



RESOURCE AND PATIENT MANAGEMENT SYSTEM

iCare Population Management GUI

(BQI)

Patient Record User Manual

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Preface

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

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

For more information about iCare basic functionality, iCare usage, or training for iCare, these resources may be consulted:

- iCare – IHS OIT available at <http://www.ihs.gov/icare/>
- iCare Population Management GUI, User Manual Version 2.2 (July 2011) available at http://www.ihs.gov/RPMS/PackageDocs/bqi/bqi_022u.pdf
- iCare Training available at http://www.ihs.gov/icare/index.cfm?module=dsp_icare_cmet_training
- Recorded Adobe Connect sessions for iCare available at <https://ihs.adobeconnect.com/r6yazmoz1gm>
- Join the iCare listserv by sending an e-mail to icare@listserv.ihs.gov

1.0 Introduction

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

For more information about iCare basic functionality, iCare usage, or training for iCare, consult the resources listed in the Preface.

1.1 Background

Along with the rest of the healthcare industry, IHS has already developed a set of chronic condition management (or register) applications. Applications included are for diabetes, asthma, and Human Immunodeficiency Virus (HIV.) This type of application provides a way for healthcare providers to manage a specific group (register) of patients for a single disease state. Register management applications assist healthcare providers to identify high-risk patients, proactively track care reminders and health status of individuals or populations, provide more standardized and appropriate care by embedding evidence-based guidelines, and report outcomes.

Many patients, however, have more than one diagnosed disease. For instance, at the current time within the Indian Health system, a diabetic asthmatic woman could be a member of four RPMS registers (diabetes, asthma, women's health, and immunizations). This 'silo' approach to patient care could potentially result in fragmented care, and could increase the risk of inadequate patient care management due to misidentification of the true level of risk.

1.2 iCare Graphical User Interface

The iCare Graphical User Interface (GUI) is intended to allow providers to see a more complete view of patients with multiple conditions, while maintaining the integrity of the user-defined, disease-specific registers.

iCare can help IHS providers by:

- Proactively identifying and managing different groups (populations) of patients who share user-defined characteristics.
- Providing an integrated view of a patient's conditions that would minimize "stove piped" care management.

- Providing an intuitive and integrated interface to the diverse patient data elements of the RPMS database.
- Facilitating provider's review of clinical quality of care measures for their own patients, to enable improvement in the quality of healthcare delivery.
- Enabling views of traditional healthcare information from the perspectives of community, population and public health.
- Providing the default tag selection as Proposed and Accepted. The tag selection for any record can be changed by selecting or de-selecting any checkbox.
- Clicking the "use AND?" check box when there are multiple tags selected. The "And" option searches for patients who have ALL the user-defined tags.

1.3 Who Should Use iCare?

Any provider who needs to identify a group of patients for long-term management or to create a temporary list should think about using iCare. Does the user fit any of the following scenarios?

- A nurse at a facility who assigns a primary care provider to each patient. Every day, there is a need to create a list of scheduled patients for two different doctors in the clinic.
- A user wants to identify which of the patients are considered obese so that recommend nutrition counseling can be given.
- Because providers at a clinic have performance goals related to annual Government Performance and Results Act (GPRA) clinical measures, a user wants to identify which of the patients are missing key clinical data.
- The Women's Health Clinic wants to focus on two clinical performance improvement initiatives this year. The personnel want to identify the performance problem areas for female patients between the ages of 18 and 50.
- One of the two part-time case managers for a group of children needs to create a patient list that both case managers can use.

2.0 Patient Record

The patient record window has several tabs and other information that shows patient data information stored in the RPMS database. This window provides a wide range of clinical data, with a focus on providing quick access to needed data. (See Figure 2-1)

The screenshot shows the 'RPMS iCare - DEMO, AMENDMENT TWO' window. At the top, there is a 'Quick Patient Search' field. Below it, patient information is displayed: Name: DEMO, AMENDMENT TWO; HRNs: [empty]; SSN: XXX-XX-4222; Sex: M; Age: 35 YRS; DOB: [empty]; Community: PARKER; Address: PO BOX 2803, ALB, NEW MEXICO 87119; Phone: 555-555-6579; Work Ph.: 555-999-7703; Alt. Phone: NONE; Email: [empty]; DPCP: [empty]. There are buttons for 'Additional Demographics', 'Add a Note', and 'View Imm Profile'. A 'Cover Sheet' tab is active, showing sub-tabs for 'Snapshot', 'Flags', 'Reminders', 'BP Prompts', 'Nat'l Measures', 'CMET', 'Summ/Supp', 'PCC', and 'Problem List'. The 'Recent Visits' section shows a table with columns for Date, Provider Narrative, and Clinic. The 'Insurance' section shows 'MEDICAID 4A' with an effective date of Jul 24, 2009. The 'Panels' section shows 'DEMO Patient Panel' and 'Dog Bite PR 937'. The 'Providers' and 'Registers' sections are partially visible at the bottom.

Figure 2-1 Sample Patient Record window

The patient record window can be accessed either by opening a patient record on a panel or by a direct search for a patient name.

The Suicide Form tab may not display. This tab is only displayed for those users assigned special keys.

The Quick Patient Search field allows a search for a patient (even one that is not on any of the user's panels.) After a successful search, the data for the indicated patient will display on the Patient Record window.

As a rule, double-clicking any date that is underlined (in the Date column) causes the Visit File pop-up to display.

2.1 Specifying the Default Tab

A user can set which tabs are displayed and the starting tab for the Patient Record window by defining it on the Patient View tab of the **User Preferences** window by selecting **Tools | User Preferences**. This means that when accessing the Patient Record window, only the checked tabs will display and the string tab will be on top. Section 20.1 provides information about User Preferences.

2.2 Patient Demographic Group Box

The top group box shows the patient demographic information. This information remains visible from any tab on the Patient Record window. (Figure 2-2)

Figure 2-2: Sample **Patient demographics** group box

2.2.1 Community Field

The Community field shows any alerts about the community in which the patient resides. If the **community alert icon** (📶) is displayed, click it to display the **Community Alerts** for pop-up. (Figure 2-3)

Type	Diagnosis	Number of Cases in the Past 30 Days	Number of Cases in the Past 24 Hours	Most Recent Occurrence
CDC NND	Measles	3	0	Mar 24, 2016
CDC NND	Rocky Mountain Spotted Fever	1	0	Mar 28, 2016

Figure 2-3: Sample **Community Alerts** for Community pop-up

2.2.1.1 Community Alerts Layout

The following provides information about the data columns.

Type: The following describes the alert types: (1) Centers for Disease Control and Prevention (CDC) Nationally Notifiable Diseases (NND) and (2) Suicidal Behavior: Ideation, Attempt and Completion. For this version, the logic will only display each alert for 30 days from the visit occurrence date.

Diagnosis: The diagnosis category for the alert.

Number of Cases Past 30 Days: The number of cases in the past 30 days.

Number of Cases in the Past 24 Hours: The number of cases in the past 24 hours.

Most Recent Occurrence: The date for the most recent occurrence.

2.2.1.2 Menus on Community Alerts for Community Pop-up

The File menu contains the following options:

Page Setup: This option allows the user to set Margin, Paper, Layout characteristics (like landscape or portrait orientation), and the Printer to use.

Print Preview: This option displays the **print preview dialog**. Section 20.13 provides information about this dialog.

Print: This option sends the page to the printer using the settings in **Page Setup**.

Close: This option closes the pop-up.

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

The **Tools menu** contains the Reset View, Search, Excel Export, and Copy Rows to Clipboard options that work like the buttons on the right side of the window. Section 20.3 provides information about these buttons.

2.2.1.3 Buttons on Community Alerts for Community Pop-up

Section 20.3 provides information about the buttons on the right side of the toolbar.

2.2.2 Allergies Field

The Allergies field pulls data about the patient directly from the **Adverse Reaction Tracking** application. Each reaction shows a tooltip (Causative Agent, Reaction, Date of Onset, Historical or Observed.) Options available for the selected rows in the grid: Export to Excel, Print, and Copy. Section 20.3 provides information about these buttons.

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


Section 20.3 provides information about the buttons on the right side of the toolbar of the Allergies.

2.2.3 Barriers to Learning Field


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

2.2.4 Phone Fields

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


Click the **pencil button** () next to the phone number to display the **Edit Patient Demographic Fields** dialog. Section 20.4 provides information about this dialog.

2.2.5 Email Field

The Email field can be edited by clicking the **pencil button** () next to the email field to display the **Edit Patient Demographic Fields** dialog. Section 20.4 provides information about this dialog.

2.2.6 DPCP Field

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

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

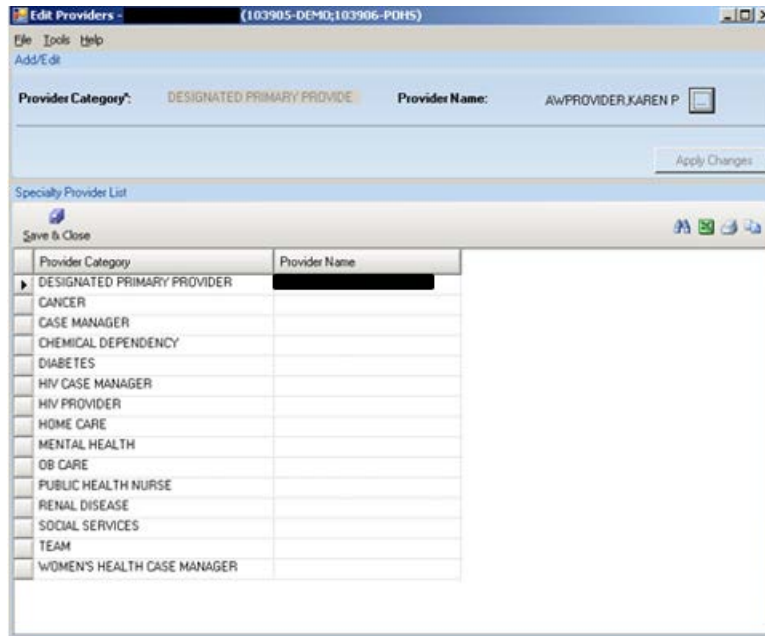


Figure 2-4: Sample **Edit Providers** dialog

Use the **Edit Providers** dialog to add, edit, or remove specialty provider names for the various provider categories. Section 20.8 provides information about this dialog.


2.2.7 Additional Demographics Button

More information about the patient's demographics can be viewed by clicking the **Additional Demographics button** (Figure 2-5) to access the **Additional Demographics** pop-up.

ENGLISH; Communication Preference: PHONE; Location of Home: . An 'OK' button is located at the bottom right of the window."/>

Figure 2-5: Sample **Additional Demographics** pop-up
Click **OK** to dismiss this pop-up.

- **Demographic Detail Tab**


Change the Race, Ethnicity, Preferred Language, and/or Communication Preferences field by clicking the **pencil button** () next to the field. This action displays the **Edit Patient Demographic Fields** dialog. Section 20.4 provides information about the dialog.

- **Household Tab**

Additional household information can be viewed by selecting the **Household** tab. These data values are from the RPMS Patient Registration application (and are view only.)

The screenshot shows a window titled "RPMS iCare - DEMO:AMENDMENT TWO - Additional Demographics". Inside, there is a "Demographic Detail" section with a "Household" tab selected. The "Number in Household" is set to 6, with a pencil icon next to it. Below this are three sections: "Emergency" with fields for Contact Name, Relationship, and Phone; "Next of Kin" with fields for Primary Name, Relationship, and Phone; and "Mother's Maiden Name". The "Father's" section includes fields for Name and Birthplace, with "GREENVILLE OH" and "PARKER AZ" entered. An "OK" button is located at the bottom right of the dialog.

Figure 2-6: Sample Information on **Household** tab

Change the Number in Household by clicking the **pencil button** () to access the **Edit Patient Demographic Fields** dialog. Section 20.4 provides information about the dialog.

2.2.8 Add a Note

Use the Add a Note button to add a Text Integration Utility (TIU) note for the current patient. This involves a two-step process:

1. Click the **Add a Note** button to access the **Add a Note** dialog and then complete the fields on this dialog. Section 20.5 provides information about the dialog.
2. Click the **Create** button on the Add a Note dialog to access the **Add TIU Note** dialog. Section 20.6 provides more information about the dialog.

After clicking the **Add a Note button**, and if no default clinics are defined in user preferences, the application displays the following message: The default clinics in user preferences must be selected before being able to enter notes. Click **OK** to dismiss the message. Select **Tools | User Preferences** to access the **RPMS iCare – User Preferences** dialog. Go to the Patient View tab to enter the **clinic codes**. Section 20.1 provides information about user preferences.

2.2.9 View IMM Profile

Use the **View IMM Profile button** (Immunization) to view the **Immunization Profile** pop-up window. See a sample of an IMM Profile in Figure 2-7.

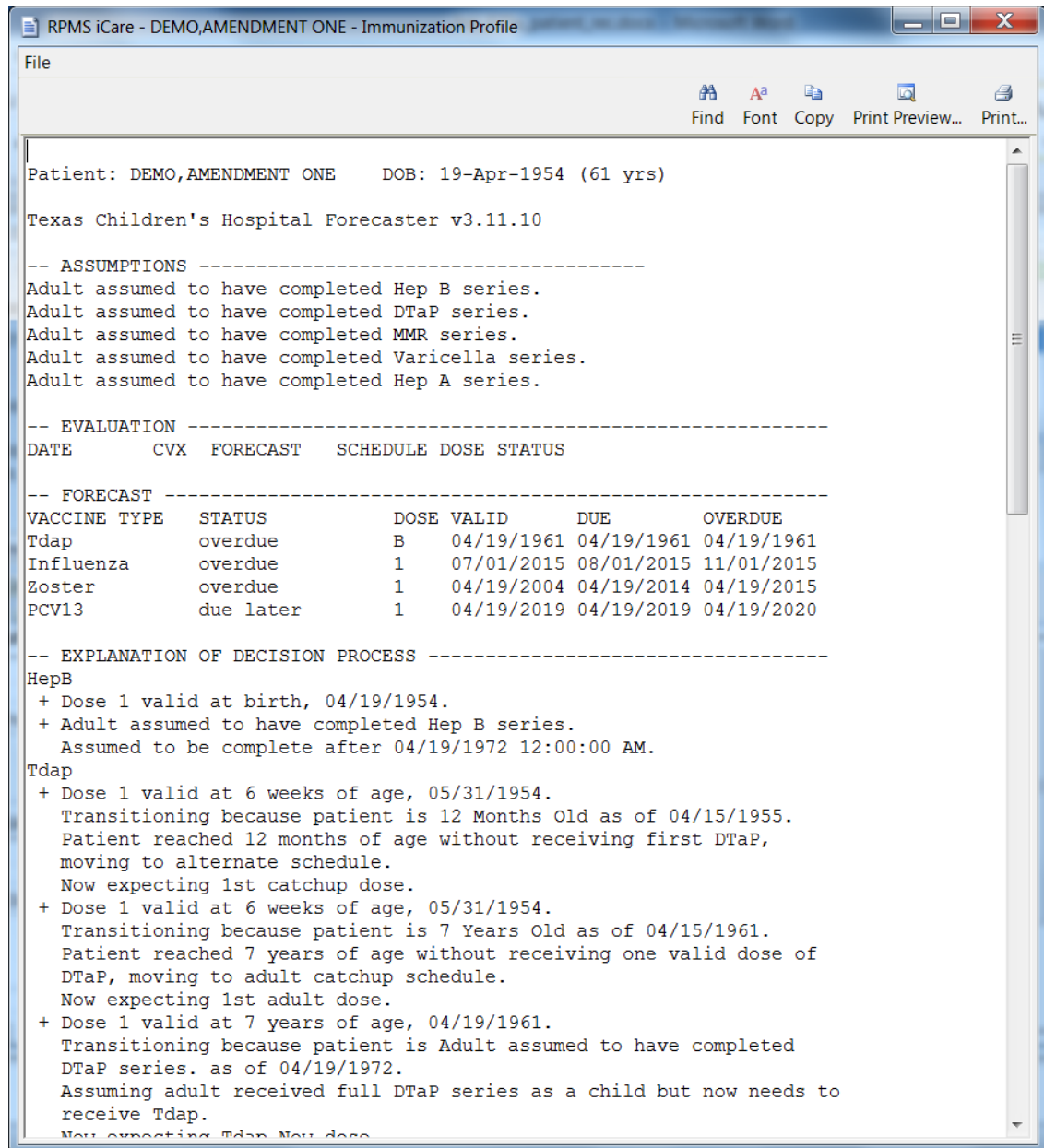


Figure 2-7: Sample **Immunization Profile** pop-up

This pop-up provides information about the patient's immunization history. Section 20.7 provides information about using the controls on the pop-up.

3.0 Cover Sheet Tab

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

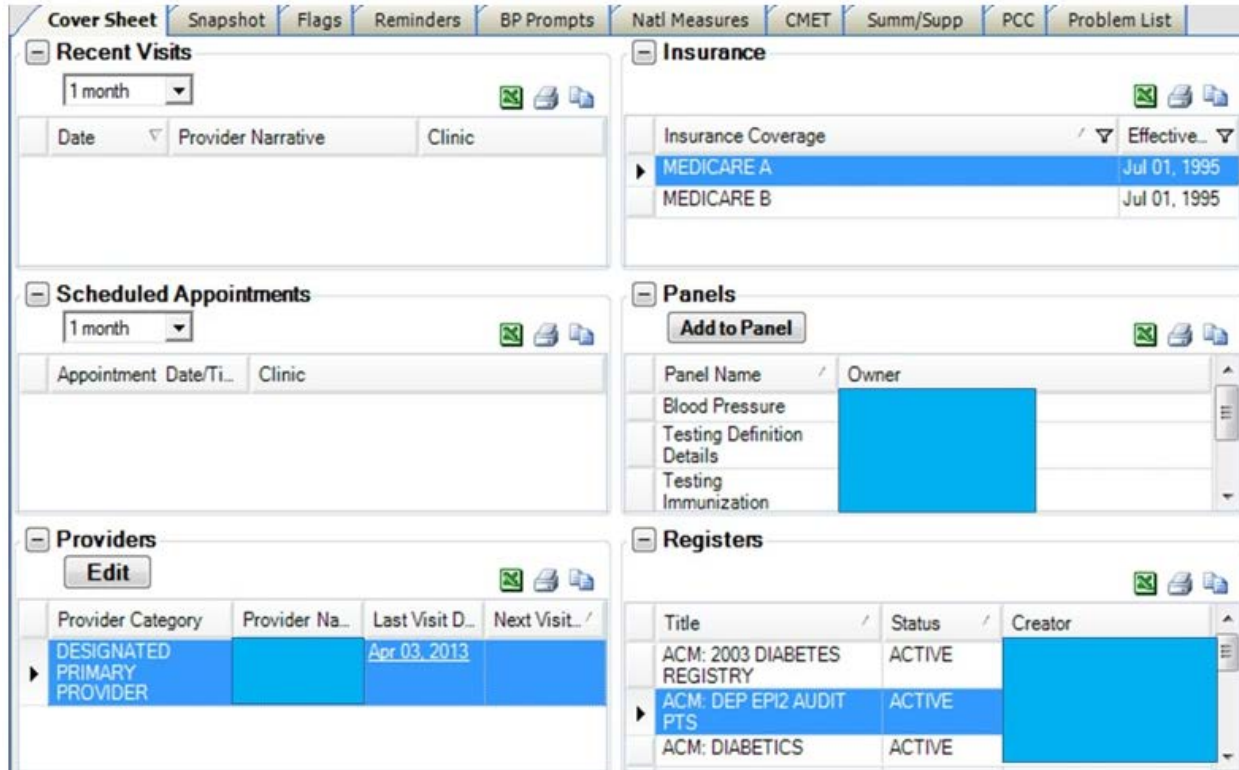


Figure 3-1: Sample Cover Sheet tab

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

- Click the **Expand symbol button** ([-]) to expand the group box.
- Click the **Collapse symbol button** ([+]) symbol to collapse the group box.

Section 20.3 provides information about the buttons on the right side of each group box.

Columns can be viewed, sorted and other functions on the columns can be executed in the various group boxes.

3.1 Recent Visits Group Box

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

Hover the mouse over a **record** to view key visit information (such as diagnosis, provider, etc.) about the visit. An example is shown in Figure 3-2.

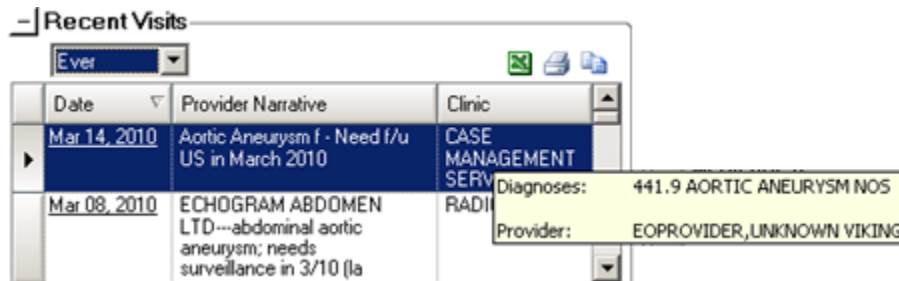


Figure 3-2: Sample **Recent Visits** group box

Double-click any row of the **Recent Visits** group box to display the **Visit Detail** pop-up. Section 20.7 provides information about how to use the controls on the pop-up.

3.2 Scheduled Appointments Group Box

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

3.3 Providers Group Box

The **Providers** group box (Figure 3-3) displays the list of specialty providers for the patient. This data comes from the RPMS.

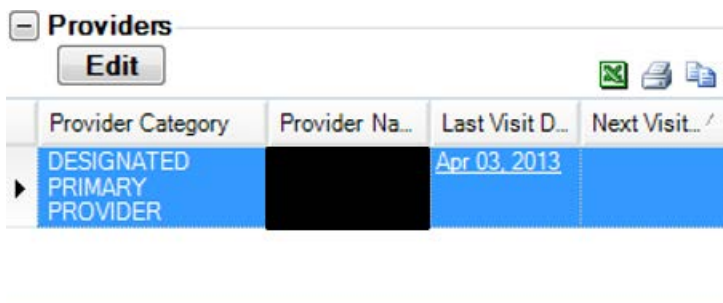



Figure 3-3: Sample **Providers** group box

3.3.1 Link to Last Visit Date

The Last Visit date is linked to the RPMS visit record. Double-click **any record** to view the **Visit Detail** pop-up. Section 20.7 provides information about using the controls on the pop-up.

3.3.2 Edit Button

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

Click the **Edit button** () to display the **Edit Providers** window (Figure 3-4.)

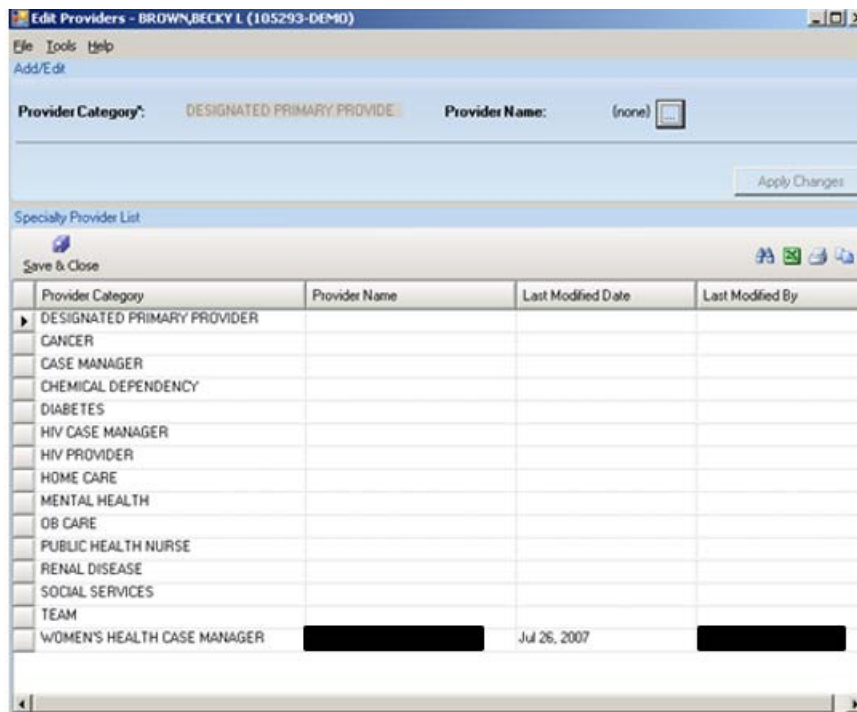


Figure 3-4: Sample Edit Providers window

Use this window to add, edit, or remove specialty provider names. Dismiss the **Edit Providers** window by selecting **File | Close**. Section 20.8 provides information about this window.

3.4 Insurance Group Box

The **Insurance** group box (Figure 3-5) displays all insurance defined as “active” in **Patient Registration**, and the effective date. There can be multiple active insurances.

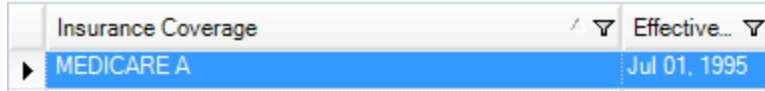


Figure 3-5: Sample Insurance group box

3.5 Panels Group Box

The **Panels** group box (Figure 3-6) displays the names of all iCare panels available to the user of which the patient is a member.

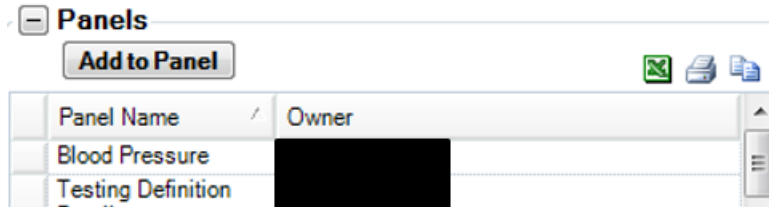


Figure 3-6: Sample **Panels** Group Box

3.5.1 Tooltip for Panel Description

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

3.5.2 Add to Panel Button

To add the patient to another panel, click the **Add to Panel button** to display the Add/Remove Panels dialog. (Figure 3-7)

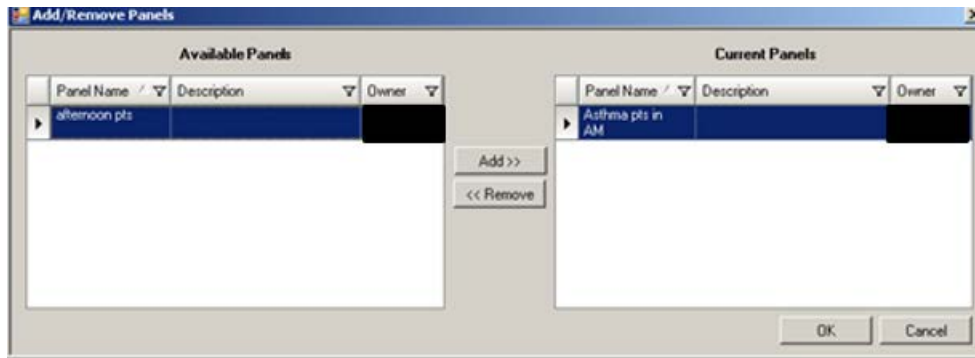


Figure 3-7: Sample **Add/Remove Panels** Dialog

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

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

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

3.6 Registers Group Box

The **Registers** group box (Figure 3-8) displays the Register names of which the patient is a member. Register names to which the user does not have security access will be inactive. The data shows the patient's register status (in the Status column).

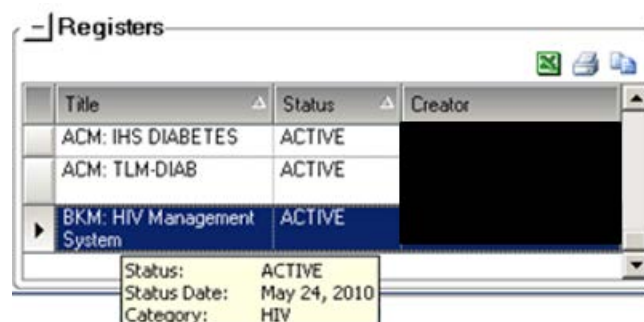


Figure 3-8: Sample **Registers** group box

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

3.7 Cover Sheet Tab Menus

3.7.1 File Menu

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

New: this option displays the **Panel Definition** dialog where a new panel definition is created. This is the same as pressing the **Ctrl+N** key combination.

Page Setup: this option is active when selecting one or more rows in the grid. This option allows a user to set Margin, Paper, and Layout characteristics (e.g. landscape or portrait orientation) for printing. A different printer can also be selected.

Print Preview: this option is active when selecting one or more rows in a grid. This option displays the **Print Preview** dialog. Section 20.13 provides information about this dialog.

Print: this option is active when selecting one or more rows in a grid. It uses the most recently selected rows (because there is more than one grid on the tab). This option displays the **Print Preview** dialog for the selected rows in the grid. This is the same as pressing the **Ctrl+P key combination**. Select **File | Print** on the dialog to output the data in the rows.

Background Jobs: this option displays a pop-up showing background jobs information. Section 20.12 provides information about the pop-up.

Close: this option dismisses the current open patient record window.

3.7.2 Tools Menu

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

Quick Patient Search: this option executes a patient search.

Excel Export, Print, Copy Rows to Clipboard: these options work the same as the [buttons on the right side of the window](#).

User Preferences: this option opens the **User Preferences** window where user preferences can be changed.

Web Links: this option shows several categories (such as Asthma) that have Web links. When a Web link is selected, the Internet browser for the category opens.

4.0 Snapshot Tab

The **Snapshot** tab (Figure 4-1) shows several types of data with a more clinical focus which are useful for case management review. The intention is to highlight more urgent information on this screen when considering various patient conditions.

The screenshot displays the 'Snapshot' tab in the iCare GUI. The interface includes a navigation bar at the top with tabs for 'Cover Sheet', 'Snapshot', 'Flags', 'Reminders', 'BP Prompts', 'Natl Measures', 'CMET', 'Summ/Supp', 'PCC', and 'Problem List'. The main content area is divided into several sections:

- Active Diagnostic Tags:** A table with columns for Tag Name, Status, Date, and Factor. A row for 'CVD Highest Risk' is highlighted, with a tooltip 'Export to Excel' showing 'Export selected rows to a MS Excel file'. The date 'Feb 22, 2011' is underlined.
- Measurements (Last Visit):** A table with columns for Value, Date Performed, and BMI. Rows include '60' (Jan 03, 2012, BMI 28.18), 'WEIGHT 144.3' (Apr 03, 2013, BMI 28.18), and 'VISION 20/150, 20/150' (Apr 09, 2013).
- Family History:** A table with columns for Relative, Diagnosis Narr., Age at Onset, and Status.
- Last Routine Events:** A table with columns for Clinical Group, Event, and Date. Rows include 'BEHAVIORAL HEALTH Alcohol Use Screen' (Mar 07, 2013), 'BEHAVIORAL HEALTH Depression Screening' (Oct 09, 2012), and 'BEHAVIORAL DV/IPV Screen' (Mar 21, 2013).
- Reproductive Factors:** A table with columns for Description, Value, Last Modified, and Documenting. Rows include 'Last Menstrual Period 1973' (May 17, 2011), 'Current Pregnancy Status NO' (May 17, 2011), and 'Lactation Status'.
- Open CMETs:** A table with columns for Category, Event Date, and 1-Event. A row for 'LIVER' is highlighted, with 'Oct 21, 2010' underlined and 'Hepatitis C Screen' in the 1-Event column.

Figure 4-1: Sample Snapshot tab

The underlined visit date listed within any of the sections of the Snapshot view links to the underlying RPMS visit record (double-click the **underlined date**).

Columns can be sorted, filtered and have other functions performed on them.

Section 20.3 provides information about the buttons on the right side of the group boxes.

4.1 Active Diagnostic Tags Group Box

The **Active Diagnostic Tags** group box (Figure 4-2) displays a list of Predefined Diagnosis definitions (“tags”) that iCare has proposed for this patient, based on the tagging function.

Tag Name	Status	Date	Factor
CVD Highest Risk	PROPOSED	Feb 22, 2011	BGP ESRD CPTS
		Feb 17, 2011	BGP ESRD CPTS

Figure 4-2: Sample **Active Diagnostic Tags** Group Box

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

4.1.1 Details Button

Select a record and then click the **Details** button to move to the DX Tags tab (on the **Patient Record** window) for the tag. This is where the status, date, item, value, and factor about the selected tag are displayed.

4.1.2 Tooltip for Active Diagnostic Tags Tab

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

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

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

4.1.3 iCare Taxonomy View/Edit

Double-click **any Factor cell** (Figure 4-3) in the **Active Diagnostic Tags** group box to display the **iCare Taxonomy View/Edit** dialog.

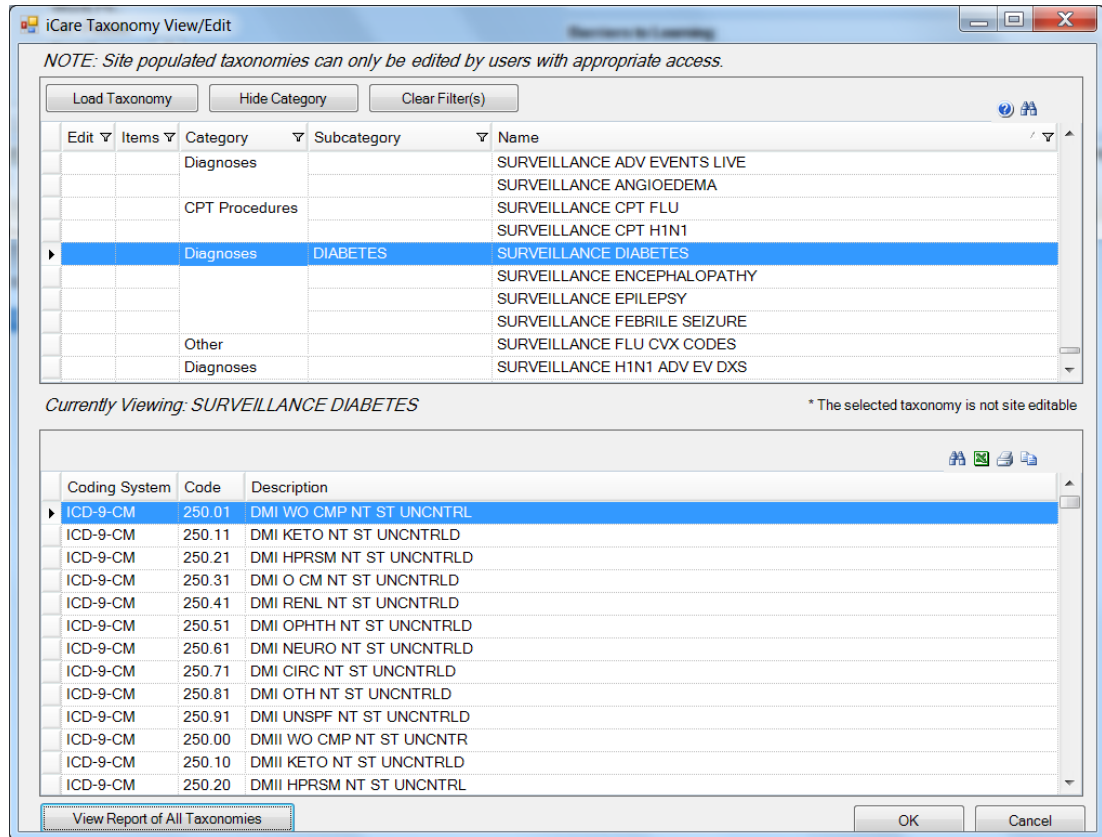


Figure 4-3: Sample iCare Taxonomy View/Edit dialog

If a user does not have access rights to edit taxonomies, this dialog will display that information.

If a user has editing privileges (iCare Taxonomy Editor with security key BQIZTXED), values can be added or removed. Section 20.9 provides information about the iCare Taxonomy Editor Function.

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

Click the **View Report of All Taxonomies button** (Figure 4-4) to access the **RPMS iCare - Taxonomy Report** pop-up. Information about each taxonomy category displays on this pop-up. For example, the high and low values for each taxonomy category can be viewed.

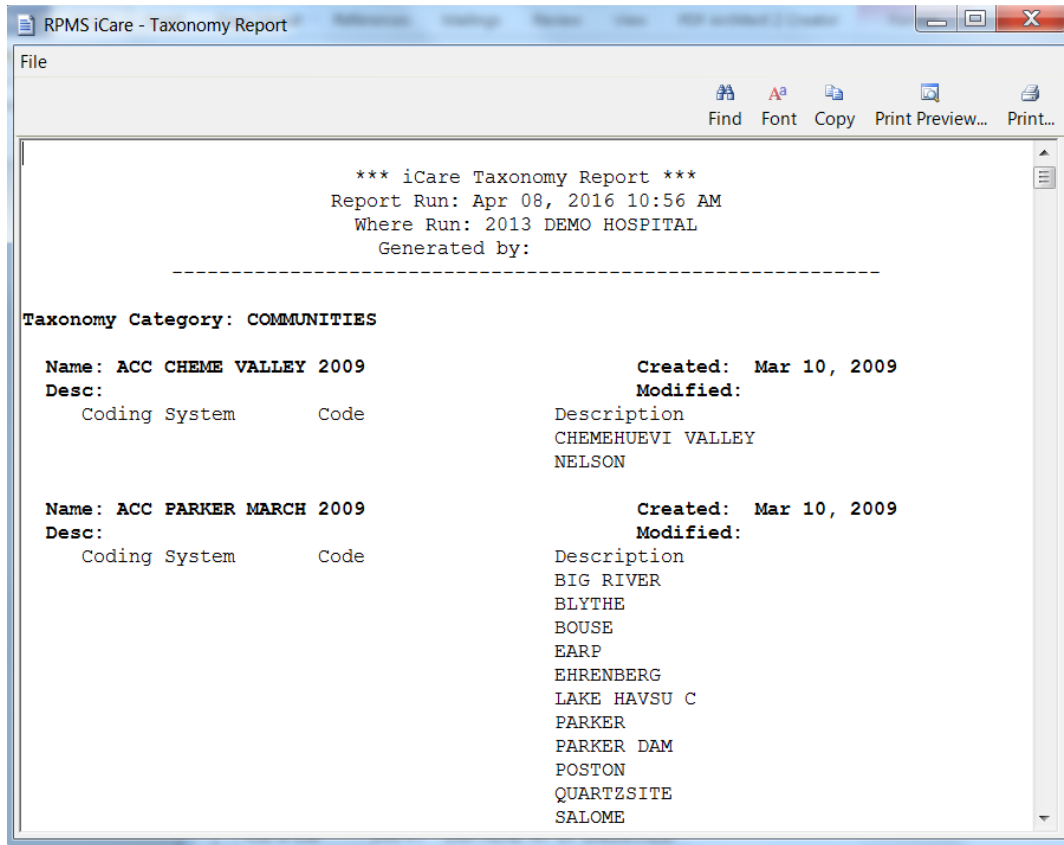


Figure 4-4: Sample **Taxonomy Report**

Section 20.7 provides information about using the controls on the pop-up.

4.2 Family History Group Box

The **Family History** group box (Figure 4-5) displays the family history information that is relevant to case management. This data is pulled directly from the IHS Dictionaries/Patient: Family History file (9000014).

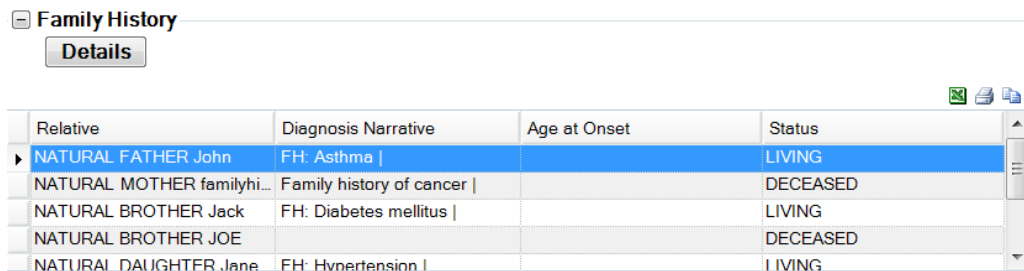


Figure 4-5: Sample **Family History** Group Box

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

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

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

4.3 Reproductive Factors Group Box

The **Reproductive Factors** group box (Figure 4-6) displays the current patient's reproductive history (from the AUPN IHS Dictionaries/ Patient Reproductive Factors file). This applies to female patients only.

Reproductive Factors

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

Figure 4-6: Sample **Reproductive Factors** Group Box

4.3.1 Fields on Reproductive Factors Group Box

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

4.3.2 Edit Reproductive Factors

Click **Edit** to access the **Edit Reproductive Factors** dialog (Figure 4-7). This is where new data can be added.

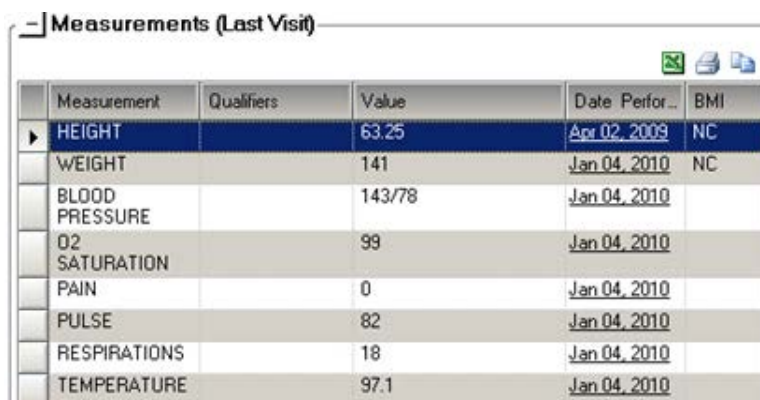
Figure 4-7: Sample **Edit Reproductive Factors** dialog

Section 20.10 provides information about completing this dialog.

4.4 Measurements (Last Visit) Group Box

The **Measurements (Last Visit)** group box (Figure 4-8) displays two sets of data:

1. The patient's most recent Height and Weight data
2. All measurement data documented at the patient's last visit. This will include a calculated BMI only if the height and weight measurements meet the standard CRS definition. This information comes from PCC, the V Measurement file.



Measurement	Qualifiers	Value	Date Perfor..	BMI
▶ HEIGHT		63.25	Apr 02, 2009	NC
WEIGHT		141	Jan 04, 2010	NC
BLOOD PRESSURE		143/78	Jan 04, 2010	
O2 SATURATION		99	Jan 04, 2010	
PAIN		0	Jan 04, 2010	
PULSE		82	Jan 04, 2010	
RESPIRATIONS		18	Jan 04, 2010	
TEMPERATURE		97.1	Jan 04, 2010	

Figure 4-8: Sample **Last Measurements** group box

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

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

Double-click **any record** in this group box (with a date) to display the **Visit Detail** pop-up. Section 20.7 provides information about using the controls on the pop-up.

4.5 Last Routine Events Group Box

The **Last Routine Events** group box (Figure 4-9) displays a list of the most recent routine screenings, based on Health Summary Reminders logic, that are tailored to the specific patient based on age, sex, etc. This information comes from PCC.



Category	Event	Date
▶ BEHAVIORAL HEALTH	Alcohol Use Screen	Jan 17, 2007
BEHAVIORAL HEALTH	Depression Screening	Apr 16, 2007
CANCER-RELATED	Tobacco Use Screening	Jan 17, 2007

Figure 4-9: Sample Last Routine Events Group Box

Double-click **any record** in this group box (with a date) to display the **Visit Detail** pop-up. Section 20.7 provides information about using the controls on the pop-up.

4.5.1 Open CMETs Group Box

The **Open CMETs** group box (Figure 4-10) shows the latest Tracked, Open CMET data for the patient.



Category	Event Date	1 - Event	2 - Finding(s)	3 - Follow-up(s)	4 - Patient Not...
BREAST	<u>May 20, 2010</u>	MAMMOGRAM SCREENING	✓	✓	✓
SKELETAL	<u>Nov 04, 2009</u>	OSTEOPOROSIS SCREENING - DXA CENTRAL	🕒		

Figure 4-10: Sample Open **CMETs** group box

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

Double-click any **underlined event date** to display the **Visit Detail** pop-up. Section 20.7 provides information about using the controls on the pop-up.

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

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

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

4.6 Snapshot Tab Menus

The options on the **File menu** of the **Snapshot** tab are the same as those on the [File menu](#) for the Cover Sheet tab.

The options on the **Tools menu** of the **Snapshot** tab are the same as those on the [Tools menu](#) for the Cover Sheet tab.

5.0 Flags Tab

The **Flags** tab (Figure 5-1) displays a list of the patient’s “flags” identified by the iCare application.

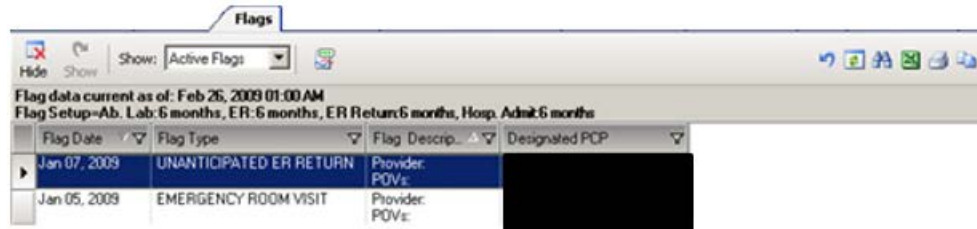


Figure 5-1: Sample **Flags** tab

5.1 Flags Tab Layout

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

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

5.1.1 Flag List Columns

The following table provides information about the columns.

Column	Meaning
Flag Date	The date the flag became active, e.g., the date of the hospital admission.
Flag Type	This can be Abnormal Lab Values, ER Visit, Unanticipated ER Return Visit, Hospital Visit. Section 5.1.2 provides information about the flag types.
Flag Description	A brief description of the event that caused the trigger.
Designated PCP	Designated Primary Care Provider, if any. Not all facilities use this field to empanel patients.

Columns can be viewed, sorted and other functions can be performed on them.

5.1.2 Flag Types

The **Flag Type** column contains various flag types, as defined in Table 1.

Table 1 **Flag** Types

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

5.2 Flags Tab Toolbar

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


5.2.1 Show Field

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

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

5.2.2 Hide


A highlighted row in the Flag List grid can be hidden by doing any of the following:

- Click the **Hide button** ()
- Select **File | Flags | Hide**
- Select the **Hide** option on the **context menu**
- Press the **F3 key** on the keyboard

The hidden flags can be viewed by selecting the **Hidden Flags** option on the Show field.


5.2.3 Show

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

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

5.2.4 Status of Background Jobs

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

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

The application displays the **RPMS iCare - Background Jobs** window. Section 20.12 provides information about this window.

5.3 Flags Tab Menus

The options on the **File menu** are the same as the options on the [File menu](#) for the **Cover Sheet** tab.

5.3.1 Tools Menu

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

Quick Patient Search: this option executes a patient search.

Reset View, Refresh, Search, Excel Export, Print, Copy Row to Clipboard: these options operate like those for the buttons on the right-side of the window. Section 20.3 provides information about these buttons.

User Preferences: this option opens the **User Preferences** window where changes to user preferences can be made.

Web Links: this option shows several categories (such as Asthma) that have Web links. When selecting a Web link, the Internet browser for the category opens.

5.3.2 Flags Menu

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

Refresh: this updates any RPMS field values on this view with new data from the server.

Hide: this hides a highlighted row in the **Flag List** grid.

Show: this causes a hidden flag to re-appear in the current view.

6.0 Reminders Tab

The **Reminders** tab (Figure 6-1) lists the national reminders that are pulled from the same data as the Health Summary report reminders in RPMS (such as lab test, immunization, etc.).

Source	Category	Reminder Name	Due Date	Next Due	Last Date Performed	Preceding CMET Event	Date of Preceding CMET Event
EHR Clinical Reminders	National	Mammogram 75-100	Apr 27, 2006	DUE NOW	Apr 27, 2005	N/A	
		Tobacco Screen	Mar 07, 2014	DUE NOW	Mar 07, 2013	N/A	
		Tobacco Screen	Mar 07, 2014	DUE NOW	Mar 07, 2013	N/A	
		Blood Pressure	Apr 03, 2014	DUE NOW	Apr 03, 2013	N/A	
Local		No Allergy Assessment on File	Aug 22, 2016	RESOLVED	Jul 22, 2016	N/A	

Figure 6-1: Sample **Reminders** tab


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

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

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

6.1 Reminders Tab Layout

Below is an overview of the columns.

- Source:** the “source” of the reminder logic. Examples are: Health Summary (i.e., Health Maintenance Reminders), HMS (HIV Management System), IZ Forecaster, EHR Clinical Reminders, CMET, etc. When the Source is “Care Management” and “HIV,” the denominator for the HMS reminders will be any patient with a proposed or accepted tag for HIV. **Note:** the register status is NOT considered for the denominator definition.
- Category:** the name of the clinical performance group, for example, Breast.
- Reminder Name:** the name of the clinical procedure that needs to be completed. View a tooltip by hovering the mouse over **any Reminder Name cell**.
- Due Date:** the date the reminder procedure is due. This column will display the warning indicator () if any of the patient’s reminders are overdue. This date is derived from the **Health Summary Reminders Next Due test**.
- Next Due:** the actual text from the **Reminders Next Due** display on the Health Summary.

- **Last Date Performed:** the date that the reminder procedure was most recently completed.
- **Preceding CMET Event:** this is populated with the tracked Event that initiated this follow-up. If the displayed reminder is not a CMET Reminder, this cell will contain N/A.
- **Date of Preceding CMET Event:** the date of the preceding CMET Event.

Columns can be sorted, filtered and have other functions performed on them.


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

6.2 Reminders Tab Toolbar


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

Section 20.3 provides information about using the buttons on the right side of the toolbar.

6.2.1 Recalc

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

6.2.2 Background Jobs

Click the **Background Jobs** button (, or select **File | Background Jobs**, to display the **Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

6.2.3 Reminders Tab Menus

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

6.2.3.1 Reminders Menu

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

6.2.3.2 File Menu

The options on the **File** menu for the **Reminders** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

6.2.3.3 Tools Menu

The options on the Tools menu are:

Quick Patient Search: this option executes a patient search.

Glossary: this option accesses the glossary information for this tab.

Reset View, Refresh, Search, Excel Export, Print, Copy Row to Clipboard: these options operate like those for the buttons on the right-side of the window. Section 20.3 provides information about these buttons.

User Preferences: this option opens the **User Preferences** window where user preferences can be changed.

Web Links: this option shows several categories (such as Asthma) that have Web links. When selecting a Web link, the Internet browser for the category opens.

7.0 BP Prompts Tab

The **Best Practice (BP) Prompts** tab (Figure 7-1) displays a list of suggested treatments based on pre-determined prompt logic (including Cardiovascular Disease (CVD) and Asthma reminders). CVD Treatment prompts are callable by the **Health Summary** or other RPMS applications. The best practice prompts can be turned off via the **PCC Health Summary functions**.

Clinical Group	Prompt Name	Guidance
CVD-RELATED	CVD Significant Risk: High BP	High BP: This patient's recent documented BP is greater than (>) or equal to 140/90. Consider intensified medical therapy.
	CVD Significant Risk: No Exercise Education	No Recent Exercise Education: Discuss and document exercise education with this patient.
	CVD Significant Risk: No Nutrition Education	No Recent Nutrition Education: Discuss and document nutrition education with this patient.

Figure 7-1: Sample **BP Prompts** tab

7.1 BP Prompts Tab Layout

The data columns on the **Best Practice Prompts** tab are described below.

Clinical Group: the name of the clinical group.

Prompt Name: the name of the best practice prompt.

Guidance: the text that defines the diagnosis.

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


7.2 BP Prompts Tab Toolbar

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


The time/date for the last data update is shown in the toolbar.

Section 20.3 provides information about the buttons on the right side of the toolbar.

7.2.1 Recalc

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

7.2.2 Background Jobs

Click the **Background Jobs button** () or select **File | Background Jobs**, to display the **Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

7.3 BP Prompts Tab Menus

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

The options on the **Tools** Menu on the **Best Practice Prompts** tab are as those of the [Tools Menu](#) for the Reminders tab.

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

8.0 Natl Measures Tab

The **Natl Measures** tab (Figure 8-1) displays the patient's GPRA performance status (based on the CRS national summary report).

Patient National Performance Measures data from CRS 2016 current as of: Apr 02, 2016 04:21 AM				
Category	Clinical Group	Measure Name	Performance Status	Adherence Value
Developmental	Immunizations	Adult IZ: 1:1:1	YES	TDAP: 12/28/11 Imm 115 (ever); TDAP/TD: 12/28/11 Imm 115 (past 10 yrs); ZOSTER: Imm 121 (ever)
	Cancer-Related	Comprehensive Cancer Screening (Dev)	YES	CRCS: 01/09/13 CPT G0105
National GPRA		Colorectal Cancer Screen 50-75	YES	COLO: 01/09/13 CPT G0105
		Colorectal Cancer Screen 50-75: FOBT/FIT	NO	COLO: 01/09/13 CPT G0105
	Dental	Topical Fluoride Pts	0	0 topical fluoride
		Dental Access	NO	
Other National	Immunizations	Influenza IZ 50-64	NO	
Developmental	Behavioral Health	Alcohol Screen: 12-75 (Dev)	NO	
		Alcohol Screen: Positive: 12-75 (Dev)	N/A	
		Depression Screening, Diagnosis or Suicide Ideation: 12-18 (Dev)	N/A	
		Depression Screening, Diagnosis or Suicide Ideation: 18+ (Dev)	NO	
		SBIRT	NO	

Figure 8-1: Sample National Measures tab

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

8.1 Natl Measures Tab Layout

Category: the name of the category; Developmental, National GPRA, Non-National, Other, or Other National.

Clinical Group: the name of the clinical performance group.

Measure Name: the measure title derived from the **Summary Report**. A description of the performance logic (tooltip) will display when hovering the mouse over the name.

Performance Status: displays the status (as of the date listed on the toolbar) of this patient's performance to the specific measure.

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

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

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

A pop-up can be viewed that defines the detailed logic for each of the national performance measures defined in the Clinical Reporting System by selecting **Help | Natl Measures Glossary**.


Columns can be sorted, filtered and have other functions performed on them.

8.2 Natl Measures Tab Toolbar


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

Section 20.3 provides information about using the buttons on the right side of the toolbar.

8.2.1 Recalc

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

8.2.2 Background Jobs

Click the **Background Jobs button** () or select **File | Background Jobs**, to display the **Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

8.3 Natl Measures Tab Menus

The options on the **File** menu of the **Natl Measures** tab are the same as those on the [File menu](#) for the Cover Sheet tab.

The options on **Tools** menu for the **Natl Measures** tab are the same as those of the [Tools Menu](#) for the **Reminders** tab.

9.0 CMET Tab

The **iCare Management Event Tracking (CMET)** tab Figure 9-1) displays the CMET data associated with the current patient. The CMET tool is designed to assist users in the electronic tracking and management of their patients’ care. CMET is reminiscent of an old fashioned “tickler file.”

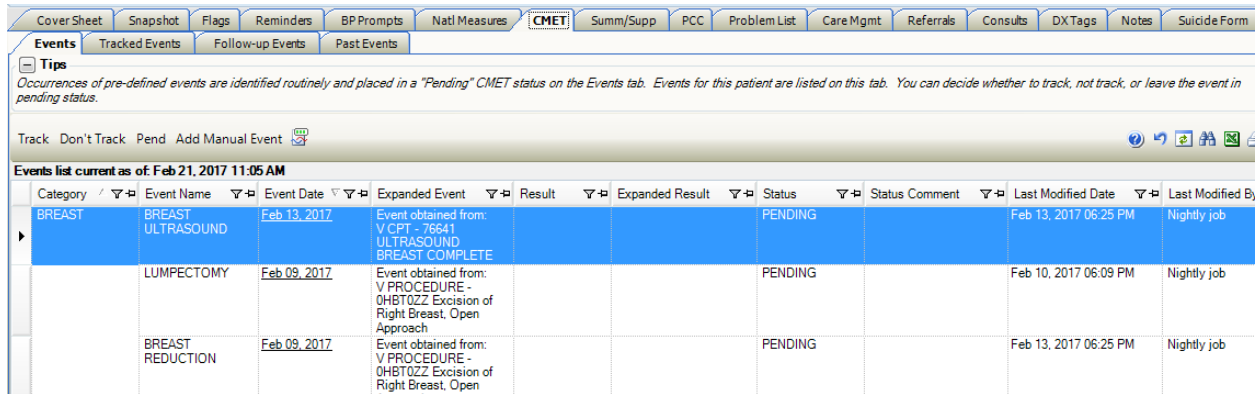


Figure 9-1: Sample CMET tab

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

9.1 Events Sub-Tab

The patient’s events display on the **Events** sub-tab (Figure 9-2.) Events are procedures, screenings and/or exams that have been pre-defined and categorized into Breast, Cervical, Colon, and Skeletal.



Figure 9-2: Sample Events sub-tab

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

The **Tips** information provides an overview of the Events sub-tab. This area can be collapsed to have more room to view the Events data.

9.1.1 Events Sub-Tab Layout

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

Category: the category of the event.

Event Name: the name of the event. Events are procedures, exams, or tests that have been documented in RPMS. Events are predefined. See the **CMET Glossary** for a list of events by selecting **Help | CMET Glossary**.

Event Date: the date the event was performed. Double click **any underlined date** to view the **Visit Detail** pop-up. Section 20.7 provides information about using the controls on the pop-up.

Result: the date of the result. Double-click the **underlined date** to access a detail pop-up, for example, **Women's Health Detail**. This cell also has hover help, such as V Radiology.

Status: the status of the event which can be tracked, pending, or not tracked.


Status Comment: any comments about the status.

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

Last Modified By: the person who last modified the record. The Initial job name means that this was an initial event.

9.1.2 Events Sub-Tab Toolbar

Section 20.3 provides information about to use the buttons on the right side of the toolbar.

Click the **Background Jobs button** () or select **File | Background Jobs**, to display the **Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

The user can decide to track, not track, or leave the event in pending status.

9.1.2.1 Track

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

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

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

If selecting only one eligible event, the application displays the **RPMS iCare - Track - Findings Due Date** dialog (Figure 9-3.)

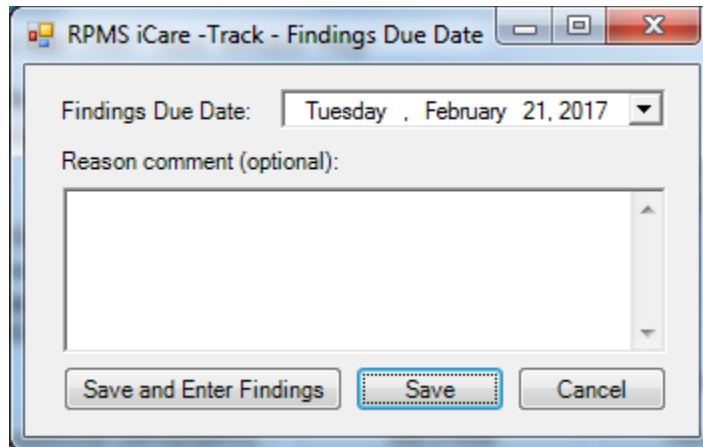


Figure 9-3: Sample **RPMS iCare - Track - Findings Due Date** dialog

If selecting more than one eligible event, the application displays the **RPMS iCare - Track - Findings Due Date** dialog (for multiple events.) (See Figure 9-4)

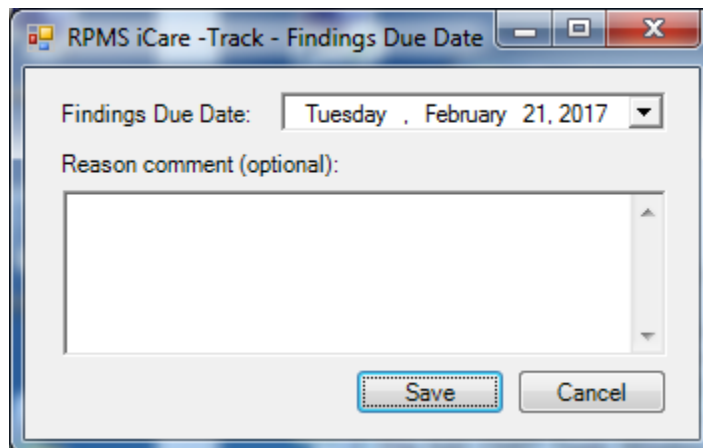


Figure 9-4: Sample **RPMS iCare - Track - Findings Due Date** dialog for multiple events

In either case, do the following:

- Make sure that the correct date is in the **Findings Due Date field** (required). Change the date by clicking the **list to access a calendar** (where another date can be selected.) The date cannot be earlier than the current date.
- Type the text of the **reason for changing** the status to TRACKED in the Free Text “Reason comment” field (not required).

- Click **Save** to save the information and to change the status of the events to Tracked. These events will display on the **Tracked Events** sub-tab of the **Patient Record** window. (Otherwise, click **Cancel**.)

If using the “Save and Enter Findings” button for a single event, the application displays the CMET Worksheet (where Findings to the event can be added, for example). Section 20.11 provides for information about the worksheet. After saving the worksheet, focus returns to the Events sub-tab.

9.1.2.2 Don't Track

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

If Tracked events were selected that are not eligible for the **Not Tracked** function, the application displays the message: Once an event has been Tracked, it cannot be changed to Not Tracked. See the **User Manual** guidance on how to manage an event that was tracked. Click **OK** to dismiss the message. If the selected Tracked event was erroneously tracked in error, section 20.16 provides information about how to handle this error.

If eligible events were selected, the application displays the **RPMS iCare – Don't Track Event dialog** (Figure 9-5.)

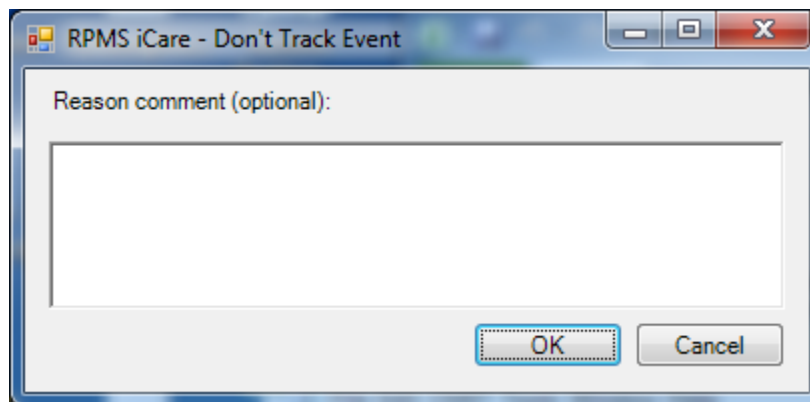


Figure 9-5: Sample **RPMS iCare – Don't Track Event** dialog

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

9.1.2.3 Pend

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

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

If eligible events are selected, the application displays the **RPMS iCare – Pend Event** dialog (Figure 9-6.)

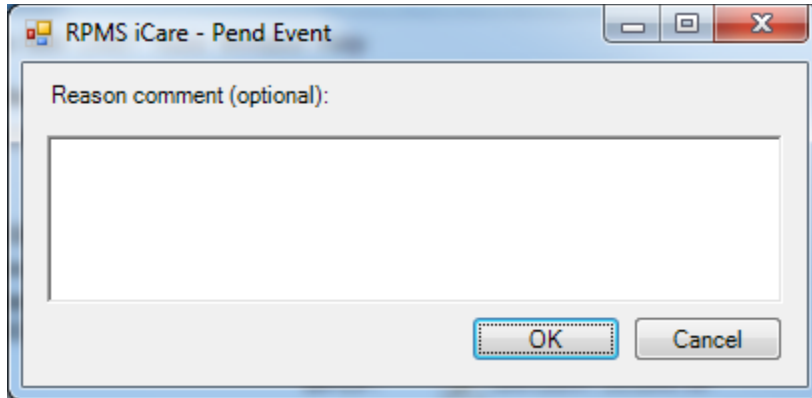


Figure 9-6: Sample **RPMS iCare – Pend Event** dialog

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

9.1.2.4 Add Manual Event

Use the **Add Manual Event** function (Figure 9-7) to add a new manual event. Select the events and then click the **Add Manual Event** button, or select **CMET | Events | Add Manual Event**.

Figure 9-7: Sample RPMS iCare – **Add Manual Event** dialog

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

Date: select a **date** for the event.

Event: select the **event**.

PCC File: select the **PCC File**.

Default Value: select a **default value** for the event.

Finding: select a **finding**, if desired for the event.

Select Location:

IHS/Tribal Facility: select a **Location**

or

Other: Enter **Outside** Location and if desired, **Outside Provider**

Use **Save** to save a new manual event.

Use **Save and Track** to save a new manual event and track. Same behavior as the Track button (Section 9.1.2.1).

Use **Save, Track and Open WorkSheet** to save a new manual event, track and open **CMET worksheet**. Use the same action as the **Open CMET Worksheet** button (Section 9.2.2.3) on **Tracked Events** tab.

9.2 Tracked Events Sub-Tab

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

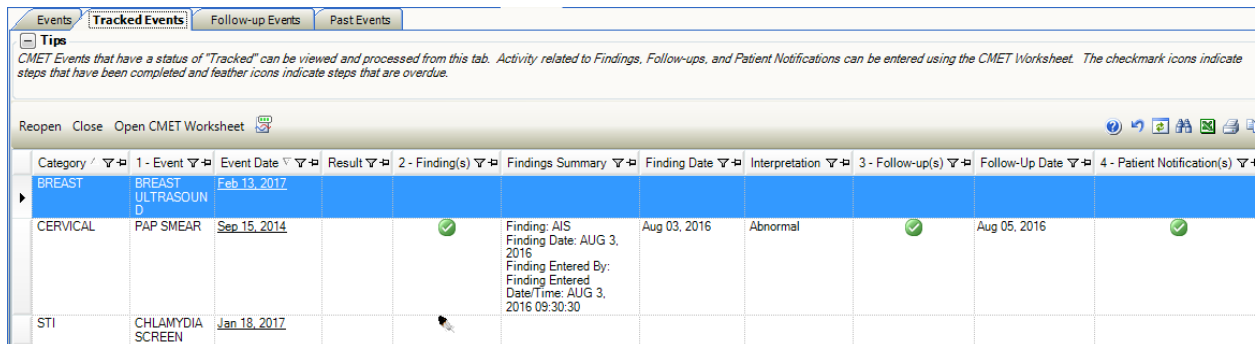


Figure 9-8: Sample **Tracked Events** sub-tab

The **Tracked Events** sub-tab (Figure 9-8) is divided into three general areas: Tips information, Tracked Events toolbar, and Tracked Events data.

The Tips information provides an overview of the **Tracked Events** sub-tab. This area can be collapsed to have more room to view the **Tracked Events** data.

9.2.1 Tracked Events Sub-Tab Layout

Table 2 provides information about the columns on the Tracked Events sub-tab.

Table 2 **Tracked Events** Sub-Tab Layout


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

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

Double-click **any record** to access the **CMET Worksheet**. Section 20.11 provides information about the worksheet.

9.2.2 Tracked Events Sub-Tab Toolbar

Section 20.3 provides information about the buttons on the right side of the toolbar.

Click the **Background Jobs button** () or select **File | Background Jobs**, to display the **Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

9.2.2.1 Reopen

Use the **Reopen** function (Figure 9-9) to change a Closed event to Open. Select *only one* event having a State of Closed and then click the **Reopen button**, or select **CMET | Tracked Events | Reopen**, to access the **RPMS iCare – Reopen Tracked Event** dialog.

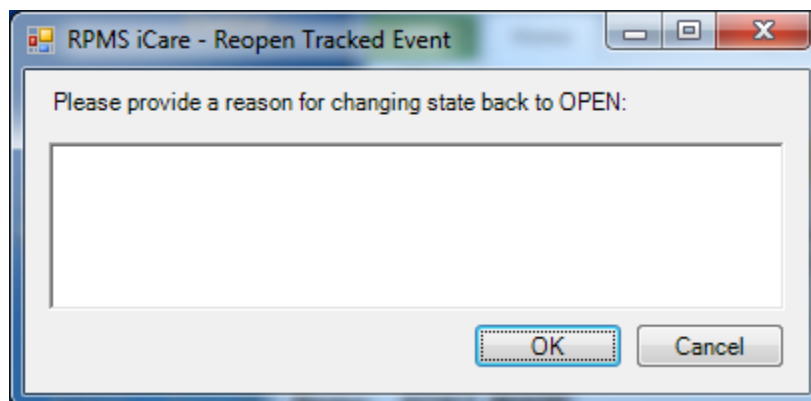


Figure 9-9: RPMS iCare – Reopen Tracked Event dialog

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

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

9.2.2.2 Close

Use the **Close** function to change an Open event to Closed. Select the events with a State of Open and then click the **Close button**, or select **CMET | Tracked Events | Close**, to access **RPMS iCare – Reason for Closing** dialog. (Figure 9-10)

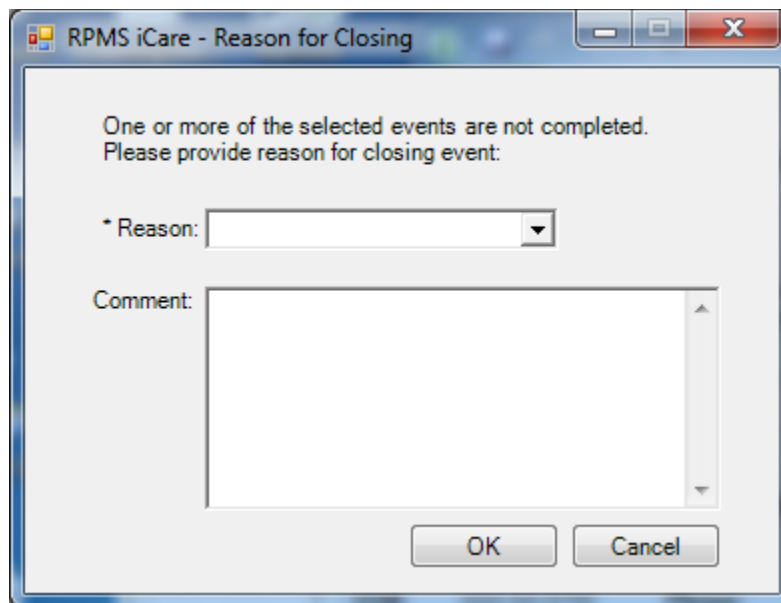


Figure 9-10: RPMS iCare – Reason for Closing dialog

Note: The fields with the asterisk (*) following the name are required.

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

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

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

9.2.2.3 Open CMET Worksheet

Select an event and then click the **Open CMET Worksheet button**, or select **CMET | Tracked Events | Open CMET Worksheet**, to access the **CMET Worksheet** (for the event). Here Finding(s), Follow-up(s), and Patient Notification(s) for the patient can be added. Section 20.11 provides for more information about the worksheet.

Note: this function can be applied to only one event.

9.3 Follow-up Events Sub-Tab

The **Follow-up Events** sub-tab (Figure 9-11) displays the patient's follow-up events. Follow-up events are generated by the third CMET step. This view lists all those events that have been recommended as follow-up.

Category	Follow-up Event Name	Follow-up Event Date	Ordered	Preceding Event
CERVICAL	CONE BIOPSY	Aug 05, 2016	No	Sep 15, 2014

Figure 9-11: Sample **Follow-up Events** sub-tab

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

The Tips information provides an overview of the **Follow-up Events** sub-tab. This area can be collapsed to have more room to view the Follow-up Events data.

Category: the category of the follow-up event.

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

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

Ordered: indicates with the follow-up has been ordered (Yes or No).


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

Double-click **any record** to access the **CMET Worksheet**. Section 20.11 provides information about the worksheet.

9.3.1 Follow-up Events Sub-Tab Toolbar

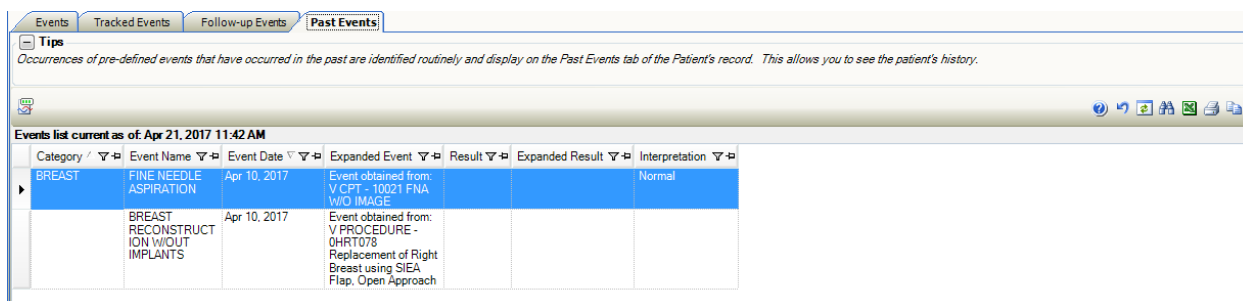
Section 20.3 provides information about the buttons on the right side of the toolbar.

Select a record in the grid and then click the **Open CMET Worksheet** button, or select **CMET | Follow-up Events | Open CMET Worksheet**, to access the **CMET Worksheet**. Section 20.11 provides information about the worksheet.

Click the **Background Jobs** button (,) or select **File | Background Jobs**, to display the **Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

9.4 Past Events Sub-Tab

The **Past Events** sub-tab (Figure 9-12) displays the patient's past CMET events. Past events come from the data mining.



Category	Event Name	Event Date	Expanded Event	Result	Expanded Result	Interpretation
BREAST	FINE NEEDLE ASPIRATION	Apr 10, 2017	Event obtained from: V CPT - 10021 FNA W/O IMAGE			Normal
BREAST	RECONSTRUCTION WITHOUT IMPLANTS	Apr 10, 2017	Event obtained from: V PROCEDURE - 0HRT078 Replacement of Right Breast using SIEA Flap, Open Approach			

Figure 9-12: Sample Past Events sub-tab

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

The Tips information provides an overview of the Past Events sub-tab. This area can be collapsed to have more to view the Past Events data.

9.4.1 Past Events Sub-Tab Layout

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

Event Name: the name of the past event.

Event Date: the date of the past event.


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

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

9.4.2 Past Events Sub-Tab Toolbar

Section 20.3 provides information about the buttons on the right side of the toolbar.

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

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

This displays the **RPMS iCare - Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

9.5 CMET Tab Menus

The options on the **File** menu are the same as those on the [File menu](#) for the **Cover Sheet**.

The options on the **Tools** menu are the same as those on the [Tools menu](#) for the **Flags** tab.

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

10.0 Summ/Supp Tab

The **Summ/Supp** tab (Figure 10-1) displays a selected type of report (shown in the **Type** field): Asthma Action Plan, Face Sheet, Health Summary, Patient Wellness Summary, Supplement. These reports are from RPMS.

When first accessing this tab, it will be blank. An option from the list for the Type field must be chosen.

Existing condition-specific (i.e., register specific) supplements can be displayed and edited.

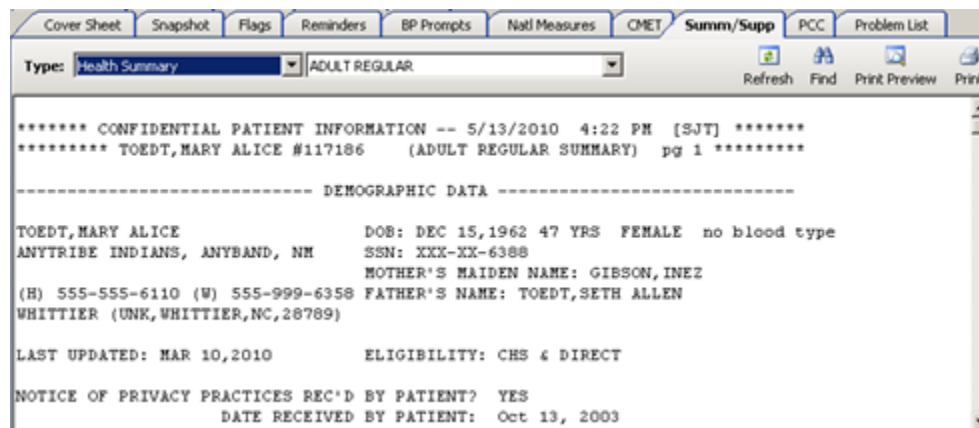


Figure 10-1: Sample **Summ/Supp** tab

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

10.1 Summ/Supp Tab Toolbar

The **Type** field determines the summary/supplement report to be displayed:

- Asthma Action Plan
- Face Sheet
- Health Summary (HS)– has secondary selection, with Adult Regular as the default
- Patient Wellness Handout – has a secondary selection
- Supplement. – has a secondary selection
- Women’s Health Profile - Brief

Refresh button: it is not intuitive to the users that when they select a second HS type, and then return to the initial HS, they must **use Refresh** to display updated data, e.g., after entering PCC data.

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

Print Preview button: displays a preview of page layout prior to printing the report on a printer. Section 20.13 provides information about the Print Preview dialog.

Print button: outputs the report. The application displays the Print dialog where the Printer, page range, and number of copies are selected.

10.2 Summ/Supp Tab Menus

10.2.1 Tools Menu

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

Quick Patient Search: this option executes a patient search. This is the same as pressing the **F8 key** on the keyboard.

Refresh: use this option when selecting a second HS type, and then return to the initial HS. A Refresh must be performed to display updated data, e.g., after entering PCC data. This is the same as pressing the **F5 key** on the keyboard or clicking the **Refresh button**.

Find: this option finds data in the current window. The application displays the Search dialog. This is same as clicking the **Find** button.

User Preferences: this option opens the **User Preferences** window where user preferences can be modified.

Web Links: this option shows several categories (such as Asthma) that have Web links. When selecting a Web link, the Internet browser for the category opens.

10.2.2 File Menu

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

11.0 PCC Tab

The **PCC tab** (Figure 11-1) displays various types of PCC data associated with the patient. This data comes the V Lab file from PCC.

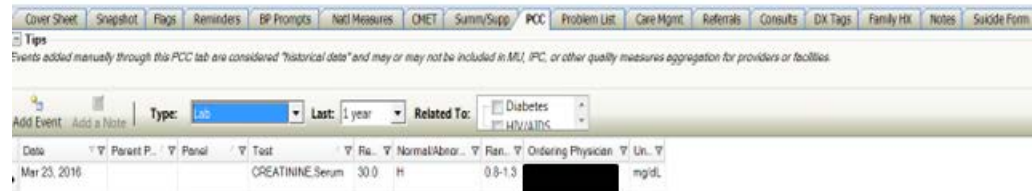


Figure 11-1: Sample **PCC** tab

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

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

The **Tips** information provides an overview of the **PCC** tab. Collapse this area to have more room to view the **PCC** data.

11.1 PCC Tab Layout

No duplicate values are displayed; e.g., if a patient has multiple immunizations on the same day, the date should be displayed only on the first line.

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

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

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

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

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

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

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

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

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

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

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

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

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

11.2 PCC Tab Toolbar

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

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

When Type = Measurement, the **Graph It!** button displays on the toolbar.

Section 20.3 provides information about using the buttons on the right side of the window.


11.2.1 Add Event

Use the **Add Event** feature (Figure 11-2) to record historical PCC data for the current patient. This feature requires either the iCare Editor (BQIZCMED) or iCare Package Manager (BQIZMGR) security key.

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

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

- The facility uses an off-site reference lab and is not using the **RPMS Reference Lab** application to send and receive lab data electronically directly into RPMS.
- A test or procedure was documented in the patient’s chart but was not entered into RPMS.
- The patient was traveling and received care at another facility that should be documented in their home facility.
- The patient received an immunization or similar public health procedure at an off-site community event.

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

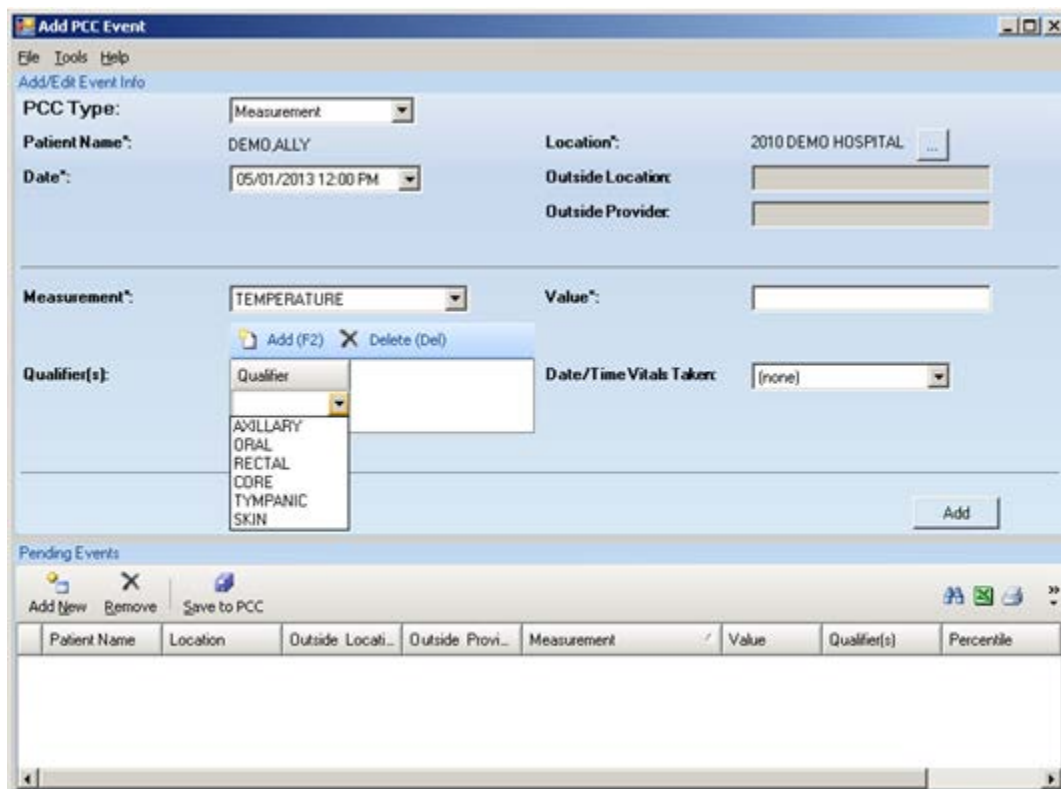


Figure 11-2: Sample **Add PCC Event**

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

When clicking an **ellipsis button** by a field, the **Table Lookup** dialog displays. Section 20.15 provides information about how to use this dialog.

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

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

11.2.1.1 Add/Edit Event Info Group Box

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

The default location is the service unit associated with the current user. This can be changed by clicking the **ellipsis button** to search for a location name. If the **Location** field is populated with OTHER, then the **Outside Location** and **Outside Provider Name** fields become active; here type in **each Free Text field** to populate it.

The fields in this group box vary by the PCC Type. Any field to be populated must be followed by an asterisk (*.)

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


11.2.1.2 Pending Events Group Box

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

Section 20.3 provides information about how to use the buttons on the right side of the toolbar of the **Pending Events** area. These same functions can be found on the **Tools** menu of the **Add PCC Event** window.

Double-clicking a **record in Pending events** group box causes the **Visit Detail** pop-up to display. Section 20.7 provides information about the using the controls on the pop-up.

Add New


1. Click the **Add New button** () or select **File | Add New**, to clear the fields in the **Add/Edit Event Info group box** where a new PCC type record can be added.

2. Appropriate fields for the selected **PCC Type** must be populated. When all fields are complete, click **Add**. This action adds a new record to the **Pending Events** area.


Edit a Record

1. Double-click a **record** in the **Pending Events** area to cause the existing record data to populate the fields in the **Add/Edit Event** Info group box.
2. Fields can be changed, as needed. When all fields are complete, click the **Apply Changes** button. This changes the record in the **Pending Events** group box.

Remove

Highlighted records in the **Pending Events** group box can be removed by clicking the **Remove** button () or selecting **File | Remove**. The “Confirm remove” window displays, confirming the deletion. Click **Yes** to remove the records. (Otherwise, click **No**.)

Save to PCC

1. Changes/additions to PCC (that are listed in the **Pending Events** group box) must be saved.
2. Click the **Save to PCC** button () or select **File | Save to PCC**, to display the “Confirm save to PCC?” information message, confirming the save to the PCC data in the patient’s PCC visit file. Click **Yes** to save the information to PCC. (Otherwise, click **No**.) In either case, the record is removed from the **Pending Events** group box.

After exiting the information message, the application updates the PCC tab on the Patient Record window and displays the “Add Chart Review?” information message that asks: Do you wish to add a Chart Review at this time? Click **OK** to add a **Chart Review** record (otherwise, click **Cancel**). If **OK** is clicked, the application displays the **Add a Note** dialog. Section 20.5 provides information about this dialog.

Please note that each type of added event must be saved. When entering a new type, iCare asks if you want to save the existing records to PCC.


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

11.2.2 Add a Note

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

Note: The **Add a Note** button is active **ONLY** if the user's electronic signature is on file.




Click the **Add a Note button** ( **Add a Note**), or select **PCC | Add a Note** to access the **Add a Note** dialog. Use this dialog to add a new chart review, follow-up letter, or telephone call note for the patient. Section 20.5 provides information about this dialog.

11.2.3 Related To

When Type = Lab, the toolbar changes where a user can indicate if he/she wants to show labs related to HIV/AIDS or Diabetes.

11.2.4 Graph It Button



The **Graph It** button ( **Graph It!**) only appears when Type = Measurement. This feature allows a user to display, print, and save a graph of measurements data.

When the current patient has measurement data, click the **Graph It button**, or select **PCC | Graph It**. The application displays the **Charting window** (Figure 11-3,) showing a graph of the various measurement types.

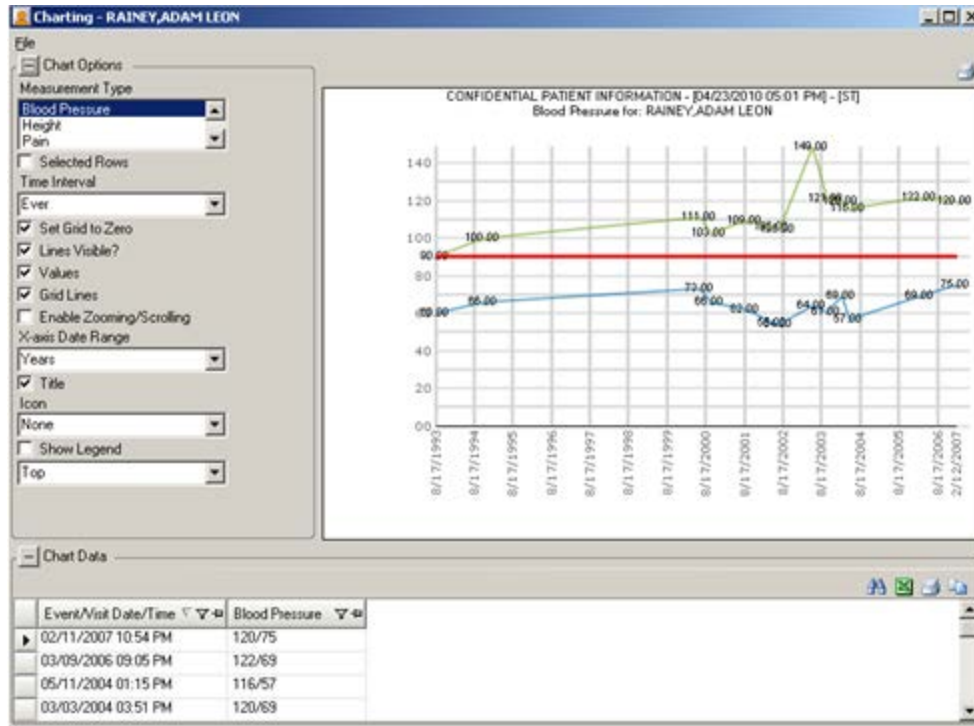


Figure 11-3: Sample **Charting** window

Section 20.14 provides information about the **Charting** window.

11.3 PCC Tab Menus

The options on the **File** menu of the **PCC** tab are the same as those on [File Menu](#) for the **Cover Sheet** tab.

The options on **Tools** Menu on the **PCC** tab are the same as those on the [Tools Menu](#) for the **Flags** tab.

The options on the **PCC** menu operate like the action buttons on the toolbar. Section 11.2 provides information about the toolbar.

12.0 Problem List Tab

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

Patient with No Problems

The **Problem List** tab for a patient with no problems is shown in Figure 12-1.

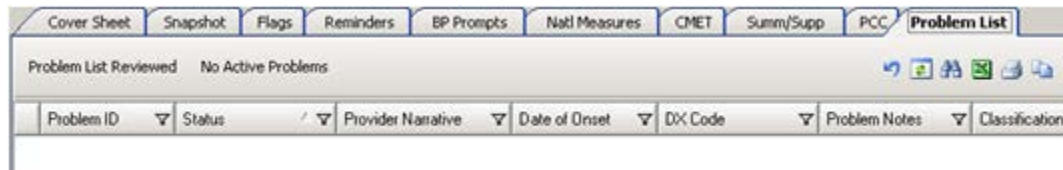


Figure 12-1: **Problem List** tab for patient with no problems

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

Patient with Problems

The **Problem List** tab (Figure 12-2) shows the patient’s current problem list. The **Problem List** data comes from the **PCC Problem List**.

Problem ID	Status	Provider Narrative	Date of Onset	DX Code	Problem Notes	Classification	Date Last Modified	User Last Modified	Facility	Class
771	CHRONIC	*TYPE 2 DIABETES MELLITUS		250.00 - DMII W/O CMP NT ST UNCINTR			Apr 21, 2008		2013 DEMO CLINIC	
772	CHRONIC	*CHRONIC LEFT OTITIS R/O LEFT MASTOIDITIS		382.9 - OTITIS MEDIA NOS			Oct 02, 1996		2013 DEMO CLINIC	
773	CHRONIC	*HTN	Dec 02, 1999	401.9 - HYPERTENSION NOS			Dec 02, 1999		2013 DEMO CLINIC	
774	CHRONIC	*PROTEINURIA		791.0 - PROTEINURIA			Oct 12, 2005		2013 DEMO CLINIC	
775	CHRONIC	*MAJOR DEPRESSION		311 - DEPRESSIVE DISORDER NEC			Oct 12, 2005		2013 DEMO CLINIC	
776	CHRONIC	*CAD		414.01 - CRNRY ATHRSCL NATVE VSSL			Oct 12, 2005		2013 DEMO CLINIC	
777	CHRONIC	*DYSLIPIDEMIA		272.4 - HYPERLIPIDEMIA NEC NOS			Oct 12, 2005		2013 DEMO CLINIC	
778	CHRONIC	*OSTEOARTHRITIS		715.90 - OSTEOARTHROS NOS-UNSPEC			Oct 12, 2005		2013 DEMO CLINIC	
779	CHRONIC	*DIABETIC NEUROPATHY		357.2 - NEUROPATHY IN DIABETES			Jun 13, 2008		2013 DEMO CLINIC	
7710	CHRONIC	*Pulpitis		522.0 - PULPITIS			Aug 18, 2010		2013 DEMO CLINIC	
7711	CHRONIC	*proliferative diabetic retinopathy		362.02 - PROLIF DIAB RETINOPATHY			Jun 01, 2011		2013 DEMO CLINIC	
7712	CHRONIC	*Nuclear Sclerosis Cataract		366.16 - SENILE NUCLEAR CATARACT			Jun 01, 2011		2013 DEMO CLINIC	

Figure 12-2: Sample **Problem List** tab

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

12.1 Problem List Tab Layout

The data columns are described below:

Problem ID: the identification label assigned to the problem.

Status: status of the problem, Active (showing Chronic, Sub-acute, episodic, social) or Inactive.

Provider Narrative: the narrative entered for the International Classification of Diseases (ICD) code for the problem.

Date of Onset: the date the symptoms started.

DX Code: the Diagnostic ICD code for the problem.

Problem Notes: any notes entered about the problem.

Classification: this shows any staging associated with the problem (for example, in Asthma Severity).

Date Last Modified: the date the problem was last modified.

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

Facility: the name facility where the login user (who entered the problem) resides.

Class: this will be blank or will contain Personal History.

The default display (sort) order will be by Status (Active first), then by Problem ID.

Columns can be sorted, filtered and have other functions performed on them.

12.2 Problem List Tab Toolbar

Section 20.3 provides information about the buttons on the right side of the toolbar.

12.2.1 No Active Problems

Use the **No Active Problems** button (Figure 12-3) to document that the patient has no active problems. Click the **No Active Problems** button to access the **No Active Problems** dialog.

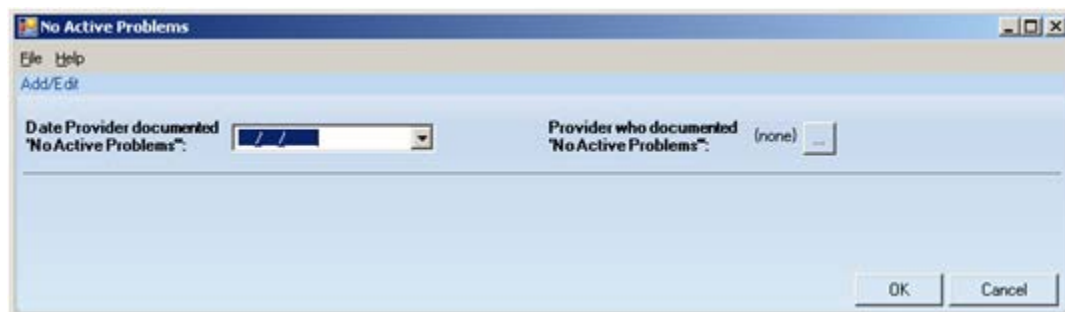


Figure 12-3: **No Active Problems** dialog

Both fields are required.

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

Provider who documented “No Active Problems”: click the **ellipsis button** to access the **Table Lookup** dialog. This is where a user can search for a name and select one from the retrieved records to populate the field. Section 20.15 provides information about using the Table Lookup dialog.

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

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

After clicking **Yes**, the **Problem List** tab will change (Figure 12-4,) showing a message that there are no active problems.



Figure 12-4: Sample **Problem List** tab showing message about no active problems

12.2.2 Problem List Reviewed

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

Click the **Problem List Reviewed button** (Figure 12-4) to access the **Problem List Reviewed** dialog.

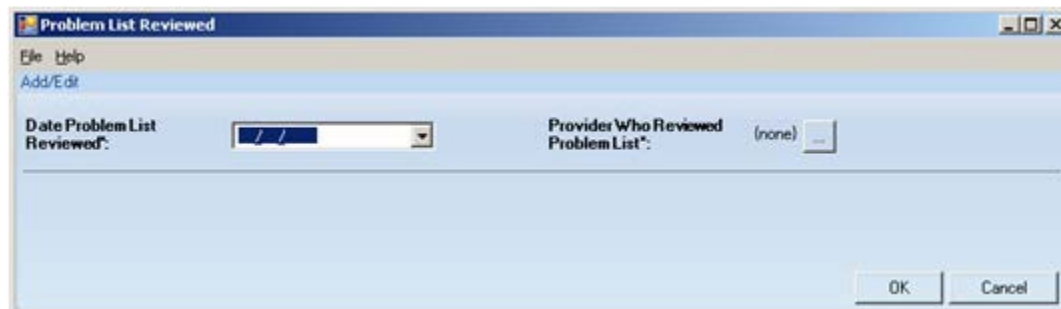


Figure 12-5: **Problem List Reviewed** dialog

Both fields are required.

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

Provider Who Reviewed Problem List: click the **ellipsis button** to access the **Table Lookup** dialog to search for a provider name. This is the provider who reviewed the problem list. Section 20.15 provides information about using the **Table Lookup** dialog.

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

After clicking **OK**, the application updates the toolbar with information about when the problem list was reviewed. (Figure 12-6)



Figure 12-6: Toolbar showing when the **problem list** was reviewed

12.3 Problem List Tab Menus

The options on the **File** menu of the **Problem List** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

The options on **Tools** menu on the **Problem List** tab are the same as those on the [Tools Menu](#) on the **Flags** tab.

13.0 Care Mgmt Tab

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

13.1 Patient with No Tag

Asthma, DM Audit, HIV/AIDS

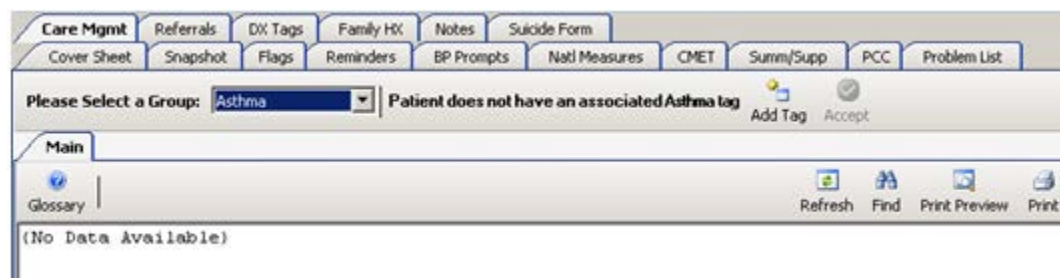


Figure 13-1: Sample **Care Management** tab for patient with No Tags for Asthma

The **Care Management** toolbar displays information that the patient does not have an associated Asthma, DM Audit, HIV/AIDS tag (Figure 13-1.)

- Section 13.1.2 provides information about using the **Add Tag** button.
- Section 13.2.1 provides information about using the **Accept** button.

HIV/AIDS

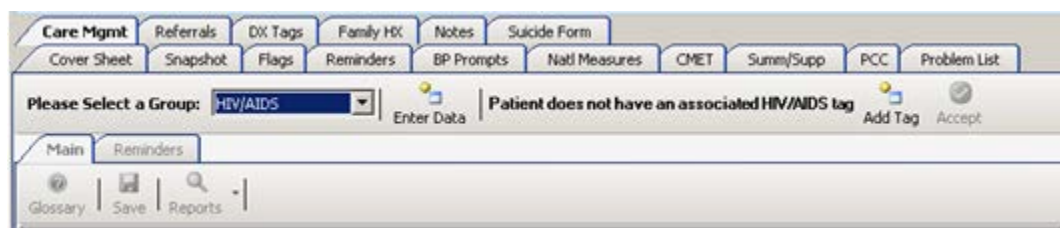



Figure 13-2: Sample **Care Management** tab for patient with No Tags for HIV/AIDS


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

13.1.1 Enter Data

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

The fields will display in the **Main** sub-tab. This feature requires either the iCare Editor (BQIZCMED) or iCare Package Manager (BQIZMGR) security key. Section 13.3 provides more information about the main sub-tab.

13.1.2 Add Tag

Use the **Add Tag** process to add a diagnostic tab. Click the **Add Tag button** (,) or select **Care Mgmt | Add Tag** to access the **Add Diagnostic Tag** dialog (Figure 13-3.) This is a manual add.

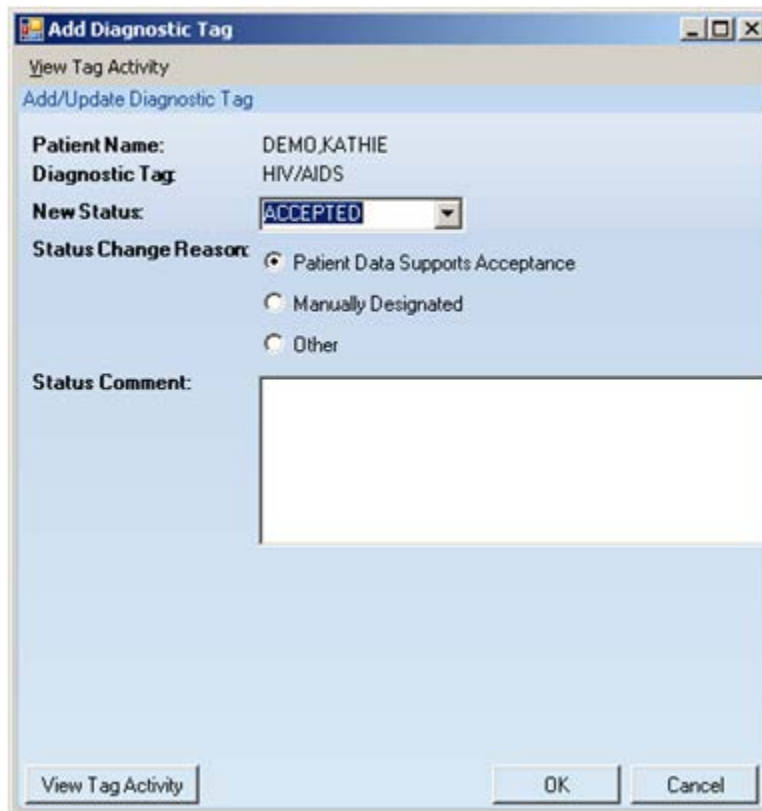


Figure 13-3: Sample **Add Diagnostic Tag** dialog

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

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

13.1.2.1 Fields

New Status: the status of the tag being changed.

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

Reason: select the appropriate radio button for the reason to change the tag.

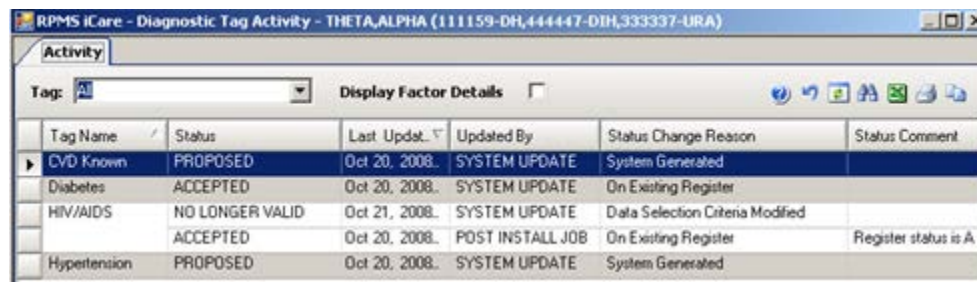
- Patient Data Supports Acceptance - use this when the patient data does not support the tag.
- Manually Designated - use this when manually designating the tag.
- Other - use this when the other reasons do not fit. The **Status Comment** field must be populated to provide the text of the reason.

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

Click **OK** to save changes. (Otherwise, click **Cancel**). If saving, the screen must be refreshed; the message beside the **Care Management Group** field will reflect the change.

13.1.2.2 View Tab Activity Button

Use the **View Tag Activity** button (Figure 13-4) to view the diagnostic tag activities. Click **View Tag Activity** to access the **RPMS iCare – Diagnostic Tag Activity** pop-up window.




Tag Name	Status	Last Updat.	Updated By	Status Change Reason	Status Comment
CVD Known	PROPOSED	Oct 20, 2008.	SYSTEM UPDATE	System Generated	
Diabetes	ACCEPTED	Oct 20, 2008.	SYSTEM UPDATE	On Existing Register	
HIV/AIDS	NO LONGER VALID	Oct 21, 2008.	SYSTEM UPDATE	Data Selection Criteria Modified	
	ACCEPTED	Oct 20, 2008.	POST INSTALL JOB	On Existing Register	Register status is A
Hypertension	PROPOSED	Oct 20, 2008.	SYSTEM UPDATE	System Generated	

Figure 13-4: Sample **Diagnostic Tag Activity** pop-up window

Tags can be viewed by selecting **an option** from the list for the Tag field.

If the “Display Factor Details” check box is chosen, the following columns will display: Factor, Date, Item, Value. This allows viewing additional details about the tags. The default view is unchecked. Columns can be sorted, filtered and have other functions performed on them.

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

The pop-up must be dismissed.

13.1.3 Accept Button

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

Section 13.2.1 provides information about using the Accept button.

13.2 Patient with Active Tags

The data will display on the **Main** sub-tab. (Figure 13-5)

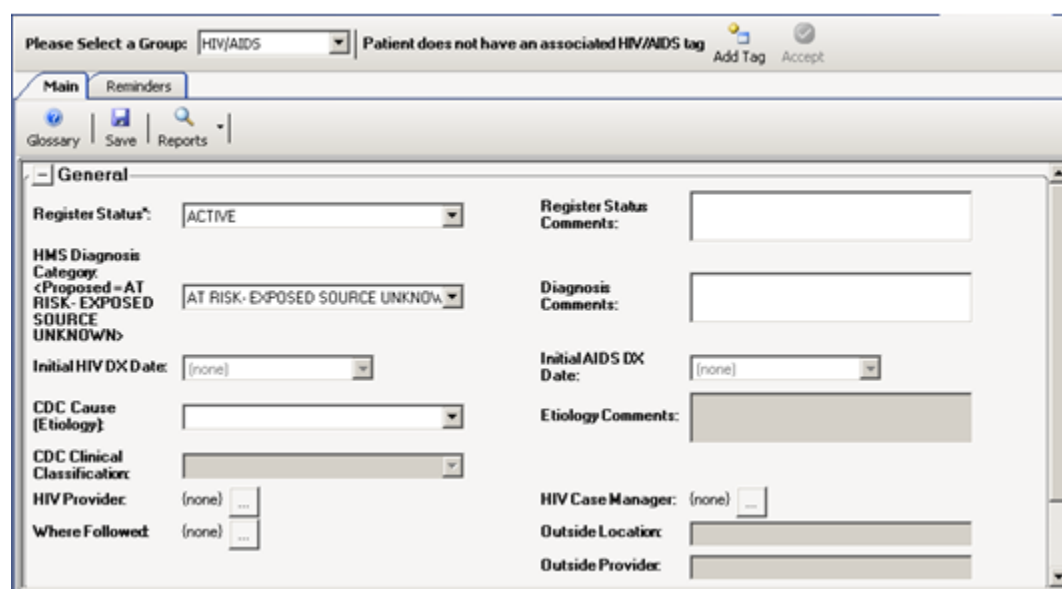


Figure 13-5: Sample **Care Management** Tab for patient with HIV/AIDS tag

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

13.2.1 Accept

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

Click the **Accept** button, or select **Care Mgmt | Accept Tag**, to display the **Update Diagnostic Tag** dialog (Figure 13-6.) This dialog displays the patient name, diagnostic tag, and status.

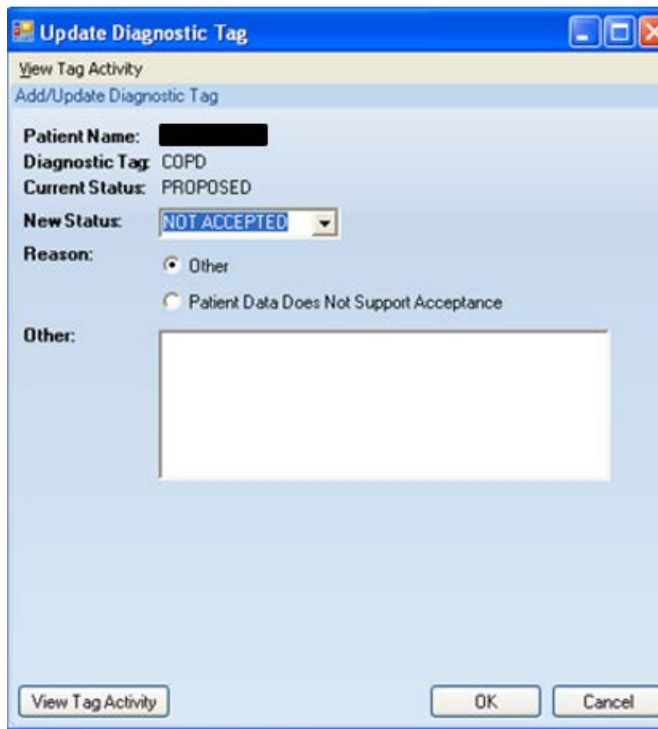


Figure 13-6: Sample **Update Diagnostic Tag** dialog

Existing tag activity about the patient by can be viewed by clicking the **View Tag Activity** button. The **Diagnostic Tag Activity** pop-up displays. Section 13.1.2.2 provides information about this pop-up.

The following fields can be edited:

New Status: the status of the tag being changed.

- **Accepted:** this option allows to “Accept” a proposed tag to provide an affirmation of its validity for a given patient.
- **Not Accept:** this option allows a user to disapprove or “Not Accept” a diagnostic tag that has been proposed for a patient.
- **Proposed:** this option allows change to the status of a diagnosis tag back to “Proposed” so that further review can take place. In certain cases, this option might not be available.

Reason: click the appropriate **radio button** for the reason to change the tag.


- Patient Data Supports Acceptance - use this when the patient data does not support the tag.

- Manually Designated - use this when manually designating the tag.
- Other - use this when the other reasons do not fit. The **Other** field must be populated with the text of the reason.

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

Click **OK** to save changes. (Otherwise, click **Cancel**). If a change is saved, the screen must be refreshed; the message besides the **Care Management Group** field will reflect the change.

13.2.2 Add Tag

Use the **Add Tag** process to add a diagnostic tab. Click the **Add Tag button** () or select **Care Mgmt | Add Tag**, to access the **Add Diagnostic Tag** dialog. This is a manual add. Section 13.1.2 provides information on using the **Add Tag** process.

13.3 Main Sub-Tab

Use the **Main** sub-tab of **Care Management** window (Figure 13-7) to add/edit patient register information.

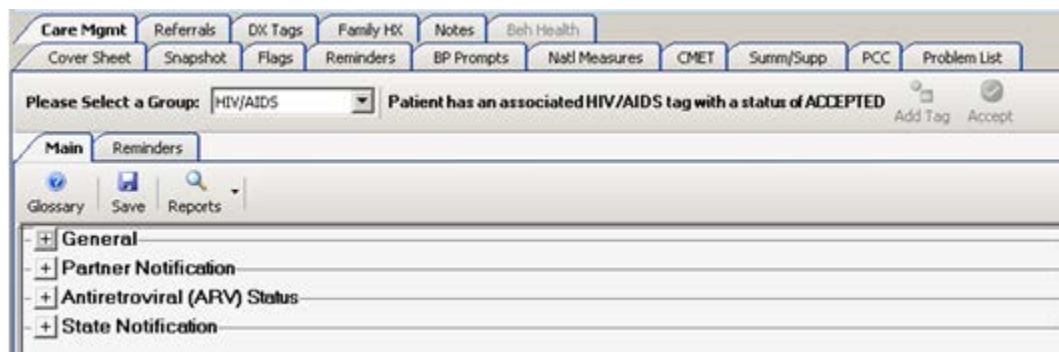


Figure 13-7: Sample **Care Management** tab after clicking Enter Data

All categories to be changed must be expanded first. They are listed below the toolbar buttons. After completing changes, click the **Save button** to save the changes. Section 13.3.4 provides information about the **Save** process.

Many of the lists (for fields) contain a “blank” option that is used when a field should have no data. Usually the “blank” option is the first one on the list.

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

13.3.1 General

Expand the **General** category (Figure 13-8) to display the fields on the **General** group box.

The screenshot shows a software interface with a 'Main' tab and 'Reminders' sub-tab. Below the navigation bar are 'Glossary', 'Save', and 'Reports' buttons. The main content area is titled 'General' and contains several form fields:

- Register Status*:** A dropdown menu with 'ACTIVE' selected.
- Register Status Comments:** A text input field.
- HMS Diagnosis Category:** A dropdown menu with 'AIDS' selected. Below it, the text '<Proposed = AT RISK- EXPOSED SOURCE UNKNOWN>' is displayed.
- Diagnosis Comments:** A text input field.
- Initial HIV DX Date:** A date picker showing '04/09/2013'.
- Initial AIDS DX Date:** A dropdown menu with '[none]' selected.
- CDC Cause (Etiology):** A dropdown menu with 'HET-Heterosexual contact' selected.
- Etiology Comments:** A text input field.
- CDC Clinical Classification:** A dropdown menu.
- HIV Provider:** A dropdown menu with '(none)' selected.
- Where Followed:** A dropdown menu with '(none)' selected.
- HIV Case Manager:** A text field containing 'EDEMO, ARLENE F' and a small icon.
- Outside Location:** A text input field.
- Outside Provider:** A text input field.

Figure 13-8: Fields for the **General** group box

All fields with an asterisk (*) are required.

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

Note: A proposed date might be displayed, based on the earliest RPMS data that meets the HIV/AIDS tag definition. The actual date must be entered, even if a user wants to “accept” the proposed date.

- **Initial AIDS DX Date:** select the **date** when this patient was first diagnosed with AIDS from the calendar on the list for this field. Only a month and year can be added;

in this case the entry will be stored in BKM as MM-01-YYYY. This field is active only when the **HMS Diagnosis Category** field with AIDS is populated.

Note: A proposed date might be displayed, based on the AIDS logic defined above in the **HMS Diagnosis Category** field. The actual date must be entered, even if a user wants to “accept” the proposed date.

- **CDC Cause (Etiology):** select **an option from the list** that indicates the cause (etiology) of the patient’s DX. The Centers for Disease Control (CDC) has categorized the ways in which an individual is exposed to HIV.
- **Etiology Comments:** type **comments** about the CDC Cause selection in this **Free Text** field (limited to 50 characters). (This field is active only when the CDC Cause (Etiology) field is populated.) A comment should always be entered if selecting “OTH - Other” in the **CDC Cause** field.
- **CDC Clinical Classification:** this field is active when the **HMS Diagnosis Category** contains AIDS or HIV. Select the clinical classification from the list.
 - The current CDC classification system combines three categories of the CD4 count with three symptom categories. The use of both the CD4 cell count and clinical categories provides shorthand for where the patient stands during the HIV/AIDS continuum. While there are guidelines in place, assign the classification only after clinical evaluation. The decision of which category to assign is always made by a clinical person. The CDC proposed that the clinical classification system be used to “guide clinical and therapeutic actions in the management of HIV infected adolescents and adults.”
 - The **HIV Provider, HIV Case Manager, and Where Followed** fields are populated by using the **Table Lookup** dialog. Section 20.15 provides more information about using this dialog.
- **HIV Provider:** click the **ellipsis button** to search for a HIV provider name at the local facility. If this patient is cared for at an outside facility, enter the **provider** in the “Outside Provider” field. This information is pulled from the **RPMS Designated Specialty Provider Management (DSPM)** application, if available, and displayed here.
- **HIV Case Manager:** click the **ellipsis button** to search for a case manager name at the local facility. This information is pulled from the **RPMS DSPM** application, if available, and displayed here.
- **Where Followed:** click the **ellipsis button** to search for name of a facility that primarily follows the patient’s care related to HIV/AIDS. If this is not the appropriate facility, select **OTHER** from the list; the specific facility can be identified in the outside location field and the provider in the **Outside Provider** field.

- **Outside Location:** manually type the **name of the facility or outside physician’s office** where the patient is followed. This is Free Text field limited to 50 characters.
- **Outside Provider:** manually type the **name of the patient’s HIV provider** at the outside location. This is **Free Text** field limited to 50 characters.

13.3.2 Partner Notification

This notification type is to document the notification of a patient’s partner of a potential exposure to HIV. The public health recommendation to notify the patient’s partner is a practice that is encouraged in all I/T/U facilities. (Figure 13-9)



Figure 13-9: Fields for **Partner Notification** group box

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

Partner Notification Status: Select an **option from the list** that indicates the partner notification status.

Partner Notification Date: This field is active when the **Partner Notification Status** contains Yes. Enter a **date that the partner was notified**; a user can select from a calendar by using the list.

13.3.2.1 Antiretroviral (ARV) Status

Expand the **ARV** category to display the fields on the **Antiretroviral ARV (Status)** group box. (Figure 13-10)

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

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

Antiretroviral (ARV) Status

ARV Appropriate:

Add (F2) X Delete (Del)

Date	Status	Comment	Last Edited By	Last Edited Date
May 21, 2010	Yes, Appropriate	testing	FELDK.LINDSAY	May 21, 2010

ARV Adherence:

Add (F2) X Delete (Del)


Date	Adherent	Comments	Last Edited By	Last Edited Date
May 21, 2010	Adherent	testing	FELDK.LINDSAY	May 21, 2010
May 14, 2010	Non-adherent	testing	FELDK.LINDSAY	May 21, 2010

ARV Stability:

Add (F2) X Delete (Del)

Date	Stability	ARV Regimen	Comments	Last Edited By	Last Edited Date
May 21, 2010	Stable	U	testing	FELDK.LINDSAY	May 21, 2010

Figure 13-10: Fields on the **ARV** group boxes

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

Date: Enter the **date the patient was assessed** for suitability for ARV (required). Click **the list** to select a date from a calendar.


Status: Select **an option from the list** that indicates the status of the **ARV Appropriate** record.


Comment: Type **a comment**, if appropriate, in this **Free Text** field, using up to 50 characters.

Last Edited By: The name of the person who last edited the record (system populated).

Last Edited Date: The date the record was last edited (system populated).

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

For **ARV Appropriate**, selected records can be deleted by clicking the **Delete button** () to display the **Delete Rows** information message. Click **Yes** to remove the records. (Otherwise, click **No**.)

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

Date: This is the date the patient was assessed for adherence to the prescribed ARV regimen (required). Click **the list** to select from a calendar.


Adherent: Select **an option** from the list that indicates the adherent status of the record.


Comment: Type a **comment**, if appropriate, in this **Free Text** field, using up to 50 characters.

Last Edited By: The name of the person who last edited the record (system populated).

Last Edited Date: The date the record was last edited (system populated).

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

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

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

Date: This is the date the patient was assessed for ARV Stability. Click the **list** to select from a calendar.

Stability: Select **an option** from the list that indicates the stability status of the record.


ARV Regimen: Click **the list** and select one of the options: Changed, Unchanged.

Comments: Add **any comments** regarding the ARV Stability data in the **Free Text** field.

Last Edited By: The name of the person who last edited the record (system populated).

Last Edited Date: The date the record was last edited (system populated).

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

For ARV Stability, selected records can be deleted by clicking the **Delete button** () to display the **Delete Rows** information message. Click **Yes** to remove the records. (Otherwise, click **No**.)

13.3.3 State Notifications

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

Expand the **State Notification category** to display the following fields on the **State Notification** group box (Figure 13-11.)

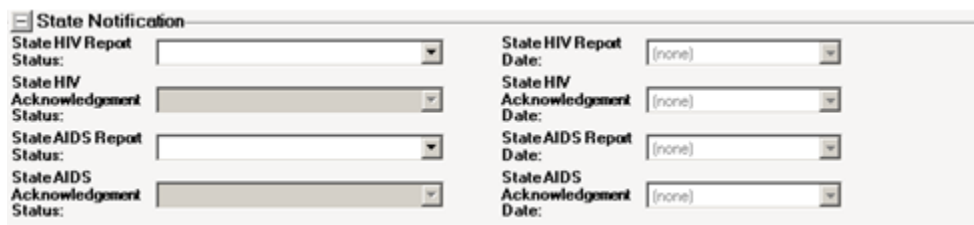


Figure 13-11: Fields on State Notification group box

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

State HIV Report Status: Select the **State HIV Report Status** from the list: N/A, No, Remind Me Later, Unknown, Yes. This answers the question: Has the state health department been notified about this patient's HIV status?

State HIV Report Date: This field is active if the **State HIV Report Status** field contains Yes. A calendar can be used to report the date by using the list. This is the date the **State HIV status** report was submitted to the state health department.

State HIV Acknowledgment Status: Select the **State HIV Acknowledgment status** from the list: No, Unknown, Yes. This answers the question: Has your facility received an acknowledgement from the state health department?

State HIV Acknowledgment Date: This field is active if the **State HIV Acknowledgment Status** field contains Yes. A calendar can be used to select the date by using the list. This is the date the state acknowledged receipt of HIV report, if any.

State AIDS Report Status: Select the **State AIDS Report Status** from the list: N/A, No, Remind Me Later, Unknown, Yes. This answers the question: Has the state health department been notified about this patient's AIDS status?

State AIDS Report Date: This field is active if the **State AIDS Report Status** field contains Yes. A calendar can be used to select the date by using the list. This is the date the AIDS status report was submitted to the state health department.

State AIDS Acknowledgment Status: Select the **State AIDS Acknowledgment status** from the list: No, Unknown, Yes. This answers the question: Has the facility received acknowledgement from the state's health department?

Note: Most sites report that they do not receive this acknowledgment.

State AIDS Acknowledgment Date: This field is active if the **State AIDS Acknowledgment Status** field contains Yes. A calendar can be used to select the date by using the list. This is the date the state acknowledged receipt of AIDS report.

13.3.4 Save Button

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

Below is one example of what happens after clicking **Yes**. What displays after clicking **Yes** depends upon if there is a tag status or not.

After clicking **Yes**, a message appears asking about changing the tag status. (Figure 13-12)



Figure 13-12: Message About **Changing Status**

If **Yes** is clicked, the Update Diagnostic Tag dialog appears.

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

If **Cancel** is clicked, the system asks to confirm cancelling the entire Save process. Clicking **Yes** exits the save process. Clicking **No** causes the application to display a message that asks: Are you sure you want to cancel the entire Save process? Click **Yes** to cancel the entire Save process. Click **No** and the application displays the message **HIV Management System** data has been saved successfully to RPMS. Click **OK** to dismiss the message.

13.3.5 Reports

Click the list for the **Reports** button, or select **Care Mgmt | Main | Reports**, to access any of the following reports:

Table 3 **Reports** Button

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

13.3.6 Glossary Button

Click the **Glossary** button to access the **HIV/AIDS / Care Management Glossary** pop-up. The glossary provides information about the following:

- Creating a panel
- The **HIV/AIDS Register** specific fields
- **HMS Patient Care Supplement**

- **Quality of Care Report**
- **Definitions**

Section 20.7 provides information about using the controls on the pop-up.

13.4 Reminders Sub-Tab

Category	Clinical Group	Reminder Name	Due Date	Next Due
Care Management	HIV	CD4 Test	Mar 01, 2010	MAY BE DUE NOW (WAS DUE 03/01/11)
		HIV Viral Load Test	Mar 01, 2010	MAY BE DUE NOW (WAS DUE 03/01/11)


Figure 13-13: Sample **Reminders** sub-tab on Care Management

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

Category: the category of the reminder, for example, **Case Management**.

Clinical Group: the clinical group of the reminder, for example, HIV.

Reminder Name: the name of the clinical procedure that needs to be done. View a tooltip by hovering the mouse over any Reminder Name cell.

Due Date: the date the reminder procedure is due. This column will display the warning indicator () if any of the patient's reminders are overdue. This date is derived from the **Health Summary Reminders Next Due** test.

Next Due: the actual text from the **Reminders Next Due** display on the **Health Summary**.

Last Date Performed: the date that the reminder procedure was most recently completed.

Preceding CMET Event: this is populated with the tracked Event that initiated this follow-up. If the displayed reminder is not a **CMET Reminder**, this cell will contain N/A.

Date of Preceding CMET Event: the date of the preceding **CMET Event**.

Columns can be viewed, filtered and other functions performed on them.

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

13.4.1 Patient with Asthma Tag

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

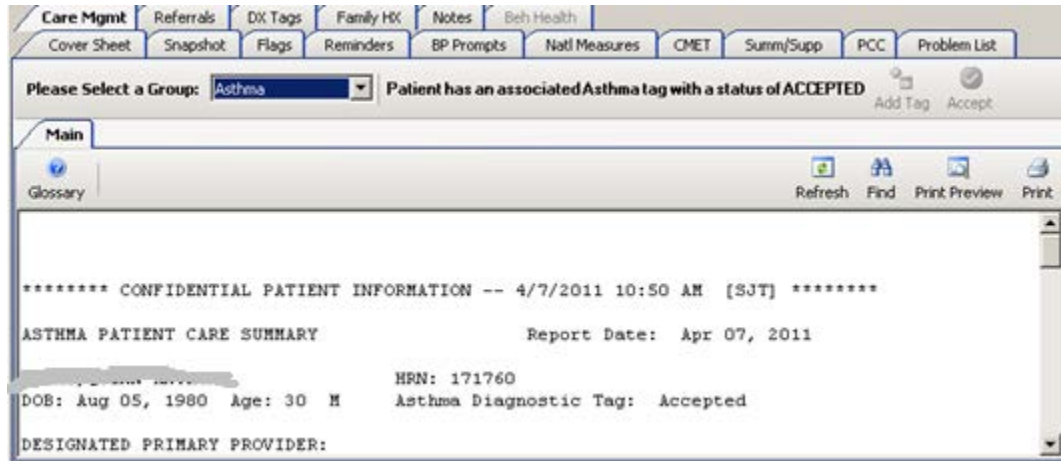


Figure 13-14: Sample Patient with Asthma tag

The **Main** sub-tab displays the existing **Asthma Patient Care Summary** (Supplement) report. Section 20.7 provides information about using the controls on the pop-up. The **Asthma Care Management** view does not include the **Reminders** sub-tab because there are no asthma-specific reminders.

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

13.5 Care Management Tab Menus

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

13.5.1 Tools Menu for Main Sub-Tab

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

13.5.2 Tools Menu for Reminders Sub-Tab

The options on the **Tools** Menu for the **Reminders** sub-tab are the same as those for the [Tools menu](#) for the **Flags** tab.

13.5.3 Care Mgmt Menu

The options on the **Care Management** window (both **Main** and **Reminders** sub-tabs) are shown below.

Both **Main** and **Reminders** sub-tabs have the following options on the **Care Mgmt** Menu:

Add Tag: This option works like the **Add Tag** button.

Accept Tag: This option works like the **Accept** button.

HIV/AIDS Management Guide: This option displays the **iCare Population Management GUI** window for online help.

13.5.3.1 Main Sub-Tab

The **Main** sub-tab for the HIV/AIDS (Group) is shown in Figure 13-15.

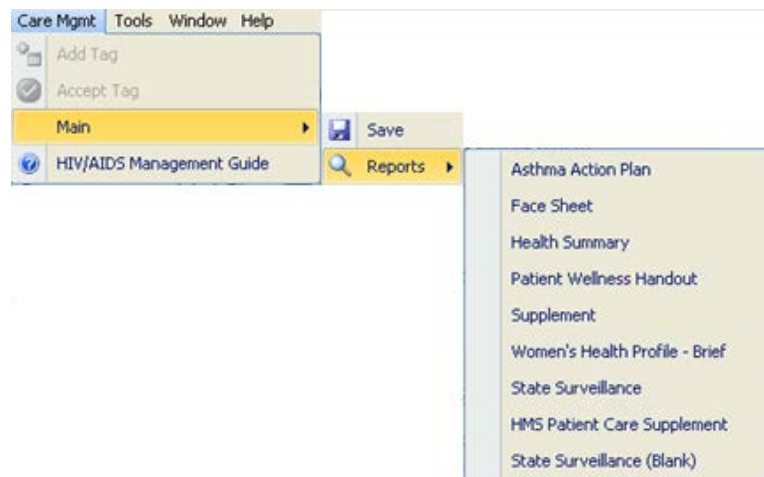


Figure 13-15: **Care Mgmt** menu options for HIV/AIDS

Save: this option functions the same as the **Save** button on the **Main** sub-tab.

Reports: this option lists the available reports listed on the **Main** sub-tab.

HIV/AIDS Management Guide: this option displays the **iCare Population Management GUI** window for online help.

The following option only displays from the **Main** sub-tab for **Asthma** group:

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

13.5.3.2 Reminders Sub-Tab

The Reminders option for the **HIV/AIDS** (Group) (Figure 13-16)

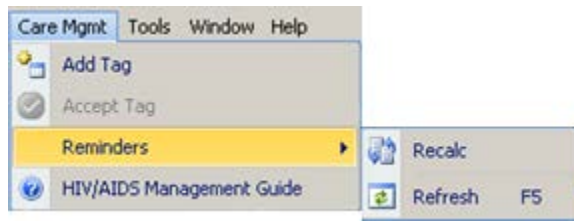


Figure 13-16: **Care Management** menu for the **Reminders** sub-tab

Add Tag: this option works like on the action button on the **Care Mgmt** window.

The following options only display on the Reminders sub-tab:

Recalc: this option gets the latest data from the server and to run the algorithm.

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

HIV/AIDS Management Guide: this option displays the **iCare Population Management GUI** window for online help.

14.0 Referrals Tab

The **Referrals** tab (Figure 14-1) displays the referrals for the selected patient in the time range shown in the “Last” field. This data comes from the **Referral Care Information System (RCIS)**.

Initiated Date	Referral Provider	Purpose of Referral	Outside Vendor	Expected Begin Date	Actual Appt Date	Referral Status
Apr 05, 2007	[REDACTED]	ADENOSINE NUCLEAR STRESS TEST 2 DAY	ASHEVILLE CARDIOLOGY ASSOCS	Apr 20, 2007		CHS
	[REDACTED]	STAGE 4 CKD	MTN KIDNEY ASSOCS PA	Apr 18, 2007		CHS
Nov 13, 2006	[REDACTED]	Debridement of left 2nd toe	SYLVA ORTHOPAEDICS	Nov 14, 2006		CHS

Figure 14-1: Sample **Referrals** tab

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

14.1 Referrals Tab Layout

The data comes from the **RCIS**. The user manual at the following URL: <http://www.ihs.gov/Cio/RPMS/index.cfm?module=home&option=documentschoice>

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

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

Table 4 provides information about the fields.

Table 4 Field Information

Field	Meaning
Initiated Date	The date that the referral was initiated.
Referral Provider	The provider who requested the referral for the patient.
Purpose of Referral	This is a narrative that describes the purpose of the referral.
Outside Vender	This is the name of the Outside vendor, such as outside providers, clinics, hospitals, labs etc. This information comes from the RCIS application.
Expected Begin Date	This applies to outpatient visits that is the expected begin date of service.
Actual Appt Date	The date that the appointment for the referral was scheduled for this patient.
RCIS Status	The RCIS status of the referral.
Referral Type	The type of referral that was made. This can be any of the following: IHS - a referral to another IHS facility CHS - a referral to an outside facility that will be paid for with CHS funds

Field	Meaning
	In-house - a referral to another clinical area within the facility Other - any other type of referral that will be paid with funds other than CHS (such as Medicaid or private insurance)
Patient Type	This is either inpatient or outpatient.

14.2 Referrals Tab Toolbar Options

The **Last** field determines the date range for the data. The default is one year. A different predefined date range can be selected.

Section 20.3 provides information about the buttons on the right side of the toolbar.

14.3 Referrals Tab Menus

The options on the **File** menu of the **Referrals** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

The options on **Tools** Menu on the **Referrals** tab are the same as those on the [Tools menu](#) for the **Flags** tab.

15.0 Consults Tab

The **Consults** tab (Figure 15-1) displays the consults for the selected patient in the time range shown in the “Timeframe” field.

Consult Date	To Service	From Location	Sending Provider	Status	Urgency	Last Action	Attention To
Aug 15, 2012	PS PUBLIC HEALTH NURSE	SWING BED		ACTIVE	ROUTINE	RECEIVED	
Jul 23, 2012	PA NUTRITION	SWING BED		PENDING	ROUTINE	CPRS RELEASED ORDER	
Jul 22, 2012	PA PHYSICAL THERAPY	SWING BED		COMPLETE	ROUTINE	COMPLETE/UPDATE	
Jul 05, 2012	PA NUTRITION	SWING BED		ACTIVE	ROUTINE	RECEIVED	
Jun 16, 2012	PA SOCIAL SERVICES	SWING BED		COMPLETE	WITHIN 72 HOURS	COMPLETE/UPDATE	

Figure 15-1: Sample **Consults** tab

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

15.1 Consults Tab Layout

Columns can be sorted, filtered and other functions performed on them.

Table 5 provides information about the fields.

Table 5 Consults Tab Layout

Field	Meaning
Consult Date	The date of the consult.
To Service	The in-house service the consult is for.
From Location	The location creating the consult.
Sending Provider	Provider who initiated consult.
Status	The status of the consult.
Urgency	What the urgency of the consult is.
Last Action	The last action taken on the consult. Actions are: ADDED COMMENT ADDENDUM ADDED TO ADMIN. CORRECTION CANCELLED COMPLETE/UPDATE CPRS RELEASED ORDER DISASSOCIATE RESULT DISCONTINUED EDIT BEFORE RELEASE EDIT/RESUBMITTED ENTERED IN CPRS FORWARDED FROM FWD TO REMOTE SERVICE INCOMPLETE RPT INITIAL REMOTE REQUEST NEW NOTE ADDED PRINTED TO

Field	Meaning
	RECEIVED REMOTE REQUEST RECEIVED SCHEDULED SERVICE ENTERED SIG FINDING UPDATE STATUS CHANGE UNKNOWN ACTION
Attention To	To whom the consult is intended for.
Request Type	The type of request. Can be Procedure or Consult.
Patient Type	This is either inpatient or outpatient.
Consult Number	The unique number assigned to each consult.
Location	The location where consult occurred.
Ordering Facility	The facility from whom the consult is being ordered.
Place of Consultation	This is the place where the consultation will take place.
Provisional Diagnosis	This is the Provisional Diagnosis the ordering clinician would specify on the Consult Form 513.
Associated Results	This is the reason for requesting the Consult or Procedure Request. (Word-processing field).

15.2 Consults Tab Toolbar Options

The **Timeframe** field determines the date range for the data. The default is one year. A different predefined date range can be selected.

Section 20.3 provides information about the buttons on the right side of the toolbar.

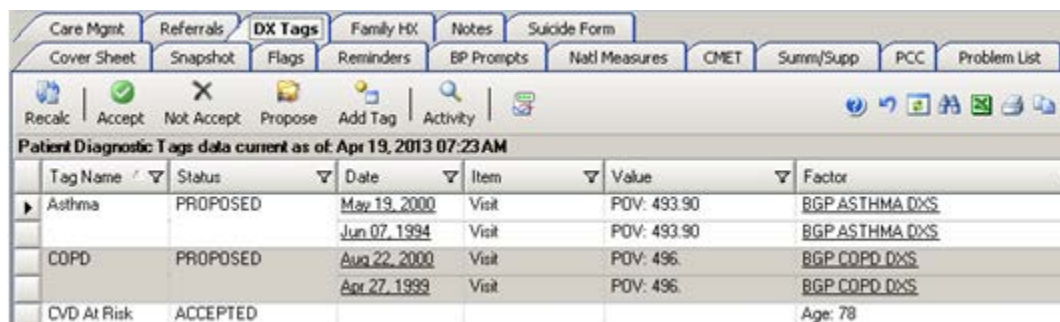
15.3 Consults Tab Menus

The options on the **File** menu of the **Consults** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

The options on **Tools** Menu on the **Consults** tab are the same as those on the [Tools menu](#) for the **Flags** tab.

16.0 DX Tags Tab

The **DX Tags** tab (Figure 16-1) displays the diagnostic tags information for the current patient. **Diagnostic** Tags are Predefined Diagnosis definitions (“tags”) that iCare has proposed for this patient, based on the tagging function. The display includes the relevant qualifying criteria data.



Tag Name	Status	Date	Item	Value	Factor
Asthma	PROPOSED	May 19, 2000	Visit	POV: 493.90	BGP ASTHMA DXS
Asthma	PROPOSED	Jun 07, 1994	Visit	POV: 493.90	BGP ASTHMA DXS
COPD	PROPOSED	Aug 22, 2000	Visit	POV: 496	BGP COPD DXS
COPD	PROPOSED	Apr 27, 1999	Visit	POV: 496	BGP COPD DXS
CVD At Risk	ACCEPTED				Age: 78

Figure 16-1: Sample **DX Tags** tab

Providers can review tags that were automatically assigned by the system, and then decide whether to accept the tags as valid for the patient.

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

16.1 DX Tags Tab Layout

The data columns are described in Table 6.

Table 6 **DX Tags** Tab Layout

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

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


Double-click **underlined Factor** to access the **iCare Taxonomy View/Edit** window. Section 20.9 provides information about this window.

16.2 DX Tags Tab Toolbar

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

Section 20.3 provides information about the buttons on the right side of the toolbar.

16.2.1 Recalc


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

16.2.2 Change the Tag Status

Change the tag status by clicking the **Accept**, **Not Accept**, or **Propose** button (or selecting the options on the **Diagnostic Tags** menu). This causes the **Update Diagnostic Tag** dialog to display where that tag status can be changed. Select the **reason for the change**, and populate the **Other field** (free text). Section 13.1.2 provides information about this dialog.


When finished with this dialog, click **OK** to accept the changes. (Otherwise, click **No**.) Changes can be viewed in the grid of records on the **DX Tags** tab.

16.2.3 Add Tag

Click the **Add Tag button** () or select **Diagnostic Tag | Add Tag**, to add a tag to the current patient. The **Add Diagnostic Tag** dialog will display. This is a manual add that allows a provider to manually assign one or more of the diagnosis tags to patients who did not meet the tag's criteria for being proposed automatically. Section 13.1.2 provides information about this dialog.


16.2.4 Activity

View existing tag activity about the patient by doing one of the following:

- Click the **Activity button** ()
- Select **Diagnostic Tags | Activity**

The **RPMS iCare - Diagnostic Tag Activity** pop-up displays. This is a view-only pop-up. Multiple users can enter the tags, so this pop-up shows all the activity. Section 13.1.2.2 provides information about this pop-up.

16.2.5 Background Jobs

Click the **Background Jobs button** () to display the **Background Jobs** pop-up. Section 20.12 provides information about this pop-up.

16.3 DX Tags Tab Menus

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

The options on **File** menu on the **DX Tags** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

The options on **Tools** Menu on the **DX Tags** tab are the same as those on the [Tools menu](#) for the **Reminders** tab.

17.0 Family HX Tab

The **Family HX** tab (Figure 17-1) displays any family history information about the patient.

Relative	Relative Modifier	Diagnosis Code	Diagnosis Narrative	Age at Onset	Status	Age at Death	Cause of Death	Multiple Birth	Provider	Date Last Modified
NATURAL FATHER	John	Z82.5-Family history of asthma and oth chronic lower resp diseases	FH: Asthma		LIVING					Jan 07, 2014
NATURAL MOTHER	familyhistory.mother	Z80.9-Family history of malignant neoplasm, unspecified	Family history of cancer		DECEASED	At age 40-49	cancer	YES, IDENTICAL TWIN		Sep 15, 2014
NATURAL BROTHER	Jack	Z83.3-Family history of diabetes mellitus	FH: Diabetes mellitus		LIVING					Jan 07, 2014
NATURAL BROTHER	JOE				DECEASED	At age 40-49		YES, IDENTICAL TWIN		Jan 07, 2014
NATURAL DAUGHTER	Jane	Z82.49-Family hx of ischem heart dis and oth dis of the circ sys	FH: Hypertension		LIVING					Jan 07, 2014
GRANDFATHER	Bob	Z84.0-Family history of diseases of the skin, subcu	FH: Eczema		DECEASED	At age 50-59	Emphasema			Jan 07, 2014

Figure 17-1: Sample **Family HX** tab

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

17.1 Family HX Tab Layout

Columns can be sorted, filtered and other functions performed on them.

Table 7 provides a description of the fields.

Table 7 **Family HX** Tab Layout

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

17.2 Family HX Tab Toolbar

Section 20.3 provides information about the buttons on the right side of the toolbar.

17.3 Family HX Tab Menus

The options on the **File** menu of the **Family HX** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

The options on the **Tools** menu of the **Family HX** tab are the same as those on the [Tools menu](#) for the **Flags** tab.

18.0 Notes Tab

The **Notes** tab (Figure 18-1) displays the existing TIU notes for the current patient.

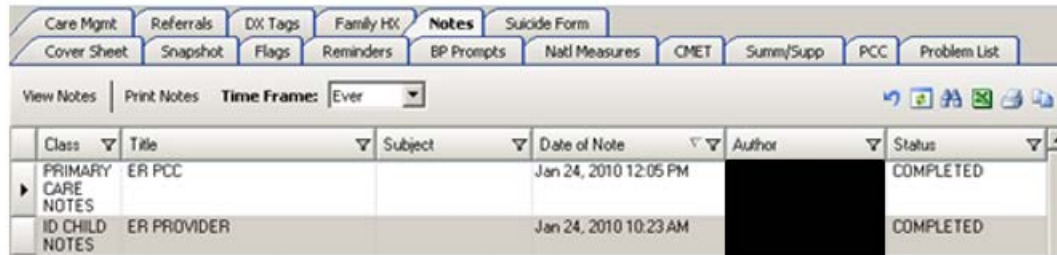


Figure 18-1: Sample **Notes** tab

18.1 Notes Tab Layout

The sort order is only by date, most recent date first.

Table 8 provides information about the fields.

Table 8 Notes Tab Layout

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

Double-clicking a **record in the grid** causes the application to display a pop-up window (Figure 18-2) showing information about the note.

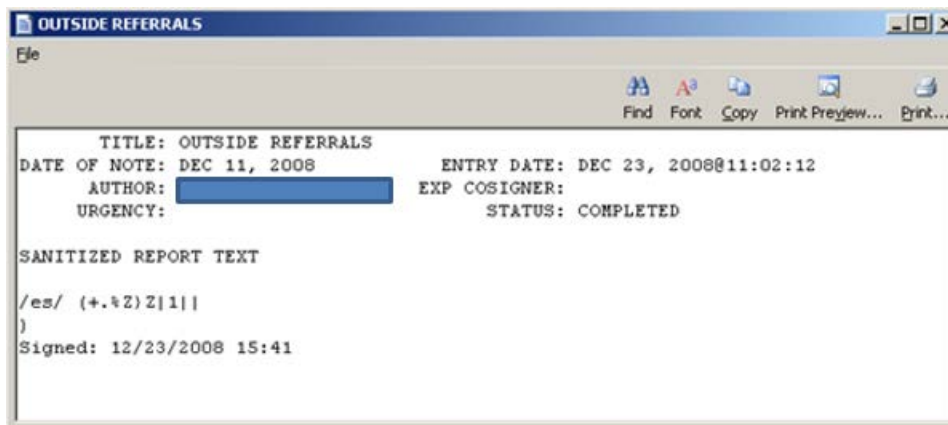


Figure 18-2: Sample Note pop-up

Section 20.7 provides information about using the controls on the pop-up.

18.2 Notes Tab Toolbar

Section 20.3 provides information about the buttons on the right side of the toolbar.

The time range for the notes can be determined by selecting an option from the **Time Frame list** (the default is 1 month).

18.2.1 View Notes

Use the **View Notes** function (Figure 18-3) view the text of one or more selected notes in the grid. Click **View Note** (or selecting **Notes | View Notes**) to access the **View Notes** pop-up with TIU headers and footers.

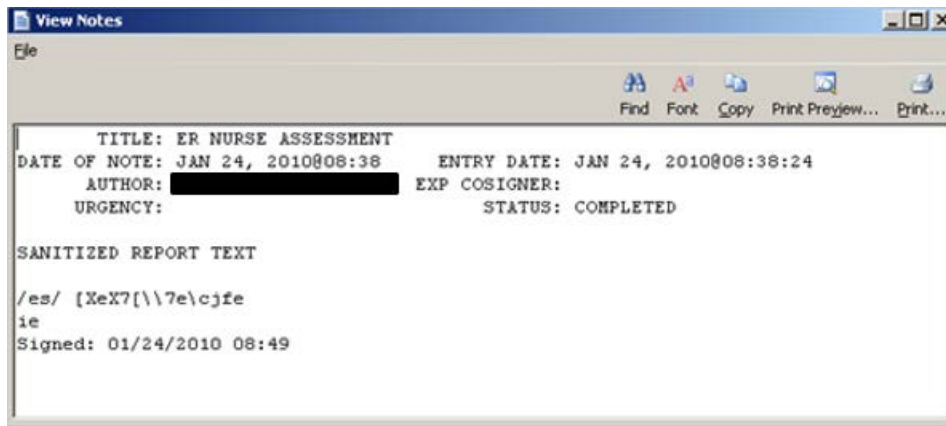


Figure 18-3: Sample **View Notes** pop-up

Section 20.7 provides information about using the controls on the pop-up.

18.2.2 Print Notes

Use the **Print Notes** button to print the **selected notes** without TIU headers and footers. Highlight **one or more selected notes** from the grid and the click **Print Notes** (or select **Notes | Print Notes**). The application displays the notes in the **Print Preview** dialog. Section 20.13 provides information about this dialog.

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

The contents can be printed on the **Print Preview** dialog by selecting **File | Print**.

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

18.3 Notes Tab Menus

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

The options on the **File** menu of the **Notes** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

The options on the **Tools** menu of the **Notes** tab are the same as those on the [Tools menu](#) for the **Flags** tab.

19.0 Suicide Form Tab

The **Suicide Form** tab (Figure 19-1) only displays for users who have been assigned specific Behavioral Health (BH) permission keys. These keys are assigned through BH only, not through **iCare User Access Management**.

Date of Act	Suicidal Behavior	Method	User Created	Date Created	User Last Modified	Date Last Modified
Mar 14, 2011	ATTD SUICIDE w/ ATTD HOMICIDE	HANGING		Apr 15, 2011		Apr 15, 2011

Figure 19-1: Sample **Suicide Form** tab

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

Double-click **any record** in the grid to access the **Suicide Form Detail**. (Figure 19-2)

```

***** CONFIDENTIAL PATIENT INFORMATION [SJT] Apr 28, 2011 *****
Suicide Reporting Form                               Date Printed: Apr 28, 2011

1. Case #: 585101041520110000001261   Local Case #:
2. PROVIDER INITIALS: RG                 3. PROVIDER DISCIPLINE:
4. SEX: FEMALE                          5. DOB: APR 08, 1955           6. AGE: 56
7. EMPLOYMENT STATUS: UNKNOWN
8. DATE OF ACT: APR 15, 2011
9. TRIBE: EASTERN BAND OF CHEROKEE IND, NC
10. COMMUNITY OF RESIDENCE: WOLFTOWN
11. COMMUNITY WHERE ACT OCCURRED: ZIA

```

Figure 19-2: Sample **Suicide Form Detail** pop-up

Besides the patient demographic information, this pop-up displays data in the fields on the SRF. Section 20.7 provides information about using the controls on the pop-up.

19.1 Suicide Form Tab Layout

Columns can be sorted, filtered and other functions performed on them.

Date of Act: The date of the suicide act.

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

Method: The method used in the suicide act.

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

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

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

19.2 Suicide Form Tab Toolbar

Section 20.3 provides information about the buttons on the right side of the toolbar.

19.3 Suicide Form Tab Menus

The options on the **File** menu of the **Suicide Form** tab are the same as those on the [File menu](#) for the **Cover Sheet** tab.

The options on the **Tools** menu of the **Suicide Form** tab are the same as those on the [Tools menu](#) for the **Flags** tab.

20.0 iCare Features Used by Patient Record

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

20.1 User Preferences

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

Figure 20-20-1: Sample **User Preferences** window

After the **User Preferences** window (Figure 20-20-1) is complete, click **OK** and the user preferences will be in effect for the operation of the **iCare application**. (Otherwise, click **Cancel**.)

20.2 Patient View Tab

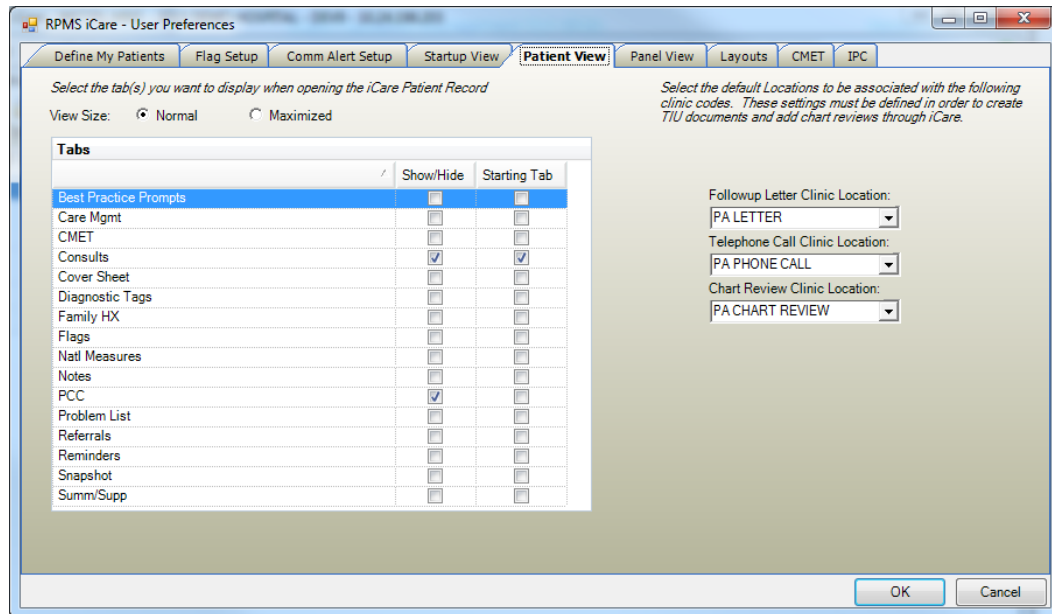


Figure 20-20-2: Sample **Patient View** tab

The selections on **Patient View** window (Figure 20-20-2) determine the following: which tabs are displayed, the startup tab that displays when first accessing the **Patient View** window, the view size, and the default location to be associated with various clinic codes.

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

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

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

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

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


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

20.3 Buttons on Right Side of Window

The buttons on the right side of any iCare window have the same functionality on any window. (Figure 20-20-3)




Figure 20-20-3: **Buttons on right side** of window

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


The application provides hover help for each button.

Some **iCare** windows might not have the mail merge and glossary buttons.


20.3.1 Reset View

Click the **Reset View button** (), or select **Tools | Reset View**, to return the current view to the default view. Use this feature when changing the view, such as resizing the column width. This is the same as using the **Ctrl+R key combination**.

20.3.2 Refresh

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

20.3.3 Search

Search for data in the current grid (Figure 20-20-4) by clicking the **Search button** (), or select **Tools | Search**, or use the **Ctrl+F key combination** to display the **Search** dialog.

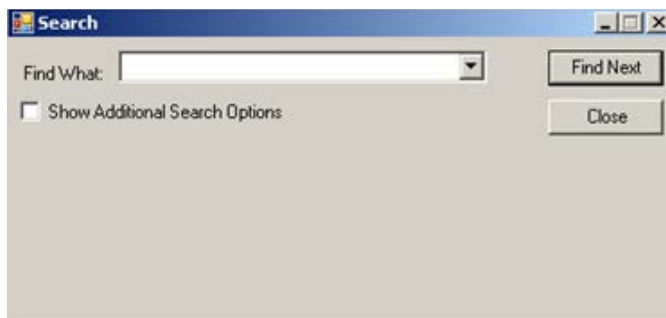


Figure 20-20-4: Search dialog

If the **Show Additional Search Options** checkbox is not selected, the search looks in all columns for a match.

If the **Show Additional Search Options** (Figure 20-20-5) checkbox is selected, the Search dialog changes to show more options for the search.

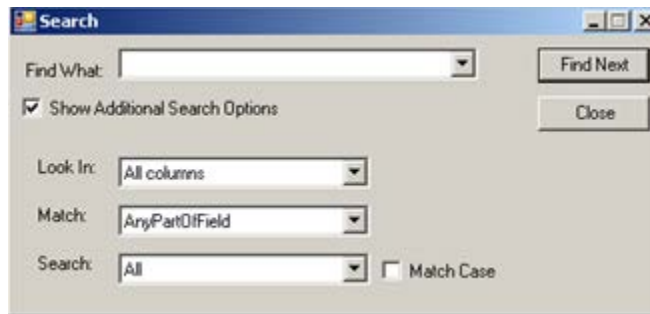


Figure 20-20-5: Search dialog with additional search options

Type the **desired subject** in the **Find What** Free Text field. The remaining fields determine the criteria for the search.

If the **Match Case** checkbox is selected, that will cause the search to match the case of the text in the **Find What** field.

20.3.3.1 Look In Field

Click the **list** for the **Look In** field to view the options for that field. The highlighted option determines what part of the window to search. (Figure 20-20-6)

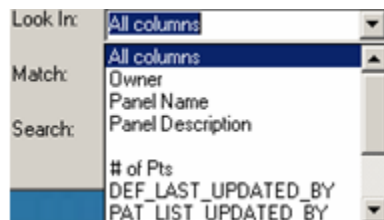


Figure 20-20-6: Sample list options for **Look In** field

What is highlighted in the upper part of the list determines the options in the lower part of the list. For example, if **Look In** field contained All columns, then the list of the column names would appear in the lower part of the list.

20.3.3.2 Match Field

Click the list for the **Match field** (Figure 20-20-7) to view the options for that field. The highlighted option determines what part of the **Find What** field will be matched in the search.



Figure 20-20-7: Sample list options for **Match** field

20.3.3.3 Search Field

Click **the list** for the **Search** field to view the options for that field. The highlighted option determines the direction of the search.(Figure 20-20-8)



Figure 20-20-8: Sample list options for **Search** field

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

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


If a match is not found, the **Datagrid Search Results** message displays. (Figure 20-20-9)



Figure 20-20-9: Sample **Datagrid Search Results**

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

20.3.4 Export to Excel

Information in the window can be exported to Microsoft Excel by clicking the **Export to Excel button** () or by selecting **Tools | Export to Excel**, or by using the **Ctrl+E** key combination.

The application displays the warning message about the export. (Figure 20-20-10)

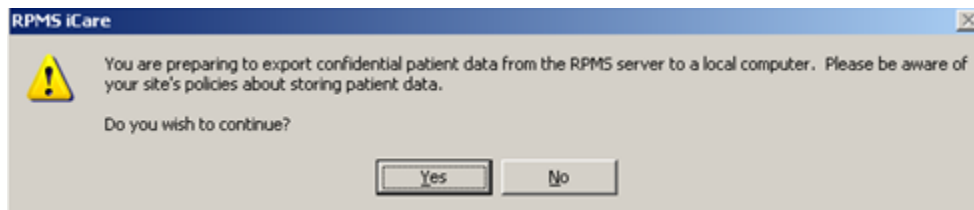


Figure 20-20-10: Warning message about exporting the patient data

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

Click **Yes** to continue the export process and to display the **Save As** dialog. (Figure 20-20-11)

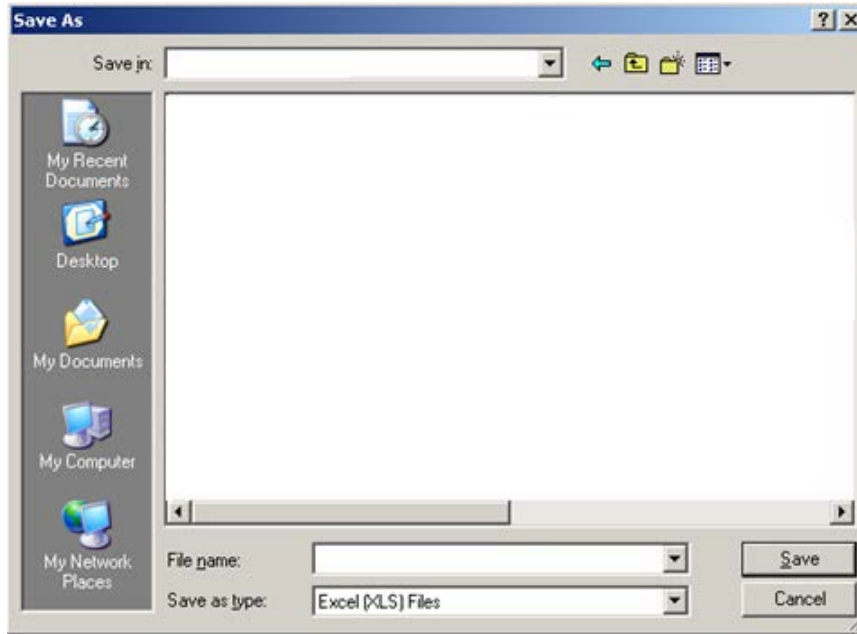


Figure 20-20-11: Sample **Save As** dialog


Make sure the correct location to save the file displays in the Save in field.

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

Click **Save**. (Otherwise, click **Cancel**.) If using Save, the **Export Panel** message “Excel export has been created.” displays when the Save command is complete; click **OK** to dismiss the message.

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

20.3.5 Print

The selected rows in the grid can be printed by clicking the **Print button** () or by selecting **Tools | Print**, or by using the **Ctrl+P key combination** to access the **Print Preview** dialog. (Figure 20-20-12.) Section 20.13 provides information about using this dialog.

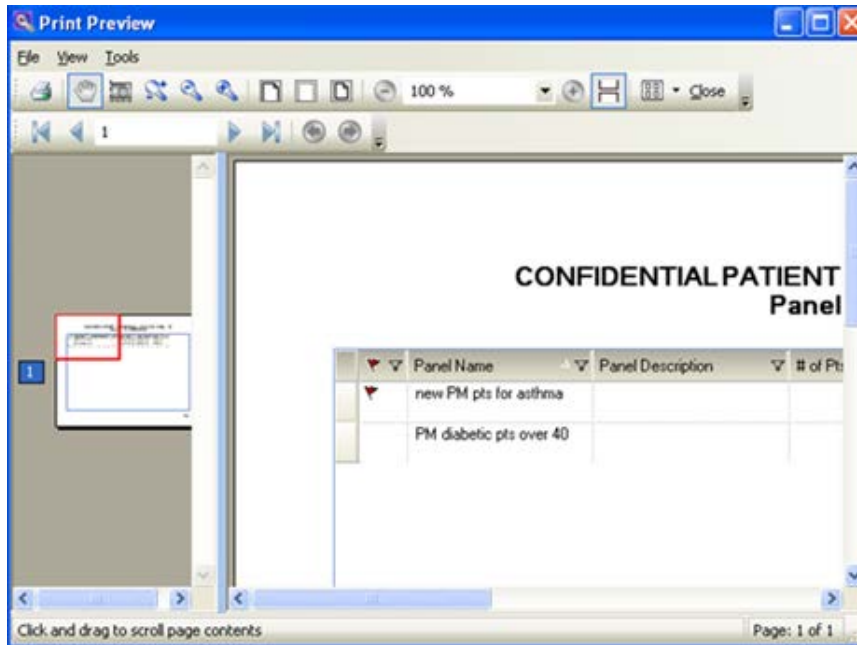


Figure 20-20-12: Sample **Print Preview** dialog

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

20.3.6 Copy to Clipboard

Selected rows in the grid can be copied to the Windows clipboard by clicking the **Copy to Clipboard button** (📄), or by selecting **Tools | Copy Rows to Clipboard**, or by using the **Ctrl+Shift+C key combination**. The contents of the Windows clipboard can be pasted to any Windows application.

20.3.7 Mail Merge

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

Follow these steps:

1. Select **one or more patients** to include in the mail merge process.
2. Click the **Mail Merge Export button** (📧), or select **Tools | Mail Merge**, to display the **Mail Merge Export** dialog. (Figure 20-20-13)

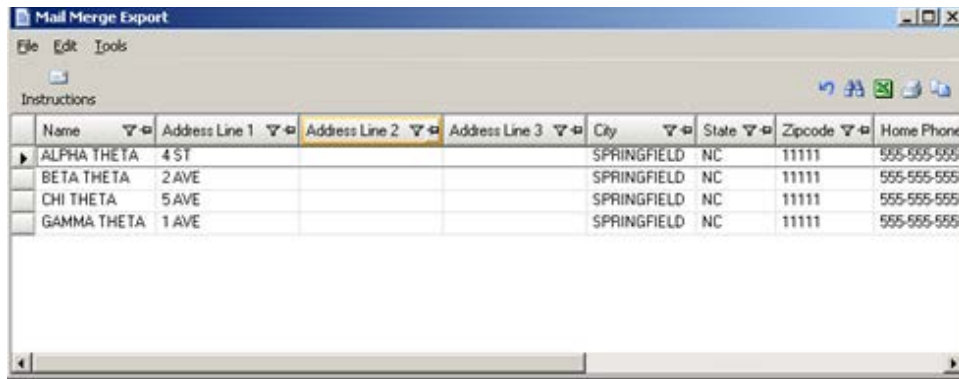



Figure 20-20-13: Sample **Mail Merge Export** dialog

Section 20.3 provides information about the buttons on the right side of the toolbar.

3. Click the **Mail Merge Instructions** button () to display the **Mail Merge Instructions** pop-up. This pop-up provides the instructions for completing the mail merge process. (Figure 20-20-14)

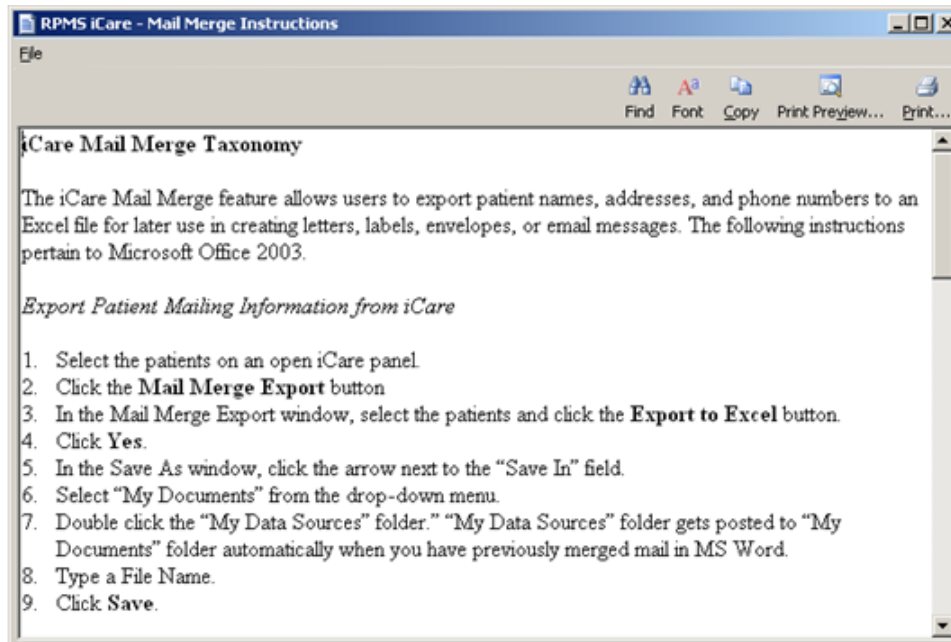



Figure 20-20-14: **Mail Merge Instructions** dialog

Note that the contents can be printed by clicking the **Print** button or by selecting **File | Print**.

See Section 20.7 for more information about how to use the controls on the pop-up.

20.3.8 Glossary

Click the **Glossary button** () or select the **glossary** from the **Help**, to display the **Glossary** pop-up. The name of the glossary pop-up varies according to the part of iCare that is being used. For example, if on the **Reminders** tab, the **Reminders Glossary** pop-up would display.

20.4 Edit Patient Demographics Fields

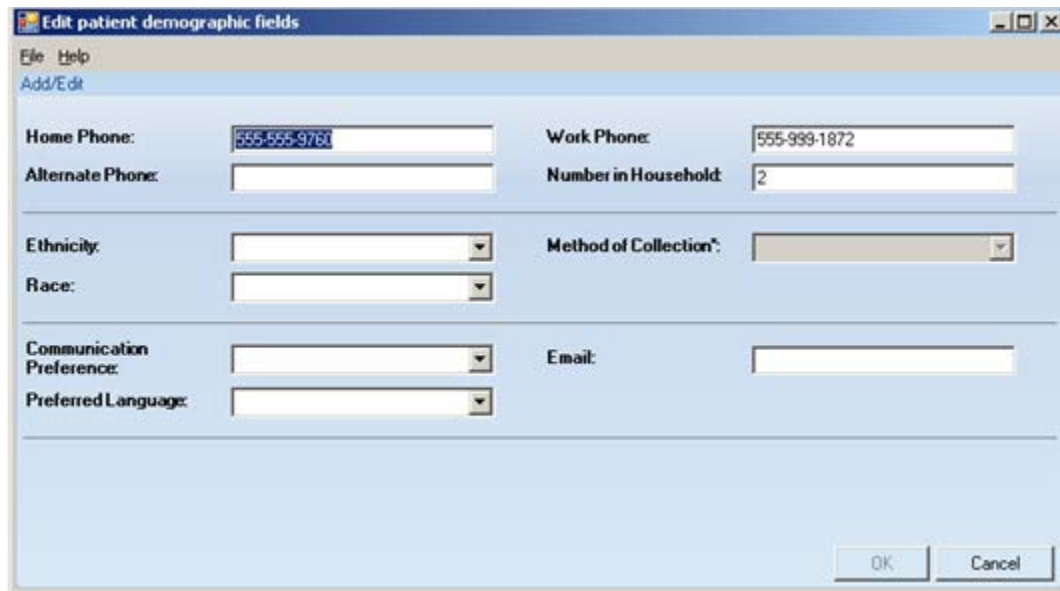


Figure 20-20-15: Sample **Edit patient demographic fields** dialog

20.4.1 Fields on Edit Patient Demographic Fields Dialog

Figure 20-20-15 shows the **Patient Demographic Fields** Dialog. The following sections describe each parameter.

The field name followed by an asterisk (*) is required.

Any field that is inactive on this dialog cannot be changed.

Phone: Populate the phone field with the **appropriate number**, using 4-60 characters in length. This applies to the patient's Home Phone, Work Phone, and Alternate Phone fields.

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

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

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

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

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

Email: Type the **patient's email address** in this field.

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

20.4.2 Menus on Edit Patient Demographic Fields Dialog

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

The Help menu has two options.

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

About iCare: use this option to review the information about the **iCare version** and other information.

20.5 Add a Note Dialog

The following information provides information about using the **Add a Note** dialog, shown in Figure 20-20-16.



Figure 20-20-16: Sample **Add a Note** dialog

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

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

Add Note: click the **Create** button to access the **Add TIU Note** dialog. Section 20.6 provides information about this dialog.

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

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

20.6 Add TIU Note Dialog

The following information provides information about using the **Add TIU Note** dialog. (Figure 20-20-17)

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

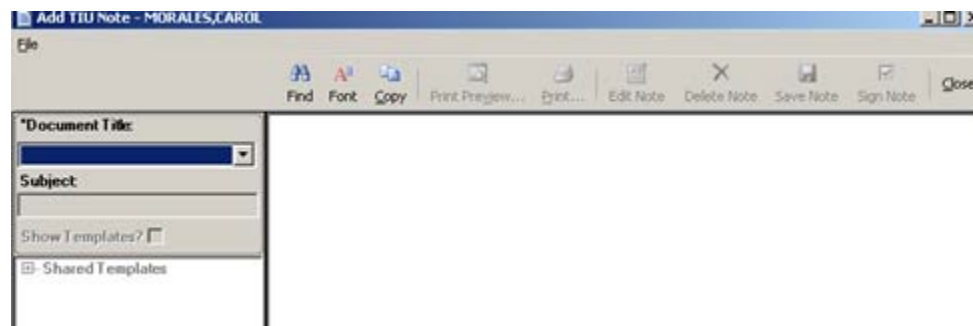


Figure 20-20-17: Sample **Add TIU Note** dialog

Note: Both fields are required.

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

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

At this point, the choices are to use a template or not.

20.6.1 Note with No Template

Choosing not to use a template, and, after populating the **Document Title and Subject** fields, the **text of the TIU note** can be typed in **Free Text** area on the right side of the dialog.

When the text is complete, the following buttons are active: Find, Font, Copy, Save Note, Sign Note, and Close. Section 20.6.3 provides information about the buttons on the dialog.

Section 20.6.2 shows an example of what happens after clicking the **Save Note** button.

20.6.2 Note with Template

After populating the **Document Title and Subject** field, select the **“Show Template?” check box**. This action shows the available templates that are available. (The Shared Templates option must be expanded.) After finding the desired template, double-click its **name**. The application will display the chosen template. A sample template is displayed in Figure 20-20-18.

Figure 20-20-18: Sample Template for **Adding Notes**

The template can be completed by using the buttons and check boxes on the template. What is used on the template determines the text of the **TIU note**.

Use the **Preview button** (on the **Template** window) to “preview” the note, in its current state. (Figure 20-20-19)

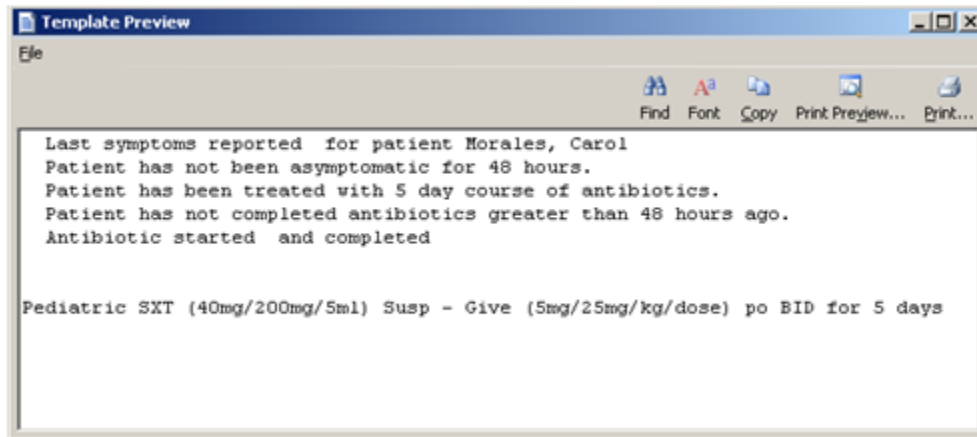


Figure 20-20-19: Sample Preview of the **TIU note**

What appears on the **Template Preview** pop-up determines what will be in the text of the **TIU note**. Section 20.7 for more information about using the controls on the pop-up. After closing the (**File | Close**) pop-up, the system returns to the **Template** window.

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

20.6.3 Buttons on Add TIU Note Dialog

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

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

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

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

Sign Note: use this button to electronically sign the selected unsigned **TIU note**. After clicking the **Sign Note button**, or selecting **File | Sign Note**, the application displays the **Enter Electronic Signature** dialog. (Figure 20-20-20)



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

Here the user enters **his/her electronic signature** in the **Free Text** field and then clicks **OK** (otherwise, click **Cancel**). After using **OK**, the user is returned to the **Add TIU Note** dialog. The text of the note shows that the note has been electronically. (Figure 20-20-21.)

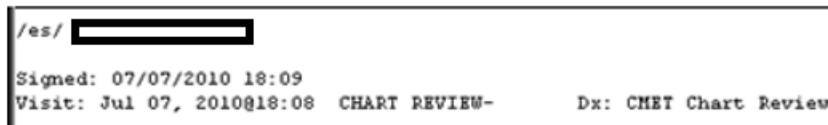


Figure 20-20-21: Sample electronic signature noted on text of TIU note

Edit Note: use this function to edit/view the note. Click the **Edit Note button**, or select **File | Edit Note**, to display the text of the note. (Figure 20-20-22)



Figure 20-20-22: Example of text of the note

After editing the text of the note, the **Save Note** button can be used again.

If the **TIU note** has already been signed, the text cannot be changed, only viewed.

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

Return to the **Add a Note** dialog (Figure 20-20-22,) with the **Preview** button next to the **Add Note** field.

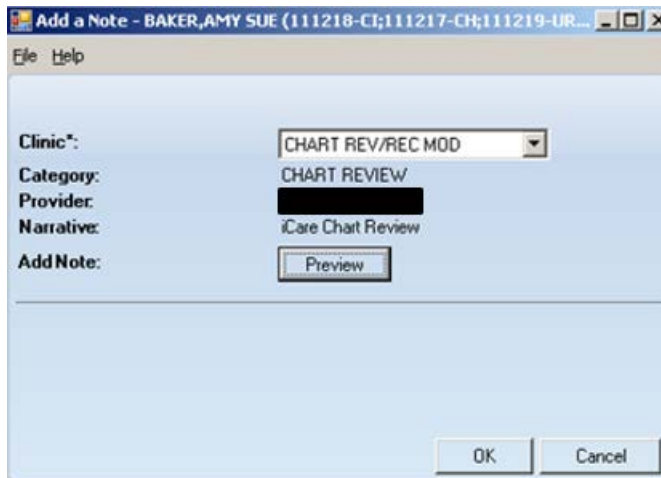


Figure 20-20-23: Sample **Add a Note** dialog with Preview button

Click the **Preview** button to display the text of the note. (Figure 20-20-24)

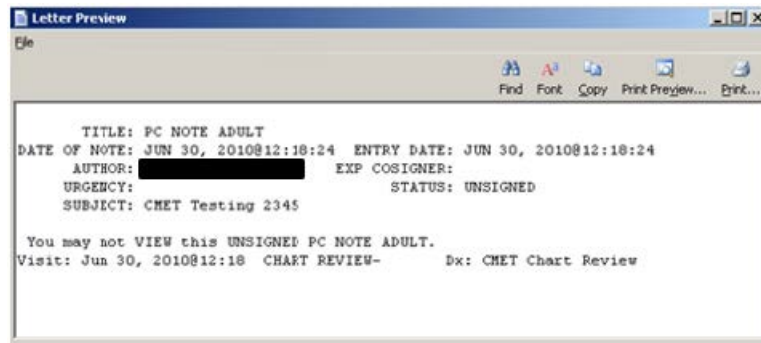


Figure 20-20-24: Sample **Letter Preview** pop-up

Section 20.7 provides information about using the controls on the pop-up.

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

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

After clicking **OK**, the application displays the **Enter Electronic Signature** dialog. (Figure 20-20-25)



Figure 20-20-25: **Enter Electronic Signature** dialog

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

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

Printing the TIU Note

When using **OK** (on the **Enter Electronic Signature** dialog), the application displays the **Print TIU Notes** information message. (Figure 20-20-26)

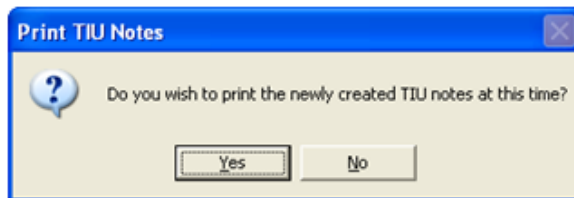


Figure 20-20-26: **Print TIU Notes** information message

Click **Yes** to print the **TUI note**. The application displays the **Print Preview** dialog. The **TIU note** from this dialog can be printed. Section 20.13 provides information about the **Print Preview** dialog.

Click **No** not to print the **TUI note**. The application displays the **Print TIU Notes** information message (Figure 20-20-27.) This provides a second chance to print the TUI note.

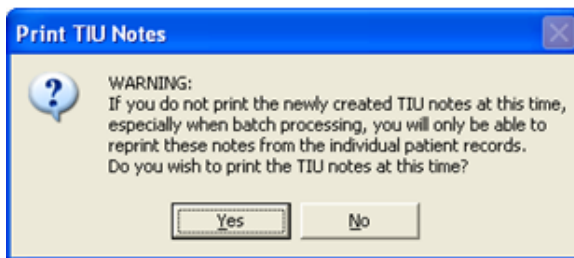


Figure 20-20-27: Print TIU Notes information message

Click **Yes** to print the TIU note now when batch processing. Otherwise, the note can only be reprinted from the individual patient record.

If using **Yes**, the application displays the **Print Preview** dialog. The TIU can be printed from this dialog. Section 20.13 provides information about the **Print Preview**.

20.7 Pop-up Functionality

Several places in iCare cause a pop-up to appear. For example, if double-clicking on **any row in the Recent Visits group box** on the **Cover Sheet** of the **Patient Record** window, a pop-up will display. (Figure 20-20-28)

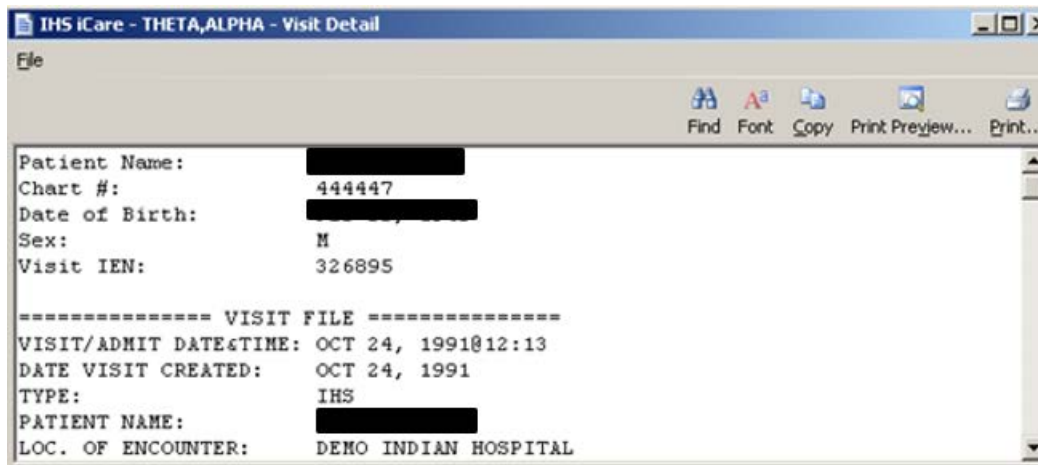




Figure 20-20-28: Sample **Visit Detail** pop-up

The following actions can be taken on this pop-up:

- Navigate through the information by using the **scroll bar**.
- Click the **Find button** (,) or select **File | Find**, to access a search tool to find data in the current window. This button works like the Search button.
- Click the **Font button** (,) or select **File | Font** to display the **Font** dialog. (Figure 20-20-29)

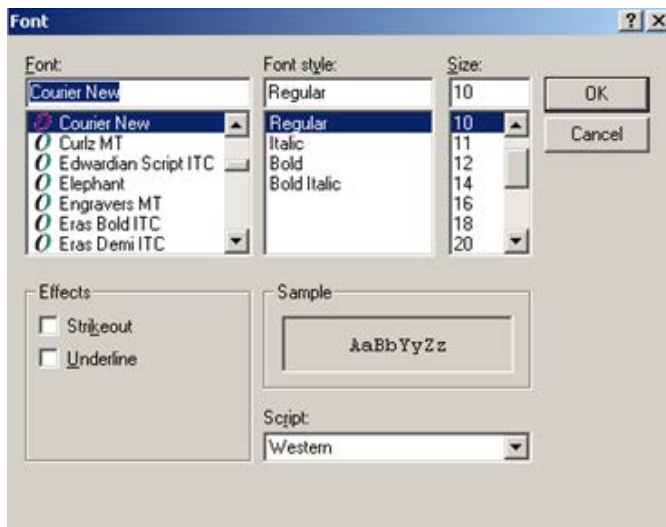





Figure 20-20-29: **Font** dialog

Here the Font name, style, and size of the text in the pop-up can be changed (applies to all the text). In addition, effects like “Strikeout” and “Underline” can be added. These perform like those effects indicated in MS Word.

Change the **Script option** to see the text displayed in another language. In addition, that language pack must be installed on the machine being used. If the language pack is not installed on the machine, the display does not change by selecting another script.

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

- Click the **Copy button** () or select **Copy option** on the context menu, or the **File** menu) to copy the selected text to the Windows clipboard.
- Click the **Print Preview button** () to view the **Print Preview** dialog. The contents of the pop-up from this dialog can be printed. Section 20.13 provides information about the **Print Preview** dialog.
- Click the **Print button** () to display a print dialog where specifying the printer to output the contents of the pop-up, the page range, and number of copies.

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

20.8 Edit Providers

When editing the list of specialty providers for the patient, the application displays the **Edit Providers** dialog (for the current patient). (Figure 20-20-30)

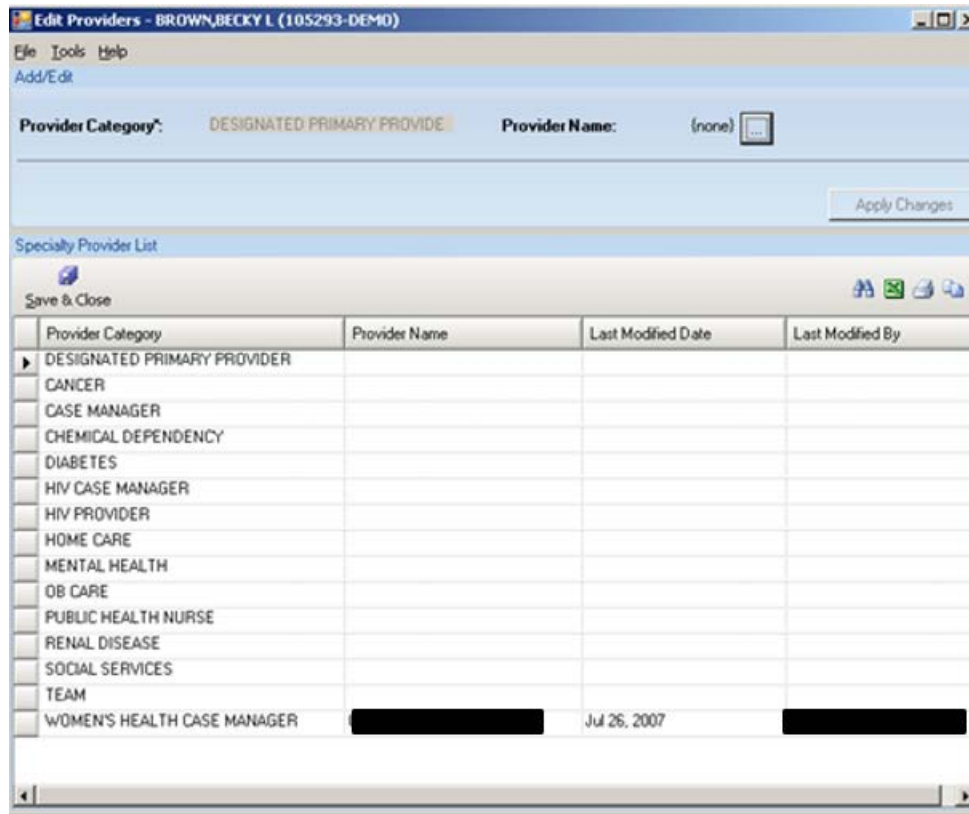


Figure 20-20-30: Sample **Edit Providers** dialog

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

1. **Add/Edit** area that has fields to add/edit a provider record
2. Specialty Provider List area that lists the providers for the patient.

Section 20.3 provides information about the buttons on the right side of the Specialty Provider List area.

20.8.1 Add/Edit New Provider

Move the cursor to the **row of the Provider Category** (in the **Specialty Provider List** grid) where the provider should be added or edited.

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

The provider for the category can be added by clicking the **ellipsis button** to search for the provider name (or initial) on the **Table Lookup** window.

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

20.8.2 Remove Provider Name

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

If **Apply Changes** is not clicked and the user attempts to go to another provider category, the application displays the “Commit changes?” information message that states: You have started to enter data in the data fields. Do you want to commit these changes now?

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

20.8.3 Save & Close Button

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

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

20.8.4 File Menu on Edit Providers

The options on the File menu are:

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

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

20.8.5 Tools Menu on Edit Providers

The options on the **Tools** menu are: Search, Excel to Export, Print, and Copy Rows to Clipboard. These options perform like the button on the right side of the window. Section 20.3 provides information about these buttons.

20.8.6 Help Menu on Edit Providers

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

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

About iCare: use this option view the version of the **iCare** GUI.

20.9 iCare Taxonomy Editor Function

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

The **iCare Taxonomy View/Edit** dialog (Figure 20-20-31) is accessed by either selecting **Tools | Taxonomy Maintenance | View/Edit Taxonomy** Entries (on the **main iCare Tools** menu) or by double-clicking the **Factor** cell in the **Active Diagnostic Tags** group box on the **Snapshot** tab of the patient record window.

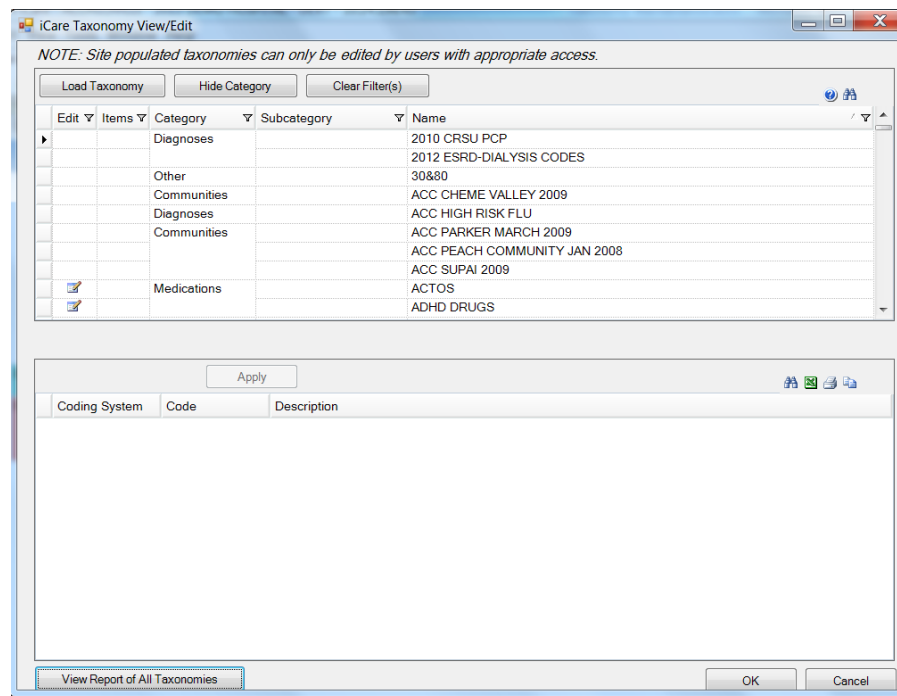


Figure 20-20-31: Sample **iCare Taxonomy View/Edit** dialog

Note: For the user who does not hold that security key, the information can only be viewed on the dialog. The following information displays: You do not currently have access rights to edit taxonomies. To edit taxonomy entries, you will need to have the iCare Taxonomy Editor security key (BQIZTXED) added to your RPMS user account.

When first accessing this view/edit dialog, all parts of the tree structure will be collapsed. One of the tree parts must be expanded to find the taxonomy to edit.

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

Please note that not all taxonomies will be editable. iCare will display a message on the view/edit dialog when this condition exists. Site populated taxonomies can only be edited by users with appropriate access.

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

20.9.1 Add Taxonomy Values

Click the **Add** button to create values for a selected item in the left group box. The application displays the **Select Taxonomy Item** dialog (Figure 20-20-32.)

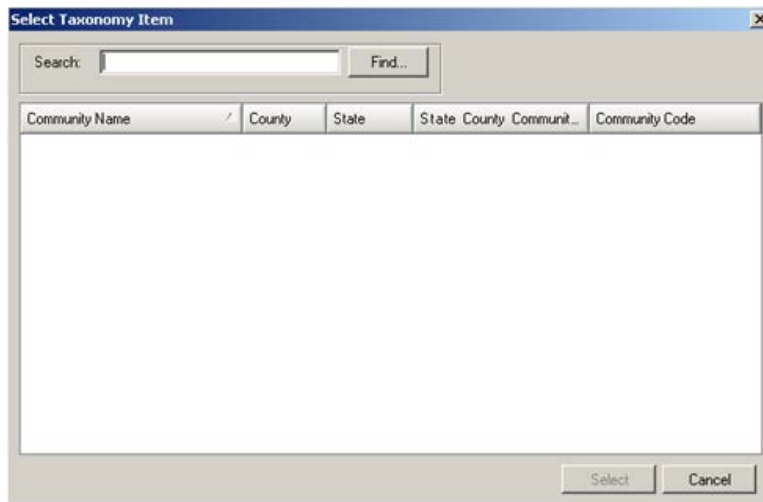


Figure 20-20-32: **Select Taxonomy Item** dialog

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

- If it already exists, a warning message about that appears (click **OK** to dismiss the message); after clicking **OK**, the system returns to the **iCare Taxonomy View/Edit** dialog.
- If it does not exist, it appends the selected item to the bottom of the list.

After adding all taxonomy values, click **Apply** to “save” your changes. If the **Apply** button is not clicked, and the user tries to move to another taxonomy or another part of the iCare application, the “Save Taxonomy changes?” information message displays, asking if you want to apply the changes now. In this case, click **Yes** to apply the changes (otherwise, click **No**).

This process can be repeated to add items to various taxonomies. When finished using the **iCare Taxonomy View/Edit dialog**, click **OK** to save (otherwise, click **Cancel**).

20.9.2 Remove Taxonomy Values

To remove one or more items from the list, highlight them and click **Remove**. The “Confirm taxonomy item remove” message displays. Click **Yes** to remove the items (otherwise, click **No**). The **iCare Taxonomy View/Edit** dialog stays open.

20.9.3 View Report of All Taxonomies Button

Click the **View Report of All Taxonomies** button to display the **Taxonomy Report** pop-up. (Figure 20-20-32)

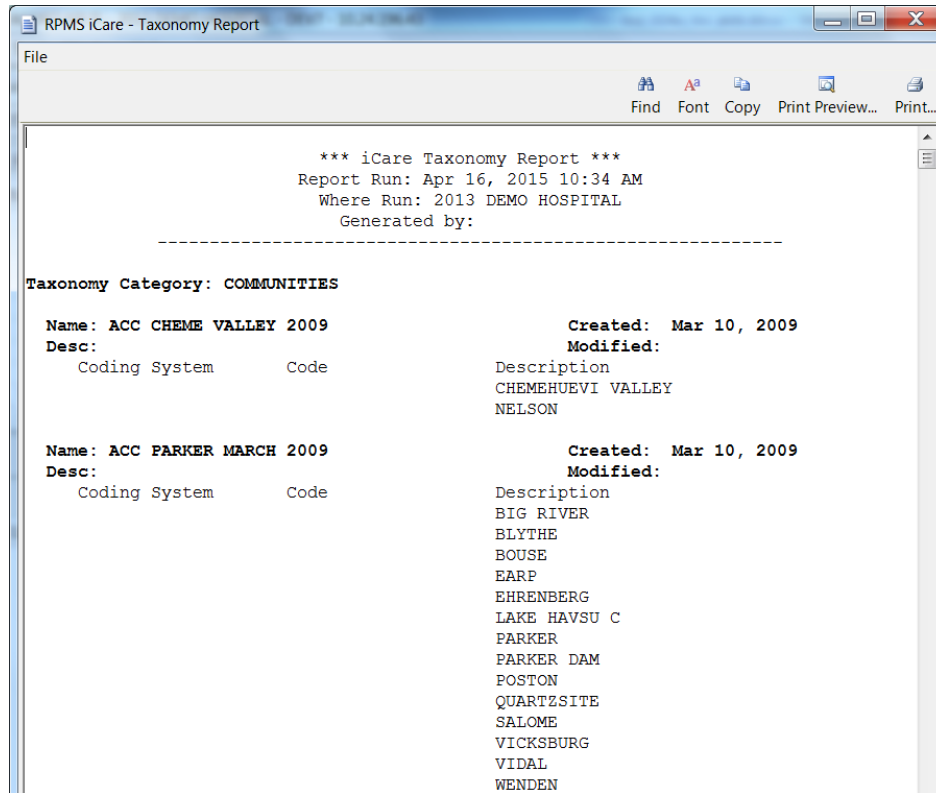


Figure 20-20-33: **Taxonomy** Report

This pop-up provides information about various **Taxonomy Categories** (listed in alphabetical order).

See Section 20.7 for more information about using the controls on the pop-up.

20.10 Edit Reproductive Factors

Figure 20-20-34: **Edit Reproductive Factors** dialog

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

Otherwise, click **Cancel**. The application displays the “Save to RPMS?” dialog asking: Do you want to save to RPMS now? Click **Yes** to save any data to RPMS. Click **No** to not save any data to RPMS. Click **Cancel** to return to the **Edit Reproductive Factors** dialog. (Figure 20-20-34)

20.10.1 Top Panel

The screenshot shows the top panel of the 'Edit Reproductive Factors' dialog. It has a light blue header with the text 'Add/Edit'. Below the header are three dropdown menus: 'Last Menstrual Period' (with a date format ' / /'), 'Lactation Status', and 'Current Pregnancy Status'.

Figure 20-20-35: Top panel of **Edit Reproductive Factors** dialog

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

Lactation Status: select **an option** from the list that specifies the lactation status of the patient.

Current Pregnancy Status: select **an option** from the list that specifies the current pregnancy status of the patient.

20.10.2 Second Panel

The screenshot shows the second panel of the 'Edit Reproductive Factors' dialog, titled 'Contraceptive Methods'. It has a light blue header with the text 'Contraceptive Methods:'. Below the header are two buttons: 'Add (F2)' and 'Delete (Del)'. Below the buttons is a table with the following columns: 'Contraception Method', 'Date Contraception Method', 'Reason Discontinued', and 'Comment'. The table is currently empty.

Figure 20-20-36: Second panel of **Edit Reproductive Factors** dialog

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

Click **Add** to add additional information about the contraceptive methods for the patient.

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

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

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

20.10.3 Third Panel

Definitive EDD:	(none) ▾	Documenting Provider:	(none) ...
EDD (LMP):	(none) ▾	Documenting Provider:	(none) ...
EDD (Ultrasound):	(none) ▾	Documenting Provider:	(none) ...
EDD (Clinical Parameters):	(none) ▾	Documenting Provider:	(none) ...
EDD (Method Unknown):	(none) ▾	Documenting Provider:	(none) ...

Figure 20-20-37: Third panel of **Edit Reproductive Factors** dialog

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

Populate **any of the EDD fields** and this action activates the **Documenting Provider** area. To populate the **Documenting Provider**, click the **ellipsis button** to access the **Table Lookup** dialog where a provider’s name can be searched. Highlight the **name to use** and then click **Select**. The selected provider name will replace the {none} text next to the ellipsis button.

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

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

20.10.4 Bottom Panel

Total Number of Pregnancies:	<input type="text"/>	Full Term Births:	<input type="text"/>
Premature Births:	<input type="text"/>	Abortions, Spontaneous:	<input type="text"/>
Abortions, Induced:	<input type="text"/>	Ectopic Pregnancies:	<input type="text"/>
Living Children:	<input type="text"/>	Multiple Births:	<input type="text"/>
Age at First Menses:	<input type="text"/>	Age at First Intercourse:	<input type="text"/>
Age at Menopause:	<input type="text"/>	DES Daughter Status:	<input type="text"/>

Figure 20-20-38: Bottom panel of **Edit Reproductive Factors** dialog

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

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

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

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

Abortions, Induced: populate with **the value** that shows the number of induced abortions for the patient.

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

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

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

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

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

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

20.10.4.1 Menus on Dialog

The **File** menu contains the **Close** option. This automatically closes the dialog.

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

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

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

20.11 CMET Worksheet

Use the **Open CMET Worksheet button** to access the **CMET Worksheet** (Figure 20-39) for a selected event on the sub-tab of the CMET window.

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

Figure 20-39: Sample **CMET Worksheet**

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

- There are two cases to use **OK**.

Case 1: if all the steps are not complete, the application updates the data on the **Tracked Events** sub-tab.

Cases 2: if all the steps are complete, the application will display the **Close Event** information message that states: The event is eligible for closing as all four steps are completed. Do you want to close the event now? Use **Yes** to close the event. Use **No** to keep the event open.

Choosing to close the event (by selecting **Yes** on the **Close Event** message), the application displays the **RPMS iCare Reason for Closing** dialog. Here, the reason for closing the event and providing a comment (required) about the closing is added. Click **OK** to save the reason for closing (otherwise, click **Cancel**).

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

- There are two cases to use **Cancel**:

Case 1: if no changes were made on the worksheet, the application closes it.

Case 2: if no changes were made on the worksheet, the application displays the “Save to RPMS?” dialog that states: You have data changes pending. Do you want to save to RPMS now? Click **Yes** to save the changes to RPMS. Click **No** not to save the changes. Click **Cancel** to return to the **CMET Worksheet**.

20.11.1 Patient Demographics Group Box

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

20.11.2 1 - Event Group Box

The data in the **1 – Event** group box (Figure 20-20-40) provides information about the event and allows changes to the State of the event. It also provides a field to enter comments about the Event and/or State. In addition, the audit history of the event can be viewed here.

1 - Event			
Event:	MASTECTOMY,BILATERAL (w/BI MOD .50)		Event Comment:
Event Date:	MAR 19, 2014	Tracked By:	[REDACTED]
Category:	BREAST	Tracked Date:	JUN 10, 2014 20:16:08
Preceding Event:	NONE	State:	CLOSED
CMET Audit History:	View	Close Reason:	Event Complete
			State Comment:

Figure 20-20-40: Sample **Event** group box

State: This field defines the State of the event.

If the **State** field is populated with **Closed**, then the **Close Reason** field becomes active and options from the list are available to describe why the event is being closed.

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

Event Comment: Use this free text field to add comments about the Event.

State Comment: Use this free text field to add comments about the State.

CMET Audit History: If the **View** label is clicked, the application will display the **CMET Audit History** pop-up. (Figure 20-20-41)

Date/Time Modified	Modified By	Field	Entry	New Value
Jun 10, 2014 08:19 PM	[REDACTED]	Notifications - Entered By	1	[REDACTED]
Jun 10, 2014 08:19 PM	[REDACTED]	Notifications - Entry Date	1	JUN 10, 2014 20:19:14
Jun 10, 2014 08:19 PM	[REDACTED]	Notifications - Method	1	IN PERSON
Jun 10, 2014 08:19 PM	[REDACTED]	Last Modified Date/Time		JUN 10, 2014 20:19:14
Jun 10, 2014 08:19 PM	[REDACTED]	Follow-ups - Date Due	1	JUL 10, 2014 00:00
Jun 10, 2014 08:19 PM	[REDACTED]	Follow-ups - Entered By	1	[REDACTED]
Jun 10, 2014 08:19 PM	[REDACTED]	Follow-ups - Date Entered	1	JUN 10, 2014 20:19:13
Jun 10, 2014 08:19 PM	[REDACTED]	Follow-ups - Event	1	BREAST RECONSTRUCTION W/IMPLANTS
Jun 10, 2014 08:19 PM	[REDACTED]	Findings - Follow-Up Needed?	1	Yes

Figure 20-20-41: Sample **CMET Audit History** pop-up

Because multiple users work on the event, the audit history provides of a history of those activities.

Section 20.12 provides information about using the controls and menus on this pop-up.

State: This determines the state of the event, either Open or Closed. If “Closed” is used, then the Close Reason field becomes active.

If “Closed” is used, this causes all the other group boxes (2 - Findings, 3 - Follow-ups, 4 - Patient Notifications) to become inactive.

Close Reason: This field is active when State = Closed. Select **an option** on the list that indicates the reason for closing the event.

20.11.3 2 - Findings Group Box

Use the **2 – Findings** group box to enter Findings data about the event.

Date	Finding	Interpretation	Comment	Follow-Up Needed?	Last Edited	Last

Figure 20-20-42: Sample **Findings** group box

This group box (Figure 20-20-42) can be minimized by clicking the **collapse button** in the upper left corner. This allows more room for viewing the other group boxes (**Follow-ups** and **Patient Notifications**).

The **Findings Due By**, **Result**, and **Follow-up Recommended?** fields become populated when using the **Add** button on the grid and saving the record.

Findings Due By: This field displays the date the findings of this event were entered into CMET. If this date passes without an entry, a “tickler” (Feather icon) is generated.

Result: This field displays the date of the result. If this field contains an underlined date, click on the **date** to display the detail of the result. For example, below is the **Radiology Case Number Detail** pop-up. (Figure 20-20-43)

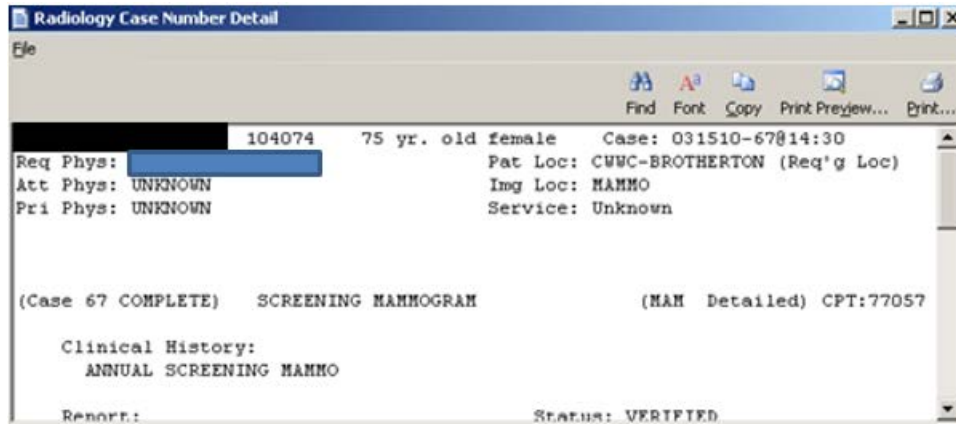


Figure 20-20-43: **Radiology Case Number Detail**

Follow-up Recommended: This field indicates if follow-up is recommended (yes or no).

20.11.3.1 Add Button

Use the **Add** function to create a new Findings record. Click the **Add** button (or press the **F2** button on the keyboard) to access the **Findings** dialog. (Figure 20-20-44)

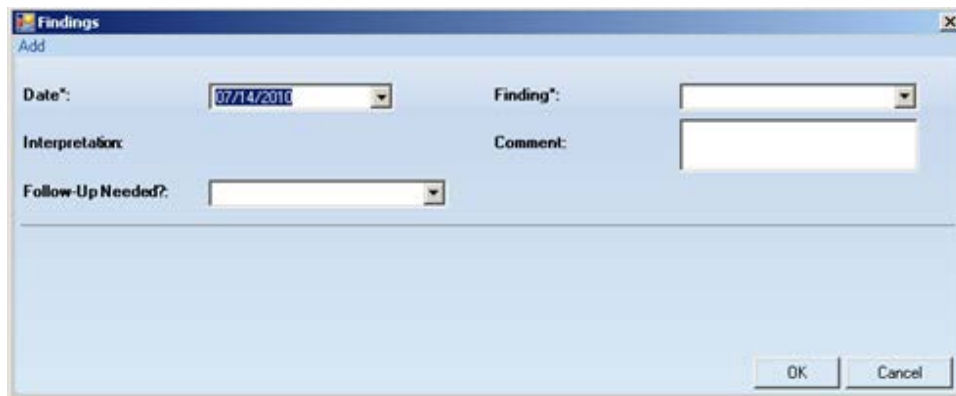


Figure 20-20-44: **Findings** dialog

The field names followed by an asterisk (*) are required.

Date: Click the **list** and select a **date** for the findings.

Finding: This is the finding associated with the event. Use **an option** from the list to populate this field.

Interpretation: The application populates this field, based on the selection in the Finding field.

Comment: Type the **text of the comments** about the Finding, if appropriate, in this Free Text field.

Follow-up Needed: Use an option from the list: **Yes** or **No**.

Click **OK** to save the data on the **Findings** dialog (otherwise, click **Cancel** to not save).

After saving the data, the application populates the grid with the record and populates the **Last Edited** (current logon user) and **Last Edited By** (current date) columns.

If saved and Yes had been chosen for “Follow-up Needed” field (on the **Findings** dialog), this will cause the **Follow-up Recommended?** field on the grid to be populated with Yes. The application will automatically display the **Follow-Ups** dialog (where any follow-up data can be entered).

20.11.3.2 Delete Button

The **Delete** function applies to events that had Findings entered but NOT saved.

If an event that is not eligible for the **Delete** function has been saved, the application displays the message: Unable to delete a previously saved entry. Please mark as ‘Entered in Error’ instead. Click **OK** to dismiss the message.

Select one or more eligible **Findings** records to delete and click the **Delete** button (or press the **Delete button** on the keyboard). The application displays the **Delete Row information** message, confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

20.11.3.3 Error Button

Use the **Error** function when **Findings** records have been saved and cannot be deleted, they should then be marked as Entered in Error. (Figure 20-20-45)

If a record has been selected that is not eligible for the **Error** function, the application displays the message: Unable to mark as ‘Entered in Error’ because the entry has not been saved in RPMS. Please delete the entry instead. Click **OK** to dismiss the message.

Select one or more eligible Findings records and click **Error**. After using this function, the application places a strikethrough mark on the text of the record.

Date	Finding	Interpretation	Comment	Follow-Up Needed?	Last Edited	La
May 05, 2010	BLAD-CATEGORY-3-P...	Abnormal				

Figure 20-20-45: Sample **Entered in Error** marking

After saving and returning to the **Tracked Events** tab, the **Result** column for the event will be blank for the event.

20.11.4 3 - Follow-ups Group Box

Use the **3 – Follow-ups** group box to add follow-up data about the event. (Figure 20-20-46)

Figure 20-20-46: **Follow-ups** group box

The **Follow-ups** group box becomes active when the **Follow-up Recommended** field (in the **Findings** group box) is set to Yes.

This group box can be minimized by clicking the **collapse button** in the upper left corner. This allows more room for viewing the other group box (**Patient Notifications**).

Follow-up Decision Due By: select a **date** from the list that indicates when the follow-up decision should be made. Populating the field creates a tickler (feather icon) for the event. In certain cases, this date is populated by the Tickler Timeframe set in the site parameters. This field can be populated with the date on which to act on the event.

20.11.4.1 Add Button

Use the **Add** button to create a new Follow-up record. Click the **Add** button (or press the **F2** button on the keyboard) to access the **Follow-Ups** dialog. (Figure 20-20-47)

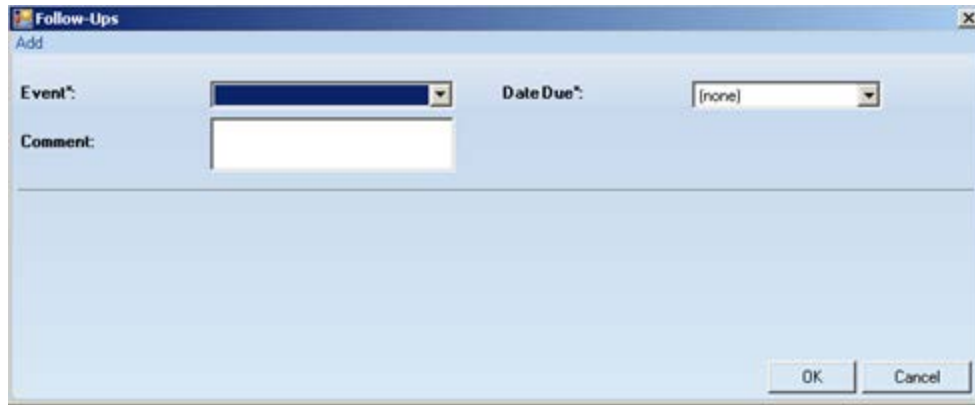


Figure 20-20-47: Sample **Follow-Ups** dialog

The required fields are those with the asterisk (*) after the name.

Event: select **an option** from the list that describes the Event for the follow-up.

Date Due: use the list to display a calendar from which to select the **due date** for the follow-up event.

Comment: use this **Free Text** field to **add comments** about the follow-up.

Click **OK** to save the data on the dialog and the follow-up record will display in the **3 - Follow-ups** group box on the **CMET Worksheet**. (Otherwise, click **Cancel**.)

20.11.4.2 Delete Button

The **Delete** function applies to events that had **Follow-ups entered** but NOT saved.

Select one or more eligible **Follow-up** records to delete and then click the **Delete button** (or press the **Delete button** on the keyboard). The application displays the **Delete Row information** message, confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

20.11.4.3 Error Button

Use the **Error** function when **Follow-up** records have been saved and cannot be deleted, and they should be marked as Entered in Error. (Figure 20-20-48)

If a record has been chosen that is not eligible for the Error button, the application displays the message: Unable to mark as 'Entered in Error' because the entry has not been saved in RPMS. Please delete the entry instead. Click **OK** to dismiss the message.

Select one or more **eligible Follow-up records** and click the **Error** button. After using this function, the application places a strikethrough mark on the text of the record.



Figure 20-20-48: Sample of **Follow-up** record marked as entered in error

20.11.5 4 - Patient Notifications Group Box

Use the **4 – Patient Notifications** group box (Figure 20-20-49) to add patient notification data about the event.

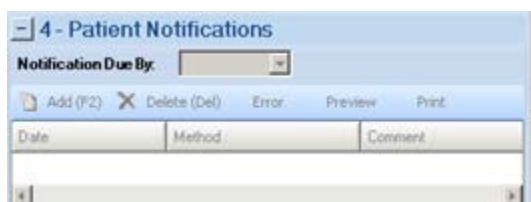


Figure 20-20-49: **Patient Notifications** group box

The **Patient Notification**, the final step, makes the patient aware of both the results and the recommendations for follow-up. Multiple types of Patient Notifications can be entered for each Event.

The **Patient Notifications** group box becomes active when the “Follow-up Recommended?” field (in the Findings group box) is set to Yes.

This group box can be minimized by clicking the **collapse button** in the upper left corner. This allows more room for viewing the Follow-ups group box.

Notification Due By: enter **the date** to have the patient notified about the results and **recommendations** of the follow-up related to this event. If this date passes without an entry, a tickler (feather) icon will be generated. In certain cases, this date is populated by the Tickler Timeframe set in the site parameters.

20.11.5.1 Add Button

If the default clinics are not defined in user preferences, the application displays the following message: Select default clinics in user preferences, which must be performed before being able to enter notes. Click **OK** to dismiss the message. Select **Tools | User Preferences** to access the **RPMS iCare – User Preferences** dialog. Go to the **Patient View** tab to enter the clinic codes.

Use the **Add** button to create a new **Patient Notification** record. Click the **Add** button (or press the **F2** button on the keyboard) to access the **Notifications** dialog. (Figure 20-20-50)



Figure 20-20-50: Sample initial **Notifications** dialog

The required fields are those with an asterisk (*) after the name.

Date: the default date is today's date. It can be changed by clicking the **list** to access a calendar from which to select another date.

Method: select an **option** from the list that identifies the type of notification.

Create: this button becomes active if selecting "Certified Letter" or "Letter" in the Method field. There must be an electronic signature on file before this function is enabled.

If an electronic signature is on file, click the **Create** button to access the **Add TIU Note** dialog. Section 20.6 provides information about this dialog.

Comment: use this **Free Text** field to add any comments about the notification.

After completing this dialog, click **OK** to save the data (otherwise, click **Cancel**). After saving, the notification record will display in the **4 - Patient Notifications** group box on the **CMET Worksheet**.

20.11.5.2 Delete Button

The **Delete** function applies to events that had Patient Notifications entered but NOT saved.

Select one or more **eligible Patient Notification records** to delete and click the **Delete** button (or press the **Delete** button on keyboard). The application displays the **Delete Row information** message, confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

20.11.5.3 Error Button

Use the **Error** function when **Patient Notification** records have been saved and they cannot be deleted, yet they should be marked Entered in Error. (Figure 20-20-51)

If a record that is not eligible for the Error function is selected, the application displays the message: Unable to mark as 'Entered in Error' because the entry has not been saved in RPMS. Please delete the entry instead. Click **OK** to dismiss the message.

Select one or more **eligible Patient Notification records** and then click the **Error** button. After using this function, the application places a strikethrough mark on the text of the record.



Figure 20-20-51: Sample **Patient Notification** record marked as entered in error

20.11.5.4 Preview

Use the Preview function to preview the letter associated with the selected Patient Notification record. This function only applies to records that are Letters or Certified Letters.

Select the record to preview and then click the **Preview** button. The application displays the **Letter Preview** pop-up. (Figure 20-20-52)

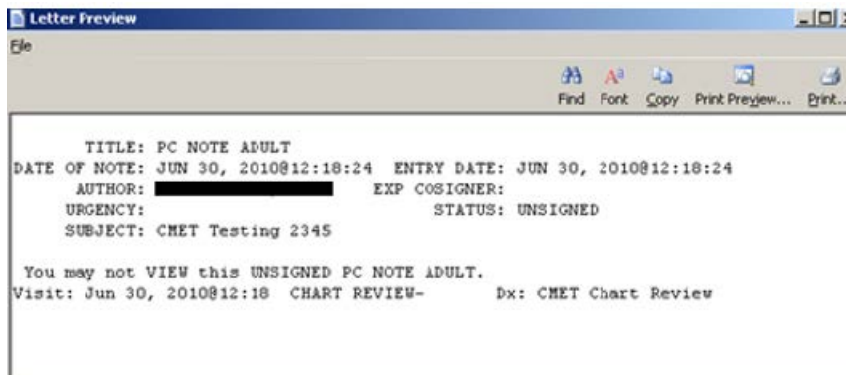



Figure 20-20-52: Sample **Letter Preview** pop-up

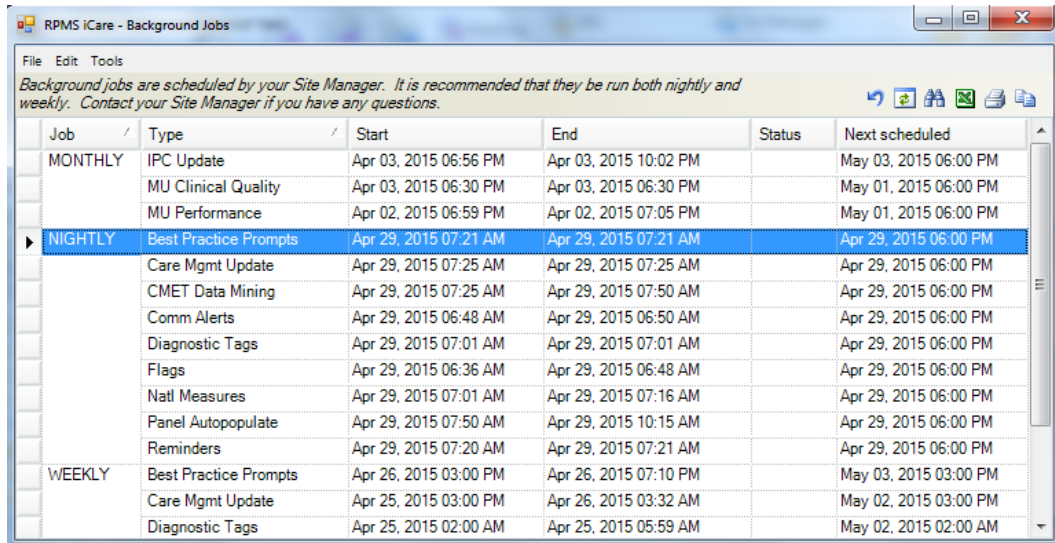
Section 20.7 provides information about using the controls on the pop-up,

20.11.5.5 Print Button

Use the **Print** button to output a letter in a selected record. After clicking **Print**, the application displays the Print dialog where the printer, page range, number of copies, etc. is specified; this dialog works like the one in MS Office.

20.12 Background Jobs Pop-up

Click the **Background Jobs** button (,) or select **File | Background Jobs**, to display the **Background Jobs** pop-up. (Figure 20-20-53)



The screenshot shows a window titled "RPMS iCare - Background Jobs". At the top, there is a menu bar with "File", "Edit", and "Tools". Below the menu bar is a message: "Background jobs are scheduled by your Site Manager. It is recommended that they be run both nightly and weekly. Contact your Site Manager if you have any questions." To the right of the message is a toolbar with several icons. The main area of the window is a table with the following columns: Job, Type, Start, End, Status, and Next scheduled. The table is organized into three sections: MONTHLY, NIGHTLY, and WEEKLY. The NIGHTLY section is currently expanded and highlighted in blue.

Job	Type	Start	End	Status	Next scheduled
MONTHLY	IPC Update	Apr 03, 2015 06:56 PM	Apr 03, 2015 10:02 PM		May 03, 2015 06:00 PM
	MU Clinical Quality	Apr 03, 2015 06:30 PM	Apr 03, 2015 06:30 PM		May 01, 2015 06:00 PM
	MU Performance	Apr 02, 2015 06:59 PM	Apr 02, 2015 07:05 PM		May 01, 2015 06:00 PM
NIGHTLY	Best Practice Prompts	Apr 29, 2015 07:21 AM	Apr 29, 2015 07:21 AM		Apr 29, 2015 06:00 PM
	Care Mgmt Update	Apr 29, 2015 07:25 AM	Apr 29, 2015 07:25 AM		Apr 29, 2015 06:00 PM
	CMET Data Mining	Apr 29, 2015 07:25 AM	Apr 29, 2015 07:50 AM		Apr 29, 2015 06:00 PM
	Comm Alerts	Apr 29, 2015 06:48 AM	Apr 29, 2015 06:50 AM		Apr 29, 2015 06:00 PM
	Diagnostic Tags	Apr 29, 2015 07:01 AM	Apr 29, 2015 07:01 AM		Apr 29, 2015 06:00 PM
	Flags	Apr 29, 2015 06:36 AM	Apr 29, 2015 06:48 AM		Apr 29, 2015 06:00 PM
	Natl Measures	Apr 29, 2015 07:01 AM	Apr 29, 2015 07:16 AM		Apr 29, 2015 06:00 PM
	Panel Autopopulate	Apr 29, 2015 07:50 AM	Apr 29, 2015 10:15 AM		Apr 29, 2015 06:00 PM
	Reminders	Apr 29, 2015 07:20 AM	Apr 29, 2015 07:21 AM		Apr 29, 2015 06:00 PM
	WEEKLY	Best Practice Prompts	Apr 26, 2015 03:00 PM	Apr 26, 2015 07:10 PM	
	Care Mgmt Update	Apr 25, 2015 03:00 PM	Apr 26, 2015 03:32 AM		May 02, 2015 03:00 PM
	Diagnostic Tags	Apr 25, 2015 02:00 AM	Apr 25, 2015 05:59 AM		May 02, 2015 02:00 AM

Figure 20-20-53: Sample **Background Jobs** pop-up

Note: The pop-up must be dismissed to use other functions in iCare.

Section 20.3 provides information about the buttons on the right side of the toolbar.

The File menu has the following options:

Page Setup: This option allows setting the Margin, Paper, Layout characteristics (like landscape or portrait orientation), and the Printer to use.

Print Preview: This option displays the print preview dialog. Section 20.13 provides information about this dialog.

Print: This option outputs the selected rows in the grid. The application displays the Print Preview dialog where the output can be viewed. Select **File | Print** (on the dialog) to output the content. The application provides a header stating Confidential Patient Information for all printed panel views.

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

Close: This option closes the Background Jobs window.

The **Edit** menu has one option: **Select All** (used to select all the records).

The **Tools** menu has options that have the same functions as those of the buttons on the right side of the toolbar.

20.13 Print Preview

The **Print Preview** dialog contains several features about reviewing and printing the current document. (Figure 20-20-54)

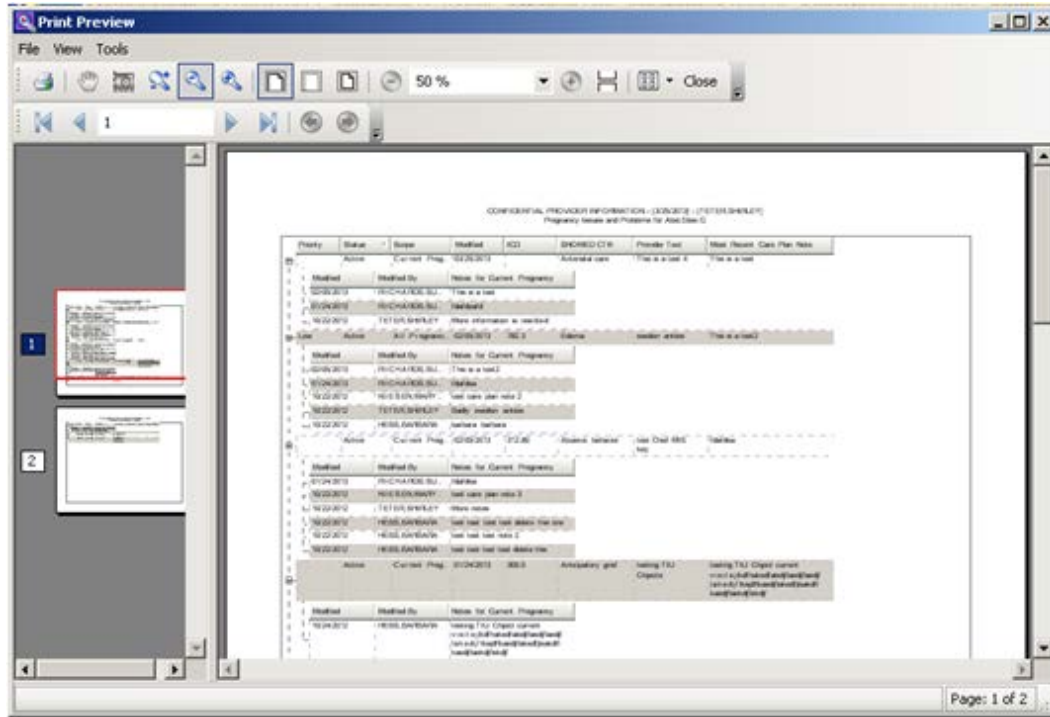















Figure 20-20-54: Sample **Print Preview** dialog

The **Print Preview** dialog contains two panels, where the left panel displays the pages in the document and the right panel displays a larger version of the page selected in the left panel.

Table 9 provides information about the various buttons on the **Print Preview** window.

Table 9 **Print Preview** Window

Button	Description
	Used to output the contents of the document. Also available by selecting Print option on the File menu.

Button	Description
	Used to move the red rectangular box on the selected page in the left panel. As the Hand Tool is moved, this changes the display in the right panel. This is used to view information in a part of a page. Also available by selecting the Hand Tool option on the Tools menu.
	Used to get a screen capture of a specified rectangular area. This screen capture copies the area to the Windows clipboard. Then a copy can be pasted in a field, for example, or another application like MS Word. Also available by selecting the Snapshot Tools option on the Tools menu.
	Used to specify the zoom magnification. Click the button and then move to the area where to apply to zoom. Right-click on the area and select the zoom magnification option from the context menu. Also available by selecting the Dynamic Zoom Tool option on the Tools menu.
	Used to zoom out by clicking the button in an area in the right panel (the image becomes smaller). Also available by selecting the Zoom Out option on the View menu.
	Used to zoom in by clicking the button in an area in the right panel (the image becomes larger). Also available by selecting the Zoom In option on the View menu.
	Used to cause the image in the right panel to display to its maximum page width (usually enlarges the image). Also available by selecting the Page Width option on the View menu.
	Used to cause the image in the right panel to display the image with no page margins showing. Also available by selecting the Margin Width option on the View menu.
	Used to display the image and its page margins in the right panel. Also available by selecting the Whole Page option on the View menu.
	Used to automatically cause the image in the right panel to zoom out (do not click in the panel). Also available by selecting the Zoom Out on the View menu.
	Used to automatically cause the image in the right panel to zoom in (do not click in the panel). Also available by selecting the Zoom In on the View menu.
	Used to cause all the pages to display in the right panel. Also available by selecting the Continuous option on the View menu.
	Used to specify the page layout. Also available by selecting the Page Setup option on the File menu.

Move through the pages in the document by using the arrow buttons on the second line in the toolbar.



Figure 20-20-55: Buttons used to move through the pages of the document

The same options are available by selecting **View | Go To** (and on the context menu for the right panel).

Use the **Zoom field** (), or select **View | Zoom**, to specify the zoom magnification for the right panel by selecting from the list.

Use the **Close** button (or select **File | Exit**) to close the **Print Preview** dialog.

Select **File | Page Setup** to access the **Page Setup** dialog. (Figure 20-20-56)

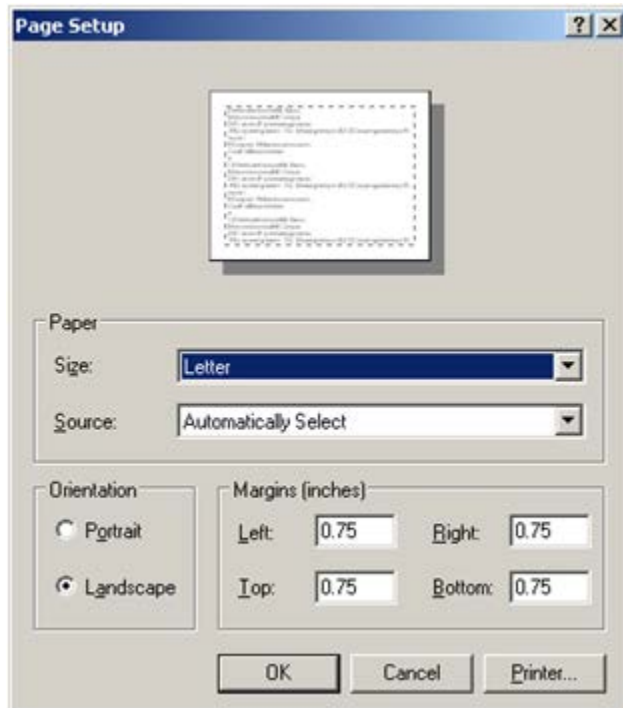


Figure 20-20-56: Sample **Page Setup** dialog

Use the **Page** group box to specify the paper size and source.

Use the **Orientation** group box to specify the orientation of the output.

Use the **Margins** group box to specify the various margins widths in inches.

Click **Printer** to access the **Printer** dialog where the output printer is chosen.

After the **Page Setup** dialog is complete, click **OK** to save the page setup options. (Otherwise, click **Cancel**.)

20.14 Graphing Measurement Data

Create a graph of selected measurement data on the patient record window by clicking the **Graph It** button (Graph It). The application displays the **Charting** window (Figure 20-20-57,) showing a graph of the measurement type. The **Graph It** button also appears on the **Nat'l Measures** view window, but those features will not be included in the following documentation.

The application creates a line chart of the data. This type of graph shows trends over time.

- The x-axis is the time axis.
- The y-axis shows the data range that includes the maximum and minimum values (this is the default setting).

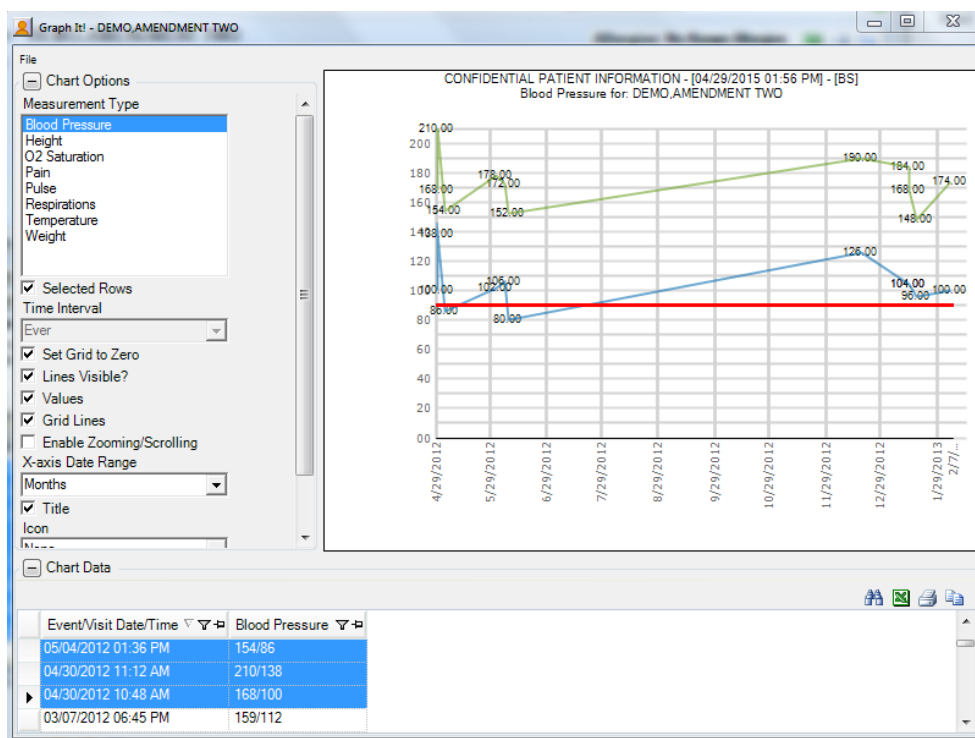


Figure 20-20-57: Sample Charting window

20.14.1 Chart Data Group Box

The **Chart Options** group box contains the data for the graph. (Figure 20-20-58)



Event/Visit Date/Time	Blood Pressure
09/24/2008 09:40 AM	125/67
09/10/2008 12:25 PM	129/81
08/14/2008 03:05 PM	126/73
06/04/2008 10:10 AM	115/78
05/15/2008 09:04 AM	146/83
04/30/2008 09:56 AM	131/65

Figure 20-20-58: Sample **Chart Data** Group Box

The data is determined by what v select in the **Measurement Type** field.

20.14.2 Chart Options Group Box

What is selected in the Chart Options group box (Figure 20-20-59) determines what the graph looks like. For example, the scale units for the x-axis can be set in the X-axis Date Range field.

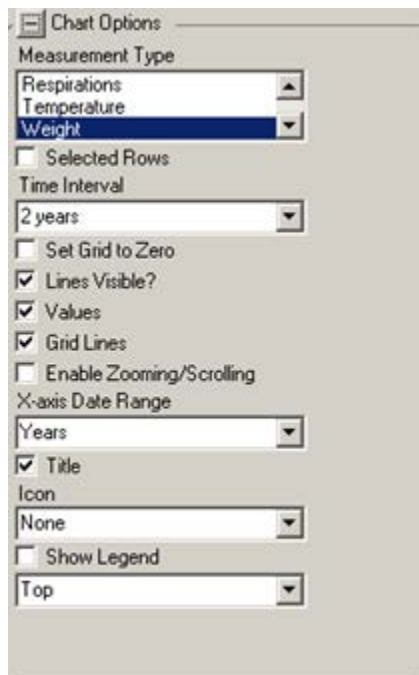


Chart Options

Measurement Type

Respirations
Temperature
Weight

Selected Rows

Time Interval

2 years

Set Grid to Zero

Lines Visible?

Values

Grid Lines

Enable Zooming/Scrolling

X-axis Date Range

Years

Title

Icon

None

Show Legend

Top

Figure 20-20-59: Sample **Chart Options** group box

Measurement Type: this shows what is being charted. This can be changed by **highlighting another measurement type**.

Chart Type: This option only displays on the National Measures Chart. This determines the type of chart (Column Chart is the default). This can be changed by selecting **an option from the list**.

Selected Rows: select this **check box** to graph the selected row(s) in the **Chart Data** grid. If this check box is not used, the application uses all the measurement values.

Time Interval: this determines the time interval for the data on the chart. The default is what is selected (in the **Last field**) on the **PCC** tab of the **patient record** window. This interval can be changed **by selecting an option from the list**.

Set Grid to Zero: select this **check box** to cause the y-axis values to start at zero and go to the maximum value of the data. When this check box is not selected, the application uses the minimum and maximum values for the y-axis.

Lines Visible?: select this **check box** to display the lines that connect the data points.

Values: select this **check box** to display the values at each data point.

Grid Lines: select this **check box** to display the grid lines on the chart.

Enable Zooming/Scrolling: select this **check box** to display zooming/scrolling of the axis lines.

X-axis Data Range: this determines the time units of measure on the x-axis of the graph. The options are: Not Set, Days, Weeks, Months, Years.

Icon: this determines the icon for each data point. The options are: circle, diamond, none, plus, square, triangle, upside down triangle, X. The default is None.

Show Legend: check this **check box** to show the legend for the graph. The field below determines the location of the legend.

20.14.3 File Menu for Charting Window

Below are the options on the **File** menu for the **Charting** window. (Figure 20-20-60)

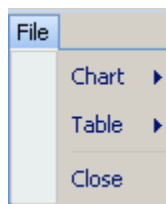


Figure 20-20-60: Options on **File** menu for the **Charting** window

Use the **Close** option to close the **charting** window.

20.14.3.1 Chart Option

The **Chart** option of the **File** menu has the following selections:

Page Setup: this selection allows a user to set Margin, Paper, and Layout characteristics (like landscape or portrait orientation) for printing. A different printer can be selected.

Print Preview: this selection displays the **Print Preview** dialog that displays how the output of the chart will look. Section 20.13 provides information about this dialog.

Print: this selection displays the **Print** dialog where the printer is selected for the chart output. This is the same as using the Ctrl+P key combination.

Save Chart for Office: this selection allows the chart to be saved in a graphics format, for example JPEG. The application displays the **Save Chart for Office** dialog. (Figure 20-20-61)

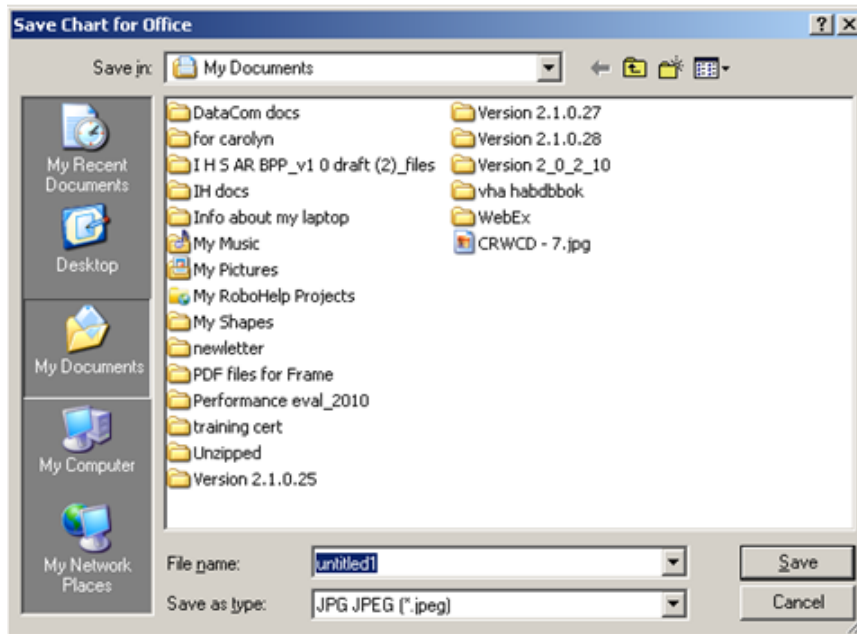


Figure 20-20-61: **Save Chart for Office** dialog for graphics format

File Name: specify the **name of the file** for the chart in graphics format.

Save as type: select the **type of graphics format** for the chart. The default is JPEG.

After completing the two fields, click **Save** to save the chart in graphics format (otherwise, click **Cancel**).

Save Chart for PDF: this selection allows the chart to be saved in PDF format. The application displays the **Save Chart for Office** dialog. (Figure 20-20-62)

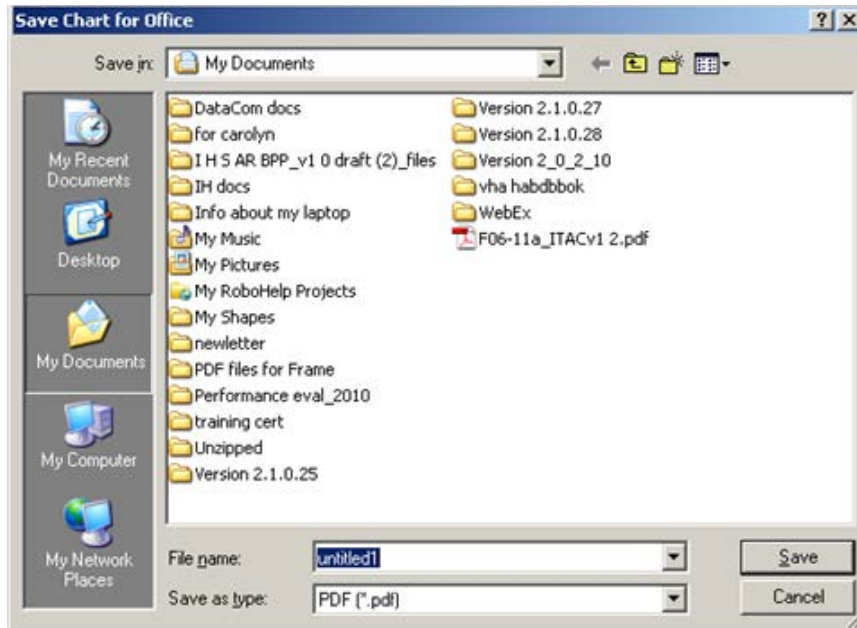


Figure 20-20-62: **Save Chart for Office** dialog for PDF format

File Name: specify the **name of the file** for the chart in graphics format.

Save as type: save as the default setting; **PDF**.

After completing the two fields, click **Save** to save the chart in PDF format (otherwise, click **Cancel**).

20.14.3.2 Table Option

The **Table** option of the **File** menu has the following selections:

1. **Search:** this selection searches for data in the Chart Data group box.
2. **Excel Export:** this selection to export the selected rows in the **Chart data** group box to Excel.
3. **Print:** this selection displays the **Print Preview** dialog of the currently selected rows in the **Chart Data** group box. Section 20.13 provides information about the **Print Preview** dialog.
4. **Copy Rows to Clipboard:** this selection copies the currently selected rows in the **Chart Data** group box to the Windows clipboard. The contents of the Windows clipboard can be pasted to any Windows application.

20.15 Table Lookup

The ellipsis button next to the field means that a search capability is available for a record in the **Table Lookup** dialog by clicking the button. In addition, the information in the field (on the form) can be cleared.

20.15.1 Searching for Record

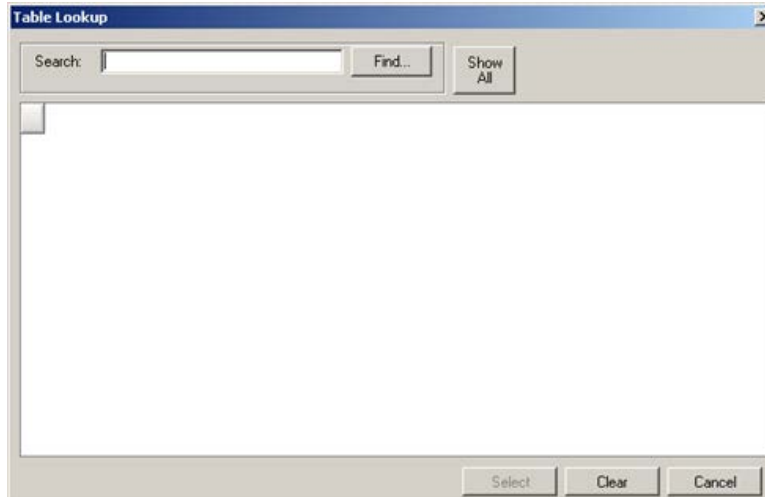


Figure 20-20-63: **Table Lookup** Dialog

This dialog provides two types of searches: for all items or for one item.

We will use an example to demonstrate each type. Assume that the search will be for CPT Code.

20.15.1.1 Using the Show All Button

If nothing is entered in the **Search** field and **Show All** is clicked, the application will display all CPT codes, as shown below. Due to the possibility of many results, the retrieval might take a little time. (Figure 20-20-64)

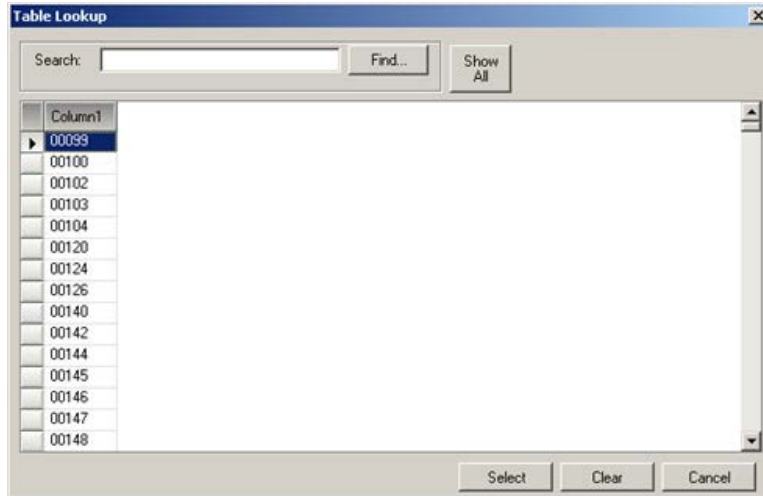


Figure 20-20-64: Sample retrieval of all CPT codes

20.15.1.2 Using the Find Button

To search for a CPT code, type a few characters in the **Search** field and then click **Find**. The retrieved records will display in the bottom area (if any). (Figure 20-20-65)

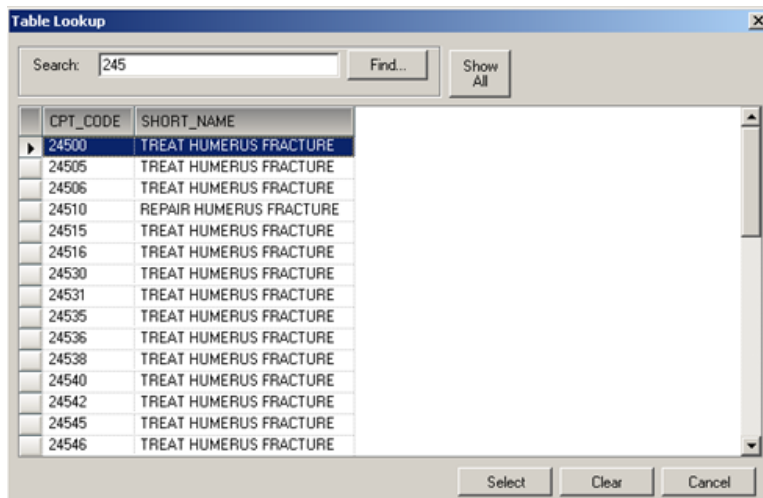


Figure 20-20-65: Sample retrieval of a CPT code

20.15.1.3 Completing the Search

In either case, select a record and click **Select**. This will close the dialog and populate the field (on the form) with the selected record. (To exit the **Table Lookup** dialog, click the **Cancel** button.)

20.15.2 Clearing Data in Field with Ellipsis Button

To clear the data in a field with the ellipsis button (on a form), click the **ellipsis button** to display the **Table Lookup** dialog. Click **Clear** (on **Table Lookup**). This will close the **Table Lookup** dialog and clear the data in the field on the form. (To exit the **Table Lookup** dialog, click the **Cancel** button.)

20.16 Erroneously Tracked Events

Once an event has been Tracked, it cannot be changed to Not Tracked. The following process is used when an event is erroneously Tracked.

1. Go to the **Tracked** tab, in any view (**Main, Panel, Patient Record**) and open a CMET worksheet for the event that was erroneously tracked. Click the **Add button** in the **Findings** area to access the **Findings** dialog. (Figure 20-20-66)

Figure 20-20-66: Sample **Findings** dialog populated

Choose the option “**ERROR/DISREGARD**” in the **Findings** field. Choose the option “**No**” in the “Follow-Up Needed?” field. Using today’s date for the Date field is recommended. Click **OK** to save and to close the dialog.

2. Go to the **Patient Notifications** area of the CMET Worksheet and click the **Add** button. The application displays the **Notifications** dialog. (Figure 20-20-67)



Figure 20-20-67: Sample **Notifications** dialog populated

Use the option “**NONE**” for the **Method** field. It is recommended to add a comment in the **Comment** field and to use today’s date for the **Date** field. Click **OK** to save and to close the dialog.

3. The application will display the **Close Event information** message. (Figure 20-20-68)

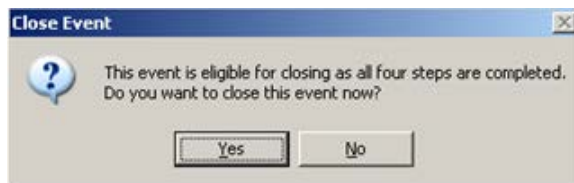


Figure 20-20-68: **Close Event** information message

Click **Yes** on the message. This closes the message.

4. The application will display the **RPMS iCare – Reason for Closing** dialog. (Figure 20-20-69)

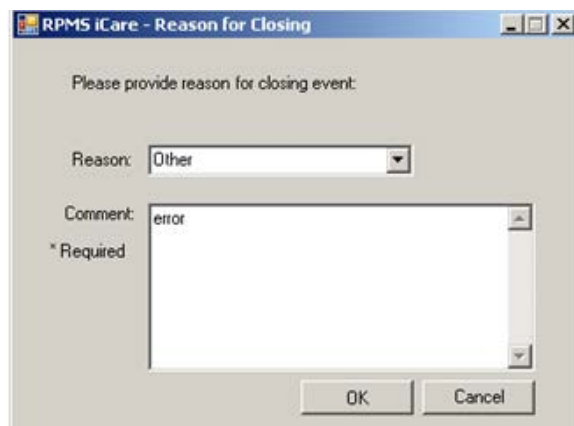


Figure 20-20-69: **RPMS iCare – Reason for Closing** dialog

Select the option “**Other**” for the **Reason** field. Enter a **comment** in the **Comment** field. Click **OK** to save and to close the dialog.

5. The application will display the Confirm save to RPMS information message. (Figure 20-20-70)



Figure 20-20-70: **Confirm save to RPMS** information message

Click **Yes** on the message to save the data to RPMS and to close the message.

This process causes the event to have a State of **CLOSED**.

Glossary

Context Menu

The menu of options that displays when an entity is right-clicked.

Designated Primary Care Provider (DPCP)

In RPMS, the provider name that is assigned as the primary care physician for a patient or group of patients at a specific facility. This is not a required function.

Free Text Field

A field where the user can type text, just like typing a note to someone.

Providers

Any staff member in an I/T/U facility who provides direct healthcare to patients, e.g. general practice or specialty physicians, registered nurses, social workers, physician assistants, etc.

Within RPMS, the term “provider” has different specific meanings. See definitions for Designated Primary Care Provider (DPCP); Primary Provider; Visit Providers.

Reminders

Health Maintenance Reminders review patient data and alert the provider to procedures that might be overdue for the patient. Reminders can be based on age and gender and include typical clinical prevention measures, such as pap smears.

“Tagging”

A process to review the patient’s data and categorize (“tag”) the patient with one or more clinical diagnoses, such as Known CVD or Diabetes. Tags will be used to provide more accurate reminders that are prioritized more appropriately for a patient’s multiple conditions.

Taxonomy

In RPMS, a grouping of functionally related data elements, such as ICD codes, that are created and maintained within the RPMS Taxonomy Setup application. Taxonomies will be used as definitions for diagnoses, procedures, lab tests, medications, and other clinical data types.

If there is a need a change or add to an existing taxonomy, please see the local CRS coordinator.

Tooltip/Hover Help

A common GUI element used to provide additional information to users. To display a Tooltip, hover the mouse pointer, without clicking, over a column heading or field.

Visit Provider

In RPMS, the provider(s) who cared for a patient on a specific visit. Each patient visit must have at least a primary provider entered. Visits can also have one or more secondary providers. The primary visit provider might or might not be the same provider as the patient's DPCP, and can change on each visit, depending on the visit type or the clinic staffing.

Acronym List

Acronym	Term Meaning
BQI	Namespace for iCare
ARV	Anti-Retro Viral Medications
BH	Behavioral Health
BP	Best Practices
CDC	Centers for Disease Control and Prevention
CHS	Contract Health Service (now known as Purchased and Referred Care (PRC))
CMET	Care Management Event Tracking
CPT	Current Procedural Terminology
CRS	Clinical Reporting System
CVD	Cardiovascular Disease
DES	Diethylstilbestrol
DM	Diabetes Mellitus
DPCP	Designated Primary Care Provider
DSPM	Designated Specialty Provider Management
DX	Diagnostics
EDD	Estimated Date of Delivery
EHR	Electronic Health Record
ER	Emergency Room
GPRA	Government Performance and Results Act
GUI	Graphical User Interface
HIV	Human Immunodeficiency Virus
HMS	HIV Management System
HS	Health Summary
HX	History
I/T/U	Indian Health Service, or Tribal or Urban Indian health programs
ICD	International Classification of Diseases
IHS	Indian Health Service
JPEG	Joint Photographic Experts Group (image format)
NND	Nationally Notifiable Diseases (CDC term)
OIT	Office of Information Technology
PCC	Patient Care Component
PCP	Primary Care Provider
PDF	Portable Document Format (Adobe Acrobat)
POV	Purpose of Visit
RCIS	Referral Care Information System
RPMS	Resource and Patient Management System
TIU	Text Integration Utility

Acronym	Term Meaning
STI	Sexually Transmitted Infection
URL	Uniform Resource Locator

Contact Information

For questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (888) 830-7280 (toll free)

Web: <http://www.ihs.gov/helpdesk/>

Email: support@ihs.gov