



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Management Reports User Manual

Version 2.0 Patch 2
March 2010

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

Preface

The richness of the Patient Care Component (PCC) database, as well as the functional need for retrieving data in an organized manner for administrative and clinical management purposes, led to the development of the PCC Management Reports module. The options available in this module allow users to quickly and easily generate reports containing the data they need from the PCC.

PCC Management Reports provides numerous reports for patient and program management. This module facilitates the retrieval of data from the PCC by offering the user predefined report options as well as tools for custom-report generation. Users specify the parameters for each of the reports in order to retrieve the data of interest. Reports are organized by category on the main menu for ease of use.

This manual has been written for Resource and Patient Management System users who will utilize the PCC Management Reports module and other data retrieval tools for clinical and administrative functions. Separate installation and technical manuals for this module are available for Information Resources Management personnel responsible for installing and maintaining this module.

Table of Contents

1.0	Introduction.....	1
2.0	Release Notes	2
2.1	Designated Provider Specialty Management (BDP)	2
2.2	PCC Data Entry (APCD).....	2
2.2.1	Mnemonics: New	2
2.2.2	Exams: New	2
2.2.3	Measurements: New.....	3
2.2.4	Measurements: Modified	3
2.2.5	Health Factors: New	3
2.2.6	Site Parameters: New.....	3
2.2.7	Family History.....	3
2.2.8	Treatment Plan	3
2.2.9	Other	3
2.3	PCC Health Summary (APCH)	4
2.3.1	Health Summary Components: New	4
2.3.2	Health Summary Components: Modified	4
2.3.3	Health Maintenance Reminders: New	4
2.3.4	Health Maintenance Reminders: Modified.....	5
2.3.5	Reports: New.....	5
2.3.6	Best Practice Prompts: New	5
2.3.7	Health Summary Supplement: New.....	5
2.3.8	Patient Wellness Handout: Modified.....	6
2.3.9	Asthma Action Plan: Modified.....	6
2.3.10	Site Parameters: New.....	6
2.4	PCC Management Reports (APCL)	6
2.4.1	Reports: New.....	6
2.4.2	Reports: Modified	6
2.4.3	PGEN/VGEN	7
2.4.4	QMAN (AMQQ)	7
2.4.5	Other	8
3.0	PCC Management Reports Menu	9
3.1	Queuing Output	10
3.2	DEMO/TEST Patients.....	10
4.0	Patient Listings (PLST)	11
4.1	Living Patients by Community of Residence (*) (CRS).....	11
4.2	Living Patients by Date of Birth (*) (DOB).....	13
4.3	Living Patients by Multiple Demographic Variables (DEM).....	14
4.3.1	Estimated Run Time	15
4.4	Deceased Patients by Date of Death (DOD)	15
4.5	Patient General Retrieval (PGEN)	17
4.6	Patient Listing by Primary Care Provider (DP).....	23

4.7	Patients by Primary Care Provider with Visit Counts (VDP)	23
4.8	Detailed Patient Register R-DMG-510 (DMG)	24
4.9	Deceased Patients Listing (DPL)	27
4.10	Tally of Elder Patients with Functional Assessment (ELFA)	28
4.11	Tally of Elder Care Functional Status Change (ELFC)	29
4.12	Tally of Elder Care Data Items (ELFT).....	30
4.13	Elder Patients with Needs Help or Dependent Assessments (ELNH).....	31
4.14	Infant Feeding Statistical Reports (IF)	31
4.14.1	Birth and Six-Month Breastfeeding Statistics (IF1)	31
4.14.2	Breastfeeding Statistics by Age Group (IF2)	32
4.15	Prescription Cost Report (PCR).....	33
4.16	Tally of Patient Internet Access (PINT).....	33
4.17	Screening Reports (IPV/DV, Alcohol, Depression) (SCR)	34
4.18	Suicide Form Data Reports (SUIC).....	39
4.19	Patients with Total Household Income/ in Household (THI).....	40
4.20	Upload Patients from Text File to Search Template (UPLP).....	40
5.0	Resource Allocation/Workload Reports (RES)	42
5.1	Estimated Run Time	42
5.2	Operations Summary for a Service Unit or Facility (OPS)	42
5.2.1	Operations Summary (OS)	43
5.2.2	List PCC Operations Summary Sections (SECT)	47
5.2.3	Create/Edit Operations Summary Type (TYPE)	47
5.2.4	Display an Operations Summary Type (DISP)	47
5.3	Registered Patients and Visits Report Types	47
5.4	Registered Patients by Age, Sex, Tribe, Community (AGE)	49
5.5	Active Patient Count Report Types.....	49
5.6	Community Health Profile Summary (CH)	50
5.7	Clinic Hourly Workload Report (CHWL).....	52
5.8	Inpatient Discharges/Days by Community (INPC)	54
5.9	Inpatient Discharges/Days by SU of Residence (INPS).....	55
5.10	Inpatient Discharges/Days by Tribe (INPT)	56
5.11	Provider Practice Description Report (PPDS).....	57
5.12	Inpatient Reports (INPT).....	59
5.13	Hospital Discharges by Month of Discharge (2A) (HDM).....	59
5.14	Hospital Discharge Listing by Date (HDD).....	60
5.14.1	Estimated Run Time	60
5.15	Hospital Discharge Listing by DX or Procedure (IICD)	60
5.15.1	Estimated Run Time	61
5.16	Hospital Discharge by Taxonomy (Template/Create) (HDT)	62
5.17	Admissions from the ER (ADER).....	62
6.0	Quality Assurance Reports (QA).....	64
6.1	Anticoagulation INR Management Report (AC)	64
6.2	Random Sample of Visits by DX and Date (AUD)	65

6.2.1	Estimated Run Time	68
6.3	Listing of Visits by Clinic Type and by Diagnosis (CICD).....	68
6.3.1	Estimated Run Time	70
6.4	Hospital Discharge Listing by Diagnosis or Procedure (INPT).....	70
6.5	Listing of Outpatient Visits with ICD Codes (VICD).....	71
6.6	Returns to ER within 72 Hours after Clinic Visit (A)	73
6.7	Listing of Clinic Visits with ADA Codes (ADA)	74
6.8	Clinic Visit Counts by Clinic Type by Zip Code (CZIP).....	76
6.9	Clinic Visit Counts within a Date Range (CVC).....	77
6.10	Patients with At Least N Visits (NVST)	78
6.11	Listing of Visits with Injury Diagnosis (INJ)	81
6.12	Injury Visit E-Code Summary Report (INJS).....	82
6.13	Provider Visit Counts (PVC)	85
6.13.1	Estimated Run Time	87
6.14	Provider or Clinic Visit Counts by Template of Patients (PVCT) ..	87
6.15	Visit General Retrieval (VGEN)	88
6.16	In/Out Control Blood Pressures (BPC)	94
6.17	Delete VGEN/PGEN Report Definition (DEL)	95
6.18	Readmissions within 30 Days of a Discharge (RADM)	96
6.19	Listing of Patient Refusals (REF).....	97
6.20	Returns to Clinic w/in 72 Hours of a Clinic Visit (RT1).....	98
6.21	Display Single Visit for a Patient (VST).....	99
6.21.1	Display Data for Patient's Last Visit to a Clinic (LCV).....	100
6.21.2	Display Data for a Patient's Last Visit (LVST).....	101
7.0	Diabetes Program QA Audit (DM)	102
7.1	Demographic Data.....	103
7.2	Clinical Data	103
7.2.1	Tobacco Use	103
7.2.2	Date of Onset of Diabetes from CMS/Problem List	104
7.2.3	Date of Earliest Diabetes Diagnosis from PCC.....	104
7.2.4	Height	104
7.2.5	Weight	104
7.2.6	BMI	104
7.2.7	Weight, Blood Pressure, and Blood Sugar Recorded 75% of Visits.....	104
7.2.8	Last Three Blood Pressures and Last Three Blood Sugars.....	105
7.2.9	HTN Documented.....	105
7.2.10	Last Hgb A1c/GHb.....	105
7.3	Examinations	105
7.4	Education.....	106
7.5	Therapy	106
7.5.1	Use of Ace Inhibitor	106
7.6	Immunizations	106
7.7	Laboratory Data	107
7.8	Program Audit Submenus.....	107

7.9	Audit Reports.....	108
7.10	Generating a Patient Cohort for the Audit Report.....	110
7.10.1	Using Your Entire DM Register as Your Audit Cohort.....	110
7.10.2	Generating a Random Sample as Your Audit Cohort.....	113
7.10.3	Generating an Audit Sample When a Diabetes Register Has Not Been Established.....	117
7.11	Display Audit Logic (DAL).....	117
7.12	Patients with No Diagnosis of DM on Problem List (NDOO).....	119
7.13	List Patients on a Register with an Appointment (APCL).....	120
7.14	DM Register Patients and Select Values in Four Months (DMV).....	121
7.15	Display a Patient's Diabetes Care Summary (DPCS).....	122
7.16	Print Health Summary for DM Patients with Appointment (HSRG).....	123
7.17	Self Monitoring of Blood Glucose Follow-Up Report (SMBG)....	125
8.0	Active Patient Count Reports (APC).....	127
8.1	PCC-Ambulatory Patient Care Report 1A (A1).....	129
8.2	APC Visit Counts by Date of Visit (DATE).....	131
8.3	APC Visit Counts by Clinic Type (CLN).....	132
8.4	APC Visit Counts by Provider Discipline (DISC).....	133
8.5	APC Visit Counts by Individual Provider (APRV).....	134
8.6	APC Visit Counts by Location of Service (LOC).....	135
8.7	PCC-Ambulatory 1 Report for Multiple Facilities (A1M).....	136
8.8	Average Number of Visits by Day of Week and Clinic (AVCL) ..	138
8.9	Average Number of Visits by Day/Clinic ALL Service (AVCS)...	140
8.10	Average Number of APC Visits per Day (AVD).....	141
8.11	Calendar Year First and Revisit Summary (CYV).....	142
8.12	List APC-1A Visits Not Exported (NOEX).....	143
9.0	Ambulatory Visit Counts (PCCV).....	145
9.1	Visit Counts by Date of Visit (DATE).....	146
9.2	Visit Counts by Clinic Type (CLIN).....	147
9.3	Visit Counts by Provider Discipline (DISC).....	149
9.4	Visit Counts by Provider (PROV).....	150
9.5	Visit Counts by Primary Diagnosis (ICD) (DX).....	152
9.6	Visit Counts by Location of Service (LOC).....	154
9.7	Visit Counts by Service Category (SC).....	155
9.8	PCC Visits (by Provider Discipline) PCC Report AA (AA).....	156
9.9	All Visits by Provider or Provider Discipline (ALL).....	158
9.10	Tally of Walk-In/Appointment Clinic Visits (APPT).....	159
9.11	California State Annual Utilization Report (CSAR).....	161
9.12	PCC Data Analysis Report (DAR).....	162
9.13	General/Dental Clinic Visits on the Same Day (GCDC).....	163
9.14	Listing of Incomplete Laboratory, Rx or Rad Visits (INCV).....	164
9.15	Primary Provider Visits – Daily/Annual Report (PPD).....	165

9.16	Primary Care Provider Visits – Monthly Report (PPM)	167
9.17	Tally of Selected Provider Disciplines by Clinics (TPC)	168
9.18	Wait Times by Clinic and Provider (WAIT).....	171
10.0	Billing Reports (BILL).....	173
10.1	Listing of Active Medicare Part A Enrollees (MCA).....	173
10.2	Listing of Active Medicare Part B Enrollees (MCB).....	174
10.3	Listing of Active Medicaid Enrollees (MCD)	175
10.4	Listing of Active Private Insurance Enrollees (PI)	175
10.5	Listing of Commissioned Officers and Dependents (CO)	176
10.6	Listing of Potentially Billable Visits by Date (VIS)	176
10.7	Visits by Commissioned Officers and Dependents (COV)	178
10.8	List of Selected Third Party Coverage(s) (TPR)	179
11.0	Activity Reports by Discipline Group (ACT).....	181
11.1	Time and Patient Services by Provider (TSPR).....	182
11.2	Time and Patient Services by Service Unit (TSSU).....	183
11.3	Primary Problem by Provider (PPPR).....	184
11.4	Primary Problem by Facility (PPLO)	184
11.5	Primary Problem by Service Unit (PPSU).....	185
11.6	Number of Individuals Seen by Provider (INPR).....	186
11.7	Number of Individuals Seen by Service Unit (INSU).....	186
11.8	Patient Services by Age and Sex (AGE).....	187
11.9	Top Ten Primary Diagnoses (TEN).....	189
11.10	Create new Activity Discipline Group (CAG).....	190
11.11	Inquire into an Activity Group (INQA).....	190
11.12	Time and Services by Provider for Chart Reviews (TSCR)	191
12.0	Dx and Procedure Count Summary Report (CNTX).....	192
12.1	CPT Code by Provider Report (CPTP)	192
12.2	Diagnoses by AGE Report (DXAG)	194
12.3	DX Tally by Local, Secondary, Tertiary Facility (DXFA).....	196
12.4	Frequency of Procedures Report (FPRC).....	196
12.5	Purpose of Visits Group by APC Codes (PAPC)	198
12.6	RX Data Analysis Report (RXDA).....	199
12.7	Frequency of Diagnoses Report (TEN).....	201
12.8	Tally of Operating Provider for Procedures (TOP)	204
13.0	Immunization Reports (IMM).....	206
13.1	Adult Immunization Needs (AIN)	206
13.2	Kids Not on Immunization Register (KNIR).....	207
14.0	Q-Man (PCC Query Utility) (QMAN).....	209
15.0	Delimited Output Reports (DELR)	211
16.0	Health Summary Displaying CMS Register(s) (CHS).....	212
17.0	Custom Letter Management (CLM)	213

18.0	Browse Health Summary (BHS)	214
19.0	Other PCC Management Reports/Options (OTH)	215
19.1	Report Template Utility (RT)	215
19.2	PCC Patient Data Retrieval Utility (DR)	215
19.2.1	Script Creation.....	215
19.3	Delete VGEN/PGEN Report Definition (RDD)	218
20.0	FileMan (General) (FM)	219
21.0	Search Template System (STS)	220
22.0	Appendix A: Statistical Database Record Definition	221
23.0	Appendix B: PGEN/VGEN Options	229
24.0	Appendix C: RPMS Rules of Behavior	243
24.1	All RPMS Users	243
24.1.1	Access.....	243
24.1.2	Logging On To the System	243
24.1.3	Information Accessibility	244
24.1.4	Accountability	244
24.1.5	Confidentiality	245
24.1.6	Integrity.....	245
24.1.7	Passwords.....	246
24.1.8	Backups.....	246
24.1.9	Reporting.....	247
24.1.10	Session Time-Outs	247
24.1.11	Hardware	247
24.1.12	Awareness.....	247
24.1.13	Remote Access	248
24.2	RPMS Developers	248
24.3	Privileged Users.....	249
25.0	Glossary	252
26.0	Contact Information	259

1.0 Introduction

The Patient Care Component (PCC) database is the central repository for data in the Resource and Patient Management System (RPMS).

The following RPMS components comprise the PCC suite:

- IHS Dictionaries (AUPN)
- Standard Tables
- PCC Health Summary, including Health Maintenance Reminders (APCH)
- PCC Data Entry (APCD)
- PCC Management Reports, including PGEN/VGEN (APCL)
- Designated Specialty Provider Management (DP)
- Q-Man (Query Manager) (AMQQ)
- Taxonomy Management (ATX)

The PCC Management Reports Module provides numerous reports for patient and program management. Access to the PCC Management Reports menus is restricted to authorized individuals and is controlled by the facility local Site Manager through the use of security keys (code words assigned to the user that allow access to a menu).

This manual provides detailed information on the use of the PCC Management Reports menus. All users should take the time to read through this guide prior to using PCC Management Reports. This manual contains special information about the report options available and includes a sample of each report.

Many of these reports can be printed instantaneously; however, some will take a considerable amount of time to generate. Notes on run time are included for reports that require longer processing times. These printouts can be queued to specific devices so that printing can occur after regular business hours.

2.0 Release Notes

BJPC Version 2.0 Patch 2 contains the following modifications and enhancements. The identification number listed in the parentheses (e.g., CR274) refers to the specific change request (CR) requirement.

2.1 Designated Provider Specialty Management (BDP)

The following modification applies to the BDP application:

- Changed reports HX, CLST and UPDT to not list patients who are inactive. (CR096)

2.2 PCC Data Entry (APCD)

The following changes apply to the APCD application.

General Modifications

- Modified the ICD Diagnosis, ICD Operation and CPT screens for inactive/active codes to use the discharge date for an inpatient encounter rather than the visit date. (CR217)
- Modified the Visit Display to display the Note Retracted date if it exists for the Note. (CR183)
- Modified the Quantity field in V CPT to allow up to 999. (CR137)
- Added a new option to the coding queue list of actions and to the Enter Data menu that allows the operator to re-sequence the Purpose of Visits on a visit. (CR159)

2.2.1 Mnemonics: New

- FI24 – 24-hour fluid intake (CR071)
- FO24 – 24-hour fluid outtake (CR071)
- FBPN – 24-hour fluid balance, positive/negative (CR071)
- NRS – Nutritional Risk Screening (CR272)
- ACTH – Anticoagulation Therapy (CR139)

2.2.2 Exams: New

- Newborn Hearing Screen (Right) (CR064)
- Newborn Hearing Screen (Left) (CR064)

- Color Blindness (CR256)

2.2.3 Measurements: New

- 24-hour fluid intake: FI24 (CR071)
- 24-hour fluid outtake: FO24 (CR071)
- 24-hour fluid balance, positive/negative: FBPN (CR071)

2.2.4 Measurements: Modified

- The Birth Measurement KG weight value displays four decimal digits. (CR060)

2.2.5 Health Factors: New

- The Confidence in Managing Health Problems category has four options: Very Sure, Somewhat Sure, Not Very Sure, and I Do Not Have Any Health Problems.

2.2.6 Site Parameters: New

- Site parameter allows site to exclude inactive patients from the patient lookup in PCC Data Entry. Message warns user of having selected a patient with an inactive chart.

2.2.7 Family History

- Family History does not allow a duplicate relation to be entered. (CR286)

2.2.8 Treatment Plan

- A patient Treatment Plan may be entered from the UPD Update Patient Related/Non Visit Data menu. Use the option TP Update Patient Treatment Plan. From this option, a user may add, edit, display, or delete a plan; enter a review, discontinue a plan, or quit. The Treatment Plan captures the following information: Type (Behavioral Health, Other, or Pain), Responsible Provider, Date Initiated, Diagnosis, Review Date, Reviewed By, Review Comment, Date Discontinued, Discontinued By, Duration, Team Members, Patient Strengths, Area of focus, Goal; Objective, Comment, Next review, Reason Discontinued, and Discontinued Comment.

2.2.9 Other

- Modified the ICD Diagnosis, ICD Operation and CPT screens for inactive/active codes to use the discharge date for an inpatient encounter rather than the visit date. (CR217)

- Modified the Visit Display to display the Note Retracted date if it exists for the Note. (CR183)
- Modified the Family History entry to not allow a duplicate relation to be entered. (CR286)
- Modified the Quantity field in V CPT to allow up to 999. (CR137)

2.3 PCC Health Summary (APCH)

The following modification applies to the APCH application:

2.3.1 Health Summary Components: New

- Nutritional Risk Screening: Displays the last 3 nutritional risk screening exams. (CR272)
- Medication Reconciliation (CR110)

Note: This component relies on the Status field of the prescription file to group medications for display. This component will not work well for sites that are not running the IHS Pharmacy system.

- Demographics – Brief w/ Adv Directives: Displays the patient's name, DOB, SSN, Age, Sex, Tribe, HRN, Address, Phone, Work Phone, Eligibility, and latest Advance Directives information. (CR205)
- Active Wait List Entries: Displays all wait list entries for the patient. Wait list entries are entered through the scheduling and ADT system when a patient is waiting to get into a clinic or ward. (CR185)
- Imaging: Displays the imaging data from the radiology package. (CR084)

2.3.2 Health Summary Components: Modified

- Coverage Type to the Private Insurance displays in the Insurance component. (CR038)

2.3.3 Health Maintenance Reminders: New

- Chlamydia Screening: Due once between the ages of 16-25. The site must attach this reminder to any summary type on which it should display. (CR104)
- HIV Screening: Due once between the ages of 13-64 for patients without a history of HIV/AIDS. The site must attach this reminder to any summary type on which it should display. (CR178)

- Newborn Hearing Screen: This reminder will prompt until the age of one or the screening exams are documented. (Child393)

2.3.4 Health Maintenance Reminders: Modified

- For all reminders, removed the text “MAY BE DUE NOW,” and replaced it with the date the item was first due. (CR175)
- Pediatric Hearing Exam reminder includes more CPT codes and diagnosis codes. It does not count any hearing test before age three. (Child429)
- Changed the Rubella Health Maintenance Reminder to a Best Practice Prompt. (CR180)
- The two Colorectal Cancer screening reminders stop at age 75. (CR237)

2.3.5 Reports: New

- Added a new report under the Health Maintenance Reminders menu to list reminders by status: LHMR – List Health Maintenance Reminders by Status. (CR100)

2.3.6 Best Practice Prompts: New

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

- Rubella (CR180)

When a patient is prescribed Warfarin in the Pharmacy package, the following six new anticoagulation-related Best Practice prompts are activated in the Health Summary (Child306):

- Anticoagulation: Anticoagulation Therapy End Date
- Anticoagulation: Duration of Anticoagulation Therapy
- Anticoagulation: INR Goal
- Anticoagulation: Safety Measure: Urinalysis
- Anticoagulation: Safety Measure: CBC
- Anticoagulation: Safety Measure: FOBT
- Added 41 CVD-related Best Practice Prompts (which are distributed with iCare but are now available on the Health Summary). (CR235)

2.3.7 Health Summary Supplement: New

- The new Anticoagulation Supplement displays in the Health Summary. (Child306)

2.3.8 Patient Wellness Handout: Modified

- The Medications component has been changed to only display Active prescriptions, prescriptions on Hold, and recently expired Chronic prescriptions. There are now two medication components that can be added to the wellness handout: Medications (Active Only) and Medications (Active and recently expired).

2.3.9 Asthma Action Plan: Modified

- The Asthma Action Plan (located in the Patient Wellness Handout menu structure) was updated so that Red and Yellow Zone instructions are stored and display as the default values in the subsequent entry. (CR239)

2.3.10 Site Parameters: New

- A new site parameter allows the site to specify how many lines of Remarks (Additional Patient Registration Information) will display in the Demographic component of the health summary. (CR162)
- A parameter was also added to define whether the first or last number of lines will display. This parameter was added because some sites append to the end of the word processing field, and other sites append to the top of the field. To set these parameters use menu patch: Health Summary Maintenance (HSM) - Update Health Summary Site parameters (HSSP).

2.4 PCC Management Reports (APCL)

The following changes apply to the APCL application.

2.4.1 Reports: New

- ACCL Auto Mark Visits as Reviewed/Complete by Clinic (CR098)
- VNR Tally/List of Visits not Reviewed in N Day (CR19)
- PRVL Provider Listing (CR090 and CR091)
- Anticoagulation INR Management Report: Helps assess the quality of anticoagulation services for a designated population at a facility during a specific month. The report population options are: Warfarin patients; anticoagulation clinic; search template; EHR personal list; and iCare panel. (Child304)

2.4.2 Reports: Modified

- TRV Tally of Reviewed/Completed Visits by Operator. Just one operator can run this report. (CR214)

- LIR List Unreviewed/Incomplete Visits. Option allows the user to select a set of visit service categories to include in the report. (CR119)
- Frequency of CPT Report: Modified the report to allow the user to select which CPT codes to include in the report. The user can select an individual code or taxonomy, or select all CPT codes. (CR215)
- Added Primary Care Provider to the delimited education output report. (CR233)
- Added a new option to the coding queue list of actions, and to the Enter Data menu that allows the operator to re-sequence the Purpose of Visits on a visit. (CR159)
- Modified all of five Depression Screening Reports under PLST-SCR-DEP to include the following as a depression screening exam: (CR207)
 - Depression Screening Exam (Exam code 36)
 - Measurements: PHQ2, PHQ9
 - Diagnoses V79.0, 14.1 (Behavioral Health Problem Code)
 - Education Topics: DEP-SCR
 - Refusal of exam code 36
- Modified all five Alcohol Screening Reports to include specific alcohol screening exams.

2.4.3 PGEN/VGEN

The following data elements have been added to PGEN/VGEN as search items:

- Total in Household (Child402)
- TIU Note Title (CR200)
- Measurements (Child417)
- Other Specialty Provider (Child420)
- VFC Eligibility (CR282)
- Active/Inactive Immunization Register Status (CR282)

The following data elements have been added to VGEN as search items:

- All CPTs (CR120)
- Chart Audit Status (CR120)

2.4.4 QMAN (AMQQ)

The following data elements have been added to QMAN as search items:

- All measurements (CR191/Child427)

- Last calculated BMI (Child428)
- Total Household Income (CR024)
- Number in Household (CR024)
- All Immunizations (CR085)

2.4.5 Other

- Added “only ones selected” logic to RX Ordering Provider and three Medication items. (CR188)
- Family history print items include relationship description if the relation is being printed. (Child430).

3.0 PCC Management Reports Menu

The PCC Management Reports menu, shown below, consists of several categories of reports from various PCC files. Each menu option represents a submenu that contains a number of reports within that category. Note that any menu option followed by an ellipses (...) contains a submenu.

```

*****
**   PCC Management Reports   **
*****
IHS PCC Suite Version 2.0

DEMO HOSPITAL

PLST Patient Listings ...
RES Resource Allocation/Workload Reports ...
INPT Inpatient Reports ...
QA   Quality Assurance Reports ...
DM   Diabetes QA Audit Menu ...
APC  APC Reports ...
PCCV PCC Ambulatory Visit Reports ...
BILL Billing Reports ...
BMI  Body Mass Index Reports ...
ACT  Activity Reports by Discipline Group ...
CNTS Dx & Procedure Count Summary Reports ...
IMM  Immunization Reports ...
QMAN Q-Man (PCC Query Utility)
DELR Delimited Output Reports ...
CHS  Health Summary Displaying CMS Register(s)
CLM  Custom letter Management ...
BHS  Browse Health Summary
OTH  Other PCC Management Reports/Options ...
FM   FileMan (General)...
STS  Search Template System ...

Select PCC Management Reports Option:

```

Figure 3-1: Example of PCC Management Reports menu screen

Extended help is available for most of the options. To access a help screen, type a question mark (?) and the label for the menu option for which the user requires help; for example, type **?PLST** to display a description of the Patient Listings option.

The following sections of this manual provide detailed information for each of the report categories shown above. The categories are presented in the order in which they appear on the report menu. A brief description of each submenu screen (for example, Patient Listings) is provided, followed by examples and descriptions of each report contained in that submenu.

3.1 Queuing Output

Do not run reports or retrievals requiring lengthy processing time during normal working hours, unless the user is operating an upgraded RISC 6000 CPU or is at a very small facility. Jobs that require lengthy processing times should be queued to run after business hours or on weekends. Throughout this manual, notations indicate which reports might have lengthy processing times. Please contact the local site manager with questions regarding report queuing.

To queue a job,

1. Type **Q** at the “Device” prompt and press Enter.
2. Then type an appropriate device number and press Enter.
3. Answer the question about when to print by typing an after-hours date and time, such as “T@6PM,” to have the job processed Today at 6:00 p.m.

3.2 DEMO/TEST Patients

All PCC Management reports have been updated to prompt the user whether to include their site’s DEMO/TEST patients in the report.

4.0 Patient Listings (PLST)

The PLST option in the PCC Management Reports menu takes the user to the Patient Listings menu. This set of reports allows the user to list groups of patients. The reports include patient listings by Date of Birth (DOB), Current Community, Date of Death (DOD), Sex, Eligibility, Classification/Beneficiary, and Tribe of Membership. In most cases, the report includes the patient's name, chart number, and DOB.

```

*****
**   PCC Management Reports   **
**   Patient Listings       **
*****
      IHS PCC Suite Version 2.0

      DEMO HOSPITAL

CRC   Living Patients by Community of Residence (*)
DOB   Living Patients by Date of Birth (*)
DEM   Living Patients by Multiple Demographic Variables
DOD   Deceased Patients by Date of Death (*)
PGEN  Patient General Retrieval
DP    Patient Listing by Primary Care Provider
VDP   Patients by Primary Care Provider w/ Visit Counts
DMG   Detailed Patient Register R-DMG-510
DPL   Deceased Patients Listing
ELFA  Tally of Elder Pt's with Functional Assessment
ELFC  Tally of Elder Care Functional Status Change
ELFT  Tally of Elder Care Data Items
ELNH  Elder Pts w/Needs Help or Dependent Assessments
IF    Infant Feeding Statistical Reports ...
PCR   Prescription Cost Report
PINT  Tally of Patient Internet Access
SCR   Screening Reports (IPV/DV, Alcohol, Depression) ...
SUIC  Suicide Form Data Reports ...
THI   Patients w/Total Household Income/ in Household
UPLP  Upload Patients from Text file to Search Template

Select Patient Listings Option:

```

Figure 4-1: Sample of PCC Management Reports patient listings screen

The asterisk (*) listed after an option denotes that report generation is instantaneous.

4.1 Living Patients by Community of Residence (*) (CRS)

The Community of Residence (CRS) report displays a list of living patients by community, along with their DOBs, sex, and tribes of membership.

1. At the “Your choice” prompt, type either **1** (Current Community) or **2** (Patient Name) to specify how to sort the report. One or both attributes can be used.

- If **1** (Current Community) is entered, the system displays the “Do you want to sort by a particular Current Community?” prompt. Type **Y** (Yes) or **N** (No).
 - If **Y** (Yes) is entered, the system displays the “Which Current Community” prompt. Specify the community.
 - The system displays the “Within Current Community, want to sort by another attribute” prompt. Type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, the system prompts for an attribute. The system lists attributes used to sort the report, and asks if the user wants to sort by a particular attribute (the name of the attribute displays in the prompt); type **Y** (Yes) or **N** (No).
 - If **2** (Patient Name) is entered, the system displays the “Do you want to sort by a particular Patient Name?” prompt. Type **Y** (Yes) or **N** (No).
 - If **Y** (Yes) is entered, the system displays the “Which Patient Name” prompt; type the patient name.
 - At the “Within Patient Name, Want To Sort By Another Attribute?” prompt; type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, the system prompts for an attribute. The system lists attributes that can be used to sort the report and asks if the user wants to sort by the particular attribute (the name of the attribute will show in the prompt); type **Y** (Yes) or **N** (No)
2. At the “Please enter a title for this report” prompt, type the title of the report, or press Enter to use the default.
 3. At the “Device” prompt, specify the device to print/display the report. Press ENTER to go to the next page of the report.

ACHI PATIENTS		JAN 25,1995 15:10	
PAGE 1			
NAME	DATE OF BIRTH	SEX	TRIBE OF MEMBERSHIP

CURRENT COMMUNITY: ACHI			
LAMBDA, MARY	JAN 1, 1925	FEMALE	TOHONO O'ODHAM NATIO
SIGMA, BILL	MAY 1, 1948	MALE	TOHONO O'ODHAM NATIO
OMEGA, THERESA	JAN 1, 1939	FEMALE	TOHONO O'ODHAM NATIO
OMICRON, DAVID	1890	MALE	TOHONO O'ODHAM NATIO
LAMBDA, BILL	MAR 1, 1962	MALE	TOHONO O'ODHAM NATIO
OMEGA, LISA	APR 1, 1963	FEMALE	TOHONO O'ODHAM NATIO
LAMBDA, IRMA	JUN 1, 1964	FEMALE	TOHONO O'ODHAM NATIO
PHIIII, BILL	MAR 1, 1964	MALE	PIMA
BETAA, SAM	MAR 1, 1928	MALE	NON-INDIAN BENEFICIA
PHIIII, JOHN	NOV 1, 1966	MALE	TOHONO O'ODHAM NATIO
BETAB, SAM	OCT 1, 1967	MALE	TOHONO O'ODHAM NATIO
THETA, LARRY	DEC 1, 1958	MALE	TOHONO O'ODHAM NATIO
THETA, THERESA	JUN 1, 1920	FEMALE	TOHONO O'ODHAM NATIO
BETAA, DENNIS	APR 1, 1940	MALE	TOHONO O'ODHAM NATIO

SUBCOUNT 14			

Figure 4-2: Example report listing patients by their community of residence

4.2 Living Patients by Date of Birth (*) (DOB)

The DOB report displays a list of all living patients by date of birth.

1. At the “Your choice” prompt, type either **1** (DOB) or **2** (Patient Name) to indicate how the report should be sorted. One or more attributes can be used.
 - If DOB was specified:
 - At the “Start with what date” prompt, type the beginning date of the date range.
 - At the “End with what date” prompt, type the ending date of the date range.
 - At the “Within DOB, want to sort by another attribute” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, the system prompts for the attribute.
 - If Patient Name was specified:
 - At the “Do you want to sort by a particular patient name?” prompt, type **Y** (Yes) or **N** (No).). If **Y** (Yes) is entered, the system prompts for the patient’s name.
 - At the “Within Patient Name, want to sort by another attribute?” prompt, type **Y** (Yes) or **N** (No).). If **Y** (Yes) is entered, the system prompts for the attribute.
2. At the “Please enter a title for this report” prompt, type the title of the report or press ENTER to use the default.
3. At the “Device” prompt, specify the device to print/display the report.

The following is a report listing patients by DOB.

PATIENT LISTING BY DATE OF BIRTH	JAN 26,1995 14:06	PAGE 1
NAME	DOB	CHART

LAMBDA, SARAH	JAN 1,1944	77467
LAMBDA, MARTIN	JAN 1,1944	99009
LAMBDA, THERESA	FEB 1,1944	98775
LAMBDA, JIM	FEB 1,1944	31382
RHOOOOOO, GEORGIE WAKEFIELD	FEB 22,1944	53466
LAMBDA, JAMES	MAR 5,1944	90774
CHIII, SUSIE	APR 8,1944	14495
GAMMA, DARLENE	MAY 1,1944	21087
SIGMAAA, SALLY ANN	MAY 14,1944	23545
OMEGA, THERESA	JUN 1,1944	94867
OMICRON, DIANE	JUL 1,1944	29574
COUNT 11		

Figure 4-3: Sample of report listing patients by their dates of birth

The following is a report listing patients by Patient Name:

PATIENT LISTING NAME	DATE OF BIRTH	JAN 20, 2009 CHART	11:52 PAGE 1
AABETA, LEA JO	09/05/1945	156368	
AABETA, MARVIN	08/05/1958	136531	
ABBETA, ADONNA LYNN	08/13/1925	130495	
ABBETA, AMANDA	06/08/1966	124730	
ABBETA, JAYDEN	09/28/1929	147347	
ABBETA, LOWERY	01/09/1997	151988	
ABBETA, ROBERT	11/17/1962	149480	

Figure 4-4: Example report by patient name

4.3 Living Patients by Multiple Demographic Variables (DEM)

The DEM report option produces the Demographic Information Report. This report can be sorted by one or more specified attributes.

- At the “Your choice” prompt, use one or more of the following attributes (mandatory) for sorting the report:
 - 1 – DOB
 - 2 – SEX
 - 3 - CURRENT COMMUNITY
 - 4 – TRIBE
 - 5 - CLASSIFICATION/BENEFICIARY
 - 6 – ELIGIBILITY
 - 7 - PATIENT NAME

If the user types **2, 4, 5, 6,** or **7**, additional prompts display.

- At the “Start with what date” prompt, type the beginning of the date range.
- At the “End with what date” prompt, type the ending of the date range.
- At the “Please enter a title for this report” prompt, type the title of the report, or press Enter to use the default.
- At the “Device” prompt, specify the device to print/display the report.

The following example report lists patients by community and date of birth.

PATIENT LISTING BY COMMUNITY AND BIRTHDATE				JAN 26, 1995 14:09
PAGE 1				
NAME	DOB	TRIBE OF MEMBERSHIP	COMMUNITY	
OMICRON, TANYA	08/15/35	TOHONO O'ODHAM NATIO	DEMO	
THETA, LILY	08/11/36	TOHONO O'ODHAM NATIO	DEMO	
GAMMA, SUSIE	04/08/44	TOHONO O'ODHAM NATIO	DEMO	
SIGMAA, ANDREW	01/01/47	TOHONO O'ODHAM NATIO	DEMO	
GARCIA, JOE FRANK	06/25/50	TOHONO O'ODHAM NATIO	DEMO	
GAMMAAAA, JUDY	10/31/52	NON-INDIAN BENEFICIA	DEMO	
NUUUUU, JERRY F	01/01/57	TOHONO O'ODHAM NATIO	DEMO	
NUU, LARRY	04/17/59	NAVAJO TRIBE OF AZ,	DEMO	
PIIIII, KAREN JEAN	03/04/63	DAKOTA (SIOUX)	DEMO	
RHOOOO, CAMERON ANTHONY	07/22/63	GILA RIVER PIMA MARI	DEMO	
BETA, JULIE PATRICIA	08/30/65	NON-INDIAN BENEFICIA	DEMO	
SIGMA, BOB	01/01/77	NON-INDIAN BENEFICIA	DEMO	

SUBCOUNT 13				

Figure 4-5: Example of report listing patients by demographic variables

4.3.1 Estimated Run Time

For facilities with numerous patient files, this report can take a long time to run unless the first sort variable selected is a specific current community. If a specific community was selected, the run time for the report will be a function of the size of that community and the number of other variables chosen for sorting. For example, a report sorting first by a small community and then by date of birth would run quickly. A report sorting first by a large community (over 1,000 patients) and then by tribe and date of birth would take a longer time.

4.4 Deceased Patients by Date of Death (DOD)

The DOD report lists deceased patients by Date of Death. The user can limit the range of dates or generate report for all patients with a DOD recorded. The user can optionally choose just one patient.

The report can be sorted by HRN, Terminal Digit HRN, Date of Death, Community, Tribe, or Patient Name.

1. At the “Which Date of Death range” prompt, type any of the following:

- A - All Patient with Date of Death Recorded
- D - A Range of Dates for DOD
- O - One Patient

If the user types **D** or **O**, additional prompts display.

2. At the “Sort Report by” prompt, type one of the following:
 - D - Date of Death
 - H – HRN
 - R - Terminal Digit HRN
 - C – Community
 - T – Tribe
 - N - Patient Name
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
4. At the “Device” prompt, specify the device to print/display the report.

The following report is for all patients with recorded DOD and sorted by patient name:

DEASEASED PATIENTS REPORT					
Date of Death: Jan 01, 1801 - Jan 20, 2009					
Patient Name	HRN	DOB	Age at DOD	Death	Tribe

SIGMAAAA, EDWIN	117204	11/25/1917	15	03/15/1933	DEMO
TRIBE, NM					
Underlying Cause of Death:					
Last Visit: 12/17/1932 DEMO INDIAN HOSPITAL - AMBULATORY					
Last Inpatient Visit:					
Community of Residence: BIG COVE					
GAMMAA, KENSEN WINTER	103600	07/07/1872	84	04/20/1957	DEMO
TRIBE, NM					
Underlying Cause of Death:					
Last Visit:					
Last Inpatient Visit: 05/19/1995 DEMO INDIAN HOSPITAL -					
HOSPITALIZATION					
Community of Residence: BIRDTOWN					
THETA AAAA, LINDA	100144	09/30/1896	69	06/15/1966	DEMO
TRIBE, NM					
Underlying Cause of Death:					
Last Visit:					
Last Inpatient Visit:					
Community of Residence: MURPHY					
Enter ENTER to continue or '^' to exit:					

Figure 4-6: Example report for DOD option

The cause of death will be displayed to the extent it has been entered through the ADT Inpatient or the PCC data entry process.

4.5 Patient General Retrieval (PGEN)

Use the PGEN option to type the PCC Patient General Retrieval.

This report lists or counts patients based on selection criteria entered by the user. There are three separate steps for this option: selection criteria must be identified, attributes to display for each patient must be chosen, and the sorting order for the list must be determined. The logic used to produce the report can be saved for future use. If a report is designed that is 80 characters or less in width, it can display on the screen or be printed. If the report is 81-132 characters wide, it must be printed, and only on a printer capable of producing 132 character lines. The patients in the report can be limited to pre-established Search Templates created in QMan, Case Management, or other RPMS tools.

An example of a Search Template of Patients would be if the template was created in Case Management or in QMan using Patients as the Search Subject.

When the list of items for selection, print, and sort display in list manager they can be sorted alphabetically or in a predefined order. The predefined order is set by the software and is how the list has historically been displayed.

1. At the “What order would you like the Items displayed” prompts, type one of the following:
 - P - Predefined Order (the original ordering)
 - A - Alphabetical Order
 - G - Groups of Related items

The predefined order is set by the software and is how the list has historically been displayed. See Section 23.0 for a complete listing of PGEN/VGEN selection, sort, and print options.

2. At the “Select Patient List from” prompt, type one of the following:
 - S - Search Template of Patients
 - P - Search All Patients
 - Q - Qman Search
 - R - CMS Register of Patients

To use a search template of patients, the system prompts for the name of the template. After typing the name of the template, a print item selection list displays. Select items to print by following the directions below.

If **P** is entered, the system searches all patients in the database, and provides the option of using report logic saved from a previous report generated with PGEN. To use previously saved report logic, type the name assigned to the report and press ENTER to run the report. If a new report is created, use the instructions that follow for selecting search criteria.

Choosing Q-Man Search transfers the user to Q-Man to create a search template. (Refer to the Q-Man user manuals for specific instructions on using Q-Man.) After creating the template, the user is returned to PGEN to select the type of report to be created.

Choosing the CMS Register of patients allows access to the case management system's register system.

3. At the "Do you want to use a previously defined report?" prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, additional prompts display.
4. The system displays the Patient Selection menu.

GENERAL RETRIEVAL	Jan 20, 2009 11:17:04	Page: 1 of 3
PATIENT Selection Menu		
<p>Patients can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all patients, hit Q.</p>		
1) Name/Chart /SSN STAGED DM	31) Medicaid Plan Name	61) Most Recent
2) Sex Recent Barriers H	32) Pvt Ins Plan Name	62) Most
3) Date of Birth Recent LEARNING P	33) Priv Ins Verified	63) Most
4) Birth Month Recent RUBELLA HF	34) HRN Record Status	64) Most
5) Birth Weight (grams) Alcohol Scree	35) HRN Disposition	65) Date Last
6) Birth Weight (Kgs) Depression S	36) Patient's Last Visit	66) Date Last
7) Race IPV/DV Scree	37) Desig Prim Care Prov	67) Date Last
8) Age Colonoscopy	38) User Updating PCP	68) Date Last
9) Age in Months Flex Sig	39) Date PCP Updated	69) Date Last
10) Veteran Status Y/N Mammogram	40) EDC	70) Date Last
11) Date of Death PAP Smear	41) Date EDC Determined	71) Date Last
12) Date Patient Establish Tobacco Scree	42) Contraception Method	72) Date Last
13) Mlg Address-State	43) EDC Determination	73) Date Last

```

Fall Risk As
14) Mlg Address-Zip          44) Last Menstrual Period  74) Date Last
Tonometry

+          Enter ?? for more actions
S   Select Item(s)      +   Next Screen      Q   Quit Item Selection
R   Remove Item(s)     -   Previous Screen  E   Exit Report
Select Action: S//

```

Figure 4-7: Options on the Patient Selection Menu

To choose the criteria for the report, type the number(s) of the criteria at the “Select Action” prompt and press Enter. An asterisk (*) indicates that an item has been selected. To select all visits, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

5. At the “Choose Type of Report” prompt, type one of the following:

- T - Total Count Only
- S - Subcounts and Total Count
- C - Cohort/Template Save
- D - Detailed Patient Listing
- L - Delimited Output File for use in Excel

The total count report prints only the total number of patients that match the selection criteria the user chose at the PATIENT Selection Menu.

The subcounts and total count report lists the total number of matches, as well as the subtotal of each different category of the sort variable selected; for example, if the report was sorted by sex, the number of males and the number of females in the group would be displayed in separate categories and subtotals.

The Cohort/Template Save option saves the patients that match the selection criteria in a template. Only the total number of matching patients is displayed. The template can be used to generate reports, and can be used to select the print and sort criteria needed each time.

The detailed patient listing allows a report to be created that prints only the data items to be sorted by the variable selected. If the detailed patient listing was selected, read the sections below for instructions on selecting the print items and sort category.

The Delimited Output File option allows a file to be generated for use in Microsoft Excel.

6. The system displays the Print Item Selection Menu.

```

GENERAL RETRIEVAL          Jan 20, 2009 12:43:14          Page: 1 of 3
                          PRINT ITEM SELECTION MENU

The following data items can be printed.  Choose the items in the
order you want them to appear on the printout.  Keep in mind that
you have an 80 column screen available, or a printer with either 80
or 132 column width.

1) Patient Name and Relation          38) Beneficiary Class          75) Family Hx
2) First, Last Name History Relation  39) Cause of Death            76) Family
3) Chart Narrative                    40) Medicare                  77) Family Hx
4) Terminal Digit Description         41) MEDICARE Y/N             78) Family Hx
5) SSN Surgery                        42) Medicare Part B          79) Hx of
6) Sex TOBACCO HF                    43) Medicare Part D          80) Most Recent
7) Date of Birth TB STATUS            44) Medicaid                 81) Most Recent
8) Birth Month ALCOHOL HF             45) MEDICAID Y/N            82) Most Recent
9) Birth Weight (grams) STAGED DM     46) Private Insurance        83) Most Recent
10) Birth Weight (Kgs) Barriers H     47) PRIVATE INSURANCE Y/N   84) Most Recent
11) Race LEARNING P                   48) Third Party Eligibilit  85) Most Recent
12) Age RUBELLA HF                    49) Medicaid Plan Name      86) Most Recent
13) Age in Months Alcohol Scre       50) Pvt Ins Plan Name       87) Date Last
14) Father's Name Depression S        51) Priv Ins Verified       88) Date Last

+          Enter ?? for more actions
S  Select Item(s)  +  Next Screen  Q  Quit Item Selection
R  Remove Item(s) -  Previous Screen E  Exit Report
Select Action: S//

```

Figure 4-8: Items in the Print Item Selection menu

7. Select the items to list on the report.
8. After selecting an item, the system prompts for the column width for the item (a default is shown). Press Enter to select the default or specify the width.
9. The system displays the Sort Item Selection menu.

```

GENERAL RETRIEVAL          Jan 20, 2009 13:15:53          Page: 1
of 2
                          SORT ITEM SELECTION MENU

```

The patients displayed can be SORTED by ONLY ONE of the following items. If you don't select a sort item, the report will be sorted by patient name.

1) Patient Name ALCOHOL HF	29) Cause of Death	57) Most Recent
2) First, Last Name STAGED DM	30) MEDICARE Y/N	58) Most Recent
3) Chart Barriers H	31) Medicare Part B	59) Most Recent
4) Terminal Digit LEARNING P	32) Medicare Part D	60) Most Recent
5) Sex RUBELLA HF	33) MEDICAID Y/N	61) Most Recent
6) Date of Birth Alcohol Scre	34) PRIVATE INSURANCE Y/N	62) Date Last
7) Birth Month Depression S	35) Any Third Party Covera	63) Date Last
8) Birth Weight (grams) IPV/DV Scree	36) Third Party Eligibilit	64) Date Last
9) Birth Weight (Kgs) Colonoscopy	37) Medicaid Plan Name	65) Date Last
10) Race Flex Sig	38) Pvt Ins Plan Name	66) Date Last
11) Age Mammogram	39) Pvt Ins Plan Type	67) Date Last
12) Age in Months Smear	40) HRN Record Status	68) Date Last PAP
13) Father's Name Tobacco Scre	41) HRN Disposition	69) Date Last
14) Mother's Name Fall Risk As	42) Patient's Last Visit	70) Date Last
+ Enter ?? for more actions		
S Select Item(s)	+ Next Screen	Q Quit Item Selection
R Remove Item(s)	- Previous Screen	E Exit Report
Select Action: S//		

Figure 4-9: Options on the SORT ITEM SELECTION MENU

10. Select one of the options listed on the SORT ITEM SELECTION MENU to specify how to sort patients. To sort patients by name, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.
11. At the “Do you want a separate page for each Patient Name” prompt, type **Y** (Yes) or **N** (No).
12. At the “Would you like a custom title for this report?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, the system prompts for the custom title.

13. At the “Do you wish to save this search/print/sort logic for future use?” prompt type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, the system prompts for a name.
14. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
15. At the “Select one of the following” prompt, type **P** to print the output or **B** to browse the output on the screen.

The system displays the Summary Page with the criteria selected for the report; for example,

PCC PATIENT LISTING			Page 1
NAME	DOB		WT (GMS)

ABETAAAAA, LAURA	02/07/1947		51.22
ABETAAAAA, MARGARET	12/08/1995		--
ABETAAAAA, MARIE	05/26/1957		88.78
ABETAAAAA, MARTHA AGN	10/10/1955		68.9
ABETAAAAA, MICHAEL	12/24/1973		--
ABETAAAAA, MICHAEL A	12/15/1983		93.94
ABETAAAAA, NATHANIEL	12/09/1994		--
ABETAAAAA, PEGGY	01/05/1945		--
ABETAAAAA, ROBERT	02/17/1995		--
ABETAAAAA, ROBIN D	04/06/1940		--
ABETAAAAA, SHERRENE	06/18/1961		--
ABETAAAAA, TRISTEN DW	07/29/1944		--
BETAA, JANET LOU	05/08/1965		99.29
BETAAAA, JAMES	04/25/1904		45.24
Enter RETURN to continue or '^' to exit:			

Figure 4-10: Example report for PGEN option

At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to quit the report.
- Type **+** (plus) to display the next screen. This option is not available for the last screen.
- Type **-** (minus) to display the previous screen. This option is not available for the first screen.

4.6 Patient Listing by Primary Care Provider (DP)

The DP report generates a list of patients for a specific primary care provider or for all primary care providers at the facility.

The following sample displays patients for all primary care providers. Note that the list of patients for each provider prints on a separate page.

DESIGNATED PROVIDER PATIENT LISTING APR 3,1996 10:41 AM PAGE 1				
CURRENT				
NAME	DOB	HRN	COMMUNITY	LAST VISIT

DESIGNATED PROVIDER: AOPROVIDER, CLAYTON				
THETA, ANNE	JAN 1, 1970	100001	BIRDTOWN	JAN 24, 1996
THETA, BETSY	MAR 5, 1941	100002	CLYDE	FEB 07, 1996
THETA, CARLA	SEP 8, 1920	100003	PAINTTOWN	JAN 25, 1996
THETA, DONNA	JAN 3, 1989	100004	BIDRTOWN	DEC 20, 1994

Figure 4-11: Example of report sorted by primary care provider

4.7 Patients by Primary Care Provider with Visit Counts (VDP)

The VP report produces a list of patients by primary care provider. It includes the patient's name, chart number, age, number of times seen by the primary care provider, number of times seen by other primary providers, and diagnoses.

The following sample displays all designated providers for the time period from October 1, 1993 to June 30, 1994. Note that the report for each provider prints on a separate page.

Page 1						
DEMO HOSPITAL/CLINIC						
PATIENTS BY DESIGNATED PROVIDER, WITH VISIT COUNTS						
DESIGNATED PROVIDER: SIGMA, JANE						
VISIT DATES: OCT 01, 1993 TO JUN 30, 1994						
PATIENT NAME	CHART	AGE	TIMES SEEN BY DP	OTHER PROVIDERS SEEN	ICD DIAGNOSES	

KAPPA, JAMES UNCOMPL/T-II/	100000	24	0	SMITH, JANE (1)	250.00 - DM	
KAPPA, LISA DIAGNOSIS	200000	61	1	SIGMA, JA (8)	.9999 - UNCODED	
				SIGMA, JA (17)	099.9 - VENEREAL DISEASE	
				SIGMA, JA (1)	250.00 - DM UNCOMPL/T-II/	
				SIGMA, JA (1)	293.82 - ORGANIC HALLUCIN	
				SIGMA, JA (1)	295.24 - CATATONIA-CHR/EX	

```

296.21 - DEPRESS PSYCHOSI
300.9 - NEUROTIC DISORDER
305.90 - DRUG ABUSE NEC/M
311. - DEPRESSIVE DISORDE
401.9 - HYPERTENSION NOS
465.9 - ACUTE URI NOS
719.40 - JOINT PAIN-UNSPE
RUN TIME (H.M.S): 0.0.03

```

Figure 4-12: Sample of report with visit counts

4.8 Detailed Patient Register R-DMG-510 (DMG)

Use the DMG option to search the Patient file for all patients selected. A report is created resembling the output from the R-DMG-510 report from the data center. The facility's chart number needs to be selected for this report.

Two additional screens display: The first screen prompts the user to search for a selected group of patients, and the second screen sorts the report output as desired.

To continue, type either **Y** (Yes) or **N** (No) at the "Select Action" prompt and press Enter. If **Y** (Yes) is entered, additional prompts display.

Follow these steps:

1. At the "Run report for patients registered at which Facility" prompt, type the name of the facility.

The system displays information about the facility and displays the General Retrieval window with the PATIENT Selection Menu.

```

GENERAL RETRIEVAL          Jan 20, 2009 11:17:04          Page: 1 of 3
                          PATIENT Selection Menu

Patients can be selected based upon any of the following items.
Select as many as you wish, in any order or combination.  An (*)
asterisk indicates items already selected.  To bypass screens and
select all patients hit Q.

1) Name/Chart /SSN          31) Medicaid Plan Name       61) Most Recent
STAGED DM
2) Sex                      32) Pvt Ins Plan Name       62) Most
Recent Barriers H
3) Date of Birth           33) Priv Ins Verified       63) Most
Recent LEARNING P
4) Birth Month             34) HRN Record Status      64) Most
Recent RUBELLA HF
5) Birth Weight (grams)    35) HRN Disposition         65) Date Last
Alcohol Scre
6) Birth Weight (Kgs)      36) Patient's Last Visit    66) Date Last
Depression S

```

```

7) Race                               37) Desig Prim Care Prov   67) Date Last
IPV/DV Scree
8) Age                               38) User Updating PCP     68) Date Last
Colonoscopy
9) Age in Months                     39) Date PCP Updated      69) Date Last
Flex Sig
10) Veteran Status Y/N              40) EDC                    70) Date Last
Mammogram
11) Date of Death                   41) Date EDC Determined   71) Date Last
PAP Smear
12) Date Patient Establish          42) Contraception Method  72) Date Last
Tobacco Scre
13) Mlg Address-State               43) EDC Determination     73) Date Last
Fall Risk As
14) Mlg Address-Zip                44) Last Menstrual Period 74) Date Last
Tonometry
+          Enter ?? for more actions

S      Select Item(s)  +      Next Screen      Q      Quit Item Selection
R      Remove Item(s) -      Previous Screen  E      Exit Report
Select Action: S//

```

Figure 4-13: Options in the Patient Selection menu

- Criteria can be listed in any order at the “Select Action” prompt. To choose criteria on the report, type the number(s) of the criteria at the “Select Action” prompt and press Enter. An asterisk (*) indicates that an item has been selected. To select all visits, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

The system displays the GENERAL RETRIEVAL screen for the SORT ITEM SELECTION MENU.

```

GENERAL RETRIEVAL           Jan 20, 2009 11:27:56   Page:    1 of 2

                          SORT ITEM SELECTION MENU

The patients displayed can be SORTED by ONLY ONE of the following
items. If you don't select a sort item, the report will be sorted by
patient name.

1) Patient Name              29) Cause of Death        57) Most Recent
ALCOHOL HF
2) First, Last Name         30) MEDICARE Y/N          58) Most Recent
STAGED DM
3) Chart                    31) Medicare Part B      59) Most Recent
Barriers H
4) Terminal Digit          32) Medicare Part D      60) Most Recent
LEARNING P
5) Sex                      33) MEDICAID Y/N         61) Most Recent
RUBELLA HF
6) Date of Birth            34) PRIVATE INSURANCE Y/N 62) Date Last

```

```

Alcohol Scre
7) Birth Month           35) Any Third Party Covera 63) Date Last
Depression S
8) Birth Weight (grams) 36) Third Party Eligibilit 64) Date Last
IPV/DV Scree
9) Birth Weight (Kgs)   37) Medicaid Plan Name     65) Date Last
Colonoscopy
10) Race                38) Pvt Ins Plan Name       66) Date Last
Flex Sig
11) Age                 39) Pvt Ins Plan Type       67) Date Last
Mammogram
12) Age in Months      40) HRN Record Status      68) Date Last PAP
Smear
13) Father's Name      41) HRN Disposition         69) Date Last
Tobacco Scre
14) Mother's Name      42) Patient's Last Visit   70) Date Last
Fall Risk As

+          Enter ?? for more actions
S   Select Item(s)      +   Next Screen           Q   Quit Item
Selection
R   Remove Item(s)     -   Previous Screen        E   Exit Report
Select Action: S//
    
```

Figure 4-14: Options in the Sort Item Selection menu

3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include all patients
- E - Exclude demo patients
- O - Include only demo patients

4. At the “Device” prompt, specify the device to print/display the report.

```

***** CONFIDENTIAL PATIENT DATA *****
          INDIAN HEALTH SERVICE                PAGE 1
          PATIENT REGISTRATION SYSTEM          DATE:4/3/96
AREA: TUCSON  SU: DEMO                        FACILITY:DEMO
HOSPITAL/CLINIC

BIRTH                BLOOD --- ELIGIBILITY ---

HRN      NAME          DATE      SEX TRB BEN QUNTM MCR MCD PVT VET CHS
RESIDEN  SOC SEC NO
-----
111112   ALPHA, JANE      1/28/90  F   282 01  1/2   X  X   DEMO
XX-XX-0000
111113   ALPHA, JOHN      1/5/90   F   096 01  FULL   X   DEMO
XXX-XX-0001
111114   ALPHA, KELLY     9/1/92   M   096 01  FULL           X  X
DEMO     XXX-XX-0002
    
```

Figure 4-15: Sample of DMG report

4.9 Deceased Patients Listing (DPL)

The DPL report generates a list of all patients who have a DOD entered into RPMS.

1. At the “Enter beginning Date of Death” prompt, type the beginning DOD.
2. At the “Enter ending Date of Death” prompt, type the ending DOD.
3. At the “List patients who are members of” prompt, type one of the following:
 - O - One particular Tribe
 - A - All tribes
 - S - Selected Set of Tribes (Taxonomy)
 If the user types **O** or **S**, additional prompts display.

4. At the “Sort Report by” prompt, type one of the following:
 - D - Date of Death
 - H – HRN
 - R - Terminal Digit HRN
 - C – Community
 - T – Tribe
 - N - Patient Name
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include all patients
 - E - Exclude demo patients
 - O - Include only demo patients
6. At the “Device” prompt, specify the device to print/display the report.

XXX	Jan 20, 2008	Page		
1				
DEMO HOSPITAL				
DECEASED PATIENTS REPORT				
Date of Death: Jun 02, 2007 - Mar 28, 2008				
Patient Name	HRN	DOB	Age at DOD	Tribe
			Death	

SIGMA,JOHN	000000	12/01/1949	57	03/02/2007 DEMO
TRIBE, NM				
Underlying Cause of Death:				

```

Last Visit: 04/03/1990 DEMO INDIAN HOSPITAL - AMBULATORY
Last Inpatient Visit: 01/23/1993 DEMO INDIAN HOSPITAL -
HOSPITALIZATION
Community of Residence: SPRINGFIELD

```

Figure 4-16: Sample of DPL report

4.10 Tally of Elder Patients with Functional Assessment (ELFA)

The ELFA report tallies by age and sex all patients who have had a functional assessment in a specified date range. The desired age range of patients must also be specified.

To determine the denominator or population of patients to review specify the following:

- A community or set of communities.
- The minimum number of times patients have been seen in the three years prior to the end of the date range.

The ELFA report provides a tally of patients only, or a tally and a list of the patients.

1. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, type the end of the date range.
3. At the “Enter an Age Range (e.g. 55-100, 55-75)” prompt, type the age range of patients to display on the report.
4. At the “Review Patients Who Live In” prompt, type one of the following:
 - O - One particular community
 - A - All communities
 - S - Selected Set of Communities (Taxonomy)
 If the user types **O** or **S**, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include all patients
 - E - Exclude demo patients
 - O - Include only demo patients
6. At the “Device” prompt, specify the device to print/display the report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XXX Page 1
DEMO HOSPITAL
PATIENTS WITH FUNCTIONAL ASSESSMENT DOCUMENTED
between Dec 19, 2007 and Mar 28, 2008
All Communities
-----

```

	FEMALES		MALES		TOTAL				
	N	%	N	%	N	%			
55	0	57	0.0	0	34	0.0	0	91	0.0
56	0	49	0.0	0	50	0.0	0	99	0.0
57	0	60	0.0	0	32	0.0	0	92	0.0
58	0	46	0.0	0	38	0.0	0	84	0.0
59	0	60	0.0	0	45	0.0	0	105	0.0
60	0	44	0.0	1	60	1.7	1	104	1.0

Figure 4-17: Example DPL report

The last page provides a Total line for the various columns containing data.

4.11 Tally of Elder Care Functional Status Change (ELFC)

The Elder Care Functional Status Change (ELFC) report tallies by age all patients who have had a change in functional status documented in a specified date range. In addition, patients who have had a decline in functional status are listed.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XXX
Page 8
DEMO HOSPITAL
PATIENTS WITH CHANGE IN FUNCTIONAL ASSESSMENT DOCUMENTED
between Jun 02, 2007 and Mar 28, 2008
-----

```

AGE	OF PATIENTS	IMPROVED		SAME		DECLINED	
		N	%	N	%	N	%
79	-	-	-	-	-	-	-
80	-	-	-	-	-	-	-
81	-	-	-	-	-	-	-
82	-	-	-	-	-	-	-
83	-	-	-	-	-	-	-
84	-	-	-	-	-	-	-
85	1	0	0.0	0	0.0	1	100.0
86	-	-	-	-	-	-	-
87	-	-	-	-	-	-	-
88	-	-	-	-	-	-	-
89	-	-	-	-	-	-	-
90	-	-	-	-	-	-	-

Figure 4-18: Example of an ELFC report

The last page of the report provides a Total for the various columns containing data.

Pressing Enter at the “Press ENTER” prompt at the end of the report displays a list of patients with a documented decline in functional status.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
SJT                                                                 Page 9
                                DEMO HOSPITAL
PATIENTS WITH CHANGE IN FUNCTIONAL ASSESSMENT DOCUMENTED
  between Jul 24, 2008 and Jan 20, 2009
Listing of Patient with a documented DECLINE in Functional Status
-----
LAST FUNCTIONAL
PATIENT NAME                HRN      SEX  DOB                AGE
ASSESSMENT
-----
-----
CRABTREE,DARLENE PARKER    105137  F   Aug 11, 1942        65   Oct
06, 2008
MARRIETTA,CAROL ADRIANNA  105342  F   Mar 14, 1940        68   Oct
17, 2008
WIKE,KAYLEE JANE          104378  F   Aug 08, 1932        75   Sep
21, 2008
End of report.  Press ENTER:

```

Figure 4-19: Example last page of ELFC report

4.12 Tally of Elder Care Data Items (ELFT)

The Elder Care Data Items (ELFT) report tallies all items from the elder care PCC form.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
XXX                                                                 Page 1
                                DEMO HOSPITAL
TALLY OF ELDER CARE DATA ITEMS
  between Sep 10, 2007 and Mar 28, 2008
-----
Total Number of Patients:  5

TOILETING
  INDEPENDENT                3          60.0%
  NEEDS HELP                 2          40.0%
  TOTALLY DEPENDENT          0           0.0%
  NOT DOCUMENTED             0           0.0%

BATHING
  INDEPENDENT                1          20.0%
  NEEDS HELP                 1          20.0%
  TOTALLY DEPENDENT          0           0.0%
  NOT DOCUMENTED             3          60.0%

```

DRESSING		
INDEPENDENT	2	40.0%
NEEDS HELP	1	20.0%
TOTALLY DEPENDENT	0	0.0%
NOT DOCUMENTED	2	40.0%

Figure 4-20: Sample of ELFT report

4.13 Elder Patients with Needs Help or Dependent Assessments (ELNH)

This report tallies the number of patients who have had two or more items in the ADL and two or more items in the IADL groups documented as Needs Help or Totally Dependent. All patients who have had a functional assessment in the year prior the “as of” date will be reviewed. A list of patients displays.

4.14 Infant Feeding Statistical Reports (IF)

Two reports can be run from this option: IF1 and IF2.

4.14.1 Birth and Six-Month Breastfeeding Statistics (IF1)

The IF1 option produces a report of how many infants were documented as being breast fed at birth and at age six months. Select the “as of” date (Report end date) and communities to report on. The report first identifies all patients aged 12-23 months in the “as of” date the user defined. The report then calculates which infants to report on from this initial population.

Birth breastfeeding statistics

- Denominator:
 - Number of infants with a visit.
 - Patients who had at least one visit to a primary care clinic between birth and six months (ages 1-179 days old).
- Numerators:
 - Infants with feeding data. Any patient with a visit with any infant feeding choice documented between birth and six months (0-179 days old)
 - Infants breastfeeding. Of the patients with feeding data (numerator 1), those with *any* infant feeding choice that includes breastfeeding (e.g., *not* formula only). The report sorts chronologically all visits in the time frame with feeding documentation and counts the patient as meeting the numerator as soon as the first feeding choice is found that includes breastfeeding.

Six-month statistics

- Same as Birth, except the visits reviewed are those that occurred between ages 180-365 days.

XXX		Jan 20, 2009		Page 1	
		DEMO HOSPITAL			
INFANT BREASTFEEDING STATISTICS, as of Jan 01, 1958					
Patients born Dec 31, 1957 - Jan 01, 1958					
NATIONAL 2003		DEMO HOSPITAL		HP 2010	
				USA RATE	AI/AN
		%	%	%	%
BREASTFEEDING AT BIRTH					
w/visit	0				
w/data recorded	0	0.0			
Breastfeeding	0	0.0	75%	71%	69%
BREASTFEEDING AT 6 MONTHS					
w/visit	0				
w/data recorded	0	0.0			
Breastfeeding	0	0.0	50%	36%	32%
End of report. PRESS ENTER:					

Figure 4-21: Example of IF1 report

4.14.2 Breastfeeding Statistics by Age Group (IF2)

The IF2 option produces a report of how many infants were documented as being breast fed at birth and at age six months. Select the “as of” date (report end date) and the communities on which the user wants to report. The report first identifies all patients who are ages 12-23 months on the “as of” date the user defined. The report calculates the infants to report on from this initial population.

Birth breastfeeding statistics

- Denominator:
 - Number of infants with a visit.
 - Patients who had at least one visit to a primary care clinic between birth and six months (ages 1-179 days old).
- Numerators:
 - Infants with feeding data. Any patient with a visit with any infant feeding choice documented between birth and six months (0-179 days old)

- Infants breastfeeding. Of the patients with feeding data (numerator 1), those with *any* infant feeding choice that includes breastfeeding (e.g., *not* formula only). The report sorts chronologically all visits in the time frame with feeding documentation, and counts the patient as meeting the numerator as soon as the first feeding choice is found that includes breastfeeding.

Six-month statistics

- Same as Birth, except the visits reviewed are those that occurred between 180-365 days old.

The system displays a cover page that reviews the criteria selected.

DEMO HOSPITAL				
INFANT BREASTFEEDING STATISTICS, as of Dec 23, 2006				
Patients born Dec 22, 2005 - Dec 23, 2006				
	DEMO HOSPITAL	HP 2010	NATIONAL	2003
	%	%	USA RATE	AI/AN
			%	%
BREASTFEEDING AT BIRTH				
w/visit	67			
w/data recorded	11	16.4		
Breastfeeding	8	72.7	75%	71%
				69%
BREASTFEEDING AT 6 MONTHS				
w/visit	80			
w/data recorded	7	8.8		
Breastfeeding	3	42.9	50%	36%
				32%

Figure 4-22: Example of IF2 report

4.15 Prescription Cost Report (PCR)

The Prescription Cost Report (PCR) can be used by a site to determine the prescription cost for a user-specified group of patients in a specified date range. The report allows sites to prepare for the Medicare Part D Prescription Drug Coverage that begins on January 2006.

4.16 Tally of Patient Internet Access (PINT)

The Tally of Patient Internet Access (PINT) report tallies the number of patients with documented internet access and the method of internet access. This report can be run for the user population, GPRA-defined active clinical population, search template of patients, or for all patients.

```

Page 1
*** PATIENT INTERNET ACCESS ***
Date Report Run: Apr 01, 2008
Site where Run: DEMO HOSPITAL
Report Generated by: USER1
Internet Access as of Date: Mar 02, 2008
-----

Total of Patients                                7,949

Total w/Internet Access Screening                5,268        66%
  with Internet Access w/% of those screened    1,859        35%

GENDER BREAKDOWN:
  Females w/internet access
    with % of those with access                  1,147        62%
  Males w/internet access
    with % of those with access                  712         38%

AGE BREAKDOWN:
  < 18 yrs old w/internet access
    with % of those with access                  570         31%
  18-35 yrs old w/internet access
    with % of those with access                  512         28%
  36-55 yrs old w/internet access
    with % of those with access                  603         32%
  > 55 yrs old w/internet access
    with % of those with access                  174         9%

```

Figure 4-23: Example portion of PINT report

4.17 Screening Reports (IPV/DV, Alcohol, Depression) (SCR)

The SCR option prompts the user to choose from the following sub-options: IPV/DV reports, alcohol screening reports, and depression screening reports.

The IPV/DV menu contains several options:

- Tally/List Patients with IPV/DV Screening (DVP):** This report tallies and optionally lists all patients who have had IPV screening (Exam Code 34) or a refusal documented in the time frame specified by the user. This report tallies the patients by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest screening is used in this report. This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- **Tally/List IPV/DV Screenings (DVS):** This report tallies and optionally lists all visits in which IPV screening (Exam code 34) or a refusal was documented in the time frame specified by the user. This report tallies the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- **List IPV/DV Screenings for Selected Patients (SSP):** This report lists all patients selected who have had IPV screening (Exam Code 34) or a refusal documented in a specified time frame. Select patients based on age, gender, result, provider, or clinic where the screening was done.

Note: All screenings done in the specified time period for the patients selected will be displayed in the report.

- **Tally/List Patients in Search Template w/IPV Screening (PST):** This report tallies and lists all patients who are members of a user-defined search template. It tallies and lists the latest IPV screening (Exam Code 34) or a refusal documented in the time frame specified by the user. This report tallies the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report. This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- **Tally/List IPV Screenings for Template of Patients (VST):** This report tallies and optionally lists all visits on which IPV screening (Exam Code 34) or a refusal was documented in the time frame specified by the user. This report tallies the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

The alcohol screening menu contains several options. Note that an Alcohol Screening is defined as any of the following:

- Alcohol Screening Exam (Exam code 35)
- Measurements: AUDC, AUDT, CRFT

- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1 (Behavioral Health Problem Code)
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of exam code 35
- **Tally/List Patients with ALCOHOL Screening (DVP):** This report tallies and optionally lists all patients who have had an alcohol screening or a refusal documented in the time frame specified by the user. This report tallies the patients by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest screening is used in this report. This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- **Tally/List ALCOHOL Screenings (DVS):** This report tallies and optionally lists all visits on which alcohol screening or a refusal was documented in the time frame specified by the user. This report tallies the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- **List Alcohol Screenings for Selected Patients (SSP):** This report lists all patients selected who have had alcohol screening or a refusal documented in a specified time frame. Select patients based on age, gender, result, provider, or clinic where the screening was done.

Note: All screenings done in the time period for the patients selected will display in the report.

- **Tally/List Pts in Search Template w/Alcohol Screening (PST):** This report tallies and lists all patients who are members of a user-defined search template. It tallies and lists the latest alcohol screening or a refusal documented in the time frame specified by the user. This report tallies the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest screening is used in this report. This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- **Tally/List Alcohol Screenings for Template of Pts (VST):** This report tallies and optionally lists all visits on which alcohol screening or a refusal was documented in the time frame specified by the user. This report tallies the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

The Depression Screening Menu has several options:

- **Tally/List Patients with Depression Screening (DVP):** This report tallies and optionally lists all patients who have a documented Depression Screening in the time frame specified by the user. This report tallies patients by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. A Depression Screening is defined as any of the following:
 - Depression Screening Exam (Exam code 36)
 - Measurements: PHQ2, PHQ9
 - Diagnoses V79.0, 14.1 (Behavioral Health Problem Code)
 - Education Topics: DEP-SCR
 - Refusal of exam code 36

Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest screening is used in this report. This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

XXX	Jan 20, 2009	Page 1
*** DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING ***		
Screening Dates: Jul 24, 2008 to Jan 20, 2009		
This report excludes Behavioral Health Clinics		
All Facilities/Locations		
All Patient Communities		
		DATE
PATIENT NAME	HRN	AGE
		SCREENED RESULT
		CLINIC

```

ALPHA,CHI          111148 18  M 10/02/08  NEGATIVE
  Primary Provider on Visit:  UNKNOWN
    Provider who screened:  IAPROVIDER,MATTHEW

DELTA,ICHI        111201 43  M 10/16/08  NEGATIVE      GENERAL
  Primary Provider on Visit:  UNKNOWN
    Provider who screened:  IAPROVIDER,MATTHEW

Enter RETURN to continue or '^' to exit:

```

Figure 4-24: Example report for DVP under depression screening

- Tally/List Depression Screenings (DVS):** This report tallies and optionally lists all visits on which depression screening or a refusal was documented in the time frame specified by the user. This report tallies the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: This report optionally looks at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- List Depression Screenings for Selected Patients (SSP):** This report lists all patients selected who have had depression screening or a refusal documented in a specified time frame. Select patients based on age, gender, result, provider, or clinic where the screening was done.

Note: All screenings done in the time period for the patients selected display in the report.

- Tally/List Patients in Search Template w/ Depression Screening (PST):** This report tallies and lists all patients who are members of a user-defined search template. It tallies and lists their latest depression screening or a refusal documented in the time frame specified by the user. This report tallies the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest screening is used in this report. This report will optionally look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- Tally/List Depression Screenings for Template of Patients (VST):** This report tallies and optionally lists all visits on which depression screening or a refusal was documented in the time frame specified by the user. This report tallies the visits

by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

Note: This report optionally looks at both PCC and the Behavioral Health databases for evidence of screening/refusal.

4.18 Suicide Form Data Reports (SUIC)

There are two reports available.

- The Output Suicide Form Data in Delimited Format report extracts all data elements of the Suicide Form in a delimited form for a date range specified by the user.
- The Aggregated Data from Suicide Reporting Forms report tallies the data items specific to the Suicide Reporting form for a date range and community specified by the user.

```

OUTPUT BROWSER          Jan 20, 2009 15:02:50          Page: 1 of 17
DEMO HOSPITAL          Jan 20, 2009          Page 1

***** AGGREGATED DATA FROM SUICIDE REPORTING FORMS *****
Act Occurred: Jan 21, 2008 - Jan 20, 2009
Community where Act Occurred: ALL Communities
-----

Age Range: 15-19 years          Total of Suicide Forms: 3

REPORT TOTALS

Self Destructive Act:  IDEATION WITH PLAN AND INTENT          2          67%
                       ATTEMPT                              1          33%

Event logged by Discipline:  HEALTH RECORDS                  1          33%
                             MEDICAL SOCIAL WORKER          2          67%

+          Enter ?? for more actions                          >>>
+  NEXT SCREEN          -  PREVIOUS SCREEN          Q  QUIT
Select Action: +//

```

Figure 4-25: Example report of aggregated data from suicide reporting forms

At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to quit the report.
- Type **+** (plus) to display the next screen. This option is not available for the last screen.

- Type – (minus) to display the previous screen. This option is not available for the first screen.

4.19 Patients with Total Household Income/ in Household (THI)

Use the THI option to produce a report of all patients who have the number in household or total household income recorded. The report can list all patients from a particular community or tribe. The report can be sorted by HRN, Terminal Digit HRN, Community, Tribe, Household Income, Number in Household, or Patient Name. An average of the household income and number in household also displays.

SJT		Jan 20, 2009					Page 1	
DEMO HOSPITAL								
HOUSEHOLD INCOME/NUMBER IN HOUSEHOLD TALLY								
Patient Name	HRN	BENI	COMMUNITY	ZIP	TRIBE	IN	TOTAL	
	FICI					HOUSE	HOUSEHOLD	
	ARY					HOLD	INCOME	
ALPHA, DAVID	BR	102982	01	BIG COVE	28719	DEMO	TRIBE	2 0
ALPHA, MARTHA	AGN	100881	01	SOUTH CAR	29356	DEMO	TRIBE	2 0
ALPHA, MICHAEL	A	121082	01	PAINTTOWN	28719	DEMO	TRIBE	6 0
ALPHA, CAROL	ANN	100351	01	BIRDTOWN	28719	DEMO	TRIBE	1 0
ALPHA, MARGARET	D	108025	01	VASSALBOR	28719	DEMO	TRIBE	2 0
ALPHA, BARBARA		119344	01	BIRDTOWN	28719	DEMO	TRIBE	1 0
ALPHA, DANI	SUE	165877	01	BETHEL	74724	CHOCTAW	NA	6 0
ALPHA, FREDIA	ANN	122649	01	MARBLE	28905	DEMO	TRIBE	4 0
ALPHA, GREGORY	PAUL	103558	01	BIRDTOWN	28719	DEMO	TRIBE	5 0
ALPHA, JAKELI	BRADFORD	118981	01	WHITTIER	28789	DEMO	TRIBE	5 0
ALPHA, JOSEPHINE		124463	01	NORTH CAR	28761	DEMO	TRIBE	2 0
ALPHA, JOSIE		122784	01	MURPHY	28906	DEMO	TRIBE	3 0
ALPHA, TRISTA	L	155765	01	BIRDTOWN	28719	DEMO	TRIBE	3 0

Enter RETURN to continue or '^' to exit:

Figure 4-26: Example THI report

4.20 Upload Patients from Text File to Search Template (UPLP)

Use the UPLP option to upload patients from a file that is in the format ASUFAC^HRN^DOB and store those patients in a search template. The system prompts for the directory path and filename where the file resides. The system also prompts for the name of the search template that will be created.

When entering the directory path, type a full path name with the ending '/'; for example,

/usr/spool/uucpublic/ or /usr/mumps/

When typing the filename, type the extension as well; for example,
MYFILE.TXT

5.0 Resource Allocation/Workload Reports (RES)

The Resource Allocation/Workload Reports provide data on the number of registered patients at a Service Unit or facility and the number of active patients, visits, APC visits, and primary care provider visits by those registered patients.

This menu includes Operations Summary submenu report options; for example,

```

*****
**          PCC Management Reports          **
** Resource Allocation/Workload Reports    **
*****
IHS PCC Suite Version 2.0

DEMO HOSPITAL/CLINIC

OPS    Operations Summary for a Service Unit or Facility ...
RPVC   Registered Patients and Visits by Community
RPVT   Registered Patients and Visits by Tribe
RPVS   Registered Pts and Visits by SU of Residence
AGE    Registered Patients by Age, Sex, Tribe, Community
ACC    Active Patient Count by Community of Residence
ACS    Active Patient Count by SU of Residence
ACT    Active Patient Count by Tribe
CH     Community Health Profile Summary
CHWL   Clinic Hourly Workload Report
INPC   Inpatient Discharges/Days by Community
INPS   Inpatient Discharges/Days by SU of Residence
INPT   Inpatient Discharges/Days by Tribe
PPDS   Provider Practice Description Report
Select Resource Allocation/Workload Reports Option:

```

Figure 5-1: Example of Resource Allocation/Workload Reports menu screen

5.1 Estimated Run Time

These reports may have lengthy run times, depending on the parameters specified. For assistance determining which reports to queue, please contact the local site manager.

5.2 Operations Summary for a Service Unit or Facility (OPS)

The following reports are available from the Operations Summary menu.

```

*****
**          PCC Management Reports          **
** Operations Summary Menu                **
*****
IHS PCC Suite Version 2.0

```

```

DEMO HOSPITAL/CLINIC
OS      Generate Operations Summary
SECT    List PCC Operations Summary Sections
TYPE    Create/Edit Operations Summary Type
DISP    Display a Operations Summary Type

```

Figure 5-2: Example of Operations Summary menu screen

5.2.1 Operations Summary (OS)

Use the OS option to produce a report that summarizes data for a single month or FY-to-date for a specific facility, a selected group of facilities, or the entire Service Unit (SU), if all data for the SU is processed on the user's computer.

When selecting the period to run the report, consider whether all data has been entered for that period. The report serves the entire patient file.

Follow these steps:

1. At the "Select operation summary type" prompt, choose the operation summary type for the report.
2. At the "Please identify your service unit" prompt, choose the SU for the report.
3. At the "Enter a code indicating what facilities/location are of interest" prompt, type one of the following codes:
 - O - One particular Facility/Location
 - S - All facilities with the unit
 - T - A taxonomy or select set of facilities

If the user types **O** or **T**, additional prompts display.

4. At the "Run report for" prompt, type one of the following:
 - 1 - A single month
 - 2 - Fiscal year
 - 3 - Date Range

Additional prompts display when **1** or **3** is chosen.

5. At the "Do you wish to exclude any diagnoses codes from the ambulatory section" prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display. For example, to eliminate pharmacy refill diagnoses, exclude V68.1 from the report.
6. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

- I - Include All patients
- E - Exclude Demo patients
- O - Include only demo patients

7. At the "Device" prompt, specify the device to print/display the report.

The following sample report displays a Complete Operations Summary.

OPERATIONS SUMMARY FOR MEMORIAL HOSPITAL
FOR FY94-To-Date as of 9-30-94

Note: In parentheses (following each statistic) is the percent increase or decrease from the same time period in the previous year. "***" indicates no data is present for one of the two time periods.

PATIENT REGISTRATION

There are 29,275 living patients (+9%) registered at this SU. This number does not represent the 'Active User Population' which is found elsewhere in PCC Reports. There have been 1,730 new patients (+12%) registered during this time period. 317 births (-8%) and 291 deaths (+2%) occurred in this period based on data in the Patient Registration File.

THIRD PARTY ELIGIBILITY

There were 277 patients (+7%) enrolled in Medicare Part A and 231 patients (+11%) enrolled in Part B at the end of this time period. There were also 1,137 patients (+20%) enrolled in Medicaid and 412 patients (+36%) with an active Private Insurance policy as of that date.

CONTRACT HEALTH SERVICES

Total CHS expenditures (obligations adjusted by payments) for this period were \$564,296 (+16%). The number and dollar amount of authorizations by type were:

43 - Hospitalization	296	(+2%)	\$312,196	(+18%)
57 - Dental	351	(+8%)	\$ 80,500	(-4%)
64 - Non-Hospital Service	1,163	(+19%)	\$171,600	(+15%)

DIRECT INPATIENT

There were 1,437 discharges (+6%) during this period, accounting for 6,754 patient days (+2%). The average length of stay was 4.7 days compared to an ALOS of 4.6 during this period last year. The five leading primary diagnoses for hospitalizations were:

1 - Normal Delivery	104	(-15%)
2 - Pneumonia	72	(+8%)
3 - Diabetes Mellitus	71	(+12%)
4 - Ischemic Heart Disease	65	(-16%)
5 - Appendicitis	60	(+26%)

AMBULATORY CARE VISITS

There were a total of 47,291 ambulatory visits (+7%) during the period for all visit types except CHS.

They are broken down below by Type, Location, Service Category, Provider Discipline and leading Diagnoses. These do not equate to "official" APC Visits which are identified in other PCC reports.

By Type:

IHS	47,001	(+7%)
638	0	()
Other	290	(+2%)

By Location:

DEMO Hosp.	45,800	(+9%)
San Xavier Clinic	0	()
San Rosa Clinic	0	()
Home	920	(-2%)
School	571	(-2%)

By Service Category:

Ambulatory	46,601	(+7%)
Telecommunication	250	(0%)
Not Found	440	(0%)
Day Surgery	0	()
Observation	0	()
Nursing Home	0	()

By Clinic Type

General	46,601	(+7%)
Audiology	250	(0%)
Well Child	440	(0%)

By Provider Type (Primary and Secondary Providers):

Phys	29,500	(+5%)
RN	14,200	(+19%)
LPN	11,150	(+6%)
CHN	4,111	(-14%)
Pharmacy	21,520	(+16%)
Surgeon	421	(-8%)
Internist	1,811	(-12%)
Optometrist	710	(+4%)
Podiatrist	1,111	(-2%)
Nurse Pract.	297	(-37%)
Total	84,831	(+10%)

The ten leading purposes of ambulatory visits by individual ICD Code and by APC groups are listed below. Both primary and secondary diagnoses are included in the counts.

By ICD Diagnosis

1 - Upper Respiratory Inf.	4,722	(+8%)
2 - Prenatal Care	3,691	(-12%)
3 - Diabetes Mellitus	3,480	(-9%)
4 - Otitis Media	3,217	(+17%)

5	- Impetigo	1,911	(+3%)
6	- Complications of Pregnancy	1,271	(-8%)
7	- Laceration	862	(-8%)
8	- Sprains/Strains	490	(+11%)
9	- Rheumatoid Arthritis	487	(+4%)
10	- Gastroenteritis	452	(-22%)
By APC Grouping			
1	- URI	5,110	(+4%)
2	- Diabetes Mellitus	3,890	(+10%)
3	- Influenza	2,001	(-10%)
4	- Impetigo	2,150	(-4%)
5	- Prenatal Care	1,200	(+8%)
6	- Well Child Care	1,180	(-11%)
7	- Conjunctivitis	850	(+17%)
8	- Physical Exams	710	(-2%)
9	- Anemia	666	(-2%)
10	- Alcoholism	652	(+5%)

INJURIES

There were 5,217 visits for injuries (-11%) reported during this period. Of these, 1,252 were new injuries (+8%). The five leading causes were:

1	- Falls	221	(+5%)
2	- Motor Vehicle	190	(-12%)
3	- Stings & Venoms	101	(-2%)
4	- Purposely Inflicted	72	(+19%)
5	- Undetermined	66	(+4%)

EMERGENCY ROOM

There were 2,911 visits (+16%) to the ER (Clinic Code=30). Of these 1,216 had an injury diagnosis (-12%) and 621 had an alcohol-related diagnosis (+4%).

PHARMACY

There were 21,000 new prescriptions (+17%) and 39,000 refills (+12%) during this period.

DENTAL

There were 4,920 patients (+12%) seen for Dental Care. They accounted for 7,826 visits (+19%). The five leading service categories were:

1	- Restoration	(+8%)
2	- Extraction	(+24%)
3	- Fluoridation	(+12%)
4	- Exam	(-1%)
5	- Sealants	(+16%)

Figure 5-3: Example of a complete Operations Summary report

5.2.2 List PCC Operations Summary Sections (SECT)

Use the SECT option to produce a report that lists the summary types available for the operations reports. A sample display is shown in Figure 5-4.

```
PCC OPERATIONS SUMMARY SECTION LIST      APR  3,1996  14:51  PAGE 1
NAME
-----
AMBULATORY
CONTRACT HEALTH SERVICES
IN-HOSPITAL
INPATIENT SERVICES
PHARMACY
POPULATION/THIRD PARTY
```

Figure 5-4: Example of SECT screen

5.2.3 Create/Edit Operations Summary Type (TYPE)

Use the TYPE option to edit an Operations Summary Type or create a new one.

Begin by typing the name of the summary type to create or the name of an existing summary type to edit. Follow the prompts to specify the components of the summary type and to indicate the listing order for the operations reports.

5.2.4 Display an Operations Summary Type (DISP)

Use the DISP option to display the components of a specified Operations Summary Type report. The components of each Operations Summary type are shown in the order in which they will display in a report.

The following sample shows the Complete Operations Summary type.

```
PCC MAN REPORTS OP SUM TYPE LIST          APR 11,1996   16:12  PAGE 1
-----
NAME: COMPLETE OPERATIONS SUMMARY
SUMMARY ORDER: 1           COMPONENT NAME: POPULATION/THIRD PARTY
SUMMARY ORDER: 2           COMPONENT NAME: CONTRACT HEALTH SERVICES
SUMMARY ORDER: 3           COMPONENT NAME: INPATIENT SERVICES
SUMMARY ORDER: 4           COMPONENT NAME: AMBULATORY
SUMMARY ORDER: 5           COMPONENT NAME: IN-HOSPITAL
SUMMARY ORDER: 6           COMPONENT NAME: PHARMACY
```

Figure 5-5: Example of a screen listing operations summary types

5.3 Registered Patients and Visits Report Types

There are three Registered Patients and Visits Report types:

- RPVC Registered Patients and Visits by Community
- RPVT Registered Patients and Visits by Tribe
- RPVS Registered Patients and Visits by SU of Residence

All three report options search the patient files and print the following:

- The number of living patients registered at the facility or SU selected
- The number of patients receiving any service
- The number of PCC services (visits) by those patients
- The number of APC visits by those patients
- The number of APC primary care provider (PCP) visits by those patients

The report can be sorted by Community of Residence, Tribe of Membership, or Service Unit of Residence.

Select which portions of the patient database to include in the report by responding to questions at the beginning of the report generation. Help screens are available. Definitions of Registered Patients, Patients Receiving a Service, PCC Services (All PCC Visits), APC Visits, and PCP Visits are available in help screens.

This is a sample RPVC report.

Current Community of residence		Reg Pts Living	Patients Rec'ing	All		
As of Today		Service	Srvs	PCC Visits	APC Visits	PCP
ALI OIDAK	6	3	4	3	3	
ANEGAM	6	3	3	1	0	
ARIVACA*	5	1	1	0	0	
ARTESA	5	1	1	1	1	
KAKA	8	0	0	0	0	
LITTLE TUCSON	6	0	0	0	0	
MARANA	1	1	10	7	7	
-----		-----	-----	-----	-----	-----
Total: 37		9	19	12	11	

Figure 5-6: Example of the RPVC report

5.4 Registered Patients by Age, Sex, Tribe, Community (AGE)

The Age Bucket report describes the demographics and epidemiology of a service population. Parameters can be defined for the age groups that appear across the top of the page, or predefined groups can be used. Sex, Tribe of Membership, or Community of Residence display down the left side of the page. Cross-tabulations and column subtotals also display.

The report includes all living patients registered through patient registration at the facility or SU selected.

TRIBE OF MEMBERSHIP By AGE GROUP									Page 1
All Living Patients Registered at DEMO HOSPITAL/CLINIC									
JAN 26, 1995									
AGE GROUPS									
TRIBE OF MEM	0	1-4	5-14	15-19	20-24	25-44	45-64	65-125	TOT
ALASKAN INDI	1	.	.	1
APACHE	.	2	.	.	1	1	2	.	6
ARAPHOE TRIB	.	.	.	1	.	.	.	.
HEMEHUEVI T	.	.	1	.	.	1	.	.	2
CHEROKEE NAT	.	.	.	1	1	.	1	.	3
CHINESE	1	.	1
COCOPAH TRIB	1	.	.	1
CREEK NATION	.	.	1	.	.	1	.	.	2
CROW TRIBE O	.	.	.	1	.	1	.	.	2
DAKOTA (SIOU	1	.	2	.	3
TOHONO O'ODH	.	21	77	38	42	136	68	61	443
UNSPECIFIED	.	3	.	.	3	1	.	.	7
TOTAL	0	26	79	41	48	143	74	61	472

Figure 5-7: Example Age Bucket report

5.5 Active Patient Count Report Types

There are three Active Patient Count Report types:

- ACC Active Patient Count by Community of Residence
- ACS Active Patient Count by SU of Residence
- ACT Active Patient Count by Tribe

All three report options search the patient file and print the following:

- The number of living patients registered at the facility or SU selected
- The number of active patients registered at the facility or SU selected

The report can be sorted by Community of Residence, Tribe of Membership, or Service Unit of Residence.

Select which portions of the patient database to include in the report by responding to questions at the beginning of the report generation. Help screens are available. Definitions of Registered Patients and Active Patients are also available in help screens.

This is a sample ACT report.

DEMO HEALTH CENTER	FEB 5,1995	Page 1
Registration and Active Patient Counts for all Patients Registered in DEMO Service Unit.		
The report is sorted by Tribe of Membership.		
Active Patients were those seen between OCT 01,1994 and FEB 5,1995.		
Tribe of Membership	Reg Pts Living As of Today	Active Patients
-----	-----	-----
ALASKAN INDIAN	1	1
NON-INDIAN BENEFICIARY	1	1
TOHONO O'ODHAM NATION OF ARIZONA	91	61
	-----	-----
Total:	93	63

Figure 5-8: Example of ACT report

5.6 Community Health Profile Summary (CH)

Use the CH option to display a profile of healthcare for patients who reside in the particular community or communities. This report compares the clinical data from selected communities with clinical data from the entire SU. The data categories included in this report are as follows:

- Patient Registration
- Top 15 POVs for Direct, Contract, and Outpatient Visits
- Top 15 Inpatient Diagnoses
- Leading Surgical Procedures
- Top 10 Causes of Injuries
- Top Dental Services

To generate the report, type a date range and identify the community or communities of interest. The example report on the following pages was generated for the Little Tucson community in the Demo Service Unit for the 1995 calendar year.

```
***** COMMUNITY HEALTH PROFILE *****
Jan 01, 1993 to Dec 31, 1995
DEMO
```

There are 274 living patients registered at DEMO HOSPITAL/CLINIC. 173 received health care services during this time period. 8 are currently enrolled in Medicare Part A; 14 in Medicare Part B; 100 in Medicaid; and 11 have Private Insurance. There were 3 births and 1 deaths during this period.

AGE/SEX Distribution as of Apr 19, 1996

	0-4	5-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80 +	TOTAL
MALE	12	11	16	28	22	21	13	7	4	2	136
FEMALE	16	14	14	33	19	12	14	5	8	1	137
TOTAL	28	25	30	61	41	33	27	12	13	3	273

The Top 15 Purposes of Direct and Contract Outpatient Visits were:
Both Primary and Secondary Diagnoses are included

LITTLE TUCSON	DEMO Service Unit
DM UNCOMPL/T-II/NIDDM,NS (169)	DENTAL EXAMINATION (4409)
DENTAL EXAMINATION (162)	DM UNCOMPL/T-II/NIDDM,NS (4289)
HYPERTENSION NOS (104)	CHRONIC RENAL FAILURE (3395)
COUNSELING,NOS (80)	ENCTR EXTRACORP DIALYSIS (2710)
OTH ACQ LIMB DEFORMITY (70)	ISSUE REPEAT PRESCRIPT (2285)
OTITIS MEDIA NOS (41)	HYPERTENSION NOS (2133)
PHYSICAL THERAPY NEC (39)	OTITIS MEDIA NOS (1749)
ACUTE URI NOS (33)	ACUTE URI NOS (1568)
IMPETIGO (32)	SUPERVIS OTH NORMAL PREG (1503)
CHRONIC ULCER OF LEG (29)	COUNSELING,NOS (1413)
ISSUE REPEAT PRESCRIPT (24)	ASTHMA W/O STATUS ASTHM (1297)
URIN TRACT INFECTION NOS (23)	RHEUMATOID ARTHRITIS (1160)
DERMATOPHYTOSIS OF FOOT (20)	URIN TRACT INFECTION NOS (930)
ASTHMA W/O STATUS ASTHM (18)	BRONCHITIS NOS (834)
ANKYLOSING SPONDYLITIS (15)	DERMATOPHYTOSIS OF FOOT (768)

The Top 15 Inpatient Diagnoses were:

LITTLE TUCSON	DEMO Service Unit
URIN TRACT INFECTION NOS (23)	DM UNCOMPL/T-II/NIDDM,NS (109)
HYPOPOTASSEMIA (18)	HYPERTENSION NOS (53)
HYPERTENSION NOS (17)	CELLULITIS OF LEG (43)
CHRONIC ULCER OF LEG (15)	ALCOHOL DEP NEC/NOS-UNSPEC (41)
PNEUMONIA, ORGANISM NOS (10)	URIN TRACT INFECTION NOS (39)
DIS PLAS PROTEIN MET NEC (10)	POSTSURG AFTERCARE NEC (38)
ANEMIA NOS (8)	OBESITY (30)
STAPHYLOCOCC SEPTICEMIA (7)	HYPOVOLEMIA (15)

The Leading Surgical Procedures were:

LITTLE TUCSON	DEMO Service Unit
EXCISIONAL DEBRIDEMENT WO (13)	EXCISIONAL DEBRIDEMENT WO (402)
INJECT ANTIBIOTIC (9)	INJECT ANTIBIOTIC (140)
NAIL REMOVAL (5)	VAGINOSCOPY (98)

INJECT/INFUSE ELECTROLYT	(3)	INJECT/INFUSE ELECTROLYT	(47)
DRESSING OF WOUND NEC	(2)	APPLICATION OF SPLINT	(38)
APPLICATION OF SPLINT	(1)	NAIL REMOVAL	(30)
PACKED CELL TRANSFUSION	(1)	TOOTH EXTRACTION	(17)
The Top 10 Causes of Injury were:			
LITTLE TUCSON		DEMO Service Unit	

ASSAULT NOS	(16)	FALL NEC NOS	(185)
FALL NEC NOS	(14)	ASSAULT NOS	(121)
STRUCK BY OBJ/PERSON NEC	(7)	TRAFFIC ACC NOS-PERS NOS	(47)
FIRE ACCIDENT NOS	(3)	ACC-CUTTING INSTRUM NEC	(35)
HORNET/WASP/BEE STING	(1)	STRUCK BY OBJ/PERSON NEC	(34)
		DOG BITE	(7)
		STRUCK IN SPORTS	(6)
The Top Dental Services were:			
LITTLE TUCSON		DEMO Service Unit	

PATIENT REVISIT	(54)	PATIENT REVISIT	(2311)
FIRST VISIT	(44)	FIRST VISIT	(2062)
OTHER DRUGS/MEDICAMENTS	(36)	OTHER DRUGS/MEDICAMENTS	(1004)
INTRAORAL PERIAPICAL, SIN	(26)	ORAL EXAMINATION, INITIAL	(987)
ORAL EXAMINATION, INITIAL	(22)	INTRAORAL PERIAPICAL, SIN	(977)
End of Report. This report is based on visit data processed on the DEMO HOSPITAL/CLINIC computer.			
RUN TIME (H.M.S): 0.1.19			
End of report. HIT RETURN:			

Figure 5-9: Example of CH report

5.7 Clinic Hourly Workload Report (CHWL)

The CHWL report generates a 24-hour period visit count by clinic for a specific date range. The report counts *all* visits, *except* the following:

- Visit Types: Contract and VA

Visit Service Categories

- Chart Review
- In-Hospital
- Ancillary
- Hospitalizations
- Events

- Telecommunications
- Visits WITHOUT a Primary Provider and Purpose of Visit

Visits **must** have a Primary Provider and Purpose of Visit.

The report is totaled by hourly time frames.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, type the end of the date range.
3. At the “Select Facility” prompt, type the name of the facility.
4. At the “Include visits from all clinics?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, specify the clinics to include.
5. At the “Would you like to restrict the report by Patient age range?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, specify the age range.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

The output must be printed on 132-column paper or on a printer that is set for condensed print.

The following sample report is a workload report for the Emergency Medicine clinic from July 12 to July 14, 1996. The data reported includes patients from one to 18 years of age only. The facility selected is Demo Hospital and data for all providers is included.

CLINIC HOURLY WORKLOAD REPORT														
LOCATION OF VISITS: DEMO HOSPITAL/CLINIC														
CLINIC: EMERGENCY MEDICINE														
VISIT DATES: JUL. 12, 1994 TO JUL 14, 1996														
AGE RANGE: 1-18														
DATE	DOW	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	12P
07/12	MON	.	.	.	2	10	.	10	.	.
8	2	10	1
.

07/13	TUE	.	.	.	.	.	.	.	.
.	.	.	.	1	.	.	10	10	.
8	2	10	1	.	.	.	.	.	.
.
07/14	WED	.	.	.	.	.	.	.	.
.	.	.	.	1	.	.	10	10	.
8	2	10	1	.	.	.	.	.	.
.
TOTALS	.	.	.	.	.	.	.	.	.
.	.	.	.	4	.	.	30	30	.
24	6	30	3	.	.	.	.	.	.

Figure 5-10: Example of hourly workload report

5.8 Inpatient Discharges/Days by Community (INPC)

Use the INPC option to produce a report of inpatient counts in a specified discharge date range by community. This option searches the Patient file for all patients registered at the SU or the facility selected. The report sorts by Community of Residence. This report supplies the following tallies:

- Adult/Pediatric Discharges in the date range specified
- Inpatient Days by Adult/Peds
- Newborn discharges
- Newborn Days
- Transfers in
- MCR/MCD/PI on the date of admission

Follow these steps:

1. At the “Do you wish to include only INDIAN patients?” prompt, type **Y** (Yes) or **N** (No).
2. At the “Starting Discharge Date for Inpatient Counts” prompt, specify the start of the date range.
3. At the “Ending Discharge Date for Inpatient Counts” prompt, specify the end of the date range.
4. At the “Do you wish to Sub-Total by Tribe?” prompt, type **Y** (Yes) or **N** (No).
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients

6. At the "Device" prompt, specify the device to print/browse the report.

```

Inpatient Discharges and Days for all Patients.
Location of Hospitalization: DEMO HOSPITAL
Discharge Dates between DEC 29,2007 and APR 7,2008.
The report is sorted by Community of Residence and by Tribe of
Membership. A '*' after the Community name indicates a Non-Service
Unit Community.

```

Current Community of PI residence	Adult /Peds Dschr	Adult /Peds Dschr	NB Days	NB IN	TX	MCR	MCD		
Community of Residence	Days		Tribe of Membership		Tribe of Membership				

32-HNDRD ACR *									
CHEROKEE NATION OF DEMO TRIBE, NM	0	6	36	0	0	0	2	1	1
		30	95	0	0	0	9	2	6

Subtotal:	36	131	0	0	0	11	3	7	
ALMOND *									
DEMO TRIBE, NM	2	7	0	0	0	0	0	0	0
NON-INDIAN BENEFICIA	2	6	0	0	0	0	0	0	0

Subtotal:	4	13	0	0	0	0	0	0	0

Figure 5-11: Example of INPC report

5.9 Inpatient Discharges/Days by SU of Residence (INPS)

Use the INPS option to produce a report of inpatient counts in a specified discharge date range by service unit (SU). This option searches the Patient file for all patients registered at the SU or the facility selected. The report sorts by SU of Residence. This report supplies the following tallies:

- Adult/Pediatric Discharges in the date range specified
- Inpatient Days by Adult/Peds
- Newborn discharges
- Newborn Days
- Transfers in
- MCR/MCD/PI on the date of admission

The report searches the entire patient and visit files.

```

Inpatient Discharges and Days for all Patients
Location of Hospitalization: DEMO HOSPITAL
Discharge Dates between DEC 29,2007 and APR 7,2008.

```

The report is sorted by Service Unit of Residence and by Community of Residence. A '*' after the Community name indicates a Non-Service Unit Community.

Service Unit of Residence	Adult	Adult	NB	NB	TX	MCR	MCD	PI
	/Peds	/Peds	Dsch	Days	IN			
Community of Residence	Dsch	Days						

CHEROKEE								
BIRDTOWN *	1	3	0	0	0	1	0	0
PAINTTOWN *	1	15	0	0	0	0	0	0
WHITTIER *	1	1	0	0	0	0	0	0

Subtotal:	3	19	0	0	0	1	0	0

Figure 5-12: Example of INPS report

5.10 Inpatient Discharges/Days by Tribe (INPT)

Use the INPT option to produce a report for inpatient counts in a specified discharge date range by tribe. This option searches the Patient file for all patients registered at the SU or the facility selected. The report sorts by Tribe of Membership.

This report supplies the following tallies:

- Adult/Pediatric Discharges in the date range specified
- Inpatient Days by Adult/Peds
- Newborn discharges
- Newborn Days
- Transfers in
- MCR/MCD/PI on the date of admission

Inpatient Discharges and Days for all Patients
 Location of Hospitalization: DEMO HOSPITAL
 Discharge Dates between DEC 29,2007 and APR 7,2008.
 The report is sorted by Tribe of Membership and by Community of Residence. A '*' after the Community name indicates a Non-Service Unit Community.

Tribe of Membership	Adult	Adult	NB	NB	TX	MCR	MCD	PI
	/Peds	/Peds	Dsch	Days	IN			

		Dsch		Days					
Community of Residence									

DEMO TRIBE, NM									
PAINTTOWN *	1	15	0	0	0	0	0	0	0
WHITTIER *	1	1	0	0	0	0	0	0	0

Subtotal:	2	16	0	0	0	0	0	0	0

Figure 5-13: Example of INPT report

5.11 Provider Practice Description Report (PPDS)

Use the PPDS option to produce a report that presents a profile of services provided by a selected provider. The user is prompted to enter a date range and to identify the provider's name. The user is prompted for either a long version (10 items in each list) or a short version (five items in each list) of the report.

OUTPUT BROWSER	Jan 22, 2009 14:53:12	Page: 2 of 8
1 - Designated Primary Provider Panel		
You are the Designated Primary Provider for 0 patients. In this time period you have provided services (any type) to 0 (0%) patients from your Designated Primary Provider Panel.		
In this time period, you provided ambulatory services at least twice to 0 patients who have no Designated Primary Provider identified.		
2 - Demographics and Workload for All Patients Served (Any Type of Service)		
In this time period you have provided services (any type) to 7 patients. 0 (0%) are from your Designated Primary Provider Panel. 7 (100%) are not from your Designated Primary Provider Panel.		
29% of your patients were Male and 71% Female.		
43% were 18 and under; 14% were 19-49; 43% were 50-64; and 0% were 65 and over.		
The leading residences for your patients are:		The leading tribes represented among your patients are:
BIG COVE	1	14%
DEMO TRIBE, NM	7	100%
PAINTTOWN	1	14%
SOUTH CAROLINA UNK	1	14%
TENNESSEE UNK	1	14%
WAYNESVILLE	1	14%

```

Of these services, 2 (29%) were chart reviews and 2 (29%) were
telecommunications services.

3 - Ambulatory Workload: You had a total of 21 ambulatory visits
during this time period. You were the Primary Provider for 21
visits (100%) and Secondary Provider for 0 visits (0%).

Your services were provided at the following
Service Categories:
  DEMO HOSPITAL          21 100%
Your services included the following locations:
  AMBULATORY            21 100%

The 5 leading Purposes of Visit
you (including Primary and Secondary POV's) prescribed or refilled
as Primary that you identified were:
  727.1 BUNION          6
  487.1 FLU W RESP MANIFEST 3
  V72.2 DENTAL EXAMINATION 3

The 5 leading Medications
Provider for the Visit were:
  034.0 STREP SORE THROAT 2
  V20.2 ROUTINE CHILD HEALT 2

For the Time Period: Dec 29, 2007 - Apr 07, 2008

The 5 leading Procedures that you
Topics that
performed as Primary Provider
for the Visit were:
  77.51 BUNIONECT/SFT/OSTEO 2
  47.01 LAPAROSCOPIC APPEND 2

The 5 leading Education
you taught were:
  28.11 TONSIL ADENOID BIOP 1
  86.64 HAIR TRANSPLANT 1

You made 0 In-Hospital Visits to patients hospitalized at your
Service Unit's Hospital and 0 In-Hospital Visits to other sites.

Enter ?? for more actions      >>>
+ NEXT SCREEN      - PREVIOUS SCREEN      Q QUIT Select Action: +//

```

Figure 5-14: Example short version of the PPDS report

At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to quit the report.
- Type **+** (plus) to display the next screen. This option is not available for the last screen.
- Type **-** (minus) to display the previous screen. This option is not available for the first screen.

5.12 Inpatient Reports (INPT)

This set of reports provides data on inpatient admissions and discharges typed into the PCC database. The available reports are listed in as menu options:

```

*****
**      PCC Management Reports      **
**          Inpatient Reports        **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL/CLINIC

HDM      Hospital Discharges by Month of Discharge(2A)
HDD      Hospital Discharge Listing By Date
IICD     Hospital Discharge Listing By DX or Procedure
HDT      Hospital Discharge by Taxonomy (Template/Create)
ADER     Admissions from the ER
    
```

Figure 5-15: Example of Inpatient Reports menu screen

5.13 Hospital Discharges by Month of Discharge (2A) (HDM)

Use the HDM option to produce a report that displays a monthly tabulation showing the number of direct (IHS, 638, or Tribal) inpatient discharges by month of discharge.

The report shows FY-to-date monthly totals for all facilities in the IHS Area Office specified. Each facility displays on a separate line. Monthly and location totals also display. The report must print on 132-column paper or a printer set for condensed print.

NUMBER OF HOSPITAL DISCHARGES BY MONTH OF DISCHARGE												Fiscal Year 94
AREA: 00		DEMO	OCT 07, 1994									Page 1
YR-TO DATE	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT

DEMO HOSPITAL/CLINIC												
3	29	3	2	1	2	3	1	4	6	1	1	1
DEMO2 HEALTH CENTER												
1	14	0	1	4	0	0	0	1	4	2	0	1
TOTAL	43	3	3	5	2	3	1	5	10	3	2	2
4												

Figure 5-16: Sample of HDM report

5.14 Hospital Discharge Listing by Date (HDD)

Use the HDD option to produce a report that shows the hospital discharges by patient population. This report is for direct services only; contract health discharges are not included. The report displays the admitting and discharge date, patient chart number, and the discharge service. The user can sort by date of discharge or location of encounter.

```

*****Confidential Patient Data Covered by Privacy Act*****
SJT                                DEMO HOSPITAL                                Page 2
                                HOSPITAL DISCHARGE LISTING BY DISCHARGE DATE
                                for Jan 23, 2008 to Jan 22, 2009

NAME                                HRCN      ADMIT DATE  DISCH DATE  DISCHARGE SERVICE
-----
LOCATION: OTHER
BETA,HENRY D                        150689    02/14/2008 02/18/2008 ALCOHOLISM
BETAA,BILL                          111111    SEP  4,1994  SURGERY
GAMMAAA,MAXINE                      111115    SEP  5,1994  OBSTETRICS
Total Discharges for OTHER: 3

```

Figure 5-17: Example of HDD report

5.14.1 Estimated Run Time

Processing time for this report can be lengthy, depending on the date range specified. When using a date range greater than one month, it may be advisable to queue this report to run at night or after regular hours. Please contact the local site manager with any questions about queuing this report.

5.15 Hospital Discharge Listing by DX or Procedure (IICD)

Use the IICD option to show a list of hospitalization visits by discharge date or admission date. Visits can be selected by ICD or procedure code and treatment specialties. Data may be printed for selected providers. The report prints ICD codes and narratives for all diagnoses and procedures.

1. Type the facility name.
2. Specify whether discharge dates or admission dates will be in the report, and enter the beginning and ending dates. Visits for a particular treating specialty can be specified to print in this report.
3. Choose one of the following four reports. A predefined taxonomy of ICD diagnoses may be used.
 - All hospitalization visits for the selected dates
 - Only those visits within a selected diagnosis code range

- Visits within a selected procedure code range
- Visits for selected providers

The report lists all inpatient discharges that meet the criteria entered during the time period specified. The report displays in alphabetical order by patient name.

The following items display for each admission:

- Patient's Name
- Chart Number
- Age
- Admission and Discharge Dates
- Provider Discipline Code
- ICD Codes
- Provider Narrative

```

*****Confidential Patient Data Covered by Privacy Act*****
XXX          DEMO HOSPITAL/CLINIC          Page 1
 4:14 pm     HOSPITALIZATION DISCHARGES
FEB 8,1995   for 09/09/94 to 09/09/94
              ALL TREATING SPECIALTIES

NAME          HRCN  AGE  VISIT DATES          PRV  ICD          PROV
NARRATIVE
BETAA,ALPHA   11111  57   08/10/94-09/09/94   00  V54.8          OPEN
REDUCTION INTER
              250.00          DIABETES
MELLITUS
              365.9           GLAUCOMA
              93.22          AMBULATION,
GAIT TRA
BETAA,BETAA   11112  84   09/01/94-09/09/94   00  285.9          POSS ANEMIA
              578.9           POSS
GASTROENTERITIS
              585.           CHRONIC
RENAL FAIL
BETAA,GAMMAA 111113  4    09/08/94-09/09/94   00  774.6          NEONATAL
HYPERBILIRU

```

Figure 5-18: Example of IICD report

5.15.1 Estimated Run Time

Processing time for this report might be lengthy, depending on the parameters specified. It may be advisable to queue this report to run at night or after regular hours. Please contact the local site manager with any questions about queuing this report.

5.16 Hospital Discharge by Taxonomy (Template/Create) (HDT)

Use the HDT option to create a search template of patients based on their hospital discharge date and diagnosis. Templates can be used with many report options, and they only display data for patients stored in the template. This allows for faster report generation because the entire database does not need to be searched each time data is printed for a specific group of patients.

Patients selected for inclusion in the template are living patients who have a discharge date within a specified time frame. Patients must also have a primary diagnosis that is in the diagnosis taxonomy.

The report excludes the following categories:

- Patients discharged before ten days old
 - Patients whose length of stay in the hospital was less than one day
 - Patients whose primary diagnosis is not in the user-selected taxonomy
1. Enter a beginning and ending discharge date for the patient search.
 2. Enter the name of the diagnosis taxonomy. Note that this taxonomy must have been defined previously. This report option does not allow the diagnosis taxonomy to be created. See the site manager for assistance in creating the diagnosis taxonomy.
 3. Type the name of the search template in which the patients will be stored. This can be an existing or new template. Saving patients in an existing taxonomy will replace the group of patients previously stored in that template.

After search criteria have been entered, the following message displays indicating the number of patients that were found and stored in the template:

```
OKAY -- HOLD ON WHILE I FIND ALL THE DISCHARGES
ALL DONE - FOUND 47 PATIENTS.
```

Figure 5-19: Example of message confirming number of patients found

5.17 Admissions from the ER (ADER)

Use the ADER option to produce a report that shows a list of admissions from the ER for a specified date range. Note that this option searches the patient file for any admissions that occurred on the same day as a visit to the ER, so the admissions listed cannot have come directly from the ER.

```
XXX DEMO HOSPITAL Page 1
HOSPITAL ADMISSIONS AFTER ER VISIT
```

VISITS DATES: JAN 1,1999 TO JAN 22, 1999						
NAME	HRCN	VISIT DATE&TIME	CLN	FAC	ICD	
PROVIDER NARRATIVE						

SAMPSON,MARGARE	DH 105336	01/01/99 12:55		DIH	786.50	
ATYPICAL CHEST PAIN						
ER Visit Information =>		01/01/99 12:00	30	DIH	786.9	
ABNORMAL FEELING IN						
SPARKS,RAYMON	DH 106575	01/02/99 15:15		DIH	410.90 ACUTE	
MYOCARDIAL IN						
					303.90 ALCOHOL	
ABUSE					401.9	
HYPERTENSION						
ER Visit Information =>		01/02/99 12:00	30	DIH	786.50 CP -	
R/O MI						
MARTINEZ,LEVASS	DH 119068	01/02/99 16:30		DIH	522.5 DENTAL	
ABSCESS						
					493.90 ASTHMA	
					250.00 ADULT	
ONSET DIABETE						

Figure 5-20: Sample of report showing admissions from ER

6.0 Quality Assurance Reports (QA)

This series of PCC Reports displays patient visit data with ICD Code information or APC recode information. See Figure 6-1 for menu options.

```

*****
**      PCC Management Reports      **
**      Quality Assurance Reports    **
*****

IHS PCC Suite Version 2.0
DEMO HOSPITAL/CLINIC

AC      Anticoagulation INR Management Report
AUD     Random Sample of Visits by DX and Date
CICD   Listing of Visits by Clinic Type and by Diagnosis
INPT   Hospital Discharge Listing By DX or Procedure
VICD   Listing of Outpatient Visits with ICD Codes
A      Returns to ER w/in 72 Hrs After Clinic Visit
ADA    Listing of Clinic Visits with ADA Codes
CZIP   Clinic Visit Counts by Clinic Type by Zip Code
CVC    Clinic Visit Counts Within a Date Range
NVST   Patients with AT LEAST N Visits
INJ    Listing of Visits with Injury Diagnosis
INJS   Injury Surveillance Summary Report
PVC    Provider Visit Counts
PVCT   Provider or Clinic Visit Counts by Template of Patients
VGEN   Visit General Retrieval
BPC    In/Out Control Blood Pressures
DEL    Delete VGEN/PGEN Report Definition
RADM   Readmissions Within 30 Days of a Discharge
REF    Listing of Patient Refusals
RT1    Returns to Clinic w/in 72 hours of a clinic visit
VST    Display Single Visit for a Patient ...

Select Quality Assurance Reports Option:

```

Figure 6-1: Quality Assurance Reports menu

6.1 Anticoagulation INR Management Report (AC)

The Anticoagulation INR Management Report helps assess the quality of anticoagulation services for a designated population at a facility during a specific month. Select from the following options:

```

W      Warfarin Patients
A      Anticoagulation Clinic Patients
S      Search Template of Patients
I      iCare Panel
E      EHR Personal List

```

Figure 6-2: Menu options for Anticoagulation INR Management Report

Different prompts display depending on which option was chosen.

The prompts in Figure 6-3 are standard.

```
The following clinics have been identified as Anticoagulation
clinics:
    D1 - Anticoagulation clinic
Do you wish to add another clinic(s)? N// NO

This is a monthly report.  Enter the month and year.
Enter Month (e.g. 1/1999): 01/2010  (JAN 2010)

You chose Jan 01, 2010 through Jan 31, 2010.
Is this correct? Y// YES

PATIENT LISTS
The following patient lists are available to be printed with this
report.
Please select which reports you would like to include with the
report.
1 - All patients in the population selected.
2 - Only patients in INR Goal Range and monitored this month
3 - Only patients in INR Goal Range but NOT monitored this month
4 - Only patients NOT in INR Goal Range but are monitored this month
5 - Only patients NOT in INR Goal Range and are NOT monitored this
month
Which population would you like to view/print:  (1-5):
NOTE: If you do not select a patient list, statistics only will
print.
Specify the community taxonomy to determine which patients will be
included in the user population/active clinical population.  You
should
have created this taxonomy using QMAN.
```

Figure 6-3: Standard prompts for Anticoagulation INR Management Report (AC)

A summary of selections display before printing the report.

6.2 Random Sample of Visits by DX and Date (AUD)

Use the AUD option to produce a report that shows a sample of visits by diagnoses and date. This option searches the PCC database for ambulatory visits that match user-defined criteria. The audit search offers two choices: (1) randomly select a user-defined number of visits that match the search criteria for each provider and diagnostic range, or (2) all visits that meet the search criteria. This routine identifies and retrieves visit information for targeted quality assurance surveys.

Define the following search criteria:

- Visit Date range
- Patient Age group

- Service Category
- Visit Type
- Clinic Type
- Location of Encounter
- ICD Diagnostic Code ranges

Only visits meeting user-defined criteria display in the report. Searches can include:

- All providers or selected providers and the search will display POVs by provider.
- A search can be done for all POVs matching the criteria or on a random sample of any desired number of matching POVs. The report of matches displays by provider and POV. For example, if the user selects a provider and ten random POVs in the search criteria, the report displays ten POVs per provider for the specified ICD Diagnostic range.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to restrict the Audit Search to Patients within an Age Range?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
4. At the “Want to restrict the Audit Search to Visits with a particular SEX?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
5. At the “Want to restrict the Audit Search to Visits with a particular SERVICE CATEGORY?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
6. At the “Want to restrict the audit search by VISIT TYPE?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
7. At the “Want to restrict the audit search by CLINIC TYPE?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
8. At the “Want to restrict the audit search by LOCATION of ENCOUNTER?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
9. The system displays the specified search criteria.
10. At the “Which visit set” prompt, type one of the following:
 - A - All visits that match

- R - Random sample of visits that match

If **R** is entered, the system reports on a randomized sampling of matching visits. The system prompts the user to enter the number of randomized visits to include on the report.

11. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include all patients
- E - Exclude demo patients
- O - Include only demo patients

12. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include all patients
- E - Exclude demo patients
- O - Include only demo patients

13. At the “Device” prompt, specify the device to print/browse the report.

The first page of the report displays the search criteria selected for generating the report. After pressing ENTER at the prompt, the remainder of the report displays. Please see the following example report.

Note: If a random sample is requested, the report displays the total number of POVs matching the selection criteria before the random selection.

If the number of matching visits is less than the number requested to display, all visits display. For example, if five random samples were requested but only four visits match the selection criteria, four visits display.

```

DEMO HOSPITAL/CLINIC                FEB 6,1995                Page 1
Audit Search for Ambulatory Visits from SEP 1,1994 through SEP
30,1994.

HRCN          Visit Date      Primary Provider   Patient Name      DOB
          ICD9              DIAGNOSIS
-----
---> ICD Code Range: ALL ICD Codes.
      Total Matches: 1    Matches Selected: 1

111183    DEC 27,2008    NPROVIDER,ERIN D  OMEGA,SIGMA      03/25/1947
          072.9              text

```

```

---> ICD Code Range: ALL ICD Codes.

      Total Matches: 1      Matches Selected: 1

777720    JAN 5,2009      SPROVIDER,JEROME      RHO,BETA    03/08/1936
          078.89          text in this place

```

Figure 6-4: Example of randomly selected reports

6.2.1 Estimated Run Time

Run time for this report is a function of the date range and number of selection criteria chosen. The report processing time might be short for a small date range or longer for a larger date range. The user might want to queue this report to print after hours. Please contact the local site manager with questions regarding queuing this report.

6.3 Listing of Visits by Clinic Type and by Diagnosis (CICD)

Use the CICD option to produce a report that shows a list of clinic visits by Clinic and ICD Code for a specific date range. If desired, the report can be very specific. The report displays in alphabetical order by patient name.

Note: To print only those visits with no associated clinic code (excluding hospitalizations), type 0 when prompted to print all clinics.

The visits included must meet the following criteria:

- Must not be deleted
- Must be for the site that the user logged into
- Must *not* be for the following service categories:
 - Hospitalization
 - Observation
 - Events
 - In-Hospital
- Must not be a contract or VA visit type

The following displays for each Clinic Visit:

- Patient's Name
- HRN
- Age
- Visit Date
- Provider Discipline Code

- ICD Codes
- Provider Narrative

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning date of the range.
2. At the “Enter ending Visit Date” prompt, type the end date of the range.
3. At the “Selection” prompt, type one of the following:
 - 1 - Print for ALL
 - 2 - Print for ONE clinic
 - 3 - Print visits with no clinic code

If **2** is entered, additional prompts display.
4. At the “Which visits should be printed” prompt, type one of the following:
 - 1 - Print all Visits
 - 2 - Print Visits for a range of POV ICD codes
 - 3 - Print Visits for a range of Procedure ICD codes

If **2** or **3** are entered, other prompts display.
5. At the “Include visits from ALL Locations” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
6. At the “Device” prompt, specify the device to print/browse the report.

```

*****Confidential Patient Data Covered by Privacy Act*****

```

NAME	HRCN	AGE	VISIT DATE	PRV	ICD	PROV NARRATIVE
ABERNATHY, BOB	125571	56	12/17/08	1000	15 822.0	test narrative fracture pa
ALPHA, ICHI	111234	83	11/12/08	1200	00 321.1	meningitis
AMMONS, FRANK	110521	43	01/07/09	1200	57 321.2	text again
BAILEY, FREDER	142895	50	01/22/09	1200	00 .9999	blah blah
BETA, GO	111225	61	11/11/08	1200	21 320.1	meningitis
BETA, SHICHI	111228	72	11/13/08	1000	21 322.2	meningitis
BROWN, ALLEN	131029	43	12/17/08	1000	15 830.0	test narrative jaw disloca
BUCHANAN, CASS	168611	46	12/17/08	1200	53 823.00	fracture upper

```

end tibia,
CHI,JEREMY      159320  71 12/19/08 1200  05  096.   This is long
standing
CHI,JU          111216  67 11/03/08 1100  23  007.1  giardia
DEMO,CORRINE   155243  19 12/06/08 1200  11  796.2  10

Enter RETURN to continue or '^' to exit:

```

Figure 6-5: Example of CICD Listing

6.3.1 Estimated Run Time

Run time for this report is a function of the date range and number of selection criteria chosen. The report processing time might be short for a small date range or longer for a larger date range. The user might want to queue this report to print after hours. Please contact the local site manager with questions regarding queuing this report.

6.4 Hospital Discharge Listing by Diagnosis or Procedure (INPT)

The INPT option prints a list of hospitalization visits by discharge date or by admission date. The visits include the user's facility only; however, treating specialties can be identified. The list includes ICD Codes and Narratives for all diagnoses and procedures. The user has the option of displaying only those visits that contain ICD codes within a given range.

The following information displays for each admission:

- Patient's Name
- HRN
- Age
- Admission and Discharge Dates
- Provider Discipline Code
- ICD Codes
- Provider Narrative

Follow these steps:

1. At the "Run for which Facility of Encounter" prompt, type the name of the facility.
2. At the Report Admission by Admission Date or Discharge Date?" prompt, type **A** (Admission Date) or **D** (Discharge Date).
3. At the "Enter beginning Discharge Date" prompt, type the beginning of the date range.
4. At the "Enter ending Discharge Date" prompt, type the end of the date range.

5. At the “Do you want All Treating Specialties?” prompt, type **Y** (Yes) or **N** (No). If the user types **N** (No), other prompts will display.
6. At the Which visits should be printed, type one of the following:
 - 1 - Print all Visits
 - 2 - Print Visits for Diagnosis Code Range
 - 3 - Print Visits for Procedure Code Range
 - 4 - Print Visits for Provider(s)
 If **2**, **3**, or **4** are entered, other prompts will display.
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
8. At the “Device” prompt, specify the device to print/browse the report.

The report displays in alphabetical order by patient name; for example,

```

*****Confidential Patient Data Covered by Privacy Act*****
XXX                DEMO HOSPITAL                Page 1
  3:07 pm          HOSPITALIZATION DISCHARGES
JAN 23,2009       for 01/24/2008 to 01/23/2009
                  ALL TREATING SPECIALTIES

NAME              HRCN   AGE  VISIT DATES          PRV  ICD   PROV
NARRATIVE

OMEGA,DELTA      111180  73  03/03/08-03/06/08
SIGMA,ANGELA     124682  21  03/12/08-03/12/08
SIGMA,ALBERT D  165110   6  01/10/08-01/25/08  HEALTH
AIDE255.OCUSING'S SYNDROME

                                TOTAL PATIENTS:   3
                                TOTAL VISITS:     3

Enter RETURN to continue or '^' to exit:
  
```

Figure 6-6: Example of INPT listing

6.5 Listing of Outpatient Visits with ICD Codes (VICD)

Use the VICD option to produce a report that lists all outpatient visits for a specific time at the RPMS facility into which the user is logged.

The visits in this report must meet the following criteria:

- Must be for the facility into which the user is logged
- Must not be a Contract or VA type visit
- Must be one of the following service categories: Ambulatory, Day Surgery, or In-Hospital
- Must not be a Dental Clinic visit

The following information will be displayed for each visit:

- Patient's Name
- HRN
- DOB
- Medicare Number
- Visit Date
- Provider Discipline Code
- First/Revisit Code
- ICD Codes
- Provider Narrative

The report is presented in alphabetical order by patient name.

Note: This report must be printed on a 132-column-width printer or a printer set for condensed print.

*****Confidential Patient Data Covered by Privacy Act*****								
XXX	DEMO HEALTH CENTER						Page 1	
FEB 7, 1990	ALL OUTPATIENT VISITS (excluding dental)							
for 09/01/88 to 09/30/88								
NAME	HRCN	DOB	MEDICARE	VISIT DATE	PROV	F/R	ICD	
PROV NARRATIVE								
BETAA, ANNE	78556	02/01/26		09/09/88	00	2	V07.9	
IMMUNIZATION								
							2	250.00 DM
TYPE II								
							2	401.9
HYPERTENSION								
BETAA, BOB	67445	12/01/40		09/09/88	11		V68.1	
MED REFILL								
							09/09/88	00 2 250.00
DIABETES								
BETAA, CHERYL	78556	08/01/11		09/09/88	08	1	367.0	
HYPEROPIAW/AS								
							1	367.4
PRESBYOPIA								
							1	379.31

APHAKIA OU							
BETAA, JOHN	11908	08/01/70		09/09/88	00	2	V68.1
MED REFILL							
BETAA, LARRY	17655	11/01/32		09/09/88	30		V72.6
LAB							
BETAA, THERESA	89532	06/01/21		09/09/88	00	2	428.0
F/U POSS CHF							
						1	645.9
URI							

Figure 6-7: Example of VICD report

6.6 Returns to ER within 72 Hours after Clinic Visit (A)

Use the A (Returns to ER within 72 Hours after Clinic Visit) option to produce a report that displays a list of patient visits resulting in a return to the ER within 72 hours of the clinic visit. Select a beginning and ending visit date range, the clinic in which the patient was initially seen, and the location of the visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning date of the range.
2. At the “Enter ending Visit Date for Search” prompt, type the ending date of the range.
3. At the “Include Returns from,” prompt, type one of the following:
 - A - ANY Clinic
 - O - One particular Clinic

If the user types **O**, other prompts will display.
4. At the “Run Report for returns w/in how many hours” prompt, type **7** for 72 hours or **4** for 48 hours.
5. At the “Include Returns from Clinic Visits to” prompt, type one of the following:
 - A - ANY Provider
 - O - One particular Provider

If **O** is entered, other prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients

7. At the "Device" prompt, specify the device to print/browse the report.

Below is the list of visits that can potentially be used for Ambulatory Indicator A-1 of the Maryland Hospital Association Project.

DEMO HOSPITAL/CLINIC							Page 1	
ER VISITS AFTER CLINIC VISITS								
VISITS DATES: JAN 01, 1994 TO DEC 31, 1995								
NAME	HRCN	VISIT DATE&TIME		CLN	FAC	ICD		
PROVIDER NARRATIVE								

SMITH, BECKY	DH 222222	05/09/94 12:00	30	SE	401.9	HTN		
		05/12/94 12:00	30	SE	250.00	DM II		
WATERMAN, ANTHON	DH 222223	09/12/94 10:00	01	SE	250.00	DM		
		09/13/94 17:30	30	SE	250.30			
DIABETIC COMA								
WATERMAN, RAE	DH 222224	09/11/94 12:00	52	SE	278.0			
MORBID OBESITY/NUTR								
		09/13/94 17:30	30	SE	250.30			
DIABETIC COMA								
ENOS, DON	DH 222225	02/06/95 12:00	14	SE	250.00	DM		
		02/06/95 12:00	30	SE	401.9	HTN		
THOMAS, RITA	DH 222226	02/08/95 12:00	14	SE	311.			
DEPRESSIVE DISORDER								
		02/08/95 12:00	30	SE	311.			
DEPRESSIVE DISORDER								
ADAMS, ROSE	DH 222227	11/01/95 09:00	01	SE	250.00	DM		
					401.9	HTN		
					382.9	OTITIS		
MEDIA								
		11/01/95 23:00	30	SE	382.9	OM - FOLLOW UP		
					487.1	FLU		
			514.			PULMONARY CONGESTIO		
RUN TIME (H.M.S): 0.0.6								
End of report. HIT RETURN:								

Figure 6-8: Example list of patient visits resulting in a return to the ER within 72 hours of the clinic visit

6.7 Listing of Clinic Visits with ADA Codes (ADA)

Use the ADA option to produce a report that lists all visits with associated ADA codes for a specific time period. Specify the date range and location of visit. A report can be generated for selected clinics or all clinics.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the ending of the date range.
3. At the “Print for ALL clinics?” prompt, **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
4. At the “Include visits from All Locations?” prompt, **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

```

*****Confidential Patient Data Covered by Privacy Act*****
          DEMO HOSPITAL/CLINIC                               Page 1
3:21 pm          CLINIC VISITS FOR DENTAL (56)
FEB 7,1996          for 01/01/96 to 01/31/96

NAME           HRCN AGE  VISIT DATE   PRV  ADA   PROV NARRATIVE
ALPHA,JANE     333333  11 01/21/96  0100 52   0000   DENTAL/ORAL HEALTH
VISIT
BETA,JENNIFER  333334  24 01/08/96  0414 52   0120   DENTAL EXAMINATION
          01/30/96 1000 52   0120   DENTAL/ORAL HEALTH VISIT
DELTA, LISA    333335  33 01/04/96  1100 52   0000   OTHER DENTAL
GAMMA,MARVIN  333336  61 01/06/96  1200 52   0130   DENTAL EXAMINATION
DELTA,JASON   333337  11 01/21/96  0400 52   0120   DENTAL/ORAL HEALTH
VISIT
          01/25/96 0000 52   0000   OTHER DENTAL
PHIII,SHARON  333338  56 01/16/96  0200 52   0130   DENTAL EXAMINATION
PHIII,LUCY    333339  65 01/13/96  0130 52   0000   DENTAL CARIES

          TOTAL PATIENTS FOR CLINIC: 7
          TOTAL VISITS FOR CLINIC: 9

RUN TIME (H.M.S): 0.0.1
End of report. HIT RETURN:

```

Figure 6-9: Example of ADA report

6.8 Clinic Visit Counts by Clinic Type by Zip Code (CZIP)

Use the CZIP options to produce a report that generates a count of visits by Clinic Type and by Zip Code for a date range specified. The report provides subtotals by location of encounter.

All visits in the database will be included in the tabulation with the *exception* of the following:

- Visit Types: Contract or VA
- Visit Service Categories
 - Chart Review
 - In-Hospital
 - Hospitalizations
 - Historical Events
 - Telephone Calls

Note: Visits must have a Primary Provider and Purpose of Visit in order to appear in this report.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Include visits from All Locations?” prompt, type **Y** (Yes) or **N** (No). If the **N** (No) is entered, other prompts will display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

```

APR 04, 1996                                     Page 1

NUMBER OF AMBULATORY VISITS BY CLINIC TYPE
LOCATION OF VISITS: ALL
VISIT DATES: JAN 01, 1995 TO JAN 04, 1995

LOCATION OF VISIT
  TYPE OF CLINIC (CODE)           ZIP CODE           VISITS
-----
DEMO HOSPITAL/CLINIC

```

ALCOHOLISM PROGRAM	(43)	88776	3
		Clinic Total:	3
CHRONIC DISEASE	(50)	88776	1
		Clinic Total:	1
DENTAL	(56)	88776	4
		Clinic Total:	4

		Location Subtotal:	8

Figure 6-10: Sample of CZIP report

6.9 Clinic Visit Counts within a Date Range (CVC)

The CVC report counts clinic visits within a specified date range. The user may run the report for a specific clinic or for all clinics.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Include visits from All Locations?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts will display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

The following sample report lists visits to the General Clinic for January 1, 1994 to February 28, 1994.

LAB	DEMO HOSPITAL/CLINIC
Page 1	
4:54 pm	VISIT COUNTS FOR GENERAL (01) CLINIC
JUL 28,1994	for 01/01/94 to 02/28/94
VISIT DATES	NUMBER OF VISITS
01/11/94	12
01/13/94	10
01/15/94	18

01/17/94	9
01/20/94	8
01/22/94	14
01/25/94	10
01/29/94	6
02/04/94	9
02/08/94	20
02/11/94	13
02/12/94	11
02/15/94	10
02/27/94	10
TOTAL VISITS FOR CLINIC	160

Figure 6-11: Sample of CVC report

6.10 Patients with At Least N Visits (NVST)

Use the NVST option to produce a report listing patients who had at least n clinic visits within a specified time frame. The output from this report can be a list of patients or a search template.

Follow these steps:

1. At the “Enter beginning Date” prompt, type the beginning of the date range.
2. At the “Enter ending Date” prompt, type the end of the date range.
3. At the “Enter the minimum number of times the patient should have been seen” prompt, type any integer between one and 100.
4. The Visit Selection Menu is displayed.

GENERAL RETRIEVAL	Jan 26, 2009 13:32:44	Page: 1 of 5
VISIT Selection Menu		
Visits can be selected based upon any of the following items. Select as many as you wish, in any order or combination. An (*) asterisk indicates items already selected. To bypass screens and select all visits hit Q.		
1) Name/Chart /SSN calculated)	58) Outside Location	115) BMI (Last
2) Sex Provider	59) Clinic Type	116) RX Ordering
3) Date of Birth Codes	60) Visit Created By	117) Dental ADA
4) Birth Month Exam	61) User Last Update	118) Radiology
5) Birth Weight (grams) Provider	62) VCN Present	119) Immunization
6) Birth Weight (Kgs)	63) 3rd Party Billed?	120) Immunization

```

Lot
7) Race                64) Hospital Location    121) Immunizations
8) Age                 65) Admitting Service    122) Exams
9) Age in Months      66) Admission Type      123) Treatments
Provided
10) Veteran Status Y/N 67) Admission Source-UB92 124) Lab Tests
11) Date of Death      68) Admitting Provider (In 125) Microbiology
Culture
12) Date Patient Establish 69) Discharge Service    126) Microbiology
Organism
13) Mlg Address-State  70) Date of Discharge    127) Medications
14) Mlg Address-Zip    71) Discharge Type      128)
Medications+SIG

+          Enter ?? for more actions
S   Select Item(s)  +   Next Screen      Q   Quit Item Selection
R   Remove Item(s) -   Previous Screen  E   Exit Report
Select Action: S//

```

Figure 6-12: Visit Selection menu

To choose the criteria for the report, type the number(s) of the criteria at the “Select Action” prompt and press Enter. An asterisk (*) indicates that an item has been selected. To select all visits, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

5. At the “type of output” prompt, type **L** (List of Patients) or **S** (Search Template of Patients). If **S** is entered, other prompts display.
6. The Sort Item Selection Menu is displayed. Only one item can be selected from the list displayed in the menu. To sort the report by patient name type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

```

GENERAL RETRIEVAL          Jan 26, 2009 13:38:42          Page: 1 of 2

                          SORT ITEM SELECTION MENU
The patients displayed can be SORTED by ONLY ONE of the following
items. If you don't select a sort item, the report will be sorted by
patient name.

1) Patient Name                29) Cause of Death          57) Most Recent
ALCOHOL HF
2) First, Last Name           30) MEDICARE Y/N           58) Most Recent
STAGED DM
3) Chart                      31) Medicare Part B       59) Most Recent
Barriers H
4) Terminal Digit            32) Medicare Part D       60) Most Recent
LEARNING P
5) Sex                       33) MEDICAID Y/N          61) Most Recent
RUBELLA HF
6) Date of Birth              34) PRIVATE INSURANCE Y/N 62) Date Last
Alcohol Scrc

```

```

7) Birth Month          35) Any Third Party Covera 63) Date Last
Depression S
8) Birth Weight (grams) 36) Third Party Eligibilit 64) Date Last
IPV/DV Scree
9) Birth Weight (Kgs)   37) Medicaid Plan Name     65) Date Last
Colonoscopy
10) Race                38) Pvt Ins Plan Name       66) Date Last
Flex Sig
11) Age                 39) Pvt Ins Plan Type       67) Date Last
Mammogram
12) Age in Months       40) HRN Record Status      68) Date Last
PAP Smear
13) Father's Name       41) HRN Disposition        69) Date Last
Tobacco Scre
14) Mother's Name       42) Patient's Last Visit   70) Date Last
Fall Risk As

+ Enter ?? for more actions
S   Select Item(s)  +   Next Screen      Q   Quit Item
Selection
R   Remove Item(s) -   Previous Screen  E   Exit Report
Select Action: S//

```

Figure 6-13: Sort Item Selection menu

7. At the “Do you want each Patient Name on a separate page? prompt, type **Y** (Yes) or **N** (No).
8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
9. At the “Device” prompt, specify the device to print/browse the report.

```

XXX                                                    Page 1
DEMO HOSPITAL/CLINIC
PATIENTS SEEN AT LEAST 10 TIMES
VISIT DATES: JAN 01, 1993 TO AUG 05, 1996

          LOCATION      PROVIDER      DX
PATIENT NAME      CHART      SEX DOB      SEEN      SEEN      CODES
VISITS
-----
Patient Name:   ALPHA, ICHI

ALPHA, ICHI      111234      M  01/24/1925  DEMO HOSPI  IAPROVIDER
321.1           8

          DEMO INDIA
          NURSING HO

```

OTHER

Figure 6-14: Example of NVST report

6.11 Listing of Visits with Injury Diagnosis (INJ)

Use the INJ option to produce a report that lists visits containing an injury diagnosis (ICD codes 800-999).

The user can select which visits to print based on any of the following criteria:

- Visit Date
- Clinic of Visit
- Service Category of Visit
- Type of Visit
- Location of Encounter
- Age range

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Include visits from All Locations?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
4. At the “Include ALL Visit Types?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
5. At the “Include ALL Visit Service Categories” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
6. At the “Include visits to ALL clinics” prompt, type **Y** (Yes) or **N** (No). If the user types **N** (No), other prompts display.
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
8. At the “Device” prompt, specify the device to print/browse the report.

The report includes a cover page that identifies the visit criteria selected.

LAB	DEMO HOSPITAL/CLINIC	Page 1
	Visits with Injury Diagnosis	

```

Visit Dates:  JAN 01, 1994 to DEC 31, 1994
PATIENT      HRCN      AGE      VISIT DATE  PRV  TYPE      SER CAT
-----
ALPHAA,BOBBIE LYN  125571    56      12/17/08  1000  15      TRIBE-NON
AMBULATORY
ICD9:  822.0      Provider Narrative:  test narrative fracture
patella closed
Cause of Injury:  E826.0 -  PEDAL CYCLE ACC-PEDEST
Date of Injury:  12/17/08
Place of Occurrence:  E849.5

ALPHAA,MARTHA AGN  100881    53      04/02/08  1200  00      TRIBE-NON
TELECOMMUN
ICD9:  959.01     Provider Narrative:  HIT HEAD
Cause of Injury:  E916. -  STRUCK BY FALLING OBJECT
Date of Injury:  04/06/08
Place of Occurrence:  E849.9
Cause of DX:  DRUG RELATED

BLANKENSHIP,LISA MAR  109272    46      02/14/08  1000  21      TRIBE-
NON AMBULATORY
ICD9:  999.0      Provider Narrative:  test

Enter RETURN to continue or '^' to exit:

```

Figure 6-15: Example of INJ report

6.12 Injury Visit E-Code Summary Report (INJS)

Use the INJS option to produce the Surveillance Injury Report, which counts visits that have an injury diagnosis (ICD codes 800-999). The visits to count can be selected based on any of the following criteria:

- Visit Date
 - Type of Visit
 - Clinic
 - Location of Encounter
 - Service Category
 - Age Range
1. Enter a beginning and ending visit date range for this report.
 - To include all visits, type **INJS** at each of the corresponding prompts.
 - To screen visits, type **No** at the corresponding prompt and then type specific variables; for instance, to screen visits by clinic, type the specific clinics of interest, such as Internal Medicine and Diabetic. Visit specifications can be saved for future use by assigning a name to each group.

The visit counts in this report are summarized by the 18 E-Code categories listed in the table below. These predefined injury code taxonomies can be used with the VGEN report option to print the cause of injury code, place of injury code, and whether the injury was work- or alcohol-related.

Category	E-Code Range	Taxonomy Name
Motor Vehicles	E800.0-E825.9, E929.0, E988.5	APCL INJ MOTOR
Boat/Water	E831.0-E831.9, E833.0-E838.9	APCL INJ WATER TRANSPORT
Air Transport	E840.0-E845.9, E988.5	APCL INJ AIR TRANSPORT
Accidental Poison	E850.0-E869.9, E929.4	APCL INJ POISONING
Environmental Factors	E900.00-E904.9, E907.0E909.9, E929.5, E988.3	APCL INJ FALLS
Stings/Venoms	E905.0-E905.9, E906.2, E906.4, E906.8, E906.9	APCL INJ FIRE
Falls	E880.0-E888.0, E929.4, E987.0-E987.9	APCL INJ ENVIRONMENTAL FACTORS
Fire/Flame	E890.0-E899.0, E929.4, E988.1-E988.2	APCL INJ STINGS VENOMS
Animal Bites	E906.0-E906.1, E906.3, E906.5	APCL INJ ANIMAL RELATED
Drowning/ Submerging	E830.0-E830.9, E832.0-E832.9, E910.4-E910.9	APCL INJ DROWNING
Cutting/Piercing	E920.3-E920.9	APCL INJ CUT
Firearms	E922.0-E922.9, E970.0, E985.0-E985.4	APCL INJ FIREARMS
Sports Injury	E917.0	APCL INJ SPORTS
Suicide	E950.0-E958.9, E983.0	APCL INJ SUICIDE
Assault	E960.0-E966.0, E968.0-E968.9	APCL INJ ASSAULTS
Child Abuse	E967.0-E967.9	APCL INJ BATTERED CHILD
Undetermined	E988.8-E988.9	APCL INJ UNDETERMINED
Other	All others in range 800-999 not listed above	APCL INJ OTHER CAUSES

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Include visits from All Locations?” prompt, **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.

4. At the “Include ALL Visit Types?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
5. At the “Include ALL Visit Service Categories” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
6. At the “Include visits to ALL clinics” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
7. At the “would you like to restrict the report by Patient age range?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
9. At the “Device” prompt, specify the device to print/browse the report.

The system then lists the report criteria, followed by the report itself.

XXX	DEMO HOSPITAL	Page 1	
INJURY SURVEILLANCE SUMMARY REPORT (E-CODES) Visits with Injury Diagnosis Visit Dates: JAN 27, 2008 to JAN 26, 2009 CAUSE OF DX			
E-CODE	CATEGORY SUMMARY	COUNT	% TOTAL (ALCOHOL RELATED)

	MOTOR VEHICLE	1	14
	WATER TRANSPORT	1	14
	AIR TRANSPORT	0	0
	ACCIDENTAL POISONING	0	0
	ACCIDENTAL FALLS	0	0
	FIRES/FLAMES	0	0
	ENVIRONMENTAL FACTORS	0	0
	STINGS/VENOMS	0	0
	ANIMAL RELATED	0	0
	DROWN/SUBMERGE	0	0
	CUT PIERCING OBJ	0	0
	FIREARMS	0	0
	SPORTS INJURY	0	0
	SUICIDE ATTEMPTS	0	0
	ASSAULTS	0	0
	BATTERED CHILD	0	0
	UNDETERMINED	0	0

OTHER CAUSES	5	71	0
	<hr/>	<hr/>	<hr/>
TOTALS:	7	100%	0
RUN TIME (H.M.S): 0.0.0			
End of report. HIT RETURN			

Figure 6-16: Example of INJS report with cover page

6.13 Provider Visit Counts (PVC)

The PVC report provides the total number of visits for each provider or provider discipline selected for a specified date range. Enter a visit date range and a single provider, a single provider discipline, or all providers. The report prints one page for each provider or provider discipline selected. Each visit date and clinic is displayed and totals by provider are included.

The following visits are included in the report:

- Visits at the facility into which the user is logged
- All Service Categories *except*:
 - Hospitalizations
 - In-Hospital, Events
 - Observation
- All Visit Types *except*:
 - CHS
 - VA

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Select which visits to display” prompt, type one of the following:
 - 1 - Print Visit counts for ONE PROVIDER
 - 2 - Print Visit counts for ONE PROVIDER CLSS
 - 3 - Print Visit counts for ALL PROVIDERS

If the user types **1** or **2**, additional prompts display.

4. At the “Which visit service categories should be included (0-7)” prompt, select which visit service categories to include, (e.g., 1, 4, 5, 6, 7) to include ambulatory,

not found, day surgery, and observations. Please note: events, hospitalizations, and in-hospital visits are automatically *excluded*.

- A – AMBULATORY
 - C - CHART REVIEW
 - T – TELECOMMUNICATIONS
 - N - NOT FOUND
 - S - DAY SURGERY
 - O – OBSERVATION
 - R - NURSING HOME
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
- I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

This is an example of the Provider Visit Counts report:

XXX	DEMO HEALTH CENTER	Page 1
6:14 pm	VISIT COUNTS FOR FOLSON, MALINDA	
FEB 6, 1995	(LICENSED PRACTICAL NURSE)	
	for 09/01/94 to 09/30/94	
VISIT DATES	CLINIC	NUMBER OF VISITS
-----	-----	-----
09/09/88	EMERGENCY MEDICINE (30)	2
	PODIATRY (65)	1
	TOTAL VISITS FOR PROVIDER:	3
	DEMO HEALTH CENTER	Page 2
6:14 pm	VISIT COUNTS FOR JOSE, MARY	
FEB 6, 1995	(LICENSED PRACTICAL NURSE)	
	for 09/01/94 to 09/30/94	
VISIT DATES	CLINIC	NUMBER OF VISITS
-----	-----	-----
09/09/94	DIABETIC (06)	2
	GENERAL (01)	3
	PODIATRY (65)	1
	TOTAL VISITS FOR PROVIDER:	6

Figure 6-17: Example of PVC report

6.13.1 Estimated Run Time

Run time for this report is a function of the date range specified. The report processing time might be short for a small date range or longer for a larger date range. The user might want to queue this report to print after hours. Please contact the local site manager with questions regarding queuing this report.

6.14 Provider or Clinic Visit Counts by Template of Patients (PVCT)

Use the PVCT option to produce a report that tallies the number of visits of a predefined set of patients by provider or by clinic. Prior to using this option, a search template for a specified group of patients must have already been created.

Follow these steps:

1. At the “Enter SEARCH TEMPLATE name” prompt, specify the template to search for the patients.
2. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date” prompt, type the end of the date range.
4. At the “Device” prompt, specify the device to print/browse the report.

The following sample report was created using a template for patients over age 60. The sample shows all visits for this group by provider.

```

*****
*      DEMO HOSPITAL/CLINIC                      APR 12, 1996 Page 1 *
*
*
*
*              NUMBER OF VISITS BY PROVIDER
*
*              SEARCH TEMPLATE: PTS OVER 60
*****

```

PROVIDER	CLASS	VISITS
HPROVIDER,RUSSELL P	15	1
KWPROVIDER,BLAKE T	21	2
SIGMAAAAA,MARY R	66	3
VNPROVIDER,JANICE M	23	1

		Total: 7

```

RUN TIME (H.M.S): 0.2.46
End of report. HIT RETURN:

```

Figure 6-18: Example of PVCT report

6.15 Visit General Retrieval (VGEN)

Use the VGEN option to produce the PCC Management Reports Visit Count report, which shows a list or count of visits entered by the user. The system prompts the user, in three separate steps, to identify selection criteria, what to display for each visit, and the sorting order for the list. The logic used to produce the report can be saved for future use.

If a report is designed that is 80 characters or less in width, it can be displayed on the screen or printed. If the report is 81-132 characters wide, it must be printed on a printer capable of producing 132 character lines.

Visits can be limited in the report to pre-established search templates created in QMan, Case Management, or other RPMS tools.

- If the template was created in Case Management or in QMan using Patients as the search subject, it is a Search Template of Patients.
- If the template was created in QMan using Visits as the search subject, it is a Search Template of Visits.

To generate a report using the Visit General Retrieval option, decide whether to list items sorted alphabetically, grouped by related items, or in a predefined order. The predefined order is set by the software and is how the list has historically been displayed. See Section 23.0 for a complete listing of PGEN/VGEN selection, sort, and print options.

Follow these steps:

1. At the “What order would you like the Items displayed in” prompt, type one of the following:
 - P - Predefined Order
 - A - Alphabetical Order
 - G - Groups of Related Items
2. At the “Select Visit List from” prompt, type one of the following:
 - P - Search Template of Patients
 - V - Search Template of Visits
 - S - Search All Visits
 - R - CMS Register of PatientsIf the user types **P**, **V**, or **R**, additional prompts display.
3. At the “Enter beginning Visit Date for search” prompt, type the beginning of the date range.

4. At the “Enter ending Visit Date for search” prompt, type the end of the date range.
5. At the “Do you want to use a PREVIOUSLY DEFINED REPORT” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
6. The Visit Selection Menu is displayed.

```

GENERAL RETRIEVAL          Jan 26, 2009 13:32:44          Page: 1 of 5
                           VISIT Selection Menu
Visits can be selected based upon any of the following items.
Select as many as you wish, in any order or combination.  An (*)
asterisk indicates items already selected.  To bypass screens and
select all visits hit Q.

1) 3rd Party Billed?      69) Exams                    137) Operation
Provider
2) AUD Screen             70) Excl Incomplete Vis    138) Oth Spec
Prv User Upd
3) AUD Waived             71) Exclude Inactive Pts  139) Other
Specialty Prov
4) Admission Source-UB92  72) Exclude Pts on a Regis 140) Outside
Location
5) Admission Type         73) External Acct          141) PCC+ FORM?
6) Admitting Provider (In 74) Family History Dx      142) PHN Level
of Interven
7) Admitting Service      75) Family History Relatio 143) PHN Type
of Dec Makin
8) Age                    76) Family Hx and Relation 144) Pain
Measurement Valu
9) Age in Months         77) Flag                    145) Patient's
Last Visit
10) Alcohol/Work Related  78) Formula Started (Days  146) Place of
Injury
11) All CPT's            79) HF Quantity/Score      147) Posting
Date of Visit
12) Any Medication Prescri 80) HRN Disposition        148) Present
on Admission
13) Any Third Party Covera 81) HRN Record Status     149) Prim Prov
Affil
14) Appointment Length    82) Health Factors         150) Prim Prov
Code
+ Enter ?? for more actions
S   Select Item(s)        + Next Screen   Q   Quit Item Selection
R   Remove Item(s)       - Previous Screen E Exit Report
Select Action: S//

```

Figure 6-19: Visit Selection menu

To choose the criteria for the report, type the number(s) of the criteria at the “Select Action” prompt and press Enter. An asterisk (*) indicates that an item has been selected. To select all visits, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

7. At the “Choose Type of Report” prompt, type one of the following:

- T - Total Count Only
- S - Subcounts and Total Count
- C - Cohort/Template Save
- D - Detailed Visit Listing
- F - Flat file of Area Database formatted records
- P - Unduplicated Patient Cohort/Template
- L - Delimited Output File for use in Excel

The total count report prints the total number of visits that match the selection criteria chosen and the total number of patients in that group. If this report type is selected, no further actions are necessary beyond this step to generate the report.

The sub counts and total count report lists the total number of matches, as well as the subtotal of each different category of the sort variable selected; for example, if the report was sorted by sex, the number of visits for males and the number of visits for females in the group would be printed. Totals and subtotals are included for both visits and patients. Skip to “Selecting a Sort Variable” for the next step in generating this report type.

The Cohort/Template Save option saves the patients that match the selection criteria in a template. Only the total number of matching visits and the number of patients in that group display. The user can then use the template for generating custom reports with VGEN.

The detailed visit listing creates a report that prints only the data items sorted by the variable selected. If the user selected the detailed visit listing, read the sections below for instructions on selecting the print items and sort category. This report logic can be saved for later use by typing **Y** (Yes) and typing a report name at the appropriate prompts. These prompts display after the selection of the sort variable.

The final output option, Flat File of Area Database Formatted Records, allows the user to capture the selected visit data in a file that is formatted for export to the Area Database. If this option is selected, a message displays indicating the name of the file to be created. The total number of visits in the selection process and the total number of visits that generated Area Database records will display. See the Site Manager for assistance using this output type. A detailed description of the file format is included in Section 22.0.

8. The system displays the Print Item Selection Menu.

```

GENERAL RETRIEVAL          Jan 26, 2009 16:46:14          Page: 1 of 6
                          PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the
order you want them to appear on the printout.  Keep in mind that
you have an 80 column screen available, or a printer with either 80
or 132 column width.

1) Patient Name           75) External Acct           149) Measurements
2) First, Last Name      76) PCC+ FORM?             150) Pain
Measurement Valu
3) Chart                 77) Visit IEN              151) Waist Circ
Value
4) Terminal Digit       78) Dependent Entry Count  152) BMI (Last
calculated)
5) SSN                  79) Type (IHS,638,etc)    153) RX Ordering
Provider
6) Sex                  80) Service Category      154) Dental ADA
Codes
7) Date of Birth        81) Visit Location        155) Radiology
Exam
8) Birth Month          82) Service Unit of PT    156)
Immunizations/Series
9) Birth Weight (grams) 83) Outside Location      157) Immunization
Provider

10) Birth Weight (Kgs)  84) Clinic Type           158) Immunization
Lot
11) Race                85) Visit Created By     159) Skin
Tests/Readings
12) Age                 86) User Last Update     160)
Immunizations
13) Age in Months       87) VCN Present          161) Exams
14) Father's Name       88) 3rd Party Billed?    162) Treatments
Provided

+          Enter ?? for more actions
S   Select Item(s) +     Next Screen           Q   Quit Item Selection
R   Remove Item(s) -    Previous Screen       E   Exit Report
Select Action: S//

```

Figure 6-20: Print Item Selection menu

9. To choose data items to list on the report, type the number(s) of the criteria at the “Select Action” prompt and press Enter. To select all visits, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

10. The system displays the Sort Item Selection menu.

```

GENERAL RETRIEVAL          Jan 20, 2009 11:27:56          Page: 1 of 2
                          SORT ITEM SELECTION MENU
The patients displayed can be SORTED by ONLY ONE of the following
items. If you don't select a sort item, the report will be sorted by

```

```

patient name.

1) Patient Name                29) Cause of Death            57) Most Recent
ALCOHOL HF
2) First, Last Name           30) MEDICARE Y/N              58) Most Recent
STAGED DM
3) Chart                      31) Medicare Part B          59) Most Recent
Barriers H
4) Terminal Digit            32) Medicare Part D          60) Most Recent
LEARNING P
5) Sex                        33) MEDICAID Y/N             61) Most Recent
RUBELLA HF
6) Date of Birth              34) PRIVATE INSURANCE Y/N    62) Date Last
Alcohol Scre
7) Birth Month                35) Any Third Party Covera    63) Date Last
Depression S
8) Birth Weight (grams)       36) Third Party Eligibilit    64) Date Last
IPV/DV Scree
9) Birth Weight (Kgs)         37) Medicaid Plan Name       65) Date Last
Colonoscopy
10) Race                      38) Pvt Ins Plan Name        66) Date Last
Flex Sig
11) Age                       39) Pvt Ins Plan Type        67) Date Last
Mammogram
12) Age in Months            40) HRN Record Status        68) Date Last
PAP Smear
13) Father's Name            41) HRN Disposition          69) Date Last
Tobacco Scre
14) Mother's Name            42) Patient's Last Visit     70) Date Last
Fall Risk As

+ Enter ?? for more actions
S   Select Item(s) +   Next Screen   Q   Quit Item Selection
R   Remove Item(s) -  Previous Screen E   Exit Report
Select Action: S//

```

Figure 6-21: Options in the SORT ITEM SELECTION MENU

11. To sort the selected patients, type **one** item at the “Select Action” prompt and press Enter. To sort the report by patient name, type **Q** (Quit Item Selection).
12. At the “Do you want a separate page for each Visit Date?” prompt, type **Y** (Yes) or **N** (No).
13. At the “Would you like a custom title for this report?” prompt, **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
14. At the “Do you wish to SAVE this SEARCH/PRINT/SORT logic for future use” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
15. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients

- E - Exclude Demo patients
- O - Include only demo patients

16. The system displays the report summary showing the criteria selected.

17. At the “Do you wish to” prompt, specify the device to print/browse the report.

This is an example of the report.

```

OUTPUT BROWSER                Jan 26, 2009 16:54:52                Page: 1 of 6

                                PCC MANAGEMENT REPORTS VISIT LISTING
                                SUMMARY PAGE

REPORT REQUESTED BY: TETER,SHIRLEY

VISIT Selection Criteria
  Encounter Date range:  OCT 28, 2008 to JAN 26, 2009

REPORT/OUTPUT TYPE
  Detailed Listing containing
  Patient Name  (20)
  Chart        (10)
  Sex          (6)

TOTAL column width: 42

Visits will be SORTED by:  Visit Date

                                PCC VISIT LISTING                Page 1
NAME                                HRN                                SEX
-----
CHI,KU                                DH111214                            MALE
OMEGA,CHI                             DH111181                            MALE
TRUETT,PAMELA                         DH128391                            FEMALE
OMEGA,ALPHA                           DH111175                            MALE
PARKER,ANNETTE                       DH100199                            FEMALE
CHI,JU                                DH111216                            MALE

DEMO,CHRISTA DANIELL                 DH172684                            FEMALE
JONATHAN,JERRI AILEN                 DH116447                            FEMALE
MUSE,KENNEDY MADISON                 DH106046                            FEMALE
BOWMAN,JANICE                        DH107256                            FEMALE
+ Enter ?? for more actions                                >>>
+ NEXT SCREEN          -          PREVIOUS SCREEN          Q          QUIT
Select Action: +//

```

Figure 6-22: Example PCC Management Reports Visit Count report

At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to quit the report.

- Type + (plus) to display the next screen. This option is not available for the last screen.
- Type – (minus) to display the previous screen. This option is not available for the first screen.

6.16 In/Out Control Blood Pressures (BPC)

Use the BPC option to produce a report that lists all patients for the specified age, sex, communities, clinic, and time period that are considered out of control based on their mean Systolic or Diastolic BP.

Follow these steps:

1. At the “Select List” prompt, type **S** (for Search Template of Patients) or **P** (for Search All Patients). If **S** is entered, other prompts display.
2. At the “List patients who live in” prompt, type one of the following:
 - O - One particular Community
 - A - All Communities
 - S - Selected Set of Communities (Taxonomy)If **O** or **S** is entered, additional prompts display.
3. At the “include visits to ALL clinics” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
4. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
5. At the “Enter ending Visit Date” prompt, type the end of the date range.
6. At the “Enter a Range of Ages (e.g., 5-12)” prompt, type a range of ages or press ENTER to include all ranges.
7. At the “Report should include” prompt, type one of the following:
 - M – Males
 - F – Females
 - B - Both
8. At the “Do you wish to include ONLY Indian/Alaska Native Beneficiaries?” prompt, type **Y** (Yes) or **N** (No).
9. At the “Report type should be” prompt, type one of the following:
 - D – Detail
 - S – Summary

- C - Cohort/Template Save
10. At the “Sort the report by” prompt, type **P** (for Patient Name) or **A** (for Age of Patient).
 11. At the “Do you wish to suppress patient identifying data” prompt, type **Y** (Yes) or **N** (No).
 12. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
 13. At the “Device” prompt, specify the device to print/browse the report.

XXX		DEMO HOSPITAL				Page 1	
BLOOD PRESSURE OUT OF CONTROL REPORT							
LIST OF BLOOD PRESSURE OUT OF CONTROL PATIENTS							
Report includes: ALL AGES, MALES & FEMALES, ALL COMMUNITIES, all CLINICS, all BENEFICIARIES							
Visit Dates: OCT 28, 2008 to JAN 26, 2009							
B/P	MEAN	PATIENT	NAME	HRN	AGE	SEX	COMMUNITY
CLINIC	COUNT	B/P					
BALSER, JACOB	167741	61	M	MARBLE			1 130/74
DEMO, JOHNNIE RU	118774	27	F	BIRDTOWN	GENERAL		1 166/94
ELKINS, KELLY LU	110023	44	F	BIG COVE			1 156/91
JONATHAN, JERRI	116447	31	F	YELLOWHILL			1 150/90
TOTAL NUMBER OF PATIENTS: 4							
End of report. HIT RETURN:							

Figure 6-23: Example of BPC report

6.17 Delete VGEN/PGEN Report Definition (DEL)

To delete a PCC Visit General Retrieval (VGEN) or Patient General Retrieval (PGEN) report definition type **DEL**. Then, type the name of the report to delete, and then confirm that the report specified is the one to be deleted. The report will be automatically deleted and is not retrievable. For example,

```
REPORT NAME: MLJ INJURY REPORT JARRET,MARY L-APR 11, 1996@07:50:02
Are you sure you want to delete the MLJ-INJURY REPORT report
definition? N// Y YES
Report Definition JARRET,MARY L-APR 11, 1996@07:50:02 deleted.
```

Figure 6-24: Example of using the DEL option

6.18 Readmissions within 30 Days of a Discharge (RADM)

To produce a report that shows patients who have had an admission within 30 days of a discharge type **RADM**. Decide whether to include admissions to any facility or to only one facility. For example, if a patient was admitted to a local facility and within 30 days was admitted to a contract facility, and if the user chose to include admissions to any facilities, both admissions will be included in the report.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Include admissions to” prompt, type **O** (for one facility only) or **A** (any facility). If **O** is entered, other prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

XXX DEMO HOSPITAL/CLINIC							Page 1
READMISSIONS WITHIN 30 DAYS OF A DISCHARGE							
VISIT DATES: Jul 01, 1996 TO Aug 02, 1996							
NAME	HRCN	ADM DATE	LOC	PROV	ICD	PROVIDER NARRATIVE	
JBETA, RAY		222222	7/3/96	DH	DOCTO11,JO	681.10	
CELLULITIS & ULCER		7/17/96	DH	DOCTOR, DON	V58.8	WOUND CARE DRESSING	
						730.27	
OSTEOMYELITIS R GRE							
RHORHO, MARIE		222223	7/17/96	DH	DOC3, JAVIE	644.20	
PREMATURE LABOR AT			7/21/96	DH	DOCTOR55, R	642.94	
STATUS POST C SECTI							
THETABBB, DALE		222224	7/14/96	DH	DOCTOR, RUD	644.20	
PREMATURE LABOR AT						648.23	
ANEMIA MODERATE			7/21/96	DH	DOCTOR3, L	648.21	
ANEMIA, ESTIMATED BL						663.31	
NORMAL SPONTANEOUS							

CSIGMAAAAA, DAVE	222225	7/18/96	DH	DOCTOR6, SU	291.8
ALCOHOL WITHDRAWAL					303.90
CHRONIC ALCOHOL ABU					493.90
REACTIVE AIRWAY DIS		7/21/96	DH	DOCTOR, JU	291.8
ALCOHOL WITHDRAWAL				303.90 ACUTE ALCOHOLISM	493.90
REACTIVE AIRWAYS DI					578.9
GASTROINTESTINAL BL					
GGAMMAGAMS, ALEXANDRA	222226	7/30/96	DH	DOC67, EILE	496.
EXACERBATION CHRONI		8/3/96	DH	DOC89, RICH	493.90
ASTHMA				496. CHRONIC OBSTRUCTIVE	

Figure 6-25: Example of RADM report

6.19 Listing of Patient Refusals (REF)

The REF report lists all refusals documented for patients. Specify which type of refusals and the date range of the refusals.

Follow these steps:

1. At the “Do you want to include ALL Refusal Types?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
2. At the “Enter Beginning Refusal Date” prompt, type the beginning of the date range.
3. At the “Enter Ending Refusal Date” prompt, type the end of the date range.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

XXX	Jan 27, 2009	Page 1
***	PATIENT REFUSAL LISTING	***
	ALL REFUSAL TYPES	
	Refusal Dates: Sep 20, 2007 to Apr 07, 2008	

PATIENT NAME	HRN	DOB	DATE REFUSED	REFUSAL	REASON

EXAM refusals					
SIGMA, ANGELA	124682	Jul 01, 1987	MAR 06, 2008	HEART EXAM	UNABLE
SIGMA, ANGELA	124682	Jul 01, 1987	MAR 04, 2008	PELVIC EXAM	REFUSED
SIGMA, ANGELA	124682	Jul 01, 1987	FEB 25, 2008	VISION EXAM	NOT MED
Enter RETURN to continue or '^' to exit:					

Figure 6-26: Example of REF report

6.20 Returns to Clinic w/in 72 Hours of a Clinic Visit (RT1)

The RT1 report produces a list of patient visits. The visits are those for which the patient had a clinic visit and then returned within 72 hours to the same clinic or another clinic. Select which clinic and which location of encounter. The list can be limited to visits to a particular provider.

Follow these steps:

1. At the “Enter beginning Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Date for Search” prompt, type the end of the date range.
3. At the “Select which scenario” prompt, type one of the following:
 - S - Returns from one particular clinic to the same clinic
 - A - Returns from any clinic to any clinic
 - O - Returns from one particular clinic to any other clinic
 - P - Returns from any clinic to one particular clinic

If **S**, **O**, or **P** are entered, additional prompts display.
4. At the “Include visits from which set of locations” prompt, type one of the following:
 - O - One location
 - A - Taxonomy of Predefined Locations
 - P - All Locations

If **O** or **A** are entered, additional prompts display.

5. At the “Include visits from which Clinic Visits to” prompt, type one of the following:
 - A - ANY Provide
 - O - One particular Provider
 If O is entered, additional prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

XXX	DEMO HOSPITAL						Page 1
CLINIC VISITS WITHIN 72 HOURS AFTER CLINIC VISITS							
RETURNS FROM CLINIC: DENTAL							
RETURNS TO CLINIC: ANY CLINIC							
VISITS DATES: SEP 20, 2007 TO APR 07, 2008							
Locations: DEMO HO							
NAME	HRCN	VISIT DATE&TIME	CLN FAC	ICD	PROVIDER	NARRATIVE	

SIGMA, JANE	11111	02/12/08 09:00	56	DH	V72.2	DENTAL/ORAL HEALTH	

Figure 6-27: Example of RT1 report

6.21 Display Single Visit for a Patient (VST)

Report options for obtaining data specific to a single visit by a selected patient have been grouped under the VST submenu. The following reports are available from the Patient Single Visit menu.

**	PCC Management Reports **
**	Patient Single Visit Menu **

IHS PCC Suite Version 2.0	
DEMO HOSPITAL	
LCV	Display Data for Patient's Last Visit to a Clinic
LVST	Display Data for a Patient's Last Visit

Figure 6-28: Example of Patient Single Visit menu screen

6.21.1 Display Data for Patient's Last Visit to a Clinic (LCV)

Use the LCV option to produce a report that displays visit-related data for a patient's last visit to a selected clinic. The user types the patient's name and specifies the clinic. All visit-related data will be displayed in the report.

Follow these steps:

1. At the "Select PATIENT NAME" prompt, type the name of the patient.
2. At the "Enter a Clinic" prompt, type the name of the clinic.
3. At the "Device" prompt, specify the device to print/browse the report.

The following sample report was generated for Art Gamma's last visit to the General Clinic.

```

~~~~~
VISIT IEN: 23251
-----
                VISIT FILE
-----
VISIT/ADMIT DATE&TIME: JAN 29, 1990@09:57
  DATE VISIT CREATED: MAR 16, 1990      TYPE: IHS
  PATIENT NAME: GAMMA,ART                LOC. OF ENCOUNTER: DEMO
HOSPITAL/CLINIC
  SERVICE CATEGORY: AMBULATORY           CLINIC: GENERAL
  DEPENDENT ENTRY COUNT: 6
-----
                V MEASUREMENT
-----
TYPE: HT                                PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57            VALUE: 56.25
  PERCENTILE: 99.9

TYPE: WT                                PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57            VALUE: 92.25
  PERCENTILE: 99.9

TYPE: VU                                PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57 VALUE: 15/20
-----
                V PROVIDER
-----
PROVIDER: REGISTERED NURSE,IHS          PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57            PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101999

PROVIDER: PHYSICIAN,VOLUNTEER          PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57            PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 600999
-----
                V POV
-----
POV: V70.9                              PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57            PROVIDER NARRATIVE: PHYSICAL
EXAM
  FIRST/REVISIT: REVISIT                PRIMARY/SECONDARY: PRIMARY
ICD NARRATIVE (c): GENERAL MEDICAL EXAM NOS
~~~~~

```

Figure 6-29: Example of LVC report

6.21.2 Display Data for a Patient's Last Visit (LVST)

Use the LVST option to produce a report that displays all visit-related data for the patient's last visit. The Visit File displays first, followed by each visit-related data file; for example, Providers, POVs, and Measurements.

Follow these steps:

1. At the "Select PATIENT NAME" prompt, type the name of the patient.
2. At the "Device" prompt, specify the device to print/browse the report.

```

----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: MAR 30, 1994@13:23
  DATE VISIT CREATED: MAR 30, 1994      TYPE: IHS
  PATIENT NAME: THETAA, MARY
  LOC. OF ENCOUNTER: DEMO HEALTH CENTER
  SERVICE CATEGORY: AMBULATORY           CLINIC: DIABETIC
  DEPENDENT ENTRY COUNT: 7              DATE LAST MODIFIED: JUN 15,
1994
  DATE VISIT EXPORTED: JUN 26, 1994

----- V MEASUREMENT -----
TYPE: BP                                PATIENT NAME: THETAA, MARY
  VISIT: MAR 30, 1994@13:23            VALUE: 140/90

----- V PROVIDER -----
PROVIDER: SIGMA, JOHN                   PATIENT NAME: THETAA, MARY
  VISIT: MAR 30, 1994@13:23            PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 100025
PROVIDER: SIGMA, JANE                   PATIENT NAME: THETAA, MARY
  VISIT: MAR 30, 1994@13:23            PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101GM

----- V POV -----
POV: 401.9                               PATIENT NAME: THETAA, MARY
  VISIT: MAR 30, 1994@13:23
  PROVIDER NARRATIVE: HYPERTENSION BP UNDER CONTROL THIS VISIT
ICD NARRATIVE (c): HYPERTENSION NOS
POV: 250.00                               PATIENT NAME: THETAA, MARY
  VISIT: MAR 30, 1994@13:23            PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM

----- V EXAM -----
EXAM: BREAST EXAM                        PATIENT NAME: THETAA, MARY
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 06
EXAM: RECTAL EXAM
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 14

```

Figure 6-30: Example of LVST report

7.0 Diabetes Program QA Audit (DM)

The Diabetes Audit Report Menu consists of options that facilitate the set-up and running of the official IHS Diabetes Audit Report. The report is part of the IHS Diabetes Management System designed to facilitate individual diabetes patient care and diabetes program management. Details on set-up for the Audit Report are described in the *PCC Diabetes Management System (Version 3.0)* user's manual. All options for adding or editing taxonomies are only used during the initial set-up process.

```

*****
**      PCC Management Reports      **
**  Diabetes Audit Report Menu    **
*****
IHS PCC Suite Version 2.0

DEMO HOSPITAL/CLINIC

DM08  2008 Diabetes Program Audit...
DM07  2008 Diabetes Program Audit...
DM06  2008 Diabetes Program Audit...
DM05  2008 Diabetes Program Audit...
DM03  2008 Diabetes Program Audit...
DM01  2008 Diabetes Program Audit...
DM20  2008 Diabetes Program Audit...
DM99  2008 Diabetes Program Audit...
DM96  2008 Diabetes Program Audit...
TS     Taxonomy Setup
DAL    Display Audit Logic
PLDX   Patients w/no Diagnosis of DM on Problem List
NDOO   DM Register Pts w/no recorded DM Date of Onset
APCL   List Patients on a Register w/an Appointment
DMV    DM Register Patients and Select Values in 4 Months
DPCS   Display a Patient's DIABETES CARE SUMMARY
HSRG   Print Health Summary for DM Patients w/Appt
SMBG   Self Monitoring of Blood Glucose Follow up Report

```

Figure 7-1: Example of Diabetes Audit Report menu

Note: Because the DM Audit Report is generated from the PCC Database, clinical information must be typed into the PCC or the report will not recognize that the clinical event occurred.

Descriptions of each item retrieved for printout on the audit report are provided in detail in this section.

7.1 Demographic Data

The following table provides information regarding demographic data.

Item	Demographic Data
Audit Date	The date the report was generated.
Report Dates	The date range specified by the person generating the report.
Chart Number	Chart number for the patient from the facility at which the report was generated.
Report Generated by	The person who ran the report.
Service Unit	The SU of the facility at which the report was run.
Area	The IHS Area in which the facility resides.
Date of Birth	The patient's date of birth.
Facility	The facility at which the report was run.
Sex	The sex of the patient.
Age	The patient's age is calculated as of the report generation date.

7.2 Clinical Data

7.2.1 Tobacco Use

Data regarding tobacco use is retrieved from the Health Status file, the PCC Problem List, or the Purpose of Visit file. The system first looks for the last occurrence of any of the following in the Health Status file (the Health Status file stores the last of each health factors).

- Current Smokeless
- Current Smoker
- Non-Tobacco User
- Previous Smokeless
- Previous Smoker

If tobacco use is not documented in the Health Status file, the system scans the PCC Problem List for a diagnosis of Tobacco Use (305.1-305.13). If no Problem List entry is found, the system scans all POVs during the indicated time frame for a diagnosis of tobacco use (305.1-305.13). If tobacco is found, the system includes it in the printout. If a problem or POV is found, the Provider Narrative is also printed. If no evidence of tobacco use is found, the message "Undocumented" will print.

7.2.2 Date of Onset of Diabetes from CMS/Problem List

The system determines the date of onset of diabetes based on the following:

1. The system checks the official Diabetes Register. If the patient exists in the register, the date of onset is obtained from the Date of Onset field in the DM Diagnoses for the client file.
2. The system scans the Problem List for a problem diagnosis of 250.00-250.93. If one is found and the date of onset has been recorded, the system uses that date.
3. If no date is found, the message “Date of Onset Not Recorded” prints.

7.2.3 Date of Earliest Diabetes Diagnosis from PCC

The system utilizes the ICD9 diagnostic codes 250.00-250.93 to determine the earliest POV for diabetes that was typed into the POV file.

Note: This date cannot be the same as the date of onset.

7.2.4 Height

The last height on record displays.

Note This height might have been recorded after the audit ending date.

7.2.5 Weight

The last weight recorded in a non-prenatal visit displays.

7.2.6 BMI

The body mass index (BMI), a commonly used index of obesity in populations, is calculated from the patient’s height and weight data and displays in the report. The value is a ratio of patient’s weight in kilograms to patient’s height in meters.

7.2.7 Weight, Blood Pressure, and Blood Sugar Recorded 75% of Visits

The system searches all visits to determine if at least one POV contains a diagnosis of diabetes (ICD code 250.00-250.93) during the indicated date range. If diabetes is found, the report displays the percentage of diabetic-related visits during which the indicated reading or test result was obtained.

7.2.8 Last Three Blood Pressures and Last Three Blood Sugars

The last three BPs and last three blood sugars during the indicated date range will be displayed, if available. BPs or blood sugars taken in the emergency room are not included in the report. The laboratory tests used to determine whether a blood sugar was done are indicated by the user during initial set-up procedures.

7.2.9 HTN Documented

The system first checks to see if there is a hypertension diagnosis (ICD Code range 401.0-405.99) in the PCC Problem List. If not, the system checks to see if the patient had a POV where they received a diagnosis of hypertension (ICD code range 401.0-405.99) in the five years prior to the end of the indicated date range.

7.2.10 Last Hgb A1c/GHb

The system finds the last instance of this test in the specified date range.

Note: There is a space on the report adjacent to the test result that may have the normal range for this test entered.

7.3 Examinations

- **Diabetic Foot Exam, Complete:** A complete diabetic foot exam indicates whether the patient had a diabetic foot exam recorded during report time frame.
- **Diabetic Eye Exam:** A complete diabetic eye exam indicates whether the patient had a diabetic eye exam recorded during the report time frame.
- **Rectal Exam:** A rectal exam is only reviewed if the patient is older than 40 years of age. It indicates whether the patient had a rectal exam during the report time frame.
- **Pap Smear:** The pap smear indicates whether a female patient had a pap smear during the report time frame.
- **Breast Exam:** A breast exam indicates whether a female patient had a breast exam during the report time frame.
- **Mammography:** A mammography indicates whether a female patient ever had a mammogram. The date of the last mammogram is reported and its accordance with the following ACS guidelines is noted:
 - Ages 40-49: mammogram within the past 24 months
 - Ages 50 and up: mammogram within the past 12 months

7.4 Education

The current PCC list of Diabetes Education Topics includes the following items:

- DM-C Complications
- DM-N Nutrition
- DM-EX Exercise
- DM-GI General Information

The previous list of Diabetes Education Topics that was in effect prior to October 1993 is no longer recommended for use, although the audit program continues to accept them.

7.5 Therapy

The system determines whether the patient received insulin, an oral hypoglycemic, or both during the four months prior to the end of the indicated time frame. If there is no evidence of drugs prescribed, the system displays “Diet Alone.”

7.5.1 Use of Ace Inhibitor

The report indicates whether the patient received an ace inhibitor during the four months prior to the end of the audit time frame. If not the message “Does Not Currently Use/Undetermined” displays. The medicines audited when determining ace inhibitor use are those specified during the initial setup procedures described above.

7.6 Immunizations

- **Flu Vaccine:** Indicates if a vaccine was given during the report time frame.
- **Pneumovax:** Indicates if ever given.
- **Td:** Indicates if given during the past ten years.
- **TB Status:** TB Status is retrieved from the Health Status file. The TB Status Health Factors are:
 - TB - Tx Complete
 - TB - Tx Incomplete
 - TB - Tx Unknown
 - TB - Tx Untreated
- **PPD:** Date of last PPD and result.
- **PPD Status Code:** A patient’s PPD status will be indicated by one or more of the following messages:

Status	Message
PPD +	Treatment Complete (based on Health Factor)

Status	Message
PPD +	Not Treated or Unknown Treatment
PPD –	Up-to-Date (placed in or after DX)
PPD –	Placed Before Date of DX
PPD –	Date of DX Unknown
PPD	Status Unknown

7.7 Laboratory Data

- **EKG:** EKG results are not available through the PCC. On the basis of a chart review, the reviewer must indicate if an EKG was ever given.
- **Urinalysis:** If the patient had a urine protein during the indicated date range, the report will indicate that a urinalysis occurred.
- **Proteinuria:** If the last urine protein during the indicated date range was 1+, 2+, or 3+, then *proteinuria* is indicated.
- **Microalbuminuria:** For those without evidence of proteinuria, indicates whether a test for *microalbuminuria* was positive, negative, or not performed.
- **Creatinine:** Creatinine indicates the result of the last creatinine during the indicated date range. If the patient has a POV code that indicates dialysis, the message “On Dialysis” will print.
- **Cholesterol:** The last cholesterol level during the indicated date range is printed.
- **Triglycerides:** The last triglyceride level during the indicated date range is printed.

7.8 Program Audit Submenus

These are the Program Audit options:

```

*****
**          PCC Management Reports          **
**    2008 Diabetes Audit Report Menu    **
*****
                          Version 3.0
                          DEMO HOSPITAL
DM08  Run 2008 Diabetes Program Audit
D8TC  Check Taxonomies for the 2008 DM Audit
D8TU  Update/Review Taxonomies for 2008 DM Audit
EAUD  Run the 2008 Audit w/predefined set of Pts
-----
PR08  Run 2008 PreDiabetes/Metabolic Syndrome Audit
PDTC  Check Taxonomies for the 2008 Pre-Diabetes Audit
PDTU  Update/Review Taxonomies for 2008 PreDiab Audit
Select 2008 Diabetes Program Audit Option:

```

Figure 7-2: Example of Program Audit Menu

7.9 Audit Reports

The following pages contain sample audit reports. An individual report is presented first, followed by a cumulative report.

```

ASSESSMENT OF DIABETES CARE, 2008      DATE AUDIT RUN: Apr 07, 2008
AUDIT DATE: Mar 08, 2008      FACILITY NAME: DEMO HOSPITAL
AREA: 23      SU: 00      FACILITY: 01      PTS ON DM REGISTER:
Does you community receive SDPI grant funds? No
TRIBAL AFFIL: 777 DEMO TRIBE, NM      STATE of Residence: NC
REVIEWER: JJJ      CHART : 11111      DOB: Jul 01, 1987      SEX: FEMALE
PRIMARY CARE PROVIDER: FPROVIDER,JOHN Y
DATE OF DIABETES DIAGNOSIS:      Lipid Lowering Agent:
  CMS Register:      None
  Problem List:      IMMUNIZATIONS
  1st DX recorded in PCC: Feb 11, 2008      Flu vaccine (past yr): No
Diabetes Type: 2      Type 2      Pneumovax Ever: No
  CMS Register:      Td in past 10 yrs: No
  Problem List:      PPD Status: NEG
  PCC POV's:      Type 2      If PPD Pos, INH Tx
Complete:
TOBACCO USE: 1      Current user - Ada Code 1320 If PPD Neg, Last PPD:
Oct 07, 2004
  Referred for (or provided) Cessation
  Counseling: Yes-2/12/2008 ADA 1320      Date of Last EKG: Feb 21,
2008

VITAL STATISTICS      LABORATORY DATA
Height: 64.00 inches 11/06/06      HbA1c (most recent):
Last Weight (in 2 yrs): 122.00 lbs 02/06/07      Date Obtained:
  BMI: 20.9
HTN (documented DX): No

Last 3 Blood Pressures (in past yr):
(in the past 12 months):      MOST RECENT SERUM VALUE
      Creatinine: N mg/dl 2/14/2008
      Estimated GFR: No
      Tot Cholesterol:
EXAMINATIONS (in past year)      HDL Cholesterol:
Foot exam-complete:      LDL Cholesterol:
  No      Triglycerides:
Eye exam (dilated/fundus):
  No      Albumin:Creatinine Ratio (UACR):
Dental exam:      Protein:Creatinine Ratio (UPCR):
  Yes-Dental Exam-Mar 06, 2008      Other quantitative urine
      protein test:
      None: X

EDUCATION (in past year)
Diet Instruction: None
Exercise Instruction: None
DM Education (Other): Yes

```

```

DM THERAPY
Select all that currently apply
X 1 Diet & Exercise Alone
  2 Insulin
  3 Sulfonylurea
  4 Metformin
  5 Acarbose
  6 Glitazones
  7 Incretin Mimetics
  8 DPP4 inhibitors
  9 Unknown/Refused
ACE Inhibitor/ARB Use: No
Aspirin/AntiPlatelet Therapy: None
Supplemental Section
Does pt have depression as an active
problem? Yes - Problem List 311.
If 'No', has pt been screened for
depression in the past year?
Local Option question:
    
```

Figure 7-3: Example of Diabetes QA audit

```

Apr 07, 2008
Page 1
*** HEALTH STATUS OF DIABETIC PATIENTS ***
DEMO HOSPITAL
Reporting Period: Mar 09, 2007 to Mar 08, 2008
-----
40 patients were reviewed
Gender
  Female 20 50%
  Male 20 50%
Age
  <15 yrs 0 0%
  15-44 yrs 2 5%
  45-64 yrs 15 38%
  65 yrs and older 23 58%
-----
40 patients were reviewed
Diabetes Type
  Type 1 0 0%
  Type 2 40 100%
  Unknown 0 0%
Duration of Diabetes
  Less than 10 years 0 0%
  10 years or more 26 65%
  Diagnosis date not recorded 14 35%
    
```

Figure 7-4: Example of Diabetes cumulative audit Page 1-2

7.10 Generating a Patient Cohort for the Audit Report

Use the PCC QA Audit Report option by typing a list of individual patient identifiers (names or chart numbers) or by typing the name of a template or cohort, of patients saved from a previous retrieval. Three methods for generating and saving a cohort for use in the Audit Report are described below.

7.10.1 Using Your Entire DM Register as Your Audit Cohort

Because the automated audit process takes less than a minute per patient, the user might want to audit all active patients in the Diabetes Register. To do so, the user must first be in the Case Management System where the Diabetes Register data resides.

1. In Case Management, select the Report Generation menu option.
2. Next, type the name of the user's Diabetes Register.
3. Then select the Patient and Statistical Reports menu option.
4. When prompted for a report type, select Diagnoses.
5. When prompted for a sort order, select Patient.
6. Type **N** (No) when prompted for a particular patient, and type **N** (No) when prompted for another sorting attribute.
7. At the prompt for choosing a patient or statistical report, type **P** (Patient).
8. When prompted to "Store Report Result as a Search Template," type **Y** (Yes). At the "Search Template" prompt, type the name of the template.
9. Type **DM Register PTS** followed by the current date; for example, DM Register PTS 10/12/95.
10. At the "Are you adding DM Register PTS 10/12/95 as a new sort template?" prompt, type **Y** (Yes).
11. At the "Device" prompt, type **Home** or queue the report to run at a later time. The system then selects and stores in the template all active patients in the user's register for use in the QA Audit Report.

After creating this template or cohort, the QA Audit Report may be run as instructed previously in this manual.

CMS Case Management System

```
*****
**          CASE MANAGEMENT SYSTEM          **
*****
```

```
VERSION 2.0
DEMO HOSPITAL
MAIN MENU
```

```
CR      Create/Modify Register Structure
AU      Add Authorized Users
BL      Build Supporting Lists
DL      Display Supporting Lists ...
AD      Add/Delete Patients ...
DE      Data Entry
RG      Report Generation ...
RD      Resource Directory ...
QM      Q-Man (PCC Query Utility)
DEL     Delete Entire Register
CLM     Custom letter Management ...
ECR     Display/Edit Register Creator
LTR     Manage Recall Letters ...
PDM     Install Pre-Diabetes Register
        Install IHS Diabetes Register
```

Select Case Management System Option: RG Report Generation

```
*****
**          CASE MANAGEMENT SYSTEM          **
*****
```

REGISTER SELECTION UTILITY

IHS DIABETES

PRE-DIABETES

REGISTER: IHS DIABETES

Register being checked to update status of deceased patients.

```
*****
IHS DIABETES REGISTER
*****
```

STATISTICAL REPORTS

```
CS      Case Summary, Individual
MS      Case Summary, Multiple
ML      Master List
PR      Patient and Statistical Reports
GEN     Register Patient General Retrieval (Lister)
LVST    Display Data for a Patient's Last Visit
```

Select Report Generation Option: PR Patient and Statistical Reports

```
*****
```

```
IHS DIABETES REGISTER
```

```
*****
```

```
STATISTICAL REPORTS
```

- | | |
|------------------------|----------------------|
| 1) REGISTER DATA | 10) FAMILY MEMBERS |
| 2) CARE PLAN | 11) INTERVENTIONS |
| 3) CASE HISTORY | 12) MEASUREMENTS |
| 4) CASE REVIEW DATE | 13) MEDICATIONS |
| 5) CASE COMMENTS | 14) PCC PROBLEM LIST |
| 6) COMPLICATIONS | 15) RISK FACTORS |
| 7) DIAGNOSES | 16) SERVICES |
| 8) DIAGNOSTIC CRITERIA | 17) RECALL DATES |
| 9) ETIOLOGY | |

```
Report Option ==> 7
```

```
*****
```

```
IHS DIABETES REGISTER
```

```
*****
```

```
REPORT SORTING UTILITY
```

The DIAGNOSES report can be sorted by one or more of the following attributes. '<==' indicates a mandatory selection.

- | | |
|----------------------|-------------------|
| 1) AGE | 5) SEVERITY |
| 2) CURRENT COMMUNITY | 6) SEX |
| 3) DIAGNOSIS | 7) WHERE FOLLOWED |
| 4) PATIENT | |

```
Your choice: 4 PATIENT
```

```
Do you want to sort by a particular PATIENT? No// (No)
```

```
Within PATIENT, want to sort by another attribute? No// (No)
```

```
'P'atient or 'S'tatistical report? ==> Patient
```

```
Store Report Result as Search Template? NO// YES
```

```
Search Template: DMREGISTER PTS 2/26/10
```

```
Are you adding 'DMREGISTER PTS 2/26/10' as A new SORT TEMPLATE?  
No// Y (Yes)
```

```

An unduplicated patient list resulting from this report
will be stored in the.....>

** DMREGISTER PTS 2/26/10 ** Search Template.

A brief report will be printed after the search template is
complete. You must enter a device for this report OR you may queue
at this time.

DEVICE: HOME// VT Right Margin: 80//

...HMMM, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

CMS DIAGNOSIS FOR THE CLIENT STATISTICS FEB 26,2010 17:00
PAGE 1
DIAGNOSIS
-----
COUNT 648
End of report. Strike <CR> to continue.

```

Figure 7-5: Example of audit for all active patients in the Diabetes Register

7.10.2 Generating a Random Sample as Your Audit Cohort

At sites with a large Diabetes Register, a random sample of active diabetes patients may be used when running the PCC QA Audit Report.

1. First perform all of the steps described in Section 7.2 to create a template or cohort containing active patients in the register.
2. Next, select Q-Man from the Case Management System main menu.
3. In Q-Man, select the Search mode and use Living Patients as the subject.
4. At the “Attribute of Living Patients” prompt, type the left square bracket ([]) followed immediately by the name of the user’s template; for example, [DM REGISTER PTS 10/12/95. Q-Man retrieves the cohort and presents four options.
5. At the prompt, type **3** to generate a random sample of the cohort.
6. The next prompt asks if the user wants a specific number of entries in the sample or a percentage of the cohort.
7. Type the number of patients to have in the sample.
8. When prompted for another Q-Man attribute, press ENTER. Several retrieval options will display. Type **4** (Store Results in a FM Search Template).

9. At the “Template name” prompt, type **Sample Of DM Pts** followed by the date; for example, Sample Of DM Pts 10/12/95.
10. At the “Are you adding this new template?” prompt type **Y** (Yes).
11. Bypass the “Description” prompt by pressing ENTER.
12. At the “Run this job in the background?” prompt, type **N** (No). Q-Man generates the sample cohort, which can then be used in the PCC DM QA Audit Report.

```

***** WELCOME TO Q-MAN: THE PCC QUERY UTILITY *****

*****
**WARNING...Q-Man produces confidential patient information.**
*View only in private.  Keep all printed reports in a secure area.*
** Ask your site manager for the current Q-Man Users Guide. **
*****

Query utility: IHS PCC SUITE Q-MAN Ver. 2.0
Current user: DEMO USER
Chart numbers will be displayed for: DEMO HOSPITAL
Access to demographic data: PERMITTED
Access to clinical data: PERMITTED
Programmer privileges: YES

Enter RETURN to continue or '^' to exit:

***** Q-MAN OPTIONS *****

Select one of the following:

1          SEARCH PCC Database (dialogue interface)
2          FAST Facts (natural language interface)
3          RUN Search Logic
4          VIEW/DELETE Taxonomies and Search Templates
5          FILEMAN Print
9          HELP
0          EXIT

Your choice: SEARCH// PCC Database (dialogue interface)

***** SEARCH CRITERIA *****

What is the subject of your search? LIVING PATIENTS //

Include list of upcoming appts for the patient? NO//

LIVING PATIENTS

```

```
Subject of search: PATIENTS
ALIVE TODAY
```

```
Attribute of LIVING PATIENTS: [DMREGISTER PTS 2/26/10
```

```
(Feb 26, 2010) User #2182 File #9000001 INQ
```

```
Select one of the following =>
```

- 1) LIVING PATIENTS must be a member of the DMREGISTER PTS 2/26/10 cohort
- 2) LIVING PATIENTS must NOT be a member of the DMREGISTER PTS 2/26/10 cohort
- 3) Select a random sample of the DMREGISTER PTS 2/26/10 cohort
- 4) Count the number of entries in the DMREGISTER PTS 2/26/10 cohort

```
Your choice (1-4): 1// 3
```

```
Counting cohort before sampling...
```

```
There are 646 entries in this cohort
Maximum sample size allowed is 50% of this total (323)
```

```
There are 2 ways to determine sample size =>
```

- 1) Sample a certain NUMBER of cohort members
- 2) Sample a certain PERCENT of cohort members

```
YOUR CHOICE (1-2): 1// 1
```

```
How many PATIENTS do you want in the sample: 10
```

```
Collecting a random sample
```

```
10
```

```
Computing Search Efficiency
```

```
Rating.....
```

```
Subject of search: PATIENTS
ALIVE TODAY
```

```
RANDOM SAMPLE OF 'DMREGISTER PTS 2/26/10' COHORT
```

```
Attribute of LIVING PATIENTS:
```

```
***** Q-MAN OUTPUT OPTIONS *****
```

Select one of the following:

- 1 DISPLAY results on the screen
- 2 PRINT results on paper
- 3 COUNT 'hits'
- 4 STORE results of a search in a FM search template
- 5 SAVE search logic for future use
- 6 R-MAN special report generator

- 7 DELIMITED file via screen capture
- 9 HELP

- 0 EXIT

Your choice: DISPLAY// 4 STORE results of a search in a FM search template

Fileman users please note =>

This template will be attached to IHS' PATIENT file (#9000001)

Enter the name of the SEARCH TEMPLATE: SAMPLE OF DM PTS 2/26/10

Are you adding 'SAMPLE OF DM PTS 2/26/10' as
a new SORT TEMPLATE? No// Y (Yes)

DESCRIPTION:

No existing text

Edit? NO//

Next, you will be asked about creating your template in background...

Answer 'YES' to run in background.

To run in background means to pass the template creation job off to Taskman.

Your terminal will be released so additional RPMS work may be performed while the template is being created. When finished, Taskman will send you a Mailman message indicating that the job is ready. Then, you may use the template in future Qman searches, PGEN, VGEN and other reports that can utilize templates.

Answer 'NO', to create the search template in foreground.

While the template is being created, data will be displayed to your screen. When the job has finished, you will have the opportunity to go to PGEN or VGEN. Remember ... some templates may take a very long time to finish.

Press ENTER to continue or '^' to quit:

Want to run this task in background? No// (No)

...EXCUSE ME, I'M WORKING AS FAST AS I CAN...

PATIENTS (Alive)	DEMO H NUMBER
ALPHA, SHELLY *	11111
BETA, DANIEL*	22222
CHARLIE, JERILYN	33333
DELTA, LORRAI *	44444
ECHO, CLARENCE*	55555
FOXTROT, WILLIAM*	66666
GOLF, FLOWER *	77777
HOTEL, JANE*	88888
INDIGO, MICAL T*	99999
KILO, STACY RE	10101

Search template completed...

This query generates 10 "hits"
Time required to create search template: 11 SECONDS

<>

Figure 7-6: PCC QA Audit Report random sample of patients

7.10.3 Generating an Audit Sample When a Diabetes Register Has Not Been Established

To use the PCC DM QA Audit Report when no Diabetes Register has been established, build a cohort or sample cohort using Q-Man only.

Use one or more QMan attributes to find and save the diabetic population in a template to be used in the Audit Report. Living Patients should be used as the QMan subject. This process is described in detail in the *Diabetes Management* manual in the "Entering Patients in the Register from a Q-Man Search of PCC Files" section.

The diabetic patients' template can be used in the Audit Report and can be used as a Q-Man attribute to generate a random sample as described in the previous section.

7.11 Display Audit Logic (DAL)

Use the DAL option to display the audit logic for either diabetes or pre-diabetes for a selected year.

Follow these steps:

1. At the “Select PCC MAN REPORTS DM AUIT TEXT AUDIT YEAR” prompt, type the year.
2. At the “CHOOSE 1-2” prompt, type **1** (Diabetes) or **2** (Prediabetes). This determines which audit logic displays.
3. The system displays the DM Logic Display window.

DM AUDIT ITEM DESCRIPTION	Jan 27, 2009 10:08	Page: 1 of 1
DM Logic Display		
1) AUDIT DATE VALUES	19) FOOT EXAM - COMPLETE	37) HBA1C
2) FACILITY NAME CREATININE	20) DIABETIC EYE EXAM	38)
3) AREA CHOLESTEROL	21) DENTAL EXAM	39) TOTAL
4) SERVICE UNIT CHOLESTEROL	22) DIET INSTRUCTION	40) HDL
5) FACILITY CODE CHOLESTEROL	23) EXERCISE INSTRUCTION	41) LDL
6) OF PATIENTS ON DM R TRIGLYCERIDES	24) DM EDUCATION (OTHER)	42)
7) REVIEWER URINALYSIS	25) DM THERAPY	43)
8) CHART PROTEINURIA	26) ACE INHIBITOR	44)
9) DOB MICROALBUMINURIA	27) ASPIRIN/ANTI-PLATELE	45)
10) GENDER AFFILIATION	28) LIPID LOWERING AGENT	46) TRIBAL
11) PRIMARY CARE PROVIDE	29) FLU VACCINE	47) COMMUNITY
12) DATE OF DIABETES DIA GRANT FUNDS	30) PNEUMOVAX EVER	48) SDPI
13) TYPE OF DIABETES CESSATION CO	31) TD IN PAST 10 YEARS	49) TOBACCO
14) TOBACCO USE DEPRESSION ON PROBLE	32) PPD STATUS	50)
15) HEIGHT DEPRESSION SCREENING	33) IF PPD POS, INH TX C	51)
16) WEIGHT PRESSURES	34) IF PPD NEG, LAST PPD	52) BLOOD
17) BMI	35) TB STATUS (TB CODE)	
18) HYPERTENSION DOCUMEN	36) EKG	
Enter ?? for more actions		
S Select Item	A Display All Items	Q Quit
Select Action: +//		

Figure 7-7: DM Audit Item Description options

4. At the “Select Action” prompt, type **S** (Select Item) to specify the items for viewing the DM logic. At the “Select Action” prompt, type **A** to display all items.

```

OUTPUT BROWSER      Jan 27, 2009 10:14:43      Page:      1 of 1
DM AUDIT LOGIC DESCRIPTIONS

                AUDIT DATE
This is the date of the audit.  The user supplies this date.  It is
used as the ending date to calculate the time range when looking for
values.  For example, if the audit date is September 30, 2005 then
data is examined during the year prior to this audit date (October
1, 2004 to September 30, 2005).
  Individual Audit:  : The audit date is displayed.  E.g. SEPTEMBER
30, 2005

Cumulative Audit:  : N/A

EPI Info Export:  : The audit date is exported in MM/DD/YYYY format.

Enter ?? for more actions                                >>>
+   NEXT SCREEN      -   PREVIOUS SCREEN      Q   QUIT
Select Action: +//

```

Figure 7-8: Logic for Audit Date

At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to quit the report.
- Type **+** (plus) to display the next screen. This option is not available for the last screen.
- Type **-** (minus) to display the previous screen. This option is not available for the first screen.

After quitting the report, the DM Logic Display window displays.

7.12 Patients with No Diagnosis of DM on Problem List (NDOO)

Use the NDOO option to produce a report listing patients on the Diabetes Register who do not have a date of diagnosis recorded in either the Register or on the problem list.

Follow these steps:

1. At the “Enter the Name of the Register” prompt, type the register name.
2. At the “Do you want to select register patients with a particular status?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I** - Include All patients

- E - Exclude Demo patients
- O - Include only demo patients

4. At the “Device” prompt, specify the device to print/browse the report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
SJT                                     Page 1
                                DEMO HOSPITAL
DIABETES REGISTER PATIENTS WITH NO RECORDED DATE OF ONSET OF
DIABETES
Patients on the CHEROKEE DIABETES PROGRAM Register

PATIENT NAME                HRN      DOB      LAST DM DX      DM DXS DM ON PL
-----
ALPHAA,DREVAN ISAIAH      119596 Mar 02, 1982  M   Jul 19, 2007  40  NO
ALPHAAAA,SHERRY D        103465 Jul 20, 1938  F   Aug 14, 2007 129 YES
ALPHB,MOLLIE              104962 Jan 30, 1950  F   Jul 27, 2007 181 YES
BETA,HEATHER LENORE      128673 Jul 07, 1969  F   Jun 12, 2001  64  YES
BETA,RAMONA                115589 Nov 22, 1975  F   Mar 07, 1995   2  NO
BETA,DARRELL              130678 Mar 21, 1938  M   Apr 10, 2007  23  NO
BETA,KOURTNEY LEE        111215 Oct 06, 1966  F   Aug 21, 2007 101 YES
BETA,GO                    111225 Jul 10, 1947  M   Aug 07, 2007  48  YES
BETAAA,MERRILL JOE       114607 Jan 09, 1974  M   Apr 09, 2007   7  NO
BETAB,MICHAEL             106569 Dec 14, 1957  M   Apr 13, 2007  25  YES
BETAB,ROSE                110797 May 28, 1961  F   Jul 19, 2007 118 YES
BETABBB,MILDRED G        131569 Jul 10, 1922  F   Nov 21, 1991   3  YES
BETABBB,MICKAYLA CHA     113249 May 26, 1971  F   Jul 29, 2007 154 YES

Enter RETURN to continue or '^' to exit:

```

Figure 7-9: Example NDOO report

7.13 List Patients on a Register with an Appointment (APCL)

Use the APCL option to produce a report listing patients on a register with an appointment in a date range in any clinic or in a selected set of clinics.

When selecting a set of clinics, the system prompts for the name of the register, the date range of the appointments, and the clinic names.

Follow these steps:

1. At the “Enter the Name of the Register” prompt, type the register name.
2. At the “Enter Beginning Appointment Date” prompt, type the beginning date of the date range.
3. At the “Enter Ending Appointment Date” prompt, type the ending date of the date range.

4. At the “Include patients with Appointments to” prompt, type **A** (for any clinic) or **S** (for one or more selected clinics). If **S** is entered, other prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

HRN	PATIENT NAME	CLINIC NAME	DATE	TIME
111207	CHI, SHI	DMFOLLOWUP	Dec 16, 2008	1:00
101050	EEEEEEE, ALEX LIVORIO	DMFOLLOWUP	Dec 31, 2008	10:45
111217	CHI, JU-ICHI	DMFOLLOWUP	Dec 10, 2008	1:45
111232	BETA, JU	DMFOLLOWUP	Dec 15, 2008	11:30
101979	FFFFFF, JIMMY WADE	DMFOLLOWUP	Dec 31, 2008	11:30
111222	BETA, SAN	DMFOLLOWUP	Dec 18, 2008	11:30
103558	ALPHA, GREGORY PAUL	DMFOLLOWUP	Dec 05, 2008	10:15
111225	BETA, GO	DMFOLLOWUP	Dec 11, 2008	12:15
111202	CHI, ICHI	DMFOLLOWUP	Dec 09, 2008	1:45
104618	CCC, CHARLOTTE	DMFOLLOWUP	Dec 30, 2008	10:00
104699	AAAA, MELINDA	DMFOLLOWUP	Dec 18, 2008	10:45
105746	BETAAAAA, JANICE	DMFOLLOWUP	Dec 10, 2008	12:15
106184	DELTA, LYNDA ASHLEY	DMFOLLOWUP	Dec 22, 2008	10:45

Enter RETURN to continue or '^' to exit:

Figure 7-10: Example APCL report

7.14 DM Register Patients and Select Values in Four Months (DMV)

Use the DMV option to produce a report that lists the patients in a specified diabetes register and will show the following information: Name, HRN, DOB, Community or Residence.

For each of the following tests, the last value in the four months prior to the specified as of date and the next most recent prior to the one will be displayed: Hbf A1C, BP, Total Cholesterol, HDL, and LDL.

Follow these steps:

1. At the “Enter the Name of the DM Register” prompt, type the DM register name.
2. At the “Do you want to select register patients with a particular status?” prompt, type Y (Yes) or N (No). If Y (Yes) is entered, other prompts display.
3. At the “Limit the report to a particular primary care provider?” prompt, type Y (Yes) or N (No). If Y (Yes) is entered, other prompts display.
4. At the “Enter As of Date for 4 month period” prompt, type the “as of” date.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients

At the “Device” prompt, specify the device to print/browse the report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
SJT                                     Page 1
                                DEMO HOSPITAL
                                Patients on the CHEROKEE DIABETES PROGRAM Register
Status: ALL
  As of Date: Jan 28, 2008   Designated Provider: ???

PATIENT NAME                      HRN      DOB              COMMUNITY
-----
CCCCC,ALBERT D SR                101812  Aug 06, 1953  32-HNDRD ACR
  Test                            In Past 4 Months      Next most recent
  ----                            -----
  Last Clinic Visit                08/16/07
  Blood Pressure (BP)              05/24/07  124/80
  Hgb A1C                          07/02/07  7.4
  Total Cholesterol                07/02/07  139
  LDL Cholesterol                  07/02/07  81
  HDL Cholesterol                  07/02/07  32

Enter RETURN to continue or '^' to exit:

```

Figure 7-11: Example DMV report

7.15 Display a Patient’s Diabetes Care Summary (DPCS)

Use the DPCS option to produce the Print Diabetes Patient Care Supplement report.

Follow these steps:

1. At the “Select PATIENT NAME” prompt, type the name of the patient.
2. At the “Do you wish to” prompt, specify the device to print/browse the report.

```

OUTPUT BROWSER                               Jan 27, 2009 10:51:28           Page: 2 of 4

+

No
In past 12 months:
Diabetic Foot Exam:   Yes   Dec 06, 2008 (Diabetic Foot Exam,
Complete)
Diabetic Eye Exam:    No
Dental Exam:         No

(Females Only)
Last Pap Smear documented in PCC/WH: May 30, 2007
                               WH Cervical TX Need: Colposcopy (by 2003)
Mammogram: ^ Clinical Breast Exam (by 11/2000)

SMBG: No Evidence in the past year
DM Education Provided (in past yr):
  Last Dietitian Visit:   Mar 10, 2005  WIC/PHONE CONSULT/NUTR
  <No Education Topics recorded in past year>

Immunizations:
Flu vaccine since August 1st: No   Nov 30, 2006
Pneumovax ever:           No

+           Enter ?? for more actions           >>>
+   NEXT SCREEN   -   PREVIOUS SCREEN           Q   QUIT
Select Action: +//

```

Figure 7-12: Example DPCS report

The last page of the report shows the patient name, DOB, and chart number.

At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to quit the report.
- Type **+** (plus) to display the next screen. This option is not available for the last screen.
- Type **-** (minus) to display the previous screen. This option is not available for the first screen.

7.16 Print Health Summary for DM Patients with Appointment (HSRG)

Use the HSRG option to produce a health summary for all patients on the Diabetes Register that have an appointment on a specified date.

Follow these steps:

1. At the “Select Diabetes QA Audit Menu Option” prompt, type HSRG (Print Health Summary for DM Patients). The system displays the following message “This option will print a health summary for all patients who are on the Diabetes Register that have an appointment on the date you specify.”
2. At the “Enter the Appointment Date” prompt, type the date.
3. At the “Enter the Official Diabetes Register” prompt type the name of the diabetes register.
4. At the “Select health summary type” prompt, specify the type of Health Summary.
5. At the “Demo Patient Inclusion/Exclusion” prompt, select one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the “DEVICE” prompt, specify the device to print/browse the report

Figure 7-13 is a partial sample of the HSRG report.

```

Select Diabetes QA Audit Menu Option: HSRG  Print Health Summary for
DM Patients

This option will print a health summary for all patients who are on
the Diabetes Register that have an appointment on the date you
specify.

Enter the Appointment Date:  T-100  (NOV 18, 2009)
Enter the Official Diabetes Register:  IHS DIABETES
Select health summary type:  ADULT REGULAR//

      Select one of the following:

          I          Include ALL Patients
          E          Exclude DEMO Patients
          O          Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion:  E//  Exclude DEMO Patients
DEVICE:  HOME//  VT      Right Margin: 80//
** CONFIDENTIAL PATIENT INFORMATION -- 11/2/2009 10:29 AM [XX] **
***** BETA,JANE #111 (ADULT REGULAR SUMMARY) pg 1 *****

----- DEMOGRAPHIC DATA -----

BETA, JANE      DOB: AUG 1,1978 31 YRS FEMALE no blood type
DOWN EAST BAND OF LOCALS IND. RES SSN: XXX-XX-7347
MOTHER'S MAIDEN NAME: SMITH,JOAN

```

```
(H) 555-555-5555

LAST UPDATED: OCT 21, 2009   ELIGIBILITY: CHS & DIRECT
NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?

      DATE RECEIVED BY PATIENT:
      WAS ACKNOWLEDGEMENT SIGNED?

HEALTH RECORD NUMBERS: 106931 DEMO HOSPITAL
```

Figure 7-13: Sample HSRG report

7.17 Self Monitoring of Blood Glucose Follow-Up Report (SMBG)

Use the SMBG option to produce a report that shows a list of patients in a register (e.g. IHS Diabetes) that either are doing self monitoring of glucose or who are not doing self monitoring of glucose.

The following definitions/logic is used:

- Yes, doing self monitoring:
 - The last health factor documented in the 365 days prior to the end date is Self Monitoring Blood Glucose-Yes
 - The patient has had strips dispensed through pharmacy in the 365 days prior to the end date.
- No, not doing self monitoring:
 - The last health factor documented in the 365 days prior to the end date is Self Monitoring Blood Glucose-No Or Self Monitoring Blood Glucose-Refused
 - The patient has had no strips dispensed through pharmacy
 - The patient has had neither strips dispensed nor a health factor documented in the 365 days prior to the end date

In the case of the following conflict: The patient's last health factor states "NO" or "REFUSED" and strips were dispensed, the patient will show up on each report with a status of Maybe.

Follow these steps:

1. At the "Enter the Name of the Register" prompt, type the register name.
2. At the "Do you want to select register patients with a particular status?" prompt, type Y (Yes) or N (No). If Y (Yes) is entered, other prompts display.
3. At the "What list of patients do you want" prompt, type one of the following:
 - Y - YES, Doing Self Monitoring

- N - No, Not doing Self Monitoring
 - B - Both
4. At the “Enter the End Date” prompt, type the end date to use in calculating the 265 day time period.
 5. At the “How would you like the report sorted” prompt, type one of the following:
 - H – HRN
 - P - Patient Name
 - C - Community of Residence
 6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
 7. At the “Device” prompt, specify the device to print/browse the report.

HRN	PATIENT NAME	COMMUNITY	LAST VISIT	SMBG?
100020	STAMPER, ANNIE T	PAINTTOWN	Jun 23, 2007	No
100035	WILLIAMS, TIMOTHY L	BIRDTOWN	Jul 27, 2007	No
100038	QUEEN, DONNALYN M	PAINTTOWN	Aug 20, 2007	No
100041	TEESATESKIE, RITA ANN	PAINTTOWN	Aug 19, 2007	No
100062	JOHNSON, RICHARD H	PAINTTOWN	Jun 27, 2003	No
100065	KEITH, SIERRA TANDY	PAINTTOWN	Jan 05, 2007	No
100072	MCMILLAN, BILLY JACOB	WOLFTOWN	Aug 13, 2007	No
100093	VIA, BETTYE JO	BIG Y	May 25, 2007	No
100108	VARELA, CLIFFORD	YELLOWHILL	Aug 14, 2007	No
100114	SUTTON, ISAAC	BIGWITCH	Jul 10, 2007	No
100117	DRIVER, RITA	PAINTTOWN	Jan 08, 2006	No
100129	SMITH, DAISY	SOCO	Aug 22, 2007	No

Enter RETURN to continue or '^' to exit:

Figure 7-14: Example SMBG report

8.0 Active Patient Count Reports (APC)

This set of reports examines PCC visits and counts all APC visits in a given time frame for the facility that you select. Figure 8-1 shows available reports:

```

*****
**      PCC Management Reports      **
**              APC Reports              **
*****
IHS PCC Suite Version 2.0

DEMO HOSPITAL/CLINIC

A1      PCC-Ambulatory Patient Care Report 1A
DATE    APC Visit Counts by Date Of Visit
CLN     APC Visit Counts by Clinic
DISC    APC Visit Counts by Provider Discipline
APRV    APC Visit Counts by Individual Provider
LOC     APC Visit Counts by Location of Service
A1M     PCC-Ambulatory 1 Report for Multiple Facilities
AVCL    Average Number of Visits by Day of Week and Clinic
AVCS    Average Number of Visits by Day/Clinic ALL Service
AVD     Average Number of APC Visits per Day
CYV     Calendar Year First and Revisit Summary
NOEX    List APC-1A Visits Not Exported

Select APC Reports Option:

```

Figure 8-1: Example APC reports menu screen

Entry of all data into the PCC includes a designation of Location of Visit, Visit Type, and Service Category. Location of Visit is the facility where the visit occurred (e.g., Crownpoint Hospital, Yakima Health Center, Home, San Simon School). Below is a list of visit types and service categories attributes.

Visit Types

- IHS
- Contract
- Tribal
- Other
- Program
- VA

Service Categories

- Ambulatory
- Hospitalization
- In-Hospital Care
- Chart Review

- Telecommunications
- Not Found
- Day Surgery
- Observation
- Event (Historical)
- Nursing Home Care

The three visit attributes (Visit, Visit Type, and Service Category), plus the Clinic Type designation for outpatient clinic visits, determine whether a visit is an official APC visit for inclusion in the IHS data system. The criteria for inclusion are listed below.

Data displayed on this set of APC Reports from PCC Files should correspond very closely to the reports received from the IHS Data Center. However, please be aware that for SU management purposes, a similar set of reports containing additional data, such as Not Found Visits, CHN Home Visits, and Telephone Calls, is a subset of the PCC Ambulatory Visit Counts, described in the next section of this manual.

To be considered an APC visit, a visit *must* meet the following criteria:

- Fall within the date range specified.
- Have other medical data linked to the visit record.
- Have a Service Category of:
 - Ambulatory
 - Day Surgery
 - Observation
 - Nursing Home
- Excludes Service Categories of:
 - Chart Review
 - Hospitalization
 - Not Found
 - In-Hospital
 - Event
- Have a Visit Type of:
 - IHS
 - 638 Program
 - Tribal
 - Other
- Have a primary POV (POV cannot be an un-coded DX .9999).
- Have a valid location.
- Have a valid primary provider.

- Excludes a Primary Provider Discipline of 13 (CHN) or 32 (CHR) AND a location of visit other than an IHS facility (code >49).
- Have a valid clinic code.

Excludes:

- Mail
- Telephone Call
- Chart Review
- Follow-up Letter
- Radio Call
- Dental
- Education Class
- Employee Health

The visit date range for use in calculating the number of visits must be entered, and select whether visits for all locations or for one location are to be included.

8.1 PCC-Ambulatory Patient Care Report 1A (A1)

Use the A1 option to produce a report that generates from PCC files and is similar to the A1 report generated by the APC System at the Data Center in Albuquerque. The user's facility should run this report on a quarterly basis to verify that all APC visits have been exported properly to the Data Center. If the user's site is new to PCC and the APC export process, this report should be run after every export until all export problems have been resolved.

The report displays FY-to-date APC visit counts by month of service. Specify the fiscal year and the facility for the report. Totals generate for each month as well as for each provider discipline. Percentage totals display for each discipline. Total primary care provider visits will also subtotal for each month.

Follow these steps:

1. At the "Enter FISCAL YEAR" prompt, specify the fiscal year for the report. The system displays the fiscal year date range.
2. At the "Run for which Facility of Encounter" prompt, type the name of the facility.
3. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients

4. At the “Device” prompt, specify the device to print/browse the report.

```

AREA: 00 DEMO PCC AMULATORY PATIENT CARE REPORT 1A DEC 07, 1989
Page 1
S.U. : 01 DEMO FISCAL YEAR 1987
FAC.: 000101 DEMO HOSPITAL/CLINIC
AMBULATORY CARE VISITS TO SERVICE LOCATION BY PRIMARY PROVIDER AND
MONTH OF SERVICE
-----
PRIMARY PROVIDER YR TO % OP
OF SERVICE DATE TOTAL OCT NOV DEC JAN FEB MAR APR MAY JUN
JULY AUG SEPT
-----
PHYSICIAN* 505 47.6 38 37 39 46 43 37 43 36 32 37 57
60
REGISTERED NURSE 29 2.7 2 1 2 4 4 2 4 1 1 3 2 3
LICENSED PRACTICAL 12 1.1 0 1 3 4 2 0 0 1 1 0 0 0
OPTOMETRIST 18 1.7 0 2 1 2 2 3 3 1 0 0 0 4
PHARMACIST 116 10.9 13 10 6 10 15 9 8 8 10 8 9 10
PHYSICAL THERAPIST 17 1.6 4 3 2 2 2 2 1 0 0 0 0 1
PHYSICIAN ASSISTANT* 48 4.4 4 5 3 7 5 3 5 1 6 1 3
5
CHN/AIDES 6 .6 0 0 0 0 1 1 0 0 0 2 1 1
OTHER 19 1.7 7 3 0 .5 2 0 1 0 0 1 1 0
NURSE MIDWIFE 37 3.5 4 1 5 3 3 5 2 6 1 1 4 2
MENTAL HEALTH 2 .2 0 0 0 0 0 0 0 1 1 4 0 0
MEDICAL STUDENT 5 .5 0 0 0 0 0 1 0 0 0 0 3 1
NURSE PRACTITIONER* 12 1.1 1 0 1 3 3 0 0 1 1 3 0 2
NURSE ASSISTANT 5 .5 0 0 1 0 0 1 0 1 1 1 1 0
LABORATORY TECHNIC 5 .5 1 0 1 1 0 0 1 1 0 0 0 0
DIETICIAN 1 1 0 0 0 1 1 0 0 0 0 0 0 0
PODIATRIST* 8 .8 1 1 1 1 1 0 2 0 0 0 1
DENTIST 8 .8 2 0 0 6 1 1 0 1 2 0 0 0
INTERNAL MEDICINE* 111 10.5 9 2 10 0 6 10 11 13 10 4 4 5
OB/GYN* 6 .6 0 9 0 3 0 1 0 1 1 0 0 0
PEDIATRICIAN* 69 6.5 2 0 7 0 3 6 8 5 9 4 4 5
SURGEON* 8 .8 0 2 1 0 0 1 1 1 0 0 0 3
OPHTHALMOLOGIST* 11 1.0 0 0 0 0 0 1 1 0 0 2 2 4
FAMILY PRACTICE* 1 .1 0 0 0 0 0 0 0 0 1 0 0 0
NEUROLOGIST* 1 .1 0 0 0 0 0 0 0 0 0 0 0 0
TOTAL 1060 100.0 88 81 82 124 97 80 91 80 77 62 91 1070
TOTAL PRIMARY PVDR 817 77.1 59 61 67 96 66 62 72 66 61 46 74 87
21 visits were not exported because of missing or invalid data. To
see a list of these visits so that they may be resubmitted, use the
option called 'List APC-1A Visits Not Exported. There were 138
instances of 2 or more visits by a patient to the same clinic on the
same day. These 138 will not be counted in the report produced at
the Data Center, but are counted in the report above. This accounts
for a total of 159 visits that will be counted in this report but
not in the 1A report from the Data Center.
    
```

Figure 8-2: Example of Ambulatory Patient Care Report 1A

8.2 APC Visit Counts by Date of Visit (DATE)

Use the Date option to produce a report that shows a count of visits by Date of Visit for a specified date range. The visits included are those that considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type of the following:

- 1 – All
- 2 – Individually
- 3 - For a Service Unit
- 4 - From a Taxonomy

If the user types **2**, **3**, or **4**, additional prompts display.

4. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

The report displays date of visit, day of week, and visits in columns and tallies visits.

```

*****
* DEMO HEALTH CENTER                      FEB 7,2008 Page 1 *
*                NUMBER OF APC VISITS BY DATE OF VISIT *
*                LOCATION OF VISITS: DEMO HEALTH CENTER *
*                REPORT DATE: SEP 01, 2004 TO SEP 5, 2004 *
*****
DATE OF VISIT          DAY OF WEEK          VISITS
SEP 01, 2004          MONDAY                104
SEP 02, 2004          TUESDAY                81
SEP 03, 2004          WEDNESDAY              92
SEP 04, 2004          THURSDAY               71
SEP 05, 2004          FRIDAY                 91
                        -----
                        Total: 439

```

Figure 8-3: Example of Date report

8.3 APC Visit Counts by Clinic Type (CLN)

Use the CLN option to produce a report that shows a count of visits by Clinic Type for a specified date range. The visits included are those that are considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy

If 2, 3, or 4 are entered, additional prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

The report displays type of clinic, clinic code and visits in columns and tallies total visits.

```

*****
* DEMO HEALTH CENTER                                FEB 7,2008  Page    *
*                                NUMBER OF APC VISITS BY CLINIC TYPE                                *
*                                LOCATION OF VISITS: DEMO HEALTH CENTER                                *
*                                REPORT DATE: SEP 01, 2004 TO SEP 02, 2004                                *
*****

```

TYPE OF CLINIC	CLINIC CODE	VISITS
DIABETIC	06	12
EMERGENCY MEDICINE	30	60
OTHER	25	8
PODIATRY	65	8
WELL CHILD	24	12

Total: ----- 100

Figure 8-4: Example of CLN report

8.4 APC Visit Counts by Provider Discipline (DISC)

The DISC report counts the number of visits by provider discipline for a specified date range. Specify totals for primary provider only or for all providers. The visits included are those that are considered APC workload reportable.

Follow these steps:

1. At the “Report should include” prompt, type **P** (Primary Provider) or **A** (All Providers).
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy

If **2**, **3**, or **4** are entered, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the “Device” prompt, specify the device to print/browse the report.

```
*****
****      * DEMO HEALTH CENTER                      FEB 7,2008   Page 1 *
*
*                NUMBER OF APC VISITS BY ALL PROVIDER DISCIPLINES      *
*                LOCATION OF VISITS: DEMO HEALTH CENTER                  *
*                REPORT DATE: SEP 01, 2004 TO SEP 02, 2004              *
*****
```

PROVIDER DISCIPLINE	DISCIPLINE CODE	VISITS
CHN/AIDES	13	5
DENTIST	52	7
INTERNAL MEDICINE	71	1
LICENSED PRACTICAL NURSE	05	12
NURSE ASSISTANT	22	7
NURSE MIDWIFE	17	1
NURSE PRACTITIONER	21	4
NUTRITIONIST	07	2
OPHTHALMOLOGIST	79	1
OPTOMETRIST	08	1
PHARMACIST	09	13
PHARMACY PRACTITIONER	30	2
PHYSICIAN	00	36
PHYSICIAN ASSISTANT	11	3
REGISTERED NURSE	01	12

	Total:	107

Figure 8-5: Example of DISC report

8.5 APC Visit Counts by Individual Provider (APRV)

Use the APRV option to produce a report that shows visits by individual provider for a specified date range. Either primary providers or all providers can be listed. The visits included are those are those considered APC workload reportable.

Follow these steps:

1. At the “Report should include” prompt, type **P** (Primary Provider) or **A** (All Providers).
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy

If the user types **2**, **3**, or **4**, additional prompts display.
5. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include ALL Patients
- E - Exclude DEMO Patients
- O - Include ONLY DEMO Patients

6. At the “Device” prompt, specify the device to print/browse the report.

```

*****
* DEMO HEALTH CENTER                                FEB 7,2008  Page 1 *
*
*          NUMBER OF APC VISITS BY ALL PROVIDERS OF SERVICE *
*          LOCATION OF VISITS:  DEMO HEALTH CENTER          *
*          REPORT DATE:  SEP 01, 2004  TO  SEP 02, 2004    *
*****

```

PROVIDER OF SERVICE	DISCIPLINE OF PROV	VISITS
ARPROVIDER,WILLIAM M	COMMUNITY HEALTH REP	1
CPROVIDER,WILLIAM L	REGISTERED NURSE	1
FNPROVIDER,CLAUDINE Y	PHYSICIAN ASSISTANT	1
HPROVIDER,RUSSELL P	OTHER	3
IAPROVIDER,MATTHEW	PHYSICIAN	3
KWPROVIDER,BLAKE T	NURSE PRACTICIONER	4
MPROVIDER,PETER EARL	OTHER	3
NPROVIDER,ERIN D	FAMILY PRACTICE	1
SCPROVIDER,ONE	HEALTH AIDE	3
TPROVIDER,TARA M	REGISTERED NURSE	1
TXPROVIDER,FRANKLIN RICHA	OTHER	2
VNPROVIDER,JANICE M	LABORATORY TECHNICIA	3
VPROVIDER,THOMAS L	LICENSED PRACTICAL N	4
WPROVIDER,MICHEAL	LABORATORY TECHNICIA	1
Total:		31

Figure 8-6: Example of APRV report

8.6 APC Visit Counts by Location of Service (LOC)

Use the LOC option to produce a report that shows a list of the number of visits by location for a specified date range. The visits included are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include All patients
 - E - Exclude Demo patients
 - O - Include only demo patients
4. At the “Device” prompt, specify the device to print/browse the report.

```

*****
* DEMO HOSPITAL                               Jan 27, 2009 Page 1*
*
*          NUMBER OF APC VISITS BY LOCATION OF SERVICE      *
*          LOCATION OF VISITS: ALL                          *
*          REPORT DATE: JUL 31, 2008 TO JAN 27, 2009      *
*****
LOCATION OF SERVICE          LOCATION CODE          VISITS
-----
CIHA A NA LE NI SGI          585160                2
DEMO HOSPITAL                230001                85
                               -----
                               Total:                87

```

Figure 8-7: Example of LOC report

8.7 PCC-Ambulatory 1 Report for Multiple Facilities (A1M)

Use the A1M option to produce a report that shows the Year to Date Ambulatory Visit Counts and Fiscal Year for a facility that the user specifies. The counts by month are for date of service. This report will resemble, but not exactly duplicate, the APC 1A report produced at the IHS Data Warehouse in Albuquerque.

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, type the fiscal year for the report. The system displays the fiscal year date range. The systems displays the following message “Please enter which FACILITY visits will be included in the list.”
2. At the “Enter a code indicating what LOCATIONS/FACILITY are of interest” prompt, type **S** (Selected Set or taxonomy of locations) or **O** (One Location/Facility).
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
4. At the “Device” prompt, specify the device to print/browse the report.

Select APC Reports Option: AlM PCC-Ambulatory 1A Report for
Multiple Facilities

***** PCC/APC REPORT 1A *****

This report will print Year to Date Ambulatory Visit Counts for the Facility and Fiscal Year that you select. The counts by month are for date of service. This report will resemble, but not duplicate exactly, the APC 1A report produced at the IHS Data Warehouse in Albuquerque.

Enter FISCAL YEAR: 2010//2009 (2009)

FISCAL Year date range: Oct 01, 2008 - Sep 30, 2009

Please enter which FACILITY visits will be included in the list.

Select one of the following:

S Selected set or Taxonomy of Locations
O ONE Location/Facility

Enter a code indicating what LOCATIONS/FACILITIES are of interest:
O// NE Location/Facility

Which LOCATION: DEMO DEMO HOSPITAL HEADQUARTERS WEST
NON SERVICE UNIT 01 MN IHS 497

THIS REPORT MUST BE PRINTED ON 132 COLUMN PAPER OR ON A PRINTER THAT IS SET UP FOR CONDENSED PRINT!!!
IF YOU DO NOT HAVE SUCH A PRINTER AVAILABLE - SEE YOUR SITE MANAGER.

Select one of the following:

I Include ALL Patients
E Exclude DEMO Patients
O Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// Include ALL Patients
DEVICE: HOME// VT Right Margin: 80//

AREA: 23 HEADQUARTERS WEST PCC-AMBULATORY
PATIENT CARE REPORT 1A
FEB 26, 2010

Page 1

S.U.: 00 NON SERVICE UNIT FISCAL YEAR 2009
FAC.: 230001 DEMO HOSPITAL

AMBULATORY CARE VISITS TO SERVICE LOCATION
BY PRIMARY PROVIDER AND MONTH OF SERVICE

```

AREA: 23 HEADQUARTERS WEST PCC-AMBULATORY
PATIENT CARE REPORT 1A
FEB 26, 2010 Page 2
S.U.: 00 NON SERVICE UNIT FISCAL YEAR 2009
FAC.: 230001 DEMO HOSPITAL
AMBULATORY CARE VISITS TO SERVICE LOCATION
BY PRIMARY PROVIDER AND MONTH OF SERVICE

```

PRIMARY PROVIDER OF SERVICE	YR-TO DATE	% OF TOTAL	OCT.	NOV.	DEC.	JAN.
FEB. MA R.						
APR.						
MAY						
JUNE						
JULY						
AUG.						
SEPT						
00 PHYSICIAN*	79	1.7	15	2	3	3
2						
2						
0						
1						
4						
13						
17						
17						

4598 visits were not exported to the National Data Warehouse because they were posted or modified after the last NDW export was generated.

0 visits were not exported because of missing or invalid data. To see a list of these visits so that they may be resubmitted use the option called 'List APC-1A Visits Not Exported.'

RUN TIME (H.M.S): 0.0.6
End of report. HIT RETURN:

Figure 8-8: Example of a partial A1M report

8.8 Average Number of Visits by Day of Week and Clinic (AVCL)

The AVCL report generates average daily outpatient visit counts by clinic for each day of the week. Specify a date range for calculating the average number daily visits. The visits included are those are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy
 If 2, 3, or 4 are entered, additional prompts display.
4. At the Demo Patient Inclusion/Exclusion” prompt, use one of the following:
 - I Include ALL Patients
 - E Exclude DEMO Patients
 - O Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

The following sample report includes the average number of visits by day of the week and clinic for January 1, 1995 to January 31, 1995.

```

*****
* DEMO HOSPITAL/CLINIC                APR 09, 2008   Page 1 *
*                AVERAGE DAILY OUTPATIENT (APC) VISITS BY CLINIC *
*                LOCATION OF VISITS: ALL *
*                REPORT DATE:  JAN 01, 2004 TO  JAN 31, 2004 *
*****
CLINIC          MONDAY  TUESDAY  WEDNESD  THURSDA  FRIDAY  SATURDA  SUNDAY
ALCOHOLISM PROGRAM  2         0         1         0         1         0         0
CHRONIC DISEASE    4         1         3         2         1         0         0
DENTAL             3         4         1         2         0         0         0
DIABETIC           1         4         5         1         0         0         0
EMERGENCY MEDICINE 1         0         1         2         0         3         2
GENERAL            5         1         3         2         0         0         0
HOME CARE          2         2         1         2         0         0         0
MEDICAL SOCIAL SERV 1         2         1         2         1         0         0
MENTAL HEALTH     2         1         2         5         1         0         0

RUN TIME (H.M.S): 0.0.4
End of report.   HIT RETURN:

```

Figure 8-9: Example of AVCL report

8.9 Average Number of Visits by Day/Clinic ALL Service (AVCS)

The AVCS report generates the average daily outpatient visit counts by clinic for each day of the week. *All* service categories and *all* clinics are included in the visit count. This report is similar to the Average Number of Visits By Day of Week & Clinic (AVCL), with the exception of the inclusion of *all* service categories/clinics. Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy
 If 2, 3, or 4 are entered, additional prompts display.
4. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

```

*****
* DEMO HOSPITAL                                009      Page 1*
*
*                AVERAGE DAILY OUTPATIENT VISITS BY CLINIC                *
*                SERVICE CATEGORIES:  ALL                                  *
*                LOCATION OF VISITS:  SELECTED                            *
*                REPORT DATE:  OCT 29, 2008  TO  JAN 27, 2009            *
*****

```

CLINIC	MONDAY	TUESDAY	WEDNESD	THURSDA	FRIDAY	SATURDA	SUNDAY
BEHAVIORAL HEALTH	1	0	0	0	0	0	0
DAY SURGERY	0	1	0	0	0	0	0
GENERAL	1	1	2	1	2	1	2
MEN'S HEALTH SCREENI	1	0	1	1	0	1	0
MENTAL HEALTH	0	0	0	1	0	1	0
URGENT CARE	1	0	0	0	0	0	0

```

WOMEN'S HEALTH SCREE 1    0    0    1    1    1    1
RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:

```

Figure 8-10: Example of AVCS report

8.10 Average Number of APC Visits per Day (AVD)

The AVD report displays the average daily outpatient visits for a specified date range. Choose visits for one clinic, selected clinics, or all clinics. The visits included are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy

If **2**, **3**, or **4** are entered, additional prompts display.
4. At the “Include visits to ALL clinics” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
5. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the “Device” prompt, specify the device to print/browse the report.

```

*****
* DEMO HOSPITAL                               Jan 27, 2009   Page 1*
*
*                               AVERAGE DAILY OUTPATIENT (APC) VISITS
*                               LOCATION OF VISITS:  SELECTED
*                               REPORT DATE:  OCT 29, 2008  TO  JAN 27, 2009
*****

```

DAY-OF-WEEK	AVERAGE	VISITS PER DAY
MONDAY		1
TUESDAY		1
WEDNESDAY		2
THURSDAY		1
SATURDAY		1
SUNDAY		2
RUN TIME (H.M.S): 0.0.0		
End of report. HIT RETURN:		

Figure 8-11: Example of AVD report

8.11 Calendar Year First and Revisit Summary (CYV)

The CYV report tabulates visit counts for the facility and clinic for a specified date range. Visit counts are summarized for Indian/Alaska Native and all other beneficiaries. Each classification is subtotaled by the following: (1) new patient's 1st, (2) established patient's 1st, and (3) all additional patient's visits.

Note: Calendar Year Reports must be inclusive and begin with the first day of the desired calendar year.

Follow these steps:

1. At the "Enter beginning Visit Date for Search" prompt, type the beginning of the date range.
2. At the "Enter ending Visit Date for Search" prompt, type the end of the date range.
3. At the "Do you want to include Visits to" prompt, type **A** (for all locations) or **O** (for one location). If **O** is entered, other prompts display.
4. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the "Device" prompt, specify the device to print/browse the report.

Report Dates:	Non-Indian mem
Jan 01, 2009 to JAN 27, 2009	Indian Ind. Household All
Other	

Date Range	Visit	Summary			
1.	New Patient's First Visit		0	0	0
2.	Established Patient's First Visit		13	0	1
3.	Total First Visits (1-2)		13	0	1
4.	Additional Visits (2nd,3rd,etc.)		0	0	0
	SUB-TOTAL		13	0	1
	GRAND TOTAL-ALL VISITS:		14		
RUN TIME (H.M.S): 0.0.1					
End of report. HIT RETURN:					

Figure 8-12: Example of CYV report

8.12 List APC-1A Visits Not Exported (NOEX)

The NOEX report will process the same as the 1A report; however, instead of producing the 1A report, it will list all visits that would be included in the 1A report that have *not* been exported to the National Data Warehouse (NDW).

Follow these steps:

1. At the "Enter FISCAL YEAR" prompt, type the fiscal year for the report.
2. At the "Run for which Facility of Encounter" prompt, type the name of the facility.
3. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
4. At the "Device" prompt, specify the device to print/browse the report.

The PCC data entry staff should review this report. All visits that have not exported should be reviewed, corrected, and reflagged for export, as appropriate.

AREA: 23	HEADQUARTERS WEST	PCC-APC REPORT 1A	Page 1
S.U.: 00	NON SVC UNIT	FISCAL YEAR 2008	
FAC.: 230001	DEMO HOSPITAL	JAN 27, 2009	
		VISITS NOT EXPORTED	

```
Total Number of APC visits counted: 107
Total Number of those APC Visits NOT Exported: 107

Of the total number of visits counted in the 1A, but NOT exported to
the National Data Warehouse, 107 were not exported because they were
posted or modified after the last NDW export tape was generated.

RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:
```

Figure 8-13: Example of NOEX report

9.0 Ambulatory Visit Counts (PCCV)

This set of reports counts all PCC Ambulatory Visits in a given time frame. These reports display a count of PCC Ambulatory Visits sorted by the attribute selected. The system prompts for the visit date range to be used in calculating the number of visits and to indicate for which location the report should print.

The following PCC Visit Count reports are available from the PCCV menu:

```

*****
**          PCC Management Reports          **
**    PCC Ambulatory Visit Counts    **
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

DATE    Visit Counts by Date of Visit
CLIN    Visit Counts by Clinic Type
DISC    Visit Counts by Provider Discipline
PROV    Visit Counts by Provider
DX       Visit Counts by Diagnosis (ICD)
LOC     Visit Counts by Location of Service
SC      Visit Counts by Service Category
AA      PCC Visits (By Provider Disc) PCC Report AA
ALL     ALL Visits by Provider or Provider Discipline
APPT    Tally of Walk-in/Appointment Clinic Visits
CSAR    California State Annual Utilization Report
DAR     PCC Data Analysis Report
GCDC    General/Dental Clinic Visits on the Same Day
INCV    Listing of Incomplete Lab, Rx or Rad Visits
PPD     Primary Provider Visits - Daily/Annual Report
PPM     Primary Provider Visits - Monthly Report
TPC     Tally of Selected Provider Disciplines by Clinics
WAIT    Wait Times by Clinic and Provider

Select PCC Ambulatory Visit Reports Option:

```

Figure 9-1: PCC Ambulatory Visit Counts menu

In order for a visit to be included in the PCC Ambulatory Visits reports, it must meet the following criteria:

- Visit Type must be:
 - IHS
 - 638 Program
 - Tribal
 - Other

- Service Category must be:
 - Ambulatory
 - Observation
 - Day Surgery
 - Not Found
 - Nursing Home
 - Telecommunications

Excludes: Chart Review, Hospitalization, In-Hospital, and Event

- Must include a *valid* primary provider.
- Must have a POV.

9.1 Visit Counts by Date of Visit (DATE)

Use the Date option to produce a report counts visits by Date of Visit for the date range specified. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy

If **2**, **3**, or **4** are entered, additional prompts display.

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the “Device” prompt, specify the device to print/browse the report.

NUMBER OF AMBULATORY VISITS BY DATE OF VISIT		
LOCATION OF VISITS: ALL		
Chart Reviews are not included		
VISIT DATES: MAR 01, 1995 TO MAR 31, 1995		
LOCATION OF VISIT	DAY OF WEEK	VISITS
DATE OF VISIT		
DEMO HOSPITAL/CLINIC		
MAR 01, 1995	WEDNESDAY	1
MAR 06, 1995	MONDAY	1
MAR 13, 1995	MONDAY	3
MAR 15, 1995	WEDNESDAY	4
MAR 20, 1995	MONDAY	1
MAR 25, 1995	SATURDAY	1
MAR 28, 1995	TUESDAY	1

	Total:	12
RUN TIME (H.M.S): 0.0.0		
End of report. HIT RETURN:		

Figure 9-2: Sample of Date report

9.2 Visit Counts by Clinic Type (CLIN)

Use the CLIN option to produce a report that counts visits by clinic type for the date range you specify. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.

2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy
 If **2**, **3**, or **4** are entered, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the “Device” prompt, specify the device to print/browse the report.

NUMBER OF AMBULATORY VISITS BY CLINIC TYPE			FEB 8, 1995 Page 1
LOCATION OF VISITS: DEMO HEALTH CENTER			
Chart Reviews are not included.			
VISIT DATES: SEP 01, 1994 TO SEP 01, 1994			
LOCATION OF VISIT			
TYPE OF CLINIC	CLINIC CODE		VISITS

DEMO HEALTH CENTER			
DIABETIC	06		12
EMERGENCY MEDICINE	30		6
GENERAL	01		20
NO CLINIC ENTERED	99999		8
PODIATRY	65		8
WELL CHILD	24		2

		Subtotal:	56

Figure 9-3: Example of CLIN report

9.3 Visit Counts by Provider Discipline (DISC)

Use the DISC option to produce a report that counts visits by provider discipline for the date range specified. Choose counts for primary providers only or for all providers. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the “Report should include” prompt, type **P** (Primary Provider Only) or **A** (All Providers).
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
5. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a TaxonomyIf **2**, **3**, or **4** are entered, additional prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients

7. At the “Device” prompt, specify the device to print/browse the report.

LOCATION OF VISIT			FEB 8, 1995	Page 1
PROVIDER DISCIPLINE			NUMBER OF AMBULATORY VISITS BY ALL PROVIDER DISCIPLINES	
DISCIPLINE CODE			LOCATION OF VISITS: DEMO HEALTH CENTER	
VISITS			Chart Review are not included.	
-----			VISIT DATES: SEP 01, 1994 TO SEP 01, 1994	
DEMO HEALTH CENTER				
CHN/AIDES	13			5
DENTIST	52			7
INTERNAL MEDICINE	71			1
LICENSED PRACTICAL NURSE	05			12
NURSE ASSISTANT	22			7
NURSE MIDWIFE	17			1
NURSE PRACTITIONER	21			4
NUTRITIONIST	07			2
OPHTHALMOLOGIST	79			1
OPTOMETRIST	08			1
PHARMACIST	09			13
PHARMACY PRACTITIONER	30			2
PHYSICIAN	00			37
PHYSICIAN ASSISTANT	11			3
REGISTERED NURSE	01			12

			Subtotal:	108

			Total:	108

Figure 9-4: Example of DISC report

9.4 Visit Counts by Provider (PROV)

Use the PROV option to produce a report that counts visits by provider of service for the date range you specify. The user can choose counts for primary providers only or for all providers. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the “Report should include” prompt, type **P** (for Primary Provider Only) or **A** (for all providers, primary and secondary).
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
5. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy
 If **2**, **3**, or **4** are entered, additional prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
7. At the “Device” prompt, specify the device to print/browse the report.

LOCATION OF VISIT		
PROVIDER OF SERVICE	DISCIPLINE OF PROV	VISITS

DEMO HEALTH CENTER		
BETAA, HAROLD C	DENTIST	2
BETA, AMY	PHYSICIAN	1
COMMUNITY HEALTH NURSE, IH	CHN/AIDES	3
DENTAL COSTEP	DENTIST	1
DENTIST, IHS	DENTIST	4
DETLA, FRANK	PHARMACIST	4

ETAA , SUSIE	REGISTERED NURSE	1
EPSILON , MALINDA	LICENSED PRACTICAL N	3
GAMMAAAA , EVELYN	NURSE PRACTITIONER	4
IOTAAAAAA , IHS	INTERNAL MEDICINE	1
IOTAA , DELPHINE	NURSE ASSISTANT	1
IOTA , MARY	LICENSED PRACTICAL N	6
LICENSED PRACTICAL NURSE ,	LICENSED PRACTICAL N	1
LAMBDAAAAA , ROBERT	PHYSICIAN	3
LDOCC , DAVID	PHYSICIAN	1
LDOCC , FRANCES	REGISTERED NURSE	2
MUUUUU , TONY	PHYSICIAN	2
MUUUUU , GRETCHEN	REGISTERED NURSE	4
MUUUUU , FRED	PHYSICIAN	1
MUUUUU , ROGER	PHARMACIST	3

	Subtotal :	48

	Total :	48

Figure 9-5: Example of PROV report

9.5 Visit Counts by Primary Diagnosis (ICD) (DX)

Use the DX option to produce a report that counts visits by Primary Diagnosis (ICD Code) for the date range specified. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a Primary Provider or Purpose of Visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, use one of the following:
 - 1 – All

- 2 – Individually
- 3 - For a Service Unit
- 4 - From a Taxonomy

If 2, 3, or 4 are entered, additional prompts display.

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- I - Include ALL Patients
- E - Exclude DEMO Patients
- O - Include ONLY DEMO Patients

6. At the “Device” prompt, specify the device to print/browse the report.

LOCATION OF VISIT		ICD DX NARRATIVE	ICD DX CODE	VISITS
FEB 8, 1995 Page 1				
NUMBER OF AMBULATORY VISITS BY PRIMARY DX (ICD CODE)				
LOCATION OF VISITS: DEMOHEALTH CENTER				
Chart Reviews are not included.				
VISIT DATES: SEP 01, 1994 TO SEP 01, 1994				

DEMO HEALTH CENTER				
	ABN GLUCOSE-ANTEPARTUM	648.83		1
	ACUTE BRONCHIOLITIS	466.1		1
	ACUTE NASOPHARYNGITIS	460.		1
	ACUTE URI NOS	465.9		5
	ANEMIA-ANTEPARTUM	648.23		1
	ANXIETY STATE NOS	300.00		1
	ATTEN-SURG DRESSNG/SUTUR	V58.3		1
	BURN NOS	949.0		1
	CHRONIC SINUSITIS NOS	473.9		2
	CONGESTIVE HEART FAILURE	428.0		1
	DENTAL DISORDER NOS	525.9		1
	DENTAL EXAMINATION	V72.2		4
	DIAB OPHTHAL MANIF ADULT/	250.50		1
	DIABETES UNCOMPL ADULT/NI	250.00		9
	EDEMA OF PENIS	607.83		1
	FX ANKLE NOS-CLOSED	824.8		1
	GINGIV/PERIODONT DIS NOS	523.9		1
	HYPERMETROPIA	367.0		1
	HYPOVOLEMIA	276.5		1
	IMPETIGO	684.		1

			Subtotal:	36

Total: -----	36
--------------	----

Figure 9-6: Example of DX report

9.6 Visit Counts by Location of Service (LOC)

Use the LOC option to produce a report that counts visits by location of service for the date range specified.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a Primary Provider or Purpose of Visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning date for the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the ending date for the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type Y (Yes) or N (No).
4. At the “Demo Patient Inclusion/Exclusion” prompt, use one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

FEB 8, 1995			Page 1
NUMBER OF AMBULATORY VISITS BY LOCATION OF SERVICE			
LOCATION OF VISITS: ALL			
Chart Reviews are not included.			
VISIT DATES: SEP 01, 1994 TO SEP 01, 1994			
LOCATION OF VISIT			
LOCATION OF SERVICE	LOCATION CODE	VISITS	

ALBUQUERQ HO	202101	3	
DEMO HOSPITAL/CLINIC	000101	14	

DEMO HEALTH CENTER	000111	57
HOME	000189	1
DEMO UNDES	000199	2
VAYA CHIN HEALTH STATION	000132	1

	Total:	78

Figure 9-7: Example of LOC report

9.7 Visit Counts by Service Category (SC)

Use the SC option to produce a report that counts visits by service category for the date range specified. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a Primary Provider or Purpose of Visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy

If **2**, **3**, or **4** are entered, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients

- O - Include ONLY DEMO Patients
6. At the “Device” prompt, specify the device to print/browse the report.

NUMBER OF AMBULATORY VISITS BY SERVICE CATEGORY OF VISIT			FEB 8, 1995	Page 1
LOCATION OF VISITS: DEMO HEALTH CENTER				
Chart Reviews are not included.				
VISIT DATES: SEP 01, 1994 TO SEP 01, 1994				
LOCATION OF VISIT				
SERVICE CATEGORY	CODE	VISITS		

DEMO HEALTH CENTER				
AMBULATORY	A	56		
NOT FOUND	N	1		
DAY SURGERY	S	2		
TELECOMMUNICATIONS	T	6		

		Subtotal:	65	

		Total:	65	

Figure 9-8: Sample of SOC report

9.8 PCC Visits (by Provider Discipline) PCC Report AA (AA)

Use the AA option to produce a report that shows year-to-date PCC visit counts for the facility and fiscal year selected. Subtotals by month are for date of service. This report is similar to the AA report produced at the Albuquerque Data Center; however, it contains all PCC visits, not just those defined as APC visits. Please see the following example report.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a primary provider or POV

Note: This report must be printed on 132-column paper or a printer set up for condensed print.

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, type the fiscal year for the report. The system displays the fiscal year date range.

2. At the “run for which Facility of Encounter” prompt, type the name of the facility.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
4. At the “Device” prompt, specify the device to print/browse the report.

```

AREA: 00 DEMO PCC-OUTPATIENT PATIENT CARE REPORT APR 19, 1996 Page 1
S.U.: 01 DEMO FISCAL YEAR 1995
FAC.: 000101 DEMO HOSPITAL/CLINIC
ALL PCC OUTPATIENT (NON-HOSPITAL) VISITS TO SERVICE LOCATION
BY PRIMARY PROVIDER AND
MONTH OF SERVICE

```

PRIMARY PROVIDER OF SERVICE	YR-TO DATE	% OF TOTAL	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT
PHYSICIAN*	18	6.7	0	5	1	2	0	1	0	2	1	0	2	1
1 2 3														
MEDICAL SOCIAL WORKE	43	16.1	6	1	0	0	0	0	0	0	0	0	0	0
0 0 5 17 14														
MENTAL HEALTH	134	50.2	2	17	11	11	16	8	9	5				
3 20 11 21														
PHARMACY PRACTICIONE	1	.4	0	0	0	0	0	0	0	0	0	0	0	0
0 0 0 0 1														
DENTIST	3	1.1	0	0	0	0	1	1	0	0	0	0	0	0
0 0 1														
COMMUNITY HEALTH REP	16	6.0	0	0	0	0	0	12	0	0	0	0	0	0
0 4 0 0 0														
INTERNAL MEDICINE*	47	17.6	1	1	5	9	2	4	5	9				
3 2 2 4														
FAMILY PRACTICE*	2	.7	0	0	1	0	0	0	0	0	0	0	0	0
0 1 0 0														
PSYCHIATRIST*	1	.4	0	1	0	0	0	0	0	0	0	0	0	0
0 0 0														
T O T A L	267	100.0	9	25	18	22	33	14	14	16				
11 29 32 44														
*TOTAL PRIMARY PVDR	68	25.5	1	7	7	11	2	5	5					
11 4 4 4 7														

```

RUN TIME (H.M.S): 0.0.2
End of report. HIT RETURN:

```

Figure 9-9: Sample of AA report

9.9 All Visits by Provider or Provider Discipline (ALL)

Use the All option to produce a report that counts all visits by provider, location of service, and service category. All visits are in the report regardless of type, service category, or clinic. The visit must have a valid provider and POV to be included. Select one or all providers, one or all provider disciplines, all providers within one discipline, one or all locations, and whether the provider is a primary provider.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Report should include and sort by” prompt, type one of the following:
 - O - One Provider Only
 - P - All Providers
 - D - One Provider Discipline
 - A - All Provider Disciplines
 - X - All Providers within One DisciplineIf **O**, **D**, or **X** are entered, additional prompts display.
4. At the “Include if Provider is” prompt, type **P** (for primary provider) or **S** for Primary or secondary provider).
5. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a TaxonomyIf **2**, **3**, or **4** are entered, additional prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
7. At the “Device” prompt, specify the device to print/browse the report.

AUG 02, 1994 Page 1

NUMBER OF CONTACTS BY PROVIDER, LOCATION AND SERVICE CATEGORY
 LOCATION OF VISITS: ALL
 PROVIDER DISCIPLINE: ALL
 PRIMARY PROVIDER ONLY
 VISIT DATES: JAN 01, 1994 TO JAN 15, 1994

LOCATION OF VISIT SERVICE CATEGORY	PROVIDER CONTACTS

Provider Discipline: PHYSICIAN	
DEMO HOSPITAL/CLINIC	
AMBULATORY	36
SAN XAVIER HEALTH CENTER	
AMBULATORY	106
CHART REVIEW	4
TELECOMMUNICATIONS	4
AMBULANCE,000177	
AMBULATORY	4
CHS PHYSICIAN OFFICE,000188	
AMBULATORY	7
IN HOSPITAL	6
VETERANS ADMIN HOSPITAL	
AMBULATORY	4
HOSPITALIZATION	1
SAINT MARY'S HOSPITAL	
AMBULATORY	5

Figure 9-10: Example of All report

The report will show subtotals and totals.

9.10 Tally of Walk-In/Appointment Clinic Visits (APPT)

Use the APPT option to produce a report that counts visits by clinic in the date range selected. Select visit counts for one or all locations and one or all clinics. The report counts each clinic visit by appointment, walk-in, or unspecified.

Follow these steps:

1. At the "Enter beginning Visit Date for Search" prompt, type the beginning of the date range.
2. At the "Enter ending Visit Date for Search" prompt, type the end of the date range.
3. At the "Do you want to select" prompt, type one of the following:
 - 1 – All
 - 2 – Individually

- 3 - For a Service Unit
- 4 - From a Taxonomy

If 2, 3, or 4 are entered, additional prompts display.

4. At the "Include visits from ALL Clinics?" prompt, type Y (Yes) or N (No). If N (No) is entered, other prompts display.
5. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the "Device" prompt, specify the device to print/browse the report.

AUG 02, 1994 Page 1									
TALLY OF CLINIC VISITS: WALK-IN, APPOINTMENT, UNSPECIFIED									
LOCATION OF VISITS: ALL									
CLINIC: ALL									
VISIT DATES: JAN 01, 1994 TO JAN 31, 1994									
LOCATION OF VISIT									
CLINIC	TOTAL	APPOINTMENTS	WALK-INS	UNSPECIFIED					
CLINIC CODE	VISITS		%	%					

DEMO OTHER									
MENTAL HEALTH	4	5	0	0.0	0	0.0	5	100.0	
Sub total:		5	0	0.0	0	0.0	5	100.0	
DEMO HOSPITAL/CLINIC									
CHRONIC DISEASE	50	17	0	0.0	0	0.0	17	100.0	
DENTAL	56	186	0	0.0	0	0.0	186	100.0	
DIABETIC	06	55	0	0.0	0	0.0	55	100.0	
DIETARY	67	18	0	0.0	0	0.0	18	100.0	
EMERGENCY MED	30	228	0	0.0	0	0.0	228	100.0	
GENERAL	01	551	0	0.0	0	0.0	551	100.0	
GROUP SERVICES	09	9	0	0.0	0	0.0	9	100.0	
GYNECOLOGY	10	15	0	0.0	0	0.0	15	100.0	
MENTAL HEALTH	14	3	0	0.0	0	0.0	3	100.0	
OBSTETRICS	16	49	0	0.0	0	0.0	49	100.0	
OPHTHALMOLOGY	17	27	0	0.0	0	0.0	27	100.0	
OPTOMETRY	18	31	0	0.0	0	0.0	31	100.0	
OTHER	25	10	0	0.0	0	0.0	10	100.0	
PHARMACY	39	203	0	0.0	0	0.0	203	100.0	
PHYSICAL THER	34	86	0	0.0	0	0.0	86	100.0	

PODIATRY	65	29	0	0.0	0	0.0	29	100.0
RADIOLOGY	63	2	0	0.0	0	0.0	2	100.0
SURGICAL	23	13	0	0.0	0	0.0	13	100.0
WELL CHILD	24	10	0	0.0	0	0.0	10	100.0
WOMEN'S HLTH SCR 70		1	0	0.0	0	0.0	1	100.0
Sub total:		1543	0	0.0	0	0.0	1543	100.0
Total		1548	0	0.0	0	0.0	1548	100.0

Figure 9-11: Example of APPT report

9.11 California State Annual Utilization Report (CSAR)

Use the CSAR option to produce the California State Annual Utilization Report of Primary Care Clinics report for a selected year.

Follow these steps:

1. At the “Enter Calendar year (e.g. 2007)” prompt, type the calendar year of interest. Use a 4-digit year, e.g., 2006.
2. At the “Include visits from ALL Locations?” prompt, type **Y** (Yes) or **N** (No). If **N** (No) is entered, other prompts display.
3. At the “Select 3P FEE TABLE SCHEDULE NUMBER” prompt, specify the FEE schedule to use in calculating the primary CPT code.
4. At the “Do you want to include a list of visits with no CPT code?” prompt, type **Y** (Yes) or **N** (No).
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the “Device” prompt, specify the device to print/browse the report.

```

CALIFORNIA ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS, 2007
      ALL LOCATIONS OF ENCOUNTER SELECTED
Reporting Period: Jan 01, 2007 to Dec 31, 2007

```

```

-----
SECTION 2
FTEs AND ENCOUNTERS BY PRIMARY CARE PROVIDER      Column 5 - No. of
Encounters                                          Encounters
                                                    (5)
LINE NO. OF

```

NO. PRIMARY CARE PROVIDERS ENCOUNTERS		

60	Physicians	18,809
61	Physician Assistants	8,661
62	Family Nurse Practitioners	4,640
63	Certified Nurse Midwives	0

Figure 9-12: Partial example of CSAR report

9.12 PCC Data Analysis Report (DAR)

Use the DAR option to produce a report that counts all visits processed in the PCC and categorizes them by type, service category, and complete/incomplete. The PCC Data Analysis Report also indicates visits excluded from the APC system.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Include visits for which Facility” prompt, type the name of the facility.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

```

DEMO HOSPITAL/CLINIC                               Apr 09, 1996   Page 1
PCC DATA ANALYSIS REPORT
*****
FACILITY: DEMO HOSPITAL/CLINIC - 000101
VISIT DATE RANGE: Jan 01, 1995 - Dec 30, 1995

Total Visits Processed in PCC: 140

as of the Date the report was run:
                                     complete   incomplete
                                     -----

```

TYPE:	IHS	100	36
	OTHER	3	1
SERVICE CATEGORY:	AMBULATORY	97	34
	CHART REVIEW	1	
	EVENT (HISTORICAL)		1
	HOSPITALIZATION	2	2
	IN HOSPITAL	3	
APC Acceptable Visits based on Headquarters Definition:			93
Exclusions from APC System:			
	Dental Clinic w/o Medication		4
	Other Excluded Clinic Type		0
	Incomplete A, O, R or S		15
	Non APC Service Category		9
	Non APC Visit Type		0
	Mult Visits same patient, same day, same clinic		19
Of the acceptable APC visits, 0 were posted or modified after the last export and would not be reflected in reports from the data center.			
Of the acceptable APC visits, 27 were not exported due to an error. These can be reviewed using other PCC reports.			
RUN TIME (H.M.S): 0.0.9			
End of report. HIT RETURN:			

Figure 9-13: Example of DAR report

9.13 General/Dental Clinic Visits on the Same Day (GCDC)

Use the GCDC option to produce a report that shows a list of patients who have had a dental clinic visit and a general clinic visit on the same day.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
 - 1 – All
 - 2 – Individually
 - 3 - For a Service Unit
 - 4 - From a Taxonomy

If **2**, **3**, or **4** are entered, additional prompts display.

4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

General Clinic and Dental Clinic Visits (Same Day)		
Location of Visits: SELECTED		
Date Range: Jan 28, 2008 to Jan 27, 2009		
Visit Date	Patient Name	Chart

Figure 9-14: Example GCDC report

9.14 Listing of Incomplete Laboratory, Rx or Rad Visits (INCV)

Use the INCV option to produce a report that lists all “orphan visits.” Select orphaned laboratory, pharmacy, or radiology visits. If laboratory is selected, all visits with no primary provider or POV entered that have a laboratory entry attached to them display. The same is true for pharmacy or radiology. If a visit has both a V LAB and a V RADIOLOGY, the visit is included in each report.

Follow these steps:

1. At the “What type of orphan visits should be included” prompt, type one of the following:
 - L – LAB
 - P – PHARMACY
 - R - RADIOLOGY
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
 - A - ALL Locations/Facilities
 - S - One SERVICE UNIT'S Locations/Facilities

- O - ONE Location/Facility
- If the user types **S** or **O**, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
 6. At the “Do you wish to” prompt, specify the device to print/browse the report.

```

OUTPUT BROWSER          Jan 27, 2009 15:37:33          Page: 1 of 2
XXX                    Jan 27, 2009                Page 1

                               INCOMPLETE LAB VISITS
                               Visit Dates: Jan 28, 2008 to Jan 27, 2009

HRN   PATIENT NAME   DATE           TIME   SC TYPE LOC   LAB RX   RAD
-----
TOTAL NUMBER OF VISITS FOUND: 13

DH 124682 SIGMA,ANGELA  Mar 12, 2008 8:00   H   T   DH     1   0   0
DH 111207 CHI,SHI     Mar 18, 2008 12:00  A   I   DH     3   0   0
DH 111228 BETA,SHICHI  Mar 28, 2008 12:00  A   I   DH     3   0   0

+           Enter ?? for more actions                >>>
+   NEXT SCREEN           -   PREVIOUS SCREEN           Q   QUIT
Select Action: +//

```

Figure 9-15: Example INVC report

At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to quit the report.
- Type **+** (plus) to display the next screen. This option is not available for the last screen.
- Type **-** (minus) to display the previous screen. This option is not available for the first screen.

9.15 Primary Provider Visits – Daily/Annual Report (PPD)

Use the PPD option to produce a report that counts visits by Primary Providers for a given day or year. The user can specify the locations or clinics to include in the report up to a total of six for an 80-column report or 12 for a 132-column report. All clinics are counted in the report, including telephone calls, dental, and chart reviews if a

clinic is not specified. However, only visits with a primary provider discipline in one of the following codes are tabulated:

Code	Primary Provider Discipline
00	Physician
11	Physician Assistant
16	Pediatric Nurse Practitioner
17	Nurse Midwife
18	Contract Physician
21	Nurse Practitioner
25	Contract Podiatrist
33	Podiatrist
41	Contract OB/Gyn
44	Physician (Tribal)
70 - 90	Physician Specialists

This report tallies the number of visits by primary care providers, provider at the locations or the clinics that the user specifies.

This report can be run for one day (daily report) or for a year (calendar).

A total number of six locations or clinics will fit on an 80 column report. The user can specify up to 12 if the report is printed with 132 columns.

Follow these steps:

1. At the “Run which Report” prompt, type **D** (Daily Report) or **Y** (Yearly Report).
2. At the “Enter DATE” prompt, type the date.
3. At the “Do you wish to tally by” prompt, type **C** (Clinic) or **F** (Facility). Other prompts will display, according the option used.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

The following sample report was run for an entire facility and six specific clinics for January 15, 1995.

XXX	DEMO HOSPITAL/CLINIC	Page 1
PRIMARY CARE PROVIDER VISITS - YEARLY REPORT		

```

VISIT DATES: JAN 1, 1995 TO DEC 31, 1995
LOCATION OF VISITS: ALL

PROVIDER  GENERAL  DIABETIC  INTERNAL  OBSTETRI  SURGICAL  EMERGENC
-----
ALPHAA,CLAYTON    10         2           0           0           0           3
SIGMA,GREG         2         2           0           0           0           0
BETABETA,LORI AN 18         0           0           0           0           0
RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:

```

Figure 9-16: Example of PPD report

9.16 Primary Care Provider Visits – Monthly Report (PPM)

Use the PPM option to produce a report that counts the number of visits by primary care providers for a given month. All clinic codes are in the report including telephone calls, dental, and chart review. Only visits with a primary provider discipline are counted.

A total of six locations or clinics will fit on an 80-column report. The user can specify up to 12 if the report is printed with 132 columns.

Follow these steps:

1. At the “At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Do you wish to tally by” prompt, type **C** (Clinic) or **F** (Facility). Other prompts display according to the option specified.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

The following sample report was run for the month of January for six selected clinics.

```

                                DEMO HOSPITAL/CLINIC                                Page 1
PRIMARY CARE PROVIDER VISITS - PRIMARY PROVIDER ONLY
VISITS DATES:  JAN 01, 1996  TO  JAN 31, 1996
LOCATION OF VISITS: ALL

DATE      GENERAL  DIABETIC  INTERNAL  OBSTETRI  EMERGENC  DENTAL

```

01/08/96	1	4	11	9	3	5
01/10/96	6	6	9	7	1	6
01/11/96	4	7	6	5	2	3
01/18/96	2	5	7	5	0	5
01/24/96	8	5	6	3	2	5
01/30/96	1	5	8	2	1	7
RUN TIME (H.M.S): 0.0.0						
End of report. HIT RETURN:						

Figure 9-17: Example of PPM report

9.17 Tally of Selected Provider Disciplines by Clinics (TPC)

The TPC option produces a report that lists a count of all visits to clinics within a taxonomy of clinics identified. The report tallies all primary and secondary providers on those visits. Only those provider disciplines within the discipline taxonomy selected will be tallied.

Follow these steps:

1. At the “At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following
 - A - ALL Locations/Facilities
 - S - One SERVICE UNIT’S Locations/Facilities
 - O - ONE Location/Facility
 - T - A taxonomy or Set of Locations/Facilities
 If **S**, **O**, or **T** are entered, other prompts display.
4. At the “Enter Clinic” prompt, type the clinic for the report. This prompt repeats so that the user may type more than one clinic.
5. At the “Enter CLASS” prompt, type the class.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients

- E - Exclude DEMO Patients
- O - Include ONLY DEMO Patients

7. At the “Device” prompt, specify the device to print/browse the report.

```
Select PCC Ambulatory Visit Reports Option: TPC Tally of Selected
Provider Disciplines by Clinics
```

```
This report will list a count of all visits to clinics that
are within a taxonomy of clinics you identify. The report
will be a tally of all primary and secondary providers
on those visits. Only those provider disciplines that are
within the discipline taxonomy you select will be tallied.
```

```
Enter Beginning Visit Date: T-200 (AUG 10, 2009)
```

```
Enter Ending Visit Date: T (FEB 26, 2010)
```

```
Select one of the following:
```

```

A          ALL Locations/Facilities
S          One SERVICE UNIT'S Locations/Facilities
O          ONE Location/Facility
T          A Taxonomy or Set of Locations/Facilities
```

```
Enter a code indicating what LOCATIONS/FACILITIES are of interest:
O// ALL Locations/Facilities
```

```
Enter CLINIC: 01 GENERAL 01
```

```
The following have been selected =>
```

```
GENERAL
```

```
Enter ANOTHER CLASS: PHYS
```

```

1  PHYSICAL THERAPIST
2  PHYSICAL THERAPY TECHNICIAN
3  PHYSICIAN
4  PHYSICIAN (CONTRACT)
5  PHYSICIAN (TRIBAL)
```

```
Press <RETURN> to see more, '^' to exit this list, OR
```

```
CHOOSE 1-5: 3 PHYSICIAN
```

```
Enter ANOTHER CLASS: PHYS
```

```

1  PHYSICAL THERAPIST
2  PHYSICAL THERAPY TECHNICIAN
3  PHYSICIAN
4  PHYSICIAN (CONTRACT)
5  PHYSICIAN (TRIBAL)
```

```
Press <RETURN> to see more, '^' to exit this list, OR
```

```
CHOOSE 1-5: 4 PHYSICIAN (CONTRACT)
```

```
Enter ANOTHER CLASS: PHYS
```

```
1  PHYSICAL THERAPIST
```

```

2  PHYSICAL THERAPY TECHNICIAN
3  PHYSICIAN
4  PHYSICIAN (CONTRACT)
5  PHYSICIAN (TRIBAL)
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 5  PHYSICIAN (TRIBAL)
Enter ANOTHER CLASS:

The following have been selected =>

    PHYSICIAN
    PHYSICIAN (CONTRACT)
    PHYSICIAN (TRIBAL)

Want to save this CLASS group for future use? No//  (No)

Select one of the following:

    I          Include ALL Patients
    E          Exclude DEMO Patients
    O          Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// Include ALL Patients
DEVICE: HOME//  VT    Right Margin: 80//

Tally of Selected Primary and Secondary Providers for selected
Clinic Visits

Visit Dates: Aug 10, 2009-Feb 26, 2010

Locations:  ALL

Clinics:
    GENERAL

Disciplines:
    PHYSICIAN
    PHYSICIAN (CONTRACT)
    PHYSICIAN (TRIBAL)

Feb 26,
2010  Page 1
TALLY OF SELECTED PRIMARY AND SECONDARY PROVIDERS FOR SELECTED
CLINIC VISITS

Visit Dates: Aug 10, 2009-Feb 26, 2010
FOR: ALL Locations
-----

Total PCC Primary Provider Workload Count:      212
Total PCC Secondary Provider Workload Count:    2

```

```

Total PCC Provider Workload Count:                214
Total Number of Visits:                            214
PRIMARY PROVIDERS                                # OF VISITS
  AQPROVIDER,NATALIE                               6
    DEMO                6
  AXPROVIDER,MERY F                                 2
    DEMO                2
  BOPROVIDER,RICHARD MD                             1
    DEMO                1
  BPPROVIDER,J                                       1
    DEMO                1

Enter RETURN to continue or '^' to exit:

                                                    Feb 26,
2010 Page 2
  TALLY OF SELECTED PRIMARY AND SECONDARY PROVIDERS FOR SELECTED
CLINIC VISITS
  Visit Dates: Aug 10, 2009-Feb 26, 2010
  FOR: ALL Locations
-----
  BPPROVIDER,MELISSA A                               1
    DEMO                1
  BETA,LORI                                           1
    DEMO                1
  CFPROVIDER,RENAE FRANCES                           13
    DEMO                13
  CNPROVIDER,TOM                                       1
    DEMO                1
  DEPROVIDER,ABDUL Z                                  1
    DEMO                1
  DLPROVIDER,ELISA                                    1
    DEMO                1
  EBPROVIDER,WALTER L                                 1
    DEMO                1
  EJPROVIDER,GLENN C                                  1
    DEMO                1
  EWPROVIDER,KIM                                       1

...
RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:

```

Figure 9-18: Example TPC report

9.18 Wait Times by Clinic and Provider (WAIT)

The WAIT option displays minimum, maximum, and mean waiting times by provider and clinic. In order for data to print in this report, the user's site must be entering the

actual time that the primary provider saw the patient. Type a beginning visit date and ending visit date for time reporting. There is an option to print waiting times for all clinics or for specific clinics.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Tally Waiting Times for ALL Clinics” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you wish to include” prompt, type **W** (Walk-ins Only) or **A** (Appointments Only).
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the “Device” prompt, specify the device to print/browse the report.

Figure 9-19 includes wait times for the Internal Medicine clinic between October 1 and October 31, 1996.

```

*****
* DEMO HOSPITAL/CLINIC NOV 25, 1996 Page 1 *
*
* WAITING TIMES BY CLINIC AND PROVIDER *
* LOCATION OF VISITS: DEMO HOSPITAL/CLINIC *
* REPORT DATE: OCT 01, 1996 TO OCT 31, 1996 *
Report includes APPOINTMENTS only.
*****

```

CLINIC	TOTAL VISITS	VSTS USED	AVG WAIT	MIN WAIT	MAX WAIT	EARLY	LATE
INTERNAL MEDICINE	120	100	10	0	33	38	62
BETAA, TED	25	20	18	5	37	0	20
GAMMAAAA, LUPE	40	40	5	0	12	18	22
SIGMAAAAAA, TOM	30	25	12	2	23	6	19
THETAA, FLYNN	25	15	8	0	18	6	9

Figure 9-19: Example of Wait report

10.0 Billing Reports (BILL)

The following reports are available from the Billing Reports menu:

```

*****
**      PCC Management Reports      **
**          Billing Reports          **
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

MCA  Listing of Active Medicare Part A Enrollees
MCB  Listing of Active Medicare Part B Enrollees
MCD  Listing of Active Medicaid Enrollees
PI   Listing of Active Private Insurance Enrollees
CO   Listing of Commissioned Officers and Dependents
VIS  Listing of Potentially Billable Visits by Date
COV  Visits by Commissioned Officers and Dependents
TPR  List of Selected Third Party Coverage(s)

Select Billing Reports Option:

```

Figure 10-1: Example billing reports main menu

10.1 Listing of Active Medicare Part A Enrollees (MCA)

Use the MCA option to produce a report that shows a list of patients registered at a specified facility who are currently enrolled in Medicare Part A. Type an “as of” date to identify patients who are actively enrolled from the date specified. The report sorts alphabetically by patient name.

Follow these steps:

1. At the “Which Facility” prompt, type the facility name.
2. At the “Patients are to be considered ACTIVE as of what date” prompt, type the date.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
4. At the “Device” prompt, specify the device to print/browse the report.

```

                DEMO HEALTH CENTER                                Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART A ENROLLEES

```

```

Actively enrolled as of FEB 7,1995
NAME          CHART    MEDICARE  (TYPE)  COVERAGE  ELIG BEG DATE  ELIG END
DATE         DATE OF BIRTH
-----
(REG) BETAN,SUSAN          6182      56932812361    FEB 01, 1938
(MCR) OMICRON,HENRY
              A          SEP 1979
              A          DEC 31, 1988
-----
(REG) GAMMA,DARLENE       6708      1234344441     JAN 01, 1989
(MCR) OMICRON,HENRY
              A          DEC 31, 1988
-----
(REG) GAMMAA,BILL         14697     57416683018    JUN 01, 1975
(MCR)
              A          JUL 1975
-----

```

Figure 10-2: Example listing of active Medicare Part A enrollees

10.2 Listing of Active Medicare Part B Enrollees (MCB)

Use the MCV option to produce a report that shows the patients registered at a specified facility and currently enrolled in Medicare Part B. Type an “as of” date to identify patients who are actively enrolled from the date specified. The report sorts alphabetically by patient name.

The prompts are the same as those for the MCA option.

```

                                DEMO HEALTH CENTER                                Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART B ENROLLEES
Actively enrolled as of FEB 7,1995

NAME          CHART    MEDICARE
(TYPE)        COVERAGE  ELIG BEG DATE  ELIG END DATE  DATE OF BIRTH
-----
(REG) BETAB,LISA          9422          526928682144    SEP 01, 1964
(MCR)
              B          JUL 1966
-----
(REG) BETAC,SUSAN        6182          56932812361     FEB 01, 1938
(MCR) WASHINGTON,HENRY
              B          SEP 1979
-----
(REG) GAMMA,DARLENE     6708          1234344441     JAN 01, 1989
(MCR) WASHINGTON,HENRY
              B          DEC 13, 1989
-----

```

Figure 10-3: Example listing of active Medicare Part B enrollees

10.3 Listing of Active Medicaid Enrollees (MCD)

Use the MCD option to produce a report showing a list of patients registered at a specified facility and currently enrolled in Medicaid. To determine which patients are actively enrolled during the specified date, type an "as of" date. The report sorts alphabetically by patient name. See the example below.

The prompts are the same as those for the MCA option.

NAME		CHART	DATE OF BIRTH

(REG)	BETAB, SAM	22222	MAY 01, 1977
(MCD)			
	MEDICAID : 0000000001		STATE: MONTANA
	NAME/INSURED:		SEX OF INSURED:

(REG)	BETAB, SUSAN	22223	FEB 01, 1938
(MCD)			
	MEDICAID : 0000000002		STATE: ARIZONA
	NAME/INSURED:		SEX OF INSURED:
	ELIG BEG DATE: JAN 1983	COVERAGE: 11	ELIG END DATE:

(REG)	GREEN, DARLENE	22224	JAN 01, 1989
(MCD)	SAME		
	MEDICAID : 0000000003		STATE: MINNESOTA
	NAME/INSURED: GREEN, DARLENE		SEX OF INSURED: F
	ELIG BEG DATE: JAN 31, 1990	COVERAGE:	ELIG END DATE: FEB 14, 1990

Figure 10-4: Example listing of active Medicaid enrollees

10.4 Listing of Active Private Insurance Enrollees (PI)

Use the PI option to produce a report showing a list of patients registered in a specified facility and currently enrolled in private insurance. To identify patients who are actively enrolled during the specified date, type an "as of" date. The report sorts alphabetically by patient name.

The prompts are the same as those for the MCA option.

PATIENT NAME		CHART	DATE OF BIRTH

GBETA, ANNE 1935	33333	MAY 01,
INSURER: AETNA		
POLICY : 123456	COVERAGE TYPE:	
INSURED: EEEE,D	REL: SELF	
ELIG BEG DATE: JAN 27, 1988	ELIG END DATE:	

GBETA, DARLENE 1989	33334	JAN 01,
INSURER: BLUE CROSS/BLUE SHIELD		
POLICY : 123457	COVERAGE TYPE:	
INSURED: WBETA,BETA	REL: SELF	
ELIG BEG DATE: JAN 01, 1989	ELIG END DATE:	

TOTAL NUMBER OF ACTIVE PRIVATE INSURANCE ENROLLEES: 2		

Figure 10-5: Example listing of active private insurance enrollees

10.5 Listing of Commissioned Officers and Dependents (CO)

Use the CO option to produce a report that lists commissioned officers and their dependents as of the current date. The last page of the report shows a total. See Figure 10-6.

			page 1
DEMO HEALTH CENTER			
COMM. OFFICERS & DEPENDENTS			
UCI: DEV			
("*" = INACTIVE)			
as of FEB 7,1995@18:54:08			
Name	IHS	SSN	CLASS.
-----	-----	-----	-----
BETAAA, SHARON	44441	xxx-xx-1111	C. O.
BETAA, EVAN	44442	xxx-xx-1112	C. O.
BETAB, THOMAS	44443	xxx-xx-1113	C. O.
BETAC, RICHARD	44444	xxx-xx-1114	C. O.
DELTA, ELIZABETH	44445	xxx-xx-1115	C. O.
GAMMAA, SHARON	44446	xxx-xx-1116	C. O.
GAMMAB, PRESTON	44447	xxx-xx-1117	C. O.
HALPHA, IDA	44448	xxx-xx-1118	C. O.
HALPHA, ISIAH	4449	xxx-xx-1119	C. O.

Figure 10-6: Example listing of commissioned officers and their dependents

10.6 Listing of Potentially Billable Visits by Date (VIS)

Use the VIS option to produce a report showing a list of potentially billable visits for all patients registered at a specified facility. This report displays visits for the period in which the patient had third-party coverage. Only visits at the location where a patient is registered display.

Note: Specific diagnostic categories that might not be covered by the patient's insurance are not considered in the report.

Follow these steps:

1. At the "Run the report for which Facility" prompt, type the facility name.
2. At the "Starting Visit Date for Billable Visits" prompt, type the start of the date range.
3. At the "Ending Visits Date for Billable Visits" prompt, type the end of the date range.
4. At the "Do you want a particular SERVICE CATEGORY?" prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
5. At the "Do you want a particular CLINIC?" prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
6. At the "Select Third Party Coverage" prompt, select one of the options listed below to display visits from the following types of third-party coverage:
 - Commissioned Officers/Dependents
 - Medicare Part A
 - Medicare Part B
 - Medicaid
 - Private Insurance
 - Non-Indians
 - All Above Coverages
7. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
8. At the "Device" prompt, specify the device to print/browse the report.

The following sample report shows billable visits from September 1, 1988 to February 7, 1990 for patients enrolled in Medicare Part B.

DEMO HEALTH CENTER	Page 1
POTENTIALLY BILLABLE VISITS FOR Medicare Part B	
Visit Dates: SEP 1,1988 and FEB 7,1990	
SERVICE CATEOGRY OF VISITS: ALL VISIT SERVICE CATEGORIES	

HRCN	Patient Name	Date of Birth	SSN				
14697	MALPHA, JAMES	JUN 01, 1975	xxx-xx-0001				
	Medicare Name:	DOB: JUN 01, 1975					
	Coverage: B	Beg. Date: JUL 1975	End. Date:				
	Medicare : 527739228B						
	Visit Date	Category	PRV	ICD DX	ICD NARRATIVE		
	JAN 01, 1990	AMBULATORY	00	465.9	ACUTE URI NOS		
4500	MARTIN, ANITA	AUG 01, 1935	xxx-xx-0002				
	Medicare Name:	DOB: AUG 01, 1935					
	Coverage: B	Beg. Date: MAR 21, 1987	End. Date:				
	Medicare : 111991111B						
	Visit Date	Category	PRV	ICD DX	ICD NARRATIVE		
	OCT 21, 1988	AMBULATORY	00	250.00	DIABETES UNCOMPL ADU		
					250.91 DIAB W COMPL NOS		
	JUV						
	MAR 28, 1989	AMBULATORY	52	V72.2	DENTAL EXAMINATION		
	OCT 24, 1989	AMBULATORY	71	250.00	DIABETES UNCOMPL ADU		

Figure 10-7: Example listing of potentially billable visits by date

10.7 Visits by Commissioned Officers and Dependents (COV)

Use the COV option to produce a report that displays visits for all commissioned officers and their dependents at the facility the user is logged in to. Specify a date range for the visits and select from the following types of visits:

- Outpatient Visits Only
- Inpatient Visits Only
- Dental Visits Only
- All Visits

Note: This report prints on 132-column paper or on a printer set up for condensed print.

*****Confidential Patient Data Covered by Privacy Act*****

DEMO HOSPITAL
 COMMISSIONED OFFICERS & DEPENDENTS VISITS
 01/01/96 to 01/28/09
 OUTPATIENT VISITS

 Patient Name Chart SSN CO or Dep Sponsor SSN Visit Date No.
 of Visits

BETAA, FRANCIS SKIRVI	169291	432-47-8159	CO	10/05/04	1
BETAAAAAAA, JULIE EL	153848	519-50-1222	CO	02/06/03	
				02/12/03	
				02/12/03	
				04/28/04	
				05/26/04	
				06/15/04	
				06/16/04	
				12/21/04	
				01/29/05	
				10/07/05	
				10/12/05	
				10/19/05	
				03/08/06	
				04/17/07	
				08/15/07	
				08/16/07	
				08/22/07	17

Figure 10-8: Example listing of visits by commissioned officers and dependents

10.8 List of Selected Third Party Coverage(s) (TPR)

The TPR option allows the user to print a list of patients registered at the facility selected, who have insurance coverage with the insurer selected.

Follow these steps:

1. At the “Which Facility” prompt, type the facility name.
2. At the “Select a type of insurance” prompt, type one of the following:
 - 1 - Medicare Part A
 - 2 - Medicare Part B
 - 3 – Medicaid
 - 4 - A Selected Private Insurance
 - 5 - Railroad Part A
 - 6 - Railroad Part B
3. At the “Do you want patients that only have this one insurer (no other coverage)?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Select Type of Eligibility Dates” prompt, type the date.
5. At the “Select Type of Eligibility Dates” prompt, type one of the following:
 - 1 - Currently Active Eligibility Dates

- 2 - Any Past or Current Eligibility Dates
 - 3 - Selected Eligibility Dates
6. At the “Do you want to print all beginning and Ending eligibility date pairs” prompt, type **Y** (Yes) or **N** (No).
 7. At the “sort the Report By” prompt, type **1** (Patient Name) or **2** (Patient HRNO).
 8. At the “Device” prompt, specify the device to print/browse the report.

01/28/07	DEMO HOSPITAL				Page 1
Patient List for Medicare Part A With any eligibility dates					
Patient Name	HRNO	MCR	SUF	Begin	End
-----	-----	-----	---	-----	-----
SIGMA, ADONNA	11111	13333333	A	11/01/90	
SIGMA, JAYDEN	11112	13333334	A	06/01/83	
SIGMA, DAVID	11113	13333335	A	07/01/93	
SIGMA, GEORGE	11114	13333336	A	05/01/82	07/31/05
SIGMA, MARTHA	11115	13333337	A	09/01/01	

Figure 10-9: Example of TPR report

11.0 Activity Reports by Discipline Group (ACT)

This set of reports provides Activity and Travel Times (in minutes) for the discipline group selected. Three discipline groups are already defined: PHN, Mental Health, and Social Services. Refer to the table below for disciplines and codes.

Group	Discipline	Code
PHN	CHN/Aides	13
	CHN (Contract)	32
Mental Health	Mental Health	19
	Psychiatrist	81
	Neurologist	85
	Contract Psychologist	50
	Psychologist	12
Social Services	Contract Psychiatrist	49
	Medical Social Worker	06
	Licensed Med Social Worker	62
	Contract Social Worker	63

New discipline groups can be defined, as appropriate, using the CAG option. However, the only method for tracking each specific discipline is to have each provider type an activity time and/or travel time on the PCC Encounter Form.

Each report can be filtered by location of encounter and clinic.

The menu includes the following reports:

```

*****
**                PCC Management Reports                **
**   Activity Reports by Discipline Group   **
*****
                IHS PCC Suite Version 2.0
                DEMO HOSPITAL/CLINIC
TSPR   Time and Patient Services by Provider
TSSU   Time and Patient Services by Service Unit
PPPR   Primary Problem by Provider
PPLO   Primary Problem by Facility
PPSU   Primary Problem by Service Unit
INPR   Number of Individuals seen by Provider
INSU   Number of Individuals seen by Service Unit
AGE    Patient Services by Age and Sex
TEN    Top Ten Primary Diagnoses
CAG    Create new Activity Discipline Group
INQA   Inquire into an Activity Group
TSCR   Time and Services by Provider for Chart Reviews
Select Activity Reports by Discipline Group Option:

```

Figure 11-1: Example activity reports by discipline group menu

11.1 Time and Patient Services by Provider (TSPR)

Use the TSPR option to produce a report that displays the number of patient contacts, total activity time, and total travel time for each provider by location of encounter within a specified provider discipline group. Type a beginning and ending visit date range and the discipline group.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, type the discipline group. The system displays information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Include visits from which set of locations” prompt, type one of the following:
 - O - One Location
 - T - Taxonomy of or Selected set of Locations
 - A - All Locations
5. At the “Include visits from which set of clinics” prompt, type one of the following:
 - O - One Clinic
 - T - Taxonomy or Selected Set of Clinics
 - A - All Clinics
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
7. At the “Device” prompt, specify the device to print/browse the report.

OCT 15, 1994	Page 1					
PATIENT CONTACT REPORT FOR MENTAL HEALTH STAFF						
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994						
All Locations						
All Clinics						
PROVIDER: VPROVIDER, THOMAS L						
TOTAL	CONTS	CONTS	PATIENT	AS PRIM.	AS SEC.	ACTIVITY

TRAVEL TIME *	LOCATION OF ENCOUNTER TIME	CONTACTS	PROVIDER	PROVIDER
DEMO OTHER	2	1	1	54 50
DEMO ADMINISTRATION	4	4	0	123 30
DEMO HOSPITAL/CLINIC	4	3	1	90 39
TOTAL:	10	8	2	267 119

* -- 1 of the visits did not have an activity time recorded.

NOTE: This report separates visits and time into individual staff member contacts. If Provider A and Provider B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each provider and 20 minutes activity time for each provider.

RUN TIME (H.M.S): 0.0.3
End of Report - Hit return

Figure 11-2: Example time and patient services report by provider

11.2 Time and Patient Services by Service Unit (TSSU)

Use the TSSU option to produce a report that displays total patient contacts, total activity time, and total travel time for a selected discipline group by SU.

The prompts are the same as the TSPR option.

TOTAL ACTIVITY PROVIDER	CONTS TRAVEL TIME *	CONTS LOCATION OF ENCOUNTER TIME	PATIENT AS PRIM. CONTACTS	AS SEC. PROVIDER
DEMO OTHER	2	2	0	54 50
DEMO HOSPITAL/CLINIC	6	5	1	110 59
TOTAL:	8	7	1	164 119

* -- 2 of the visits did not have an activity time recorded.

NOTE: This report counts one visit regardless of the number of PHN staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.

Figure 11-3: Example time and patient services report by service unit report

11.3 Primary Problem by Provider (PPPR)

Use the PPPR option to produce a time and services report that totals primary problems for each provider in a specified discipline group, totals for patient contacts, activity times, and travel times for each diagnosis display.

Type a beginning and ending visit date range and a discipline group. Check the report heading.

OCT 15, 1994							Page 1
PRIMARY PROBLEM REPORT BY PROVIDER PHN STAFF							
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994							
PROVIDER: COMMUNITY HEALTH NURSE, IHS							
TOTAL	CONTS	CONTS					
PATIENT	AS PRIM.	AS SEC.	ACTIVITY	TRAVEL			
PRIMARY PROBLEM	CONTACTS	PROVIDER	PROVIDER	TIME*	TIME		

DIABETES	2	1	1	54	50		
OTHER DIS OF THE NERVOUS		4	4	0	123	30	
PRENATAL, FIRST TRIMESTER			4	3	1	90	39
TOTAL:	10	8	2	267	119		
* -- 1 of the visits did not have an activity time recorded.							
NOTE: This report separates visits and time into individual staff member contacts. If Provider A and Provider B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each provider and 20 minutes activity time for each provider.							
RUN TIME (H.M.S): 0.0.3							
End of Report - Hit return							

Figure 11-4: Example primary problem report by provider report

11.4 Primary Problem by Facility (PPLO)

The PPLO report totals primary problems for a specific discipline group and Location of Encounter. The report displays totals for activity times, travel times, and patient contacts for each problem.

Type a beginning and ending visit date range and a discipline group.

The prompts are the same as the TSPR option.

JAN 28, 2009							Page 1
PRIMARY DX REPORT BY LOCATION OF ENCOUNTER FOR GENERAL STAFF							
VISIT DATES: AUG 01, 2008 TO JAN 28, 2009							

All Locations All Clinics LOCATION OF ENCOUNTER: DEMO HOSPITAL						
PRIMARY DX	TOTAL PATIENT CONTACTS	VISITS AS PRIM. PROVIDER	VISITS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME	
MUMPS UNCOMPLICATED	1	1	0	0.00	0.00	
TOTAL:	1	1	0	0.00	0.00	

* -- 1 of the visits did not have an activity time recorded.

NOTE: This report counts one visit regardless of the number of GENERAL staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.

RUN TIME (H.M.S): 0.0.1
End of report. HIT RETURN:

Figure 11-5: Example primary problem report by facility report

11.5 Primary Problem by Service Unit (PPSU)

The PPSU report displays primary problems for a specific SU. Totals are shown for patient contacts, activity times, and travel times for each provider within the discipline group selected.

Type a beginning and ending visit date range, SU, and discipline group.

The prompts are the same as the TSPR option.

JAN 28, 2009							Page 1
PRIMARY DX REPORT BY SERVICE UNIT FOR PHN STAFF							
VISIT DATES: JAN 01, 2003 TO JAN 28, 2009							
All Locations All Clinics							
SERVICE UNIT: NON SVC UNIT							
PRIMARY DX	TOTAL PATIENT CONTACTS	VISITS AS PRIM. PROVIDER	VISITS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME		
DIABETES	58	54	4	11.70	6.58		
GENERAL/MULTIPLE	158	158	0	78.27	8.68		

TOTAL:	216	212	4	89.97	15.27
* -- 4 of the visits did not have an activity time recorded.					
NOTE: This report counts one visit regardless of the number of GENERAL staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.					
Enter RETURN to continue or '^' to exit:					

Figure 11-6: Example primary problem report by service unit report

11.6 Number of Individuals Seen by Provider (INPR)

The INPR report displays the number of individuals seen by each provider within a discipline by location of encounter for the discipline group selected.

The system prompts for beginning and ending visit dates and discipline group.

The prompts are the same as the TSPR option.

OCT 15, 1994	Page 1
NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF	
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994 COMMUNITY HEALTH PROVIDER:	
PROVIDER: COMMUNITY HEALTH PROVIDER, IHS	
TOTAL NUMBER OF INDIVIDUALS SEEN	

DEMO OTHER	101
DEMO ADMINISTRATION	99
DEMO HOSPITAL/CLINIC	250
TOTAL:	450

Figure 11-7: Example number of individuals seen by provider report

11.7 Number of Individuals Seen by Service Unit (INSU)

Use the INSU option to produce the number of individuals seen by SU for staff members in the specified discipline group. The report displays, by location of encounter, the number of individuals seen by providers within a discipline group selected for a specified SU.

The system prompts for beginning and ending visit dates and the discipline group.

The prompts are the same as the TSPR option.

OCT 15, 1994		Page 1
NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF		
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994		
All Locations		
All Clinics		
SERVICE UNIT: DEMO		
		TOTAL NUMBER OF
		INDIVIDUALS SEEN

DEMO CLINIC		99
DEMO OTHER		101
DEMO HOSPITAL/CLINIC		250
	TOTAL:	450

Figure 11-8: Example number of individuals seen by service unit report

11.8 Patient Services by Age and Sex (AGE)

Use the AGE option to produce a report that lists all visits on which staff members of a discipline group selected was a provider, and time and patient services by age and sex.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, specify the discipline group. The system displays information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Include visits from which set of locations” prompt, type one of the following:
 - O - One Location
 - T - Taxonomy of or Selected set of Locations
 - A - All Locations
5. At the “Include visits from which set of clinics” prompt, type one of the following:
 - O - One Clinic
 - T - Taxonomy or Selected Set of Clinics
 - A - All Clinics

6. The age groups to be used are currently defined as:
 - 0-0
 - 1-4
 - 5-14
 - 15-19
 - 20-24
 - 25-44
 - 45-64
 - 65-125
7. At the “Do you wish to modify these age groups?” prompt, type **Y** (Yes) or **N** (No) (consider the age groups shown above). If the user types **Y** (Yes), other prompts display.
8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
9. At the “Device” prompt, specify the device to print/browse the report.

OCT 15,1994						Page 1
TIME AND PATIENT SERVICES REPORT BY AGE AND SEX FOR PHN STAFF						
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994						
All Locations						
All Clinics						
SEX: FEMALE						
		TOTAL	CONTS	CONTS		
TRAVEL	AGE GROUP	PATIENT	AS PRIM.	AS SEC.	ACTIVITY	
TIME*	TIME	CONTACTS	CONTACTS	PROVIDER	PROVIDER	
0-0 years		15	15	.	100	.
1-4 years		30	25	5	50	.
5-14 years		10	5	5	100	.
15-19 years		30	20	5	240	30
20-24 years	
25-44 years	
45-64 years		50	30	20	500	100
>64 years	
TOTAL:		135	95	35	990	130

* -- 1 of the visits did not have an activity time recorded.
 NOTE: This report counts one visit regardless of the number of PHN staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.

Figure 11-9: Example time and patient services report by age and sex report

11.9 Top Ten Primary Diagnoses (TEN)

The TEN report displays the top ten primary POVs by providers within the discipline group selected. The report generates for a specified SU.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, type the discipline group. The system displays information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Which Service Unit” prompt, type the SU name.
5. At the “Include visits from which set of clinics” prompt, type one of the following:
 - O - One Clinic
 - T - Taxonomy or Selected Set of Clinics
 - A - All Clinics
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
7. At the “Device” prompt, specify the device to print/browse the report.

APR 10, 1996 Page 1
 TOP TEN PRIMARY DX REPORT BY SERVICE UNIT PHN STAFF
 VISIT DATES: JAN 01, 1995 TO JAN 31, 1995
 All Clinics
 SERVICE UNIT: DEMO

PRIMARY DX	TOTAL PATIENT CONTACTS
------------	------------------------

```

WELL CHILD CARE                19
DIABETES                        14
HYPERTENSION                    8
GENERAL/MULTIPLE                6
PRENATAL, FIRST TRIMESTER      4
OTHER SUBSTANCE ABUSE          3
TUBERCULOSIS, REACTOR/CONV     2
SCABIES                          1

RUN TIME (H.M.S): 0.2.16
End of report. HIT RETURN:

```

Figure 11-10: Example top 10 diagnoses report by SU report

11.10 Create new Activity Discipline Group (CAG)

The CAG option provides a means to define and create a new discipline group. Once the new group is created and providers within that discipline record their activity and travel times on the PCC Encounter Form, activity reports can be generated for the new discipline group.

```

Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP: NURSES
  ARE YOU ADDING 'NURSES' AS A NEW PCC MAN REPORTS ACTIVITY
  GROUP (THE 4TH)? Y (YES)
NAME OF GROUP: NURSES//
Select DISCIPLINES IN GROUP: 05 LICENSED PRACTICAL NURSE
  ARE YOU ADDING 'LICENSED PRACTICAL NURSE' AS
  A NEW DISCIPLINES IN GROUP (THE 1ST FOR THIS PCC MAN REPORTS
  ACTIVITY
  GROUP)? Y (YES)
Select DISCIPLINES IN GROUP: 01 REGISTERED NURSE
  ARE YOU ADDING 'REGISTERED NURSE' AS A NEW DISCIPLINES IN GROUP
  (THE 2ND FOR THIS PCC MAN REPORTS ACTIVITY
  GROUP)? Y (YES)

```

Figure 11-11: Creating a new activity discipline group

11.11 Inquire into an Activity Group (INQA)

Use the INQA option to view information about an established activity group.

```

NAME OF GROUP: PHN                ICD RECODE ROUTINE: APCLRCHA
  RECODE GLOBAL: AUTTCHA          PIECE FOR DESC. IN RECODE
FILE: 3
  STANDARD: YES
DISCIPLINES IN GROUP: CHN/AIDES    DISCIPLINE CODE: 13
DISCIPLINES IN GROUP: CHN (CONTRACT) DISCIPLINE CODE: 32
Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP:

```

Figure 11-12: Inquiring into an activity group

11.12 Time and Services by Provider for Chart Reviews (TSCR)

The TSCR report displays by location of encounter, the number of patient chart reviews and the total activity and travel time for each provider with a discipline in the provider discipline group selected.

The prompts are the same as the TSPR option.

JAN 28, 2009							Page 1
CHART REVIEW REPORT FOR PHN STAFF							
VISIT DATES: JAN 01, 2006 TO JAN 28, 2009							
All Locations							
All Clinics							
PROVIDER: IOPROVIDER,DEBRA M							
LOCATION OF ENCOUNTER	TOTAL CHART	CR'S AS PRIM.	CR'S AS SEC. REVIEWS	ACTIVITY PROVIDER	TRAVEL PROVIDER	TIME*	TIME
HOME	1	1	0	0.25	0.08		
CIHA DIABETES CLINIC	6	6	6	0	0.42	0.00	
TOTAL:		7	7	0	0.67	0.08	

* -- 1 of the visits did not have an activity time recorded.
 NOTE: This report separates visits and time into individual staff member contacts. If Staff Member A and Staff Member B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each staff member.

Figure 11-13: Example TSCR report

12.0 Dx and Procedure Count Summary Report (CNTX)

Use the CNTX option to access the options for the Count Summary menu.

```

*****
**      PCC Management Reports      **
**      Count Summary Menu         **
*****
IHS PCC Suite Version 2.0

DEMO HOSPITAL

CPTP  CPT Code by Provider Report
DXAG  Diagnoses by AGE report
DXFA  DX Tally by Local, Secondary, Tertiary Facility
FCPT  Frequency of CPTs Report
FPRC  Frequency of Procedures Report
PAPC  Purpose of Visits grouped by APC codes
RXDA  RX Data Analysis Report
TEN   Frequency of Diagnoses Report
TOP   Tally of Operating Provider for Procedures

Select Dx & Procedure Count Summary Reports Option:

```

Figure 12-1: Options on the Count Summary Menu

12.1 CPT Code by Provider Report (CPTP)

Use the CPTP option to produce a report that shows the CPT codes entered by a specified provider. The date range; whether to include outpatient (ambulatory, day surgery, observation), inpatient visits or both; tally CPT codes by primary provider only or primary and secondary provider; and whether to include only visits to one facility, a service unit or to patients who are members of a particular tribe can be specified.

Note: If both primary and secondary providers have been chosen, the following logic will be applied: If the CPE mnemonic is used, or the CPT code is entered through EHR, the CPT code links to the encounter provider documented. If there is no encounter provider documented, the CPT code is tallied under each provider on that visit; thus the counts will include the same CPT code multiple times.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.

2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Report should include” prompt, type **P** (Primary Provider Only) or **A** (All Providers).
4. At the “Report should include” prompt, use one of the following:
 - O - Outpatient Visits (ambulatory, day surgery, observation)
 - I – Inpatient
 - B - Both
5. At the “Enter a code indicating which visits are of interest” prompt, type one of the following:
 - S - One Service Unit
 - L - One Location/Facility
 - T - One Tribe
 - A - All visits

If **S**, **L**, or **T** are entered, additional prompts display.
6. At the “Select an Output Option” prompt, type one of the following:
 - P - Print Report on Printer or Screen
 - D - Create Delimited output file (for use in Excel)
 - B - Both a Printed Report and Delimited File
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
8. At the “Device” prompt, specify the device to print/browse the report.

SJT	Jan 28, 2009	Page 1
*** CPT Code by Provider Report ***		
Visit Dates: Jan 01, 2006 to Jan 28, 2009		
Provider Name	Discipline	
AAPROVIDER,GORDON	NURSE ASSISTANT	
Ambulatory/Outpatient Services:		
CPT Code	CPT Narrative	Subtotalled by CPT

10060	DRAINAGE OF SKIN ABSCESS	2
11100	BIOPSY, SKIN LESION	1
11200	REMOVAL OF SKIN TAGS	1
11730	REMOVAL OF NAIL PLATE	3
11732	REMOVE NAIL PLATE, ADD-ON	1
17000	DESTRUCT PREMALG LESION	3
17003	DESTRUCT PREMALG LES, 2-14	1
17110	DESTRUCT B9 LESION, 1-14	1
20552	INJ TRIGGER POINT, 1/2 MUSCL	3
20605	DRAIN/INJECT, JOINT/BURSA	1
29130	APPLICATION OF FINGER SPLINT	1
36000	PLACE NEEDLE IN VEIN	4
51701	INSERT BLADDER CATHETER	1
59025	FETAL NON-STRESS TEST	1
59430	CARE AFTER DELIVERY	1
69210	REMOVE IMPACTED EAR WAX	7
70160	X-RAY EXAM OF NASAL BONES	1
70450	CT HEAD/BRAIN W/O DYE	1
70486	CT MAXILLOFACIAL W/O DYE	1

Figure 12-2: Example CTPT report

12.2 Diagnoses by AGE Report (DXAG)

Use the DXAG option to produce the Frequency of Diagnoses By Age report that lists diagnoses by age group.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning date of the date range.
2. At the “Enter ending Visit Date” prompt, type the ending date of the date range.
3. The application displays the following information:

```
When I search the database, I can "screen" POVs according to any one
of the following attributes:
      PATIENT SEX
      FACILITY OF ENCOUNTER
      PRIMARY PROVIDER
      CLINIC TYPE
      SERVICE CATEGORY (Hospitalizations, Ambulatory, Chart
Reviews Nursing Home, etc.)

VISIT TYPE (IHS, Contract, Tribal, 638, Other, VA)
```

4. At the “Want to use one or more of these ‘screens’?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.

The application displays the following information:

The Age Groups to be used are currently defined as:

```

0 - 0
1 - 4
5 - 14
15 - 19
20 - 24
25 - 44
45 - 64
65 - 125

```

5. At the “Do you wish to modify these age groups?” prompt, type **Y** (Yes) or **N** (No) (considering the currently defined age groups). If **Y** (Yes) is entered, other prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
7. At the “Device” prompt, specify the device to print/browse the report.

This report should be printed on 132-column paper or on a printer that is set for condensed print. If the user does not have such a printer available, see the site manager.

SJT		DEMO HOSPITAL		Diagnoses by Age Report					Page 1
Visit Dates:		OCT 30, 2008 to JAN 28, 2009		Type of Visit:					
ALL		Service Category: ALL							
		Location of Encounter: ALL		Clinic: ALL					
		Sex of Patient: BOTH							
		Primary Provider: ALL		Purpose of Visits: Primary and					
		Seconday POV's							
				AGE GROUPS					
ICD Code	ICD Narrative	0-0	1-4	5-14	15-19	20-24	25-44		
45-64	65-125	TOTAL							

007.1	GIARDIASIS			.	.	.	.
			1						
				1					
					2				
Enter RETURN to continue or '^' to exit									

Figure 12-3: Example DXAG report

12.3 DX Tally by Local, Secondary, Tertiary Facility (DXFA)

Use the DSFA option to produce a report showing a tally of all diagnoses for patients in a community or communities. The report tallies the diagnoses for the community's local, secondary, and tertiary facilities. Each community's report has one page for outpatient diagnoses and one page for inpatient diagnoses.

Follow these steps:

1. At the "Please Identify your Service Unit" prompt, type the service unit name.
2. At the "Enter Beginning Visit Date" prompt, type the beginning of the date range.
3. At the "Enter Ending Visit Date" prompt, type the end of the date range.
4. At the "Enter a code indicating what COMMUNITIES of RESIDENCE are of interest" prompt, type one of the following:
 - O - One Particular Community
 - S - All communities within the XXX UNIT (where XXX is the unit's name)
 - T - A TAXONOMY or selected set of communities

If **S** or **T** are entered, additional prompts display.

The system checks the community table for the required items; if any are missing, the process stops. See the site manager about fixing the community entries. The user can select other communities or exit the report.

5. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
6. At the "Device" prompt, specify the device to print/browse the report.

12.4 Frequency of Procedures Report (FPRC)

Use the FPRC option to produce the Frequency of Procedures report, which shows the top number of procedures done at a specified facility.

Follow these steps:

1. At the "Please Identify your Service Unit" prompt, type the SU name.
2. At the "Enter Beginning Visit Date" prompt, type the beginning of the date range.

3. At the “How many entries do you want in the list (5-100)” prompt, type any integer between five and 100.
4. The system displays the VISIT Selection Menu

```

GENERAL RETRIEVAL                Jan 26, 2009 13:32:44      Page: 1 of 5
                                VISIT Selection Menu
Visits can be selected based upon any of the following items. Select
as many as you wish, in any order or combination. An (*) asterisk
indicates items already selected. To bypass screens and select all
visits hit Q.

1) Name/Chart /SSN                58) Outside Location            115) BMI (Last
   calculated)                    116) RX
2) Sex                            59) Clinic Type                 117) Dental
   Ordering Provider              60) Visit Created By           118) Radiology
3) Date of Birth                  61) User Last Update           119)
   ADA Codes                       62) VCN Present                120)
4) Birth Month                    63) 3rd Party Billed?          121)
   Exam                            64) Hospital Location          122) Exams
5) Birth Weight (grams)           65) Admitting Service           123)
   Immunization Provider          66) Admission Type             124) Lab Tests
6) Birth Weight (Kgs)             67) Admission Source-UB92      125)
   Immunization Lot               68) Admitting Provider (In
7) Race                           69) Discharge Service          126)
   Immunizations                  70) Date of Discharge          127)
8) Age                            71) Discharge Type             128)
9) Age in Months                  14) Mlg Address-Zip
   Treatments Provided            Medications+SIG
10) Veteran Status Y/N           +          Enter ?? for more actions
11) Date of Death                 S   Select Item(s)   +   Next Screen   Q   Quit Item Selection
   Microbiology Culture           R   Remove Item(s)   -   Previous Screen E   Exit Report
12) Date Patient Establish        Select Action: S//
13) Mlg Address-State
14) Mlg Address-Zip
Medications+SIG

```

Figure 12-4: VISIT Selection menu

To choose the criteria for listing visits on the report, type the number(s) of the criteria at the “Select Action” prompt and press Enter. An asterisk (*) indicates that an item has been selected. To select all visits, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

5. At the “Demo Patient Inclusion/Exclusion” prompt, use one of the following:

- I - Include ALL Patients
- E - Exclude DEMO Patients
- O - Include ONLY DEMO Patients

6. At the “Device” prompt, specify the device to print/browse the report.

```

***** FREQUENCY OF PROCEDURES REPORT *****
REPORT REQUESTED BY: THETA,SHIRLEY

The following report contains a PCC Visit report based on the
following criteria:

VISIT Selection Criteria

      Encounter Date range:  AUG 01, 2006 to JAN 28, 2009

ALL VISITS IN DATE RANGE SELECTED.

Total COUNT of Visits:  484

No. VISITs: 484      No. PRCs: 573      PRC/VISIT ratio: 1.18 (min. std.
> 1.6)

TOP 10 PRC's =>
  1.  89.54  ELECTROGRAPHIC MONITORING  (88)
  2.  94.62  ALCOHOL DETOXIFICATION  (61)
  3.  99.04  PACKED CELL TRANSFUSION  (38)
  4.  70.24  VAGINAL BIOPSY  (35)
  5.  45.23  FLEX FIBEROPTIC COLONOSC  (28)

  6.  39.95  HEMODIALYSIS  (21)
  7.  47.01  LAPAROSCOPIC APPENDECTOMY  (15)
  8.  88.01  C.A.T. SCAN OF ABDOMEN  (13)
  9.  67.32  CERVICAL LES CAUTERIZAT  (11)
 10.  94.65  DRUG DETOXIFICATION  (11)

RUN TIME (H.M.S): 0.0.3
End of report. HIT RETURN:

```

Figure 12-5: Example Frequency of Procedures report (FPRC)

12.5 Purpose of Visits Group by APC Codes (PAPC)

Use the PAPC option to produce the Purpose of Visits Count report, which shows only Ambulatory Visits within a specified date range.

Follow these steps:

1. At the “Please Identify your Service Unit” prompt, type the SU name.
2. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.

3. At the “Should the counts only include visits for patients from a specific community?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the “Device” prompt, specify the device to print/browse the report.

DEMO HOSPITAL		JAN 28, 2009 Page 1	
POV Counts for Ambulatory Visits from AUG 1, 2008 through JAN 28, 2009. ICD9 Subcounts are restricted to the leading 20 Purposes of Visit.			
APC	APC Category	Count	
303	INFLUENZA	13	
	ICD9 ICD9 Description		

	487.1 FLU W RESP MANIFEST NEC	13	
999	NO REPORTED DIAGNOSIS	11	
	ICD9 ICD9 Description		

	V62.84 SUICIDAL IDEATION	6	
	.9999 UNCODED DIAGNOSIS	5	

Figure 12-6: Example PAPC report

12.6 RX Data Analysis Report (RXDA)

Use the RXDA option to produce the RX Data Analysis Report, which tallies all RXs for a specified date range and breaks them down by Time Released and Count by Hour increments. This option allows the report to be printed for *all* divisions or for *one* specified division.

Follow these steps:

1. At the “Enter Beginning RX Release Date” prompt, type the beginning of the date range.
2. At the “Enter Ending RX Release Date” prompt, type the end of the date range.

3. At the "Include RX's from ALL DIVISIONS?" prompt, type **Y** (Yes) or **N** (No). If the user types **N** (No), other prompts display.
4. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
5. At the "Device" prompt, specify the device to print/browse the report.

DEMO HOSPITAL		Jan 28, 2009		Page 1
RX ANALYSIS REPORT				
RX RELEASE TIME WORKLOAD DISTRIBUTION				

DIVISION: ALL DIVISIONS				
RX RELEASE DATE RANGE: Jan 01, 2006 - Jan 28, 2009				
Total Prescriptions Dispensed: 214769				
	RX COUNT	ACT % TOTAL	ADJ % TOTAL	
	-----	-----	-----	
AM Prescriptions Dispensed				

Total RX's Before 8:00:	11927	6	NA	
Total RX's 8:00- 8:59:	14114	7	NA	
Total RX's 9:00- 9:59:	22986	11	12	
Total RX's 10:00-10:59:	27362	13	14	
Total RX's 11:00-11:59:	23669	11	13	
PM Prescriptions Dispensed				

Total RX's 12:00-12:59:	17134	8	9	
Total RX's 1:00- 1:59:	17410	8	9	
Total RX's 2:00- 2:59:	27045	13	14	
Total RX's 3:00- 3:59:	25789	12	14	
Total RX's 4:00- 4:59:	17242	8	9	
Total RX's 5:00- 5:59:	9083	4	5	
Total RX's 6:00- 6:59:	841	0	0	
Total RX's 7:00- 7:59:	53	0	0	
Total RX's 8:00- 8:59:	40	0	0	
Total RX's 9:00- 9:59:	35	0	0	
Total RX's 10:00-10:59:	33	0	0	
Total RX's 11:00-11:59:	6	0	0	
	-----	-----	-----	
	214769	100%	100%	
SUMMARY				
ACT Total-All Hours:	214769	ADJ Total After 9:00 AM:	188728	
ACT Percent After 2:00 PM:	37%	ADJ Percent After 2:00 PM:	42%	
ACT Percent After 3:00 PM:	25%	ADJ Percent After 3:00 PM:	28%	
ACT Percent After 4:00 PM:	13%	ADJ Percentage After 4:00 PM:	14%	

```

*****
NOTE: ACT Total includes all hours - ADJ Total excludes all Non-
Pharmacy and evening dispensed RX's that are typically encoded
between 8:00-9:00 AM.

RUN TIME (H.M.S): 0.1.45
End of report. HIT RETURN:

```

Figure 12-7: Example RX Data Analysis report (RXDA)

12.7 Frequency of Diagnoses Report (TEN)

Use the TEN option to produce the Frequency of Diagnoses report, which shows the most frequent diagnosis for that date range.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, type the end of the date range.
3. At the “Include which patients in the tally of diagnoses” prompt, type **A** (All Patients) or **S** (Search Template of Patients). If **S** is entered, other prompts display.
4. At the “How many entries do you want in the list (5-100)” prompt, type any integer between five and 100.
5. The system displays the VISIT Selection Menu.

```

GENERAL RETRIEVAL          Jan 26, 2009 13:32:44          Page: 1 of 5
                        VISIT Selection Menu
Visits can be selected based upon any of the following items.
Select as many as you wish, in any order or combination. An (*)
asterisk indicates items already selected. To bypass screens and
select all visits hit Q.

1) Name/Chart /SSN          58) Outside Location          115) BMI (Last
   calculated)
2) Sex                      59) Clinic Type              116) RX
   Ordering Provider
3) Date of Birth            60) Visit Created By        117) Dental
   ADA Codes
4) Birth Month              61) User Last Update        118) Radiology
   Exam
5) Birth Weight (grams)    62) VCN Present             119)
   Immunization Provider
6) Birth Weight (Kgs)      63) 3rd Party Billed?      120)
   Immunization Lot
7) Race                    64) Hospital Location       121)
   Immunizations

```

```

8) Age                               65) Admitting Service           122) Exams
9) Age in Months                     66) Admission Type              123)
Treatments Provided
10) Veteran Status Y/N               67) Admission Source-UB92       124) Lab Tests
11) Date of Death                    68) Admitting Provider (In      125)
Microbiology Culture
12) Date Patient Establish            69) Discharge Service           126)
Microbiology Organism
13) Mlg Address-State                70) Date of Discharge           127)
Medications
14) Mlg Address-Zip                  71) Discharge Type              128)
Medications+SIG

+          Enter ?? for more actions
S   Select Item(s)  +   Next Screen      Q   Quit Item Selection
R   Remove Item(s)  -   Previous Screen  E   Exit Report
Select Action: S//

```

Figure 12-8: VISIT Selection Menu

To choose criteria for the report, type the number(s) of the criteria at the “Select Action” prompt and press Enter. An asterisk (*) indicates that an item has been selected. To select all visits, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.

6. At the “Report should include” prompt, type **P** (Primary POV) or **A** (All POVs).
7. The system displays the following information:

```

You have the opportunity to exclude certain diagnoses from this
report. For example, to eliminate Pharmacy refill diagnoses, you
need to exclude V68.1 from this report. If you chose to include only
the primary pov then visits with a primary pov of V68.1 will be
excluded.

```

8. At the “Do you wish to exclude any diagnoses codes from the report?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) is entered, other prompts display.
9. At the “Select TYPE OF OUTPUT” prompt, type **L** (List of items with counts) or **B** (Bar chart, 132 columns).
10. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
11. At the “Device” prompt, specify the device to print/browse the report.

```

***** FREQUENCY OF DIAGNOSES REPORT *****
Report run at: DEMO HOSPITAL

REPORT REQUESTED BY: THETA,SHIRLEY

The following report contains a PCC Visit report based on the
following criteria:

VISIT Selection Criteria

Encounter Date range: AUG 01, 2008 to JAN 28, 2009

ALL VISITS IN DATE RANGE SELECTED.

ALL (Primary and Secondary) POV's included.

Total COUNT of Visits: 100
No. VISITs: 100 No. POVs: 108 POV/VISIT ratio: 1.08 (min. std.
> 1.6)

TOP 10 POV's =>

```

			Visits	Patients
1.	072.9	MUMPS UNCOMPLICATED	23	23
2.	487.1	FLU W RESP MANIFEST NEC	13	5
3.	V62.84	SUICIDAL IDEATION	6	6
4.	.9999	UNCODED DIAGNOSIS	5	5
5.	079.81	HANTAVIRUS INFECTION	4	3
6.	401.9	HYPERTENSION NOS	3	3
7.	007.1	GIARDIASIS	3	2
8.	055.9	MEASLES UNCOMPLICATED	3	3
9.	114.0	PRIMARY COCCIDIOIDOMYCOSIS	3	2
10.	493.90	ASTHMA UNSPECIFIED WITHOUT MEN	3	3

```

TOP 10 DIAGNOSTIC CATEGORIES =>

1. INFECTIOUS & PARASITIC (43)
2. EAR, NOSE, MOUTH & THROAT (16)
3. NERVOUS SYSTEM (7)
4. RESPIRATORY SYSTEM (6)
5. MENTAL DISEASES & DISORDERS (6)
6. CIRCULATORY SYSTEM (5)
7. DIGESTIVE SYSTEM (5)
8. HEALTH STATUS FACTORS (5)
9. MUSCULOSKELETAL & CONNECTIVE T (4)
10. HEPATOBILIARY & PANCREAS (3)

RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:

```

Figure 12-9: Example Frequency of Diagnosis report (TEN)

12.8 Tally of Operating Provider for Procedures (TOP)

Use the TOP option to produce the Listing/Tally of Visits with Selected Procedure Codes report, which tallies the operating provider for selected procedures done. A list of all visits with the selected procedures can be obtained.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, type the end of the date range.
3. At the “Include ALL Visit Service Categories?” prompt, type **Y** (Yes) or **N** (No). If the user types **N** (No), other prompts display.
4. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type **A** (All Locations/Facilities) or **O** (One Location/Facility). If **O** is entered, other prompts display.
5. At the “Enter a code indicating what ICD Procedure codes are of interest” prompt, type **A** (for all procedures) or **S** (selected set of ICD Procedure codes). If **S** is entered, other prompts display.
6. At the “Do you want a List of all the procedures in addition to the tally?” prompt, type **Y** (Yes) or **N** (No).
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
8. At the “Device” prompt, specify the device to print/browse the report.

XXX	Jan 28, 2009	Page 1
*** PROCEDURE TALLY/LISTING ***		
Visit Dates: Jan 29, 2008 to Jan 28, 2009		
Service Categories: ALL		
Procedures included in this report: ALL ICD PROCEDURES		

Total of Procedures:		28
Tally BY Operating Providers:		
Operating Provider		of Procedures
BETAAAA, LORI		
29.39	EXC/DESTR LES/TIS PHARY	1
45.24	FLEXIBLE SIGMOIDOSCOPY	1

Total Procedures for BUTCHER, LORI	2
FAPROVIDER, USER	
47.2 DRAIN APPENDICEAL ABSC	1
Total Procedures for FAPROVIDER, USER	1
GAMMA, U	
18.29 DESTRUCT EXT EAR LES NEC	1
28.11 TONSIL ADENOID BIOPSY	1
45.23 FLEX FIBEROPTIC COLONOSC	2
45.24 FLEXIBLE SIGMOIDOSCOPY	2
47.01 LAPAROSCOPIC APPENDECTOMY	4
51.23 LAPAROSCOPIC CHOLECYSTECT	1
86.27 DEBRIDE NAIL/BED/FOLD	1
Total Procedures for GAMMA, U	12

Figure 12-10: Example TOP report

13.0 Immunization Reports (IMM)

The following immunization reports are available from the Immunization Report menu. These reports address the immunization needs of the adults and children at the user's facility.

```

*****
**      PCC Management Reports      **
**      Immunization Report Menu    **
*****
IHS PCC Suite Version 2.0

DEMO HOSPITAL/CLINIC

AIN   Adult Immunization Needs
KNIR  Kids Not on Immunization Register

```

Figure 13-1: Example Immunization report main menu

13.1 Adult Immunization Needs (AIN)

The Adult Immunization Needs (AIN) report displays the most recent Td, pneumococcal, and influenza vaccinations for adults considered at high risk. Prior to running this report, Q-Man must be used to create a cohort (template) of patients to search. Developing a cohort of high-risk adults typically consists of selecting living patients over age 65 or who have one or more specific chronic diseases.

The following example report was generated using a search template of patients over 65 years old.

DEMO HOSPITAL		Apr 14, 2008		Page 1	
*****		ADULT IMMUNIZATION NEEDS		*****	
DEMO H	LAST PATIENT NAME	NUMBER	COMMUNITY	AGE	LAST Td
LAST FLU	PNEUMOVAX				
ALPHAA, JANE	111111	SPRINGFIELD	67	04/09/2005	
10/25/2006	10/22/1990				
OMICRONN, JENNIFER	111112	SPRINGFIELD	59	02/20/2007	
11/17/2005	01/13/2004				
MUUUU, SUSAN	111113	SPRINGFIELD	70	11/03/2004	
11/05/2004	04/19/1990				
THETA, RENEE	111114	SPRINGFIELD	66	05/20/2006	
11/30/1994	04/30/2007				
BETAAA, SHARON	111115	SPRINGFIELD	65	03/09/2006	
10/06/2003	08/07/2006				
GAMMAAAA, ELIZABETH	111116	SPRINGFIELD	61	09/28/1996	
BETA, SUZANNE	111117	SPRINGFIELD	64	01/15/2006	

```

12/01/2006 01/17/2006

IOTA, LAUREN          111118  SPRINGFIELD    67  03/28/1995
10/06/2003 06/01/1994
GAMMA, SHANNON       111119  SPRINGFIELD    63  02/17/1997
MUUUUUU, MARY        111121  SPRINGFIELD    70  09/13/2001
10/22/1998 07/30/1996
RHOO, GRETA          111122  SPRINGFIELD    67  07/30/2000
02/21/2007
PIIIIIII, CINDY      111123  SPRINGFIELD    80  11/00/1993
11/07/2000
IOTAAAAA, BEATRICE   111124  SPRINGFIELD    83
11/14/2006 11/15/1994
ALPHA, FRANCES       111125  SPRINGFIELD    74
10/27/2004 01/08/2001

Enter RETURN to continue or '^' to exit:

```

Figure 13-2: Example adult immunization needs report

13.2 Kids Not on Immunization Register (KNIR)

The Kids Not on Immunization Register (KNIR) report lists all children in a specified age range who are not in the immunization register. Type an age range and select a particular community, a group of communities, or all communities.

Follow these steps:

1. At the “Enter an AGE range” prompt, type the age range or press Enter to include all ages.
2. At the “List children who live in” prompt, type one of the following:
 - O - One particular Community
 - A - All Communities
 - S - Selected Set of Communities (Taxonomy)

If the user types **O** or **S**, additional prompts display.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - I - Include ALL Patients
 - E - Exclude DEMO Patients
 - O - Include ONLY DEMO Patients
4. At the “Device” prompt, specify the device to print/browse the report.

The following sample report shows children ages 5-to-8 in the Achi and Ajo communities, who are not in the immunization register.

```
WARNING: CONFIDENTIAL PATIENT INFORMATION, PRIVACY ACT APPLIES

      DEMO HOSPITAL                               Apr 14, 2008  Page 1
***** CHILDREN NOT ON IMMUNIZATION REGISTER *****

Community: ACHI
-----
SIGMA,JOHN      (111111)   Nov 12, 1988   19 Years      MALE

                No prior immunizations listed

SIGMA,JANE      (111112)   Nov 01, 1992   15 Years      FEMALE

                No prior immunizations listed

SIGMA,JAMES     (111113)   Oct 15, 1993   14 Years      MALE

                Jan 26, 1994  HEP B PED
                Mar 29, 1994  DTaP, IPV
                Sep 11, 1995  DTaP, MMR

Enter RETURN to continue or '^' to exit:
```

Figure 13-3: Example report listing children not in immunization register

14.0 Q-Man (PCC Query Utility) (QMAN)

Q-Man (the PCC Query System) is a utility for “mining” the PCC database. It facilitates retrieval of demographic and clinical information.

```

***** WELCOME TO Q-MAN: THE PCC QUERY UTILITY *****

*****
**          WARNING...Q-Man produces confidential patient information.
**
**  View only in private.  Keep all printed reports in a secure
area.  **
**    Ask your site manager for the current Q-Man Users Guide.
**
*****
*****

Query utility: IHS PCC SUITE Q-MAN Ver. 2.0
Current user: SIGMA THETA
Chart numbers will be displayed for: DEMO HOSPITAL
Access to demographic data: PERMITTED
Access to clinical data: PERMITTED
Programmer privileges: YES

Enter RETURN to continue or '^' to exit:

```

Figure 14-1: Opening information for QMAN option

- To exit Q-Man, type a caret (^).
- The following options display when pressing Enter at the “Enter RETURN to continue or ‘^’ to exit” prompt:

```

***** Q-MAN OPTIONS *****

Select one of the following:

1  SEARCH PCC Database (dialogue interface)
2  FAST Facts (natural language interface)
3  RUN Search Logic
4  VIEW/DELETE Taxonomies and Search Templates
5  FILEMAN Print
9  HELP
0  EXIT

Your choice: SEARCH//

```

Figure 14-2: Example Q-Man options menu

No special knowledge of MUMPS, FileMan, or the PCC file structure is required to use Q-Man. Generate a query by initiating a dialogue with the computer. Each query has a subject, attribute, condition, and value.

For example, consider the following query:

```
"Find all patients over 60 years of age."  
  SUBJECT = Patients  
  ATTRIBUTE = Age  
  CONDITION = Over  
  VALUE = 60
```

Figure 14-3: Sample Q-Man query

To define a search the word “and” can be used for multiple queries.

The output of the search is either a standard columnar display on the screen, a printed report, or a FileMan search template (i.e., a cohort of patients).

In addition to the dialogue interface described above, there is also a natural language interface to Q-Man. Type a one attribute query in English. Frequently, Q-Man will correctly interpret the query and print the results on the screen. If Q-Man does not understand the question, it will beep and prompt the user to try again. Sample queries for the Rapid Report option are:

```
"SHOW ME MARY MARTIN'S LAST BLOOD SUGAR"  
"FIND ALL PATIENTS WHO LIVE IN TUCSON"  
"SHOW ME EVERYONE WHOSE TRIBE OF MEMBERSHIP IS NAVAJO"  
"I WANT LISA JONES' AVERAGE WEIGHT"  
"NOW GET HER SSN"
```

Figure 14-4: Sample queries for the rapid report

Notice that the word “and” does not appear in any of the queries, and that all queries in Figure 14-4 have one attribute only. If this method of querying does not provide the intended results, use the dialogue interface.

A separate *Q-Man User Manual* describing the use of the Query System in depth is available.

15.0 Delimited Output Reports (DELR)

The **Delimited Output Reports** menu contains the following option:



EDU Create Delimited File of Visits w/Education Done

Figure 15-1: Example FileMan menu options

This EDU option creates a delimited output file of all visits in which patient education was done. The report includes primary care provider. This report is used by uploading the data file into Microsoft Excel or other software application.

16.0 Health Summary Displaying CMS Register(s) (CHS)

The CHS option displays the register the patient belongs to and allows the patient's Health Summary to be printed.

1. At the "Select patient" prompt, type the name of the patient. The system displays information about the particular patient.
2. At the "Select health summary type" prompt, specify the type of Health Summary to display.
3. At the "Device" prompt, specify the device to print/browse the report.

For example,

```

CONFIDENTIAL PATIENT INFORMATION -- 1/29/2009 10:07 AM [SJT]
** DEMO,JOHNNIE RUTH 118774 <A> (ADULT REGULAR SUMMARY) pg 1 **

----- DEMOGRAPHIC DATA -----

DEMO,JOHNNIE RUTH      DOB: MAR 1,1981  27 YRS  FEMALE  no blood type
DEMO TRIBE, NM                SSN: XXX-XX-4021
                                MOTHER'S MAIDEN NAME: CROWE,VIRGINIA J
(H) 555-555-3791              FATHER'S NAME: DEMO,MICHAEL
BIRDTOWN (P.O. BOX 1340,VASSALBORO,NC,28719)

LAST UPDATED: MAY 24,2007          ELIGIBILITY: CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?  YES
DATE RECEIVED BY PATIENT: Apr 14, 2003
WAS ACKNOWLEDGEMENT SIGNED?  YES
WOMEN'S HEALTH CASE MANAGER:  SPROVIDER,JEROME
DESIGNATED PRIMARY PROVIDER:  NPROVIDER,ERIN D
DIABETES: AVPROVIDER,TERESA D
OB CARE: TETER,SHIRLEY

ON CMS REGISTER(S):  ASTHMA (PERSISTENT)  Status: ACTIVE
                    DYSLIPIDEMIA  Status: ACTIVE
                    CARDIOVASCULAR DISEASE  Status: ACTIVE
                    ALPHA TEAM  Status: ACTIVE

----- INSURANCE INFORMATION -----

INSURANCE      NUMBER      SUFF COV      EL DATE      SIG DATE      END DATE
NC MEDICAID    138784952      PW            08/01/06
Plan Name: ALL STATES COVERAGE INC
BLUE CROSS BLUE SHIELD-N.C.HPG880422843      02/01/06

```

Figure 16-1: Example CHS menu option report

17.0 Custom Letter Management (CLM)

The Custom Letter Management option contains the following menu options:

CCL	Create/Modify Custom Letter
PCL	Print Custom Letters for Selected Patients

Figure 17-1: Example CLM menu options

- The **CCL** (Create/Modify Custom Letters) option allows the user to add, edit, and delete a customized letter, and view letter inserts.
- The **PCL** (Print Custom Letters for Selected Patients) option allows the user to print custom letters for selected patients.

18.0 Browse Health Summary (BHS)

The BHS option allows the user to browse the specified Health Summary for a particular patient. The following screen displays:

```

Select PCC Management Reports Option: BHS  Browse Health Summary
Select health summary type: DENTAL//
Select patient: DEMO,JOHNNIE RUTH          <A>  F 03-01-1981 XXX-
XX-4021   DH 118774

OUTPUT BROWSER           Jan 15, 2009 15:27:20      Page: 1 of 6
PCC Health Summary for DEMO,JOHNNIE RUTH

** CONFIDENTIAL PATIENT INFORMATION -- 1/15/2009  3:27 PM  [SJT]**
***DEMO,JOHNNIE RUTH 118774 <A>  (DENTAL SUMMARY)  pg 1 ***

----- DEMOGRAPHIC DATA -----

DEMO,JOHNNIE RUTH          DOB: MAR 1,1981  27 YRS  FEMALE  no
blood type
DEMO TRIBE, NM             SSN: XXX-XX-4021
                           MOTHER'S MAIDEN NAME: CROWE,VIRGINIA J
(H) 555-555-3791          FATHER'S NAME: DEMO,MICHAEL
BIRDTOWN (P.O. BOX 1340,VASSALBORO,NC,28719)

LAST UPDATED: MAY 24,2007      ELIGIBILITY: CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?  YES
                           DATE RECEIVED BY PATIENT:  Apr 14, 2003
                           WAS ACKNOWLEDGEMENT SIGNED?  YES

+      Enter ?? for more actions                >>>
+      NEXT SCREEN          -      PREVIOUS SCREEN      Q      QUIT
Select Action: +//

```

Figure 18-1: Example Health Summary information

19.0 Other PCC Management Reports/Options (OTH)

The Other PCC Management Reports/Options menu contains the following options:

RT	Report Template Utility ...
DR	PCC Patient Data Retrieval Utility
RDD	Delete VGEN/PGEN Report Definition

Figure 19-1: Example OTH menu options

19.1 Report Template Utility (RT)

The Report Template Utility contains the following options:

CR	Create Report Template
MD	Modify/Delete Report Template
PR	Print Report Template
TC	Taxonomy Creation For A Script

Figure 19-2: Example RT menu options

19.2 PCC Patient Data Retrieval Utility (DR)

The PCC Patient Data Retrieval Utility uses scripts to retrieve patient information from the PCC. Typing DR displays a prompt asking for the patient's name. Create a script to retrieve patient clinical or demographic information.

19.2.1 Script Creation

A script is an instruction to the PCC Data Retrieval Utility to obtain patient information from the PCC database. Both demographic and clinical information can be retrieved for a patient.

Demographic Data

To obtain demographic data for a patient, the first word typed at the prompt must be either **PT** or **Patient**. Then additional information can be added. If the text typed at the prompt is ambiguous, the system will not return a value.

The following list includes patient demographic data items that are most frequently requested. Other demographic information can be displayed.

- PT NAME
- PT CURRENT COMMUNITY
- PT AGE
- PT DOB
- PT TRIBE OF MEM

Clinical Data

Scripts can be used to retrieve clinical data. The following sample scripts show some of the types of information that can be retrieved from the PCC database.

```

LAST 3 MEAS BP;DURING 1991 - RETURNS LAST 3 BLOOD PRESSURES
                              TAKEN DURING 1991
LAB GLUCOSE;ON SEP 3, 1992 - RETURNS ALL GLUCOSSES TAKEN ON
                              SEPT 3, 1992
FIRST ACTIVE.PROBLEM - RETURNS FIRST ACTIVE PROBLEM FROM THE
                              PROBLEM LIST; DATE DETERMINED BY DATE
                              ENTERED OR LAST MODIFIED
LAST IMMUN PNEUMOVAX - RETURNS LAST PNEUMOVAX GIVEN

```

Figure 19-3: Sample scripts used to retrieve clinical data

The script in Figure 19-4 can be broken into four component parts for further explanation. LAST 3 MEAS BP; DURING 1991 will be used for this example.

```

LAST 3      - Limits occurrences; use first, last, or all.
            - Can indicate number of instances.
            - Optional; if not used system will default to 'all.'
MEAS       - Data Class; i.e., AS LABS, POV, ADA.CODE.
BP         - Optional; what you are looking for within the data
class
            - If not indicated, system will look at all values
within data
            class.
DURING 1991 - Optional use of date parameters.

```

Figure 19-4: Example script

The four components are explained in detail below.

- Limits Occurrences: Use First, Last, or All

The first word of the script must be either First, Last, or All. The default value is All. For example, for the number of occurrences for which a particular value should be retrieved either First 3 or Last 2 can be specified.

- Data Class

The second word is the data class. The second word in the script may be Lab, Rx, Ada.Code, Exam, Visit, Pov, Measurement, Procedures, Skin.Test, Immunization, Radiology, Education, Active.Prob, Inactive.Prob, Family.History, Personal.History, or Health.Factors.

If the data class has more than one word, each word **must** be separated by a period when typed into the script; for example, Ada.Code. Two words are not required; the data retriever can determine the class from the first word. Many classes, such as Dental Services and Medications, have acronyms. In most instances, type only the first few identifying characters of a data class. For

instance, to specify Active Problems, type **ACT** instead of spelling it out. The data retriever will recognize these three letters as “Active Problems.”

- Value within the Data Class

The third word is the value, or what the user is searching for, within the data class. For example, the value would be a laboratory test for labs and an Ada Code for dental services. Also, instead of entering an ICD9 code, a narrative such as Diabetes or DM can be used.

- Date Parameters

The date range can be restricted by placing a semicolon (;) at the end of the script, followed by a restriction on the date, such as: on, equals, before, during, between, or a symbol (>, <, <>, =). An exact date or a range of dates can be entered by placing a dash (-) between the two dates. Dates must be in standard FileMan format. The month and year, year only, or full dates can be entered. (See the sample scripts on the following page for examples of typing date parameters.)

- Taxonomy Creation

If an asterisk (*) is typed for the value within the data class, the system will prompt for multiple values associated with the selected data class. For example, a range of ICD9 codes for POVs or multiple Ada Codes, can be entered. Not all data classes allow entry of more than one value. Available data classes for taxonomy creation are: diagnosis, ADA code, RX, procedure (medical), patient education topic, and health factors. These multiple values can be stored in a taxonomy. Then the user can type the name of the taxonomy prefaced by a left square bracket ([) to indicate the desired values to retrieve.

The following report shows the data received from the sample script.

```
Select PATIENT NAME:      SMITH, JANE
                                F 11-10-70 XXX-XX-1234 DH
333333
ENTER SCRIPT: LAST 3 MEAS BP

VISIT DATE: 06/23/1993      VALUE: 120/90      TYPE: BP
VISIT DATE: 03/04/1993      VALUE: 100/80      TYPE: BP
VISIT DATE: 08/25/1992      VALUE: 120/80      TYPE: BP

ENTER SCRIPT: LAST VISIT

VISIT DATE: 08/02/1993      VALUE: VISIT

ENTER SCRIPT: LAST POV DM

250.00 (DIABETES UNCOMPL TYPE II/NIDDM)
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NONINSULIN
DEPENDENT/ADULT-ONSET
```

```
OK? Y//
```

```
VISIT DATE: 07/19/1993    VALUE: 250.00
```

Figure 19-5: Example of data retrieved using script

19.3 Delete VGEN/PGEN Report Definition (RDD)

Use the RDD option to delete a PCC Visit or Patient General Retrieval report definition. The system confirms the deletion.

20.0 FileMan (General) (FM)

The FileMan utility is a set of retrieve-only options from the File Manager database management system. The menu contains the following options:

```
1 Search File Entries
2 Print File Entries
3 Inquire to File Entries
4 Statistics
5 List File Attributes
```

Figure 20-1: Example FileMan menu options

The Search and Print options allow the user to create *ad hoc* reports. The Inquire option allows the user to see entries within a file. The Statistics option is a menu that, when appropriate, allows for the creation of a histogram or scattergram or gives basic mathematical statistics for a report generated by the Print or Search option. The Statistics menu options must be run just after the report is generated, as results will not be saved once another report is printed. Note that the Statistics menu options cannot be used if a report is queued to a printer. List File Attributes displays the fields and attributes of those fields that make up a FileMan file. These create the data dictionary of the file.

A separate File Manager user's manual that describes the use of these utilities in depth is available.

21.0 Search Template System (STS)

This system has options that allow search templates to be created either through the FileMan Search option or manually. A search template comparison utility is also available that permits the user to match the contents of one FileMan search template with another. The STS provides the capability to delete and add entries to existing search templates the user has created. In addition, FileMan (General) may be accessed from this menu.

Note: If a search template is created via the search template utility or the option that allows for manual creation of a search template, there will be no search logic associated with these templates. Search templates created via the FileMan Search option have search logic stored with them. This means the user can utilize this template's search logic within the search option of FileMan.

```

Search Template System
Version 2.5
Site Set To DEMO HO

      SRCH   Search Template Comparison Utility
      CRE    Create Search Template Manually
      ADD    Add Entries Into An Existing Search Template
      DENT   Delete Entries From An Existing Search Template
      CNT    Count Entries In A Search Template
      SRT    Inquire Into Sort/Search Template File
      DEL    Delete Search Template
      SAVE   Save Search Template
      FGEN   FileMan (General) ...

Select Search Template System Option:

```

Figure 21-1: Example Search Template System main menu

A separate STS user's manual that describes the use of this system in-depth is available.

22.0 Appendix A: Statistical Database Record Definition

Record 1 of 2

Item	Beg Col	End Col	Length	REQ	Description of Data Item
RECORD CODE	1	2	2	Y	Will always be 00
SEQUENCE	3	3	1	Y	Will always be 1
UNIQUE ID	4	19	16	Y	Unique ID for this visit. ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	20	31	12	Y	Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DOB	32	38	7	Y	DOB in format CYYMMDD; for example, 2960908.
SEX	39	39	1	Y	Sex. M or F
SSN	40	48	9	Y	SSN of patient or 9 blanks. No dashes.
PRIMARY TRIBE	49	51	3	Y	Tribe code from standard code book.
COMMUNITY OF RESIDENCE	52	58	7	Y	STCTYCOM code of patient's residence. Taken from the current community field.
CLASSIFICATION /BENEFICIARY	59	60	2	Y	Beneficiary Code from Standard Code book.
ELIGIBILITY	61	61	1	Y	Eligibility Status from Standard Code book.
MEDICAID ELIG ON VISIT DATE	62	62	1	Y	Y or N. If patient was Medicaid eligible on the visit date, this is set to Y; if not, N.
MEDICARE ELIG ON VISIT DATE	63	63	1	Y	Y or N. If patient was Medicare eligible on the visit date, this is set to Y; if not, N.
PRIVATE INSURANCE ELIGIBILITY ON VISIT DATE	64	64	1	Y	Y or N. If patient was Private Insurance eligible on the visit date, this is set to Y; if not, N.
VISIT/ ADMISSION DATE	65	71	7	Y	Date of Visit in CYYMMDD format.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
TIME OF DAY	72	75	4	Y	Time of day in internal FileMan format; for example,1000, 1310, 0805
DAY OF WEEK	76	76	1	Y	DOW in APC record definition format.
LOCATION OF ENCOUNTER	77	82	6	Y	ASUFAC of location of encounter.
TYPE	83	83	1	Y	Type of Visit. C, I, O, 6, T, U, V, S, etc.
SERVICE CATEGORY	84	85	2	Y	Service Category; for example, A, H, I, C, T
CLINIC	86	87	2	N	Clinic of Visit, standard 2 digit code.
EVALUATION AND MANAGEMENT CPT CODE	88	92	5	N	CPT CODE from Evaluation and Management field of Visit file.
LEVEL OF SERVICE	93	93	1	N	Level of Service code from PCC form.
EDUCATION DONE OF THIS VISIT	94	94	1	N	Was an education topic provided on this visit? Y or N
EXAMS DONE ON THIS VISITQ	95	95	1	N	Was one or more exams done on this visit? Y or N
OF LAB TESTS DONE	96	98	3	N	of laboratory tests done.
OF RX'S	99	100	2	N	of prescriptions filled.
VITAL SIGNS DONE	101	101	1	N	Were vital signs taken? Y or N
PRIMARY PROV AFFILIATION/DISCIPLINE	102	104	3	Y	Primary Provider's Affiliation and Discipline; for example, 101
OTHER PROVIDER AFFILIATION/DISCIPLINE	105	107	3	N	First Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/DISCIPLINE	108	110	3	N	2nd Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/DISCIPLINE	111	113	3	N	3rd Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/DISCIPLINE	114	116	3	N	4th Secondary Provider Affiliation/Discipline.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
PRIMARY ICD DX	117	122	6	Y	Primary ICD Dx. If this is a non-hospitalization visit, it is the 1 st diagnosis entered.
APC CODE 1	123	125	3	Y	APC Recode for diagnosis 1
CAUSE OF DX 1	126	126	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 1
CAUSE OF INJURY	127	132	6	N	Valid ICD9 E code for an injury. If Diagnosis 1 is an injury 800-999.9.
PLACE OF INJURY	133	133	1	N	PCC place of injury code for Diagnosis 1 if Diagnosis 1 is an injury.
DIAGNOSIS 2	134	139	6	Y	ICD Dx 2. If this is a non-hospitalization visit, it is the 2nd diagnosis entered.
APC CODE 2	140	142	3	Y	APC Recode for diagnosis 2
CAUSE OF DX 2	143	143	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 2
CAUSE OF INJURY	144	149	6	N	Valid ICD9 E code for an injury. If Diagnosis 2 is an injury 800-999.9.
PLACE OF INJURY	150	150	1	N	PCC place of injury code for Diagnosis 2 if Diagnosis 2 is an injury.
DIAGNOSIS 3	151	156	6	Y	ICD Dx 3. If this is a non-hospitalization visit, it is the 3rd diagnosis entered.
APC CODE 3	157	159	3	Y	Recode for diagnosis 3
CAUSE OF DX 3	160	160	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 3
CAUSE OF INJURY	161	166	6	N	Valid ICD9 E code for an injury. If Diagnosis 3 is an injury 800-999.9.
PLACE OF INJURY	167	167	1	N	PCC place of injury code for Diagnosis 3 if Diagnosis 3 is an injury.
DIAGNOSIS 4	168	173	6	Y	Dx 4. If this is a non-hospitalization visit, it is the 4th diagnosis entered.
APC CODE 4	174	176	3	Y	APC Recode for diagnosis 4

Item	Beg Col	End Col	Length	REQ	Description of Data Item
CAUSE OF DX 4	177	177	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 4
CAUSE OF INJURY	178	183	6	N	Valid ICD9 E code for an injury. If Diagnosis 4 is an injury 800-999.9.
PLACE OF INJURY	184	184	1	N	PCC place of injury code for Diagnosis 4 if Diagnosis 4 is an injury.
DIAGNOSIS 5	185	190	6	Y	ICD Dx 5. If this is a non-hospitalization visit, it is the 5th diagnosis entered.
APC CODE 5	191	193	3	Y	APC Recode for Diagnosis 5
CAUSE OF DX 5	194	194	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 5
CAUSE OF INJURY	195	200	6	N	Valid ICD9 E code for an injury. If Diagnosis 5 is an injury 800-999.9.
PLACE OF INJURY	201	201	1	N	PCC place of injury code for Diagnosis 5 if Diagnosis 5 is an injury.
DIAGNOSIS 6	202	207	6	Y	ICD Dx 6. If this is a non-hospitalization visit, it is the 6th diagnosis entered.
APC CODE 6	208	210	3	Y	APC Recode for Diagnosis 6
CAUSE OF DX 6	211	211	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 6
CAUSE OF INJURY	212	217	6	N	Valid ICD9 E code for an injury. If Diagnosis 6 is an injury 800-999.9.
PLACE OF INJURY	218	218	1	N	PCC place of injury code for Diagnosis 6 if Diagnosis 6 is an injury.
DIAGNOSIS 7	219	224	6	Y	ICD Dx 7. If this is a non-hospitalization visit, it is the 7th diagnosis entered.
APC CODE 7	225	227	3	Y	APC Recode for Diagnosis 7
CAUSE OF DX 7	228	228	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 7

Item	Beg Col	End Col	Length	REQ	Description of Data Item
CAUSE OF INJURY 7	229	234	6	N	Valid ICD9 E code for an injury. If Diagnosis 7 is an injury 800-999.9.
PLACE OF INJURY 7	235	235	1	N	PCC place of injury code for Diagnosis 7 if Diagnosis 7 is an injury.

Record 2 of 2

Item	Beg Col	End Col	Length	REQ	Description of Data Item
RECORD CODE 7	1	2	2	Y	00
SEQ	3	3	1	Y	2
UNIQUE ID	4	19	16	Y	Use ASUFAC and HRN at location of encounter, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
ASUFAC_HRN	20	31	12	Y	Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DIAGNOSIS 8	32	37	6	Y	ICD Dx 8. If this is a non-hospitalization visit, it is the 8th diagnosis entered.
APC CODE 8	38	40	3	Y	APC Recode for Diagnosis 8
CAUSE OF DX 8	41	41	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 8
CAUSE OF INJURY	42	47	6	N	Valid ICD9 E code for an injury. If Diagnosis 8 is an injury 800-999.9.
PLACE OF INJURY	48	48	1	N	PCC place of injury code for Diagnosis 8 if Diagnosis 8 is an injury.
DIAGNOSIS 9	49	54	6	Y	ICD Dx 9. If this is a non-hospitalization visit, it is the 9th diagnosis entered.
APC CODE 9	55	57	3	Y	APC Recode for Diagnosis 9
CAUSE OF DX 9	58	58	1	N	1-Hospital acquired, 2- alcohol-related, 3-battered child, 4-employment-related for Diagnosis 9
CAUSE OF INJURY	59	64	6	N	Valid ICD9 E code for an injury. If Diagnosis 9 is an injury 800-999.9.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
ICD PROC CODE (1)	65	69	5	N	ICD Operation Code
PROC DATE (1)	70	76	7	N	Internal FileMan format of date of procedure.
INFECTION (1)	77	77	1	N	Y-Yes N-No
PROC PROV AFF/DISC(1)	78	80	3	N	Operating Provider's Affiliation/Discipline Code.
CPT CODE (1)	81	85	5	N	CPT Code for this procedure
DX DONE FOR (1)	86	86	1	N	The number (1-9) of the diagnosis that this procedure was done for.
ICD PROC CODE (2)	87	91	5	N	ICD Operation Code
PROC DATE (2)	92	98	7	N	Internal FileMan format of date of procedure.
INFECTION (2)	99	99	1	N	Y-Yes N-No
PROC PROV AFF/DISC(2)	100	102	3	N	Operating Provider's Affiliation/Discipline Code
CPT CODE (2)	103	107	5	N	CPT Code for this Procedure
DX DONE FOR (2)	108	108	1	N	The number (1-9) of the diagnosis that this procedure was done for.
ICD PROC CODE (3)	109	113	5	N	ICD Operation Code
PROC DATE (3)	114	120	7	N	Internal FileMan format of date of procedure.
INFECTION (3)	121	121	1	N	Y-Yes N-No
PROC PROV AFF/DISC(3)	122	124	3	N	Operating Provider's Affiliation/Discipline Code
CPT CODE (3)	125	129	5	N	CPT Code for this Procedure
DX DONE FOR (3)	130	130	1	N	The number (1-9) of the diagnosis that this procedure was done for.
IMMUNIZATION CODE	131	132	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	133	133	1	N	Set of codes
IMMUNIZATION CODE	134	135	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	136	136	1	N	Set of codes

Item	Beg Col	End Col	Length	REQ	Description of Data Item
IMMUNIZATION CODE	137	138	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	139	139	1	N	Set of codes
ADA CODE (1)	140	143	4	N	ADA CODE
ADA UNITS (1)	144	145	2	N	OF UNITS
ADA CODE (2)	146	149	4	N	ADA CODE
ADA UNITS (2)	150	151	2	N	OF UNITS
ADA CODE (3)	152	155	4	N	ADA CODE
ADA UNITS (3)	156	157	2	N	OF UNITS
ADA CODE (4)	158	161	4	N	ADA CODE
ADA UNITS (4)	162	163	2	N	OF UNITS
ADA CODE (5)	164	167	4	N	ADA CODE
ADA UNITS (5)	168	169	2	N	OF UNITS
ADA CODE (6)	170	173	4	N	ADA CODE
ADA UNITS (6)	171	175	2	N	OF UNITS
APC CODE 4	174	176	3	Y	APC Recode for diagnosis 4
ADMISSION DATE	176	182	7	N	Admission date in internal FileMan format.
ADMISSION SERVICE	183	184	2	N	Admitting Service (2-digit IHS code)
ADMISSION TYPE	185	185	1	N	Admission Type
ATTENDING PHYSICIAN	186	191	6	N	Affiliation/Discipline code
CAUSE OF DEATH	192	197	6	N	ICD CODE
OF CONSULTS	198	200	3	N	Number of consults during an Inpatient Stay
DISCHARGE DATE	201	207	7	N	Internal FileMan Format of discharge date.
DISCHARGE SERVICE	208	209	2	N	From Standard Treating Specialty table
DISCHARGE TYPE	210	210	1	N	IHS Standard Code for Discharge Type
FACILITY TRANSFER TO (ASUFAC)	211	216	6	N	From Location table
LENGTH OF STAY	217	219	3	N	Length of stay

Item	Beg Col	End Col	Length	REQ	Description of Data Item
MIDWIFERY	220	220	1	N	1 if midwife was a provider
ACTIVITY TIME	221	224	4	N	Minutes
TRAVEL TIME	225	228	4	N	Minutes
CHS COST	229	234	6	N	For CHS visits, total cost info.

23.0 Appendix B: PGEN/VGEN Options

Below is a table of PGEN/VGEN selection, sort, and print options organized by Groups of Related Items.

Group	Field	PGEN SELEC T ORDE R	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELEC T ORDE R	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Patient Name		1	1		1	1
Patient Demographics	First, Last Name		2	2		2	2
Patient Demographics	Chart		3	3		3	3
Patient Demographics	Terminal Digit		4	4		4	4
Patient Demographics	SSN		5			5	
Patient Demographics	Sex	2	6	5	2	6	5
Patient Demographics	Date of Birth	3	7	6	3	7	6
Patient Demographics	Birth Month	4	8	7	4	8	7
Patient Demographics	Race	5	9	8	5	9	8
Patient Demographics	Age	6	10	9	6	10	9
Patient Demographics	Age in Months	7	11	10	7	11	10
Patient Demographics	Father's Name		12	11		12	11
Patient Demographics	Mother's Name		13	12		13	12
Patient Demographics	Veteran Status Y/N	8	14	13	8	14	13
Patient Demographics	Date of Death	9	15	14	9	15	14

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Date Patient Established	10	16	15	10	16	15
Patient Demographics	Mlg Address-Street		17	16		17	16
Patient Demographics	Mlg Address-City		18			18	
Patient Demographics	Mlg Address-State	11	19	17	11	19	17
Patient Demographics	Mlg Address-State Abbrv		20	18		20	18
Patient Demographics	Mlg Address-Zip	12	21	19	12	21	19
Patient Demographics	Mlg Address-Complete		22			22	
Patient Demographics	City of Birth		23			23	
Patient Demographics	Home Phone		24			24	
Patient Demographics	State of Birth		25			25	
Patient Demographics	Employer of Patient	13	26	20			
Patient Demographics	Office Phone		27				
Patient Demographics	Total Household Income	14	28	21	13	26	20
Patient Demographics	Mother's Maiden Name		29			27	
Patient Demographics	Next of Kin		30				
Patient Demographics	Community	17	31	22	16	28	21
Patient Demographics	Tribe	18	32	23	17	29	22
Patient Demographics	County of Residence	19	33	24	18	30	23
Patient Demographics	Eligibility Status	20	34	25	19	31	24

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Beneficiary Class	21	35	26	20	32	25
Patient Demographics	HRN Record Status	22	36	27	21	33	26
Patient Demographics	HRN Disposition	23	37	28	22	34	27
Patient Demographics	Service Unit of PT	24	38	29	23	35	28
Patient Demographics	Indian Blood Quantum	28	39	30	28	36	29
Patient Demographics	Name/Chart /SSN	1			1		
Patient Demographics	Living Pts	15			14		
Patient Demographics	Chart Facility	16			15		
Patient Demographics	Inactive Patients	25			24		
Patient Demographics	Exclude Inactive Pts	26			25		
Patient Demographics	Exclude Pts on a Regis	27			26		
Patient Demographics	Excl Incomplete Vis				27		
Patient Demographics	Total in Household	15	29	22	14	27	21
Patient Insurance Data	Medicare		1		1	1	
Patient Insurance Data	MEDICARE Y/N		2	1		2	1
Patient Insurance Data	Medicare Part B	2	3	2	2	3	2
Patient Insurance Data	Medicare Part D	3	4	3	3	4	3
Patient Insurance Data	Medicaid	1	5		4	5	
Patient Insurance Data	MEDICAID Y/N		6	4		6	4

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Insurance Data	Private Insurance	4	7		5	7	
Patient Insurance Data	PRIVATE INSURANCE Y/N		8	5		8	5
Patient Insurance Data	Third Party Eligibility		9	7		9	7
Patient Insurance Data	Medicaid Plan Name	7	10	8	7	10	8
Patient Insurance Data	Pvt Ins Plan Name	8	11	9	8	11	9
Patient Insurance Data	Priv Ins Verified	9	12		9	12	
Patient Insurance Data	Pvt Ins Plan Type		13	10		13	10
Patient Insurance Data	Any Third Party Coverage	6		6	6		6
Other Patient Related Data	Birth Weight (grams)	1	1	1	1	1	1
Other Patient Related Data	Birth Weight (Kgs)	2	2	2	2	2	2
Other Patient Related Data	ADD'L REG INFORMATION		3			3	3
Other Patient Related Data	Cause of Death	3	4	3			
Other Patient Related Data	Desig Prim Care Prov	4	5	4	3	4	4
Other Patient Related Data	User Updating PCP	5	6	5	4	5	5
Other Patient Related Data	Date PCP Updated	6	7	6	5	6	6
Other Patient Related Data	Internet Access Update D	7	8	7	6	7	7
Other Patient Related Data	Internet Access?	8	9	8	7	8	8
Other Patient Related Data	Internet Access-Method	9	10	9	8	9	9
Other Patient Related Data	Upcoming Appointments	10	11			10	10

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Patient Related Data	Reason WH Prov Updated	11	12	10	10	11	11
Other Patient Related Data	Immun Case Managerte	12	13	11	11	12	12
Other Patient Related Data	Other Specialty Provider	7	8		6	7	
Other Patient Related Data	Immunity Register Status	13	14	10	12	13	9
Patient Clinical Data Elements	Patient's Last Visit	1	1	1	1	1	1
Patient Clinical Data Elements	EDC	2	2	2	2	2	2
Patient Clinical Data Elements	Date EDC Determined	3	3	3	3	3	3
Patient Clinical Data Elements	Contraception Method	4	4	4	4	4	4
Patient Clinical Data Elements	EDC Determination	5	5	5	5	5	5
Patient Clinical Data Elements	Last Menstrual Period	6	6	6	6	6	6
Patient Clinical Data Elements	Prob List Dx (ANY)	7	7		7	7	
Patient Clinical Data Elements	Prob List Dx (ACTIVE)	8	8		8	8	
Patient Clinical Data Elements	Prob List Dx (INACTIVE)	9	9		9	9	
Patient Clinical Data Elements	Problem List Narrative		10			10	
Patient Clinical Data Elements	Problem Date of Onset	10	11		10	11	
Patient Clinical Data Elements	Family History Dx	11	12		11	12	
Patient Clinical Data Elements	Family Hx and Relation	12	13		12	13	
Patient Clinical Data Elements	Family History Relation	13	14		13	14	
Patient Clinical Data Elements	Family Hx Narrative		15			15	

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Clinical Data Elements	Family Hx Description		16			16	
Patient Clinical Data Elements	Hx of Surgery	14	17		14	17	
Patient Clinical Data Elements	BMI (Last calculated)	15	18	7	15	18	7
Patient Clinical Data Elements	Formula Started (Days)	16	19	8	16	19	8
Patient Clinical Data Elements	Breast Feeding Stopped	17	20	9	17	20	9
Patient Clinical Data Elements	Solids Food Started (D)	18	21	10	18	21	10
Most Recent of Clinical Items	Most Recent TOBACCO HF	1	1	1	1	1	1
Most Recent of Clinical Items	Most Recent TB STATUS HF	2	2	2	2	2	2
Most Recent of Clinical Items	Most Recent ALCOHOL HF	3	3	3	3	3	3
Most Recent of Clinical Items	Most Recent STAGED DM HF	4	4	4	4	4	4
Most Recent of Clinical Items	Most Recent Barriers HF	5	5	5	5	5	5
Most Recent of Clinical Items	Most Recent LEARNING PRE	6	6	6	6	6	6
Most Recent of Clinical Items	Most Recent RUBELLA HF	7	7	7	7	7	7
Most Recent of Clinical Items	Date Last Alcohol Screen	8	8	8			
Most Recent of Clinical Items	Date Last Depression Scr	9	9	9			
Most Recent of Clinical Items	Date Last IPV/DV Screen	10	10	10			
Most Recent of Clinical Items	Date Last Colonoscopy	11	11	11			
Most Recent of Clinical Items	Date Last Flex Sig	12	12	12			

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Most Recent of Clinical Items	Date Last Mammogram	13	13	13			
Most Recent of Clinical Items	Date Last PAP Smear HF	14	14	14			
Most Recent of Clinical Items	Date Last Tobacco Screening	15	15	15			
Most Recent of Clinical Items	Date Last Fall Risk Assess	16	16	16			
Most Recent of Clinical Items	Date Last Tonometryen	17	17	17			
Most Recent of Clinical Items	Date Last Vision Exam	18	18	18			
Most Recent of Clinical Items	Date Last Head Circumf	19	19	19			
Most Recent of Clinical Items	Date Last Dental Exam	20	20	20			
Most Recent of Clinical Items	Date Last Diabetic Foo	21	21	21			
Most Recent of Clinical Items	Date Last Osteo Scrn	22	22	22			
Visit Demographics	Visit Date					1	1
Visit Demographics	Visit Date&Time					2	2
Visit Demographics	Appt Date&Time					3	3
Visit Demographics	Check Out Date&Time					4	4
Visit Demographics	Appointment Length				1	5	5
Visit Demographics	Type of Appointment				2	6	6
Visit Demographics	Date Visit Last Modified				3	7	7
Visit Demographics	Posting Date of Visit				4	8	8
Visit Demographics	Time of Visit				5	9	9

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Demographics	Month of Visit					10	10
Visit Demographics	External Acct				6	11	11
Visit Demographics	PCC+ FORM?				7	12	12
Visit Demographics	Visit IEN					13	13
Visit Demographics	Dependent Entry Count					14	14
Visit Demographics	Type (IHS,638,etc)				8	15	15
Visit Demographics	Service Category				9	16	16
Visit Demographics	Visit Location				10	17	17
Visit Demographics	Outside Location				11	18	18
Visit Demographics	Clinic Type				12	19	19
Visit Demographics	Visit Created By				13	20	20
Visit Demographics	User Last Update				14	21	21
Visit Demographics	VCN Present				15	22	22
Visit Demographics	3rd Party Billed?				16	23	23
Visit Demographics	3P Bill					24	24
Visit Demographics	Appt/Walk-In				17	25	25
Visit Demographics	FlagEC				18	26	26
Visit Demographics	DRG				19	27	27
Visit Demographics	Level of Service				20	28	28

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Demographics	Eval&Management CPT				21	29	29
Visit Demographics	Amount Billed					30	
Visit Demographics	Activity/Travel Time					31	
Visit Demographics	Day of Week				22	32	30
Visit Demographics	NDW Export Date				23	33	31
Visit Demographics	NDW Exported?				24	34	32
Visit Demographics	Dt Visit Exported (PCC					35	
Visit Provider Data Elements	Prim Prov Time Seen					1	1
Visit Provider Data Elements	Primary Prov Name				1	2	2
Visit Provider Data Elements	Prim/Sec Prov Name				2	3	
Visit Provider Data Elements	Prim Prov Disc				3	4	3
Visit Provider Data Elements	Prim/Sec Prov Disc				4	5	
Visit Provider Data Elements	Prim Prov Affil				5	6	4
Visit Provider Data Elements	Prim/Sec Prov Affil				6	7	
Visit Provider Data Elements	Prim Prov Code				7	8	5
Visit Provider Data Elements	Prim/Sec Prov Code				8	9	
Visit Provider Data Elements	Primary Provider IEN					10	6
Visit Provider Data Elements	Prim/Sec Prov IEN					11	
Visit Diagnosis/Procedure Data	Diagnosis Code				1	1	

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Diagnosis/Procedure Data	Primary Dx (POV)				2	2	1
Visit Diagnosis/Procedure Data	Diagnosis Prov Narr				3	3	
Visit Diagnosis/Procedure Data	Diagnosis ICD Narr					4	
Visit Diagnosis/Procedure Data	Stage of Dx (POV)				4	5	
Visit Diagnosis/Procedure Data	Present on Admission (PO				5	6	
Visit Diagnosis/Procedure Data	Alcohol/Work Related				6	7	
Visit Diagnosis/Procedure Data	Cause of DX (POV)				7	8	
Visit Diagnosis/Procedure Data	Cause of Injury				8	9	
Visit Diagnosis/Procedure Data	Place of Injury				9	10	
Visit Diagnosis/Procedure Data	Operation Code				10	11	
Visit Diagnosis/Procedure Data	Operation CPT Code				11	12	
Visit Diagnosis/Procedure Data	Operation Prov Narr)					13	
Visit Diagnosis/Procedure Data	Operation ICD Narr					14	
Visit Diagnosis/Procedure Data	Operations w/dates					15	
Visit Diagnosis/Procedure Data	Operating Prov				12	16	2
Visit Diagnosis/Procedure Data	CPT Code				13	17	
Visit Diagnosis/Procedure Data	CPT Modifier				14	18	
Visit Diagnosis/Procedure Data	Tran Code (Chargemaste				15	19	
Visit Diagnosis/Procedure Data	Tran Code CAN				16	20	

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Labs/Meds Clinical	RX Ordering Provider				1	1	
Visit Labs/Meds Clinical	Lab Tests and Results				2	2	
Visit Labs/Meds Clinical	Lab Test Names (ALL)					3	
Visit Labs/Meds Clinical	Microbiology Culture				3	4	
Visit Labs/Meds Clinical	Microbiology Organism				4	5	
Visit Labs/Meds Clinical	Microbiology Result					6	
Visit Labs/Meds Clinical	Medications				5	7	
Visit Labs/Meds Clinical	Medications+SIG				6	8	
Visit Labs/Meds Clinical	Medication Name/Qty/Day				7	9	
Visit Labs/Meds Clinical	Any Medication Prescri				8	10	1
Visit Labs/Meds Clinical	Lab Test/Loinc Codes				9	11	
Other Visit Clinical Items	Measurements					1	
Other Visit Clinical Items	Pain Measurement Value				1	2	
Other Visit Clinical Items	Waist Circ Value				2	3	1
Other Visit Clinical Items	Dental ADA Codes				3	4	
Other Visit Clinical Items	Radiology Exam				4	5	
Other Visit Clinical Items	Immunizations/Series					6	
Other Visit Clinical Items	Immunization Provider				5	7	
Other Visit Clinical Items	Immunization Lot				6	8	

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Visit Clinical Items	Skin Tests/Readings					9	
Other Visit Clinical Items	Immunizations				7	10	
Other Visit Clinical Items	Exams				8	11	
Other Visit Clinical Items	Treatments Provided				9	12	
Other Visit Clinical Items	Education Topics				10	13	
Other Visit Clinical Items	Education Provider				11	14	
Other Visit Clinical Items	Education Comments					15	
Other Visit Clinical Items	Education Length (min)				12	16	
Other Visit Clinical Items	Education Ind/Grp					17	
Other Visit Clinical Items	Education GOAL Status				13	18	
Other Visit Clinical Items	Education Objectives				14	19	
Other Visit Clinical Items	Education Prov Disc				15	20	
Other Visit Clinical Items	Health Factors				16	21	
Other Visit Clinical Items	HF Quantity/Score				17	22	
Other Visit Clinical Items	Hlth Factor by Categor				18	23	
Other Visit Clinical Items	TIU Notes					24	
Other Visit Clinical Items	Treatment Contract				19	25	
Other Visit Clinical Items	EKG's				20	26	
Other Visit Clinical Items	Diagnostic Procedure				21	27	

Group	Field	PGEN SELECTION ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECTION ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Visit Clinical Items	Infant Feeding Choice				22	28	
Other Visit Clinical Items	TIU Note Title				22	26	
Other Visit Clinical Items	Measurements				1	1	
Other Visit Clinical Items	VFC Eligibility				8	9	
Inpatient Visit Specific	Hospital Location				1	1	1
Inpatient Visit Specific	Admitting Service				2	2	2
Inpatient Visit Specific	Admission Type				3	3	3
Inpatient Visit Specific	Admission Source-UB92				4	4	4
Inpatient Visit Specific	Discharge Service				5	5	5
Inpatient Visit Specific	Date of Discharge				6	6	6
Inpatient Visit Specific	Discharge Type				7	7	7
Inpatient Visit Specific	Length of Stay				8	8	8
ER Specific Data Items	ER Urgency				1	1	1
ER Specific Data Items	ER Means of Arrival				2	2	2
ER Specific Data Items	ER Other Means of Arriva					3	3
ER Specific Data Items	ER Entered ER BY				3	4	4
ER Specific Data Items	ER Informant					5	5
ER Specific Data Items	ER Notified				4	6	6
ER Specific Data Items	ER Disposition				5	7	7

Group	Field	PGEN SELEC T ORDE R	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELEC T ORDE R	VGEN PRINT ORDER	VGEN SORT ORDER
ER Specific Data Items	ER Other Disposition					8	8
ER Specific Data Items	ER Condition on Departu					9	9
ER Specific Data Items	ER Depart Date/Time				6	10	10
ER Specific Data Items	ER Transferred To					11	11
PHN Specific Data Items	PHN Level of Interventio				1	1	1
PHN Specific Data Items	PHN Type of Dec Making				2	2	2
PHN Specific Data Items	PHN Psycho/Social/Env					3	
PHN Specific Data Items	PHN Nsg Dx					4	
PHN Specific Data Items	PHN Short Term Goals					5	
PHN Specific Data Items	PHN Long Term Goals					6	

24.0 Appendix C: RPMS Rules of Behavior

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

24.1 All RPMS Users

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

24.1.1 Access

RPMS users shall:

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

Users shall not:

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

24.1.2 Logging On To the System

RPMS users shall:

- Have a unique User Identification/Account name and password.

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

24.1.3 Information Accessibility

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

Users shall:

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

24.1.4 Accountability

Users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local ISSO.

- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Shall abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior and IT information processes.

24.1.5 Confidentiality

Users shall:

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

Users shall not:

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

24.1.6 Integrity

Users shall:

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

Users shall not:

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

24.1.7 Passwords

Users shall:

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

Users shall not:

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

24.1.8 Backups

Users shall:

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

Users shall not:

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

24.1.9 Reporting

Users shall:

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

Users shall not:

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

24.1.10 Session Time-Outs

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

Users shall:

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

24.1.11 Hardware

Users shall:

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

Users shall not:

- Do not eat or drink near system equipment

24.1.12 Awareness

Users shall:

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

24.1.13 Remote Access

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

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

Remote users shall:

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

Remote users shall not:

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

24.2 RPMS Developers

Developers shall:

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.

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

Developers shall not:

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

24.3 Privileged Users

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

Privileged users shall:

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.

- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, CISO, and systems owner.
- Protect the supervisor, superuser or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and back up files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to; abide by all Department and Agency policies and procedures

Privileged users shall not:

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

25.0 Glossary

@ symbol

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

Acute

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

Append

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

Billable Visit

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

Best Practice Prompts

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

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

Billable Visit

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

Caret (“Up Hat”)

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

Chart Number

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

Chronic

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

Clinical

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

Command

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

Community of Service

The community where the encounter took place.

Community of Residence

The community where the patient resides.

CPT Code

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

Database

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

Default Response

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

Designated Primary Care Provider (DPCP)

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

Device

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

DOB

Date of Birth

DOD

Date of Death

DOS

Date of Service

DX

Common abbreviation for “diagnosis”

EDC

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

EDD

Expected/estimated date of delivery.

Export

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

Fields

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

Free Text Field

This field type will accept numbers, letters, and most of the symbols on the keyboard. There may be restrictions on the number of characters the user is allowed to type.

Health Factors

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

Health Management Reminders (HMRs)

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

Health Record Number (HRN)

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

Health Summary

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

HRN

Health Record Number, also referred to as a Chart Number

HS

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

HX

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

ICD

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

Interfaces

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

Menu

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

Mnemonic

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

Narrative Description

A detailed description given using words rather than codes.

Patient Care Component (PCC)

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

Patient Wellness Handout (PWH)

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

PGEN

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

Problem List

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

POV

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

Prompt

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

Provider

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

Provider Narrative

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

QMan

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

Retrieval

To obtain data from another location.

Roll-and-Scroll

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

RPMS

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

Secondary Providers

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

Security Key

A means of securing menus to limit accessibility. To use certain functions, such as those in a manager's menu, the user must be assigned the appropriate key by the site manager.

Select

To choose one option from a list of options.

Site Manager

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

Specialty Providers

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

Submenu

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

Supplement

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

Tally

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

VGEN

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

26.0 Contact Information

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

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

Fax: (505) 248-4363

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

Email: support@ihs.gov