Montana Department of Health
CaST 6.1
User Manual

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CaST II

Introduction

CaST II Ver. 6.1 (CaST) is the Cancer Screening and Tracking system prepared by Information Management Services, Inc. (IMS) in cooperation with & supported by The Centers for Disease Control and Prevention (CDC). The Montana Cancer Screening Program (MCSP) data systems, including the Site Data System (SDS), link to CaST.

CaST allows the user to collect information on screening and diagnostic procedures done for breast, cervical, and colorectal cancer. It provides a means to report the Minimum Data Elements (MDEs) and Colorectal Cancer Data Elements (CCDEs) to the (CDC).

Technical Assistance

To obtain technical assistance in the use of CaST, contact the state office or use the Help menu, see Help menu section.

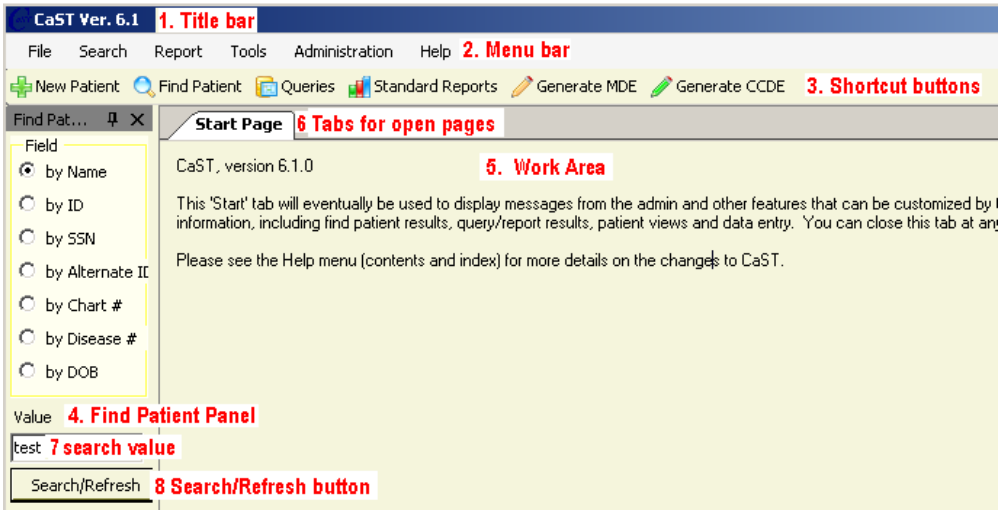
Getting Permission to use CaST

Contact the MCSP state data manager to get a user name, password, and permissions for CaST.

Main Menu Overview

The CaST main screen components:

1. The title bar shows the name of the program, “CaST Ver. 6.1”.
2. The Menu Bar shows the program options.
3. Shortcut Buttons, short cuts for the most used CaST options.
4. The Find Patient Panel is used to search the database for clients.
5. The Work Area is where the user displays the information he/she is using, usually a client’s record.



6. The tabs for open pages display the different pages open in the work area. To go to a page click on the tab. In this window the Start Page is open. The Start Page tab will eventually contain content posted by the system administrator such as messages. Right click on the tab and choose close to close the page.
7. This is where the user enters a value to search for a client.
8. When the value #7 is entered the user clicks the Search/Refresh button to open the Search Result page.

Each section of the system can be accessed using the buttons on the tool bar or the menu options on the menu bar.

You can select a button or menu bar item by either using the mouse or by using a keystroke sequence. For example, to select New Patient, press the Alt and N keys at the same time. All buttons in CaST have one character underlined and can be accessed in the same manner. To select the File menu, press Alt and F. Once the menu bar is selected, you can use the up and down arrow keys or the underlined letter of the menu item to access the various items on the menu bar.

If there is not a letter underlined on your menu options press the alt key.

Main Menu Options

The chart Menu Options for CaST Ver 6.1 list the menu options
The menu options in black are used by the SDS users and are covered in this manual.

Menu Options for CaST Ver. 6.1				
File	Search	Report	Tools	Help
New Patient	Find Patient By Name	Standard Reports	Edit Profile	Contents and Index
Provider List	Find Patient by ID	User Defined Queries	Generate MDE	Technical Support
Edit	Find Patient By SSN	NBCCEDP Patient Reminders	Generate CCDE	About
Resync	Find Patient by Alternate ID	CRCCP Patient Reminders	Format Editor	
Resize window/tab settings	Find Patient by Chart #			
Exit	Find Patient By Disease #			
	Find Patient By DOB			
	Find Duplicate Patients			
	Import Edit Records			

File Menu: Exit – Exit closes CaST and any windows open in CaST. You can also close CaST by clicking the X button in the upper right corner of the Title bar.

Search Menu:

- Find Patient**:** The MCSP uses the options by Name, ID, SSN, and DOB to search the database for a client. These buttons provide the same function as the Find Patient shortcut buttons and the Find Patient panel options. The MCSP doesn't use Chart # or Disease # or an Alternate ID.
- Find Duplicate Patients – This report will list clients that are entered twice in CaST. Clients from all sites are included in the report. The state office runs this report monthly. A site may run the report and look for their duplicate clients. When a duplicate occurs it is usually because a client has given the site a SSN that is different from the SSN given in a previous enrollment span. If you find a client on the list, please notify the state office and provide the correct SSN information.
- Import Edit Records - Allows the user to specify a file to import.

Report Menu

- Standard Reports - Same as the Standard Reports button. Displays the Standard reports panel. The standard reports panel gives the user the ability to print a variety of reports.
- User Defined Queries - Same as the Queries button. Displays the Query Editor. The query editor gives the user the ability to query CaST.
- NBCCEDP Patient Reminders - The Patient Reminders module allows the user to generate a list and corresponding mailing labels for patients due in for routine, short-term follow-up or first time screenings. Users can generate reminders for Breast and/or Cervical screening services.
- CRCCP Patient Reminders – The CRCCP patient reminders will be similar to the NBCCEDP patient reminders. At this time (2/12/2010) they are not yet available.

Help Menu
Contents and Index - Accesses the online help.

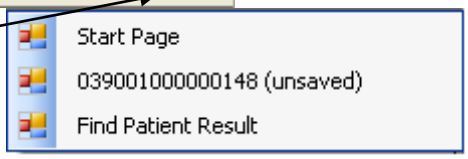
About – Displays information about the CaST version, database location.

Navigating

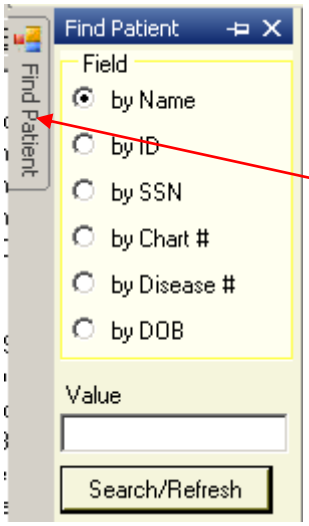
Tabs and Panels

The words “Start Page” and “Find Patient Results” each label a tab.

To view a tab, click on the tab or click the down arrow on the left side of the screen by the black X and select the tab from the drop down list.

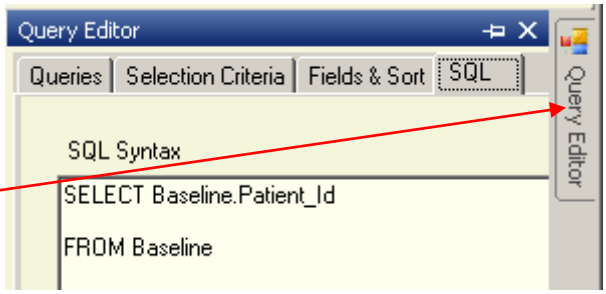


Close tabs by clicking the X on the tab bar while the tab is highlighted (e.g. Find Patient Result is in white) or by right clicking on the tab and clicking Close.



Sizing the Find Patient and Query Editor panels

A picture of the Find Patient Panel appears to the left. A picture of the Query Editor appears to the right. There is a vertical panel button to access the panel, open, close, or hide it when it’s not in use. The vertical buttons are controlled by the auto hide icon in the title bar of the panel.



If the auto-hide icon is sideways,

- Clicking the vertical panel button will open the panel.
- Clicking off of the open panel will close the panel, displaying only the vertical panel button

If the auto hide button is upright, the panel will stays open and the work area will be smaller.

To close the both the panels and their vertical panel buttons, click the X in the top right corner of the panel.

To open them

1. Click their shortcut buttons Find Patient Queries or
2. Choose the option from the Menu bar.
   a. Search, Find Patient to open the Find Patient panel
   b. Report, User Defined Queries to open the Query Editor Panel

The panels can be expanded and minimized by moving the mouse cursor over the border of the panel until it becomes a line with a double arrow through it. Hold down the left mouse key and drag the mouse to expand or contract the panel.

Screening Cycle Definitions:

A screening cycle is the proper completion of the MDE record. It begins with a pap test, mammogram, Clinical Breast Exam, FOBT/FIT or colonoscopy and ends, most of the time, with a normal screening result. However, for a

client with an abnormal screening result, the screening cycle will not be complete until the diagnostic work-up, final diagnosis, and treatment data and enrollment span close date are entered.

Short-Term Follow-up

A short term follow-up is defined as cases, in which the provider decides that an immediate diagnostic work-up is not needed, and there is a planned delay between the current and the subsequent visit for the client. A short term follow-up begins a new enrollment span in the Site Data system and a new cycle in CaST.

A procedure that is done based on the recommendation for surgical follow-up is not reported in the CaST data. The intent of the procedure is for surgical follow-up, not screening or diagnostic follow-up.

An exam for a second opinion, which is only on pre-approval basis, is not a short term follow-up or a screening exam and should not be reported. It is not entered in the CaST data.

Cycles and Procedures

Data entry in CaST is comprised of baseline data, along with cycle and procedure information for breast, cervical, and colorectal cancer screening and follow-up. Cycle information includes location, referral information, and final diagnosis and treatment results. Most cycles begin with a screening procedure, a Mammogram, a CBE, a Pap test, and FOBT/FIT, or a colonoscopy. If further diagnostic tests are necessary, additional procedures will be entered for that cycle.

Required fields

The fields required by the CDC, the Minimum Data Elements (MDE's)/Colorectal Cancer Data Elements (CCDE's), are shaded in pink, with red field labels

Short Cut Keys

Throughout this manual you will find short cut keys that can be used to navigate the system. Short cut keys are provided to eliminate the need to use the mouse. Although the following can be found in other sections in the manual, they are provided here for quick reference.

To select a button: Press the Alt key and corresponding underlined character. For example, on the main menu, to select New Patient, press the Alt key and N key at the same time.
To move forward: Press the Enter or Tab key.
To move backwards: Press the Shift and Tab keys at the same time.
To display the values in a drop down field, or list box, press F4. You can then scroll down to the correct value using the up/down keys, or select the value by typing the first few characters (type-ahead feature). Note: You can use the type-ahead feature without the F4 key.
To move to the next tab: Press the Ctrl and Tab keys at the same time.
To automatically run a query or report, double click on the item. This will run the query or report as if you selected the item and clicked Go.

Data Entry Field Types

There are several different types of fields in CaST. An example of each type and a brief description is provided below.
Text box - Used for free text or numbers, only for set length fields:

List box - Used for formatted fields, user can only select items in list (Press F4 to display values or click the down arrow.): Ethnicity:

Date fields: User must enter date using mm/dd/yyyy format. Note: All dates will have the '/' visible before data entry is done: Date of Birth: __/__/____

Memo fields - Used for free text fields, no maximum on number of characters:

Comments:

Moving from Field to Field

Once information is entered for a field, you can move to the next field by either pressing the Enter or Tab key. To move in the opposite direction, press the Shift and Tab keys at the same time. You can also move to another field by using the mouse.

Saving Data

Each data entry page has several Save buttons and a Cancel button in the bottom left corner of the screen. To save a record, select one of the Save buttons. If you try to navigate to a different screen without saving, you will be prompted to save.

Save will save and stay at the current screen.

Save/New will save and then display a tab with blank fields so data can be entered for a new screen of the same type (patient, cycle, procedure).

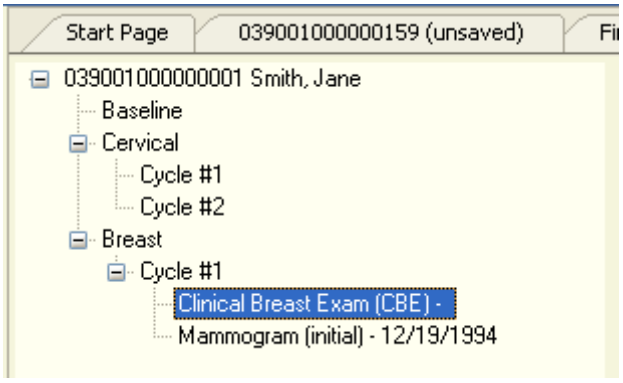
Save/Next will save and then display the next entity (cycle, procedure) for the same patient if there is more than one.

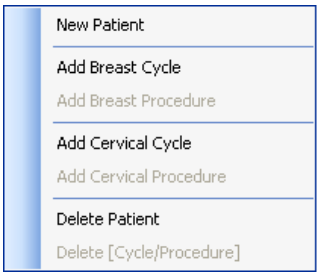
Save/Close will save, close the record and return to the previous screen in view mode.

If you are adding or modifying data and don't want to save the changes, select the Cancel button. This will ignore any changes to the record and restore the information to what it was before the last save was performed.

Tree View

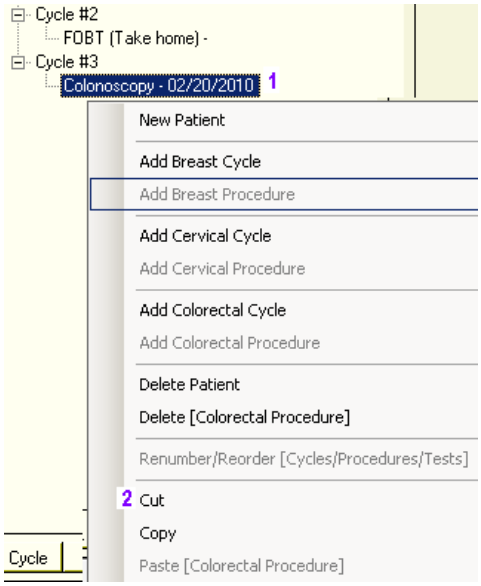
Once a client's record is accessed the screen is divided into two areas; the work area on the right side of the screen and the tree view on the left side of the screen. Each word (branch) in the tree view navigates to the area of a patient's data history that the word describes. The right side is used to display the detailed information related to the word (branch) selected on the left. If you click on the words "Clinical Breast Exam (CBE) under the words "Cycle #1" on the left side of the screen, the data for the procedure will display on the right side of the screen.





If you right click in the tree view, you will see the menu to the left:

If you right click on a branch you will see the same menu with the type of cycle or procedure specified after Delete and three additional options added:



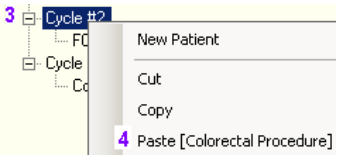
The Cut, Copy and Paste options can be used to copy information from one cycle to another. You cannot delete the procedure or cycle. Notify state staff to remove the incorrect data entry once you've corrected it. For instance, if a procedure was entered into the wrong cycle, you can copy the procedure from the one cycle and paste it into the correct cycle. To do this:

1. Select the procedure and open the drop down menu.

In the tree view place the cursor over the procedure; left click the procedure. The procedure will be highlighted. Right click with the mouse

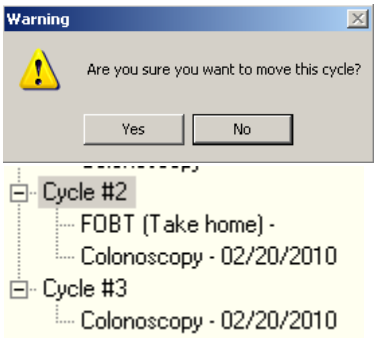
2. Select Cut from the menu.

Place the cursor over the word cut on the menu. Left click with the mouse. The menu will close



3. Select the cycle in which the procedure belongs and open the drop down menu.

Place the cursor over the cycle; left click the cycle. The cycle will be highlighted. Click the right mouse button.



4. Paste the procedure in the correct cycle.

Click the option Paste [Colorectal Procedure].You will get a warning box that says, "Are you sure you want to move this cycle." If you're sure click yes, if not, click no.

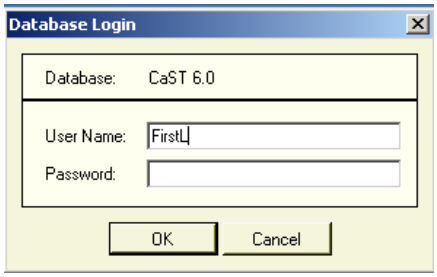
5. Notify the state if you need a cycle or procedure deleted.

The colonoscopy was copied to Cycle #2, but is still in Cycle #3. Cycle #3 and the colonoscopy are no longer needed. Call the state and tell them specifically which client's cycle and procedures to delete.

You can also perform this same function by dragging and dropping the procedure. Instead of using the right mouse button, select the procedure with the left mouse button, continue to hold the button down and drag the procedure into the correct cycle. When you release the button, you will be asked if you would like to move the procedure.

Note: The system will only allow you to copy/paste procedures into the correct 'node'. For instance, you can only copy/move Breast procedures into the Breast cycle 'node'.

Open CaST



1. Double click the CaST 6 icon.
2. Log On:
   - Enter your assigned User Name. It is your first name and the first letter of your last name. (e.g. McClientT)
   - Type in your Password, then click the OK button or hit the Enter key. CaST then verifies that you are a valid user and opens the program.

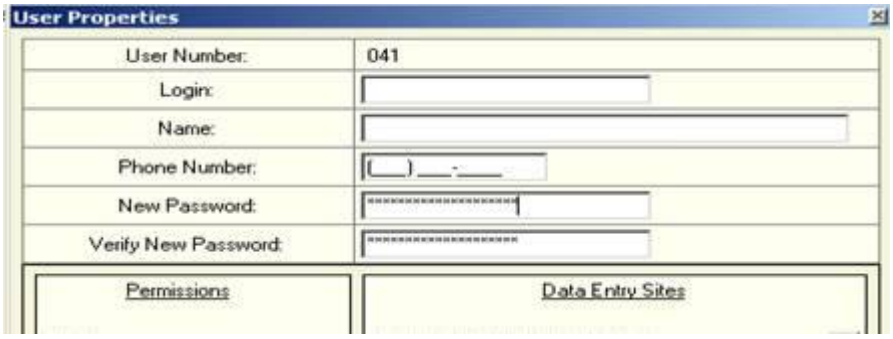
If you have trouble logging on or forget your user name or password, please contact state staff

If are a new CaST user you will need to create a password. If you are a veteran CaST user you will need to update your password. Please do so at least every 3 months.

1. Create your password the first time you open CaST. You may want to use the same password you use to logon to your system when you turn on your computer. Change your CaST password each time you change your system password.

a. Click on the **Tools** icon and click on **Edit Profile**, the **User Properties** screen will be displayed.

b. Press the **Tab** key until the cursor is positioned in the **New Password** field or click in the field.



c. Highlight the asterisks in the field and press the **Delete** key.

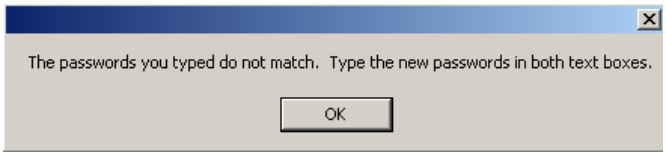
d. Key in your new password.

e. Press the **Tab** key again to move to the **Verify New Password** field or click in it.

f. Highlight the asterisks in the Verify New Password field.

g. Press the **Delete** key, and then retype your new password.

h. Click on the **Save** button and answer **Yes** to save the changes. If the password in the New Password field is different from the password in the Verify New Password field you will get a dialogue box with the error message, "The passwords typed do not match. Type the new password in both text boxes. Click OK and start over.



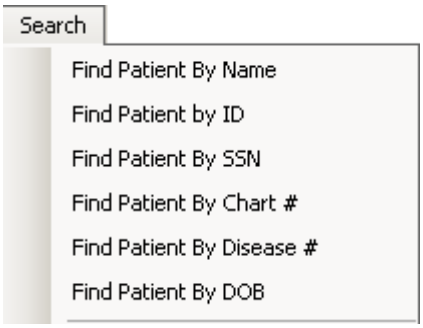
2. Click the OK button or hit the Enter key.

Find Patient Options

There are 3 options to find a patient.

- The Search option on the menu bar
- The Find Patient quick button
- The Find Patient pane.

Search option on the menu bar



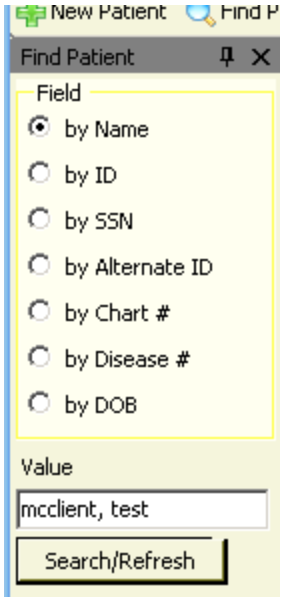
Use the search option to find an existing patient or determine if the patient is in the database. If the Find Patient panel is hidden this option will display the Find Patient panel.

To use the Search option on the menu bar:
1. Expand the Search menu: Click the word Search with the mouse or simultaneously hold down the Alt key and touch the letter "S".

1. Choose an option:

a. Click the option with the mouse.
b. Use the up and down arrow keys or tab key to move to the option and press the Enter key.

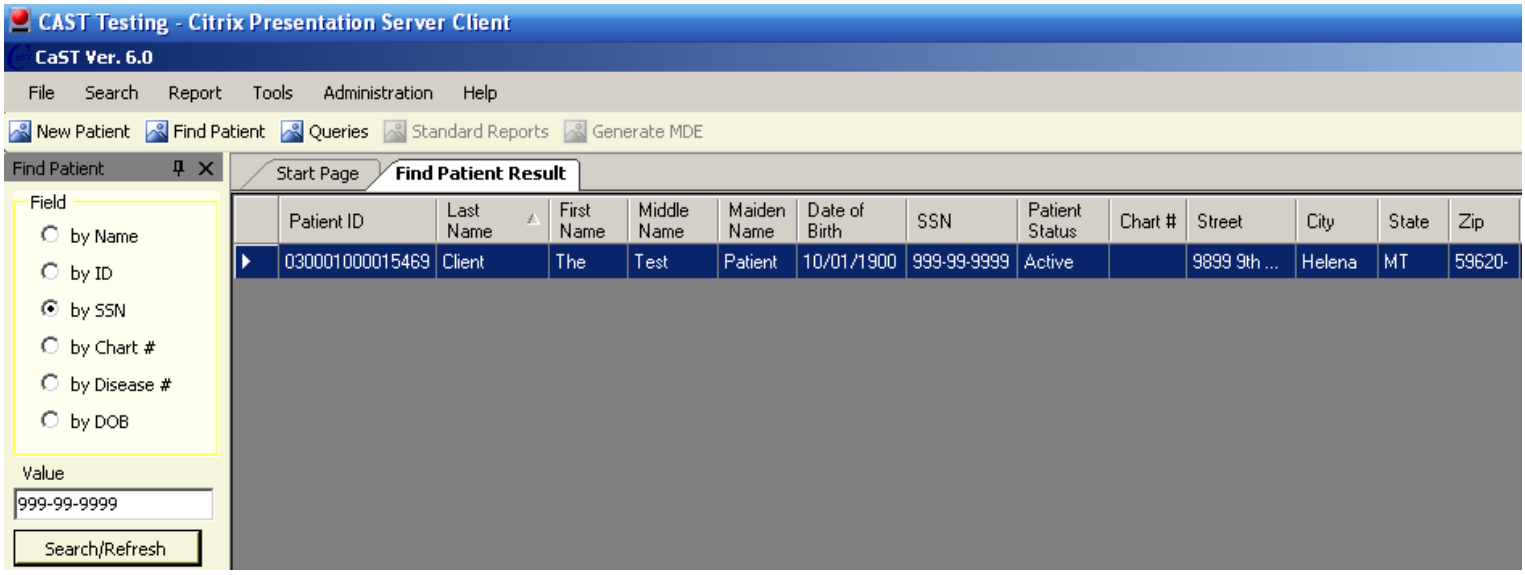
2. Click the option button in the Find Patient panel next to the type of data you will in the search value text box.
3. In the Find Patient panel enter the search "Value according to the type of option button you clicked.
4. Click the Search/Refresh button.



Find Patient Quick button
The Find Patient Quick button opens the Find Patient panel.

Find Patient panel
Use the Find Patient panel to search for a client. If the panel is not displayed, click the Find Patient button or select one of the Find Patient options from the Search menu.
1. Choose a search field: Click in the circle (option button) next to the one of the labels. (The MCSP doesn't enter Alternate ID, Chart# or Disease#)
   a. by Name: enter the last name comma first name.
   b. by ID: enter the client's patient id eg.030001000010000
   c. by SSN: enter the client's social security number.
   d. by DOB: enter the client's date of birth.
2. As soon as you chose an option the cursor will move to the Value text box. Enter the value for the chosen option.
3. Open the Find Patient Result tab that matches the value entered; Key "Enter" or click the Search/Refresh button.

Find Patient Result tab



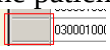
The Find Patient Result page opens as a result of clicking the Search/Refresh button. Every record that meets the criteria is displayed. The by Name and by ID options allow the user to search on a partial criteria. For instances if the option chosen was "by Name" and the Value entered was "Lou" every record with a client having a last name, first name, or middle name beginning with the letters Lou will be displayed. If the options for by SSN or by DOB are chosen the user must enter the complete criteria.

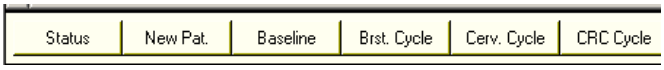
By default, the results are displayed in ascending order by Last Name. To sort the results by other fields, click on the field name. You will notice a triangle to the right of the field name, indicating

either ascending or descending order. Clicking on the field name will sort the displayed results from ascending to descending or descending to ascending. The next time you click the Search/Refresh button, the new results will be sorted by the field you last selected.

Select multiple patients listed sequentially by highlighting them with your mouse or clicking once on the first patient you want, holding down the Shift key and clicking on the last patient you want. You can select multiple patients listed anywhere in the list by holding down the Ctrl key as you click each patient once.

Compare the Last name, SSN and Date of Birth to verify the patient you are searching for matches the patient you have found. Access the data entry screens for the patient by:

1. Double clicking in the patient's record and going directly to the overview of the patient records
2. Selecting the patient; click once on the square to the left of the patient record  and clicking one of the buttons at the bottom of the Find Patient Result page. This opens the view of the client's record that displays the tree view and:

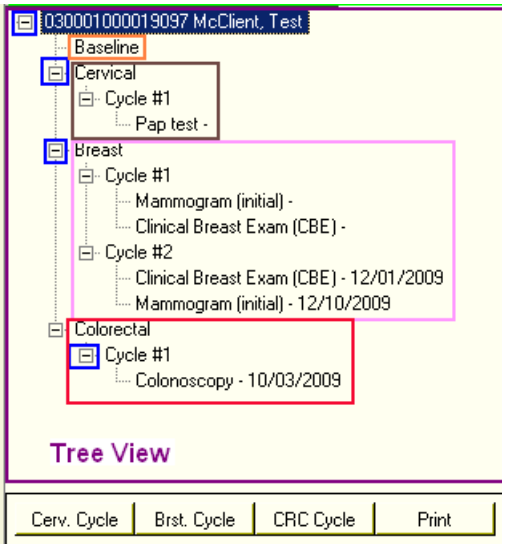


   - Status: The history of the patient, a button to print the patient's history and buttons to access the data entry screens.
   - New Pat: a blank patient record. MCSP doesn't use this function. The new patient data is entered in the Site Data System and transferred to CaST.
   - Baseline: The baseline data.
   - Brst Cycle: The most recent breast cycle.
   - Cerv Cycle: The most recent cervical cycle.
   - CRC Cycle: The most recent colorectal cycle.

Tabs: There is a tab at the top of the page for each window that is open. In the figure 3 pages are open. The Start Page is the main menu. The Find Patient Result page is the set of records that resulted from the Search.

The tab with numbers is a patient's page. The number is the patient's id. To close a tab click the black X on the far left side of the tabs bar.

Tree View: The Tree View panel shows the patient's history. Click on a **box** with the minus or plus sign in it, next to a label to expand or close the client's records.



There is one **Baseline** record and one **Cervical**, **Breast**, and **Colorectal** heading for each client. Under the heading are the client's cycles. Under the cycles are the client's procedures.

Click on the words in the tree view to navigate the client's data. E.g. To see the client's second cycle click the words "Cycle #2. To see a clients mammogram done 12/10/09, click the words "Mammogram (initial) – 12/10/2009"

Clicking the Cerv Cycle Brst Cycle or CRC Cycle button will open the patient's most current cycle.

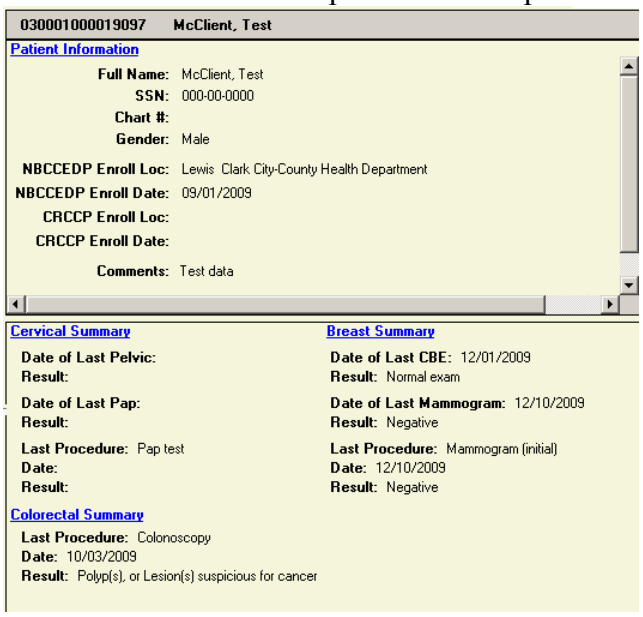
The Print button will display the patient's summary report. This report is the same Patient History with Comments report found under Standard Reports.

Patient Status Screen

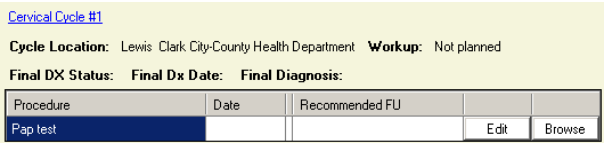
Click on the Patient ID

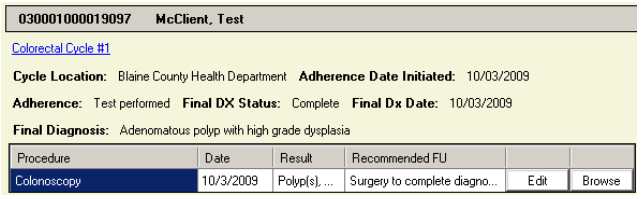
at the top of the tree to access the Patient Status screen.

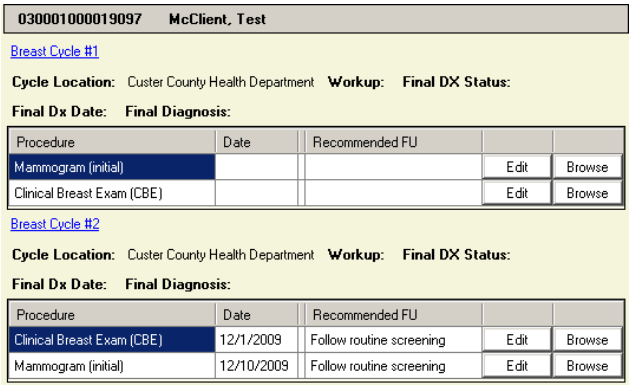
The Patient Status screen provides a comprehensive view of a patient's data. It includes a brief overview of the patient, including cycle summary information and last procedure performed. Clicking the Patient Information link will display the



Baseline screen and clicking the links Cervical Summary, Breast Summary, and Colorectal Summary will display the Summary screens.

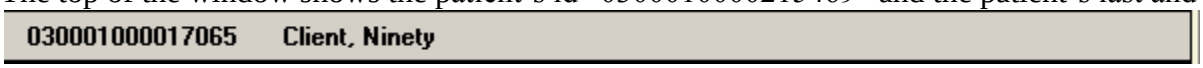






Baseline Information Data Entry

The top of the window shows the patient's id "0300010000215469" and the patient's last and first name.



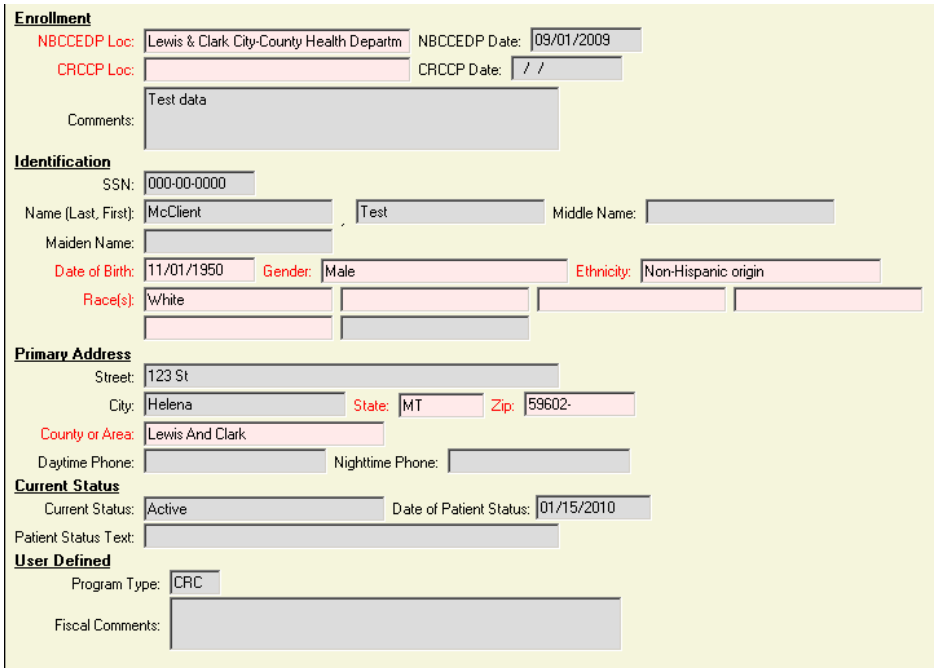
Baseline Mode toolbar:

Browse Patient – Data is viewable, but not editable.
Edit Patient – Data is viewable and editable.
New Patient –We don't use this option. Our client data transfers to CaST from the Site Data System. Delete Patient – Removes the patient data from the database, including all clinical history related to the patient.
Revert – Removes any changes that were made since the last save.

Data Entry Site: Flathead City Cnty Health Dept. Please ignore this label. Data Entry Site is not used at this time and defaults to Flathead.

In the above example, the Delete Patient and Revert buttons are not showing on the Baseline Mode toolbar. When all the buttons are not displayed there will be a drop down arrow to the left of the Data Entry Site. Click this arrow to access the options that are not showing.

i. Compare the enroll dates. If the enrollment date on the enrollment form is not the same as the NBCCEDP date.
ii. The data from the Site Data system was not transferred or
iii. The data has not yet been entered in the Site Data system.



2. Enter the data fields.
   - NBCCEDP Location: The administrative site that is processing the client's breast and cervical data. auto fill. (transfers from SDS)
   - NBCCEDP Date: The date of the client begins the most recent enrollment span. (Transfers from SDS).
   - CRCCP Loc: If the client had a colorectal cycle, enter the administrative sites that processed the client's colorectal cycle.
   - CRCCP Date: If the client had a colorectal cycle, enter the date the client began the most recent enrollment span.
   - Comments: If the client has a diagnosis of cancer or a precancer, enter "Dx Ca" and the date of the final diagnosis. Other comments can be entered if applicable.

- SSN: The client's social security number transfers from SDS.
- Name (Last, First,): Enter the client's last and first name, transfers from SDS.
- Middle Name: The client's middle name or middle initial, optional. transfers from SDS
- Maiden: The client's maiden name or any other last name she has used, optional
- Date of Birth: The client's date of birth, transfers from SDS.
- Ethnicity: The client's ethnicity, transfers from SDS.
- Race: The client's race(s) up to 5 choices, transfers from SDS.
- Street: The client's physical or mailing address as given to the administrative site, transfers from SDS.
- City: The city that goes with the street address, transfers from SDS.
- State: The state that goes with the street address, transfers from SDS.
- County or Area: The county that goes with the client's street address, transfers from SDS
- Zip Code: The zip code that goes with the client's street address, transfers from SDS.
- Daytime Phone: The client's work phone number, transfers from SDS. This field is used by the state so it may be blank in the eligibility date (site data system). If so it will be blank here, optional
- Night time phone: The client's home phone number, transfers from SDS. This field was not used at the state so it may be blank in the eligibility date (site data system). If so it will be blank here, optional
- Current Status: The Current Status should be Active unless the client is deceased or had Medicaid or Medicare B, transfers from SDS.
- Date of Death: If the Current Status is set to deceased then enter the date of the client's death. If the client has Medicaid or Medicare B, enter the date he/she started. If the client is temporarily in the Montana Breast and Cervical Cancer Treatment Program leave them set to active and enter "Dx Ca" and the date they began in the Comments field of the Baseline screen.

User Defined control tab

- Program Type: The type of program in which the client will participate, Breast and Cervical (BC), Colorectal (CRC) or Both, transfers from SDS.
- Fiscal Comments: The fiscal agent uses this field. Admin sites can ignore it.

3. Save the data if you make an update.

Save buttons

Click the Edit Patient button on the Mode toolbar to enable the save buttons.

Save/New – Posts the changes and opens a new Patient tab.
Save/Next – Posts the changes and displays the next patient if more than one patient record is open.
Save – Posts the changes and stays on the current screen.
Save/Close – Posts the changes and change the screen to view mode.
Cancel – Ignores changes that were made since the last save and will restore the record to its previous state.

When you are finished entering the Baseline information, use the buttons on the bottom of the tree panel to open the most current Cervical or Breast cycle.

Breast Cycle/Procedure Data Entry

Basic Breast Cycle Information:

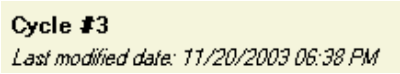
The client's name and patient id are at the top of the screen in the gray border. Make sure it is the name of the client whose data you are entering.

The Mode bar shows the cycle options.

- Browse: View the cycle data but don't change it
- Edit Cycle: Change the data or add new data to the cycle.
- New Cycle: Add a new cycle.
- New Procedure: Add a new procedure to the current cycle.
- Delete Cycle: Delete the cycle.
- Revert: Click this button to change the data back to what it was before you began entering. Once you click a Save the button you cannot revert. "Revert" only works in Edit Mode.

Note: Deleting a cycle will delete the current cycle and all procedures associated with the cycle.

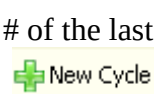
If there is more than one breast cycle for the patient, you can use the navigation buttons to go to the First, Previous, Next and Last breast cycle.

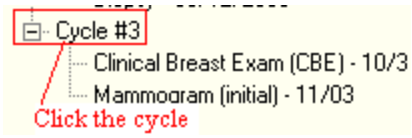


Cycle #3 means you are looking the client's third cycle. The cycles are number sequentially as they are entered. The procedure dates should also be sequential. If you discover you forgot to enter a cycle and it was previous to the last entered cycle call the state for assistance getting the cycles in a sequential order.

Last modified date is the date of the most recent data entry to the breast cycle.

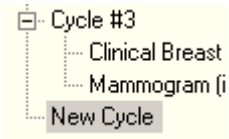
Enter a Breast Cycle: To add a breast cycle, click on the word Cycle # of the last breast cycle in the tree view and click the New Cycle button on the Mode tool bar.





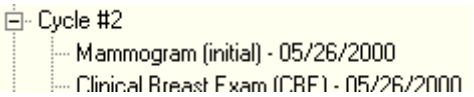
Cycle Location: This is the name of the administrative site that enrolled the client in the current enrollment span. If this is the client's first cycle, the cycle location transferred from the site data system. If the client has at least one completed cycle the cycle location will be blank.

Add a breast cycle or use the breast cycle that's open. Determine if you are entering data in the breast cycle that is open or a new cycle.

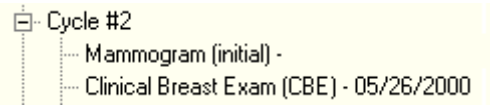


The cycle in which you are entering data is highlighted in the tree view. If you are adding data to a Cycle then the words Cycle # will be highlighted. If you are adding data to a new cycle the words New Cycle will be highlighted until you saved the cycle. Then the words New Cycle would change to Cycle # with a number.

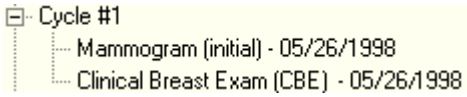
Look at the procedures in the most current cycle in the tree panel. In the picture, the most recent cycle is Cycle#2.



A mammogram is entered with the date 5/26/2000. If the mammogram you are entering was done 5/26/2000 it is already entered; you don't need to add a new cycle or the procedure.

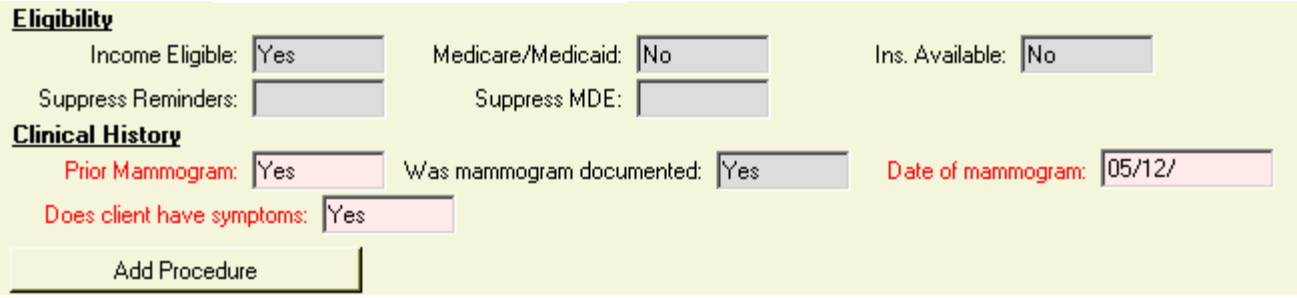


If a CBE is entered and there is a mammogram without a date then you would enter the 5/26/2000 mammogram in Cycle #2. You would not add a new cycle.



If the dates of the procedures in the current cycle (5/26/1998) are previous to the dates of the procedure you are entering (5/26/2000 mammogram), then you need to open a new cycle and enter the procedure(s).

Eligibility and Clinical History: If this is the client's first breast cycle, the Eligibility and Clinical History data transfer from the site data system. If the client has at least one completed breast cycle they transfer from the previous cycle.



a. Verify that the data in the following fields are accurate; correct it if needed.
   - Income Eligible: see paper Eligibility Form – Yearly Income, Number of People in Household.
   - Medicare/Medicaid: see paper Eligibility Form – Do you have, Medicare Part B, Medicaid?
   - Ins. Available: see paper Eligibility Form – Do you have Health insurance that may cover these services?
   - Ins Available: If the client has health insurance that covers the breast procedure(s) enter yes, otherwise enter no.
   - Ignore Suppress Reminders and Suppress MDE:

b. Date of (prior) Mammogram: If the client had a prior mammogram, before the enrollment span begin enter yes, otherwise enter no.

c. Was mammogram documented: Enter
   - Yes, if the client had a prior mammogram and it is entered in a previous breast cycle on the Procedures performed grid
   - No, if the client did not have a prior mammogram.
   - No, if the client says they had a previous mammogram, but it was not recorded in a previous cycle.

d. Date of mammogram:
   - If Prior mammogram = No N/A.
   - If Prior mammogram = Yes, see paper Eligibility Form - Date of Last Mammogram;
     - Keep the date in the CaST prior mammogram field if the data of the prior mammogram on the paper screening form is the same or is earlier than the date in the CaST prior mammogram field.
     - Enter the date on the paper Eligibility form if the date of the prior mammogram on the paper screening form
       - indicates that a mammogram was done, but not recorded in a previous cycle
       - is after the date in the Date of mammogram field, by at least 3 months.

e. Does client have symptoms: See paper Eligibility form Are You Having any breast problems?

Add Breast Procedures

If you are adding a new procedure

- Click the Save Cycle/Add Procedure button. This saves the cycle information to the database and opens a procedure screen.
- to an existing breast cycle,
  - click the name of the procedure on the tree view or
  - if you are in the breast cycle click the New Procedure button on the Mode bar.
- If you want to change or view the data in an existing breast procedure,
  - in the tree view click the procedure name or
  - if you are in the breast cycle, click the edit procedure button or the browse procedure button next to the procedure you want to edit,

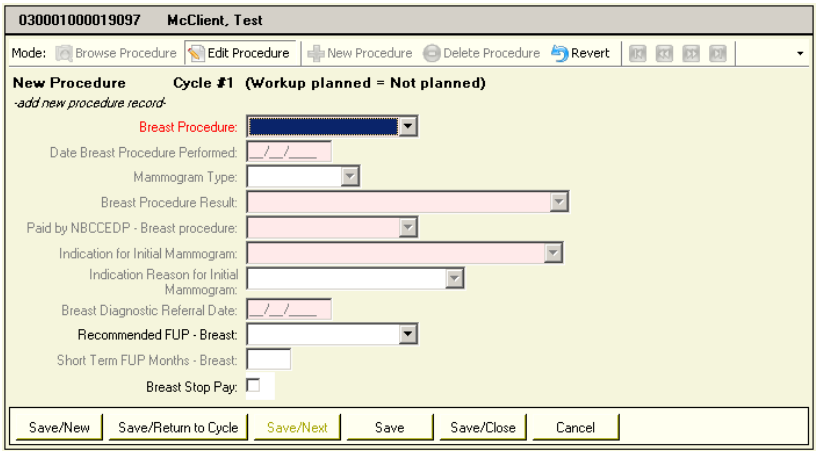
Procedure	Date	Result		
Clinical Breast Exam (CBE)	10/31/	Benign finding	Edit	Browse

The mode buttons at the top of the Procedure screens are the same as the mode buttons at the top of the cycle screens.

Breast procedure fields:

Depending on the procedure you are entering:

- Fields that are not required are locked.
- The field's label will turn red if it can be entered. Sometimes the label is red and the field is optional.



Breast Procedure CBE:

Clinical Breast Exam (CBE)

Always enter a CBE. If it wasn't done then this removes doubt that it was done, but not entered. MDE If the procedure was done.

- Date Breast Procedure Performed: MDE Enter the date of the CBE.
- Mammogram Type: Locked
- Breast Procedure Result: MDE Enter one of the following
  - Benign finding
  - Discrete palp mass-Susp for Ca goes with Abnormal Suspicious for Cancer
  - Discrete palp mass (Dx Benign)
  - Normal Exam
  - Not done – other/unk reason. If the result is set to "Not Done " for any reason set the fields Paid by NBCCEDP and Date Breast Procedure Performed to blank.
- Paid by NBCCEDP-Breast procedure: MDE, If the CBE was done and paid for with MCSP funds enter Yes. This field is locked if the Date Breast Procedure Performed is blank.
- Indication for Initial Mammogram: Locked
- Indication Reason for Initial Mammogram: Locked
- Breast Diagnostic Referral Date: Locked
- Recommended FUP – Breast: Enter the option that is most representative of the provider's recommendation. Follow Routine Screening should be used if the provider doesn't give a recommendation and the client doesn't need additional diagnostic procedures. This field is not an MDE and is for the use of tracking clients.

- Months for short term FUP – Breast
- Breast Stop Pay: To prevent the payment of a claim for a CBE, as soon as you submit the enrollment span to CaST enter the fields: Breast Procedure = Clinical Breast Exam (CBE), Breast Procedure Result = Not done – oth/unk reason, Breast Stop Pay is checked.

Breast Procedure Mammogram (initial): MDE Always enter a Mammogram. If it wasn't done then this removes doubt that it was done, but not entered.

Use the diagnostic mammogram as the initial mammogram if an initial mammogram wasn't done and you have a procedure that can be used to complete a planned workup other then the diagnostic mammogram.

- **Date Breast Procedure performed**: MDE: Enter the date of any procedures that were done.
- **Mammogram type**: Enter digital or conventional.
- **Breast Procedure Result**: MDE: Use the drop down box to view the options. Choose one
  - Assessment is incomplete, need additional imaging;
  - Benign finding
  - Film Comparison Required
  - Highly sugg of malig
  - Negative
  - Probably benign
  - Result unk, presumed abn, non-program funded
  - Susp abn (consider Bx)
  - Unsatisfactory
- **Paid by NBCCEDP – Breast procedure:** MDE: Enter "Yes," if the screening procedure was done and paid for with MCSP funds. If the mammogram was
- **Indication for Initial Mammogram:** MDE: The purpose of the indication fields is to document why the mammogram was done. Enter one of the options in the Initial Mammogram procedure record whether or not it was done.

  - Routine Screening mammogram: If the initial mammogram was performed as part of a routine or annual screening schedule and in the absence of symptoms and the CBE was normal.
  - Symptoms, abnormal CBE or previous abnormal Mam- On the form as "Evaluate symptoms, positive CBE/previous abnormal mammogram". The client had an abnormal procedure that was previous to the mammogram, including a CBE in the same cycle and/or a short term follow up.
  - Mam not done, CBE only or proceeded directly to DX- On form as "Not done only received CBE or diagnostics" If the woman received only a CBE; or if the woman did not have an initial mammogram performed and she goes directly to Diagnostic Work-up.
  - DX referral -On form as "Done outside the MBCHP, diagnostics only".) The client's breast cycle does not have a CBE or mammogram; only diagnostic procedures.
  - Cervical Record Only. No breast procedures were done.
  - Unknown. The mammogram was done before Jan 1, 2009.

Example scenarios. In the same screening cycle a woman has both a CBE and a mammogram.

- Woman comes in for a routine screening; first gets a mammogram…indication would be Routine Screening Mammogram.
- Woman comes in for routine screening, first gets a normal CBE result, then a mammogram…the indication would be Routine Screening Mammogram.
- Woman comes in for routine screening, first gets an abnormal CBE result, then a mammogram…the indication would be Symptoms, abnormal CBE or previous abnormal Mam. The reason is that now you have an abnormal CBE, so you are not just doing a routine mammogram, but a mammogram to follow up on the abnormal CBE. (Usually, if a woman has a normal CBE result then the woman is referred for a screening mammogram, but if however the woman has an abnormal CBE result then it is expected that the woman would now be referred for a diagnostic mammogram instead.)

- **Indication for Initial Mammogram:** MDE When the field Indication for Initial Mammogram is to add more information about why the Initial Mammogram was not done.

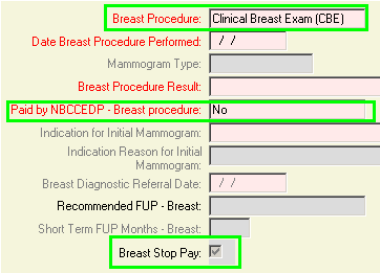
- **Indication Reason for Initial Mammogram:** This field holds the value of not done for data entered previous to January 2009. Optional

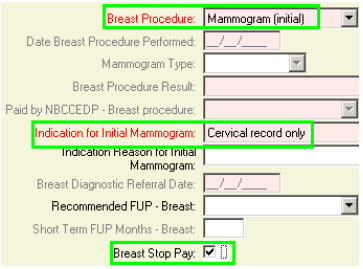
- **Breast Diagnostic Referral Date:** MDE: Enter the date the client was enrolled in the MBCHP; when the mammogram and the CBE were not done. Set "workup planned/additional procedures" to planned.

- **Recommended FUP - Breast:** Enter the provider recommended follow-up. Use this to help track what you expect to see on the next cycle. Optional.

- **Months for short term FUP - Breast**: Enter the number of months between the date of the breast procedure that indicated the client would need a short term follow up and the date of the short term follow up.

- **Breast Stop Pay:** To prevent the fiscal agent from paying claims for a mammogram or CBE in the current cycle
  - Submit the enrollment span to CaST
  - Enter the mammogram/CBE data immediately.
  -
  - Enter the fields: for a CBE
    - Breast Procedure = Clinical Breast Exam (CBE),
    - Paid by NBCCEDP – Breast procedure = No
    - Check Breast Stop Pay
    -
  - Enter the fields: for a Mammogram (initial)
    - Breast Procedure = Mammogram (initial),
    - Indication for Mammogram = Cervical Record Only or DX referral or Mam not done, CBE only or proceeded directly to DX,
  - Check Breast Stop Pay.





Breast Diagnostic Procedures: Enter only the diagnostic procedures that are done. If the client refused to have a breast diagnostic procedure that the provider recommended or if a breast diagnostic procedure is not paid for with the MCSP funds, don't enter it. If the client has a planned workup and refuses the procedure the Status of Final Dx field on the cycle is set to Refused.

Diagnostic Procedures:

If a screening procedure is abnormal or workup planned is set to yes the client must have diagnostic procedures.

Leave the following fields blank

- Indication for Initial Mammogram
- Indication Reason for Initial Mammogram
- Breast Diagnostic Referral Date
- Mammogram Type

Enter the remaining fields for each procedure the client had done:

- Breast Procedure: Enter the name of the procedure
- Paid by NBCCEDP – MDE: Breast Procedure: Enter yes
- Date Breast Procedure Performed: MDE: Enter the date done
- Breast Procedure Result: MDE: Choose one

- Recommended FUP – Breast: Use this field to indicate what the follow up should be and what to expect in the next cycle.

Additional mam views: To specify if additional mammographic views were performed.

The diagnostic mammogram is the initial mammogram when:

- The diagnostic (dx) mammogram is normal, and the client did not have a CBE
- The diagnostic mammogram was normal and the client had a normal CBE. (See chart to right.)
- Anytime a client has a diagnostic mammogram with other diagnostic procedures and did not have a screening mammogram enter the diagnostic mammogram as the initial mammogram.

		Results of dx mamm	cbe result	Wup planned	Enter dx mamm as Sx mamm
No sx mamm Had a dx mamm	No CBE	normal	na	No	yes
		abnormal	na	Yes	No
	Had CBE	normal	normal	No	Yes
			abnormal	Yes	No
		abnormal	normal	Yes	No
			abnormal	Yes	No

If a client has more than one set of additional mammographic views, during the same or separate visits, in the same cycle to obtain a final imaging outcome, enter additional mammograms only once with the worst result.

If the client has an additional mammographic view, enter the final imaging outcome and the date of final imaging. An additional mammographic view is an imaging procedure

Breast Procedure Result: MDE: Enter the result that best fits.

- Assessment is incomplete, need additional imaging;
- Benign finding
- Film Comparison Required
- Highly sugg of malig
- Negative
- Probably benign
- Result unk, presumed abn, non-program funded
- Unsatisfactory

Biopsy – To specify if an incisional or excisional biopsy or lumpectomy was performed.

- Breast Procedure Result: MDE: Enter Normal breast tissue or Abnormal.

Consultant-Repeat CBE: (Cnslt Rpt CBE) To specify if a repeat beast exam and/or a surgical consultation were performed.

- Breast Procedure Result: Enter Normal Exam or Abnormal.
- Anytime a client has a Consult Repeat CBE and other diagnostic procedures and did not have a screening CBE enter the Consult Repeat CBE as the screening CBE.

		Result of Cnslt Rpt CBE	Result of sx mamm	Wup planned	Enter Surg Cnslt Rpt CBE as Sx CBE
No sx CBE Had a Cnslt, Rpt CBE.	No sx Mamm	normal	na	No	yes
		abnormal	na	Yes	No
	Had sx mamm	normal	normal	No	Yes
			abnormal	Yes	No
		abnormal	normal	Yes	No
			abnormal	Yes	No

Film Comparison: To specify if a film comparison was done when required to further evaluate an initial mammogram test result of assessment incomplete. The only time you report a film comparison is when the initial mammogram had a result of assessment incomplete. Otherwise don't enter it.

- Breast Procedure Result: Enter Negative or Abnormal. This is an imaging procedure; in the Cycle data enter the final imaging outcome and the date of final imaging.

Fine needle aspirate (FNA): To specify if a fine needle or cyst aspiration was performed.

- Breast Procedure Result: Enter Not Susp for Ca or Abnormal

Surgical consultation: Use the Repeat CBE, Surgical Consult.

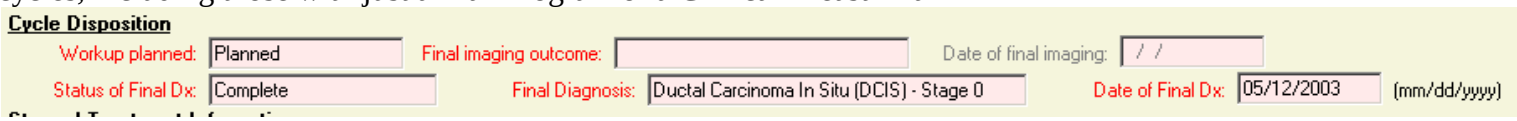
- Breast Procedure Result

Ultrasound: To specify is an ultrasound was performed. This is an imaging procedure; in the Cycle data enter the final imaging outcome and the date of final imaging.

- Breast Procedure Result: Enter Abnormal or Negative.

When you are finished entering each procedure, click one of the Save buttons to post the changes to the database. If you attempt to navigate to a different screen without saving changes, the system will prompt you to save the changes first.

Cycle Disposition: This section contains important cycle status information, including the Workup Planned field, which indicates whether further diagnostic procedures are expected. This field must be completed for all breast cycles, including those with just a Mammogram or a Clinical Breast Exam



a. Workup Planned:
   1. Enter "Not Planned" if additional procedures were not needed.
   2. Workup Planned: Enter "Planned" if the provider recommended additional diagnostic procedures.

Once the Workup Planned Field is complete the labels of the required fields turn red.

b. Final imaging outcome:

- If the client had one or more final imaging procedures, film comparison, additional mammographic views, or an ultrasound, enter a Final Imaging Outcome.
- If the client did not have a final imaging procedure, enter "No Add, Breast Imaging Performed".

c. Date of Final imaging:
   - If the client had a final imaging procedure, enter the last final imaging procedure.
   - If the client did not have a final imaging procedure the date of the final imaging is locked.

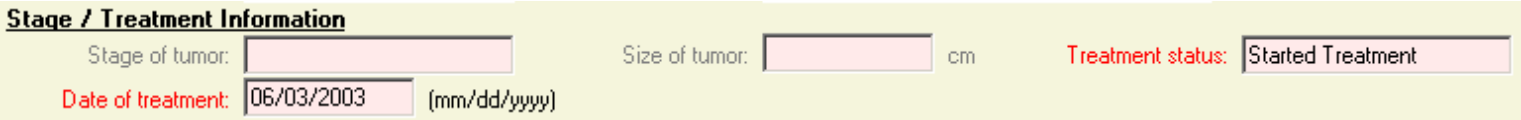
d. Status of Final Dx:
   - Complete: Once a client receives a final diagnosis enter Complete.
   - Deceased: If the client dies before a final diagnosis is determined enter Deceased as the Status of Final Dx. Once Deceased is entered the Final Diagnosis field is locked.
   - Lost to Follow-Up: If the client's location becomes unknown before a final diagnosis is determined enter Lost to Follow Up as the Status of Final Dx. Once Lost to follow-up is entered the Final Diagnosis field is locked.
   - Pending: Enter the Status of Final Dx as pending when
     1. The provider has not returned the paper Abnormal form or
     2. The data returned on the paper Abnormal form is incomplete or unclear or
     3. The diagnostic follow up is inadequate.

     The fields, final diagnosis and Date of Final Diagnosis are locked when Status is set to Pending.
   - Refused: If the client refused diagnostic testing and a final diagnosis cannot be determined enter refused, otherwise enter complete as the Status of Final Dx.

e. Final Diagnosis: Enter a final diagnosis. Recurrent Cancer is used when the client's cancer is not a primary cancer. All cancers are checked with the tumor registry. At that time if it is discovered the cancer was a reoccurrence the data manager will update this field. However, if you know at the time of data entry that it is a reoccurrence please enter it as such.

f. Date of Final Dx: Enter the final diagnosis

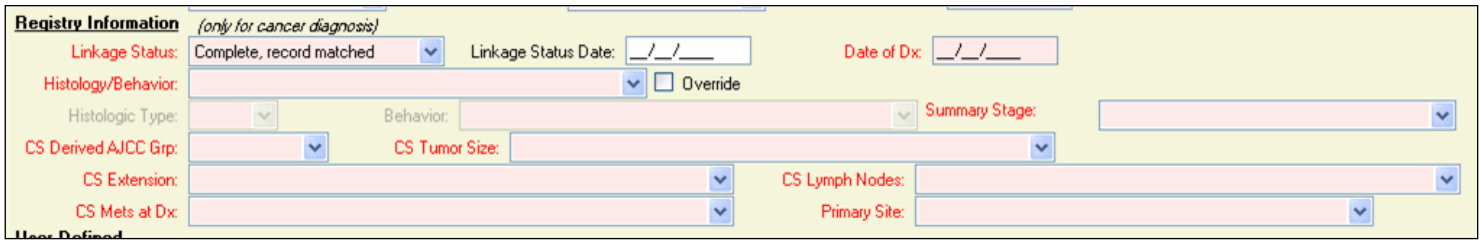
Stage/Treatment Information



The treatment status must be completed if the final diagnosis is bolded on the abnormal form. It may be completed for other results if treatment was planned.

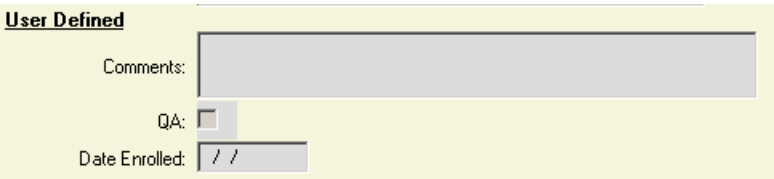
The Stage of tumor and Size of tumor fields are collected from the Montana Tumor registry.
Treatment Status: Enter a treatment status.
Date of treatment: Enter the date the client begin treatment.

Registry Information



If the final diagnosis is a type of cancer, the Registry Information section will appear on the screen. This data is collected from the Montana Tumor registry. Leave it blank.

The User Defined section



Comments: Use the comments to enter comments and questions about the procedure data. A comment would be the client had a hysterectomy as a result of the cycle. Enter a question and check QA if you need quality assurance assistance from the state office.

QA: To ask the quality assurance person at the state a question pertaining to the current cycle check QA.

Date Enrolled: Enter the date of the enrollment span that covers the procedures in this cycle.

Cervical Cycle/Procedure Data Entry

Cervical Cycle Introduction:

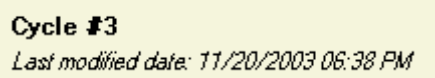
The client's name and patient id are at the top of the screen in the gray border. Make sure it is the name of the client whose data you are entering.

The Mode bar shows the cycle options.

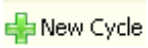
Browse: View the cycle data but don't change it
Edit Cycle: Change the data or add new data to the cycle.
New Cycle: Add a new cycle.
New Procedure: Add a new procedure to the current cycle.
Delete Cycle: Delete the cycle.
Revert: Click this button to change the data back to what it was before you began entering. Once you click a Save button you cannot revert. "Revert" only works in Edit Mode.

Note: Deleting a cycle will delete the current cycle and all procedures associated with the cycle.

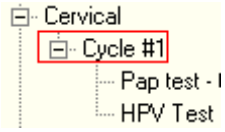
If there is more than one cervical cycle for the patient, you can use the navigation buttons to go to the First, Previous, Next, and Last cervical cycle.

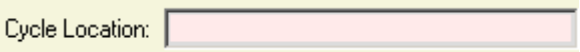


Cycle # is the number of the cycle.
Last modified date is the date of the most recent data entry or updates to the cervical cycle information.

Open a new Cervical Cycle screen: To add a cervical cycle, click on the word Cycle # of the last cervical cycle in the tree view and click the New Cycle button 

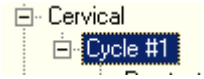
on the Mode tool bar.



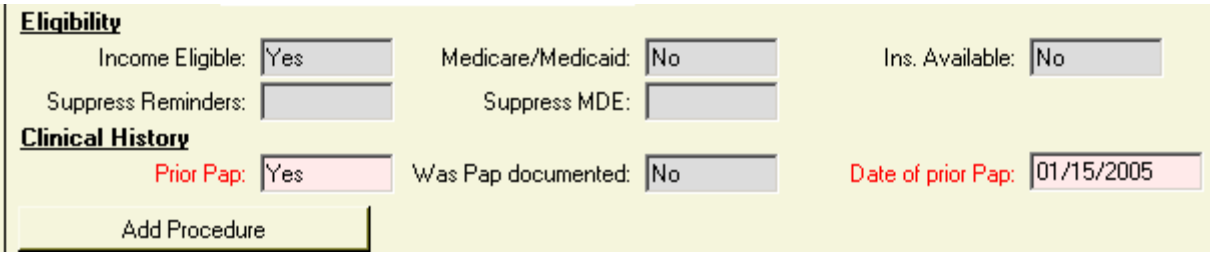


Cycle Location: The name of the administrative site that enrolled the client in the current enrollment span. If this is the client's first cycle, the cycle location transfers from the site data system. If the client has at least one completed cycle the Cycle Location will be blank and you will have to enter it.

Add a cervical cycle or use the cervical cycle that's open. Determine if the information you are entering goes in the cervical cycle that is open or if you need to add a new cycle. The cycle you are entering is highlighted in the tree view. For example if you add data to Cycle #1 then the words Cycle #1 are highlighted. If you add data to a new cycle the words New Cycle are highlighted until you save the cycle. Then the words New Cycle will change to Cycle #N where N is the previous cycle number plus one.



Eligibility and Clinical History: If this is the client's first cervical cycle, the Eligibility and Clinical History data transfer from the site data system. If the client has at least one completed cervical cycle the data transfer from the previous cycle.



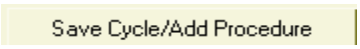
Eligibility

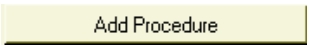
Verify that the data in the following fields are accurate; correct if needed.

- **Income Eligible**: see paper Eligibility Form – Yearly Income, Number of People in Household.
- **Medicare/Medicaid**: see paper Eligibility Form – Do you have, Medicare Part B, Medicaid?
- **Ins. Available**: see paper Eligibility Form – Do you have Health insurance that may cover these services?
- **Suppress Reminders:** Ignore
- **Suppress MDE**: Ignore

Clinical History

- **Prior Pap**: If the client had a prior Pap test, before the enrollment span begin enter yes, otherwise enter no.
- **Was Pap documented**: Enter
  - Yes, if the client had a prior Pap test and it is entered in a previous cervical cycle on the Procedures performed grid
  - No, if the client did not have a prior Pap test.
  - No, if the client says they had a previous Pap test, but it was not recorded in a previous cycle.
- **Date of prior Pap:** see paper Eligibility Form - Date of Last Pap test
  - If Prior Pap test = No field is disabled.
  - If Prior Pap test = Yes enter the date of the prior Pap test.
    - Keep the date transferred from the CaST prior Pap test field if the date of the prior Pap test on the paper screening form is the same or is earlier than the date in the CaST prior Pap test field.
    - Enter the date on the paper Eligibility form if the date of the prior Pap test on the paper screening form
      - indicates that a Pap test was done, but not recorded in a previous cycle and
      - the date of the Pap test is after the date in the CaST Date of Pap test field, by at least 3 months.
- **Save Cycle/Add Procedure – Add Procedure button:** Click this button to add a procedure to the cycle. It is labeled Save Cycle/Add Procedure in Edit mode. It is labeled Add Procedure in Browse Cycle mode once the cycle has been saved.





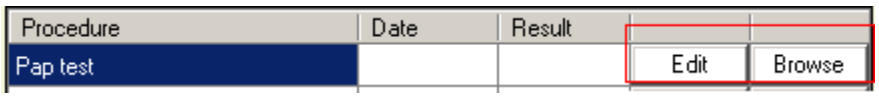
Add Cervical Procedures

If you are adding a new procedure to

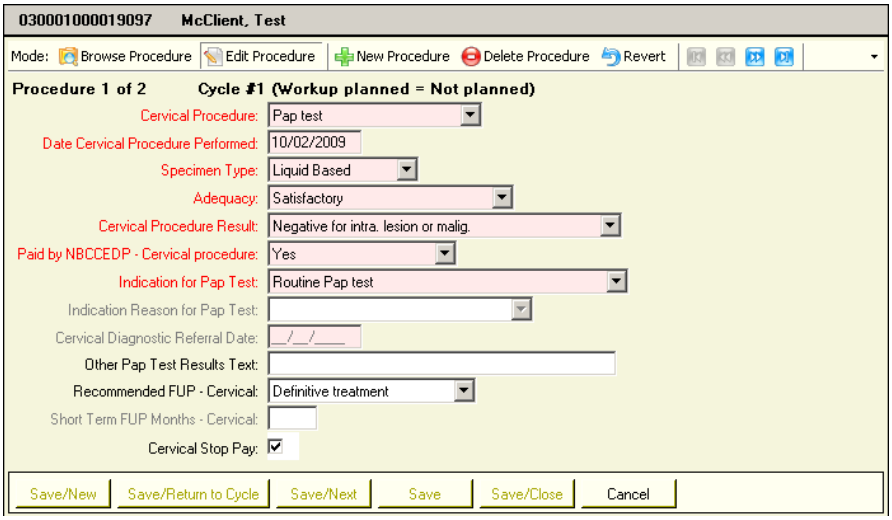
- A new cervical cycle click the Save Cycle/Add Procedure (Add Procedure) button to post the cycle information to the database and open a procedure screen. The button is labeled Save Cycle/Add Procedure in Edit mode and Add Procedure once the cycle is saved.
- to an existing cervical cycle,
  - click the name of the procedure on the tree view

- in the cervical cycle click the New Procedure button on the Mode bar.

- To change or view the data in an existing cervical procedure,
  - in the tree view click the procedure name
  - in the cervical cycle, click the edit procedure button or the browse procedure button next to the procedure you want to view or edit.



The top of the Procedure screen has the same mode buttons as the cycle.



Cervical procedure fields
Depending on the procedure you are entering:

- Fields that are not required are locked.
- The field's label will turn red if it can be entered. Sometimes the label is red and the field is optional.

Cervical Procedure Pap test
Always enter a record, for the screening Pap test even if the client didn't have one. This indicates that the data entry wasn't forgotten; the client didn't have a Pap test.

- **Date Cervical Procedure performed**: Enter the date the Pap test was done.

- **Specimen type**: Enter the kind of Pap test; Liquid Based or Conventional Smear.

- **Adequacy**: Enter Satisfactory or Unsatisfactory: It the adequacy of the specimen type is unsatisfactory the Pap test result is always left blank and the Pap test should be repeated immediately.

- **Cervical Procedure Result**: Use the drop down box to view the options. Choose a result.
  - Adenocarcimoma
  - AGC (Atypical glandular cells); this replaces AGUS. If you get the result of AGUS, enter AGC.
  - AIS (Endocervical Adenocarcinoma in situ)
  - ASC-H
  - ASC-US
  - High grade SIL
  - Low grade SIL/HPV
  - Negative for intra. lesion or malig.
  - Other – enter the Other Pap test Results Test field
  - Result Pending: Don't use this; don't enter the data until you have the result.
  - Result unk, presumed abn, non-program funded: If a client had a Pap test outside the program and will began her cervical cycle with a diagnostic test.
  - Squamous cell carcinoma

  - **Paid by NBCCEDP – Cervical procedure:** Enter yes if the Pap test was done. If the Pap test was not done this field is disabled. You cannot enter no.
- **Indication for Pap Test**:

- Breast record only: The client will not have a cervical procedure but will have a breast cycle.
- Dx referral: The client's cycle will begin with a diagnostic test
- Pap test not done; proceed directly to DX or HPV test: The client will not have a Pap test but will have a diagnostic test or HPV test.
- Patient under surveillance for a previous abnormal test: The Pap test was performed for a woman under management for a cervical abnormality detected prior to this cycle.
- Routine Pap test: The Pap test was performed as part of a routine screening schedule.

- **Indication reason for Pap test:** To show the reason for the Pap test entered before Jan 1, 2009.

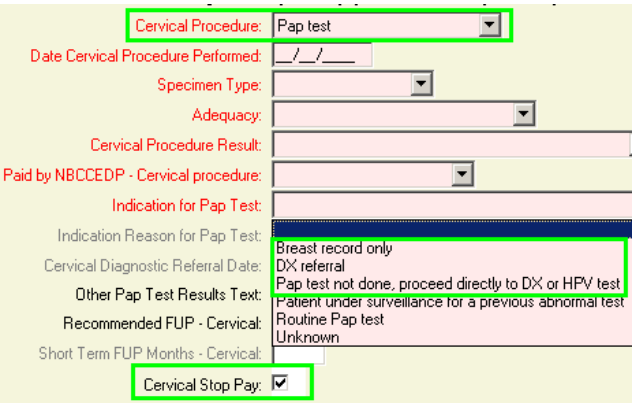
- **Cervical Diagnostic Referral Date:** This item is to specify the enrollment date when the Indication for Pap test is "DX referral If the indication reason is Pap test not done, proceed directly to DX or HPV test, leave this field blank.

- **Other Pap Test Results Text:** If the client had an unlisted Pap test result that contributes to a final cervical diagnosis list it here. Please check with the state office to determine if the result can be entered in this field.

- **Recommended FUP** – Cervica**l:** Enter the provider recommended follow-up. Optional.

- **Short Term FUP Months – Cervical:** Enter the number of months between the date or the cervical procedure that indicated the client would need a short term follow up and the date of the short term follow up.

- **Cervical Stop Pay:** To prevent the fiscal agent from paying claims for a Pap test, complete the fields:
  - Cervical Procedure set to Pap test
  - Indication for Pap test set to
    - Breast Record only
    - Dx referral
    - Pap test not done, proceed directly to Dx or HPV test
  - Cervical Stop Pay; check the box



Cervical Diagnostic Procedures

- If a screening procedure result is abnormal or workup planned equals yes the client must have diagnostic procedures. When the result is abnormal choose the option "abnormal'. There isn't a result of "normal", so for a normal result enter the result that is most applicable.

- Enter only the diagnostic procedures that were done. If the client refused to have a cervical diagnostic procedure that the provider recommended the status of final diagnosis should be set to refused; don't enter it. If a cervical diagnostic procedure is not paid for with the MCSP funds, don't enter it.

  Leave the following fields blank for diagnostic procedures
  - Specimen Type
  - Adequacy
  - Indication for Pap test
  - Indication Reason for Pap test
  - Cervical Diagnostic Referral Date
  - Other Pap Test Results Text:

Enter the remaining fields for each procedure the client had done:

- Cervical Procedure: MDE: Enter the name of the procedure
- Date Cervical Procedure Performed: MDE: Enter the date the procedure was done.
- Cervical Procedure Result: MDE: Choose one.
- Paid by NBCCEDP – Cervical Procedure: MDE: Enter yes. Don't enter a diagnostic procedure that isn't paid for with NBCCEDP Montana Cancer Screening Program funds
- Recommended FUP – Cervical: Use this field to indicate what the follow up should be and what to expect in the next cycle. Optional
-

Cold Knife Cone:
To indicate a Cold Knife Cone (CKC) was performed as a diagnostic procedure. Don't enter a cold knife cone that is performed as treatment.

Colposcopy
If more than one colposcopy with a biopsy is performed in the same cycle, enter only one; enter the one with the worst result.

If a client has more than one of the following in the same cycle, enter only one.

- Colposcopy **without** a biopsy
- Colposcopy **with** a biopsy
- Colposcopy with an ECC

Enter the colposcopy that best defines the final diagnosis.

Colposcopy with biopsy:
To specify if a colposcopy with a biopsy as performed.

Colposcopy with ECC:
To specify if a colposcopy with an ECC was performed.

Colposcopy without biopsy:
To specify if a colposcopy without a biopsy was performed.

Endocervical curettage (ECC):
To indicate if a stand-alone ECC was performed. It should not be used to report an ECC that is done in conjunction with a colposcopy. A stand alone ECC is an appropriate option for diagnostic work-up of a Pap test result of AGC when endometrial cells are present.

If more than one stand alone ECC is performed for a woman in the same cycle, report the procedure that best defines the final diagnosis.

Gynecologic consultation:
To specify a Gynecologic consultation was done.

HPV test:
To report results of a high risk HPV test performed.

HPV DNA testing is a reimbursable procedure if it is used as follow-up to a Pap test with an ASC-US.

LEEP:
To specify if a LEEP (Loop Electrosurgical Excision Procedure) was performed as a diagnostic service. If the LEEP was performed as treatment, don't enter it.

Other biopsy – not colposcopic:
Please check with the quality assurance person before entering this option. Other biopsy – not colposcopic is to specify if a biopsy other than a colposcopic biopsy was done. Only diagnostic procedure performed as management of a suspected cervical lesion, such as an endometrial biopsy, the excision of endocervical polyps or gynecologic consultation should be reported in this item.

Pelvic Exam:
To specify a Pelvic Exam was done. Pelvic Exam findings should not be reported as Other Pap test results. They are not reported in the MDE's, but can be collected for individual site purposes.

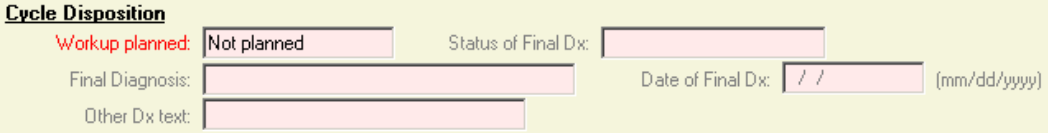
When you are finished entering a procedure, click one of the Save buttons to post the changes to the database

- Save New: Save the current procedure and open a blank record for a new procedure.
- Save/Return to Cycle: Save the current procedure, close it and return to the current cycle.
- Save/Next: Save the current procedure and go to the next procedure in the list.
- Save: Save the current procedure and browse it.
- Save/Close: Close the client's record.
- Cancel: Undo all the data you just entered in the current procedure.

If you attempt to navigate to a different screen without saving changes, the system will prompt you to save the changes first.

If there is more than one procedure in a cycle, use the navigation buttons on the mode bar to go to the First, Previous, Next and Last procedures.

The Cycle Disposition section contains the Workup Planned field, which indicates whether further diagnostic procedures are expected. This field must be completed for all cervical cycles. If the client has a planned workup the fields may be MDE's



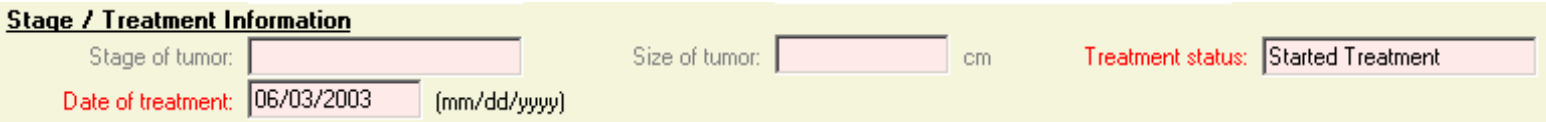
- **Workup Planned:** MDE
  - Enter "Not Planned" if additional procedures were not needed.
  - Workup Planned: Enter "Planned" if the provider recommended additional diagnostic procedures.

Once the Workup Planned Field is complete the labels of the required fields, MDE's turn red.

- **Status of Final Dx:** Enter the status of the final diagnosis.
  - Complete: Enter the Final Diagnosis and any information preceded by a red label.
  - Deceased: If the client dies before a final diagnosis is determined enter Deceased, otherwise enter Complete as the Status of Final Dx. After the client's claims are submitted by the provider and paid by the fiscal agent set the Baseline Client status to deceased and enter the date of death if it is available.
  - Lost to Follow-Up: If the client's location becomes unknown before a final diagnosis is determined enter Lost to Follow Up, otherwise enter complete as the Status of Final Dx,
  - Pending: Enter the Status of Final Dx as pending when

    * The provider has not returned the paper Abnormal form or
    * The data returned on the paper Abnormal form is incomplete or unclear or
    * The diagnostic follow up is inadequate.
  - Refused: If the client refused diagnostic testing and a final diagnosis cannot be determined enter refused, otherwise enter complete as the Status of Final Dx.
- **Final Diagnosis:** Enter the final diagnosis
- **Date of Final Dx:** Enter the date of the procedure that determined the final diagnosis.
- **Other Dx text:** To specify an "other" cervical final diagnosis. Talk to the data manager.

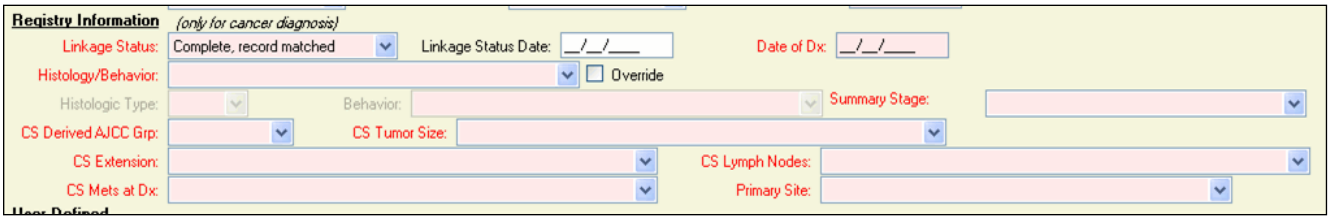
Stage/Treatment Information



The treatment status must be completed if the client has a final diagnosis that is bolded on the abnormal form. It may be completed for other results if treatment was planned. The Stage of tumor and Size of tumor are collected from the Montana Tumor registry.

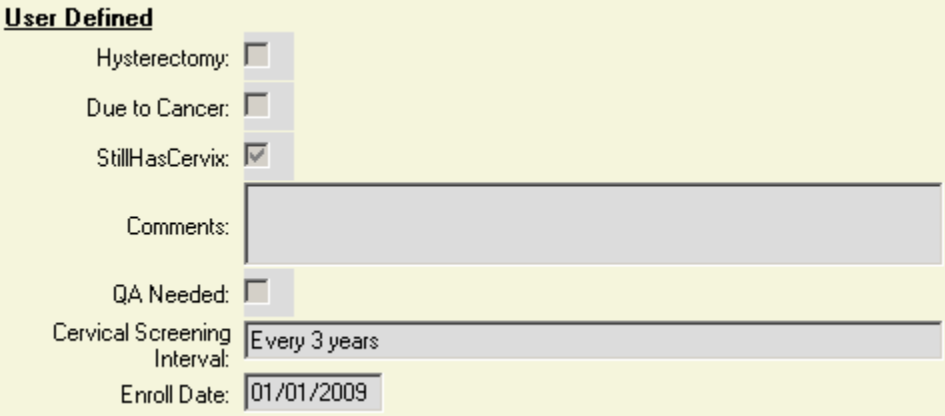
- **Treatment Status:** Enter a treatment status.
- **Date of treatment:** Enter the date the client begin treatment.

Registry Information



If the Final Diagnosis is cancer, the Registry Information section is opened. This data is collected from the Montana Tumor registry. Leave it blank.

The User Defined section



- **Hysterectomy:** Check if the client has had a hysterectomy.
- **Due to Cancer:** Check if the client has had a hysterectomy and it was due to cancer.
- **StillHasCervix:** Check if the client still has a cervix, whether or not she had a hysterectomy. If the client still has a cervix and did not have a hysterectomy and you leave this blank, the software assumes she doesn't have a cervix and denies claims for Pap tests.
- **Comments:** Use the comments to enter comments documentation, and questions about the procedure data.

  An example of a comment would be the client had a hysterectomy and the date.

Document unusual behaviors: If a provider chose a short term follow-up for a client who had a Pap test with a result of AGC so the client can complete a course of antibiotics document the provider's decision and the result of his decision and how he/she followed up with the client, especially if the behavior affects the MDE's.

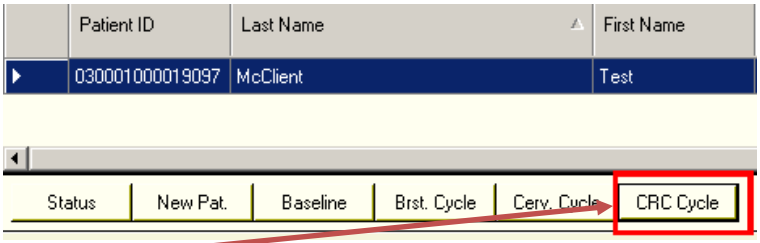
Enter a question and check QA if you need quality assurance assistance from the state office. In the above example where a provider chooses to give a client a different protocol then that required by the CDC you would check QA.

- **QA Needed:** To ask the quality assurance person at the state a question pertaining to the current cycle or to inform the quality assurance person that something outside the required algorithms has taken place check QA.

- **Cervical Screening Interval:** How often the provider recommends the client have a cervical screening. See the PPM for liquid and conventional Pap test policy.

- **Enroll Date:** Enter the date of the enrollment span that covers the procedures in this cycle started.

Colorectal Cycle/Procedure Data Entry

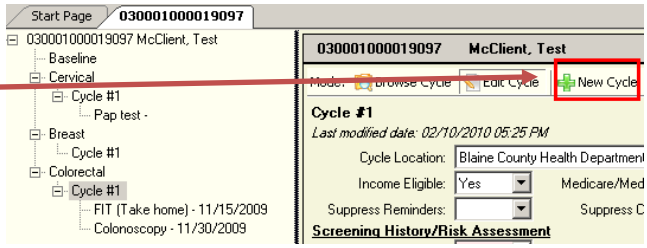


To enter a colorectal cycle

1. In CaST search for the client's record. When it is displayed on the Find Patient Result Page select it by clicking on it. The record will be highlighted.

2. Click the CRC Cycle button at the bottom of the Find Patient Result page. If the client has never had a colorectal cycle this will open a new colorectal cycle in edit mode. You can begin entry.

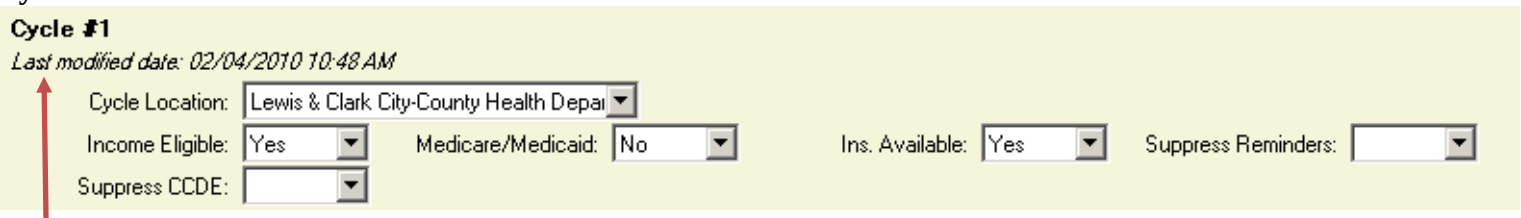
If the client has one or more colorectal cycles this will open the most current colorectal cycle. Click the New Cycle button on the mode menu bar at the top of the page.



If you are already in the client's record click on the most current cycle in the tree view. E.g. a client has 3 cycles, click on the words Cycle #3 under Colorectal. Then click the New Cycle button.

The fields Cycle location, Income Eligible, Medicare/Medicaid, Ins. Available in the first cycle (Cycle #1) are transferred from the Site Data System and is current. The next time the client is screened the above fields transfer from the previous CaST cycle, which is usually about a year old. Check it for changes since the last enrollment span.

Cycle Information



- **Last modified date:** This is the date the cycle was last updated.

- **Cycle location:** Enter the administrative site that enrolled the client.

- **Income Eligible:** Enter yes, if the client's income is at or less than 200% of the federal poverty level otherwise enter no. (See Site Data System, main screen, poverty levels and PPM Chapter 9, B. Eligibility, 1. General Criteria.)

- **Medicare/Medicaid:** Enter no. If the client receives either Medicare Part B or Medicaid he/she is not eligible for CRC services. (See PPM Chapter 9, A. General Description, 3. Reimbursement.)

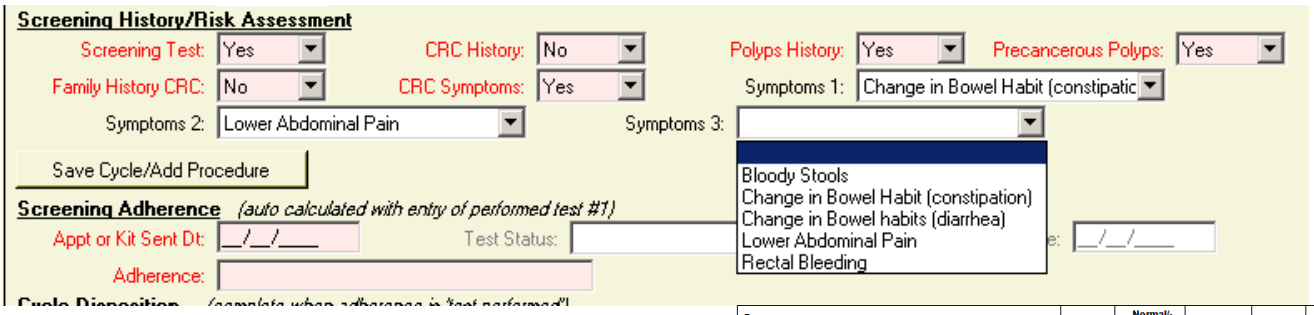
  Enter yes if a client is screened and then it is discovered the client has Medicare part B or Medicaid, notify the state and the fiscal agent. They may be able to get a reimbursed for the services. .

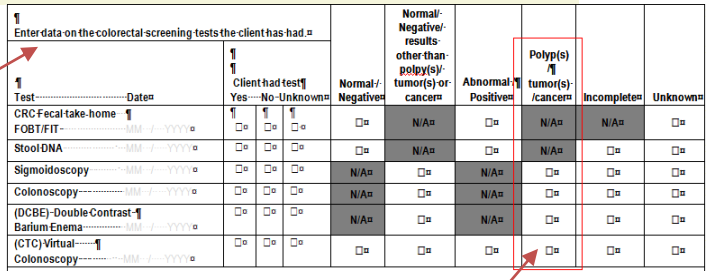
- **Ins. Available:** If the client has health insurance that covers the breast procedure(s) enter yes, otherwise enter no. (See PPM Chapter 9, A. General Description, 3. Reimbursement.)

- **Suppress Reminders/Suppress CCDE:** Ignore these fields; they are used at the state level.

Screening History/Risk Assessment

The data for this section comes from the Colorectal Eligibility and Enrollment Form, the grid labeled Screening History/Risk Assessment. See the Policy and Procedure Manual, Chapter 9, B. Eligibility, 2. Exception to the Age Criteria and 3. Additional Eligibility Guidelines for Colorectal Screening.





Screening History

- Screening Test: MDE: Enter Yes, if the client has checked yes to one of the screening tests on the enrollment form in the grid labeled "Enter data on the colorectal screening test the client has had" If not check no.

- CRC History: MDE: If the client checked yes to the question on the enrollment form "Have you been diagnosed with colorectal cancer or precancerous polyps?" enter yes; if not enter no.

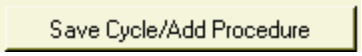
- Polyps History: MDE: If the client checked the box in the Poly(s)/tumor(s) cancer column, of test results, enrollment form in the grid labeled "Enter data on the colorectal screening test the client has had", enter yes; if not enter no.

- Precancerous Polyps: MDE: If the client checked yes to the question "Have you been diagnosed with colorectal cancer or precancerous polyps?" enter yes; if not enter no.

- Family History of CRC: MDE: If the client checked Yes to the question, "Has a blood relative been diagnosed with colorectal cancer or precancerous polyps and indicated a blood relative had colorectal cancer enter yes; if not enter no.

- CRC Symptoms: MDE: If the client checks any of the boxes on the enrollment form in the section labeled "Are you currently experiencing colorectal cancer symptoms?", check yes; if not check no.

- Symptoms 1- Symptoms 2 - Symptoms 3: MDE: Enter a symptom for each symptom the client checked up to 3 symptoms. If the client didn't check any don't enter any.

Save Cycle/Add Procedure 

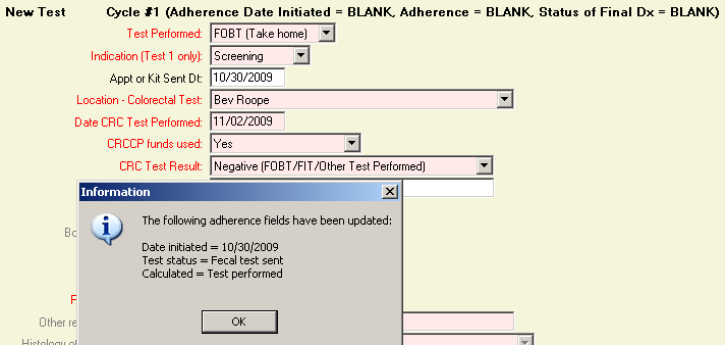
Click the Save Cycle/Add Procedure button,
The button says Save Cycle/Add Procedure if the cycle is in edit mode. In browse mode the button is labeled Add Procedure.

Have all the data for each colorectal procedure before entering the procedure. You cannot enter a dummy procedure in colorectal data. The record will not save if data is missing.

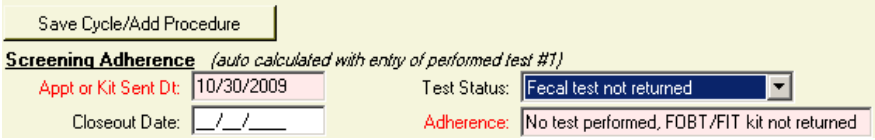
Screening Adherence
Note: Under the Add Procedure button is the Screening Adherence section with the note (*auto calculated with the test #1*).

If the client:

- **Returned a completed FOBT/FIT test or the client kept his/her initial appointment**: The fields "Appt or Kit Sent Dt", "Test Status" and "Adherence" will be auto filled when the data fields for the first procedure are entered. When you open the procedure screen the top row says Cycle #1 (Adherence Date Initial = Blank etc. Once the data is entered and you click save you get the Informational window that the adherence fields have been updates. Click Ok and continue.



- **2. Did not return a completed FOBT/FIT test or did not keep his/her appointment** fill out the Screening Adherence section and don't enter the procedure.

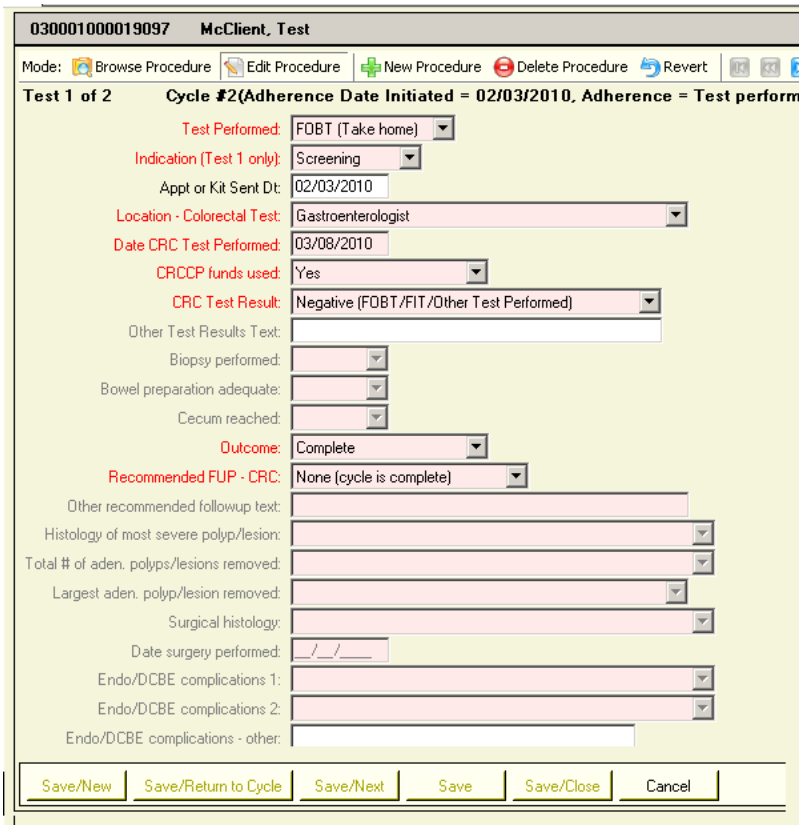


→ Appt or Kit Sent Dt: MDE: Enter the date the client was given the fecal kit or the date of the initial test appointment.
→ Test Status: MDE: Enter Fecal test not returned if the client did not return the fecal card. Enter Endoscopy/other appt not kept if the client did not keep their appointment.
→ Don't enter a procedure.

The FOBT/FIT procedure fields differ from the colonoscopy fields

FOBT/FIT (Take home)

The information for the following fields comes from the colorectal screening data collection form. Each description lists the name of the field on the screening form that matches the information in the CaST field.



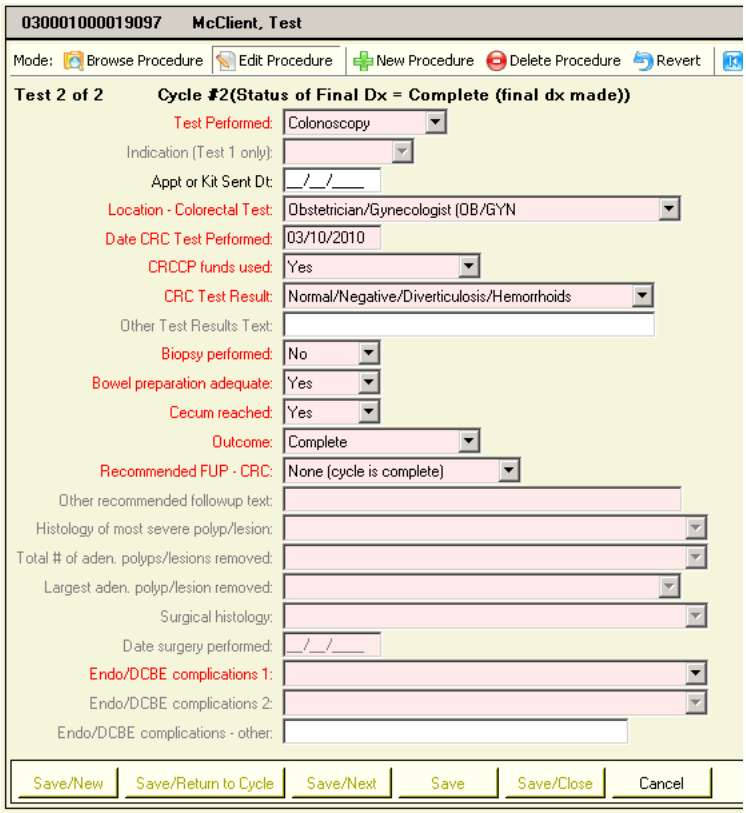
- **Test Performed:** MDE: Enter FOBT (take home); if the fields in the section beginning with the field labeled Take home FOBT/Fit are completed including the result, outcome, provider specialty, and next test recommended in this cycle.
- **Indication (Test 1 only):** MDE: Enter "screening". This is the only option for an FOBT. (data collection form, Indication for test.)
- **Appt or Kit Sent Dt:** MDE: The date the client was given the FOBT test, (data collection form "Date initial test scheduled or fecal kit distributed".) When this date and the Indication field above are entered the adherence information in the cycle is auto filled.
- **Location – Colorectal Test:** MDE: (data collection form, Provider Specialty next to the FOBT/FIT information.)
- **Date CRC Test Performed:** MDE: The date the of the FOBT/FIT lab result. (data collection form, Date under label "Take home FOBT/FIT".)
- **CRCCP funds used:** MDE: If the test was paid with Montana Cancer Screening Program funds enter yes; if not, don't enter the FOBT/FIT procedure data.
- **CRC Test Results:** MDE: The result of the FOBT/Fit test, negative or positive, (data collection form, Result)
- **Other test Results Text:** N/A for an FOBT/FIT
- **Outcome:** MDE: **(**data collection form, Outcome)
    - Complete – The fecal kit test had a result of positive or negative.
    - Incomplete/Inadequate – The client didn't return the test or a result cannot be determined.
- **Recommended FUP – CRC:** MDE: The test recommended by the provider. (data collection form, Next test recommended in this cycle). The only two follow-up tests for an FOBT/FIT are:
    - Colonoscopy
    - "None cycle is complete".

If the provider recommended follow up is "Other", the follow-up may not be paid for by the MCSP. Notify the state program manager.

- **Other recommended follow-up text:** MDE: A description of a provider recommended follow-up of other.
- **Save the cycle: Click**
    - Save/New to save the procedure and enter another procedure
    - Save/Return to cycle to save the procedure and return to the cycle screen.
    - Save/Next, should be disabled
    - Save to save the procedure and stay in the procedure screen.
    - Save/Close to close the clients records
    - Cancel to close the procedure screen and return to the cycle screen
- An Information box telling the user "The following adherence fields have been updated will open if this is the first procedure entered. Click OK. You will return to the cycle screen.

Colonoscopy

The information for the following fields is from the Colorectal Screening data collection form, beginning with the label Colonoscopy Date. Each description lists the name of the field on the screening form that matches the information in the CaST field.



- **Test Performed:** MDE: Enter Colonoscopy.
- Indication (Test 1 only): MDE: If the Colonoscopy is the first test in the cycle, then enter this field. If an FOBT/Fit was done it must always be the first test in the cycle.
- **Appt or Kit Sent Dt:** MDE: If the colonoscopy is the first test of the colorectal cycle enter the appointment date, (data collection form, Colonoscopy Date)
- **Location – Colorectal Test:** MDE: The type of provider, (data collection form, Provider Specialty)
- **Date CRC Test Performed:** MDE: The date the colonoscopy was done, (data collection form, Colonoscopy date)
- **CRCCP funds used:** MDE: If the test was paid for using Montana Cancer Screening Program funds enter yes; if not, don't enter the colonoscopy procedure.
- **CRC Test Results:** MDE: The result determined by the provider. (data collection form, Result)
- **Other Test Results Text:** MDE: Use this field if the provider indicates the CRC Test Result is:"Other findings, not suggestive of cancer/polyps." Notify the state data manager.
- **Biopsy performed:** MDE: (data collection form, "Was a biopsy/polypectomy performed during the endoscopy?"). If the answer is yes the field Histology of most sever polyp/lesion must be answered.
- **Bowel preparation adequate:** MDE: (data collection form, "Adequate bowel preparation (decided by clinician that did endoscopy))
- **Cecum reached:** MDE: (data collection form, Was the Cecum reached during this colonoscopy?)
- **Outcome:** MDE: The outcome of the Colonoscopy, (data collection form, Outcome.)
- **Recommended FUP – CRC:** MDE: The next test recommended to reach a diagnosis in this cycle, (data collection form, Next test recommended this cycle.)
- **Other recommended follow-up text:** MDE: The provider recommended follow-ups on the colorectal screening form.

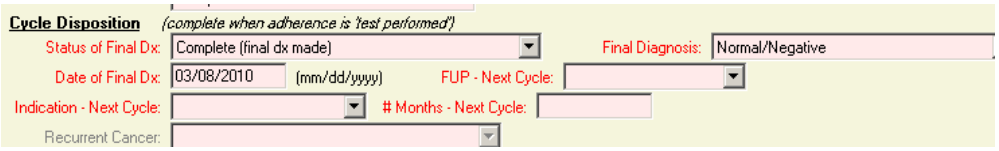
The information for the following fields is from the Colorectal Abnormal data collection form. Each description lists the name of the field on the screening form that matches the information in the CaST field **Histology of most severe polyp/lesion:** MDE: This should be completed if a biopsy or polypectomy was done during the colonoscopy. Don't include information from surgical resections. That goes in the field "Surgical histology", (data collection form, Histology of most severe polyp/lesion)

- **Total # of aden. Polyps/lesions removed:** MDE: If the histology of the most sever polyp or lesion is an Adenoma or cancer this must be completed, (data collection form, Number of adenomatous polyps/lesions.)
- **Largest aden. Polyps/lesion removed:** MDE: Does not include information from surgical resections, (data collection form, Size of largest adenomatous polyp/lesion)

- **Surgical histology:** MDE: Enter if the client has a surgical resection to complete the diagnosis, (data collection form, Histology from surgical resection.)
- **Date surgery performed:** MDE: Enter if the client has a surgical resection, (data collection form, Date surgery performed.)
- **Endo/DCBE complications 1:** MDE: Use the worst complication listed. (data collection form, Complications of endoscopy requiring observation or treatment.)
- **Endo/DCBE complications 2:** MDE: If the clinician checks more than two complications use the worst. (data collection form, Complications of endoscopy requiring observation or treatment.)
- **Endo/DCBE complications –other:** MDE: (data collection form, Complications of endoscopy requiring observation or treatment.) If the clinician checks other there must be a brief description.

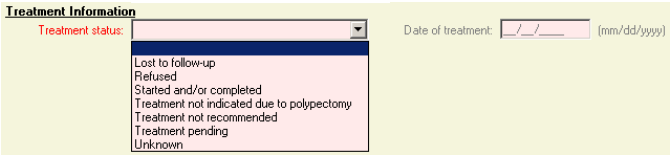
Save the procedure and return to the cycle

Cycle Disposition



- **Status of Final Dx:** MDE: (colorectal screening data collection form, Status of final diagnosis):
  - Complete: There is a final diagnosis.
  - Pending: The client has not completed all the tests needed to reach a final diagnosis or the data forms have not been completed and/or collected.
  - Refused: The client refused additional procedures required to reach a final diagnosis.
  - Lost to follow – up before final dx was made: The client cannot be reached and a final diagnosis cannot be determined without further procedures.
  - Irreconcilable: This should never be used. Please call the state office if you feel you have a case that is irreconcilable.
- **Date of Final Dx:** MDE: The date of the procedure that determined the final diagnosis. If the client refused diagnostic procedures or was lost to follow-up, enter the date the client was determined to have that status, (colorectal screening data collection form, Date of final diagnosis, refused, or lost to follow-up).
- **FUP – Next Cycle:** The provider recommended follow-up for the next colorectal cycle, (colorectal screening data collection form, Recommended test for next cycle)
- **Indication – Next Cycle:** The reason for the next cycle, (colorectal abnormal screening form, Indication for screening or surveillance test for next cycle)
- **# Months – Next Cycle:** The amount of time until the client's next colorectal cycle, (colorectal abnormal screening form, Number of months before screening or surveillance test for next cycle --- if none leave blank).
- **Recurrent Cancer:** (colorectal screening data collection form, Recurrent cancers)

Treatment Information



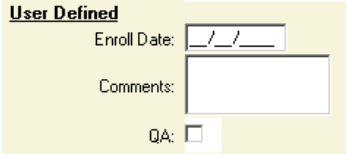
- **Treatment Status:** (colorectal abnormal screening form, Status of treatment).
  - Lost to follow-up: The client location is unknown.
  - Refused: The client has refused treatment or chosen an alternative treatment not recommended by the provider.
  - Started and/or completed: The client has at a minimum started treatment.
  - Treatment not indicated due to polypectomy
  - Treatment not indicated:
  - Treatment pending: The client is in the process of arranging for treatment.

- **Date of Treatment:** (colorectal abnormal screening form, Indication for screening or surveillance test for next cycle) Enter the date
  - the client started treatment;
  - the date the client refused treatment, (PPM, chpt 9, Quality Assurance, Client Refusal of Follow-up Tests or Treatment,
  - the date the client was lost to follow up, (PPM, chpt 9, Quality Assurance, Clients "Lost to Follow-up")

Registry Information

Registry Information is collected from the Montana Central Tumor Registry. For a description of the fields call the MCSP Data Manager.

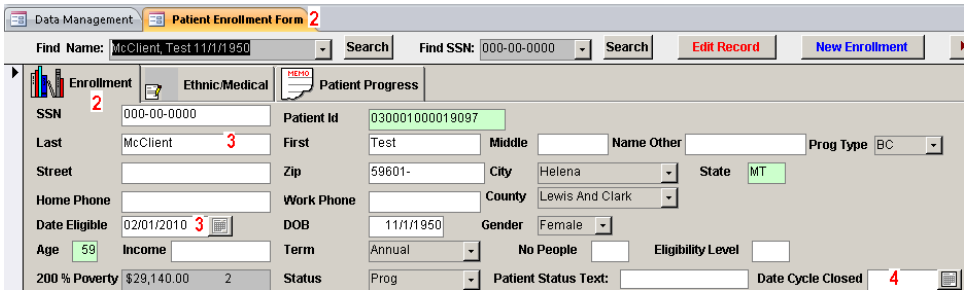
User Defined Information



- Enroll Date: The date the client was enrolled in the Site Data System. This is the date of the enrollment span that covers the colorectal procedures associated with the enrollment span.
- Comments: This is an information field for the users benefit. Suggested entries are: Comments that explain or document part or all of the cycle, a question for QA, and a note for future reference.
- QA: Check this if you would like the state quality assurance person to review the cycle with you. Enter comments and questions in the Comments text box that will inform the QA person of your concerns.

Enter the Close Date

After all of the data is entered that is covered by the enrollment span enter the close date in the site data system. Don't do this if the Status of the Final Diagnosis is "Pending" in any of the cycles; breast, cervical, or colorectal.



(1) Open the Site Data System.
(2) Open the Enrollment form, Enrollment tab.
(3) Open the record of the client's enrollment span that covers the client's procedures.
(4) Click in the Date cycle closed field.
(5) If Workup Planned/Additional Procedures is
   A. Not Planned: Enter the date of the last procedure plus 30 days. This allows the fiscal agent to pay claims for services done after the last procedures such as lab work.
   B. Planned: If the Status of the Final Diagnosis is:
      (i) Complete
         a. And the final diagnosis of the breast, cervical and colorectal cycles are not a cancer or precancer, enter the date of the last procedure in the enrollment span plus 30 days.
         b. And the final diagnosis of the breast or cervical cycle is cancer or a precancer; enter the date of the last procedure in the cycle with the cancer or precancer diagnosis.

      (ii) Deceased:
         a. If no claims are submitted enter the date the client died. (See the Enrollment Button, Enrollment tab, Field Descriptions, Status, and Decd.)
         b. If a provider submits claims follow the protocol for a Completed cycle
            1. Lost to Follow Up: Enter the date the client was Lost to Follow Up.

2. Pending: Don't enter a date. Wait to close the cycle until one of the other statuses is chosen.
3. Refused: Enter the date the client refused diagnostic tests.

Once a client is on MBCCTP they are no longer eligible for screening services paid for by MCSP.
Any screening procedures occurring after the date of diagnosis will be covered by Medicaid.
Anything that happens prior to the date of diagnosis is covered by MCSP.

You do not need to collect and enter data about services that Medicaid pays for unless you need it to complete the cycle.
E.g. Client Test McClient has the following cycles:

Breast cycle	Cervical Cycle
Jan 17 CBE	Jan 17 Pap HGSIL
Jan 20 Mamm	Jan 25 Colposcopy Diagnosis Negative
Jan 20 US	
Jan 20 Biopsy Diagnosis Invasive Breast Cancer	

Even though Medicaid would pay for the Jan 25 Colposcopy you would need to collect the colonoscopy data, and enter it, setting the field "Pd by NBCCEDP" = No, to complete the cervical cycle.

Set the close date to Jan 20 the day client was diagnosed with Breast Cancer

If a client's screening services are scheduled when the client is on Medicaid it is the sites choice to

- Re-schedule those services so MCSP covers them and they will count toward their screening goal.
- Keep the services as scheduled and let Medicaid cover them and use the money to screen another client.

If a client is diagnosed with cancer but will not be eligible for MBCCTP, do not close the cycles until 30 days after all screenings are completed.

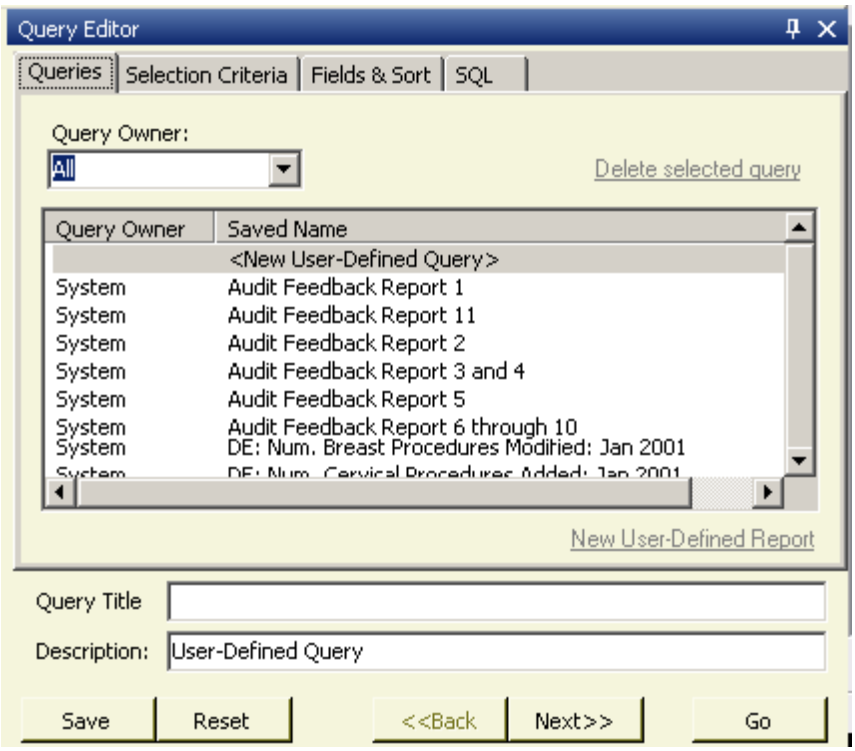
If a client is diagnosed with cancer and is eligible for MBCCTP In the comments box of the Baseline form of CaST enter "Dx Ca" and the date of the final diagnosis of the cycle with the cancer or precancer diagnosis.

Queries: Introduction to Queries

One of the most important aspects of a database system is the ability to retrieve information based on certain criteria. The Query Editor in CaST provides a powerful and easy to use interface for retrieving specific information from any of the tables in CaST.

Use the query editor to sift through all patient records in the database and select only the ones that satisfy your specified criteria, to select the fields you wish to view and to choose the order in which you want the records to be displayed.

CaST also allows you to save queries for future use. In addition, CaST contains several pre-defined system queries.



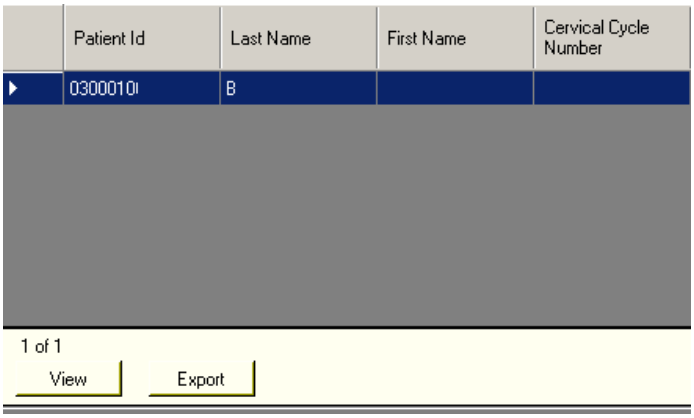
Retrieving a Saved Query

To execute a saved query, click the Queries button. The Query Editor panel will appear. Three types of saved queries are available for display: System queries, which include standard audits, All queries, including those saved by other users, and queries saved by the current user. You can access these types by selecting the appropriate choice from the Query Owner drop-down

To execute a query, select the query and select Go. You can also select a query and double click.

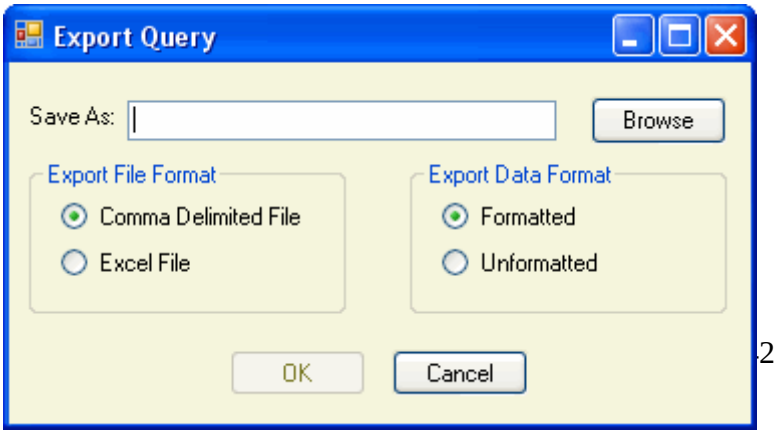
Working with Query Results

To the right is an example of the results displayed after execution of a query.



The number of records is displayed at the bottom. You can scroll through the results, using the horizontal and/or vertical scroll bars. These scroll bars are only visible if the number of records or number of fields is greater than the viewing area.

You have two other options regarding the results of the query. You can view particular patients displayed in the results or export the results.



To access the Patient Status screen for a patient displayed in the results, select the patient and select the View button. Note: This option is only available if the Patient ID field is selected as one of the fields in the query.

To export the results, select the Export button. This will open the Export Query dialog, as shown below.

This will allow you to save the results in either a comma-delimited format, or as an Excel spreadsheet. If you want to see the values as they are defined in the database, (For example – C_Final_DX_Status = Complete), choose Formatted for Export Data Format. If you want to see the values as they are input (For example – C_Final_DX_Status = 1), choose Unformatted. You can use the Browse button to select a directory and file name.

Creating a New Query

Creating a New Query -- Getting Started

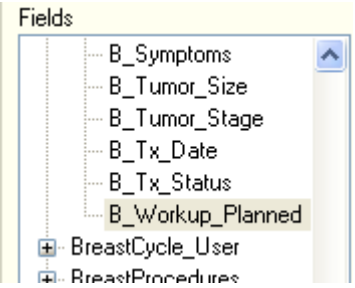
The first step in creating a new query is determining whether you need to start from scratch. You can often build upon other user's queries, even the system queries. If you only need additional fields displayed, a different sort order, or a slightly different subset, you can modify an existing query and save it under a different query name. You can find more information on how to modify an existing query later in this section.

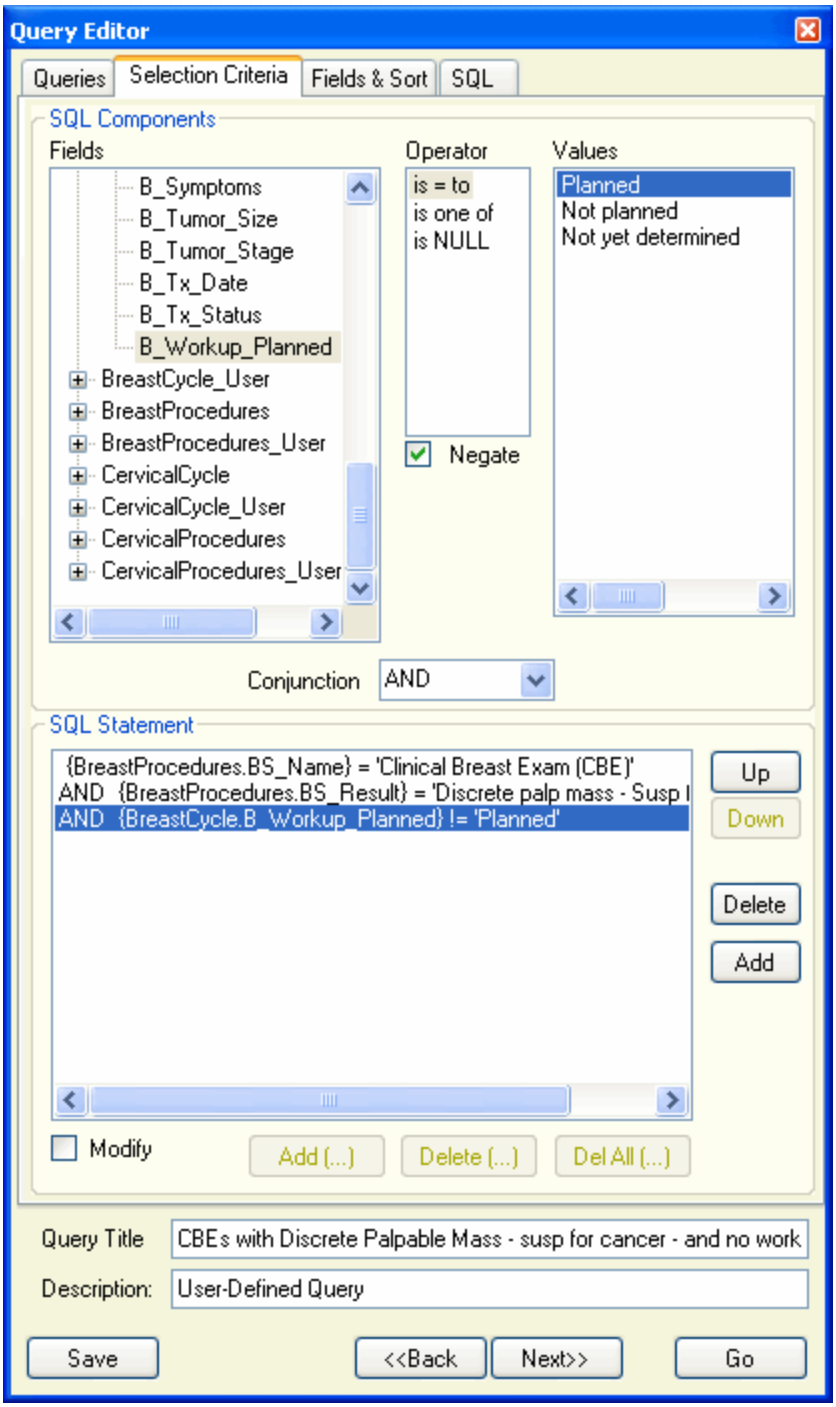
To create an entirely new query, select the New User Defined Report link on the Query Editor panel. Enter a title in the Query Title field and click Next.

Selection Criteria

The next step in building a query is defining the selection criteria.

There are five sections on the Selection Criteria tab: Fields, Operator, Values, Conjunction, and SQL Statement. The first four sections will determine what is created or displayed in the SQL Statement section. The four sections described below will allow you to build one or more search statements:





The Fields section contains all tables and corresponding fields in the database, including user-defined tables. Clicking the + to the left of the table name will expand the list of fields contained in the table. You will build your search statement by selecting one field at a time. In the example, the criteria for the first search statement are using CBE procedures. This is a breast procedure, so you would select the Breast Procedures table and select BS_Name, which holds the procedure name.

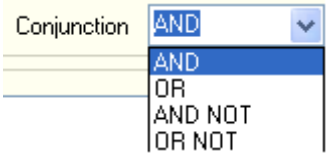
The next part of the search statement is the operator. Using the mouse, select the operator you wish to use with the selected field. In our example, select is = to for the operator.

selected
Last Name,

example,
search to
value, click
statements.

The next part of the search statement is the value you wish to search for in the field. The value you specify is dependent on the type of field. For text fields, like you would enter the text. For date fields, you would enter the entire date (in MM/DD/YYYY format – including the '/'). For formatted fields, like our the available values will be displayed under the Values box. If you would like to see if a field is blank, enter the word Null in the value box. When you select the Add, this will add the entire statement (field – operator – value) to the search

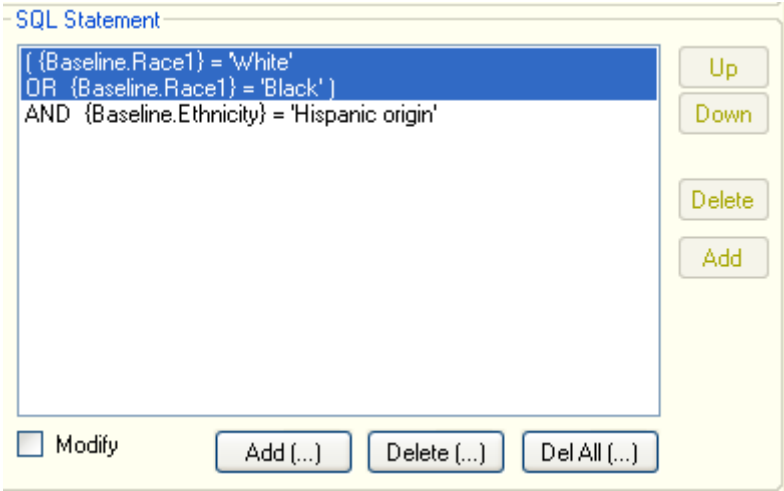
Conjunction



If you are only creating one search statement, you do not need to use the conjunctions. Conjunctions are used when you use two or more statements. You can select the conjunctions before or after you create the statement

The conjunctions (AND, OR, AND NOT, OR NOT) control the logic of the statements. Placing the AND between two query statements will result in records where BOTH statements are true. Placing the OR between two query statements will result in records where EITHER statement is true. The AND NOT and OR NOT can be used to select the opposite of a statement. For instance, if you are searching for all Races BESIDES White, you can build a statement AND NOT Race = White.

The three buttons below the SQL Statement field are used to group logic statements together or ungroup statements. For instance, if you wanted to search for race equal to White OR Black, along with Ethnicity equal to Hispanic Origin, you would need to add parentheses to group the two search statements on race. Use the mouse to highlight the two rows for Race1 and click the Add (…) button to add the parentheses.



So, the statement would be: (Race1 = White OR Race1 = Black) AND (Ethnicity = Hispanic Origin).

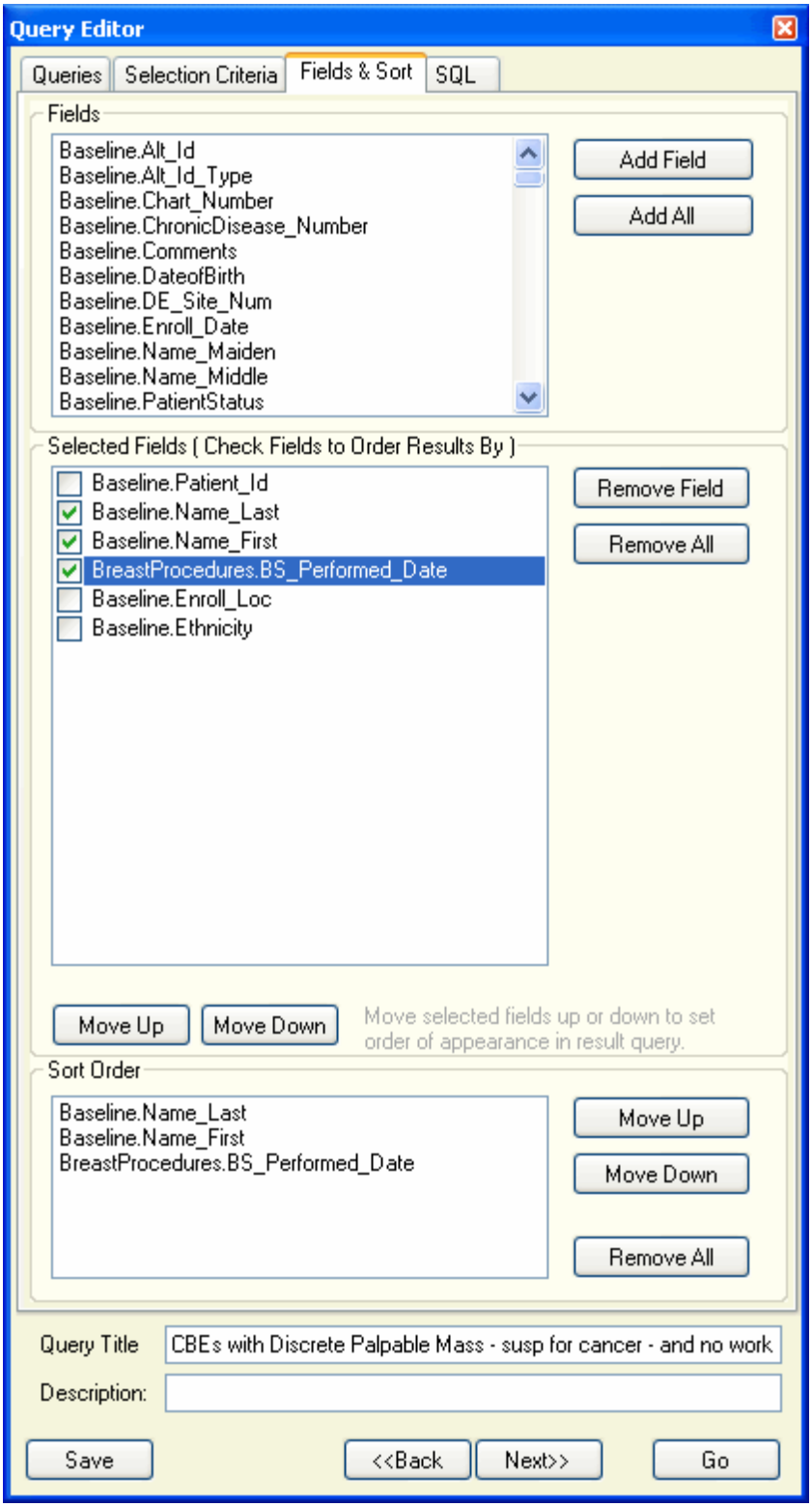
You can add or remove these parentheses at any time. To remove, use the mouse to highlight the lines again and click Delete (…). The Del All (…) button will remove all of the added parentheses in the highlighted statements.

The Up and Down buttons are used to change the order of the parts of the statement. Use the mouse to highlight a line and then use the Up and Down buttons to move the line.

The Delete button removes the highlighted line.

Helpful hint: For complicated queries, it is sometimes easier to first create all your search lines, then go back and add the conjunctions (AND, OR, AND NOT, OR NOT), along with the parentheses.

Fields Selection and Sort Order



The Fields & Sort tab allows you to specify what fields are displayed in your query and to specify how the results will be sorted.

All fields in the database are listed in the Fields box and the fields you select to be displayed are listed in the Selected Fields box. You can move the fields from the Fields box to the Selected Fields box in several ways. You can move one field at a time by double clicking on the field or by clicking once on the field and then clicking Add Field. You can move a group of contiguous fields by clicking on the first field you want to move, holding down the Shift key and clicking the last field you want to move and then clicking Add Field. You can move all of the fields by clicking Move All.

You can remove all of the fields from the Selected Fields box by clicking Remove All or you can remove one field at a time by clicking on the field and then clicking Remove Field.

The Move Up and Move Down buttons are used to order the selected fields. To move a field, click on it and then click on one of the move buttons.

IMPORTANT: In order to access the Patient Status screen from the Query Results window, Baseline.Patient_Id must be selected as one of your fields. CaST will automatically select this field when you create a new query.

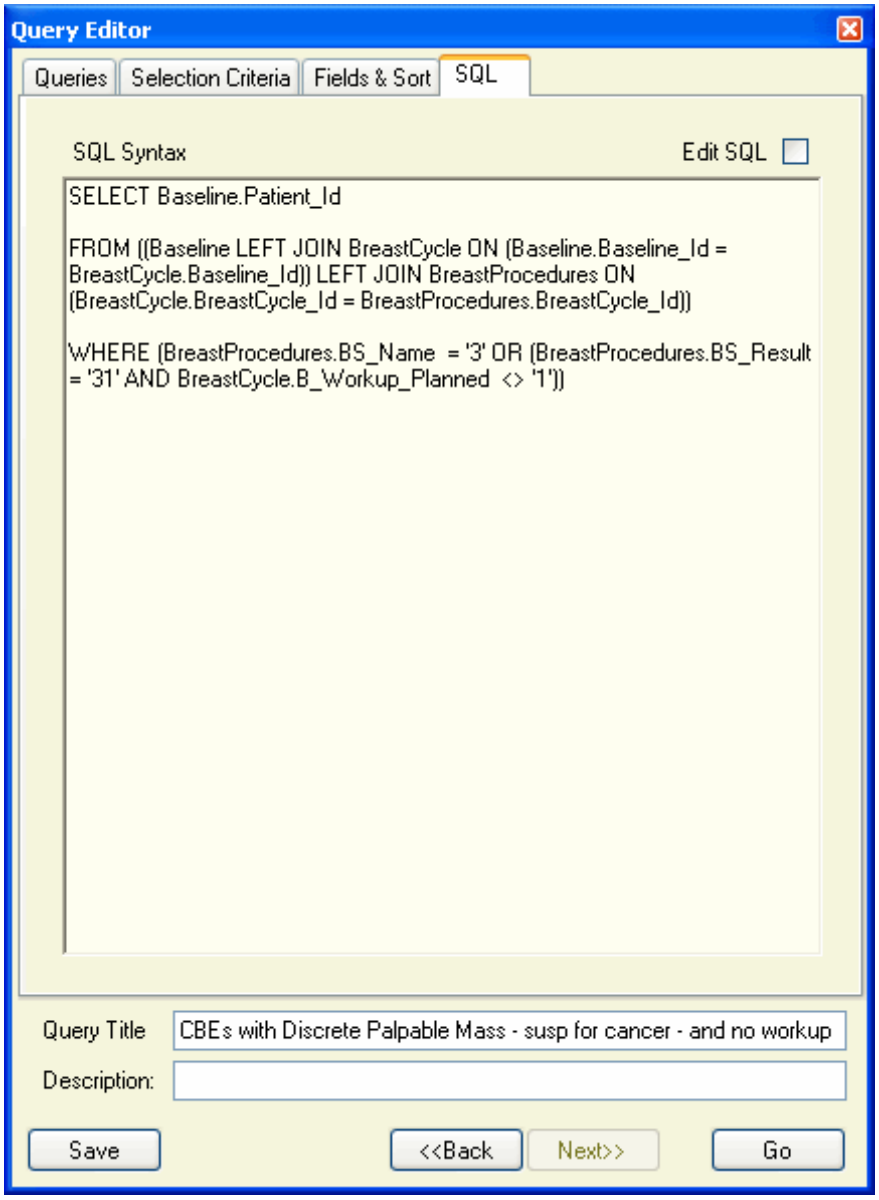
Note: The number of records displayed is partially determined by which fields you choose on this screen. For example, if you are searching for a baseline field (i.e. Race), but choose fields from the Breast Procedures tables, you will most likely get multiple records per women, since the procedure tables hold all procedure records for the woman.

Check the boxes next to the fields you would like to sort by to copy them to the Sort Order box. To change the order of the fields, click a field that you want to move and click the Move Up and Move Down buttons next to the Sort Order box. Individual fields can be removed from the Sort Order box by removing the checks in the Selected Fields box. Click Remove All next to the Sort Order box to remove all of the fields.

SQL Tab

This final tab allows you to view the SQL code which constitutes the query and save the query for later use. You can also specify a report title and select Go from this tab and from the other tabs in the Query Editor. When you select Go, the results of the query will be available for viewing and saving. Please see Working with Query Results for more information.

The Edit SQL button is used to modify the SQL code. This is explained in the Advanced SQL section.



Modifying an Existing Query

If you have an existing query, either a used-defined or system query, which you would like to modify, CaST allows you to modify the query and save it as one of your user-defined queries.

To modify a query, select the query from the Query Editor screen. Scroll through the various tabs and make changes as necessary. Click Save when finished. If you are the owner of the query (i.e. you originally created the query), you can overwrite the existing version. If you are not the owner, you must specify a different name for the query. Queries that you create/save will show up when you select your user name from the Query Owner drop-down on the Queries tab.

You will notice that some queries do not have the normal search statements, field, or sort options available for editing. These queries were created using Advanced SQL. You can still modify these queries, but you need to do all of the modifications in the SQL tab, which requires a familiarity with SQL code.

Advanced SQL

The SQL tab in the Query Editor contains an Edit SQL check box on the top right hand side of the screen. This box can be used to edit the SQL code for any query. To use this feature, you must have an understanding of SQL or have access to an SQL editor, such as Microsoft Access. If you use Access to build your own queries on the data tables, you can cut and paste SQL code into the SQL tab. This is necessary to execute complex queries such as the System Query Calc: Average Number of Days: Breast Procedures. This query uses the Group By option and calculates Min and Max values.

When using this feature, please be aware that the Selection Criteria and Fields & Sort tabs will not be available for future modifications. Please also be aware that selection criteria must be created using valid SQL code.

Note: When creating criteria statements, you must use single quotes around values instead of double quotes. By default, Access uses double quotes for ‘text’ fields. Also, if you are using the SQL Server Database option, there are other differences between Access and the query language needed for SQL Server. For instance, Access uses '#' around date values while SQL Server requires single quotes.

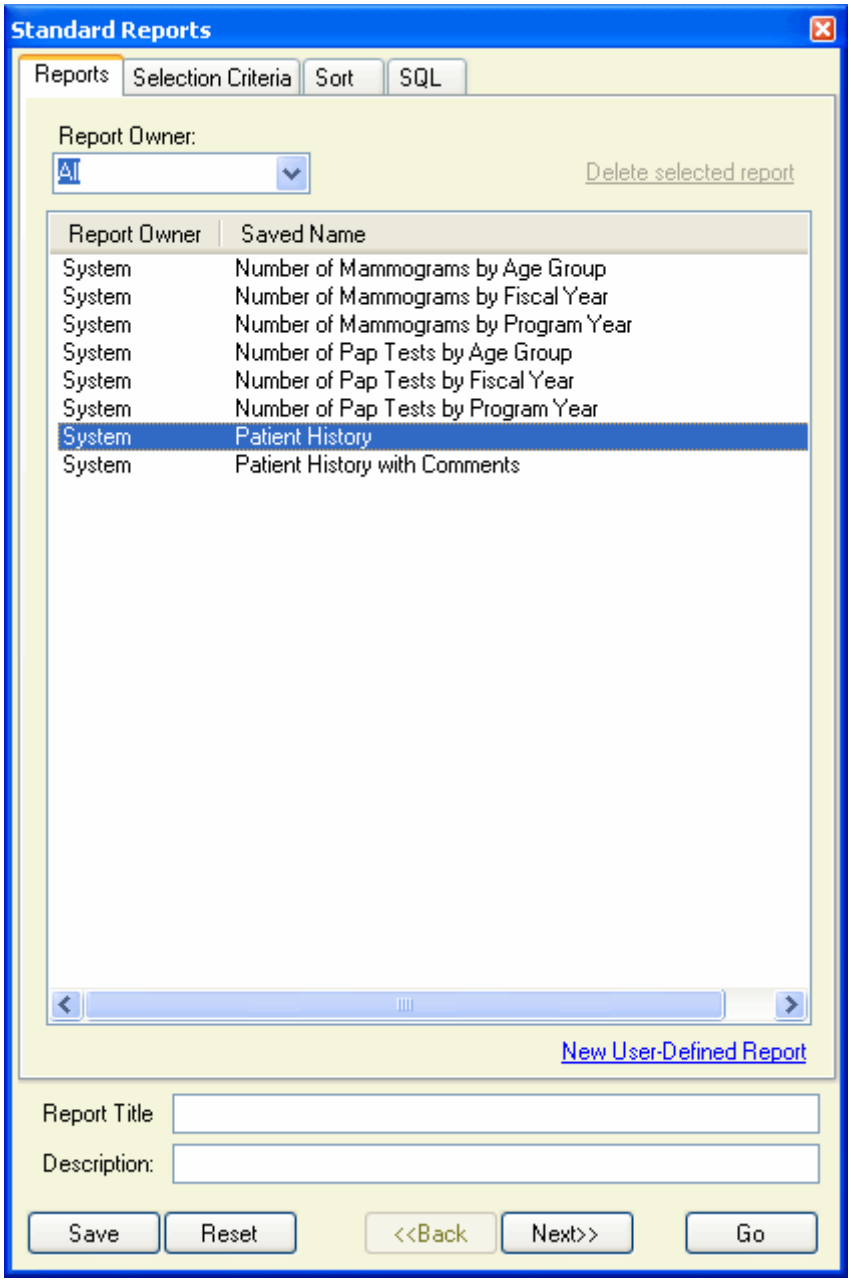
Standard Reports

What are Standard Reports?

Standard Reports are an extension of the Queries function in CaST. The difference between queries and standard reports is that standard reports use a graphical reporting package and are displayed in an easier to read format.

The standard reports window is very similar to the queries or Search Editor window. The differences are that you can't create a new standard report from scratch and you are limited to predefined tables and fields in the selection criteria tab.

There are several "system" Reports provided with the installation of CaST. You can run these reports directly or you can run the reports using a different subset, by modifying the Selection Criteria.



Running a Standard Report

To run a standard report, click the Standard Reports button or select Report > Standard Reports from the menu. The Standard Reports panel will appear.

Three types of saved reports are available for display: system reports, which include those provided with the installation, all reports, including those saved by other users, and reports saved by the current user. You can access these types by selecting the Report Owner drop-down box.

To execute a report, select the report and select Go (or double click). A basic report window is displayed. You can view the results and print the output from this window.

After you execute the report, you can print the report by clicking the Print icon or save the report in Excel format or as a PDF by clicking the Save As icon and selecting Excel or Acrobat (PDF) file. You will be asked to provide the name and location for the new file. If you have Adobe Acrobat on your machine, you can then open a file saved as a PDF.

Modifying an Existing Standard Report

Although you can't modify the design of a standard report, you can modify the underlying subset or sort order. You can use the Standard Reports screen the same way you would to modify Queries. You will not be able to change the tables or fields related to the report.

After making the changes to the Selection Criteria and/or Sort tabs, you can save the options by renaming the report in the Report Title field at the bottom of the panel. The current report with your modified changes will be saved for future use.

State of Montana, DPHHS, Intranet and Internet Policy

Users of the Site Data System are users of the state system and are responsible for complying with all policy concerning use of the state of Montana computer systems. Non-compliance can result in legal charges. Please read the following policy. If you have questions please notify the program manager(s) at the state Montana Breast and Cervical Health Program.

The policies can be found at: http://ours.hhs.mt.gov/policies.shtml

Click DPHHS
Under Information Technology
Click Information Security & Data Access
Click Internet, Intranet & E-mail

State of Montana Department of Public Health and Human Services

Information Security and Data Access Policy

August 02, 2004

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Information Security and Database Access Policy

I. Background:

The Department of Public Health and Human Services (DPHHS) is the designated single state agency responsible for the administration of: TANF, Foster Care, DD, Medicaid, Child Support & Welfare Services, Aging and Basic Support Programs, and numerous smaller programs assigned by Federal or State authority. In addition, DPHHS is the sole successor agency of those agencies previously providing these services. As such, program administration is defined to encompass all of the individual service areas under DPHHS' single agency jurisdiction. To properly administer these programs, the Department must collect vital records, information relative to the state's population and information on individuals and applicants for state services and benefits. This information is, in many cases, not releasable outside the actual collection unit without modification to preserve confidentially of client records or without proper authorization based on a "need-to-know" for purposes related to the administration of Departmental programs. DPHHS has the responsibility for ensuring that confidential information under the control of the Department are not compromised, while at the same time ensuring that the programs are properly administered. Therefore, it is essential that the Department establish a policy and process that will validate any request for access to privileged information against a framework of legitimacy criteria designed to test the appropriateness of the request.

II. Policy:

It is the policy of the Department of Public Health and Human Services to protect the confidentiality of the DPHHS client information and to ensure that access to such information is restricted to legitimate purposes of program administration. This policy is not intended to provide a barrier to program management. Although each employee is expected to abide by the letter of the policy and their signed confidentiality agreements, there may be situations where special circumstances or effective management requirements would indicate a need to deviate from this policy. In this event, Division Administrators should refer the situation to the DPHHS Director or his/her designee**,** with a request for a change or exception to the policy or an exception to an individual's confidentiality agreement. The governing principle that must be followed is that only the minimum necessary client information will be shared on a "need to know" basis that is in the best interest of the client, effective administration of the program and the health and safety of Montana's citizens.

III. Applicability:

Certain agencies and organizations outside of, but with ties to, the Department also have a legitimate "need-to know" relative to some program information. These agencies are defined as any organization, either public or private:

(1) That the Department contracts for specific services;

(2) That has a legitimate need-to-know; and

(3) With which the Department has a Business Associate Contract or a Memorandum of Understanding to protect the confidentiality of the information.

The collective term for combined Department and "contract" agencies will be the "Department/Contractor organization". Agencies and individuals outside this organization also occasionally request such information and may have a legitimate need-to-know. This policy and process is therefore applicable to both the Department/Contractor organization and all other agencies and individuals.

IV. Scope:

This document is intended to address requests for and sharing of, on a need-to-know basis, all information compiled and maintained by any component of the Department/Contractor organization relative to individuals or groups of individuals served by the organization, or any information utilized in the administration and management of programs assigned to the Department. Such information may be contained in computer databases including mainframes, mid-tier computers and PCs, or non-automated data files. Requests may range from one time, individual requests for specific and limited information to requests for continuous, direct electronic access to an entire computer database. Requests may originate from components within the Department/Contractor organization other than the custodial component, or from any agency or individual outside of this organization. The scope of this document will cover all possibilities within this framework.

V. Administration:

Administration of the policy and process for controlling information distribution will be the responsibility of the Information Security Officer. The function of this person is to:

1) Review and process all requests for release information made by entities outside the Department/Contractor organization after appropriate Division approval**.**

2) Review and process all requests for release of information from the originating Division to other Department/Contractor organizations that are forwarded by the Division Administrators (or their designee) for processing, and all requests from non-DPHHS entities approved by the Division Administrator (or their designee);

3) Periodically review access policies that affect confidentiality of information.

In all cases within this policy where the Division Administrator is authorized to release client information, the Administrator concerned may delegate approval authority and establish written rules and procedures within the division as desired to facilitate effective program management and policy compliance. Any such written rules and procedures must bear the approval signature of the Division Administrator and shall be reviewed on an annual basis to ensure continued compliance with this policy and the associated HIPAA policies.

VI. Priority:

This policy is intended to provide guidance to maintain the confidentiality of client information in situations where no other policy exists. This policy does not preempt federal policies relative to any individual program under the administration of DPHHS. Federal policies shall have precedence over any provision of this policy. In that all requests for information or access to information are submitted to Division Administrators (or their designee) for approval or review and comment, Division Administrators shall ensure that all State and Federal confidentially requirements for programs under their purview are adhered to.

VII. Process:

Any process that controls dissemination of information must address the interests of the clients being served, on which the information are accumulated, as well as both the custodian and the requestor of the information. The process must also take into account the nature of the information involved in terms of the level of sensitivity relative to the privacy rights of the clients.

A. Sensitivity Levels:

In an effort to define categories of sensitivity on which to base access control measures, the following "sensitivity-levels" have been established

Level 1: This is information of a general nature about the characteristics of the population served by a program. Information is presented in such a way that individual clients cannot be identified from analysis of the information. Examples include: TANF population characteristics, such as average length of stay, mean payment level, and recidivism rate and; Medicaid client information such as the average age of clients, geographic distribution, and outcome analysis, such as relationships between preventive services and cost of care. Basically, Level 1 information represents information summary type information rather than individual-specific information.

Level 2: This is the client demographic and basic service information. Generally, Level 2 demographic information is program specific and is limited to information necessary to identify if an individual or family is known to the Department and to determine their program eligibility. Demographic information would be limited to name, address, phone number, date of birth and social security or other identification number. Service information would be limited to the type of service(s) received or being received, dates of service(s) and the component within the Department providing the service(s). Level 2 information is considered "Confidential" in that the fact that an individual or family is known to the Department and has received or is receiving services is controlled by the Department on a need-to-know basis, but is not considered to be "sensitive" information in terms of the following Level 3 definition.

Level 3: Information at this level is detailed information about an individual client's personal background or previous and present services provided by the Department. Level 3 information is considered as "sensitive" information in that if the information is improperly used, serious damage could occur to the individual or family concerned. Examples of Level 3 information would include medical status and history including past and present conditions or illnesses, specifics of medical diagnosis or tests, treatment plans, family background, child support requirements and status if

appropriate, financial status and specific information relative to the services provided by the Department. (See Section VII-B below for further definition.)

B. Determination of Sensitivity:

To be able to implement an access control process based on sensitivity-level classification, each Division must be able to determine the sensitivity levels associated with the client-specific information elements collected and maintained by the Division. By previous definition, individual information elements cannot, by themselves, be Level 1, in that Level 1 are summary information, or the sum, average, mean, etc. of many individual records of the same or combination of the same information element(s). All individual information elements therefore fall within Level 2 or Level 3 categories. For the purpose of structuring and administering this program, it will be sufficient to assume that those information elements that are not Level 3 will automatically be Level 2. The test for Level 3 classification is as follows: Any information element which, when taken together with client-identifying information elements would create "sensitive" information, is considered to be a Level 3 information element. An example of this would be a information element for medical diagnosis that shows "HIV positive", together with a name or other identifying element. This would identify a specific individual as being HIV positive, a fact that could be damaging to the individual if improperly used. This would make the medical diagnosis element "sensitive" and as such would be Level 3.

C. Sources of Information:

To administer this program all sources of information that are subject to sharing must be identified. Each Division Administrator (or their designee) shall determine a listing of all such sources, including information located on the state's mainframe, contractors' systems, the Department's mid-tier computer (RS6000), and all PC based programs, as well as all non-automated information files. These listings should include a brief description of the type, purpose and content of the information or file, where it is located and who the custodian and/or point of contact is. This information should be provided to the Administrator of the Operations and Technology Division (or their designee) for compilation and distribution and should be kept current at all times.

D. Requesting Information (Information):

1. Requests for information from within the Department/Contractor organization:

Level 1 requests made to a component of the Department holding the information, by another component within the Department or from a contracting agency, will be in writing and must be submitted to the specific individual or component holding the information, or to the appropriate Bureau or Division. Division Administrators (or their designee) shall establish internal procedures and policies regarding the maintenance and release of Level 1 information, and may

designate selected staff members who have authority to release such information. Requests for Level 1 information may be made informally and verbally if desired.

Requests for Level 2 information must be submitted to and approved by the Division Administrator (or their designee) of the Division having custody of the information. Division Administrators are responsible for ensuring that information provided is no higher than Level 2 information.

Level 3 information requests must be submitted to and approved by the Division Administrator (or their designee) of the Division having custody of the information. However, these requests may be deferred, at the discretion of the Division Administrator, to the Director or his/her designee for final action.

Requests for Level 2 and Level 3 information must be in writing, utilizing the appropriate form. (See matrix in paragraph 3 below). All requests must include adequate justification for receiving the information and list the specific information elements requested.

2. Requests for information from outside the Department/Contractor organization:

Requests for Level 1 information from outside the Department/Contractor organization must be in writing, and must be submitted to the Data Owner of the information. Division Administrators (or their designee) shall establish internal procedures and policies regarding the maintenance and release of Level I information, including requirements for written requests as desired, and may designate selected staff members who have authority to release such information.

Requests for Level 2 or Level 3 information must be in writing utilizing the “NON-DPHHS EMPLOYEE SYSTEM/FILE ACCESS REQUEST” form (DPHHS-OM-300B - attached). All Level 2 and Level 3 information requests must be initially submitted to the Division Administrator (or their designee) of the Division having custody of the information for review and comment prior to consideration by the Security Officer. (See matrix in paragraph 4 below).

All requests must include adequate justification for receiving the information, an explanation of how the information will be utilized and a list of the specific information elements requested.

3. Exceptions to Director Approval Requirements:

To insure that the administration of Department programs is not negatively affected by this policy, the following situations are exempt from Director approval requirements:

a) The Division Administrator (or their designee) of the Division owning the information may approve requests from Department employees or Contractors' staff that require information to perform their assigned duties.

b) The Department Security Officer must approve requests from Department employees or Contractors' staff that requires online information access to perform their assigned duties, with oversight authority for the information involved.

c) Information which is required to link records from different information sets obtained from various Divisions, or to group records within a information set obtained from other Divisions, may be released by the Administrators of those Divisions (or their designee) in order to perform specific analyses for the purposes of public health research, assessment and assurance.

d) Requests for information by County Public Health agencies relative to their own county only may be approved by the Division Administrator (or their designee) of the Division owning the information. Typically, this are information that has been provided by the county, has been assimilated into the system, compiled and is being provided back to the originating county.

e) Approval for and confidentially of client information provided to medical service providers relative to individuals' eligibility and other essential information is covered in the HIPAA PRIVACY POLICY #002 (Attachment iii) and in the provider enrollment agreements.

f) Information may be released to one program in a DPHHS component by a different program in another DPHHS component where the two components have been asked to provide, or are providing, simultaneous services to the same client or family, and the process does not violate federal privacy and safeguard policy.

g) Information that has been determined to be a matter of public knowledge may be released by the Administrator of the Division (or their designee) having custody of the information. An example of this would be the names of parents delinquent in child support payments, with the amount owed.

h) Information may be released by Division Administrators (or their designee) to outside agencies or individuals where federal or state law requires or allows the sharing of information. Examples of this are: Sharing information on communicable diseases with

CDC; allowing access to TEAMS and SEARCHS databases to the Department of Justice for the purpose of fraud and abuse investigations; and providing information to individuals for purposes such as peer reviews. Division Administrators (or their designees) may provide a one time written authorization for routine, long term releasing of information to such Agencies or individuals by division personnel without written requests and approval for each occurrence. Such authorizations must be reviewed by Division Administrators (or their designees) on a semi-annual basis to maintain currency. In cases of releasing information to outside agencies, a memorandum of understanding with the outside agencies, or a signed DPHHS request form is required. For release of information to outside individuals, either a signed (information) request form as reflected above, or a separate, signed Business Associate Agreement is required.

4. Submission of Requests:

DPHHS or Contractor / Business Associate:

Sens. Level	Form(at)	Submit To	Approved By
1	Any Verbal or Written	Indiv/Div. Holding Info	Division Administrator or designee
2	DPHHS-OM-300A	Indiv/Div. Holding Info	Division Administrator or designee
3	DPHHS-OM-300A	Indiv/Div. Holding Info	Division Administrator or designee

Non-DPHHS or Contractor / Business Associate:

Sens. Level	Form(at)	Submit To	Approved By
1	Any Verbal or Written	Indiv/Div. Holding Info	Division Administrator or designee
2	DPHHS-OM-300B	Indiv/Div. Holding Info	Division Administrator or designee
3	DPHHS-OM-300B	Indiv/Div. Holding Info	Division Administrator or designee

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Technology Services Division

Internet, Intranet, & E-Mail Acceptable Use Policy

Don't say, do, write, view, or acquire anything that you wouldn't be proud to have everyone in the world learn about if the electronic records are laid bare.

Scope: This policy applies to all Department employees and state contractors using DPHHS computers.

Policy Statement: Internet, Intranet and e-mail access provided by the department is intended for department business use, but limited access for personal use is allowed. The department encourages the use of the Internet, Intranet and e-mail, because they make communication and research more efficient and effective. Use of the department time, facilities, equipment or supplies for an employee's private business, either for profit or non-profit, is statutorily prohibited and is a misdemeanor crime, Section 2-2-121, MCA. Every employee and contractor has a responsibility to maintain and enhance the Department's image and to use the Internet, Intranet and e-mail in a productive manner. To ensure that all employees and contractors are responsible, the following guidelines have been established for use of the Internet, Intranet and e-mail.

Acceptable Use: Internet, Intranet and e-mail use is intended for state business purposes but employees may use these services for personal use with certain restrictions. Personal use may be permitted at the discretion of the employee's supervisor. Personal use of the Internet is not considered part of an employee's paid work time. The supervisor determines at what times during the day the Internet, Intranet and e-mail may be accessed for personal use by their employees. The supervisor may prohibit employees from using the Internet at any time. The Department of Administration manages Internet filtering (blocking) of individual websites or classes of websites. Requests for exceptions to any filtered site should be directed to the DPHHS Security Manager, who can also provide a list of currently filtered sites.

Misuse of Computer Resources:

The department-provided Internet, Intranet and e-mail access may not be used **at any time** for:

- Transmitting, retrieving or storing any communication of a discriminatory or harassing nature, or materials that are offensive, obscene or x-rated. Examples of offensive, obscene or x-rated materials include but are not limited to: items, either pictures, movies or text, which describe or depict nudity, sexual activity, sexual offenses against individuals or other situations involving a sex act, or which describe or depict other bodily functions or situations which are inappropriate in business setting.
- Knowingly transferring or allowing to be transferred to, from or within the agency, textual or graphical material commonly considered child pornography.
- Any purpose which is illegal, or is against state or department policy.
- For-profit and non-profit business activities including activities for service organizations not related to the job.
- Excessive use for private, recreational or personal activities.
- Gambling.
- Raising funds for political candidates or issues.
- Promoting political candidates in any way.
- Promoting personal political issues.

Gathering information for furtherance of a crime.

Circulating chain letters.

Using personal e-mail accounts, such as Hotmail, Yahoo, AOL etc without permission from the DPHHS Security Officer.

Using computer resources to create, access, download, or disperse derogatory, racially offensive, sexually offensive, harassing, threatening or discriminatory materials.

Downloading, installing, or running security programs or utilities which reveal weaknesses in the security of the state's computer resources unless a job specifically requires it.

Use of computers and UserIDs for which there is no authorization, or use of UserIDs for purposes outside of those for which they have been issued.

Attempting to modify, install or remove computer equipment, software, or peripherals without proper authorization. This includes installing any non-work related software on State-owned equipment.

Accessing computers, computer software, computer data information, or networks without proper authorization, regardless of whether the computer, software, data, information, or network in question is owned by the State. (This means, if you use the networks to which the State has access or the computers at other sites connected to those networks for which you do not have authorization, the Department will consider this matter an abuse of your computing privileges, and violation of this policy.)

Circumventing or attempting to circumvent logon procedures, and security regulations, or exceeding the system's capacity limits by downloading excessive materials.

The use of computing facilities, UserIDs, or computer data for purposes other than those for which they are intended or authorized.

Breaking into another user's e-mailbox, or unauthorized personnel reading someone else's e-mail without permission.

Sending fraudulent electronic transmissions, including but not limited to statements intended to mislead the receiver and are known to be untrue, fraudulent requests for confidential information, fraudulent submission of electronic purchase requisitions or journal vouchers, or fraudulent electronic authorization of purchase requisitions or journal vouchers.

Violating any software license agreement or copyright, including copying or redistributing copyrighted computer software, data, or reports without proper, recorded authorization.

Taking advantage of another user's naivete or negligence to gain access to any UserID, data, software, or file that is not your own and for which you have not received explicit authorization to access.

Physically interfering with other users' access to the State's computing facilities.

Encroaching on or disrupting others' use of the State's shared network resources by creating unnecessary network traffic (for example, playing games or sending excessive messages); excessive use of using memory, bandwidth and disk space resources; interfering with connectivity to the network; modifying system facilities, operating systems, or disk partitions without authorization; attempting to crash or tie up a State computer; damaging or vandalizing State computing facilities, equipment, software, or computer files).

Disclosing or removing proprietary information, software, printed output or magnetic media without the explicit permission of the owner.

Reading other users' data, information, files, or programs on a display screen, as printed output, or via electronic means, without the owner's explicit permission. This does not prohibit supervisors having access to their employees' computers.

Generating, Receiving and Maintaining Electronic Records: All messages created, sent or retrieved over the state's system are the property of the State of Montana. Employees should not have expectations of privacy for any messages. In drafting or sending e-mail messages, employees should not include anything that would not be appropriate for dissemination to the public. E-mail communication must reflect professional and respectful business correspondence. Electronic communications will be monitored for performance, trouble-shooting purposes, and detection of abuse. In addition, employees should use their best judgment in sending messages that contain information required by law to be confidential.

Information Technology Services Division staff, during the course of their analysis, will monitor and report any access to a site or class of sites that does not appear to be work related and that is of sufficient volume that may be a potential capacity issue to ITSD management.

Communication sent or received by the e-mail system may be considered "documents" under Article II, Section 9 of the Montana Constitution or public records under section 2-6-101, MCA, and may be subject to public disclosure. Therefore, care should be taken in generating and maintaining these records. Release of information to a member of the public regarding an employee's use of the Internet or e-mail, or requests from law enforcement for records not otherwise available to the public involving an employee's Internet or E-mail records can only be approved by the appropriate Division Administrator. This does not preclude ITSD or any other agency from contacting law enforcement as part of an investigation initiated by the agency. Agency legal counsel should be consulted whenever a court order is served or an investigation involves contact with law enforcement.

Employees should consider the following to better manage e-mail activities:

- Employees should delete items from their in-tray and out-tray when they are no longer needed. If a mail item needs to be retained it should be moved to an archive folder, a disk, or be printed. Items placed in an employee's archive should be evaluated after six months to determine if they should be retained. Employees can contact the DPHHS Records Manager with any questions on retention schedules.
- Unsolicited mail should be deleted immediately. If the problem persists, contact the DPHHS Security Officer.
- Employees should check their e-mail with a frequency appropriate to their jobs and as directed by the supervisor. Employees who will be absent for more than one day should utilize the "out of office" feature, or make arrangements for a supervisor or co-worker to check for messages that need attention.
- It is possible to receive a virus when receiving e-mail, and some viruses are embedded in attachments. If you receive a suspicious e-mail, do not open it, but instead contact the DPHHS Technology Services Center at 444-9500.
- Some computer features increase e-mail traffic, and employees should strive to keep message and attachment sizes as small as possible. Avoid the use of graphics in auto-signatures or other parts of the message or attachments. Use of stationery should be avoided, as well as moving graphics and/or audio objects as they consume more disk space, network bandwidth, and detract from the message content.
- Users must log off the network at the end of each day and power off their workstations. Department resources should be logged off when not is use.
- Users leaving their computers unattended for more than 15 minutes should consider logging off the network.

Reporting Violations: Users will cooperate with DPHHS Management concerning requests for information regarding computing activities; follow Department and State procedures and guidelines in handling diskettes and external files in order to maintain a secure, virus-free computing environment; follow Department procedures and guidelines for backing up data and making sure that critical data is saved to an appropriate location; and honor the Acceptable Use policies of any non-state networks accessed. Contact the DPHHS Technology Services office at 444-9500 for information on the policies and guidelines. Copies are attached.

Users will report unacceptable use and other security violations to their immediate supervisor, the DPHHS Security Officer or the Human Resources Office.

Each employee is responsible for the content of all text, audio or images that they place or send over Internet, Intranet or e-mail. No e-mail or other electronic communications may be sent which hides the identity of the sender or represents the sender as someone else. All messages communicated on the Internet, Intranet or e-mail system should contain the employee's name.

Copyright Issues: Department employees must honor copyright laws regarding protected commercial software or intellectual property. Duplicating, transmitting, or using software not in compliance with software license agreements is considered copyright infringement. Department employees shall not make copies of software or literature in violation of copyright laws without the full legal right to do so. Unauthorized use of copyrighted materials or another person's original writings is considered copyright infringement. Copyrighted materials belonging to others may not be transmitted by staff members on the Internet without permission. Users may download copyright material from the Internet, but its use must be strictly within the agreement as posted by the author or current copyright law. Copyrighted agency information used on web sites must be clearly labeled as such.

Training: Employees are required to attend e-mail training prior to using the State of Montana e-mail system. Training may include formal classes or on the job instruction. Employees should have the opportunity to attend training on the use of the Internet, but it is not required.

Internet Use Agreement: All Department employees having access to the Internet and E-mail must acknowledge that all network activity is the property of the State and should not consider any Internet activity to be private. An electronic form of the Internet Use Agreement is accessible (Public Folder and DPHHS Website) and is meant to ensure that every employee with Internet and E-mail access is familiar with the Department policy. Each user is required to read and understand the policy and acknowledge by completing the form.

Security: The department reserves the right to access and monitor any messages or files. Employees should not assume that electronic communications are private and should transmit highly confidential or personal information another way rather than by electronic means. Users are responsible for controlling the access to their computers, properly logging on and off the network, and not using another employee's UserID.

Contact the DPHHS Technology Services Center at 444-9500 with questions concerning this policy. You may also call this number for more information on the Information Security and Database Access procedures.

Violations of this policy may result in disciplinary action up to and including termination of employment with the Department.

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