

PCC+ (PCC Plus) is a new application released by ITSC for IHS-wide deployment in July 2001 that enables PCC users to build a customized encounter form in real time for each patient visit that combines the best features of the PCC encounter form, superbill and health summary in one integrated document.

This Site Evaluation Survey is one of the early steps in the PCC+ implementation process, which requires a multi-disciplinary Implementation Team at each site to plan and implement the application and associated process changes. Fact sheets describing the system requirements and implementation guidelines are available from the ITSC Project Lead listed below, if your site has not received them.

Please complete the following Site Evaluation Survey as accurately as possible. The information provided will enable ITSC to better assist your site in planning for, installing, training and implementing PCC+. Please contact the ITSC Project Lead listed below with any questions or concerns.

This electronic form can be downloaded from www.ihs.gov/CIO/pccplus

To complete the Survey electronically:

- Answer all questions either by selecting the appropriate Yes/No box or typing the appropriate information in the gray shaded space.
- When completed, save this Survey document as “[sitename]-survey.doc”.
- E-mail the completed survey to the ITSC Project Lead listed below.

Site Name:	_____	Address:	_____	Contact Name:	_____	Phone:	_____	E-mail:	_____
	Position/Department:	_____							
Date Form Completed:	_____								

OUTPATIENT

1. In the table below, list the clinic types associated with your facility:

Clinic Name	Average Daily # of Clinic Walk-ins	Average Daily # of Appointments	Average Show Rate (%)	Average Wait Time (minutes)	Using Over-printed PCC Form?	Using Superbill?
ER					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Walk-In					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Well Child					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pediatrics					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



Please return completed survey forms to
 Theresa Cullen, MD; tcullen@hqt.ihs.gov; 520-670-4803



Clinic Name	Average Daily # of Clinic Walk-ins	Average Daily # of Appointments	Average Show Rate (%)	Average Wait Time (minutes)	Using Over-printed PCC Form?	Using Superbill?
Optometry					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapy					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. In the table below, break down the make-up of your clinical staff.

Clinical Staff	Full-time employees	Part-time employees	Employees with 3 or more years
MD/DO			
NP/PA			
RN/LPN			

3A. Have providers *on the PCC+ Implementation Team* received training on RPMS/ PCC?

All None Some Most

3B. Have *all* providers site-wide received training on RPMS/ PCC?

All None Some Most

3C. If training has been provided, select as many methods as apply.

Classroom style off-site Video On-site training Other: describe: _____

3D. If not, describe proposed training plan.

INPATIENT

4. Does your site have an inpatient facility? Yes No

If yes, how many beds (based on JCAHO report)? _____ Beds

5. What is your average daily inpatient occupancy? _____

6. What is your annual average inpatient length of stay? _____ Days



AMBULATORY SURGERY

- 7. Does your site have an ambulatory surgical center? Yes No
- 8. What is the average *monthly* number of procedures performed in this center? _____

REGISTRATION

- 9. Who currently registers patients? _____
 Is this a centralized function or by clinic
 Number of FTEs registering patients _____
- 10. How often is patient registration data updated? _____
- 11. Average time:
 to register a *new* patient: _____ minutes
 to register a check-in: _____ minutes
 to pull walk-in medical records: _____ minutes

DATA ENTRY

- 12. How many PCC forms are generated each week (average) by providers? _____
- 13. What is the average number of forms returned to providers each week due to missing/illegible data? _____
 If forms are returned for other reasons, please describe: _____
- 14. What date is your data entry staff working on for PCC entry at your facility *today*? _____ (date)
- 15. What is the data entry backlog at your facility? Percentage of PCC forms entered in:
 1 – 3 days: _____ %
 4 – 7 days: _____ %
 8 – 14 days: _____ %
 More than 15 days: _____ %
- 16. Who enters patient visits/procedures from PCC into RPMS? _____ (Name and position description(s)).
- 17. Who codes the visits? Medical Records Business Office Other (Describe: _____)
- 18. In the table below, indicate # of visits by code:

Code Description	Code	Average # of Visits per Month	Average # of Visits for 3 months
Brief Level I - New	99201		
Brief Level I - Established	99211		
Level II – New	99202		
Level II – Established	92212		
Level III – New	99203		
Level III – Established	99213		
Level IV - New	99204		
Level IV - Established	99214		
Level V – New Comprehensive	99205		
Level V - Established	99215		



BILLING

19. Of **all** patients seen, indicate percentage from the following insurers: (*Note: the percentages below will not total 100%*)

- Medicare _____ %
- Medicaid _____ %
- Private Insurer _____ %

20. Provide the volume and revenue by insurer by month:

- Medicare: Volume _____ Revenue \$ _____
- Medicaid: Volume _____ Revenue \$ _____
- Private Insurer Volume _____ Revenue \$ _____

21. What is the average number of days it takes to bill a patient’s insurance? _____ Days

22. Percentage of claims billed and not yet paid (accounts receivable) in the following time periods

Days after Billing:

- 1-30 _____ %
- 31-60 _____ %
- 61-90 _____ %
- 91-120 _____ %
- Over 120 days _____ %

Average total dollars in Accounts Receivable: \$ _____

23. Average number of claims denied per month. _____

Indicate primary denial reason (e.g., incorrect identification number; incomplete information provided on claim form; incorrect procedure code, etc.): _____

24. Average number of claims with billing errors per month. _____

IMPLEMENTATION TEAM

25. Received Site Implementation Recommendations document? Yes No

26. Has your site selected its Implementation Team members yet? Yes No

If yes, indicate Team members in the table below (*Site Implementation Recommendations* document defines the various roles):

Name	Position	E-mail	Phone	Fax
Project Lead				
Clinical Lead				



Name	Position	E-mail	Phone	Fax
Site Manager				
Backup IT Lead				
Designated Forms Editors (to provide hands-on editing and customization of forms) (at least 2)				
Coding Specialist(s)				
Additional Team Members				

SOFTWARE/HARDWARE

27. Have you received System Requirements document? Yes No Don't Know
 Has your site IT staff reviewed and planned for the hardware and software requirements? Yes No Don't Know
28. What is your existing word processing software and version in patient registration, data entry, and billing?

29. Do you have a dedicated printer in registration? Yes No
 If yes, what is the model and name of the printer: _____
30. Who on the Implementation Team, would be rated as an Intermediate or Expert user with MS Word, preferably Word 2000? _____

