



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Data Entry User Manual

Version 2.0
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Preface

The Resource and Patient Management System (RPMS) of the Indian Health Service (IHS) is an integrated group of automated data systems designed to operate on micro- and mini-computers located in any IHS or tribal health facility (i.e., hospital or full-time clinic). The system also links health facilities to each other and to administrative units, such as Area Offices. The primary objective is to integrate patient care and cost data in a single automated data processing system that collects and stores a core set of health and management data that cuts across disciplines and facilities. A typical RPMS configuration in a health facility might include these systems: Patient Registration, Pharmacy, Dental, Maternal and Child Health, Contract Health Services, Laboratory, and the Patient Care Component (PCC).

The PCC provides for the collection, integration, and storage, on local RPMS computers, of a broad range of health data resulting from inpatient, outpatient, and field visits at IHS, tribal, contract, and community sites. It is designed to support healthcare delivery, planning, management, and research. For health professionals, the PCC is a tool that assists in providing the type of care that addresses all of a patient's known health problems and preventive health needs. Planners use information such as the numbers of various types of visits and the reasons for these visits. Managers use aggregate information such as numbers of patients who have insurance and the types of insurance. Researchers use the information for a variety of locally designed projects. PCC data types include date, type, and location of visit; providers of service; measurements; diagnoses and procedures; health problems and treatment plans; personal and family history; reproductive factors; laboratory test results; and a variety of other health-related information.

This manual provides a complete description of the PCC Data Entry.

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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)

2.0 Release Notes

BJPC v2.0 contains the following modifications and enhancements. The identification number listed in the parentheses (e.g., CR#274) refers to the specific change request (CR) requirement.

2.1 Designated Provider Specialty Management (BDP)

The following modifications apply to the BDP application:

- **Do Not Display Flag:** Added functionality to allow the site to flag a provider category to not be displayed in the Demographic component of the health summary. This was accomplished by adding a new field to the BDP DESG SPEC PROV CATEGORY file called “DISPLAY ON HEALTH SUMMARY?.” The option called Add Local Provider Categories was renamed Add/Edit Provider Categories and this field was added to the list of data elements to update. (CR#295)
- **New Specialty Categories:** Added 3 new categories: HIV Case Manager, HIV Provider, and Public Health Nurse. (CR#274 and CR#102)
- **Populate New Specialty Categories:** Added a post-init action that copies the existing HIV Case Manager and HIV Provider from the HIV Management System to this package. (CR#274)

2.2 PCC Data Entry (APCD)

The following changes apply to the APCD application.

Family History Modifications

- Modified the FHX mnemonic to be a list manager-based interface that allows the user to add, edit, or delete Family History entries.(CR#216 and CR#320)
- Modified the entry of family history to stuff the ICD narrative if no provider narrative is entered. (CR #324)

2.2.1 Visit Re-Linker Log

Created a log to track all visits modified through the visit re-linker process. These visits have had 1 or more V File entries moved or ‘re-linked’ to another visit. A report will list all visits that were modified by the re-linker process, and options are provided to purge the log and to display a visit by its Internal Entry Number (IEN) to make review of the visits easier. This is a prospective change, meaning that only visits affected by the re-linker after the installation date of this version (v2.0) of the IHS PCC Suite will be logged and reported. (CR#013)

2.2.2 Visit Delete/Merge Log

Created a log to keep track of all deleted or merged visits. A report will list all deleted or merged visits, and an option to purge the log is provided. The visit delete option was modified to prompt for a reason for the visit deletion; this prompt is optional. This is a prospective change, meaning that only visits deleted or merged after the installation date of this version (v2.0) of the IHS PCC Suite will be logged and reported.

These options can be found on the following menu under the PCC Supervisor menu: (CR#239)

- VRLR List of Visits Modified by the Visit Re-Linker
- PVRL Purge Visit Re-linker Log
- PVDM List of Visits Deleted/Merged
- PUDM Purge Visit Delete/Merge Log
- VIEN Display a Visit by Visit IEN

2.2.3 3M Present on Admission

Added Present on Admission as a prompt in the 3M coder interface. (CR#254)

2.2.4 Personal History (PHX)

Added 2 new fields: Multiple Birth? and Multiple Birth Type to the PHX mnemonic. (CR#244)

2.2.5 Problem List Note Narrative Length

Expanded the Note Narrative to 160 characters. (CR#323)

2.2.6 Provider Narrative Length

All mnemonics that prompt for provider narrative will accept up to 160 characters for the provider narrative. This has been increased from 80 characters.

2.2.7 Patient Education (PED): Readiness to Learn

Added Readiness to Learn and resequenced the prompts according to the Education workgroup recommendations. (CR#242)

2.2.8 Asthma Control (ACON)

Added a new mnemonic, ACON, to update and record a patient's asthma control. (CR#240)

2.2.9 POV Stage

Disabled the stage prompt for asthma severity when an asthma diagnosis is entered; this function has been moved to the new Problem List Classification. (CR#278)

2.2.10 Problem List Classification Field

Added a new field in the BGP ASTHMA DXS taxonomy, Classification, to be prompted for when an asthma diagnosis is entered. Allowable values are 1, 2, 3, or 4, which stand for 1-Intermittent, 2-Mild Persistent, 3-Moderate Persistent, and 4-Severe Persistent. The following mnemonics were updated: PL, PO, and MP. (CR#207, CR#276)

2.2.11 Reproductive Factors Mnemonics

FP and RF mnemonics have been restructured to prompt for reproductive history with individual fields rather than a string.

2.3 PCC Health Summary (APCH)

The following changes apply to the APCH application.

2.3.1 Patient Wellness Handout Management

Created a new menu for managing patient wellness handouts (PWHs). The user can now select from 14 components to create a customized PWH.

Menu

- PWH - Generate a Patient Wellness Handout
- DEF - Update Default PWH for a Site
- AAP - Print Asthma Action Plan
- MPWT - Create/Modify Patient Wellness Type
- TPWH - Number of PWHs Given to Patients Report

The following PWH components are available:

ACTIVITY LEVEL
ALLERGIES
ASK ME THREE QUESTIONS
BLOOD PRESSURE
CANCER SCREENING
CHOLESTEROL
DIABETES CARE
HEIGHT/WEIGHT/BMI
HIV SCREENING
IMMUNIZATIONS DUE
IMMUNIZATIONS RECEIVED
MEDICATIONS
PATIENT GOALS
QUALITY OF CARE TRANSPARENCY REPORT CARD

- Two standard PWH types are distributed with this version:
- **Adult Regular:** contains all 14 components
- **Medication Reconciliation:** contains Medications and Allergies

A PWH log has been created. Each time a PWH is generated, the log will record the patient to whom the handout was given, the date, the location, and the user who generated the handout. A report has been developed to tally PWH production.

The default wellness handout to be used at a site can be defined by updating that field in the PCC Master control file using option DEF Update Default PWH for a Site.

2.3.2 Health Summary Component (New) for Tallying Patient Wellness Handouts

Created a new component to list the PWHs given to a patient.

2.3.3 Health Summary Component (New) for Patient Wellness Handout

Created a component to display the full PWH for a patient.

2.3.4 Health Summary Component (New) for Meds - Controlled Substances

Created a component to list all prescriptions for controlled substances.

2.3.5 Health Summary Component Modification: Lab

Added the date and time of lab results to both the LAB DATA - MOST RECENT BY DATE and the LABORATORY DATA - MOST RECENT components. (CR#171)

2.3.6 Health Summary Component Modification: Medication

Modified the text “on hold” to “active but not yet dispensed.”

2.3.7 Health Summary Component Modification: Family History

Modified the format to sort by the new Relationship field and display the new fields, and renamed the component to FAMILY HEALTH HISTORY. The component now displays the following fields: Relationship (to patient), Relation Description, Status (e.g., Living, Deceased, etc.), Diagnosis, Age at Onset; Multiple Birth (Y/N), and Type (e.g., Twin, etc.). If Status is “deceased,” Age at Death and Cause of Death are displayed. (CR#225, CR#325)

2.3.8 Health Summary Component Modification: Reproductive Factors

The previous Reproductive Factors (REPFAC) string display (G#P#LC#SA#TA#) has been changed to the following string, which is a concatenation of the new Reproductive History Component fields with each field separated by a semicolon. The entire string will be displayed for any patient who has *at least one value* in any of the Component fields.

Total # of Pregnancies #; Full Term #; Premature #; Abortions, Induced #; Abortions, Spontaneous #; Ectopic Pregnancies #; Multiple Births #; Living Children #

2.3.9 Reminder (New): Osteoporosis Screening

Added a reminder for osteoporosis screening in women ages 65 and older; the logic is consistent with the Clinical Reporting System (CRS) performance measure. The screening is due every two years. The reminder is turned off in the default package; to see this reminder on a health summary, a site must activate the reminder and attach it to the summary types. (CR#237)

2.3.10 Reminder (New): Assessment of Function

Added a reminder for assessment of function as an annual screening for patients 65 and older. Assessment of function includes assessing ability for toileting, bathing, shopping, etc. This data is captured in PCC using the EL mnemonic and it populates the V Elder file. The reminder is turned off in the default package; to see this reminder on a health summary, a site must activate the reminder and attach it to the summary types. (CR#188)

2.3.11 Reminder Modification: Pap and Mammogram Reminders

Modified the Pap and Mammogram health maintenance reminders to use the next due date in Women’s Health only if it is more current than the due date in Health Summary reminders. (CR#257)

2.3.12 Reminder Modification: Alcohol Screening

Added a check for Current Procedural Terminology (CPT) codes using the BGP ALCOHOL SCREENING CPTS taxonomy (99408, 99409, G0396, G0397, and H0049) in both PCC and the Behavioral Health module, making the reminder more consistent with the CRS performance measure. (CR#109)

2.3.13 Reminder Modification: Adult MMR 2-DOSE Version

Fixed this reminder to look for CPT codes, diagnosis codes, and procedure codes for the measles, mumps, and rubella (MMR) vaccines. (CR#109)

2.3.14 Reminder Modification: Diabetes Screening

Changed category to “General”. (CR#109)

2.3.15 Reminder Modification: Colorectal Scope/XRAY

Modified logic to reference BGP COLO PROCS and BGP SIG PROCS taxonomies, rather than individual procedure codes. (CR#109)

2.3.16 Asthma Action Plan (New Report)

Added the asthma action plan from the asthma register system to the health summary. This menu option can be found under the new PATIENT WELLNESS HANDOUT menu. The action plan has been redesigned according to the Asthma Workgroup specifications and includes new fields added in this PCC version as well as the previous version. (CR#281)

2.3.17 Problem List Display

Added classification to the problem list display if it is entered. (CR#277)

2.3.18 Supplement Modifications: Asthma

Redesigned the asthma supplement according to the Asthma Workgroup specifications and included new fields added in this PCC version as well as the previous version. (CR#289)

2.3.19 Reminders and Best Practice Prompts Text Modifications

Updated the description, logic, display text, and tooltips for all reminders and Best Practice prompts.

2.3.20 Best Practice Prompts Modifications

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

- ASTHMA: ACTION PLAN
- ASTHMA: ADD/INCREASE INHALED STEROIDS
- ASTHMA: CONTROL CLASSIFICATION
- ASTHMA: FLU SHOT
- ASTHMA: INCREASED RISK FOR EXACERBATION
- ASTHMA: PRIMARY CARE PROVIDER
- ASTHMA: SEVERITY CLASSIFICATION

2.4 PCC Management Reports (APCL)

The following changes apply to the APCL application.

2.4.1 Activity Reports

Modified certain reports to prompt the user for two additional filters, Location of encounter and Clinic, which limit the report to a selected set of locations or clinics. The following reports, listed by discipline group, were updated: (CR#205)

- 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
- TSCR Time and Services by Provider for Chart Reviews

2.4.2 DEMO PATIENTS Report Filter

All PCC Management reports have been updated to prompt users whether to include a site's Demo/Test patients in their reports.

To use this feature, the site's demo patient search template must be updated to include all of its Demo/Test patients. This option is locked with the security key APCLZ UPDATE DEMO TEMPLATE, which should be assigned to the user or users who manage this list of patients. Choosing the new option, DPST Update the Demo/Test Patient Search Template (under OTH Other PCC Management Reports/Options in the PCC Management Reports menu), adds the Demo/Test patients to the list.

The following prompt now appears when a management report is run:

```
Select one of the following:
      I      Include ALL Patients
      E      Exclude DEMO Patients
      O      Include ONLY DEMO Patients
Demo Patient Inclusion/Exclusion: E//
```

Choose E to exclude any patient who is on the Demo/Test patient list from the report. Choose I to include all patients, including the Demo/Test patients, or choose O to include only the Demo/Test patients. (CR#287)

2.4.3 PGEN/VGEN Menus

Updated to allow the user to select one of three menu display options for the Selection, Print, and Sort items: 1) in a predefined order (the original display option); 2) in alphabetical order by item title; or 3) in order by category group. (CR#251)

2.4.4 PGEN/VGEN

Added the new Select/Sort/Print options listed below:

- Date of Last Osteoporosis Screen: added as a PGEN Select, Sort, and Print item because it is a new health maintenance reminder. (CR#226)
- Readiness to Learn: removed as a Health Factor PGEN and VGEN Select, Sort, and Print item, because it is no longer a health factor. (CR#242)
- Upcoming Appointments: added as a PGEN Select and Print item and a VGEN Print and Sort item. When used as a Select item, the user can select the appointment date range and appointment clinics. The report will list only patients who have an appointment in one of those clinics during that date range, and the Print item will display only upcoming or pending appointments. Walk-in and chart requests are excluded from the pending appointment display in the Print item. (CR#126)

- Problem List Date of Onset: added as a PGEN and VGEN Select and Print item. If used as a Select item, the user must enter the beginning and ending date and may specify a particular set of diagnoses. When used as a Print item, the system will print all entries from the problem list with the date of onset, unless this item was also used as a Select item. In this case only the problem list entries matching the selected diagnoses will be printed. (CR#072)
- Family History-related: Family History Dx, Family Hx and Relation, Family History Relation, Family Hx Narrative and Family Hx Description (diagnosis, narrative, age at onset, relation) were all added as PGEN and VGEN Select and Print items. (CR# Child315)
- Present on Admission (POA): added as a VGEN Select and Print item. (CR#062)
- CPT Modifier: added as a VGEN Select and Print item.

2.5 QMAN (AMQQ)

The following changes apply to the AMQQ application:

- Added DV as a synonym for IPV.
- Changed attribute text from PRIMARY PROVIDER to PRIMARY CARE PROVIDER
- Added upcoming appointments as a Print item when printing a list of patients in QMan.
- Corrected the diagnosis display for the IHS Prediabetes Register.
- Added Family History as a search option.
- Updated Health Factor selection to allow the user to enter a category to retrieve a list of its health factors.
- Added the ability to create a delimited output of the QMan results by having the output print to a screen, and then taking a screen capture of the delimited output.
- Added the ability to go directly to VGEN or PGEN's print output from QMan by creating a search template in QMan. When template creation is complete, the user is transferred to PGEN or VGEN.

2.6 General Database (AUPN)

- **V Asthma:** Added field .14 – Asthma Control. (CR#206)
- **V Lab:** Added field 1502 – FINDINGS to the V LAB file. This field will be populated by the Procedure Workflow Tracking System (BTPW) when the software is deployed. (CR#239)
- **V Patient Education:** Added Readiness to Learn as field 1102. (CR#242)

- **V Radiology:** Added field 1502 – FINDINGS to the V RADIOLOGY file. This field will be populated by the Procedure Workflow Tracking System (BTPW) when the software is deployed. (CR#239)
- **Personal History:** Added field .06 – MULTIPLE BIRTH? to the Personal History File. Patient Multiple Birth?: Yes/No/Unknown. (CR#244)
- **Personal History:** Added field .07 – MULTIPLE BIRTH TYPE to the Personal History file. Multiple Birth Type values: Twin, Unspecified (TU); Identical Twin (IT); Fraternal Twin (FT); Triplet (TR); Other Multiple (OTH). (CR#244)
- **Problem:** Expanded Note narrative to 160 characters. (CR#323)
- **Provider Narrative:** Expanded narrative to 160 characters. (CR#258)
- **FAMILY HISTORY FAMILY MEMBERS:** Created new file with the following fields (CR #199/CR #322):
 - .01 - RELATIONSHIP
 - .02 - PATIENT
 - .03 - RELATION DESCRIPTION
 - .04 - STATUS
 - .05 - AGE AT DEATH
 - .06 - CAUSE OF DEATH
 - .07 - MULTIPLE BIRTH?
 - .08 - MULTIPLE BIRTH TYPE
- **FAMILY HISTORY:** Modified the existing file (CR #199/CR #322):
 - Moved the Status field to the new FAMILY HISTORY FAMILY MEMBER file.
 - Added an asterisk (*) in front of the STATUS field to alert users that it will be going away.
 - Added field .09, which is a pointer to the Family History Family Member file.
 - Inactivated field .07 – Relationship.
 - Added new MULTIPLE BIRTH and MULTIPLE BIRTH TYPE fields. (CR#199)
 - Added CAUSE OF DEATH field, which is displayed if the STATUS field is DECEASED. (CR#199)
 - Added new AGE AT ONSET and AGE AT DEATH fields with the following choices:

In Infancy
Before age 20
At age 20-29
At age 30-39
At age 40-49
At age 50-59
60 and older
Age Unknown

- Inactivated the numeric Diagnosis Onset Age field.
- Changed field .01 to allow only ICD Diagnosis codes V16*; V17*; V18*; and V19*. (CR#245)
- REPRODUCTIVE FACTORS: Implemented requested changes to Reproductive Factors fields.
 - Added and/or activated the following new fields: Full Term (previous request); Premature Births (previous request for Preterm Births); Ectopic Pregnancies; Multiple Births.
 - Inactivated Parity and Abortions/Miscarriages/Ectopic Pregnancies fields.
- V Telehealth: Created new file with the following fields:
 - .01 - Primary Modality
 - .02 - Patient Name
 - .03 - Visit
 - .04 - Originating Date/Time
 - .0 - Service Date/Time
 - .06 - Secondary Modality
 - .07 - Case ID
 - .08 - Originating Provider
 - .09 - Requesting Provider
 - .11 - Service Delivery
 - .12 - Originating Visit
 - .13 - Status Field
 - .14 - Duration
 - 110 - Comments
 - 110 - Link To Case

2.6.1 Table Changes

- **PCC RELATIONSHIPS:** Created new table for Family History.
- **TELEHEALTH:** Created new tables for Modality and Service Category.
- **EXAM:** Inactivated the following exam codes: (CR#241)
 - 23 - Audiometric Screening
 - 08 - Heart Exam
 - 05 - Neck Exam
- **HEALTH FACTORS:** Modified the Health Factors file to display the category when a lookup is performed on the file, and to allow the user to type the category name to retrieve a list of health factors to choose from. (CR#255, CR#256, CR#217)

Changed the name of the following Health Factors: (CR#234)

OLD NAME	NEW NAME
ASTHMA TRIGGER-AIR POLLUTANTS	AIR POLLUTANTS
ASTHMA TRIGGER-ANIMAL	ANIMAL
ASTHMA TRIGGER-COCKROACHES	COCKROACHES
ASTHMA TRIGGER-DUST MITES	DUST MITES
ASTHMA TRIGGER-EXERCISE	EXERCISE
ASTHMA TRIGGER-MOLD	MOLD
ASTHMA TRIGGER-POLLEN	POLLEN
ASTHMA TRIGGER-TOBACCO SMOKE	TOBACCO SMOKE
BARRIERS TO LEARN-BLIND	BLIND
BARRIERS TO LEARN-DEAF	DEAF
BARRIERS TO LEARN-DOESN'T READ ENGLISH	DOESN'T READ ENGLISH
BARRIERS-FINE MOTOR SKILLS DEFICIT	FINE MOTOR SKILLS DEFICIT
BARRIERS TO LEARN-HARD OF HEARING	HARD OF HEARING
BARRIERS TO LEARNING-INTERPRETER NEEDED	INTERPRETER NEEDED
BARRIERS TO LEARNING-NO BARRIERS	NO BARRIERS
BARRIERS TO LEARNING-VALUES/BELIEFS	VALUES/BELIEFS
BARRIERS TO LEARN-VISUALLY IMPAIRED	VISUALLY IMPAIRED
SELF MONITORING BLOOD GLUCOSE-NO	NO
SELF MONITORING BLOOD GLUCOSE-REFUSED	REFUSED
SELF MONITORING BLOOD GLUCOSE-YES	YES
LEARNING PREFERENCE-DO/PRACTICE	DO/PRACTICE
LEARNING PREFERENCE-READ	READ
LEARNING PREFERENCE-SMALL GROUP	SMALL GROUP
LEARNING PREFERENCE-TALK	TALK
LEARNING PREFERENCE-VIDEO	MEDIA

OLD NAME	NEW NAME
RUBELLA IMMUNE	IMMUNE
RUBELLA NON-IMMUNE	NON-IMMUNE
RUBELLA STATUS INDETERMINATE	STATUS INDETERMINATE
TB-TX COMPLETE	TX COMPLETE
TB-TX INCOMPLETE	TX INCOMPLETE
TB-TX UNKNOWN	TX UNKNOWN
TB-TX UNTREATED	TX UNTREATED

Added the following Health Factors: (CR#234)

FACTOR	CATEGORY
CHANGE IN WEATHER	ASTHMA TRIGGERS
MENSES	ASTHMA TRIGGERS
OTHER TRIGGER	ASTHMA TRIGGERS
STRONG EMOTIONAL EXPRESSION	ASTHMA TRIGGERS
VIRAL INFECTION	ASTHMA TRIGGERS
LESS THAN 6 TH GRADE EDUCATION	ASTHMA TRIGGERS
RETIRED	OCCUPATION
TX IN PROGRESS	TB STATUS

Inactivated the following Health Factors: (CR#234)

FACTOR
BARRIERS TO LEARN-COGNITIVE IMPAIRMENT
DOES NOT SPEAK ENGLISH
EMOTIONAL IMPAIRMENT
BARRIERS-SIGN INTERPRETER NEEDED
READINESS TO LEARN-NOT READY
READINESS TO LEARN-PAIN
READINESS TO LEARN-RECEPTIVE
READINESS TO LEARN-SEVERITY OF ILLNESS
READINESS TO LEARN-UNRECEPTIVE
7-FOOD AND EXERCISE (MAINTAIN)

2.7 Other Changes

2.7.1 Asthma Severity Conversion

Used a conversion to move asthma severity from the V POV file to the Problem List. (CR#207)

2.7.2 Taxonomies

The following national taxonomies were added for use with the Asthma Supplement, Action Plan, and Best Practice Prompts:

- BAT ASTHMA SHRT ACT RELV NDC (reliever)
- BAT ASTHMA SHRT ACT RELV MEDS (reliever)
- BAT ASTHMA SHRT ACT INHLR NDC (reliever)
- BAT ASTHMA SHRT ACT INHLR MEDS (reliever)
- BAT ASTHMA LEUKOTRIENE NDC (controller)
- BAT ASTHMA LEUKOTRIENE MEDS (controller)
- BAT ASTHMA CONTROLLER NDC (controller)
- BAT ASTHMA INHLD STEROIDS NDC (controller)

2.7.3 New APIs for the VA Reminders

Added APIs for the VA Reminders package to retrieve the last of each item. (CR#172)

Each call is in the following format:

S X=\$\$linelabel^APCLAPIR(dfn, beginning date, ending date)

where

dfn = Patient DFN

beginning date = internal fileman date to begin searching for the item; if blank, DOB will be used.

ending date = internal fileman date to end searching for the item; if blank, DT (today's date) will be used.

The output of each call is in the following format:

1 or 0^date^item^value^visit ien^file^file ien

where

piece 1 = 1 if item found, 0 if no item found in the date range

piece 2 = date of last item found

piece 3 = text of item found

piece 4 = result

piece 5 = ien of visit on which item was found

piece 6 = file in which item was found (usually a V File #)

piece 7 = ien of V File in which entry was found

The following APIs have been added:

Alcohol Screening	\$\$REMALSC^APCLAPIR
Depression Screening	\$\$REMDEPS^APCLAPIR
Assessment of Function	\$\$REMAOF^APCLAPIR
Blood Pressure	\$\$REMBP^APCLAPIR
Breast Exam	\$\$REMBRST^APCLAPIR
Cholesterol	\$\$REMCHOL^APCLAPIR
Dental Exam	\$\$REMDENT^APCLAPIR
Diabetes Screening	\$\$REMGLUC^APCLAPIR
Intimate Partner Violence Screening	\$\$REMIPVS^APCLAPIR
EPSDT Screening	\$\$REMEPSDT^APCLAPIR
Head Circumference	\$\$REMHC^APCLAPIR
Hearing Exam	\$\$REMHEAR^APCLAPIR
Height	\$\$REMHT^APCLAPIR
Influenza Immunization	\$\$REMFLU^APCLAPIR
Mammogram	\$\$REMMAMM^APCLAPIR
Osteoporosis Screening	\$\$REMOSTEO^APCLAPIR
Pap Smear	\$\$REMPAP^APCLAPIR
Pelvic Exam	\$\$REMPEVL^APCLAPIR
Physical Exam	\$\$REMPHYS^APCLAPIR
Pneumovax	\$\$REMPNEU^APCLAPIR
Rectal Exam	\$\$REMRECT^APCLAPIR
Rubella	\$\$REMRUBEL^APCLAPIR
TD	\$\$REMTD^APCLAPIR
Tobacco Screening	\$\$REMTOBS^APCLAPIR
Tonometry	\$\$REMTON^APCLAPIR
Visual Acuity Exam	\$\$REMVAE^APCLAPIR
Weight	\$\$REMWT^APCLAPIR

2.7.4 Family History Data Conversion

Added a post-init routine to perform the following tasks: (CR#199 and CR#321)

- Convert the relationship and status data from the Family History file and move it to the new Family History Family Member file.
- Stuff a family member of UNKNOWN into the Family member field for all entries that currently have no Relation/Family member entered.
- Convert the existing numeric diagnosis onset age (if any) to the corresponding new Age of Onset codes.

2.7.5 Reproductive History String Conversion

Converted the existing Reproductive History field to new fields. If the existing Reproductive History field is populated with a number, including the “0” option, any existing values in the string are copied to new fields as follows:

G = Gravida
P = Full Term
LC = Living Children
SA = Spontaneous Abortions
TA = Therapeutic Abortions

3.0 System Navigation

The accurate and timely entry of the information, upon receipt from Medical Records, is the responsibility of the PCC data entry operator. The PCC Data Entry Operator's Manual is the first of two manuals designed to help the operator carry out these tasks.

The second, the PCC Data Entry Mnemonics Manual, displays all the PCC data entry mnemonics step-by-step and includes all operator help prompts. A detailed explanation of each mnemonic is provided.

The PCC Data Entry Operator's Manual provides an example of each data entry option and displays the actual sequence of system and operator responses all placed inside a special screen. Operator keyboard entries and responses are shown using a special font, like type YES. Some help prompts have been included and display as special text that can be bypassed, as they are not necessary for data entry. Warning messages that may be encountered will be displayed by a single bold line around the message. This *does not* indicate that the warning message will occur at that point in the operation, only that it *can* occur.

Help screens are available that serve as a brief reference to the operations, functions, or actions and can be used during execution of an option rather than referring back to this manual. Copies of these Help Screens are not included as a part of the manual. A Help Screen can be obtained by typing a question mark (?) followed by the option mnemonic or name, e.g., ?ENT and press ENTER to select the Enter Data help prompt. Help screens for a particular prompt can be obtained by typing ?? at the prompt; if any help is available, the system will display the information.

4.0 Data Entry Overview

The Data Entry Module (DEM) facilitates entry of information about a patient from a variety of forms into the PCC. The most commonly used form is the PCC Ambulatory Encounter Record, IHS-803.

Health information is collected for each patient visit at an IHS, 638, or tribal clinic or hospital and typed into the PCC. This can be expanded to include visits at contract facilities, by IHS field health personnel such as Community Health Nurses, Mental Health and Social Workers, and tribal healthcare program workers.

4.1 Data

The data entry system consists of the following features:

- Online help screens
- Online help prompts
- Online entry to multiple PCC dictionaries (e.g., Visit, Provider, Purpose of Visit (POV), Measurement, etc.)
- Online editing and visual verification of data entered
- Computer-assisted ICD-9 diagnostic and procedural coding

4.2 Form Requirements

Each form requires the following information before it can be processed:

- Date and Time of Encounter

Examples of Valid Dates:

JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057

T (Today), T+1 (Tomorrow), T+2, T+7

T-1 (Yesterday), T-3W (3 Weeks Ago)

If the year is omitted, the computer assumes a date in the PAST.

You may omit the precise day, as: JAN, 1957.

- Location of Visit (clinic/hospital, office, home, etc.)
- Clinic type (required only for clinic visits)
- Service Category

- A purpose of visit/diagnosis
- Identification and signature of the **primary** care provider.
- Patient identification (such as name, facility health record number, date of birth (DOB), and sex)

Identify the patient in one of the following ways:

- Enter the patient's name or a portion of the name in the following format:
Horsechief,John Doe or Horsechief,John. Use the following guidelines:
 - Use from 3 to 30 letters
 - A comma must follow the last name
 - If 'JR' or 'II', etc, is included, follow the form Smith,John Mark,Jr.
 - No spaces after commas.
- Enter the patient's IHS Chart Number
- Enter the patient's DOB in one of the following forms:
B012266 or any valid date e.g. 01/22/66, 01-22-66, JAN 22,1966
- Enter the patient's Social Security Number (SSN) or the last four digits of the SSN
- If the patient is an inpatient, type the ward or room-bed in the form:
66-2 PEDIATRICS

In addition, a patient must exist in the PCC database before any medical data can be entered for that patient. Patients are entered into the IHS Registration System at the patient's first encounter at the clinic or hospital.

5.0 ICD-9 Coding Guidelines and Requirements for PCC Visit

5.1 Use of Both Alphabetic Index and Tabular List

Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specific code selection.

Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

5.2 Level of Specificity in Coding

Diagnostic and procedure codes are used at their highest level of specificity.

- Assign three-digit codes only if there are no four-digit codes within that code category.
- Assign four-digit codes only if there is no fifth-digit subclassification for that category.
- Assign the fifth-digit subclassification code for those categories where it exists.

5.3 Other (NEC) and Unspecified (NOS) Code Titles

Codes labeled “other specified” (NEC – not elsewhere classified) or “unspecified” (NOS – not otherwise specified) are used only when neither the diagnostic statement nor a thorough review of the medical record provides adequate information to permit assignment of a more specific code.

- Use the code assignment for “other” or NEC when the information specifies a condition, but no separate code for that condition is provided.
- Use “unspecified” (NOS) when the information does not permit either a more specific or “other” code assignment.

When the Alphabetic Index assigns a code to a category labeled “other (NEC)” or to a category labeled “unspecified (NOS),” refer to the Tabular List and review the titles and inclusion terms in the subdivisions under that particular three-digit category (or subdivision under the four-digit code) to determine if the information can be appropriately assigned to a more specific code.

5.4 Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

5.5 Combination Code

A single code used to classify two diagnoses, or a diagnosis with an associated secondary process (manifestation), or an associated complication is called a combination code. Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when the code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code may be used as a secondary code.

5.6 Multiple Coding of Diagnoses

Multiple coding is required for certain conditions not subject to the rules for combination codes.

Instructions for conditions that require multiple coding appear in the Alphabetic Index and the Tabular List.

- **Alphabetic Index:** Codes for both etiology and manifestation of a disease appear following the subentry term, with the second code italicized and in slanted brackets. Assign both codes in the same sequence as they appear in the Alphabetic Index.
- **Tabular List:** Instructional terms, such as “Code also...,” “Use additional code for any...,” and “Note...,” indicate when to use more than one code.

“Code also underlying disease” – Assign the codes for both the manifestation and underlying cause. The codes for manifestations that are printed in italics cannot be used (designated) as principal diagnosis.

“Use additional code, if desired, to identify manifestation , as ..” – Assign the code that identifies the manifestation, such as, but not limited to, the examples listed. The codes for manifestation that appear in italicized print cannot be used (designated) as principal diagnosis.

- Apply multiple coding instructions throughout the classification where appropriate, whether or not multiple coding directions appear in the Alphabetic Index or the Tabular List. Avoid indiscriminate multiple coding or irrelevant information, such as symptoms or signs characteristic of the diagnosis.

6.0 Data Entry Mnemonics

Mnemonics are used to facilitate entry of patient data into the PCC system. A mnemonic consists of two to three characters that represent a specific data type and speed entry by reducing the number of key strokes necessary to type patient health information.

Learn detailed information about each mnemonic in the “PCC Data Entry Mnemonics” manual, which is separate from this manual.

A complete list of the mnemonics can be viewed by typing **?** and pressing ENTER after the “Mnemonic” prompt. The system will respond with the question: “Do you want entire rpms pcc data entry control list?” A response of **Y** for Yes will quickly display all the data mnemonics. Alternately, typing **??** at the “Mnemonic” prompt will bypass the “Do you want ...” question and go directly to the list.

Note: If the system responds to a single question mark with a message like “Do you want the entire V list?”, answer **No** or you will receive a list of all entries that have ever been added to that visit related file (V File) on your system and cause the system to slow down considerably.

```

MNEMONIC: EX           Examinations ALLOWED           VISIT RELATED ONLY
Enter EXAM Type: ?
Answer with V EXAM
Do you want the entire V EXAM List? N (No)
Answer with EXAM NAME Do you want the entire EXAM List? Y
Choose from:
  ALCOHOL SCREENING           35
  AUDIOMETRIC SCREENING       23
  DENTAL EXAM                 30
  DEPRESSION SCREENING        36
  DIABETIC EYE EXAM           03
  DIABETIC FOOT EXAM, COMPLETE 28

```

Figure 6-1: Viewing mnemonics

For the “Do you want the entire V EXAM List?” prompt, answer **No** to a V question like this or you will receive a list of every exam that has ever been entered on your system.

At the “Do you want the entire EXAM List?” prompt, you will see the list of acceptable choices for this mnemonic.

7.0 Overview of Menu Options

The Data Entry Module is menu controlled. There are six items in the primary menu. Three of the items shown are submenus, as indicated by the ellipsis (...) following the menu text. A display of the primary menu and a brief description of the six items follows.

```

*****
**   PCC Data Entry Module   **
*****
          IHS PCC Version 2.0

          DEMO HOSPITAL

ENT   Enter/Modify/Append PCC Data ...
DSP   Display Data for a Specific Patient Visit
PEF   Print a PCC Visit in Encounter Form format
UPD   Update Patient Related/Non Visit Data ...
DEU   Data Entry Utilities ...
VIEN  Display a Visit by Visit IEN
BHS   Browse Health Summary
DVB   Display a PCC Visit w/limited Lab Display
GHS   Generate Health Summary
PDV   Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option:

```

Figure 7-1: Primary data entry module menu

7.1 Enter/Modify/Append PCC Data (ENT)

The ENT option contains a submenu of all options necessary to create and modify PCC visit data. Each of the ENT options are described in detail in the “Main Data Menu: ENT” section of this manual.

7.2 Display Data for a Specific Patient Visit (DSP)

Use the DSP option to display all visit-related data for a specific date that has been included for a patient. DSP can be used for a number of reasons including:

- To verify data before appending (adding) to a visit
- To review data after modifying (changing) data
- To assist in determining whether to merge (combine) two or more visits into one

The visit information will automatically display on the terminal using the full screen display with browser. The operator can scroll through the visit by pressing ENTER to accept default, by typing plus (+) to move forward, or by typing minus (-) to move backward. In addition, typing the code ?? will produce a list of all actions that can be selected by the user.

7.3 Print a PCC Visit in Encounter Form format (PEF)

Use the PEF option to print a PCC visit in an Encounter Form format.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
PCC ENCOUNTER RECORD
*** Computed Generated Encounter Record ***

*****

Visit Date/Time: Feb 14, 2008@08:00 Primary Provider:
Clinic: Not Specified AMBULATORY
Location: DEMO HOSPITAL
*****
Procedure: 47.01 Procedure Date:
Feb 14, 2008
Provider Narrative: APPENDICITIS
-----
HR#: 000000 SSN: 000000000
NAME: SMITH, JANE SEX: FEMALE
DOB: JAN 01, 1999 TRIBE: DEMO
RESIDENCE: SPRINGFIELD
FACILITY: DEMO HOSPITAL

PROVIDER SIGNATURE:

```

Figure 7-2: Example of Encounter Form format

7.4 Update Patient Related/Non Visit Data (UPD)

The UPD option contains a submenu with all the options used to create and modify data that is patient related and does not generate a visit record.

7.5 Data Entry Utilities (DEU)

The DEU option contains a submenu of various utility options and the Supervisor menu.

7.6 Display a Visit by Visit IEN (VIEN)

Use the VIEN to display a visit by the IEN number.

7.7 Browse Health Summary (BHS)

Use the BHD option to view a Health Summary on the screen, but rather than merely printing it to the screen, the browser will let you scroll forward and backward to view specific parts of the Health Summary. In addition, the browser can search for specified text strings to allow jumping to desired parts of the Health Summary.

7.8 Generate Health Summary (GHS)

The GHS option is located here and in the Data Entry Utilities menu. Use it to display a health summary for specific patient(s) on the screen or printer.

7.9 Display a PCC Visit with a Limited Lab Display (DVB)

Use the DVB option to generate visit-related information for a specified date, with limited laboratory display.

7.10 Print a PCC Visit Display to a Printer (PDV)

Use the PDV option to view a PCC Visit file related to a specific visit.

8.0 Main Data Entry Menu (ENT)

Use the ENT option in the PCC data Entry Module menu to view a menu that contains all the options necessary to create or to modify a PCC visit, as well as to append information to an existing visit.

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:

```

Figure 8-1: Main menu for all data entry activities

Each of the options is described in detail below.

8.1 Data Entry Using Mnemonics (MIN)

Use the MIN option to type a new Ambulatory or Inpatient visit for a patient into the PCC System. The visit can be for Contract Health, Field Health, 638, or a Tribal Health encounter.

The operator is prompted to enter the following: 1) Location of Encounter, 2) Type of Visit, 3) Service Category, 4) Date of Visit, 5) Time of Visit, and 6) Patient Name or Health Record Number. The MIN option then automatically enters the appropriate mnemonics for the required data items only: CL (Clinic - Ambulatory visits only), IP (Inpatient - Hospitalizations only), PRV (Primary Provider), and PV (Purpose of Visit). TM (Time) is included if the visit was created by another module, e.g. Lab, Pharmacy, etc.

Once the required data items are entered, other visit-related health data such as measurements and examinations are added using the appropriate data mnemonics. The following mnemonics can be used in MIN that allow the operator to make changes to or delete problem-related data without exiting the MIN option, e.g., MPO, MNN, RPO, RNO. The MOD mnemonic can be used to correct or delete *any* data item while in the MINI option.

Every Ambulatory visit created in PCC through this menu option requires a Clinic Code, Primary Provider, and POV, except when typing data with a Service Category of Event. Every visit, when created, is automatically assigned a Date Visit Created (Posting Date) of today's date. The Date Last Modified (Posting Date) is used by the system when transmitting PCC data to the APC system in Albuquerque. The data entry supervisor could use these dates for monitoring timeliness of data entry. The Date Last Modified changes to the current when a visit is modified.

Inpatient visits can be a Contract Health or IHS encounter. The IP mnemonic is then automatically entered, requesting the following: Date of Discharge, Admission Type, Admission Code, Admitting Service, Discharge Service, Discharge Type, Number of Consults, and Admitting DX. Other visit-related health data, such as provider, diagnosis, measurements, examinations, etc., are typed using the appropriate data mnemonics. The MOD mnemonic can be used to change or delete any data item typed in error.

8.2 Enter Data (ENT)

Use the ENT option to type a new Ambulatory or Inpatient visit for a patient into the PCC System. However, this option *does not* automatically prompt for all required data items, except IP on hospitalization visits. The MIN and ENT option can be used interchangeably, depending on the preference of the operator.

A hospitalization visit created in PCC through the ENT menu option requires the Inpatient data, Primary Provider, and POV, except when typing data with a Service Category of Event. Like the Mini option above, a Date Visit Created and a Date Last Modified (Posting Date) is automatically assigned to every visit created using today's date.

8.3 Modify Data (MOD)

The MOD option allows you to modify, correct, or delete data that has already been typed into the PCC. It is used to correct data that was typed in error, modify data that might have been incomplete at the time of entry, or delete a specific data item.

This option can be used to change the status of existing problems and notes (e.g., Active, Inactive, or Remove), as well as the narrative for a problem already displayed in the Problem List. As mentioned above, the mnemonics PL, MPO, RPO, MNN, and RNO can be used in the MINI or ENT options to modify problem-related data. Additionally, the MOD mnemonic can be used to change or delete *any* data item while in the MINI or ENT menu options.

If a visit is modified and has not been transmitted to the IHS Data Center, the transmission flag is reset automatically to the date modified. This visit will be included in a subsequent transmission. When modifying data for a visit that has been transmitted, the system *will not reset* the transmission flag. The data entry supervisor must manually reset the transmission flag from the supervisor's menu so that the visit will be included in a subsequent transmission. If the information has already been posted in the IHS Statistical System at the Data Center, errors will not be corrected, although the local computer will contain the corrected data. This is the only means of correcting errors typed into PCC.

8.4 Append Data to an Existing Visit Record (APP)

Use the APP option to add information to an existing visit. It is commonly used when some information is not available at the time the visit was created in the PCC, when a provider wishes to add additional information to the patient's record concerning a specific visit, or when the operator mistyped one or more data items during the original processing of the form.

This option will automatically reset a transmission flag for a visit not previously transmitted to the IHS Data Center and be included in a subsequent transmission. If a visit must be resubmitted to the Data Center, the data entry supervisor must manually reset the transmission flag from the supervisor's menu.

8.5 Append Data Using Item List Display (APL)

Use the APL option to add information to an existing visit, and the List Manager provides for screen data entry instead of the traditional roll-and-scroll format used by the MIN and ENT data entry options. A detailed example of this option is given later in this manual.

8.6 Modify Visit Date And/Or Time (TIM)

Use the TIM option to correct visit date and/or time. TIM is most useful for correcting a batch of forms entered with the wrong visit date and/or time.

8.7 Enter Data with Visit Display And Actions (EAC)

The EAC option provides for data entry utilizing a full screen display and browser function. This allows you to view the visit and scroll forward and backward to see various parts of the visit. In addition, you can select from a list of actions that allow data entry without any knowledge of the data entry mnemonics.

8.8 Enter PCC Data Using Item List Display (MNE)

Like the EAC option, the MNE option allows entry of data without using mnemonics. It does not contain the visit display function found in the EAC option.

8.9 Group Preventive Form Entry (GRP)

The GRP option is designed to be used with the Group Preventive Services Record, Form IHS-367. The Preventive Services Record is most often used by field health personnel to record various surveillance procedures performed in a group setting, e.g. school, specialty clinic, etc. With the GRP menu option, one initial patient visit is entered establishing the Type, Service Category, Clinic Code, Primary Provider and POV for all patients listed on the form. Each time a patient name is typed, a new visit is created duplicating the initial visit setting, as listed above. The operator can type any varying information for a patient by using the appropriate mnemonic, e.g. immunizations, exam, etc. The option allows you to print the encounter visits entered.

8.10 Enter Historical Inpatient Visits (HIN)

Use the HIN option to type past data regarding patient hospitalizations that occurred at other facilities or that occurred at this facility before PCC was implemented. This data is *not* transmitted.

8.11 Tran Code (DTC) Entry for All Visits (DTC)

Use the DTC option to associate Chargemaster Transaction Codes with diagnostic procedures. The codes are usually recorded on special-purpose billing forms such as a Superbill. A Chargemaster Transaction File must be loaded at your site to make use of this option.

8.12 Enter Trans Codes on In-Hospital Visits (TCH)

Use the TCH option to associate Chargemaster Transaction Codes with an In-Hospital visit. A Chargemaster Transaction File must be loaded at your site to make use of this option.

8.13 Enter Trans Codes on Outpatient Visits (TCO)

Use the TCO menu option to associate Chargemaster Transaction Codes an Outpatient visit. A Chargemaster Transaction File must be loaded at your facility to make use of this option.

8.14 Update Diabetes Patient Data (DMU)

Use the DMU option to update a patient's file with diabetes-related information, including: date of DM onset, height and weight, blood pressure (BP), health factors, foot exam date and result, eye exam date and result, depression screening date and result, dental exam date, pap smear date, mammogram date and type, EKG date and result, immunizations, PPD date and reading, patient education, labs, and medications.

8.15 Entry of Data for a Cohort of Patients (EC)

Use the EC option to select data items to be entered in a PCC Visit for specific patients.

8.16 Display a Count of Forms You Have Processed (MFC)

Use the MFC option to display a count of forms you have processed. You can organize the list by clinic type, service category, visit type, or simply list all of these.

8.17 Enter/Edit Suicide Forms (SF)

The SF option contains a submenu that allows you to review suicide reporting forms by date or to update a suicide reporting form for a patient.

8.18 EHR/PCC Coding Audit Menu (EHRC)

The EHRC option contains a submenu that presents several options, as shown below.

EHRD	EHR/PCC Coding Audit for Visits in Date Range
PEHR	EHR/PCC Coding Audit for One Patient
ACDR	Add new Chart Deficiency Reason to Table
TUR	Count Unreviewed Visits by Date/Service Category
ACRX	Auto-Complete Pharmacy Education Only Visits
CASP	Update EHR Coding Audit Site Parameters
INCV	List Visits Marked as Incomplete
LIR	List Unreviewed/Incomplete Visits
TRV	Tally of Reviewed/Completed Visits by Operator

Figure 8-2: EHRC menu options

8.19 Enter Data from Log (lab/rad/cpt/apc) (LOG)

Use the LOG option to type data from forms other than the traditional PCC encounter forms. Examples of this form of data entry include logged items from the Laboratory or X-ray departments, entry of CPT codes from a Superbill, and finally, entry of PCC data from APC forms at sites that have not implemented PCC.

9.0 Preparation and Flow of Forms

9.1 Type of Forms

Data is typed into PCC from a variety of forms. The forms most commonly processed are listed below.

- PCC AMBULATORY ENCOUNTER RECORD: IHS-803
- EMERGENCY VISIT RECORD: IHS-114
- PCC BRIEF VISIT RECORD: IHS-464
- PCC MULTI-VISIT ENCOUNTER RECORD: IHS-372
- CLINICAL RECORD BRIEF - IHS INPATIENT SERVICES: IHS-44-1
- PCC INPATIENT SUPPLEMENT & DISCHARGE FOLLOW-UP RECORD: IHS-485
- PCC GROUP PREVENTIVE SERVICES: IHS-367
- PCC ADULT HISTORY AND PHYSICAL EXAMINATION RECORD: IHS-465
- PUBLIC HEALTH NURSE PCC ENCOUNTER RECORD: IHS-802
- CONTRACT HEALTH SERVICE/HOSPITAL SERVICES RENDERED: IHS 431A (only if Contract Health Service [CHS] – PCC link is not activated)
- CONTRACT HEALTH SERVICE OTHER THAN HOSPITAL INPATIENT OR DENTAL: IHS 64-1A (only if CHS-PCC link is not activated)
- AMBULATORY PATIENT CARE REPORT: IHS 406 (minimal visit data, only if PCC has not been implemented)

It is important to capture information from a wide variety of sources if the PCC database is to be complete and accurate. Therefore, clinically relevant data should be typed from non-PCC forms, such as consultation reports, referral documents, discharge summaries, etc., as determined to be appropriate by the PCC facility's policies. In addition, community-based services provided by disciplines like Community Health Nurses (CHNs) should be typed in PCC. If the facility is not utilizing the CHR data entry program, clinically relevant CHR services should also be entered.

All the RPMS PCC forms are discussed in detail in the PCC Forms Manual. The relevance and importance of PCC data to healthcare providers is discussed in detail in the PCC Health Summary Manual. Data entry operators *must* become familiar with these forms and the information contained in these manuals.

9.2 Preparing Forms for Data Entry

All forms must be screened for the following items prior to being entered. Because these items are required by PCC, any items missing can be detected early and corrected to expedite the processing time.

- Readability
- Date of encounter
- Location of visit (clinic/hospital, office, home, etc.)
- Clinic type (required on clinic visits only)
- Primary provider identification and signature
- POV/diagnosis
- Patient identification (name, facility, health record number, sex, and date of birth)

All forms should be sorted into batches by location of visit, type, and, within type, by service category. This will expedite and simplify the entry of data into PCC.

Outpatient forms should be checked for completeness, batched by medical record encounter date, and submitted the day following the visit to the PCC data entry staff.

Inpatient forms should be submitted, upon completion by the provider, by medical records to the PCC data entry staff. If the Service Unit (SU) elects to use the Inpatient Supplement and Discharge Follow-Up Record, this form *must* be submitted with the Inpatient Clinical Record Brief.

All other forms submitted by CHS IHS field health personnel, such as CHNs, Mental Health, Social Workers, and Tribal Health Programs should be sorted and batched by location of encounter before submission to PCC data entry. However, this process can be done by the data entry staff.

All forms should be submitted in a timely manner for PCC data entry.

9.3 Pharmacy Recording and Entry Guidelines for PCC Forms

9.3.1 Using the Pharmacy Module

For a “pharmacy only” visit, a PCC encounter should be initiated by the Medical Records Department or the pharmacy staff if the patient appears for service without a medical record in hand. The time of arrival entered on the form corresponds to the time the patient appeared at the sign-in desk or the pharmacy seeking service. The time entered on the encounter form is the time that must be typed into the RPMS Pharmacy Module at the “Time” prompt to ensure proper linkage of medications to the visit data in PCC. The PCC data entry operator will append (add) medical data to this already-created pharmacy visit using the Mini, Enter or Append menu options, depending on the preference of the operator.

When prompted by the Pharmacy Module for Time, the pharmacy staff must type the time recorded on the encounter form in the Time Of Arrival field. This will properly link the pharmacy and outpatient clinic data in the PCC during data entry.

PCC forms should be initiated by medical records or pharmacy staff, as described above, for each visit to the pharmacy considered a separate event. The time entry in the Pharmacy Module must be the same as the time of arrival on the encounter form in which the dispensed medication is recorded. For example, if a patient sees a physician and pharmacist as part of one visit, and then returns later in the day for an over the counter (OTC) medication, the following would occur. The pharmacist types the time into the Pharmacy Module exactly as it appears on the encounter form initiated in the clinic for the first visit. When the patient returns for the OTC medication, a second form is initiated and the time of arrival from that form is entered into the Pharmacy Module.

9.3.2 Using the Dental Module

When a patient is seen in a Dental Clinic that uses the RPMS Dental Module, the dental staff creates a PCC Visit in the Dental Module. Each visit created in the PCC by the Dental Module is a complete entity containing Clinic code of 56, Provider, POV, and Dental Service Codes.

Under normal circumstances, no form is sent to the PCC data entry staff and no further action is required. These dental visits will export to the IHS Dental Statistical System and are not APC visits, unless a dental visit results in the dentist prescribing a medication. This constitutes an APC visit. As such, an encounter form must be generated by the dentist or the pharmacist who dispenses the medication. Whoever generates the form records a time of arrival, which approximates when the patient sought service at the station initiating the form. When the dispensing of the medication is typed into the Pharmacy Module by the pharmacy staff, the time on the encounter form is typed into the Pharmacy Module at the “Time” prompt. This will create a second visit in PCC that is not linked to the original dental visit. The PCC data entry operator should merge these two visits together. Whether or not the visits are merged, the PCC export process will generate only one APC visit for transmission to the Data Center.

When a patient has a dental clinic visit *and* an outpatient clinic visit that results in medication, *two* visits are generated in the PCC and should *not* be merged together. The data entry operator sees both visits: one dental visit and one pharmacy visit. When the operator detects that the medication on the encounter form is the one attached to the pharmacy-created visit, the operator selects the pharmacy visit and adds the remaining medical data (diagnoses, measurement, etc.) to the existing pharmacy visit. Only one APC visit is generated in this instance, whether or not the dental and outpatient visits were merged. The key regarding dental and APC statistical records is that dental statistical records are not generated from the PCC but from the Dental Package itself, and APC visits for dental services are generated by the PCC only when medication is dispensed.

10.0 Data Entry Using Mnemonics (MIN)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT   Enter Data
MOD   Modify Data
APP   Append Data To An Existing Visit Record
APL   Append Data using Item List Display
TIM   Modify Visit Date and/or Time
EAC   Enter Data with Visit Display and Actions
MNE   Enter PCC Data Using Item List Display
GRP   Group Preventive Form Entry
HIN   Enter Historical INPATIENT Visits
DTC   Tran Code (DTC) Entry for All Visits
TCH   Enter Trans Codes on IN-Hospital Visits
TCO   Enter Trans Codes on Outpatient Visits
DMU   Update Diabetes Patient Data
EC    Entry of Data for a Cohort of Patients
MFC   Display a Count of Forms you have Processed
SF    Enter/Edit Suicide Forms ...
EHRC  EHR/PCC Coding Audit Menu ...
LOG   Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: MIN Data Entry Using
Mnemonics

```

Figure 10-1: Selecting MIN option from main data entry menu

Ambulatory encounter forms are typed into the PCC system using MIN upon receipt by the data entry staff. The example used throughout this section corresponds to the sample Ambulatory form in Appendix F of this manual.

The following prompts appear for entry: (1) “Location of Encounter,” (2) “Type of Visit,” (3) “Service Category,” (4) “Date of Visit,” (5) “Time of Visit,” and (6) “Patient Name or Health Record Number.” Once typed, these data items will create a Visit File. MIN will then automatically prompt the operator to type the required data items: CL (clinic), PRV (primary provider), and PV (purpose of visit). If the visit being entered was created by another module, e.g. Pharmacy, Lab, Dental, etc., TM (time) also automatically appears so that the operator can correct the encounter time, if necessary, to that indicated in the upper left corner of the form. TM will not appear if the visit is initially created at the time of data entry. Once the mandatory data items have been typed, the “Mnemonic” prompt appears so the operator can select the appropriate data mnemonic to type the remaining recorded medical information on the form.

MIN is used for data entry of all ambulatory visits in an IHS or tribal health facility. This includes: field and contract health, chart reviews, telecommunications, and “not found.” Forms containing the terms Did Not Answer (DNA) or Left Without Being Seen will also be processed into PCC if the patient signed up for service, but left prior to being seen by the primary provider. When these forms are entered, the ICD-9 code is .0860 and the provider’s narrative is indicated on the form. Visit data is not typed into PCC when patients do not keep appointments (DNKAs), whether or not this is noted on a PCC form and filed in the patient’s medical record. If this represents a chronic problem on the part of the patient, it should be typed into the computer during a routine visit or through chart review, as a note in the PCC Problem List. The RPMS Clinic Scheduling System provides the capability to capture this information.

The following data items are required to process forms into the PCC system:

- Patient ID
- Date, Time, Location of Visit
- Clinic Type
- Primary Provider
- Primary POV

In addition, the following data items will be typed if recorded properly on the form:

- Secondary Provider(s)
- Measurements: Height, Weight, Blood Pressure, Head Circumference, and Vision
- Laboratory Tests Ordered (only if Laboratory Module is not operational)
- Secondary POVs
- Procedures
- Examinations Performed
- Immunizations Administered

- Skin Test Readings/Results
- Problems and/or Notes
- Cause and Place of Injury on First Visits
- Reproductive Factors
- Personal or Family History
- History of Immunization, Skin Test Readings, and Procedures

The following data items are optional and are typed at the facility's discretion:

- Other Measurements - Abdominal Girth, Fundal Height, Fetal Heart Tones
- Pulse and Temperature
- Patient Education
- Treatments Provided
- Eyeglass Prescriptions
- Physical Therapy
- Health Factors
- Historical Events – Exams, Radiological Procedures
- CPT codes
- Waiting time data

Once the visit file is created, the required mnemonics CL, PRV, and PV are automatically entered by the MIN option, and the operator cannot exit from the patient visit until this data is typed.

10.1.1 Prompts for MIN

Follow these steps:

1. At the "Select Enter/Modify/Append PCC Data Option" prompt, type **MIN** and press ENTER.
2. You enter the Mini, ENTER mode of the PCC Data Entry Module (information displayed on the screen).

- At the “Select Location Name” prompt, you can accept the default by pressing ENTER. The application display information about the location. Otherwise, specify the location name.

Use the abbreviation or name of the location where the visit took place for the batch of forms to be processed, e.g., Lame Deer Health Center, Santa Rosa Clinic, Sells Hospital, etc. The location of the visit can be found in the patient identification section of the Encounter Form. The abbreviation for the location must be identified in the Mnemonic field of the Location File before it can be used. If your location entry is not allowed, contact your site/PCC manager.

```
PCC Data Entry Module
*****
* Mini (APC) ENTER Mode *
*****
          Select LOCATION NAME: SX      SAN XAVIER HEALTH
          CENTER TUCSON SELLS TUCSON 11 TUCSON SELLS TUCSON 11
```

Figure 10-2: Typing name of location where visit occurred

- At the “Type” prompt, type the code specifying the type of visit to differentiate between various categories of visit type. For example, a visit provided by contract care funds versus a visit directing provided by IHS.
- At the “Service Category” prompt, press ENTER to accept the default. Otherwise, specify the code that defines the service category.

The Type and Service Category describe the location for the forms being processed.

Note: Ambulatory is the most common service at most locations. Data entry from various forms is handled in a similar manner.

- At the “Visit/Admit Date” prompt, specify the date.

If the same date is used to enter subsequent forms, and the location name, type, and service category are the same, press the SPACE BAR and ENTER keys at the “Visit/Admit Date” prompt. Once a date is typed, a new form can be processed.

- At the “Time of Visit” prompt, specify the time.

Time can be typed either in standard or military format. If no time is recorded, type **D** for the default time of 12:00 Noon, as noted in the help prompt below. Time is required for all forms and can be typed in any one of following formats:

STANDARD: 6 or 6A for 6 AM or 6P or 6PM for 6 PM

MILITARY: 0600 for 6AM or 1800 for 6 PM

If a visit time is designated between 6:00 PM – 11:59 PM on the form, you must type the time using a **P** for PM, or the system will assume AM. The system assumes AM from 12 midnight to 12 noon and PM from 12:01PM - 5:59PM.

If the patient has existing visits on that date, the system will display the following message:

```
PATIENT: SMITH,JANE has VISITS, same date, location.

1 Create New VISIT
2 Exit without selecting VISIT
3 Display one of the existing VISITS

Or select one of the following existing VISITS:

4 TIME: 08:00 TYPE: T CATEGORY: A CLINIC: <NONE> DEC: 5
Choose one: (1-4): 4//
```

Figure 10-3: System finding visit on same date

8. At the “Select Patient Name” prompt, specify the patient for the visit.

Enter the patient’s name or Health Record Number (HRN) from the Patient Identification section of the Ambulatory Encounter Form. Typing the HRN is faster, and therefore the preferred response.

9. At the “Clinic” prompt, specify the code for the clinic. This points to the Clinic Stop file. Your response should reflect the clinic in which this visit took place; for example Pediatrics, General, etc.
10. At the “Was this an appointment or walk in?” prompt, type **W** for walk in, **A** for appointment, or **U** for unspecified.
11. The system provides information about the providers for the visit.
12. At the “Enter Provider (code/initial or name)” prompt, specify the provider.
13. At the “Enter a Secondary Provider (code/initial or name)” prompt, specify the secondary provider, if any. If there is no secondary provider, press ENTER at this prompt.

Primary Provider is located in the top right box, last line; secondary providers will be designated in the first three lines. Once a primary provider is entered, subsequent entries are automatically assigned as secondary, and the operator no longer sees the “P)primary or S)econdary ?” prompt. Note that provider times may be typed, if appropriate.

```
Providers (Primary/Secondary) ALLOWED VISIT RELATED ONLY
Enter PROVIDER (code/initials or name): AAM   METTAA,ARTHUR A
P)primary or S)econdary: P   PRIMARY
Date Provider Seen: Jan 22, 1999//           (JAN 22, 1999)
Time Provider Seen: 8:10
Jan 22, 1999@8:10 (JAN 22, 1999@08:10)
Enter a SECONDARY PROVIDER (code/initials or
name): PMB   BETABETA,PATRICIA M
```

Figure 10-4: Provider information display

If a provider has not been added to the Provider File or has been inactivated, PCC will respond with:

```
Enter PROVIDER (code/initials or name: SIGMA ??
Enter PROVIDER (code/initials or name):
```

Figure 10-5: Provider not found in Provider File Modify Visit Date and/or Time

If you have verified that the name, “SIGMA,” was typed correctly and the above error appears, notify your site/PCC manager. “SIGMA” will have to be added to the Provider File or activated.

It is critical that providers are added to the system correctly, and many sites have limited access to the option that allows adding and editing providers for selected individuals. Contact your RPMS site manager or PCC supervisor to determine who is authorized to add new providers.

14. The system displays information about the POV.

15. At the “Enter Purpose of Visit” prompt, type the code that specifies the POV.

The POV is located in the middle of the Ambulatory Encounter form. The provider is required to record at least one POV for the current visit. The POV might be a condition, symptom, diagnosis, or assessment. Other types of data can also be recorded in this section, such as:

```
PROBLEMS - PL/PO
PERSONAL HISTORY - PHX
FAMILY HISTORY - FHX
SURGICAL HISTORY - SHX
HEALTH FACTORS - HF (far right side of the POV section)
```

If these items are recorded, the operator must include this information with the visit information.

15. At the “Provider Narrative” prompt, type the provider narrative as shown on the PCC form.

The Provider Narrative must always be recorded verbatim. The operator can use the = symbol at the “Provider Narrative” prompt if it is *exactly* the same as that typed at the “Enter Purpose of Visit” prompt. All mnemonics that prompt for provider narrative will accept up to 160 characters. (This was increased from 80 characters.) The Provider Narrative displays in the Adult Regular Health Summary.

16. At the “Cause of DX” prompt, specify the code that identifies the cause of the DX. This is only typed if indicated by the provider in the Injury 1st Visit portion of the form.
17. The prompts repeat, starting with the “Enter Purpose of Visit” prompt. Here you can type another POV. If there is no other POV, press ENTER.
18. At the “Mnemonic” prompt, type the code for the mnemonic. See Section 6 for more information.

If the visit was created in error, press ENTER to enter nothing at the “Clinic,” “Provider,” and “POV” prompts and type XIT at the “Mnemonic” prompt to exit and delete the visit. XIT *cannot* be used to delete visits created by another module (Pharm, Lab, Dent).

Note: An error is displayed if the XIT mnemonic is typed at the “Clinic” prompt. You must press ENTER at the CL, PRV and PV mnemonics to reach the “Mnemonic” prompt. XIT can only be typed at this prompt. You can also create a new visit in this screen.

Note: Caution should always be exercised when using the XIT mnemonic. Once a delete is complete, the visit cannot be retrieved and all data will have to be retyped.

Note: If entering field visits, location must be typed as Home or Office

10.1.2 Using the Dental, Laboratory, Pharmacy Modules

If the Dental, Laboratory, and/or Pharmacy modules are operational at your facility, or if data entry was performed using one of the LOG data entry options, the data entry operator will see the visit(s) created by these modules. These modules create a visit in PCC that includes the visit time (this will vary from site to site) and a Clinic Code of None, excluding Dental, which contains a Clinic of Dental. Because data is typed when the service is rendered, the data is passed to the PCC and visits are immediately created by these modules. The data entry operator must display (Step 3 above) the visit(s) to determine if the data they are going to type should:

- Create an entirely new visit (Item 1)
- Exit completely without doing anything (Item 2)
- Append to an already existing visit (select Item 4 or 5)
- Append and merge visits if more than one exists, as in the above example, if it has been determined that these visits should be merged. This would involve selecting Item 4 or 5 above, preferably the visit that has laboratory data *and* returning to the main data entry menu to access the Merge menu option. Merging to the Laboratory visit avoids any internal loss of data pointing.

It is the responsibility of data entry to clean up patient visits after the data has been typed, regardless of who created the visit(s), Pharmacy, Laboratory, and/or Dental. These modules, excluding Dental, create visits that do not contain all the required data items: Clinic Code, Primary Provider, and POV. If left unattended, errors will result in the Visit Review Report when generated by the data entry supervisor.

Note: Occasionally patients have more than one visit for a given date, and choice number 1 would be typed. For example, if a patient had a dental appointment and, upon completion, signed in for General Clinic, a second visit would be generated.

After typing the patient HRN, the Mini option automatically enters the TM mnemonic (only when the visit was created by another module), the CL, PRV, and PV mnemonics. TM displays so that data entry can correct the visit time as designated on the form. Each facility is responsible for establishing procedures on typing visit times, although many times other modules default to 12:00. Ultimately the data entry operator is responsible for verifying the time.

```

4 TIME: 08:00 TYPE: T CATEGORY: A CLINIC: GENERAL DEC: 6
Choose one: (1-4): 4//

      TIME of Visit      ALLOWED      VISIT RELATED ONLY
Enter new time: 0800//0900
Now changing time... (FEB 14, 2008@09:00)

      Clinic Type      ALLOWED      VISIT RELATED ONLY
CLINIC: GENERAL//

```

Figure 10-6: Time of visit display

“Clinic” is the first prompt to automatically display if the visit is created at the time of data entry. The clinic is located at the top left of the Ambulatory Encounter Form. Following selection of the clinic type, the operator can indicate appointment or walk in status, if appropriate.

```

Clinic Type ALLOWED VISIT RELATED ONLY
CLINIC: 01// GENERAL 01
WAS THIS AN APPOINTMENT OR WALK IN?: A APPOINTMENT
Enter the APPOINTMENT DATE: Jan 22, 1999// (JAN 22, 1999)
Enter APPOINTMENT TIME: 8
Jan 22, 1999@8 (JAN 22, 1999@08:00)

```

Figure 10-7: Clinic prompts

The PV mnemonic contains various prompts depending on the nature of the visit. The first prompt requests the ICD-9 code for the visit. This can be obtained by typing the provider narrative or the ICD-9 code (if known). The ICD-9 look-up file is invoked and responds in one of four ways, as shown below:

- An exact match for the Purpose of Visit and one ICD code. The Operator must determine whether the code is correct.
- A display of multiple ICD codes from which the Operator must select the appropriate code.
- A response of: **TOO MANY TERMS MEET YOUR CRITERIA, PLEASE REFINE YOUR SEARCH, SEARCH WAS UNSUCCESSFUL.** This means there are more than twenty ICD-9 codes meeting the criteria. In which case the operator must either enter a variation of different terms or refer to the ICD-9 code book to obtain the code.
- A response of: **SEARCH WAS UNSUCCESSFUL** indicates that the terms entered were not found in the ICD-9 file. The operator must either enter a variation of different terms or refer to the ICD-9 code book to obtain the code.

Figure 10-8: Obtaining the ICD-9 code

In the last two cases, if the operator cannot locate the appropriate code in the ICD-9 book, the code .9999 (Uncoded Diagnosis) should be typed at the “Enter PURPOSE of VISIT” prompt.

- Operators should *never spend* more than a couple of minutes per POV when determining an ICD-9 code.
- The PCC manager or data entry supervisor is responsible for assigning the proper code to visits typed with an uncoded diagnosis (.9999).
- The data entry operator is responsible for maintaining a list of frequently used diagnoses that are *not* readily assigned an ICD-9 code. This list is then given to the supervisor, who is responsible for updating the ICD-9 file in the utilities for the Auto-Coding System.

This procedure shortens the delay when obtaining the ICD-9 code the next time these diagnoses are entered. All facilities running PCC are responsible for customizing their ICD-9 file.

The second prompt of the PV mnemonic requests the provider narrative recorded on the form. The provider narrative must always be recorded verbatim. The operator can type the equal sign (=) at the “Provider Narrative” prompt if it is *exactly* the same as that typed at the “Enter Purpose of Visit” prompt. All mnemonics that prompt for provider narrative will accept up to 160 characters. (This was increased from 80 characters.) The provider narrative displays in the Adult Regular Health Summary.

The next prompt of the PV mnemonic is the “Cause of DX” prompt.

The next prompt of the PV mnemonic depends on whether or not the ICD-9 Diagnostic code is an injury code between 800 – 999. If not, the PV mnemonic will continue with Modifier, explained below. If the code is between 800 – 999, First (first time seen for this injury) is automatically assigned and the system displays additional prompts relating to the injury. The operator must check the Injury 1st Visit section in the lower left portion of the encounter form to see if the provider recorded this information. Press ENTER where no information is recorded. Refer to the PV mnemonic in the Data Entry Mnemonics manual for an example of an injury related visit.

“Modifier” is the next prompt in the PV mnemonic. This is included only if the provider has used any of the terms in the narrative on the form.

The “Cause Of DX” is the last prompt of the PV mnemonic. This is only typed if indicated by the provider in the Injury 1st Visit portion of the form.

If applicable, another PV can be typed at the “Enter Purpose of Visit” prompt.

```

PURPOSE OF VISIT
Enter PURPOSE of VISIT: ELEVATED BLOOD PRESSURE
401.9 (HYPERTENSION NOS)
UNSPECIFIED ESSENTIAL HYPERTENSION
OK? Y//
PROVIDER NARRATIVE: =   ELEVATED BLOOD PRESSURE
CAUSE OF DX: ??
    Choose from:
    1      HOSPITAL ACQUIRED
    2      ALCOHOL RELATED
    3      BATTERED CHILD
    4      EMPLOYMENT RELATED
    5      DOMESTIC VIOLENCE RELATED
    6      DRUG RELATED
CAUSE OF DX:
MODIFIER: ?
CHOOSE FROM:
C      CONSIDER
D      DOUBTFUL
F      FOLLOW UP
M      MAYBE, POSSIBLE, PERHAPS
O      RULE OUT
P      PROBABLE
R      RESOLVED
S      SUSPECTED, SUSPICIOUS
T      STATUS POST
MODIFIER:

```

Figure 10-9: “Cause of DX” and “Modifier” prompts in the PV mnemonic

Note: If text for provider narrative matches exactly what was typed at “Purpose of Visit” prompt, the equal sign (=) sign can be typed here.

Note: If any of these terms were used in the provider narrative above, select the appropriate choice.

Continue with typing another POV or press ENTER at the “Mnemonic” prompt to complete typing data recorded on the form. The list of data mnemonics can always be requested, as shown in Figure 10-10. This is recommended when initially starting data entry to aid the operator in becoming familiar with the terms. A complete list of mnemonics is not shown due to its length; however, see Section 6 for more information about mnemonics.

After each data item is typed, the system returns to the “Mnemonic” prompt. When using the MIN option, the Purpose of Visit and Treatment plan sections should be completed before going back to the top of the form. Although it is not necessary to type the data in the order shown, it is strongly recommended that a similar pattern be established to ensure that information is not accidentally omitted.

```

MNEMONIC: ?
Answer with RPMS PCC DATA ENTRY CONTROL MNEMONIC, or
DESCRIPTION, or ASSOCIATED FILE, or COHORT ENTRY LIST ORDER 1,
Or COHORT ENTRY LIST ORDER 2

Do you want the entire RPMS PCC DATA ENTRY CONTROL List? Y
Choose from:
3M          3M Coder Interface    ALLOWED      VISIT RELATED ONLY
ACON        Asthma Control                ALLOWED      VISIT RELATED ONLY
ACPT        Anesthesia CPT            ALLOWED      VISIT RELATED ONLY

```

Figure 10-10: Requesting the list of data mnemonics

10.1.3 Entries Entered in Error

If an entry is typed in error, the MOD mnemonic would be used to temporarily switch to the Modify option without actually returning back to the main data entry menu. MOD is operational for one entire mnemonic, then immediately switches back to the enter mode. The operator may use the MOD mnemonic as many times as necessary to correct or delete data. The PV entry above is used to demonstrate the MOD mnemonic. Notice the modifier was not typed and bypassed completely. **MOD** will be typed first at the “Mnemonic” prompt, followed by **PV**.

```

MNEMONIC: MOD
Switching to Modify Mode for ONE Mnemonic ONLY!
MNEMONIC: PV  PURPOSE OF VISIT
1  796.2  SMITH,ANGELA  MAR 21, 2008@13:00
   Prov Narrative: ELEVATED BLOOD PRESSURE
2  401.9  SMITH,ANGELA  MAR 21, 2008@13:00
   Prov Narrative: HYPERTENSION
CHOOSE: 1
POV: 796.2//
PROVIDER NARRATIVE: ELEVATED BLOOD PRESSURE//

```

```

MODIFIER: ?
CHOOSE FROM:
C      CONSIDER
D      DOUBTFUL
F      FOLLOW UP
M      MAYBE, POSSIBLE, PERHAPS
O      RULE OUT
P      PROBABLE
R      RESOLVED
S      SUSPECTED, SUSPICIOUS
T      STATUS POST
          MODIFIER: R <RETURN> RESOLVED
CAUSE OF DX:
Switching back to ENTER Mode!
MNEMONIC:

```

Figure 10-11: Correcting an error using the MOD mnemonic

Note: Any part of the PV mnemonic can be changed after each “//.” The “at” sign (@) (and press ENTER) would be used after the first “//” to delete the entire PV.

MOD automatically returns to the “Mnemonic” prompt and the enter mode so the operator can continue typing data. Other changes can be made at any time by typing **MOD** at the “Mnemonic” prompt, followed by the appropriate mnemonic requiring the change.

10.1.4 Using the PL/PO Mnemonic

Adding problem(s) recorded in the Purpose of Visit section on the Encounter Form are typed by using either the PL or PO mnemonic. Other problem-related mnemonics (PPV, APO, IPO, MPO, NO, MNN, RNO) and their appropriate use are discussed later in this manual. This particular narrative is typed only as a problem because the provider skipped a line after the POV before typing the problem narrative and designated “A” (Active) in the Problem List column.

A problem will also be entered as a POV when it is the only narrative recorded on the form or when the narrative is recorded on the next line immediately following the last POV. A blank line or a defined drawn line is the standard convention used by providers to separate a problem from a POV. An “A” (Active) or “AI” (Inactive) must be indicated by the provider before a problem is typed by the operator. Both appear in the Adult Regular Health Summary.

Problems can be updated in one of two ways: by using the PL (Problem List Update) or PO (Problem Only) mnemonic. Both methods are described below. The method an operator chooses to update a Problem List will vary depending on the change(s) required and the skill level of the operator when typing data.

The PL mnemonic allows updating a patient's Problem List without using mnemonics for the data entry, and is an efficient way of updating a problem list. It essentially performs all functions problem-related mnemonics (PO, APO, IPO, MPO, NO, MNN, RNO) currently perform.

Once the PL mnemonic is typed, the user is presented with the List Manager display of items that can be selected to update the patient's Problem List. The patient's problems (Active and Inactive) will display, followed by an Action/Command, virtually allowing any Problem List manipulation by selecting the correct action.

The top portion of the List Manager display contains patient demographics, followed by a list of the patient's problems. A complete list of possible actions appears at the bottom of the display. To add a problem, type **AP**.

Problem List Update		Oct 22, 2008 14:13:20		Page: 1 of 4	

Patient Name: SIGMA,JANE		DOB: JUL 01, 1977		Sex: F HRN: 1111	

1)	Problem ID: DIH5	DX: 785.2	Status: ACTIVE	Onset:	
	Provider Narrative: HEART M SYSTOLIC IN PULMONIC REGION				
2)	Problem ID: DIH6	DX: 311.	Status: ACTIVE	Onset:	
	Provider Narrative: DEPRESSION 2ND TO LOSS OF PARENT				
3)	Problem ID: DIH7	DX: 780.9	Status: ACTIVE	Onset:	
	Provider Narrative: EXPOSED 2NDARY SMOKE				
4)	Problem ID: THC1	DX: 780.79	Status: ACTIVE	Onset:	
	Provider Narrative: FLAT AFFECT				
5)	Problem ID: DH1	DX: 655.21	Status: ACTIVE	Onset:	
+ Enter ?? for more actions					
AP	Add Problem	IP	Inactivate Problem	RN	Remove Note
EP	Edit Problem	DD	Detail Display	HS	Health Summary
DE	Delete Problem	NO	Add Note	FA	Face Sheet
AC	Activate Problem	MN	Edit Note	Q	Quit
Select Action: +// AP					

Figure 10-12: Patient problem display

Once the PO mnemonic is typed, all patients' problems (Active and Inactive) will display if the Site File parameter is set for your facility, as shown. If working in other menu options, e.g., MOD, the prompt "Enter PROBLEM NUMBER" will appear in place of "Enter PROBLEM DIAGNOSIS" prompt.

```

MNEMONIC: PO      Problem Only      ALLOWED      NON-VISIT/VISIT MNEMONIC

*****          ACTIVE PROBLEMS AND NOTES          *****

DIH5      08/23/1999  HEART M SYSTOLIC IN PULMONIC REGION
DIH6      08/23/1999  DEPRESSION 2ND TO LOSS OF PARENT
DIH7      03/12/2008  EXPOSED 2NDARY SMOKE
THC1      05/01/2002  FLAT AFFECT
DH1       03/12/2008  FAMILY HX
DH2       08/22/2008  NONE
DH3       10/07/2008  DIABETES MELLITUS
DH4       10/08/2008  NONE
DH5       10/14/2008  ALLERGY TO DUST (ONSET: 08/15/2008)
WW1      11/15/2005  MOTHER W/BREAST CANCER 30'S

*****          INACTIVE PROBLEMS AND NOTES          *****

DIH1      03/13/2008  WBC-HIGH PRIORITY INFANT TRACKING -JACKSON
CO.H.DEPT.
DIH1DH1           PHYSICAL THERAPY
DIH2      03/24/1997  LOM 3/8/88
DIH3      02/21/2001  DDST SCREENING/WITHIN NORMAL LIMITS
DIH4      03/24/1997  RECURRENT OM

Press return to continue
Enter Problem Diagnosis:

```

Figure 10-13: Problem Only display

The Note Facility name is the same as the problem indicated on the form if both problem and note are new; this will display SX2SX1 immediately below Problem SX2 in the Adult Regular Health Summary. If the provider is linking a new Note to a new Problem, a temporary variable (X, Y, or Z) will identify the link next to the Problem number and the Note narrative. If there is no Note to link, press ENTER.

```

MNEMONIC: PO          Problem Only          ALLOWED          NON-VISIT/VISIT MNEMONIC
***** ACTIVE PROBLEMS AND NOTES *****
DIH5      08/23/1999  HEART M SYSTOLIC IN PULMONIC REGION
DIH6      08/23/1999  DEPRESSION 2ND TO LOSS OF PARENT
DIH7      03/12/2008  EXPOSED 2NDARY SMOKE
THC1      05/01/2002  FLAT AFFECT
  DH1      03/12/2008  FAMILY HX
  DH2      08/22/2008  NONE
  DH3      10/07/2008  DIABETES MELLITUS
  DH4      10/08/2008  NONE
  DH5      10/14/2008  ALLERGY TO DUST  (ONSET: 08/15/2008)
  DH6      10/22/2008  ARTHRITIS  (ONSET: 01/02/2008)
WW1       11/15/2005  MOTHER W/BREAST CANCER 30'S

***** INACTIVE PROBLEMS AND NOTES *****
DIH1      03/13/2008  WBC-HIGH PRIORITY INFANT TRACKING -JACKSON
CO.H.DEPT.
DIH1DH1   PHYSICAL THERAPY
DIH2      03/24/1997  LOM 3/8/88

DIH3      02/21/2001  DDST SCREENING/WITHIN NORMAL LIMITS
DIH4      03/24/1997  RECURRENT OM

Enter Problem Diagnosis: ARTHRITIS
716.90 (ARTHROPATHY NOS-UNSPEC)
UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIED
OK? Y//
PROVIDER NARRATIVE: = ARTHRITIS
DATE OF ONSET: 01/2008 (JAN 2008)
NMBR: 7//
CLASS: ?
  Choose from:
    P          PERSONAL HISTORY
CLASS: P PERSONAL HISTORY
STATUS: A// ?
  Enter the current status of this problem, active or inactive.
  Choose from:
    A          ACTIVE
    I          INACTIVE
STATUS: A// ACTIVE

```

```
Add a new Problem Note for this Problem? N// YES
Adding DEMO HOSPITAL Note #1
NOTE NARRATIVE: ?
    Answer must be 3-160 characters in length.
NOTE NARRATIVE: FOLLOW-UP MONTHLY
Problem Notes:
    DEMO HOSPITAL
        Note#1           FOLLOW-UP MONTHLY
Add a new Problem Note for this Problem? N//  O
MNEMONIC:
```

Figure 10-14: Listing of patient problems, both active and inactive

10.1.5 Using the MPO Mnemonic

When the provider wants to change a Problem Narrative, a “C” (change), Problem Number and Problem Narrative must also be available, and the operator would use the MPO mnemonic. This example changes only the narrative, although any or all entries of the problem can be changed.

```

MNEMONIC: MPO Correct/Modify Problem ALLOWED NON-VISIT/VISIT MNEMONIC
***** ACTIVE PROBLEMS AND NOTES *****
DIH5      08/23/1999  HEART M SYSTOLIC IN PULMONIC REGION
DIH6      08/23/1999  DEPRESSION 2ND TO LOSS OF PARENT
DIH7      03/12/2008  EXPOSED 2NDARY SMOKE
THC1      05/01/2002  FLAT AFFECT
DH1       03/12/2008  FAMILY HX
DH2       08/22/2008  NONE
DH3       10/07/2008  DIABETES MELLITUS
DH4       10/08/2008  NONE
DH5       10/14/2008  ALLERGY TO DUST (ONSET: 08/15/2008)
DH6       10/22/2008  ARTHRITIS (ONSET: 01/02/2008)
DH7       10/22/2008  ARTHRITIS (ONSET: 01/00/2008)
DH7DH1    FOLLOW-UP MONTHLY
WW1       11/15/2005  MOTHER W/BREAST CANCER 30'S
***** INACTIVE PROBLEMS AND NOTES *****
DIH1      03/13/2008  WBC-HIGH PRIORITY INFANT TRACKING -JACKSON
CO.H.DEPT.
DIH1DH1   PHYSICAL THERAPY
DIH2      03/24/1997  LOM 3/8/88
DIH3      02/21/2001  DDST SCREENING/WITHIN NORMAL LIMITS
DIH4      03/24/1997  RECURRENT OM

Enter Problem Number: DIH1
DIAGNOSIS: V20.2//
CLASS:
PROVIDER NARRATIVE: WBC-HIGH PRIORITY INFANT TRACKING -JACKSON CO.H.DEPT.
//WBC-HIGH PRIORITY INFANT TRACKING - WILMINGTON COUNTY HEALTH DEPT
DATE OF ONSET:
STATUS: INACTIVE//

```

Figure 10-15: Using the MPO mnemonic to modify a problem

10.1.6 Using the PPV Mnemonic

The PPV mnemonic is used to type a POV and Problem (PO). The provider *must* type an **A** or **AI** in the A/AI/C column with the POV narrative before it can be entered as both. PPV automatically duplicates the operator entry for the POV Diagnosis into the PO Diagnosis and the POV Provider Narrative into the PO Provider Narrative. Prompts specific to POV and PO are displayed for entry.

```

MNEMONIC: PPV          P O V and PROBLEM entry
This mnemonic will automatically generate a PROBLEM on the PROBLEM
LIST. Use the PV mnemonic to enter POV's only!
*****ACTIVE PROBLEMS AND NOTES *****
SX1 03/21/91 ARTHRITIS
SX1SX1 FOLLOW-UP MONTHLY
*****INACTIVE PROBLEMS AND NOTES*****
SE1 08/03/88 MENINGITIS
Enter PURPOSE of VISIT: DM
250.00 (DIABETES UNCOMPL ADULT/NIDDM)
  ADULT-ONSET TYPE DIABETES MELLITUS WITHOUT MENTION OF
  COMPLICATION/NONINSULIN DEPENDENT
OK? Y//
PROVIDER NARRATIVE: =      DM
MODIFIER:

CAUSE OF DX:
Now creating PROBLEM on PROBLEM LIST. . .
NMBR: 2//
CLASS:
STATUS A// ?
CHOOSE FROM:
A ACTIVE
I INACTIVE
DATE OF ONSET: T      (JAN 27, 1999)
STATUS: A//      ACTIVE
Add a new Problem Note for this Problem? N// Y >YES
Adding SELLS HOSPITAL Note #1
NOTE NARRATIVE: FOLLOW-UP MONTHLY
Problem Notes:
SELLS HOSPITAL
Note #1 1/26/99 FOLLOW-UP MONTHLY
Add a new Problem Note for this Problem? N//

```

Figure 10-16: Sample PPV

Note: Problems display only if the Site File parameter is set. The Problem begins at the “Now creating PROBLEM on PROBLEM LIS” prompt. The ICD-9 code and Provider Narrative typed above the prompt have been duplicated and bypassed for the Problem.

10.1.7 Using the NO Mnemonic

Notes are added to existing problems using the NO mnemonic. In this case, a provider wants to link a note to an already existing problem (SE2). The provider *must* record the entire problem number (from the Health Summary) in the Treatment Plan section before entry is completed by the operator. If a note narrative is longer than 80 characters, two notes should be typed. When a new note is linked to an existing problem, the operator should always verify the Note Facility on the form. It may be different than the problem, as in the example that follows. Notes can also be added using the PL (Problem List Update) mnemonic.

10.1.8 Using the RNO Mnemonic

Notes are deleted using the RNO (Remove Note Narrative) mnemonic. The provider *must* indicate the *entire* note number in the Remove Plan # section located in the middle of the encounter form. RNO deletes only the note specified and not the problem. Note narratives may be modified using the MNN (Modify Note Narrative) mnemonic. Notes can also be deleted or note narratives modified using the PL (Problem List Update) mnemonic.

```

MNEMONIC: NO          Note          ALLOWED          NON-VISIT/VISIT MNEMONIC
***** ACTIVE PROBLEMS AND NOTES *****
DIH5      08/23/1999  HEART M SYSTOLIC IN PULMONIC REGION
DIH6      08/23/1999  DEPRESSION 2ND TO LOSS OF PARENT
DIH7      03/12/2008  EXPOSED 2NDARY SMOKE
THC1      05/01/2002  FLAT AFFECT
DH1       03/12/2008  FAMILY HX
DH2       08/22/2008  NONE
DH3       10/07/2008  DIABETES MELLITUS
DH4       10/08/2008  NONE
DH5       10/14/2008  ALLERGY TO DUST (ONSET: 08/15/2008)
DH6       10/22/2008  ARTHRITIS (ONSET: 01/02/2008)
DH7       10/22/2008  ARTHRITIS (ONSET: 01/00/2008)
DH7DH1    FOLLOW-UP MONTHLY
DH8       10/22/2008  DM (ONSET: 10/22/2008)
DH8DH1    FOLLOW-UP MONTHLY
WW1       11/15/2005  MOTHER W/BREAST CANCER 30'S

***** INACTIVE PROBLEMS AND NOTES *****
DIH1      10/22/2008  WBC-HIGH PRIORITY INFANT TRACKING - WILMINGTON COUNTY
                    HEALTH DEPT
DIH1DH1    PHYSICAL THERAPY
DIH2      03/24/1997  LOM 3/8/88
DIH3      02/21/2001  DDST SCREENING/WITHIN NORMAL LIMITS
DIH4      03/24/1997  RECURRENT OM

Enter Problem Number: DH5

Problem Number: DH5                      Diagnosis: 995.3

Add a new Problem Note for this Problem? N// YES

Adding DEMO HOSPITAL Note #1
NOTE NARRATIVE: ?
      Answer must be 3-160 characters in length.
NOTE NARRATIVE: ALLERGY TO PET DANDER??

Problem Number: DH5                      Diagnosis: 995.3
Problem Notes:
      DEMO HOSPITAL
      Note#1                      ALLERGY TO PET DANDER

Add a new Problem Note for this Problem? N//

```

Figure 10-17: Problem notes display

Note: A note narrative may be modified using the MNN (Modify Note Narrative) mnemonic.

10.1.9 Mnemonics for Reproductive Factors

Reproductive Factors is the last section that may have data typed in the Purpose of Visit area. The FP (Family Planning) and RF (Reproductive Factors) mnemonics are used to type this data to capture female reproductive factors and family planning data. The reproductive factors include: Gravida, Full Term Births, Premature Births, Therapeutic Abortions, Spontaneous Abortions, Ectopic Pregnancies, Multiple Births, Living Children, Last Menstrual Period, EDC, How EDC Determined, Contraceptive Method, and Contraception Begun. Caution should be exercised when typing reproductive factors, as an incomplete entry will overlay a previously complete one.

Use the LMP (Last Menstrual Period) mnemonic to type the date of the patient's last menstrual period. Use the FP (Family Planning Method) to type the patient's contraceptive method and time begun. Use the EDC (Expected Date of Confinement) to enter the EDC date and how the EDC was determined. The options for the prompt are Unknown Method, Sonogram, Dates, and Clinical Parameters.

```

MNEMONIC: FP      Family Planning      ALLOWED      NON-VISIT/VISIT
MNEMONIC
GRAVIDA: 5//
FULL TERM BIRTHS: 3//
PREMATURE BIRTHS: 0// >
THERAPEUTIC ABORTIONS (TA): 0//
SPONTANEOUS ABORTIONS (SA): 0//
ECTOPIC PREGNANCIES: 2//
MULTIPLE BIRTHS: 3//
LIVING CHILDREN: 1//
LAST MENSTRUAL PERIOD: JUN 1,2007//
EDC: MAR 12,2008//
HOW EDC DETERMINED: CLINICAL PARAMETERS//
CONTRACEPTIVE METHOD: ORAL CONTRACEPTIVES// ?
  Enter type of contraception currently employed
  Choose from:
    0      EDUCATION ONLY
    1      ORAL CONTRACEPTIVES
    2      IUD
    3      SURGICAL STERILIZATION
    4      BARRIER METHODS
    5      PARTNER STERILIZED
    6      NATURAL TECHNIQUES
    7      MENOPAUSE
    8      NONE
    9      OTHER
   10     HORMONAL IMPLANT
   11     HORMONE INJECTION
   12     ABSTINENCE
CONTRACEPTIVE METHOD: ORAL CONTRACEPTIVES//
CONTRACEPTION BEGUN:

```

Figure 10-18: Using the FP mnemonic to type reproductive history

Note: Press ENTER to enter nothing where appropriate *or* use the single mnemonic for entry, e.g. LMP if LMP date was the only information recorded on the form.

10.1.10 Mnemonics for Problem Manipulation

After the Purpose of Visit area of the Encounter form has been completed, return to the top of the form labeled “Problem List Update.” Use this section to: (1) remove (delete) a problem(s), (2) change a problem(s) status from Inactive to Active, and (3) change a problem(s) status from Active to Inactive. All problem changes require that the provider write the *entire* problem number in the appropriate box.

The mnemonics used for problem manipulation are:

- RPO (Remove Problem)
- APO (Activate an Inactive Problem)
- IPO (Inactivate an Active Problem)

The MPO (Modify Problem) mnemonic can also be used to change any or all of a problem, including deleting the Problem and Notes linked to it. In addition, the PL (Problem List Update) mnemonic can be used for the various actions described.

The method an operator chooses will vary depending on the change(s) required and the skill level of the operator when typing data.

The first example is RPO to remove the problem SE3, as designated by the provider. The operator should always verify the problem before pressing ENTER. If the problem was deleted in error, it would have to be retyped entirely.

```

MNEMONIC: RPO      REMOVE PROBLEM ENTRY
*****ACTIVE PROBLEMS AND NOTES *****
                SE2   09/06/89   DIABETES MELLITUS
                SX1   03/21/91   ARTHRITIS
                SX1SX2          FOLLOW-UP MONTHLY
*****INACTIVE PROBLEMS AND NOTES*****
                SE1   08/03/88   MENINGITIS
                SE3   03/03/86   CHRONIC UTI X 3
CONSIDER IVP AFTER NEXT EPISODE
Enter Problem Number: SE3      SELLS HOSPITAL/CLINIC
Enter Problem Number: SE3
Are you sure that you want to remove Problem Number SE3 (Y/N)Y
Removing Problem SE3 ...
MNEMONIC:

```

Figure 10-19: Using the RPO mnemonic to remove a problem entry

Note: Both Problem and Note(s) are deleted.

When the provider writes a complete problem number in the “Change to Inactive” box of the Problem List Update section, the IPO mnemonic will apply. This is the recommended method when it is the only change for that problem. If other changes are also indicated for the problem, refer to the MPO/PL mnemonic.

```

MNEMONIC: IPO   INACTIVATE A PROBLEM
*****ACTIVE PROBLEMS AND NOTES *****
          SE2   09/06/89   DIABETES MELLITUS
          SX1   03/21/91   ARTHRITIS
          SX1SX2          FOLLOW-UP MONTHLY
*****INACTIVE PROBLEMS AND NOTES*****
          SE1   08/03/88   MENINGITIS
Enter Problem Number: SE2   SELLS HOSPITAL/CLINIC
          TUCSON SELLS TUCSON 01 TUCSON SELLS TUCSON 01
Inactivating Problems SE2. . .
MNEMONIC:

```

Figure 10-20: Using the IPO mnemonic to inactivate a problem

When the provider writes a complete problem number in the “Change to Active” box of the Problem List Update section, the APO mnemonic will apply. This is the recommended method when it is the only change for that problem. If other changes are also indicated for the problem, refer to the MPO/PL mnemonic.

```

MNEMONIC: AP0   ACTIVATE A PROBLEM
*****ACTIVE PROBLEMS AND NOTES *****
          SX1   03/21/91   ARTHRITIS
          SX1SX2          FOLLOW-UP MONTHLY
*****INACTIVE PROBLEMS AND NOTES*****
          SE1   08/03/88   MENINGITIS
          SE2   09/06/89   DIABETES MELLITUS
Enter Problem Number: <SE1> <RETURN> SELLS HOSPITAL/CLINIC
          TUCSON SELLS TUCSON 01 TUCSON SELLS TUCSON 01
Activating Problems SE1. . .
MNEMONIC:

```

Figure 10-21: Using the APO mnemonic to activate a problem

10.1.11 Entering Measurements

Measurements are located along the upper right side of the form and are generally the next data typed. To help ensure that accurate information is typed, some measurements, such as blood pressure, must fall within certain ranges or the system will not accept the data. Typing ? when the system requests a specific value or measurement will cause the system to display a help prompt containing the range limits and a specific format for typing the data.

Not all the measurements can be recorded on a visit; therefore, some or all of these fields on the form may be blank. Type only the mnemonics that have information recorded. The measurement mnemonics are:

Mnemonic	Meaning
AKBK	Ankle Blood Pressure
AUD	Audiometry
BM	Birth Measurement
BP	Blood Pressure
BPF	Best Peak Flow
CHC	Centimeter Head Circumference
CHT	Centimeter Height
FEF	FEF 25-75
FEV1	FEV1 - LITERS
FV1P	FEV1 %
FVC	Forced Vital Capacity (Liters)
FVCP	Forced Vital Capacity - %
GWT	Gram Weight
HC	Head Circumference
HT	Height
KWT	Kilogram Weight
MEAS	Measurement Entry
O2	O2 Saturation
PF	Peak Flow
PU	Pulse
RS	Respiration
TMP	Temperature
TON	Tonometry
VC	Vision Corrected
VU	Vision Uncorrected
WC	Waist Measurement
WT	Weight

If the operator types a measurement mnemonic in error, the caret (^) cannot be used to exit. Once the "Value" prompt is reached, an entry is required and the operator must type a dummy value. The dummy value would then be deleted by using the MOD mnemonic and the "at" sign (@). Refer to the MOD mnemonic at the beginning of this section for assistance with deleting a data item.

The operator can proceed down the right side of the form. Type the mnemonic in the appropriate field. Two measurements have been typed in this example:

```

MNEMONIC: BP      BLOOD PRESSURE
VALUE: ?
Enter as SYSTOLIC/DIASTOLIC (120/80). SYSTOLIC must be between 20
and 275.
           DIASTOLIC must be between 20 and 200.
VALUE: 160/90
MNEMONIC: WT      WEIGHT
VALUE: ?

If entering weight in LBS and OZs: enter lbs oz (132 12), lbs
fraction(132 3/4), or Weight must be 2-750 lbs and
fractional/decimal part must be a multiple of
1/16 (.0625).
VALUE: 203
MNEMONIC:

```

Figure 10-22: Using the BP and WT mnemonic to type patient information

10.1.12 Entering Tests, Exams, Immunizations

Orders indicate that a test, examination, or immunization was ordered. Only those items that have been initialed as being completed should be typed. These items support the Health Maintenance Reminders section in the Health Summary.

Laboratory tests ordered are only typed when the Laboratory Module is *not* operational at your facility. Enter the test by laboratory test code or name. Results are not captured. The Lab mnemonic *or* the Lab Log Data Entry menu option *or* the Lab module are used to type laboratory results if a facility chooses to do so.

```

MNEMONIC: 49 (UA) URINALYSIS ORDERED - NO RESULTS
MNEMONIC: BS BLOOD SUGAR ORDERED - NO RESULTS
CURRENT LAB TESTS AND RESULTS FOR THIS VISIT
Visit Date MAR 21,1998@13:00 Patient Name: Metaa, Betty Ann
UA
MNEMONIC:

```

Figure 10-23: Ordered laboratory tests and results display

The three types of examinations listed in the Orders section of the form are Pelvic, Breast, and Rectal. There are many other examinations that can be entered. Type the examinations performed using the EX mnemonic. Type the exam by exam code or name at the prompt.

```

MNEMONIC: EX
Select V EXAM: ?
ANSWER WITH V EXAM
DO YOU WANT THE ENTIRE V EXAM LIST? N NO
YOU MAY ENTER A NEW V EXAM, IF YOU WISH
ANSWER WITH EXAM NAME
DO YOU WANT THE ENTIRE 26-ENTRY EXAM LIST? Y YES
CHOOSE FROM:
    ABDOMEN EXAM 09
    AUDIOMETRIC SCREENING 23
    BREAST EXAM 06
SELECT V EXAM: 15          PELVIC EXAM 15
RESULT: N          NORMAL
MNEMONIC: EX
SELECT V EXAM: BREAST          06 BREAST EXAM 06
RESULT:
MNEMONIC:

```

Figure 10-24: Using the EX mnemonic to enter examinations performed

Note: Never answer **Yes** to the Entire V ... List question. Type exam result *only* if indicated on the encounter form.

Immunizations are located at the bottom of the Orders section. Type the immunization(s) administered by using the IM mnemonic. Enter Immunization type by typing the name or code. A complete list of all immunizations can be found in Appendix D. Each immunization will be followed by a “Series” prompt. A series should be recorded and typed for DPT and OPV, or press ENTER to enter nothing. Lot number is included, if available. Entries will vary because the file is customized locally at each facility.

```

MNEMONIC: IM
Enter IMMUNIZATION given: ?
ANSWER WITH V IMMUNIZATION LIST? N (NO)
YOU MAY ENTER A NEW V IMMUNIZATION, IF YOU WISH
ANSWER WITH IMMUNIZATION NAME
DO YOU WANT THE ENTIRE 24-ENTRY IMMUNIZATION LIST? Y (YES)
CHOOSE FROM:
    A/NJ MONOVALENT FLU SWINE MONO 08
    A/VICT-A//NJ BIVAL FLU SWINE BIVA 09
    BCG BCG 16
    CHOLERA CHOLERA 13
    DIP.,PERT.,TET (DPT) 03
Enter IMMUNIZATION given: TD-ADULT

```

```
TETANUS DIPHTHERIA (TD-ADULT) 02
SERIES: ?
CHOOSE FROM:
    P PARTIALLY COMPLETE
    C COMPLETE
    B BOOSTER
    1 SERIES 1
    2 SERIES 2
    3 SERIES 3
    4 SERIES 4
    5 SERIES 5
    6 SERIES 6
    7 SERIES 7
    8 SERIES 8
SERIES: <Enter>
LOT: <?> <Enter>
LOT MUST BE AVAILABLE AND MUST BE A VALID
LOT FOR THE IMMUNIZATION BEING ENTERED.
ANSWER WITH IMMUNIZATION LOT NMBR
CHOOSE FROM:
    0490322
LOT: 0490322
MNEMONIC:
```

Figure 10-25: Using the IM mnemonic to type immunizations administered

Note: Lot numbers should be typed, if provided, but must be stored in the system on receipt of vaccines in order to be available at time of data entry.

Skin tests are located in the last block of the Orders section, and therefore will be typed last. Skin tests specific to a particular area can be located in the Medications/Treatments/Procedures/Patient Education section, along with the appropriate data recorded. Only those skin tests with recorded readings and/or results are typed using the ST mnemonic. Provider initials do *not* indicate a reading or results and will be ignored by the data entry operator. The skin test name or code can be used for entry.

```
MNEMONIC: ST
SELECT V SKIN TEST: COCCI      21
READING: ?
TYPE A WHOLE NUMBER BETWEEN 0 AND 40
READING: 5
RESULTS: ?
      P for POSITIVE
      N for NEGATIVE
      D for DOUBTFUL
      0 for NO TAKE
RESULTS: <RETURN>
DATE READ: Jan 26,1999//
MNEMONIC:
```

Figure 10-26: Using the ST mnemonic to type skin tests with recorded readings and/or results

Note: To only record that a skin test was applied, use the STP (Skin Test Placed) mnemonic.

When a form is complete, the operator presses ENTER at the “Mnemonic” prompt and the “Visit/Admit Date” prompt appears. The system is now ready to process another form. Press the SPACE BAR followed by the ENTER key at this prompt for processing forms in batches by date. However, the time of visit must be typed for each form.

```
MNEMONIC:
VISIT/ADMIT DATE:      Mar 21, 1998
TIME OF VISIT: 3      (Mar 21, 1998 @15:00)
Select PATIENT NAME: 1852
```

Figure 10-27: Prompt indicating the system has completed one form and is ready to process another

Note: This begins a new form.

10.1.13 Error in Visit

When the “Visit/Admit Date” prompt is reached and an error is discovered in the visit currently being processed, the operator can switch to the Modify or Append menu option and correct the error without exiting the MINI option. Keep in mind that this can only be done before beginning entry of another form. If an error is detected much later, the operator must return to the main data entry menu to make the change by selecting the appropriate menu option.

```
MNEMONIC:
VISIT/ADMIT DATE:      (Mar 21, 1998)
TIME OF VISIT: 1      (Mar 21, 1998@13:00)
Select PATIENT NAME:
You have reselected the same patient.
LAST VISIT is 03-21-91@13:00
  1  Modify last VISIT
  2  Append to last VISIT
  3  Add new VISIT
  4  Quit
Choose:
```

Figure 10-28: “Visit/Admit Date” menu switching

Note: If changes need to be made to data already entered, select 1-Modify. If data was left out prior to completing the form, select 2-Append. If a completely new visit must be created, select 3-Add new Visit or 4 to quit.

This completes the MIN-Date entry Using Mnemonics menu option. For more details on using other mnemonics, refer to the Mnemonics Manual.

11.0 Enter Data (ENT)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHR  EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: ENT Enter Data

```

Figure 11-1: Selecting ENT option from main data entry menu

Ambulatory (IHS-803), Inpatient Services (IHS-44-1), contract health, or any other type of encounter form can be used to enter data into the PCC system using the ENT (Enter Data) menu option. This excludes group forms that are entered under the GRP menu option described in a separate chapter of this manual.

The PCC data entry operator will be prompted to type the following: (1) location of encounter, (2) type of visit, (3) service category, (4) date of visit, (5) time of visit, and (6) patient name or HRN. Once typed, these data items will create a visit indicated on the screen by a Visit File.

- A Service Category entry of A requires the entry of a Clinic (CL), Provider (PRV) and Purpose of Visit (PV) data mnemonics.
- A Service Category entry of H (hospitalization) automatically displays the IP (inpatient) mnemonic.

After all fields have been entered, the “Mnemonic” prompt appears so the operator can select the appropriate data mnemonic to type the remaining recorded medical information on the form, e.g., PV, PRV, OP, etc.

All hospitalizations require entry of the IP, PV and PRV data items. The Inpatient Services (IHS-44-1) form may also have an Inpatient Supplement and Discharge (IHS-485) form attached that contains data to be typed, e.g., HCT, BS, BP, WT, PO, etc. Data is typed from a Supplement and Discharge form only when attached to the appropriate Inpatient Services form.

PCC is used for entering hospitalization data only when Admissions/Discharge/Transfer (ADT) system is *not* running at a facility. ADT should be used for entering data from the IHS Inpatient Services form, if available. ADT automatically creates a visit and passes the following data items to PCC: Admission/Discharge information or IP mnemonic, PRV, PV and OP. Additional information recorded on the Supplemental form must be entered through the PCC data entry menu using the appropriate mnemonic. A future version of ADT will allow entry of any PCC mnemonic.

The following data items are required to process hospitalization forms into the PCC system:

- Patient ID
- Admission/Discharge Date/Time
- Admission/Discharge Type
- Admission/Discharge Service
- Admitting Diagnosis
- Primary Provider
- Primary Purpose of Visit

In addition, the following data items will be entered if recorded properly on the form:

- Secondary Purpose of Visits
- Operations/Procedures
- Cause and Place of Injury on First Visits

The following data items will be entered if recorded properly on the Inpatient Supplement and attached to the Inpatient Services form:

- Problems and/or Notes
- Reproductive factors
- Measurements (BP, WT, HT, etc.)
- Examinations Performed

- Laboratory Tests
- Personal or Family History
- History of Immunization, Skin Test Readings, and Procedures
- Immunizations Administered
- Skin Test Readings/Results

Once the visit file is created, the IP mnemonic displays for entry and prompts the following items: Admission Type, Admission Code, Admitting Service, Discharge Service, Discharge Type, Number of Consults, and Admitting DX. After the DX is entered, the system returns to the “Mnemonic” prompt so the operator can type the remaining information. Attempting to exit from the visit after the IP mnemonic will display an error message if the PV and PRV have not been typed. These are required data items.

If the visit was created in *error*, press ENTER at the “Mnemonic” prompt and type the XIT or /., mnemonic to exit and delete the visit.

```

----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: DEC 16, 1990@22:30
DATE VISIT CREATED: JAN 3, 1998 TYPE: IHS
PATIENT NAME: SIGMA,DALE LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC
SERVICE CATEGORY: HOSPITALIZATION DATE LAST MODIFIED: JAN 3, 1998
~~~~~
      INPATIENT
Enter Date of Discharge: XIT    ??
Enter a Date that is later than or equal to the date of Admission as
in 3/4/75 or Mar 3, 1975.
Time is optional.
Enter Date of Discharge:
MNEMONIC: XIT    QUICK OUT
This is the 'QUICK EXIT' from Data Entry Mode. This visit will be
deleted and you will be returned to the 'VISIT/DATE TIME' prompt.
Do you wish to Proceed with the Deletion? Y//    YES..
VISIT/ADMIT DATE:

```

Figure 11-2: Quick out

Note: An error is displayed if the XIT mnemonic is typed at the Date of Discharge prompt. XIT can only be typed at “Mnemonic:” prompt.

Note: Caution should always be exercised when using the XIT or /., mnemonics. Once a delete is complete, the visit cannot be retrieved and all data would have to be retyped. If an entry is made at the “Enter Date of Discharge” prompt, consecutive IP prompts will also be required before the “Mnemonic” prompt can be reached and the XIT is allowed.

This example uses the completed IHS Inpatient Services form shown in the PCC Forms Manual, Exhibit 5. Other encounter forms can also be used to type PCC data, for example, Contract Health form. The techniques and procedures are the same; however, depending on the form from which the data is extracted, the Location Name, Type, and Service Category will change.

Follow these steps:

1. At the “Select Location Name” prompt, press ENTER if you want to accept the default location. Otherwise, specify another location.

Type the abbreviation or name of the hospital where the service was provided. This is located in Box 11 on the top of the form, e.g. Sells Indian Hospital, PIMC, etc. The abbreviation for the location must be identified in the Mnemonic field of the Location File before it can be used. If your location entry is not allowed, contact your site/PCC manager.

```
PCC Data Entry Module
*****
*          ENTER Mode          *
*****

Select LOCATION NAME: SELLS HOSPITAL/CLINIC//
TUCSON SELLS TUCSON      01          TUCSON          SELLS TUCSON          01
```

Figure 11-3: Typing service location in PCC data entry module

Note: A default value of Sells has been set in the Site File to display during data entry.

2. At the “Type” prompt, type the code that specifies the form being processed.

I	IHS
C	CONTRACT
T	TRIBE-NON 638/NON-COMPACT
O	OTHER
6	TRIBE-638 PROGRAM
V	VA
P	TRIBE-COMPACTED TRIBAL PROGRAM
U	URBAN CLINIC
S	STATE

Figure 11-4: Selections for the type

3. At the “Service Category” prompt, type the code that specifies the service category for the form being processed. The various service categories are defined in detail in Appendix A of this manual.

Note: Default values can be displayed for Type and Service Category established in the Site File of the Supervisor’s menu.

```

TYPE: I      (IHS)
SERVICE CATEGORY: ?

Choose from:
A      AMBULATORY
H      HOSPITALIZATION
I      IN HOSPITAL
C      CHART REVIEW
T      TELECOMMUNICATIONS
N      NOT FOUND
S      DAY SURGERY
O      OBSERVATION
E      EVENT (HISTORICAL)
R      NURSING HOME
D      DAILY HOSPITALIZATION DATA
X      ANCILLARY PACKAGE DAILY DATA

SERVICE CATEGORY: H

```

Figure 11-5: Entering location service category

Note: The H is typed for the IHS 44-1 form. In-hospital is only used when a provider visits a patient while in the hospital. Refer to Appendix A of this manual for a complete description of service categories.

4. At the “Visit/Admit Date” prompt, specify the date. Time can be entered either in standard or military format. If no time is recorded, type **D** for the default time of 12:00 Noon as noted in the help prompt below. Time is required for all forms and can be typed in any one of following formats:

STANDARD: 6 or 6A for 6AM or 6P or 6PM for 6 PM

MILITARY: 0600 for 6AM or 1800 for 6 PM

If a visit time is designated between as 6:00 PM – 11:59 PM on the form, you must type the time using a P for PM or the system will assume AM. The system assumes AM from 12 midnight to 12 noon and PM from 12:01 PM - 5:59 PM.

```
VISIT/ADMIT DATE: ?
Examples of Valid Dates:
Jan 20 1998 or 20 Jan 91 or 1/20/91 or 012091
T (for) TODAY, T+1 (for TOMORROW), T+2, T+7, etc.
T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
If the year is omitted, the computer uses the CURRENT YEAR. Two
digit year assumes no more than 20 years in the future, or 80 years
in the past.

You may omit the precise day, as : JAN, 1998
If only the time is entered, the current date is assumed.
    Follow the date with a time, such as JAN 20@10, T@10AM, 10:30,
etc.
    You may enter a time, such as NOON, MIDNIGHT or NOW.
    You may enter NOW+3' (for current date and time Plus 3
minutes
    *Note--the Apostrophe following the number of minutes)

VISIT/ADMIT DATE: t-3 (DEC 14, 2008
TIME OF VISIT: 13:45 (DEC 14, 2008@13:45)
```

Figure 11-6: Typing visit/admit date and time

5. At the “Select Patient Name” prompt, type the patient’s HRN from Block 1, IHS Unit Number.
6. At the “Mnemonic” prompt, specify the code of the mnemonic you want to add to the visit. The remaining prompts depend upon the mnemonic indicated.

The remaining does not apply to ENT

Once entered, the system will briefly pause and respond in one of two ways: (1) Create a visit and display the Visit File as shown or (2) find an existing visit(s) for that same date. Because the Enter and Mini options function the same, refer to Section 8.1 for details regarding these choices. This example assumes there are no other visits for this date and creates the Visit File.

```
Select PATIENT NAME: 20000
~~~~~
----- V I S I T F I L E -----
VISIT/ADMIT DATE&TIME: APR 16 1998@22:30
DATE VISIT CREATED: MAY 1, 1998 TYPE: IHS
PATIENT NAME: SIGMA, JOHN D.
LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC
SERVICE CATEGORY: HOSPITALIZATION          DATE LAST MODIFIED:
MAY 1, 1998
~~~~~
INPATIENT
Enter Date of Discharge:
```

Figure 11-7: Creating a visit file

After the VISIT FILE has been created and displayed, the operator is ready to type specific inpatient data items from the form. As previously mentioned, the IP mnemonic is automatically entered by the system when the operator types a Service Category of H hospitalization.

```
Enter Date of Discharge: 4-23          (APR 23, 1990)
ADMISSION TYPE: ?

ANSWER WITH ADMISSION TYPE NUMBER, OR NAME, OR IHS CODE
CHOOSE FROM:
  1 DIRECT
  2 TRANS-NON IHS HOSPITAL
  3 TRANS-IHS HOSPITAL
  4 REFERRED FROM IHS CLINIC
  5 OTHER
ADMISSION TYPE: 1          DIRECT
ADMITTING SERVICE: ?
ANSWER WITH TREATING SPECIALTY NAME, OR CODE
CHOOSE FROM:
  ALCOHOLISM 15
  DENTAL 01
  FAMILY PRACTICE 17
  GENERAL MEDICINE 03
```

Figure 11-8: Typing specific inpatient data items

Note: The Date of Discharge is taken from Block 20 (Disposition Date). Block 16 (Admission Code) is typed here under Admission Type. Block 17 and Block 18 (Clinical Service Admitted To and Clinical Service Code) are typed at the following two prompts. A complete list of Clinical Service Codes is provided in Appendix A of this manual.

```

ADMITTING SERVICE: 03      GENERAL MEDICINE 03
DISCHARGE SERVICE: 03      GENERAL MEDICINE 03
DISCHARGE TYPE: ?
ANSWER WITH DISCHARGE TYPE NUMBER, OR NAME, OR IHS CODE
CHOOSE FROM:
  1      REGULAR DISCHARGE 1
  2      TRANSFERRED 2
  3      IRREGULAR DISCHARGE 3
  4      DEATH W/I 48 HRS W AUTOPSY 4
  5      DEATH W/I 48 HRS W/O AUTOPSY 5
  6      DEATH AFTER 48 HRS W AUTOPSY 6
  7      DEATH AFTER 48 HRS W/O AUTOPSY 7
  8      TRANSFERRED IHS HOSPITAL 2
  9      TRANSFERRED NON-IHS HOSPITAL 2
 10     IRREGULAR (AMA) 3

DISCHARGE TYPE: 1      REGULAR DISCHARGE 1

```

Figure 11-9: Typing inpatient data items, continued

Note: Block 37 and 38 contain the Discharge Clinical Service and Code to be typed here. The same choices apply as to the Admitting Service above. Discharge is taken from Block 34 (Disposition) indicated in the appropriate choice by an **X**. The Discharge choices will vary from site to site.

When a Discharge Type of Death (Choices 4 through 7 above) is typed, the following prompt appears. The operator would enter Block 45, Cause of Death, from the form. This information is passed to the Patient Registration system.

```

DISCHARGE TYPE: 4      DEATH W/I 48 HRS W/O AUTOPSY 6
UNDERLYING CAUSE OF DEATH: 427.5      CARDIAC ARREST

```

Figure 11-10: Discharge type – death

When a Discharge Type of Transferred (Choices 2, 8, 9 above) is typed, the following prompt appears for entry. The operator *must* refer to Block 35, Name of Facility Transferred To, and type the appropriate choice, e.g. Phoenix Indian Medical Center is an IHS facility, Good Samaritan Hospital is Non-IHS, etc. For assistance with entering this field, see your PCC supervisor/manager. Although Entries 2 and 3 below revert to Transferred (1) when exported to the Data Center, original entries are maintained on the local computer for retrieval purposes.

```
DISCHARGE TYPE: TRANSFERRED
1      TRANSFERRED      2
2      TRANSFERRED IHS HOSPITAL      2
3      TRANSFERRED NON-IHS HOSPITAL  2
DISCHARGE TYPE: 3      TRANSFERRED NON-IHS HOSPITAL

TRANSFERRED TO: ?
Enter the facility to which the patient was transferred.
Enter one of the following:
VA/IHS.EntryName to select a VA & IHS FACILITIES
VENDOR.EntryName to select a OTHER INPATIENT FACILITIES
To see the entries in any particular file, type <Prefix.??>

TRANSFERRED TO: ST MARY'S HOSPITAL
```

Figure 11-11: Discharge type – transferred

Note: The “Transferred To” entry *must* exist in the IHS Location or CHS Vendor File before an entry is allowed. Press ENTER to enter nothing.

```
NUMBER OF CONSULTS: ?
TYPE A WHOLE NUMBER BETWEEN 0 AND 99
NUMBER OF CONSULTS:
ADMITTING DX: ?
DX Cannot be an E code or an inactive code, and it must be
appropriate for the Patient's age and sex.
ADMITTING DX: ORGANIC BRAIN SYNDROME
310.9 (NONPSYCHOT BRAIN SYN NOS) UNSPECIFIED NONPSYCHOTIC MENTAL
DISORDER FOLLOWING ORGANIC BRAIN DAMAGE
OK? Y//
MNEMONIC:
```

Figure 11-12: Number of consults and admitting DX prompt

Note: Number Of Consults is typed only if a number is provided in Block 39 or press ENTER to enter nothing. ADMITTING DX is entered from Block 25, Admitting Diagnosis/Admitting Doctor. This completes the IP mnemonic portion of the hospitalization visit.

When all entries of the IP mnemonic are complete, the system returns to the “Mnemonic” prompt as shown. If the operator attempts to exit the visit at this time, an error will occur. This visit is not complete, as the PRV and PV have not been entered. Other information that is recorded on the form must also be entered.

```
MNEMONIC:
WARNING: No purpose of visit entered for this visit!
WARNING: No provider of service entered for this VISIT!
WARNING: No PRIMARY POV entered for this Hospitalization!
WARNING: No primary provider entered for this visit!
PV mnemonic required!
```

Figure 11-13: Incomplete hospital visit

The POV is entered using Block 28, Lines 1-6. Line 1 is always designated the Primary Purpose of Visit for Hospitalizations.

```

MNEMONIC: PV          PURPOSE OF VISIT
Enter PURPOSE of VISIT: ORGANIC BRAIN SYNDROME
310.9          NONPSYCHOT BRAIN          SYN NOS...OK? YES// (YES)
PRIMARY/SECONDARY: P
PRIMARY PROVIDER NARRATIVE: ORGANIC BRAIN SYNDROME, UNK ETIOL
MODIFIER: ?
CHOOSE FROM:
    C          CONSIDER
    D          DOUBTFUL
    F          FOLLOW UP
    M          MAYBE, POSSIBLE, PERHAPS
    O          RULE OUT
    P          PROBABLE
    R          RESOLVED
    S          SUSPECT SUSPICIOUS
    T          STATUS POST
MODIFIER:
CAUSE OF DX: ?
CHOOSE FROM:
    1  HOSPITAL ACQUIRED
    2  ALCOHOL RELATED
    3  BATTERED CHILD
    4  EMPLOYMENT RELATED
    5  DOMESTIC VIOLENCE RELATED
CAUSE OF DX:
Enter PURPOSE of VISIT: BRAIN DEGENERATION
The following matches were found:
  1: 294.1 (DEMENTIA IN OTH DISEASES) DEMENTIA IN CONDITIONS
CLASSIFIED ELSEWHERE
  2: 331.2 (SENILE DEGENERAT BRAIN) SENILE DEGENERATION OF BRAIN
  3: 331.9 (CEREB DEGENERATION NOS) CEREBRAL DEGENERATION,
UNSPECIFIED
Select 1-3: 3
PROVIDER NARRATIVE: MILD CEREBELLAR ATROPHY BY CT SCAN
MODIFIER:

```

Figure 11-14: Typing the purpose of visit

Note: Always type the provider narrative exactly as indicated on the form. Type modifier only if the provider used one of these terms in the provider narrative entered above. The second PV is taken from Block 28, Line 2.

```

CAUSE OF DX:
Enter PURPOSE of VISIT: UTI
599.0 (URIN TRACT INFECTION NOS)
URINARY TRACT INFECTION, SITE NOT SPECIFIED
OK? Y//
PROVIDER NARRATIVE: URINARY TRACT INFECTION, E.COLI
  MODIFIER:
CAUSE OF DX:
Enter PURPOSE of VISIT: E COLI
( COLI/COLIC/COLIFORM/COLITIS E )
The following matches were found:
  1:      320.8 (BACTERIAL MENINGITIS NEC)
          MENINGITIS DUE TO OTHER SPECIFIED BACTERIA
  2:      771.8 (PERINATAL INFECTION NEC)
          OTHER TYPE OF INFECTION SPECIFIC TO THE PERINATAL PERIOD
  3:      008.0 (E. COLI ENTERITIS)
          INTESTINAL INFECTION DUE TO ESCHERICHIA COLI (E. COLI)
  4:      038.42 (E. COLI SEPTICEMIA)
          SEPTICEMIA DUE TO ESCHERICHIA COLI (E. COLI)
  5:      041.4 (E. COLI INFECT NOS)
          ESCHERICHIA COLI (E. COLI) INFECTION IN CONDITIONS
          CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE

Select 1-5: 5
PROVIDER NARRATIVE: < = >      E COLI
MODIFIER:
CAUSE OF DX:
Enter PURPOSE of VISIT: ELEVATED LIVER

( ELEVATED LIVER )
794.8 (ABN LIVER FUNCTION STUDY)
NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF LIVER
OK? Y//>
PROVIDER NARRATIVE: ELEVATED LIVER FUNCTION TEST >
  MODIFIER:
CAUSE OF DX:
Enter PURPOSE of VISIT:

```

Figure 11-15: POV, continued

Note: The third PV is taken from Block 28, Line 3. The next PV entry is made for ICD coding purposes only, also taken from Line 3. The equal sign (=) can only be typed if the provider narrative matches exactly what the operator typed at the “Purpose of Visit” prompt. It is never appropriate to type = if an ICD-9 code was typed at the “Purpose of Visit” prompt.

This completes entry of all PVs for this hospital visit.

Many times hospital visits contain Operative and Selected Procedures, Block 31. This *must* be entered during data entry using the OP mnemonic. Line 1 of Block 31 is *always* designated the primary procedure. This data will display in the History of Surgery section of the Adult Regular Health Summary.

```

MNEMONIC:  OP      OPERATIONS
Enter OPERATION/PROCEDURE:  LUMBAR PUNCTURE
03.31 (SPINAL TAP)
SPINAL TAP OK? Y//
PROVIDER NARRATIVE:  = LUMBAR PUNCTURE
DIAGNOSIS:  ORGANIC BRAIN SYNDROME
310.9 (NONPSYCHOT BRAIN SYN NOS)
UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING
ORGANIC BRAIN DAMAGE OK? Y//
PROCEDURE DATE:  APR 16,1990//<4-17      (APR 17, 1990)
PRINCIPLE PROCEDURE:  ?
CHOOSE FROM:
      Y  YES
      N  NO
PRINCIPLE PROCEDURE:  Y      YES
INFECTION:  ?
CHOOSE FROM:
      Y  YES
      N  NO
INFECTION:
OPERATING PROVIDER:  SIGMA,GEO      PHYSICIAN IHS
OPERATION/PROCEDURE:

```

Figure 11-16: Using the OP mnemonic to type the operative and selected procedures of a patient visit

Note: The equal sign (=) can be used when the provider narrative exactly matches what the operator typed at the “Operation/Procedure” prompt above. The date will be entered from Block 33. The Y for Principle Procedure only applies when located on Line 1 of Block 31. Enter an infection only when provided in the appropriate box of Block 32. Enter Operation Provider only when specified in Block 33a – Operating Physician.

All hospital visits must contain a primary provider. This is taken from Block 50a, Attending Physician Code. When a hospitalization visit has an Inpatient Supplement and Discharge Record attached, another provider may be designated in Section F, Follow-Up Recommendation, e.g. a physical therapy treatment initiated by the physical therapist. The data entry operator would enter the physical therapist as a secondary provider at this time. The Inpatient and Inpatient Supplement form should contain the same provider signature and code at the bottom of each form.

```

MNEMONIC: PRV                PROVIDERS (PRIMARY/SECONDARY)
Enter PROVIDER (code/initials or name): CTJ      JKKKKKK,CATHY
P)rietary or S)econdary: P    PRIMARY
O)perating or A)ttending: A    ATTENDING
Date Provider Seen: Jan 10, 1999// (JAN 10, 1999)
Time Provider Seen:
Enter a SECONDARY PROVIDER (code/initials or name):
MNEMONIC:

```

Figure 11-17: Using PRV mnemonic to type providers

Note: Enter Provider from Block 50a. The O)perating or A)ttending entry will always be A)ttending.

Although entry of the Inpatient Services form, IHS 44-1 is complete, an Inpatient Supplement and Discharge Follow-Up Record can be attached and requires entry. The Supplemental form may contain items for entry such as: problem list additions or changes (PL, PO, APO, IPO, MPO, RPO), treatment plan additions or changes (NO, RNO, MNN), reproductive factors (FP, RF, LMP, FM, EDC), measurements (BP, WT, etc.), laboratory entries (HCT, UA, etc.), examinations (EX), immunizations (IM), skin tests (ST), and patient education (PED). The following example uses Exhibit 6 from the PCC Forms Manual to demonstrate data entry of the PCC Inpatient Supplement & Discharge Follow-Up Record.

Problem list additions or changes should be typed first. This data is typed using the sections at the top of the form labeled Problem List and Problem List Additions or Changes. The provider has indicated two active (A) problems are to be added (PO) to the Health Summary and two problems are to be removed (RPO) from the Health Summary.

```

MNEMONIC: PO          PROBLEM ONLY
***** No ACTIVE Problems on file for this Patient
***** INACTIVE PROBLEMS AND NOTES*****
SX17   02/24/83          OBESITY
SX17SX1          NUTRITION CLASSES
SX19   08/26/85          ECZEMA
Enter Problem Diagnosis: CONGESTIVE HEART FAILURE
428.0 (CONGESTIVE HEART FAILURE)
CONGESTIVE HEART FAILURE OK? Y//
PROVIDER NARRATIVE:= CONGESTIVE HEART FAILURE
DATE OF ONSET:12/23/98

NMBR: 1//
CLASS: ?
      CHOOSE FROM:
          P PERSONAL HISTORY
          F FAMILY HISTORY
CLASS:
STATUS: A// ?
      CHOOSE FROM:
          A ACTIVE
          I INACTIVE
STATUS: A// ACTIVE
Add a new Problem Note for this Problem? N//
MNEMONIC: PO          PROBLEM ONLY

***** ACTIVE PROBLEMS AND NOTES *****
SE1 05/01/91 CONGESTIVE HEART FAILURE
***** INACTIVE PROBLEMS AND NOTES*****
SX17   02/24/83          OBESITY
SX17SX1          NUTRITION CLASSES
SX19   08/26/85          ECZEMA

Enter Problem Diagnosis: DIABETES MELLITUS
250.00 (DIABETES UNCOMPL ADULT/NIDDM)
ADULT-ONSET TYPE DIABETES MELLITUS WITHOUT MENTION OF
  COMPLICATION/NONINSULIN DEPENDENT OK? Y//
  PROVIDER NARRATIVE: = DIABETES MELLITUS
DATE OF ONSET:
NMBR: 2//
CLASS:
STATUS: A// ACTIVE
Add a new Problem Note for this Problem? N//
MNEMONIC:

```

Figure 11-18: Using the PO mnemonic to enter or change patient problems

Note: Problem display is designated in the Site file of the Supervisor's menu. Person or Family must be indicated by the provider, e.g., family history of diabetes or press ENTER to enter nothing. A or AI *must* be indicated by the provider. Both appear in the Adult Regular Health Summary.

For details regarding Notes, refer to Section 8.3.

To delete problems (RPO) from the Health Summary, the provider *must* type the *entire* problem number (e.g. SX 17, SX 19) in the first block of PCC Update section of the form. When a problem status is changed from Active to Inactive (IPO), the entire problem number must be typed in the second block of the PCC Update section. When a problem status is changed from Inactive to Active (APO), the entire problem number must be typed in the third block of the PCC Update section. The IPO and APO mnemonics function in the same manner as the RPO mnemonic.

```

MNEMONIC: RPO      REMOVE PROBLEM ENTRY
***** ACTIVE PROBLEMS AND NOTES*****
SE1      05/01/91    CONGESTIVE HEART FAILURE
SE2      05/01/91    DIABETES MELLITUS
***** INACTIVE PROBLEMS AND NOTES*****
  SX17   02/24/83    OBESITY
SX17SX1          NUTRITION CLASSES
SX19     08/26/85    ECZEMA
Enter Problem Number: SX17
Are you sure that you want to remove Problem Number SE1?(Y/N) Y
Removing Problem SX17 ...
MNEMONIC: RPO
***** ACTIVE PROBLEMS AND NOTES*****
SE1      05/01/91    CONGESTIVE HEART FAILURE
SE2      05/01/91    DIABETES MELLITUS
***** INACTIVE PROBLEMS AND NOTES*****
SX19 08/26/85      ECZEMA
Enter Problem Number: SX19
Are you sure that you want to remove Problem Number SE1? (Y/N)Y
Removing Problem SX19 ...
MNEMONIC:

```

Figure 11-19: Using the RPO mnemonic to remove a problem entry

Note: Type the *entire* problem number to be removed (deleted). Problem SX17 and note SX1 no longer display. Notes linked to problems are automatically deleted with the problem.

The next data items to be entered are measurements located along the right side of the form under the PCC Update section. This form indicates a blood pressure (BP) and weight in lb-oz (WT) should be entered. Other measurements that might be available are height, head circumference, vision uncorrected, and vision corrected. Measurement types will be appropriately marked, for example, GM for gram weight, CM for centimeter head circumference.

```

MNEMONIC: BP          BLOOD PRESSURE
VALUE: ?
Enter as SYSTOLIC/DIASTOLIC (120/80).SYSTOLIC must be between 20 and 275.
      DIASTOLIC must be between 20 and 200.
VALUE: 115/70

MNEMONIC: WT          WEIGHT

VALUE: ?
If entering weight in LBS and OZs:  enter lbs oz (132 12), lbs fraction (132
3/4), or eight must be 2-750 lbs and fractional/decimal part must be a
multiple of 1/16 (.0625).

Metric ranges:
Kilograms: enter between 1 and 340 (fractions and decimals allowed)
Grams: enter between 1000 and 340000 grams (fractions and decimals allowed)

Fractions must be entered as in 4000 1/2 or 4 2/3

VALUE: 112
MNEMONIC: HT          HEIGHT
VALUE: ?
Enter height in inches and fractions (64 3/4), or inches and decimal
(64.75).
Height must be between 10 and 80 inches.
Centimeter range: 26 and 203.
VALUE: 76
MNEMONIC:

```

Figure 11-20: Using the BP and WT mnemonic to enter patient information

Note: Use KWT mnemonic to record weight in KG and use the GWT mnemonic to record weight in GM. Use CHT mnemonic to record height in CM.

An entry in the Enter Date section indicates that a test(s), examination(s), or immunization(s) was done. Only those items that have dates entered as complete should be typed. This section is typed in the same manner as the Orders section of the Ambulatory visit record. Refer to Section 10 for specific instructions. These items support the Health Maintenance Reminders section in the Health Summary.

Laboratory test ordered should be entered only if the Laboratory Module is *not* operational at your facility. Enter the test by laboratory test code or name.

```

MNEMONIC: UA          49 URINALYSIS ORDER-NO RESULTS
MNEMONIC: HCT         20 HEMATOCRIT ORDERED
CURRENT LAB TESTS AND RESULTS FOR THIS VISIT
Visit Date: JAN 31, 1998@12:00    Patient Name: SIGMA,BOB
HCT
MNEMONIC: BS          11 BLOOD SUGAR ORDERED
CURRENT LAB TESTS AND RESULTS FOR THIS VISIT
Visit Date: JAN 31, 1998@12:00    Patient Name: SIGMA,BOB
HCT
URINALYSIS
MNEMONIC:

```

Figure 11-21: Ordered laboratory tests and results display

Note: Any labs already typed for this visit will display.

This completes entry of the Inpatient and Supplement form using the Enter menu option. For assistance typing other data items that might be available, such as reproductive factors, patient education, treatment plans, etc. refer to the appropriate examples throughout Section 4 or the Mnemonics Manual.

12.0 Modify Data (MOD)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
                                Version 2.0

                                DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: MOD  Modify Data

```

Figure 12-1: Selecting MOD option from main data entry menu

Use the MOD option to modify, correct, or delete any information that was already entered into PCC. This is done by typing a two- or three-character mnemonic at the “Mnemonic” prompt. In addition, this option can be used to change the status of existing problems or notes (e.g., Active, Inactive, or Remove (Delete)) and to change the narrative for an existing problem in the Problem List.

This option does not delete a patient’s Visit File, although individual data items can be deleted by using the appropriate mnemonic and the “at” sign (@). If an entire visit should be deleted, notify the PCC manager or data entry supervisor. Visits should be deleted only when entered in error; delete an entire visit by using the menu option Del-Delete All Data For A Visit. If the Visit file is to be changed, the VST mnemonic can be used in either the MOD or ENT menu options.

The MOD mnemonic should be used to change or delete data while in the ENT or APP menu option. MOD eliminates the need to change menus.

Mnemonic	Meaning
APO	ACTIVATE AN INACTIVE PROBLEM
BT	BLOOD TYPE ENTRY
DHS	DISPLAY HEALTH SUMMARY
DP	DESIGNATED PROVIDER
ECD	ESTIMATED DATE OF CONFINEMENT
FHX	FAMILY HISTORY
FM	FAMILY PLANNING METHOD
FP	FAMILY PLANNING
IPO	INACTIVATE A PROBLEM
LMP	LAST MENSTRUAL PERIOD
MNN	MODIFY NOTE NARRATIVE
MPO	MODIFY PROB NARRATIVE
NO	NOTE
OHX	OFFSPRING HISTORY
PHX	PERSONAL HISTORY
PO	PROBLEM ONLY
RF	REPRODUCTIVE FACTORS
RNO	REMOVE NOTE FROM PROB
RPO	REMOVE PROBLEM ONLY
WHO	WHO IS THE PATIENT?
XIT	QUICK OUT

Follow these steps:

1. At the “Select Enter/Modify/Append PCC Data Option” prompt, type **MOD** and press ENTER.
2. At the “Select Patient Name” prompt, specify the patient.
3. At the “VISIT relate? YES/?” prompt, type **Y** or **N**.

If the response is **N(o)**, the following message will display: “Select Non Visit Related mnemonics only.” Only the following non-visit-related mnemonics can be accessed.

If the response is **Y(es)**, the “Enter VISIT date” prompt displays. Specify the visit date that you want to modify.

The operator must respond **Y(es)** when asked if this is visit-related for the following mnemonics. EVENT visits are created with these mnemonics and are visit-related; however, the EX, IM, LAB, RX, ST, and/or OP, etc. mnemonics will be used to modify or delete the data along with the visit date:

HBS - HISTORICAL BLOOD SUGAR ENTRY
HEKG - HISTORICAL EKG
HEX - HISTORICAL EXAMINATION
HHC - HISTORICAL HEMATOCRIT
HIM - HISTORICAL IMMUNIZATION
HLAB - HISTORICAL LAB TEST
HPAP - HISTORICAL PAP SMEAR
HRAD - HISTORICAL RADIOLOGICAL PROCEDURE
HRX - HISTORICAL RX
HS - HISTORICAL SKIN TEST
HUA - HISTORICAL UA ENTRY
SHX - HISTORY OF SURGERY

4. At the “Mnemonic” prompt, specify the code for the mnemonic.

Other prompts will display, depending upon the mnemonic specified.

12.1 Examples of Using MOD

The following examples are some of the more common uses for the Modify Data menu option.

```
RPMS Patient Care Component Data Entry (Modify Mode) - Version 2.0 |
Select PATIENT NAME: 4662      METAA, BETTY ANN F 06-21-57
VISIT related? Y//
Enter VISIT date: 0327      (MAR 27, 1998)
```

Figure 12-2: Modify mode main screen

12.1.1 Using the PV Mnemonic

To modify an ICD-9 CODE and/or Provider Narrative, the PV mnemonic is typed and the system displays the ICD-9 code(s) for the visit. If more than one code is displayed, select the appropriate code that requires correcting. Any changes to the ICD-9 code or Provider Narrative will be typed after the double slashes (//). If a new code is typed, a confirmation response is required to accept the new code. Press ENTER to leave an item the same at any or all of the PV prompts.

```

MNEMONIC: PV      PURPOSE OF VISIT
1      465.9      METAA, BETTY ANN Mar 27, 1998 @ 13:23
POV: 465.9// 460      460. ACUTE NASOPHARYNGITIS
OK? YES//
PROVIDER NARRATIVE: URI// COLD
MODIFIER:
CAUSE OF DX:
MNEMONIC:

```

Figure 12-3: Using the PV mnemonic to modify ICD-9 code or provider narrative

Note: The first ICD-9 code, 465.9, has been changed to 460, and the Provider Narrative from URI to COLD. The Provider Narrative could have been entered to obtain the correct ICD-9 code.

To change the status of existing problems or delete problems, the provider must first record the problem number(s) in the appropriate boxes in the Problem List Update section before this is exercised by data entry.

When the status of a problem is changed, any notes linked to this problem will automatically change status as well, e.g., if a problem is removed, any notes linked to this problem will automatically be removed.

12.1.2 Using the APO Mnemonic

The APO (Activate an Inactive Problem) mnemonic provided in the following example functions the same as the IPO (Inactivate a Problem) and RPO (Remove [delete] Problem Only) mnemonics. All three mnemonics, APO, IPO, and RPO, can also be used in the ENT menu option. These mnemonics were developed to make modification of Problems easier; however, Problems may be also be modified using the APO mnemonic and going through each prompt, as in the PV mnemonic described above.

```

MNEMONIC:  APO          ACTIVATE AN INACTIVE PROBLEM
***** ACTIVE PROBLEMS AND NOTES *****
SX1      01/01/89      Hypertension, Well Controlled with Medication
SX1SX1          HCTZ AM DAILY
***** INACTIVE PROBLEMS AND NOTES *****
SX2      01/30/89      Pneumonia RSV 3/89

Enter Problem Number:  ?
Enter a Problem Number in the form XXXNN, where XXX is the 2-4 digit
location abbreviation
and NN is a problem number from 1 to 999.99
Enter Problem Number:  SX2          SAN XAVIER HEALTH CENTER
TUCSON SELLS TUCSON 11 TUCSON SELLS TUCSON 11
Activating Problem SX 2. . .

```

Figure 12-4: Using the APO mnemonic to activate an inactive problem

Note: Patient problems will display if the Site File parameter is set.

This problem is presently Active. Problem number SX2 will now appear in the Active Problem Section of the Health Summary.

12.1.3 Using the MNN Mnemonic

To modify an existing Note Narrative, the provider must record the entire note number as shown on the Health Summary; for example, SX1SX1, in the Treatment Plan section of the form. The MNN mnemonic was developed to make modifying Notes easier; however, Notes can be also be modified using the NO mnemonic and going through each prompt as in the PV mnemonic described in Step 1 of this Section. MNN can also be used in the Enter menu option.

```

MNEMONIC: MNN          MODIFY NOTE NARRATIVE
***** ACTIVE PROBLEMS AND NOTES *****
SX1      0507/89      DIABETES MELLITUS
SX1SX1          DIABINESE 250 MG
*****No INACTIVE Problems on file for this Patient*****
Enter Problem Number: SX1          SAN XAVIER HEALTH CENTER
TUCSON SELLS TUCSON 11
Select NOTE FACILITY: SX          SAN XAVIER HEALTH CENTER
TUCSON SELLS TUCSON 11
Select NOTE NMBR: 1//
NOTE NARRATIVE: DIABINESE 250 MG// DIABINESE 100 MG
STATUS: ACTIVE//
Select NOTE FACILITY:
MNEMONIC:

```

Figure 12-5: Using the MNN mnemonic to modify a note narrative

Note: Type the appropriate facility name other than that which is displayed. Type the appropriate Note number to modify. The change is entered after the //.

The “at” sign (@) symbol is used to delete an entry and is generally typed at the first prompt. Use the RPO and RNO mnemonics to delete Problems and Notes. A data item should only be deleted if typed in error. The following visit will be deleted, as a duplicate entry was made.

```

MNEMONIC: PV          PURPOSE OF VISIT
1 250.00      METAA, BETTY ANN      MAR 21, 1998@13:00
1 250.00      METAA, BETTY ANN      MAR 21, 1998@13:00
Choose: 1
POV: 250.00// @
SURE YOU WANT TO DELETE THE ENTIRE V POV? Y      (YES)
MNEMONIC:

```

Figure 12-6: Deleting a duplicate entry

To delete a measurements, type the “at” sign (@) symbol after the “TYPE //” prompt. PCC will automatically display all measurements in alphabetical order for a specific visit date regardless of which mnemonic was typed.

```
MNEMONIC: WT      WEIGHT
1      BP METAA, BETTY ANN      MAR 21,1998@13:00 120/80
2      WT DEMO, PATIENT        MAR 21,1998@13:00 250
Choose: 2
TYPE: WT// @
SURE YOU WANT TO DELETE THE ENTIRE V MEASUREMENT? Y
MNEMONIC:
```

Figure 12-7: Deleting a measurement

12.1.4 Using the RPO Mnemonic

The RPO mnemonic is used to delete a Problem and Notes linked to the problem.

```
MNEMONIC: RPO      REMOVE PROBLEM ONLY
***** ACTIVE PROBLEMS AND NOTES *****
SX1      0507/8  DIABETES MELLITUS
  SX1SX1      DIABINESE 250 MG
***** INACTIVE PROBLEMS AND NOTES*****
SX2      08/03/89  CHRONIC UTI X 3
  SX2SX2      CONSIDER IVP AFTER NEXT EPISODE
Enter Problem Number: SX2
ARE YOU SURE THAT YOU WANT TO REMOVE PROBLEM NUMBER SX2?
(Y/N) Y
Removing Problem SX2 . . .
MNEMONIC:
```

Figure 12-8: Deleting a problem and notes linked to the problem

Note: Patient problems will only display if the Site File parameter is set. When the Problem number is typed, the system automatically deletes the Problem and notes (if any).

12.1.5 Using the RNO Mnemonic

The RNO mnemonic is used to delete a Note. Providers must indicate the entire note to be deleted, for example, SX1SX2.

```

MNEMONIC: RNO          REMOVE NOTE FROM PROBLEM
***** ACTIVE PROBLEMS AND NOTES *****
          12/18/89    CHRONIC URINARY TRACT INFECTION
SX1SX
SX1SX2          PO BID X 10 DAYS
*****No INACTIVE Problems on file for this
Patient*****
Enter Problem Number: SX1    SAN XAVIER HEALTH CENTER

TUCSON SELLS TUCSON 11
Select NOTE FACILITY: SAN XAVIER HEALTH CENTER// <RETURN>
SAN XAVIER HEALTH CENTER TUCSON SELLS TUCSON 11
Select NOTE NUMBER: 2
Are you sure you want to remove Note Number 2? (Y/N) Y
Removing Note Number 1
Select NOTE NMBR:
Select NOTE FACILITY:
MNEMONIC:

```

Figure 12-9: Deleting a note

Note: You must type **Y** or **N** before the Note is deleted. If another note is to be deleted, type at the “NOTE NMBR” prompt.

12.1.6 Reviewing the Changes

After data has been modified or deleted for visit related data items, the operator can use the mnemonics DISP and WHAT to review the visit changes on the screen. If non-visit-related data items were modified, e.g., Problems or Notes, etc., the operator can use the DHS mnemonic to review the data or the appropriate mnemonic, e.g. FHS, PHX, etc.

13.0 Append Data to Existing Visit Record (APP)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHR  EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: APP Append Data to an
Existing Visit Record

```

Figure 13-1: Selecting APP option from main data entry menu

Use the APP option to add data to an existing visit. It is commonly used in any of the following:

- Information is not available at the time the visit was initially entered into the system.
- A provider wants to add information to a patient's record concerning a specific visit.
- The operator missed typing one or more data items during the original processing of the form.

After the operator types the visit date to be Appended, the system searches for the visit(s). If more than one visit is found, the system displays the visits and requires the operator to make a selection. If only one visit is found, a Visit File is immediately displayed.

```

You are currently processing the following Patient Visit:

Patient Name: DEMO,JOHNNIE RUTH          Chart #: 118774
Date of Birth: MAR 01, 1981             Sex: F
Visit Date: DEC 06, 2008@13:45         Location: DEMO HOSPITAL
Type: T                                 Service Category: A
Clinic: GENERAL

===== MEASUREMENT'S =====
TYPE: WT      VALUE: 100

TYPE: WT      VALUE: 100

===== EXAM'S =====
EXAM: FALL RISK      RESULT: NORMAL/NEGATIVE
ENCOUNTER PROVIDER: UWPROVIDER,LISA R

===== CHART AUDIT'S =====
DATE OF AUDIT: DEC 16, 2008@16:25:07    CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 16, 2008@16:25:37    CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 16, 2008@16:28:53    CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 16, 2008@16:29:25    CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 16, 2008@16:29:40    CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 16, 2008@16:30:53    CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

MNEMONIC:

```

Figure 13-2: Only one visit is found and the visit file is being displayed

```
PATIENT: METAA, BETTY ANN has one or more VISITS on this date. 1
TIME: 14:00 LOC: SX TYPE: I CATEGORY: A CLINIC: DENTAL 2 TIME: 10:00
LOC: SX TYPE: I CATEGORY: A CLINIC: GENERAL Select one: 2
```

Figure 13-3: More than one visit found

This will display only if more than one visit is found for the patient on the visit date entered above.

```
Patient Name: METAA, BETTY ANN                      Chart#: 4662
Date of Birth: 06-21-57                               Sex: F
Visit Date: MAR 21, 1998@10:00
Type: I
Location: SAN XAVIER HEALTH CENTER      Service Category: A
Clinic: GENERAL
===== PROVIDER'S =====
PROVIDER: METAA, ARTHUR A PRIMARY/SECONDARY: PRIMARY
===== POV'S =====
          POV: 465.9                                PROVIDER NARRATIVE: URI

TYPE: BP BLOOD PRESSURE
VALUE: 120/80
MNEMONIC:
```

Figure 13-4: Patient visit information

Type the mnemonic for the data to be appended and respond to each data field as appropriate. The system will return to the “Mnemonic” prompt after entry of data for the mnemonic. Press ENTER to return to the primary Data Entry menu.

14.0 Append Data Using Item List Display (APL)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHR  EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: APL Append Data using
Item List Display

```

Figure 14-1: Selecting APL option from main data entry menu

Use the APL option to add data to an already existing visit. This option, however, uses screen data entry instead of the traditional roll-and-scroll, as previously described in the APP option.

The screen presented to the operator consists of the following parts:

- A header indicating that the user is in the option to update a PCC visit. It also contains the current date and time. This section may be using “reverse video,” and may, depending on the user’s computer or terminal color settings, be difficult to read. For example, dark blue text on a black background can be hard to see. If this is a problem, please contact your RPMS site manager to make the necessary adjustments.
- Basic visit data, including patient demographics, visit date and time, and clinic.
- A numeric list of all possible data elements to be modified using the APL option.

- Actions or commands that the operator can select are displayed in the bottom portion of the screen with a one- or two-character mnemonic for the desired action. Because this is the APL option, the default action is AD.

```

You are currently processing the following Patient Visit:

Patient Name: DEMO,JOHNNIE RUTH          Chart #: 118774
Date of Birth: MAR 01, 1981              Sex: F
Visit Date: DEC 06, 2008@13:45          Location: DEMO HOSPITAL
Type: T                                  Service Category: A
Clinic: GENERAL

===== MEASUREMENT'S =====
TYPE: WT      VALUE: 100

TYPE: WT      VALUE: 100

TYPE: AUD     VALUE:
100/100/100/95/90/90/85/80/105/105/105/105/100/100/95/90/

===== EXAM'S =====
EXAM: FALL RISK      RESULT: NORMAL/NEGATIVE
ENCOUNTER PROVIDER: UWPROVIDER,LISA R

===== CHART AUDIT'S =====
DATE OF AUDIT: DEC 16, 2008@16:25:07      CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 16, 2008@16:28:53      CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 16, 2008@16:30:53      CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

DATE OF AUDIT: DEC 17, 2008@14:36:44      CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: THETA,SHIRLEY

PCC DATA ENTRY VISIT UPDATE   Dec 17, 2008 14:37:17   Page: 1 of 1

Patient Name: DEMO,JOHNNIE RUTH   DOB: MAR 01, 1981   Sex: F   HRN:
11877
Visit Date: Dec 06, 2008@13:45     Clinic: GENERAL

1) Providers                15) Edema                29) Skin Test
w/Result
2) Blood Pressure           16) Presentation (OB)   30) Exam
3) Weight in LBS/OZs       17) Cervix Dilatation  31) Physical
Therapy
4) Gram Weight             18) Effacement         32) Patient
Education

```

```

5) Height in Inches           19) Station (Pregnancy)   33)
Treatments Provided
6) Height (Centimeter)       20) Vision Corrected     34) Activity
Time
7) Head Circumference        21) Vision Uncorrected   35) CPT Codes
8) Head Circ-Centimeter      22) Purpose of Visit     36) Visit
Information
9) Temperature               23) Uncoded POV         37) Clinic
10) Pulse                    24) POV and Problem      38)
Appointment Date/Time
11) Respiration              25) Operation/Procedures 39)
Evaluation&Management
12) Fundal Height            26) Uncoded Procedure    40)
Reproductive Factors
13) Fetal Heart Tones        27) Immunization        41) LMP
14) Abdominal Girth          28) Skin Test Placed    42) Other
Item-Mnemonics

          Enter ?? for more actions
AD  Add PCC Item              DV  Display Visit            HS  Health
Summary
MD  Modify PCC Item          OT  Other Items              HI  Historical
Data Entry
DE  Delete PCC Item          PL  Problem List Update     Q   Quit
Select Action: AD//

```

Figure 14-2: General patient and visit information and actions to take using APL

15.0 Modify Visit Date and/or Time (TIM)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHR  EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: TIM Modify Visit Date
and/or Time

```

Figure 15-1: Selecting the TIM option from the main data entry menu

Use the TIM option to change the date and/or time of a visit. A (AM) or P (PM) should be typed following the time to designate time of day. Both a date and time must be typed in one of the following formats:

DEC 28 @ 12P or 02 DEC 89 @ 12P or T@12P or
T-2 @ 12P or 120288 @ 12 P or 1202 @ 12P

```

Modify Visit Date and/or Time
Select PATIENT NAME: METAA, BETTY ANN      F   062157   4662
Enter VISIT date: 0321   (MAR 21, 1998)
VISIT/ADMIT DATE & TIME: MAR 21, 1998@13:00
DATE VISIT CREATED: MAR 30, 1998          TYPE: IHS
PATIENT NAME: METAA R, BETTY ANN          LOC. OF ENCOUNTER: DEMO HOSPITAL
SERVICE CATEGORY: AMBULATORY             CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 4                  DATE LAST MODIFIED: MAR 30, 1998

```

```

WALK IN/APP: UNSPECIFIED                      CREATED BY USER: BETAA,IRMA
USER LAST UPDATE: BETAA,IRMA
OLD/UNUSED UNIQUE VISIT ID: 5851010002522175
DATE/TIME LAST MODIFIED: DEC 17, 2008@14:42:48
CHART AUDIT STATUS: REVIEWED/COMPLETE
NDW UNIQUE VISIT ID (DBID): 000000002522175
VISIT ID: 1BJ3T-CIX

Do you want to see V FILE entries? No//

```

Figure 15-2: Modifying visit date and/or time

Note: The Y(es) allows the operator to review the V Files (Provider, POV, etc) before making decision.

```

-----
VISIT IEN: 2522175

HRN: DH 118774

----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: DEC 06, 2008@13:45
DATE VISIT CREATED: DEC 16, 2008           TYPE: TRIBE-NON 638/NON-COMPACT
PATIENT NAME: DEMO,JOHNNIE RUTH           LOC. OF ENCOUNTER: DEMO HOSPITAL
SERVICE CATEGORY: AMBULATORY              CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 12                 DATE LAST MODIFIED: DEC 17, 2008
WALK IN/APPT: WALK IN                     CREATED BY USER: TETER,SHIRLEY
USER LAST UPDATE: TETER,SHIRLEY
OLD/UNUSED UNIQUE VISIT ID: 5851010002522175
DATE/TIME LAST MODIFIED: DEC 17, 2008@14:42:48
CHART AUDIT STATUS: REVIEWED/COMPLETE
NDW UNIQUE VISIT ID (DBID): 000000002522175
VISIT ID: 1BJ3T-CIX

Enter to continue, '^' to halt

----- V MEASUREMENT -----
TYPE: WT                                PATIENT NAME: DEMO,JOHNNIE RUTH
VISIT: DEC 06, 2008@13:45              VALUE: 100
%RW (c): 74% ^
TYPE: WT                                PATIENT NAME: DEMO,JOHNNIE RUTH
VISIT: DEC 06, 2008@13:45              VALUE: 100
%RW (c): 74% ^
TYPE: AUD                                PATIENT NAME: DEMO,JOHNNIE RUTH

```



```
DATE OF AUDIT: DEC 17, 2008@14:36:44    PATIENT: DEMO,JOHNNIE RUTH
VISIT: DEC 06, 2008@13:45              CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: TETER,SHIRLEY

DATE OF AUDIT: DEC 17, 2008@14:42:47    PATIENT: DEMO,JOHNNIE RUTH
VISIT: DEC 06, 2008@13:45              CHART AUDIT STATUS:
REVIEWED/COMPLETE
AUDITOR/USER: TETER,SHIRLEY

~~~~~

End of visit display, <ENTER> to Continue

The date and time of the VISIT is DEC 6,2008@13:45

Enter new date and time:
```

Figure 15-3: Display of information and prompt to type new date and time

16.0 Enter Data with Visit Display and Actions (EAC)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHR  EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: EAC Enter Data with
Visit Display and Actions

```

Figure 16-1: Selecting EAC option from main data entry menu

Use the EAC option to create a new visit, modify data in an existing visit, or append data to an existing visit.

- For new visits, the operator is prompted for basic visit data, e.g. date and time of visit, location, type, and service category in the traditional roll-and-scroll format.
- Once the basic visit data has been typed, the display changes to a screen format that lists patient demographics at the top, visit information in the center, and finally the actions the user can take in order to edit the visit.

```

                                PCC Data Entry Module

*****
***** PCC DATA ENTRY UPDATE VISIT BY ITEM *****
*****

Select LOCATION NAME: DEMO HOSPITAL//           HEADQUARTERS WEST           NON SVC UNIT
01                      NM HOSPITAL 1601
TYPE: T// TRIBE-NON 638/NON-COMPACT
SERVICE CATEGORY: A// AMBULATORY

ISIT DATE: T-11 (DEC 06, 2008)

Select PATIENT NAME: DEMO,JOHNNIE RUTH
DEMO,JOHNNIE RUTH           <A>   F 03-01-1981 XXX-XX-4021  DIH 118773
                                                                DH 118774
                                                                URA 118775

                                Ok? Yes// (Yes)

PATIENT: DEMO,JOHNNIE RUTH has VISITs, same date, location.

1 Create New VISIT
2 Exit without selecting VISIT
3 Display one of the existing VISITs

Or select one of the following existing VISITs:

4 TIME: 13:45 TYPE: T CATEGORY: A CLINIC: GENERAL DEC: 12
Choose one: (1-4): 4//

PCC VISIT EDIT                      Dec 17, 2008 15:23:33                      Page: 1 of 5

Patient Name: DEMO,JOHNNIE RUTH
Chart #: 118774
Date of Birth: MAR 01, 1981
Sex: F

<1> ===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: DEC 06, 2008@13:45
DATE VISIT CREATED: DEC 16, 2008
TYPE: TRIBE-NON 638/NON-COMPACT
PATIENT NAME: DEMO,JOHNNIE RUTH
LOC. OF ENCOUNTER: DEMO HOSPITAL
SERVICE CATEGORY: AMBULATORY
CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 12
DATE LAST MODIFIED: DEC 17, 2008
WALK IN/APPT: WALK IN
CREATED BY USER: TETER,SHIRLEY

+      - Prev Screen      Q Quit      ?? for More Actions
1 Add Provider           4 Add Measurement      7 Edit/Delete Item
2 Add Diagnosis         5 Add Skin Test        8 Edit Problem List
3 Add Procedure         6 Add Immunization    9 Other PCC Visit Items
Select Item(s): +//

```

Figure 16-2: PCC visit edit display

You can take the following actions at the “Select Item(s)” prompt:

- If you are not on the last page of data, type plus (+) to display the next page of information.
- If you are not on the first page of data, type minus (-) to display the previous page of information.
- Type **Q** to quit the screen.
- Type one of the numbered actions to update the visit.

To add a primary provider to the visit, type **1** and press ENTER to see the following screen:

```

Adding Providers

Enter PROVIDER (code/initials or name): SMITH, SCPROVIDER ONE
P)rimary or S)econdary: p PRIMARY

Date Provider Seen: Jan 12, 1999// (JAN 12, 1999)
Time Provider Seen: 13:45
JAN 12, 1999@13:45
Enter a SECONDARY PROVIDERS (code/initials or name):

```

Figure 16-3: Adding providers

If you type the Other PCC Visit Items, selection 9, you will have access to all editable PCC data items. The following screen will display:

```

PCC DATA ENTRY VISIT      Jan 21, 1999 10:39:49      Page: 1 of 1
Patient Name: MOUSE,MINNIE  DOB: JAN 25, 1941  Sex: F  HRN 1000010
Visit Date: Jan 12, 1999@12:00  Clinic: GENERAL

1) Providers                15) Edema                    29) Skin Test w/Result
2) Blood Pressure           16) Presentation (OB)       30) Exam
3) Weight in LBS/OZs        17) Cervix Dilatation       31) Physical Therapy
4) Gram Weight              18) Effacement              32) Patient Education
5) Height in Inches         19) Station (Pregnancy)     33) Treatments Provided
6) Height (Centimeter)      20) Vision Corrected        34) Activity Time
7) Head Circumference       21) Vision Uncorrected      35) CPT Codes
8) Head Circ-Centimeter     22) Purpose of Visit        36) Visit Information
9) Temperature              23) Uncoded POV            37) Clinic
10) Pulse                   24) POV and Problem         38) Appointment Date/Time
11) Respiration             25) Operation/Procedures    39) Evaluation&Management
12) Fundal Height           26) Uncoded Procedure       40) Reproductive Factors
13) Fetal Heart Tones       27) Immunization            41) LMP
14) Abdominal Girth         28) Skin Test Placed        42) Other Item-Mnemonics

Enter ?? for more actions

AD  Add PCC Item            DV  Display Visit              HS  Health Summary
MD  Modify PCC Item         OT  Other Items                 HI  Historical Data Entry
DE  Delete PCC Item         PL  Problem List Update        Q   Quit
Select Action: AD//

```

Figure 16-4: Display of data to add

17.0 Enter PCC Data Using Item List Display (MNE)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: MNE Enter PCC Data Using
Item List Display

```

Figure 17-1: Selecting MNE option from main data entry menu

The MNE option functions very much like that previously discussed for EAC (Enter Data with Visit Display and Actions). The main difference is that the MNE option does not display the items contained in the current visit.

First, the user is prompted for the basic visit data elements of location, type, service category, visit date, patient name, and clinic.

```

Select PATIENT NAME: DEMO,JOHNNIE RUTH

  DEMO,JOHNNIE RUTH      <A>   F 03-01-1981 XXX-XX-4021  DIH 118773
                                                                DH 118774
                                                                URA 118775

                                Ok? Yes//   (Yes)

PATIENT: DEMO,JOHNNIE RUTH has VISITs, same date, location.

1  Create New VISIT
2  Exit without selecting VISIT
3  Display one of the existing VISITs
Or select one of the following existing VISITs:

4  TIME: 13:45 TYPE: T  CATEGORY: A  CLINIC: GENERAL  DEC: 15
Choose one:  (1-4): 4//

PCC DATA ENTRY VISIT UPDATE   Dec 17, 2008 15:43:47   Page: 1 of 1

Patient Name: DEMO,JOHNNIE RUTH  DOB: MAR 01, 1981  Sex: F  HRN: 11877
Visit Date:  Dec 06, 2008@13:45   Clinic:  GENERAL

1)  Providers          15)  Edema                29)  Skin Test w/Result
2)  Blood Pressure     16)  Presentation (OB)  30)  Exam
3)  Weight in LBs/OZs  17)  Cervix Dilatation  31)  Physical Therapy
4)  Gram Weight        18)  Effacement        32)  Patient Education
5)  Height in Inches   19)  Station (Pregnancy) 33)  Treatments Provided
6)  Height (Centimeter) 20)  Vision Corrected  34)  Activity Time
7)  Head Circumference 21)  Vision Uncorrected 35)  CPT Codes
8)  Head Circ-Centimeter 22)  Purpose of Visit  36)  Visit Information
9)  Temperature        23)  Uncoded POV       37)  Clinic
10)  Pulse              24)  POV and Problem    38)  Appointment Date/Time
11)  Respiration        25)  Operation/Procedures 39)  Evaluation&Management
12)  Fundal Height      26)  Uncoded Procedure  40)  Reproductive Factors
13)  Fetal Heart Tones  27)  Immunization       41)  LMP
14)  Abdominal Girth    28)  Skin Test Placed   42)  Other Item-Mnemonics

      Enter ?? for more actions
AD  Add PCC Item        DV  Display Visit          HS  Health Summary
MD  Modify PCC Item     OT  Other Items            HI  Historical Data Entry
DE  Delete PCC Item     PL  Problem List Update   Q   Quit
Select Action: AD//

```

Figure 17-2: Prompt for basic visit data elements

There are numerous actions listed at the bottom of the screen from which the operator can choose. The most commonly selected action is AD (Add PCC Item), which is the default.

To add a Diabetic Foot Exam, Complete, the user selects the AD action followed by Item 28, as shown below:

```

Adding Exam

Select V EXAM: ??

  Choose from:
  FALL RISK
    You may enter a new V EXAM, if you wish
    This is the entry in the Exam file that represents what type
of exam was done at the encounter.

  Choose from:
  ALCOHOL SCREENING          35
  DENTAL EXAM                30
  DEPRESSION SCREENING      36
  DIABETIC EYE EXAM         03
  DIABETIC FOOT EXAM, COMPLETE 28
  FALL RISK                  37
  FOOT INSPECTION           29
  INTIMATE PARTNER VIOLENCE  34
Select V EXAM: 28  DIABETIC FOOT EXAM, COMPLETE  28
RESULT: ??

N is a valid choice for all exam types
PR, PAP, PA are only valid for Intimate Partner Violence exam type
A is not valid for Intimate Partner Violence/Alcohol
Screening/Depression Screening exam types
PO is valid for Depression Screening and Alcohol Screening exam
types
  Choose from:
  A      ABNORMAL
  N      NORMAL/NEGATIVE
  PR     PRESENT
  PAP    PRESENT AND PAST
  PA     PAST
  PO     POSITIVE
RESULT: A  ABNORMAL
COMMENTS:
PROVIDER PERFORMING EXAM: smith
  1  SMITH  ETEST,JENNIFER J
  2  SMITH  QPROVIDER,KENT W
  3  SMITH  KPROVIDER,PETER
  4  SMITH  PPROVIDER,JUANITA
  5  SMITH  OXPROVIDER,DAMA J
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 2  QPROVIDER,KENT W

Press return to continue...:

```

Figure 17-3: Selecting the AD action

After you press ENTER, you are returned to the list of items that you can add/change or delete.

18.0 Group Preventative Form Entry (GRP)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventative Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHR  EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: GRP Group Preventive
Form Entry

```

Figure 18-1: Selecting GRP option from main data entry menu

Use the GRP option to type data from the PCC Group Preventive Services Form, IHS-367 used by PHNs/CHNs. Use of this option is not limited to those provider classes, however. It can be used any time an identical service is provided to multiple patients where the encounter occurred at the same location on the same date and time.

This menu option requires the data entry operator to first type all constant information, e.g. Visit Type, Location, Provider, Purpose of Visit and Clinic once for all patients and then type variable information, e.g. immunization, skin test readings, etc. individually for each patient. When a patient name is entered, a new visit is automatically generated duplicating the above set data items (Type, Location, PRV PV and CL). The system then leaves the operator at the “Mnemonic” prompt in a patient’s visit so individual mnemonics can be typed. Press ENTER at the “Mnemonic” prompt completes the visit for that patient.

Correcting an error is done in the same manner as other visits created in PCC. The MOD mnemonic is typed at the "Mnemonic" prompt, followed by the mnemonic that requires the change. Refer to MOD in Section 10.0

```

                                PCC Data Entry Module

                                *****
                                * GROUP PREVENTIVE FORM ENTER Mode *
                                *****

LOCATION OF GROUP VISIT: DEMO INDIAN HOSPITAL      TUCSON      NON SVC UNIT
01      NM                                  1601
TYPE.....: IHS
SERVICE CATEGORY.....: a AMBULATORY
VISIT/ADMIT DATE.....: t-11 (DEC 06, 2008)
TIME OF VISIT.....: 12:00// (DEC 06, 2008@12:00)
CLINIC.....:
WARNING: No Clinic Type entered for this visit and clinic is required!

VISIT/ADMIT DATE.....: t-11 (DEC 06, 2008)
TIME OF VISIT.....: 12:00// (DEC 06, 2008@12:00)
CLINIC.....: 82 DAY TREATMENT PROG      82
Enter PRIMARY Provider.: SCPROVIDER,ONE
Enter SECONDARY Provider:

Enter PURPOSE of VISIT: 401.1      BENIGN HYPERTENSION
PROVIDER NARRATIVE: 19 19

Enter PURPOSE of VISIT:
Any Patient Education to add to each patient's visit? N// NO

The following information will be used for the visits being created for
this group form. Please review the information for accuracy.

Visit Date:   Dec 06, 2008@12:00      Type: IHS
Location:     DEMO INDIAN HOS      Service Category: AMBULATORY
Clinic:       DAY TREATMENT PROG

Providers:    SCPROVIDER,ONE      PRIMARY

POV's:       401.1      Narrative: 19

Do you want to continue? Y// YES

The form ID for this group form is G3623.
Please make a note of this. It will be needed if and when you need to
re-print forms.

```

Figure 18-2: Sample PCC Group Preventive Services Form

19.0 Enter Historical Inpatient Visits (HIN)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: HIN Enter Historical
INPATIENT Visits

```

Figure 19-1: Selecting HIN option from main data entry menu

Use the HIN option to type patient data regarding a stay at another facility or in the past at your facility. For example, if a patient stayed at the Phoenix Indian Medical Center and the provider wants to capture the data about the hospitalization on their local computer, the HIN option would be used. This captures the data and displays it in the Health Summary for use by the provider, but does *not* allow it to be transmitted in the Data Transmission. This option will *not* be used for capturing regular Inpatient stays at your facility, but rather the Enter/Mini option and the IP mnemonic would be used. When HIN is used, a visit is created and the system automatically goes into the IP (Inpatient) mnemonic. HIN is used with the form IHS 44-1 Clinical Record Brief-IHS Inpatient Services.

```

                                PCC Data Entry Module

*****
*   Historical Inpatient ENTER Mode   *
*****

Select LOCATION NAME: SELLS HOSP      TUCSON  SELLS  01
TYPE: i  IHS
VISIT/ADMIT DATE: 041691  (APR 16, 1991)
TIME OF VISIT: 10:39P  (APR 16, 1991@22:39)

Select PATIENT NAME: SIGMA,BETA
                                <A>   F 10-23-1948 XXX-XX-7721  DIH 100546
                                                                DH 777721
                                                                URA 100548

                                Ok? Yes//  (Yes)

-----

VISIT IEN: 2522182

HRN: DH 777721
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: APR 16, 1991@22:39
DATE VISIT CREATED: DEC 17, 2008      TYPE: IHS
PATIENT NAME: SIGMA,BETA              LOC. OF ENCOUNTER: SELLS HOSP
SERVICE CATEGORY: HOSPITALIZATION     DATE LAST MODIFIED: DEC 17, 2008
DATE VISIT EXPORTED: DEC 17, 2008     CREATED BY USER: TETER,SHIRLEY
USER LAST UPDATE: TETER,SHIRLEY
OLD/UNUSED UNIQUE VISIT ID: 5851010002522182
DATE/TIME LAST MODIFIED: DEC 17, 2008@16:15:01
NDW UNIQUE VISIT ID (DBID): 000000002522182
VISIT ID: 1BJ43-CIX

-----

Hospitalization Information      ALLOWED      VISIT RELATED ONLY
Enter Date of Discharge: 042391  (APR 23, 1991)
ADMISSION TYPE: 1 DIRECT      ADMISSION      ACTIVE      1
ADMITTING SERVICE: 03
  1  03  GENERAL MEDICINE      GMS      03
  2  030 MEDICINE OBSERVATION  MEDO      030
CHOOSE 1-2: 1 GENERAL MEDICINE  GMS      03
DISCHARGE SERVICE: 03
  1  03  GENERAL MEDICINE      GMS      03
  2  030 MEDICINE OBSERVATION  MEDO      030
CHOOSE 1-2: 1 GENERAL MEDICINE  GMS      03
DISCHARGE TYPE: 1 REGULAR DISCHARGE      DISCHARGE      ACTIVE  1
NUMBER OF CONSULTS: 0
ADMITTING DX: .012
  1  .012 .0120      AVERAGE RISK GE
  2  .0121      HIGH RISK GE
  3  .0122      UNKNOWN RISK GE
CHOOSE 1-3: 1 .0120      AVERAGE RISK GE

```

```

Providers (Primary/Secondary)      ALLOWED      VISIT RELATED ONLY
Enter PROVIDER (code/initials or name): FJPROVIDER,SYED ISHRAT
P)rietary or S)econdary: p  PRIMARY
O)perating or A)ttending: o  OPERATING
Date Provider Seen: Apr 16, 1991//  (APR 16, 1991)
Time Provider Seen: 13:45
Apr 16, 1991@13:45  (APR 16, 1991@13:45)
Enter a SECONDARY PROVIDER (code/initials or name):

Purpose of Visit      ALLOWED      VISIT RELATED ONLY
Enter PURPOSE of VISIT: ??

Choose from:
.007      TB CONVERTOR (NEG WITHIN 1 YR)
.012      AVERAGE RISK GE
.0121     HIGH RISK GE
.0122     UNKNOWN RISK GE
.014      ALCOHOLIC SEIZURE
.015      UNMET SURGICAL NEEDS
.0151     PERSONAL HISTORY
.0152     FAMILY HISTORY
.04       POS CULTURE,ACID-FAST BACILLUS
.041      POSITIVE CULTURE FOR GONORRHEA
.042      POSITIVE CULTURE, STREP THROAT
.0534     SINGLE PARENT
.054      TEENAGE PARENT
.065      COPING WITH DEATH AND DYING
.068      SUICIDE ATTEMPTS/GESTURES
.069      SUICIDE COMPLETED
.072      PROBLEMS WITH HEALTH SYSTEM
.079      ARRESTED AND CURRENTLY JAILED
.0791     PROBATION AND PAROLE
          ^
Enter PURPOSE of VISIT:

```

Figure 19-2: Using the HIN option to type past patient visit information

Note: Refer to the IP mnemonics in the Mnemonics manual for details on each item, including help prompts.

Type any other data contained on the form using the appropriate mnemonic at the “Mnemonic” prompt, e.g., PO (Problems Only), etc. Notice that the Visit File has the Date Exported automatically populated using the date the form was entered. This means the visit will not transmit.

20.0 Tran Code (DTC) Entry for All Visits (DTC)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: DTC Tran Code (DTC)
Entry for All Visits

```

Figure 20-1: Selecting DTC option from main data entry menu

Use the DTC option to associate Chargemaster Transaction Codes with visits containing diagnostic procedures. The codes are usually recorded on special-purpose billing documents such as a Superbill. In order to use this option, a Chargemaster Transaction File must be loaded on the RPMS system. For specific directions on using tran codes, refer to instructions from the provider of the Chargemaster Transaction File.

21.0 Enter Tran Codes on IN-HOSPITAL Visits (TCH)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: TCH Enter Trans Codes on
IN-Hospital Visits

```

Figure 21-1: Selecting TCH option from main data entry menu

Use the TCH option to associate Chargemaster Transaction Codes with In-Hospital visit procedures. The codes are usually recorded on a special-purpose billing form such as a Superbill. In order to use this option, a Chargemaster Transaction File must be loaded on your system. For specific directions on correct utilization of tran codes, refer to instructions from the provider of the Chargemaster Transaction File.

22.0 Enter Tran Codes on Outpatient Visits (TCO)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                IHS PCC Suite Version 2.0

                DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: TCO Enter Trans Codes on
Outpatient Visits

```

Figure 22-1: Selecting TCO option from main data entry menu

Use the TCO option to associate Chargemaster Transaction Codes with Outpatient visit procedures. The codes are usually recorded on a special-purpose billing form such as a Superbill. In order to use this option, a Chargemaster Transaction File must be loaded on your system. For specific directions on correct utilization of tran codes, refer to instructions from the provider of the Chargemaster Transaction File.

23.0 Update Diabetes Patient Data (DMU)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: DMU Update Diabetes
Patient Data

```

Figure 23-1: Selecting DMU option from main data entry menu

Use the DMU option to update a patient's file with diabetes-related information, including: date of DM onset, height and weight, BP, health factors, foot exam date and result, eye exam date and result, depression screening date and result, dental exam date, pap smear date, mammogram date and type, EKG date and result, immunizations, PPD date and reading, patient education, labs, and medications.

```

                                PCC DATA ENTRY

                                Diabetes Patient Data Update

Select PATIENT NAME: DEMO,CHRISTA DANIELLE                F 03-14-2006
DH 172684

The data you enter for the above patient will be updated in the PCC
database.

Do you wish to continue? Y// YES

                ***** DIABETES PATIENT DATA UPDATE *****
Patient Name: DEMO,CHRISTA DANIELLE                HRN: 172684
-----
Problem Number:                Date of DM Onset:
Height Date:                Height Value:
Weight Date:                Weight Value (lbs):
BP Date:                BP Value:
Any HEALTH FACTORS to record? N
Foot Exam Date:                Foot Exam Result:
Eye Exam Date:                Eye Exam Result:
Depression Screening Date:                Depression Screening Result:
Dental Exam Date:                Pap Smear Date:
Mammogram Date: NOV 12, 2006                Type of Mammogram: ABDOMEN 3 OR MORE
VIEWS
EKG Date:                EKG Result:
Do wish to enter Td, Influenza or Pneumovax immunizations? N
PPD Date:                PPD Reading:
Any EDUCATION to record? N Any LABs to enter? N Any Medications to Enter?
N

-----
Exit      Save      Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                Press <PF1>H for help      Insert

```

Figure 23-2: The DMU data entry menu

Press ENTER to move from one field to another.

After you type the information, you may do any of the following at the “Command” prompt:

- Type **Exit** to leave the screen (you will be asked to save if you changed any data and have used the Save command).
- Type **Save** to save the data you entered. You remain on the screen.
- Type **Refresh** to refresh the display of data on the screen.
- Type a caret (^) before a caption to jump to the specified field.

24.0 Entry of Data for a Cohort of Patients (EC)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC  Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: EC Entry of Data for a
Cohort of Patients

```

Figure 24-1: Selecting EC option from main data entry menu

Use the EC option to select data items to type in a PCC Visit for specific patients of your choosing.

```

PCC Item Selection          Mar 07, 2008 11:09:42          Page: 1 of 1
PCC ITEM SELECTION MENU
The following data items can be selected to be entered on a PCC Visit.
Choose the items you wish to enter on each PCC Visit.

1)  Providers                15)  CPT Codes                29)  Patient Education
2)  Purpose of Visit        16)  Exam                    30)  Health Factor
3)  Blood Pressure          17)  Immunization           31)  Radiology Exam
4)  Height in Inches        18)  Skin Test w/Result      32)  EKG
5)  Weight in Lbs/OZs      19)  Skin Test Placed       33)  Activity Time
6)  Head Circumference     20)  Lab Test                34)  PHN FORM ITEMS
7)  Hearing                  21)  Urinalysis Ordered     35)  ER Visit Record
8)  Vision Uncorrected     22)  Hematocrit Ordered     36)  Elder Care
9)  Vision Corrected       23)  Pap Smear Ordered      37)  Reproductive Factors
10)  Temperature           24)  Blood Sugar Ordered    38)  LMP
11)  Pulse                  25)  CBC Ordered            39)  Family Plan Method
12)  Respiration           26)  Prescription RX        40)  Family Planning
13)  Evaluation&Managemen  27)  Physical Therapy       41)  EDC
14)  Operation/Procedures  28)  Treatments Provided

Enter ?? for more actions
S   Select PCC Item        R   Remove PCC Item        Q   Quit
Select Action: S//

```

Figure 24-2: The Cohort of Patients menu

At the “Select Action” prompt, select the number of the item you would like to type for each PCC visit. Enter the items one at a time. When you are finished selecting items, type **Q** to exit from this menu.

The system will prompt you to type the location name, type, service category, and clinic. Next, you will be asked to select whether to enter a cohort (template) of patient names or individual patient names.

The following PCC Data Items will be prompted for each visit created:

EX Exam

Select LOCATION NAME: DEMO HOSPITAL// HEADQUARTERS WEST NON SVC UNI
 T 01 NM HOSPITAL 1601
 TYPE: T// TRIBE-NON 638/NON-COMPACT
 SERVICE CATEGORY: A// AMBULATORY
 Enter CLINIC: GENERAL// 01

Select one of the following:

C Enter a COHORT (template) of Patient Names
 I Be prompted for Individual Patient Names

Would you like to: I// Be prompted for Individual Patient Names

Select PATIENT NAME: DEMO
 1 DEMO,BIANCA SHOOK F 05-19-1935 XXX-XX-2531 DIH 103476
 DH 103477
 URA 103478
 2 DEMO,CHRISTA DANIELLE F 03-14-2006 DH 172684
 3 DEMO,CORRINE ALYSE F 11-30-1989 DIH 155242
 DH 155243
 URA 155244
 4 DEMO,JOHNNIE RUTH <A> F 03-01-1981 XXX-XX-4021 DIH 118773
 DH 118774
 URA 118775
 5 DEMO,KYLE VANCE M 03-05-1957 XXX-XX-8353 DIH 164281
 DH 164282
 URA 164283

ENTER '^' TO STOP, OR

CHOOSE 1-5: 5

DEMO,KYLE VANCE M 03-05-1957 XXX-XX-8353 DIH 164281
 DH 164282
 URA 164283

Ok? Yes// (Yes)

Generating PCC Visit for DEMO,KYLE VANCE DOB: Mar 05, 1957

VISIT/ADMIT DATE: T-25 (NOV 22, 2008)

TIME OF VISIT: 13:30 (NOV 22, 2008@13:30)

Examinations ALLOWED VISIT RELATED ONLY
 Select V EXAM: 28 DIABETIC FOOT EXAM, COMPLETE 28

RESULT: A ABNORMAL

COMMENTS:

PROVIDER PERFORMING EXAM: SMITH, OXPROVIDER,DAMA J

You may now enter other data using any of the data entry mnemonics.
 To display the visit type DISP, to display a health summary type DHS.
 Press enter to exit.

MNEMONIC:

WARNING: No purpose of visit entered for this visit!

WARNING: No provider of service entered for this VISIT!

WARNING: No primary provider entered for this visit!

Is coding complete for this visit (is all data entry completed)? Y// YES

```
Please update the visit status for this visit.

CHART AUDIT STATUS: REVIEWED/COMPLETE//  REVIEWED/COMPLETE
Do you want to update the Chart Audit Notes for this visit? N// NO
PV mnemonic required!

MNEMONIC: XIT          Quick Out      ALLOWED      VISIT RELATED ONLY

This is the 'Quick Exit' from Data Entry Enter Mode.  This visit
will be deleted and you will be returned to the 'VISIT/DATE TIME' prompt.

Do you wish to Proceed with the Deletion? N// NO
Do you still wish to EXIT this Visit? Y// YES

WARNING - You may be leaving an INCOMPLETE VISIT!!
Looking for ancillary data to merge into this visit...

Select PATIENT NAME:
```

Figure 24-3: The Cohort of Patients menu, continued

25.0 Display a Count of Forms You Have Processed (MFC)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: MFC Display a Count of
Forms you have Processed

```

Figure 25-1: Selecting MFC

Use the MFC option to display a count of forms you have processed. You may organize the list by clinic type, service category, visit type, or simply list all of these.

```

Select Enter/Modify/Append PCC Data Option: MFC Display a Count of Forms
you have processed
This report will generate a count of visits entered by you for a date range
that you specify.
The report can be subtotaled by CLINIC TYPE, SERVICE CATEGORY OR BY VISIT
TYPE.
Enter beginning Posting Date: T-10 (FEB 26, 2008)
Enter ending Posting Date: FEB 26, 2008// T (MAR 07, 2008)
  Select one of the following:
    1          CLINIC TYPE
    2          SERVICE CATEGORY
    3          VISIT TYPE
    4          INCLUDE ALL VISITS
Count number of Forms Processed by: 4// INCLUDE ALL VISITS

Subtotal by Visit Date? N//
DEVICE: HOME//      VT      Right Margin: 80//

Mar 07, 2006   Page 1
DEMO HOSPITAL
NUMBER OF FORMS KEYED
DATE ENTRY OPERATOR: OPERATOR1
VISIT POSTING DATES: Feb 26, 2008 TO Mar 07, 2008

          POSTING DATE    # FORMS    # DEP ENT    AVG # DEP ENT
-----
          FEB 27, 2008    1          5            5
          MAR 06, 2008    1          4            4
          -----
Totals for OPERATOR1          2          9            4.5

RUN TIME (H.M.S): 0.0.0
Enter RETURN to continue or '^' to exit:

```

Figure 25-2: Displaying a count of forms

26.0 Enter/Edit Suicide Forms (SF)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: SF Enter/Edit Suicide
Forms ...

```

Figure 26-1: Select SF

The Suicide Form (SF) option contains a submenu that allows you to review suicide reporting forms by date or to update a suicide reporting form for a patient.

```

SFD  Review Suicide Reporting Forms by Date
SFP  Update Suicide Reporting Form for a Patient

```

Figure 26-2: SF submenu options

Below is an example of the SFD option.

```

Select Enter/Modify/Append PCC Data Option: SF  Enter/Edit Suicide Forms

*****
**      PCC Data Entry Module      **
**  Enter/Edit Suicide Forms      **
*****
      IHS PCC Suite Version 2.0

      DEMO HOSPITAL

SFD  Review Suicide Reporting Forms by Date
SFP  Update Suicide Reporting Form for a Patient

Select Enter/Edit Suicide Forms Option: SFD  Review Suicide Reporting Forms
by Date
      Review/Update Suicide Reporting Forms by Date
Enter Beginning Suicide form date:  T-10  (FEB 26, 2008)
Enter Ending Suicide form date:    T  (MAR 07, 2008)

REVIEW SUICIDE FORMS           Mar 07, 2008 11:22:29      Page: 1 of 1
Suicide Reporting Form Review: Feb 26, 2008 - Mar 07, 2008
      Date                               Self Destructive
No.  of Act  Patient      HRN    DOB      Act                PRV Loc
1)   03/06/08 SMITH,JANE  000000 07/01/89 ATTEMPT      DR. JONES 11

Enter ?? for more actions                                >>>
AF  Add Form                XF  Delete Form                Q  Quit
EF  Edit Form                +  Next Screen
DF  Display Form            -  Previous Screen
Select Action:+// Q

```

Figure 26-3: Review Suicide Reporting form

Below is an example of the SFP option.

```

*****
**      PCC Data Entry Module      **
**      Enter/Edit Suicide Forms    **
*****
      IHS PCC Suite Version 2.0

      DEMO HOSPITAL

SFD      Review Suicide Reporting Forms by Date
SFP      Update Suicide Reporting Form for a Patient

Select Enter/Edit Suicide Forms Option: SFP  Update Suicide Reporting Form
for a Patient
Update Suicide Forms
Select PATIENT NAME: 000000

View/Update Suicide Form      Mar 07, 2008 11:25:41      Page: 1 of 1
Suicide Reporting Forms on File for: SIGMA,JANE

HRN: 000000      FEMALE      DOB: Jul 01, 1989
Tribe: DEMO TRIBE Community: DEMO

1) Local Case #: 11      Computer Generated Case #:
00000000000000000000
   Date of Act: MAR 01, 2007      Provider: DR. SIGMA
   Self Destructive Act: ATTEMPT
   Method: STABBING/LACERATION

Enter ?? for more actions      >>>
AF      Add Suicide Form      XF      Delete Suicide Form
EF      Edit Suicide Form      HS      Health Summary
DF      Display Suicide Form   Q      Quit
Select Item(s): Quit// Q

```

Figure 26-4: Update Suicide Reporting form

27.0 EHR/PCC Coding Audit Menu (EHRC)

```

*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: EHRC EHR/PCC Coding
Audit Menu ...

```

Figure 27-1: Selecting EHRC

The EHRC option contains a submenu that presents several options, as shown below.

```

EHRD  EHR/PCC Coding Audit for Visits in Date Range
PEHR  EHR/PCC Coding Audit for One Patient
ACDR  Add new Chart Deficiency Reason to Table
TUR   Count Unreviewed Visits by Date/Service Category
ACRX  Auto-Complete Pharmacy Education Only Visits
CASP  Update EHR Coding Audit Site Parameters
INCV  List Visits Marked as Incomplete
LIR   List Unreviewed/Incomplete Visits
TRV   Tally of Reviewed/Completed Visits by Operator

```

Figure 27-2: Options in the EHRC submenu

27.1 EHR/PCC Audit for Visits in Date Range (EHRD)

Use the EHRD option to display the following information:

```

DEMO HOSPITAL                                PCC/EHR CODING AUDIT
This list can be used to audit visits that are created by EHR users.
The visits displayed in the list are those with an INCOMPLETE or blank chart
audit status. This list can be sorted by date, primary provider clinic
code, hospital location (scheduling clinic), and facility. Once the visit
has been reviewed, the review status can be set as reviewed/complete or
incomplete. All visits set as reviewed/complete will be passed to the
IHS/RPMS billing package.
Contract Health visits are excluded. Visits that do not have a primary
provider are also excluded.
Visits with the following service categories are INCLUDED in the list:
  - A Ambulatory          S Day Surgery          O Observation
  - T Telecommunications C Chart Review        R Nursing Home
  - I In Hospital
PLEASE NOTE: A visit will NOT pass to Billing until it is marked
as reviewed/completed.
PLEASE ALSO NOTE: Incomplete/orphan ancillary visits do not show up
on this list. These visits will show up on the LIR and PPPV reports
and will need to be completed and flagged as complete through the normal
data entry process.

You should limit your date range to no more than 7 days. Viewing more than
7 days worth of visits may take a while to process.
Enter Beginning Visit Date:

```

Figure 27-3: Beginning information about the EHRD option

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, enter the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, enter the end of the date range.
3. At the “Do you wish to continue with this date range? Y//” prompt, type **Y** to continue with the date range. Otherwise, type **N** and type a new date range.
4. At the “Select one of the following” prompt, you may type any of the following choices.

A - ALL Locations/Facilities
 S - Selected set or Taxonomy of Locations
 O - ONE Location/Facility

If you use S or O, other prompts will display.

5. At the “Enter a code indicating what Clinics (IHS clinic code) are of interest” prompt, type the clinic code.

6. At the “Enter a code indicating what providers are of interest” prompt, type the code for the providers.
7. At the “Select visits based on chart deficiency reason” prompt, enter the code for the visits.
8. At the “Demo Patient Inclusion/Exclusion” prompt, type the code of inclusion or exclusion.
9. The following information is included to the user:

```

Do you wish to continue? Y// ES

Please note:  On the list of visits that will be displayed
there is a column labeled 'INS', in this column M stands for
Medicare, C stands for Medicaid and P stands for Private
Insurance.  This does not mean the visit is billable, it just
is an indication of whether or not the patient has a policy on
file that is currently active.

      Select one of the following:

          N      Patient Name
          H      HRN
          D      Date of Visit
          T      Terminal Digit of HRN
          S      Service Category
          L      Location of Encounter
          C      Clinic
          O      Hospital Location
          P      Primary Provider
          A      Chart Audit Status
          R      Chart Deficiency Reason (Last one entered)
          I      Has Medicare/Medicaid or PI

How would you like the list of visits sorted:

```

Figure 27-4: More information about what to type

10. At the “How would you like the list of visits sorted” prompt, type the code for how to sort the data.

The application displays the following information:

```

PCC/EHR VISIT AUDIT           Jan 12, 2009 13:17:48      Page: 1 of 1
Visit Dates:  Oct 14, 2008 to Jan 12, 2009
* an asterisk beside the visit number indicates the visit has an error
#  VISIT DATE      PATIENT NAME  HRN    FAC  HOSP LOC  CL INS  PRIM PROV STATU
1)* 01/07/09@09:00 BETA,KU      111231 DH    A 30 M/C/P      NO
2)* 12/31/08@12:00 GAMMAA,IRA   123457 DH  A 01 M  JKPROVIDE I .99
3)  10/14/08@18:00 SIGMA,ANGELA 124682 DH  A 01 P  JOPROVIDE I
4)  10/22/08@12:00 SIGMA,ANGELA 124682 DH  A 01 P  JOPROVIDE I
5)  12/17/08@10:00 ALPHAAAAA,BOB 125571 DH  A 01 P  TXPROVIDE I
6)  12/17/08@10:00 BETAA,ALLEN  131029 DH  A 01   TXPROVIDE I
7)  12/06/08@12:00 DEMO,CORRINE 155243 DH  A 01   FNPROVIDE I
8)  12/17/08@12:00 BETAAAAA,CASS 168611 DH  A 01 C  ARPROVIDE I
9)  12/17/08@14:00 SIGMA,ADAM   169631 DH  A 01   KWPROVIDE I

      Q - Quit/?? for more actions/+ next/- previous      >>>
D  Display Visit      R  Resort List      F  F  Move V File
N  Note Display      C  Chart Audit History  E  E Move V File 2 Dates
M  Modify Visit      H  Health Summary      T  T  Change Date/Time
A  Append to Visit   O  One Patient's Visits Z  Z  Add a Visit
G  Visit Merge      X  Visit Delete
S  Status Update    B  B  Merge 2 Diff Dates
Select Action: D//

```

Figure 27-5: Actions to take on the output

You can do one of the following at the “Select Action” prompt:

- Type **Q** to quit the screen. You will be returned to the EHR/PCC Coding Audit Menu.
- If you are not on the last page, type plus (+) to display the next page.
- If you not on the first page, type minus (-) to display the previous page.
- Type one of the actions listed.

27.2 EHR/PCC Audit for One Patient (PEHR)

Use the PEHR option to review visits created by EHR users for one patient.

The visits displayed in the list are those with an Incomplete or blank chart audit status. This list can be sorted by date, primary provider clinic code, hospital location (scheduling clinic), and facility.

Once the visit has been reviewed, the review status can be set as Reviewed/Complete or Incomplete. All visits set as Reviewed/Complete will be passed to the IHS/RPMS billing package.

The visits that are excluded include the following:

- Contract Health visits
- Visits that do not have a primary provider

Visits with the following service categories are included in the list:

- A - Ambulatory
- S - Day Surgery
- O - Observation
- T - Telecommunications
- C - Chart Review
- R - Nursing Home
- I - In Hospital

Note: A visit will *not* pass to Billing until it is marked as Reviewed/Completed.

Follow these steps:

1. At the Select Patient Name” prompt, specify the name of the patient.
2. At the “How would you like the list of visits sorted” prompt, type one of the following:

- D - Date of Visit
- S - Service Category
- L - Location of Encounter
- C - Clinic
- O - Hospital Location
- P - Primary Provider
- A - Chart Audit Status
- R - Chart Deficiency Reason (Last one entered)

The application displays the following screen:

```

PCC/EHR VISIT AUDIT          Dec 18, 2008 13:38:54      Page: 1 of 1
Visit Dates: Jul 01, 2005 to Dec 18, 2008
* an asterisk beside the visit number indicates the visit has an error
# VISIT DATE      PATIENT NAME  HRN    FAC  HOSP LOC   CL INS  PRIM PROV STATU
1)  07/05/05@18:11 DEMO,JOHNNIE 118774 DH          A 30      JPROVIDER
2)  07/15/05@15:29 DEMO,JOHNNIE 118774 DH  MCKIT'TRI A 01      EFPROVIDE

          Q - Quit/?? for more actions/+ next/- previous      >>>
N  Note Display          C  Chart Audit History  E  E Move V File 2 Dates
M  Modify Visit         H  Health Summary      T  Change Date/Time
A  Append to Visit     O  One Patient's Visits Z  Add a Visit
G  Visit Merge         X  Visit Delete
S  Status Update       B  B Merge 2 Diff Dates
Select Action:

```

Figure 27-6 List of actions you can take on the screen

You can do one of the following at the “Select Action” prompt:

- Type **Q** to quit the screen. You will be returned to the EHR/PCC Coding Audit Menu.
- If you are not on the last page, type plus (+) to display the next page.
- If you not on the first page, type minus (-) to display the previous page.
- Type one of the actions listed.

27.3 Add new Chart Deficiency Reason to Table (ACDR)

Use the ACRD option to add one or more new outpatient chart deficiency reason to the table.

Follow these steps:

1. At the “Select Outpatient Chart deficiency reasons” prompt, type the deficiency reason.
2. The prompt repeats until you type a caret (^) at the prompt.

27.4 Count Unreviewed Visits by Date/Service Category (TUR)

Use the TUR option to produce a count of all visits with a chart audit status of Incomplete or blank. The visits can be selected and sorted by date, primary provider, or chart audit status.

Contract Health visits are excluded.

Visits with the following service categories are included in the list:

- A - Ambulatory
- S - Day Surgery
- T - Telecommunications
- C - Chart Review
- R - Nursing Home
- N - Not found

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 “Enter a code indicating what Locations/Facilities are of interest” prompt, type one of the following:

- A - All Locations/Facilities
- S - Selected set or Taxonomy of Locations
- O - One Location/Facility

If you type **S** or **O**, other prompts will display.

4. At the “Enter a code indicating what clinics (IHS clinic code) are of interest” prompt, type one of the following

- A - All Clinics
- S - Selected set or Taxonomy of Clinics
- O - One Location/Facility

If you type **S** or **O**, other prompts will display.

5. At the “Enter a code indicating which providers are of interest” prompt, type one of the following:

- A - All Providers
- S - Selected set or Taxonomy of Providers
- O - One Provider

If you type **S** or **O**, other prompts will display.

6. At the “Select visits based on chart deficiency reason” prompt, type one of the following:

- D - Do *not* screen on Chart Deficiency Reason
- S - Screen on Chart Deficiency Reason

A chart deficiency reason might have been previously entered for a visit. If you want to display only visits whose *last* chart deficiency reason matches one or more that you select, type them.

7. At the “Device” prompt, type how you want the data to display.

Below is a sample screen:

```

Dec 18, 2008                                     Page: 1
                                           PCC Data Entry Module
*****
      *   COUNT OF VISITS WITH CHART AUDIT STATUS OF
INCOMPLETE/BLANK   *
*****
                VISIT Date Range: NOV 03, 2008 through DEC 18, 2008

VISIT DATE      SERV CAT      # UNREVIEWED VISITS      # W/NO PROV
(ANCILLARY)
-----
Nov 10, 2008    AMBULATORY    4                          4
Dec 03, 2008    AMBULATORY    2                          2
Dec 06, 2008    AMBULATORY    1                          1
Dec 17, 2008    AMBULATORY    4                          4

Totals:                11                          6

RUN TIME (H.M.S): 0.0.0
Enter RETURN to continue or '^' to exit:

```

Figure 27-7 Example screen for TUR option

You can do one of the following at the last prompt:

- Press ENTER to continue and to display the next page of information.
- Type a caret (^) to exit the screen. You will be returned to the EHR/PCC Coding Audit Menu.

27.5 Auto-Complete Pharmacy Education Only Visits (ACRX)

Use the ACRX option to automatically complete/review all visits in a date range that meet the following criteria:

- POV is V65.49 or V65.19
- there is no Medication dispensed
- Clinic is 39 - Pharmacy
- there is no other Purpose of visit/diagnosis

A list of visits will be provided.

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 the report by” prompt, type one of the following:

T - Terminal Digit Order
 H - Health Record Number Order
 D - Visit Date Order

- At the “Device” prompt, type how you want to output the data.

The following output is displayed:

```

XXX                               Dec 18, 2008                               Page 1
                                DEMO HOSPITAL
                                Visits Automatically Completed/Reviewed

  PATIENT NAME  HRN    VISIT DATE  SC CL    Purpose of Visits
  -----
NO DATA TO REPORT

End of report.  PRESS ENTER:

```

Figure 27-8 Example output for ACRX option

27.6 Update EHR Coding Audit Site Parameters (CASP)

Use the CASP option to update the EHR coding queue parameters for a specified site.

- Service Category exclusions:** If you would like to exclude visits with a particular service category from the list of visits displayed in the coding queue, you must type those service categories to the list below. For example, if you do not wish to have I - In Hospital visits in the list, you should add 'I' to the list.

Note: If you leave the list blank (empty) then all direct (non-CHS) visits will display in the coding queue.

Event visits never display in the coding queue.

Follow these steps:

- At the “Select PCC data site parameters site name” prompt, specify the name of the site.

The following information is displayed:

```

Your site is currently set up to exclude visits with the
following service categories from the coding queue:
    I - IN HOSPITAL
    H - HOSPITALIZATION
    O - OBSERVATION

Select one of the following:

    A          Add another service category to the list
    R          Remove a service category from the list
    Q          Quit - list looks good
  
```

Figure 27-9 List of categories for the specified site

You can do one of the following:

- Use the **A** option to add another service category to the list. You will be asked which one to add.
- Use the **R** option to remove a service category to the list. You will be asked which one to remove.
- Use the **Q** option to leave the screen without making changes.

If you type **Q**, the process continues:

You have the option to see all visits in the coding queue regardless of how they were created. You can see all visits or limit the list of visits in the coding queue to only those for which a provider has been entered. If you choose to only see visits for which a provider was entered, you will not see visits created by an ancillary package. Most, if not all, visits created by EHR users will have provider.

2. At the “Include all visits in the coding queue list” prompt, type one of the following:
 - 1** - Yes, Include Visits With No Provider
 - 0** - No, Don't Include Visits With No Provider
3. At the “Default Response for ‘Is Coding Complete’ in Data Entry” prompt, type one of the following:
 - Y - Yes
 - N - No
4. At the “Require Chart Deficiency Reason on Visits marked as Incomplete?” prompt, type one of the following:
 - Y - Yes
 - N - No

You will be returned to the Enter PCC Data Menu Options menu.

27.7 List Visits Marked as Incomplete (INCV)

Use the INCV option to produce a report that lists all visits with a chart audit status of I for Incomplete.

The visits can be selected by date, primary provider, or chart audit status. This list can be sorted by date, primary provider clinic code, hospital location (scheduling clinic), or facility.

Contract Health visits are excluded.

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 “Enter a code indicating what locations/facilities are of interest” prompt, type one of the following:

A - All Locations/Facilities

S - Selected set or Taxonomy of Locations

O - One Location/Facility

If you type **S** or **O**, other prompts will display.

4. At the “Enter a code indicating what clinics (IHS clinic code) are of interest” prompt, type one of the following

A - All Clinics

S - Selected set or Taxonomy of Clinics

O - One Location/Facility

If you type **S** or **O**, other prompts will display.

5. At the “Enter a code indicating what Hospital Locations are of interest” prompt, type one of the following:

A - All Hospital Locations

S - Selected set of Hospital Locations

O - One Hospital Location

If you type **S** or **O**, other prompts will display.

6. At the “Enter a code indicating which providers are of interest” prompt, type one of the following:

- A - All Providers
- S - Selected set or Taxonomy of Providers
- O - One Provider

If you type **S** or **O**, other prompts will display.

7. At the “Select visits based on chart deficiency reason” prompt, type one of the following:

- D - Do *not* screen on Chart Deficiency Reason
- S - Screen on Chart Deficiency Reason

A chart deficiency reason may have been previously entered for a visit. If you want to display only visits whose *last* chart deficiency reason matches one or more that you select, please type them.

8. At the “How would you like the list of visits sorted” prompt, type one of the following:

- D - Date of Visit
- S - Service Category
- L - Location of Encounter
- C - Clinic
- O - Hospital Location
- P - Primary Provider
- A - Chart Audit Status
- R - Chart Deficiency Reason (Last one entered)

9. At the “Device” prompt, type how you want the data to display.

The following screen displays:

```

Dec 18, 2008                                     Page: 1
                                PCC Data Entry Module
*****
* LIST OF VISITS WITH CHART AUDIT STATUS OF INCOMPLETE *
*****
                                VISIT Date Range: NOV 03, 2008 through DEC 18, 2008

VISIT DATE          HRN          PATIENT NAME          LOCATION    SC CL HOSP LOC
DEC
-----
Dec 03, 2008@12:00 DH 106455  GILLESPIE,PATTY J  DEMO HOSPI A    5
This visit has: MEASUREMENTS
Status Update          User          Chart Deficiency Reason
12/3/2008  INCOMPLETE  BETHEA,LINZA
12/3/2008  INCOMPLETE  BETHEA,LINZA
12/3/2008
Dec 03, 2008@12:00 DH 777710  GAMMA,KAPPA          DEMO HOSPI A    70 1
This visit has:
Status Update          User          Chart Deficiency Reason
12/12/2008 INCOMPLETE  SPAULDING,MARY      PROBLEM LIST UPDATE

Enter RETURN to continue or '^' to exit:

```

Figure 27-10: Example output for INCV option

You can do one of the following at the last prompt:

- Press Enter to continue and to display the next page of information.
- Type a carat (^) to exit the screen. You will be returned to the EHR/PCC Coding Audit menu.

27.8 List Unreceived/Incomplete Visits (LIR)

Use the LIR option to produce a report that lists all visits with a chart audit status of Incomplete or blank.

The visits can be selected and sorted by date, primary provider, or chart audit status. This list can be sorted by date, primary provider clinic code, hospital location (scheduling clinic), or facility.

Contract Health visits are excluded.

Visits with the following service categories are included in the list:

- A - Ambulatory
- S - Day Surgery
- T - Telecommunications
- C - Chart Review
- R - Nursing Home
- N - Not found

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 “Enter a code indicating what Locations/Facilities are of interest” prompt, type one of the following:

- A - All Locations/Facilities
- S - Selected set or Taxonomy of Locations
- O - One Location/Facility

If you type **S** or **O**, other prompts will display.

4. At the “Enter a code indicating which providers are of interest” prompt, type one of the following:

- A - All Providers
- S - Selected set or Taxonomy of Providers
- O - One Provider

If you type **S** or **O**, other prompts will display.

5. At the “Select visits based on chart deficiency reason” prompt, type one of the following:

- D - Do *not* screen on Chart Deficiency Reason
- S - Screen on Chart Deficiency Reason

A chart deficiency reason may have been previously entered for a visit. If you want to display only visits whose *last* chart deficiency reason matches one or more that you select, please enter them.

6. At the “Device” prompt, type how you want the data to display.

The following is a sample report:

```

Dec 18, 2008                                     Page: 1
                PCC Data Entry Module
*****
* LIST OF VISITS WITH CHART AUDIT STATUS OF INCOMPLETE/BLANK *
*****
                VISIT Date Range: NOV 03, 2008 through DEC 18, 2008

VISIT DATE          HRN          PATIENT NAME          LOCATION  SC CL HOSP LOC  DEC
-----
Nov 10, 2008@11:40 DIH 107255  BOWMAN,JANICE        DEMO INDIA A   76 GENERAL    1
    This visit has:  LAB's

Nov 10, 2008@11:45 DIH 102981  ABERCROMBIE,DAVID    DEMO INDIA A   76 GENERAL    1
    This visit has:  LAB's

Nov 10, 2008@11:53 DIH 160741  DEERINWATER-COLLA    DEMO INDIA A   76 GENERAL    1
    This visit has:  LAB's

Nov 10, 2008@12:16 DIH 160741  DEERINWATER-COLLA    DEMO INDIA A   76 GENERAL    1
    This visit has:  LAB's

Enter RETURN to continue or '^' to exit:

```

Figure 27-11 Example Report for LIR option

You can do one of the following at the last prompt:

- Press ENTER to continue and to display the next page of information.
- Type a caret (^) to exit the screen. You will be returned to the EHR/PCC Coding Audit menu.

27.9 Tally of Reviewed/Completed Visits by Operator (TRV)

Use the TRV option to produce a report that shows a tally of visits reviewed/completed by the user who reviewed/completed the visit.

Note: This report will only look all visits that have been reviewed and marked as either Reviewed/Complete or Incomplete. If a visit has never been reviewed, it is not counted in this report. You must enter the review date range. This is the date range for which visits were reviewed.

Note: Any visit reviewed through the normal data entry process (not through the coding queue) will only be counted if it was reviewed *after* Jan 16, 2007. The review dates for data entry options were not logged prior to this date.

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 “Do you wish to see a subtotal by Review Date” prompt, type **Y** or **N**.
4. At the “Device” prompt, type how you want the data to display.

The following screen displays:

```

Dec 18, 2008                                     Page: 1
                                     PCC Data Entry Module
*****
*   COUNT OF VISITS REVIEWED/COMPLETED BY OPERATOR   *
*****
      REVIEW Date Range: Nov 03, 2008 through Dec 18, 2008

Operator                                     # of visits   # of visits
                                     reviewed         marked
-----                                     -----
BETAAA, LINZA                               14             1
      Nov 05, 2008                           2             1
      Dec 03, 2008                           3             0
      Dec 17, 2008                           9             0

GAMMAAAAAA, CINDY                          17            12
      Nov 03, 2008                           9             8
      Nov 17, 2008                           8             4

SIGMAAAAA, MARY R                            1             0
      Dec 12, 2008                            1             0

Enter RETURN to continue or '^' to exit:

```

Figure 27-12 Example Report using the TRV option

You can do one of the following at the last prompt:

- Press ENTER to continue and to display the next page of information.
- Type caret (^) to exit the screen. You will be returned to the EHR/PCC Coding Audit menu.

The total number of visits is shown on the last page of the report.

28.0 Enter Data from LOGS (LAB/RAD/CPT/APC) (LOG)

```

**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options    **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

MIN  Data Entry Using Mnemonics
ENT  Enter Data
MOD  Modify Data
APP  Append Data To An Existing Visit Record
APL  Append Data using Item List Display
TIM  Modify Visit Date and/or Time
EAC  Enter Data with Visit Display and Actions
MNE  Enter PCC Data Using Item List Display
GRP  Group Preventive Form Entry
HIN  Enter Historical INPATIENT Visits
DTC  Tran Code (DTC) Entry for All Visits
TCH  Enter Trans Codes on IN-Hospital Visits
TCO  Enter Trans Codes on Outpatient Visits
DMU  Update Diabetes Patient Data
EC   Entry of Data for a Cohort of Patients
MFC  Display a Count of Forms you have Processed
SF   Enter/Edit Suicide Forms ...
EHRC EHR/PCC Coding Audit Menu ...
LOG  Enter Data From LOG (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: LOG Enter Data From LOG
(lab/rad/cpt/apc) ...

```

Figure 28-1: Selecting LOG option from main data entry menu

Use the LOG option to display a menu of data entry options that allow you to type information recorded on a variety of forms other than the standard PCC encounter forms. Examples of data that can be typed from a log or other form include: Laboratory Tests, CPT Codes, Radiological Procedures, and APC Form Data.

```
*****
**      PCC Data Entry Module      **
**      PCC LOG Data Entry         **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

APC      Enter Data from APC Forms
CPT      CPT Log Entry
LAB      Lab Log Data Entry
          **> Out of order:  NOT AVAILABLE
RAD      Radiology Log Data Entry

Select Enter Data From LOGS (lab/rad/cpt/apc) Option
```

Figure 28-2: Data entry options other than the standard PCC encounter forms

The LAB option is out of order and not available.

28.1 Enter Data from APC Forms (APC)

For those sites that have not implemented PCC, this option will allow the facility to obtain some of the benefits of PCC without having to utilize PCC encounter forms. Minimal visit-related data is entered directly from the APC form (IHS-406), and APC diagnosis codes are automatically converted to the most likely ICD9 equivalent. Use of this option will create some PCC V files, but it should not be considered a replacement for the PCC program.

The flow for entry of information using this option follows the APC form, starting at the top with patient information, and proceeds down the form through the emergency-related codes. Diagnostic (POV) codes are generally entered from information checked on the reverse of the form, along with some generic laboratory, radiological, and exam information. When finished typing data from the APC form, the user will see the “PCC Mnemonic” prompt, at which time any of the regular PCC mnemonics can be selected for data entry.

```

                                PCC Data Entry Module

*****
* APC FORM ENTRY Mode *
*****

Enter LOCATION of VISIT.....: SELLS HOSPITAL//   TUCSON SELLS
Enter VISIT DATE.....: 10300
Entering forms for SELLS HOSPITAL for visit date Dec 01, 1998
Enter PATIENT NAME.....: 10300 KAPPA,CARMEN      F 02-22-1977
                                                SE10300

Ok? Yes// (Yes)

Enter TIME OF DAY: (1/2/3/4):   NOON - 5PM
Enter TYPE OF CLINIC CODE....: 01 GENERAL 01 (DEC 01, 1998@12:00)
Enter PRIMARY Provider.....: SHOT SIGMA,GEORGE   PHYSICIAN
Enter OTHER Provider.....: GM BETA,GERALDINE     REGISTERED NURSE
Enter OTHER Provider.....:
Enter APC CODE.....: 080      DIABETES MELLITUS
Enter APC CODE.....: 283      HYPERTENSIVE DISEASE
Enter APC CODE.....:
You may now enter any other information using the PCC mnemonics.
MNEMONIC: BP      Blood Pressure      ALLOWED      VISIT RELATED ONLY
VALUE: 166/94

MNEMONIC:      Examinations      ALLOWED      VISIT RELATED ONLY
Enter EXAM Type: RECTAL      RECTAL EXAM      14
RESULT:
MNEMONIC: HF      Health Factors      ALLOWED      VISIT RELATED ONLY
Enter HEALTH FACTOR: CURRENT SMOKER
LEVEL/SEVERITY:
PROVIDER:
QUANTITY:
MNEMONIC:

```

Figure 28-3: APC entry option

Note: APC codes are converted to ICD-9 codes. Type any information provided where appropriate.

28.2 CPT Log Entry (CPT)

Use the CPT option to append a CPT code to an existing visit. In addition, a visit can be created using this option that will contain only the basic visit information (location, type, service category) and the typed CPT code(s). In order for the visit to be complete, a data entry operator must complete the visit by typing the remainder of the visit- and non-visit-related data recorded on the PCC encounter form.

```

                                PCC Data Entry Module

                                *****
                                *   CPT Log ENTER Mode   *
                                *****

Select LOCATION NAME:SELLS HO   SELLS HOSPITAL   TUCSON
TYPE: I   IHS
SERVICE CATEGORY: A   AMBULATORY
Enter VISIT DATE: 120198   (DEC 01, 1998)
Select PATIENT NAME: 100993
  KAPPA,CARMEN           F 02-22-1977   030010300   HID   100992
                                SE 100993

Ok? Yes// >
  PATIENT: KETCHUP,CARMEN has VISITs, same date, location.
  1 Create New VISIT
  2 Exit without selecting VISIT
  3 Display one of the existing VISITs
  Or select one of the following existing VISITs:
  4 TIME: 12:00   TYPE: I   CATEGORY: A   CLINIC: GENERAL   DEC: 8
Choose one: (1-4): 4//
Select V CPT: 99214           OFFICE/OUTPATIENT VISIT, EST
OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MGMT OF
AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE
...OK? Yes//   (Yes)
                                QUANTITY: 1
                                Select PATIENT NAME:

```

Figure 28-4: CPT entry option

Note: Users will only see this message if there is already a visit on file for this patient on the same day. Any valid CPT code can be typed at the “Select V CPT” prompt.

28.3 RAD – Radiology Log Data Entry

Use the RAD option to record radiological procedures prior to or after completing the remainder of the visit. If used before the medical portion of the visit is typed, this option will create an incomplete visit that will ne CPT Log ENTER Mode ed to be completed by the data entry staff. If the visit was begun by some other department (e.g. pharmacy, data entry, laboratory, etc.), the radiology data entry person will need to append that data to the existing visit.

```

                                PCC Data Entry Module

                                *****
                                * Radiology Log ENTER Mode *
                                *****

Select LOCATION NAME: SELLS HOSPITAL  TUCSON  SELLS      01
TYPE: I IHS
SERVICE CATEGORY: A  AMBULATORY

Enter VISIT DATE:  01/10/99  (JAN 10, 1999)

Select PATIENT NAME: 100010
METAA, SALLY                F 01-25-1951 000350003 PIMC 100008
                                HID 100009
                                SE 100010
                                SX 100011

                                Ok?  Yes//  (Yes)
Select V RADIOLOGY RADIOLOGY PROCEDURE: BILAT MAMMOGRAM
(BILAT/BILATERAL MAMMOGRAM )      76091 (76091)
MAMMOGRAM, BOTH BREASTS
MAMMOGRAPHY; BILATERAL

OK? Y// YES      MAMMOGRAM BILAT      (Detailed) CPT:76091
ABNORMAL: N

IMPRESSION: NO EVIDENCE OF ABNORMALITIES - NORMAL MAMMO GRAM

```

Figure 28-5: RAD entry option

Note: Operator can type the appropriate CPT code at the “Select V RADIOLOGY PROCEDURE prompt” instead of the description.
The impression can be up to 245 characters, if necessary.

With the exception of the APC - Enter Data from APC Forms, the LOG data entry options will not return the operator to the “Mnemonic” prompt. Therefore, if an error is made using one of the LOG data entry options, correction must be made using the MOD - Modify Data option; or if the wrong patient was selected, the visit must be deleted using the Del - Delete All Data for a Visit in the Data Entry Utilities menu.

29.0 Display Data for a Specific Patient Visit (DSP)

Use the DSP option to display or view all data entered for a selected patient visit date on the screen. Only visit-related data items will display. When typing data from another menu option (MINI, ENT) the DISP mnemonic can be used in lieu of the DSP menu option. The DISP mnemonic functions in the same manner, but eliminates the need to change menus. The display can be used to:

- Verify data before adding medical data to a visit
- Review data after modifying
- Monitor quality control by the data entry supervisor
- Assist in determining whether or not to merge multiple visits into one

```

*****
**      PCC Data Entry Module      **
*****
                IHS PCC Suite Version 2.0
                  DEMO HOSPITAL

ENT      Enter/Modify/Append PCC Data ...
DSP    Display Data for a Specific Patient Visit
PEF      Print a PCC Visit in Encounter Form format
UPD      Update Patient Related/Non Visit Data ...
DEU      Data Entry Utilities ...
VIEN     Display a Visit by Visit IEN
BHS      Browse Health Summary
DVB      Display a PCC Visit w/limited Lab Display
GHS      Generate Health Summary
PDV      Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: DSP Display Data for a
Specific Patient Visit

```

Figure 29-1: Selecting the DSP menu option

The DSP option uses the List Manager in its display. Basic visit information is shown at the top of the screen. The center of the screen contains the specific items that were typed for the visit. This part of the display can consist of more than one page, and the user will need to use the + and – actions to make the center of the display scroll to the desired page. The bottom portion of the screen contains all allowable actions the user can perform while in the display. The default action is + to move to the next page.

```

Select PATIENT NAME: MOUSE,MINNIE      F 01-25-1941
0000350003 PIMC 1000008                SE 1000018

Enter VISIT date: 01/21/99
PCC DATA ENTRY VISIT      Jan 21, 1999 10:39:49      Page: 1 of 3

Patient Name:              MOUSE,MINNIE
Chart #:                   100001000
Date of Birth:             JAN 25, 1941
Sex:                       F
Visit IEN                  2522175

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: JAN 12, 1999@12:00
DATE VISIT CREATED:      JAN 22, 1999
TYPE:                     IHS
PATIENT NAME:             MOUSE,MINNIE
LOC. OF ENCOUNTER:       SELLS HOSPITAL
SERVICE CATEGORY:       AMBULATORY
CLINIC:                   GENERAL
DEPENDENT ENTRY COUNT:   2
DATE LAST MODIFIED:     JAN 22, 1999
WALK IN/APPT:           UNSPECIFIED
CREATED BY USER:       ALPHA,BETA G
USER LAST UPDATE        ALPHA,BETA G

+   Enter ?? for more Actions
+   Next Screen          -   Previous Screen          Q   Quit
Select Action: +//

PCC VISIT DISPLAY      Jan 12, 1999
===== PROVIDERS =====
PROVIDER:              GAMMA, RAY
AFF.DISC.CODE:        100GIS
PRIMARY/SECONDARY:    PRIMARY
EVENT DATE AND TIME:  JAN 12, 1999
PROVIDER:              BETA, GERALDINE
AFF.DISC.CODE:        101GM
PRIMARY/SECONDARY:    SECONDARY
EVENT DATE AND TIME:  JAN 12, 1999

```

Figure 29-2: DSP visit display screen

Note: The top portion of this display contains basic visit information. Following are data items that have been entered for this visit, which might consist of more than one page of items. Press ENTER to scroll to the next page of data items.

Do the following on each page:

- If you are not on the last page, type plus (+) to go to the next page.
- If you are not on the first page, type minus (-) to go to the previous page.
- Type **Q** to quit the screen.

```

===== POVs =====
POV:                250.02
ICD NARRATIVE:      SM UNCOMPL/T-II/NIDDM,UNCON
PROVIDER NARRATVIE: DIABETES TYPE 2
FIRST/REVISIT      REVISIT
===== EXAMS =====
EXAM:                DIABETIC FOOT EXAM, COMPLETE
EXAM CODE:          8
Result:              Normal
Encounter Provider: UWPROVIDER,LISA R
===== PATIENT EDs =====
TOPIC:               DM-NUTRITION
CPT CODE (computed) 99402
PROVIDER:            GAMMA,RAY
LEVEL OF UNDERSTANDIN: FAIR
INDIVIDUAL/GROUP:   INDIVIDUAL
LENGTH OF EDUC (MINUT: 20

+   Enter ?? for more Actions
+   Next Screen          -   Previous Screen          Q   Quit
Select Action: +//

```

Figure 29-3: Remainder of visit display

30.0 Update Patient Related/Non Visit Data (UPD)

```

*****
**          PCC Data Entry Module          **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
VIEN Display a Visit by Visit IEN
BHS  Browse Health Summary
DVB  Display a PCC Visit w/limited Lab Display
GHS  Generate Health Summary
PDV  Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: UPD

```

Figure 30-1: Selecting the UPD menu option

The UPD option of the PCC Data Entry Module menu contains the options used to create and modify data that is patient related and does not generate a visit record. It consists of the following menu items:

```

NVD  Enter Non-Visit Data
HDI  Enter Historical or Non Visit Related Patient Data
PRL  Problem List Update

```

Figure 30-2: UPD options

30.1 Enter Non-Visit Data (NVD)

Use the NVD option to type patient data into the system *without* creating a visit, except for the historical mnemonics HIM, HS, and SHX, etc. When typing data using these mnemonics, the system will automatically create an Event Visit. The most common use of this option is:

- To type new problems and/or treatment plan notes relating to a specific health problem.
- To type historical immunization(s).
- To type skin test reading(s) and/or results(s).
- To type historical laboratory test(s).

Encounter forms that should be processed using this option are Chart Review, Telecommunication, Not Found, and Did Not Keep Appointment (DNKA), all of which do not have any other appropriate Purpose of Visit (PV) recorded. None of these terms are considered acceptable PVs; however, other data recorded on the form would meet the criteria of non-visit-related data and can be typed into the system. In certain circumstances, these types of forms may not have any data to enter, in which case the operator will draw an “X” across the front of the form and initial the lower left corner (Patient Identification section), indicating the form has been reviewed.

The only data mnemonics that can be used for the Enter Non-Visit Data option are listed below. This list can always be displayed at the “Mnemonic” prompt while in this menu option.

Mnemonic	Meaning
APO	ACTIVATE AN INACTIVE PROBLEM
BT	BLOOD TYPE ENTRY
CODE	CIDING GUIDELINES DISPLAY
DHS	DATA ENTRY HEALTH SUMMARY
DISP	VISIT DISPLAY
DP	DESIGNATED PROVIDER
EDC	EXPECTED DATE OF CONFINEMENT
FHX	FAMILY HISTORY
FM	FAMILY PLANNING METHOD
FP	FAMILY PLANNING
FS	FUTURE SCHEDULED ENCOUNTER
HBS	HISTORIC BLOOD SUGAR ENTRY
HCBC	HISTORIC CBC ENTRY
HEKG	HISTORIC EKG
HEX	HISTORIC EXAMINATION
HHCT	HISTORICAL HEMATOCRIT
HIM	HISTORICAL IMMUNIZATION
HLAB	HISTORICAL LAB TEST
HLST	HEALTH STATUS
HMSR	HISTORICAL MEASUREMENT
HPAP	HISTORICAL PAP SMEAR
HRAD	HISTORICAL RAD. PROCEDURE
HRX	HISTORICAL RX
HS	HISTORICAL SKIN TEST
HUA	HISTORICAL UA ENTRY
IPO	INACTIVATE A PROBLEM
LMP	LAST MENSTRUAL PERIOD
MNN	MODIFY NOTE NARRATIVE

Mnemonic	Meaning
MPO	CORRECT/MODIFY PROBLEM
NO	NOTE
OHX	OFFSPRING HISTORY
ORX	OUTSIDE RX (HISTORICAL)
PCP	PRIMARY CARE PROVIDER
PHX	PERSONAL HISTORY
PL	PROBLEM LIST UPDATE MENU
PO	PROBLEM ONLY
RF	REPRODUCTIVE FACTORS
RNO	REMOVE NOTE FROM PROBLEM
RPO	REMOVE PROBLEM ENTRY
SHX	HISTORY OF SURGERY
UCD	UNDERLYING CAUSE OF DEATH
WHAT	DEMOGRAPHIC & VISIT DISPLAY

```
Select PATIENT NAME: 100109
ALPHA,MOLLY   F 01-06-1928 003280032   HID 100109
                                     SE 100110
Select LOCATION NAME: SEL   SELLS HOSPITAL   TUCSON   SELLS
Enter Date Information Was Collected:   (JAN 26, 1999)
Select non VISIT related mnemonics only!
MNEMONIC:
```

Figure 30-3: Selecting a non-visit-related mnemonic

Type the appropriate mnemonic (from the above list) at the “Mnemonic:” prompt and populate each field. Refer to the Mnemonics manual for details on typing each mnemonic.

30.2 Enter Historical or Non-Visit-Related Patient Data (HDI)

Use the HDI option to type patient and historical clinical data utilizing the list display.

```
Patient Care Component (PCC)
*****
***** PCC DATA ENTRY UPDATE HISTORICAL DATA BY ITEM *****
*****
Select PATIENT NAME:ALPHA,MOL
ADAMS,MOLLY   F 01-06-1928 003280032   HID 100109
                                     SE 100110
                                     SX 100111
Select LOCATION NAME: SELLS HOS   SELLS HOSPITAL   TUCSON
Enter Date Information Was Collected: T   (JAN 26,1999)
```

Figure 30-4: Typing patient and historical clinical data

The top portion of the screen contains patient identification, followed by a list of 35 patient/non-visit data items that can be selected.

Finally, the bottom portion of the display contains a list of possible actions by the operator. The default action is AD to add an item, as shown below.

Historical Patient Data		Dec 18, 2008 15:13:49	Page: 1 of 2
Patient Name: DEMO,CHRISTA DANIELLE		DOB: MAR 14, 2006	Sex: F HRN: 1
Date of Update: Dec 18, 2008			
1) Family History	16) Historical Exam	31) Problem Note	
2) Personal History	17) Historical ADA codes	32) Remove Problem	
3) History of Surgery	18) Hist. Immunization	33) Inactivate	
Problem			
4) Offspring History	19) HCPT	34) Activate Problem	
5) Historical BS	20) Hist Measurement	35) Remove Problem	
Note			
6) Historical CBC	21) Historical Radiology	36) Change Note	
Narrative			
7) Historical FOBT	22) Historical Skin Test	37) Modify Problem	
8) Hist. Sigmoidoscopy	23) Outside RX Entry	38) Future	
Appointment			
9) Historical BE	24) Historical RX	39) Blood Type	
10) Hist. Colonoscopy	25) Family Planning	40) Primary Care	
Provider			
11) Historical Hematocrit	26) EDC	41) Health Status	
12) Historical Lab Test	27) LMP	42) Under. Cause	
Death			
13) Historical Pap Smear	28) Family Plan Method		
14) Historical UA	29) Reproductive Factors		
+ Enter ?? for more actions			
AD Add Item	DE Delete Item	PL Problem List Update	
MD Modify Item	HS Health Summary	Q Quit	
Select Action: AD//			

Figure 30-5: Patient information display

30.3 Problem List Update (PRL)

Use the PRL option to update a patient's Problem List without using mnemonics for the data entry. After selecting the PRL option, the system asks for the patient's name, the location of the Problem List Update, and the date of the update. After successfully typing that information, the List Manager displays items that can be selected in order to update the patient's Problem List. Virtually any problem list manipulation can be carried out by selecting the correct action.

```

Patient Care Component (PCC)
*****
* Update PCC Patient Problem List *
*****

Select PATIENT NAME:<100110><RETURN>
ALPHA,MOLLY F 01-06-1928 003280032 HID 100109
SE 100110
Location where Problem List update occurred: SELLS HOSPITAL//
TUSON
SELLS

Date Problem List Updated: T

```

Figure 30-6: Updating patient Problem List

The top portion of the List Manager display contains patient demographics, followed by a list of the patient's problems. A complete list of possible actions appears at the bottom of the display. To edit the narrative associated with this patient's problem number SE1, type **EP** to edit the problem, followed by the correct number in the list of problems.

```

Problem List Update      Jan 26,1999 15:45:07      Page:      1 of  1
-----
Patient Name: GAMMA,BETA      DOB: JAN 06, 1928      Sex: F      HRN: 100110
-----

1) Problem ID: SE1  DX: 250.00      Status: ACTIVE      Onset:
   Provider Narrative: AODM

Enter ?? for more actions
AP  Add Problem              IP  Inactivate Problem      RN  Remove Note
EP  Edit Problem             DD  Detail Display          HS  Health Summary
DE  Delete Problem           NO  Add Note                 FA  Face Sheet
AC  Activate Problem         MN  Edit Note                Q   Quit
Select Action: +// EP
Select Problem: (1-1): 1
Editing Problem ...

Editing Problem Number SE1 for ALPHA,MOL

DIAGNOSIS: 250.00//
PROVIDER NARRATVIE: AODM// TYPE 2 DIABETES  TYPE 2 DIABETES
CLASS:
NMBR: 1// >
STATUS: ACTIVE//
DATE OF ONSET: 04/88

Problem List Update      Jan 26, 1999 16:17:36      Page:      1 of  1
-----
Patient Name: GAMMA,BETA      DOB: JAN 06, 1928      Sex: F      HRN: 100110
-----

1) Problem ID: SE1  DX: 250.00      Status: ACTIVE      Onset:04/00/88
   Provider Narrative: TYPE 2 DIABETES

Enter ?? for more actions
AP  Add Problem              IP  Inactivate Problem      RN  Remove Note
EP  Edit Problem             DD  Detail Display          HS  Health Summary
DE  Delete Problem           NO  Add Note                 FA  Face Sheet
AC  Activate Problem         MN  Edit Note                Q   Quit
Select Action: +// Q

```

Figure 30-7: Updated patient Problem List display

31.0 Data Entry Utilities (DEU)

```

*****
**          PCC Data Entry Module          **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
VIEN Display a Visit by Visit IEN
BHS  Browse Health Summary
DVB  Display a PCC Visit w/limited Lab Display
GHS  Generate Health Summary
PDV  Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: DEU

```

The DEU option contains several menu options displayed below. Each is described in detail except the supervisor's menu. This option will be covered in a separate manual for distribution to data entry supervisors, PCC managers and site managers.

```

*****
**          PCC Data Entry Module          **
**          Data Entry Utilities Menu      **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

LST          List Visits for a Patient in a Date Range
AUN          Find CHS Entry for a Given Authorization Number
MRG          Merge two Visits on Same Date
DEL          Delete All Data For A Visit
SUP          Data Entry SUPERVISORY Options and Utilities ...
COD          Display IHS Coding Guidelines
GC           Pediatric Growth Charts
MR2          Merge 2 Visits on 2 Different Dates
MV2D        MV2D Move Data from one visit to a different date
MVD          Move Data Items From One to Another
RGF          Reprint Group PCC Visit Forms

Select Data Entry Utilities Option:

```

Figure 31-2: Data entry utilities menu options

31.1 List Visits for a Patient in a Date Range (LST)

Use the LST option to list all visits for a patient within a specific posting or visit date range. Posting date refers to date the PCC visit was created or modified. If Posting Date is selected, visits that occurred before the starting posting date will be displayed as long as the visit was modified during the posting date range. Only the visits will display and not data items for each visit. The list can be displayed on the screen using the browser or sent to a printer for a hard copy printout.

The following example will list visits by visit date within a range from earliest visit date to latest. The output will use the browser, which allows the user to scroll forward or backward in the display area.

Follow these steps:

1. At the “Report Run by” prompt, type one of the following:
 - 1 - Posting Date
 - 2 - Visit Date
2. At the “Enter beginning Posting(or Visit) Date” prompt, type the beginning of the date range.
3. At the “Enter ending Posting(or Visit) Date” prompt, type the end of the date range.
4. At the “Patient Name Prompt, specify the name of the patient.
5. At the “Do you want to” prompt, type one of the following:
 - B - Browse Output on Screen
 - P - Print Output to Printer

The output on the Output Browser:

```

OUTPUT BROWSER           Dec 18, 2008 15:22:58           Page: 1 of 175
Visit List in Date Range

Visits for DEMO,JOHNNIE RUTH in Posting date range 2001 to 2008
Health Record Number: 118774

VISIT/ADMIT DATE&TIME: NOV 14, 2000@12:00
  DATE VISIT CREATED: JAN 08, 2001           TYPE: IHS
  THIRD PARTY BILLED: VISIT DATE PRIOR TO BACKBILLING LIMIT
  PATIENT NAME: DEMO,JOHNNIE RUTH           LOC. OF ENCOUNTER: DEMO INDIAN
HOSPITAL
  SERVICE CATEGORY: AMBULATORY               CLINIC: OPHTHALMOLOGY

DEPENDENT ENTRY COUNT: 7                     DATE LAST MODIFIED: JAN 08, 2001
DATE VISIT EXPORTED: MAR 22, 2001           WALK IN/APPT: APPOINTMENT
CREATED BY USER: BDEMO,JEANETTE           USER LAST UPDATE: BDEMO,JEANETTE
AMOUNT BILLED: 24.5
OLD/UNUSED UNIQUE VISIT ID: 5151010001278708
DATA WAREHOUSE EXPORT DATE: OCT 14, 2004
NDW UNIQUE VISIT ID (DBID): 000000001278708
  367.1      MYOPIA OU

+           Enter ?? for more actions                >>>
+  NEXT SCREEN           -  PREVIOUS SCREEN           Q  QUIT

```

Figure 31-3 Example Output Browser screen for LST option

You can take the following actions on the Output Browser screen:

- If you are not on the last page, type plus (+) to display the next screen.
- If you are not on the first page, type minus (-) to display the previous screen.
- Type **Q** to exit the Output Browser screen. You will be returned to the “Select Data Entry Utilities Option” prompt.

31.2 Find CHS Entry for a Given Authorization NUMBER (AUN)

The AUN menu option is used only if your facility is typing contract healthcare data into the PCC. This option enables the operator to find and display the entry in the V CHS file that used a particular Authorization Number. Most facilities activate the CHS-PCC link, which causes CHS information to be passed to PCC when a CHS purchase order is paid and ICD-9 information recorded.

```
Select Patient Care Data Entry Menu Option: <AUTH> <RETURN> Find CHS Entry
for a Given Authorization Number
This routine will find and display a V CHS entry for a given Authorization
Number.
Enter an Authorization Number: ?
THE number entered must be a 10 digit Authorization Number in the form: 2
digit FY, then a 3 digit location code, then a 5 digit number. For example:
9112312345
Enter an Authorization Number: 9112312345
This CHS entry has been entered with Authorization Number 9112312345
AUTHORIZING FACILITY: SELLS HOSPITAL/CLINIC
PATIENT NAME: METAA, BETTY ANN          VISIT: MAR 21, 1998@12:00
AUTHORIZATION NO.: 9112312345          PAY STATS: FULL PAY
TOTAL CHARGES: 69.00                   NO OF VISITS: 1
VENDOR: SIGMAA MD, THOMAS
PRESS 'RETURN' To Continue:
```

Figure 31-4: Find CHS entry option

31.3 Merge Two Visits on Same Date (MRG)

The MRG option is used to combine two or more separate patient visits into one visit. If visits with different dates are to be merged, the incorrect visit date must first be corrected using TIME-Modify Visit Date and/or Time.

Prior to using Merge, the data entry operator should determine whether or not a merge is necessary by using the DISP -Display All Data For A Patient Visit option to view the patient's visits. Once determined and Merge is selected, the operator will type the Merge From visit followed by the Merge To visit at the appropriate prompts:

- A Merge From visit is defined as the visit losing its Visit File and adding all remaining data items to the Merge To visit.
- The Merge To visit is defined as the visit retaining its Visit File and receiving all other data items from the Merge From visit.
- The system will display these visits along with the data item(s) already typed for each visit.

The order to type the visits to be merged depends on the entries in the visits:

- The visit with less data items and/or incomplete Visit File should be typed first at the “Select ‘From’ visit” prompt.
- The visit with a more complete Visit File should be typed second at the “Select ‘To’ visit” prompt, retaining the time and/or CL data items already included in the Visit File. An incomplete Visit File will replace a more complete Visit File if typed in reverse order, thereby losing data, e.g., a CL entry of General could be replaced by None.
- If your facility is running the Lab module, visits must be merged to the Lab visit. If a visit is not merged to a Lab visit, the internal link between PCC and Lab is lost, although this is not apparent to the operator. If a merge of visits is completed and data is lost, the most efficient option for retyping data is through the Enter menu selection.

```
Select PATIENT NAME: META,BETA AN      F 062157      4662
Select 'From' visit.
Enter VISIT date: 0321      (MAR 21,1998)
PATIENT: META,BETA AN has one or more VISITS on this date..
1 TIME: 12:00 LOC: SX              TYPE: I          CATEGORY: A CLINIC: <NONE>
2 TIME: 14:00 LOC: SX              TYPE: I          CATEGORY: A CLINIC: <GENERAL>
Select one: 1
Select 'To' visit.
PATIENT: META,BETA AN has one or more VISITS on this date..
1 TIME: 12:00 LOC: SX              TYPE: I          CATEGORY: A CLINIC: <NONE>
2 TIME: 14:00 LOC: SX              TYPE: I          CATEGORY: A CLINIC: <GENERAL>
Select one: 2
```

Figure 31-5: Selecting visits to merge

```
***FROM VISIT***
-----
----- VISIT FILE -----
-----
VISIT/ADMIT DATE & TIME: MAR 21, 1998@12:00
DATE VISIT CREATED: MAR 21, 1998 TYPE: IHS
PATIENT NAME: META,BETA AN
LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER
SERVICE CATEGORY: AMBULATORY DEPENDENT ENTRY COUNT: 1
DATE LAST MODIFIED: MAR 30, 1998 CREATED BY USER: SMITH,ANN
USER LAST UPDATE: SIGMA,ANN
-----V MED-----
MEDICATION: DIABINESE 250MG TAB          PATIENT NAME: META,BETA
AN
VISIT: MAR 21, 1998@12:00
-----
```

Figure 31-6: “From” visit display

```

***TO VISIT***
-----
----- VISIT FILE -----
VISIT/ADMIT DATE & TIME: MAR 21, 1998@14:00
DATE VISIT CREATED: MAR 21, 1998 TYPE: IHS
  PATIENT NAME: META,BETA ANN
LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER
SERVICE CATEGORY: AMBULATORY CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 3   DATE LAST MODIFIED: MAR 21, 1998
CREATED BY USER: SIGMA,ANN   USER LAST UPDATE: SIGMA,ANN
----- V MEASUREMENT -----
TYPE: BP   PATIENT NAME: META,BETA AN
VISIT: MAR 21, 1998@14:00 VALUE: 130/70
----- V PROVIDER -----
PROVIDER: SIGMA, ANDREW   PATIENT NAME: META,BETA AN
VISIT: MAR 21, 1998@14:00   PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 100AS
----- V POV -----
POV: 250.00 PATIENT NAME: META,BETA ANN
VISIT: MAR 21, 1998@14:00 PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM)
VISIT: MAR 21, 1998@14:00 VALUE: 130/70
----- V PROVIDER -----
PROVIDER: S.BETA, ANDREW PATIENT
-----
Do you want to merge the two visits? (Y/N) Y//   9000010.07.

```

Figure 31-7: Merging the two visits

```

*** MERGED VISIT ***
-----
----- VISIT FILE -----

VISIT/ADMIT DATE & TIME: MAR 21, 1998@12:00 14:00
DATE VISIT CREATE: MAR 21, 1998 TYPE: IHS
PATIENT NAME: META,BETA AN
LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER
SERVICE CATEGORY: AMBULATORY CLINIC: GENERA
DEPENDENT ENTRY COUNT: 4   DATE LAST MODIFIED: MAR 21, 1998
----- V MEASUREMENT -----
TYPE: BP   PATIENT NAMER: META,BETA AN
VISIT: MAR 21. 1998@14:00   VALUE 130/70
----- V PROVIDER -----
PROVIDER: DELTA,KEITH PATIENT NAME: META GAMMA
VISIT: MAR 21, 1998 @14:00
AFF DISC CODE ©: 100 AS

```

Figure 31-8 Merged Visit

```

----- V POV -----
POV: 250.00                PATIENT NAME: META,BETA AN
VISIT: MAR 21, 1998@14:00  PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM)
----- V MED -----
MEDICATION: DIABINESE 250MG TAB      PATIENT NAME: META,BETA AN
VISIT: MAR 21, 1998@12:00
~~~~~

```

Figure 31-9: Merged visit display

If both the From and To visit contained a primary provider, the merged visit will have two primary providers, which is not allowed. The operator will need to use the MOD option subsequent to the merge to remove one of the primary providers contained in the merged visit.

Once the two visits are MERGED as one and displayed and shown as above, the system returns to the main Data Entry menu.

31.4 Delete All Data for a Visit (DEL)

The DEL option is used to delete or remove a patient's visit *permanently* from the system and is usually only available to the data entry supervisor. DEL should only be used if a visit is created in error. If an operator types the wrong patient for data entry and recognizes the error *after* the Visit File is created, DEL could be used. The XIT mnemonic can also be used to delete visits typed in error while in a data entry menu (MINI, ENT).

```

Delete All Data For A Visit
Select PATIENT NAME: 4462
META,BETA AN      F      06-21-57      4462
Enter VISIT date: 0403      (APR 03, 1990)
~~~~~
-----VISIT FILE-----
VISIT/ADMIT DATE & TIME: MAR 21, 1998@14:00
DATE VISIT CREATED: MAR 21, 1998 TYPE: IHS
PATIENT NAME: META,BETA AN
LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER
SERVICE CATEGORY: AMBULATORY CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 2      DATE LAST MODIFIED: MAR 21, 1998
PROVIDER: IHS PHYSICIAN      PATIENT NAME: META,BETA AN
VISIT: MAR 21, 1998@1:00      PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 100999
----- V POV -----
POV: .9999      PATIENT NAME: META,BETA AN
VISIT: MAR 21, 1998@1:00      PROVIDER NARRATIVE: ERROR
ICD NARRATIVE (c): UNCODED DIAGNOSIS
~~~~~
THE ABOVE VISIT AND RELATED V FILE ENTRIES WILL BE REMOVED
FOREVER!!!
Sure you want to delete? NO// Y (YES)..

```

Figure 31-10: Delete all data for a visit display

Always review the V files before responding **Y**(es). Once the delete is complete, the system returns to the DEU menu.

31.5 Data Entry Supervisor Options and Utilities (SUP)

The SUP option will not be covered in this manual. The Data Entry Supervisor manual contains a detailed description of all the items contained in the Supervisors menu.

31.6 Display IHS Coding Guidelines (COD)

Use the COD option to view the IHS ICD-9 Coding Guidelines document on the screen. This option utilizes the browser and functions in a similar manner to the Browse Health Summary option, allowing the user to scroll forward and backward in the document. In addition, the entire document can be printed by selecting the PL action.

31.7 Pediatric Growth Charts (GC)

Use the CG option to view a patient's growth compared to standard growth charts. The available growth charts are: Weight For Age Infant; Length For Age Infant; Weight For Recumbent Length; Head Circumference For Age; Weight For Stature; Weight For Age; Stature For Age; and Body Mass Index For Age.

31.8 Merge 2 Visits on 2 Different Dates (MR2)

Use the MR2 option to merge two visits on two different dates. Be very careful when using this option. This will typically be used only when a laboratory or radiology visit that occurred after midnight needs to be merged with a visit that occurred before midnight.

31.9 MV2D Move Data from one visit to a different date (MVD2)

Use the MV2D option to move data from one patient's visit to a visit on a different date.

31.10 Move Data Items from One Visit to Another (MVD)

Use the MVD option to selectively move certain data items (Medications, Lab Tests, Dental, Radiology, Microbiology) from one visit to another. Both the From and To visit must be for the same patient on the same date.

MVD is useful when some component of a visit was incorrectly linked to a visit by the Visit Relinker utility, which is usually scheduled to run at night to look for visits that do not have a Primary Provider or POV. It attempts to find a visit for the patient on the same day as the incomplete visit and then link the data items with the complete visit.

A good use for the MVD utility would be to move prescription entries that were linked to a dental visit before data entry took place for the medical visit. If the MVD option finds more than one of a certain type of data items to be moved, the user will be asked if s/he wants to confirm the move of each item. If the user answers **No**, all entries of that type will be moved. If answered **Yes**, the user will be prompted with each item and asked to confirm the move.

```

Select PATIENT NAME: ALPHA, SAM
Alpha, SAMANTHA                F 01-25-1958 000350003 SE100008
Enter the visit that the ITEMS WILL BE REMOVED FROM

Enter VISIT date: <120998><RETURN> (DEC 09, 1998)
PATIENT: ADAMS, SAMANTHA has one or more VISITs on this date.
1 TIME: 08:00   LOC: SE   TYPE: I CATEGORY: A CLINIC: GENERAL   DEC: 7
2 TIME: 12:00   LOC: SE   TYPE: I CATEGORY: A CLINIC: GENERAL   DEC: 2
Select one: <2><RETURN>

```

Figure 31-11: Choosing the patient and visit

```

***FROM VISIT ***
VISIT IEN: 760582
-----VISIT FILE-----
VISIT/ADMIT DATE&TIME: DEC 09, 1998@12:00
DATE VISIT CREATED: FEB 05, 1999   TYPE: TRIBAL
PATIENT NAME: ALPHA, SAMANTHA
LOC. OF ENCOUNTER: SELLS HOSPITAL
  SERVICE CATEGORY: AMBULATORY           CLINIC: DENTAL
DEPENDENT ENTRY COUNT: 4                DATE LAST MODIFIED: FEB 05, 1999
WALK IN/APPT: UNSPECIFIED               CREATED BY USER: RHORHO, WILMA
USER LAST UPDATE: RHORHO, WILMA

-----V DENTAL-----
SERVICE CODE: 2140      PATIENT NAME: ALPHA, SAMANTHA
VISIT: DEC 09, 1998@12:00   NO. OF UNITS: 1
OPERATIVE SITE: PERMANENT SECOND MOLAR, MAND LEFT

SERVICE CODE: 0000      PATIENT NAME: ALPHA, SAMANTHA
VISIT: DEC 09, 1998@12:00   NO. OF UNITS: 1

-----V PROVIDER-----
PROVIDER: GAMMAA, MELVIN   PATIENT NAME: ALPHA, SAMANTHA
VISIT: DEC 09, 1998@12:00   PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 352MG

----- V POV -----
POV: V72.2                PATIENT NAME: ALPHA, SAMANTHA
VISIT: DEC 09, 1998@12:00
PROVIDER NARRATIVE: DENTAL/ORAL HEALTH VISIT
ICD NARRATIVE (c): DENTAL EXAMINATION

-----V MEDICATION-----
MEDICATION: INDOMETHACIN 25MG CAP   PATIENT NAME: ALPHA, SAMANTHA

```

Figure 31-12: Move From visit

```
End of visit display, <ENTER> to Continue

Enter the visit that the ITEMS WILL BE APPENDED TO

PATIENT: ALPHA,SAMANTHA has one or more VISITs on this date.

1 TIME: 08:00
LOC: SE LOC: I CATEGORY: A CLINIC: GENERAL      DEC: 7
2 TIME: 12:00
LOC: SE LOC: I CATEGORY: A CLINIC: GENERAL      DEC: 4
Select one: 1
```

Figure 31-13: Choosing the To visit

```

*** TO VISIT ***

VISIT IEN: 76793
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: DEC 09, 1998@08:00
DATE VISIT CREATED: DEC 09, 1998   TYPE: IHS
PATIENT NAME: ALPHA,SAMANTHA       LOC. OF ENCOUNTER: SELLS HOSPITAL
SERVICE CATEGORY: AMBULATORY       CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 7           DATE LAST MODIFIED: FEB 05, 1999
WALK IN/APPT: UNSPECIFIED          CREATED BY USER: RHO,ALPHA
USER LAST UPDATE: RHO,ALPHA
----- V MEASUREMENT -----
TYPE: HT                            PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00          VALUE: 63
----- V PROVIDER -----
PROVIDER: CLASSY,ALPHA              PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00          PRIMARY/SECONDARY: PRIMARY
EVENT DATE AND TIME: DEC 09, 1998
AFF.DISC.CODE@: 100ACC
----- V POV -----
POV: 250.02                         PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00         PROVIDER NARATIVE: DIABETES TYPE 2
FIRST/REVIST: REVISIT
ICD NARRATIVE (c): DM UNCOMPL/T-II-NIDDM,UNCONNTR
----- V EXAM -----
EXAM: DIABETIC FOOT EXAM, COMPLETE  PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00          PROVIDER: MATTY,BETA
EXAM CODE (c): 28
EXAM: DIABETIC EYE EXAM            PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00          PROVIDER: MATTY,GAMMA
EXAM CODE (c): 29
----- V PATIENT ED -----
TOPIC: DM-NUTRITION                 PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00          PROVIDER: ALPHA,BETA
LEVEL OF UNDERSTANDING: FAIR        INDIVIDUAL/GROUP: INDIVIUA;
LENGTH OF EDUC (MINUTES): 20
CPT CODE (computer) (c): 99402

```

Figure 31-14: To Visit

```

End of visit display, <ENTER> to Continue

1) MEDICATIONS
   2) LAB TESTS
   3) DENTAL
   4) RADIOLOGY
   5) MICROBIOLOGY
Choose WHICH DATA TIEM TO MOVE: (1-5): 5// 1   MEDICATIONS

```

Figure 31-15: Move To visit and choosing which data item to move

```

I will move the following from the FROM visit to the TO visit

===== MEDICATION's =====
MEDICATION: INDOMETHACIN 25MG CAP
Are you sure you want to do this? N// YES
Do you want to be asked before moving each V File entry? N// YES
9000010.14
MEDICATION: INDOMETHACIN 25MG CAP      PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@12:00      SIG: T1C TID

Do you want to Move this Entry? Y//

```

Figure 31-16: Prompt for verification

```

*** COMPLETED VISIT WITH MEDS ***
VISIT IEN: 76793
-----VISIT FILE -----
VISIT/ADMIT DATE&TIME: DEC 09, 1998@08:00
DATE VISIT CREATED: DEC 09, 1998      TYPE: IHS
PATIENT NAME: ALPHA,SAMANTHA          LOC. OF ENCOUNTER: SELLS HOSPITAL
SERVICE CATEGORY: AMBULATORY          CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 8              DATE LAST MODIFIED: FEB 05, 1999
WALK IN/APPT: UNSPECIFIED             CREATED BY USER: RUBRIC,GAMMA
USER LAST UPDATE: RUBRIC,GAMMA
-----V MEASUREMENT -----
TYPE: HT                               PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00             VALUE: 63
-----V PROVIDER -----
PROVIDER: CHIII,CHARLES                PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00             PRIMARY/SECONDARY: PRIMARY
EVENT DATE AND TIME: DEC 09, 1998
AFF.DISC.CODE (c): 100ACC
-----V POV -----
POV: 250.02                            PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00             PROVIDER NARRATIVE: DIABETES TYPE 2
FIRST/REVISIT: REVISIT
ICD NARRATIVE (c): DM UNCOMPL/T-II/NIDDM,UNCONTR
-----V EXAM -----
EXAM: DIABETIC FOOT EXAM, COMPLETE PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00
EXAM CODE (c): 28
EXAM: DIABETIC EYE EXAM                PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00             RESULT: NORMAL
EXAM CODE (c): 29

<PATIENT EDUCATION OMITTED TO CONSERVE SPACE ON THIS PAGE>

-----V MEDICATION -----
MEDICATION: INDOMETHACIN 25MG CAP PATIENT NAME: ALPHA,SAMANTHA
VISIT: DEC 09, 1998@08:00      SIG: T1C TID FPA

```

Figure 31-17: Verification display

31.11 Reprint Group PCC Visit Forms (RGF)

Use the RFG option to reprint group encounter forms. You must know the group ID form number or the date of the group visit.

Only group forms typed after PCC Data Entry Patch 5 was installed are available for re-printing.

32.0 Generate Health Summary (GHS)

```
*****
**          PCC Data Entry Module          **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
VIEN Display a Visit by Visit IEN
BHS  Browse Health Summary
DVB  Display a PCC Visit w/limited Lab Display
GHS  Generate Health Summary
PDV  Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: GHS
```

Figure 32-1: Selecting the GHS menu option

Use the GHS option to browse a particular Health Summary for a specified patient.

The prompts and output are the same as those for the BHS (Browse Health Summary) option. See Section 33.0 for more information.

33.0 Browse Health Summary (BHS)

```

*****
**          PCC Data Entry Module          **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
VIEN Display a Visit by Visit IEN
BHS  Browse Health Summary
DVB  Display a PCC Visit w/limited Lab Display
GHS  Generate Health Summary
PDV  Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: BHS

```

Figure 33-1: Selecting the BHS menu option

Use the BHS option to browse a particular Health Summary for a specified patient.

Follow these steps:

1. At the “Select Patient Care Data Entry Menu Option” prompt, type **BHS** and press ENTER.
2. At the “Select health summary type” prompt, specify the type of Health Summary you want to view.
3. At the “Select patient” prompt, specify the patient.

The following shows an example of Output Browser for a Dental Health Summary:

```

OUTPUT BROWSER          Jan 13, 2009 13:51:58          Page: 1 of 6
PCC Health Summary for DEMO,JOHNNIE RUTH

***** CONFIDENTIAL PATIENT INFORMATION -- 1/13/2009  1:51 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

HEALTH RECORD NUMBERS: 118773 DEMO INDIAN HOSPITAL
118774 DEMO HOSPITAL
118775 DEMO HEALTH & MEDICAL DIV
DESIGNATED PROVIDERS
WOMEN'S HEALTH CASE MANAGER: SPROVIDER,JEROME
DESIGNATED PRIMARY PROVIDER: NPROVIDER,ERIN D
DIABETES: TETER,SHIRLEY
ON CMS REGISTER(S): ASTHMA (PERSISTENT) Status: ACTIVE
DYSLIPIDEMIA Status: ACTIVE
CARDIOVASCULAR DISEASE Status: ACTIVE
ALPHA TEAM Status: ACTIVE

----- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) -----
Allergies: LATEX (verified) -
----- ALLERGIES (FROM PROBLEM LIST) -----

***** ALLERGIES *****
***** ALLERGY: LATEX *****

----- ACTIVE PROBLEMS -----

ENT. MODIFIED
DIH1 10/02/89 10/02/89 ALLERGIES
DIH1DIH1 REFERRAL TO ALLERGIST 10/2/89
DIH2 10/02/89 10/02/89 ASTHMA
DIH5 05/08/95 05/08/95 TAYLOR'S BUNION R FOOT
DIH8 08/25/00 08/25/00 QUESTIONABLE BIOPSY-RIGHT MEDIAL FOREARM
(onset 08/22/00)
DIH9 02/07/01 02/07/01 ALLERGY: LATEX
DIH10 04/15/02 04/15/02 DYSLIPIDEMIA (onset 08/17/01)
- CURRENT MEDICATIONS (TWICE DURATION OF RX - MINIMUM 60 DAYS) (max 1 year)
-

----- OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) -----

01/13/09 DEMO HO DS TREATED FOR LOBOMYCOSIS
12/06/08 DEMO HO GEN <purpose of visit not yet entered>
11/14/08 DEMO HO GEN DIABETES MELLITUS
HYPERTENSIVE DISEASE

```

```

02/25/08  ANALENISGI  MH          MENTAL HEALTH VISIT
07/16/07  DEMO HO         W. I. C.  WIC-NF
07/05/07  DEMO HO         CASE MAN  CHART REVIEW
05/30/07  DEMO HO         GEN       Post Partum Pap Smear
                                Post partum mental disorder
                                Stress reaction; impending divorce
05/24/07  DEMO HO         PHARM     Medication counseling by proxy
05/15/07  DEMO HO         W. I. C.  WIC-RECERT
05/09/07  DEMO HO         GEN       Post Partum Evaluation

----- DENTAL (max 10 visits or 3 years) -----

                FAILED DENTAL APPOINTMENTS:
12/13/94  BROKEN
06/10/94  BROKEN

                ACTIVE DENTAL FOLLOWUP SUMMARY:
12/22/99  ROUTINE RECALL LIST Action: 12/21/00

<No Previous Followup>
                SERVICES PROVIDED:

*** END  CONFIDENTIAL PATIENT INFORMATION -- 1/13/2009  1:51 PM  [SJT] ***

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

```

Figure 33-2: Sample Health Summary data

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

- If you are not on the last page, type plus (+) to display the next screen.
- If you are not on the first page, type minus (-) to display the previous screen.
- Type **Q** to exit the Output Browser screen. You will be returned to the “Select Data Entry Utilities Option” prompt.

34.0 Display a PCC Visit with Limited Lab Display (DVB)

```
*****
**          PCC Data Entry Module          **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
VIEN Display a Visit by Visit IEN
BHS  Browse Health Summary
DVB  Display a PCC Visit w/limited Lab Display
GHS  Generate Health Summary
PDV  Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: DVB
```

Figure 34-1: Selecting the DVB menu option

Use the DVB option to display a PCC visit with limited laboratory display.

Follow these steps:

1. At the “Select Patient Name” prompt, specify the patient name.
2. At the “Enter Visit date” prompt, specify the date for the PCC visit.
3. At the “Device” prompt, type how you want the data to display/print.

```

PCC VISIT DISPLAY                Jan 12, 2009 14:19:13                Page: 1 of 36

Patient Name:                    DEMO,JOHNNIE RUTH
Chart #:                         118774
Date of Birth:                   MAR 01, 1981
Sex:                             F
Visit IEN:                       1288795

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME:          FEB 07, 2001@08:50
DATE VISIT CREATED:             FEB 07, 2001
TYPE:                           IHS
THIRD PARTY BILLED:             VISIT DATE PRIOR TO BACKBILLING LIMIT
PATIENT NAME:                   DEMO,JOHNNIE RUTH
LOC. OF ENCOUNTER:              DEMO INDIAN HOSPITAL
SERVICE CATEGORY:              AMBULATORY
CLINIC:                         EMERGENCY MEDICINE

DEPENDENT ENTRY COUNT:          77
DATE LAST MODIFIED:             FEB 07, 2002
DATE VISIT EXPORTED:           JUN 22, 2001
WALK IN/APPT:                  UNSPECIFIED
CREATED BY USER:               HOPROVIDER,MONICA LEE
USER LAST UPDATE:              AQPROVIDER,DWAYNE
OLD/UNUSED UNIQUE VIS:         5151010001288795
DATA WAREHOUSE EXPORT:         OCT 14, 2004
NDW UNIQUE VISIT ID (:         000000001288795

===== MEASUREMENTs =====
TYPE:                           BP
VALUE:                          122/73

TYPE:                           WT
VALUE:                          169

===== PROVIDERS =====
PROVIDER:                       LVPROVIDER,CHARLOTTE
AFF.DISC.CODE:                  280567
PRIMARY/SECONDARY:              PRIMARY
EVENT DATE AND TIME:           FEB 07, 2001
PROVIDER:                       WSPROVIDER,JAMES R
AFF.DISC.CODE:                  901468
PRIMARY/SECONDARY:              SECONDARY
EVENT DATE AND TIME:           FEB 07, 2001@08:55

```

```

===== POVs =====
POV:                276.5
ICD NARRATIVE:      HYPOVOLEMIA
PROVIDER NARRATIVE: DEHYDRATION 2NDARY TO N/V/D
FIRST/REVISIT:      REVISIT

POV:                787.01
ICD NARRATIVE:      NAUSEA WITH VOMITING
PROVIDER NARRATIVE: NAUSEA AND VOMITING
FIRST/REVISIT:      REVISIT

POV:                558.9
ICD NARRATIVE:      NONINF GASTROENTERIT NEC
PROVIDER NARRATIVE: DIARRHEA
FIRST/REVISIT:      REVISIT

===== LABS =====
LAB TEST:           ZZCHEM 7
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER:  XEPROVIDER,FELICIA Z
ORDERING DATE:      FEB 07, 2001@09:53:29
CPT PTR:            CHEM 7
CPT - BILLABLE ITEMS:
80051|16.00|||;82947|24.50|||;84520|21.50|||;82565|28.

LAB TEST:           GLUCOSE
RESULTS:            79.
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER:  XEPROVIDER,FELICIA Z
ORDERING DATE:      FEB 07, 2001@09:53:29
CPT PTR:            CHEM 7

LAB TEST:           UREA NITROGEN
RESULTS:            16.0
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER:  XEPROVIDER,FELICIA Z
ORDERING DATE:      FEB 07, 2001@09:53:29
CPT PTR:            CHEM 7

LAB TEST:           CREATININE
RESULTS:            0.8
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER:  XEPROVIDER,FELICIA Z
ORDERING DATE:      FEB 07, 2001@09:53:29
CPT PTR:            CHEM 7

```

LAB TEST: SODIUM
RESULTS: 142.
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER: XEPROVIDER,FELICIA Z
ORDERING DATE: FEB 07, 2001@09:53:29
CPT PTR: CHEM 7

LAB TEST: POTASSIUM
RESULTS: 4.3
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER: XEPROVIDER,FELICIA Z
ORDERING DATE: FEB 07, 2001@09:53:29
CPT PTR: CHEM 7

LAB TEST: CHLORIDE
RESULTS: 111.
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER: XEPROVIDER,FELICIA Z
ORDERING DATE: FEB 07, 2001@09:53:29
CPT PTR: CHEM 7

LAB TEST: CO2
RESULTS: 21.
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER: XEPROVIDER,FELICIA Z
ORDERING DATE: FEB 07, 2001@09:53:29
CPT PTR: CHEM 7

LAB TEST: AST/SGOT
RESULTS: 18.
SOURCE OF DATA INPUT: LAB
CURRENT STATUS FLAG: RESULTED
COLLECTION DATE AND T: FEB 07, 2001
ORDERING PROVIDER: XEPROVIDER,FELICIA Z
ORDERING DATE: FEB 07, 2001@09:53:29
CPT PTR: AST/SGOT
CPT - BILLABLE ITEMS: 84450|21.50|||

```

LAB TEST:                ALT/SGPT
RESULTS:                 27.
SOURCE OF DATA INPUT:  LAB
CURRENT STATUS FLAG:    RESULTED
COLLECTION DATE AND T:  FEB 07, 2001
ORDERING PROVIDER:     XEPROVIDER,FELICIA Z
ORDERING DATE:         FEB 07, 2001@09:53:29
CPT PTR:               ALT/SGPT
CPT - BILLABLE ITEMS:  84460|21.50||||

LAB TEST:                CBC
SOURCE OF DATA INPUT:  LAB
CURRENT STATUS FLAG:    RESULTED
COLLECTION DATE AND T:  FEB 07, 2001
ORDERING PROVIDER:     XEPROVIDER,FELICIA Z
ORDERING DATE:         FEB 07, 2001@09:53:29
CPT PTR:               CBC
CPT - BILLABLE ITEMS:  85025|33.00||||

LAB TEST:                WBC
RESULTS:                 8.2
SOURCE OF DATA INPUT:  LAB
CURRENT STATUS FLAG:    RESULTED
COLLECTION DATE AND T:  FEB 07, 2001
ORDERING PROVIDER:     XEPROVIDER,FELICIA Z
ORDERING DATE:         FEB 07, 2001@09:53:29
CPT PTR:               CBC

LAB TEST:                NEUTROPHILS %
RESULTS:                 73
SOURCE OF DATA INPUT:  LAB
CURRENT STATUS FLAG:    RESULTED
COLLECTION DATE AND T:  FEB 07, 2001
ORDERING PROVIDER:     XEPROVIDER,FELICIA Z
ORDERING DATE:         FEB 07, 2001@09:53:29
CPT PTR:               CBC

LAB TEST:                LYMPH %
RESULTS:                 16
SOURCE OF DATA INPUT:  LAB
CURRENT STATUS FLAG:    RESULTED
COLLECTION DATE AND T:  FEB 07, 2001
ORDERING PROVIDER:     XEPROVIDER,FELICIA Z
ORDERING DATE:         FEB 07, 2001@09:53:29
CPT PTR:               CBC

LAB TEST:                MONO %
+           Enter ?? for more actions
+   Next Screen           -   Previous Screen           Q   Quit
Select Action: +//

```

Figure 34-2: Example report

You can do the following at the “Select Action” prompt:

- If you are not on the last page, type plus (+) to go to the next page
- If you are not on the first page, type minus (-) to go the previous page.
- Type **Q** to quit the screen. You will be returned to the “Select Patient Care Data Entry Menu Option” prompt.

35.0 Print a PCC Visit Display to a Printer (PVD)

```
*****
**          PCC Data Entry Module          **
*****
          IHS PCC Suite Version 2.0

          DEMO HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
PEF  Print a PCC Visit in Encounter Form format
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
VIEN Display a Visit by Visit IEN
BHS  Browse Health Summary
DVB  Display a PCC Visit w/limited Lab Display
GHS  Generate Health Summary
PDV  Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: PVD
```

Figure 35-1: Selecting the PDV menu option

Use the PDV option to print a PCC Visit Information for a specified patient to a specified printer.

Follow these steps:

1. At the “Select Patient Name” prompt, specify the patient name.
2. At the “Enter Visit date” prompt, specify the date for the PCC visit.
3. At the “Device” prompt, type how you want the data to display/print.

```
VISIT IEN: 1251552

HRN: DH 118774
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: AUG 25, 2000@12:00
  DATE VISIT CREATED: OCT 10, 2000      TYPE: IHS
  THIRD PARTY BILLED: VISIT DATE PRIOR TO BACKBILLING LIMIT
  PATIENT NAME: DEMO,JOHNNIE RUTH      LOC. OF ENCOUNTER: DEMO INDIAN
HOSPITAL
  SERVICE CATEGORY: AMBULATORY          CLINIC: CHART REV/REC MOD
  DEPENDENT ENTRY COUNT: 3              DATE LAST MODIFIED: OCT 10, 2000
  DATE VISIT EXPORTED: JAN 26, 2001    WALK IN/APPT: UNSPECIFIED
  CREATED BY USER: BDEMO,JEANETTE     USER LAST UPDATE: BDEMO,JEANETTE
  OLD/UNUSED UNIQUE VISIT ID: 5151010001251552
  DATA WAREHOUSE EXPORT DATE: AUG 31, 2001
  NDW UNIQUE VISIT ID (DBID): 000000001251552

----- V PROVIDER -----
PROVIDER: LVPROVIDER,CHARLOTTE          PATIENT NAME: DEMO,JOHNNIE RUTH
  VISIT: AUG 25, 2000@12:00            PRIMARY/SECONDARY: PRIMARY
  EVENT DATE AND TIME: AUG 25, 2000
  AFF.DISC.CODE (c): 280567

Enter to continue, '^' to halt
```

Figure 35-2: Example Visit Information

36.0 Appendix A: Useful RPMS Codes

The following are useful codes and definitions.

36.1 Clinic Codes

Below is a list of the available clinic codes:

Code	Clinic
01	General
02	Cardiology
03	Chest and TB
04	Crippled Children
05	Dermatology
06	Diabetic
07	Ent
08	Family Planning
09	Grouped Services
10	Gynecology
11	Home Care
12	Immunization
13	Internal Medicine
14	Mental Health (Psychiatry)
15	Obesity
16	Obstetrics
17	Ophthalmology
18	Optometry
19	Orthopedic
20	Pediatric
21	Rehabilitation
22	School
23	Surgical
24	Well Child
25	Other
26	High Risk
27	General Preventive
28	Family Practice
29	Plastic Surgery

Code	Clinic
30	Emergency Medicine
31	Hypertensive
32	Postpartum
33	Respiratory Care
34	Physical Therapy
35	Audiology
36	W. I. C.
37	Neurology
38	Rheumatology
39	Pharmacy
40	Infant Stimulation
41	Indirect
42	Mail
43	Alcohol and Substance
44	Day Surgery
45	Phn Clinic Visit
46	Nih Clinic
47	Fetal Alcohol Syndrome
48	Medical Social Services
49	Nephrology
50	Chronic Disease
51	Telephone Call
52	Chart Rev/Rec Mod
53	Follow-Up Letter
54	Radio Call
55	Cast Room
56	Dental
57	Epsdt
58	Cancer Screening
59	Std
60	Education Classes
61	Devel. Assessment
62	Cancer Chemotherapy
63	Radiology
64	Retinopathy
65	Podiatry

Code	Clinic
66	Ultrasound
67	Dietary
68	Employee Health Un
69	Endocrinology
70	Women's Health Screening
71	Computed Tomography
72	Mammography
73	Genetics
74	Speech Pathology
75	Urology
76	Laboratory Services
77	Case Management Services
78	OTC Medications
79	Triage
80	Urgent Care
81	Men's Health Screening
82	Day Treatment Prog
83	Labor And Delivery
84	Pain Management
85	Teen Clinic
86	Traditional Medicine
87	Observation
88	Sports Medicine
89	Evening
90	Telemedicine
91	Teleradiology
92	Dialysis
93	Occupational Therapy
94	Tobacco Cessation Clinic
95	Dialysis Laboratory Services
96	Pediatric Outpatient Use Of Inp Trtmnt Rm
97	Surgical Outpatient Use Of Inp Trtmnt Room
98	Diabetes Education-Group
99	Third Party Dental

Code	Clinic
A1	Diabetes Education-Individual
A2	Diabetic Retinopathy
A3	Ambulance
A4	Perinatologist
A5	Complementary Medicine
A6	Chiropractic
A7	Ryan White Early Intervention
A8	Wellness
A9	Ph Preparedness (Bioterrorism)
B1	Maternity Case Mgmt Supp Serv
B2	Radiation Exposure Screening
B3	Sands (Stop Atherosc In Native Diab Study)
B4	Wisewoman
B5	Nurse Clinic
B7	Diabetic Foot Clinic
B8	Gastroenterology-Hepatology
B9	Oncology-Hematology
C1	Neurosurgery
C2	Pulmonology
C3	Colposcopy
C4	Behavioral Health
C5	Wound Care
C6	Health Aide Clinic
C7	Elder Care
C8	Home Based Care
C9	Telebehavioral Health
XX	Default Code For Nulls/Blanks

36.2 Exam Codes

Below is a list of the available exam codes:

Code	Exam Name
03	Diabetic Eye Exam
28	Diabetic Foot Exam, Complete
29	Foot Inspection
30	Dental Exam
34	Intimate Partner Violence
35	Alcohol Screening
36	Depression Screening
37	Fall Risk

36.3 Health Factors

Tobacco Use and Exposure Health Factor	Definition
Ceremonial Use Only	Uses tobacco for ceremonial or religious purposes only.
Cessation Smokeless	Is transitioning from a Current Smokeless tobacco user to a Previous Smokeless tobacco user. The time period between stopping smokeless tobacco and the present date is less than 6 months.
Cessation Smoker	Is transitioning from a Current Smoker to a Previous Smoker. The time period between the stop date and the present date is less than 6 months.
Current Smokeless	Currently uses smokeless tobacco (chew, dip, snuff, etc.).
Current Smoker	Currently smokes tobacco (cigarettes, cigars, pipe, etc.).
Current Smoker and Smokeless	Currently uses both smoke and smokeless tobacco.
Exposure to Environmental Tobacco Smoke	Is exposed to secondhand smoke at work or outside the home.
Non-Tobacco User	Does not and has never used tobacco products.
Previous Smokeless	Has quit smokeless tobacco for 6 months or more.
Previous Smoker	Has quit smoking tobacco for 6 months or more.
Smoke Free Home	No exposure to tobacco smoke at home.
Smoker in Home	Is exposed to secondhand smoke at home.

The following are CAGE health factors:

CAGE Health Factor	Definition
CAGE 0/4	Answers NO to all four questions.
CAGE 1/4	Answers YES to one of the four questions.
CAGE 2/4	Answers YES to two of the four questions.
CAGE 3/4	Answers YES to three of the four questions.
CAGE 4/4	Answers YES to all four questions.

The following are Activity Level health factors:

Activity Level Health Factor	Definition
Inactive	Engages in little or no physical activity.
Some Activity	Engages in < 150 minutes (approximately 30 minutes 4 or fewer times a week) of physical activity per week.
Active	Engages in 150 minutes (30 minutes 5 times a week) of physical activity per week.
Very Active	Engages in > 150 minutes (more than 30 minutes 5 or more times a week) of physical activity per week.

The following are Occupation health factors:

Occupation Health Factor	Definition
Dayshift	Works predominantly during daylight hours.
Nightshift	Works predominantly during nighttime hours.
Mixed Shift	Works during different hours of the day.
Manager or Administrator	Works in an administrative capacity.
Staff Employee	Works under an administrator or other supervisor.
Desk Job	Works predominantly at a desk with little activity involved during the workday.
Lifting	Is actively involved in lifting objects and physical activity during the workday.
Risky work	Works in a job that is considered to possess some degree of danger to health and safety.
Outdoor job	Works in an outside environment.
Works with food	Works with food preparation or raw meats.
Works with animals	Works with animals.
Unemployed	Currently not employed.
Retired	Currently retired and not working.

The following are Diabetes Self Monitoring health factors:

Diabetes Self Monitoring Health Factor	Definition
Yes	Patient performs self monitoring of blood glucose.

Diabetes Self Monitoring Health Factor	Definition
No	Patient does not perform self monitoring of blood glucose.
Refused	Patient refuses to perform self monitoring of blood glucose.

The following are Tuberculosis Treatment health factors:

Tuberculosis Treatment Health Factor	Definition
TX Complete	Patient has completed a course of TB treatment.
TX In Progress	Patient is currently receiving TB treatment.
TX Incomplete	Patient has not completed a course of TB treatment.
TX Unknown	Status of TB treatment is uncertain.
TX Untreated	TB has not been treated.

The following are Rubella Immunity Status health factors:

Rubella Immunity Status Health Factor	Definition
Immune	Immunity to rubella is documented.
Non-Immune	Patient is not immune to rubella.
Status Indeterminate	Immunity to rubella is uncertain.

The following are Barrier to Learning Health Factors:

Barriers to Learning Health Factor	Definition	Assessment
< 6 th Grade Education (EDUC)	The patient has not completed elementary-level education	Must assess by asking grade level completed.
Blind (BLND)	The patient is blind and cannot compensate with low vision devices.	The patient may divert the eyes, wear sunglasses inside, state his or her inability to see, or is diagnosed with blindness (best corrected vision is $\geq 20/200$ or ≥ 20 degrees of visual field in the better eye).
Childhood Development (PEDI)	That patient has normal cognitive development but is too young to understand health information. There is no cutoff age for this, since childhood cognition can develop at different rates.	The pediatric patient is of an age or cognition level that s/he relies on others for care.

Barriers to Learning Health Factor	Definition	Assessment
Deaf (DEAF)	The patient is deaf and cannot compensate with increased volume or hearing devices.	The patient may not respond to questions, may look intently at your lips as you speak, may motion to communicate by writing, may use sign language to indicate deafness, or may have a diagnosis of deafness.
Dementia (DEMN)	The patient may have difficulty learning because of impaired thought processes.	The patient may answer questions inappropriately, behave inappropriately, or display symptoms of confusion or forgetfulness. The patient may have a documented diagnosis of dementia.
Developmental Delay (DEV D)	The patient demonstrates developmental delay beyond childhood.	The patient may behave younger than actual age.
Does Not Read English (DNRE)	The patient is unable to read English.	Ask the patient or the patient's family about his or her ability to read English. The patient may be embarrassed to admit s/he cannot read English or may make excuses such as "I forgot my glasses." This is a sensitive subject and must be treated accordingly. Stress "English" in this evaluation and acknowledge that the patient's primary language may be unwritten. Another technique is to have the patient read a sentence that could be interpreted in different ways and ask the patient how s/he interprets the sentence. If the patient is unable, state that reading English can be hard for people who learned another language first and ask if this applies to him or her.
Emotional Stressors (EMOT)	The patient's ability to learn is limited due to emotional stressors.	The patient may appear distraught, avoid eye contact, or show anger. The stressors can be acute or ongoing, as in the case of conflict, mental disorders, disease, death, alcohol or substance abuse, or domestic violence. Social stressors are external while emotional stressors are internal.

Barriers to Learning Health Factor	Definition	Assessment
Fine Motor Skills Deficit (FIMS)	The patient has fine motor skills impairment which can interfere with tasks requiring manual dexterity.	The patient may have difficulty or lack the physical control to direct or manage body movement, such as paralysis, arthritis, amputation, unable to handle testing supplies (for example checking blood sugars or measuring medications).
Hard of Hearing (HEAR)	The patient has a problem hearing that can be compensated with increased volume or hearing devices.	The patient may not respond to questions initially and may ask for things to be repeated, may speak loudly, bend ear or lean toward the speaker, or wear a hearing device.
Interpreter Needed (INTN)	The patient does not readily understand spoken English.	The patient may verbalize the need for an interpreter, answer questions inappropriately, or answer or nod "yes" to all questions. These actions could also imply hearing difficulty and many require further assessment.
Learning Disability (LDIS)	The patient has a learning disability, such as dyslexia.	The patient may comment about a learning disability or be diagnosed as such.
No Barriers (NONE)	The patient has no apparent barriers to learning.	
Social Stressors (STRS)	The patient's ability to learn is limited due to social stressors from current personal difficulties or ongoing mental or behavioral health issues.	The patient may appear distraught, avoid eye contact, or show anger. The stressors may be acute or ongoing, as in the case of conflict, mental disorders, disease, death, alcohol or substance abuse, or domestic violence. Social stressors are external while emotional stressors are internal.
Speaks English as a Second Language (ESLA)	The patient's primary language is not English	The patient speaks English fluently, but may have minor barriers due to differences in primary language.
Values or Beliefs (VALU)	The patient has values or beliefs that may impact learning; this may also include traditional Native American/Alaska Native values or beliefs that may impact the medical or clinical aspects of health care.	The patient may comment or be asked about values or beliefs in relation to health information or medical or clinical aspects of health care.

Barriers to Learning Health Factor	Definition	Assessment
Visually Impaired (VISI)	The patient has difficulty seeing even with best-corrected vision. The difficulty can be compensated with the use of other measures, devices, or both to improve vision (large print, better lighting, magnifying glasses).	The patient may divert the eyes, squint, or state his or her difficulty seeing.

The following are Health Literacy health factors:

Barriers to Learning Health Factor	Definition	Assessment
Health Literate (NLHL)	The patient demonstrates the ability to perform basic reading and numerical tasks required to function in a health care environment. Distinct from education and reading ability.	Assessment is made by a low score on a health literacy screening tool.
Low Health Literacy (LOHL)	The patient does not demonstrate the ability to perform basic reading and numerical tasks required to function in a health care environment. Distinct from education and reading ability.	Assessment is made by a low score on a health literacy screening tool.

The following are Learning Preferences health factors:

Learning Preferences Health Factor	Definition
Do or Practice	The patient states that doing or practicing a new skill is the preferred style of learning new information.
Read	The patient, or the patient's family, states that reading is a preferred style of learning.
Small Group	The patient, or the patient's family, states that participating in small groups is a preferred style of learning.
Talk	The patient, or the patient's family, states that talking and asking questions is a preferred style of learning.
Media	The patient, or the patient's family, states that media (kiosk, videos, interactive displays) is a preferred style of learning.

The following are Asthma Triggers health factors:

Asthma Triggers Health Factor	Definition
Air Pollutants	The patient's asthma status worsens when exposed to air pollutants or when the air quality index is low.
Animal	The patient's asthma status worsens when around animals and pets, including rodents and birds.
Change in Weather	The patient's asthma status worsens with changes in weather, such as cold air, high humidity, or heat.
Cockroaches	The patient's asthma status worsens when exposed to cockroaches.
Dust Mites	The patient's asthma status worsens when exposed to dust and dust mites.
Exercise	The patient's asthma status worsens when exercising/cold.
Menses	The female patient's asthma status worsens during menses.
Mold	The patient's asthma status worsens when exposed to mold and/or mildew
Other Trigger	Use only if no other trigger is appropriate. Type the specific asthma trigger in the comments section.
Pollen	The patient's asthma status worsens when exposed to pollen or other seasonal triggers.
Strong Emotional Expression	Strong emotional expressions cause worsening of the patient's asthma status.
Tobacco Smoke	The patient's asthma status worsens when exposed to tobacco smoke.
Viral Infection	Viral infections worsen the patient's asthma status.

38.0 Appendix C: RPMS Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general Rules of Behavior for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS web site,

<http://security.ihs.gov/>

The Rules of Behavior listed in the following sections are specific to RPMS.

38.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., PCC, Dental, Pharmacy).

38.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or non-public agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS 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 your 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.

38.1.2 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.

RPMS 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 may 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.

38.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Logout 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.

38.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hardcopy information, and protect it accordingly.
- Store hardcopy 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.

RPMS 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.

38.1.5 Integrity

RPMS 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.

RPMS 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.

38.1.6 System Logon

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).

38.1.7 Passwords

RPMS 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 alpha, numeric 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 your ISSO.
- Keep user identifications (ID) and passwords confidential.

RPMS 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 8 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.

38.1.8 Backups

RPMS 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.

38.1.9 Reporting

RPMS users shall

- Contact and inform your ISSO that you have identified an IT security incident and you will begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS 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

38.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS 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 your screen after some period of inactivity.

38.1.11 Hardware

RPMS 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.

RPMS users shall not

- Eat or drink near system equipment

38.1.12 Awareness

RPMS 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.

38.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may 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 non-recovery 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 RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) when ever 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 RPMS users shall not

- Disable any encryption established for network, internet, and web browser communications.

38.2 RPMS Developers

RPMS 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.
- Shall not access live production systems without obtaining appropriate written access, shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Shall observe separation of duties policies and procedures to the fullest extent possible.
- Shall 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.
- Shall use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Shall follow industry best standards for systems they are assigned to develop or maintain; abide by all Department and Agency policies and procedures.
- Shall document and implement security processes whenever available.

RPMS 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.
- Not release any sensitive agency or patient information.

38.3 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 RPMS 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 RPMS 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.
- Not release any sensitive agency or patient information.

39.0 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 entering 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 are displayed 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 symbol ^ (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 in reducing 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 considered 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, you will find a prompt requesting specific types of data. 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 you are 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 Summary User Manual.

Health Maintenance 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. They are displayed 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, 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 entering 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 (blood pressure).

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 (blood pressure), WT (weight), HT (height), HC (head circumference) etc.

Patient Wellness Handout

The Patient Wellness Handout is a type of Health Summary 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 by.

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, 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 enter 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 on a Manager's menu, you 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 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.

40.0 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