

If you have changes and do not click the **Apply Changes** button and try to navigate to another provider category, the application displays the **Commit changes?** information message that states: “You have started to enter data in the data fields. Do you want to commit these changes now?”

- Click **Yes** to commit the changes and the focus returns to the **Edit Providers** dialog.
- Click **No** to not commit the changes and the focus returns to the **Edit Providers** dialog. This action removes the changes.
- Click **Cancel** and the focus returns to **Edit Providers** dialog. This action retains the changes.

4.7.3 Save & Close Button

Click the **Save & Close** (

) button (or select **File** | **Save & Close**) to display the **Confirm save to RPMS** information message. Click **Yes** to save all changed data to RPMS (otherwise, click **No**). The **Edit Providers** window closes.

If you save the data, it will be reflected in the **Provider** group box on the **Cover Sheet** tab of the **Patient Record** window.

4.7.4 File Menu on Edit Providers

The **File** menu options are as follows:

Save & Change: This is the same as clicking the **Save & Close** button. This action displays the RPMS information message. Click **Yes** to save the data to RPMS (otherwise, click **No**). If you click **Yes**, the data populates the **Providers** group box on the **Cover Sheet** of the patient record window.

Close: Use this option to close the **Edit Providers** dialog.

4.7.5 Tools Menu on Edit Providers

The options on the **Tools** menu are **Search**, **Export to Excel**, **Print**, and **Copy Rows to Clipboard**. These options perform like the buttons on the right side of the window. Section 4.2 provides information about these buttons.

4.7.6 Help Menu on Edit Providers

The options on the Help menu are as follows:

iCare Help: Use this option to access the online help information about the **Edit Providers** dialog. This is the same as pressing F1.

About iCare: Use this option view the iCare GUI version information.

4.8 iCare Taxonomy Editor Function

The iCare Taxonomy Editor holds the security key (BQIZTXED) allowing that person to read/edit iCare taxonomies.

Access the **iCare Taxonomy View/Edit** dialog by either selecting **Tools** | **Taxonomy Maintenance** | **View/Edit Taxonomy** Entries (on the main iCare Tools menu) or by double-clicking the **Factor** cell in the **Active Diagnostic Tags** group box on the **Snapshot** tab of the patient record window.

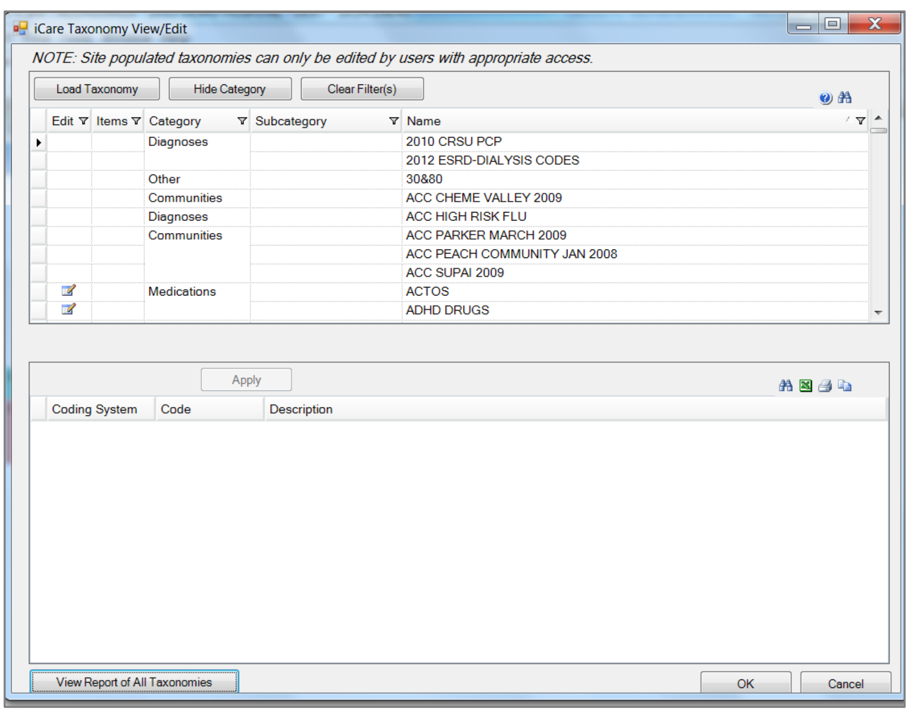


Figure 4-31: Sample **iCare Taxonomy View/Edit** dialog

> **Note**: If you do not hold the security key, you can only view the information on the dialog. The following information displays: "You do not currently have access rights to edit taxonomies. In order to edit taxonomy entries, you will need to have the iCare Taxonomy Editor security key (BQIZTXED) added to your RPMS user account."

When you first access this **View/Edit** dialog, all parts of the tree structure will be collapsed. Expand one of the tree parts to find the taxonomy you want to edit.

In general, select the taxonomy from the list in the left group box that you want to view. This causes the **Add** and **Remove** buttons to display in the right group box of the dialog.

Please note that not all taxonomies can be edited. iCare will display a message on the **View/Edit** dialog for these taxonomies. Site-populated taxonomies can only be edited by users who have appropriate access.

The difference between the **Apply** and **OK** buttons is as follows:

The **Apply** button is used when adding more than one taxonomy value to the **iCare Taxonomy View/Edit** dialog.

4.8.1 Add Taxonomy Values

Click the **Add** button to create values for a selected item in the left group box. The application displays the **Select Taxonomy Item** dialog.

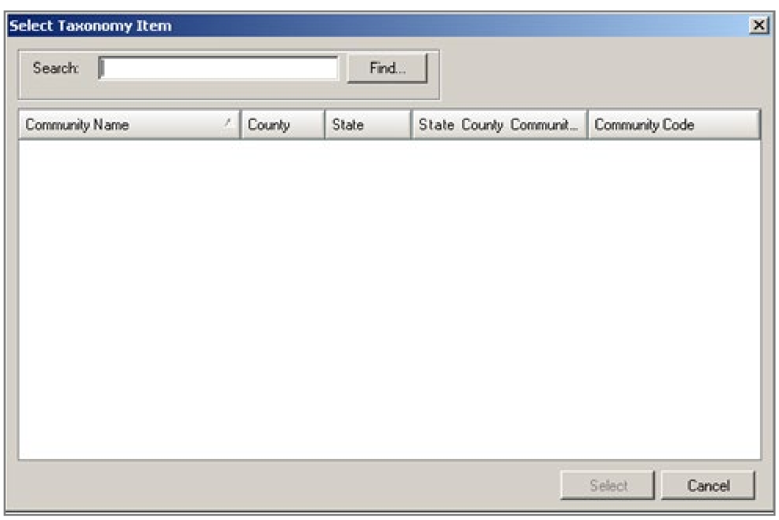


Figure 4-32: **Select Taxonomy Item** dialog

Use the **Search** field to search for a taxonomy item. Highlight the item you want to add and click **Select**. The application checks to see if it already exists.

- If it already exists, you will receive a warning message. Click **OK** to dismiss the message; after clicking **OK**, you return to the **iCare Taxonomy View/Edit** dialog.
- If the item does not exist, it appends the selected item to the bottom of the list.

After you finish adding taxonomy values, click **Apply** to save your changes. If you do *not* click **Apply** and try to move to another taxonomy or another part of the iCare application, the **Save Taxonomy changes?** information message displays, asking if you want to apply the changes now. Click **Yes** to apply the changes (otherwise, click **No**).

You can repeat adding items to various taxonomies. When you are finished using the iCare Taxonomy View/Edit dialog, click **OK** to save (otherwise, click **Cancel**).

4.8.2 Remove Taxonomy Values

If you want to remove one or more items from the list, highlight them and click **Remove**. The **Confirm taxonomy item remove** message displays. Click **Yes** to remove the items (otherwise, click **No**). You remain on the **iCare Taxonomy View/Edit d**ialog.

4.8.3 View Report of All Taxonomies Button

Click the **View Report of All Taxonomies** button to display the **Taxonomy Report** dialog.

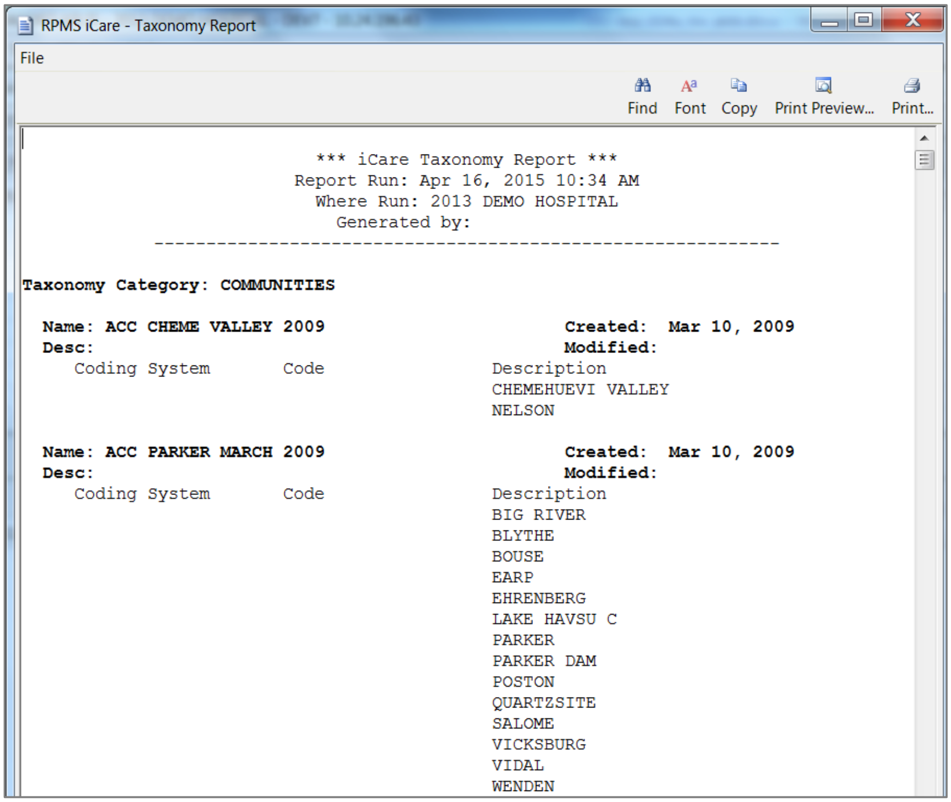


Figure 4-33: **Taxonomy Report** window

This dialog provides information about various Taxonomy Categories (listed in alphabetical order).

See Section 4.6 for more information about using the controls on the dialog.

4.9 Edit Reproductive Factors

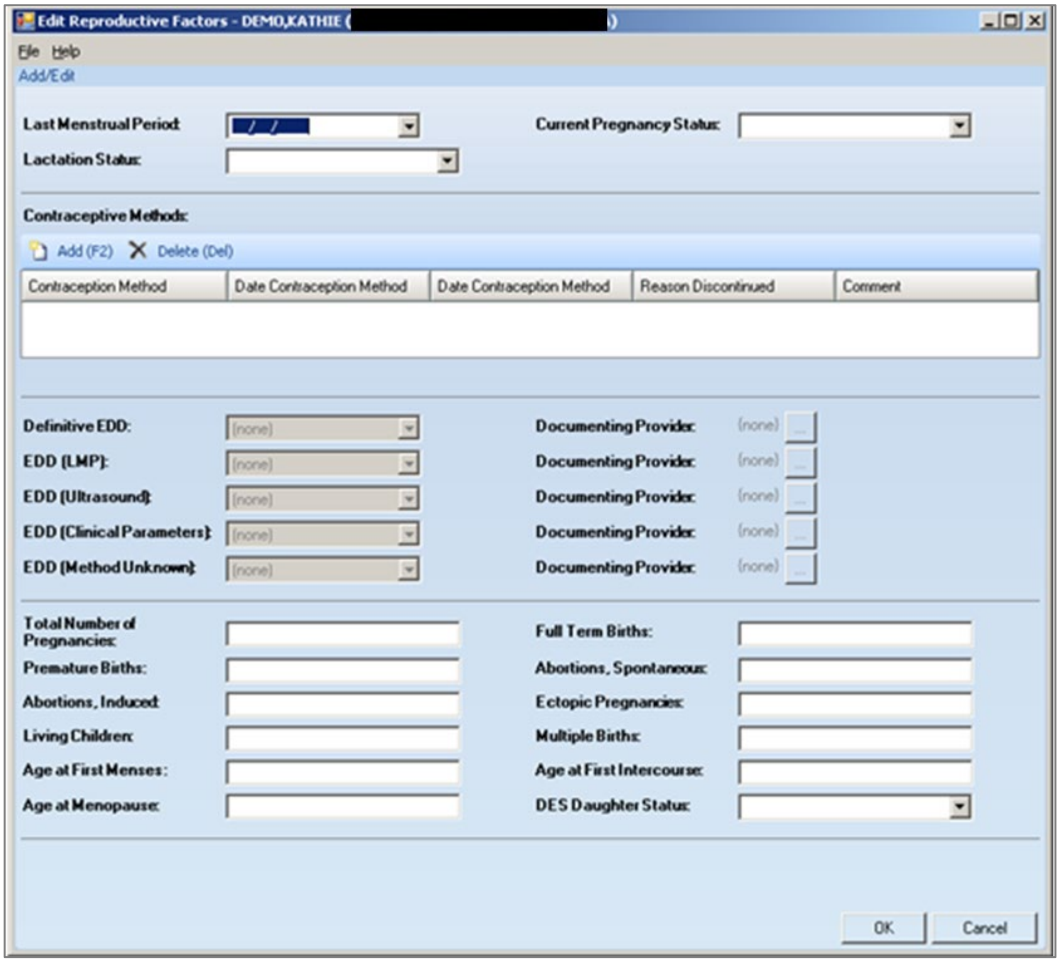


Figure 4-34: **Edit Reproductive Factors** dialog

After completing the dialog, click **OK** to save the data. These values populate the fields on the **Reproductive Factors** group box on the **Snapshot** tab of the patient record window.

Otherwise, click **Cancel**. The application displays the **Save to RPMS?** dialog: "Do you want to save to RPMS now?" Click **Yes** to save to RPMS. Click **No** to not save any data to RPMS. Click **Cancel** to return to the **Edit Reproductive Factors** dialog.

4.9.1 Top Panel

Figure 4-35: Top panel of **Edit Reproductive Factors** dialog

Last Menstrual Period: Populate with the date of the patient's last menstrual period (required field).

Lactation Status: Select an option from the list that specifies the patient's lactation status.

Current Pregnancy Status: Select an option from the list that specifies the patient's current pregnancy status.

4.9.2 Second Panel

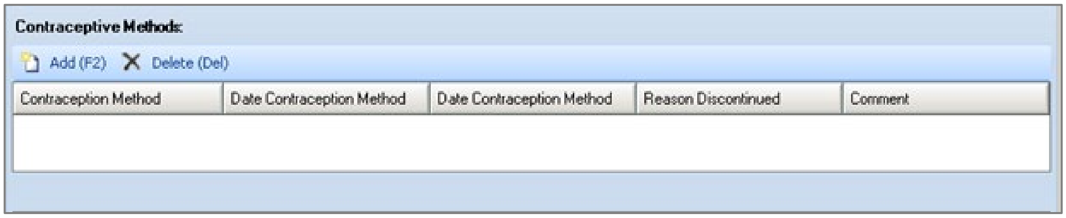


Figure 4-36: The second panel of **Edit Reproductive Factors** dialog

Select one or more rows in the second panel to delete and click **Delete**. The **Delete Rows** information message displays asking if you want to delete the selected rows. Click **Yes** to delete or **No** to not delete.

Click **Add** to add addition information about the patient's contraceptive methods.

The **Contraception Method and Date Contraception** fields in the new row have lists to populate these fields.

The **Reason Discontinued** is a Free Text field where you type the reason for discontinued contraceptive method.

The **Comment** is a Free Text field where you type any comments about the contraceptive methods.

4.9.3 Third Panel

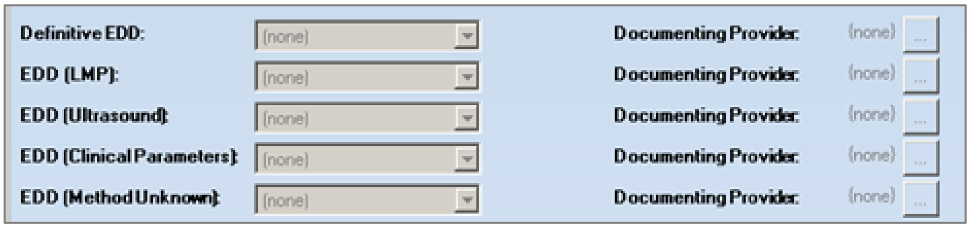


Figure 4-37: The third panel of **Edit Reproductive Factors** dialog

The third panel provides information about the estimated date of delivery (EDD). These fields become active if the **Current Pregnancy Status** field is set to YES.

If you populate any of the EDD fields, the Documenting Provider area becomes active. To populate the Documenting Provider, click the ellipsis button to access the **Table Lookup** dialog where you can search for the provider's name. Highlight the name to use and then click **Select**. The selected provider name will replace the {none} text next to the ellipsis button.

Click **Clear** (on the **Table Lookup** dialog) to clear the name of the documenting provider on the third panel.

Click **Cancel** to exit the **Table Lookup** dialog.

4.9.4 Bottom Panel

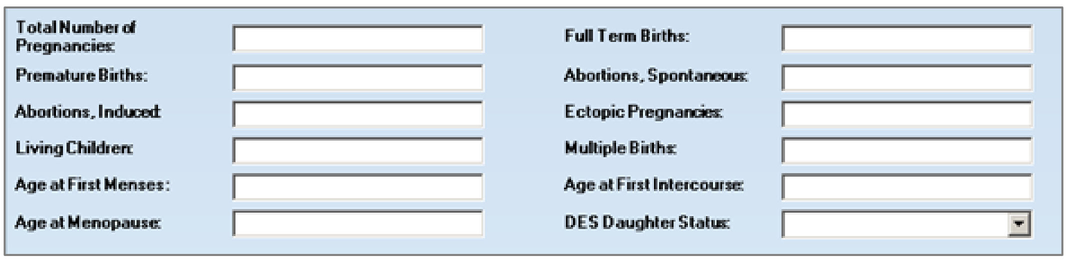


Figure 4-38: Bottom panel of Edit Reproductive Factors dialog

Total Number of Pregnancies: Populate with the value that shows the number of times this patient has been pregnant.

Full Term Births: Populate with the value that shows the number of full-term births for the patient.

Premature Births: Populate with the value that shows the number of premature births for the patient.

Abortions, Spontaneous: Populate with the value shows the number of spontaneous abortions for the patient.

Abortions, induced: Populate with the value that shows the number of induced abortions for the patient.

Ectopic Pregnancies: Populate with the value that shows the number of gestations elsewhere than in the uterus (such as in a fallopian tube or in the peritoneal cavity).

Living Children: Populate with the value that shows number of living children of the patient.

Multiple Births: Populate with the value that shows the number of multiple births for the patient.

Age at First Menses: Populate with the age for the first menstrual day.

Age at First Intercourse: Populate with the age of the first sexual intercourse.

DES Daughter: DES Daughters are defined as women born between 1938 and 1971 who were exposed to diethylstilbestrol (DES) before birth (in the womb). Populate this field by selecting an option from the list.

4.9.4.1 Menus on Dialog

The **File** menu contains the **Close** option, which closes the dialog.

The **Help** menu contains the following options:

iCare Help: Use this option to access the online help for the dialog. This is the same as pressing the F1 key.

About iCare: Use this option to review the iCare version and other information.

4.10 CMET Worksheet

Use the **Open CMET Worksheet** button to access the CMET Worksheet for a selected event on the particular sub-tab of the CMET window.

Use this worksheet to process the Care Management Events that you have chosen to track. Enter data related to **Findings**, **Follow-up**, and **Patient Notification**. The **Due By** Site parameters default dates set by the CMET Package Manager can also be edited in this screen.

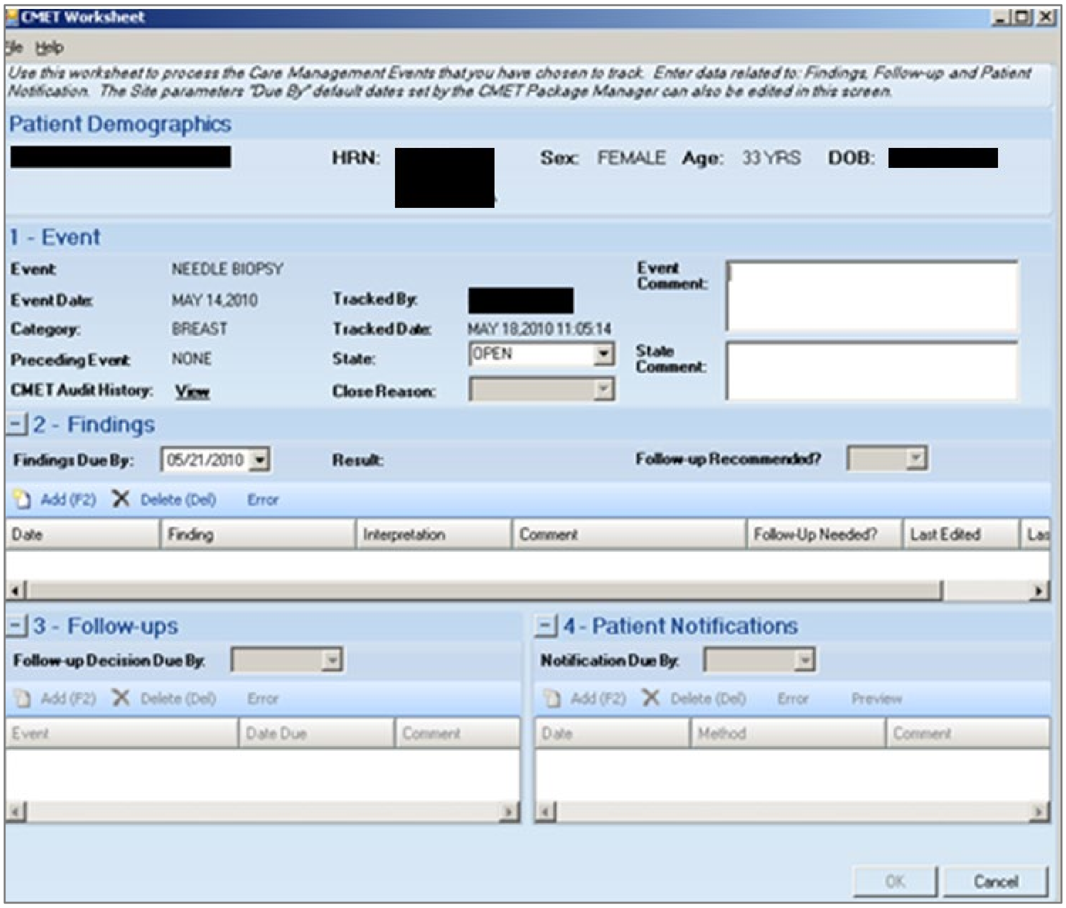


Figure 4-39: Sample **CMET Worksheet**

When the worksheet is complete, click **OK** (otherwise, click **Cancel**).

When you click **OK**, there are two cases.

- Case 1: If all of the steps are not complete, the application updates the data on the **Tracked Events** sub-tab.
- Case 2: If all of the steps are complete, the application will display the **Close Event** information message that states: "The event is eligible for closing as all four steps are completed. Do you want to close the event now?" Click **Yes** to close the event. Click **No** to not close the event.

  If you choose to close the event (by selecting **Yes** on the **Close Event** message), the application displays the **RPMS iCare Reason for Closin**g dialog. Here you select a reason for closing the event and provide a comment (required) about the closing. Click **OK** to save the reason for closing (otherwise, click **Cancel**).

  If you click **OK** on the **Reason for Closing** dialog, the application displays the **Save to RPMS?** dialog: "You have data changes pending. Do you want to save to RPMS now?" Click **Yes** to save the changes to RPMS. Click **No** to not save the changes.

When you click **Cancel**, there are two cases:

- Case 1: If you did not make any changes on the worksheet, the application closes it.
- Case 2: If you made changes on the worksheet, the application displays the **Save to RPMS?** dialog: “You have data changes pending. Do you want to save to RPMS now?” Click **Yes** to save the changes to RPMS. Click **No** to not save the changes. Click **Cancel** to return to the CMET Worksheet.

4.10.1 Patient Demographics Group Box

The **Patient Demographics** group box displays the patient’s name, HRN, Sex, Age, and DOB.

4.10.2 1 - Event Group Box

The data in the **1 – Event** group box provides information about the event and allows you to change the State of the event as well as provide comments about the Event and/or State. In addition, you can view the event’s audit history.

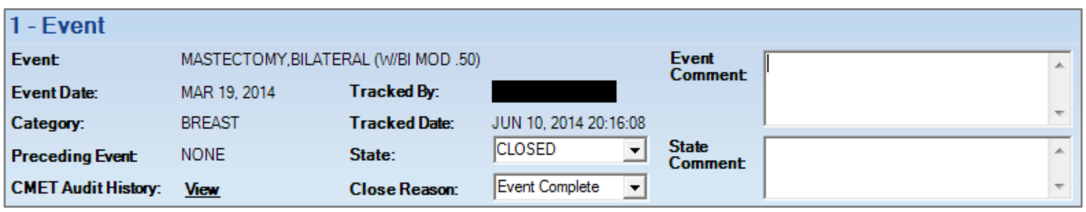


Figure 4-40: Sample **Event** group box

State: This field defines the event State.

If you populate the **State** field with Closed, the **Close Reason** field becomes active. Select an option from the list that describes why you are closing the event.

When an Event has a State of Closed, the other group boxes (Findings, Follow-up, Patient Notifications) will be inactive.

Event Comment: Use this Free Text field to add comments about the Event.

State Comment: Use this Free Text field to add comments about the State.

CMET Audit History: If you click the **View** label, the application will display the **CMET Audit History** dialog.

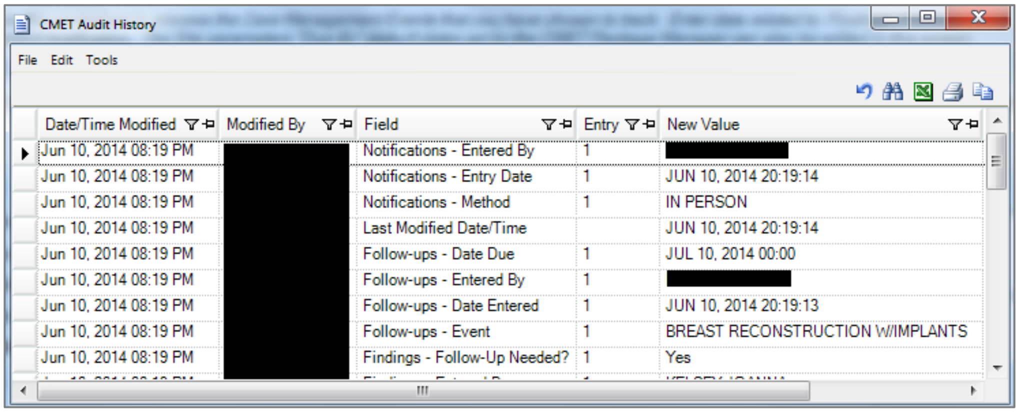


Figure 4-41: Sample **CMET Audit History** dialog

Because multiple users work on the event, the audit history provides of a history of those activities.

Section 4.11 provides information about using the controls and menus on this dialog.

State: This determines the state of the event, either Open or Closed. If Closed is used, the **Close Reason** field becomes active and all the other group boxes (2 - Findings, 3 - Follow-ups, 4 - Patient Notifications) become inactive.

Close Reason: This field is active when State is Closed. Select an option from the list that indicates the reason for closing the event.

4.10.3 2 - Findings Group Box

Use the **2 – Findings** group box to enter Findings data about the event.

Figure 4-42: Sample **Findings** group box

You can minimize this group box by clicking the collapse button in the upper left corner. This allows more room for viewing the other group boxes (Follow-ups and Patient Notifications).

The **Findings Due By**, **Result**, and **Follow-up Recommended?** fields are populated when you use the **Add** button on the grid and save the record.

Findings Due By: This field displays the date the findings of this event were entered into CMET. If this date passes without an entry, a "tickler" (Feather icon) is generated.

Result: This field displays the date of the result. If this field contains an underlined date, click on the date to display the detail of the result. For example, Figure 4-43 shows an example of the **Radiology Case Number Detail** dialog.

Figure 4-43: **Radiology Case Number Detail** dialog

Follow-up Recommended? This field indicates if a follow-up is recommended (yes or no).

4.10.3.1 Add Button

Use the Add function to create a new Findings record. Click the **Add** button (or press F2) to access the **Findings** dialog.

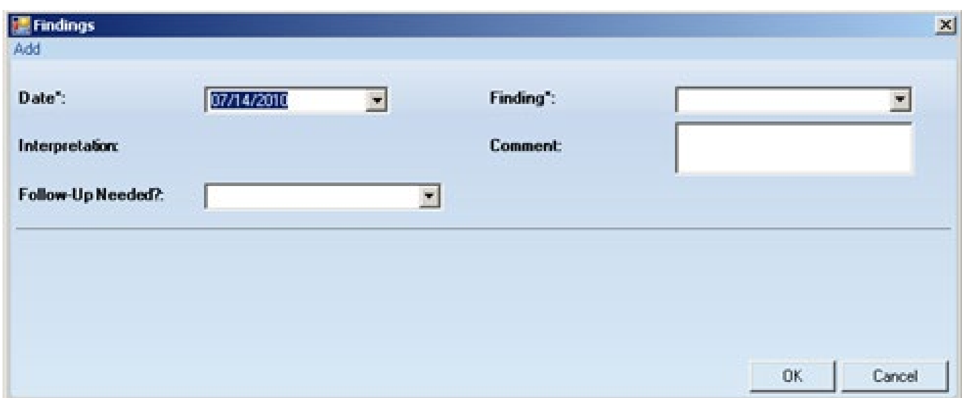


Figure 4-44: **Findings** dialog

The field names followed by an asterisk (*) are required.

Date: Click the list and select a date for the findings.

Finding: This is the finding associated with the event. Select an option from the list to populate this field.

Interpretation: The application populates this field, based on your selection in the **Finding** field.

Comment: Type the text of the comments about the Finding, if appropriate, in this Free Text field.

Follow-up Needed: Select an option from the list: Yes or No.

Click **OK** to save your data on the **Findings** dialog (otherwise, click **Cancel**).

After saving the data, the application populates the grid with the record and populates the Last Edited (current logged-in user) and Last Edited By (current date) columns.

If you select Yes for the **Follow-up Needed** field (on the Findings dialog) and save, the **Follow-up Recommended?** field on the grid will populate with Yes, and the application will automatically display the **Follow-Ups** dialog (where you can enter follow-up data).

4.10.3.2 Delete Button

The Delete function applies to events that had Findings entered but *not* saved.

If you select an event that is not eligible for the Delete function, the application displays the message: "Unable to delete a previously saved entry. Please mark as 'Entered in Error' instead." Click **OK** to dismiss the message.

Select one or more eligible **Findings** records you want to delete and click the **Delete** button (or press Delete). The application displays the **Delete Row** information message, confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

4.10.3.3 Error Button

Use the Error function when Findings records have been saved and you cannot delete them but want to mark them as Entered in Error.

If you select a record that is not eligible for the Error function, the application displays the message: "Unable to mark as 'Entered in Error' because the entry has not been saved in RPMS. Please delete the entry instead." Click **OK** to dismiss the message.

Select one or more eligible Findings records and click **Error**. After using this function, the application places a strikethrough mark on the text of the record.

Figure 4-45: Sample Entered in Error marking

After you save and return to the **Tracked Events** tab, the **Result** column for the event will be blank for the particular event.

4.10.4 3 - Follow-ups Group Box

Use the **3 – Follow-ups** group box to add follow-up data about the event.

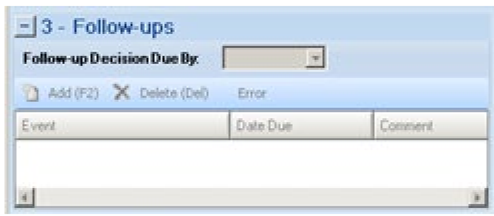


Figure 4-46: **Follow-ups** group box

The Follow-ups group box becomes active when the **Follow-up Recommended** field (in the Findings group box) is set to Yes.

You can minimize this group box by clicking the collapse button in the upper left corner. This allows more room for viewing the other group box (Patient Notifications).

Follow-up Decision Due By: Select a date from the list that indicates when the follow-up decision should be made. Populating the field creates a tickler (feather icon) for the event. In certain cases, this date is populated by the Tickler Timeframe set in the site parameters. You can populate this field with the date you want to take action on the event.

4.10.4.1 Add Button

Use the Add button to create a new Follow-up record. Click the **Add** button (or press F2) to access the **Follow-Ups** dialog.

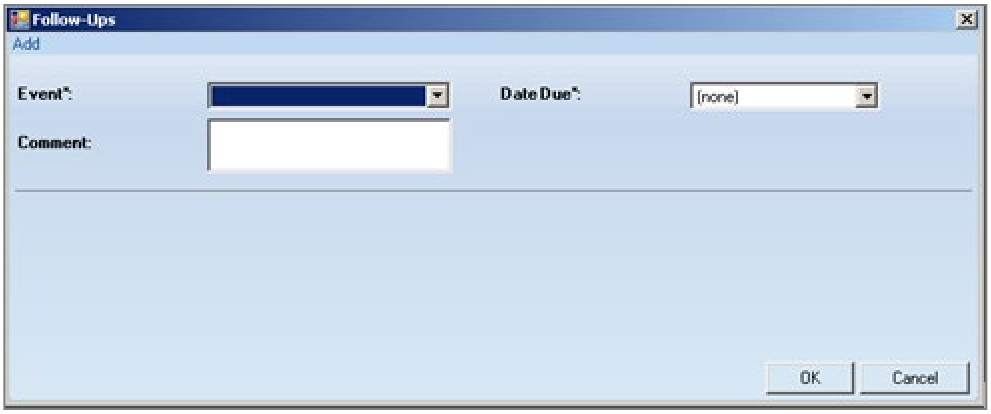


Figure 4-47: Sample **Follow-Ups** dialog

The required fields are marked with an asterisk (*) after the name.

Event: Select an option from the list that describes the Event for the follow-up.

Date Due: Use the list to display a calendar from which to select the due date for the follow-up event.

Comment: Use this Free Text field to add comments about the follow-up.

Click **OK** to save the data on the dialog and the follow-up record will display in the **3 - Follow-ups** group box on the CMET Worksheet. (Otherwise, click **Cancel**.)

4.10.4.2 Delete Button

The Delete function applies to events with Follow-ups entered but *not* saved.

Select one or more eligible Follow-up records to delete and click the **Delete** button (or press Delete). The application displays the **Delete Row** information message confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

4.10.4.3 Error Button

Use the Error function when Follow-up records have been saved and you cannot delete them but want to mark them as Entered in Error.

If you select a record that is not eligible for the **Error** button, the application displays the message: “Unable to mark as ‘Entered in Error’ because the entry has not been saved in RPMS. Please delete the entry instead.” Click **OK** to dismiss the message.

Select one or more eligible Follow-up records and click the **Error** button. After using this function, the application places a strikethrough mark on the text of the record.

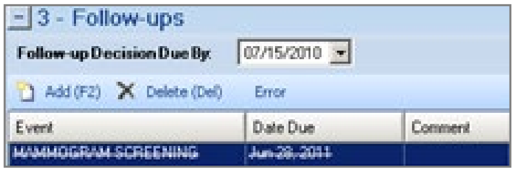


Figure 4-48: Sample of **Follow-up** record marked as entered in error

4.10.5 4 - Patient Notifications Group Box

Use the **4 – Patient Notifications** group box to add patient notification data about the event.

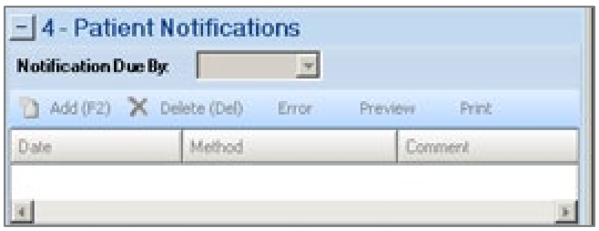


Figure 4-49: **Patient Notifications** group box

The Patient Notification, the final step, makes the patient aware of both the results and the follow-up recommendations. Multiple types of Patient Notifications can be entered for each Event.

The **Patient Notifications** group box becomes active when the **Follow-up Recommended?** field (in the **Findings** group box) is set to Yes.

You can minimize this group box by clicking the collapse button in the upper left corner. This allows more room for viewing the **Follow-ups** group box.

Notification Due By: Enter the date to have your patient notified about the results and recommendations of the follow-up related to this event. If this date passes without an entry, a tickler (feather) icon will be generated. In certain cases, this date is populated by the Tickler Timeframe set in the site parameters.

4.10.5.1 Add Button

If you do not have default clinics defined in user preferences, the application displays the following message: You must select default clinics in user preferences before being able to enter notes. Click **OK** to dismiss the message. Select **Tools** | **User Preferences** to access the **RPMS iCare – User Preferences** dialog. Go to the **Patient View** tab to enter the clinic codes.

Use the **Add** button to create a new Patient Notification record. Click the **Add** button (or press F2) to access the **Notifications** dialog.

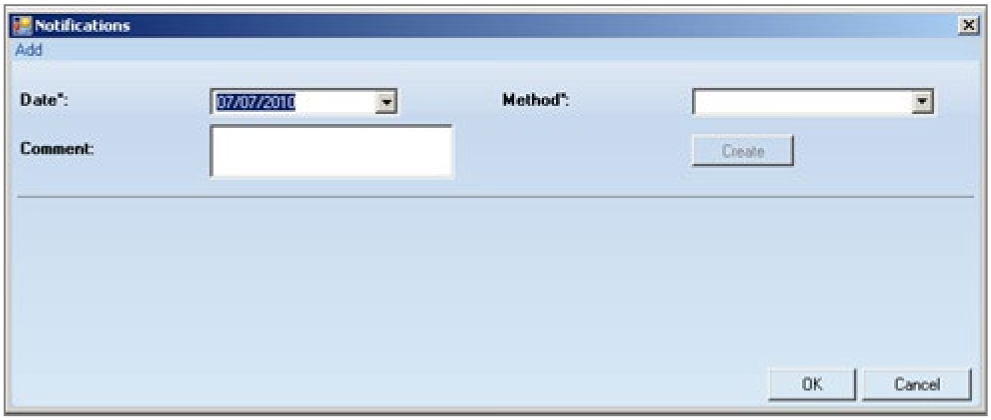


Figure 4-50: Sample initial **Notifications** dialog

Required fields are marked with an asterisk (*) following the name.

Date: The default date is today's date. Change it by clicking the list to access a calendar from which to select another date.

Method: Select an option from the list that identifies the type of notification.

Create: This button becomes active if you select Certified Letter or Letter in the **Method** field. You must have an electronic signature on file before you can use this function.

If you have an electronic signature on file, click the **Create** button to access the **Add TIU Note** dialog. Section 4.5 provides information about this dialog.

Comment: Use this Free Text field to add any comments about the notification.

After completing this dialog, click **OK** to save the data (otherwise, click **Cancel**). After saving, the notification record will display in the **4 - Patient Notifications** group box on the **CMET Worksheet**.

4.10.5.2 Delete Button

The **Delete** function applies to events that had Patient Notifications entered but *not* saved.

Select one or more eligible Patient Notification records to delete and click the **Delete** button (or press Delete). The application displays the **Delete Row** information message confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

4.10.5.3 Error Button

Use the **Error** function when Patient Notification records have been saved and you cannot delete them but want to mark them as Entered in Error.

If you select a record that is not eligible for the Error function, the application displays the message: "Unable to mark as 'Entered in Error' because the entry has not been saved in RPMS. Please delete the entry instead." Click **OK** to dismiss the message.

Select one or more eligible Patient Notification records and click the **Error** button. After using this function, the application places a strikethrough mark on the text of the record.

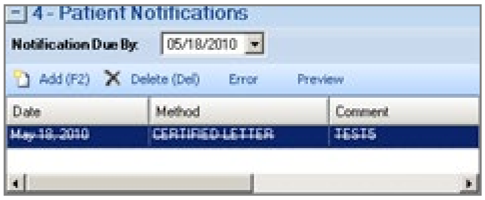


Figure 4-51: Sample **Patient Notification** record marked as entered in error

4.10.5.4 Preview

Use the **Preview** function to preview the letter associated with the selected Patient Notification record. This function only applies to records that are Letters or Certified Letters.

Select the record you want to preview and click the **Preview** button. The application displays the **Letter Preview** dialog.

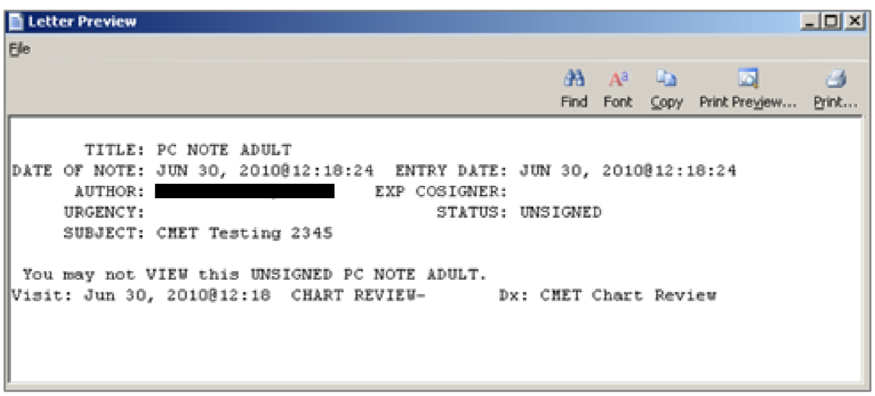


Figure 4-52: Sample **Letter Preview** dialog

Section 4.6 provides information about using the controls on the dialog,

4.10.5.5 Print Button

Use the **Print** button to output a letter in a selected record. After clicking **Print**, the application displays the **Print** dialog where you specify the printer, page range, number of copies, etc.; this dialog works like the one in MS Office.

4.11 Background Jobs Dialog

Click the **Background Jobs** ( ) button (or select **File** | **Background Jobs**) to display the **Background Jobs** dialog.

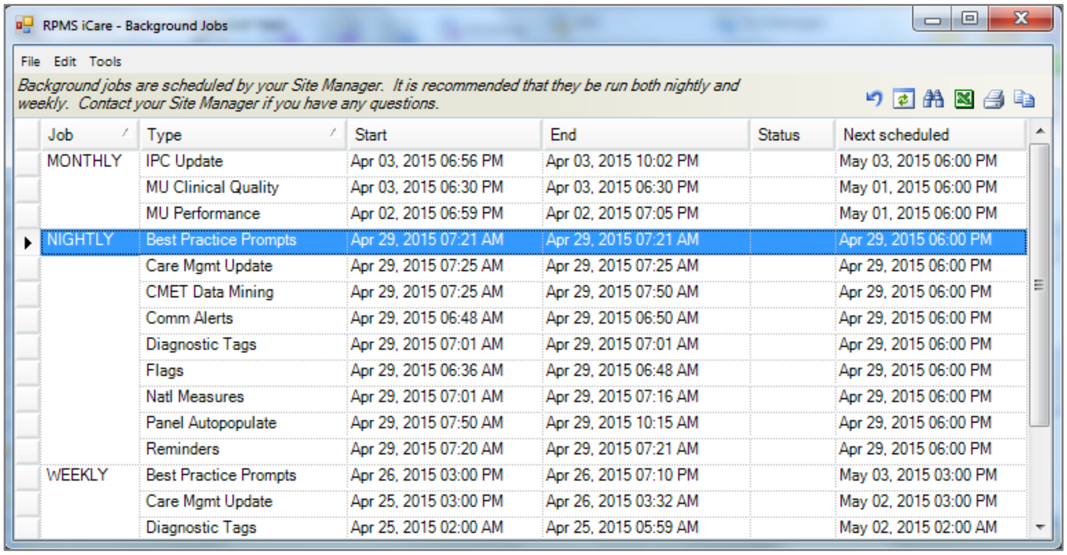


Figure 4-53: Sample **Background Jobs** dialog

You must dismiss the dialog to use other functions in iCare.

Section 4.2 provides information about the buttons on the right side of the toolbar.

The **File** menu has the following options:

Page Setup: This option allows you to set the Margin, Paper, Layout characteristics (e.g., landscape or portrait orientation), and which Printer to use.

Print Preview: This option displays the **Print Preview** dialog. Section 4.12 provides information about this dialog.

Print: This option outputs the selected rows in the grid. The application displays the **Print Preview** dialog where you can view the output. Select **File** | **Print** (on the dialog) to output the content. The application provides a Confidential Patient Information header for all printed panel views.

If you do not select any rows, the application displays a warning message: “You have not selected any rows to print. Do you want to proceed and print all rows in this view or cancel this print?” Click **Yes** to print all the rows. Click **No** to cancel the print function.

Close: This option closes the **Background Jobs** window.

The **Edit** menu has one option: **Select All** (use to select all of the records).

The **Tools** menu has options that have the same functions as those of the buttons on the right side of the toolbar.

4.12 Print Preview

The **Print Preview** dialog contains several features about reviewing and printing the current document.

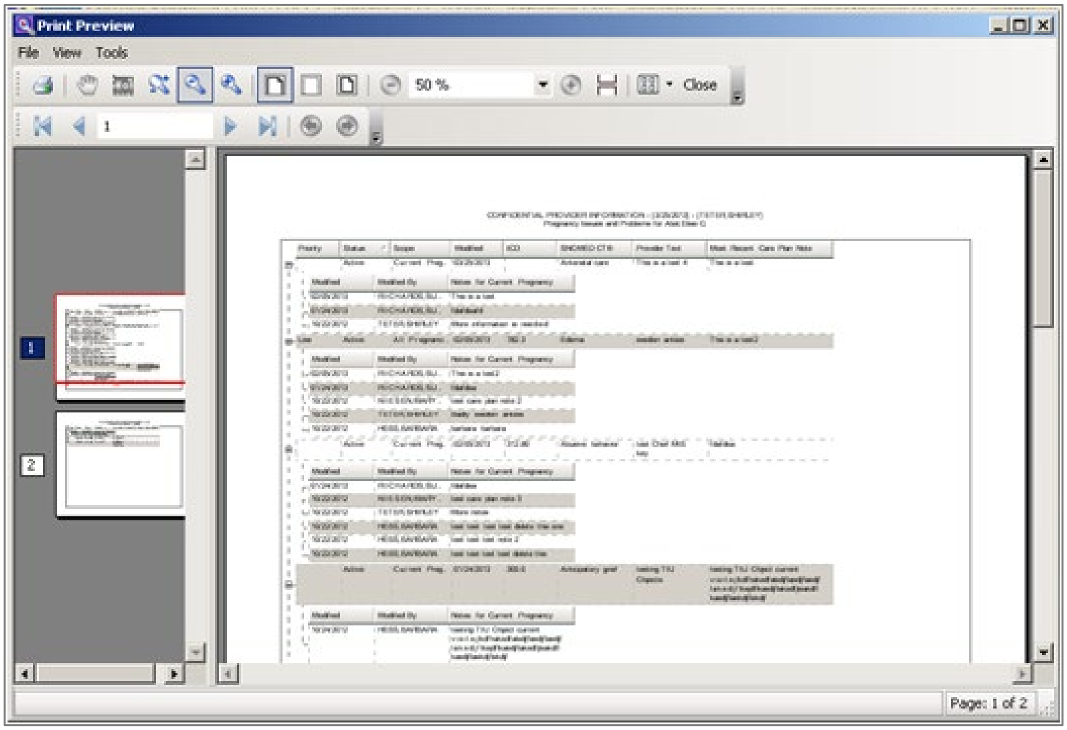
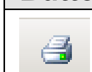


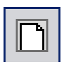
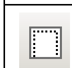
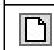
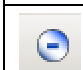
Figure 4-54: Sample **Print Preview** dialog

The **Print Preview** dialog contains two panels, where the left panel displays the pages in the document and the right panel displays a larger version of the page selected in the left panel.

Table 4-1 provides information about the buttons on the **Print Preview** window.

Table 4-1: **Print Preview** buttons and descriptions

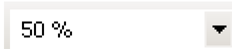
Button	Description
	Use to output the contents of the document. Also available by selecting the **Print** option on the **File** menu.
	Use to move the red rectangular box on the selected page in the left panel. As you move the Hand Tool, this changes the display in the right panel. This is used to view information in a particular part of a page. Also available by selecting the **Hand Tool** option on the **Tools** menu.

Button	Description
	Use to get a screen capture of a specified rectangular area. This screen capture copies the area to the Windows clipboard. Then you can paste the copy in a particular field, for example, or another application like MS Word. Also available by selecting the **Snapshot Tools** option on the **Tools** menu.
	Use to specify the zoom magnification. Click the button and then move to the area where you want to apply to zoom. Right-click on the area and select the zoom magnification option from the context menu. Also available by selecting the **Dynamic Zoom Tool** option on the **Tools** menu.
	Use to zoom out by clicking the button in an area in the right panel (the image becomes smaller). Also available by selecting the **Zoom Out** option on the **View** menu.
	Use to zoom in by clicking the button in an area in the right panel (the image becomes larger). Also available by selecting the **Zoom In** option on the **View** menu.
	Use to cause the image in the right panel to display to its maximum page width (usually enlarges the image). Also available by selecting the **Page Width** option on the **View** menu.
	Use to cause the image in the right panel to display the image with no page margins showing. Also available by selecting the **Margin Width** option on the **View** menu.
	Use to display the image and its page margins in the right panel. Also available by selecting the **Whole Page** option on the **View** menu.
	Use to automatically cause the image in the right panel to zoom out (you do not click in the panel). Also available by selecting the **Zoom Out** on the **View** menu.
	Use to automatically cause the image in the right panel to zoom in (you do not click in the panel). Also available by selecting the **Zoom In** option on the **View** menu.
	Use to display all of the pages in the right panel. Also available by selecting the **Continuous** option on the **View** menu.
	Use to specify the page layout. Also available by selecting the **Page Setup** option on the **File** menu.

Navigate through the pages in the document by using the arrow buttons on the second line in the toolbar.

Figure 4-55: Buttons to aid navigation through the document pages

The same options are available by selecting **View** | **Go To** (and on the context menu for the right panel).

Use the **Zoom** 

field (or select **View** | **Zoom**) to specify the zoom magnification for the right panel by selecting from the list.

Use the **Close** button (or select **File** | **Exit**) to close the **Print Preview** dialog.

Select **File** | **Page Setup** to access the **Page Setup** dialog.

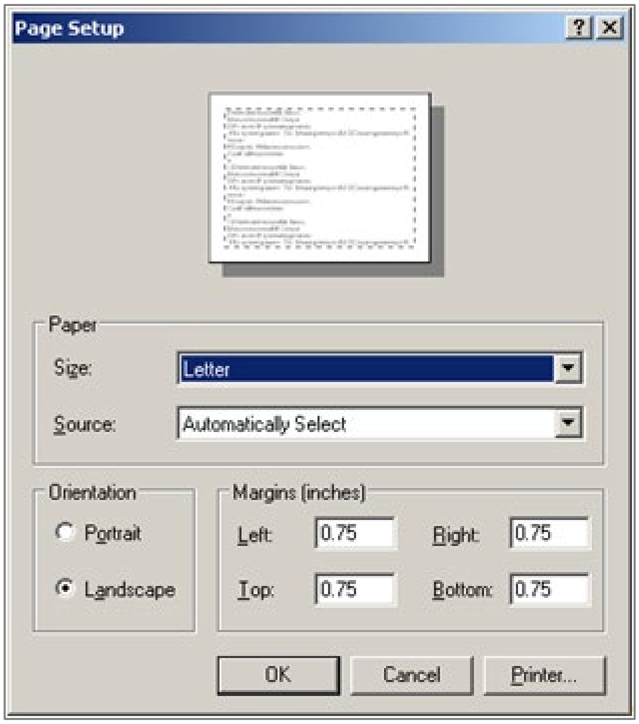


Figure 4-56: Sample **Page Setup** dialog

Use the **Page** group box to specify the paper size and source.

Use the **Orientation** group box to specify the orientation of the output.

Use the **Margins** group box to specify the various margins widths in inches.

Click **Printer** to access the **Printer** dialog and choose the printer to which to output the contents of the document.

After the **Page Setup** dialog is complete, click **OK** to save the page setup options. (Otherwise, click **Cancel**.)

4.13 Graphing Measurement Data

You can create a graph of selected measurement data on the patient record window by clicking the **Graph It!** (

) button. The application displays the **Charting** window, showing a graph of the particular measurement type. The **Graph It** button also displays on the **Nat'l Measures** view window, but those features will not be included in the following documentation.

The application creates a line chart of the data. This type of graph shows trends over time.

- The x-axis is the time axis.
- The y-axis shows the data range that includes the maximum and minimum values (this is the default setting).

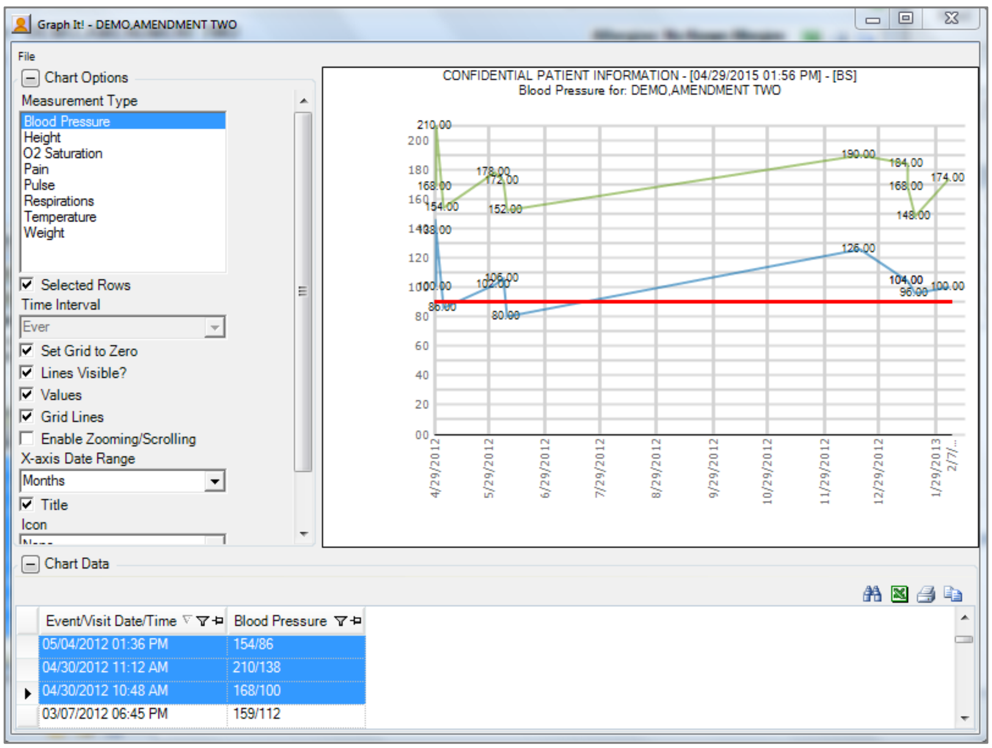


Figure 4-57: Sample Charting window

4.13.1 Chart Data Group Box

The **Chart Options** group box contains the data for the graph.

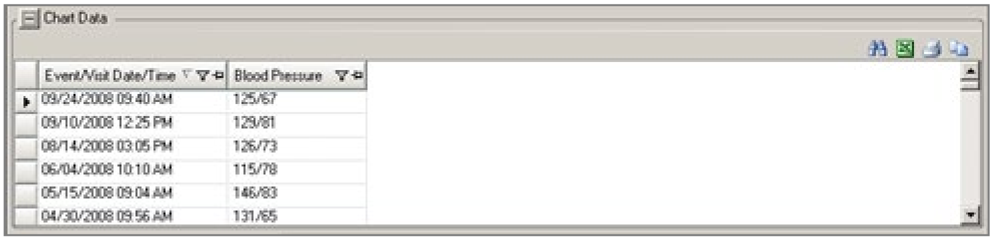


Figure 4-58: Sample **Chart Data** group box

The data is determined by what you select in the **Measurement Type** field.

4.13.2 Chart Options Group Box

What you select in the **Chart Options** group box determines what the graph looks like. For example, you can determine the scale units for the x-axis in the **X-axis Date Range** field.

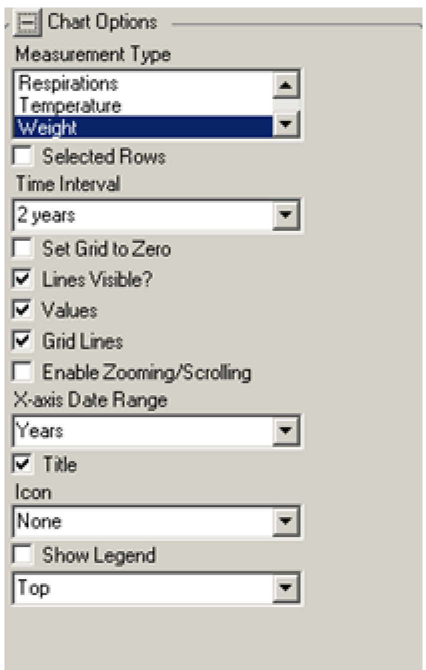


Figure 4-59: Sample **Chart Options** group box

Measurement Type: This shows what is being charted. You can change this by highlighting another measurement type.

Chart Type: This option only displays on the National Measures chart. This determines the type of chart (Column Chart is the default). You can change this by selecting an option from the list.

Selected Rows: select this check box to graph the selected row(s) in the Chart Data grid. If you do not use this check box, the application uses all of the measurement values.

Time Interval: This determines the time interval for the data on the chart. The default is what you selected (in the **Last** field) on the **PCC** tab of the patient record window. You can change this interval by selecting an option from the list.

Set Grid to Zero: Select this check box to cause the y-axis values to start at zero and go to the maximum data value. When you do not select this check box, the application uses the minimum and maximum values for the y-axis.

Lines Visible?: Select this check box to display the lines that connect the data points.

Values: Select this check box to display the values at each data point.

Grid Lines: Select this check box to display the grid lines on the chart.

Enable Zooming/Scrolling: Select this check box to display zooming/scrolling of the axis lines.

X-axis Data Range: This determines the time units of measure on the x-axis of the graph. The options are Not Set, Days, Weeks, Months, and Years.

Icon: This determines the icon for each data point. The options are circle, diamond, none, plus, square, triangle, upside down triangle, and X. The default is None.

Show Legend: Select this check box to show the legend for the graph. The field that follows determines the location of the legend.

4.13.3 File Menu for Charting Window

The following are the **File** menu options for the Charting window.

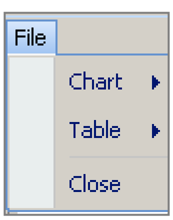


Figure 4-60: File menu options for the Charting window

Use the **Close** option to close the charting window.

4.13.3.1 Chart Option

The **Chart** option of the **File** menu has the following selections:

Page Setup: This selection allows you to set Margin, Paper, and Layout characteristics (like landscape or portrait orientation) for printing. You can select a different printer.

Print Preview: This selection displays the **Print Preview** dialog that displays how the output of the chart will look. Section 4.12 provides information about this dialog.

Print: This selection displays the **Print** dialog where you select the printer to output the chart. This is the same as pressing Ctrl-P.

Save Chart for Office: This option lets you save the chart in a particular graphics format, for example JPEG. The application displays the **Save Chart for Office** dialog.

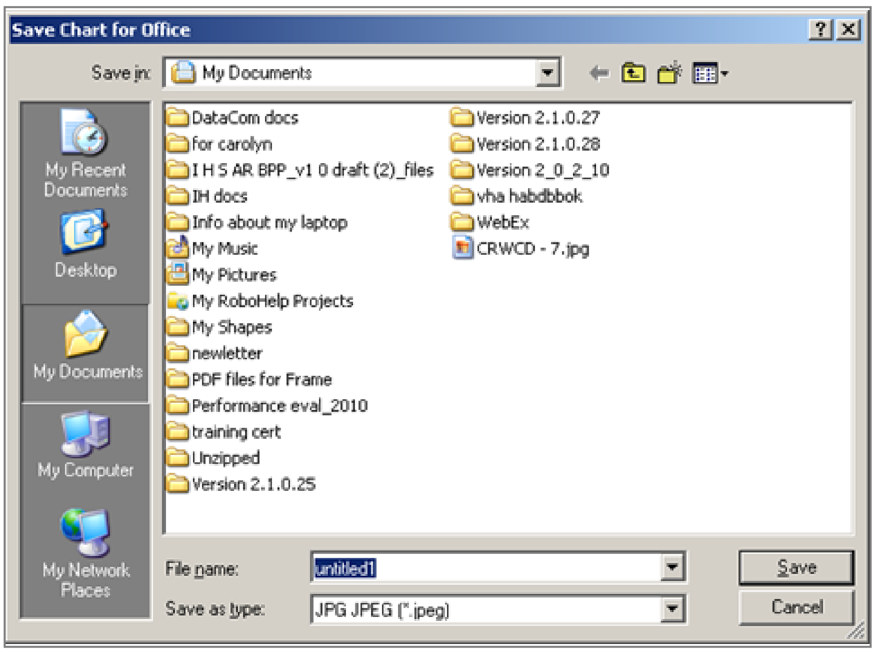


Figure 4-61: **Save Chart for Office** dialog for graphics format

File Name: Specify the name of the file for the chart in graphics format.

Save as type: Select the type of graphics format for the chart. The default is JPEG.

After completing the two fields, click **Save** to save the chart in graphics format (otherwise, click **Cancel**).

Save Chart for PDF: This selection lets you save the chart in PDF format. The application displays the **Save Chart for Office** dialog.

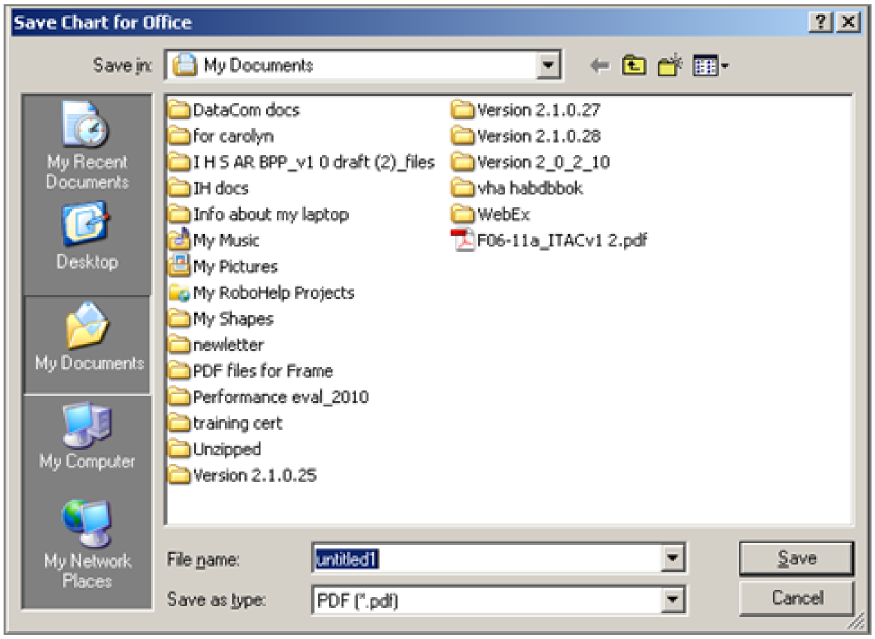


Figure 4-62: **Save Chart for Office** dialog for PDF format

File Name: Specify the name of the file for the chart in graphics format.

Save as type: Use the default PDF.

After completing the two fields, click **Save** to save the chart in PDF format (otherwise, click **Cancel**).

4.13.3.2 Table Option

The **Table** option of the **File** menu has the following selections:

Search: This selection searches for data in the **Chart Data** group box.

Excel Export: This selection to export the selected rows in the **Chart Data** group box to Excel.

Print: This selection displays the **Print Preview** dialog of the currently selected rows in the **Chart Data** group box. Section 4.12 provides information about the **Print Preview** dialog.

Copy Rows to Clipboard: This selection copies the currently selected rows in the **Chart Data** group box to the Windows clipboard. You can paste the contents of the Windows clipboard to any Windows application.

4.14 Table Lookup

The ellipsis button next to the field means you can search for a particular record in the **Table Lookup** dialog by clicking the button. In addition, you can clear the information in the particular field (on the form).

4.14.1 Searching for Record

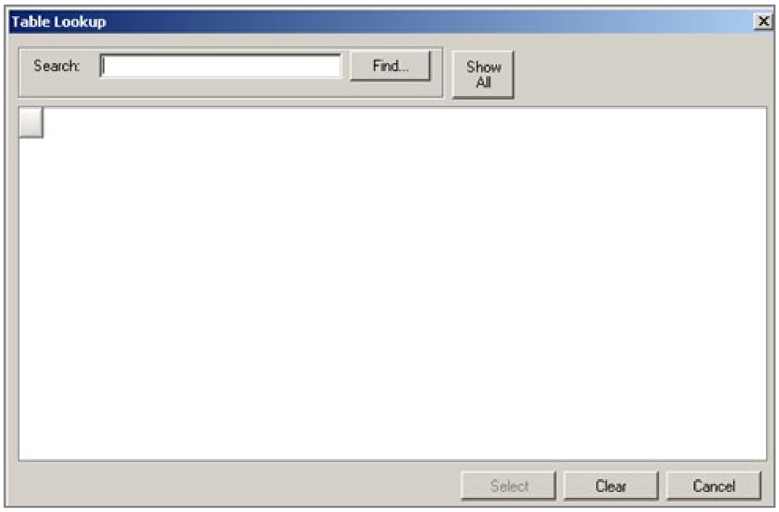


Figure 4-63: **Table Lookup** dialog

This dialog provides two types of searches: for all items or for a particular item.

We will use an example to demonstrate each type and assume you will search for a CPT Code.

4.14.1.1 Using the Show All Button

If you do not enter anything in the **Search** field and click **Show All**, the application will display all CPT codes, as follows. (The retrieval might take a little time.)

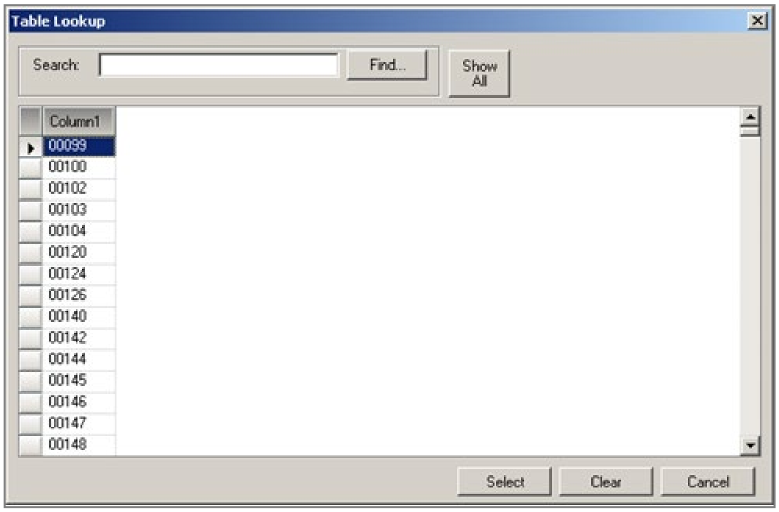


Figure 4-64: Sample retrieval of all CPT codes

4.14.1.2 Using the Find Button

To search for a particular CPT code, type a few characters in the **Search** field and click **Find**. The retrieved records will display in the bottom area (if any).

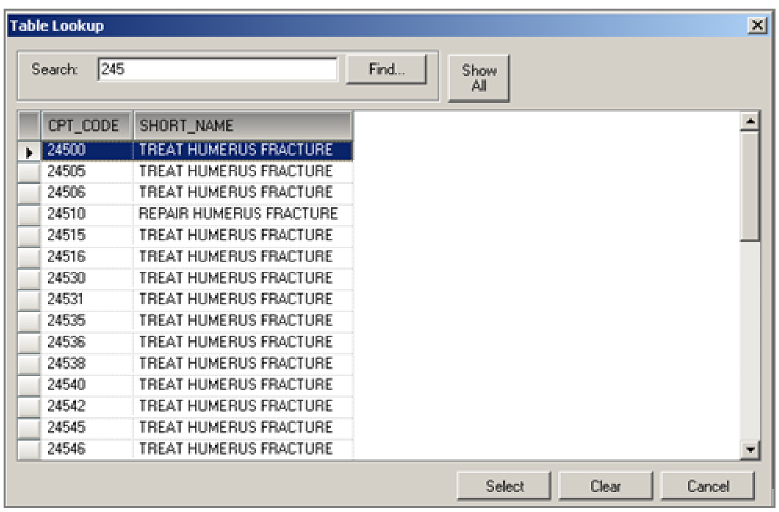


Figure 4-65: Sample retrieval of a particular CPT code

4.14.1.3 Completing the Search

In either case, select a record and click **Select**. This will close the dialog and populate the field (on the form) with the selected record. (To exit the **Table Lookup** dialog, click the **Cancel** button.)

4.14.2 Clearing Data in Field with Ellipsis Button

To clear the data in a field with the ellipsis button (on a form), click the ellipsis button to display the **Table Lookup** dialog. Click **Clear** (on **Table Lookup**). This will close the **Table Lookup** dialog and clear the data in the field on the form. (To exit the **Table Lookup** dialog, click **Cancel**.)

4.15 Erroneously Tracked Events

Once an event has been Tracked, it cannot be changed to Not Tracked. The following process is used when you erroneously Tracked an event.

1. Go to the **Tracked** tab, in any view (Main, Panel, Patient Record) and open a CMET worksheet for the event you erroneously tracked. Click the **Add** button in the **Findings** area to access the **Findings** dialog.

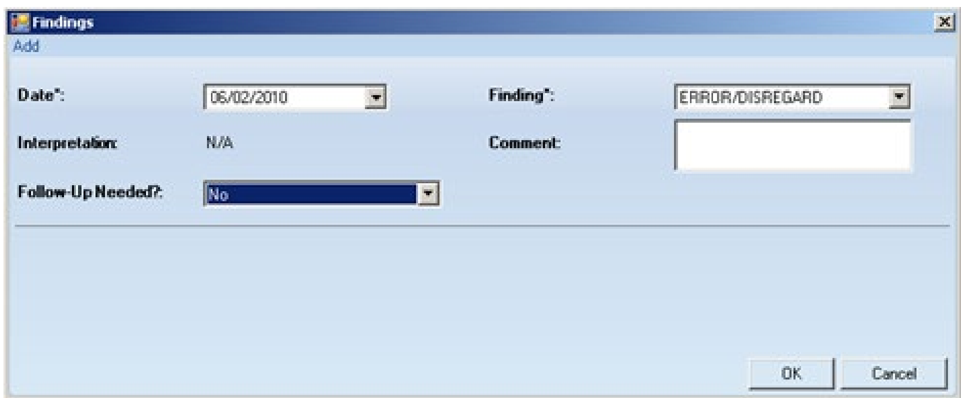


Figure 4-66: Sample **Findings** dialog populated

Choose the ERROR/DISREGARD option in the **Findings** field. Select No in the **Follow-Up Needed?** field. We suggest using today’s date for the **Date** field. Click **OK** to save and to close the dialog.

2. Go to the Patient Notifications area of the CMET Worksheet and click the **Add** button. The application displays the **Notifications** dialog.

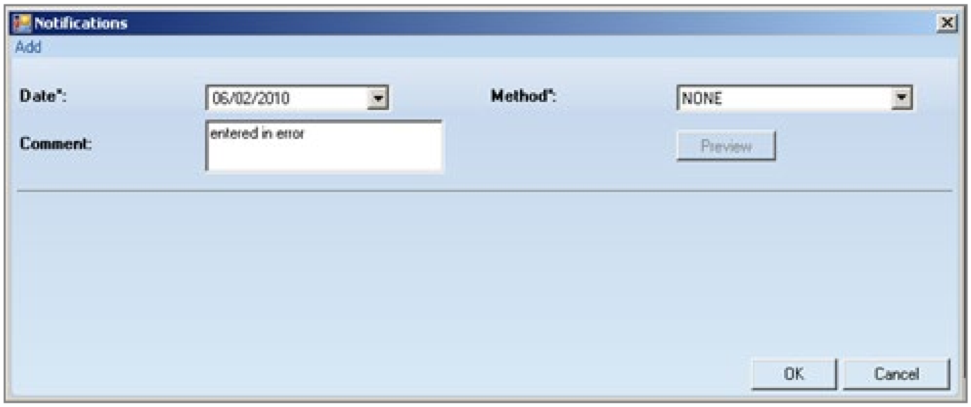


Figure 4-67: Sample **Notifications** dialog populated

Use the **NONE** option for the **Method** field. We recommend adding a comment in the **Comment** field and to using today's date for the **Date** field. Click **OK** to save and close the dialog.

3. The application will display the **Close Event** information message.

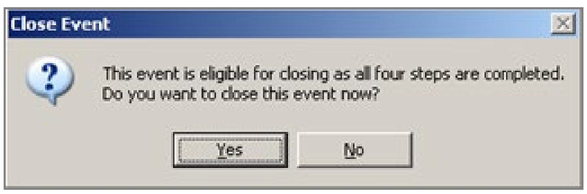


Figure 4-68: **Close Event** information message

Click **Yes** on the message. This closes the message.

4. The application will display the **RPMS iCare – Reason for Closing** dialog.

Figure 4-69: **RPMS iCare – Reason for Closing** dialog

Select the Other option for the **Reason** field. Enter a comment in the **Comment** field. Click **OK** to save and to close the dialog.

5. The application will display the **Confirm save to RPMS** information message.

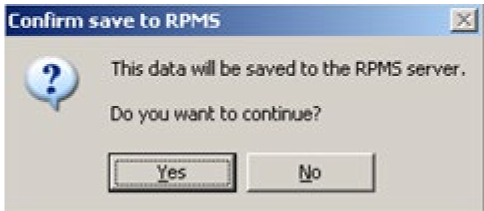


Figure 4-70: **Confirm save to RPMS** information message

Click **Yes** on the message to save the data to RPMS and close the message.

This process causes the particular event to have a State of CLOSED.

Glossary

Context Menu

The menu of options that displays when you right-click on an entity.

Designated Primary Care Provider

In RPMS, the provider name that is assigned as the primary care physician for a patient or group of patients at a specific facility. This is not a required function.

Free Text Field

A field where the user can type text, just like typing a note to someone.

Providers

Any staff member in an I/T/U facility who provides direct healthcare to patients, e.g., general practice or specialty physicians, registered nurses, social workers, physician assistants, etc.

Within RPMS, the term "provider" has different specific meanings. See definitions for DPCP, Primary Provider, and Visit Providers.

Reminders

Health Maintenance Reminders review patient data and alert the provider to procedures that might be overdue for the patient. Reminders can be based on age and gender and include typical clinical prevention measures, such as pap smears.

"Tagging"

A process to review the patient's data and categorize ("tag") the patient with one or more clinical diagnoses, such as Known CVD or Diabetes. Tags will be used to provide more accurate reminders that are prioritized more appropriately for a patient's multiple conditions.

Taxonomy

In RPMS, a grouping of functionally related data elements, such as ICD codes, that are created and maintained within the RPMS Taxonomy Setup application. Taxonomies will be used as definitions for diagnoses, procedures, lab tests, medications, and other clinical data types.

If you need a change or addition to an existing taxonomy, please see your CRS coordinator.

Tooltip/Hover Help

A common GUI element used to provide additional information to users. To display a Tooltip, hover the mouse pointer, without clicking, over a column heading or field.

Visit Provider

In RPMS, the provider(s) who cared for a patient on a specific visit. Each patient visit must have at least a primary provider entered. Visits can also have one or more secondary providers. The primary visit provider might or might not be the same provider as the patient's DPCP, and can change on each visit, depending on the visit type or the clinic staffing.

Acronym List

Acronym	Term Meaning
ARV	Antiretroviral
BH	Behavioral Health
BP	Best Practice
CDC	Centers for Disease Control and Prevention
CMET	Care Management Event Tracking
CPT	Current Procedural Terminology
CRS	Clinical Reporting System
DM	Diabetes Mellitus
DPCP	Designated Primary Care Provider
DSPM	Designated Specialty Provider Management
DX	Diagnostics
EDD	Estimated Date of Delivery
EHR	Electronic Health Record
ER	Emergency Room
GPRA	Government Performance and Results Act
GUI	Graphical User Interface
HIV	Human Immunodeficiency Virus
HS	Health Summary
HX	History
I/T/U	Indian Health Service, or Tribal or Urban Indian health programs
ICD	International Classification of Diseases
IHS	Indian Health Service
JPEG	Joint Photographic Experts Group (image format)
NND	Nationally Notifiable Infections Diseases
OIT	Office of Information Technology
PCC	Patient Care Component
PDF	Portable Document Format
RCIS	Referral Care Information System
POV	Purpose of Visit
RPMS	Resource and Patient Management System
STI	Sexually Transmitted Infection
TIU	Text Integration Utility
URL	Uniform Resource Locator

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

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