

Division of Diabetes Treatment and Prevention

Diabetes Audit Training

Overview of the RPMS Diabetes Management System 2016

Karen L. Mundy, BS, MT (ASCP)
Cimarron Medical Informatics, LLC

Karen Mundy:

Hello! My name is Karen Mundy, of Cimarron Medical Informatics. I am a member of the 2016 diabetes Audit team, along with others from OIT and the Division of Diabetes Treatment and Prevention. In this session we will be covering an overview of the RPMS Diabetes Management System. This is the first of four recordings to cover the 2016 IHS Diabetes Audit and how to prepare.

The Diabetes Management System is just one of the applications in RPMS. This particular recording is not intended to cover the same information that we cover in a three-day diabetes management training class.

The Diabetes Management System can be referred to as DM or DMS or BDM. BDM being the programming name space used for all the diabetes management routines and globals. When you're at your facility, when you look at your menus, you may have an acronym of DM or DMS or BDM, so just to let you know that these are all referring to the same application.

We do have two versions of the Diabetes Management System. One is the legacy or roll and scroll in RPMS or on the resource tab on EHR. The second version, we call Visual DMS. It's a Windows-based tool, also referred to as a GUI, a graphical user interface. When you're looking at the Visual DMS, you're able to use your mouse to select action items. Our current version will be 2.0 patch 9, which is due to be released either the end of this month or early in February.

The components of the Diabetes Management System exist primarily for the maintenance of the diabetes register. The diabetes register is one of the registers that you can have in the case management system. But it has attached to it several applications or several options in order to print specific reports for your diabetes patients or to print specific diabetes health summaries or to also do your automated audit of the diabetes standards of care. So again, it offers you the capability to track your diabetic patients, to access all PCC clinical data for those patients in the register, to perform your audit, to display a diabetes health summary which has diabetes specific health maintenance reminders, a flow sheet, and recent diabetes-related lab results and measurements, and it includes a diabetes supplement, which indicates the Standards of Care for diabetes.

Also in the Diabetes Management System are various canned and ad hoc reports that were put together specifically for the Diabetes Management System. You have follow-up letters, (lists and letters), master lists, lab and medication lists, the ability to run a report to find those inactive patients that are on your register, to find those patients that have a diagnosis of diabetes but are not on your register, and then there is an ad hoc report generation tool called "GEN" or general retrieval.

The big part of this Diabetes Management System is the ability to be able to run your program audit, the tool for assessing the quality of diabetes care. It requires the establishment of medication, laboratory test, and education taxonomies at the local level. It permits you to audit an individual patient's care or all of the patients in the register.



And again, you have the ability to generate a variety of reports in the audit, an individual audit report for a patient and/or a cumulative statistical summary for all patients. It allows you to create your audit export file and, relatively new, is the ability to run the SDPI key measures report. All of these reports are dependent upon quality data recording by your providers.

There's a standard diabetes health summary with the Diabetes Management System, and this provides you with your clinical reminders for the diabetes periodic screening: the diabetic foot exam complete, the diabetic eye exam, a dental exam, cholesterol, triglyceride, creatinine and the UACR laboratory results. It also allows you to be able to set up a diabetes flow sheet so that you can monitor certain lab tests or measurements in a flow sheet manner. It also gives you a diabetes information supplement at the end of the health summary, which is very similar to the diabetes audit report. It has all of the elements of the audit, however, the logic is just slightly different, maybe a little bit more forgiving than with the audit report.

In order for the diabetes information supplement, which is similar to the DM audit report for a patient, to print or to display on the diabetes health summary, that patient must have a diagnosis of diabetes on the problem list.

The Diabetes Management System requires certain security keys and Fileman access codes. The Fileman access code of M is required. Security keys needed are BDMZ MENU in order for the Diabetes Management System to display on your primary menu. The BDMZ REGISTER MAINTENANCE key is needed if you are the person who is maintaining or is the manager of the diabetes register. This key that allows you to add users, it allows you to remove users, it allows you to add patients, and it allows you to make changes in the register itself. The BDMZ EDIT key allows a user who holds that key to be able to enter or change information on the register for a patient.

In order for you to be able to look at a register or to access a register, you must be an authorized user of that register. As I mentioned early on, this diabetes management register is simply one register under the case management system but a variety of reports and menu options have been put together specifically for the Diabetes Management System.

The RPMS Diabetes Management System Menu has several menu options underneath it. As you will note, some of the menu options listed like RP for Report, RM for Register Maintenance have three periods at the end of their name. What that means is that if you were to select RP for report, what will come up is yet another list of menu options to select from. For those menu options that do not have those three periods following the name, that means that once you select them, you will be expected to perform a task. There will be no other menu options below them.

Patient management is where we go to review and edit by patient. So we'll be looking at a single patient and be able to look at various items for that patient related to their healthcare. It will also allow you to edit register information.

Under Report, there are various reports that are available, both canned and ad hoc reports and we'll be looking at those in just a moment.

Register Maintenance is where you can make changes to the register, add authorized users and such.

Delete Patient from a Register, I will caution you if you're thinking about using this particular menu option, you'll see that it does not have those three periods, so once you pick DEL, it's going to expect you to enter in patient information, whether it's the patient's name or health record number, in order to delete them from the register. You should only use this particular option if you are totally certain that that patient should not be on the register at all. If it's simply that the patient is no longer coming to your

clinic or is a transient type of person, then I would recommend that instead of deleting them totally from the register, you go into Patient Management and change their status to inactive or transient.

Letter Management, we won't go into this too much in this particular recorded session. But that is where you can create or edit letters that you can use to send out to your diabetic patients. These letters are linked to the diabetes register, so you can use those diabetes specific letters to send out appointment letters, reminders and such to your diabetes patients on the register.

If you have more than one diabetes register at your facility, you can use the SR to switch to another diabetes register.

The DA menu option is the Diabetes QA Audit Menu and you'll see that once we go in to that, there are a variety of audit menus for the various years that we've been doing the audit, plus this is where you can look at your audit logic.

The last, DMU, Update Diabetes Patient Data, this menu option is used to be able to enter diabetes related data, such as immunizations or lab tests that were not picked up in PCC data entry or by your EHR data entry, and that were probably performed offsite. To get that information updated, you would use the DMU. DMU, once you enter information in there, it will update your PCC data. So again, you want to be cautious when you're using DMU, that you're not duplicating data entry that may have already been put in via PCC or EHR.

Lastly, I hope to be able to display for you the Visual DMS. We've been talking about the roll and scroll side until now, but the Visual DMS is a Windows-based tool where you can use your mouse. The menu options are on the tabs that are on the top of the Visual DMS window, it looks like what you see on your primary DMS menu in roll and scroll. But then you've got all of the underlying menu options listed down the side with the ability to open up by clicking on the plus sign to see all the various pieces that are underneath each of the other menu items.

I'm going to break out of this presentation and move onto a training database, to be able to demonstrate some of these pieces for you.

This is an ICD-10 testing database. Because of the keys that I have assigned, I have access to all the possible applications within RPMS. But the one that we're going to be working on is BDM, the Diabetes Management System. As I mentioned initially, your acronym on your database could be BDM, it could be DM, or it could be DMS - that varies with how your systems are set up.

You can select a menu option by using the acronym by entering in DIA in order to pull up the Diabetes Management System. You'll see here I have access to three different diabetes registers. I'm going to be using the one KLM diabetes register only because it's a smaller group of patients. So, hopefully, most of our reports won't take very long to run. Many of you will have just an IHS DIABETES register or, if you happen to have several divisions within your database, you may have separate registers for each one of your divisions, and if you're given access as an authorized user to those registers, they will show up as well.

We're going to first look at PM, for Patient Management. You need to pick a patient and you can enter your patient with a normal standard naming convention of "last name, first" or you can use a health record number. What we see above the big bold black line is the register data that is contained for this particular patient. The patient name and demographics all come from Patient Registration. The status is the status of the patient within the register. We have several other fields that are totally optional, whether you want to use is up to your DM team. WHERE FOLLOWED is a field to use if your patients are followed at an outside location, away from your facility. This entry must be in the IHS Location file. It is not free text. Your REGISTER PROVIDER field can be used if you have a particular provider that monitors the register, you can put their name in here. If you're using case managers, then you can

enter in a name of a case manager if your patients are perhaps tracked in groups by particular folks. The register provider and the case manager must be in your RPMS system in order to select them.

The CONTACT, however, is a free text field. If there is someone in particular that you would need to contact regarding this patient's care or perhaps it's a relative or a daughter or an interpreter that you need to contact whenever you need to relay any information about this particular patient.

The ENTRY DATE is when this patient was put in to the register. The LAST EDITED DATE, when they were last edited. The DIAGNOSIS field is the diagnosis within the register. You can add a diagnosis in the register as well as complications in the register. This may or may not be what is in PCC for this patient. This is contained, these two pieces, the diagnosis and the complication, solely in the register as well as the onset date within the register.

Underneath this line are our action items. These are the actions or the options that we can use while we are in patient management. You select them by entering the corresponding number. It says to enter two question marks for more actions, so I will go ahead and show you that just so you can see what other possible actions can be performed. It gives us some help text as to how we can use this List Manager. You can use the plus keys or the up and down arrow keys to move within the window. If there is more information to the left or the right, then you can shift your view by using the chevron keys either to move to the right or to the left of the screen. You can move to the first screen, the last screen or you can even print or search from this particular menu.

I'm going to go ahead and edit some register data. You'll see that we're not able to do anything to this upper part of the demographic data because that is maintained in patient reg. But it does give us the opportunity to change the patient's status, and if you type question marks, you will see that choices are shown down here at the bottom of the screen: active, inactive, transient, unreviewed, deceased, non-IHS, lost to follow up or non-compliant.

When you move through this particular window, you can use your tab key, you can use your up and down arrow keys or you can use your enter key. I recommend that using the tab or the up or down arrow keys in order to move through the window and you can change these fields as need be. If you are using local options for your audit, then you would enter in the code and the text of those local options for your audit. To break out of this, you can either go all the way down to the bottom of the screen, save and exit, or you can enter an up hat, (a shift+six) to move down to the bottom, they both work, and save and exit. So you can use any of these other action items. Let's say we want to look at Comments. I want to mention this because case comments are only found within the register. This is the only place that this information is stored. So you might want to use it if you want to relay information to the next person that might be reviewing this patient's case. You might want to go ahead and enter in a message with the date and what follow-up might be needed on the next visit, so that the next time someone looks at the particular comments, they will see that there is something that needs to be done on the patient.

You can look at the health summary. There are several types of health summaries. The one that we're going to use is the Diabetic Standard. It takes a little while for the information to load up. It's gathering all the information for all the components on the standard diabetes health summary.

Many of you are probably already used to seeing a health summary, so I won't belabor this too much. This is the browser mode, so again you can use your up and down arrow keys to go line by line, or you can hit the enter key to go to the next screen, or you can use the LS to go to the last screen of FS to go back to the first screen. But the other nice tool here with the browser mode is the ability to search, so by doing SL to search my list and enter in LABORATORY. It will take me right to the laboratory data that is on the health summary.

You can also print. So here we did select the browser mode to look at it, but if we want to print this now, then we have those two print action items, either PL to print the whole thing or PS to just print the screen. I'll do these two question marks again, and you'll see that we have the PS, to print just the screen, or PL, to print the entire thing and send it to a printer.

We'll go ahead and look at through the rest of this particular health summary. Our immunizations don't work on this particular health summary because the immunizations forecaster is not set up on this database. But at your facility you would be able to see the immunization status.

On the screen here, is the flow sheet that is available on the diabetes standard. You can modify this in order to capture whatever pieces of information you would want to capture as a flow sheet. On this particular flow sheet we get to see the blood pressures, the weight, the hemoglobin A1C, creatinine, UACR, cholesterol, and the HDL. So if your patient has had any of these recorded in PCC, they will show up on the flow sheet. At the very end, if the patient has a diagnosis of diabetes recorded on the problem list, they will get this diabetes patient care summary. This summary mimics very closely the audit status on this patient. The items are the same but the logic is not exactly the same, but it does give you the opportunity to see the patient's status if you were to run the audit at the time that you printed up the health summary.

At facilities where I worked before, we would print up the diabetes patient care summary for the provider for the patients coming in the next day to be seen. So the providers could review it and perhaps highlight the things that needed to be addressed when the patient did come in for their appointment.

So on the Summary we're capturing all the pieces of an audit. You get to see the onset date and where that onset date is taken from. In this instance, it is taken from the problem list. You can also see height and weight, exam, diabetes medications, ACE inhibitor, aspirin use, and statins. And you'll notice that the ACE inhibitor and the statins are in the past six months whereas the aspirin is in the past year. The reason for that is, generally speaking, when aspirin is prescribed it's given in a large amount, 360 or 365 tablets to last a year. So we go back a whole year to look at that particular prescription.

Exams, depression screening, immunization information, and the most recent laboratory results also display. When we see this, we see the name of the laboratory test as we see it on the audit, the result, and when it was done. And what also is displayed is the actual RPMS lab test name as it is in your database. You can see here these particular tests have an underscore in front of them. This one does not. This one has SQL in front of it. These are various naming conventions that can be used in your facility.

So I will show you in a little bit how we can determine how tests are named in your facility. The tests used for the DM Supplement and Audit have to reside in a taxonomy in order to be recognized as an A1C, or a creatinine, or an estimated GFR, etc.

Here we see our diabetes education provided, whether it was a dietician's visit or whether it was an actual topic that was given.

You can also run an audit on your patient from PM just for this one patient. You would use your audit date for 2016, which is the end of December, 2015. You have the option of whether or not to print the name of the patient and whether you want to print or browse it.

We're going to go ahead and browse to the screen. Here again, we do see what an individual audit would look like on this patient if you were to run it from the audit section of the DMS application. So we see all the pieces of the audit. You see the date of the diabetes diagnosis, the date on the DM register itself, the date on the problem list and the date it was first recorded in PCC. You'll see the type of

diabetes, whether it was type 1 or type 2, how it listed in the register, what the ICD-9 Code is on the problem list, and then whether your purpose of your visit in PCC shows it as type 1 or type 2.

We see all the tobacco screening. Then we see the measurements, height and weight, blood pressure, exams and when they were performed, education, mental health and DM therapy. If no DM medications are being prescribed for your patient then it automatically defaults to diet and exercise alone. Then displayed are the ACE inhibitor, aspirins, anti-platelet, anti-coagulation, therapy, statins, TB testing, and whether CVD has been diagnosed. This was a new element last year and displayed is where it is recorded. Here, for this patient, it's recorded on the problem list. Then follows the immunization information, any laboratory data, and urine protein testing.

At the bottom of the supplement is the combined measure. The combined measure for this year is that the A1C is less than eight, statin has been prescribed, and the mean blood pressure is less than 140 over less than 90. This particular patient does not meet this measure. The A1C was 12, statin prescribed is no, and the mean blood pressure was 130 over 80. So we did meet the blood pressure criteria but not the other two, so it turns out to be a no.

We see that the patient never had an EGFR or UACR.

There are no local option questions. And again, because this is a browser mode, you can use the PL to go ahead and print this out to review on paper if you desire. Here we will enter "Q" to quit.

One of the options that changed last year is that we no longer can edit the problem list from patient management, but we can display the problem list for your patient. Here displays the problem list, when it was reviewed, when it was updated, and the various problems that are listed there.

When we use DMU, which we'll come to later, it asks for the problem ID. That's the number here listed on the problem list. So, if you need to change something in DMU. You would need to know which problem ID that pertains to. And that in this case would be DEMO 2.

Next, we'll look at some reports. There are two new reports on this menu for this year, the DXNR which is Patient with a diabetes diagnosis and not on your register, and INA, List possible inactive patient in your DM register. So, when you're going to start to clean up your register, you might want to consider running this INA so that you can see those patients who have not had a visit in the one year timeframe for the audit, so that you can change their status to inactive or unreviewed, so they would not be included in your audit.

Most of these particular reports listed here are canned reports, meaning that you select one and you'll be asked for some specific information on the patients that you want to review. But then the display is automatic; you do not get to determine how you want the display to show. I'll go ahead and run the INA on my register. As I mentioned, you'll be prompted to answer a few questions as you go through this. This is asking me, do I want a particular status from my patient, and yes, I want to look at my patients that are considered active in the register. Then if I want to look at a list of clinics that I determined to be my primary care clinic, you can enter a clinic one at a time or use a taxonomy.

Again, we would go through this more in-depth in a classroom setting, but I'll let you know that there is a GPRA group of primary care clinics that you can start with. In the BGP taxonomy of clinics, that is the name space for GPRA, we have general diabetics, internal medicine, pediatrics, well-child and family practice that automatically get selected. If I want to enter in endocrinology, it will then add it to my group.

Then you want to look for visit dates. For the 2016 audit, you're going to use the year 2015. So, we're going to go back to 01/01/2015 to 12/31/2015, and we're going to browse. Then it says: "Do you want to include all patients or do you want to exclude your demo patients or include only your demo

patients?” We want to exclude them. I only have one patient who is in my register, who has a status of active but their last visit says 08/06/2015. Well, they had a visit in 2015, but why would they show up on this report?

We'll want to go back and look at that visit. Obviously, they did not have a visit in any of our primary care clinics because otherwise he wouldn't be on this report. So, I'm going to hop back to PM and put in my patient, and I want to look at his last visit. What do we see here? We see that there was a visit to the clinic laboratory services and we can see that a lab test was done. This was a lab-only-visit, so it did not get captured as a visit in a primary care clinic.

So, we'll say, “Well, maybe we better do some more research on this patient” and “Do we need to keep this patient on our register as active or not?” If we decide not, what we can do here from PM is to edit our register data, number one, and change our patient to unreviewed. That way this patient will not be included in the audit. They have not had a visit to a primary care clinic in the past year, but we're not removing them, we're just changing them to unreviewed and then we can come back and check our patients who have had their status changed to see why they have not been coming into clinic, to a primary care clinic.

We'll go back to reports. I will show you a follow-up report. The follow-up report looks at many of the items that are on the audit. It allows you to look for those patients that are due now or within the next 30 days for any of these particular elements. How this is set up, is first in categories of all exams or procedures, all patient education, all immunization, and all lab tests. Underneath are the components of each large category. We can do a report on all of the exams at once or we can pick by exam.

You run your audit, your cumulative audit, and you see that you're delinquent in a particular piece, perhaps creatinine. Your creatinine counts are really low. Then you can run this particular report to see who has not had their creatinine.

I'm going to go ahead and enter a 45 for creatinine. I'm going to use my register members or if I already had a cohort of patients or templates, I could use that. But I'm going to use my register members and I want them to be active. Here, when we see diagnosis, this refers to what is recorded in the register. These are not PCC diagnoses. This is how the patient got recorded in the register, if they did at all. Not all facilities use that particular field in the register.

So for training purposes, we tell folks just select all diagnoses unless you know for certain that someone is maintaining that particular field in the register. We don't need to see our list of upcoming appointments, but if you are using the appointment system, you may want to do that so you can see when the patients are due for their next appointment.

We can select how we want the follow up printed by; we're going to select by community and we're going to select all communities. So I just hit enter and you can do a follow-up report alone, just to get the report. Or you can go ahead and generate your letters, if you have a letter set up. Or you can do both. I'm going to go ahead and do both. We only have one letter in our system at this point. I'm going to go ahead and select that one. I'm going to exclude my demo patients and then I'm going to send it to the screen. This is one of those places where we're not allowed to use a browser mode. So it's a little bit inconvenient, but we're going to go ahead and show this report to you.

Here we have five of our patients that are in our register that are either due now or within the next 30 days for a creatinine. We see here patient, Alfonso, has not had a creatinine at all, and we see that Caitlin, her last creatinine was back at February 2013. I go ahead and hit enter. Now, our letters will print.

So this is a letter that was created in the letter management of DMS. You create your letter using certain letter inserts in order to be able to pull-up dates, to pull-up patient name and address. Also, in

this particular letter, we have some creatinine education that is provided. Here, we're going to see displayed in the letter: Creatinine level is done at least yearly information to provide the patient to let them know that they need to come in, in order to have their creatinine drawn. Letters can be created for any of the follow-up needs.

The other one I want to show for you is under RR. You see RR register report has those three periods. So there are more reports yet under there. I want to show you your master list. You're going to pick your register and you can select particular status if you want. I'm not going to. You can restrict by age range or communities. I want all my communities. You can select out by sex or gender whether you want to look at a particular case manager or where followed, and then how do you want to sort it. I want to sort this by register status. You can have a secondary if you want. I'm just going to bypass that, and I'm going to browse. I'm going to exclude my demo patients.

Here we get to see the list of patients that are in our register. Now, I have a total number of 11 patients in this register. Six of them are considered active, and we do get to see the date of their last visit. I'm using my right arrow key to move on over, shift over so I can see the next review date that was entered in the register. There, my six patients who are active. They were seen in the last calendar year. Then we see some that are marked inactive. So you might wonder why these are marked inactive when they were seen. So you might want to do some chart review on them to see why they were determined inactive.

Then we have that one that we just put in as unreviewed. So this is a way that once you do change register status (to perhaps unreviewed or inactive), that you can look to see which patients actually are in that status. The GEN or the register patient general retrieval, you can do the same type of thing as the master list, except that you can select out particular items about your patient that you want to either select them by or to print, where as you know, with the master list, we didn't get to designate what we could print. It was a canned report, and it just printed what it was programmed to print.

The other report that is relatively new to Diabetes Management System is the LMR which allows you to list your labs and medications used at this facility. And for those of you that are not familiar with laboratory test names or not familiar with medication names, this is a very handy report to look and see what labs and medication are used at your facility.

So I'll do LMR, I'm going to look first at my lab tests and I'm going to go to 01/01/15, the beginning of my audit year, to 12/31/15 and browse. And what this is going to show us is a list of all the lab tests that have been reported within that timeframe, and it will also show us whether or not it has been included in one of the taxonomies. There is a separate recorded session on taxonomies. But I wanted to show you that this list will list all your test names, and you can see right from this one, there are various naming conventions that the laboratory folks have selected. This one has an asterisk in front of it. This one has two dots in front of it, which you would not know if you were just looking for a particular test. So, it's good to be able to look here to see what their naming conventions have been. We see the name of the test. We see the internal entry number. We see how many of them were done. If there was a unit of measure, it's there. And if there was a result, it would be there.

Now, this particular first one, the IRON/TIBC, is a panel so you're not going to have a result. Here we have the albumin creatinine ratio; it has a result. We also see underneath, DM audit quantitative UACR, that means that this test is put in the taxonomy for the quantitative UACR.

We have internal entry numbers. This is a way to identify tests uniquely by where they sit within the laboratory test file. So, you might find it useful to note the IEN or the internal entry number if you need to modify a test to get it into a taxonomy or to remove it if it shouldn't be there. So for example, this ALT should be in our ALT taxonomy that's used for determining statin use. And I can remember ALT pretty easy but if it was a long drawn-out name, I might want to just go ahead and grab the internal entry number to use to update the taxonomy.

Here, we see that a CMP is also in the ALT taxonomy and that is not correct because we do not put any panels in our diabetes taxonomies. But I can show you later where we can also find those mistakes.

We're going to look at register maintenance but not delve into it too much. When you go into register maintenance, this is where you can set up the users, those people who are authorized to use it, add patients from a template, and, if you've gathered up a template of patients as a group, add to your register. This is where you update to maintain your complications list and set up your flow sheet. Here, you can also add or edit your DMS letters (besides in the letter management). You can edit a primary care provider, the designated primary care provider for your patient as well. In order to do any of these you have to hold the BDMC REGISTER MAINTENANCE key.

For letters, you can add or edit your DMS letters and these letters are associated with those patients in your register, and then you can print them from this particular menu option. We're not going to go into creating letters, but I do want to show you the letter inserts that are available to incorporate into your letter in order to be able to extract from the database particular information. So here, you can see, these are the inserts that are available to automatically pull in a patient's first name or last name, the address, if you want them to show on the letter, and the date of the letter.

And then we have various education topics that are covered. So if you're creating one letter for foot exam education, you're having a podiatrist come in for a special session and you find those folks that need to have a foot exam, you can create a letter informing them about this particular visit and that if they'd like to make an appointment, the education insert will explain what the foot exam is about.

If you want to look at the individual information -- I'll pick number 11. This is what the eye exam education is going to say: the diabetes eye exam is recommended at least yearly to detect problems that can lead to vision loss if left unrecognized and untreated, early detection is the key. So, were you to create a letter concerning an eye exam, you can incorporate this insert in there without having to type all that information into your letter.

SR, if you have a different register, you can use SR to switch to a different register.

DA, this is where all of our audit options reside. We have one option for every audit since 2009 listed on here. So, if for some reason, you wanted to go back and run an audit on your current patients back using older elements that were covered at that time, you can do that. But what I want to show you here in particular is your audit logic. If you run your audit and you find that you are delinquent in something or maybe your numbers are too high, maybe you have something included in a taxonomy that shouldn't be, then you can look at your audit logic for that particular year and you see all the elements that are covered on the audit and then you can select which one you need to review and to find out where you might be missing some data. If I'm going to go ahead and look at dental exam for example, I'm going to do "S" to select and then "Dental Exam" and it's going to show me the logic in the order that the software looks.

It first looks for a dental exam code of 30. If it's not there then it goes to look for visits to the dental clinic, and that it's not a no-show. If it doesn't find a hit there, then it goes to visit with a dentist if it's not a no-show. And then if it doesn't find anything there, then goes to look for a CPT code from the taxonomy of dental exam CPTs. This is new with the 2016 Audit.

If you just wanted to print a diabetes care summary, that piece that goes underneath a diabetes standard health summary, that last page, then you can also run that directly here from the DA menu.

We again will cover more on the actual audit itself in separate recording, but here, we have the opportunity to check our taxonomies before we run the audit; update them if we need to. We can look

at any of the taxonomies that are already set up to see what's in them. Let's say we just want to look at the ones that we locally populate, number 15 is the creatine kinase taxonomy for laboratory tests. You have to first select "S", and then the number, and we see that here we have all of these CK tests listed in this taxonomy. This is a locally defined list of the various CK or creatine kinase tests that are performed.

You will see that we also have CPT taxonomies, ICD taxonomies, lab LOINC taxonomies, operation and procedure taxonomies; those particular taxonomies are prepopulated for you. You do not locally define them. The drug taxonomies, the laboratory test taxonomies and the Patient Education taxonomies can be locally defined.

And then lastly, we're going to look at DMU. This is where you would be able to populate information on your patient if this patient information is not already collected in PCC data entry or EHR. This might be for information you're gathering from your patient before they came to your clinic, their immunization information that was not performed at your clinic but you want to go ahead and get that in there. Perhaps they got their pneumococcal vaccine or flu shot at Walgreens and you want to go ahead and get that captured into PCC but it didn't actually happen at your facility. Then you can enter it into DMU. And it does tell us right upfront the data you enter for the above patient will be updated in the PCC database, and "Do you want to continue," and we'll say, yes.

Now it's telling you one more thing. If you want to update the DM date of onset, then you have to have the patient's DM problem number available in order to enter that in. And if you'll remember, I showed that to you when we looked at the problem list for the patient under PM, we saw that DEMO2 was the number. Then if we needed to update the date of onset, we would need to have that number in order to do it.

So we see here where we can enter information for our patient and let's say we want to just go ahead and update a flu vaccine on this patient.

I can use tab, I can use the up and down arrow keys, to get to the Immunization field, and I'm going to say, yes. And I'm going to go ahead and update the influenza. And let's just take number three and the date that it was given. I'm going to go ahead and say that this was given back in November at Walgreens; close and then I'm done. So, I can do my "A" or caret, to "shift 6", to go down to the bottom, save, and exit. And you see that it is updating the PCC database so that this will be in there. It will be recorded by the date that we gave for the flu shot.

It does give us the opportunity to enter in any patient refusals or services not done. The only refusals we capture in the DMS audit now would be for immunizations, if the patient does indeed refuse an immunization.

Now, what I'd like to do is to show you some of these options in Visual DMS.

When you open Visual DMS, the first thing it showed you, and it just zipped on by, is that we are on patch 9. I'm going to have to enter in my new connection because it's not already here. But at your facility, you will already have this in your system and this actually displays on your desktop.

And then, you're going to enter in your access and verify code just like you do in roll and scroll with the exception that you have to try to remember not to hit the enter key after the access code but rather tab or use your mouse to move down to the verify code option.

And I apologize I cannot make the screen any larger. I'll move it to the center; maybe that will help a little bit.

If you have more than one division at your facility, you'll have the list of them here to select from. We only have one, and I'm just going to click OKAY, and then it will bring up for you your list of registers that you have access to. I'm going to go ahead and just select mine.

We see across the top, tabs to select a patient, to delete a patient, to change your register. If we're running reports, we have tab here to show us report status, and exit the system gracefully. We do have help texts, and we do have an about tab.

When you look at the about tab, you will want to again look and see -- it flashed by too fast for us earlier-- that we are running version 2.0.9. And your DMS Visual has to be at the same patch level as what is in RPMS. If it's not, you will get an error immediately trying to open it because you will not match up with the patch level in your RPMS roll and scroll.

We have a lot of help texts. Here we go. And it's based upon what you see on that current page of the help text that is available. So if you needed more information, just on Visual DMS or in the patient management portion, or reports, or register maintenance, or the audit, or any of these particular components, you would just click on it to view your help text.

As with the roll and scroll, before I can do anything in patient management, I have to select a patient. But if I open this up, expand the entry, these are the pieces, or the action items, that we saw under patient management that had numbers associated with them. Here, you simply just need to click on the action item in order to look at that particular item.

Before picking patient profile, I must select a patient. I'll go ahead and select the person I've been working with here. I can highlight the patient displayed and it will put the patient name down at the bottom of this window. So, anything you do within these action items will pertain to the patient listed at the bottom of the screen. We can look at the profile, and we'll see the register data up top that is greyed out. We can't change any of this as it is patient registration information but we could change the primary care provider. We could change the status by clicking on the down arrow. We can select to add a case manager, or register provider or where they're followed. And where followed, also I didn't mention, does need to be entered in your RPMS system as a valid location, so this is not free text for where followed.

But your contact information is free text, so you can enter in maybe something like if you needed to make sure that there was contact information for this patient. Anything that is greyed out here, you can't change. But you can change, perhaps, our next review date that we want to see her in three more months, so maybe just go one, two, three. Or next a reminder for next review date. Then, you have to save. Once you've saved, then you can use the "X" to get out of this particular window.

So, all of these particular items work the same just as they do in the roll and scroll. The Health Summary and any of the other items that can be displayed in a report format are put it in Microsoft Word format.

Here, we see we've got some wrap around so I can change the layout, and then you can print this if you'd like, or just look at it. All the pieces, the same components that we saw in the roll and scroll RPMS Health Summary, including the flowsheet, are present, and then at the end is that diabetes patient care summary.

You do not want to save these reports to your desktop or in your personal documents. This is patient health information that is protected. So you need to go ahead and exit out and don't save.

If you wanted to print it to a printer in your facility, just make sure that you're either printing to a secure printer in a secured environment and/or go pick it up immediately once you've printed it out.

What's available on the Visual DMS that we do not have in roll and scroll is the ability to graph some of your patient data. So if I wanted to graph Marie's labs -- I'm going to go back several years because I'm not sure how much data actually is on this particular database. You have to select your lab tests -- I just happen to know that our hemoglobin A1C start with SQL, so you put in a string of characters and ending string. And then I try to look for my SQL hemoglobin A1C -- it's not there. So, let's try underscore -- that's why it's good to be able to look at your LMR report to see how your tests are named. There we go, _SQL A1C, and then I'm going to say, OK.

We see this report as Microsoft Excel format where we do get to see the Hemoglobin A1Cs and when they were performed. We get the dates down here at the bottom and it is graphed out. You could then print this out if you wanted to, to give it to your patient to say, "You're not doing such a good job." Or, if it was going the other direction, say, "You're really doing a great job," just to give kudos where it's deserved. But, you do not save this to your own desktop or to your own documents but rather exit out to get back to your visual.

What we don't see in this particular set of menu options that we do have in roll and scroll is that letter option to be able to create and print letters. But we do have reports and these are the same reports that we see in roll and scroll. We do have register maintenance and we do have our audit along with the ability to display your audit logic. If we go into the 2016 audit, we are able to run the audit, check the taxonomies, update the taxonomies, review the taxonomies; view a SNOMED list is also there. We can run any of the audits for the previous years and display the logic.

Using Update Patient Data (DMU), we can update by patient the education topic, update the labs, update the meds, immunizations, health factors, any refusal for the patient.

Let's update the hemoglobin A1C. Let's just see if we such a test in here -- and we do. So we're going to go ahead and select it and then we can put in the results and when it was done, let's say that it was done on Saturday; then we can add it. So now, the patient will be credited for having a hemoglobin A1C drawn and it will save into PCC.

Then we can enter in a cholesterol, the results, and the date that it was done. We added it and it comes down here, it says not saved. You have to remember to press the save button in order to save it, and then you can exit out. We can also get help text here on how to use this particular window by just clicking on that question mark.

Again, this is the DMU, the diabetes patient data update, and it will now update PCC data. So, you didn't get the warnings on this one that you do get with roll and scroll that this is going to put data into PCC and it says it was filed successfully, and we're back to our menu.

So from this particular menu, you can also just create a health summary for your patient. You could do multiple health summaries on a variety of patients.

I'm going to go ahead and exit out of here because I just want to show you one other thing. I want to show the IHS website.

If you go to the Indian Health Service website and go to the tab for Providers and select Health & Wellness Programs and you can go to the Diabetes Treatment and Prevention, and then go into Audit information, and we have various tabs for information about how to perform your audit. We have a RPMS/DMS info tab that will allow you to pull down the original diabetes management user manual, in addition to the most recent addendum that's been posted. Since the software for the audit 2016 has not yet been released at the time of this recording, we still have the addendum for audit 2015 listed. But as soon as our software has been released, then you will have the addendum for audit 2016 there.

You may find this (2015) addendum of use now because it will cover many of the same topics that will apply to the audit 2016. And it is in Adobe format. If we go and look at the table of contents, we'll see the information in the addendum that pertains here to the 2015 but it will give you an opportunity to look to see how to perform some of these items now before the actual 2016 audit comes out so that you can start working on cleaning up your register or pulling up from your general population template. It also explains how to use your taxonomies, how to update them, and then how to run the audit itself.

So that concludes this recording for an overview of the DMS application. If you would please note on the screen that there is a link to the SurveyMonkey, and we thank you for attending this training session, and if you would please provide your feedback on this training. You'll also receive a certificate of completion. Thank you again, and have a good day.