Sentinel

Electronic Disease Surveillance System (EDSS)

Application User Guide

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1 PREFACE—ELECTRONIC DISEASE SURVEILLANCE SYSTEMS

Historically, public health communicable Electronic Disease Surveillance Systems (EDSS) have been comprised of disparate paper-based systems or data collection systems that utilized older technology. The reported data often lacked timeliness and completeness. These systems were not as robust, accurate, or timely as they needed to be in order to reliably monitor disease outbreaks, potential bioterrorism incidents, or newly emergent infectious diseases.

Past surveillance systems were not developed with data integration in mind. Varying architectures, data definitions, and uses led to the creation of individual datasets, often with redundant information and no readily available means of relating to other existing data resources.

To address these issues, the Centers for Disease Control and Prevention (CDC) initiated efforts to standardize public health datasets and maximize their effectiveness. The Public Health Information Network (PHIN) promotes existing and emerging national standards for sharing public health information, such as:

- Security standards that address the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Standard electronic exporting of health data through Health Level 7 (HL7)
- Public Health Logical Data Model

These standards and guidelines offer public health a new roadmap toward developing a productive technical infrastructure. With these standards and guidelines, an integrated surveillance system to support public health will ultimately incorporate data from a variety of sources including: emergency responders, pharmaceutical retailers, laboratories, hospitals, physicians, schools, and many other resources within the community.

SENTINEL ELECTRONIC DISEASE SURVEILLANCE SYSTEM VISION – AND THE FUTURE

Sentinel is part of an overall vision to enhance decision-making based on more timely and accurate provision of communicable disease information; thus, facilitate a more effective public health intervention. Sentinel is designed to be an integral component of a larger surveillance environment for the state that will support communicable disease and bioterrorism investigation efforts.

CONFIDENTIALITY

While modern communication methods have made our lives easier, they also pose a threat to the privacy and security of personal information.

Sentinel seeks to safeguard health information privacy and security by:

- Governing the privacy of individually identifiable health information
- Restricting uses and disclosures of protected health information (PHI)
- Protecting against unauthorized and unnecessary access to protected health information

All Sentinel users have a responsibility to maintain the confidentiality of data stored within this system.

2 ABOUT THE GUIDE

The Sentinel Application User Guide is designed to enhance your knowledge and ease of use of the Sentinel Electronic Disease Surveillance System application. It assumes you are familiar with basic Internet terminology and have the authority to access Sentinel. Additionally, this guide provides an introduction for those unfamiliar with the Sentinel application.

For additional information, refer to the following:

- Sentinel System Administration Guide
- Sentinel Quick Reference Pamphlet
- Sentinel Online Help

TERMS USED INTERCHANGEABLY

The following terms are used interchangeably throughout this guide:

- **Case** and **investigation** refer to the public health communicable disease event.
- **Disease specific forms**, **supplemental forms**, and **data collection forms** refer to the forms used in Sentinel to collect case investigation data. These forms are available in two formats: Adobe PDF and HTML. Since both formats contain the same fields, you can use either one (depending on your preference).
- **LHJ** (Local Health Jurisdiction), **LPHU** (Local Public Health Unit), and **PHD** (Public Health District) refer to your state's "Local/Public Health" department, jurisdiction, unit, etc.
- **Region** and **District** refer to your state's region or district but both are used interchangeably in this document; thus, some screenshots may display region versus district and vice versa.
- **Reportable Condition #2** and **Disease Name 2**; used primarily in reports.

- **Sentinel**, **Sentinel application**, **application**, and **system** all refer to the Sentinel Electronic Disease Surveillance System application.

The Sentinel application may differ slightly depending on your state's configuration. Because each state may differ slightly, all possible options are included in this guide and may not appear for your specific state.

DOCUMENTATION STANDARDS AND CONVENTIONS

This guide uses the following documentation standards:

- Menu names, options, and buttons are bolded and capitalized. Example: Click the **CASE INVESTIGATIONS** menu, and then on the Menu, click the **NEW CASE** option.

- Dialog boxes and application screen names are enclosed in quotes with the first letter capitalized.
Example: The "Case Listings" screen appears.

- Important notes are indicated with the word Note (in bold/italics). Example:

Note: This screen is read-only; you cannot make changes to this screen.

- Field names and descriptions are listed in tables.

- Text you type appears in Courier font, so you can easily read it in the document. Example:

`Lincoln Medical Center`

PRINTING THIS GUIDE

This guide uses a double-sided layout; thus, when sent to a duplex printer, the page numbers will print properly on the outside edge just as they do in a book.

REPORTING DISCREPANCIES IN THIS GUIDE

If you should happen to find a discrepancy in the guide, a typographical error, or the information is unclear, please contact your local state's help desk to fill out a job ticket for a documentation correction/clarification.

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3 ABOUT THE SENTINEL APPLICATION

This chapter describes the following characteristics about the application:

- Methods for Entering Data into Fields
- Standards of Common Application Characteristics
- Tools for Navigating from Screen-to-Screen
- Tips for Using the Keyboard and Mouse
- Tips for Correcting Validation Errors

Note: Software requirements and system settings for using Sentinel are described in Appendix A.

METHODS FOR ENTERING DATA INTO APPLICATION FIELDS

The following table describes Sentinel data entry characteristics.

Table 3-1: Entering Data into Sentinel

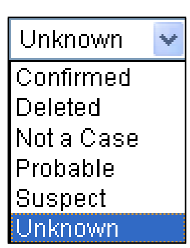
ENTERING DATA INTO SENTINEL	
DATES	The expected date format is mm/dd/yyyy, requiring a four-digit year (2003 instead of 03). Dates are checked for numerical characters and slashes before being validated.
VALIDATION ERRORS	When you enter incorrect data into a field, an error message appears, usually at the top of the screen. You must correct the errors before continuing. Refer to the section titled, “Tips for Correcting Validation Errors” for more information. Examples of Validations are: • Field lengths • Field formats (phone number, dates, numeric/non-numeric, age, etc.) • Dates

ENTERING DATA INTO SENTINEL	
LETTERCASE	First and last (patient) names, cities, etc. will be stored in all uppercase letters.
PHONE AND FAX NUMBERS	The expected format for phone numbers is 10 digits or xxx-xxx-xxxx. As you type the information in the field, Sentinel inserts the dashes into the phone number in the appropriate positions or displays an error if 10 digits or non-numeric characters are entered.
ZIP CODES	The expected format for zip codes is xxxxx for five-digit ZIP codes and xxxxx-xxxx for nine-digit ZIP codes. As you type the information in the field for a nine-digit zip code, Sentinel inserts the dash in the appropriate position.

STANDARDS OF COMMON APPLICATION CHARACTERISTICS

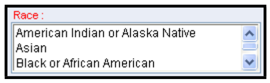
The following table summarizes common Sentinel characteristics. Familiarity with these characteristics will aid your ease of use of Sentinel.

Table 3-2: Application Characteristics

APPLICATION CHARACTERISTICS	
STOP—DO NOT…. 	Do not use your Internet browser's **BACK**, **FORWARD**, or **REFRESH** buttons. Use the **BACK**, **CONTINUE**, and programmed buttons within Sentinel to navigate the application.
DROP-DOWN MENU 	When you click a drop-down menu arrow, a list of valid options appears in either alphabetical or most frequently used order. Only one option may be selected. While the options are displayed, you may type the first letter or letters of the word and the first occurrence will be highlighted. To locate the next occurrence, type the letter or letters again.

APPLICATION CHARACTERISTICS

LIST BOX



Similar to a drop-down menu, a list box presents multiple options from which to select. However, a list box allows you to select one or multiple options.

- To **select one option**, click it.
- To **select a sequential list of options**, click the first option of the sequence, press and hold the SHIFT key, and then click the last option of the sequence.
- To **select options that are not in sequence**, click the first option you want to select, press and hold the CTRL key, and then click each additional option you want to select.
- To **deselect specific options after you have selected multiple options (in or out of sequence)**, press and hold the CTRL key, and then click the options you want to deselect. The deselected options are longer be highlighted.
- To **deselect multiple selections and select only one option**, click the option you want to select.
- To **deselect all options**, press and hold the CTRL key, and then click any option in the list.

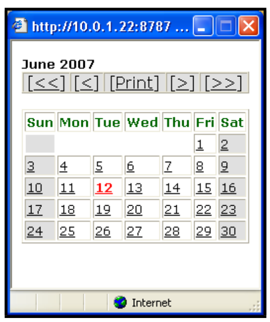
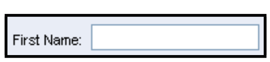
MULTI-SELECT BOX

This type of selection box allows you to select more than one item for the field.

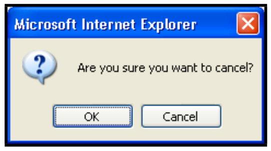
The box on the left is referred to as the "Selected Items" box. The box on the right is referred to as the "Unselected Items" box containing the multiple choice items.

To add an item to the "Selected Items" box, click the plus sign (+) (located to the right of the choice). The choice will be moved from the "Unselected Items" box to the "Selected Items" box.

To remove an item from the "Selected Items" box to

APPLICATION CHARACTERISTICS	
	the “Unselected Items” box, click the minus sign (-) (located to the right of the choice). The choice will be moved from the “Selected Items” box to the “Unselected Items” box.
REQUIRED FIELD 	A field in RED font with an asterisk indicates an entry is required before proceeding.
CHECK BOX 	A type of data input that provides an active/inactive (enabled/disabled) status.
CALENDAR  	The calendar icon picker displays the current month’s calendar. Click the date if it is in the current month. • To **scroll back one month at a time**, click the [<] button the number of times to scroll backward. • To **scroll ahead one month at a time**, click the [>] button the number of times to scroll forward. • To **scroll back one year at a time**, click the [<<] button the number of times to scroll backward. • To **scroll ahead one year at a time**, click the [>>] button the number of times to scroll forward.
RADIO BUTTON 	Radio buttons are a mutually exclusive set of options. Clicking one button within a group selects it while deselecting all other buttons within the group; thus, only one radio button may be chosen.
TEXT AREAS 	Text areas allow you to enter data using a standard keyboard or using copy and paste.
DIALOG BOXES	Dialog boxes are small windows that display a message and request a response. When adding or updating records, a dialog box may appear to notify you of a problem before validating the data.

APPLICATION CHARACTERISTICS

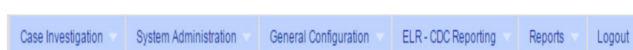


Sentinel uses several dialog boxes, including the following:

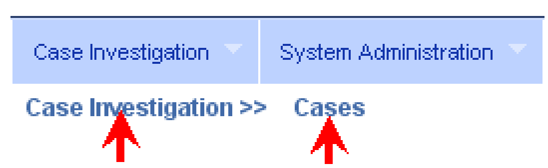
- Cancel Confirmation - Asks if you are sure you want to cancel.
- Delete Confirmation - Asks if you are sure you want to delete.
- Date of Birth Reminder Box - Appears if you leave the **DATE OF BIRTH**, **AGE**, and **AGE UNITS** information fields blank (or at their defaulted values) and asks you to supply **DATE OF BIRTH** or **AGE** information.
- Data Loss Warning – Appears if you click another tabbed section of the “Case Detail” before you save your changes. If you leave the current screen without saving your changes, your data changes are lost.
- Confirm Unlock - When resolving a “Pending Work Queue” item, such as a deferred deduplication, you must “lock” the record so other users cannot access that record while you are resolving it. If the “lock” is never released, the SuperUser or Administrator can “unlock” the record by clicking the **UNLOCK** button on the corresponding Pending Work Queue record.
- Change in Jurisdiction Warning - Appears if you change the Onset Date, Home Address, or Home Address To and From Dates. Case jurisdiction determination is based on the Home Address at Onset Date (or the Referral Date if the Onset Date is unavailable). Changes to the Home Address can cause the case to be changed to another jurisdiction. Since the “To” and “From” address dates relate to the Onset Date, changing these dates can result in case reassignment to another jurisdiction.

TOP NAVIGATION BAR

The Top Navigation Bar (TopBar) consists of the following menus.



The arrow pointing downward is an indicator that options are available to that menu. Hover the mouse pointer above the menu to display the options.

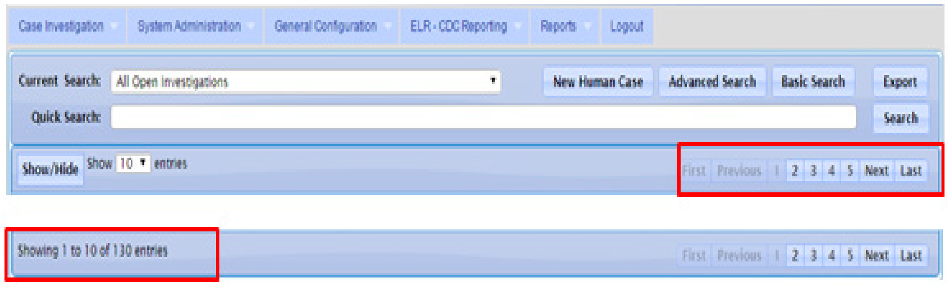
APPLICATION CHARACTERISTICS	
	• **CASE INVESTIGATION** – Contains all the options to manage cases. You can add, change, and search the communicable disease information stored within Sentinel. This is the default menu that appears when you log into Sentinel. • **SYSTEM ADMINISTRATION** – Contains all the options necessary for a System Administrator to create/maintain User-IDs, Facilities, perform a NETSS Export, etc. **Note**: This menu only appears for users with the System Administration access/role. Instructions are in a separate user guide. • **GENERAL CONFIGURATION –** • **ELR- CDC REPORTING** – • **REPORTS** – Contains all available Sentinel reports. You can specify the type of report to create and the information to include on the report. • **LOGOUT** – Terminates your session and returns you to the initial Sentinel Login screen.
MENU AND OPTION NAME	Directly below the Top Navigation Bar the Menu and Option you are currently viewing displays. The illustration shows the Case Investigation Menu with the Cases option. 
FOOT NAVIGATION BAR	The Foot Navigation Bar (FootBar) displays hyperlinks that are available throughout Sentinel which may differ for your state. Examples of hyperlinks are: • Sentinel Support • Reset Password Clicking a hyperlink displays a new browser window. Since this is a new browser window, you can close it

APPLICATION CHARACTERISTICS	
	without closing the Sentinel application browser window. To return to the Sentinel browser window without closing the new browser window, locate the Sentinel Browser window from the Windows Taskbar (bottom of your display). Additionally, the following is displayed: • Version and Build Number • Last Update – Date the new version/build was installed • Logged In – User's first and last name currently logged into the application.
SCREEN NAVIGATION TOOLS	The Screen Navigation Tools will only appear on windows that contain more data than one screen can fill. Refer to the section titled, "Tools for Navigating from Screen-to-Screen" for details.

TOOLS FOR NAVIGATING FROM SCREEN-TO-SCREEN

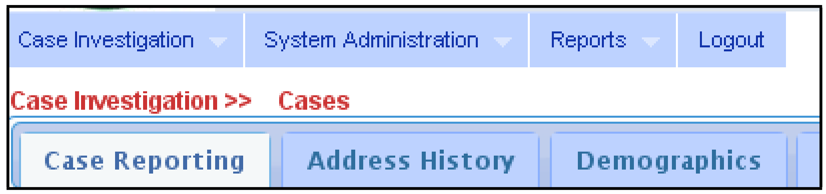
Some of the screens such as "Case Listings" display groups of ten (10) records per screen. When there are more than 10 total records in Sentinel, text on the screen indicates how many records (results) were retrieved and which group of 10 is currently displayed. For example, if the first group of ten records is displayed out of a total of 220 records, the following appears on the screen:

Figure 3-1: Screen-to-Screen Navigation Methods



The following table describes the links (available at the top and bottom of the screen) that allow you to quickly navigate the records on full screens.

Table 3-3: Case Listings Screen Navigation Links

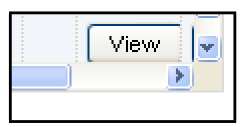
LINK	DESCRIPTION
MENU & OPTION	The Menu and option you are currently viewing will be displayed directly below the TopBar of Menu Names.  You can click on the menu option to return to that level. For example, while viewing Case Details, pointing/clicking the Cases option redisplays the Case Listing screen.
<<	Displays the very “first” group of 10 record results.
>	Displays the “next” group of 10 record results.
>>	Displays the very “last” group of 10 or fewer record results.
<	Displays the “previous” group of 10 record results as long as you are not displaying the first group of 10.
PAGE NUMBER LINKS **1 2 3**	Each “page number” is a link to a group of 10 records (the last page number may represent less than 10 records). The current page number does not appear as a link (no underline).

Tips for Using the Keyboard and Mouse

The following table provides tips on using the keyboard and mouse:

Table 3-4: Keyboard and Mouse Tips

KEYBOARD or MOUSE MOVEMENT	TIP
TAB **SHIFT TAB**	All fields are part of a tab order. When the cursor is in a field, press the **TAB** key to move cursor to the next field in the order. To move to the previous field in the tab order, press and hold the **SHIFT** key and then press the **TAB** key.
ENTER	Pressing the **ENTER** key (on most windows), executes, or processes, the active page. For example, while on the Login screen, pressing **ENTER** executes the Login process.
PAGE UP	If the cursor is in a drop-down menu list, pressing the **PAGE UP** key moves up several options in the list. If the cursor is not in any field (you click in the application window but not in any field), pressing the **PAGE UP** key moves the screen up one page.
PAGE DOWN	If the cursor is in a drop-down menu list, pressing the **PAGE DOWN** key moves down several options in the list. If the cursor is not in any field (you click in the application window but not in any field), pressing the **PAGE DOWN** key moves the window down one page.
HOME	If the cursor is in a field, pressing the **HOME** key moves to the top of that field. If the cursor is not in any field (you click in the application window but not in any field), pressing the **HOME** key moves you to the top of the screen.
END	If the cursor is in a field, pressing the **END** key moves to the end of that field. If the cursor is not in any field (you click in the application window but not in any field), pressing the **END** key moves you to the bottom of the screen.
ARROW KEYS	If the cursor is in a text field, pressing the **LEFT ARROW** key moves the cursor one character to

KEYBOARD or MOUSE MOVEMENT	TIP
	the left and pressing the **RIGHT ARROW** key moves the cursor one character to the right. If the cursor is in a drop-down menu list, pressing the **UP ARROW** key moves up one option in the list and pressing the **DOWN ARROW** key moves down one option in the list. If the cursor is not in any field (you click in the application window but not in any field), pressing the **UP ARROW** key moves the screen up and pressing the **DOWN ARROW** key moves the screen down (in smaller increments than when using the **PAGE UP** and **PAGE DOWN** keys).
BACKSPACE	If the cursor is in a text box, press the **BACKSPACE** key to delete text before the cursor.
MOUSE CURSOR	Clicking the mouse button can be used to get from one field to the next.
VERTICAL SCROLL BAR	Clicking the scroll arrows moves the screen up or down in small increments, while clicking the scroll bar above or below the scroll box moves the screen up or down in larger increments. You can also drag the scroll box to move the screen up/down. 
HORIZONTAL SCROLL BAR	Clicking the scroll arrows moves the screen left or right in small increments, while clicking the scroll bar to the left or right of the scroll box moves the screen left or right in larger increments. You can also drag the scroll box to move the screen left or right.

Tips for Correcting Validation Errors

After you add or edit data and click the **SAVE** or **CONTINUE** button, a data validation process begins. Sentinel verifies that the field changes do

not violate any data validation rules. When a validation error occurs, the system informs you of the error and does not allow you to proceed until you correct the error or cancel the action.

To correct validation errors, perform the following:

1. When a validation error occurs, the screen redisplays with an error message displayed at the top. This message directs you to the problem and explains the error.

Figure 3-2: Sample Error Message

2. For each error listed, make the necessary change.
3. Click the appropriate **SAVE** or **CONTINUE** button. If your corrections pass validation, the screen redisplays with the new information.

SENTINEL INTEGRATION WITH OTHER PRODUCTS

Sentinel has the ability to interface with other systems such as the Outbreak Management System (OMS) to allow for queries, creating new human and non-human cases, and updating outbreak names. It can also interface with the Hospital Case Management Reporting System, also known as the Health Care Facility (HCF) Reporting System to search, create, and edit health care facility cases, and if authorized may run report(s).

Sentinel also has the ability to interface with an immunization registry that can accept HL7 standard requests for patient immunization records.

Please contact your STC Representative for technical specifications and instructions.

The Case Notification Messaging Support (CNMS) updates and supports:

- Full Varicella support in Sentinel
- Generic Message support in Sentinel
- West Nile Virus (Arbonet) message support in Sentinel

4 LOGGING IN AND LOGGING OUT

This chapter provides instructions on requesting access to Sentinel, as well as logging in and logging out of the application.

SENTINEL ACCESS REQUIREMENTS

Before you can access and start using Sentinel, you may need to perform the following:

- Obtain a valid User-ID and Password
- Request permission to access Sentinel
- Be assigned a role within Sentinel

Contact your System Administrator for more information.

ACTIVE BROWSER CONNECTIONS / SESSIONS

Sentinel does not allow multiple concurrent logins; you cannot be logged in on one PC and then try to log in on another PC while still logged in on the first PC.

When you visit a website and a connection is established, the website responds by providing a unique identity, called a **session**, to that browser connection.

Sentinel enforces security by requiring that you provide a valid login ID and password before it establishes a session. This login id and password are then tied to the Sentinel session; therefore, you are not allowed multiple concurrent sessions.

As the browser makes requests of the website, the website returns its response to the browser. The response received often depends on where you are within the application. If multiple windows are making requests of the website using the same session, the website can no longer determine where the request was made within the application.

Sessions remain active until the website is instructed to terminate a session. This is usually accomplished by logging off or exiting. Visiting a different website or simply closing the browser does not terminate the session.

Logging out of Sentinel using the **LOGOUT** menu instructs the website to terminate your session immediately. However, if you improperly attempt to log out by closing the browser and then you attempt to login again before the administrative timeout setting, a message appears asking if you want to destroy (invalidate) the previously stored session or quit the login process. Refer to the section titled, "Automatic Logout" for more information.

LOGGING INTO SENTINEL

You must have access to the system before logging in. Refer to the section titled, "Sentinel Access Requirements" for more information.

Note: For the state of New Hampshire, an additional warning appears on the "Login" screen that states: "WARNING! This is a State of NH secure access system and is provided only for authorized use. Users have no implicit or explicit expectation of privacy. State and federal statutes make it a crime to attempt and/or gain unauthorized access. Unauthorized use may be subject to criminal, civil and/or administrative action....."

To log into the application, perform the following:

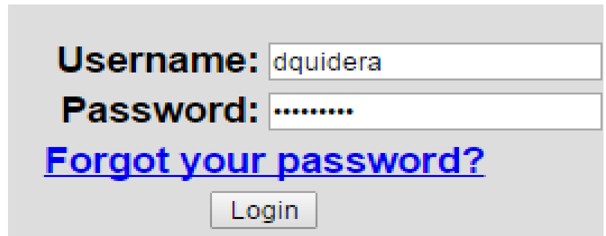
1. Open your browser and type/point the browser to your state's URL. For example:

`https://Sentinel.stchome.com`

2. Press the **ENTER** key. The "Login" screen appears.

Note: The background of the "Login" screen may differ somewhat depending on your state; regardless, the Username and Password fields appear.

Figure 4-1: Login



Note: If you forgot your password, click the **FORGOT YOUR PASSWORD?** hyperlink and refer to the section titled, "Forgot Password – Requesting a Password" for instructions.

3. Type your User ID in the **USERNAME** field, type your password in the **PASSWORD** field, and then click the **LOGIN** button (or press the **ENTER** key).

    - If there are any "Messages," they will appear; otherwise, the "Case Investigation" screen appears showing the "Case Listings" screen. Refer to the sections titled, "VIEW MESSAGES" or "Sentinel Application Screen Components Overview" for more information; respectively.

IMPORTANT NOTES REGARDING PASSWORDS

The "Password Rules Logic" can differ per state and are administered by your state's Database and/or System Administrator.

Some password logic examples for Mississippi are:

- Require at least one uppercase letter in password.
- Require at least one lowercase letter in password.
- Do not allow username or user's full name as password.
- Prevent password reuse in number of previous passwords.
    - 0 indicates do not prevent reuse; otherwise, the number is the number of previous passwords to check (STC_CONFIG). A table was added to store previous passwords (in encrypted form) to prevent reuse.
    - A message will display to the user if the password has already been used by the user.

- The first time a user signs in, their password is expired. After a password is reset, the user should be required to change their password (i.e., the reset password is expired)

Other logic examples are:

- Passwords must contain a minimum of one number.

SENTINEL APPLICATION SCREEN COMPONENTS OVERVIEW

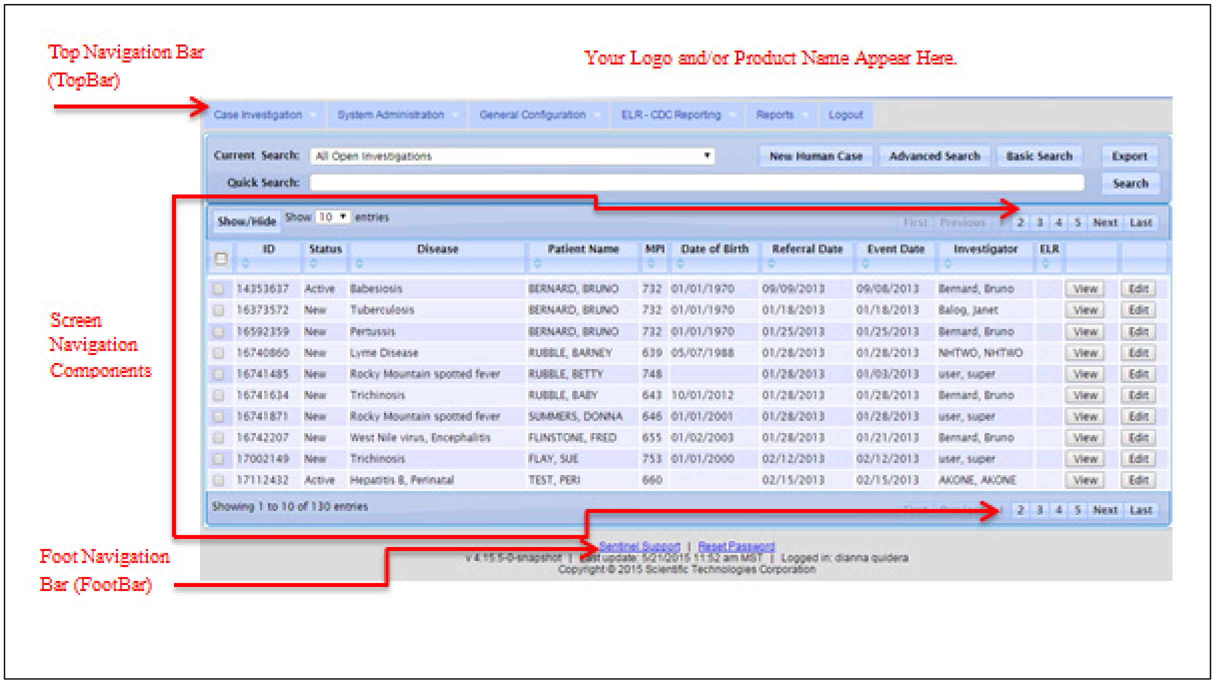
Note: For detailed information on Sentinel Screen Components, refer to “Table 3-2: Application Characteristics.”

When you log in, the following application components display (see figure below):

- The **CASE INVESTIGATION** menu in the TopBar is selected (indicated by the bold blue lettering).

- The “Screen Navigation Components” appear on screens that have more data than will fit on one screen.

Figure 4-2: Sentinel Navigation Components



Each menu contains the first menu option's screen upon opening the menu.

To view more cases on the "Case Listings" screen, click one of the Screen Navigation Component Tools.

To switch to a different menu, click it in the TopBar. For example, to access the "Reports" options, click the **REPORTS** menu in the TopBar.

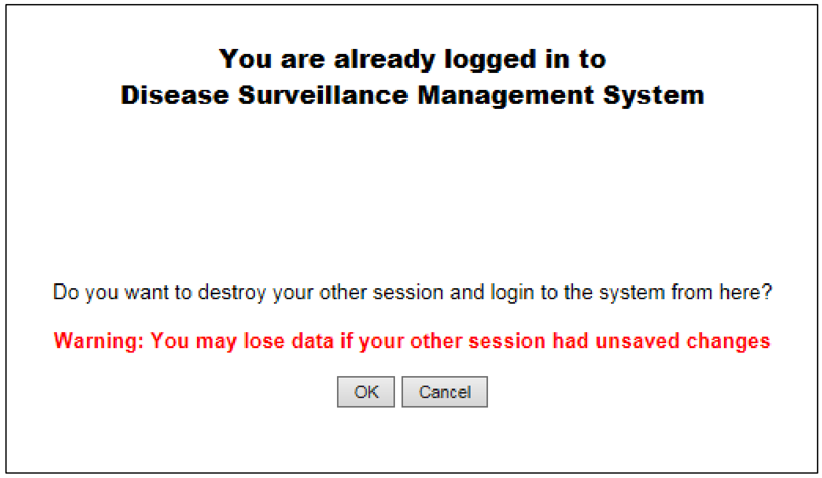
Destroying an Active Login Session

If you log into the application from one computer and then want to log in from a different computer, you must "destroy" the first session before beginning the second session.

To destroy an active login session, perform the following:

1. Repeat steps 1–3 in the section titled, "Logging into Sentinel." After you click the **LOGIN** button, the "Already Logged In / Destroy Session" screen appears.

Figure 4-3: Already Logged In / Destroy Session



Note: If you destroy the previous session and you were in the middle of entering/editing data, you may lose any unsaved data.

2. Click one of the following buttons:

- **OK** – destroys the first login session on the other computer and begins a new session.
- **CANCEL** – <u>does not</u> destroy the first login session and redisplays the “Login” window.

FORGOT PASSWORD – REQUESTING A PASSWORD RESET

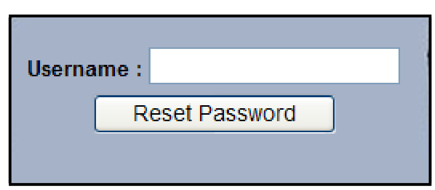
If you forget your password, you can reset it by requesting a new password from your System Administrator.

To reset your password, perform the following:

1. Repeat steps 1–2 in the section titled, “Logging into Sentinel.”

2. On the “Login” screen, click the **FORGOT YOUR PASSWORD?** hyperlink. The “User” screen appears.

Figure 4-4: User Reset Password



3. Type your **USERID** in the **USERNAME** field and click the **RESET PASSWORD** button to send your request to the System Administrator's email in-box.
4. You will promptly receive an email with your newly assigned password. Each state's verbiage may differ so an example is not shown.

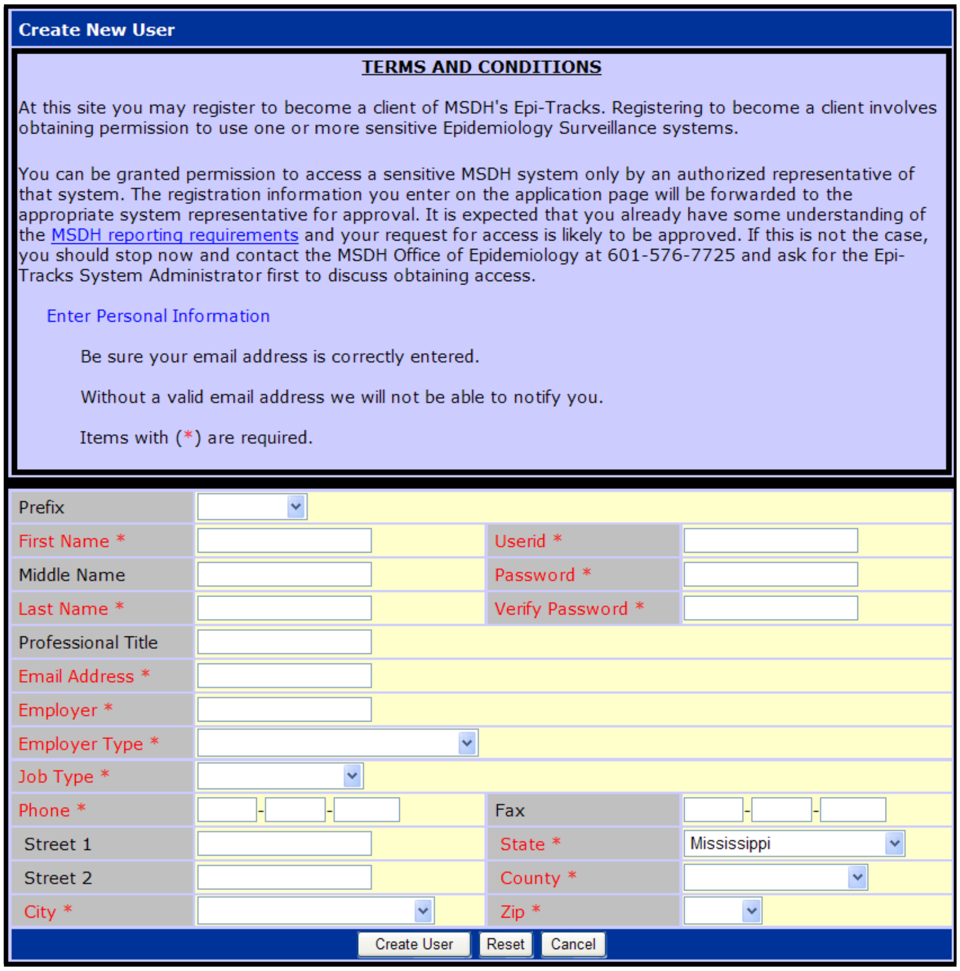
CREATE NEW USER

[This is a state-configurable option and may not appear for your state.]

The "Create New User" option is currently used by the state of Mississippi for Physician Clients to request access to the application in order to enter physician card data; however, this option can be configured differently depending on each state's needs.

1. From the "Login" screen, click the **CREATE NEW USER** hyperlink. The "Create New User" screen appears.

Figure 4-5: Create New User



2. The fields and their descriptions are listed in the table.

Table 4-1: Create New User Field Descriptions

FIELD	DESCRIPTION
PREFIX	Prefix at the beginning of the user's name. Examples are: • Mr. • Ms. • Doctor/Dr.
FIRST NAME	First name of the user.
MIDDLE NAME	Middle name of the user.

FIELD	DESCRIPTION
LAST NAME	Last name of the user.
PROFESSIONAL TITLE	Professional title of the user.
EMAIL ADDRESS	Email address of the user. When you click the email link, your email application creates a new email with the user's email address inserted.
EMPLOYER	Name of the user's Employer.
EMPLOYER TYPE	Category of the user's Employer.
JOB TYPE	Type of job the user holds.
PHONE	Phone number of the user.
STREET1	First line of the user's address.
STREET2	Second line of the user's address.
CITY	Name of the user's city.
USERID	User Identification name of the user.
PASSWORD	Password of the user. The "Password Rules Logic" can differ per state and are administered by your state's Database and/or System Administrator. Logic examples for Mississippi are: • Require at least one uppercase letter in password. • Require at least one lowercase letter in password. • Do not allow username or user's full name as password. • Prevent password reuse in number of previous passwords. 0 indicates do not prevent reuse; otherwise, the

FIELD	DESCRIPTION
	number is the number of previous passwords to check (STC_CONFIG). A table was added to store previous passwords (in encrypted form) to prevent reuse. A message will display to the user if the password has already been used by the user. • The first time a user signs in, their password is expired. After a password is reset, the user should be required to change their password (i.e., the reset password is expired) Other logic examples are: • Passwords must contain a minimum of one number.
VERIFY PASSWORD	You must enter the same value you entered in the **PASSWORD** field.
FAX	Facsimile number for the user.
STATE	Name of the State where the user is located.
COUNTY	Name of the County where the user is located.
ZIP	Zip Code where the user is located.

3. At a minimum enter the red asterisked (*) fields.

4. Click one of the available buttons:

- **CREATE USER** – submits the request to the system administrator.
  - **a)** A message stating, "New user was created successfully. Please go back to Login. Your username is Sherri" appears.
  - **b)** Click on the **LOGIN** hyperlink.
  - **c)** Continue to the section titled, "Logging into Sentinel" for instructions.
- **RESET** – erases any newly typed entries in the fields and remains on the same window to reenter data.

- **CANCEL** – returns to the previous window.

SUPPORT INFORMATION – (SENTINEL SUPPORT)

To access your application's support resources information, click the **SUPPORT** hyperlink located in the FootBar of the application. The following types of information are available and may differ per state:

- Reporting problems with the system, contact the System Administrator.
- Questions about specific diseases, contact the Office of Epidemiology.
- Fax number for faxing disease reports.
- Website address for more information on disease surveillance and reporting.

1. From any screen within the application, click the **SUPPORT** hyperlink. The application's "Resource Information" screen appears in a new Browser window listing various resources and phone numbers, etc.

2. When finished, close the Browser window by clicking the X in the upper right-hand corner.

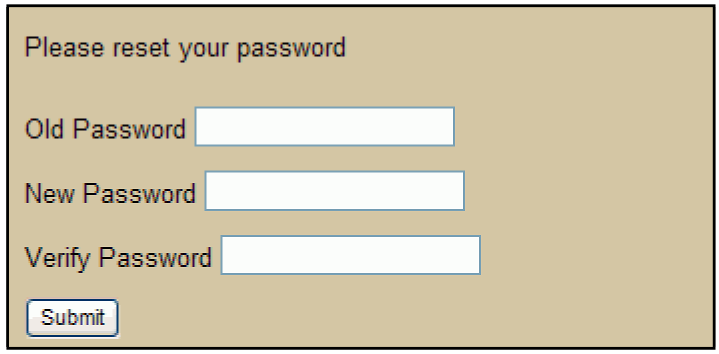
CHANGE PASSWORD – (RESET PASSWORD HYPERLINK)

When you want to change your password, you can change it by clicking on the hyperlink at the bottom of the "Case Listings" screen.

Note: Refer to the section titled, "Important Notes Regarding Passwords" for password rules.

1. From the "Case Listings" screen, click the **RESET PASSWORD** hyperlink. The "Change Password" screen appears.

Figure 4-6: Change Password



2. The fields and their descriptions are listed in the table.

Table 4-2: Change Password Field Descriptions

FIELDS	DESCRIPTION
OLD PASSWORD	Type your old password.
NEW PASSWORD	Type a new password.
VERIFY PASSWORD	Re-type the new password.

3. Click the **SUBMIT** button. An email is sent to you containing your new password.
4. Log back into the application and change your password to something memorable.

Logging Out

Logging out performs three important functions:

- It removes any potentially sensitive information that may have been residual from cached files or temporary Internet files on your computer. This is especially important if you are working from a location outside of the State and others could have access to your machine.
- It removes your user session and session variables from the server's memory. This speeds up the system by providing additional memory and valuable system resources are freed.

- It unlocks any case records or Pending Work Queue records that you may have been editing.

To prevent unauthorized users from accessing Sentinel, you should log out whenever you are finished using the application.

To log out of Sentinel, perform the following:

1. Click the **LOGOUT** menu on the TopBar.

2. This terminates your application session and returns you to the "Login" screen.

AUTOMATIC LOGOUT

After a preset number of minutes of continuous inactivity (as set by the System Administrator), Sentinel automatically logs you out and deletes the cached files on your local computer. This is referred to as a "session timeout" or a "forced session timeout."

When your inactivity time forces a session timeout, any unsaved work is lost, and a screen appears notifying you that inactivity has forced a logout. To access Sentinel, you <u>must</u> log in again.

Note: The automatic timeout setting may differ per user role/permission. For more information, contact your System Administrator.

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5 CASE INVESTIGATION

The “Case Investigation” menu contains all the options to manage cases, allowing you to search, view, add, and change the communicable disease information stored within Sentinel.

The following table describes all of the possible options on the “Case Investigation” menu.

Table 5-1: Case Investigations Menu Options

OPTION	DESCRIPTION
CASES	View your accessible summary of cases. Refer to the section titled, “CASES (Case Listings)“ for more information.
NEW HUMAN CASE	Create/add new human cases. Refer to the section titled, “Creating a New Human Case” for more information.
PHYS CARD	(State configurable.) Access the Physicians’ Disease Reporting Module to enter a stack of cards from a single facility with minimal repeated data entry.
NEW NON HUMAN CASE	Create/add new non-human (cat, dog, fox, etc.) cases. Refer to the section titled, “Creating a Non Human Case for more information.
SEARCHES	View the types of “available” saved searches (includes case information such as patient's last name). Refer to the section titled, “SEARCHES (Saved)“ for more information.

OPTION	DESCRIPTION
ADVANCED SEARCH	This is a state-configurable option and may not appear on your menu. This search option allows you to enter fields that will refine your search. You can enter information in the patient name, case general information, outbreak information, investigation dates, completion dates, investigator, disease conditions/symptoms, patient date of birth/age, patient demographics, patient address, investigation address, patient maiing address, patient parent/guardian, and/or animal case information field.
NEW SEARCH	Create a new search. Refer to the section titled, “NEW SEARCH” for more information.
NEW SUPPLEMENTAL FORM SEARCH	Search case listings based on the supplemental form’s disease name. Refer to the section titled, “NEW SUPPLEMENTAL FORM SEARCH – DATA EXPORTER” for more information.
ALERT RULES	Create rules and send email notification alerts when specific thresholds, such as disease name or time span, are met. Refer to the section titled, “ALERT RULES” for more information.
MESSAGE MANAGEMENT	This is a state-configurable option and may not appear on your menu. This option is available for users that have the “messages” permission; otherwise, it will not appear on the menu. This option is used to create, edit, and delete important messages that will appear after a user enters a valid user-id and password. Refer to the section titled, “MESSAGE MANAGEMENT” for more information as well as the section titled, “VIEW MESSAGES.”

VIEW MESSAGES	This is a state-configurable option and may not appear on your menu. Important messages appear immediately after entering a valid user-id and password and will disappear after clicking on a menu/option. The View Messages option allows you to review the messages again. Refer to the section titled, “VIEW MESSAGES” for more information.
ILI	This is a state-configurable option and may not appear on your menu. After clicking on this option a ILI List will appear with the date the case(s) were reported, the district where the case(s) were reported, the reporting facility, number of total patients, number of total ILIs, and an option to edit.
OMS ACCESS	(State configurable.) Accesses the Outbreak Management System

OPTION	DESCRIPTION
	(OMS) to enter outbreak case information.
HOSPITAL CASE MANAGEMENT	(State configurable.) Accesses the Hospital Case Management System to search, create, and edit health care facility cases, and if authorized may run report(s).

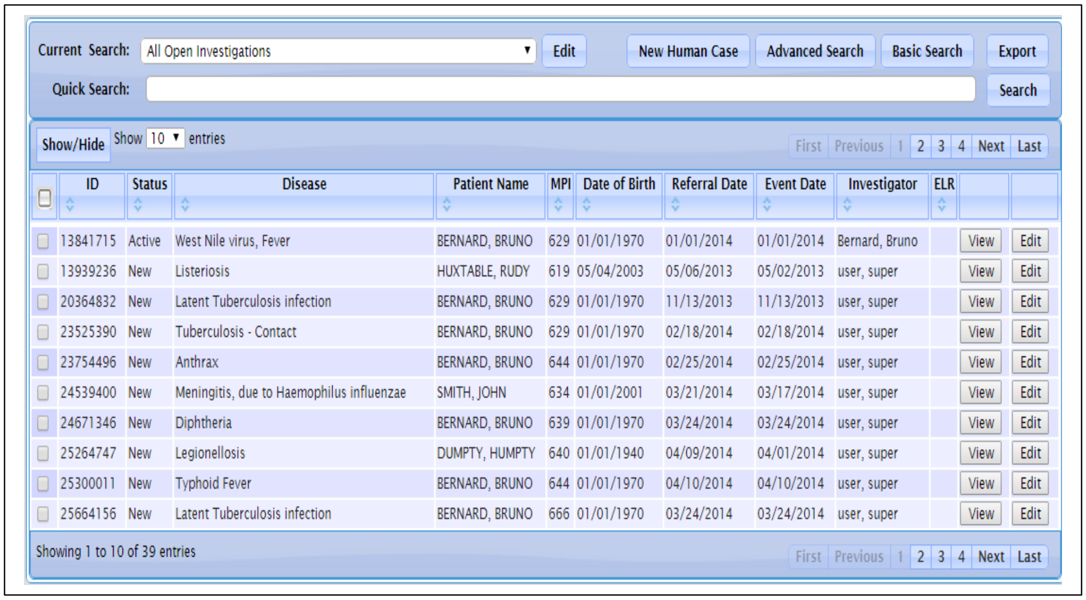
CASES (CASE LISTINGS)

The “Case Listings” screen appears after you log in and is the first option on the “Case Investigation” menu. If you are already logged in, you can access this screen by:

- Clicking the **CASE INVESTIGATION** menu on the TopBar.
- Clicking the **CASES** option on the Menu if you are already on a different “Case Investigation” screen.

The “Case Listings” screen displays summary information on one line for each case within Sentinel that you have permission to access and that match your selected default search criteria.

Figure 5-1: Case Listings Screen



You can perform the following tasks on the “Case Listings” screen.

- View more in-depth data, referred to as the “Case Details.” Refer to the section titled, “Viewing/Editing Case Details.”

- Export case summary data to your local computer. Refer to the section titled, “Exporting Data.”

Sort, Reorder, and Resize the Case Listing. Refer to the Sections Titled, “Searching using Quick Search

The Quick Search field allows you to perform a quick search using the following criteria:

- Name
- DOB
- Event Date
- Investigation ID
- MPI ID

Refer to the table for examples of use and their results.

SEARCH TYPE	SEARCH ENTRY	QUALIFIERS	RESULTS
NAME			
	JONES, EDWARD	Must have a space after the comma	Either of these entries returns all the cases which has a First name as Edward and Last name as Jones
	Edward Jones	No comma.	
	E* JONES	Asterisk * * is used as a wild card character representing "All"	Returns any case whose First name starts with E and Last name is Jones.
	Edward J*		Returns any case who has a First name as Edward and Last name starts with J.
	Edward *		Returns all the cases with a First name as Edward
	* JONES		Returns all the cases with a Last name as Jones
DATE OF BIRTH			
	01/01/2011	Use Slashes in between mm/dd/yyyy	Returns all the cases with the Date of Birth 01/01/2011.
EVENT DATE			
	E01/01/2011	No space between E(uppercase) and the date	Returns all the cases with Event date 01/01/2011

SEARCH TYPE	SEARCH ENTRY	QUALIFIERS	RESULTS
INVESTIGATION ID			
	21073		Returns all the cases that contain these numbers in sequence in the Investigation number.
MPI ID			
	M21073	No space between M (uppercase) and the Id)	Returns all the cases that contain these numbers in sequence in the MPI number.

1. Type your "Search Entry" in the **QUICK SEARCH** field and click the **SEARCH** button (located to the right of the Quick Search field).

- If a match is found, only those cases will display.
- The "Current Search" field will display "Temporary."

2. To display all the cases, select the **ALL CASES** preset option of one of the other "Preset Options."

- Sorting the Case," "Reordering the Case Listing Columns," and "Resizing the Case Listing Columns," respectively.
- Copy and paste information off the Case Listing into a file of your preference. Refer to the section titled, "Copying/Pasting Case Listing Data."
- Search cases using Quick Search. Refer to the section titled, "Searching using Quick Search."
- Search cases. Refer to the section titled, "Searching Cases."
- Export Data and/or CDC Data Forms. Refer to the section titled, "Exporting Data and/or CDC Data Forms."

- Print Case Summary data for all records listed. Refer to the section titled, "Printing Case Summary Data."

The following table describes the fields and buttons on the "Case Listings" screen.

Note: This table lists all fields/buttons for every state; thus, this table lists all fields for all states.

Table 5-2: Case Listings Field and Column Descriptions

FIELD/COLUMN	DESCRIPTION
PRINT BUTTON	Displays a printable version of the "Case Listings" records in a new browser window. Refer to the section titled, "Printing Case Summary Data" for more information.
QUICK SEARCH	Allows a Quick Search to be performed for the following criteria: • Name • DOB • Event Date • Investigation ID • MPI ID Refer to the section titled, "Searching using Quick Search" for more information.
SEARCH BUTTON	There are two SEARCH buttons: One used with the QUICK SEARCH and the other used with the CURRENT SEARCH. Continue to the section "Searching using Quick Search" for more information; otherwise, continue to the next paragraph. The second SEARCH button allows you to search cases by specific preset criteria. After your User-ID is created, the default search finds all open investigations assigned to your Sentinel User-ID and jurisdiction (region/district, department, etc.). Available preset search options are: • All Cases • All Open Investigations

FIELD/COLUMN	DESCRIPTION
	• My Open Investigations To change the default search and for more information on these search options, refer to the section titled, "Searching Cases" for more information.
EXPORT BUTTON	Allows you to export case summary data as a CSV (Comma Separated Value) file, which you can view/open a CSV file using such applications as Microsoft Word, Microsoft Notepad, and Microsoft Excel. For more information on exporting data, refer to the section titled, "Exporting Data."
ID	A unique, system-generated number that is automatically assigned to the investigation.
STATUS	Status of the investigation. The **STATUS** can be system-generated (NEW) or manually-selected (all other options). When you add a new case, Sentinel automatically sets the status to **NEW**. This field is expected to be resolved to **CLOSED, COMPLETED,** or **CANCELED** as a result of the investigation. Available options are: • **ACTIVE** – The case is open and has been assigned to an investigator. • **CANCELED** – The case is closed and, upon review, was determined to not be a disease name. • **CLOSED** – The case has been completed and is finished. • **COMPLETED** – The case has been completed and has been reviewed by Quality Assurance. • **NEW** – The case is open and has not been assigned to an investigator. This is the only option that is system-generated. • **PENDING –** The case is in the process of being assigned. • **PREVIOUSLY REPORTED –** The case was reported previously. • **REVIEWED –** The case has been reviewed by an investigator.

FIELD/COLUMN	DESCRIPTION
	• **SUPERCEDED** – The investigation has been preempted by an existing case. Superceding an investigation is similar to manually identifying a duplicate record. Investigations identified as “Superceded” are not reported to the CDC.
DISEASE	Disease name associated with the case.
PATIENT NAME	Patient’s first and last name (last name listed first).
MPI ID	Master Patient Index (MPI) Identification (ID) number for the patient. The MPI is a repository of basic patient demographic information to prevent users from entering duplicate patients/cases. Sentinel queries MPI to determine if the patient already exists and obtains the latest basic demographic information. Sentinel updates MPI with any new patients or new demographic information for existing patients. • When you create a case for a new patient, this field is empty and the MPI ID is assigned after you save the case. • When you create a case for an existing patient, the MPI ID field is automatically populated because that patient already has a MPI ID. **Note**: If you are an MPI ADMIN user, a # will appear before the MPI ID in the “Case Listing” if the MPI is out of sync for Sentinel for this case (unless it is sitting in the Pending Work Queue).
DATE OF BIRTH	Patient’s birth date.
REFERRAL DATE	System date when the New Case was entered into Sentinel.
EVENT DATE	The Event Date can be one of the following for all Sentinel application users: • If there is an **ONSET DATE**, that is the Event Date. • If there is no Onset Date, but there is a **DIAGNOSIS DATE**, that is the Event Date. • If there is no Onset or Diagnosis Date, the

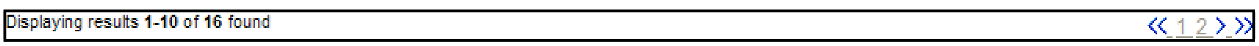
FIELD/COLUMN	DESCRIPTION
	EARLIEST LAB DATE is used. • If there is no Onset Date, Diagnosis Date, and no Labs, then the **REFERRAL DATE** (a required field) is used. **Note**: For **TB PAM**, the above rules are ignored if anything is defined in the TB Disease Group then the **REFERRAL DATE** is used for the Event Date.
INVESTIGATOR	(This field does not display for Louisiana.) Name of the person assigned to the case. The address and/or disease name data you enter when adding a new case determines case assignment. The assignment takes place internally in Sentinel.
JURISDICTION	Field or area of the Investigator. The investigator and jurisdiction assignment takes place internally in Sentinel.
REGION / PARISH	[May not appear for your state.] Name and number of the Region/Parish
ORIGINATING SITE	(Appears only for Louisiana.) This field displays the value based on the user type. • For Hospital users (or Facility) it is set to the Facility they are assigned to. • For State users, it is set to Statewide. • For Regional users, it is set to the Region they are assigned to.
REPORTING FACILITY	[May not appear for your state.] Originating site facility that reported the case.
CENTRAL CASE CLASSIFICATION	[May not appear for your state.] Case classification.
ELR	If an “X” appears, it indicates there is an Electronic Lab Report for this case. Select the EDIT button and then click on the LAB REPORTS tab to view it.

FIELD/COLUMN	DESCRIPTION
VIEW BUTTON	Displays the “Case Reporting” tab, which is the first of several tabs (collectively referred to as Case Details) that contain case data for viewing purposes only.
EDIT BUTTON	Displays the “Case Reporting” tab, which is the first of several tabs (collectively referred to as Case Details) that contain case data you can edit.

NAVIGATING THE CASE LISTINGS SCREEN

Case listings are displayed in groups of ten (10) records per screen, but can be changed to display groups of fifteen (15), twenty (20), or twenty-five (25) as well. When there are more than 10 total records in Sentinel, text on the screen indicates how many records (results) were retrieved and which group of 10 is currently displayed. For example, if the first group of ten records is displayed out of total of 16 records, the following appears on the screen:

Figure 5-2: Case Listings Navigation Tools



The following table describes the links (available at the top and bottom of the screen) that allow you to quickly navigate the records on the “Case Listings” screen.

Table 5-3: Case Listings Screen Navigation Links

LINK	DESCRIPTION
PAGE NUMBER LINKS **1 2 3**	Each “page number” is a link to a group of 10 records (the last page number may represent less than 10 records). The current page number does not appear as a link (no underline).
FIRST	Redirects you to the first page of the search results.
LAST	Redirects you to the last page of the search results.

SEARCHING USING QUICK SEARCH

The Quick Search field allows you to perform a quick search using the following criteria:

- Name
- DOB
- Event Date
- ID
- MPI ID

Refer to the table for examples of use and their results.

<table>
<tr><th>SEARCH TYPE</th><th>SEARCH ENTRY</th><th>QUALIFIERS</th><th>RESULTS</th></tr>
<tr><td colspan="4">NAME</td></tr>
<tr><td></td><td>JONES, EDWARD</td><td>Must have a space after the comma</td><td rowspan="2">Either of these entries returns all the cases which has a First name as Edward and Last name as Jones</td></tr>
<tr><td></td><td>Edward Jones</td><td>No comma.</td></tr>
<tr><td></td><td>E* JONES</td><td rowspan="3">Asterisk *

* is used as a wild card character representing “All”</td><td>Returns any case whose First name starts with E and Last name is Jones.</td></tr>
<tr><td></td><td>Edward J*</td><td>Returns any case who has a First name as Edward and Last name starts with J.</td></tr>
<tr><td></td><td>Edward *</td><td>Returns all the cases with a First</td></tr>
</table>

SEARCH TYPE	SEARCH ENTRY	QUALIFIERS	RESULTS
			name as Edward
	* JONES		Returns all the cases with a Last name as Jones
DATE OF BIRTH			
	01/01/2011	Use Slashes in between mm/dd/yyyy	Returns all the cases with the Date of Birth 01/01/2011.
EVENT DATE			
	E01/01/2011	No space between E(uppercase) and the date	Returns all the cases with Event date 01/01/2011
ID			
	21073		Returns all the cases that contain these numbers in sequence in the Investigation number.
MPI ID			
	M21073	No space between M (uppercase) and the Id)	Returns all the cases that contain these numbers in sequence in the MPI number.

3. Type your "Search Entry" in the **QUICK SEARCH** field and click the **SEARCH** button (located to the right of the Quick Search field).

- If a match is found, only those cases will display.
- The "Preset Criteria" field will display "Temporary."

4. To display all the cases, select the **ALL CASES** preset option of one of the other "Preset Options."

SORTING THE CASE LISTING

The default sort order for cases is by **ID** (this is the default sort when your User-ID is created and whenever you access the "Case Listings" screen thereafter).

Sorting can be done in ascending/descending order and/or the columns can be reordered by clicking/dragging the **COLUMN HEADER** as well as resized by clicking and dragging the column to a new position.

To sort "Case Listings" records, perform the following:

1. From the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Click on any of the **COLUMN HEADERS**. The data will sort first in ascending order. If clicked again, in descending order.

Note: The column headers may differ depending on your state.

Figure 5-3: Sort Options

RESIZING THE CASE LISTING COLUMNS

To Resize the Case Listing Columns, perform the following:

1. Determine the column to **RESIZE**.

2. Hover the mouse on top of the column separator (represented by a dotted line) until a cross-hair symbol appears.

3. Point, click, and drag the mouse to the desired position.

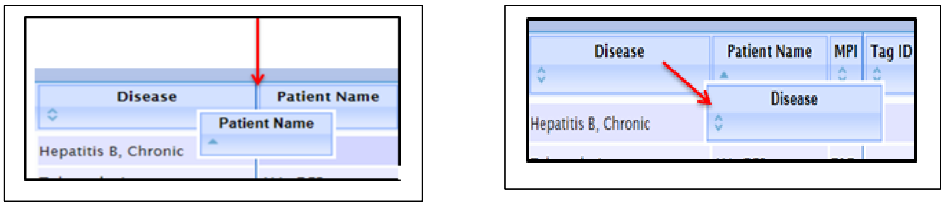
4. Release the mouse button.

REORDERING THE CASE LISTING COLUMNS

To Reorder the Case Listing Columns, perform the following:

1. Determine the column to **REORDER**.
2. Point, click and drag the column to the new position using the column separators.
   - For example, move the Disease Column to the left of the first column. The initial movement appears similar to the one shown below on the left.

Figure 5-4: Reorder Column Symbols



3. Locate the Column Separator to the left of where you want the column to display.
   - For example, in the illustration (above right), the Disease column will be positioned to the left of the Patient Name.

COPYING/PASTING CASE LISTING DATA

To Copy and Paste Case Listing Data into a file of your choice, perform the following:

1. Point, click, and drag the text on the Case Listing screen that you want to copy/paste.
2. Right-mouse click and choose **COPY**.
3. Paste the data into the desired file.

SEARCHING CASES

The "Case Listings" screen displays cases based on the selected search criteria and your access role and permissions (based on your User-ID). The "Patient Address" is used for searches which may not always be the same as "Case Address" in cases where the patient has a different current address than the case address.

When your User-ID is created, the system automatically creates the following searches:

- **ALL CASES** – returns all cases that fall within your case viewing permissions (your area of responsibility, such as a jurisdiction, region/district, or department).

- **ALL OPEN INVESTIGATIONS** – returns all open cases that fall within your case viewing permissions (your area of responsibility, such as a jurisdiction, region/district, or department). **This is the default search.**

- **MY OPEN INVESTIGATIONS** – returns all open case records assigned to you.

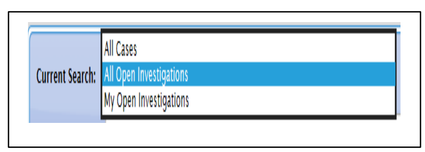
When you select a different search option, that search becomes your default search for the duration of your session or until you select another search option (which then becomes the default). However, when you log out and then log back in, **ALL OPEN INVESTIGATIONS** is the default Search option.

At least one saved search is required and you cannot delete the default search. Selecting a different search option may limit or expand the number of cases displayed.

To search cases, perform the following:

1. From the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.
2. From the **CURRENT SEARCH** drop-down menu, select a search option.

Figure 5-5: Search Options



Note: If the **SEARCH** drop-down menu contains only one option (search), you may want to create a new search. Refer to the section titled, "Creating a Search" for instructions.

EXPORTING DATA AND/OR CDC DATA FORMS

In Sentinel, exporting data is the process of creating a file that contains a subset of data representing fields that are common to all cases; these fields are referred to as "core" fields. The file you create is a CSV (Comma Separated Value) file. You can view/open a CSV file using such applications as Microsoft Word, Microsoft Notepad, and Microsoft Excel.

Exports are related to searches; you export data for records returned in a search or specific CDC Data Form. Regardless of the search/form you select, Sentinel exports the same core fields, even though different Searches result in different fields containing data. For example, you can export data for the default "All Open Investigations" search and for a search you create, such as a search named "Lyme Disease" that searches all cases that have a "Disease name" of "Lyme Disease." The resulting exported data may be different, where:

- Exported "All Open Investigations" data contains all records where "Investigation = Active or New" regardless of "Disease name."
- Exported "Lyme Disease" data contains all records where the "Disease name" is "Lyme Disease" regardless of whether the case is "Active or New" or not.

The following table lists a sample of the exported column label names, in the order in which they appear in the CSV file:

Table 5-4: Sample of Core Export Fields

EXPORT FIELDS
Reportable Condition
Reportable Condition #2
Disease Class
Case Type
Region Case Classification
Case Classification

EXPORT FIELDS
Investigation Status
Investigation ID
Flag
Investigator Last Name
Investigator First Name
Originating Site
Onset Date
Referral Date
Diagnostic Date
Event Date
Supplemental Form Status
Last Update Date
Last Updated By
MMWR Week
MMWR Year
First Completion Date
Last Completion Date
First Region Completion Date
Last Region Completion Date

Died
Date of Death
Inpatient/Outpatient/ER
Hospitalized
Days Hospitalized
MPI Id
State Id
Patient Status Date
Patient First Name
Patient Middle Name

EXPORT FIELDS
Patient Last Name
Patient Address (Street1)
Patient Address (City)
Patient Address (County)
Patient Address (State)
Patient Address (Zip)
Investigation Address (Street1)
Investigation Address (Street2)
Investigation Address (City)
Investigation Address (County)
Investigation Address (State)
Investigation Address (Zip)
Investigation Address (Jurisdiction)
Patient Sex
Patient Race
Patient Ethnicity
Patient Date Of Birth
Patient Age
Patient Age Unit

Patient Age Group

EXPORT FIELDS
Patient Country of Birth
Patient Home Phone
Patient Work Phone
Outbreak
Outbreak Name
Outbreak Id
Disease Imported
Occupation Type
Worksites/School
Occupations/Grade
NETSS Export Id
CDC First Report Date
CDC Last Report Date
Referral Person First Name
Referral Person Last Name
Referral Person Phone Number
Referral Person Email Address
Referral Person Name of Reporting Facility
Referral Person Type of Reporting Facility

Referral Person State
Physician First Name
Physician Last Name

EXPORT FIELDS
Physician Phone Number
Physician Email
Physician Facility
Physician Address (Street 1)
Physician Address (Street 2)
Physician Address (City)
Physician Address (Zip)
Physician Address (County)
Physician Address (State)
Animal Species
Fever > 100
Cough
Sore Throat
Vaccination Received
Vaccination Last Date Received (mm/dd/yyyy)
Jaundiced
Pregnant During Illness
EDC or Delivery Date
EDC Date Type

	Method of Diagnosis
	Physician Communications: First Letter Sent
	Physician Communications: First Letter Sent Date
	Physician Communications: Second Letter Sent
	Physician Communications: Second Letter Sent Date
	Physician Communications: First Call to Provider
	Physician Communications: First Call Date
	Physician Communications: Second Call to Provider
	Physician Communications: Second Call Date
	Physician Communications: Case Report Form
	Physician Communications: Case Report Form Date
	Linked Cases (Type)
	Linked Cases (Direct Links)
	Linked Cases (Audit)
	Linked Cases: Contact Investigation
	Linked Cases: Contacts Count (Total)
	Linked Cases: Known Contacts Count
	Linked Cases: Known Contacts Count (Direct)

Linked Cases: Known Contacts Count (Indirect)
Linked Cases: Additional Contacts Count
Linked Cases: Notified of Exposure Counts
Linked Cases: Recommended Prophylaxis Counts
Linked Cases: Recommended Testing Counts
Linked Cases: Developed Illness Counts
Lab Report Source
ELR
ELR#
ELR Last Received
Manual Lab Report #
Lab 1 Test Name
Lab 1 Laboratory Name
Lab 1 Ordering Facility
Lab 1 Ordering Provider
Lab 1 Ordering Provider Phone Number
Lab 1 Specimen Accession Number
Lab 1 Parent Result
Lab 1 Report Date

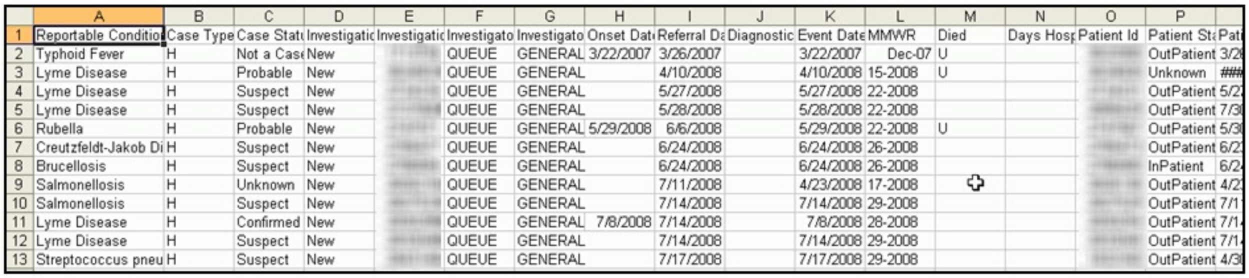
Lab 1 Specimen Collection Date

EXPORT FIELDS
Lab 1 Specimen Source
Lab 1 Specimen Site
Lab 1 Organism Name
Lab 1 Organism Species
Lab 1 Organism Serogroup
Lab 1 Organism Serotype
Lab 1 Pattern 1
Lab 1 Pattern 2
Lab 1 Pattern 3
Lab 1 CDC Pattern 1
Lab 1 CDC Pattern 2
Lab 1 CDC Pattern 3
Lab 1 Obs 1 Test Description
Lab 1 Obs 1 Result Description
Lab 1 Obs 1 Text Result
Lab 1 Obs 1 Numeric Value
Lab 1 Obs 1 Numeric Unit
Lab 1 Obs 1 Reference Range
Lab 1 Obs 1 Observation Result Status

Lab 1 Obs 1 Abnormal Flag
Lab 1 Obs 1 Comments
Lab 1 Obs 1 Test Code
Lab 1 Obs 1 Result Code

The following figure shows a sample exported CSV file opened in Microsoft Excel.

Figure 5-6: Sample CSV File in Microsoft Excel



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	
1	Reportable Conditio	Case Type	Case Stat	Investigatic	Investigatic	Investigato	Investigato	Onset Dat	Referral Da	Diagnostic	Event Date	MMWR	Died	Days Hosp	Patient Id	Patient St	Pati
2	Typhoid Fever	H	Not a Case	New	[illegible]	QUEUE	GENERAL	3/22/2007	3/26/2007		3/22/2007	Dec-07	U		[illegible]	OutPatient	3/2
3	Lyme Disease	H	Probable	New	[illegible]	QUEUE	GENERAL		4/10/2008		4/10/2008	15-2008	U		[illegible]	Unknown	###
4	Lyme Disease	H	Suspect	New	[illegible]	QUEUE	GENERAL		5/27/2008		5/27/2008	22-2008			[illegible]	OutPatient	5/2
5	Lyme Disease	H	Suspect	New	[illegible]	QUEUE	GENERAL		5/28/2008		5/28/2008	22-2008			[illegible]	OutPatient	7/3
6	Rubella	H	Probable	New	[illegible]	QUEUE	GENERAL	5/29/2008	6/6/2008		5/29/2008	22-2008	U		[illegible]	OutPatient	5/3
7	Creutzfeldt-Jakob Di	H	Suspect	New	[illegible]	QUEUE	GENERAL		6/24/2008		6/24/2008	26-2008			[illegible]	OutPatient	6/2
8	Brucellosis	H	Suspect	New	[illegible]	QUEUE	GENERAL		6/24/2008		6/24/2008	26-2008			[illegible]	InPatient	6/2
9	Salmonellosis	H	Unknown	New	[illegible]	QUEUE	GENERAL		7/11/2008		4/23/2008	17-2008			[illegible]	OutPatient	4/2
10	Salmonellosis	H	Suspect	New	[illegible]	QUEUE	GENERAL		7/14/2008		7/14/2008	29-2008			[illegible]	OutPatient	7/1
11	Lyme Disease	H	Confirmed	New	[illegible]	QUEUE	GENERAL	7/8/2008	7/14/2008		7/8/2008	28-2008			[illegible]	OutPatient	7/1
12	Lyme Disease	H	Suspect	New	[illegible]	QUEUE	GENERAL		7/14/2008		7/14/2008	29-2008			[illegible]	OutPatient	7/1
13	Streptococcus pneu	H	Suspect	New	[illegible]	QUEUE	GENERAL		7/17/2008		7/17/2008	29-2008			[illegible]	OutPatient	4/3

An exported CSV file consists of the following information:

- Header – first row of data that contains the name (label) of the exported data fields followed by a row of data for each exported case (record).

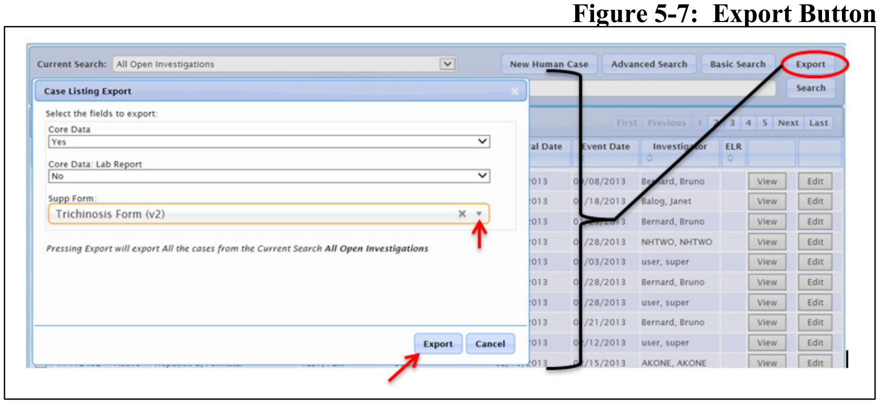
- Laboratory – these fields are not consistently exported since there can be multiple laboratory reports associated with each case, or none at all. If multiple laboratory reports are associated with a case, each laboratory report is identified consecutively as “Lab 1,” “Lab 2,” “Lab 3,” and so forth.

To export data, perform the following:

1. From the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.
2. Determine the type of search you want to perform.
   - Click the **CURRENT SEARCH** drop-down menu, select the search that retrieves the data you want to export and then click the EXPORT button.
   - Click the **SUPP FORM** drop-down menu to select the form that retrieves the data you want to export.

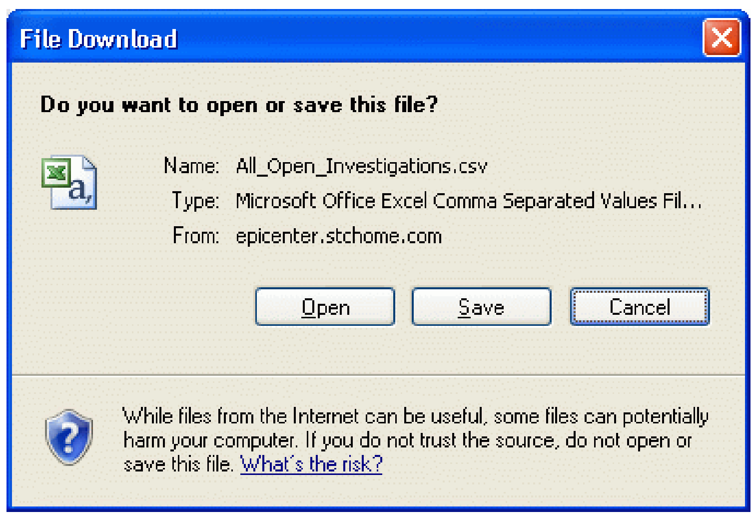
Note: Only active CDC Data Forms with associated disease cases will appear in the drop-down list. All disease cases associated with that form will have fields exported.

Figure 5-7: Export Button



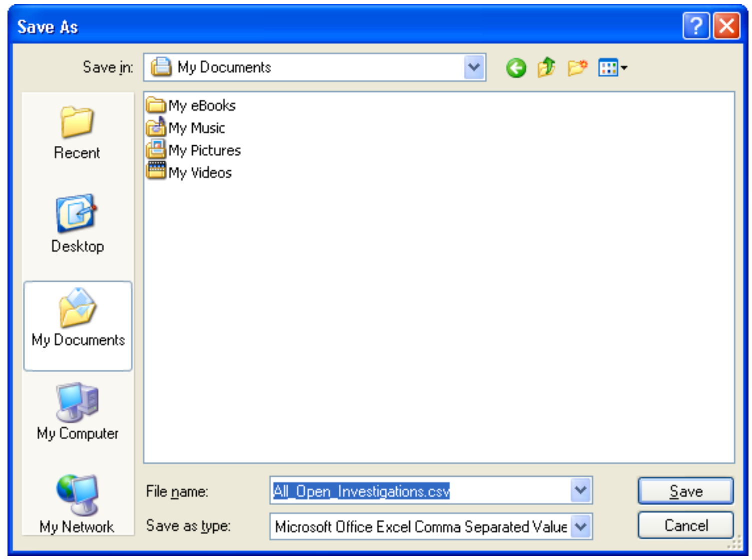
3. Click the **EXPORT** button. The “File Download” dialog box appears, asking you to open, save, or cancel the export file download. There may be a brief delay before the “File Download” dialog box appears; the delay is relative to the number of cases you are exporting.

Figure 5-8: File Download Dialog Box



4. Click the **SAVE** button. The “Save As” dialog box appears.

Figure 5-9: Save As Dialog Box



5. Navigate to the folder in which you want to save the file, and accept the default file name (defaults to the name of the selected search option) or type a different file name in the **FILE NAME** box.

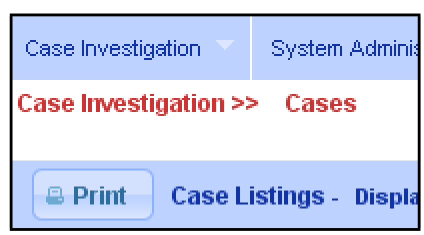
6. Click the **SAVE** button. Your exported data file is saved to your computer in the location you specified.

PRINTING CASE SUMMARY DATA

To print case summary data, perform the following:

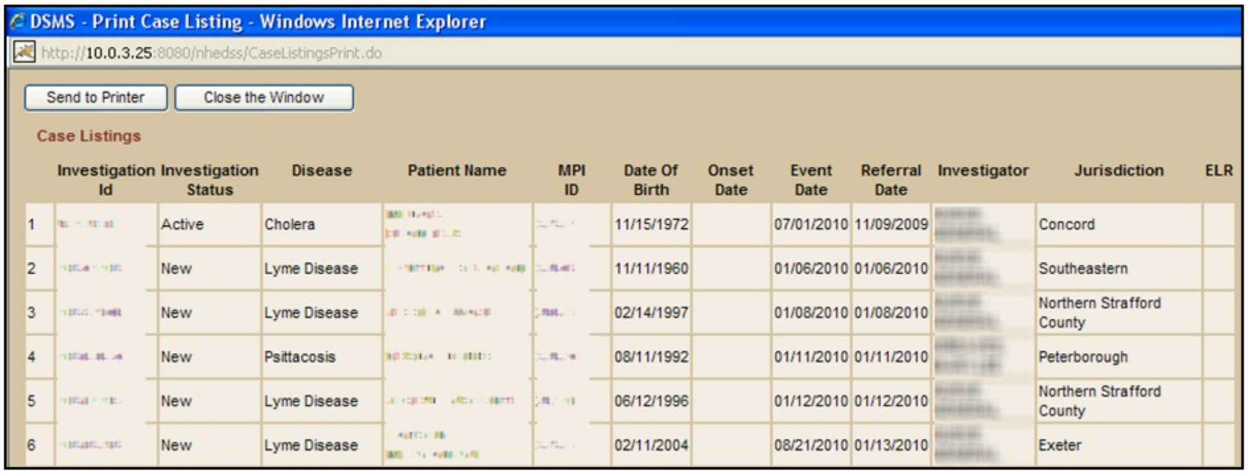
1. From the “Case Investigation” menu, click the **CASES** option. The “Case Listings” screen appears.

Figure 5-10: Print Button



2. Click the **PRINT** button. A new browser window opens, displaying all the records on the “Case Listings” screen.

Figure 5-11: Case Summary Data in New Browser Window


DSMS - Print Case Listing - Windows Internet Explorer

http://10.0.3.25:8080/nhedss/CaseListingsPrint.do

Send to Printer | Close the Window

Case Listings

	Investigation Id	Investigation Status	Disease	Patient Name	MPI ID	Date Of Birth	Onset Date	Event Date	Referral Date	Investigator	Jurisdiction	ELR
1	[illegible]	Active	Cholera	[illegible]	[illegible]	11/15/1972		07/01/2010	11/09/2009	[illegible]	Concord	
2	[illegible]	New	Lyme Disease	[illegible]	[illegible]	11/11/1960		01/06/2010	01/06/2010	[illegible]	Southeastern	
3	[illegible]	New	Lyme Disease	[illegible]	[illegible]	02/14/1997		01/08/2010	01/08/2010	[illegible]	Northern Strafford County	
4	[illegible]	New	Psittacosis	[illegible]	[illegible]	08/11/1992		01/11/2010	01/11/2010	[illegible]	Peterborough	
5	[illegible]	New	Lyme Disease	[illegible]	[illegible]	06/12/1996		01/12/2010	01/12/2010	[illegible]	Northern Strafford County	
6	[illegible]	New	Lyme Disease	[illegible]	[illegible]	02/11/2004		08/21/2010	01/13/2010	[illegible]	Exeter	

3. If you do not desire to print the case summary data, click the **CLOSE THE WINDOW** button; otherwise, click the **SEND TO PRINTER** button. The "Printer Dialog" box appears for your default printer.

4. Make the desired selections and then click the **PRINT** button. The Summary Data will be printed on your selected printer.

5. Click the **CLOSE THE WINDOW** button to close the window.

VIEWING/EDITING CASE DETAILS

While viewing the Case Details, every tab will contain "header information" indicating the following:

- Patient
- Condition
- Event Date
- Case Classification
- Locked By
- Created By
- Creation Date
- Last Update Date

When you edit "Case Details," the case is "locked" by the first user that clicked the **EDIT** button on the "Case Details" is the user that will display in the "Locked by" field.

For example, the following figure below shows that the case is locked by the user named **SHERRIB.** If another user attempts to edit the same case, the fields will be grayed out which means they are not available for editing.

Figure 5-12: Header Information - Locked Case Created by another User (Read-Only)

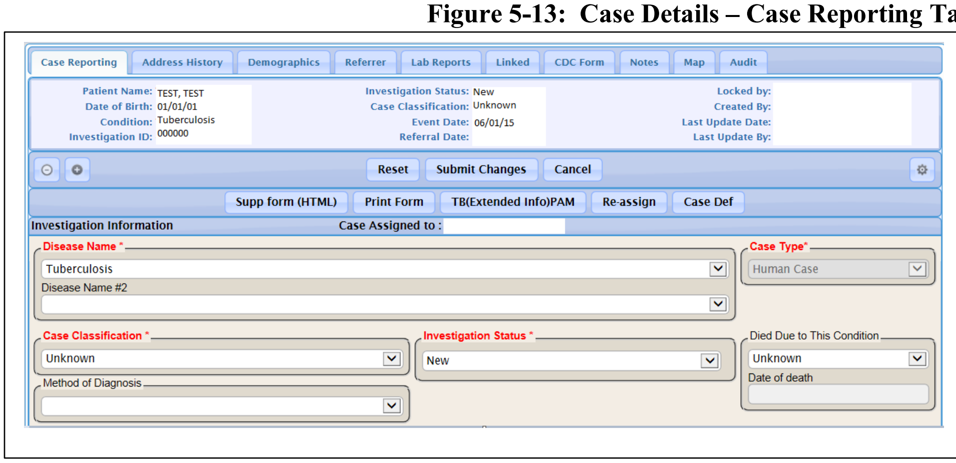
The lock remains in affect until the first user who accesses the case details cancels, submits the changes, or otherwise navigates away from that record. If the session terminates before the lock is released, the lock is released when that user's session times out.

To view/edit case details, perform the following:

1. On the "Case Investigation" menu and click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case for which you want to view/edit details and click the **VIEW** or **EDIT** button (located to the far right of the case). The "Case Reporting" tab appears.

Figure 5-13: Case Details – Case Reporting Tab



Note: These instructions assume you clicked the **EDIT** button; thus, if the **VIEW** button was pressed, the fields will be locked to prevent editing and some of the buttons will not appear.

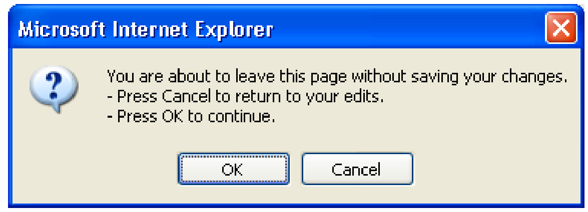
The tabbed sections that are available within "Case Details" are:

- **CASE REPORTING** – Contains information regarding the case, patient, and investigation.
- **ADDRESS HISTORY** – Contains summary information for each of the addresses associated with a patient.
- **DEMOGRAPHICS** – Contains information such as the patient's sex, race, ethnicity, date of birth/age, parent/guardian, work, occupation, school grade, etc.
- **REFERRER** – Contains information regarding the primary physician and the person who made the referral.
- **LAB REPORTS** – Contains summary information for each of the laboratory reports associated with the patient.
- **NOTES** – Contains free-form notes for comments or other supporting information regarding the case.
- **MAP** – Displays an interactive map showing the case's location.
- **AUDIT** – Contains historical information regarding the changes made to an investigation. This information contains who made the change, what was changed, and when the change occurred.
- **CDC DATA FORM** – Displays the case (in view only mode) that has a disease associated with CDC supplemental data.

3. To view/edit one of the tabbed sections, click the tab and make the necessary changes and continue to Step 4; otherwise, click a different menu/option to exit.

- If you make any changes to the data that you are viewing and you click a different menu or Menu option to exit the screen, the following dialog box appears.

Figure 5-14: Editing Case Details Dialog Box



a) Click the **OK** button to continue to the menu/option you clicked (without saving your changes).

b) Click the **CANCEL** button to remain on the current tab with the changes you made intact, make any additional changes if desired, and then continue to Step 4.

4. Click the appropriate button at the Top or Bottom of the tab. The following buttons appear on several of the tabs.

- **RESET** – erases any changes you made back to the previous save, and remains on the same screen.
- **SUBMIT CHANGES** – begins a validation process and if there are no errors, saves the changes you made.
- **CANCEL** – terminates the process of editing the case and returns you to the "Case Listings" screen. If you have changed any case information, a dialog box appears asking if you are sure you want to cancel.

  a) If you click the **CANCEL** button, you remain on the current tab with the data you entered/changed intact.

  b) If you click the **OK** button, you will lose any edits that you entered.

CASE REPORTING TAB

The "Case Reporting" tab contains information regarding the case, patient, and investigation that is entered when the case is added via the **NEW HUMAN CASE** option or the **NEW NON HUMAN CASE** option.

You can perform the following from the "Case Reporting" tab depending on whether you click the **VIEW** or **EDIT** button on the "Case Listings" window:

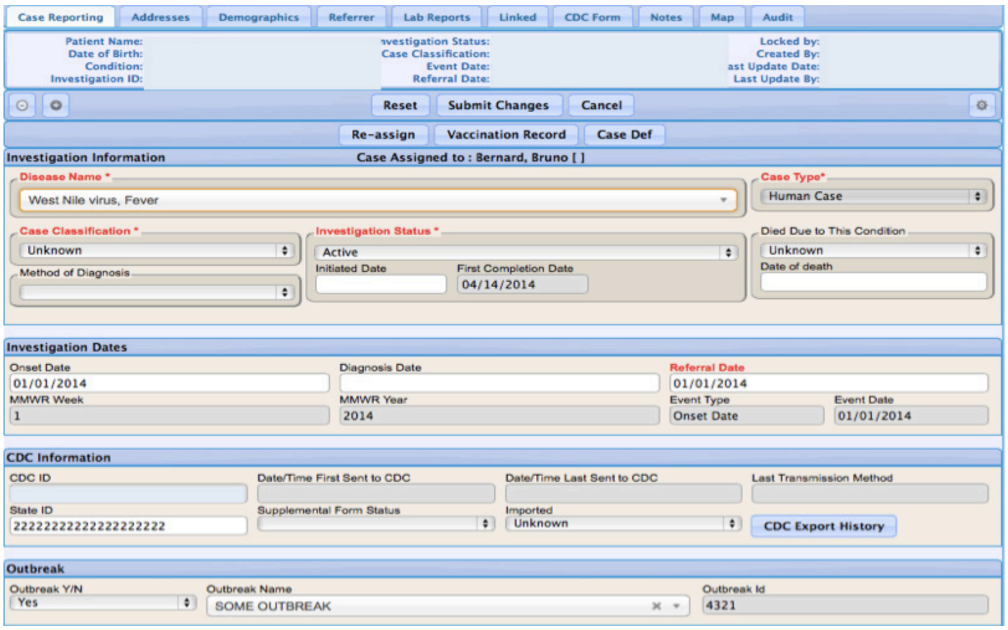
ACTION	VIEW	EDIT
PRINT FORM (PDF)	X	X
PRINT INVESTIGATION	X	X
CASE DEF (CDC CASE DEFINITION)	X	X
VACCINATION RECORD	X	X
DISABLE MPI		X
RE-ASSIGN		X
SUPP FORM (HTML)		X

- **View** or **Edit** case information such as disease name, case and investigation status, and patient information. Continue reading this section.
- **Re-assign** a case (with the appropriate authorization in EDIT mode). Refer to the section titled, "Reassigning a Case" for more information.
- **Print Form** in Portable Document Format (PDF). Refer to the section titled, "Printing a Supplemental Form" for more information.
- **Print** a summary of **case information**. Refer to the section titled, "Printing Case Summary Data" for more information.
- **Display** the CDC Case Definitions. Refer to the section titled, "Displaying Case Definitions" for more information.
- **Disable MPI** to prevent the case from synchronizing with the MPI deduplication program. Refer to the section titled, Disabling MPI" for more information.

The "Case Reporting" tab (as well as Address History, Demographics, Referrer, Lab Reports, Notes, Map, and Audit) appears when you click the **EDIT** or **VIEW** button (for a case) on the "Case Listings" screen.

Note: If you click the **VIEW** button, the fields will be grayed out; thus, you cannot edit them.

Figure 5-15: Case Reporting Tab – Edit Mode



N

ote: Case jurisdiction is based on the investigation address at the "Onset Date" (or the "Referral Date" if the "Onset Date" is unavailable). Changes to "Onset Date" can result in case referral to another jurisdiction.

Note: If a note has been added and the "Check here to set an alert message on the Case Reporting Tab page header. (This alert informs users that there is more information for this case inside the Notes Tab)" has been checked, the message appears in red text below the header information.

The following table describes the fields you can edit on the "Case Reporting" tab. However, there may be some impact when editing certain fields; these effects are noted in the table. All fields in RED* are required; you cannot delete one of these field values and leave it blank. All other fields are optional.

Table 5-5: Case Reporting Tab Field Descriptions

FIELD	DESCRIPTION
INVESTIGATION INFORMATION	

INVESTIGATION ID	Unique, system-generated number that is automatically assigned to the investigation.
ASSIGNED TO	Name of the investigator assigned to the case.
RE-ASSIGN BUTTON	Allows you to reassign a case to your supervisor for review. This button only appears if you are authorized to reassign a case. Refer to the section titled, "Reassigning a Case" for more information.
DISABLE MPI/ **ENABLE MPI**	(This option must be requested by the client and is currently a permission (MPI ADMIN) that is setup using the database.) Allows you to disable the Master Patient Index (MPI) application from deduplicating a case. After this button is pressed, the button will toggle to ENABLE MPI if the case needs

FIELD	DESCRIPTION
	to communicate with MPI. If a case accidentally ends up in the Pending Work Queue, it may be deleted from the Pending Work Queue by an administrator; however, the case will still need to be removed from the MPI application. Refer to the MPI User Guide for instructions. If cases have been entered into Sentinel and shouldn't be in the application, they may still show up in the Pending Work Queue. A DELETE button will display with the RESOLVE button allowing the administrator to delete the case. **Note**: The administrator may also directly access the MPI application and delete cases.
CASE TYPE	Type of case: Human or Non Human. This is a read-only field.
DISEASE NAME	Condition being reported for the case. Staff may view and edit any case that is located within their jurisdiction and program area privileges. **Note**: The disease name Tuberculosis – Contact is used when you want the Tuberculosis Contact Investigation Form fields to appear. In order for this disease option to appear it must be set up in the Disease Program Group as well as the Program Group Management option (TB Program – Tuberculosis-Contact) with the "Edit" privilege, as well as access to TB in Roles – Program Access.
CASE CLASSIFICATION	Case status based on set definitions and criteria to determine evidence of disease. This field is expected to be resolved to **CONFIRMED** or **NOT A CASE** as a result of the investigation. A more detailed discussion of Case Status is available within the CDC Case Definitions.

FIELD	DESCRIPTION
	Available options are: • **CONFIRMED** – It has been determined that the patient has this disease. When the investigation is complete (**INVESTIGATION STATUS** is set to **COMPLETED/CLOSED**), this case is reported to the CDC. • **DELETED** – This option is generally for cases that were entered in error. Marking a case as **DELETED** does not remove the case from the system; however, deleted cases no longer appear in reports or in a NETSS Export. • **NOT A CASE** – It has been determined that the patient does not have this disease. This case is not reported to the CDC. • **PROBABLE** – An initial indicator that the patient is likely to have this disease and further investigation is warranted. • **SUSPECT** – An initial indicator that the patient may have this disease and further investigation is warranted. • **UNKNOWN** – The person making the referral could not determine the likeliness. Follow-up is warranted.
INVESTIGATION STATUS	Status of the investigation. The **INVESTIGATION STATUS** can be system-generated (NEW) or manually-selected (all other options). When you add a new case, Sentinel automatically sets the status to **NEW**. This field is expected to be resolved to **CLOSED** or **CANCELED** as a result of the investigation. Available options are: • **ACTIVE** – The case is open and has been assigned to an investigator. • **CANCELED** – The case is closed and, upon review, was determined to not be a disease name. • **CLOSED** – The case has been completed and is finished. Once the case is Completed or Closed,

FIELD	DESCRIPTION
	Facility Users cannot edit the case. • **COMPLETED** – The case has been completed and has been reviewed by Quality Assurance. Once the case is Completed or Closed, Facility Users cannot edit the case. • **NEW** – The case is open and <u>has not</u> been assigned to an investigator. This is the only option that is system-generated. • **PENDING –** The case is in the process of being assigned. • **PREVIOUSLY REPORTED –** The case was reported previously. • **REVIEWED –** The case has been reviewed by an investigator. • **SUPERCEDED** – The investigation has been preempted by an existing case. Superceding an investigation is similar to manually identifying a duplicate record. Investigations identified as "Superceded" are not reported to the CDC.
OUTBREAK Y/N	Indicates whether the condition was part of an Outbreak (Y) or not (N), or is unknown. **Note**: Additional information is available via the OMS application.
OUTBREAK NAME	Name of the Outbreak if the **OUTBREAK** field is set to **YES**. **Note**: Additional information is available via the OMS application.
OUTBREAK ID	This is a user-defined number assigned to an Outbreak that associates a case to the Outbreak. Ex: For multiple cases related to a Food borne Outbreak (in the OMS application), you may enter an outbreak number of 100 for each one. Afterward, when an epidemiologist searches for all cases related

FIELD	DESCRIPTION
	to outbreak number 100, all related cases are returned. **Note**: Additional information is available via the OMS application.
ONSET DATE	Date the symptoms of this disease first appeared. Either type the date or click the calendar to select a date. **IMPACTS OF CHANGING THE ONSET DATE** The case Onset Date is related to other fields within Sentinel, specifically the Address "To" and "From" dates and the patient's age. • Sentinel attempts to determine the patient's age at disease onset; therefore, the patient's age is not their current age and changes to the Onset Date can result in changes to the age. If a change in the Onset Date results in the age dropping below 18 years, Sentinel requires the parent/guardian information to be supplied. • Onset date also plays a key role in determining the investigation address. The Address "To" and "From" dates are compared to the Onset Date to verify that the address is valid for the duration of the case investigation. If a change is made to the Onset Date that results in the address information no longer being valid, the case could be referred to another jurisdiction. For example, a patient who contracted a communicable disease while residing in County1 and moved to another jurisdiction on February 1, 2003 would be referred to the County jurisdiction when the address history is completed showing an address in County1 and the Onset Date is set to be prior to February 1, 2003. • Case jurisdiction is based on the investigation address at the Onset Date (or the Referral Date if the Onset Date is unavailable). Changes to Onset Date can result in case referral to another

FIELD	DESCRIPTION
	jurisdiction.
DIAGNOSIS DATE	Date the case was diagnosed. Type a date or click the calendar to select a date.
REFERRAL DATE	When you add a new case, this date defaults to the system date at the time of new case entry; however, you can type a new date, or click the calendar icon to select a date. When you edit a case and change the Patient Status, this date is set to the system date at the time of the change. **Note**: The Referral Date automatically populates the following fields: • MMWR Week • MMWR Year • Event Date • CDC ID
MMWR WEEK	Morbidity and Mortality Weekly Report (MMWR) publication week when the case was created. Sentinel calculates the **MMWR WEEK** value based on the **EVENT DATE** value. This is a read-only field and is populated when the Referral Date is entered.
MMWR YEAR	Morbidity and Mortality Weekly Report (MMWR) publication year when the case was created. Sentinel calculates the **MMWR YEAR** value based on the **EVENT DATE** value. This is a read-only field and is populated when the Referral Date is entered.
EVENT TYPE	

EVENT DATE	The Event Date can be one of the following for all Sentinel application users: • If there is an **ONSET DATE**, that is the Event Date. • If there is no Onset Date, but there is a **DIAGNOSIS DATE**, that is the Event

FIELD	DESCRIPTION
	Date. • If there is no Onset or Diagnosis Date, the **EARLIEST LAB DATE** is used. • If there is no Onset Date, Diagnosis Date, and no Labs, then the **REFERRAL DATE** (a required field) is used. This is a read-only field and is populated when the Referral Date is entered. **Note**: For **TB PAM**, the above rules are ignored if anything is defined in the TB Disease Group then the **REFERRAL DATE** is used for the Event Date.
CDC ID	Unique, system-generated ID used to identify the case record in the NETSS export. This is a read-only field and is populated when the Referral Date is entered.
STATE ID	Patient ID or animal case ID for cases migrated from legacy HAWK system.
DIED DUE TO THIS CONDITION	Whether or not the patient died. Available options are: • No • Unknown • Yes **Note**: If the incoming data displays "No" in the "DIED DUE TO THIS CONDITION" field but the person has a "DATE OF DEATH," the "DIED DUE TO THIS CONDITION" drop-down will not appear but will instead display, "Patient died on mm/dd/yyyy from condition associated with case id #XXXXXX."
DATE OF DEATH	If the "DIED DUE TO THIS CONDITION" field contains YES, then the "DATE OF DEATH" field must have an entry; otherwise, this field is disabled. Type the date using the format mmddyyyy or click on the Calendar Icon to select a date.

FIELD	DESCRIPTION
	This date Must be greater than the “Onset Date’ as well as the “Diagnosis Date.” **Note**: If the "DIED DUE TO THIS CONDITION" field is set to “Yes” and then set to “No,” the “DATE OF DEATH” field will be cleared.
SUPPLEMENTAL FORM STATUS	Status of the supplemental (disease specific) form. Available options are: • Form Approved • Form Complete • Form Sent to CDC • Form in Progress • Not Done **Note**: Once the case is Completed or Closed, this option is disabled for Facility Users.
IMPORTED	Indicates where the case came from. Available options are: • In-State • Out of Country • Out of State • Unknown
METHOD OF DIAGNOSIS	Indicates the diagnosis method. Available options are: • Blank • Clinical • Laboratory • Both Clinical and Laboratory
PATIENT NAME	
NAME TYPE	Type of name. Available options are: • Also Known As • Default/Common

FIELD	DESCRIPTION
	• Legal • Maiden • Nickname
PREFIX	Prefix for the patient; i.e., Miss, Ms., etc.
LAST	Last name of the patient.
FIRST	First name of the patient.
MIDDLE	Middle name of the patient, if any.
SUFFIX	Extension of the patient's name; i.e., Junior, III, etc.
MPI ID	This is a state-specific, read-only field. Master Patient Index (MPI) Identification (ID) Number. The MPI is a repository of basic patient demographic information to prevent users from entering duplicate patients/cases. Sentinel queries MPI to determine if the patient already exists and obtains the latest basic demographic information. Sentinel updates MPI with any new patients or new demographic information for existing patients. • When you create a case for a new patient, this field is empty and the MPI ID is assigned after you save the case. • When you create a case for an existing patient, the MPI ID field is automatically populated because that patient already has a MPI ID.
PATIENT ALTERNATE NAME	
NAME TYPE	Type of name. Available options are: • Also Known As • Default/Common

FIELD	DESCRIPTION
	• Legal • Maiden • Nickname These fields are the same as those listed in the PATIENT NAME section.
PREFIX	Alternate prefix for the patient; i.e., Miss, Ms., etc.
LAST	Alternate last name of the patient.
FIRST	Alternate first name of the patient.
MIDDLE	Alternate middle name of the patient, if any.
SUFFIX	Alternate extension of the patient's name; i.e., Junior, **III**, etc.
INVESTIGATION ADDRESS (the address that was entered when the case was created unless the user has gone into the Address History Tab and selected "case address" for a specific address.	
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the street address. This address can be any of the following: • Patient Home Address – A valid patient home address is entered and the Onset Date (or Referral Date if Onset Date is not available) is between the "From" and "To" dates of a patient's address history. Blank "From" and "To" dates are interpreted as prior to disease onset and the current date, respectively. • Providing Physician Address – The patient home address is either invalid or unavailable and a valid physician address is provided. • Submitting Laboratory Address – Submitting Laboratory addresses are used for an investigation address if (1) the case was created based on a submitted laboratory report, and neither

FIELD	DESCRIPTION
	the patient address nor the physician address is available and acceptable. Submitting Laboratory addresses are not considered for the investigation address for manually entered cases. • Blank – None of the three requested addresses are acceptable. For this event, the case is assigned to the State Supervisor for review. A subsequent referral to an LPHU (Field Epi Region/District or Local Health Department), will occur if an address can be obtained.
GEOCODE SOURCE	Indicates if the Investigation Address has been geocoded (Y=Yes, N=No).
CITY	City name of the investigation address.
COUNTY	County name of the investigation address.
STATE	State name of the investigation address.
ZIP	Zip code of the investigation address.
JURISDICTION	Jurisdiction of the investigation address.
CONDITIONS/SYMPTOMS	
FEVER > 100	This drop-down menu is used to denote that the symptom included a fever over 100 degrees. Choices are: • Yes • No • Unknown
COUGH	This drop-down menu is used to denote that the symptom included a cough. Choices are: • Yes • No • Unknown

FIELD	DESCRIPTION
SORE THROAT	This drop-down menu is used to denote that the symptom included a sore throat. Choices are: • Yes • No • Unknown
VACCINATION RECEIVED	Indicates whether or not a flu vaccination was given or not. Options are: • No • Unknown • Yes
LAST VACCINATION DATE	Date the flu vaccination was received. Type a date or click the calendar to select a date. This date be "on" or after the "date of birth (if entered)," and not a future date.
JAUNDICED	Indicates whether or not the case was jaundiced or not. Options are: • No • Unknown (Default) • Yes
PREGNANT DURING ILLNESS	Indicates whether or not the case was pregnant during the illness or not. Options are: • No • Unknown (Default) • Yes
EDC or DELIVERY DATE	Allows for the EDC or Delivery Date to be entered using the calendar that will pop up.

DATE TYPE	Indicates what the date type is. Options are: • EDC • Delivery Date
HOSPITAL INFORMATION	
HOSPITALIZED	Whether the patient was hospitalized (**YES, NO,** or **UNKNOWN**). • If YES, then Hospital Name is required AND Inpatient is automatically selected for the "InPatient/OutPatient/ER" field. • If NO, then nothing is automatically

FIELD	DESCRIPTION
	selected for the "InPatient/OutPatient/ER" field and the "Date Discharged" and "Number of days Hospitalized" fields are disabled. • If UNKNOWN, then Hospital Name must be disabled and the "Inpatient/Outpatient/ER" field cannot be Inpatient or Outpatient.
INPATIENT/OUTPATIENT/ER	If the "Hospitalized" field contains a YES, then "In Patient" is automatically populated. If the "Hospitalized" field contains a NO, then nothing is automatically selected for this field. If the "Hospitalized" field contains UNKNOWN, then Hospital Name is disabled and the "Inpatient/Outpatient/ER" field cannot be Inpatient or Outpatient.
HOSPITAL NAME	Name of the hospital. The name chosen automatically populates the following fields: • Facility ID • Street • City • Zip • State • County
FACILITY ID	Identification number of the Facility. This is a read-only field and is populated when the Hospital Name is selected.
STREET	Street address of the hospital. This is a read-only field and is populated when the Hospital Name is selected.
CITY	City location of the hospital.

FIELD	DESCRIPTION
	This is a read-only field and is populated when the Hospital Name is selected.
ZIP	Zip code of the hospital location. This is a read-only field and is populated when the Hospital Name is selected.
STATE	State code of the hospital location. This is a read-only field and is populated when the Hospital Name is selected.
COUNTY	County location of the hospital. This is a read-only field and is populated when the Hospital Name is selected.
DATE ADMITTED	Date the patient was first admitted into the hospital.
DATE DISCHARGE	Date the patient was released/discharged from the hospital.
NUMBER OF DAYS HOSPITALIZED	Number of days the patients was hospitalized.
MEDICAL RECORD NUMBER	Medical Record Number for the patient.
ANIMAL CASE INFORMATION (ONLY APPEARS FOR NON-HUMAN CASES)	
ANIMAL SPECIES	Species of the animal, such as bat, dog, or fox, related to the non-human case.
TAG NUMBER	Numeric identifier for non-human West Nile Virus cases.
TAG NUMBER TYPE	Type of tag number. Available options are: • Avian • Mosquito • Veterinary

FIELD	DESCRIPTION
	This field is required if you enter a value in the **TAG NUMBER** field.
LOCATION	Location where the animal was encountered. Ex: For animal rabies cases, location may be where the rabid animal was seen, such as a treetop, backyard, etc.

VIEWING/EDITING CASE REPORTING INFORMATION

To view or edit "Case Reporting" tab information, perform the following:

1. On the "Case Investigation" menu, click the **CASES** option. The "Case Listings" screen appears.
2. Locate the desired case and click the **EDIT** or **VIEW** button (located to the far right of the case). The "Case Reporting" tab appears.

   Note: These instructions assume you are editing; thus, the fields are not locked so that you can edit the field and more buttons are available.

3. Using the previous table as a guide, make the desired changes. All fields in RED* are required; you **cannot** delete one of these field values and leave it blank. All other fields are optional.
4. Click one of the following buttons:

   Note: The "Reset," "Submit Changes," "Cancel," and "Case Def" buttons appear at the top and bottom of this window.

   - **RESET** – erases any changes you made up to the previous save and remains on the same screen.
   - **SUBMIT CHANGES** – (appears only in Edit Mode) begins a validation process and if there are no errors, saves the changes you made.

Note: All changes that are made are recorded in an audit trail. This audit identifies who made the change, when the change was made, and what the change consisted of. Audit information appears on the "Audit" tab of Case Details.

- **CANCEL** – terminates the process of editing and returns to the "Case Listings" screen. If you have changed any case information, a dialog box appears asking if you are sure you want to cancel.

  a) If you click the **OK** button, you will lose any edits you just made and you are returned to the "Case Listings" screen.

  b) If you click the **CANCEL** button, you remain on the "Case Reporting" tab with the data you entered intact.

- **VACCINATION RECORD** – displays the "Vaccination Record" from the Registry application, if one exists. Continue to the section titled, "Displaying Vaccination Records" for more information.
- **CASE DEF** – displays the CDC case definitions in a separate Adobe Reader window.
- **PRINT INVESTIGATION** – displays a case summary offering a print option. Continue to the section titled, "Printing Case Summary Data" for more information.
- **REASSIGN** – (appears only in EDIT Mode) allows the user to reassign the case to a different jurisdiction.
- **SUPP FORM (HTML)** – (appears only in EDIT Mode) allows the user to display the Supplemental Form in HTML assuming one exists. If this button does not appear, the form will be available under the CDC Data Tab.
- **PRINT SUPP FORM (PDF)** – (appears only in EDIT Mode) allows the user to display and print out all the case details providing both core and supplemental data.
- **Disable MPI** to prevent the case from synchronizing with the MPI deduplication program. Refer to the section titled, Disabling MPI" for more information.

DISPLAYING VACCINATION RECORDS

[This is a state-configurable option and may not appear for your state.]

If a patient has a vaccination recorded in the IWeb registry application and the system is setup to talk to the registry, you can display it using the Vaccination Record button. This viewing exchange is achieved using a Health Level Seven (HL7) interface between Sentinel and IWeb, whereby Sentinel queries IWeb using a shared Master Patient Index ID (MPI ID). It is assumed the patient has a first name, last name, and Date of Birth (DOB) in Sentinel; otherwise, the Vaccination Record button will not display.

Note: The Vaccination Record button is only available on the "Case Reporting" tab.

1. From the "Case Reporting" Tab screen, click the **VACCINATION RECORD** button. The "Patient Vaccination Record View" screen appears in a new Browser window.

Figure 5-16: Patient Vaccination Record View

2. The fields and their descriptions are listed in the table.

Table 5-6: Patient Vaccination Record View Field Descriptions

FIELD	DESCRIPTION
NAME	First name, middle name, and last name of the patient.

FIELD	DESCRIPTION
BIRTH DATE	Patient's date of birth.
VACCINE FAMILY	Name of the vaccine family of the vaccination given to patient.
VACCINE DATE	Date the vaccine was provided to the patient.
VACCINE MANUFACTURER	Name of the Vaccine Manufacturer for the associated vaccine.
LOT NUMBER	Lot Number of the Vaccine.
CONTRAINDICATION	

3. When finished viewing the record, close the Browser window by clicking the **X** in the upper right-hand corner.

ENTERING CASE DATA USING SUPP FORMS (HTML)

This button is used to enter Case Information using Disease Specific forms. Refer to the section titled, "Editing Cases Using Disease Specific (Supp) Forms" or the section titled, "Viewing/Editing the CDC Disease Fields" for instructions.

PRINTING SUPP FORMS (PDF)

This option allows the user to display and print all the case details providing both core and supplemental data (including Conditions/Symptoms for flu symptoms as well as "Jaundiced" or "Pregnant during Illness" fields). It displays a form consisting of information such as: Epidemiologic Case History, Patient Demographic Information, Referrer Information, Clinical Information, General Exposures, Food and Beverage History, and Comments/Additional Information.

Note: The information on this form may differ depending on the disease form.

Printing Case Details using the disease specific forms allows you to print a completed investigation with detailed information. If you only want to print summary information for a case, refer to the section titled, “Printing Case Investigations” for more information.

Note: You may make changes and then send them to the printer; however, you cannot save the changes to the form.

To print a case using a disease specific form, perform the following:

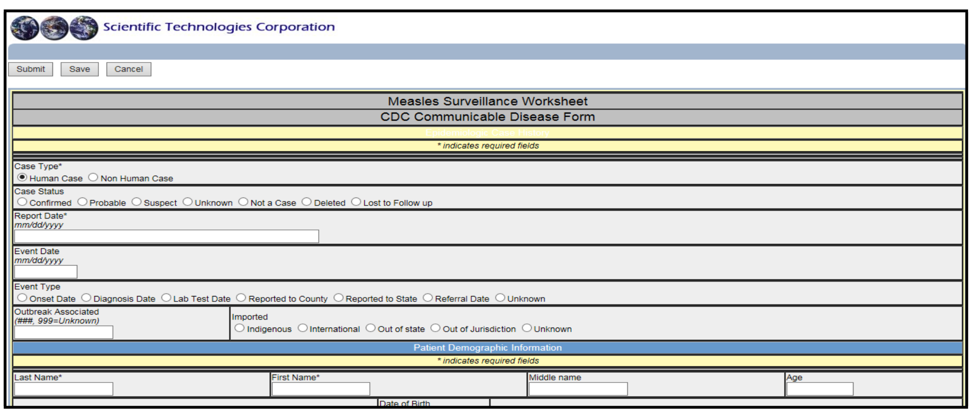
1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.

2. Locate the case you want to print and click the **EDIT** button (located on the same row). The “Case Reporting” tab appears.

> ***Note:*** Print Supp Form on a case for a disease that does not have a supp form or did not have a supp form in the past, will not have an associated form and the button will be disabled. Print investigation should be used for cases that have a CDC form and Print Supp Form should be used for cases that have a Supp Form.

3. Click the **PRINT SUPP FORM (PDF)** button (located below the **DISEASE NAME** drop-down menu). The Supplemental Form appears.

Figure 5-17: Supp Form (PDF)



4. Before printing, verify your printer settings are set to print the form properly.

5. To print, perform either of the following:

- In the browser's toolbar, click the printer icon to print all pages and click the **OK** button to print.

- Use the File – Print option to select a specific page range.

6. When you are finished, click the **CANCEL FORM** button. A dialog box displays asking if you are sure you want to cancel.
   - If you click the **YES** button, you will return to the “Case Listings” screen.
   - If you click the **NO** button or the **CANCEL** button, you remain on the form with the values you entered intact.

Completing or Closing a Case

You must have the appropriate role/permissions to Complete or Close a case. The user is expected to set both the **CASE CLASSIFICATION** and **INVESTIGATION STATUS** fields on the “Case Reporting” tab.

To close a case, perform the following:

1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.
2. Locate the case you want to close and click the **EDIT** button (located to the far right of the case). The “Case Reporting” tab appears.
3. From the **CASE CLASSIFICATION** drop-down menu, select either **CONFIRMED** or **NOT A CASE**.
4. From the **INVESTIGATION STATUS** drop-down menu, select **COMPLETED** or **CLOSED.**
5. Click the **SUBMIT CHANGES** button to save the changes.

Note: Investigations with the **CASE CLASSIFICATION** of **CONFIRMED** and **INVESTIGATION STATUS** of **COMPLETED or CLOSED** are reported to the CDC.

Reassigning a Case

You must have the appropriate role/permissions to reassign a case. With this permission, a **RE-ASSIGN** button appears at the top of the “Case Reporting” tab and you can reassign a case to your supervisor for review. Sentinel allows a supervisor to change the investigator assignment.

If the SuperUser attempts to assign a case to a user whose jurisdiction does not match the jurisdiction on the case, Sentinel disallows this and displays an error.

Note: If a user has "edit access" to a case through the "Program Group Management" menu, the case can be reassigned.

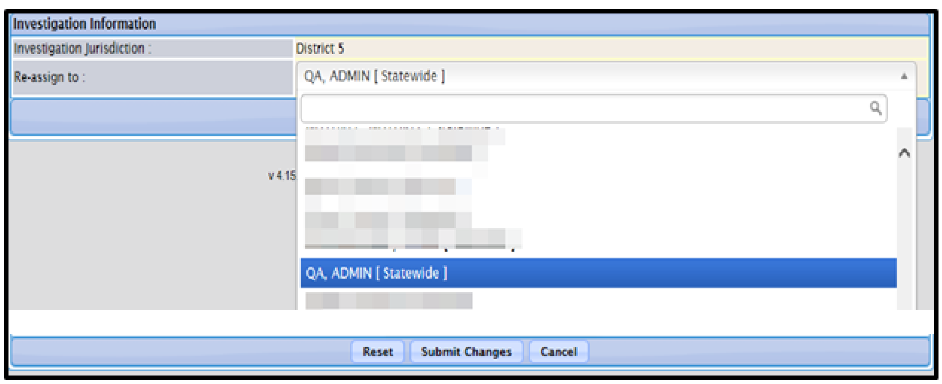
To reassign a case, perform the following:

1. On the "Case Investigation" menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case you want to reassign and click the **EDIT** button (located on the same row). The "Case Reporting" tab appears.

3. Click the **RE-ASSIGN** button. The "Re-assign Investigation" screen appears.

Figure 5-18: Re-assign Investigation Screen



4. In the **RE-ASSIGN TO** section, select the new investigator from the list.

5. Click one of the following buttons:

- **RESET** – erases any changes you made and remains on the screen.
- **SUBMIT CHANGES** – saves and returns to the "Case Listings" screen.
- **CANCEL** – <u>does not</u> save changes and returns you to the "Case Reporting" tab. If you changed any information, a dialog box appears asking if you are sure you want to cancel.

a) If you click the **CANCEL** button, you remain on the “Re-assign Investigation” screen.

b) If you click the **OK** button, you will lose any data that you entered.

DISABLING/ENABLING MPI

The option to **DISABLE MPI** must be requested by the client and is the MPI ADMIN permission. It allows the user to disable the Master Patient Index (MPI) application from deduplicating a specific case. After the **DISABLE MPI** button is pressed, the button will toggle and display **ENABLE MPI** in the case where the case needs to synchronize and communicate with MPI.

If a case accidentally ends up in the Pending Work Queue, it may be deleted from the Pending Work Queue by an administrator; however, the case will still need to be removed from the MPI application. Refer to the MPI User Guide for instructions.

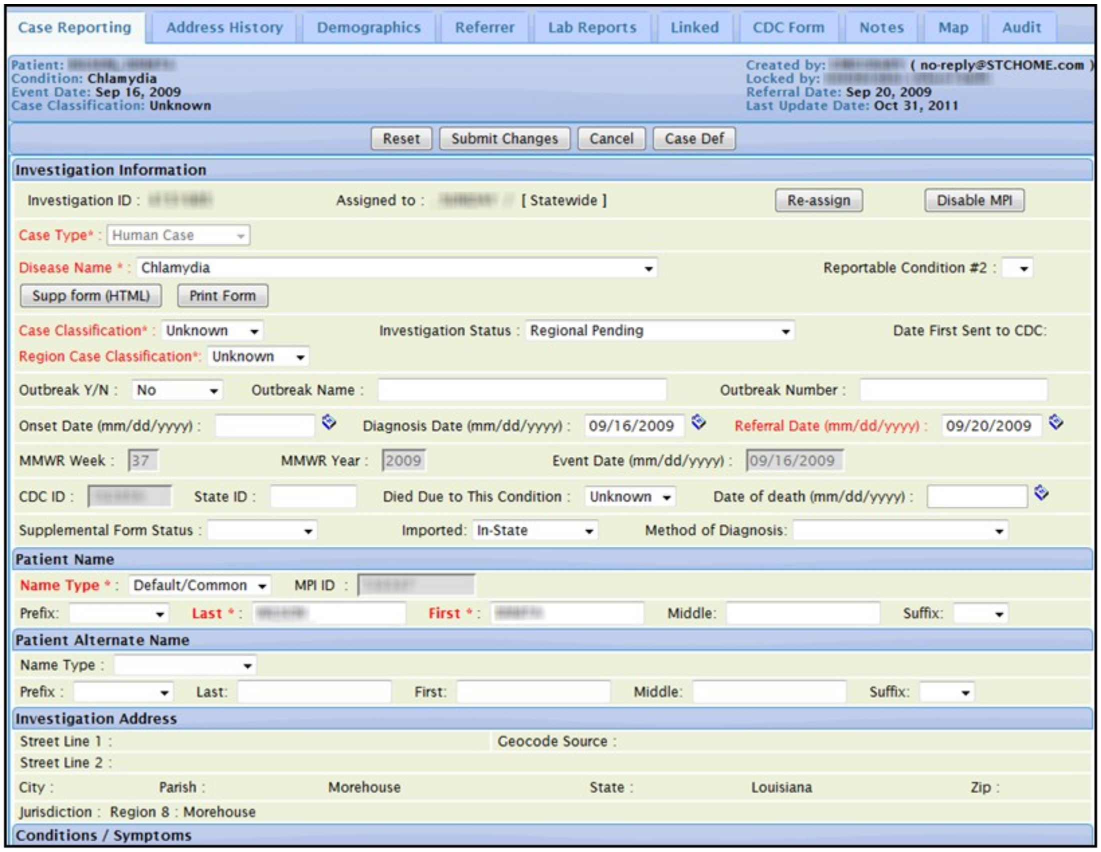
If cases have been entered into Sentinel and shouldn’t be in the application, they may still show up in the Pending Work Queue. A **DELETE** button will display with the **RESOLVE** button allowing the administrator to delete the case.

Note: The administrator may also directly access the MPI application and delete cases.

To disable MPI for a case, perform the following:

1. On the “Case Investigation” menu, click the **CASES** option. The “Case Listings” screen appears.
2. Locate the case you want to disable MPI for and click the **EDIT** button (located on the same row). The “Case Reporting” tab appears.

Figure 5-19: Case Reporting – Disable MPI



3. In the "Investigation Information" section of the window, click the **DISABLE MPI** button.

4. You may be asked to fill in required fields before the case is disabled. The button will then display **ENABLE MPI**.

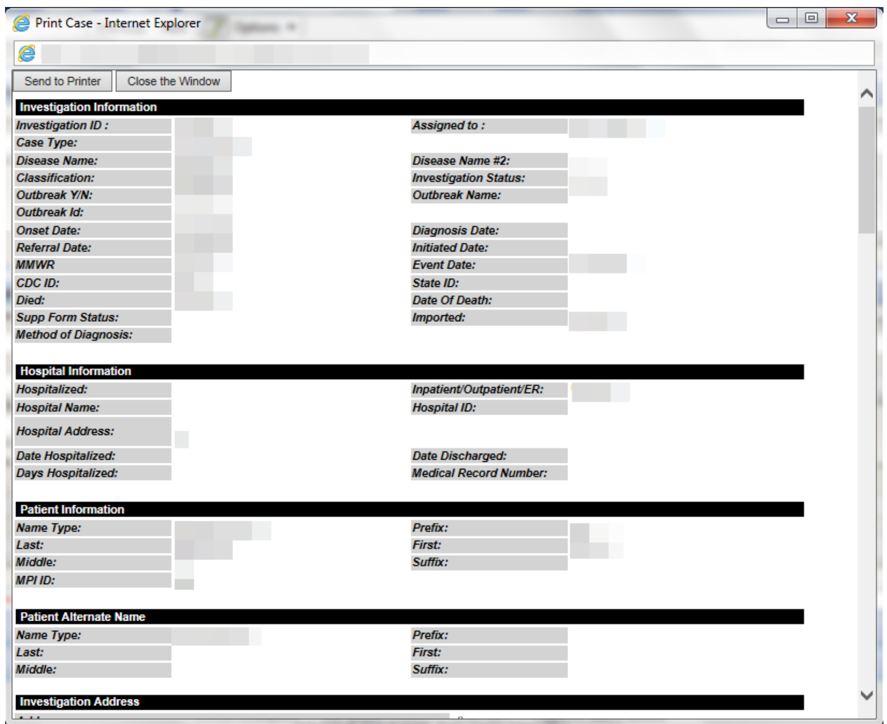
Printing Case Investigations

The **PRINT INVESTIGATION** button, which only appears on the "Case Reporting" tab, allows you to print a case summary. Although the Case Summary contains information similar to what you enter when adding a new case, it does not include all the detailed information associated with a case investigation. Information categories include: Investigation Information, Hospital Information, Patient Information, Patient Alternate Name, Investigation Address, Address History, Sex/race, Date of Birth/Age, Mailing Address, Parent/Guardian (if under 18), Work/Occupation or School/Grade, Travel History, Person Providing Report, Primary or Attending Physician, Conditions/Symptoms

Information (includes “Jaundiced” and “Pregnant during Illness” fields), Lab Reports, and Investigation Notes, etc.

Note: Print Supp Form on a case for a disease that does not have a supp form or did not have a supp form in the past, will not have an associated form and the button will be disabled. Print investigation should be used for cases that have a CDC form and Print Supp Form should be used for cases that have a Supp Form.

Figure 5-20: Sample (Partial Page) Printed Case Summary



To print a case investigation, perform the following:

1. On the “Case Investigation” menu, click the **CASES** option. The “Case Listings” screen appears.

2. Locate the case you want to print and click the **EDIT** button (located to the far right of the case). The “Case Reporting” tab appears.

3. Click the **PRINT INVESTIGATION** button. The “Print Case Investigation” window appears.

4. Click one of the following buttons:

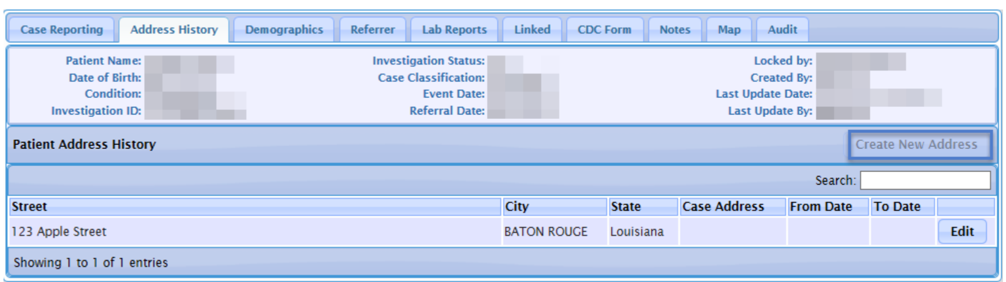
   - **SEND TO PRINTER** – sends the case summary to your local printer. A “Print” dialog box may appear for you to select the printer.

   - **CLOSE THE WINDOW** – closes the “Print Case Investigation” window and redisplays the previous window.

ADDRESS HISTORY TAB

The “Address History” tab contains all address information associated with a patient.

Figure 5-21: Address History Tab



You can perform the following from the “Address History” tab:

- Create a new address
- Edit an address
- Print the investigation

The following table describes the “Address History” tab fields. All the columns on this screen are read-only. Refer to the section titled, “Impact of Changing Address Information” for more information.

Table 5-7: Address History Tab Fields

FIELD	DESCRIPTION
CREATE NEW ADDRESS	Displays the “Address Information” screen. Refer to “Creating a New Address” for information on creating a

FIELD	DESCRIPTION
BUTTON	new address. This button only appears if: • There is no address currently associated with the patient. • There is an address associated with the patient and that address has a defined date range.
STREET	Street name of the patient's address.
CITY	City of the patient's address.
STATE	State name of the patient's address.
CASE ADDRESS	The application will automatically calculate the "Case Address" based on the following information: • Will be the Patient's address if the "From/To Dates" for the address fall around the case's "Event Date." If there are no valid dates, the address is considered to be current and is assumed the address is the same as what was provided at the "Event Date." • If there is no home address, but instead a mailing address is in place, it will be used as the "Investigation Address." • If there is no patient address, the Physician's (Referrer) address is used.
FROM DATE AND TO DATE	**FROM DATE** is the date the patient took residence at the address. **TO DATE** is the date the patient left the provided address. A blank **FROM DATE** is considered to be prior to the case investigation and a blank **TO DATE** is considered to be the current date. These dates are compared to the Onset Date (or the Referral Date if the Onset Date is unavailable) when determining the investigation address. When a single address exists, the system leaves the **TO DATE** and **FROM DATE** empty. This implies that the address is valid and has been valid throughout the duration of the case investigation. Once another address is present within the address history, the system must be told when the address became effective. This is done by supplying the address "To"

FIELD	DESCRIPTION
	and "From" date information. Before adding a new address, you must designate the **TO DATE** and **FROM DATE** of each existing address. This can be accomplished by editing the existing addresses. Type the date or click the calendar to select a date.

Impact of Changing Address Information

Changes to the address information listed in the following table can cause the case to be referred to another jurisdiction.

Table 5-8: Impact on Address History Changes

Change	Impact
ADDRESS	If you change any of the following address information, Sentinel re-examines the case for the best possible address source (in the order below) to establish the case investigation addresses: • Will be the Patient's address if the From/To dates for the address fall around the case's "Event Date." • If there are no valid dates, the address is considered to be current and is assumed the address to be the same as what was provided at the "Event Date." • If there is no home address, but instead a mailing address is in place, it will be used as the "Investigation Address." • If there is no patient address, the Physician's (Referrer) address is used. Sentinel automatically attempts to geocode the investigation address after a change has been made; this may result in a change of jurisdiction if the new address is in a distinct jurisdiction. For example, providing a patient's home address where previously only a provider's address in a distinct jurisdiction was available, results in referral to the patient's jurisdiction. A referred case is no longer listed within the "Case Listings" of the original jurisdiction, but now appears in

Change	Impact
	the "Case Listings" of the appropriate jurisdiction. If the patient has/had previous public health case investigations, changes to address history information may also affect the jurisdiction of those cases. After a case is changed to out of state, the jurisdiction becomes "statewide" so the local user will not be able to view it.
TO/FROM DATES	When adding a new address or editing an existing address, the "To" and "From" dates must not overlap.

CREATING A NEW ADDRESS

Refer to the section titled, "Impact of Changing Address Information" before creating a new address.

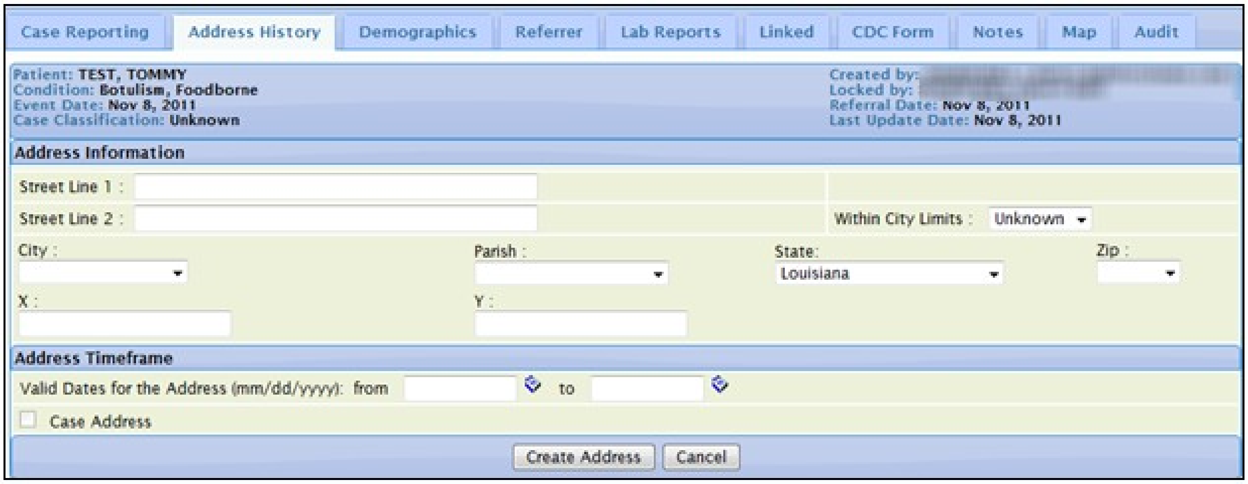
You can only create a new address under the following conditions:

- If there is no address currently associated with the patient.
- If there is an address associated with the patient and that address has a defined date range.

To create a new address, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.
2. Locate the case for which you want to create an address and click the **EDIT** button. The "Case Reporting" tab appears.
3. Click the "Address History" tab. The entire "Address History" tab appears.
4. Click the **CREATE NEW ADDRESS** button. The "Address Information" screen appears.

Figure 5-22: Creating a New Address



5. Using the following table as a guide, make the desired changes.

Table 5-9: Address Information Screen Fields

FIELD	DESCRIPTION
ADDRESS INFORMATION	
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the street address.
CITY	City of the new address.
COUNTY/BOROUGH OF RESIDENCE OR PARISH	County, Borough, or Parish of the new address.
STATE	State name of the new address.
ZIP	Zip code of the new address.
GEOCODE SOURCE	Source of the geocoding. For example, ArcIMS.
COORDINATES X	Manually-entered latitude of the address (this value **is not** filled in when an address is geocoded).
COORDINATES Y	Manually-entered longitude of the address (this value **is not** filled in when an address is geocoded).

ADDRESS TIMEFRAME	
FROM/TO	Date range for the specific address is valid. Type the beginning date (From Date) and ending date (To Date). If there is more than one address and the following is entered: • Address 1 "To Date" earlier than "Event Date" and flagged as "Case Address" • Address 2 "From Date" earlier than "Event Date" This would result in Address 2 becoming the Investigation Address (address, jurisdiction, and case address) or the "Case Address."
CASE ADDRESS (CHECKBOX)	The case address is calculated based on the "Event Date" and the address that is actually in effect at the time of the Event Date. This is a read-only field. If the checkbox is checked, the date range that the address is valid is using the "Case Address." An "X" will appear on the Address History Tab in the "Case Address" column.

6. Click one of the following buttons:
   - **CREATE ADDRESS** – saves the address. A dialog box appears indicating that you changed data that could affect the case assignment.

a) Click the **OK** button to save and continue to the "Address History" tab.

b) Click the **CANCEL** button to not save and remain on the "Address Information" screen.

- **CANCEL** – terminates the process of adding a new address and returns you to the "Address History" tab. If you entered any information, a dialog box appears asking you to verify you want to cancel.

  a) If you click the **OK** button, you will lose any data that you have input and return to the "Address History" tab.

  b) If you click the **CANCEL** button, you will remain on the "Address Information" screen with the data you entered intact.

EDITING AN ADDRESS

Refer to the section titled, "Impact of Changing Address Information" before editing an address.

Note: If the patient has or had previous public health case investigations, changes to the address history information can also affect the jurisdiction of those cases; whereby, preventing the user to view the case after the change.

To edit an existing address, perform the following:

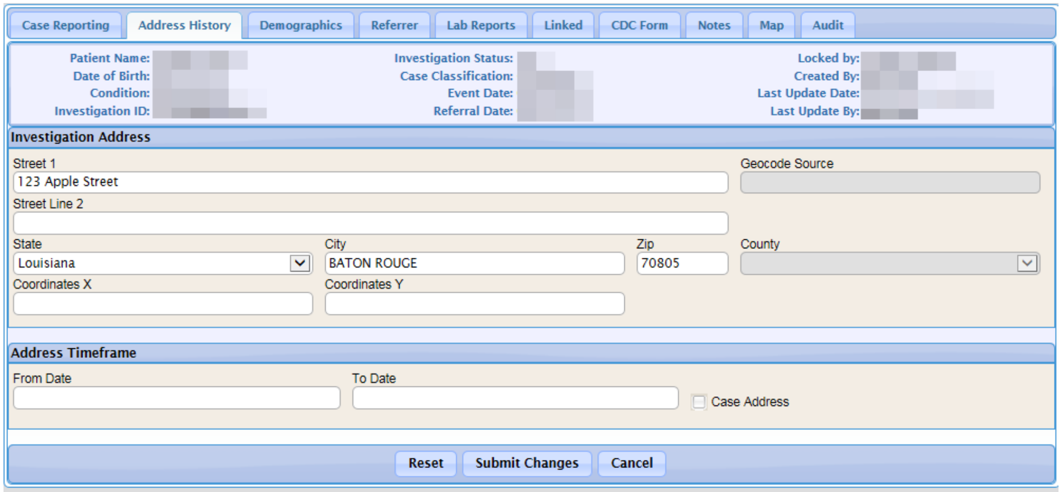
1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case for which you want to edit an address and click the **EDIT** button. The "Case Reporting" tab appears.

3. Click the "Address History" tab. The entire "Address History" tab appears.

4. Locate the address you want to edit (there may be multiple addresses) and click the **EDIT** button. The "Address Information" screen appears with the current address information.

Figure 5-23: Case Address - Edit



Note: If the new address is outside a user's jurisdiction area and depending on the user roles/permissions, the case will no longer appear in their "Case Listings" and thus, will not be able to view the case.

5. Using "Table 5-9: Address Information Screen Fields" as a guide, make the desired changes.

6. Click one of the following buttons:

- **RESET** – erases any changes you made and remains on the "Address Information" screen.
- **SUBMIT CHANGES** – begins a validation process and if there are no errors, saves the changes you made and returns to the "Address History" tab.
- **CANCEL** – terminates the process of editing and returns to the "Address History" tab. If you changed any case information, a dialog box appears asking if you are sure you want to cancel.

  a) If you click the **OK** button, you will lose any edits you just made and you return to the "Address History" tab.

  b) If you click the **CANCEL** button, you remain on the "Address Information" screen with the values you entered intact.

DEMOGRAPHICS TAB

You can change the following information on the "Demographics" tab:

- Sex, race, and ethnicity
- Date of birth/age
- Mailing address
- Parent/guardian information (if patient is under the age of 18)
- Work/school, occupations/grade information
- Travel history

EDITING DEMOGRAPHICS INFORMATION

To edit the demographics information, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.
2. Locate the case for which you want to edit demographics information and click the **EDIT** button. The "Case Reporting" tab appears.
3. Click the "Demographics" tab. The "Demographics" tab appears.

Figure 5-24: Referrer Tab

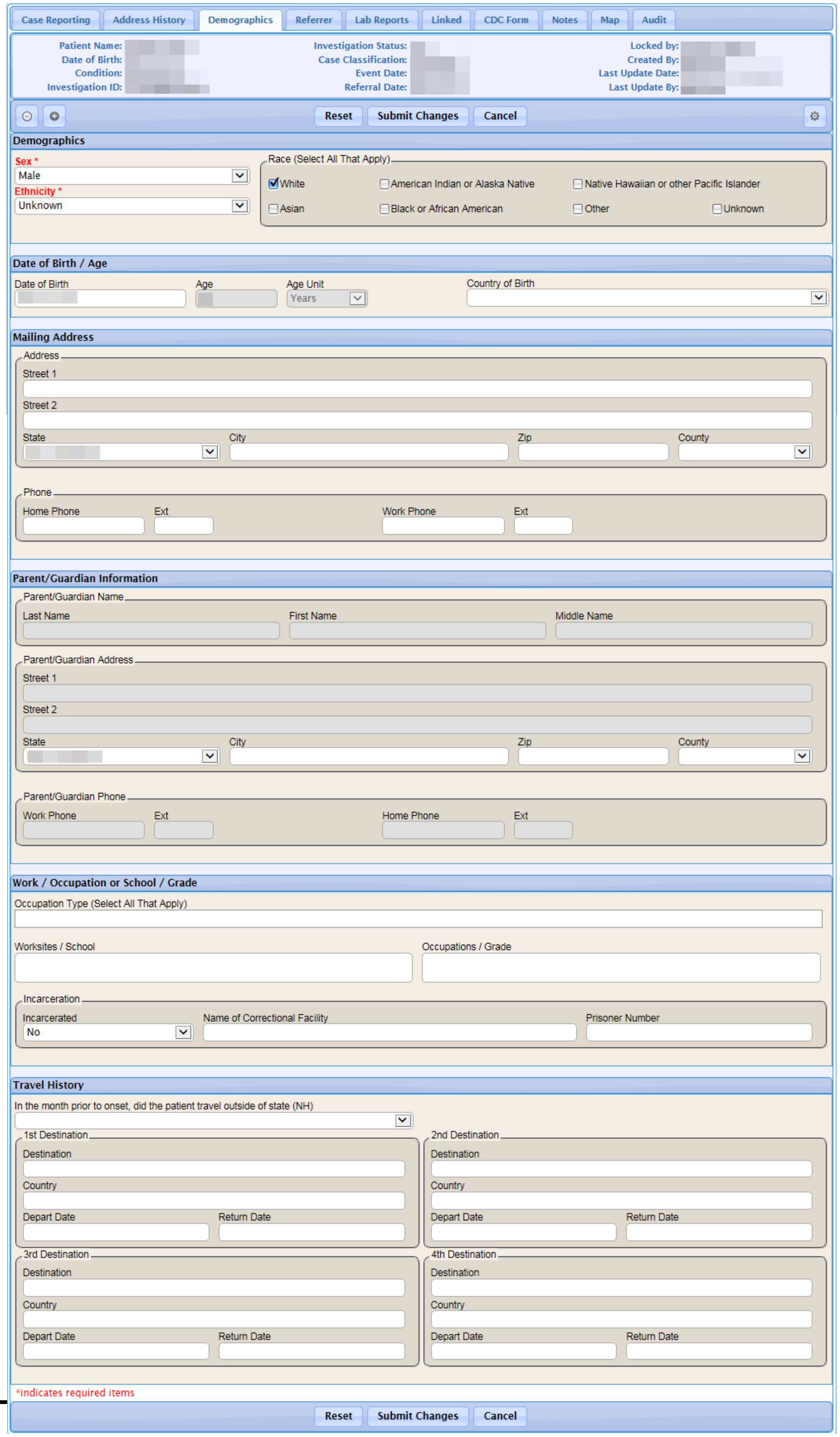

Case Reporting
Address History
Demographics
Referrer
Lab Reports
Linked
CDC Form
Notes
Map
Audit
Patient Name:
Date of Birth:
Condition:
Investigation ID:
Investigation Status:
Case Classification:
Event Date:
Referral Date:
Locked by:
Created By:
Last Update Date:
Last Update By:
Reset
Submit Changes
Cancel
Demographics
Sex *
Male
Ethnicity *
Unknown
Race (Select All That Apply)
White
American Indian or Alaska Native
Native Hawaiian or other Pacific Islander
Asian
Black or African American
Other
Unknown
Date of Birth / Age
Date of Birth
Age
Age Unit
Years
Country of Birth
Mailing Address
Address
Street 1
Street 2
State
City
Zip
County
Phone
Home Phone
Ext
Work Phone
Ext
Parent/Guardian Information
Parent/Guardian Name
Last Name
First Name
Middle Name
Parent/Guardian Address
Street 1
Street 2
State
City
Zip
County
Parent/Guardian Phone
Work Phone
Ext
Home Phone
Ext
Work / Occupation or School / Grade
Occupation Type (Select All That Apply)
Worksites / School
Occupations / Grade
Incarceration
Incarcerated
No
Name of Correctional Facility
Prisoner Number
Travel History
In the month prior to onset, did the patient travel outside of state (NH)
1st Destination
Destination
Country
Depart Date
Return Date
2nd Destination
Destination
Country
Depart Date
Return Date
3rd Destination
Destination
Country
Depart Date
Return Date
4th Destination
Destination
Country
Depart Date
Return Date
*indicates required items
Reset
Submit Changes
Cancel

Figure 5-24: Demographics Tab

4. Using the following table as a guide, make the desired changes.

Table 5-10: Demographics Fields

FIELD	DESCRIPTION
DEMOGRAPHICS	
SEX	Gender of the patient. Click the drop-down menu arrow to view/select a valid choice. Examples are: • Female • Male • Not Reported • Other
ETHNICITY	Ethnicity of the patient.
RACE	Race of the patient. There are two boxes; the one on the left contains the "Selected Items;" the one on the right contains the "Available Items." All races will be listed in the "Available Items" multi-selection box. Click each one that applies by clicking the plus sign (+). That choice will be moved to the "Selected Items" box. To add all races, click the **ADD ALL** hyperlink. To remove an item from the "Selected Items" box, click the minus sign from the "Selected Items" box. That choice will be moved to the "Unselected Items" Race box. To remove all selected races, click the **REMOVE ALL** hyperlink.
DATE OF BIRTH / AGE	
DATE OF BIRTH (MM/DD/YYYY)	Patient's data of birth, if available. Type the date or use the calendar icon to select a date. If patient's date of birth is not available, use the **AGE** field.
AGE (IF DATE OF BIRTH UNKNOWN)	Approximate age of the patient at time of disease onset. If the date of birth is not known, enter an age value in the **AGE** field and then enter an age unit value in the **AGE UNIT** field. Since **AGE** does not reflect the

FIELD	DESCRIPTION
	exact age of the patient, it does not vary over time.
AGE UNIT	Pertains to the measurement of the age of the patient at disease onset (in days, months, or years). If the **DATE OF BIRTH** is not supplied, **AGE UNIT** can be entered directly. However, if the **AGE** is calculated, Sentinel determines the **AGE UNIT**, where: • **AGE UNIT** = Days if the calculated **AGE** is less than a calendar month increment of the **DATE OF BIRTH**. • **AGE UNIT** = Months if calculated **AGE** is less than 2 years. • **AGE UNIT** = Years if the calculated **AGE** is greater than or equal to 2 years.
COUNTRY OF BIRTH	Country where the patient was born.
MAILING ADDRESS INFORMATION	
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the mailing address.
STATE	State name of the patient's home address. Click the drop-down menu arrow to view/select a state. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
CITY	City of the patient's home address. First, choose a state, and then begin to type the first four letters of the City name and a "pop up" list of City names and zip codes appears. Point and click a city name/zip to select it. The City, Zip Code, and County fields will populate with the stored information. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
ZIP	Zip code of the patient's home address. This field is automatically populated by choosing the City field.

FIELD	DESCRIPTION
	Note: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
COUNTY/BOROUGH OR PARISH	County, Borough, or Parish of the mailing address. Click the drop-down menu arrow to view/select a County/Borough or Parish. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
WORK PHONE/ EXT	Daytime telephone number and an extension, if applicable, of the patient's mailing address.
HOME PHONE/ EXT	Evening telephone number (or cell phone number) and an extension, if applicable, of the patient's mailing address.
PARENT/GUARDIAN	
LAST NAME	Last name of the patient's parent or guardian.
FIRST NAME	First name of the patient's parent or guardian.
MIDDLE NAME	Middle name of the patient's parent or guardian.
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the patient's parent or guardian.
STATE	State name of the patient's parent or guardian. Click the drop-down menu arrow to view/select a state. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
CITY	City of the patient's parent or guardian. First, choose a state, and then begin to type the first four letters of the City name and a "pop up" list of City names and zip codes appears. Point and click a city name/zip to

FIELD	DESCRIPTION
	select it. The City, Zip Code, and County fields will populate with the stored information. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
ZIP	Zip code of the patient's parent or guardian. This field is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
COUNTY /BOROUGH OR PARISH	County, Borough, or Parish of the patient's parent or guardian. This is automatically populated when choosing a City/Zip Code. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
WORK PHONE/ EXT	Daytime telephone number and an extension, if applicable, of the patient's parent or guardian.
HOME PHONE/ EXT	Evening telephone number and an extension, if applicable, of the patient's parent or guardian.
WORK/OCCUPATION OR SCHOOL/GRADE	
OCCUPATION TYPE	All occupation types will be listed in the list box. Occupations such as Correctional Staff, Daycare worker, Healthcare worker, retired, and Unknown. Click all applicable choices. • To **select one option**, click it. • To **select a sequential list of options**, click the first option of the sequence, press and hold the SHIFT key, and then click the last option of the sequence. • To **select options that are not in sequence**, click the first option you want to select, press

FIELD	DESCRIPTION
	and hold the CTRL key, and then click each additional option you want to select. • To **deselect specific options after you have selected multiple options (in or out of sequence)**, press and hold the CTRL key, and then click the options you want to deselect. The deselected options are longer be highlighted. • To **deselect multiple selections and select only one option**, click the option you want to select. • To **deselect all options**, press and hold the CTRL key, and then click any option in the list.
WORKSITES/ SCHOOL	Additional details about the worksite or school (based on the type of occupation selected in the **OCCUPATION TYPE** field) relating to possible sources of exposure or the spread of a disease.
OCCUPATIONS/ GRADE	Additional details about the worksite occupation or school grade (based on the type of occupation selected in the **OCCUPATION TYPE** field) relating to possible sources of exposure or the spread of a disease.
INCARCERATED	Whether the patient was incarcerated (**YES** or **NO**).
NAME OF CORRECTIONAL FACILITY	Name of the correctional facility if you selected **YES** in the **INCARCERATED** field.
PRISONER NUMBER	Prisoner number of the patient if you selected **YES** in the **INCARCERATED** field.
TRAVEL HISTORY	
IN THE MONTH PRIOR TO ONSET, DID THE PATIENT TRAVEL OUTSIDE OF STATE (MS) :	(State Configurable – MS) Indicates whether the patient travelled outside of the state. Click the drop-down menu arrow to view/select a valid choice. Choices are: • Yes • No • Unknown

FIELD	DESCRIPTION
DESTINATION	Locations (four different fields) the patient visited.
COUNTRY	Name of the countries (four different fields) of the destinations the patent visited.
DEPART DATE	Start date (four different fields) that the patient visited the destinations. Type the date or use the Calendar Icon to select a date.
RETURN DATE	End date (four different fields) that the patient returned from visiting the destinations. Type the date or use the Calendar Icon to select a date.

5. Click one of the following buttons:

Note: The "Reset," "Submit Changes," and "Cancel" buttons appear at the top and bottom of this window.

- **RESET** – erases any changes you made and remains on the "Demographics" tab.
- **SUBMIT CHANGES** – begins a validation process and if there are no errors, saves the changes you made and you remain on the "Demographics" tab.
- **CANCEL** – terminates the process of editing and returns to the "Case Listings" screen. If you have changed any case information, a dialog box appears asking if you are sure you want to cancel.
  - **a)** If you click the **OK** button, you will lose any edits you just made and you return to the "Case Listings" screen.
  - **b)** If you click the **CANCEL** button, you remain on the "Demographics" tab with the values you entered intact.

Referrer Tab

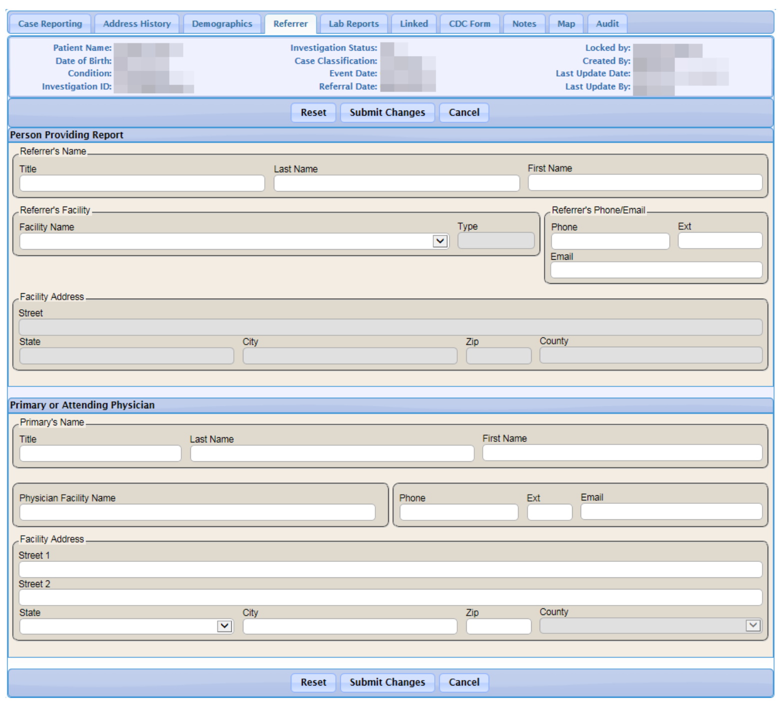
The “Referrer” tab allows you to view/edit details on the person providing the report and the attending/primary physician.

Editing Referrer Information

To edit referrer information, perform the following:

1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.
2. Locate the case for which you want to edit referrer information and click the **EDIT** button. The “Case Reporting” tab appears.
3. Click the “Referrer” tab. The entire “Referrer” tab appears.

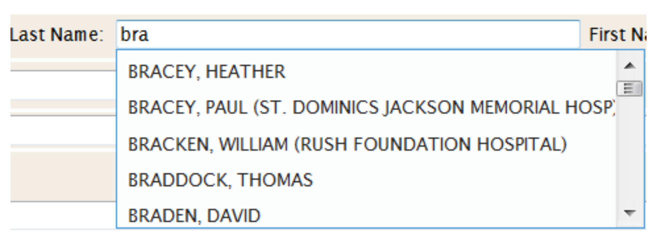
Figure 5-25: Referrer Tab



4. Using the following table as a guide, make the desired changes.

Table 5-11: Referrer Tab Fields

FIELD	DESCRIPTION
PERSON PROVIDING REPORT	
TITLE	Title of the person providing the report.
LAST NAME	Last name of the person providing the report.
FIRST NAME	First name of the person providing the report.
PHONE/EXT	Phone number and extension, if applicable, of the person providing the report.
EMAIL	Email address of the person providing the report.
FACILITY NAME	Name of the facility of the person providing the report. When you select a facility from this drop-down menu, the following fields are automatically filled in: • Reporting Facility ID • Type of Facility • Hospital Region/District • Street • City • County • State • Zip **Note**: For Electronic Lab Reports, the "Name of Reporting Facility" will match the "Sending Laboratory Name."
TYPE	A facility can be of more than one type. For example, Central Hospital (facility name) can be a hospital or a lab (facility types).

FIELD	DESCRIPTION
HOSPITAL REGION/DISTRICT	Geographic grouping of hospitals into bioterrorism regions/districts. This is a read-only field.
STREET	Street address of the person providing the report.
CITY	City of the person providing the report.
COUNTY/BOROUGH OR PARISH	County, Borough, or Parish of the person providing the report.
STATE	State name of the person providing the report.
ZIP	Zip code of the person providing the report.
PRIMARY OR ATTENDING PHYSICIAN	
TITLE	Title of the primary or attending physician.
LAST NAME	Last name of the primary or attending physician. Begin to type the first letters of the Physician's first or last name and a "pop up" list of Physician Names appears. Point and click a name to select it. The remaining physician fields will populate with the stored information. 
FIRST NAME	First name of the primary or attending physician. Begin to type the first letters of the Physician's first or last name and a "pop up" list of Physician Names appears. Point and click a name to select it. The remaining physician fields will populate with the stored information.

PHYSICIAN FACILITY NAME	Name of the Facility that the Primary or Attending Physician are affiliated with.

FIELD	DESCRIPTION
PHONE/EXT	Phone number and extension, if applicable, of the primary or attending physician.
EMAIL	Email address of the primary or attending physician.
STREET LINE 1 **STREET LINE 2**	Street address of the primary or attending physician.
STATE	State name of the primary or attending physician. Click the drop-down menu arrow to view/select a state. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
CITY	City of the patient's home address. First, choose a state, and then begin to type the first four letters of the City name and a "pop up" list of City names and zip codes appears. Point and click a city name/zip to select it. The City, Zip Code, and County fields will populate with the stored information. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
ZIP	Zip code of the patient's home address. This field is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
COUNTY/BOROUGH OR PARISH	County, Borough, or Parish of the primary or attending physician. This is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.

5. Click one of the following buttons:

- **RESET** – erases any changes you made and remains on the “Referrer” tab.
- **SUBMIT CHANGES** – begins a validation process and if there are no errors, saves the changes you made and you remain on the “Referrer” tab.
- **CANCEL** – terminates the process of editing and returns to the “Case Listings” screen. If you have changed any case information, a dialog box appears asking if you are sure you want to cancel.

  a) If you click the **OK** button, you will lose any edits you just made and you return to the “Case Listings” screen.

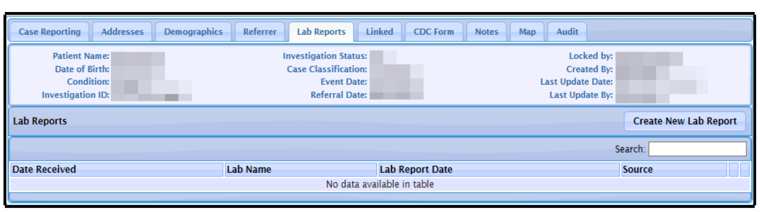
  b) If you click the **CANCEL** button, you remain on the “Referrer” tab with the values you entered intact.

LAB REPORTS TAB

The “Lab Reports” tab contains summary information for each laboratory report (tests used to diagnose the disease) associated with the patient, not just the case.

Note: If you are using the “Health Care Facility (HCF) Reporting” application, all HCF case information will be available in the Sentinel Application including Lab Reports. The HCF Lab Reports are available from the “Case Listing-Lab Reports” screen via the **VIEW HOSPITAL LAB** button.

Figure 5-26: Lab Reports Tab



The following table describes the “Lab Reports” tab fields.

Table 5-12: Lab Report Fields

FIELD	DESCRIPTION
CREATE NEW LAB REPORT (BUTTON)	Displays the "Lab Order Information" screen, which allows you to create a new manual lab report. Refer to the section titled, "Creating a Manual Lab Report" for more information.
DATE RECEIVED	Date the lab report was received.
LAB NAME	Clinical Laboratory Improvement Amendments (CLIA) name for the laboratory where the specimen was tested.
LAB REPORT DATE	Date the lab report was completed.
ELECTRONIC	Whether the lab test was electronic (ELR) or manual. • Yes = Electronic (ELR) • No = Manual

You can perform the following on the "Lab Reports" tab:

- View lab reports (manual or electronic)
- Create a manual lab report
- Edit a manual lab report
- Delete a manual lab report

VIEWING ALL LAB REPORTS

A patient can be the subject of multiple cases; therefore, any changes or additions to laboratory reports will appear on all cases for that patient, not just the case with which you are currently working.

You can enter laboratory tests into Sentinel from two sources:

- Electronically via an HL7 import

- Manually via the "Lab Reports" tab

You can view both electronic and manual lab reports from the "Lab Reports" tab.

To view lab reports, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.
2. Locate the case with the lab reports you want to view/edit and click the **EDIT** button. The "Case Reporting" tab appears.
3. Click the "Lab Reports" tab. The entire "Lab Reports" tab appears, displaying all the lab reports for that case. Refer to Figure 5-26 for an illustration.

VIEWING ELECTRONIC LAB REPORTS

When the State Public Health Laboratory confirms the diagnosis of a disease name, the laboratory sends this information to the application in the form of an Electronic Laboratory Report (ELR). The ELR file is formatted using HL7 v. 2.3.z. ELRs are read-only; you cannot change them, but they can be deleted if they were appended/created incorrectly.

Alaska's ELR data comes in a file that is caret (**^**) delimited with the exception of the patient's first and last names. The first and last names are separated by a comma and processed by Diplomat so that the first and last names come in together into the AK STARS application. Now, Diplomat has been modified so that the first and last names are split into two separate fields and therefore, can be processed correctly in the AK STARS application.

Note: Sentinel can accept electronic laboratory reports from commercial laboratories, provided they are formatted consistently with the HL7 v. 2.3.z.

ELR files are processed several times per day via a background process that requires no intervention. The background process checks for the existence of an ELR file and processes the records contained in the file.

Note: If an ELR is received with an invalid state abbreviation, the state will display "Unknown."

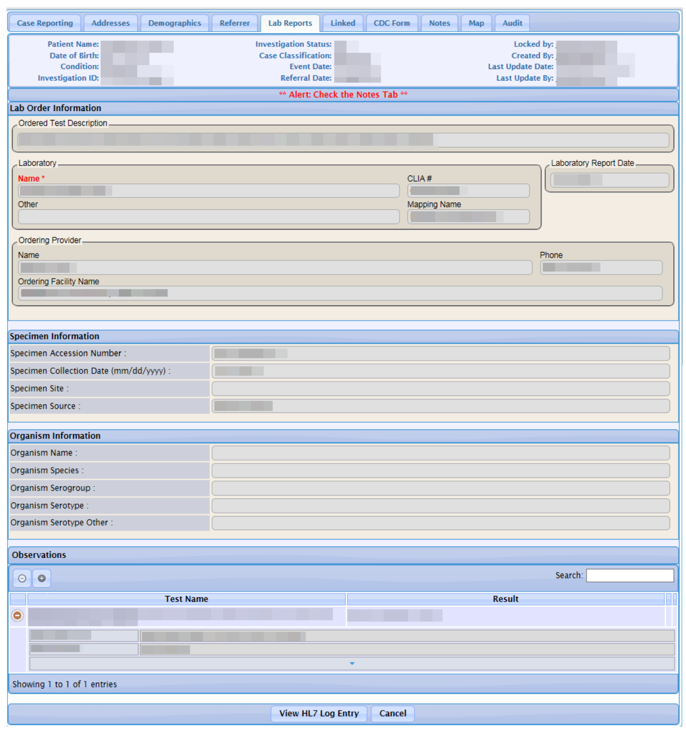
Each record that is received within an ELR file undergoes the same QA procedures (Geocoding and Deduplication) as manually entered cases. Therefore, an ELR can create a new case within Sentinel or it can provide information to an existing case.

Note: For Electronic Lab Reports, the "Name of Reporting Facility" will match the "Sending Laboratory Name."

To view an electronic lab report, perform the following from the "Lab Reports" Tab:

1. From the "Lab Reports" Tab, locate the Electronic Lab Report by looking at the Electronic column containing "Yes" and click on the **VIEW** button. The "Lab Order Information" screen appears.

Figure 5-27: Lab Reports – Electronic Lab Information



Note: When the lab report is an electronic lab report, all field values on the “Lab Order Information” screen appear grayed out indicating that changes are not allowed. To exit, click the **CANCEL** button.

2. Refer to Table 5-14 for a list of field descriptions.

3. Click one of the available buttons:

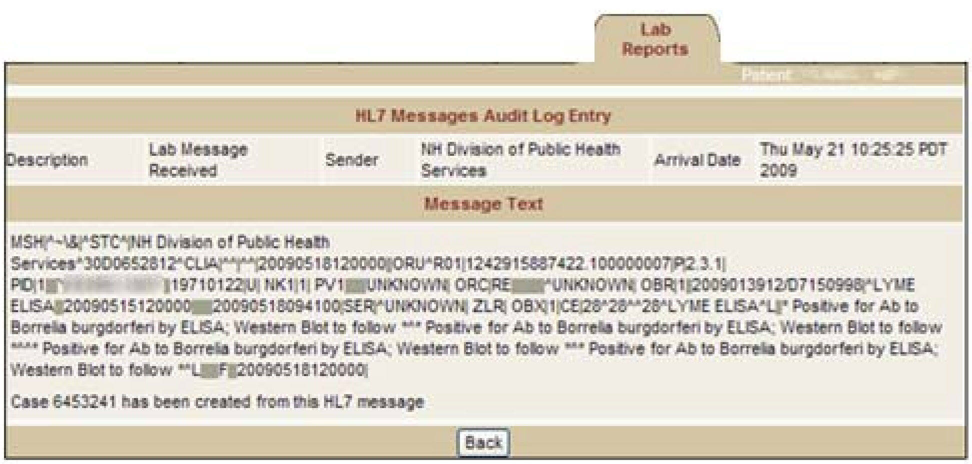
- **RESET** – to erase any newly entered data back to the point of the previous save.
- **VIEW HL7 LOG ENTRY** – to view the electronic lab report HL7 entity. Refer to the section titled, “Viewing the Electronic HL7 Log Entry” for additional information.
- **CANCEL** – to return to the previous window.

VIEWING THE ELECTRONIC HL7 LOG ENTRY

To view the Electronic Lab Reports HL7 entity, perform the following:

1. On the “Lab Reports – Electronic Lab Information” screen, click the **VIEW HL7 LOG ENTRY** button. The “HL7 Messages Audit Log Entry” screen appears.

Figure 5-28: HL7 Messages Audit Log Entry



2. The fields and their descriptions are listed in the table.

Table 5-13: HL7 Messages Audit Log Entry

FIELD	DESCRIPTION
DESCRIPTION	Description of the type of Message Received.
SENDER	Name of the Entity sending the Message
ARRIVAL DATE	Day, Date, and Timestamp of the Message.
MESSAGE TEXT	Context of the Message followed by the result of the Message, such as: • Case XXXX has been created from this HL7 Message • Lab Report appended to Case XXXX • This is a duplicate Lab Report already in Case XXXX • Blank indicates a Pending Work Queue Item has been created. Refer to the section titled, "Pending Work Queue" for more information.

3. Click the **BACK** button to return to the previous window.

ELR - SNOMED Codes

Systematized Nomenclature of Medicine (SNOMED) codes, where available, are sent within the Electronic Laboratory Reports. Within Sentinel, these codes are associated to a disease name. If a laboratory report does not have a SNOMED code or the SNOMED code does not relate to a disease name, the laboratory report is assigned to the administrator for review in the **Pending Work Queue**.

ELR—New Case Assignment

When a new case is initiated from an electronic laboratory report (ELR), the case must be assigned to a jurisdiction and to an investigator. In addition, electronic laboratory reports that are associated with an existing case may provide dissimilar address information. Case assignment and jurisdiction determination for electronic laboratory report are handled as follows:

- If an ELR is associated with a case and the laboratory report contains patient or physician address information that is different from the patient or physician address information within the associated case, the investigation address could be affected along with the case assignment and jurisdiction.
- If an ELR cannot be associated with an existing case and it does not contain address information, a new case is created and assigned to the state.
- If an ELR cannot be associated with an existing case and it does not contain patient or physician address information but it does contain the laboratory address, a new case is created using the laboratory address for jurisdiction determination and case assignment.

DELETING ELECTRONIC LAB REPORTS (ELR)

To delete an ELR that was inadvertently appended or created, perform the following:

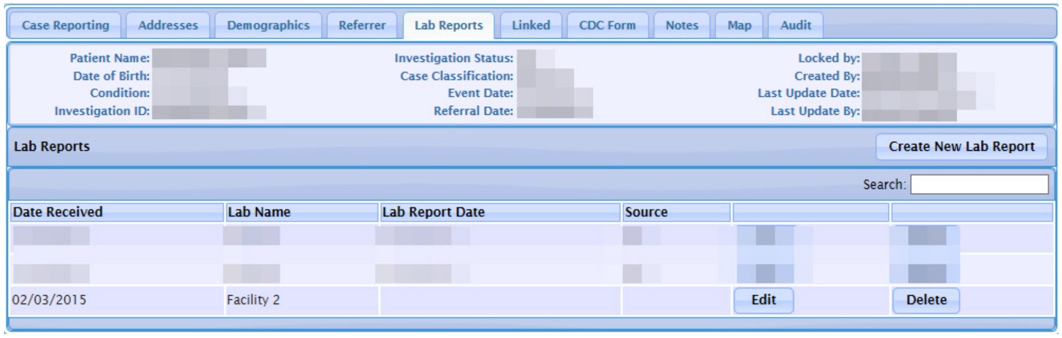
1. From the "Case Listings" window, locate the case to be deleted by viewing the ELR column; it should contain an "**X**."
2. Click the **EDIT** button. The "Case Details" window appears.
3. Click the **LAB REPORTS** tab. Locate the Lab Report to delete and click the corresponding **DELETE** button. A confirmation dialog box appears asking "Are you sure you want to delete dialog box?"
4. Click the **OK** to confirm deletion; otherwise, click the **CANCEL** button to abort deletion.

VIEWING/EDITING MANUAL LAB REPORTS

A manual lab report is a laboratory report that you enter directly into the "Lab Reports" tab of an existing case.

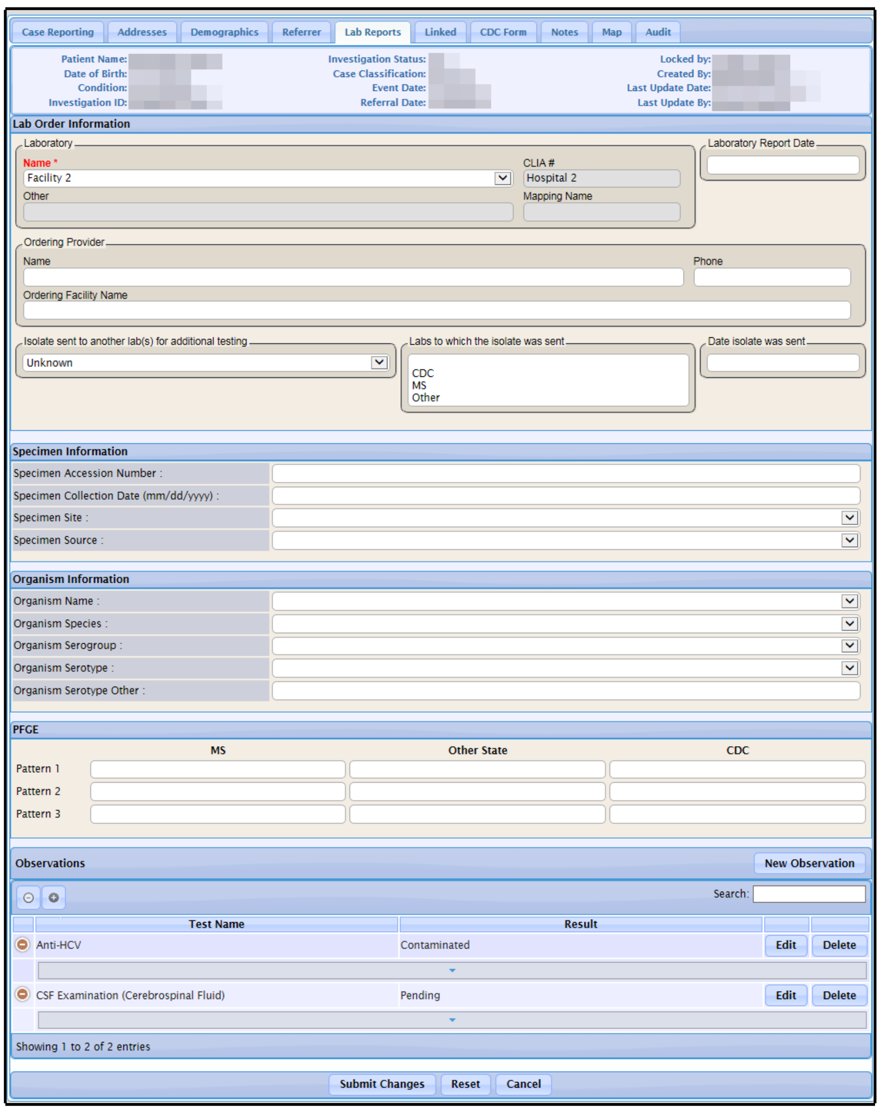
1. From the "Lab Reports" Tab, locate the Manual Lab Report by looking at the Electronic column containing "No" and click on the **VIEW** and/or **EDIT** button. The "Lab Reports" screen appears.

Figure 5-29: Manual Lab Reports



2. Click the **VIEW** or **EDIT** button. The "Lab Order Information" screen appears.

Figure 5-30: Manual Lab Order Information



3. If you are viewing, no changes/edits can be made.

4. Click one of the available buttons:

- **CANCEL** – to return to the previous window.
- **RESET** – to erase any newly entered data back to the point of the previous save.
- **SUBMIT CHANGES** – to save any changes made and return to the previous window.

CREATING A MANUAL LAB REPORT

You create a manual lab report using the “Lab Order Information” screen, which is accessible from the “Lab Reports” tab.

Note: Facility users have access to create non-human cases and add lab reports. The lab reports are visible to the Facility user until a non-facility user updates the lab report.

To create a manual lab report, perform the following:

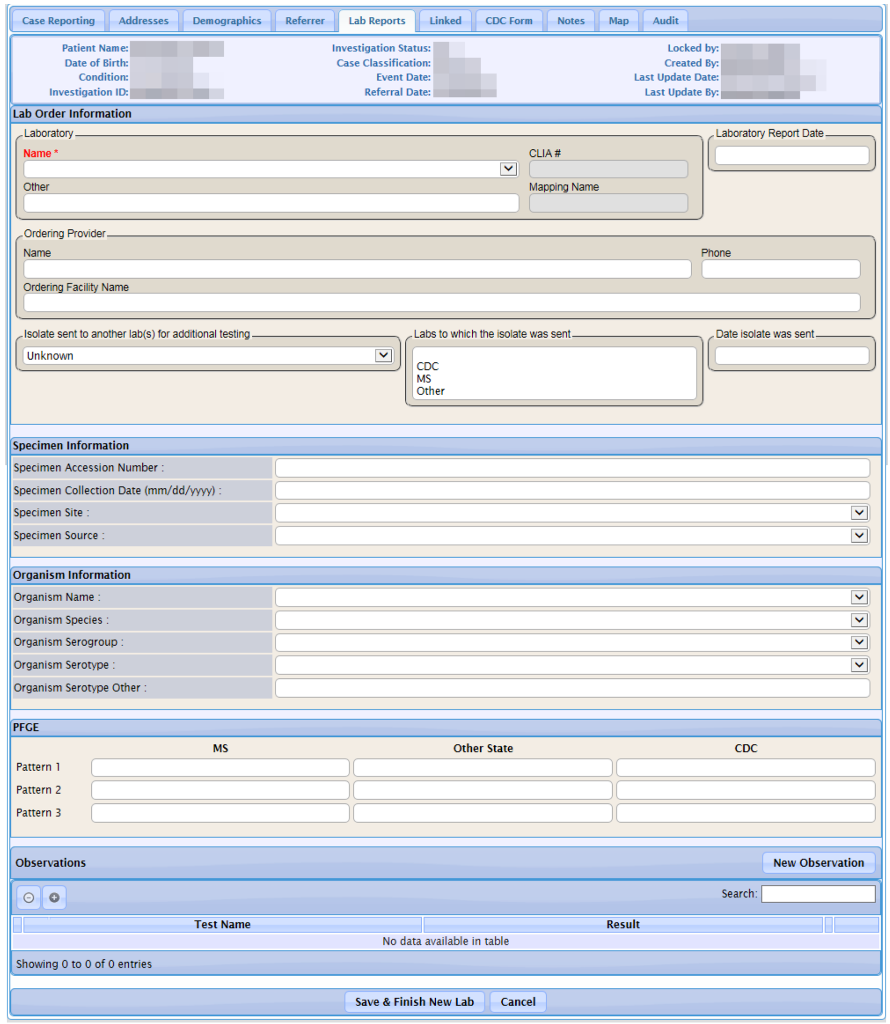
1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.

2. Locate the case for which you want to create a manual lab report and click the **EDIT** button. The “Case Reporting” tab appears.

3. Click the “Lap Reports” tab. The entire “Lab Reports” tab appears.

4. Click the **CREATE NEW LAB REPORT** button. The “Lab Order Information” screen appears.

Figure 5-31: Manual Lab Report - Create New Lab Order Information



5. Using the following table as a guide, make the desired changes. At a minimum, fill in the **RED** labeled field(s).

Table 5-14: Lab Order Information Screen Fields

FIELD	DESCRIPTION
LAB ORDER INFORMATION	
TEST DESCRIPTION	Electronic Laboratory Test Description. Only appears on the Electronic Lab Information.
LABORATORY NAME	Clinical Laboratory Improvement Amendments (CLIA) name for the laboratory

FIELD	DESCRIPTION
	where the specimen was tested. Click on the drop-down menu to view/select a valid choice. Sentinel accepts a **LABORATORY NAME** value of **UNKNOWN** for lab reports where detailed source information has not been determined. **Note**: Once the Laboratory Name has been entered, it cannot be changed.
CLIA #	Clinical Laboratory Improvement Amendments (CLIA) number for the laboratory where the specimen was tested.
LAB NAME OTHER	Free-form text field where you can enter the name of the lab if it is not available from the **LABORATORY NAME** drop-down menu.
LAB REPORT DATE	Date the lab report was completed. Use the format mm/dd/yyyy or click the calendar and select a date.
LOINC/SNOMED MAPPING NAME	This field remains blank for manual lab reports but will contain the name of the Mapping for new Electronic Lab Reports if set in the Facility. **Note**: This field will not contain a mapping name if the mapping has not been added to the Facility; thus, when adding a Result, the Reported Test Name and Coded Result fields may not contain the expected drop-down menu lists.
ORDERING PROVIDER NAME	Person, typically the physician, who ordered the lab report.
ORDERING PROVIDER PHONE	Phone number of the person who ordered the lab report.
ORDERING FACILITY NAME	Facility, such as a hospital, physician's office, clinic, etc., that ordered the lab report.

FIELD	DESCRIPTION
ISOLATE SENT TO ANOTHER LAB(S) FOR ADDITIONAL TESTING	Indicates if the isolate was sent to another lab for testing (**YES**), not sent (**NO**), or **UNKNOWN**.
LABS TO WHICH THE ISOLATE WAS SENT	Lab to which the isolate was sent if you selected **YES** in the **ISOLATE SENT TO ANOTHER LAB(S) FOR ADDITIONAL TESTING** field.
DATE ISOLATE WAS SENT	Date the isolate was sent to the other lab if you selected **YES** in the **ISOLATE SENT TO ANOTHER LAB(S) FOR ADDITIONAL TESTING** field.
SPECIMEN INFORMATION	
SPECIMEN ACCESSION NUMBER	Number of the specimen in succession order.
SPECIMEN COLLECTION DATE	Date the specimen was collected for testing. Use the format mm/dd/yyyy or click the calendar and select a date.
SPECIMEN SITE	Anatomical site from which the human specimen was collected.
SPECIMEN SOURCE	Origin of the specimen/sample (e.g., Amniotic fluid, Aspirate, Biopsy/Tissue, etc.).
ORGANISM INFORMATION	
ORGANISM NAME	Name of the organism.
ORGANISM SPECIES	Fundamental category of taxonomic classification, ranking below a genus or subgenus and consisting of related organisms capable of interbreeding. Example: For *Herpes simplex*, *Herpes* is the genus name and *Herpes simplex* describes a species (or category) of Herpes virus. Click the drop-down menu arrow to

FIELD	DESCRIPTION
	view/select a valid choice. Samples of choices are: • Abortus • Agalactiae • Beta
ORGANISM SEROGROUP	Used when an organism may have a serogroup designation.
ORGANISM SEROTYPE	Used when an organism may have a serotype designation.
ORGANISM SEROTYPE OTHER	Free-form text field where you can enter the name of the serotype if it is not available from the **ORGANISM SEROTYPE** drop-down menu.
PFGE (PULSED FIELD GEL ELECTROPHORESIS)	
PATTERN (1 THROUGH 3) **PATTERN OTHER STATE (1 THROUGH 3)** **PATTERN CDC (1 THROUGH 3)**	Pattern created by pulsed field gel electrophoresis (PFGE), used to identify genetically similar (and therefore, potentially epidemiologically-linked) isolates. There are three Pattern areas: • Your State (Alaska) • Other State • CDC

6. Click one of the following buttons:

-
- **SAVE & FINISH NEW LAB** – begins a validation process and if there are no errors, saves the new Lab Report, and returns you to the “Lab Reports” tab.

- **CANCEL** – terminates the process of adding a Lab Report. If you have changed any information, a dialog box appears asking if you are sure you want to cancel.

  a) If you click the **OK** button, you will lose any data that you entered and you return to the "Lab Reports" tab.

  b) If you click the **CANCEL** button, you remain on the "Lab Order Information" screen with the values you entered intact.

Note: If you attempt to navigate to another screen without clicking the **CANCEL** button or the **SAVE & FINISH NEW LAB** button, a dialog box appears.

EDITING A MANUAL LAB REPORT

To edit a manual lab report, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case for the lab report you want to edit and click the **EDIT** button. The "Case Reporting" tab appears.

3. Click the "Lap Reports" tab. The entire "Lab Reports" tab appears.

4. Locate the manual lab report you want to edit and click the **EDIT** button. The "Lab Order Information" screen appears with results listed at the bottom.

5. Using "Table 5-14: Lab Order Information Screen Fields" as a guide, make the desired changes.

6. Click one of the following buttons:

-
- **EDIT** – begins a validation process and if there are no errors, it saves the changes to the Lab Report and displays the "Lab Test Result" screen to allow you to edit an existing Lab Test result.

- **RESET** – erases any changes that you made and you remain on the remains on the "Lab Order Information" screen.
- **SUBMIT CHANGES** – begins a validation process and if there are no errors, saves the changes you made.
- **CANCEL** – terminates the process of editing the lab report and returns you to the "Lab Reports" tab. If you changed any information, a dialog box appears asking if you are sure you want to cancel.
  - **a)** If you click the **OK** button, you will lose changes that you made and you return to the "Lab Reports" tab.
  - **b)** If you click the **CANCEL** button, you remain on the "Lab Order Information" screen with the values you entered intact.

Note: If you attempt to navigate to another screen without clicking the **RESET** button or the **SUBMIT CHANGES** button, a dialog box appears.

DELETING A MANUAL LAB REPORT

To delete a manual lab report, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case for the lab report you want to delete and click the **EDIT** button. The "Case Reporting" tab appears.

3. Click the "Lap Reports" tab. The entire "Lab Reports" tab appears.

4. Locate the lab report you want to delete and click the **DELETE** button (located to the right of the lab report). A dialog box appears asking if you are sure you want to delete the lab report.

5. Click one of the following buttons.

- **OK** – deletes the manual lab report and returns you to the "Lab Reports" tab.
- **CANCEL** – <u>does not</u> delete the manual lab report and returns you to the "Lab Reports" tab.

Adding Lab Test Results to a Manual Lab Report

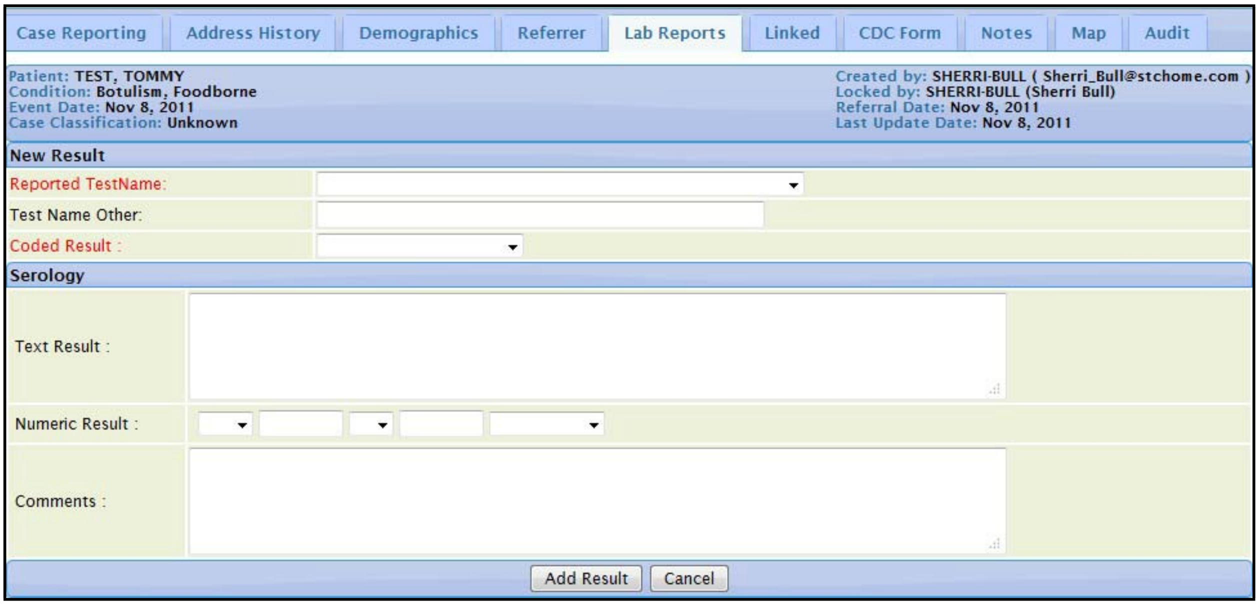
You can add new laboratory test results to both new and existing manual lab reports. However, when adding new laboratory test results to a new manual lab report, you have to type a value in the **TEST NAME** and **LABORATORY NAME** fields before clicking the **SAVE & FINISH NEW LAB** button; otherwise, an error message appears at the top left of the "Lab Order Information" screen.

You use the "New Result" screen to add new laboratory test results.

To add lab test results to a manual lab report, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.
2. Locate the case for the lab report to which you want to add lab test results and click the **EDIT** button. The "Case Reporting" tab appears.
3. Click the "Lap Reports" tab. The entire "Lab Reports" tab appears.
4. Locate the lab report to which you want to add lab test results and click the **EDIT** button. The "Lab Order Information" screen appears.
5. Click the **NEW RESULT** button. The "New Result" screen appears.

Figure 5-32: Manual Lab Report - New Result Screen



6. Using the following table as a guide, make the desired changes.

Table 5-15: Manual Lab Report - New Result Screen Fields

FIELD	DESCRIPTION
NEW RESULT	
REPORTED TEST NAME	Name of the Test. Click the drop-down menu arrow to view/select a valid choice. Examples are: • Biopsy • CT Scan • Culture (Viral)
TEST NAME OTHER	If the “Reported Test Name” contains “Other,” type the name of the test in this field.
CODED RESULT	Coded result of the reported test name.
SEROLOGY	
TEXT RESULT	Free-form description of a reported observation. Text results are a non-standard representation of the observation.

FIELD	DESCRIPTION
NUMERIC RESULT	Provides a means of capturing the measured values of the test outcomes in a standard way.
COMMENTS	Free-form text to be appended to the reported observation.

7. Click one of the following buttons:

- **ADD RESULT** – begins a validation process and if there are no errors, saves the new lab result for this lab report and returns you to the "Lab Order Information" screen. The added lab result appears in the "Results" section at the bottom of the "Lab Order Information" screen.

Figure 5-33: Result Added at Bottom of Lab Order Information Screen

- **CANCEL** – terminates the process of adding a lab result. If you have changed any information, a dialog box appears asking if you are sure you want to cancel.

  a) If you click the **OK** button, you will lose any data that you entered and you return to the "Lab Order Information" screen.

  b) If you click the **CANCEL** button, you remain on the "New Result" screen with the values you entered intact.

Note: If you attempt to navigate to another screen without clicking the **CANCEL** button or the **SAVE & FINISH NEW LAB** button, a dialog box appears.

> ***Note:*** When there is a Result Code that is not known by the system an "Assign Condition" item will show up in the Pending Work Queue for the administrator to resolve.

EDITING MANUAL LAB TEST RESULTS

Note: Once a Lab Test Result has been added to the Lab Report, no changes can be made.

To edit lab test results, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case for the lab report for which you want to edit lab test results and click the **EDIT** button. The "Case Reporting" tab appears.

3. Click the "Lap Reports" tab. The entire "Lab Reports" tab appears.

4. Locate the lab report for which you want to edit lab test results and click the **EDIT** button. The "Lab Order Information" screen appears.

5. In the **RESULTS** section, locate the lab test results you want to edit and click the **EDIT** button. The "New Result" screen appears.

6. Using "Table 5-15: Manual Lab Report - New Result Screen Fields" as a guide, make the desired changes.

7. Click one of the following buttons:

- **RESET** – erases any changes that you made and you remain on the "New Result" screen.
- **SUBMIT CHANGES** – begins a validation process and if there are no errors, saves the changes you made.
- **CANCEL** – terminates the process of editing the Lab Result and returns you to the "Lab Reports" tab. If you changed any information, a dialog box appears asking if you are sure you want to cancel.
  - **a)** If you click the **OK** button, you will lose any changes you made and you return to the "Lab Order Information" screen.

b) If you click the **CANCEL** button, you remain on the "New Result" screen with the changes you made intact.

Note: If you attempt to navigate to another screen without clicking the **RESET** button or the **SUBMIT CHANGES** button, a dialog box appears.

DELETING LAB TEST RESULTS

To delete lab test results, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case for the lab report for which you want to delete lab test results and click the **EDIT** button. The "Case Reporting" tab appears.

3. Click the "Lab Reports" tab. The entire "Lab Reports" tab appears.

4. Locate the lab report for which you want to delete lab test results and click the **EDIT** button. The "Lab Order Information" screen appears.

5. Locate the test result you want to delete and click the **DELETE** button. A warning dialog box appears asking if you are sure you want to delete the lab test results.

6. Click one of the following buttons.

- **OK** – deletes the lab test results and returns you to the "Lab Reports" tab.
- **CANCEL** – <u>does not</u> delete the lab test results and returns you to the "Lab Reports" tab.

LINKED CASES TAB

The Linked Cases Tab displays a line listing of the suspect cases that have come into contact with the "source" case; thus, a search must be performed in order to possibly link cases that have come in contact with the source; thus, the possible suspect cases are referred to as a "target" case.

This option is NOT available to Facility Users. If there are conditions of which the user does not have permission to view, these entries will not be displayed in the "Linked Cases" or "Case Listings."

The terminology is as follows:

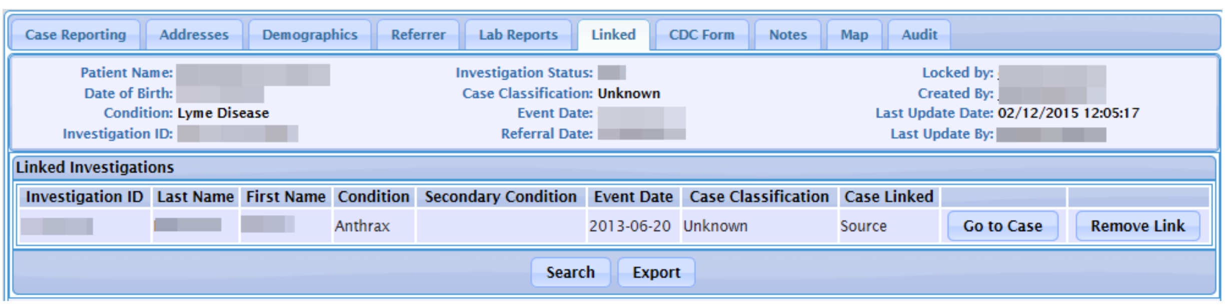
- ***Source*** = initial case that contracted the disease/condition.
- ***Target*** = those cases that contracted the disease/condition from the source.

SEARCHING FOR LINKED CASES

To search for linked cases, perform the following:

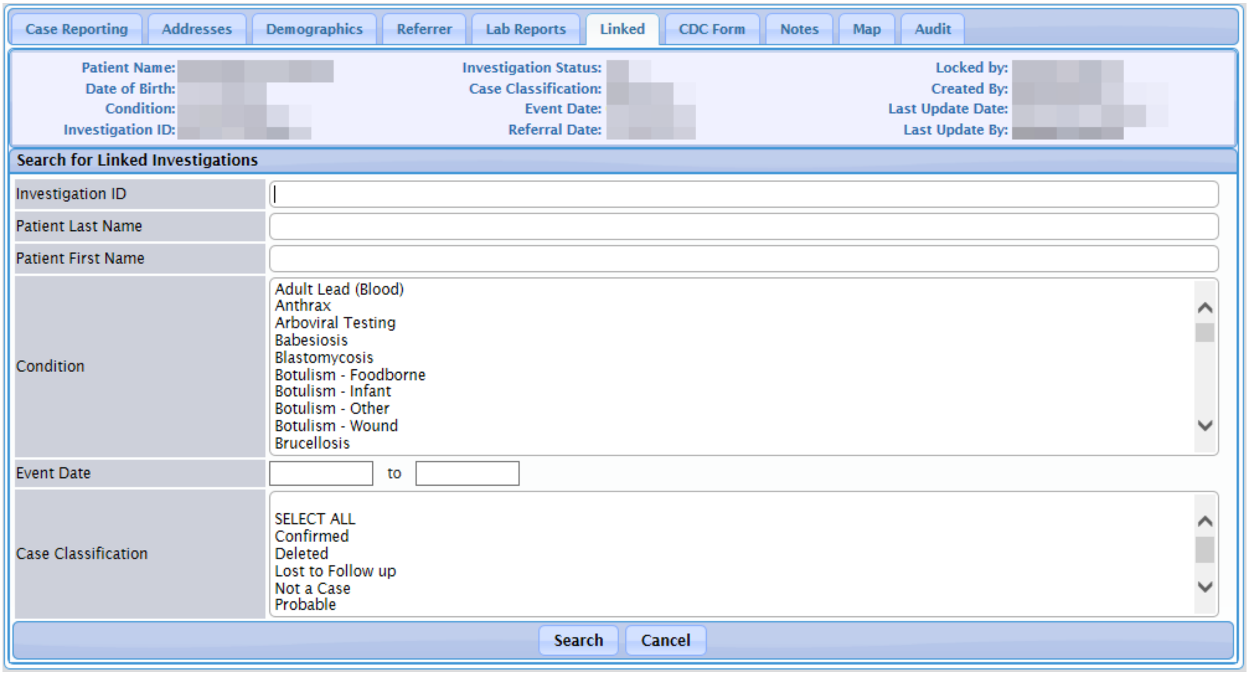
1. Click the **LINKED** Tab. The "Linked Investigations" screen appears with any currently linked cases.

Figure 5-34: Linked Cases Listing



2. To search for others, click the **SEARCH** button. The "Search for Linked Investigations" screen appears.

Figure 5-35: Search for Linked Investigations



3. The fields and their descriptions are listed in the table.

Table 5-16: Searching for Linked Cases Field Descriptions

FIELD	DESCRIPTION
INVESTIGATION ID	To search for a specific Investigation Id, type the number in this field.
PATIENT LAST NAME	To search for a specific Patient's Last Name, type the name in this field.
PATIENT FIRST NAME	To search for a specific Patient's First Name, type the name in this field.
CONDITION	To search for a specific Condition, point and click each condition to search. • To select one, point and click it. • To select more than one in a sequence, press and hold the SHIFT key while clicking the first Condition and the last Condition. • To select more than one NOT in a sequence, press and hold the CTRL key while clicking each

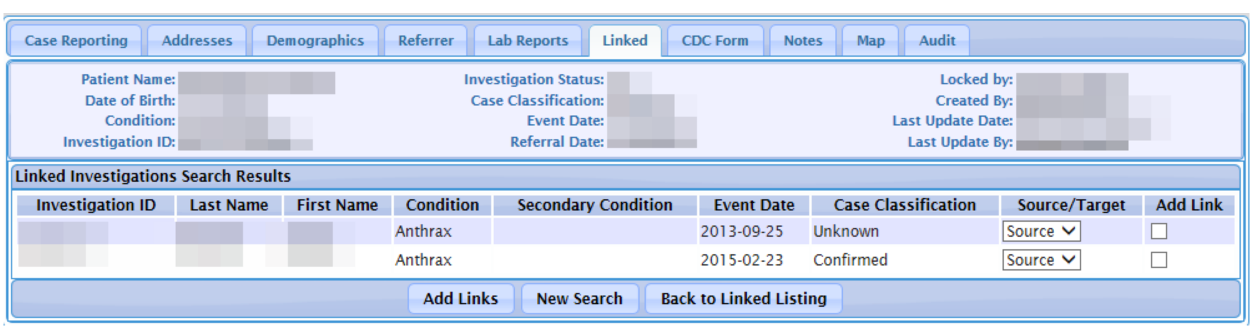
FIELD	DESCRIPTION
	condition.
EVENT DATE	To search for a specific date range, enter the beginning date in the first field followed by the ending date in the second field.
CASE CLASSIFICATION	To search for a specific Case Classification, point and click each classification to search. • To select one, point and click it. • To select more than one in a sequence, press and hold the SHIFT key while clicking the first Classification and the last Classification. • To select more than one NOT in a sequence, press and hold the CTRL key while clicking each Classification.

4. Enter the search criteria (using at least one of the fields) and click one of the available buttons:

   - **CANCEL** – to abort the search function and return to the previous screen.
   - **SEARCH** – to begin the search function and display the “Linked Investigations Search Results” screen. All suspected cases appear as a “Source” which may then be linked.

Note: Search results will NOT include “Deleted” or “Superceded” cases. Also, if a case is already linked to the current case (either as the source or the target), it will NOT appear in the “Search Results.”

Figure 5-36: Linked Investigations Search Results



Note: There can be no more than one link between any two cases.

5. Determine the action to perform and continue to its corresponding section. The following actions can be performed on this screen.

- Adding a Link
- Performing a new Search – Continue from Step 1 above.
- Displaying the Linked Listing

ADDING A LINK

To add a link to the displayed case, perform the following

1. From the "Search Results" screen, check the **ADD LINK** checkbox and pick "Target" ("Source" is the default) from the **SOURCE/TARGET** drop-down menu to indicate the nature of the link. The specific row will be highlighted after the checkbox is checked.

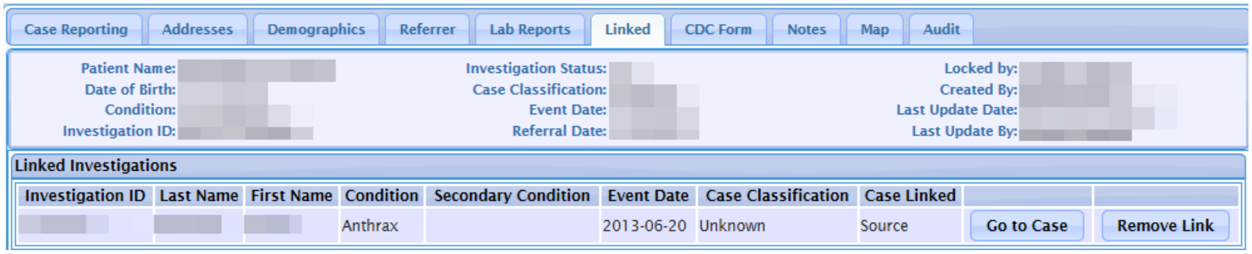
2. Click one of the available buttons.

- **ADD LINKS** – to complete the linking of the cases. The specific case(s) will get moved to the "Linked Listings" screen.
- **NEW SEARCH** – to return to the "Search Criteria" screen to enter new search criteria. Continue from Step 3 above.
- **BACK TO LINKED LISTING** – to display the "Linked Listing" screen. Continue to the next section for instructions.

DISPLAYING THE LINKED LISTING

The "Linked Investigation Listing" displays all the cases that have been linked to the current "source" case which is displayed in the header (shown below).

Figure 5-37: Current "Source" Header Information



This screen is accessed by clicking the **BACK TO LINKED LISTING** button on the "Linked Investigations Search Results" screen.

1. Assuming the **BACK TO LINKED LISTING** button was pressed, the "Linked Investigation Listing" screen appears.

Figure 5-38: Linked Listing

2. The Source Cases are listed first, followed by all the Target Cases based on the Condition (disease name). The "Source/Target" describes the nature of the link from the standpoint of the current case.

3. Determine the action to perform.

   - **GO TO CASE** – displays the "Case Reporting Tab" for the selected case.

     a) To return back to the "Linked Listing," press the "Linked Tab" again.

     b) Click on the **GO TO CASE** button again to display the original source case; then click on the "Linked Tab" again to return to the originating case(s).

   - **REMOVE LINK** – to remove the linkage from the displayed case and remain on the "Linked Listings" screen.

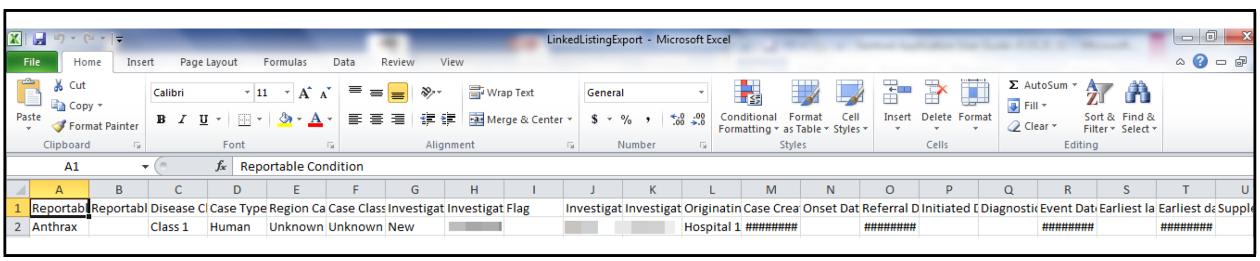
- **SEARCH** – to begin another search for the currently displayed "source" case. Continue to the section titled, "Searching for Linked Cases" for instructions.
- **EXPORT** – to open MS Excel and display the "Linked Case Listing." Continue to the section titled, "

EXPORTING LINKED CASES

To export linked cases, perform the following:

1. Click the **LINKED** Tab. The "Linked Investigations" screen appears with any currently linked cases.
2. To search for others, click the **SEARCH** button. The "Search for Linked Investigations" screen appears.
3. Type/enter your search criteria. The "Linked Investigations Search Results" screen appears.
4. Click the **BACK TO LINKED LISTING** button. The "Linked Investigation Listing" appears.
5. Click the **EXPORT** button. The "Dialog Box" appears asking if you want to **OPEN** or **SAVE** the file (you may also abort the export by clicking the **CANCEL** button). These instructions assume you clicked the **OPEN** button. MS Excel opens and the .CSV Export File is displayed.

Figure 5-39: Linked Export Listing



CDC FORM TAB

The CDC Form Data Tab displays the CDC disease fields for all cases that have an existing form. Eventually, this Tab will replace the "Supp Form (HTML)" button option (that allows editing a disease form) located on the "Case Reporting Tab." This means that the Supp Form (HTML) button will eventually be removed from the "Case Reporting Tab."

The CDC Data Tab allows users to edit (in Edit mode) or view (in View mode) the CDC disease fields. Every CDC Form will have: Person Completing This Form, Agency, Investigator Phone Number, Date of Investigation, and Comments/Additional Information.

When a disease has a valid FormBuilder Form association (in Forms Management), and does not yet have a CDC screen, the Supp Form (HTML) Form button option will still appear.

All the states will have the CDC Data Tab screens for the active Diseases with forms for their State Health Department.

Note: Since every disease form differs, every form is NOT documented in this section.

VIEWING/EDITING THE CDC DISEASE FIELDS

To view/edit the CDC Disease Fields via the CDC Data Tab, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case for which you want to view CDC Data information and click the **VIEW** or **EDIT** button. The "Case Reporting" tab appears.

3. Click the **CDC Data Tab**. One of the following screens will appear.

- The Supplemental form (HTML) CDC Disease Form, if one is available for the disease and is associated in FormBuilder (shown in Figure 5-44).
- The "CDC Data Communicable Disease Form" for the specific disease case appears, if one is available (fields will differ per disease/state). Examples are:

  a) For West Nile Virus…

  i. The Immune Condition field is a drop-down menu containing 248 codes in order to be compliant with the Arboviral message mapping guide 1.2.

ii. The field “Published Indicator” is a required field and the valid options are “Yes,” and “No” only.
iii. Added the text, “If "Died" is selected, Date of Death is captured on the CASE REPORTING tab.” Culture Results have the following options in the drop-down list: “Positive,” “Negative,” “Not Done,” and “Unknown.” Text was added, “If Positive, prompt the user to enter the Culture Results in the Lab Test Results section on the Lab Results Tab.”

b) For Q Fever…

i. travel outside of the U.S. information displays on the “Demographics” tab. Also, the Investigator Name, Investigation Date, Investigator Phone Number, Investigator Agency, and Comments will appear in the “Additional Information” section.

c) For CJD (Creutzfeldt-Jakob Disease)…

i. State of death occurrence displays if the patient is set as died on the Case Reporting Tab.
ii. County of Death occurrence displays if the patient is set as died on the Case Reporting Tab.
iii. Age at death is computed using the Date of Birth.
iv. Month and year of initial symptoms is the Onset Date on the Case Reporting Tab.
v. Patient's Code Number is the Medical Record Number.
vi. Date form Filled Out is the “Date of Investigation.”
vii. Comments are added in the additional information section of the form.

- A message indicating that a disease form is not available.

Figure 5-40: CDC Supplemental HTML Disease Form

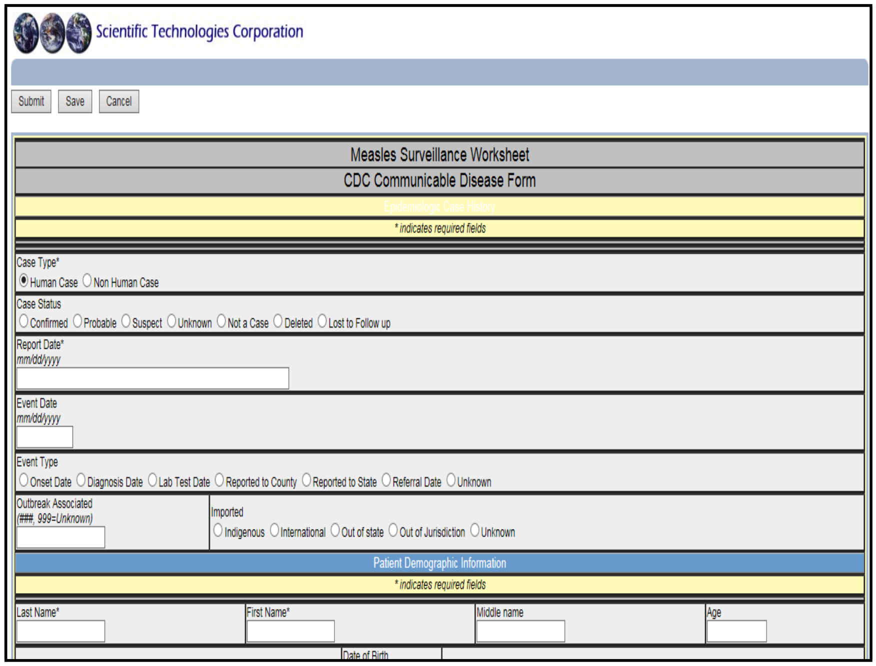
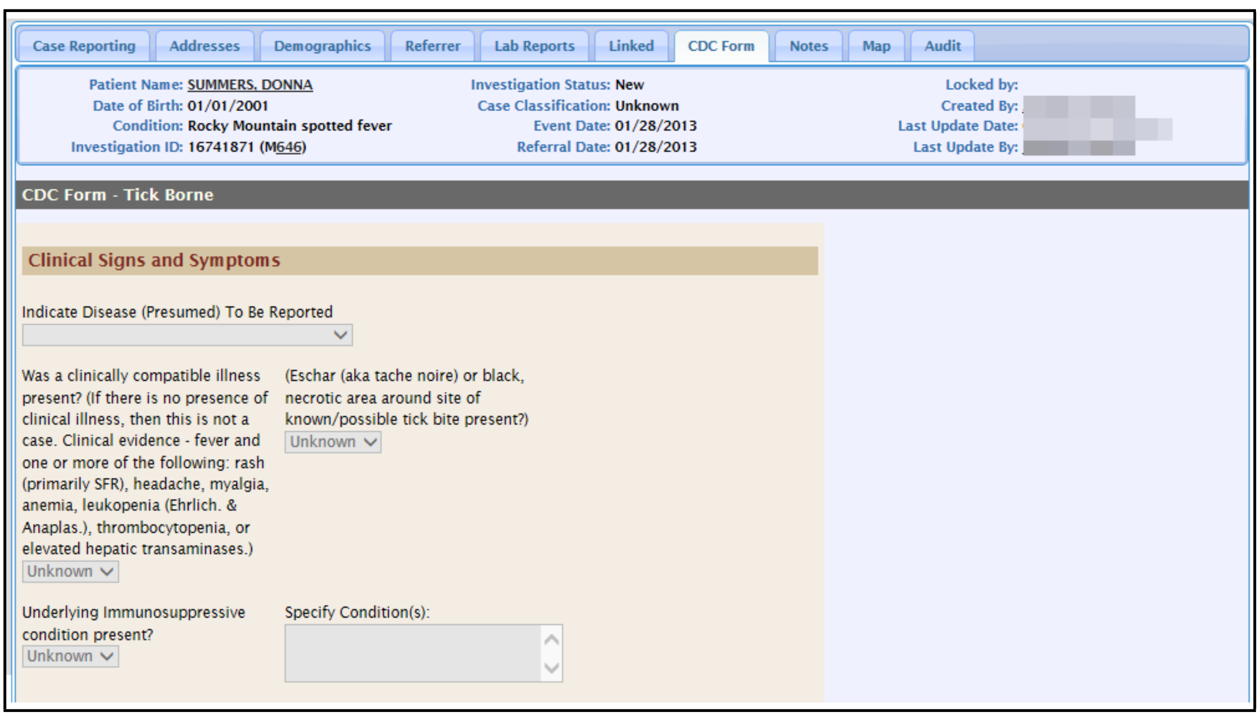


Figure 5-41: CDC Data Communicable Disease Form – Clinical (Partial View)



4. Make the editing changes and click one of the available buttons:

- **SUBMIT FORM** – begins the validation process of the field values on the Supplemental Form and if the validation is successful (no errors), the case is saved to the database. You will be returned to the “Case Listings” screen or you may enter “Patient Deduplication (if you have deduplication privileges and the patient you entered matches an existing patient in the system).
- **CANCEL FORM** – returns you to the “Case Reporting Tab” screen. Any changes you made to the form are not saved.
- **SUBMIT CHANGES** – begins the validation process of the field values on the CDC Data Tab and if the validation is successful (no errors), the case is saved to the database.
- **RESET** – erases any newly typed data prior to the **SUBMIT** button being pressed.
- **CANCEL** – returns to the previous window.

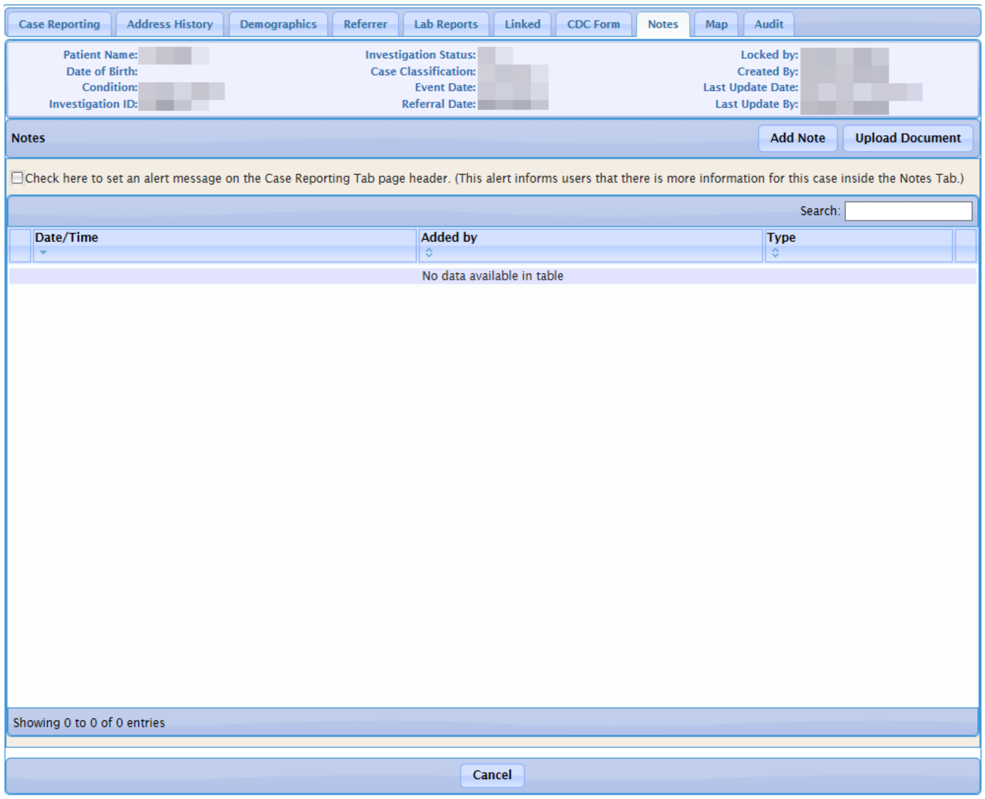
5. Refer to the section titled, “Background Processing When Saving Cases” for information about what occurs when you save a case.

NOTES TAB

The “Notes” tab allows you to add “free-form” case notes (comments or supporting information) or you can add an existing document by uploading it.

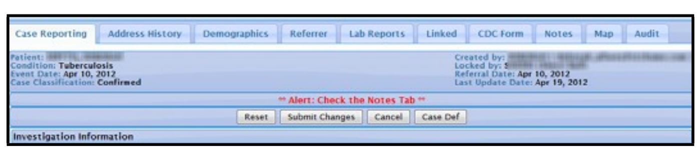
Note: Facility users have access to create non-human cases, add lab reports, and add notes. The lab reports and notes are visible to the Facility user until a non-facility user updates the lab report or note.

Figure 5-42: Notes Tab



The following table describes the “Notes” tab fields.

Table 5-17: Notes Tab Field Descriptions

FIELD	DESCRIPTION
SET AN ALERT MESSAGE ON THE CASE REPORTING TAB	When this checkbox is checked, a red alert displays in the Case Header above the “Investigation Information” section of the “Case Reporting Tab.” It displays, “ ** Alert: Check the Notes Tab ** (as shown below).”  **Note**: In order for the user to be notified, the user must have the “Notification on Case Modification” option set for their user-id.
CASE NOTES	Displays any current notes. You <u>cannot</u> edit existing notes. Each entry is marked with the time of entry and

FIELD	DESCRIPTION
	User-ID.
ALSO SEND AN E-MAIL TO ADMINISTRATOR	[State Configurable; used by: AK, NH, and LA] When this checkbox is checked, an email containing the “Note” content is sent to the Sentinel System Administrator. The System Administrator can view the email sent by referencing the Case ID # and the notes text in the Case – Notes tab. The Administrator can take follow up action in the Sentinel system for the Facility profile or as requested in notes. An example message is shown below in blue. On Thursday, April 19, 2012 3:40:43 PM, sherri @stchome.com wrote: You have received a note for investigation 63652937. This is a new note that I entered to see if it displays on the Case Reporting Tab as an alert.
NEW NOTE	Click the **ADD NOTE** button to add a new note and pop up window will appear where you can type note. **Note**: If the user has the Notification on Case Modification” option set, the user will be notified when notes are added/updated and/or files uploaded; however, if the assigned investigator is the same user that is logged in, no email will be sent. If the assigned investigator is not setup to receive notification of changes, an email will not be sent.
UPLOAD DOCUMENT	When you use the **UPLOAD DOCUMENT** button to locate a file to upload, the file path of the selected file appears in this field. **Note**: If the user has the “Notification on Case Modification” option set, the user will be notified when notes are added/updated and/or files uploaded; however, if the assigned investigator is the same user that is logged in, no email will be sent. If the assigned investigator is not setup to receive notification of changes, an email will not be sent.

ADDING A NOTE TO THE CASE

To add a note to the case, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.

2. Locate the case to which you want to add notes and click the **EDIT** button. The "Case Reporting" tab appears.

3. Click the **Notes Tab**. The entire "Notes" tab appears.

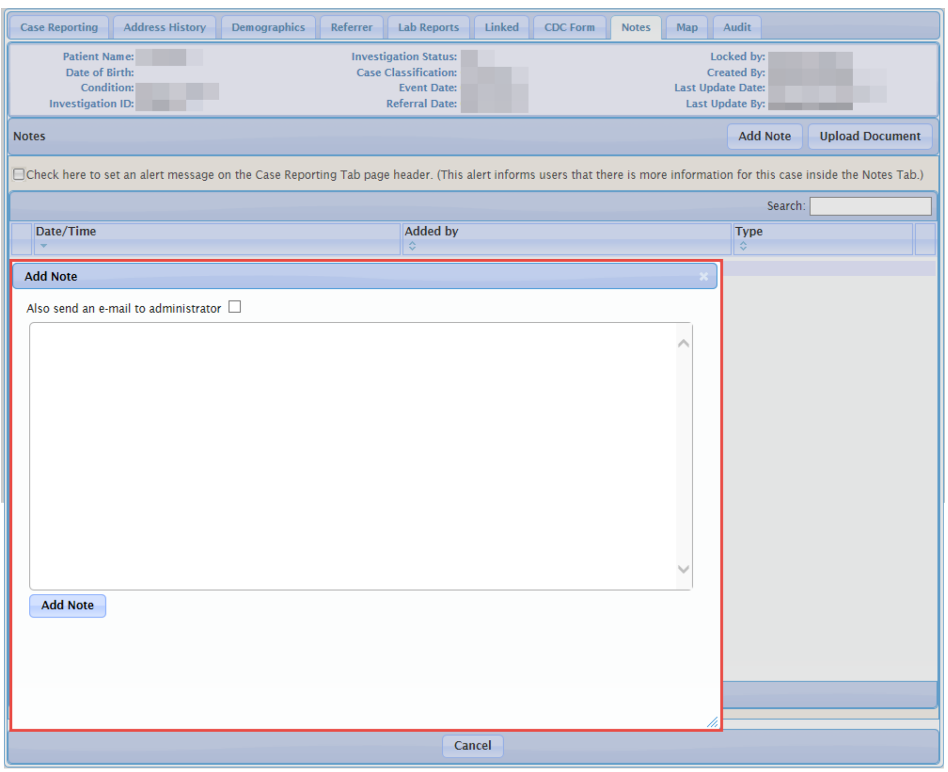
4. Click the **ADD** Note button and a new window will appear.

4. Type your note in the **ADDNOTE** text box.

5. Click one of the following buttons:

- **ADD NOTE** – begins a validation process and if there are no errors, saves the note you entered.

Figure 5-43: Notes Tab After Adding a Note



- If you wish to not add the note you are able to click the "**X**" in the right corner of the new window. If you do go forth with adding the note you will be redirected to the note screen where you can click **DELETE** if you wish to not have your note appear on the **NOTES TAB**. This will prompt a window where if you click **OK** it will delete the new note added if you click **CANCEL** the note will remain on the **NOTES TAB**.

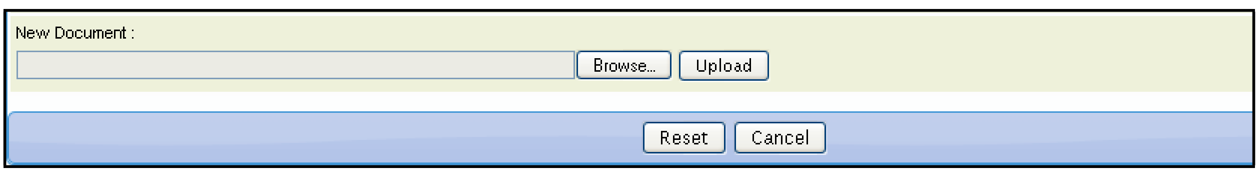
a) If you click the **CANCEL** button, you remain on the "Notes" tab with the text you entered intact.

UPLOADING AN EXISTING FILE AS A NOTE

To upload an existing file as a note, perform the following:

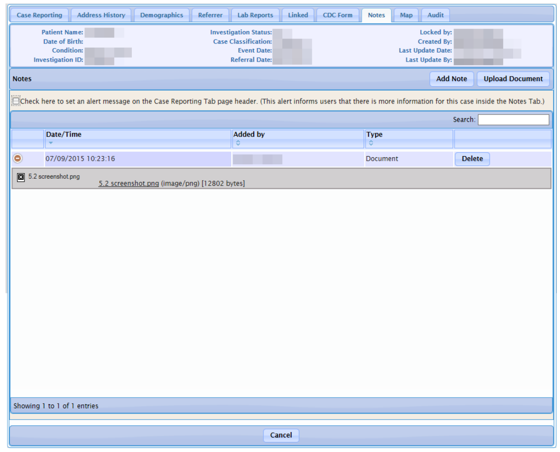
1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.
2. Locate the case to which you want to upload notes and click the **EDIT** button. The "Case Reporting" tab appears.
3. Click the "Notes" tab. The entire "Notes" tab appears.
4. Click the **UPLOAD DOCUMENT** button, then click **BROWSE** when the new window appears, locate and click the file you want to upload, and click the **OPEN** button. The file path and name appear in the **NEW DOCUMENT** field.

Figure 5-44: File Name of Uploaded Note



5. Click the **UPLOAD** button. The file name appears in the **CASE NOTES** area.

Figure 5-45: Uploaded Note in Case Notes Area



MAP TAB

The “Map” tab displays an interactive map of the investigation address. The map also shows those cases with the same disease or condition within the last seven days (based on the Onset Date or on the Referral Date if the Onset Date is unavailable) within the jurisdiction of the person viewing the map.

Note: The Map Tab is not available to Facility users.

Figure 5-46: NH Map Tab

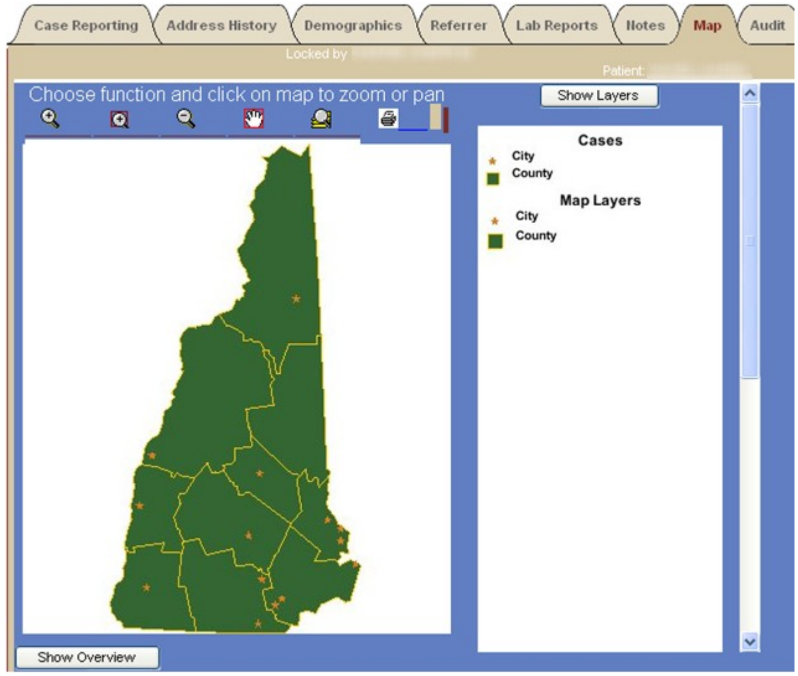
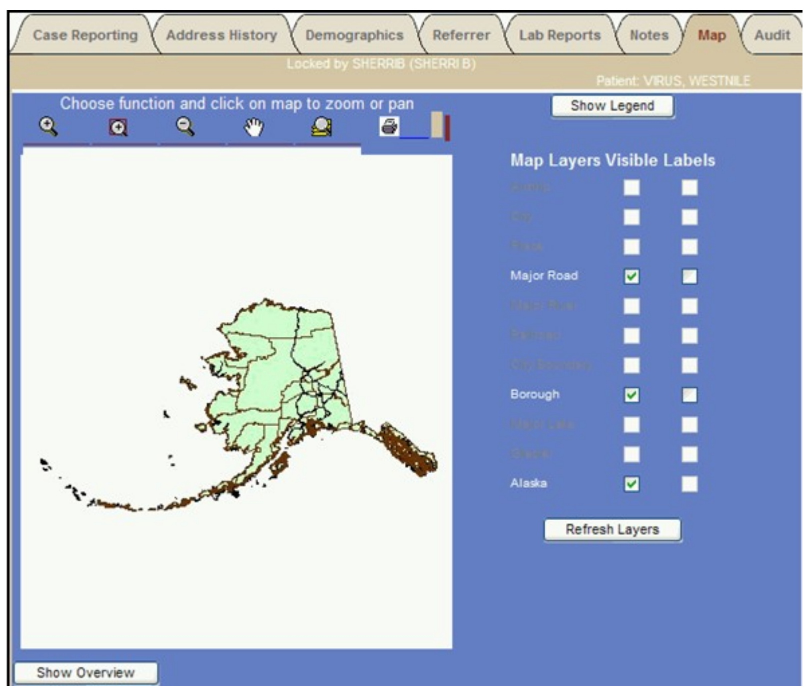


Figure 5-47: AK Map Tab

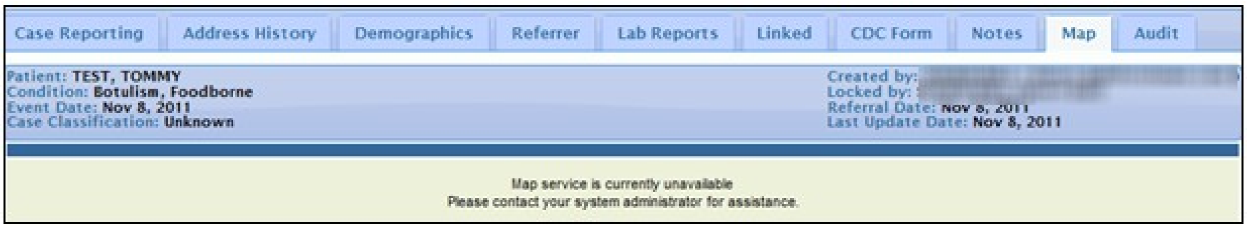


The case map layer and other selected map layers appear in a stack, similar to that of overlaid transparencies.

LPHU users can view individually-mapped cases only within their jurisdiction, while State users can view individually-mapped cases throughout the district. The Reports function provides LPHU and State users the ability to prepare geographic maps without individual case details.

If the map service is unavailable, such as during server maintenance, a screen similar to the one shown below appears.

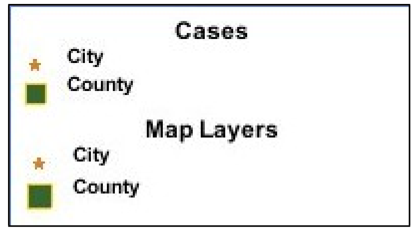
Figure 5-48: Map Service Unavailable



The following table describes the “Map” tab fields.

Table 5-18: Map Tab Fields

FIELD	DESCRIPTION
MAP NAVIGATION TOOLBAR	Buttons located at the top left of the tab that allow you to navigate the map (zoom in, zoom out, pan, etc.). Refer to the section titled, “Navigating the Map“ for instructions on using these buttons.
MAP	Interactive map that you can navigate and display with specific layers and labels.
MAP LAYERS Show Layers **MAP LEGEND** Show Legend	The right side of the tab shows either the **MAP LAYERS** area or the **MAP LEGEND** area. You switch between viewing these areas using the **SHOW LEGEND** and **SHOW LAYERS** buttons. • The **SHOW LEGEND** button appears above the **MAP LAYERS** area. Clicking this button displays the **MAP LEGEND** area.

<table>
<tr><th>FIELD</th><th>DESCRIPTION</th></tr>
<tr><td></td><td>


The SHOW LAYERS button appears above the MAP LEGEND area. Clicking this button displays the MAP LAYERS selection area.

The MAP LAYERS area allows you to select which map layers you want to display and if you want to display the labels. Refer to the section titled, “

Displaying/Hiding Map Layers“ for more information.

The MAP LEGEND area describes the identification markers of each map layer selected.
</td></tr>
<tr><td>
SHOW OVERVIEW

HIDE OVERVIEW

</td><td>
The SHOW OVERVIEW and HIDE OVERVIEW buttons allow you to display and hide a small window (at the bottom left of the screen) that shows the general area of the case within the state. The overview area is outlined in red.

</td></tr>
</table>

To view the map for a case investigation address, perform the following:

1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.
2. Locate the case for which you want to view the map and click the **EDIT** button. The “Case Reporting” tab appears.
3. Click the “Map” tab. The entire “Map” tab appears.

NAVIGATING THE MAP

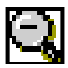
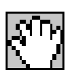
The “Map” tab includes a navigation toolbar located at the top left of the tab.

Figure 5-49: Map Tab Navigation Toolbar

The following table describes how to use the navigation toolbar buttons.

Table 5-19: Map Tab Navigation Toolbar Button Descriptions

BUTTON/ ACTION	DESCRIPTION
ZOOM IN 	Zooming in decreases the aerial view of the map to a more precise location. To zoom in on the map: 1. Click the **ZOOM IN** button. A red border appears around the button to show it is the selected/active button. 2. Click the area of the map on which you want to zoom in. The **ZOOM IN** button remains selected to allow you to zoom in further. 3. Repeat Step 2 as necessary to zoom in to the desired magnification.
ZOOM TO SELECTED RECTANGLE 	Zooming in to a selected rectangle lets you select a specific rectangular area on which to zoom in. For example, you may want to zoom in on a specific county or city block. To zoom in on a selected rectangle on the map: 1. Click the **ZOOM TO SELECTED RECTANGLE**

BUTTON/ ACTION	DESCRIPTION
	button. A red border appears around the button to show it is the selected/active button. 2. Press and hold the left mouse button to indicate the upper left corner of the rectangle you want to draw, drag the mouse to the lower right region/district of the rectangle, and then release the mouse button.
ZOOM OUT 	Zooming out increases the aerial view of the map to a broader location. To zoom out on the map: 1. Click the **ZOOM OUT** button. A red border appears around the button to show it is the selected/active button. 2. Click the area of the map on which you want to zoom out. The **ZOOM OUT** button remains selected to allow you to zoom out further. 3. Repeat Step 2 as necessary to zoom out to the desired magnification. If the map contains several layers, zooming out may slow the response time as each layer is redrawn.
PAN 	Panning moves the center of the map horizontally and/or vertically to the location where you click the mouse. To pan (move the center of) the map: 1. Click the **PAN** button. A red border appears around the button to show it is the selected/active button. 2. Click the area of the map that you want to appear as the center of the map. The **PAN** button remains selected to allow you to zoom out further.
FULL EXTENT 	Full Extent changes the aerial view of the map to the highest view. The highest view is the entire state (if you have Statewide access); otherwise, the full extent is the user’s jurisdiction. To show the full extent of the map: 1. Click the **FULL EXTENT** button. A red border appears around the button to show it is the

BUTTON/ ACTION	DESCRIPTION
	selected/active button. 2. Click any part of the map. Depending on your role, the full extent of the map appears. The **FULL EXTENT** button remains selected to allow you to zoom out further.
PRINT MAP 	Displays a printable version of the map in a new browser window.

DISPLAYING/HIDING MAP LAYERS

Map Layers display resource locations and administrative boundaries. You can only display labels for visible layers. If a layer name appears grayed out, you cannot display that layer.

To **display** map layers and labels, perform the following:

1. If the map legend is displayed, click the **SHOW LAYERS** button to display the map layers selection area.
2. Select the **VISIBLE** check box for the layer you want to display, and if desired, select the corresponding **LABELS** check box to display the label.
3. Repeat the previous step for each additional layer/label you want to display.
4. Click the **REFRESH LAYERS** button.
5. If a layer is already displayed without the label and you want to display label, select the appropriate **LABELS** check box and click the **REFRESH LAYERS** button.

To **hide** map layers and labels, perform the following:

1. Deselect the **VISIBLE** check box for the layer you want to hide; you do not need to deselect the corresponding **LABELS** check box to hide the label.

2. Repeat the previous step for each additional layer/label you want to hide.

3. Click the **REFRESH LAYERS** button.

4. If a layer is already displayed without the label and you want to display the label, select the appropriate **LABELS** check box and click the **REFRESH LAYERS** button.

AUDIT TAB

The “Audit” tab provides information regarding changes made to an investigation/case including cases imported or exported from the Outbreak Management System (OMS). The date and time of the change along with the User-ID, user name, jurisdiction, and role of the user making the change is recorded and displayed on this screen. The following tasks can be performed:

- Search the Audit Log for a specific date and/or user log entry.
- Sort/Filter the Audit Log
- Show/Hide the Audit Log Details
- Print the Audit Log

The “Audit” tab is read-only; you cannot make changes on this screen.

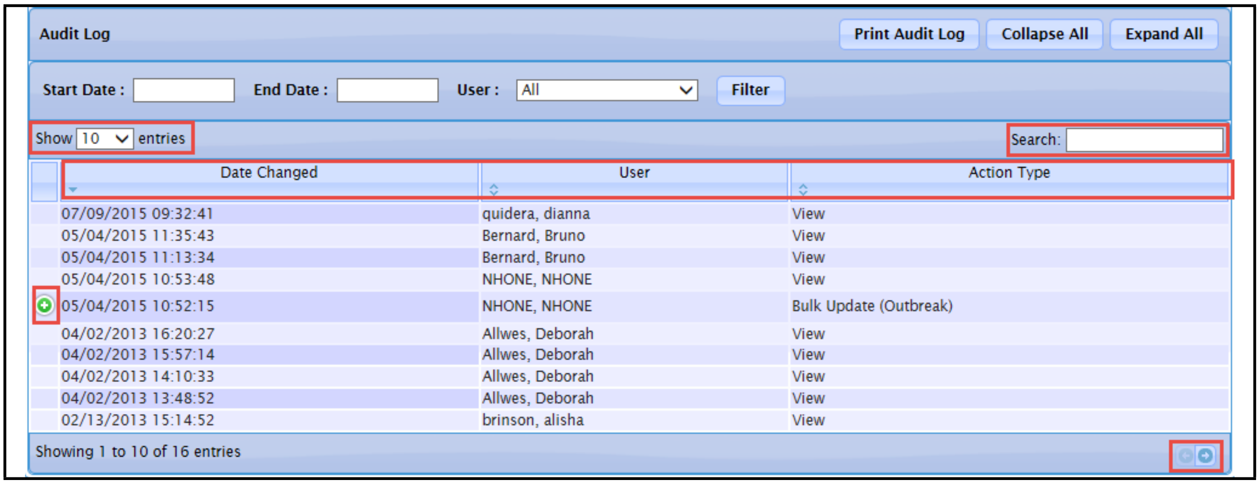
To view Audit tab information, perform the following:

1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.

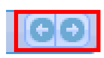
2. Locate the case for which you want to view audit information and click the **EDIT** button. The “Case Reporting” tab appears.

3. Click the **AUDIT** tab. The “Audit” tab appears.

Figure 5-50: Audit Tab



4. To organize the screen data and/or screen entries, perform the following (these items are framed in red in the illustration):

- **Show nn Entries** – Allows you to control the number of rows that display on the screen. Click the drop-down arrow to select 10, 25, 50, or 100 rows.
-  - Allows you to scroll the pages backward and forward, respectively.
- **Sort the Heading Rows** (Date Changed, User, Action Type) – Allows you to sort the data in ascending or descending order. Click the desired row header to sort the data.

  Note: The "Sorted" column will display darker than the other columns and the arrow in the header will tell you which way it is sorted.

- **Search** – Allows you to search for specific column data; i.e., Date Changed, User, Action Type. Type a string that you want to search for and as you type, the data list will only show you the name(s) that match your criteria. To redisplay all entries, remove the search characters from the "Search" field.

5. The fields/columns and their descriptions are listed in the table.

Table 5-20: Audit Fields/Columns

FIELD/COLUMN	DESCRIPTION
	A green **PLUS** sign indicates there are details associated with the Entry. Click it to expand the list to display the details screen. The green **PLUS** sign becomes a red **MINUS** sign once it has been expanded. Refer to the section titled, "Expanding/Collapsing Audit Log Details" for additional information.
START DATE / END DATE	Beginning and ending date for a specific audit log entry. Used with the **FILTER** button to begin a search for any audit entries that matches the criteria.
USER	User-id of the person that made a change. It is used with the **FILTER** button to begin a search for any audit entries that matches the criteria.
DATE CHANGED	This column displays the date and time stamp when the case was changed. The column label itself is a hyperlink that when clicked will resort the entries in ascending/descending order and vice versa. Upon entry, the Audit Log is sorted in chronological date order (yyyy/mm/dd) with the last change displaying first.
USER	This column displays the full name associated with the User-ID that performed the change. The column label itself is a hyperlink that when clicked will resort the entries in ascending/descending alphabetical order and vice versa.
ACTION TYPE	This column displays the type of action performed to the patient/case. The column label itself is a hyperlink that when clicked will resort the entries in ascending/descending alphabetical order and vice versa.

SEARCHING/FILTERING THE AUDIT LOG

To search the Audit Log, perform the following:

1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.
2. Locate the case for which you want to view audit information and click the **EDIT** button. The “Case Reporting” tab appears.
3. Click the “Audit” tab. The “Audit” tab appears. Refer to Figure 5-50 for an illustration.
4. Type/enter the search criteria by typing a **START DATE** and **END DATE**, or click the drop-down menu arrow to view/select a valid **USER** (or leave **ALL** selected).
5. Click the **FILTER** button. The matching criteria, if any, appear at the bottom of the window.

SORTING THE AUDIT LOG

The Audit Log can be sorted in order by Date Changed, User, or Action Type.

To sort the Audit Log, perform the following:

1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.
2. Locate the case for which you want to view audit information and click the **EDIT** button. The “Case Reporting” tab appears.
3. Click the “Audit” tab. The “Audit” tab appears. Refer to Figure 5-50 for an illustration.
4. Click on the appropriate column header:
   - Date Changed (yyyy/mm/dd format)
   - User
   - Action Type
5. The log will resort in the chosen order.

EXPANDING/COLLAPSING AUDIT LOG DETAILS

To show or hide Audit Log Details, perform the following:

1. On the “Case Investigation” Menu, click the **CASES** option. The “Case Listings” screen appears.

2. Locate the case for which you want to view audit information and click the **EDIT** button. The "Case Reporting" tab appears.

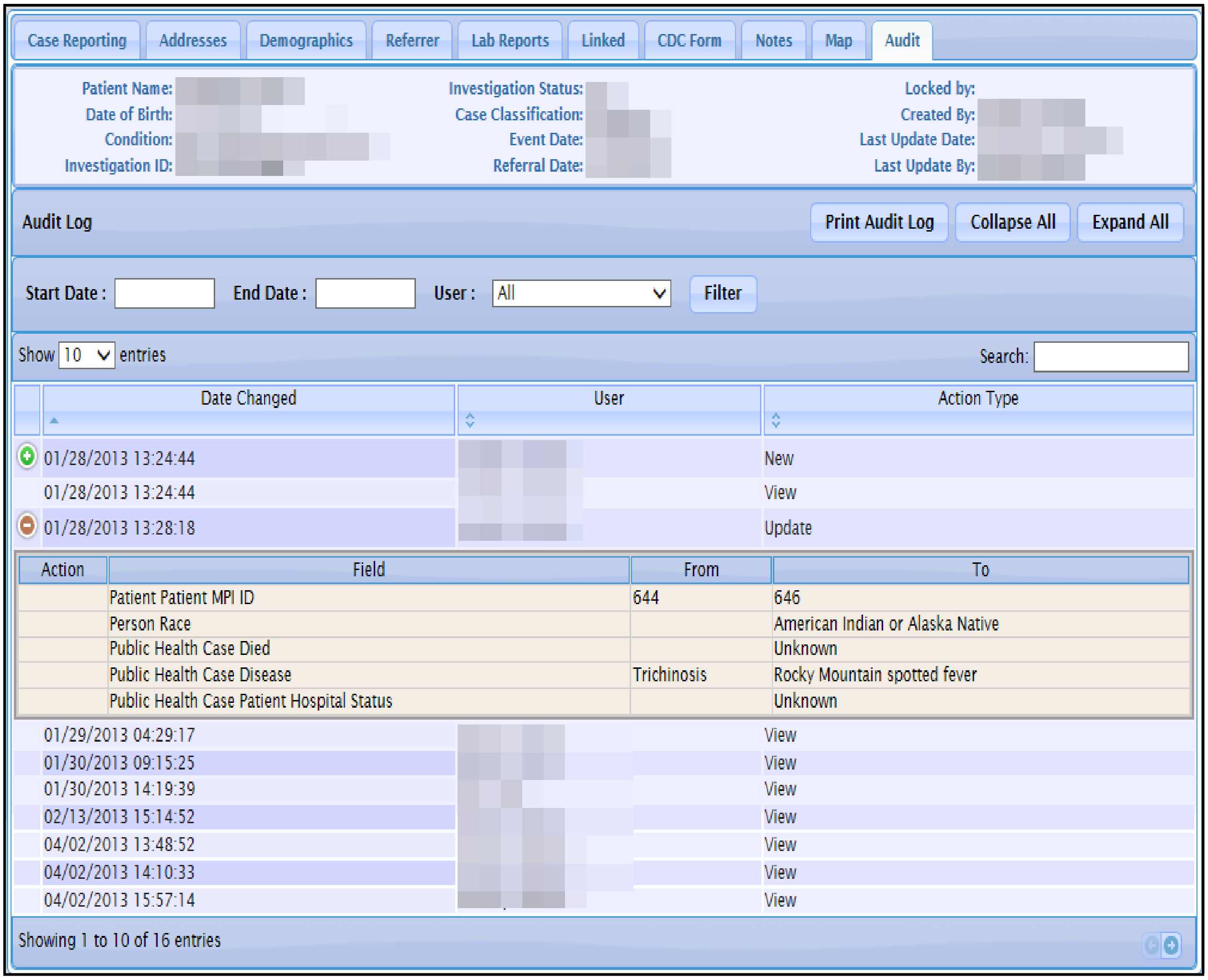
3. Click the "Audit" tab. The "Audit" tab appears. Refer to Figure 5-50 for an illustration.

4. Enter the search criteria and perform a **SEARCH**.

5. Locate the entry whose details you want to

   - Display or **EXPAND** and click the **green PLUS sign**.
   - Not display or **COLLAPSE**, click the **red MINUS sign.**

Figure 5-51: Audit Log Details - EXPAND



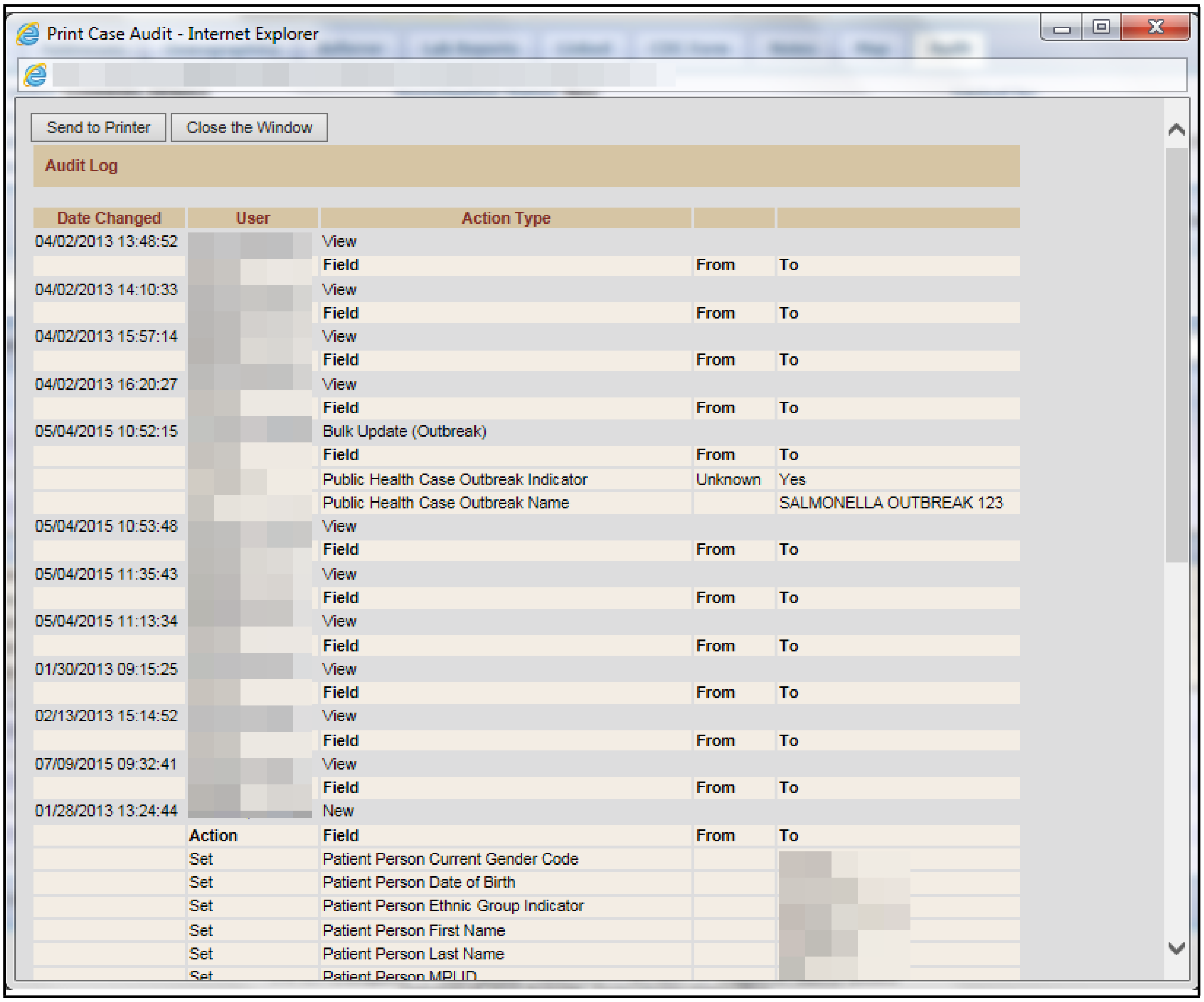
6. To quickly close all the **SHOW** details, click the **COLLAPSE ALL** button. Conversely, to quickly open all the details, click the **EXPAND ALL** button.

PRINTING THE AUDIT LOG

To print the Audit Log, perform the following:

1. On the "Case Investigation" Menu, click the **CASES** option. The "Case Listings" screen appears.
2. Locate the case for which you want to view audit information and click the **EDIT** button. The "Case Reporting" tab appears.
3. Click the "Audit" tab. The "Audit" tab appears. Refer to Figure 5-50 for an illustration.
4. Enter the search criteria and perform a **SEARCH**.
5. Click the **PRINT AUDIT LOG** button. The "Audit Log" appears in a new browser window.

Figure 5-52: Print Audit Log Report



Date Changed	User	Action Type		
04/02/2013 13:48:52		View		
		Field	**From**	**To**
04/02/2013 14:10:33		View		
		Field	**From**	**To**
04/02/2013 15:57:14		View		
		Field	**From**	**To**
04/02/2013 16:20:27		View		
		Field	**From**	**To**
05/04/2015 10:52:15		Bulk Update (Outbreak)		
		Field	**From**	**To**
		Public Health Case Outbreak Indicator	Unknown	Yes
		Public Health Case Outbreak Name		SALMONELLA OUTBREAK 123
05/04/2015 10:53:48		View		
		Field	**From**	**To**
05/04/2015 11:35:43		View		
		Field	**From**	**To**
05/04/2015 11:13:34		View		
		Field	**From**	**To**
01/30/2013 09:15:25		View		
		Field	**From**	**To**
02/13/2013 15:14:52		View		
		Field	**From**	**To**
07/09/2015 09:32:41		View		
		Field	**From**	**To**
01/28/2013 13:24:44		New		
	Action	**Field**	**From**	**To**
	Set	Patient Person Current Gender Code		
	Set	Patient Person Date of Birth		
	Set	Patient Person Ethnic Group Indicator		
	Set	Patient Person First Name		
	Set	Patient Person Last Name		
	Set	Patient Person MPI ID		

6. Use the Browser's **PRINT** option to send the report to a printer and/or **CLOSE** the Browser when finished.

NEW HUMAN CASE

Cases can be added by accessing and filling out the necessary fields on all the screens (Patient Information, Referral/Physician, and Work/Travel) or by filling out a Supplemental Form, if a form exists for the disease/condition being reported.

Regardless of the method chosen when adding a new case, a Search is always performed first using Sentinel's database and Master Patient Index (MPI). This reduces the possibility of entering a duplicate case. The application will query the MPI for First Name, Last Name, and DOB. The MPI will return MPI IDs and then Sentinel will lookup patient and cases that have this MPI ID.

For example, if you have a “Case A” for Patient 1 and if Patient 1 had been merged with Patient 2 and if there is an unresolved Pending Work Queue (PWQ) item saying that Patient 1 had been merged with Patient 2, then the new Patient/Case Search will not show Patient 1 or 2 or Case A. The main reason is that the Sentinel Database has not been synchronized yet with the MPI, thus the MPI is returning Patient 2 for the New Patient Search and Patient 2 is unknown for Sentinel until it is resolved in the PWQ.

Searching for a Human Case

When you do a new case search, you are instructing the application to search the Master Patient Index (MPI) for a matching case, and if any matches are located, display the possible matches/cases.

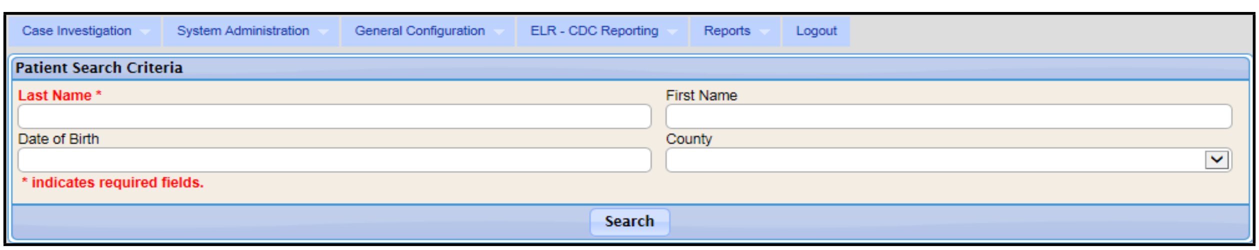
When you are trying to create a new case, first you are trying to find a case that is already in Sentinel or any that match an existing case(s) in order to start with some known data.

Note: Superceded cases will not be listed in the “Create New Case Search” results.

To search/add a new case, perform the following:

1. Click on the **NEW HUMAN CASE** option on the “Case Investigation” menu. The “Patient Search Criteria” screen appears.

Figure 5-53: Patient Search Criteria



2. The fields and their descriptions are listed in the table.

Table 5-21: Patient Search Field Descriptions

FIELD	DESCRIPTION
LAST NAME	Last name of the patient.
FIRST NAME	First name of the patient.
SEARCH USING SOUNDEX	(This is a state-specific option and may not appear on your screen.) This option is used to search for a LAST NAME using a phonetic algorithm to index names by "sound" as they are pronounced in English. For example Johns and Jons sound the same but are spelled differently.
DATE OF BIRTH (MM/DD/YYYY)	Date of birth of the patient.
BOROUGH/COUNTY OR PARISH	Borough, County, or Parish of the patient's address. Click the drop-down menu arrow to view/select a valid choice.

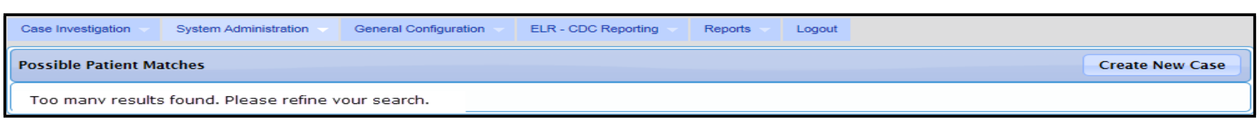
3. Enter the desired information. You must complete fields in **RED***; all other fields are optional

4. Click the **SEARCH** button. The "Possible Patient Matches" screen appears with or without matches.

Note: Superceded and Deleted Cases are eliminated from the results presented in New Human Case Search Results.

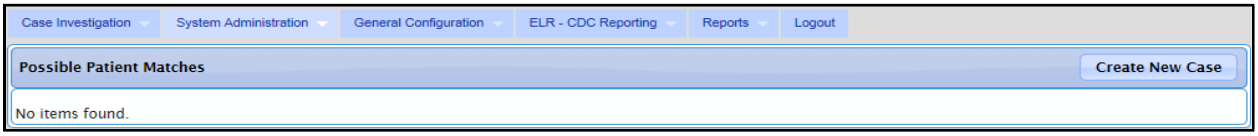
- If there are too many possible matches, the screen appears as shown below. You will need to enter additional "search criteria" to narrow the possible results.

Figure 5-54: Possible Patient Matches – Too many Found



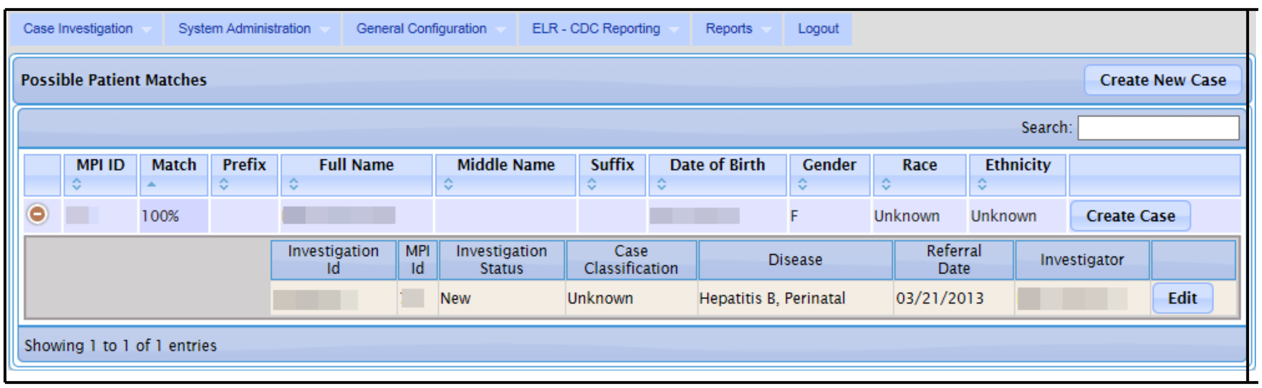
- If there are no possible matches, the screen appears as shown below.

Figure 5-55: Possible Patient Matches – No Matches Found



- If there are possible matches, the screen appears as shown below with the most probable case listed at the top.

Figure 5-56: Possible Patient Matches – Matches Found



5. Refer to Table 5-2 for a list of field descriptions.
6. Determine the action to perform and click the appropriate button:
   - **CREATE NEW CASE** – to create a new case when there are no possible matches. The “Patient Name – Investigation Information” screen appears.
   - **CREATE CASE** – to create another case for the “displayed” patient that matched the “patient search criteria.” The “Patient Name – Investigation Information” screen appears. The fields used in your search will automatically populate into the respective fields if you

entered them (**FIRST** (name of patient), **LAST** (name of patient), **SEX**, **RACE**, and **ETHNICITY**)

- **EDIT** – to edit the existing "displayed" case information.

7. These instructions assume you are adding a New Human Case and/or are adding a New Human Case to an Existing Patient. Continue to the next section titled, "Creating a New Human Case " to continue adding a "new" human case.

Creating a New Human Case

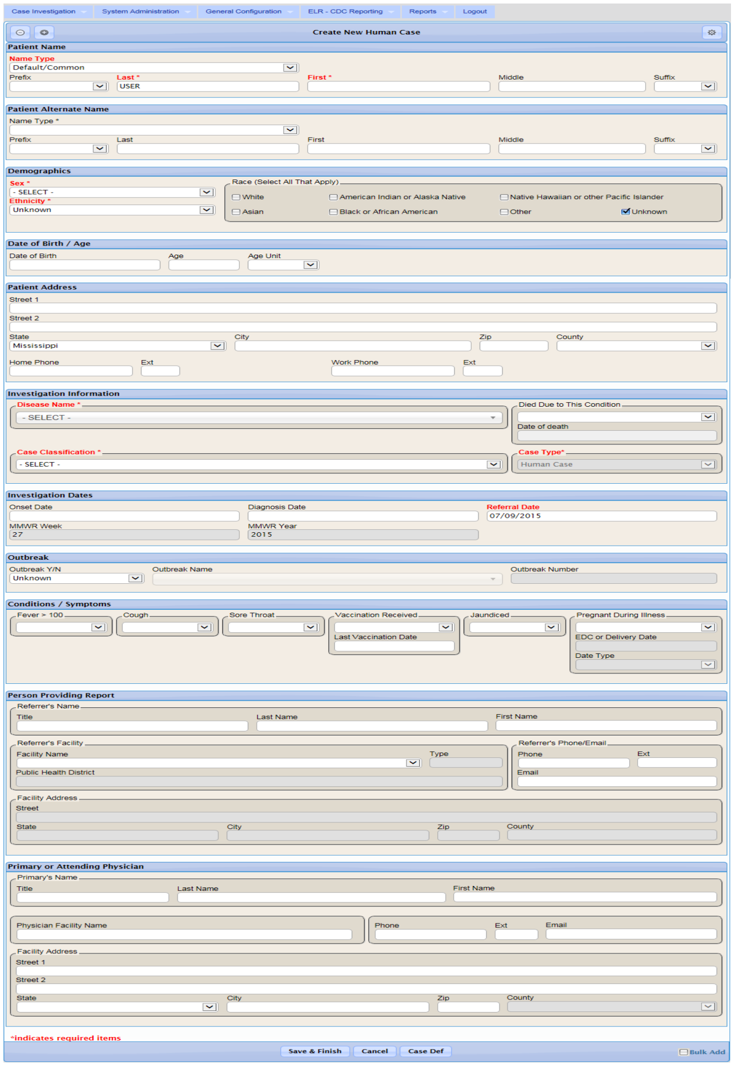
There are four sections of information you will enter when creating a new case.

- Patient Information
- Conditions/Symptoms
- Person Providing Report (Hospital Information)
- Primary or Attending Physician

Once a case has been created and the reportable condition has a Disease Form, also referred to as a Supplemental Form, you may edit the case using the screens or supplemental forms, assuming a Supplemental Form exists.

Note: New cases also appear on the "Case Listings" screen through laboratory and health care provider referrals.

Figure 5-57: Patient Information



To enter all the sections for the new case, perform the following:

1. Using the following table as a guide, enter the appropriate information. You must complete fields in RED*; all other fields are optional.

Table 5-22: Patient Information Screen Field Descriptions

FIELD	DESCRIPTION
PATIENT NAME	
NAME TYPE	Type of name. Available options are:

FIELD	DESCRIPTION
	• Also Known As • Default/Common (default selection) • Legal • Maiden • Nickname
MPI ID	This is a state-specific, read-only field. Master Patient Index Identification (MPI ID) Number. The MPI is a repository of basic patient demographic information to prevent users from entering duplicate patients/cases. Sentinel queries MPI to determine if the patient already exists and obtains the latest basic demographic information. Sentinel updates MPI with any new patients or new demographic information for existing patients. • When you create a case for a new patient, this field is empty and the MPI ID is assigned after you save the case. • When you create a case for an existing patient, the MPI ID field is automatically populated because that patient already has a MPI ID.
PREFIX	Prefix for the patient; i.e., Miss, Ms., etc.
LAST	Last name of the patient.
FIRST	First name of the patient.
MIDDLE	Middle name of the patient, if any.
SUFFIX	Extension of the patient's name; i.e., Junior, III, etc.
PATIENT ALTERNATE NAME	
NAME TYPE	Type of name. Available options are: • Also Known As • Default/Common (default selection) • Legal

FIELD	DESCRIPTION
	• Maiden • Nickname
PREFIX	Alternate prefix for the patient; i.e., Miss, Ms., etc.
LAST	Alternate last name of the patient.
FIRST	Alternate first name of the patient.
MIDDLE	Alternate middle name of the patient, if any.
SUFFIX	Alternate extension of the patient's name; i.e., Junior, III, etc.
DEMOGRAPHICS	
SEX	Gender of the patient. Click the drop-down menu arrow to view/select a valid choice. Examples are: • Female • Male • Not Reported • Other
ETHNICITY	Ethnicity of the patient; defaults to "Unknown." (Does not display for non-human cases.)
RACE	Race of the patient; defaults to "Unknown" and will not allow "Unknown" to be removed. Either leave "Unknown" selected or add a race by clicking the appropriate plus (+) sign. This field does not display for non-human cases. The box on the left is referred to as the "Selected Items" box. The box on the right is referred to as the "Unselected Items" box containing the multiple choice items. To add an item to the "Selected Items" box, click the plus sign (+) (located to the right of the choice). The choice will be moved from the "Unselected Items" box to the "Selected Items" box.

FIELD	DESCRIPTION
	To remove an item from the "Selected Items" box to the "Unselected Items" box, click the minus sign (-) (located to the right of the choice). The choice will be moved from the "Selected Items" box to the "Unselected Items" box.
DATE OF BIRTH / AGE	
DATE OF BIRTH (MM/DD/YYYY)	Patient's data of birth, if available. If patient's date of birth is not available, use the **AGE** and **AGE UNIT** fields.
AGE **AGE UNIT**	(Required for Louisiana) **AGE** is the age in days, months, or years of the patient and **AGE UNIT** is the unit of measurement of the **AGE** value. If you enter a **DATE OF BIRTH**, Sentinel calculates the **AGE** and **AGE UNIT** as follows: • **AGE UNIT** = **DAYS** if the current date is less than a calendar month after the **DATE OF BIRTH**. • **AGE UNIT** = **MONTHS** if the current date is less than two years after the **DATE OF BIRTH**. • **AGE UNIT** = **YEARS** if the current date is two years or more after the **DATE OF BIRTH**. If you do not know the **DATE OF BIRTH**, you can leave the **DATE OF BIRTH** field empty and manually enter an **AGE** and **AGE UNIT**. When you manually enter an **AGE**, this value does not vary over time since it does not reflect the exact age of the patient.
PATIENT ADDRESS	
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the patient's home address.
STATE	State name of the patient's home address. Click the drop-down menu arrow to view/select a state. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the

FIELD	DESCRIPTION
	customer's state, county will be disabled. If County is changed, City and Zip will be cleared. **Note**: When using the SUPP FORM (HTML) option to enter data, modifications to the City, State, County, and Zip Code cannot be done using supplemental forms. Changes to these fields can only be done in "Case Management" which will appear in the Supp Form (HTML).
CITY	City of the patient's home address. First, choose a state, and then begin to type the first four letters of the City name and a "pop up" list of City names and zip codes appears. Point and click a city name/zip to select it. The city, zip, and County code fields will populate with the stored information. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared. **Note**: When using the SUPP FORM (HTML) option to enter data, modifications to the City, State, County, and Zip Code cannot be done using supplemental forms. Changes to these fields can only be done in "Case Management" which will appear in the Supp Form (HTML).
ZIP	Zip code of the patient's home address. This field is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared. **Note**: When using the SUPP FORM (HTML) option to enter data, modifications to the City, State, County, and Zip Code cannot be done using supplemental forms. Changes to these fields can only be done in "Case Management" which will appear in the Supp Form (HTML).
COUNTY/BOROUGH OR PARISH	(Required for Louisiana) County, Borough, or Parish of the patient's home address. **Note**: If the state is changed, the City, Zip and

FIELD	DESCRIPTION
	County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared. **Note**: When using the SUPP FORM (HTML) option to edit data, modifications to the City, State, County, and Zip Code cannot be done using supplemental forms. Changes to these fields can only be done in "Case Management" which will appear in the Supp Form (HTML).
WORK PHONE/EXT	Daytime telephone number of the patient and an extension, if applicable.
HOME PHONE/EXT	Evening telephone number of the patient and an extension, if applicable.
INVESTIGATION INFORMATION	

FIELD	DESCRIPTION
CASE TYPE	Type of case: Human or Non Human. This is automatically filled in; thus, is a read-only field.
DISEASE NAME	Disease being reported for the case. After you select a Disease Name and save the case information, Sentinel retrieves the Disease Group (to which the Disease Name belongs) from its system reference tables. **Note**: Tuberculosis-LTBI has been added. A case with this disease displays in the new Patient Surveillance Report screen for TBPAM. Tuberculosis will be the "Disease Name" and "LTBI" will be selected for the "Reportable Condition 2" field.
CASE CLASSIFICATION	Case status based on set definitions and criteria to determine evidence of disease. This field is expected to be resolved to **CONFIRMED** or **NOT A CASE** as a result of the investigation. A more detailed discussion of Case Status is available within the CDC Case Definitions. Click the drop-down menu option to view/select a valid choice. Available choices are: • **CONFIRMED** – It has been determined that the patient has this disease. When the investigation is complete (**INVESTIGATION STATUS** is set to **COMPLETED OR CLOSED**), this case is reported to the CDC. • **DELETED** – This option is generally for cases that were entered in error. Marking a case as **DELETED** does not remove the case from the system; however, deleted cases no longer appear in reports or in a NETSS Export. • **NOT A CASE** – It has been determined that the

FIELD	DESCRIPTION
	patient does not have this disease. This case is not reported to the CDC. • **PROBABLE** – An initial indicator that the patient is likely to have this disease and further investigation is warranted. • **SUSPECT** – An initial indicator that the patient may have this disease and further investigation is warranted. • **UNKNOWN** – The person making the referral could not determine the likeliness. Follow-up is warranted.
REGION CASE CLASSIFICATION	(Required for Louisiana) Case status based on set definitions and criteria to determine evidence of disease for the specific Region. Refer to the previous field, "Case Classification" for a list of valid choices.
OUTBREAK	
OUTBREAK Y/N	Indicates whether the condition was associated to an Outbreak (Y) or not (N), or is unknown.
OUTBREAK NAME	Name of Outbreak if the **OUTBREAK** field is set to **YES**.
OUTBREAK NUMBER	This is the user-defined number used to associate a case to an outbreak. Ex: For multiple cases related to a Food borne Outbreak, you may enter an outbreak number of 100 for each one. Afterward, when an epidemiologist searches for all cases related to Outbreak Number 100, all related cases are returned.
INVESTIGATION DATES	

ONSET DATE	Date the symptoms of this disease first appeared. Type a date or click the calendar to select a date. **IMPACTS OF CHANGING THE ONSET DATE** The case Onset Date is related to other fields within Sentinel, specifically the Address "To" and "From" dates and the patient's age. • Sentinel attempts to determine the patient's age at disease onset. Therefore, the patient's age is

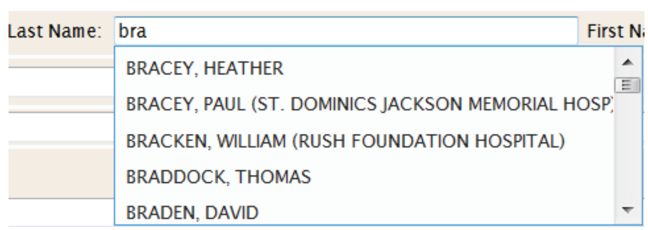
FIELD	DESCRIPTION
	not their current age and changes to the Onset Date can result in changes to the age. If a change in the Onset Date resulted in the age dropping below 18 years, Sentinel will require the parent/guardian information to be supplied. • Onset date also plays a key role in determining the investigation address. The Address “To” and “From” dates are compared to the Onset Date to verify that the address is valid for the duration of the case investigation. If a change is made to the Onset Date that would result in invalid address information, the case could be referred to another investigator. • Case assignment is based on the investigation address at the Onset Date (or the Date Received if the Onset Date is unavailable). Changes to Onset Date can result in case referral to another investigator.
DIAGNOSIS DATE	Date the case was diagnosed. Type a date or click the calendar to select a date.
REFERRAL DATE	When you add a new case, this date defaults to the system date at the time of new case entry. When you edit a case and change the Patient Status, this date is set to the system date at the time of the change. Accept the default date, type a new date, or click the calendar icon and select a date.
MMWR WEEK	Morbidity and Mortality Weekly Report (MMWR) publication week when the case was created. Sentinel calculates the **MMWR WEEK** value based on the **EVENT DATE** value. This is a read-only field.
MMWR YEAR	Morbidity and Mortality Weekly Report (MMWR) publication year when the case was created. Sentinel calculates the **MMWR YEAR** value based on the **EVENT DATE** value. This is a read-only field.

FIELD	DESCRIPTION
CDC CASE ID	Unique, system-generated ID used to identify the case record in the NETSS export. This is a read-only field and appears after a case is entered/saved.
STATE ID	Patient ID or animal case ID for cases migrated from legacy HAWK system.
IMPORTED	Indicates whether the case was imported from any of the following: • In-State • Out of Country • Out of State • Unknown
DIED DUE TO THIS CONDITION	Whether or not the patient died. Available options are: • No • Unknown • Yes **Note**: If the incoming data displays “No” in the "DIED DUE TO THIS CONDITION” field but the person has a “DATE OF DEATH,” the “DIED DUE TO THIS CONDITION” drop-down will not appear but will instead display, “Patient died on mm/dd/yyyy from condition associated with case id #XXXXXX.”
DATE OF DEATH	If the “DIED DUE TO THIS CONDITION” field contains YES, then the “DATE OF DEATH” field must have an entry; otherwise, this field is disabled. Type the date using the format mmddyyyy or click on the Calendar Icon to select a date. This date Must be greater than the “Onset Date’ as well as the “Diagnosis Date.” **Note**: If the "DIED DUE TO THIS CONDITION" field is set to “Yes” and then set to “No,” the “DATE OF DEATH” field will be cleared.

FIELD	DESCRIPTION
CONDITIONS/SYMPTOMS **Note**: If you cannot see the field names listed below, click on the section name to open this section of the screen.	
FEVER > 100	Indicates whether the patient had a fever greater than 100 degrees. Click the checkbox to indicate Yes; unchecked to indicate No.
COUGH	Indicates whether the patient had a cough. Click the checkbox to indicate Yes; unchecked to indicate No.
SORE THROAT	Indicates whether the patient had a sore throat. Click the checkbox to indicate Yes; unchecked to indicate No.
VACCINATION RECEIVED	Indicates whether the patient received a vaccination. Click the drop-down menu arrow to view/select a valid choice. Choices are: • Unknown (Default) • No • Yes
LAST DATE RECEIVED (MM/DD/YYYY)	Date the flu vaccination was received. Type a date or click the calendar to select a date. This date be “on” or after the “date of birth (if entered),” and not a future date.
JAUNDICED	Indicates whether or not the patient has or had jaundice. Click the drop-down menu arrow to view/select a valid choice. Choices are: • Unknown (Default) • No • Yes
PREGNANT DURING ILLNESS	Indicates whether or not the patient is or was pregnant during this illness. Click the drop-down menu arrow to view/select a valid choice. Choices are: • Unknown (Default) • No

FIELD	DESCRIPTION
	• Yes
PERSON PROVIDING REPORT **Note**: If you cannot see the field names listed below, click on the section name to open this section of the screen.	
TITLE	Title of the person providing the report.
LAST NAME	Last name of the person providing the report.
FIRST NAME	First name of the person providing the report.
PHONE/EXT	Phone number and extension, if applicable, of the person providing the report.
EMAIL	Email address of the person providing the report.
NAME OF REPORTING FACILITY	Name of the facility of the person providing the report. When you select a facility from this drop-down menu, the following fields (in the **PERSON PROVIDING REPORT** section) are automatically filled in: • Reporting Facility ID • Type of Reporting Facility • Hospital Region/District • Street • City • County • State • Zip
REPORTING FACILITY ID	Clinical Laboratory Improvement Amendments (CLIA) ID of the facility of the person providing the report. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
TYPE OF REPORTING	Type of facility of the person providing the report, such as Clinics, ER, Hospital, and Laboratory. This

FIELD	DESCRIPTION
FACILITY	field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field. A facility can be of more than one type. For example, Central Hospital (**FACILITY NAME**) can be a hospital or a lab (**TYPE OF REPORTING FACILITY**).
HOSPITAL REGION/DISTRICT	Geographic grouping of hospitals into bioterrorism regions/districts. This is a read-only field. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
STREET	Street address of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
CITY	City of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
HOSPITAL REGION/DISTRICT	Geographic grouping of hospitals into bioterrorism regions/districts. This is a read-only field. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
STREET	Street address of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
CITY	City of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
COUNTY/BOROUGH OR PARISH	County, Borough, or Parish of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.

FIELD	DESCRIPTION
STATE	State name of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
ZIP	Zip code of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
PRIMARY OR ATTENDING PHYSICIAN **Note**: If you cannot see the field names listed below, click on the section name to open this section of the screen.	
TITLE	Title of the primary or attending physician. For example, M.D.
LAST NAME	Last name of the primary or attending physician. Begin to type the first letters of the Physician's first or last name and a "pop up" list of Physician Names appears. Point and click a name to select it. The remaining physician fields will populate with the stored information. 
FIRST NAME	First name of the primary or attending physician. Begin to type the first letters of the Physician's first or last name and a "pop up" list of Physician Names appears. Point and click a name to select it. The remaining physician fields will populate with the stored information.
PHONE/EXT	Phone number and extension, if applicable, of the primary or attending physician.
EMAIL	Email address of the primary or attending physician.

FIELD	DESCRIPTION
PHYSICIAN FACILITY NAME	Name of the facility the Physician is associated with.
STREET LINE 1 **STREET LINE 2**	Street address of the primary or attending physician.
STATE	State name of the patient's home address. Click the drop-down menu arrow to view/select a state. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
CITY	City of the patient's home address. First, choose a state, and then begin to type the first four letters of the City name and a "pop up" list of City names and zip codes appears. Point and click a city name/zip to select it. The City, Zip Code, and County fields will populate with the stored information. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
ZIP	Zip code of the patient's home address. This field is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
COUNTY/BOROUGH OR PARISH	(Required for Louisiana) County, Borough, or Parish of the primary or attending physician. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.

2. Click one of the following buttons:

- **SAVE & FINISH** – begins the validation process and if the validation is successful (no errors), it saves the case to the database and displays the "Case Reporting" tab for the newly created case. If there are errors, they must be corrected before you can finish.
- **CANCEL** – terminates the process of adding a new case and redisplays the "Case Listings" screen. If you entered information on the screen, a dialog box appears asking if you are sure you want to cancel.
  - **a)** Click the **OK** button to terminate the process of adding a new case and redisplay the "Case Listings" screen.
  - **b)** Click the **CANCEL** button to remain on the "Patient Information" screen with the data you entered intact.
- **CASE DEF** – opens another browser window and displays the Centers for Disease Control and Prevention (CDC) or other source, such as "Red Book Online."

BACKGROUND PROCESSING WHEN SAVING CASES

Sentinel performs the following background processes before saving the new case to the database and in this order.

1. Geocoding – Determines the longitude and latitude coordinates of the investigation address. Refer to the next section, "Geocoding Process" for more information.

2. Deduplication – Process of attempting to locate possible duplicate patients and/or cases. Refer to "Deduplication Process" for more information.

3. Case Assignment & Jurisdiction – Assignment of the case after the jurisdiction (Region/District, Program Area, etc.) has been determined according to configured Assignment rules. Refer to the section titled, "Case Assignment & Jurisdiction" for more information.

GEOCODING PROCESS

Geocoding is the process of identifying an address and determining the longitude and latitude coordinates of that address. The resulting coordinates are used for two important features within Sentinel—jurisdiction determination and case maps.

Before Geocoding can occur, the Investigation Address must be determined. The Investigation Address is determined by the availability, validity, and accuracy of the three requested addresses:

- Patient Home Address – A valid patient home address is entered and the “Onset Date” (or “Referral Date” if “Onset Date” is not available) is between the “From” and “To” dates of a patient’s address history. Blank “From” and “To” dates are interpreted as prior to disease onset and the current date, respectively.

- Providing Physician Address – The patient home address is either invalid or unavailable and a valid physician address is provided.

- Submitting Laboratory Address – Submitting Laboratory addresses are used for an investigation address if (1) the case was created based on a submitted laboratory report, and (2) neither the patient nor the physician address are available and acceptable. Submitting Laboratory addresses are not considered for the investigation address for manually-entered cases.

- Blank – None of the three requested addresses are acceptable. For this event, the case is assigned to the State Supervisor for review. A subsequent referral to an LPHU (Field Epi Region/District or Local Health Department) will occur if an address can be obtained.

Once the investigation address is determined, the street address is separated into components. For example, the following components can be identified from a street address:

- House or street number

- Street name

- Street suffix (e.g., road, drive, avenue)

- Street direction (e.g., east, west, north)

- Secondary unit descriptors (e.g., apartment, room, building)

Using the official United States Postal Service abbreviations, elongated address components such as “Road” are replaced with the postal abbreviation of “RD.” The standard postal abbreviations are available at:

http://www.usps.com/ncsc/lookups/usps_abbreviations.html

At a minimum, the geocoder requires the following address components to successfully return the address coordinates. If the address does not contain these components, Sentinel will not call the geocoder.

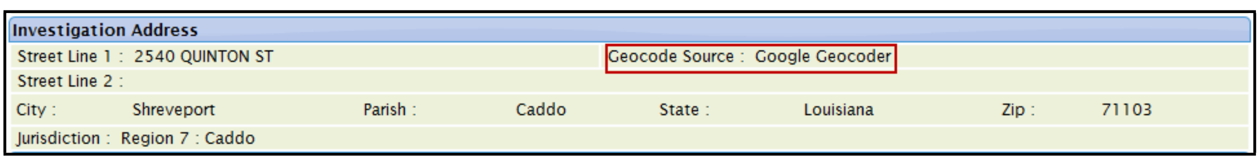
- House or street number
- Street name
- City or ZIP code

The geocoder does not support the following:

- PO boxes, RR and RFD addresses. If the address contains this type of information, Sentinel will attempt to determine the jurisdiction based on the city, county, and ZIP code information, but case location cannot be mapped.
- Out-of-state addresses. If the address is an out-of-state address, the case is referred to the State for investigation and/or referral to the appropriate authorities.

GEOCODE SOURCE is a read-only field in the "Investigation Address" section of the "Case Reporting" tab as well as the "Address History" Tab; it indicates the geocoding source for the investigation address coordinates.

Figure 5-58: Geocode Source



After the geocoding process is complete, the **GEOCODE SOURCE** field indicates if the address was successfully geocoded.

Deduplication Process

Note: This section assumes your application uses STC's MPI application for patient/case deduplication. If your state uses a different application, your screens and procedures may differ.

Deduplication is a term that is used to describe a transparent process that runs in the background to determine if the patient or case already exists in the system. The deduplication process consists of two sub-processes:

- The first process is “Patient Deduplication.” This stage relies on Master Patient Index (MPI) and focuses on patient demographic information. Depending on whether the patient has been determined to be a duplicate and is merged (automatically or manually), determines whether the case deduplication process begins.
- The second process is “Case Deduplication.” This process is optional and it occurs only for the case deduplication. It relies on the functionality available in the Sentinel application itself. It is triggered when certain case deduplication criteria are met. The second state is initiated only if the first stage is completed successfully. The deduplication criteria that affect case deduplication are the same “Reportable Condition” and “Look-back Intervals” (which vary depending on the “Reportable Condition”).

The end result for each of those processes is to determine whether the patient or case is a “definite match,” “not a definite match,” or is a “probable match.”

The settings for MPI Patient Deduplication are done within the MPI application while the Sentinel Case Deduplication settings are done within Sentinel’s System Administration menu using the Disease Code Management option. Refer to the System Administration Guide and/or the MPI Application User Guide for more information.

When you enter and save a new case, Sentinel informs MPI about the patient record.

- If a match is not found, MPI returns a new MPI ID to Sentinel.
- If the patient already exists in MPI, then MPI returns the existing patient's MPI ID information side-by-side with the new information.
- If MPI does not have enough information to determine if the patient is a match, it defers the record to an Administrator in the MPI Possible Merge Notifications to resolve.

Sentinel deduplicates patient records at the time of New Case entry or from the **PENDING WORK QUEUE** option on the “System Administration” Menu.

Note: Healthcare providers and laboratories that submit referrals will not need to perform deduplication tasks.

Duplicate patients are identified by comparing the following field values:

- Patient First Name - Approximate string comparator (inexact matching algorithm) and nickname searches.
- Patient Last Name - Approximate string comparators (inexact matching algorithm).
- Patient Date of Birth
- Patient Sex
- Patient’s Street Address - Inexact matching using approximate string comparators (multiple inexact matching algorithms).

As each field is compared, a value is applied to the degree that it matches. Once a value is applied to each field, the values are weighed and the Deduplication Rank is calculated. The Deduplication Rank determines whether a record is an exact or possible match of an existing record. Ranks above a certain threshold are automatically merged, while ranks below another threshold are considered non-matches. Ranks in between the two thresholds are sent to manual review in the MPI as possible matches.

Note: The thresholds are set in the Deduplication configuration file.

The deduplication process in the MPI handles merging of the patient demographic information. Sentinel stores the information and a copy of the demographics data within its own database. After a merge is performed in the MPI, a notification is added to the “Pending Work Queue” in Sentinel. This allows an administrator to review the data stored in Sentinel and update it accordingly.

Note: Refer to the Sentinel System Administration Guide for more information on merging.

When there is a possible match and you have update privileges, the "Patient Record Update" screen appears. Continue to the section titled, "Resolving Possible Duplicate Records" for instructions.

CASE ASSIGNMENT & JURISDICTION PROCESS

The State of Mississippi handles case assignment statewide uniquely per disease; otherwise, Sentinel determines the correct jurisdiction for a case and then assigns the case to the Local Health Jurisdiction administrator who is designated to receive the automated case assignment. This case assignment logic is based on Roles - Investigation Permissions and Data Access Level and the roles assigned to the User. Regardless of the state, it is assumed the User Profile - Auto Case Assignment is set to "active."

The following will be assigned during Case Assignment.

- Investigator First Name – During Case Assignment, the case is assigned to an investigator within the determined jurisdiction. Once the investigator is assigned, the Investigator's First Name is retrieved from the User information found in the System Administration module.

- Investigator Last Name – During Case Assignment, the case is assigned to an investigator within the determined jurisdiction. Once the investigator is assigned, the Investigator's Last Name is retrieved from the User information found in the System Administration module.

- Investigator User ID – During Case Assignment, the case is assigned to an investigator within the determined jurisdiction. Once the investigator is assigned, the Investigator's User-ID is retrieved from the User information found in the System Administration module.

The jurisdiction is determined by the county of the investigation address. If coordinates are not available, county can be determined based on city or ZIP code.

Each jurisdiction is designated to one of several identified regions/districts within the state. Once the jurisdiction is determined, that value is used to retrieve the corresponding region/district.

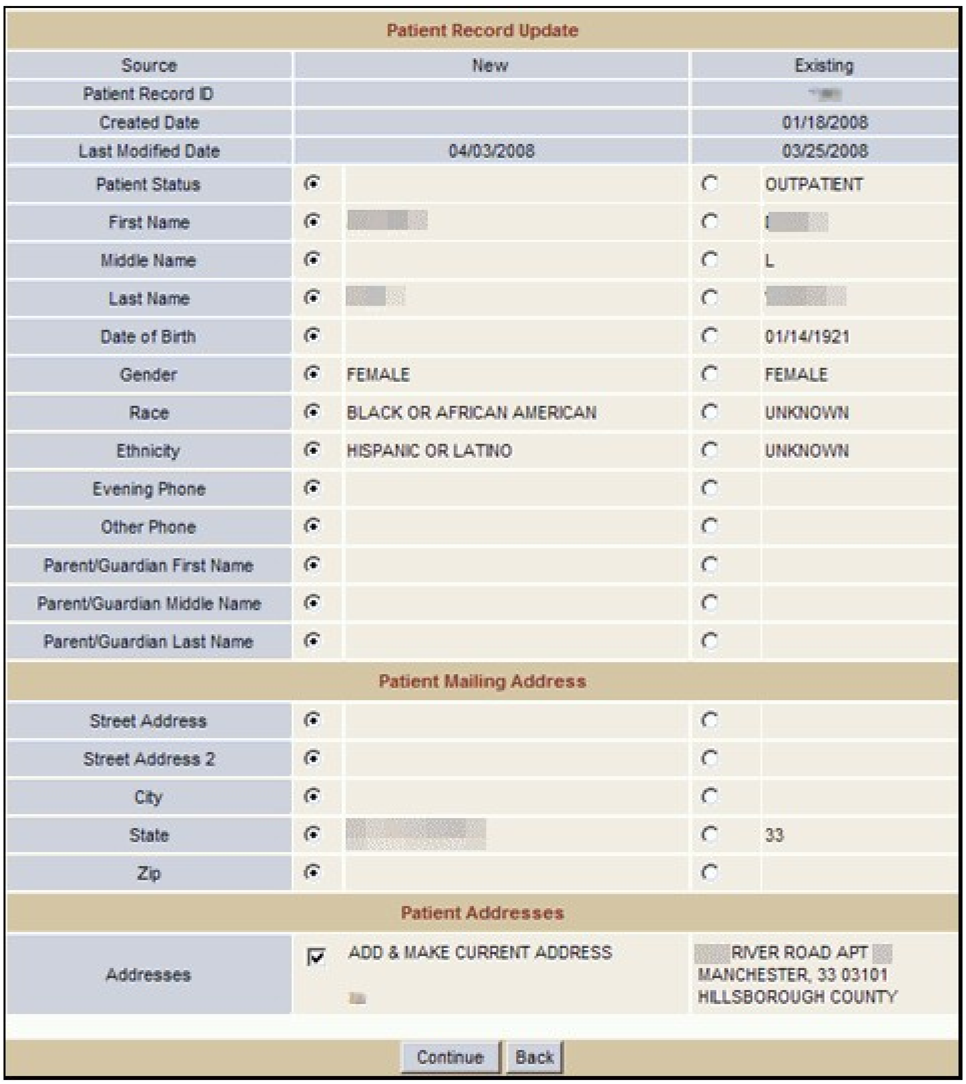
Once the correct jurisdiction is established for a case, the case is assigned to the administrator of that jurisdiction who is designated to receive the automated case assignment. The administrator can then assign that case to any investigator within their jurisdiction.

For the special program areas such as Hepatitis, the case assignments are handled separately. These cases are assigned to their respective program-area user based on the automatic case assignment designation in the user account setup.

Resolving Possible Duplicate Records

When there is a possible match and you have update privileges, the "Patient Record Update" screen appears.

Figure 5-59: Patient Record Update Screen



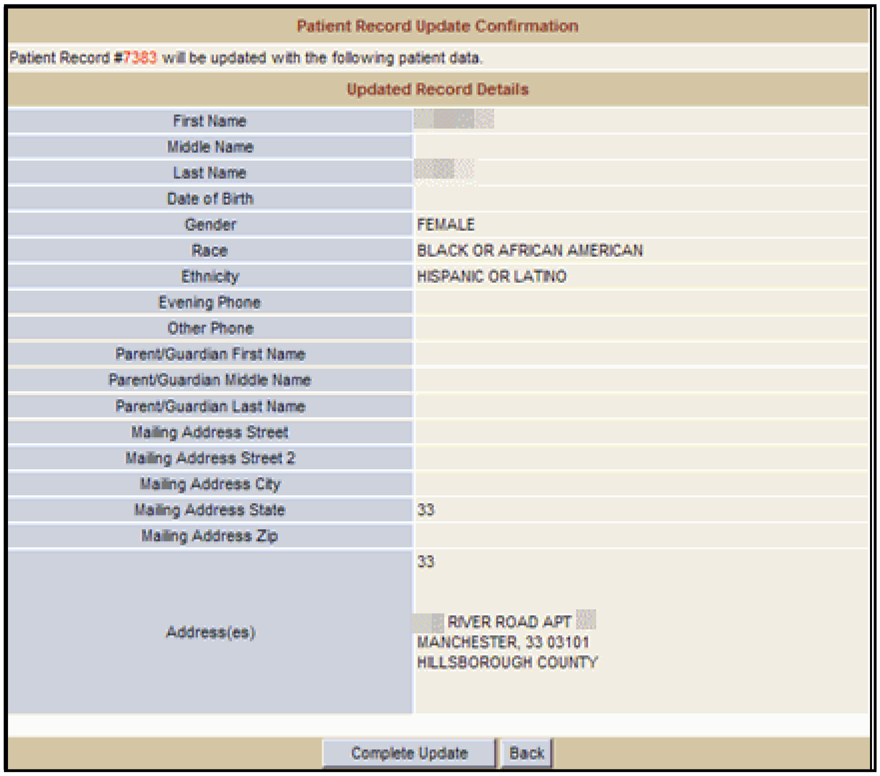
Patient Record Update		
Source	New	Existing
Patient Record ID		
Created Date		01/18/2008
Last Modified Date	04/03/2008	03/25/2008
Patient Status		OUTPATIENT
First Name		
Middle Name		L
Last Name		
Date of Birth		01/14/1921
Gender	FEMALE	FEMALE
Race	BLACK OR AFRICAN AMERICAN	UNKNOWN
Ethnicity	HISPANIC OR LATINO	UNKNOWN
Evening Phone		
Other Phone		
Parent/Guardian First Name		
Parent/Guardian Middle Name		
Parent/Guardian Last Name		
Patient Mailing Address		
Street Address		
Street Address 2		
City		
State		33
Zip		
Patient Addresses		
Addresses	ADD & MAKE CURRENT ADDRESS	RIVER ROAD APT MANCHESTER, 33 03101 HILLSBOROUGH COUNTY

Continue | Back

To resolve possible duplicate records following new case entry, perform the following:

1. On the "Patient Record Update" screen, review both columns of information. The left column represents the new patient just added and the right column represents the existing patient that was located.
2. Select each radio button for the data you want to keep/merge.
3. In the **PATIENT ADDRESSES** section:
   - If you want to add the address and set it to be the current address, select the check box.
   - If you want add the address but do not want it to be the current address, select the check box and then edit the address via the "Address History" tab. Refer to the section titled, "Editing an Address" for more information.
   - If you do not want to add the address to be part of the patient's address history, deselect (clear) the check box.
4. Click one of the following buttons:
   - **BACK** – returns to the previous window.
   - **CONTINUE** – merges the records and displays the "Patient Record Update Confirmation" screen. Continue to the next step.

Figure 5-60: Patient Record Update Confirmation Screen



Patient Record Update Confirmation	
Patient Record #7383 will be updated with the following patient data.	
Updated Record Details	
First Name	
Middle Name	
Last Name	
Date of Birth	
Gender	FEMALE
Race	BLACK OR AFRICAN AMERICAN
Ethnicity	HISPANIC OR LATINO
Evening Phone	
Other Phone	
Parent/Guardian First Name	
Parent/Guardian Middle Name	
Parent/Guardian Last Name	
Mailing Address Street	
Mailing Address Street 2	
Mailing Address City	
Mailing Address State	33
Mailing Address Zip	
Address(es)	33 RIVER ROAD APT MANCHESTER, 33 03101 HILLSBOROUGH COUNTY

Complete Update | Back

5. Verify that you want to merge the data and then click one of the following buttons:

- **COMPLETE UPDATE** – completes and saves the merge. Sentinel maintains a log of records that have been merged.
- **BACK** – returns to the "Patient Record Update" screen.

Editing Cases Using Disease Specific (Supp) Forms

These instructions are for both options of editing a human case as well as non-human cases using disease specific forms.

Note: Once you enter a case into Sentinel, you must use the "Case Detail-Address History" screen to maintain all patient address information. Patient address information within the disease specific forms is unavailable during an edit (but can be viewed and/or printed).

In addition to editing a case using the application screens, if a Disease Supplemental form exists for the condition, you may edit the case using the forms. A disease specific form is an **HTML** file that is similar to the communicable disease forms used in a case investigation. These forms allow you to enter the same type of disease specific information into Sentinel using drop-down lists, check boxes, radio buttons, etc.

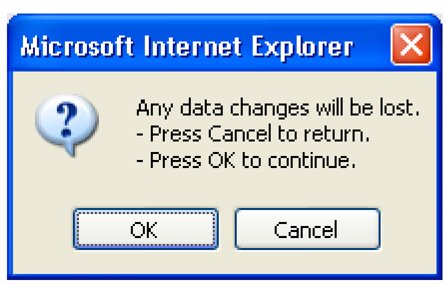
You can view and print a disease specific form at any stage in the case investigation using any of the following:

- Blank form
- Partial form
- Completed form

To edit a case using the disease specific form, perform the following:

1. On the “Case Investigation” menu, click one of the following options:
   - Cases
   - New Human Case
   - New Non Human Case
2. Locate the case you want to edit:
   - From the Case Listings screen, click the **EDIT** button
   - From the Search screens, enter the search criteria, select the case you want to edit, and then click the **EDIT** button.
3. The “Case Details – Case Reporting Tab” screen appears.
4. Click the **SUPP FORM (HTML)** button (located below the **DISEASE NAME** drop-down menu) or click the CDC Data Tab (if there is no button). The following dialog box appears.

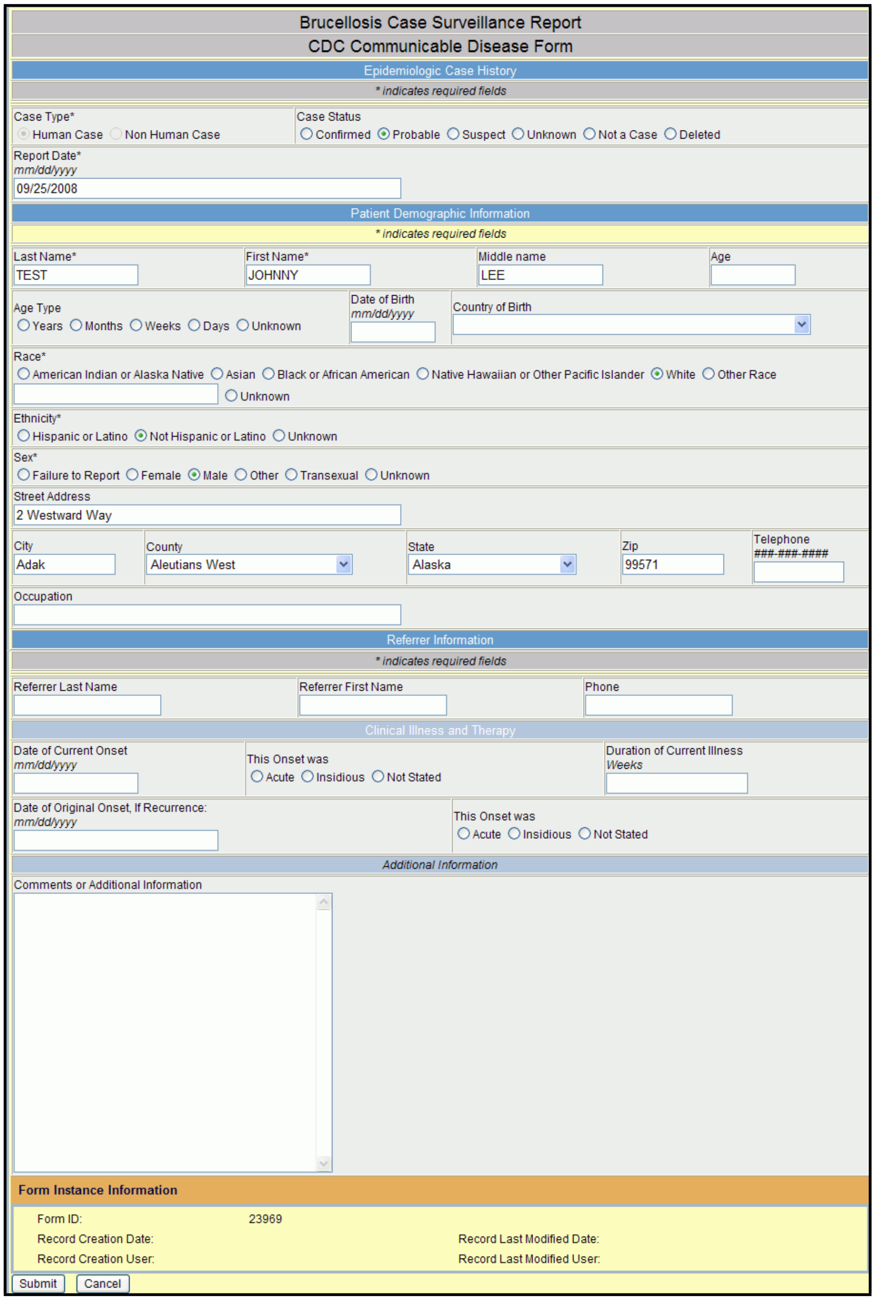
Figure 5-61: Disease Specific Form Dialog Box



6. Click the **OK** button to continue with the **HTML** form. Sentinel responds in one of the following ways:

- If the selected disease name has a disease specific form associated with it, the HTML form for the disease specific form opens (condensed version shown below).

Figure 5-62: HTML Disease Specific Form Example


Brucellosis Case Surveillance Report
CDC Communicable Disease Form
Epidemiologic Case History
* indicates required fields
Case Type*
Human Case Non Human Case
Case Status
Confirmed Probable Suspect Unknown Not a Case Deleted
Report Date*
mm/dd/yyyy
09/25/2008
Patient Demographic Information
* indicates required fields
Last Name* TEST
First Name* JOHNNY
Middle name LEE
Age
Age Type
Years Months Weeks Days Unknown
Date of Birth
mm/dd/yyyy
Country of Birth
Race*
American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other Race
Unknown
Ethnicity*
Hispanic or Latino Not Hispanic or Latino Unknown
Sex*
Failure to Report Female Male Other Transexual Unknown
Street Address
2 Westward Way
City Adak
County Aleutians West
State Alaska
Zip 99571
Telephone
###-###-####
Occupation
Referrer Information
* indicates required fields
Referrer Last Name
Referrer First Name
Phone
Clinical Illness and Therapy
Date of Current Onset
mm/dd/yyyy
This Onset was
Acute Insidious Not Stated
Duration of Current Illness
Weeks
Date of Original Onset, If Recurrence:
mm/dd/yyyy
This Onset was
Acute Insidious Not Stated
Additional Information
Comments or Additional Information
Form Instance Information
Form ID: 23969
Record Creation Date:
Record Last Modified Date:
Record Creation User:
Record Last Modified User:
Submit Cancel

- If the selected disease name <u>does not</u> have a disease specific form associated with it, a message appears stating that no form is available.

- Click the **CDC FORM** tab to enter the information via the application screens.

7. Type or select the values for the fields. Refer to “Table 5-22” for a list of fields and descriptions.

8. Click one of the following buttons:

- **SUBMIT FORM** – begins the validation process of the field values and if the validation is successful (no errors), the case is saved to the database.

  You are returned to the “Case Listings” screen or you may enter “Patient Deduplication” (if you have deduplication privileges and the patient you entered matches an existing patient in the system).

- **CANCEL FORM** – returns you to the “Case Listings” screen. Any changes you made to the form are not saved.

Refer to the section titled, “Background Processing When Saving Cases” for information on what occurs when you save a case.

TIPS FOR FILLING OUT DISEASE SPECIFIC FORMS

The following table provides tips on using the Forms. Additional information is within Adobe Reader Online Help.

Table 5-23: Disease Specific Form Tips

ITEM	DESCRIPTION
POINTER TYPES	The “I-beam” pointer allows you to type text. The arrow pointer allows you to select a button, check box, radio button, or an item from a drop down menu. The “Hand” pointer (PDF Form) allows you to select a radio button.
KEYBOARD KEYS	
TAB	Accepts the field value change and moves the cursor to the next field.

ITEM	DESCRIPTION
SHIFT + TAB	Accepts the field value change and moves the cursor to the previous field.
ENTER	On a standard keyboard and on a numeric keypad, pressing ENTER accepts the field value change and moves the cursor away from the field. In a multi-line text field, pressing ENTER moves to the next line in the same field.
ESC	Rejects (resets) the field value change and moves the cursor away from the field.

EDITING THE INVESTIGATION STATUS FIELD (COMPLETED/CLOSED)

Once a case's Investigation Status is set to "Completed" or "Closed," the case can be opened and viewed by clicking on the **EDIT** button within the "Case Listing" screen…

- if the user does not have permission to "Reopen Completed Cases" or "Reopen Closed Cases," the case will be opened for view only (read-only mode). Any "TAB" or "HTML FORM" can be selected, but changes cannot be saved.

- if the user has permission to "Reopen Completed Cases" or "Reopen Closed Cases," the user can change the "Investigation Status" to any other status. When a status other than "Completed" or "Closed" is selected and saved, all fields are able to be edited by any user with permission to view the case.

Note: Each state has their own business practices regarding the status of this field. For example, New Hampshire prefers the status to be changed to ACTIVE.

PHYSICIAN REPORTING

[This is a state-configurable option and may not appear for your state.]

The Physician Reporting Menu and options are for statewide Physicians' and accredited Disease reporting Healthcare Professionals to add a minimum set of data into the Sentinel application to report a disease case. This information was previously sent manually on Form No. 135 and now it will be stored directly into the Sentinel Case Database.

Note: New Hampshire uses the Physician Card option for their Facility Users to create new human cases; thus a "Facility" role has been created.

Access to this option will be based on a userid and/or access role.

- If the user is using both Sentinel and Physician Card Data Entry, then the user must have the **Physician Card Admin** privilege.
- If the user is only using the Physician Card Entry application, then the user should have the **Phys Card Entry** permission.

Note: For the State of Mississippi, "Individual case reports of influenza-like illnesses are not required and Campylobacter pylori is not reportable" will appear at the bottom of the screen (shown in the illustration below).

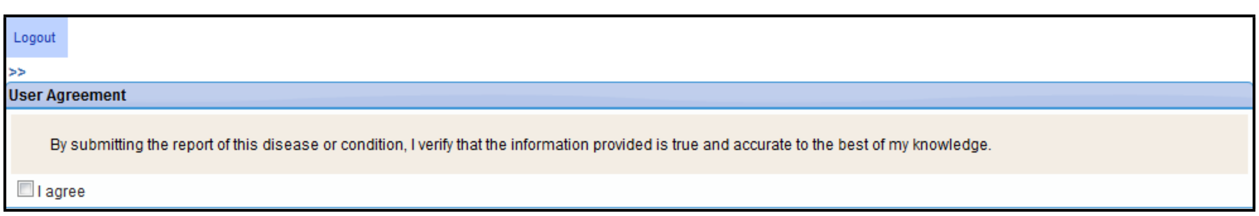
After a user accesses the Physician Reporting application, the "Physician Reporting – User Agreement" appears.

ACCEPTING THE USER AGREEMENT

To accept the user agreement, perform the following:

1. Once a user enters a valid username and password, the "User Agreement" appears.

Figure 5-63: Physician Reporting – User Agreement



Note: This Agreement will appear every time a Physician Card user logs into the application.

2. Click the **I AGREE** checkbox. Once the checkbox is clicked, the “Physician Reporting” menu appears (to the left of the **LOGOUT**) option.

3. Continue to the desired menu option.

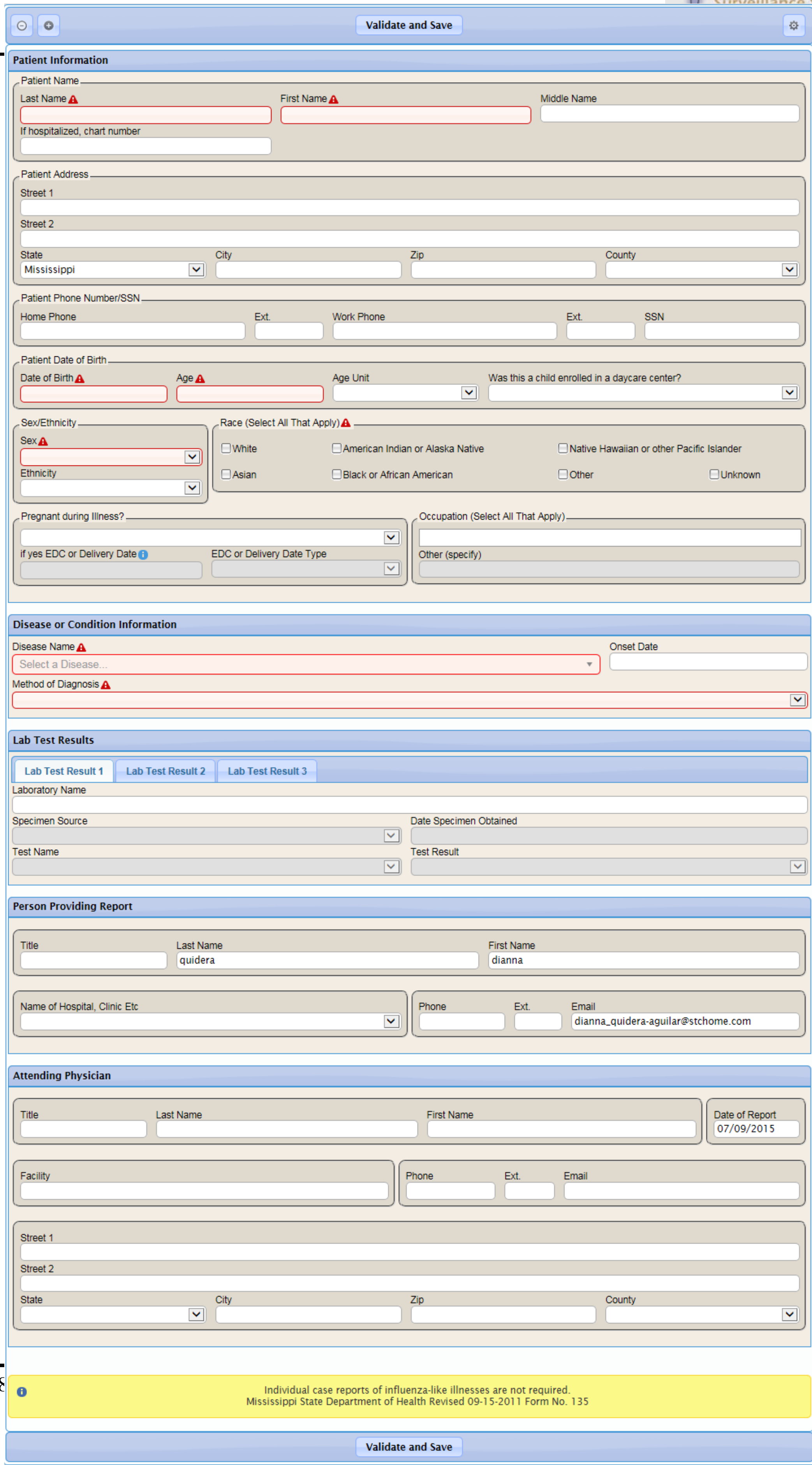
ENTERING PHYSICIAN CARD DATA

Depending on your user access and privileges, access either begins from the “Case Investigation Menu” or the “Physician Reporting Menu.”

To enter Physician Card Data, perform the following:

1. On the “Physician Reporting” Menu (or “Case Investigations Menu,”) click the **PHYSICIAN CARD** option. The “Physician Reporting” screen appears.

Figure 5-64: Physician Card Entry



Validate and Save

Patient Information

Patient Name

Last Name | First Name | Middle Name

If hospitalized, chart number

Patient Address

Street 1

Street 2

State: Mississippi | City | Zip | County

Patient Phone Number/SSN

Home Phone | Ext. | Work Phone | Ext. | SSN

Patient Date of Birth

Date of Birth | Age | Age Unit | Was this a child enrolled in a daycare center?

Sex/Ethnicity

Sex

Ethnicity

Race (Select All That Apply)

White | American Indian or Alaska Native | Native Hawaiian or other Pacific Islander

Asian | Black or African American | Other | Unknown

Pregnant during Illness?

if yes EDC or Delivery Date | EDC or Delivery Date Type

Occupation (Select All That Apply)

Other (specify)

Disease or Condition Information

Disease Name: Select a Disease... | Onset Date

Method of Diagnosis

Lab Test Results

Lab Test Result 1 | Lab Test Result 2 | Lab Test Result 3

Laboratory Name

Specimen Source | Date Specimen Obtained

Test Name | Test Result

Person Providing Report

Title | Last Name: quidera | First Name: dianna

Name of Hospital, Clinic Etc | Phone | Ext. | Email: dianna_quidera-aguilar@stchome.com

Attending Physician

Title | Last Name | First Name | Date of Report: 07/09/2015

Facility | Phone | Ext. | Email

Street 1

Street 2

State | City | Zip | County

Individual case reports of influenza-like illnesses are not required.
Mississippi State Department of Health Revised 09-15-2011 Form No. 135

Validate and Save

Note: The health disclaimer at the bottom of this screen only appears for the state of Mississippi.

2. The fields and their descriptions are listed in the table.

Table 5-24: Physician Card Field Descriptions

ITEM	DESCRIPTION
DISEASES OR CONDITIONS INFORMATION	
DISEASE NAME	This is the Reportable Condition or Disease Name. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Anthrax • Botulism – Food borne • Brucellosis These diseases/conditions are maintained by the System Administrator. **Note**: The Disease Name determines the other fields that appear. For example, if the disease is Hepatitis, Tuberculosis, or Trauma, extra fields specific to the disease will appear on the screen. • Hepatitis – displays Hepatitis Specific Information and Hepatitis Chemistry Results. • Tuberculosis – displays Mycobacterial Disease Information. • Spinal Cord Injuries – displays Injury Related Information. **Note for Mississippi**: When you enter a Class 1 reportable disease, a message will appear in red bold font stating, “Class 1 diseases and conditions require an immediate public health response and must be reported directly to the Mississippi State Department of Health (MSDH) by telephone within 24 hours of first knowledge or suspicion. Submission of this information through this website does NOT relieve the reporter of their obligation to call in the report. Reporting Hotline: 1-800-556-0003; Monday - Friday, 8:00am - 5:00pm For Nights, Weekends, Holidays please call: (601) 576-7400.

ITEM	DESCRIPTION
ONSET DATE	Date the symptoms of this disease first appeared. Either type the date using the format mm/dd/yyyy or click the calendar icon to select a date.
METHOD OF DIAGNOSIS	Indicates the diagnosis method. Click the drop-down menu arrow to view available options.. Available options are: • Blank • Clinical • Laboratory • Both Clinical and Laboratory **Note**: The Method Of Diagnosis determines other fields that appear. For example, if the Method of Diagnosis is "Laboratory," then Laboratory Name, Lab Name Other, Specimen Source, and Lab Test Result fields/sections appear.
LABORATORY NAME	If the "Method of Diagnosis" field contains Laboratory, then the Laboratory Name field appears. This is the Laboratory where testing was performed and results obtained from. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Alliance Health Center • Baptist Memorial Hospital – Gold Triangle • Calhoun Health Service **Note**: If the name of the Laboratory is not in the list, select the "blank" option and then fill in the "Lab Name Other" field with the name.
LAB NAME OTHER	If the "Laboratory Name" field contains a blank indicating the name of the lab was not in the drop-down menu, fill in the name of the lab in this field. An email will be sent to the administrator to add the Lab Name to the list.
SPECIMEN SOURCE	Type of specimen collected. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Abscess

ITEM	DESCRIPTION
	• Biopsy • Catheter tip
LAB TEST RESULT	
TEST NAME	Name of the test. Click on the drop-down menu arrow to view/select a valid name. This field is required if “Method of Diagnosis” contains “Laboratory” or “Clinical and Laboratory.” This list is derived from the LOINC-SNOMED table.
TEST RESULT	Result of the test. Click on the drop-down menu arrow to view/select a valid result. This field is required if “Method of Diagnosis” contains “Laboratory” or “Clinical and Laboratory.” This list is derived from the LOINC-SNOMED table.
IF HOSPITALIZED, CHART NUMBER	Patient’s hospital chart number, if the patient was hospitalized. Type the number (maximum 20 characters). If this field is entered, the Hospital Name does not need to be entered.
DATE SPECIMEN OBTAINED	Date the laboratory specimen was obtained. Either type the date using the format mm/dd/yyyy or click the calendar to select a date.
PATIENT INFORMATION	
LAST NAME	Patient’s last name (maximum 30 characters).
FIRST NAME	Patient’s first name (maximum 30 characters).
MIDDLE NAME	Patient’s middle name (maximum 30 characters).
OCCUPATION	Patient’s occupation (maximum 30 characters). There are two boxes; the one on the left contains the “Selected Items;” the one on the right contains the “Available Items.” All occupations will be listed in the “Available Items” multi-selection box. Click each one that applies by clicking the plus sign (+). That choice will be moved to the “Selected Items” box. To add all occupations, click the **ADD**

ITEM	DESCRIPTION
	ALL hyperlink. To remove an item from the "Selected Items" box, click the minus sign from the "Selected Items" box. That choice will be moved to the "Unselected Items" Occupations box. To remove all selected races, click the **REMOVE ALL** hyperlink.
STREET ADDRESS LINE 1	Patient's first line of address (maximum 30 characters).
STREET ADDRESS LINE 2	Patient's second line of address (maximum 30 characters).
CITY	Patient's city of address. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Abbeville • Bailey • Cadaretta **Note**: If "Out of State" is selected, the County and Zip fields will be blank (or null).
COUNTY	Patient's county of address. This will automatically populate if only one county is located in the selected city; otherwise, click the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Lafayette • Lauderdale • Calhoun
STATE	Patient's state of address. This will automatically default and display the "home state" of the user. At that time, a drop-down menu will appear to view/select a valid choice.
ZIP	Patient's zip code of address. This field is driven by the "City" field. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are:

ITEM	DESCRIPTION
	• 38601 • 39320 • 38929
HOME PHONE	Patient's home phone number. Type the phone number with only numbers; the dashes will automatically be embedded.
(HOME PHONE) EXT	Patient's home phone extension, if any.
WORK PHONE	Patient's work phone number. Type the phone number with only numbers; the dashes will automatically be embedded.
(WORK PHONE) EXT	Patient's work phone extension, if any.
DATE OF BIRTH	Patient's date of birth. Either type the date using the format mm/dd/yyyy or click the calendar to select a date.
AGE	Patient's current age. If the "Date of Birth" was entered, this will automatically calculate.
AGE UNIT	Unit of the current age. If the "Date of Birth" was entered, this will automatically calculate.
SEX	Patient's gender/sex. Click on the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Female • Male • Not Reported
ETHNICITY	Patient's ethnicity. Click on the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Hispanic or Latino • Not Hispanic or Latino • Unknown

ITEM	DESCRIPTION
RACE	Patient's race. There are two boxes; the one on the left contains the "Selected Items;" the one on the right contains the "Available Items." All races will be listed in the "Available Items" multi-selection box. Click each one that applies by clicking the plus sign (+). That choice will be moved to the "Selected Items" box. To add all races, click the **ADD ALL** hyperlink. To remove an item from the "Selected Items" box, click the minus sign from the "Selected Items" box. That choice will be moved to the "Unselected Items" Race box. To remove all selected races, click the **REMOVE ALL** hyperlink.
SSN	Patient's social security number. This field will be required if the "Disease or Condition" field is Tuberculosis. Type the social security number. The dashes will automatically embed appropriately. For example: 123-45-6789.
IF HOSPITALIZED, CHART NUMBER	If the patient is hospitalized, provide the patient's chart number. This field will transfer into the Sentinel application and populate the Case Reporting Tag – Hospital Information – Medical Record Number field. **Note**: If this field is entered, the Hospital Name is not required.
WAS THIS A CHILD ENROLLED IN A DAYCARE FACILITY?	This is a checkbox that will either contain a checkmark indicating YES or unchecked indicating NO.
PERSON PROVIDING REPORT **NOTE: THIS INFORMATION WILL POPULATE THE REFFERER TAB IN SENTINEL.**	
TITLE	Title of the person providing the disease report.
LAST NAME	Last Name of the person providing the disease report. This will automatically populate from the userid information (maximum 30 characters) unless

ITEM	DESCRIPTION
	it was changed by the user. If it was changed, this will automatically display what was previously entered.
FIRST NAME	First name of the person providing the disease report. This will automatically populate from the userid information (maximum 30 characters) unless it was changed by the user. If it was changed, this will automatically display what was previously entered.
PHONE	Telephone number of the person providing the report. Type the value using the format ###-###-####. This will automatically display what was previously entered.
EXT	Telephone extension of the attending physician.
EMAIL	Email address of the person providing the report. Type the Email address. This will automatically display what was previously entered.
NAME OF HOSPITAL, CLINIC, ETC.	Name of the reporting facility-hospital, clinic, etc providing the disease report. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are: • Alliance Health Center • Baptist Memorial Hospital – Golden Triangle • Calhoun Health Services **Note**: This field is not required it the If Hospitalized, Chart Number has been entered.
DATE OF REPORT	This is the Referral Date which defaults to “today’s date” but can be changed by the user. This date will automatically populate the Referral Date on the Case Reporting Tab of Sentinel. Either type the date using the format mm/dd/yyyy or click the calendar to select a date.
ATTENDING PHYSICIAN	

ITEM	DESCRIPTION
LAST NAME	Last name of the attending physician. Type the name (maximum 30 characters).
FIRST NAME	First name of the attending physician. Type the name (maximum 30 characters).
PHONE	Telephone number of the attending physician. Type the value using the format ###-###-####.
EXT	Telephone number extension, if any.
EMAIL	Email address of the attending physician. Type the Email address.
STREET ADDRESS LINE 1	Patient's first line of address (maximum 30 characters).
STREET ADDRESS LINE 2	Patient's second line of address (maximum 30 characters).
CITY	Patient's city of address. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are:
COUNTY	Patient's county of address. This will automatically populate if only one county is located in the selected city; otherwise, click the drop-down menu
STATE	Patient's state of address. This will automatically default and display the "home state" of the user. At that time, a drop-down menu will appear to view/select a valid choice.
ZIP	Patient's zip code of address. This field is driven by the "City" field. Click the drop-down menu arrow to view/select a valid choice. Examples of choices are:
HEPATITIS SPECIFIC INFORMATION **NOTE: ONLY APPEARS WHEN THE DISEASE NAME IS HEPATITIS RELATED.**	

HEPATITIS A IGM ANTIBODY	Hepatitis A IgM antibody. This field is required if the “Disease or Condition” is “Acute Hepatitis A.” Click the drop-down menu arrow to view/select a valid choice. Valid choices are: • Positive – requires the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name”. • Negative • Not Done (Blank) • Pending – indicates the user created a case of Hepatitis and selected the “Method of Diagnosis” of "Lab" or "Both Clinical & Lab," this option indicates the Test Result is pending. **Note**: This field populates the Lab Test Description and Lab Result Description in Sentinel.
HEPATITIS B IGM CORE ANTIBODY	Hepatitis B IgM core antibody. This field is required if the “Disease or Condition” is “Acute Hepatitis B.” Click the drop-down menu arrow to view/select a valid choice. Valid choices are: • Positive – requires the “Method of Diagnosis”

ITEM	DESCRIPTION
	field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” • Negative • Not Done (Blank) **Note**: This field populates the Lab Test Description and Lab Result Description in Sentinel.
HEPATITIS C ANTIBODY	Hepatitis C antibody. This field is required if the “Disease or Condition” is any “Hepatitis C.” Click the drop-down menu arrow to view/select a valid choice. Valid choices are: • Positive – requires the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” • Negative • Not Done (Blank) **Note**: This field populates the Lab Test Description and Lab Result Description in Sentinel.
WAS PATIENT JAUNDICED?	This question indicates whether or not the patient was jaundiced. This field is required if the “Disease or Condition” is any Hepatitis. Click the drop-down menu arrow to view/select a valid choice. Valid choices are: • Yes • No • Unknown **Note**: This field will automatically populate the supplemental form.
WAS PATIENT PREGNANT?	This question indicates whether or not the patient is pregnant. This field is required if the “Disease or Condition” is Acute Hepatitis B. Click the drop-down menu arrow to view/select a valid choice. Valid choices are: • Yes • No • Unknown

ITEM	DESCRIPTION
	Note: This field will automatically populate the supplemental form.
HEPATITIS CHEMISTRY RESULTS	
TOTAL BILIRUBIN	Total Bilirubin. Type the value of the total (maximum 30 characters). If this field is populated, it requires the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” **Note**: This field will automatically populate the supplemental form.
NORMAL RANGE FOR BILIRUBIN TEST	Normal range for the Bilirubin Test. Type the value of the range (maximum 30 characters). If this field is populated, it requires that the “Total Bilirubin” field to be populated; the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” **Note**: This field will automatically populate the Lab Test Description and Lab Result Description in Sentinel as well as automatically populate the supplemental form.
SGOT(AST)	SGOT(AST). Type the value of the total (maximum 30 characters). If this field is populated, it requires the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” **Note**: This field will automatically populate the supplemental form.
NORMAL RANGE FOR SGOT(AST) TEST	Normal range for the SGOT(AST) Test. Type the value of the range (maximum 30 characters). If this field is populated, it requires that the “SGOT(AST)” field to be populated; the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” **Note**: This field will automatically populate the Lab Test Description and Lab Result Description in Sentinel as well as automatically populate the supplemental form.

ITEM	DESCRIPTION
SGPT(ALT)	SGPT(ALT). Type the value of the SGPT(ALT) (maximum 30 characters). If this field is populated, it requires the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” **Note**: This field will automatically populate the Lab Test Description and Lab Result Description in Sentinel as well as automatically populate the supplemental form.
NORMAL RANGE FOR SGPT(ALT)	Normal range for the SGPT(ALT) Test. Type the value of the range (maximum 30 characters). If this field is populated, it requires that the “SGPT(ALT)” field to be populated; the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.” **Note**: This field will automatically populate the Lab Test Description and Lab Result Description in Sentinel as well as automatically populate the supplemental form.
MYCOBACTERIAL DISEASE INFORMATION **NOTE: APPEARS WHEN THE DISEASE NAME IS TUBERCULOSIS. THIS DATA WILL POPULATE A SEPARATE TAB IN SENTINEL THAT IS VISIBLE ONLY TO USERS WITH TB PERMISSIONS.**	
PPD MANTOUX DATE	This field is used to store the PPD Mantoux Date. Either type the date using the format mm/dd/yyyy or click the calendar to select a date. If this field is populated, it will require that the “PPD Mantoux Size” be populated as well as the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.”
PPD MANTOUX SIZE	This field is used to store the PPD Mantoux Size in millimeters. Type the value (maximum of 30 characters). If this field has an entry, the PPD Mantoux Date must be populated. If this field is populated, it requires that the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.”
SPUTUM DATE	This is the date of the Sputum. Either type the date using the format mm/dd/yyyy or click the calendar

ITEM	DESCRIPTION
	to select a date. If this field is populated, it will require that the “Sputum Test Type” be populated as well as the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.”
SPUTUM TEST TYPE (SOURCE)	Source of the Sputum. Click the drop-down menu arrow to view/select a valid Type. Examples of Types are: • Smear • Culture If this field has an entry, the Sputum Date must be populated. If this field is populated, it requires that the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.”
TISSUE OR BODY FLUID DATE	Tissue or Body Fluid Date. Either type the date using the format mm/dd/yyyy or click the calendar to select a date. If this field is populated, it will require that the “Tissue or Body Fluid Source” be populated as well as the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.”
TISSUE OR BODY FLUID TEST TYPE	Source of the Body Fluid Test. Click the drop-down menu arrow to view/select a valid Type. Examples of Types are: • Smear • Culture If this field has an entry, the Tissue or Body Fluid Date must be populated. If this field is populated, it requires that the “Method of Diagnosis” field to be “Laboratory” or “Clinical and Laboratory” thus, requires “Laboratory Name.”
CHEST X-RAY DATE	This field is used to store the Chest X-Ray Date. Either type the date using the format mm/dd/yyyy or click the calendar to select a date. If this field is populated, it will require that the “Chest X-Ray Results” be populated as well as the “Method of Diagnosis” field to be “Laboratory” or “Clinical and

ITEM	DESCRIPTION
	Laboratory" thus, requires "Laboratory Name."
CHEST X-RAY RESULTS	Results of the Chest X-Ray. If this field is populated, it will require that the "Chest X-Ray Date" be populated as well as the "Method of Diagnosis" field must be "Laboratory" or "Clinical and Laboratory" thus, requires "Laboratory Name." Click the drop-down menu arrow to view/select a valid choice. Valid choices are: • Abnormal • Cavitary • Noncavitary • Normal **Note**: This field will automatically populate the supplemental form.
H. INFLUENZAE, N. MENINGITIDIS, SHIGELLA, SALMONELLA, OR CAMPYLOBACTER RESULTS	
ORGANISM SEROGROUP	Organism Serogroup. If this field is populated, the "Method of Diagnosis" field must be "Laboratory" or "Clinical and Laboratory" thus, requires "Laboratory Name." Click the drop-down menu arrow to view/select a valid choice. Valid choices are those listed in the Sentinel Disease Table. **Note**: This field will automatically populate the Sentinel application.
ORGANISM SEROTYPE	Organism Serotype. If this field is populated, the "Method of Diagnosis" field must be "Laboratory" or "Clinical and Laboratory" thus, requires "Laboratory Name." Click the drop-down menu arrow to view/select a valid choice. Valid choices are those listed in the Sentinel Disease Table. **Note**: This field will automatically populate the Sentinel application.

ITEM	DESCRIPTION
INJURY RELATED INFORMATION **NOTE: THIS INFORMATION ONLY APPEARS WHEN THE DISEASE NAME IS SPINAL CORD OR HEAD INJURIES. THERE WILL BE A SECTION IN SENTINEL AVAILABLE TO THOSE AUTHORIZED TO VIEW THIS TYPE OF INJURY.**	
WORK RELATED	Indicates whether or not the injury was work-related. If this field is populated, the "Cause" and "Geographic Location of Occurrence" fields must be populated. Click on the drop-down menu arrow to view/select a valid choice. Valid choices are: • Yes • No • Unknown
CAUSE (CIRCUMSTANCES)	Indicates the cause of injury. This field must contain a value if the "Work Related" field contains a value (Yes/No). If this field is populated, the "Geographic Location of Occurrence" field must also be populated. Click on the drop-down menu arrow to view/select a valid choice. Examples of valid choices are: • Falls – Fall from one level to another • Firearms and Other Weapons – Blunt instrument • Sports/Recreation - Football
GEOGRAPHIC LOCATION OF OCCURRENCE	Geographic location of the occurrence. Type the location of the occurrence (maximum 30 characters). This field must contain a value if the "Work Related" field contains a value (Yes/No). If this field is populated, the "Cause" field must also be populated.

3. At a minimum, fill in all the red asterisked (*) fields and click one of the available buttons:

- **VALIDATE & SAVE** – to perform error validation on the entered fields and save the data to the database if there are no errors; otherwise, correct the errors and click the VALIDATE & SAVE button again. The "Physician Card" screen reappears.

Note: A dialog box stating, "Class 1 diseases and conditions require an immediate public health response and must be reported directly to the State Department of Health by telephone within 24 hours of first knowledge or suspicion. Submission of this information through this website does NOT relieve the reporter of their obligation to call and report. Reporting Hotline: 1-800-556-0003 Monday - Friday, 8:00am - 5:00pm. For Nights, Weekends, Holidays please call: (601) 576-7400.

- **RESET** – to erase any newly typed/selected data from all of the fields to reenter the data.

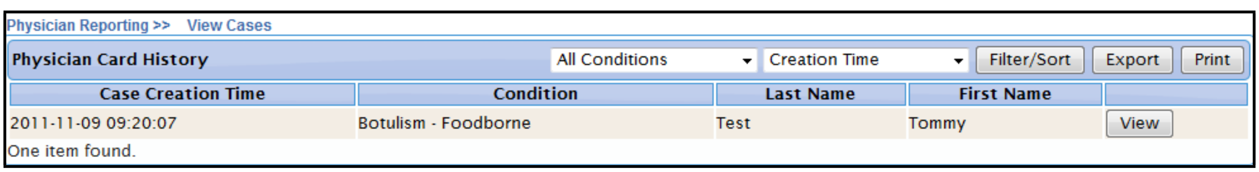
VIEWING PHYSICIAN CARD HISTORY CASE LISTING

This option is used to view the Physician Card Data you have entered. From this screen, you may Filter/Sort the Listing and View/Print the Case Information.

To view your Cases, perform the following:

1. On the "Physician Reporting" Menu, click the **VIEW CASES** option. The "Physician Card History" screen appears.

Figure 5-65: Physician Card History



2. Determine the action to perform and continue to the corresponding section below. The actions to perform are:

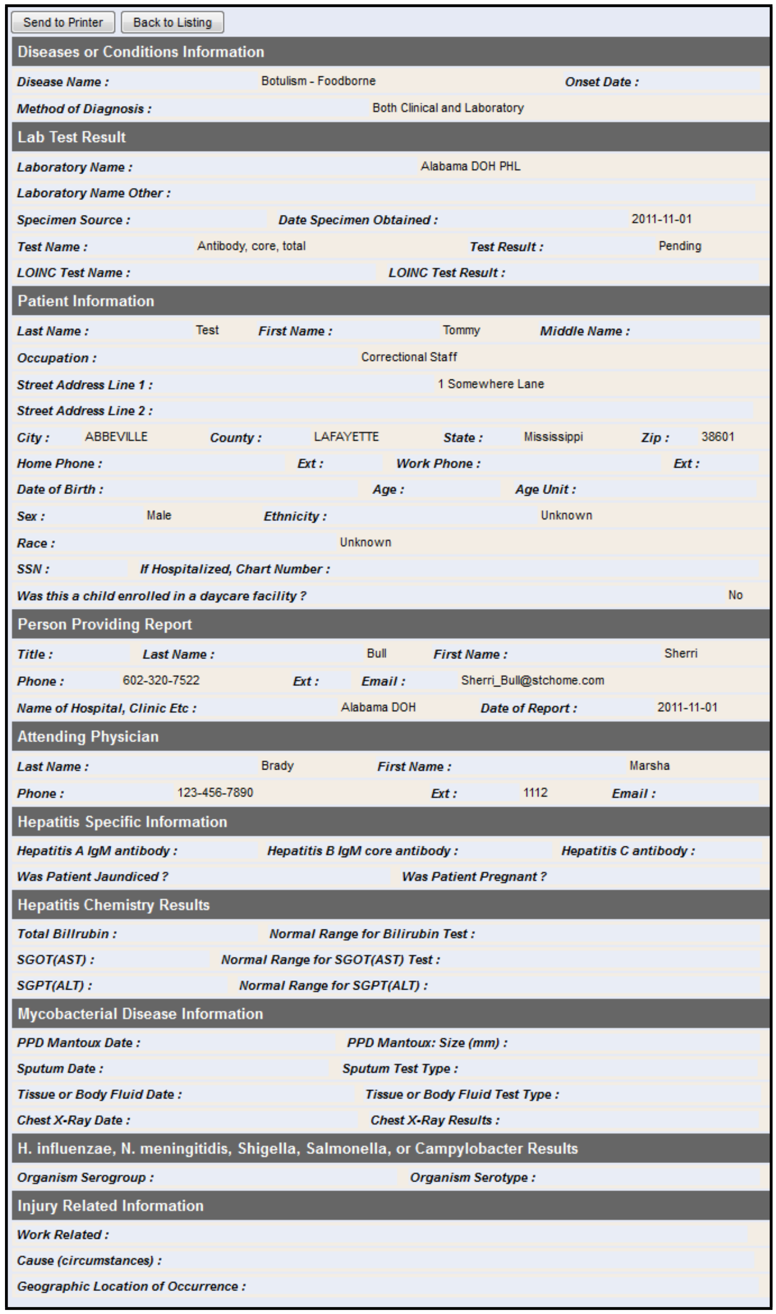
- Viewing the Case Details
- Filtering/Sorting the Case Listing
- Exporting the Case Listing
- Viewing/Printing the Case Listing

VIEWING THE PHYSICIAN CARD CASE DETAILS

To view the Physician Card Case Details for a specific case, perform the following:

1. On the "Physician Reporting" Menu, click the **VIEW CASES** option. The "Physician Card History" screen appears.
2. Locate the Case for whose Details you want to view and click the **VIEW** button. The "Case Details" screen appears.

Figure 5-66: Physician Reporting Case Details


Send to Printer | Back to Listing

Diseases or Conditions Information

Disease Name : Botulism - Foodborne *Onset Date :*
Method of Diagnosis : Both Clinical and Laboratory

Lab Test Result

Laboratory Name : Alabama DOH PHL
Laboratory Name Other :
Specimen Source : *Date Specimen Obtained :* 2011-11-01
Test Name : Antibody, core, total *Test Result :* Pending
LOINC Test Name : *LOINC Test Result :*

Patient Information

Last Name : Test *First Name :* Tommy *Middle Name :*
Occupation : Correctional Staff
Street Address Line 1 : 1 Somewhere Lane
Street Address Line 2 :
City : ABBEVILLE *County :* LAFAYETTE *State :* Mississippi *Zip :* 38601
Home Phone : *Ext :* *Work Phone :* *Ext :*
Date of Birth : *Age :* *Age Unit :*
Sex : Male *Ethnicity :* Unknown
Race : Unknown
SSN : *If Hospitalized, Chart Number :*
Was this a child enrolled in a daycare facility ? No

Person Providing Report

Title : *Last Name :* Bull *First Name :* Sherri
Phone : 602-320-7522 *Ext :* *Email :* Sherri_Bull@stchome.com
Name of Hospital, Clinic Etc : Alabama DOH *Date of Report :* 2011-11-01

Attending Physician

Last Name : Brady *First Name :* Marsha
Phone : 123-456-7890 *Ext :* 1112 *Email :*

Hepatitis Specific Information

Hepatitis A IgM antibody : *Hepatitis B IgM core antibody :* *Hepatitis C antibody :*
Was Patient Jaundiced ? *Was Patient Pregnant ?*

Hepatitis Chemistry Results

Total Billrubin : *Normal Range for Bilirubin Test :*
SGOT(AST) : *Normal Range for SGOT(AST) Test :*
SGPT(ALT) : *Normal Range for SGPT(ALT) :*

Mycobacterial Disease Information

PPD Mantoux Date : *PPD Mantoux: Size (mm) :*
Sputum Date : *Sputum Test Type :*
Tissue or Body Fluid Date : *Tissue or Body Fluid Test Type :*
Chest X-Ray Date : *Chest X-Ray Results :*

H. influenzae, N. meningitidis, Shigella, Salmonella, or Campylobacter Results

Organism Serogroup : *Organism Serotype :*

Injury Related Information

Work Related :
Cause (circumstances) :
Geographic Location of Occurrence :

3. Determine if you want to print the details or return to the "Physician Card History" screen and click the corresponding button.

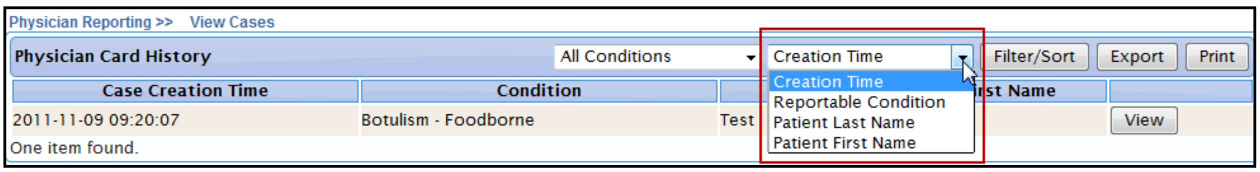
FILTERING/SORTING THE PHYSICIAN CARD CASES

To Sort the Physician Card Cases, perform the following:

1. On the "Physician Reporting" Menu, click the **VIEW CASES** option. The "Physician Card History" screen appears. Refer to the previous illustration.

2. Click the **SORT** drop-down menu (located to the left of the Sort button to view/select a sort method.

Figure 5-67: Physician Card History – Sort



3. Click the **FILTER/SORT** button. The cases will sort according to the method selected. Possible methods include:

- Creation Time
- Reportable Condition
- Patient last Name
- Patient First Name

EXPORTING THE PHYSICIAN CASES

To export the Physician Cases into a CSV (Comma Separated Value) file, perform the following:

1. On the "Physician Reporting" Menu, click the **VIEW CASES** option. The "Physician Card History" screen appears.

2. Click the **EXPORT** button. The "File Download" dialog box appears.

3. Click one of the available buttons:

- **OPEN** – to open the "Physician Card History – Cases" in MS EXCEL.

- **SAVE** – to save the comma separated value file to a specific directory location.
- **CANCEL** – to abort the exportation and return to the “Physician Card History – View Cases” screen.

Note: You can view/open a CSV file using such applications as Microsoft Word, Microsoft Notepad, and Microsoft Excel.

VIEWING/PRINTING THE PHYSICIAN CASE LISTING

To view and/or print the Physician Data Case, perform the following:

1. On the “Physician Reporting” Menu, click the **VIEW CASES** option. The “Physician Card History” screen appears. Refer to Figure 5-65 for an illustration.

2. Click the **PRINT** button. The “Physician Card History Listing” screen appears.

Figure 5-68: Physician Card – Viewing/Printing Physician Card Cases

Send to Printer | Close the Window

Physician Card History Listings

	Creation Time	Reportable Condition	Patient Last Name	Patient First Name
1	2011-11-09 09:20:07	Botulism - Foodborne	Test	Tommy

3. Click one of the available buttons:

- **SEND TO PRINTER** – sends the displayed report to the printer.
- **BACK TO LISTING** – returns you to the “Physician Card History” listing screen without printing the displayed report.

NEW NON HUMAN CASE

Cases can be added by accessing and filling out the necessary fields on all the sections (Patient Information, Referral/Physician, and Work/Travel) or by filling out a Supplemental Form, if a form exists for the disease/condition being reported.

Regardless of the method chosen when adding a new case, a Search is always performed first. This reduces the possibility of entering a duplicate case. The application will search all cases for a matching first name and last name before allowing a new case to be added.

After you complete the "Animal Search Criteria," complete the following sections (in order) to add a new case:

- Demographics (Section 1)
- Referral/Physician (Section 2)
- Work/Travel (Section 3)

Note: After you complete the "Animal Search Criteria," you use the same methods as when creating a new human case; therefore, after completing the "Animal Search Criteria" screen, you proceed to the Patient Information by clicking on it, etc.

After you complete the "Animal Search Criteria," you can complete an HTML form instead of completing the three remaining screens listed above. From the "Patient Information" section, you can select a disease name and then display a disease specific form (in HTML format) related to that condition. You then fill out the form and submit it and the information is added to Sentinel. Refer to Adding a New Case Using Disease Specific Forms for instructions. Not all disease names have an associated form.

Note: New cases also appear on the "Case Listings" screen through laboratory and health care provider referrals.

SEARCHING FOR A NON HUMAN CASE

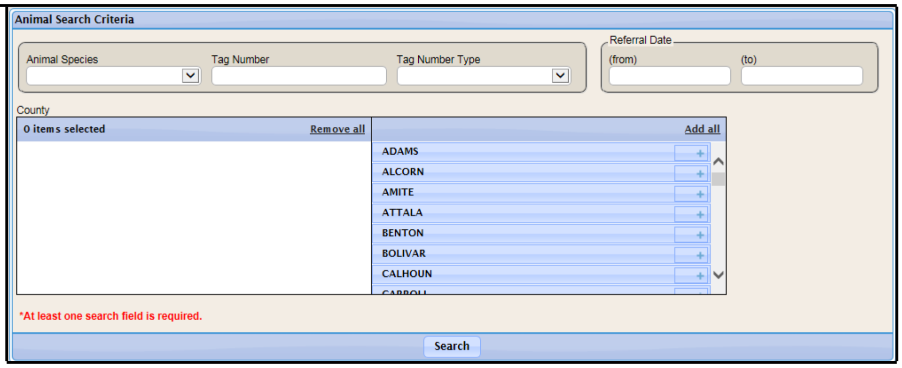
When you do a new case search, you are instructing the application to search the Master Patient Index (MPI) for a matching case, and if any are located, display the possible matches/cases.

When you are trying to create a new case, first you are trying to find a case that is already in Sentinel or any that match an existing case(s) in order to start with some known data.

To search for a non-human case, perform the following:

1. On the "Case Investigation" Menu, click the **NEW NON HUMAN CASE** option. The "Animal Search Criteria" screen appears.

Figure 5-69: Animal Search Criteria Screen



2. Using the following table as a guide, enter the desired information.

Table 5-25: Animal Search Criteria Fields

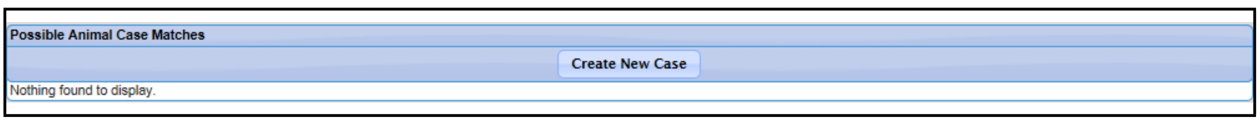
FIELD	DESCRIPTION
ANIMAL SPECIES	Species of the animal, such as bat, dog, or fox, related to the non-human case.
TAG NUMBER	Numeric identifier for non-human West Nile Virus cases.
COUNTY **BOROUGH** **PARISH**	Name of the County, Parish, or Borough. Click the scroll arrows to view the list. Click the desired county name by clicking the plus sign (+). This type of selection box allows you to select more than one item for the field. The box on the left is referred to as the “Selected Items” box. The box on the right is referred to as the “Unselected Items” box containing the multiple choice items. To add an item to the “Selected Items” box, click the plus sign (+) (located to the right of the choice). The choice will be moved from the “Unselected Items” box to the “Selected Items” box. To remove an item from the “Selected Items” box to the “Unselected Items” box, click the minus sign (-) (located to the right of the choice). The choice will be moved from the “Selected Items” box to the “Unselected

FIELD	DESCRIPTION
	Items" box.
TAG NUMBER TYPE	Type of tag number. Available options are: • Avian • Mosquito • Veterinary
REFERRAL DATE (FROM AND TO)	Date of referral. Type the date using the format mm/dd/yyyy or click the "Date Picker Icon" to select a date.

3. Click the **SEARCH** button. The "Possible Animal Case Matches" screen appears.

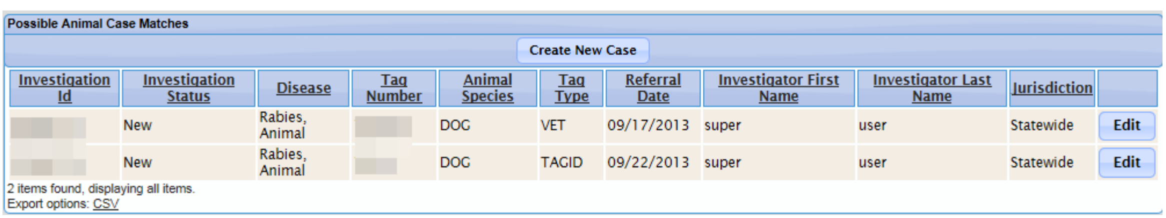
   - If there are NO possible matches, the screen appears as shown below.

Figure 5-70: Possible Animal Case Matches – No Matches Found



   - If there ARE possible matches, the screen appears as shown below (the following figure displays on a matching record).

Figure 5-71: Possible Animal Case Matches – Matches Found


Possible Animal Case Matches

Create New Case

Investigation Id	Investigation Status	Disease	Tag Number	Animal Species	Tag Type	Referral Date	Investigator First Name	Investigator Last Name	Jurisdiction	
[redacted]	New	Rabies, Animal	[redacted]	DOG	VET	09/17/2013	super	user	Statewide	Edit
[redacted]	New	Rabies, Animal	[redacted]	DOG	TAGID	09/22/2013	super	user	Statewide	Edit

2 items found, displaying all items.
Export options: CSV

4. Click the **CREATE NEW CASE** button. The "Demographics" screen appears.

Creating a Non Human Case

When you complete each screen and click the **CONTINUE** button, Sentinel validates your entries before allowing you to continue. Refer to the section titled, "Tips for Correcting Validation Errors" for more information on the validation process.

There are two sections of information you will enter when creating a new non-human case.

- Demographics Information – Contains the following: Sex, Date of Birth, Patient Name, Patient Address, Investigation Information, and Animal Case Information.
- Investigation Information – Contains Hospital Information.
- Animal Case Information – Contains Animal Case Information.

Note: Facility users have access to create non-human cases and add lab reports. The lab reports are visible to the Facility user until a non-facility user updates the lab report.

Once a case has been created and the reportable condition has a Disease form, also referred to as a Supplemental Form, you may edit the case using the screens or supplemental forms, assuming a Supplemental Form exists.

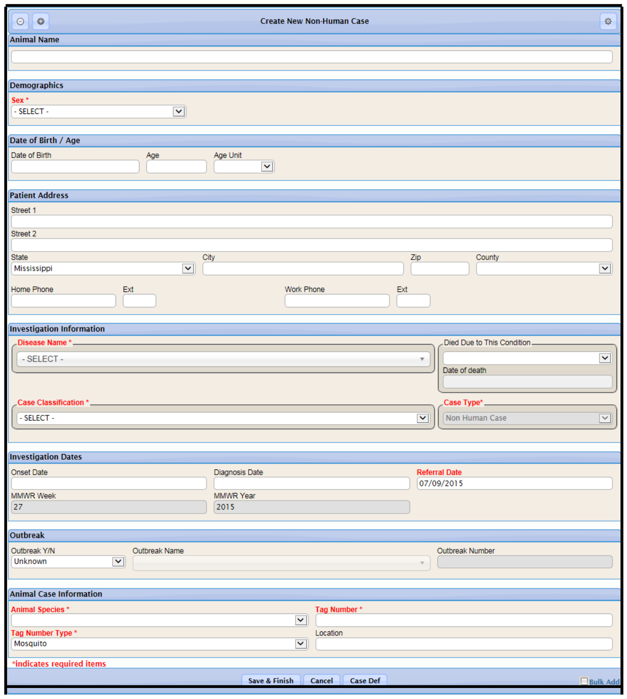
To add a non-human case and enter all sections, perform the following:

1. On the “Case Investigation” menu, click the **NEW NON HUMAN CASE** option. The “Animal Search Criteria” screen appears. Refer to Figure 5-69 for an illustration.

2. Perform a **Search**. The “Possible Animal Case Matches” screen appears.

3. Verify there are no matches and click the **CREATE NEW CASE** button. The “Demographics” screen appears.

Figure 5-72: Non-Human Demographics Screen



4. Using the following table as a guide, enter the appropriate information. You must complete fields in RED*; all other fields are optional.

Table 5-26: Non-Human Case

FIELD	DESCRIPTION
DEMOGRAPHICS	
SEX	Gender of the patient. Click the drop-down menu arrow to view/select a valid choice. Examples are: • Female • Male • Not Reported • Other
DATE OF BIRTH / AGE	
DATE OF BIRTH (MM/DD/YYYY)	Patient's date of birth, if available. If patient's date of birth is not available, use the

FIELD	DESCRIPTION
	AGE and **AGE UNIT** fields.
AGE **AGE UNIT**	**AGE** is the age in days, months, or years of the patient and **AGE UNIT** is the unit of measurement of the **AGE** value. If you enter a **DATE OF BIRTH**, Sentinel calculates the **AGE** and **AGE UNIT** as follows: • **AGE UNIT** = **DAYS** if the current date is less than a calendar month after the **DATE OF BIRTH**. • **AGE UNIT** = **MONTHS** if the current date is less than two years after the **DATE OF BIRTH**. • **AGE UNIT** = **YEARS** if the current date is two years or more after the **DATE OF BIRTH**. If you do not know the **DATE OF BIRTH**, you can leave the **DATE OF BIRTH** field empty and manually enter an **AGE** and **AGE UNIT**. When you manually enter an **AGE**, this value does not vary over time since it does not reflect the exact age of the patient.
PATIENT NAME	
PATIENT NAME	Name of the patient.
PATIENT ADDRESS	
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the patient's home address.
STATE	State name of the primary or attending physician. Click the drop-down menu arrow to view/select a state. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.

FIELD	DESCRIPTION
CITY	City of the patient’s home address. First, choose a state, and then begin to type the first four letters of the City name and a “pop up” list of City names and zip codes appears. Point and click a city name/zip to select it. The City, Zip Code, and County fields will populate with the stored information. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer’s state, county will be disabled. If County is changed, City and Zip will be cleared.
ZIP	Zip code of the patient's home address. This field is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer’s state, county will be disabled. If County is changed, City and Zip will be cleared.
COUNTY/BOROUGH	County, Borough, or Parish of the primary or attending physician. This is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer’s state, county will be disabled. If County is changed, City and Zip will be cleared.
WORK PHONE/EXT	Daytime telephone number of the patient and an extension, if applicable.
HOME PHONE/EXT	Evening telephone number of the patient and an extension, if applicable.
INVESTIGATION INFORMATION	
CASE TYPE	Type of case: Human or Non Human. This is a read-only field.

<table>
<tr><th>FIELD</th><th>DESCRIPTION</th></tr>
<tr><td>DISEASE NAME</td><td>Disease being reported for the case.

After you select a Disease Name and save the case information, Sentinel retrieves the Disease Group (to which the Disease Name belongs) from its system reference tables.</td></tr>
<tr><td>CASE CLASSIFICATION</td><td>Case status based on set definitions and criteria to determine evidence of disease.

This field is expected to be resolved to CONFIRMED or NOT A CASE as a result of the investigation. A more detailed discussion of Case Status is available within the CDC Case Definitions.

Available options are:
CONFIRMED – It has been determined that the patient has this disease. When the investigation is complete (INVESTIGATION STATUS is set to COMPLETED OR CLOSED), this case is reported to the CDC.
DELETED – This option is generally for cases that were entered in error. Marking a case as DELETED does not remove the case from the system; however, deleted cases no longer appear in reports or in a NETSS Export.
NOT A CASE – It has been determined that the patient does not have this disease. This case is not reported to the CDC.
PROBABLE – An initial indicator that the patient is likely to have this disease and further investigation is warranted.
SUSPECT – An initial indicator that the patient may have this disease and further investigation is warranted.
UNKNOWN – The person making the referral could not determine the likeliness. Follow-up is warranted.</td></tr>
<tr><td>OUTBREAK Y/N</td><td>Indicates whether the condition was associated to an Outbreak (Y) or not (N), or is unknown.</td></tr>
</table>

FIELD	DESCRIPTION
OUTBREAK NAME	Name of Outbreak if the **OUTBREAK** field is set to **YES**.
OUTBREAK NUMBER	This is the user-defined number used to associate a case to an outbreak. Ex: For multiple cases related to a Food borne Outbreak, you may enter an outbreak number of 100 for each one. Afterward, when an epidemiologist searches for all cases related to Outbreak Number 100, all related cases are returned.
ONSET DATE	Date the symptoms of this disease first appeared. Type a date or click the calendar to select a date. **IMPACTS OF CHANGING THE ONSET DATE** The case Onset Date is related to other fields within Sentinel, specifically the Address “To” and “From” dates and the patient's age. • Sentinel attempts to determine the patient's age at disease onset. Therefore, the patient's age is not their current age and changes to the Onset Date can result in changes to the age. If a change in the Onset Date resulted in the age dropping below 18 years, Sentinel will require the parent/guardian information to be supplied. • Onset date also plays a key role in determining the investigation address. The Address “To” and “From” dates are compared to the Onset Date to verify that the address is valid for the duration of the case investigation. If a change is made to the Onset Date that would result in invalid address information, the case could be referred to another investigator. • Case assignment is based on the investigation address at the Onset Date (or the Date Received if the Onset Date is unavailable). Changes to Onset Date can result in case referral to another investigator.
DIAGNOSIS DATE	Date the case was diagnosed. Type a date or click the calendar to select a date.

<table>
<tr><th>FIELD</th><th>DESCRIPTION</th></tr>
<tr><td>REFERRAL DATE</td><td>When you add a new case, this date defaults to the system date at the time of new case entry.

When you edit a case and change the Patient Status, this date is set to the system date at the time of the change.

Accept the default date, type a new date, or click the calendar icon and select a date.</td></tr>
<tr><td>MMWR WEEK</td><td>Morbidity and Mortality Weekly Report (MMWR) publication week when the case was created. Sentinel calculates the MMWR WEEK value based on the EVENT DATE value.

This is a read-only field.</td></tr>
<tr><td>MMWR YEAR</td><td>Morbidity and Mortality Weekly Report (MMWR) publication year when the case was created. Sentinel calculates the MMWR YEAR value based on the EVENT DATE value.

This is a read-only field.</td></tr>
<tr><td>CDC CASE ID</td><td>Unique, system-generated ID used to identify the case record in the NETSS export.

This is a read-only field.</td></tr>
<tr><td>STATE ID</td><td>Patient ID or animal case ID for cases migrated from legacy HAWK system.</td></tr>
<tr><td>DIED DUE TO THIS CONDITION</td><td>Whether or not the patient died. Available options are:
• No
• Unknown
• Yes</td></tr>
<tr><td>DATE OF DEATH</td><td>If patient died what is the date of their death.</td></tr>
</table>

SUPPLEMENTAL FORM STATUS	Status of the supplemental (disease specific) form. Available options are: • Approved • Form Complete • Form Sent to CDC

FIELD	DESCRIPTION
	• Form in Progress • Not Done
IMPORTED	Indicates where the case came from. Available options are: • In-State • Out of Country • Out of State • Unknown
ANIMAL CASE INFORMATION	
ANIMAL SPECIES	Species of the animal, such as bat, dog, fox, opossum, or woodchuck related to the non-human case.
TAG NUMBER	Numeric identifier for non-human West Nile Virus cases.
TAG NUMBER TYPE	Type of tag number. Available options are: • Avian • Mosquito • Veterinary This field is required if you enter a value in the **TAG NUMBER** field.
LOCATION	Location where the animal was encountered. Ex: For animal rabies cases, location may be where the rabid animal was seen, such as a treetop, backyard, etc.

5. Click one of the available buttons:

- **CANCEL** – terminates the process of adding a new case and redisplays the "Case Listings" screen. If you entered information on the screen, a dialog box appears asking if you are sure you want to cancel.

a) Click the **OK** button to terminate the process of adding a new case and redisplay the “Case Listings” screen.

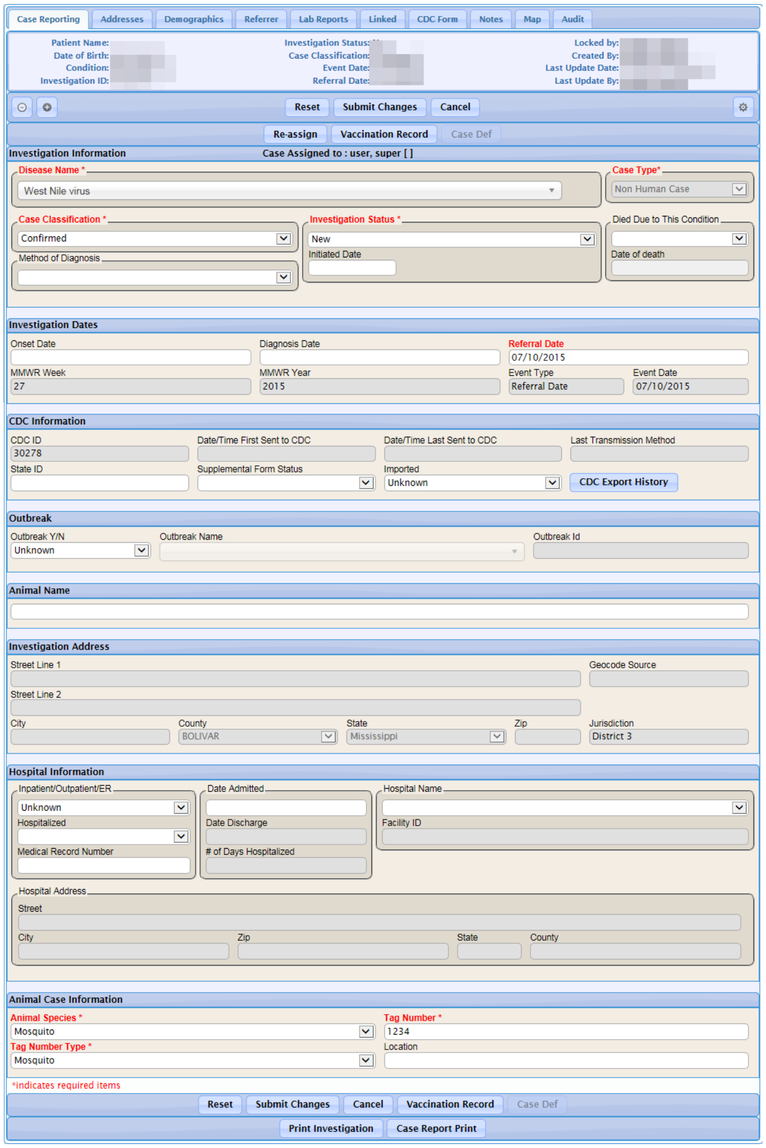
b) Click the **CANCEL** button to remain on the “Demographics” screen with the data you entered intact.

•

- **CASE DEF** – opens another browser window and displays the Centers for Disease Control and Prevention (CDC) or other source, such as “Red Book Online.”
- **SAVE & FINISH** – begins the validation process and if the validation is successful (no errors), the “Case Reporting Tab - Hospital Information” screen appears. If there are errors, Sentinel will not display the “Case Reporting Tab – Hospital Information” screen until you correct them. Refer to the section titled, “Tips for Correcting Validation Errors” for more information.

6. The information gathered appears on the Case Detail tabs, where the:
    - Hospital Information appears on the “Case Reporting” tab.
    - Person Providing Report and Primary or Attending Physician Information appears on the “Referrer” tab.

Figure 5-73: Non-Human Case - Hospital Information



7. The fields and their descriptions are listed in the table.

Table 5-27: Non-Human Case – Hospital Information Field Descriptions

FIELD	DESCRIPTION
HOSPITAL INFORMATION	
HOSPITALIZED	Whether the patient was hospitalized (**YES** or **NO**).

FIELD	DESCRIPTION
PATIENT STATUS DATE	Defaults to the system date at the time of new case entry.
HOSPITAL NAME	Name of the hospital. Once this field is selected, the following fields will be populated: • Facility ID • Hospital Street Name • Hospital City • Hospital Zip • Hospital State • Hospital County
FACILITY ID	Identifying number of the hospital facility. This field automatically populates based on the chosen hospital in the Hospital Name field. This field is a read-only field.
STREET	Street address of the hospital facility. This field automatically populates based on the chosen hospital in the Hospital Name field. This field is a read-only field.
CITY	City name of the hospital facility. This field automatically populates based on the chosen hospital in the Hospital Name field. This field is a read-only field.
ZIP	Zip code of the hospital facility. This field automatically populates based on the chosen hospital in the Hospital Name field. This is a read-only field.
STATE	State name of the hospital facility. This field automatically populates based on the chosen hospital in the Hospital Name field. This field is a read-only field.
COUNTY/BOROUGH	County or Borough of the hospital facility.

FIELD	DESCRIPTION
DATE HOSPITALIZED	Date the patient was first hospitalized.
NUMBER OF DAYS HOSPITALIZED	Number of days the patients was hospitalized.

8. Click on the **REFERRER TAB** to enter the “Person Providing the Report” and/or the “Primary or Attending Physician Information.”

FIELD	DESCRIPTION
REFERRER TAB - PERSON PROVIDING REPORT	
TITLE	Title of the person providing the report.
LAST NAME	Last name of the person providing the report.
FIRST NAME	First name of the person providing the report.
PHONE/EXT	Phone number and extension, if applicable, of the person providing the report.
EMAIL	Email address of the person providing the report.
NAME OF REPORTING FACILITY	Name of the facility of the person providing the report. When you select a facility from this drop-down menu, the following fields (in the **PERSON PROVIDING REPORT** section) are automatically filled in: • Reporting Facility ID • Type of Reporting Facility • Hospital Region/District • Street • City • County • State

FIELD	DESCRIPTION
	• Zip
REPORTING FACILITY ID	Clinical Laboratory Improvement Amendments (CLIA) ID of the facility of the person providing the report. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
TYPE OF REPORTING FACILITY	Type of facility of the person providing the report, such as Clinics, ER, Hospital, and Laboratory. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field. A facility can be of more than one type. For example, Central Hospital (**FACILITY NAME**) can be a hospital or a lab (**TYPE OF REPORTING FACILITY**).
HOSPITAL REGION/DISTRICT	Geographic grouping of hospitals into bioterrorism regions/districts. This is a read-only field. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
STREET	Street address of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
CITY	City of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
COUNTY/BOROUGH	County or Borough of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
STATE	State name of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.

FIELD	DESCRIPTION
ZIP	Zip code of the reporting facility. This field automatically populates based on the chosen facility in the Name of the Reporting Facility field. This field is a read-only field.
PRIMARY OR ATTENDING PHYSICIAN **Note**: If you cannot see the field names listed below, click on the section name to open this section of the screen.	
TITLE	Title of the primary or attending physician.
LAST NAME	Last name of the primary or attending physician. Begin to type the first letters of the Physician's first or last name and a "pop up" list of Physician Names appears. Point and click a name to select it. The remaining physician fields will populate with the stored information.
FIRST NAME	First name of the primary or attending physician. First name of the primary or attending physician. Begin to type the first letters of the Physician's first or last name and a "pop up" list of Physician Names appears. Point and click a name to select it. The remaining physician fields will populate with the stored information.
PHONE/EXT	Phone number and extension, if applicable, of the primary or attending physician.
EMAIL	Email address of the primary or attending physician.
PHYSICIAN FACILITY NAME	Name of the facility the Physician is associated with.
STREET LINE 1 **STREET LINE 2**	Street address of the primary or attending physician.
STATE	State name of the primary or attending physician. Click the drop-down menu arrow to view/select a state. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the

FIELD	DESCRIPTION
	customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
CITY	City of the patient's home address. First, choose a state, and then begin to type the first four letters of the City name and a "pop up" list of City names and zip codes appears. Point and click a city name/zip to select it. The City, Zip Code, and County fields will populate with the stored information. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
ZIP	Zip code of the patient's home address. This field is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.
COUNTY, BOROUGH, OR PARISH	(Required for Louisiana) County, Borough, or Parish of the primary or attending physician. This is automatically populated by choosing the City field. **Note**: If the state is changed, the City, Zip and County will be cleared. If the state is not the customer's state, county will be disabled. If County is changed, City and Zip will be cleared.

9. Click one of the available buttons:

- **SUBMIT CHANGES** – begins the validation process and if the validation is successful (no errors), redisplays the "Case Reporting Tab – Hospital Information" screen appears. If there are errors, you will need to correct them. Refer to the section titled, "Tips for Correcting Validation Errors" for more information.
- **CANCEL** – terminates the process of adding a new case and redisplays the "Case Listings" screen. If you entered

information on the screen, a dialog box appears asking if you are sure you want to cancel.

a) Click the **OK** button to terminate the process of adding a new case and redisplay the "Case Listings" screen.

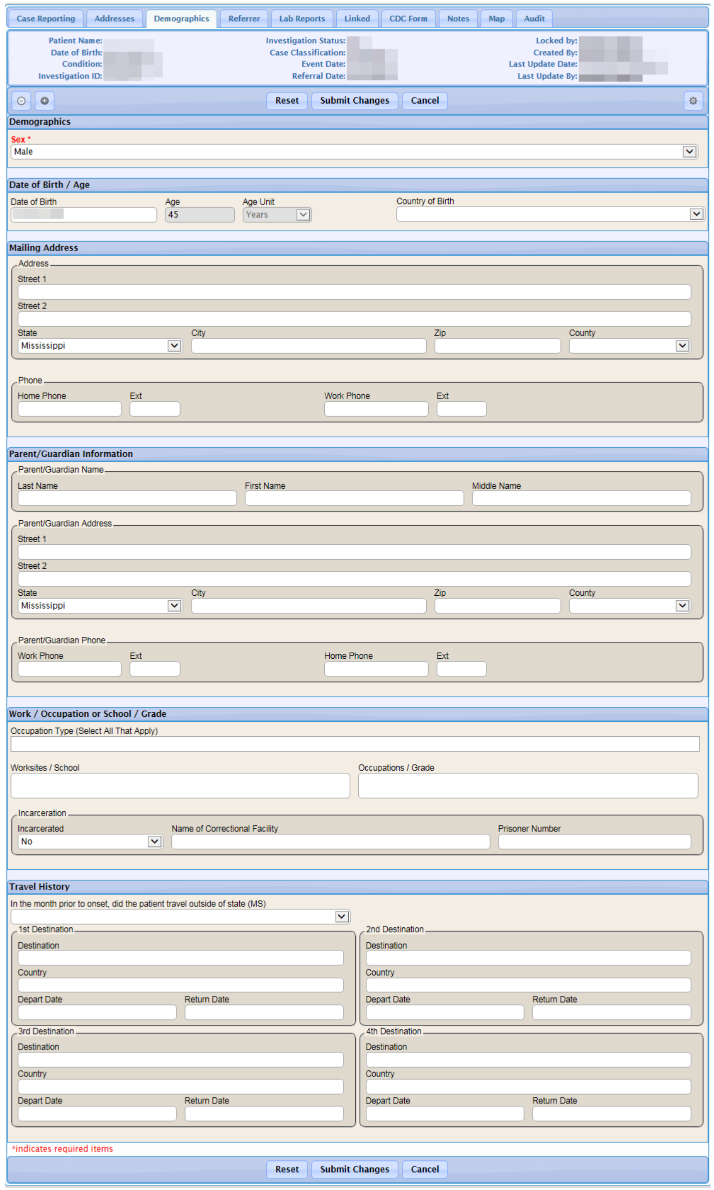
b) Click the **CANCEL** button to remain on the "Demographics" screen with the data you entered intact.

- **RESET** – erases any newly typed entries in the fields and remains on the same window to reenter data.
- **CASE DEF** – opens another browser window and displays the Centers for Disease Control and Prevention (CDC) or other source, such as "Red Book Online."

10. To enter Occupation or Travel information, continue with these instructions. The "Work/Occupation or School/Grade" screen appears on the "Demographics Tab." The information gathered from this screen appears on the Case Detail tabs, where:

- Work/Occupation or School/Grade and Travel History sections appear on the "Demographics" tab.
- Case Notes section appears on the "Notes" tab.

Figure 5-74: Non-Human Case Demographics - Work/Occupation or School/Grade



11. Using the following table as a guide, enter the appropriate information. You must complete fields in **RED***; all other fields are optional.

Table 5-28: Non-Human Case - Work/Occupation or School/Grade Field Descriptions

FIELD	DESCRIPTION
WORK/OCCUPATION OR SCHOOL/GRADE	

FIELD	DESCRIPTION
OCCUPATION TYPE	Type of occupations, such as Correctional Staff, Daycare worker, Healthcare worker, and Unknown.
WORKSITES/ SCHOOL	Additional details about the worksite or school (based on the type of occupation selected in the **OCCUPATION TYPE** field) relating to possible sources of exposure or the spread of a disease. This is a free-form text field.
OCCUPATIONS/ GRADE	Additional details about the worksite occupation or school grade (based on the type of occupation selected in the **OCCUPATION TYPE** field) relating to possible sources of exposure or the spread of a disease. This is a free-form text field.
INCARCERATED	Whether the patient was incarcerated (**YES** or **NO** (the default).
NAME OF CORRECTIONAL FACILITY	Name of the correctional facility if you selected **YES** in the **INCARCERATED** field.
PRISONER NUMBER	Prisoner number of the patient if you selected **YES** in the **INCARCERATED** field.
TRAVEL HISTORY	
DESTINATION (1ST, 2ND, 3RD, 4TH)	Locations (four different fields) the patient visited.
COUNTRY (1ST, 2ND, 3RD, 4TH)	Name of the countries (four different fields) of the destinations the patent visited.
DEPART DATE	Start date (four different fields) that the patient visited the destinations. Type the date using the format mm/dd/yyyy or click the Calendar Icon to view/select a date.

FIELD	DESCRIPTION
RETURN DATE	End date (four different fields) that the patient returned from visiting the destinations. Type the date using the format mm/dd/yyyy or click the Calendar Icon to view/select a date.
CASE NOTES	
TEXT BOX	Allows you to type freeform text case notes.

12. Click one of the available buttons:

- **SUBMIT** – begins the validation process and if the validation is successful (no errors), it saves the case to the database and displays the "Case Reporting" tab for the newly created case.
- **RESET** – erases any newly typed entries in the fields and remains on the same window to reenter data.
- **CANCEL** – terminates the process of adding a new case and redisplays the "Case Listings" screen. If you entered information on the screen, a dialog box appears asking if you are sure you want to cancel.

  a) Click the **OK** button to terminate the process of adding a new case and redisplay the "Case Listings" screen.

  b) Click the **CANCEL** button to remain on the same screen with the data you entered intact.

13. When you save a new case, Sentinel performs a series of background processes before the "Case Listings" screen appears. Refer to the next section titled, "Background Processing When Saving Cases" for more information.

Editing a New Non Human Case Using Disease Specific Forms

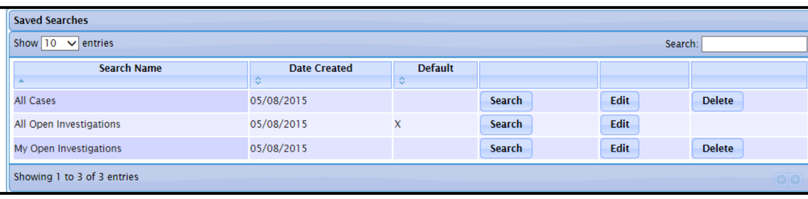
The instructions for editing a new non-human case are the same as those when editing a new human case. Please refer to the section titled, "Editing Cases Using Disease Specific (Supp) Forms" for instructions.

SEARCHES (SAVED)

The "Saved Searches" screen displays a summary list of all your saved searches and allows you to:

- Execute a search. Refer to the section titled, "Executing a Saved Search from the Searches Screen" for instructions.
- Edit a search. Refer to the section titled, "Editing a Saved Search" for instructions.
- Setting a saved search to be your default search. Refer to the section titled, "Setting a Saved Search to be your Default Search" for instructions.
- Delete a search (excluding the default search). Refer to the section titled, "Deleting a Saved Search" for instructions.

Figure 5-75: Saved Searches



When a new user is added to Sentinel, the system creates three default saved searches:

- **ALL CASES** – returns all cases that fall within your case viewing permissions (your area of responsibility, such as a jurisdiction, region/district, or department).
- **MY OPEN INVESTIGATIONS** – returns all open case records assigned to you.
- **ALL OPEN INVESTIGATIONS** – returns all open cases within your case viewing permissions.

You can perform a search from the following screens:

- "Searches" screen. Refer to the following section, "Executing a Saved Search from the Searches Screen" for instructions.

- "Searches" screen while editing a search. Refer to the section titled, "Editing a Saved Search" for instructions.
- "Case Listings" screen. Refer to the section titled, "CASES (Case Listings)" for instructions.

EXECUTING A SAVED SEARCH FROM THE SEARCHES SCREEN

When you execute a saved search from the "Searches" screen, the screen closes and the "Case Listings" screen appears showing the search results.

To execute a saved search from the "Searches" screen, perform the following:

1. On the "Case Investigation" Menu, click the **SEARCHES** option. The "Saved Searches" screen appears.
2. Locate the **SEARCH NAME** you want to execute and click the **SEARCH** button on the same row. The "Case Listings" screen appears displaying the cases matching the search criteria.

EDITING A SAVED SEARCH

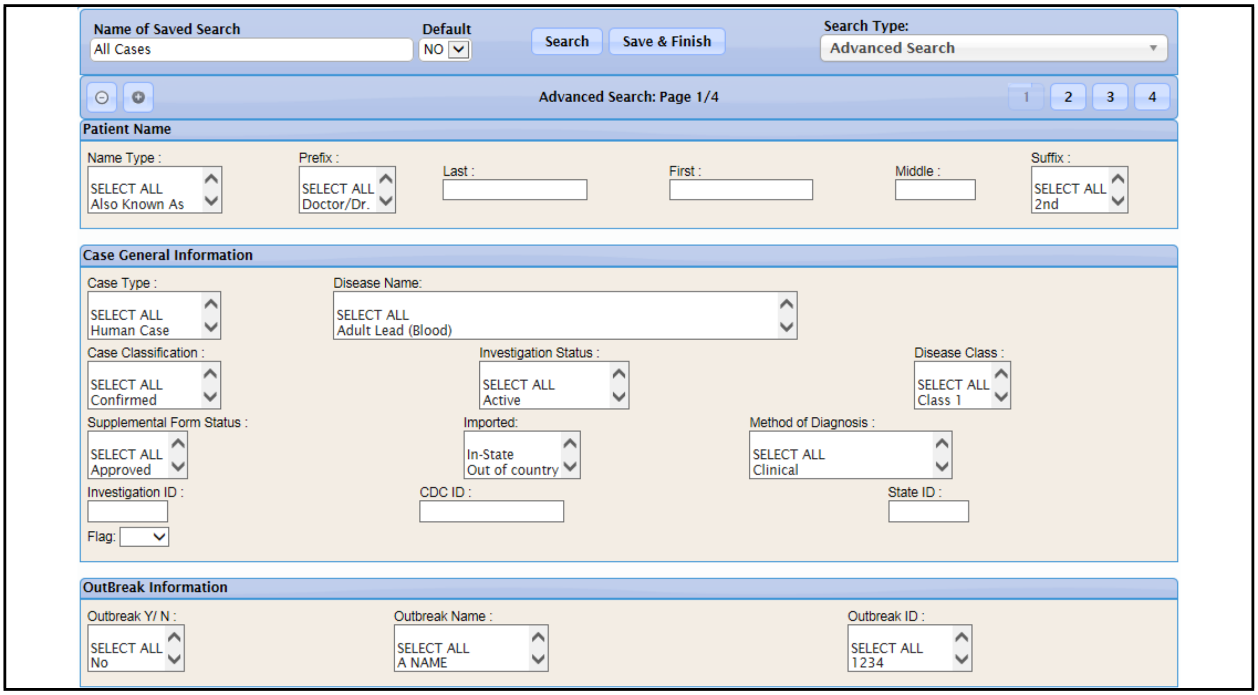
There are three search screens on which you can select information to search. Since you are not required to make selections on each screen; you may only be editing information on one screen (or two or all screens).

Each of the four screens contains a **SAVE & FINISH** button; thus, you can make a change on one of the screens and complete your edits at that point.

To edit a saved search, perform the following:

1. On the "Case Investigation" menu, click the **SEARCHES** option. The "Saved Searches" screen appears.
2. Locate the saved search you want to edit and click the **EDIT** button. The "Saved Search" screen appears for the selected search (condensed version shown below).

Figure 5-76: Saved Search – (Screen 1 of 3)



3. Using the "Table 5-31: Search Parameters" as a guide, make the desired changes.

4. *(Optional)* Use the **CONTINUE** and/or **BACK** buttons to move back and forth between the first, second, and third "Search Parameters" screens and make the desired selections using the same table.

5. When you have completed your edits, click one of the following buttons:

   - **SEARCH** – begins a validation process and if there are no errors, the search begins to execute (does not save) with any changes that you may have made. After the search executes, the results appear on the "Case Listings" screen.

   - **SAVE & FINISH** – begins a validation process and if there are no errors, saves the changes that you made to the search, and returns you to the "Saved Searches" screen with the new search listed on the screen.

   - **CANCEL** – terminates the process of adding or editing and returns you to the "Saved Searches" screen. If you changed any information, a dialog box appears asking if you are sure you want to cancel.

a) If you click the **OK** button, you will lose any data you entered and you return to the "Saved Searches" screen.

b) If you click the **CANCEL** button, you remain on the "Search Parameters" screen with the data you entered intact.

SETTING A SAVED SEARCH TO BE YOUR DEFAULT SEARCH

To set a saved search to become your new default search, perform the following:

1. On the "Case Investigation" menu, click the **SEARCHES** option. The "Saved Searches" screen appears.
2. Locate the search you want to set as your default search and click the **EDIT** button on the same row. The first "Search Parameters" screen appears.
3. To set the search as your default search, click the **DEFAULT SEARCH** check box in the upper right corner.

   Note: You can set a search to be your default search from any of the three "Search Parameters" screens.

4. Click the **SAVE & FINISH** button. The "Saved Searches" screen appears with an X in the **DEFAULT** column for the search you designated as the default search.

DELETING A SAVED SEARCH

You can delete any searches you create, but you cannot delete the saved default search.

To delete a saved search, perform the following:

1. On the "Case Investigation" menu, click the **SEARCHES** option. The "Saved Searches" screen appears.

2. Locate the saved search you want to delete and click the **DELETE** button on the same row. A dialog box appears asking if you are sure you want to delete.

3. Click one of the following buttons:

   - **OK** – deletes your saved search and you remain on the "Saved Searches" screen.
   - **CANCEL** – <u>does not</u> delete your saved search and you remain on the "Saved Searches" screen.

NEW SEARCH

The **NEW SEARCH** option allows you to create a new search using any or all of the three "Search Parameters" screens. This function searches the Sentinel database for cases based on the entered criteria.

HOW THE SEARCH PROCESS WORKS

The search process relies on the values you enter (user-defined criteria) on the Search screens and these values are compared to the corresponding data in each case record. Nearly all the data collected for a case can be included in the search criteria; however, Sentinel compares your roles and permissions to these user-defined criteria before returning a case as a match.

Sentinel uses **AND** and **OR** search types, as described in the following table. **AND** and **OR** searches are not exclusive to each other. You can create search criteria that is based on several **AND**, **OR**, and **AND/OR** combinations.

Table 5-29: AND and OR Search Types

SEARCH TYPE	DESCRIPTION
AND	Analyzes data from different fields. An **AND** search reduces the number of cases returned as a match. Example: If you set the following criteria: DISEASE NAME=CHICKEN POX **<u>AND</u>** PATIENT LAST NAME=JOHN Sentinel only matches cases that meet both criteria. If Jane has Chicken Pox and John has Mumps, neither

SEARCH TYPE	DESCRIPTION
	case is returned as a match.
OR	Analyzes multiple values from the same field. An **OR** search increases the number of cases returned as a match. Example: If you set the following criteria: DISEASE NAME=CHICKEN POX **OR** DISEASE NAME=MUMPS Sentinel matches cases where the DISEASE NAME is either Chicken Pox or Mumps. If Jane has Chicken Pox and John has Mumps, both cases are returned as a match.

Defining the Search Criteria

When building your search criteria, the more search criteria you define, the faster the system returns your results. If you do not define search criteria, Sentinel executes a wide-open search. During a wide-open search, Sentinel searches every case in the database, from the beginning to the end, which uses more system resources.

When the Database Administrator created the database, indexes were defined to logically organize the data. Indexes look for predefined similarities within the case records; these similarities are stored in reference locations that the search can use to narrow the number of case records it compares. Searching without using an index is similar to looking for the last name "Smith" in a list of unsorted names.

Search Methods

Different types of data require different search methods. The following table describes the search methods available in Sentinel.

Table 5-30: Search Methods

SEARCH METHOD	DESCRIPTION
SINGLE SELECTION	One value is compared to one data field within each

SEARCH METHOD	DESCRIPTION
	case record. This is the most restrictive search method, but it is useful if you want to display one type of case result. For example, you may only want to display "Confirmed" cases.
MULTIPLE SELECTION	Multiple values are compared to one data field within each case record. This search method is useful if you want to display specific cases that can be one value or another. For example, you may only want to display "Mumps" or "Chicken Pox" cases.
TEXTUAL	A word or phrase you type is compared to the corresponding data field within each case record. If this word or phrase exists anywhere within the value of the corresponding field, the case is a match. This search method is useful if you want to find all patients who attend a specific school.
RANGE	Requires multiple search values to be defined, generally a "beginning of range" and an "ending of range." This type of search method is often used for searching numeric data or dates. The "beginning value" and the "ending value" are ignored if left blank. If you supply a "beginning value (date)" but no "ending value (date)," Sentinel compares cases where the corresponding date is equal to or greater than the beginning date specified, regardless of an ending date. ***Note:*** Range values are inclusive (equal to or greater than the beginning value and less than or equal to the ending value).
WILDCARD	Indicated by an asterisk (*), this search method is used on text fields where the results can be any value that matches the specified value in combination with the wildcard symbols. • If the wildcard symbol precedes a character, word, or phrase, the search returns the cases where the value within the corresponding data field ends in that character, word, or phrase. Example: Searching for ***on** returns both **Johnson** and **Wilson**. • If the wildcard symbol is embedded within a set

SEARCH METHOD	DESCRIPTION
	of characters, a word, or a phrase, the search returns the cases where the value within the corresponding data field begins with the characters preceding the wildcard, and ends with the characters following the wildcard. Example: Searching for **J*n** returns both **Jackson** and **Johnson**. • If the wildcard symbol follows a set of characters, a word, or phrase, the search returns the cases where the value within the corresponding data field begins with the characters preceding the wildcard. Example: Searching for **J*** returns **James**, **Jackson**, and **Johnson**.

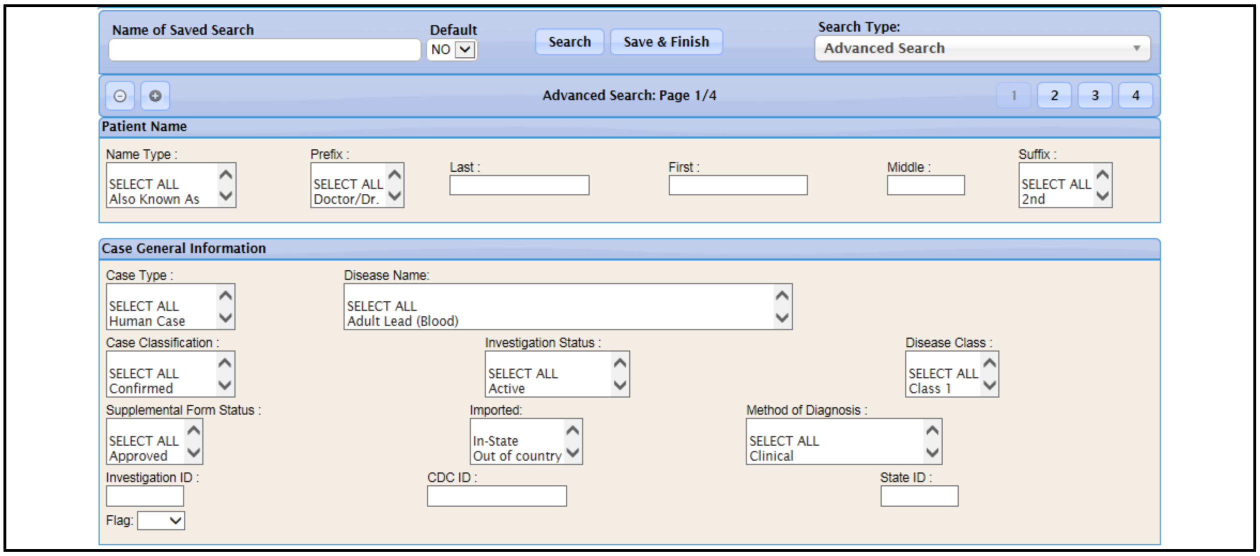
Search Parameters - Screen 1 of 3

There a three “Search Parameters” screens. You do not need to make selections on each screen and you can make selections on any combination of screens.

Note: Only cases that are **CURRENTLY** assigned to the Investigator(s) selected in the Search Criteria will be displayed.

Due to the size of the Search Screens, illustrations are provided in partial.

Figure 5-77: New Search – Screen 1



The following table describes the search criteria fields on the first "Search Parameters" screen.

Note: The "Search Parameters" are inclusive of all states using the Sentinel application; thus, your state may not have a specific parameter listed in the table below.

Table 5-31: Search Parameters (Screen 1 of 3)

FIELD	DESCRIPTION
NAME OF SAVED SEARCH	Type the name of the new search.
DEFAULT SEARCH CHECK BOX	Select the check box to make this search the default search. ***Note**:* You must have at least one search selected as your default search. To make another search the default search, edit that search and select the **DEFAULT SEARCH** check box.
CASE TYPE	Human or Non Human case.
DISEASE NAME	Condition reported for the case.
CASE	Case classification based on set definitions and

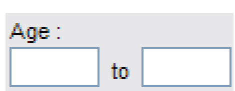
FIELD	DESCRIPTION
CLASSIFICATION	criteria to determine evidence of disease. This field is expected to be resolved to **CONFIRMED** or **NOT A CASE** as a result of the investigation. A more detailed discussion of case status is available within the CDC Case Definitions. Available options are: • **CONFIRMED** – It has been determined that the patient has this disease. Once the investigation is complete (the **INVESTIGATION STATUS** is set to **COMPLETED OR CLOSED**), this case will be reported to the CDC. • **PROBABLE** – This is an initial indicator that the patient is likely to have this disease and further investigation is warranted. • **SUSPECT** – This is an initial indicator that the patient may have this disease and further investigation is warranted. • **DELETED** • **NOT A CASE** – It has been determined that the patient does not have this disease. This case will not be reported to the CDC. • **UNKNOWN** – The person making the referral could not determine the likeliness. Follow-up is warranted.
INVESTIGATION STATUS	Status of the investigation. The **INVESTIGATION STATUS** can be system-generated (**NEW**) or manually selected (all other options). When you add a new case, Sentinel automatically sets the status to **NEW**. This field is expected to be resolved to **COMPLETED/CLOSED** or **CANCELED** as a result of the investigation. Available options are: • **ACTIVE** – The case is open and has been assigned to an investigator. • **CANCELED** – The case is closed and, upon review, was determined to not be a disease name. • **CLOSED** – The case has been completed and is finished. • **COMPLETED** – The case has been completed and has been reviewed by Quality Assurance.

FIELD	DESCRIPTION
	• **NEW** – The case is open and has not been assigned to an investigator. This is the only option that is system generated. • **PENDING –** The case is in the process of being assigned. • **PREVIOUSLY REPORTED –** The case was reported previously. • **REVIEWED –** The case has been reviewed by an investigator. • **SUPERCEDED** – The investigation has been preempted by an existing case. Superceding an investigation is similar to manually identifying a duplicate record. Investigations identified as “Superceded” are not reported to the CDC.
SUPPLEMENTAL FORM STATUS	Status of the supplemental (disease specific) form. Available options are: • Form Approved • Form Complete • Form Sent to CDC • Form in progress • Not Done
INVESTIGATION ID	Unique, system-generated number that is automatically assigned to the investigation.
OUTBREAK Y/N	Indicates whether the condition was an outbreak (**Y**) or not (**N**), or is unknown.
OUTBREAK NAME	Name of the outbreak (if the condition reported appears to be an outbreak).
OUTBREAK NUMBER	User-defined number used to associate a case to an outbreak. Ex: For multiple cases related to a food borne outbreak, an outbreak number of 100 may have been entered for each one. Afterward, when an epidemiologist searches for all cases related to outbreak number 100, all related cases are returned.
ONSET DATE	Date the symptoms of this disease first appeared.

FIELD	DESCRIPTION
(FROM / TO)	Either type the date or click the Calendar Icon to select a date. One or both dates can be entered to use a date range.
DIAGNOSIS DATE	Date the case was diagnosed. Type the date using the format mm/dd/yyyy or click the Calendar Icon to view/select a date.
REFERRAL DATE	Referral date when entering a new case. Type the date using the format mm/dd/yyyy or click the Calendar Icon to view/select a date.
MMWR WEEK (FROM / TO)	MMWR publication week when the case was created. MMWR Week is a computed value during case entry. Either type the date or click the calendar to select a date. One or both dates can be entered to use a date range.
EVENT DATE	The Event Date can be one of the following for all Sentinel application users: • If there is an **ONSET DATE**, that is the Event Date. • If there is no Onset Date, but there is a **DIAGNOSIS DATE**, that is the Event Date. • If there is no Onset or Diagnosis Date, the **EARLIEST LAB DATE** is used. • If there is no Onset Date, Diagnosis Date, and no Labs, then the **REFERRAL DATE** (a required field) is used. **Note**: For **TB PAM**, the above rules are ignored if anything is defined in the TB Disease Group then the **REFERRAL DATE** is used for the Event Date.
CDC ID	Unique, system-generated ID used to identify the case record in the NETSS export.
STATE ID	Patient ID or animal case ID for cases migrated from legacy HAWK system.
DIED Y/N	Whether or not the patient died. Available options are: • No

FIELD	DESCRIPTION
	• Unknown • Yes
INVESTIGATOR USER ID	During Case Assignment, the case is assigned to an investigator within the determined Jurisdiction. Once the investigator is assigned, the Investigator's User-ID is retrieved from the User information found in the "System Administration" module.
INVESTIGATOR LAST NAME	Last name of the Investigator. During Case Assignment, the case is assigned to an investigator within the associated Jurisdiction. Once the investigator is assigned, the Investigator's **LAST NAME** is retrieved from the User information found in the "System Administration" module.
INVESTIGATOR FIRST NAME	First name of the Investigator. During Case Assignment, the case is assigned to an investigator within the associated Jurisdiction. Once the investigator is assigned, the Investigator's **FIRST NAME** is retrieved from the User information found in the System Administration module.
ORIGINATING SITE	[Only for the State of Louisiana] Allows the user to create a query using one or more "originating sit(e)" that entered the record. • To select one site, click it. • To select multiple sites in sequence, hold down the SHIFT key, click the top site, and then click the bottom site. • To select multiple sites NOT in sequence, hold down the CTRL key while clicking each site. This option lists all the cases in the case listing that belong to the selected originating site(s).
FEVER > 100	Searches for cases with those that experienced a fever greater than 100 degrees. Choices are: • Select All • No

FIELD	DESCRIPTION
	• Yes • Unknown
COUGH	Searches for cases with those that experienced a cough. Choices are: • Select All • No • Yes • Unknown
SORE THROAT	Searches for cases with those that experienced a sore throat. Choices are: • Select All • No • Yes • Unknown
VACCINATION RECEIVED	Searches for those that have a vaccination received entry. Options are: • Select All • No • Unknown • Yes
JAUNDICED	Indicates whether or not the case was jaundiced or not. Options are: • Select All • No • Unknown (Default) • Yes
PREGNANT DURING ILLNESS	Indicates whether or not the case was pregnant during the illness or not. Options are: • Select All • No • Unknown (Default) • Yes

FIELD	DESCRIPTION
PATIENT NAME	
NAME TYPE	Type of name. Available options are: • Also Known As • Default/Common (default selection) • Legal • Maiden • Nickname
PREFIX	Prefix for the patient; i.e., Miss, Ms., etc.
LAST	Last name of the patient.
FIRST	First name of the patient.
MIDDLE	Middle name of the patient.
SUFFIX	Extension of the patient's name; i.e., Junior, III, etc.
DATE OF BIRTH / AGE	
DATE OF BIRTH	Birth date range for the patients for which you are searching. Type the date using the format mm/dd/yyyy or click the Calendar Icon to view/select a date.
AGE 	The **AGE** fields work in conjunction with the **AGE UNIT** field to provide a numeric range search to determine the correct measurement for the age provided. • To search all ages – Do not type a beginning or ending age range. All cases are returned regardless of the patient's age. • To search for a range of ages – Type the beginning range in the left **AGE** field and the ending range in the right **AGE** field. Only cases where the patient's age falls within the range are returned. • To search without a beginning date – Type the

FIELD	DESCRIPTION
	ending date only in the right **AGE** field. The search is a “less than” search and all cases that fall on or before the ending date are returned. • To search without an ending date – Type the beginning date only in the left **AGE** field. The search is a “greater than” search and all cases that fall on or after the beginning date are returned.
AGE UNIT	The **AGE UNIT** field works in conjunction with the **AGE** fields to determine the correct measurement for the age provided. The patient's reported age is not converted to days, months, or years during the comparison. For example, a search of “21 years” will not match a patient's reported age of 260 months. Available options are: • To search all age units – Do not select an age unit. All cases are returned regardless of the age unit. • **DAYS** – Returns only those cases where the patient's age was reported in days. • **HOURS** – Returns only those cases where the patient's age was reported in hours. • **MONTHS** – Returns only those cases where the patient's age was reported in months. • **UNKNOWN** – Returns only those cases where the patient's age was not reported. • **WEEKS** – Returns only those cases where the patient's age was reported in weeks. • **YEARS** – Returns only those cases where the patient's age was reported in years.
COUNTRY OF BIRTH	Birth country of the patient. Click the drop-down menu arrow to view/select a valid choice.
DEMOGRAPHICS	
SEX	Gender of the patient. Click the drop-down menu arrow to view/select a valid choice. Examples are: • Female

FIELD	DESCRIPTION
	• Male • Not Reported • Other
RACE	Race of the patient.
ETHNICITY	Ethnicity group of the patient.
PATIENT ADDRESS (THE ADDRESS IN EFFECT TODAY)	
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the patient's home address.
CITY	The **CITY** field searches against the investigation address and allows single, multiple, and wildcard searches. • To select all cities – Do not enter a city name. All cases are returned regardless of the investigation city. • To select a single city – Type the exact name into the **CITY** field (e.g., Phoenix.) The search returns all cases where the investigation city is “Phoenix.” • To select multiple cities – Separate each city name with a comma (e.g., Tucson, Phoenix.) The search returns all cases where the investigation city is “Tucson” or “Phoenix.” • To select using a partial city name – Type the city name using the wildcard (*) symbol (e.g., Rochester*.) For this example, the search returns all cases where the investigation city is “Rochester” or “Rochester Hills.”
COUNTY/BOROUGH	County or Borough name of the patient's address.
STATE	State name of the patient's home address.
ZIP	The **ZIP** field searches against the investigation address and allows single, multiple, and range selection searches. • To select all zip codes – Do not enter a zip

FIELD	DESCRIPTION
	code. All cases are returned regardless of the investigation address zip code. • To select a single zip code – Type the exact value into the **ZIP** field (e.g., 48910, 48910-0493). Only cases with the investigation address zip code are returned. If the last four digits of a nine-digit zip code are supplied in the search criteria, only cases with that exact nine-digit zip code are returned. • To select multiple zip codes – Separate each zip code with a comma (e.g., 48893, 48394). The last four digits of a nine-digit zip code are ignored in a multiple zip code search. • To select a range of zip codes – Separate the beginning and ending zip codes with a colon (e.g., 48910:48919). The last four digits of a nine-digit zip code are ignored in a zip code range search.
DAYTIME PHONE/ EXT	Daytime telephone number of the patient and an extension, if applicable.
EVENING PHONE/ EXT	Evening telephone number of the patient and an extension, if applicable.
INVESTIGATION ADDRESS	
CITY	City name of the Investigation Address. Click the arrows in the desired direction to locate your selection. Click it to select it.
COUNTY	County name of the Investigation Address. Click the arrows in the desired direction to locate your selection. Click it to select it.
DISTRICT	District name of the Investigation Address. Click the arrows in the desired direction to locate your selection. Click it to select it.
STATE	State name of the Investigation Address. Click the arrows in the desired direction to locate your selection. Click it to select it.

FIELD	DESCRIPTION
ZIP	Zip Code of the Investigation Address. Click the arrows in the desired direction to locate your selection. Click it to select it.
MAILING ADDRESS INFORMATION	
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the patient's mailing address.
CITY	City of the patient's mailing address.
COUNTY	County of the patient's mailing address.
STATE	State name of the patient's mailing address.
ZIP	Zip code of the patient's mailing address.
PARENT/GUARDIAN	
LAST	Last name of the patient's parent or guardian.
FIRST	First name of the patient's parent or guardian.
MIDDLE	Middle name of the patient's parent or guardian.
STREET LINE 1 **STREET LINE 2**	Line 1 and Line 2 of the home address of the patient's parent or guardian.
CITY	City of the home address of the patient's parent or guardian.
COUNTY/BOROUGH	County or Borough of the home address of the patient's parent or guardian.
STATE	State name of the home address of the patient's parent or guardian.
ZIP	Zip code of the home address of the patient's parent or guardian.

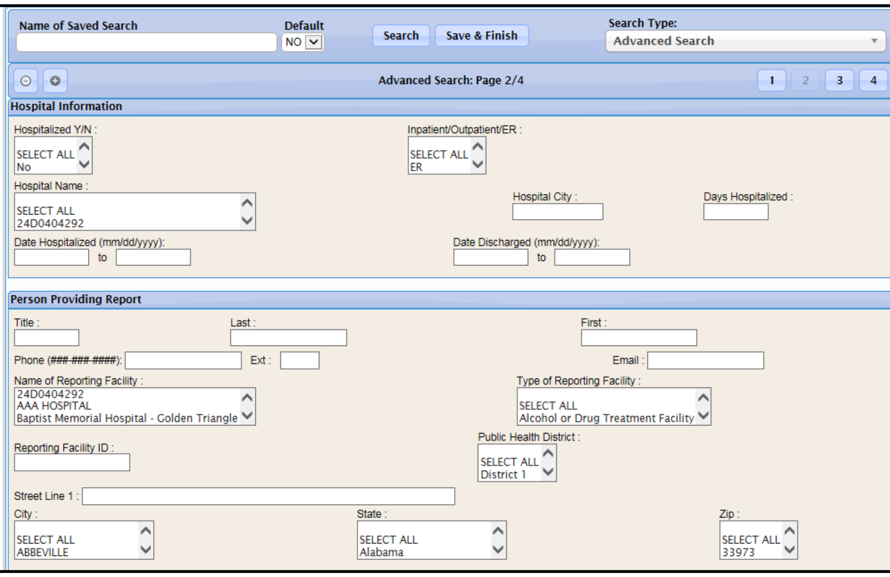
FIELD	DESCRIPTION
DAYTIME PHONE/ EXT	Daytime telephone number and an extension, if applicable, of the patient's parent or guardian.
EVENING PHONE/ EXT	Evening telephone number and an extension, if applicable, of the patient's parent or guardian.
ANIMAL CASE INFORMATION	
ANIMAL SPECIES	Species of the animal, such as bat, dog, or fox, related to the non-human case.
TAG NUMBER TYPE	Type of tag number. Available options are: • Avian • Mosquito • Veterinary
TAG NUMBER	Numeric identifier for non-human West Nile Virus cases.
LOCATION	Location where the animal was encountered. Ex: For animal rabies cases, location may be where the rabid animal was seen, such as a treetop, backyard, etc.

SEARCH PARAMETERS - SCREEN 2 OF 3

There a three “Search Parameters” screens. You do not need to make selections on each screen and you can make selections on any combination of screens.

Note: Due to the size of the Search Screens, illustrations are provided in partial.

Figure 5-78: New Search – Hospital Information (Screen 2 of 3)



The following table describes the search criteria fields on the second "Search Parameters" screen.

Table 5-32: Search Parameters (Screen 2 of 3)

FIELD	DESCRIPTION
HOSPITAL INFORMATION	
HOSPITALIZED Y/N	Whether the patient was hospitalized (**YES** or **NO**).
HOSPITAL NAME	The **HOSPITAL NAME** field searches "Hospital" values on the disease specific form. This search automatically limits the results to disease names that request this information on the disease specific form. • To select all hospitals – <u>Do not</u> enter a hospital name. All cases are returned regardless of whether data has been supplied for the "Hospital" question on the disease specific form. • To select a specific hospital – Type the exact value into the "Hospital" text box (e.g., Phoenix Regional Hospital.) The search returns all cases where the response to the question "Hospital" on the disease specific form is "Phoenix Regional Hospital." To select using a partial hospital name – Type the

FIELD	DESCRIPTION
	hospital name using the wildcard (*) symbol (e.g., Phoenix*). In this example, the search returns all cases where the response to the question "Hospital" on the disease specific form is "Phoenix," "Phoenix Regional," or "Phoenix Regional Hospital."
HOSPITAL CITY	City location of the hospital.
DAYS HOSPITALIZED	Number of days the patients was hospitalized (From and To Date Range).
DATE HOSPITALIZED	Date the patient was first hospitalized (From and To Date Range). Type the date using the format mm/dd/yyyy or click the Calendar Icon to select a date.
PATIENT STATUS DATE	Defaults to the system date at the time of new case entry.
PERSON PROVIDING REPORT	
TITLE	Title of the person providing the report.
LAST	Last name of the person providing the report.
FIRST	First name of the person providing the report.
PHONE/EXT	Phone number and extension, if applicable, of the person providing the report.
EMAIL	Email address of the person providing the report.
NAME OF REPORTING FACILITY	Name of the facility of the person providing the report.
TYPE OF REPORTING FACILITY	Type of facility of the person providing the report, such as Clinics, ER, Hospital, Military, and Laboratory. A facility can be of more than one type. For example, Central Hospital (**FACILITY NAME**) can be a hospital or a lab (**TYPE OF REPORTING FACILITY**).

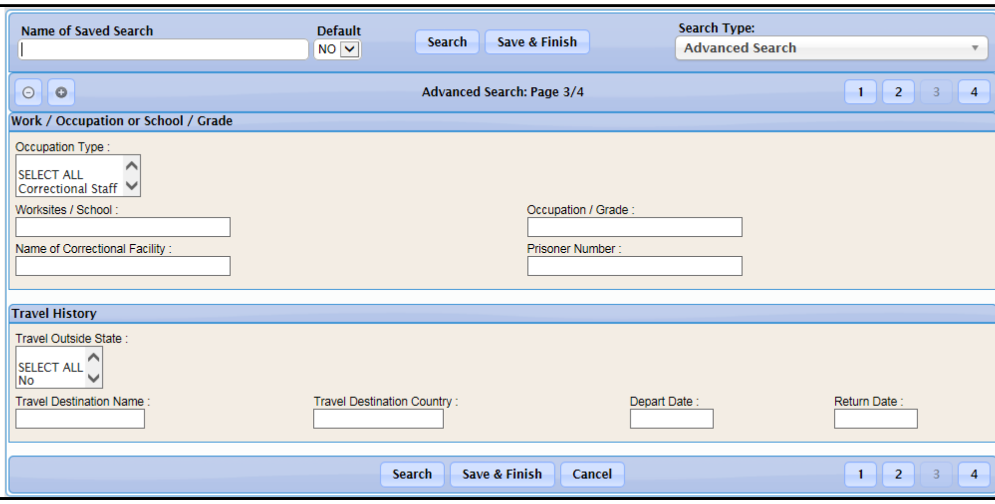
FIELD	DESCRIPTION
REPORTING FACILITY ID	Clinical Laboratory Improvement Amendments (CLIA) ID of the facility of the person providing the report.
HOSPITAL REGION/DISTRICT	Geographic grouping of hospitals into bioterrorism regions/districts. This is a read-only field.
STREET LINE 1	Street address of the reporting facility.
CITY	City of the reporting facility.
STATE	State name of the reporting facility.
ZIP	Zip code of the reporting facility.
PRIMARY OR ATTENDING PHYSICIAN	
TITLE	Title of the primary or attending physician.
LAST	Last Name of the primary/attending physician.
FIRST	First Name of the primary/attending physician.
PHONE/EXT	Phone number and extension, if applicable, of the primary or attending physician.
EMAIL	Email address of the primary or attending physician.
PHYSICIAN FACILITY	Facility of the primary or attending physician.
STREET LINE 1 **STREET LINE 2**	Street address of the primary or attending physician.
CITY	City of the primary/attending physician.
COUNTY/BOROUGH	County or Borough name of the primary/attending physician.

FIELD	DESCRIPTION
STATE	State name of the primary/attending physician.
ZIP	Zip code of the primary/attending physician.

Search Parameters - Screen 3 of 3

There a three "Search Parameters" screens. You do not need to make selections on each screen and you can make selections on any combination of screens.

Figure 5-79: New Search – Work/Occupation or School/Grade (Screen 3 of 3)



The following table describes the search criteria fields on the third "Search Parameters" screen.

Note: Due to the size of the Search Screens, illustrations are provided in partial.

Table 5-33: Search Parameters (Screen 3 of 3)

FIELD	DESCRIPTION
WORK/OCCUPATION OR SCHOOL/GRADE	
OCCUPATION	Type of occupations, such as Correctional Staff,

FIELD	DESCRIPTION
TYPE	Daycare worker, Healthcare worker, and Unknown.
WORKSITES/ SCHOOL	Additional details about the worksite or school (based on the type of occupation relating to possible sources of exposure or the spread of a disease.
OCCUPATION/ GRADE	Additional details about the worksite occupation or school grade relating to possible sources of exposure or the spread of a disease.
NAME OF CORRECTIONAL FACILITY	Name of the correctional facility.
PRISONER NUMBER	Prisoner number of the patient.
TRAVEL HISTORY	
DESTINATION NAME	Location the patient visited.
DESTINATION COUNTRY	Name of the country of the destination the patient visited.
DEPART DATE	Start date that the patient visited the destination. Type the date using the format mm/dd/yyyy or click the Calendar Icon to select a date.
RETURN DATE	End date that the patient returned from visiting the destination. Type the date using the format mm/dd/yyyy or click the Calendar Icon to select a date.

CREATING A SEARCH

To create a search, perform the following:

1. On the “Case Investigation” menu, click the **NEW SEARCH** option. The first “Search Parameters” screen appears.
2. Using “Table 5-31: Search Parameters” as a guide, enter the desired search criteria.

3. *(Optional)* Use the **CONTINUE** and/or **BACK** buttons to move back and forth between the first, second, and third "Search Parameters" screens and make the desired selections using the same table.

4. When you have completed your selections, click one of the following buttons:

   - **SEARCH** – begins a validation process and if there are no errors, the search begins to execute (does not save) with any changes that you may have made. After the search executes, the "Case Listings" screen appears.

     a) If the search does not locate any results, a dialog box appears indicating, "No results were found matching your search criteria and privileges." Click the OK button to re-enter search criteria.

   - **SAVE & FINISH** – begins a validation process and if there are no errors, saves the changes that you made and returns you to the "Saved Searches" screen.

   - **CANCEL** – terminates the process of creating a search returns you to the "Saved Searches" screen. If you made any selections, a dialog box appears asking if you are sure you want to cancel.

     a) If you click the **OK** button, you will lose any data you entered and the "Saved Searches" screen appears.

     b) If you click the **CANCEL** button, you remain on the current "Search Parameters" screen with the data you entered intact.

NEW SUPPLEMENTAL FORM SEARCH - DATA EXPORTER

The "New Supplemental Form Search" functionality is processed via the "Data Exporter."

In both the "Search by Example" and "Query by Example" options, you may skip directly to selecting a form version and export the supplemental data associated with the form regardless of the associated condition.

DATA EXPORTER OVERVIEW

Data Exporter allows you to select multiple criteria as the basis for exporting data fields in Data Type forms or Data Collection forms. You can also export and display these search results in Sentinel.

Data Exporter includes the following features:

- Search by Example and Query by Example Capabilities
- View and Save Queries
- Many-to-one relationships for questions with multiple responses
- If a Data Type form is selected, returns all data from all containing Data Collection forms (subject to security constraints)
- Export data as a collection of cross-referenced CSV files
- Export as HTML and XML

DATA TYPE FORMS VS DATA COLLECTION FORMS

You can search using a Data Type form or a Data Collection form. The differences between these forms are defined.

Data Type form – pre-existing, reusable form that contains related questions, such as patient demographics, and can be incorporated into Data Collection Forms. You cannot edit a Data Type form.

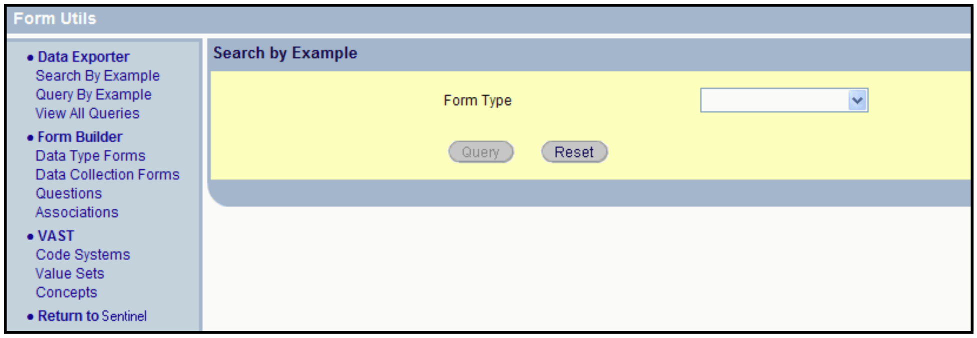
Data Collection form – unique, editable form created in Form Builder that may include Data Type forms and other Data Collection forms.

ACCESSING DATA EXPORTER

To access Data Exporter, perform the following:

- On the “Case Investigation” menu, click the **NEW SUPPLEMENTAL FORM SEARCH** option. The “Data Exporter” window appears displaying the “Search by Example” screen.

Figure 5-80: Data Exporter



Search by Example – Disease & Form

You may either search by Disease & Form, or directly by form. To search directly by form, continue to the section titled, "Search by Example – Form Version" for instructions.

To search by example, perform the following:

1. On the "Case Investigation" menu, click the **NEW SUPPLEMENTAL FORM SEARCH** option. The "Data Exporter" window appears displaying the "Search by Example" screen.

- or -

If you are already in the "Data Exporter" window, on the "Data Exporter" menu, click the **SEARCH BY EXAMPLE** option to display the "Search by Example" screen.

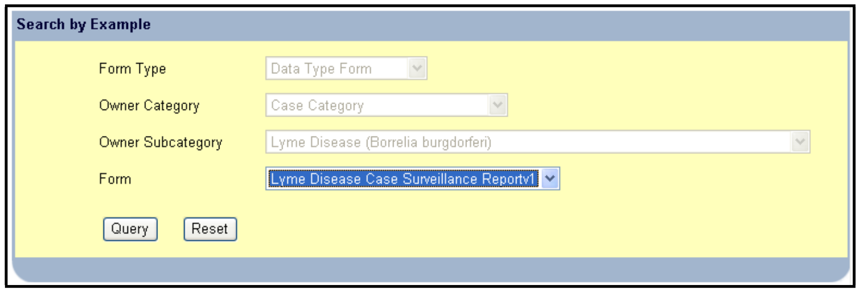
2. From the **FORM TYPE** drop-down menu, select the type of form you want to use. The **OWNER CATEGORY TYPE** drop-down menu appears.

3. From the **OWNER CATEGORY TYPE** drop-down menu, select a type. The **OWNER SUBCATEGORY** drop-down menu appears.

4. From the **OWNER SUBCATEGORY** drop-down menu, select a subcategory. The **FORM** drop-down menu appears.

5. From the **FORM** drop-down menu, select a specific form. The following figure shows the "Search by Example" screen after all four fields are visible on the screen.

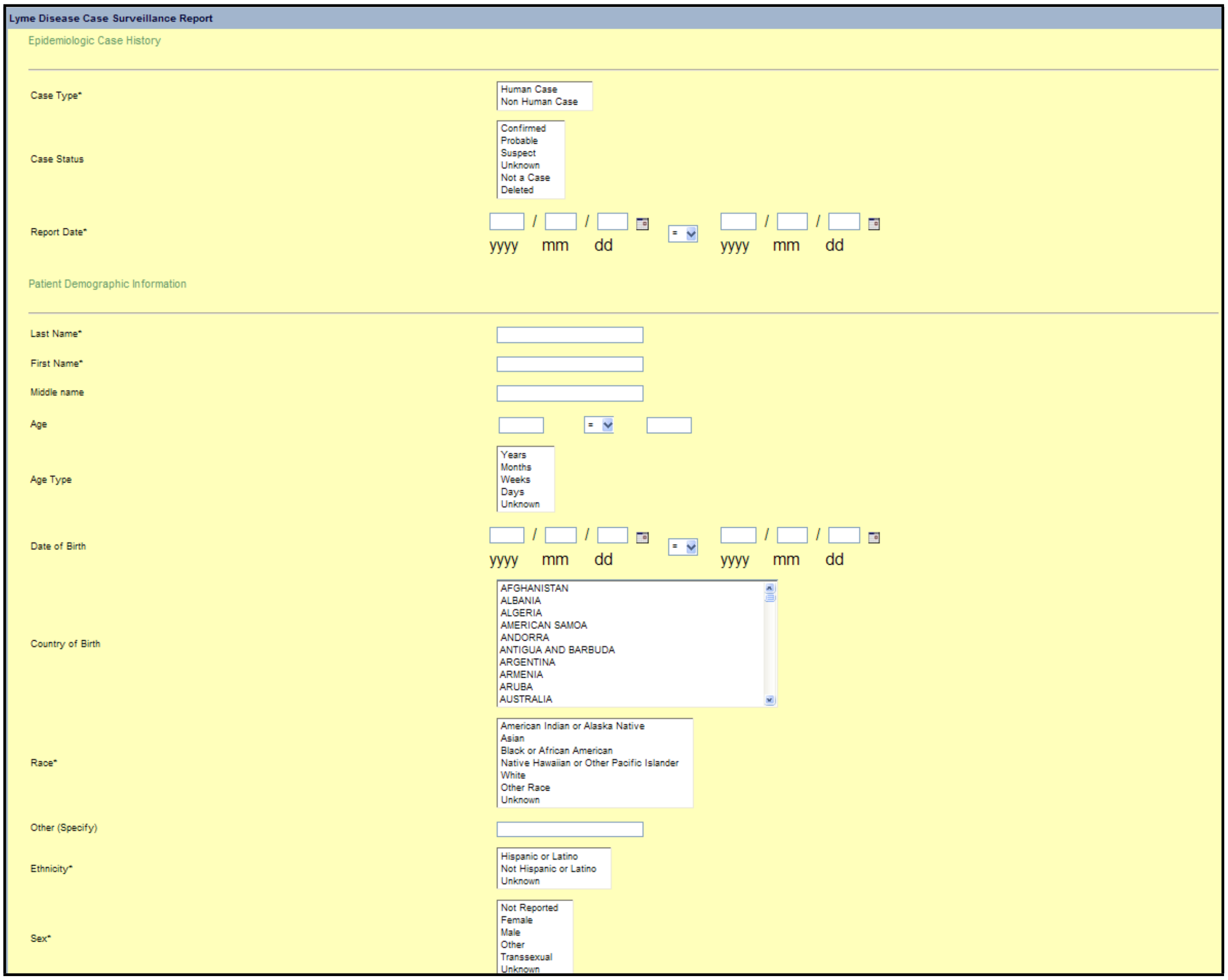
Figure 5-81: Search by Example Screen with All Selection Fields



6. Click one of the following buttons;

- **RESET** – If you want to erase the field data and start over with all empty fields, click the button to clear all the fields.
- **QUERY** – To process the “Search Criteria” and display the “Search Criteria” screen.

Figure 5-82: Search Criteria Screen



7. (Optional) You can save the search from this screen or from the "Query Results" screen. Refer to the section titled, "Query by Example – Form Version" for more information.
8. Select and/or type your search criteria in the fields provided.

Note: Date of Birth should be edited in the Sentinel Core – Demographics Tab.

9. Click the **SUBMIT** button. The search is executed and the search results are displayed on the "Case Listings" screen in Sentinel.

SEARCH BY EXAMPLE – FORM VERSION

You may either search by Disease & Form, or directly by Form Version. To search directly by Form Version, perform the following:

1. On the "Case Investigation" menu, click the **NEW SUPPLEMENTAL FORM SEARCH** option. The "Data Exporter" window appears displaying the "Search by Example" screen.

   - or -

   If you are already in the "Data Exporter" window, on the "Data Exporter" menu, click the **SEARCH BY EXAMPLE** option to display the "Search by Example" screen.

2. From the **FORM TYPE** drop-down menu, select the **DATA COLLECTION FORM**. The **OWNER CATEGORY TYPE** drop-down menu appears.
3. From the **OWNER CATEGORY TYPE** drop-down menu, select **CASE CATEGORY**. The **OWNER SUBCATEGORY** drop-down menu appears.
4. From the **OWNER SUBCATEGORY** drop-down menu, select **STANDARD**. The **FORM** drop-down menu appears.
5. From the **FORM** drop-down menu, select the Form.
6. Click the **QUERY** button to process the query or **RESET** to erase the fields and re-enter Query data.

QUERY BY EXAMPLE – DISEASE & FORM

You may either search by Disease & Form, or directly by form. To search directly by form, continue to the section titled, "Query by Example – Form Version" for instructions.

To query by example by Disease & Form, perform the following:

1. On the "Case Investigation" menu, click the **NEW SUPPLEMENTAL FORM SEARCH** option. The "Data Exporter" window appears displaying the "Search by Example" screen.
2. Click the **QUERY BY EXAMPLE** option. The "Query by Example" screen appears.

3. From the **FORM TYPE** drop-down menu, select the type of form you want to use. The **OWNER CATEGORY TYPE** drop-down menu appears.

4. From the **OWNER CATEGORY TYPE** drop-down menu, select one of the following types:

   - **CASE CATEGORY** – to search case-specific forms.
   - **ANIMAL CASE CATEGORY** – to search animal case-specific forms.

   The **OWNER SUBCATEGORY** drop-down menu appears.

5. From the **OWNER SUBCATEGORY** drop-down menu, select a subcategory. The **FORM** drop-down menu appears.

6. From the **FORM** drop-down menu, select a specific form.

7. Click one of the following buttons:

   - **RESET** – If you want to erase the field data and start over with all empty fields, click the button to clear all the fields.
   - **QUERY** – To process the "Search Criteria" and display the "Search Criteria" screen.

8. (Optional) You can save the query from this screen or from the "Query Results" screen. Refer to the section titled, "Query by Example – Form Version" for more information.

9. Select and/or type your search criteria in the fields provided.

10. Click the **SUBMIT** button. The "Query Results" screen appears.

11. To export the results in CSV, HTML, or XML format, click the appropriate button at the bottom of the screen.

    - **EXPORT AS CSV** – When exporting in CSV format, the results are exported in multiple, cross-referenced files to allow for fields with one-to-many relationships (i.e., field with multiple possible answers) and "CDC Use" modules. These additional files are referenced from the main Start.csv file.
    - **EXPORT AS HTML** – opens a browser window listing the query results. Multiple tables are used for the one-to-many fields and the "CDC Use" modules.
    - **EXPORT AS XML** – exports the data in XML format.

QUERY BY EXAMPLE – FORM VERSION

You may either search by Disease & Form, or directly by Form Version. To search directly by Form Version, perform the following:

1. On the “Case Investigation” menu, click the **NEW SUPPLEMENTAL FORM SEARCH** option. The “Data Exporter” window appears displaying the “Search by Example” screen.

- or -

If you are already in the “Data Exporter” window, on the “Data Exporter” menu, click the **QUERY BY EXAMPLE** option to display the “Query by Example” screen.

2. From the **FORM TYPE** drop-down menu, select the **DATA COLLECTION FORM**. The **OWNER CATEGORY TYPE** drop-down menu appears.

3. From the **OWNER CATEGORY TYPE** drop-down menu, select **CASE CATEGORY**. The **OWNER SUBCATEGORY** drop-down menu appears.

4. From the **OWNER SUBCATEGORY** drop-down menu, select **STANDARD**. The **FORM** drop-down menu appears.

5. From the **FORM** drop-down menu, select the Form.

6. Click the **QUERY** button to process the query or **RESET** to erase the fields and re-enter Query data.

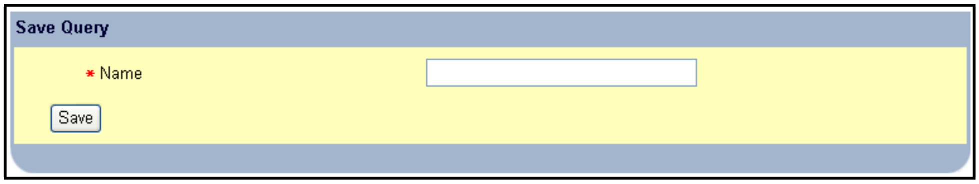
SAVING A QUERY

Saving a query allows you to rerun the query in the future without having to recreate it. You can save a query while performing a Search by Example or a Query by Example.

To save a query, perform the following:

1. On the “Search Criteria” screen (while performing a Search by Example or a Query by Example) or the “Query Results” screen (while performing a Query by Example), click the **SAVE QUERY** button. The “Save Query” screen appears, prompting you to enter a name for your query.

Figure 5-83: Saving Queries



2. Type a name for the query and click the **SAVE** button.

VIEWING ALL SAVED QUERIES

To view all saved queries, perform the following:

1. On the "Data Exporter" menu, click the **VIEW ALL QUERIES** option. The "All Queries" screen appears.
2. *(Optional)* To view details for a specific query, locate the query and click the **VIEW QUERY** button on the same row. The "Query Details" screen appears.

RUNNING A SAVED QUERY

To run a saved query, perform the following:

1. On the "Data Exporter" menu, click the **VIEW ALL QUERIES** option. The "All Queries" screen appears.
2. Locate the query you want to run and click the **RUN QUERY** button. The "Query Results" screen appears.
3. Click the **DISPLAY RESULTS** button. The "Query Results" screen shows the results.

DELETING A QUERY

To delete a query, perform the following:

1. On the menu, under **SMRF FORMS**, click the **VIEW ALL QUERIES** option. The "All Queries" screen appears.
2. Select the check box (left column) for the query you want to delete and then click the **DELETE** button. A message appears stating the query was deleted.

ALERT RULES

Sentinel can automatically transmit alerts to users based on alert rules. Alerts inform users that a predefined group of disease counts, time frame, and geography has occurred.

When the activating case matches the requirements of the alert configuration, alerts are sent via email. Other higher priority messages can be sent through the state's Health Alert Network (HAN), which can provide alerts through other modes of communication such as text pagers and the telephone.

Note: Although HAN signaling information is captured on the "Alert Rules" configuration screens, HAN integration is not part of Sentinel. Email-only alerts do not go through the HAN, but low- medium- and high-level alerts will be executed using HAN. When HAN integration takes place, the Sentinel user must be a State HAN user with a valid HAN User-ID and authority to send alerts through the State's HAN. The HAN authority is confirmed prior to a message being sent through the State's HAN. If the alert is invalid, the HAN returns a message to Sentinel, which then emails the user that there was a failed attempt to send an automated alert through the State's HAN using their HAN User-ID.

Sentinel allows investigators to specify alert rules, but the content structure is fixed. Users can create alert rules for themselves within their own jurisdiction. Local Health Administrators can create alert rules for themselves and other users within their jurisdiction.

You can perform the following tasks using the "Alert Rules List" screen:

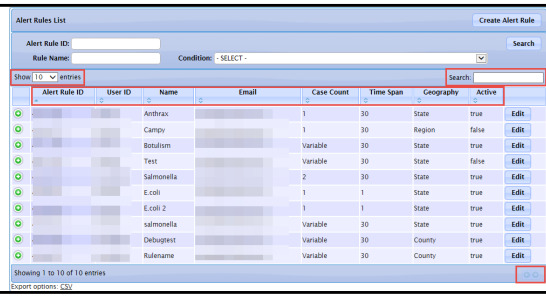
- Create an alert rule. Refer to the section titled, "Creating an Alert Rule" for instructions.
- Edit an alert rule. Refer to the section titled, "Editing an Alert Rule" for instructions.
- Inactivate an alert rule. Refer to the section titled, "Inactivating an Alert Rule" for instructions.

VIEWING THE ALERT RULES

To view the Alert Rules, perform the following:

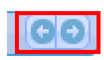
1. From the "Case Investigation" menu, click the **ALERT RULES** option. The "Alert Rules List" appears with any current alerts.

Figure 5-84: Alert Rules List Screen



2. To organize the screen data and/or screen entries, perform the following (these items are framed in red in the illustration):

   - **Show nn Entries** – Allows you to control the number of rows that display on the screen. Click the drop-down arrow to select 10, 25, 50, or 100 rows.

   -  - Allows you to scroll the pages backward and forward, respectively.

   - **Sort the Heading Rows** (Alert Rule ID, User Id, Name, Email, Case Count, Time Span, Geography, Active, etc.) – Allows you to sort the data in ascending or descending order. Click the desired row header to sort the data.

     Note: The "Sorted" column will display darker than the other columns and the arrow in the header will tell you which way it is sorted.

   - **Search** – Allows you to search for specific column data; i.e., Alert Rule ID, User Id, Name, Email, Case Count, Time Span, Geography, Active, etc. Type a string that you want to search for and as you type, the data list will only show you the name(s) that match your criteria. To redisplay all entries, remove the search characters from the "Search" field.

3. Refer to Table 5-34 for a list of fields/columns and their descriptions.

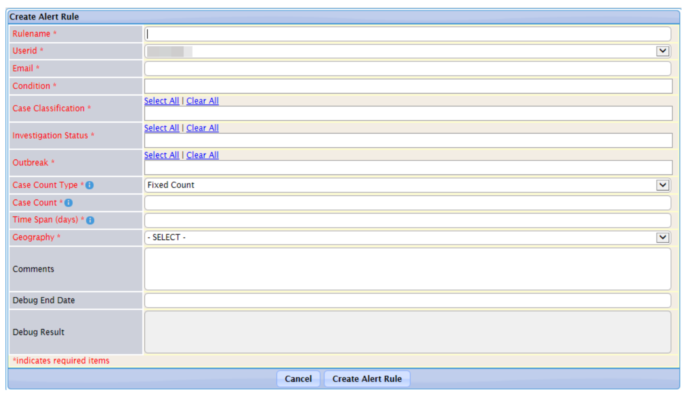
4. Determine the action to perform and continue to its corresponding section within this chapter for instructions.

CREATING AN ALERT RULE

To create an alert rule, perform the following:

1. On the “Case Investigation” menu, click the **ALERT RULES** option. The “Alert Rules List” screen appears.
2. Click the **CREATE ALERT RULE** button. The “Create Alert Rule” screen appears.

Figure 5-85: Create Alert Rule



3. Using the following table as a guide, enter the desired information. You must complete all the fields on this screen.

Table 5-34: View, Create, and Edit Alert Rule Field Descriptions

FIELD	DESCRIPTION
	A green PLUS sign indicates there is more information associated with the Alert. Click it to expand the list to display all of the conditions associated with the Alert. • The green PLUS sign becomes a red MINUS sign once it has been expanded. • Click the red MINUS sign to collapse the conditions and return to the ALERTS list screen.
ALERT RULE ID	System-generated number identifying the alert rule. Appears when viewing the “Alert List” and when editing an Alert Rule.

FIELD	DESCRIPTION
RULENAME	Name for the alert rule.
USER ID	User-ID of the user creating the alert rule.
EMAIL	Email address that will receive the alert.
CONDITION	Predefined condition on which the alert focuses.
CASE CLASSIFICATION	
INVESTIGATION STATUS	
OUTBREAK	
CASE COUNTTYPE	
CASE COUNT	Minimum number of cases that trigger the alert. This must be a whole number.
TIME SPAN (DAYS)	Number of days for which the alert will focus. This must be a whole number.
GEOGRAPHY	Area or location of the condition that triggered the alert. Examples are: • County • Local • Region • State
ACTIVE	Displays **true** (active) or **false** (inactive). Appears when Viewing the Alert List and when Editing an Alert Rule.

4. Click one of the following buttons:

- **CANCEL** – terminates the process of adding a new alert rule and returns you to the “Alert Rules List” screen. If you entered any information, a dialog box appears asking if you are sure you want to cancel.

a) If you click the **OK** button, you will lose your changes and return to the “Alert Rules List” screen.

b) If you click the **CANCEL** button, you remain on the “Create Alert Rule” screen with the data you entered intact.

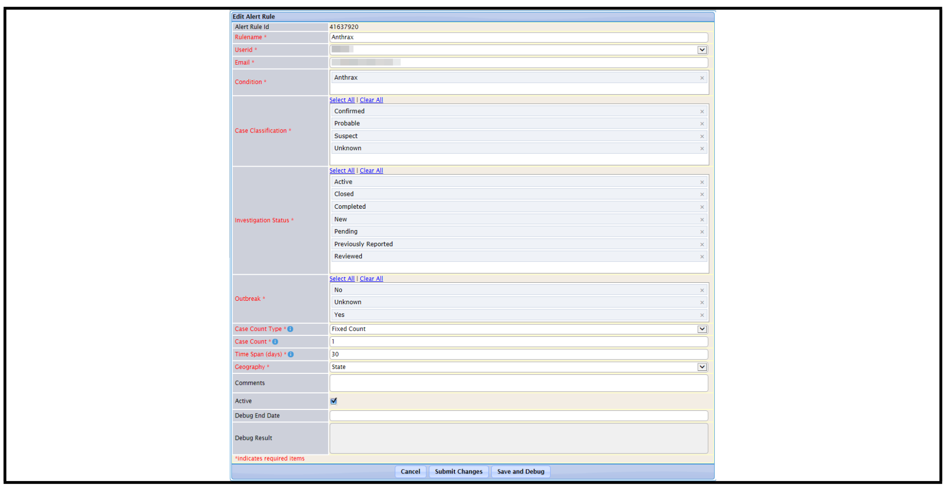
- **RESET** – erases any changes made since the previous save and remains on the same screen.
- **CREATE ALERT RULE** – begins a validation process and if there are no errors, saves the new alert rule and returns you to the “Alert Rules List” screen (which displays the newly created alert rule). If there are errors, you must correct them before Sentinel saves the alert rule.

EDITING AN ALERT RULE

To edit an alert rule, perform the following:

1. On the “Case Investigation” menu, click the **ALERT RULES** option. The “Alert Rules List” screen appears.
2. Locate the alert rule you want to edit and click the **EDIT** button. The “Edit Alert Rule” screen appears.

Figure 5-86: Edit Alert Rule



3. Refer to Table 5-34 for a list of field/column descriptions.
4. Enter the desired information. You must complete fields in RED*; all other fields are optional.
5. Click one of the following buttons:
   - **CANCEL** – terminates the process of editing the Alert Rule and returns you to the “Alert Rules List” screen. If you changed any information, a dialog box appears asking if you are sure you want to cancel.

a) If you click the **OK** button, you will lose your changes and you return to the “Alert Rules List” screen.

b) If you click the **CANCEL** button, you remain on the “Edit Alert Rule” screen with the data you entered intact.

- **RESET** – erases any changes that you made since the previous save and remains on the same screen.
- **SUBMIT CHANGES** – begins a validation process and if there are no errors, saves the edited alert rule and returns to the “Alert Rules List” screen. If there are errors, you must correct them before Sentinel saves the alert rule changes.

Alert Message Automatic Generation

An alert message is automatically generated when the specified number of cases has entered the system over the specified time frame and geographic area. The cases do not need to be confirmed to be considered part of the count.

The time frame is based on 24-hour periods instead of actual days, and the time and date the case entered the system is considered when determining whether the case occurred within the time criteria. An alert is generated for each additional new case that enters the system if it occurs within the specified time frame.

The email alerts that are initiated via the alert rules are sent to the email address designated in the alert configuration.

The following table describes the information contained in the email alert.

Table 5-35: Email Alert Information

EMAIL ALERT INFORMATION	DESCRIPTION
SUBJECT	Indicates the Alert Message and source of the environment the alert is being sent from; i.e., Epi-Tracks, Epi-Tracks QA, Epi-Tracks Test, AKSTARS, AKSTARS Dev Staging, NHEDSS, NHEDSS Train, and STC QA <State> 8080 or 8082, etc.

EMAIL ALERT INFORMATION	DESCRIPTION
MESSAGE	Alert message. Example: "You have received an automated alert corresponding to Alert Number 220003 from Sentinel. Log into the Sentinel application for additional information."
ALERT NUMBER	Coincides with the alert rule number in your set of alert rules.

INACTIVATING AN ALERT RULE

To inactivate an alert rule, perform the following:

1. On the "Case Investigation" menu, click the **ALERT RULES** option. The "Alert Rules List" screen appears.
2. Locate the alert rule you want to delete and click the **EDIT** button. The "Edit Alert Rule" window appears.
3. Click the **ACTIVE** checkbox to change the status from active to **INACTIVE**.

MESSAGE MANAGEMENT

This option is available for users that have the Administrative Permission – Create, modify, and delete system messages;" otherwise, it will not appear on the menu. This option is used to create, edit, and delete messages that will appear on users' windows after entering a valid user-id and password.

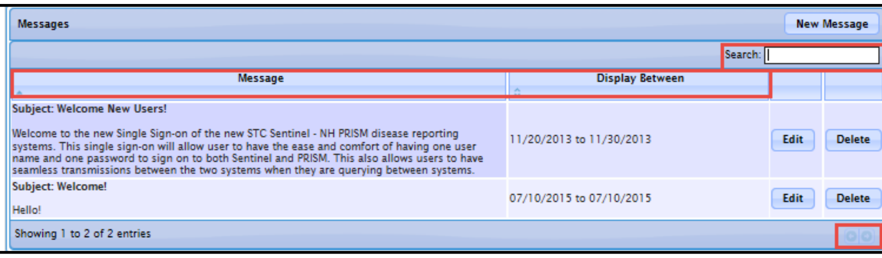
Once a message is created, it will appear to users immediately after they login. A **VIEW MESSAGES** option will appear on the user's menu so messages can be viewed again.

VIEWING THE MESSAGE LIST

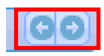
To view the "Message List," perform the following:

1. On the "Case Investigation" menu, click the **MESSAGE MANAGEMENT** option. The "Messages" list screen appears.

Figure 5-87: Messages List



2. To organize the screen data and/or screen entries, perform the following (these items are framed in red in the illustration):

   -  - Allows you to scroll the pages backward and forward, respectively.
   - **Sort the Heading Rows** (Message, Display Between) – Allows you to sort the data in ascending or descending order. Click the desired row header to sort the data.

     Note: The "Sorted" column will display darker than the other columns and the arrow in the header will tell you which way it is sorted.

   - **Search** – Allows you to search for specific column data; i.e., Message, Display Between. Type a string that you want to search for and as you type, the data list will only show you the name(s) that match your criteria. To redisplay all entries, remove the search characters from the "Search" field.

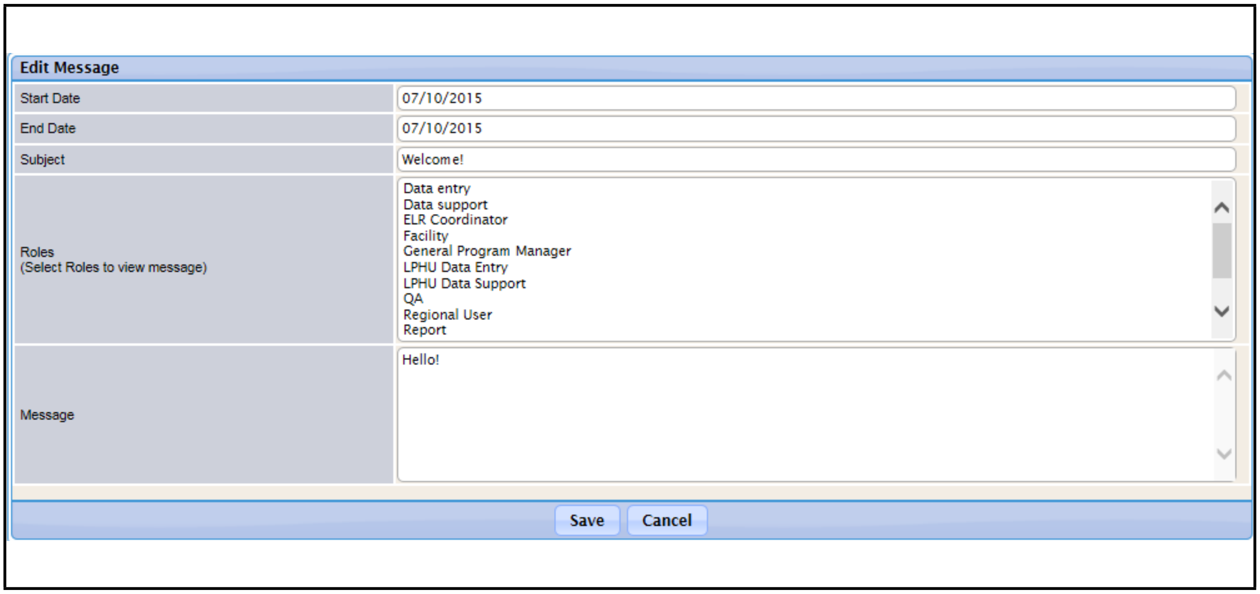
3. Refer to Table 5-36 for a list of field descriptions.
4. Determine the action to perform and continue to the section below for instructions. The actions to perform are:
   - Add a New Message
   - Edit a Message
   - Delete a Message

Adding a New Message

To add a new message, perform the following:

1. On the “Case Investigation” menu, click the **MESSAGE MANAGEMENT** option. The “Messages” list screen appears. Refer to Figure 5-87 for an illustration.
2. Click the **NEW MESSAGE** button. The “Add/Edit Message” window appears.

Figure 5-88: Edit Message – Add Mode



3. The fields and their descriptions are listed in the table:

Table 5-36: Add/Edit Message Field Descriptions

FIELD	DESCRIPTION
START DATE	The date on which the message should begin to display. If no date is given, the message will display immediately. Type the date or click the “Date Picker Icon” to select a date.
END DATE	The date on which the message should stop displaying. If no date is given, the message will always display. Type the date or click the “Date Picker Icon” to select a date.
SUBJECT	Title of the message. This title/subject will separate the messages on the “Message List.”
ROLES	Allows a selection of specific role(s) to view the message being created or edited.

FIELD	DESCRIPTION
	• To select one role, click it. • To select more than one role in a sequence, press the SHIFT key, click the first role, and while holding the SHIFT key, click the last role. • To select more than one role not in a sequence, press the CTRL key and click each role. • To deselect, use the SHIFT or CTRL key and click the role.
MESSAGE	Text of the message to display. If the message exceeds 2048 characters, it will be cut-off (referred to as "truncated").

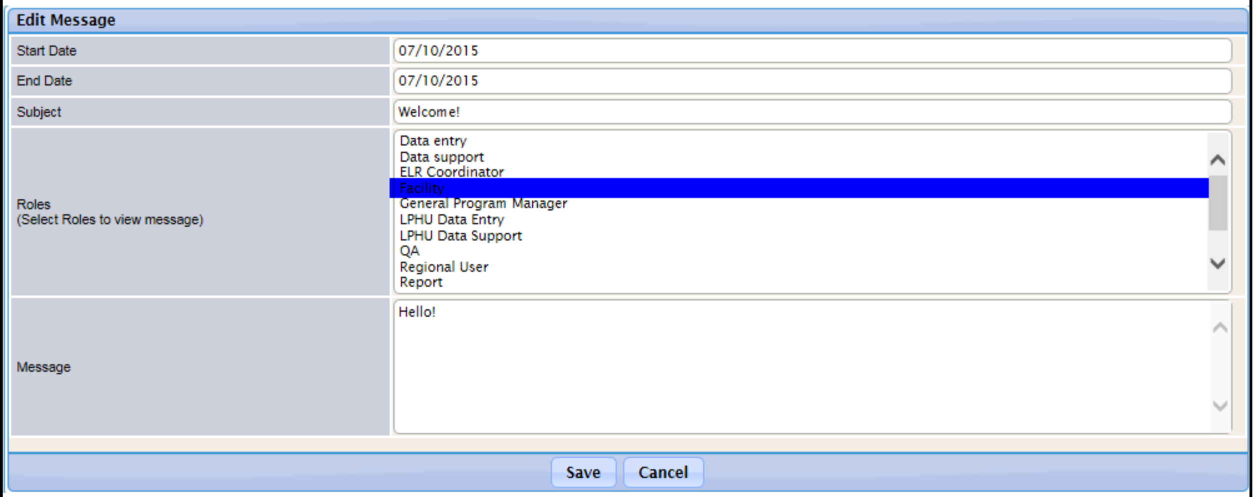
4. Type data into the fields and click one of the available buttons:
   - **SAVE** – to save the message to the database.
   - **CANCEL** – to not save the message to the database and return to the previous window.

Editing a Message

To edit an existing message, perform the following:

1. On the "Case Investigation" menu, click the **MESSAGE MANAGEMENT** option. The "Messages" list screen appears. Refer to Figure 5-87 for an illustration.
2. Locate the message you want to edit, and click its corresponding **EDIT** button. The "Add/Edit Message" window appears.

Figure 5-89: Edit Message – Edit Mode



3. Make the necessary edits and click one of the available buttons:
   - **SAVE** – to save the message to the database.
   - **CANCEL** – to not save the message to the database and return to the previous window.

DELETING/INACTIVATING A MESSAGE

To delete a message, perform the following:

1. On the "Case Investigation" menu, click the **MESSAGE MANAGEMENT** option. The "Messages" list screen appears. Refer to Figure 5-87 for an illustration
2. Locate the message you want to delete (inactivate), and click its corresponding **DELETE** button. The message will immediately be removed from the "Messages" window.

Note: Messages are not deleted from the database, but instead are flagged as "inactive."

VIEW MESSAGES

Messages will automatically appear after you have provided a valid user-id and password. Once you click on a different option after initially viewing the message, the messages will be removed from your screen. The **VIEW MESSAGES** option allows you to review the messages again.

VIEWING PREVIOUSLY VIEWED MESSAGES

To view the previously viewed messages, perform the following:

1. Click the **VIEW MESSAGES** option. The “Today’s Messages” window appears.

Figure 5-90: View Today’s Messages

2. Click a different menu option to view a different window.

BT/ILI

[This is a state-configurable option and may not appear for your state.]

The BT/ILI option is used to enter and edit Influenza-Like Illnesses.

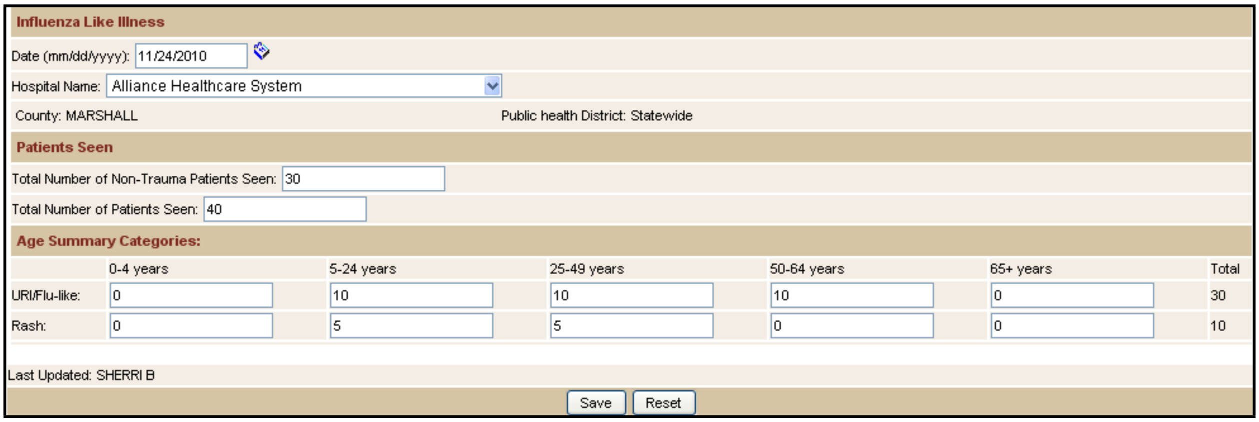
Note: Only those users authorized to access the BT/ILI application will be able to see and use this option.

ENTERING BT/ILI DATA

To view and enter BT/ILI data, perform the following:

1. Click the **BT/ILI** option. The “Influenza-Like Illness” screen appears.

Figure 5-91: Influenza-Like Illness



2. The fields and their descriptions are listed in the table.

Table 5-37: Influenza-Like Illness Field Descriptions

FIELD	DESCRIPTION
DATE	The date the Influenza-Like Illness is being entered. The date will default to "Today's Date" but you can type a different date or click the "Date Picker Icon" to select a date.
HOSPITAL NAME	Name of the hospital where the Influenza-Like Illness is being reported. Click the drop-down menu arrow to view/select a valid choice.
COUNTY	The County field automatically populates based on the Hospital Name's County from the Facilities table; thus, if the County is not entered, it will not appear.
PUBLIC HEALTH DISTRICT	Name of the Public Health District of which the Hospital Name/County are located in.
PATIENTS SEEN	
TOTAL NUMBER OF NON-TRAUMA PATIENTS SEEN	Type the total number (whole numbers only) of non-trauma patients seen at this facility/hospital.
TOTAL NUMBER OF PATIENTS SEEN	Type the total number (whole numbers only) of patients seen at this facility/hospital.

FIELD	DESCRIPTION
AGE SUMMARY CATEGORIES **NOTE: EACH NUMBER IN EACH AGE RANGE MUST BE LESS THAN THE TOTAL NUMBER OF NON-TRAUMA PATIENTS SEEN AND TOTAL NUMBER OF PATIENTS SEEN.**	
URI/FLU-LIKE	Type the (whole) number of URI/Flu-Like patients per age group. Age groups are: • 0 – 4 Years • 5 – 24 Years • 25 – 49 • 50 – 64 Years • 65+ Years • Total – This total automatically calculates and is less than the total number of non-trauma patients seen and less than Total Number of Patients seen.
RASH	Type the (whole) number of Rash patients per age group. Age groups are: • 0 – 4 Years • 5 – 24 Years • 25 – 64 Years • 65+ Years • Total – This total automatically calculates and is less than the total number of non-trauma patients seen and less than Total Number of Patients seen.
LAST UPDATED	Username of the person that last changed the data.

3. Type the data and click one of the available buttons:

- **SAVE** – saves the data to the database and remains on the screen.

  a) If another entry is entered for the same day/facility, the user must decide whether to create a new entry or delete the previous entry by clicking the corresponding radio button. Continue to the next section for instructions.

- **RESET** – erases the data from the fields and remains on the screen.

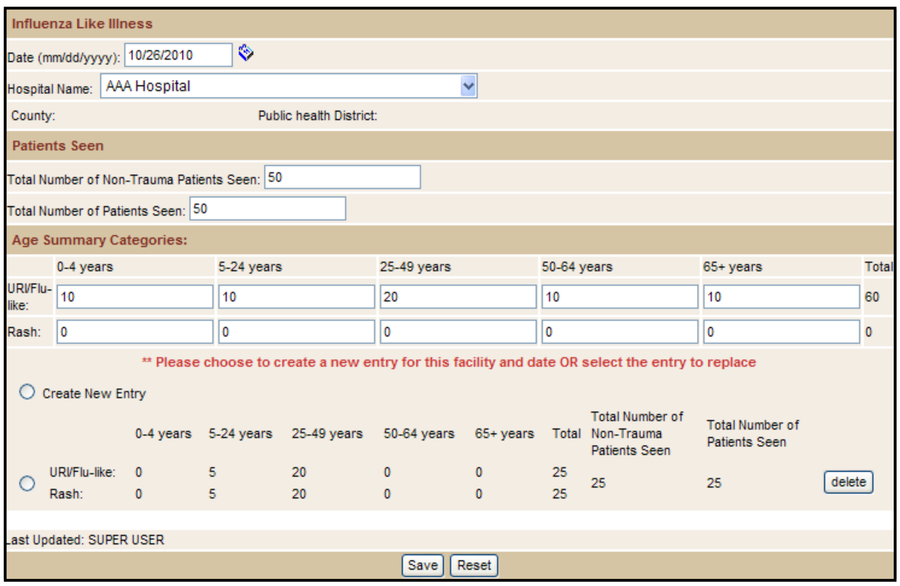
4. Choose another menu option to exit the screen.

EDITING/DELETING A BT/ILI ENTRY

To edit and/or delete a BT/ILI Entry, perform the following:

1. Click the **BT/ILI** option. The "Influenza-Like Illness" screen appears.
2. Type/select the **DATE** of which you want to edit/delete. The "Influenza-Like Illness" screen appears with editing information at the bottom.

Figure 5-92: BT/ILI – Edit Mode



3. Determine whether you want to create a new entry or delete the existing entry(ies).
   - Create a New Entry – Click the **CREATE NEW ENTRY** radio button and enter the new values.
   - Delete Existing Values – Click the **URI/FLU LIKE RASH** button and click its corresponding **DELETE** button. The row will be removed from the screen.
4. Click the **SAVE** button when finished.

OMS ACCESS

[This is a state-configurable option and may not appear for your state.]

This option is used to access the Outbreak Management System (OMS). Since this application can be used as a stand-alone application as well as integrated with Sentinel, it has a separate guide for instructions. Please refer to the "OMS Application User Guide" for more information.

HOSPITAL CASE MANAGEMENT

[This is a state-configurable option and may not appear for your state.]

This option is used to access the Hospital Case Management System, also referred to as the Health Care Facility (HCF) Reporting System. Since this application can be used as a stand-alone application as well as integrated with Sentinel, it has a separate guide for instructions. Please refer to the "Health Care Facility (HCF) Reporting System User Guide" for more information.

6 REPORTS MENU

When you click the **REPORTS** menu on the TopBar, all Sentinel report options appear in the Menu along with the first report's parameter selection screen.

The available reports are:

- Case Listing
- Diseases by Demographics
- Yearly Report by Month/Week
- Disease - 5 Year History
- Year-to-Date Disease by Area and Time
- Single Disease by Area and Time
- Disease by Geographic Area
- Summary Disease Report
- Epi Curve Report
- Animal Rabies
- BT/ILI Report

REPORT OUTPUT FORMAT

There may be several reasons to specify a format for the export including perceived audience, method of sharing, and requirements for further analysis.

Most of the reports can be presented in one of the following formats:

- **PDF** - Portable Document Format - a non-editable format. This report output opens in Adobe Reader in a new browser window in PDF format. This format is NOT available for the “Case Listing” report.
- **CSV** - Comma Separated Value - a text file format. This report output is best viewed in Microsoft Excel or other spreadsheet, but

can be viewed with many database and word processing applications.

- **HTML** - Hypertext Markup Language - standard Web page format. This report output opens in a new browser window. This format is NOT available for the "Case Listing" report or the "Epi Curve" report.

REPORT DATA RESTRICTIONS

All reports, excluding the Line Listing report, present only **aggregate count summary data** (as opposed to aggregate diseases) and have no restrictions on statewide users; thus, counts of all aggregate reports can be seen by all local and regional/district users.

The Line Listing report presents patient-level data; your role must have the appropriate permission to view that level of data in Sentinel for you to view/export this report.

Local users have a Small Cell Count Rule applied to Geographic Levels below County for geographic areas outside their Local Health Jurisdiction (LPHU). Users from one LPHU can view aggregate summary count data within other LPHUs, but counts below a certain threshold do not display when the geographic level of detail is city, school district, or ZIP Code.

The Small Cell Count Rule minimizes the risk of identifying individual cases by displaying:

- Counts and rates of less than five as "**< 5**" rather than the actual value.
- Counts and rates of zero as "**0.**"
- Counts or rates of five or greater as the actual count or rate.

SELECTING REPORT PARAMETERS

On each report selection screen, you can specify the following:

- Which cases you want to include on the report.
- Specify values for "Case Status" and "Investigation Status."

- Select the fields to display in the report output.

The "Case Listing" report is a detailed list that allows a date range to be selected for one or more of the "key" investigation dates; i.e., Onset Date, Diagnosis Date, Referral Date, and/or Event Date.

The following table describes all the categories that appear on the report selection screens. Each report includes several categories (areas of the screen) of selection parameters; however, not all reports have the same categories.

Table 6-1: Report Limitations/Selections

SCREEN AREA	DESCRIPTION
DISPLAY COLUMNS	Determines which columns appear on the report. You can select one or multiple columns. Examples are: • ID • Name • Age • Reportable Condition 2 • Case Status
DISPLAY INTERVAL	Determines "how" the report will display the information. Examples are: • Year • Month (Type/select the "From" date and the "Through" date) • Week (Type/select the "From" date and the "Through" date)
DISPLAY VARIABLE 1 **DISPLAY VARIABLE 2**	Allows you to break down the count or rate information on the report by a demographic variable. DISPLAY **VARIABLE 1** is required; however, you can select **NONE** for DISPLAY **VARIABLE 2**. Available options are: • Sex – Male, Female, and Unknown. • Age Group – Incremental age breakdown Ex: less than 1 year, 1-4 years, and 5-9 years determined by the Event Date. • Race – Breakdown by race Ex: Caucasian, Asian, African-American

SCREEN AREA	DESCRIPTION
	• Ethnicity – Breakdown by ethnic group. Available options are: Hispanic or Latino Non Hispanic or Latino Unknown • None – This option is only available for DISPLAY **VARIABLE 2**. If you select NONE, report data is broken down only by DISPLAY **VARIABLE 1**. If you select one of the other options for DISPLAY **VARIABLE 2**, report data is broken down by DISPLAY **VARIABLE 1** and then by DISPLAY **VARIABLE 2**. Example: If you select **SEX** for DISPLAY **VARIABLE 1** and select **ETHNICITY** for DISPLAY **VARIABLE 2**, report data is broken down by sex and then broken down by ethnicity. The report includes columns for sex, and within each sex column, the report includes columns for ethnicity.
GEOGRAPHIC AREA	The geographic area for the report is compared against the Investigation Address of the case. Only cases that fall within the selected geographic area are included on the report. Only one radio button can be chosen. • **BOROUGH/COUNTY**– All cases reported within the selected boroughs/counties are included on the report. No selection indicates all counties. • **DISTRICT/REGION**– All cases reported within the selected (LHD) district/region are included on the report. No selection indicates all districts/regions. • **HOSPITAL REGION/DISTRICT** – All cases reported within the selected hospital regions/districts are included on the report. No selection indicates all regions/districts. • **LOCAL HEALTH JURISDICTION** – All cases reported within the selected jurisdictions are included on the report. No selection indicates all jurisdictions. • **NATIONWIDE** – All cases reported within the Nation are included on the report. • **OUT OF STATE** – All cases reported out of state are included on the report. • **STATE WIDE** – All cases reported within the State are included on the report.

SCREEN AREA	DESCRIPTION
	• **ZIP** – All cases reported within the ZIP code are included on the report. No entry indicates all zip codes.
GEOGRAPHIC BREAKDOWN	Determines how data is arranged by columns on the report. Example: If you select the **CITY** option, a separate column appears for each city in the **GEOGRAPHIC AREA** you select. Refer to **GEOGRAPHIC AREA** in this table for more information.
LAB RELATED DISPLAY COLUMNS	Determines which lab-related columns appear on the CSV reports. Select one or multiple columns. Examples are: • Lab Report Date • Test Name • Specimen Collection Date
REPORT SELECTION CRITERIA	Allows you to select specific selection criteria for the report to include: • **CASE CLASSIFICATION** – cases such as confirmed, probable, not a case, etc. • **INVESTIGATION STATUS** – cases with an investigation status of All, Active, Canceled, etc. Select one or both (Case and/or Investigation Status). • **DISEASE NAME** or **DISEASE NAME #2** – Cases can be grouped by Disease Name and/or Disease Name #2. The Disease Name #2 field is enabled only when you select one (and only one) disease name and that disease has secondary diseases. • **DISEASE GROUP or DISEASE CLASS –** Cases can be grouped by Disease Group or Class providing they have the user permission (Run Reports by Disease Group and/or Run Reports by Disease Class). **Note**: Diseases include Active and Inactive Diseases only for the diseases that the user has access to according to the “Report Program Access.”
TABLE TYPE	Allows you to select either disease count (**COUNT**) or

SCREEN AREA	DESCRIPTION
	percentage information (**PERCENTAGE**) for the report.
TIME INTERVAL	The "Onset Date" must fall within the specified time period range. If the "Onset Date" is unavailable, the system will compare against the "Referral Date." The time period may be a selection of the following: **Month**—limits the report to cases within the month selected. If the month radio button is selected you must select a month from the drop-down menu. **Day**—limits the report to cases within the days provided in the TIME PERIOD. If the DAY radio button is selected, you must provide a FROM and TO date for the TIME PERIOD. **MMWR Week**—limits the report to cases within the "MMWR Week" provided in the TIME PERIOD's WEEK field. If the MMWR Week radio button is selected, you must provide a valid MMWR week in the format of a two-digit week and a four-digit year (i.e., 23-2004.)
TIME PERIOD	The available options depend on the report you select: • **FROM DATE/TO DATE** – Type a date using the format mm/dd/yyyy or click the calendar icon and select a date. Note: The "date range" for all summary reports is determined by the "Event Date." Additionally, reports use the "Case Address (aka Investigation Address)" for report selection criteria. • **YEAR** – Limits the report to cases within the year you type. The year must be a valid four-digit year and cannot be greater than the current year. • **FIVE YEAR PERIOD ENDING YEAR** – Limits the report to cases within the year you type and preceding four years (automatically calculating the beginning year). The ending year must be a valid four-digit year and cannot be greater than the current year. • **MONTH / YEAR** – Limits the report to cases within the selected month and the corresponding year you type. The year must be a valid four-digit year and cannot be greater than the current year. • **MMWR WEEK/YEAR** – Limits the report to cases within the MMWR Week you type. This field is

SCREEN AREA	DESCRIPTION
	automatically populated with the current MMWR Week, but you can change it if necessary. The week must be a two-digit week and a four-digit year. Ex: 23-2004
TYPE	Used for the "Animal Rabies" report. Includes animal types such as: • Bat • Cat • Dog

RUNNING A REPORT

You can only run a report for the geographic area and program area to which you have access. You cannot view cases (even in report results) outside of the geographic area and program areas to which you have access.

Although the report titles and selection parameters differ, the process of running a report is the same.

To run a report, perform the following:

1. On the TopBar, click the **REPORTS** menu. All the report names appear in the Menu with the first report's parameters screen appears.

Figure 6-1: Reports Menu

2. To select a different report, click the report title on the Menu.

3. Enter the desired values for the report parameters. You must complete fields in RED*; all other fields are optional.

4. Click one of the following buttons:

- **VIEW HTML REPORT** – displays the report in HTML format. This format is NOT available for the “Case Listing” or the “Epi Curve” report.
- **VIEW PDF REPORT** – displays the report in PDF format. This format is NOT available for the “Case Listing” report.
- **VIEW CSV REPORT** – displays a File Download dialog box (continue to the next step).
- **RESET** – erases any selections back to the default settings.

5. When you click the **VIEW CSV REPORT** button, a File Download dialog box may appear, asking you to confirm the download of the report output file.

5. Click one of the following buttons:

- **OPEN** – opens a new window to display the CSV report output. You can view and print your report output from this new window. Close the window when you are finished.

- **SAVE** – displays the "Save As" dialog box, which allows you to save the report output on your computer in the format selected. After you click the **SAVE** button in the "Save As" dialog box, your report output file is saved on your computer in the location that you specified.
- **CANCEL** – terminates the process of viewing the report and returns you to the "Report Parameter" screen.

Report Descriptions and Examples

Reports do not include Non-Human Cases or Cases where the Investigation Status is Deleted with the exception of the Animal Rabies report which includes ONLY Non Human Cases.

Case Listing Report

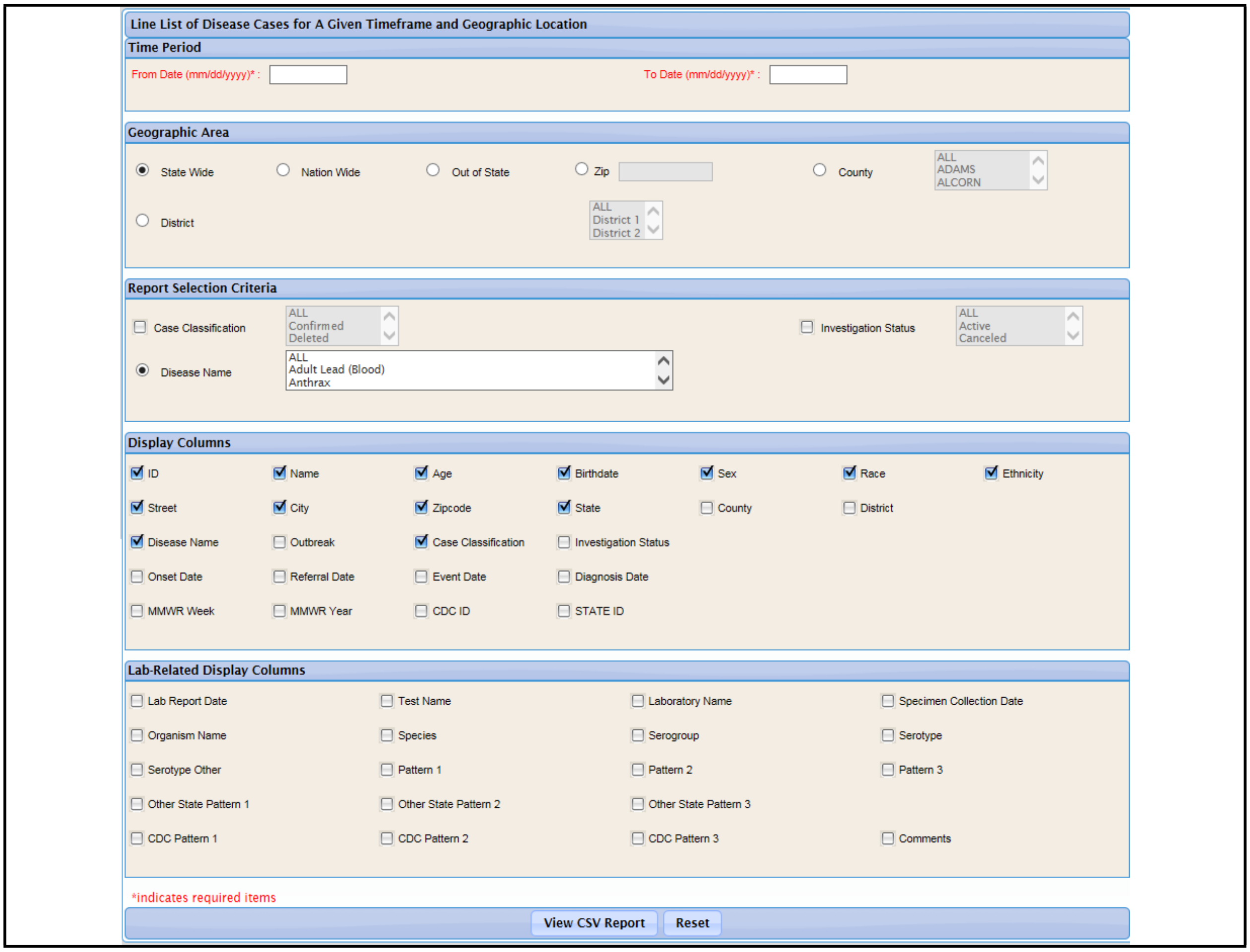
This report is also referred to as the, "Line List of Disease Cases for a Given Timeframe and Geographic Location."

The "Case Listing" report displays a patient-level list of all cases that fall within the specified time period, geographic area, and disease information as defined by the report parameters. You can determine the information to include in your report output by selecting the desired "Display Columns" check boxes.

Note: The Disease Name #2 field is enabled only when you select one (and only one) disease name and that disease has secondary diseases.

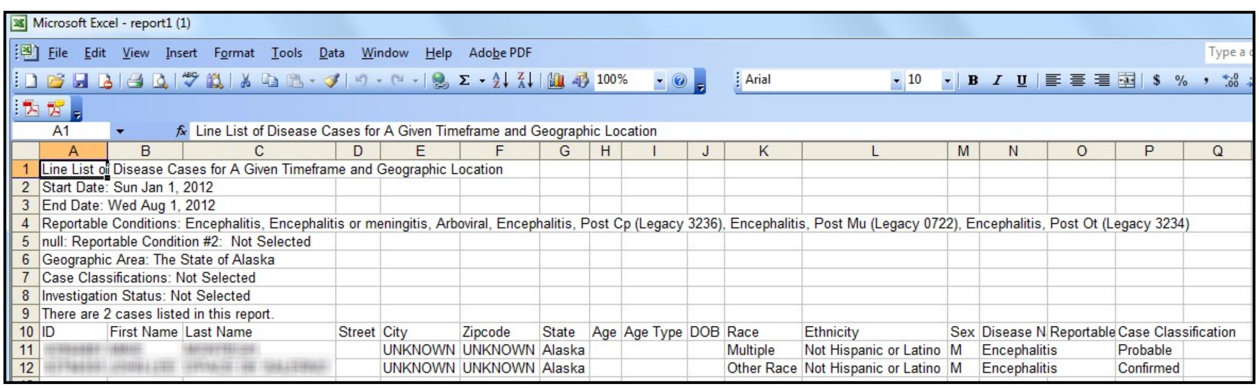
Note: The Line List report will produce CSV output (in MS Excel) that varies from the other outputs for the same report. The CSV file, due to limitations in the number of columns supported by many spreadsheet programs, will produce multiple lines for a case that has multiple lab reports; i.e., one line per report.

Figure 6-2: Case Listing Report Parameters



A sample report (HTML format) is shown below.

Figure 6-3: Sample Case Listing Report (CSV)

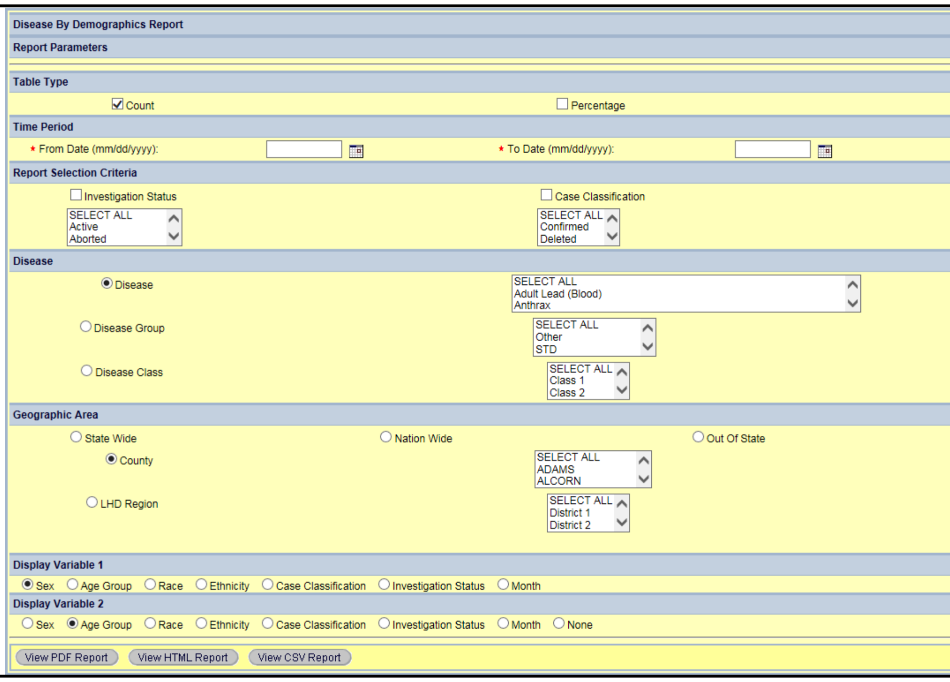


DISEASES BY DEMOGRAPHICS

The “Diseases by Demographics” report displays a table of count or percentage information for all diseases that fall within a specified time period, geographic area, and investigation criteria as defined by the report parameters. The count or percentage information can be further broken down by demographic information by selecting the appropriate display variables. Subtotals per disease are included with grand totals at the bottom of the report.

After the report is displayed, you can click the ID of the patient to display the “Case Details.”

Figure 6-4: Diseases by Demographics Report Parameters



A sample report (HTML format) is shown below.

Figure 6-5: Sample Diseases by Demographics Report (HTML)

Disease by Demographics

Time Period from 7/10/13 to 7/10/15
Display Variable 1: Sex
Display Variable 2: Age Group
Report Type: Count
Geographic Area: All
Case Classification: Not Selected
Investigation Status: Not Selected

		Female				Male			Unknown	Total (Average)
		00 to 04	10 to 14	30 to 34	35 to 39	15 to 19	30 to 34	40 to 44	00 to 04	
Foodborne	Botulism - Foodborne		1							1 (0.25)
	Campylobacter						1		2	3 (0.75)
	Subtotal		1				1		2	4
Other	Streptococcus Group A/B								2	2 (1.0)
	Subtotal								2	2
Vaccine Preventable	Haemophilus influenzae Invasive Infection, other								2	2 (0.33)
	Hepatitis B, Perinatal								3	3 (0.5)
	Pertussis					1				1 (0.16)
	Subtotal					1			5	6
Vectorborne	Babesiosis				1			1		2 (0.4)
	Dengue fever			1						1 (0.2)
	Lyme Disease	1	1							2 (0.4)
	Subtotal	1	1	1	1			1		5
Total		1	2	1	1	1	1	1	9	17

Produced on 7/10/15

Page 1 of 1

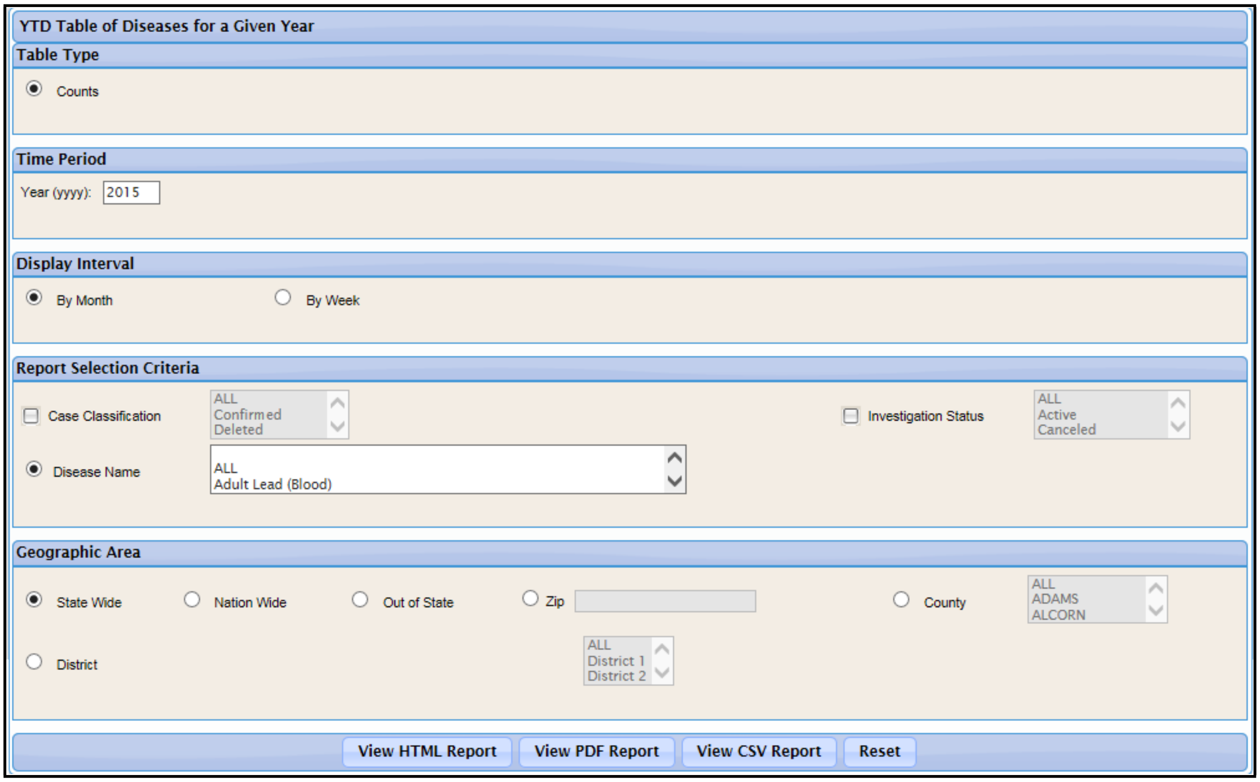
YEARLY REPORT BY MONTH/WEEK

This report is also referred to as the, "YTD Table of Diseases for a Given Year."

The "Yearly Report by Month/Week" report displays a table of year-to-date count information for all diseases that fall within the selected year and geographic area as defined by the report parameters. The count information can be displayed by month or week.

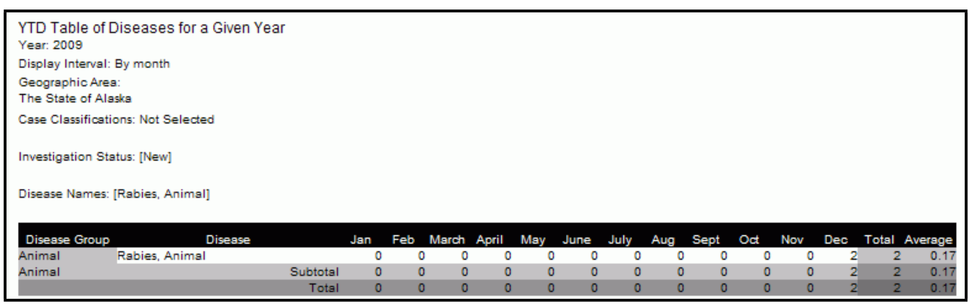
Note: The Disease Name #2 field is enabled only when you select one (and only one) disease name and that disease has secondary diseases.

Figure 6-6: Yearly Report by Month/Week Parameters



A sample report (HTML format) is shown below.

Figure 6-7: Sample Yearly Report by Month/Week (HTML)


YTD Table of Diseases for a Given Year
Year: 2009
Display Interval: By month
Geographic Area:
The State of Alaska
Case Classifications: Not Selected

Investigation Status: [New]

Disease Names: [Rabies, Animal]

Disease Group	Disease	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total	Average
Animal	Rabies, Animal	0	0	0	0	0	0	0	0	0	0	0	2	2	0.17
Animal	Subtotal	0	0	0	0	0	0	0	0	0	0	0	2	2	0.17
	Total	0	0	0	0	0	0	0	0	0	0	0	2	2	0.17

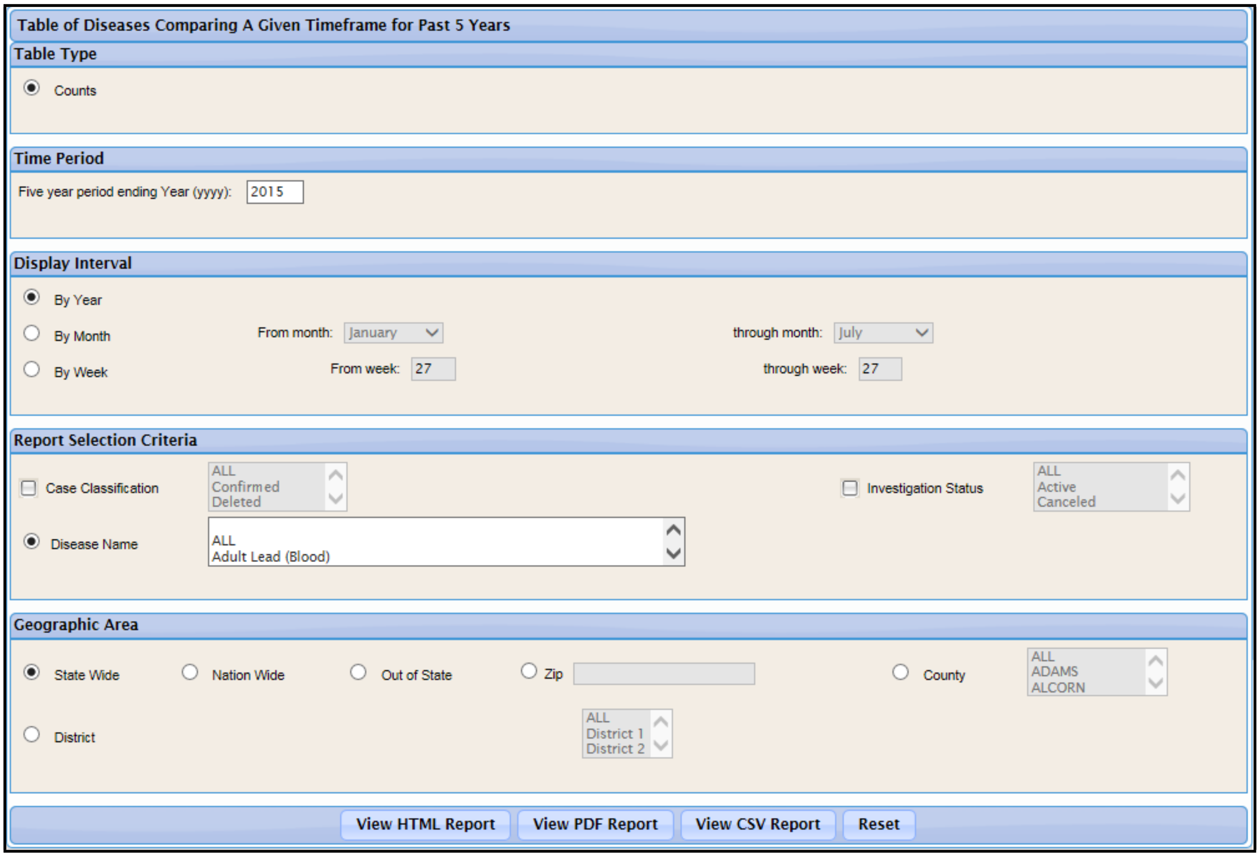
DISEASES – 5 YEAR HISTORY REPORT

This report is also referred to as the, "Table of Diseases Comparing A Given Timeframe for Past 5 Years" report.

The "Diseases – 5 Year History" report displays a comparison table of count information for all diseases reported for the present year and preceding four years within the geographic area as defined by the report parameters. The count information can be displayed by year, month, or week.

Note: The Disease Name #2 field is enabled only when you select one (and only one) disease name and that disease has secondary diseases.

Figure 6-8: Diseases 5-Year History Report Parameters



A sample report (CSV format in Microsoft Excel) is shown below.

Figure 6-9: Sample Diseases 5-Year History Report (CSV in Microsoft Excel)

report4[1]

	A	B	C	D	E	F	G	H
1	Table of Diseases Comparing A Given Timeframe for Past 5 Years							
2	Year: 2005-2009							
3	Display Interval: By Year							
4	Geographic Area: The State of Alaska							
5	Case Classifications: No Selected							
6	Investigation Status: No Selected							
7	Disease Classes: [All]							
8	Disease Group	Disease	2005	2006	2007	2008	2009	Total
9	ABC	GAS, invasive disease (Streptococcus pyogenes)						
10			0	0	0	0	0	0
11	ABC	GBS, invasive disease (Streptococcus agalactiae)						
12			0	0	0	0	0	0
13	ABC	Streptococcal Toxic-Shock Syndrome (STSS) (Legacy 0349)						
14			0	0	0	0	0	0
15	ABC	Streptococcus pneumoniae (pneumococcus) invasive disease						
16			0	0	0	0	0	0
17	ABC	Toxic-Shoc	0	0	0	0	0	0
18	ABC	Subtotal	0	0	0	0	0	0
19	Animal	Rabies, Ar	0	0	0	0	2	2
20	Animal	Subtotal	0	0	0	0	2	2

YEAR-TO-DATE DISEASE BY AREA AND TIME

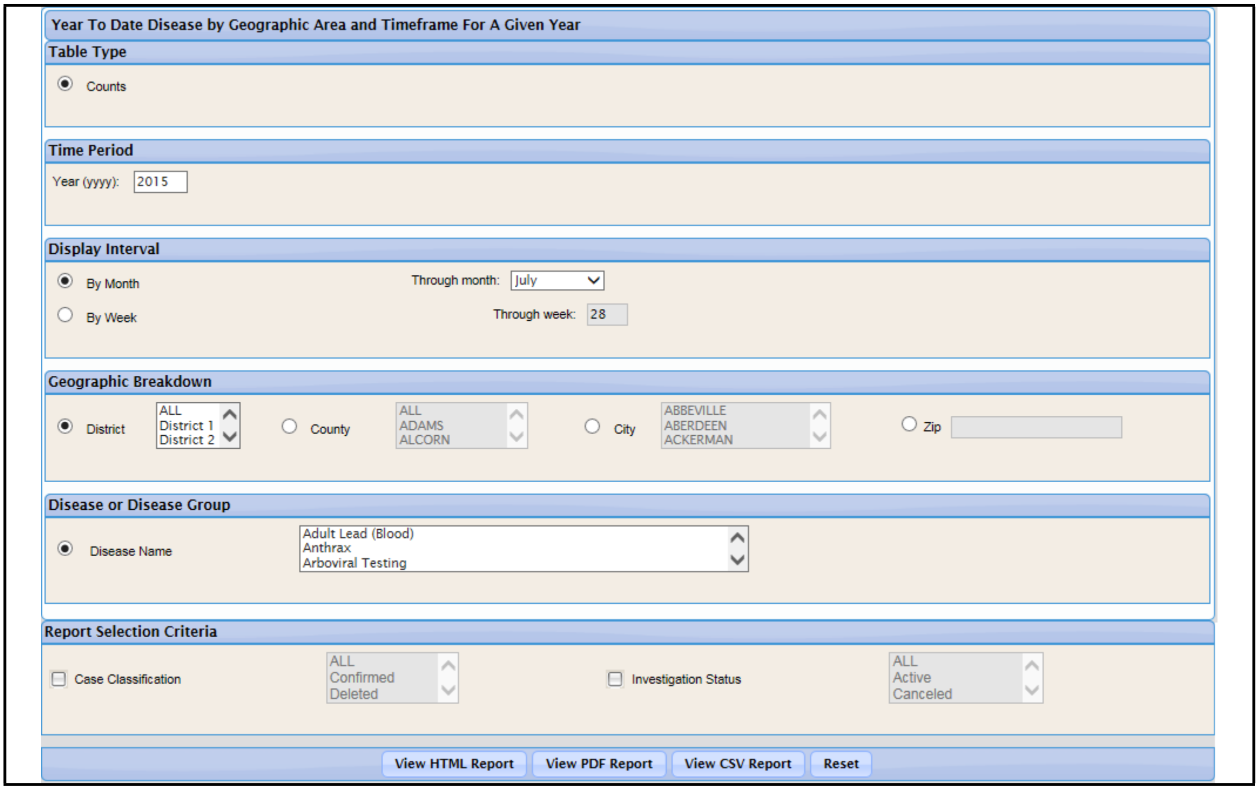
This report is also referred to as the, "Year To Date Disease by Geographic Area and Timeframe For A Given Year" report.

The "Year to Date Disease by Geographic Area and Time" report displays a count of all cases that fall within the specified time period, geographic area, and disease information as defined by the report parameters. You can determine the information to include in your report output by selecting the radio buttons and check boxes.

Note: The Disease Name #2 field is enabled only when you select one (and only one) disease name and that disease has secondary diseases.

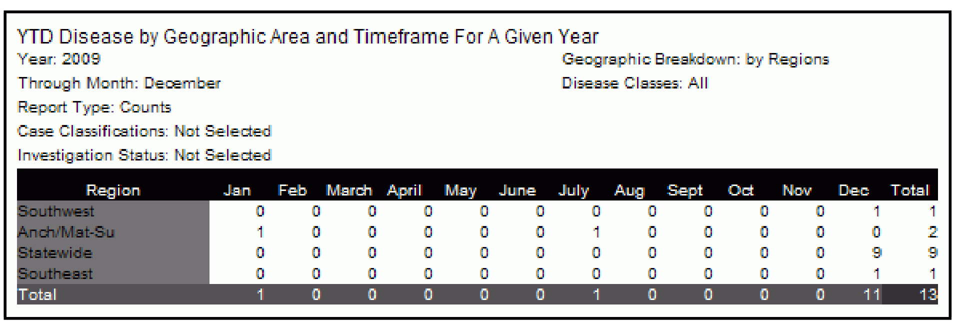
Note: It is possible for a case to be excluded from the counts if a piece of geographical detail is missing. For example, if a case has a region/district (due to their being a county for the case), the case would be counted in the Regional/district version of the report. If the breakdown is by ZIP and there is no zip code on the address, then the case is excluded from the counts when run by zip.

Figure 6-10: Year-To-Date Disease by Area and Time Report Parameters



A sample report (HTML format) is shown below.

Figure 6-11: Sample YTD Disease by Area and Time


YTD Disease by Geographic Area and Timeframe For A Given Year

Year: 2009
Through Month: December
Report Type: Counts
Case Classifications: Not Selected
Investigation Status: Not Selected

Geographic Breakdown: by Regions
Disease Classes: All

Region	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Southwest	0	0	0	0	0	0	0	0	0	0	0	1	1
Anch/Mat-Su	1	0	0	0	0	0	1	0	0	0	0	0	2
Statewide	0	0	0	0	0	0	0	0	0	0	0	9	9
Southeast	0	0	0	0	0	0	0	0	0	0	0	1	1
Total	1	0	0	0	0	0	1	0	0	0	0	11	13

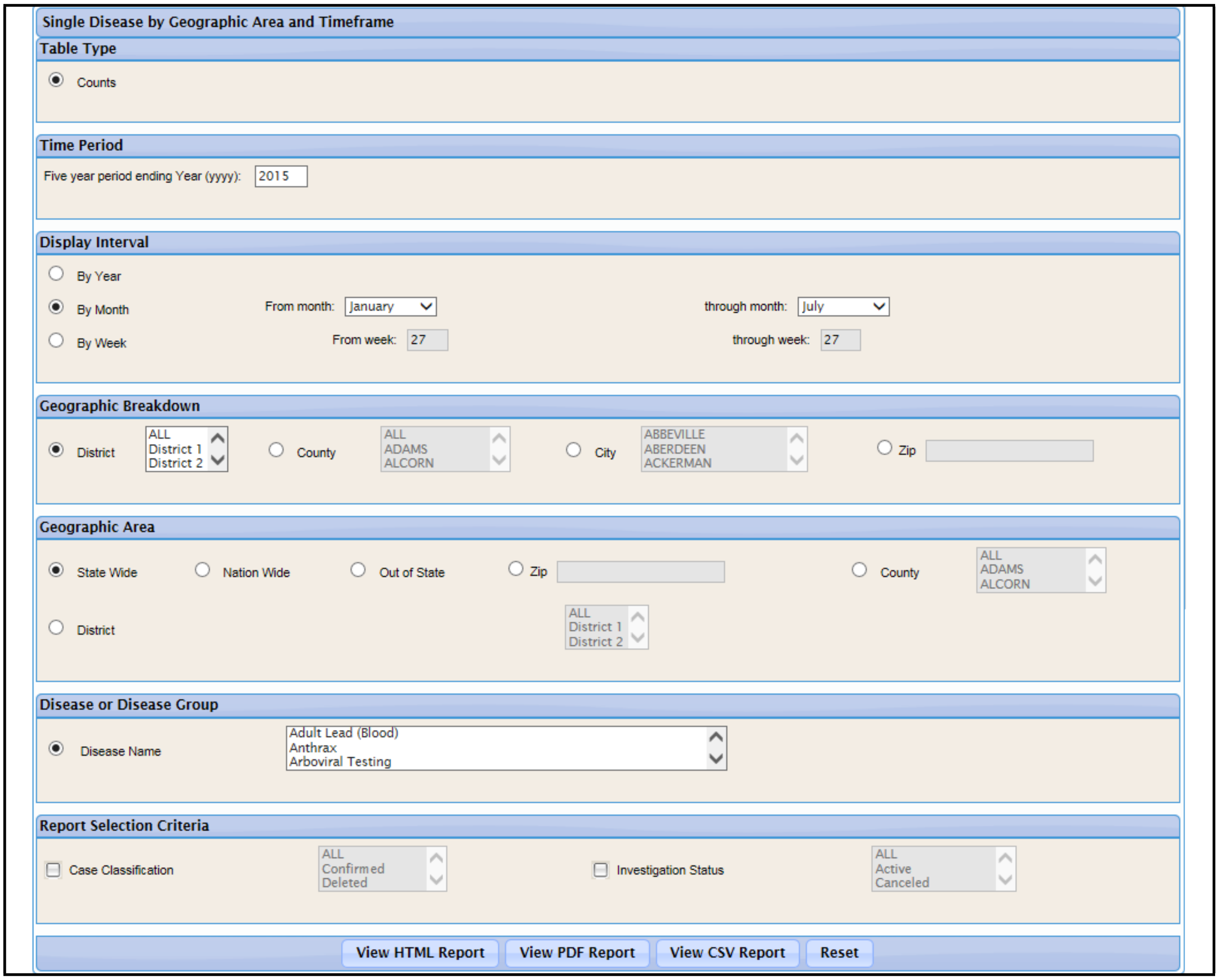
SINGLE DISEASE BY AREA AND TIME

This report is also referred to as the, "Single Disease by Geographic Area and Timeframe" report.

The "Single Disease by Geographic Area and Time" report displays a count of all cases that fall within the specified time period, geographic area, and disease information as defined by the report parameters. You can determine the information to include in your report output by selecting the radio buttons and check boxes.

Note: The Disease Name #2 field is enabled only when you select one (and only one) disease name and that disease has secondary diseases.

Figure 6-12: Single Disease by Area and Time Report Parameters



A sample report (HTML format by "year") is shown below.

Figure 6-13: Sample Single Disease by Area and Time Report

Single Disease by Geographic Area and Timeframe

Years: 2005-2009

Geographic Breakdown: by Regions

Disease Classes: All

Report Type: Counts

Case Classifications: Not Selected

Investigation Status: Not Selected

Region	2005	2006	2007	2008	2009	Total
Southwest	0	0	0	0	1	1
Anch/Mat-Su	0	0	0	0	2	2
Statewide	0	0	0	0	9	9
Southeast	0	0	0	0	1	1
Total	0	0	0	0	13	13

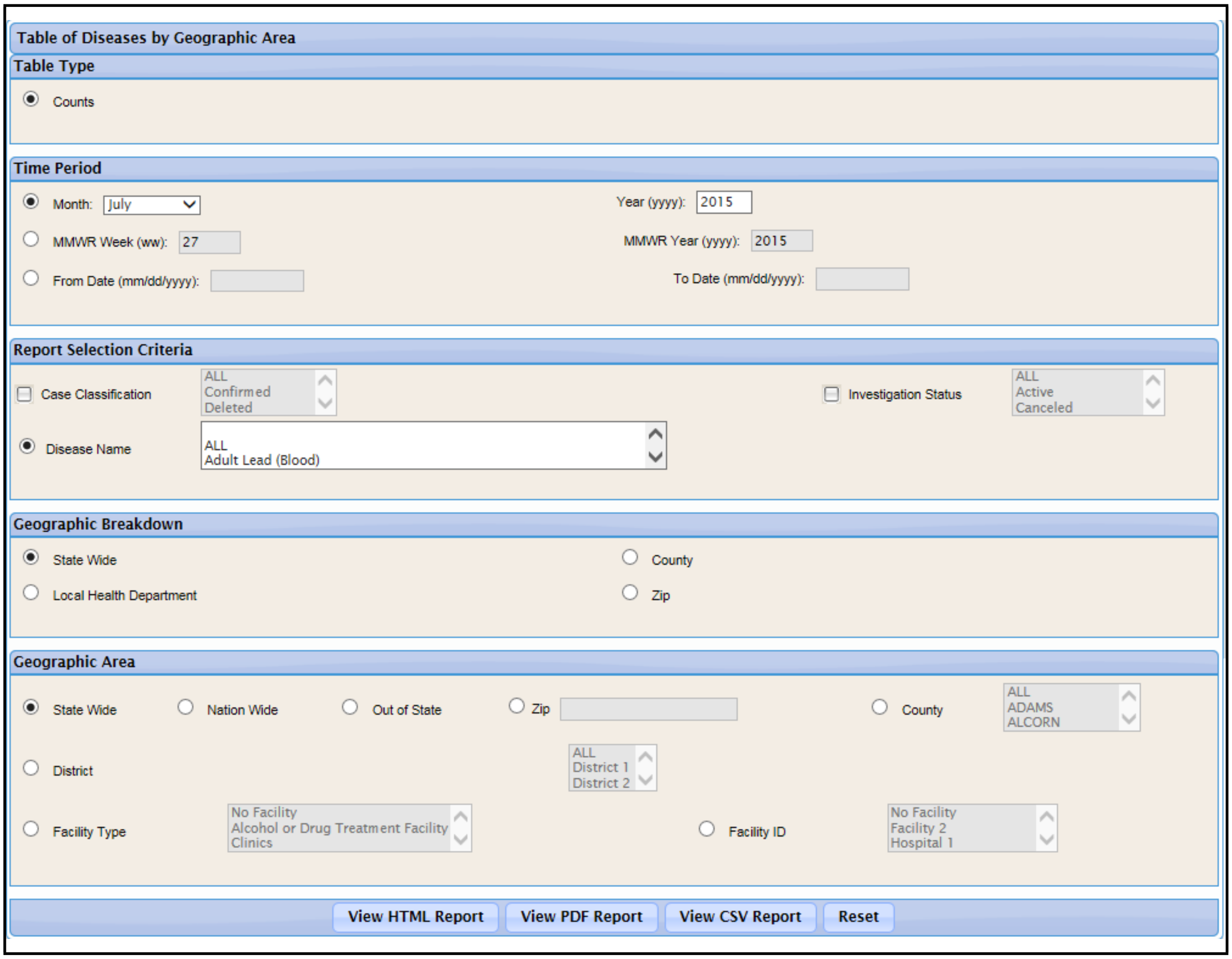
DISEASE BY GEOGRAPHIC AREA

This report is also referred to as the, "Table of Diseases by Geographic Area" report.

The "Disease by Geographic Area" report displays a table of count information for all diseases that fall within the selected time period and geographic area defined by the report parameters. The count or rate information can be displayed by geographic boundaries and areas.

Note: The Disease Name #2 field is enabled only when you select one (and only one) disease name and that disease has secondary diseases.

Figure 6-14: Disease by Geographic Area Report Parameters



A sample report (PDF format) is shown below.

Figure 6-15: Sample Disease by Geographic Area Report (PDF)

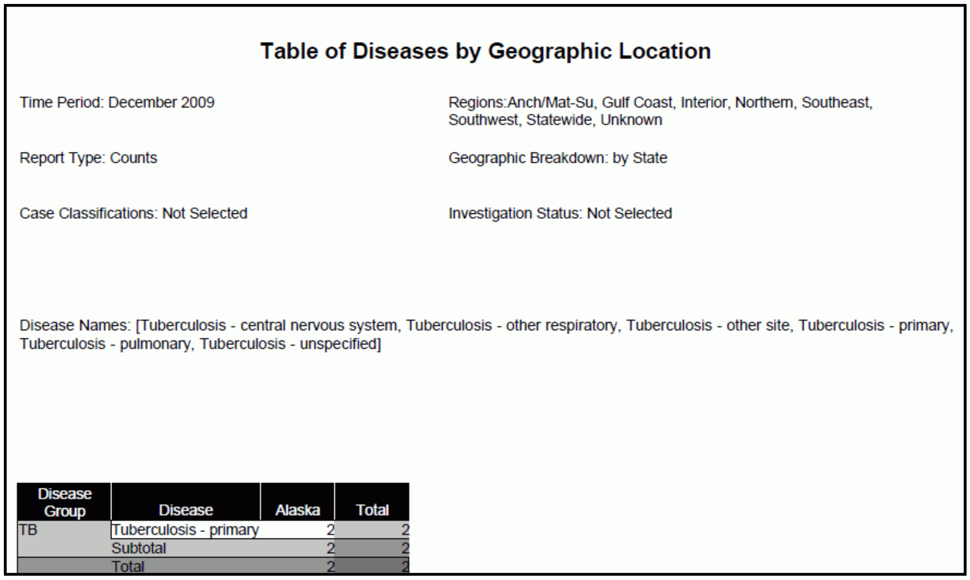


Table of Diseases by Geographic Location

Time Period: December 2009

Regions:Anch/Mat-Su, Gulf Coast, Interior, Northern, Southeast, Southwest, Statewide, Unknown

Report Type: Counts

Geographic Breakdown: by State

Case Classifications: Not Selected

Investigation Status: Not Selected

Disease Names: [Tuberculosis - central nervous system, Tuberculosis - other respiratory, Tuberculosis - other site, Tuberculosis - primary, Tuberculosis - pulmonary, Tuberculosis - unspecified]

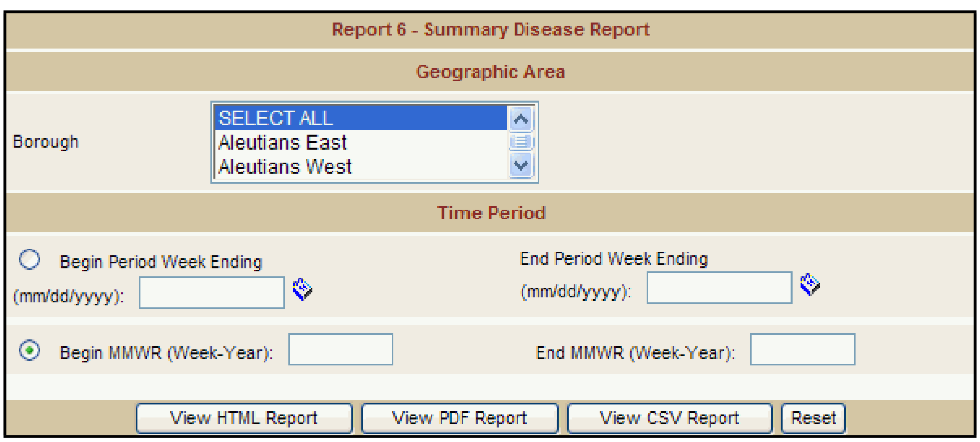
Disease Group	Disease	Alaska	Total
TB	Tuberculosis - primary	2	2
	Subtotal	2	2
	Total	2	2

Summary Disease Report

[This is a state-configurable option and may not appear for your state.]

The “Summary Disease” report displays a comparison table of count information for all cases that fall within the specified year and preceding four years. The count is displayed by borough and can be broken down by time period.

Figure 6-16: Summary Disease Report Parameters



A sample report (PDF format) is shown below.

Figure 6-17: Sample Summary Disease Report (PDF)

Summary Disease Report

Report by: Disease

Based on: Week Ending

Begin: 1990-01-01

End: 2008-09-24

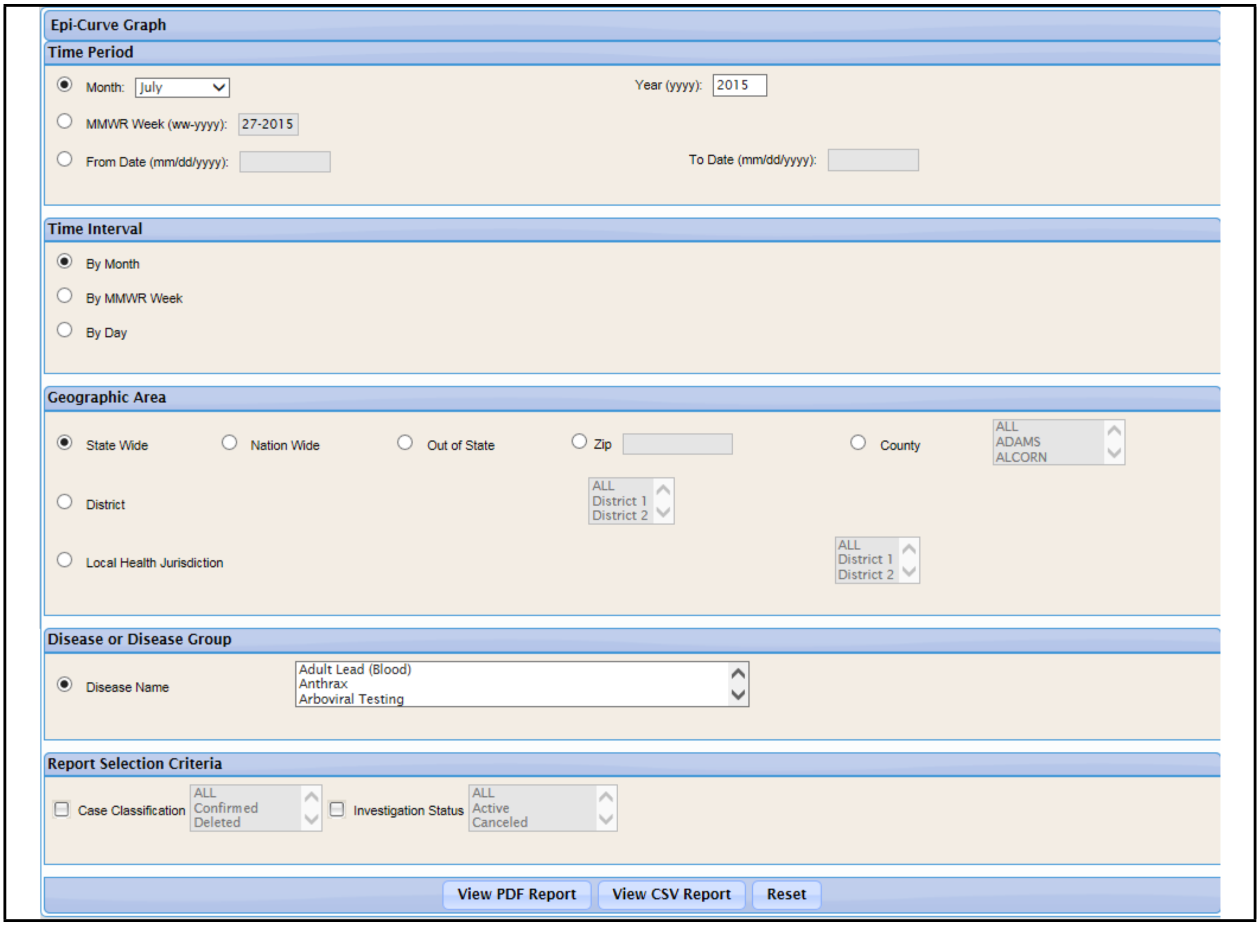
County: All

EPI CURVE REPORT

The “Epi Curve” report displays a graph in which the number of new cases of the selected disease is plotted against the selected time period defined by the report parameters. The graph information can be further broken down by time interval.

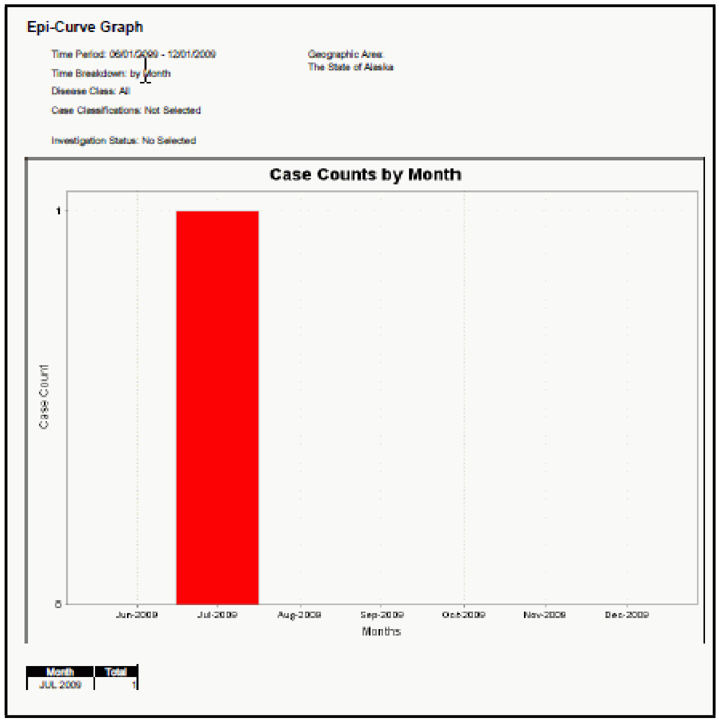
This report does not offer HTML output and only the PDF report includes both the graph and data. The CSV format report includes the data, but you must use other software, such as a spreadsheet or database program, to create and view the graph.

Figure 6-18: Epi Curve Report Parameters



A sample report (PDF format) is shown below.

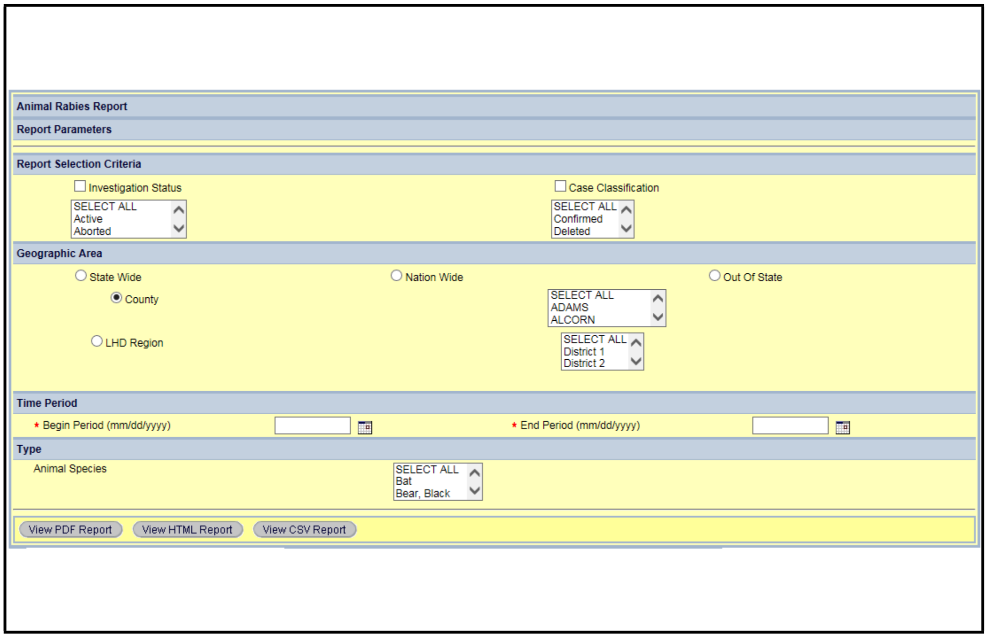
Figure 6-19: Sample Epi Curve Report (PDF)



Animal Rabies

The “Animal Rabies” report displays an animal-level list of all Rabies cases that fall within the specified time period, geographic area, and disease information as defined by the report parameters. You can determine the information to include in your report output by selecting the desired parameters.

Figure 6-20: Animal Rabies Report Parameters



A sample report (HTML format) is shown below.

Figure 6-21: Sample Animal Rabies Report

Animal Rabies

Species submitted between: 12/31/99 and 5/1/09
Species: All

Case Classification: All
Investigation Status: All

		Animal Species							Total
		Bat	Cat	Fox	Raccoon	Sheep	Skunk	Unknown	
County	BELKNAP	0	0	1	5	0	4	10	20
	CARROLL	0	0	0	1	0	0	1	2
	CHESHIRE	0	0	0	2	0	2	4	8
	GRAFTON	0	0	0	2	2	2	7	13
	HILLSBOROUGH	2	0	0	4	0	2	7	15
	MERRIMACK	1	0	1	3	0	0	8	13
	ROCKINGHAM	1	1	3	4	0	7	13	29
	STRAFFORD	1	0	0	3	0	1	6	11
	SULLIVAN	0	0	0	6	0	3	9	18
	Unknown	0	0	0	0	0	2	105	107
Total		5	1	5	30	2	23	170	236

Produced on 5/19/09

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BT/ILI REPORT

The BT/ILI Report will list BT/ILI information for a specific date range in one of the following ways:

- BT_ERLOG Tabulation by District and Reporting Week – displays a weekly report for the Reporting Yr-Week, Week Ending, Total Patients, Non-Trauma, URI/Flu-Like, Estimated Number of Cases (% of patients) with Point Estimates (Lower 95^{th} and Upper 95^{th})

- Comparison of Public Health District and the State for URI and Flu-like Illness – displays the percentage of patients with URI/ILI, and Reporting Week and Year for the Organization Weekly and State Weekly.

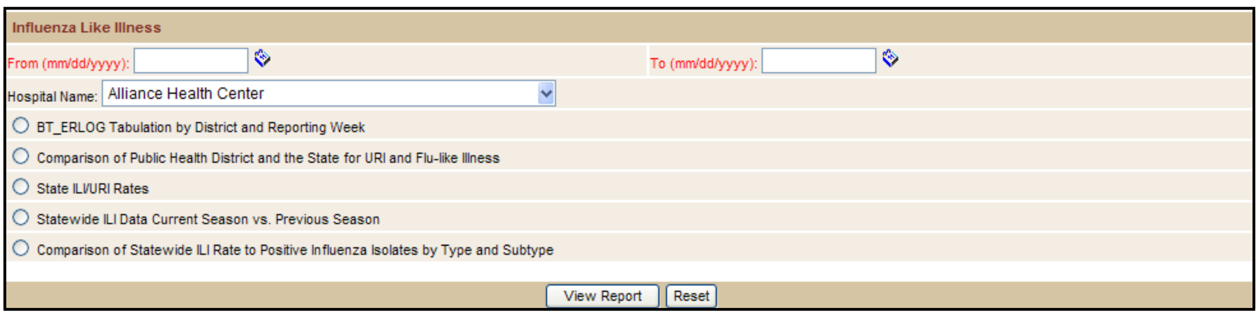
- State ILI/URI Rates – displays the percentage of patients with URI/ILI, and Reporting Week and Year for the State.

- Statewide ILI Data Current Season vs. Previous Season – displays the percentage of patients with URI/ILI, and Reporting Week for the Previous Season and Current Season.

- Comparison of Statewide ILI Rate to Positive Influenza Isolates by Type and Subtype – displays the percentage of patients with URI/ILI, and Reporting Week and Year for the ILI Percentage and Cases.

Note: Users must have the BT/ILI Reports privilege in order to run/view this report.

Figure 6-22: BT/ILI Report Parameters



You can determine the information to include in your report output by selecting the desired parameter radio button.

A sample is shown below:

Figure 6-23: Sample BT/ILI Report – BT_ERLOG Tabulation by District and Reporting Week

BT_ERLOG Tabulation by District and Reporting Week

Reporting Yr-Week:	Week Ending:	Total Patients:	Non-Trauma:	URI/Flu-Like:	Estimated Number of Cases (% of patients): Point Est:	Lower 95th:	Upper 95th:

Date Run: 12/27/2010 *NOTE: Reporting Week is Monday - Sunday* *1 of 1*

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7 APPENDICES

APPENDIX A: SOFTWARE REQUIREMENTS AND SYSTEM SETTINGS

Sentinel requires the following software:

- Internet Explorer v5.5 SP2, v6.x, or higher
- Adobe Reader v5.1 or higher

  Sentinel uses PDF files for Case Management and Reports, allowing you to print blank forms and enter investigation information into Sentinel.

To obtain current versions of Internet Explorer and Adobe Reader, download them from their respective sites:

- Microsoft Internet Explorer (http://www.microsoft.com)
- Adobe Reader (http://www.adobe.com)

Browser settings can affect the appearance and functionality of the application. The following settings are recommended to optimize the appearance of the application.

Note: Regardless of the type of browser you use, **do not** use the **BACK**, **FORWARD**, and **REFRESH** buttons within the application. These buttons have been disabled to avoid concurrency errors and potential duplication of processing; however, buttons have been coded within the application to perform these processes.

INTERNET EXPLORER SETTINGS

Perform the following in Internet Explorer:

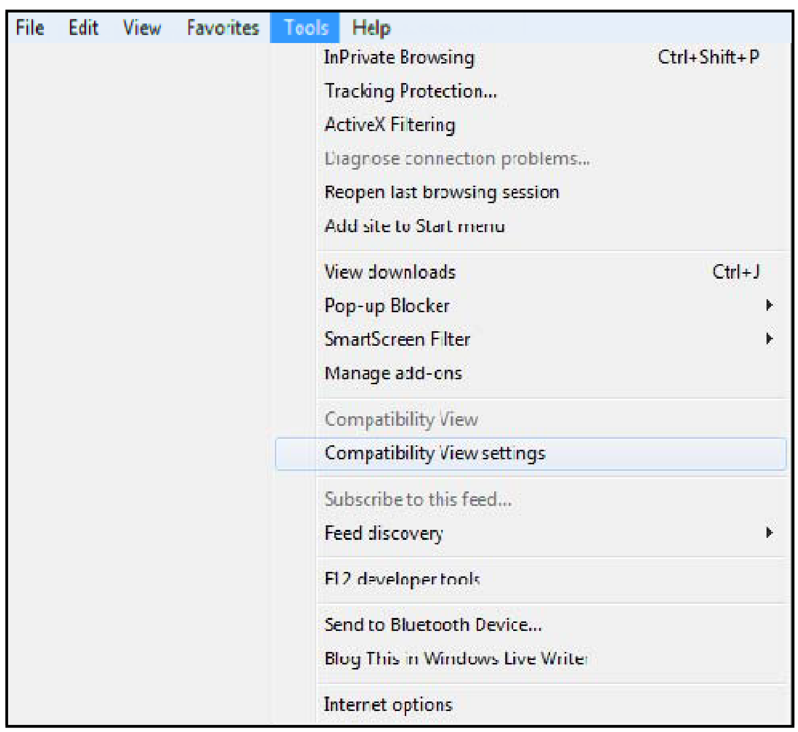
- Compatibility View Settings (for IE8 and IE9)
- Set font styles
- Set text size
- Disable AutoComplete

COMPATIBILITY VIEW SETTINGS (IE8 AND IE9)

For best results, please ensure that the Compatibility View Settings are disabled. The steps are the same for both versions of Internet Explorer (IE).

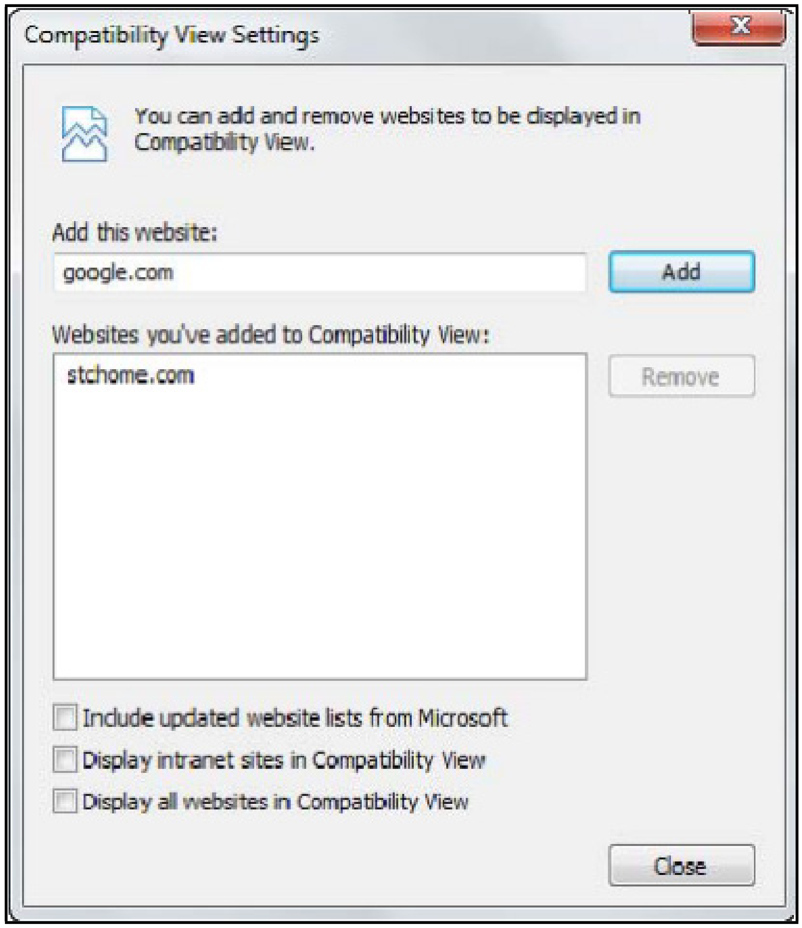
1. Point to the **TOOLS** menu in IE and select the Compatibility View Settings option. It looks like this.

Figure 7-1: Internet Explorer – Tools Menu



2. The "Compatibility View Settings" screen appears.

Figure 7-2: Internet Explorer – Tools – Compatibility View Settings



3. Ensure the bottom two boxes are **UNCHECKED**.

- Display intranet sites in Compatibility View
- Display all websites in Compatibility View

4. Ensure that no Sentinel URLs are included in the "Websites you've added to Compatibility View:" box. If they are, please highlight the website URL and click the **REMOVE** button.

SETTING FONT STYLES

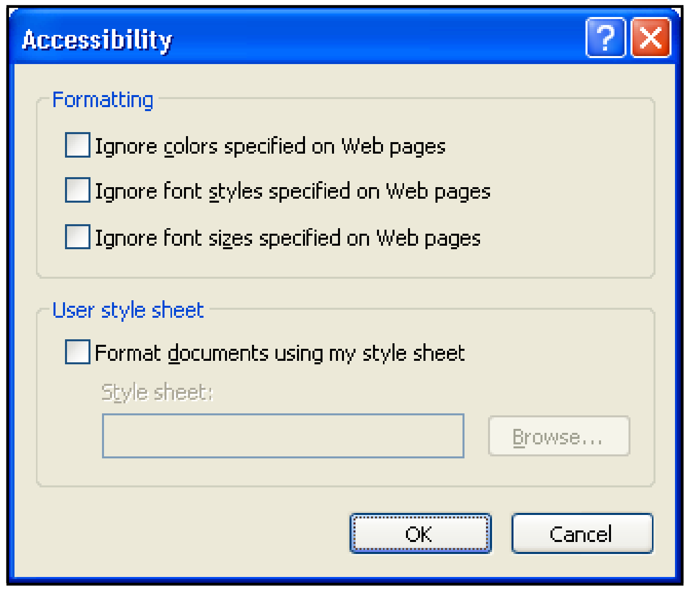
Font styles are specified by the application.

To verify correct font styles, perform the following:

1. Open Internet Explorer.

2. On the **TOOLS** menu, click **INTERNET OPTIONS**. The "Internet Options" window appears with the "General" tab displayed.
3. Click the **ACCESSIBILITY** button. The "Accessibility" window appears.

Figure 7-3: Accessibility Window



4. If necessary, deselect (clear) all check boxes.
5. Click the **OK** button. The "Accessibility" window closes.
6. Click the **OK** button in the "Internet Options" window.

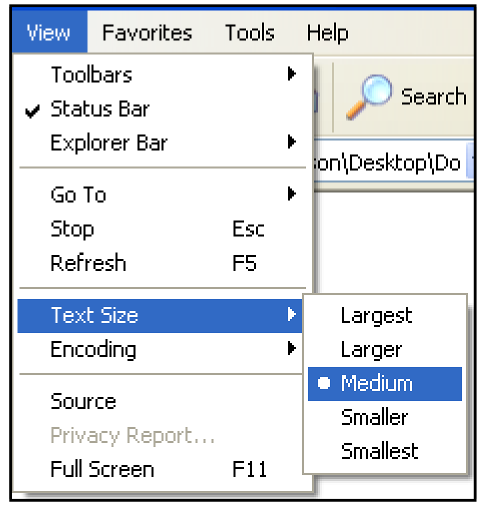
SETTING THE TEXT SIZE

The text size is specified by the application.

To verify the correct text size, perform the following:

1. Open Internet Explorer.
2. On the **VIEW** menu, click **TEXT SIZE**. The "Text Size" menu appears.
3. Click **MEDIUM**. The menu flow appears similar to that shown below.

Figure 7-4: Internet Explorer Text Size



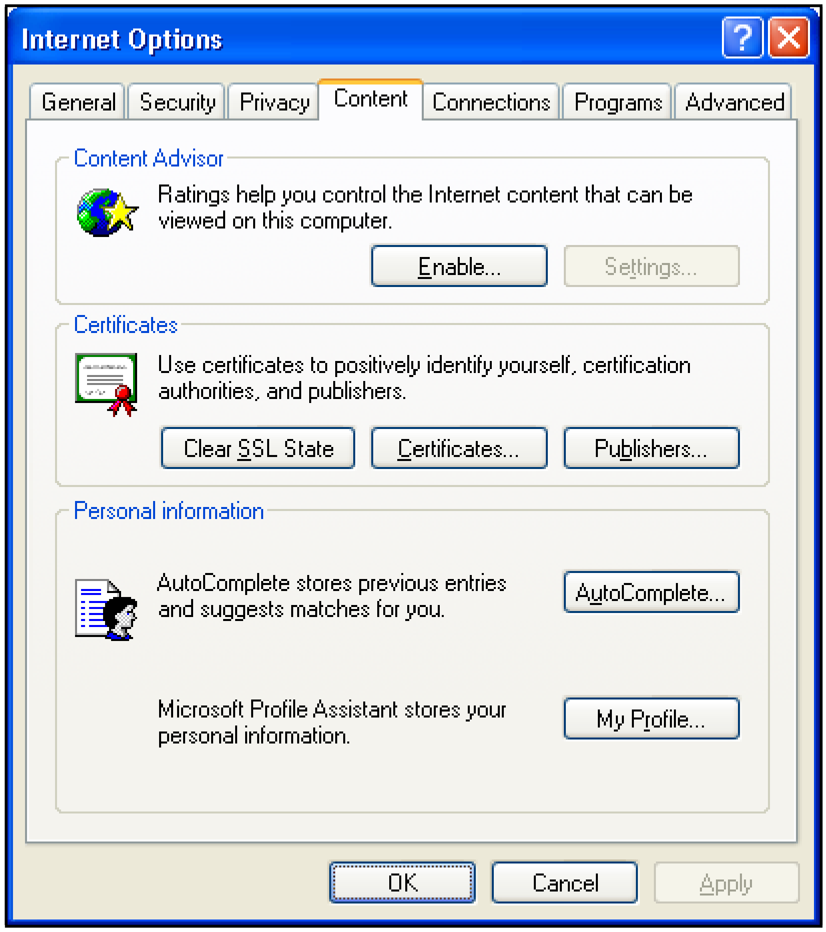
Disabling AutoComplete

AutoComplete allows Internet Explorer to save data you enter into online forms. When you type data into the form, AutoComplete suggests possible matches. Due to the sensitive nature of the application data, your state may require that AutoComplete be disabled to not allow the capture of this data.

To disable AutoComplete, perform the following:

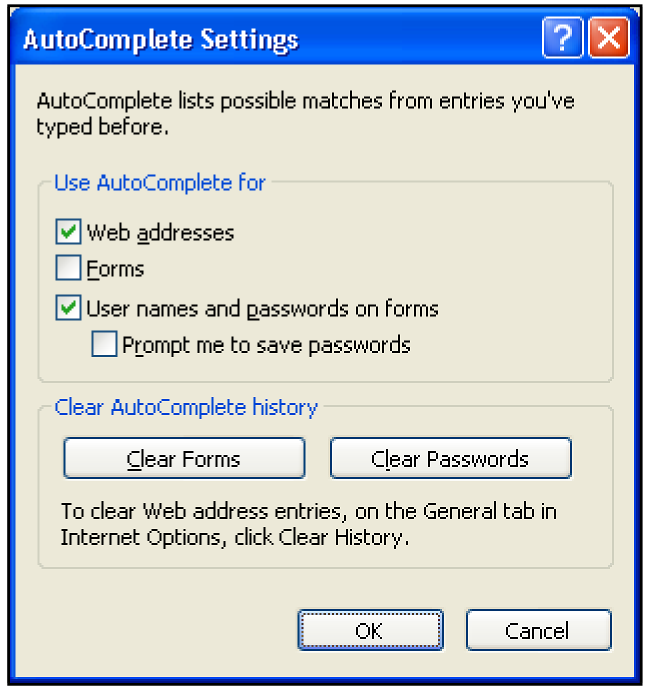
1. Open Internet Explorer.
2. On the **TOOLS** menu, click **INTERNET OPTIONS**. The “Internet Options” window appears with the “General” tab displayed.
3. Click the **CONTENT** tab. The entire “Content” tab appears.

Figure 7-5: Internet Options Window – Content Tab



4. In the **PERSONAL INFORMATION** section, click the **AUTOCOMPLETE** button. The “AutoComplete Settings” window appears.

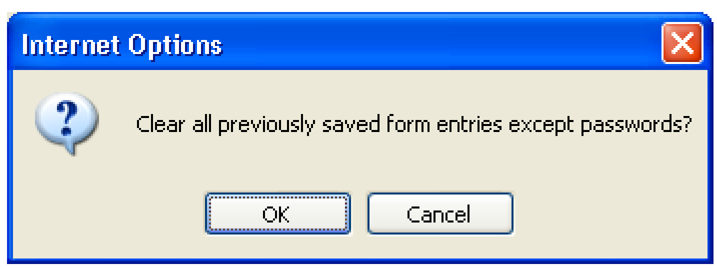
Figure 7-6: AutoComplete Settings



5. If necessary, in the **USE AUTOCOMPLETE FOR** section, deselect (clear) the **FORMS** check box.

6. Click the **CLEAR FORMS** button to remove any existing saved application data. An “Internet Options” confirmation dialog box appears.

Figure 7-7: Internet Options Confirmation Dialog Box



7. Click the **OK** button. The “Internet Options” confirmation dialog box closes.

8. Click the **OK** button in the “AutoComplete Settings” window to close that window.

9. Click the **OK** button in the “Internet Options” window to close that window.

SYSTEM SETTINGS – SCREEN RESOLUTION AND FONT SIZE

Setting the screen resolution and font size to recommended values optimizes the appearance Sentinel. Sentinel is designed to run in 800x600 pixel screen resolution and the Display Font Size should be set to Normal Size (96 dpi); however, you may want to change these values depending on your preferences.

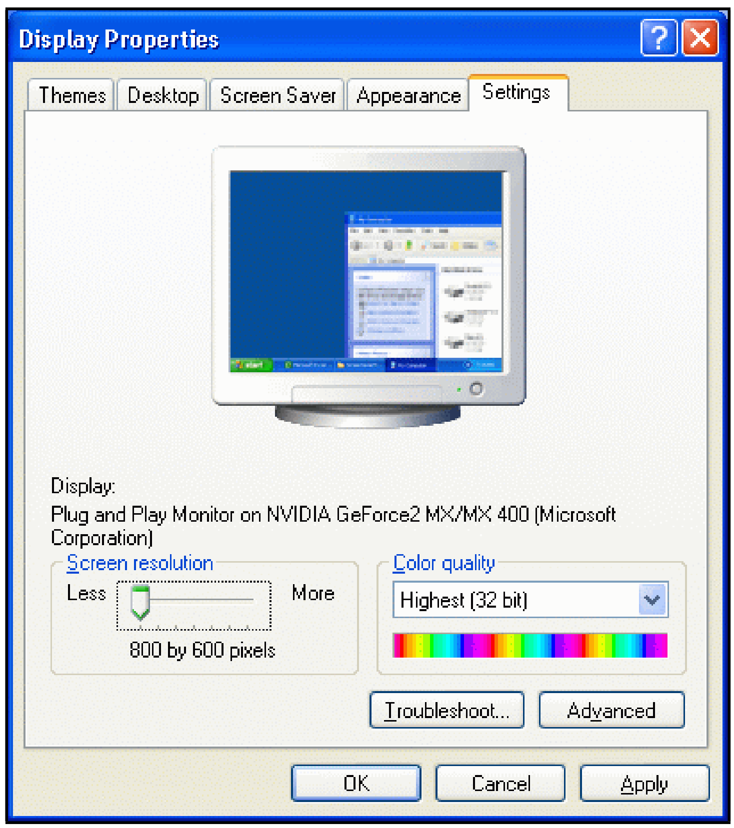
To set the screen resolution and font size, perform the following:

1. Right-click the Windows desktop.

2. From the shortcut menu that appears, click **PROPERTIES**. The "Display Properties" window appears.

3. Click the **SETTINGS** tab, and in the **SCREEN RESOLUTION** section, drag the slider until the setting reads "800 by 600 pixels."

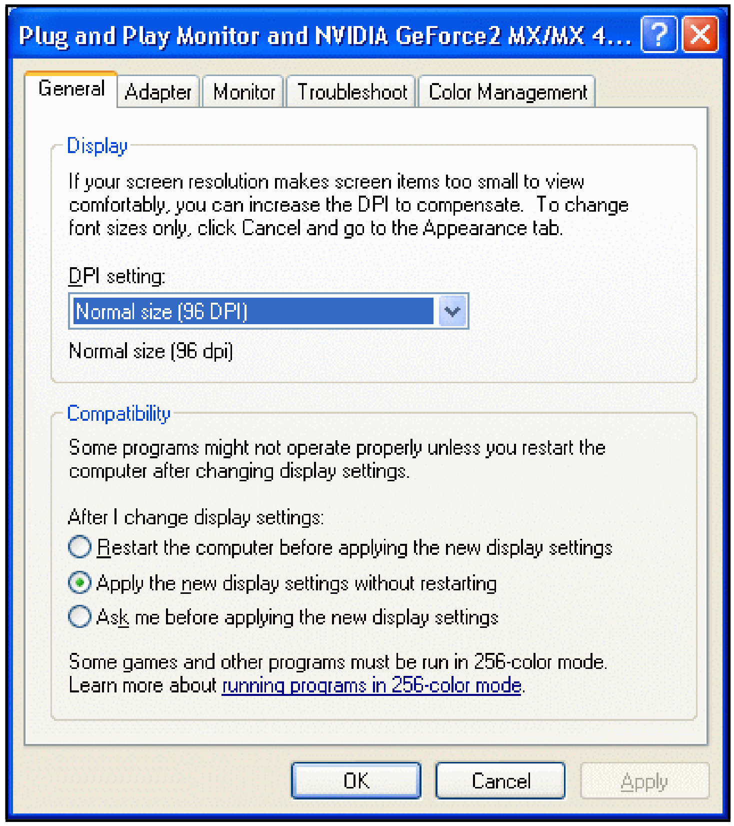
Figure 7-8: Display Settings



4. Click the **APPLY** button to save the screen resolution setting.

5. Click the **ADVANCED** button. The "Properties" window for the display (monitor) appears with the "General" tab displayed.

Figure 7-9: Display Advanced Settings



6. In the **DISPLAY** section, from the **DPI SETTING** drop-down menu, select **NORMAL SIZE (96 DPI)**.
7. Click the **OK** button. The “Properties” window for the display (monitor) closes.
8. Click the **OK** button. The “Display Properties” window closes.

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8 INDEX