



RESOURCE AND PATIENT MANAGEMENT SYSTEM

iCare Population Management GUI

(BQI)

Patient Record User Manual

Version 2.4
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Office of Information Technology (OIT)
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Table of Contents

1.0	Introduction.....	1
1.1	Background	1
1.2	iCare Graphical User Interface	1
1.3	Who Should Use iCare?	2
1.4	Features Introduced in Version 2.4.....	2
1.4.1	ICD-10 Updates.....	3
1.4.2	Non ICD-10 Updates	4
2.0	Patient Record	6
2.1	Specifying the Default Tab.....	7
2.2	Patient Demographic Group Box	7
2.2.1	Community Field.....	7
2.2.2	Allergies Field	9
2.2.3	Barriers to Learning Field	9
2.2.4	Phone Fields.....	9
2.2.5	Email Field.....	10
2.2.6	DPCP Field.....	10
2.2.7	Additional Demographics Button	11
2.2.8	Add a Note.....	12
2.2.9	View IMM Profile.....	12
3.0	Cover Sheet Tab	14
3.1	Recent Visits Group Box.....	14
3.2	Scheduled Appointments Group Box.....	15
3.3	Providers Group Box	15
3.3.1	Link to Last Visit Date.....	15
3.3.2	Edit Button	16
3.4	Insurance Group Box.....	16
3.5	Panels Group Box.....	17
3.5.1	Tooltip for Panel Description.....	17
3.5.2	Add to Panel Button.....	17
3.6	Registers Group Box	18
3.7	Cover Sheet Tab Menus.....	18
3.7.1	File Menu.....	18
3.7.2	Tools Menu.....	19
4.0	Snapshot Tab.....	20
4.1	Active Diagnostic Tags Group Box	20
4.1.1	Details Button	21
4.1.2	Tooltip for Active Diagnostic Tags Tab	21
4.1.3	iCare Taxonomy View/Edit	21
4.2	Family History Group Box.....	23
4.3	Reproductive Factors Group Box.....	24

4.3.1	Fields on Reproductive Factors Group Box.....	24
4.3.2	Edit Reproductive Factors	24
4.4	Measurements (Last Visit) Group Box	25
4.5	Last Routine Events Group Box	26
4.5.1	Open CMETs Group Box.....	27
4.6	Snapshot Tab Menus.....	27
5.0	Flags Tab.....	28
5.1	Flags Tab Layout	28
5.1.1	Flag List Columns.....	28
5.1.2	Flag Types.....	28
5.2	Flags Tab Toolbar.....	29
5.2.1	Show Field.....	29
5.2.2	Hide	29
5.2.3	Show	30
5.2.4	Status of Background Jobs.....	30
5.3	Flags Tab Menus	30
5.3.1	Tools Menu.....	30
5.3.2	Flags Menu.....	31
6.0	Reminders Tab.....	32
6.1	Reminders Tab Layout	32
6.2	Reminders Tab Toolbar	33
6.2.1	Recalc	33
6.2.2	Background Jobs.....	33
6.2.3	Reminders Tab Menus	33
7.0	BP Prompts Tab.....	35
7.1	BP Prompts Tab Layout.....	35
7.2	BP Prompts Tab Toolbar	35
7.2.1	Recalc	35
7.2.2	Background Jobs.....	36
7.3	BP Prompts Tab Menus.....	36
8.0	Natl Measures Tab.....	37
8.1	Natl Measures Tab Layout.....	37
8.2	Natl Measures Tab Toolbar	38
8.2.1	Recalc	38
8.2.2	Background Jobs.....	38
8.3	Natl Measures Tab Menus.....	38
9.0	CMET Tab.....	39
9.1	Events Sub-Tab	39
9.1.1	Events Sub-Tab Layout	40
9.1.2	Events Sub-Tab Toolbar.....	40
9.2	Tracked Events Sub-Tab	43
9.2.1	Tracked Events Sub-Tab Layout	43

9.2.2	Tracked Events Sub-Tab Toolbar.....	44
9.3	Follow-up Events Sub-Tab	46
9.3.1	Follow-up Events Sub-Tab Toolbar	46
9.4	Past Events Sub-Tab.....	47
9.4.1	Past Events Sub-Tab Layout.....	47
9.4.2	Past Events Sub-Tab Toolbar.....	47
9.5	CMET Tab Menus.....	48
10.0	Summ/Supp Tab	49
10.1	Summ/Supp Tab Toolbar.....	49
10.2	Summ/Supp Tab Menus	50
10.2.1	Tools Menu.....	50
10.2.2	File Menu.....	50
11.0	PCC Tab	51
11.1	PCC Tab Layout	51
11.2	PCC Tab Toolbar.....	52
11.2.1	Add Event.....	52
11.2.2	Add a Note.....	56
11.2.3	Related To.....	56
11.2.4	Graph It Button	56
11.3	PCC Tab Menus	57
12.0	Problem List Tab	58
12.1	Problem List Tab Layout.....	58
12.2	Problem List Tab Toolbar	59
12.2.1	No Active Problems	59
12.2.2	Problem List Reviewed.....	60
12.3	Problem List Tab Menus.....	61
13.0	Care Mgmt Tab.....	62
13.1	Patient with No Tag	62
13.1.1	Enter Data	63
13.1.2	Add Tag.....	63
13.1.3	Accept Button	65
13.2	Patient with Active Tags	65
13.2.1	Accept	66
13.2.2	Add Tag.....	68
13.3	Main Sub-Tab.....	68
13.3.1	General.....	69
13.3.2	Partner Notification	71
13.3.3	State Notifications.....	74
13.3.4	Save Button.....	75
13.3.5	Reports.....	76
13.3.6	Glossary Button	76
13.4	Reminders Sub-Tab.....	77
13.4.1	Patient with Asthma Tag.....	77

13.5	Care Management Tab Menus	78
13.5.1	Tools Menu for Main Sub-Tab	78
13.5.2	Tools Menu for Reminders Sub-Tab.....	78
13.5.3	Care Mgmt Menu.....	78
14.0	Referrals Tab.....	81
14.1	Referrals Tab Layout	81
14.2	Referrals Tab Toolbar Options	82
14.3	Referrals Tab Menus	82
15.0	DX Tags Tab.....	83
15.1	DX Tags Tab Layout.....	83
15.2	DX Tags Tab Toolbar	84
15.2.1	Recalc	84
15.2.2	Change the Tag Status.....	84
15.2.3	Add Tag.....	84
15.2.4	Activity	84
15.2.5	Background Jobs.....	85
15.3	DX Tags Tab Menus.....	85
16.0	Family HX Tab.....	86
16.1	Family HX Tab Layout	86
16.2	Family HX Tab Toolbar.....	86
16.3	Family HX Tab Menus	86
17.0	Notes Tab	88
17.1	Notes Tab Layout	88
17.2	Notes Tab Toolbar	89
17.2.1	View Notes	89
17.2.2	Print Notes.....	89
17.3	Notes Tab Menus	90
18.0	Suicide Form Tab	91
18.1	Suicide Form Tab Layout.....	91
18.2	Suicide Form Tab Toolbar	92
18.3	Suicide Form Tab Menus.....	92
19.0	iCare Features Used by Patient Record	93
19.1	User Preferences.....	93
19.2	Buttons on Right Side of Window	94
19.2.1	Reset View	94
19.2.2	Refresh.....	95
19.2.3	Search	95
19.2.4	Export to Excel	97
19.2.5	Print	98
19.2.6	Copy to Clipboard.....	99
19.2.7	Mail Merge.....	99
19.2.8	Glossary	101

19.3	Edit Patient Demographics Fields.....	101
19.3.1	Fields on Edit Patient Demographic Fields Dialog.....	101
19.3.2	Menus on Edit Patient Demographic Fields Dialog.....	102
19.4	Add a Note Dialog.....	102
19.5	Add TIU Note Dialog.....	103
19.5.1	Note with No Template	104
19.5.2	Note with Template.....	104
19.5.3	Buttons on Add TIU Note Dialog.....	106
19.6	Pop-up Functionality	110
19.7	Edit Providers	112
19.7.1	Add/Edit New Provider	112
19.7.2	Remove Provider Name	113
19.7.3	Save & Close Button	113
19.7.4	File Menu on Edit Providers	113
19.7.5	Tools Menu on Edit Providers.....	114
19.7.6	Help Menu on Edit Providers.....	114
19.8	iCare Taxonomy Editor Function	114
19.8.1	Add Taxonomy Values	115
19.8.2	Remove Taxonomy Values.....	116
19.8.3	View Report of All Taxonomies Button	116
19.9	Edit Reproductive Factors	118
19.9.1	Top Panel	119
19.9.2	Second Panel	119
19.9.3	Third Panel	120
19.9.4	Bottom Panel.....	120
19.10	CMET Worksheet	121
19.10.1	Patient Demographics Group Box	123
19.10.2	1 - Event Group Box	123
19.10.3	2 - Findings Group Box.....	124
19.10.4	3 - Follow-ups Group Box.....	127
19.10.5	4 - Patient Notifications Group Box.....	129
19.11	Background Jobs Pop-up	132
19.12	Print Preview	133
19.13	Graphing Measurement Data	136
19.13.1	Chart Data Group Box	136
19.13.2	Chart Options Group Box	137
19.13.3	File Menu for Charting Window	138
19.14	Table Lookup.....	141
19.14.1	Searching for Record.....	141
19.14.2	Clearing Data in Field with Ellipsis Button	143
19.15	Erroneously Tracked Events.....	143
	Glossary.....	146
	Acronym List	148
	Contact Information	149

Preface

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

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

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

- 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 AdobeConnect 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 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 they view patient data.

For more information about iCare basic functionality, iCare usage, or training for iCare, you can consult the resources listed above 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, including for diabetes, asthma, and 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 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 providers a 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. You can change the tag selection for any record 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 of 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. Do you fit any of the following scenarios?

- I am a nurse at a facility that assigns a primary care provider to each patient. Every day, I want to create a list of scheduled patients for two different doctors in my clinic.
- I want to identify which of my patients are considered obese so I can recommend nutrition counseling.
- Because providers at our clinic have performance goals related to annual GPRA clinical measures, I want to identify which of my patients are missing key clinical data.
- Our Women’s Health Clinic wants to focus on two clinical performance improvement initiatives this year. We want to identify the performance problem areas for female patients between the ages of 18 and 50.
- I am one of two part-time case managers for a group of children, and I want to create a patient list that we both can use.
- I am a site manager working to ensure our site meets Meaningful Use objectives.

1.4 Features Introduced in Version 2.4

iCare Version 2.4 is composed of three different builds/packages:

- ICARE MANAGEMENT SYSTEM 2.4
- CARE MANAGEMENT EVENT TRACKING 1.1
- HIV MANAGEMENT SYSTEM 2.2

The majority of changes in this release are to update the three parts of iCare to incorporate ICD-10.

1.4.1 ICD-10 Updates

1.4.1.1 Update Glossaries and Help Files

The iCare application displays several glossaries, listed below, to describe and document the criteria used by the nightly and weekly jobs to perform the data analysis for the various data displayed in iCare. The displays are dependent on taxonomies and therefore, the taxonomy updates documented above will require the following glossaries to reflect those changes.

- Best Practice Prompts Glossary
- Care Management - Asthma Glossary
- Care Management – COPD
- Care Management - Diabetes
- Care Management – HIV/AIDS Glossary
- Community Alerts Glossary
- Diagnostic Tags Glossary
- IPC Glossary
- iCare Online Help

1.4.1.2 Community Alerts Update

The iCare application displays Community Alerts which are identified by the nightly background jobs. The Community Alerts criteria depend on new and updated taxonomies. The ICD-10 conversion will require that the Community Alerts logic be validated with the updated taxonomies and the documentation of the logic visible in iCare via glossary and help to reflect those changes. For those Community Alerts without an associated taxonomy, a new taxonomy will be created with both ICD-9 and ICD-10 codes rather than relying on checking individual codes.

1.4.1.3 Diagnostic Tags Update

The iCare application displays Diagnostic Tags which are identified by the nightly and weekly background jobs. The Diagnostic Tag criteria depend on taxonomies updated to include ICD-10 codes. The ICD-10 conversion will require that the Diagnostic Tag logic be validated with the updated taxonomies and the documentation of the logic visible in iCare via glossary and help will need to reflect those changes. Diagnostic Tags update will affect Diagnostic Tag views in panels and patient records.

1.4.1.4 Family History Update

The iCare application displays Family History data in the Patient Record. The ability to add/edit/delete Family History conditions has been disabled.

1.4.1.5 Problem List Update

The iCare application displays Problem List data in the Patient Record. The ability to add/edit/delete Problems has been disabled.

1.4.1.6 PCC Procedures Update

The iCare application displays PCC Procedure data in the Patient Record. PCC Procedures include a field for a procedure code based on the ICD-9 procedure code set. The ICD-10 conversion will require an update to the display of the PCC procedure in iCare be updated to show the appropriate ICD code.

1.4.1.7 Taxonomy Update

The iCare application displays taxonomies and their respective entries. A new way of displaying taxonomies has been implemented. The ICD-10 conversion will require that the display of taxonomy entries be updated to allow for ICD-10 codes to be included. This will include a new column indicating which code is ICD-9 and which code is ICD-10.

Additionally, the dialog will be updated to improve usability and display other associated fields like matches at your facility to the associated LOINC code and NDC code.

Further, the ability to view the SNOMED subsets defined for IPL will be included.

1.4.2 Non ICD-10 Updates

1.4.2.1 Patient Demographics

Two new fields were added to Patient demographics list:

- Last Immunization Notification
- Last Reminder Notification

This will list the last notification created for the patient.

1.4.2.2 Care Mgmt Group

A new Care Mgmt Group has been added for Prenatal patient care. It is composed of the following columns:

- Currently Pregnant? - Marked as “yes” in the Reproductive factors file
- Estimated Delivery Date - The definitive EDD from Reproductive Factors
- Estimated Gestational Age - The EGA measurement from V Measurement
- High Risk - If the patient has any active prenatal problems that are marked as high priority, show the provider narrative(s).

Additionally, a new lab test taxonomy was created called BQI PRENATAL TAX. You may populate this taxonomy with the lab tests that you want to see for your prenatal population. Each lab test will display as a column and show the RESULT (DATE).

Note: After updating this taxonomy, the iCare Nightly Job must run to do the update.

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.

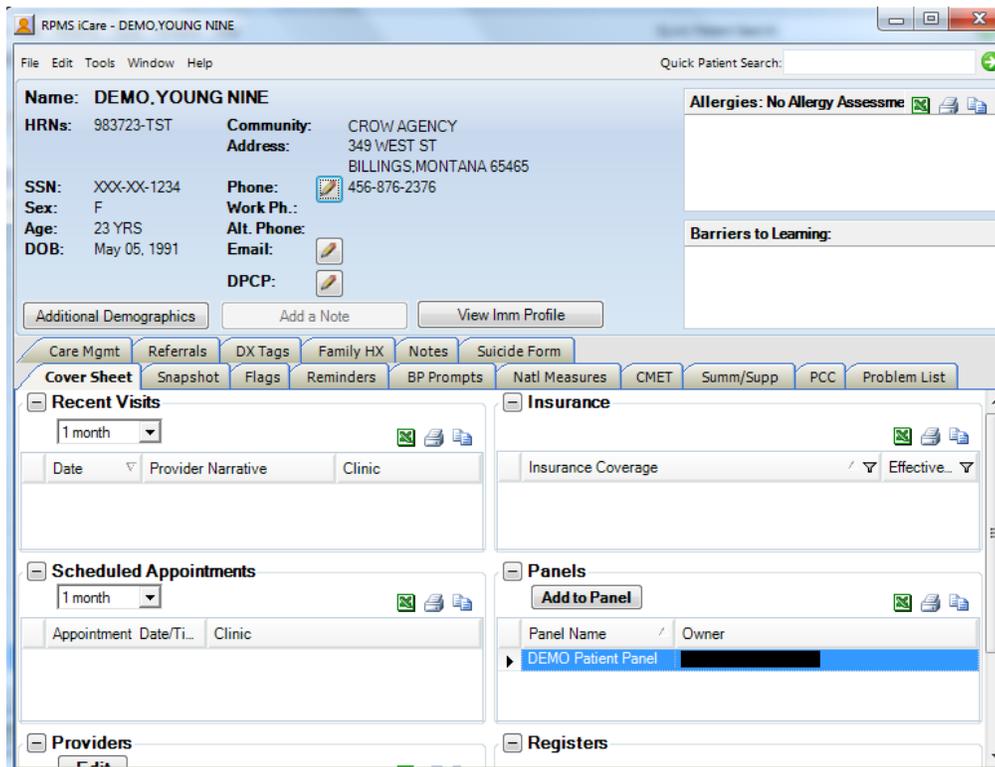


Figure 2-1: Sample Patient Record window

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

The Suicide Form tab might not display. This tab displays for those with special keys.

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

As a general rule, when you double-click any date that is underlined (in the Date column), the Visit File pop-up will display.

2.1 Specifying the Default Tab

You can set the default tab for the Patient Record window by defining it on the Patient View tab of the User Preferences window (select **Tools | User Preferences**). This means that when you access the Patient Record window, the default tab will be on top. Section 19.1 provides information about User Preferences.

If you do NOT specify a default tab, the default tab will be Cover Sheet.

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: 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**.

The screenshot shows a window titled "Community Alerts for LITTLE ROCK from Jul 19, 2009 to Aug 17, 2009". The table contains the following data:

Type	Diagnosis	Number of Cases in the Past 30 Days	Number of Cases in the Past 24 Hours	Most Recent Occur
Public Health	IU	1		Aug 05, 2009

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) CDC Nationally Notifiable Infections Diseases (NND) and (2) Suicidal Behavior: Ideation, Attempt and Completion. For this version, the logic will only display each alert for 30 days from the visit occurrence date.

- The CDC Nationally Notifiable Infectious Diseases (NND) alert is defined as: Any primary care visit within the past 30 days with any POV identified in the CDC NND table. Only one alert per patient per 30 day period will be displayed. The CDC NND logic will review primary care visits only. Primary care clinics are defined in CRS (BGP) in the BGP CONTROL FILE, Field 1201 CLINIC CODES FOR 2ND VISIT (90241.0112). Any primary care visit within the RPMS database will be reviewed, regardless of the facility location.
- The Suicidal Behavior alert is defined as: Any AMH or PCC visit within the past 30 days with Suicide Ideation, Attempt, Completion or Not Categorized (see definitions below). Only one alert per patient per 30 day period should be displayed. Both AMH (Behavioral Health) and PCC Visit files will be reviewed for visit data. First identify any AMH visits with BH visit codes 39, 40 or 41. Next, identify any additional PCC visits in the timeframe that were not documented in AMH with diagnosis or Ecode defined below.
- AMH Ideation: BH Visit Code 39.
- AMH Attempt: BH 40
- AMH Completion: BH 41
- PCC Ideation: V62.84
- PCC Not Categorized: Ecodes E950-E959

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 you 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 19.12 provides information about this dialog.

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

Close: The option closes the pop-up.

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

The Tools menu contains the Reset View, Search, Excel Export, Copy Rows to Clipboard options that work like the buttons on the right side of the window. Section 19.2 provides information about these buttons.

2.2.1.3 Buttons on Community Alerts for Community Pop-up

Section 19.2 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). You can do the following with the selected rows in the grid: Export to Excel, Print, Copy; section 19.2 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 EHR for the patient.

Section 19.2 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.

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 19.3 provides information about this dialog.

2.2.5 Email Field

You can edit the Email field by clicking the pencil () button next to the Email field to display the **Edit Patient Demographic Fields** dialog. Section 19.3 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.

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

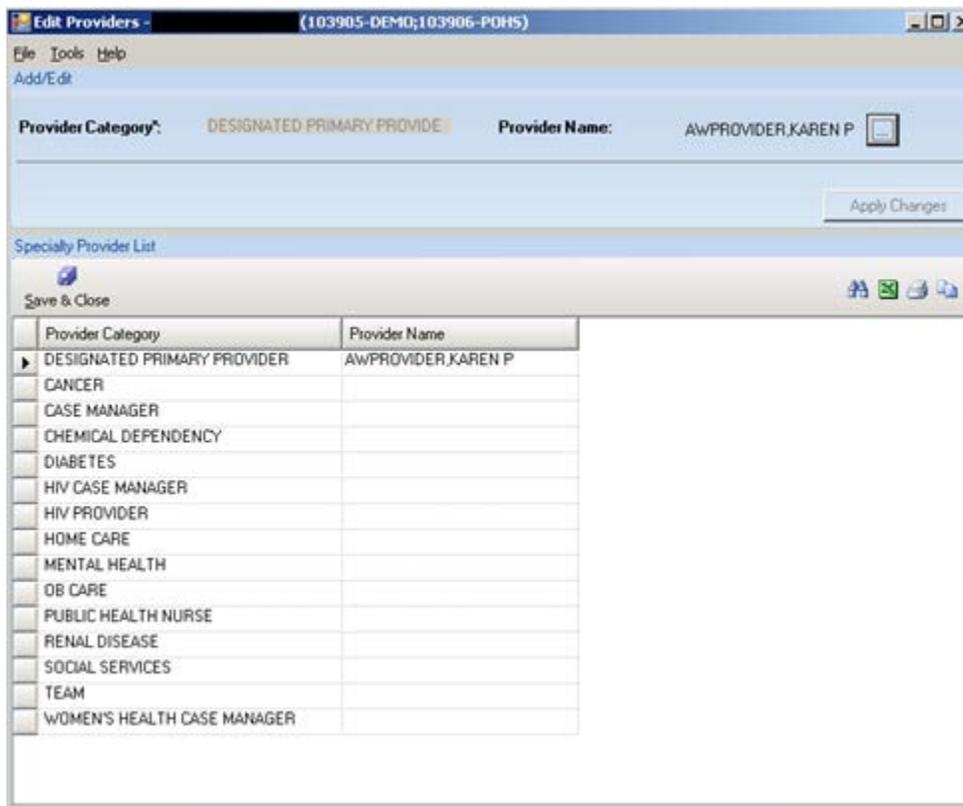


Figure 2-4: Sample Edit Providers dialog

Use the Edit Providers dialog to add, edit, or remove specialty provider names for the various provider categories. Section 19.7 provides information about this dialog.

2.2.7 Additional Demographics Button

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

Field	Value
Marital Status:	MARRIED
Race:	[Pencil Icon]
Ethnicity:	[Pencil Icon]
Classification/Beneficiary:	INDIAN/ALASKA NATIVE
Tribe	
Membership:	EASTERN BAND OF CHEROKEE IND, NC
Enrollment Number:	TN - 1054
Quantum:	61/64
Indian Blood Quantum:	61/64
Other Tribe:	
Place of Birth (City/State):	ANYCITY NC
Preferred Language:	[Pencil Icon]
Communication Preference:	[Pencil Icon]
Location of Home:	

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 19.3 provides information about the dialog.

Household Tab

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

The screenshot shows a dialog box titled "RPMS iCare - JONES, LOGAN EARL - Additional Demographics". It has two tabs: "Demographic Detail" and "Household". The "Household" tab is active. The dialog contains the following information:

Number in Household:	
Emergency	
Contact Name:	JONES, BRENDA SUE
Relationship:	MOTHER
Phone:	
Next of Kin	
Primary Name:	JONES, BRENDA SUE
Relationship:	MOTHER
Phone:	
Mother's Maiden Name:	BURKE, MAGEN JALAINÉ
Mother's Birthplace:	SOMEWHERE MN
Father's Name:	JONES, ANTONIO
Father's Birthplace:	SOMEWHERE MN

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 19.3 provides information about the dialog.

2.2.8 Add a Note

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

Step 1: Click the **Add a Note** button to access the **Add a Note** dialog and then complete the fields on this dialog. Section 19.4 provides information about the dialog.

Step 2: Click the **Create** button on the **Add a Note** dialog to access the **Add TIU Note** dialog. Section 19.5 provides more information about the dialog.

After clicking the **Add a Note** button and if no default clinics are defined in user preferences, the application displays the following message: You must select default clinics in user preferences before being able to enter notes. Click **OK** to dismiss the message. Select **Tools | User Preferences** to access the **RPMS iCare – User Preferences** dialog. Go to the **Patient View** tab to enter the clinic codes. Section 19.1 provides information about user preferences.

2.2.9 View IMM Profile

Use the **View IMM Profile** button to view the **Immunization Profile** pop-up window.

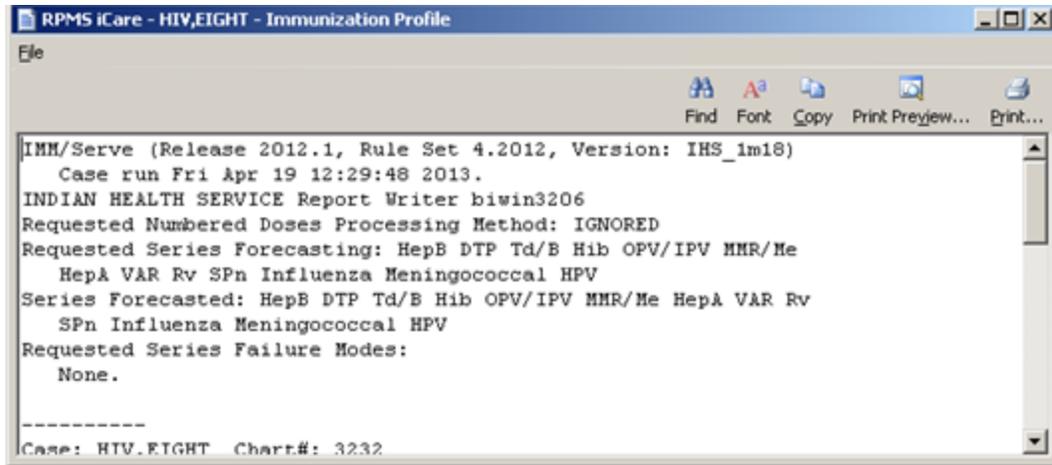


Figure 2-7: Sample Immunization Profile pop-up

This pop-up provides information about the patient's immunization history, including contraindicated vaccines, the mother's HBsAg status, the immunizations that are due, the immunizations that will be due, and the vaccine series that are complete or no longer relevant. Section 19.6 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.

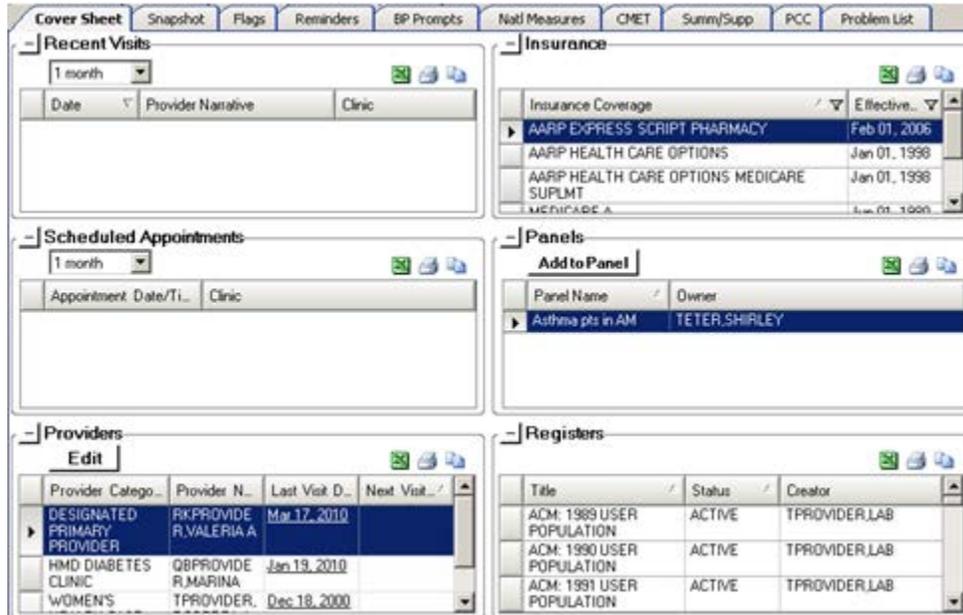


Figure 3-1: Sample Cover Sheet tab

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 to expand the group box.
- Click the Collapse (+) symbol to collapse the group box.

Section 19.2 provides information about the buttons on the right side of each group box.

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

3.1 Recent Visits Group Box

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

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

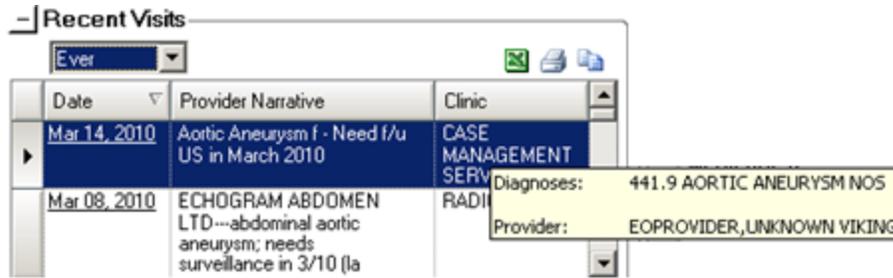


Figure 3-2: Sample Recent Visits group box

Double-click any row of the **Recent Visits** group box to display the **Visit Detail** pop-up. Section 19.6 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 drop-down list to determine the time interval for the appointments displayed (the default is 1 month).

3.3 Providers Group Box

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

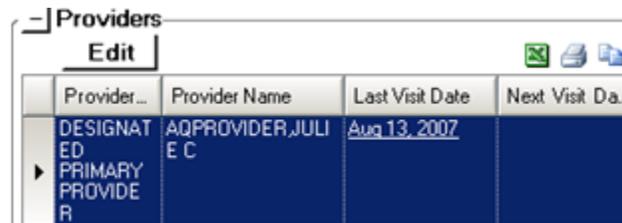


Figure 3-3: Sample Providers group box

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 19.6 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.

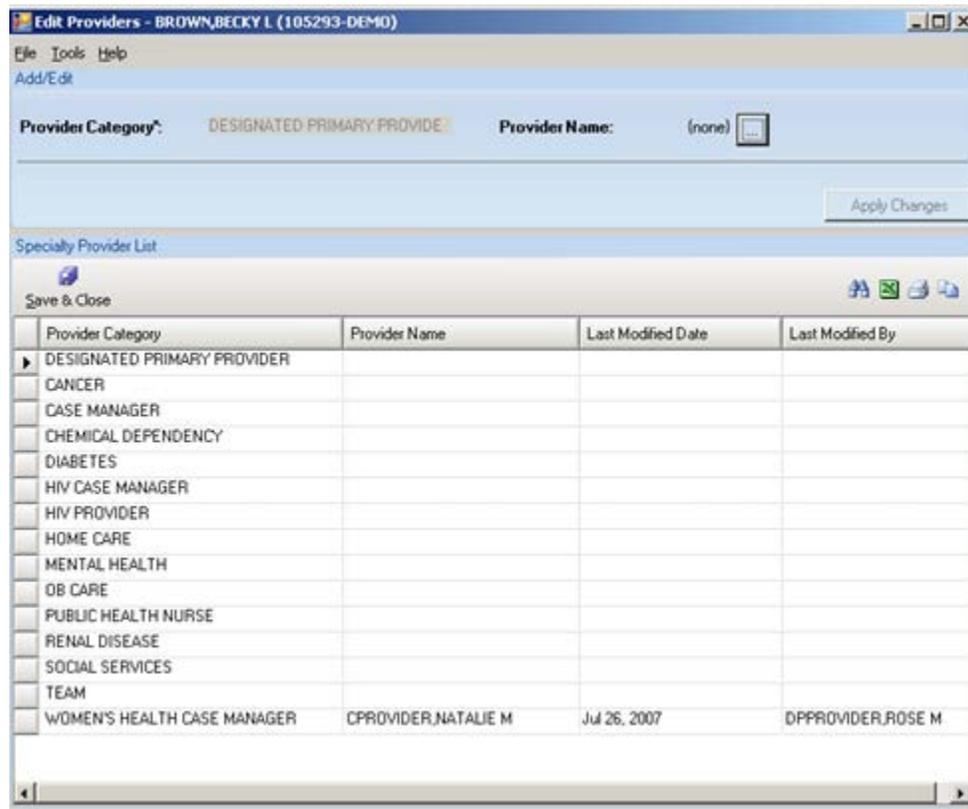


Figure 3-4: Sample Edit Providers window

Use this window to add, edit, or remove specialty provider names. Dismiss the Edit Providers window by selecting **File | Close**. Section 19.7 provides information about this window.

3.4 Insurance Group Box

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

Insurance Coverage	Effective Date
KANAWHA INSURANCE CO.	Sep 01, 2004

Figure 3-5: Sample Insurance group box

3.5 Panels Group Box

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

Panel Name	Owner
new PM pts for asthma	TETER,SHIRLEY

Figure 3-6: Sample Panels Group Box

3.5.1 Tooltip for Panel Description

Hover your 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.

Available Panels			Current Panels		
Panel Name	Description	Owner	Panel Name	Description	Owner
afternoon pts		TETER,SHIRLEY	Asthma pts in AM		TETER,SHIRLEY

Add >> << Remove

OK Cancel

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.

Please note that if you select a panel in the Current Panels group box and click **Remove**, and if the selected panel is open, the application displays the message that is 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 displays the Register names of which the patient is a member. Register names that the user does not have security access to will be inactive. The data shows the patient's register status (in the Status column).



Title	Status	Creator
ACM: IHS DIABETES	ACTIVE	SDEMO,KAT
ACM: TLM-DIAB	ACTIVE	WBPROVIDER,WALTE R H
BKM: HIV Management System	ACTIVE	

Status:	ACTIVE
Status Date:	May 24, 2010
Category:	HIV

Figure 3-8: Sample Registers group box

Hover your 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 you create a new panel definition. This is the same as pressing the Ctrl+N key combination.

Page Setup: this option is active when you select one or more rows in the grid. This option allows you to set Margin, Paper, and Layout characteristics (like landscape or portrait orientation) for printing. You can select a different printer.

Print Preview: this option is active when you select one or more rows in a grid. This option displays the Print Preview dialog. Section 19.12 provides information about this dialog.

Print: this option is active when you select one or more rows in a grid. It uses the most recently selected rows (because there are 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 19.11 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 like the [buttons on the right side of the window](#).

User Preferences: this option opens the User Preferences window where you can change your user preferences.

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

4.0 Snapshot Tab

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

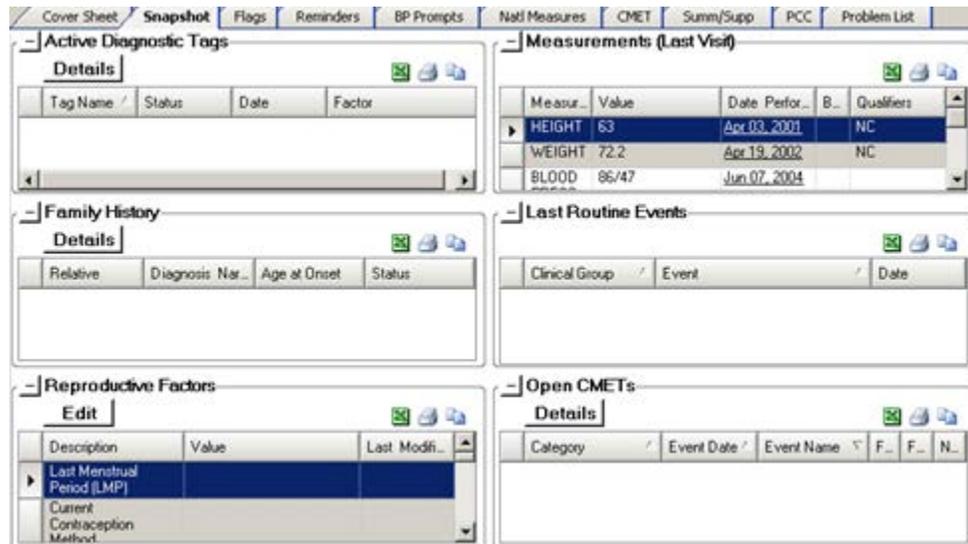


Figure 4-1: Sample Snapshot tab

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

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

Section 19.2 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 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
Asthma	ACCEPTED	Aug 06, 2008	BGP ASTHMA DXS
CVD Known	PROPOSED	Oct 24, 2003	BGP CARG CPTS
Hypertension	PROPOSED	Feb 25, 1988	BGP HYPERTENSION DXS

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 particular tag. Here you view the status, date, item, value, and factor about the selected tag.

4.1.2 Tooltip for Active Diagnostic Tags Tab

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

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

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

4.1.3 iCare Taxonomy View/Edit

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

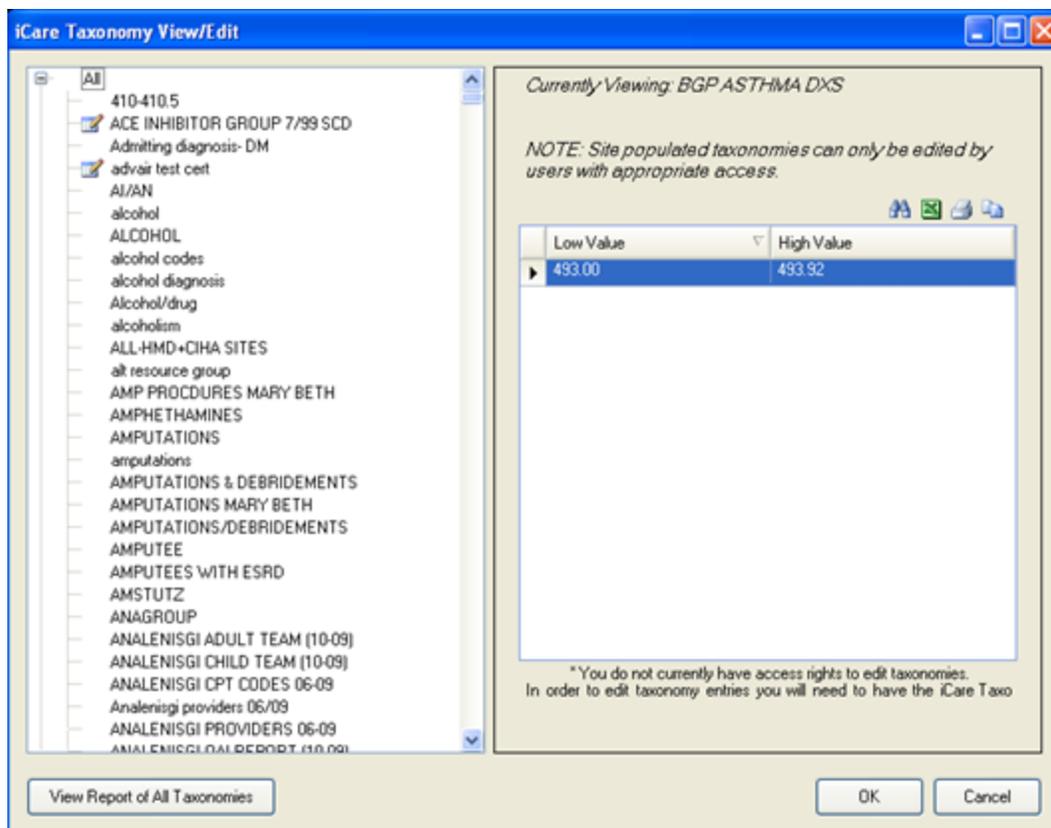


Figure 4-3: Sample iCare Taxonomy View/Edit dialog

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

If you have edit privileges (iCare Taxonomy Editor with security key BQIZTXED), you can add/remove values. Section 19.8 provides information about the iCare Taxonomy Editor Function.

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

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

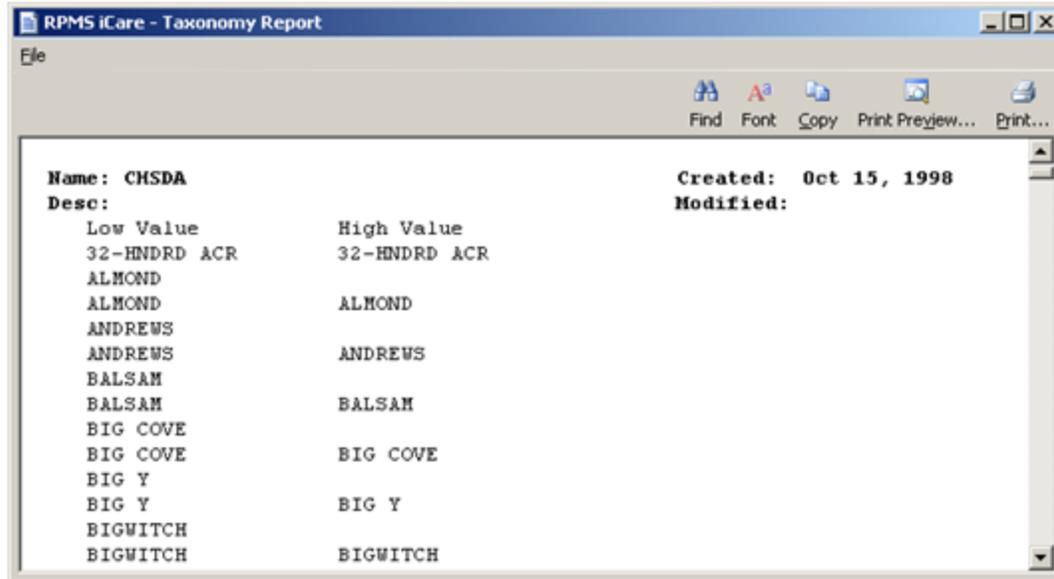


Figure 4-4: Sample Taxonomy Report

Section 19.6 provides information about using the controls on the pop-up.

4.2 Family History Group Box

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

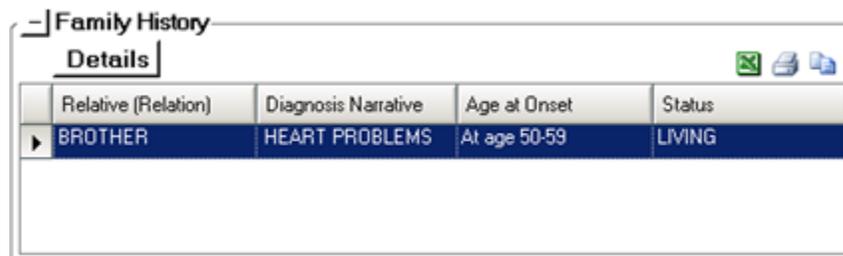


Figure 4-5: Sample Family History Group Box

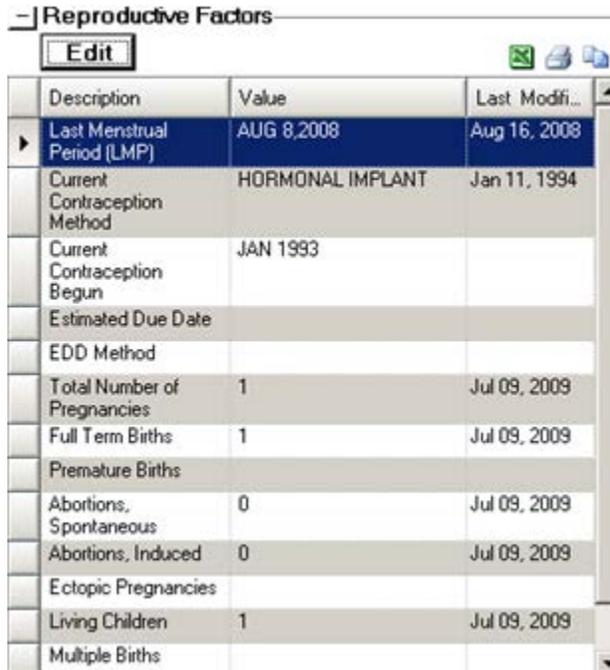
The default display will be sorted by Sort Order and then by Relationship.

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



Description	Value	Last Modified
Last Menstrual Period (LMP)	AUG 8, 2008	Aug 16, 2008
Current Contraception Method	HORMONAL IMPLANT	Jan 11, 1994
Current Contraception Begun	JAN 1993	
Estimated Due Date		
EDD Method		
Total Number of Pregnancies	1	Jul 09, 2009
Full Term Births	1	Jul 09, 2009
Premature Births		
Abortions, Spontaneous	0	Jul 09, 2009
Abortions, Induced	0	Jul 09, 2009
Ectopic Pregnancies		
Living Children	1	Jul 09, 2009
Multiple Births		

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

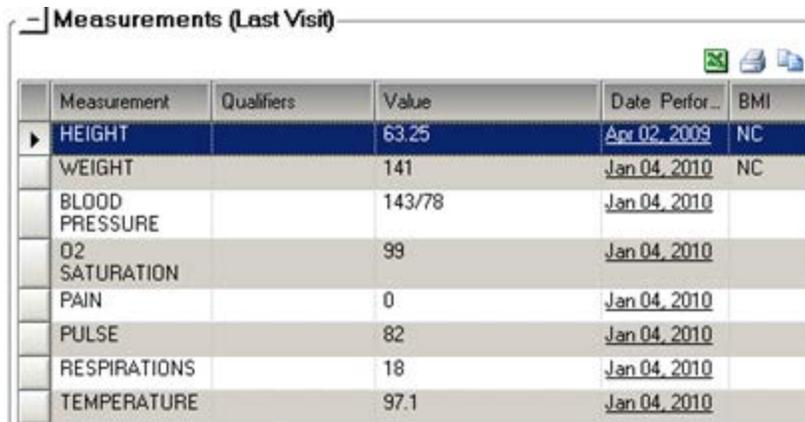
Click **Edit** to access the **Edit Reproductive Factors** dialog (where you can add new data).

Figure 4-7: Sample Edit Reproductive Factors dialog

Section 19.9 provides information about completing this dialog.

4.4 Measurements (Last Visit) Group Box

The Measurements (Last Visit) group box displays two sets of data: (1) the patient's most recent Height and Weight data and (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

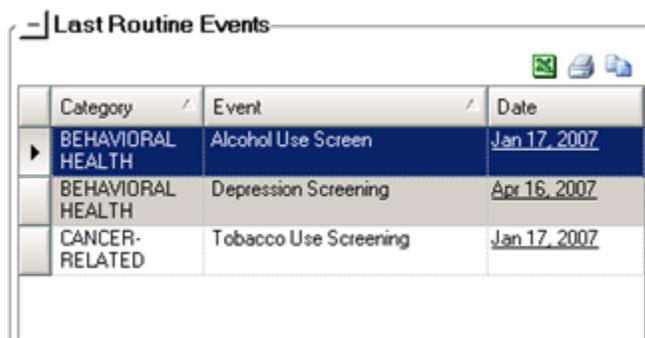
There will always be height and weight values. After height and weight, the measurements are displayed in alphabetical order by Measurement name.

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 19.6 provides information about using the controls on the pop-up.

4.5 Last Routine Events Group Box

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



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 19.6 provides information about using the controls on the pop-up.

4.5.1 Open CMETs Group Box

The Open CMETs group box 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 19.6 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 help shows the Finding Date and Finding Value.
 - In the Follow-up(s) cell, the hover help shows the Follow-up Date and Follow-up Value.
 - In the Notifications cell, the hover help shows the Notification Date and the type of Notification.
- A tickler  icon indicates that the element is overdue. The element Due Date is prior to Today's date (shown in hover help).
- The cell is blank if it is not completed but is not overdue.

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

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 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 the 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 if a particular date has more than one flag, the date will be displayed only on the first row.

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

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.

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

5.1.2 Flag Types

The Flag Type column contains various flag types, as defined in the following table:

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

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. Your choices are:

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

5.2.2 Hide

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

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

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

5.2.3 Show

If you need to cause a hidden flag to re-appear in the current view, select it from the list on the Hidden Flags option (from 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 your 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 19.11 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: this options operate like those for the buttons on the right-side of the window. Section 19.2 provides information about these buttons.

User Preferences: this option takes you to the User Preferences window where you can change your user preferences.

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

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 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 P...
Health Summary	ELDER	Tonometry	Dec 23, 1983	12/23/83	
		Visual Acuity Exam	Jul 17, 2004	07/17/04	Jul 18, 2002
		Fall Risk Assessment	Dec 23, 2008	12/23/08	
	CANCER-RELATED	Mammogram	Aug 19, 2009	CBE and MAM (by 08/19/2009) (per Women's Health system)	Aug 18, 2008
		Pap Smear	Aug 19, 2009	Routine PAP (by 08/19/2009) Date 11/19/2009	Aug 19, 2008

Figure 6-1: Sample Reminders tab

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

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

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

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), DMS (Diabetes Management System), EHR Clinical Reminders, CMET, etc. When the Source is “Care Management” and “HIV,” the denominator for the HMS reminders will be any patient with a proposed or accepted tag for HIV. **Note:** the register status is NOT considered for the denominator definition.

Category: the name of the clinical performance group, for example, Breast.

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

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

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

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

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

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

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

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

6.2 Reminders Tab Toolbar

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

Section 19.2 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 19.11 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 and Refresh options; these perform like the buttons 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: this options operate like those for the buttons on the right-side of the window. Section 19.2 provides information about these buttons.

User Preferences: this option takes you to the User Preferences window where you can change your user preferences.

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

7.0 BP Prompts Tab

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

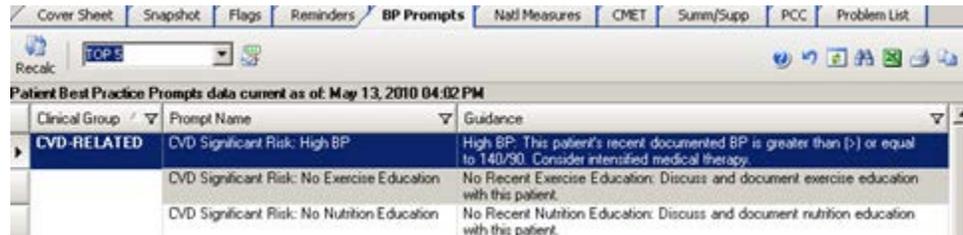


Figure 7-1: Sample BP Prompts tab

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 your 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 drop-down 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 19.2 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 19.11 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 displays the patient's GPRA performance status (based on the CRS national summary report).

Category	Clinical Group	Measure Name	Performance Status	Adherence Value
Non National	CVD-Related	23+ LDL <=100	NO	CHOL 03/15/10 224.LDL 03/15/10 1!
		23+ LDL >160	NO	CHOL 03/15/10 224.LDL 03/15/10 1!
		23+ LDL 101-130	NO	CHOL 03/15/10 224.LDL 03/15/10 1!
		23+ LDL 131-160	YES	CHOL 03/15/10 224.LDL 03/15/10 1!
		23+ LDL Assessed	YES	CHOL 03/15/10 224.LDL 03/15/10 1!
		Obese Pts 6+ Medical Nutrition Counseling	NO	
		Overweight Pts 6+ Medical Nutrition Counseling	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 you hover the mouse over the name.

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

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

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

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

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

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

8.2 Natl Measures Tab Toolbar

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

Section 19.2 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 19.11 provides information about this pop-up.

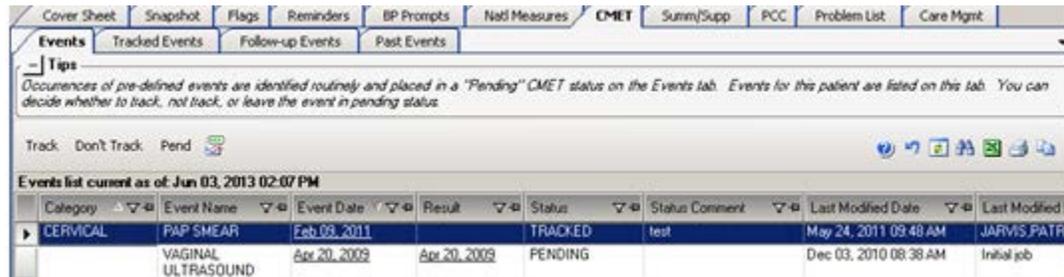
8.3 Natl Measures Tab Menus

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 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."



The screenshot shows the CMET tab interface with a table of events. The table has columns for Category, Event Name, Event Date, Result, Status, Status Comment, Last Modified Date, and Last Modified By. The data is as follows:

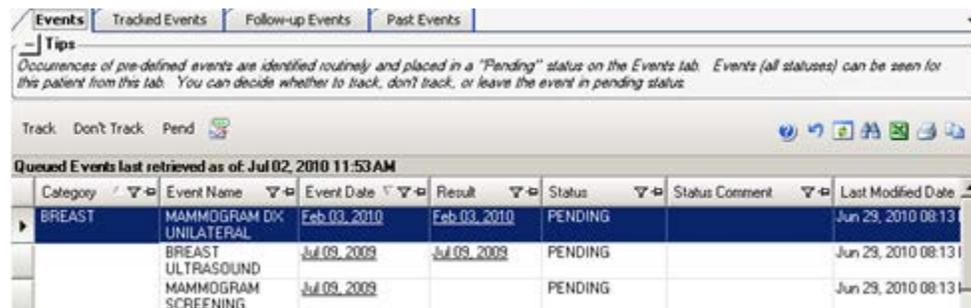
Category	Event Name	Event Date	Result	Status	Status Comment	Last Modified Date	Last Modified By
CERVICAL	PAP SMEAR	Feb 03, 2011		TRACKED	test	May 24, 2011 09:48 AM	JARVIS.PATR
	VAGINAL ULTRASOUND	Apr 20, 2009	Apr 20, 2009	PENDING		Dec 03, 2010 08:38 AM	Initial job

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. Events are procedures, screenings and/or exams that have been pre-defined and categorized into Breast, Cervical, Colon, and Skeletal.



The screenshot shows the Events sub-tab interface with a table of queued events. The table has columns for Category, Event Name, Event Date, Result, Status, Status Comment, and Last Modified Date. The data is as follows:

Category	Event Name	Event Date	Result	Status	Status Comment	Last Modified Date
BREAST	MAMMOGRAM DX UNILATERAL	Feb 03, 2010	Feb 03, 2010	PENDING		Jun 29, 2010 08:13
	BREAST ULTRASOUND	Jul 09, 2009	Jul 09, 2009	PENDING		Jun 29, 2010 08:13
	MAMMOGRAM SCREENING	Jul 09, 2009		PENDING		Jun 29, 2010 08:13

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. You can collapse this area in order 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 19.6 provides information about using the controls on the pop-up.

Result: the date of the result. Double-click the underlined date to access a particular 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 not tracked, pending, tracked.

Status Comment: any comments about the status.

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

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

9.1.2 Events Sub-Tab Toolbar

Section 19.2 provides information about to use the buttons on the right side of the toolbar.

Click the Background Jobs () button (or select **File | Background Jobs**) to display the **Background Jobs** pop-up. Section 19.11 provides information about this pop-up.

You can decide whether 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 particular event was changed to Tracked and that is not correct, you need to go to the Tracked tab, then access the CMET worksheet for the event you tracked in error.

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

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

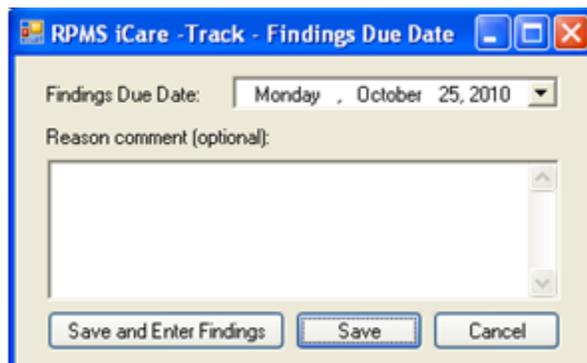


Figure 9-3: Sample RPMS iCare - Track - Findings Due Date dialog

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

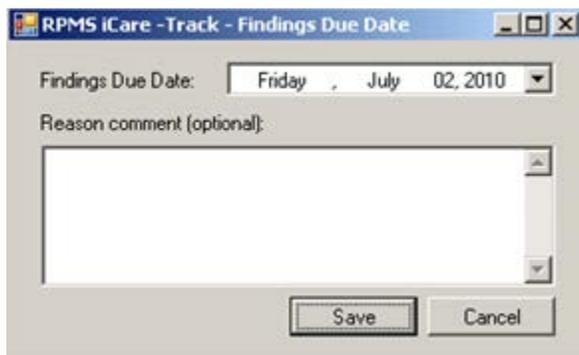


Figure 9-4: Sample RPMS iCare - Track - Findings Due Date dialog for multiple events

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

If you use the “Save and Enter Findings” button for a single event, the application displays the CMET Worksheet (where you can add Findings to the event, for example). Section 19.10 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 you select Tracked events and they are not eligible for the Not Tracked function, the application displays the message: Once an event has been Tracked, it cannot be changed to Not Tracked. See the User Manual guidance on how to manage an event that was tracked. Click **OK** to dismiss the message. If the selected Tracked event was erroneously tracked in error, section 19.15 provides information about how to handle this error.

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

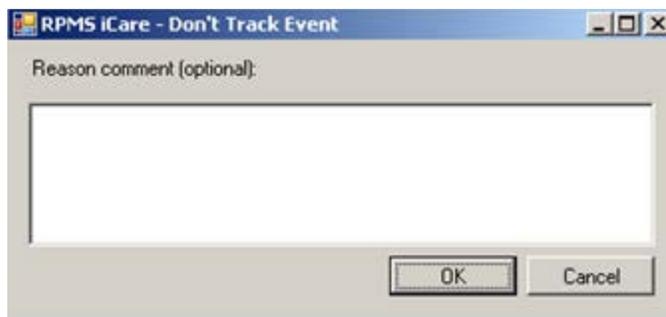


Figure 9-5: Sample RPMS iCare – Don't Track Event dialog

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

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

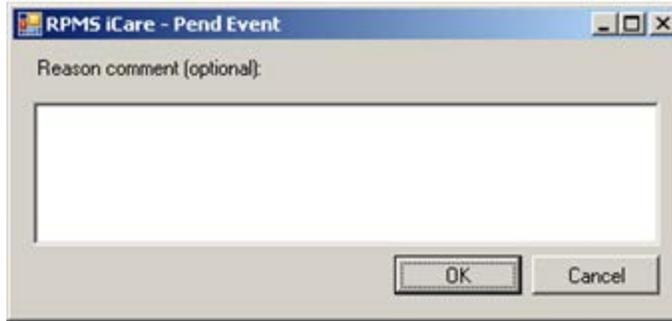


Figure 9-6: Sample RPMS iCare – Pend Event dialog

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**.)

9.2 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.

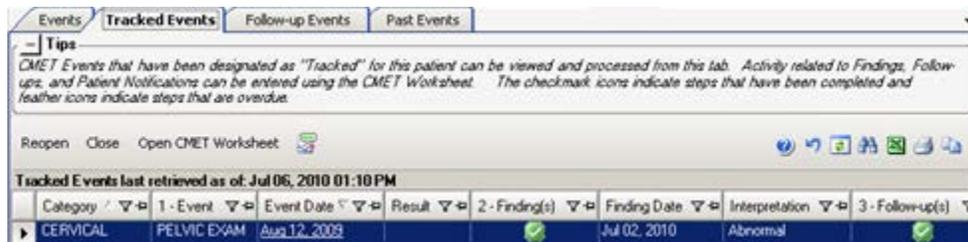


Figure 9-7: Sample Tracked Events sub-tab

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

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

9.2.1 Tracked Events Sub-Tab Layout

The following table provides information about the columns on the Tracked Events sub-tab.

Column Name	Meaning
Category	The name of the category for the tracked event: Breast, Cervical, Colon, Skeletal, STI.
1 - Event	The name of the event. Events are procedures, exams, or tests that have been documented in RPMS. Events are predefined.
Event Date	The date the event was performed.

Column Name	Meaning
Result	The date the result was entered. Hover help will describe where the result came from (V-RADIOLOGY, V-LAB).
2 - Finding(s)	Icon that indicates if the event has any 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 19.10 provides information about the worksheet.

9.2.2 Tracked Events Sub-Tab Toolbar

Section 19.2 provides information about the buttons on the right side of the toolbar.

Click the Background Jobs (🖨️) button (or select **File | Background Jobs**) to display the **Background Jobs** pop-up. Section 19.11 provides information about this pop-up.

9.2.2.1 Reopen

Use the Reopen function 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 9-8: RPMS iCare – Reopen Tracked Event dialog

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

If you select more than one event and use the Reopen function, the application displays 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.

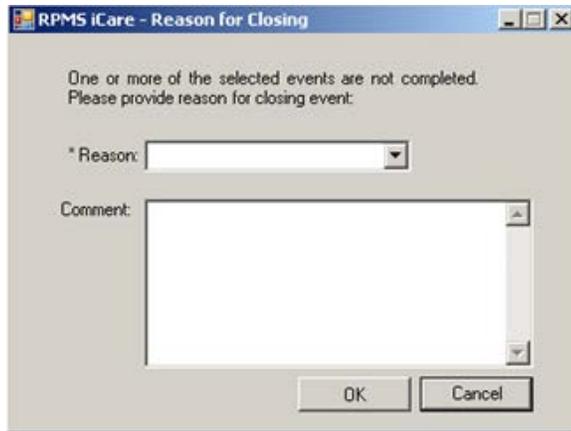


Figure 9-9: RPMS iCare – Reason for Closing dialog

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

Reason: select an option from the drop-down 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 you can enter Finding(s), Follow-up(s), and Patient Notification(s) for the patient. Section 19.10 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 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
SKELETAL	OSTEOPOROSIS SCREENING - QUANTITATIVE CT	Feb 28, 2011	No	Mar 17, 2010
BREAST	MAMMOGRAM SCREENING	Aug 06, 2010	No	Aug 06, 2009
CERVICAL	PAP SMEAR	Apr 29, 2010	No	Apr 29, 2008

Figure 9-10: Sample Follow-up Events sub-tab

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

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

Category: the category of the follow-up event.

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

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

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

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

Double-click any record to access the CMET Worksheet. Section 19.10 provides information about the worksheet.

9.3.1 Follow-up Events Sub-Tab Toolbar

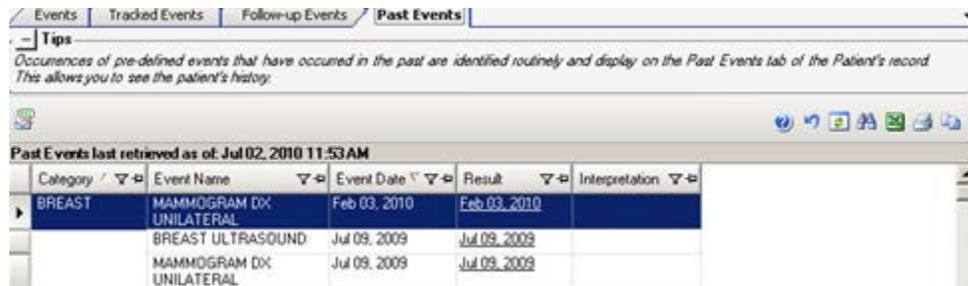
Section 19.2 provides information about the buttons on the right side of the toolbar.

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 19.10 provides information about the worksheet.

Click the Background Jobs () button (or select **File | Background Jobs**) to display the **Background Jobs** pop-up. Section 19.11 provides information about this pop-up.

9.4 Past Events Sub-Tab

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



Past Events last retrieved as of: Jul 02, 2010 11:53AM

Category	Event Name	Event Date	Result	Interpretation
BREAST	MAMMOGRAM DX: UNILATERAL	Feb 03, 2010	<u>Feb 03, 2010</u>	
	BREAST ULTRASOUND	Jul 09, 2009	<u>Jul 09, 2009</u>	
	MAMMOGRAM DX: UNILATERAL	Jul 09, 2009	<u>Jul 09, 2009</u>	

Figure 9-11: Sample Past Events sub-tab

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

The Tips information provides an overview of the Past Events sub-tab. You can collapse this area in order 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 particular 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 19.2 provides information about the buttons on the right side of the toolbar.

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

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

This displays the **RPMS iCare - Background Jobs** pop-up. Section 19.11 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 displays a selected type of report (shown in the Type field): Asthma Action Plan, Face Sheet, Health Summary, Patient Wellness Summary, Supplement. These reports are from RPMS.

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

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

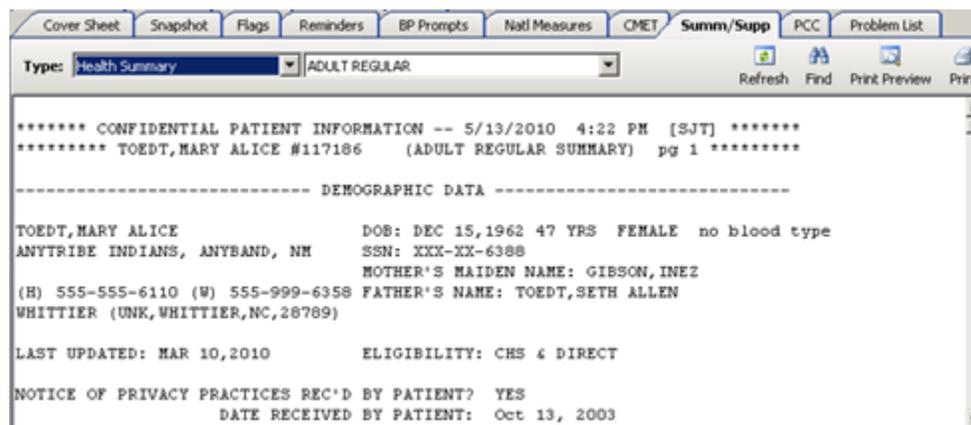


Figure 10-1: Sample Summ/Supp tab

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

10.1 Summ/Supp Tab Toolbar

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

- Asthma Action Plan
- Face Sheet
- Health Summary – 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 have to use Refresh in order 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 19.12 provides information about the Print Preview dialog.

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

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 your keyboard.

Refresh: this option when you select a second HS type, and then return to the initial HS, you have to Refresh in order to display updated data, e.g., after entering PCC data. This is the same as pressing the F5 key on your keyboard or clicking the Refresh button.

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

User Preferences: this option takes you to the **User Preferences** window where you can change your user preferences.

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

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

Date	Health Factor Category	Health Factor	Level/Severity	Quantity	Provider	Comments
Mar 05, 2010	TOBACCO (SMOKELESS - CHEWING/DIP)	NEVER USED SMOKELESS TOBACCO				
	TOBACCO (SMOKING)	NEVER SMOKED				
	TOBACCO (SMOKING)	NON-TOBACCO USER				

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 drop-down list.

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

The Tips information provides an overview of the PCC tab. You can collapse this area in order 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, Continence, 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, you are limited to lab tests only (you are not allowed entry of lab panels because panels have no result since they are comprised of multiple individual tests with associated results). You can filter Lab data by “Related to” (currently HIV register-related).

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

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

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

The **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; you can select different predefined date ranges (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 you can select for other data types.

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

Section 19.2 provides information about using the buttons on the right side of the window.

11.2.1 Add Event

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

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

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

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

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

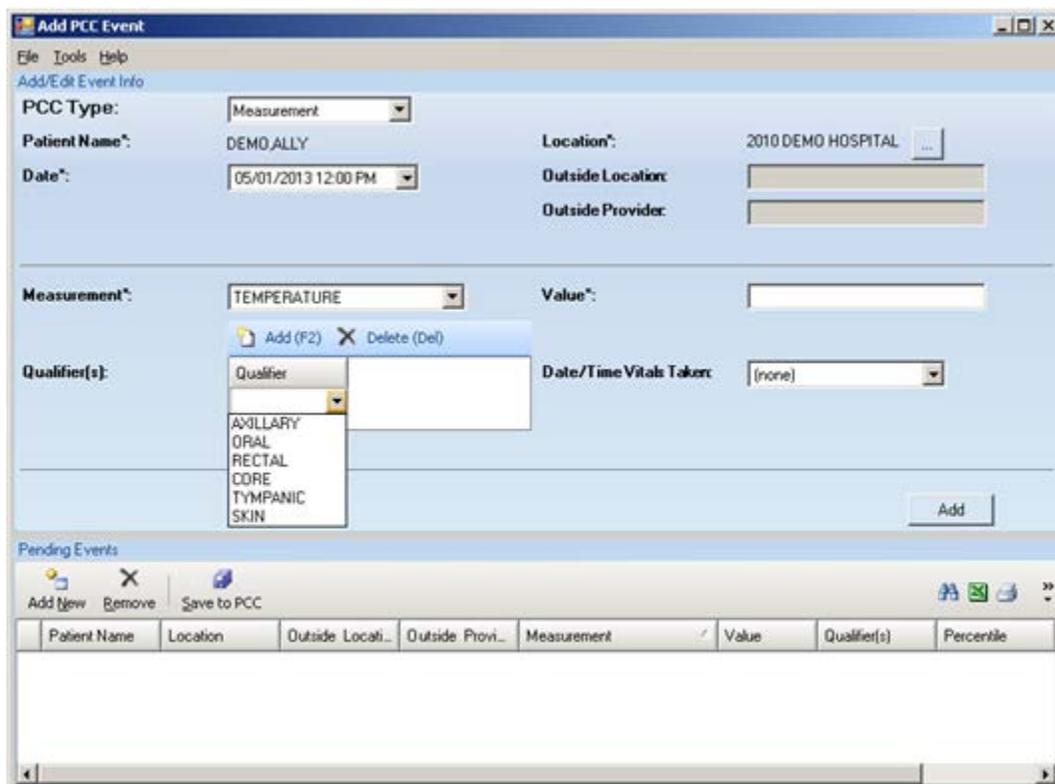


Figure 11-2: Sample Add PCC Event

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

When you click a ellipsis button by a field, the **Table Lookup** dialog displays. Section 19.14 provides information about how to use this dialog.

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

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

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. You can change this by clicking the ellipsis button to search for a location name. If the Location field is populated with OTHER, then the Outside Location and Outside Provider Name fields become active; here you type in each Free Text field to populate it.

The fields in this group box vary by the PCC Type. You need to populate any field 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 qualifies of auxiliary, oral, rectal, core, tympanic, skin.

11.2.1.2 Pending Events Group Box

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

Section 19.2 provides information about how to use the buttons on the right side of the toolbar of the Pending Events area. These same functions can be found on the Tools menu of the Add PCC Event window.

If you double-click a record in **Pending** events group box, the **Visit Detail** pop-up will display. Section 19.6 provides information about the using the controls on the pop-up.

Add New

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

You need to populate the appropriate fields for the selected PCC Type. When all fields are complete, click **Add**. This action adds a new record to the **Pending Events** area.

Edit a Record

Double-click a record in the **Pending Events** area to cause the existing record data to populate the fields in the **Add/Edit Event** Info group box.

You can change the fields, as needed. When all fields are complete, click the **Apply Changes** button. This changes the record in the **Pending Events** group box.

Remove

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

Save to PCC

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

After you exit the information message, the application updates the PCC tab on the Patient Record window and displays the “Add Chart Review?” information message 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 you use **OK**, the application displays the **Add a Note** dialog. Section 19.4 provides information about this dialog.

Please note that for each type of added event, you will be need to save. When you try to enter 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 you have your electronic signature on file.



Click the **Add a Note** ( **Add a Note**) button (or select **PCC | Add a Note**) to access the **Add a Note** dialog. Use this dialog to add a new chart review, follow-up letter, or telephone call note for the patient. Section 19.4 provides information about this dialog.

11.2.3 Related To

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

11.2.4 Graph It Button



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

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

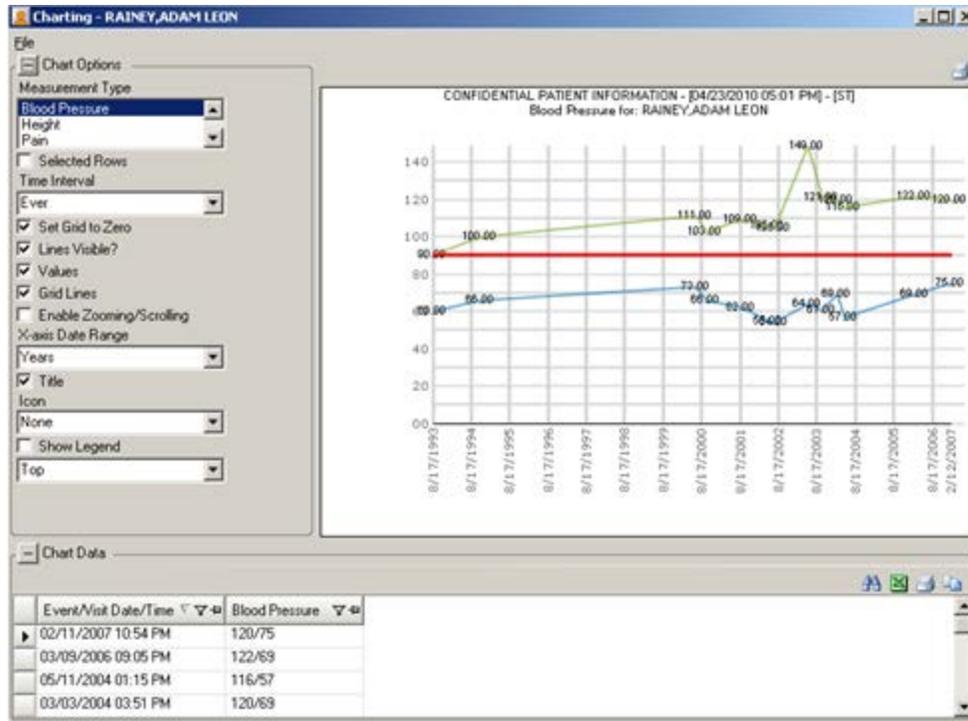


Figure 11-3: Sample Charting window

Section 19.13 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 below.



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 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
Dx3	CHRONIC	POSTHERPETIC NEURALGIA		053.19 - H ZOSTER NERV SYST NEC			Jul 20, 1999
DH14	CHRONIC	Secondary Hyperparathyroidism (of Renal Origin)		598.81 - SEC HYPERPARATHYROID -RENAL	DH14C1 APR 24, 2007 Intact PTH 77 1/2007		Jun 04, 2007
DH18	CHRONIC	R EYE LASER 2NDARY RETINOPATHY 4/4/02 L EYE LASER 2NDARY		362.02 - PROLIF DIAB RETINOPATHY			Apr 24, 2007

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 ICD code for the problem.

Date of Onset: the date the symptoms started.

DX Code: the ICD code for the problem.

Problem Notes: any notes entered about the problem.

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

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

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

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

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

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

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

12.2 Problem List Tab Toolbar

Section 19.2 provides information about the buttons on the right side of the toolbar.

12.2.1 No Active Problems

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

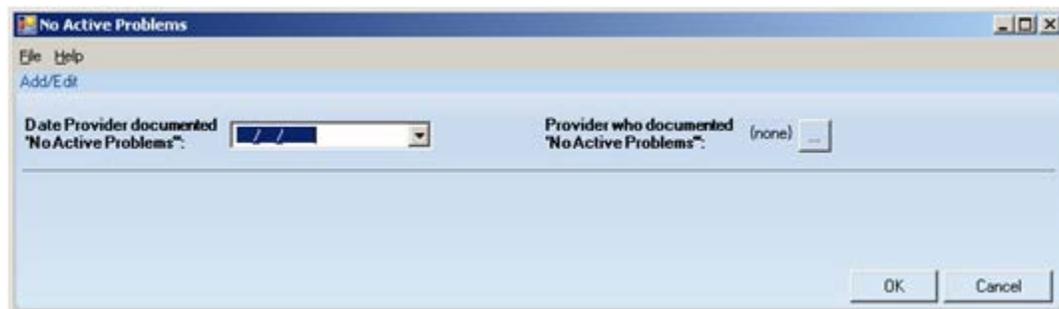


Figure 12-3: No Active Problems dialog

Both fields are required.

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

Provider who documented “No Active Problems”: click the ellipsis button to access the Table Lookup dialog. Here you search for a name and select one from the retrieved records to populate the field. Section 19.14 provides information about using the Table Lookup dialog.

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

After clicking **OK**, the application displays the Confirm save to RPMS information message 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, showing a message that there is 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 to access the **Problem List Reviewed** dialog.

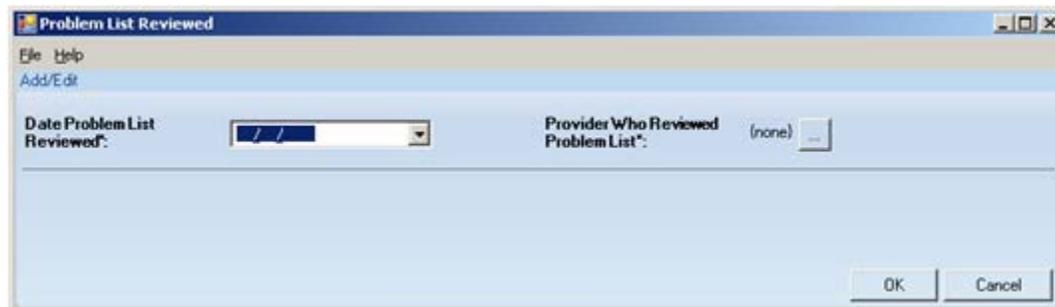


Figure 12-5: Problem List Reviewed dialog

Both fields are required.

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

Provider Who Reviewed Problem List: click the ellipsis button to access the **Table Lookup** dialog where you search for a provider name. This is the provider who reviewed the problem list. Section 19.14 provides information about using the Table Lookup dialog.

When the dialog is complete, click **OK** (otherwise, click **Cancel**). After clicking **OK**, the application displays the Save to RPMS? information message 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: 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. You must select an option from the “Please Select a Group” field in order 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, Diabetes, Immunizations, Employee Health, COPD

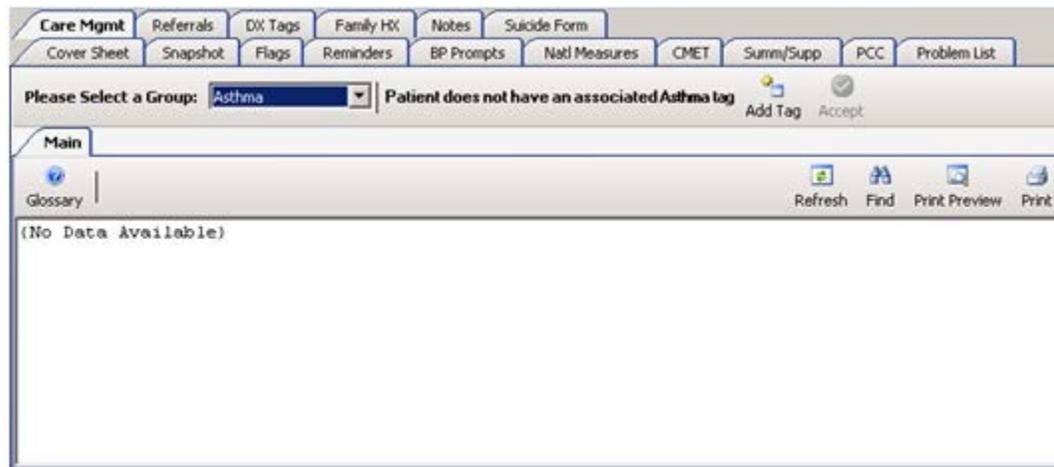


Figure 13-1: Sample Care Management tab for patient with No Tags for Asthma

The Care Management toolbar displays information that the patient does not have an associated Asthma, Diabetes, Immunizations, Employee Health, or COPD tag.

- 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

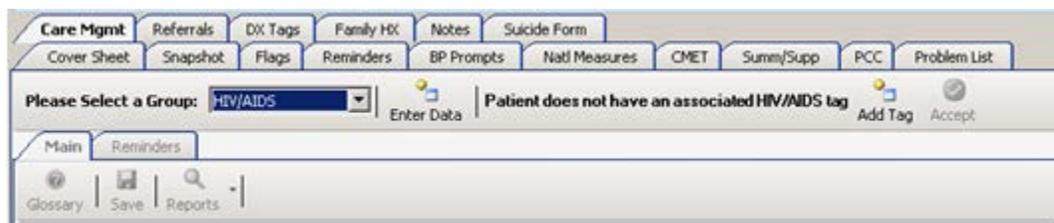


Figure 13-2: Sample Care Management tab for patient with No Tags for HIV/AIDS

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. 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 that did not meet the tag's criteria for being proposed automatically.

Note: If you are adding the Asthma diagnostic tag, the Diagnostic Tag field will be Asthma.

13.1.2.1 Fields

New Status: the status of the tag being changed.

ACCEPTED: this option allows you to “Accept” a proposed tag to provide an affirmation of its validity for a given patient.

NOT ACCEPT: this option allows you to disapprove or “Not Accept” a diagnostic tag that has been proposed for a patient.

PROPOSED: this option allows you to change the status of a diagnosis tag back to “Proposed” so that further review can take place.

Reason: select the appropriate 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 you manually designate the tag.
- Other - use this when the other reasons do not fit. You must populate the Status Comment field to provide the text of the reason.

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

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

13.1.2.2 View Tab Activity Button

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

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

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

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

You must dismiss the pop-up.

13.1.3 Accept Button

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

Section 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.

The screenshot shows a software window titled "Please Select a Group: HIV/AIDS" with a status message "Patient does not have an associated HIV/AIDS tag". The window has two tabs: "Main" (selected) and "Reminders". Below the tabs is a toolbar with "Glossary", "Save", and "Reports" buttons. The main content area is titled "General" and contains the following fields:

- Register Status: ACTIVE
- HMS Diagnosis Category: <Proposed = AT RISK - EXPOSED SOURCE UNKNOWN> (AT RISK - EXPOSED SOURCE UNKNOWN)
- Initial HIV DX Date: (none)
- CDC Cause (Etiology):
- CDC Clinical Classification:
- HIV Provider: (none)
- Where Followed: (none)
- Register Status Comments:
- Diagnosis Comments:
- Initial AIDS DX Date: (none)
- Etiology Comments:
- HIV Case Manager: (none)
- Outside Location:
- Outside Provider:

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

Note: Only the Main sub-tab displays for Diabetes, Immunizations, Employee Health, and COPD.

13.2.1 Accept

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

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



Figure 13-6: Sample Update Diagnosis Tag Dialog

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

You can edit the following fields:

New Status: the status of the tag being changed.

ACCEPTED: this option allows you to “Accept” a proposed tag to provide an affirmation of its validity for a given patient.

NOT ACCEPT: this option allows you to disapprove or “Not Accept” a diagnostic tag that has been proposed for a patient.

PROPOSED: this option allows you to change the status of a diagnosis tag back to “Proposed” so that further review can take place. In certain cases, this option might not be available.

Reason: click the appropriate 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 you manually designate the tag.

- Other - use this when the other reasons do not fit. You must populate the Other field to provide the text of the reason.

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

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

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

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

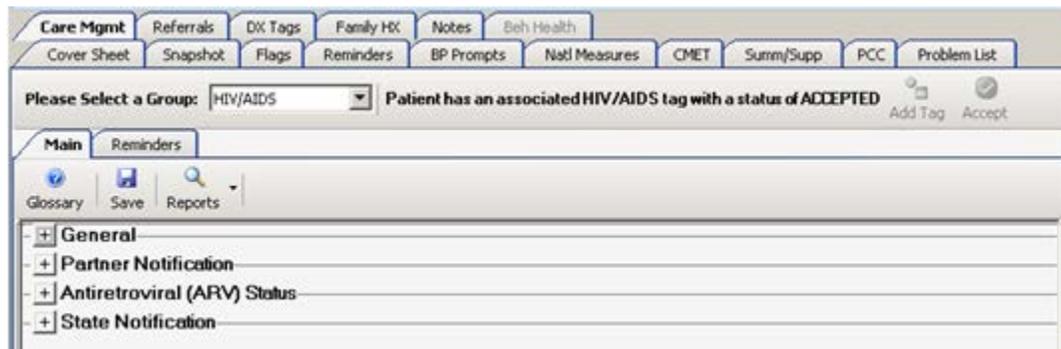


Figure 13-7: Sample Care Management tab after clicking Enter Data

You need to expand any category (listed below the toolbar buttons) that you want to change. After completing your changes, use the Save button to save your changes. Section 13.3.4 provides information about the Save process.

Many of the drop-down lists (for fields) contain a “blank” option that you use when you want the particular field to have no data. Usually the “blank” option is the first one on the drop-down list.

Note: Only the Main sub-tab displays for Diabetes, Immunizations, Employee Health, and COPD.

13.3.1 General

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

Figure 13-8: Fields for the General group box

All fields with an asterisk (*) are required.

Register Status: select an option from the drop-down 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 drop-down 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 drop-down list for this field. You can enter a month and year only; in this case the entry will be stored in BKM as MM-01-YYYY. This field is active only when you have populated the HMS Diagnosis Category field with HIV.

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

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

Note: A proposed date might be displayed, based on the AIDS logic defined above in the HMS Diagnosis Category field. You must enter the actual date even if you want to “accept” the proposed date.

CDC Cause (Etiology): select an option from the drop-down list that indicates the cause (etiology) of the patient’s DX. The Centers for Disease Control has categorized the ways in which an individual is exposed to HIV.

Etiology Comments: type comments about the CDC Cause selection in this Free Text field (limited to 50 characters). (This field is active only when the CDC Cause (Etiology) field is populated.) A comment should always be entered if you select “OTH - Other” in the CDC Cause field.

CDC Clinical Classification: this field is active when the HMS Diagnosis Category contains AIDS or HIV. Select the clinical classification from the drop-down list.

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

The HIV Provider, HIV Case Manager, and Where Followed fields are populated by using the Table Lookup dialog. Section 19.14 provides more information about using this dialog.

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

HIV Case Manager: click the ellipsis button to search for a case manager name at your facility. This information is pulled from the RPMS Designated Specialty Provider Management (DSPM) application, if available, and displayed here.

Where Followed: click the ellipsis button to search for name of a facility that primarily follows the patient's care related to HIV/AIDS. If this is not your facility, select OTHER from the list; you can identify the specific facility in the outside location field and the provider in the Outside Provider field.

Outside Location: manually type the name of the facility or outside physician's office where the patient is followed. This is 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: 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 drop-down list that indicates the partner notification status.

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

13.3.2.1 Antiretroviral (ARV) Status

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

Use this group box to enter ARV (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, 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 drop-down list from which to select or a Free Text field where you enter information. Data can be entered at any time and can be done so retrospectively.

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

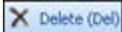
Status: Select an option from the drop-down list that indicates the status of the ARV Appropriate record.

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

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

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

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

For **ARV Appropriate**, you can delete your own selected records by clicking the **Delete** () 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 drop-down list from which to select or a Free Text field where you enter information.

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

Adherent: Select an option from the drop-down list that indicates the adherent status of the record.

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

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

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

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

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

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

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

Stability: Select an option from the drop-down list that indicates the stability status of the record.

ARV Regimen: Click the drop-down list and select one of the options: Changed, Unchanged.

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

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

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

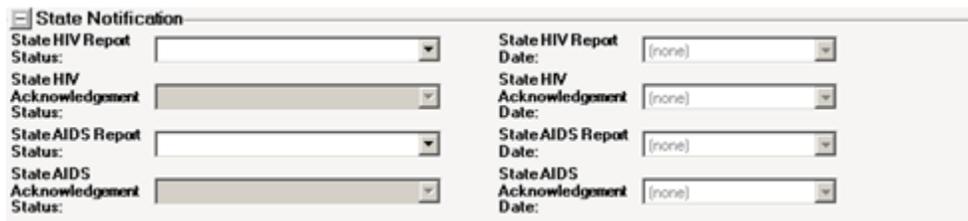
After you click **Save**, iCare confirms that you want to add the record. After clicking Yes, iCare populates the Last Edited By field (name of user who populated the record) and today's date in the Last Edited Date.

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

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:



The screenshot shows a 'State Notification' group box with the following fields:

Field Name	Field Type	Current Value
State HIV Report Status	Drop-down	(empty)
State HIV Report Date	Drop-down	(none)
State HIV Acknowledgment Status	Drop-down	(empty)
State HIV Acknowledgment Date	Drop-down	(none)
State AIDS Report Status	Drop-down	(empty)
State AIDS Report Date	Drop-down	(none)
State AIDS Acknowledgment Status	Drop-down	(empty)
State AIDS Acknowledgment Date	Drop-down	(none)

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 drop-down 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. You can select from a calendar by using the drop-down 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 drop-down 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. You can select from a calendar by using the drop-down 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 drop-down 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. You can select from a calendar by using the drop-down 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 drop-down list: No, Unknown, Yes. This answers the question: Has your facility received acknowledgement from the state's health department? NOTE: Most sites report that they do not receive this acknowledgment.

State AIDS Acknowledgment Date: This field is active if the State AIDS Acknowledgment Status field contains Yes. You can select from a calendar by using the drop-down list. This is the date the state acknowledged receipt of AIDS report

13.3.4 Save Button

You 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 you are 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 you click **Yes**. What displays after you click **Yes** depends upon if there is a tag status or not.

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



Figure 13-12: Message About Changing Status

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

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

If you click **Cancel**, the system asks if you want to cancel the entire Save process. If you click **Yes**, you exit the save process. If you click **No**, the application displays a message that ask: 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 drop-down list for the **Reports** button (or select **Care Mngt | Main | Reports**) to access any of the following reports:

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

13.3.6 Glossary Button

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

Section 19.6 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 Diabetes, Immunizations, Employee Health, and COPD.

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

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

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

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

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

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

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

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

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

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.

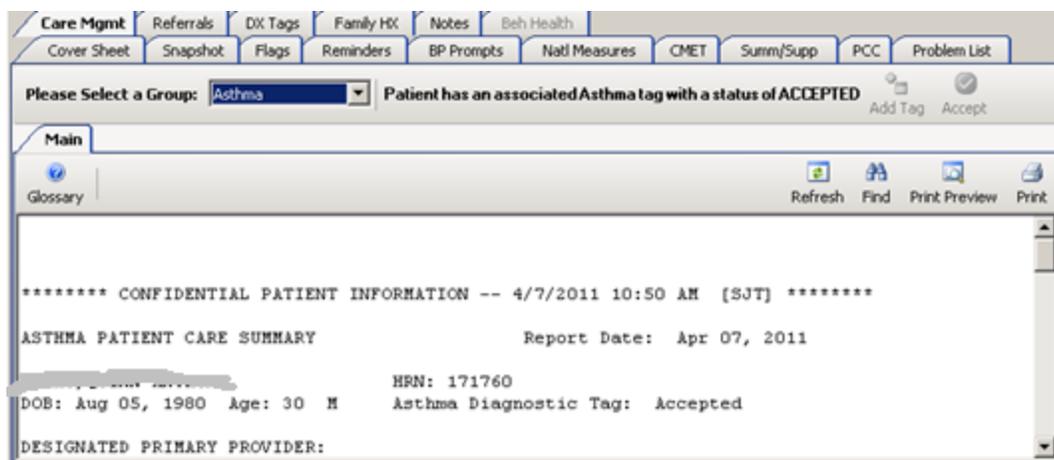


Figure 13-14: Sample Patient with Asthma tag

The Main sub-tab displays the existing Asthma Patient Care Summary (Supplement) report. Section 19.6 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):

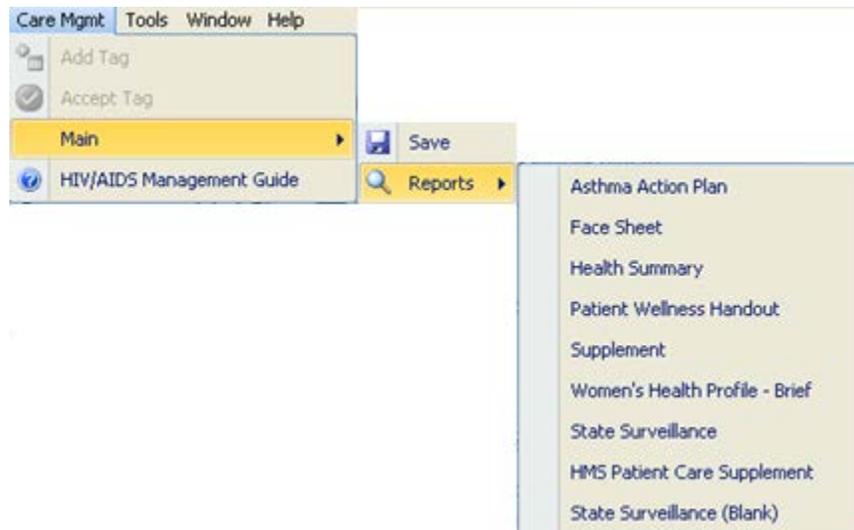


Figure 13-15: Care Mgmt menu options for HIV/AIDS

Save: this option does the same things as the Save button on the Main sub-tab.

Reports: this option lists the available report on the Main sub-tab.

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

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

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

13.5.3.2 Reminders Sub-Tab

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



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 display if you are 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 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
Apr 05, 2007	STUDENT, RONALD J	ADENOSINE NUCLEAR STRESS TEST 2 DAY	ASHEVILLE CARDIOLOGY ASSOCS	Apr 20, 2007		CHS
	STUDENT, RONALD J	STAGE 4 CKD	MTN KIDNEY ASSOCS PA	Apr 18, 2007		CHS
Nov 13, 2006	MPROVIDER, MONICA M	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 (Referred Care Information System). You can review the user manual at the following URL:

<http://www.ihc.gov/Cio/RPMS/index.cfm?module=home&option=documentschoice>

Select “Referred Care Information System” from the drop-down list. On the next page, select the User Manual.

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

The following table provides information about the fields.

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.

Field	Meaning
Referral Type	The type of referral that was made. This can be any of the following: IHS - a referral to another IHS facility CHS - a referral to an outside facility that will be paid for with CHS funds In-house - a referral to another clinical area within the facility Other - any other type of referral that will be paid with funds other than CHS (such as Medicaid or private insurance)
Patient Type	This is either inpatient or outpatient.

14.2 Referrals Tab Toolbar Options

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

Section 19.2 provides information about the buttons on the right side of the toolbar.

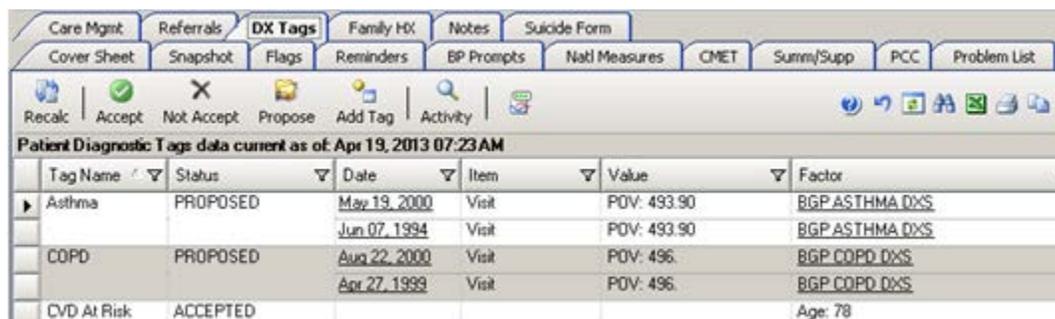
14.3 Referrals Tab Menus

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 DX Tags Tab

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



Tag Name	Status	Date	Item	Value	Factor
Asthma	PROPOSED	<u>May 19, 2000</u>	Visit	POV: 493.90	BGP ASTHMA DXS
Asthma	PROPOSED	<u>Jun 07, 1994</u>	Visit	POV: 493.90	BGP ASTHMA DXS
COPD	PROPOSED	<u>Aug 22, 2000</u>	Visit	POV: 496	BGP COPD DXS
COPD	PROPOSED	<u>Apr 27, 1999</u>	Visit	POV: 496	BGP COPD DXS
CVD At Risk	ACCEPTED				Age: 79

Figure 15-1: Sample DX Tags tab

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

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

15.1 DX Tags Tab Layout

The data columns are described below.

Column	Meaning
Tag Name	The diagnostic tab name. You can view the tooltip by hovering your mouse over this column (shows the definition of the tag).
Status	The status of the tag. You can view the tooltip by hovering your mouse over this column. ACCEPTED: 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 19.8 provides information about this window.

15.2 DX Tags Tab Toolbar

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

Section 19.2 provides information about the buttons on the right side of the toolbar.

15.2.1 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.

15.2.2 Change the Tag Status

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

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

15.2.3 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 that did not meet the tag's criteria for being proposed automatically. Section 13.1.2 provides information about this dialog.

15.2.4 Activity

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

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

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

15.2.5 Background Jobs

Click the Background Jobs () button to display the **Background Jobs** pop-up. Section 19.11 provides information about this pop-up.

15.3 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.

16.0 Family HX Tab

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

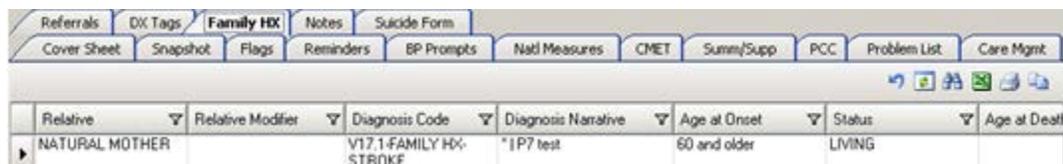


Figure 16-1: Sample Family HX tab

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

16.1 Family HX Tab Layout

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

The following table provides a description of the fields.

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.
Last Date Modified	This displays the date the record was modified (system populated).

16.2 Family HX Tab Toolbar

Section 19.2 provides information about the buttons on the right side of the toolbar.

16.3 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.

17.0 Notes Tab

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

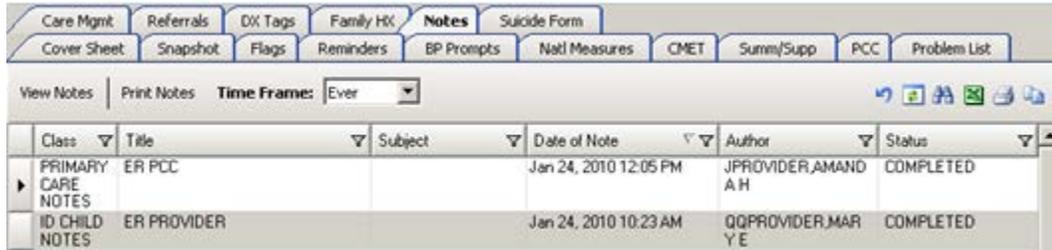


Figure 17-1: Sample Notes tab

17.1 Notes Tab Layout

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

The following table provides information about the fields.

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

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

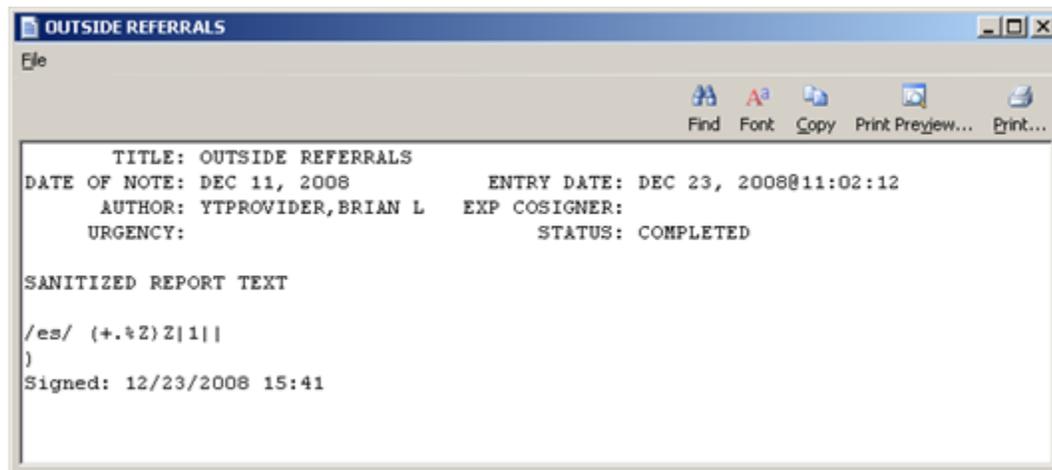


Figure 17-2: Sample Note pop-up

Section 19.6 provides information about using the controls on the pop-up.

17.2 Notes Tab Toolbar

Section 19.2 provides information about the buttons on the right side of the toolbar.

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

17.2.1 View Notes

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

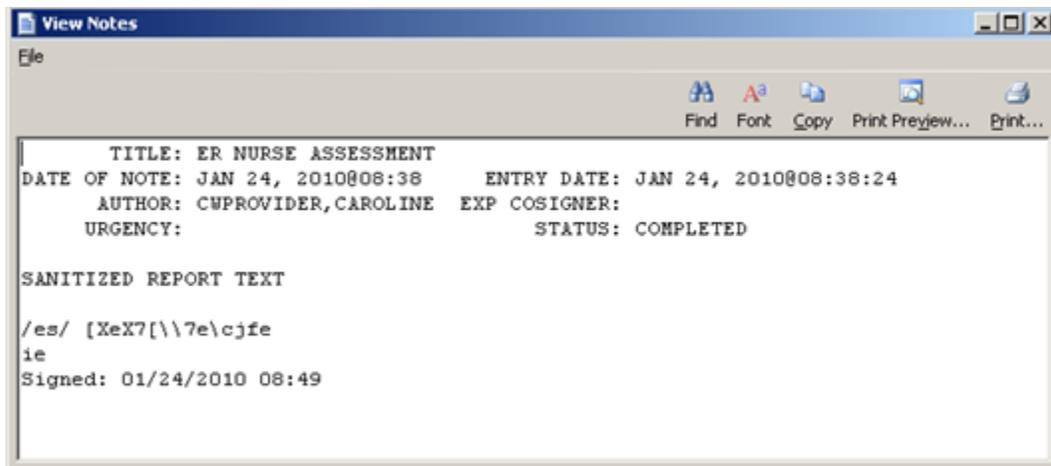


Figure 17-3: Sample View Notes pop-up

Section 19.6 provides information about using the controls on the pop-up.

17.2.2 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 19.12 provides information about this dialog.

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

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

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

17.3 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.

18.0 Suicide Form Tab

The Suicide Form tab 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	ATT'D SUICIDE W/ ATT'D HOMICIDE	HANGING	GARCIA,RYAN	Apr 15, 2011	GARCIA,RYAN	Apr 15, 2011

Figure 18-1: 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.

```

***** 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 18-2: Sample Suicide Form Detail pop-up

Besides the patient demographic information, this pop-up displays data in the fields on the SRF. Section 19.6 provides information about using the controls on the pop-up.

18.1 Suicide Form Tab Layout

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

Date of Act: The date of the suicide act.

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

Method: The method used in the suicide act.

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

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

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

18.2 Suicide Form Tab Toolbar

Section 19.2 provides information about the buttons on the right side of the toolbar.

18.3 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.

19.0 iCare Features Used by Patient Record

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

19.1 User Preferences

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

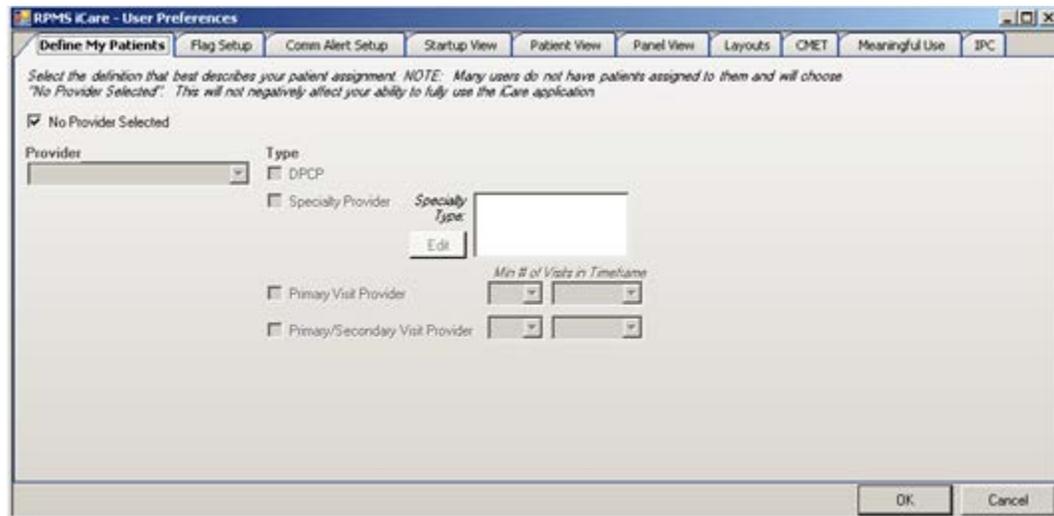


Figure 19-1: Sample User Preferences window

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

Patient View Tab

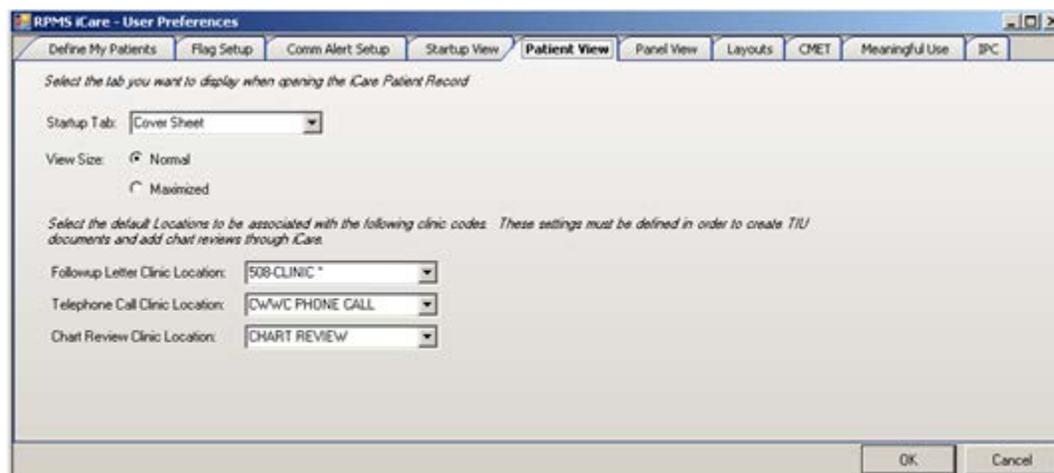


Figure 19-2: Sample Patient View tab

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

Startup Tab: The default tab is the Cover Sheet as the startup tab for the Patient Record window. If you want to change to a different tab, select one from the drop-down list (lists the primary tabs that are on the patient view window).

View Set: 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 you use the “Add a Note” button on the Patient Record window.

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

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

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

19.2 Buttons on Right Side of Window

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



Figure 19-3: Buttons on right side of window

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

The application provides hover help for each button.

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

19.2.1 Reset View

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

19.2.2 Refresh

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

19.2.3 Search

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

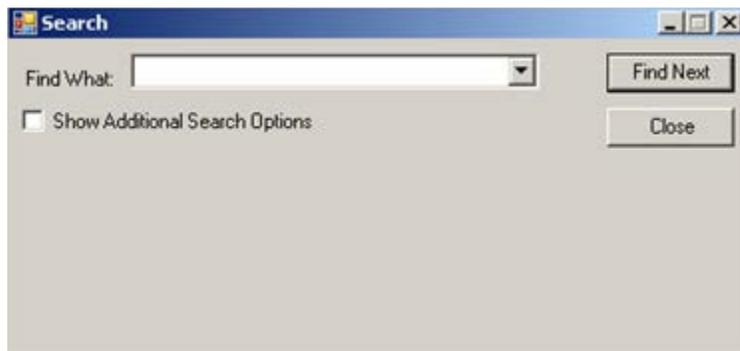


Figure 19-4: Search dialog

If you **DO NOT** select the **Show Additional Search Options** checkbox, the search looks in all columns for a match.

If you select the **Show Additional Search Options** checkbox, the Search dialog changes to show more options for the search.

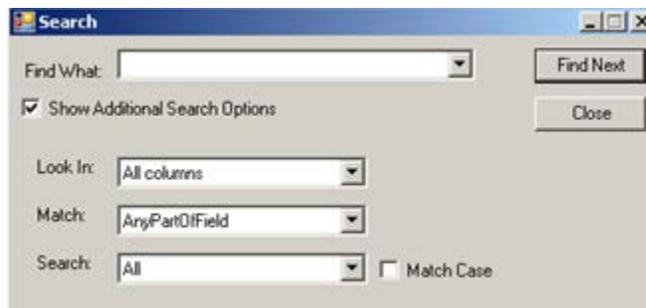


Figure 19-5: Search dialog with additional search options

Type what you want to search for in the “Find What” Free Text field. The remaining fields determine the criteria for the search.

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

19.2.3.1 Look In Field

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

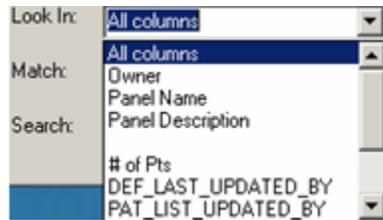


Figure 19-6: Sample drop-down list options for Look In field

What you have 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 drop-down list.

19.2.3.2 Match Field

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



Figure 19-7: Sample drop-down list options for Match field

19.2.3.3 Search Field

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



Figure 19-8: Sample drop-down 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). If you want to continue the same search, click the **Find Next** button again; repeat this process as needed.

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



Figure 19-9: Sample Datagrid Search Results

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

19.2.4 Export to Excel

You can export the information in the window to Excel by clicking the Export to Excel () button (or by selecting **Tools** | **Export to Excel** or by using the Ctrl+E key combination).

The application displays the warning message about the export.

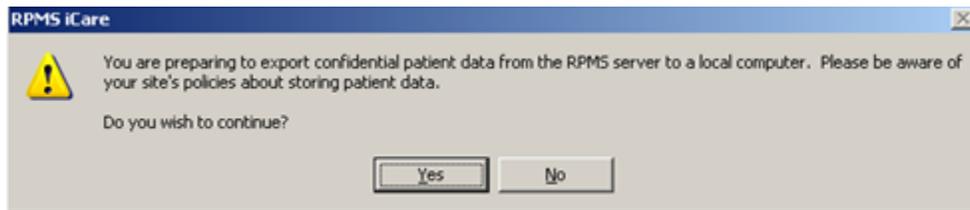


Figure 19-10: Warning message about exporting the patient data

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.

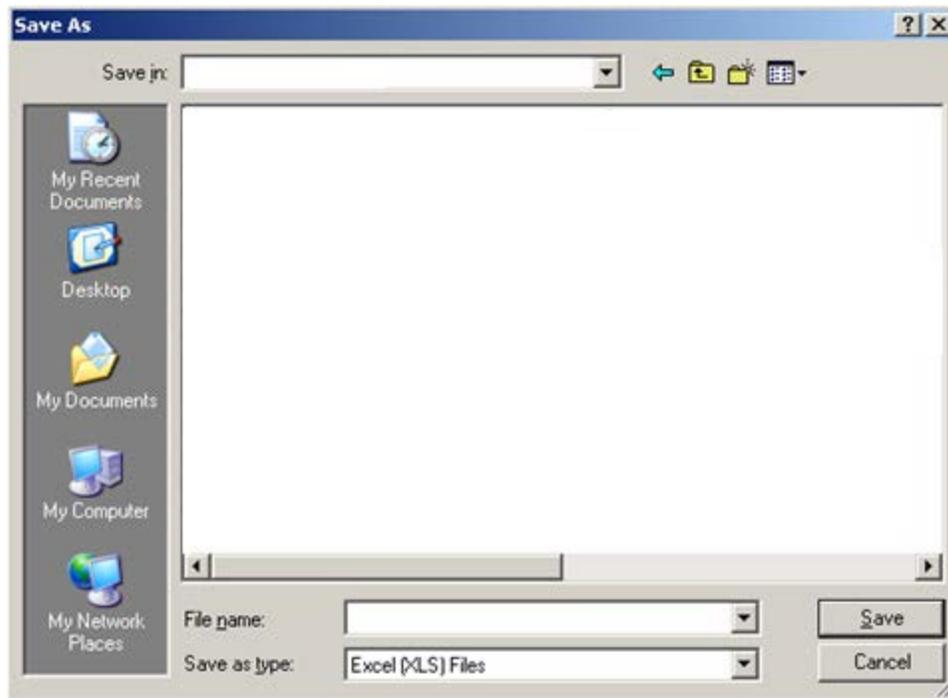


Figure 19-11: Sample Save As dialog

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

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

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

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

19.2.5 Print

You can print the selected rows in the grid by clicking the Print() button (or by selecting **Tools | Print** or by using the Ctrl+P key combination) to access the **Print Preview** dialog. Section 19.12 provides information about using this dialog.

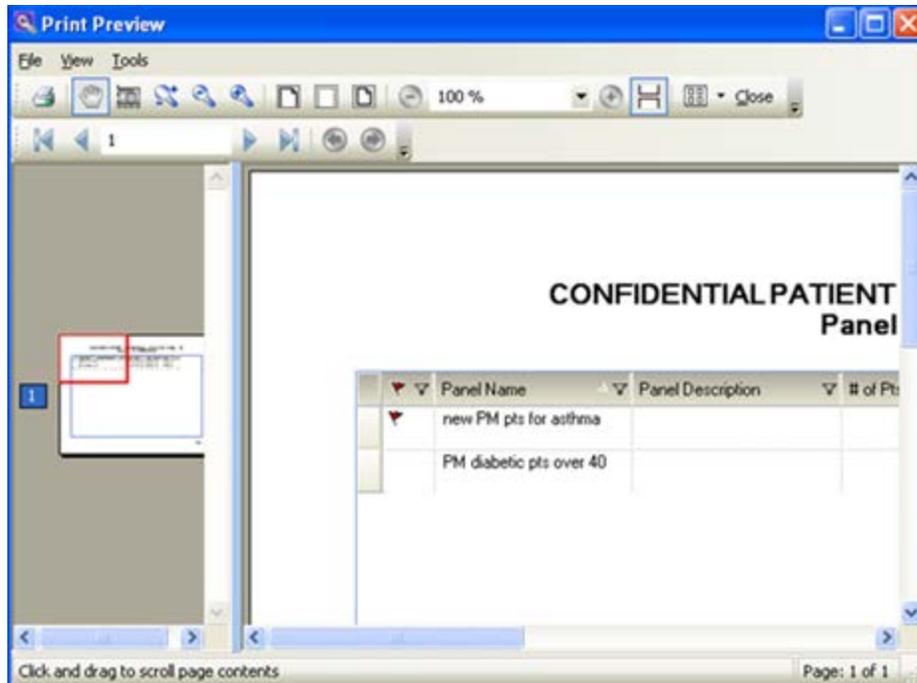


Figure 19-12: Sample Print Preview dialog

If you do not select any rows, 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.

19.2.6 Copy to Clipboard

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

19.2.7 Mail Merge

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

Follow these steps:

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

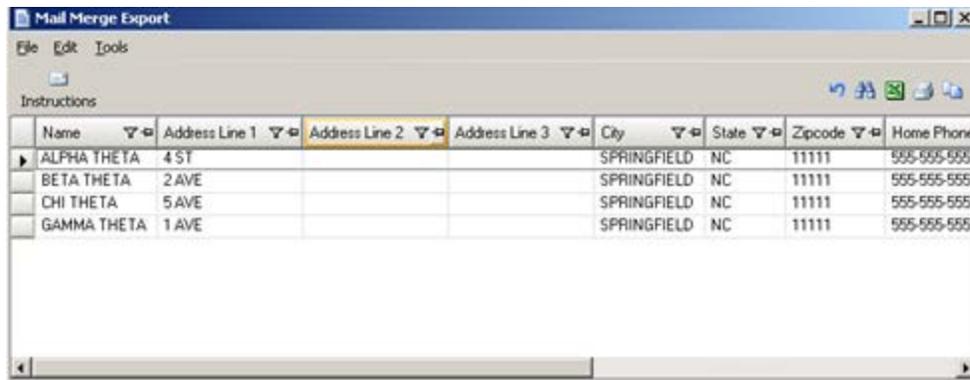


Figure 19-13: Sample Mail Merge Export dialog

Section 19.2 provides information about the buttons on the right side of the toolbar.

- 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.

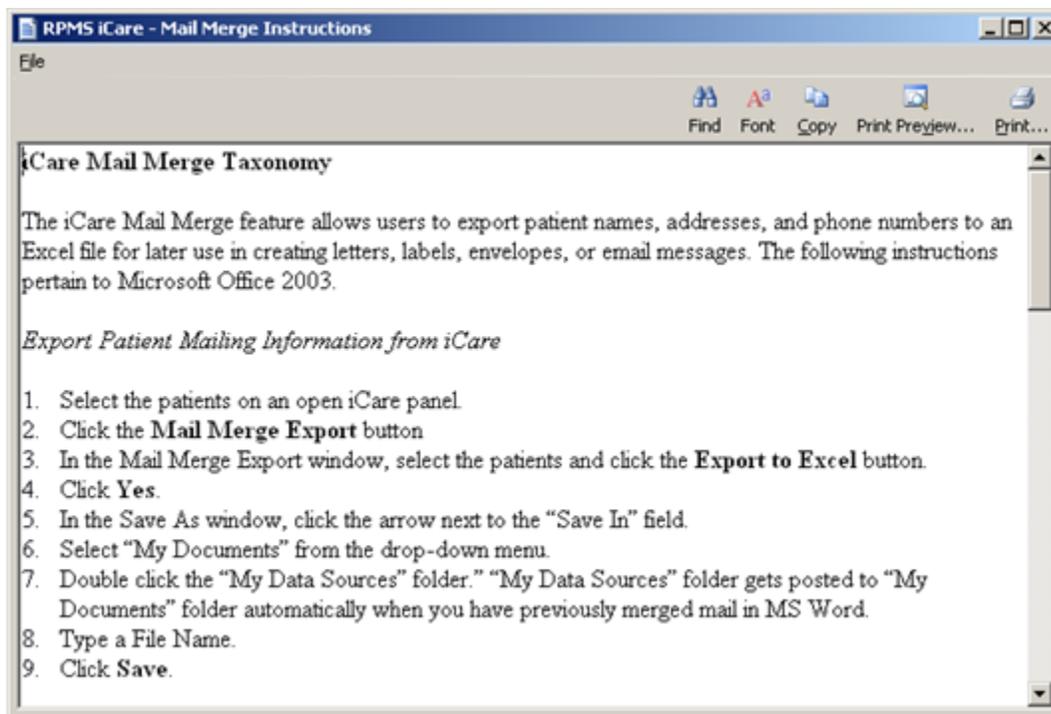


Figure 19-14: Mail Merge Instructions dialog

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

Section 19.6 for more information about how to use the controls on the pop-up.

19.2.8 Glossary

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

19.3 Edit Patient Demographics Fields

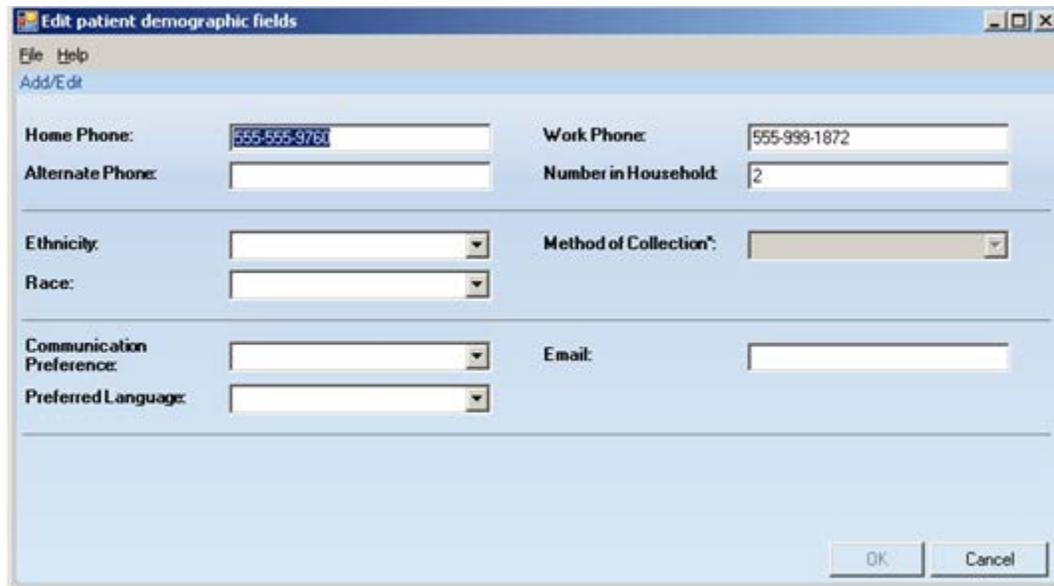


Figure 19-15: Sample Edit patient demographic fields dialog

19.3.1 Fields on Edit Patient Demographic Fields Dialog

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

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

Phone: Populate the phone 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 drop-down 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 drop-down list to define the method of collection for the ethnicity.

Race: Use any option on the drop-down list to define the patient's race.

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

Email: Populate with the patient's email address.

Preferred Language: Use any option on the drop-down list to defined the patient's preferred language.

19.3.2 Menus on Edit Patient Demographic Fields Dialog

Use File | Close to dismiss this dialog.

The Help menu has two options.

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

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

19.4 Add a Note Dialog

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

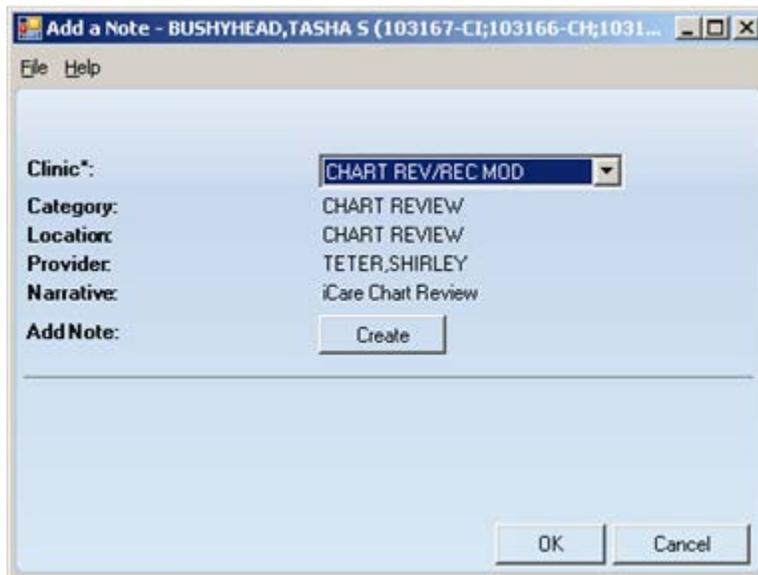


Figure 19-16: Sample Add a Note dialog

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 drop-down 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 19.5 provides information about this dialog.

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

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

19.5 Add TIU Note Dialog

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

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

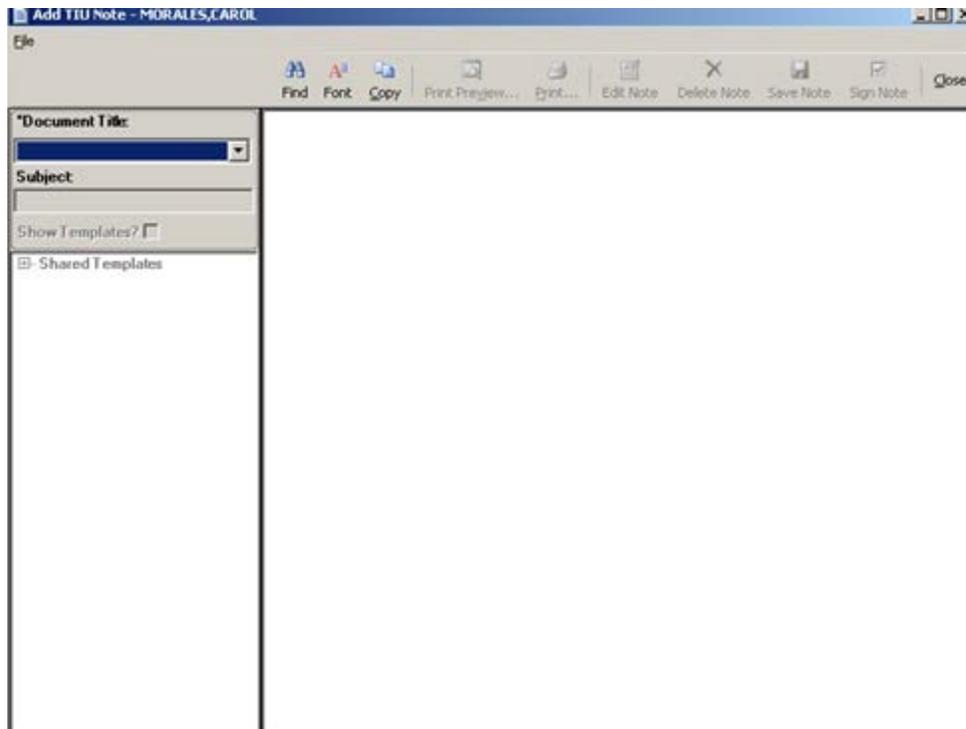


Figure 19-17: Sample Add TIU Note dialog

Both fields are required.

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

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

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

19.5.1 Note with No Template

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

When the text is complete, the following buttons are active: Find, Font, Copy, Save Note, Sign Note, Close. Section 19.5.3 provides information about the buttons on the dialog.

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

19.5.2 Note with Template

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

Figure 19-18: Sample Template

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

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

Figure 19-19: 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 19.6 for more information about using the controls on the pop-up. After you close (File | Close) the pop-up, you return to the Template window.

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

19.5.3 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.
- You should adjust the font size before saving the TIU note, if needed.

Delete Note: use this button to delete the current unsigned note. (This button does not apply to signed notes.) Click the **Delete Note** button (or select **File | Delete Note**) to access the Delete Note Confirmation 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 19-20: Enter Electronic Signature dialog

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

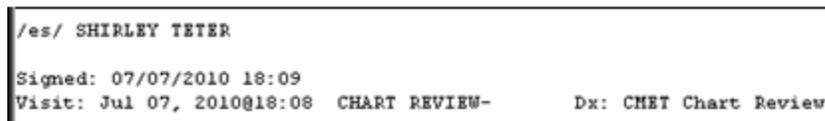


Figure 19-21: Sample electronic signature noted on text of TIU note

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 19-22: Example of text of the note

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

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

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

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



Figure 19-23: Sample Add a Note dialog with Preview button

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

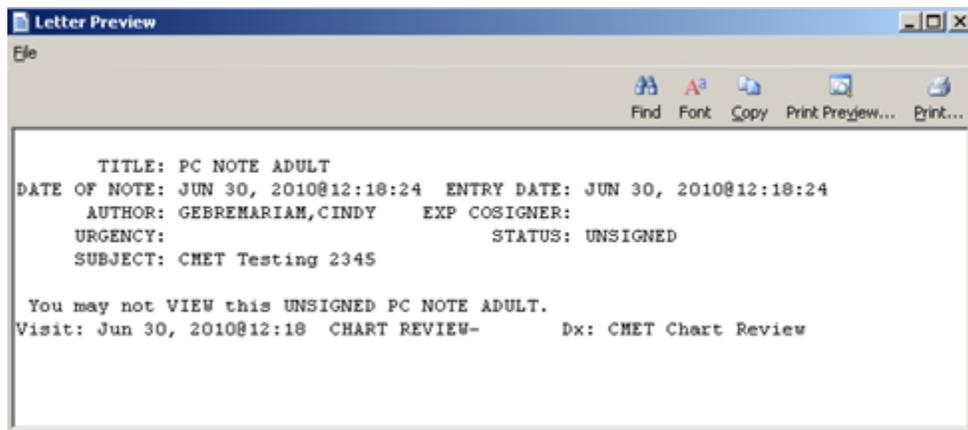


Figure 19-24: Sample Letter Preview pop-up

Section 19.6 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 19-25: Enter Electronic Signature dialog

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

- If you click **OK** and had entered an invalid electronic signature, the application displays the Invalid Attempt information message that states: Invalid electronic signature. Try again? Click **Retry** to return to the Enter Electronic Signature dialog. Click **Cancel** and the application displays the message: Unable to save with a signed note; click **OK** to return to the **Add a note** dialog.
- If you click **OK** and had entered 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 you use **OK** (on the **Enter Electronic Signature** dialog), the application displays the **Print TIU Notes** information message.

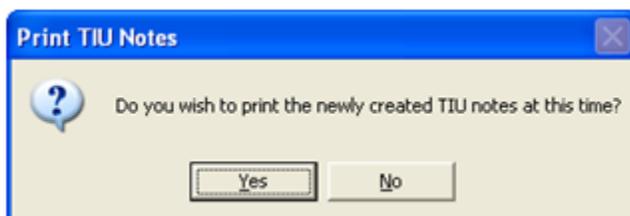


Figure 19-26: Print TIU Notes information message

Click **Yes** to print the TUI note. The application displays the **Print Preview** dialog. You can print the TIU note from this dialog. Section 19.12 provides information about the **Print Preview** dialog.

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

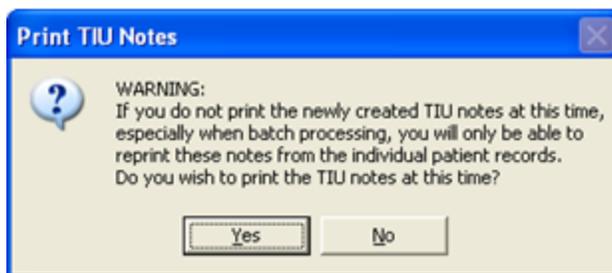


Figure 19-27: Print TIU Notes information message

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

If you use **Yes**, the application displays the **Print Preview** dialog. You can print the TIU from this dialog. Section 19.12 provides information about the **Print Preview**.

19.6 Pop-up Functionality

Several places in iCare you will be viewing a pop-up. For example, if you double-click on any row in the **Recent Visits** group box on the **Cover Sheet** of the **Patient Record** window, you will view a pop-up.

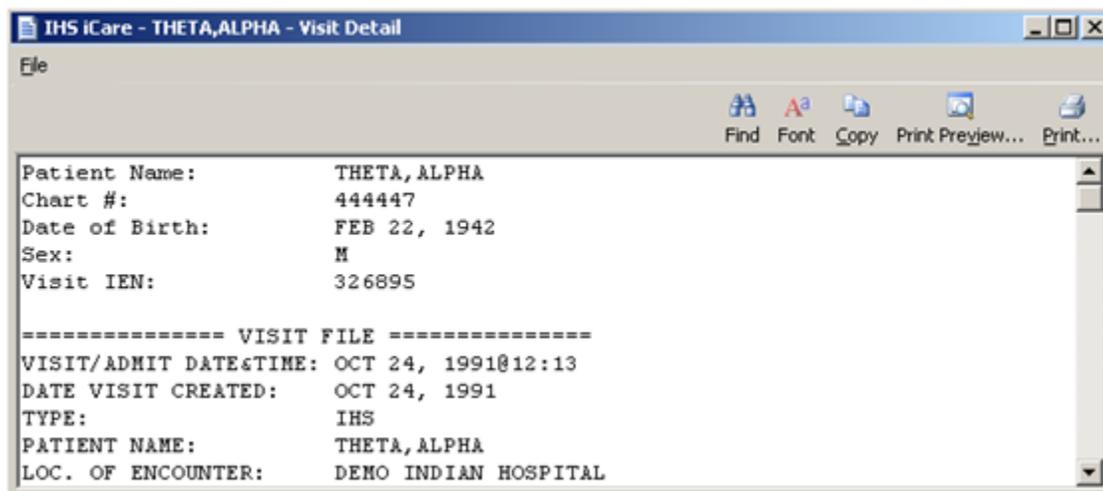


Figure 19-28: Sample Visit Detail pop-up

You can take the following actions 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.

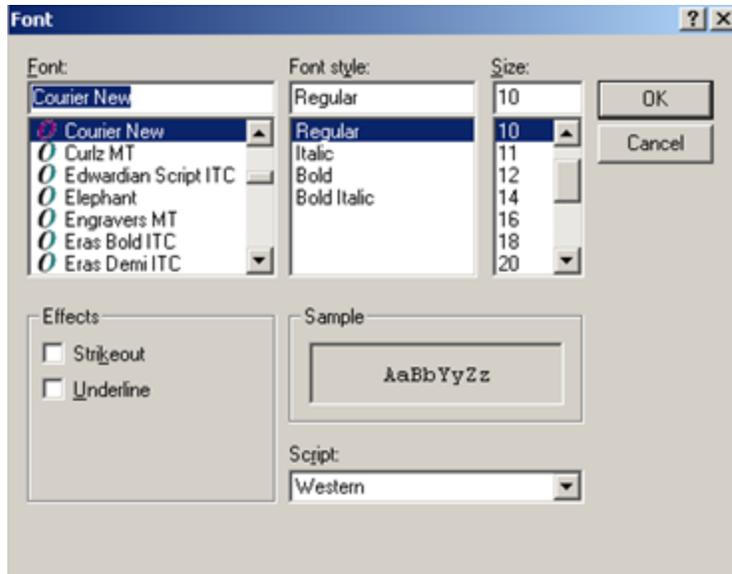


Figure 19-29: Font dialog

Here you can change the Font name, style, and size of the text in the pop-up (applies to all of the text). In addition, you can add effects like “Strikeout” and “Underline” - these perform like those effects indicated in MS Word.

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

Click **OK** to apply your changes to the text in the current 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. You can print the contents of the pop-up from this dialog. Section 19.12 provides information about the **Print Preview** dialog.
- Click the **Print** () button to display a print dialog where you specify 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).

19.7 Edit Providers

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

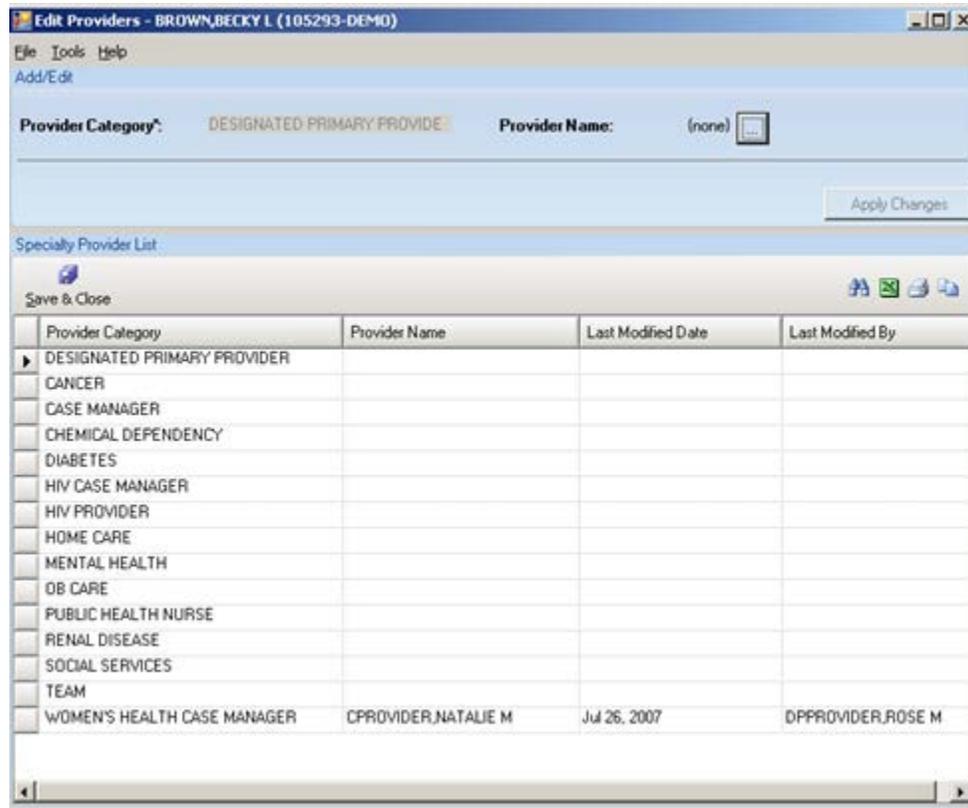


Figure 19-30: Sample Edit Providers dialog

The Edit Providers window is divided into two areas: (1) Add/Edit area that has fields to add/edit a provider record and (2) Specialty Provider List area that lists the providers for the patient. Section 19.2 provides information about the buttons on the right side of the Specialty Provider List area.

19.7.1 Add/Edit New Provider

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

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

You can add the provider for the category and 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.

19.7.2 Remove Provider Name

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

If you do not click **Apply Changes** (and have commit changes) and try 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** to not 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.

19.7.3 Save & Close Button

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

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

19.7.4 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 you use **Yes**, the data populates the **Providers** group box on the **Cover Sheet** of the patient record window.

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

19.7.5 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 19.2 provides information about these buttons.

19.7.6 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 your keyboard.

About iCare: use this option view the version of the iCare GUI.

19.8 iCare Taxonomy Editor Function

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

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

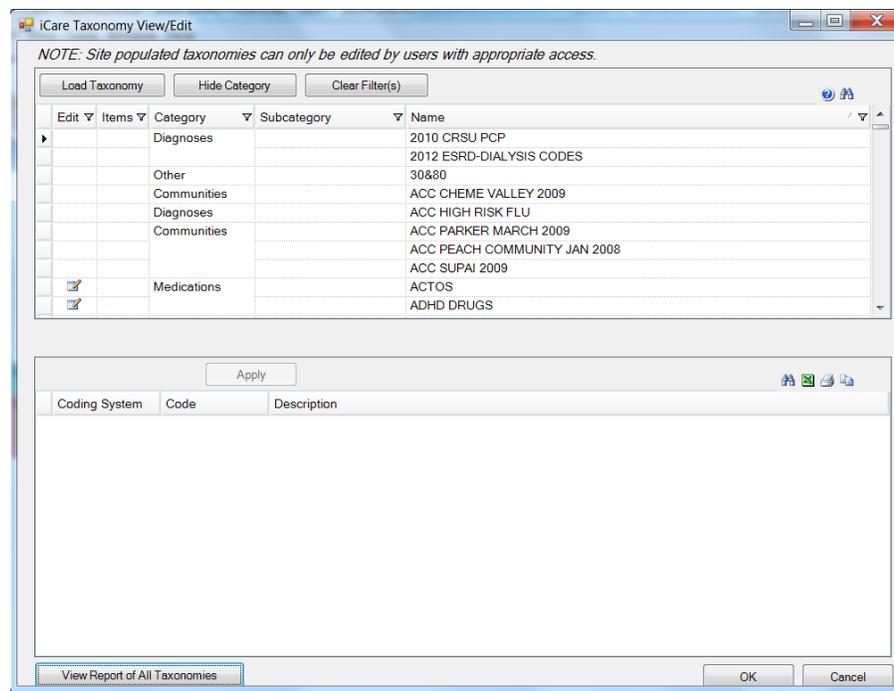


Figure 19-31: Sample iCare Taxonomy View/Edit dialog

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

When you first access this view/edit dialog, all parts of the tree structure will be collapsed. You need to expand one of the tree parts and find the taxonomy you want to edit.

In general, select the taxonomy from the list in the left group box that you want to view. This causes the Add and Remove buttons to 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 you add more than one taxonomy value to the iCare Taxonomy View/Edit dialog.

19.8.1 Add Taxonomy Values

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

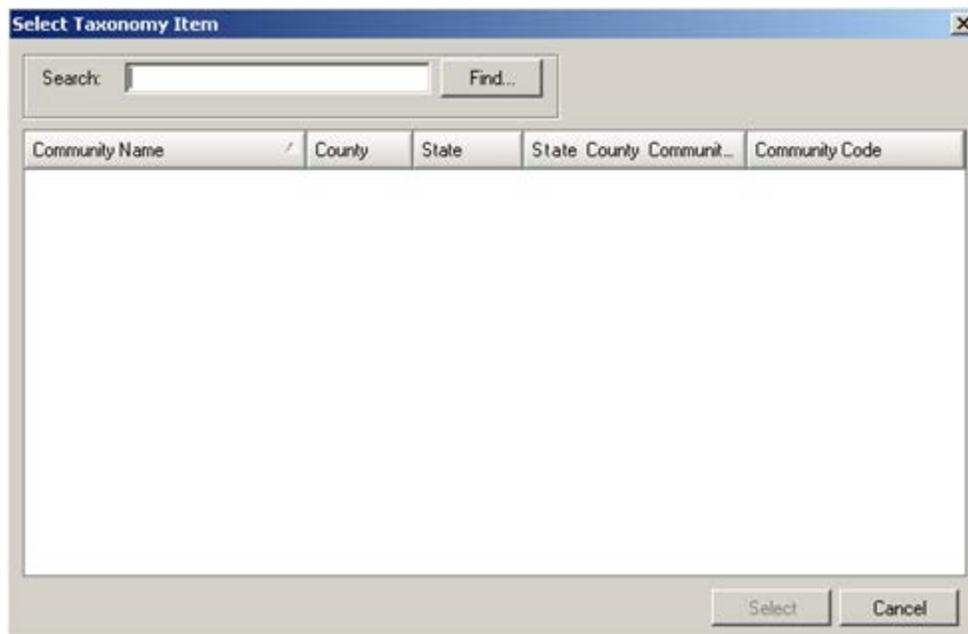


Figure 19-32: Select Taxonomy Item dialog

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

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

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

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

19.8.2 Remove Taxonomy Values

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

19.8.3 View Report of All Taxonomies Button

Click the **View Report of All Taxonomies** button to display the **Taxonomy Report** pop-up.

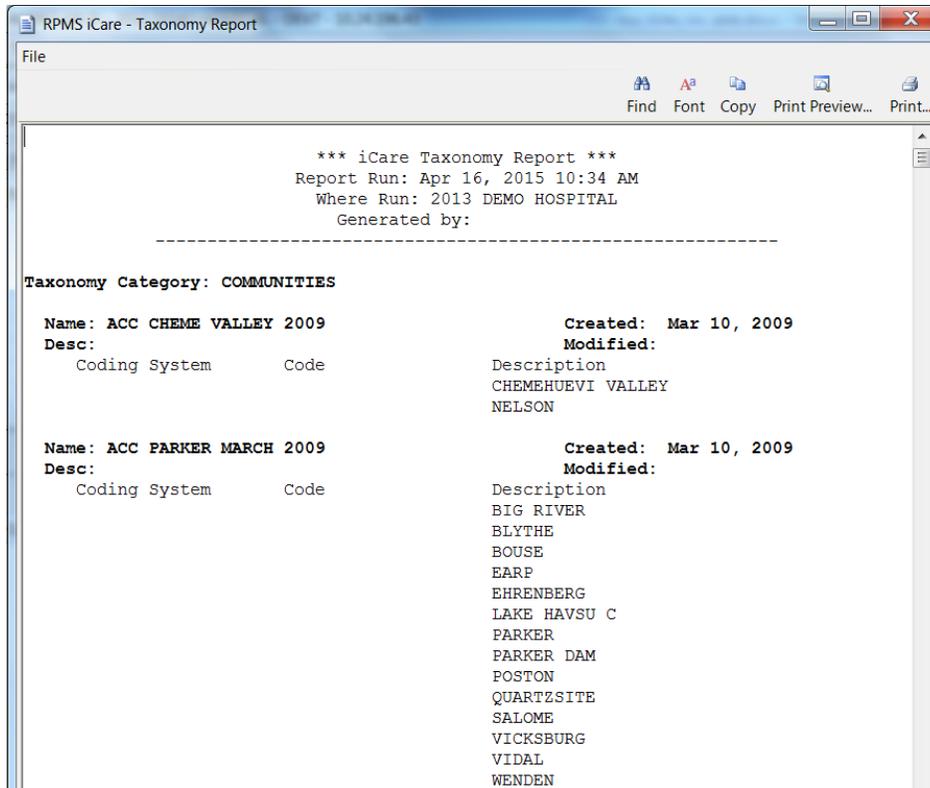


Figure 19-33: Taxonomy Report

This pop-up provides information about various Taxonomy Categories (listed in alphabetical order).

Section 19.6 for more information about using the controls on the pop-up.

19.9 Edit Reproductive Factors

Figure 19-34: 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.

19.9.1 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 19-35: 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 drop-down list that specifies the lactation status of the patient.

Current Pregnancy Status: select an option from the drop-down list that specifies the current pregnancy status of the patient.

19.9.2 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', 'Date Contraception Method', 'Reason Discontinued', and 'Comment'. The table is currently empty.

Figure 19-36: 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 drop-down lists to populate these fields.

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

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

19.9.3 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 19-37: 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 you can search for the provider’s name. Highlight the name to use and then click **Select**. The selected provider name will replace the {none} text next to the ellipsis button.

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

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

19.9.4 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 19-38: 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 drop-down list.

19.9.4.1 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 your keyboard.

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

19.10 CMET Worksheet

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

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

Figure 19-39: Sample CMET Worksheet

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

- When you use OK, there are two cases.

Case 1: if all of the steps are not complete, the application updates the data on the Tracked Events sub-tab.

Cases 2: if all of the steps are complete, the application will display the Close Event information message that states: The event is eligible for closing as all four steps are completed. Do you want to close the event now? Use Yes to close the event. Use No to not close the event.

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

If you use 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.

- When you use Cancel, there are two cases:
 - Case 1: if you did not make any changes on the worksheet, the application closes it.
 - Case 2: if you did make changes 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** to not save the changes. Click **Cancel** to return to the **CMET Worksheet**.

19.10.1 Patient Demographics Group Box

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

19.10.2 1 - Event Group Box

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

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 19-40: Sample Event group box

State: This field defines the State of the event.

If you populate the State field with Closed, then the Close Reason field becomes active where you select an option from the drop-down list that describes why you are closing the event.

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

Event Comment: Use this free text field to add comments about the Event.

State Comment: Use this free text field to add comments about the State.

CMET Audit History: If you click the **View** label, the application will display the **CMET Audit History** pop-up.

Date/Time Modified	Modified By	Field	Entry	New Value
Jun 10, 2014 08:19 PM		Notifications - Entered By	1	
Jun 10, 2014 08:19 PM		Notifications - Entry Date	1	JUN 10, 2014 20:19:14
Jun 10, 2014 08:19 PM		Notifications - Method	1	IN PERSON
Jun 10, 2014 08:19 PM		Last Modified Date/Time		JUN 10, 2014 20:19:14
Jun 10, 2014 08:19 PM		Follow-ups - Date Due	1	JUL 10, 2014 00:00
Jun 10, 2014 08:19 PM		Follow-ups - Entered By	1	
Jun 10, 2014 08:19 PM		Follow-ups - Date Entered	1	JUN 10, 2014 20:19:13
Jun 10, 2014 08:19 PM		Follow-ups - Event	1	BREAST RECONSTRUCTION W/IMPLANTS
Jun 10, 2014 08:19 PM		Findings - Follow-Up Needed?	1	Yes

Figure 19-41: Sample CMET Audit History pop-up

Because multi-users work on the event, the audit history provides a history of those activities.

Section 19.11 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 of 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 drop-down list that indicates the reason for closing the event.

19.10.3 2 - Findings Group Box

Use the 2 – Findings group box to enter Findings data about the event.

Figure 19-42: Sample Findings group box

You can minimize this group box by clicking the collapse button in the upper left corner. This allows more room for viewing the other group boxes (Follow-ups and Patient Notifications).

The Findings Due By, Result, and Follow-up Recommended? fields become populated when you use the Add button on the grid and save the record.

Findings Due By: This field displays the date the findings of this event were entered into CMET. If this date passes without an entry, a “tickler” (Feather icon) is generated.

Result: This field displays the date of the result. If this field contains an underlined date, click on the date to display the detail of the result. For example, below is the **Radiology Case Number Detail** pop-up.

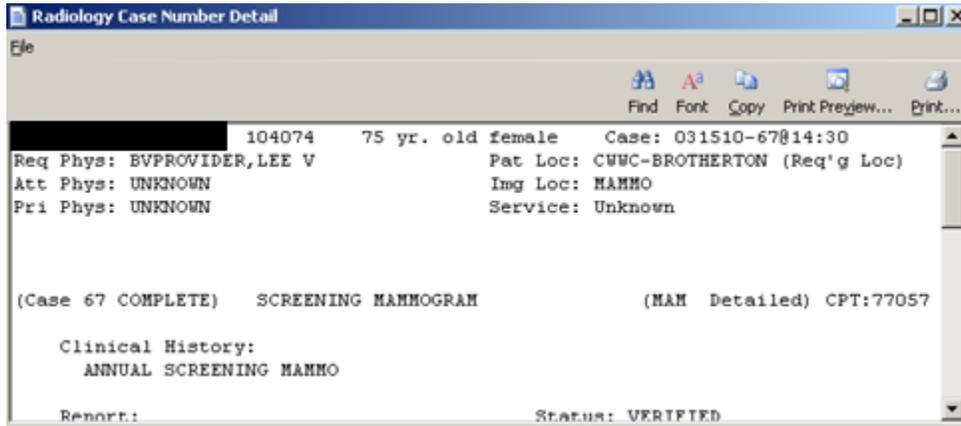


Figure 19-43: Radiology Case Number Detail

Follow-up Recommended?: This field indicates if follow-up is recommended (yes or no).

19.10.3.1 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.

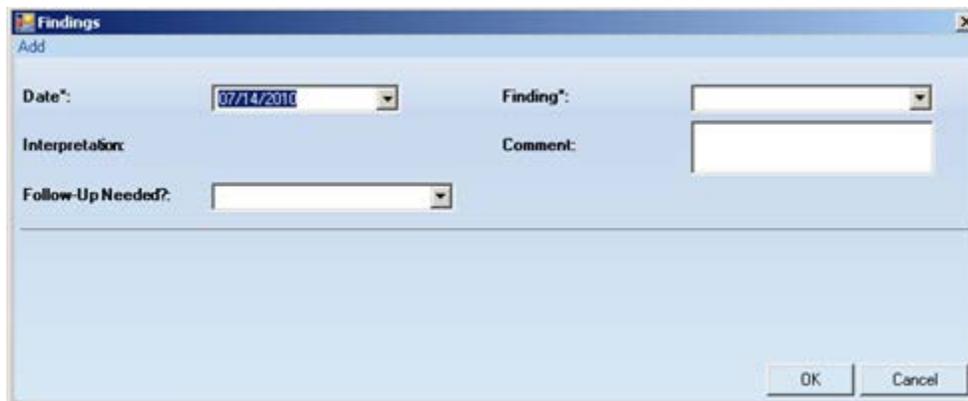


Figure 19-44: Findings dialog

The field names followed by an asterisk (*) are required.

Date: Click the drop-down list and select a date for the findings.

Finding: This is the finding associated with the event. Use an option from the drop-down list to populate this field.

Interpretation: The application populates this field, based on your selection in the Finding field.

Comment: Type the text of the comments about the Finding, if appropriate, in this Free Text field.

Follow-up Needed: Use an option from the drop-down list: Yes or No.

Click **OK** to save your 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 you saved and had selected Yes 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 and the application will automatically display the Follow-Ups dialog (where you can enter follow-up data).

19.10.3.2 Delete Button

The Delete function applies to events that had Findings entered but NOT saved.

If you select an event that is not eligible for the Delete function, the application displays the message: Unable to delete a previously saved entry. Please mark as ‘Entered in Error’ instead. Click **OK** to dismiss the message.

Select one or more eligible **Findings** records you want to delete and click the **Delete** button (or press the Delete button on your keyboard). The application displays the Delete Row information message, confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

19.10.3.3 Error Button

Use the Error function when Findings records have been saved and you cannot delete them and you want to mark them as Entered in Error.

If you select a record that is not eligible for the Error function, the application displays the message: Unable to mark as ‘Entered in Error’ because the entry has not been saved in RPMS. Please delete the entry instead. Click **OK** to dismiss the message.

Select one or more eligible Findings records and click **Error**. After using this function, the application places a strikethrough mark on the text of the record.

Date	Finding	Interpretation	Comment	Follow-Up Needed?	Last Edited	La
May-05-2010	BLRAD-CATEGORY-3--P...	Abnormal				

Figure 19-45: Sample Entered in Error marking

After you save and return to the **Tracked Events** tab, the **Result** column for the event will be blank for the particular event.

19.10.4 3 - Follow-ups Group Box

Use the 3 – Follow-ups group box to add follow-up data about the event.

Figure 19-46: Follow-ups group box

The Follow-ups group box becomes active when the Follow-up Recommended field (in the Findings group box) is set to Yes.

You can minimize this group box by clicking the collapse button in the upper left corner. This allows more room for viewing the other group box (Patient Notifications).

Follow-up Decision Due By: select a date from the drop-down list that indicates when the follow-up decision should be made. Populating the field creates a tickler (feather icon) for the event. In certain cases, this date is populated by the Tickler Timeframe set in the site parameters. You can populate this field with the date you want to take action on the event.

19.10.4.1 Add Button

Use the Add button to create a new Follow-up record. Click the **Add** button (or press the F2 button on your keyboard) to access the **Follow-Ups** dialog.

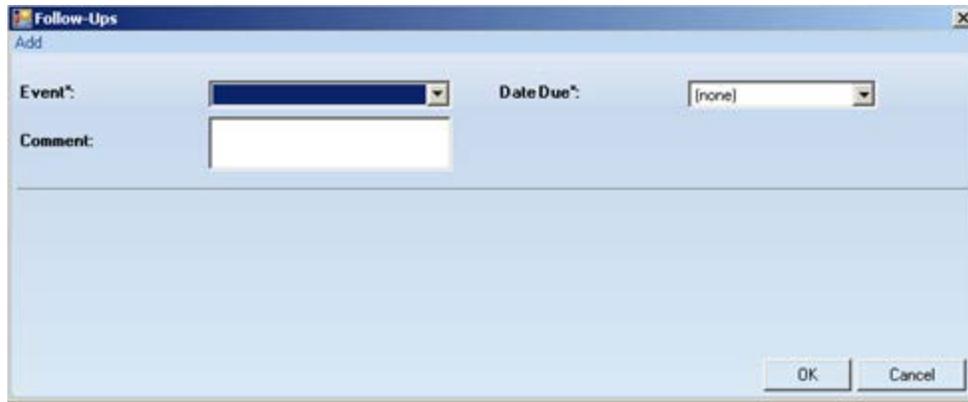


Figure 19-47: Sample Follow-Ups dialog

The required fields are those with the asterisk after the name.

Event: select an option from the drop-down list that describes the Event for the follow-up.

Date Due: use the drop-down 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**.)

19.10.4.2 Delete Button

The Delete function applies to events that had Follow-ups entered but NOT saved.

Select one or more eligible Follow-up records you want to delete and then click the **Delete** button (or press the Delete button on your keyboard). The application displays the Delete Row information message, confirming the deletion. Click **Yes** to delete the selected records. (Otherwise, click **No**.)

19.10.4.3 Error Button

Use the Error function when Follow-up records have been saved and you cannot delete them and you want to mark them as Entered in Error.

If you select a record that is not eligible for the Error button, the application displays the message: Unable to mark as 'Entered in Error' because the entry has not been saved in RPMS. Please delete the entry instead. Click **OK** to dismiss the message.

Select one or more eligible Follow-up records and click the **Error** button. After using this function, the application places a strikethrough mark on the text of the record.



Figure 19-48: Sample of Follow-up record marked as entered in error

19.10.5 4 - Patient Notifications Group Box

Use the 4 – Patient Notifications group box to add patient notification data about the event.



Figure 19-49: 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.

You can minimize this group box by clicking the collapse button in the upper left corner. This allows more room for viewing the Follow-ups group box.

Notification Due By: enter the date to have your patient notified about the results and recommendations of the follow-up related to this event. If this date passes without an entry, a tickler (feather) icon will be generated. In certain cases, this date is populated by the Tickler Timeframe set in the site parameters.

19.10.5.1 Add Button

If you do not have default clinics defined in user preferences, the application displays the following message: You must select default clinics in user preferences before being able to enter notes. Click **OK** to dismiss the message. Select **Tools | User Preferences** to access the **RPMS iCare – User Preferences** dialog. Go to the **Patient View** tab to enter the clinic codes.

Use the Add button to create a new Patient Notification record. Click the **Add** button (or press the F2 button on your keyboard) to access the **Notifications** dialog.



Figure 19-50: Sample initial Notifications dialog

The required fields are those with the asterisk after the name.

Date: the default date is today's date. You can change it by clicking the drop-down list to access a calendar from which to select another date.

Method: select an option from the drop-down list that identifies the type of notification.

Create: this button becomes active if you select "Certified Letter" or "Letter" in the Method field. You must have an electronic signature on file before you can use this function.

If you have an electronic signature on file, click the **Create** button to access the **Add TIU Note** dialog. Section 19.5 provides information about this dialog.

Comment: use this Free Text field to add any comments about the notification.

After completing this dialog, click **OK** to save the data (otherwise, click **Cancel**). After saving, the notification record will display in the 4 - **Patient Notifications** group box on the **CMET Worksheet**.

19.10.5.2 Delete Button

The Delete function applies to events that had Patient Notifications entered but NOT saved.

Select one or more eligible Patient Notification records you want to delete and click the **Delete** button (or press the Delete button on your keyboard). The application displays the Delete Row information message, confirming the deletion. Click Yes to delete the selected records. (Otherwise, click **No**.)

19.10.5.3 Error Button

Use the Error function when Patient Notification records have been saved and you cannot delete them and you want to mark them as Entered in Error.

If you select a record that is not eligible for the Error function, the application displays the message: Unable to mark as 'Entered in Error' because the entry has not been saved in RPMS. Please delete the entry instead. Click **OK** to dismiss the message.

Select one or more eligible Patient Notification records and then click the **Error** button. After using this function, the application places a strikethrough mark on the text of the record.

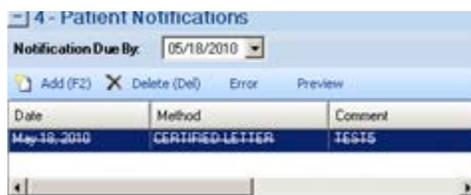


Figure 19-51: Sample Patient Notification record marked as entered in error

19.10.5.4 Preview

Use the Preview function to preview the letter associated with the selected Patient Notification record. This function only applies to records that are Letters or Certified Letters.

Select the record you want to preview and then click the **Preview** button. The application displays the **Letter Preview** pop-up.

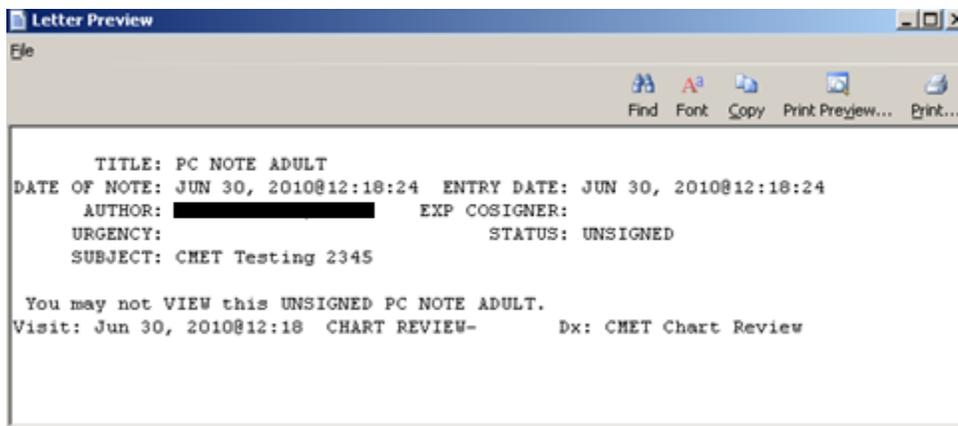


Figure 19-52: Sample Letter Preview pop-up

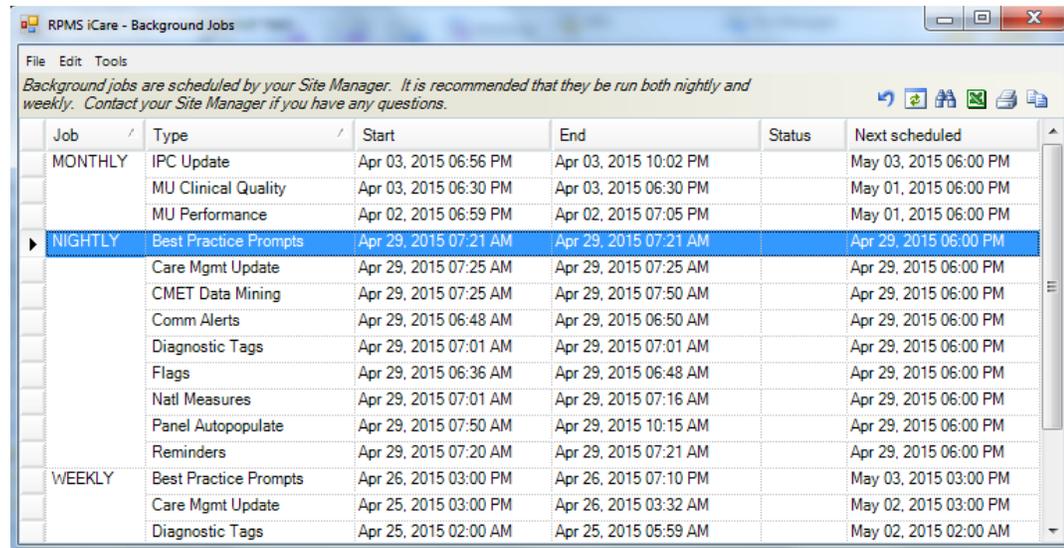
Section 19.6 provides information about using the controls on the pop-up,

19.10.5.5 Print Button

Use the Print button to output a letter in a selected record. After clicking **Print**, the application displays the Print dialog where you specify the printer, page range, number of copies, etc.; this dialog works like the one in MS Office.

19.11 Background Jobs Pop-up

Click the Background Jobs () button (or select **File | Background Jobs**) to display the **Background Jobs** pop-up.



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.

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
	Best Practice Prompts	Apr 26, 2015 03:00 PM	Apr 26, 2015 07:10 PM		May 03, 2015 03:00 PM
WEEKLY	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 19-53: Sample Background Jobs pop-up

You must dismiss the pop-up in order to use other functions in iCare.

Section 19.2 provides information about the buttons on the right side of the toolbar.

The File menu has the following options:

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

Print Preview: This option displays the print preview dialog. Section 19.12 provides information about this dialog.

Print: This option outputs the selected rows in the grid. The application displays the Print Preview dialog where you can view the output. Select **File | Print** (on the dialog) to output the content. The application provides a header stating Confidential Patient Information for all printed panel views.

If you do not select any rows, 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 of the records).

The Tools menu has options that have the same functions as those of the buttons on the right side of the toolbar.

19.12 Print Preview

The Print Preview dialog contains several features about reviewing and printing the current document.

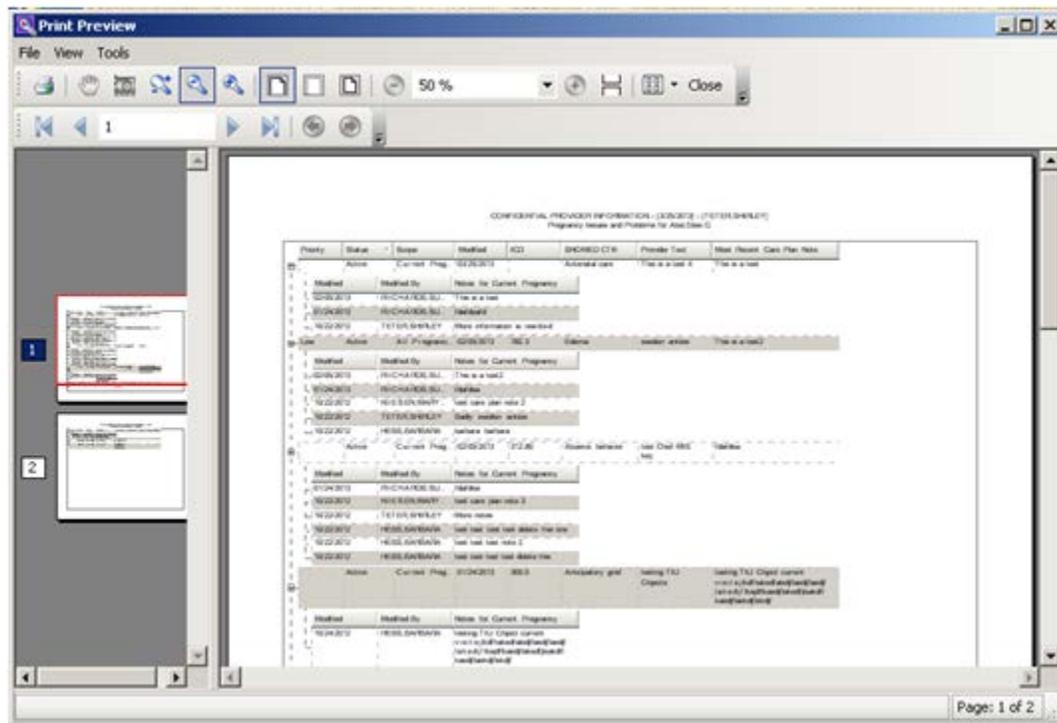


Figure 19-54: Sample Print Preview dialog

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.

The following table provides information about the various buttons on the Print Preview window.

Button	Description
	Used to output the contents of the document. Also available by selecting Print option on the File menu.
	Used to move the red rectangular box on the selected page in the left panel. As you move the Hand Tool, this changes the display in the right panel. This is used to view information in a particular part of a page. Also available by selecting the Hand Tool option on the Tools menu.
	Used to get a screen capture of a specified rectangular area. This screen capture copies the area to the Windows clipboard. Then you can paste the copy in a particular field, for example, or another application like MS Word. Also available by selecting the Snapshot Tools option on the Tools menu.
	Used to specify the zoom magnification. Click the button and then move to the area where you want to apply to zoom. Right-click on the area and select the zoom magnification option from the context menu. Also available by selecting the Dynamic Zoom Tool option on the Tools menu.
	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 (you 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 (you do not click in the panel). Also available by selecting the Zoom In on the View menu.
	Used to cause all of 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.

You move through the pages in the document by using the arrow buttons on the second line in the toolbar.

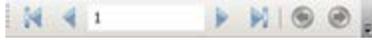


Figure 19-55: Buttons used to move through the pages of the document

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 drop-down 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.

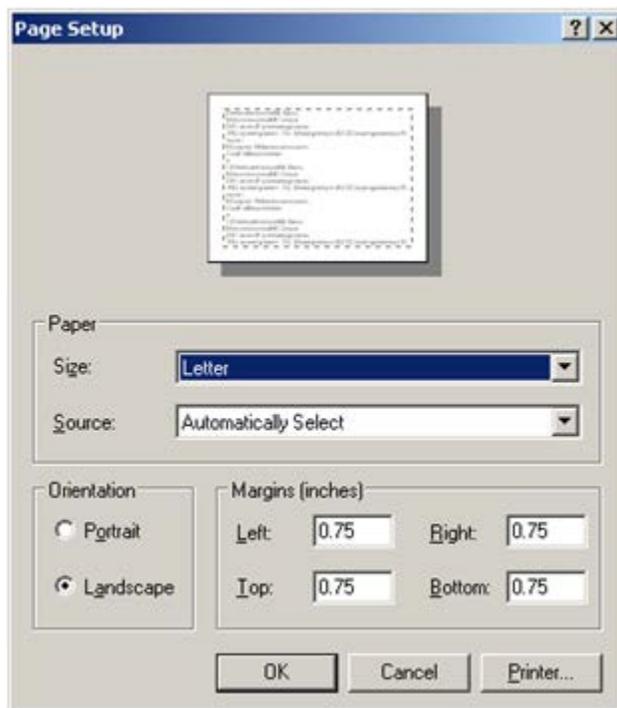


Figure 19-56: Sample Page Setup dialog

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 you choose the printer to output the contents of the document.

After the **Page Setup** dialog is complete, click **OK** to save the page setup options. (Otherwise, click **Cancel**.)

19.13 Graphing Measurement Data

You can create a graph of selected measurement data on the patient record window by

clicking the **Graph It** () button. The application displays the **Charting** window, showing a graph of the particular measurement type. The **Graph It** button also appear 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).

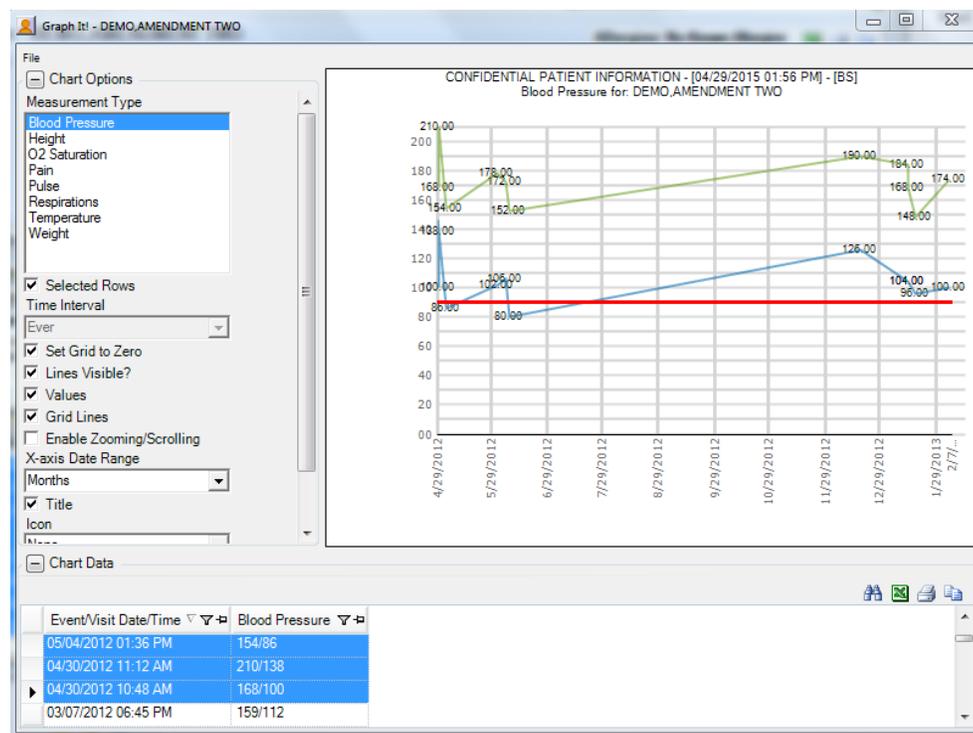


Figure 19-57: Sample Charting window

19.13.1 Chart Data Group Box

The Chart Options group box contains the data for the graph.



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 19-58: Sample Chart Data Group Box

The data is determined by what you select in the **Measurement Type** field.

19.13.2 Chart Options Group Box

What you select in the Chart Options group box determines what the graph looks like. For example, you can determine the scale units for the x-axis in the X-axis Date Range field.

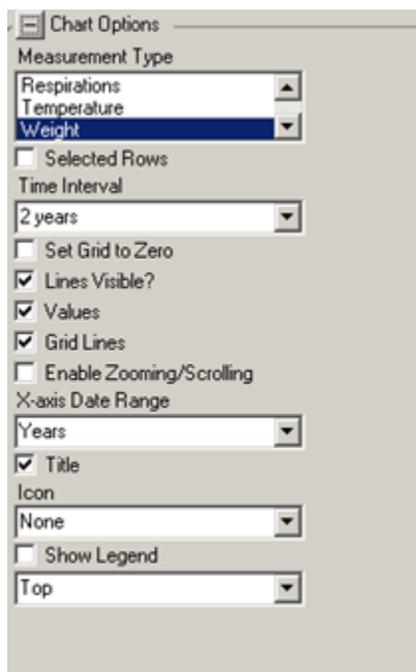


Chart Options

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 19-59: Sample Chart Options group box

Measurement Type: this shows what is being charted. You can change this by highlighting another measurement type.

Chart Type: This option only displays on the National Measures chart. This determines the type of chart (Column Chart is the default). You can change this by selecting an option from the drop-down list.

Selected Rows: select this check box to graph the selected row(s) in the Chart Data grid. If you do not use this check box, the application uses all of the measurement values.

Time Interval: this determines the time interval for the data on the chart. The default is what you selected (in the Last field) on the PCC tab of the patient record window. You can change this interval by selecting an option from the drop-down 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 you do not select this check box, the application uses the minimum and maximum values for the y-axis.

Lines Visible?: select this check box to display the lines that connect the data points.

Values: select this check box to display the values at each data point.

Grid Lines: select this check box to display the grid lines on the chart.

Enable Zooming/Scrolling: select this check box to display zooming/scrolling of the axis lines.

X-axis Data Range: this determines the time units of measure on the x-axis of the graph. The options are: Not Set, Days, Weeks, Months, 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.

19.13.3 File Menu for Charting Window

Below are the options on the File menu for the Charting window.

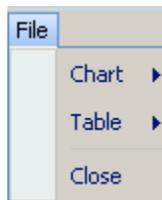


Figure 19-60: Options on File menu for the Charting window

Use the Close option to close the charting window.

19.13.3.1 Chart Option

The Chart option of the File menu has the following selections:

Page Setup: this selection allows you to set Margin, Paper, and Layout characteristics (like landscape or portrait orientation) for printing. You can select a different printer.

Print Preview: this selection displays the Print Preview dialog that displays how the output of the chart will look. Section 19.12 provides information about this dialog.

Print: this selection displays the Print dialog where you select the printer to output the chart. This is the same as using the Ctrl+P key combination.

Save Chart for Office: this selection lets you save the chart in a particular graphics format, for example JPEG. The application displays the Save Chart for Office dialog.

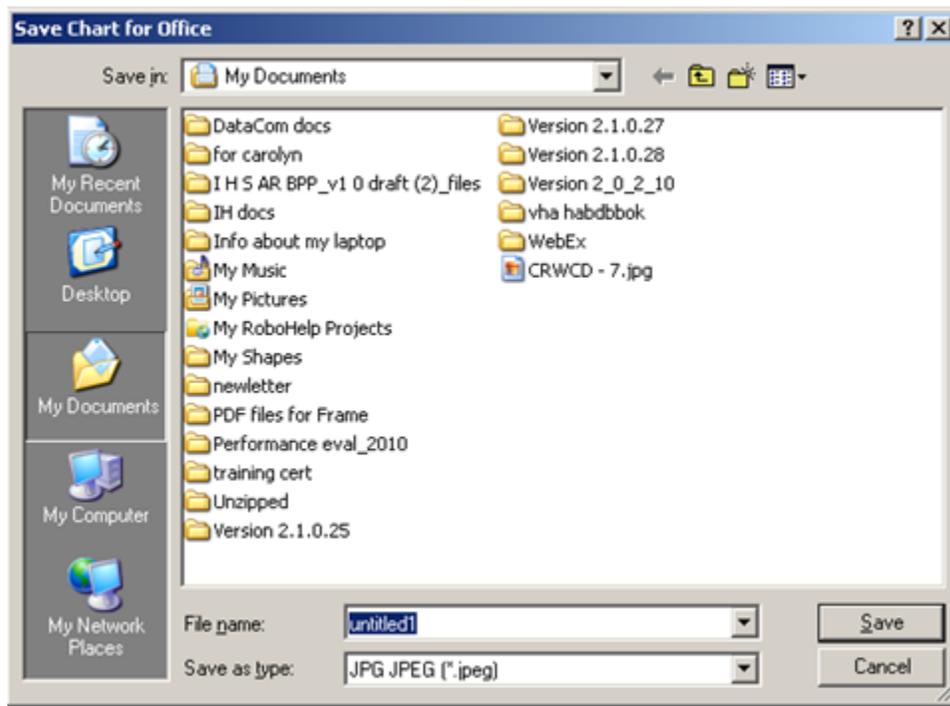


Figure 19-61: Save Chart for Office dialog for graphics format

File Name: specify the name of the file for the chart in graphics format.

Save as type: select the type of graphics format for the chart. The default is JPEG.

After completing the two fields, click **Save** to save the chart in graphics format (otherwise, click **Cancel**).

Save Chart for PDF: this selection lets you save the chart in PDF format. The application displays the **Save Chart for Office** dialog.

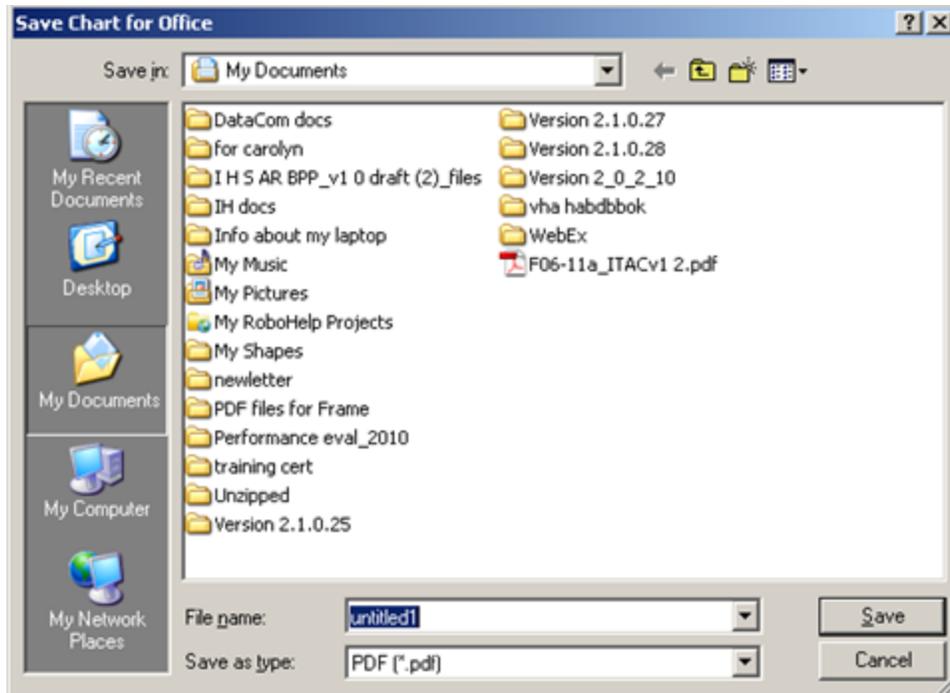


Figure 19-62: Save Chart for Office dialog for PDF format

File Name: specify the name of the file for the chart in graphics format.

Save as type: use the default PDF.

After completing the two fields, click **Save** to save the chart in PDF format (otherwise, click **Cancel**).

19.13.3.2 Table Option

The Table option of the File menu has the following selections:

Search: this selection searches for data in the Chart Data group box.

Excel Export: this selection to export the selected rows in the Chart data group box to Excel.

Print: this selection displays the Print Preview dialog of the currently selected rows in the Chart Data group box. Section 19.12 provides information about the Print Preview dialog.

Copy Rows to Clipboard: this selection copies the currently selected rows in the Chart Data group box to the Windows clipboard. You can paste the contents of the Windows clipboard to any Windows application.

19.14 Table Lookup

The ellipsis button next to the field means you can search for a particular record in the **Table Lookup** dialog by clicking the button. In addition, you can clear the information in the particular field (on the form).

19.14.1 Searching for Record

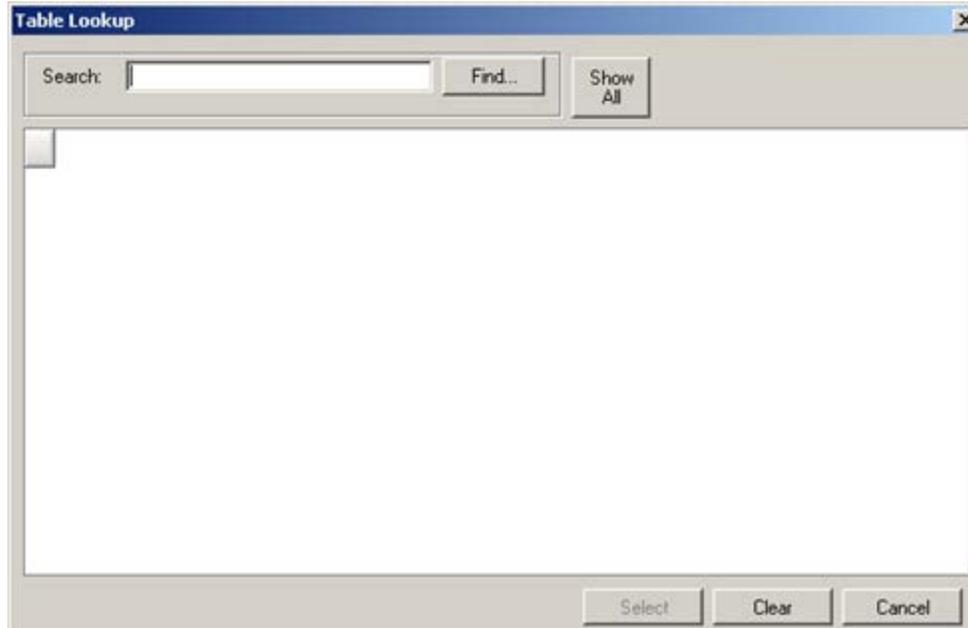


Figure 19-63: Table Lookup Dialog

This dialog provides two types of searches: for all items or for a particular item.

We will use an example to demonstrate each type. Assume you are going to search for CPT Code.

19.14.1.1 Using the Show All Button

If you do not enter anything in the Search field and just click **Show All**, the application will display all CPT codes, as shown below. (The retrieval might take a little time.)

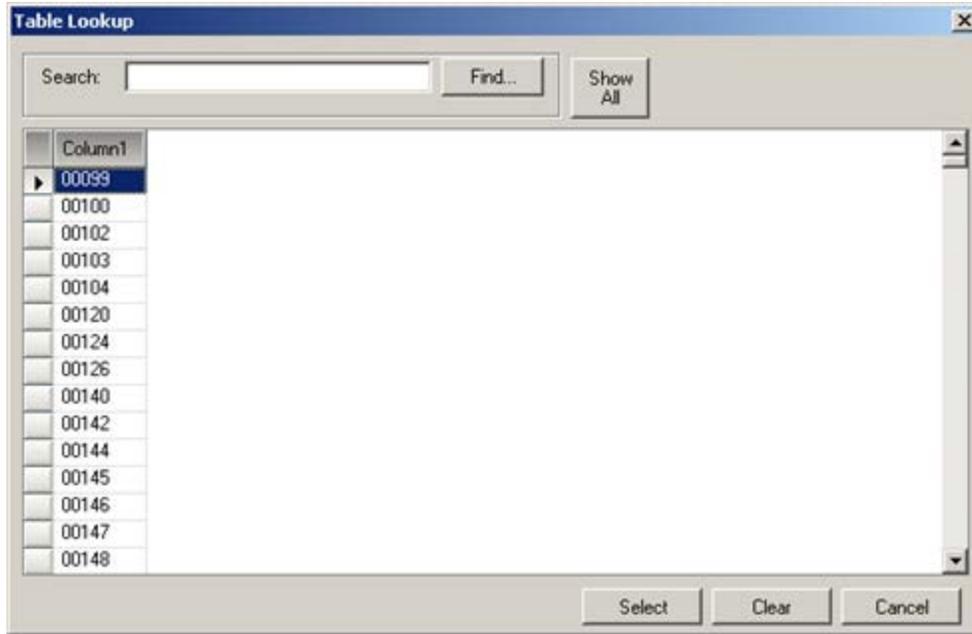


Figure 19-64: Sample retrieval of all CPT codes

19.14.1.2 Using the Find Button

To search for a particular 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).

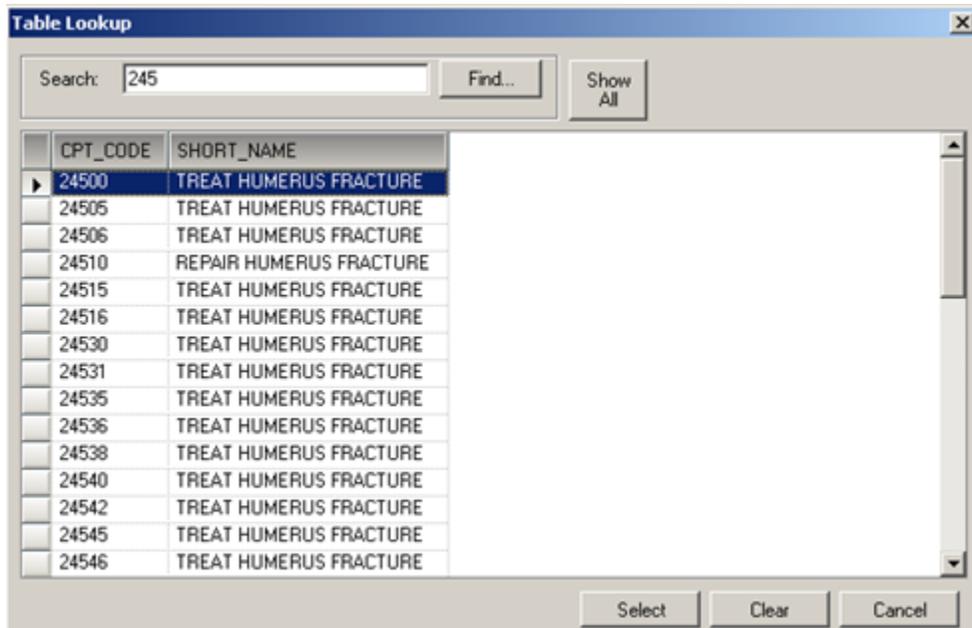


Figure 19-65: Sample retrieval of a particular CPT code

19.14.1.3 Completing the Search

In either case, select a record and click **Select**. This will close the dialog and populate the field (on the form) with the selected record. (To exit the **Table Lookup** dialog, click the **Cancel** button.)

19.14.2 Clearing Data in Field with Ellipsis Button

To clear the data in a field with the ellipsis button (on a form), click the ellipsis button to display the **Table Lookup** dialog. Click **Clear** (on **Table Lookup**). This will close the **Table Lookup** dialog and clear the data in the field on the form. (To exit the **Table Lookup** dialog, click the **Cancel** button.)

19.15 Erroneously Tracked Events

Once an event has been Tracked, it cannot be changed to Not Tracked. The following process is used when you erroneously Tracked an event.

1. Go to the **Tracked** tab, in any view (Main, Panel, Patient Record) and open a CMET worksheet for the event you erroneously tracked. Click the **Add** button in the **Findings** area to access the **Findings** dialog.

Figure 19-66: Sample Findings dialog populated

Choose the option “ERROR/DISREGARD” in the Findings field. Choose the option “No” in the “Follow-Up Needed?” field. We suggest to use today’s date for the Date field. Click **OK** to save and to close the dialog.

2. Go to the Patient Notifications area of the CMET Worksheet and click the **Add** button. The application displays the **Notifications** dialog.



Figure 19-67: Sample Notifications dialog populated

Use the option “NONE” for the Method field. We recommend 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.

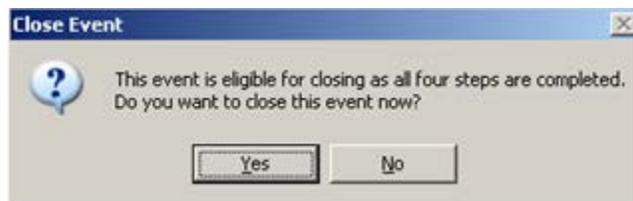


Figure 19-68: Close Event information message

Click **Yes** on the message. This closes the message.

4. The application will display the **RPMS iCare – Reason for Closing** dialog.



Figure 19-69: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 19-70: 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 particular event to have a State of **CLOSED**.

Glossary

Context Menu

The menu of options that displays when you right-click on an entity.

Designated Primary Care Provider (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 you need a change or addition to an existing taxonomy, please see your CRS coordinator.

Tooltip/Hover Help

A common GUI element used to provide additional information to users. To display a Tooltip, hover the mouse pointer, without clicking, over a column heading or field.

Visit Provider

In RPMS, the provider(s) who cared for a patient on a specific visit. Each patient visit must have at least a primary provider entered. Visits can also have one or more secondary providers. The primary visit provider might or might not be the same provider as the patient's DPCP, and can change on each visit, depending on the visit type or the clinic staffing.

Acronym List

Acronym	Term Meaning
BQI	Namespace for iCare
GUI	Graphical User Interface
HHS	Health and Human Services
IHS	Indian Health Service
OIT	Office of Information Technology
RPMS	Resource and Patient Management System

Contact Information

If you have any 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