RESOURCE AND PATIENT MANAGEMENT SYSTEM

Case Management System

(ACM)

User Manual

Version 2.0
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Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico
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1.0 Enhancement Summary

The new Case Management System (CMS) is an extremely useful patient care management tool designed to allow health care providers the resource to design and develop generic or customized Registers for a specific targeted patient population. The CMS is utilized primarily as a list keeper, but may include up to 17 Data Components for developing a Customized Register for patient care tracking purposes.

The Register Owner is responsible for entry of data. However, the CMS Package affords convenient full linkage to all Patient Care Component (PCC) data.

Based upon input from CMS Users, the new Case Management System is designed to simplify the creation and utilization of Registers and offers significant enhancements/modifications to the existing CMS Package.

For sites utilizing fairly simple Registers, there will be a complete conversion of data from the old system to the new. However, for those sites utilizing certain components of the current Case Management System, some of the data will be lost during the conversion to the new system. Our main objective is to make the system simpler to use; permit retention of as much data as possible from existing Registers currently operational in the field; and to eliminate complicated linkages between multiple data elements which were a source of error and confusion.

Listed below is a summary of the new CMS modifications and enhancements:

1. All major functions have been placed on the Main Menu to eliminate frequent jumping from the Main Menu to Sub-Menu Options. In addition, terminology of Menu Options has been improved.

2. Help prompts have been amplified greatly throughout the package. In addition, help prompts have been added to the “Register Creation” process for the purpose of describing each of the 16 CMS Data Components.

3. Registers are completely private with all data entered unique to each Register. All Supporting Lists (e.g., Complications, Interventions, etc.) are now tied to a specific Register so that the ‘User’ will only see the Lists associated with their specific Register when entering a ‘?’ for choice selection.

4. The ‘User’ is now able to indicate whether patients in a specific Register should be identified on Health Summary displays as being a member of that Register.

5. “LAYGO” during data entry has been eliminated.

6. “Categories” have been eliminated; only “Lists” have been retained. The Diagnostic Modifiers Component has also been eliminated. There is no longer a linkage between Interventions and the Diagnosis Components.
7. The Automatic Template Transfer of multiple patients into a specific Register now allows the ‘User’ to choose the Status for these patients; e.g., Active, Inactive, Unreviewed, Transient.

8. The “Appointments” Component has been changed to “Recall Dates” and simplified greatly. Linkage to Services and Resources has been completely eliminated. Each Recall includes Date, Referral Organization and Provider, Purpose, Recall Status, and Contact Person for Recall. The concept is that this is not an appointment, in the literal sense, but, rather, Recall Dates (often many months in the future) at which time the patient is to be contacted to schedule an appointment. The System will also print a “Recall Letter,” with a standard text (plus an additional customized text area) and the name and telephone number of the contact person. The ‘User’ is now able to view the letter structure and content prior to final printing.

9. The “Resource Directory” Component has been moved out of the Register management options and is now a stand-alone Menu Option for the purpose of building and printing Resource Directory Listings.

10. Major additions and enhancements have been incorporated into the Report Generation Menu Options:

   • Report extraction capabilities have been significantly improved throughout the Patient and Statistical Reports Menu Option.

   • A Report Generator, similar to the “Patient Lister” (PGEN) in PCC Management Reports has been added. This will permit selection, printing, and sorting of all CMS Data Element Components plus many demographic and clinical data types.

   • Creation of Templates may now be run in the background mode. A description of a Template may be generated on a printer or terminal screen, producing a brief listing containing the Register Name, Template Name, Creator of the Template, and Number of entries in Template.

11. For convenience of PCC data retrieval, the Q-Man Menu Option is also available within the CMS Menu Structure.

12. Improved Register Security/Confidentiality has been addressed in the New CMS Package. Only the "Creator" of the Register may modify the existing Register Structure, or assign an Authorized User to that Register, or Delete that Entire Register.
2.0 General Operating Tips/Suggestion

The following is the suggested sequence of operations in creating and utilizing the new CMS Package:

Operating Sequence:

1. Create a Register
2. Customize the Register
3. Add Authorized Users
4. Build Reference Tables (Supporting Lists)
5. Add Patients: Manually, one at a time; or Transfer lists of patients automatically from a Template
6. Enter specific Patient data
7. Produce Case Summaries
8. Generate a variety of reports

Helpful Hints or Caveats:

1. Start Simple
2. Minimize Tracking Items (Register Data Components)
3. Minimize Data Entry
4. Do Not Track Visit-based Data

Resource Manual Examples:

1. Screen Displays are provided as (step-by-step Guides) for each Data Type Component and each Menu Option.

2. The _______ Underscore Line and BOLD TEXT indicate ‘User’ Data Entry.
### 3.0 Menu Structure

<table>
<thead>
<tr>
<th>DL Display Supporting Lists</th>
<th>AD Add/Delete Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL  Complications List</td>
<td>AP  Add Patient(s)</td>
</tr>
<tr>
<td>LD  Diagnoses List</td>
<td>DP  Delete Patient from Register</td>
</tr>
<tr>
<td>CR  Diagnostic Criteria</td>
<td>TX  Data Transfer From A Search Template</td>
</tr>
<tr>
<td>SL  Services List</td>
<td>LTR Manage Recall Letters</td>
</tr>
<tr>
<td>EL  Etiology List</td>
<td>LTP Print Specified Recall Letter(s)</td>
</tr>
<tr>
<td>AL  Intervention Plan List</td>
<td>LTS Setup/Modify Letter Format Structure</td>
</tr>
<tr>
<td>ML  Medications List</td>
<td></td>
</tr>
<tr>
<td>RFL Risk Factors List</td>
<td></td>
</tr>
</tbody>
</table>

**RG Report Generation**

| CS  Case Summary Individual | RE  Add or Edit A Resource Directory |
| MS  Case Summary, Multiple  | RI  Inquire To A Specific Resource   |
| ML  Master List             | RL  Resource Directory (Detailed Listing) |
| PR  Patient and Statistical Reports | RS  Print Resource (By Services Available) |

**RD Resource Directory**

<table>
<thead>
<tr>
<th>GEN Register Patient General Retrieval (Lister)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVST Display Data for a Patient’s Last Visit</td>
</tr>
</tbody>
</table>
4.0 User Instructions

4.1 CR Create/Modify Register

Note: There are 16 different Data Component Types in the CMS. The system has been developed so you can customize your register to use only those data type components which are relevant to the content and scope of your register. It is important to note that you can return at any time to add or delete data types. When you remove a data type from a Register, none of the patient specific data you have entered or the Register Supporting Data is deleted. This process only deactivates that data type so you will no longer see it when you are managing a particular Register.

After answering a few basic Register Setup questions, the 16 Data Type Components will be displayed. You must first indicate whether you are ‘A’ Adding or ‘D’ Deleting Data Type Components by entering an ‘A’ or ‘D’. You can choose ALL the components by selecting Number 17; or by separating each number by commas. After you have indicated your selection, strike <CR>. Your new configuration will be displayed (<= indicates component selection). If you need to make changes, repeat the Add of Delete process.

In addition, Help Text for each Data Type Component is available by entering an ‘H’ at the Select Data Type prompt and selecting the desired Component number.
REGISTER SELECTION UTILITY

REGISTER: EMPLOYEE HEALTH

ARE YOU ADDING 'EMPLOYEE HEALTH' AS
A NEW CMS REGISTER TYPE (THE 19TH)? Y (YES)

REGISTER NAME: EMPLOYEE HEALTH REGISTER Replace
DATE ESTABLISHED: T (MAY 12, 1995)
REGISTER CREATOR: JARLAND, TONI M// Defaults to User-Change if Desired
HEALTH SUMMARY DISPLAY: ?

A "YES" entry will display a message on the PCC Health Summary that the
patient is a member of this Register.
Consider the CONFIDENTIAL nature of this Register before answering "YES".

CHOOSE FROM:
1   YES
0   NO

HEALTH SUMMARY DISPLAY: YES
BRIEF DESCRIPTION: ?

You may enter a Brief Description regarding the content & purpose of this
Register. Answer must be 3-65 characters in length.

****************************************
** CUSTOMIZE EMPLOYEE HEALTH REGISTER **
****************************************

1)   CARE PLANS              9) FAMILY MEMBERS
2)   CASE HISTORY            10) INTERVENTIONS
3)   CASE REVIEW DATES <**   11) MEASUREMENTS
4)   COMMENTS                12) MEDICATIONS
5)   COMPLICATIONS           13) RECALLS
6)   DIAGNOSES               14) REGISTER DATA <**
7)   DIAGNOSTIC CRITERIA     15) RISK FACTORS
8)   ETIOLOGY                16) SERVICES

17) ALL DATA TYPES

<** Indicates automatic selection of Register Component
'A' to ADD, 'D' to DELETE option(s) or 'H' for HELP ==> ADD
'<= ' indicates option already selected for this register. To select
several data types separate them with commas.
For example: ==> 1,3,7,9

Select option(s) ==> 1,2,4,5,6

Note: The Screen Display after Choosing Register Data type
Component above.
<table>
<thead>
<tr>
<th>Data Type Component Description Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CARE PLAN COMPONENT</strong> <strong>CASE HISTORY COMPONENT</strong> <strong>CASE REVIEW DATES COMPONENT</strong></td>
</tr>
<tr>
<td><strong>CARE PLAN COMPONENT</strong> The CARE PLAN COMPONENT consists of six specific plans. They are Medical, Nursing, Social Services, Educational, Mental Health, and Other. You may record care plans for any or all of these care plan categories. Plans are entered as free text fields of unlimited length.</td>
</tr>
<tr>
<td><strong>CASE HISTORY COMPONENT</strong> The CASE HISTORY COMPONENT is used to describe the events and factors which lead to the patient’s enrollment in the register. This component consists of three fields: Date of Onset, Place of Onset, and Description. The Description field is a text, or word-processing, field of unlimited length. It permits recording information that might not appear in the list of problems or diagnoses found on the PCC Health Summary.</td>
</tr>
<tr>
<td><strong>CASE REVIEW DATES COMPONENT</strong> The CASE REVIEW DATES COMPONENT permits entry of the date you review a patient’s case and the date you plan to review it again in the future. This component facilitates retrieval of all patients that have not been reviewed in a specified time frame, such as the past year, or those scheduled to be reviewed in a specified time frame, such as next month. The CASE REVIEW DATES COMPONENT is automatically included with every register.</td>
</tr>
</tbody>
</table>
** COMMENTS COMPONENT **

The COMMENTS COMPONENT is a free text field for entering miscellaneous information that does not easily fit into any of the other component types. Length of the field is unlimited. Despite the free text nature of the field, you can selectively retrieve information from COMMENTS using the Case Management Patient Lister Report. If you know of specific information, or terms, that you wish to retrieve, it is essential that you use the same terminology whenever you enter that term because retrieval will be accomplished by use of a text search. For example, you can find all patients with the term “AMPUTATION” or the term “STAGE IV” if you enter it consistently; i.e., case sensitive The term to be retrieved can be entered anywhere in the COMMENTS text; it does not have to be at the beginning of a line or on a specific line.

** COMPLICATIONS COMPONENT **

The COMPLICATIONS COMPONENT is utilized for identifying complications associated with the diagnosis or health problems for which a patient was entered into this register. For a diabetes register, for example, complications might include amputations, diabetic retinopathy, diabetic nephropathy, etc. In order to utilize the COMPLICATIONS COMPONENT, you must first build a list of complications that are appropriate for this register (BL Build Supporting Lists Menu Option). The COMPLICATIONS COMPONENT has fields for recording Onset Date and Comments for each complication.

** DIAGNOSES COMPONENT **

This component is for entry of the specific diagnosis or diagnoses that resulted in this patient’s inclusion on this register. This is not a field for entering a patient’s list of, or history of, diagnoses. For problem-specific registers, such as Diabetes, there is usually only one diagnosis entered. For a Children’s Special Needs Register, there might be several diagnoses for a particular child. In order to utilize the DIAGNOSES COMPONENT, you must first build a list of those diagnoses that pertain to this particular register (BL Build Supporting Lists Menu Option). This component also contains fields for entry of Onset Date and Severity for each diagnosis.

** DIAGNOSTIC CRITERIA COMPONENT **

If it is important to document how a diagnosis was arrived at, you may utilize the DIAGNOSTIC CRITERIA COMPONENT to do so. For example, you may wish to specify the objective criteria by which the diagnosis was made. For patients on a Diabetes Register, you may wish to identify one of the following criteria: Two abnormal fasting blood sugars over 140; Non-fasting blood sugar over 200 with classic symptoms; or Abnormal GTT. In order to utilize this component, you must first build a list of diagnostic criteria appropriate for this register (BL Build Supporting Lists Menu Option).
** ETIOLOGY COMPONENT **

The ETIOLOGY COMPONENT is used to identify the cause of the disease that resulted in a patient’s inclusion in this register. In order to utilize the ETIOLOGY COMPONENT, you must first build a list of etiologies appropriate for this register (BL Build Supporting Lists Menu Option).

** FAMILY MEMBERS COMPONENT **

The FAMILY MEMBERS COMPONENT is used only for registers pertaining to a health problem for which knowledge of family members is germane, such as breast cancer, diabetes, etc. Only family members registered on your computer can be entered in this component. For those family members entered, you may enter their relationship to the patient and whether or not they have a diagnosis related to the patient’s diagnosis.

** INTERVENTIONS COMPONENT **

The INTERVENTIONS COMPONENT is for recording actions planned or taken by you or others in the care of this patient. You may record type of intervention, date of intervention, results, and date due in the future. Examples of interventions are Diet Education, Smoking Cessation Program, Referral to Specialist, Exercise Program, etc. In order to utilize the INTERVENTIONS COMPONENT, you must first build a list of interventions appropriate for this register (BL Build Supporting Lists Menu Options).

** MEASUREMENT COMPONENT **

You may use the MEASUREMENT COMPONENT for recording the following measurement types:

- Abdominal Girth
- Audiometry
- Blood Pressure
- Fundal Height
- Fetal Heart Tones
- Head Circumference
- Hearing
- Height
- Pulse
- Respiration
- Temperature
- Tonometry
- Vision Corrected
- Vision Uncorrected
- Weight

You may enter only one of each type measurement for a patient along with the date of the measurement. If a measurement value already exists, you may delete it or replace it with a more current one.

WARNING. It is recommended that you NOT enter measurements in your register that are already collected in the PCC. This creates extra work for you that is not necessary since you have access to data contained in the PCC for each of your register patients.
** MEDICATIONS COMPONENT **

The MEDICATIONS COMPONENT may be used for entering medications the patient is taking which are germane to this register. You may consider using this component to record a class of medications for each patient such as Insulin and Oral Hypoglycemic for a Diabetes Register, rather than recording each specific drug type and strength. You may also enter a SIG (directions) for each drug or class. In order to utilize this component, you must first build a list of drugs or drug classes appropriate for this register.

REMEMBER - Do NOT duplicate all of the meds that are already collected in and available through the PCC.

** RECALL COMPONENT **

The RECALL COMPONENT permits you to establish a future date when you wish to contact the patient for follow-up relevant to this register. These are not appointments, but, rather, are approximate dates, often several months or a year in the future, at which time you wish to contact a patient, often for the purpose of making a specific appointment.

You may enter multiple recall dates for each patient. For each recall, you may enter Purpose, Referral Organization, Referral Provider, Appointment Date, and Appointment Status (Open, Pending, Missed, etc.). You will also be asked to enter a Contact Name (often your own name) and Phone Number to be used in Recall Letters, if you chose to use this capability of the Case Management System.

In Case Management Reports, you can get a list of all patients with Recall Dates in a specified time frame, and, as indicated above, generate Recall Letters to patients.

** REGISTER DATA COMPONENT **

The REGISTER DATA COMPONENT contains basic administrative data about each patient in the register. Available data fields in this component are Patient Status (Active, Inactive, Transient, Unreviewed, Deceased, Non-IHS), Priority, Patient's Primary Provider, Case Manager, Patient’s PHN, Facility Where Followed, and a Contact for the Patient. You may utilize any or all of these fields as your needs dictate. The use of Patient Status and Facility Where Followed is recommended. This component is automatically included with all registers.

NOTE: Only those patients identified with a STATUS = ACTIVE will be displayed on all Report Generations, unless you choose to ‘Sort By’ particular Status.

** RISK FACTORS COMPONENT **

The RISK FACTORS COMPONENT is for medical, social, educational, family, and environmental factors which may affect the care of this patient and/or the progression of the health problem(s) being followed. Examples of risk factors are: Heavy Smoker, Personal Hygiene, Distance from Clinic, Doesn’t Speak English, Alcohol in Home,
Doesn’t Keep Appointments, Poor Diet, etc. In order to utilize the RISK FACTORS COMPONENT, you must first build a list of risk factors appropriate for this register (BL Build Supporting Lists Menu Option).

** SERVICES COMPONENT **

The SERVICES COMPONENT is provided for documenting services required for each patient. These might include podiatry, physical therapy, speech therapy, specialty consultations, etc. To utilize this component, you must first build a list of services that are appropriate for this register (BL Build Supporting List Menu Option).

There is also a field in the SERVICES COMPONENT for recording the availability or status of the services you enter, such as Referral Made, On Waiting List, Unavailable, etc.

4.2 ** AU Add Authorized Users **

```
**************************************************************************
** CASE MANAGEMENT SYSTEM **
** VERSION 2.0 **
**************************************************************************

MAIN MENU

CR   Create/Modify Register Structure
AU   Add Authorized Users
BL   Build Supporting Lists ...
DL   Display Supporting Lists ...
AD   Add/Delete ...
DE   Data Entry
RG   Report Generation ...
RD   Resource Directory ...
QM   Q-Man (PCC Query Utility)
DEL  Delete Entire Register
LTR  Manage Recall Letters ...

NOTE: It is essential that those Users requiring access to a Register are added as an ‘Authorized User’ to that specific Register. It is equally important that those who do not need to view register information are prohibited from gaining access. This is accomplished through the process of adding authorized user.

SPECIAL```
NOTE: Improved Register Security/Confidentiality has been addressed in the New CMS Package. Only the CREATOR of the Register may (1) Add or Delete an Authorized User for each Register; (2) Modify the existing Register Structure; or (3) Delete that Entire Register.

** CASE MANAGEMENT SYSTEM **
REGISTER SELECTION UTILITY

EMPLOYEE HEALTH
REGISTER: EMPLOYEE HEALTH

****************************************
** EMPLOYEE HEALTH REGISTER **
****************************************
AUTHORIZED USERS

Select AUTHORIZED USER: JARLAND,TONI M TMJ

ARE YOU ADDING 'JARLAND,TONI M' AS A NEW AUTHORIZED USER (THE 1ST FOR THIS CMS REGISTER TYPE)? Y (YES)

NOTE: Enter the name of the User you want to add. The name should be in the standard FileMan format; i.e., LAST NAME,FIRST NAME. You may enter a ‘?’ to obtain a list of existing Users and a list of name choices. The name entered must be a ‘User’ on the System; ask your Computer Site Manager for assistance if necessary.

4.3 BL Build Supporting Lists

****************************************
** CASE MANAGEMENT SYSTEM **
** VERSION 2.0 **
****************************************

MAIN MENU

CR  Create/Modify Register Structure
AU  Add Authorized Users
BL  Build Supporting Lists ...
DL  Display Supporting Lists ...
AD  Add/Delete ...
DE  Data Entry
RG  Report Generation ...
RD  Resource Directory ...
QM  Q-Man (PCC Query Utility)
DEL Delete Entire Register
LTR Manage Recall Letters ...
Install IHS Diabetes Register
NOTE: Only those Reister Data Type components for the Register Selected will be displayed AND only those which require a Table List to be built. For purposes of demonstration, however, ALL Data Type Supporting Lists will be displayed. Since the data entry process is (almost) identical for all data types, we will use the data type to illustrate the DIAGNOSES Build Supporting Lists Menu Option.

SPECIAL

NOTE: "Categories" have been eliminated; only "Lists" have been retained. The Diagnostic Modifiers Component has also been eliminated. There is no longer a linkage between Interventions and the Diagnosis Components. Registers are completely private with all data entered unique to each Register. All Supporting Lists (e.g. Diagnosis, Complications, Interventions, etc.) are now tied to a specific Register so that the 'User' will only see the Lists associated with their specific Register when entering a "?" for choice selection.

********************
EMPLOYEE HEALTH REGISTER
********************
LOCAL SYSTEMS SETUP

1) DIAGNOSES LIST 6) MEDICATION LIST
2) COMPLICATIONS LIST 7) RISK FACTORS LIST
3) DIAGNOSTIC CRITERIA LIST 8) SERVICES LIST
4) ETIOLOGY LIST 9) ALL DATA
5) INTERVENTION LIST

To select several options separate them with commas.
For example: ==> 1,3,7,9

Select Option(s)==> 1

********************
EMPLOYEE HEALTH REGISTER
********************
DIAGNOSES LIST MANAGEMENT UTILITY

Update DIAGNOSES LIST

DIAGNOSIS: ?

DO YOU WANT THE ENTIRE CMS DIAGNOSIS LIST ENTRY?
Y (YES)

YOU MAY ENTER A NEW CMS DIAGNOSIS LIST ENTRY, IF YOU WISH
Answer must be 3-30 characters in length.

DIAGNOSIS: DIABETES
ARE YOU ADDING 'DIABETES' AS A NEW CMS DIAGNOSIS LIST ENTRY? Y (YES)

DIAGNOSIS: HYPERTENSION

ARE YOU ADDING 'Hypertension' AS A NEW CMS DIAGNOSIS LIST ENTRY? Y (YES)

DIAGNOSIS: BELLS PALSY

ARE YOU ADDING 'Bells Palsy' AS A NEW CMS DIAGNOSIS LIST ENTRY? Y (YES)

DIAGNOSIS: ?

CHOOSE FROM:
- DIABETES
- HYPERTENSION
- BELLS PALSY

DIAGNOSIS: ?

NOTE: Data Entry will only display these 3 Diagnosis List Choices for this particular Register. You will not see Diagnosis List Entries from other Registers.

4.4 DL Display Supporting Lists

******************************
** CASE MANAGEMENT SYSTEM **
** VERSION 2.0 **
******************************

MAIN MENU

CR  Create/Modify Register Structure
AU  Add Authorized Users
BL  Build Supporting Lists ...
DL  Display Supporting Lists ...
AD  Add/Delete ...
DE  Data Entry
RG  Report Generation ...
RD  Resource Directory ...
QM  Q-Man (PCC Query Utility)
DEL Delete Entire Register
LTR Manage Recall Letters ...
Install IHS Diabetes Register

NOTE: The display of Supporting Lists allows the User to print all LIST entries associated with a particular Register. This is provided to display the contents of all Data Type LISTS you established for your Register to ensure that you have the underlying content of each Register.
SELLS HOSPITAL/CLINIC

LOCAL OPTION REPORTS

SUB MENU . . .

DL Display Supporting Lists
   CL Complications List
   LD Diagnoses List
   CR Diagnostic Criteria
   SL Services List
   EL Etiology List
   AL Intervention Plan List
   ML Medications List
   RFL Risk Factors List

Select Display Supporting Lists Option: LD Diagnoses List

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

Report Example:

******************************************************************************
EMPLOYEE HEALTH REGISTER
******************************************************************************

DIAGNOSIS LIST

REPORT DATE: MAY 12, 1995                     PAGE: 1

---------------------------------------------------------------------------
DIAGNOSIS                           REGISTER
=========================================================                               
DIABETES                            EMPLOYEE HEALTH                           
HYPERTENSION                        EMPLOYEE HEALTH                           
BELLS PALSY                         EMPLOYEE HEALTH                           

4.5  AD Add/Delete Patients

******************************************************************************

** CASE MANAGEMENT SYSTEM **
**       VERSION 2.0      **
******************************************************************************

MAIN MENU

CR  Create/Modify Register Structure
AU  Add Authorized Users
BL  Build Supporting Lists ...
DL  Display Supporting Lists ...
AD  Add/Delete ...
DE  Data Entry
RG  Report Generation ...
RD  Resource Directory ...
QM  Q-Man (PCC Query Utility)
DEL Delete Entire Register
LTR Manage Recall Letters ...
Install IHS Diabetes Register
NOTE: Patients may be added manually (one at a time) OR You may select the TX Data transfer from A Search Template Menu Option & automatically add all patients in the template at one time.

******************************************************************************
** CASE MANAGEMENT SYSTEM **
******************************************************************************
REGISTER SELECTION UTILITY
EMPLOYEE HEALTH

REGISTER: EMPLOYEE HEALTH

******************************************************************************
** EMPLOYEE HEALTH REGISTER **
******************************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

PATIENT DATA MANAGEMENT

SUB MENU . . .

AD Add/Delete Patients
   AP Add Patient(s)
   DP Delete Patients from Register
   TX Data Transfer From A Search Template

Select Option: AP Add Patient(s)

Add patient(s) to the EMPLOYEE HEALTH register.
NAME, DOB OR CHART: GRANT, ABE M 05-24-86 065180651 SE 101770
Add ABE GRANT to the EMPLOYEE HEALTH REGISTER? YES// (YES)

******************************************************************************
** EMPLOYEE HEALTH REGISTER **
******************************************************************************
NAME, DOB OR CHART: SMITH, BOB M 02-04-88 071730717 SE 101846
Add BOB SMITH to the EMPLOYEE HEALTH register? YES// (YES)

Would you like to Edit the Data for SMITH, BOB? NO//

NOTE: A 'Yes' entry will allow edit of all Data Type Components for this patient - identical to choosing the DE Data Entry Menu Option

NOTE: Be sure you want to delete this patient from the Register. Once, deleted, all data for this particular patient will be lost.
EMPLOYEE HEALTH REGISTER

VERSION 2.0
SELLS HOSPITAL/CLINIC

PATIENT DATA MANAGEMENT

SUB MENU . . .

AD   Add/Delete Patients
AP   Add Patient(s)
DP   Delete Patients from Register
TX   Data Transfer From A Search Template

Select Option: DP  Delete Patient from Register

EMPLOYEE HEALTH REGISTER

PATIENT LOOKUP UTILITY

Select CLIENT
NAME OR CHART: SMITH, BOB  M 02-04-88 071730717 SE 101846

****** WARNING ******
This procedure will delete ALL data for BOB SMITH from the EMPLOYEE HEALTH register.

Are you certain you want to do this? NO// Y (YES)

........ Deletion of BOB SMITH

NOTE: Patients may be added manually (one at a time) through the AP Add Patients Menu Option. However, you may also load all patients from a Template into your Register by utilizing the TX Data Transfer From A Search Template Option.
EMPLOYEE HEALTH REGISTER

Transfer from SEARCH TEMPLATE

Select SEARCH TEMPLATE: ENTER TEMPLATE NAME HERE

This will automatically add all the patients in this Template to your Register.

There are ____ patients in this SEARCH TEMPLATE.

REGISTER SELECTION UTILITY

EMPLOYEE HEALTH

REGISTER: EMPLOYEE HEALTH

Select one of the following:

A   ACTIVE
I   INACTIVE
U   UNREVIEWED

Enter Patient Transfer Status: A// A

The following transfer has been selected:

From SEARCH TEMPLATE: Template Name Would Appear Here
To CMS register: EMPLOYEE HEALTH REGISTER
Transfer Status: A - ACTIVE

Is that what you want? NO// Y (YES)

Transfer of patients will be done in background mode. All patients will be entered as ACTIVE. All cases should be reviewed and all patient data updated in the EMPLOYEE HEALTH register.

4.6 DE Data Entry Menu

**************************
** CASE MANAGEMENT SYSTEM **
**      VERSION 2.0      **
**************************

MAIN MENU

CR   Create/Modify Register Structure
AU   Add Authorized Users
BL   Build Supporting Lists ...
DL   Display Supporting Lists ...
AD   Add/Delete ...
DE   Data Entry
RG   Report Generation ...
RD   Resource Directory ...
QM   Q-Man (PCC Query Utility)
DEL  Delete Entire Register
LTR  Manage Recall Letters ...
Install IHS Diabetes Register
NOTE: Only those Data Type Components for the Register selected will be displayed as Data Entry choice. However, for demonstration purposes, all Register Data Type Components will be displayed.

***********************************************************************
** CASE MANAGEMENT SYSTEM **
***********************************************************************
REGISTER SELECTION UTILITY
EMPLOYEE HEALTH

REGISTER: EMPLOYEE HEALTH
Select CLIENT
NAME OR CHART: GRANT, ABE    M 05-24-86 065180651 SE 101770

***********************************************************************
** CUSTOMIZE EMPLOYEE HEALTH REGISTER **
***********************************************************************

DATA ENTRY
for ABE GRANT

1) REGISTER DATA
2) CARE PLAN
3) CASE HISTORY
4) CASE REVIEW DATE
5) CASE COMMENTS
6) COMPLICATIONS
7) DIAGNOSES
8) DIAGNOSTIC CRITERIA
9) ETIOLOGY
10) FAMILY MEMBERS
11) INTERVENTIONS
12) MEASUREMENTS
13) MEDICATIONS
14) RISK FACTORS
15) SERVICES
16) RECALL DATES
17) ALL DATA

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 1 REGISTER DATA

NOTE: ** REGISTER DATA COMPONENT **
The REGISTER DATA COMPONENT contains basic administrative data about each patient in the register. Available data fields in this component are Patient Status (Active, Inactive, Transient, Unreviewed, Deceased, Non-IHS), Priority, Patient’s Primary Provider, Case Manager, Patient’s PHN, Facility Where Followed, and a Contact for the Patient. You may utilize any or all of these fields as your needs dictate. The use of Patient Status and Facility Where Followed is recommended. This component is automatically included with all registers.

Only those patients identified with a STATUS = ACTIVE will be displayed on all Report Generations, unless you choose to ‘Sort By’ particular Status.
EMPLOYEE HEALTH REGISTER

Update REGISTER DATA for ABE GRANT

CURRENT STATUS FOR THIS CLIENT

DOB: MAY 24, 1986            AGE: 8 YRS        CHART: 101770
CONTACT: NOT STATED        COMMUNITY: SELLS
STATUS: ACTIVE            CASE PRIORITY: NOT STATED
PRIMARY PRVD: NONE ASSIGNED       INIT ENTRY: MAY 12, 1995
CASE MANAGER: NONE ASSIGNED       WHERE FLWD: NOT STATED
PUB HLTH NRS: NONE ASSIGNED

Do you want to update this information? NO//Y (YES)

STATUS.............: ACTIVE//?

CHOOSE FROM:
A   ACTIVE
I   INACTIVE
T   TRANSIENT
U   UNREVIEWED
D   DECEASED
N   NON-IHS

STATUS.............: ACTIVE//U UNREVIEWED
INITIAL ENTRY DATE: MAY 12, 1995/

CASE PRIORITY.....: ?

CHOOSE FROM:
L   LOW
M   MEDIUM
H   HIGH
C   CRITICAL

CASE PRIORITY: C CRITICAL

PRIMARY PROVIDER..: ?

DO YOU WANT THE ENTIRE 456-ENTRY NEW PERSON LIST?

PRIMARY PROVIDER..: DOUGLAS,BILL
CASE MANAGER.......: BUTCHER,LORI ANN
PUBLIC HEALTH NRS.: JARLAND,TONI M
WHERE FOLLOWED.....: TUCSON MED CENTER

CLIENT CONTACT....: ?
Answer must be 3-30 characters in length.

CLIENT CONTACT....: GRANDMOTHER

EMPLOYEE HEALTH REGISTER

Update REGISTER DATA for ABE GRANT

CURRENT STATUS FOR THIS CLIENT

DOB: MAY 24, 1986            AGE: 8 YRS        CHART: 101770
CONTACT: GRANDMOTHER        COMMUNITY: SELLS
STATUS: UNREVIEWED          CASE PRIORITY: NOT STATED
PRIMARY PRVD: DOUGLAS,BILL       INIT ENTRY: MAY 12, 1995
CASE MANAGER: BUTCHER,LORI WHERE FLWD: TUCSON MED CTR
PUB HLTH NRS: JARLAND,TONI
EMPLOYEE HEALTH REGISTER

Update REGISTER DATA
for ABE GRANT

1) REGISTER DATA 10) FAMILY MEMBERS
2) CARE PLAN 11) INTERVENTIONS
3) CASE HISTORY 12) MEASUREMENTS
4) CASE REVIEW DATE 13) MEDICATIONS
5) CASE COMMENTS 14) RISK FACTORS
6) COMPLICATIONS 15) SERVICES
7) DIAGNOSES 16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 2  CARE PLAN

NOTE: ** CARE PLAN COMPONENT **
The CARE PLAN COMPONENT consists of six specific plans. They are Medical, Nursing, Social Services, Educational, Mental Health, and Other. You may record care plans for any or all of these care plan categories. Plans are entered as free text fields of unlimited length.

Screen Display after editing the Care Plan
NOTE: **CASE HISTORY COMPONENT**

The CASE HISTORY COMPONENT is used to describe the events and factors which lead to the patient’s enrollment in the register. This component consists of three fields: Date of Onset, Place of Onset, and Description. The Description field is a text, or word-processing, field of unlimited length. It permits recording information that might not appear in the list of problems or diagnoses found on the PCC Health Summary.
Update REGISTER DATA
for AARON JOHNSON
1) REGISTER DATA 10) FAMILY MEMBERS
2) CARE PLAN 11) INTERVENTIONS
3) CASE HISTORY 12) MEASUREMENTS
4) CASE REVIEW DATE 13) MEDICATIONS
5) CASE COMMENTS 14) RISK FACTORS
6) COMPLICATIONS 15) SERVICES
7) DIAGNOSES 16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 4  CASE REVIEW DATE

NOTE: **CASE REVIEW DATES COMPONENT**
The CASE REVIEW DATES COMPONENT permits entry
of the date you review a patient’s case and the date you
plan to review it again in the future. This component
facilitates retrieval of all patients that have not been
reviewed in a specified time frame, such as the past year, or
those scheduled to be reviewed in a specified time frame,
such as next month. The CASE REVIEW DATES
COMPONENT is automatically included with every
register.

Update REGISTER DATA
for AARON JOHNSON

LAST REVIEW: T (JUNE 08, 1995)

NEXT REVIEW: AUG 8, 1995
6) COMPLICATIONS  15) SERVICES
7) DIAGNOSES       16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: =>> 1,3,7,9

Which Option: 5 CASE COMMENTS

NOTE: ** COMMENTS COMPONENT **
The COMMENTS COMPONENT is a free text field for entering miscellaneous information that does not easily fit into any of the other component types. Length of the field is unlimited. Despite the free text nature of the field, you can selectively retrieve information from COMMENTS using the Case Management Patient Lister Report. If you know of specific information, or terms, that you wish to retrieve, it is essential that you use the same terminology whenever you enter that term because retrieval will be accomplished by use of a text search. For example, you can find all patients with the term “AMPUTATION” or the term “STAGE IV” if you enter it consistently; i.e., case sensitive. The term to be retrieved can be entered anywhere in the COMMENTS text; it does not have to be at the beginning of a line or on a specific line.

***********************************************************************
EMPLOYEE HEALTH REGISTER
***********************************************************************
Update CASE COMMENTS
for AARON JOHNSON

CASE COMMENTS
1>THIS IS AARON JOHNSON'S CASE COMMENTS WORD PROCESSING FIELD
2>ENTER PERTINENT INFORMATION RELATIVE TO ALL CASE COMMENTS.
3>

***********************************************************************
EMPLOYEE HEALTH REGISTER
***********************************************************************
Update REGISTER DATA
for AARON JOHNSON
1) REGISTER DATA   10) FAMILY MEMBERS
2) CARE PLAN       11) INTERVENTIONS
3) CASE HISTORY    12) MEASUREMENTS
4) CASE REVIEW DATE 13) MEDICATIONS
5) CASE COMMENTS   14) RISK FACTORS
6) COMPLICATIONS   15) SERVICES
7) DIAGNOSES      16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY
To select several options separate them with commas.
For example: ==> 1,3,7,9
Which Option: 6 COMPLICATIONS

NOTE: **COMPLICATIONS COMPONENT**

The COMPLICATIONS COMPONENT is utilized for identifying complications associated with the diagnosis or health problems for which a patient was entered into this register. For a diabetes register, for example, complications might include amputations, diabetic retinopathy, diabetic nephropathy, etc. In order to utilize the COMPLICATIONS COMPONENT, you must first build a list of complications that are appropriate for this register (BL Build Supporting Lists Menu Option). The COMPLICATIONS COMPONENT has fields for recording Onset Date and Comments for each complication.

*****************************************
EMPLOYEE HEALTH REGISTER
*****************************************

Update REGISTER DATA for AARON JOHNSON

<table>
<thead>
<tr>
<th>COMPLICATIONS</th>
<th>ONSET DT</th>
<th>ST COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>--------------</td>
<td>---------</td>
<td>-------------</td>
</tr>
</tbody>
</table>

COMPLICATION: ?
ANSWER WITH CMS COMPLICATION LIST ENTRY REGISTER
DO YOU WANT THE ENTIRE CMS COMPLICATION LIST ENTRY LIST? Y (YES)

CHOOSE FROM:
AMPUTATIONS
DIABETIC NEPHROPATHY
DIABETIC RETINOPATHY
HIGH BLOOD PRESSURE
HTN
SMOKER

COMPLICATION: HTN

ONSET DATE: T (JUNE 08, 1995)
STATUS: ?
ANSWER WITH CMS COMPLICATIONS STATUS COMPLICATION STATUS
DO YOU WANT THE ENTIRE 11-ENTRY CMS COMPLICATIONS STATUS LIST? Y (YES)

CHOOSE FROM:
A NO RISK
B LOW RISK
C MODERATE RISK
D HIGH RISK
E EARLY SIGNS
F IMMINENT ONSET
G MILD INVOLVEMENT
H MODERATE INVOLVE
I SEVERE INVOLVE
J CONDITION PRSNT
**K END STAGE**

STATUS: A - NO RISK

COMMENTS:
1>THIS IS THE COMPLICATION COMMENTS WORD PROCESSING FIELD.
2>ENTER ANY PERTINENT INFORMATION RELATIVE TO AARON JOHNSON'S
3>COMPLICATION OF HYPERTENSION (HTN) HERE.
4>

**************************************************************
EMPLOYEE HEALTH REGISTER
**************************************************************

Update REGISTER DATA
for AARON JOHNSON

1) REGISTER DATA  10) FAMILY MEMBERS
2) CARE PLAN      11) INTERVENTIONS
3) CASE HISTORY   12) MEASUREMENTS
4) CASE REVIEW DATE 13) MEDICATIONS
5) CASE COMMENTS  14) RISK FACTORS
6) COMPLICATIONS  15) SERVICES
7) DIAGNOSES      16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 7  DIAGNOSIS

**NOTE: ** **DIAGNOSIS COMPONENT **

This component is for entry of the specific diagnosis or
diagnoses that resulted in this patient’s inclusion on this
register. This is not a field for entering a patient’s list of, or
history of, diagnoses. For problem-specific registers, such
as Diabetes, there is usually only one diagnosis entered. For
a Children’s Special Needs Register, there might be several
diagnoses for a particular child. In order to utilize the
DIAGNOSES COMPONENT, you must first build a list of
those diagnoses that pertain to this particular register (BL
Build Supporting Lists Menu Option). This component also
contains fields for entry of Onset Date and Severity for
each diagnosis.

**************************************************************
EMPLOYEE HEALTH REGISTER
**************************************************************

Update REGISTER DATA
for AARON JOHNSON

DIAGNOSES  ONSET DATE  SEVERITY
-----------  ---------- --------

DIAGNOSIS: ??

CHOOSE FROM:

CHRONIC RENAL FAILURE
DIABETES MELLITUS TYPE II
HTN
OTITIS MEDIA
DIAGNOSIS: OTITIS MEDIA
ONSET DATE: T (JUN 08, 1995)
SEVERITY: ??
CHOOSE FROM:
N NORMAL
M MILD
MO MODERATE
S SEVERE

**************************************
EMPLOYEE HEALTH REGISTER
**************************************
Update REGISTER DATA
for AARON JOHNSON
1) REGISTER DATA 10) FAMILY MEMBERS
2) CARE PLAN 11) INTERVENTIONS
3) CASE HISTORY 12) MEASUREMENTS
4) CASE REVIEW DATE 13) MEDICATIONS
5) CASE COMMENTS 14) RISK FACTORS
6) COMPLICATIONS 15) SERVICES
7) DIAGNOSES 16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 8 DIAGNOSTIC CRITERIA

NOTE: ** DIAGNOSTIC CRITERIA COMPONENT **
If it is important to document how a diagnosis was arrived at, you may utilize the DIAGNOSTIC CRITERIA COMPONENT to do so. For example, you may wish to specify the objective criteria by which the diagnosis was made. For patients on a Diabetes Register, you may wish to identify one of the following criteria: Two abnormal fasting blood sugars over 140; Non-fasting blood sugar over 200 with classic symptoms; or Abnormal GTT. In order to utilize this component, you must first build a list of diagnostic criteria appropriate for this register (BL Build Supporting Lists Menu Option).

**************************************
EMPLOYEE HEALTH REGISTER
**************************************
Update REGISTER DATA
for AARON JOHNSON
DIAGNOSTIC CRITERIA DATE ESTABLISHED
------------------- ----------------
Case Management System (ACM) Version 2.0

CRITERION: ?

CHOOSE FROM:
   ABNORMAL GTT
   FASTING BLOOD SUGARS > 140
   NON-FASTING BLOOD SUGARS > 200
   POSITIVE PPD

CRITERION: ABNORMAL GTT

**************************************
EMPLOYEE HEALTH REGISTER
**************************************

Update REGISTER DATA for AARON JOHNSON
   1) REGISTER DATA            10) FAMILY MEMBERS
   2) CARE PLAN                11) INTERVENTIONS
   3) CASE HISTORY             12) MEASUREMENTS
   4) CASE REVIEW DATE         13) MEDICATIONS
   5) CASE COMMENTS            14) RISK FACTORS
   6) COMPLICATIONS            15) SERVICES
   7) DIAGNOSES                16) RECALL DATES
   8) DIAGNOSTIC CRITERIA      17) ALL DATA
   9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 9 ETIOLOGY

NOTE: ** ETIOLOGY COMPONENT **
The ETIOLOGY COMPONENT is used to identify the cause of the disease that resulted in a patient’s inclusion in this register. In order to utilize the ETIOLOGY COMPONENT, you must first build a list of etiologies appropriate for this register (BL Build Supporting Lists Menu Option).

**************************************
EMPLOYEE HEALTH REGISTER
**************************************

Update REGISTER DATA for AARON JOHNSON

ETIOLOGY
-------

ETIOLOGY: ?

CHOOSE FROM:
   ENVIRONMENTAL CAUSES
   GENETICS

ETIOLOGY: ENVIRONMENTAL CAUSES
NOTE: **FAMILY MEMBERS COMPONENT**

The FAMILY MEMBERS COMPONENT is used for registers pertaining to a health problem for which knowledge of family members is germane, such as breast cancer, diabetes, etc. Only family members registered on your computer can be entered in this component. For those family members entered, you may enter their relationship to the patient and whether or not they have a diagnosis related to the patient’s diagnosis.

---

**FAMILY MEMBER**

<table>
<thead>
<tr>
<th>CHART</th>
<th>RELATION</th>
<th>RELATED DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>05-24-86 065180651</td>
<td>FATHER</td>
<td>?</td>
</tr>
</tbody>
</table>

**RELATIONSHIP:**

1. FATHER
2. FATHER-IN-LAW

**CHOOSE FROM:**

- Y YES
- N NO
- U UNK

**RELATED DX:**

Y YES
EMPLOYEE HEALTH REGISTER

* * * * * * * * * * * * * * * * * * * * * *
Update REGISTER DATA
for AARON JOHNSON
1) REGISTER DATA 10) FAMILY MEMBERS
2) CARE PLAN 11) INTERVENTIONS
3) CASE HISTORY 12) MEASUREMENTS
4) CASE REVIEW DATE 13) MEDICATIONS
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7) DIAGNOSES 16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 11  INTERVENTIONS

NOTE: ** INTERVENTIONS COMPONENT **
The INTERVENTIONS COMPONENT is for recording actions planned or taken by you or others in the care of this patient. You may record type of intervention, date of intervention, results, and date due in the future. Examples of interventions are Diet Education, Smoking Cessation Program, Referral to Specialist, Exercise Program, etc. In order to utilize the INTERVENTIONS COMPONENT, you must first build a list of interventions appropriate for this register (BL Build Supporting Lists Menu Options).

* * * * * * * * * * * * * * * * * * * * * *
EMPLOYEE HEALTH REGISTER

* * * * * * * * * * * * * * * * * * * * * *
Update REGISTER DATA
for AARON JOHNSON

INTERVENTION       RESULTS       RESULT DATE       NEXT DATE DUE
-----------------       -------       -----------       -----------

INTERVENTION: ??

CHOOSE FROM:
DIET EDUCATION
EXERCISE PROGRAM
PHYSICAL THERAPY
REFERRAL TO SPECIALIST
SMOKING CESSATION PROGRAM

INTERVENTION: DIET EDUCATION

RESULTS: MINIMAL

RESULTS DATE: T (JUNE 08, 1995)
Update REGISTER DATA for AARON JOHNSON

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 12 MEASUREMENTS

NOTE: **MEASUREMENTS COMPONENT**

You may use the MEASUREMENTS COMPONENT for recording the following measurement types:
- Abdominal Girth Pulse
- Audiometry
- Respiration
- Blood Pressure
- Temperature
- Fundal Height
- Tonometry
- Fetal Heart Tones
- Vision Corrected
- Head Circumference
- Vision Uncorrected
- Hearing Weight
- Height

You may enter only one of each type measurement for a patient along with the date of the measurement. If a measurement value already exists, you may delete it or replace it with a more current one.

WARNING: It is recommended that you NOT enter measurements in your register that are already collected in the PCC. This creates extra work for you that is not necessary since you have access to data contained in the PCC for each of your register patients.
MEASUREMENT: WT WEIGHT
VALUE: 250
DATE OF MEASUREMENT: TODAY

NOTE: ** MEDICATIONS COMPONENT **
The MEDICATIONS COMPONENT may be used for entering medications the patient is taking which are germane to this register. You may consider using this component to record a class of medications for each patient such as Insulin and Oral Hypoglycemics for a Diabetes Register, rather than recording each specific drug type and strength. You may also enter a SIG (directions) for each drug or class. In order to utilize this component, you must first build a list of drugs or drug classes appropriate for this register.
REMEMBER: Do NOT duplicate all of the meds that are already collected in and available through the PCC.

***************************************************************
EMPLOYEE HEALTH REGISTER
***************************************************************
Update REGISTER DATA
for AARON JOHNSON
MEDICATIONS SIG
----------- ---
MEDICATION: ??

CHOOSE FROM:
INSULIN
ORAL HYPOGLYCEMICS

MEDICATION: INSULIN
SIGS: WEEKLY

***************************************************************
EMPLOYEE HEALTH REGISTER
***************************************************************
Update REGISTER DATA
for AARON JOHNSON
1) REGISTER DATA 10) FAMILY MEMBERS
2) CARE PLAN 11) INTERVENTIONS
3) CASE HISTORY 12) MEASUREMENTS
4) CASE REVIEW DATE 13) MEDICATIONS
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7) DIAGNOSES 16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 14 RISK FACTORS

NOTE: ** RISK FACTORS COMPONENT **
The RISK FACTORS COMPONENT is for medical, social, educational, family, and environmental factors which may affect the care of this patient and/or the progression of the health problem(s) being followed. Examples of risk factors are: Heavy Smoker, Personal Hygiene, Distance from Clinic, Doesn’t Speak English, Alcohol in Home, Doesn’t Keep Appointments, Poor Diet, etc. In order to utilize the RISK FACTORS COMPONENT, you must first build a list of risk factors appropriate for this register (BL Build Supporting Lists Menu Option).
**EMPLOYEE HEALTH REGISTER**

Update REGISTER DATA for AARON JOHNSON

**RISK FACTORS**

RISK FACTOR: ??

CHOOSE FROM:
- ALCOHOL IN HOME
- DISTANCE FROM CLINIC
- DOESN'T KEEP APPOINTMENTS
- DOESN'T SPEAK ENGLISH
- HEAVY SMOKER
- PERSONAL HYGIENE
- POOR DIET

RISK FACTOR: DISTANCE FROM CLINIC

**EMPLOYEE HEALTH REGISTER**

Update REGISTER DATA for AARON JOHNSON

1) REGISTER DATA  10) FAMILY MEMBERS
2) CARE PLAN  11) INTERVENTIONS
3) CASE HISTORY  12) MEASUREMENTS
4) CASE REVIEW DATE  13) MEDICATIONS
5) CASE COMMENTS  14) RISK FACTORS
6) COMPLICATIONS  15) SERVICES
7) DIAGNOSES  16) RECALL DATES
8) DIAGNOSTIC CRITERIA  17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 15 SERVICES

**NOTE: ** SERVICES COMPONENT **

The SERVICES COMPONENT is provided for documenting services required for each patient. These might include podiatry, physical therapy, speech therapy, specialty consultations, etc. To utilize this component, you must first build a list of services that are appropriate for this register (BL Build Supporting List Menu Option). There is also a field in the SERVICES COMPONENT for recording the availability or status of the services you enter, such as Referral Made, On Waiting List, Unavailable, etc.
Update REGISTER DATA
for AARON JOHNSON

SERVICES NEEDED BY THIS CLIENT          AVAILABILITY STATUS
------------------------------------------          -------------------
SERVICE: ???

CHOOSE FROM:
  PHYSICAL THERAPY
  PODIATRY
  SPECIALTY CONSULTATIONS
  SPEECH THERAPY

SERVICE: PHYSICAL THERAPY

AVAILABILITY: ???

CHOOSE FROM:
  F FUTURE F/U
  R REFERRED
  E ENROLLED
  W WAITING LIST
  N UNAVAILABLE

AVAILABILITY: REFERRED

EMLOYEE HEALTH REGISTER

Update REGISTER DATA
for AARON JOHNSON

1) REGISTER DATA     10) FAMILY MEMBERS
2) CARE PLAN         11) INTERVENTIONS
3) CASE HISTORY      12) MEASUREMENTS
4) CASE REVIEW DATE  13) MEDICATIONS
5) CASE COMMENTS     14) RISK FACTORS
6) COMPLICATIONS     15) SERVICES
7) DIAGNOSES         16) RECALL DATES
8) DIAGNOSTIC CRITERIA 17) ALL DATA
9) ETIOLOGY

To select several options separate them with commas.
For example: ==> 1,3,7,9

Which Option: 16 RECALL DATES
NOTE: **RECALL DATES COMPONENT**

The **RECALL DATES COMPONENT** permits you to establish a future date when you wish to contact the patient for follow-up relevant to this register. These are not appointments, but, rather, are approximate dates, often several months or a year in the future, at which time you wish to contact a patient, often for the purpose of making a specific appointment.

You may enter multiple recall dates for each patient. For each recall, you may enter Purpose, Referral Organization, Referral Provider, Appointment Date, and Appointment Status (Open, Pending, Missed, etc.). You will also be asked to enter a Contact Name (often your own name) and Phone Number to be used in Recall Letters, if you chose to use this capability of the Case Management System.

In Case Management Reports, you can get a list of all patients with Recall Dates in a specified time frame, and, as indicated above, generate Recall Letters to patients.

---

**EMPLOYEE HEALTH REGISTER**

Update REGISTER DATA for AARON JOHNSON

<table>
<thead>
<tr>
<th>NO.</th>
<th>RECALL DT</th>
<th>PURPOSE</th>
<th>DATE TIME</th>
<th>REFERRAL ORG/PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select one of the following:

A ADD

Enter CHOICE: ADD

Enter Date of Recall: T+30 (JULY 08, 1995)

Purpose of Recall: ANNUAL CHECKUP

Contact Person: MRS. BETH JOHNSON

Contact Phone Number: 470-6870

Referral Organization: INDIAN HEALTH SERVICE

Referral Provider: DR. SMITH

Next Appt: T+30 (JULY 08, 1995)

Appointment Status: ??

CHOOSE FROM:

K KEPT

M MISSED

O OPEN

Appointment Status: OPEN
### 4.7 RG Report Generation

<table>
<thead>
<tr>
<th>SUB MENU . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>RG Report Generation</td>
</tr>
</tbody>
</table>

- CS Case Summary, Individual
- MS Case Summary, Multiple
- ML Master List
- PR Patient and Statistical Reports
- GEN Register Patient General Retrieval (Lister)
- LVST Display Data for a Patient’s Last Visit

Select Report Generation Option: CS Case Summary, Individual

**NOTE:** Individual Health Summaries are one of the most frequently used reports. This report, similar to the PCC Health Summary report, displays all patient data for the each of the selected 16 Data Type Component for your Customized Register.

In addition, you are given the opportunity to print the PCC HEALTH SUMMARY report, along with the selected Patient’s CMS Case Summary, if desired.

---

**Employee Health Register**

Select CLIENT

NAME OR CHART: GRANT, ABE  M 05-24-86 065180651 SE 101770

Include PCC HEALTH SUMMARY? NO//NO

DEVICE: Enter a Device Number; or Hit Return To Display To Screen

---INDIVIDUAL CASE SUMMARY REPORT DISPLAY---///

CLIENT: CHART: GRANT, ABE  CHART: 101770
DOB: MAY 24, 1986  AGE: 9 YRS
CONTACT: MOTHER  COMMUNITY: SELLS
STATUS: ACTIVE  CASE PRIORITY: LOW
PRIMARY PRVD: DOUGLAS, BILL  INIT ENTRY: JUL 1, 1994
CASE MANAGER: JONES, BOB  WHERE FLWD: SELLS HOSP
PUB HLTH NRS: BUTCHER, LORI ANN  

PLAN OF CARE

CASE HISTORY

ONSET DATE: 12/17/94 PLACE OF ONSET: TUCSON
CASE HX: THIS IS THE CASE HISTORY FOR PATIENT ABE GRANT

************************************************* COMMENTS *************************************************

THIS IS CASE COMMENTS SECTION FOR ABE GRANT.

************************************************* COMPLICATIONS *************************************************

<table>
<thead>
<tr>
<th>COMPLICATION</th>
<th>ONSET DATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LASER TX FOR RETINOPATHY</td>
<td>01/01/95</td>
<td>A - NO RISK</td>
</tr>
<tr>
<td>CVA</td>
<td>07/09/95</td>
<td>A - NO RISK</td>
</tr>
<tr>
<td>SMOKER</td>
<td>06/09/50</td>
<td>A - HIGH RISK</td>
</tr>
</tbody>
</table>

************************************************* REGISTER DIAGNOSES *************************************************

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>DX DATE</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELLS PALSY</td>
<td>11/16/94</td>
<td>NORMAL</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>2/22/94</td>
<td>SEVERE</td>
</tr>
</tbody>
</table>

************************************************* DIAGNOSTIC CRITERIA *************************************************

2 FBS OVER 200 DATE ESTABLISHED: DEC 19,1994

ETIOLOGY

EXPOSURE TO TOXIC MATERIALS

GRANT, HELEN 102706 COUSIN

SMITH, BOB 101846 FATHER-IN-LAW

************************************************* INTERVENTION PLAN *************************************************

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>LAST DATE</th>
<th>RESULTS</th>
<th>DATE DUE</th>
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<tr>
<td>DIET INTERVENTION</td>
<td>2/29/94</td>
<td>MINIMAL</td>
<td>01/08/95</td>
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************************************************* MEASUREMENTS *************************************************

<table>
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<th>MEASUREMENT DATE</th>
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<tr>
<td>BP</td>
<td>135/100</td>
<td>02/02/95</td>
</tr>
<tr>
<td>WT</td>
<td>250</td>
<td>02/02/95</td>
</tr>
</tbody>
</table>

************************************************* REGISTER MEDICATIONS *************************************************

INSULIN  WEEKLY

TYLENOL  AS NEEDED FOR PAIN

************************************************* RISK FACTORS *************************************************

AMPUTATED FOOT

************************************************* SERVICES *************************************************

OCCUPATIONAL THERAPY  UNAVAILABLE

WEIGHT WATCHERS  ENROLLED

************************************************* RECALL DATES *************************************************

RECALL DATE: 06/06/95 PURPOSE: ANNUAL CHECKUP STATUS: OPEN NXT DATE/TIME: 08/01/95

************************************************* CASE REVIEW DATES *************************************************

LAST REVIEW DATE: DEC 19, 1994 NEXT REVIEW DATE: JAN 18, 1995

End of report for ABE GRANT

************************************************* TONI TEST REGISTER *************************************************

************************************************* SUB MENU . . . *************************************************

RG  Report Generation
NOTE: When you need to produce the CMS Case Summary on several patients, use the MS Case summary, Multiple option. This report is identical to the Individual Case Summaries, but will produce Summaries for multiple patients, based upon the ‘Sorting Option Choice’; i.e., Case Manager, Current Community, Next Case Review, and Where Followed. Review these screens carefully - and the method of setting up your sorts for your reports should become easy to use.

In addition, you are given the opportunity to print the PCC HEALTH SUMMARY report, along with the selected Patient’s CMS Case Summary, if desired.

---------------------------------------------

TONI TEST REGISTER

---------------------------------------------

REPORT SORTING UTILITY

The MULTIPLE SUMMARIES report can be sorted by one or more of the following attributes. ‘<==’ indicates a mandatory selection.

1) CASE MANAGER         4) PATIENT
2) CURRENT COMMUNITY    5) WHERE FOLLOWED
3) NEXT CASE REVIEW

Your choice: 1 CASE MANAGER

Do you want to sort by a particular CASE MANAGER? NO// YES

Which CASE MANAGER: DOUGLAS,BILL

Within CASE MANAGER, want to sort by another attribute? NO// NO

Store Report Result as Search Template? NO// NO

Include PCC HEALTH SUMMARY? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

NOTE: This selection would produce Individual Case Summaries for all Patient's who's Case Manager is Bill Douglas.
NOTE: The Master List is similar to the PR Patient and Statistical Reports Option. The ‘Sort Choices’ will depend upon the Data Type Component you choose through the “Sorting Process”.

You will also be given the choice to save the report results in a Template. Creation of Templates may now be run in the background mode. A description of a Template may be generated on a printer or terminal screen, producing a brief listing containing the Register Name, Template Name, Creator of the Template and the number of entries (hits) in the Template.

Only those patients identified with a STATUS=ACTIVE will appear on the Master List, unless you ‘Sort By’ a particular Status.

You may utilize this Template within the Q-Man Query Software Package to access all PCC demographic and/or clinical data.

REPORT SORTING UTILITY

The MASTER LIST report can be sorted by one or more of the following attributes.

`<=` indicates a mandatory selection.

1) AGE
2) CASE MANAGER
3) CURRENT COMMUNITY
4) PUBLIC HEALTH NURSE
5) SEX
6) STATUS

Your choice: 5 SEX

Do you want to sort by a particular SEX? NO// Y (YES)

You may select one of the following choices

M = MALE
F = FEMALE
Your choice: F = FEMALE

---

**EMLOYEE HEALTH REGISTER**

**REPORT SORTING UTILITY**

The MASTER LIST report can be sorted by one or more of the following attributes. ‘<==’ indicates a mandatory selection.

1) AGE 4) PUBLIC HEALTH NURSE
2) CASE MANAGER 5) SEX
3) CURRENT COMMUNITY 6) STATUS

Your choice: 3 CURRENT COMMUNITY

Do you want to sort by a particular CURRENT COMMUNITY? NO// (NO)

Within CURRENT COMMUNITY, want to sort by another attribute? NO// (NO)

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

---

---

**EMPLOYEE HEALTH REGISTER**

**REPORT DATE JUNE 8, 1995**

---

<table>
<thead>
<tr>
<th>CHART PATIENT</th>
<th>CASE MANAGER</th>
<th>NEXT REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT:CURRENT COMMUNITY: COCKLEBURR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>101702 ADAMS, DANIELLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT:CURRENT COMMUNITY: RIPLEY</td>
<td>05/05/95</td>
<td></td>
</tr>
<tr>
<td>100018 ROBERTS, DIANE</td>
<td>06/05/95</td>
<td></td>
</tr>
<tr>
<td>100420 ADAMS, CANDY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**EMPLOYEE HEALTH REGISTER**

**VERSION 2.0**

SELLS HOSPITAL/CLINIC

**SUB MENU . . .**

RG Report Generation

CS Case Summary, Individual
MS Case Summary, Multiple
ML Master List
PR Patient and Statistical Reports
GEN Register Patient General Retrieval (Lister)
LVST Display Data for a Patient’s Last Visit

Select Report Generation Option:  _PR_ Patient and Statistical Reports

NOTE: The screen you will see in your Register will include only the reports for the Data Type Components you selected when you customized your Register. For demonstration purposes, ALL Data Type Components will be displayed. The 'Sort Choices' will depend upon the Data Type Component you choose through the 'Sorting Process'. You will also be given the choice of producing either the 'P' Patient or "S' Statistical print display. The 'P' Patient choice displays all detail related to the Data Type Component selected; the 'S' Statistical choice displays only the count of hits for the Data Type Component selected.

You will also be given the choice to save the report results in a Template. Creation of Templates may now be run in the background mode. A description of a Template may be generated on a printer or terminal screen, producing a brief listing containing the Register Name, Template Name, Creator of the Template, and the number of entries (hits) in the Template.

Only those patients identified with a STATUS=ACTIVE will on all Report Generations, unless you 'Sort By' a particular Status; i.e., Active, Inactive, Transient, Unreviewed, Deceased, or Non-IHS.

For demonstration purposes, an example of each of the 16 Data Type Components is provided, along with a Report Display example. All report outputs vary, depending upon the User’s ‘Sort Selection Choice’.

******************************************************************************
EMPLOYEE HEALTH REGISTER
******************************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES 9) ETIOLOGY
2) CARE PLAN 10) FAMILY MEMBERS
3) CASE HISTORY 11) INTERVENTIONS
4) CASE REVIEW DATE 12) MEASUREMENTS
5) CASE COMMENTS 13) MEDICATIONS
6) COMPLICATIONS 14) REGISTER DATA
7) DIAGNOSES 15) RISK FACTORS
8) DIAGNOSTIC CRITERIA 16) SERVICES

Report Option ==> 1 RECALL DATES
REPORT SORTING UTILITY

The RECALL DATES report can be sorted by one or more of the following attributes.
'<==' indicates a mandatory selection.

1) APPOINTMENT STATUS  5) PATIENT
2) CASE MANAGER       6) PUBLIC HEALTH NURSE
3) CURRENT COMMUNITY  7) RECALL DATES
4) NEXT APPOINTMENT DATE  8) WHERE FOLLOWED

Your choice: 7 RECALL DATES
Start with date: 1-1-95 Enter a Date Here
End with date: 1-1-95

Within RECALL DATES, want to sort by another attribute? NO// NO

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO You may save in a Template to get a Count of Hits for future Use.

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

---RECALL DATE REPORT DISPLAY EXAMPLE---

RECALL DATES
SORTED BY: RECALL DATE
REPORT DATE: MAY 15, 1995 PAGE: 1

CHART  PATIENT      RECALL DATE   PURPOSE            S - NXT APPT
       3061    ADAMS,ROSE   JAN 1, 1995   ANNUAL CHECKUP O   MAY 13, 1995
       101770  GRANT,ABE    JAN 1, 1995   FOLLOWUP APPT K    FEB 13, 1995
       9999     GRANT,SAM    JAN 1, 1995   DIABETES CLINIC
       5656     SMITH,GRANT  JAN 1, 1995   FOOT EXAM          M
The CARE PLAN report can be sorted by one or more of the following attributes. ’<=’ indicates a mandatory selection.

1) CURRENT COMMUNITY  4) PATIENT
2) NEXT APPOINTMENT DATE  5) WHERE FOLLOWED
3) NEXT CASE REVIEW

Your choice: 4 PATIENT

Do you want to sort by a particular PATIENT? NO// (NO)

Within PATIENT, want to sort by another attribute? NO// (NO)

Store Report Result as Search Template? NO// YES

TEMPLATE: TMJ PATIENT CARE PLANS
Enter the name of a Template Here. It is recommended ALL Template Names begin with your Initials, which will assist in identifying only your templates for future Use.

ARE YOU ADDING 'TEMPLATE NAME' AS A NEW TEMPLATE? YES

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

This is Abe Grant's Plan of Care for the Mental Health Care Plan Category. Mr. Grant will benefit greatly from this Care Plan.
EMPLOYEE HEALTH REGISTER

REPORT SORTING UTILITY

The CARE PLAN report can be sorted by one or more of the following attributes.
'<=>' indicates a mandatory selection.

1) PATIENT

Your choice: 1 PATIENT

Do you want to sort by a particular PATIENT? NO// (NO)

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

CASE HISTORY REPORT DISPLAY---\\\-

REPORT DATE: MAY 15, 1995 PAGE: 1

CHART PATIENT REGISTER ONSET DATE PLACE OF ONSET
3061 ADAMS, ROSE EMPLOYEE HEALTH 04/15/95 ARIZONA
101770 GRANT, ABE EMPLOYEE HEALTH 03/01/90
101770 GRANT, ABE EMPLOYEE HEALTH 07/04/90
**Case Management System (ACM) Version 2.0**

**User Manual**

**December 1995**

<table>
<thead>
<tr>
<th>101770</th>
<th>GRANT, ABE</th>
<th>EMPLOYEE HEALTH</th>
<th>05/05/95</th>
<th>RESERVATION</th>
</tr>
</thead>
</table>

**PLAN OF CARE:**

This is Abe Grant’s Case History. The Class/Stage are no longer a part of the Data Entry Fields. Place of Onset is a Free-Text Field of the Case History Component. Mr. Grant will benefit greatly from this pertinent information.

---

**EMPLOYEE HEALTH REGISTER**

**VERSION 2.0**

SELLS HOSPITAL/CLINIC

**PATIENT AND STATISTICAL REPORT GENERATION**

1) RECALL DATES  9) ETIOLOGY
2) CARE PLAN     10) FAMILY MEMBERS
3) CASE HISTORY  11) INTERVENTIONS
4) CASE REVIEW DATE  12) MEASUREMENTS
5) CASE COMMENTS  13) MEDICATIONS
6) COMPLICATIONS  14) REGISTER DATA
7) DIAGNOSES     15) RISK FACTORS
8) DIAGNOSTIC CRITERIA  16) SERVICES

Report Option ==> 4  CASE REVIEW DATE

---

**EMPLOYEE HEALTH REGISTER**

**REPORT SORTING UTILITY**

The CARE PLAN report can be sorted by one or more of the following attributes. '==' indicates a mandatory selection.

1) CASE MANAGER  4) PATIENT
2) CURRENT COMMUNITY  5) RECALL DATES
3) NEXT CASE REVIEW DATE  6) WHERE FOLLOWED

Your choice: 3 NEXT CASE REVIEW DATE

Start with date: 1-1-95 Enter a Date Here
End with date: 1-1-95

Within NEXT CASE REVIEW DATE, want to sort by another attribute? NO// NO

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

You may save in a Template to get a Count of Hits for future Use.

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

---

**EMPLOYEE HEALTH REGISTER**
**RECALL DATES**

REPORT DATE: MAY 15, 1995 PAGE: 1

<table>
<thead>
<tr>
<th>CHART</th>
<th>PATIENT</th>
<th>CASE MANAGER</th>
<th>LAST REVIEW</th>
<th>NEXT REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>3061</td>
<td>ADAMS, ROSE</td>
<td>DOUGLAS, BILL</td>
<td>03/16/94</td>
<td>01/01/95</td>
</tr>
<tr>
<td>101770</td>
<td>GRANT, ABE</td>
<td>DOUGLAS, BILL</td>
<td>12/12/94</td>
<td>01/01/95</td>
</tr>
<tr>
<td>9999</td>
<td>GRANT, SAM</td>
<td>JOHNSON, DOCTOR</td>
<td>01/01/95</td>
<td></td>
</tr>
<tr>
<td>5656</td>
<td>SMITH, GRANT</td>
<td>SMITH, JAMES</td>
<td>10/31/94</td>
<td>01/01/95</td>
</tr>
</tbody>
</table>

**EMPLOYEE HEALTH REGISTER**

**VERSION 2.0**

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**PATIENT AND STATISTICAL REPORT GENERATION**

1) RECALL DATES  9) ETIOLOGY
2) CARE PLAN    10) FAMILY MEMBERS
3) CASE HISTORY 11) INTERVENTIONS
4) CASE REVIEW DATE 12) MEASUREMENTS
5) CASE COMMENTS 13) MEDICATIONS
6) COMPLICATIONS 14) REGISTER DATA
7) DIAGNOSES    15) RISK FACTORS
8) DIAGNOSTIC CRITERIA 16) SERVICES

Report Option ==> 5 CASE COMMENTS

**REPORT SORTING UTILITY**

The CARE PLAN report can be sorted by one or more of the following attributes.
'<=:' indicates a mandatory selection.

1) PATIENT

**EMPLOYEE HEALTH REGISTER**

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Your choice: 1 PATIENT

Do you want to sort by a particular PATIENT? NO// (NO)
Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen
### ---CASE COMMENTS REPORT DISPLAY---/---

---

**CASE COMMENTS**

**REPORT DATE:** MAY 15, 1995

<table>
<thead>
<tr>
<th>CHART</th>
<th>PATIENT</th>
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<tbody>
<tr>
<td>3061</td>
<td>ADAMS, ROSE</td>
</tr>
<tr>
<td>101770</td>
<td>GRANT, ABE</td>
</tr>
<tr>
<td>3991</td>
<td>ADAMS, DONALD</td>
</tr>
</tbody>
</table>

This is Abe Grant's Case Comments Field. This is a word processing Field which has limitless text to describe, in detail, comments relative to the case.

---

**REPORT SORTING UTILITY**

The CARE PLAN report can be sorted by one or more of the following attributes.

- Age
- Complication
- Complication Status
- Current Community
- Patient
- Sex
- Where Followed

Report Option ==> 2 COMPLICATIONS

---

**PATIENT AND STATISTICAL REPORT GENERATION**

1) RECALL DATES 9) ETIOLOGY
2) CARE PLAN 10) FAMILY MEMBERS
3) CASE HISTORY 11) INTERVENTIONS
4) CASE REVIEW DATE 12) MEASUREMENTS
5) CASE COMMENTS 13) MEDICATIONS
6) COMPLICATIONS 14) REGISTER DATA
7) DIAGNOSES 15) RISK FACTORS
8) DIAGNOSTIC CRITERIA 16) SERVICES

---
Do you want to sort by a particular COMPLICATION? NO// YES

Which COMPLICATION: HTN  

Enter the desired Complication Here
Entering a '?' will display Choices

Within COMPLICATION, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

///////////////////////////////////////////////////////////////////////////

EMPLOYEE HEALTH REGISTER
COMPLICATIONS
SORTED BY: COMPLICATION

REPORT DATE: MAY 15, 1995 PAGE: 1

CHART       PATIENT                COMPLICATION
3061        ADAMS,ROSE             HTN
            DIABETIC
            RETINOPATHY
100018      ROBERTS,Diane          HTN

******************************************************************************

EMPLOYEE HEALTH REGISTER
VERSION 2.0
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PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES       9) ETIOLOGY
2) CARE PLAN         10) FAMILY MEMBERS
3) CASE HISTORY      11) INTERVENTIONS
4) CASE REVIEW DATE  12) MEASUREMENTS
5) CASE COMMENTS     13) MEDICATIONS
6) COMPLICATIONS     14) REGISTER DATA
7) DIAGNOSES         15) RISK FACTORS
8) DIAGNOSTIC CRITERIA 16) SERVICES

Report Option ==> 7  DIAGNOSES

******************************************************************************

The DIAGNOSES report can be sorted by one or more of the following
attributes. 
'<==' indicates a mandatory selection.

1) AGE                  5) PATIENT
2) COMPLICATION         6) SEX
3) COMPLICATION STATUS  7) WHERE FOLLOWED
4) CURRENT COMMUNITY

Your choice: 3 DIAGNOSIS

Do you want to sort by a particular DIAGNOSIS? NO// Y

Which DIAGNOSIS: CHRONIC RENAL FAILURE Enter the desired Complication Here
Entering a '?' will display Choices

Within DIAGNOSIS, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

/////--DIAGNOSIS REPORT DISPLAY--/////

**************
EMPLOYEE HEALTH REGISTER
**************
PATIENT DIAGNOSES

SORTED BY: COMPLICATION

REPORT DATE: MAY 15, 1995                                               PAGE: 1
CHART   PATIENT        DIAGNOSIS        DX DATE         SEVERITY
3061    ADAMS, ROSE     CHRONIC RENAL    10/27/94        NORMAL
FAILURE
9999    SMITH, JOHN     CHRONIC RENAL    01/27/93        SEVERE
FAILURE

**************
EMPLOYEE HEALTH REGISTER
**************
VERSION 2.0
SELLS HOSPITAL/CLINIC

PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES           9) ETIOLOGY
2) CARE PLAN              10) FAMILY MEMBERS
3) CASE HISTORY           11) INTERVENTIONS
4) CASE REVIEW DATE       12) MEASUREMENTS
5) CASE COMMENTS          13) MEDICATIONS
6) COMPLICATIONS          14) REGISTER DATA
7) DIAGNOSES              15) RISK FACTORS
8) DIAGNOSTIC CRITERIA   16) SERVICES

Report Option ==> 8 DIAGNOSTIC CRITERIA
### REPORT SORTING UTILITY

The DIAGNOSTIC CRITERIA report can be sorted by one or more of the following attributes. '=<=' indicates a mandatory selection.

1) DIAGNOSTIC CRITERIA  2) PATIENT

Your choice: 1 DIAGNOSTIC CRITERIA

Do you want to sort by a particular DIAGNOSTIC CRITERIA? NO// YES

Which DIAGNOSTIC CRITERIA: ABNORMAL GTT Enter the desired Complication Here

Entering a '?' will display Choices

Within DIAGNOSTIC CRITERIA, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

---

#### --DIAGNOSTIC CRITERIA REPORT DISPLAY--

<table>
<thead>
<tr>
<th>CHART</th>
<th>PATIENT</th>
<th>CRITERIA</th>
<th>ESTABLISHED</th>
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<tbody>
<tr>
<td>018</td>
<td>ROBERTS, DIANE</td>
<td>ABNORMAL GTT</td>
<td>04/00/91</td>
</tr>
</tbody>
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---

#### PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES  9) ETIOLOGY  
2) CARE PLAN  10) FAMILY MEMBERS  
3) CASE HISTORY  11) INTERVENTIONS  
4) CASE REVIEW DATE  12) MEASUREMENTS  
5) CASE COMMENTS  13) MEDICATIONS  
6) COMPLICATIONS  14) REGISTER DATA  
7) DIAGNOSES  15) RISK FACTORS  
8) DIAGNOSTIC CRITERIA  16) SERVICES
Report Option ==> 9  ETIOLOGY

*****************************************************************************
EMPLOYEE HEALTH REGISTER
*****************************************************************************
REPORT SORTING UTILITY

The ETIOLOGY report can be sorted by one or more of the following attributes. '<<=' indicates a mandatory selection.

1) AGE       3) PATIENT
2) ETIOLOGY   4) SEX

Your choice: ** 2 ETIOLOGY 

Do you want to sort by a particular ETIOLOGY? NO// Y

Which ETIOLOGY: ENVIRONMENTAL CAUSES Enter the desired Complication Here

Entering a '? will display Choices

Within ETIOLOGY, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

*****************************************************************************
EMPLOYEE HEALTH REGISTER
*****************************************************************************
ETIOLOGY REPORT

SORTED BY ETIOLOGY

REPORT DATE: MAY 15, 1995                                   PAGE: 1
CHART     PATIENT                   ETIOLOGY
3061      ADAMS,ROSE                ENVIRONMENTAL CAUSES

*****************************************************************************
EMPLOYEE HEALTH REGISTER
*****************************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES           9) ETIOLOGY
2) CARE PLAN              10) FAMILY MEMBERS
3) CASE HISTORY           11) INTERVENTIONS
4) CASE REVIEW DATE       12) MEASUREMENTS
5) CASE COMMENTS          13) MEDICATIONS
6) COMPLICATIONS          14) REGISTER DATA
7) DIAGNOSES  15) RISK FACTORS
8) DIAGNOSTIC CRITERIA  16) SERVICES

Report Option ==> 10  FAMILY MEMBERS

********************************************************************************
EMPLOYEE HEALTH REGISTER
********************************************************************************
REPORT SORTING UTILITY

The FAMILY MEMBERS report can be sorted by one or more of the following attributes.
'<=' indicates a mandatory selection.

1) CURRENT COMMUNITY  3) WHERE
2) PATIENT

Your choice: 2 PATIENT

Do you want to sort by a particular PATIENT? NO// NO

Within PATIENT, want to sort by another attribute? NO// NO

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

********************************************************************************
EMPLOYEE HEALTH REGISTER
********************************************************************************
FAMILY MEMBERS
SORTED BY PATIENT

REPORT DATE: MAY 15, 1995  PAGE: 1
CLIENT          RELTD FAMILY MEMBER    RELATIONSHIP         DX
ADAMS,ROSE      ADAMS,BRYAN            BROTHER              UNKNOWN
GRANT,ABE       GRANT,COLEEN           MOTHER               YES
ROBERTS,DIANE   ROBERTS,BARRY          BROTHER              NO

********************************************************************************
EMPLOYEE HEALTH REGISTER
********************************************************************************
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SELLS HOSPITAL/CLINIC

PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES  9) ETIOLOGY
2) CARE PLAN  10) FAMILY MEMBERS
3) CASE HISTORY  11) INTERVENTIONS
4) CASE REVIEW DATE  12) MEASUREMENTS

User Manual  December 1995
5) CASE COMMENTS          13) MEDICATIONS
6) COMPLICATIONS          14) REGISTER DATA
7) DIAGNOSES              15) RISK FACTORS
8) DIAGNOSTIC CRITERIA    16) SERVICES

Report Option ==> 11  INTERVENTIONS

**************************************
EMPLOYEE HEALTH REGISTER
**************************************
REPORT SORTING UTILITY

The FAMILY MEMBERS report can be sorted by one or more of the following attributes.
'=' indicates a mandatory selection.
1) INTERVENTIONS     3) PATIENT
2) NEXT CASE REVIEW  4) SEX

Your choice: 3 PATIENT
Do you want to sort by a particular PATIENT? NO// NO
Within PATIENT, want to sort by another attribute? NO// NO
'Patient or 'Statistical report? ==> P Patient
Store Report Result as Search Template? NO// NO
DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

///--INTERVENTION REPORT DISPLAY--///--

**************************************
EMPLOYEE HEALTH REGISTER
**************************************
FAMILY MEMBERS

REPORT DATE: MAY 15, 1995                                         PAGE: 1

PATIENT           INTERVENTION      DATE DUE     RESULT DT      RESULTS
ADAMS, ROSE       PHYSICAL          05/08/95     04/30/95       POSITIVE
ROBERTS, DIANE    EXERCISE          05/10/95     04/15/95       GOOD
PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES  9) ETIOLOGY
2) CARE PLAN   10) FAMILY MEMBERS
3) CASE HISTORY 11) INTERVENTIONS
4) CASE REVIEW DATE 12) MEASUREMENTS
5) CASE COMMENTS 13) MEDICATIONS
6) COMPLICATIONS 14) REGISTER DATA
7) DIAGNOSES  15) RISK FACTORS
8) DIAGNOSTIC CRITERIA 16) SERVICES

Report Option ==> 12 MEASUREMENTS

**********************************************
EMPLOYEE HEALTH REGISTER
**********************************************

REPORT SORTING UTILITY

The FAMILY MEMBERS report can be sorted by one or more of the following attributes.  
'<=' indicates a mandatory selection.

1) INTERVENTIONS  3) PATIENT
2) MEASUREMENT TYPE  4) SEX

Your choice: 4 SEX

Do you want to sort by a particular SEX? NO// (NO)

Within SEX, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

**********************************************
EMPLOYEE HEALTH REGISTER
**********************************************

MEASUREMENTS

REPORT DATE: MAY 15, 1995        PAGE: 1

<table>
<thead>
<tr>
<th>CHART</th>
<th>PATIENT</th>
<th>MEASUREMENT</th>
<th>VALUE</th>
<th>DATE OF MEASUREMENT</th>
</tr>
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<tbody>
<tr>
<td>100018</td>
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<td>VC</td>
<td>10/10</td>
<td>01/01/95</td>
</tr>
<tr>
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<td>ROBERTS, DIANE</td>
<td>HT</td>
<td>64.75</td>
<td>01/01/95</td>
</tr>
<tr>
<td>100018</td>
<td>ROBERTS, DIANE</td>
<td>TON</td>
<td>/7.5/800.0</td>
<td>02/02/95</td>
</tr>
<tr>
<td>100018</td>
<td>ROBERTS, DIANE</td>
<td>WT</td>
<td>135</td>
<td>04/01/95</td>
</tr>
<tr>
<td>100018</td>
<td>SMART, MAXWELL</td>
<td>VC</td>
<td>10/10</td>
<td>01/01/95</td>
</tr>
<tr>
<td>100018</td>
<td>SMITH, ROBERT</td>
<td>HT</td>
<td>64.75</td>
<td>01/01/95</td>
</tr>
<tr>
<td>100018</td>
<td>HANSON, WAYNE</td>
<td>TON</td>
<td>/7.5/800.0</td>
<td>02/02/95</td>
</tr>
<tr>
<td>100018</td>
<td>JONES, BOB</td>
<td>WT</td>
<td>135</td>
<td>04/01/95</td>
</tr>
</tbody>
</table>
EMPLOYEE HEALTH REGISTER

REPORT SORTING UTILITY

The MEDICATIONS report can be sorted by one or more of the following attributes.
'*' indicates a mandatory selection.

1) MEDICATIONS
2) PATIENT
3) SEX

Your choice: 2  PATIENT

Do you want to sort by a particular PATIENT? NO// (NO)
Within PATIENT, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P  Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

///--MEDICATION REPORT DISPLAY--///
**Case Management System (ACM) Version 2.0**

**User Manual**

**Error! No text of specified style in document.**

---

**EMPLOYEE HEALTH REGISTER**

**VERSION 2.0**

SELLS HOSPITAL/CLINIC

**PATIENT AND STATISTICAL REPORT GENERATION**

1) RECALL DATES  9) ETIOLOGY  
2) CARE PLAN  10) FAMILY MEMBERS  
3) CASE HISTORY  11) INTERVENTIONS  
4) CASE REVIEW DATE  12) MEASUREMENTS  
5) CASE COMMENTS  13) MEDICATIONS  
6) COMPLICATIONS  14) REGISTER DATA  
7) DIAGNOSES  15) RISK FACTORS  
8) DIAGNOSTIC CRITERIA  16) SERVICES

Report Option ==> 14 REGISTER DATA

---

**EMPLOYEE HEALTH REGISTER**

**REPORT SORTING UTILITY**

The REGISTER DATA report can be sorted by one or more of the following attributes.

'= indicates a mandatory selection.

1) CURRENT COMMUNITY  5) SEX  
2) NEXT APPOINTMENT DATE  6) STATUS  
3) NEXT CASE REVIEW FOLLOWED  7) WHERE  
4) PUBLIC HEALTH NURSE

Your choice: 6 STATUS

Do you want to sort by a particular STATUS? NO// (NO)

Within STATUS, want to sort by another attribute? NO// (NO)

Store Report Result as Search Template? NO//

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

---

**REGISTER STATUS DATA**

CLIENT: GRANT, ABE  CHART: 101770  
FOLLOWD: TUCSON MEDICAL CE  DOB: 05/24/86  AGE: 9 YRS  
PROVIDR: DOUGLAS, BILL  STATUS: ACTIVE  PRIORITY: HIGH  
MGR: DOUGLAS, BILL  PHN: JARLAND, TONI M  COMM: SELLS

---

**REGISTER STATUS DATA**

CLIENT: ADAMS, ROSE  CHART: 3061  
FOLLOWD: SAN XAVIER HEALTH DOB: 01/01/62  AGE: 33 YRS  
PROVIDR: CURTIS, CLAYTON  STATUS: ACTIVE  PRIORITY: MEDIUM
MGR: MONTOUR, VINA J. PHN: BUTCHER, LORI ANN COMM: SELLS
******************************** REGISTRATION STATUS DATA **************
CLIENT: ROBERTS, DIANE CHART: 100018
FOLLOWD: SELLS HOSPITAL/CL DOB: 05/11/97 AGE: 98 YRS
PROVIDR: STATUS: ACTIVE PRIORITY:
MGR: PHN: COMM: RIPLEY

**************************************
EMPLOYEE HEALTH REGISTER
**************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

PATIENT AND STATISTICAL REPORT GENERATION

1) RECALL DATES 9) ETIOLOGY
2) CARE PLAN 10) FAMILY MEMBERS
3) CASE HISTORY 11) INTERVENTIONS
4) CASE REVIEW DATE 12) MEASUREMENTS
5) CASE COMMENTS 13) MEDICATIONS
6) COMPLICATIONS 14) REGISTER DATA
7) DIAGNOSES 15) RISK FACTORS
8) DIAGNOSTIC CRITERIA 16) SERVICES

Report Option ==> 15 RISK FACTORS

**************************************
EMPLOYEE HEALTH REGISTER
**************************************
REPORT SORTING UTILITY

The RISK FACTORS report can be sorted by one or more of the following attributes.
'<' indicates a mandatory selection.
'= ' indicates a mandatory selection.

1) AGE 4) SEX
2) PATIENT 5) WHERE FOLLOWED
3) RISK FACTOR

Your choice: 2 PATIENT

Do you want to sort by a particular PATIENT? NO// (NO)
Within PATIENT, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

///--RISK FACTORS REPORT DISPLAY--///

**************************************
EMPLOYEE HEALTH REGISTER

RISK FACTORS FOR THE PATIENT

SORTED BY PATIENT

REPORT DATE: MAY 15, 1995

CHART PATIENT FACTORS
3061 ADAMS, ROSE POOR DIET
100018 ROBERTS, DIANE DISTANCE FROM CLINIC
100018 ROBERTS, DIANE DOESN'T KEEP APPOINTMENTS

EMPLOYEE HEALTH REGISTER

RISK FACTORS report can be sorted by one or more of the following attributes.
'<==' indicates a mandatory selection.

1) AGE 5) SERVICE AVAILABILITY
2) CURRENT COMMUNITY 6) SEX
3) PATIENT 7) WHERE FOLLOWED
4) SERVICE

Your choice: 3 PATIENT

Do you want to sort by a particular PATIENT? NO// (NO)

Within PATIENT, want to sort by another attribute? NO// (NO)

'Patient or 'Statistical report? ==> P Patient

Store Report Result as Search Template? NO// NO

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen
EMPLOYEE HEALTH REGISTER

PATIENTS BY SERVICE

SORTED BY PATIENT

REPORT DATE: MAY 15, 1995

CHART      PATIENT               SERVICE              STATUS
3061       ADAMS, ROSE            PHYSICAL THERAPY     ENROLLED
3061       ADAMS, ROSE            SPECIALTY            WAITING LIST
CONSULTATIONS
100018     ROBERTS, DIANE P       ODIAetry              FUTURE F/U

EMPLOYEE HEALTH REGISTER

VERSION 2.0

SELLS HOSPITAL/CLINIC

PATIENT AND STATISTICAL REPORT GENERATION

SUB MENU . . .
RG Report Generation

CS Case Summary, Individual
MS Case Summary, Multiple
ML Master List
PR Patient and Statistical Reports
GEN Register Patient General Retrieval (Lister)
LVST Display Data for a Patient’s Last Visit

Select Report Generation Option: GEN Register Patient General Retrieval (Lister)

CASE MANAGEMENT REGISTER PATIENT GENERAL RETRIEVAL

This report will produce a listing of Patients on a Register selected by the user. You will be asked (in three separate steps) to identify your selection criteria; what you wish displayed for each patient; and the sorting order for your list. You may save the logic used to produce the report for future use. If you design a report that is 80 characters or less in width, it can be displayed on your screen or printed. If your report is 81-132 characters wide, it must be printed - and only on a printer capable of producing 132 character lines.

REGISTER: EMPLOYEE HEALTH USER: JARLAND, TONI M

The Patients displayed can be selected based on any of the following criteria:
1) Patient Name
2) Patient Sex
3) Patient DOB
4) Patient DOD
5) Living Patients
6) Chart Facility
7) Patient Community
8) Patient Name
9) Medicaid Eligibility
10) Priv Ins Eligibility
11) PCC Designated Provider
12) Register Status
13) Case Priority
14) Medicaid Eligibility
15) Priv Ins Eligibility
16) PCC Designated Provider
17) Register Status
18) Case Priority
19) Case Manager
20) PHN
21) Last Review Date
22) Care-Plan Comment
23) Complication Comment
24) Diagnoses
25) Date of Onset
26) Date of Onset
27) Case History
28) Interventions
29) Care Plan
30) Care-Plan Comment
31) Complications
32) Complication Comment
33) Diagnoses
34) Date of Onset

User Manual December 1995
9) Patient Tribe  22) Next Review Date  35) Etiology
10) Eligibility Status  23) Where PT Followed  36) Risk Factors
11) Class/Beneficiary  24) Date Last Edited  37) Medications
12) Cause of Death  25) Case Comments  38) Services
13) Medicare Eligibility  26) Primary Provider

<Enter a list or a range. E.g. 1-4,5,20 or 10,12,20,30>

<<HIT RETURN to conclude selections or bypass screens>>

Select Patients based on which of the above: (1-38): 19

ENTER Case Manager: DOUGLAS,BILL

CMS REGISTER PATIENT Selection Criteria:
Case Manager: DOUGLAS,BILL

Would you like to select additional PATIENT criteria? NO// NO

Select one of the following:
  T Total Count Only
  S Sub-counts and Total Count
  D Detailed Patient Listing

Choose Type of Report: D// D Detailed Patient Listing

REGISTER: EMPLOYEE HEALTH USER: JARLAND,TONI M
PRINT Data Items Menu

The following data items can be printed. You can use up to 132 characters.
Choose the data items in the order you want them printed.

Total Report width (including column margins - 2 spaces): 0

1) Patient Name  17) Medicare Eligibility  33) Case History
2) Patient Chart #  18) Medicaid Eligibility  34) Interventions
3) Patient Sex  19) Priv Ins Eligibility  35) Care Plan
4) Patient SSN  20) Patient's Last Visit  36) Care-Plan Comment
5) Patient DOB  21) PCC Designated Provider  37) Complications
6) Patient Age  22) Register Status  38) Complication Comment
7) Patient DOD  23) Case Priority  39) Diagnoses
8) Mailing Address-Street  24) Case Manager  40) Date of Onset
9) Mailing Address-City  25) PHN  41) Etiology
10) Home Phone  26) Last Review Date  42) Family Members
11) Mother's Name  27) Next Review Date  43) Risk Factors
12) Patient Community  28) Where PT Followed  44) Medications
13) Patient Tribe  29) Date Last Edited  45) Services
14) Eligibility Status  30) Case Comments
15) Class/Beneficiary  31) Client Contact
16) Cause of Death  32) Primary Provider

<Enter a list or a range. E.g. 1-4,5,18 or 10,12,18,30>

<<HIT RETURN to conclude selections or '^' to exit>>

Select print item(s): (1-45): 1,2,3,4,24

Enter Column width for Patient Name (suggested: 20): (2-80): 20/

Enter Column width for Patient Chart # (suggested: 8): (2-80): 8/
Total Report width (including column margins - 2 spaces): 32
Enter Column width for Patient Sex (suggested: 6): (2-80): 6//
Total Report width (including column margins - 2 spaces): 40
Enter Column width for Patient SSN (suggested: 11): (2-80): 11//
Total Report width (including column margins - 2 spaces): 53
Enter Column width for Case Manager (suggested: 20): (2-80): 20//

PRINT Items Selected:
   Patient Name - column width 20
   Patient Chart # - column width 8
   Patient Sex - column width 6
   Patient SSN - column width 11
   Case Manager - column width 20

Total Report width (including column margins - 2 spaces): 75

REGISTER: EMPLOYEE HEALTH USER: JARLAND, TONI M
The Patients displayed can be SORTED by any one of the following:

1) Patient Name
2) Patient Age
3) Patient Community
4) Patient Sex
5) Patient Tribe
6) Patient Chart #
7) PCC Designated Provider
8) Classification/Beneficiary
9) Eligibility Status
10) Cause of Death
11) Patient DOB
12) Patient DOD
13) Register Status
14) Last Review Date
15) Next Review Date
16) Date Last Edited
17) Case Priority
18) Case Manager
19) PHN
20) Where PT Followed
21) Primary Provider

<<If you don't select a sort criteria the report will be sorted by Patient Name.>>

Sort Patients by which of the above: (1-21): RETURN KEY

No sort criteria selected ... will sort by Patient Name
Would you like a custom title for this report? N// NO

REPORT SUMMARY

CMS REGISTER PATIENT Selection Criteria:
Case Manager: DOUGLAS, BILL

PRINT Items Selected:
   Patient Name - column width 20
   Patient Chart # - column width 8
   Patient Sex - column width 6
   Patient SSN - column width 11
   Case Manager - column width 20

Total Report width (including column margins - 2 spaces): 75

CMS REGISTER PATIENT SORTING Criteria:
CMS REGISTER PATIENTS will be sorted by: Patient Name

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen
REPORT REQUESTED BY: JARLAND, TONI M

REGISTER: EMPLOYEE HEALTH

The following report contains a Patient report based on the following criteria:

PATIENT Selection Criteria
Case Manager: DOUGLAS, BILL

PRINT Field Selection
Patient Name (20)
Patient Chart # (8)
Patient Sex (6)
Patient SSN (11)
Case Manager (20)
TOTAL column width: 75

Patients will be SORTED by: Patient Name

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>CASE MGR</th>
<th>SEX</th>
<th>SSN</th>
<th>DOB</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAMS, AANDA</td>
<td>99999</td>
<td>DOUGLAS, BILL</td>
<td>FEMALE</td>
<td>077-38-0473</td>
<td>SEP 19, 1991</td>
<td>4</td>
</tr>
<tr>
<td>ADAMS, ANDY</td>
<td>88888</td>
<td>DOUGLAS, BILL</td>
<td>FEMALE</td>
<td>077-19-0781</td>
<td>JAN 3, 1989</td>
<td>6</td>
</tr>
<tr>
<td>ADAMS, LAURA</td>
<td>77777</td>
<td>DOUGLAS, BILL</td>
<td>FEMALE</td>
<td>077-66-0746</td>
<td>JULY 6, 1988</td>
<td>6</td>
</tr>
<tr>
<td>ADAMS, MAUDE</td>
<td>66666</td>
<td>DOUGLAS, BILL</td>
<td>FEMALE</td>
<td>067-68-0696</td>
<td>JULY 26, 1987</td>
<td>7</td>
</tr>
<tr>
<td>ADAMS, WILMA</td>
<td>55555</td>
<td>DOUGLAS, BILL</td>
<td>FEMALE</td>
<td>077-50-0755</td>
<td>AUG 29, 1988</td>
<td>6</td>
</tr>
<tr>
<td>BROEN, DON</td>
<td>44444</td>
<td>DOUGLAS, BILL</td>
<td>MALE</td>
<td>077-27-0792</td>
<td>FEB 28, 1989</td>
<td>9</td>
</tr>
</tbody>
</table>

******************************************************************************

EMPLOYEE HEALTH REGISTER
******************************************************************************

VERSION 2.0
SELLS HOSPITAL/CLINIC

PATIENT AND STATISTICAL REPORT GENERATION

SUB MENU . . .

RG Report Generation
CS Case Summary, Individual
MS Case Summary, Multiple
ML Master List
FR Patient and Statistical Reports
GEN Register Patient General Retrieval (Lister)
LVST Display Data for a Patient’s Last Visit

Select Report Generation Option: LVST Display Data for a Patient’s Last Visit

Select PATIENT NAME: GRANT, ABE M 05-24-86 065180651 SE 101770
DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

///----DISPLAY DATA FOR A PATIENT'S LAST VISIT REPORT DISPLAY---///

VISIT/ADMIT DATE & TIME: APR 17, 1995@12:00
DATE VISIT CREATED: APR 17, 1995 TYPE: IHS
PATIENT NAME: GRANT, ABE LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC
SERVICE CATEGORY: AMBULATORY CLINIC: MENTAL HEALTH
DEPENDENT ENTRY COUNT: 3 DATE LAST MODIFIED: APR 17, 1995
WALK IN/APPT: WALK IN

----------------------------- V PROVIDER -----------------------------
PROVIDER: JARLAND, TONI M PATIENT NAME: GRANT, ABE
VISIT: APR 17, 1995@12:00 PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 119TJ

----------------------------- V POV -----------------------------
POV: V61.20 PATIENT NAME: GRANT, ABE
VISIT: APR 17, 1995@12:00
PROVIDER NARRATIVE: PARENT-CHILD PROBLEM NOS
ICD NARRATIVE (c): PARENT-CHILD PROBLEM NOS

----------------------------- V ACTIVITY TIME -----------------------------
ACTIVITY TIME: 20 PATIENT NAME: GRANT, ABE
VISIT: APR 17, 1995@12:00
TOTAL TIME (c): 20
VISIT EIN: 72247
End of visit display, <RETURN> to Continue

4.8 RD Resource Directory

**********************************************************************
** CASE MANAGEMENT SYSTEM **
**********************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC
RESOURCE DIRECTORY LISTING

SUB MENU . . .
RD Resource Directory
**********************************************************************
These Options are provided for the purpose of developing a directory of
resources (IHS, state, private, tribal etc.) used for patients on a particular Register. A
Resource
Directory is NOT required for a Register--
**********************************************************************
RE Add or Edit a Resource Directory
RI Inquire To A Specific Resource
RL Resource Directory (Detailed Listing)
RS Print Resource (By Services Available)
SI Inquire To A Specific Service Available

Select Resource Directory Option: RE Add or Edit a Resource Directory

**********************************************************************
** CASE MANAGEMENT SYSTEM **
***************************************************************************
These Options are provided for the purpose of developing a directory of resources (IHS, state, private, tribal etc.) used for patients on a particular Register. A
Resource Directory is NOT required for a Register—
***************************************************************************
RE   Add or Edit a Resource Directory
RI   Inquire To A Specific Resource
RL   Resource Directory (Detailed Listing)
RS   Print Resource (By Services Available)
SI   Inquire To A Specific Service Available

Select Resource Directory Option: RI Inquire To A Specific Resource

***************************************************************************
**   CASE MANAGEMENT SYSTEM   **
***************************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

RESOURCE DIRECTORY LISTING

Select CMS RESOURCE: DR. SMITH

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

---------INQUIRE TO A SPECIFIC RESOURCE REPORT DISPLAY--------

***************************************************************************
**   CASE MANAGEMENT SYSTEM   **
***************************************************************************
LOCAL RESOURCE DIRECTORY

REPORT DATE: 06/08/95 PAGE: 1
NAME: DR. SMITH
STREET: 123 NORTH STREET
CITY: BILLINGS STATE: MONTANA ZIP: 59102
PHONE: 652-1295
CONTACT: RECEPTIONIST
HOURS: 9:00 AM TO 5:00 PM
REGION: MONTANA

SERVICES(S): SERVICE CLINIC DATES DESCRIPTIVE DATE
------- -------------- --------------
SPEECH THERAPY JUNE 8, 1995 1ST TUESDAY OF EACH MONTH

PROGRAM DESCRIPTION
THIS IS THE PROGRAM DESCRIPTION FIELD FOR DR. SMITH

ELIGIBILITY REQUIREMENTS
COST INFORMATION
ENTER COST FIGURES HERE
HOW TO APPLY
ENTER PERTINENT INFORMATION RELATED TO APPLICATION
OTHER INFORMATION
THIS IS PROVIDED FOR OTHER INFORMATION

***************************************************************************
** CASE MANAGEMENT SYSTEM **
***************************************************************************
** CASE MANAGEMENT SYSTEM **
***************************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

RESOURCE DIRECTORY LISTING

SUB MENU ...
RD Resource Directory
***************************************************************************
These Options are provided for the purpose of developing a directory of resources (IHS, state, private, tribal etc.) used for patients on a particular Register. A Resource Directory is NOT required for a Register—
***************************************************************************
RE Add or Edit a Resource Directory
RI Inquire To A Specific Resource
RL Resource Directory (Detailed Listing)
RS Print Resource (By Services Available)
SI Inquire To A Specific Service Available

Select Resource Directory Option: RL Resource Directory (Detailed Listing)

***************************************************************************
** CASE MANAGEMENT SYSTEM **
***************************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

RESOURCE DIRECTORY LISTING

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

***************************************************************************
** CASE MANAGEMENT SYSTEM **
***************************************************************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

LOCAL RESOURCE DIRECTORY

REPORT DATE: 06/08/95 PAGE: 1
NAME: DR. FANG
STREET: 123 STREET
CITY: TUCSON STATE: ARIZONA ZIP: 85711
PHONE: (520) 295-2533
CONTACT: RECEPTIONIST
HOURS: 8-5
REGION:
SERVICES(S): SERVICE CLINIC DATES DESCRIPTIVE DATE
-------- ------------- ---------------
FAMILY MEDICINE 5 DAYS/WEEK

***************************************************************************
** CASE MANAGEMENT SYSTEM **
***************************************************************************
NAME: DR. SMITH
STREET: 123 NORTH STREET
CITY: BILLINGS STATE: MONTANA ZIP: 59102

RE   Add or Edit a Resource Directory
RI   Inquire To A Specific Resource
RL   Resource Directory (Detailed Listing)
RS   Print Resource (By Services Available)
SI   Inquire To A Specific Service Available

Select Resource Directory Option: RS Print Resource (By Services Available)
SERVICES PROVIDED

REPORT DATE: JUNE 8, 1995

RESOURCE               PHONE                     CONTACT

SERVICES PROVIDED: FAMILY MEDICINE
DR. FANG (520) 295-2533 RECEPTIONIST
TUCSON MED CTR

SERVICES PROVIDED: SPEECH THERAPY
DR. SMITH 652-1295 RECEPTIONIST

SUB MENU . . .
RD Resource Directory
***************************************************************************
These Options are provided for the purpose of developing a directory of resources (IHS, state, private, tribal etc.) used for patients on a particular Register. A Resource Directory is NOT required for a Register-
***************************************************************************
RE Add or Edit a Resource Directory
RI Inquire To A Specific Resource
RL Resource Directory (Detailed Listing)
RS Print Resource (By Services Available)
SI Inquire To A Specific Service Available

Select Resource Directory Option: SI Inquire To A Specific Service Available

///--PRINT RESOURCE (BY SERVICES AVAILABLE) REPORT DISPLAY--///
4.9 QM Q-Man (PCC Query Utility)

** CASE MANAGEMENT SYSTEM **
** VERSION 2.0 **
****************************

MAIN MENU

CR Create/Modify Register Structure
AU Add Authorized Users
BL Build Supporting Lists ...
DL Display Supporting Lists ...
AD Add/Delete ...
DE Data Entry
RG Report Generation ...
RD Resource Directory ...
QM Q-Man (PCC Query Utility)
DEL Delete Entire Register
LTR Manage Recall Letters ...

Install IHS Diabetes Register

Select Main Menu Option: QM Q-Man (PCC Query Utility)

NOTE: Major additions have been incorporated into the Report Generation Menu Options. Creation of Templates, within the CMS Package, maybe utilized in linking all PCC visit related data to those patients in your Register. Utilizing any one of the CMS Report Options, you may create a Template (List of Register Patients). You may, then, use this Template within the Q-Man Query Utility and access a limitless number of demographic and/or clinical data for these patients.

The example below demonstrates how to access the last 3 PCC visits for only those patients residing in a Template which was created within the CMS Reports Options. You may want to refer to the Q-Man User Manual for quick reference in utilizing the Q-Man Software Application.

***** WELCOME TO Q-MAN: THE PCC QUERY UTILITY *****
****************************************************************
** WARNING...Q-Man produces confidential patient information.  **
** View only in private. Keep all printed reports in a secure area. **
** Ask your site manager for the current Q-Man Users Guide.     **
****************************************************************

Query utility: IHS Q-MAN Ver. 2
Current user: TONI M JARLAND
Chart numbers will be displayed for: YOUR FACILITY
Access to demographic data: PERMITTED
Access to clinical data: PERMITTED
Programmer privileges: YES
***** Q-MAN OPTIONS *****

Select one of the following:
1 SEARCH PCC Database (dialogue interface)
2 FAST Facts (natural language interface)
3 RUN Search Logic
4 VIEW/DELETE Taxonomies and Search Templates
5 FILEMAN Print
9 HELP
0 EXIT

Your choice: SEARCH// SEARCH PCC Database (dialogue interface)

***** SEARCH CRITERIA *****

What is the subject of your search? LIVING PATIENTS // LIVING PATIENTS

Attribute of LIVING PATIENTS: [ENTER A TEMPLATE NAME CREATED FROM A CMS REPORT]
Select one of the following =>

1) LIVING PATIENTS must be a member of the CMS TEMPLATE NAME cohort
2) LIVING PATIENTS must NOT be a member of the CMS TEMPLATE NAME cohort
3) Select a random sample of the CMS TEMPLATE NAME cohort
4) Count the number of entries in the CMS TEMPLATE NAME cohort

Your choice (1-4): 1//

Attribute of LIVING PATIENTS: VISIT

SUBQUERY: Analysis of multiple VISITS

First condition/attribute of "VISIT": LAST
Enter the value which goes with LAST; e.g., LAST 3, LAST 10, etc.
Value: 3

Next condition/attribute of "VISIT":

Subject of search: PATIENTS
ALIVE TODAY [SER = .02]
MEMBER OF 'TMJ AGE GR 80' COHORT [SER = 99.00]
Subject of subquery: VISIT
LAST 3

***** Q-MAN OUTPUT OPTIONS *****

Select one of the following:
1 DISPLAY results on the screen
2 PRINT results on paper Note:
3 COUNT 'hits' Choose the Output Option. You may
4 STORE results of a search in a FM search template also save Q-Man runs in a Template
5 SAVE search logic for future use (Option #4) and Transfer patients
6 R-MAN special report generator automatically into your Register.
9 HELP See TX Transfer Patients.
0 EXIT

Your choice: DISPLAY/ / 1 DISPLAY results on the screen

You have 2 options for listing VISITS =>

1) For ea. patient, list all VISITS which match your criteria
2) List all PATIENTS with VISITS meeting your criteria, but do not list the individual values of ea. VISIT
Your choice (1 or 2): 1// (1)

///==Q-MAN REPORT DISPLAY OPTION==///

Please note: Patients whose names are marked with an "*" may have aliases.

<table>
<thead>
<tr>
<th>PATIENTS</th>
<th>NUMBER</th>
<th>VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Alive)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROBERTS, DIANE*</td>
<td>100016</td>
<td>JUNE 8, 1995</td>
</tr>
<tr>
<td>ROBERTS, DIANE*</td>
<td>100016</td>
<td>JUNE 6, 1995</td>
</tr>
<tr>
<td>ROBERTS, DIANE*</td>
<td>100016</td>
<td>MAY 24, 1995</td>
</tr>
<tr>
<td>JOHNSON, MARTHA*</td>
<td>999995</td>
<td>MAR 13, 1992</td>
</tr>
<tr>
<td>JOHNSON, MARTHA*</td>
<td>999995</td>
<td>APR 17, 1991</td>
</tr>
<tr>
<td>JOHNSON, MARTHA*</td>
<td>999995</td>
<td>FEB 1, 1990</td>
</tr>
<tr>
<td>GREENJEANS, ERIC*</td>
<td>100127</td>
<td>MAY 26, 1993</td>
</tr>
<tr>
<td>GREENJEANS, ERIC*</td>
<td>100127</td>
<td>APR 23, 1992</td>
</tr>
<tr>
<td>GREENJEANS, ERIC*</td>
<td>100127</td>
<td>NOV 30, 1989</td>
</tr>
<tr>
<td>REAGAN, VALERIE*</td>
<td>100241</td>
<td>OCT 21, 1992</td>
</tr>
</tbody>
</table>

4.10 DEL  Delete Entire Register

******************************************************
** CASE MANAGEMENT SYSTEM **
**      VERSION 2.0       **
******************************************************

MAIN MENU

CR   Create/Modify Register Structure
AU   Add Authorized Users
BL   Build Supporting Lists ...
DL   Display Supporting Lists ...
AD   Add/Delete ...
DE   Data Entry
RG   Report Generation ...
RD   Resource Directory ...
QM   Q-Man (PCC Query Utility)
DEL  Delete Entire Register

Select Main Menu Option:  DEL  Delete Entire Register

WARNING:

The next procedure will allow you to COMPLETELY delete an entire register from the Case Management System. The register, including all patients and all information on all patients will be deleted WITH NO POSSIBILITY of recovering any of the data. Be absolutely certain this is what you want before preceding.
REGISTER: EMPLOYEE HEALTH
Are you certain you want to delete the entire EMPLOYEE HEALTH register?
NO//YES
...DELETING ALL PATIENT RELATED DATA.................................
...DELETING ALL REGISTER RELATED LIST ENTRIES............................
...DELETING ALL PATIENTS FROM THE REGISTER...............................
...DELETING THE REGISTER....

4.11 LTR Manage Recall Letters

**************************
** CASE MANAGEMENT SYSTEM **
**************************

VERSION 2.0
SELLS HOSPITAL/CLINIC

SUB MENU...
LTR Manage Recall Letters

LTP Print Specified Recall Letter(s)
LTS Setup/Modify Letter Format Structure

NOTE: The Setup/Modify Letter Format Structure is provided so you may ‘Customize’ the format structure for each individual Register. Upon completion, ALL Letters for this particular Register will be displayed in this standard format.

Address Starting Line The Number of Lines from the Top of the Page
Address Starting Column The Number of Lines from the left margin
Letter Signature Name of the Person who signs the letter
Letter Head Line 1 & 2 Desired Letter Head which will appear at the top of each letter.
Additional Letter Statement If desired, an additional customized text field is Provided for the purpose of adding pertinent information relative to the content and scope of a Register letter.

************************************************
** CASE MANAGEMENT SYSTEM **
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REGISTER SELECTION UTILITY

EMPLOYEE HEALTH

REGISTER: EMPLOYEE HEALTH

************************************************
EMPLOYEE HEALTH REGISTER
************************************************
Format Structure for RECALL LETTERS:
ADDRESS STARTING LINE.. 10 (Top Margin Start Position Number)
ADDRESS STARTING COLUMN: 20 (Left Margin Start Position Number)
LETTER SIGNATURE........: MRS. JANE SMITH (Person Signing All Letters)
LETTER HEAD LINE 1......: BILLINGS AREA INDIAN HEALTH SERVICE
                         (First Header line)
LETTER HEAD LINE 2......: BILLINGS, MONTANA (Second Header line)

In addition to the standard narrative content, RECALL LETTERS may also contain specified text content. If desired, you may enter this additional information in the following Word Processing Field:

ADDITIONAL LETTER STATEMENT:
1>THIS IS EMPLOYEE HEALTH ADDITIONAL STATEMENT PARAGRAPH
2>THIS IS LINE #2 OF THE STATEMENT PARAGRAPH. YOU MAY ENTER
3>ANY ADDITIONAL INFORMATION WHICH WILL APPEAR ON THE LETTER.

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** CASE MANAGEMENT SYSTEM **
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VERSION 2.0
SELLS HOSPITAL/CLINIC

RECALL LETTER MANAGEMENT

NOTE: Recall Letters may be sorted by:
(1) Appointment Status, (2) Next Appointment Date, (3) Patient, or (4) Recall Date.
The Referral, Provider, Purpose, Next Appointment Date, Contact Person, and Contact Telephone Number (which appear on each Patient’s Recall Letter) are obtained from each Patient’s Recall Date entry. This information is entered under the DE Data Entry Menu Option and selecting the Data Entry Choice of RECALL DATE.
A sample of the Recall Letter may be displayed, prior to printing the Recall Letter. If you answer ‘Yes’ to display the Recall Letter, you will also be asked if you want to modify the letter format and/or the additional text field. If you answer ‘Yes’ to modify the letter format, you will be prompted for each field identical to Menu Option LTS Setup/Modify Letter Format Structure.

*******************************
** CASE MANAGEMENT SYSTEM **
*******************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

RECALL LETTER MANAGEMENT

SUB MENU . . .
LTR Manage Recall Letters
LTP Print Specified Recall Letter(s)
LTS Setup/Modify Letter Format Structure

*******************************
** CASE MANAGEMENT SYSTEM **
*******************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

RECALL LETTER MANAGEMENT

SUB MENU . . .
LTR Manage Recall Letters
LTP Print Specified Recall Letter(s)
LTS Setup/Modify Letter Format Structure

NOTE: Recall Letters may be sorted by:
(1) Appointment Status, (2) Next Appointment Date, (3) Patient, or (4) Recall Date.
The Referral, Provider, Purpose, Next Appointment Date, Contact Person, and Contact Telephone Number (which appear on each Patient’s Recall Letter) are obtained from each Patient’s Recall Date entry. This information is entered under the DE Data Entry Menu Option and selecting the Data Entry Choice of RECALL DATE.
A sample of the Recall Letter may be displayed, prior to printing the Recall Letter. If you answer ‘Yes’ to display the Recall Letter, you will also be asked if you want to modify the letter format and/or the additional text field. If you answer ‘Yes’ to modify the letter format, you will be prompted for each field identical to Menu Option LTS Setup/Modify Letter Format Structure.

*******************************
** CASE MANAGEMENT SYSTEM **
*******************************
VERSION 2.0
SELLS HOSPITAL/CLINIC

RECALL LETTER MANAGEMENT

SUB MENU . . .
LTR Manage Recall Letters
LTP Print Specified Recall Letter(s)
LTS Setup/Modify Letter Format Structure

NOTE: Recall Letters may be sorted by:
(1) Appointment Status, (2) Next Appointment Date, (3) Patient, or (4) Recall Date.
The Referral, Provider, Purpose, Next Appointment Date, Contact Person, and Contact Telephone Number (which appear on each Patient’s Recall Letter) are obtained from each Patient’s Recall Date entry. This information is entered under the DE Data Entry Menu Option and selecting the Data Entry Choice of RECALL DATE.
A sample of the Recall Letter may be displayed, prior to printing the Recall Letter. If you answer ‘Yes’ to display the Recall Letter, you will also be asked if you want to modify the letter format and/or the additional text field. If you answer ‘Yes’ to modify the letter format, you will be prompted for each field identical to Menu Option LTS Setup/Modify Letter Format Structure.
**REPORT SORTING UTILITY**

The RECALL LETTERS report can be sorted by one or more of the following attributes. 
'<=>' indicates a mandatory selection.

1) APPOINTMENT STATUS     3) PATIENT
2) NEXT APPOINTMENT DATE  4) RECALL DATES

Your choice: 4 RECALL DATES

Start with what date: 5-15-95 (MAY 15, 1995)
End with what date: 5-15-95 (MAY 15, 1995)

Within RECALL DATES, want to sort by another attribute? NO// (NO)

Do you want to VIEW the Standard Letter before printing? NO// (NO)

DEVICE: Enter a Device Number or; Hit Return Key to Display to Screen

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**Recall Letter Display Example:**

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MAY 26, 1995

BILLINGS AREA INDIAN HEALTH SERVICE
BILLINGS, MONTANA

Dear Client:

Review of our records indicate ABE GRANT (Chart #: 101770)

is scheduled for the following appointment with:

REFERRAL: IHS  
PROVIDER: DR. DONALD JONES  
PURPOSE: ANNUAL PHYSICAL  
APPT DATE: 06/25/95

To arrange an appointment date/time, please contact:

MRS. JOHNSON  
295-2570

THIS IS EMPLOYEE HEALTH ADDITIONAL STATEMENT PARAGRAPH.  
THIS IS LINE #2 OF THE STATEMENT PARAGRAPH. YOU MAY ENTER  
ANY ADDITIONAL INFORMATION WHICH WILL APPEAR ON THE LETTER.

MRS. JANE SMITH  
GRANDMOTHER  
PO BOX 3355  
BILLINGS, MT 59103
4.12 Install IHS Diabetes Register

Note: IHS NATIONAL DIABETES REGISTER

If you have already installed the IHS DIABETES REGISTER at your Site, DO NOT proceed with this Menu Option.

The new IHS Diabetes Management System is a Standardized Case Management Register and group of computer programs designed to facilitate individual diabetes patient care and diabetes program management. Features of the Diabetes Management System include:

- A Diabetes Register, using the PCC CASE MANAGEMENT SYSTEM.
- A Diabetes Flow Sheet included on the PCC Health Summary
- A monitoring/prompting of important care items on the Health Summary
- Standard nomenclature for recording diabetes exams and education on PCC Forms
- An automated Diabetes Program Audit Report - PCC Management Reports Application
- Access to all PCC Clinical Data

If you have any questions regarding the Diabetes Register, consult your local Site Manager and/or refer to the PCC
Diabetes Management System Resource Manual (dated January 1994) for further detailed information on this Register.

SPECIAL NOTE:

Most Sites do not have a locally developed Diabetes Register within the CMS Package. Those sites would install the IHS DIABETES REGISTER and would not have to worry about converting data. A few Sites may already have their own locally developed register and will want to convert it to the IHS Standard elements, diagnoses, and complications. Some sites may have a FileMan file containing patient names and data. After installing the IHS DIABETES REGISTER, the User can utilize Q-Man to retrieve the patient names from their FileMan file and move (only) those names into the new IHS DIABETES REGISTER.