



SPINAL CORD DYSFUNCTION  
(SCD)  
USER MANUAL

Version 2.0

February 2000

Revised October 2003



## Revision History

Date	Revision	Page	Description
December 2002	Revision		Document reviewed and updated.
January 2003	Patch SPN*2.0*19		Enhancements
October 2003	Patch SPN*2.0*21		Enhancements/Revisions
		1	Added Text (Aggregate Statistical Reports by care type)
		5	New option - Inquire to a Registry Patient
		5	New option – Aggregate Outcomes Report
		7	New option and updated text
		18	Second Note added – “Depending on the Care Type you have selected, you will see only those score types pertaining to that particular Care Type.”
		31	New option – Aggregate Outcomes Report
		34-40	New option, text, and report examples (Aggregate Outcomes Report)



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# Introduction

## Overview

The Spinal Cord Dysfunction (SCD) package, a component of the Veterans Health Information Systems Technology Architecture (VistA), is a software product that permits the identification and tracking of patients with a spinal cord dysfunction due to trauma or disease and the medical resources utilized during their treatment. The programs and files support the maintenance of a local and national registry for patients with a spinal cord dysfunction. The package also provides clinical, administrative, and ad hoc reports for medical center use.

The SCD package accesses several other VistA files, which contain information concerning diagnosis, prescriptions, lab tests, radiology exams, hospital admissions, and clinic, visits. This allows your clinical staff to take advantage of the wealth of clinical data supported through VistA.

The SCD package accomplishes the following:

Uploads patient data to the National SCD Registry. The National Registry is used to provide VA-wide review of patient demographics, clinical aspects of disease, and resource utilization involved in providing care to patients.

Provides a variety of management reports for local use, including <sup>1</sup>aggregate statistical reports by care type, patients lost to follow-up, frequency of visits, and volume of lab tests and prescriptions per patient.

The ad hoc reporting capability provides the users with the ability to design their own custom reports.

Several functional measures/scales are provided with the package (CHART, FAM, DIENER, DUSOI) in addition to the FIM and the Self Report of Function. For multiple sclerosis patients, two measures/scales are available (the KURTZKE and the EDSS). Each of these scales/measures allows patient progress to be tracked over time.

---

<sup>1</sup> SPN\*2.0\*21 – Added Text (aggregate statistical reports by care type).

## Functional Description

The Spinal Cord Dysfunction software:

Allows efficient entry of data into the local registry and outcome modules.

Provides a watch list of those patients currently not being seen at the medical center.

Tracks the utilization of resources used during treatment.

Extracts data on outpatient visits, inpatient activity, drugs, radiology, and lab tests specified by the SCD Expert Panel (EP) and the SCD Advisory Board.

Transports local data to the National SCD database at Austin, Texas.

# Package Management

This package does not require special procedures for patient privacy other than that required by all VistA packages. All patients contribute data to the VA's National SCD Registry.

Any research conducted using the National Registry, which requires absolute patient identification will be expected to secure consent from those patients.

Access to the package on a local level is restricted to users associated with the package. For the IRM Applications Coordinator, as well as the SCI Coordinator, the SCD Package Management Menu is restricted further to those holding the SPNL SCD MGT. For all users, access to reports with patient sensitive data is further restricted to those holding the SPNL SCD PTS key (see Package Operation for specific options).



# Package Operation

The SCD package is comprised of the SCD Coordinator Menu to be given to the clinician or SCI Coordinator, and the SCD Package Management Menu for the IRM Applications Coordinator and the SCI Coordinator. Both of these menus are contained under the primary package menu, Spinal Cord Dysfunction.

## **SCD Coordinator Menu...**

Registration and Health Care Information

<sup>1</sup>Clinical Information

Inpatient Rehabilitation Outcomes

Outpatient Rehabilitation Outcomes

Annual Evaluation Outcomes

Continuum of Care Outcomes

SCD Reports Menu...

Change your Division Assignment

Inquire to an Outcome

Edit Non-conforming Outcome

<sup>2</sup>Inquire to a Registry Patient

## **SCD Reports Menu...**

SCI/SCD Admissions

<sup>3</sup>Aggregate Outcomes Report

Applications for Inpatient Care

SCI/SCD Discharges

Filtered Reports...

SCD Ad Hoc Reports...

Registration Ad Hoc Report

Self Report of Function Ad Hoc Report

FIM Ad Hoc Report

ASIA Ad Hoc Report

CHART Ad Hoc Report

FAM Ad Hoc Report

DIENER Ad Hoc Report

DUSOI Ad Hoc Report

Multiple Sclerosis Ad Hoc Report

Comprehensive Outcomes Ad Hoc Report

Basic Patient Information (132 Column)

Breakdown of Patients

CHART/FAM/DIENER/DUSOI Scores

Current Inpatients \*\*Locked: SPNL SCD PTS\*\*

Expanded Patient List (255 Column)

Patients with Future Appointments

Functional Independence Measures

---

<sup>1</sup> Patch SPN\*2.0\*19 - New option.

<sup>2</sup> Patch SPN\*2.0\*21 - New option.

<sup>3</sup> Patch SPN\*2.0\*21 - New option.

- Follow-Up (Last Annual Rehab Eval Received) **\*\*Locked: SPNL SCD PTS\*\***
- Follow-Up (Last Seen) **\*\*Locked: SPNL SCD PTS\*\***
- Health Summary **\*\*Locked: SPNL SCD PTS\*\***
- Inpatient/Outpatient Activity
- Inpatient/Outpatient Activity (Specific)
- New SCI/SCD Patients
- Mailing Labels
- Patient Listing
- Patient Listing (Sort by State and County)
- Registrant General Report
- Registrant Injury Report
- | <sup>1</sup>Self Report of Function
- Utilization Reports...
  - Laboratory Utilization
  - Laboratory Utilization (Specific)
  - Pharmacy Utilization
  - Pharmacy Utilization (Specific)
  - Radiology Utilization
- | Functional Status Scores
- | ICD9 Code Search
- | Print MS Help Text
- | MS (Kurtzke) Measures
- | MS Patient Listing
- | Patient Summary Report
- | Show Sites Where Patient has been Treated

**SCD Package Management Menu ... **\*\*Locked: SPNL SCD MGT\*\*****

- Edit Site Parameters
- Activate an SCD Registrant
- Delete an Outcome Record
- Delete Registry Record
- Enter/Edit Etiology SYNONYM
- Inactivate an SCD Registrant

Three of the above options (Laboratory Utilization, Pharmacy Utilization, Radiology Utilization) within the SCD Reports Menu were designed so that Laboratory, Pharmacy, and Radiology Service personnel can obtain statistical data without compromising patient confidentiality.

---

<sup>1</sup> Patch SPN\*2.0\*19 - New option.

# SCD Coordinator Functions

<sup>1</sup>The following options appear for selection.

REG	Registration and Health Care Information
CL	Clinical Information
IN	Inpatient Rehabilitation Outcomes
OUT	Outpatient Rehabilitation Outcomes
ANN	Annual Evaluation Outcomes
CON	Continuum of Care Outcomes
REP	SCD Reports Menu...
DIV	Change your Division Assignment
INQ	Inquire to an Outcome
OLD	Edit Non-conforming Outcome
<sup>2</sup> INQR	Inquire to a Registry Record

Screen borders indicate dialogue that is on the computer screen. User input is indicated in bold print. Use the return key and/or the up, down, and side arrows when navigating through the screens. Enter one (?) or two (??) question marks to get field descriptions (two question marks will give a more detailed description). Use the up-arrow (^) to exit the screen at any prompt.

**Note:** The following screens are examples only and not meant to reflect real data.

---

<sup>1</sup> Patch SPN\*2.0\*19- New options added and updated text.

<sup>2</sup> Patch SPN\*2.0\*21 – New option added.

## Registration and Health Care Information

<sup>1</sup>The Registration and Health Care Information option is used to enter a new registrant into the SCD local registry or edit an existing registrant. Information consists of patient and administrative data describing the patient's dysfunction history and registration profile.

Select SCD Coordinator Menu Option: **Registration** and Health Care Information

Select SCD (SPINAL CORD) REGISTRY PATIENT:

SCD REGISTRY	REGISTRATION SCREEN	DECEASED:	PAGE 1 OF 2
PATIENT:	SSN:	DOB:	
VA SCI INDICATOR (MAS):	PARAPLEGIA-NONTRAUMATIC	PHONE:	
<hr/>			
VA SCI STATUS:	PARAPLEGIA-TRAUMATIC	DATE OF ORIGINAL	
REGISTRATION:			
SCI NETWORK (Y/N):	YES	JUL 16, 2002	
REGISTRATION STATUS:	EXPIRED	DATE OF LAST REVIEW	
		AUG 20, 2002@14:15	
CAUSE OF SCD (Etiology)	DATE OF ONSET	DESCRIBE OTHER	
VEHICULAR	JUL 16, 2002		
SCI LEVEL: C05	EXTENT OF SCI: COMPLETE		
REMARKS:	MS Subtype:		
<hr/>			
Exit	Save	Next Page	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.			
COMMAND:	Press <PF1>H for help	Insert	

<sup>1</sup> Patch SPN\*2.0\*19 – Updated text with revised displays.

SCD REGISTRY HEALTH CARE SCREEN

PATIENT:

PAGE 2 OF 2

SSN:

DOB:

---

AMOUNT VA IS USED: VA ONLY

PRIMARY CARE VA: SAN DIEGO HCS

ANNUAL REHAB VA: SAN DIEGO HCS

ADDITIONAL CARE RECEIVED AT VAMC:

NON-VA SOURCE OF CARE:

PRI CARE PROV:

SCD-R COORD: G

REFERRAL SOURCE: OTHER VA

REFERRAL VA: LONG BEACH HCS

INITIAL REHAB SITE: VA FACILITY WITH SCI CENTER DATE OF D/C: OCT 2,2000

DIVISION

SAN DIEGO VAMC

ANNUAL REHAB EVAL: OFFERED  
AUG 2,2002

RECEIVED  
AUG 3,2002

NEXT DUE  
AUG 3,2003

---

Exit

Save

Refresh

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

COMMAND:

Press <PF1>H for help

Insert

## Clinical Information

The Clinical Information option allows you to enter findings from a clinical evaluation. (The information contained in this option is not required; therefore, use of it is entirely up to the medical center.) There are **two** screens associated with this module.

<sup>1</sup>Select SCD (SPINAL CORD) REGISTRY PATIENT: **CATT,FELIX**

CLINICAL REGISTRATION MODULE	PHYSICAL IMPAIRMENT SCREEN	PAGE 1 OF 2
PATIENT:	SSN:           DOB:	
	VA SCI FLAG:	
<hr/>		
MEMORY/THINKING AFFECTED (Y/N): NO	EYES AFFECTED (Y/N): NO	
ONE ARM AFFECTED (Y/N): NO	ONE LEG AFFECTED (Y/N): NO	
BOTH ARMS AFFECTED (Y/N): YES	BOTH LEGS AFFECTED (Y/N): YES	
BOWEL AFFECTED (Y/N): YES	BLADDER AFFECTED (Y/N): YES	
OTHER BODY PART AFFECTED (Y/N): NO	DESCRIBE OTHER:	
<<1-Full Useful Movement>>	<<1-Full Feeling>>	
<<2-Some Useful Movement>>	<<2-Some Feeling>>	
<<3- No Useful Movement>>	<<3- No Feeling>>	
EXTENT OF MOVEMENT: NO USEFUL MOVEMENT	EXTENT OF FEELING: NO FEELING	
HAD AMPUTATION (Y/N)? : NO	HAD BRAIN INJURY (Y/N)? : NO	
<hr/>		
Exit	Save	Next Page    Refresh
Enter a command or '^' followed by a caption to jump to a specific field.		
COMMAND: N	Press <PF1>H for help	Insert

CLINICAL REGISTRATION MODULE	CLINICAL CARE	PAGE 2 OF 2
PATIENT:	SSN:           DOB:	
	VA SCI FLAG:	
<hr/>		
BWL CARE REMB: YES	DATE CERT.: APR 4,1999	PROVIDER: SMITH,L
ANNUAL REHAB EVAL:   OFFERED	RECEIVED	NEXT DUE
JAN 7,1997	JAN 8,1997	JAN 8,1998
DEC 20,1999	DEC 20,1999	DEC 19, 2000
<hr/>		
Exit	Save	Refresh

<sup>1</sup> Patch SPN\*2.0\*19 – Revised displays.

# <sup>1</sup>Inpatient Rehabilitation Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records for inpatient rehabilitation episodes of care. An episode of care consists of a series of outcome records with the same care start date and the same care end date.

Select SCD (SPINAL CORD) REGISTRY PATIENT: DAVIDSON, HARLEY

```
Current INPATIENT Episode of Care

Patient:      SSN:
Care Start Date: 11/01/2002
-----
1) 11/01/2002  INPT START          ASIA
2) 11/01/2002  INPT START          FIM
-----
Select 1-2 of 2 to view/edit an outcome, '^' to exit, or
<A> to Add a new outcome
<P> to view/edit a Previous episode of care
Selection: 1
```

```
PATIENT:      SSN:      DOB:      FIM      PAGE 1 OF 4
-----
Care Start Date: 11/01/2002
Record Date: 11/01/2002

Score Type: INPT START          DISPOSITION: 6 SKILLED NURSING FACILITY

<<IT IS RECOMMENDED CLINICIANS OBTAINING FIM DATA ARE FIM CREDENTIALLED>>

Select CLINICIAN: HENDRICKS, BERTHA R

DAYS OF INTERRUPTED CARE:
-----
Exit      Save      Next Page      Refresh

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

COMMAND:      Press <PF1>H for help      Insert
```

<sup>1</sup> Patch SPN\*2.0\*19 – New option with revised displays.

FIM PAGE 2 OF 4 |

PATIENT: SSN: DOB:

---

Record Date: NOV 1,2002

Modified Independence -- Helper

1=Total Assist (Subject 0%+) 2=Maximal Assist (Subject=25%+)  
3=Moderate Assist (Subject=50%+) 4=Minimal Assist (Subject=75%+)  
5=Supervision

Independence -- No Helper

6=Modified Independence (Device) 7=Complete Independence  
(Timely,Safely)

SELF CARE

EATING: TOTAL ASSISTANCE DRESSING UPPER BODY: TOTAL ASSISTANCE  
GROOMING: TOTAL ASSISTANCE DRESSING LOWER BODY: TOTAL ASSISTANCE  
BATHING: TOTAL ASSISTANCE TOILETING: TOTAL ASSISTANCE

SPHINCTER CONTROL

BLADDER CONTROL: TOTAL ASSISTANCE BOWEL CONTROL: TOTAL ASSISTANCE

---

Exit Save Next Page Refresh

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

COMMAND: Press <PF1>H for help Insert

FIM PAGE 3 OF 4

PATIENT: SSN: DOB:

---

Record Date: NOV 1,2002

Modified Independence -- Helper

1=Total Assist (Subject 0%+) 2=Maximal Assist (Subject=25%+)  
3=Moderate Assist (Subject=50%+) 4=Minimal Assist (Subject=75%+)  
5=Supervision

Independence -- No Helper

6=Modified Independence (Device) 7=Complete Independence (Timely,Safely)

MOBILITY/TRANSFER

BED,CHAIR,WHEELCHAIR: TOTAL ASSISTANCE TOILET: TOTAL ASSISTANCE  
TUB,SHOWER: TOTAL ASSISTANCE

LOCOMOTION

WALK/WHEELCHAIR METHOD: WHEELCHAIR WALK/WHLCHAIR LEVEL: TOTAL ASSISTANCE  
STAIRS: TOTAL ASSISTANCE

---

Exit Save Next Page Refresh

<sup>1</sup> Patch SPN\*2.0\*19 – New display.

<sup>1</sup>FIM PAGE 4 OF 4 |

PATIENT:                   SSN:    DOB:

---

Record Date: NOV 1,2002

Modified Independence -- Helper

1=Total Assist (Subject 0%+)                   2=Maximal Assist (Subject=25%+)

3=Moderate Assist (Subject=50%+)           4=Minimal Assist (Subject=75%+)

5=Supervision

Independence -- No Helper

6=Modified Independence (Device)           7=Complete Independence (Timely,  
Safely)

COMMUNICATION

COMPREHENSION METHOD: BOTH                   COMPREHENSION LEVEL: TOTAL ASSISTANCE

EXPRESSION METHOD: BOTH                      EXPRESSION LEVEL: TOTAL ASSISTANCE

SOCIAL COGNITION

<sup>2</sup>SOCIAL INTERACTION: COMPLETE INDEPENDENCE   PROBLEM SOLVING: COMPLETE INDEPENDENCE

MEMORY: COMPLETE INDEPENDENCE

---

Exit        Save        Refresh

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

```

=====
Motor FIM Score:                               13.0
Cognitive FIM Score:                           23.0
Total FIM Score:                               36.0
=====

```

<sup>1</sup> Patch SPN\*2.0\*19 – New display.

<sup>2</sup> Patch SPN\*2.0\*21 – Updated Display

<sup>1</sup>You have entered an INPT START or OUTPT START FIM for a patient with a C1-C3 spinal cord injury level and a motor complete ASIA Impairment Scale of A or B. Do you want to see a goal setting template you can copy and paste into a CPRS progress note? No// **Y** (Yes)

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Press Return to continue// **<RET>**

	Bwl	Bldr	Trnsfr	Eat	DUB	DLB	Grmgng	Bathe	WC Prp
Start	1	1	1	1	1	1	1	1	1
Median	1	1	1	1	1	1	1	1	1
Exp	1	1	1	1	1	1	1	1	6
Range	1	1	1	1	1	1	1	1	1-6
Goal									

The median FIM Motor Score for individuals with similar SCIs at one year following their injury is 13 (interquartile range 13-18). Other important considerations for individuals with motor complete C1-C3 tetraplegia include ventilator use and inability to clear secretions, equipment, or assistance to provide pressure relief and/or positioning, and communication equipment or assistance. Accessible public transportation or an attendant-operated van with lift and tie-downs is needed. The veteran should be able to instruct all aspects of care, but will need total assistance for homemaking.

<sup>1</sup> Patch SPN\*2.0\*19 – New display and text.

## <sup>1</sup>Outpatient Rehabilitation Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records for outpatient rehabilitation episodes of care. An episode of care consists of a series of outcomes records with the same care start date and the same care end date.

Select SCD (SPINAL CORD) REGISTRY PATIENT:

```
Current OUTPATIENT Episode of Care

Patient:      SSN:
  Care Start Date: 09/04/2002
-----
1) 09/04/2002  OUTPT START          ASIA
2) 09/04/2002  OUTPT GOAL           FIM
3) 09/04/2002  OUTPT INTERIM        FIM
4) 09/10/2002  OUTPT INTERIM        DIENER
5) 09/11/2002  OUTPT INTERIM        DUSOI
6) 09/28/2002  OUTPT START          FIM
-----
Select 1-6 of 6 to view/edit an outcome, '^' to exit, or
<A> to Add a new outcome
<P> to view/edit a Previous episode of care
```

---

<sup>1</sup> Patch SPN\*2.0\*19 – New option and screen captures.

## <sup>1</sup>Annual Evaluation Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records stemming from an annual evaluation. In this care type, therefore, the rehabilitation episode of care model is not utilized.

Select SCD (SPINAL CORD) REGISTRY PATIENT:

Annual Evaluation	
Patient:	SSN:
-----	
1)	01/02/2000 ASIA
2)	01/15/2000 Self Report of Function
3)	02/15/2000 FIM
4)	02/16/2000 ASIA
5)	02/19/2000 CHART
6)	02/21/2000 Self Report of Function
7)	02/21/2000 Self Report of Function
8)	03/01/2000 Self Report of Function
9)	03/15/2000 FIM
10)	03/19/2000 CHART
11)	03/21/2000 Self Report of Function
12)	04/01/2000 CHART
13)	04/15/2000 CHART
-----	
Select 1-13 of 32 to view/edit an outcome, '^' to exit, or press <Return> to see the next group <A> to Add a new outcome	
Selection:	

<sup>1</sup> Patch SPN\*2.0\*19 – New option with revised displays.

## <sup>1</sup>Continuum of Care Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records as part of a patient's continuum of care. A continuum of care outcome is not related to a discrete episode of inpatient or outpatient rehabilitation or an annual evaluation. In this care type, therefore, the episode of care model is not utilized.

Select SCD (SPINAL CORD) REGISTRY PATIENT:

Continuum of Care	
Patient:	SSN:
-----	
1)	03/29/1999 CHART
2)	04/15/1999 CHART
3)	05/30/1999 FIM
4)	06/13/1999 Self Report of Function
5)	07/31/1999 Self Report of Function
6)	08/15/1999 ASIA
7)	02/13/2000 CHART
8)	02/19/2000 ASIA
9)	03/15/2000 ASIA
10)	03/15/2000 CHART
11)	04/15/2000 CHART
12)	05/16/2000 ASIA
13)	06/15/2000 ASIA
-----	
Select 1-13 of 29 to view/edit an outcome, '^' to exit, or press <Return> to see the next group <A> to Add a new outcome	

<sup>1</sup> Patch SPN\*2.0\*19 – New option with revised displays.

## <sup>1</sup>Record Types

Within a given Care Type option (Inpatient Outcomes, Outpatient Outcomes, Annual Evaluation Outcomes, and Continuum of Care Outcomes), you may enter any of the seven different Record Types, which are:

1. Self Report of Function
2. FIM
3. ASIA
4. CHART
5. FAM
6. DIENER
7. DUSOI

**Note:** The Multiple Sclerosis type is displayed only if the patient has an etiology of MS.

The procedure for adding a new outcome record consists of selecting Care Type from the SCD Coordinator Menu, then selecting a patient, then pressing <A> to add a new outcome record, then answering the prompt for Score Type, selecting one of the following:

- |   |                      |
|---|----------------------|
| 1 | INPT START           |
| 2 | INPT GOAL            |
| 3 | INPT INTERIM         |
| 4 | INPT REHAB FINISH    |
| 5 | INPT FOLLOW/UP (END) |
| 6 | UNKNOWN              |

Select the score type you wish to enter/edit: **3**

**Note:** If you are creating a brand new episode of care, the software will automatically insert a score type of INPT START or OUTPT START, whichever the case may be on the very first outcome. Thereafter, the user will be prompted for score type on each subsequent outcome.

<sup>2</sup>**Note:** Depending on the Care Type you have selected, you will see only those score types pertaining to that particular Care Type.

Having selected #3 (INPT INTERIM), as an example, you will then be prompted to enter a Record Date for this outcome record.

Enter a New Record Date: **03/16/2000**

Upon entering a Record Date, you will be presented with a ScreenMan screen for data entry.

In the following pages are examples of data entry sessions for each of the eight different Record Types.

---

<sup>1</sup> Patch SPN\*2.0\*19 – New and updated Record Types.

<sup>2</sup> Patch SPN\*2.0\*21 – Second note added

## <sup>1</sup>Self Report of Function

SELF REPORT OF FUNCTION		PAGE 1 OF 3
PATIENT:	SSN:	DOB:
Care Start Date: 03/05/2000		Care End Date: 04/28/2000
Record Date: 03/16/2000		
Score Type: INPT INTERIM	DISPOSITION: 3 HOME ASSISTED	
RESPONDENT TYPE:		
<<1-Total Help or Never Do>>	<<2-Some Help>>	
<<3-Extra Time or Special Tool>>	<<4-No Extra Time or Help>>	
MOVE AROUND INSIDE HOUSE: TOTAL HELP OR	STAIRS: SOME HELP	
TRANSFER TO BED/CHAIR: TOTAL HELP OR	TRANSFER - TOILET: SOME HELP	
TRANSFER - TUB/SHOWER: EXTRA TIME OR	EATING: NO EXTRA TIME	
GROOMING: SOME HELP	BATHING: SOME HELP	
DRESSING UPPER BODY: TOTAL HELP OR	DRESSING LOWER BODY: SOME HELP	
TOILETING: TOTAL HELP OR	BLADDER MANAGEMENT: SOME HELP	
BOWEL MANAGEMENT: EXTRA TIME OR		
Exit	Save	Next Page Refresh
Enter a command or '^' followed by a caption to jump to a specific field.		
COMMAND:	Press <PF1>H for help Insert	

<sup>1</sup> Patch SPN\*2.0\*19 – New Record Type with revised displays.

```

                1SELF REPORT OF FUNCTION                PAGE 2 OF 3
PATIENT:                SSN:                DOB:
-----
Record Date: MAR 16,2000

    <<1-Without Help>>                <<2-With Help>>                <<3-Unable>>

        GET TO PLACES OUTSIDE OF HOME: WITH HELP
                SHOPPING: WITH HELP
    PLANNING AND COOKING OWN MEALS: WITH HELP
                DOING HOUSEWORK: WITH HELP
                HANDLING MONEY: WITHOUT HELP
-----
Exit    Save    Next Page    Refresh

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

COMMAND: n                Press <PF1>H for help    Insert

```

```

                SELF REPORT OF FUNCTION                PAGE 3 OF 3
PATIENT:                SSN:                DOB:
-----
Record Date: MAR 16,2000

        HELP DURING LAST 2 WEEKS: YES
    NUMBER OF HOURS OF HELP IN LAST 2 WEEKS: 30
    NUMBER OF HOURS OF HELP IN LAST 24 HOURS: 16

        <<1-Without Help>>                <<2-With Device>>
        <<3-Cannot Walk >>                <<4-Bedridden >>

        METHOD AMBULATION (WALKING): CANNOT WALK

        <<1-Manual >>                <<2-Motorized>>
        <<3-Does Not Use W/Chr>>                <<4-Bedridden>>

        METHOD AMBULATION (WHEELCHAIR): MOTORIZED
-----
Exit    Save    Refresh

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

COMMAND: S                Press <PF1>H for help    Insert

```

```

=====
Self report of function total score: 26.0
=====

```

<sup>1</sup> Patch SPN\*2.0\*19 – Updated report header.

## <sup>1</sup>Functional Independence Measure (FIM)

PATIENT:	FIM SSN:	DOB:	PAGE 1 OF 4
Care Start Date: 07/05/2001		Care End Date: 07/28/2001	
Record Date: 07/09/2001			
Score Type: INPT INTERIM	DISPOSITION: 4 MILITARY BARRACKS ASSISTED		
<<Enter '??' to see pre-existing Clinician entries>>			
<<IT IS RECOMMENDED CLINICIANS OBTAINING FIM DATA ARE FIM CREDENTIALLED>>			
Select CLINICIAN:			
This list will include everyone who works at the hospital.			
Type in the last name to get a short list to choose from.			
Exit	Save	Next Page	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.			
COMMAND: N	Press <PF1>H for help		Insert

<sup>1</sup> Patch SPN\*2.0\*19 – New Record Type with revised displays.

	<sup>1</sup> FIM	PAGE 2 OF 4
PATIENT:	SSN:	DOB:

---

Record Date: FEB 25,2000

Modified Independence - No Helper

1=Total Assist (Subject 0%+)	2=Maximal Assist (Subject=25%+)
3=Moderate Assist (Subject=50%+)	4=Minimal Assist (Subject=75%+)
5=Supervision	

Independence -- No Helper

6=Modified Independence (Device)	7=Complete Independence
----------------------------------	-------------------------

(Timely,Safely)

SELF CARE

EATING: MODERATE ASSISTANCE	DRESSING UPPER BODY: MODERATE ASSISTANCE
GROOMING: MAXIMAL ASSISTANCE	DRESSING LOWER BODY: MODERATE ASSISTANCE
BATHING: MODERATE ASSISTANCE	TOILETING: MAXIMAL ASSISTANCE

SPHINCTER CONTROL

BLADDER CONTROL: TOTAL ASSISTANCE	BOWEL CONTROL: TOTAL ASSISTANCE
-----------------------------------	---------------------------------

---

Exit      Save      Next Page      Refresh

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

COMMAND: **N** Press <PF1>H for help      Insert

	FIM	PAGE 3 OF 4
PATIENT:	SSN:	DOB:

---

Record Date: FEB 25,2000

Modified Independence -- Helper

1=Total Assist (Subject 0%+)	2=Maximal Assist (Subject=25%+)
3=Moderate Assist (Subject=50%+)	4=Minimal Assist (Subject=75%+)
5=Supervision	

Independence -- No Helper

6=Modified Independence (Device)	7=Complete Independence
----------------------------------	-------------------------

(Timely,Safely)

MOBILITY/TRANSFER

BED,CHAIR,WHEELCHAIR:	TOILET: COMPLETE INDEPENDENCE
TUB,SHOWER: COMPLETE INDEPENDENCE	

LOCOMOTION

WALK/WHLCHAIR METHOD: WHEELCHAIR	WALK/WHLCHAIR LEVEL: COMPLETE INDEPENDENCE
STAIRS: COMPLETE INDEPENDENCE	

---

Exit      Save      Next Page      Refresh

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

COMMAND: **N** Press <PF1>H for help      Insert

<sup>1</sup> Patch SPN\*2.0\*19 – Updated report header.



## <sup>1</sup>Craig Handicap Assessment and Reporting Technique (CHART)

CRAIG HANDICAP ASSESSMENT AND REPORTING TECHNIQUE (CHART)		PAGE 1 OF 1
PATIENT:	SSN:	DOB:
<hr/>		
Record Date: 02/19/2000		
DISPOSITION: 1 HOME UNASSISTED		
CRAIG HANDICAP ASSESSMENT AND REPORTING TECHNIQUE (CHART)		
PHYSICAL INDEPENDENCE (0-100): 78		
MOBILITY (0-100): 76		
OCCUPATION (0-100): 56		
SOCIAL INTERACTION (0-100): 76		
ECONOMIC SELF SUFFICIENCY (0-100): 78		
COGNITIVE INDEPENDENCE (0-100): 89		
		CHART TOTAL SCORE: 453
<hr/>		
Exit	Save	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.		
COMMAND: <b>E</b>	Press <PF1>H for help	Insert

<sup>1</sup> Patch SPN\*2.0\*19 – New Record Type with revised displays.

## <sup>1</sup>Functional Assessment Measure (FAM)

FUNCTIONAL ASSESSMENT MEASURE (FAM)		PAGE 1 OF 1
PATIENT:	SSN:	DOB:
<hr/>		
Record Date: 04/15/2000		
DISPOSITION: 4 MILITARY BARRACKS ASSISTED		
1 = Total Assistance	2 = Maximal Assistance	3 = Moderate Assistance
4 = Minimal Assistance	5 = Supervision	6 = Modified Independence
7 = Complete Independence		
EMPLOYABILITY: MINIMAL ASSISTANCE	AR TRANSFERS: MODERATE ASSISTANCE	
COMMUNITY ACCESS: MAXIMAL ASSISTANCE	READING: MODERATE ASSISTANCE	
SPEECH CLARITY: MODERATE ASSISTANCE	WRITING: MODERATE ASSISTANCE	
EMOTIONAL STATUS: MODERATE ASSISTANCE	ATTENTION: MODERATE ASSISTANCE	
SAFETY JUDGEMENT: MINIMAL ASSISTANCE	ORIENTATION: MINIMAL ASSISTANCE	
ADJ TO LIMITATION: MINIMAL ASSISTANCE	SWALLOWING: MINIMAL ASSISTANCE	
<hr/>		
Exit	Save	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.		
COMMAND:	Press <PF1>H for help	Insert

<sup>1</sup> Patch SPN\*2.0\*19 – New Record Type with revised displays.

## <sup>1</sup>Diener's Satisfaction with Life Scale (DIENER)

DIENER'S (1985) SATISFACTION WITH LIFE SCALE	PAGE 1 OF 1
PATIENT:                   SSN:                   DOB:	
<hr/>	
Care Start Date: 09/04/2002	
Record Date: 09/10/2002	
Score Type: OUTPT INTERIM	DISPOSITION: 4 MILITARY BARRACKS ASSISTED
DIENER'S (1985) SATISFACTION WITH LIFE SCALE	
DIENER COMPOSITE SCORE (0-35): 22	
<hr/>	
Exit	Save      Refresh
Enter a command or '^' followed by a caption to jump to a specific field.	
COMMAND:	Press <PF1>H for help      Insert

<sup>1</sup> Patch SPN\*2.0\*19 – New Record Type with revised displays.

# <sup>1</sup>Duke University Severity of Illness Index (DUSOI)

DUKE UNIVERSITY SEVERITY OF ILLNESS INDEX (DUSOI)		PAGE 1 OF 1
PATIENT:	SSN:	DOB:
<hr/>		
Care Start Date: 09/04/2002		
Record Date: 09/11/2002		
Score Type: OUTPT INTERIM	DISPOSITION: 5 ASSISTED LIVING FACILITY	
DUKE UNIVERSITY SEVERITY OF ILLNESS INDEX (DUSOI)		
DUSOI COMPOSITE SCORE (0-100): 99		
<hr/>		
Exit	Save	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.		
COMMAND:	Press <PF1>H for help Insert	

<sup>1</sup> Patch SPN\*2.0\*19 – New Record Type with revised displays.

# <sup>1</sup>American Spinal Injury Association (ASIA)

PATIENT:	SSN:	ASIA DOB:	PAGE 1 OF 2
Care Start Date: 07/05/2001    Care End Date: 07/28/2001			
Record Date: 07/07/2001			
Score Type: INPT START	DISPOSITION: 4 MILITARY BARRACKS ASSISTED		
ASIA IMPAIRMENT SCALE: C	ASIA COMPLETE/INCOMPLETE: INCOMPLETE		
TOTAL MOTOR SCORE: 65	TOTAL PIN PRICK SCORE: 65		
TOTAL LIGHT TOUCH SCORE: 45	ASIA HIGHEST NEURO LEVEL: T02		
Exit	Save	Next Page	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.			
COMMAND:	Press <PF1>H for help    Insert		

PATIENT:	SSN:	ASIA DOB:	PAGE 2 OF 2
Record Date: APR 7,1998			
NEUROLEVEL-SENSORY RIGHT: T02	NEUROLEVEL-SENSORY LEFT: T02		
NEUROLEVEL-MOTOR RIGHT: L04	NEUROLEVEL-MOTOR LEFT: L04		
PARTIAL PRESERVATION-SENSORY R: L04	PARTIAL PRESERVATION-SENSORY L: L04		
PARTIAL PRESERVATION-MOTOR R: L04	PARTIAL PRESERVATION-MOTOR L: L04		
COMMAND:	Press <PF1>H for help    Insert		

<sup>1</sup> Patch SPN\*2.0\*19 – Record Type with revised displays.

## <sup>1</sup>Multiple Sclerosis

Multiple Sclerosis	
PATIENT:	SSN:      DOB:
Care Start Date: 07/05/2001      Care End Date: 07/28/2001	
Record Date: 07/16/2001	
Score Type: INPT INTERIM	DISPOSITION: 1 HOME UNASSISTED
Select one of the following:	
1) Kurtzke Functional Systems Scale (FSS)	
2) Kurtzke Expanded Disability Status Scale (EDSS)	
Select the type of record you wish to enter/edit: 1	
COMMAND:	Press <PF1>H for help      Insert

<sup>1</sup>Patch SPN\*2.0\*19 – Record Type with revised displays.

## KURTZKE Functional System Scale (FSS)

KURTZKE FUNCTIONAL SYSTEM SCALE (FSS)		PAGE 1 OF 1
PATIENT:	SSN:	DOB:
<hr/>		
Record Date: JUL 16,2001		
?? for options		
PYRAMIDAL: 1 Abnormal signs without disability		
BRAINSTEM: 2 Moderate nystagmus or other mild disability		
SENSORY: 0 Normal		
CEREBRAL: 0 Normal		
CEREBELLAR: 3 Moderate trunk or limb ataxia (interferes with function)		
BWL/BLDDR: 4 Constant cath (and constant use of measure to evacuate stool)		
VISUAL: 0 Normal		
OTHER:		
<hr/>		
COMMAND:	Press <PF1>H for help	Insert

## KURTZKE Expanded Disability Status Scale (EDSS)

KURTZKE EXPANDED DISABILITY STATUS SCALE (EDSS)		PAGE 1 OF 1
PATIENT:	SSN:	DOB:
<hr/>		
Record Date: JUN 28,2000		
?? for options		
99.9 for Unknown		
EDSS score:		
4.5 1 FS grade 4; walk without aid or rest 300 m		
<hr/>		
Exit	Save	Refresh
Enter a command or '^' followed by a caption to jump to a specific field.		
COMMAND:	Press <PF1>H for help	Insert

## SCD Reports Menu

The SCD Reports Menu groups together the various reports and forms that can be printed with the SCD package.

### SCD Reports Menu ...

- SCI/SCD Admissions
- <sup>1</sup>Aggregate Outcomes Report
- Applications for Inpatient Care
- SCI/SCD Discharges
- Filtered Reports...
  - SCD Ad Hoc Reports...
    - <sup>2</sup>Registration Ad Hoc Report
    - Self Report of Function Ad Hoc Report
    - FIM Ad Hoc Report
    - ASIA Ad Hoc Report
    - CHART Ad Hoc Report
    - FAM Ad Hoc Report
    - DIENER Ad Hoc Report
    - DUSOI Ad Hoc Report
    - Multiple Sclerosis Ad Hoc Report
    - Comprehensive Outcomes Ad Hoc Report
  - Basic Patient Information (132 Column)
  - Breakdown of Patients
  - CHART/FAM/DIENER/DUSOI Scores
  - Current Inpatients
  - Expanded Patient List (255 Column)
  - Patients with Future Appointments
  - Functional Independence Measures
  - Follow-Up (Last Annual Rehab Eval Received)
  - Follow-Up (Last Seen)
  - Health Summary
  - Inpatient/Outpatient Activity
  - Inpatient/Outpatient Activity (Specific)
  - New SCI/SCD Patients
  - Mailing Labels
  - Patient Listing
  - Patient Listing (Sort by State and County)
  - Registrant General Report
  - Registrant Injury Report
  - Self Report of Function
  - Utilization Reports...
    - Laboratory Utilization
    - Laboratory Utilization (Specific)
    - Pharmacy Utilization
    - Pharmacy Utilization (Specific)

---

<sup>1</sup> Patch SPN\*2.0\*21 - New option.

<sup>2</sup> Patch SPN\*2.0\*19 – New options.

## Radiology Utilization

Functional Status Scores

ICD9 Code Search

Print MS Help Text

MS (Kurtzke) Measures

MS Patient Listing

Patient Summary Report

Show Sites Where Patient has been Treated

## SCD Reports Menu...

### SCI/SCD Admissions

This report provides a list of SCD patients who have been admitted within a user-specified date range. The list consists of admitted patients who are either in the SCD Registry or who have been marked as SCI in the Patient file (i.e., field 57.4, "SPINAL CORD INJURY", has been populated). This option will also highlight patients that are not in the Registry.

```
Select SCD Reports Menu Option: ADM  SCI/SCD Admissions
Enter START Date: 090100  (SEP 01, 2000)
Enter END Date: T  (SEP 28, 2000)
Select DEVICE: HOME//  {VIRTUAL/CURRENT DEVICE}
```

Date Admitted		Ward	Room-Bed	Diagnosis Codes
Patient: SSN:		SCI: QUADRIPLÉGIA-TRAUMÁTIC		
Etiology: VEHICULAR		Registration Date: 08/07/2000		
09/12/2000@13:31:19		1ESCI	1E-B1109-02	BRONCHITIS NOS TRACHEA/BRONCHUS DIS NEC QUADRIPLÉGIA C5-C7, COMPL LATE EFF SPINAL CORD INJ LATE EFF MOTOR VEHIC ACC
Patient: SSN:		SCI: PARAPLEGIA-TRAUMÁTIC		
09/07/2000@16:29:20		5ENSGY	5E-B5217-05	COMP-OTH INT ORTHO DEVICE PARAPLEGIA NOS SPINAL CORD DISEASE NOS LATE EFF ACCIDENTAL FALL
***NOT IN THE REGISTRY!***				

## SCD Reports Menu...

### <sup>1</sup>Aggregate Outcomes Report

This option produces a statistical report of Outcomes information across diagnostic categories, based on user-selected choices of care type and range of care end dates.

The following are examples of reports for each of the four care types and the definitions of each row displayed in the reports

### Inpatient Rehabilitation Outcomes Report

#### Example:

```
Care Type: 1  INPATIENT
Beginning date: 1-1-2000  (JAN 01, 2000)
Ending date:    T  (OCT 17, 2003)

Select DEVICE: HOME//  {VIRTUAL/CURRENT DEVICE}
```

INPATIENT Rehabilitation Outcomes Report  
Date of Report: 10/17/2003  
Based on Care End Dates from 01/01/2000 to 10/17/2003

---

	HI TETRA	LO TETRA	PARA	ASIA D	ALL
# and % of Patients	1 (20%)	2 (40%)	2 (40%)	0 ( 0%)	5(100%)
Age (yrs)	84	61.5	57.5	N/A	64.4
Age Range	84-84	53-70	41-74	0-0	0-84
Gender (% Male pts)	100%	100%	50%	N/A	80%
Length of Rehab (days)	27	39	11	N/A	25
Length of Rehab Range	27-27	3-75	6-16	0-0	0-75
Total FIM Change	25	19.5	25.5	N/A	23.0
MSCIS Total FIM Change	12.4	27.8	41.5	41.2	35.9
FIM Efficiency	0.93	0.50	2.32	N/A	0.91
MSCIS FIM Efficiency	0.13	0.28	0.76	0.84	0.55
FIM Goal Attainment	N/A	29.5	16.5	N/A	23.0
% Discharged to Community	100%	100%	100%	N/A	100%
FIM Durability	11	14	-33.5	N/A	-10.5
Diener SWLS Change	N/A	10	9	N/A	9.3
Diener SWLS Durability	N/A	2	4	N/A	3.3

<sup>1</sup> Patch SPN\*2.0\*21 - New option, text, and report examples (Aggregate Outcomes Report).

<b>Term</b>	<b>Definition</b>
# and % of Patients	Number of patients in the diagnostic category and the percentage of all patients that number represents.
Age (yrs)	Mean (average) age in years.
Age Range	Range of age from lowest to highest age.
Gender (% Male pts)	Percentage of patients who are male.
Length of Rehab (days)	Number of days patients were in Inpatient Rehabilitation, excluding the 3 longest interruptions in care.
Length of Rehab Range	Range of individual patient Length of Rehab from fewest numbers of days to most number of days.
Total FIM Change	Change in Total FIM score from Inpatient Start to Inpatient Rehab Finish
MSCIS Total FIM Change	Norm for Total FIM change, from the Model Spinal Cord Injury System.
FIM Efficiency	Total FIM Change divided by Length of Rehab. This efficiency score measures the amount of FIM improvement per day of inpt rehab care.
MSCIS FIM Efficiency	Norm for Total FIM Efficiency, from the Model Spinal Cord Injury System.
FIM Goal Attainment	Mean difference in Total FIM score between Inpt Goal and Inpt Rehab Finish. This measures the degree to which rehab goals were met (attained) at the conclusion (Finish) of inpt rehab care.
% Discharged to Comm (Community)	Percentage of patients discharged to a non-institutional (community) setting.
FIM Durability	Mean difference in Total FIM score between Inpt Rehab Finish and Inpt Follow-Up (End). This measures the degree to which FIM performance is maintained following inpatients rehab care.
Diener SWLS Change	Mean change in Diener Satisfaction With Life Scale from Inpt Start to Inpt Rehab Finish.
Diener SWLS Durability	Mean difference in Diener SWLS between Inpt Rehab Finish and Inpt Follow-Up (End). This measures the degree to which satisfaction with life (expressed as Diener SWLS) is maintained following inpt rehab care.

## OUTPATIENT Rehabilitation Outcomes Report

### Example:

Care Type: <b>2</b> OUTPATIENT							
Beginning date: <b>1-1-2000</b> (JAN 01, 2000)							
Ending date: <b>T</b> (OCT 17, 2003)							
Select DEVICE: HOME// {VIRTUAL/CURRENT DEVICE}							
<p>OUTPATIENT Rehabilitation Outcomes Report  Date of Report: 10/17/2003  Based on Care End Dates from 01/01/2000 to 10/17/2003</p>							
-----							
	HI	TETRA	LO	TETRA	PARA	ASIA D	ALL
# and % of Patients	1	(50%)	1	(50%)	0	(0%)	2(100%)
Age (yrs)	77		77		N/A	N/A	77.0
Age Range	77-77		77-77		0-0	0-0	0-77
Gender (% Male pts)	100%		100%		N/A	N/A	100%
Total FIM Change	-55		-42		N/A	N/A	-48.5
FIM Goal Attainment	-73		-56		N/A	N/A	-64.5
FIM Durability	82		76		N/A	N/A	79.0
Diener SWLS Change	4		10		N/A	N/A	7.0
Diener SWLS Durability	1		2		N/A	N/A	1.5

Term	Definition
# and % of Patients	Number of patients in the diagnostic category and the percentage of all patients that number represents.
Age (yrs)	Mean (average) age in years.
Age Range	Range of age from lowest to highest age.
Gender (% Male pts)	Percentage of patients who are male.
Total FIM Change	Mean change in Total FIM score from Outpt Start to Outpt Rehab Finish.
FIM Goal Attainment	Mean difference in Total FIM score between Outpt Goal and Outpt Rehab Finish. Measures the degree to which rehab goals were met (attained) at the conclusion (Finish) of inpatients rehab care.
FIM Durability	Mean difference in Total FIM score between Outpt Rehab Finish and Outpt Follow-Up (End). Measures the degree to which FIM performance is maintained following inpatients rehab care.
Diener SWLS Change	Mean change in Diener Satisfaction With Life Scale from Outpt Start to Outpt Rehab Finish.
Diener SWLS Durability	Mean difference in Diener SWLS between Outpt Rehab Finish and Outpt Follow-Up (End). Measures the degree to which satisfaction with life (expressed as Diener SWLS) is maintained following inpatients rehab care.

## ANNUAL EVALUATION Outcomes Report

### Example:

Care Type: 3 ANNUAL EVALUATION					
Beginning date: 1-1-2000 (JAN 01, 2000)					
Ending date: T (OCT 17, 2003)					
Select DEVICE: HOME// {VIRTUAL/CURRENT DEVICE}					
ANNUAL EVALUATION Outcomes Report Date of Report: 10/17/2003 Based on Observations from 01/01/2000 to 10/17/2003					
-----					
	HI TETRA	LO TETRA	PARA	ASIA D	ALL
# and % of Patients	1 (17%)	2 (33%)	2 (33%)	1 (17%)	6(100%)
Age (yrs)	74	38.5	60.5	68	56.7
Age Range	74-74	38-39	56-65	68-68	38-74
Gender (% Male pts)	100%	100%	100%	100%	100%
Total FIM Score	55	70.5	72	46	62.8
Motor FIM Score	40	48.5	55	34	45.2
Cognitive FIM Score	15	22	17	12	17.6
CHART Physical Indep	N/A	88	N/A	N/A	88.0
CHART Cognitive Indep	N/A	21	N/A	N/A	21.0
CHART Mobility	N/A	24	N/A	N/A	24.0
CHART Occupation	N/A	34	N/A	N/A	34.0
CHART Social Interaction	N/A	26	N/A	N/A	26.0
CHART Economic	N/A	31	N/A	N/A	31.0
Diener SWLS	N/A	28	N/A	N/A	28.0

Term	Definition
# and % of Patients	Number of patients in the diagnostic category and the percentage of all patients that number represents.
Age (yrs)	Mean (average) age in years.
Age Range	Range of age from lowest to highest age.
Gender (% Male pts)	Percentage of patients who are male.
Total FIM Score	Mean Total FIM score
Motor FIM Score	Mean Motor FIM score
Cognitive FIM Score	Cognitive FIM score
CHART Physical Indep	Mean CHART Physical Independence score
CHART Cognitive Indep	CHART Cognitive Independence score
CHART Mobility	Mean CHART Mobility score
CHART Occupation	Mean CHART Occupation score

Terms and definitions continue on the next page.

<b>Term</b>	<b>Definition</b>
CHART Social Interact	Mean CHART Social Interaction score
CHART Economic	Mean CHART Economic Self-Sufficiency score
Diener SWLS Score	Mean Diener SWLS Score

## CONTINUUM OF CARE Outcomes Report

### Example:

Care Type: <b>4</b> CONTINUUM OF CARE								
Beginning date: <b>1-1-2000</b> (JAN 01, 2000)								
Ending date: <b>T</b> (OCT 17, 2003)								
Select DEVICE: HOME// {VIRTUAL/CURRENT DEVICE}								
CONTINUUM OF CARE Outcomes Report Date of Report: 10/17/2003 Based on Care Dates from 01/01/2000 to 10/17/2003								
	HI	TETRA	LO	TETRA	PARA	ASIA D	ALL	
# and % of Patients	1	(33%)	0	( 0%)	2	(67%)	0 ( 0%)	3(100%)
Age (yrs)	77.0		N/A		64.5		N/A	68.7
Age Range	77-77		0-0		55-74		0-0	0-77
Gender (% Male pts)	100%		N/A		100%		N/A	100%
Length of Stay (days)	67		N/A		109.5		N/A	95
Length of Stay Range	67-67		0-0		59-160		0-0	0-160
Total FIM Change	28		N/A		25.5		N/A	26.3
FIM Efficiency	0.42		N/A		0.23		N/A	0.28
FIM Goal Attainment	2		N/A		11		N/A	8.0
% Discharged to Community	100%		N/A		100%		N/A	100%
FIM Durability	5		N/A		.5		N/A	2.0
Diener SWLS Change	4		N/A		N/A		N/A	4.0
Diener SWLS Durability	2		N/A		N/A		N/A	2.0

Term	Definition
# and % of Patients	Number of patients in the diagnostic category and the percentage of all patients that number represents.
Age (yrs)	Mean (average) age in years.
Age Range	Range of age from lowest to highest age.
Gender (% Male pts)	Percentage of patients who are male.
Length of Stay (days)	Mean number of days pts were in Continuum of Care.
Length of Stay Range	Range of individual pt Length of Stay from least number of days to most number of days.
Total FIM Change	Mean change in Total FIM score from CC Admit to CC Discharge.
Total FIM Efficiency	Mean total FIM Change divided by Length of Stay. This efficiency score measures the amount of FIM improvement per day of care.

Terms and definitions continue on the next page.

<b>Term</b>	<b>Definition</b>
FIM Goal Attainment	Mean difference in total FIM scores between CC Goal and CC Discharge. This measures the degree to which rehab foals were met (attained) at the conclusion of care.
% Discharged to Comm (Community)	Percentage of patients discharged to a non-institutional (community) setting.
FIM Durability	Mean difference in Total FIM score between CC Discharge and CC Outpt. This measures the degree to which FIM performance is maintained after discharge.
Diener SWLS Change	Mean change in Diener Satisfaction With Life Scale from CC Admit to CC Discharge.
Diener SWLS Durability	Mean difference in Diener SWLS between CC Discharge and CC Output. This measures the degree. Measures the degree to which satisfaction with life (expressed as Diener SWLS) is maintained after discharge.

## SCD Reports Menu...

### Applications for Inpatient Care

This option produces reports on applications for inpatient care during a specific range of dates in your local SCD registry. Enter start date and end date as shown below.

Report Filter:

Enter START Date: **1/93** (JAN 1993)

Enter END Date: **T** (NOV 15, 1996)

Select DEVICE: HOME// {VIRTUAL/CURRENT DEVICE}

May 10, 2000@09:03:59

Page: 1

Applications for Inpatient Care  
From: 1/0/93 to: 5/10/00

Patient	Date of Dispos.	Disposition
---------	--------------------	-------------

---

	2/29/96	SCHEDULE FUTURE APPOINTMENT TYPE OF BENEFIT: HOSPITAL
--	---------	--

	5/27/98	SCHEDULE FUTURE APPOINTMENT TYPE OF BENEFIT: HOSPITAL
--	---------	--

	2/27/94	SCHEDULE FUTURE APPOINTMENT TYPE OF BENEFIT: HOSPITAL
--	---------	--

	12/29/97	SCHEDULE FUTURE APPOINTMENT TYPE OF BENEFIT: HOSPITAL
--	----------	--

## SCD Reports Menu...

### SCI/SCD Discharges

This option produces reports on discharged patients for a given date range displaying discharge dates, discharge location, diagnosis codes, a frequency table of discharge destination, and other information as shown in the dialogue below.

Report Filter:

Enter START Date: **11/1/94** (NOV 01, 1994)

Enter END Date: **11/1/96** (NOV 01, 1996)

Select DEVICE: HOME// {VIRTUAL/CURRENT DEVICE}

Nov 05, 1996@08:09:11	Page: 1		
SCD/SCI Discharge Patients From: 11/1/94 to: 11/1/96			
Date D/C	LOS	D/C Location	Diagnosis Codes
-----			
Patient:		SSN:	SCI: NOT APPLICABLE
Etiology: FALL			
11/17/94	1	3 SOUTH	MALIGNANT HYPERTENSION ANXIETY STATE NEC
Enter RETURN to continue or '^' to exit: <RET>			



## SCD Reports Menu...

### Filtered Reports

#### Using Filtered Reports

When you use Filtered Reports, you can choose to eliminate certain types of records you don't want in your report or you can choose to not use filters which means all records will appear in your report.

Do you wish to use the SCD filters with the reports? YES// <RET>

- If you answer NO to the above prompt, no filters will be applied to your reports except for those few that are specific to some of the reports. Note the individual reports in the following chapters to see those filters that do apply.
- If you answer YES to the above prompt, the filters can be applied to select or all reports you choose to print under the Filtered Reports menu.

#### Up Front Filters

If you answer YES to use the SCD filters and you plan to print more than one report, determine the following:

**Filter all the reports the same for SCI Network Status and/or Registration Status?** If you want to filter all reports the same, make those selections at this point and for every report you choose to print, the filters will apply.

**Note:** These filters will apply to all reports you choose before exiting the Filtered Reports menu.

```
Up Front Filters:
SCI Network Status
  A) SCI Network
  B) Non-SCI Network
  C) Both A and B
Select SCI Network: A SCI Network
Registration Status
  A) SCD-Currently served
  B) SCD-Not Currently served
  C) Both A&B
  D) Not SCD
  E) Expired
Select Registration Status: A SCD-Currently served
```

In the above example, you would get only those records in all the reports you print that are designated as SCI Network (patients followed within the SCI network) and SCD-Currently Served (true SCD patients who are seen at the facility on a continuing basis) in your report.

**Do not filter all the reports the same way?** If you do not want to filter all reports the same way, bypass the Up Front Filters by pressing the <RET> key for each. By doing this, the Up Front Filters will appear for selection after each report you choose to print. You may decide then which filters you want to apply to each report.

```
Up Front Filters:
SCI Network Status
    A) SCI Network
    B) Non-SCI Network
    C) Both A and B
Select SCI Network: <RET>
Registration Status
    A) SCD-Currently served
    B) SCD-Not Currently served
    C) Both A&B
    D) Not SCD
    E) Expired
Select Registration Status: <RET>
```

### Filterable Reports

You can apply the Up Front Filters to the following reports. This menu appears after either selecting Up Front Filters or bypassing them.

```
ADH    SCD Ad Hoc Reports ...
BPI    Basic Patient Information (132 Column)
BRK    Breakdown of Patients
1CFDD  CHART/FAM/DIENER/DUSOI Scores
CI     Current Inpatients
EPL    Expanded Patient List (255 Column)
FA     Patients with Future Appointments
FIM    Functional Independence Measures
FULE   Follow-Up (Last Annual Rehab Eval Received)
FULS   Follow-Up (Last Seen)
HS     Health Summary
IOA    Inpatient/Outpatient Activity
IOAS   Inpatient/Outpatient Activity (Specific)
LNS    New SCI/SCD Patients
ML     Mailing Labels
PL     Patient Listing
PLSC   Patient Listing (Sort by State and County)
RGR    Registrant General Report
RIR    Registrant Injury Report
SELF   Self Report of Function
UTL    Utilization Reports...
```

---

<sup>1</sup> Patch SPN\*2.0\*19 – New options.

### Automatic Filters

Once you select a report, you may also be given the opportunity to use Automatic Filters and User Selectable Filters. Automatic Filters and User Selectable Filters are not available with every report. Automatic Filters allow you to select records of patients by the cause of the injury and/or the extent of injury:

```
Automatic Filters:
  Cause of Injury:
    T) Traumatic
    N) Non-traumatic
    B) Both Traumatic and Non-traumatic
    U) Unknown
  Select Cause:
    Extent of Injury:
      P) Paraplegia
      Q) Quadriplegia
      B) Both
  Select Injury:
```

### User Selectable Filters

User Selectable Filters, also not available with every report, allow you to narrow your record selection even further.

```
Choose from:
  ADDITIONAL CARE VA
  AGE
  ANNUAL REHAB EVAL NEXT DUE
  ANNUAL REHAB VA
  COUNTY
  DIVISION
  ETIOLOGY
  FEE BASIS
  GEOGRAPHICAL AREA
  HOURS OF HELP NEEDED
  IMPAIRMENTS
  IN/OUT PATIENT VISIT
  MEDICATIONS
  PRIMARY CARE VA
  PROSTHETICS
  RACE
  REGISTRATION STATUS
  SCI LEVEL
  SERVICE CONNECTION
  SEX
  TOTAL FIMS CHANGE OVER TIME
  VITAL STATUS
  WALK / WHEELCHAIR
```

**Note:** You cannot use more than **three** User Selectable Filters for one report.

**Additional Care VA:** This field was added for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with INSTITUTION NUMBER, NAME, STATION NUMBER, OFFICIAL VA NAME, or CURRENT LOCATION.

Enter a Facility from the list shown.

Additional Care VA: SAN DIEGO

1	SAN DIEGO COUMADIN LAB	CA		664.1
2	SAN DIEGO, CA	CA	VAMC	664
3	SAN DIEGO-RO	CA		377
CHOOSE 1-3:	2	SAN DIEGO, CA	CA	VAMC 664

Sequence: 1

ADDITIONAL CARE VA=SAN DIEGO, CA

**Age:** If you want to limit your report to patients within a specific age group, use the Age filter. You might want a report that breaks out the data in age ranges. Enter the beginning and ending age for the entire range and the ages will be shown in five-year increments.

Select Filter: **AGE**

Age range start value: 35

Age range end value: 44

Sequence: 1

BEGINNING AGE=35

ENDING AGE=44

**Annual Rehab Eval Next Due:** If you want to limit your report to patients who are due for their annual rehab evaluation, then use the Annual Rehab Eval Next Due filter. This would be particularly handy for printing mailing addresses for veterans due for evaluation.

Select Filter: **ANNUAL REHAB EVAL NEXT DUE**

Beginning date: 1/1/2000 (JAN 01, 2000)

Ending date: 1/31/2000 (JAN 31, 2000)

Sequence: 1

BEGINNING DATE=JAN 1,2000

ENDING DATE=JAN 31,2000

**Annual Rehab VA:** This field was added mainly for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with INSTITUTION NUMBER, NAME, STATION NUMBER, OFFICAL VA NAME, or CURRENT LOCATION.

Enter a Facility from the list shown.

Annual Rehab VA Facility: San Diego

1	SAN DIEGO COUMADIN LAB	CA		664.1
2	SAN DIEGO, CA	CA	VAMC	664
3	SAN DIEGO-RO	CA		377
CHOOSE 1-3:	2	SAN DIEGO, CA	CA	VAMC 664

Sequence: 1

ANNUAL REHAB VA=SAN DIEGO, CA

**County:** If you want to limit the records to a specific county, use the County filter. This might be useful when printing mailing labels or reviewing patient demographics.

```
Select Filter: COUNTY
Select STATE NAME: ILLINOIS
Select COUNTY: COOK      031
Sequence: 1
                COUNTY=COOK
                STATE=ILLINOIS
```

**Division:** This field was added mainly for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with MEDICAL CENTER DIVISION NUM, NAME, FACILITY NUMBER, or TREATING SPECIALTY.

```
Select Filter: DIVISION
Division: Choose from: Enter a Division from the list shown.

1          SAN DIEGO VAMC      664
4          MISSION VALLEY VAOPC  664BY
5          EL CENTRO VAOPC     664GA
6          VISTA CBOC         664GB
7          CHULA VISTA CBOC    664GC
8          ESCONDIDO CBOC     664GD

Enter Division: 1 SAN DIEGO VAMC      664
```

**Etiology:** If you want to limit your report to patients with a specific etiology, use the Etiology filter.

```
Select Filter: ETIOLOGY
SCD Etiology: ??

Choose from:
1          SPORTS ACTIVITY      TRAUMATIC CAUSE
2          ACT OF VIOLENCE      TRAUMATIC CAUSE
3          VEHICULAR            TRAUMATIC CAUSE
4          FALL                 TRAUMATIC CAUSE
5          INFECTION OR ABSCESS  NON-TRAUMATIC CAUSE
6          OTHER - TRAUMATIC     TRAUMATIC CAUSE
7          MOTOR NEURON DISEASE  NON-TRAUMATIC CAUSE
8          MULTIPLE SCLEROSIS    NON-TRAUMATIC CAUSE
9          TUMOR                NON-TRAUMATIC CAUSE
10         OTHER                UNKNOWN
11         OTHER - DISEASE       NON-TRAUMATIC CAUSE
12         POLIOMYELITIS        NON-TRAUMATIC CAUSE
13         UNKNOWN              NON-TRAUMATIC CAUSE
14         UNKNOWN              TRAUMATIC CAUSE
15         SYRINGOMYELIA        NON-TRAUMATIC CAUSE
16         ARTHRITIC DISEASE OF THE SPINE  NON-TRAUMATIC CAUSE

Enter an etiology from the list shown.

SCD Etiology: 1 SPORTS ACTIVITY      TRAUMATIC CAUSE
                ...OK? Yes// <RET> (Yes)
Sequence: 1
                ETIOLOGY=SPORTS ACTIVITY
```

**Fee Basis:** If you want to see only Fee Basis patients in your report, use the Fee Basis Filter.

```
Select Filter: FEE BASIS
Beginning date: 1/1/99 (JAN 01, 1999)
Ending date: 1/1/2000 (JAN 01, 2000)
Sequence: 1
      BEGINNING DATE=JAN 1,1999
      ENDING DATE=JAN 1,2000
```

**Geographical Area:** If you want a report of patients located within a specific zip code area, use the Geographical Area filter.

```
Select Filter: GEOGRAPHICAL AREA
Zip code range start value: 60612
Zip code range end value: 60613
Sequence: 1
      BEGINNING ZIP=60612
      ENDING ZIP=60613
```

**Hours of Help Needed:** If you want a report of patients requiring a certain amount of help, use the Hours of Help Needed filter.

```
Select Filter: HOURS OF HELP NEEDED
Hours of help needed start value: 100
Hours of help needed end value: 224
Beginning date: T-14 (DEC 08, 1999)
Ending date: T (DEC 22, 1999)
Sequence: 1
      BEGINNING # HRS HELP=100
      ENDING # HRS HELP=224
Sequence: 1.1
      BEGINNING DATE=DEC 8,1999
      ENDING DATE=DEC 22,1999
```

**Impairments:** If you want a report showing patients with a certain impairment level, use the Impairments filter. Note: You may enter a range of impairments or discrete impairments for your report.

Select Filter: **IMPAIRMENTS**

Impairments: ??

- 0 - DON'T KNOW
- 1 - NONE
- 2 - INCOMPLETE MOTOR
- 3 - INCOMPLETE SENSORY
- 4 - COMPLETE MOTOR
- 5 - COMPLETE SENSORY
- 6 - INCOMPLETE SENSORY AND MOTOR
- 7 - COMPLETE SENSORY AND INCOMPLETE MOTOR
- 8 - INCOMPLETE SENSORY AND COMPLETE MOTOR

You may enter a range of impairments '1-3', discrete impairments '1,3,5', or any combination of these '1-3,5,7'.  
Choose any combination of impairments by number

Impairments: **3,5**

Sequence: 1

COMPLETENESS OF INJURY=INCOMPLETE SENSORY; COMPLETE SENSORY

**In/Out Patient Visit:** If you want to restrict your report to inpatients or outpatients, use the In/Out Patient Visit filter.

Select Filter: **IN/OUT PATIENT VISIT**

Type of Visit: ??

Enter 'I', 'O', or 'B'.

Select one of the following:

- |   |                             |
|---|-----------------------------|
| I | INPATIENT                   |
| O | OUTPATIENT                  |
| B | BOTH INPATIENT & OUTPATIENT |

Type of Visit: **INPATIENT**

Beginning date: **T-14** (DEC 08, 1999)

Ending date: **T** (DEC 22, 1999)

Sequence: 1

VISIT TYPE=INPATIENT

Sequence: 1.2

BEGINNING DATE=DEC 8,1999

ENDING DATE=DEC 22,1999

**Medications:** If you want a report of patients on specific types of medications, use the Medications filter. More than one type of medication can be selected.

```
Select Filter: MEDICATIONS
Select VA DRUG CLASS CODE: 84 CN400 ANTICONVULSANTS
...OK? Yes// <RET> (Yes)

Select VA DRUG CLASS CODE: <RET>

Enter the date range to search for the selected Medications
Beginning date: T-14 (DEC 08, 1999)
Ending date: T (DEC 22, 1999)
Sequence: 1
                DRUG CLASS=CN400

Sequence: 1.1
        BEGINNING DATE=DEC 8,1999
        ENDING DATE=DEC 22,1999
```

**Primary Care VA:** This field was added mainly for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with INSTITUTION NUMBER, or NAME, STATION NUMBER, OFFICAL VA NAME, or CURRENT LOCATION.

```
Primary Care VA: SAN DIEGO
1 SAN DIEGO COUMADIN LAB CA 664.1
2 SAN DIEGO, CA CA VAMC 664
3 SAN DIEGO-RO CA 377
CHOOSE 1-3: 2 SAN DIEGO, CA CA VAMC 664
Sequence: 1
        PRIMARY CARE VA=SAN DIEGO, CA
```

**Prosthetics:** If you want a report of patients using specific prosthetics, use the Prosthetics filter. You may select any number you need for your report.

```
Select Filter: PROSTHETICS
Select PROS AMIS CODES: ??

Choose from:
1 01 A AID FOR BLIND ADMINISTRATIVE ISSUE
2 01 B SPEC BLIND EQP OVER $2,000
ADMINISTRATIVE ISSUE
3 04 A ART LEG,IPOP ADMINISTRATIVE ISSUE
4 04 B ART LEG,TEM ADMINISTRATIVE ISSUE

Select PROS AMIS CODES: 75 08 E BRACES, ALL OTHER ORTHOTIC LAB
...OK? Yes// <RET> (Yes)
        BRACES, ALL OTHER
Another: 71 08 A BRACES, ANKLE ORTHOTIC LAB
...OK? Yes// <RET> (Yes)
        BRACES, ANKLE
Another: 72 08 B BRACES, CERVICAL, CUSTOM-MADE ORTHOTIC LAB
...OK? Yes// <RET> (Yes)
        BRACES, CERVICAL, CUSTOM-MADE
Another: 73 08 C BRACES, LEG, A/K ORTHOTIC LAB
...OK? Yes// <RET> (Yes)
```

```

BRACES, LEG, A/K
Another: 74 08 D BRACES, SPINAL ORTHOTIC LAB
...OK? Yes// <RET> (Yes)
BRACES, SPINAL
Another: <RET>
Sequence: 1
PROSTH=BRACES, ANKLE
PROSTH=BRACES, CERVICAL, CUSTOM-MADE
PROSTH=BRACES, LEG, A/K
PROSTH=BRACES, SPINAL
PROSTH=BRACES, ALL OTHER

```

**Race:** If you want a report on patients by race, use the Race filter.

```

Select Filter: RACE
Patient race: ??

Choose from:
1 AMERICAN INDIAN OR ALASKA NATIVE 3
2 ASIAN OR PACIFIC ISLANDER 5 **INACTIVE**
3 BLACK, NOT OF HISPANIC ORIGIN 4 **INACTIVE**
4 HISPANIC, BLACK 2 **INACTIVE**
5 HISPANIC, WHITE 1 **INACTIVE**
6 UNKNOWN 7 **INACTIVE**
7 WHITE, NOT OF HISPANIC ORIGIN 6 **INACTIVE**
8 ASIAN A
9 BLACK OR AFRICAN AMERICAN B
10 DECLINED TO ANSWER D
11 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER H
12 UNKNOWN BY PATIENT U
13 WHITE W

Enter a race from the list shown.
Patient race: WHITE W
Sequence: 1
RACE= WHITE

```

**Registration Status:** If you want your report on patients in a particular registration status, use the Registration Status filter.

```

Select Filter: REGISTRATION STATUS
Registration status: ?

Enter the desired registration status A-E.

Select one of the following:

A SCD-Currently served
B SCD-Not Currently served
C Both A&B
D Not SCD
E Expired

Registration status: D NOT SCD
Sequence: 1
REGISTRATION STATUS=NOT SCD

```

**SCI Level:** If you want a report on patients within a level of injury range, use the SCI Level filter.

Select Filter: **SCI LEVEL**  
NLOI start value: ??

Choose from:

1	C01	CERVICAL	01
2	C02	CERVICAL	02
3	C03	CERVICAL	03
4	C04	CERVICAL	04
5	C05	CERVICAL	05
6	C06	CERVICAL	06
7	C07	CERVICAL	07
8	C08	CERVICAL	08
9	T01	THORACIC	01
10	T02	THORACIC	02
11	T03	THORACIC	03
12	T04	THORACIC	04
13	T05	THORACIC	05
14	T06	THORACIC	06
15	T07	THORACIC	07
16	T08	THORACIC	08
17	T09	THORACIC	09
18	T10	THORACIC	10
19	T11	THORACIC	11
20	T12	THORACIC	12
21	L01	LUMBAR	01
22	L02	LUMBAR	02
23	L03	LUMBAR	03
24	L04	LUMBAR	04
25	L05	LUMBAR	05
26	S01	SACRAL	01
27	S02	SACRAL	02
28	S03	SACRAL	03
29	S04	SACRAL	04
30	S05	SACRAL	05
31	UNK	UNKNOWN	

Enter the top-most vertebral level desired.

SCI Level start value: **9** T01 THORACIC 01  
...OK? Yes// **<RET>** (Yes)

SCI Level end value: **20** T12 THORACIC 12  
...OK? Yes// **<RET>** (Yes)

Sequence: 1  
BEGINNING SCI LEVEL=T01  
ENDING SCI LEVEL=T12

**Service Connection:** If you want a report of patients by their service connection, use the Service Connection filter.

```
Select Filter: SERVICE CONNECTION
Service connected percentage start value: 50
Service connected percentage end value: 100
Sequence: 1
          BEGINNING SVC CONNECTED %=50
          ENDING SVC CONNECTED %=100
```

**Sex:** If you want a report of either Male or Female patients, use the Sex filter.

```
Select Filter: SEX
Patient sex: FEMALE
Sequence: 1
          SEX=FEMALE
Select Filter:
```

**Total FIMS Change Over Time:** If you want a report that shows the FIMS change for a delta value range, use the Total FIMS Change over Time filter.

```
Select Filter: TOTAL FIMS CHANGE OVER TIME
Record Type: ?

Enter 1 for 1Self Report of Function, or 2 for FIM

      Select one of the following:

          1      Self Report of Function
          2      FIM

Record Type: 2 FIM
Beginning delta value: ?

Enter a number from -108 to 108.

Beginning delta value: 0
Ending delta value: 108
Beginning date: T-100 (SEP 18, 1999)
Ending date: T (DEC 27, 1999)
Sequence: 1
          RECORD TYPE=FIM
Sequence: 1.1
          BEGINNING DELTA VALUE=0
          ENDING DELTA VALUE=108
Sequence: 1.2
          BEGINNING DATE=SEP 18,1999
          ENDING DATE=DEC 27,1999
```

---

<sup>1</sup> Patch SPN\*2.0\*19 – New Record Types.

**Vital Status:** If you want a report of patients within a specific vital status (Alive or Dead), use the Vital Status filter.

Select Filter: **VITAL STATUS**  
Patient vital status: ??

Enter 0 for alive or 1 for dead patients.

Select one of the following:

0	ALIVE
1	DEAD

Patient vital status: **1** DEAD  
Sequence: 1  
VITAL STATUS=DEAD

**Walk / Wheelchair:** If you want a report of patients by method of ambulation, use the Walk / Wheelchair filter.

Select Filter: **WALK / WHEELCHAIR**  
Method of ambulation: ?

Enter 1 or 2 if the patient can walk, 3 or 4 if the patient uses a wheelchair.

Select one of the following:

1	WALK WITHOUT HELP
2	WALK WITH DEVICE
3	MANUAL WHEELCHAIR
4	MOTORIZED WHEELCHAIR

Method of ambulation: **4** MOTORIZED WHEELCHAIR  
Beginning date: **t-100** (SEP 18, 1999)  
Ending date: **t** (DEC 27, 1999)  
Sequence: 1  
AMBULATION=MOTORIZED WHEELCHAIR  
Sequence: 1.1  
BEGINNING DATE=SEP 18,1999  
ENDING DATE=DEC 27,1999

## SCD Reports Menu...

### Filtered Reports...

In the following chapters on the individual filtered reports, assume that SCD filters are not being used with the reports. We will only the sorts/filters that are specific to each report and that appear regardless of whether or not you choose to use the SCD filters.

### SCD Ad Hoc Reports

<sup>1</sup> REG	Registration Ad Hoc Report
SEL	Self Report of Function Ad Hoc Report
FIM	FIM Ad Hoc Report
AS	ASIA Ad Hoc Report
CHA	CHART Ad Hoc Report
FAM	FAM Ad Hoc Report
DEN	DIENER Ad Hoc Report
DUS	DUSOI Ad Hoc Report
MS	Multiple Sclerosis Ad Hoc Report
OUT	Comprehensive Outcomes Ad Hoc Report

Select SCD Ad Hoc Reports Option:      **REG**      Registration Ad Hoc Report

---

<sup>1</sup> Patch SPN\*2.0\*19 – New options.

## SCD Ad Hoc Report for Registry

Create reports in this option using data from the Registry.  
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

=====  
Registration Ad Hoc Report Generator  
=====

1 Patient	21 Describe Other	41 Annual Eval Received
2 SSN	22 Onset by Trauma	42 Next Annual Eval Due
3 Date of Birth	23 MS Subtype	43 Last Annual Eval Offered
4 Date of Death	24 Had Brain Injury?	44 Last Annual Eval Received
5 Age	25 Had Amputation?	45 Last Annual Eval Due
6 Registration Date	26 Memory/Think Affected	46 Primary Care Provider
7 Registration Status	27 Eyes Affected	47 SCD-Registry Coordinator
8 Date of Last Update	28 One Arm Affected	48 Referral Source
9 Last Updated By	29 One Leg Affected	49 Referral VA
10 Division	30 Both Arms Affected	50 Initial Rehab Site
11 SCI Network	31 Both Legs Affected	51 Init Rehab Discharge Date
12 SCI Level	32 Other Body Prt Affected	52 Bowel Care Reimbursement
13 VA SCI Status	33 Descr Other Body Part	53 BCR Date Certified
14 Amount VA is Used	34 Extent of Movement	54 BCR Provider
15 Primary Care VAMC	35 Extent of Feeling	55 Sensory/Motor Loss
16 Annual Rehab VAMC	36 Bowel Affected	56 Class of Paralysis
17 Additional Care VAMC	37 Bladder Affected	57 Type of Injury
18 Non-VA Care	38 Remarks	58 Enrollment Priority
19 Etiology	39 Extent of SCI	
20 Date of Onset	40 Annual Eval Offered	

Sort selection # 1 :

---

<sup>1</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 14, 47, & 58).

## SCD Ad Hoc Report for CHART, FAM, DIENER, DUSOI

Create reports in this option using data from the Outcomes file of the Registry.  
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

Select SCD Ad Hoc Reports Option: <sup>1</sup>CHA      CHART Ad Hoc Report

===== CHART Ad Hoc Report Generator =====

1 Patient	9 Record Type	17 CHART Mobility
2 SSN	10 Score Type	18 CHART Occupation
3 <sup>2</sup> Date of Birth	11 Division	19 CHART Social Interact
4 Date of Death	12 Disposition	20 CHART Econ Self Suff
5 Age	13 Respondent Type	21 CHART Total Score
6 Care Type	14 Date Recorded	
7 Care Start Date	15 CHART Physical Indep	
8 Care End Date	16 CHART Cognitive Indep	

Sort selection # 1 :

---

<sup>1</sup> Patch SPN\*2.0\*19 – New options.

<sup>2</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 4-8).

## SCD Ad Hoc Report for FIM

Create reports in this option using data from the Outcomes file of the Registry.  
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

Select SCD Ad Hoc Reports Option: <sup>1</sup>**FIM Ad** Hoc Report

===== FIM Ad Hoc Report Generator =====

1 Patient	15 Clinician	29 Stairs
2 SSN	16 Eating	30 Comprehension Level
3 Date of Birth	17 Grooming	31 Method of Comprehension
4 <sup>2</sup> Date of Death	18 Bathing	32 Expression Level
5 Age	19 Dressing Upper Body	33 Method of Expression
6 Care Type	20 Dressing Lower Body	34 Social Interaction
7 Care Start Date	21 Toileting	35 Problem Solving
8 Care End Date	22 Bladder Management	36 Memory
9 Record Type	23 Bowel Management	37 FIM Motor Score
10 Score Type	24 Xfer Bed/Chr/Whlchr	38 FIM Cognitive Score
11 Division	25 Xfer Toilet	39 FIM Total Score
12 Disposition	26 Xfer to Tub/Shower	40 Length of Rehab in Days
13 Respondent Type	27 Walk/Wheelchair	
14 Date Recorded	28 Method of Wlk/Whlchr	

Sort selection # 1 :

---

<sup>1</sup> Patch SPN\*2.0\*19 – New options.

<sup>2</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 4-8).

## SCD Ad Hoc Report for ASIA

Create reports in this option using data from the Outcomes file of the Registry.  
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
Select SCD Ad Hoc Reports Option: 1AS ASIA Ad Hoc Report

===== ASIA Ad Hoc Report Generator =====

1 Patient           11 Division        21 Neurolevel-Motor L
2 SSN              12 Disposition     22 Complete/Incomplete
3 Date of Birth    13 Respondent Type 23 Partial Pres-Sensory R
4 2Date of Death    14 Date Recorded   24 Partial Pres-Sensory L
5 Age              15 Motor Score     25 Partial Pres-Motor R
6 Care Type        16 Pin Prick Score 26 Partial Pres-Motor L
7 Care Start Date  17 Light Touch Score 27 Highest Neuro Level
8 Care End Date    18 Neurolevel-Sensory R 28 Impairment Scale
9 Record Type      19 Neurolevel-Sensory L
10 Score Type      20 Neurolevel-Motor R

Sort selection # 1 :
```

---

<sup>1</sup> Patch SPN\*2.0\*19 –New option.

<sup>2</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 4-8).

## SCD Ad Hoc Report for Multiple Sclerosis

Create reports in this option using data from the Outcomes file of the Registry.  
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

Select SCD Ad Hoc Reports Option: <sup>1</sup>MS Multiple Sclerosis Ad Hoc Report

===== MS Ad Hoc Report Generator =====

1 Patient	10 Score Type	19 Cerebral
2 SSN	11 Division	20 Cerebellar
3 Date of Birth	12 Disposition	21 Bowel & Bladder Funct
4 <sup>2</sup> Date of Death	13 Respondent Type	22 Visual
5 Age	14 Date Recorded	23 Other
6 Care Type	15 Clinician	24 EDSS
7 Care Start Date	16 Pyramidal	
8 Care End Date	17 Brainstem	
9 Record Type	18 Sensory	

Sort selection # 1 :

---

<sup>1</sup> Patch SPN\*2.0\*19 –New option.

<sup>2</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 4-8).

## SCD Ad Hoc Report for Self-Report of Function

Create reports in this option using data from the Outcomes file of the Registry.  
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
Select SCD Ad Hoc Reports Option: 1SEL Self Report of Function Ad Hoc Report
```

```
===== Self Report of Function Ad Hoc Report Generator =====
```

```
1 Patient                14 Mvment inside House    27 Method of Walk/Wheelchr
2 SSN                    15 Xfr Bed/Chr/Whlchr     28 Stairs
3 Date of Birth          16 Xfer Tub/Shower        29 Get 2 Places Outside Home
4 Date of Death          17 Xfer to Toilet         30 Shopping
5 Care Type              18 Toileting              31 Planning Cooking Meals
6 Care Start Date        19 Bladder Management     32 Doing Housework
7 Care End Date          20 Bowel Management       33 Handling Money
  Record Type            21 Eating                 34 Help During Last 2 Weeks
9 Score Type             22 Grooming               35 Number of Hours of Help
10 Division              23 Bathing                36 Hrs of Hlp Last 24hrs
11 Disposition           24 Dressing Upper Body    37 Method Ambulation Walkng
12 Respondent Type       25 Dressing Lower Body    38 Method Ambulation Whlchr
13 Date Recorded         26 Walk/Wheelchair
```

Sort selection # 1:

---

<sup>1</sup> Patch SPN\*2.0\*19 – New option.

## SCD Ad Hoc Report for Comprehensive Outcomes

Create reports in this option using data from the Outcomes file of the Registry.  
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

Select SCD Ad Hoc Reports Option: <sup>1</sup>OUT Comprehensive Outcomes Ad Hoc Report

===== SCD Outcomes Ad Hoc Report Generator =====

1 Patient	33 Social Interaction	65 FAM Community Access
2 SSN	34 Problem Solving	66 FAM Reading
3 Date of Birth	35 Memory	67 FAM Writing
4 Date of Death	36 Clinician	68 FAM Speech Intel
5 Age	37 To Places Outside Home	69 FAM Emotional Status
6 <sup>2</sup> Care Type	38 Shopping	70 FAM Adj to Limitations
7 Care Start Date	39 Planning Cooking Meals	71 FAM Employability
8 Care End Date	40 Doing Housework	72 FAM Orientation
9 Record Type	41 Handling Money	73 FAM Attention
10 Score Type	42 Method Amb Wlk	74 FAM Safety Judgement
11 Division	43 Method Amb Whlchr	75 Diener Composite Score
12 Disposition	44 Help During Last 2 Wks	76 DUSOI Composite Score
13 Respondent Type	45 Number of Hrs of Hlp	77 FIM Motor Score
14 Date Recorded	46 Hrs of Hlp Last 24Hrs	78 FIM Cognitive Score
15 Eating	47 Sensory Kurtzke	79 FIM Total Score
16 Grooming	48 Cerebral Kurtzke	80 Length of Rehab in Days
17 Bathing	49 Cerebellar Kurtzke	81 ASIA Impairment Scale
18 Dressing Upper Body	50 Bwl Blad Funct Kurtzke	82 Motor Score
19 Dressing Lower Body	51 Visual Kurtzke	83 Pin Prick Score
20 Toileting	52 Other Kurtzke	84 Light Touch Score
21 Bladder Management	53 Pyramidal Kurtzke	85 Neurolevel-Sensory R
22 Bowel Management	54 Brainstem Kurtzke	86 Neurolevel-Sensory L
23 Xfer Bed/Chr/Whlchr	55 EDSS	87 Neurolevel-Motor R
24 Xfer Toilet	56 CHART Physical Indep	88 Neurolevel-Motor L
25 Xfer Tub/Shower	57 CHART Mobility	89 Complete/Incomplete
26 Walk/Wheelchair	58 CHART Occupation	90 Partial Pres-Sensory R
27 Method of Wlk/Whlchr	59 CHART Social Interact	91 Partial Pres-Sensory L
28 Stairs	60 CHART Econ Self Suff	92 Partial Pres-Motor R
29 Comprehension Level	61 CHART Cognitive Indep	93 Partial Pres-Motor L
30 Method of Comp	62 CHART Total Score	94 Highest Neuro Level
31 Expression	63 FAM Swallowing	
32 Method of Expression	64 FAM Car Transfers	

Sort selection # 1 :

<sup>1</sup> Patch SPN\*2.0\*19 – New option.

<sup>2</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 6-8).

**SCD Reports Menu...**  
**Filtered Reports...**

**Basic Patient Information (132 Column)**

This report prints the patient's Name, SSN, DOB, Phone, Street Address 1, Street Address 2, City, State, and Zip Code on a single line. It is designed for 132-column printing/displaying. Therefore, if printing a hardcopy, send it to a 132-column printer or subtype. If displaying to screen for file capture, at the DEVICE prompt enter 0;132;9999 without spaces.

```
### This report is designed for 132 column viewing/printing    ###
### Set your terminal display to 132 columns                    ###
### For screen viewing, answer DEVICE prompt with 0;132        ###
### For file capture, answer DEVICE prompt with 0;132;9999     ###
### For a hardcopy, answer with a 132 column printer or subtype ###
```

Select DEVICE: HOME// **0;132;9999** VIRTUAL/CURRENT DEVICE

***** BASIC PATIENT INFORMATION *****							
12/29/1999							
Patient	SSN	DOB	Phone	Street Address 1	Street Address 2	City	St Zip

**SCD Reports Menu...**  
**Filtered Reports...**

**Breakdown of Patients**

This report breaks down the caseload of patients. You can specify only living patients or all patients (including those who are deceased) and you can limit your report to a specific period.

Include deceased patients? NO// **YES**

Include only those patients seen during a specified period? NO// **Y** YES

Start date for period: **1/1/99** (JAN 01, 1999)

End date for period: (1/1/1999 - 12/29/1999): TODAY// **<RET>** (DEC 29, 1999)

DEVICE: HOME// (Enter a device)

Gathering patient data...

SCD - Patient Registry Breakdown  
 SUPPORT ISC  
 Patients Currently Alive Seen During the Period 01/01/99 to 12/29/99

	Female	Male	Total
Total	2	8	10
20-24 years		1	1
35-39 years		1	1
45-49 years	1		1
50-54 years	1	2	3
55-59 years		1	1
65-69 years		1	1
85-89 years		2	2
ASIAN		1	1
BLACK OR AFRICAN AMERICAN		1	1
DECLINED TO ANSWER		1	1
UNKNOWN BY PATIENT	1	1	2
UNSPECIFIED RACE		2	2
HISPANIC, BLACK	1	2	3
Means Test CATEGORY A		1	1
Means Test NO LONGER REQUIRED	1	2	3
Means Test NOT REQUIRED		4	4
Means Test REQUIRED	1	1	2
NSC	1	3	4
SC LESS THAN 50%	1		1
SERVICE CONNECTED 50% to 100%		2	2
UNSPECIFIED ELIGIBILITY		3	3
OTHER OR NONE		1	1
POST-VIETNAM		1	1
PRE-KOREAN		1	1
UNSPECIFIED PERIOD OF SERVICE		3	3
VIETNAM ERA	2		2
WORLD WAR II		2	2
Seen in Laboratory	1		1
Seen as Inpatient	2	5	7
Seen as Outpatient	1	3	4
Seen in Radiology	2	8	10

**SCD Reports Menu...**  
**Filtered Reports...**

**<sup>1</sup>CHART/FAM/DIENER/DUSOI Scores**

This report provides CHART/FAM/DIENER/DUSOI scores for a patient or group of patients. The acronyms are described as follows:

CHART - Craig Handicap Assessment and Reporting Technique  
FAM - Functional Assessment Measure  
DIENER - Diener's Satisfaction with Life Scale  
DUSOI - Duke University Severity of Illness Index

**CHART**

- 1 CHART
- 2 FAM
- 3 DIENER
- 4 DUSOI

Pick an Outcome report from above list: **1**

Select a patient: YES

MILITARY RETIREE

Select a patient: **<RET>**

One Moment Please...

DEVICE: {VIRTUAL/CURRENT DEVICE}

Patient:	SSN:	DOB:
-----		
CHART Scores		
Date Recorded SEP 24,1999		
Craig Handicap Assessment and Reporting Technique(CHART)		
Physical Independence:	50	
Mobility:	65	
Occupation:	42	
Social Interaction:	87	
Economic Self Sufficiency:	33	
Cognitive Independence:	90	
-----		
Chart Total Score:	367	

<sup>1</sup> Patch SPN\*2.0\*19 – New Option and display.

| <sup>1</sup>FAM

- | 1 CHART
- | 2 FAM
- | 3 DIENER
- | 4 DUSOI

| Pick an Outcome report from above list: **2**  
| Select a patient: YES  
| MILITARY RETIREE  
| Select a patient: **<RET>**  
| One Moment Please...  
| DEVICE: {VIRTUAL/CURRENT DEVICE}

Patient:	SSN:	DOB:
-----		
Functional Assessment Measure (FAM)		
Date Recorded: 01/20/2000		
Swallowing: SUPERVISION		
Car Transfers: MAXIMAL ASSISTANCE		
Community Access: TOTAL ASSISTANCE		
Reading: COMPLETE INDEPENDENCE		
Writing: COMPLETE INDEPENDENCE		
Speech Intelligibility: COMPLETE INDEPENDENCE		
Emotional Status: SUPERVISION		
Adjustment to Limitations: MINIMAL ASSISTANCE		
Employability: TOTAL ASSISTANCE		
Orientation: MODIFIED INDEPENDENCE		
Attention: SUPERVISION		
Safety Judgement: SUPERVISION		

<sup>1</sup> Patch SPN\*2.0\*19 – New Option and display.

**<sup>1</sup>DIENER**

- 1 CHART
- 2 FAM
- 3 DIENER
- 4 DUSOI

Pick an Outcome report from above list: 3  
Select a patient: YES  
MILITARY RETIREE  
Select a patient: <RET>  
One Moment Please...  
DEVICE: {VIRTUAL/CURRENT DEVICE}

Patient:	SSN:	DOB:
-----		
Diener's (1985) Satisfaction with Life Scale		
Date Recorded: 07/28/2001		
Diener Composite Score: 34		

**DUSOI**

- 1 CHART
- 2 FAM
- 3 DIENER
- 4 DUSOI

Pick an Outcome report from above list: 4  
Select a patient: YES  
MILITARY RETIREE  
Select a patient: <RET>  
One Moment Please...  
DEVICE: {VIRTUAL/CURRENT DEVICE}

Patient:	SSN:	DOB:
-----		
Duke University of Illness Index (DUSOI)		
Date Recorded: 07/28/2001		
DUSOI Composite Score: 34		

<sup>1</sup> Patch SPN\*2.0\*19 – New Option and display.

**SCD Reports Menu...**  
**Filtered Reports...**

**Current Inpatients**

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

The Current Inpatients report shows those patients in your local SCD registry who are currently on an inpatient status.

SCD - Current Inpatients						
SUPPORT ISC						
Total Inpatients: 4						
Name	Last Four	Ward	Admission Date	Curr LOS	FYTD LOS	
	4444	2AS	06/15/99	198	180	
Adm dx: QUADRAPLEGIA						Room-Bed: 310-1
	4444	3AS	04/04/96	1,365	90	
Adm dx: TRAUMATIC PARAPLEGIA						Room-Bed: 310-2
	6666	6AS	04/02/96	1,367	90	
Adm dx: PROSTATIC CA						Room-Bed: 312-1
	9870	7AS	04/03/98	636	90	
Adm dx: QUADRAPLEGIA						Room-Bed: 312-2

**SCD Reports Menu...**  
**Filtered Reports...**

**Expanded Patient List (255 Column)**

This report is designed for spreadsheet use. It displays the Patient, SSN, Home Phone, NtWk, Reg Status, and Address including County, Last AE Offered, Last AE Received, Primary VA, Provider, SCI, Level Etiology, and Date Occ.

```
### This report is designed for importing into a spreadsheet    ###  
### Turn OFF line wrap.  Capture file as raw text              ###  
### For file capture, answer DEVICE prompt with 0;255;9999    ###  
### File will import into spreadsheet, 1 patient per row      ###
```

Select DEVICE: HOME// **0;255;9999** (Set the file capture before pressing the  
<RET> key.) <RET>TELNET

**SCD Reports Menu...**  
**Filtered Reports...**

**Patients with Future Appointments**

This report lists patients having future clinic appointments within a user specified date range. A prompt allows you to select patients in the SCD Registry or patients not in the SCD Registry but with a Spinal Cord Injury (as determined from the patient file), or you can select both. This report can be of great assistance in keeping your Registry up to date.

Enter a START date: OCT 3,2000// <ret> (OCT 03, 2000)  
 Enter a ENDING date: OCT 17,2000//1003 (OCT 04, 2000)

Select one of the following:

- 1 Patients in the Registry only.
- 2 Patients marked as SCI but not in the Registry.
- 3 Both.

Enter response: 1 Patients in the Registry only.  
 Select DEVICE: HOME// (Enter a Device)

Patients in the Registry only							Page: 1
Listing appointments from							
OCT 3,2000 TO OCT 4,2000@23:59							
Appointment date	Time	Clinic	Patient	SSN	Reg	SCI	SCI
			Status		LVL	NETWRK	
OCT 3,2000							
-----							
	07:00	AMB[DAY]SURG/AREA	5N	NNNN	SCD-CURRENT	L04	YES
	08:30	4N-RM 4016-PULM-SLEE		NNNN	SCD-CURRENT		YES
	08:30	DERM F/U LJ-CHEN-A		NNNN	SCD-CURRENT		
	08:40	UROLOGY-NURSE-AREA	1	NNNN	SCD-CURRENT	L03	
OCT 4,2000							
-----							
	08:00	AMB[ORTHO]SURG/NP/PR		NNNN	SCD-CURRENT	C07	YES
	08:02	DENTAL CLINIC		NNNN	SCD-CURRENT	T12	YES
	08:10	AMB[PHYSICAL THERAPY		NNNN	SCD-CURRENT	C07	YES

**SCD Reports Menu...**  
**Filtered Reports...**

**Functional Independence Measures**

<sup>1</sup>This report is designed to print out FIM (Functional Independence Measure) scores for a patient or a group of patients.

Select a patient: NO  
PILL

Enrollment Priority: Category: IN PROCESS End Date:

Select a patient: <RET>

One Moment Please...  
DEVICE: (Enter a device)

---

<sup>1</sup> Patch SPN\*2.0\*19 – Revised option description.

SSN:    DOB:

-----  
                  Functional Independence Measures (FIM)

                  Date Recorded:   DEC 17,1999

                  Score Type:   INPT START

Disposition:   3 HOME ASSISTED

                  Clinician(s)

-----  
                                  Self Care

                  Eating:   MINIMAL ASSISTANCE

                  Grooming:  MINIMAL ASSISTANCE

                  Bathing:   MAXIMAL ASSISTANCE

          Dressing Upper Body:  MODERATE ASSISTANCE

          Dressing Lower Body:  MODERATE ASSISTANCE

                  Toileting:  MAXIMAL ASSISTANCE

                                  Sphincter Control

          Bladder Management:  TOTAL ASSISTANCE

          Bowel Management:   TOTAL ASSISTANCE

                                  Mobility/Transfer

          Transfer Bed/Chair/Wheel chair:  MAXIMAL ASSISTANCE

                  Transfer to toilet:  MODERATE ASSISTANCE

          Transfer to Tube/Shower:  MODERATE ASSISTANCE

                                  Locomotion

          Method of Walk/Wheelchair:  WHEELCHAIR

                  Walk/Wheelchair:  MODIFIED INDEPENDENCE

                  Stairs:   TOTAL ASSISTANCE

-----  
          Motor Score:   35.0

                                  Communication

          Comprehension Method:  BOTH

          Comprehension Level:  COMPLETE INDEPENDENCE

          Expression Method:   BOTH

          Expression Level:   COMPLETE INDEPENDENCE

                                  Social Cognition

          Social Interaction:  COMPLETE INDEPENDENCE

          Problem Solving:   COMPLETE INDEPENDENCE

          Memory:   COMPLETE INDEPENDENCE

-----  
          Cognitive Score:  35.0

-----  
          Total FIM Score:  70.0

**SCD Reports Menu...**  
**Filtered Reports...**

**Follow-Up (Last Annual Rehab Eval Received)**

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This report identifies patients who have not had a rehab evaluation within a specified period of time. You are prompted to select that period of time. The system default is 180 days prior to TODAY and is ed as (180D//). An authorized user (i.e., one who possesses the SPNL SCD MGT key) can change it through the Edit Site Parameters option. "Last Four" in the report header refer to the last four digits of the patient's SSN.

Show patients whose last physical exam was more than how long ago?: 180D//  
<RET> 180D

DEVICE: {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Patient Follow Up		
SAN DIEGO, CA		
Patients at Risk of Loss to Follow Up		
(Last Annual Rehab Eval Received over 180 Days ago, before 12/10/97)		
Last Eval	Name	Last Four
01/02/1997		
01/08/1997		

**SCD Reports Menu...**  
**Filtered Reports...**

**Follow-Up (Last Seen)**

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This report identifies patients who have not been seen at your facility within a specified period of time. You are prompted to select a period of time. The system default is 180 days prior to TODAY and is ed as (180D//). It can be changed through the Edit Site Parameters option by an authorized user (i.e., possessing the SPNL SCD MGT key).

The report s the patients and the last four digits of their SSNs.

Show patients last seen more than how long ago?: 180D// <RET> 180D

DEVICE: (Enter a device)

Gathering patient data

SCD - Patient Follow Up SAN DIEGO, CA Patients at Risk of Loss to Follow Up (Not seen in over 180 Days, since before 07/02/99)		
Last Seen	Name	Last Four
04/16/1999		
04/20/1999		

**SCD Reports Menu...**  
**Filtered Reports...**

**Health Summary**

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

The Health Summary option integrates clinical data from ancillary support modules into patient health summaries, which can be viewed by clinicians on monitors or as printed reports.

The Health Summary option integrates clinical data from the following VistA modules:

PIMS Medicine  
PIMS Scheduling      Laboratory  
Outpatient Pharmacy      Vital Signs  
IV Pharmacy      Dietetics  
Unit Dose Pharmacy      Surgery  
Radiology/Nuclear Medicine      CPRS  
Text Integration Utility

Clinicians are able to select from a list of predefined Health Summary types. Examples of clinical patient data that can be retrieved are listed below:

Demographics      Admissions  
Discharges      Past and Future Clinic Visits  
Radiology Procedures      Surgical Procedures  
Medical Procedures      Transfers  
Medications      Lab Results  
Temperature/Pulse/Blood Pressure

For more information on Health Summary, refer to the VistA Health Summary User's manual.

Select PATIENT: YES SC  
VETERAN  
Select Health Summary Type Name: **SAMPLE ONLY**  
DEVICE: {VIRTUAL/CURRENT DEVICE} )

```
11/18/96 10:24
***** CONFIDENTIAL SAMPLE ONLY SUMMARY *****
                DOB:
----- MEDS - Med (1 line) Summary -----

MAR 14,1996@13:52      BRONCHOSCOPY
-----
                Summary:  NORMAL
    Procedure Summary:  This is a summary of the procedure ...

FEB 28,1996@13:08      PULMONARY FUNCTION TEST
-----
.....

* END *
```

**SCD Reports Menu...**  
**Filtered Reports...**

**Inpatient/Outpatient Activity**

This option produces reports on inpatients and outpatients over a specific range of dates.

**Note:** A "stop" is credited for each entry of a stop code. A "visit" is distributed among each stop credited on a given date. Thus, a single visit with two stop codes credited shows as 0.5 visit for each stop code. A total of 1.00 visit is given for outpatient activity on a given date.

The "Number of highest users to identify" refers to the number of patients to show on the report that were the most active.

Start date for period: **1/1/99** (JAN 01, 1999)  
End date for period: (1/1/1999 - 12/29/1999): TODAY// **<RET>** (DEC 29, 1999)

Number of highest users to identify: (0-100): 0// **2**  
DEVICE: HOME// {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Inpatient and Outpatient Activity	
SUPPORT ISC	
Outpatient Activity	
For the Period 01/01/99 to 12/29/99	
Totals: 8 patients for 116 visits (204 stops)	
Patients	Visits
1	81
1	12
1	10
2	4
2	2
1	1

SCD - Inpatient and Outpatient Activity  
 SUPPORT ISC  
 Outpatient Activity  
 For the Period 01/01/99 to 12/29/99

Clinic	Patients	Visits	Stops
102. ADMITTING/SCREENING	1	2.00	2
105. X-RAY	1	1.00	1
108. LABORATORY	1	2.50	7
203. AUDIOLOGY	8	99.33	179
204. SPEECH PATHOLOGY	2	2.83	4
216. TELEPHONE/REHAB AND SUPPORT	1	3.33	6
301. GENERAL INTERNAL MEDICINE	1	4.00	4
557. PSYCHIATRY-GROUP	1	1.00	1

SCD - Inpatient and Outpatient Activity  
 SUPPORT ISC  
 Outpatient Activity  
 For the Period 01/01/99 to 12/29/99

Highest Utilization of Visits

Patient Name	SSN	Visits	Different Stop Codes

SCD - Inpatient and Outpatient Activity  
 SUPPORT ISC  
 Inpatient Activity  
 For the Period 01/01/99 to 12/29/99

Totals: 7 patients for 11 stays and 1,722 days inpatient care

Patients	Stays
4	1
2	2
1	3

SCD - Inpatient and Outpatient Activity  
 SUPPORT ISC  
 Inpatient Activity  
 For the Period 01/01/99 to 12/29/99

Median Length of Stay (MLOS): 198.0 days

Specialty	Patients	Stays	Days	MLOS
DOMICILIARY	1	1	13	13.0
GENERAL SURGERY	3	3	922	363.0
GENERAL (ACUTE MEDICINE)	1	1	221	221.0
MEDICAL OBSERVATION	4	6	204	1.0
NHCU	1	1	363	363.0

SCD - Inpatient and Outpatient Activity  
 SUPPORT ISC  
 Inpatient Activity  
 For the Period 01/01/99 to 12/29/99

Highest Number of Stays

Patient Name	SSN	Stays	Days

SCD - Inpatient and Outpatient Activity  
 SUPPORT ISC  
 Inpatient Activity  
 For the Period 01/01/99 to 12/29/99

Highest Number of Days

Patient Name	SSN	Days	Stays

**SCD Reports Menu ...**  
**Filtered Reports ...**

**Inpatient/Outpatient Activity (Specific)**

This option is used to obtain information on patients in your local SCD registry who have utilized specific inpatient or outpatient resources. For outpatient activity, the option indicates the number of visits during the indicated time period to the clinic STOP CODE(s) specified. The number of stays and length of stay within a specific Specialty indicate inpatient activity.

On selection of this option, you are asked to define the starting and ending dates for the analysis, and the desired clinic Stop Code. The stop code is the subject area indicator for outpatient activity reported to Austin. You may select any number of stops codes by name or number.

Following a null response, you are asked to specify a specialty name for specific inpatient activity. The specialty names which may be selected are restricted to those used for reporting on the Patient Treatment File (PTF).

A "stop" is credited for each entry of a stop code, while a "visit" is distributed among each stop credited on a given date. Thus, a single visit with two stop codes credited shows as 0.5 visit for each stop code. A total of 1.00 visit is given for outpatient activity on a given date.

Start date for period: **JAN 1 95** (JAN 01, 1995)  
End date for period: (1/1/95 - 11/18/96): TODAY// **<RET>** (NOV 18, 1996)

Select a CLINIC STOP: **<RET>**  
Select a SPECIALTY: **15** GENERAL(ACUTE MEDICINE)  
Another SPECIALTY: **<RET>**  
Do you want to see patient usage data? YES// **<RET>**  
DEVICE: {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Specific Inpatient and Outpatient Activity			
Your Facility Name Here			
Selected Inpatient Activity			
For the Period 01/01/95 to 11/18/96			
GENERAL(ACUTE MEDICINE)			
Totals:	1 patient	2	19
Patient Name	SSN	Stays	Days

**SCD Reports Menu ...**  
**Filtered Reports ...**

**New SCI/SCD Patients**

This option produces a report on new SCI/SCD patients in the SCD registry. You will be prompted to select a range of dates for this report.

Report Filter:

Enter Original Registration START Date: **7/99** (JUL 1999)

Enter Original Registration END Date: **T** (MAY 11, 2000)

Select DEVICE: {VIRTUAL/CURRENT DEVICE}

May 11, 2000@09:34:02		Page: 1	
Listing of NEW SCD/SCI Patients Since Jul 1999			
Patient	SSN	Original Regis Date	Etiology VA SCI Status
-----			
			TUMOR PARAPLEGIA-NONT
			ARTHRITIC DISEASE QUADRIPLLEGIA-NO
			OTHER - TRAUMATIC PARAPLEGIA-TRAU
			VEHICULAR PARAPLEGIA-TRAU
			ARTHRITIC DISEASE QUADRIPLLEGIA-NO
			VEHICULAR QUADRIPLLEGIA-TR
			FALL QUADRIPLLEGIA-TR
			MULTIPLE SCLEROSIS QUADRIPLLEGIA-NO
			ACT OF VIOLENCE PARAPLEGIA-TRAU
			VEHICULAR QUADRIPLLEGIA-TR
			MULTIPLE SCLEROSIS QUADRIPLLEGIA-NO
			OTHER - DISEASE PARAPLEGIA-NONT
			MULTIPLE SCLEROSIS PARAPLEGIA-NONT
			VEHICULAR PARAPLEGIA-TRAU

## SCD Reports Menu... Filtered Reports...

### Mailing Labels

This option produces mailing labels for patients in the SCD registry.

The following is a step-by-step procedure for using this option, your PC's terminal emulator, and Microsoft Word to print properly formatted mailing labels.

#### How to Create Mailing Labels from SCD Registry

1. From your SCD Reports menu, select FIL (Filtered Reports). Answer a Yes/No prompt regarding filters (a Yes answer enables you to custom select the patients). You then select the ML (Mailing Labels) filtered reports option. If you chose to use filters, answer the filtered prompts as desired.
2. At the prompt "Select DEVICE:", hit return. You will see the message "Prepare to capture list: Hit return when you are ready:"

**ProComm users:** Click the file capture icon on your toolbar (looks like a butterfly net). Hit return. This starts the file capture. Wait momentarily. When you see "---END---", click the file capture icon again to close the capture. Hit return again. You now have captured the file onto your PC. Minimize or close ProComm. (Note: If your captured file contains fewer than 24 records, you may need to edit the file and remove the unnecessary lines at the top.)

**Smart Term users:** Click Tools, then click Start Capture. A dialogue box will appear where you can specify the file name and the directory for saving the file. It is recommended you save it in the same directory as your Microsoft Word documents. Then click the Start Capture button in the dialogue box. Hit return. This starts the file capture. Wait momentarily. When you see "---END---", click Tools, and click Stop Capture to close the capture. Hit return again. You now have captured the file onto your PC. Minimize or close SmartTerm.

#### Example:

Select DEVICE: <RET>

Prepare to capture list: Hit return when you are ready:

When you see ---END--- Close the capture file and hit return.

<RET>

FNAME , LNAME , ADDRESS1 , ADDRESS2 , ADDRESS3 , CITY , STATE , ZIPCODE

---END---

### 3. Start Microsoft Word.

- a) Click File then “Open” and open the capture file. Save the capture file as a Word document.
- b) Click File again, then “New”.
- c) Click Tools, and then click Mail Merge. At the Mail Merge Helper, click #1 Create, click Mailing Labels, and then click “Active Window”. Next, click #2 “Get Data”. Choose “Open Data Source” then find and select the capture file. Click “Set up Main Document” button (a Label Options box will appear). Select the type of label you will be using (ex: Avery Labels 5160), then click OK...A Create Labels box appears next. Click “Insert Merge Field” (IMF) button. Begin arranging your mailing labels by clicking “FNAME” then hit “Enter”, hit space bar to insert a space then click IMF button to insert “LNAME”, click the IMF button again, click “ADDRESS 1” then hit “Enter”. Click the IMF button again then click “ADDRESS 2” then hit “Enter”. Click IMF button again, then click “ADDRESS 3” then hit “Enter”. Click the IMF button again to insert “CITY”, and then enter a comma and a space. Click IMF button again, then click “STATE”. Press space bar twice, click IMF button, and then click “ZIP CODE”. Then click OK.

**Note:** Your mailing label arrangement should look like this...

```
<<FNAME>> <<LNAME>>  
<<ADDRESS 1>>  
<<ADDRESS 2>>  
<<ADDRESS 3>>  
<<CITY>>, <<STATE>> <<ZIP CODE>>
```

Click #3, Merge. A “Merge” dialog box appears. Click Merge.

**SCD Reports Menu...**  
**Filtered Reports...**

**Patient Listing**

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This option produces a report of patients from your local SCD registry. The report includes Patient Name, SSN, Date of Birth and, if there is a Date of Death in the Patient File, the notation "Deceased."

```
### This report is designed for 132 column viewing/printing    ###
### Set your terminal display to 132 columns                    ###
### For screen viewing, answer DEVICE prompt with 0;132       ###
### For file capture, answer DEVICE prompt with 0;132;9999     ###
### For a hardcopy, answer with a 132 column printer or subtype ###
```

Select DEVICE: *(Enter a device)*

Patient Listing		Date: 05/11/2000				
Patient	SSN	DOB	Eligibility	Means	LOI	Prov. Et

**SCD Reports Menu...**  
**Filtered Reports...**

**Patient Listing (Sort by State and County)**

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This option produces a report of patient data from your local SCD registry, which is sorted by state and county.

```
### This report is designed for 132 column viewing/printing      ###
### Set your terminal display to 132 columns                       ###
### For screen viewing, answer DEVICE prompt with 0;132          ###
### For file capture, answer DEVICE prompt with 0;132;9999       ###
### For a hardcopy, answer with a 132 column printer or subtype  ###
```

Select DEVICE: HOME// **0;132** VIRTUAL/CURRENT DEVICE

Patient Listing by State and County

Patient	SSN	DOB	Eligibility	Means	LOI	Prov. Etiology	Date Occ	AE Receivd	AE Next
State: ALABAMA		County: BARBOUR		VERIFIED	T09	OCONN MULTIPLE SCLEROSIS	00/00/1986		
State: ALABAMA		County: BLOUNT	SERVICE CONNECT	VERIFIED	T10	GERHA VEHICULAR	11/04/1996	03/23/1998	
03/23/1999									
State: ALABAMA		County: BUTLER	NSC	VERIFIED		OTHER			
State: ALABAMA		County: BUTLER	NSC			OTHER			
State: ALABAMA		County: BUTLER	SERVICE CONNECT	VERIFIED	T12	VEHICULAR	04/00/1967		
State: ALABAMA		County: CHILTON	SERVICE CONNECT	VERIFIED	C05	VEHICULAR	03/18/1995	05/13/1998	
05/13/1999									

**SCD Reports Menu...**  
**Filtered Reports...**

**Registrant General Report**

The Registrant General Report option produces a standard VA FileMan report that allows for individual customization. Patient data associated with active and inactive SCD Registrants are extracted exclusively from your local SCD registry. Enter two question marks (??) at any prompt to receive help.

SORT BY: NUMBER// <RET>  
START WITH NUMBER: FIRST// <RET>  
DEVICE: {VIRTUAL/CURRENT DEVICE}

SCD Registrant General Report				MAY 11,2000 11:04	PAGE 1
PATIENT	SSN	DOB	REGISTR DATE	STATUS	
LAST ANN	SERVICE	LAST			
EVAL RECD	CONNECTED	UPDATED			
-----					
NUMBER: 74					
OCT 22,1997	YES	APR 4,2000	MAY 22,1995	SCD - CURRENT	
.....					

**SCD Reports Menu...**  
**Filtered Reports...**

**Registrant Injury Report**

This option produces a standard VA FileMan report that allows for individual customization. Patient data associated with active and inactive SCD registrants are extracted exclusively from your local SCD registry. Enter two question marks (??) at any prompt to receive help.

SORT BY: NUMBER// <RET>  
START WITH NUMBER: FIRST// <RET>  
DEVICE: {VIRTUAL/CURRENT DEVICE}

SCD Registrant Injury Report			MAY 11, 2000	11:11	PAGE 1
PATIENT	SSN	DOB	SCI LEVEL	EXTENT OF SCI	
INFO SOURCE FOR SCD	ETIOLOGY		DATE OF ONSET	TRAUMA	
-----					
	NUMBER: 74				
CHART REVIEW	FALL		DEC 1980	C04 INCOMPLETE TRAUMATI	
...					

**SCD Reports Menu...**  
**Filtered Reports...**

**<sup>1</sup>Self Report of Function**

Use this option to obtain the Self Report of Function scores for a patient or a group of patients. Enter ALL at the "Select a patient" prompt to obtain a report on all patients.

Select a patient: NO EMPLOYEE

Select a patient: <RET>

One Moment Please...

DEVICE: {VIRTUAL/CURRENT DEVICE}

Patient: SSN: DOB:

-----  
<sup>2</sup>Self Report of Function Scores |

Date Recorded: SEP 4,1996 Respondent Type: PATIENT

Score Type:

Disposition:

Move around inside house: SOME HELP  
Stairs: TOTAL HELP OR NEVER DO  
Transfer to Bed/Chair: SOME HELP  
Transfer to Toilet: SOME HELP  
Transfer to tub/shower: EXTRA TIME OR SPECIAL TOOL  
Eating: EXTRA TIME OR SPECIAL TOOL  
Grooming: EXTRA TIME OR SPECIAL TOOL  
Bathing: EXTRA TIME OR SPECIAL TOOL  
Dressing upper body: SOME HELP  
Dressing lower body: EXTRA TIME OR SPECIAL TOOL  
Toileting: EXTRA TIME OR SPECIAL TOOL  
Bladder management: TOTAL HELP OR NEVER DO  
Bowel Management: TOTAL HELP OR NEVER DO  
  
Get to places outside of home: UNABLE  
Shopping: UNABLE  
  
Planning and cooking own meals: UNABLE  
Doing housework: UNABLE  
Handling money: WITH HELP  
  
Help during last 2 weeks: YES  
Number of hours of help in last 2 weeks: 70  
Number of hours of help in last 24 hours: 7  
  
Method ambulation (Walking): WITH DEVICE  
  
Method ambulation (Wheelchair): MOTORIZED  
-----  
Total Self Report of Function Score: 29.0

<sup>1</sup> Patch SPN\*2.0\*19 – New report.

<sup>2</sup> Patch SPN\*2.0\*19 – Updated display.

**SCD Reports Menu...**  
**Filtered Reports...**

**Utilization Reports...**

**Laboratory Utilization**

This option produces a report of laboratory use by patients in your SCD registry over a selected date range.

Start date for period: **12/1/99** (DEC 01, 1999)  
 End date for period: (12/1/1999 - 12/29/1999): TODAY// **<RET>** (DEC 29, 1999)  
 Minimum number of results reported for a test to be listed :(1-999999):  
 3//**<RET>**

Number of highest users to identify: (0-100): 0// **5**  
 DEVICE: {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Laboratory Utilization SUPPORT ISC For the Period 12/01/99 to 12/29/99	
Totals: 9 orders placed (75 results reported) for 1 patient (These include 31 different lab tests)	
Patients	Orders
1	9

SCD - Laboratory Utilization SUPPORT ISC For the Period 12/01/99 to 12/29/99 Lab Tests with 3 or more Results			
Lab Test	Results	Max # Results Patients	(# patients)
CHLORIDE	4	1	
CO2	4	1	
CREATININE	4	1	
GLUCOSE	4	1	
POTASSIUM	4	1	
SODIUM	4	1	
UREA NITROGEN	4	1	
HGB	3	1	

SCD - Laboratory Utilization  
SUPPORT ISC  
For the Period 12/01/99 to 12/29/99

Different Patient Name	SSN	Orders	Results	Lab Tests
---------------------------	-----	--------	---------	-----------

**SCD Reports Menu...**  
**Filtered Reports...**  
**Utilization Reports...**

**Laboratory Utilization (Specific)**

This option produces specific lab utilization reports for patients in your SCD registry. You are prompted to enter a range of dates and laboratory test names to receive this report.

Start date for period: **1/1/99** (JAN 01, 1999)  
End date for period: (1/1/1999 - 12/29/1999): TODAY// **<RET>** (DEC 29, 1999)  
Select LABORATORY TEST NAME: **Creatinine**  
Another LABORATORY TEST NAME: **<RET>**

Do you want to see patient usage data? YES// **<RET>**  
DEVICE: {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Laboratory Utilization (Specific)		
SUPPORT ISC		
For the Period 01/01/99 to 12/29/99		
CREATININE		
Total: 1 patient		4
Patient Name	SSN	Tests

**SCD Reports Menu...**  
**Filtered Reports...**  
**Utilization Reports...**

**Pharmacy Utilization**

This option produces pharmacy utilization reports of patients in your SCD registry. You are prompted to enter a range of dates and how dollar costs should be reported.

Start date for period: **1/1/99** (JAN 01, 1999)

End date for period: (1/1/1999 - 12/29/1999): TODAY// **<RET>** (DEC 29, 1999)

Minimum number of fills to display: (1-999999): 2// **<RET>**

Minimum dollar cost of dispensed fills to display: (0-9999999): 10// **<RET>**

Select one of the following:

- 1 Actual cost at the time
- 2 Current cost today

How should dollar costs of prescription drugs be reported?: **1** Actual cost at the time

Number of highest users to identify: (0-100): 0// **5**

DEVICE: {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Pharmacy Prescription Utilization	
SUPPORT ISC	
For the Period 01/01/99 to 12/29/99	
Totals: 50 fills reported for 6 patients	
(These include 20 different drugs)	
Patients	Fills
1	21
3	7
1	6
1	2

SCD - Pharmacy Prescription Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/29/99

Drugs with 2 or more fills

Drug	Fills	Patients	Max # Fills (# patients)
DIGOXIN 0.25MG TAB	7	3	3 (2)
DIGOXIN (LANOXIN) 0.125MG TAB	4	3	2 (1)
PROCAINAMIDE 500MG CAPSULE	4	3	2 (1)
GLYBURIDE 2.5MG TAB	4	2	2 (2)
ALBUTEROL INHALER 17GM	4	1	
BECLOMETHASONE INHALER 16.8GM	4	1	
LOVASTATIN 10MG TAB	3	2	2 (1)
WARFARIN 5MG TAB	3	2	2 (1)
DIAZEPAM 5MG TAB	3	1	
ASPIRIN 325MG TAB	2	1	
QUINIDINE SULFATE 200MG TAB	2	1	
TERFENADINE 60MG TABLET	2	1	

SCD - Pharmacy Prescription Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/29/99

Drugs with fills totaling \$10.00 or more

Drug	Actual Cost	Fills	Qty Disp	Pats
TERFENADINE 60MG TABLET	180.00	2	180	1
GLYBURIDE 2.5MG TAB	144.00	4	360	2
LOVASTATIN 10MG TAB	90.00	3	90	2
NEFAZODONE 100MG TABLET	50.01	1	30	1
DIAZEPAM 5MG TAB	31.95	3	90	1
DIGOXIN (LANOXIN) 0.125MG TAB	28.80	4	360	3
BECLOMETHASONE INHALER 16.8GM	24.18	4	6	1
NIFEDIPINE 10MG CAP	22.44	1	120	1
DIGOXIN 0.25MG TAB	20.85	7	510	3
ALBUTEROL INHALER 17GM	15.00	4	4	1
PROCAINAMIDE 500MG CAPSULE	12.00	4	480	3
TOTAL for listed drugs	619.23			
TOTAL (including unlisted drugs)	640.01			

SCD - Pharmacy Prescription Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/29/99

Patients	Dollar Cost of Fills
1	300-399
2	100-199
3	0- 99

SCD - Pharmacy Prescription Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/29/99

Highest Utilization Patients Based on Fills

Patient Name	SSN	Total Fills	Different Drugs	Total Cost
--------------	-----	----------------	--------------------	---------------

SCD - Pharmacy Prescription Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/29/99

Highest Utilization Patients Based on Cost

Patient Name	SSN	Total Fills	Different Drugs	Total Cost
--------------	-----	----------------	--------------------	---------------

**SCD Reports Menu...**  
**Filtered Reports...**  
**Utilization Reports...**

**Pharmacy Utilization (Specific)**

This option produces specific pharmacy utilization reports for patients in your SCD registry showing the dollar cost of prescriptions. You are prompted to enter a range of dates and to select a generic drug name.

Start date for period: 1/1/99 (JAN 01, 1999)  
End date for period: (1/1/1999 - 12/29/1999): TODAY// <RET> (DEC 29, 1999)  
Select a GENERIC DRUG NAME: **WARFARIN**  
1 WARFARIN (COUMADIN) NA 2.5MG TAB BL100  
2 WARFARIN 5MG TAB BL100  
CHOOSE 1-2: 2 WARFARIN 5MG TAB BL100  
Another GENERIC DRUG NAME: <RET>

Do you want to see patient usage data? YES// <RET>  
DEVICE: {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Pharmacy Prescription Utilization					
SUPPORT ISC					
For the Period 01/01/99 to 12/29/99					
WARFARIN 5MG TAB, currently \$0.0360/unit					
Total:	2 patients		3	90	\$3.24
Patient Name	SSN	Fills	Qty	Value	

**SCD Reports Menu...**  
**Filtered Reports...**  
**Utilization Reports...**

**Radiology Utilization**

This option produces a multi-part report showing the various completed radiology procedures and their associated costs (if the cost data is present) during the period specified.

Radiology personnel may also use this option. However, unless they possess the SPNL SCD PTS security key, they are not given the opportunity to see specific patients. This preserves patient confidentiality.

Start date for period: **1/1/99** (JAN 01, 1999)  
End date for period: (1/1/1999 - 12/29/1999): TODAY// **<RET>** (DEC 29, 1999)  
Minimum number of procedures to display: (1-99999): 2// **1**  
Minimum dollar cost of procedures to display: (0-999): 10// **<RET>**

Number of highest users to identify: (0-100): 0// **5**  
DEVICE: {VIRTUAL/CURRENT DEVICE}

Gathering patient data

SCD - Radiology Utilization	
SUPPORT ISC	
For the Period 01/01/99 to 12/30/99	
Totals: 8 procedures reported for 6 patients	
(These include 8 different procedures)	
Patients	Procedures
2	2
4	1

SCD - Radiology Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/30/99

1 or More Procedures

Radiology Procedure	CPT Code	Procedures	Value	Patients
ABDOMEN 2 VIEWS	74010	1	\$. \$\$	1
ANGIO BRACHIAL RETROGRADE CP	75659	1	\$. \$\$	1
ANKLE 2 VIEWS	73600	1	\$. \$\$	1
CHEST 4 VIEWS	71030	1	\$. \$\$	1
CLAVICLE	73000	1	\$. \$\$	1
FOOT 3 OR MORE VIEWS	73630	1	\$. \$\$	1
HIP 1 VIEW	73500	1	\$. \$\$	1
KNEE 3 VIEWS	73562	1	\$. \$\$	1

SCD - Radiology Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/30/99

Radiology procedures totaling \$10.00 or more

Radiology Procedure	CPT Code	Value	Procedures	Patients
TOTAL for all procedures		\$. \$\$		

SCD - Radiology Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/30/99

Highest Utilization Patients Based on Number of Procedures

Patient Name	SSN	Total Procs	Different Procs	Total Value
--------------	-----	-------------	-----------------	-------------

SCD - Radiology Utilization  
SUPPORT ISC  
For the Period 01/01/99 to 12/30/99

Highest Utilization Patients Based on Value

Patient Name	SSN	Total Procs	Different Procs	Total Value
--------------	-----	-------------	-----------------	-------------

## SCD Reports Menu...

### Functional Status Scores

This option prints a patient's functional status scores for either the <sup>1</sup>Self Report of Function or FIM.

Select one of the following:

- 1 Self Report of Function
- 2 FIM

Select the type of Functional Status you wish to print: **1** Self Report of Function

Enter the beginning date range: **T-14**

Enter the ending date range: **T**

Select PATIENT: NO

PILL

Enrollment Priority: GROUP 5 Category: IN PROCESS End Date:

Another one: <RET>

DEVICE: {VIRTUAL/CURRENT DEVICE}

Self Report of Function Total Score													Page: 1						
for													Dec 30, 1999						
SSN: DOB:																			
Extent & Completeness: TETRAPLEGIA - COMPLETE SENSORY AND MOTOR																			
Type of Injury: INDETERMINATE																			
DATE	SCORE	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
12/17/99	29.0	3	3	2	2	2	2	2	2	2	2	2	2	2	3				
A-EATING		G-BLADDER MANAGEMENT						M-STAIRS											
B-GROOMING		H-BOWEL MANAGEMENT						N-COMPREHENSION											
C-BATHING		I-TRANSFER TO BED/CHAIR						O-EXPRESSION											
D-DRESSING UPPER BODY		J-TRANSFER TO TOILET						P-SOCIAL INTERACTION											
E-DRESSING LOWER BODY		K-TRANSFER TO TUB/SHOWER						Q-PROBLEM SOLVING											
F-TOILETING		L-MOVE AROUND INSIDE YOUR HOUSE						R-MEMORY											
Star "*" indicates the score is incomplete.																			

<sup>1</sup> Patch SPN\*2.0\*19 - New Report.

<sup>2</sup> Patch SPN\*2.0\*19 - Updated display.

## ICD9 Code Search

This option allows users to find patients in or out of the SCD Registry who have just one particular ICD9 code, have several particular ICD9 codes, or fall in a range of ICD9 codes. The report searches the patients in the PTF file (#45) according to user-specified admission dates, and will include patients who have any of the ICD9 codes

```

Select SCD Reports Menu Option: ICD  ICD9 Code Search

Do you want patients in the Registry only? Yes// Y  (Yes)
Would you like to sort on a Range of ICD9 codes? No// Y  (Yes)
Starting ICD9 Code: 192.2  192.2      MAL NEO SPINAL CORD      COMPLICATION/COMORY
...OK? Yes// <RET>  (Yes)

Ending ICD9 code: 952.16  952.16      COMPLETE LES CORD/T7-T12      COMPLICATION/Y
...OK? Yes// <RET>  (Yes)

Enter an Admission STARTING date: JAN 19,2001//010101  (JAN 01, 2001)
Enter an Admission ENDING date: JAN 16,2001//013101  (JAN 31, 2001)
Select DEVICE: HOME// <RET>  VIRTUAL/CURRENT DEVICE

                Patients in the Registry only
                    ICD9 Code Search
                Ran on admissions from JAN 1,2001 to JAN 31,2001@23:59
                Page: 1

Patient              SSN              Registration Status      SCI Level
Admission Date
-----

Admission: JAN 03, 2001@21:12:28
DXLS: 996.31  ICD2: 427.31  ICD3: 427.32  ICD4: 344.00  ICD5: 907.2
ICD6:          ICD7:          ICD8:          ICD9:          ICD10:
-----

Admission: JAN 05, 2001@16:15
DXLS: V58.49  ICD2: 239.4  ICD3: 344.1  ICD4: 907.2  ICD5:
ICD6:          ICD7:          ICD8:          ICD9:          ICD10:
-----

Admission: JAN 24, 2001@23:08:58
DXLS: 340.    ICD2: 599.0  ICD3: 041.04  ICD4: V09.0  ICD5: 041.3
ICD6: 288.0  ICD7: 596.54  ICD8: 446.5  ICD9: 401.9  ICD10:
-----

```

## SCD Reports Menu...

### Print MS Help Text

This option prints or displays the Multiple Sclerosis help.

Display expanded Multiple Sclerosis descriptions

Select DEVICE: HOME// (Press the <RET> key or enter a device name.)

MS Expanded Help Text

Page: 1 MAY 31,2000

---

#### PYRAMIDAL

=====

Normal

Abnormal Signs without disability.

Minimal disability.

Mild to moderate paraparesis or hemiparesis; severe monoparesis.

Marked paraparesis or hemiparesis; moderate quadriparesis, or  
monoplegia.

Paraplegia, hemiplegia, or marked quadriparesis.

Quadriplegia.

Unknown

#### BRAINSTEM

=====

Normal

Signs only.

Moderate nystagmus or other mild disability.

Severe nystagmus, marked extraocular weakness.

Marked dysarthria.

Inability to swallow or speak.

Unknown

#### SENSORY

=====

Normal

Vibration or finger-writing decrease only, in 1 or 2 limbs.

Mild decrease in touch or pain or position sense, and/or

moderate decrease in vibration in 1 or 2 limbs or vibration  
decrease alone in 3 or 4 limbs.

Moderate decrease in touch or pain or position sense, and/or

essentially lost vibration in 1 or 2 limbs; mild decrease in  
touch or pain and/or moderate decrease in all proprioceptive  
tests in 3 or 4 limbs.

Marked decrease in touch or pain or loss of proprioception, alone

or combined, in 1 or 2 limbs; or moderate decrease in touch or  
pain and/or severe proprioception decrease in more than 2 limbs.

Sensation essentially lost below head.

Unknown

CEREBRAL

=====

Normal

Mood alteration only.

Mild decrease in mentation.

Moderate decrease in mentation.

Marked decrease in mentation.

Dementia or chronic brain syndrome.

Unknown

CEREBELLAR

=====

Normal

Abnormal signs without disability.

Mild ataxia.

Moderate truncal or limb ataxia (tremor or clumsy movements interfere with function in all spheres).

Severe ataxia in all limbs (most function is very difficult).

Unable to perform coordinated movements due to ataxia.

Weakness (grade 3 or more on pyramidal) interferes with testing.

Unknown

BOWEL & BLADDER

=====

Normal

Mild hesitancy.

Moderate hesitance, urgency, retention or rare incontinence (intermittent self-catheterization, manual compression to evacuate bladder or finger evacuation of stool).

Frequent urinary incontinence.

In need of almost constant catheterization (and constant use of measure to evacuate stool).

Loss of bladder function.

Loss of bladder and bowel function.

Unknown

VISUAL

=====

Normal

Scotoma with visual acuity (corrected) better than 20/30.

Worse eye with scotoma with maximum visual acuity (corrected) of 20/30 to 20/59.

Worse eye with large scotoma, or moderate decrease in fields, but with maximal visual acuity of 20/60 to 20/99.

Worse eye with marked decrease of fields and maximal visual acuity (corrected) of 20/100 to 20/200; grade 3 plus maximal acuity better eye 20/60 or less.

Worse eye with maximal visual acuity or (corrected) less than 20/20; grade 4 plus maximal acuity of better eye 20/60 or less.

Grade 5 plus maximal visual acuity of better eye 20/60 or less.

Presence of temporal pallor.

Unknown

OTHER

=====

None

Any other neurological finding attributed to MS.

Unknown

EDSS

====

Normal neurological exam.

No disability, minimal signs in one FS.

No disability, minimal signs in more than one FS.

Minimal disability in one FS.

Minimal disability on two FS.

Moderate disability in one FS.

Fully ambulatory but with moderate disability in one FS and one or two FSs grade 2; or two FSs grade 3; or five FSs grade 2.

Fully ambulatory without aid, self-sufficient, up and about some 12 hrs despite relatively severe disability consisting of one FS grade 4, or combinations of lesser grades exceeding limits of previous steps.

Fully ambulatory without aid up and about much of the day, able to work full day may otherwise have some limitations of full activity or require minimal assistance.

Ambulatory without aid or rest for about 200 meters, disability severe enough to impair full daily activity.

Ambulatory without aid or rest for about 100 meters, disability severe enough to preclude full daily activity.

Intermittent or unilateral constraint assistance (cane, crutch, brace) required to walk about 100 meters with or without resting.

Constant bilateral assistant (cane, crutches, brace) required to walk about 20 meters without resting.

Unable to walk beyond about 5 meters even with aid; essentially restricted to wheelchair, wheels self in standard wheelchair and transfers alone; up and about in wheelchair some 12 hours a day.

Unable to take more than a few steps; restricted to wheelchair; may need aid in transfer; wheels self, but cannot carry on in standard wheelchair a full day; may require motorized wheelchair.

Essentially restricted to bed or chair or perambulated in wheelchair, but may be out of bed himself/herself much of the day; retains many self-care functions; generally has effective use of arms.

Essentially restricted to bed much of the day; has some effective use of arms; retains some self-care functions.

Helpless bed patient; can communicate and eat.

Totally helpless bed patient; unable to communicate effectively or eat/swallow.

Death due to MS

## SCD Reports Menu...

### MS (Kurtzke) Measures

This option allows you to produce an MS (Kurtzke) Measures report (functional system) on selected patients. You have the option of choosing all patients or entering specific patients as illustrated below. This report will result in an EDSS (Expanded Disability Status Scale) score. To select all patients, enter ALL at the "Select a patient" prompt.

Select a patient: NO  
EMPLOYEE

Select a patient: <RET>  
One Moment Please...  
DEVICE: {VIRTUAL/CURRENT DEVICE}

Patient:	SSN:	DOB:
-----		
Date Recorded: SEP 4,1996		
Functional System (Kurtzke)		
Pyramidal:	3	Mild-mod para or hemiparesis
Brainstem:	3	Sev nystag, mark extraocular
Sensory:	5	Sensation essentially lost b
Cerebral:	5	Dementia or chronic brain sy
Cerebellar:	1	Abnormal signs without disab
BWL & BLDR:	2	Mod hes, urg, ret, rare inco
Visual:	3	Worse eye large scotoma, \ \
Other:		
Expanded Disability Status Scale (EDSS/Kurtzke)		
EDSS Score:		
4.5 1 FS grade 4; walk without aid or rest 300 m		

## SCD Reports Menu...

### MS Patient Listing

Use this option to obtain a list of Multiple Sclerosis patients. You can filter out patients you don't want on the list. Your selection choices are shown in the example.

Select one of the following:

A	ALL
0	NOT SCD
1	SCD - CURRENTLY SERVED
2	SCD - NOT CURRENTLY SERVED
X	EXPIRED

Select a Registration Status: A// 1 SCD - CURRENTLY SERVED

Select one of the following:

A	ALL
Y	SCI NETWORK YES
N	SCI NETWORK NO

Select a SCI NETWORK: A// <RET>LL

Select one of the following:

A	ALL
UN	UNKNOWN
RR	RELAPSING-REMITTING
PP	PRIMARY PROGRESSIVE
SP	SECONDARY PROGRESSIVE
PR	PROGRESSIVE RELAPSING

Select a MS Subtype value: A// <RET>LL

Select DEVICE: HOME// (Press the <RET> key or select a printer.)

Patient (Last / Next Eval)	MS Patient Listing Report SSN	MAY 31,2000 MS Subtype Date of Onset	Page: 1 Provider (EDSS Date & Score)
( )		( )	
(JAN 07, 1999 JAN 07, 2000)		MAY 6,1989	( )
(FEB 02, 1999 FEB 02, 2000)		JUN 7,1989	( )

## SCD Reports Menu...

### Patient Summary Report

This option allows you to print the contents of a patient's SCD record.

Select PATIENT: NO PILL  
Enrollment Priority: Category: IN PROCESS End Date:

Another one: <RET>

DEVICE: {VIRTUAL/CURRENT DEVICE}

Patient:	SSN:	DOB:
Registration Status: NOT SCD		Registration Date: 04/07/1998
VA SCI Status: QUADRIPLÉGIA-NONTRAUMATIC		
SCI Level: T02		Extent of SCI: COMPLETE
Last Annual Rehab Received:		
BCR Care Remb: YES	BCR Date Cert:..04/04/1999	BCR Provider: KELLY,MARC
MS Subtype: RELAPSING-REMITTING		
Date of Last Update: 05/11/2000		Last Update By:
Date ofOnset	Etiology	Type of Cause
=====	=====	=====
10/02/99	MULTIPLE SCLEROSIS	NON-TRAUM

### Show Sites Where Patient has been Treated

Use this option to view/print the facilities (other VA sites) where a patient has been treated. This information is derived from the Treating Facility List file (#391.91) and requires the installation of CIRN (Clinical Information Resource Network).

Select SCD (SPINAL CORD) REGISTRY PATIENT: **TEST,PATIENT** 11-7-55 0  
Enrollment Priority: GROUP 5 Category: IN PROCESS End Date:

Pt Has Been Treated at	Date Last Treated
DENVER, CO	03/28/2000
HAMPTON, VA.	02/13/2000

## Change your Division Assignment

When you first access the Spinal Cord Dysfunction program, your division assignment is displayed.

```
Hello <Your Name>
You are working under the division of <Division Number> / <Division
Name>
```

Use this option to change the division.

### <sup>1</sup>Inquire to an Outcome

This option is used to view completed data fields for a particular Outcome record.

PATIENT:	RECORD TYPE: ASIA	
DATE RECORDED: JUL 19, 2001		DISPOSITION: 3 HOME ASSISTED
ASIA IMPAIRMENT SCALE: A		ASIA HIGHEST NEURO LEVEL: T04
SSN (c):		DOB (c):
AGE (c): 77		MOTOR SCORE (c): ERROR
COGNITIVE SCORE (c): ERROR		TOTAL SCORE (c): ERROR
CHART TOTAL SCORE (c): 0		LENGTH OF REHAB IN DAYS (c): 0
DATE OF DEATH (c): DEC 10,1996@11:02		

---

<sup>1</sup> Patch SPN\*2.0\*19 – New Option, text, and display.

## <sup>1</sup>Edit Non-conforming Outcome

This option is used to edit older outcome records, i.e., those outcomes that were on file prior to the adoption of the "episode of care" clinical model, introduced in patch SPN\*2\*19. Accordingly, this option is restricted to only those records.

This edit option is limited to OLDER outcomes only, i.e., outcomes on file before the adoption of the 'episode of care' clinical model. Editing an older outcome record will not convert it to the new model. This option is not intended for regular use, but does provide a way to access older, heritage outcomes to correct data inaccuracies.

```
Patient:      SSN:  
Record Type: ASIA      Date Recorded: 07/19/2001  
-----
```

```
DISPOSITION: 3 HOME ASSISTED//  
ASIA IMPAIRMENT SCALE: A//  
TOTAL MOTOR SCORE:  
TOTAL PIN PRICK SCORE:  
TOTAL LIGHT TOUCH SCORE:  
NEUROLEVEL-SENSORY RIGHT:  
NEUROLEVEL-SENSORY LEFT:  
NEUROLEVEL-MOTOR RIGHT:  
NEUROLEVEL-MOTOR LEFT:  
ASIA COMPLETE/INCOMPLETE:  
PARTIAL PRESERVATION-SENSORY R:  
PARTIAL PRESERVATION-SENSORY L:  
PARTIAL PRESERVATION-MOTOR R:  
PARTIAL PRESERVATION-MOTOR L:  
ASIA HIGHEST NEURO LEVEL: T04//
```

---

<sup>1</sup> Patch SPN\*2.0\*19 – New Option, text, and display.

# <sup>1</sup>Inquire to a Registry Patient

This is a read-only (inquire) option providing a view of completed fields in the SCD Registry for a particular patient

Select SCD (SPINAL CORD) REGISTRY PATIENT:

YES SC VETERAN  
Enrollment Priority: GROUP 1 Category: NOT ENROLLED End Date:  
DEVICE: {VIRTUAL/CURRENT DEVICE}

```
SCD (SPINAL CORD) REGISTRY LIST      NOV 25,2003  16:22  PAGE 1
-----
PATIENT: REGISTRATION DATE: APR 09, 2003
REGISTRATION STATUS: SCD - NOT CURRENTLY SERVED
DATE OF LAST REVIEW: AUG 12, 2003@08:22
LAST UPDATED BY: REED,WILLIAM  SCI NETWORK: YES
SCI LEVEL: C03                      VA SCI STATUS: QUADRIPLLEGIA-TRAUMATIC
DIVISION: SAN DIEGO VAMC
DIVISION: ESCONDIDO CBOC
DIVISION: CHULA VISTA CBOC
EXTENT OF SCI: COMPLETE
ETIOLOGY: FALL                      DATE OF ONSET: MAR 07, 2003
ANNUAL REHAB EVAL OFFERED: MAR 20, 2003
ANNUAL REHAB EVAL RECEIVED: MAR 21, 2003
NEXT ANNUAL REHAB EVAL DUE: MAR 20, 2004
REMARKS: A test here.
```

<sup>1</sup> Patch SPN\*2.0\*21 – New Option, text, and display.

# SCD Package Management Functions

The following options are utilities that Systems Managers can use to set up and maintain the SCD package. The SCD Package Management Menu is locked with the SPNL SCD MGT security key. This security key is required to edit your SCD Site Parameters file (#154.91). It should be given to the SCI Coordinator and/or IRM Support person.

## **SCD Package Management Menu...**

- Edit Site Parameters
- Activate an SCD Registrant
- Delete an Outcome Record
- Delete Registry Record
- Enter/Edit Etiology SYNONYM
- Inactivate an SCD Registrant

## **SCD Package Management Menu...**

### **Edit Site Parameters**

The SCD Site Parameters file (#154.91) controls the duration of time for follow up reporting and the admission/discharge notice system.

#### **Follow up Reporting**

F/U RPT (LAST SEEN) PERIOD

F/U RPT (LAST PHY EXAM) PERIOD

Enter duration of time during which patients have not been seen at your facility for reporting purposes. Both of these fields have default of 180 days. These fields are used for the reports: Follow-Up (Last Seen) and Follow-Up (Last Annual Rehab Eval Received).

#### **Admission/Discharge Notice System**

If your site wants to be able to notify a specific group when patients with SCI or MS are admitted or discharged, then mail groups should be created for that purpose and members added prior to setting the parameters for SCI Notification Mail Group and MS Notification Mail Group. If the people for the groups are the same, you may want to consider creating just one group and using it for both types of notifications.

SEND NOTIFICATION

Enter YES to notify a mail group that a patient with SCI (Spinal Cord Injury) or MS (Multiple Sclerosis) has been admitted or discharged, NO to suppress notifications. The message will be sent to the mail group for the site parameter SCI Notification Mail Group or MS Notification Mail Group depending on whether the patient is MS or SCI.

SCI NOTIFICATION MAIL GROUP

The default for this is the SPNL SCD Coordinator mail group. If your site created a specific mail group and you want that group to receive these notifications, then enter it here.

MS NOTIFICATION MAIL GROUP

The default for this is the SPNL SCD Coordinator mail group. If your site created a specific mail group and you want that group to receive these notifications, then enter it here.

The Facility Number cannot be edited directly through the Edit Site Parameters option. It is automatically updated from the Kernel Site Parameters file (#4.3) every time you execute this option. Updating the Kernel Site Parameters file can only make changes to the Facility Number.

Select SCD Package Management Menu Option: **Edit Site Parameters**

F/U RPT (LAST SEEN) PERIOD: 180D// ??

This is the period which the Follow Up (Last Seen) report uses. Patients who haven't been seen for this period of time will be ed in the report. The default may be changed through the Site Parameters menu.

For example, 180D is 180 days; 6M is 6 months.

F/U RPT (LAST SEEN) PERIOD: 180D// <RET>

F/U RPT (LAST PHY EXAM) PERIOD: 180D// ??

This is the period, which the Follow Up (Last Physical Exam) report uses. Patients who haven't had a physical exam for this period of time will be ed in the report. The default may be changed through the Site Parameters menu. For example, 180D is 180 days; 6M is 6 months.

F/U RPT (LAST PHY EXAM) PERIOD: 180D// <RET>

SEND NOTIFICATION: YES// <RET>

SCI NOTIFICATION MAIL GROUP: SPNL SCD COORDINATOR//

**SPNL SCI**

MS NOTIFICATION MAIL GROUP: SPNL SCD COORDINATOR//

**SPNL MS**

## SCD Package Management Menu...

### Activate an SCD Registrant

You may use this option to reactivate a record that has been inactivated in your local SCD registry. (Even though the record was inactivated, it was not deleted from VistA.) After responding YES to the "Are you sure..." prompt, the patient is automatically activated in the local registry.

You can inactivate an active record by one of two methods: by using the option Inactivate an SCD Registrant or by resetting the REGISTRATION STATUS to SCD - NOT CURRENTLY SERVED in the Registration and Health Care Information option.

Select SCD Package Management Menu Option: **Activate** an SCD Registrant

```
Select PATIENT: NO EMPLOYEE
Are you sure you want active? NO// Y YES
is now active.
```

## SCD Package Management Menu...

### Delete an Outcome Record

If you entered a record in error, you can remove it from the database by using this option. This option deletes only the outcomes record.

Anytime you delete a record, a mail message is sent to the SPNL SCD Coordinator mail group informing the members of the deletion.

Select SCD Package Management Menu Option: **Delete an Outcome Record**

```
Select Outcome Record to Delete:          YES
MILITARY RETIREE
  1                666770000  CLINICIAN REPORTED  JUN 21, 1995
  2                666770000  CLINICIAN REPORTED  MAR 23, 1995
  3                666770000  FOUR LEVEL FUNCTIO  JUN 23, 1994
  4                666770000  CLINICIAN REPORTED  SEP 12, 1995
  5                666770000  FOUR LEVEL FUNCTIO  DEC 08, 1995
TYPE '^' TO STOP, OR <RET>
CHOOSE 1-5: 2

OK to delete this record: No// YES

Select Outcome Record to Delete: <RET>

Sending deletion notification to the SPNL SCD COORDINATOR mail group...
```

## SCD Package Management Menu...

### Delete Registry Record

If you entered a record in error, you can remove it from the database by using this option. This option deletes only the registry record.

Anytime you delete a record, a mail message is sent to the SPNL SCD COORDINATOR mail group informing the members of the deletion.

Select SCD Package Management Menu Option: **Delete** Registry Record

Select Registry Record to Delete:

YES SC VETERAN

OK to delete this record: No// YES

Select Registry Record to Delete: <RET>

Sending deletion notification to the SPNL SCD COORDINATOR mail group...

## SCD Package Management Menu...

### Enter/Edit Etiology SYNONYM

This option allows you to enter/edit the cause of a spinal cord dysfunction. As shown in the prompts and responses below, you may enter the number of the etiology, description (first few letters of entry), type of cause (traumatic or non-traumatic), or one or more synonyms.

Select SCD Package Management Menu Option: **Enter**/Edit Etiology SYNONYM

Select ETIOLOGY (Cause of SCD): ?

Answer with ETIOLOGY NUMBER, or DESCRIPTION, or TYPE OF CAUSE, or SYNONYM

Do you want the entire 16-Entry ETIOLOGY List? **Y** (Yes)

Choose from:

1	SPORTS ACTIVITY	TRAUMATIC CAUSE
2	ACT OF VIOLENCE	TRAUMATIC CAUSE
3	VEHICULAR	TRAUMATIC CAUSE
4	FALL	TRAUMATIC CAUSE
5	INFECTION OR ABSCESS	NON-TRAUMATIC CAUSE
6	OTHER - TRAUMATIC	TRAUMATIC CAUSE
7	MOTOR NEURON DISEASE	NON-TRAUMATIC CAUSE
8	MULTIPLE SCLEROSIS	NON-TRAUMATIC CAUSE
9	TUMOR	NON-TRAUMATIC CAUSE
10	OTHER	UNKNOWN
11	OTHER - DISEASE	NON-TRAUMATIC CAUSE
12	POLIOMYELITIS	NON-TRAUMATIC CAUSE
13	UNKNOWN	NON-TRAUMATIC CAUSE
14	UNKNOWN	TRAUMATIC CAUSE
15	SYRINGOMYELIA	NON-TRAUMATIC CAUSE
16	ARTHRITIC DISEASE OF THE SPINE	NON-TRAUMATIC CAUSE

Select ETIOLOGY (Cause of SCD): **8** MULTIPLE SCLEROSIS NON-TRAUMATIC CAUSE

ETIOLOGY: MULTIPLE SCLEROSIS  
TYPE OF CAUSE: NON-TRAUMATIC CAUSE

Select Etiology SYNONYM: MS  
NEUROLOGICAL DIS OF SPINE & BRAIN

Are you adding 'NEUROLOGICAL DIS OF SPINE & BRAIN' as a new SYNONYM (the 2ND for this ETIOLOGY)? Y

Save changes before leaving form (Y/N)? Y

COMMAND: E

Press <PF1>H for help Insert

## Inactivate an SCD Registrant

This option gives you the ability to inactivate a patient in your local registry. Use this option when the patient is not expected to return to your facility or in the case of the patient's death.

After entering a patient's name and responding YES to the "Are you sure..." prompt, the patient is automatically inactivated in the local registry.

You can activate an inactive record by one of two methods: by using the option Activate an SCD Registrant or by resetting the REGISTRATION STATUS field to SCD -CURRENTLY SERVED in the Registration and Health Care Information option.

Select SCD Package Management Menu Option: **Inactivate an SCD Registrant**

Select PATIENT: NO EMPLOYEE

Are you sure you want inactive? NO// **YES**  
is now inactive.

## Appendix A – National SCD Registry Data Transmission

All fields in the SCD (Spinal Cord) Registry file (#154) and the Outcomes file (#154.1) are transmitted to the National Spinal Cord Dysfunction Registry. This process is performed through the use of HL7.

Adding or editing a record triggers the transmission process:

Whenever a patient's record is added or edited, an HL7 message is generated and sent to the Q-SCD.MED.VA.GOV domain. This domain is located at the Austin Automation Center in Austin Texas. Once there, the data is placed into a comprehensive National SCD database. This information will be used for national reports and trending of Spinal Cord Injury patients.

No extra steps need to be performed to trigger this event. There will be no outward indication informing you that this process is occurring.



## Appendix B – Levels of Injuries & Etiologic Origins

### Category List of SCD Neurological Levels Of Injuries

The following is a list of possible Neurological Levels Of Injuries associated with a spinal cord dysfunction. The field name, which holds the patient's data, is called "SCI LEVEL".

C01	CERVICAL	01
C02	CERVICAL	02
C03	CERVICAL	03
C04	CERVICAL	04
C05	CERVICAL	05
C06	CERVICAL	06
C07	CERVICAL	07
C08	CERVICAL	08
L01	LUMBAR	01
L02	LUMBAR	02
L03	LUMBAR	03
L04	LUMBAR	04
L05	LUMBAR	05
S01	SACRAL	01
S02	SACRAL	02
S03	SACRAL	03
S04	SACRAL	04
S05	SACRAL	05
T01	THORACIC	01
T02	THORACIC	02
T03	THORACIC	03
T04	THORACIC	04
T05	THORACIC	05
T06	THORACIC	06
T07	THORACIC	07
T08	THORACIC	08
T09	THORACIC	09
T10	THORACIC	10
T11	THORACIC	11
T12	THORACIC	12
UNK	UNKNOWN	

## Category List of SCD Etiologic Origins

The following is a list of possible etiologic origins associated with a spinal cord dysfunction.

Act of Violence	Traumatic Cause
Arthritic Disease of the Spine	Non-Traumatic Cause
Fall	Traumatic Cause
Infection or Abscess	Non-Traumatic Cause
Motor Neuron Disease	Non-Traumatic Cause
Multiple Sclerosis	Non-Traumatic Cause
Other	Unknown
Other - Disease	Non-Traumatic Cause
Other - Traumatic	Traumatic Cause
Poliomyelitis	Non-Traumatic Cause
Sports Activity	Traumatic Cause
Syringomyelia	Non-Traumatic Cause
Tumor	Non-Traumatic Cause
Unknown	Non-Traumatic Cause
Unknown	Traumatic Cause
Vehicular	Traumatic Cause

# Appendix C – Using Ad Hoc Reports

## Creating Simple Reports

The Ad Hoc Reports functionality lets you design your own reports using information from either the patient's outcomes (SCD Ad Hoc Report for Outcomes option) or the patient's registry data (SCD Ad Hoc Report for Registry option). In this appendix, we will use the SCD Ad Hoc Report for Registry option to show how reports are built using the ad hoc functionality.

Here is a simple report showing patients with evaluations due. Note that the sort criterion does not include free text and word processing fields (unnumbered selections). Also, all selections can be made at the first selection prompt with each selection separated by a comma. Comments are *italicized*.

### Selecting Sort Fields:

```
===== Registration Ad Hoc Report Generator =====

1 Patient                21 Describe Other        41 Annual Eval Received
2 SSN                   22 Onset by Trauma       42 Next Annual Eval Due
3 Date of Birth         23 MS Subtype            43 Last Annual Eval Offered
4 Date of Death         24 Had Brain Injury?     44 Last Annual Eval Received
5 Age                   25 Had Amputation?      45 Last Annual Eval Due
6 Registration Date     26 Memory/Think Affected 46 Primary Care Provider
7 Registration Status   27 Eyes Affected        47 SCD-Registry Coordinator
8 Date of Last Update   28 One Arm Affected     48 Referral Source
9 Last Updated By      29 One Leg Affected     49 Referral VA
10 Division             30 Both Arms Affected   50 Initial Rehab Site
11 SCI Network          31 Both Legs Affected   51 Init Rehab Discharge Date
12 SCI Level            32 Other Body Prt Affected 52 Bowel Care Reimbursement
13 VA SCI Status       33 Descr Other Body Part 53 BCR Date Certified
14 1Amount VA is Used  34 Extent of Movement   54 BCR Provider
15 Primary Care VAMC    35 Extent of Feeling     55 Sensory/Motor Loss
16 Annual Rehab VAMC    36 Bowel Affected       56 Class of Paralysis
17 Additional Care VAMC 37 Bladder Affected     57 Type of Injury
18 Non-VA Care         38 Remarks              58 Enrollment Priority
19 Etiology            39 Extent of SCI
20 Date of Onset       40 Annual Eval Offered
```

```
Sort selection # 1:
Sort selection # 1: 42,46 [Selections are separated by commas. Only 4
                        sort fields are allowed.]
```

```
Sort by: Next Annual Rehab Eval Due
Sort from: BEGINNING// 1/1/2000 (JAN 01, 2000)
```

```
Sort to: ENDING// 1/31/2000 (JAN 31, 2000)
```

```
Sort by: Primary Care Provider
```

```
Sort from: BEGINNING// <RET>
```

<sup>1</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 14, 47, & 58).



SCD (SPINAL CORD) REGISTRY SEARCH DEC 28,1999 11:12 PAGE 1  
 Sort Criteria: NEXT ANNUAL REHAB EVAL DUE from Jan 1,2000 to Jan 31,2000@24:00  
 PRIMARY CARE PROVIDER not null

<b>Patient</b>	<b>SSN</b>	<b>Date Of Birth</b>	<b>Etiology</b>	<b>SCI LEVEL</b>	<b>Remarks</b>
					Next Annual Rehab Eval Due: JAN 3,2000 Primary Care Provider: ARTHRITIC DISEASE OF THE SPINE T03 these are the remarks for this patient.
					Next Annual Rehab Eval Due: JAN 4,2000 Primary Care Provider: FALL L04 these are the remarks for this patient.
					Next Annual Rehab Eval Due: JAN 5,2000 Primary Care Provider: ARTHRITIC DISEASE OF THE SPINE L05
					Next Annual Rehab Eval Due: JAN 7,2000 Primary Care Provider: MULTIPLE SCLEROSIS L05 these are the remarks for this patient.
					Next Annual Rehab Eval Due: JAN 10,2000 Primary Care Provider: ACT OF VIOLENCE C05 These are the remarks for this patient.

All the print field headers (bolded) appear above the "----" line.  
 The Next Annual Rehab Eval Due and the Primary Care Provider sort field sub-headers are shown (bolded) below the "----" line.

The above report is okay but not particularly easy to read. You can use Sort and Print prefixes and suffixes to affect the appearance of the report.

## Sort Prefixes

- # new page for each new value of the specified field.
- sort field values in reverse order. (numeric & date/time fields only)
- + print subtotals for specified field totals. (Requires a print modifier to complete it's function)
- ! give sequential number to each new value within specified field.
- @ suppress sub-headers for specified field.
- ' range without sorting.

## Sort Suffixes

- Sort suffixes all begin with a ";".
- ;Cn start the sub-header caption at a specified column number.
- ;Ln sort by the first 'n' characters of the value of the sort field.
- ;Sn skip 'n' lines every time the value of the sort field changes. You may use ;S to skip a single line (equivalent to ;S1)
- ;"xxx" use 'xxx' as the sub-header captions. You may use ;"" if not sub-header captions is desired.
- ;TXT force digits to be sorted as strings not as numbers.

## Print Prefixes

- & print totals for the field.
- ! print a count of the field.
- + print totals, counts, and mean for the field.
- # print totals, count, mean, maximum, minimum and standard deviation for the field.

## Print Suffixes

- ;Cn start the output for the selected field in column 'n'.
- ;Dn round numeric fields to 'n' decimal places.
- ;Ln left justify data in a field of 'n' characters. If the data is more than 'n' characters in length, it will be truncated to fit.
- 'N do not print duplicated data for a field.
- ;Rn right justify data in a field of 'n' characters. If the data is more than 'n' characters in length, it will NOT be truncated to fit.
- ;Sn skip 'n' lines before printing the data for the selected field. You may use ;S to skip a single line (equivalent to ;S1).
- ;T use the field title as the header.
- ;Wn wrap the output of the selected field in a field of 'n' characters. Breaks will occur at word divisions. Use ;W for default wrapping.
- ;X omit the spaces between print fields and suppress the column header.
- ;Yn start the output for the selected field at line (row) number 'n'.
- ;"xxx" use 'xxx' as the column header.
- ;"" suppress column header.

## Using Sort and Print Prefixes and Suffixes

Now let's take the same report and apply some of the above prefixes and suffixes. To improve the appearance of the report we will do the following:

- Shorten the print field names for Date of Birth and Highest Level of Injury. (Print suffix ";"xxx")
- Separate the individual records by skipping a line. (Print suffix ";"S")
- (Sort prefix "#")
- Count the number of patients for each provider. (Sort prefix "+") (Print prefix "&")
- Control where the data is printed for each record. (Print suffix ";"Cn")
- Sort and Print the Next Annual Rehab Eval Due date so the records are sorted by due date but it is not a sub-header.

**Sort selections:**

Sort selection # 1 : **#+44;"",40**

**#+44;""** Start a new page for each new Primary Care Provider, count the number of patients for the provider, and suppress printing the sub-heading "Primary Care Provider:"  
**40** Sort the records within each provider by the date.

Sort by: Primary Care Provider

Sort from: BEGINNING// **<RET>**

Sort by: Next Annual Rehab Eval Due

Sort from: BEGINNING// **1/1/2000** (JAN 01, 2000)

Sort to: ENDING// **1/31/2000** (JAN 31, 2000)

**Print Selections:**

Print selection # 1 : 40;S1;"Date  
Due";L12,!1;C15;L25,2;C45,3;"DOB";C60,9;C10; "Level",17,36;C10

**40;S1;"Date Due";L12** Print the Next Annual Rehab Eval Due so the date will not be a sub-header, skip 1 line between each new date, use "Date Due" as the header, and limit the number of characters printed to 12.

**!1;C15;L25** Count each patient for the provider, start printing the patient at column 15, and limit the length of the name to 25 characters.

**2;C45** Start printing the SSN in column 45.

**3;"DOB";C60** Use "DOB" as the header for Date of birth and start printing in column 60.

**9;C10;"Level"** Start printing the SCI Level in column 10 and use "Level" as the header.

**17** Print the Etiology

**36;C10** Print the Remarks starting in column 10.

Enter special report header, if desired (maximum of 60 characters).

Include the sort criteria in the header? No// **y** (Yes)

Do not queue this report if you used up-front or user selectable filters.

DEVICE: {VIRTUAL/CURRENT DEVICE}

Date Due	Patient	SSN	DOB	Level	Etiology	Remarks
-----						
	C05				ACT OF VIOLENCE	These are the remarks for this patient.
-----						
SUBCOUNT	1					

Date Due	Patient	SSN	DOB	Level	Etiology	Remarks
-----						
	L04				FALL	These are the remarks for this patient.
	L05				ARTHROITIC DISEASE OF THE SPINE	
-----						
SUBCOUNT	2					

Date Due	Patient	SSN	DOB	Level	Etiology	Remarks
-----						
	T03				ARTHROITIC DISEASE OF THE SPINE	These are the remarks for this patient.
	L05				MULTIPLE SCLEROSIS	These are the remarks for this patient.
-----						
SUBCOUNT	2					
-----						
COUNT	5					

## Macro Functions

Now that we have the report the way we want it to look, we want to be able to print out the same report every month. We can use macros to save the design and call it up again.

- [L]** Load sort (and print) macro. You will use this to bring up the macro in order to print your report.
- [S]** Save sort (and print) macro. You cannot build a macro that sorts and prints. You create a sort macro and a print macro.
- [O]** Output macro. The output macro will print a blank ad hoc macro report or one with the fields and modifiers that you have entered. This does not save the entries. There are two ways to obtain a record of both sort and print fields and modifiers: Enter **[O]** at the beginning of sort and at the beginning of print. Enter **[O]** only at the beginning of the print selections.
- [I]** Inquire sort (and print) macro. This function will let you look at the sort fields or print fields for the macro that you choose.
- [D]** Delete sort (and print) macro. This function deletes any macros that you want to eliminate.

## Save Macro

Now let's create a sort and print macro for the report we designed.

SCD Ad hoc report for Registry

```
===== Registration Ad Hoc Report Generator =====

1 Patient                21 Describe Other        41 Annual Eval Received
2 SSN                    22 Onset by Trauma       42 Next Annual Eval Due
3 Date of Birth          23 MS Subtype            43 Last Annual Eval Offered
4 Date of Death          24 Had Brain Injury?     44 Last Annual Eval Received
5 Age                    25 Had Amputation?      45 Last Annual Eval Due
6 Registration Date      26 Memory/Think Affected 46 Primary Care Provider
7 Registration Status    27 Eyes Affected        47 SCD-Registry Coordinator
8 Date of Last Update    28 One Arm Affected     48 Referral Source
9 Last Updated By       29 One Leg Affected     49 Referral VA
10 Division              30 Both Arms Affected   50 Initial Rehab Site
11 SCI Network           31 Both Legs Affected   51 Init Rehab Discharge Date
12 SCI Level             32 Other Body Prt Affected 52 Bowel Care Reimbursement
13 VA SCI Status         33 Descr Other Body Part 53 BCR Date Certified
14 1Amount VA is Used    34 Extent of Movement   54 BCR Provider
15 Primary Care VAMC     35 Extent of Feeling     55 Sensory/Motor Loss
16 Annual Rehab VAMC     36 Bowel Affected       56 Class of Paralysis
17 Additional Care VAMC  37 Bladder Affected     57 Type of Injury
18 Non-VA Care           38 Remarks              58 Enrollment Priority
19 Etiology              39 Extent of SCI
20 Date of Onset         40 Annual Eval Offered
```

Sort selection # 1 :

---

<sup>1</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 14, 47, & 58).

Sort selection # 1 : [Save sort macro]  
[At the first Sort selection prompt, enter "[S".]

The macro will be saved when you exit the sort menu.

=====  
Registration Ad Hoc Report Generator  
=====

1 Patient	Describe Other	41 Annual Eval Received
2 SSN	22 Onset by Trauma	42 Next Annual Eval Due
3 Date of Birth	23 MS Subtype	43 Last Annual Eval Offered
4 Date of Death	24 Had Brain Injury?	44 Last Annual Eval Received
5 Age	25 Had Amputation?	45 Last Annual Eval Due
6 Registration Date	26 Memory/Think Affected	46 Primary Care Provider
7 Registration Status	27 Eyes Affected	47 SCD-Registry Coordinator
8 Date of Last Update	28 One Arm Affected	48 Referral Source
9 Last Updated By	29 One Leg Affected	49 Referral VA
10 Division	30 Both Arms Affected	50 Initial Rehab Site
11 SCI Network	31 Both Legs Affected	51 Init Rehab Discharge Date
12 SCI Level	32 Other Body Prt Affected	52 Bowel Care Reimbursement
13 VA SCI Status	Descr Other Body Part	53 BCR Date Certified
14 Amount VA is Used	34 Extent of Movement	BCR Provider
15 Primary Care VAMC	35 Extent of Feeling	Sensory/Motor Loss
16 Annual Rehab VAMC	36 Bowel Affected	56 Class of Paralysis
17 Additional Care VAMC	37 Bladder Affected	57 Type of Injury
Non-VA Care	Remarks	58 Enrollment Priority
19 Etiology	39 Extent of SCI	
20 Date of Onset	40 Annual Eval Offered	

Sort selection # 1 :  
Sort selection # 1 : **#+46;"",42** [Enter your sort values.]

Sort by: Primary Care Provider

Sort from: BEGINNING// **<RET>**

Sort by: Next Annual Rehab Eval Due

Sort from: BEGINNING// **1/1/2000** (JAN 01, 2000)

Sort to: ENDING// **1/31/2000** (JAN 31, 2000)

Save sort macro name: **SPN EVAL DUE**  
[Give the sort macro a name that describes what the macro does.]  
Are you adding 'SPN EVAL DUE' as a new AD HOC MACRO? No// **Y** (Yes)

Ask user BEGINNING/ENDING values for Primary Care Provider? No// **<RET>**  
(No)  
[For this report, we always want all the primary care providers, so we need not enter beginning and ending values].

Ask user BEGINNING/ENDING values for Next Annual Rehab Eval Due? No// **Y**  
(Yes)  
[We will always want different date values, so we respond YES to beginning and ending values for the Eval Due date].

=====  
 ===== Registration Ad Hoc Report Generator =====

1 Patient	21 Describe Other	41 Annual Eval Received
2 SSN	22 Onset by Trauma	42 Next Annual Eval Due
3 Date of Birth	23 MS Subtype	43 Last Annual Eval Offered
4 Date of Death	24 Had Brain Injury?	44 Last Annual Eval Received
5 Age	25 Had Amputation?	45 Last Annual Eval Due
6 Registration Date	26 Memory/Think Affected	46 Primary Care Provider
7 Registration Status	27 Eyes Affected	47 SCD-Registry Coordinator
8 Date of Last Update	28 One Arm Affected	48 Referral Source
9 Last Updated By	29 One Leg Affected	49 Referral VA
10 Division	30 Both Arms Affected	50 Initial Rehab Site
11 SCI Network	31 Both Legs Affected	51 Init Rehab Discharge Date
12 SCI Level	32 Other Body Prt Affected	52 Bowel Care Reimbursement
13 VA SCI Status	33 Descr Other Body Part	53 BCR Date Certified
14 <sup>1</sup> Amount VA is Used	34 Extent of Movement	54 BCR Provider
15 Primary Care VAMC	35 Extent of Feeling	55 Sensory/Motor Loss
16 Annual Rehab VAMC	36 Bowel Affected	56 Class of Paralysis
17 Additional Care VAMC	37 Bladder Affected	57 Type of Injury
18 Non-VA Care	38 Remarks	58 Enrollment Priority
19 Etiology	39 Extent of SCI	
20 Date of Onset	40 Annual Eval Offered	

Print selection # 1: **[Save print macro]**  
 [Enter "[S" to create and save the print macro.]

The macro will be saved when you exit the print menu.

=====  
 ===== Registration Ad Hoc Report Generator =====

1 Patient	21 Describe Other	41 Annual Eval Received
2 SSN	22 Onset by Trauma	42 Next Annual Eval Due
3 Date of Birth	23 MS Subtype	43 Last Annual Eval Offered
4 Date of Death	24 Had Brain Injury?	44 Last Annual Eval Received
5 Age	25 Had Amputation?	45 Last Annual Eval Due
6 Registration Date	26 Memory/Think Affected	46 Primary Care Provider
7 Registration Status	27 Eyes Affected	47 SCD-Registry Coordinator
8 Date of Last Update	28 One Arm Affected	48 Referral Source
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10 Division	30 Both Arms Affected	50 Initial Rehab Site
11 SCI Network	31 Both Legs Affected	51 Init Rehab Discharge Date
12 SCI Level	32 Other Body Prt Affected	52 Bowel Care Reimbursement
13 VA SCI Status	33 Descr Other Body Part	53 BCR Date Certified
14 Amount VA is Used	34 Extent of Movement	54 BCR Provider
15 Primary Care VAMC	35 Extent of Feeling	55 Sensory/Motor Loss
16 Annual Rehab VAMC	36 Bowel Affected	56 Class of Paralysis
17 Additional Care VAMC	37 Bladder Affected	57 Type of Injury
18 Non-VA Care	38 Remarks	58 Enrollment Priority
19 Etiology	39 Extent of SCI	
20 Date of Onset	40 Annual Eval Offered	

Print selection # 1 : **42;S1;"Date  
 Due";L12,!1;C15;L25,2;C45,3;"DOB";C60,19;C10;"Level",12,38;C10**  
 [Enter the print values.]

<sup>1</sup> Patch SPN\*2.0\*19 – Revised field selection (fields 14, 47, & 58).

Save print macro name: **SPN EVAL DUE**

[Because these sort and print macros will always go together, we will give them the same names.

**Note:** You can mix and match sort and print macros. You may have a sort macro that you use with several print macros].

Are you adding 'SPN EVAL DUE' as a new AD HOC MACRO? No// **Y** (Yes)

Enter special report header, if desired (maximum of 60 characters). **<RET>**

Include the sort criteria in the header? No// **Y** (Yes)

Do not queue this report if you used up-front or user selectable filters.

DEVICE: {VIRTUAL/CURRENT DEVICE}

SCD (SPINAL CORD) REGISTRY STATISTICS		DEC 29,1999 08:13		PAGE 1		
Sort Criteria: PRIMARY CARE PROVIDER not null						
NEXT ANNUAL REHAB EVAL DUE from Jan 1,2000 to Jan 31,2000@24:00						
Date Due	Patient	SSN	DOB	Level	Etiology	Remarks
-----						
...						

## Output and Load Macros

You can obtain a printout of the content of the macro by using the "[O" Output Macro command.

At the first Sort selection prompt, enter "[L".

```
Sort selection # 1 : [Load sort macro]
```

```
Load sort macro name: SPN EVAL DUE
```

```
Sort by: Next Annual Rehab Eval Due
```

```
Sort from: BEGINNING// <RET>
```

At the first Print selection prompt, enter "[O".

```
Print selection # 1: [Output macro]
```

```
You will be prompted for an output  
device when you exit the print menu.
```

At the next Print selection prompt, enter "[L".

```
Print selection # 1 : [Load print macro]
```

```
Load print macro name: SPN EVAL DUE
```

```
Output macro to device: HOME// {VIRTUAL/CURRENT DEVICE} printer name]
```

=====  
|| AD HOC REPORT GENERATOR MACRO REPORT ||  
=====

Report name: \_\_\_\_\_

Sort fields:  
-----

Macro: SPN EVAL DUE

- 1) Field: Primary Care Provider  
Entry: #+56;"  
From: Beginning To: Ending
- 2) Field: Next Annual Rehab Eval Due  
Entry: 52  
From: Ask User To: Ask User
- 3) Field: \_\_\_\_\_  
Entry: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_
- 4) Field: \_\_\_\_\_  
Entry: \_\_\_\_\_  
From: \_\_\_\_\_ To: \_\_\_\_\_

Enter RETURN to continue or '^' to exit:

Print fields:  
-----

Macro: SPN EVAL DUE

- 1) Field: Next Annual Rehab Eval Due  
Entry: 52;S1;L12;"Date Due"
- 2) Field: Patient  
Entry: !1;C15;L25
- 3) Field: SSN  
Entry: 2;C45
- 4) Field: Date Of Birth  
Entry: 3;C60;"DOB"
- 5) Field: SCI Level  
Entry: 9;C10;"Level"
- 6) Field: Etiology  
Entry: 17
- 7) Field: Remarks  
Entry: 42;C10

Header: \_\_\_\_\_

Sort criteria in report header: Yes Device: \_\_\_\_\_

## Inquire Macro

Use the Inquire macro when you are unsure what the macro values are.

Sort selection # 1: [**Inquire** sort macro]

Inquire sort macro name: **SPN EVAL DUE**

Sort macro: SPN EVAL DUE

-----

- 1) Field: Primary Care Provider  
Entry: #+56;" "  
From: Beginning To: Ending
- 2) Field: Next Annual Rehab Eval Due  
Entry: 52  
From: Ask User To: Ask User



# Glossary

ABBREVIATED RESPONSE	This feature allows you to enter data by typing only the first few characters for the desired response. This feature will not work unless the information is already stored in the computer.
ACCESS CODE	A code that allows the computer to identify you as a user authorized to gain access to the computer. Your code is greater than six and less than twenty characters long; can be numeric, alphabetic, or a combination of both; and is usually assigned by a site manager or application coordinator. (See the term <b>verify code</b> in the Glossary.)
ADPAC	<b>A</b> utomated <b>D</b> ata <b>P</b> rocessing <b>A</b> pplication <b>C</b> oordinator
APPLICATION COORDINATOR	Designated individuals responsible for user-level management and maintenance of an application package such as IFCAP, Lab, Pharmacy, Mental Health, etc.
APPLICATION PACKAGE	In VistA, software and documentation that support the automation of a service, such as Laboratory or Pharmacy, within VA medical centers (see the term <b>Package</b> in the Glossary). The Kernel is like an operating system relative to other VistA applications.
AUTO-MENU	An indication to Menu Manager that the current user's menu items should be ed automatically. When auto-menu is not in effect, the user must enter a question mark at the menu's select prompt to see the list of menu items.
BEDSECTION	Also referred to as "Specialty" in this document. Specific services in a hospital have their own floors or rooms where patients can be admitted and monitored by that service. A patient is admitted to the hospital through a particular service, which has its own bedsection (i.e., SCI service has its own bedsection where care and treatment is administered to SCI patients).
CARET	A symbol expressed as up caret (^), left caret (<), or right caret (>). In many M systems, a right caret is used as a system prompt and an up caret as an exiting tool from an option. Also known as the up-arrow symbol or shift-6 key.

CLINICAL ASSESSMENT	Evaluation of a patient's condition by a clinician.
CLINICAL OBSERVATION	Inspection of a patient's condition by a clinician.
COMMAND	A combination of characters that instruct the computer to perform a specific operation.
COMMON MENU	Options available to all users. Entering two question marks at the menu select prompt s any secondary menu options available to the signed-on user, along with the common options available to all users.
CONTROL KEY	The Control Key ( <b>Ctrl</b> on the keyboard) performs a specific function in conjunction with another key. In word-processing, for example, holding down the <b>Ctrl</b> key and typing an <b>A</b> causes a new set of margins and tab settings to occur; <b>Ctrl-S</b> causes printing on the terminal screen to stop; <b>Ctrl-Q</b> restarts printing on the terminal screen; <b>Ctrl-U</b> deletes an entire line of data entry <u>before</u> the Return key is pressed.
CROSS REFERENCE	<p>An indexing method whereby files can include pre-sorted lists of entries as part of the stored database. Cross-references (x-refs) facilitate look-up and reporting.</p> <p>A file may be cross-referenced to provide direct access to its entries in several ways. For example, VA FileMan allows the Patient file to be cross-referenced by name, social security number, and bed number. When VA FileMan asks for a patient, the user may then respond with the patient's name, social security number, or his bed number. A cross-reference speeds up access to the file, both for looking up entries and for printing reports.</p> <p>A cross-reference is also referred to as an index or cross-index.</p>
CURSOR	A flashing image on your screen (generally a horizontal line or rectangle) that alerts you that the computer is waiting for you to make a response to an instruction (prompt).
DATA	A representation of facts, concepts, or instructions in a formalized manner for communication, interpretation, or processing by humans or by automatic means. The information you enter for the computer to store and retrieve. Characters stored in the computer system as the values of local or global variables. VA FileMan fields hold data values for file entries.

DATA ATTRIBUTE	A characteristic of a unit of data such as length, value, or method of representation. VA FileMan field definitions specify data attributes.
DATA DICTIONARY	<p>The Data Dictionary is a global containing a description of what kind of data is stored in the global corresponding to a particular file. The data is used internally by FileMan for interpreting and processing files.</p> <p>A Data Dictionary (DD) contains the definitions of a file's elements (fields or data attributes); relationships to other files; and structure or design. Users generally review the definitions of a file's elements or data attributes; programmers review the definitions of a file's internal structure.</p>
DATA DICTIONARY ACCESS	A user's authorization to write/update/edit the data definition for a computer file. Also known as <b>DD Access</b> .
DATA DICTIONARY LISTING	This is the printable report that shows the data dictionary. DDs are used by users and programmers.
DATA PROCESSING	Logical and arithmetic operations performed on data. These operations may be performed manually, mechanically, or electronically: sorting through a card file by hand would be an example of the first method; using a machine to obtain cards from a file would be an example of the second method; and using a computer to access a record in a file would be an example of the third method.
DATABASE	A set of data, consisting of at least one file, that is sufficient for a given purpose. The VistA database is composed of a number of VA FileMan files. A collection of data about a specific subject, such as the PATIENT file; a data collection has different data fields (e.g., patient name, SSN, Date of Birth, and so on). An organized collection of data about a particular topic.
DATABASE MANAGEMENT SYSTEM	A collection of software that handles the storage, retrieval, and updating of records in a database. A <b>Database Management System (DBMS)</b> controls redundancy of records and provides the security, integrity, and data independence of a database.
DATABASE, NATIONAL	A database, which contains data, collected or entered for all VHA sites.
DBA	<b>Database Administrator</b> , oversees package development with respect to VistA Standards and Conventions (SAC) such as name spacing. Also, this term refers to the <b>Database Administration</b> function and staff.

DBIA	<b>D</b> atabase <b>I</b> ntegration <b>A</b> greement, a formal understanding between two or more VistA packages which describes how data is shared or how packages interact. The DBA maintains a list of DBIAs.
DBIC	<b>D</b> atabase <b>I</b> ntegration <b>C</b> ommittee. Within the purview of the DBA, the committee maintains a list of DBIC approved callable entry points and publishes the list on FORUM for reference by application programmers and verifiers.
DEBUG	To correct logic errors or syntax errors or both types in a computer program. To remove errors from a program.
DEFAULT	A response the computer considers the most probable answer to the prompt being given. It is identified by double slash marks (//) immediately following it. This allows you the option of accepting the default answer or entering your own answer. To accept the default you simply press the enter (or return) key. To change the default answer, type in your response.
DELETE	The key on your keyboard (may also be called rubout or backspace on some terminals) which allows you to delete individual characters working backwards by placing the cursor immediately after the last character of the string of characters you wish to delete. The @ sign (uppercase of the 2 key) may also be used to delete a file entry or data attribute value. The computer asks “Are you sure you want to delete this entry?” to insure you do not delete an entry by mistake.
DELIMITER	A special character used to separate a field, record or string. VA FileMan uses the ^ character as the delimiter within strings.
DEVICE	A peripheral connected to the host computer, such as a printer, terminal, disk drive, modem, and other types of hardware and equipment associated with a computer. The host files of underlying operating systems may be treated like devices in that they may be written to (e.g., for spooling).
DICTIONARY	A database of specifications of data and information processing resources. VA FileMan’s database of data dictionaries is stored in the FILE of files (#1).
DISK	The media used in a disk drive for storing data.

DISK DRIVE	A peripheral device that can be used to “read” and “write” on a hard or floppy disk.
DOUBLE QUOTE (")	A symbol used in front of a Common option’s menu text or synonym to select it from the Common menu. For example, the five character string "TBOX" selects the User’s Toolbox Common option.
DSCC	<b>D</b> ocumentation <b>S</b> tandards and <b>C</b> onventions <b>C</b> ommittee. Package documentation is reviewed in terms of standards set by this committee.
DUZ	A local variable holding the user number that identifies the signed-on user.
DUZ(0)	A local variable that holds the File Manager Access Code of the signed-on user.
ENCRYPTION	Scrambling data or messages with a cipher or code so that they are unreadable without a secret key. In some cases encryption algorithms are one directional, that is, they only encode and the resulting data cannot be unscrambled (e.g., access/verify codes).
ENTER	Pressing the return or enter key tells the computer to execute your instruction or command or to store the information you just entered.
ENTRY	A VA FileMan record. It is uniquely identified by an internal entry number (the .001 field) in a file.
ETIOLOGY	The study or theory of the factors that cause disease and the method of their introduction to the host; the cause(s) or origin of a disease or disorder.
EXPERT PANEL	Representative users from the field and Program Office who make recommendations for software development. The Expert Panels (EPs) report to and are formed by the ARGs.
EXTRACTOR	A specialized routine designed to scan data files and copy or summarize data for use by another process.

FIELD	In a record, specified areas used for the value of a data attribute. The data specifications of each VA FileMan field are documented in the file's data dictionary. A field is similar to blanks on forms. It is preceded by words that tell you what information goes in that particular field. The blank, marked by the cursor on your terminal screen, is where you enter the information.
FILE	A set of related records treated as a unit. VA FileMan files maintain a count of the number of entries or records.
FILE MANAGER (VA FILEMAN)	The VistA's Database Management System (DBMS). The central component of the Kernel that defines the way standard VistA files are structured and manipulated.
FOIA	The <b>Freedom Of Information Act</b> . Under the provisions of this public law, software developed within the VA is made available to other institutions, or the general public, at a nominal cost.
FORCED QUEUING	A device attribute indicating that the device can only accept queued tasks. If a job is sent for foreground processing, the device rejects it and prompts the user to queue the task instead.
FREE TEXT	The use of any combination of numbers, letters, and symbols when entering data.
GLOBAL VARIABLE	A variable that is stored on disk (M usage).
GO-HOME JUMP	A menu jump that returns the user to the Primary menu presented at sign-on. It is specified by entering two up-arrows (^) at the menu's select prompt. It resembles the rubber band jump but without an option specification after the up-arrows.
HARDWARE	The physical equipment pieces that make up the computer system (e.g., terminals, disk drives, central processing units). The physical components of a computer system.
HEALTH SERVICES RESEARCH & DEVELOPMENT (HSR&D)	Established in 1973 to assist in the search for the most cost-effective approaches to delivering quality health care to the nation's veterans through the support of health services research studies.

HELP FRAMES	Entries in the HELP FRAME file that may be distributed with application packages to provide on-line documentation. Frames may be linked with other related frames to form a nested structure.
HELP PROMPT	The brief help that is available at the field level when entering one question mark.
HINQ	<b>H</b> ospital <b>I</b> nquiry. A system that permits medical centers to query the Veterans Benefits Administration systems via the VADATS network.
HIS	<b>H</b> ospital <b>I</b> nformation <b>S</b> ystems
ICD	<b>I</b> nternational <b>C</b> lassification of <b>D</b> iseases
IFCAP	<b>I</b> ntegrated <b>F</b> unds Distribution, <b>C</b> ontrol Point Activity, <b>A</b> ccounting, and <b>P</b> rourement
IHS	<b>I</b> ndian <b>H</b> ealth <b>S</b> ervice
IHS	<b>I</b> ntegrated <b>H</b> ospital <b>S</b> ystem
INPATIENT	A patient who has been admitted to a hospital in order to be treated for a particular condition.
KERNEL	A set of VistA software routines that function as an intermediary between the host operating system and the VistA application packages such as Laboratory, Pharmacy, IFCAP, etc. The Kernel provides a standard and consistent user and programmer interface between application packages and the underlying M implementation.
KEY	The purpose of Security Keys is to set a layer of protection on the range of computing capabilities available with a particular software package. The availability of options is based on the level of system access granted to each user.
KEYWORD	A word or phrase used to call up several codes from the reference files in the LOCAL LOOK-UP file. One specific code may be called up by several different keywords.

LAYGO ACCESS	A user's authorization to create a new entry when editing a computer file. (Learn As You GO allows you the ability to create new file entries.)
LINK	Non-specific term referring to ways in which files may be related (via pointer links). Files have links into other files.
LOG IN/ON	The process of gaining access to a computer system.
LOG OUT/OFF	The process of exiting from a computer system.
MAIL MESSAGE	An entry in the MESSAGE file. The VistA electronic mail system (MailMan) supports local and remote networking of messages.
MAILMAN	An electronic mail system that allows you to send and receive messages from other users via the computer.
MANAGER ACCOUNT	A UCI that can be referenced by non-manager accounts such as production accounts. Like a library, the MGR UCI holds percent routines and globals (e.g., ^%ZOSF) for shared use by other UCIs.
MANDATORY FIELD	This is a field that requires a value. A null response is not valid.
MEDICAL CARE COST RECOVERY (MCCR)	A VA project to collect data from entities which owe payment to VA for care of patients. Also referred to by the acronym MCCR.
MENU	A list of choices for computing activity. A menu is a type of option designed to identify a series of items (other options) for presentation to the user for selection. When ed, menu-type options are preceded by the word "Select" and followed by the word "option" as in Select Menu Management option: (the menu's select prompt).
MENU CYCLE	The process of first visiting a menu option by picking it from a menu's list of choices and then returning to the menu's select prompt. Menu Manager keeps track of information, such as the user's place in the menu trees, according to the completion of a cycle through the menu system.
MENU SYSTEM	The overall Menu Manager logic as it functions within the Kernel framework.

MENU TEMPLATE	An association of options as pathway specifications to reach one or more final destination options. The final options must be executable activities and not merely menus for the template to function. Any user may define user-specific menu templates via the corresponding Common option.
MENU TEXT	The descriptive words that appear when a list of option choices is ed. Specifically, the Menu Text field of the OPTION file. For example, User's Toolbox is the menu text of the XUSERTOOLS option. The option's synonym is TBOX.
MS	Multiple Sclerosis.
NATIONAL SPINAL CORD DYSFUNCTION (SCD) REGISTRY	This VistA package consists of two major components: 1) a local registry for use within a VA health care facility, and 2) a National Registry reflecting the events of care for patients at all VA facilities.
NUMERIC FIELD	A response that is limited to a restricted number of digits. It can be dollar valued or a decimal figure of specified precision.
OPERATING SYSTEM	A basic program that runs on the computer, controls the peripherals, allocates computing time to each user, and communicates with terminals.
OPTION	An entry in the OPTION file. As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity. Options may also be scheduled to run in the background, non-interactively, by TaskMan.
OPTION NAME	The Name field in the OPTION file (e.g., XUMAIN for the option that has the menu text "Menu Management"). Options are namespaced according to VistA conventions monitored by the DBA.
OUTPATIENT	A patient who comes to the hospital, clinic, or dispensary for diagnosis and/or treatment but does not occupy a bed.

PACKAGE	The set of programs, files, documentation, help prompts, and installation procedures required for a given software application. For example, Laboratory, Pharmacy, and MAS are packages. A VistA software environment composed of elements specified via the Kernel's Package file. Elements include files and associated templates, namespaced routines, and namespaced file entries from the Option, Key, Help Frame, Bulletin, and Function files. Packages are transported using VA FileMan's DIFROM routine that creates initialization routines to bundle the files and records for export. Installing a package involves the execution of initialization routines that create the required software environment. Verified packages include documentation. As public domain software, verified packages may be requested through the Freedom of Information Act (FOIA).
PARALYZED VETERANS OF AMERICA (PVA)	A congressionally chartered veterans service organization founded following World War II, has developed a unique expertise in a wide variety of issues involving the needs of its members—veterans of the armed forces who have experienced spinal cord injury or dysfunction.
PASSWORD	A user's secret sequence of keyboard characters, which must be entered at the beginning of each computer session to provide the user's identity.
PERIPHERAL DEVICE	Any hardware device other than the computer itself (central processing unit plus internal memory). Typical examples include card readers, printers, CRT units, and disk drives.
PHANTOM JUMP	Menu jumping in the background. Used by the menu system to check menu pathway restrictions.
POINTER	A relationship between two VA FileMan files, a pointer is a file entry that references another file (forward or backward).
PRIMARY MENUS	The list of options presented at sign-on. Each user must have a primary menu in order to sign-on and reach Menu Manager. Users are given primary menus by IRM. This menu should include most of the computing activities the user needs.
PRINTER	A printing or hard copy terminal.
PRODUCTION ACCOUNT	The UCI where users log on and carry out their work, as opposed to the manager, or library, account.

PROGRAM	A list of instructions written in a programming language and used for computer operations.
PROMPT	The computer interacts with the user by issuing questions called <b>prompts</b> , to which the user issues a response.
PVA	<b>Paralyzed Veterans of America</b> —a congressionally chartered veterans service organization founded following World War II, has developed a unique expertise in a wide variety of issues involving the needs of its members—veterans of the armed forces who have experienced spinal cord injury or dysfunction.
QUEUING	Requesting that a job be processed in the background rather than in the foreground within the current session. Jobs are processed sequentially (first-in, first-out). The Kernel’s Task Manager handles the queuing of tasks.
QUEUING REQUIRED	An option attribute that specifies that the option must be processed by TaskMan (the option can only be queued). The option may be invoked and the job prepared for processing, but the output can only be generated during the specified time periods.
READ ACCESS	A user’s authorization to read information stored in a computer file.
RECORD	A set of related data treated as a unit. An entry in a VA FileMan file constitutes a record. A collection of data items that refer to a specific entity (e.g., in a name-address-phone number file, each record would contain a collection of data relating to one person).
RESOURCE	Sequential processing of tasks can be controlled through the use of resources. Resources are entries in the DEVICE file which must be allocated to a process(es) before that process can continue.
RETURN	On the computer keyboard, the key located where the carriage return is on an electric typewriter. It is used in VistA to terminate “reads.” Symbolized by <RET>.
SCHEDULING OPTIONS	This is a technique of requesting that TaskMan run an option at a given time, perhaps with a given rescheduling frequency.

SCI	Spinal Cord Injury.
SCI CENTERS	First established in 1946, these centers coordinate and administer the long-term care and treatment of spinal cord injured veterans.
SCI COORDINATOR	A social worker, who identifies SCI patients, evaluates their socioeconomic status and advises them on eligibility criteria for VA benefits. SCI coordinators and other field personnel are the primary users of the local registries.
SCI LEVEL	Pertains to the vertebra and specific area of the spine affected or impaired by a disease or injury (e.g., Cervical: C01–C08, Thoracic: T01–T12; Lumbar: L01–L05; Sacral: S01–S05).
SCI PATIENTS	Patients whose spinal cord has been impaired due to trauma.
SCREEN	A CRT, monitor or video terminal
SECONDARY MENUS	Options assigned to individual users to tailor their menu choices. If a user needs a few options in addition to those available on the Primary menu, the options can be assigned as secondary options. To facilitate menu jumping, secondary menus should be specific activities, not elaborate and deep menu trees.
SECURITY KEY	The purpose of Security Keys is to set a layer of protection on the range of computing capabilities available with a particular software package. The availability of options is based on the level of system access granted to each user.
SERVER	An entry in the OPTION file. An automated mail protocol that is activated by sending a message to a server at another location with the “S.server” syntax. This activity is specified in the OPTION file.
SET OF CODES	Usually a preset code with one or two characters. The computer may require capital letters as a response (e.g., M for male and F for female). If anything other than the acceptable code is entered, the computer rejects the response.
SIGN-ON/SECURITY	The Kernel module that regulates access to the menu system. It performs a number of checks to determine whether access can be permitted at a particular time. A log of sign-ons is maintained.

SITE MANAGER/ IRM CHIEF	At each site, the individual who is responsible for managing computer systems, installing and maintaining new modules, and serving as liaison to the ISCs.
SPACEBAR RETURN	You can answer a VA FileMan prompt by pressing the spacebar and then the Return key. This indicates to VA FileMan that you would like the last response you were working on at that prompt recalled.
SPECIAL QUEUING	An option attribute indicating that TaskMan should automatically run the option whenever the system reboots.
SPECIALTY	The particular subject area or branch of medical science to which one devotes professional attention.
SPINAL CORD DYSFUNCTION (SCD)	Specified diseases and conditions that result in an impairment or abnormality of the spinal cord and/or cauda equina. Specified list includes conditions of both traumatic and nontraumatic etiology.
SPINAL CORD INJURY (SCI)	Damage to the spinal cord as a result of a traumatic incident. Trauma is a sudden external force which damages the spinal cord. This includes surgical trauma (i.e., which is both sudden and external) but excludes sudden damage to the vertebrae caused by disease (i.e., the disease process is not sudden). If both traumatic and non traumatic causes are present, classify as traumatic.
SPOOLER	Spooling (under any system) provides an intermediate storage location for files (or program output) for printing at a later time.  In the case of VistA, the Kernel manages spooling so that the underlying OS mechanism is transparent. The Kernel subsequently transfers the text to the ^XMBS global for despooling (printing).
STOP CODE	A number (i.e., a subject area indicator) assigned to the various clinical, diagnostic, and therapeutic sections of a facility for reporting purposes. For example, all outpatient services within a given area (e.g., Infectious Disease, Neurology, and Mental Hygiene—Group) would be reported to the same clinic stop code.
SYNONYM	A field in the OPTION file. Options may be selected by their menu text or synonym (see Menu Text).

TASKMAN	The Kernel module that schedules and processes background tasks (also called Task Manager).
TEMPLATE	A means of storing report formats; data entry formats, and sorted entry sequences. A template is a permanent place to store selected fields for use at a later time. Edit sequences are stored in the INPUT TEMPLATE file, print specifications are stored in the PRINT TEMPLATE file, and search or sort specifications are stored in the SORT TEMPLATE file.
TERMINAL	May be either a printer or CRT/monitor/video terminal.
TIMED-READ	The amount of time a READ command waits for a user response before it times out.
TREE STRUCTURE	A term sometimes used to describe the structure of an M array. This has the same structure as a family tree, with the root at the top and ancestor nodes arranged below according to their depth of subscripting. All nodes with one subscript are at the first level, all nodes with two subscripts at the second level, and so on.
TRIGGER	A type of VA FileMan cross reference. Often used to update values in the database given certain conditions (as specified in the trigger logic). For example, whenever an entry is made in a file, a trigger could automatically enter the current date into another field holding the creation date.
TYPE-AHEAD	A buffer used to store characters that are entered before the corresponding prompt appears. Type-ahead is a shortcut for experienced users who can anticipate an expected sequence of prompts.
UP-ARROW JUMP	In the menu system, entering an up-arrow (^) followed by an option name accomplishes a jump to the target option without needing to take the usual steps through the menu pathway.

USER ACCESS	<p>This term is used to refer to a limited level of access, to a computer system, which is sufficient for using/operating a package, but does not allow programming, modification to data dictionaries, or other operations that require programmer access. Any option, for example, can be locked with the key XUPROGMODE, which means that invoking that option requires programmer access.</p> <p>The user's access level determines the degree of computer use and the types of computer programs available. The Systems Manager assigns the user an access level.</p>
USER INTERFACE	<p>The way the package is presented to the user—issuing of prompts, help messages, menu choices, etc. A standard user interface can be achieved by using VA FileMan for data manipulation, the menu system to provide option choices, and VA FileMan's Reader, the ^DIR utility, to present interactive dialogue.</p>
VA	<p>The Department of Veterans Affairs</p>
VA FILEMAN	<p>A set of programs used to enter, maintain, access, and manipulate a database management system consisting of files. A package of on-line computer routines written in the M language which can be used as a stand-alone database system or as a set of application utilities. In either form, such routines can be used to define, enter, edit, and retrieve information from a set of computer stored files.</p>
VERIFY CODE (SEE PASSWORD)	<p>An additional security precaution used in conjunction with the Access Code. Like the Access Code, it is also 6 to 20 characters in length and, if entered incorrectly, will not allow the user to access the computer. To protect the user, both codes are invisible on the terminal screen.</p>

VistA

**Veterans Health Information Systems and Technology Architecture**, formerly **Decentralized Hospital Computer Program** of the **Veterans Health Administration (VHA)**, **Department of Veterans Affairs (VA)**. VistA software, developed by VA, is used to support clinical and administrative functions at VA Medical Centers nationwide. It is written in M and, via the Kernel, runs on all major M implementations regardless of vendor. VistA is composed of packages which undergo a verification process to ensure conformity with namespaces and other VistA standards and conventions.