



INDIAN HEALTH SERVICE

**RESOURCE AND PATIENT MANAGEMENT SYSTEM
RPMS ADP SYSTEMS MANUAL**

Patient Care Component (PCC) Data Entry (APCD)

Operator's Manual

**March 1999
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.

The Patient Care Component (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 health care 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.

A more complete description of the Patient Care Component and its key features is contained in the RPMS manual entitled "PCC Overview."

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

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1 INTRODUCTION

The Data Entry Module (DEM) facilitates entry of information about a patient from a variety of forms into the Patient Care Component (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 entered into the PCC. This can be expanded to include entry of visits at contract facilities, by IHS field health personnel such as Community Health Nurses, Mental Health and Social Workers, and tribal health care program workers.

1.1 DATA

The data entry system consists of the following features:

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

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

- Date of Encounter
- Location of Visit (clinic/hospital, office, home, etc.)
- Clinic type (required only for clinic visits)
- A purpose of visit/diagnosis
- Patient identification (such as name, facility health record number, date of birth, and sex)
- Identification and signature of the **primary** care provider.

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

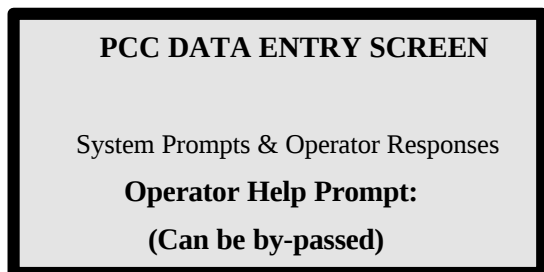
2 HOW TO USE THE MANUAL

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 shadowed screen. Operator keyboard entries and responses are offset by bold characters enclosed in the < > symbols, e.g., <RETURN>. **The operator will only enter the keys inside the < > symbols.** Some help prompts have been included and display as shaded text which can be by-passed 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. See below.

Help screens are available which 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 may be obtained by entering a question mark (?) followed by the option mnemonic or name, e.g., <?ENT> <RETURN> to select the ENTER DATA help prompt.



3 OVERVIEW OF MENU OPTIONS

The Data Entry Module is menu controlled. There are six items on the primary menu. Three of the items shown are sub menus as indicated by the ellipsis (three dots) following the menu text. A display of the primary menu and a brief description of the six items follows:

```
*****
**   PCC Data Entry Module   **
*****

Version 2.0
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ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
GHS  Generate Health Summary
BHS  Browse Health Summary

Select Patient Care Data Entry Menu Option:
```

ENT – Enter/Modify/Append PCC Data ... This menu item is a sub menu that contains all the options necessary to create and modify PCC visit data. Each of the ENT options will be described in detail in its section of the manual.

DSP – Display Data for a Specific Patient Visit: This menu option will display all **visit related data for a specific date** that has been entered for a patient. DISP may be used for a number of reasons including: 1) to verify data before appending (adding) to a visit, 2) to review data after modifying (changing) data, or 3) to assist in determining whether to merge (combine) two or more visits into one. The visit information will automatically display on the terminal utilizing the full screen display with browser. The operator may scroll through the visit by pressing <RETURN> to accept default <+> to move forward, or <-> to move backward. In addition, <??> will produce a list of all actions that may be selected by the user.

When working in other data entry menu options, the **DISP mnemonic** should be used at the MNEMONIC prompt to display the patient file and avoid returning back to the menu. The DISP mnemonic functions the same as the DSP menu option except the operator remains active in another mode, e.g. Mini, Ent, Mod, etc. and can only display the patient currently being accessed.

UPD - Update Patient Related/Non Visit Data ... This sub menu contains the options that are used to create and modify data that is patient related and does not generate a visit record. A complete description of each of the UPD options will be presented in that section of the manual.

DEU – Data Entry Utilities ... This sub menu contains various utility options and the Supervisor menu. All of the DEU options and utilities are described in detail in that section of the manual.

GHS – Generate Health Summary This menu appears here and in the **Data Entry Utilities** menu. It is used to display a health summary for specific patient(s) on the screen or printer. A complete description and example of this option will be presented in the Data Entry Utilities portion of the manual.

BHS – Browse Health Summary This menu option allows the operator to view a health summary on the screen, but rather than merely printing it to the screen, the browser lets the user 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.

4 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 enter patient health information.

A complete list of the mnemonics can be viewed by typing a <?> <RETURN> 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.

WARNING: If the system responds to a single <?> with a message like **Do you want the entire V list?**, answer **NO** or you will get a list of all entries that have ever been added to that V File (visit related file) on your system and cause the system to slow down considerably.

```
MNEMONIC: EX      Examinations  ALLOWED  VISIT RELATED ONLY
Enter EXAM Type: <?><RETURN>
Answer with V EXAM
Do you want the entire V EXAM List? <N><RETURN> (No)
Answer with EXAM NAME
Do you want the entire EXAM List? <Y><RETURN>
Choose from:
  ABDOMEN EXAM    09
  AUDIOMETRIC SCREENING  23
  AUDIOMETRIC THRESHOLD  24
  BREAST EXAM     06
  CHEST EXAM      07
  DIABETIC EXAM   22
  DIABETIC EYE EXAM  03
  DIABETIC FOOT CHECK  29
  DIABETIC FOOT EXAM, COMPLETE  28
```

Important: Answer NO to a V question like this or you will get a list of every exam that has ever been entered on your system.

←

←

Yes is appropriate here to see the list of acceptable choices for this mnemonic.

Listed below are the mnemonics available for entry of data and a brief description. Bold text indicates a mnemonic that is new with V. 2.0 of PCC Data Entry.

	ADX	ADMITTING DIAGNOSIS
	AG	ABDOMINAL GIRTH
	AL	APPOINTMENT LENGTH
	APO	ACTIVATE AN INACTIVE PROBLEM
	APPT	APPOINTMENT DATE & TIME
	AT	ACTIVITY AND TRAVEL TIME
	AUD	AUDIOMETRY
	BP	BLOOD PRESSURE
*	BS	11 BLOOD SUGAR ORDERED
	BT	BLOOD TYPE ENTRY
	CBC	CBC ORDERED
**	CHA	CHS - AMBULATORY (HRSA 64)
	CHC	CENTIMETER HEAD CIRCUMFERENCE
**	CHH	CHS - HOSPITALIZATION HRSA 43
**	CHI	CHS - IN HOSPITAL HRSA 64
	CHT	CENTIMETER HEIGHT
	CKO	CHECK OUT DATE AND TIME
	CL	CLINIC TYPE
	CODE	CODING GUIDELINES
	CPE	CPT CODES WITH ENTRY OF ENCOUNTER PROVIDER
	CPT	CPT CODES
	CXD	CERVIX DILATED
*	DDS	DENTAL-DIRECT SERVICE
	DHS	DATA ENTRY HEALTH SUMMARY
	DISP	VISIT DISPLAY
	DP	DESIGNATED PROVIDER
	DTC	DIAGNOSTIC PROCEDURE TRAN CODE (CHARGEMASTER)
	ECOD	APPEND AN E-CODE TO A PURPOSE OF VISIT
	ED	EDEMA MEASUREMENT
	EDC	EXPECTED DATE OF CONFINEMENT
	EFF	EFFACEMENT
	EKG	EKG DIAGNOSTIC PROCEDURE
	EM	EVALUATION & MANAGEMENT CPT
	ER	EMERGENCY ROOM DATA
	EX	EXAMINATIONS
	FH	FUNDAL HEIGHT
	FHX	FAMILY HISTORY
	FL	FLAG FIELD

FM FAMILY PLANNING METHOD
FP FAMILY PLANNING
FS FUTURE SCHEDULED ENCOUNTER
FT FETAL HEART TONES
GP EYEGLASS PRESCRIPTION
GWT GRAM WEIGHT
HBS HISTORICAL BLOOD SUGAR ENTRY
HC HEAD CIRCUMFERENCE IN INCHES
HCBC HISTORICAL CBC ORDERED
* HCT 20 HEMATOCRIT ORDERED
HE HEARING
HEKG HISTORICAL ELECTROCARDIOGRAM ENTRY
HEX HISTORICAL EXAMINATION ENTRY
HF HEALTH FACTORS
HHCT HISTORICAL HEMATOCRIT (HCT)
HIM HISTORICAL IMMUNIZATION
HL HOSPITAL LOCATION
HLAB HISTORICAL LABORATORY ENTRY
HLST HEALTH STATUS
HMSR HISTORICAL MEASUREMENT
HPAP HISTORICAL PAP SMEAR
HRAD HISTORICAL RADIOLOGY PROCEDURE
HRX HISTORICAL PRESCRIPTION
HS HISTORICAL SKIN TEST
HT HEIGHT IN INCHES
HUA HISTORICAL UA ENTRY
IM IMMUNIZATIONS
IOP ICD OPERATION NARRATIVE OP
* IP INPATIENT
IPO INACTIVATE A PROBLEM
IPV ICD NARRATIVE PURPOSE OF VISIT
KWT KILOGRAM WEIGHT
* LAB LAB TEST ENTRY
LMP LAST MENSTRUAL PERIOD
LS LEVEL OF SERVICE
MEAS MEASUREMENT ENTRY
MNN CHANGE NOTE NARRATIVE
MOD SWITCH TO MODIFY MODE
MPO CORRECT/MODIFY PROBLEM
NO NOTE
NT NARRATIVE TEXT
OHX OFFSPRING HISTORY

OLOC OUTSIDE LOCATION
 OP OPERATIONS
 PAP 31 PAP SMEAR ORDERED
PCP PRIMARY CARE PROVIDER (DP)
PCPT PROCEDURE ENTRY USING CPT CODING
 PED PATIENT EDUCATION
PHN PUBLIC HEALTH NURSING FORM DATA
 PHX PERSONAL HISTORY
PL PROBLEM LIST UPDATE
 PO PROBLEM ONLY
 PPV P O V AND PROBLEM ENTRY
PR PRESENTATION
 PRV PROVIDERS (PRIMARY/SECONDARY)
PRX PRESCRIBED RX
 PT PHYSICAL THERAPY
 PU PULSE ALLOWED
 PV PURPOSE OF VISIT
 RAD RADIOLOGY
 RF REPRODUCTIVE FACTORS
 RNO REMOVE NOTE FROM PROBLEM
 RPO REMOVE PROBLEM ENTRY
 RS RESPIRATION
 RX MEDICATIONS
 SHX HISTORY OF SURGERY
 SPV PURPOSE OF VISIT WITH STAGE PROMPT
 ST SKIN TEST
 STG STAGE IN PURPOSE OF VISIT
STN STATION (PREGNANCY MEASUREMENT TYPE)
STP SKIN TEST PLACED
TA TIME OF APPOINTMENT
TC TRAN CODE (CHARGEMASTER)
TD TYPE OF DECISION MAKING
TE TRAN CODE WITH ENTRY OF ENCOUNTER PROVIDER
 TM TIME OF VISIT
 TMP TEMPERATURE
 TON TONOMETRY
 TP TREATMENTS PROVIDED
 * UA 49 URINALYSIS ORDER-NO RESULTS
UCD UNDERLYING CAUSE OF DEATH
UOP UNCODED OPERATION/PROCEDURE
UPV UNCODED PURPOSE OF VISIT
 VC VISION CORRECTED

VST VISIT FILE INFORMATION MODIFY
VU VISION UNCORRECTED
WHAT DEMOGRAPHIC AND VISIT DISPLAY
WHO INFORMATION ON PATIENT
WT WEIGHT IN LBS/OZS
XIT QUICK OUT

* Use only if Laboratory Module is not operational.

** Use only when entering data from a specific form, and the CHS-PCC link is not activated.

5 THE MAIN DATA ENTRY MENU

ENT – Enter/Modify/Append PCC Data: This is the main menu for all data entry activities and contains all the options necessary to create or modify a PCC visit as well as appending information to an existing visit.

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                        Version 2.0
                        SELLS 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
LOG      Enter Data From LOG (lab/rad/cpt/apc) ...

```

Each of the **Enter PCC Data Menu Options** are described in detail on the following pages.

MIN - MINI PCC DATA ENTRY (APC EQUIVALENT): This option is used to **enter 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. Mini then **automatically enters the appropriate mnemonics for the required data items only: CL** (Clinic - Ambulatory visits only), **IP** (Inpatient - Hospitalizations only), **PRV** (Primary Provider), **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 entered using the appropriate data mnemonics. The following mnemonics can be used in MINI which allow the operator to make changes to or delete problem related data without exiting the MINI 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, Purpose of Visit except** when entering 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. Also, 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 entered using the appropriate data mnemonics. The MOD mnemonic can be used to change or delete any data item entered in error.

ENT - ENTER DATA: This option is also used to **enter 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 Purpose of Visit except** when entering 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.

MOD - MODIFY DATA: This menu option allows the operator to **modify, correct, or delete data** which has already been entered into PCC. It is used to make corrections to data which was entered in error, to modify data which might have been incomplete at the time of entry, or to 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 change the narrative for a problem already displayed on 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 and this visit will be included in a subsequent transmission. When **modifying data for a visit which 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 which have been entered into PCC.

APP - APPEND DATA TO AN EXISTING VISIT RECORD: This menu option allows information to be **ADDED to an already 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 missed entering 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 re-submitted to the Data Center, the Data Entry Supervisor must manually reset the transmission flag from the Supervisor's menu.

APL – APPEND DATA USING ITEM LIST DISPLAY This menu option allows information to be ADDED to an existing visit, but uses the List Manager to provide for screen data entry instead of the traditional “Roll & Scroll” format utilized by the MIN and ENT data entry options. A detailed example of this option is displayed later in this manual.

TIM – MODIFY VISIT DATE AND/OR TIME This option allows the operator to correct an incorrect visit date and/or time. TIM is most useful for correcting a batch of forms entered with the wrong visit date and/or time.

EAC – ENTER DATA WITH VISIT DISPLAY AND ACTIONS This menu option provides for data entry utilizing a full screen display and browser function which allows the user to view the visit and scroll forward and backward to see various parts of the visit. In addition, the user may select from a list of actions that will allow data entry without any knowledge of the data entry mnemonics.

MNE – ENTER PCC DATA USING ITEM LIST DISPLAY Like the EAC option, this menu option allows entry of data without using mnemonics. It does not contain the visit display function found in the EAC option.

GRP - GROUP PREVENTIVE FORM ENTRY: This menu option has been designed to use 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 Purpose of Visit for all patients listed on the form. Each time a patient name is entered, a new visit is created duplicating the initial visit setting as listed above. The operator may enter any varying information for a patient by using the appropriate mnemonic, e.g. immunizations, exam, etc. The option allows printing of the encounter visits entered.

HIN - ENTER HISTORICAL INPATIENT VISITS: This menu option is used to enter past data regarding patient hospitalizations that occurred at other facilities or occurred at this facility before PCC was implemented. This data is NOT transmitted.

DTC – TRAN CODE (DTC) ENTRY FOR ALL VISITS The DTC menu option allows for the association of 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.

TCH – ENTER TRANS CODES ON IN-HOSPITAL VISITS The TCH menu option allows Chargemaster Transaction Codes to be associated with an In-Hospital visit. A Chargemaster Transaction File must be loaded at your site to make use of this option.

TCO – ENTER TRANS CODES ON OUTPATIENT VISITS The TCO menu option allows Chargemaster Transaction Codes to be associated with an Outpatient visit. A Chargemaster Transaction File must be loaded at your facility to make use of this option.

LOG – ENTER DATA FROM LOG (lab/rad/cpt/apc) The LOG menu option allows entry of data from forms other than the traditional PCC encounter forms. Examples of this form of data entry include entry of items from a log 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.

6 PREPARATION AND FLOW OF FORMS

6.1 TYPE OF FORMS

Data is entered 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 43-1A (only if 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 entered 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 such as CHN's should be entered in PCC and 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 health care 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.

6.2 PREPARING FORMS FOR DATA ENTRY

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

- Readable
- Date of Encounter
- Location of Visit (clinic/hospital, office, home, etc.)
- Clinic Type (required on clinic visits only)
- Primary provider identification and signature
- A purpose of visit/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 encounter date by medical records and submitted one 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 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 Contract Health Services, IHS field health personnel such as Community Health Nurse, 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.

6.3 PHARMACY RECORDING & ENTRY GUIDELINES FOR PCC FORMS

- a) For a "Pharmacy only" visit, a PCC encounter should be initiated in the Medical Records Department or by 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 at the pharmacy seeking service. Whatever time has been entered on the encounter form is the time that must be entered 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.
- b) When prompted by the Pharmacy Module for Time, the pharmacy staff must enter the time that was recorded on the encounter form in the time of arrival field. This will cause the pharmacy and outpatient clinic data to be linked properly in the PCC during data entry.
- c) PCC forms should be initiated by medical records or pharmacy staff, as described above, for each visit to the pharmacy that is considered to be a separate event. The time entry in the Pharmacy Module must be the same as the Time Arrival recorded on the encounter form on 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 enters the time into the Pharmacy Module just as it was recorded on the encounter form initiated in the clinic for the first visit. When the patient returns for the OTC med, a second form is initiated and the Time of Arrival from that form is entered into the Pharmacy Module.
- d) When a patient is seen in a Dental Clinic that is running the RPMS Dental Module, a PCC Visit is automatically created for each visit entered by dental staff into the Dental Module. Each visit created in the PCC by the Dental Module is a complete entity containing Clinic code of 56, Provider, Purpose of Visit, 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. However, the exception to this process is when a dental visit results in the prescribing of a medication by the dentist. 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 entered into the pharmacy Module by pharmacy staff, the time on the encounter form is entered into the Pharmacy Module at the Time prompt. This will create a second visit in PCC, not linked to the original dental visit. The PCC data entry operator should merge these two visits together. Whether or not the visits get merged, the PCC export process will generate only one APC visit for transmission to the Data Center.

- e) When a patient has a dental clinic visit AND an outpatient clinic visit that results in a medication, TWO visits are generated in the PCC which 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 that is 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. As in "e" above, only one APC visit gets generated in this instance whether or not the dental and outpatient visits were merged together. 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 there is a medication dispensed.

7 THE MIN OPTION (DATA ENTRY USING MNEMONICS)

```

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

          Version 2.0
        SELLS 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
LOG      Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<MIN><RETURN>

```

1 Ambulatory encounter forms are to be entered into the PCC system using MIN upon receipt by the data entry staff. The example used throughout this chapter corresponds with 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 entered, these data items will **create a visit** indicated on the screen by a Visit File. MIN will then automatically prompt the operator to enter 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 entered, the MNEMONIC prompt appears so the operator can select the appropriate data mnemonic to enter the remaining recorded medical information on the form.

MIN will be used for entry of data from 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 will be .0860 and the provider's narrative as indicated on the form. Visit data is not entered into PCC when patients do not keep appointments (DNKA's), 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 entered 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 Purpose of Visit

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

- Secondary Provider(s)
- Measurements: Height, Weight, Blood Pressure, Head Circumference, and Vision
- Lab Tests Ordered (only if Laboratory Module is not operational)
- Secondary Purpose of Visits
- 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 entered 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 (Clinic code), PRV (Primary Provider) and PV (Purpose of Visit), are automatically entered by the MIN option and the operator cannot exit from the patient visit until this data is entered.

If the visit was created in ERROR, the operator must <RETURN> to enter nothing at the CLINIC, PROVIDER and POV prompts and use the XIT mnemonic at the MNEMONIC prompt to exit and delete the visit. **XIT CANNOT be used for deleting visits created by another module (Pharm, Lab, Dent).**

```

CLINIC TYPE
CLINIC: <XIT> <RETURN>
ANSWER WITH CLINIC STOP NAME, OR CODE
CLINIC: <RETURN>
PROVIDERS (PRIMARY/SECONDARY)
Enter PROVIDER (code/initials or name): <RETURN>
PURPOSE OF VISIT
Enter PURPOSE of VISIT: <RETURN>
MNEMONIC: <XIT> <RETURN> 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// <RETURN> YES..

VISIT/ADMIT DATE:

```

Note that an error is displayed if the XIT mnemonic is entered here. You **MUST** <RETURN> at the CL, PRV and PV mnemonics to reach the MNEMONIC prompt

XIT can only be entered at this point

You may create a new visit here

NOTE: Caution should always be exercised when using the XIT mnemonic. Once a delete is complete, the visit cannot be retrieved and all data would have to be re-entered.

2 Enter the abbreviation or name of the **location** where the visit took place for the batch of forms to be processed, e.g., Lane 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 name 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><RETURN> SAN XAVIER HEALTH
CENTER TUCSON SELLS TUCSON 11 TUCSON SELLS TUCSON 11

```

If entering field visits, location must be entered as HOME or OFFICE

3 Enter the **Type and Service Category** that describes the location for the **forms** being processed.

TYPE: <?> <RETURN>

I FOR IHS
C FOR CONTRACT
T FOR TRIBE – NON 638 / NON COMPACT
6 FOR 638 PROGRAM
P FOR TRIBE-COMPACT TRIBAL PROGRAM
V FOR VA
S FOR STATE
O FOR OTHER

TYPE: <I> <RETURN> (IHS)

SERVICE CATEGORY: <?> <RETURN>

A for AMBULATORY
H for HOSPITALIZATION
I for IN HOSPITAL
C for CHART REVIEW
T for TELECOMMUNICATIONS
N for NOT FOUND
S for DAY SURGERY
O for OBSERVATION
E for EVENT (HISTORICAL)
R for NURSING HOME

SERVICE CATEGORY: <A> <RETURN>

The various Service Categories are defined in detail in Appendix A of this manual. If a field visit indicates NOT FOUND, N would be entered here.

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

4 Time can be entered either in standard or military format. If no time is recorded, use the '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 entered in any one of following formats:

STANDARD: <6> or <6A> for 6AM OR <6P> or <6PM> for 6PM

MILITARY: <0600> for 6AM OR <1800> for 6PM

If a visit time is designated between 6:00PM - 11:59PM on the form, you must enter 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.

VISIT/ADMIT DATE: <?> <RETURN>

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.

You may omit the precise day, as : JAN, 1998

VISIT/ADMIT DATE: <0321> <RETURN> MAR 21, 1998)

TIME OF VISIT: <?> <RETURN>

Enter time of visit, or 'D' for default.

TIME OF VISIT: <1> <RETURN> (Mar 21,1998 @ 1300)

If the same date is to be used to enter subsequent forms, and the Location Name, Type, and Service Category are the same, the operator can enter the SPACE BAR & RETURN at the VISIT/ADMIT DATE prompt. Once a date is entered, a new form can be processed.

5 Enter the **patient's** name or Health Record Number (HRN) from the patient identification section of the Ambulatory Encounter Form. Entering **the HRN is faster** and therefore, the preferred response. 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 as displayed in Figure 4.2. Once the Visit File is created, the MIN option executes entry of the required data items as shown in steps 6a, 6b, 6c, 6d.

```

Select PATIENT NAME: <4462> <RETURN>

~~~~~
----- VISIT FILE -----
VISIT/ADMIT DATE&TIME: MAR 21 1998@13:00

DATE VISIT CREATED: MAR 21, 1998    TYPE: IHS

PATIENT NAME: MILLER, BETTY ANN

LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER

SERVICE CATEGORY: AMBULATORY    DATE LAST MODIFIED: MAR 21, 1998

~~~~~
Clinic Type    ALLOWED    VISIT RELATED ONLY

CLINIC:

```

1. Create New VISIT
2. Exit without selecting VISIT
3. Display one of the following existing VISITS:
Or select one of the following existing VISITS:
4. TIME 11:30 TYPE: I CATEGORY: A CLINIC: NONE
5. TIME 12:30 TYPE: I CATEGORY: A CLINIC: NONE

Figure 4.2 Data entry finds an existing visit(s)

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, data entry operator will see the visit(s) created by these modules as displayed in Figure 4.2 (items 4 and 5). These modules create a visit in PCC including 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 entered when the service is rendered, the data is passed to the PCC and visits are created immediately by these modules. **The data entry operator must display** (item 3 above) **the visit(s)** to determine if the data they are going to enter should:

- 1) Create an entirely new visit (item 1)
- 2) Exit completely without doing anything (item 2) or
- 3) Append to an already existing visit (select item 4 or 5),
- 4) Append **and** Merge visits if more than one exists as in the above example, if its been determined that these visits should be merged. This would involve selecting item 4 or 5 above, preferably the visit which has lab data AND returning to the main data entry menu to access the Merge menu option. Merging **TO** the **Lab** 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 entered regardless of who created the visit(s), Pharmacy, Lab and/or Dental. These modules, excluding Dental, create visits that do not contain all the required data items: Clinic Code, Primary Provider, and Purpose of Visit. If left unattended, errors will result in the Visit Review Report when generated by the Data Entry Supervisor.

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

6a After entering 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 entering visit times, although many times other modules default to the 12:00 time. Ultimately the data entry operator is responsible for verifying the time.

TIME OF VISIT

Enter new time: 12:00// <9:30> <RETURN>

Now changing time... (November 15, 1990@09:30)

6b **Clinic** will be 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 may 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)
```

6C **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 Secondary and the operator no longer sees P)primary or S)secondary ? Note that provider times may be entered if appropriate.

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

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: <SMITH><RETURN> ??
Enter PROVIDER (code/initials or name):
```

Figure 4.3 Provider not found in Provider File Modify Visit Date and/or Time

If you have verified that the name, SMITH, was entered correctly and the above error appears, notify your Site/PCC Manager. SMITH will have to be added to the Provider File or activated.

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

6d The **Purpose of Visit** is located in the middle of the Ambulatory Encounter form. The provider is **required to record at least one Purpose of Visit** for the current visit. The Purpose of Visit 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 Purpose of Visit Section)

If these items are recorded, the operator must enter this information during the entry of the visit information.

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 entering 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 in Figure 4.4:

- 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 4.4. 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 entered at the **Enter PURPOSE of VISIT:** prompt. **Operators should NEVER SPEND more than a couple of minutes per PURPOSE OF VISIT when determining an ICD-9 code.** The PCC Manager or Data Entry Supervisor is responsible for assigning the proper code to visits entered 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 use the = symbol at the Provider Narrative prompt if it is EXACTLY the same as that entered in the Enter Purpose of Visit prompt. The Provider Narrative displays on the Adult Regular Health Summary.

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 next. 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 form in the INJURY 1st VISIT section in the lower left portion of the encounter form to see if the provider has recorded this information. A <RETURN> is entered 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 of the PV mnemonic. This is entered 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 entered if indicated by the provider in the Injury 1st Visit portion of the form.

If applicable, another PV may be entered at the Enter "Purpose of Visit" prompt.

```

PURPOSE OF VISIT
Enter PURPOSE of VISIT: <ELEVATED BLOOD PRESSURE> <RETURN>
401.9 (HYPERTENSION NOS)
UNSPECIFIED ESSENTIAL HYPERTENSION
OK? Y// <RETURN>
PROVIDER NARRATIVE: <=> <RETURN> ELEVATED BLOOD PRESSURE
MODIFIER: <?> <RETURN>
  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: <RETURN>

```

If text for provider narrative matches exactly what was entered at Purpose of Visit prompt, = sign may be used here
←

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

```

CAUSE OF DX: <?> <RETURN>
CHOOSE FROM:
  1    HOSPITAL ACQUIRED
  2    ALCOHOL RELATED
  3    BATTERED CHILD
4  4    EMPLOYMENT RELATED
5  5    DOMESTIC VIOLENCE RELATED

CAUSE OF DX<RETURN>
Enter PURPOSE of VISIT: <OTITIS MEDIA> <RETURN>
382.9 (OTITIS MEDIA NOS)
UNSPECIFIED OTITIS MEDIA
OK? Y// <RETURN>
PROVIDER NARRATIVE: <RESOLVED OTITIS MEDIA> <RETURN>
MODIFIER: <RETURN>
CAUSE OF DX: <RETURN>
Enter PURPOSE of VISIT: <RETURN>
MNEMONIC:

```

Enter only when indicated on the Injury 1st visit section.

This begins another purpose of visit

CANNOT use = symbol in this case.

Another purpose of visit can be entered here.

7 Continue with entering another Purpose of Visit or <RETURN> to the MNEMONIC prompt to complete entering data recorded on the form. The list of data mnemonics can always be requested as shown in the following screen. This is recommended when initially starting data entry to aid the operator in becoming familiar with them. A complete list of mnemonics is not shown due to its length; however, one is provided in Chapter Two of this manual.

After each data item is entered, 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 enter the data in the order shown, it is strongly recommended that a similar pattern be established to insure that information is not left out by oversight.

```
MNEMONIC: <??> <RETURN>
ANSWER WITH RPMS PCC DATA ENTRY CONTROL MNEMONIC OR DESCRIPTION
DO YOU WANT THE ENTIRE RPMS PCC DATA ENTRY CONTROL LIST?
<Y><RETURN>
      AG      ABDOMINAL GIRTH
      APO      ACTIVATE AN INACTIVE PROBLEM
      AT      ACTIVITY AND TRAVEL TIME
```

If an entry is entered 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 can use the MOD mnemonic as many times as necessary to correct or delete data. The PV entry above will be used to demonstrate the MOD mnemonic. Notice the Modifier was not entered and by-passed completely. MOD will be entered first at the MNEMONIC prompt followed by PV.

```

MNEMONIC: <MOD> <RETURN>
Switching to Modify Mode for ONE Mnemonic ONLY!
MNEMONIC: <PV> <RETURN> PURPOSE OF VISIT
1 382.9 MILLER, BETTY ANN MAR 21, 1998@13:00
POV: 382.9// <RETURN>
    OK? Y// <RETURN>
    PROVIDER NARRATIVE: RESOLVED OTITIS MEDIA// <RETURN>
    MODIFIER: <?><RETURN>
        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: <R> <RETURN> RESOLVED
        CAUSE OF DX: <RETURN>
Switching back to ENTER Mode!
MNEMONIC:

```

Any part of the PV mnemonic can be changed after each //. An <@><RETURN> would be used after the first // to delete the entire PV, e.g. 382.9//<@><RETURN>

MOD automatically returns to the MNEMONIC prompt and the enter mode so the operator can continue with entering data. Other changes can be made at any time by entering MOD at the MNEMONIC prompt followed by the appropriate mnemonic requiring the change.

Figure 4.5 Correcting an error using the MOD mnemonic

8a Adding Problem(s) recorded in the Purpose of Visit section on the Encounter Form are entered by using either the PL/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 will be entered only as a problem because the provider skipped a line after the Purpose of Visit before entering the problem narrative and designated "A" (Active) in the Problem List column.

A problem will also be entered as a Purpose of Visit when the problem is the only narrative recorded on the form or when the narrative is recorded on the next line immediately following the last Purpose of Visit. **A blank line or a defined drawn line is the standard convention used by providers for separating a problem from a Purpose of Visit.** An "A" (Active) or "AI" (Inactive) must be indicated by the provider before a problem is entered by the operator. Both appear on the Adult Regular Health Summary.

Problems can be updated 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 entering data.

8b The PL mnemonic allows for updating a patient's problem list without using mnemonics for the data entry and an efficient way of updating a problem list. It essentially performs all the functions problem-related mnemonics (PO, APO, IPO, MPO, NO, MNN, RNO) currently perform.

Once the PL mnemonic is entered, the user is prompted for the location of the Problem List Update, and the date of the update. After entering that information, the user is presented with the List Manager display of items which may be selected in order 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.

Patient Care Component (PCC)

* Update PCC Patient Problem List *

Select PATIENT NAME:<100110><RETURN>

ADAMS,MOLLY F 01-06-1928 003280032 HID 100109

 SE 100110

Location where Problem List update occurred: SELLS HOSPITAL// <RETURN>

TUCSON SELLS

Date Problem List Updated: T<RETURN>

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 Jan 26, 1999 15:45:07 Page: 1 of 1

Patient Name: **ADAMS,MOLLY** DOB: JAN 06, 1928 Sex: F HRN: 100110

1) Problem ID: SE2 DX: 250.00 Status: ACTIVE Onset:
 Provider Narrative: DIABETES MELLITUS

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><RETURN>

Enter PROBLEM DIAGNOSIS: <ARTHRITIS><RETURN>

716.90 (ARTHROSCOPY NOS-UNSPEC)

UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIED

PROVIDER NARRATIVE: <?><RETURN>

Answer with PROVIDER NARRATIVE

PROVIDER NARRATIVE: = ARTHRITIS

DATE OF ONSET: <02/97><RETURN> (FEB 1997)

NBR: 3// <RETURN>

CLASS: <?><RETURN>

CHOOSE FROM:

 P PERSONAL HISTORY

 F FAMILY HISTORY

CLASS: <RETURN>

STATUS: A// <RETURN>

Add a new Problem Note for this Problem? N// <RETURN>

Patient
problems
display

Problem List Update		Jan 26, 1999 16:17:36		Page: 1 of 1	

Patient Name: ADAMS,MOLLY		DOB: JAN 06, 1928		Sex: F HRN: 100110	

1) Problem ID: SE2		DX: 250.00 Status: ACTIVE		Onset: 04/00/88	
Provider Narrative: TYPE 2 DIABETES					
2) Problem ID....SE3		DX: 716.90 Status: ACTIVE		Onset: 02/00/97	
Provider Narrative: ARTHRITIS					
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

Provider narrative may be 2-80 characters in length.

Enter onset date if provide.

8C Once the PO mnemonic is entered, all patient's Problems (Active & 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".

PERSON or FAMILY must be indicated by the provider, e.g., family history of diabetes, or <RETURN> to enter nothing. 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 on the Adult Regular Health Summary. If the provider is linking a new Note to a new Problem, a temporary variable (X, Y, Z) will be used to identify the link next to the Problem number and the Note narrative. If there is no Note to link, <RETURN>.

MNEMONIC: <PO> <RETURN> PROBLEM ONLY
 *****ACTIVE PROBLEMS AND NOTES*****
 SE2 09/06/89 DIABETES MELLITUS
 *****INACTIVE PROBLEMS AND NOTES*****
 SE1 08/03/88 MENINGITIS

Enter PROBLEM DIAGNOSIS: <ARTHRITIS> <RETURN>

716.90 (ARTHROPATHY NOS-UNSPEC)

UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIED

OK? Y// <RETURN>

PROVIDER NARRATIVE: <?> <RETURN>

Answer with PROVIDER NARRATIVE

PROVIDER NARRATIVE: = ARTHRITIS

DATE OF ONSET: 01/92 <RETURN> (JAN 1992)

MBR: 1// <RETURN>

CLASS: <?> <RETURN>

CHOOSE FROM:

P PERSONAL HISTORY

F FAMILY HISTORY

CLASS: <RETURN>

STATUS A// <?> <RETURN>

CHOOSE FROM:

A ACTIVE

I INACTIVE

STATUS: A// <RETURN>

Add a new Problem Note for this Problem? N// <YES><RETURN>

Adding SAN XAVIER HEALTH CENTER Note #1

NOTE NARRATIVE: <?><RETURN>

Answer must be 3-80 characters in length.

NOTE NARRATIVE: <FOLLOW-UP MONTHLY><RETURN>

Problem Notes:

SELLS HOSPITAL

Note #1 FOLLOW-UP MONTHLY

Add a new Problem Note for this Problem? N//<RETURN>

MNEMONIC:

Patient problems display
when Site File parameter
is set.

Provider narrative may be
2-80 characters in length.

Enter onset date if provided.

8d 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> <RETURN> MODIFY PROBLEM
*****ACTIVE PROBLEMS AND NOTES*****
SE2 09/06/89  DIABETES MELLITUS
*****INACTIVE PROBLEMS AND NOTES*****
SE1 08/03/88  MENINGITIS

```

```

Enter PROBLEM NUMBER: <SE1> <RETURN>
DIAGNOSIS: 322.9// MENINGOCOCCAL MENINGITIS<RETURN> MENINGITIS
MENINGOCOCCAL
.
036.0 (MENINGOCOCCAL MENINGITIS)
MENINGOCOCCAL MENINGITIS OK? Y// <RETURN>
PROVIDER NARRATIVE: MENINGITIS// <MENINGOCOCCAL
MENINGITIS><RETURN>
CLASS: <RETURN>
STATUS ACTIVE <RETURN>
Select NOTE FACILITY: <RETURN>
MNEMONIC:

```

8e The PPV mnemonic is used to enter a Purpose of Visit (POV) AND Problem (PO). The provider MUST enter an "A" or "AI" in the A/AI/C column with the Purpose of Visit 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 Purpose of Visit and Problem are displayed for entry.

MNEMONIC: <PPV> <RETURN> 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> <RETURN>

250.00 (DIABETES UNCOMPL ADULT/NIDDM))

ADULT-ONSET TYPE DIABETES MELLITUS WITHOUT MENTION OF
COMPLICATION/NONINSULIN DEPENDENT

OK? Y// <RETURN>

PROVIDER NARRATIVE: <=> <RETURN> DM

MODIFIER: <RETURN>

CAUSE OF DX: <RETURN>

Now creating PROBLEM on PROBLEM LIST. . .

NMBR: 2// <RETURN>

CLASS: <RETURN>

STATUS A// <?> <RETURN>

CHOOSE FROM:

A ACTIVE

I INACTIVE

DATE OF ONSET: T <RETURN> (JAN 27, 1999)

STATUS: A// <RETURN> ACTIVE

Add a new Problem Note for this Problem? N// <Y><RETURN>YES

Adding SELLS HOSPITAL Note #1

NOTE NARRATIVE: <FOLLOW-UP MONTHLY>< RETURN>

Problem Notes:

SELLS HOSPITAL

Note #1 1/26/99 FOLLOW-UP MONTHLY

Add a new Problem Note for this Problem? N//<RETURN>

Problems display
only of the Site File
parameter is set.

The Problem begins
here. The ICD-9 code
and Provider Narrative
entered above have been
duplicated and by-
passed for the Problem.

**Figure 4.6 Sample
PPV**

9 Notes are added to existing problems by 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 would be entered. 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.

Notes are DELETED by 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> <RETURN> NOTE

*****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><RETURN>

Problem Number: SE18 Diagnosis: 250.00

Problem Notes:

SELLS HOSPITAL

Note #1 1/26/99 FOLLOW-UP MONTHLY

Add a new Problem Note for this Problem? N// <Y><RETURN>YES

Adding SELLS HOSPITAL Note #2

NOTE NARRATIVE:<?><RETURN>?

Answer must be 3-80 characters in length.

NOTE NARRATIVE: <METFORMIN 500MG BID><RETURN>

Problem Number: SE18 Diagnosis: 250.00

Problem Notes:

SELLS HOSPITAL

Note #1 1/26/99 FOLLOW-UP MONTHLY

Note #2 1/26/99 METFORMIN 500MG BID

Add a new Problem Note for this Problem? N//<RETURN>

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

10 Reproductive factors is the last section that may have data to be entered in the Purpose of Visit area. The FP (Family Planning) mnemonic is used to enter this data to capture female reproductive factors and family planning data. The reproductive factors include Last Menstrual Period (LMP), Family Planning (FP) Method, and Date Begun for that method. The reproductive history includes: Gravidity (G), Parity (P), Living Children (LC), Spontaneous Abortions (SA), and Therapeutic Abortions (TA). Caution should be exercised when entering the reproductive factors as **an incomplete entry will overlay a previously complete one**. EDC (Estimated date of Confinement) is the last data item entered as part of this mnemonic. The provider may enter this data as part of the POV and designate "EDC".

Four (4) separate mnemonics can also be used to enter this data: RF (reproductive factors), LMP (last menstrual period), FM (family planning/contraception method-date begun), EDC (estimated date of confinement).

MNEMONIC: <FP> <RETURN> FAMILY PLANNING
 NAME: MILLER, BETTY ANN//
 REPRODUCTIVE HISTORY: <?> <RETURN>
 Enter gravidity,parity,live children,SAB,TAB: e.g., G5P3LC1SA1TA1
 REPRODUCTIVE HISTORY: <G3P2LC2SA0TA1> <RETURN>
 LAST MENSTRUAL PERIOD: <6-20-90> <RETURN> (June 20, 1990)
 CONTRACEPTION METHOD: <?> <RETURN>

Enter type of contraception currently employed
 CHOOSE FROM:

- 0 EDUCATION ONLY- NONE
 - 1 ORAL CONTRACEPTIVES
 - 2 INTRAUTERINE DEVICE
 - 3 SURGICAL STERILIZATION
 - 4 BARRIER METHODS
 - 5 PARTNER STERILIZED
 - 6 NATURAL TECHNIQUES
 - 7 MENOPAUSE
 - 8 NONE
 - 9 OTHER
 - 10 HORMONAL IMPLANT
 - 11 HORMONAL INJECTION
- CONTRACEPTION METHOD: <6> <RETURN>NATURAL TECHNIQUES

<RETURN> 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.

```

CONTRACEPTION BEGUN: <?> <RETURN>
CONTRACEPTION BEGUN: <T-365> <RETURN> (MAR 21, 1997)
EDC: <T+7> <RETURN> (MAR 28, 1998)
HOW EDC OBTAINED <?> <RETURN>
  CHOOSE FROM:
    0    UNKNOWN METHOD
    1    SONOGRAM
    2    DAT ES
    3    CLINICAL PARAMETERS
HOW EDC OBTAINED: <2><RETURN> DATES
MNEMONIC:

```

11a After entry of the Purpose of Visit area of the Encounter form has been completed, return to the top of the form labeled "Problem List Update". This section is used 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 here 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 also 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 entering data. The first example is RPO to remove the problem SE3 as designated by the provider. The operator should always verify the problem before <RETURN>. If the Problem was deleted in error, it would have to be re-entered entirely.

```

      MNEMONIC: <RPO> <RETURN> 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> <RETURN> SELLS HOSPITAL/CLINIC

```

```

Enter Problem Number: SE3
Are you sure that you want to remove Problem Number SE3? (Y/N) <Y><RET>
Removing Problem SE3...
MNEMONIC:

```

Both Problem
and Note(s) are
deleted.

11b 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> <RETURN> 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> <RETURN> SELLS HOSPITAL/CLINIC
TUCSON SELLS TUCSON 01  TUCSON SELLS TUCSON 01
Inactivating Problems SE2. . .
MNEMONIC:

```

11c 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: <APO> <RETURN> 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:
```

12 **Measurements** are located along the upper right-hand side of the form and is normally the next data which will be entered. To help insure that accurate information is entered, some measurements, such as blood pressure, must fall within certain ranges or the system will not accept the data. Entering a <?> <RETURN> 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 entering the data.

Not all the measurements may be recorded on a visit; therefore, some or all of these fields on the form may be blank. **Enter only the mnemonics that have information recorded.** The measurement mnemonics are: BP (blood pressure), HT (height in inches), CHT (centimeter height), HC (head circumference in inches), CHC (centimeter head circumference), WT (weight in pounds and ounces), GWT (gram weight), KWT (kilogram weight).

If the operator enters a measurement mnemonic in error, the "^" CANNOT be used to exit. Once the VALUE prompt is reached an entry is required and the operator must enter a dummy value. The dummy value would then be deleted by using the MOD mnemonic and the @ symbol. Refer to the MOD mnemonic at the beginning of this chapter for assistance with deleting a data item.

The operator may proceed down the right-hand side of the form. Enter the mnemonic for the field for which data is to be entered. Two measurements have been entered in this example:

MNEMONIC: <BP> <RETURN> BLOOD PRESSURE

VALUE: <?> <RETURN>

Enter as SYSTOLIC/DIASTOLIC (120/80). SYSTOLIC must be between 20 and 275.

DIASTOLIC must be between 20 and 200.

VALUE: <160/90> <RETURN>

MNEMONIC: <WT> <RETURN> WEIGHT

VALUE: <?> <RETURN>

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> <RETURN>

MNEMONIC: <RETURN>

13a Orders indicate that a test(s), examination(s), or immunization(s) was ordered. **Only those items which have been initialed as being completed should be entered.** These items support the Health Maintenance Reminders section on the Health Summary.

Laboratory tests ordered are only entered when the Laboratory Module is NOT operational at your facility. Enter the test by lab 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 enter lab results if a facility chooses to do so.

MNEMONIC: <49> <RETURN> (UA) URINALYSIS ORDERED - NO RESULTS

MNEMONIC: <BS> <RETURN> BLOOD SUGAR ORDERED - NO RESULTS

CURRENT LAB TESTS AND RESULTS FOR THIS VISIT

Visit Date MAR 21,1998@13:00 Patient Name: Miller, Betty Ann

UA

MNEMONIC:

13b The three types of **Examinations** listed in the Orders section of the form are PELVIC, BREAST, and RECTAL. There are many other examinations which can be entered and a complete list of all the exams can be found in Appendix C. Enter the examinations performed by using the EX mnemonic. Enter the exam by exam code or name at the prompt.

MNEMONIC: <EX> <RETURN>
 Select V EXAM: <?> <RETURN>
 ANSWER WITH V EXAM
 DO YOU WANT THE ENTIRE V EXAM LIST? <N> <RETURN> 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> <RETURN> YES
 CHOOSE FROM:
 ABDOMEN EXAM 09
 AUDIOMETRIC SCREENING 23
 BREAST EXAM 06
 SELECT V EXAM: <15> <RETURN> PELVIC EXAM 15
 RESULT:<N><RETURN> NORMAL
 MNEMONIC: <EX> <RETURN>
 SELECT V EXAM: <BREAST> <RETURN> 06 BREAST EXAM 06
 RESULT:<RETURN>
 MNEMONIC:

Never answer yes to the **Entire V ... list** question.

Enter exam result **only** if indicated on the encounter form.

13c Immunizations are located at the bottom of the Orders section. Enter the immunization(s) administered by using the IM mnemonic. Enter Immunization type by entering 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 entered for DPT and OPV or <RETURN> to enter nothing. Lot number is entered if available. Entries will vary since the file is customized locally at each facility.

MNEMONIC: <IM> <RETURN>

Enter IMMUNIZATION given: <?> <RETURN>

ANSWER WITH V IMMUNIZATION LIST? <N> <RETURN> (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> <RET>(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><RETURN>

TETANUS DIPHTHERIA (TD-ADULT) 02

SERIES: <?><RETURN>

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: <RETURN>

LOT: <?> <RETURN>

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> <RETURN>

MNEMONIC: < RETURN>

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

13d Skin Tests are located in the last block of the Orders section and therefore, will be entered last. Skin tests specific to a particular area may 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 entered** 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. A complete list of all skin test types can be found in Appendix E.

```

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

```

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

14 When a form is complete, the operator will <RETURN> at the MNEMONIC prompt and the VISIT/ADMIT DATE prompt appears. The system is now ready to process another form. The <SPACE BAR> <RETURN> can be used at this prompt for processing forms in batches by date. However, the Time of Visit must be entered for each form.

MNEMONIC: <RETURN>

VISIT/ADMIT DATE: <SPACE BAR> <RETURN> Mar 21, 1998

TIME OF VISIT: <3> <RETURN> (Mar 21, 1998 @15:00)

Select PATIENT NAME: <1852> <RETURN>

This begins a new form.

When the VISIT/ADMIT DATE prompt is reached and an error is discovered on 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: <RETURN>

VISIT/ADMIT DATE: <SPACE BAR> <RETURN> (Mar 21, 1998)

TIME OF VISIT: <1> <RETURN> (Mar 21, 1998@13:00)

Select PATIENT NAME: <SPACE BAR> <RETURN>

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:

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.

Figure 4.7 "Visit/Admit Date" menu switching

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

8 THE ENT OPTION (ENTER DATA)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                        Version 2.0
                      SELLS 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
LOG      Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Patient Care Data Entry Menu Option:<ENT> <RETURN>

```

1 Ambulatory (IHS-803), Inpatient Services (IHS-44-1), contract health or any other type of encounter form may be used to enter data into the PCC system using the ENTER menu option. This excludes group forms which are entered under the GRP menu option described in a separate chapter of this manual. The PCC data entry operator will be 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. Once entered, 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 of the IP mnemonic has been entered, the MNEMONIC prompt appears so the operator can select the appropriate data mnemonic to enter 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 entered, e.g. HCT, BS, BP, WT, PO, etc. Data is entered 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
- Lab 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, Admitting DX. After the DX is entered, the system returns to the MNEMONIC prompt so the operator can enter 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 entered. These are REQUIRED data items.

If the visit was created in ERROR, the operator will <RETURN> to the MNEMONIC prompt and enter 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: SMITH,DALE   LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC
SERVICE CATEGORY: HOSPITALIZATION   DATE LAST MODIFIED: JAN 3, 1998
~~~~~
INPATIENT

Enter Date of Discharge: <XIT> <RETURN> ??

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: <RETURN>

MNEMONIC: <XIT> <RETURN> 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// <RETURN> YES..

VISIT/ADMIT DATE:

```

Notice that an error is displayed if the XIT mnemonic is entered here.

XIT can only be entered at this point.

You may create a new visit here.

Figure 5.1 Quick Out

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 re-entered. Also, 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.

2 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 enter PCC data, e.g. Contract Health form, etc. 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.

Enter 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 name 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//<RETURN>
TUCSON SELLS TUCSON  01    TUCSON  SELLS TUCSON  01

```

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

3 Enter the Type and Service Category that describes the location for the **forms** being processed. The various Service Categories are defined in detail in Appendix A of this manual.

```

TYPE: <?> <RETURN>
I FOR IHS
C FOR CONTRACT
T FOR TRIBAL - NON 638 NON COMPACT
O FOR OTHER
6 FOR 638 PROGRAM
P FOR TRIBAL - COMPACTED PROGRAM
S FOR STATE
V FOR VA

```

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

TYPE: <I> <RETURN> (IHS)
 SERVICE CATEGORY: <?> <RETURN>
 A for AMBULATORY
 H for HOSPITALIZATION
 I for IN HOSPITAL
 C for CHART REVIEW
 T for TELECOMMUNICATIONS
 N for NOT FOUND
 S for DAY SURGERY
 O for OBSERVATION
 E for EVENT (HISTORICAL)
 R for NURSING HOME

SERVICE CATEGORY: <H> <RETURN>

<H> is entered 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 Time can be entered either in standard or military format. If no time is recorded, use the '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 entered in any one of following formats:

STANDARD: <6> or <6A> for 6AM OR <6P> or <6PM> for 6PM
 MILITARY: <0600> for 6AM OR <1800> for 6PM

If a visit time is designated between as 6:00PM - 11:59PM on the form, you must enter 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.

VISIT/ADMIT DATE: <?> <RETURN>
 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.
 You may omit the precise day, as : JAN, 1998
 VISIT/ADMIT DATE: <0321> <RETURN> MAR 21, 1998)
 TIME OF VISIT: <?> <RETURN>
 Enter time of visit, or 'D' for default.
 TIME OF VISIT: <1> <RETURN> (Mar 21, 1998@13:00)

5 Enter the patient's Health Record Number (HRN) from Block 1, IHS Unit Number. 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. Since the Enter and Mini options function the same, refer to Chapter 4, step 5 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> <RETURN>

~~~~~  
~

----- VISIT FILE -----

VISIT/ADMIT DATE&TIME: APR 16 1998@22:30

DATE VISIT CREATED: MAY 1, 1998      TYPE: IHS

PATIENT NAME: SMITH, JOHN D.

LOC. OF ENCOUNTER: SELLS HOSPITAL/CLINIC

SERVICE CATEGORY: HOSPITALIZATION      DATE LAST MODIFIED: MAY 1, 1998

~~~~~

INPATIENT

Enter Date of Discharge:

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

```

Enter Date of Discharge: <4-23> <RETURN> (APR 23, 1990)

ADMISSION TYPE: <?> <RETURN>
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> <RETURN> DIRECT
ADMITTING SERVICE: <?> <RETURN>
ANSWER WITH TREATING SPECIALTY NAME, OR CODE
CHOOSE FROM:
    ALCOHOLISM      15
    DENTAL           01
    FAMILY PRACTICE  17
    GENERAL MEDICINE 03
  
```

This is taken from block 20 – Disposition Date

Block 16 – Admission Code is entered here.

Block 17 and Block 18 – Clinical Service Admitted To and Clinical Service Code is entered here. A complete list is provided in Appendix F of this manual.

```

ADMITTING SERVICE: <03> <RETURN> GENERAL MEDICINE 03
DISCHARGE SERVICE: <03> <RETURN> GENERAL MEDICINE 03
DISCHARGE TYPE: <?> <RETURN>
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> <RETURN> REGULAR DISCHARGE 1
  
```

Block 37 and 38 contain the Discharge Clinical Service and Code to be entered 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 entered, 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> <RETURN> DEATH W/I 48 HRS W/O AUTOPSY    6
UNDERLYING CAUSE OF DEATH: <427.5> <RETURN> CARDIAC ARREST
```

Figure 5.2 Discharge Type - Death

When a Discharge Type of Transferred (choices 2, 8, 9 above) is entered, the following prompt appears for entry. The operator MUST refer to Block 35, Name of Facility Transferred To, and enter 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> <RETURN>
1      TRANSFERRED      2
2      TRANSFERRED IHS HOSPITAL      2
3      TRANSFERRED NON-IHS HOSPITAL      2
DISCHARGE TYPE: <3> <RETURN> TRANSFERRED NON-IHS HOSPITAL
TRANSFERRED TO: <?> <RETURN>
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.??>
TRANSEERRED TO: <ST MARY'S HOSPITAL> <RETURN>
```

The "Transferred To" entry MUST exist in the IHS Location or CHS Vendor File before an entry is allowed. <RETURN> to enter nothing.

Figure 5.3 Discharge Type - Transferred

NUMBER OF CONSULTS: <?> <RETURN>
 TYPE A WHOLE NUMBER BETWEEN 0 AND 99

NUMBER OF CONSULTS: <RETURN>

ADMITTING DX: <?> <RETURN>
 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><RETURN>
 310.9 (NONPSYCHOTIC BRAIN SYN NOS)
 UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING
 ORGANIC BRAIN DAMAGE
 OK? Y// <RETURN>

MNEMONIC:

This is entered only if a number is provided in Block 39 or <RETURN> to enter nothing.

This is entered from Block 25, Admitting Diagnosis / Admitting Doctor

This completes the IP mnemonic portion of the hospitalization visit.

7 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: <RETURN>

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 5.4
Incomplete Hospital Visit

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

```

MNEMONIC: <PV> <RETURN>      PURPOSE OF VISIT
Enter PURPOSE of VISIT: <ORGANIC BRAIN SYNDROME><RETURN>
310.9    NONPSYCHOT BRAIN          SYN NOS...OK? YES// (YES)
PRIMARY/SECONDARY: <P> <RETURN> PRIMARY
PROVIDER NARRATIVE:<ORGANIC BRAIN SYNDROME,UNK ETIOL><RETURN>
MODIFIER: <?> <RETURN>
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: <RETURN>
CAUSE OF DX: <?> <RETURN>
CHOOSE FROM:
1    HOSPITAL ACQUIRED
2    ALCOHOL RELATED
3    BATTERED CHILD
4    EMPLOYMENT RELATED
5    DOMESTIC VIOLENCE RELATED
CAUSE OF DX: <RETURN>
Enter PURPOSE of VISIT: <BRAIN DEGENERATION> <RETURN>
( BRAIN DEGENERATION/DEGENERATIONS )
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> <RETURN>
PROVIDER NARRATIVE: <MILD CEREBELLAR ATROPHY BY CT SCAN><RET>
MODIFIER: <RETURN>

```

Always enter EXACTLY as indicated on the form.

Enter modifier only if the provider used one of these terms in the provider narrative entered above.

This begins the second PV taken from Block 28, line 2

CAUSE OF DX: <RETURN>

Enter PURPOSE of VISIT: <UTI><RETURN>

599.0 (URIN TRACT INFECTION NOS)

URINARY TRACT INFECTION, SITE NOT SPECIFIED

OK? Y//

PROVIDER NARRATIVE: <URINARY TRACT INFECTION, E.COLI><RETURN>

MODIFIER: <RETURN>

CAUSE OF DX: <RETURN>

Enter PURPOSE of VISIT: <E COLI><RETURN>

(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><RETURN>

PROVIDER NARRATIVE: < = > <RETURN> E COLI

MODIFIER: <RETURN>

CAUSE OF DX: <RETURN>

Enter PURPOSE of VISIT: <ELEVATED LIVER> <RETURN>

(ELEVATED LIVER)

794.8 (ABN LIVER FUNCTION STUDY)

NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF LIVER

OK? Y// <RETURN>

PROVIDER NARRATIVE: <ELEVATED LIVER FUNCTION TEST><RETURN>

MODIFIER: <RETURN>

CAUSE OF DX: <RETURN>

Enter PURPOSE of VISIT: <RETURN>

This begins the third PV, taken from Block 28, line 3.

This entry is made for ICD coding purposes only, also taken from line 3.

An <=> can only be used if the provider narrative matches exactly what the operator entered at the Purpose of Visit prompt. **It is never appropriate to use <=> if an ICD-9 code was entered at the Purpose of Visit prompt.**

This completes entry of all PV's for this hospital visit.

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

```

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

PRINCIPLE PROCEDURE: <Y> <RETURN>  YES
INFECTION: <?> <RETURN>
CHOOSE FROM:
      Y      YES
      N      NO
INFECTION: <RETURN>

OPERATING PROVIDER:< SHORT,GEO><RETURN>  PHYSICIAN IHS
Enter OPERATION/PROCEDURE: <RETURN>

```

An <=> may be used when the provider narrative matches EXACTLY with what the operator entered at the Operation / Procedure prompt above.

Date will be entered from Block 33

<Y> only applies when located on line one of Block 31

Enter only when provided on the appropriate box of Block 32

Enter only when specified in Block 33a – Operating Physician

9 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><RETURN> PROVIDERS (PRIMARY/SECONDARY)
 Enter PROVIDER (code/initials or name):<CTJ><RETURN>JACKSON,CATHY
 P)primary or S)econdary: <P><RETURN> PRIMARY
 O)perating or A)ttending: <A><RETURN> ATTENDING
 Date Provider Seen: Jan 10, 1999// (JAN 10, 1999)
 Time Provider Seen:
 Enter a SECONDARY PROVIDER (code/initials or name): <RETURN>
 MNEMONIC:

Entered from
Block 50a

This entry will
always be
A)ttending.

Check the
Supplemental
form IHS-485

10a Although entry of the Inpatient Services form, IHS 44-1 is complete, an Inpatient Supplement and Discharge Follow-up Record may 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.), Lab 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.**

Entering problem list additions or changes should be entered first. This data is entered using the sections at the top of the form labeled: Problem list and Problem List Additions or Changes. Refer to Chapter 4, step 8a and 8b of this manual for details on problems. 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> <RETURN> 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> <RETURN>
428.0 (CONGESTIVE HEART FAILURE)
CONGESTIVE HEART FAILURE    OK? Y//
PROVIDER NARRATIVE:<=> <RETURN>CONGESTIVE HEART FAILURE
DATE OF ONSET:<12/23/98><RETURN>

NMBR: 1// <RETURN>
CLASS: <?> <RETURN>
      CHOOSE FROM:
      P    PERSONAL HISTORY
      F    FAMILY HISTORY

CLASS: <RETURN>

STATUS: A// <?> <RETURN>
      CHOOSE FROM:
      A    ACTIVE
      I    INACTIVE
STATUS: A// <RETURN> ACTIVE
Add a new Problem Note for this Problem? N//<RETURN>

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

```

Problems display
of designated in
Site File of
Supervisor's menu.

PERSON or
FAMILY must be
indicated by the
provider, e.g., family
history of diabetes or
<RETURN> to enter
nothing.

A or AI MUST be
indicated by the
provider. Both
appear on the Adult
Regular Health
Summary.

For details regarding Notes, refer to the Chapter 4, step 8a, 9 and 11a. Problems and Notes are entered in the same manner regardless of Visit Type and/or Service Category.

10b

To delete problems (RPO) from the Health Summary, the provider **MUST** enter 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 to be changed from Active to Inactive (IPO), the entire problem number must be entered in the second block of the PCC Update section. When a problem status is to be changed from Inactive to Active (APO), the entire problem number must be entered in the third block of the PCC Update section. The IPO and APO mnemonics function in the same manner as the RPO mnemonic. Refer to Chapter 4, steps 11a, 11b and 11c for details.

MNEMONIC: <RPO> <RETURN> 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> <RETURN>

Are you sure that you want to remove Problem Number SE1?(Y/N) <Y><RETURN>

Removing Problem SX17 ...

MNEMONIC: <RPO> <RETURN>

***** 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> <RETURN>

Are you sure that you want to remove Problem Number SE1? (Y/N)<Y><RETURN>

Removing Problem SX19 ...

MNEMONIC:

Enter 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.

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

MNEMONIC: <BP> <RETURN> BLOOD PRESSURE

VALUE: <?> <RETURN>

Enter as SYSTOLIC/DIASTOLIC (120/80). SYSTOLIC must be between 20 and 275.

DIASTOLIC must be between 20 and 200.

VALUE: <115/70> <RETURN>

MNEMONIC: <WT> <RETURN> WEIGHT

VALUE: <?> <RETURN>

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> <RETURN>

MNEMONIC: <HT> <RETURN> HEIGHT

VALUE: <?> <RETURN>

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> <RETURN>

MNEMONIC:

For more details regarding measurement entries, refer to Chapter 4, step 12

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.

12 An entry in the "Enter Date" section indicates that a test(s), examination(s), or immunization(s) was done. Only those items which have dates entered as complete should be entered. This section is entered in the same manner as the "Orders" section of the Ambulatory visit record. Refer to Chapter 4, steps 13a, 13b, and 13c for specific instructions. These items support the Health Maintenance Reminders section on the Health Summary.

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

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

Any labs already entered for this visit will display.

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

9 THE MOD OPTION (MODIFY DATA)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                Version 2.0
              SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<MOD><RETURN>

```

1 This option is used to modify, correct, or delete any information that has already been entered into PCC. This is done by entering 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 on 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 @ symbol. 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.

When MOD is first selected, PCC requests if the change to be made will be Visit related or not. The operator must respond Y(es) or N(o). 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:

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

If this N(o) response was in error, the operator must return back to the **Visit related?** prompt and change the response to Y(es).

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	HPAP	HISTORICAL PAP SMEAR
HEKG	HISTORICAL EKG	HRAD	HISTORICAL RADIOLOGICAL ENTRY
HEX	HISTORICAL EXAMINATION	HRX	HISTORICAL PRESCRIPTION
HHCT	HISTORICAL HEMATOCRIT	HUA	HISTORICAL URINALYSIS
HIM	HISTORICAL IMMUNIZATION	HS	HISTORICAL SKIN TEST
HLAB	HISTORICAL LABORATORY ENTRY	SHX	HISTORY OF SURGERY

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> <RETURN> MILLER, BETTY ANN  F 06-21-57
VISIT related? Y// <RETURN>
Enter VISIT date: <0327> <RETURN> (MAR 27, 1998)
```

2 To modify an ICD-9 CODE and/or Provider Narrative, the PV mnemonic is entered 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 entered after the double slashes (/). If a new code is entered, a confirmation response is required to accept the new code. <RETURN> can be entered to leave an item the same at any or all of the PV prompts.

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

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

3 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.

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 Enter menu option. These mnemonics have been developed to make modifying easier for Problems; however, Problems can be also be modified using the PO mnemonic and going through each prompt as in the PV mnemonic described in Step 2 above.

```

MNEMONIC: <APO> <RETURN> 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: <?> <RETURN>
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> <RETURN> SAN XAVIER HEALTH CENTER
TUCSON SELLS TUCSON 11 TUCSON SELLS TUCSON 11
Activating Problem SX 2. . .

```

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.

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

```

MNEMONIC: <MNN> <RETURN> 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> <RETURN> SAN XAVIER HEALTH CENTER
TUCSON SELLS TUCSON 11
Select NOTE FACILITY: <SX> <RETURN> SAN XAVIER HEALTH CENTER
TUCSON SELLS TUCSON 11
Select NOTE NMBR: 1// <RETURN>

NOTE NARRATIVE: DIABINESE 250 MG// <DIABINESE 100 MG><RET>
STATUS: ACTIVE// <RETURN>

Select NOTE FACILITY: <RETURN>

MNEMONIC:

```

Enter the appropriate facility name of other than that which is displayed.

Enter the appropriate Note number to modify.

The change is entered after the //.

5a The @ symbol is used to delete an entry and is generally entered at the first prompt. Use the RPO and RNO mnemonics to delete Problems and Notes. A data item should only be deleted if entered in error. The following visit will be deleted as a duplicate entry was made.

```

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

```

5b To delete a measurements, enter the @ symbol after the TYPE // prompt. PCC will automatically display all measurements in alphabetical order for a specific visit date regardless of which mnemonic was entered.

```

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

```

5c The RPO mnemonic is used to delete a Problem and Notes linked to the problem.

```

MNEMONIC: <RPO><RETURN> 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> <RETURN>
ARE YOU SURE THAT YOU WANT TO REMOVE PROBLEM NUMBER SX2?
(Y/N) <Y> <RETURN>
Removing Problem SX2 . . .
MNEMONIC:

```

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

When the Problem number is entered, the system automatically DELETES the Problem and notes (if any)

5d The RNO mnemonic is used to delete a Note. Providers **must indicate the entire note** to be deleted, e.g., SX1SX2.

```

MNEMONIC: <RNO><RETURN> REMOVE NOTE FROM PROBLEM
***** ACTIVE PROBLEMS AND NOTES *****
SX1      12/18/89      CHRONIC URINARY TRACT INFECTION
SX1SX1    SCHEDULE FOR FCUG/RENAL SONO AT GEN HOSP
SX1SX2    PO BID X 10 DAYS
*****No INACTIVE Problems on file for this Patient*****
Enter Problem Number: <SX1> <RETURN> 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 NMBR: <2> <RETURN>
Are you sure you want to remove Note Number 2? (Y/N) <Y> <RETURN>
Removing Note Number 1
Select NOTE NMBR: <RETURN>
Select NOTE FACILITY: <RETURN>
MNEMONIC:

```

You must respond Y or N before the Note is deleted. If another note is to be deleted, enter at the NOTE NMBR prompt

After data has been modified or deleted for visit related data items, the operator may 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 may use the DHS mnemonic to review the data or the appropriate mnemonic, e.g. FHS, PHX, etc.

10 THE APP OPTION (APPEND DATA TO AN EXISTING VISIT RECORD)

```
*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options     **
*****

          Version 2.0
          SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option: <APP><RET>
```

This option allows data to be **added to an already existing visit**. It is commonly used when:

- 1) information is not available at the time the visit was initially entered into the system,
- 2) a provider wishes to add information to a patient's record concerning a specific visit, or
- 3) the operator missed entering one or more data items during the original processing of the form.

After the operator enters 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.

```
RPMS Patient Care Component Data Entry (Append Mode) - Version 1.6
Select PATIENT NAME: Miller, Betty Ann   F 06-21-57  4662
Enter VISIT date: <0321> <RETURN> (MAR 21, 1998)
```

```
PATIENT: MILLER, 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> <RETURN>
```

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

```
Patient Name: MILLER,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: MORGAN, ARTHUR A    PRIMARY/SECONDARY: PRIMARY
===== POV's =====
POV: 465.9                     PROVIDER NARRATIVE: URI

TYPE: BP  BLOOD PRESSURE
VALUE: <120/80> <RETURN>
MNEMONIC:
```

When APP is executed, a MINI DISPLAY (the WHAT mnemonic) of the patient's visit will appear automatically.

Any mnemonic can be entered at the Mnemonic prompt, however, the operator should check the entries to avoid duplication of data.

Enter 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. <RETURN> to return to the primary DATA ENTRY MENU.

11 THE APL OPTION (APPEND DATA USING ITEM LIST DISPLAY)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                        Version 2.0
                      SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<APL><RET>

```

The **APL – APPEND DATA USING ITEM LIST DISPLAY** menu option allows data to be added to an already existing visit. This option, however, uses screen data entry instead of the traditional “Roll & Scroll” as previously described in this manual.

The screen which the operator is presented with consists of the following parts:

- 1) 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 utilizing “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 may be hard to see. If this is a problem for you, please contact your RPMS site manager to help you make necessary adjustments.
- 2) Basic visit data including Patient Demographics, Visit Date and Time, and Clinic.

- 3) A numeric list of all possible data elements to be modified utilizing the APL option.
- 4) Actions or commands that the operator may select are displayed in the bottom portion of the screen with a one or two character mnemonic for use in choosing the desired action. Since this is the APL option, the default action is AD.

Select PATIENT NAME: **MILLER,SALLY** <RETURN>

Enter VISIT date: 120998 <RETURN> (DEC 09, 1998)

You are currently processing the following Patient Visit:

Patient Name: MILLER,SALLY Chart #: 100010
Date of Birth: JAN 25, 1951 Sex: F
Visit Date: DEC 09, 1998@08:00 Location: SELLS HOSPITAL
Type: I Service Category: A
Clinic: GENERALL

===== PROVIDER's =====
PROVIDER: SHOTT,GEORGE PRIMARY/SECONDARY: PRIMARY
EVENT DATE AND TIME: DEC 09, 1998

PROVIDER: MANN,GERALDINE PRIMARY/SECONDARY: SECONDARY
EVENT DATE AND TIME: DEC 09, 1998

===== POV's =====
POV: 250.02 PROVIDER NARRATIVE: DIABETES TYPE 2
FIRST/REVISIT: REVISIT

Following selection of the patient and visit date, a MINI DISPLAY (the WHAT mnemonic) of the patient's visit will automatically appear.

Following display of the patient's visit, the operator may select from a list of items to append to the visit selected. The operator must enter the AD action, followed by the item(s) which need to be appended or added to the visit. If more than one item must be appended to the visit, the operator may indicate multiple items for selection by separating the items with a comma, e.g. 1,3,5 or by using a range of items such as 1-4.

PCC DATA ENTRY VISIT UPDATE Jan 21, 1999 10:39:49 Page: 1 of 1

Patient Name: **MILLER,SALLY** DOB: JAN 25, 1951 Sex: F HRN: 100010
Visit Date: Dec 09, 1998@08:00 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// <RETURN>

Add which visit item(s): (1-42): 30,32 <RETURN>

Adding Exam

Enter EXAM Type: **DIABETIC FOOT EXAM, COMPLETE** <RETURN>

RESULT: <RETURN>

Adding Patient Education

Enter PATIENT EDUCATION Topic: **DM-NUTRITION** <RETURN>

PROVIDER: **GM** <RETURN> MANN,GERALDINE REGISTERED NURSE

LEVEL OF UNDERSTANDING: **FAIR** <RETURN> FAIR

INDIVIDUAL/GROUP: **I**<RETURN> INDIVIDUAL

LENGTH OF EDUC (MINUTES): **30**<RETURN>

CPT CODE: <RETURN>

COMMENT:<RETURN>

Press Return to Continue ...:

Basic visit information

List of items which data entry operator may select to add to the visit.

Actions which may be performed by data entry operator. May select individually or separated by ',' as shown here.

Entry of Exam type without results will record the fact that the exam was performed.

Patient Education documentation must include at least the disease process, topic and level of understanding by the patient.

<Return> to get back to main screen to select additional actions or quit.

Although this option is labeled as an Append option, several other actions are possible as shown at the bottom of the screen. For example, to modify the Primary Provider for a visit, the operator would select the MD action, pick the provider to modify and make the necessary change.

```

PCC DATA ENTRY VISIT UPDATE  Jan 21, 1999 10:39:49      Page:  1 of  1

Patient Name: MILLER,SALLY  DOB: JAN 25, 1951  Sex: F  HRN: 100010
Visit Date: Dec 09, 1998@08:00  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/Procedure 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//MD<RETURN>

Modify which visit item(s): (1-42):1<RETURN>

Modifying Providers

1 SHOTT,GEORGE  MILLER,SALLY  DEC 9,1998@08:00
2 MANN,GERALDINE MILLER,SALLY  DEC 9,1998@08:00

Choose: 1<RETURN>

PROVIDER: SHOTT,GEORGE// CLARKE,CHARLES <RETURN>  PHYSICIAN
PRIMARY/SECONDARY: PRIMARY//<RETURN>
DATE/TIME PROVIDER SEEN: DEC 9,1998//<RETURN>

Press return to continue...:

```

12 THE **TIM** OPTION (MODIFY VISIT DATE AND/OR TIME)

```
*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                Version 2.0
                SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<TIM><RET>
```

The **MODIFY VISIT DATE AND/OR TIME** menu option is used only to change the date and/or time of a visit. A (AM) or P (PM) should be entered following the time to designate time of day. Both a date and time must be entered 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: <MILLER,BETTY ANN> <RETURN> F 062157 4662

Enter VISIT date: <0321> <RETURN> (MAR 21,1998)

VISIT/ADMIT DATE & TIME: MAR 21, 1998@13:00

DATE VISIT CREATED: MAR 30, 1998 TYPE: IHS

PATIENT NAME: MILLER,BETTY ANN

LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER

SERVICE CATEGORY: AMBULATORY CLINIC: GENERAL

DEPENDENT ENTRY COUNT: 4 DATE LAST MODIFIED: MAR 30, 1998

WALK IN/APP: UNSPECIFIED CREATED BY USER: BROWN,IRMA

USER LAST UPDATE: BROWN,IRMA

DO YOU WANT TO SEE V FILE ENTRIES? NO// <RETURN> (NO)

The date and time of the VISIT is MAR 21,1998@13:00

Enter new date and time: <0322@230P> <RETURN> <WAIT>.....

DATE VISIT CREATED: MAR 30, 1998 TYPE: IHS

PATIENT NAME: MILLER,BETTY ANN

LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER

SERVICE CATEGORY: AMBULATORY CLINIC: GENERAL

DEPENDENT ENTRY COUNT: 4 DATE LAST MODIFIED: MAR 30, 1998

WALK IN/APP: UNSPECIFIED CREATED BY USER: BROWN,IRMA

USER LAST UPDATE: BROWN,IRMA

A Y(es) response would allow the operator to review the V Files (Provider, POV, etc before making decision.

The new date and time is displayed after the change is made.

13 THE EAC OPTION (ENTER DATA WITH VISIT DISPLAY AND ACTIONS)

```

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

          Version 2.0
        SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<EAC>RETURN>

```

This option allows the user to create a new visit, modify data in an already existing visit, or append data to an existing visit. For new visits, the operator is prompted for basic visit data, e.g. date & time of visit, location, type, service category in the traditional roll and scroll format. Once the basic visit data has been entered, the display changes to a screen format which lists patient demographics at the top, visit information in the center portion of the screen, and finally the actions which the user may take in order to edit the visit.

The screen display makes use of reverse video for part of the display. If your terminal or computer current color settings causes these areas to be difficult to read, contact your RPMS site manager for assistance in modifying the color settings.

PCC VISIT EDIT Jan 22, 1999 12:40:42 Page: 1 of 2

Patient Name: BROEN,LEE
 Chart #: 101953
 Date of Birth: APR 11, 1996
 Sex: M

<1> ===== VISIT FILE =====
 VISIT/ADMIT DATE&TIME: JAN 12, 1999@12:00
 DATE VISIT CREATED: JAN 22, 1999
 TYPE: IHS
 PATIENT NAME: BROEN,LEE
 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: GREENJEANS,ROBERTA

+ - 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): +//<RETURN>

PCC VISIT EDIT Jan 22, 1999 13:01:04 Page: 2 of 2

USER LAST UPDATE: GREENJEANS,ROBERTA

<2> ===== MEASUREMENTs =====
 TYPE: BP
 VALUE: 130/76

<3> ===== PROVIDERs =====
 PROVIDER: SHOTT,GEORGE
 AFF.DISC.CODE: 100GIS
 PRIMARY/SECONDARY: PRIMARY
 EVENT DATE AND TIME: JAN 12, 1999

- 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): +//

Pressing
 <RETURN> to
 accept the default
 +// will cause the
 center of the screen
 to scroll to the next
 page as shown at
 the bottom of this
 example.

User may select any
 of the numeric
 choices displayed at
 the bottom of the
 screen to perform
 the corresponding
 action. Selecting 9
 will produce a
 complete list of
 items available to
 edit.

To add a secondary provider to the visit, the operator would select item **1** and press **<RETURN>** to see the following screen:

Adding Providers

Enter a SECONDARY PROVIDER (code/initials or name): **GM <RETURN>** MANN,GERALDINE
REGISTERED NURSE

Date Provider Seen: Jan 12, 1999// (JAN 12, 1999)

Time Provider Seen:

Enter a SECONDARY PROVIDER (code/initials or name):**<RETURN>** or select more secondary providers

After pressing **<RETURN>** the display reverts back to the screen format with the newly added information visible in the visit display area

PCC VISIT EDIT Jan 22, 1999 13:14:25 Page: 2 of 2

USER LAST UPDATE: GREENJEANS,ROBERTA

<2> ===== MEASUREMENTs =====

TYPE: BP

VALUE: 130/76

<3> ===== PROVIDERs =====

PROVIDER: SHOTT,GEORGE

AFF.DISC.CODE: 100GIS

PRIMARY/SECONDARY: PRIMARY

EVENT DATE AND TIME: JAN 12, 1999

PROVIDER: MANN,GERALDINE

PRIMARY/SECONDARY: SECONDARY

EVENT DATE AND TIME: JAN 12, 1999

- 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): +//

Picking action item 9, as shown below, will give the user access to all editable PCC data items that may be selected at the Mnemonic prompt in the MIN or ENT data entry options.

PCC DATA ENTRY VISIT UPDATE Jan 22, 1999 13:26:07 Page: 1 of 1

Patient Name: BROEN,LEE DOB: APR 11, 1996 Sex: M HRN: 101953

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//

14 THE MNE OPTION (ENTER PCC DATA USING ITEM LIST DISPLAY)

```
*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                Version 2.0
                SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<MNE >RETURN>
```

The **MNE – ENTER PCC DATA USING ITEM LIST DISPLAY** menu option functions very much like the previously discussed **EAC – Enter Data with Visit Display and Actions**. The main difference between the options 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 and clinic.

PCC Data Entry Module

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

Select LOCATION NAME: SELLS HOSPITAL// <RETURN> TUCSON SELLS

TYPE: I// <RETURN>IHS

SERVICE CATEGORY: A// <RETURN>AMBULATORY

VISIT DATE: T-1 <RETURN> (JAN 21, 1999)

Select PATIENT NAME: 101803<RETURN>

WHEELWRIGHT,YVETTE F 02-13-1994 068040680 SE 101803

Ok? Yes// <RETURN> (Yes)

Please enter the clinic this patient is attending.

Select CLINIC STOP NAME: 01<RETURN>

Following successful entry of the basic visit data the user is presented with the screen list of items which can be selected for edit. Note that not all data items are displayed on the screen and that the OT action may be selected to display another page of items to edit.

There are numerous actions listed at the bottom of the screen display from which the operator may choose. The most commonly selected action is AD (Add PCC Item) and that is the default. Additional actions may be listed by typing <??>.

PCC DATA ENTRY VISIT UPDATE Jan 21, 1999 10:39:49 Page: 1 of 1

Patient Name: **WHEELWRIGHT, YVETTE** DOB: JAN 25, 1951 Sex: F HRN: 101803
 Visit Date: Dec 09, 1998@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
 MD Modify PCC Item
 DE Delete PCC Item
 Select Action: AD//

DV Display Visit
 OT Other Items
 PL Problem List Update

HS Health Summary
 HI Historical Data Entry
 Q Quit

In order to add a Diabetic Foot Exam, Complete, the user would need to select the AD action followed by item 30.

Select Action: AD// <RETURN> Add PCC Item

Add which visit item(s): (1-42): 30 <RETURN>

Adding Exam

Enter EXAM Type: **DIAB** <RETURN>

- | | | |
|---|------------------------------|----|
| 1 | DIABETIC EXAM | 22 |
| 2 | DIABETIC EYE EXAM | 03 |
| 3 | DIABETIC FOOT CHECK | 29 |
| 4 | DIABETIC FOOT EXAM, COMPLETE | 28 |

CHOOSE 1-4: **4** <RETURN>

RESULT: <RETURN>

Press return to continue...: <RETURN>

Recording a result is not required to document that an exam was performed.

Patient Name: **WHEELWRIGHT, YVETTE** DOB: FEB 13, 1994 Sex: F HRN: 1018
Visit Date: Jan 21, 1999@12:00 Clinic: GENERAL

- | | | |
|---------------------------|---------------------------|-------------------------|
| 1) Kilogram Weight | 15) ICD Narrative POV | 29) Family Plan Method |
| 2) Audiometry | 16) Pov w/Stage | 30) Family Planning |
| 3) Tonometry | 17) Stage in POV | 31) Under. Cause Death |
| 4) Hearing | 18) ICD Narrative OP | 32) EKG |
| 5) Outside Location | 19) Medications/RXs | 33) Radiology Exam |
| 6) Inpatient | 20) Eyeglass Prescription | 34) Lab Test |
| 7) Primary Care Provider | 21) Future Appointment | 35) Pap Smear Ordered |
| 8) ER Visit Record | 22) Decision Making | 36) Hematocrit Ordered |
| 9) PHN FORM ITEMS | 23) Time of Visit | 37) Urinalysis Ordered |
| 10) Admitting Diagnosis | 24) Blood Type | 38) Blood Sugar Ordered |
| 11) CHS - Ambulatory | 25) Health Factor | 39) CBC Ordered |
| 12) CHS - Hospitalization | 26) Health Status | 40) CODE |
| 13) CHS-In Hospital (64) | 27) Line Item-3P Billing | |
| 14) E-CODE in POV | 28) EDC | |

Enter ?? for more actions >>>

AD Add PCC Item	DE Delete PCC Item	HS Health Summary
MD Modify PCC Item	DV Display Visit	Q Go Back

Select Action: AD//

Second page of potential items for edit was obtained by selecting the **OT** action and pressing <RET>

15 THE GRP OPTION (GROUP PREVENTIVE FORM ENTRY)

```
*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                        Version 2.0
                        SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<GRP><RETURN>
```

The **GRP – GROUP PREVENTIVE FORM ENTRY** menu option is used to enter 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 may be used any time an identical service was provided to multiple patients where the encounter occurred at the same location on the same date & time.

This menu option requires the data entry operator to first enter all constant information, e.g. Visit Type, Location, Provider, Purpose of Visit and Clinic ONCE FOR ALL PATIENTS and then enter 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 entered. <RETURN> 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 entered at the MNEMONIC prompt followed by the mnemonic that requires the change. Refer to MOD in Chapter 4, Figure 4.5 Correcting an error using the MOD mnemonic.

PCC Data Entry Module

 * GROUP PREVENTIVE FORM ENTER Mode *

LOCATION OF GROUP VISIT: <SE> <RETURN> SELLS HOSPITAL/CLINIC
 TYPE.....: <I> <RETURN> HS
 SERVICE CATEGORY.....: <A> <RETURN> MBULATORY
 VISIT/ADMIT DATE.....: <2-28> <RETURN> (FEB 28, 1998)
 TIME OF VISIT: 12:00// <RETURN> (FEB 28, 1998@12:00)
 CLINIC.....: <09> <RETURN> GROUP SERVICES 09
 Enter PRIMARY Provide.....: <113ABC> <RETURN> ANN CARLSON CHN
 Enter SECONDARY Provider....: <RETURN>
 Enter PURPOSE of VISIT: <INFLUENZA IMMUNIZATION > <RETURN>

The following matches were found:

- 1: V04.8 (VACCIN FOR INFLUENZA)
 NEED FOR PROPHYLACTIC VACCINATION AND INOCULATION
 AGAINST INFLUENZA
- 2: V03.81 (VACC FOR H INFLUENZA,TYPE B)
 PROPHYLACTIC VACCINATION AGAINST HEMOPHILUS
 INFLUENZA,TYPE B [Hib]

Select 1-2: 1

PROVIDER NARRATIVE: < = > <RETURN> INFLUENZA IMMUNIZATION

All data items
 entered here are
 set for ALL
 patients
 including the
 second POV.

Enter PURPOSE of VISIT : <RETURN>

Select PATIENT NAME: <SMITH,BOB> <RETURN> M 02-04-88 071730717
Ok? YES// <RETURN> (YES)

Checking Visit and POV data for this Patient...
(FEB 28, 1998@12:00)
Creating PCC Visit

Creating POV Record
Creating Provider Record

You are currently processing the following Patient Visit:

Patient Name: **SMITH,BOB** Chart #: **101846**
Date of Birth: **FEB 04, 1938** Sex: **M**
Visit Date: **FEB 28, 1998@12:00**
Location: **SELLS HOSPITAL/CLINIC**
Type: **IHS** Service Category: **A**
Clinic: **GROUP SERVICES**

===== PROVIDER's =====
PROVIDER: REGISTERED NURSE,IHS PRIMARY/SECONDARY: PRIMARY

===== POV's =====
POV: **V04.8** PROVIDER NARRATIVE: **INFLUENZA IMMUNIZATION**

MNEMONIC: <IM> <RETURN> IMMUNIZATIONS
Enter IMMUNIZATION Given: <INF > <RETURN> INFLUENZA 12
SERIES: <RETURN>
LOT: <RETURN>

MNEMONIC: <RETURN>

Select PATIENT NAME: <JONES,ANDREW><RETURN> M 11-12-27 070830708
Ok? YES// <RETURN> (YES)

Checking Visit and POV data for this Patient...
(FEB 28, 1998@12:00)
Creating PCC Visit

Creating POV Record
Creating Provider Record

You are currently processing the following Patient Visit:

Patient Name: **JONES,ANDREW** Chart #: **101836**
Date of Birth: **NOV 12, 1927** Sex: **M**
Visit Date: **FEB 28, 1998@12:00**
Location: **SELLS HOSPITAL/CLINIC**
Type: **I** Service Category: **A**
Clinic: **GROUP SERVICES**

At the
MNEMONIC
prompt any
entry is allowed
for the above
patient.

A new visit for
another patient
begins at NAME.

```
===== PROVIDER's =====  
PROVIDER: REGISTERED NURSE,IHS PRIMARY/SECONDARY: PRIMARY  
===== POV's =====  
POV: V06.1 PROVIDER NARRATIVE: DPT BOOSTERS
```

```
MNEMONIC: IM IMMUNIZATIONS  
Enter IMMUNIZATION Given: <INF> <RETURN> INFLUENZA 12  
SERIES: <3> <RETURN> SERIES 3  
LOT:
```

MNEMONIC:

```
Select PATIENT NAME.....: <RETURN>  
VISIT/ADMIT DATE.....: <RETURN>  
SERVICE CATEGORY.....: <RETURN>  
TYPE .....: <RETURN>  
LOCATION OF GROUP VISIT <RETURN>
```

Signed hard copy print-outs of the encounter form may be placed in the patient's chart as the official record of the visit. See Example in Figure 12.1.

```
Do you wish to PRINT a hard copy encounter form for each patient in the group? Y// <RETURN>YES  
DEVICE:
```

If the response is "NO", the forms cannot be printed at a later time.

The system returns to the main data entry menu.

***** CONFIDENTIAL PATIENT INFORMATION *****
PCC AMBULATORY ENCOUNTER RECORD
*** Computer Generated Encounter Record from GROUP FORM ***

Visit Date: OCT 31, 1998 Primary Provider: MANN,GERALDINE
Clinic: GROUP SERVICES
Arrival Time: 12:00

MEASUREMENTS: BP 118/66
WT 188

EXAMS: DIABETIC FOOT CHECK RESULTS: N

ICD9 CODE	PURPOSE OF VISIT (POV)
V65.49	DIABETIC EDUCATION CLASS

MEDICATIONS: GLYBURIDE 5MG TAB	QUANTITY: 60 DAYS: 30
SIG: 1 TABLET BID	

HR#: 101300 SSN: 040020400
NAME: THATCHER,TONY
SEX: MALE TRIBE: MICHIGAN POTAWATOMI
DOB: JAN 08, 1982
RESIDENCE: SELLS
FACILITY: SELLS HOSPITAL LOCATION: SELLS HOSPITAL

PROVIDER SIGNATURE:

Figure 12.1 Example of computer generated encounter form

16 THE HIN OPTION (ENTER HISTORICAL INPATIENT VISITS)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                        Version 2.0
                        SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<HIN><RETURN>

```

The **ENTER HISTORICAL INPATIENT VISITS** menu option allows patient data regarding a stay at another facility or in the past at your facility to be entered. 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, HINP would be used. This captures the data and displays it on 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 HINP is entered, a visit is created and the system automatically goes into the IP (Inpatient) mnemonic. HINP is used with the form IHS 44-1 Clinical Record Brief-IHS Inpatient Services.

* Historical Inpatient ENTER Mode *

Select Patient Care Data Entry Menu Option: <HINP> <RETURN> Enter Historical
INPATIENT Visits

Entry of Historical Inpatient Visits into PCC

Select LOCATION NAME: <SE><RETURN> SELLS HOSPITAL/CLINIC

TUCSON SELLS TUCSON 01 TUCSON SELLS TUCSON 01

TYPE: <I> <RETURN>

VISIT/ADMIT DATE: <041691> <RETURN> (APR 16, 1998)

TIME OF VISIT: <10:30P> <RETURN>(APR 16, 1998@22:30)

Select PATIENT NAME: <SMITH,JOHN D> <RETURN> M 11-4-35 20000

~~~~~

----- VISIT FILE -----

VISIT/ADMIT DATE&TIME: APR 16, 1998@22:30

DATE VISIT CREATED: APR 19, 1998 TYPE: IHS

PATIENT NAME: SMITH, JOHN D.

LOC. OF ENCOUNTER: SELLS HOSPITAL

SERVICE CATEGORY: HOSPITALIZATION DATE LAST MODIFIED: APR 19, 1998

DATE VISIT EXPORTED: APR 19,1998

~~~~~

INPATIENT

ENTER DATE OF DISCHARGE: <042391> <RETURN> (APR 23, 1998)

ADMISSION TYPE: <1> <RETURN> DIRECT

ADMITTING SERVICE: <03> <RETURN> GENERAL MEDICINE 03

DISCHARGE SERVICE: <03> <RETURN> GENERAL MEDICINE 03

DISCHARGE TYPE: <1> <RETURN> 1 REGULAR DISCHARGE

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

NUMBER OF CONSULTS: <RETURN>

ADMITTING DX: <ORGANIC BRAIN SYNDROME> <RETURN>

310.9 (NONSCHOT BRAIN SYN NOS)

UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING
ORGANIC BRAIN DAMAGE OK? Y// <RETURN>

ENTER PROVIDER: <100CTJ> <RETURN> PHYSICIAN, IHS 100CTJ

PRIMARY/SECONDARY: <P><RETURN> PRIMARY

OPERATING/ATTENDING: <A> <RETURN>

Date Provider Seen: Apr 16,1991//<RETURN>

Time Provider Seen:<RETURN>

Enter a SECONDARY PROVIDER (code/initials or name): <RETURN>

ENTER PURPOSE of VISIT: <ORGANIC BRAIN SYNDROME> <RETURN>

310.9 (NONPSYCHOT BRAIN SYN NOS)

UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER FOLLOWING ORGANIC BRAIN
DAMAGE OK? Y// <RETURN>

PRIMARY/SECONDARY: <P> <RETURN> PRIMARY

PROVIDER NARRATIVE:: <ORGANIC BRAIN SYNDROME> <RETURN>

MODIFIER: <RETURN>

CAUSE OF DX: <RETURN>

Select V POV: <RETURN>

MNEMONIC:

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

Enter 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 entered using the date the form was entered. This means the visit will not transmit.

17 THE DTC OPTION (TRAN CODE (DTC) ENTRY FOR ALL VISITS)

```

*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                Version 2.0
                SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:

```

The **DTC – TRAN CODE (DTC) ENTRY FOR ALL VISITS** menu option allows the user to associate Chargemaster Transaction Codes to be associated 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 utilizing tran codes, refer to instructions from the provider of the Chargemaster Transaction File.

18 THE TCH OPTION (ENTER TRANS CODES ON IN-HOSPITAL VISITS)

```
*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options      **
*****

          Version 2.0
        SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

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

The **TCH - ENTER TRANS CODES ON IN-HOSPITAL VISITS** menu option allows Chargemaster Transaction Codes to be associated 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 direction on correct utilization of tran codes, refer to instructions from the provider of the Chargemaster Transaction File.

19 THE TCO OPTION (ENTER TRANS CODES ON OUTPATIENT VISITS)

```
*****
**          PCC Data Entry Module          **
**      Enter PCC Data Menu Options      **
*****
                Version 2.0
                SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

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

The **TCO - ENTER TRANS CODES ON OUTPATIENT VISITS** menu option allows Chargemaster Transaction Codes to be associated 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 direction on correct utilization of tran codes, refer to instructions from the provider of the Chargemaster Transaction File.

20 THE LOG OPTION (ENTER DATA FROM LOGS (LAB/RAD/CPT/APC))

```
*****
**          PCC Data Entry Module          **
**          Enter PCC Data Menu Options     **
*****
                        Version 2.0
                        SELLS 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
LOG   Enter Data From LOGS (lab/rad/cpt/apc) ...

Select Enter/Modify/Append PCC Data Option:<LOG><RETURN>
```

The **LOG – ENTER DATA FROM LOGS** menu option is a menu of data entry options that allows the operator to enter information recorded on a variety of forms other than the standard PCC encounter forms. Examples of data that may be entered from a log or other form include:

LABORATORY TESTS
CPT CODES

RADIOLOGICAL PROCEDURES
APC FORM DATA

```
*****
**      PCC Data Entry Module      **
**      PCC LOG Data Entry         **
*****

Version 2.0
SELLS HOSPITAL

APC   Enter Data from APC Forms
CPT   CPT Log Entry
LAB   Lab Log Data Entry
RAD   Radiology Log Data Entry

Select Enter Data From LOGS (lab/rad/cpt/apc) Option
```

APC – ENTER DATA FROM APC FORMS 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 ICD-9 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 (purpose of visit) codes are generally entered from information checked on the reverse of the form along with some generic lab, radiological and exam information. When finished with entry of data from the APC form, the user will see the PCC MNEMONIC prompt at which time any of the regular PCC mnemonics may be selected for data entry.

PCC Data Entry Module

* APC FORM ENTRY Mode *

Enter LOCATION of VISIT.....: SELLS HOSPITAL// <RETURN> TUCSON SELLS

Enter VISIT DATE.....: 10300<RETURN>

Entering forms for SELLS HOSPITAL for visit date Dec 01, 1998

Enter PATIENT NAME.....: <10300><RETURN>KETCHUP,CARMEN F 02-22-1977
SE10300

Ok? Yes// (Yes)

Enter TIME OF DAY: (1/2/3/4): <RETURN> NOON - 5PM

Enter TYPE OF CLINIC CODE....: <01><RETURN> GENERAL 01 (DEC 01, 1998@12:00)

Enter PRIMARY Provider.....: <SHOT><RETURN>SHOTT,GEORGE PHYSICIAN

Enter OTHER Provider.....: GM<RETURN> MANN,GERALDINE REGISTERED NURSE

Enter OTHER Provider.....:<RETURN>

Enter APC CODE.....: 080 <RETURN> DIABETES MELLITUS

Enter APC CODE.....: 283 <RETURN> HYPERTENSIVE DISEASE

Enter APC CODE.....:<RETURN>

You may now enter any other information using the PCC mnemonics.

MNEMONIC: BP<RETURN> Blood Pressure ALLOWED VISIT RELATED ONLY
VALUE: 166/94<RETURN>

MNEMONIC: <RETURN> Examinations ALLOWED VISIT RELATED ONLY

Enter EXAM Type: <RECTAL><RETURN> RECTAL EXAM 14

RESULT:<RETURN>

MNEMONIC: HF <RETURN>Health Factors ALLOWED VISIT RELATED ONLY

Enter HEALTH FACTOR: CURRENT SMOKER <RETURN>

LEVEL/SEVERITY:<RETURN>

PROVIDER:<RETURN>

QUANTITY:<RETURN>

MNEMONIC:

APC codes
are
converted to
ICD-9
codes.Enter any
information
provided where
appropriate

CPT – CPT LOG ENTRY This menu option allows the operator to append a CPT code to an already existing visit. In addition, a visit may be created using this option which will contain only the basic visit information (location, type, service category) and the CPT code (s) entered by the user. In order for the visit to be complete, a data entry operator must complete the visit by entering 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><RETURN>  SELLS HOSPITAL      TUCSON
TYPE: I<RETURN>IHS
SERVICE CATEGORY: <A><RETURN>AMBULATORY
Enter VISIT DATE: 120198 <RETURN>(DEC 01, 1998)
Select PATIENT NAME: 100993<RETURN>
      KETCHUP,CARMEN              F 02-22-1977 030010300  HID 100992
                                SE 100993

Ok? Yes//<RETURN>
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//<RETURN>
Select V CPT: 99214 <RETURN>  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// <RETURN> (Yes)
                                QUANTITY: 1
                                Select PATIENT NAME:<RETURN>

```

User will only see this message if there already is a visit on file for this patient on the same day.

Any valid CPT code may be entered at the **Select V CPT:** prompt

LAB – LAB LOG DATA ENTRY This menu option is used to enter lab results taken from lab slips or logs manually maintained in the laboratory. This is used when the Lab module is NOT operating at your facility and it is strongly recommended that the entry be done by Lab personnel. This menu option will CREATE A VISIT. When Lab Log Data Entry is used, the operator should display existing patient visits to determine whether or not a Merge, Append, or Create is necessary for entering patient data. Lab data can be entered by Test Type or Patient. If one patient was given many different tests, PATIENT would be used. If one test type was given to many different patients, TEST TYPE would be used. A sample of each is provided. The VISIT date is to used for entry and not the date the results were received or entered.

```
*****
**      LAB LOG ENTER MODE      **
*****

Select LOCATION NAME: <SX> <RETURN> SAN XAVIER HEALTH CENTER TUCSON SELLS
                        TUCSON 11 TUCSON SELLS TUCSON 11
                        TYPE: <I> <RETURN>
                        SERVICE CATEGORY: <A> <RETURN> (AMBULATORY)
                        Enter VISIT date: <0321> <RETURN> (MAR 21,1998)

ENTER LAB TEST RESULTS BY:
1). TEST TYPE
2). PATIENT
```

ENTRY BY TEST TYPE:

```
CHOOSE: <1> <RETURN>
Enter LAB TEST type: <HEMOGLOBULIN> <RETURN>
Select PATIENT NAME: <4662> <RETURN> MILLER,BETTY ANN F 062157 4662
RESULTS: <?> <RETURN>
TYPE A NUMBER BETWEEN 0 AND 1500
RESULTS: <55> <RETURN>
ABNORMAL: <N> <RETURN>
Select PATIENT NAME:
```

For more entries, continue entering at the Patient Name prompt. A new visit is created after the Patient name is entered with a time of 12:00 and a Clinic Code of None. Later when the form is received by Data Entry, this visit could be Appended to add the remaining data items.

ENTRY BY PATIENT NAME:

```
CHOOSE: <2> <RETURN>
Select PATIENT NAME: <4662> <RETURN> MILLER,BETTY ANN  F 062157  4662
Select V LAB TEST: <FIBRINOGEN> <RETURN>
RESULTS: <5> <RETURN>
ABNORMAL: <N> <RETURN>
Select V LAB LAB TEST:
```

Continue entering lab results, if necessary, at the V Lab Test: prompt. Once entered, a new visit is created with a time of 12:00 and Clinic Code of None.

RAD – RADIOLOGY LOG DATA ENTRY This menu option allows the user to record radiological procedures prior to or after completion of the remainder of the visit by data entry personnel. If used before the medical portion of the visit is entered, this option will create an incomplete visit which will need to be completed by the data entry staff. If the visit was begun by some other department, e.g. pharmacy, data entry, lab etc., the radiology data entry person will need to append that data to the already existing visit.

```
PCC Data Entry Module

*****
*   Radiology Log ENTER Mode   *
*****

Select LOCATION NAME: SELLS HOS <RETURN>PITAL      TUCSON      SELLS      01
TYPE: I <RETURN>IHS
SERVICE CATEGORY: A<RETURN> AMBULATORY

Enter VISIT DATE: 01/10/99<RETURN> (JAN 10, 1999)
```

Select PATIENT NAME: **100010**<RETURN>

MILLER,SALLY F 01-25-1951 000350003 PIMC 100008

HID 100009

SE 100010

SX 100011

Ok? Yes// <RETURN> (Yes)

Select V RADIOLOGY RADIOLOGY PROCEDURE:**BILAT MAMMOGRAM**<RET>

(BILAT/BILATERAL MAMMOGRAM) 76091 (76091)

MAMMOGRAM, BOTH BREASTS

MAMMOGRAPHY; BILATERAL

OK? Y//<RETURN>YES MAMMOGRAM BILAT (Detailed) CPT:76091

ABNORMAL:<RETURN>

IMPRESSION: **N0 EVIDENCE OF ABNORMALITIES - NORMAL MAMMO**

GRAM<RETURN>

Select PATIENT NAME:<RETURN>

Enter VISIT DATE:<RETURN>

SERVICE CATEGORY: ^<RETURN>

TYPE:<RETURN>

Select LOCATION NAME:<RETURN>

Operator may enter the appropriate CPT code at this prompt instead of the description.

The impression may be up to 245 characters if necessary.

Return to menu.

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.

21 THE DSP OPTION (DISPLAY DATA FOR A SPECIFIC PATIENT VISIT)

The **DISPLAY ALL DATA FOR A PATIENT VISIT** menu option is used to display or view all data entered for a selected patient visit date on the screen. Only visit-related data items will display. When entering 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. Display may 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 to merge multiple visits into one

```
*****
**      PCC Data Entry Module      **
*****

Version 2.0
SELLS HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
GHS  Generate Health Summary
BHS  Browse Health Summary

Select Patient Care Data Entry Menu Option: DSP<RETURN>
```

The **DSP** menu option utilizes 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 have been entered for the visit. This part of the display may consist of more than one page, and the user

will need to use the + and – symbols to make the center of the display scroll to the desired page. The bottom portion of the screen will contain all allowable actions which the user may perform while in the display. The default action is + to move to the next page.

Select PATIENT NAME: **MILLER,SALLY<RETURN>** F 01-25-1951
000350003 PIMC 100008 SE 100018

Enter VISIT date: **12/09/98 <RETURN>**
PCC VISIT DISPLAY Jan 26, 1999 10:10:17 Page: 1 of 3
Patient Name: **MILLER,SALLY**
Chart #: 100010
Date of Birth: JAN 25, 1951
Sex: F

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: DEC 09, 1998@08:00
DATE VISIT CREATED: DEC 09, 1998
TYPE: IHS
PATIENT NAME: MILLER,SALLY
LOC. OF ENCOUNTER: SELLS HOSPITAL
SERVICE CATEGORY: AMBULATORY
CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 5
DATE LAST MODIFIED: JAN 22, 1999
WALK IN/APPT: UNSPECIFIED
CREATED BY USER: BEGAY,AMBER
USER LAST UPDATE: BEGAY,AMBER

+ Enter ?? for more actions >>>
+ Next Screen - Previous Screen Q Quit
Select Action: +//<RETURN>

PCC VISIT DISPLAY Jan 26, 1999 10:28:41
===== PROVIDERs =====
PROVIDER: CLARKE,CHARLES
AFF.DISC.CODE: 100ACC
PRIMARY/SECONDARY: PRIMARY
EVENT DATE AND TIME: DEC 09, 1998
PROVIDER: MANN,GERALDINE
AFF.DISC.CODE: 101GM
PRIMARY/SECONDARY: SECONDARY
EVENT DATE AND TIME: DEC 09, 1998

Basic visit information.

=====

Data items which have been entered for this visit. May consist of more than one page of items.

Press <RETURN> to scroll to the next page of data items.

```
===== POVs =====
POV:                                250.02
ICD NARRATIVE:                      DM UNCOMPL/T-II/NIDDM,UNCON
PROVIDER NARRATIVE:                  DIABETES TYPE 2
FIRST/REVISIT:                       REVISIT
===== EXAMs =====
EXAM:                               DIABETIC FOOT EXAM, COMPLETE
EXAM CODE:                           8
===== PATIENT EDs =====
TOPIC:                              DM-NUTRITION
CPT CODE (computed):                 99402
PROVIDER:                           MANN,GERALDINE
LEVEL OF UNDERSTANDIN:              FAIR
INDIVIDUAL/GROUP:                   INDIVIDUAL
LENGTH OF EDUC (MINUT:              20
```

Remainder of visit display

```
Enter ?? for more actions >>>
```

```
+ Next Screen          - Previous Screen    Q Quit<RETURN>
Select Action: +//
```

22 THE UPD OPTION (UPDATE PATIENT RELATED/NON VISIT DATA)

```
*****
**      PCC Data Entry Module      **
*****

Version 2.0
SELLS HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
GHS  Generate Health Summary
BHS  Browse Health Summary

Select Update Patient Related / Non Visit Data Option:<UPD><RETURN>
```

UPD - UPDATE PATIENT RELATED/NON VISIT DATA ... This menu contains the options that are 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

Each of these options will be discussed on the following pages

22.1 NVD – ENTER NON VISIT DATA

```
*****
**          PCC Data Entry Module          **
**          Update Patient-Related Data      **
*****
Version 2.0
SELLS HOSPITAL

NVD  Enter Non-Visit Data
HDI  Enter Historical or Non Visit Related Patient Data
PRL  Problem List Update

Select Update Patient Related/Non Visit Data Option:<NVD><RETURN>
```

This option allows patient data to entered into the system WITHOUT creating a visit, except for the historical mnemonics HIM, HS, and SHX etc. When entering data using these mnemonics, the system will automatically create an Event Visit. The most common use of this option is:

- 1) To enter new problems and/or treatment plan notes relating to a specific health problem,
- 2) Enter historical immunization(s),
- 3) Enter skin test reading(s) and/or results(s),
- 4) Enter historical lab test(s).

Encounter forms that should be processed using this option are Chart Review, Telecommunication, Not Found, 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 PV's; however, other data recorded on the form would meet the criteria of non-visit related data and can be entered into the system. There may be instances when 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 on the lower left-hand corner (patient identification section) indicating the form had been reviewed.

The only data mnemonics that can be used to Enter Non-visit Data option are listed below. This list can always be displayed at the MNEMONIC: prompt while in this menu option.

APO	ACTIVATE AN INACTIVE PROBLEM	HPAP	HISTORICAL PAP SMEAR
BT	BLOOD TYPE ENTRY	HRAD	HISTORICAL RAD. PROCEDURE
CODE	CIDING GUIDELINES DISPLAY	HRX	HISTORICAL RX
DHS	DATA ENTRY HEALTH SUMMARY	HS	HISTORICAL SKIN TEST
DISP	VISIT DISPLAY	HUA	HISTORICAL UA ENTRY
DP	DESIGNATED PROVIDER	IPO	INACTIVATE A PROBLEM
EDC	EXPECTED DATE OF CONFINEMENT	LMP	LAST MENSTRUAL PERIOD
FHX	FAMILY HISTORY	MNN	MODIFY NOTE NARRATIVE
FM	FAMILY PLANNING METHOD	MPO	CORRECT/MODIFY PROBLEM
FP	FAMILY PLANNING	NO	NOTE
FS	FUTURE SCHEDULED ENCOUNTER	OHX	OFFSPRING HISTORY
HBS	HISTORIC BLOOD SUGAR ENTRY	ORX	OUTSIDE RX (HISTORICAL)
HCBC	HISTORIC CBC ENTRY	PCP	PRIMARY CARE PROVIDER
HEKG	HISTORIC EKG	PHX	PERSONAL HISTORY
HEX	HISTORIC EXAMINATION	PL	PROBLEM LIST UPDATE MENU
HHCT	HISTORICAL HEMATOCRIT	PO	PROBLEM ONLY
HIM	HISTORICAL IMMUNIZATION	RF	REPRODUCTIVE FACTORS
HLAB	HISTORICAL LAB TEST	RNO	REMOVE NOTE FROM PROBLEM
HLST	HEALTH STATUS	RPO	REMOVE PROBLEM ENTRY
HMSR	HISTORICAL MEASUREMENT	SHX	HISTORY OF SURGERY
UCD	UNDERLYING CAUSE OF DEATH	WHAT	DEMOGRAPHIC & VISIT DISPLAY

Select PATIENT NAME: 100109<RETURN>

ADAMS,MOLLY

F 01-06-1928 003280032 HID 100109

SE 100110

Select LOCATION NAME: <SEL><RETURN>SELLS HOSPITAL TUCSON SELLS

Enter Date Information Was Collected: <RETURN> (JAN 26, 1999)

Select non VISIT related mnemonics only!

MNEMONIC:

Enter the appropriate mnemonic (from the above list) at the MNEMONIC: prompt and respond to each field. Refer to the Mnemonics manual for details on entering each mnemonic.

22.2 HDI – ENTER HISTORICAL OR NON VISIT RELATED PATIENT DATA

```
*****
**          PCC Data Entry Module          **
**          Update Patient-Related Data      **
*****

Version 2.0
SELLS HOSPITAL

NVD  Enter Non-Visit Data
HDI  Enter Historical or Non Visit Related Patient Data
PRL  Problem List Update

Select Update Patient Related/Non Visit Data Option:<HDI ><RETURN>
```

This menu option allows the entry of patient and historical clinical data utilizing the list display.

```
Patient Care Component (PCC)

*****
***** PCC DATA ENTRY UPDATE HISTORICAL DATA BY ITEM *****
*****

Select PATIENT NAME:ADAMS,MOL<RETURN>

ADAMS,MOLLY          F 01-06-1928 003280032  HID 100109
                      SE 100110
                      SX 100111

Select LOCATION NAME: <SELLS HOS><RETURN>  SELLS HOSPITAL      TUCSON

Enter Date Information Was Collected: <T><RETURN> (JAN 26,1999)
```

The top portion of the screen display contains patient identification followed by a list of thirty-five patient/non-visit data items which may 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      Jan 26, 1999 14:42:21      Page:  1 of  1

Patient Name: ADAMS,MOLLY  DOB: JAN 06, 1928      Sex: F  HRN: 100110
Date of Update: Jan 26, 1999

1) Family History          13) Hist. Immunization  25) Remove Problem
2) Personal History        14) Hist Measurement   26) Inactivate Problem
3) History of Surgery      15) Historical Radiology 27) Activate Problem
4) Offspring History       16) Historical Skin Test 28) Remove Problem Note
5) Historical BS           17) Outside RX Entry    29) Change Note Narratvie
6) Historical CBC          18) Family Planning     30) Modify Problem
7) Historical Hematocrit   19) EDC                 31) Future Appointment
8) Historical Lab Test     20) LMP                 32) Blood Type
9) Historical Pap Smear    21) Family Plan Method  33) Primary Care Provider
10) Historical UA          22) Reproductive Factors 34) Health Status
11) Historical EKG         23) Problem Only        35) Under. Cause Death
12) Historical Exam        24) Problem Note

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//<RETURN>

Add which visit item(s): (1-35):<11><RETURN>
Adding Historical EKG

Enter Date of Historical EKG: 06-23-98 <RETURN> (JUN 23, 1998@12:00)
TYPE: I// <RETURN> IHS
LOC. OF ENCOUNTER: PIMC <RETURN> PHOENIX INDIAN MED CTR
PHOENIX    01
Updating V Diagnostic Procedure file...

VALUE: NORMAL<RETURN>

Press return to continue...:

```

22.3 PRL – PROBLEM LIST UPDATE

```

*****
**          PCC Data Entry Module          **
**          Update Patient-Related Data      **
*****

Version 2.0
SELLS HOSPITAL

NVD  Enter Non-Visit Data
HDI  Enter Historical or Non Visit Related Patient Data
PRL  Problem List Update

Select Update Patient Related/Non Visit Data Option:<PRL ><RETURN>

```

The **PRL** menu option allows for updating a patient's problem list without using mnemonics for the data entry. After selecting the PRL option, the user is asked to enter the patient's name, followed by the location of the Problem List Update, and date of the update. After successfully entering that information, the user is presented with the List Manager display of items which may be selected in order to update the patient's problem list. Virtually any problem list manipulation may be carried out by selecting the correct action.

```

Patient Care Component (PCC)

*****
* Update PCC Patient Problem List *
*****

Select PATIENT NAME:<100110><RETURN>
ADAMS,MOLLY                F 01-06-1928 003280032  HID 100109
                           SE 100110
Location where Problem List update occurred: SELLS HOSPITAL// <RETURN>  TUSON
SELLS

Date Problem List Updated: T<RETURN>

```

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: ADAMS,MOLLY	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 >>> <table border="0"> <tr> <td>AP Add Problem</td> <td>IP Inactivate Problem</td> <td>RN Remove Note</td> </tr> <tr> <td>EP Edit Problem</td> <td>DD Detail Display</td> <td>HS Health Summary</td> </tr> <tr> <td>DE Delete Problem</td> <td>NO Add Note</td> <td>FA Face Sheet</td> </tr> <tr> <td>AC Activate Problem</td> <td>MN Edit Note</td> <td>Q Quit</td> </tr> </table>			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
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><RETURN>														
Select Problem: (1-1): 1<RETURN>														
Editing Problem ...														
Editing Problem Number: SE1 for ADAMS,MOLLY.														
DIAGNOSIS: 250.00//<RETURN>														
PROVIDER NARRATIVE: AODM// TYPE 2 DIABETES TYPE 2 DIABETES														
CLASS:														
NMBR: 1//<RETURN>														
STATUS: ACTIVE//<RETURN>														
DATE OF ONSET: 04/88 <RETURN>														

Problem List Update	Jan 26, 1999 16:17:36	Page: 1 of 1												

Patient Name: ADAMS,MOLLY	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 >>> <table border="0"> <tr> <td>AP Add Problem</td> <td>IP Inactivate Problem</td> <td>RN Remove Note</td> </tr> <tr> <td>EP Edit Problem</td> <td>DD Detail Display</td> <td>HS Health Summary</td> </tr> <tr> <td>DE Delete Problem</td> <td>NO Add Note</td> <td>FA Face Sheet</td> </tr> <tr> <td>AC Activate Problem</td> <td>MN Edit Note</td> <td>Q Quit</td> </tr> </table>			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
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><RETURN>														

No onset date recorded; old terminology in narrative

Note onset date and new narrative

23 THE DEU OPTION (DATA ENTRY UTILITIES)

```
*****
**   PCC Data Entry Module   **
*****

Version 2.0
SELLS HOSPITAL

ENT  Enter/Modify/Append PCC Data ...
DSP  Display Data for a Specific Patient Visit
UPD  Update Patient Related/Non Visit Data ...
DEU  Data Entry Utilities ...
GHS  Generate Health Summary
BHS  Browse Health Summary

Select Patient Care Data Entry Menu Option:<DEU><RET>
```

The **DATA ENTRY UTILITIES** menu 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   **
*****

      Version 2.0
      SELLS HOSPITAL

LST      List Visits for a Patient in a Date Range
GHS      Generate Health Summary
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 ...
BHS      Browse Health Summary
COD      Display IHS Coding Guidelines
MVD      Move Data Items From One to Another

Select Data Entry Utilities Option:
```

LIST VISITS FOR A PATIENT IN A DATE RANGE (LST) This menu option is used 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 the data items for each visit. The List may be displayed on the screen using the **browser** or sent to a printer for a hardcopy printout.

The following example will **List Visits by Visit Date** within a range from earliest visit date to latest. The output will utilize the **browser** which will allow the user to scroll forward or backward in the display area.

This routine will list all Visits for a Selected Patient in a specified Posting Date or Visit Date Range.

Select one of the following:

- 1 Posting Date
- 2 Visit Date

Run Report by: P// <2><RETURN>Visit Date

Enter beginning Visit Date for Search: 100198 <RETURN> (OCT 01, 1998)

Enter ending Visit Date for Search: (10/1/98 - 1/28/99): OCT 01, 1998// **103198**<RETURN> (OCT 31, 1998)

Select PATIENT NAME:

MILLER,SALLY F 01-25-1951 000350003 SE 100010

Select one of the following:

- B BROWSE Output on Screen
- P PRINT Output to Printer

Do you want to: B//<RETURN>

OUTPUT BROWSER Jan 28, 1999 16:04:01 Page: 1 of 4

Visit List in Date Range

Visits for MILLER,SALLY in Visit date range OCT 01, 1998 to OCT 31, 1998
Health Record Number: 100010

VISIT/ADMIT DATE&TIME: OCT 27, 1998@08:00

DATE VISIT CREATED: OCT 28, 1998 TYPE: IHS
PATIENT NAME: MILLER,SALLY LOC. OF ENCOUNTER: SELLS HOSPITAL
SERVICE CATEGORY: AMBULATORY CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 3 DATE LAST MODIFIED: OCT 28, 1998
WALK IN/APPT: UNSPECIFIED CREATED BY USER: PARSONS,CHERYL
USER LAST UPDATE: PARSONS,CHERYL

VISIT/ADMIT DATE&TIME: OCT 14, 1998@12:00

DATE VISIT CREATED: OCT 14, 1998 TYPE: IHS
PATIENT NAME: MILLER,SALLY LOC. OF ENCOUNTER: SELLS HOSPITAL
SERVICE CATEGORY: AMBULATORY CLINIC: GENERAL
DATE LAST MODIFIED: OCT 14, 1998 CREATED BY USER: PARSONS,CHERYL

+ Enter ?? for more actions >>>>

+ NEXT SCREEN - PREVIOUS SCREEN Q QUIT

Select Action: +//

Type '+' to
scroll
forward and
'-' to scroll
backward in
display area.

The data entry operator may use this option to verify entry of various data items. When entering data while in another menu option (MIN, ENT), the **DHS mnemonic** can be used in lieu of the **HS menu option**. The DHS mnemonic functions in the same manner but eliminates the need to change menus. To review another type of health summary, enter the type (Pediatric, Immunization, Dental, etc.) after ADULT REGULAR//. A <RETURN> automatically accepts Adult Regular.

***** NO ALLERGY NOTED ON 11/29/98 *****

In order for allergies to print, allergy must be recorded as a problem, or NO KNOWN ALLERGIES with ICD-9 code 799.9 See problem section.

----- MEASUREMENT PANELS (max 5 visits or 2 years) -----

	HT	WT	BP	BMI	%RW	VU	VC
12/09/98	63						
12/02/98			120/80				
11/29/98		188	130/76	33.8	149%		20/20-20/40
09/16/98			134/86				
08/07/98		333	140/90	59.8	264%		

----- REPRODUCTIVE HISTORY -----

G2P2 (obtained 11/29/98) LMP <not recorded>

----- ACTIVE PROBLEMS -----

	ENT.	MODIFIED	
SE1SE1	SE1	08/06/92 12/09/98	DIABETES TYPE 2 (onset 06/88)
SE1SE1			HOME GLUCOSE MONITORING
SE1.1	11/18/98 12/09/98		DIABETIC FOOT ULCER (onset 02/98)
SE3	02/13/91 12/09/98		RHEUMATOID ARTHRITIS
SE3SE1			RA REACTIVE
SE5	11/29/98 11/29/98		NO KNOWN ALLERGIES (onset 12/04/98)

ICD-9 code
799.9 used to
document NO
KNOWN

----- INACTIVE PROBLEMS -----

	ENT.	MODIFIED	
SE2	02/18/89 12/09/98	S/P D& C FOR MENOMETRORRHAGIA	

----- HISTORY OF SURGERY -----

01/01/80	TONSILLECTOMY
----------	---------------

----- HEALTH FACTORS -----

-- Tobacco use --
11/29/98 PREVIOUS SMOKER

----- CURRENT MEDICATIONS (max 1 year) -----

12/01/98	IBUPROFEN 400MG TAB 40S # (30 days) -- Ran out 12/31/98
11/29/98	CAPTOPRIL 50MG TABS # (30 days) -- Ran out 12/29/98

----- HOSPITALIZATION STAYS (max 5 visits or 5 years) -----

04/30/96-05/07/96	SELLS HOSP PYELONEPHRITIS, UNKNOWN ORGANISM
-------------------	---

----- OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) -----

12/09/98	SELLS HOSP GEN	DIABETES TYPE 2
12/02/98	SELLS HOSP GEN	MED REFILLS
01/29/98	SELLS HOSP GEN	CELLULITIS OF LEFT KNEE

----- REFERRED CARE (max 10 visits or 2 years) -----

<<< RCIS REFERRALS >>>

No Referred Care Referral records on file.

----- MOST RECENT PATIENT EDUCATION (max 5 visits or 2 years) -----

01/08/97 SELLS HOSP DM-GENERAL INFORMATION - GOOD UNDERSTANDING

----- MOST RECENT RADIOLOGY STUDIES (max 10 visits or 5 years) -----

MAMMOGRAM BILAT (11/11/98) DIAGNOSTIC CODE: <none recorded>
IMPRESSION: NO EVIDENCE OF MALIGNANCY

----- MOST RECENT EXAMINATIONS -----

DIABETIC EYE EXAM	(11/29/98)
BREAST EXAM	(12/01/98) N
DIABETIC FOOT EXAM, COMPLETE	(12/09/98)

----- HEALTH MAINTENANCE REMINDERS -----

	LAST	NEXT
BLOOD PRESSURE	12/02/98	MAY BE DUE NOW
PAP SMEAR	10/09/98	Colposcopy (by 05/15/99)
REVIEW OF TOBACCO USE	11/29/98	11/29/99
DM CHOLESTEROL	10/09/98	10/09/99
DM URINE PROTEIN	11/29/98	11/29/99
DM DENTAL EXAM	07/16/98	07/16/99

If the DIABETES STANDARD health summary is selected for patients that have had diabetes recorded on the problem list, a diabetes flow sheet will be appended to the health summary as shown below.

----- FLOWSHEETS (max 1 year) -----						
DIABETIC FLOWSHEET						
Wt.	DM Labs	BP	Foot Chk.	DM Meds	Pt Ed	

12/09/98 : 188	: HGBA1c= 12.4	: 166/92	: DIABETIC	: GLYBURIDE 5MG	: DM-NUTRITI	
:	:	:	: FOOT CHE	: BID	: ON (F)	

10/09/98 :	: CHOLESTEROL	:	:	:	:	:
:	: =164	:	:	:	:	:

The **FIND CHS ENTRY FOR A GIVEN AUTHORIZATION NUMBER (AUN)** menu option is used only if your facility is entering contract health care 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 will activate the CHS-PCC link which will cause 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: <?> <RETURN>

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> <RETURN>

This CHS entry has been entered with Authorization Number 9112312345

AUTHORIZING FACILITY: SELLS HOSPITAL/CLINIC

PATIENT NAME: MILLER, BETTY ANN

VISIT: MAR 21, 1998@12:00

AUTHORIZATION NO.: 9112312345

PAY STATS: FULL PAY

TOTAL CHARGES: 69.00

NO OF VISITS: 1

VENDOR: SMITH MD, THOMAS

PRESS 'RETURN' To Continue: <RETURN>

The **MERGE TWO VISITS ON SAME DATE (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 the 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 enter 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 entered for each visit.

The order to enter 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 entered **first** at the **Select 'From visit'** prompt.
- The visit with a more **complete Visit File** should be entered second at the **Select 'To' visit** prompt retaining the Time and/or CL data items already entered in the Visit File. An incomplete Visit File will replace a more complete Visit File if entered 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 re-entering data is through the Enter menu selection.

```
Select PATIENT NAME: <MILLER,BETTY ANN> <RETURN> F 062157 4662
Select 'From' visit.
Enter VISIT date: <0321> <RETURN> (MAR 21,1998)
PATIENT: MILLER,BETTY ANN 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> <RETURN>
Select 'To' visit.
PATIENT: MILLER,BETTY ANN 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> <RETURN>
```

FROM VISIT

```
~~~~~
----- VISIT FILE -----
VISIT/ADMIT DATE & TIME: MAR 21, 1998@12:00
DATE VISIT CREATED: MAR 21, 1998 TYPE: IHS
PATIENT NAME: MILLER,BETTY ANN
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: SMITH,ANN
-----V MED-----
MEDICATION: DIABINESE 250MG TAB  PATIENT NAME: MILLER,BETTY ANN
VISIT: MAR 21, 1998@12:00
~~~~~
```

~~~~~

VISIT/ADMIT DATE & TIME: MAR 21, 1998@14:00  
DATE VISIT CREATED: MAR 21, 1998 TYPE: IHS  
PATIENT NAME: MILLER,BETTY 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: SMITH,ANN USER LAST UPDATE: SMITH,ANN

TYPE: BP      PATIENT NAME: MILLER,BETTY ANN  
VISIT: MAR 21, 1998@14:00      VALUE: 130/70

PROVIDER: SMITH, ANDREW    PATIENT NAME: MILLER,BETTY ANN  
VISIT: MAR 21, 1998@14:00    PRIMARY/SECONDARY: PRIMARY  
AFF.DISC.CODE (c): 100AS

|                                                  |                                |
|--------------------------------------------------|--------------------------------|
| POV: 250.00                                      | PATIENT NAME: MILLER,BETTY 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                  |

## PROVIDER: SMITH, ANDREW PATIENT

~~~~~

VISIT/ADMIT DATE & TIME: MAR 21, 1998@14:00
DATE VISIT CREATED: MAR 21, 1998 TYPE: IHS
PATIENT NAME: MILLER,BETTY ANN
LOC. OF ENCOUNTER: SAN XAVIER HEALTH CENTER
SERVICE CATEGORY: AMBULATORY CLINIC: GENERAL
DEPENDENT ENTRY COUNT: 4 DATE LAST MODIFIED: MAR 21, 1998

TYPE: BP	PATIENT NAME: MILLER,BETTY ANN
VISIT: MAR 21, 1998@14:00	VALUE 130/70

PROVIDER: SMITH,ANDREW PATIENT NAME: MILLER,BETTY ANN
VISIT: MAR 21, 1998 @1400
AFF.DISC.CODE (c): 100AS

```

----- V POV -----
POV: 250.00                                PATIENT NAME: MILLER,BETTY ANN
VISIT: MAR 21, 1998@14:00                PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM)
----- V MED -----
MEDICATION: DIABINESE 250MG TAB          PATIENT NAME: MILLER,BETTY ANN
VISIT: MAR 21, 1998@12:00
~~~~~

```

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.

The **DELETE ALL DATA FOR A VISIT (DEL)** menu 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. **Delete should only be used if a visit is created in error.** If an operator enters the wrong patient for data entry and recognizes the error AFTER the Visit File is created, Delete could be used. The XIT mnemonic can also be used to delete visits entered in error while in a data entry menu (MINI, ENT). Refer also to Figure 4.1 Quick Out in chapter 4 for an explanation of an ERROR Visit.

```

Delete All Data For A Visit
Select PATIENT NAME: <4462> <RETURN>
MILLER,BETTY ANN F 06-21-57 4462
Enter VISIT date: <0403> <RETURN> (APR 03, 1990)
~~~~~
-----VISIT FILE-----
VISIT/ADMIT DATE & TIME: MAR 21, 1998@14:00
DATE VISIT CREATED: MAR 21, 1998 TYPE: IHS
PATIENT NAME: MILLER,BETTY ANN
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: MILLER,BETTY ANN
VISIT: MAR 21, 1998@1:00    PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 100999
----- V POV -----
POV: .9999    PATIENT NAME: MILLER,BETTY ANN
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> <RETURN> (YES)..
```

Always review the V files before responding Y(es). Once the delete is complete, the system returns to the DEU menu.

The **DATA ENTRY SUPERVISOR (SUP)** Options and Utilities 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.

The **BROWSE HEALTH SUMMARY (BHS)** menu option is similar to the Generate Health Summary option, except that rather than print the output to a printer or terminal, the output is displayed on the screen in a browser utility which allows the user to easily scroll forward and backward in the display to review various parts of the patients health summary. In addition, the user may process other commands allowed by the browser including searching for specific text which allows the user to jump to a particular part of the health summary display.

```
Select Data Entry Utilities Option: BHS <RETURN>Browse Health Summary
Select health summary type: ADULT REGULAR//<RETURN>

Select patient: <MILLER,SAL><RETURN>    MILLER,SALLY        F    SE100010
                                           SX100100

Patient's Chart Number is: 100010

...EXCUSE ME ... HOLD ON ...
```

```

OUTPUT BROWSER      Jan 29, 1999 10:38:11      Page:  2 of  7
PCC Health Summary for  MILLER,SALLY
+

** CONFIDENTIAL PATIENT INFORMATION -- JAN 28,1999 10:34 AM [AMH] **
***** MILLER,SALLY #100010 (ADULT REGULAR SUMMARY) pg 1 *****

----- DEMOGRAPHIC DATA -----

MILLER,SALLY          DOB: JAN 25,1951      48 YRS FEMALE no blood type
TOHONO O'ODHAM NATION OF ARIZONA  SSN: 000-35-0003
                                MOTHER'S MAIDEN NAME: MILLER,SOPHIA
(H) 602-555-0003 (W) 602-456-7890  FATHER'S NAME: MILLER,BARRY
SANTA ROSA (777 N. 33RD ST.,ALBUQUERQUE,NM,88776)

LAST UPDATED: NOV 10,1998      ELIGIBILITY: CHS & DIRECT

HEALTH RECORD NUMBERS: 100008 PHOENIX INDIAN MED CTR
                        100009 HIS IID
                        100010 SELLS HOSPITAL
                        100011 SAN XAVIER HEALTH CENTER

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

```

This portion of the display will change when actions are selected. <??> will provide list of all possible actions.

By pressing <RETURN> to accept the default '+' the display will scroll forward one page to display the next part of the health summary. If the user selects '-' at any time except the first screen, the display will scroll backward one page.

```

OUTPUT BROWSER      Jan 29, 1999 10:38:11      Page:  2 of 17
PCC Health Summary for  MILLER,SALLY

DESIGNATED PROVIDER: SHOTT,GEORGE

----- INSURANCE INFORMATION -----

INSURANCE      NUMBER  SUFF COV   EL DATE  SIG DATE  END DATE
AZ MEDICAID    000330003   1E    03/86

----- ALLERGIES -----

***** NO ALLERGY NOTED ON 11/29/98 *****

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

```

To jump forward in the health summary to the Problem List, the user would need to type SL for the search action, followed by a few characters of the word 'PROBLEM'.

```

Select Action: +// <SL><RETURN>  SL
Search for: PROB <RETURN>

      OUTPUT BROWSER      Jan 29, 1999 10:39:10      Page:  3 of  17
PCC Health Summary for MILLER,SALLY
+
----- ACTIVE PROBLEMS -----

      ENT.  MODIFIED
SE1      08/06/92 12/09/98 DIABETES TYPE 2 (onset 06/88)
SE1SE1    HOME GLUCOSE MONITORING - ACCUCHECK
SE1.1     11/18/98 12/09/98 DIABETIC FOOT ULCER (onset 02/98)
SE3       02/13/91 12/09/98 RHEUMATOID ARTHRITIS
SE3SE1    RA REACTIVE

+      Enter ?? for more actions      >>>

Find Next 'PROB'? Yes//<N><RETURN> NO

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

```

At any time the user may type '??' to get additional help regarding commands that are available. To exit the Browse Health Summary option, select Q to quit and press <RETURN>.

The **DISPLAY IHS CODING GUIDELINES (COD)** option will allow the operator 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 may be printed by selecting the PL action.

MOVE DATA ITEMS FROM ONE TO ANOTHER (MVD) This Data Entry Utilities menu option allows the operator 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 Purpose of Visit. 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.

An example of a good use for the MVD utility would be to move prescription entries which 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 he/she wants to confirm the move of each item. If the user answers NO, all of the 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:<ADAMS,SAM><RETURN>
ADAMS,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>
```

***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: ADAMS,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: RUBOUT,WILMA

USER LAST UPDATE: RUBOUT,WILMA

----- V DENTAL -----

SERVICE CODE: 2140 PATIENT NAME: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@12:00 NO. OF UNITS: 1

OPERATIVE SITE: PERMANENT SECOND MOLAR,MAND LEFT

SERVICE CODE: 0000 PATIENT NAME: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@12:00 NO. OF UNITS: 1

----- V PROVIDER -----

PROVIDER: GOLDEN,MELVIN PATIENT NAME: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@12:00 PRIMARY/SECONDARY: PRIMARY

AFF.DISC.CODE (c): 352MG

----- V POV -----

POV: V72.2 PATIENT NAME: ADAMS,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: ADAMS,SAMANTHA

End of visit display, <ENTER> to Continue

Enter the visit that the ITEMS WILL BE APPENDED TO

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: 4

Select one: <1><RETURN>

*** 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: ADAMS,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: RUBOUT,WILMA

USER LAST UPDATE: RUBOUT,WILMA

----- V MEASUREMENT -----

TYPE: HT PATIENT NAME: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@08:00 VALUE: 63

----- V PROVIDER -----

PROVIDER: CLARKE,CHARLES PATIENT NAME: ADAMS,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: ADAMS,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: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@08:00

EXAM CODE (c): 28

EXAM: DIABETIC EYE EXAM PATIENT NAME: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@08:00 RESULT: NORMAL

EXAM CODE (c): 29

----- V PATIENT ED -----

TOPIC: DM-NUTRITION PATIENT NAME: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@08:00 PROVIDER: MATSON,GLADYS

LEVEL OF UNDERSTANDING: FAIR INDIVIDUAL/GROUP: INDIVIDUAL

LENGTH OF EDUC (MINUTES): 20

CPT CODE (computed) (c): 99402

~~~~~

End of visit display, &lt;ENTER&gt; to Continue

## 1) MEDICATIONS

2) LAB TESTS

3) DENTAL

4) RADIOLOGY

5) MICROBIOLOGY

Choose WHICH DATA ITEM TO MOVE: (1-5): 5//&lt;1&gt;&lt;RETURN&gt; MEDICATIONS

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: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@12:00      SIG: T1C TID

Do you want to Move this Entry? Y//<RETURN>

\*\*\* 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: ADAMS,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: RUBOUT,WILMA

USER LAST UPDATE: RUBOUT,WILMA

----- V MEASUREMENT -----

TYPE: HT      PATIENT NAME: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@08:00      VALUE: 63

----- V PROVIDER -----

PROVIDER: CRANE,CHARLES      PATIENT NAME: ADAMS,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: ADAMS,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: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@08:00

EXAM CODE (c): 28

EXAM: DIABETIC EYE EXAM      PATIENT NAME: ADAMS,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: ADAMS,SAMANTHA

VISIT: DEC 09, 1998@08:00      SIG: T1C TID FPA

## APPENDIX A: SERVICE CATEGORIES

| CODE | NAME              | DESCRIPTION                                                                                                                                                                                                                                                                               |
|------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A    | Ambulatory        | A routine patient contact in the clinic or field where the patient or his/her representative is physically present.                                                                                                                                                                       |
| H    | Hospitalization   | A patient hospitalized for a period of time without interruption except by possible intervening leaves of absences.                                                                                                                                                                       |
| I    | In-Hospital       | A patient seen by a consultant while in the hospital, e.g., receiving physical therapy treatment during a Hospitalization.                                                                                                                                                                |
| C    | Chart Review      | Review of medical data from other sources without the patient's physical presence or consultation services provided at another facility without the patient's physical presence. A valid Purpose of Visit (POV) other than "Chart Review" must be present in the POV section of the form. |
| T    | Telecommunication | Review of medical data via a telecommunications device. A valid POV other than "Telecommunication" must be present in the POV section of the form.                                                                                                                                        |
| N    |                   | Not Found A field visit, generally by a PHN/CHN, to a patient's home and the patient is not found. A valid POV other than "Not Found" must be present in the POV section of the form.                                                                                                     |
| S    | Day Surgery       | Surgery performed on an outpatient basis without admitting the patient                                                                                                                                                                                                                    |
| O    |                   | Observation A patient admitted for observation. This stay should usually be no longer than 24 hours.                                                                                                                                                                                      |

|   |              |                                                                                                                                                                                                                                                                                                                                                         |
|---|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| E | Event        | Entry of historical data such as immunizations or skin test reading/results, and procedures. These types of data should be entered using the option NVD – Enter Non Visit Data if there is no valid POV present in the POV section of the form. This is the only Service Category which does NOT require a POV or PRV (Primary Provider) at entry time. |
| R | Nursing Home | When a provider goes to a nursing home to provide service.                                                                                                                                                                                                                                                                                              |

## APPENDIX B: CLINIC CODES

These Clinic codes are intended for organized clinics and MUST be recorded on the PCC Encounter Form for an ambulatory care visit when the visit is IHS, 638, Tribal or Tribal – Compacted, and the facility (location) code is between 0 and 49.

|                             |    |                          |    |
|-----------------------------|----|--------------------------|----|
| ALCOHOL AND SUBSTANCE ABUSE | 43 | MAMMOGRAPHY              | 72 |
| AUDIOLOGY                   | 35 | MEDICAL SOCIAL SERVICES  | 48 |
| CANCER CHEMOTHERAPY         | 62 | MEN'S HEALTH SCREENING   | 81 |
| CANCER SCREENING            | 58 | MENTAL HEALTH            | 14 |
| CARDIAC                     | 02 | NEPHROLOGY               | 49 |
| CASE MANAGEMENT SERVICES    | 77 | NEUROLOGY                | 37 |
| CAST ROOM                   | 55 | NIH CLINIC               | 46 |
| CHART REVIEW/RECORD MOD     | 52 | OBESITY                  | 15 |
| CHEST/TB                    | 03 | OBSTETRICS               | 16 |
| CHRONIC DISEASE             | 50 | OPHTHALMOLOGY            | 17 |
| COMPUTED TOMOGRAPHY         | 71 | OPTOMETRY                | 18 |
| CRIPPLED CHILDREN           | 04 | ORTHOPEDIC               | 19 |
| DAY TREATMENT PROGRAM       | 82 | OTC MEDICATIONS          | 78 |
| DENTAL                      | 56 | OTHER                    | 25 |
| DENTAL(THIRD PARTY)         | 99 | OUTPATIENT SURGERY       | 44 |
| DERMATOLOGY                 | 05 | PAIN REDUCTION           | 84 |
| DEVELOPMENTAL ASSESSMENT    | 61 | PEDIATRIC                | 20 |
| DIABETIC                    | 06 | PHARMACY                 | 39 |
| DIETARY                     | 67 | PHN CLINIC VISIT         | 45 |
| EDUCATION CLASSES           | 60 | PHYSICAL THERAPY         | 34 |
| EMERGENCY MEDICINE          | 30 | PLASTIC SURGERY          | 29 |
| EMPLOYEE HEALTH UNIT        | 68 | PODIATRY                 | 65 |
| ENDOCRINOLOGY               | 69 | POSTPARTUM               | 32 |
| ENT                         | 07 | RADIO CALL               | 54 |
| EPSDT                       | 57 | RADIOLOGY                | 63 |
| FAMILY PLANNING             | 08 | REHABILITATION           | 21 |
| FAMILY PRACTICE             | 28 | RETINOPATHY              | 64 |
| FETAL ALCOHOL SYNDROME      | 47 | RHEUMATOLOGY             | 38 |
| FOLLOW-UP LETTER            | 53 | SCHOOL                   | 22 |
| GENERAL                     | 01 | SPEECH PATHOLOGY         | 74 |
| GENERAL PREVENTIVE          | 27 | SUPPLIES                 | 42 |
| GENETICS                    | 73 | SURGICAL                 | 23 |
| GROUP SERVICES              | 09 | TEEN CLINIC              | 85 |
| GYNECOLOGY                  | 10 | TELEPHONE CALL           | 51 |
| HIGH RISK                   | 26 | TRIAGE                   | 79 |
| HOME CARE                   | 11 | ULTRASOUND               | 66 |
| HYPERTENSION                | 31 | URGENT CARE              | 80 |
| IMMUNIZATION                | 12 | UROLOGY                  | 75 |
| INDIRECT                    | 41 | VD                       | 59 |
| INFANT STIMULATION          | 40 | WELL CHILD               | 24 |
| INHALATION THERAPY          | 33 | WIC                      | 36 |
| INTERNAL MEDICINE           | 13 | WOMEN'S HEALTH SCREENING | 70 |
| LABOR AND DELIVERY          | 83 |                          |    |
| LABORATORY SERVICES         | 76 |                          |    |



**APPENDIX C: EXAMINATIONS**

|                              |    |
|------------------------------|----|
| ABDOMEN EXAM                 | 09 |
| AUDIOMETRIC SCREENIN         | 23 |
| AUDIOMETRIC THRESHOLD        | 24 |
| BREAST EXAM                  | 06 |
| CHEST EXAM                   | 07 |
| DENTAL EXAM                  | 30 |
| DIABETIC EXAM                | 22 |
| DIABETIC EYE EXAM            | 03 |
| DIABETIC FOOT CHECK          | 29 |
| DIABETIC FOOT EXAM, COMPLETE | 28 |
| EAR EXAM                     | 02 |
| EYE MUSCLE BALANCE EXAM      | 18 |
| GENERAL DEVELOPMENT EXAM     | 16 |
| GENERAL EXAM                 | 01 |
| HEARING EXAM                 | 17 |
| HEART EXAM                   | 08 |
| HERNIA EXAM                  | 10 |
| MOUTH EXAM                   | 04 |
| NECK EXAM                    | 05 |
| NEUROLOGICAL EXAM            | 11 |
| ORTHO EXAM                   | 12 |
| OTO EXAM                     | 21 |
| PELVIC EXAM                  | 15 |
| RECTAL EXAM                  | 14 |
| SCOLIOSIS SCREENING          | 27 |
| SEX DEVELOPMENT EXAM         | 20 |
| TONOMETRY                    | 26 |
| TYMPANOGRAM                  | 25 |
| VISION EXAM                  | 19 |



**APPENDIX D: IMMUNIZATIONS**

| <b>NAME</b>                     | <b>OTHER NAME</b> | <b>CODE</b> |
|---------------------------------|-------------------|-------------|
| A/NJ MONOVALENT FLU             | SWINE MONO        | 08          |
| A/VICT-A/NJ BIVAL FLU           | SWINE BIVA        | 09          |
| BCG                             | BCG               | 16          |
| CHOLERA                         | CHOLERA           | 13          |
| DIPHTHERIA, TETANUS & PERTUSSIS | DTP               | 03          |
| DIPHTHERIA, TETANUS & PERTUSSIS | DTP               | 42          |
| DIPHTHERIA-TETANUS (DT-PEDS)    | DT                | 34          |
| HEPATITIS A                     | HEP A             | 40          |
| HEPATITIS B                     | HEP B VAC         | 10          |
| HEMOPHILUS INFLUENZAE B PS      | HIB-PS            | 35          |
| HIBTITER (HIB PRP-CRM)          | HIBTITER          | 38          |
| INACTIVATED POLIO               | IPV               | 07          |
| INFLUENZA                       | INFLUENZA         | 12          |
| MEASLES                         | MEASLES           | 11          |
| MEASLES,RUBELLA (MR)            | MR                | 18          |
| MEASLES,MUMPS,RUBELLA (MMR)     | MMR               | 17          |
| MUMPS                           | MUMPS             | 15          |
| ORAL POLIO (TRIVALENT)          | OPV               | 06          |
| PEDVAXHIB (HIB PRB-OMP)         | PEDVAXHIB         | 39          |
| PNEUMONOCOCCAL                  | PNEUMO-VAC        | 19          |
| PROHIBIT (HIB PRP-D)            | PROHIBIT          | 37          |
| RABIES                          | RABIES            | 33          |
| RECOMBIVAX                      | RECOMBIVAX        | 36          |
| RUBELLA                         | RUBELLA           | 14          |
| SMALLPOX                        | SMALLPOX          | 01          |
| TETANUS DIPHTHERIA (ADULT)      | Td                | 02          |
| TETANUS TOXOID                  | TET TOX           | 04          |
| TYPHOID                         | TYPHOID           | 05          |
| TYPHUS                          | TYPHUS            | 32          |
| VARICELLA                       | VARICELLA         | 41          |
| YELLOW FEVER                    | YELLOW FEV        | 31          |



**APPENDIX E: SKIN TESTS**

| <b>NAME</b> | <b>CODE</b> |
|-------------|-------------|
| COCCI       | 23          |
| MONO-VACC   | 24          |
| PPD         | 21          |
| SCHICK      | 22          |
| TINE        | 20          |



## APPENDIX F: PCC AMBULATORY ENCOUNTER RECORD

| IHS-803-1A (10/96)             |         | PL 96-511 N.A.                                                            |                  | PCC AMBULATORY ENCOUNTER RECORD |                    |                         |                 |
|--------------------------------|---------|---------------------------------------------------------------------------|------------------|---------------------------------|--------------------|-------------------------|-----------------|
| Date                           | 01      | PROBLEM LIST UPDATE<br>(Enter Problem Numbers From Health Summary)        |                  |                                 | AFFIL.             | DIS.                    | INITIALS / CODE |
| Arrival Time                   | 1:00 AM | Remove                                                                    | Move to Inactive | Move to Active                  | PROVIDERS          |                         |                 |
| Clinic                         |         | SE3                                                                       | SE1              | SK2                             | PRIMARY PROVIDER   | 1                       | 01              |
| Appt.                          | Walk-in |                                                                           |                  |                                 |                    | 1                       | 01              |
|                                |         |                                                                           |                  |                                 | TEMP               | PULSE                   | RESP            |
|                                |         |                                                                           |                  |                                 |                    |                         | 16090           |
| CHIEF COMPLAINT                |         |                                                                           |                  |                                 | WT.                |                         | 203             |
| SUBJECTIVE/OBJECTIVE           |         |                                                                           |                  |                                 | HT.                |                         |                 |
|                                |         |                                                                           |                  |                                 | HEAD               |                         |                 |
|                                |         |                                                                           |                  |                                 | VISION-UNCORRECTED |                         |                 |
|                                |         |                                                                           |                  |                                 | R                  | L                       |                 |
|                                |         |                                                                           |                  |                                 | VISION-CORRECTED   |                         |                 |
|                                |         |                                                                           |                  |                                 | R                  | L                       |                 |
|                                |         |                                                                           |                  |                                 | ✓                  | ORDER                   | INITIALS        |
|                                |         |                                                                           |                  |                                 | ✓                  | HCT.                    |                 |
|                                |         |                                                                           |                  |                                 | ✓                  | UA                      | PB              |
|                                |         |                                                                           |                  |                                 | ✓                  | HCG                     |                 |
|                                |         |                                                                           |                  |                                 | ✓                  | BS-F/BS-R               | PB              |
|                                |         |                                                                           |                  |                                 |                    | CBC                     |                 |
|                                |         |                                                                           |                  |                                 |                    | Urine culture           |                 |
|                                |         |                                                                           |                  |                                 |                    | Throat culture          |                 |
|                                |         |                                                                           |                  |                                 |                    | Stool Culture           |                 |
|                                |         |                                                                           |                  |                                 |                    | STS                     |                 |
|                                |         |                                                                           |                  |                                 |                    | GC                      |                 |
|                                |         |                                                                           |                  |                                 |                    | PAP                     |                 |
|                                |         |                                                                           |                  |                                 | ✓                  | Pelvic                  | AAM             |
|                                |         |                                                                           |                  |                                 | ✓                  | Breast                  | AAM             |
|                                |         |                                                                           |                  |                                 |                    | Mammogram               |                 |
|                                |         |                                                                           |                  |                                 |                    | Rectal                  |                 |
|                                |         |                                                                           |                  |                                 |                    | Chest X-ray             |                 |
|                                |         |                                                                           |                  |                                 |                    | EKG                     |                 |
|                                |         |                                                                           |                  |                                 |                    | Soak                    |                 |
|                                |         |                                                                           |                  |                                 |                    | Hep B #                 |                 |
|                                |         |                                                                           |                  |                                 |                    | Hep A #                 |                 |
|                                |         |                                                                           |                  |                                 |                    | OPV #                   |                 |
|                                |         |                                                                           |                  |                                 |                    | DTP #                   |                 |
|                                |         |                                                                           |                  |                                 |                    | DT aP #                 |                 |
|                                |         |                                                                           |                  |                                 |                    | DT                      |                 |
|                                |         |                                                                           |                  |                                 | ✓                  | Td                      | PB              |
|                                |         |                                                                           |                  |                                 |                    | MMR #                   |                 |
|                                |         |                                                                           |                  |                                 |                    | Varicella               |                 |
|                                |         |                                                                           |                  |                                 |                    | Influenza               |                 |
|                                |         |                                                                           |                  |                                 |                    | Hib TITER/ActHIB #      |                 |
|                                |         |                                                                           |                  |                                 |                    | Pedvax HIB #            |                 |
|                                |         |                                                                           |                  |                                 |                    | Pneumo Vax              |                 |
|                                |         |                                                                           |                  |                                 |                    | PPD                     | mm              |
|                                |         |                                                                           |                  |                                 | ✓                  | Type of Decision Making |                 |
|                                |         |                                                                           |                  |                                 |                    | Straightforward         |                 |
|                                |         |                                                                           |                  |                                 |                    | Low Complexity          |                 |
|                                |         |                                                                           |                  |                                 |                    | Moderate Complexity     |                 |
|                                |         |                                                                           |                  |                                 |                    | High Complexity         |                 |
| OTHER TESTS/PROCEDURES ORDERED |         |                                                                           |                  |                                 |                    |                         |                 |
| PROBLEM LIST                   |         | PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)          |                  |                                 | Health Factors     |                         |                 |
| A-A-C                          | #       |                                                                           |                  |                                 |                    |                         |                 |
|                                |         | Elevated Blood Pressure                                                   |                  |                                 | Prov Smoker        |                         |                 |
|                                |         | Resolved Otitis Media                                                     |                  |                                 |                    |                         |                 |
| A                              | X       | Arthritis                                                                 |                  |                                 | Onset 2/97         |                         |                 |
| C                              | SE1     | Meningococcal Meningitis                                                  |                  |                                 |                    |                         |                 |
| REPRODUCTIVE FACTORS           |         | G 3 P 2 LC 2 SA 0 TA 1 LMP 06-20-97 FP METHOD Natural DATE BEGUN 03-21-97 |                  |                                 |                    |                         |                 |
| PROBLEM LIST NOTES             |         | STORE NOTE FOR PROB. X Follow-up Monthly                                  |                  |                                 | REMOVE NOTE #      |                         |                 |
| STORE NOTE FOR PROB.           |         | SX1 Glyburide 5mg                                                         |                  |                                 |                    |                         |                 |
| MEDICATIONS                    |         | MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION                 |                  |                                 |                    |                         |                 |
|                                |         | Cocci 5mm Reading PB                                                      |                  |                                 |                    |                         |                 |
| HR #                           |         | 4462 181-00-999 SSN #                                                     |                  |                                 |                    |                         |                 |
| NAME                           |         | Miller, Betty Ann                                                         |                  |                                 |                    |                         |                 |
| B DATE                         |         | 06-21-57 SEX F NAVAJO TRIBE                                               |                  |                                 |                    |                         |                 |
| RESIDENCE                      |         | Tucson                                                                    |                  |                                 |                    |                         |                 |
| FACILITY                       |         | SX 07-21-97 DATE                                                          |                  |                                 |                    |                         |                 |
|                                |         | REVISIT/ REFERRAL TO:                                                     |                  |                                 |                    |                         |                 |
|                                |         | PURPOSE:                                                                  |                  |                                 |                    |                         |                 |
|                                |         | INSTRUCTIONS TO PATIENT:                                                  |                  |                                 |                    |                         |                 |
|                                |         | SIGN RELEASE RECORDS                                                      |                  |                                 |                    |                         |                 |
|                                |         | PROV. SIGNATURE                                                           |                  |                                 |                    |                         |                 |