INPATIENT REHABILITATION VALIDATION AND ENTRY SYSTEM (JIRVEN) USER GUIDE

In support of Software Version 1.4.0 (October 2017)
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INTRODUCTION
The Inpatient Rehabilitation Validation and Entry System (jIRVEN) was developed by the Centers for Medicare & Medicaid Services (CMS). jIRVEN is a free Java based software application which provides an option for Inpatient Rehabilitation Facilities to collect and maintain Patient Assessment Instrument (PAI) information. jIRVEN displays the IRF Patient Assessment Instrument (IRF-PAI) similar to the paper version of the forms. Facilities are able to enter and subsequently export their data from the application for submission to the appropriate national data repository.

INSTALLATION

INSTALLERS ACCESS RIGHTS
To install jIRVEN the User must be logged into the PC as a Workstation Administrator.

Users of the application MUST have read/write access to the location where the database is installed.

HARDWARE/SOFTWARE SPECIFICATIONS
The Minimum and Recommended System Requirements may be found on the QIES Technical Support Office home page: https://www.qtso.com/index.php

SECURITY
Making information security one of your organizations core values ensures the prevention of unauthorized viewing of Personally Identifiable Information (PII) or Protected Health Information (PHI).

It is important that providers work with their Information Technology (IT) team or other resources to build a security-minded organizational culture which enforces strong authentication and access controls as well as limits physical access to devices (e.g., laptops, handhelds, desktops, servers, thumb drives, CDs, backups) containing PII or PHI data.

CMS recommends that providers encrypt the hard drive of any electronic device which has access to data containing PII or PHI, such as exported assessment records. Once assessments have been exported from the jIRVEN application the data will no longer be encrypted. It is also recommended that those electronic devices, which contain PII or PHI, be physically secured and locked (password protected) when not in use.

WINDOWS SETTINGS
In order to ensure the reliable operation of the jIRVEN software application use of a supported Microsoft Windows operating system is imperative. The Font Size property must be set to “Small Fonts”. This property can be found under the Settings tab of desktop properties: Start\Control Panel\Appearance and Personalization\Display\.
SYSTEM CONFIGURATION/INSTALLATION TYPE

STANDALONE
The Standalone installation is self-contained on one workstation.

NETWORK CLIENT
The Network Client/Server installation uses a server to support one or more individual workstations, all accessing one database by multiple computers and users.

- Servers hold the central database and must utilize the Server installation file first.
- Network Clients are placed on the users individual workstations which then access the database on the Server. The Network Client is installed after the Server installation has been successfully completed.

Please refer to the jIRVEN Installation Guide for assistance installing and setting up the jIRVEN application. The QIES Help Desk is available for technical support and assistance if needed and may be contacted by phone at 800-339-9313 or by email to help@qtso.com.

VERSION VERIFICATION
Information about the version of jIRVEN currently installed may be found by selecting ‘About Quality Management System’ from the Help drop-down on the Menu Bar.

The System Configuration/Installation Type, Feature Label and Feature Version are displayed in the lower left side of the screen.
When the jIRVEN application is accessed and the computer running jIRVEN has an internet connection, the application will compare the version currently installed with the version available on the QIES Technical Support Office (QTSO) website. If a new version of jIRVEN is available, a message will display directing the user to the QTSO website to download the latest version.

GENERAL OVERVIEW

jIRVEN software provides the following functionality:

- Facility Setup/Maintenance
- User Setup/Maintenance
- Patient Setup/Maintenance
- Assessment Maintenance
- Import/Export
- Reporting

ACCESS

Once jIRVEN has been installed, access the program using one of the following methods:

- Start Menu – Select the jIRVEN icon from the Start Menu
- Desktop – Double click the jIRVEN icon found on the desktop
- Directory – Navigate to the directory where jIRVEN is installed, double click the jIRVEN.exe
ACCESSIBILITY
Selecting the ‘Enable Accessibility Features’ checkbox at the bottom of the login screen will turn on accessibility features for users requiring assistive technology (e.g. screen readers). The box will remain checked or unchecked until changed by the user.

![Login screen with accessible features checkbox]

SCREEN LAYOUT
TITLE BAR
- Displays the name of the software application: jIRVEN.

MENU BAR
- Located just below the Title Bar, the Menu Bar consists of drop-down lists which contain command selections dependent on user role and the screen that is currently active.

- Pressing the Alt key on the keyboard will place the cursor in the menu bar. Using the arrow keys on the keyboard, users can navigate through the selections on the menu bar. For example: On the Assessment Search screen, if the cursor is on the File menu item, pressing the right directional arrow will move the cursor to the next menu item. Pressing the up and/or down directional arrows will provide navigation through the drop-down menu list.

TOOL BAR
- Located just below the Menu Bar, the Tool Bar contains screen specific buttons and icons to assist the user. Hover or “mouse over” the icons to display a description of the available functionality.

SCREEN TABS
- Located just below the Tool Bar, Screen Tabs will display the open screens (e.g. Facility, Patient, User, and Assessment). An asterisk (*) will display on the tab to the left of the tab title if there are screen changes which need to be saved.

SCREEN AND COLUMN SIZE CONTROL
The various screens available are divided into distinct functional sections. Search and Summary sections may be collapsed by a single click of the arrow located next to the section title. Clicking on the arrow a second time will expand the section.

Columns and sections may be resized if needed by hovering over the line which separates the sections or column headers. The cursor will create an arrow. Click and drag the “left-right arrow” icon to the desired width.
FIELD TYPES

TEXT

Text fields allow data to be entered manually. Data entered must adhere to the rules of the IRF-PAI Data Specifications (length, use of special characters etc.). The following is an example of a text field.

<table>
<thead>
<tr>
<th>Patient First Name (4)*</th>
</tr>
</thead>
</table>

DATE

Date fields are formatted for the entry of a valid date (MM-DD-YYYY) where MM = 01-12, DD = 01-31, and YYYY = the four digit year. Some date fields allow other data to be entered, such as a (-) for ‘not assessed/no information’, these fields will be defined by the IRF-PAI Data Specifications. The following is an example of a date field.

<table>
<thead>
<tr>
<th>Birth Date (6)*</th>
</tr>
</thead>
</table>

Please Note: When the ‘Enable Accessibility Features’ checkbox is checked on the jIRVEN Login Screen the calendar icon will NOT be displayed. When the ‘Enable Accessibility Features’ checkbox is unchecked on the jIRVEN Login Screen there will be a calendar icon next to each date field that the user may utilize instead of manually entering in a date.

CHECKBOX

Checkboxes allow the selection of “yes” answers simply by clicking the box next to the appropriate value. Double clicking the check box will mark the response as ‘not assessed’ when this is a valid response according to the IRF-PAI Data Specifications. Clicking the check box a third time will uncheck the box for a selection of “no”. The following is an example of a checkbox.

<table>
<thead>
<tr>
<th>Race/Ethnicity (9)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) American Indian or Alaska Native</td>
</tr>
<tr>
<td>(B) Asian</td>
</tr>
<tr>
<td>(C) Black or African American</td>
</tr>
<tr>
<td>(D) Hispanic or Latino</td>
</tr>
<tr>
<td>(E) Native Hawaiian or Other Pacific Islander</td>
</tr>
<tr>
<td>(F) White</td>
</tr>
</tbody>
</table>

DROP-DOWN LIST

Drop-down lists contain allowable answers to a specific field. To answer a drop-down question, tab to the field and use the arrow keys on the keyboard to navigate through the answer options. Once the appropriate answer is displayed, use the Tab key to move to the next question. A mouse may also be used to select an answer in a drop-down list. Click the arrow on the right side of the field to expand the list. Click the desired answer. Click the mouse on the next question. The ‘Delete’ key on the keyboard can be used to clear the field. The following is an example of a drop-down list.
GRID

Grids should be used to enter ICD codes. Similar to text fields, grids allow data to be entered manually. Data entered must adhere to the rules of the IRF-PAI Data Submission Specifications (length, use of special characters etc.). jIRVEN does not verify the validity of ICD-9 or ICD-10 codes and will only verify that a code has been properly formatted. For assistance with ICD coding please see the Help section of this guide.

Clicking on the grid button 
 will open the ICD code display window. Use the ‘New’ icon to add rows for additional selections or the ‘Delete’ icon to remove previous selections if needed.

The following is an example of the grid display window.
EDITS
Data integrity edits are applied as information is entered into jIRVEN. These edits are unique messages put in place to assist users with the accurate completion of data entry. Some edits will present a pop-up message and must be addressed when displayed in order to proceed. Other edits may not appear until the assessment is saved and validated. The following types of edits may occur in jIRVEN:

ERRORS
This type of edit lets the user know information is missing or invalid. It must be entered or corrected before the information will be saved.

WARNINGS
This type of edit indicates there is information entered that should be verified as accurate, or serve as a reminder of how some fields should be populated.

INFORMATIONAL
This type of edit gives the user general information about the assessment.

DATA ENTRY TIPS
- For optimization of the skip patterns and/or edits, it is recommended that assessment data be entered in the order the questions appear on the screen.
- Enter data in each field and use the ‘Tab’ key on the keyboard to navigate from field to field. This allows skip patterns and edits to be appropriately applied and helps ensure all fields are addressed.
- Some fields require use of additional keys. For example, checkbox fields use the ‘Tab’ and ‘Shift + Tab’ keys to scroll through the available responses. Once the desired response is highlighted, pressing the spacebar will make the selection. Press the ‘Tab’ key to move to the next field and ‘Shift + Tab’ to go to the previous selection. The mouse may also be used to move to a field and make a selection.

ORDER OF DATA ENTRY:
- Create a facility
- Create a user
- Create a patient
- Create an assessment
- Export the assessment

LOGIN
Please Note: The Default User account (jirven) cannot be used to create patients or assessments. For detailed instructions regarding the initial login please consult the jIRVEN Installation Guide.

Complete the following steps to login to jIRVEN:

1. Launch the jIRVEN application from the start menu, desktop or directory where installed.
2. The jIRVEN splash screen containing the CMS logo displays momentarily.
3. The ‘Welcome to jIRVEN’ screen will display while the program is loading. This may take a few minutes and requires no response from the user.

4. The ‘Login’ screen displays.
5. Enter the assigned User ID.

6. Enter the Password. When logging in for the first time enter your assigned User ID in both the ‘User ID’ and ‘Password’ fields; these are case sensitive.

7. Click ‘Login’.

8. When logging in for the first time, the ‘Change Password’ screen displays as follows:
   - The new password and the confirm new password must match.
   - The new password must be at least 8 characters long.
   - The new password must be no more than 20 characters long.
   - The new password must not contain any space.
   - The new password must not contain the User ID, First Name, Last Name, or Email.
   - The new password must not begin with a number.
   - The new password can only contain a maximum of 3 repetitive characters.
   - The new password must contain at least one for each of the following type of characters:
     - Upper-case Character: A-Z
     - Lower-case Character: a-z
     - Number: 0-9
     - Special Character: &~'!-@#$%^*()_+={}\|:"<>?,./
   - The new password must not match any of the user's most recent 6 passwords.
   - The new password will be set to expire in 60 days.

9. Enter a new password in the ‘New Password’ and ‘Confirm New Password’ fields. The password is case sensitive and must match in both fields.

10. Select ‘Continue’ to complete the login process.
Please Note: Selecting ‘Cancel’ will display the following message: “You must change your password before accessing the system. If you do not change your password, you will be logged off the system.” Clicking ‘Cancel’ on this pop-up will take the User back to the previous ‘Change Password’ pop-up. Clicking ‘OK’ takes the User to the login screen where they must re-enter the assigned User ID in both the ‘User ID’ and ‘Password’ fields.

11. The ‘Security Questions’ screen displays the following questions:

- What city were you born in?
- What year did you graduate from high school?
- What is your favorite sport?
- What was the make of your first car?
- What was the color of your first car?
- What is your mother’s maiden name?
- What was the name of your first pet?
- What size shoe do you wear?
- What is your favorite season of the year?
- What is your favorite movie?

To enable the OK button, a minimum of 6 answers are required.

What city were you born in? 
What year did you graduate from high school? 
What is your favorite sport? 
What was the make of your first car? 
What was the color of your first car? 
What is your mother’s maiden name? 
What was the name of your first pet? 
What size shoe do you wear? 
What is your favorite season of the year? 
What is your favorite movie?

[OK] [Cancel]

12. Complete the answers to a minimum of six (6) questions.

13. Tab to the bottom of the list to enable the ‘OK’ button.

14. Click ‘OK’ to continue to the ‘Home’ screen.

The following ‘Welcome to jIRVEN’ message will be displayed in front of the ‘Home’ screen only when ‘Enable Accessibility Features’ has been selected upon login.
HOME SCREEN

The options displayed on the ‘Home’ screen are dependent upon User Type. A System Administrator will have full access while a Data Entry User will have limited access. Please see the User Setup and Maintenance section for additional information regarding User Types. Below is an example of the System Administrator’s ‘Home’ screen.

HOME SCREEN DEFAULT

By default, the ‘Home’ screen will be displayed upon each login. The screen may be closed by selecting the white “X” on the tab titled ‘Home’. This will close the ‘Home’ screen for the remainder of the user’s session.

To reactivate the ‘Home’ screen once it has been closed, select ‘Help’ from the Menu Bar at the upper right followed by ‘Home Screen’ OR use the short-cut, Ctrl+Alt+W.

If the user does not wish to see the ‘Home’ screen upon each login the default setting may be turned off by placing a checkmark into the box at the lower left corner of the screen next to the following statement: “Do not display this home screen after logging into the application”. Placing a checkmark into this box will only affect the user currently logged into the application. All other users will continue to see the ‘Home’ screen.
FACILITY SETUP AND MAINTENANCE

The Default User must create at least one Facility before being permitted to add any further data to the jIRVEN application. Please consult the jIRVEN Installation Guide for detailed instructions regarding the initial login and setup by the Default User.

The ‘Facility Information’ screen allows users, dependent upon their User Type, to setup and modify facilities.

The ‘Facility Information’ screen displays in two sections:

- Facility Summary (on the left)
- Facility Detail (on the right)
  - All facility data entry is done in this section.

ADD A FACILITY

Complete the following steps to create a new facility:

1. Select ‘Facility’ from the Administration drop-down on the Menu Bar or ‘Go To Facility’ from the ‘Home’ screen.

2. The ‘Facility Information’ screen displays.

3. Enter the appropriate facility information into the Facility Detail section. Required fields display on the screen in bold type with an asterisk.
4. After facility information has been entered, click the ‘Save’ icon. Saved facility information will display in the Facility Summary section on the left side of the screen.

5. To add additional facilities, click the ‘New’ icon, enter data and click the ‘Save’ icon.

**MODIFY A FACILITY**

Complete the following steps to modify an existing facility:

1. Locate and highlight the facility in the Facility Summary section.
2. Make the appropriate changes in the Facility Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

**DELETE A FACILITY**

Complete the following steps to delete a facility:

1. Locate and highlight the facility in the Facility Summary section.
2. Click the ‘Delete’ icon.
   - Only a System Administrator can delete a facility.
   - Deletions cannot be made if Users, Patients, or Assessments are currently associated to a facility.

**USER SETUP AND MAINTENANCE**

**USER TYPES**

To enhance the security of data there are four User Types available within the jIRVEN application, each having a unique level of access:

- Default User (jirven)
- System Administrator
- Data Entry
- View Only

The Default User ID may only be used to add or modify Facilities and Users. This ID should be held by someone who does not need access to Patient information. After successfully creating at least one Facility and one System Administrator account, the Default User should log out of the application. Note, the Default User does not have access to the full jIRVEN menu. Please consult the jIRVEN Installation Guide for detailed instructions regarding the initial login and setup by the Default User.

A Security Administrator will have the highest level of access and a View Only User will have the least. The table below provides a summary of the functions available to each User Type. An “X” denotes that a function will be available to that particular User Type unless otherwise specified. Note, you will not see the Default User in this summary as it may only be used to add/maintain facility and user information.
### ADD A USER

The ‘User Information’ screen allows users, dependent upon their User Type, to modify and setup new user accounts. The term ‘user’ refers to the individuals who will be viewing or entering data into the jIRVEN application.

The ‘User Information’ screen displays in two sections:

- User Summary (on the left)
- User Detail (on the right)
  - All user data entry is done in this section.

Complete the following steps to add a new user:

1. Select ‘User’ from the Administration drop-down on the Menu Bar or ‘Go to User’ from the ‘Home’ screen.

2. The ‘User Information’ screen displays.
3. Enter the appropriate user information into the User Detail section. Required fields display on the screen in bold type with an asterisk.

4. After entering all required user information, click the ‘Save’ icon. Saved user information will display in the User Summary section on the left side of the screen.

5. To add additional users, click the ‘New’ icon, enter data and click the ‘Save’ icon.

**TERMINATION DATE**

A Termination Date should only be entered if an active user is no longer valid (e.g., no longer works for the facility). If there is only one System Administrator and that person terminates his/her position, a new System Administrator must be setup prior to entering the Termination Date for the existing System Administrator.

If a Termination Date is entered for a user who has active assessments in the database a Termination Date message box will be displayed advising that any assessments associated with the terminated User ID will be updated to an active User ID when an active user opens the assessment.

![Termination Date Message]

**MODIFY A USER**

Complete the following steps to modify an existing user:

1. Locate and highlight the user in the User Summary section.
2. Make the appropriate changes in the User Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

**DELETE A USER**

User ID’s may not be deleted if the user has created or modified Facility, Patient or Assessment data. User ID’s which are successfully deleted may not be reused. Use of the Termination Date field is recommended if a user is no longer valid (e.g., no longer works for the facility).

Complete the following steps to delete a user:

1. Locate and highlight the user in the User Summary section.
2. Click the ‘Delete’ icon.

**CHANGE PASSWORD**

User passwords may be changed at any time.

Complete the following steps to change a password:
1. Login to jIRVEN.

2. Select ‘Change Password’ from the Security drop-down on the Menu Bar.

3. The ‘Change Password’ screen displays along with the following rules:
   
   - The new password and the confirm new password must match.
   - The new password must be at least 8 characters long.
   - The new password must be no more than 20 characters long.
   - The new password must not contain any space.
   - The new password must not contain the User ID, First Name, Last Name, or Email.
   - The new password must not begin with a number.
   - The new password can only contain a maximum of 3 repetitive characters.
   - The new password must contain at least one for each of the following type of characters:
     - Upper-case Character: A-Z
     - Lower-case Character: a-z
     - Number: 0-9
     - Special Character: &~!@#$%^*()_+={}\[:;"'<,.?/]
   - The new password must not match any of the user's most recent 6 passwords.
   - The new password will be set to expire in 60 days.
4. Enter the current password in the ‘Password’ box.

5. Enter a new password in the ‘New Password’ and ‘Confirm New Password’ box.

6. Select ‘Change Password’. Selecting ‘Cancel’ will close the ‘Change Password’ screen and will not change the existing password.

**FORGOT PASSWORD**

Complete the following steps if you have forgotten your password:

1. Enter the User ID and select the ‘Forgot Password’ button.

2. The ‘Security Questions’ pop-up window displays with three (3) of the security questions which were answered during the initial setup of the given User ID.

3. Enter responses to the questions provided.

4. Select ‘OK’ to continue to the ‘Change Password’ screen. Selecting ‘Cancel’ will close the security questions and return to the login screen.

**LOCKED USER ACCOUNT**

jIRVEN will allow three (3) login attempts prior to locking a user account and removing the ability to login. The following message will be displayed when a user account becomes locked: “Your account has been locked. Contact your System Administrator or click Forgot Password Alt+F to unlock your account.”
As stated in the error message there are two options when a user account has become locked. Click ‘OK’ to return to the ‘Login’ screen. Follow the instructions for Forgot Password to unlock the account.

The user may also contact a System Administrator who can reset the account using the following steps:

1. Select ‘User’ from the Administration drop-down on the Menu Bar.

2. Locate and highlight the locked user account in the User Summary section. Locked user accounts will display in bold type.

3. Check the ‘Reset Password/Unlock The Account’ checkbox in the User Detail section on the right side of the screen.

4. Click the ‘Save’ icon.

5. The user account is now unlocked. The password has been reset to match the User ID. Please note the password is case sensitive and must match in both the ‘User ID’ and ‘Password’ fields.

Please Note: In the event the primary System Administrator account becomes locked, a second System Administrator OR the Default User (User ID = jirven) may log in and reset the account by following the steps defined above.

If the System Administrator account cannot be unlocked using the Forgot Password instructions or the Locked User Account instructions please contact the QIES Help Desk for further assistance. The Help Desk will reset the Default User account (User ID=jirven) which may then be used to unlock the account or setup a new System Administrator.

PATIENT SETUP AND MAINTENANCE

The ‘Patient Information’ screen allows users, depending on User Type, to add, edit, delete and search for patients.

The ‘Patient Information’ screen displays in 4 sections:

- Search Criteria (top of the screen)
- Patient Summary (on the left)
- Patient Detail (on the right)
  - All patient data entry is done in this section.
- Actions (on lower right)
**ADD A PATIENT**

Complete the following steps to add a new patient:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.

<table>
<thead>
<tr>
<th>File</th>
<th>Administration</th>
<th>Import/Export</th>
<th>Reports</th>
<th>Security</th>
<th>Assessment</th>
<th>Help</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Facility</td>
<td>Ctrl+F</td>
<td>Patient</td>
<td>Ctrl+T</td>
<td>User</td>
<td>Ctrl+R</td>
</tr>
</tbody>
</table>

2. The ‘Patient Information’ screen displays.

3. Enter the appropriate patient information into the Patient Detail section. Required fields display on the screen in bold type with an asterisk.

4. After entering the required patient information, select the ‘Add Patient’ icon located in the Actions section on the right side of the screen or click the ‘Save’ icon.

5. Saved patient information will display in the Patient Summary section.

6. To add additional patients click the ‘New’ icon. Enter data and click the ‘Save’ icon.
HIDE A PATIENT RECORD
The ‘Hide Patient Record’ field located in the Patient Detail section allows users to hide records that no longer need to be accessed. For example, when a patient is no longer in the facility and all associated assessments have been exported; the user can hide the patient record. To hide a patient’s records, select the “Yes, hide record” option within the Patient Detail section.

PATIENT SEARCH
The ‘Search Criteria’ section is located at the top of the ‘Patient Information’ screen. To retrieve all existing patient records, leave the Search Criteria blank and click the ‘Search’ button.

Complete the following steps to retrieve one or more records based on Search Criteria:

1. Select criteria from the ‘Field Name’ and ‘Condition’ lists.
2. Enter a ‘Field Value’.
3. Select the box next to ‘Show Hidden’ to include records marked ‘Yes, hide record’ in the Patient Details section.
4. Click the ‘Search’ button.
5. Click the ‘Clear’ button to remove search criteria and begin a new patient search.

Please Note: A System Administrator will see duplicate patients listed in the Patient Summary section if a patient has been at multiple facilities and the System Administrator has access to all of those facilities within the jIRVEN application.

MODIFY A PATIENT
Complete the following steps to modify an existing patient:

1. Locate and highlight the patient in the Patient Summary section.
2. Make the appropriate changes in the Patient Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

The following message will display on the ‘Assessment Search’ screen when opening an existing assessment after patient information has been modified: “The patient information has changed, would you like to update the assessment to reflect these changes?”

The user will be shown the field name values currently in the assessment (Before Value) as well as the value after selecting ‘Yes’ on the Patient Data Updated pop-up window (After Value).
• Selecting ‘Yes’ will update the patient information within the selected assessment record to reflect what is in the Patient Detail section of the ‘Patient Information’ screen.

• Selecting ‘No’ will open the record without updating patient information within the selected assessment record.

Please Note: This message will continue to be displayed each time an assessment is opened after modifying the patient data until ‘Yes’ is selected.

DELETE A PATIENT
Complete the following steps to delete a patient:

1. Locate and highlight the patient in the Patient Summary section.
2. Click the ‘Delete’ icon or the ‘Delete Patient’ button in the Actions section of the ‘Patient Information’ screen.
   • Deletions cannot be made if one or more assessments have been created for the patient.

MOVE A PATIENT
In the event a patient is moved from one IRF to another within the same corporation, it is necessary to reassign the patient to the appropriate facility. Before reassigning a patient to a new facility ALL existing assessments must be in an ‘Exported’, ‘Complete’ or ‘Outdated’ status.

Verify Assessment Status
Complete the following steps to verify the status of a patient’s assessments:

1. Perform an assessment search by following the Assessment Search procedure. It is recommended that the ‘show hidden’ checkbox be applied to ensure all existing records are shown.
2. If all assessments found have an ‘Exported’, ‘Complete’ or ‘Outdated’ status, proceed to Assign a New Facility ID below.
3. If ‘Non-Exported’ assessments are found an error message indicating as such will be displayed. Enter any remaining applicable data to complete the assessment record. Required fields will appear in bold type in the ‘Navigator’ section of the ‘Assessment’ screen. You may also choose to delete an assessment if it has been entered in error.
4. Click the ‘Save and Validate’ icon.

5. If the assessment is complete you will have achieved a status of ‘Complete’, ‘Outdated’ or ‘Export Ready’. Close the assessment.

6. For ‘Export Ready’ assessments, follow the Export procedure to set the status appropriately.

**Assign a New Facility ID**

Complete the following steps to assign a patient to a new facility:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.

2. The ‘Patient Information’ screen displays.

3. Perform a **Patient Search** for the patient you wish to move.

4. Locate and highlight the patient to be reassigned in the Patient Summary section.

5. Verify the patient information in the Patient Detail section on the right.

6. Select the new facility from the ‘Facility Name’ drop-down.

7. Click the ‘Save’ icon.

When a patient has assessments which are in a ‘Complete’ status a decision message asking “Are you sure you want to change the facility for patient (First Name/Last Name)?” will be displayed as shown in the example below. To continue select the ‘Finish’ button. Assessments listed will remain in the ORIGINAL facility where they were created. In the event the assessments listed belong under the newly assigned facility they will need to be deleted and re-entered accordingly.
8. A confirmation message will be displayed indicating that the patient information has been saved.

9. Click ‘OK’ to complete the patient move process and assign the new facility information. Saved patient information will display in the Patient Summary section of the Patient Screen.

ASSESSMENT NAVIGATION AND MAINTENANCE

SCREEN TABS
Tabs for active screens (e.g. Home, Patient, Assessment Search, and Assessment) will display below the Toolbar at the top of the screen. The ‘Assessment’ tab will display the assessment type, patient name and assessment date.

When the assessment screen is open no other screens may be accessed.

If an attempt to view a subsequent screen tab such as ‘Assessment Search’ while the ‘Assessment’ screen is active, the user will receive an error message stating that this function is not allowed as shown in the example below. Click ‘OK’ to close the error message and return to the ‘Assessment’ screen.
ASSESSMENT SCREEN TABS
When an assessment is opened the following additional tabs will be displayed:

- Assessment
- Patient Details
- Facility Details
- Assessment Determination

ASSESSMENT
The ‘Assessment’ tab displays the patient assessment; this is where all assessment data entry will be completed.

PATIENT DETAILS
The ‘Patient Details’ tab displays patient demographic data as it was entered on the Patient Screen in a view only, non-editable format.

FACILITY DETAILS
The ‘Facility Details’ tab displays facility information as it was entered on the Facility Screen in a view only, non-editable format.

ASSESSMENT DETERMINATION
The ‘Assessment Determination’ tab displays data as entered on the ‘Add Assessment’ wizard in a view only, non-editable, format.

NAVIGATOR
The assessment ‘Navigator’ is located in the top left corner of the ‘Assessment’ screen and will display all assessment items in a collapsible tree format. Unanswered questions will appear in bold type.

As questions are answered, they are removed from the tree. To change the display of the tree to continue showing answered questions utilize the ‘Show/Hide’ icon in the Toolbar at the top of the screen.

TIP: Clicking on an item in the tree will move the cursor to the selected field within the assessment.
EDITS

Data integrity edits are applied as information is entered into jIRVEN. These edits are unique messages put in place to assist users with the accurate completion of the IRF-PAI. Some edits will present a pop-up message and must be addressed when displayed in order to proceed. Other edits may not appear until the assessment is saved and validated.

The assessment ‘Edits’ section is located in the bottom left corner of the ‘Assessment’ screen. This section displays applicable errors or warnings found within an assessment after selecting the ‘Save and Validate’ icon.
The following types of edits may occur in jIRVEN:

(!) **ERRORS**
This type of edit informs the user that information is missing or invalid. Data must be entered or corrected before the assessment may be completed.

(#) **WARNINGS**
This type of edit indicates there is data entered that should be verified as accurate, or serves as a reminder regarding how certain fields should be completed.

(?) **INFORMATIONAL**
This type of edit gives the user general information about the assessment data entered.

**TIP:** Clicking on an edit message will move the cursor to the appropriate field within the assessment so it may be verified or corrected. An Assessment Error Report may be printed which will display all edits shown on the ‘Edits’ section of the ‘Assessment’ screen. Utilize the ‘Print Error Report’ button at the bottom of the Edits Section to print the Assessment Error Report.

**ADD AN ADMISSION ASSESSMENT**
Complete the following steps to create an admission assessment:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.

2. Complete a Patient Search or add a new patient.

3. In the Patient Summary section, double click on the patient you wish to add an assessment for, OR highlight the patient row by clicking on the patient and click the ‘Add Assessment’ button at the bottom of the Actions Section.

4. The ‘Add Assessment’ wizard displays.
5. Enter information into the fields as appropriate. Required fields display on the screen in **bold** type with an asterisk.

6. Click ‘Finish’ to display the ‘Assessment’ screen and continue entering assessment data OR click ‘Cancel’ to return to the ‘Patient Information’ screen.

**Please Note:** After clicking ‘Finish’ errors and/or warning messages, if applicable, will display in a pop-up window before opening the ‘Assessment’ screen. Below is an example of the ‘Assessment’ screen.
7. Enter data as appropriate on the ‘Assessment’ screen. Required fields will appear in bold type in the ‘Navigator’ section at the upper left. Clicking on an item in the ‘Navigator’ will move the cursor to the selected field within the assessment.

Please Note: For optimization of the skip patterns and/or edits, it is recommended that data be entered in the order the questions appear on the screen.

8. To save progress as data is entered, click the ‘Save’ icon or utilize the short-cut, Ctrl+S.

9. When data entry is complete click the ‘Save and Validate’ icon to validate the assessment for errors or warnings.

10. A confirmation message indicating that the assessment data has been saved will be displayed which includes the number of warnings and/or errors found as well as the assessment status as shown in the example below.

11. Select ‘OK’ to continue.

**DUPLICATE ASSESSMENTS**

In the event that the information entered on the ‘Add Assessment’ wizard duplicates an existing record within the assessment database, the ‘Next’ button will enable on the ‘Add Assessment’ wizard, instead of the ‘Finish’ button. The following screen will display with a list of duplicate assessments.
Complete the following steps to proceed in the event of a duplicate assessment:

1. Click to highlight the assessment.

2. Select the ‘Back’ button to return to the Add Assessment’ wizard to make changes if needed. Select the ‘Cancel’ button to return to the Patient Information Screen OR select the ‘Finish’ button to continue data entry of the existing assessment.

If the assessment found to be a duplicate is already in an Exported status, the following message will display: “Duplicate assessment found has a status of “EXPORTED” and cannot be opened from this window. Please use the assessment search screen.” The user will need to navigate to the Assessment Search screen to modify or remove the assessment before proceeding.

**ASSessment Search**

Complete the following steps to search for an assessment:

1. Select ‘Search’ from the Assessment drop-down on the Menu Bar.

2. The ‘Assessment Search’ screen displays.
3. To retrieve all existing assessment records leave the Search Criteria blank and click the ‘Search’ button.

4. To retrieve one or more assessment records based on Search Criteria:
   a) Select criteria from the Field Name and Condition lists.
   b) Enter a corresponding Field Value.
   c) Click the ‘Search’ button.
   d) Click the ‘Clear’ button to remove search criteria.

Please Note: Selecting the box next to ‘Show Hidden’ will include records for patients marked ‘Yes, Hide Record’ on the ‘Patient’ screen. It is recommended when conducting a search after updating Patient and/or Facility information that the user close any open tabs and begin with a new ‘Assessment Search’ screen.

**VIEW ONLY**
Occasionally it may be necessary to view previously entered information where there is not a need to modify or edit the data. To view assessment data without editing or resetting the assessment status (e.g. Exported assessment) users may utilize the ‘View Only’ checkbox.

Complete the following steps to open an assessment in ‘View Only’ mode:

1. Complete an Assessment Search to locate the desired assessment.

2. Click to place a checkmark into the ‘View Only’ checkbox at the bottom of the screen.

3. Highlight the desired assessment record and select the ‘View Assessment’ button at the bottom of the ‘Assessment Search’ screen, or double click to open the assessment for viewing.

4. The ‘Assessment’ screen opens in ‘View Only’ mode.

Please Note: Assessments may not be modified in ‘View Only’ mode. To make changes to this assessment OR subsequent assessment records the ‘View Only’ checkbox MUST be unchecked.
**ADD A DISCHARGE ASSESSMENT**

You must [Add An Admission Assessment](#) prior to adding a discharge. The status of the admission assessment must be ‘Complete’ in order to begin entering the discharge assessment information.

Complete the following steps to add a discharge assessment:

1. Select ‘Search’ from the Assessment drop-down on the Menu Bar.

![Assessment Menu Bar](image)

2. Complete an [Assessment Search](#) to locate the admission assessment of the patient you wish to discharge.

3. Click to highlight the patient’s admission assessment and select the ‘Edit Assessment’ button OR double-click to initiate the discharge assessment.

![Assessment Search Interface](image)

4. A decision message will display the following options:
   - Open this assessment in read only mode
   - Create a Discharge Assessment
   - Reset Status and Edit

![Decision Message](image)
5. Click the radio button next to ‘Create a Discharge Assessment’.

6. Select the ‘OK’ button to open the discharge assessment for data entry.

7. Enter data as appropriate on the ‘Assessment’ screen. Required fields will appear in bold type in the ‘Navigator’ section at the upper left. Clicking on an item in the ‘Navigator’ will move the cursor to the selected field within the assessment.

Please Note: For optimization of the skip patterns and/or edits, it is recommended that data be entered in the order the questions appear on the screen.

8. To save progress as data is entered, click the ‘Save’ icon or utilize the short-cut, Ctrl+S.

9. When data entry is complete click the ‘Save and Validate’ icon to validate the assessment for errors or warnings.

10. A confirmation message indicating that the assessment data has been saved will be displayed which includes the number of warnings and/or errors found as well as the assessment status as shown in the example below.

11. Select ‘OK’ to continue.
**MODIFY AN ASSESSMENT**

When modifying an assessment the user must first determine the assessment status. The assessment status may be viewed on the ‘Assessment Search’ screen as shown in the example below or on the Tool Bar once an assessment record has been opened. The following assessment statuses may occur within jIRVEN:

- NEW
- IN_USE
- DATA_ENTRY
- COMPLETE
- EXPORT_READY
- EXPORTED
- OUTDATED (assessment record greater than 36 months old)

---

**NEW, IN_USE, DATA_ENTRY, EXPORT_READY, COMPLETE or OUTDATED**

Complete the following steps to modify an existing assessment with a status of NEW, IN_USE, DATA_ENTRY, EXPORT_READY or OUTDATED:

1. Complete an [Assessment Search](#) to locate the desired assessment.

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment for modification.

**Please Note:** When an OUTDATED assessment is opened the following decision message will be displayed: “(Target Date) is greater than 36 months old. Would you like to continue and open this assessment?” Select ‘Yes’ to continue.

3. The ‘Assessment’ screen will display.

**TIP:** Unanswered questions will appear in **bold** type in the Navigator section at the upper left corner of the ‘Assessment’ screen. Clicking on an item in the Navigator tree will move the cursor to the selected field within the assessment.
4. Modify the assessment as appropriate.

5. Select the ‘Save and Validate’ icon on the toolbar to display any applicable warnings or errors found within an assessment.

**EXPORTED**

Only a user with System Administrator access may modify an assessment that has been exported.

Complete the following steps to modify an assessment with a status of EXPORTED:

1. Complete an **Assessment Search** to locate the desired assessment.

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment for modification.

3. The ‘Exported Assessment’ pop-up window displays with the following options:

   - **Open this assessment in read only mode** - Assessment opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘Assessment Search’ screen. All other assessments will be view only until this box is unchecked.

   - **Create a correction record** – Assessment opens and displays all previously selected answers. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard.

   - **Create an inactivation record** – Inactivation assessment opens. Once saved and validated the assessment type will be changed to XX- Inactivation.

   - **Reset Status and Edit** – Assessment opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. The assessment status will be changed to IN_USE.

4. Select one of the four options provided on the ‘Exported Assessment’ pop-up window. For additional guidance regarding which selection is appropriate please review Appendix B of the IRF-PAI Submission User’s Guide.
5. Select ‘OK’ to continue.

6. Modify the assessment if applicable.

7. Click the ‘Save and Validate’ icon on the toolbar.

COPY AN INACTIVATED ASSESSMENT

Occasionally it may be necessary to inactivate a record which subsequently needs to be modified for re-submission to the national data repository. For example, IRF policy instructs the provider to submit an inactivation record when the first name, last name, SSN, gender and/or birthdate is to be corrected. A new record with the correct information is then submitted. For additional information regarding the IRF-PAI correction/inactivation policy please review Appendix B of the IRF-PAI Submission User’s Guide.

After updating the patient information (see Modify a Patient) a copy of the inactivated record can be made to avoid the need to re-enter all of the assessment data.

Complete the following steps to copy an inactivated assessment with a status of Exported:

1. Complete an Assessment Search to locate the inactivated assessment. Note that the assessment type will be shown as XX- IRF-PAI Inactivation on the ‘Assessment Search’ screen.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Admission Date</th>
<th>Number of Correction Requests</th>
<th>Assessment Type</th>
<th>Assessment Status</th>
<th>Facility</th>
<th>Assessor ID</th>
<th>Assessment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>07-21-2016</td>
<td>00</td>
<td>AD-IRF-PAI Part 1 Admission</td>
<td>IN_USE</td>
<td>Facility</td>
<td>SysAdmin</td>
<td>07-21-2016</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>07-29-2016</td>
<td>00</td>
<td>AD-IRF-PAI Part 1 Admission</td>
<td>DATA ENTRY</td>
<td>Facility</td>
<td>SysAdmin</td>
<td>07-21-2016</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>07-21-2016</td>
<td>00</td>
<td>AD-IRF-PAI Part 1 Admission</td>
<td>NEW</td>
<td>Facility</td>
<td>SysAdmin</td>
<td>07-21-2016</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
<td>07-20-2016</td>
<td>01</td>
<td>XX-IRF-PAI Inactivation</td>
<td>EXPORTED</td>
<td>Facility</td>
<td>SysAdmin</td>
<td>07-21-2016</td>
</tr>
</tbody>
</table>

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment.

3. The ‘Exported Assessment’ pop-up window displays with the following options:

   - **Open this assessment in read only mode** – Inactivation assessment opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘Assessment Search’ screen. All other assessments will be view only until this box is unchecked.

   - **Create a copy** – Assessment opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add Assessment’ wizard. Only one copy per inactivated assessment is allowed.

   - **Reset Status** – Inactivation Assessment opens and displays all fields in a view only format. The Assessment Status will be changed to IN_USE.

4. Select one of the three options provided on the ‘Exported Assessment’ pop-up window.

5. Select ‘OK’ to continue.

**Please Note:** The following message will display prior to opening the assessment if patient information has been modified: “The patient information has changed, would you like to update the assessment to reflect these changes?”

   - Select ‘Yes’ to update the assessment with the ‘After Value’.
   - Select ‘No’ to open the assessment without updating patient information.
6. The ‘Assessment’ screen opens.

7. Modify the assessment data if applicable.

8. Click the ‘Save and Validate’ icon on the toolbar.

9. Close the assessment.

**DELETE AN ASSESSMENT**

Only a user with System Administrator access may delete an assessment. Assessments with a status of EXPORTED cannot be deleted; the status of these records must be reset to complete the deletion.

Complete the following steps to delete an assessment:

1. Complete an Assessment Search to locate the desired assessment.

2. Click once to highlight the assessment.

3. Click the ‘Delete Assessment’ button at the bottom of the ‘Assessment Search’ screen to delete the selected assessment.

4. The ‘Confirm Assessment Delete’ pop-up window displays the following message: “Are you sure you want to delete assessment [patient last name, first name, admission/re-entry date (A1600)]?”

5. Select ‘OK’ to delete the assessment. Select ‘Cancel’ to close the pop-up window. The assessment will not be deleted.
If an assessment with a current status of EXPORTED needs to be deleted the user should first verify that the assessment record has not been submitted to the national data repository.

Complete the following steps to delete an assessment that has been previously exported:

1. Complete an Assessment Search to locate the desired assessment.

2. Highlight the assessment and select the ‘Edit Assessment’ button at the bottom of the ‘Assessment Search’ screen or double click to open the assessment.

3. The ‘Exported Assessment’ pop-up window displays with the following options:
   - Open this assessment in read only mode
   - Create a correction record
   - Create an inactivation record
   - Reset Status and Edit

4. Select the ‘Reset Status and Edit’ radio button.

5. Select ‘OK’.

6. The ‘Assessment’ screen will open setting the assessment status to IN_USE.

7. Close the assessment.

8. Follow the instructions to Delete an Assessment to complete the removal of the assessment record.

**EXPORT**

The ‘Export Assessments’ screen allows the user to export records for subsequent submission to the appropriate national data repository.

Complete the following steps to export an assessment:

1. Select ‘Export’ from the Import/Export drop-down on the Menu Bar.
2. The ‘Export Assessments’ screen displays.

3. The export process will depend upon which Export Type is chosen. Select one of the following Export Types from the drop-down at the upper left corner of the ‘Export Assessments’ screen:

- New Export (Assessments marked as “Export Ready”)
- Previous Export (Assessments marked as “Export Ready” or “Exported”)

The process for each Export Type has been defined below.

**NEW EXPORT**
(Assessments marked as “Export Ready”)

Complete the following steps when selecting New Export:

1. Click the ‘Browse’ button to select the Export Path. This is the location where the exported files will be saved.

2. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.

3. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.

4. Select the assessments to be included in the export file by placing a checkmark into the boxes next to the desired assessment records. A minimum of one selection is required.

   - The ‘Select All’ button will select all assessments displayed in the list to be included in the export file.
   - The ‘Clear Selection’ button will unselect all assessments previously selected.
5. If desired, select the ‘Print Assessment List’ button to print a list of all assessments selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user’s choice.

6. If desired, select the ‘Error Check’ button to validate all assessments selected for export. Warnings and/or Error results will display in a new screen.
   - Select the ‘Save to File’ button to save the error report.
   - Select the ‘Close’ icon in the upper right corner to close the error report.

7. Select the ‘Export’ button to complete the export process.

8. The ‘Export Complete’ pop-up window displays notifying the user that the export process is complete. The number of assessments which have been exported as well as the location of the exported files displays within this pop-up window.

![Export process complete - 1 assessment was exported. Please submit the file to the national system.](C:\Users\[Username]\Desktop\Export3.ZIP)

**PREVIOUS EXPORT**
(Assessments marked as “Export Ready or “Exported”)

Complete the following steps when selecting Previous Export:

1. Begin by highlighting a previously exported file from the list in the Previous Exports section located in the center of the ‘Export Assessments’ screen.

![Previous Exports](C:\Users\[Username]\Desktop\Export3.ZIP)

2. A list of assessments included in the previous exports will be displayed in the section titled Previously Exported Assessments located at the bottom of the ‘Export Assessments’ screen.
3. Select the assessments to be included in the export file by placing a checkmark into the boxes next to the desired assessment records. While all assessments included in the previous export will be displayed, ONLY assessments with a status of “Export Ready” or “Exported” may be selected for inclusion in a new export file. A minimum of one selection is required.

- The ‘Select All’ button will select all assessments displayed in the list to be included in the export file.
- The ‘Clear Selection’ button will unselect all assessments previously selected.

4. Click the ‘Browse’ button to select the Export Path. This is the location where the exported files will be saved.

5. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.

**Please Note:** By default the original Export Path and Export Name will be displayed. It is recommended to use the same Export Path for each export file; however, the Export Name should be unique for each export file created. Failure to create a new Export Name may result in the following pop-up window: “The file you are attempting to export already exists, overwrite file?”

- Selecting ‘Yes’ will replace the original export file saved.
- Selecting ‘No’ will return the user to the ‘Export Assessments’ screen so they may select a new Export Name.

6. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.

7. If desired, select the ‘Print Assessment List’ button to print a list of all assessments selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user’s choice.

8. If desired, select the ‘Error Check’ button to validate all assessments selected for export. Warnings and/or Error results will display in a new screen.

- Select the ‘Save to File’ button to save the error report.
• Select the ‘Close’ icon in the upper right corner to close the error report.

9. Select the ‘Export’ button to complete the export process.

10. The ‘Export Complete’ pop-up window displays notifying the user that the export process is complete. The number of assessments which have been exported as well as the location of the exported files displays within this pop-up window.

**IMPORT**

The ‘Import Assessments’ screen allows users to import Patients and Assessment information into jIRVEN.

Complete the following steps to import an assessment:

1. Select ‘Import’ from the Import/Export drop-down on the toolbar.

2. The ‘Import Assessments’ screen displays.

3. Click the ‘Browse’ button to navigate to the location of the files to be imported.

   **Please Note:** There may be an increased wait time when importing a large number of assessment records due to database encryption.
PREFERENCES

PATIENT DATA OPTIONS CHECKBOX
Selecting this checkbox turns off the warning message displayed when a new patient is imported. “Do not give warning when new patient is added during import.”

MISCELLANEOUS DATA OPTIONS CHECKBOXES
- “Do not display warnings in error check results.” Selecting this checkbox removes warning messages from the error check results report that displays after importing data. ONLY fatal errors are included in the report. Please note assessments which contain fatal errors in accordance with the IRF-PAI Data Specifications will NOT be imported into jIRVEN.
- “Assign Exported status to assessments without errors (instead of Export Ready).” Selecting this checkbox sets the status of imported assessments to ‘Exported’. It is recommended to select this option if all records have been previously accepted by the ASAP System.
- “Associate assessments with a blank facility ID field to the selected facility below.” Selecting this checkbox links import records which are missing a facility ID to the selected facility.

4. Set the desired preferences. You may select preferences individually or click the ‘Select All Options’ button to check or uncheck all checkboxes.

5. Optional: Select the ‘Error Check File’ button to validate the assessments contained in the import file before completing the import process. A Status Report will display error results in a new window. The following image is an example of the Error Check File Status Report.
   - Select the ‘Save to File’ button to save the error report in a .txt file format.
   - Click the ‘Close’ icon in the top right corner to close the Status Report.
6. Click the ‘Import’ button to import the selected assessment records into jIRVEN.

7. If the import file chosen contains assessment records for patients who have not previously been entered into jIRVEN a ‘New Patient’ message will be displayed.

“A new patient is being added to (Facility – FAC ID). Continue with the import of (Patient Name - SSN)?”

- Click ‘Yes’ to continue.
- Click ‘No’ or ‘Cancel’ to stop the import process for that Patient.
- This message will NOT be shown if the Patient Data Options checkbox has been selected.

8. Import timing will vary based on the number of records included in the selected file. Once complete, the ‘Import Complete’ confirmation message will display along with an Import Status Report for all assessments included in the import file.
9. If none of the selected files are successfully imported, the ‘Import Failed’ message displays along with an Import Status Report.

![Import Failed Message]

10. Click the ‘OK’ button on the ‘Import Complete’ pop-up window to view the Status Report.

**ATTENTION!**
Only ONE import status report may be open at a time; additional functions cannot be selected until the report is either saved or closed. **This is the ONLY opportunity the user will have to view OR save the Import Status Report.** It is strongly recommended to save or print this report for future reference as needed. Below is an example of the Import Status Report.

![Import Status Report Example]

11. Click the ‘Save to File’ button on the bottom of the Import Status Report to save a copy.

12. Click ‘Close’ in the top right corner to close the Status Report.
REPORTS

jIRVEN reports allow users to preview and print assessment information as well as detail and summary information for both facilities and patients.

In addition to the previously mentioned status reports the following reports are available within the jIRVEN application:

- Print Assessment Report
- Print Assessment Error Report
- Event Tracking
- Assessment Data Entry – By Status

PRINT ASSESSMENT REPORT

The Print Assessment Report provides a listing of all data which has been entered into the assessment record and may be generated at any time in the data entry process once the assessment has been created. Complete the following steps to obtain the Print Assessment Report.

1. After selecting the assessment on the Assessment Search Screen, use one of the following methods:
   - Select the ‘Print Assessment Report’ icon on the Toolbar.
   - Utilize the short-cut Ctrl+A.
   - Select ‘Print Assessment Report’ from the File drop-down on the Menu Bar.

2. The Print Assessment Report criteria selection window is displayed. This criteria selection window may be used to designate the number of signature lines shown on the printed report. The default number of signature lines will be 12. The Additional Signature Lines item is a *required field.

3. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the Print Assessment Report criteria selection window. The Print Assessment Report will not be generated.

4. To print the report, click the ‘Print’ icon on the Report Viewer screen.

5. To save the report, click the ‘Save’ icon on the Report Viewer screen.

6. To export the report, click the arrow next to the ‘Save’ icon.

7. The following export type values display:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
• Export as Single Sheet XLS
• Export as Multi Sheet XLS
• Export as CSV
• Export as XML
• Export as XML with Images

8. Select an export type.

9. Select the location in which you wish to save the report. Below is an example of a Print Assessment Report in PDF format.
jiRVEN - Inpatient Rehabilitation Facility - Patient Assessment Instrument

Facility: Facility Name
Last Name: Last
Assessment Date: 07/28/2017
Date: 07/28/2017
Requested by: SysAdmin

Last Entry Date: 07/28/2017
Data Entry Time: 00:02:12
Data Entry User: SysAdmin

Assessment Type: DC-IRF-PAI Part 2_Discharge
Admission Date: 07/27/2017
Patient Name: Last, First
SSN: 999-11-2222

CMG Code: A0101
CMG Version: 2.90
Error Code: 0
DLL Code: 2.90
Cognitive: 35
Motor: 84.0
Age: 106

*ASSESSMENT DETERMINATION
12 Admission Date: 07/27/2017
VERSION Select the time period
Discharge Date equal to 10/01/2016 thru 09/30/2017
ASMNTTYPE Assessment Type: DC-IRF-PAI Part 2_Discharge

*Admission Information
12 Admission Date: 07/27/2017
13 Assessment Reference Date: 07/26/2017
14 Admission Class: 01 Initial Rehab
15A Admit From: 01 Home (private home/apt., board/care, assisted living, group home, transitional living)
16A Pre-Hospital Living Setting: 01 Home (private home/apt., board/care, assisted living, group home, transitional living)
17 Pre-Hospital Living With: 01 Alone

*Payer Information
20A Primary Payment Source: 02 Medicare - Fee for Service

*Medical Information
21A Impairment Group: Admission
0001 2 - Stroke: Right Body Involvement (Left Brain)

*The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. (C)1983, 2001
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07/28/2017 
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ASSESSMENT ERROR REPORT

The Assessment Error Report provides a printable listing of all edits received once an assessment has been saved and validated against the IRF-PAI Data Submission Specifications. Complete the following steps to obtain the Assessment Error Report.

1. After selecting ‘Save and Validate’, use one of the following methods:
   - Click the ‘Print Error Report’ button located at the bottom of the ‘Edits’ section.
   - Click the ‘Print Assessment Error Report’ icon on the Toolbar.
   - Utilize the short-cut Ctrl+P.
   - Select ‘Print Assessment Error Report’ from the File drop-down on the Menu Bar.

2. The Assessment Error Report is displayed.

3. To print the report, click the ‘Print’ icon on the Report Viewer screen.

4. To save the report, click the ‘Save’ icon on the Report Viewer screen.

5. To export the report, click the arrow next to the ‘Save’ icon.

   The following export type values display:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
   - Export as Single Sheet XLS
   - Export as Multi Sheet XLS
   - Export as CSV
   - Export as XML
   - Export as XML with Images

6. Select an export type.

7. Select the location in which you wish to save the report. Below is an example of an Assessment Error Report in PDF format.
## Assessment Error Report

**Assessment Type:** DC-IRF-PAI Part 2_Discharge  
**Assessment Date:** 07-28-2017  
**Last Name:** Last  
**Admission Date:** 07-27-2017

<table>
<thead>
<tr>
<th>Question</th>
<th>Severity</th>
<th>Error Number</th>
<th>Error Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Warning</td>
<td>12D502</td>
<td>Inconsistent 12/13: The Assessment Reference Date (13) usually must be two days later than the Admission Date (12).</td>
</tr>
</tbody>
</table>

[ ] = Not Assessed, [*] = Skipped
EVENT TRACKING

The Event Tracking report may be used to monitor additions, deletions and/or modifications which are made to the Facility, User, Patient or Assessment screens.

Complete the following steps to run the Event Tracking report:

1. Select ‘Event Tracking’ from the Reports drop-down on the Menu Bar.

![Event Tracking Menu](image)

2. The ‘Event Tracking’ criteria selection window displays.

![Event Tracking Window](image)

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk.

4. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘Event Tracking’ criteria selection window.

5. To print the report, click the ‘Print’ icon on the Report Viewer screen.

6. To save the report, click the ‘Save’ icon on the Report Viewer screen.

7. To export the report, click the arrow next to the ‘Save’ icon.

   The following export type values display:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
   - Export as Single Sheet XLS
   - Export as Multi Sheet XLS
   - Export as CSV
   - Export as XML
   - Export as XML with Images
9. Select an export type.

10. Select the location in which you wish to save the report. Below are examples of two Event Tracking Reports in PDF format, Patient Event Tracking and Assessment Event Tracking.

<table>
<thead>
<tr>
<th>Event Type</th>
<th>User ID</th>
<th>Event Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Hide Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add</td>
<td>SysAdmin</td>
<td>07/28/2017 12:04 AM</td>
<td>Last</td>
<td>First</td>
<td>999-11-2222</td>
<td>10/10/1910</td>
<td>0</td>
</tr>
<tr>
<td>Modify</td>
<td>SysAdmin</td>
<td>07/28/2017 1:04 PM</td>
<td>Last</td>
<td>First</td>
<td>999-11-2222</td>
<td>10/10/1910</td>
<td>0</td>
</tr>
</tbody>
</table>

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ASSessment DATA ENTRY – BY STATUS

The Assessment Data Entry – By Status report provides a listing of all assessment records for the chosen status. The following statuses are available in jIRVEN:

- New
- In Use
- Data Entry
- Complete
- Export Ready
- Exported
- Outdated

Complete the following steps to run the Assessment Data Entry – By Status report:

1. Select ‘Assessment Data Entry – By Status’ from the Reports drop-down on the Menu Bar.
2. The ‘Assessment Data Entry – By Status’ criteria selection window displays.

![Assessment Data Entry – By Status criteria selection window]

3. Complete the required fields. Required fields display on the screen in bold type with an asterisk. To select two or more statuses, hold the Ctrl OR the Shift button on your keyboard while you select or scroll through the list.

4. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘Assessment Data Entry – By Status’ criteria selection window.

5. The Report Viewer screen opens displaying the generated report.

6. To print the report, click the ‘Print’ icon on the Report Viewer screen.

7. To save the report, click the ‘Save’ icon on the Report Viewer screen.

8. To export the report, click the arrow next to the ‘Save’ icon. The following export type values display:
   - Export as PDF
   - Export as RTF
   - Export as Jasper Reports
   - Export as HTML
   - Export as Single Sheet XLS
   - Export as Multi Sheet XLS
   - Export as CSV
   - Export as XML
   - Export as XML with Images
9. Select an export type.

10. Select the location in which you wish to save the report. Below are two examples of Assessment Data Entry – By Status Reports in PDF format, Complete and Exported.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Social Security</th>
<th>Gender</th>
<th>Birth Date</th>
<th>Assessment Type</th>
<th>Assessment Date</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last, First</td>
<td>986-11-2222</td>
<td>Male</td>
<td>10/10/1910</td>
<td>AD-RF-PAI Part 1 Admission</td>
<td>07/28/2017</td>
<td>SysAdmin</td>
</tr>
</tbody>
</table>

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CLOSE THE APPLICATION

To close the jIRVEN application select ‘Exit’ from the File drop-down on the Menu Bar. jIRVEN may also be closed by selecting the close icon in the upper right corner of the screen.
LOGOUT
To log out and return to the jIRVEN ‘Login’ screen, select ‘Logout’ from the Security drop-down on the Menu Bar.

SESSION TIME OUT
To enhance the security of data stored within the jIRVEN application the system will issue a timeout warning if there has been no activity by the user for ten (10) minutes. The following decision message will be displayed: “Do you wish to cancel the session time out?”

To continue with the session click ‘OK’. If the user does not cancel the session time out by selecting ‘OK’ prior to 15 minutes of inactivity jIRVEN will close the active screens and return the user to the ‘Login’ screen. If assessment data has been entered but not saved when a time out occurs the application will perform an auto save of the assessment data.

DATA BACKUP
It is strongly recommended that users backup the database each time new data is entered. In the event of data loss database backup files may be used to restore the jIRVEN application to a previous date and time.

When closing an active session of jIRVEN the user will receive the following decision message along with a listing of the current backup location: “Would you like to backup the database?”

- Select ‘Yes’ to backup the database and close jIRVEN.
- Select ‘No’ to decline the database backup and close the jIRVEN application.
Please Note: If a database backup has not occurred with one of the prior seven active sessions, jIRVEN will automatically backup the database when the application is closed.

CHANGING THE BACKUP FILE LOCATION

The default location for the database backup is located in a database/backup folder where the application is installed. Only a System Administrator may change the location where the backup will be stored.

Complete the following steps to change the location where the backup will be stored:

1. Select ‘Change Backup File Location’ from the File drop-down on the Menu Bar.

2. The ‘Change Backup File Location’ pop-up window displays with the current backup location highlighted.

3. Select the desired backup location.

4. Select ‘OK’ to set the location and close the pop-up window.

5. Selecting ‘Cancel’ will close the pop-up window without changing the location of the backup files.
**DATA RESTORE**

In the event of data loss database backup files may be used to restore the jIRVEN application to a previous date and time. A database restore requires the assistance of the QIES Help Desk. Please note, a backup file of the same version as the installed application is required to successfully restore.

When attempting to restore a database using a backup file which is older than that of the installed version of jIRVEN the following error message will be displayed:

“The version of the backup you selected is older than the current version of jIRVEN. Please select a backup of the same version.”

Select ‘OK’ to return to the ‘Login’ screen and restore using the appropriate backup file.

**GET HELP**

**PATIENT ASSESSMENT INSTRUMENT (IRF-PAI)**

Please utilize the IRF-PAI Clinical Manual for assistance completing the IRF Patient Assessment Instrument. For item-by-item guidance section four has been organized to correspond with each section of the instrument.

The IRF-PAI Clinical Manual may be found on the following CMS webpage:


**ICD CODING**

For questions relating to ICD-9 coding please visit the following CMS webpage:  
[https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html](https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html)

For questions relating to ICD-10 coding please visit the following CMS webpage:  

**JIRVEN HELP MENU**

Direct links to the CMS webpages above are also available via the jIRVEN Menu Bar. Complete the following steps to access links to help documentation:

2. The jIRVEN ‘Get Help’ screen will be displayed, including direct links to the CMS webpage where the IRF-PAI Clinical Manual and/or ICD coding assistance may be found.

Please utilize the IRF-PAI Clinical Manual for assistance completing the IRF Patient Assessment Instrument. For item-by-item guidance section four has been organized to correspond with each section of the IRF-PAI.

The IRF-PAI Clinical Manual may be found on the following CMS webpage:


For questions relating to ICD-9 coding please visit the following CMS webpage:

http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosisCodes/codes.html

For questions relating to ICD-10 coding please visit the following CMS webpage:


QIES HELP DESK
For additional technical support and assistance please contact the QIES Help Desk.

Hours: Monday - Friday 7AM – 7PM CST
Phone: 800-339-9313
Email: help@qtso.com
Website: https://www.qtso.com