



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Taxonomy System User Manual

Version 2.0
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Preface

The purpose of this manual is to provide information specific to the Taxonomy System.

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1.0 Introduction

The Taxonomy System allows you to create diagnosis taxonomies, which are groups of related International Classification of Diseases (ICD) diagnosis codes. A particular disease, such as tuberculosis, can have many ICD diagnosis codes associated with it. If you want all patients who have a tuberculosis-related diagnosis, you would need to include all the ICD diagnosis codes within a taxonomy called, for example, Tuberculosis. ICD reference books should be available from Patient Care Component (PCC) data entry or medical records personnel at your facility, so that you can select appropriate codes for your taxonomy.

The system allows an automatically updated list of patients who fall into this taxonomy. Every time a purpose of visit that is one of the ICD codes located within a taxonomy is entered through the PCC data entry process, the patient list for this taxonomy will be updated. Search templates can be created for a taxonomy to store all the patients within that taxonomy and all the purpose of visit entries related to the taxonomy. Also included within this system are the Search Template Comparison System, which has its own user manual, and FileMan General, which is used for ad hoc retrievals and report generation.

1.1 Taxonomy System Structure

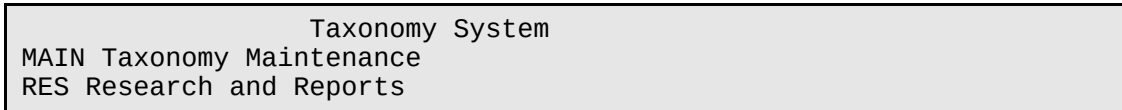
The Taxonomy system consists of the following files:

- Taxonomy
- Pt Taxonomy

The Taxonomy file stores the name, description, and ICD codes of a taxonomy. If you decide to store patients that fall under this taxonomy, an entry is made in the Pt Taxonomy file. This entry is the name of the taxonomy in the taxonomy file. There is a multiple field in the Pt Taxonomy file under the taxonomy entry called “patient.” It is here that the patients are entered for a given taxonomy. For each patient in the Pt Taxonomy file, there is a visit counter. Each time a patient is seen for a purpose of visit related to a taxonomy, the visit counter is increased by one.

1.2 Taxonomy Menus

The Taxonomy System is made up of two main menus. Upon entering the system, the following menu displayed on the terminal:

A screenshot of a terminal window showing the Taxonomy System menu. The text is as follows:

```
Taxonomy System
MAIN Taxonomy Maintenance
RES Research and Reports
```

Figure 1-1: Taxonomy system menus

2.0 Release Notes

BJPC v2.0 contains the following modifications and enhancements. The identification number listed in the parentheses (e.g., CR#274) refers to the specific change request (CR) requirement.

2.1 Designated Provider Specialty Management (BDP)

The following modifications apply to the BDP application:

- **Do Not Display Flag:** Added functionality to allow the site to flag a provider category to not be displayed in the Demographic component of the health summary. This was accomplished by adding a new field to the BDP DESG SPEC PROV CATEGORY file called “DISPLAY ON HEALTH SUMMARY?.” The option called Add Local Provider Categories was renamed Add/Edit Provider Categories and this field was added to the list of data elements to update. (CR#295)
- **New Specialty Categories:** Added 3 new categories: HIV Case Manager, HIV Provider, and Public Health Nurse. (CR#274 and CR#102)
- **Populate New Specialty Categories:** Added a post-init action that copies the existing HIV Case Manager and HIV Provider from the HIV Management System to this package. (CR#274)

2.2 PCC Data Entry (APCD)

The following changes apply to the APCD application.

2.2.1 Family History Modifications

- Modified the FHX mnemonic to be a list manager-based interface that allows the user to add, edit, or delete Family History entries.(CR#216 and CR#320)
- Modified the entry of family history to stuff the ICD narrative if no provider narrative is entered. (CR #324)

2.2.2 Visit Re-Linker Log

Created a log to track all visits modified through the visit re-linker process. These visits have had 1 or more V File entries moved or 're-linked' to another visit. A report will list all visits that were modified by the re-linker process, and options are provided to purge the log and to display a visit by its Internal Entry Number (IEN) to make review of the visits easier. This is a prospective change, meaning that only visits affected by the re-linker after the installation date of this version (v2.0) of the IHS PCC Suite will be logged and reported. (CR#013)

2.2.3 Visit Delete/Merge Log

Created a log to keep track of all deleted or merged visits. A report will list all deleted or merged visits, and an option to purge the log is provided. The visit delete option was modified to prompt for a reason for the visit deletion; this prompt is optional. This is a prospective change, meaning that only visits deleted or merged after the installation date of this version (v2.0) of the IHS PCC Suite will be logged and reported.

These options can be found on the following menu under the PCC Supervisor menu: (CR#239)

- VRLR List of Visits Modified by the Visit Re-Linker
- PVRL Purge Visit Re-linker Log
- PVDM List of Visits Deleted/Merged
- PUDM Purge Visit Delete/Merge Log
- VIEN Display a Visit by Visit IEN

2.2.4 3M Present on Admission

Added Present on Admission as a prompt in the 3M coder interface. (CR#254)

2.2.5 Personal History (PHX)

Added 2 new fields: Multiple Birth? and Multiple Birth Type to the PHX mnemonic. (CR#244)

2.2.6 Problem List Note Narrative Length

Expanded the Note Narrative to 160 characters. (CR#323)

2.2.7 Provider Narrative Length

All mnemonics that prompt for provider narrative will accept up to 160 characters for the provider narrative. This has been increased from 80 characters.

2.2.8 Patient Education (PED): Readiness to Learn

Added Readiness to Learn and resequenced the prompts according to the Education workgroup recommendations. (CR#242)

2.2.9 Asthma Control (ACON)

Added a new mnemonic, ACON, to update and record a patient's asthma control. (CR#240)

2.2.10 POV Stage

Disabled the stage prompt for asthma severity when an asthma diagnosis is entered; this function has been moved to the new Problem List Classification. (CR#278)

2.2.11 Problem List Classification Field

Added a new field in the BGP ASTHMA DXS taxonomy, Classification, to be prompted for when an asthma diagnosis is entered. Allowable values are 1, 2, 3, or 4, which stand for 1-Intermittent, 2-Mild Persistent, 3-Moderate Persistent, and 4-Severe Persistent. The following mnemonics were updated: PL, PO, and MP. (CR#207, CR#276)

2.2.12 Reproductive Factors Mnemonics

FP and RF mnemonics have been restructured to prompt for reproductive history with individual fields rather than a string.

2.3 PCC Health Summary (APCH)

The following changes apply to the APCH application.

2.3.1 Patient Wellness Handout Management

Created a new menu for managing patient wellness handouts (PWHs). The user can now select from 14 components to create a customized PWH.

Menu

PWH - Generate a Patient Wellness Handout
DEF - Update Default PWH for a Site
AAP - Print Asthma Action Plan
MPWT - Create/Modify Patient Wellness Type
TPWH - Number of PWHs Given to Patients Report

The following PWH components are available:

ACTIVITY LEVEL
ALLERGIES
ASK ME THREE QUESTIONS
BLOOD PRESSURE
CANCER SCREENING
CHOLESTEROL
DIABETES CARE
HEIGHT/WEIGHT/BMI
HIV SCREENING
IMMUNIZATIONS DUE
IMMUNIZATIONS RECEIVED
MEDICATIONS
PATIENT GOALS
QUALITY OF CARE TRANSPARENCY REPORT CARD

Two standard PWH types are distributed with this version:

- **Adult Regular:** contains all 14 components
- **Medication Reconciliation:** contains Medications and Allergies

A PWH log has been created. Each time a PWH is generated, the log will record the patient to whom the handout was given, the date, the location, and the user who generated the handout. A report has been developed to tally PWH production.

The default wellness handout to be used at a site can be defined by updating that field in the PCC Master control file using option DEF Update Default PWH for a Site.

2.3.2 Health Summary Component (New) for Tallying Patient Wellness Handouts

Created a new component to list the PWHs given to a patient.

2.3.3 Health Summary Component (New) for Patient Wellness Handout

Created a component to display the full PWH for a patient.

2.3.4 Health Summary Component (New) for Meds - Controlled Substances

Created a component to list all prescriptions for controlled substances.

2.3.5 Health Summary Component Modification: Lab

Added the date and time of lab results to both the LAB DATA - MOST RECENT BY DATE and the LABORATORY DATA - MOST RECENT components. (CR#171)

2.3.6 Health Summary Component Modification: Medication

Modified the text “on hold” to “active but not yet dispensed.”

2.3.7 Health Summary Component Modification: Family History

Modified the format to sort by the new Relationship field and display the new fields, and renamed the component to FAMILY HEALTH HISTORY. The component now displays the following fields: Relationship (to patient), Relation Description, Status (e.g., Living, Deceased, etc.), Diagnosis, Age at Onset; Multiple Birth (Y/N), and Type (e.g., Twin, etc.). If Status is “deceased,” Age at Death and Cause of Death are displayed. (CR#225, CR#325)

2.3.8 Health Summary Component Modification: Reproductive Factors

The previous Reproductive Factors (REPFAC) string display (G#P#LC#SA#TA#) has been changed to the following string, which is a concatenation of the new Reproductive History Component fields with each field separated by a semicolon. The entire string will be displayed for any patient who has *at least one value* in any of the Component fields.

Total # of Pregnancies #; Full Term #; Premature #; Abortions, Induced #; Abortions, Spontaneous #; Ectopic Pregnancies #; Multiple Births #; Living Children #

2.3.9 Reminder (New): Osteoporosis Screening

Added a reminder for osteoporosis screening in women ages 65 and older; the logic is consistent with the Clinical Reporting System (CRS) performance measure. The screening is due every two years. The reminder is turned off in the default package; to see this reminder on a health summary, a site must activate the reminder and attach it to the summary types. (CR#237)

2.3.10 Reminder (New): Assessment of Function

Added a reminder for assessment of function as an annual screening for patients 65 and older. Assessment of function includes assessing ability for toileting, bathing, shopping, etc. This data is captured in PCC using the EL mnemonic and it populates the V Elder file. The reminder is turned off in the default package; to see this reminder on a health summary, a site must activate the reminder and attach it to the summary types. (CR#188)

2.3.11 Reminder Modification: Pap and Mammogram Reminders

Modified the Pap and Mammogram health maintenance reminders to use the next due date in Women's Health only if it is more current than the due date in Health Summary reminders. (CR#257)

2.3.12 Reminder Modification: Alcohol Screening

Added a check for Current Procedural Terminology (CPT) codes using the BGP ALCOHOL SCREENING CPTS taxonomy (99408, 99409, G0396, G0397, and H0049) in both PCC and the Behavioral Health module, making the reminder more consistent with the CRS performance measure. (CR#109)

2.3.13 Reminder Modification: Adult MMR 2-DOSE Version

Fixed this reminder to look for CPT codes, diagnosis codes, and procedure codes for the measles, mumps, and rubella (MMR) vaccines. (CR#109)

2.3.14 Reminder Modification: Diabetes Screening

Changed category to "General". (CR#109)

2.3.15 Reminder Modification: Colorectal Scope/XRAY

Modified logic to reference BGP COLO PROCS and BGP SIG PROCS taxonomies, rather than individual procedure codes. (CR#109)

2.3.16 Asthma Action Plan (New Report)

Added the asthma action plan from the asthma register system to the health summary. This menu option can be found under the new PATIENT WELLNESS HANDOUT menu. The action plan has been redesigned according to the Asthma Workgroup specifications and includes new fields added in this PCC version as well as the previous version. (CR#281)

2.3.17 Problem List Display

Added classification to the problem list display if it is entered. (CR#277)

2.3.18 Supplement Modifications: Asthma

Redesigned the asthma supplement according to the Asthma Workgroup specifications and included new fields added in this PCC version as well as the previous version. (CR#289)

2.3.19 Reminders and Best Practice Prompts Text Modifications

Updated the description, logic, display text, and tooltips for all reminders and Best Practice prompts.

2.3.20 Best Practice Prompts Modifications

Updated the logic and text for the following Best Practice prompts:

- ASTHMA: ACTION PLAN
- ASTHMA: ADD/INCREASE INHALED STEROIDS
- ASTHMA: CONTROL CLASSIFICATION
- ASTHMA: FLU SHOT
- ASTHMA: INCREASED RISK FOR EXACERBATION
- ASTHMA: PRIMARY CARE PROVIDER
- ASTHMA: SEVERITY CLASSIFICATION

2.4 PCC Management Reports (APCL)

The following changes apply to the APCL application.

2.4.1 Activity Reports

Modified certain reports to prompt the user for two additional filters, Location of encounter and Clinic, which limit the report to a selected set of locations or clinics. The following reports, listed by discipline group, were updated: (CR#205)

- TSPR Time and Patient Services by Provider
- TSSU Time and Patient Services by Service Unit
- PPPR Primary Problem by Provider
- PPLO Primary Problem by Facility
- PPSU Primary Problem by Service Unit
- INPR Number of Individuals seen by Provider
- INSU Number of Individuals seen by Service Unit
- AGE Patient Services by Age and Sex
- TEN Top Ten Primary Diagnoses
- TSCR Time and Services by Provider for Chart Reviews

2.4.2 DEMO PATIENTS Report Filter

All PCC Management reports have been updated to prompt users whether to include a site's Demo/Test patients in their reports.

To use this feature, the site's demo patient search template must be updated to include all of its Demo/Test patients. This option is locked with the security key APCLZ UPDATE DEMO TEMPLATE, which should be assigned to the user or users who manage this list of patients. Choosing the new option, DPST Update the Demo/Test Patient Search Template (under OTH Other PCC Management Reports/Options in the PCC Management Reports menu), adds the Demo/Test patients to the list.

The following prompt now appears when a management report is run:

```
Select one of the following:
      I      Include ALL Patients
      E      Exclude DEMO Patients
      O      Include ONLY DEMO Patients
Demo Patient Inclusion/Exclusion: E//
```

Choose E to exclude any patient who is on the Demo/Test patient list from the report. Choose I to include all patients, including the Demo/Test patients, or choose O to include only the Demo/Test patients. (CR#287)

2.4.3 PGEN/VGEN Menus

Updated to allow the user to select one of three menu display options for the Selection, Print, and Sort items: 1) in a predefined order (the original display option); 2) in alphabetical order by item title; or 3) in order by category group. (CR#251)

2.4.4 PGEN/VGEN

Added the new Select/Sort/Print options listed below:

- Date of Last Osteoporosis Screen: added as a PGEN Select, Sort, and Print item because it's a new health maintenance reminder. (CR#226)
- Readiness to Learn: removed as a Health Factor PGEN and VGEN Select, Sort, and Print item, because it's no longer a health factor. (CR#242)
- Upcoming Appointments: added as a PGEN Select and Print item and a VGEN Print and Sort item. When used as a Select item, the user can select the appointment date range and appointment clinics. The report will list only patients who have an appointment in one of those clinics during that date range, and the Print item will display only upcoming or pending appointments. Walk-in and chart requests are excluded from the pending appointment display in the Print item. (CR#126)
- Problem List Date of Onset: added as a PGEN and VGEN Select and Print item. If used as a Select item, the user must enter the beginning and ending date and may specify a particular set of diagnoses. When used as a Print item, the system will print all entries from the problem list with the date of onset, unless this item was also used as a Select item. In this case only the problem list entries matching the selected diagnoses will be printed. (CR#072)
- Family History-related: Family History Dx, Family Hx and Relation, Family History Relation, Family Hx Narrative and Family Hx Description (diagnosis, narrative, age at onset, relation) were all added as PGEN and VGEN Select and Print items. (CR# Child315)

- Present on Admission (POA): added as a VGEN Select and Print item. (CR#062)
- CPT Modifier: added as a VGEN Select and Print item.

2.5 QMAN (AMQQ)

The following changes apply to the AMQQ application:

- Added DV as a synonym for IPV.
- Changed attribute text from PRIMARY PROVIDER to PRIMARY CARE PROVIDER
- Added upcoming appointments as a Print item when printing a list of patients in QMan.
- Corrected the diagnosis display for the IHS Prediabetes Register.
- Added Family History as a search option.
- Updated Health Factor selection to allow the user to enter a category to retrieve a list of its health factors.
- Added the ability to create a delimited output of the QMan results by having the output print to a screen, and then taking a screen capture of the delimited output.
- Added the ability to go directly to VGEN or PGEN's print output from QMan by creating a search template in QMan. When template creation is complete, the user is transferred to PGEN or VGEN.

2.6 General Database (AUPN)

- **V Asthma:** Added field .14 – Asthma Control. (CR#206)
- **V Lab:** Added field 1502 – FINDINGS to the V LAB file. This field will be populated by the Procedure Workflow Tracking System (BTPW) when the software is deployed. (CR#239)
- **V Patient Education:** Added Readiness to Learn as field 1102. (CR#242)
- **V Radiology:** Added field 1502 – FINDINGS to the V RADIOLOGY file. This field will be populated by the Procedure Workflow Tracking System (BTPW) when the software is deployed. (CR#239)
- **Personal History:** Added field .06 – MULTIPLE BIRTH? to the Personal History File. Patient Multiple Birth?: Yes/No/Unknown. (CR#244)
- **Personal History:** Added field .07 – MULTIPLE BIRTH TYPE to the Personal History file. Multiple Birth Type values: Twin, Unspecified (TU); Identical Twin (IT); Fraternal Twin (FT); Triplet (TR); Other Multiple (OTH). (CR#244)

- **Problem:** Expanded Note narrative to 160 characters. (CR#323)
- **Provider Narrative:** Expanded narrative to 160 characters. (CR#258)
- **FAMILY HISTORY FAMILY MEMBERS:** Created new file with the following fields (CR #199/CR #322):
 - .01 - RELATIONSHIP
 - .02 - PATIENT
 - .03 - RELATION DESCRIPTION
 - .04 - STATUS
 - .05 - AGE AT DEATH
 - .06 - CAUSE OF DEATH
 - .07 - MULTIPLE BIRTH?
 - .08 - MULTIPLE BIRTH TYPE
- **FAMILY HISTORY:** Modified the existing file (CR #199/CR #322):
 - Moved the Status field to the new FAMILY HISTORY FAMILY MEMBER file.
 - Added an asterisk (*) in front of the STATUS field to alert users that it will be going away.
 - Added field .09, which is a pointer to the Family History Family Member file.
 - Inactivated field .07 – Relationship.
 - Added new MULTIPLE BIRTH and MULTIPLE BIRTH TYPE fields. (CR#199)
 - Added CAUSE OF DEATH field, which is displayed if the STATUS field is DECEASED. (CR#199)
 - Added new AGE AT ONSET and AGE AT DEATH fields with the following choices:
 - In Infancy
 - Before age 20
 - At age 20-29
 - At age 30-39
 - At age 40-49
 - At age 50-59
 - 60 and older
 - Age Unknown
 - Inactivated the numeric Diagnosis Onset Age field.
 - Changed field .01 to allow only ICD Diagnosis codes V16*; V17*; V18*; and V19*. (CR#245)
- **REPRODUCTIVE FACTORS:** Implemented requested changes to Reproductive Factors fields.

- Added and/or activated the following new fields: Full Term (previous request); Premature Births (previous request for Preterm Births); Ectopic Pregnancies; Multiple Births.
- Inactivated Parity and Abortions/Miscarriages/Ectopic Pregnancies fields.
- V Telehealth: Created new file with the following fields:
 - .01 - Primary Modality
 - .02 - Patient Name
 - .03 - Visit
 - .04 - Originating Date/Time
 - .05 - Service Date/Time
 - .06 - Secondary Modality
 - .07 - Case ID
 - .08 - Originating Provider
 - .09 - Requesting Provider
 - .11 - Service Delivery
 - .12 - Originating Visit
 - .13 - Status Field
 - .14 - Duration
 - 1101 - Comments
 - 1102 - Link To Case

2.6.1 Table Changes

- PCC RELATIONSHIPS: Created new table for Family History.
- TELEHEALTH: Created new tables for Modality and Service Category.
- EXAM: Inactivated the following exam codes: (CR#241)
 - 23 Audiometric Screening
 - 08 Heart Exam
 - 05 Neck Exam
- HEALTH FACTORS: Modified the Health Factors file to display the category when a lookup is performed on the file, and to allow the user to type the category name to retrieve a list of health factors to choose from. (CR#255, CR#256, CR#217)

Changed the name of the following Health Factors: (CR#234)

OLD NAME	NEW NAME
ASTHMA TRIGGER-AIR POLLUTANTS	AIR POLLUTANTS
ASTHMA TRIGGER-ANIMAL	ANIMAL
ASTHMA TRIGGER-COCKROACHES	COCKROACHES
ASTHMA TRIGGER-DUST MITES	DUST MITES

OLD NAME	NEW NAME
ASTHMA TRIGGER-EXERCISE	EXERCISE
ASTHMA TRIGGER-MOLD	MOLD
ASTHMA TRIGGER-POLLEN	POLLEN
ASTHMA TRIGGER-TOBACCO SMOKE	TOBACCO SMOKE
BARRIERS TO LEARN-BLIND	BLIND
BARRIERS TO LEARN-DEAF	DEAF
BARRIERS TO LEARN-DOESN'T READ ENGLISH	DOESN'T READ ENGLISH
BARRIERS-FINE MOTOR SKILLS DEFICIT	FINE MOTOR SKILLS DEFICIT
BARRIERS TO LEARN-HARD OF HEARING	HARD OF HEARING
BARRIERS TO LEARNING-INTERPRETER NEEDED	INTERPRETER NEEDED
BARRIERS TO LEARNING-NO BARRIERS	NO BARRIERS
BARRIERS TO LEARNING-VALUES/BELIEFS	VALUES/BELIEFS
BARRIERS TO LEARN-VISUALLY IMPAIRED	VISUALLY IMPAIRED
SELF MONITORING BLOOD GLUCOSE-NO	NO
SELF MONITORING BLOOD GLUCOSE-REFUSED	REFUSED
SELF MONITORING BLOOD GLUCOSE-YES	YES
LEARNING PREFERENCE-DO/PRACTICE	DO/PRACTICE
LEARNING PREFERENCE-READ	READ
LEARNING PREFERENCE-SMALL GROUP	SMALL GROUP
LEARNING PREFERENCE-TALK	TALK
LEARNING PREFERENCE-VIDEO	MEDIA
RUBELLA IMMUNE	IMMUNE
RUBELLA NON-IMMUNE	NON-IMMUNE
RUBELLA STATUS INDETERMINATE	STATUS INDETERMINATE
TB-TX COMPLETE	TX COMPLETE
TB-TX INCOMPLETE	TX INCOMPLETE
TB-TX UNKNOWN	TX UNKNOWN
TB-TX UNTREATED	TX UNTREATED

Added the following Health Factors: (CR#234)

FACTOR	CATEGORY
CHANGE IN WEATHER	ASTHMA TRIGGERS
MENSES	ASTHMA TRIGGERS
OTHER TRIGGER	ASTHMA TRIGGERS
STRONG EMOTIONAL EXPRESSION	ASTHMA TRIGGERS
VIRAL INFECTION	ASTHMA TRIGGERS
LESS THAN 6 TH GRADE EDUCATION	ASTHMA TRIGGERS
RETIRED	OCCUPATION
TX IN PROGRESS	TB STATUS

Inactivated the following Health Factors: (CR#234)

FACTOR
BARRIERS TO LEARN-COGNITIVE IMPAIRMENT
DOES NOT SPEAK ENGLISH
EMOTIONAL IMPAIRMENT
BARRIERS-SIGN INTERPRETER NEEDED
READINESS TO LEARN-NOT READY
READINESS TO LEARN-PAIN
READINESS TO LEARN-RECEPTIVE
READINESS TO LEARN-SEVERITY OF ILLNESS
READINESS TO LEARN-UNRECEPTIVE
7-FOOD AND EXERCISE (MAINTAIN)

2.7 Other Changes

2.7.1 Asthma Severity Conversion

Used a conversion to move asthma severity from the V POV file to the Problem List.
(CR#207)

2.7.2 Taxonomies

The following national taxonomies were added for use with the Asthma Supplement, Action Plan, and Best Practice Prompts:

- BAT ASTHMA SHRT ACT RELV NDC (reliever)
- BAT ASTHMA SHRT ACT RELV MEDS (reliever)
- BAT ASTHMA SHRT ACT INHLR NDC (reliever)
- BAT ASTHMA SHRT ACT INHLR MEDS (reliever)
- BAT ASTHMA LEUKOTRIENE NDC (controller)
- BAT ASTHMA LEUKOTRIENE MEDS (controller)
- BAT ASTHMA CONTROLLER NDC (controller)
- BAT ASTHMA INHLD STEROIDS NDC (controller)

2.7.3 New APIs for the VA Reminders

Added APIs for the VA Reminders package to retrieve the last of each item.
(CR#172)

Each call is in the following format:

S X=\$\$linelabel^APCLAPIR(dfn, beginning date, ending date)

where

dfn = Patient DFN

beginning date = internal fileman date to begin searching for the item; if blank, DOB will be used.

ending date = internal fileman date to end searching for the item; if blank, DT (today's date) will be used.

The output of each call is in the following format:

1 or 0^date^item^value^visit ien^file^file ien

where

piece 1 = 1 if item found, 0 if no item found in the date range

piece 2 = date of last item found

piece 3 = text of item found

piece 4 = result

piece 5 = ien of visit on which item was found

piece 6 = file in which item was found (usually a V File #)

piece 7 = ien of V File in which entry was found

The following APIs have been added:

Alcohol Screening	\$\$REMAISC^APCLAPIR
Depression Screening	\$\$REMDEPS^APCLAPIR
Assessment of Function	\$\$REMAOF^APCLAPIR
Blood Pressure	\$\$REMBP^APCLAPIR
Breast Exam	\$\$REMBRST^APCLAPIR
Cholesterol	\$\$REMCHOL^APCLAPIR
Dental Exam	\$\$REMDENT^APCLAPIR
Diabetes Screening	\$\$REMGLUC^APCLAPIR
Intimate Partner Violence Screening	\$\$REMIPVS^APCLAPIR
EPSDT Screening	\$\$REMEPSDT^APCLAPIR
Head Circumference	\$\$REMHC^APCLAPIR
Hearing Exam	\$\$REMHEAR^APCLAPIR
Height	\$\$REMHT^APCLAPIR
Influenza Immunization	\$\$REMFLU^APCLAPIR
Mammogram	\$\$REMMAMM^APCLAPIR

Osteoporosis Screening	\$\$REMOSTEO^APCLAPIR
Pap Smear	\$\$REMPAP^APCLAPIR
Pelvic Exam	\$\$REMPEVL^APCLAPIR
Physical Exam	\$\$REMPHYS^APCLAPIR
Pneumovax	\$\$REMPNEU^APCLAPIR
Rectal Exam	\$\$REMRECT^APCLAPIR
Rubella	\$\$REMRUBEL^APCLAPIR
TD	\$\$REMTD^APCLAPIR
Tobacco Screening	\$\$REMTOBS^APCLAPIR
Tonometry	\$\$REMTON^APCLAPIR
Visual Acuity Exam	\$\$REMVAE^APCLAPIR
Weight	\$\$REMWT^APCLAPIR

2.7.4 Family History Data Conversion

Added a post-init routine to perform the following tasks: (CR#199 and CR#321)

- Convert the relationship and status data from the Family History file and move it to the new Family History Family Member file.
- Stuff a family member of UNKNOWN into the Family member field for all entries that currently have no Relation/Family member entered.
- Convert the existing numeric diagnosis onset age (if any) to the corresponding new Age of Onset codes.

2.7.5 Reproductive History String Conversion

Converted the existing Reproductive History field to new fields. If the existing Reproductive History field is populated with a number, including the “0” option, any existing values in the string are copied to new fields as follows:

- G = Gravida
- P = Full Term
- LC = Living Children
- SA = Spontaneous Abortions
- TA = Therapeutic Abortions

3.0 Taxonomy Maintenance Menu (MAIN)

The Taxonomy Maintenance menu contains options to add, modify, and delete taxonomies, as well as the following options:

- Send a bulletin (an email message) whenever a patient's purpose of visit is one of the entries within a taxonomy.
- Allow patients to be entered into a separate Pt Taxonomy file that can be prospectively updated.
- Remove a patient list for a taxonomy file.
- Display a description of a taxonomy.
- Retrieve a list and count of patients within a taxonomy.
- Create lab test taxonomies, which are used by the Diabetes Audit Program.

```
Indian Health Service - RPMS
Taxonomy System
IHS PCC Suite Version 2.0
DEMO HOSPITAL

Taxonomy Maintenance Menu

ADD Create a Taxonomy
MOD Modify a Taxonomy
DEL Delete a Taxonomy
BUL Enter Bulletin for a Taxonomy
RBL Remove Bulletin from a Taxonomy
ENT Enter Patients into Pt Taxonomy File
REM Remove Patients from the Pt Taxonomy File
TAX Description of a Taxonomy
PAT List Patients within a Taxonomy
LAB Enter/Edit a Lab Test Taxonomy

Select Taxonomy Maintenance Option:
```

Figure 3-1: Taxonomy maintenance menu options (MAIN)

3.1 Taxonomy Creation (ADD)

In PCC, a taxonomy can be thought of as a group of diagnoses that relate to a particular medical disorder or problem. Reference books that classify the ICD diagnosis codes should be available from the PCC data entry or Medical Records personnel at your facility.

Follow these steps to create a taxonomy:

1. Determine which ICD codes will fall into the new taxonomy.
2. Type the name of the taxonomy.
3. Type a short description of the taxonomy.
4. Type a longer description of the taxonomy (optional).
5. Type ICD codes for the taxonomy.

The following is a sample taxonomy creation session.

```
Select Taxonomy Maintenance Option: ADD <Enter>  Create A Taxonomy
Select TAXONOMY NAME: DIABETES <Enter>
ARE YOU ADDING 'DIABETES' AS A NEW TAXONOMY (THE 6TH)?  Y <Enter>
(YES)
BRIEF DESCRIPTION: [DX DIABETES.RELATED DISORDERS]
EXTENDED DESCRIPTION:
1 Includes gestational and nongestational diabetes
2
EDIT Option: <Enter>
ENTER DX: ? <Enter>

Enter ICD9 diagnosis code or narrative. You may enter a range of
codes by placing a "-" between two codes. Codes in a range will
include the first and last codes indicated and all codes that fall
between. Only one code or one range of codes at a time. You may also
enter "[TAXONOMY NAME]" to select codes already within a taxonomy.
You can also "deselect" a code or range of codes by placing a "-" in
front of it. (e.g. '-250.00' or '-250.01-250.93')
```

```
ENTER DX: 250.00-250.11 <Enter>  250.00 DIABETES UNCOMPL ADULT/NIDDM
...OK? YES// <Enter>
250.11 DIAB W COMPL NOS JUVEN/IDDM

ICD codes in this range =>
250.00 DIABETES UNCOMPL ADULT/NIDDM
250.01 DIABETES UNCOMPL JUVEN/IDDM
250.10 DIAB KETOACIDOSIS ADULT/NIDDM
250.11 DIAB KETOACIDOSIS JUVEN/IDDM

Press return to continue <Enter>
```

If a long range of codes is entered, only a screenful of codes and their descriptions will be displayed at a time. A "< >" will appear at the bottom of each screen. Enter "^" to stop the display of codes or return to display the next screenful of codes in the range. Whether or not you display the entire range of codes, the range of codes will be accepted as entered by the user.

ICD Code Range(s) Selected So Far =>

1) 250.00-250.11

ENTER ANOTHER DX: **SURVEILLANCE DIABETES** <Enter>

The user has decided to choose the range of codes that are located within the SURVEILLANCE DIABETES taxonomy. The code range for this taxonomy is 250.00-250.93.

ICD Code Ranges) Selected So Far =>

1) 250.00-250.93

ENTER ANOTHER DX: **775.1** <Enter> NEONAT DIABETES MELLITUS

ICD Code Range(s) Selected So Far =>

1) 250.00-250.93

2) 775.1

ENTER ANOTHER DX: **??** <Enter>

Enter an Item Number from the table above to display code(s): **2**

<Enter>

ICD Codes in this range =>

775.1 NEONAT DIABETES MELLITUS

Press return to continue<Enter>

ICD Code Range(s) Selected So Far =>

1) 250.00-250.93

2) 775.1

ENTER ANOTHER DX: <Enter>

Is everything okay? Y// <Enter>

Answering 'no' here will allow you to modify the entered range(s)

One moment please ...

Entry of this taxonomy's name will now be made for each code that falls under this taxonomy in background under Taskman!

Figure 3-2: Sample taxonomy creation session (ADD)

3.2 Taxonomy Modification (MOD)

Use the Modify a Taxonomy option to change the name of the taxonomy, the brief description, the extended description, and the ICD codes that had previously been entered.

If an ICD code is being deleted from a taxonomy for which patients are being entered prospectively into the Pt Taxonomy file, any patients who had only been entered with the deleted code will be removed from the taxonomy. If a patient has had visits entered for several codes in the modified taxonomy, a visit counter will be decremented by the number of visits with a purpose of visit corresponding to the deleted ICD code.

If an ICD code (or range of codes) is being added to the taxonomy, the patient list in the Pt Taxonomy file will be updated with purposes of visits corresponding to the added ICD codes. Visit counters for patients already on the list will be incremented appropriately, and new patients will be added to the list. The patient list will be updated for visits that occurred on or after the date entered in the Starting Date for Patient List field.

In the following sample taxonomy modification session, the user removes codes 250.30 thru 250.41 and code 775.1 from the Diabetes taxonomy, and then decides to add 250.40 and 250.41 back again.

```
Select Taxonomy Maintenance Option: MOD <Enter>  Modify A Taxonomy
Select TAXONOMY: DIABETES <Enter>
NAME: DIABETES// <Enter>
BRIEF DESCRIPTION DX DIABETES RELATED DISORDERS replace <Enter>
EXTENDED DESCRIPTION 1)Includes gestational and non-gestational
diabetes

EDIT Option: 1 <Enter>
Line one is selected and will be changed by the user to indicate ICD
code changes.
ICD Code Range(s) Selected So Far =>
1) 250.00-250.93
2) 775.1

ENTER ANOTHER DX: -250.30-250.41 <Enter>  DIABETES COMA NEC ADULT/
...OK? YES//<Enter>

250.50 DIAB OPTHAL MANIF ADULT/NIDDM
... OK? YES//<Enter>

ICD codes in this range =>
250.30 DIABETES COMA NEC ADULT/NIDDM
250.31 DIABETES COMA NEC JUVEN/IDDM
250.40 DIABETES RENAL MANIF ADULT/NIDDM
250.41 DIABETES RENAL MANIF JUVEN/IDDM

Press return to continue <Enter>
```

```
ICD Code Range(s) Selected So Far =>
1) 250.00-250.21
2) 250.51-250.933)
3) 775.1

ENTER ANOTHER DX: -775.1 <Enter>  NEONAT DIABETES MELLITUS
... OK? YES// <Enter>

ICD Code Range(s) Selected So Far =>
1) 250.00-250.21
2) 250.51-250.93

ENTER ANOTHER DX: 250.40-250.41 <Enter>  250.40 DIAB RENAL MANIF
ADULT/NIB
... OK? YES// <Enter>  (YES)
250.41 DIAB RENAL MANIF JW EN/IDDM ... OK? YES// <Enter>  (YES)

ICD codes in this range =>
250.40 DIAB RENAL MANIF ADULT/NIDDM
250.41 DIAB RENAL MANIF JUVEN/NIDDM

Press return to continue <Enter>

ICD Code Range(s) Selected So Far =>
1) 250.00-250.21
2) 250.40-250.41
3) 250.50-250.93

ENTER ANOTHER DX: <Enter>

Is everything okay? Y// <Enter>

One moment please ..
Taxonomy will now be modified (if changes were made) in background
by Taskman.
```

Figure 3-3: Sample taxonomy modification session (MOD)

3.3 Taxonomy Deletion (DEL)

Use the Delete a Taxonomy option to remove a taxonomy. When a taxonomy is deleted, the patients stored under this taxonomy in the Pt Taxonomy file are removed, and the taxonomy is deleted from both the Taxonomy and Pt Taxonomy files.

The following is a sample taxonomy deletion session.

```
Select Taxonomy Maintenance Option: DEL      Delete a Taxonomy
Select TAXONOMY NAME: DIABETES      DX DIABETES/RELATED DISORDERS
ARE SURE YOU WANT TO DELETE THE ENTIRE TAXONOMY? YES// (YES)
The taxonomy will now be deleted in background by TASKMAN.
```

Figure 3-4: Sample taxonomy deletion session (DEL)

3.4 Bulletin Creation for a Taxonomy (BUL)

A bulletin for a taxonomy is an email message sent to a specified group of recipients when a patient's purpose of visit matches one of the entries within the taxonomy. The selection of a taxonomy within the "Enter Bulletin for a Taxonomy" option will automatically create a bulletin to be sent to the recipients within the designated mail group.

This option will create the message for the taxonomy of interest. You can then designate a mail group to whom the bulletin will be sent. If this is a new mail group, you will be asked for the names of the people you would like to have as members of this mail group.

Once a mail group has been established, modification of this group must be done with the assistance of the site manager using File Manager option 1. Additional mail groups can be created for this taxonomy's bulletin utilizing the same File Manager option. Within the Bulletin file, select the bulletin that is the name of your taxonomy prefaced by the letters ATX and modify the mail group field. To change a mail group for a bulletin, delete the bulletin for the taxonomy, reenter the bulletin, and designate a new mail group. Deleting the old mail group must be done using the "Remove Bulletin from a Taxonomy" option.

Bulletins should be used only for unusual or special purpose of visits. Otherwise you receive electronic mail very frequently.

This option asks you for the type of visit for which a bulletin should be sent. The following visit types are available:

- Hospitalization only
- Ambulatory only
- Both Hospitalization and Ambulatory

This option will also ask for a location, which is the location of encounter for a patient visit. Enter a location if you are interested in receiving bulletins for patient visits to that facility only. If you want to receive bulletins regardless of the facility the patient visited, do not enter a location. You will be sent a bulletin for any location where the patient has had diagnosis that falls within the selected taxonomy. The chart number displayed for the patient will be the patient's chart number at the facility at which the patient was treated. If the database does not have the patient's chart number at that facility, the chart number at the facility where the bulletin is generated will be used.

3.4.1 Injury Control Bulletin

The Taxonomy System comes with the Injury Control Bulletin bullet created and ready to use. This bulletin was developed for Injury Control officers and is sent anytime a patient is seen with an injury diagnosis (ICD9 codes 800.0-999.0). To enable this bulletin, the following procedures are required. These procedures should be performed by the site manager in conjunction with your local injury control officer or other Environmental Health representative.

The ATX Injury Control Notif bulletin is triggered each time an injury-related purpose of visit is entered in PCC. However, you must first create an Injury Control mail group on your system before these bulletins will function. The following steps outline this procedure.

1. Create a new Injury Control mail group in the Mail Group file through FileMan, or by using the appropriate menu option on the Manage Mailman menu. Enter the appropriate members in this group.
2. Add the Injury Control mail group to the mail group field of the bulletin ATX Injury Control Notif. This can be done through FileMan or by using the Bulletin Edit option on the Manage Mailman menu.
3. Using FileMan, type "ATX Injury Control Notif" in the Bulletin field of the Taxonomy file for the entry called ATX Injury Control.

When the Injury Control bulletin is enabled, a bulletin is sent each time an injury diagnosis is entered for a patient.

You can customize the sending of bulletins in various ways. You can limit bulletins to be sent for specific service categories and/or specific facilities. This is done by editing the Bulletin Service Category or the Location field of the taxonomy entry. Again, your site manager can be of assistance in setting this up.

3.5 Bulletin Removal from a Taxonomy (RBL)

To stop sending a bulletin for a taxonomy, use the Remove Bulletin from a Taxonomy option.

To resume sending a bulletin after it has been deleted, recreate it using the Enter Bulletin for a Taxonomy option.

As described in Section 3.4, to change the mail group receiving a bulletin, use the Remove Bulletin from a Taxonomy option to delete the bulletin, and then recreate the bulletin with the new mail group using the Enter Bulletin for a Taxonomy option.

The following is a sample Remove Bulletin from a Taxonomy session:

```
Select Taxonomy Maintenance Option RBL Remove Bulletin From A
Taxonomy
Select TAXONOMY NAME: DIABETICS
Are you sure you want to no longer have a bulletin issued for this
taxonomy? NO// [Y]
Okay, the bulletin has been deleted for this taxonomy
```

Figure 3-5: Sample bulletin removal session (RBL)

3.6 Entering Patients into the Pt Taxonomy File (ENT)

All patients with a purpose of visit that corresponds to an ICD Diagnosis code within a taxonomy will be entered in the Pt Taxonomy file under the appropriate taxonomy.

The list of patients in the Pt Taxonomy file is updated automatically each time an appropriate ICD code is entered in a patient's V POV (Purpose of Visit) file during PCC data entry. If the patient is already in the list for a particular taxonomy, a visit counter is incremented by one; otherwise, the patient is added to the list. The list of patients is updated accordingly whenever an existing entry in a V POV file is modified.

To begin adding patients to the Pt Taxonomy file, enter the starting date for the patient list. The date you enter will be the starting date for those patients who had a purpose of visit (POV) related to the selected taxonomy. If the date entered is before the first visit in your database, all patients who have ever had a POV for this taxonomy will appear on the patient list in the Pt Taxonomy file.

Because you probably will not know the first visit by a patient in your database, if you want to start at the first visit, enter a date such as January 1, 1960. You can also enter a future date and the patients will be added to the list starting on that date. Future dates cannot exceed one year from the current date.

All patient lists in the Pt Taxonomy file will be updated prospectively. A prospective list means that whenever a purpose of visit whose ICD code falls within a particular taxonomy is added to the V POV file during PCC data entry, the patient will automatically be added to the patient list for that taxonomy, or the visit counter will be increased by one if the patient is already in the list.

If you are interested in patients who have previously been diagnosed with an ICD diagnosis within the taxonomy you created, do not enter patients into the Pt Taxonomy file. This option is only for building a list that will be updated as patients visit your facility in the future. Instead, use the Research and Reports menu in the Taxonomy System or Q-Man to obtain a retrospective list of patients that fall within your taxonomy.

After patients have been entered into the Pt Taxonomy file, you cannot modify the Starting Date for Patient List field. To change the starting date for the list, use the Remove Patients from Pt Taxonomy File option to remove the patient list, and then return to the Enter Patients Into Pt Taxonomy File option and enter new information in this field.

Sample Session A

A user wants any patient who had a past visit for a diagnosis that falls within this taxonomy to be added to the Pt Taxonomy file. Prospective updating will begin immediately.

```
Select Taxonomy Maintenance Option: ENT <Enter>  Enter Patients Into
Pt Taxonomy File

Select TAXONOMY NAME: DIABETES <Enter>
STARTING DATE FOR PATIENT LIST: ? <Enter>
  ENTER THE DATE YOU WOULD LIKE THE PATIENT LIST TO BEGIN. YOU MAY
  START FROM ANY DATE IN THE PAST OR A FUTURE DATE UP TO ONE YEAR
  FROM TODAY.
  Examples of Valid Dates:
    JAN 20, 1957 or 20 JAN 57 or 1/20/57 or 012057
    T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
    T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
  If the year is omitted, the computer uses the CURRENT YEAR.

STARTING DATE TO BEGIN PATIENT LIST: JAN 1 1960 <Enter>

Entries for this taxonomy into the Pt Taxonomy file will now occur
via TASKMAN in background!
```

Figure 3-6: Sample session to enter patients in the Pt Taxonomy file

Sample Session B

A user does not want past patients entered into the Pt Taxonomy file for this taxonomy, but elects to have the patient list begin on a future date. For this example, we will use the date April 30, 1991; updating of the patient list for this taxonomy will begin on that date. the starting date can be modified as long as updating of a patient list has not begun. In this example, the date can still be modified anytime prior to April 30, 1991.

```
Select Taxonomy Maintenance Option: ENT <Enter>  Enter Patients into
Pt Taxonomy File

Select TAXONOMY NAME: DIABETES <Enter>
STARTING DATE FOR PATIENT LIST: 4/30/91 <Enter>
```

Figure 3-7: Sample session to enter patients in the Pt Taxonomy file, starting at a future date

3.7 Removing Patients from the Pt Taxonomy File (REM)

Use the REM option to remove patient entries under a taxonomy in the Pt Taxonomy file. If necessary, use the Enter Patients into Pt Taxonomy File option to re-enter patients under a taxonomy.

The following is a sample Remove Patients from Pt Taxonomy File session:

```
Select Taxonomy Maintenance Option: REM <Enter>  Remove Patients
From The Pt Taxonomy File

Select PT TAXONOMY NAME: DIABETES <Enter>
ARE YOU SURE YOU WANT TO DELETE THE PATIENT LIST FOR THIS TAXONOMY?
YES// <Enter>  (YES)
DONE!
```

Figure 3-8: Sample session to delete patients listed under a taxonomy in the Pt Taxonomy file (REM)

3.8 Viewing a Description of a Taxonomy (TAX)

Use the TAX option to view a description of a taxonomy and the range of ICD codes within that taxonomy.

The following is a sample session to view a description of a taxonomy:

```
Select Taxonomy Maintenance Option: TAX <Enter>  Description of A
Taxonomy
Select TAXONOMY NAME: DIABETES <Enter>

NAME: DIABETES BRIEF DESCRIPTION: DX DIABETES RELATED DISORDERS
ENTER PST INTO PT TAX FILE: YES CREATOR: LASTNAME, FIRSTNAME
STARTING DATE FOR A LIST: JANUARY 1, 1960
CREATED BY TAXONOMY SYSTEM: YES TYPE: RANGE
ENTRIES IN TAXONOMY FROM FILE: ICD DIAGNOSIS
EXTENDED DESCRIPTION: Includes non-gestational ICD Diagnosis codes
for diabetes

LOW ICD: 250.00 HIGH ICD: 250.21
LOW ICD: 250.40 HIGH ICD: 250.41
LOW ICD: 250.40 HIGH ICD: 250.93
```

Figure 3-9: Sample session to view a description of a taxonomy (TAX)

3.9 Listing Patients within a Taxonomy (PAT)

Use the PAT option to view or print a list of all the patients within a taxonomy in the Pt Taxonomy file. This option also counts all the patients within a taxonomy.

The following is a sample List Patients within a Taxonomy session:

```
Select Taxonomy Maintenance Option: PAT <Enter> List Patients
Within A Taxonomy
Select PT TAXONOMY NAME: DIABETES <Enter>

DEVICE: RIGHT MARGIN: 80// <Enter>

PATIENT TAXONOMY LISTING                               Nov 10, 1988 14:31 Page 1
-----
TAXONOMY name: DIABETES

LASTNAME1, FIRSTNAME
LASTNAME2, FIRSTNAME
LASTNAME3, FIRSTNAME
LASTNAME4, FIRSTNAME
LASTNAME5, FIRSTNAME
LASTNAME6, FIRSTNAME
LASTNAME7, FIRSTNAME
LASTNAME8, FIRSTNAME
-----
Count 8
```

Figure 3-10: Sample session to view a list of patients within a taxonomy (PAT)

3.10 Enter/Edit a Lab Test Taxonomy (LAB)

Use the LAB menu option to enter or edit a laboratory test taxonomy. A lab test taxonomy is similar to an ICD taxonomy, except that it stores lab test names and allows you to select a site and/or specimen appropriate for that test.

At this time, the only systems using lab test taxonomies are the Diabetes Audit Program and the Patient Data Fetcher.

The following is a sample Enter/Edit a Lab Test Taxonomy session:

```
Select Taxonomy Maintenance Option: LAB <Enter>  Enter/Edit Lab Test Taxonomy

It is recommended that you have the laboratory personnel assist you when entering this data.

Select LAB TAXONOMY NAME: CHOL TAX <Enter>
ARE YOU ADDING 'CHOL TAX' AS A NEW LAB TAXONOMY (THE 2ND)? Y <Enter> (YES)
BRIEF DESCRIPTION: ? <Enter>
Answer must be 3-50 characters in length.
BRIEF DESCRIPTION: CHOLESTEROL TAXONOMY <Enter>

Select LAB TEST: ? <Enter>
YOU MAY ENTER A NEW LAB TESTS, IF YOU WISH
ANSWER WITH LABORATORY TEST NAME, OR LOCATION (DATA NAME)
DO YOU WANT THE ENTIRE 953-ENTRY LABORATORY TEST LIST? N <Enter> (NO)
Select LAB TEST: CHOLESTEROL <Enter>

Select SITE/SPECIMEN: ? <Enter>
ANSWER WITH SITE/SPECIMEN
YOU MAY ENTER A NEW SITE/SPECIMEN, IF YOU WISH
ANSWER WITH TOPOGRAPHY FIELD SYNONYM, OR SNOMED CODE, OR ABBREVIATION
DO YOU WANT THE ENTIRE 8539-ENTRY TOPOGRAPHY FIELD LIST? N <Enter> (NO)
Select SITE/SPECIMEN: BLOOD <Enter>

Select LAB TEST:
```

Figure 3-11: Sample session to enter a lab test taxonomy (LAB)

4.0 Research and Reports Menu (RES)

The Research and Reports menu has options that allow you to search the database for data related to the patients and visits contained within a taxonomy. You can create search templates to store the patients or purpose of visit entries contained within a taxonomy. You can then search other files and compare these newly created search templates to the template related to the taxonomy that is of interest to you.

The Search Template Comparison System option is also located on the Research and Reports menu (a separate user manual is available for this system). This option allows you to compare search templates linked to various files. See the help frames for this option for a more detailed explanation of this system.

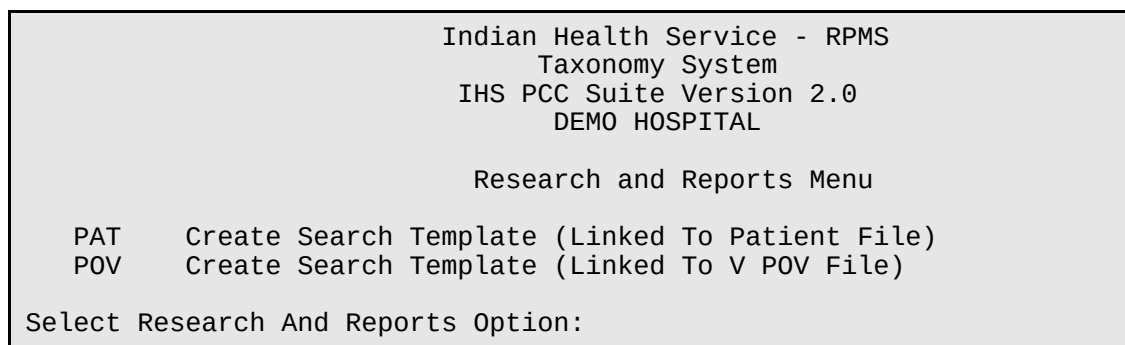


Figure 4-1: Options on Research and Reports Menu

4.1 Creating a Search Template Linked to the Patient File (PAT)

The PAT option creates a template with the names of all patients who have had at least one visit associated with the taxonomy of interest. This occurs whether or not patients were entered into the Pt Taxonomy file. The template created can then be used by the Search Comparison Utility or by the Print option of FileMan (General).

To use the template within the Print option, enter the Patient file as the file from which to print. At the “Sort by Number” prompt, enter the name of the template that you created preceded by a left bracket. You can then do a sort based on the patients within the template. Using the print option is an easy way of listing the names of the patients who fall under the taxonomy, if they were not entered into the Pt Taxonomy file.

It is recommended that you do not enter the patients into the Pt Taxonomy file (Taxonomy Maintenance menu, ENT option), if you are not interested in patients being added prospectively to the Pt Taxonomy file.

Sample Session A

In this example, there is no patient list in the Pt Taxonomy file being updated. If a patient came to the clinic for bubonic plague during the specified time frame, the patient's name will be stored in your search template.

```
Select Research and Reports Option: PAT <Enter>  Create Search
Template

Select TAXONOMY NAME: BUB <Enter> ONIC PLAGUE Tracks bubonic plague
patients

Select SEARCH TEMPLATE: BUBONIC PLAGUE PTS <Enter>
ARE YOU ADDING 'BUBONIC PLAGUE PTS' AS A NEW SORT TEMPLATE? Y
<Enter>  (YES)

DESCRIPTION:
1 Plague patients who had a visit (ICD code) 020.0
2 October 1 1988 - September 30 1989
3
EDIT Option: <Enter>

SORT TEMPLATE NAME: BUBONIC PLAGUE PTS <Enter>

Enter a range of visit dates from which to extract entries:
Enter beginning visit date: FIRST// October 1 1988 <Enter>  (OCT 01,
1988)
Enter ending visit date: LAST// September 30 1989 <Enter>  (SEP 30,
1989)

Do you want to queue the search template creation to another device?
NO// Y <Enter>  (YES)

QUEUE TO PRINT ON DEVICE: HOME// 4 <Enter>

REQUESTED START TIME: NOW (or a time after working hours)//
```

Figure 4-2: Sample session to create a search template linked to the Patient file (PAT)

Sample Session B

If a patient list for this taxonomy exists in the Pt Taxonomy file, choice 1 will be presented. To include patients in a search template who were seen for bubonic plague earlier than the start date in the Pt Taxonomy file, select choice 2.

```
Select Research and Reports Option: PAT <Enter> Create Search
Template

Select TAXONOMY NAME: BUB <Enter> ONIC PLAGUE Tracks bubonic
patients

Select, by number, one of the following:
1 Create a search template that will contain a list of all patients
pt taxonomy file. This list of patients starts with the visit date
Nov 6, 1989.
2 Create a search template of patients seen during a range of visit
dates.
These patients will have had a purpose of visit that falls within
this taxonomy.

Your choice (1 or 2): 1 <Enter>

Select SEARCH TEMPLATE: AFTER 11/5 BUBONIC PTS <Enter>
ARE YOU ADDING 'AFTER 11/5 BUBONIC PTS' AS A NEW SORT TEMPLATE? Y
<Enter> (YES)
DESCRIPTION:
1 POV AFTER 11/5/89
2
EDIT Option: <Enter>

SORT TEMPLATE NAME: BUBONIC PLAGUE PTS// <Enter>
Do you want to queue the search template creation to another device?
NO// <Enter> (NO)
There was 2 entry in the AFTER 11/5 BUBONIC PTS template.
```

Figure 4-3: Sample session to create a search template linked to the Patient file containing all patients in Pt Taxonomy file (PAT)

4.2 Creating a Search Template Linked to the V POV File (POV)

The POV option goes through the V POV (Purpose of Visit) file and finds the purpose of visit entries that are within the taxonomy of interest. These V POV entries will be stored in a search template linked to the V POV file.

Note: You will be asked for a range of visit dates from which entries from the V POV file will be selected for this taxonomy.

Sample Session to Create Search Template Linked to the V POV File:

You might want to store the purpose of visit entries from the V POV file for patients who were diagnosed with Bubonic Plague. Like other search templates, this one requires a date range.

```
Select Research and Reports Option: POV <Enter> Create Search
Template (Linked To V POV File)

Select TAXONOMY NAME: BUB <Enter> ONIC PLAGUE

Select SEARCH TEMPLATE: POV OF BUBONIC PLAGUE PTS <Enter>
ARE YOU ADDING 'POV OF BUBONIC PLAGUE PTS' AS A NEW SORT TEMPLATE? Y
<Enter> (YES)

DESCRIPTION:
1 ICD CODE 020.0
2

EDIT Option: <Enter>
SORT TEMPLATE NAME: POV OF BUBONIC PLAGUE PTS <Enter> Replace
<Enter>
Enter a range of visit dates from which to extract entries:
Enter beginning visit date: FIRST// <Enter>
Enter ending visit date: LAST// September 30 <Enter> (SEP 30,1989)

Do you want to queue the search template creation to another device?
NO// Y <Enter> (YES)
QUEUE TO PRINT ON DEVICE: HOME// 4 <Enter>
REQUESTED START TIME: NOW//
```

Figure 4-4: Sample session to create a search template linked to the V POV file (POV)

5.0 Setup of Injury Control Bulletin System

The following applies to Taxonomy System Version 5.1.

Local Mailman must be running in order to take advantage of this bulletin system.

The following actions should be performed by the Site Manager, in conjunction with the local Injury Control officer or other OEH representative.

1. The Taxonomy System, version 5.1, comes with the ATX Injury Control Notif bulletin, which is triggered each time an injury-related purpose of visit is coded into the PCC. Bulletins are mail messages sent by the Taxonomy System to provide information for members of a mail group. If you have not created an injury control mail group, you must create a mail group for this bulletin on your system.

Set up the mail group and bulletin as follows:

- a. Create the mail group in the Mail Group file. Add mail group members to this mail group.
- b. Go into the Bulletin file and add the mail group to the ATX Injury Control Notif bulletin.
- c. Select option 1 of File Manager and edit the Bulletin field in the Taxonomy file for the ATX Injury Control taxonomy.

Type **ATX Injury Control Notif** as a value for this field, if your site wants bulletins sent to notify appropriate users of injuries.

2. Customize the issuing of a bulletin as follows:
 - a. Select option 1 of File Manager and edit the Bulletin Service Category field in the Taxonomy file for the ATX Injury Control taxonomy. Selecting Hospitalization will more likely ensure that users will be notified about severe injuries only.
 - b. Also, edit the Location field for this taxonomy. If you want bulletins sent for this taxonomy from only one facility (location of encounter), enter that facility's name in this field. If you want bulletins sent regardless of where the patient was seen for their injury, do not enter a location in this field.

3. Some sites might want to edit the ICD codes sent with the ATX Injury Control taxonomy. Do so as follows:
 - a. Go into programmer mode and set the variable DUZ=0, i.e., S DUZ=0.
 - b. Then D^AATXEMP and modify the ICD code ranges. Remove the “F” code ranges, as they will never be used by the Data Entry staff for a purpose of visit. They are used by the cause of injury field, which is not utilized by this bulletin system.

6.0 Appendix A: RPMS Rules of Behavior

The information in this required section was written by the IHS Office of Information Technology. It does not contain any information about the functionality of the software.

6.1 All RPMS Users

In addition to these rules, each application can include additional RoBs, which can be defined within the individual application's documentation (e.g., PCC, Dental, Pharmacy).

6.1.1 Access

RPMS users shall:

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer *before* providing any type of information system access, sensitive information, or non-public agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions Indian Health Manual Chapter 6 OMS Limited Personal Use of Information Technology Resources TN 03-05," August 6, 2003.

Users shall not:

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform your OFFICIAL duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their job or by divulging information to anyone not authorized to know that information.

6.1.2 Logging On To the System

RPMS users shall:

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after 5 successive failed login attempts within a specified time period (e.g., one hour).

6.1.3 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

Users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users might be afforded additional privileges based on the function they perform such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.
- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Logout of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO).
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Shall abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and IT information processes.

6.1.4 Accountability

Users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Logout of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO).
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior and IT information processes.

6.1.5 Confidentiality

Users shall:

- Be aware of the sensitivity of electronic and hardcopy information, and protect it accordingly.
- Store hardcopy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media, prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all HIPAA regulations to ensure patient confidentiality.

Users shall not:

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

6.1.6 Integrity

Users shall:

- Protect your system against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

Users shall not:

- Violate Federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware or public domain software on/with the system without your manager's written permission and without scanning it for viruses first.

6.1.7 Passwords

Users shall:

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha, numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts, or batch files).
- Change password immediately if password has been seen, guessed or otherwise compromised; and report the compromise or suspected compromise to your ISSO.
- Keep user identifications (ID) and passwords confidential.

Users shall not:

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per 8 characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

6.1.8 Backups

Users shall:

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

Users shall not:

- Violate Federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware or public domain software on/with the system without your manager's written permission and without scanning it for viruses first.

6.1.9 Reporting

Users shall:

- Contact and inform your ISSO that you have identified an IT security incident and you will begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in IHS SOP 05-03, Incident Handling Guide.

Users shall not:

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

6.1.10 Session Time Outs

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

Users shall:

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on your screen after some period of inactivity.

6.1.11 Hardware

Users shall:

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

Users shall not:

- Eat or drink near system equipment.

6.1.12 Awareness

Users shall:

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS Manuals for the applications used in their jobs.

6.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees can work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal and non-recovery of temporary files created in processing sensitive data, virus protection, intrusion detection, and provides physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote users shall:

- Remotely access RPMS through a virtual private network (VPN) when ever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote users shall not:

- Disable any encryption established for network, internet and web browser communications.

6.2 RPMS Developers

Developers shall:

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain; abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

Developers shall not:

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

6.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators have added responsibilities to ensure the secure operation of RPMS.

Privileged users shall:

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need to know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, CISO, and systems owner.
- Protect the supervisor, superuser or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and back up files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to; abide by all Department and Agency policies and procedures.

Privileged users shall not:

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

7.0 Glossary

@ symbol

This symbol (key combination of Shift+2) has two functions: (1) to delete an entry and (2) to separate a date and time.

Acute

Used to describe a condition that lasts for a short time. Used in contrast to *chronic*.

Append

To add additional data items to an existing visit, usually at the end of entering the data.

Billable Visit

A visit from a patient that has third party insurance coverage that a hospital/clinic can bill services.

Best Practice Prompts

Best Practice Prompts are a set of clinical messages related to procedures such as lab tests, immunizations, procedures etc. that are generally recommended for a subset of the population who share a common diagnosis (e.g. Asthma, CVD). They are displayed in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Users can turn on (activate) and display BP Prompts on Health Summaries, similar to the Health Maintenance Reminder function.

Billable Visit

A visit from a patient that has third party insurance coverage that a hospital/clinic can then bill for services.

Caret (“Up Hat”)

The symbol ^ obtained by using the key combination Shift+6. Commonly used in RPMS character-based interfaces to exit out of a routine or to back up from the previous field.

Chart Number

A unique numerical identifier assigned to each patient. This is also referred to as Health Record Number.

Chronic

Used to describe a condition that has an indefinite duration or with a frequent occurrence. Used in contrast to *acute*.

Clinical

To do with treatment in or as a clinic: involving or concerned with direct observation and treatment of patients.

Command

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

Community of Service

The community where the encounter took place.

Community of Residence

The community where the patient resides.

CPT Code

Current Procedural Terminology code. Used to identify procedures provided during an encounter and for billing outpatient services provided.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Default Response

Many of the prompts in the RPMS applications contain responses that can be activated simply by pressing the Return key . For example: “Do you really want to quit? No//.” Pressing the Return key tells the system you do not want to quit. “No//” is considered the default response. The default is generally set to the most frequently used response for the prompt.

Designated Primary Care Provider (DPCP)

The primary care provider designated for the patient. This is distinguished from a primary or secondary visit provider for a specific visit.

Device

The name of the printer you want the system to use when printing information. *Home* means the computer screen.

DOB

Date of Birth

DOD

Date of Death

DOS

Date Of Service

DX

Common abbreviation for Diagnosis

EDC

Expected/estimated date of confinement, that is the expected/estimated due or delivery date for a pregnancy.

EDD

Expected/estimated date of delivery.

Export

To format data so it can be used by another application.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, you will find a prompt requesting specific types of data. There are nine basic field types in RPMS programs, and each collects a specific type of information.

Free Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters you are allowed to enter.

Health Factors

Health Factors are data elements utilized by RPMS to record health status information about the patient. Current Smoker use is an example of a health factor in the Tobacco category. Health Factor data are recorded in the PCC V Health Factor file. For a current list of Health Factors, see the Health Summary User Manual.

Health Management Reminders (HMRs)

Health Maintenance Reminders are a set of clinical reminders related to procedures such as lab tests, immunizations, procedures etc. that are generally recommended for a subset of the population. They are displayed in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Health Record Number (HRN)

A unique numerical identifier assigned to each patient. This is also referred to as a Chart Number.

Health Summary

The Health Summary is a patient report displaying related data built from the PCC V files such as laboratory and pharmacy. There are many different types of Health Summaries available to users at each site. Users are also able to design a health summary on-the-fly from the available components.

HRN#

Health Record Number, also referred to as a Chart Number

HS

Health Summary, a summary of a patient's medical care. The RPMS PCC is distributed with several standard health summaries, but can be customized. Examples of standard health summaries are: Adult Regular, Behavioral Health, CHR, Dental.

HX

Abbreviation for History. History is an event taking place in the past, such as surgery, immunizations, etc.

ICD

International Classifications of Diseases. This is a national coding system primarily used for: (1) classifying morbidity and mortality information for statistical purposes, (2) indexing of hospital records by disease and operations, and (2) data storage and retrieval. In addition, this is the coding system physicians must use for billing purposes of Medicare, Medicaid, and private insurance for services rendered.

Interfaces

A boundary where two systems can communicate. RPMS applications contain both character-based (“roll-and-scroll”) and graphical user (GUI) interfaces. PCC Data Entry is an example of a character-based interface; RPMS EHR is an example of a GUI.

Menu

The menu is a list of different options you may select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt. A menu option followed by the ellipsis (...) indicates there are submenus.

Mnemonic

An abbreviation used to name a menu option or report used in the RPMS character-based packages. RPMS PCC data entry mnemonics to enter a data type can be two, three, or four characters, e.g., BP (blood pressure).

Narrative Description

A detailed description given using words rather than codes.

Patient Care Component (PCC)

PCC is the core of the RPMS applications and functions as a clinical data repository. Most RPMS applications “pass” key data elements to PCC, stored in V (visit) files, e.g., V Lab. Other data is entered directly into V files, e.g., V Patient Education, BP (blood pressure), WT (weight), HT (height), HC (head circumference) etc.

Patient Wellness Handout

The Patient Wellness Handout is a type of Health Summary that is directed to the patient. It displays personal medical information in easy to interpret language.

PGEN

Abbreviation for Patient General Retrieval Report. PGEN is the Patient General Retrieval report located in PCC Management Reports. The General Retrieval reports allow users to create on-the-fly reports by choosing specific data elements to select, print and sort by.

Problem List

A list of important/chronic medical, social, or psychiatric problems, related notes, and treatment plans for a patient that are recorded and updated as part of the patient's health record. The Health Summary has two categories: Active and Inactive.

POV

Purpose of Visit - one or more diagnoses (ICD codes) that are identified as the reason for the patient's visit, recorded in the PCC V POV file.

Prompt

Text displayed onscreen indicating that the system is waiting for input to a field. Once the computer displays a prompt, it waits for you to enter some specific information.

Provider

One who provides direct medical care to a patient i.e., physician, nurse, mid-level provider).

Provider Narrative

A detailed description of the patient's conditions, using words rather than codes.

QMan

Short for Query Manager, QMan is a VA-based search utility that allows users to construct detailed searches of the RPMS database. QMan is part of the integrated PCC suite.

Retrieval

To obtain data from another location.

Roll-and-Scroll

The roll-and-scroll (character-based) data entry format captures the same information as the screen format but uses a series of prompts for recording data. This is typically the most efficient method for data entry.

RPMS

Resource and Patient Management System; a suite of integrated software packages used by IHS

Secondary Providers

A provider for a patient's visit other than the patient's primary visit provider. A patient visit might have multiple secondary providers, depending on the services provided.

Security Key

A means of securing menus to limit accessibility. To use certain functions, such as those on a Manager's menu, you must be assigned the appropriate key by the Site Manager.

Select

To choose one option from a list of options.

Site Manager

The person in charge of setting up and maintaining the technical aspects of the RPMS System at the facility or area level.

Specialty Providers

Defined through the Designated Specialty Provider Management (BDP) application.

Submenu

A menu that is accessed through another menu. A menu option followed by the ellipsis (...) indicates there are submenus.

Supplement

A Supplement is a type of modified Health Summary that is related to a specific condition such as Diabetes or HIV/AIDS. It displays personal medical information related to that condition.

Tally

To make a count, total, or subtotal a number of items.

VGEN

Short for Visit General Retrieval Report. VGEN is one of the search utilities that enable users to construct searches of the RPMS database. The General Retrieval reports allow users to create on-the-fly reports by choosing specific data elements to select, print and sort by.

8.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: support@ihs.gov