



record. In checking for records to export, the routine first checks the date stamp on records in the patient.dbf file. If the date stamp on a record in patient.dbf is within the time frame you have chosen for your upload export, the patient record will be selected for upload, plus any newly created, modified, or deleted event records connected to the patient record that also have a date-stamp within the chosen date range. Changing the patient record itself or modifying any related events causes an update to the patient date/time stamp and will make it eligible for upload. Limited updates to patient and address records will be uploaded. If the incoming patient record matches an existing patient and if the existing patient has a blank or unknown value for DOB, age, sex, race, or ethnicity, the existing patient record will be updated with the known values. Also, if the incoming address record matches the existing current address record for that patient, and the existing address has blank/unknowns for street, city, county, zip or state, they will also be updated. Name changes (such as spelling corrections or changing from a maiden to a married name) will not be updated. After looking for new patient records, the export routine next looks for new event records. If any new event records have been created, that event record will be chosen for upload, along with its associated patient record.

Next, the user must enter the drive and directory where the export files will be created (i.e., *C:\upload*). **NOTE:** the export files may be created on a floppy disk; however, if the files are larger than the floppy disk will permit, the user will not get an error message. Instead, the files are simply truncated. If you have previously exported data in STD\*MIS upload format and the files already exist on the specified drive and directory, you will get a message prior to creating these records letting you know that these files already exist. You will be asked if you wish to overwrite the existing records. Choosing ANO@ will not allow the export to proceed. If you wish to retain a copy of the previously exported files you must rename them, or place them in a different folder. Choosing AYES@ will allow the export to begin selecting records for export.



If all thirteen files have been created properly, you will see a box with AExport Complete. Press any key to view the export summary report.@



Pressing a key will display the report which gives you the name of each export file, the number of total records exported, the number of records not deleted, and the number of records deleted. The deleted and non-deleted records should add up to the total number of records. Deleted records are exported to overwrite any records previously submitted to the Central database. Choosing AP@ for print will allow you to print the report, send it to a file or both. This report should be maintained as documentation.

06/13/2004		STD*MIS UPLOAD EXPORT IN -> C:\TEMP\		
STD*MIS File Name	Export File Name	# Records Exported	# Records NOT Deleted	# Recor Delete
CONGENITAL	CS101EXP.DBF	0	0	0
FIELD	FR101EXP.DBF	6	6	0
HISTORY	HI101EXP.DBF	0	0	0
INTERVIEW	IR101EXP.DBF	4	4	0
MORBIDITY	MO101EXP.DBF	5	4	1
PATIENT	PA101EXP.DBF	6	6	0
REMOTE	RE101EXP.DBF	19	19	0
RISK	RI101EXP.DBF	0	0	0
SIGN	SI101EXP.DBF	0	0	0
SYMPTOM	SY101EXP.DBF	0	0	0
TEST	TE101EXP.DBF	5	5	0
TREATMENT	RX101EXP.DBF	0	0	0

P = Print,    Cursor Keys = Browse,    Esc = Exit

The following variables are encrypted in the STD\*MIS upload files you create: Last Name, First Name, Middle Initial, DOB, SSN, HARS id number and street address (phone number, medical record number are also encrypted in STD\*MIS 4.x). The patient DOB does not appear to be encrypted, but it is. These fields are also stored in encrypted format in the upload databases into which they are imported.

If any of the thirteen files are not created properly, the Central STD\*MIS System will not accept the import.

Twelve of the thirteen file names are created as follows: The upload files use the first two letters of the event that the file contains, followed by a "1" and then two numbers representing the STD\*MIS site code, followed by AEXP@, and then a dbf extension. The thirteenth file, called RE1xxEXP.dbf, is the remote file. This file contains a summary of the records in seven of the remote files (**bolded below**.) This summary is what can be viewed through the UPLOADED RECORDS event at the site receiving the records from the remote site.

NOTE: Under no circumstances should you ever export your local STD\*MIS data and then import it back into your own STD\*MIS system. Doing so will duplicate **ALL** event records!!

<b>CS1XXEXP.dbf</b>	Congenital syphilis records in upload format
<b>FR1XXEXP.dbf</b>	Field Records in upload format
HI1XXEXP.dbf	History records (from clinic visit event) in upload format
<b>IR1XXEXP.dbf</b>	Interview records in upload format
<b>MO1XXEXP.dbf</b>	Morbidity records in upload format

PA1XXEXP.dbf	Patient and address records upload format
RE1XXEXP.dbf	Contains remote records, which are a summary of all uploaded records in text format. This file is accessed when there is a check mark beside AUPLOADED RECORDS@ in the Central Office system.
RI1XXEXP.dbf	Risk records in upload format
<b>RX1XXEXP.dbf</b>	Treatment records in upload format
SI1XXEXP.dbf	Clinical signs records (from clinic visit event) in upload format
SY1XXEXP.dbf	Symptom records in upload format
<b>TE1XXEXP.dbf</b>	Laboratory test records in upload format
<b>VI1XXEXP.dbf</b>	Visit to clinic records in upload format

### Importing STD\*MIS records in upload format from a remote STD\*MIS site

Before importing upload records into STD\*MIS, it is strongly advised that you reindex the data files in STD\*MIS. To import STD\*MIS records from a remote site, go to ASystem Utilities, Import Data, STD\*MIS Uploaded data@ and press <enter>. You will be prompted to enter the drive and directory where the data is located. These fields are user specified and can not be left blank. If the correct 13 files are in the directory indicated, the Asites for import@ line will tell you which sites are ready for import. Data from more than one remote site can be uploaded in a single session. **NOTE:** Remote installations of STD\*MIS must each have a unique site code.



Pressing enter will cause the import process to begin. If the import files are large, this could take some time. A progress line which tells you what files are being imported will be displayed. The index files are opened along with the data files and are updated as the data files are updated, so

reindexing after the import is complete is not necessary, although it is good practice.

**Import complete. Press any key to view import summary report.**

Press a key to display the report, which lists the name of each import file, the number of records processed, the number of event records added to newly created patient records, the number of event records added to existing patient records, the number of existing events updated, the number of existing events deleted, and the number of records not processed. (Records will not be processed for the following reasons: a new event record came up but it was deleted (no need to add a deleted record that had never been uploaded) or a summary record (remote.dbf) did not get added because the patient was not added). Deleted and modified records from the remote site overwrite any records previously submitted to the Central database.

06/13/2004		STD*MIS UPLOAD IMPORT				
		IN -> C:\TEMP\				
STD*MIS File Name	Import File Name	Processed Records	Added To New	Updated Existing	Deleted Existing	Processed No Action
CONGENITAL	CS101EXP.DBF	0	0	0	0	0
FIELD	FR101EXP.DBF	6	6	0	0	0
HISTORY	HI101EXP.DBF	0	0	0	0	0
INTERVIEW	IR101EXP.DBF	4	4	0	0	0
MORBIDITY	MO101EXP.DBF	5	4	0	0	1
PATIENT	PA101EXP.DBF	6	6	0	0	0
REMOTE	RE101EXP.DBF	19	19	0	0	0
RISK	RI101EXP.DBF	0	0	0	0	0
SIGN	SI101EXP.DBF	0	0	0	0	0
SYMPTOM	SY101EXP.DBF	0	0	0	0	0
TEST	TE101EXP.DBF	5	5	0	0	0
TREATMENT	RX101EXP.DBF	0	0	0	0	0

P = Print,      Cursor Keys = Browse,      Esc = Exit

Choosing AP@ for print will allow you to print the report, send it to a file or both. This report should be maintained as documentation.

If the files cannot be found, because you provided an incorrect drive or directory, you will see a red box with ANo uploaded files found.@ In this instance you need to determine where the records are stored and then try again.

**No uploaded files found.**

If all the necessary files are not present, the Asites for import@ line will tell you that the site has missing files. At this point you should choose ANO@ for import sites with complete data. If you press AYES@, it will appear to be uploading data, but no records will actually import. You must then call the remote site to determine why all the files were not present. The remote site will need to retransmit the upload files.

Once all records have been imported the data will be viewable in the Central site STD\*MIS

database. The actual import files will be renamed when they are imported with a \$\$\$ extension, and cannot be imported again. The imported data are stored in separate databases as follows.

CS1XXEXP.dbf	CSUPLD.DBF
FR1XXEXP.dbf	FRUPLD.DBF
HI1XXEXP.dbf	HISTUPLD.DBF
IR1XXEXP.dbf	IRUPLD.DBF
MO1XXEXP.dbf	MORBUPLD.DBF
PA1XXEXP.dbf	See note**
RE1XXEXP.dbf	REMOTE.DBF
RI1XXEXP.dbf	RISKUPLD.DBF
RX1XXEXP.dbf	RXUPLD.DBF
SI1XXEXP.dbf	SIGNUPLD.DBF
SY1XXEXP.dbf	SYMPUPLD.DBF
TE1XXEXP.dbf	TESTUPLD.DBF
VI1XXEXP.dbf	VISUPLD.DBF

**\*\*NOTE:** PATUPLD.dbf is simply the template for creating a patient upload file and does not store data. The data in the PAXXXEXP.dbf file is used to create a new patient record at the Central Office site, using the Central Office STD\*MIS site code. A file called UPLDLINK.dbf is the link between uploaded and local (native) patient records; it stores the remote site patient\_id number as remote\_id and the newly created Central site patient\_id number as local\_id. Creation of a new patient record with a local\_id allows the Central site patient record to contain both uploaded and native events.

The first time a record is uploaded from a remote site, a new patient record will be created in patient.dbf. If that patient record is uploaded again, it will find the patient record created on the previous upload, and add, modify or delete event records. If selected patient information (see page 2) was missing or unknown the first time the patient record was uploaded, that information will be updated by the data in the upload. If the patient record is subsequently uploaded with modified information (i.e., a known value has been modified to another known value), the patient record will not be updated.

If a remote site performs duplicate patient maintenance and merges patient records together, the patient\_id number for one of the patient records is Alost@ while the other patient\_id number is

retained. If both remote records had already been uploaded prior to the merge, then merging locally and then updating will have the following effect on the central office database:

- The remote record that was deleted (tossed) will be deleted out of the central office UpdLink file, thus indicating to the central office system that the record no longer exists at the remote site. Also, any records in Remote.dbf for that patient from that site would also be deleted. However, the patient record that is in the central Patient.dbf will remain, mainly due to the fact that the upload doesn't know whether additional events have been linked to that record at the central site and hence it can't just blindly delete it just because the remote site did.
- The remote patient record that was kept during the merge will have a whole new history written out in Remote.dbf, a history that now includes records that formerly belonged to the tossed patient.
- If the matching patient record in the central Patient.dbf has certain fields entered as unknown (like race and sex) and the remote patient record that was kept has known values for these fields, then the central office patient record will be updated with the known values.

If only one of these patient records had already been uploaded, it may change its patient\_id number during the merge process. If this occurs, the same patient record will be uploaded again with a new patient\_id number. In this case, a new patient record for the same patient will be created in the Central system. *Example: remote patient #001 is created; upload to central; remote patient #008 created; patient records #001 and #008 are merged, with patient #001 being discarded; upload to central (upload includes new patient #008 and deleted patient #001); central import - #008 gets added as new patient, #001 gets deleted from updlink.dbf and has all related records in Remote.dbf deleted, but remains in central patient registry; central patient registry now contains # 001 and #008.* This problem can be addressed by routine duplicate patient maintenance performed at the Central level after each import in upload format.

Once data is imported it can be used by the system in generating reports and can be exported (in other formats) through ASystem Utilities, Export Data.@ (Uploaded data cannot be exported in upload format again.) See page 10 for a list of STD\*MIS 'canned' reports which include uploaded data.

### Viewing uploaded data

As mentioned previously, there are two ways of viewing uploaded data within STD\*MIS. The easiest method of viewing this data can be accessed through AData Entry, Patient Registry, Events, Uploaded Records.@ As with any other area within Patient Registry, a record search for the patient can be done at this point. However, the information that can be viewed is a condensed version of the event listed. This is the data stored in remote.dbf. Below is a list of what can be viewed in the different record records in the event of Uploaded Records:

Congenital syphilis (2 Records per case)	Record 1 (mother=s) report date, baby=s name, vital*, classification** Record 2 (baby=s) report date, mother=s name, vital*, classification**
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Field record	Initiation date, disease, worker #, referral basis, disposition, dispo date, diagnosis, county
Interview record	Assigned date, diagnosis, worker number, interviewed, closure date, county
Morbidity	Diagnosis date, diagnosis, PID, county, district, provider, report date
Rx (Treatment)	Treatment date, treatment, provider
Test	Date of collection, provider, test type, site of collection, quantitative result, qualitative result
Visit	Date of visit, clinic (provider), (provider) type, reason, county, district

\*Vital - 1 = Alive

2 = Born alive, then died

3 = Still born

9 = Unknown

\*\*Class - 1 = Not a case

2 = Confirmed case

3 = Syphilitic stillborn

4 = Presumptive case

Each event is preceded by the Site Code of the remote area that uploaded the information.

**BROWSE UPLOADED RECORDS**

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**PATIENT'S UPLOADED HISTORY**

**Patient:** DANGEROUS, JOHNNIE      **DOB:** / /      **Age:** 33  
**Sex:** 1      **Race:** 7      **Local race:**      **Other sites:** 01  
**Address:**      **Phone:**

UPLOADED FIELD RECORDS						
Site	Init Dt	Disease	Worker	Ref. Basis	Dispo	Dispo Dt
01	06/03/2004	900	007	S3		/ /

Press <Esc> to exit.

History, risk, signs, and symptoms are not viewable records in this fashion. The commonality of these records is that they can not stand on their own as the other records can. These events are contingent on the others.

The second, and more complicated, method of viewing uploaded data can be accessed through ASystem Utilities, View Uploaded Data.@ However, once the user chooses one of the six events to view, the user will need to know the Record id in order to locate a particular record. The record

id=s needed to perform a search are as follows:

Congenital Syphilis	CS_ID
Field Records,	FR_ID
Interview Records,	IX_ID
Lab Tests	TEST_ID
Morbidity Files	MORB_ID
Visits to Clinic	VISIT_ID

These are system-generated id numbers. The next task is to find the appropriate id for the desired record. Using AUtilities, Access EpiInfo programs, Analysis,@ the user can follow the steps listed below as needed. This is not the only method of identifying the required id number, and may not be the easiest method of accessing the data.

**Congenital Syphilis:**

```
READ CSUPLD.DBF <ENTER>
SELECT CASEID = AXXXXXXXXXX@
<ENTER>
LIST CS_ID <ENTER>
```

**Lab Test\***

```
READ TESTUPLD.DBF <ENTER>
SELECT PATIENT_ID=@XXXXXXXXXX@
<ENTER>
LIST TEST_ID COLLECT_DT TEST_DISEA
<ENTER>
```

**Field Records**

```
READ FRUPLD.DBF <ENTER>
SELECT FR_NO = AXXXXXXXXXX@
<ENTER>
LIST FR_ID <ENTER>
```

**Morbidity Files\***

```
READ MORBUPLD.DBF <ENTER>
SELECT PATIENT_ID=@XXXXXXXXXX@
<ENTER>
LIST MORB_ID DX_DATE DIAGNOSIS
<ENTER>
```

**Interview Record**

```
Read IRUPLD.DBF <ENTER>
SELECT CASE_NO = AXXXXXXXXXX@
<ENTER>
LIST IX_ID <ENTER>
```

**Visits To Clinic\***

```
READ VISUPLD.DBF <ENTER>
SELECT PATIENT_ID=@XXXXXXXXXX@
<ENTER>
LIST VISIT_ID VISIT_DT CLINIC <ENTER>
```

\*The remote area patient\_id must be known and there may need to be some evaluation of the output to determine which id is the correct id for the particular search.

AXXXXXXXXXX@ is the actual variable information, i.e. the field record number of the desired field record or the case id (caseid) number from the congenital syphilis case.

Users may also note that once in Analysis they may list or view the data found through the select statements as opposed to going AView Uploaded Records.@ It should also be noted that though there is more information available than the line listing in the patient registry concerning uploaded records, the related information, such as risk factors, signs, symptoms, and history, are still not available. The linked information can be related by exporting the data through AUtilities, Export Data, Analysis format.@ The resulting DBF can be read then related through event\_id to either risk factors, signs, symptoms, and/or history as desired.

Uploaded records are available for use in reports. The following STD\*MIS ‘canned’ reports **DO** include uploaded records:

- Congenital Syphilis by Age Group & Race
- Congenital Syphilis by Month or Quarter
- All Morbidity Reports
- Infected FR's Without Morbidity
- Morbidity Listing
- Provider Diagnosis to Treatment Time Frame
- Interview Record List
- Pregnancy Status Report for Interview Records
- Open Field Records
- Open Interview Records
- View Open Interview Records
- Case Management
- Field Investigation Workload
- Field Investigation Outcomes
- Program Indicators
- Worker Interview Activity
- Field Record Investigation Outcomes by Priority

The following ‘canned’ STD\*MIS reports **DO NOT** include uploaded records:

- Clinic Visit Statistics
- Lab/Provider Reporting Time Frames
- Syphilis Reactor Grid Evaluation Report
- Test Results by Test Type
- Summary of Laboratory Reporting for STD's
- Syphilis Reactor Report
- Duplicate Morbidity
- Interview Records Without Morbidity
- Morbidity Missing lab and/or Treatment
- No. Records Entered by USER\_ID
- Patients With Multiple Morbidity
- Positive Labs w/o Morbidity
- Patients with Multiple Interviews

- Patients with Multiple Morbidity
- Open OoJ Log
- Open OoJ Field Records
- Pending Morbidity
- Open Surveillance Log

Additionally, the seekkeys and checkkeys reports (Check for Blanks and Duplicates and Referential Integrity Report), located under Maintenance, System Checks, Database QA Reports, do not currently check the upload databases. It is incumbent upon the remote site to perform system maintenance prior to creating an export in upload format in order to avoid transmitting errors to the Central Office.