



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Management Reports User Manual

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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 (RPMS) 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.

1.0 Introduction

The PCC database is the central repository for data in RPMS.

The following RPMS components comprise the PCC suite:

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

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

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

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

2.0 Release Notes

BJPC v2.0 patch 7 contains the following modifications and enhancements:

2.1 PCC Data Entry

The following changes apply to the PCC Data Entry (APCD) application.

2.1.1 New Patient Goal Component

Added the new option, PATG Patient Goals Update. to the UPD Update Patient Related/Non-Visit Data menu. The option is in List Manager format. The user can enter, modify and delete patient goals and steps along with progress notes.

2.1.2 Mnemonic Changes

- EX: result is now required on all exam entries
- ER: urgency levels have been modified to include the following:
 - R Resuscitation (1)
 - E Emergent (2)
 - U Urgent (3)
 - L Less Urgent (4)
 - N Routine (5)
- PED: Patient education topics can now be added using Current Procedural Terminology (CPT) codes.
- BM: Birth Length field added.
- RF: Added new fields; DES Daughter?, Age at First Menses, Age at First Vaginal Intercourse, Age at Onset of Menopause
- FP: Added the new fields below.
 - DES DAUGHTER?:
 - AGE at FIRST MENSES:
 - AGE at FIRST VAGINAL INTERCOURSE:
 - AGE at ONSET of MENOPAUSE:
 - CURRENTLY PREGNANT?:
 - PROVIDER WHO UPDATED CURRENTLY PREGNANT:
 - EDD (Method Unknown):
 - PROVIDER WHO DOCUMENTED EDD (METHOD UNKNOWN):

- EDD (METHOD UNKNOWN) COMMENT:
- EDD (LMP):
- PROVIDER WHO UPDATED EDD (LMP):
- EDD (LMP) COMMENT:
- EDD (ULTRASOUND):
- PROVIDER WHO UPDATED EDD (ULTRASOUND):
- EDD (ULTRASOUND) COMMENT:
- EDD (CLINICAL PARAMETERS):
- PROVIDER WHO UPDATED EDD (CLINICAL PARAMETERS):
- EDD (CLIN PARAMETERS) COMMENT:
- DEFINITIVE EDD:
- PROVIDER WHO UPDATED DEFINITIVE EDD:
- DEFINITIVE EDD COMMENT:
- LACTATION STATUS:
- Added the option to add, edit or delete a contraceptive method. The ability to record multiple contraceptive methods for a patient is available and the list of contraceptive methods available to choose is expanded.
- PV, IPV, PPV, and SPV: Modified these mnemonics to prompt for a First/Revisit entry when an injury is added. When the user is in Modify (MOD) mode the First/Revisit prompt displays for injury and non-injury entries.
- Added an encounter provider prompt to the following mnemonics:
 - Any measurement (BP, WT, HT, etc)
 - Any Purpose of Visit (PV, IPV, PPV, SPV, UPV)
 - Any CPT entry (ACPT, CPT, PCPT)
 - ADA codes (ADA)
 - Operation entry (OP, AOP, UOP)
 - Diagnostic procedure entry (DXP)
 - Elder care entry (EL)
 - Eye Glass entry (GP)
 - Health Factor entry (HF)
 - Infant Feeding Choice (IF)
 - Lab entry (LAB)
 - Physical Therapy entry (PT)
 - Radiology Exam entry (RAD)
 - Skin Test entry (ST, STP)

- Immunization entry (IM)
- Medication (RX)
- Emergency Room (ER)

2.1.3 Mnemonics: New

- PTG: Patient Goal mnemonic which allows access to the new Patient Goal component
- EGA: New Estimated Gestational Age measurement
- MMSE: New Mini Mental Status Exam measurement

2.1.4 Health Factors: New and Modified

- Category Health Literacy and its associated factors are inactivated.
- Category Barriers to Learning:
 - Factors Childhood Development, Learning Disability, Developmental Delay, <6th Grade Education, and Social Stressors are inactivated.
 - Renamed factor Emotional Stressors to Stressors.
 - Added factors Low Health Literacy and Cognitive Impairment.

2.1.5 Coding Queue Changes

- EHRD/PEHR: added View Any Visit and View BH Note actions.
- EHRD/PEHR: added Status Update action prompt that allows users to edit or delete chart audit notes when a visit is marked as Reviewed/Complete.
- EHRD: added No Primary Visit Provider and No Clinic Assigned to the selection list of visit choices.
- PEHR: added Change Patient action to allow the user to switch patients without going back to the menu.

2.2 PCC Health Summary

The following modifications apply to the PCC Health Summary (APCH) application.

2.2.1 Health Summary Modifications

- Added Lactation Status, Current Contraception Methods and EDD information to the Reproductive History - Brief and Reproductive History – All EDDs components.

- **Modify Health Summary:** added a health summary definition parameter “Display Comments w/Reasons Service Not Done:” under the General Info selection option. Enter “Yes” to allow refusal comments to display in the refusal components.
- Added a Patient Goal Component.
- Added the new option, Generate a Health Summary Supplement, to the Health Summary Menu. The option allows a user to print or view a supplement without a summary type defined.

2.2.2 Health Maintenance Reminders

- Removed V72.31 from the Pap Smear reminder logic.

2.2.3 Patient Wellness Handout

- The following new components are available:
 - Anticoagulation
 - Appointments
 - Diabetes Screening
 - Education Forms
 - Family History
 - Intake Forms
 - Pediatric Screening
 - Procedures
 - Recent BP History
 - Recent Weight History
- The Patient Goal component is modified to include goals from the new Patient Goals functionality.
- The Quality of Care Transparency Report Card is inactivated.

2.3 PCC Management Reports

The following changes apply to the PCC Management Reports (APCL) application.

2.3.1 PGEN/VGEN

- The following data elements have been added to PGEN as search items:
 - Contraception Method
 - EDD (Any/All types)

- Definitive EDD
- EDD (LMP)
- EDD (Ultrasound)
- EDD (Clinical Parameters)
- EDD (Method Unknown)
- EDD (Last Documented)
- The following data elements have been added to VGEN as search items:
 - Visit Auditor
 - Any Immunization Administered?
 - EDD (Any/All types
 - Definitive EDD
 - EDD (LMP)
 - EDD (Ultrasound)
 - EDD (Clinical Parameters)
 - EDD (Method Unknown)
 - EDD (Last Documented)
 - Contraceptive Methods

2.3.2 QMAN

- The following have been added to QMAN (AMQQ) as search attributes:
 - Hospital Location
 - Patient Registration Inactivation Date
 - IMM Patient Active
 - IMM Patient Inactive
 - VFC Eligibility

2.3.3 Management Report Changes

- RTI Returns to Clinic within 72 hours report: Added two new prompts:
 - Ask for same diagnosis - if the user answers yes, only visits with the same primary diagnosis are listed.
 - Include Incomplete Visits? If the user answers yes, incomplete visits will be listed.
- Added totals to reports, DP Patient Listing by Primary Care Provider and VDP Pts by Designated Primary Care Prov w/Visit Counts.

- Added the ability to run the reports CH Community Health Profile Summary and PPDS Provider Practice Description Report using a search template of patients.
- PCCV reports: Added ability to print totals for all visits, regardless of encounter location.

2.4 Other

DM Data Entry Option: Added the message “the data you enter for the above patient will be updated in the PCC database. Do you wish to continue? Y/N.”

2.5 Designated Specialty Provider Management

A new report, “NODP List of Patients with No,” is available.

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 ellipses (...) contains a submenu.

```

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

                2010 DEMO HOSPITAL

MUR      Meaningful Use Performance Reports ...
PLST     Patient Listings ...
RES      Resource Allocation/Workload Reports ...
INPT     Inpatient Reports ...
QA       Quality Assurance Reports ...
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)
BHS      Browse Health Summary
CLM      Custom letter Management ...
OTH      Other PCC Management Reports/Options ...
EPIX     EPI Program HL7 Exports ...
FM       FileMan (General) ...
IPC      Improving Patient Care Collaborative (IPC) Reports...
STS      Search Template System ...
TS       Taxonomy Setup

Select PCC Management Reports Option:

```

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

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

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

3.1 Queuing Output

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

To queue a job:

1. Type **Q** at the “Device” prompt and press Enter.
2. 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 Meaningful Use Reports

These reports will calculate and determine if the minimum requirements to achieve Meaningful Use (MU) have been met. For Stage 1 of the Centers for Medicare (CMS) and Medicaid Services Electronic Health Record (EHR) Incentive Program, there are 15 core Performance Measures for eligible providers (EP) and 14 core Performance Measures for eligible hospitals (including critical access hospitals) that must be met simultaneously during the EHR reporting period. Additionally, both eligible providers and eligible hospitals must meet five of the ten menu set Performance Measures simultaneously, one of which must be designated as a Public Health Performance Measure. Public Health measures will be identifiable by an asterisk throughout the report.

```

*****
**          PCC Management Reports          **
** Meaningful Use Performance Reports **
*****
IHS PCC Suite Version 2.0

DEMO IHS CLINIC

      MUIP   Stage 1 MU Performance Report-EPs
      PLP    Stage 1 MU Patient Lists-EPs
      MUIH   Stage 1 MU Performance Report-Hospitals
      HLP    Stage 1 MU Patient List-Hospitals
      MUCD   Establish Meaningful Use 'Clean Date'

Select Meaningful Use Performance Reports Option:

```

Figure 4-1: Example of Meaningful Use Performance Reports menu screen

4.1 Estimated Run Time

Users may want to generate these reports at a low volume time. The run time will depend on the size of your site's database.

4.2 Establish Meaningful Use 'Clean Date' (MUCD)

Option MUCD "Establish Meaningful Use 'Clean Date'" was created to allow sites to see EHR order check parameter settings, related to MU measures, which are set incorrectly. This option runs a sub-routine in the MU report that checks all the EHR Order Check Configuration parameters that are required by MU. Sites should use the data to correct any discrepancies.

Note: The Meaningful Use Report will fail one or more of its core elements until the parameters are set properly.

When the site is configured correctly, the “Establish Meaningful Use ‘Clean Date’ option will run to completion and set the Meaningful Use ‘Clean Date’ equal to that day’s date. Running the option again doesn’t reset the date. The initial clean date’ remains the same.

```

**      PCC Management Reports          **
** Meaningful Use Performance Reports  **
*****
IHS PCC Suite Version 2.0

2010 DEMO HOSPITAL

MU1P  Stage 1 MU Performance Report-EPs
PLP   Stage 1 MU Patient Lists-EPs
MU1H  Stage 1 MU Performance Report-Hospitals
HLP   Stage 1 MU Patient List-Hospitals
MUCD  Establish Meaningful Use 'Clean Date'

Select Meaningful Use Performance Reports Option: MUCD Establish Meaningful
Use' Clean Date'
Yes

Meaningful Use 'Clean Date' set to APR 13, 2011

```

Figure 4-2: Meaningful Use ‘Clean Date’ displays after Order Check Parameters corrected.

4.3 MU Performance Reports for Eligible Providers (MU1P)

The message shown below displays when the user chooses the Stage 1 MU Performance Report for EPs. The sections below describe the steps that occur after the user has selected the report.

```

*** IHS 2011 Stage 1 Meaningful Use Performance Report for EPs ***

This report determines if primary providers have met the minimum
requirements to achieve Meaningful Use. The report identifies the 15 Core
Performance Measures and 10 Menu Set Performance Measures designated by the
CMS Final Rule for Stage 1, July 28, 2010.

In order to achieve Meaningful Use, a provider must meet all 15 Core
Performance Measures simultaneously. They must also meet 5 of the 10 Menu
Set Performance Measures simultaneously, one of which must be a designated
Public Health Performance Measure. Public Health measures are identified
within the report by an asterisk.

Press Enter to Continue:

```

Figure 4-3: Example of Report Definition

4.3.1 Eligibility Notice for EPs

This report does not verify participation eligibility. It is important to note that this report can indicate a professional who is not eligible to participate in the program has achieved MU. Eligibility is determined by running the Meaningful Use Patient Volume Report for Eligible Professionals located in the Third-Party Billing application. The notice below displays before the user is given the option to run the report. A “yes” entry brings the user to Patient List set up. A “no” entry returns the user to the main menu.

```

***** IMPORTANT NOTICE *****

This report does not verify CMS Medicare or Medicaid EHR Incentive Program
eligibility. Please speak to your Area Meaningful Use Coordinator for
guidance in determining eligibility.

Do you wish to continue to report? Y//

```

Figure 4-4: Example of Important Eligibility Notice

4.3.2 Full Report or Summary Report Selection

The user may generate a full report or a summary report. A full report includes the Cover Page and details on each Performance Measure along with corresponding logic. The Full Report also includes a Summary Report. The Summary Report does not include programming logic. Both reports display previous and current performance results as well as Stage 1 targets.

```

A full report will include an itemized listing of all Performance Measures
and will include a summary report. The summary report excludes itemized
data. The full report will produce approximately 40 pages of data for each
provider. Please take this into consideration when running print jobs,
ensuring dedicated time on your printer and sufficient paper supplies to
complete your job.

Select one of the following:

      F          Full Report
      S          Summary Report

Enter Selection: F//

```

Figure 4-5: Example of Full or Summary Report Selection Screen

4.3.3 Report Period Selection

Users can choose to run the report for a full year, a 90-day period, or a User Defined Date Range. The full year and 90-day options coincide with the CMS program parameters for reporting periods.

Note: This report can be run for any date; however, per CMS guidelines, MU cannot be achieved with the RPMS EHR prior to its date of certification and installation.

For example, if the certified version of RPMS EHR is installed at your site on July 27th, users may run this report for periods prior to this date, but MU can only be achieved on performance for a period that begins on or after July 28th.

```
Report may be run for a 90-day, one year or a user defined time period.

Select one of the following:

    A  January 1 - December 31
    B  User Defined 90-Day Report
    C  User Defined Date Range
Select Report Period: [A/B]
```

Figure 4-6: Example of Reporting Period Selection

4.3.3.1 Calendar Year Selection

The MU program for eligible providers runs on a calendar year. Users are prompted to enter a calendar year for which they wish to run the report.

```
Enter Calendar Year for which report is to be run. Use a 4 digit year, e.g.
2011.

Enter Year: [CCYY]
```

Figure 4-7: Example of Calendar Year Reporting Period for EPs

4.3.3.2 Calculating Previous Period Option for Calendar Year

If the user chooses to include previous period data, data is calculated from the calendar year immediately preceding the selected year in the previous step. If the user chooses not to include the previous period, N/A displays under the “Previous Period” column in the report output.

```
Historical data from the previous calendar year can be included in this
report? IMPORTANT NOTICE: Including previous period data may significantly
increase run time.

Do you wish to include the previous period? Y//
```

Figure 4-8: Include previous period prompt

4.3.3.3 User Defined 90-Day Report Selection

Enter a start date for the 90-day report.

```
Enter Start Date for the 90-day Report (e.g. 01/01/2011):
```

Figure 4-9: Example of 90-Day Reporting Period Selection

4.3.3.4 Calculating Previous Period Option for 90-Day Report Period

If the user chooses to include previous period data, data is calculated from the period immediately preceding the selected 90-day report period in the previous step. For example, if the user selects June 1, 2011 – August 31, 2011, report would also display March 1, 2011 – May 31, 2011. If the user chooses not to include the previous period, N/A displays under the “Previous Period” column in the report output.

```
Historical data from the 90-days immediately preceding the currently
selected report period can be included? IMPORTANT NOTICE: Including
previous period data may significantly increase run time.
```

```
Do you wish to include the previous period? Y//
```

Figure 4-10: Include previous period prompt

4.3.3.5 User Defined Date Range Selection

Enter a beginning date for the report.

```
Enter Beginning Date:
```

Figure 4-11: Example of Beginning Date for User Defined Date Range Selection

Enter an end date for the report.

```
Enter Ending Date:
```

Figure 4-12: Example of End Date for User Defined Date Range Selection

4.3.3.6 Calculating Previous Period Option for User Defined Report Period

If the user chooses to include previous period data, data is calculated for the same period of the year preceding the selected User Defined report period in the previous step. For example, if the user selects June 1, 2011 – June 30, 2011, report would also display June 1, 2010 – June 30, 2010. If the user chooses not to include the previous period, N/A displays under the “Previous Period” column in the report output.

```
IMPORTANT NOTICE: Including previous period data may significantly increase
run time.
```

```
Do you wish to include the previous period? Y//
```

Figure 4-13: Include previous period prompt

4.3.4 Provider Selection

The user may choose one of the provider options below.

```
Select one of the following:

    IP Individual Provider
    SEL   Selected Providers (User Defined)
    TAX Provider Taxonomy List

Enter Selection: [XXX]
```

Figure 4-14: Example of Provider Selections for EPs

4.3.4.1 Individual Provider (IP)

If Individual Provider is chosen, the user is prompted to enter the provider name. Either the full or summary report as previously selected will be generated for the designated provider. Reminder: this report does not verify the selected provider is eligible to participate.

```
Enter the name of the provider for whom the Meaningful Use Report will be
run.

Enter PROVIDER NAME: [Provider Name]
```

Figure 4-15: Example of Individual Provider Report Selection for EPs

4.3.4.2 Selected Providers (SEL)

If Selected Providers is chosen, the user is prompted to enter multiple provider names. Either the full or summary report as previously selected will be generated for each designated provider. Reminder: this report does not verify the selected provider is eligible to participate.

```
Enter the name of the provider for whom the Meaningful Use report will be
run.

Enter PROVIDER NAME: [Provider Name]
Enter PROVIDER NAME: [Provider Name]
Enter PROVIDER NAME: [Provider Name]
Enter PROVIDER NAME: [Provider Name]
Enter PROVIDER NAME: [Provider Name]
```

Figure 4-16: Example of Selected Provider Report Type for EPs

4.3.4.3 Provider Taxonomy List (TAX)

If taxonomy list is chosen, the user is prompted for the taxonomy list name. Either the full or summary report as previously selected will be generated for each provider on the list.

```
Enter PROVIDER TAXONOMY NAME: [Taxonomy List Name]
```

Figure 4-17: Example of Report Definition

4.3.5 Demo Patient Selection

Users may choose to include or exclude demo patients in their report.

```
Select one of the following:

I   Include ALL Patients
E   Exclude DEMO Patients
O   Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E//
```

Figure 4-18: Example of Demo Patient Options

4.3.6 Attestation Performance Measures for EPs

The Meaningful Use report calculates all rate performance measures – measures that have a numerator and denominator. For all attestation measures, the user will be prompted to answer a yes or no attestation question for each provider for whom the report is being run.

```
Clinical Decision Support Rule: Were any of the following configured
during the EHR reporting period: National Clinical Reminders or Health
Summary Supplements which include Diabetes Supplement, Pre-Diabetes
Supplement, Anti-Coagulation Supplements, Immunization Forecasting and
Health Maintenance Reminders?

Does WALKER,MICHAEL attest to this? Y//
```

Figure 4-19: Example of Attestation Question

Note: Although Timely Electronic Access to Health Information is a rate measure, it is being answered via attestation at this time.

4.3.7 Output Selection

A summary of the selections the user made in the previous steps displays. The user may choose from the following output selections:

- **P:** Print Report on Printer or Screen
- **D:** Create Delimited output file (for use in Excel)
- **B:** Both a Printed Report and Delimited File

```
SUMMARY OF 2011 MEANINGFUL USE REPORT TO BE GENERATED

The date ranges for this report are:
  Report Period:  [Specified Report Period]
  Previous Period: [Period Immediately Preceding Specified Report Period]

Providers:

[Provider Name]
[Provider Name]

Please choose an output type. For an explanation of the delimited file
please see the user manual.

Select 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

Select an Output Option: P//
```

Figure 4-20: Example of Output Selection

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

4.4 Patient List for Eligible Providers (PLP)

The PLP option provides users with a patient list in addition to a Full or Summary report for EPs (M1IP). The Patient List includes patient-specific information for each measure that is selected. The user defines which measures to include in the report and is given the following options for each selected performance measure:

- Include Patients who met the measure
- Include Patients who did not meet the measure
- Include patients who met and did not meet the measure.

After choosing the Patient List options, the user is guided through the above steps (Section 4.2) for running the EP reports.

Note: Key APCMZ PATIENT LISTS is needed to access these reports. The facility's site manager will need to assign this key to the local MU Coordinator and other applicable individuals as appropriate.

4.4.1 Patient List for Eligible Providers (PLP)

The message shown below displays when the user chooses the PLP report. The User must press enter to continue.

```
*** IHS 2011 Stage 1 Meaningful Use Patient List for EPs ***

This Patient List will display patient-specific data used to calculate the
results documented in the Meaningful Use Performance Report. One or more
lists may be selected.

Press Enter to Continue:
```

Figure 4-21: Example of Patient List Selection

4.4.1.1 Eligibility Notice for EPs

The message below displays before the EP is able to set up a Patient List and run the EP report. This report does not verify participation eligibility. It is important to note that this report can indicate a professional who is not eligible to participate in the program has achieved MU. Eligibility is determined by running the Meaningful Use Patient Volume Report for Eligible Professionals (PVP) located in the Third-Party Billing application.

At the “Do you wish to continue to report” prompt, A “yes” entry brings the user to Patient List set up. A “no” entry returns the user to the main menu.

```
***** IMPORTANT NOTICE *****

This report does not verify CMS Medicare or Medicaid EHR Incentive Program
eligibility. Please speak to your Area Meaningful Use Coordinator for
guidance in determining eligibility.

Do you wish to continue to report? Y//
```

Figure 4-22: Example of Important Eligibility Notice

4.4.1.2 Patient List Type Selection

The user is prompted to select a patient list type.

```
Select one of the following reports:

S Selected set of MU Performance Measures
A All MU Performance Measures
```

```
Run the report on: S//
```

Figure 4-23: Example of Patient List Options

4.4.1.2.1 *Selected set of MU Performance Measures for EPs*

The user may select for which of the 16 rate-calculated performance measures to generate a patient list. If no measure is selected, user is returned to Full or Summary report Selection in order to run MU Performance Report for EPs without a patient list. The user can select all measures, individual measures or they can select all core or all menu set measures. Core and Menu set measures are indicated by (C) and (M) respectively.

Note: Although Timely Electronic Access to Health Information is a rate measure, it is being answered via attestation at this time and will not appear in this list.

```
PERFORMANCE MEASURE SELECTION Mar 15, 2011 15:29:50      Page:      1 of      2
IHS MU PERFORMANCE MEASURE
* Indicates the Performance Measure has been selected.

1)  (C) CPOE Medication
2)  (C) Drug Interaction Checks
3)  (C) Maintain Problem List
4)  (C) e-Prescribing (e-Rx)
5)  (C) Active Medication List
6)  (C) Medication Allergy List
7)  (C) Record Demographics
8)  (C) Record Vital Signs
9)  (C) Record Smoking Status
10) (C) Clinical Quality Measures
11) (C) Clinical Decision Support Rule
12) (C) Electronic Copy of Health Information
13) (C) Clinical Summaries
14) (C) Electronic Exchange of Clinical Information
15) (C) Protect Electronic Health Information
16) (M) Drug-Formulary Checks
+   Enter ?? for more actions
S   Select Measure      C   Core Measure
D   De Select Measure  M   Menu Set Measures
Select Action:++//
```

Figure 4-24: Example of List of Measures for Patient List

4.4.1.2.2 *All MU Performance Measures for EPs*

The User is prompted to specify if patient lists are desired for any of the measures. A “no” entry brings the User to the Full or Summary Report Selection in the MIP report. You may complete the selection criteria to run the MU Performance Report for EPs with a Patient List. A “yes” entry displays the MU Measure List Selection. The user may choose the measures for which a patient list is desired.

```
PATIENT LISTS
Do you want patient lists for any of the measures? N//
```

Figure 4-25: Example of Patient List Confirmation

4.5 Stage 1 MU Performance Report-Hospitals (M1IH)

The message shown below displays if the user chooses the Stage 1 MU Performance Report for Eligible Hospitals. The sections below describe the steps that occur after the user has selected the report.

```
*** IHS 2011 Stage 1 MU Performance Report for Hospitals & CAHs ***

This report determines if a hospital or CAH has met the minimum
requirements to achieve Meaningful Use. Primary and secondary providers are
included in Meaningful Use calculations. The report identifies the 14 Core
Performance Measures and 10 Menu Set Performance Measures designated by the
CMS Final Rule for Stage 1, July 28, 2010.

In order to achieve Meaningful Use, a hospital or CAH must meet all 14 Core
Performance Measures simultaneously. They must also meet 5 of the 10 Menu
Set Performance Measures simultaneously, one of which must be a designated
Public Health Performance Measures. Public Health measures are identified
within the report by an asterisk.

Press Enter to Continue:
```

Figure 4-26: Example of Report Definition

4.5.1 Eligibility Notice for Eligible Hospitals and CAHs

This report does not verify participation eligibility. It is important to note that this report can indicate MU has been achieved by a facility that is not eligible to participate in the program. Eligibility is determined by running the Meaningful Use Patient Volume Report for Eligible Hospitals (PVH) located in the Third-Party Billing. The notice below displays before the user is given the option to run the report. A “yes” entry brings the user to Patient List set up. A “no” entry returns the user to the main menu.

```
***** IMPORTANT NOTICE *****

This report does not verify CMS Medicare or Medicaid EHR Incentive Program
eligibility. Please speak to your Area Meaningful Use Coordinator for
guidance in determining eligibility.

Do you wish to continue to report? Y//
```

Figure 4-27: Example of Important Eligibility Notice

4.5.2 Full Report or Summary Report Selection

The user may generate a full report or a summary report. A full report includes the Cover Page and details on each Performance Measure along with corresponding logic. The Full Report also includes a Summary Report. The Summary Report does not include programming logic. Both reports display previous and current performance results as well as Stage 1 targets.

A full report will include an itemized listing of all Performance Measures and will include a summary report. The summary report excludes itemized data. The full report will produce approximately 40 pages of data for the facility. Please take this into consideration when running print jobs, ensuring dedicated time on your printer and sufficient paper supplies to complete your job.

Select one of the following:

F	Full Report
S	Summary Report

Enter Selection: F//

Figure 4-28: Example of Full or Summary Report Selection Screen

4.5.3 Report Period Selection

Users can choose to run the report for a full year, a 90-day period, or a User Defined Date Range. The full year and 90-day options coincide with the CMS program parameters for reporting periods.

Note: This report can be run for any date; however, per CMS guidelines, MU cannot be achieved with the RPMS EHR prior to its date of certification and installation.

For example, if the certified version of RPMS EHR is installed at your site on July 27th, users may run this report for periods prior to this date, but MU can only be achieved on performance for a period that begins on or after July 28th.

Report may be run for a 90-day, one year or a user defined time period.

Select one of the following:

A	October 1 - September 30
B	User Defined 90-Day Report
C	User Defined Date Range

Select Report Period: [A/B]

Figure 4-29: Example of Reporting Period Selection

4.5.3.1 Federal Fiscal Year Selection

The MU program for eligible hospitals/CAHs runs on a fiscal year. Users are prompted to enter the fiscal year for which they wish to run report.

```
Enter the Federal Fiscal Year for which report is to be run. Use a year,
e.g. 2011.

Enter Year: [FFYY]
```

Figure 4-30: Example of Federal Fiscal Year Reporting Period for EPs

4.5.3.2 Calculating Previous Period Option for Federal Fiscal Year

If the user chooses to include previous period data, data is calculated from the federal fiscal year immediately preceding the selected year in the previous step. If the user chooses not to include the previous period, N/A displays under the “Previous Period” column in the report output.

```
Would you like to include historical data from the previous federal fiscal
year? IMPORTANT NOTICE: Including previous period data may significantly
increase run time.

Do you wish to include the previous period? Y//
```

Figure 4-31: Previous period option

4.5.3.3 User Defined 90-Day Report

Enter a start date for the 90-day report.

```
IMPORTANT NOTE: This report may be run for any 90-day period. For
submission to CMS, the report should not span Federal Fiscal Years.

Enter Start Date for the 90-day Report (e.g. 01/01/2011):
```

Figure 4-32: Example of 90-Day Reporting Period Selection

4.5.3.4 Calculating Previous Period Option for 90-Day Report Period

If the user chooses to include previous period data, data is calculated from the period immediately preceding the selected 90-day report period in the previous step. For example, if user selects June 1, 2011 – August 31, 2011, report would also display March 1, 2011 – May 31, 2011. If the user chooses not to include the previous period, N/A displays under the “Previous Period” column in the report output.

```
Historical data from the 90-days immediately preceding the currently
selected report period can be included? IMPORTANT NOTICE: Including
previous period data may significantly increase run time.
```

```
Do you wish to include the previous period? Y//
```

Figure 4-33: Previous period option

4.5.3.5 User Defined Date Range Selection

Enter a beginning date for the report.

```
Enter Beginning Date:
```

Figure 4-34: Example of Beginning Date for User Defined Date Range Selection

Enter an end date for the report.

```
Enter Ending Date:
```

Figure 4-35: Example of End Date for User Defined Date Range Selection

4.5.3.6 Calculating Previous Period Option for User Defined Report Period

If the user chooses to include previous period data, data is calculated for the same period of the year preceding the selected User Defined report period in the previous step. For example, if the user selects June 1, 2011 – June 30, 2011, report would also display June 1, 2010 – June 30, 2010. If the user chooses not to include the previous period, N/A displays under the “Previous Period” column in the report output.

```
IMPORTANT NOTICE: Including previous period data may significantly increase run time.
```

```
Do you wish to include the previous period? Y//
```

Figure 4-36: Include previous period prompt

4.5.4 Hospital or CAH Selection

Specify the Hospital or CAH you want to include in the report.

```
Select Hospital or CAH: DEMO IHS CLINIC//
```

Figure 4-37: Example of Facility Selection

4.5.5 Demo Patient Selection

Users may choose to include or exclude demo patients in their report.

```
Select one of the following:
```

```
I Include ALL Patients
E Exclude DEMO Patients
```

```

O Include ONLY DEMO Patients
Demo Patient Inclusion/Exclusion: E//

```

Figure 4-38: Example of Demo Patient Options

4.5.6 Attestation Performance Measures for Hospitals

The Meaningful Use report calculates all rate performance measures – measures that have a numerator and denominator. For all attestation measures, the user will be prompted to answer a yes or no attestation question for each provider for whom the report is being run.

```

Several Stage 1 Meaningful Use Performance Measures require an attestation
of Yes or No for each provider for which the report is being run.

Do you wish to continue? Y//

```

Figure 4-39: Example of Attestation Explanation

4.5.7 Output Selection

A summary of the selections the user made in the previous steps displays. The user may choose from the following output selections:

- **P:** Print Report on Printer or Screen
- **D:** Create Delimited output file (for use in Excel)
- **B:** Both a Printed Report and Delimited File

```

SUMMARY OF 2011 MEANINGFUL USE REPORT TO BE GENERATED

The date ranges for this report are:
  Report Period: [Specified Report Period]
  Previous Period: [Period Immediately Preceding Specified Report Period]

Hospital: DEMO ISH CLINIC

Please choose an output type. For an explanation of the delimited file
please see the user manual.

Select 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

Select an Output Option: P//

```

Figure 4-40: Example of Output Selection

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

4.6 Patient List for Eligible Hospitals and CAHs (PLH)

The PLH option provides users with a patient list in addition to a Full or Summary report for hospitals/CAH (M1IH). The Patient List includes patient-specific information for each measure that is selected. The user defines which measures to include in the report and is given the following options for each selected performance measure:

- Include Patients who met the measure
- Include Patients who did not meet the measure
- Include patients who met and did not meet the measure.

After choosing the Patient List options, the user is guided through the above steps (Section 4.2) for running the EP reports.

Note: Key APCMZ PATIENT LISTS is needed to access these reports. The facility's site manager will need to assign this key to the local MU Coordinator and other applicable individuals as appropriate.

4.6.1 Patient List for Eligible Hospitals and CAHs (PLH)

The following message displays when the user chooses the PLH report. User must press enter to continue.

```
*** IHS 2011 Stage 1 MU Patient List for Hospitals & CAHs ***

This report will enable a provider to review his or her Meaningful Use
performance by patient-specific data. You will be asked to select one or
more Performance Measures on which to report.

Press enter to continue.
```

Figure 4-41: Example of Patient List Selection

4.6.1.1 Eligibility Notice for Eligible Hospitals and CAHs

This report does not verify participation eligibility. It is important to note that this report can indicate a MU has been achieved by a facility that is not eligible to participate in the program. Eligibility is determined by running the Meaningful Use Patient Volume Report for Eligible Hospitals (PVH) located in the Third-Party Billing application. The notice below displays before the user is given the option to run the report. A “yes” entry brings the user to Patient List set up. A “no” entry returns the user to the main menu.

```
***** IMPORTANT NOTICE *****
```

```
This report does not verify CMS Medicare or Medicaid EHR Incentive Program
eligibility. Please speak to your Area Meaningful Use Coordinator for
guidance in determining eligibility.
```

```
Do you wish to continue to report? Y//
```

Figure 4-42: Example of Important Eligibility Notice

4.6.1.2 Patient List Type Selection

The user is prompted to select a patient list type.

```
Select one of the following reports:

      S   Selected set of MU Performance Measures
      A   All MU Performance Measures

Run the report on: S//
```

Figure 4-43: Example of Patient List Options

4.6.1.2.1 *Selected set of MU Performance Measures for Hospitals*

The user may select for which of the 16 rate-calculated performance measures to generate a patient list. If no measure is selected, the user is returned to Full or Summary report Selection in order to run MU Performance Report for eligible hospitals without a patient list. The user can select all measures, individual measures or they can select all core or all menu set measures.

```
PERFORMANCE MEASURE SELECTION Mar 15, 2011 15:57:36           Page:    1 of
2
IHS MU PERFORMANCE MEASURE
* Indicates the Performance Measure has been selected.

1) (C) CPOE Medications
2) (C) Drug Interaction Checks
3) (C) Maintain Problem List
4) (C) Active Medication List
5) (C) Medication Allergy List
6) (C) Record Demographics
7) (C) Record Vital Signs
8) (C) Record Smoking Status
9) (C) Clinical Quality Measures
10) (C) Clinical Decision Support Rule
11) (C) Electronic Copy of Health Information
12) (C) Electronic Copy of Discharge Instructions
13) (C) Electronic Exchange of Clinical Information
14) (C) Protect Electronic Health Information
15) (M) Drug-Formulary Checks
16) (M) Advance Directives
+      Enter ?? for more actions
S      Select Measure           D      De Select Measure
Select Action: +//
```

Figure 4-44: Example of List of Measures for Patient List

4.6.1.2.2 *All MU Performance Measures for Eligible Hospitals and CAHs*

The User is prompted to verify if patient lists are desired for any of the measures. A “yes” must be entered here to continue. After patient list selection, the user is directed to Full or Summary Report Selection in the M1IH report. The user may complete the selection criteria to run the MU Performance Report with a Patient List.

```
PATIENT LISTS  
Do you want patient lists for any of the measures? N//
```

Figure 4-45: Example of Patient List Confirmation

5.0 Patient Listings (PLST)

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

```

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

DEMO HOSPITAL

CRC  Living Patients by Community of Residence (*)
DOB  Living Patients by Date of Birth (*)
DEM  Living Patients by Multiple Demographic Variables
DOD  Deceased Patients by Date of Death (*)
PGEN  Patient General Retrieval
DP   Patient Listing by Primary Care Provider
VDP  Patients by Primary Care Provider w/ Visit Counts
DMG  Detailed Patient Register R-DMG-510
DPL  Deceased Patients Listing
ELFA  Tally of Elder Pt's with Functional Assessment
ELFC  Tally of Elder Care Functional Status Change
ELFT  Tally of Elder Care Data Items
ELNH  Elder Pts w/Needs Help or Dependent Assessments
IF    Infant Feeding Statistical Reports ...
PCR  Prescription Cost Report
PINT  Tally of Patient Internet Access
SCR  Screening Reports (IPV/DV, Alcohol, Depression) ...
SUC  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 5-1: Sample of PCC Management Reports patient listings screen

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

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

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

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

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

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

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

SUBCOUNT 14				

Figure 5-2: Example report listing patients by their community of residence

5.2 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 **1** (DOB) or **2** (Patient Name) to indicate how the report should be sorted. One or more attributes can be used.
 - a. If DOB was specified:
 - At the “Start with what date” prompt, type the beginning date of the date range.
 - At the “End with what date” prompt, type the ending date of the date range.
 - At the “Within DOB, want to sort by another attribute” prompt, type **Y** (Yes) or **N** (No). If Y is entered, the system prompts for the attribute.
 - b. If Patient Name was specified:
 - At the “Do you want to sort by a particular patient name?” prompt, type **Y** (Yes) or **N** (No). If Y is entered, the system prompts for the patient’s name.
 - At the “Within Patient Name, want to sort by another attribute?” prompt, type **Y** (Yes) or **N** (No). If Y is entered, the system prompts for the attribute.
2. At the “Please enter a title for this report” prompt, type the title of the report or press ENTER to use the default.
3. At the “Device” prompt, specify the device to print/display the report.

The following is a report listing patients by DOB.

PATIENT LISTING BY DATE OF BIRTH	JAN 26,1995 14:06	PAGE 1
NAME	DOB	CHART
LAMBDA, SARAH	JAN 1,1944	77467
LAMBDA, MARTIN	JAN 1,1944	99009
LAMBDA, THERESA	FEB 1,1944	98775
LAMBDA, JIM	FEB 1,1944	31382
RHO0000, 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 5-3: Sample of report listing patients by their dates of birth

The following is a report listing patients 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 5-4: Example report by patient name

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

2. At the “Start with what date” prompt, type the beginning of the date range.
3. At the “End with what date” prompt, type the ending of the date range.
4. At the “Please enter a title for this report” prompt, type 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 5-5: Example of report listing patients by demographic variables

5.3.1 Estimated Run Time

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

5.4 Deceased Patients by Date of Death (DOD)

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

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

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

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

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

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

- **D**—Date of Death
- **H**—HRN
- **R**—Terminal Digit HRN

- C–Community
 - T–Tribe
 - N–Patient Name
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
- I–Include All patients
 - E–Exclude Demo patients
 - O–Include only demo patients
4. At the “Device” prompt, specify the device to print/display the report.

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

DEASEASED PATIENTS REPORT					
Date of Death: Jan 01, 1801 - Jan 20, 2009					
Patient Name	HRN	DOB	Age at DOD	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					
THETA AAA,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 5-6: 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.

5.5 Patient General Retrieval (PGEN)

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

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

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

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

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

The predefined order is set by the software and is how the list has historically been displayed. See Section 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, the system prompts for the name of the template. After typing the name of the template, a print item selection list displays. Select items to print by following the directions below.

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

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

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

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

```

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

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 5-7: Options on the Patient Selection Menu

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

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

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

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

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

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

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

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

6. The system displays the Print Item Selection Menu.

```

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

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

1) Patient Name           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  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 5-8: Items in the Print Item Selection menu

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

```

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

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

1) Patient Name        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
Scree
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 5-9: Options on the SORT ITEM SELECTION MENU

10. Select one of the options listed on the SORT ITEM SELECTION MENU to specify how to sort patients. To sort patients by name, type **Q** (Quit Item Selection) at the “Select Action” prompt and press Enter.
11. At the “Do you want a separate page for each Patient Name” prompt, type **Y** (Yes) or **N** (No).
12. At the “Would you like a custom title for this report?” prompt, type **Y** (Yes) or **N** (No). If Y is entered, the system prompts for the custom title.
13. At the “Do you wish to save this search/print/sort logic for future use?” prompt type **Y** (Yes) or **N** (No). If Y is entered, the system prompts for a name.
14. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I**–Include All patients
 - **E**–Exclude Demo patients
 - **O**–Include only demo patients
15. At the “Select one of the following” prompt, type **P** to print the output or **B** to browse the output on the screen.

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

PCC PATIENT LISTING		Page 1
NAME	DOB	WT (GMS)
ABETAAAAA, LAURA	02/07/1947	51.22
ABETAAAAA, MARGARET	12/08/1995	--

```

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

```

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

Figure 5-10: Example report for PGEN option

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

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

5.6 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:  APROVIDER,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 5-11: Example of report sorted by primary care provider

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

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

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

```

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

```

PATIENT NAME	CHART	AGE	TIMES OTHER		ICD DIAGNOSES
			SEEN	PROVIDERS	

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-UNSP

```

RUN TIME (H.M.S): 0.0.03

```

Figure 5-12: Sample of report with visit counts

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

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

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

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

Follow these steps:

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

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

```

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

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

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

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

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

```

Figure 5-13: Options in the Patient Selection menu

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

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

```

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

                          SORT ITEM SELECTION MENU

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

1) Patient Name           29) Cause of Death           57) Most Recent ALCOHOL
HF
2) First, Last Name       30) MEDICARE Y/N             58) Most Recent STAGED
DM
3) Chart                  31) Medicare Part B         59) Most Recent Barriers
H
4) Terminal Digit        32) Medicare Part D         60) Most Recent LEARNING
P
5) Sex                   33) MEDICAID Y/N           61) Most Recent RUBELLA
HF
6) Date of Birth         34) PRIVATE INSURANCE Y/N   62) Date Last
Alcohol Scree
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
Scree
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 5-14: Options in the Sort Item Selection menu

3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I**—Include all patients
 - **E**—Exclude demo patients

- **O**–Include only demo patients
4. At the “Device” prompt, specify the device to print/display the report.

```

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

BIRTH                BLOOD --- ELIGIBILITY ---

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

```

Figure 5-15: Sample of DMG report

5.9 Deceased Patients Listing (DPL)

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

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

If the user types O or S, additional prompts display.
4. At the “Sort Report by” prompt, type one of the following:
 - **D**–Date of Death
 - **H**–HRN
 - **R**–Terminal Digit HRN
 - **C**–Community
 - **T**–Tribe
 - **N**–Patient Name

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I**–Include all patients
 - **E**–Exclude demo patients
 - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/display the report.

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

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 5-16: Sample of DPL report

5.10 Tally of Elder Patients with Functional Assessment (ELFA)

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

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

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

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

1. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, type the end of the date range.
3. At the “Enter an Age Range (e.g. 55-100, 55-75)” prompt, type the age range of patients to display on the report.
4. At the “Review Patients Who Live In” prompt, type one of the following:

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

If the user types O or S, additional prompts display.

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

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

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

```

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

```

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

Figure 5-17: Example DPL report

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

5.11 Tally of Elder Care Functional Status Change (ELFC)

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

```

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

```

AGE	OF PATIENTS	IMPROVED %	SAME %	DECLINED %

79	-	-	-	-	-	-	-
80	-	-	-	-	-	-	-
81	-	-	-	-	-	-	-
82	-	-	-	-	-	-	-
83	-	-	-	-	-	-	-
84	-	-	-	-	-	-	-
85	1	0	0.0	0	0.0	1	100.0
86	-	-	-	-	-	-	-
87	-	-	-	-	-	-	-
88	-	-	-	-	-	-	-
89	-	-	-	-	-	-	-
90	-	-	-	-	-	-	-

Figure 5-18: Example of an ELFC report

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

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

```

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

Figure 5-19: Example last page of ELFC report

5.12 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 5-20: Sample of ELFT report

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

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

5.14 Infant Feeding Statistical Reports (IF)

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

5.14.1 Birth and Six-Month Breastfeeding Statistics (IF1)

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

5.14.1.1 Birth breastfeeding statistics

- Denominator:
 - Number of infants with a visit.
 - Patients who had at least one visit to a primary care clinic between birth and six months (ages 1 to 179 days old).
- Numerators:

- Infants with feeding data. Any patient with a visit with any infant feeding choice documented between birth and six months (0 to 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.

5.14.1.2 Six-month statistics

Same as Birth, except the visits reviewed are those that occurred between ages 180 to 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 5-21: Example of IF1 report

5.14.2 Breastfeeding Statistics by Age Group (IF2)

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

5.14.2.1 Birth breastfeeding statistics

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

5.14.2.2 Six-month statistics

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

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

DEMO HOSPITAL					
INFANT BREASTFEEDING STATISTICS, as of Dec 23, 2006					
Patients born Dec 22, 2005 - Dec 23, 2006					
	DEMO HOSPITAL	HP 2010	NATIONAL USA RATE	2003 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 5-22: Example of IF2 report

5.15 Prescription Cost Report (PCR)

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

5.16 Tally of Patient Internet Access (PINT)

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

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

Total of Patients	7,949		
Total w/Internet Access Screening	5,268	66%	
with Internet Access w/% of those screened	1,859	35%	
GENDER BREAKDOWN:			
Females w/internet access			
with % of those with access	1,147	62%	
Males w/internet access			
with % of those with access	712	38%	
AGE BREAKDOWN:			
< 18 yrs old w/internet access			
with % of those with access	570	31%	
18-35 yrs old w/internet access			
with % of those with access	512	28%	
36-55 yrs old w/internet access			
with % of those with access	603	32%	
> 55 yrs old w/internet access			
with % of those with access	174	9%	

Figure 5-23: Example portion of PINT report

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

The SCR option prompts the user 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 tallies and optionally lists all patients who have had IPV screening (Exam Code 34) or a refusal documented in the time frame specified by the user. This report tallies the patients by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Depression Screening Menu has several options:

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

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

```

XXX                               Jan 20, 2009                               Page 1

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

PATIENT NAME           HRN      AGE  DATE 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 5-24: Example report for DVP under depression screening

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

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

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

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

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

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

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

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

5.18 Suicide Form Data Reports (SUIC)

There are two reports available.

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

OUTPUT BROWSER	Jan 20, 2009 15:02:50	Page: 1 of 17
DEMO HOSPITAL	Jan 20, 2009	Page 1
***** AGGREGATED DATA FROM SUICIDE REPORTING FORMS *****		
Act Occurred: Jan 21, 2008 - Jan 20, 2009		
Community where Act Occurred: ALL Communities		

Age Range: 15-19 years	Total	of Suicide Forms: 3
REPORT TOTALS		
Self Destructive Act:	IDEATION WITH PLAN AND INTENT	2 67%
	ATTEMPT	1 33%

```

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

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

```

Figure 5-25: Example report of aggregated data from suicide reporting forms

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

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

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

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

SJT		Jan 20, 2009				Page 1			
DEMO HOSPITAL									
HOUSEHOLD INCOME/NUMBER IN HOUSEHOLD TALLY									
Patient Name	HRN	BENI	COMMUNITY	ZIP	TRIBE	IN	TOTAL		
	FICI					HOUSE	HOUSEHOLD		
	ARY					HOLD	INCOME		
ALPHA,DAVID BR	102982	01	BIG COVE	28719	DEMO	TRIBE	2	0	
ALPHA,MARTHA AGN	100881	01	SOUTH CAR	29356	DEMO	TRIBE	2	0	
ALPHA,MICHAEL A	121082	01	PAINTTOWN	28719	DEMO	TRIBE	6	0	
ALPHA,CAROL ANN	100351	01	BIRDTOWN	28719	DEMO	TRIBE	1	0	
ALPHA,MARGARET D	108025	01	VASSALBOR	28719	DEMO	TRIBE	2	0	
ALPHA,BARBARA	119344	01	BIRDTOWN	28719	DEMO	TRIBE	1	0	
ALPHA,DANI SUE	165877	01	BETHEL	74724	CHOCTAW	NA	6	0	
ALPHA,FREDIA ANN	122649	01	MARBLE	28905	DEMO	TRIBE	4	0	
ALPHA,GREGORY PAUL	103558	01	BIRDTOWN	28719	DEMO	TRIBE	5	0	
ALPHA,JAKELI 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 5-26: Example THI report

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

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

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

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

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

MYFILE.TXT

6.0 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 6-1: Example of Resource Allocation/Workload Reports menu screen

6.1 Estimated Run Time

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

6.2 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 6-2: Example of Operations Summary menu screen

6.2.1 Operations Summary (OS)

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

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

Follow these steps:

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

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

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

Additional prompts display when 1 or 3 is chosen.

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

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

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

The following sample report displays a Complete Operations Summary.

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

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

PATIENT REGISTRATION

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

THIRD PARTY ELIGIBILITY

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

CONTRACT HEALTH SERVICES

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

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

DIRECT INPATIENT

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

The five leading primary diagnoses for hospitalizations were:

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

AMBULATORY CARE VISITS

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

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

By Type:

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

By Location:

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

By Service Category:

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

By Clinic Type

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

By Provider Type (Primary and Secondary Providers):

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

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

By ICD Diagnosis		
1 -	Upper Respiratory Inf.	4,722 (+8%)
2 -	Prenatal Care	3,691 (-12%)
3 -	Diabetes Mellitus	3,480 (-9%)
4 -	Otitis Media	3,217 (+17%)
5 -	Impetigo	1,911 (+3%)
6 -	Complications of Pregnancy	1,271 (-8%)
7 -	Laceration	862 (-8%)
8 -	Sprains/Strains	490 (+11%)
9 -	Rheumatoid Arthritis	487 (+4%)
10 -	Gastroenteritis	452 (-22%)
By APC Grouping		
1 -	URI	5,110 (+4%)

2	- Diabetes Mellitus	3,890	(+10%)
3	- Influenza	2,001	(-10%)
4	- Impetigo	2,150	(-4%)
5	- Prenatal Care	1,200	(+8%)
6	- Well Child Care	1,180	(-11%)
7	- Conjunctivitis	850	(+17%)
8	- Physical Exams	710	(-2%)
9	- Anemia	666	(-2%)
10	- Alcoholism	652	(+5%)
INJURIES			
There were 5,217 visits for injuries (-11%) reported during this period. Of these, 1,252 were new injuries (+8%). The five leading causes were:			
	1 - Falls	221	(+5%)
	2 - Motor Vehicle	190	(-12%)
	3 - Stings & Venoms	101	(-2%)
	4 - Purposely Inflicted	72	(+19%)
	5 - Undetermined	66	(+4%)
EMERGENCY ROOM			
There were 2,911 visits (+16%) to the ER (Clinic Code=30). Of these 1,216 had an injury diagnosis (-12%) and 621 had an alcohol-related diagnosis (+4%).			
PHARMACY			
There were 21,000 new prescriptions (+17%) and 39,000 refills (+12%) during this period.			
DENTAL			
There were 4,920 patients (+12%) seen for Dental Care. They accounted for 7,826 visits (+19%). The five leading service categories were:			
	1 - Restoration		(+8%)
	2 - Extraction		(+24%)
	3 - Fluoridation		(+12%)
	4 - Exam		(-1%)
	5 - Sealants		(+16%)

Figure 6-3: Example of a complete Operations Summary report

6.2.2 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 6-4.

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 6-4: Example of SECT screen

6.2.3 Create/Edit Operations Summary Type (TYPE)

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

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

6.2.4 Display an Operations Summary Type (DISP)

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

The following sample shows the Complete Operations Summary type.

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

Figure 6-5: Example of a screen listing operations summary types

6.3 Registered Patients and Visits Report Types

There are three Registered Patients and Visits Report types:

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

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

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

- The number of APC primary care provider (PCP) visits by those patients

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

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

This is a sample RPVC report.

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

Figure 6-6: Example of the RPVC report

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

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

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

TRIBE OF 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 6-7: Example Age Bucket report

6.5 Active Patient Count Report Types

There are three Active Patient Count Report types:

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

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

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

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

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

This is a sample ACT report.

DEMO HEALTH CENTER	FEB 5,1995	Page 1
Registration and Active Patient Counts for all Patients Registered in DEMO Service Unit.		
The report is sorted by Tribe of Membership.		
Active Patients were those seen between OCT 01,1994 and FEB 5,1995.		
Tribe of Membership	Reg Pts Living As of Today	Active Patients

ALASKAN INDIAN	1	1
NON-INDIAN BENEFICIARY	1	1
TOHONO O'ODHAM NATION OF ARIZONA	91	61
	-----	-----
Total:	93	63

Figure 6-8: Example of ACT report

6.6 Community Health Profile Summary (CH)

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

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

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

```

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

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

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

The Top 15 Purposes of Direct and Contract Outpatient Visits were:
Both Primary and Secondary Diagnoses are included
LITTLE TUCSON                                DEMO Service Unit
-----
DM UNCOMPL/T-II/NIDDM,NS (169)  DENTAL EXAMINATION (4409)
DENTAL EXAMINATION (162)      DM UNCOMPL/T-II/NIDDM,NS (4289)
HYPERTENSION NOS (104)       CHRONIC RENAL FAILURE (3395)

```

COUNSELING,NOS	(80)	ENCTR EXTRACORP DIALYSIS	(2710)
OTH ACQ LIMB DEFORMITY	(70)	ISSUE REPEAT PRESCRIPT	(2285)
OTITIS MEDIA NOS	(41)	HYPERTENSION NOS	(2133)
PHYSICAL THERAPY NEC	(39)	OTITIS MEDIA NOS	(1749)
ACUTE URI NOS	(33)	ACUTE URI NOS	(1568)
IMPETIGO	(32)	SUPERVIS OTH NORMAL PREG	(1503)
CHRONIC ULCER OF LEG	(29)	COUNSELING,NOS	(1413)
ISSUE REPEAT PRESCRIPT	(24)	ASTHMA W/O STATUS ASTHM	(1297)
URIN TRACT INFECTION NOS	(23)	RHEUMATOID ARTHRITIS	(1160)
DERMATOPHYTOSIS OF FOOT	(20)	URIN TRACT INFECTION NOS	(930)
ASTHMA W/O STATUS ASTHM	(18)	BRONCHITIS NOS	(834)
ANKYLOSING SPONDYLITIS	(15)	DERMATOPHYTOSIS OF FOOT	(768)

The Top 15 Inpatient Diagnoses were:

LITTLE TUCSON		DEMO Service Unit	

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

The Leading Surgical Procedures were:

LITTLE TUCSON		DEMO Service Unit	

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

The Top 10 Causes of Injury were:

LITTLE TUCSON		DEMO Service Unit	

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

The Top Dental Services were:

LITTLE TUCSON		DEMO Service Unit	

PATIENT REVISIT	(54)	PATIENT REVISIT	(2311)
FIRST VISIT	(44)	FIRST VISIT	(2062)
OTHER DRUGS/MEDICAMENTS	(36)	OTHER DRUGS/MEDICAMENTS	(1004)
INTRAORAL PERIAPICAL, SIN	(26)	ORAL EXAMINATION, INITIAL	(987)

```

ORAL EXAMINATION, INITIAL      (22)      INTRAORAL PERIAPICAL, SIN(977)

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

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

```

Figure 6-9: Example of CH report

6.7 Clinic Hourly Workload Report (CHWL)

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

- Visit Types: Contract and VA

Visit Service Categories

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

Visits must have a Primary Provider and Purpose of Visit.

The report is totaled by hourly time frames.

Follow these steps:

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

- **E**–Exclude Demo patients
 - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

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

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

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

6.8 Inpatient Discharges/Days by Community (INPC)

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

- Adult/Pediatric Discharges in the date range specified
- Inpatient Days by Adult/Peds
- Newborn discharges
- Newborn Days

- Transfers in
- MCR/MCD/PI on the date of admission

Follow these steps:

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

```

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

Current Community of      Adult  Adult  NB      NB      TX      MCR      MCD  PI
residence                /Peds /Peds  Dsch   Days   IN      Tribe of Membership
                        Dsch   Days
-----
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 6-11: Example of INPC report

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

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

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

The report searches the entire patient and visit files.

```

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

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

Service Unit of Residence Adult Adult NB NB TX MCR MCD PI
                        /Peds /Peds Dsch Days IN
                        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 6-12: Example of INPS report

6.10 Inpatient Discharges/Days by Tribe (INPT)

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

This report supplies the following tallies:

- Adult/Pediatric Discharges in the date range specified

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

```

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

Tribe of Membership   Adult   Adult   NB     NB     TX     MCR   MCD   PI
                    /Peds  /Peds  Dsch   Days   IN
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 6-13: Example of INPT report

6.11 Provider Practice Description Report (PPDS)

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

```

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

1 - Designated Primary Provider Panel

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

In this time period, you provided ambulatory services at least twice to 0
patients who have no Designated Primary Provider identified.
2 - Demographics and Workload for All Patients Served (Any Type of Service)

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

29% of your patients were Male and 71% Female.
    
```



```

43% were 18 and under; 14% were 19-49; 43% were 50-64; and 0% were 65 and
over.

The leading residences for your patients are:
BIG COVE 1
DEMO TRIBE, NM 7
PAINTTOWN 1
SOUTH CAROLINA UNK 1
TENNESSEE UNK 1
WAYNESVILLE 1

The leading tribes represented among your patients are:
14%
100%
14%
14%
14%
14%

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

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

Your services were provided at the following locations:
DEMO HOSPITAL 21 100%

Your services included the following Service Categories:
AMBULATORY 21 100%

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

The 5 leading Medications you prescribed or refilled as Primary
Provider for the Visit were:

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 performed as Primary Provider
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

The 5 leading Education Topics that you taught were:

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 6-14: Example short version of the PPDS report

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

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

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

6.12 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 6-15: Example of Inpatient Reports menu screen

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

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

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

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

Figure 6-16: Sample of HDM report

6.14 Hospital Discharge Listing by Date (HDD)

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

```

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

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

```

Figure 6-17: Example of HDD report

6.14.1 Estimated Run Time

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

6.15 Hospital Discharge Listing by DX or Procedure (IICD)

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

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

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

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

The following items display for each admission:

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

```

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

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

```

Figure 6-18: Example of IICD report

6.15.1 Estimated Run Time

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

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

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

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

The report excludes the following categories:

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

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

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

Figure 6-19: Example of message confirming number of patients found

6.17 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
HOSPITAL ADMISSIONS AFTER ER VISIT
```

```
Page 1
```

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 6-20: Sample of report showing admissions from ER

7.0 Quality Assurance Reports (QA)

This series of PCC Reports displays patient visit data with ICD Code information or APC recode information. See Figure 7-1 for menu options.

```

*****
**      PCC Management Reports      **
**      Quality Assurance Reports    **
*****
          IHS PCC Suite Version 2.0
          DEMO HOSPITAL/CLINIC

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

Select Quality Assurance Reports Option:

```

Figure 7-1: Quality Assurance Reports menu

7.1 Anticoagulation INR Management Report (AC)

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

```

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

```

Figure 7-2: Menu options for Anticoagulation INR Management Report

Different prompts display depending on which option was chosen.

The prompts in Figure 7-3 are standard.

```

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

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

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

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

```

Figure 7-3: Standard prompts for Anticoagulation INR Management Report (AC)

A summary of selections display before printing the report.

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

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

Define the following search criteria:

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

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

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

Follow these steps:

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

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

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

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

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

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

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

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

HRCN	Visit Date ICD9	Primary Provider DIAGNOSIS	Patient Name	DOB
DEMO HOSPITAL/CLINIC				
FEB 6,1995				
Page 1				
Audit Search for Ambulatory Visits from SEP 1,1994 through SEP 30,1994.				

---> ICD Code Range: ALL ICD Codes.				
Total Matches: 1 Matches Selected: 1				
111183	DEC 27,2008 072.9	NPROVIDER,ERIN D text	OMEGA,SIGMA	03/25/1947
---> ICD Code Range: ALL ICD Codes.				
Total Matches: 1 Matches Selected: 1				
777720	JAN 5,2009 078.89	SROVIDER,JEROME text in this place	RHO,BETA	03/08/1936

Figure 7-4: Example of randomly selected reports

7.2.1 Estimated Run Time

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

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

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

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

The visits included must meet the following criteria:

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

The following displays for each Clinic Visit:

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

Follow these steps:

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

2. At the “Enter ending Visit Date” prompt, type the end date of the range.
3. At the “Selection” prompt, type one of the following:
 - 1–Print for ALL
 - 2–Print for ONE clinic
 - 3–Print visits with no clinic code
 If 2 is entered, additional prompts display.
4. At the “Which visits should be printed” prompt, type one of the following:
 - 1–Print all Visits
 - 2–Print Visits for a range of POV ICD codes
 - 3–Print Visits for a range of Procedure ICD codes
 If 2 or 3 is entered, other prompts display.
5. At the “Include visits from ALL Locations” prompt, type Y (Yes) or N (No). If N is entered, other prompts display.
6. At the “Device” prompt, specify the device to print/browse the report.

```

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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 7-5: Example of CICD Listing

7.3.1 Estimated Run Time

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

7.4 Hospital Discharge Listing by Diagnosis or Procedure (INPT)

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

The following information displays for each admission:

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

Follow these steps:

1. At the "Run for which Facility of Encounter" prompt, type the name of the facility.
2. At the Report Admission by Admission Date or Discharge Date?" prompt, type **A** (Admission Date) or **D** (Discharge Date).
3. At the "Enter beginning Discharge Date" prompt, type the beginning of the date range.
4. At the "Enter ending Discharge Date" prompt, type the end of the date range.
5. At the "Do you want All Treating Specialties?" prompt, type **Y** (Yes) or **N** (No). If the user types **N** (No), other prompts will display.
6. At the Which visits should be printed, type one of the following:

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

If 2, 3, or 4 is entered, other prompts will display.

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

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

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

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

```

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

NAME                               HRCN   AGE  VISIT DATES          PRV  ICD   PROV NARRATIVE
OMEGA,DELTA                       111180  73  03/03/08-03/06/08
SIGMA,ANGELA                       124682  21  03/12/08-03/12/08
SIGMA,ALBERT D                     165110   6  01/10/08-01/25/08  HEALTH AIDE255.0CUSING'S
SYNDROME

                                TOTAL PATIENTS:   3
                                TOTAL VISITS:    3

Enter RETURN to continue or '^' to exit:

```

Figure 7-6: Example of INPT listing

7.5 Listing of Outpatient Visits with ICD Codes (VICD)

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

The visits in this report must meet the following criteria:

- Must be for the facility into which the user is logged
- Must not be a Contract or VA type visit

- Must be one of the following service categories: Ambulatory, Day Surgery, or In-Hospital
- Must not be a Dental Clinic visit

The following information will be displayed for each visit:

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

The report is presented in alphabetical order by patient name.

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

```

*****Confidential Patient Data Covered by Privacy Act*****
XXX                DEMO HEALTH CENTER                Page 1
FEB 7, 1990      ALL OUTPATIENT VISITS (excluding dental)
                for 09/01/88 to 09/30/88

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

```

Figure 7-7: Example of VICD report

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

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

Follow these steps:

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

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

If O is entered, other prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I**–Include All patients
 - **E**–Exclude Demo patients
 - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

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

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

NAME NARRATIVE	HRCN	VISIT DATE&TIME	CLN	FAC	ICD	PROVIDER
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
COMA		09/13/94 17:30	30	SE	250.30	DIABETIC
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 7-8: Example list of patient visits resulting in a return to the ER within 72 hours of the clinic visit

7.7 Listing of Clinic Visits with ADA Codes (ADA)

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

Follow these steps:

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

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I**–Include All patients
 - **E**–Exclude Demo patients
 - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

```

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

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

NAME                HRCN AGE  VISIT DATE  PRV  ADA  PROV NARRATIVE
ALPHA,JANE          333333  11 01/21/96 0100 52  0000  DENTAL/ORAL HEALTH VISIT
BETA,JENNIFER       333334  24 01/08/96 0414 52  0120  DENTAL EXAMINATION
                   01/30/96 1000 52  0120  DENTAL/ORAL HEALTH VISIT
DELTA, JASON        333337  11 01/21/96 0400 52  0120  DENTAL/ORAL HEALTH VISIT
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 7-9: Example of ADA report

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

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

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

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

– Telephone Calls

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

Follow these steps:

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

APR 04, 1996		Page 1	
NUMBER OF AMBULATORY VISITS BY CLINIC TYPE			
LOCATION OF VISITS: ALL			
VISIT DATES: JAN 01, 1995 TO JAN 04, 1995			
LOCATION OF VISIT			
TYPE OF CLINIC (CODE)	ZIP CODE	VISITS	

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

Figure 7-10: Sample of CZIP report

7.9 Clinic Visit Counts within a Date Range (CVC)

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

Follow these steps:

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

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

LAB		DEMO HOSPITAL/CLINIC		Page 1
4:54 pm		VISIT COUNTS FOR GENERAL (01) CLINIC		
JUL 28,1994		for 01/01/94 to 02/28/94		
VISIT DATES		NUMBER OF VISITS		
01/11/94		12		
01/13/94		10		
01/15/94		18		
01/17/94		9		
01/20/94		8		
01/22/94		14		
01/25/94		10		
01/29/94		6		
02/04/94		9		
02/08/94		20		
02/11/94		13		
02/12/94		11		
02/15/94		10		
02/27/94		10		
TOTAL VISITS FOR CLINIC		160		

Figure 7-11: Sample of CVC report

7.10 Patients with At Least N Visits (NVST)

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

Follow these steps:

1. At the “Enter beginning Date” prompt, type the beginning of the date range.
2. At the “Enter ending Date” prompt, type the end of the date range.
3. At the “Enter the minimum number of times the patient should have been seen” prompt, type any integer between 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 7-12: Visit Selection menu

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

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

```

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

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

1) Patient Name          29) Cause of Death          57) Most Recent ALCOHOL
HF
2) First, Last Name      30) MEDICARE Y/N            58) Most Recent STAGED
DM
3) Chart                 31) Medicare Part B        59) Most Recent Barriers
H
4) Terminal Digit       32) Medicare Part D        60) Most Recent LEARNING
P
5) Sex                   33) MEDICAID Y/N           61) Most Recent RUBELLA
HF
6) Date of Birth        34) PRIVATE INSURANCE Y/N  62) Date Last Alcohol
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
Scre
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 7-13: Sort Item Selection menu

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

```

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

                                LOCATION    PROVIDER    DX

```

PATIENT NAME VISITS	CHART	SEX	DOB	SEEN	SEEN	CODES

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

Figure 7-14: Example of NVST report

7.11 Listing of Visits with Injury Diagnosis (INJ)

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

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

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

Follow these steps:

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

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

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

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

LAB		DEMO HOSPITAL/CLINIC				Page 1	
Visits with Injury Diagnosis							
Visit Dates: JAN 01, 1994 to DEC 31, 1994							
PATIENT	HRCN	AGE	VISIT DATE	PRV	TYPE	SER CAT	

ALPHAA,BOBBIE LYN	125571	56	12/17/08	1000	15	TRIBE-NON	
AMBULATORY							
ICD9: 822.0		Provider Narrative: test narrative fracture patella closed					
Cause of Injury: E826.0		- PEDAL CYCLE ACC-PEDEST					
Date of Injury: 12/17/08							
Place of Occurrence: E849.5							
ALPHAA,MARTHA AGN	100881	53	04/02/08	1200	00	TRIBE-NON	
TELECOMMUN							
ICD9: 959.01		Provider Narrative: HIT HEAD					
Cause of Injury: E916.		- STRUCK BY FALLING OBJECT					
Date of Injury: 04/06/08							
Place of Occurrence: E849.9							
Cause of DX: DRUG RELATED							
BLANKENSHIP,LISA MAR	109272	46	02/14/08	1000	21	TRIBE-NON	
AMBULATORY							
ICD9: 999.0		Provider Narrative: test					
Enter RETURN to continue or '^' to exit:							

Figure 7-15: Example of INJ report

7.12 Injury Visit E-Code Summary Report (INJS)

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

- Visit Date
- Type of Visit
- Clinic
- Location of Encounter

- Service Category
- Age Range

Enter a beginning and ending visit date range for this report.

- To include all visits, type **INJS** at each of the corresponding prompts.
- To screen visits, type **No** at the corresponding prompt and then type specific variables; for instance, to screen visits by clinic, type the specific clinics of interest, such as Internal Medicine and Diabetic. Visit specifications can be saved for future use by assigning a name to each group.

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

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

Follow these steps:

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

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

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

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 7-16: Example of INJS report with cover page

7.13 Provider Visit Counts (PVC)

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

The following visits are included in the report:

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

Follow these steps:

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

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

4. At the “Which visit service categories should be included (0-7)” prompt, select which visit service categories to include, (e.g., 1, 4, 5, 6, 7) to include ambulatory, not found, day surgery, and observations. Please note: events, hospitalizations, and in-hospital visits are automatically excluded.
- **A**–AMBULATORY
 - **C**–CHART REVIEW
 - **T**–TELECOMMUNICATIONS
 - **N**–NOT FOUND
 - **S**–DAY SURGERY
 - **O**–OBSERVATION
 - **R**–NURSING HOME
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
- **I**–Include All patients
 - **E**–Exclude Demo patients
 - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

This is an example of the Provider Visit Counts report:

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

Figure 7-17: Example of PVC report

7.13.1 Estimated Run Time

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

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

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

Follow these steps:

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

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

```

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

```

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

	Total:	7

```

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

```

Figure 7-18: Example of PVCT report

7.15 Visit General Retrieval (VGEN)

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

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

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

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

To generate a report using the Visit General Retrieval option, decide whether to list items sorted alphabetically, grouped by related items, or in a predefined order. The predefined order is set by the software and is how the list has historically been displayed. See 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
 - **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 the user types P, V, or R, additional prompts display.

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

```

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

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

```

Figure 7-19: Visit Selection menu

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

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

- **T**–Total Count Only

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

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

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

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

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

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

8. The system displays the Print Item Selection Menu.

GENERAL RETRIEVAL

Jan 26, 2009 16:46:14
PRINT ITEM SELECTION MENU

Page: 1 of 6


```

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 7-20: Print Item Selection menu

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

10. The system displays the Sort Item Selection menu.

```

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

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

1) Patient Name          29) Cause of Death      57) Most Recent ALCOHOL
HF
2) First, Last Name     30) MEDICARE Y/N        58) Most Recent STAGED
DM
3) Chart                31) Medicare Part B     59) Most Recent Barriers
H
4) Terminal Digit      32) Medicare Part D     60) Most Recent LEARNING
P
5) Sex                 33) MEDICAID Y/N        61) Most Recent RUBELLA
HF
6) Date of Birth       34) PRIVATE INSURANCE Y/N 62) Date Last Alcohol
Scre
7) Birth Month         35) Any Third Party Covera 63) Date Last
Depression S

```

```

8) Birth Weight (grams) 36) Third Party Eligibilit 64) Date Last IPV/DV
Scree
9) Birth Weight (Kgs) 37) Medicaid Plan Name 65) Date Last
Colonoscopy
10) Race 38) Pvt Ins Plan Name 66) Date Last Flex Sig
11) Age 39) Pvt Ins Plan Type 67) Date Last Mammogram
12) Age in Months 40) HRN Record Status 68) Date Last PAP Smear
13) Father's Name 41) HRN Disposition 69) Date Last Tobacco
Scree
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 7-21: Options in the SORT ITEM SELECTION MENU

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

This is an example of the report.

```

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

                PCC MANAGEMENT REPORTS VISIT LISTING
                SUMMARY PAGE

REPORT REQUESTED BY: TETER, SHIRLEY

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

```

```

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

TOTAL column width: 42

Visits will be SORTED by:  Visit Date

NAME                PCC VISIT LISTING      Page 1
                   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 7-22: Example PCC Management Reports Visit Count report

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

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

7.16 In/Out Control Blood Pressures (BPC)

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

Follow these steps:

1. At the “Select List” prompt, type **S** (for Search Template of Patients) or **P** (for Search All Patients). If **S** is entered, other prompts display.
2. At the “List patients who live in” prompt, type one of the following:
 - **O**—One particular Community

- **A**–All Communities
 - **S**–Selected Set of Communities (Taxonomy)
- If O or S is entered, additional prompts display.
3. At the “include visits to ALL clinics” prompt, type **Y** (Yes) or **N** (No). If N is entered, other prompts display.
 4. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
 5. At the “Enter ending Visit Date” prompt, type the end of the date range.
 6. At the “Enter a Range of Ages (e.g., 5–12)” prompt, type a range of ages or press ENTER to include all ranges.
 7. At the “Report should include” prompt, type one of the following:
 - **M**–Males
 - **F**–Females
 - **B**–Both
 8. At the “Do you wish to include ONLY Indian/Alaska Native Beneficiaries?” prompt, type **Y** (Yes) or **N** (No).
 9. At the “Report type should be” prompt, type one of the following:
 - **D**–Detail
 - **S**–Summary
 - **C**–Cohort/Template Save
 10. At the “Sort the report by” prompt, type **P** (for Patient Name) or **A** (for Age of Patient).
 11. At the “Do you wish to suppress patient identifying data” prompt, type **Y** (Yes) or **N** (No).
 12. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I**–Include All patients
 - **E**–Exclude Demo patients
 - **O**–Include only demo patients
 13. At the “Device” prompt, specify the device to print/browse the report.

XXX

DEMO HOSPITAL

Page 1

BLOOD PRESSURE OUT OF CONTROL REPORT
 LIST OF BLOOD PRESSURE OUT OF CONTROL PATIENTS

```

Report includes: ALL AGES, MALES & FEMALES,
                ALL COMMUNITIES, all CLINICS,
                all BENEFICIARIES

Visit Dates:   OCT 28, 2008 to JAN 26, 2009
B/P           MEAN      PATIENT NAME      HRN      AGE  SEX  COMMUNITY  CLINIC
COUNT       B/P
-----
BALSER, JACOB      167741   61  M   MARBLE                1  130/74
DEMO, JOHNNIE RU  118774   27  F   BIRDTOWN  GENERAL            1  166/94
ELKINS, KELLY LU  110023   44  F   BIG COVE                1  156/91
JONATHAN, JERRI   116447   31  F   YELLOWHILL             1  150/90

TOTAL NUMBER OF PATIENTS: 4
End of report.  HIT RETURN:

```

Figure 7-23: Example of BPC report

7.17 Delete VGEN/PGEN Report Definition (DEL)

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

```

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

```

Figure 7-24: Example of using the DEL option

7.18 Readmissions within 30 Days of a Discharge (RADM)

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

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date” prompt, type the end of the date range.
3. At the “Include admissions to” prompt, type **O** (for one facility only) or **A** (any facility). If **O** is entered, other prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

XXX		DEMO HOSPITAL/CLINIC				Page 1	
READMISSIONS WITHIN 30 DAYS OF A DISCHARGE							
VISIT DATES: Jul 01, 1996 TO Aug 02, 1996							
NAME	HRCN	ADM DATE	LOC	PROV	ICD	PROVIDER	NARRATIVE
JBETA, RAY ULCER		222222	7/3/96	DH	DOCTO11, JO	681.10	CELLULITIS & ULCER
		7/17/96	DH	DOCTOR, DON	V58.8	730.27	WOUND CARE DRESSING
OSTEOMYELITIS R GRE							
RHORHO, MARIE LABOR AT		222223	7/17/96	DH	DOC3, JAVIE	644.20	PREMATURE
C SECTI			7/21/96	DH	DOCTOR55, R	642.94	STATUS POST
THETABBB, DALE LABOR AT		222224	7/14/96	DH	DOCTOR, RUD	644.20	PREMATURE
MODERATE						648.23	ANEMIA
ANEMIA, ESTIMATED BL			7/21/96	DH	DOCTOR3, L	648.21	
SPONTANEOUS						663.31	NORMAL
CSIGMAAAAA, DAVE WITHDRAWAL		222225	7/18/96	DH	DOCTOR6, SU	291.8	ALCOHOL
ALCOHOL ABU						303.90	CHRONIC
AIRWAY DIS						493.90	REACTIVE
WITHDRAWAL			7/21/96	DH	DOCTOR, JU	291.8	ALCOHOL
						303.90	ACUTE ALCOHOLISM
AIRWAYS DI						493.90	REACTIVE
GASTROINTESTINAL BL						578.9	
GGAMMAGAMS, ALEXANDRA EXACERBATION CHRONI		222226	7/30/96	DH	DOC67, EILE	496.	
			8/3/96	DH	DOC89, RICH	493.90	ASTHMA
					496.		CHRONIC OBSTRUCTIVE

Figure 7-25: Example of RADM report

7.19 Listing of Patient Refusals (REF)

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

Follow these steps:

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

```

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

PATIENT NAME      HRN      DOB      DATE REFUSED REFUSAL      REASON
-----
EXAM refusals

SIGMA,ANGELA     124682 Jul 01, 1987 MAR 06, 2008 HEART EXAM UNABLE
SIGMA,ANGELA     124682 Jul 01, 1987 MAR 04, 2008 PELVIC EXAM REFUSED
SIGMA,ANGELA     124682 Jul 01, 1987 FEB 25, 2008 VISION EXAM NOT MED

Enter RETURN to continue or '^' to exit:

```

Figure 7-26: Example of REF report

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

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

Follow these steps:

1. At the “Enter beginning Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Date for Search” prompt, type the end of the date range.
3. At the “Select which scenario” prompt, type one of the following:
 - **S**–Returns from one particular clinic to the same clinic
 - **A**–Returns from any clinic to any clinic
 - **O**–Returns from one particular clinic to any other clinic
 - **P**–Returns from any clinic to one particular clinicIf S, O, or P is entered, additional prompts display.
4. At the “Include visits from which set of locations” prompt, type one of the following:
 - **O**–One location
 - **A**–Taxonomy of Predefined Locations
 - **P**–All LocationsIf O or A is entered, additional prompts display.
5. At the “Include visits from which Clinic Visits to” prompt, type one of the following:
 - **A**–ANY Provide
 - **O**–One particular ProviderIf O is entered, additional prompts display.
6. At the “Should the visits have the same primary diagnosis?” prompt, type **Y** (Yes) or **N** (No).
7. At the “Should Incomplete visits be excluded?” prompt, type **Y** (Yes) or **N** (No).
8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
 - **I**–Include All patients
 - **E**–Exclude Demo patients
 - **O**–Include only demo patients
9. At the “Device” prompt, specify the device to print/browse the report.

XXX	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 7-27: Example of RT1 report

7.21 Display Single Visit for a Patient (VST)

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

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

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

Figure 7-28: Example of Patient Single Visit menu screen

7.21.1 Display Data for Patient’s Last Visit to a Clinic (LCV)

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

Follow these steps:

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

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

~~~~~
VISIT IEN: 23251

```

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

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

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

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

```

Figure 7-29: Example of LVC report

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

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

Follow these steps:

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

```

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

```

```

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

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

VISIT: MAR 30, 1994@13:23 PRIMARY/SECONDARY: SECONDARY
AFF.DISC.CODE (c): 101GM
----- V POV -----
POV: 401.9 PATIENT NAME: THETAA,MARY
VISIT: MAR 30, 1994@13:23
PROVIDER NARRATIVE: HYPERTENSION BP UNDER CONTROL THIS VISIT
ICD NARRATIVE (c): HYPERTENSION NOS
POV: 250.00 PATIENT NAME: THETAA,MARY
VISIT: MAR 30, 1994@13:23 PROVIDER NARRATIVE: DM
ICD NARRATIVE (c): DIABETES UNCOMPL ADULT/NIDDM
----- V EXAM -----
EXAM: BREAST EXAM PATIENT NAME: THETAA,MARY
VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 06
EXAM: RECTAL EXAM
VISIT: MAR 30, 1994@13:23
EXAM CODE (c): 14

```

Figure 7-30: Example of LVST report

## 8.0 Active Patient Count Reports (APC)

This set of reports examines PCC visits and counts all APC visits in a given time frame for the facility that you select. Figure 8-1 shows available reports:

```

** PCC Management Reports **
** APC Reports **

IHS PCC Suite Version 2.0

DEMO HOSPITAL/CLINIC

A1 PCC-Ambulatory Patient Care Report 1A
DATE APC Visit Counts by Date Of Visit
CLN APC Visit Counts by Clinic
DISC APC Visit Counts by Provider Discipline
APRV APC Visit Counts by Individual Provider
LOC APC Visit Counts by Location of Service
A1M PCC-Ambulatory 1 Report for Multiple Facilities
AVCL Average Number of Visits by Day of Week and Clinic
AVCS Average Number of Visits by Day/Clinic ALL Service
AVD Average Number of APC Visits per Day
CYV Calendar Year First and Revisit Summary
NOEX List APC-1A Visits Not Exported

Select APC Reports Option:

```

Figure 8-1: Example APC reports menu screen

Entry of all data into the PCC includes a designation of Location of Visit, Visit Type, and Service Category. Location of Visit is the facility where the visit occurred (e.g., Crownpoint Hospital, Yakima Health Center, Home, San Simon School). Below is a list of visit types and service categories attributes.

### Visit Types

- IHS
- Contract
- Tribal
- Other
- Program
- VA

### Service Categories

- Ambulatory
- Hospitalization

- In-Hospital Care
- Chart Review
- Telecommunications
- Not Found
- Day Surgery
- Observation
- Event (Historical)
- Nursing Home Care

The three visit attributes (Visit, Visit Type, and Service Category), plus the Clinic Type designation for outpatient clinic visits, determine whether a visit is an official APC visit for inclusion in the IHS data system. The criteria for inclusion are listed below.

Data displayed on this set of APC Reports from PCC Files should correspond very closely to the reports received from the IHS Data Center. However, please be aware that for SU management purposes, a similar set of reports containing additional data, such as Not Found Visits, CHN Home Visits, and Telephone Calls, is a subset of the PCC Ambulatory Visit Counts, described in the next section of this manual.

To be considered an APC visit, a visit must meet the following criteria:

- Fall within the date range specified.
- Have other medical data linked to the visit record.
- Have a Service Category of:
  - Ambulatory
  - Day Surgery
  - Observation
  - Nursing Home
- Excludes Service Categories of:
  - Chart Review
  - Hospitalization
  - Not Found
  - In-Hospital
  - Event
- Have a Visit Type of:
  - IHS

- 638 Program
- Tribal
- Other
- Have a primary POV (POV cannot be an un-coded DX .9999).
- Have a valid location.
- Have a valid primary provider.
- Excludes a Primary Provider Discipline of 13 (CHN) or 32 (CHR) AND a location of visit other than an IHS facility (code >49).
- Have a valid clinic code.

Excludes:

- Mail
- Telephone Call
- Chart Review
- Follow-up Letter
- Radio Call
- Dental
- Education Class
- Employee Health

The visit date range for use in calculating the number of visits must be entered, and select whether visits for all locations or for one location are to be included.

## 8.1 PCC-Ambulatory Patient Care Report 1A (A1)

Use the A1 option to produce a report that generates from PCC files and is similar to the A1 report generated by the APC System at the Data Center in Albuquerque. The user's facility should run this report on a quarterly basis to verify that all APC visits have been exported properly to the Data Center. If the user's site is new to PCC and the APC export process, this report should be run after every export until all export problems have been resolved.

The report displays FY-to-date APC visit counts by month of service. Specify the fiscal year and the facility for the report. Totals generate for each month as well as for each provider discipline. Percentage totals display for each discipline. Total primary care provider visits will also subtotal for each month.

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, specify the fiscal year for the report. The system displays the fiscal year date range.
2. At the “Run for which Facility of Encounter” prompt, type the name of the facility.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
4. At the “Device” prompt, specify the device to print/browse the report.

```

AREA: 00 DEMO PCC AMULATORY PATIENT CARE REPORT 1A DEC 07, 1989 Page 1
S.U. : 01 DEMO FISCAL YEAR 1987
FAC.: 000101 DEMO HOSPITAL/CLINIC
AMBULATORY CARE VISITS TO SERVICE LOCATION BY PRIMARY PROVIDER AND MONTH
OF SERVICE

PRIMARY PROVIDER YR TO % OP
OF SERVICE DATE TOTAL OCT NOV DEC JAN FEB MAR APR MAY JUN JULY
AUG SEPT

PHYSICIAN* 505 47.6 38 37 39 46 43 37 43 36 32 37 57 60
REGISTERED NURSE 29 2.7 2 1 2 4 4 2 4 1 1 3 2 3
LICENSED PRACTICAL 12 1.1 0 1 3 4 2 0 0 1 1 0 0 0
OPTOMETRIST 18 1.7 0 2 1 2 2 3 3 1 0 0 0 4
PHARMACIST 116 10.9 13 10 6 10 15 9 8 8 10 8 9 10
PHYSICAL THERAPIST 17 1.6 4 3 2 2 2 2 1 0 0 0 0 1
PHYSICIAN ASSISTANT* 48 4.4 4 5 3 7 5 3 5 1 6 1 3 5
CHN/AIDES 6 .6 0 0 0 0 1 1 0 0 0 2 1 1
OTHER 19 1.7 7 3 0 .5 2 0 1 0 0 1 1 0
NURSE MIDWIFE 37 3.5 4 1 5 3 3 5 2 6 1 1 4 2
MENTAL HEALTH 2 .2 0 0 0 0 0 0 0 1 1 4 0 0
MEDICAL STUDENT 5 .5 0 0 0 0 0 1 0 0 0 0 3 1
NURSE PRACTITIONER* 12 1.1 1 0 1 3 3 0 0 1 1 3 0 2
NURSE ASSISTANT 5 .5 0 0 1 0 0 1 0 1 1 1 1 0
LABORATORY TECHNIC 5 .5 1 0 1 1 0 0 1 1 0 0 0 0
DIETICIAN 1 1 0 0 0 1 1 0 0 0 0 0 0 0
PODIATRIST* 8 .8 1 1 1 1 1 1 0 2 0 0 0 1
DENTIST 8 .8 2 0 0 6 1 1 0 1 2 0 0 0
INTERNAL MEDICINE* 111 10.5 9 2 10 0 6 10 11 13 10 4 4 5
OB/GYN* 6 .6 0 9 0 3 0 1 0 1 1 0 0 0
PEDIATRICIAN* 69 6.5 2 0 7 0 3 6 8 5 9 4 4 5
SURGEON* 8 .8 0 2 1 0 0 1 1 1 0 0 0 3
OPHTHALMOLOGIST* 11 1.0 0 0 0 0 0 1 1 0 0 2 2 4
FAMILY PRACTICE* 1 .1 0 0 0 0 0 0 0 0 1 0 0 0
NEUROLOGIST* 1 .1 0 0 0 0 0 0 0 0 0 0 0 0
TOTAL 1060 100.0 88 81 82 124 97 80 91 80 77 62 91 1070
TOTAL PRIMARY PVDR 817 77.1 59 61 67 96 66 62 72 66 61 46 74 87

```

21 visits were not exported because of missing or invalid data. To see a list of these visits so that they may be resubmitted, use the option called 'List APC-1A Visits Not Exported. There were 138 instances of 2 or more visits by a patient to the same clinic on the same day. These 138 will not be counted in the report produced at the Data Center, but are counted in the report above. This accounts for a total of 159 visits that will be counted in this report but not in the 1A report from the Data Center.

Figure 8-2: Example of Ambulatory Patient Care Report 1A

## 8.2 APC Visit Counts by Date of Visit (DATE)

Use the Date option to produce a report that shows a count of visits by Date of Visit for a specified date range. The visits included are those that considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type of the following:
  - 1–All
  - 2–Individually
  - 3–For a Service Unit
  - 4–From a Taxonomy

If the user types 2, 3, or 4, additional prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - I–Include All patients
  - E–Exclude Demo patients
  - O–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

The report displays date of visit, day of week, and visits in columns and tallies visits.

```
***** DEMO
HEALTH CENTER FEB 7,2008 Page 1 *
* NUMBER OF APC VISITS BY DATE OF VISIT *
* LOCATION OF VISITS: DEMO HEALTH CENTER *
* REPORT DATE: SEP 01, 2004 TO SEP 5, 2004 *
```



```

DATE OF VISIT DAY OF WEEK VISITS
SEP 01, 2004 MONDAY 104
SEP 02, 2004 TUESDAY 81
SEP 03, 2004 WEDNESDAY 92
SEP 04, 2004 THURSDAY 71
SEP 05, 2004 FRIDAY 91

Total: 439

```

Figure 8-3: Example of Date report

### 8.3 APC Visit Counts by Clinic Type (CLN)

Use the CLN option to produce a report that shows a count of visits by Clinic Type for a specified date range. The visits included are those that are considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
  2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
  3. At the “Do you want to select” prompt, type one of the following:
    - 1–All
    - 2–Individually
    - 3–For a Service Unit
    - 4–From a Taxonomy
- If 2, 3, or 4 is entered, additional prompts display.
4. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:
    - I–Include All patients
    - E–Exclude Demo patients
    - O–Include only demo patients
  5. At the “Device” prompt, specify the device to print/browse the report.

The report displays type of clinic, clinic code and visits in columns and tallies total visits.

```

* DEMO HEALTH CENTER FEB 7,2008 Page *
* NUMBER OF APC VISITS BY CLINIC TYPE *

```

```

* LOCATION OF VISITS: DEMO HEALTH CENTER *
* REPORT DATE: SEP 01, 2004 TO SEP 02, 2004 *

TYPE OF CLINIC CLINIC CODE VISITS
DIABETIC 06 12
EMERGENCY MEDICINE 30 60
OTHER 25 8
PODIATRY 65 8
WELL CHILD 24 12

Total: -----
 100

```

Figure 8-4: Example of CLN report

## 8.4 APC Visit Counts by Provider Discipline (DISC)

The DISC report counts the number of visits by provider discipline for a specified date range. Specify totals for primary provider only or for all providers. The visits included are those that are considered APC workload reportable.

Follow these steps:

1. At the “Report should include” prompt, type **P** (Primary Provider) or **A** (All Providers).
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to select” prompt, type one of the following:
  - **1**–All
  - **2**–Individually
  - **3**–For a Service Unit
  - **4**–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients

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

```

* DEMO HEALTH CENTER FEB 7,2008 Page 1 *
*
* NUMBER OF APC VISITS BY ALL PROVIDER DISCIPLINES
* LOCATION OF VISITS: DEMO HEALTH CENTER
* REPORT DATE: SEP 01, 2004 TO SEP 02, 2004

```

PROVIDER DISCIPLINE	DISCIPLINE CODE	VISITS
CHN/AIDES	13	5
DENTIST	52	7
INTERNAL MEDICINE	71	1
LICENSED PRACTICAL NURSE	05	12
NURSE ASSISTANT	22	7
NURSE MIDWIFE	17	1
NURSE PRACTITIONER	21	4
NUTRITIONIST	07	2
OPHTHALMOLOGIST	79	1
OPTOMETRIST	08	1
PHARMACIST	09	13
PHARMACY PRACTITIONER	30	2
PHYSICIAN	00	36
PHYSICIAN ASSISTANT	11	3
REGISTERED NURSE	01	12
		-----
	Total:	107

Figure 8-5: Example of DISC report

## 8.5 APC Visit Counts by Individual Provider (APRV)

Use the APRV option to produce a report that shows visits by individual provider for a specified date range. Either primary providers or all providers can be listed. The visits included are those are those considered APC workload reportable.

Follow these steps:

1. At the “Report should include” prompt, type **P** (Primary Provider) or **A** (All Providers).
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to select” prompt, type one of the following:
  - 1–All

- **2**—Individually
- **3**—For a Service Unit
- **4**—From a Taxonomy

If the user types 2, 3, or 4, additional prompts display.

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

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

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

```

* DEMO HEALTH CENTER FEB 7,2008 Page 1 *
*
* NUMBER OF APC VISITS BY ALL PROVIDERS OF SERVICE *
* LOCATION OF VISITS: DEMO HEALTH CENTER *
* REPORT DATE: SEP 01, 2004 TO SEP 02, 2004 *

PROVIDER OF SERVICE DISCIPLINE OF PROV VISITS
ARPROVIDER,WILLIAM M COMMUNITY HEALTH REP 1
CPROVIDER,WILLIAM L REGISTERED NURSE 1
FNPROVIDER,CLAUDINE Y PHYSICIAN ASSISTANT 1
HPROVIDER,RUSSELL P OTHER 3
IAPROVIDER,MATTHEW PHYSICIAN 3
KWPROVIDER,BLAKE T NURSE PRACTICIONER 4
MPROVIDER,PETER EARL OTHER 3
NPROVIDER,ERIN D FAMILY PRACTICE 1
SCPROVIDER,ONE HEALTH AIDE 3
TPROVIDER,TARA M REGISTERED NURSE 1
TXPROVIDER,FRANKLIN RICHA OTHER 2
VNPROVIDER,JANICE M LABORATORY TECHNICIA 3
VPROVIDER,THOMAS L LICENSED PRACTICAL N 4
WPROVIDER,MICHEAL LABORATORY TECHNICIA 1
Total: -----
 31

```

Figure 8-6: Example of APRV report

## 8.6 APC Visit Counts by Location of Service (LOC)

Use the LOC option to produce a report that shows a list of the number of visits by location for a specified date range. The visits included are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
4. At the “Device” prompt, specify the device to print/browse the report.

```

* DEMO HOSPITAL Jan 27, 2009 Page 1*
*
* NUMBER OF APC VISITS BY LOCATION OF SERVICE *
* LOCATION OF VISITS: ALL *
* REPORT DATE: JUL 31, 2008 TO JAN 27, 2009 *

LOCATION OF SERVICE LOCATION CODE VISITS

CIHA A NA LE NI SGI 585160 2
DEMO HOSPITAL 230001 85

 Total: 87

```

Figure 8-7: Example of LOC report

## 8.7 PCC-Ambulatory 1 Report for Multiple Facilities (A1M)

Use the A1M option to produce a report that shows the Year to Date Ambulatory Visit Counts and Fiscal Year for a facility that the user specifies. The counts by month are for date of service. This report will resemble, but not exactly duplicate, the APC 1A report produced at the IHS Data Warehouse in Albuquerque.

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, type the fiscal year for the report. The system displays the fiscal year date range. The systems displays the following message “Please enter which FACILITY visits will be included in the list.”
2. At the “Enter a code indicating what LOCATIONS/FACILITY are of interest” prompt, type S (Selected Set or taxonomy of locations) or O (One Location/Facility).
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

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

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

```

Select APC Reports Option: A1M PCC-Ambulatory 1A Report for Multiple
Facilities

***** PCC/APC REPORT 1A *****

This report will print Year to Date Ambulatory Visit Counts for the
Facility and Fiscal Year that you select. The counts by month are for date
of service. This report will resemble, but not duplicate exactly, the APC
1A report produced at the IHS Data Warehouse in Albuquerque.

Enter FISCAL YEAR: 2010//2009 (2009)

FISCAL Year date range: Oct 01, 2008 - Sep 30, 2009

Please enter which FACILITY visits will be included in the list.

Select one of the following:

S Selected set or Taxonomy of Locations
O ONE Location/Facility

Enter a code indicating what LOCATIONS/FACILITIES are of interest: O// NE
Location/Facility
Which LOCATION: DEMO DEMO HOSPITAL HEADQUARTERS WEST NON
SERVICE UNIT 01 MN IHS 497

THIS REPORT MUST BE PRINTED ON 132 COLUMN PAPER OR ON A PRINTER THAT IS SET
UP FOR CONDENSED PRINT!!!
IF YOU DO NOT HAVE SUCH A PRINTER AVAILABLE - SEE YOUR SITE MANAGER.

Select one of the following:

I Include ALL Patients
E Exclude DEMO Patients
O Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// Include ALL Patients
DEVICE: HOME// VT Right Margin: 80//

AREA: 23 HEADQUARTERS WEST PCC-AMBULATORY PATIENT
CARE REPORT 1A
FEB 26, 2010 Page 1
S.U.: 00 NON SERVICE UNIT FISCAL YEAR 2009
FAC.: 230001 DEMO HOSPITAL
AMBULATORY CARE VISITS TO SERVICE LOCATION BY
PRIMARY PROVIDER AND MONTH OF SERVICE

```

```

AREA: 23 HEADQUARTERS WEST PCC-AMBULATORY PATIENT
CARE REPORT 1A
FEB 26, 2010 Page 2
S.U.: 00 NON SERVICE UNIT FISCAL YEAR 2009
FAC.: 230001 DEMO HOSPITAL
AMBULATORY CARE VISITS TO SERVICE LOCATION BY
PRIMARY PROVIDER AND MONTH OF SERVICE

```

PRIMARY PROVIDER OF SERVICE	YR-TO DATE	% OF TOTAL	OCT.	NOV.	DEC.	JAN.	FEB.
MA R.							
APR.							
MAY							
JUNE							
JULY							
AUG.							
SEPT							
00 PHYSICIAN*	79	1.7	15	2	3	3	2
2							
0							
1							
4							
13							
17							
17							

4598 visits were not exported to the National Data Warehouse because they were posted or modified after the last NDW export was generated.

0 visits were not exported because of missing or invalid data. To see a list of these visits so that they may be resubmitted use the option called 'List APC-1A Visits Not Exported.'

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

Figure 8-8: Example of a partial A1M report

## 8.8 Average Number of Visits by Day of Week and Clinic (AVCL)

The AVCL report generates average daily outpatient visit counts by clinic for each day of the week. Specify a date range for calculating the average number daily visits. The visits included are those are those considered APC workload reportable.

Follow these steps:

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

2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
  - 1–All
  - 2–Individually
  - 3–For a Service Unit
  - 4–From a Taxonomy
 If 2, 3, or 4 is entered, additional prompts display.
4. At the Demo Patient Inclusion/Exclusion” prompt, use one of the following:
  - I–Include All patients
  - E–Exclude Demo patients
  - O–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

The following sample report includes the average number of visits by day of the week and clinic for January 1, 1995 to January 31, 1995.

```

* DEMO HOSPITAL/CLINIC APR 09, 2008 Page 1 *
* AVERAGE DAILY OUTPATIENT (APC) VISITS BY CLINIC *
* LOCATION OF VISITS: ALL *
* REPORT DATE: JAN 01, 2004 TO JAN 31, 2004 *

CLINIC MONDAY TUESDAY WEDNESD THURSDA FRIDAY SATURDA SUNDAY
ALCOHOLISM PROGRAM 2 0 1 0 1 0 0
CHRONIC DISEASE 4 1 3 2 1 0 0
DENTAL 3 4 1 2 0 0 0
DIABETIC 1 4 5 1 0 0 0
EMERGENCY MEDICINE 1 0 1 2 0 3 2
GENERAL 5 1 3 2 0 0 0
HOME CARE 2 2 1 2 0 0 0
MEDICAL SOCIAL 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, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
  - 1–All
  - 2–Individually
  - 3–For a Service Unit
  - 4–From a Taxonomy
 If 2, 3, or 4 is entered, additional prompts display.
4. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - I–Include All patients
  - E–Exclude Demo patients
  - O–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

```

* DEMO HOSPITAL 009 Page 1*
*
* AVERAGE DAILY OUTPATIENT VISITS BY CLINIC *
* SERVICE CATEGORIES: ALL
* LOCATION OF VISITS: SELECTED
* REPORT DATE: OCT 29, 2008 TO JAN 27, 2009

```

CLINIC	MONDAY	TUESDAY	WEDNESD	THURSDA	FRIDAY	SATURDA	SUNDAY
BEHAVIORAL HEALTH	1	0	0	0	0	0	0
DAY SURGERY	0	1	0	0	0	0	0
GENERAL	1	1	2	1	2	1	2
MEN'S HEALTH SCREENI	1	0	1	1	0	1	0
MENTAL HEALTH	0	0	0	1	0	1	0
URGENT CARE	1	0	0	0	0	0	0

```

WOMEN'S HEALTH SCREE 1 0 0 1 1 1 1
RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:

```

Figure 8-10: Example of AVCS report

## 8.10 Average Number of APC Visits per Day (AVD)

The AVD report displays the average daily outpatient visits for a specified date range. Choose visits for one clinic, selected clinics, or all clinics. The visits included are those considered APC workload reportable.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
  - 1–All
  - 2–Individually
  - 3–For a Service Unit
  - 4–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.
4. At the “Include visits to ALL clinics” prompt, type **Y** (Yes) or **N** (No). If N is entered, other prompts display.
5. At the Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

```

* DEMO HOSPITAL Jan 27, 2009 Page 1*
*
* AVERAGE DAILY OUTPATIENT (APC) VISITS *
* LOCATION OF VISITS: SELECTED *
* REPORT DATE: OCT 29, 2008 TO JAN 27, 2009 *

```

```

DAY-OF-WEEK AVERAGE VISITS PER DAY
MONDAY 1
TUESDAY 1
WEDNESDAY 2
THURSDAY 1
SATURDAY 1
SUNDAY 2
RUN TIME (H.M.S): 0.0.0
End of report. HIT RETURN:

```

Figure 8-11: Example of AVD report

## 8.11 Calendar Year First and Revisit Summary (CYV)

The CYV report tabulates visit counts for the facility and clinic for a specified date range. Visit counts are summarized for Indian/Alaska Native and all other beneficiaries. Each classification is subtotaled by the following: (1) new patient's 1st, (2) established patient's 1st, and (3) all additional patient's visits.

**Note:** Calendar Year Reports must be inclusive and begin with the first day of the desired calendar year.

Follow these steps:

1. At the "Enter beginning Visit Date for Search" prompt, type the beginning of the date range.
2. At the "Enter ending Visit Date for Search" prompt, type the end of the date range.
3. At the "Do you want to include Visits to" prompt, type **A** (for all locations) or **O** (for one location). If **O** is entered, other prompts display.
4. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
  - **I**—Include All patients
  - **E**—Exclude Demo patients
  - **O**—Include only demo patients
5. At the "Device" prompt, specify the device to print/browse the report.

```

Report Dates:
Jan 01, 2009 to JAN 27, 2009 Indian Ind. Household Non-Indian mem All Other
 Non-Indian mem
 All Other

Date Range Visit Summary

```

1. New Patient's First Visit	0	0	0
2. Established Patient's First Visit	13	0	1
3. Total First Visits (1-2)	13	0	1
4. Additional Visits (2nd,3rd,etc.)	0	0	0
SUB-TOTAL	13	0	1
GRAND TOTAL-ALL VISITS:	14		
RUN TIME (H.M.S): 0.0.1			
End of report. HIT RETURN:			

Figure 8-12: Example of CYV report

## 8.12 List APC-1A Visits Not Exported (NOEX)

The NOEX report will process the same as the 1A report; however, instead of producing the 1A report, it will list all visits that would be included in the 1A report that have not been exported to the National Data Warehouse (NDW).

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, type the fiscal year for the report.
2. At the “Run for which Facility of Encounter” prompt, type the name of the facility.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
4. At the “Device” prompt, specify the device to print/browse the report.

The PCC data entry staff should review this report. All visits that have not exported should be reviewed, corrected, and reflagged for export, as appropriate.

AREA: 23	HEADQUARTERS WEST	PCC-APC REPORT 1A	Page 1
S.U.: 00	NON SVC UNIT	FISCAL YEAR 2008	
FAC.: 230001	DEMO HOSPITAL	JAN 27, 2009	
		VISITS NOT EXPORTED	
-----			
Total Number of APC visits counted: 107			
Total Number of those APC Visits NOT Exported: 107			

Of the total number of visits counted in the 1A, but NOT exported to the National Data Warehouse, 107 were not exported because they were posted or modified after the last NDW export tape was generated.

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

Figure 8-13: Example of NOEX report

## 9.0 Ambulatory Visit Counts (PCCV)

This set of reports counts all PCC Ambulatory Visits in a given time frame. These reports display a count of PCC Ambulatory Visits sorted by the attribute selected. The system prompts for the visit date range to be used in calculating the number of visits and to indicate for which location the report should print. Each report gives the user the option to include a total page which will include all locations combined, if selected.

The following PCC Visit Count reports are available from the PCCV menu:

```

** PCC Management Reports **
** PCC Ambulatory Visit Counts **

IHS PCC Suite Version 2.0

DEMO HOSPITAL

DATE Visit Counts by Date of Visit
CLIN Visit Counts by Clinic Type
DISC Visit Counts by Provider Discipline
PROV Visit Counts by Provider
DX Visit Counts by Diagnosis (ICD)
LOC Visit Counts by Location of Service
SC Visit Counts by Service Category
AA PCC Visits (By Provider Disc) PCC Report AA
ALL ALL Visits by Provider or Provider Discipline
APPT Tally of Walk-in/Appointment Clinic Visits
CSAR California State Annual Utilization Report
DAR PCC Data Analysis Report
GCDC General/Dental Clinic Visits on the Same Day
INCV Listing of Incomplete Lab, Rx or Rad Visits
PPD Primary Provider Visits - Daily/Annual Report
PPM Primary Provider Visits - Monthly Report
TPC Tally of Selected Provider Disciplines by Clinics
WAIT Wait Times by Clinic and Provider

Select PCC Ambulatory Visit Reports Option:

```

Figure 9-1: PCC Ambulatory Visit Counts menu

In order for a visit to be included in the PCC Ambulatory Visits reports, it must meet the following criteria:

- Visit Type must be:
  - IHS
  - 638 Program
  - Tribal
  - Other

- Service Category must be:
  - Ambulatory
  - Observation
  - Day Surgery
  - Not Found
  - Nursing Home
  - Telecommunications

Excludes: Chart Review, Hospitalization, In-Hospital, and Event

- Must include a valid primary provider.
- Must have a POV.

## 9.1 Visit Counts by Date of Visit (DATE)

Use the Date option to produce a report counts visits by Date of Visit for the date range specified. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits must have a primary provider or POV.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, type one of the following:
  - **1**–All
  - **2**–Individually
  - **3**–For a Service Unit
  - **4**–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

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	DAY OF WEEK	VISITS
DATE OF VISIT		
-----		
DEMO HOSPITAL/CLINIC		
MAR 01, 1995	WEDNESDAY	1
MAR 06, 1995	MONDAY	1
MAR 13, 1995	MONDAY	3
MAR 15, 1995	WEDNESDAY	4
MAR 20, 1995	MONDAY	1
MAR 25, 1995	SATURDAY	1
MAR 28, 1995	TUESDAY	1
		-----
	Total:	12
RUN TIME (H.M.S): 0.0.0		
End of report. HIT RETURN:		

Figure 9-2: Sample of Date report

## 9.2 Visit Counts by Clinic Type (CLIN)

Use the CLIN option to produce a report that counts visits by clinic type for the date range you specify. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits must have a primary provider or POV.

Follow these steps:

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



2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, type one of the following:
  - **1**–All
  - **2**–Individually
  - **3**–For a Service Unit
  - **4**–From a Taxonomy
 If 2, 3, or 4 is entered, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

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 specified. Choose counts for primary providers only or for all providers. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits must have a primary provider or POV.

Follow these steps:

1. At the “Report should include” prompt, type **P** (Primary Provider Only) or **A** (All Providers).
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
5. At the “Do you want to select” prompt, type one of the following:
  - **1**–All
  - **2**–Individually
  - **3**–For a Service Unit
  - **4**–From a TaxonomyIf 2, 3, or 4 is entered, additional prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

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. The user can choose counts for primary providers only or for all providers. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits must have a primary provider or POV.

Follow these steps:

1. At the "Report should include" prompt, type **P** (for Primary Provider Only) or **A** (for all providers, primary and secondary).
2. At the "Enter beginning Visit Date for Search" prompt, type the beginning of the date range.

3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
5. At the “Do you want to select” prompt, type one of the following:
  - **1**–All
  - **2**–Individually
  - **3**–For a Service Unit
  - **4**–From a Taxonomy
 If 2, 3, or 4 is entered, additional prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

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 specified. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits must have a Primary Provider or Purpose of Visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, use one of the following:
  - **1**–All
  - **2**–Individually
  - **3**–For a Service Unit
  - **4**–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients

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

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

LOCATION OF VISIT			
ICD DX NARRATIVE	ICD DX CODE		VISITS
-----			
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 OPTHAL MANIF ADULT/	250.50		1
DIABETES UNCOMPL ADULT/NI	250.00		9
EDEMA OF PENIS	607.83		1
FX ANKLE NOS-CLOSED	824.8		1
GINGIV/PERIODONT DIS NOS	523.9		1
HYPERMETROPIA	367.0		1
HYPOVOLEMIA	276.5		1
IMPETIGO	684.		1
			-----
		Subtotal:	36
			-----
		Total:	36

Figure 9-6: Example of DX report

## 9.6 Visit Counts by Location of Service (LOC)

Use the LOC option to produce a report that counts visits by location of service for the date range specified.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA

- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits must have a Primary Provider or Purpose of Visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning date for the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the ending date for the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Demo Patient Inclusion/Exclusion” prompt, use one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

NUMBER OF AMBULATORY VISITS BY LOCATION OF SERVICE		
FEB 8, 1995 Page 1		
LOCATION OF VISITS: ALL		
Chart Reviews are not included.		
VISIT DATES: SEP 01, 1994 TO SEP 01, 1994		
LOCATION OF VISIT	LOCATION CODE	VISITS
LOCATION OF SERVICE		
ALBUQUERQ HO	202101	3
DEMO HOSPITAL/CLINIC	000101	14
DEMO HEALTH CENTER	000111	57
HOME	000189	1
DEMO UNDES	000199	2
VAYA CHIN HEALTH STATION	000132	1
		-----
	Total:	78

Figure 9-7: Example of LOC report

## 9.7 Visit Counts by Service Category (SC)

Use the SC option to produce a report that counts visits by service category for the date range specified. The report provides subtotals by location of encounter.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events

Visits must have a Primary Provider or Purpose of Visit.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to include visits with a CHART REVIEW service category?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Do you want to select” prompt, type one of the following:
  - **1**–All
  - **2**–Individually
  - **3**–For a Service Unit
  - **4**–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

LOCATION OF VISIT		CODE	VISITS
SERVICE CATEGORY			
DEMO HEALTH CENTER			
AMBULATORY	A		56



NOT FOUND	N	1
DAY SURGERY	S	2
TELECOMMUNICATIONS	T	6
		-----
	Subtotal:	65
		-----
	Total:	65

Figure 9-8: Sample of SOC report

## 9.8 PCC Visits (by Provider Discipline) PCC Report AA (AA)

Use the AA option to produce a report that shows year-to-date PCC visit counts for the facility and fiscal year selected. Subtotals by month are for date of service. This report is similar to the AA report produced at the Albuquerque Data Center; however, it contains all PCC visits, not just those defined as APC visits. Please see the following example report.

All visits in the database are included in the tabulation except the following:

- Visit Types: Contract, VA
- Visit Service Categories: Chart Review, In-Hospital, Hospitalizations, Historical Events
- Visits without a primary provider or POV

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

Follow these steps:

1. At the “Enter FISCAL YEAR” prompt, type the fiscal year for the report. The system displays the fiscal year date range.
2. At the “run for which Facility of Encounter” prompt, type the name of the facility.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
4. At the “Device” prompt, specify the device to print/browse the report.

```
AREA: 00 DEMO PCC-OUTPATIENT PATIENT CARE REPORT APR 19, 1996 Page 1
S.U.: 01 DEMO FISCAL YEAR 1995
FAC.: 000101 DEMO HOSPITAL/CLINIC
ALL PCC OUTPATIENT (NON-HOSPITAL) VISITS TO SERVICE LOCATION BY
PRIMARY PROVIDER AND
```

MONTH OF SERVICE													
PRIMARY PROVIDER OF SERVICE	YR-TO DATE	% OF TOTAL											
OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT		
PHYSICIAN* 3	18	6.7	0	5	1	2	0	1	0	2	1	1	2
MEDICAL SOCIAL WORKE 5 17 14		43	16.1	6	1	0	0	0	0	0	0	0	0
MENTAL HEALTH 11 21	134	50.2	2	17	11	11	16	8	9	5	3	20	
PHARMACY PRACTICIONE 0 0 1	1	.4	0	0	0	0	0	0	0	0	0	0	0
DENTIST 1	3	1.1	0	0	0	0	1	1	0	0	0	0	0
COMMUNITY HEALTH REP 0 0 0		16	6.0	0	0	0	0	12	0	0	0	4	
INTERNAL MEDICINE* 2 4	47	17.6	1	1	5	9	2	4	5	9	3	2	
FAMILY PRACTICE* 0 0	2	.7	0	0	1	0	0	0	0	0	0	1	
PSYCHIATRIST* 0 0	1	.4	0	1	0	0	0	0	0	0	0	0	
T O T A L 32 44	267	100.0	9	25	18	22	33	14	14	16	11	29	
*TOTAL PRIMARY PVDR 4 4 7		68	25.5	1	7	7	11	2	5	5	11	4	
RUN TIME (H.M.S): 0.0.2													
End of report. HIT RETURN:													

Figure 9-9: Sample of AA report

## 9.9 All Visits by Provider or Provider Discipline (ALL)

Use the All option to produce a report that counts all visits by provider, location of service, and service category. All visits are in the report regardless of type, service category, or clinic. The visit must have a valid provider and POV to be included. Select one or all providers, one or all provider disciplines, all providers within one discipline, one or all locations, and whether the provider is a primary provider.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Report should include and sort by” prompt, type one of the following:
  - **O**—One Provider Only
  - **P**—All Providers

- **D**–One Provider Discipline
- **A**–All Provider Disciplines
- **X**–All Providers within One Discipline

If O, D, or X is entered, additional prompts display.

4. At the “Include if Provider is” prompt, type **P** (for primary provider) or **S** for Primary or secondary provider).

5. At the “Do you want to select” prompt, type one of the following:

- **1**–All
- **2**–Individually
- **3**–For a Service Unit
- **4**–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.

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

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

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

AUG 02, 1994 Page 1	
NUMBER OF CONTACTS BY PROVIDER, LOCATION AND SERVICE CATEGORY	
LOCATION OF VISITS: ALL	
PROVIDER DISCIPLINE: ALL	
PRIMARY PROVIDER ONLY	
VISIT DATES: JAN 01, 1994 TO JAN 15, 1994	
LOCATION OF VISIT SERVICE CATEGORY	PROVIDER CONTACTS
-----	
Provider Discipline: PHYSICIAN	
DEMO HOSPITAL/CLINIC	
AMBULATORY	36
SAN XAVIER HEALTH CENTER	
AMBULATORY	106
CHART REVIEW	4
TELECOMMUNICATIONS	4
AMBULANCE,000177	
AMBULATORY	4
CHS PHYSICIAN OFFICE,000188	
AMBULATORY	7
IN HOSPITAL	6
VETERANS ADMIN HOSPITAL	

AMBULATORY	4
HOSPITALIZATION	1
SAINT MARY'S HOSPITAL AMBULATORY	5

Figure 9-10: Example of All report

The report will show subtotals and totals.

## 9.10 Tally of Walk-In/Appointment Clinic Visits (APPT)

Use the APPT option to produce a report that counts visits by clinic in the date range selected. Select visit counts for one or all locations and one or all clinics. The report counts each clinic visit by appointment, walk-in, or unspecified.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:

- 1–All
- 2–Individually
- 3–For a Service Unit
- 4–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.

4. At the “Include visits from ALL Clinics?” prompt, type **Y** (Yes) or **N** (No). If **N** is entered, other prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

```

AUG 02, 1994 Page 1
TALLY OF CLINIC VISITS: WALK-IN, APPOINTMENT, UNSPECIFIED
LOCATION OF VISITS: ALL
CLINIC: ALL
VISIT DATES: JAN 01, 1994 TO JAN 31, 1994

```

LOCATION OF VISIT									
CLINIC TOTAL	APPOINTMENTS		WALK-INS		UNSPECIFIED				
CLINIC CODE	VISITS		%		%		%		
-----									
DEMO OTHER									
MENTAL HEALTH	4	5	0	0.0	0	0.0	5	100.0	
Sub total:		5	0	0.0	0	0.0	5	100.0	
DEMO HOSPITAL/CLINIC									
CHRONIC DISEASE	50	17	0	0.0	0	0.0	17	100.0	
DENTAL	56	186	0	0.0	0	0.0	186	100.0	
DIABETIC	06	55	0	0.0	0	0.0	55	100.0	
DIETARY	67	18	0	0.0	0	0.0	18	100.0	
EMERGENCY MED	30	228	0	0.0	0	0.0	228	100.0	
GENERAL	01	551	0	0.0	0	0.0	551	100.0	
GROUP SERVICES	09	9	0	0.0	0	0.0	9	100.0	
GYNECOLOGY	10	15	0	0.0	0	0.0	15	100.0	
MENTAL HEALTH	14	3	0	0.0	0	0.0	3	100.0	
OBSTETRICS	16	49	0	0.0	0	0.0	49	100.0	
OPHTHALMOLOGY	17	27	0	0.0	0	0.0	27	100.0	
OPTOMETRY	18	31	0	0.0	0	0.0	31	100.0	
OTHER	25	10	0	0.0	0	0.0	10	100.0	
PHARMACY	39	203	0	0.0	0	0.0	203	100.0	
PHYSICAL THER	34	86	0	0.0	0	0.0	86	100.0	
PODIATRY	65	29	0	0.0	0	0.0	29	100.0	
RADIOLOGY	63	2	0	0.0	0	0.0	2	100.0	
SURGICAL	23	13	0	0.0	0	0.0	13	100.0	
WELL CHILD	24	10	0	0.0	0	0.0	10	100.0	
WOMEN'S HLTH SCR	70	1	0	0.0	0	0.0	1	100.0	
Sub total:		1543	0	0.0	0	0.0	1543	100.0	
Total		1548	0	0.0	0	0.0	1548	100.0	

Figure 9-11: Example of APPT report

## 9.11 California State Annual Utilization Report (CSAR)

Use the CSAR option to produce the California State Annual Utilization Report of Primary Care Clinics report for a selected year.

Follow these steps:

1. At the "Enter Calendar year (e.g. 2007)" prompt, type the calendar year of interest. Use a 4-digit year, e.g., 2006.
2. At the "Include visits from ALL Locations?" prompt, type **Y** (Yes) or **N** (No). If **N** is entered, other prompts display.

3. At the “Select 3P FEE TABLE SCHEDULE NUMBER” prompt, specify the FEE schedule to use in calculating the primary CPT code.
4. At the “Do you want to include a list of visits with no CPT code?” prompt, type **Y** (Yes) or **N** (No).
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

CALIFORNIA ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS, 2007		
ALL LOCATIONS OF ENCOUNTER SELECTED		
Reporting Period: Jan 01, 2007 to Dec 31, 2007		
-----		
SECTION 2		
FTEs AND ENCOUNTERS BY PRIMARY CARE PROVIDER		Column 5 - No. of
Encounters		(5)
LINE NO. OF		
NO.	PRIMARY CARE PROVIDERS	ENCOUNTERS
-----		
60	Physicians	18,809
61	Physician Assistants	8,661
62	Family Nurse Practitioners	4,640
63	Certified Nurse Midwives	0

Figure 9-12: Partial example of CSAR report

## 9.12 PCC Data Analysis Report (DAR)

Use the DAR option to produce a report that counts all visits processed in the PCC and categorizes them by type, service category, and complete/incomplete. The PCC Data Analysis Report also indicates visits excluded from the APC system.

Follow these steps:

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

3. At the “Include visits for which Facility” prompt, type the name of the facility.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

```

DEMO HOSPITAL/CLINIC Apr 09, 1996 Page 1
PCC DATA ANALYSIS REPORT

FACILITY: DEMO HOSPITAL/CLINIC - 000101
VISIT DATE RANGE: Jan 01, 1995 - Dec 30, 1995

Total Visits Processed in PCC: 140

as of the Date the report was run:

 complete incomplete
 ----- -----

TYPE: IHS 100 36
 OTHER 3 1
SERVICE CATEGORY: AMBULATORY 97 34
 CHART REVIEW 1
 EVENT (HISTORICAL) 1
 HOSPITALIZATION 2 2
 IN HOSPITAL 3

APC Acceptable Visits based on Headquarters Definition: 93

Exclusions from APC System:

 Dental Clinic w/o Medication 4
 Other Excluded Clinic Type 0
 Incomplete A, O, R or S 15
 Non APC Service Category 9
 Non APC Visit Type 0
 Mult Visits same patient, same day, same clinic 19

Of the acceptable APC visits, 0 were posted or modified after the last
export and would not be reflected in reports from the data center.

Of the acceptable APC visits, 27 were not exported due to an error.
These can be reviewed using other PCC reports.

RUN TIME (H.M.S): 0.0.9
End of report. HIT RETURN:

```

Figure 9-13: Example of DAR report

## 9.13 General/Dental Clinic Visits on the Same Day (GCDC)

Use the GCDC option to produce a report that shows a list of patients who have had a dental clinic visit and a general clinic visit on the same day.

Follow these steps:

1. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Do you want to select” prompt, type one of the following:
  - 1–All
  - 2–Individually
  - 3–For a Service Unit
  - 4–From a Taxonomy

If 2, 3, or 4 is entered, additional prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - I–Include All patients
  - E–Exclude Demo patients
  - O–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

General Clinic and Dental Clinic Visits (Same Day)		
Location of Visits: SELECTED		
Date Range: Jan 28, 2008 to Jan 27, 2009		
Visit Date	Patient Name	Chart
-----		

Figure 9-14: Example GCDC report

## 9.14 Listing of Incomplete Laboratory, Rx or Rad Visits (INCV)

Use the INCV option to produce a report that lists all “orphan visits.” Select orphaned laboratory, pharmacy, or radiology visits. If laboratory is selected, all visits with no primary provider or POV entered that have a laboratory entry attached to them display. The same is true for pharmacy or radiology. If a visit has both a V LAB and a V RADIOLOGY, the visit is included in each report.



Follow these steps:

1. At the “What type of orphan visits should be included” prompt, type one of the following:
  - **L**–LAB
  - **P**–PHARMACY
  - **R**–RADIOLOGY
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following:
  - **A**–ALL Locations/Facilities
  - **S**–One SERVICE UNIT'S Locations/Facilities
  - **O**–ONE Location/Facility

If the user types S or O, additional prompts display.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Do you wish to” prompt, specify the device to print/browse the report.

OUTPUT BROWSER	Jan 27, 2009 15:37:33	Page: 1 of 2							
XXX	Jan 27, 2009	Page 1							
INCOMPLETE LAB VISITS									
Visit Dates: Jan 28, 2008 to Jan 27, 2009									
HRN	PATIENT NAME	DATE	TIME	SC	TYPE	LOC	LAB	RX	RAD
-----									
TOTAL NUMBER OF VISITS FOUND: 13									
DH 124682	SIGMA,ANGELA	Mar 12, 2008	8:00	H	T	DH	1	0	0
DH 111207	CHI,SHI	Mar 18, 2008	12:00	A	I	DH	3	0	0
DH 111228	BETA,SHICHI	Mar 28, 2008	12:00	A	I	DH	3	0	0
+ Enter ?? for more actions >>>									
+ NEXT SCREEN - PREVIOUS SCREEN Q QUIT									

Select Action: +/-
--------------------

Figure 9-15: Example INVC report

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

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

## 9.15 Primary Provider Visits – Daily/Annual Report (PPD)

Use the PPD option to produce a report that counts visits by Primary Providers for a given day or year. The user can specify the locations or clinics to include in the report up to a total of six for an 80-column report or 12 for a 132-column report. All clinics are counted in the report, including telephone calls, dental, and chart reviews if a clinic is not specified. However, only visits with a primary provider discipline in one of the following codes are tabulated:

Code	Primary Provider Discipline
00	Physician
11	Physician Assistant
16	Pediatric Nurse Practitioner
17	Nurse Midwife
18	Contract Physician
21	Nurse Practitioner
25	Contract Podiatrist
33	Podiatrist
41	Contract OB/Gyn
44	Physician (Tribal)
70 - 90	Physician Specialists

This report tallies the number of visits by primary care providers, provider at the locations or the clinics that the user specifies.

This report can be run for one day (daily report) or for a year (calendar).

A total number of six locations or clinics will fit on an 80 column report. The user can specify up to 12 if the report is printed with 132 columns.

Follow these steps:

1. At the “Run which Report” prompt, type **D** (Daily Report) or **Y** (Yearly Report).

2. At the “Enter DATE” prompt, type the date.
3. At the “Do you wish to tally by” prompt, type **C** (Clinic) or **F** (Facility). Other prompts will display, according the option used.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

The following sample report was run for an entire facility and six specific clinics for January 15, 1995.

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

Figure 9-16: Example of PPD report

## 9.16 Primary Care Provider Visits – Monthly Report (PPM)

Use the PPM option to produce a report that counts the number of visits by primary care providers for a given month. All clinic codes are in the report including telephone calls, dental, and chart review. Only visits with a primary provider discipline are counted.

A total of six locations or clinics will fit on an 80-column report. The user can specify up to 12 if the report is printed with 132 columns.

Follow these steps:

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

3. At the “Do you wish to tally by” prompt, type **C** (Clinic) or **F** (Facility). Other prompts display according to the option specified.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

The following sample report was run for the month of January for six selected clinics.

DEMO HOSPITAL/CLINIC							Page 1
PRIMARY CARE PROVIDER VISITS - PRIMARY PROVIDER ONLY							
VISITS DATES: JAN 01, 1996 TO JAN 31, 1996							
LOCATION OF VISITS: ALL							
DATE	GENERAL	DIABETIC	INTERNAL	OBSTETRI	EMERGENC	DENTAL	
01/08/96	1	4	11	9	3	5	
01/10/96	6	6	9	7	1	6	
01/11/96	4	7	6	5	2	3	
01/18/96	2	5	7	5	0	5	
01/24/96	8	5	6	3	2	5	
01/30/96	1	5	8	2	1	7	
RUN TIME (H.M.S): 0.0.0							
End of report. HIT RETURN:							

Figure 9-17: Example of PPM report

## 9.17 Tally of Selected Provider Disciplines by Clinics (TPC)

The TPC option produces a report that lists a count of all visits to clinics within a taxonomy of clinics identified. The report tallies all primary and secondary providers on those visits. Only those provider disciplines within the discipline taxonomy selected will be tallied.

Follow these steps:

1. At the “At the “Enter beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
3. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type one of the following

- **A**–ALL Locations/Facilities
- **S**–One SERVICE UNIT’S Locations/Facilities
- **O**–ONE Location/Facility
- **T**–A taxonomy or Set of Locations/Facilities

If S, O, or T is entered, other prompts display.

4. At the “Enter Clinic” prompt, type the clinic for the report. This prompt repeats so that the user may type more than one clinic.
5. At the “Enter CLASS” prompt, type the class.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

```

Select PCC Ambulatory Visit Reports Option: TPC Tally of Selected Provider
Disciplines by Clinics
This report will list a count of all visits to clinics that are within a
taxonomy of clinics you identify. The report will be a tally of all primary
and secondary providers on those visits. Only those provider disciplines
that are within the discipline taxonomy you select will be tallied.

Enter Beginning Visit Date: T-200 (AUG 10, 2009)
Enter Ending Visit Date: T (FEB 26, 2010)

Select one of the following:

A ALL Locations/Facilities
S One SERVICE UNIT'S Locations/Facilities
O ONE Location/Facility
T A Taxonomy or Set of Locations/Facilities

Enter a code indicating what LOCATIONS/FACILITIES are of interest: O// ALL
Locations/Facilities

Enter CLINIC: 01 GENERAL 01

The following have been selected =>

GENERAL

Enter ANOTHER CLASS: PHYS
1 PHYSICAL THERAPIST
2 PHYSICAL THERAPY TECHNICIAN
3 PHYSICIAN
4 PHYSICIAN (CONTRACT)

```

```

 5 PHYSICIAN (TRIBAL)
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 3 PHYSICIAN
Enter ANOTHER CLASS: PHYS
 1 PHYSICAL THERAPIST
 2 PHYSICAL THERAPY TECHNICIAN
 3 PHYSICIAN
 4 PHYSICIAN (CONTRACT)
 5 PHYSICIAN (TRIBAL)
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 4 PHYSICIAN (CONTRACT)
Enter ANOTHER CLASS: PHYS
 1 PHYSICAL THERAPIST
 2 PHYSICAL THERAPY TECHNICIAN
 3 PHYSICIAN
 4 PHYSICIAN (CONTRACT)
 5 PHYSICIAN (TRIBAL)
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 5 PHYSICIAN (TRIBAL)
Enter ANOTHER CLASS:

The following have been selected =>

 PHYSICIAN
 PHYSICIAN (CONTRACT)
 PHYSICIAN (TRIBAL)

Want to save this CLASS group for future use? No// (No)

 Select one of the following:

 I Include ALL Patients
 E Exclude DEMO Patients
 O Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// Include ALL Patients
DEVICE: HOME// VT Right Margin: 80//

 Tally of Selected Primary and Secondary Providers for selected Clinic
 Visits

 Visit Dates: Aug 10, 2009-Feb 26, 2010

Locations: ALL

Clinics:
 GENERAL

Disciplines:
 PHYSICIAN
 PHYSICIAN (CONTRACT)
 PHYSICIAN (TRIBAL)

 Feb 26, 2010

Page 1
TALLY OF SELECTED PRIMARY AND SECONDARY PROVIDERS FOR SELECTED CLINIC
VISITS

```

Visit Dates: Aug 10, 2009-Feb 26, 2010	
FOR: ALL Locations	
-----	
Total PCC Primary Provider Workload Count:	212
Total PCC Secondary Provider Workload Count:	2
Total PCC Provider Workload Count:	214
Total Number of Visits:	214
PRIMARY PROVIDERS	# OF VISITS
AQPROVIDER,NATALIE	6
DEMO	6
AXPROVIDER,MERY F	2
DEMO	2
BOPROVIDER,RICHARD MD	1
	1
BPPROVIDER,J	1
DEMO	1
Enter RETURN to continue or '^' to exit:	
	Feb 26, 2010
Page 2	
TALLY OF SELECTED PRIMARY AND SECONDARY PROVIDERS FOR SELECTED CLINIC VISITS	
Visit Dates: Aug 10, 2009-Feb 26, 2010	
FOR: ALL Locations	
-----	
BPPROVIDER,MELISSA A	1
DEMO	1
BETA,LORI	1
DEMO	1
CFPROVIDER,RENAE FRANCES	13
DEMO	13
CNPROVIDER,TOM	1
DEMO	1
DEPROVIDER,ABDUL Z	1
DEMO	1
DLPROVIDER,ELISA	1
DEMO	1
EBPROVIDER,WALTER L	1
DEMO	1
EJPROVIDER,GLENN C	1
DEMO	1
EWPROVIDER,KIM	1
RUN TIME (H.M.S): 0.0.0	
End of report. HIT RETURN:	

Figure 9-18: Example TPC report

## 9.18 Wait Times by Clinic and Provider (WAIT)

The WAIT option displays minimum, maximum, and mean waiting times by provider and clinic. In order for data to print in this report, the user's site must be entering the actual time that the primary provider saw the patient. Type a beginning visit date and ending visit date for time reporting. There is an option to print waiting times for all clinics or for specific clinics.

Follow these steps:

1. At the "Enter beginning Visit Date for Search" prompt, type the beginning of the date range.
2. At the "Enter ending Visit Date for Search" prompt, type the end of the date range.
3. At the "Tally Waiting Times for ALL Clinics" prompt, type **Y** (Yes) or **N** (No).
4. At the "Do you wish to include" prompt, type **W** (Walk-ins Only) or **A** (Appointments Only).
5. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
  - **I**—Include All patients
  - **E**—Exclude Demo patients
  - **O**—Include only demo patients
6. At the "Device" prompt, specify the device to print/browse the report.

Figure 9-19 includes wait times for the Internal Medicine clinic between October 1 and October 31, 1996.

```

* DEMO HOSPITAL/CLINIC NOV 25, 1996 Page 1 *
*
* WAITING TIMES BY CLINIC AND PROVIDER *
* LOCATION OF VISITS: DEMO HOSPITAL/CLINIC *
* REPORT DATE: OCT 01, 1996 TO OCT 31, 1996 *
Report includes APPOINTMENTS only.

```

CLINIC	TOTAL VISITS	VSTS USED	AVG WAIT	MIN WAIT	MAX WAIT	EARLY	LATE
INTERNAL MEDICINE	120	100	10	0	33	38	62
BETAA, TED	25	20	18	5	37	0	20
GAMMAAAA, LUPE	40	40	5	0	12	18	22
SIGMAAAAAA, TOM	30	25	12	2	23	6	19



---

THETAA, FLYNN	25	15	8	0	18	6	9
---------------	----	----	---	---	----	---	---

Figure 9-19: Example of Wait report

## 10.0 Billing Reports (BILL)

The following reports are available from the Billing Reports menu:

```

** PCC Management Reports **
** Billing Reports **

 IHS PCC Suite Version 2.0

 DEMO HOSPITAL

MCA Listing of Active Medicare Part A Enrollees
MCB Listing of Active Medicare Part B Enrollees
MCD Listing of Active Medicaid Enrollees
PI Listing of Active Private Insurance Enrollees
CO Listing of Commissioned Officers and Dependents
VIS Listing of Potentially Billable Visits by Date
COV Visits by Commissioned Officers and Dependents
TPR List of Selected Third Party Coverage(s)

Select Billing Reports Option:

```

Figure 10-1: Example billing reports main menu

### 10.1 Listing of Active Medicare Part A Enrollees (MCA)

Use the MCA option to produce a report that shows a list of patients registered at a specified facility who are currently enrolled in Medicare Part A. Type an “as of” date to identify patients who are actively enrolled from the date specified. The report sorts alphabetically by patient name.

Follow these steps:

1. At the “Which Facility” prompt, type the facility name.
2. At the “Patients are to be considered ACTIVE as of what date” prompt, type the date.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
4. At the “Device” prompt, specify the device to print/browse the report.

```

 DEMO HEALTH CENTER Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART A ENROLLEES

Actively enrolled as of FEB 7,1995

```

NAME DATE OF BIRTH	CHART	MEDICARE (TYPE)	COVERAGE	ELIG BEG DATE	ELIG END DATE
(REG) BETAN,SUSAN (MCR) OMICRON,HENRY		6182	56932812361	FEB 01, 1938	
	A		SEP 1979		
	A		DEC 31, 1988		
(REG) GAMMA,DARLENE (MCR) OMICRON,HENRY		6708	1234344441	JAN 01, 1989	
	A		DEC 31, 1988		
(REG) GAMMAA,BILL (MCR)		14697	57416683018	JUN 01, 1975	
	A		JUL 1975		

Figure 10-2: Example listing of active Medicare Part A enrollees

## 10.2 Listing of Active Medicare Part B Enrollees (MCB)

Use the MCV option to produce a report that shows the patients registered at a specified facility and currently enrolled in Medicare Part B. Type an “as of” date to identify patients who are actively enrolled from the date specified. The report sorts alphabetically by patient name.

The prompts are the same as those for the MCA option.

DEMO HEALTH CENTER						Page 1
REGISTERED PATIENTS - ACTIVE MEDICARE PART B ENROLLEES						
Actively enrolled as of FEB 7,1995						
NAME (TYPE)	CHART	MEDICARE (TYPE)	COVERAGE	ELIG BEG DATE	ELIG END DATE	DATE OF BIRTH
(REG) BETAB,LISA (MCR)		9422	526928682144	SEP 01, 1964		
	B		JUL 1966			
(REG) BETAC,SUSAN (MCR) WASHINGTON,HENRY		6182	56932812361	FEB 01, 1938		
	B		SEP 1979			
(REG) GAMMA,DARLENE (MCR) WASHINGTON,HENRY		6708	1234344441	JAN 01, 1989		
	B		DEC 13, 1989			

Figure 10-3: Example listing of active Medicare Part B enrollees

### 10.3 Listing of Active Medicaid Enrollees (MCD)

Use the MCD option to produce a report showing a list of patients registered at a specified facility and currently enrolled in Medicaid. To determine which patients are actively enrolled during the specified date, type an “as of” date. The report sorts alphabetically by patient name. See the example below.

The prompts are the same as those for the MCA option.

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 (MCD)	22222	MAY 01, 1977
MEDICAID : 0000000001		STATE: MONTANA
NAME/INSURED:		SEX OF INSURED:
-----		
(REG) BETAB,SUSAN (MCD)	22223	FEB 01, 1938
MEDICAID : 0000000002		STATE: ARIZONA
NAME/INSURED:		SEX OF INSURED:
ELIG BEG DATE: JAN 1983	COVERAGE: 11	ELIG END DATE:
-----		
(REG) GREEN,DARLENE (MCD) SAME	22224	JAN 01, 1989
MEDICAID : 0000000003		STATE: MINNESOTA
NAME/INSURED: GREEN,DARLENE		SEX OF INSURED: F
ELIG BEG DATE: JAN 31, 1990	COVERAGE:	ELIG END DATE: FEB
14,1990		
-----		

Figure 10-4: Example listing of active Medicaid enrollees

### 10.4 Listing of Active Private Insurance Enrollees (PI)

Use the PI option to produce a report showing a list of patients registered in a specified facility and currently enrolled in private insurance. To identify patients who are actively enrolled during the specified date, type an “as of” date. The report sorts alphabetically by patient name.

The prompts are the same as those for the MCA option.

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	COVERAGE TYPE:
POLICY : 123456	REL: SELF
INSURED: EEEE,D	ELIG END DATE:
ELIG BEG DATE: JAN 27, 1988	
-----	
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. The last page of the report shows a total. See Figure 10-6.

				page 1
DEMO HEALTH CENTER				
COMM. OFFICERS & DEPENDENTS				
UCI: DEV				
("*" = INACTIVE)				
as of FEB 7,1995@18:54:08				
Name	IHS	SSN	CLASS.	
-----				
BETAAA, SHARON	44441	xxx-xx-1111	C. O.	
BETAA, EVAN	44442	xxx-xx-1112	C. O.	
BETAB, THOMAS	44443	xxx-xx-1113	C. O.	
BETAC, RICHARD	44444	xxx-xx-1114	C. O.	
DELTA, ELIZABETH	44445	xxx-xx-1115	C. O.	
GAMMAA, SHARON	44446	xxx-xx-1116	C. O.	
GAMMAB, PRESTON	44447	xxx-xx-1117	C. O.	
HALPHA, IDA	44448	xxx-xx-1118	C. O.	
HALPHA, ISIAH	4449	xxx-xx-1119	C. O.	

Figure 10-6: Example listing of commissioned officers and their dependents

## 10.6 Listing of Potentially Billable Visits by Date (VIS)

Use the VIS option to produce a report showing a list of potentially billable visits for all patients registered at a specified facility. This report displays visits for the period in which the patient had third-party coverage. Only visits at the location where a patient is registered display.

**Note:** Specific diagnostic categories that might not be covered by the patient's insurance are not considered in the report.

Follow these steps:

1. At the “Run the report for which Facility” prompt, type the facility name.
2. At the “Starting Visit Date for Billable Visits” prompt, type the start of the date range.
3. At the “Ending Visits Date for Billable Visits” prompt, type the end of the date range.
4. At the “Do you want a particular SERVICE CATEGORY?” prompt, type **Y** (Yes) or **N** (No). If Y is entered, other prompts display.
5. At the “Do you want a particular CLINIC?” prompt, type **Y** (Yes) or **N** (No). If Y is entered, other prompts display.
6. At the “Select Third Party Coverage” prompt, select one of the options listed below to display visits from the following types of third-party coverage:
  - Commissioned Officers/Dependents
  - Medicare Part A
  - Medicare Part B
  - Medicaid
  - Private Insurance
  - Non-Indians
  - All Above Coverages
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
8. At the “Device” prompt, specify the device to print/browse the report.

The following sample report shows billable visits from September 1, 1988 to February 7, 1990 for patients enrolled in Medicare Part B.

DEMO HEALTH CENTER		Page 1	
POTENTIALLY BILLABLE VISITS FOR Medicare Part B			
Visit Dates: SEP 1,1988 and FEB 7,1990			
SERVICE 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 the user is logged in to. Specify a date range for the visits and select from the following types of visits:

- Outpatient Visits Only
- Inpatient Visits Only
- Dental Visits Only
- All Visits

**Note:** This report prints on 132-column paper or on a printer set up for condensed print.

```

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

DEMO HOSPITAL
COMMISSIONED OFFICERS & DEPENDENTS VISITS
01/01/96 to 01/28/09
OUTPATIENT VISITS

Patient Name Chart SSN CO or Dep Sponsor SSN Visit Date No. of
Visits

BETAA, FRANCIS SKIRVI 169291 432-47-8159 CO 10/05/04 1
BETAAAAAAA, JULIE EL 153848 519-50-1222 CO 02/06/03
 02/12/03
 02/12/03
 04/28/04
 05/26/04
 06/15/04

```

	06/16/04	
	12/21/04	
	01/29/05	
	10/07/05	
	10/12/05	
	10/19/05	
	03/08/06	
	04/17/07	
	08/15/07	
	08/16/07	
	08/22/07	17

Figure 10-8: Example listing of visits by commissioned officers and dependents

## 10.8 List of Selected Third Party Coverage(s) (TPR)

The TPR option allows the user to print a list of patients registered at the facility selected, who have insurance coverage with the insurer selected.

Follow these steps:

1. At the “Which Facility” prompt, type the facility name.
2. At the “Select a type of insurance” prompt, type one of the following:
  - **1**–Medicare Part A
  - **2**–Medicare Part B
  - **3**–Medicaid
  - **4**–A Selected Private Insurance
  - **5**–Railroad Part A
  - **6**–Railroad Part B
3. At the “Do you want patients that only have this one insurer (no other coverage)?” prompt, type **Y** (Yes) or **N** (No).
4. At the “Select Type of Eligibility Dates” prompt, type the date.
5. At the “Select Type of Eligibility Dates” prompt, type one of the following:
  - **1**–Currently Active Eligibility Dates
  - **2**–Any Past or Current Eligibility Dates
  - **3**–Selected Eligibility Dates
6. At the “Do you want to print all beginning and Ending eligibility date pairs” prompt, type **Y** (Yes) or **N** (No).
7. At the “sort the Report By” prompt, type **1** (Patient Name) or **2** (Patient HRNO).



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

01/28/07		DEMO HOSPITAL			Page 1	
Patient List for Medicare Part A						
With any eligibility dates						
Patient Name	HRNO	MCR	SUF	Begin	End	
-----	-----	-----	---	-----	-----	
SIGMA, ADONNA	11111	13333333	A	11/01/90		
SIGMA, JAYDEN	11112	13333334	A	06/01/83		
SIGMA, DAVID	11113	13333335	A	07/01/93		
SIGMA, GEORGE	11114	13333336	A	05/01/82	07/31/05	
SIGMA, MARTHA	11115	13333337	A	09/01/01		

Figure 10-9: Example of TPR report

## 11.0 Activity Reports by Discipline Group (ACT)

This set of reports provides Activity and Travel Times (in minutes) for the discipline group selected. Three discipline groups are already defined: PHN, Mental Health, and Social Services. Refer to the table below for disciplines and codes.

Group	Discipline	Code
PHN	CHN/Aides	13
	CHN (Contract)	32
Mental Health	Mental Health	19
	Psychiatrist	81
	Neurologist	85
	Contract Psychologist	50
	Psychologist	12
Social Services	Contract Psychiatrist	49
	Medical Social Worker	06
	Licensed Med Social Worker	62
	Contract Social Worker	63

New discipline groups can be defined, as appropriate, using the CAG option. However, the only method for tracking each specific discipline is to have each provider type an activity time and/or travel time on the PCC Encounter Form.

Each report can be filtered by location of encounter and clinic.

The menu includes the following reports:

```

** PCC Management Reports **
** Activity Reports by Discipline Group **

 IHS PCC Suite Version 2.0
 DEMO HOSPITAL/CLINIC
TSPR Time and Patient Services by Provider
TSSU Time and Patient Services by Service Unit
PPPR Primary Problem by Provider
PPLO Primary Problem by Facility
PPSU Primary Problem by Service Unit
INPR Number of Individuals seen by Provider
INSU Number of Individuals seen by Service Unit
AGE Patient Services by Age and Sex
TEN Top Ten Primary Diagnoses
CAG Create new Activity Discipline Group
INQA Inquire into an Activity Group
TSCR Time and Services by Provider for Chart Reviews
Select Activity Reports by Discipline Group Option:

```

Figure 11-1: Example activity reports by discipline group menu

## 11.1 Time and Patient Services by Provider (TSPR)

Use the TSPR option to produce a report that displays the number of patient contacts, total activity time, and total travel time for each provider by location of encounter within a specified provider discipline group. Type a beginning and ending visit date range and the discipline group.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, type the discipline group. The system displays information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Include visits from which set of locations” prompt, type one of the following:
  - **O**–One Location
  - **T**–Taxonomy of or Selected set of Locations
  - **A**–All Locations
5. At the “Include visits from which set of clinics” prompt, type one of the following:
  - **O**–One Clinic
  - **T**–Taxonomy or Selected Set of Clinics
  - **A**–All Clinics
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

OCT 15,1994	Page 1					
PATIENT CONTACT REPORT FOR MENTAL HEALTH STAFF						
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994						
All Locations						
All Clinics						
PROVIDER: VPROVIDER, THOMAS L						
TOTAL	CONTS	CONTS	PATIENT	AS PRIM.	AS SEC.	ACTIVITY

TRAVEL TIME	LOCATION OF ENCOUNTER	CONTACTS	PROVIDER	PROVIDER	TIME *
DEMO OTHER		2	1	54	50
DEMO ADMINISTRATION		4	4	123	30
DEMO HOSPITAL/CLINIC		4	3	90	39
TOTAL:		10	8	267	119

* -- 1 of the visits did not have an activity time recorded.

NOTE: This report separates visits and time into individual staff member contacts. If Provider A and Provider B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each provider and 20 minutes activity time for each provider.

RUN TIME (H.M.S): 0.0.3  
End of Report - Hit return

Figure 11-2: Example time and patient services report by provider

## 11.2 Time and Patient Services by Service Unit (TSSU)

Use the TSSU option to produce a report that displays total patient contacts, total activity time, and total travel time for a selected discipline group by SU.

The prompts are the same as the TSPR option.

TOTAL TRAVEL TIME	CONTS LOCATION OF ENCOUNTER	CONTS PATIENT CONTACTS	AS PRIM. PROVIDER	AS SEC. PROVIDER	ACTIVITY 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 display.

Type a beginning and ending visit date range and a discipline group. Check the report heading.

OCT 15,1994							Page 1
PRIMARY PROBLEM REPORT BY PROVIDER PHN STAFF							
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994							
PROVIDER: COMMUNITY HEALTH NURSE,IHS							
TOTAL	CONTS	CONTS		ACTIVITY	TRAVEL		
PATIENT	AS PRIM.	AS SEC.		PROVIDER	TIME*		TIME
PRIMARY PROBLEM	CONTACTS	PROVIDER					
DIABETES	2	1		1	54		50
OTHER DIS OF THE NERVOUS		4		4	0		123 30
PRENATAL,FIRST TRIMESTER			4	3	1		90 39
TOTAL:	10	8		2	267		119
* -- 1 of the visits did not have an activity time recorded.							
NOTE: This report separates visits and time into individual staff member contacts. If Provider A and Provider B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each provider and 20 minutes activity time for each provider.							
RUN TIME (H.M.S): 0.0.3							
End of Report - Hit return							

Figure 11-4: Example primary problem report by provider report

### 11.4 Primary Problem by Facility (PPLO)

The PPLO report totals primary problems for a specific discipline group and Location of Encounter. The report displays totals for activity times, travel times, and patient contacts for each problem.

Type a beginning and ending visit date range and a discipline group.

The prompts are the same as the TSPR option.

JAN 28, 2009		Page 1
PRIMARY DX REPORT BY LOCATION OF ENCOUNTER FOR GENERAL STAFF		
VISIT DATES: AUG 01, 2008 TO JAN 28, 2009		
All Locations		
All Clinics		

LOCATION OF ENCOUNTER: DEMO HOSPITAL					
PRIMARY DX	TOTAL PATIENT CONTACTS	VISITS AS PRIM. PROVIDER	VISITS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME
MUMPS UNCOMPLICATED	1	1	0	0.00	0.00
TOTAL:	1	1	0	0.00	0.00

* -- 1 of the visits did not have an activity time recorded.

NOTE: This report counts one visit regardless of the number of GENERAL staff involved in that visit, and time represents total time reported regardless of the number of staff reporting on a single PCC Encounter Form.

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

Figure 11-5: Example primary problem report by facility

## 11.5 Primary Problem by Service Unit (PPSU)

The PPSU report displays primary problems for a specific SU. Totals are shown for patient contacts, activity times, and travel times for each provider within the discipline group selected.

Type a beginning and ending visit date range, **SU**, and discipline group.

The prompts are the same as the TSPR option.

JAN 28, 2009						Page 1
PRIMARY DX REPORT BY SERVICE UNIT FOR PHN STAFF						
VISIT DATES: JAN 01, 2003 TO JAN 28, 2009						
All Locations						
All Clinics						
SERVICE UNIT: NON SVC UNIT						
PRIMARY DX	TOTAL PATIENT CONTACTS	VISITS AS PRIM. PROVIDER	VISITS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL TIME	
DIABETES	58	54	4	11.70	6.58	
GENERAL/MULTIPLE	158	158	0	78.27	8.68	
TOTAL:	216	212	4	89.97	15.27	

* -- 4 of the visits did not have an activity time recorded.

```
NOTE: This report counts one visit regardless of the number of GENERAL
staff involved in that visit, and time represents total time reported
regardless of the number of staff reporting on a single PCC Encounter Form.

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

Figure 11-6: Example primary problem report by service unit report

## 11.6 Number of Individuals Seen by Provider (INPR)

The INPR report displays the number of individuals seen by each provider within a discipline by location of encounter for the discipline group selected.

The system prompts for beginning and ending visit dates and discipline group.

The prompts are the same as the TSPR option.

OCT 15,1994		Page 1
NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF		
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994 COMMUNITY HEALTH PROVIDER:		
PROVIDER: COMMUNITY HEALTH PROVIDER,IHS		
TOTAL NUMBER OF INDIVIDUALS SEEN		
-----		
DEMO OTHER		101
DEMO ADMINISTRATION		99
DEMO HOSPITAL/CLINIC		250
TOTAL:		450

Figure 11-7: Example number of individuals seen by provider report

## 11.7 Number of Individuals Seen by Service Unit (INSU)

Use the INSU option to produce the number of individuals seen by SU for staff members in the specified discipline group. The report displays, by location of encounter, the number of individuals seen by providers within a discipline group selected for a specified SU.

The system prompts for beginning and ending visit dates and the discipline group.

The prompts are the same as the TSPR option.

OCT 15,1994		Page 1
NUMBER OF INDIVIDUALS SEEN REPORT FOR PHN STAFF		
VISIT DATES: JAN 01, 1994 TO OCT 15, 1994		
All Locations		
All Clinics		
SERVICE UNIT: DEMO		
TOTAL NUMBER OF		
INDIVIDUALS SEEN		

-----	
DEMO CLINIC	99
DEMO OTHER	101
DEMO HOSPITAL/CLINIC	250
TOTAL:	450

Figure 11-8: Example number of individuals seen by service unit report

## 11.8 Patient Services by Age and Sex (AGE)

Use the AGE option to produce a report that lists all visits on which staff members of a discipline group selected was a provider, and time and patient services by age and sex.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, specify the discipline group. The system displays information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Include visits from which set of locations” prompt, type one of the following:
  - **O**–One Location
  - **T**–Taxonomy of or Selected set of Locations
  - **A**–All Locations
5. At the “Include visits from which set of clinics” prompt, type one of the following:
  - **O**–One Clinic
  - **T**–Taxonomy or Selected Set of Clinics
  - **A**–All Clinics
6. The age groups to be used are currently defined as:
  - 0–0
  - 1–4
  - 5–14



- 15–19
  - 20–24
  - 25–44
  - 45–64
  - 65–125
7. At the “Do you wish to modify these age groups?” prompt, type **Y** (Yes) or **N** (No) (consider the age groups shown above). If the user types Y (Yes), other prompts display.
8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
- **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
9. At the “Device” prompt, specify the device to print/browse the report.

OCT 15, 1994 <span style="float: right;">Page 1</span>					
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					
AGE GROUP	TOTAL PATIENT CONTACTS	CONTS AS PRIM. PROVIDER	CONTS AS SEC. PROVIDER	ACTIVITY TIME*	TRAVEL 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 ten primary POVs by providers within the discipline group selected. The report generates for a specified SU.

Follow these steps:

1. At the “Enter the Provider Discipline Group you wish to report on” prompt, type the discipline group. The system displays information about the selected group.
2. At the “Enter beginning Visit Date for Search” prompt, type the beginning of the date range.
3. At the “Enter ending Visit Date for Search” prompt, type the end of the date range.
4. At the “Which Service Unit” prompt, type the SU name.
5. At the “Include visits from which set of clinics” prompt, type one of the following:
  - **O**–One Clinic
  - **T**–Taxonomy or Selected Set of Clinics
  - **A**–All Clinics
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

```

APR 10, 1996 Page 1
TOP TEN PRIMARY DX REPORT BY SERVICE UNIT PHN STAFF
VISIT DATES: JAN 01, 1995 TO JAN 31, 1995
All Clinics
SERVICE UNIT: DEMO

PRIMARY DX TOTAL PATIENT CONTACTS
WELL CHILD CARE 19
DIABETES 14
HYPERTENSION 8
GENERAL/MULTIPLE 6
PRENATAL, FIRST TRIMESTER 4
OTHER SUBSTANCE ABUSE 3
TUBERCULOSIS, REACTOR/CONV 2
SCABIES 1

RUN TIME (H.M.S): 0.2.16

```

```
End of report. HIT RETURN:
```

Figure 11-10: Example top 10 diagnoses report by SU report

## 11.10 Create new Activity Discipline Group (CAG)

The CAG option provides a means to define and create a new discipline group. Once the new group is created and providers within that discipline record their activity and travel times on the PCC Encounter Form, activity reports can be generated for the new discipline group.

```
Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP: NURSES
 ARE YOU ADDING 'NURSES' AS A NEW PCC MAN REPORTS ACTIVITY
GROUP (THE 4TH)? Y (YES)
NAME OF GROUP: NURSES//
Select DISCIPLINES IN GROUP: 05 LICENSED PRACTICAL NURSE
 ARE YOU ADDING 'LICENSED PRACTICAL NURSE' AS
 A NEW DISCIPLINES IN GROUP (THE 1ST FOR THIS PCC MAN REPORTS ACTIVITY
GROUP)? Y (YES)
Select DISCIPLINES IN GROUP: 01 REGISTERED NURSE
 ARE YOU ADDING 'REGISTERED NURSE' AS A NEW DISCIPLINES IN GROUP
 (THE 2ND FOR THIS PCC MAN REPORTS ACTIVITY
GROUP)? Y (YES)
```

Figure 11-11: Creating a new activity discipline group

## 11.11 Inquire into an Activity Group (INQA)

Use the INQA option to view information about an established activity group.

```
NAME OF GROUP: PHN ICD RECODE ROUTINE: APCLRCHA
RECODE GLOBAL: AUTTCHA PIECE FOR DESC. IN RECODE FILE: 3
STANDARD: YES
DISCIPLINES IN GROUP: CHN/AIDES DISCIPLINE CODE: 13
DISCIPLINES IN GROUP: CHN (CONTRACT) DISCIPLINE CODE: 32
Select PCC MAN REPORTS ACTIVITY GROUP NAME OF GROUP:
```

Figure 11-12: Inquiring into an activity group

## 11.12 Time and Services by Provider for Chart Reviews (TSCR)

The TSCR report displays by location of encounter, the number of patient chart reviews and the total activity and travel time for each provider with a discipline in the provider discipline group selected.

The prompts are the same as the TSPR option.

JAN 28, 2009

Page 1

CHART REVIEW REPORT FOR PHN STAFF  
VISIT DATES: JAN 01, 2006 TO JAN 28, 2009

All Locations All Clinics PROVIDER: IOPROVIDER,DEBRA M						
LOCATION OF ENCOUNTER	TOTAL CHART	CR'S AS PRIM.	CR'S AS SEC. REVIEWS	ACTIVITY PROVIDER	TRAVEL PROVIDER	TIME* TIME
HOME	1	1	0	0.25	0.08	
CIHA DIABETES CLINIC	6	6	6	0	0.42	0.00
TOTAL:	7	7	7	0	0.67	0.08

* -- 1 of the visits did not have an activity time recorded.  
 NOTE: This report separates visits and time into individual staff member contacts. If Staff Member A and Staff Member B participated on the same visit for a patient and spent 20 minutes in that visit, that is displayed on this report as a contact for each staff member.

Figure 11-13: Example TSCR report

## 12.0 Dx and Procedure Count Summary Report (CNTX)

Use the CNTX option to access the options for the Count Summary menu.

```

** PCC Management Reports **
** Count Summary Menu **

IHS PCC Suite Version 2.0

DEMO HOSPITAL

CPTP CPT Code by Provider Report
DXAG Diagnoses by AGE report
DXFA DX Tally by Local, Secondary, Tertiary Facility
FCPT Frequency of CPTs Report
FPRC Frequency of Procedures Report
PAPC Purpose of Visits grouped by APC codes
RXDA RX Data Analysis Report
TEN Frequency of Diagnoses Report
TOP Tally of Operating Provider for Procedures

Select Dx & Procedure Count Summary Reports Option:

```

Figure 12-1: Options on the Count Summary Menu

### 12.1 CPT Code by Provider Report (CPTP)

Use the CPTP option to produce a report that shows the CPT codes entered by a specified provider. The date range; whether to include outpatient (ambulatory, day surgery, observation), inpatient visits or both; tally CPT codes by primary provider only or primary and secondary provider; and whether to include only visits to one facility, a service unit or to patients who are members of a particular tribe can be specified.

**Note:** If both primary and secondary providers have been chosen, the following logic will be applied: If the CPE mnemonic is used, or the CPT code is entered through EHR, the CPT code links to the encounter provider documented. If there is no encounter provider documented, the CPT code is tallied under each provider on that visit; thus the counts will include the same CPT code multiple times.

Follow these steps:

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

3. At the “Report should include” prompt, type **P** (Primary Provider Only) or **A** (All Providers).
4. At the “Report should include” prompt, use one of the following:
  - **O**–Outpatient Visits (ambulatory, day surgery, observation)
  - **I**–Inpatient
  - **B**–Both
5. At the “Enter a code indicating which visits are of interest” prompt, type one of the following:
  - **S**–One Service Unit
  - **L**–One Location/Facility
  - **T**–One Tribe
  - **A**–All visits

If S, L, or T is entered, additional prompts display.
6. At the “Select an Output Option” prompt, type one of the following:
  - **P**–Print Report on Printer or Screen
  - **D**–Create Delimited output file (for use in Excel)
  - **B**–Both a Printed Report and Delimited File
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
8. At the “Device” prompt, specify the device to print/browse the report.

SJT	Jan 28, 2009	Page 1
*** CPT Code by Provider Report ***		
Visit Dates: Jan 01, 2006 to Jan 28, 2009		
Provider Name	Discipline	
AAPROVIDER,GORDON	NURSE ASSISTANT	
Ambulatory/Outpatient Services:		
CPT Code	CPT Narrative	Subtotalled by CPT
10060	DRAINAGE OF SKIN ABSCESS	2
11100	BIOPSY, SKIN LESION	1

11200	REMOVAL OF SKIN TAGS	1
11730	REMOVAL OF NAIL PLATE	3
11732	REMOVE NAIL PLATE, ADD-ON	1
17000	DESTRUCT PREMALG LESION	3
17003	DESTRUCT PREMALG LES, 2-14	1
17110	DESTRUCT B9 LESION, 1-14	1
20552	INJ TRIGGER POINT, 1/2 MUSCL	3
20605	DRAIN/INJECT, JOINT/BURSA	1
29130	APPLICATION OF FINGER SPLINT	1
36000	PLACE NEEDLE IN VEIN	4
51701	INSERT BLADDER CATHETER	1
59025	FETAL NON-STRESS TEST	1
59430	CARE AFTER DELIVERY	1
69210	REMOVE IMPACTED EAR WAX	7
70160	X-RAY EXAM OF NASAL BONES	1
70450	CT HEAD/BRAIN W/O DYE	1
70486	CT MAXILLOFACIAL W/O DYE	1

Figure 12-2: Example CTPT report

## 12.2 Diagnoses by AGE Report (DXAG)

Use the DXAG option to produce the Frequency of Diagnoses By Age report that lists diagnoses by age group.

Follow these steps:

1. At the “Enter beginning Visit Date” prompt, type the beginning date of the date range.
2. At the “Enter ending Visit Date” prompt, type the ending date of the date range.
3. The application displays the following information:

```
When I search the database, I can "screen" POVs according to any one of the
following attributes:
 PATIENT SEX
 FACILITY OF ENCOUNTER
 PRIMARY PROVIDER
 CLINIC TYPE
 SERVICE CATEGORY (Hospitalizations, Ambulatory, Chart
Reviews Nursing Home, etc.)
VISIT TYPE (IHS, Contract, Tribal, 638, Other, VA)
```

Figure 12-3: Attributes for screening

4. At the “Want to use one or more of these ‘screens’?” prompt, type **Y** (Yes) or **N** (No). If Y is entered, other prompts display.

The application displays the following information:

```
The Age Groups to be used are currently defined as:
```

```

0 - 0
1 - 4
5 - 14
15 - 19
20 - 24
25 - 44
45 - 64
65 - 125

```

Figure 12-4: Age groups

5. At the “Do you wish to modify these age groups?” prompt, type **Y** (Yes) or **N** (No) (considering the currently defined age groups). If **Y** is entered, other prompts display.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
7. At the “Device” prompt, specify the device to print/browse the report.

This report should be printed on 132-column paper or on a printer that is set for condensed print. If the user does not have such a printer available, see the site manager.

```

SJT DEMO HOSPITAL 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 Secondary
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 12-5: Example DXAG report



## 12.3 DX Tally by Local, Secondary, Tertiary Facility (DXFA)

Use the DSFA option to produce a report showing a tally of all diagnoses for patients in a community or communities. The report tallies the diagnoses for the community's local, secondary, and tertiary facilities. Each community's report has one page for outpatient diagnoses and one page for inpatient diagnoses.

Follow these steps:

1. At the "Please Identify your Service Unit" prompt, type the service unit name.
2. At the "Enter Beginning Visit Date" prompt, type the beginning of the date range.
3. At the "Enter Ending Visit Date" prompt, type the end of the date range.
4. At the "Enter a code indicating what COMMUNITIES of RESIDENCE are of interest" prompt, type one of the following:
  - **O**—One Particular Community
  - **S**—All communities within the XXX UNIT (where XXX is the unit's name)
  - **T**—A TAXONOMY or selected set of communities

If S or T is entered, additional prompts display.

The system checks the community table for the required items; if any are missing, the process stops. See the site manager about fixing the community entries. The user can select other communities or exit the report.

5. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
  - **I**—Include All patients
  - **E**—Exclude Demo patients
  - **O**—Include only demo patients
6. At the "Device" prompt, specify the device to print/browse the report.

## 12.4 Frequency of Procedures Report (FPRC)

Use the FPRC option to produce the Frequency of Procedures report, which shows the top number of procedures done at a specified facility.

Follow these steps:

1. At the "Please Identify your Service Unit" prompt, type the SU name.
2. At the "Enter Beginning Visit Date" prompt, type the beginning of the date range.

3. At the “How many entries do you want in the list (5-100)” prompt, type any integer between 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 12-6: VISIT Selection menu

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

5. At the “Demo Patient Inclusion/Exclusion” prompt, use one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
6. At the “Device” prompt, specify the device to print/browse the report.

```
***** FREQUENCY OF PROCEDURES REPORT *****
```

```

REPORT REQUESTED BY: THETA,SHIRLEY

The following report contains a PCC Visit report based on the
following criteria:

VISIT Selection Criteria

 Encounter Date range: AUG 01, 2006 to JAN 28, 2009

ALL VISITS IN DATE RANGE SELECTED.

Total COUNT of Visits: 484

No. VISITs: 484 No. PRCs: 573 PRC/VISIT ratio: 1.18 (min. std. > 1.6)

TOP 10 PRC's =>
 1. 89.54 ELECTROGRAPHIC MONITORING (88)
 2. 94.62 ALCOHOL DETOXIFICATION (61)
 3. 99.04 PACKED CELL TRANSFUSION (38)
 4. 70.24 VAGINAL BIOPSY (35)
 5. 45.23 FLEX FIBEROPTIC COLONOSC (28)

 6. 39.95 HEMODIALYSIS (21)
 7. 47.01 LAPAROSCOPIC APPENDECTOMY (15)
 8. 88.01 C.A.T. SCAN OF ABDOMEN (13)
 9. 67.32 CERVICAL LES CAUTERIZAT (11)
 10. 94.65 DRUG DETOXIFICATION (11)

RUN TIME (H.M.S): 0.0.3
End of report. HIT RETURN:

```

Figure 12-7: Example Frequency of Procedures report (FPRC)

## 12.5 Purpose of Visits Group by APC Codes (PAPC)

Use the PAPC option to produce the Purpose of Visits Count report, which shows only Ambulatory Visits within a specified date range.

Follow these steps:

1. At the “Please Identify your Service Unit” prompt, type the SU name.
2. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
3. At the “Should the counts only include visits for patients from a specific community?” prompt, type **Y** (Yes) or **N** (No). If **Y** is entered, other prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients

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

DEMO HOSPITAL		JAN 28, 2009 Page 1	
POV Counts for Ambulatory Visits from AUG 1, 2008 through JAN 28, 2009. ICD9 Subcounts are restricted to the leading 20 Purposes of Visit.			
APC	APC Category	Count	
303	INFLUENZA	13	
	ICD9 ICD9 Description		
	-----		
	487.1 FLU W RESP MANIFEST NEC	13	
999	NO REPORTED DIAGNOSIS	11	
	ICD9 ICD9 Description		
	-----		
	V62.84 SUICIDAL IDEATION	6	
	.9999 UNCODED DIAGNOSIS	5	

Figure 12-8: Example PAPC report

## 12.6 RX Data Analysis Report (RXDA)

Use the RXDA option to produce the RX Data Analysis Report, which tallies all RXs for a specified date range and breaks them down by Time Released and Count by Hour increments. This option allows the report to be printed for all divisions or for one specified division.

Follow these steps:

1. At the “Enter Beginning RX Release Date” prompt, type the beginning of the date range.
2. At the “Enter Ending RX Release Date” prompt, type the end of the date range.
3. At the “Include RX’s from ALL DIVISIONS?” prompt, type **Y** (Yes) or **N** (No). If the user types N, other prompts display.
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
5. At the “Device” prompt, specify the device to print/browse the report.

DEMO HOSPITAL		Jan 28, 2009 Page 1	
RX ANALYSIS REPORT			

```

RX RELEASE TIME WORKLOAD DISTRIBUTION

DIVISION: ALL DIVISIONS
RX RELEASE DATE RANGE: Jan 01, 2006 - Jan 28, 2009

Total Prescriptions Dispensed: 214769
 RX COUNT ACT % TOTAL ADJ % TOTAL
 ----- -
AM Prescriptions Dispensed

Total RX's Before 8:00: 11927 6 NA
Total RX's 8:00- 8:59: 14114 7 NA
Total RX's 9:00- 9:59: 22986 11 12
Total RX's 10:00-10:59: 27362 13 14
Total RX's 11:00-11:59: 23669 11 13

PM Prescriptions Dispensed

Total RX's 12:00-12:59: 17134 8 9
Total RX's 1:00- 1:59: 17410 8 9
Total RX's 2:00- 2:59: 27045 13 14
Total RX's 3:00- 3:59: 25789 12 14
Total RX's 4:00- 4:59: 17242 8 9
Total RX's 5:00- 5:59: 9083 4 5
Total RX's 6:00- 6:59: 841 0 0
Total RX's 7:00- 7:59: 53 0 0
Total RX's 8:00- 8:59: 40 0 0
Total RX's 9:00- 9:59: 35 0 0
Total RX's 10:00-10:59: 33 0 0
Total RX's 11:00-11:59: 6 0 0
 ----- -
 214769 100% 100%

SUMMARY
ACT Total-All Hours: 214769 ADJ Total After 9:00 AM: 188728
ACT Percent After 2:00 PM: 37% ADJ Percent After 2:00 PM: 42%
ACT Percent After 3:00 PM: 25% ADJ Percent After 3:00 PM: 28%
ACT Percent After 4:00 PM: 13% ADJ Percentage After 4:00 PM: 14%

NOTE: ACT Total includes all hours - ADJ Total excludes all Non-Pharmacy
and evening dispensed RX's that are typically encoded between 8:00-9:00 AM.

RUN TIME (H.M.S): 0.1.45
End of report. HIT RETURN:

```

Figure 12-9: Example RX Data Analysis report (RXDA)

## 12.7 Frequency of Diagnoses Report (TEN)

Use the TEN option to produce the Frequency of Diagnoses report, which shows the most frequent diagnosis for that date range.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, type the end of the date range.
3. At the “Include which patients in the tally of diagnoses” prompt, type **A** (All Patients) or **S** (Search Template of Patients). If **S** is entered, other prompts display.
4. At the “How many entries do you want in the list (5-100)” prompt, type any integer between 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 12-10: VISIT Selection Menu

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

6. At the “Report should include” prompt, type **P** (Primary POV) or **A** (All POVs).

## 7. The system displays the following information:

You have the opportunity to exclude certain diagnoses from this report. For example, to eliminate Pharmacy refill diagnoses, you need to exclude V68.1 from this report. If you chose to include only the primary pov then visits with a primary pov of V68.1 will be excluded.

Figure 12-11: System message

8. At the “Do you wish to exclude any diagnoses codes from the report?” prompt, type **Y** (Yes) or **N** (No). If Y is entered, other prompts display.
9. At the “Select TYPE OF OUTPUT” prompt, type **L** (List of items with counts) or **B** (Bar chart, 132 columns).
10. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
11. At the “Device” prompt, specify the device to print/browse the report.

```

***** FREQUENCY OF DIAGNOSES REPORT *****
Report run at: DEMO HOSPITAL

REPORT REQUESTED BY: THETA,SHIRLEY

The following report contains a PCC Visit report based on the
following criteria:

VISIT Selection Criteria

Encounter Date range: AUG 01, 2008 to JAN 28, 2009

ALL VISITS IN DATE RANGE SELECTED.

ALL (Primary and Secondary) POV's included.

Total COUNT of Visits: 100
No. VISITS: 100 No. POVs: 108 POV/VISIT ratio: 1.08 (min. std. > 1.6)

TOP 10 POV's =>

```

		Visits	Patients
1.	072.9 MUMPS UNCOMPLICATED	23	23
2.	487.1 FLU W RESP MANIFEST NEC	13	5
3.	V62.84 SUICIDAL IDEATION	6	6
4.	.9999 UNCODED DIAGNOSIS	5	5
5.	079.81 HANTAVIRUS INFECTION	4	3
6.	401.9 HYPERTENSION NOS	3	3
7.	007.1 GIARDIASIS	3	2
8.	055.9 MEASLES UNCOMPLICATED	3	3
9.	114.0 PRIMARY COCCIDIOIDOMYCOSIS	3	2
10.	493.90 ASTHMA UNSPECIFIED WITHOUT MEN	3	3

```

TOP 10 DIAGNOSTIC CATEGORIES =>

 1. INFECTIOUS & PARASITIC (43)
 2. EAR, NOSE, MOUTH & THROAT (16)
 3. NERVOUS SYSTEM (7)
 4. RESPIRATORY SYSTEM (6)
 5. MENTAL DISEASES & DISORDERS (6)
 6. CIRCULATORY SYSTEM (5)
 7. DIGESTIVE SYSTEM (5)
 8. HEALTH STATUS FACTORS (5)
 9. MUSCULOSKELETAL & CONNECTIVE T (4)
 10. HEPATOBILIARY & PANCREAS (3)

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

```

Figure 12-12: Example Frequency of Diagnosis report (TEN)

## 12.8 Tally of Operating Provider for Procedures (TOP)

Use the TOP option to produce the Listing/Tally of Visits with Selected Procedure Codes report, which tallies the operating provider for selected procedures done. A list of all visits with the selected procedures can be obtained.

Follow these steps:

1. At the “Enter Beginning Visit Date” prompt, type the beginning of the date range.
2. At the “Enter Ending Visit Date” prompt, type the end of the date range.
3. At the “Include ALL Visit Service Categories?” prompt, type **Y** (Yes) or **N** (No). If the user types N (No), other prompts display.
4. At the “Enter a code indicating what LOCATIONS/FACILITIES are of interest” prompt, type **A** (All Locations/Facilities) or **O** (One Location/Facility). If O is entered, other prompts display.
5. At the “Enter a code indicating what ICD Procedure codes are of interest” prompt, type **A** (for all procedures) or **S** (selected set of ICD Procedure codes). If S is entered, other prompts display.
6. At the “Do you want a List of all the procedures in addition to the tally?” prompt, type **Y** (Yes) or **N** (No).
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
8. At the “Device” prompt, specify the device to print/browse the report.



XXX		Jan 28, 2009		Page 1	
*** PROCEDURE TALLY/LISTING ***					
Visit Dates: Jan 29, 2008 to Jan 28, 2009					
Service Categories: ALL					
Procedures included in this report: ALL ICD PROCEDURES					
-----					
Total of Procedures:				28	
Tally BY Operating Providers:					
Operating Provider		of Procedures			
BETAAAA,LORI					
29.39	EXC/DESTR LES/TIS PHARY			1	
45.24	FLEXIBLE SIGMOIDOSCOPY			1	
Total Procedures for BUTCHER,LORI				2	
FAPROVIDER,USER					
47.2	DRAIN APPENDICEAL ABSC			1	
Total Procedures for FAPROVIDER,USER				1	
GAMMA,U					
18.29	DESTRUCT EXT EAR LES NEC			1	
28.11	TONSIL ADENOID BIOPSY			1	
45.23	FLEX FIBEROPTIC COLONOSC			2	
45.24	FLEXIBLE SIGMOIDOSCOPY			2	
47.01	LAPAROSCOPIC APPENDECTOMY			4	
51.23	LAPAROSCOPIC CHOLECYSTECT			1	
86.27	DEBRIDE NAIL/BED/FOLD			1	
Total Procedures for GAMMA,U				12	

Figure 12-13: Example TOP report

## 13.0 Immunization Reports (IMM)

The following immunization reports are available from the Immunization Report menu. These reports address the immunization needs of the adults and children at the user's facility.

```

** PCC Management Reports **
** Immunization Report Menu **

IHS PCC Suite Version 2.0

DEMO HOSPITAL/CLINIC

AIN Adult Immunization Needs
KNIR Kids Not on Immunization Register

```

Figure 13-1: Example Immunization report main menu

### 13.1 Adult Immunization Needs (AIN)

The Adult Immunization Needs (AIN) report displays the most recent Td, pneumococcal, and influenza vaccinations for adults considered at high risk. Prior to running this report, Q-Man must be used to create a cohort (template) of patients to search. Developing a cohort of high-risk adults typically consists of selecting living patients over age 65 or who have one or more specific chronic diseases.

The following example report was generated using a search template of patients over 65 years old.

DEMO HOSPITAL		Apr 14, 2008 Page 1					
		***** ADULT IMMUNIZATION NEEDS *****					
DEMO H	LAST PATIENT NAME	NUMBER	COMMUNITY	AGE	LAST Td	LAST	
FLU	PNEUMOVAX						
	ALPHAA, JANE	111111	SPRINGFIELD	67	04/09/2005	10/25/2006	
	10/22/1990						
	OMICRONN, JENNIFER	111112	SPRINGFIELD	59	02/20/2007	11/17/2005	
	01/13/2004						
	MUUUU, SUSAN	111113	SPRINGFIELD	70	11/03/2004	11/05/2004	
	04/19/1990						
	THETA, RENEE	111114	SPRINGFIELD	66	05/20/2006	11/30/1994	
	04/30/2007						
	BETAAA, SHARON	111115	SPRINGFIELD	65	03/09/2006	10/06/2003	
	08/07/2006						
	GAMMAAAA, ELIZABETH	111116	SPRINGFIELD	61	09/28/1996		
	BETA, SUZANNE	111117	SPRINGFIELD	64	01/15/2006		
	12/01/2006						
	01/17/2006						
	IOTA, LAUREN	111118	SPRINGFIELD	67	03/28/1995	10/06/2003	
	06/01/1994						

GAMMA, SHANNON	111119	SPRINGFIELD	63	02/17/1997	
MUUUUU, MARY	111121	SPRINGFIELD	70	09/13/2001	10/22/1998
07/30/1996					
RHOO, GRETA	111122	SPRINGFIELD	67	07/30/2000	02/21/2007
PIIIIII, CINDY	111123	SPRINGFIELD	80	11/00/1993	11/07/2000
IOTAAAA, BEATRICE	111124	SPRINGFIELD	83		11/14/2006
11/15/1994					
ALPHA, FRANCES	111125	SPRINGFIELD	74		10/27/2004
01/08/2001					
Enter RETURN to continue or '^' to exit:					

Figure 13-2: Example adult immunization needs report

## 13.2 Kids Not on Immunization Register (KNIR)

The Kids Not on Immunization Register (KNIR) report lists all children in a specified age range who are not in the immunization register. Type an age range and select a particular community, a group of communities, or all communities.

Follow these steps:

1. At the “Enter an AGE range” prompt, type the age range or press Enter to include all ages.
2. At the “List children who live in” prompt, type one of the following:
  - **O**–One particular Community
  - **A**–All Communities
  - **S**–Selected Set of Communities (Taxonomy)

If the user types O or S, additional prompts display.
3. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
  - **I**–Include All patients
  - **E**–Exclude Demo patients
  - **O**–Include only demo patients
4. At the “Device” prompt, specify the device to print/browse the report.

The following sample report shows children ages 5-to-8 in the Achi and Ajo communities, who are not in the immunization register.

WARNING: CONFIDENTIAL PATIENT INFORMATION, PRIVACY ACT APPLIES	
DEMO HOSPITAL	Apr 14, 2008 Page 1
***** CHILDREN NOT ON IMMUNIZATION REGISTER *****	
Community: ACHI	

```

SIGMA,JOHN (111111) Nov 12, 1988 19 Years MALE
 No prior immunizations listed
SIGMA,JANE (111112) Nov 01, 1992 15 Years FEMALE
 No prior immunizations listed
SIGMA,JAMES (111113) Oct 15, 1993 14 Years MALE
 Jan 26, 1994 HEP B PED
 Mar 29, 1994 DTaP, IPV
 Sep 11, 1995 DTaP, MMR

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

Figure 13-3: Example report listing children not in immunization register

## 14.0 Q-Man (PCC Query Utility) (QMAN)

Q-Man (the PCC Query System) is a utility for “mining” the PCC database. It facilitates retrieval of demographic and clinical information.

```

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

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

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

Enter RETURN to continue or '^' to exit:

```

Figure 14-1: Opening information for QMAN option

- To exit Q-Man, type a caret (^).
- The following options display when pressing Enter at the “Enter RETURN to continue or ‘^’ to exit” prompt:

```

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

Select one of the following:

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

Your choice: SEARCH//

```

Figure 14-2: Example Q-Man options menu

No special knowledge of MUMPS, FileMan, or the PCC file structure is required to use Q-Man. Generate a query by initiating a dialogue with the computer. Each query has a subject, attribute, condition, and value.

For example, consider the following query:

```

"Find all patients over 60 years of age."
SUBJECT = Patients
ATTRIBUTE = Age

```

```
CONDITION = Over
VALUE = 60
```

Figure 14-3: Sample Q-Man query

To define a search the word “and” can be used for multiple queries.

The output of the search is either a standard columnar display on the screen, a printed report, or a FileMan search template (i.e., a cohort of patients).

In addition to the dialogue interface described above, there is also a natural language interface to Q-Man. Type a one attribute query in English. Frequently, Q-Man will correctly interpret the query and print the results on the screen. If Q-Man does not understand the question, it will beep and prompt the user to try again. Sample queries for the Rapid Report option are:

```
"SHOW ME MARY MARTIN'S LAST BLOOD SUGAR"
"FIND ALL PATIENTS WHO LIVE IN TUCSON"
"SHOW ME EVERYONE WHOSE TRIBE OF MEMBERSHIP IS NAVAJO"
"I WANT LISA JONES' AVERAGE WEIGHT"
"NOW GET HER SSN"
```

Figure 14-4: Sample queries for the rapid report

Notice that the word “and” does not appear in any of the queries, and that all queries in Figure 4-14 have one attribute only. If this method of querying does not provide the intended results, use the dialogue interface.

A separate Q-Man User Manual describing the use of the Query System in depth is available.

## 15.0 Delimited Output Reports (DELR)

The Delimited Output Reports menu contains the following option:



EDU Create Delimited File of Visits w/Education Done

Figure 15-1: Example FileMan menu options

This EDU option creates a delimited output file of all visits in which patient education was done. The report includes primary care provider. This report is used by uploading the data file into Microsoft Excel or other software application.

## 16.0 Health Summary Displaying CMS Register(s) (CHS)

The CHS option displays the register the patient belongs to and allows the patient's Health Summary to be printed.

1. At the "Select patient" prompt, type the name of the patient. The system displays information about the particular patient.
2. At the "Select health summary type" prompt, specify the type of Health Summary to display.
3. At the "Device" prompt, specify the device to print/browse the report.

```

CONFIDENTIAL PATIENT INFORMATION -- 1/29/2009 10:07 AM [SJT]
** DEMO,JOHNNIE RUTH 118774 <A> (ADULT REGULAR SUMMARY) pg 1 **

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

DEMO,JOHNNIE RUTH DOB: MAR 1,1981 27 YRS FEMALE no blood type
DEMO TRIBE, NM SSN: XXX-XX-4021
 MOTHER'S MAIDEN NAME: CROWE,VIRGINIA J
(H) 555-555-3791 FATHER'S NAME: DEMO,MICHAEL
BIRDTOWN (P.O. BOX 1340,VASSALBORO,NC,28719)

LAST UPDATED: MAY 24,2007 ELIGIBILITY: CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT? YES
DATE RECEIVED BY PATIENT: Apr 14, 2003
WAS ACKNOWLEDGEMENT SIGNED? YES
WOMEN'S HEALTH CASE MANAGER: SPROVIDER,JEROME
DESIGNATED PRIMARY PROVIDER: NPROVIDER,ERIN D
DIABETES: AVPROVIDER,TERESA D
OB CARE: TETER,SHIRLEY
ON CMS REGISTER(S): ASTHMA (PERSISTENT) Status: ACTIVE
DYSLIPIDEMIA Status: ACTIVE
CARDIOVASCULAR DISEASE Status: ACTIVE
ALPHA TEAM Status: ACTIVE

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

INSURANCE NUMBER SUFF COV EL DATE SIG DATE END DATE
NC MEDICAID 138784952 PW 08/01/06
Plan Name: ALL STATES COVERAGE INC
BLUE CROSS BLUE SHIELD-N.C.HPG880422843 02/01/06

```

Figure 16-1: Example CHS menu option report



## 17.0 Custom Letter Management (CLM)

The Custom Letter Management option contains the following menu options:

CCL	Create/Modify Custom Letter
PCL	Print Custom Letters for Selected Patients

Figure 17-1: Example CLM menu options

- The CCL (Create/Modify Custom Letters) option allows the user to add, edit, and delete a customized letter, and view letter inserts.
- The PCL (Print Custom Letters for Selected Patients) option allows the user to print custom letters for selected patients.

## 18.0 Browse Health Summary (BHS)

The BHS option allows the user to browse the specified Health Summary for a particular patient. The following screen displays:

```

Select PCC Management Reports Option: BHS Browse Health Summary
Select health summary type: DENTAL//
Select patient: DEMO,JOHNNIE RUTH <A> F 03-01-1981 XXX-XX-4021
DH 118774

OUTPUT BROWSER Jan 15, 2009 15:27:20 Page: 1 of 6
PCC Health Summary for DEMO,JOHNNIE RUTH

** CONFIDENTIAL PATIENT INFORMATION -- 1/15/2009 3:27 PM [SJT]**
***DEMO,JOHNNIE RUTH 118774 <A> (DENTAL SUMMARY) pg 1 ***

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

DEMO,JOHNNIE RUTH DOB: MAR 1,1981 27 YRS FEMALE no blood type
DEMO TRIBE, NM SSN: XXX-XX-4021
 MOTHER'S MAIDEN NAME: CROWE,VIRGINIA J
(H) 555-555-3791 FATHER'S NAME: DEMO,MICHAEL
BIRDTOWN (P.O. BOX 1340,VASSALBORO,NC,28719)

LAST UPDATED: MAY 24,2007 ELIGIBILITY: CHS & DIRECT

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT? YES
 DATE RECEIVED BY PATIENT: Apr 14, 2003
 WAS ACKNOWLEDGEMENT SIGNED? YES

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

```

Figure 18-1: Example Health Summary information

## 19.0 Other PCC Management Reports/Options (OTH)

The Other PCC Management Reports/Options menu contains the following options:

RT	Report Template Utility...
DR	PCC Patient Data Retrieval Utility
RDD	Delete VGEN/PGEN Report Definition

Figure 19-1: Example OTH menu options

### 19.1 Report Template Utility (RT)

The Report Template Utility contains the following options:

CR	Create Report Template
MD	Modify/Delete Report Template
PR	Print Report Template
TC	Taxonomy Creation For A Script

Figure 19-2: Example RT menu options

### 19.2 PCC Patient Data Retrieval Utility (DR)

The PCC Patient Data Retrieval Utility uses scripts to retrieve patient information from the PCC. Typing DR displays a prompt asking for the patient's name. Create a script to retrieve patient clinical or demographic information.

#### 19.2.1 Script Creation

A script is an instruction to the PCC Data Retrieval Utility to obtain patient information from the PCC database. Both demographic and clinical information can be retrieved for a patient.

##### 19.2.1.1 Demographic Data

To obtain demographic data for a patient, the first word typed at the prompt must be either PT or Patient. Then additional information can be added. If the text typed at the prompt is ambiguous, the system will not return a value.

The following list includes patient demographic data items that are most frequently requested. Other demographic information can be displayed.

- PT NAME
- PT CURRENT COMMUNITY
- PT AGE

- PT DOB
- PT TRIBE OF MEM

### 19.2.1.2 Clinical Data

Scripts can be used to retrieve clinical data. The following sample scripts show some of the types of information that can be retrieved from the PCC database.

```

LAST 3 MEAS BP;DURING 1991 - RETURNS LAST 3 BLOOD PRESSURES
 TAKEN DURING 1991
LAB GLUCOSE;ON SEP 3, 1992 - RETURNS ALL 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 in Figure 19-4 can be broken into four component parts for further explanation. LAST 3 MEAS BP; DURING 1991 will be used for this example.

```

LAST 3 - Limits occurrences; use first, last, or all.
 - Can indicate number of instances.
 - Optional; if not used system will default to 'all.'
MEAS - Data Class; i.e., AS LABS, POV, ADA.CODE.
BP - Optional; what you are looking for within the data class
 - If not indicated, system will look at all values within data
 class.
DURING 1991 - Optional use of date parameters.

```

Figure 19-4: Example script

The four components are explained in detail below:

- Limits Occurrences: Use First, Last, or All

The first word of the script must be either First, Last, or All. The default value is All. For example, for the number of occurrences for which a particular value should be retrieved either First 3 or Last 2 can be specified.

- Data Class

The second word is the data class. The second word in the script may be Lab, Rx, Ada.Code, Exam, Visit, Pov, Measurement, Procedures, Skin.Test, Immunization, Radiology, Education, Active.Prob, Inactive.Prob, Family.History, Personal.History, or Health.Factors.

If the data class has more than one word, each word must be separated by a period when typed into the script; for example, Ada.Code. Two words are not required; the data retriever can determine the class from the first word. Many classes, such as Dental Services and Medications, have acronyms. In most instances, type only the first few identifying characters of a data class. For instance, to specify Active Problems, type ACT instead of spelling it out. The data retriever will recognize these three letters as “Active Problems.”

- Value within the Data Class

The third word is the value, or what the user is searching for, within the data class. For example, the value would be a laboratory test for labs and an Ada Code for dental services. Also, instead of entering an ICD9 code, a narrative such as Diabetes or DM can be used.

- Date Parameters

The date range can be restricted by placing a semicolon (;) at the end of the script, followed by a restriction on the date, such as: on, equals, before, during, between, or a symbol (>, <, <>, =). An exact date or a range of dates can be entered by placing a dash (-) between the two dates. Dates must be in standard FileMan format. The month and year, year only, or full dates can be entered. (See the sample scripts on the following page for examples of typing date parameters.)

- Taxonomy Creation

If an asterisk (*) is typed for the value within the data class, the system will prompt for multiple values associated with the selected data class. For example, a range of ICD9 codes for POVs or multiple Ada Codes, can be entered. Not all data classes allow entry of more than one value. Available data classes for taxonomy creation are: diagnosis, ADA code, RX, procedure (medical), patient education topic, and health factors. These multiple values can be stored in a taxonomy. Then the user can type the name of the taxonomy prefaced by a left square bracket ([) to indicate the desired values to retrieve.

The following report shows the data received from the sample script.

```
Select PATIENT NAME: SMITH, JANE
 F 11-10-70 XXX-XX-1234 DH 333333
ENTER SCRIPT: LAST 3 MEAS BP

VISIT DATE: 06/23/1993 VALUE: 120/90 TYPE: BP
VISIT DATE: 03/04/1993 VALUE: 100/80 TYPE: BP
VISIT DATE: 08/25/1992 VALUE: 120/80 TYPE: BP

ENTER SCRIPT: LAST VISIT

VISIT DATE: 08/02/1993 VALUE: VISIT

ENTER SCRIPT: LAST POV DM
```

```
250.00 (DIABETES UNCOMPL TYPE II/NIDDM)
DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION/TYPE II/NONINSULIN
DEPENDENT/ADULT-ONSET

OK? Y//

VISIT DATE: 07/19/1993 VALUE: 250.00
```

Figure 19-5: Example of data retrieved using script

### 19.3 Delete VGEN/PGEN Report Definition (RDD)

Use the RDD option to delete a PCC Visit or Patient General Retrieval report definition. The system confirms the deletion.

## 20.0 EPIX–EPI Program HL7 Exports

### 20.1 IL and Lab EPI Program Exports in HL7 Format

This set of options allows the site to export their ILI surveillance data and selected lab result data to the EPI Program in HL7 format. This addition supports MU. The options are locked with a key–APCSZ EPI EXPORTS and should only be run when requested to do so by the EPI Program. The options are:

- HLIL Export my H1N1/ILI data
- HLLB Export Lab Data

The documentation on how to use these options can be found in the addendum for this patch.

```

** PCC Management Reports **
** EPI Program HL7 Exports **

 IHS PCC Suite Version 2.0

 2010 DEMO HOSPITAL

HLIL Export my H1N1/ILI data
HLLB Export Lab Data

Select EPI Program HL7 Exports Option:

```

Figure 20-1: The HLIL and HLLB options

## 21.0 FileMan (General) (FM)

The FileMan 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 21-1: Example FileMan menu options

The Search and Print options allow the user to create ad hoc reports. The Inquire option allows the user to see entries within a file. The Statistics option is a menu that, when appropriate, allows for the creation of a histogram or scattergram or gives basic mathematical statistics for a report generated by the Print or Search option. The Statistics menu options must be run just after the report is generated, as results will not be saved once another report is printed. Note that the Statistics menu options cannot be used if a report is queued to a printer. List File Attributes displays the fields and attributes of those fields that make up a FileMan file. These create the data dictionary of the file.

A separate File Manager user's manual that describes the use of these utilities in depth is available.



## 22.0 Improving Patient Care Collaborative (IPC) Reports (IPC)

This menu contains two IPC reports that the Improving Patient Care Collaborative (IPC) sites may use to manage their designated primary care panels.

For instructions on running these reports, refer to the IPC Measures Guide located on the IPC portal: <http://www.improvingindianhealth.org/> > IPC > team resources > resources > Measurement and Reporting > Measures Guide > 2011 IPC Measures Guide.

The menu also includes reports described in other sections of this manual, which IPC sites may find useful.

CC	Continuity of Care to a Primary Care Provider
PE	Percent Empanelled

Figure 22-1: IPC reports

## 23.0 Search Template System (STS)

This system has options that allow search templates to be created either through the FileMan Search option or manually. A search template comparison utility is also available that permits the user to match the contents of one FileMan search template with another. The STS provides the capability to delete and add entries to existing search templates the user has created. In addition, FileMan (General) may be accessed from this menu.

**Note:** If a search template is created via the search template utility or the option that allows for manual creation of a search template, there will be no search logic associated with these templates. Search templates created via the FileMan Search option have search logic stored with them. This means the user can utilize this template's search logic within the search option of FileMan.

```
Search Template System
Version 2.5
Site Set To DEMO HO

 SRCH Search Template Comparison Utility
 CRE Create Search Template Manually
 ADD Add Entries Into An Existing Search Template
 DENT Delete Entries From An Existing Search Template
 CNT Count Entries In A Search Template
 SRT Inquire Into Sort/Search Template File
 DEL Delete Search Template
 SAVE Save Search Template
 FGEN FileMan (General) ...

Select Search Template System Option:
```

Figure 23-1: Example Search Template System main menu

A separate STS user's manual that describes the use of this system in-depth is available.

## 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.
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.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
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 1 st diagnosis entered.
APC CODE 1	123	125	3	Y	APC Recode for diagnosis 1
CAUSE OF DX 1	126	126	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 1
CAUSE OF INJURY	127	132	6	N	Valid ICD9 E code for an injury. If Diagnosis 1 is an injury 800-999.9.
PLACE OF INJURY	133	133	1	N	PCC place of injury code for Diagnosis 1 if Diagnosis 1 is an injury.
DIAGNOSIS 2	134	139	6	Y	ICD Dx 2. If this is a non-hospitalization visit, it is the 2nd diagnosis entered.
APC CODE 2	140	142	3	Y	APC Recode for diagnosis 2
CAUSE OF DX 2	143	143	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4 employment-related for Diagnosis 2

Item	Beg Col	End Col	Length	REQ	Description of Data Item
CAUSE OF INJURY	144	149	6	N	Valid ICD9 E code for an injury. If Diagnosis 2 is an injury 800-999.9.
PLACE OF INJURY	150	150	1	N	PCC place of injury code for Diagnosis 2 if Diagnosis 2 is an injury.
DIAGNOSIS 3	151	156	6	Y	ICD Dx 3. If this is a non-hospitalization visit, it is the 3rd diagnosis entered.
APC CODE 3	157	159	3	Y	Recode for diagnosis 3
CAUSE OF DX 3	160	160	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 3
CAUSE OF INJURY	161	166	6	N	Valid ICD9 E code for an injury. If Diagnosis 3 is an injury 800-999.9.
PLACE OF INJURY	167	167	1	N	PCC place of injury code for Diagnosis 3 if Diagnosis 3 is an injury.
DIAGNOSIS 4	168	173	6	Y	Dx 4. If this is a non-hospitalization visit, it is the 4th diagnosis entered.
APC CODE 4	174	176	3	Y	APC Recode for diagnosis 4
CAUSE OF DX 4	177	177	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 4
CAUSE OF INJURY	178	183	6	N	Valid ICD9 E code for an injury. If Diagnosis 4 is an injury 800-999.9.
PLACE OF INJURY	184	184	1	N	PCC place of injury code for Diagnosis 4 if Diagnosis 4 is an injury.
DIAGNOSIS 5	185	190	6	Y	ICD Dx 5. If this is a non-hospitalization visit, it is the 5th diagnosis entered.
APC CODE 5	191	193	3	Y	APC Recode for Diagnosis 5
CAUSE OF DX 5	194	194	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 5
CAUSE OF INJURY	195	200	6	N	Valid ICD9 E code for an injury. If Diagnosis 5 is an injury 800-999.9.
PLACE OF INJURY	201	201	1	N	PCC place of injury code for Diagnosis 5 if Diagnosis 5 is an injury.
DIAGNOSIS 6	202	207	6	Y	ICD Dx 6. If this is a non-hospitalization visit, it is the 6th diagnosis entered.
APC CODE 6	208	210	3	Y	APC Recode for Diagnosis 6
CAUSE OF DX 6	211	211	1	N	1-Hospital acquired, 2-alcohol-related, 3-battered child, 4-employment-related for Diagnosis 6

Item	Beg Col	End Col	Length	REQ	Description of Data Item
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.
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.

Item	Beg Col	End Col	Length	REQ	Description of Data Item
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
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

Item	Beg Col	End Col	Length	REQ	Description of Data Item
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.



## Appendix B: PGEN/VGEN Options

Below is a table of PGEN/VGEN selection, sort, and print options organized by Groups of Related Items.

Group	Field	PGEN 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	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	7	11	10	7	11	10
Patient Demographics	Age in Months	8	12	11	8	12	11
Patient Demographics	Father's Name		13	12		13	12

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Mother's Name		14	13		14	13
Patient Demographics	Veteran Status Y/N	9	15	14	9	15	14
Patient Demographics	Date of Death	10	16	15	10	16	15
Patient Demographics	Date Patient Establishe	11	17	16	11	17	16
Patient Demographics	Mlg Address-Street		18	17		18	17
Patient Demographics	Mlg Address-State	12	20	18	12	20	18
Patient Demographics	Mlg Address-State Abbrv		21	19		21	19
Patient Demographics	Mlg Address-Zip	13	22	20	13	22	20
Patient Demographics	Total Household Income	15	29	22	14	27	21
Patient Demographics	Total in Household	17	30	23	15	28	22
Patient Demographics	Community	19	33	24	18	30	23
Patient Demographics	Tribe	20	34	25	19	31	24
Patient Demographics	County of Residence	21	35	26	20	32	25

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Eligibility Status	24	38	29	23	35	28
Patient Demographics	Beneficiary Class	25	39	30	24	36	29
Patient Demographics	HRN Record Status	26	40	31	25	37	30
Patient Demographics	HRN Disposition	27	41	32	26	38	31
Patient Demographics	Service Unit of PT	28	42	33	27	39	32
Patient Demographics	Indian Blood Quantum	32	43	34	32	40	33
Patient Demographics	SSN		5			5	
Patient Demographics	Mlg Address-City		19			19	
Patient Demographics	Mlg Address-Complete		23			23	
Patient Demographics	City of Birth		24			24	
Patient Demographics	Home Phone		25			25	
Patient Demographics	State of Birth		26			26	
Patient Demographics	Mother's Maiden Name		31			29	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Demographics	Name/Chart /SSN	1			1		
Patient Demographics	Living Pts	16			16		
Patient Demographics	Chart Facility	18			17		
Patient Demographics	Inactive Patients	29			28		
Patient Demographics	Exclude Inactive Pts	30			29		
Patient Demographics	Exclude Pts on a Regis	31			30		
Patient Demographics	Excl Incomplete Vis				31		
Patient Demographics	Employer of Patient	14	27	21			
Patient Demographics	Office Phone		28				
Patient Demographics	Next of Kin		32				
Patient Demographics	Ethnicity	6	10	9	6	10	9
Patient Demographics	Preferred Language	22	36	27	21	33	26
Patient Demographics	Preferred Reminder Met	23	37	28	22	34	27

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Patient Insurance Data	Medicare		1		1	1	
Patient Insurance Data	MEDICARE Y/N		2	1		2	1
Patient Insurance Data	Medicare Part B	2	3	2	2	3	2
Patient Insurance Data	Medicare Part D	3	4	3	3	4	3
Patient Insurance Data	Medicaid	1	5		4	5	
Patient Insurance Data	MEDICAID Y/N		6	4		6	4
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

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
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

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Patient Related Data	Immun Case Managerte	12	13	11	11	12	12
Other Patient Related Data	Other Specialty Provider	7	8		6	7	
Other Patient Related Data	Immunity Register Status	13	14	10	12	13	9
Patient Clinical Data Elements	Patient's Last Visit	1	1	1	1	1	1
Patient Clinical Data Elements	EDD/Any/All Types	2	2		2	2	
Patient Clinical Data Elements	Definitive EDD	3	3	2	3	3	2
Patient Clinical Data Elements	EDD (LMP)	4	4	3	4	4	3
Patient Clinical Data Elements	EDD (Ultrasound)	5	5	4	5	5	4
Patient Clinical Data Elements	EDD (Clinical Parameters)	6	6	5	6	6	5
Patient Clinical Data Elements	EDD (Method Unknown)	7	7	6	7	7	6
Patient Clinical Data Elements	EDD (Last Documented)	8	8	7	8	8	7
Patient Clinical Data Elements	Contraception Method	9	9		9	9	
Patient Clinical Data Elements	Last Menstrual Period	10	10	8	10	10	18

<b>Group</b>	<b>Field</b>	<b>PGEN SELECT ORDER</b>	<b>PGEN PRINT ORDER</b>	<b>PGEN SORT ORDER</b>	<b>VGEN SELECT ORDER</b>	<b>VGEN PRINT ORDER</b>	<b>VGEN SORT ORDER</b>
Patient Clinical Data Elements	Prob List Dx (ANY)	11	11		11	11	
Patient Clinical Data Elements	Prob List Dx (ACTIVE)	12	12		12	12	
Patient Clinical Data Elements	Prob List Dx (INACTIVE)	13	13		13	13	
Patient Clinical Data Elements	Problem List Narrative		14			14	
Patient Clinical Data Elements	Problem Date of Onset	14	15		14	15	
Patient Clinical Data Elements	Family History Dx	15	16		15	16	
Patient Clinical Data Elements	Family Hx and Relation	16	17		16	17	
Patient Clinical Data Elements	Family History Relation	17	18		17	18	
Patient Clinical Data Elements	Family Hx Narrative		19			19	
Patient Clinical Data Elements	Family Hx Description		20			20	
Patient Clinical Data Elements	Hx of Surgery	18	21		18	21	
Patient Clinical Data Elements	BMI (Last calculated)	19	22	9	19	22	9
Patient Clinical Data Elements	Formula Started (Days)	20	23	10	20	23	10



<b>Group</b>	<b>Field</b>	<b>PGEN SELECT ORDER</b>	<b>PGEN PRINT ORDER</b>	<b>PGEN SORT ORDER</b>	<b>VGEN SELECT ORDER</b>	<b>VGEN PRINT ORDER</b>	<b>VGEN SORT ORDER</b>
Patient Clinical Data Elements	Breast Feeding Stopped	21	24	11	21	24	11
Patient Clinical Data Elements	Solids Food Started (D)	22	25	12	22	25	12
Most Recent of Clinical Items	Date PL Last Reviewed	1	1	1			
Most Recent of Clinical Items	Date PL Last Updated	2	2	2			
Most Recent of Clinical Items	No Active Problems (Date Last)	3	3	3			
Most Recent of Clinical Items	PL Review Provider (Last)	4	4	4			
Most Recent of Clinical Items	PL Update Provider (Last)	5	5	5			
Most Recent of Clinical Items	Prov No Active Prob (Last)	6	6	6			
Most Recent of Clinical Items	Date Allergy list Reviewed	7	7	7			
Most Recent of Clinical Items	Allergy List Rev Prov	8	8	8			
Most Recent of Clinical Items	Most Recent TOBACCO HF	9	9	9	1	1	1
Most Recent of Clinical Items	Most Recent TB STATUS HF	10	10	10	2	2	2
Most Recent of Clinical Items	Most Recent ALCOHOL HF	11	11	11	3	3	3

<b>Group</b>	<b>Field</b>	<b>PGEN SELECT ORDER</b>	<b>PGEN PRINT ORDER</b>	<b>PGEN SORT ORDER</b>	<b>VGEN SELECT ORDER</b>	<b>VGEN PRINT ORDER</b>	<b>VGEN SORT ORDER</b>
Most Recent of Clinical Items	Most Recent STAGED DM HF	12	12	12	4	4	4
Most Recent of Clinical Items	Most Recent Barriers HF	13	13	13	5	5	5
Most Recent of Clinical Items	Most Recent LEARNING PRE	14	14	14	6	6	6
Most Recent of Clinical Items	Most Recent RUBELLA HF	15	15	15	7	7	7
Most Recent of Clinical Items	Most Recent Activity L	16	16	16	8	8	8
Most Recent of Clinical Items	Date Last Alcohol Screen	17	17	17			
Most Recent of Clinical Items	Date Last Depression Scr	18	18	18			
Most Recent of Clinical Items	Date Last IPV/DV Screen	19	19	19			
Most Recent of Clinical Items	Date Last Colonoscopy	20	20	20			
Most Recent of Clinical Items	Date Last Flex Sig	21	21	21			
Most Recent of Clinical Items	Date Last Mammogram	22	22	22			
Most Recent of Clinical Items	Date Last PAP Smear HF	23	23	23			
Most Recent of Clinical Items	Date Last Tobacco Screening	24	24	24			

<b>Group</b>	<b>Field</b>	<b>PGEN SELECT ORDER</b>	<b>PGEN PRINT ORDER</b>	<b>PGEN SORT ORDER</b>	<b>VGEN SELECT ORDER</b>	<b>VGEN PRINT ORDER</b>	<b>VGEN SORT ORDER</b>
Most Recent of Clinical Items	Date Last Fall Risk Assess	25	25	25			
Most Recent of Clinical Items	Date Last Tonometryen	26	26	26			
Most Recent of Clinical Items	Date Last Vision Exam	27	27	27			
Most Recent of Clinical Items	Date Last Head Circumf	28	28	28			
Most Recent of Clinical Items	Date Last Dental Exam	29	29	29			
Most Recent of Clinical Items	Date Last Diabetic Foo	30	30	30			
Most Recent of Clinical Items	Date Last Osteo Scrn	31	31	31			
Most Recent of Clinical Items	Date Med Last Reviewed	36	36	36			
Most Recent of Clinical Items	Date MED Last Updated	37	37	37			
Most Recent of Clinical Items	No Active Meds (Date Last)	38	38	38			
Most Recent of Clinical Items	MED Review Provider (Last)	39	39	39			
Most Recent of Clinical Items	MED Update Provider (Last)	40	40	40			
Most Recent of Clinical Items	Prov No Active MED (Last)	41	41	41			

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
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
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

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
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	Chart Audit Status				15	22	22
Visit Demographics	Visit Auditor				16	23	23
Visit Demographics	VCN Present				17	24	24
Visit Demographics	3rd Party Billed?				18	25	25
Visit Demographics	3P Bill #					26	26

<b>Group</b>	<b>Field</b>	<b>PGEN SELECT ORDER</b>	<b>PGEN PRINT ORDER</b>	<b>PGEN SORT ORDER</b>	<b>VGEN SELECT ORDER</b>	<b>VGEN PRINT ORDER</b>	<b>VGEN SORT ORDER</b>
Visit Demographics	Appt/Walk-In				19	27	27
Visit Demographics	Flag				20	28	28
Visit Demographics	DRG				21	29	29
Visit Demographics	Level of Service				22	30	30
Visit Demographics	Eval&Management CPT				23	31	31
Visit Demographics	Amount Billed					32	
Visit Demographics	Activity/Travel Time					33	
Visit Demographics	Day of Week				24	34	32
Visit Demographics	NDW Export Date				25	35	33
Visit Demographics	NDW Exported?				26	36	34
Visit Demographics	Dt Visit Exported (PCC					37	
Visit Provider Data Elements	Prim Prov Time Seen					1	1
Visit Provider Data Elements	Primary Prov Name				1	2	2

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/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	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Diagnosis/Procedure Data	Stage of Dx (POV)				4	5	
Visit Diagnosis/Procedure Data	Present on Admission (PO				5	6	
Visit Diagnosis/Procedure Data	Alcohol/Work Related				6	7	
Visit Diagnosis/Procedure Data	Cause of DX (POV)				7	8	
Visit Diagnosis/Procedure Data	Cause of Injury				8	9	
Visit Diagnosis/Procedure Data	Place of Injury				9	10	
Visit Diagnosis/Procedure Data	Operation Code				10	11	
Visit Diagnosis/Procedure Data	Operation CPT Code				11	12	
Visit Diagnosis/Procedure Data	Operation Prov Narr)					13	
Visit Diagnosis/Procedure Data	Operation ICD Narr					14	
Visit Diagnosis/Procedure Data	Operations w/dates					15	
Visit Diagnosis/Procedure Data	Operating Prov				12	16	2
Visit Diagnosis/Procedure Data	CPT Code				13	17	



Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
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

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Visit Labs/Meds Clinical	Lab Test/Loinc Codes				9	11	
Other Visit Clinical Items	Problem List Reviewed?				1	1	
Other Visit Clinical Items	Problem List Updated?				2	2	
Other Visit Clinical Items	No Active Problems?				3	3	
Other Visit Clinical Items	Prov Rev Prob List				4	4	
Other Visit Clinical Items	Prov Updating PL				5	5	
Other Visit Clinical Items	Prov Updating NAP				6	6	
Other Visit Clinical Items	Allergy List Reviewed?				7	7	
Other Visit Clinical Items	Prov Rev Allergy List				8	8	
Other Visit Clinical Items	Measurements				9	9	
Other Visit Clinical Items	Pain Measurement Value				10	11	
Other Visit Clinical Items	Waist Circ Value				11	12	1
Other Visit Clinical Items	Dental ADA Codes				12	13	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Visit Clinical Items	Radiology Exam				13	14	
Other Visit Clinical Items	Any Immunization Administered				14	15	
Other Visit Clinical Items	Immunizations/Series					16	
Other Visit Clinical Items	Immunization Provider				14	17	
Other Visit Clinical Items	Immunization Lot				15	18	
Other Visit Clinical Items	VFC Eligibility				16	19	
Other Visit Clinical Items	Skin Tests/Readings					20	
Other Visit Clinical Items	Immunizations				17	21	
Other Visit Clinical Items	Exams				18	22	
Other Visit Clinical Items	Treatments Provided				20	24	
Other Visit Clinical Items	Med List Reviewed?				21	25	
Other Visit Clinical Items	Medication List Update				22	26	
Other Visit Clinical Items	No Active Medications				23	27	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Visit Clinical Items	Prov Rev MED List				24	28	
Other Visit Clinical Items	Prov Updating Med List				25	29	
Other Visit Clinical Items	Prov Updating NAM				26	30	
Other Visit Clinical Items	Education Topics				27	31	
Other Visit Clinical Items	Education Provider				11	32	
Other Visit Clinical Items	Education Comments					33	
Other Visit Clinical Items	Education Length (min)				12	34	
Other Visit Clinical Items	Education Ind/Grp					35	
Other Visit Clinical Items	Education GOAL Status				13	36	
Other Visit Clinical Items	Education Objectives				14	37	
Other Visit Clinical Items	Education Prov Disc				15	38	
Other Visit Clinical Items	Health Factors				16	39	
Other Visit Clinical Items	HF Quantity/Score				17	40	

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Other Visit Clinical Items	Hlth Factor by Categor				18	41	
Other Visit Clinical Items	TIU Notes						
Other Visit Clinical Items	Treatment Contract				19	43	
Other Visit Clinical Items	EKG's				20	44	
Other Visit Clinical Items	Diagnostic Procedure				21	47	
Other Visit Clinical Items	Infant Feeding Choice				22	48	
Other Visit Clinical Items	TIU Note Title				22	42	
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

Group	Field	PGEN SELECT ORDER	PGEN PRINT ORDER	PGEN SORT ORDER	VGEN SELECT ORDER	VGEN PRINT ORDER	VGEN SORT ORDER
Inpatient Visit Specific	Discharge Type				7	7	7
Inpatient Visit Specific	Length of Stay				8	8	8
ER Specific Data Items	ER Urgency				1	1	1
ER Specific Data Items	ER Means of Arrival				2	2	2
ER Specific Data Items	ER Other Means of Arriva					3	3
ER Specific Data Items	ER Entered ER BY				3	4	4
ER Specific Data Items	ER Informant					5	5
ER Specific Data Items	ER Notified				4	6	6
ER Specific Data Items	ER Disposition				5	7	7
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

<b>Group</b>	<b>Field</b>	<b>PGEN SELECT ORDER</b>	<b>PGEN PRINT ORDER</b>	<b>PGEN SORT ORDER</b>	<b>VGEN SELECT ORDER</b>	<b>VGEN PRINT ORDER</b>	<b>VGEN SORT ORDER</b>
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	

## Appendix C: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: <http://security.ihs.gov/>.

The ROB listed in the following sections are specific to RPMS.

### C.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

#### C.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."



RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform 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 jobs or by divulging information to anyone not authorized to know that information.

### C.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

### C.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- 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.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

#### C.1.4 Confidentiality

RPMS 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 Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

#### C.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.

- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

### C.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

### C.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords 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.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per 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.

### C.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

### C.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

### C.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

### C.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

### C.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

### C.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) 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 RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

## C.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- 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, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.

- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

### C.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (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 backup 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, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.



# Glossary

**@ symbol**

This symbol (Shift+2) has two functions: (1) to delete an entry and (2) to separate a date and time.

**Acute**

Used to describe a condition that lasts for a short time. Used in contrast to chronic.

**Append**

To add additional data items to an existing visit, usually at the end of typing the data.

**Billable Visit**

A visit from a patient with third-party insurance coverage that a hospital/clinic can bill services.

**Best Practice Prompts**

Best Practice Prompts are a set of clinical messages related to procedures such as laboratory tests, immunizations, procedures, etc. that are generally recommended for a subset of the population who share a common diagnosis (e.g. Asthma, CVD). They display in a variety of places, including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

Users can turn on (activate) and display BP Prompts on Health Summaries, similar to the Health Maintenance Reminder function.

**Billable Visit**

A visit from a patient with third-party insurance coverage that a hospital/clinic can then bill for services.

**Caret (^)**

The caret symbol (^) obtained by pressing Shift+6. Commonly used in RPMS character-based interfaces to exit out of a routine or to back up from the previous field.

**Chart Number**

A unique numerical identifier assigned to each patient. This is also referred to as Health Record Number.

**Chronic**

Used to describe a condition that has an indefinite duration or with a frequent occurrence. Used in contrast to acute.

**Clinical**

To do with treatment in or as a clinic: involving or concerned with direct observation and treatment of patients.

**Command**

The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

**Community of Service**

The community where the encounter took place.

**Community of Residence**

The community where the patient resides.

**CPT Code**

Current Procedural Terminology code. Used to identify procedures provided during an encounter and for billing outpatient services provided.

**Database**

A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps reduce the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

**Default Response**

Many of the prompts in the RPMS applications contain responses that can be activated simply by pressing ENTER. For example: “Do you really want to quit? No//.” Pressing ENTER tells the system you do not want to quit. “No//” is the default response. The default is generally set to the most frequently used response for the prompt.

**Designated Primary Care Provider (DPCP)**

The primary care provider designated for the patient. This is distinguished from a primary or secondary visit provider for a specific visit.

**Device**

The name of the printer you want the system to use when printing information. Home means the computer screen.

**DX**

Common abbreviation for “diagnosis”

**EDC**

Expected/estimated date of confinement; that is, the expected/estimated due or delivery date for a pregnancy.

**EDD**

Expected/estimated date of delivery.

**Export**

To format data so it can be used by another application.

**Fields**

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, a prompt requesting specific types of data displays. There are nine basic field types in RPMS programs, and each collects a specific type of information.

**Free Text Field**

This field type will accept numbers, letters, and most of the symbols on the keyboard. There may be restrictions on the number of characters the user is allowed to type.

**Health Factors**

Health factors are data elements utilized by RPMS to record health status information about the patient. Current Smoker, Status Unknown is an example of a health factor in the Tobacco (Smoking) category. Health factor data are recorded in the PCC V Health Factor file. For a current list of health factors, see the Health Summary User Manual.

**Health Maintenance Reminders (HMRs)**

Health Maintenance Reminders are a set of clinical reminders related to procedures, such as laboratory tests, immunizations, procedures etc. that are generally recommended for a subset of the population. HMRs display in a variety of places including the Health Summary, Supplements, and the Patient Record in both EHR and iCare.

**Health Record Number (HRN)**

A unique numerical identifier assigned to each patient. This is also referred to as a Chart Number.

**Health Summary**

The Health Summary is a patient report displaying related data built from the PCC V files, such as laboratory and pharmacy. There are many different types of Health Summaries available to users at each site. Users are also able to design a Health Summary on-the-fly from the available components.

**HRN**

Health Record Number, also referred to as a Chart Number

**HS**

Health Summary: a summary of a patient's medical care. The RPMS PCC is distributed with several standard Health Summaries, but can be customized. Examples of standard Health Summaries are: Adult Regular, Behavioral Health, CHR, and Dental.

**HX**

Abbreviation for History. History is an event taking place in the past, such as surgery, immunizations, etc.

**ICD**

International Classifications of Diseases. This is a national coding system primarily used for: (1) classifying morbidity and mortality information for statistical purposes, (2) indexing of hospital records by disease and operations, and (2) data storage and retrieval. In addition, this is the coding system physicians must use for billing purposes of Medicare, Medicaid, and private insurance for services rendered.

**Interfaces**

A boundary where two systems can communicate. RPMS applications contain both character-based ("roll-and-scroll") and graphical user (GUI) interfaces. PCC Data Entry is an example of a character-based interface; RPMS EHR is an example of a GUI.

**Menu**

The menu is a list of different options you may select at a given time. To choose a specific task, select one of the items from the list by typing the established abbreviation or synonym at the appropriate prompt. A menu option followed by the ellipsis (...) indicates there are submenus.

**Mnemonic**

An abbreviation used to name a menu option or report used in the RPMS character-based packages. RPMS PCC data entry mnemonics to enter a data type can be two, three, or four characters, e.g., BP.

**Narrative Description**

A detailed description given using words rather than codes.

**Patient Care Component (PCC)**

PCC is the core of the RPMS applications and functions as a clinical data repository. Most RPMS applications “pass” key data elements to PCC, stored in V (visit) files, e.g., V Lab. Other data is entered directly into V files, e.g., V Patient Education, BP, WT (weight), HT (height), HC (head circumference) etc.

**Patient Wellness Handout (PWH)**

The Patient Wellness Handout is a type of Health Summary that is directed to the patient. It displays personal medical information in easy-to-interpret language.

**PGEN**

Abbreviation for Patient General Retrieval Report. PGEN is the Patient General Retrieval report located in PCC Management Reports. The General Retrieval reports allow users to create on-the-fly reports by choosing specific data elements to select, print, and sort.

**Problem List**

A list of important/chronic medical, social, or psychiatric problems, related notes, and treatment plans for a patient that are recorded and updated as part of the patient’s health record. The Health Summary has two categories: Active and Inactive.

**POV**

Purpose of Visit - one or more diagnoses (ICD codes) identified as the reason for the patient’s visit, and recorded in the PCC V POV file.

**Prompt**

Text displayed onscreen indicating that the system is waiting for input to a field. Once the computer displays a prompt, it waits for you to add some specific information.

**Provider**

One who provides direct medical care to a patient, i.e., physician, nurse, mid-level provider).

**Provider Narrative**

A detailed description of the patient’s conditions, using words rather than codes.

**QMan**

Short for Query Manager, QMan is a VA-based search utility that allows users to construct detailed searches of the RPMS database. QMan is part of the integrated PCC suite.

**Retrieval**

To obtain data from another location.

**Roll-and-Scroll**

The roll-and-scroll (character-based) data entry format captures the same information as the screen format, but uses a series of prompts for recording data. This is typically the most efficient method for data entry.

**RPMS**

Resource and Patient Management System; a suite of integrated software packages used by IHS

**Secondary Providers**

A provider for a patient's visit other than the patient's primary visit provider. A patient visit might have multiple secondary providers, depending on the services provided.

**Security Key**

A means of securing menus to limit accessibility. To use certain functions, such as those in a manager's menu, the user must be assigned the appropriate key by the site manager.

**Select**

To choose one option from a list of options.

**Site Manager**

The person in charge of setting up and maintaining the technical aspects of the RPMS at the facility or area level.

**Specialty Providers**

Defined through the Designated Specialty Provider Management (BDP) application.

**Submenu**

A menu that is accessed through another menu. A menu option followed by the ellipsis (...) indicates there are submenus.

**Supplement**

A supplement is a type of modified Health Summary that is related to a specific condition, such as diabetes or HIV/AIDS. It displays personal medical information related to that condition.

**Tally**

To make a count, total, or subtotal a number of items.

**VGEN**

Short for Visit General Retrieval Report. VGEN is one of the search utilities that enable users to construct searches of the RPMS database. The General Retrieval reports allow users to create on-the-fly reports by choosing specific data elements to select, print and sort by.

## Acronym List

<b>CAH</b>	Critical Access Hospital
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CPT</b>	Current Procedural Terminology
<b>DOB</b>	Date of Birth
<b>DOD</b>	Date of Death
<b>DOS</b>	Date of Service
<b>EHR</b>	Electronic Health Record
<b>EP</b>	Eligible Professional
<b>IHS</b>	Indian Health Service
<b>MU</b>	Meaningful Use
<b>PCC</b>	Patient Care Component
<b>RPMS</b>	Resource and Patient Management System



## Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

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