RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Management Reports User Manual

Version 2.0
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Preface

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

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

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

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1.0 Introduction

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

The following RPMS components comprise the PCC suite:

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

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

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

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

2.0 Release Notes

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

2.1 Designated Provider Specialty Management (BDP)

The following modifications apply to the BDP application:

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

2.2 PCC Data Entry (APCD)

The following changes apply to the APCD application.

Family History Modifications

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

2.2.1 Visit Re-Linker Log

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

2.2.2 Visit Delete/Merge Log

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

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

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

2.2.3 3M Present on Admission

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

2.2.4 Personal History (PHX)

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

2.2.5 Problem List Note Narrative Length

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

2.2.6 Provider Narrative Length

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

2.2.7 Patient Education (PED): Readiness to Learn

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

2.2.8 Asthma Control (ACON)

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

2.2.9 POV Stage

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

2.2.10 Problem List Classification Field

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

2.2.11 Reproductive Factors Mnemonics

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

2.3 PCC Health Summary (APCH)

The following changes apply to the APCH application.

2.3.1 Patient Wellness Handout Management

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

Menu

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

The following PWH components are available:

ACTIVITY LEVEL
ALLERGIES
ASK ME THREE QUESTIONS
BLOOD PRESSURE
CANCER SCREENING
CHOLESTEROL
DIABETES CARE
HEIGHT/WEIGHT/BMI
HIV SCREENING

IMMUNIZATIONS DUE
IMMUNIZATIONS RECEIVED
MEDICATIONS
PATIENT GOALS
QUALITY OF CARE TRANSPARENCY REPORT CARD

Two standard PWH types are distributed with this version:

- **Adult Regular:** contains all 14 components
- **Medication Reconciliation:** contains Medications and Allergies

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

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

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

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

2.3.3 Health Summary Component (New) for Patient Wellness Handout

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

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

Created a component to list all prescriptions for controlled substances.

2.3.5 Health Summary Component Modification: Lab

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

2.3.6 Health Summary Component Modification: Medication

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

2.3.7 Health Summary Component Modification: Family History

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

2.3.8 Health Summary Component Modification: Reproductive Factors

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

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

2.3.9 Reminder (New): Osteoporosis Screening

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

2.3.10 Reminder (New): Assessment of Function

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

2.3.11 Reminder Modification: Pap and Mammogram Reminders

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

2.3.12 Reminder Modification: Alcohol Screening

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

2.3.13 Reminder Modification: Adult MMR 2-DOSE Version

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

2.3.14 Reminder Modification: Diabetes Screening

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

2.3.15 Reminder Modification: Colorectal Scope/XRAY

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

2.3.16 Asthma Action Plan (New Report)

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

2.3.17 Problem List Display

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

2.3.18 Supplement Modifications: Asthma

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

2.3.19 Reminders and Best Practice Prompts Text Modifications

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

2.3.20 Best Practice Prompts Modifications

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

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

2.4 PCC Management Reports (APCL)

The following changes apply to the APCL application.

2.4.1 Activity Reports

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

- TSPR Time and Patient Services by Provider
- TSSU Time and Patient Services by Service Unit
- PPPR Primary Problem by Provider
- PPLO Primary Problem by Facility
- PPSU Primary Problem by Service Unit
- INPR Number of Individuals seen by Provider
- INSU Number of Individuals seen by Service Unit
- AGE Patient Services by Age and Sex
- TEN Top Ten Primary Diagnoses
- TSCR Time and Services by Provider for Chart Reviews

2.4.2 DEMO PATIENTS Report Filter

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

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

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

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

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

2.4.3 PGEN/VGEN Menus

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

2.4.4 PGEN/VGEN

Added the following new Select/Sort/Print options:

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

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

2.5 QMAN (AMQQ)

The following changes apply to the AMQQ application:

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

2.6 General Database (AUPN)

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

- **V Radiology**: Added field 1502 – FINDINGS to the V RADIOLOGY file. This field will be populated by the Procedure Workflow Tracking System (BTPW) when the software is deployed. (CR#239)
- **Personal History**: Added field .06 – MULTIPLE BIRTH? to the Personal History File. Patient Multiple Birth?: Yes/No/Unknown. (CR#244)
- **Personal History**: Added field .07 – MULTIPLE BIRTH TYPE to the Personal History file. Multiple Birth Type values: Twin, Unspecified (TU); Identical Twin (IT); Fraternal Twin (FT); Triplet (TR); Other Multiple (OTH). (CR#244)
- **Problem**: Expanded Note narrative to 160 characters. (CR#323)
- **Provider Narrative**: Expanded narrative to 160 characters. (CR#258)
- FAMILY HISTORY FAMILY MEMBERS: Created new file with the following fields (CR #199/CR #322):

  .01 - RELATIONSHIP
  .02 - PATIENT
  .03 - RELATION DESCRIPTION
  .04 - STATUS
  .05 - AGE AT DEATH
  .06 - CAUSE OF DEATH
  .07 - MULTIPLE BIRTH?
  .08 - MULTIPLE BIRTH TYPE

- FAMILY HISTORY: Modified the existing file (CR #199/CR #322):
  - Moved the Status field to the new FAMILY HISTORY FAMILY MEMBER file.
  - Added an asterisk (*) in front of the STATUS field to alert users that it will be going away.
  - Added field .09, which is a pointer to the Family History Family Member file.
  - Inactivated field .07 – Relationship.
  - Added new MULTIPLE BIRTH and MULTIPLE BIRTH TYPE fields. (CR#199)
  - Added CAUSE OF DEATH field, which is displayed if the STATUS field is DECEASED. (CR#199)
  - Added new AGE AT ONSET and AGE AT DEATH fields with the following choices:

    In Infancy
    Before age 20
    At age 20-29
    At age 30-39
    At age 40-49

At age 50-59
60 and older
Age Unknown

- Inactivated the numeric Diagnosis Onset Age field.
- Changed field .01 to allow only ICD Diagnosis codes V16*; V17*; V18*; and V19*. (CR#245)

- REPRODUCTIVE FACTORS: Implemented requested changes to Reproductive Factors fields.
  - Added and/or activated the following new fields: Full Term (previous request); Premature Births (previous request for Preterm Births); Ectopic Pregnancies; Multiple Births.
  - Inactivated Parity and Abortions/Miscarriages/Ectopic Pregnancies fields.
- V Telehealth: Created new file with the following fields:

  .01 - Primary Modality
  .02 - Patient Name
  .03 - Visit
  .04 - Originating Date/Time
  .05 - Service Date/Time
  .06 - Secondary Modality
  .07 - Case ID
  .08 - Originating Provider
  .09 - Requesting Provider
  .11 - Service Delivery
  .12 - Originating Visit
  .13 - Status Field
  .14 - Duration
  1101 - Comments
  1102 - Link To Case

2.6.1 Table Changes

- PCC RELATIONSHIPS: Created new table for Family History.
- TELEHEALTH: Created new tables for Modality and Service Category.
- EXAM: Inactivated the following exam codes: (CR#241)

  23 - Audiometric Screening
  08 - Heart Exam
  05 - Neck Exam

- HEALTH FACTORS: Modified the Health Factors file to display the category when a lookup is performed on the file, and to allow the user to type the category name to retrieve a list of health factors to choose from. (CR#255, CR#256, CR#217)

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

OLD NAME	NEW NAME
ASTHMA TRIGGER-AIR POLLUTANTS	AIR POLLUTANTS
ASTHMA TRIGGER-ANIMAL	ANIMAL
ASTHMA TRIGGER-COCKROACHES	COCKROACHES
ASTHMA TRIGGER-DUST MITES	DUST MITES
ASTHMA TRIGGER-EXERCISE	EXERCISE
ASTHMA TRIGGER-MOLD	MOLD
ASTHMA TRIGGER-POLLEN	POLLEN
ASTHMA TRIGGER-TOBACCO SMOKE	TOBACCO SMOKE
BARRIERS TO LEARN-BLIND	BLIND
BARRIERS TO LEARN-DEAF	DEAF
BARRIERS TO LEARN-DOESN’T READ ENGLISH	DOESN’T READ ENGLISH
BARRIERS-FINE MOTOR SKILLS DEFICIT	FINE MOTOR SKILLS DEFICIT
BARRIERS TO LEARN-HARD OF HEARING	HARD OF HEARING
BARRIERS TO LEARNING-INTERPRETER NEEDED	INTERPRETER NEEDED
BARRIERS TO LEARNING-NO BARRIERS	NO BARRIERS
BARRIERS TO LEARNING-VALUES/BELIEFS	VALUES/BELIEFS
BARRIERS TO LEARN-VISUALLY IMPAIRED	VISUALLY IMPAIRED
SELF MONITORING BLOOD GLUCOSE-NO	NO
SELF MONITORING BLOOD GLUCOSE-REFUSED	REFUSED
SELF MONITORING BLOOKD GLUCOSE-YES	YES
LEARNING PREFERENCE-DO/PRACTICE	DO/PRACTICE
LEARNING PREFERENCE-READ	READ
LEARNING PREFERENCE-SMALL GROUP	SMALL GROUP
LEARNING PREFERENCE-TALK	TALK
LEARNING PREFRENCE-VIDEO	MEDIA
RUBELLA IMMUNE	IMMUNE
RUBELLA NON-IMMUNE	NON-IMMUNE
RUBELLA STATUS INDETERMINATE	STATUS INDETERMINATE
TB-TX COMPLETE	TX COMPLETE
TB-TX INCOMPLETE	TX INCOMPLETE
TB-TX UNKNOWN	TX UNKNOWN
TB-TX UNTREATED	TX UNTREATED

Added the following Health Factors: (CR#234)

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

Inactivated the following Health Factors: (CR#234)

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

2.7 Other Changes

2.7.1 Asthma Severity Conversion

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

2.7.2 Taxonomies

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

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

- BAT ASTHMA LEUKOTRIENE MEDS (controller)
- BAT ASTHMA CONTROLLER NDC (controller)
- BAT ASTHMA INHLD STEROIDS NDC (controller)

2.7.3 New APIs for the VA Reminders

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

Each call is in the following format:

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

where

dfn = Patient DFN

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

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

The output of each call is in the following format:

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

where

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

piece 2 = date of last item found

piece 3 = text of item found

piece 4 = result

piece 5 = ien of visit on which item was found

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

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

The following APIs have been added:

Alcohol Screening	$$REMALSC^APCLAPIR
Depression Screening	$$REMDEPS^APCLAPIR
Assessment of Function	$$REMAOF^APCLAPIR
Blood Pressure	$$REMBP^APCLAPIR
Breast Exam	$$REMBRST^APCLAPIR
Cholesterol	$$REMCHOL^APCLAPIR

Dental Exam	$$REMDENT^APCLAPIR
Diabetes Screening	$$REMGLUC^APCLAPIR
Intimate Partner Violence Screening	$$REMIPVS^APCLAPIR
EPSDT Screening	$$REMEPSDT^APCLAPIR
Head Circumference	$$REMHC^APCLAPIR
Hearing Exam	$$REMHEAR^APCLAPIR
Height	$$REMHT^APCLAPIR
Influenza Immunization	$$REMFLU^APCLAPIR
Mammogram	$$REMMAMM^APCLAPIR
Osteoporosis Screening	$$REMOSTEO^APCLAPIR
Pap Smear	$$REMPAP^APCLAPIR
Pelvic Exam	$$REMPEVL^APCLAPIR
Physical Exam	$$REMPHYS^APCLAPIR
Pneumovax	$$REMPNEU^APCLAPIR
Rectal Exam	$$REMRECT^APCLAPIR
Rubella	$$REMRUBEL^APCLAPIR
TD	$$REMTD^APCLAPIR
Tobacco Screening	$$REMTOBS^APCLAPIR
Tonometry	$$REMTON^APCLAPIR
Visual Acuity Exam	$$REMVAE^APCLAPIR
Weight	$$REMWT^APCLAPIR

2.7.4 Family History Data Conversion

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

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

2.7.5 Reproductive History String Conversion

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

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

3.0 PCC Management Reports Menu

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

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

                             DEMO HOSPITAL

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

Select PCC Management Reports Option:
```

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

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

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

3.1 Queuing Output

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

To queue a job,

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

3.2 DEMO/TEST Patients

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

4.0 Patient Listings (PLST)

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

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

                             DEMO HOSPITAL

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

Select Patient Listings Option:
```

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

The asterisk (*) denotes that the report is instantaneous.

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

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

1. At the “Your choice” prompt, use one of the following to indicate how the report should be sorted. You can use one or more of the attributes.

   1 - Current Community
   2 - Patient Name

   - If you type 1 for current community, the system displays the “Do you want to sort by a particular Current Community?” prompt. Type **Y** or **N**.

     If **Y**, the system displays the “Which Current Community” prompt. Specify the community.

     The system then displays the “Within Current Community, want to sort by another attribute” prompt. Type **Y** or **N**. If you type **Y**, you will be asked for the attribute. The system lists the attributes that can be used to sort the report and asks if you want to sort by the particular attribute (the name of the attribute will show in the prompt); type **Y** or **N**.

   - If you type 2, the system displays the “Do you want to sort by a particular Patient Name?” prompt. Type **Y** or **N**.

     If **Y**, the system displays the “Which Patient Name” prompt; specify the patient name.

     The system the displays the “Within Patient Name, Want To Sort By Another Attribute?” prompt; type **Y** or **N**. If you type **Y**, you will be asked for the attribute. The system lists the attributes that can be used to sort the report and asks if you want to sort by the particular attribute (the name of the attribute will show in the prompt); type **Y** or **N**.

2. At the “Please enter a title for this report” prompt, specify the title of the report, or press Enter to use the default.

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

```
ACHI PATIENTS                      JAN 25,1995  15:10
PAGE 1
                   DATE OF
NAME               BIRTH        SEX        TRIBE OF MEMBERSHIP
-------------------------------------------------------------------
-------
CURRENT COMMUNITY:  ACHI
LAMBDA,MARY        JAN 1,1925   FEMALE     TOHONO O'ODHAM NATIO
SIGMA,BILL         MAY 1,1948   MALE       TOHONO O'ODHAM NATIO
OMEGA,THERESA      JAN 1,1939   FEMALE     TOHONO O'ODHAM NATIO
OMICRON,DAVID      1890         MALE       TOHONO O'ODHAM NATIO
LAMBDA,BILL        MAR 1,1962   MALE       TOHONO O'ODHAM NATIO
OMEGA,LISA         APR 1,1963   FEMALE     TOHONO O'ODHAM NATIO
LAMBDA,IRMA        JUN 1,1964   FEMALE     TOHONO O'ODHAM NATIO
PHIIII,BILL        MAR 1,1964   MALE       PIMA
BETAA,SAM          MAR 1,1928   MALE       NON-INDIAN BENEFICIA
PHIIII,JOHN        NOV 1,1966   MALE       TOHONO O'ODHAM NATIO
BETAB,SAM          OCT 1,1967   MALE       TOHONO O'ODHAM NATIO
THETA,LARRY        DEC 1,1958   MALE       TOHONO O'ODHAM NATIO
THETA,THERESA      JUN 1,1920   FEMALE     TOHONO O'ODHAM NATIO
BETAA,DENNIS       APR 1,1940   MALE       TOHONO O'ODHAM NATIO
-----------------
SUBCOUNT 14
```

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

Press ENTER to go to the next page of the report.

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

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

1. At the “Your choice” prompt, type one of the following to indicate how the report should be sorted. You can use one or more of the attributes.

   1 - DOB
   2 - Patient Name

   - If you specified DOB:

     At the “Start with what date” prompt, specify the beginning date of the date range.

     At the “End with what date” prompt, specify the ending date of the date range.

     At the “Within DOB, want to sort by another attribute” prompt, type **Y** or **N**. If you type **Y**, you will be asked for the attribute.

- If you specified Patient Name:

  At the “Do you want to sort by a particular patient name?” prompt, type **Y** or **N**. If you type **Y**, you will be asked to specify the particular patient name.

  At the “Within Patient Name, want to sort by another attribute? prompt, type **Y** or **N**. If you type **Y**, you will be asked to specify the attribute.

2. At the “Please enter a title for this report” prompt, specify the title of the report or press ENTER to use the default.

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

The following is the report by DOB.

```
PATIENT LISTING BY DATE OF BIRTH     JAN 26,1995 14:06       PAGE 1
NAME                              DOB                       CHART #
-------------------------------------------------------------------
LAMBDA,SARAH                      JAN 1,1944                77467
LAMBDA,MARTIN                     JAN 1,1944                99009
LAMBDA,THERESA                    FEB 1,1944                98775
LAMBDA,JIM                        FEB 1,1944                31382
RHOOOOOO,GEORGIE WAKEFIELD        FEB 22,1944               53466
LAMBDA,JAMES                      MAR 5,1944                90774
CHIII,SUSIE                       APR 8,1944                14495
GAMMA,DARLENE                     MAY 1,1944                21087
SIGMAAA,SALLY ANN                 MAY 14,1944               23545
OMEGA,THERESA                     JUN 1,1944                94867
OMICRON,DIANE                     JUL 1,1944                29574
COUNT  11
```

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

The following is the report by Patient Name:

```
PATIENT LISTING                       JAN 20,2009  11:52    PAGE 1
          NAME            DATE OF BIRTH                CHART #
-------------------------------------------------------------------

      AABETA,LEA JO                       09/05/1945  156368
          AABETA,MARVIN                   08/05/1958  136531
          ABBETA,ADONNA LYNN              08/13/1925  130495
          ABBETA,AMANDA                   06/08/1966  124730
          ABBETA,JAYDEN                   09/28/1929  147347
          ABBETA,LOWERY                   01/09/1997  151988
          ABBETA,ROBERT                   11/17/1962  149480
```

Figure 4-4: Example report by patient name

4.3 Living Patients by Multiple Demographic Variables (DEM)

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

1. At the “Your choice” prompt, use one or more of the following attributes (mandatory) for sorting the report:

   1 - DOB
   2 - SEX
   3 - CURRENT COMMUNITY
   4 - TRIBE
   5 - CLASSIFICATION/BENEFICIARY
   6 - ELIGIBILITY
   7 - PATIENT NAME

   If you use 2, 4, 5, 6, or 7, additional prompts are displayed.

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

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

```
  PATIENT LISTING BY COMMUNITY AND BIRTHDATE     JAN 26,1995 14:09
PAGE 1
NAME                  DOB       TRIBE OF MEMBERSHIP        COMMUNITY
-------------------------------------------------------------------
OMICRON,TANYA         08/15/35      TOHONO O'ODHAM NATIO       DEMO
THETA,LILY            08/11/36      TOHONO O'ODHAM NATIO       DEMO
GAMMA,SUSIE           04/08/44      TOHONO O'ODHAM NATIO       DEMO
SIGMAA,ANDREW         01/01/47      TOHONO O'ODHAM NATIO       DEMO
GARCIA,JOE FRANK      06/25/50      TOHONO O'ODHAM NATIO       DEMO
GAMMAAAA,JUDY         10/31/52      NON-INDIAN BENEFICIA       DEMO
NUUUUU,JERRY F        01/01/57      TOHONO O'ODHAM NATIO       DEMO
NUU,LARRY             04/17/59      NAVAJO TRIBE OF AZ,        DEMO
PIIIII,KAREN JEAN     03/04/63      DAKOTA (SIOUX)             DEMO
RHOOOO,CAMERON ANTHONY    07/22/63      GILA RIVER PIMA MARI
DEMO
BETA,JULIE PATRICIA   08/30/65      NON-INDIAN BENEFICIA       DEMO
SIGMA,BOB             01/01/77      NON-INDIAN BENEFICIA       DEMO
-----------------------------
SUBCOUNT 13
```

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

4.3.1 Estimated Run Time

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

4.4 Deceased Patients by Date of Death (DOD)

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

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

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

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

   If you choose D or O, additional prompts are displayed.

2. At the “Sort Report by” prompt, use one of the following:

   D - Date of Death
   H - HRN
   R - Terminal Digit HRN
   C - Community
   T - Tribe
   N - Patient Name

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

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

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

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

```
                            DEASEASED PATIENTS REPORT
                    Date of Death: Jan 01, 1801 - Jan 20, 2009

Patient Name             HRN    DOB        Age at DOD        Tribe
                                           Death
-------------------------------------------------------------------
SIGMAAAA,EDWIN           117204 11/25/1917   15   03/15/1933 DEMO
TRIBE, NM
  Underlying Cause of Death:
  Last Visit: 12/17/1932 DEMO INDIAN HOSPITAL  - AMBULATORY
  Last Inpatient Visit:
  Community of Residence: BIG COVE
GAMMAA,KENSEN WINTER     103600 07/07/1872   84   04/20/1957 DEMO
TRIBE, NM
  Underlying Cause of Death:
  Last Visit:
  Last Inpatient Visit: 05/19/1995 DEMO INDIAN HOSPITAL  -
HOSPITALIZATION
  Community of Residence: BIRDTOWN
THETAAAA,LINDA           100144 09/30/1896   69   06/15/1966 DEMO
TRIBE, NM
  Underlying Cause of Death:
  Last Visit:
  Last Inpatient Visit:
  Community of Residence: MURPHY

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

Figure 4-6: Example report for DOD option

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

4.5 Patient General Retrieval (PGEN)

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

This report will list or count patients based on selection criteria typed by the user. You will be asked, in three separate steps, to identify your selection criteria, what you wish displayed for each patient, and the sorting order for your list. You can save the logic used to produce the report for future use. If you design a report that is 80 characters or less in width, it can be displayed on your screen or printed. If your report is 81-132 characters wide, it must be printed, and only on a printer capable of producing 132 character lines. You can limit the patients in your report to pre-established Search Templates you have created in QMan, Case Management, or other RPMS tools. If your template was created in Case Management or in QMan, using Patients as the Search Subject, this is a Search Template of Patients.

When the list of items for selection, print, and sort are displayed to you in list manager, would you like them sorted alphabetically or in a predefined order? The predefined order is set by the software and is how the list has historically been displayed.

1. At the "What order would you like the Items displayed" prompts, use one of the following:

   P - Predefined Order (the original ordering
   A - Alphabetical Order
   G - Groups of Related items

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

2. At the "Select Patient List from" prompt, type one of the following:

   S - Search Template of Patients
   P - Search All Patients
   Q - Qman Search
   R - CMS Register of Patients

   To use a search template of patients, you will be prompted for the name of the template. After typing the name of the template, you will be presented with a print item selection list. Select items to print by following the directions in the corresponding section that follows.

   If you select to search all patients in the database, you will have the option of using report logic you saved from a previous report generated with PGEN. To use previously saved report logic, type the name you assigned to the report and press ENTER to run the report. If you are creating a new report, use the instructions that follow for selecting search criteria.

   Choosing Q-Man Search will transfer you to Q-Man to create a search template. (Refer to the Q-Man user manuals for specific instructions on using Q-Man.) After you create the template you will be returned to PGEN to select the type of report desired. Continue to create the report according to the following directions.

   Choosing the CMS Register of patients will allow you to access the case management system's register system.

3. At the "Do you want to use a previously defined report?" prompt, type **Y** or **N**. If you type **Y**, additional prompts are displayed.

4. The system displays the Patient Selection menu.

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

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

1) Name/Chart #/SSN        31) Medicaid Plan Name     61) Most Recent STAGED DM
2) Sex                     32) Pvt Ins Plan Name      62) Most Recent Barriers H
3) Date of Birth           33) Priv Ins Verified      63) Most Recent LEARNING P
4) Birth Month             34) HRN Record Status      64) Most Recent RUBELLA HF
5) Birth Weight (grams)    35) HRN Disposition        65) Date Last Alcohol Scre
6) Birth Weight (Kgs)      36) Patient's Last Visit   66) Date Last Depression S
7) Race                    37) Desig Prim Care Prov   67) Date Last IPV/DV Scree
8) Age                     38) User Updating PCP      68) Date Last Colonoscopy
9) Age in Months           39) Date PCP Updated       69) Date Last Flex Sig
10) Veteran Status Y/N     40) EDC                    70) Date Last Mammogram
11) Date of Death          41) Date EDC Determined    71) Date Last PAP Smear
12) Date Patient Establish 42) Contraception Method   72) Date Last Tobacco Scre
13) Mlg Address-State      43) EDC Determination      73) Date Last Fall Risk As
14) Mlg Address-Zip        44) Last Menstrual Period  74) Date Last Tonometry

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

Figure 4-7: Options on the Patient Selection Menu

You can select patients based on as many of the items shown on the menu, in any order or in any combination. After you specify the items, an asterisk will indicate the items already selected.

Otherwise, you can bypass this screen by specifying the action Quit Item Selection (Q). This action selects all patients.

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

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

The total count report prints only the total number of patients that match the selection criteria you chose.

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

The Cohort/Template Save option saves the patients that match your selection criteria in a template. Only the total number of matching patients is displayed. You can then use the template for generating reports and select the print and sort criteria that you need each time.

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

The Delimited Output File option allows you to generate a file for use in Microsoft Excel.

6. The system displays the Print Item Selection Menu.

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

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

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

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

Select the items to appear on the report.

After selecting an item, the system asks to enter the column width for the item (a default is shown). Press Enter to select the default or specify the width.

7. The system displays the Sort Item Selection menu.

```
GENERAL RETRIEVAL     Jan 20, 2009 13:15:53                    Page:    1 of 2

                         SORT ITEM SELECTION MENU

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

1) Patient Name         29) Cause of Death         57) Most Recent ALCOHOL HF

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

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

Figure 4-9: Options on the Sort Item Selection menu

You can specify how to sort the patients by selecting one of the options.

If you want to sort the patients by name, type **Q** for quit item selection.

8. At the “Do you want a separate page for each Patient Name” prompt, type **Y** or **N**.

9. At the “Would you like a custom title for this report?” prompt, type **Y** or **N**. If **Y**, specify the custom title.

10. At the “Do you wish to save this search/print/sort logic for future use?” prompt type **Y** or **N**. If **Y**, you are asked for a name.

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

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

12. At the “Select one of the following” prompt, type **P** to print the output or **B** to browse the output on the screen.

The system display the Summary Page showing the criteria you selected for the report; for example,

```
            PCC PATIENT LISTING    Page 1
NAME                   DOB           WT (GMS)
--------------------------------------------

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

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

Figure 4-10: Example report for PGEN option

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

- If you are not on the last page, type plus (+) to view the next screen
- If you are not on the first page, type minus (-) to view the previous screen
- Type **Q** to quit the report

4.6 Patient Listing by Primary Care Provider (DP)

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

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

```
DESIGNATED PROVIDER PATIENT LISTING  APR 3,1996  10:41 AM     PAGE 1

CURRENT

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

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

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

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

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

```
Page 1
DEMO HOSPITAL/CLINIC
PATIENTS BY DESIGNATED PROVIDER, WITH VISIT COUNTS
DESIGNATED PROVIDER: SIGMA,JANE
VISIT DATES: OCT 01, 1993 TO JUN 30, 1994

                           TIMES OTHER
                           SEEN  PROVIDERS
PATIENT NAME   CHART #  AGE  BY DP SEEN            ICD DIAGNOSES
-----------------------------------------------------------------
KAPPA,JAMES   100000   24     0  SMITH,JANE (1)  250.00 - DM
UNCOMPL/T-II/

KAPPA,LISA    200000   61     1  SIGMA,JA (8)    .9999 - UNCODED
DIAGNOSIS
                          SIGMA,JA (17)   099.9 - VENEREAL DISEASE
                          SIGMA,JA (1)    250.00 - DM UNCOMPL/T-II/
                          SIGMA,JA (1)    293.82 - ORGANIC HALLUCIN
                          SIGMA,JA (1)    295.24 - CATATONIA-CHR/EX
                                          296.21 - DEPRESS PSYCHOSI
                                          300.9 - NEUROTIC DISORDER
                                          305.90 - DRUG ABUSE NEC/M
                                          311. - DEPRESSIVE DISORDE
                                          401.9 - HYPERTENSION NOS
                                          465.9 - ACUTE URI NOS
                                          719.40 - JOINT PAIN-UNSPE
RUN TIME (H.M.S): 0.0.03
```

Figure 4-12: Sample of report with visit counts

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

Use the DMG option to search the Patient file for all patients you select. A report will be created resembling the output from the R-DMG-510 report from the data center.

You will asked to select which facility's chart number should be displayed in the report.

Two additional screens will also be displayed: the first screen allows the user to search for a selected group of patients and the second screen allows the user to sort the report output as desired.

You will be asked if you want to continue; if you respond **Y** the prompts start. (Otherwise, if you respond **N**, you leave the option.)

Follow these steps:

1. At the “Run report for patients registered at which Facility” prompt, specify the name of the facility.

   The system displays information about the facility and displays the General Retrieval window with the Patient Selection menu.

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

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

1) Name/Chart #/SSN        31) Medicaid Plan Name     61) Most Recent STAGED DM
2) Sex                     32) Pvt Ins Plan Name      62) Most Recent Barriers H
3) Date of Birth           33) Priv Ins Verified      63) Most Recent LEARNING P
4) Birth Month             34) HRN Record Status      64) Most Recent RUBELLA HF
5) Birth Weight (grams)    35) HRN Disposition        65) Date Last Alcohol Scre
6) Birth Weight (Kgs)      36) Patient's Last Visit   66) Date Last Depression S
7) Race                    37) Desig Prim Care Prov   67) Date Last IPV/DV Scree
8) Age                     38) User Updating PCP      68) Date Last Colonoscopy
9) Age in Months           39) Date PCP Updated       69) Date Last Flex Sig
10) Veteran Status Y/N     40) EDC                    70) Date Last Mammogram
11) Date of Death          41) Date EDC Determined    71) Date Last PAP Smear
12) Date Patient Establish 42) Contraception Method   72) Date Last Tobacco Scre
13) Mlg Address-State      43) EDC Determination      73) Date Last Fall Risk As
14) Mlg Address-Zip        44) Last Menstrual Period  74) Date Last Tonometry

+         Enter ?? for more actions

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

Figure 4-13: Options in the Patient Selection menu

2. You can select patients based on as many of the items shown on the menu, in any order or in any combination. After you specify the items, an asterisk will indicate the items already selected.

   Otherwise, you can bypass this screen by typing Q at the “Select Action” prompt. This action selects all patients.

The system displays the General Retrieval screen for Sort Item Selection menu.

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

                         SORT ITEM SELECTION MENU

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

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

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

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

3. You can specify one item by which to sort the selected patients. Otherwise, type **Q** (Quit Item Selection) to sort the report by patient name.

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

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

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

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

BIRTH                BLOOD --- ELIGIBILITY ---

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

Figure 4-15: Sample of DMG report

4.9 Deceased Patients Listing (DPL)

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

1. At the “Enter beginning Date of Death” prompt, specify the beginning DOD.
2. At the “Enter ending Date of Death” prompt, specify the ending DOD.
3. At the “List patients who are members of” prompt, type one of the following:

   O - One particular Tribe
   A - All tribes
   S - Selected Set of Tribes (Taxonomy)

   If you type **O** or **S**, additional prompts are displayed.

4. At the “Sort Report by” prompt, type one of the following:

   D - Date of Death
   H - HRN
   R - Terminal Digit HRN
   C - Community
   T - Tribe
   N - Patient Name

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

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

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

```
XXX                          Jan 20, 2008                       Page 1
DEMO HOSPITAL

DEACEASED PATIENTS REPORT
Date of Death: Jun 02, 2007 - Mar 28, 2008

Patient Name             HRN    DOB        Age at DOD        Tribe
                                           Death
-------------------------------------------------------------------
SIGMA,JOHN              000000 12/01/1949   57    03/02/2007 DEMO TRIBE, NM
  Underlying Cause of Death:
  Last Visit: 04/03/1990 DEMO INDIAN HOSPITAL  - AMBULATORY
  Last Inpatient Visit: 01/23/1993 DEMO INDIAN HOSPITAL  - HOSPITALIZATION
  Community of Residence: SPRINGFIELD
```

Figure 4-16: Sample of DPL report

4.10 Tally of Elder Patients with Functional Assessment (ELFA)

The ELFA report tallies by age/sex all patients who have had a functional assessment in a date range you specify. You will also specify the desired age range of patients. In order to determine the denominator or population of patients to review, you will be asked if you want patients who live a particular community or set of communities. In addition, you must specify the minimum number of times the patients have been seen in the three years prior to the end of your date range in order to be included in the report.

You will be given the opportunity to obtain a tally of patients only, or a tally and a list of the patients.

1. At the At the “Enter Beginning Visit Date” prompt, specify the beginning of the date range.

2. At the “Enter Ending Visit Date” prompt, specify the end of the date range.

3. At the “Enter an Age Range (e.g. 55-100, 55-75)” prompt, specify the age range of patients you want on the report.

4. At the “Review Patients Who Live In” prompt, type one of the following:

   O - One particular community
   A - All communities
   S - Selected Set of Communities (Taxonomy)

   If you type **O** or **S**, additional prompts are displayed.

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

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

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

```
      ********** CONFIDENTIAL PATIENT INFORMATION **********
XXX   Page 1
DEMO HOSPITAL
PATIENTS WITH FUNCTIONAL ASSESSMENT DOCUMENTED
between Dec 19, 2007 and Mar 28, 2008
All Communities
-----------------------------------------------------------------
            FEMALES              MALES                TOTAL
          #     N    %       #      N    %       #     N     %

        ------------------  ------------------  ----------------

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

Figure 4-17: Example DPL report

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

4.11 Tally of Elder Care Functional Status Change (ELFC)

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

```
              ********** CONFIDENTIAL PATIENT INFORMATION **********
XXX                                                                Page 8
DEMO HOSPITAL
PATIENTS WITH CHANGE IN FUNCTIONAL ASSESSMENT DOCUMENTED
between Jun 02, 2007 and Mar 28, 2008
-------------------------------------------------------------------
         # OF            IMPROVED            SAME            DECLINED
AGE     PATIENTS         #      %          #       %         #       %
  ------------       -------------      -------------
  79       -            -      -          -       -         -    -
  80       -            -      -          -       -         -    -
  81       -            -      -          -       -         -    -
  82       -            -      -          -       -         -    -
  83       -            -      -          -       -         -    -
  84       -            -      -          -       -         -    -
  85      1            0   0.0           0    0.0          1  100.0
  86       -            -      -          -       -         -    -
  87       -            -      -          -       -         -    -
  88       -            -      -          -       -         -    -
  89       -            -      -          -       -         -    -
  90       -            -      -          -       -         -    -
```

Figure 4-18: Example of an ELFC report

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

After pressing Enter, the following data displays, showing a list of patient with a documented decline in functional status.

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

Figure 4-19: Example last page of report

4.12 Tally of Elder Care Data Items (ELFT)

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

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

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

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

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

Figure 4-20: Sample of ELFT report

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

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

4.14 Infant Feeding Statistical Reports (IF)

There are two reports that can be run from this option: IF1 and IF2.

4.14.1 Birth and Six-Month Breastfeeding Statistics (IF1)

The IF1 option will produce a report of how many infants were documented as being breast fed at birth and at age 6 months. You will select the “as of” date (report end date) and the communities on which you want to report. The report first identifies all patients ages 12-23 months in the “as of” date you defined. The report calculates which infants to report on from this initial population.

- Birth breastfeeding statistics:
- Denominator: Number of infants with a visit. Patients who had at least one visit to a primary care clinic between birth and 6 months (ages 1-179 days old).
- Numerators:
  - Infants with feeding data. Any patient with a visit with any infant feeding choice documented between birth and 6 months (0-179 days old)
  - Infants breastfeeding. Of the patients with feeding data (numerator #1), those with *any* infant feeding choice that includes breastfeeding (e.g., *not* formula only). The report sorts chronologically at all visits in the time frame with feeding documentation and counts the patient as meeting the numerator as soon as the first feeding choice is found that includes breastfeeding.
- Six-month statistics: same as Birth, except the visits reviewed are those that occurred between ages 180-365 days.

```
   XXX                    Jan 20, 2009                        Page 1
                            DEMO HOSPITAL

              INFANT BREASTFEEDING STATISTICS, as of Jan 01, 1958
                   Patients born Dec 31, 1957 - Jan 01, 1958
-------------------------------------------------------------------

                               DEMO HOSPITAL          HP 2010   NATIONAL  2003
                                                    USA RATE  AI/AN
                      #         %            %         %         %

BREASTFEEDING AT BIRTH

  w/visit              0
  w/data recorded      0       0.0
  Breastfeeding        0       0.0          75%       71%       69%

BREASTFEEDING AT 6 MONTHS

  w/visit              0
  w/data recorded      0       0.0
  Breastfeeding        0       0.0          50%       36%       32%

End of report.  PRESS ENTER:
```

Figure 4-21: Example of IF1 report

4.14.2 Breastfeeding Statistics by Age Group (IF2)

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

Birth breastfeeding statistics:

- Denominator: Number of infants with a visit. Patients who had at least one visit to a primary care clinic between birth and 6 months (ages 1-179 days old).
- Numerators:
  - Infants with feeding data. Any patient with a visit with any infant feeding choice documented between birth and 6 months (0-179 days old)
  - Infants breastfeeding. Of the patients with feeding data (numerator #1), those with *any* infant feeding choice that includes breastfeeding (e.g., *not* formula only). The report sorts chronologically all visits in the time frame with feeding documentation, and counts the patient as meeting the numerator as soon as the first feeding choice is found that includes breastfeeding.
- Six-month statistics. Same as Birth, except the visits reviewed are those that occurred between 180-365 days old.

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

```
DEMO HOSPITAL

INFANT BREASTFEEDING STATISTICS, as of Dec 23, 2006
Patients born Dec 22, 2005 - Dec 23, 2006
-------------------------------------------------------------------

                            DEMO HOSPITAL  HP 2010   NATIONAL   2003
                                                     USA RATE   AI/AN
                              #     %         %         %         %
-------------------------------------------------------------------

BREASTFEEDING AT BIRTH

  w/visit                   67
  w/data recorded           11     16.4
  Breastfeeding             8      72.7      75%       71%       69%

BREASTFEEDING AT 6 MONTHS

  w/visit                   80
  w/data recorded           7      8.8
  Breastfeeding             3      42.9      50%       36%       32%
```

Figure 4-22: Example of IF2 report

4.15 Prescription Cost Report (PCR)

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

4.16 Tally of Patient Internet Access (PINT)

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

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

Total # of Patients                                  7,949

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

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

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

Figure 4-23: Example portion of PINT report

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

The SCR option prompts you to choose from the following suboptions: IPV/DV reports, alcohol screening reports, and depression screening reports.

The IPV/DV menu contains several options:

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

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

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

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

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

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

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

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

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

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

The alcohol screening menu contains several options:

- **Tally/List Patients with ALCOHOL Screening (DVP)**: This report will tally and optionally list all patients who have had alcohol screening (Exam Code 35) or a refusal documented in the time frame specified by the user. This report will tally the patients by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

- **Tally/List ALCOHOL Screenings (DVS)**: This report will tally and optionally list all visits on which alcohol screening (Exam code 35) or a refusal was documented in the time frame specified by the user. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

- **List Alcohol Screenings for Selected Patients (SSP)**: This report will list all patients you select who have had alcohol screening (Exam Code 35) or a refusal documented in a specified time frame. You will select the patients based on age, gender, result, provider, or clinic where the screening was done.

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

- **Tally/List Pts in Search Template w/Alcohol Screening (PST)**: This report will tally and list all patients who are members of a user-defined search template. It will tally and list their latest alcohol screening (Exam Code 35) or a refusal documented in the time frame specified by the user. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

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

- **Tally/List Alcohol Screenings for Template of Pts (VST)**: This report will tally and optionally list all visits on which alcohol screening (Exam Code 35) or a refusal was documented in the time frame specified by the user. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

The depression screening menu contains several options:

- **Tally/List Patients with Depression Screening (DVP)**: This report will tally and optionally list all patients who have had depression screening (Exam Code 36) or a refusal documented in the time frame specified by the user. This report will tally the patients by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

```
   XXX                      Jan 20, 2009                  Page 1

   ***  DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Jul 24, 2008 to Jan 20, 2009
                 This report excludes Behavioral Health Clinics
                            All Facilities/Locations
                            All Patient Communities

                                     DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
-----------------------------------------------------------------

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

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

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

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

- **Tally/List Depression Screenings (DVS)**: This report will tally and optionally list all visits on which depression screening (Exam Code 36) or a refusal was documented in the time frame specified by the user. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

- List Depression Screenings for Selected Patients (SSP): This report will list all patients you select who have had depression screening (Exam Code 36) or a refusal documented in a specified time frame. Select the patients based on age, gender, result, provider, or clinic where the screening was done.

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

- **Tally/List Patients in Search Template w/ Depression Screening (PST)**: This report will tally and list all patients who are members of a user-defined search template. It will tally and list their latest depression screening (Exam Code 36) or a refusal documented in the time frame specified by the user. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

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

- **Tally/List Depression Screenings for Template of Patients (VST)**: This report will tally and optionally list all visits on which depression screening (Exam Code 36) or a refusal was documented in the time frame specified by the user. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

4.18 Suicide Form Data Reports (SUIC)

There are two reports available.

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

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

DEMO HOSPITAL         Jan 20, 2009                       Page 1

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

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

REPORT TOTALS

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

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

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

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

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

- If you are not on the last page, type + to view the next screen.
- If you are not on the first page, type - to view the previous screen.
- Type Q to quit the report.

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

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

```
   SJT                        Jan 20, 2009                  Page 1
                                 DEMO HOSPITAL

                HOUSEHOLD INCOME/NUMBER IN HOUSEHOLD TALLY

Patient Name    HRN    BENI COMMUNITY ZIP   TRIBE    # IN    TOTAL
                  FICI                              HOUSE   HOUSEHOLD
                  ARY                               HOLD    INCOME
-----------------------------------------------------------------
ALPHAAAAAAA,DAVID BR  102982  01  BIG COVE  28719 DEMO TRIBE   2  0
ALPHAAAAA,MARTHA AGN  100881  01  SOUTH CAR 29356 DEMO TRIBE   2  0
ALPHAAAAA,MICHAEL A   121082  01  PAINTTOWN 28719 DEMO TRIBE   6  0
ALPHAAAA,CAROL ANN    100351  01  BIRDTOWN  28719 DEMO TRIBE   1  0
ALPHA,MARGARET D      108025  01  VASSALBOR 28719 DEMO TRIBE   2  0
ALPHA,BARBARA         119344  01  BIRDTOWN  28719 DEMO TRIBE   1  0
ALPHA,DANI SUE        165877  01  BETHEL    74724 CHOCTAW NA   6  0
ALPHA,FREDIA ANN      122649  01  MARBLE    28905 DEMO TRIBE   4  0
ALPHA,GREGORY PAUL    103558  01  BIRDTOWN  28719 DEMO TRIBE   5  0

ALPHA,JAKELI BRADFOR  118981  01  WHITTIER  28789 DEMO TRIBE   5  0
ALPHA,JOSEPHINE       124463  01  NORTH CAR 28761 DEMO TRIBE   2  0
ALPHA,JOSIE           122784  01  MURPHY    28906 DEMO TRIBE   3  0
ALPHA,TRISTA L        155765  01  BIRDTOWN  28719 DEMO TRIBE   3  0

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

Figure 4-26: Example THI report

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

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

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

/usr/spool/uucppublic/ or /usr/mumps/

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

MYFILE.TXT

5.0 Resource Allocation/Workload Reports (RES)

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

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

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

DEMO HOSPITAL/CLINIC

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

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

5.1 Estimated Run Time

These reports might have lengthy run times, depending on the parameters you specify. If you need assistance determining which reports to queue, please contact you local site manager.

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

The following reports are available from the Operations Summary menu.

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

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

Figure 5-2: Example of Operations Summary menu screen

5.2.1 Operations Summary (OS)

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

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

Follow these steps:

1. At the “Select operation summary type” prompt, specify the operation summary type for the report.
2. At the “Please identify your service unit” prompt, specify the SU for the report.
3. At the “Enter a code indicating what facilities/location are of interest” prompt, type one of the following codes:

   O - One particular Facility/Location
   S - All facilities with the unit
   T - A taxonomy or select set of facilities

   If you type **O** or **T**, additional prompts are displayed.

4. At the “Run report for” prompt, type one of the following:

   1 - A single month
   2 - Fiscal year
   3 - Date Range

   If you type **1** or **3**, additional prompts are displayed.

5. At the “Do you wish to exclude any diagnoses codes from the ambulatory section” prompt, type **Y** or **N**. If you type **Y**, other prompts will display. For example, to eliminate pharmacy refill diagnoses, you need to exclude V68.1 from the report.

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

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

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

The following sample report displays a Complete Operations Summary.

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

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

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

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

CONTRACT HEALTH SERVICES
Total CHS expenditures (obligations adjusted by payments) for this
period were $564,296 (+16%).  The number and dollar amount of
authorizations by type were:
  43 - Hospitalization          296    ( +2%)    $312,196   (+18%)
  57 - Dental                   351    ( +8%)    $ 80,500   ( -4%)
  64 - Non-Hospital Service   1,163    (+19%)    $171,600   (+15%)
```

```
DIRECT INPATIENT

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

The five leading primary diagnoses for hospitalizations were:

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

AMBULATORY CARE VISITS

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

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

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

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

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

By Clinic Type
      General               46,601    ( +7%)
      Audiology                250    (  0%)
      Well Child               440    (  0%)
```

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

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

       By ICD Diagnosis
 1  -  Upper Respiratory Inf.        4,722  ( +8%)
 2  -  Prenatal Care                 3,691  (-12%)
 3  -  Diabetes Mellitus             3,480  ( -9%)
 4  -  Otitis Media                  3,217  (+17%)
 5  -  Impetigo                      1,911  ( +3%)
 6  -  Complications of Pregnancy    1,271  ( -8%)
 7  -  Laceration                      862  ( -8%)
 8  -  Sprains/Strains                 490  (+11%)
 9  -  Rheumatoid Arthritis            487  ( +4%)
10  -  Gastroenteritis                 452  (-22%)

       By APC Grouping
 1  -  URI                           5,110  ( +4%)
 2  -  Diabetes Mellitus             3,890  (+10%)
 3  -  Influenza                     2,001  (-10%)
 4  -  Impetigo                      2,150  ( -4%)
 5  -  Prenatal Care                 1,200  ( +8%)
 6  -  Well Child Care               1,180  (-11%)
 7  -  Conjunctivitis                  850  (+17%)
 8  -  Physical Exams                  710  ( -2%)
 9  -  Anemia                          666  ( -2%)
10  -  Alcoholism                      652  ( +5%)

INJURIES

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

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

```
EMERGENCY ROOM

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

PHARMACY

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

DENTAL

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

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

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

5.2.2 List PCC Operations Summary Sections (SECT)

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

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

Figure 5-4: Example of SECT screen

5.2.3 Create/Edit Operations Summary Type (TYPE)

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

Begin by typing the name of the summary type you would like to create or the name of an existing summary type to edit. Then follow the prompts to specify the components of the summary type and indicate the order in which you want them to appear in your operations reports.

5.2.4 Display an Operations Summary Type (DISP)

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

The following sample shows the Complete Operations Summary type.

```
PCC MAN REPORTS OP SUM TYPE LIST        APR 11,1996    16:12 PAGE 1
-----------------------------------------------------------------

NAME: COMPLETE OPERATIONS SUMMARY
SUMMARY ORDER: 1            COMPONENT NAME: POPULATION/THIRD PARTY
SUMMARY ORDER: 2            COMPONENT NAME: CONTRACT HEALTH SERVICES
SUMMARY ORDER: 3            COMPONENT NAME: INPATIENT SERVICES
SUMMARY ORDER: 4            COMPONENT NAME: AMBULATORY
SUMMARY ORDER: 5            COMPONENT NAME: IN-HOSPITAL
SUMMARY ORDER: 6            COMPONENT NAME: PHARMACY
```

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

5.3 Registered Patients and Visits Report Types

1) RPVC Registered Patients and Visits by Community
2) RPVT Registered Patients and Visits by Tribe
3) RPVS Registered Patients and Visits by SU of Residence

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

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

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

Select which portions of the patient database are included in the report by responding to various questions at the beginning of the report generation. Help screens are available to assist you with responding to these questions. Definitions of the following are also available in help screens: Registered Patients, Patients Receiving a Service, PCC Services (All PCC Visits), APC Visits, PCP Visits.

This is a sample RPVC report.

```
DEMO HOSPITAL/CLINIC           FEB 5,1995                  Page 1
Registration and Visit Counts for all Patients Registered at
DEMO HOSPITAL/CLINIC Facility.
The report is sorted by Community of Residence. A '*' after the
Community name indicates a Non-Service Unit Community.
Visit Counts between SEP 1,1994 and DEC 31,1994.

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

Figure 5-6: Example of the RPVC report

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

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

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

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

Figure 5-7: Example Age Bucket report

5.5 Active Patient Count Report Types

1) ACC Active Patient Count by Community of Residence
2) ACS Active Patient Count by SU of Residence
3) ACT Active Patient Count by Tribe

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

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

The report can be sorted by Community of Residence, Tribe of Membership, or Service Unit of Residence, depending on the option you select.

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

This is a sample ACT report.

```
DEMO HEALTH CENTER                        FEB 5,1995         Page 1
Registration and Active Patient Counts for all Patients Registered
in DEMO Service Unit.

The report is sorted by Tribe of Membership.

Active Patients were those seen between OCT 01,1994 and FEB 5,1995.

Tribe of Membership              Reg Pts Living          Active
                                As of Today             Patients
-----------------------------------------------------------------
ALASKAN INDIAN                        1                       1
NON-INDIAN BENEFICIARY                1                       1
TOHONO O'ODHAM NATION OF ARIZONA     91                      61
                                  ------                  ------
                              Total:     93                      63
```

Figure 5-8: Example of ACT report

5.6 Community Health Profile Summary (CH)

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

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

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

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

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

```
                AGE/SEX Distribution as of Apr 19,  1996
 0-4   5-9  10-19 20-29 30-39 40-49 50-59 60-69 70-79 80 + TOTAL
-------------------------------------------------------------------
MALE    12   11   16   28   22   21   13      7     4    2   136
FEMALE  16   14   14   33   19   12   14      5     8    1   137
 TOTAL  28   25   30   61   41   33   27     12    13    3   273

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

The Top 15 Inpatient Diagnoses were:

LITTLE TUCSON                            DEMO Service Unit
-----------------------------------------------

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

The Leading Surgical Procedures were:

LITTLE TUCSON                            DEMO Service Unit
-----------------------------------------------
EXCISIONAL DEBRIDEMENT WO  (13)   EXCISIONAL DEBRIDEMENT WO   (402)
INJECT ANTIBIOTIC          (9)    INJECT ANTIBIOTIC           (140)
NAIL REMOVAL               (5)    VAGINOSCOPY                  (98)
INJECT/INFUSE ELECTROLYT   (3)    INJECT/INFUSE ELECTROLYT     (47)
DRESSING OF WOUND NEC      (2)    APPLICATION OF SPLINT        (38)
APPLICATION OF SPLINT      (1)    NAIL REMOVAL                 (30)
PACKED CELL TRANSFUSION    (1)    TOOTH EXTRACTION             (17)
```

```
The Top 10 Causes of Injury were:

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

The Top Dental Services were:

LITTLE TUCSON                            DEMO Service Unit
----------------------------------------------
PATIENT REVISIT              (54)    PATIENT REVISIT         (2311)
FIRST VISIT                  (44)    FIRST VISIT             (2062)
OTHER DRUGS/MEDICAMENTS      (36)    OTHER DRUGS/MEDICAMENTS (1004)
INTRAORAL PERIAPICAL, SIN    (26)    ORAL EXAMINATION, INITIAL(987)
ORAL EXAMINATION, INITIAL    (22)    INTRAORAL PERIAPICAL, SIN(977)

End of Report.   This report is based on visit data processed on the
DEMO HOSPITAL/CLINIC computer.

RUN TIME (H.M.S):  0.1.19
End of report.  HIT RETURN:
```

Figure 5-9: Example of CH report

5.7 Clinic Hourly Workload Report (CHWL)

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

- Visit Types

  Contract
  VA

- Visit Service Categories

  Chart Review
  In-Hospital
  Ancillary
  Hospitalizations
  Events
  Telecommunications
  Visits WITHOUT a Primary Provider and Purpose of Visit

The visits must have a Primary Provider and Purpose of Visit.

The report will be totaled by hourly time frames.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, specify the end of the date range.
3. At the “Select Facility” prompt, specify the name of the facility.
4. At the “Include visits from all clinics?” prompt, type **Y** or **N**. If **N**, specify the clinics to include.
5. At the “Would you like to restrict the report by Patient age range?” prompt, type **Y** or **N**. If you type **Y**, specify the age range.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

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

The following sample report is a workload report for the Emergency Medicine clinic from July 12 to July 14, 1996. The data reported includes patients from 1 to 18 years of age only. The facility selected is Demo Hospital and data for all providers is included.

```
CLINIC HOURLY WORKLOAD REPORT
LOCATION OF VISITS: DEMO HOSPITAL/CLINIC
CLINIC: EMERGENCY MEDICINE
VISIT DATES: JUL. 12, 1994 TO JUL 14, 1996
AGE RANGE: 1-18

DATE    DOW 12AM  1AM  2AM  3AM  4AM  5AM  6AM  7AM  8AM  9AM  10AM
11AM  12PM  1PM  2PM  3PM  4PM  5P  6P  7P  8P  9P  10P 11P  12P

07/12  MON           .         .         .         .         .
.          .         .       2         .          10        10
8        2      10      1         .         .     .     .     .    .
.     .       .
07/13  TUE           .         .         .         .         .
.          .         .        1         .          10        10
8        2      10      1         .         .     .     .     .    .
.     .       .
07/14  WED          .         .         .         .         .
.          .         .        1         .          10        10
8        2      10      1         .         .     .     .     .    .
.     .       .
TOTALS                 .         .         .         .         .
.          .         .        4         .          30        30
24        6       30      3         .         .     .     .     .
.        .     .       .
```

Figure 5-10: Example of hourly workload report

5.8 Inpatient Discharges/Days by Community (INPC)

Use the INPC option to produce a report of inpatient counts in a specified discharge date range by community. This option will search the Patient file for all patients registered at the SU or the facility you select. The report will be sorted by Community of Residence. This report will supply the following tallies:

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

Follow these steps:

1. At the “Do you wish to include only INDIAN patients?” prompt, type **Y** or **N**.

2. At the “Starting Discharge Date for Inpatient Counts” prompt, specify the start of the date range.
3. At the “Ending Discharge Date for Inpatient Counts” prompt, specify the end of the date range.
4. At the “Do you wish to Sub-Total by Tribe?” prompt, type **Y** or **N**.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

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

Current Community of    # Adult # Adult # NB   # NB   # TX   # MCR
# MCD # PI residence     /Peds   /Peds   Dsch   Days   IN
           Dsch    Days                       Tribe of Membership
-------------------------------------------------------------------
32-HNDRD ACR *

 CHEROKEE NATION OF O   6     36    0    0      0    2    1      1
 DEMO TRIBE, NM        30     95    0    0      0    9    2      6

 -------------------------------------------------------
 Subtotal:       36    131      0    0    0     11    3      7

ALMOND *

 DEMO TRIBE, NM         2      7    0    0      0    0    0      0
 NON-INDIAN BENEFICIA   2      6    0    0      0    0    0      0

 -------------------------------------------------------
Subtotal:        4     13      0      0      0      0      0      0
```

Figure 5-11: Example of INPC report

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

Use the INPS option to produce a report of inpatient counts in a specified discharge date range by service unit. This option will search the Patient file for all patients registered at the SU or the facility that you select. The report will be sorted by SU of Residence. This report will supply the following tallies:

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

The report will search the entire patient and visit files.

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

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

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

-------------------------------------------------------
Subtotal:      3     19      0      0       0      1      0      0
```

Figure 5-12: Example of INPS report

5.10 Inpatient Discharges/Days by Tribe (INPT)

Use the INPT option to produce a report for inpatient counts in a specified discharge date range by tribe. This option will search the Patient file for all patients registered at the SU or the facility you select. The report will be sorted by Tribe of Membership.

This report will supply the following tallies:

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

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

Tribe of Membership  # Adult # Adult # NB   # NB   # TX   # MCR  #
MCD # PI
                     /Peds   /Peds   Dsch   Days   IN
                     Dsch    Days
 Community of Residence
-------------------------------------------------------------------
DEMO TRIBE, NM

 PAINTTOWN *    1     15      0      0      0       0      0      0
 WHITTIER *     1      1      0      0      0       0      0      0

-------------------------------------------------------
Subtotal:      2     16      0      0      0       0      0      0
```

Figure 5-13: Example of INPT report

5.11 Provider Practice Description Report (PPDS)

Use the PPDS option to produce a report that presents a profile of services provided by a selected provider. You will be asked to enter a date range and identify the provider's name. You will also be asked if you want a long version (10 items in each list) or short version (5 items in each list) of the report.

```
OUTPUT BROWSER           Jan 22, 2009 14:53:12        Page: 2 of 8

1 - Designated Primary Provider Panel

You are the Designated Primary Provider for 0 patients.  In this
time period you have provided services (any type) to 0 (0%) patients
from your Designated Primary Provider Panel.

In this time period, you provided ambulatory services at least twice

 to 0 patients who have no Designated Primary Provider identified.
2 - Demographics and Workload for All Patients Served (Any Type of
Service)

In this time period you have provided services (any type) to 7
patients.  0 (0%) are from your Designated Primary Provider Panel.
7 (100%) are not from your Designated Primary Provider Panel.

29% of your patients were Male and 71% Female.
43% were 18 and under; 14% were 19-49; 43% were 50-64; and 0% were
65 and over.

The leading residences for your    The leading tribes represented
patients are:                      among your patients are:
 BIG COVE                     1   14%
 DEMO TRIBE, NM               7  100%
 PAINTTOWN                    1   14%
 SOUTH CAROLINA UNK           1   14%
 TENNESSEE UNK                1   14%
 WAYNESVILLE                  1   14%

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

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

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

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

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

 034.0  STREP SORE THROAT        2
 V20.2  ROUTINE CHILD HEALT      2

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

 28.11  TONSIL ADENOID BIOP      1
 86.64  HAIR TRANSPLANT          1

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

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

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

At the “Select Action” prompt,

- If you are not on the last page, type plus (+) to view the next screen.
- If you are not on the first page, type minus (-) to view the previous screen.
- Type **Q** to quit the report.

5.12 Inpatient Reports (INPT)

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

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

                          DEMO HOSPITAL/CLINIC

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

Figure 5-15: Example of Inpatient Reports menu screen

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

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

The report shows FY-to-date monthly totals for all facilities in the IHS Area you specify. Each facility displays on a separate line. Monthly and location totals also display.

The report must print on 132-column paper or a printer set for condensed print.

This is an example of the HDM report:

```
NUMBER OF HOSPITAL DISCHARGES BY MONTH OF DISCHARGE  Fiscal Year 94
AREA: 00    DEMO    OCT 07, 1994           Page 1
-------------------------------------------------------------------------
 YR-TO DATE   OCT  NOV  DEC  JAN  FEB  MAR  APR  MAY  JUN  JULY  AUG  SEPT
-------------------------------------------------------------------------
DEMO HOSPITAL/CLINIC
        29     3    2    1    2    3    1    4    6    1     1    1     3

DEMO2 HEALTH CENTER
        14     0    1    4    0    0    0    1    4    2     0    1     1

TOTAL   43     3    3    5    2    3    1    5    10   3     2    2     4
```

Figure 5-16: Sample of HDM report

5.14 Hospital Discharge Listing by Date (HDD)

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

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

NAME                HRCN    ADMIT DATE DISCH DATE DISCHARGE SERVICE
-------------------------------------------------------------------

LOCATION: OTHER
BETA,HENRY D                150689  02/14/2008 02/18/2008 ALCOHOLISM
BETAA,BILL                  111111   SEP  4,1994      SURGERY
GAMMAAA,MAXINE              111115   SEP  5,1994      OBSTETRICS
Total Discharges for OTHER:  3
```

Figure 5-17: Example of HDD report

5.14.1 Estimated Run Time

Processing time for this report can be lengthy, depending on the date range you specify. If you are using a date range greater than one month, you might want to queue this report to run at night or after regular hours. Please contact your local site manager if you have any questions about queuing this report.

5.15 Hospital Discharge Listing by DX or Procedure (IICD)

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

First, type the facility name. Then specify whether you are interested in discharge dates or admission dates and enter the beginning and ending dates for the report. You can specify visits to print for a particular treating specialty, if desired.

You will need to choose one of the following four reports. You may use a predefined taxonomy of ICD diagnoses.

- All hospitalization visits for the selected dates
- Only those visits within a selected diagnosis code range
- Visits within a selected procedure code range
- Visits for selected providers

The report lists all inpatient discharges that meet the criteria you entered during the time period specified. The report displays in alphabetical order by patient name. The following items display for each admission:

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

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

XXX                 DEMO HOSPITAL/CLINIC                     Page 1
 4:14 pm            HOSPITALIZATION DISCHARGES
FEB 8,1995         for 09/09/94 to 09/09/94
                     ALL TREATING SPECIALTIES

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

Figure 5-18: Example of IICD report

5.15.1 Estimated Run Time

Processing time for this report might be lengthy, depending on the parameters you specify. You might want to queue this report to run at night or after regular hours. Please contact your local site manager if you have any questions about queuing this report.

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

Use the HDT option to create a search template of patients based on their hospital discharge date and diagnosis. The template you create can then be used with many report options to display data for only those patients stored in the template. The template allows for faster report generation because the entire database does not need to be searched each time you print data for this group of patients.

The patients selected for inclusion in the template will be living patients who have a discharge date within the time frame you specify. They must also have a primary diagnosis that is in the diagnosis taxonomy you select.

The report excludes the following categories:

- Patients discharged before 10 days old
- Patients whose length of stay in the hospital was less than 1 day
- Patients whose primary diagnosis is not in the user-selected taxonomy

You will first be prompted to enter a beginning and ending discharge date for the patient search. Next you will enter the name of the diagnosis taxonomy. Note that this taxonomy must have been defined previously. This report option does not allow you to create the diagnosis taxonomy. See your site manager for assistance if you need to create the diagnosis taxonomy.

Finally, you will type the name of the search template in which the patients will be stored. You can save them in an existing template or create a new one. If you are saving the patients in an existing taxonomy, this new group of patients will replace the group of patients previously stored in that template.

When you have finished typing your search criteria, the following message appears indicating the number of patients that were found and stored in the template:

```
OKAY -- HOLD ON WHILE I FIND ALL THE DISCHARGES

ALL DONE - FOUND 47 PATIENTS.
```

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

5.17 Admissions from the ER (ADER)

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

```
XXX                      DEMO HOSPITAL                        Page 1
HOSPITAL ADMISSIONS AFTER ER VISIT
VISITS DATES:  JAN 1,1999  TO  JAN 22, 1999

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

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

6.0 Quality Assurance Reports (QA)

This series of PCC Reports displays patient visit data with ICD Code information or APC recode information. Options are available from the Quality Assurance Reports menu.

```
                    ************************************
                    **     PCC Management Reports     **
                    **    Quality Assurance Reports   **
                    ************************************
                          IHS PCC Suite Version 2.0

                             DEMO HOSPITAL/CLINIC

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

Select Quality Assurance Reports Option:
```

Figure 6-1: Sample of quality assurance reports menu screen

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

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

Define the following search criteria:

- Visit Date range
- Patient Age group
- Service Category
- Visit Type
- Clinic Type
- Location of Encounter
- ICD Diagnostic Code ranges

Only visits meeting the user-defined criteria will display in the report. If you select the search to include all providers or selected providers, the search displays POVs by provider. Alternatively, you can ignore the provider entirely. Finally, you can ask for all POVs that match the criteria or retrieve a random sample of any desired number of matching POVs. The report of matches displays by provider and POV. For example, if you select provider and 10 random POVs in the search criteria, the report displays 10 POVs per provider for the specified ICD Diagnostic range.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to restrict the Audit Search to Patients within an Age Range? prompt, type **Y** or **N**. If you type **Y**, other prompts display.
4. At the “Want to restrict the Audit Search to Visits with a particular SEX?” prompt, type **Y** or **N**. If you type **Y**, other prompts display.
5. At the “Want to restrict the Audit Search to Visits with a particular SERVICE CATEGORY? prompt, type **Y** or **N**. If you type **Y**, other prompts display.
6. At the “Want to restrict the audit search by VISIT TYPE?” prompt, type **Y** or **N**. If you type **Y**, other prompts display.
7. At the “Want to restrict the audit search by CLINIC TYPE?” prompt, type **Y** or **N**. If you type **Y**, other prompts display.
8. At the “Want to restrict the audit search by LOCATION of ENCOUNTER?” prompt, type **Y** or **N**. If you type **Y**, other prompts display.
9. The system displays the search criteria that you specified.
10. At the “Which visit set” prompt, type one of the following:

A - all visits that match
R - random sample of visits that match

If you type **R**, it will report on a randomized sampling of matching visits. The system asks for how many randomized visits you want on the report.

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

    I - include all patients
    E - exclude demo patients
    O - include only demo patients

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

    I - include all patients
    E - exclude demo patients
    O - include only demo patients

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

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

Note:	If you request a random sample, the report displays the total number of POVs matching the selection criteria before the random selection. If the number of matching visits is less than the number that you requested to display, all the visits display. For example, if you request five random samples but only four visits match your selection criteria, four visits display.

```
DEMO HOSPITAL/CLINIC              FEB 6,1995                Page 1

Audit Search for Ambulatory Visits from SEP 1,1994 through SEP 30,1994.

HRCN        Visit Date   Primary Provider   Patient Name    DOB
            ICD9         DIAGNOSIS
-------------------------------------------------------------------

---> ICD Code Range: ALL ICD Codes.
      Total Matches: 1    Matches Selected: 1

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

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

      Total Matches: 1    Matches Selected: 1

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

Figure 6-2: Example of randomly selected reports

6.1.1 Estimated Run Time

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

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

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

> **Note:** To print only those visits with no associated clinic code (excluding hospitalizations), type 0 when asked if you want to print all clinics.

The visits included must meet the following criteria:

- Must not be deleted
- Must be for the site that you logged into

- Must *not* be for the following service categories:

  Hospitalization
  Observation
  Events
  In-Hospital

- Must not be a contract or VA visit type

The following displays for each Clinic Visit:

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

Follow these steps:

1. At the "Enter beginning Visit Date" prompt, specify the beginning date of the range.

2. At the "Enter ending Visit Date" prompt, specify the end date of the range.

3. At the "Selection" prompt, type one of the following:

   1 - Print for ALL
   2 - Print for ONE clinic
   3 - Print visits with no clinic code

   If you type **2**, other prompts will display.

4. At the "Which visits should be printed" prompt, type one of the following:

   1 - Print all Visits
   2 - Print Visits for a range of POV ICD codes
   3 - Print Visits for a range of Procedure ICD codes

   If you type **2** or **3**, other prompts will display.

5. At the "Include visits from ALL Locations" prompt, type **Y** or **N**. If you type **N**, other prompts will display.

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

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


XXX                      DEMO HOSPITAL                        Page 1
 3:47 pm         CLINIC VISITS FOR GENERAL (01)
JAN 22,2009        for 10/24/08 to 01/22/09

NAME            HRCN  AGE  VISIT DATE    PRV  ICD    PROV NARRATIVE

ABERNATHY,BOB  125571  56 12/17/08 1000  15  822.0   test narrative
fracture pa
ALPHA,ICHI     111234  83 11/12/08 1200  00  321.1   meningitis
AMMONS,FRANK   110521  43 01/07/09 1200  57  321.2   text again
BAILEY,FREDER  142895  50 01/22/09 1200  00  .9999   blah blah
BETA,GO        111225  61 11/11/08 1200  21  320.1   meningitis

BETA,SHICHI    111228  72 11/13/08 1000  21  322.2   meningitis
BROWN,ALLEN    131029  43 12/17/08 1000  15  830.0   test narrative
jaw disloca
BUCHANAN,CASS  168611  46 12/17/08 1200  53  823.00  fracture upper
end tibia,
CHI,JEREMY     159320  71 12/19/08 1200  05  096.    This is long
standing
CHI,JU         111216  67 11/03/08 1100  23  007.1   giardia
DEMO,CORRINE   155243  19 12/06/08 1200  11  796.2   10

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

Figure 6-3: Example of CICD Listing

6.2.1 Estimated Run Time

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

6.3 Hospital Discharge Listing by Diagnosis or Procedure (INPT)

The INPT option allows you to print a list of hospitalization visits by discharge date or by admission date. The visits include your facility only; however, you can identify treating specialties. The list includes ICD Codes and Narratives for all diagnoses and procedures. You have the option of displaying only those visits that contain ICD codes within a given range.

The following information displays for each admission:

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

Follow these steps:

1. At the "Run for which Facility of Encounter" prompt, specify the name of the facility.

2. At the Report Admission by Admission Date or Discharge Date?" prompt, type **A** for admission date or **D** for discharge date.

3. At the "Enter beginning Discharge Date" prompt, specify the beginning of the date range.

4. At the "Enter ending Discharge Date" prompt, specify the end of the date range.

5. At the "Do you want All Treating Specialties? prompt, type **Y** or **N**. If you type **N**, other prompts will display.

6. At the Which visits should be printed, type one of the following:

   1 - Print all Visits
   2 - Print Visits for Diagnosis Code Range
   3 - Print Visits for Procedure Code Range
   4 - Print Visits for Provider(s)

   If you type **2**, **3**, or **4**, other prompts will display.

7. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

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

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

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

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

NAME            HRCN   AGE  VISIT DATES       PRV  ICD    PROV NARRATIVE

OMEGA,DELTA     111180  73 03/03/08-03/06/08

SIGMA,ANGELA    124682  21 03/12/08-03/12/08

SIGMA,ALBERT D  165110   6 01/10/08-01/25/08  HEALTH AIDE255.0CUSING'S
SYNDROME
                                         TOTAL PATIENTS:  3

                                           TOTAL VISITS:  3

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

Figure 6-4: Example of INPT listing

6.4 Listing of Outpatient Visits with ICD Codes (VICD)

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

The visits in this report must meet the following criteria:

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

The following information will be displayed for each visit:

- Patient’s Name
- HRN
- DOB
- Medicare Number
- Visit Date
- Provider Discipline Code
- First/Revisit Code

- ICD Codes
- Provider Narrative

The report is presented in alphabetical order by patient name.

> **Note:** You must print this report on a 132-column-width printer or a printer set for condensed print.

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

XXX               DEMO HEALTH CENTER                        Page 1
FEB 7, 1990    ALL OUTPATIENT VISITS (excluding dental)

                           for 09/01/88 to 09/30/88

NAME         HRCN   DOB      MEDICARE# VISIT DATE PROV F/R ICD    PROV
NARRATIVE
BETAA,ANNE  78556   02/01/26           09/09/88    00   2  V07.9
IMMUNIZATION
                                                           2  250.00 DM TYPE II
                                                           2  401.9
HYPERTENSION
BETAA,BOB   67445   12/01/40           09/09/88    11      V68.1  MED REFILL
                                       09/09/88    00   2  250.00 DIABETES
BETAA,CHERYL 78556  08/01/11           09/09/88    08   1  367.0
HYPEROPIAW/AS
                                                           1  367.4  PRESBYOPIA
                                                           1  379.31 APHAKIA OU
BETAA,JOHN   11908  08/01/70           09/09/88    00   2  V68.1  MED REFILL
BETAA,LARRY  17655  11/01/32           09/09/88    30      V72.6  LAB
BETAA,THERESA 89532 06/01/21           09/09/88    00   2  428.0  F/U POSS
CHF
                                                           1  645.9  URI
```

Figure 6-5: Example of VICD report

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

Use the A option to produce a report that shows a list of patient visits resulting in a return to the ER within 72 hours of the clinic visit. Select a beginning and ending visit date range, the clinic in which the patient was initially seen, and the location of the visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning date of the range.
2. At the “Enter ending Visit Date for Search” prompt, specify the ending date of the range.

3. At the “Include Returns from,” prompt, type one of the following:

   A - ANY Clinic
   O - One particular Clinic

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

4. At the “Run Report for returns w/in how many hours” prompt, type **7** for 72 hours or **4** for 48 hours.

5. At the “Include Returns from Clinic Visits to” prompt, type one of the following:

   A - ANY Provider
   O - One particular Provider

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

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

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

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

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

```
                    DEMO HOSPITAL/CLINIC                    Page 1
ER VISITS AFTER CLINIC VISITS
VISITS DATES:  JAN 01, 1994 TO DEC 31, 1995

    NAME         HRCN        VISIT DATE&TIME    CLN  FAC  ICD      PROVIDER
NARRATIVE
-------------------------------------------------------------------
SMITH,BECKY   DH 222222  05/09/94 12:00     30   SE   401.9    HTN
                         05/12/94 12:00     30   SE   250.00   DM II

WATERMAN,ANTHON   DH 222223  09/12/94 10:00   01   SE   250.00   DM
                             09/13/94 17:30   30   SE   250.30   DIABETIC COMA

WATERMAN,RAE      DH 222224  09/11/94 12:00   52   SE   278.0    MORBID OBESITY/NUTR
                             09/13/94 17:30   30   SE   250.30   DIABETIC COMA

ENOS,DON          DH 222225  02/06/95 12:00   14   SE   250.00   DM
                             02/06/95 12:00   30   SE   401.9    HTN

THOMAS,RITA       DH 222226  02/08/95 12:00   14   SE   311.     DEPRESSIVE DISORDER
                             02/08/95 12:00   30   SE   311.     DEPRESSIVE DISORDER

ADAMS,ROSE        DH 222227  11/01/95 09:00   01   SE   250.00   DM

                                                       401.9    HTN
                                                       382.9    OTITIS MEDIA
              11/01/95 23:00     30   SE   382.9    OM - FOLLOW UP
                                                      487.1    FLU
                                     514.     PULMONARY CONGESTIO

RUN TIME (H.M.S): 0.0.6
End of report.  HIT RETURN:
```

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

6.6 Listing of Clinic Visits with ADA Codes (ADA)

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

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, specify the ending of the date range.
3. At the “Print for ALL clinics?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.

4. At the “Include visits from All Locations?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.

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

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

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

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

                    DEMO HOSPITAL/CLINIC                 Page 1
 3:21 pm               CLINIC VISITS FOR DENTAL (56)
FEB 7,1996               for 01/01/96 to 01/31/96

NAME            HRCN AGE  VISIT DATE   PRV  ADA   PROV NARRATIVE

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

                          TOTAL PATIENTS FOR CLINIC: 7

                            TOTAL VISITS FOR CLINIC: 9

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

Figure 6-7: Example of ADA report

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

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

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

- Visit Types

  Contract
  VA

- Visit Service Categories

  Chart Review
  In-Hospital
  Hospitalizations
  Historical Events
  Telephone Calls

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

Follow these steps:

1. At the "Enter beginning Visit Date" prompt, specify the beginning of the date range.
2. At the "Enter ending Visit Date" prompt, specify the end of the date range.
3. At the "Include visits from All Locations?" prompt, type **Y** or **N**. If you type **N**, other prompts will display.
4. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

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

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

```
APR 04, 1996                                                  Page 1

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

LOCATION OF VISIT
     TYPE OF CLINIC (CODE)          ZIP CODE              # VISITS
-------------------------------------------------------------------

DEMO HOSPITAL/CLINIC

ALCOHOLISM PROGRAM   (43)
                                    88776                       3
                                        Clinic Total:           3
CHRONIC DISEASE        (50)
                                    88776                       1
                                        Clinic Total:           1
DENTAL      (56)
                                    88776                       4
                                        Clinic Total:           4
                                                              -----
                                        Location Subtotal:      8
```

Figure 6-8: Sample of CZIP report

6.8 Clinic Visit Counts within a Date Range (CVC)

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

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, specify the end of the date range.
3. At the “Include visits from All Locations?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

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

```
LAB                        DEMO HOSPITAL/CLINIC
Page 1
 4:54 pm            VISIT COUNTS FOR GENERAL (01) CLINIC
JUL 28,1994               for 01/01/94 to 02/28/94

                  VISIT DATES          NUMBER OF VISITS
                   01/11/94                    12
                   01/13/94                    10
                   01/15/94                    18
                   01/17/94                     9
                   01/20/94                     8
                   01/22/94                    14
                   01/25/94                    10
                   01/29/94                     6
                   02/04/94                     9
                   02/08/94                    20
                   02/11/94                    13
                   02/12/94                    11
                   02/15/94                    10
                   02/27/94                    10

                   TOTAL VISITS FOR CLINIC    160
```

Figure 6-9: Sample of CVC report

6.9 Patients with At Least N Visits (NVST)

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

Follow these steps:

1. At the “Enter beginning Date” prompt, specify the beginning of the date range.
2. At the “Enter ending Date” prompt, specify the end of the date range.
3. At the “Enter the minimum number of times the patient should have been seen” prompt, specify any integer between 1 and 100.

4. The Visit Selection Menu is displayed.

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

1) Name/Chart #/SSN     58) Outside Location      115) BMI (Last calculated)
2) Sex                  59) Clinic Type           116) RX Ordering Provider
3) Date of Birth        60) Visit Created By      117) Dental ADA Codes
4) Birth Month          61) User Last Update      118) Radiology Exam
5) Birth Weight (grams) 62) VCN # Present         119) Immunization Provider
6) Birth Weight (Kgs)   63) 3rd Party Billed?     120) Immunization Lot #
7) Race                 64) Hospital Location     121) Immunizations
8) Age                  65) Admitting Service     122) Exams
9) Age in Months        66) Admission Type        123) Treatments Provided
10) Veteran Status Y/N  67) Admission Source-UB92 124) Lab Tests
11) Date of Death       68) Admitting Provider (In 125) Microbiology Culture
12) Date Patient Establish 69) Discharge Service  126) Microbiology Organism
13) Mlg Address-State   70) Date of Discharge     127) Medications
14) Mlg Address-Zip     71) Discharge Type        128) Medications+SIG

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

Figure 6-10: Visit Selection menu

You may determine the criteria for selecting which visits appear on the report by using the Select Item(s) action option. After selecting an item, an asterisk (*) indicates that the items were selected.

Otherwise, type **Q** (Quit Item Selection) to specify that you want to use all visits.

5. At the “type of output” prompt, type **L** (List of Patients) or **S** (Search Template of Patients). If you type **S**, other prompts will display.

6. The Sort Item Selection Menu is displayed.

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

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

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

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

Figure 6-11: Sort Item Selection menu

Here you select only one item for how to sort the report by using the Select Item(s) action.

Otherwise, use Quit Item Selection (Q) action to specify that you want the report to be sorted by patient name.

7. At the “Do you want each Patient Name on a separate page? prompt, type **Y** or **N**.

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

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

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

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

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

ALPHA,ICHI        111234   M  01/24/1925 DEMO HOSPI  IAPROVIDER
321.1        8
                            DEMO INDIA
                            NURSING HO
                            OTHER
```

Figure 6-12: Example of NVST report

6.10 Listing of Visits with Injury Diagnosis (INJ)

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

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

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

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date” prompt, specify the endof the date range.

3. At the “Include visits from All Locations?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.

4. At the “Include ALL Visit Types? prompt, type **Y** or **N**. If you type **N**, other prompts will display.

5. At the “Include ALL Visit Service Categories” prompt, type **Y** or **N**. If you type **N**, other prompts will display.

6. At the “Include visits to ALL clinics” prompt, type **Y** or **N**. If you type **N**, other prompts will display.

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

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

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

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

```
LAB                    DEMO HOSPITAL/CLINIC                 Page 1
                          Visits with Injury Diagnosis
               Visit Dates:  JAN 01, 1994 to DEC 31, 1994

PATIENT      HRCN    AGE      VISIT DATE    PRV   TYPE      SER CAT
-----------------------------------------------------------------

ALPHAA,BOBBIE LYN  125571    56    12/17/08 1000   15    TRIBE-NON AMBULATORY
ICD9:  822.0       Provider Narrative:  test narrative fracture patella closed
Cause of Injury:   E826.0  -  PEDAL CYCLE ACC-PEDEST
Date of Injury:    12/17/08
Place of Occurencet:  E849.5

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

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

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

Figure 6-13: Example of INJ report

6.11 Injury Visit E-Code Summary Report (INJS)

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

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

You will be prompted to enter a beginning and ending visit date range for this report. You will then have the option of screening visits by the additional criteria listed above. If you do not want to screen visits, select INJS at each of the corresponding prompts to include all visits. If you are screening visits, you will type **No** at the corresponding prompt and then type the specific variables; for instance, if you are screening visits by clinic, you would type the specific clinics of interest, such as Internal Medicine and Diabetic. These visit specifications you select can be saved for future use by assigning a name to each group.

The visit counts in this report are summarized by the following 18 E-Code categories. You may also use these predefined injury code taxonomies with the VGEN report option and print the cause of injury code, place of injury code, and whether the injury was work- or alcohol-related.

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

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, specify the end of the date range.

3. At the “Include visits from All Locations?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
4. At the “Include ALL Visit Types? prompt, type **Y** or **N**. If you type **N**, other prompts will display.
5. At the “Include ALL Visit Service Categories” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
6. At the “Include visits to ALL clinics” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
7. At the “would you like to restrict the report by Patient age range?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

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

```
XXX                          DEMO HOSPITAL                      Page 1

                       INJURY SURVEILLANCE SUMMARY REPORT
                                 (E-CODES)
                         Visits with Injury Diagnosis
                                 Visit Dates:
                         JAN 27, 2008 to JAN 26, 2009
                               CAUSE OF DX

E-CODE CATEGORY SUMMARY          COUNT     % TOTAL (ALCOHOL RELATED)
-----------------------------------------------------------------

     MOTOR VEHICLE                        1        14            0
     WATER TRANSPORT                      1        14            0
     AIR TRANSPORT                        0         0            0
     ACCIDENTAL POISONING                 0         0            0
     ACCIDENTAL FALLS                     0         0            0
     FIRES/FLAMES                         0         0            0
     ENVIRONMENTAL FACTORS                0         0            0
     STINGS/VENOMS                        0         0            0
     ANIMAL RELATED                       0         0            0
     DROWN/SUBMERGE                       0         0            0
     CUT PIERCING OBJ                     0         0            0
     FIREARMS                             0         0            0
     SPORTS INJURY                        0         0            0
     SUICIDE ATTEMPTS                     0         0            0
     ASSAULTS                             0         0            0
     BATTERED CHILD                       0         0            0
     UNDETERMINED                         0         0            0
     OTHER CAUSES                         5        71            0
                                     _____     _____        _____

     TOTALS:                            7        100%           0

RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN
```

Figure 6-14: Example of INJS report with cover page

6.12 Provider Visit Counts (PVC)

The PVC report provides the total number of visits for each provider or provider discipline selected for a specified date range. You must enter a visit date range and a single provider, a single provider discipline, or all providers.

The report prints one page for each provider or provider discipline selected. Each visit date and clinic is displayed and totals by provider are included.

The following visits are included in the report:

- Visits at the facility into which you are logged
- All Service Categories *except*:

  Hospitalizations
  In-Hospital, Events
  Observation

- All Visit Types *except*:

  CHS
  VA

Follow these steps:

1. At the "Enter beginning Visit Date" prompt, specify the beginning of the date range.
2. At the "Enter ending Visit Date" prompt, specify the end of the date range.
3. At the "Select which visits to display" prompt, type one of the following:

   1 - Print Visit counts for ONE PROVIDER
   2 - Print Visit counts for ONE PROVIDER CLSS
   3 - Print Visit counts for ALL PROVIDERS

   If you type **1** or **2**, additional prompts are displayed.

4. At the "Which visit service categories should be included (0-7)" prompt, select which visit service categories you want to include, e.g., 1,4,5,6,7 to include ambulatory, not found, day surgery, and observations. Please note: events, hospitalizations, and in-hospital visits are automatically *excluded*.

   A - AMBULATORY
   C - CHART REVIEW
   T - TELECOMMUNICATIONS
   N - NOT FOUND
   S - DAY SURGERY
   O - OBSERVATION
   R - NURSING HOME

5. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

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

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

This is an example of the Provider Visit Counts report:

```
XXX                    DEMO HEALTH CENTER                   Page 1
 6:14 pm           VISIT COUNTS FOR FOLSON,MALINDA
FEB 6,1995           (LICENSED PRACTICAL NURSE)
                      for 09/01/94 to 09/30/94

VISIT DATES     CLINIC                             NUMBER OF VISITS
-----------     ------                             ---------------
09/09/88        EMERGENCY MEDICINE (30)                          2
                PODIATRY (65)                                    1
                      TOTAL VISITS FOR PROVIDER:                 3

                      DEMO HEALTH CENTER                   Page 2
 6:14 pm              VISIT COUNTS FOR JOSE,MARY
FEB 6,1995             (LICENSED PRACTICAL NURSE)
                      for 09/01/94 to 09/30/94

VISIT DATES     CLINIC                              NUMBER OF VISITS
-----------     ------                            ---------------
09/09/94        DIABETIC (06)                                    2
                GENERAL (01)                                     3
                PODIATRY (65)                                    1

                     TOTAL VISITS FOR PROVIDER:                  6
```

Figure 6-15: Example of PVC report

6.12.1 Estimated Run Time

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

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

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

Follow these steps:

1. At the “Enter SEARCH TEMPLATE name” prompt, specify the template to search for the patients.
2. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.
3. At the “Enter ending Visit Date” prompt, specify the end of the date range.

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

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

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

     PROVIDER                       CLASS                    # VISITS

     HPROVIDER,RUSSELL P            15                              1
     KWPROVIDER,BLAKE T             21                              2
     SIGMAAAAA,MARY R               66                              3
     VNPROVIDER,JANICE M            23                              1
                                                              -------
                                                       Total:        7

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

Figure 6-16: Example of PVCT report

6.14 Visit General Retrieval (VGEN)

Use the VGEN option to produce the PCC Management Reports Visit Count report, which shows a list or count of visits entered by the user. You will be asked, in three separate steps, to identify your selection criteria, what you wish displayed for each visit, and the sorting order for your list. You can save the logic used to produce the report for future use.

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

You can limit the visits in your report to pre-established search templates created in QMan, Case Management, or other RPMS tools.

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

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

Follow these steps:

1. At the “What order would you like the Items displayed in” prompt, type one of the following:

   P - Predefined Order (the original ordering)
   A - Alphabetical Order
   G - Groups of Related Items

2. At the “Select Visit List from” prompt, type one of the following:

   P - Search Template of Patients
   V - Search Template of Visits
   S - Search All Visits
   R - CMS Register of Patients

   If you type **P**, **V**, or **R**, additional prompts are displayed.

3. At the “Enter beginning Visit Date for search” prompt, specify the beginning of the date range.

4. At the “Enter ending Visit Date for search” prompt, specify the end of the date range.

5. At the “Do you want to use a PREVIOUSLY DEFINED REPORT” prompt, type **Y** or **N**. If you type **Y** other prompts will display.

6. The Visit Selection Menu is displayed.

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

1) Name/Chart #/SSN   58) Outside Location    115) BMI (Last calculated)

2) Sex                     59) Clinic Type            116) RX Ordering Provider
3) Date of Birth           60) Visit Created By       117) Dental ADA Codes
4) Birth Month             61) User Last Update       118) Radiology Exam
5) Birth Weight (grams)    62) VCN # Present          119) Immunization Provider
6) Birth Weight (Kgs       63) 3rd Party Billed?      120) Immunization Lot#
7) Race                    64) Hospital Location      121) Immunizations
8) Age                     65) Admitting Service      122) Exams
9) Age in Months           66) Admission Type         123) Treatments Provided
10) Veteran Status Y/N     67) Admission Source-UB92  124) Lab Tests
11) Date of Death          68) Admitting Provider (In 125) Microbiology Culture
12) Date Patient Establish 69) Discharge Service      126) Microbiology Organism
13) Mlg Address-State      70) Date of Discharge      127) Medications
14) Mlg Address-Zip        71) Discharge Type         128) Medications+SIG

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

Figure 6-17: Visit Selection menu

You select visits based on the criteria you choose at the “Select Item(s)” action. An asterisk indicates the items already selected.

Otherwise, type the Quit Item Selection (**Q**) option to specify that you want to use all visits.

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

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

The total count report prints only the total number of visits that match the selection criteria you chose, as well as the total number of patients in that group. If you select this report type, no further actions are necessary beyond this step to generate the report.

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

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

The detailed visit listing allows you to create a report that prints only the data items you need sorted by the variable you select. If you have selected the detailed visit listing, read the sections below for instructions on selecting the print items and sort category. You can save this report logic for use later by responding **Y** and typing a report name at the appropriate prompts. These prompts appear after the selection of the sort variable.

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

8. The system displays the Print Item Selection Menu.

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

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

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

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

Figure 6-18: Print Item Selection menu

Select the order in which the items are to appear on the report at the “Select Action” prompt. After selecting an item, specify the column width. When you have completed your selection, type the Quit Item Selection (**Q**) action.

9. The system displays the Sort Item Selection menu.

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

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

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

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

Figure 6-19: Options in the Sort Item Selection menu

You can specify one item by which to sort the selected patients. Otherwise, type the Quit Item Selection (**Q**) option to sort the report by patient name.

10. At the Do you want a separate page for each Visit Date?” prompt, type **Y** or **N**.

11. At the “Would you like a custom title for this report?” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.

12. At the “Do you wish to SAVE this SEARCH/PRINT/SORT logic for future use” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.

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

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

14. The system displays the report summary showing the criteria you selected.

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

This is an example of the report.

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

               PCC MANAGEMENT REPORTS VISIT LISTING
                            SUMMARY PAGE

REPORT REQUESTED BY: TETER,SHIRLEY

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

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

TOTAL column width: 42

Visits will be SORTED by:  Visit Date

            PCC VISIT LISTING     Page 1
NAME                  HRN         SEX
-------------------------------------------

CHI,KU                DH111214    MALE
OMEGA,CHI             DH111181    MALE
TRUETT,PAMELA         DH128391    FEMALE
OMEGA,ALPHA           DH111175    MALE
PARKER,ANNETTE        DH100199    FEMALE
CHI,JU                DH111216    MALE

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

Figure 6-20: Example PCC Management Reports Visit Count report

You may do the following at the “Select Action” prompt:

- If you are not on the last page, type plus (+) to view the next screen
- If you are not on the first page, type minus (-) to view the previous screen
- Type **Q** to quit the report

6.15 In/Out Control Blood Pressures (BPC)

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

Follow these steps:

1. At the "Select List" prompt, type **S** (for Search Template of Patients) or **P** (for Search All Patients. If you type **S**, other prompts will display.
2. At the "List patients who live in" prompt, type one of the following:

   O - One particular Community
   A - All Communities
   S - Selected Set of Communities (Taxonomy)

   If you type **O** or **S**, additional prompts are displayed.
3. At the "include visits to ALL clinics" prompt, type **Y** or **N**. If you type **N**, other prompts will display.
4. At the "Enter beginning Visit Date" prompt, specify the beginning of the date range.
5. At the "Enter ending Visit Date" prompt, specify the end of the date range.
6. At the "Enter a Range of Ages (e.g., 5-12)" prompt, type a range of ages or press ENTER to include all ranges.
7. At the "Report should include" prompt, type one of the following:

   M - Males
   F - Females
   B - Both
8. At the "Do you wish to include ONLY Indian/Alaska Native Beneficiaries?" prompt, type **Y** or **N**.
9. At the "Report type should be" prompt, type one of the following:

   D - Detail
   S - Summary
   C - Cohort/Template Save
10. At the "Sort the report by" prompt, type **P** (for Patient Name) or **A** (for Age of Patient).
11. At the "Do you wish to suppress patient identifying data" prompt, type **Y** or **N**.

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

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

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

```
XXX                          DEMO HOSPITAL                   Page 1
                       BLOOD PRESSURE OUT OF CONTROL REPORT
                  LIST OF BLOOD PRESSURE OUT OF CONTROL PATIENTS
                   Report includes: ALL AGES, MALES & FEMALES,
                          ALL COMMUNITIES, all CLINICS,
                                all BENEFICIARIES

                     Visit Dates:  OCT 28, 2008 to JAN 26, 2009
B/P       MEAN   PATIENT NAME     HRN #   AGE  SEX  COMMUNITY
CLINIC        COUNT       B/P
-----------------------------------------------------------------
BALSER,JACOB     167741   61  M    MARBLE                 1  130/74
DEMO,JOHNNIE RU  118774   27  F    BIRDTOWN    GENERAL    1  166/94
ELKINS,KELLY LU  110023   44  F    BIG COVE               1  156/91
JONATHAN,JERRI   116447   31  F    YELLOWHILL             1  150/90

TOTAL NUMBER OF PATIENTS: 4
End of report.  HIT RETURN:
```

Figure 6-21: Example of BPC report

6.16 Delete VGEN/PGEN Report Definition (DEL)

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

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

Figure 6-22: Example of using the DEL option

6.17 Readmissions within 30 Days of a Discharge (RADM)

Type **RADM** to produce a report that shows patients who have had an admission within 30 days of a discharge.

The user will decide whether to include admissions to any facility or to only one facility. For example, if a patient was admitted to the local facility and within 30 days was admitted to a contract facility, and if you choose to included all facilities in the report, this admission will be included in the report.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, specify the end of the date range.
3. At the “Include admissions to” prompt, type **O** (for one facility only) or **A** (any facility). If you type **O**, other prompts will display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
XXX                    DEMO HOSPITAL/CLINIC                    Page 1
READMISSIONS WITHIN 30 DAYS OF A DISCHARGE
VISIT DATES: Jul 01, 1996 TO Aug 02, 1996

NAME        HRCN    ADM DATE LOC  PROV    ICD    PROVIDER NARRATIVE
-------------------------------------------------------------------
JBETA,RAY               222222  7/3/96  DH   DOCTO11,JO 681.10 CELLULITIS & ULCER
               7/17/96 DH   DOCTOR,DON V58.8  WOUND CARE DRESSING
                                                   730.27 OSTEOMYELITIS R GRE

RHORHO,MARIE            222223  7/17/96 DH   DOC3,JAVIE 644.20 PREMATURE LABOR AT
                                7/21/96 DH   DOCTOR55,R 642.94 STATUS POST C SECTI

THETABBB,DALE           222224  7/14/96 DH   DOCTOR,RUD 644.20 PREMATURE LABOR AT
                                                   648.23 ANEMIA MODERATE
                                7/21/96 DH   DOCTOR3,L  648.21 ANEMIA,ESTIMATED BL
                                                   663.31 NORMAL SPONTANEOUS

CSIGMAAAAA,DAVE         222225  7/18/96 DH   DOCTOR6,SU 291.8  ALCOHOL WITHDRAWAL
                                                   303.90 CHRONIC ALCOHOL ABU
                                                   493.90 REACTIVE AIRWAY DIS
                                7/21/96 DH   DOCTOR,JU  291.8  ALCOHOL WITHDRAWAL
                                          303.90 ACUTE ALCOHOLISM
                                                   493.90 REACTIVE AIRWAYS DI
                                                   578.9  GASTROINTESTINAL BL

GGAMMAGAMS,ALEXANDRA    222226  7/30/96 DH   DOC67,EILE 496.
   EXACERBATION CHRONI
                                 8/3/96 DH   DOC89,RICH 493.90 ASTHMA
                                         496.   CHRONIC OBSTRUCTIVE
```

Figure 6-23: Example of RADM report

6.18 Listing of Patient Refusals (REF)

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

Follow these steps:

1. At the “Do you want to include ALL Refusal Types?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
2. At the “Enter Beginning Refusal Date” prompt, specify the beginning of the date range.
3. At the “Enter Ending Refusal Date” prompt, specify the end of the date range.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

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

PATIENT NAME     HRN    DOB     DATE REFUSED REFUSAL      REASON
-----------------------------------------------------------------
EXAM refusals

SIGMA,ANGELA   124682 Jul 01, 1987 MAR 06, 2008 HEART EXAM UNABLE
SIGMA,ANGELA   124682 Jul 01, 1987 MAR 04, 2008 PELVIC EXAM REFUSED
SIGMA,ANGELA   124682 Jul 01, 1987 FEB 25, 2008 VISION EXAM NOT MED

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

Figure 6-24: Example of REF report

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

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

Follow these steps:

1. At the “Enter beginning Date for Search” prompt, specify the beginning of the date range.

2. At the “Enter ending Date for Search” prompt, specify the end of the date range.

3. At the “Select which scenario” prompt, type one of the following:

   S - Returns from one particular clinic to the same clinic
   A - Returns from any clinic to any clinic
   O - Returns from one particular clinic to any other clinic
   P - Returns from any clinic to one particular clinic

   If you type **S**, **O**, or **P**, additional prompts are displayed.

4. At the “Include visits from which set of locations” prompt, type one of the following:

   O - One location
   A - Taxonomy of Predefined Locations
   P - All Locations

   If you type **O** or **A**, additional prompts are displayed.

5. At the “Include visits from which Clinic Visits to” prompt, type one of the following:

   A - ANY Provide
   O - One particular Provider

   If you type **O**, additional prompts are displayed.

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

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

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

```
XXX                          DEMO HOSPITAL                    Page 1
               CLINIC VISITS WITHIN 72 HOURS AFTER CLINIC VISITS
                           RETURNS FROM CLINIC: DENTAL
                          RETURNS TO CLINIC: ANY CLINIC
                   VISITS DATES:  SEP 20, 2007  TO  APR 07, 2008
                               Locations: DEMO HO

NAME    HRCN   VISIT DATE&TIME  CLN FAC  ICD    PROVIDER NARRATIVE
-------------------------------------------------------------------

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

Figure 6-25: Example of RT1 report

6.20 Display Single Visit for a Patient (VST)

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

```
                    ************************************
                    **     PCC Management Reports     **
                    **   Patient Single Visit Menu    **
                    ************************************
                         IHS PCC Suite Version 2.0

                              DEMO HOSPITAL

LCV    Display Data for Patient's Last Visit to a Clinic
LVST   Display Data for a Patient's Last Visit
```

Figure 6-26: Example of Patient Single Visit menu screen

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

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

Follow these steps:

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

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

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

-------------------    V MEASUREMENT   ----------------------------
TYPE: HT                                PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57             VALUE: 56.25
  PERCENTILE: 99.9

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

TYPE: VU                                PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57 VALUE: 15/20

------------------     V PROVIDER     -----------------------------
PROVIDER: REGISTERED NURSE,IHS          PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57             PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101999
PROVIDER: PHYSICIAN,VOLUNTEER           PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57             PRIMARY/SECONDARY: PRIMARY
AFF.DISC.CODE (c): 600999
------------------        V POV       -----------------------------
POV: V70.9                              PATIENT NAME: GAMMA,ART
  VISIT: JAN 29, 1990@09:57             PROVIDER NARRATIVE: PHYSICAL
EXAM
  FIRST/REVISIT: REVISIT                PRIMARY/SECONDARY: PRIMARY
ICD NARRATIVE (c): GENERAL MEDICAL EXAM NOS

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 6-27: Example of LVC report

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

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

Follow these steps:

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

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

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

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

  VISIT: MAR 30, 1994@13:23             PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101GM
---------------------        V POV       --------------------------
POV: 401.9                              PATIENT NAME: THETAA,MARY
  VISIT: MAR 30, 1994@13:23
  PROVIDER NARRATIVE: HYPERTENSION BP UNDER CONTROL THIS VISIT
ICD NARRATIVE (c): HYPERTENSION NOS
POV: 250.00                             PATIENT NAME: THETAA,MARY
  VISIT: MAR 30, 1994@13:23             PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM
------------------       V EXAM       --------------------------
EXAM: BREAST EXAM                       PATIENT NAME: THETAA,MARY
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 06
EXAM: RECTAL EXAM
  VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 14
```

Figure 6-28: Example of LVST report

7.0 Diabetes Program QA Audit (DM)

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

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

                        DEMO HOSPITAL/CLINIC

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

Figure 7-1: Example of Diabetes Audit Report menu

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

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

7.1 Demographic Data

The following table provides information regarding demographic data.

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

7.2 Clinical Data

7.2.1 Tobacco Use

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

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

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

7.2.2 Date of Onset of Diabetes from CMS/Problem List

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

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

7.2.3 Date of Earliest Diabetes Diagnosis from PCC

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

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

7.2.4 Height

The last height on record is displayed.

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

7.2.5 Weight

The last weight recorded in a non-prenatal visit is displayed.

7.2.6 BMI

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

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

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

7.2.8 Last Three Blood Pressures and Last Three Blood Sugars

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

7.2.9 HTN Documented

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

7.2.10 Last Hgb A1c/GHb

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

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

7.3 Examinations

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

7.4 Education

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

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

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

7.5 Therapy

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

7.5.1 Use of Ace Inhibitor

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

7.6 Immunizations

- **Flu Vaccine**: Indicates if a vaccine was given during the report time frame.
- **Pneumovax**: Indicates if ever given.
- **Td**: Indicates if given during the past ten years.
- **TB Status**: TB Status is retrieved from the Health Status file. The TB Status Health Factors are:

  TB - Tx Complete
  TB - Tx Incomplete
  TB - Tx Unknown
  TB - Tx Untreated

- **PPD**: Date of last PPD and result.

- **PPD Status Code**: A patient's PPD status will be indicated by one or more of the following messages:

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

7.7 Laboratory Data

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

7.8 Program Audit Submenus

These are the Program Audit options:

```
                    ****************************************
                    **        PCC Management Reports      **
                    **   2008 Diabetes Audit Report Menu  **
                    ****************************************
                                 Version 3.0

                               DEMO HOSPITAL

   DM08   Run 2008 Diabetes Program Audit
   D8TC   Check Taxonomies for the 2008 DM Audit
   D8TU   Update/Review Taxonomies for 2008 DM Audit
   EAUD   Run the 2008 Audit w/predefined set of Pts
           ----------------------------------------
   PR08   Run 2008 PreDiabetes/Metabolic Syndrome Audit
   PDTC   Check Taxonomies for the 2008 Pre-Diabetes Audit
   PDTU   Update/Review Taxonomies for 2008 PreDiab Audit

Select 2008 Diabetes Program Audit Option:
```

Figure 7-2: Example of Program Audit Menu

7.9 Audit Reports

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

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

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

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

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

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

Figure 7-3: Example of Diabetes QA audit

```
Apr 07, 2008                        Page 1

                  ***  HEALTH STATUS OF DIABETIC PATIENTS  ***
                                DEMO HOSPITAL
                 Reporting Period: Mar 09, 2007 to Mar 08, 2008

-------------------------------------------------------------------

40 patients were reviewed                       n      Percent

Gender
       Female                                   20        50%
       Male                                     20        50%

Age
       <15 yrs                                  0         0%
       15-44 yrs                                2         5%
       45-64 yrs                               15        38%
       65 yrs and older                        23        58%

-----------------------------------------------------------------

40 patients were reviewed                       n      Percent

Diabetes Type
       Type 1                                   0         0%
       Type 2                                  40       100%
       Unknown                                  0         0%

Duration of Diabetes
       Less than 10 years                       0         0%
       10 years or more                        26        65%
       Diagnosis date not recorded             14        35%
```

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

7.10 Generating a Patient Cohort for the Audit Report

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

7.10.1 Using Your Entire DM Register as Your Audit Cohort

Because the automated audit process takes less than a minute per patient, you might want to audit all active patients in your Diabetes Register. To do so, you must first be in the Case Management System where your Diabetes Register data resides. In Case Management, select the Report Generation menu option. Next, type the name of your Diabetes Register. Then select the Patient and Statistical Reports menu option.

When prompted for a report type, select Diagnoses. When prompted for a sort order, select Patient. Respond **No** when prompted for a particular patient and **No** when prompted for another sorting attribute. When asked for a patient or statistical report, respond by typing **P**, for patient.

When prompted to "Store Report Result as a Search Template," respond **Yes**. You will then see "Search Template:" which is prompting you to name your template. Type **DM Register PTS** followed by the current date; for example, **DM Register PTS 10/12/95**. The computer then asks, "Are you adding DM Register PTS 10/12/95 as a new sort template?" Respond **Yes**.

At the prompt for "Device," type **Home** or queue the report to run at a later time. The system will then select and store in your template all active patients in your register for use in the QA Audit Report.

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

7.10.2 Generating a Random Sample as Your Audit Cohort

At sites with a large Diabetes Register, you might want to use a random sample of your active diabetes patients when running the PCC QA Audit Report. To accomplish this, first perform all of the steps described above to create a template or cohort containing active patients in your register.

Next, select Q-Man from the Case Management System main menu. In Q-Man, select the Search mode and use Living Patients as your subject. When the prompt "Attribute of Living Patients" displays, type the left square bracket (**[**) followed immediately by the name of your template; for example, **[DM REGISTER PTS 10/12/95**. Q-Man will retrieve your cohort and present you with four options. Select Option 3 to generate a random sample of your cohort. You will then be asked whether you want a specific number of entries in your sample or a percentage of your cohort. Select 1 and then type the number of patients you want to have in your sample.

When prompted for another Q-Man attribute, press ENTER. You will then be given several retrieval options. Select the "4–Store Results in a FM Search Template" option. At the template name prompt, type **Sample Of DM Pts** followed by the date; for example, **Sample Of DM Pts 10/12/95.** Respond **Yes** when the "Are you adding this new template?" prompt displays. Bypass the description prompt by pressing ENTER. Respond **No** at the "Run this job in the background?" prompt. Q-Man generates your sample cohort, which can then be used in the PCC DM QA Audit Report.

7.10.3 Generating an Audit Sample When You Do Not Have a Diabetes Register

If you have not established your Diabetes Register but want to make use of the PCC DM QA Audit Report, build a cohort or sample cohort using Q-Man only.

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

After using this procedure to create and name a template of diabetics, that template can be used in the Audit Report. You may also use your template of diabetics as a Q-Man attribute to generate a random sample as described in the previous section.

7.11 Display Audit Logic (DAL)

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

Follow these steps:

1. At the "Select PCC MAN REPORTS DM AUIT TEXT AUDIT YEAR" prompt, specify the year.
2. At the "CHOOSE 1-2" prompt, type **1** for Diabetes or **2** for prediabetes. This determines which audit logic you want to display.

3. The system displays the DM Logic Display window.

```
DM AUDIT ITEM DESCRIPTION     Jan 27, 2009 10:08       Page: 1 of 1
DM Logic Display

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

          Enter ?? for more actions
S    Select Item          A    Display All Items    Q    Quit
Select Action: +//
```

Figure 7-5: DM Audit Item Description options

4. At the “Select Action” prompt, type the Select Item (**S**) option and then specify the items for which you want to view the DM logic. (Otherwise, if you select “Display All Items” option, the logic for all items will display.)

Below is the logic for Audit Date.

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

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

Cumulative Audit: : N/A

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

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

Figure 7-6: Logic for Audit Date

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

- If you are not on the last page, type plus (+) to view the next screen
- If you are not on the first page, type minus (-) to view the previous screen
- Type **Q** to quit the report

After you quit the report, you will be returned to the DM Logic Display window where you can select another option.

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

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

Follow these steps:

1. At the “Enter the Name of the Register” prompt, specify the register name.
2. At the “Do you want to select register patients with a particular status?” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.

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

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

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

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

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

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

Figure 7-7: Example NDOO report

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

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

You will be asked to type the name of the register, the date range of the appointments, and the clinic names, if selecting a set of clinics.

Follow these steps:

1. At the “Enter the Name of the Register” prompt, specify the register name.

2. At the “Enter Beginning Appointment Date” prompt, specify the beginning date of the date range.

3. At the “Enter Ending Appointment Date” prompt, specify the ending date of the date range.

4. At the “Include patients with Appointments to” prompt, type **A** (for any clinic) or **S** (for one or more selected clinics). If you type **S**, other prompts will display.

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

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

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

```
   SJT                      Jan 27, 2009                  Page 1

PATIENTS ON THE CHEROKEE DIABETES PROGRAM REGISTER WITH AN
APPOINTMENT
           Appointment Dates: Oct 29, 2008 to Jan 27, 2009
                              CLINICS: ANY

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

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

Figure 7-8: Example APCL report

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

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

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

Follow these steps:

1. At the “Enter the Name of the DM Register” prompt, specify the DM register name.
2. At the “Do you want to select register patients with a particular status?” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.
3. At the “Limit the report to a particular primary care provider?” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.
4. At the “Enter As of Date for 4 month period” prompt, specify the “as of” date.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

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

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

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

Figure 7-9: Example DMV report

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

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

Follow these steps:

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

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

+
No
In past 12 months:
Diabetic Foot Exam:   Yes   Dec 06, 2008 (Diabetic Foot Exam,
Complete)
Diabetic Eye Exam:    No
Dental Exam:          No
(Females Only)
Last Pap Smear documented in PCC/WH: May 30, 2007
                WH Cervical TX Need: Colposcopy (by 2003)
Mammogram: ^  Clinical Breast Exam (by 11/2000)

SMBG: No Evidence in the past year
DM Education Provided (in past yr):
  Last Dietitian Visit:     Mar 10, 2005  WIC/PHONE CONSULT/NUTR
     <No Education Topics recorded in past year>

Immunizations:
Flu vaccine since August 1st:  No   Nov 30, 2006
Pneumovax ever:                No

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

Figure 7-10: Example DPCS report

The last page of the report shows the patient name, DOB, and chart number.

At the "Select Action" prompt, you may do one of the following:

- If you are not on the last page, type plus (+) to view the next screen
- If you are not on the first page, type minus (-) to view the previous screen
- Type **Q** to quit the report

7.16 Print Health Summary for DM Patients with Appointment (HSRG)

Use the HSRG option to produce a health summary for all patients on the Diabetes Register that have an appointment on a specified date.

Follow these steps:

1. At the “Enter the Appointment Date” prompt, specify the date of the appointment.
2. At the “Enter the Official Diabetes Register” prompt, specify the name of the diabetes register.
3. At the “Select health summary type” prompt, specify the type of Health Summary you want.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

Figure 8-11 is a sample report.

Figure 7-11: Sample HSRG report

7.17 Self Monitoring of Blood Glucose Follow-Up Report (SMBG)

Use the SMBG option to produce a report that shows a list of patients in a register (e.g. IHS Diabetes) that either are doing self monitoring of glucose or who are not doing self monitoring of glucose.

The following definitions/logic is used:

- Yes, doing self monitoring:
  - The last health factor documented in the 365 days prior to the end date is Self Monitoring Blood Glucose-Yes
  - The patient has had strips dispensed through pharmacy in the 365 days prior to the end date.

- No, not doing self monitoring:
  - The last health factor documented in the 365 days prior to the end date is Self Monitoring Blood Glucose-No Or Self Monitoring Blood Glucose-Refused
  - The patient has had no strips dispensed through pharmacy
  - The patient has had neither strips dispensed nor a health factor documented in the 365 days prior to the end date

In the case of the following conflict: the patient's last health factor states NO or REFUSED but they have had strips dispensed they will show up on each report with a status of Maybe.

Follow these steps:

1. At the "Enter the Name of the Register" prompt, specify the register name.
2. At the "Do you want to select register patients with a particular status?" prompt, type **Y** or **N**. If you type **Y**, other prompts will display.
3. At the "What list of patients do you want" prompt, type one of the following:

   Y - YES, Doing Self Monitoring
   N - No, Not doing Self Monitoring
   B - Both

4. At the "Enter the End Date" prompt, specify the end date to use in calculating the 265 day time period.
5. At the "How would you like the report sorted" prompt, type one of the following:

   H - HRN
   P - Patient Name
   C - Community of Residence

6. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

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

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

```
   SJT                    Jan 27, 2009                      Page 1

PATIENTS ON THE CHEROKEE DIABETES PROGRAM REGISTER - BLOOD GLUCOSE
SELF MONITORING

      List of Patients w/Self Monitoring of Blood Glucose Status
                        End Date: Jan 26, 2009

HRN    PATIENT NAME             COMMUNITY       LAST VISIT    SMBG?
-------------------------------------------------------------------
100020 STAMPER,ANNIE T          PAINTTOWN       Jun 23, 2007   No
100035 WILLIAMS,TIMOTHY L       BIRDTOWN        Jul 27, 2007   No
100038 QUEEN,DONNALYN M         PAINTTOWN       Aug 20, 2007   No
100041 TEESATESKIE,RITA ANN     PAINTTOWN       Aug 19, 2007   No
100062 JOHNSON,RICHARD H        PAINTTOWN       Jun 27, 2003   No
100065 KEITH,SIERRA TANDY       PAINTTOWN       Jan 05, 2007   No
100072 MCMILLAN,BILLY JACOB     WOLFTOWN        Aug 13, 2007   No
100093 VIA,BETTYE JO            BIG Y           May 25, 2007   No
100108 VARELA,CLIFFORD          YELLOWHILL      Aug 14, 2007   No
100114 SUTTON,ISAAC             BIGWITCH        Jul 10, 2007   No
100117 DRIVER,RITA              PAINTTOWN       Jan 08, 2006   No
100129 SMITH,DAISY              SOCO            Aug 22, 2007   No

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

Figure 7-12: Example SMBG report

8.0 Active Patient Count Reports (APC)

This set of reports examines PCC visits and counts all APC visits in a given time frame for the facility that you select. These are the available reports :

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

                            DEMO HOSPITAL/CLINIC

A1           PCC-Ambulatory Patient Care Report 1A
DATE         APC Visit Counts by Date Of Visit
CLN          APC Visit Counts by Clinic
DISC         APC Visit Counts by Provider Discipline
APRV         APC Visit Counts by Individual Provider
LOC          APC Visit Counts by Location of Service
A1M          PCC-Ambulatory 1 Report for Multiple Facilities
AVCL         Average Number of Visits by Day of Week and Clinic
AVCS         Average Number of Visits by Day/Clinic ALL Service
AVD          Average Number of APC Visits per Day
CYV          Calendar Year First and Revisit Summary
NOEX         List APC-1A Visits Not Exported

Select APC Reports Option:
```

Figure 8-1: Example APC reports menu screen

Entry of all data into the PCC includes a designation of Location of Visit, Visit Type, and Service Category.

Location of Visit is the facility where the visit occurred (e.g., Crownpoint Hospital, Yakima Health Center, Home, San Simon School).

- Visit Types

  IHS
  Contract
  Tribal
  Other
  Program
  VA

- Service Categories

  Ambulatory
  Hospitalization
  In-Hospital Care
  Chart Review
  Telecommunications
  Not Found
  Day Surgery
  Observation
  Event (Historical)
  Nursing Home Care

These three visit attributes (Visit, Visit Type, and Service Category), plus the Clinic Type designation for outpatient clinic visits, determine whether a visit is an official APC visit for inclusion in the IHS data system. The criteria for inclusion are listed below.

Data displayed on this set of APC Reports from PCC Files should correspond very closely to the reports received from the IHS Data Center. However, please be aware that for SU management purposes, a similar set of reports containing additional data, such as Not Found Visits, CHN Home Visits, and Telephone Calls, is a subset of the PCC Ambulatory Visit Counts, described in the next section of this manual.

To be considered an APC visit, a visit *must* meet the following criteria:

- Fall within the date range specified.
- Have other medical data linked to the visit record.
- Have a Service Category of:

  Ambulatory
  Day Surgery
  Observation
  Nursing Home

  Excludes: Chart Review, Hospitalization, Not Found, In-Hospital, and Event

- Have a Visit Type of:

  IHS
  638 Program
  Tribal
  Other

- Have a primary POV (POV cannot be an uncoded DX .9999).
- Have a valid location.

- Have a valid primary provider.

  Excludes: A Primary Provider Discipline of 13 (CHN) or 32 (CHR) AND a location of visit other than an IHS facility (code >49).

- Have a valid clinic code.

  Excludes:

  Mail
  Telephone Call
  Chart Review
  Follow-up Letter
  Radio Call
  Dental
  Education Class
  Employee Health

You must type the visit date range for use in calculating the number of visits and select whether visits for all locations or for one location are to be included.

8.1 PCC-Ambulatory Patient Care Report 1A (A1)

Use the A1 option to produce a report that generates from PCC files and is similar to the A1 report generated by the APC System at the Data Center in Albuquerque. Your facility should run this report on a quarterly basis to verify that all APC visits have been exported properly to the Data Center. If your site is new to PCC and the APC export process, this report should be run after every export until all export problems have been resolved.

The report displays FY-to-date APC visit counts by month of service. Specify the fiscal year and the facility for the report. Totals generate for each month as well as for each provider discipline. Percentage totals display for each discipline. Total primary care provider visits will also subtotal for each month.

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, specify the fiscal year for the report. The system the display the fiscal year date range.

2. At the “Run for which Facility of Encounter” prompt, specify the name of the facility.

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

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

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

```
AREA: 00 DEMO  PCC AMULATORY PATIENT CARE REPORT 1A DEC 07, 1989 Page 1
S.U.  :   01   DEMO  FISCAL YEAR 1987
FAC.:   000101   DEMO HOSPITAL/CLINIC
AMBULATORY CARE VISITS  TO SERVICE LOCATION BY PRIMARY PROVIDER AND MONTH OF
SERVICE
-------------------------------------------------------------------
PRIMARY PROVIDER   YR TO   % OP
OF SERVICE DATE  TOTAL  OCT  NOV  DEC  JAN  FEB  MAR  APR  MAY  JUN  JULY
AUG  SEPT
-----------------------------------------------------------------
PHYSICIAN*  505  47.6  38  37  39  46  43  37  43  36  32  37  57  60
REGISTERED NURSE  29  2.7  2  1  2  4  4  2  4  1  1  3  2  3
LICENSED PRACTICAL  12  1.1  0  1  3  4  2  0  0  1  1  0  0  0
OPTOMETRIST    18  1.7    0  2  1  2  2  3  3  1  0  0  0  4
PHARMACIST    116  10.9    13  10  6  10  15  9  8  8  10  8  9  10
PHYSICAL THERAPIST    17  1.6    4  3  2  2  2  2  1  0  0  0  0  1
PHYSICIAN ASSISTANT*    48  4.4    4  5  3  7  5  3  5  1  6  1  3  5
CHN/AIDES    6  .6    0  0  0  0  1  1  0  0  0  2  1  1
OTHER       19  1.7   7  3  0 .5  2  0  1  0  0  1  1  0
NURSE MIDWIFE 37 3.5  4  1  5  3  3  5  2  6  1  1  4  2
MENTAL HEALTH 2 .2    0  0  0  0  0  0  0  1  1  4  0  0
MEDICAL STUDENT 5 .5  0  0  0  0  0  1  0  0  0  0  3  1
NURSE PRACTITIONER* 12 1.1 1 0 1 3 3 0  0  1  1  3  0  2
NURSE ASSISTANT 5 .5 0   0  1  0  0  1  0  1  1  1  1  0
LABORATORY TECHNIC 5 .5 1 0  1 1  0  0  1  1  0  0  0  0
DIETICIAN      1   1  0  0  0  1  1  0  0  0  0  0  0  0
PODIATRIST*    8  .8  1  1  1  1  1  1  0  2  0  0  0  1
DENTIST        8  .8  2  0  0  6  1  1  0  1  2  0  0  0
INTERNAL MEDICINE* 111 10.5 9 2 10 0 6 10 11 13 10 4 4 5
OB/GYN*        6  .6  0  9  0  3  0  1  0  1  1  0  0  0
PEDIATRICIAN* 69 6.5  2  0  7  0  3  6  8  5  9  4  4  5
SURGEON*       8  .8  0  2  1  0  0  1  1  1  0  0  0  3
OPHTHALMOLOGIST* 11 1.0 0 0 0  0  0  1  1  0  0  2  2  4
FAMILY PRACTICE* 1 .1 0  0  0  0  0  0  0  0  1  0  0  0
NEUROLOGIST*   1  .1  0  0  0  0  0  0  0  0  0  0  0  0
TOTAL       1060 100.0 88 81 82 124 97 80 91 80 77 62 91 1070
TOTAL PRIMARY PVDR 817 77.1 59 61 67 96 66 62 72 66 61 46 74 87
21 visits were not exported because of missing or invalid data. To see a
list of these visits so that they may be resubmitted, use the option called
‘List APC-1A Visits Not Exported. There were 138 instances of 2 or more
visits by a patient to the same clinic on the same day.   These 138 will not
be counted in the report produced at the Data Center, but are counted in the
report above. This accounts for a total of 159 visits that will be counted
in this report but not in the 1A report from the Data Center.
```

Figure 8-2: Example of Ambulatory Patient Care Report 1A

8.2 APC Visit Counts by Date of Visit (DATE)

Use the Date option to produce a report that shows a count of visits by Date of Visit for a specified date range. The visits included are those that considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to select” prompt, use type of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
*******************************************************************
* DEMO HEALTH CENTER                          FEB 7,2008  Page 1    *
*                    NUMBER OF APC VISITS BY DATE OF VISIT          *
*                LOCATION OF VISITS:  DEMO HEALTH CENTER            *
*                  REPORT DATE: SEP 01, 2004  TO  SEP 5, 2004       *
*******************************************************************

DATE OF VISIT               DAY OF WEEK              # VISITS
SEP 01, 2004                MONDAY                        104
SEP 02, 2004                TUESDAY                        81
SEP 03, 2004                WEDNESDAY                      92
SEP 04, 2004                THURSDAY                       71
SEP 05, 2004                FRIDAY                         91
                                                      -------
                                                    Total: 439
```

Figure 8-3: Example of Date report

8.3 APC Visit Counts by Clinic Type (CLN)

Use the CLN option to produce a report that shows a count of visits by Clinic Type for a specified date range. The visits included are those that are considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
*******************************************************************
* DEMO HEALTH CENTER                          FEB 7,2008  Page     *
*                    NUMBER OF APC VISITS BY CLINIC TYPE           *
*               LOCATION OF VISITS:  DEMO HEALTH CENTER            *
*                REPORT DATE:  SEP 01, 2004  TO  SEP 02, 2004      *
*******************************************************************

TYPE OF CLINIC                CLINIC CODE              # VISITS

DIABETIC                      06                            12
EMERGENCY MEDICINE            30                            60
OTHER                         25                             8
PODIATRY                      65                             8
WELL CHILD                    24                            12
                                                         -------
                                                Total:      100
```

Figure 8-4: Example of CLN report

8.4 APC Visit Counts by Provider Discipline (DISC)

The DISC report counts the number of visits by provider discipline for a specified date range. Specify totals for primary provider only or for all providers. The visits included are those that are considered APC workload reportable.

Follow these steps:

1. At the “Report should include” prompt, type **P** (for Primary Provider only) or **A** (for All Providers, primary and secondary).
2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
4. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you use 2, 3, or 4, additional prompts are displayed.

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

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

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

```
*******************************************************************
****   * DEMO HEALTH CENTER                    FEB 7,2008   Page 1 *
*                                                                 *
*              NUMBER OF APC VISITS BY ALL PROVIDER DISCIPLINES    *
*               LOCATION OF VISITS:  DEMO HEALTH CENTER            *
*                REPORT DATE:  SEP 01, 2004  TO  SEP 02, 2004      *
*******************************************************************

PROVIDER DISCIPLINE           DISCIPLINE CODE         # VISITS

CHN/AIDES                     13                             5
DENTIST                       52                             7
INTERNAL MEDICINE             71                             1
LICENSED PRACTICAL NURSE      05                            12
NURSE ASSISTANT               22                             7
NURSE MIDWIFE                 17                             1
NURSE PRACTITIONER            21                             4
NUTRITIONIST                  07                             2
OPHTHALMOLOGIST               79                             1
OPTOMETRIST                   08                             1
PHARMACIST                    09                            13
PHARMACY PRACTITIONER         30                             2
PHYSICIAN                     00                            36
PHYSICIAN ASSISTANT           11                             3
REGISTERED NURSE              01                            12
                                                       -------
                                                Total:     107
```

Figure 8-5: Example of DISC report

8.5 APC Visit Counts by Individual Provider (APRV)

Use the APRV option to produce a report that shows visits by individual provider for a specified date range. You can choose to list primary providers only or all providers. The visits included are those are those considered APC workload reportable.

Follow these steps:

1. At the “Report should include” prompt, type **P** (for primary provider only) or **A** (for all providers, primary and secondary).
2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.

4. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
*******************************************************************
* DEMO HEALTH CENTER                            FEB 7,2008  Page 1 *
*                                                                  *
*              NUMBER OF APC VISITS BY ALL PROVIDERS OF SERVICE    *
*                LOCATION OF VISITS:   DEMO HEALTH CENTER          *
*                REPORT DATE:  SEP 01, 2004   TO  SEP 02, 2004     *
*******************************************************************

PROVIDER OF SERVICE           DISCIPLINE OF PROV       # VISITS

ARPROVIDER,WILLIAM M          COMMUNITY HEALTH REP            1
CPROVIDER,WILLIAM L           REGISTERED NURSE                1
FNPROVIDER,CLAUDINE Y         PHYSICIAN ASSISTANT             1
HPROVIDER,RUSSELL P           OTHER                           3
IAPROVIDER,MATTHEW            PHYSICIAN                       3
KWPROVIDER,BLAKE T            NURSE PRACTICIONER              4
MPROVIDER,PETER EARL          OTHER                           3
NPROVIDER,ERIN D              FAMILY PRACTICE                 1
SCPROVIDER,ONE                HEALTH AIDE                     3
TPROVIDER,TARA M              REGISTERED NURSE                1
TXPROVIDER,FRANKLIN RICHA     OTHER                           2
VNPROVIDER,JANICE M           LABORATORY TECHNICIA            3
VPROVIDER,THOMAS L            LICENSED PRACTICAL N            4
WPROVIDER,MICHEAL             LABORATORY TECHNICIA            1
                                                         -------
                                                  Total:        31
```

Figure 8-6: Example of APRV report

8.6 APC Visit Counts by Location of Service (LOC)

Use the LOC option to produce a report that shows a list of the number of visits by location for a specified date range. The visits included are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
*********************************************************************
*  DEMO HOSPITAL                                  Jan 27, 2009  Page 1*
*                                                                    *
*                 NUMBER OF APC VISITS BY LOCATION OF SERVICE        *
*                           LOCATION OF VISITS:  ALL                 *
*                 REPORT DATE:  JUL 31, 2008  TO  JAN 27, 2009       *
*********************************************************************

LOCATION OF SERVICE           LOCATION CODE            # VISITS

CIHA A NA LE NI SGI           585160                          2
DEMO HOSPITAL                 230001                         85
                                                          -------
                                                Total:        87
```

Figure 8-7: Example of LOC report

8.7 PCC-Ambulatory 1 Report for Multiple Facilities (A1M)

Use the A1M option to produce a report that shows the Year to Date Ambulatory Visit Counts and Fiscal Year for a facility that you specify. The counts by month are for date of service. This report will resemble, but not exactly duplicate, the APC 1A report produced at the IHS Data Warehouse in Albuquerque.

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, specify the fiscal year for the report. The system the display the fiscal year date range.
2. At the “Enter a code indicating what LOCATIONS/FACILITY are of interest” prompt, type **S** (for selected set or taxonomy of locations) or **O** (for one location/facility). Other prompts display according to your choice.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

Figure 8-8: Example A1M report

8.8 Average Number of Visits by Day of Week and Clinic (AVCL)

The AVCL report generates average daily outpatient visit counts by clinic for each day of the week. Specify a date range for calculating the average number daily visits. The visits included are those are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:

1 - All
2 - Individually
3 - For a Service Unit
4 - From a Taxonomy

If you type **2**, **3**, or **4**, additional prompts are displayed.

4. At the Demo Patient Inclusion/Exclusion" prompt, use one of the following:

   I Include All patients

   E Exclude Demo patients

   O Include only demo patients

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

The following sample report includes the average number of visits by day of the week and clinic for January 1, 1995 to January 31, 1995.

```
*******************************************************************
*  DEMO HOSPITAL/CLINIC                     APR 09, 2008    Page 1 *
*               AVERAGE DAILY OUTPATIENT (APC) VISITS BY CLINIC    *
*                          LOCATION OF VISITS: ALL                 *
*                 REPORT DATE:  JAN 01, 2004 TO  JAN 31, 2004      *
*******************************************************************

CLINIC         MONDAY  TUESDAY WEDNESD THURSDA FRIDAY SATURDA SUNDAY
ALCOHOLISM PROGRAM  2       0       1       0       1      0       0
CHRONIC DISEASE     4       1       3       2       1      0       0
DENTAL              3       4       1       2       0      0       0
DIABETIC            1       4       5       1       0      0       0
EMERGENCY MEDICINE  1       0       1       2       0      3       2
GENERAL             5       1       3       2       0      0       0
HOME CARE           2       2       1       2       0      0       0
MEDICAL SOCIAL SERVI1       2       1       2       1      0       0
MENTAL HEALTH       2       1       2       5       1      0       0

RUN TIME (H.M.S): 0.0.4
End of report.   HIT RETURN:
```

Figure 8-9: Example of AVCL report

8.9 Average Number of Visits by Day/Clinic ALL Service (AVCS)

The AVCS report generates the average daily outpatient visit counts by clinic for each day of the week. *All* service categories and *all* clinics are included in the visit count. This report is similar to the Average Number of Visits By Day of Week & Clinic (AVCL), with the exception of the inclusion of *all* service categories/clinics.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
*******************************************************************
*  DEMO HOSPITAL                                        009    Page 1*
*                                                                    *
*                AVERAGE DAILY OUTPATIENT VISITS BY CLINIC          *
                           SERVICE CATEGORIES:  ALL
*                       LOCATION OF VISITS:  SELECTED               *
*                 REPORT DATE:  OCT 29, 2008  TO  JAN 27, 2009      *
*******************************************************************

CLINIC     MONDAY  TUESDAY WEDNESD THURSDA FRIDAY  SATURDA SUNDAY
BEHAVIORAL HEALTH 1     0       0       0       0       0       0
DAY SURGERY       0       1       0       0       0       0       0
GENERAL           1       1       2       1       2       1       2
MEN'S HEALTH SCREENI 1    0       1       1       0       1       0
MENTAL HEALTH     0       0       0       1       0       1       0
URGENT CARE       1       0       0       0       0       0       0
WOMEN'S HEALTH SCREE 1    0       0       1       1       1       1

RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:
```

Figure 8-10: Example of AVCS report

8.10 Average Number of APC Visits per Day (AVD)

The AVD report displays the average daily outpatient visits for a specified date range. Choose visits for one clinic, selected clinics, or all clinics. The visits included are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.

3. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

4. At the “Include visits to ALL clinics” prompt, type **Y** or **N**. If you type **N**, other prompts will display.

5. At the Demo Patient Inclusion/Exclusion" prompt, type one of the following:

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

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

```
*********************************************************************
*  DEMO HOSPITAL                                Jan 27, 2009    Page 1*
*                                                                    *
*                      AVERAGE DAILY OUTPATIENT (APC) VISITS         *
*                         LOCATION OF VISITS:  SELECTED              *
*                  REPORT DATE:  OCT 29, 2008  TO  JAN 27, 2009      *
*********************************************************************

DAY-OF-WEEK              AVERAGE # VISITS PER DAY

MONDAY                             1
TUESDAY                            1
WEDNESDAY                          2
THURSDAY                           1
SATURDAY                           1
SUNDAY                             2
RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:
```

Figure 8-11: Example of AVD report

8.11 Calendar Year First and Revisit Summary (CYV)

The CYV report tabulates visit counts for the facility and clinic for a specified date range. Visit counts are summarized for Indian/Alaska Native and all other beneficiaries. Each classification is subtotaled by the following: (1) New patient's 1st (2) established patient's 1st and (3) all additional patient's visits.

> **Note:** Calendar Year Reports must be inclusive and begin with the first day of the desired calendar year.

Follow these steps:

1. At the "Enter beginning Visit Date for Search" prompt, specify the beginning of the date range.

2. At the "Enter ending Visit Date for Search" prompt, specify the end of the date range.

3. At the "Do you want to include Visits to" prompt, type **A** (for all locations) or **O** (for one location). If you type **O**, other prompts will display.

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

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

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

```
Report Dates:                                          Non-Indian mem
Jan 01, 2009 to JAN 27, 2009          Indian  Ind. Household   All
Other
_____________________________________________________________________

 Date Range Visit Summary

 1.  New Patient's First Visit              0            0    0

 2.  Established Patient's First Visit     13            0    1

 3.  Total First Visits (1-2)              13            0    1

 4.  Additional Visits (2nd,3rd,etc.)       0            0    0
                                        _______       ____  ____
  SUB-TOTAL                                 13           0    1

     GRAND TOTAL-ALL VISITS:         14

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

Figure 8-12: Example of CYV report

8.12 List APC-1A Visits Not Exported (NOEX)

The NOEX report will process the same as the 1A report; however, instead of producing the 1A report, it will list all visits that would be included in the 1A report that have *not* been exported to the National Data Warehouse (NDW).

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, specify the fiscal year for the report.

2. At the “Run for which Facility of Encounter” prompt, specify the name of the facility.

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

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

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

The PCC data entry staff should review this report. All visits that have not exported should be reviewed, corrected, and reflagged for export, as appropriate.

```
-------------------------------------------------------------------
AREA:  23      HEADQUARTERS WEST         PCC-APC REPORT 1A    Page 1
S.U.:  00      NON SVC UNIT              FISCAL YEAR 2008
FAC.:  230001  DEMO HOSPITAL             JAN 27, 2009
                                         VISITS NOT EXPORTED
-------------------------------------------------------------------

Total Number of APC visits counted:  107
Total Number of those APC Visits NOT Exported:  107

Of the total number of visits counted in the 1A, but NOT exported to
the National Data Warehouse, 107 were not exported because they were
posted or modified after the last NDW export tape was generated.

RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:
```

Figure 8-13: Example of NOEX report

9.0 Ambulatory Visit Counts (PCCV)

This set of reports will count all PCC Ambulatory Visits in a given time frame. These reports display a count of PCC Ambulatory Visits sorted by the attribute you select. You will be prompted to type the visit date range to be used in calculating the number of visits and to indicate for which location the report should print.

The following PCC Visit Count reports are available from the PCCV menu:

```
                    ***************************************
                    **      PCC Management Reports       **
                    **    PCC Ambulatory Visit Counts    **
                    ***************************************
                          IHS PCC Suite Version 2.0

                              DEMO HOSPITAL

  DATE    Visit Counts by Date of Visit
  CLIN    Visit Counts by Clinic Type
  DISC    Visit Counts by Provider Discipline
  PROV    Visit Counts by Provider
  DX      Visit Counts by Diagnosis (ICD)
  LOC     Visit Counts by Location of Service
  SC      Visit Counts by Service Category
  AA      PCC Visits (By Provider Disc) PCC Report AA
  ALL     ALL Visits by Provider or Provider Discipline
  APPT    Tally of Walk-in/Appointment Clinic Visits
  CSAR    California State Annual Utilization Report
  DAR     PCC Data Analysis Report
  GCDC    General/Dental Clinic Visits on the Same Day
  INCV    Listing of Incomplete Lab, Rx or Rad Visits
  PPD     Primary Provider Visits - Daily/Annual Report
  PPM     Primary Provider Visits - Monthly Report
  TPC     Tally of Selected Provider Disciplines by Clinics
  WAIT    Wait Times by Clinic and Provider

Select PCC Ambulatory Visit Reports Option:
```

Figure 9-1: Example of PCC Ambulatory Visit Counts menu screen

In order for a visit to be included in the PCC Ambulatory Visits reports, it must meet the following criteria:

- Visit Type must be:

  IHS
  638 Program
  Tribal
  Other

- Service Category must be:

  Ambulatory
  Observation
  Day Surgery
  Not Found
  Nursing Home
  Telecommunications

  Excludes: Chart Review, Hospitalization, In-Hospital, and Event

- Must include a *valid* primary provider.
- Must have a POV.

9.1 Visit Counts by Date of Visit (DATE)

Use the Date option to produce a report counts visits by Date of Visit for the date range you specify. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** or **N**.
4. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
                                                  APR 09, 1996  Page 1
                  NUMBER OF AMBULATORY VISITS BY DATE OF VISIT
                            LOCATION OF VISITS: ALL
Chart Reviews are not included
                  VISIT DATES:  MAR 01, 1995  TO MAR 31, 1995

 LOCATION OF VISIT
DATE OF VISIT               DAY OF WEEK              # VISITS
-------------------------------------------------------------------

DEMO HOSPITAL/CLINIC
      MAR 01, 1995                WEDNESDAY                       1
      MAR 06, 1995                MONDAY                          1
      MAR 13, 1995                MONDAY                          3
      MAR 15, 1995                WEDNESDAY                       4
      MAR 20, 1995                MONDAY                          1
      MAR 25, 1995                SATURDAY                        1
      MAR 28, 1995                TUESDAY                         1
                                                            --------
                                                     Total:       12

 RUN TIME (H.M.S): 0.0.0
 End of report.  HIT RETURN:
```

Figure 9-2: Sample of Date report

9.2 Visit Counts by Clinic Type (CLIN)

Use the CLIN option to produce a report that counts visits by clinic type for the date range you specify. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.

3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** or **N**.

4. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
                                                        FEB 8,1995 Page 1
NUMBER OF AMBULATORY VISITS BY CLINIC TYPE
LOCATION OF VISITS: DEMO HEALTH CENTER
Chart Reviews are not included.
VISIT DATES:  SEP 01, 1994 TO  SEP 01,  1994

 LOCATION OF VISIT
TYPE OF CLINIC              CLINIC CODE              # VISITS
 ---------------------------------------------------------------------

 DEMO HEALTH CENTER

DIABETIC                    06                            12
EMERGENCY MEDICINE          30                             6
GENERAL                     01                            20
NO CLINIC ENTERED           99999                          8
PODIATRY                    65                             8
WELL CHILD                  24                             2
                                                     --------
                                            Subtotal:        56
```

Figure 9-3: Example of CLIN report

9.3 Visit Counts by Provider Discipline (DISC)

Use the DISC option to produce a report that counts visits by provider discipline for the date range you specify. Choose counts for primary providers only or for all providers. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the "Report should include" prompt, type **P** (for Primary Provider Only) or **A** (for all providers - primary and secondary).
2. At the "Enter beginning Visit Date for Search" prompt, specify the beginning of the date range.
3. At the "Enter ending Visit Date for Search" prompt, specify the end of the date range.
4. At the "Do you want to include visits with a CHART REVIEW service category?" prompt, type **Y** or **N**.
5. At the "Do you want to select" prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.
6. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

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

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

```
                                                    FEB 8,1995   Page 1
NUMBER OF AMBULATORY VISITS BY ALL PROVIDER DISCIPLINES
LOCATION OF VISITS: DEMO HEALTH CENTER
Chart Review are not included.
VISIT DATES: SEP 01, 1994 TO SEP 01, 1994

 LOCATION OF VISIT
      PROVIDER DISCIPLINE         DISCIPLINE CODE         # VISITS
 ----------------------------------------------------------------

 DEMO HEALTH CENTER

      CHN/AIDES                   13                            5
      DENTIST                     52                            7
      INTERNAL MEDICINE           71                            1
      LICENSED PRACTICAL NURSE    05                           12
      NURSE ASSISTANT             22                            7
      NURSE MIDWIFE               17                            1
      NURSE PRACTITIONER          21                            4
      NUTRITIONIST                07                            2
      OPHTHALMOLOGIST             79                            1
      OPTOMETRIST                 08                            1
      PHARMACIST                  09                           13
      PHARMACY PRACTITIONER       30                            2
      PHYSICIAN                   00                           37
      PHYSICIAN ASSISTANT         11                            3
      REGISTERED NURSE            01                           12
                                                        --------
                                                Subtotal:     108

                                                        --------
                                                   Total:     108
```

Figure 9-4: Example of DISC report

9.4 Visit Counts by Provider (PROV)

Use the PROV option to produce a report that counts visits by provider of service for the date range you specify. You can choose counts for primary providers only or for all providers. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits *must* have a primary provider or POV.

Follow these steps:

1. At the “Report should include” prompt, type **P** (for Primary Provider Only) or **A** (for all providers, primary and secondary).
2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
4. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** or **N**.
5. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
                                                  FEB 8,1995   Page 1
NUMBER OF AMBULATORY VISITS BY ALL PROVIDERS OF SERVICE
LOCATION OF VISITS:  DEMO HEALTH CENTER
Chart Reviews are included.
VISIT DATES:  SEP 01, 1994  TO SEP 01, 1994

LOCATION OF VISIT
     PROVIDER OF SERVICE          DISCIPLINE OF PROV       # VISITS
-------------------------------------------------------------------

DEMO HEALTH CENTER

     BETAA,HAROLD C               DENTIST                        2
     BETA,AMY                     PHYSICIAN                      1
     COMMUNITY HEALTH NURSE,IH    CHN/AIDES                      3
     DENTAL COSTEP                DENTIST                        1
     DENTIST,IHS                  DENTIST                        4
     DETLA,FRANK                  PHARMACIST                     4
     ETAA,SUSIE                   REGISTERED NURSE               1
     EPSILON,MALINDA              LICENSED PRACTICAL N           3
     GAMMAAAA,EVELYN              NURSE PRACTITIONER             4
     IOTAAAAAA,IHS                INTERNAL MEDICINE              1
     IOTAA,DELPHINE               NURSE ASSISTANT                1
     IOTA,MARY                    LICENSED PRACTICAL N           6
     LICENSED PRACTICAL NURSE,    LICENSED PRACTICAL N           1
     LAMBDAAAAA,ROBERT            PHYSICIAN                      3
     LDOCC,DAVID                  PHYSICIAN                      1
     LDOCC,FRANCES                REGISTERED NURSE               2
     MUUUUU,TONY                  PHYSICIAN                      2
     MUUUUU,GRETCHEN              REGISTERED NURSE               4
     MUUUUU,FRED                  PHYSICIAN                      1
     MUUUUU,ROGER                 PHARMACIST                     3
                                                          --------
                                                Subtotal:       48

                                                          --------
                                                   Total:       48
```

Figure 9-5: Example of PROV report

9.5 Visit Counts by Primary Diagnosis (ICD) (DX)

Use the DX option to produce a report that counts visits by Primary Diagnosis (ICD Code) for the date range you specify. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

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

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** or **N**.
4. At the “Do you want to select” prompt, use one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
                                                FEB 8,1995    Page 1

NUMBER OF AMBULATORY VISITS BY PRIMARY DX (ICD CODE)
LOCATION OF VISITS: DEMOHEALTH CENTER
Chart Reviews are not included.
VISIT DATES:  SEP 01, 1994  TO  SEP 01, 1994

LOCATION OF VISIT
     ICD DX NARRATIVE             ICD DX CODE              # VISITS
-------------------------------------------------------------------

DEMO HEALTH CENTER

     ABN GLUCOSE-ANTEPARTUM       648.83                          1
     ACUTE BRONCHIOLITIS          466.1                           1
     ACUTE NASOPHARYNGITIS        460.                            1
     ACUTE URI NOS                465.9                           5
     ANEMIA-ANTEPARTUM            648.23                          1
     ANXIETY STATE NOS            300.00                          1
     ATTEN-SURG DRESSNG/SUTUR     V58.3                           1
     BURN NOS                     949.0                           1
     CHRONIC SINUSITIS NOS        473.9                           2
     CONGESTIVE HEART FAILURE     428.0                           1
     DENTAL DISORDER NOS          525.9                           1
     DENTAL EXAMINATION           V72.2                           4
     DIAB OPHTHAL MANIF ADULT/    250.50                          1
     DIABETES UNCOMPL ADULT/NI    250.00                          9
     EDEMA OF PENIS               607.83                          1
     FX ANKLE NOS-CLOSED          824.8                           1
     GINGIV/PERIODONT DIS NOS     523.9                           1
     HYPERMETROPIA                367.0                           1
     HYPOVOLEMIA                  276.5                           1
     IMPETIGO                     684.                            1
                                                            --------

                                                Subtotal:       36

                                                            --------
                                                   Total:       36
```

Figure 9-6: Example of DX report

9.6 Visit Counts by Location of Service (LOC)

Use the LOC option to produce a report that counts visits by location of service for the date range you specify.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

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

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning date for the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the ending date for the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, use Y or N.
4. At the “Demo Patient Inclusion/Exclusion” prompt, use one of the following:

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

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

```
                                                  FEB 8,1995   Page 1
NUMBER OF AMBULATORY VISITS BY LOCATION OF SERVICE
LOCATION OF VISITS: ALL
Chart Reviews are not included.
VISIT DATES:  SEP 01, 1994  TO  SEP 01, 1994

LOCATION OF VISIT
     LOCATION OF SERVICE           LOCATION CODE           # VISITS

-------------------------------------------------------------------
ALBUQUERQ HO                       202101                        3
DEMO HOSPITAL/CLINIC               000101                       14
DEMO HEALTH CENTER                 000111                       57
HOME                               000189                        1
DEMO UNDES                         000199                        2
VAYA CHIN HEALTH STATION           000132                        1
                                                            --------
                                                     Total:       78
```

Figure 9-7: Example of LOC report

9.7 Visit Counts by Service Category (SC)

Use the SC option to produce a report that counts visits by service category for the date range you specify. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

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

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** or **N**.
4. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.
5. At the “Demo Patient Inclusion/Exclusion” prompt, use one of the following:

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

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

```
                                                  FEB 8,1995    Page 1
NUMBER OF AMBULATORY VISITS BY SERVICE CATEGORY OF VISIT
LOCATION OF VISITS: DEMO HEALTH CENTER
Chart Reviews are not included.
VISIT DATES:   SEP 01, 1994  TO  SEP 01, 1994

LOCATION OF VISIT
     SERVICE CATEGORY              CODE                    # VISITS
-----------------------------------------------------------------

DEMO HEALTH CENTER

     AMBULATORY                    A                            56
     NOT FOUND                     N                             1
     DAY SURGERY                   S                             2
     TELECOMMUNICATIONS            T                             6
                                                           --------
                                                Subtotal:       65

                                                           --------
                                                   Total:       65
```

Figure 9-8: Sample of SOC report

9.8 PCC Visits (by Provider Discipline) PCC Report AA (AA)

Use the AA option to produce a report that shows year-to-date PCC visit counts for the facility and fiscal year you select. Subtotals by month are for date of service. This report is similar to the AA report produced at the Albuquerque Data Center; however, it contains all PCC visits, not just those defined as APC visits. Please see the following example report.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a primary provider or POV

> **Note:** This report must be printed on 132-column paper or a printer set up for condensed print.

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, specify the fiscal year for the report. The system the display the fiscal year date range.

2. At the “run for which Facility of Encounter” prompt, specify the name of the facility.

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

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

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

```
AREA: 00 DEMO PCC-OUTPATIENT PATIENT CARE REPORT APR 19, 1996 Page 1
      S.U.: 01     DEMO                    FISCAL YEAR 1995
      FAC.: 000101 DEMO HOSPITAL/CLINIC
       ALL PCC OUTPATIENT (NON-HOSPITAL) VISITS TO SERVICE LOCATION BY PRIMARY
PROVIDER AND
        MONTH OF SERVICE
_____________________________________________________________________
PRIMARY PROVIDER  YR-TO  % OF
OF SERVICE        DATE   TOTAL
OCT. NOV. DEC. JAN. FEB. MAR. APR. MAY JUNE JULY AUG. SEPT
_____________________________________________________________________
PHYSICIAN*    18    6.7    0    5    1    2    0    1    0    2    1 1   2     3
MEDICAL SOCIAL WORKE   43   16.1    6    1    0    0    0    0    0 0    0    5  17
14
MENTAL HEALTH 134   50.2    2   17   11   11   16    8    9    5    3   20  11    21
PHARMACY PRACTICIONE 1     .4    0    0    0    0    0    0    0    0    0    0   0
1
DENTIST       3    1.1    0    0    0    0    1    1    0    0    0 0   0     1
COMMUNITY HEALTH REP   16    6.0    0    0    0    0   12    0    0 0    4    0   0
0
INTERNAL MEDICINE* 47   17.6    1    1    5    9    2    4    5    9 3    2   2
4
FAMILY PRACTICE*    2     .7    0    0    1    0    0    0    0    0 0    1   0
0
PSYCHIATRIST*  1     .4    0    1    0    0    0    0    0    0    0 0   0     0
T O T A L      267  100.0    9   25   18   22   33   14   14   16   11   29  32
44
*TOTAL PRIMARY PVDR    68   25.5    1    7    7   11    2    5    5 11    4    4   4
7

RUN TIME (H.M.S): 0.0.2
End of report.  HIT RETURN:
```

Figure 9-9: Sample of AA report

9.9 All Visits by Provider or Provider Discipline (ALL)

Use the All option to produce a report that counts all visits by provider, location of service, and service category. All visits are in the report regardless of type, service category, or clinic. The visit must have a valid provider and POV to be included. Select one or all providers, one or all provider disciplines, all providers within one discipline, one or all locations, and whether the provider is a primary provider.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.

3. At the “Report should include and sort by” prompt, use one of the following:

   O - One Provider Only
   P - All Providers
   D - One Provider Discipline
   A - All Provider Disciplines
   X - All Providers within One Discipline

   If you use O, D, or X, additional prompts are displayed.

4. At the “Include if Provider is” prompt, type **P** (for primary provider) or **S** for Primary or secondary provider).

5. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

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

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

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

```
                                                AUG 02, 1994  Page 1
NUMBER OF CONTACTS BY PROVIDER, LOCATION AND SERVICE CATEGORY
LOCATION OF VISITS:  ALL
PROVIDER DISCIPLINE:  ALL
PRIMARY PROVIDER ONLY
VISIT DATES: JAN 01, 1994  TO  JAN 15, 1994

     LOCATION OF VISIT
          SERVICE CATEGORY                      # PROVIDER CONTACTS
-------------------------------------------------------------------

Provider Discipline:  PHYSICIAN
     DEMO HOSPITAL/CLINIC
          AMBULATORY                                     36
     SAN XAVIER HEALTH CENTER
          AMBULATORY                                    106
          CHART REVIEW                                    4
          TELECOMMUNICATIONS                              4
     AMBULANCE,000177
          AMBULATORY                                      4
     CHS PHYSICIAN OFFICE,000188
          AMBULATORY                                      7
          IN HOSPITAL                                     6
     VETERANS ADMIN HOSPITAL
          AMBULATORY                                      4
          HOSPITALIZATION                                 1
     SAINT MARY'S HOSPITAL
          AMBULATORY                                      5
```

Figure 9-10: Example of All report

The report will show subtotals and totals.

9.10 Tally of Walk-In/Appointment Clinic Visits (APPT)

Use the Appt option to produce a report that counts visits by clinic in the date range you select. Select visit counts for one or all locations and one or all clinics. The report counts each clinic visit by appointment, walk-in, or unspecified.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.

3. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.

4. At the “Include visits from ALL Clinics?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.

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

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

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

```
                                                AUG 02, 1994   Page 1
TALLY OF CLINIC VISITS: WALK-IN, APPOINTMENT, UNSPECIFIED
LOCATION OF VISITS:  ALL
CLINIC:  ALL
VISIT DATES: JAN 01, 1994  TO  JAN 31, 1994

LOCATION OF VISIT
CLINIC TOTAL   APPOINTMENTS    WALK-INS    UNSPECIFIED
CLINIC  CODE  # VISITS    #     %       #     %       #     %
-----------------------------------------------------------------

DEMO OTHER

  MENTAL HEALTH   4         5      0   0.0    0   0.0      5  100.0
Sub total:                  5      0   0.0    0   0.0      5  100.0

DEMO HOSPITAL/CLINIC

CHRONIC DISEASE  50        17      0   0.0    0   0.0     17  100.0
DENTAL           56       186      0   0.0    0   0.0    186  100.0
DIABETIC         06        55      0   0.0    0   0.0     55  100.0
DIETARY          67        18      0   0.0    0   0.0     18  100.0
EMERGENCY MED    30       228      0   0.0    0   0.0    228  100.0

GENERAL          01       551      0   0.0    0   0.0    551  100.0

GROUP SERVICES   09         9      0   0.0    0   0.0      9  100.0
  GYNECOLOGY     10        15      0   0.0    0   0.0     15  100.0
  MENTAL HEALTH  14         3      0   0.0    0   0.0      3  100.0
  OBSTETRICS     16        49      0   0.0    0   0.0     49  100.0
  OPHTHALMOLOGY  17        27      0   0.0    0   0.0     27  100.0
  OPTOMETRY      18        31      0   0.0    0   0.0     31  100.0
  OTHER          25        10      0   0.0    0   0.0     10  100.0

  PHARMACY       39       203      0   0.0    0   0.0    203  100.0
  PHYSICAL THER  34        86      0   0.0    0   0.0     86  100.0
  PODIATRY       65        29      0   0.0    0   0.0     29  100.0
  RADIOLOGY      63         2      0   0.0    0   0.0      2  100.0
  SURGICAL       23        13      0   0.0    0   0.0     13  100.0
  WELL CHILD     24        10      0   0.0    0   0.0     10  100.0
  WOMEN'S HLTH SCR 70       1      0   0.0    0   0.0      1  100.0
Sub total:               1543      0   0.0    0   0.0   1543  100.0

Total                    1548      0   0.0    0   0.0   1548  100.0
```

Figure 9-11: Example of APPT report

9.11 California State Annual Utilization Report (CSAR)

Use the CSAR option to produce the California State Annual Utilization Report of Primary Care Clinics report for a selected year.

Follow these steps:

1. At the “Enter Calendar year (e.g. 2007)” prompt, specify the calendar year of interest. Use a 4-digit year, e.g., 2006.
2. At the Include visits from ALL Locations?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
3. At the “Select 3P FEE TABLE SCHEDULE NUMBER” prompt, specify the FEE schedule to use in calculating the primary CPT code.
4. At the “Do you want to include a list of visits with no CPT code?” prompt, type **Y** or **N**.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
CALIFORNIA ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS, 2007
                      ALL LOCATIONS OF ENCOUNTER SELECTED
                  Reporting Period: Jan 01, 2007 to Dec 31, 2007

-----------------------------------------------------------------

SECTION 2
FTEs AND ENCOUNTERS BY PRIMARY CARE PROVIDER    Column 5 - No. of
Encounters
                                                                (5)
LINE NO. OF
NO.  PRIMARY CARE PROVIDERS
ENCOUNTERS
-----------------------------------------------------------------

 60  Physicians                                              18,809

 61  Physician Assistants                                     8,661

 62  Family Nurse Practitioners                               4,640

 63  Certified Nurse Midwives                                     0
```

Figure 9-12: Partial example of CSAR report

9.12 PCC Data Analysis Report (DAR)

Use the DAR option to produce a report that counts all visits processed in the PCC and categorizes them by type, service category, and complete/incomplete. It also indicates which visits would be excluded from the APC system.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Include visits for which Facility” prompt, specify the name of the facility.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
   DEMO HOSPITAL/CLINIC                        Apr 09, 1996   Page 1
PCC DATA ANALYSIS REPORT
*******************************************************************
FACILITY:  DEMO HOSPITAL/CLINIC - 000101
VISIT DATE RANGE:  Jan 01, 1995 - Dec 30, 1995

Total Visits Processed in PCC:  140

as of the Date the report was run:
                                          # complete   # incomplete
                                          ----------   ------------

TYPE:               IHS                         100           36
                    OTHER                         3            1
SERVICE CATEGORY:   AMBULATORY                   97           34
                    CHART REVIEW                  1
                    EVENT (HISTORICAL)                          1
                    HOSPITALIZATION               2            2
                    IN HOSPITAL                   3

APC Acceptable Visits based on Headquarters Definition:     93

Exclusions from APC System:

          Dental Clinic w/o Medication                           4
          Other Excluded Clinic Type                             0
          Incomplete A, O, R or S                               15
          Non APC Service Category                               9
          Non APC Visit Type                                     0
          Mult Visits same patient, same day, same clinic       19

Of the acceptable APC visits,      0 were posted or modified afterthe last
export and would not be reflected in reports from the data center.

Of the acceptable APC visits, 27 were not exported due to an error.
These can be reviewed using other PCC reports.

RUN TIME (H.M.S): 0.0.9
End of report.  HIT RETURN:
```

Figure 9-13: Example of DAR report

9.13 General/Dental Clinic Visits on the Same Day (GCDC)

Use the GCDC option to produce a report that shows a list of patients who have had a dental clinic visit and a general clinic visit on the same day.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:

   1 - All
   2 - Individually
   3 - For a Service Unit
   4 - From a Taxonomy

   If you type **2**, **3**, or **4**, additional prompts are displayed.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

   I - Include All patients
   E - Exclude Demo patients
   O - Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

```
                General Clinic and Dental Clinic Visits (Same Day)
                         Location of Visits:  SELECTED

Date Range: Jan 28, 2008 to Jan 27, 2009

Visit Date          Patient Name                       Chart #
-------------------------------------------------------------------
```

Figure 9-14: Example GCDC report

9.14 Listing of Incomplete Laboratory, Rx or Rad Visits (INCV)

Use the INCV option to produce a report that lists all “orphan visits.” You will be asked to select whether you want orphaned laboratory, pharmacy, or radiology visits. If you select laboratory, you will see all visits with no primary provider or POV entered that have a laboratory entry attached to them. The same is true for pharmacy or radiology.

If a visit has both a V LAB and a V RADIOLOGY, the visit would be included in each report.

Follow these steps:

1. At the “What type of orphan visits should be included” prompt, type one of the following:

   L - LAB
   P - PHARMACY
   R - RADIOLOGY

2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.

3. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.

4. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:

   A - ALL Locations/Facilities
   S - One SERVICE UNIT'S Locations/Facilities
   O - ONE Location/Facility

   If you type **S** or **O**, additional prompts are displayed.

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

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

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

```
OUTPUT BROWSER          Jan 27, 2009 15:37:33          Page: 1 of 2
XXX                     Jan 27, 2009                       Page 1

                            INCOMPLETE LAB VISITS
                   Visit Dates: Jan 28, 2008 to Jan 27, 2009

#   #   #
HRN   PATIENT NAME  DATE       TIME  SC TYPE LOC  LAB RX  RAD
-----------------------------------------------------------------

TOTAL NUMBER OF VISITS FOUND: 13

DH 124682 SIGMA,ANGELA  Mar 12, 2008 8:00   H   T  DH    1    0   0
DH 111207 CHI,SHI  Mar 18, 2008 12:00  A   I  DH    3    0   0
DH 111228 BETA,SHICHI  Mar 28, 2008 12:00  A   I  DH    3    0   0

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

Figure 9-15: Example INVC report

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

- If you are not on the last page, type plus (+) to view the next screen
- If you are not on the first page, type minus (-) to view the previous screen
- Type **Q** to quit the report

9.15 Primary Provider Visits – Daily/Annual Report (PPD)

Use the PPD option to produce a report that counts visits by Primary Providers for a given day or year. You can specify the locations or clinics to include in the report up to a total of six for an 80-column report or 12 for a 132-column report. All clinics are counted in the report, including telephone calls, dental, and chart reviews if a clinic is not specified. However, only visits with a primary provider discipline in one of the following codes are tabulated:

Code	Primary Provider Discipline
00	Physician
11	Physician Assistant
16	Pediatric Nurse Practitioner
17	Nurse Midwife
18	Contract Physician
21	Nurse Practitioner
25	Contract Podiatrist
33	Podiatrist
41	Contract OB/Gyn
44	Physician (Tribal)
70 - 90	Physician Specialists

This report will tally the number of visits by primary care providers, provider at the locations ,or the clinics that you specify.

This report can be run for one day (daily report) or for a year (calendar).

A total number of 6 locations or clinics will fit on an 80 column report. You can specify up to 12 if you print the report with 132 columns.

Follow these steps:

1. At the “Run which Report” prompt, type **D** (for daily report) or **Y** (for yearly report).
2. At the “Enter DATE” prompt, specify the date.
3. At the “Do you wish to tally by” prompt, type **C** (for clinic) or **F** (for Facility). Other prompts will display, according the option you use.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

The following sample report was run for an entire facility and six specific clinics for January 15, 1995.

```
XXX                    DEMO HOSPITAL/CLINIC                    Page 1
PRIMARY CARE PROVIDER VISITS - YEARLY REPORT
VISIT DATES: JAN 1, 1995 TO DEC 31, 1995
LOCATION OF VISITS: ALL

PROVIDER  GENERAL  DIABETIC  INTERNAL  OBSTETRI  SURGICAL  EMERGENC
-------------------------------------------------------------------
ALPHAA,CLAYTON   10        2         0         0         0         3
SIGMA,GREG        2        2         0         0         0         0
BETABETA,LORI AN 18        0         0         0         0         0
RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:
```

Figure 9-16: Example of PPD report

9.16 Primary Care Provider Visits – Monthly Report (PPM)

Use the PPM option to produce a report that counts the number of visits by primary care providers for a given month. All clinic codes are in the report including telephone calls, dental, and chart review. Only visits with a primary provider discipline are counted.

A total of 6 locations or clinics will fit on an 80-column report. You can specify up to 12 if you print the report with 132 columns.

Follow these steps:

1. At the “At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date” prompt, specify the end of the date range.

3. At the “Do you wish to tally by” prompt, type **C** (for clinic) or **F** (for facility). Other prompts will display according to the option you specified.

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

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

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

The following sample report was run for the month of January for six selected clinics.

```
                        DEMO HOSPITAL/CLINIC                    Page 1
PRIMARY CARE PROVIDER VISITS - PRIMARY PROVIDER ONLY
VISITS DATES:   JAN 01, 1996  TO   JAN 31, 1996
LOCATION OF VISITS: ALL

DATE     GENERAL   DIABETIC   INTERNAL  OBSTETRI  EMERGENC   DENTAL
-----------------------------------------------------------------------

01/08/96     1         4         11         9         3          5
01/10/96     6         6          9         7         1          6
01/11/96     4         7          6         5         2          3
01/18/96     2         5          7         5         0          5
01/24/96     8         5          6         3         2          5
01/30/96     1         5          8         2         1          7

RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:
```

Figure 9-17: Example of PPM report

9.17 Tally of Selected Provider Disciplines by Clinics (TPC)

The TPC option produces a report that lists a count of all visits to clinics within a taxonomy of clinics you identify. The report is a tally of all primary and secondary providers on those visits. Only those provider disciplines within the discipline taxonomy you select will be tallied.

Follow these steps:

1. At the “At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following

   A - ALL Locations/Facilities
   S - One SERVICE UNIT'S Locations/Facilities
   O - ONE Location/Facility
   T - A taxonomy or Set of Locations/Facilities

   If you type **S**, **O**, or **T**, other prompts will display.
4. At the “Enter Clinic” prompt, specify the clinic for the report. This prompt repeats so that you may type more than one clinic.
5. At the “Enter CLASS” prompt, specify the class.

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

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

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

Figure 9-18: Example TPC report

9.18 Wait Times by Clinic and Provider (WAIT)

The Wait report displays minimum, maximum, and mean waiting times by provider and clinic. In order for data to print in this report, your site must be entering the actual time that the primary provider saw the patient.

You will type a beginning visit date and ending visit date for the time reporting. Then you have the option of printing waiting times for all clinics or only specific clinics that you include.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
3. At the “Tally Waiting Times for ALL Clinics” prompt, type **Y** or **N**.
4. At the “Do you wish to include” prompt, type **W** (for walk-ins only) or **A** (appointments only).
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

Figure 10-19 includes wait times for the Internal Medicine clinic between October 1 and October 31, 1996.

```
*****************************************************************
*   DEMO HOSPITAL/CLINIC                    NOV 25, 1996   Page 1 *
*                                                                 *
*                   WAITING TIMES BY CLINIC AND PROVIDER          *
*                LOCATION OF VISITS:  DEMO HOSPITAL/CLINIC        *
*               REPORT DATE:  OCT 01, 1996  TO  OCT 31, 1996      *
Report includes APPOINTMENTS only.
*****************************************************************

CLINIC           TOTAL  # VSTS    AVG    MIN    MAX     #       #
              VISITS   USED    WAIT   WAIT   WAIT     EARLY   LATE
---------------------------------------------------------------

INTERNAL MEDICINE  120   100      10      0     33      38       62
BETAA,TED           25    20      18      5     37       0       20
GAMMAAAA,LUPE       40    40       5      0     12      18       22
SIGMAAAAAA,TOM      30    25      12      2     23       6       19
THETAA,FLYNN        25    15       8      0     18       6        9
```

Figure 9-19: Example of Wait report

10.0 Billing Reports (BILL)

The following reports are available from the Billing Reports menu:

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

                              DEMO HOSPITAL

      MCA   Listing of Active Medicare Part A Enrollees
      MCB   Listing of Active Medicare Part B Enrollees
      MCD   Listing of Active Medicaid Enrollees
      PI    Listing of Active Private Insurance Enrollees
      CO    Listing of Commissioned Officers and Dependents
      VIS   Listing of Potentially Billable Visits by Date
      COV   Visits by Commissioned Officers and Dependents
      TPR   List of Selected Third Party Coverage(s)

Select Billing Reports Option:
```

Figure 10-1: Example billing reports main menu

10.1 Listing of Active Medicare Part A Enrollees (MCA)

Use the MCA option to produce a report that shows a list of patients registered at a specified facility who currently enrolled in Medicare Part A. You will type an “as of” date for identifying those patients who are actively enrolled from the date you specified. The report sorts alphabetically by patient name.

Follow these steps:

1. At the “Which Facility” prompt, specify the facility name.
2. At the “Patients are to be considered ACTIVE as of what date” prompt, specify the date.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
                        DEMO HEALTH CENTER                      Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART A ENROLLEES
Actively enrolled as of FEB 7,1995

NAME     CHART #  MEDICARE # (TYPE)  COVERAGE  ELIG BEG DATE  ELIG
END DATE   DATE OF BIRTH
---------------------------------------------------------------------
(REG) BETAN,SUSAN          6182      56932812361      FEB 01, 1938
(MCR) OMICRON,HENRY
                  A             SEP 1979
                  A             DEC 31, 1988
-------------------------------------------------------------------
(REG) GAMMA,DARLENE        6708      1234344441       JAN 01, 1989
(MCR) OMICRON,HENRY
                  A             DEC 31, 1988
---------------------------------------------------------------------
(REG) GAMMAA,BILL          14697      57416683018      JUN 01, 1975
(MCR)
                  A             JUL 1975
-------------------------------------------------------------------
```

Figure 10-2: Example listing of active Medicare Part A enrollees

10.2 Listing of Active Medicare Part B Enrollees (MCB)

Use the MCV option to produce a report that shows the patients registered at a specified facility and currently enrolled in Medicare Part B. You will type an “as of” date for identifying those patients who are actively enrolled from the date specified. The report sorts alphabetically by patient name.

The prompts are the same as those for the MCA option.

```
                      DEMO HEALTH CENTER                      Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART B ENROLLEES
Actively enrolled as of FEB 7,1995

   NAME                          CHART #        MEDICARE #
(TYPE)      COVERAGE  ELIG BEG DATE  ELIG END DATE   DATE OF BIRTH
-----------------------------------------------------------------
(REG) BETAB,LISA      9422           526928682144    SEP 01, 1964
(MCR)
                 B    JUL 1966
-----------------------------------------------------------------
(REG) BETAC,SUSAN     6182           56932812361     FEB 01, 1938
(MCR) WASHINGTON,HENRY
                 B    SEP 1979
-----------------------------------------------------------------
(REG) GAMMA,DARLENE   6708           1234344441      JAN 01, 1989
(MCR) WASHINGTON,HENRY
                 B    DEC 13, 1989
-----------------------------------------------------------------
```

Figure 10-3: Example listing of active Medicare Part B enrollees

10.3 Listing of Active Medicaid Enrollees (MCD)

Use the MCD option to produce a report that shows a list of patients registered at a specified facility and currently enrolled in Medicaid who are registered at the facility you select. You will type an “as of” date for determining those patients actively enrolled from the date that you have specified. The report sorts alphabetically by patient name.

The prompts are the same as those for the MCA option.

```
                      DEMO HEALTH CENTER                      Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART B ENROLLEES
Actively enrolled as of FEB 7,1995

   NAME                          CHART #         DATE OF BIRTH
-----------------------------------------------------------------
(REG) BETAB,SAM                  22222           MAY 01, 1977
(MCD)
      MEDICAID #: 0000000001                   STATE: MONTANA
      NAME/INSURED:                            SEX OF INSURED:
-----------------------------------------------------------------
(REG) BETAB,SUSAN                22223           FEB 01, 1938
(MCD)
      MEDICAID #: 0000000002                   STATE: ARIZONA
      NAME/INSURED:                            SEX OF INSURED:
      ELIG BEG DATE: JAN 1983       COVERAGE: 11  ELIG END DATE:
-----------------------------------------------------------------
(REG) GREEN,DARLENE                   22224      JAN 01, 1989
(MCD) SAME
      MEDICAID #: 0000000003                   STATE: MINNESOTA
      NAME/INSURED: GREEN,DARLENE              SEX OF INSURED: F
      ELIG BEG DATE: JAN 31, 1990   COVERAGE:     ELIG END DATE: FEB
14,1990
-----------------------------------------------------------------
```

Figure 10-4: Example listing of active Medicaid enrollees

10.4 Listing of Active Private Insurance Enrollees (PI)

Use the PI option to produce a report that shows a list of patients registered in a specified facility and currently enrolled in private insurance. You will type an “as of” date for identifying those patients who are actively enrolled from the date that you specify. The report sorts alphabetically by patient name.

The prompts are the same as those for the MCA option.

```
                      DEMO HEALTH CENTER                      Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART B ENROLLEES
Actively enrolled as of FEB 7,1995

PATIENT NAME                              CHART #      DATE OF BIRTH
-------------------------------------------------------------------
GBETA,ANNE                                      33333        MAY 01,
1935
       INSURER: AETNA
       POLICY #: 123456                         COVERAGE TYPE:
       INSURED: EEEE,D                          REL: SELF
       ELIG BEG DATE: JAN 27, 1988              ELIG END DATE:
-----------------------------------------------------------------
GBETA,DARLENE                                   33334        JAN 01,
1989
      INSURER: BLUE CROSS/BLUE SHIELD
      POLICY #: 123457                          COVERAGE TYPE:
      INSURED: WBETA,BETA                       REL: SELF
      ELIG BEG DATE: JAN 01, 1989               ELIG END DATE:
-------------------------------------------------------------------
TOTAL NUMBER OF ACTIVE PRIVATE INSURANCE ENROLLEES: 2
```

Figure 10-5: Example listing of active private insurance enrollees

10.5 Listing of Commissioned Officers and Dependents (CO)

Use the CO option to produce a report that lists commissioned officers and their dependents as of the current date.

```
                                                                  page 1
DEMO HEALTH CENTER
COMM. OFFICERS & DEPENDENTS
UCI: DEV
("*" = INACTIVE)
as of FEB 7,1995@18:54:08

 Name                                 IHS #     SSN           CLASS.
--------------------------------- ------   -----------   ----------
BETAAA,SHARON                      44441   xxx-xx-1111     C. O.
BETAA,EVAN                         44442   xxx-xx-1112     C. O.
BETAB,THOMAS                       44443   xxx-xx-1113     C. O.
BETAC,RICHARD                      44444   xxx-xx-1114     C. O.
DELTA,ELIZABETH                    44445   xxx-xx-1115     C. O.
GAMMAA,SHARON                      44446   xxx-xx-1116     C. O.
GAMMAB,PRESTON                     44447   xxx-xx-1117     C. O.
HALPHA,IDA                         44448   xxx-xx-1118     C. O.
HALPHA,ISAIAH                      4449    xxx-xx-1119     C. O.
```

Figure 10-6: Example listing of commissioned officers and their dependents

The last page of the report shows a total.

10.6 Listing of Potentially Billable Visits by Date (VIS)

Use the VIS option to produce a report showing a list of potentially billable visits for all patients registered at a specified facility. This report displays visits for the period in which the patient had third-party coverage. Only visits at the location where a patient is registered will display.

> **Note**: Specific diagnostic categories that might not be covered by the patient's insurance are not considered in the report.

Follow these steps:

1. At the "Run the report for which Facility" prompt, specify the facility name.
2. At the "Starting Visit Date for Billable Visits" prompt, specify the start of the date range.
3. At the "Ending Visits Date for Billable Visits" prompt, specify the end of the date range.
4. At the "Do you want a particular SERVICE CATEGORY?" prompt, type **Y** or **N**. If you type **Y**, other prompts display.

5. At the “Do you want a particular CLINIC?” prompt, type **Y** or **N**. If you type **Y**, other prompts display.
6. At the “Select Third Party Coverage” prompt, select to display visits from the following types of third-party coverage:
   a. Commissioned Officers/Dependents
   b. Medicare Part A
   c. Medicare Part B
   d. Medicaid
   e. Private Insurance
   f. Non-Indians
   g. All Above Coverages
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

The following sample report shows billable visits from September 1, 1988 to February 7, 1990 for patients enrolled in Medicare Part B.

```
                        DEMO HEALTH CENTER                    Page 1
POTENTIALLY BILLABLE VISITS FOR Medicare Part B
Visit Dates: SEP 1,1988 and FEB 7,1990
SERVICE CATEOGYR OF VISITS: ALL VISIT SERVICE CATEGORIES

HRCN   Patient Name                      Date of Birth       SSN
-----------------------------------------------------------------
14697   MALPHA,JAMES                JUN 01, 1975        xxx-xx-0001
        Medicare Name:              DOB: JUN 01, 1975
        Coverage: B Beg. Date: JUL 1975         End. Date:
        Medicare #: 527739228B
        Visit Date      Category     PRV   ICD DX   ICD NARRATIVE
       ---------------------------------------------------------------
        JAN 01, 1990    AMBULATORY    00   465.9    ACUTE URI NOS

4500    MARTIN,ANITA               AUG 01, 1935       xxx-xx-0002
        Medicare Name:              DOB: AUG 01, 1935
        Coverage: B Beg. Date: MAR 21, 1987     End. Date:
        Medicare #: 111991111B
        Visit Date      Category     PRV   ICD DX   ICD NARRATIVE
       ---------------------------------------------------------------
OCT 21, 1988    AMBULATORY    00   250.00   DIABETES UNCOMPL ADU
                                            250.91   DIAB W COMPL NOS JUV
MAR 28, 1989    AMBULATORY    52   V72.2    DENTAL EXAMINATION
OCT 24, 1989    AMBULATORY    71   250.00   DIABETES UNCOMPL ADU
```

Figure 10-7: Example listing of potentially billable visits by date

10.7 Visits by Commissioned Officers and Dependents (COV)

Use the COV option to produce a report that displays visits for all commissioned officers and their dependents at the facility you are logged in to. Specify a date range for the visits and select from the following types of visits:

- Outpatient Visits Only
- Inpatient Visits Only
- Dental Visits Only
- All Visits

Note: This report prints on 132-column paper or on a printer set up for condensed print.

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

DEMO HOSPITAL
COMMISSIONED OFFICERS & DEPENDENTS VISITS
01/01/96 to 01/28/09
OUTPATIENT VISITS
-------------------------------------------------------------------
Patient Name  Chart #  SSN  CO or Dep  Sponsor  SSN  Visit Date  No.
of Visits
-------------------------------------------------------------------

BETAA,FRANCIS SKIRVI   169291    432-47-8159    CO  10/05/04      1
BETAAAAAAAA,JULIE EL   153848    519-50-1222    CO  02/06/03
                                                   02/12/03
                                                   02/12/03
                                                   04/28/04
                                                   05/26/04
                                                   06/15/04
                                                   06/16/04
                                                   12/21/04
                                                   01/29/05
                                                   10/07/05
                                                   10/12/05
                                                   10/19/05
                                                   03/08/06
                                                   04/17/07
                                                   08/15/07
                                                   08/16/07
                                                   08/22/07    17
```

Figure 10-8: Example listing of visits by commissioned officers and dependents

10.8 List of Selected Third Party Coverage(s) (TPR)

The TPR option allows you to print a list of patients registered at the facility you select, who have insurance coverage with the insurer you select.

Follow these steps:

1. At the “Which Facility” prompt, specify the facility name.
2. At the “Select a type of insurance” prompt, type one of the following:

   1 - Medicare Part A
   2 - Medicare Part B
   3 - Medicaid
   4 - A Selected Private Insurance
   5 - Railroad Part A
   6 - Railroad Part B

3. At the “Do you want patients that only have this one insurer (no other coverage)? prompt, type **Y** or **N**.
4. At the “Select Type of Eligibility Dates” prompt, specify the date.
5. At the “Select Type of Eligibility Dates” prompt, type one of the following:

   1 - Currently Active Eligibility Dates
   2 - Any Past or Current Eligibility Dates
   3 - Selected Eligibility Dates

6. At the “Do you want to print all beginning and Ending eligibility date pairs” prompt, type **Y** or **N**.
7. At the “sort the Report By” prompt, type **1** (for patient name) or **2** (for patient HRNO.
8. At the “Device” prompt, specify the device to print/browse the report.

```
01/28/07                        DEMO HOSPITAL                  Page 1
                       Patient List for Medicare Part A
                          With any eligibility dates

Patient Name               HRNO      MCR #    SUF    Begin     End
------------             ------   ---------  ---  --------  --------
SIGMA,ADONNA              11111    13333333    A   11/01/90
SIGMA,JAYDEN              11112    13333334    A   06/01/83
SIGMA,DAVID               11113    13333335    A   07/01/93
SIGMA,GEORGE              11114    13333336    A   05/01/82  07/31/05
SIGMA,MARTHA              11115    13333337    A   09/01/01
```

Figure 10-9: Example of TPR report

11.0 Activity Reports by Discipline Group (ACT)

This set of reports provides Activity and Travel Times (in minutes) for the discipline group you select. Three discipline groups are already defined:

Group	Discipline	Code
PHN	CHN/Aides	13
	CHN (Contract)	32
Mental Health	Mental Health	19
	Psychiatrist	81
	Neurologist	85
	Contract Psychologist	50
	Psychologist	12
	Contract Psychiatrist	49
Social Services	Medical Social Worker	06
	Licensed Med Social Worker	62
	Contract Social Worker	63

You can define new discipline groups, as appropriate, using the CAG option. However, the only method for tracking each specific discipline is to have each provider type an activity time and/or travel time on the PCC Encounter Form.

Each report can be filtered by location of encounter and clinic.

The menu includes the following reports:

```
                 ************************************************
                 **           PCC Management Reports           **
                 **    Activity Reports by Discipline Group    **
                  ************************************************
                             IHS PCC Suite Version 2.0

                               DEMO HOSPITAL/CLINIC

       TSPR   Time and Patient Services by Provider
       TSSU   Time and Patient Services by Service Unit
       PPPR   Primary Problem by Provider
       PPLO   Primary Problem by Facility
       PPSU   Primary Problem by Service Unit
       INPR   Number of Individuals seen by Provider
       INSU   Number of Individuals seen by Service Unit
       AGE    Patient Services by Age and Sex
       TEN    Top Ten Primary Diagnoses
       CAG    Create new Activity Discipline Group
       INQA   Inquire into an Activity Group
       TSCR   Time and Services by Provider for Chart Reviews

Select Activity Reports by Discipline Group Option:
```

Figure 11-1: Example activity reports by discipline group menu

11.1 Time and Patient Services by Provider (TSPR)

Use the TSPR option to produce a report that displays the number of patient contacts, total activity time, and total travel time for each provider by location of encounter within a specified provider discipline group.

Type a beginning and ending visit date range and the discipline group.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, specify the discipline group. Then the system will display information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
4. At the “Include visits from which set of locations” prompt, type one of the following:

O - One Location
T - Taxonomy of or Selected set of Locations
A - All Locations

5. At the “Include visits from which set of clinics” prompt, type one of the following:

   O - One Clinic
   T - Taxonomy or Selected Set of Clinics
   A - All Clinics

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

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

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

```
OCT 15,1994                                                    Page 1
PATIENT CONTACT REPORT FOR MENTAL HEALTH STAFF
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994
All Locations
All Clinics
PROVIDER: VPROVIDER, THOMAS L

TOTAL     # CONTS     # CONTS  PATIENT   AS PRIM.    AS SEC.  ACTIVITY    TRAVEL
LOCATION OF ENCOUNTER        CONTACTS  PROVIDER PROVIDER  TIME *      TIME
-------------------------------------------------------------------
DEMO OTHER             2         1           1        54          50
DEMO ADMINISTRATION    4         4           0        123         30
DEMO HOSPITAL/CLINIC   4         3           1        90          39

             TOTAL:   10        8           2        267        119

* -- 1 of the visits did not have an activity time recorded.

NOTE: This report separates visits and time into individual staff member contacts.
If Provider A and Provider B participated on the same visit for a patient and spent
20 minutes in that visit, that is displayed on this report as a contact for each
provider and 20 minutes activity time for each provider.

RUN TIME (H.M.S): 0.0.3
End of Report - Hit return
```

Figure 11-2: Example time and patient services report by provider

11.2 Time and Patient Services by Service Unit (TSSU)

Use the TSSU option to produce a report that displays total patient contacts, total activity time, and total travel time for a selected discipline group by SU.

The prompts are the same as the TSPR option.

```
OCT 15,1994                                                    Page 1
LOCATION OF ENCOUNTER REPORT BY SERVICE UNIT FOR PHN STAFF
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994
All Locations
All Clinics
SERVICE UNIT: DEMO

TOTAL     # CONTS     # CONTS  PATIENT   AS PRIM.    AS SEC.   ACTIVITY
TRAVEL LOCATION OF ENCOUNTER  CONTACTS  PROVIDER    PROVIDER  TIME *
TIME
-----------------------------------------------------------------
 DEMO OTHER     2          2           0          54         50
 DEMO HOSPITAL/CLINIC   6          5           1          110        59
TOTAL:         8          7           1          164       119

* -- 2 of the visits did not have an activity time recorded.

NOTE: This report counts one visit regardless of the number of PHN staff
involved in that visit, and time represents total time reported regardless
of the number of staff reporting on a single PCC Encounter Form.
```

Figure 11-3: Example time and patient services report by service unit report

11.3 Primary Problem by Provider (PPPR)

Use the PPPR option to produce a time and services report that totals primary problems for each provider in a specified discipline group. totals for patient contacts, activity times, and travel times for each diagnosis are displayed.

Type a beginning and ending visit date range and a discipline group. Check the report heading.

```
OCT 15,1994                                                    Page 1
PRIMARY PROBLEM REPORT BY PROVIDER PHN STAFF
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994
PROVIDER: COMMUNITY HEALTH NURSE,IHS

    TOTAL #   CONTS #     CONTS
    PATIENT   AS PRIM.    AS SEC.   ACTIVITY    TRAVEL
PRIMARY PROBLEM  CONTACTS  PROVIDER    PROVIDER  TIME*       TIME
-----------------------------------------------------------------
DIABETES           2        1         1         54          50
OTHER DIS OF THE NERVOUS    4        4         0         123     30
PRENATAL,FIRST TRIMESTER         4        3         1         90 39

TOTAL:               10       8         2         267        119

* -- 1 of the visits did not have an activity time recorded.

NOTE: This report separates visits and time into individual staff
member contacts. If Provider A and Provider B participated on the
same visit for a patient and spent 20 minutes in that visit, that is
displayed on this report as a contact for each provider and 20
minutes activity time for each provider.

RUN TIME (H.M.S): 0.0.3
End of Report - Hit return
```

Figure 11-4: Example primary problem report by provider report

11.4 Primary Problem by Facility (PPLO)

The PPLO report totals primary problems for a specific discipline group and Location of Encounter. Totals for activity times, travel times, and patient contacts for each problem are displayed.

You will type a beginning and ending visit date range and a discipline group.

The prompts are the same as the TSPR option.

```
JAN 28, 2009                                              Page 1
          PRIMARY DX REPORT BY LOCATION OF ENCOUNTER FOR GENERAL STAFF
                  VISIT DATES:  AUG 01, 2008  TO  JAN 28, 2009
                                 All Locations
                                  All Clinics
                       LOCATION OF ENCOUNTER:  DEMO HOSPITAL

                  TOTAL     # VISITS  # VISITS
                 PATIENT   AS PRIM.  AS SEC.   ACTIVITY   TRAVEL
PRIMARY DX      CONTACTS  PROVIDER  PROVIDER  TIME*      TIME
-------------------------------------------------------------------

MUMPS UNCOMPLICATED   1         1         0      0.00      0.00

          TOTAL:      1         1         0      0.00      0.00


* -- 1 of the visits did not have an activity time recorded.

NOTE:  This report counts one visit regardless of the number of GENERAL
staff involved in that visit, and time represents total time reported
regardless of the number of staff reporting on a single PCC Encounter Form.

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

Figure 11-5: Example primary problem report by facility report

11.5 Primary Problem by Service Unit (PPSU)

The PPSU report displays primary problems for a specific SU. Totals are shown for patient contacts, activity times, and travel times for each provider within the discipline group you select.

You will type a beginning and ending visit date range, SU, and discipline group.

The prompts are the same as the TSPR option.

```
JAN 28, 2009                                                Page 1
                PRIMARY DX REPORT BY SERVICE UNIT FOR PHN STAFF
                  VISIT DATES:  JAN 01, 2003  TO  JAN 28, 2009
                                 All Locations
                                  All Clinics
                            SERVICE UNIT:  NON SVC UNIT

                  TOTAL     # VISITS  # VISITS
                  PATIENT   AS PRIM.  AS SEC.   ACTIVITY   TRAVEL
PRIMARY DX        CONTACTS  PROVIDER  PROVIDER  TIME*      TIME
-------------------------------------------------------------------

DIABETES            58        54         4     11.70      6.58
GENERAL/MULTIPLE   158       158         0     78.27      8.68

          TOTAL:   216       212         4     89.97     15.27


* -- 4 of the visits did not have an activity time recorded.

NOTE:  This report counts one visit regardless of the number of GENERAL
staff involved in that visit, and time represents total time reported
regardless of the number of staff reporting on a single PCC Encounter Form.

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

Figure 11-6: Example primary problem report by service unit report

11.6 Number of Individuals Seen by Provider (INPR)

The INPR report displays the number of individuals seen by each provider within a discipline by location of encounter for the discipline group you select.

You will be prompted to type the beginning and ending visit dates and discipline group.

The prompts are the same as the TSPR option.

```
OCT 15,1994                                                Page 1
NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994 COMMUNITY HEALTH PROVIDER:
PROVIDER: COMMUNITY HEALTH PROVIDER,IHS

                          TOTAL NUMBER OF INDIVIDUALS SEEN
-------------------------------------------------------------
 DEMO OTHER                                          101
 DEMO ADMINISTRATION                                  99
 DEMO HOSPITAL/CLINIC                                250

            TOTAL:                                   450
```

Figure 11-7: Example number of individuals seen by provider report

11.7 Number of Individuals Seen by Service Unit (INSU)

Use the INSU option to produce the number of individuals seen by SU for staff members in the specified disciple group. The report displays, by location of encounter, the number of individuals seen by providers within a discipline group you select for a specified SU.

You will be prompted to type the beginning and ending visit dates and the discipline group.

The prompts are the same as the TSPR option.

```
OCT 15,1994                                                    Page 1
NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994
All Locations
All Clinics
SERVICE UNIT: DEMO

                           TOTAL NUMBER OF
                           INDIVIDUALS SEEN
-------------------------------------------------------------------
DEMO CLINIC                                          99
DEMO OTHER                                          101
DEMO HOSPITAL/CLINIC                                250

            TOTAL:                                  450
```

Figure 11-8: Example number of individuals seen by service unit report

11.8 Patient Services by Age and Sex (AGE)

Use the Age option to produce a report that shows, for all visits on which staff members of a discipline group you selected was a provider, time and patient services by age and sex.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, specify the discipline group. Then the system will display information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
4. At the “Include visits from which set of locations” prompt, type one of the following:

O - One Location
T - Taxonomy of or Selected set of Locations
A - All Locations

5. At the “Include visits from which set of clinics” prompt, type one of the following:

   O - One Clinic
   T - Taxonomy or Selected Set of Clinics
   A - All Clinics

6. The age groups to be used are currently defined as:

   0-0
   1-4
   5-14
   15-19
   20-24
   25-44
   45-64
   65-125

7. At the “Do you wish to modify these age groups?” prompt, type **Y** or **N** (consider the age groups shown above). If you type **Y**, other prompts will display.

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

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

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

```
OCT 15,1994                                                    Page 1
TIME AND PATIENT SERVICES REPORT BY AGE AND SEX FOR PHN STAFF
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994
All Locations
All Clinics
SEX: FEMALE

                    TOTAL      # CONTS      # CONTS

                   PATIENT      AS PRIM.     AS SEC.   ACTIVITY   TRAVEL
AGE GROUP          CONTACTS      PROVIDER     PROVIDER  TIME*      TIME
-----------------------------------------------------------------
0-0 years       15             15            .     100         .
1-4 years       30             25            5     50          .
5-14 years      10              5            5     100         .
15-19 years     30             20            5     240         30
20-24 years     .               .            .       .         .
25-44 years     .               .            .       .         .
45-64 years     50             30           20     500       100
>64 years       .              .            .        .         .

TOTAL:          135             95           35     990       130

* -- 1 of the visits did not have an activity time recorded.
NOTE:  This report counts one visit regardless of the number of PHN staff
involved in that visit, and time represents total time reported regardless
of the number of staff reporting on a single PCC Encounter Form.
```

Figure 11-9: Example time and patient services report by age and sex report

11.9 Top Ten Primary Diagnoses (TEN)

The Ten report displays the top 10 primary POVs by providers within the discipline group you select. The report generates for a specified SU.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, specify the discipline group. Then the system will display information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, specify the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, specify the end of the date range.
4. At the “Which Service Unit” prompt, specify the SU name.

5. At the “Include visits from which set of clinics” prompt, type one of the following:

   O - One Clinic
   T - Taxonomy or Selected Set of Clinics
   A - All Clinics

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

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

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

```
APR 10, 1996                                                    Page 1
TOP TEN PRIMARY DX REPORT BY SERVICE UNIT PHN STAFF
VISIT DATES: JAN 01, 1995 TO JAN 31, 1995
All Clinics
SERVICE UNIT: DEMO

PRIMARY DX                      TOTAL PATIENT CONTACTS
-----------------------------------------------------------------
WELL CHILD CARE                                19
DIABETES                                       14
HYPERTENSION                                   8
GENERAL/MULTIPLE                               6
PRENATAL, FIRST TRIMESTER                      4
OTHER SUBSTANCE ABUSE                          3
TUBERCULOSIS, REACTOR/CONV                     2
SCABIES                                        1

RUN TIME (H.M.S): 0.2.16
End of report. HIT RETURN:
```

Figure 11-10: Example top 10 diagnoses report by SU report

11.10 Create new Activity Discipline Group (CAG)

The CAG option provides a means to define and create a new discipline group. Once the new group is created and providers within that discipline record their activity and travel times on the PCC Encounter Form, activity reports can be generated for the new discipline group.

```
Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP: NURSES
  ARE YOU ADDING 'NURSES' AS A NEW PCC MAN REPORTS ACTIVITY
GROUP (THE 4TH)? Y (YES)
NAME OF GROUP: NURSES//
Select DISCIPLINES IN GROUP: 05 LICENSED PRACTICAL NURSE
  ARE YOU ADDING 'LICENSED PRACTICAL NURSE' AS
    A NEW DISCIPLINES IN GROUP (THE 1ST FOR THIS PCC MAN REPORTS
ACTIVITY
GROUP)? Y (YES)
Select DISCIPLINES IN GROUP: 01 REGISTERED NURSE
  ARE YOU ADDING 'REGISTERED NURSE' AS A NEW DISCIPLINES IN GROUP
 (THE 2ND FOR THIS PCC MAN REPORTS ACTIVITY
GROUP)? Y (YES)
```

Figure 11-11: Creating a new activity discipline group

11.11 Inquire into an Activity Group (INQA)

Use the INQA option to view information about an established activity group.

```
NAME OF GROUP: PHN                        ICD RECODE ROUTINE: APCLRCHA
  RECODE GLOBAL: AUTTCHA                  PIECE FOR DESC. IN RECODE
FILE: 3
  STANDARD: YES
DISCIPLINES IN GROUP: CHN/AIDES           DISCIPLINE CODE: 13
DISCIPLINES IN GROUP: CHN (CONTRACT)      DISCIPLINE CODE: 32

Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP:
```

Figure 11-12: Inquiring into an activity group

11.12 Time and Services by Provider for Chart Reviews (TSCR)

The TSCR report displays ,by location of encounter, the number of patient chart reviews and the total activity and travel time for each provider with a discipline in the provider discipline group you select.

The prompts are the same as the TSPR option.

```
JAN 28, 2009                                                    Page 1
                      CHART REVIEW REPORT FOR PHN STAFF
                   VISIT DATES:  JAN 01, 2006  TO  JAN 28, 2009
                                  All Locations
                                   All Clinics
                           PROVIDER:  IOPROVIDER,DEBRA M

       TOTAL     # CR'S    # CR'S
       CHART     AS PRIM.  AS SEC.   ACTIVITY   TRAVEL
LOCATION OF ENCOUNTER       REVIEWS   PROVIDER  PROVIDER  TIME* TIME
-------------------------------------------------------------------
HOME     1         1         0      0.25      0.08
CIHA DIABETES CLINIC 6         6         0      0.42      0.00
          TOTAL:     7         7         0      0.67      0.08

* -- 1 of the visits did not have an activity time recorded.
NOTE:  This report separates visits and time into individual staff
member contacts.  If Staff Member A and Staff Member B participated
on the same visit for a patient and spent 20 minutes in that visit,
that is displayed on this report as a contact for each staff member.
```

Figure 11-13: Example TSCR report

12.0 Dx and Procedure Count Summary Report (CNTX)

Use the CNTX option to access the options for the Count Summary menu:

```
                      ************************************
                      **     PCC Management Reports     **
                      **       Count Summary Menu       **
                      ************************************
                            IHS PCC Suite Version 2.0

                                  DEMO HOSPITAL

   CPTP   CPT Code by Provider Report
   DXAG   Diagnoses by AGE report
   DXFA   DX Tally by Local, Secondary, Tertiary Facility
   FCPT   Frequency of CPTs Report
   FPRC   Frequency of Procedures Report
   PAPC   Purpose of Visits grouped by APC codes
   RXDA   RX Data Analysis Report
   TEN    Frequency of Diagnoses Report
   TOP    Tally of Operating Provider for Procedures

Select Dx & Procedure Count Summary Reports Option:
```

Figure 12-1: Options on the Count Summary Menu

12.1 CPT Code by Provider Report (CPTP)

Use the CPTP option to produce a report that shows the CPT codes entered by a specified provider. You will be able to specify the date range; whether to include outpatient (ambulatory, day surgery, observation), inpatient visits or both; tally CPT codes by primary provider only or primary and secondary provider; and whether to include only visits to one facility, a service unit or to patients who are members of a particular tribe.

> **Note**: If you choose both primary and secondary providers, the following logic will be applied:

If you use the CPE mnemonic or the CPT code is entered through EHR, the CPT code will be linked to the encounter provider documented. If there is no encounter provider documented, the CPT code will be tallied under each provider on that visit; thus the counts will include the same CPT code multiple times.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date” prompt, specify the end of the date range.

3. At the “Report should include” prompt, type **P** (for primary provider only) or **A** (for all providers, primary and secondary).

4. At the “Report should include” prompt, use one of the following:

   O - Outpatient Visits (ambulatory, day surgery, observation)
   I - Inpatient
   B - Both

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

   S - One Service Unit
   L - One Location/Facility
   T - One Tribe
   A - All visits

   If you type **S**, **L**, or **T**, additional prompts are displayed.

6. At the “Select an Output Option” prompt, type one of the following:

   P - Print Report on Printer or Screen
   D - Create Delimited output file (for use in Excel)
   B - Both a Printed Report and Delimited File

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

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

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

```
   SJT                    Jan 28, 2009                        Page 1

                     ***  CPT Code by Provider Report  ***
                   Visit Dates: Jan 01, 2006 to Jan 28, 2009

Provider Name                                  Discipline
AAPROVIDER,GORDON                              NURSE ASSISTANT

Ambulatory/Outpatient Services:

CPT Code   CPT Narrative                           # Subtotaled by
CPT
10060      DRAINAGE OF SKIN ABSCESS                          2
11100      BIOPSY, SKIN LESION                               1
11200      REMOVAL OF SKIN TAGS                              1
11730      REMOVAL OF NAIL PLATE                             3
11732      REMOVE NAIL PLATE, ADD-ON                         1
17000      DESTRUCT PREMALG LESION                           3
17003      DESTRUCT PREMALG LES, 2-14                        1
17110      DESTRUCT B9 LESION, 1-14                          1
20552      INJ TRIGGER POINT, 1/2 MUSCL                      3
20605      DRAIN/INJECT, JOINT/BURSA                         1
29130      APPLICATION OF FINGER SPLINT                      1
36000      PLACE NEEDLE IN VEIN                              4
51701      INSERT BLADDER CATHETER                           1
59025      FETAL NON-STRESS TEST                             1
59430      CARE AFTER DELIVERY                               1
69210      REMOVE IMPACTED EAR WAX                           7
70160      X-RAY EXAM OF NASAL BONES                         1
70450      CT HEAD/BRAIN W/O DYE                             1
70486      CT MAXILLOFACIAL W/O DYE                          1
```

Figure 12-2: Example CTPT report

12.2 Diagnoses by AGE Report (DXAG)

Use the DXAG option to produce the Frequency of Diagnoses By Age report that shows diagnoses by age group.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, specify the beginning of the date range.

2. At the “Enter ending Visit Date” prompt, specify the e of the date range.

3. The application displays the following information:

```
When I search the database, I can "screen" POVs according to any one
of the following attributes:
               PATIENT SEX
               FACILITY OF ENCOUNTER
               PRIMARY PROVIDER
               CLINIC TYPE
               SERVICE CATEGORY (Hospitalizations, Ambulatory, Chart
Reviews Nursing Home, etc.)

VISIT TYPE (IHS, Contract, Tribal, 638, Other, VA)
```

4. At the “Want to use one or more of these ‘screens’?” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.

   The application displays the following information:

```
The Age Groups to be used are currently defined as:

0 - 0
1 - 4
5 - 14
15 - 19
20 - 24
25 - 44
45 - 64
65 - 125
```

5. At the “Do you wish to modify these age groups?” prompt, type **Y** or **N** (considering the currently defined age groups). If you type **Y**, other prompts will display.

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

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

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

This report should be printed on 132-column paper or on a printer that is set for condensed print. If you do not have such a printer available, see your site manager.

```
SJT           DEMO HOSPITAL                                  Page 1
                                       Diagnoses by Age Report
   Visit Dates:  OCT 30, 2008 to JAN 28, 2009     Type of Visit:
ALL
        Service Category:  ALL
   Location of Encounter:  ALL            Clinic:  ALL
        Sex of Patient:  BOTH
   Primary Provider:  ALL     Purpose of Visits:  Primary and
Seconday POV's

                                        AGE GROUPS
ICD Code  ICD Narrative   0-0   1-4   5-14   15-19   20-24   25-44
45-64    65-125   TOTAL
-----------------------------------------------------------------
007.1     GIARDIASIS                 .        .        .        .

.
          .
                             1
                                   1
                                          2

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

Figure 12-3: Example DXAG report

12.3 DX Tally by Local, Secondary, Tertiary Facility (DXFA)

Use the DSFA option to produce a report showing a tally of all diagnoses for patients in a community or communities you select. The report will tally the diagnoses for the community's local, secondary, and tertiary facilities. Each community's report will be two pages long: one page for outpatient diagnoses and one for inpatient diagnoses.

Follow these steps:

1. At the "Please Identify your Service Unit" prompt, specify the service unit name.
2. At the "Enter Beginning Visit Date" prompt, specify the beginning of the date range.
3. At the "Enter Ending Visit Date" prompt, specify the end of the date range.

4. At the “Enter a code indicating what COMMUNITIES of RESIDENCE are of interest” prompt, type one of the following:

   O - One Particular Community
   S - All communities within the XXX UNIT (where XXX is the unit’s name)
   T - A TAXONOMY or selected set of communities

   If you type **S** or **T**, additional prompts are displayed.

   The system checks the community table for the required items; if any are missing, the process will stop. See you site manager about fixing the community entries. You can the select other communities or exit the report.

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

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

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

Figure 12-4: Example DSFA report

12.4 Frequency of Procedures Report (FPRC)

Use the FPRC option to produce the Frequency of Procedures report, which shows the top number of procedures done at a specified facility.

Follow these steps:

1. At the “Please Identify your Service Unit” prompt, specify the SU name.
2. At the “Enter Beginning Visit Date” prompt, specify the beginning of the date range.
3. At the “How many entries do you want in the list (5-100)” prompt, specify any integer between 5 and 100.

4. The system displays the Visit Selection Menu

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

1) Name/Chart #/SSN        58) Outside Location      115) BMI (Last calculated)
2) Sex                     59) Clinic Type            116) RX Ordering Provider
3) Date of Birth           60) Visit Created By       117) Dental ADA Codes
4) Birth Month             61) User Last Update       118) Radiology Exam
5) Birth Weight (grams)    62) VCN # Present          119) Immunization Provider
6) Birth Weight (Kgs)      63) 3rd Party Billed?      120) Immunization Lot #
7) Race                    64) Hospital Location      121) Immunizations
8) Age                     65) Admitting Service      122) Exams
9) Age in Months           66) Admission Type         123) Treatments Provided
10) Veteran Status Y/N     67) Admission Source-UB92  124) Lab Tests
11) Date of Death          68) Admitting Provider (In 125) Microbiology Culture
12) Date Patient Establish 69) Discharge Service      126) Microbiology Organism
13) Mlg Address-State      70) Date of Discharge      127) Medications
14) Mlg Address-Zip        71) Discharge Type         128) Medications+SIG

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

Figure 12-5: Visit Selection menu

You can select the criteria for selecting which visits to appear on the report by using the Select Item(s) action option. After selecting an item, an asterisk (*) indicates that the items was selected.

Otherwise, type **Q (**Quit Item selection) to specify that you want to use all visits.

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

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

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

```
          ********** FREQUENCY OF PROCEDURES REPORT **********

REPORT REQUESTED BY: THETA,SHIRLEY

The following report contains a PCC Visit report based on the
following criteria:

VISIT Selection Criteria

      Encounter Date range:  AUG 01, 2006 to JAN 28, 2009

ALL VISITS IN DATE RANGE SELECTED.

Total COUNT of Visits:  484

No. VISITs: 484     No. PRCs: 573   PRC/VISIT ratio: 1.18 (min. std. > 1.6)

TOP 10 PRC's =>
   1.  89.54   ELECTROGRAPHIC MONITORING  (88)
   2.  94.62   ALCOHOL DETOXIFICATION  (61)
   3.  99.04   PACKED CELL TRANSFUSION  (38)
   4.  70.24   VAGINAL BIOPSY  (35)
   5.  45.23   FLEX FIBEROPTIC COLONOSC  (28)

   6.  39.95   HEMODIALYSIS  (21)
   7.  47.01   LAPAROSCOPIC APPENDECTOMY  (15)
   8.  88.01   C.A.T. SCAN OF ABDOMEN  (13)
   9.  67.32   CERVICAL LES CAUTERIZAT  (11)
   10. 94.65   DRUG DETOXIFICATION  (11)

RUN TIME (H.M.S): 0.0.3
End of report.  HIT RETURN:
```

Figure 12-6: Example FPRC report

12.5 Purpose of Visits Group by APC Codes (PAPC)

Use the PAPC option to produce the Purpose of Visits Count report, which shows only Ambulatory Visits within a specified date range.

Follow these steps:

1. At the “Please Identify your Service Unit” prompt, specify the SU name.
2. At the “Enter Beginning Visit Date” prompt, specify the beginning of the date range.
3. At the “Should the counts only include visits for patients from a specific community?” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.

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

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

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

```
DEMO HOSPITAL                                     JAN 28,2009 Page 1

POV Counts for Ambulatory Visits from AUG 1,2008 through JAN 28,2009. ICD9
Subcounts are restricted to the leading 20 Purposes of Visit.

APC    APC Category                                        Count
-----------------------------------------------------------------

303    INFLUENZA                                              13

       ICD9   ICD9 Description
       ------ ------------------------
       487.1  FLU W RESP MANIFEST NEC                         13

999    NO REPORTED DIAGNOSIS                                  11

       ICD9   ICD9 Description
       ------ ------------------------
       V62.84 SUICIDAL IDEATION                               6
       .9999  UNCODED DIAGNOSIS                               5
```

Figure 12-7: Example PAPC report

12.6 RX Data Analysis Report (RXDA)

Use the RXDA option to produce the RX Data Analysis Report, which tallies all RXs for a specified date range and breaks them down by Time Released and Count by Hour increments. It also allows printing the report for *all divisions* or for one specified division.

Follow these steps:

1. At the “Enter Beginning RX Release Date” prompt, specify the beginning of the date range.
2. At the “Enter Ending RX Release Date” prompt, specify the end of the date range.
3. At the “Include RX’s from ALL DIVISIONS?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
   DEMO HOSPITAL                                  Jan 28, 2009  Page 1
                              RX ANALYSIS REPORT
                        RX RELEASE TIME WORKLOAD DISTRIBUTION
*****************************************************************

DIVISION:  ALL DIVISIONS
RX RELEASE DATE RANGE:  Jan 01, 2006 - Jan 28, 2009

Total Prescriptions Dispensed:  214769
                         RX COUNT       ACT % TOTAL    ADJ % TOTAL
                         ________       ___________    ___________

**AM Prescriptions Dispensed**
******************************
Total RX's Before 8:00:           11927            6             NA
Total RX's  8:00- 8:59:           14114            7             NA
Total RX's  9:00- 9:59:           22986           11             12
Total RX's 10:00-10:59:           27362           13             14
Total RX's 11:00-11:59:           23669           11             13

**PM Prescriptions Dispensed**
******************************
Total RX's 12:00-12:59:           17134            8              9
Total RX's  1:00- 1:59:           17410            8              9
Total RX's  2:00- 2:59:           27045           13             14
Total RX's  3:00- 3:59:           25789           12             14
Total RX's  4:00- 4:59:           17242            8              9
Total RX's  5:00- 5:59:           9083             4              5
Total RX's  6:00- 6:59:           841              0              0
Total RX's  7:00- 7:59:           53               0              0
Total RX's  8:00- 8:59:           40               0              0
Total RX's  9:00- 9:59:           35               0              0
Total RX's 10:00-10:59:           33               0              0
Total RX's 11:00-11:59:           6                0              0
                           ________        ________       ________
                                  214769         100%           100%

                              ***SUMMARY***
ACT Total-All Hours:      214769    ADJ Total After 9:00 AM: 188728
ACT Percent After 2:00 PM:  37%   ADJ Percent After 2:00 PM:     42%
ACT Percent After 3:00 PM:  25%   ADJ Percent After 3:00 PM:     28%
ACT Percent After 4:00 PM:  13%   ADJ Percentage After 4:00 PM:  14%
                              *************
NOTE: ACT Total includes all hours - ADJ Total excludes all Non-
Pharmacy and evening dispensed RX's that are typically encoded
between 8:00-9:00 AM.


RUN TIME (H.M.S): 0.1.45
End of report.  HIT RETURN:
```

Figure 12-8: Example TXDA report

12.7 Frequency of Diagnoses Report (TEN)

Use the TEN option to produce the Frequency of Diagnoses report, which shows the most frequent diagnosis for that date range.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, specify the end of the date range.
3. At the “Include which patients in the tally of diagnoses” prompt, type **A** (for all patients) or **S** (for search template of patients. If you type **S**, other prompts will display.
4. At the “How many entries do you want in the list (5-100)” prompt, specify any integer between 5 and 100.
5. The system displays the Visit Selection menu.

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

1) Name/Chart #/SSN        58) Outside Location       115) BMI (Last calculated)
2) Sex                     59) Clinic Type            116) RX Ordering Provider
3) Date of Birth           60) Visit Created By       117) Dental ADA Codes
4) Birth Month             61) User Last Update       118) Radiology Exam
5) Birth Weight (grams)    62) VCN # Present          119) Immunization Provider
6) Birth Weight (Kgs)      63) 3rd Party Billed?      120) Immunization Lot#
7) Race                    64) Hospital Location      121) Immunizations
8) Age                     65) Admitting Service      122) Exams
9) Age in Months           66) Admission Type         123) Treatments Provided
10) Veteran Status Y/N     67) Admission Source-UB92  124) Lab Tests
11) Date of Death          68) Admitting Provider (In 125) Microbiology Culture
12) Date Patient Establish 69) Discharge Service      126) Microbiology Organism
13) Mlg Address-State      70) Date of Discharge      127) Medications
14) Mlg Address-Zip        71) Discharge Type         128) Medications+SIG

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

Figure 12-9: Visit Selection menu

Select the criteria for selecting which visits to appear on the report by using the Select Item(s) action option. After selecting an item, an asterisk (*) indicates that the items were selected. Otherwise, type Quit Item selection (**Q**) option to specify that you want to use all visits.

6. At the “Report should include” prompt, type **P** (for primary POV) or **A** (for all POVs).

7. The system displays the following information:

```
You have the opportunity to exclude certain diagnoses from this
report. For example, to eliminate Pharmacy refill diagnoses, you
need to exclude V68.1 from this report. If you chose to include only
the primary pov then visits with a primary pov of V68.1 will be
excluded.
```

8. At the “Do you wish to exclude any diagnoses codes from the report?” prompt, type **Y** or **N**. If you type **Y**, other prompts will display.

9. At the “Select TYPE OF OUTPUT” prompt, type **L** (for list of items with counts) or **B** (for bar chart, 132 columns).

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

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

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

```
          ********** FREQUENCY OF DIAGNOSES REPORT **********
                       Report run at: DEMO HOSPITAL

REPORT REQUESTED BY: THETA,SHIRLEY

The following report contains a PCC Visit report based on the
following criteria:

VISIT Selection Criteria

      Encounter Date range:  AUG 01, 2008 to JAN 28, 2009

     ALL VISITS IN DATE RANGE SELECTED.

     ALL (Primary and Secondary) POV's included.

Total COUNT of Visits:  100
No. VISITs: 100    No. POVs: 108   POV/VISIT ratio: 1.08 (min. std. > 1.6)

TOP 10 POV's =>
                                          # Visits  # Patients
   1.  072.9   MUMPS UNCOMPLICATED        23               23
   2.  487.1   FLU W RESP MANIFEST NEC    13                5
   3.  V62.84  SUICIDAL IDEATION          6                 6
   4.  .9999   UNCODED DIAGNOSIS          5                 5
   5.  079.81  HANTAVIRUS INFECTION       4                 3
   6.  401.9   HYPERTENSION NOS           3                 3
   7.  007.1   GIARDIASIS                 3                 2
   8.  055.9   MEASLES UNCOMPLICATED      3                 3
   9.  114.0   PRIMARY COCCIDIOIDOMYCOSIS 3                 2
   10. 493.90  ASTHMA UNSPECIFIED WITHOUT MEN   3           3

TOP 10 DIAGNOSTIC CATEGORIES =>

   1.  INFECTIOUS & PARASITIC   (43)
   2.  EAR, NOSE, MOUTH & THROAT   (16)
   3.  NERVOUS SYSTEM   (7)
   4.  RESPIRATORY SYSTEM   (6)
   5.  MENTAL DISEASES & DISORDERS   (6)
   6.  CIRCULATORY SYSTEM   (5)
   7.  DIGESTIVE SYSTEM   (5)
   8.  HEALTH STATUS FACTORS   (5)
   9.  MUSCULOSKELETAL & CONNECTIVE T   (4)
   10. HEPATOBILIARY & PANCREAS   (3)

RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:
```

Figure 12-10: Example TEN report

12.8 Tally of Operating Provider for Procedures (TOP)

Use the TOP option to produce the Listing/Tally of Visits with Selected Procedure Codes report, which tallies the operating provider for selected procedures done. You can optionally obtain a list of all the visits with these procedures.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, specify the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, specify the end of the date range.
3. At the “Include ALL Visit Service Categories?” prompt, type **Y** or **N**. If you type **N**, other prompts will display.
4. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type **A** (for all locations/facilities) or **O** (for one location/facility). If you type **O**, other prompts will display.
5. At the “Enter a code indicating what ICD Procedure codes are of interest” prompt, type **A** (for all procedures) or **S** (selected set of ICD Procedure codes). If you type **S**, other prompts will display.
6. At the “Do you want a List of all the procedures in addition to the tally?” prompt, type **Y** or **N**.
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```
   XXX                    Jan 28, 2009                        Page 1

                       ***  PROCEDURE TALLY/LISTING  ***
                   Visit Dates: Jan 29, 2008 to Jan 28, 2009
Service Categories: ALL
Procedures included in this report:  ALL ICD PROCEDURES
-------------------------------------------------------------------

Total # of Procedures:                                    28

Tally BY Operating Providers:
   Operating Provider                              # of Procedures

BETAAAA,LORI
     29.39   EXC/DESTR LES/TIS PHARY                     1
     45.24  FLEXIBLE SIGMOIDOSCOPY                       1
   Total # Procedures for BUTCHER,LORI                   2

FAPROVIDER,USER
     47.2   DRAIN APPENDICEAL ABSC                       1
   Total # Procedures for FAPROVIDER,USER                1

GAMMA,U
     18.29  DESTRUCT EXT EAR LES NEC                     1
     28.11  TONSIL ADENOID BIOPSY                        1
     45.23  FLEX FIBEROPTIC COLONOSC                     2

     45.24  FLEXIBLE SIGMOIDOSCOPY                       2
     47.01  LAPAROSCOPIC APPENDECTOMY                    4
     51.23  LAPAROSCOPIC CHOLECYSTECT                    1
     86.27  DEBRIDE NAIL/BED/FOLD                        1
   Total # Procedures for GAMMA,U                       12
```

Figure 12-11: Example TOP report

13.0 Immunization Reports (IMM)

The following immunization reports are available from the Immunization Report menu. These reports address the immunization needs of the adults and children at your facility.

```
                    ***********************************
                    **    PCC Management Reports    **
                    **   Immunization Report Menu   **
                    ***********************************
                        IHS PCC Suite Version 2.0

                           DEMO HOSPITAL/CLINIC

            AIN   Adult Immunization Needs
            KNIR  Kids Not on Immunization Register
```

Figure 13-1: Example Immunization report main menu

13.1 Adult Immunization Needs (AIN)

The Adult Immunization Needs (AIN) report displays the most recent Td, pneumococcal, and influenza vaccinations for adults considered at high risk. Prior to running this report, you must use Q-Man to create a cohort (template) of patients to search. Developing a cohort of high-risk adults typically consists of selecting living patients over age 65 or who have one or more specific chronic diseases.

The following example report was generated using a search template of patients over 65 years old.

```
  DEMO HOSPITAL                                  Apr 14, 2008  Page 1
                 ********  ADULT IMMUNIZATION NEEDS  ********

DEMO H        LAST PATIENT NAME  NUMBER  COMMUNITY   AGE   LAST Td  LAST FLU
PNEUMOVAX
-----------------------------------------------------------------

ALPHAA,JANE           111111  SPRINFIELD    67  04/09/2005 10/25/2006 10/22/1990
OMICRONN,JENNIFER     111112  SPRINFIELD    59  02/20/2007 11/17/2005 01/13/2004
MUUUU,SUSAN           111113  SPRINFIELD    70  11/03/2004 11/05/2004 04/19/1990
THETA,RENEE           111114  SPRINFIELD    66  05/20/2006 11/30/1994 04/30/2007
BETAAA,SHARON         111115  SPRINFIELD    65  03/09/2006 10/06/2003 08/07/2006
GAMMAAAA,ELIZABETH    111116  SPRINFIELD    61  09/28/1996
BETA,SUZANNE          111117  SPRINFIELD    64  01/15/2006 12/01/2006 01/17/2006
```

```
IOTA,LAUREN           111118  SPRINFIELD    67  03/28/1995 10/06/2003 06/01/1994
GAMMA,SHANNON         111119  SPRINFIELD    63  02/17/1997
MUUUUU,MARY           111121  SPRINFIELD    70  09/13/2001 10/22/1998 07/30/1996
RHOO,GRETA            111122  SPRINFIELD    67  07/30/2000 02/21/2007
PIIIIII,CINDY         111123  SPRINFIELD    80  11/00/1993 11/07/2000
IOTAAAAA,BEATRICE     111124  SPRINFIELD    83             11/14/2006 11/15/1994
ALPHA,FRANCES         111125  SPRINFIELD    74             10/27/2004 01/08/2001

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

Figure 13-2: Example adult immunization needs report

13.2 Kids Not on Immunization Register (KNIR)

The Kids Not on Immunization Register (KNIR) report lists all children in a specified age range who are not in the immunization register. Type an age range and select a particular community, a group of communities, or all communities.

Follow these steps:

1. At the “Enter an AGE range” prompt, specify the age range or press Enter to include all ages.

2. At the “List children who live in” prompt, type one of the following:

   O - One particular Community
   A - All Communities
   S - Selected Set of Communities (Taxonomy)

   If you type **O** or **S**, additional prompts are displayed.

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

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

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

The following sample report shows children ages 5-to-8 in the Achi and Ajo communities, who are not in the immunization register.

```
   WARNING: CONFIDENTIAL PATIENT INFORMATION, PRIVACY ACT APPLIES

    DEMO HOSPITAL                                Apr 14, 2008  Page 1
********  CHILDREN NOT ON IMMUNIZATION REGISTER  ********

Community: ACHI
---------------
SIGMA,JOHN        (111111)   Nov 12, 1988    19 Years        MALE

            No prior immunizations listed

SIGMA,JANE        (111112)   Nov 01, 1992    15 Years        FEMALE

            No prior immunizations listed

SIGMA,JAMES       (111113)   Oct 15, 1993    14 Years        MALE

                Jan 26, 1994  HEP B PED
                Mar 29, 1994  DTaP, IPV
                Sep 11, 1995  DTaP, MMR

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

Figure 13-3: Example report listing children not in immunization register

14.0 Q-Man (PCC Query Utility) (QMAN)

Q-Man (the PCC Query System) is a utility for “mining” the PCC database. It facilitates retrieval of demographic and clinical information.

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

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

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

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

Figure 14-1: Opening information for QMAN option

- If you type a caret (^), you will exit the QMAN option.
- If you press Enter, the following options are displayed:

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

   Select one of the following:

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

   Your choice: SEARCH//
```

Figure 14-2: Example Q-Man options menu

No special knowledge of MUMPS, FileMan, or the PCC file structure is required to use Q-Man. Generate a query by initiating a dialogue with the computer. Each query has a subject, attribute, condition, and value.

For example, consider the following query:

```
"Find all patients over 60 years of age."
      SUBJECT = Patients
    ATTRIBUTE = Age
    CONDITION = Over
        VALUE = 60
```

Figure 14-3: Sample Q-Man query

Multiple queries can be “and’ed” together to define a search.

The output of the search is either a standard columnar display on the screen, a printed report, or a FileMan search template (i.e., a cohort of patients).

In addition to the dialogue interface described above, there is also a natural language interface to Q-Man. Type a simple (1 attribute only) query in English. Frequently, Q-Man will correctly interpret the query and print the results on the screen. If Q-Man does not understand the question, it will beep and ask you to try again. Sample queries for the Rapid Report option are:

```
   "SHOW ME MARY MARTIN'S LAST BLOOD SUGAR"
   "FIND ALL PATIENTS WHO LIVE IN TUCSON"
   "SHOW ME EVERYONE WHOSE TRIBE OF MEMBERSHIP IS NAVAJO"
   "I WANT LISA JONES' AVERAGE WEIGHT"
   "NOW GET HER SSN"
```

Figure 14-4: Sample queries for the rapid report

Notice that the word “and” does not appear in any of the queries and that all queries are quite simple. Try it. If it doesn’t work for you, use the dialogue interface.

A separate *Q-Man User Manual* that describes the use of the Query System in depth is available.

15.0 Delimited Output Reports (DELR)

The **Delimited Output Reports** menu contains the following option:

```
    EDU    Create Delimited File of Visits w/Education Done
```

Figure 15-1: Example FileMan menu options

This EDU option creates a delimited output file of all visits in which patient education was done. This report is used by uploading the data file into Microsoft Excel or other software application.

16.0 Health Summary Displaying CMS Register(s) (CHS)

The CHS option displays the register to which the patient belongs, then allows you to print the patient's Health Summary.

1. At the "Select patient" prompt, specify the name of the patient. The system displays information about the particular patient.
2. At the "Select health summary type" prompt, specify the type of Health Summary you want to display.
3. At the "Device" prompt, specify the device to print/browse the report.

For example,

```
CONFIDENTIAL PATIENT INFORMATION -- 1/29/2009 10:07 AM  [SJT]
** DEMO,JOHNNIE RUTH #118774 <A> (ADULT REGULAR SUMMARY) pg 1 **

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

DEMO,JOHNNIE RUTH    DOB: MAR 1,1981  27 YRS  FEMALE  no blood type
DEMO TRIBE, NM                    SSN: XXX-XX-4021
                     MOTHER'S MAIDEN NAME: CROWE,VIRGINIA J
(H) 555-555-3791                  FATHER'S NAME: DEMO,MICHAEL
BIRDTOWN (P.O. BOX 1340,VASSALBORO,NC,28719)

LAST UPDATED: MAY 24,2007         ELIGIBILITY: CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?  YES
                    DATE RECEIVED BY PATIENT:  Apr 14, 2003
                  WAS ACKNOWLEDGEMENT SIGNED?  YES
           WOMEN'S HEALTH CASE MANAGER:  SPROVIDER,JEROME
           DESIGNATED PRIMARY PROVIDER:  NPROVIDER,ERIN D
                              DIABETES:  AVPROVIDER,TERESA D
                               OB CARE:  TETER,SHIRLEY
ON CMS REGISTER(S):  ASTHMA (PERSISTENT)  Status: ACTIVE
                     DYSLIPIDEMIA  Status: ACTIVE
                     CARDIOVASCULAR DISEASE  Status: ACTIVE
                     ALPHA TEAM  Status: ACTIVE

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

INSURANCE      NUMBER    SUFF COV       EL DATE   SIG DATE  END DATE
NC MEDICAID    138784952      PW        08/01/06
   Plan Name: ALL STATES COVERAGE INC
BLUE CROSS BLUE SHIELD-N.C.HPG880422843          02/01/06
```

Figure 16-1: Example CHS menu option report

17.0 Custom Letter Management (CLM)

The **Custom Letter Management** option contains the following menu options:

```
CCL    Create/Modify Custom Letter
PCL    Print Custom Letters for Selected Patients
```

Figure 17-1: Example CLM menu options

The **CCL** option allows you to add, edit, and delete a customized letter, and view letter inserts.

The **PCL** option allows you to print custom letters for selected patients.

18.0 Browse Health Summary (BHS)

The BHS option allows you to browse the specified Health Summary for a particular patient. The following screen is displayed:

```
Select PCC Management Reports Option: BHS  Browse Health Summary
Select health summary type: DENTAL//
Select patient:  DEMO,JOHNNIE RUTH         <A>   F 03-01-1981 XXX-
XX-4021    DH 118774

OUTPUT BROWSER           Jan 15, 2009 15:27:20     Page: 1 of 6
PCC Health Summary for DEMO,JOHNNIE RUTH

** CONFIDENTIAL PATIENT INFORMATION -- 1/15/2009  3:27 PM  [SJT]**
***DEMO,JOHNNIE RUTH #118774 <A>   (DENTAL SUMMARY)  pg 1 ***

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

DEMO,JOHNNIE RUTH            DOB: MAR 1,1981  27 YRS  FEMALE  no
blood type
DEMO TRIBE, NM               SSN: XXX-XX-4021
                             MOTHER'S MAIDEN NAME: CROWE,VIRGINIA J
(H) 555-555-3791             FATHER'S NAME: DEMO,MICHAEL
BIRDTOWN (P.O. BOX 1340,VASSALBORO,NC,28719)

LAST UPDATED: MAY 24,2007         ELIGIBILITY: CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?  YES
                    DATE RECEIVED BY PATIENT:  Apr 14, 2003
                  WAS ACKNOWLEDGEMENT SIGNED?  YES

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

Figure 18-1: Example Health Summary information

19.0 Other PCC Management Reports/Options (OTH)

The **Other PCC Management Reports/Options** menu contains the following options:

```
RT     Report Template Utility ...
DR     PCC Patient Data Retrieval Utility
RDD    Delete VGEN/PGEN Report Definition
```

Figure 19-1: Example OTH menu options

19.1 Report Template Utility (RT)

The **Report Template Utility** contains the following options:

```
CR     Create Report Template
MD     Modify/Delete Report Template
PR     Print Report Template
TC     Taxonomy Creation For A Script
```

Figure 19-2: Example RT menu options

19.2 PCC Patient Data Retrieval Utility (DR)

The **PCC Patient Data Retrieval Utility** uses scripts to retrieve patient information from the PCC. Upon typing this option, you will be asked for a patient's name. Create a script to retrieve patient clinical or demographic information.

19.2.1 Script Creation

A script is an instruction to the PCC Data Retrieval Utility to obtain patient information from the PCC database. Both demographic and clinical information can be retrieved for a patient.

Demographic Data

To obtain demographic data for a patient, the first word you type must be either **PT** or **Patient**. Then add the type of information you desire. If the text you type is ambiguous, you will not receive a value in return.

For example, you may type the following:

- PT NAME
- PT CURRENT COMMUNITY
- PT AGE
- PT DOB
- PT TRIBE OF MEM

This list includes patient demographic data items that are most frequently requested. You may ask for other demographic information as well.

Clinical Data

Scripts can be used to retrieve clinical data. The following sample scripts show some of the types of information you can retrieve from the PCC database.

```
LAST 3 MEAS BP;DURING 1991 - RETURNS LAST 3 BLOOD PRESSURES
                             TAKEN DURING 1991
LAB GLUCOSE;ON SEP 3, 1992 - RETURNS ALL GLUCOSES TAKEN ON
                             SEPT 3, 1992
FIRST ACTIVE.PROBLEM - RETURNS FIRST ACTIVE PROBLEM FROM THE
                       PROBLEM LIST; DATE DETERMINED BY DATE
                       ENTERED OR LAST MODIFIED
LAST IMMUN PNEUMOVAX - RETURNS LAST PNEUMOVAX GIVEN
```

Figure 19-3: Sample scripts used to retrieve clinical data

The script on the previous page can be broken into its four component parts for further explanation. LAST 3 MEAS BP; DURING 1991 will be used for this example.

```
LAST 3     - Limits occurrences; use first, last, or all.
           - Can indicate number of instances.
           - Optional; if not used system will default to 'all.'
MEAS       - Data Class; i.e., AS LABS, POV, ADA.CODE.
BP         - Optional; what you are looking for within the data class
           - If not indicated, system will look at all values    within data
             class.
DURING 1991 - Optional use of date parameters.
```

Figure 19-4: Example script

These four components are explained in detail below.

- Limiting Occurrences: Use of First, Last, and All

  The first word of the script must be either First, Last, or All. If First, Last, or All is not typed, then the system will assume you mean All. You can specify the number of occurrences for which a particular value should be retrieved; for example, First 3 or Last 2.

- Data Class

  The second word in the script may be Lab, Rx, Ada.Code, Exam, Visit, Pov, Measurement, Procedures, Skin.Test, Immunization, Radiology, Education, Active.Prob, Inactive.Prob, Family.History, Personal.History, or Health.Factors. The second word is known as the data class. If the data class has more than one word, each word must be separated by a period when typed into the script; for example, Ada.Code. However, you do not have to include a second word for any of the scripts because the first word is enough for the data retriever to know which class you are selecting. Many of the classes, such as Dental Services and Medications, have acronyms. In most instances, you need only type the first few identifying characters of a data class. For instance, if you wanted to specify Active Problems, you can type ACT instead of spelling it out. The data retriever would recognize these three letters as Active Problems.

- Value within the Data Class

  The third word is the value, or what you are looking for, within the data class. For example, the value would be a laboratory test for labs and an Ada Code for dental services. Also, instead of typing an ICD9 code, you may type a narrative such as Diabetes or DM.

- Date Parameters

  You may restrict the date range from which to retrieve patient information by placing a semicolon (;) at the end of the script, followed by a restriction on the date, such as on, equals, before, during, between, or a symbol (>, <, < >, =). You may then type an exact date or a range of dates by placing a dash (-) between the two dates. Dates must be in standard FileMan format. You may type the month and year or year only in addition to full dates. (See the sample scripts on the following page for examples of typing date parameters.)

- Taxonomy Creation

  If an asterisk (*) is typed for the value within the data class, you will be asked for multiple values associated with the selected data class. You could then type a range of ICD9 codes for POVs or multiple Ada Codes, for example. Not all data classes allow entry of more than one value. Available data classes for taxonomy creation are: diagnosis, ADA code, RX, procedure (medical), patient education topic, and health factors. These multiple values can be stored in a taxonomy, if you choose. Then you can type the name of the taxonomy prefaced by a left square bracket ([) as an indication of the desired values to be retrieved.

The following report shows the data received from the sample script.

```
Select PATIENT NAME:       SMITH,JANE
                                        F 11-10-70 XXX-XX-1234 DH
333333
ENTER SCRIPT: LAST 3 MEAS BP

VISIT DATE: 06/23/1993      VALUE: 120/90     TYPE: BP
VISIT DATE: 03/04/1993      VALUE: 100/80     TYPE: BP
VISIT DATE: 08/25/1992      VALUE: 120/80     TYPE: BP

ENTER SCRIPT: LAST VISIT

VISIT DATE: 08/02/1993    VALUE: VISIT

ENTER SCRIPT: LAST POV DM

250.00 (DIABETES UNCOMPL TYPE II/NIDDM)
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NONINSULIN
DEPENDENT/ADULT-ONSET

OK? Y//

VISIT DATE: 07/19/1993    VALUE: 250.00
```

Figure 19-5: Example of data retrieved using script

19.3 Delete VGEN/PGEN Report Definition (RDD)

Use the RDD option to delete a PCC Visit or Patient General Retrieval report definition. The system confirms the deletion.

20.0 FileMan (General) (FM)

The FileMan utility is a set of retrieve-only options from the File Manager database management system. The menu contains the following options:

```
1   Search File Entries
2   Print File Entries
3   Inquire to File Entries
4   Statistics
5   List File Attributes
```

Figure 20-1: Example FileMan menu options

The Search and Print options allow you to create *ad hoc* reports. The Inquire option allows you to see entries within a file. The Statistics option is a menu that, when appropriate, allows the creation of a histogram or scattergram or gives basic mathematical statistics for a report generated by the Print or Search option. The Statistics menu options must be run just after the report is generated, as results will not be saved once another report is printed. Note that the Statistics menu options cannot be used if a report is queued to a printer. List File Attributes displays the fields and attributes of those fields that make up a FileMan file. These create the data dictionary of the file.

A separate File Manager user's manual that describes the use of these utilities in depth is available.

21.0 Search Template System (STS)

This system has options that allow you to create search templates either through the FileMan Search option or manually. A search template comparison utility is also available that permits you to match the contents of one FileMan search template with another. The STS provides the capability to delete and add entries to existing search templates you have created. In addition, you may access FileMan (General) from this menu.

> **Note:** If you create a search template via the search template utility or the option that allows for manual creation of a search template, there will be no search logic associated with these templates. Search templates created via the FileMan Search option have search logic stored with them. This means you can utilize this template's search logic within the search option of FileMan.

```
Search Template System
Version 2.5
Site Set To DEMO HO

     SRCH   Search Template Comparison Utility
     CRE    Create Search Template Manually
     ADD    Add Entries Into An Existing Search Template
     DENT   Delete Entries From An Existing Search Template
     CNT    Count Entries In A Search Template
     SRT    Inquire Into Sort/Search Template File
     DEL    Delete Search Template
     SAVE   Save Search Template
     FGEN   FileMan (General) ...

Select Search Template System Option:
```

Figure 21-1: Example search template system main menu

A separate user's manual for the STS that describes the use of this system in depth is available.

22.0 Appendix A: Statistical Database Record Definition

Record 1 of 2

Item	Beg Col	End Col	Length	REQ	Description of Data Item
RECORD CODE	1	2	2	Y	Will always be 00
SEQUENCE	3	3	1	Y	Will always be 1
UNIQUE ID #	4	19	16	Y	Unique ID for this visit. ASUFAC_IEN of the visit. IEN of visit is left zero filled to 10 digits.
ASUFAC_HRN	20	31	12	Y	Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DOB	32	38	7	Y	DOB in format CYYMMDD; for example, 2960908.
SEX	39	39	1	Y	Sex. M or F
SSN	40	48	9	Y	SSN of patient or 9 blanks. No dashes.
PRIMARY TRIBE	49	51	3	Y	Tribe code from standard code book.
COMMUNITY OF RESIDENCE	52	58	7	Y	STCTYCOM code of patient's residence. Taken from the current community field.
CLASSIFICATION /BENEFICIARY	59	60	2	Y	Beneficiary Code from Standard Code book.
ELIGIBILITY	61	61	1	Y	Eligibility Status from Standard Code book.
MEDICAID ELIG ON VISIT DATE	62	62	1	Y	Y or N. If patient was Medicaid eligible on the visit date, this is set to Y; if not, N.
MEDICARE ELIG ON VISIT DATE	63	63	1	Y	Y or N. If patient was Medicare eligible on the visit date, this is set to Y; if not, N.
PRIVATE INSURANCE ELIGIBILITY ON VISIT DATE	64	64	1	Y	Y or N. If patient was Private Insurance eligible on the visit date, this is set to Y; if not, N.
VISIT/ ADMISSION DATE	65	71	7	Y	Date of Visit in CYYMMDD format.
TIME OF DAY	72	75	4	Y	Time of day in internal FileMan format; for example,1000, 1310, 0805
DAY OF WEEK	76	76	1	Y	DOW in APC record definition format.
LOCATION OF ENCOUNTER	77	82	6	Y	ASUFAC of location of encounter.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
TYPE	83	83	1	Y	Type of Visit. C, I, O, 6, T, U, V, S, etc.
SERVICE CATEGORY	84	85	2	Y	Service Category; for example, A, H, I, C, T
CLINIC	86	87	2	N	Clinic of Visit, standard 2 digit code.
EVALUATION AND MANAGEMENT CPT CODE	88	92	5	N	CPT CODE from Evaluation and Management field of Visit file.
LEVEL OF SERVICE	93	93	1	N	Level of Service code from PCC form.
EDUCATION DONE OF THIS VISIT	94	94	1	N	Was an education topic provided on this visit? Y or N
EXAMS DONE ON THIS VISITQ	95	95	1	N	Was one or more exams done on this visit? Y or N
# OF LAB TESTS DONE	96	98	3	N	# of laboratory tests done.
# OF RX'S	99	100	2	N	# of prescriptions filled.
VITAL SIGNS DONE	101	101	1	N	Were vital signs taken? Y or N
PRIMARY PROV AFFILIATION/DISCIPLINE	102	104	3	Y	Primary Provider's Affiliation and Discipline; for example, 101
OTHER PROVIDER AFFILIATION/ DISCIPLINE	105	107	3	N	First Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	108	110	3	N	2nd Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	111	113	3	N	3rd Secondary Provider Affiliation/Discipline.
OTHER PROVIDER AFFILIATION/ DISCIPLINE	114	116	3	N	4th Secondary Provider Affiliation/Discipline.
PRIMARY ICD DX	117	122	6	Y	Primary ICD Dx. If this is a non-hospitalization visit, it is the 1st diagnosis entered.
APC CODE 1	123	125	3	Y	APC Recode for diagnosis 1
CAUSE OF DX 1	126	126	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 1
CAUSE OF INJURY	127	132	6	N	Valid ICD9 E code for an injury. If Diagnosis 1 is an injury 800-999.9.
PLACE OF INJURY	133	133	1	N	PCC place of injury code for Diagnosis 1 if Diagnosis 1 is an injury.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
DIAGNOSIS 2	134	139	6	Y	ICD Dx 2. If this is a non-hospitalization visit, it is the 2nd diagnosis entered.
APC CODE 2	140	142	3	Y	APC Recode for diagnosis 2
CAUSE OF DX 2	143	143	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 2
CAUSE OFINJURY	144	149	6	N	Valid ICD9 E code for an injury. If Diagnosis 2 is an injury 800-999.9.
PLACE OF INJURY	150	150	1	N	PCC place of injury code for Diagnosis 2 if Diagnosis 2 is an injury.
DIAGNOSIS 3	151	156	6	Y	ICD Dx 3. If this is a non-hospitalization visit, it is the 3rd diagnosis entered.
APC CODE 3	157	159	3	Y	Recode for diagnosis 3
CAUSE OF DX 3	160	160	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 3
CAUSE OF INJURY	161	166	6	N	Valid ICD9 E code for an injury. If Diagnosis 3 is an injury 800-999.9.
PLACE OFINJURY	167	167	1	N	PCC place of injury code for Diagnosis 3 if Diagnosis 3 is an injury.
DIAGNOSIS 4	168	173	6	Y	Dx 4. If this is a non-hospitalization visit, it is the 4th diagnosis entered.
APC CODE 4	174	176	3	Y	APC Recode for diagnosis 4
CAUSE OF DX 4	177	177	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 4
CAUSE OF INJURY	178	183	6	N	Valid ICD9 E code for an injury. If Diagnosis 4 is an injury 800-999.9.
PLACE OF INJURY	184	184	1	N	PCC place of injury code for Diagnosis 4 if Diagnosis 4 is an injury.
DIAGNOSIS 5	185	190	6	Y	ICD Dx 5. If this is a non-hospitalization visit, it is the 5th diagnosis entered.
APC CODE 5	191	193	3	Y	APC Recode for Diagnosis 5
CAUSE OF DX 5	194	194	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 5
CAUSE OF INJURY	195	200	6	N	Valid ICD9 E code for an injury. If Diagnosis 5 is an injury 800-999.9.
PLACE OF INJURY	201	201	1	N	PCC place of injury code for Diagnosis 5 if Diagnosis 5 is an injury.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
DIAGNOSIS 6	202	207	6	Y	ICD Dx 6. If this is a non-hospitalization visit, it is the 6th diagnosis entered.
APC CODE 6	208	210	3	Y	APC Recode for Diagnosis 6
CAUSE OF DX 6	211	211	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 6
CAUSE OF INJURY	212	217	6	N	Valid ICD9 E code for an injury. If Diagnosis 6 is an injury 800-999.9.
PLACE OF INJURY	218	218	1	N	PCC place of injury code for Diagnosis 6 if Diagnosis 6 is an injury.
DIAGNOSIS 7	219	224	6	Y	ICD Dx 7. If this is a non-hospitalization visit, it is the 7th diagnosis entered.
APC CODE 7	225	227	3	Y	APC Recode for Diagnosis 7
CAUSE OF DX 7	228	228	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 7
CAUSE OF INJURY 7	229	234	6	N	Valid ICD9 E code for an injury. If Diagnosis 7 is an injury 800-999.9.
PLACE OF INJURY 7	235	235	1	N	PCC place of injury code for Diagnosis 7 if Diagnosis 7 is an injury.

Record 2 of 2

Item	Beg Col	End Col	Length	REQ	Description of Data Item
RECORD CODE 7	1	2	2	Y	00
SEQ #	3	3	1	Y	2
UNIQUE ID	4	19	16	Y	Use ASUFAC and HRN at location of encounter, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
ASUFAC_HRN	20	31	12	Y	Use ASUFAC and HRN at location of encounter, if one exists. Otherwise, ASUFAC_HRN at DUZ(2). Chart number is left zero filled.
DIAGNOSIS 8	32	37	6	Y	ICD Dx 8. If this is a non-hospitalization visit, it is the 8th diagnosis entered.
APC CODE 8	38	40	3	Y	APC Recode for Diagnosis 8
CAUSE OF DX 8	41	41	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 8
CAUSE OF INJURY	42	47	6	N	Valid ICD9 E code for an injury. If Diagnosis 8 is an injury 800-999.9.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
PLACE OF INJURY	48	48	1	N	PCC place of injury code for Diagnosis 8 if Diagnosis 8 is an injury.
DIAGNOSIS 9	49	54	6	Y	ICD Dx 9. If this is a non-hospitalization visit, it is the 9th diagnosis entered.
APC CODE 9	55	57	3	Y	APC Recode for Diagnosis 9
CAUSE OF DX 9	58	58	1	N	1-Hospital acquired, 2- alcohol-related, 3-battered child, 4-employment-related for Diagnosis 9
CAUSE OF INJURY	59	64	6	N	Valid ICD9 E code for an injury. If Diagnosis 9 is an injury 800-999.9.
ICD PROC CODE (1)	65	69	5	N	ICD Operation Code
PROC DATE (1)	70	76	7	N	Internal FileMan format of date of procedure.
INFECTION (1)	77	77	1	N	Y-Yes N-No
PROC PROV AFF/DISC(1)	78	80	3	N	Operating Provider's Affiliation/Discipline Code.
CPT CODE (1)	81	85	5	N	CPT Code for this procedure
DX DONE FOR (1)	86	86	1	N	The number (1-9) of the diagnosis that this procedure was done for.
ICD PROC CODE (2)	87	91	5	N	ICD Operation Code
PROC DATE (2)	92	98	7	N	Internal FileMan format of date of procedure.
INFECTION (2)	99	99	1	N	Y-Yes N-No
PROC PROV AFF/DISC(2)	100	102	3	N	Operating Provider's Affiliation/Discipline Code
CPT CODE (2)	103	107	5	N	CPT Code for this Procedure
DX DONE FOR (2)	108	108	1	N	The number (1-9) of the diagnosis that this procedure was done for.
ICD PROC CODE (3)	109	113	5	N	ICD Operation Code
PROC DATE (3)	114	120	7	N	Internal FileMan format of date of procedure.
INFECTION (3)	121	121	1	N	Y-Yes N-No
PROC PROV AFF/DISC(3)	122	124	3	N	Operating Provider's Affiliation/Discipline Code
CPT CODE (3)	125	129	5	N	CPT Code for this Procedure
DX DONE FOR (3)	130	130	1	N	The number (1-9) of the diagnosis that this procedure was done for.
IMMUNIZATION CODE	131	132	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	133	133	1	N	Set of codes
IMMUNIZATION CODE	134	135	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	136	136	1	N	Set of codes

Item	Beg Col	End Col	Length	REQ	Description of Data Item
IMMUNIZATION CODE	137	138	2	N	Immunization given, from standard codes
IMMUNIZATION SERIES	139	139	1	N	Set of codes
ADA CODE (1)	140	143	4	N	ADA CODE
ADA UNITS (1)	144	145	2	N	# OF UNITS
ADA CODE (2)	146	149	4	N	ADA CODE
ADA UNITS (2)	150	151	2	N	# OF UNITS
ADA CODE (3)	152	155	4	N	ADA CODE
ADA UNITS (3)	156	157	2	N	# OF UNITS
ADA CODE (4)	158	161	4	N	ADA CODE
ADA UNITS (4)	162	163	2	N	# OF UNITS
ADA CODE (5)	164	167	4	N	ADA CODE
ADA UNITS (5)	168	169	2	N	# OF UNITS
ADA CODE (6)	170	173	4	N	ADA CODE
ADA UNITS (6)	171	175	2	N	# OF UNITS
APC CODE 4	174	176	3	Y	APC Recode for diagnosis 4
ADMISSION DATE	176	182	7	N	Admission date in internal FileMan format.
ADMISSION SERVICE	183	184	2	N	Admitting Service (2-digit IHS code)
ADMISSION TYPE	185	185	1	N	Admission Type
ATTENDING PHYSICIAN	186	191	6	N	Affiliation/Discipline code
CAUSE OF DEATH	192	197	6	N	ICD CODE
# OF CONSULTS	198	200	3	N	Number of consults during an Inpatient Stay
DISCHARGE DATE	201	207	7	N	Internal FileMan Format of discharge date.
DISCHARGE SERVICE	208	209	2	N	From Standard Treating Specialty table
DISCHARGE TYPE	210	210	1	N	IHS Standard Code for Discharge Type
FACILITY TRANSFER TO (ASUFAC)	211	216	6	N	From Location table
LENGTH OF STAY	217	219	3	N	Length of stay
MIDWIFERY	220	220	1	N	1 if midwife was a provider
ACTIVITY TIME	221	224	4	N	Minutes
TRAVEL TIME	225	228	4	N	Minutes
CHS COST	229	234	6	N	For CHS visits, total cost info.

23.0 Appendix B: PGEN/VGEN Options

Below is a table of PGEN selection, sort, and print options by group.

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Patient Name		1	1		1	1
Patient Demographics	First, Last Name		2	2		2	2
Patient Demographics	Chart #		3	3		3	3
Patient Demographics	Terminal Digit #		4	4		4	4
Patient Demographics	SSN		5			5	
Patient Demographics	Sex	2	6	5	2	6	5
Patient Demographics	Date of Birth	3	7	6	3	7	6
Patient Demographics	Birth Month	4	8	7	4	8	7
Patient Demographics	Race	5	9	8	5	9	8
Patient Demographics	Age	6	10	9	6	10	9
Patient Demographics	Age in Months	7	11	10	7	11	10
Patient Demographics	Father's Name		12	11		12	11
Patient Demographics	Mother's Name		13	12		13	12
Patient Demographics	Veteran Status Y/N	8	14	13	8	14	13
Patient Demographics	Date of Death	9	15	14	9	15	14
Patient Demographics	Date Patient Establishe	10	16	15	10	16	15
Patient Demographics	Mlg Address-Street		17	16		17	16
Patient Demographics	Mlg Address-City		18			18	
Patient Demographics	Mlg Address-State	11	19	17	11	19	17
Patient Demographics	Mlg Address-State Abbrv		20	18		20	18
Patient Demographics	Mlg Address-Zip	12	21	19	12	21	19

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Mlg Address-Complete		22			22	
Patient Demographics	City of Birth		23			23	
Patient Demographics	Home Phone		24			24	
Patient Demographics	State of Birth		25			25	
Patient Demographics	Employer of Patient	13	26	20			
Patient Demographics	Office Phone		27				
Patient Demographics	Total Household Income	14	28	21	13	26	20
Patient Demographics	Mother's Maiden Name		29			27	
Patient Demographics	Next of Kin		30				
Patient Demographics	Community	17	31	22	16	28	21
Patient Demographics	Tribe	18	32	23	17	29	22
Patient Demographics	County of Residence	19	33	24	18	30	23
Patient Demographics	Eligibility Status	20	34	25	19	31	24
Patient Demographics	Beneficiary Class	21	35	26	20	32	25
Patient Demographics	HRN Record Status	22	36	27	21	33	26
Patient Demographics	HRN Disposition	23	37	28	22	34	27
Patient Demographics	Service Unit of PT	24	38	29	23	35	28
Patient Demographics	Indian Blood Quantum	28	39	30	28	36	29
Patient Demographics	Name/Chart #/SSN	1			1		
Patient Demographics	Living Pts	15			14		
Patient Demographics	Chart Facility	16			15		
Patient Demographics	Inactive Patients	25			24		
Patient Demographics	Exclude Inactive Pts	26			25		
Patient Demographics	Exclude Pts on a Regis	27			26		
Patient Demographics	Excl Incomplete Vis				27		
Patient Insurance Data	Medicare		1		1	1	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Insurance Data	MEDICARE Y/N		2	1		2	1
Patient Insurance Data	Medicare Part B	2	3	2	2	3	2
Patient Insurance Data	Medicare Part D	3	4	3	3	4	3
Patient Insurance Data	Medicaid	1	5		4	5	
Patient Insurance Data	MEDICAID Y/N		6	4		6	4
Patient Insurance Data	Private Insurance	4	7		5	7	
Patient Insurance Data	PRIVATE INSURANCE Y/N		8	5		8	5
Patient Insurance Data	Third Party Eligibility		9	7		9	7
Patient Insurance Data	Medicaid Plan Name	7	10	8	7	10	8
Patient Insurance Data	Pvt Ins Plan Name	8	11	9	8	11	9
Patient Insurance Data	Priv Ins Verified	9	12		9	12	
Patient Insurance Data	Pvt Ins Plan Type		13	10		13	10
Patient Insurance Data	Any Third Party Coverage	6		6	6		6
Other Patient Related Data	Birth Weight (grams)	1	1	1	1	1	1
Other Patient Related Data	Birth Weight (Kgs)	2	2	2	2	2	2
Other Patient Related Data	ADD'L REG INFORMATION		3			3	3
Other Patient Related Data	Cause of Death	3	4	3			
Other Patient Related Data	Desig Prim Care Prov	4	5	4	3	4	4
Other Patient Related Data	User Updating PCP	5	6	5	4	5	5
Other Patient Related Data	Date PCP Updated	6	7	6	5	6	6
Other Patient Related Data	Internet Access Update D	7	8	7	6	7	7
Other Patient Related Data	Internet Access?	8	9	8	7	8	8
Other Patient Related Data	Internet Access-Method	9	10	9	8	9	9
Other Patient Related Data	Upcoming Appointments	10	11			10	10
Other Patient Related Data	Reason WH Prov Updated	11	12	10	10	11	11
Other Patient Related Data	Immun Case Managerte	12	13	11	11	12	12

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Clinical Data Elements	Patient's Last Visit	1	1	1	1	1	1
Patient Clinical Data Elements	EDC	2	2	2	2	2	2
Patient Clinical Data Elements	Date EDC Determined	3	3	3	3	3	3
Patient Clinical Data Elements	Contraception Method	4	4	4	4	4	4
Patient Clinical Data Elements	EDC Determination	5	5	5	5	5	5
Patient Clinical Data Elements	Last Menstrual Period	6	6	6	6	6	6
Patient Clinical Data Elements	Prob List Dx (ANY)	7	7		7	7	
Patient Clinical Data Elements	Prob List Dx (ACTIVE)	8	8		8	8	
Patient Clinical Data Elements	Prob List Dx (INACTIVE)	9	9		9	9	
Patient Clinical Data Elements	Problem List Narrative		10			10	
Patient Clinical Data Elements	Problem Date of Onset	10	11		10	11	
Patient Clinical Data Elements	Family History Dx	11	12		11	12	
Patient Clinical Data Elements	Family Hx and Relation	12	13		12	13	
Patient Clinical Data Elements	Family History Relation	13	14		13	14	
Patient Clinical Data Elements	Family Hx Narrative		15			15	
Patient Clinical Data Elements	Family Hx Description		16			16	
Patient Clinical Data Elements	Hx of Surgery	14	17		14	17	
Patient Clinical Data Elements	BMI (Last calculated)	15	18	7	15	18	7
Patient Clinical Data Elements	Formula Started (Days	16	19	8	16	19	8
Patient Clinical Data Elements	Breast Feeding Stopped	17	20	9	17	20	9
Patient Clinical Data Elements	Solids Food Started (D	18	21	10	18	21	10
Most Recent of Clinical Items	Most Recent TOBACCO HF	1	1	1	1	1	1
Most Recent of Clinical Items	Most Recent TB STATUS HF	2	2	2	2	2	2
Most Recent of Clinical Items	Most Recent ALCOHOL HF	3	3	3	3	3	3
Most Recent of Clinical Items	Most Recent STAGED DM HF	4	4	4	4	4	4
Most Recent of Clinical Items	Most Recent Barriers HF	5	5	5	5	5	5

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Most Recent of Clinical Items	Most Recent LEARNING PRE	6	6	6	6	6	6
Most Recent of Clinical Items	Most Recent RUBELLA HF	7	7	7	7	7	7
Most Recent of Clinical Items	Date Last Alcohol Screen	8	8	8			
Most Recent of Clinical Items	Date Last Depression Scr	9	9	9			
Most Recent of Clinical Items	Date Last IPV/DV Screen	10	10	10			
Most Recent of Clinical Items	Date Last Colonoscopy	11	11	11			
Most Recent of Clinical Items	Date Last Flex Sig	12	12	12			
Most Recent of Clinical Items	Date Last Mammogram	13	13	13			
Most Recent of Clinical Items	Date Last PAP Smear HF	14	14	14			
Most Recent of Clinical Items	Date Last Tobacco Screening	15	15	15			
Most Recent of Clinical Items	Date Last Fall Risk Assess	16	16	16			
Most Recent of Clinical Items	Date Last Tonometryen	17	17	17			
Most Recent of Clinical Items	Date Last Vision Exam	18	18	18			
Most Recent of Clinical Items	Date Last Head Circumf	19	19	19			
Most Recent of Clinical Items	Date Last Dental Exam	20	20	20			
Most Recent of Clinical Items	Date Last Diabetic Foo	21	21	21			
Most Recent of Clinical Items	Date Last Osteo Scrn	22	22	22			
Visit Demographics	Visit Date					1	1
Visit Demographics	Visit Date&Time					2	2
Visit Demographics	Appt Date&Time					3	3
Visit Demographics	Check Out Date&Time					4	4
Visit Demographics	Appointment Length				1	5	5
Visit Demographics	Type of Appointment				2	6	6
Visit Demographics	Date Visit Last Modified				3	7	7
Visit Demographics	Posting Date of Visit				4	8	8
Visit Demographics	Time of Visit				5	9	9

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Demographics	Month of Visit					10	10
Visit Demographics	External Acct #				6	11	11
Visit Demographics	PCC+ FORM?				7	12	12
Visit Demographics	Visit IEN					13	13
Visit Demographics	Dependent Entry Count					14	14
Visit Demographics	Type (IHS,638,etc)				8	15	15
Visit Demographics	Service Category				9	16	16
Visit Demographics	Visit Location				10	17	17
Visit Demographics	Outside Location				11	18	18
Visit Demographics	Clinic Type				12	19	19
Visit Demographics	Visit Created By				13	20	20
Visit Demographics	User Last Update				14	21	21
Visit Demographics	VCN # Present				15	22	22
Visit Demographics	3rd Party Billed?				16	23	23
Visit Demographics	3P Bill #					24	24
Visit Demographics	Appt/Walk-In				17	25	25
Visit Demographics	FlagEC)				18	26	26
Visit Demographics	DRG				19	27	27
Visit Demographics	Level of Service				20	28	28
Visit Demographics	Eval&Management CPT				21	29	29
Visit Demographics	Amount Billed					30	
Visit Demographics	Activity/Travel Time					31	
Visit Demographics	Day of Week				22	32	30
Visit Demographics	NDW Export Date				23	33	31
Visit Demographics	NDW Exported?				24	34	32
Visit Demographics	Dt Visit Exported (PCC					35	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Provider Data Elements	Prim Prov Time Seen					1	1
Visit Provider Data Elements	Primary Prov Name				1	2	2
Visit Provider Data Elements	Prim/Sec Prov Name				2	3	
Visit Provider Data Elements	Prim Prov Disc				3	4	3
Visit Provider Data Elements	Prim/Sec Prov Disc				4	5	
Visit Provider Data Elements	Prim Prov Affil				5	6	4
Visit Provider Data Elements	Prim/Sec Prov Affil				6	7	
Visit Provider Data Elements	Prim Prov Code				7	8	5
Visit Provider Data Elements	Prim/Sec Prov Code				8	9	
Visit Provider Data Elements	Primary Provider IEN					10	6
Visit Provider Data Elements	Prim/Sec Prov IEN					11	
Visit Diagnosis/Procedure Data	Diagnosis Code				1	1	
Visit Diagnosis/Procedure Data	Primary Dx (POV)				2	2	1
Visit Diagnosis/Procedure Data	Diagnosis Prov Narr				3	3	
Visit Diagnosis/Procedure Data	Diagnosis ICD Narr					4	
Visit Diagnosis/Procedure Data	Stage of Dx (POV)				4	5	
Visit Diagnosis/Procedure Data	Present on Admission (PO				5	6	
Visit Diagnosis/Procedure Data	Alcohol/Work Related				6	7	
Visit Diagnosis/Procedure Data	Cause of DX (POV)				7	8	
Visit Diagnosis/Procedure Data	Cause of Injury				8	9	
Visit Diagnosis/Procedure Data	Place of Injury				9	10	
Visit Diagnosis/Procedure Data	Operation Code				10	11	
Visit Diagnosis/Procedure Data	Operation CPT Code				11	12	
Visit Diagnosis/Procedure Data	Operation Prov Narr)					13	
Visit Diagnosis/Procedure Data	Operation ICD Narr					14	
Visit Diagnosis/Procedure Data	Operations w/dates					15	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Diagnosis/Procedure Data	Operating Prov				12	16	2
Visit Diagnosis/Procedure Data	CPT Code				13	17	
Visit Diagnosis/Procedure Data	CPT Modifier				14	18	
Visit Diagnosis/Procedure Data	Tran Code (Chargemaste				15	19	
Visit Diagnosis/Procedure Data	Tran Code CAN				16	20	
Visit Labs/Meds Clinical	RX Ordering Provider				1	1	
Visit Labs/Meds Clinical	Lab Tests and Results				2	2	
Visit Labs/Meds Clinical	Lab Test Names (ALL)					3	
Visit Labs/Meds Clinical	Microbiology Culture				3	4	
Visit Labs/Meds Clinical	Microbiology Organism				4	5	
Visit Labs/Meds Clinical	Microbiology Result					6	
Visit Labs/Meds Clinical	Medications				5	7	
Visit Labs/Meds Clinical	Medications+SIG				6	8	
Visit Labs/Meds Clinical	Medication Name/Qty/Day				7	9	
Visit Labs/Meds Clinical	Any Medication Prescri				8	10	1
Visit Labs/Meds Clinical	Lab Test/Loinc Codes				9	11	
Other Visit Clinical Items	Measurements					1	
Other Visit Clinical Items	Pain Measurement Value				1	2	
Other Visit Clinical Items	Waist Circ Value				2	3	1
Other Visit Clinical Items	Dental ADA Codes				3	4	
Other Visit Clinical Items	Radiology Exam				4	5	
Other Visit Clinical Items	Immunizations/Series					6	
Other Visit Clinical Items	Immunization Provider				5	7	
Other Visit Clinical Items	Immunization Lot #				6	8	
Other Visit Clinical Items	Skin Tests/Readings					9	
Other Visit Clinical Items	Immunizations				7	10	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Visit Clinical Items	Exams				8	11	
Other Visit Clinical Items	Treatments Provided				9	12	
Other Visit Clinical Items	Education Topics				10	13	
Other Visit Clinical Items	Education Provider				11	14	
Other Visit Clinical Items	Education Comments					15	
Other Visit Clinical Items	Education Length (min)				12	16	
Other Visit Clinical Items	Education Ind/Grp					17	
Other Visit Clinical Items	Education GOAL Status				13	18	
Other Visit Clinical Items	Education Objectives				14	19	
Other Visit Clinical Items	Education Prov Disc				15	20	
Other Visit Clinical Items	Health Factors				16	21	
Other Visit Clinical Items	HF Quantity/Score				17	22	
Other Visit Clinical Items	Hlth Factor by Categor				18	23	
Other Visit Clinical Items	TIU Notes					24	
Other Visit Clinical Items	Treatment Contract				19	25	
Other Visit Clinical Items	EKG's				20	26	
Other Visit Clinical Items	Diagnostic Procedure				21	27	
Other Visit Clinical Items	Infant Feeding Choice				22	28	
Inpatient Visit Specific	Hospital Location				1	1	1
Inpatient Visit Specific	Admitting Service				2	2	2
Inpatient Visit Specific	Admission Type				3	3	3
Inpatient Visit Specific	Admission Source-UB92				4	4	4
Inpatient Visit Specific	Discharge Service				5	5	5
Inpatient Visit Specific	Date of Discharge				6	6	6
Inpatient Visit Specific	Discharge Type				7	7	7
Inpatient Visit Specific	Length of Stay				8	8	8

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
ER Specific Data Items	ER Urgency				1	1	1
ER Specific Data Items	ER Means of Arrival				2	2	2
ER Specific Data Items	ER Other Means of Arriva					3	3
ER Specific Data Items	ER Entered ER BY				3	4	4
ER Specific Data Items	ER Informant					5	5
ER Specific Data Items	ER Notified				4	6	6
ER Specific Data Items	ER Disposition				5	7	7
ER Specific Data Items	ER Other Disposition					8	8
ER Specific Data Items	ER Condition on Departu					9	9
ER Specific Data Items	ER Depart Date/Time				6	10	10
ER Specific Data Items	ER Transferred To					11	11
PHN Specific Data Items	PHN Level of Interventio				1	1	1
PHN Specific Data Items	PHN Type of Dec Making				2	2	2
PHN Specific Data Items	PHN Psycho/Social/Env					3	
PHN Specific Data Items	PHN Nsg Dx					4	
PHN Specific Data Items	PHN Short Term Goals					5	
PHN Specific Data Items	PHN Long Term Goals					6	

24.0 Appendix C: RPMS Rules of Behavior

The information in this required section was written by the IHS Office of Information Technology. It does not contain any information about the functionality of the software.

24.1 All RPMS Users

In addition to these rules, each application can include additional rules of behavior (RoBs), which can be defined within the individual application's documentation (e.g., PCC, Dental, Pharmacy).

24.1.1 Access

RPMS users shall:

- Only use data for which they have been granted authorization.
- Only give information to personnel who have access authority and a need to know.
- Always verify a caller's identification and job purpose with their supervisor or the entity provided as employer *before* providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions Indian Health Manual Chapter 6 OMS Limited Personal Use of Information Technology Resources TN 03-05, August 6, 2003.

Users shall not:

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their official duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their job or by divulging information to anyone not authorized to know that information

24.1.2 Logging On To the System

RPMS users shall:

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after 5 successive failed login attempts within a specified time period (e.g., one hour).

24.1.3 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

Users shall:

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users can be afforded additional privileges based on the function they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS polices and procedures prior to interconnection to or transferring data from RPMS.
- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Shall abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and IT information processes

24.1.4 Accountability

Users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local ISSO.
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Shall abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior and IT information processes.

24.1.5 Confidentiality

Users shall:

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all HIPAA regulations to ensure patient confidentiality

Users shall not:

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting

24.1.6 Integrity

Users shall:

- Protect your system against viruses and similar malicious programs.
- Observe all software license agreements.

- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

Users shall not:

- Violate Federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without your manager's written permission and without scanning it for viruses first

24.1.7 Passwords

Users shall:

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alphanumeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts, or batch files.
- Change password immediately if password has been seen, guessed or otherwise compromised; and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential

Users shall not:

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.

- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

24.1.8 Backups

Users shall:

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment

Users shall not:

- Violate Federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without your manager's written permission and without scanning it for viruses first.

24.1.9 Reporting

Users shall:

- Contact and inform the ISSO that they have identified an IT security incident and will begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in IHS SOP 05-03, Incident Handling Guide

Users shall not:

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

24.1.10 Session Time-Outs

RPMS system implements system-based timeouts that back users out of a prompt after no more than five minutes of inactivity.

Users shall:

- Utilize a screen saver with password protection set to suspend operations at no greater than 10-minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

24.1.11 Hardware

Users shall:

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment

Users shall not:

- Do not eat or drink near system equipment

24.1.12 Awareness

Users shall:

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

24.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees can work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, intrusion detection, and provides physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote users shall:

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures

Remote users shall not:

- Disable any encryption established for network, internet and web browser communications

24.2 RPMS Developers

Developers shall:

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain; abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available

Developers shall not:

- Write any code that adversely impacts RPMS, such as backdoor access, “Easter eggs,” time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

24.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as system security administrators, systems administrators, and database administrators have added responsibilities to ensure the secure operation of RPMS.

Privileged users shall:

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, CISO, and systems owner.
- Protect the supervisor, superuser or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).

- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and back up files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.
- Shall follow industry best standards for systems they are assigned to; abide by all Department and Agency policies and procedures

Privileged users shall not:

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

25.0 Glossary

@ symbol

This symbol (Shift+2) has two functions: (1) to delete an entry and (2) to separate a date and time.

Acute

Used to describe a condition that lasts for a short time. Used in contrast to *chronic*.

Append

To add additional data items to an existing visit, usually at the end of typing the data.

Billable Visit

A visit from a patient with third-party insurance coverage that a hospital/clinic can bill services.

Best Practice Prompts

Best Practice Prompts are a set of clinical messages related to procedures such as laboratory tests, immunizations, procedures, etc. that are generally recommended for a subset of the population who share a common diagnosis (e.g. Asthma, CVD). They are displayed in a variety of places, including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Users can turn on (activate) and display BP Prompts on Health Summaries, similar to the Health Maintenance Reminder function.

Billable Visit

A visit from a patient with third-party insurance coverage that a hospital/clinic can then bill for services.

Caret (“Up Hat”)

The caret symbol (^) obtained by pressing Shift+6. Commonly used in RPMS character-based interfaces to exit out of a routine or to back up from the previous field.

Chart Number

A unique numerical identifier assigned to each patient. This is also referred to as Health Record Number.

Chronic

Used to describe a condition that has an indefinite duration or with a frequent occurrence. Used in contrast to *acute*.

Clinical

To do with treatment in or as a clinic: involving or concerned with direct observation and treatment of patients.

Command

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

Community of Service

The community where the encounter took place.

Community of Residence

The community where the patient resides.

CPT Code

Current Procedural Terminology code. Used to identify procedures provided during an encounter and for billing outpatient services provided.

Database

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps reduce the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Default Response

Many of the prompts in the RPMS applications contain responses that can be activated simply by pressing ENTER. For example: “Do you really want to quit? No//.” Pressing ENTER tells the system you do not want to quit. “No//” is considered the default response. The default is generally set to the most frequently used response for the prompt.

Designated Primary Care Provider (DPCP)

The primary care provider designated for the patient. This is distinguished from a primary or secondary visit provider for a specific visit.

Device

The name of the printer you want the system to use when printing information. *Home* means the computer screen.

DOB

Date of Birth

DOD

Date of Death

DOS

Date of Service

DX

Common abbreviation for “diagnosis”

EDC

Expected/estimated date of confinement; that is, the expected/estimated due or delivery date for a pregnancy.

EDD

Expected/estimated date of delivery.

Export

To format data so it can be used by another application.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, you will find a prompt requesting specific types of data. There are nine basic field types in RPMS programs, and each collects a specific type of information.

Free Text Field

This field type will accept numbers, letters, and most of the symbols on the keyboard. There may be restrictions on the number of characters you are allowed to type.

Health Factors

Health factors are data elements utilized by RPMS to record health status information about the patient. Current Smoker use is an example of a health factor in the Tobacco category. Health factor data are recorded in the PCC V Health Factor file. For a current list of health factors, see the Health SummaryUser Manual.

Health Management Reminders (HMRs)

Health Maintenance Reminders are a set of clinical reminders related to procedures, such as laboratory tests, immunizations, procedures etc. that are generally recommended for a subset of the population. They are displayed in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Health Record Number (HRN)

A unique numerical identifier assigned to each patient. This is also referred to as a Chart Number.

Health Summary

The Health Summary is a patient report displaying related data built from the PCC V files, such as laboratory and pharmacy. There are many different types of Health Summaries available to users at each site. Users are also able to design a Health Summary on-the-fly from the available components.

HRN#

Health Record Number, also referred to as a Chart Number

HS

Health Summary: a summary of a patient's medical care. The RPMS PCC is distributed with several standard Health Summaries, but can be customized. Examples of standard Health Summaries are: Adult Regular, Behavioral Health, CHR, and Dental.

HX

Abbreviation for History. History is an event taking place in the past, such as surgery, immunizations, etc.

ICD

International Classifications of Diseases. This is a national coding system primarily used for: (1) classifying morbidity and mortality information for statistical purposes, (2) indexing of hospital records by disease and operations, and (2) data storage and retrieval. In addition, this is the coding system physicians must use for billing purposes of Medicare, Medicaid, and private insurance for services rendered.

Interfaces

A boundary where two systems can communicate. RPMS applications contain both character-based ("roll-and-scroll") and graphical user (GUI) interfaces. PCC Data Entry is an example of a character-based interface; RPMS EHR is an example of a GUI.

Menu

The menu is a list of different options you may select at a given time. To choose a specific task, select one of the items from the list by typing the established abbreviation or synonym at the appropriate prompt. A menu option followed by the ellipsis (…) indicates there are submenus.

Mnemonic

An abbreviation used to name a menu option or report used in the RPMS character-based packages. RPMS PCC data entry mnemonics to enter a data type can be two, three, or four characters, e.g., BP.

Narrative Description

A detailed description given using words rather than codes.

Patient Care Component (PCC)

PCC is the core of the RPMS applications and functions as a clinical data repository. Most RPMS applications "pass" key data elements to PCC, stored in V (visit) files, e.g., V Lab. Other data is entered directly into V files, e.g., V Patient Education, BP, WT (weight), HT (height), HC (head circumference) etc.

Patient Wellness Handout (PWH)

The Patient Wellness Handout is a type of Health Summary that is directed to the patient. It displays personal medical information in easy-to-interpret language.

Narrative Description

A detailed description given using words rather than codes.

PGEN

Abbreviation for Patient General Retrieval Report. PGEN is the Patient General Retrieval report located in PCC Management Reports. The General Retrieval reports allow users to create on-the-fly reports by choosing specific data elements to select, print, and sort.

Problem List

A list of important/chronic medical, social, or psychiatric problems, related notes, and treatment plans for a patient that are recorded and updated as part of the patient's health record. The Health Summary has two categories: Active and Inactive.

POV

Purpose of Visit - one or more diagnoses (ICD codes) identified as the reason for the patient's visit, and recorded in the PCC V POV file.

Prompt

Text displayed onscreen indicating that the system is waiting for input to a field. Once the computer displays a prompt, it waits for you to add some specific information.

Provider

One who provides direct medical care to a patient, i.e., physician, nurse, mid-level provider).

Provider Narrative

A detailed description of the patient's conditions, using words rather than codes.

QMan

Short for Query Manager, QMan is a VA-based search utility that allows users to construct detailed searches of the RPMS database. QMan is part of the integrated PCC suite.

Retrieval

To obtain data from another location.

Roll-and-Scroll

The roll-and-scroll (character-based) data entry format captures the same information as the screen format, but uses a series of prompts for recording data. This is typically the most efficient method for data entry.

RPMS

Resource and Patient Management System; a suite of integrated software packages used by IHS

Secondary Providers

A provider for a patient's visit other than the patient's primary visit provider. A patient visit might have multiple secondary providers, depending on the services provided.

Security Key

A means of securing menus to limit accessibility. To use certain functions, such as those in a manager's menu, you must be assigned the appropriate key by the site manager.

Select

To choose one option from a list of options.

Site Manager

The person in charge of setting up and maintaining the technical aspects of the RPMS at the facility or area level.

Specialty Providers

Defined through the Designated Specialty Provider Management (BDP) application.

Submenu

A menu that is accessed through another menu. A menu option followed by the ellipsis (…) indicates there are submenus.

Supplement

A supplement is a type of modified Health Summary that is related to a specific condition, such as diabetes or HIV/AIDS. It displays personal medical information related to that condition.

Tally

To make a count, total, or subtotal a number of items.

VGEN

Short for Visit General Retrieval Report. VGEN is one of the search utilities that enable users to construct searches of the RPMS database. The General Retrieval reports allow users to create on-the-fly reports by choosing specific data elements to select, print and sort by.

26.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov