## Revision History

Initiated on 11/19/04

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Project Manager</th>
<th>Technical Writer</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/2016</td>
<td>PX<em>1</em>210 – Made updates to sections: 3.13, 3.15, 5.2, 6.1, 6.1.1, Added sections: 6.4, 6.5, 6.6 and formatting edits.</td>
<td>VA PM: Keith Magoon</td>
<td>Alan Monosky/ Kathy Steele/ Shelita Davis</td>
</tr>
<tr>
<td>03/2015</td>
<td>PX<em>1</em>206 – Updates to Skin Test information.</td>
<td>VA PM: Keith Magoon</td>
<td>Alan Monosky / Kathy Steele</td>
</tr>
<tr>
<td>12/2014</td>
<td>PX<em>1</em>201 – Remediated doc for 508 compliance.</td>
<td>VA PM: Keith Magoon</td>
<td>Helena Gilbert</td>
</tr>
<tr>
<td>10/2014</td>
<td>PX<em>1</em>201 – Made additions to the PCE Update Encounter screen and some format edits.</td>
<td>VA PM: Keith Magoon</td>
<td>Alan Monosky / Shelita Davis</td>
</tr>
<tr>
<td>08/2014</td>
<td>Manual updated to show changes with patch PX<em>1</em>201</td>
<td>VA PM: Keith Magoon</td>
<td>Alan Monosky / Constance Ray / Shelita Davis</td>
</tr>
<tr>
<td>06/2014</td>
<td>PX<em>1</em>199 – Updates for ICD-10</td>
<td>VA PM: Curtis Clay</td>
<td>Ellen Phelps / Bob Thomas</td>
</tr>
<tr>
<td></td>
<td>PCE Encounter Actions:</td>
<td>HP PM: Mike Klein</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Changed DX Diagnosis (ICD9) to DX Diagnosis (ICD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(pp. 19, 21-27, 29-30, 34-36, 38-39, 41-42, 44, 47)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Changed Diagnosis Ranked by Frequency Report codes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(pp. 57-59, 105, 113, 115-116)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Miscellaneous ICD changes (pp. 108, 129, 134) Technical Edit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/19/2004</td>
<td>Manual updated to comply with SOP 192-352 Displaying Sensitive Data</td>
<td></td>
<td>Corinne Bailey</td>
</tr>
<tr>
<td>03/17/2005</td>
<td>Manual updated to show changes with Patch PX<em>1</em>380</td>
<td>Beverly Jones</td>
<td>Berry Anderson</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td>Authors</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>08/10/2005</td>
<td>Manual updated to show changes with patch PX<em>1</em>153: added option PCE Delete Encounters W/O Visit</td>
<td>Carol Greening</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tim Dawson</td>
<td></td>
</tr>
<tr>
<td>09/05/2005</td>
<td>Manual updated to show changes with patch PX<em>1</em>124</td>
<td>Brenda Manies</td>
<td></td>
</tr>
<tr>
<td>07/10/2007</td>
<td>Manual updated to include clarification of PCE Encounter Data Entry-Supervisor role-PX<em>1</em>183</td>
<td>Carol Greening</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gary Werner</td>
<td></td>
</tr>
<tr>
<td>10/31/2008</td>
<td>Formatting Edits</td>
<td>Corinne Bailey</td>
<td></td>
</tr>
<tr>
<td>03/30/2009</td>
<td>PX<em>1</em>168 – Enrollment VistA Changes Release 2 (EVC R2) Changed <em>environmental contaminants to SW Asia Conditions</em></td>
<td>Laura Prietula</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corinne Bailey</td>
<td></td>
</tr>
</tbody>
</table>
Table of Contents

1.0 INTRODUCTION .................................................................................................................. 1
  1.1. PURPOSE AND BENEFITS OF PCE ................................................................................ 1
    1.1.1. Goals of Ambulatory Data Capture Project ............................................................. 1
  1.2. SOFTWARE NECESSARY TO SUPPORT ADCP ............................................................. 1
  1.3. FUNCTIONALITY OF PCE ............................................................................................... 2
    1.3.1. Interactive Interfaces ................................................................................................. 2
    1.3.2. Non-interactive Interfaces ......................................................................................... 2
  1.4. DEFINITIONS .................................................................................................................... 2
  1.5. POTENTIAL PCE WORKFLOW ....................................................................................... 3
  1.6. SOURCES OF DATA ........................................................................................................ 4
  1.7. DESIGNING ENCOUNTER FORMS .................................................................................. 4
  1.8. XU*8*27 - NEW PERSON FILE PATCH ........................................................................ 4

2.0 ORIENTATION ....................................................................................................................... 5
  2.1. SCREEN DISPLAY ............................................................................................................ 5
    2.1.1. Other (Hidden) Actions ............................................................................................. 6
  2.2. REVIEW SCREENS ......................................................................................................... 6
    2.2.1. List by Appointment ................................................................................................. 6
    2.2.2. List by Encounter ..................................................................................................... 7
  2.3. SELECT NEW PATIENT, VIEW BY CLINIC, CHANGE DATE RANGE ............................... 7
    2.3.1. Expand Appointment ............................................................................................... 8
    2.3.2. Appointment ............................................................................................................ 10

3.0 USING PCE .......................................................................................................................... 10
  3.1. PCE DATA ENTRY OPTIONS .......................................................................................... 11
    3.1.1. PCE Encounter Data Entry - Supervisor ................................................................. 11
    3.1.2. PCE Encounter Data Entry ..................................................................................... 11
    3.1.3. PCE Encounter Data Entry and Delete ................................................................. 11
    3.1.4. PCE Encounter Data Entry without Delete ............................................................ 11
  3.2. PCE ACTIONS .................................................................................................................. 11
  3.3. ADDING AND EDITING PATIENT CARE ENCOUNTERS ............................................... 13
    3.3.1. Adding New Encounters ......................................................................................... 13
  3.4. MAKE A HISTORICAL ENCOUNTER ............................................................................. 14
  3.5. UPDATE ENCOUNTER ..................................................................................................... 15
    3.5.1. Quick Tricks ............................................................................................................. 16
  3.6. EDIT AN ITEM .................................................................................................................. 17
3.7. DELETE AN ITEM ......................................................................................... 18
3.8. HOW TO ADD OR EDIT AN ENCOUNTER ......................................................... 20
3.9. HOW TO ADD OR EDIT A PROVIDER .............................................................. 21
3.10. HOW TO ADD OR EDIT DIAGNOSES (ICD9) ..................................................... 21
3.11. HOW TO ADD OR EDIT A CPT (PROCEDURE) ............................................... 23
3.12. HOW TO ADD OR EDIT TREATMENTS ......................................................... 25
3.13. HOW TO ADD OR EDIT AN IMMUNIZATION ................................................... 26
3.14. HOW TO ADD OR EDIT A PATIENT ED ......................................................... 28
3.15. HOW TO ADD OR EDIT A SKIN TEST ........................................................... 29
3.16. HOW TO ADD OR EDIT AN EXAM ............................................................... 30
3.17. HOW TO ADD OR EDIT HEALTH FACTORS ................................................... 31
3.18. HOW TO ADD OR EDIT THE CHECKOUT INTERVIEW .................................... 32
3.19. ADDING OR EDITING DIRECTIONS TO PATIENT’S HOME .............................. 35
3.20. KEY CONCEPTS .......................................................................................... 36

4.0 PCE AND HEALTH SUMMARY ....................................................................... 36
4.1. PCE CLINICAL REPORTS .............................................................................. 37
4.2. CASELOAD PROFILE BY CLINIC ................................................................. 38
4.3. WORKLOAD BY CLINIC ............................................................................... 40
4.4. DIAGNOSIS RANK BY FREQUENCY .............................................................. 41
4.5. LOCATION ENCOUNTER COUNTS ................................................................. 44
4.6. PROVIDER ENCOUNTER COUNTS ................................................................. 45
4.7. SELECTED PERSON CLASSES ...................................................................... 46
4.8. PATIENT ACTIVITY BY LOCATION ............................................................... 47
    4.8.1. Admission/Discharge Activities ............................................................... 48
    4.8.2. Emergency Room Clinic Activities ....................................................... 48
    4.8.3. Critical Lab Values .............................................................................. 48
4.9. KEY CONCEPTS .......................................................................................... 50

5.0 MANAGING PCE .......................................................................................... 50
5.1. PCE MENUS AND OPTIONS ....................................................................... 50
5.2. PCE COORDINATOR MENU ....................................................................... 51
5.3. KEY CONCEPTS .......................................................................................... 52
5.4. PCE SITE PARAMETERS ............................................................................... 52
    5.4.1. PCE Site Parameters Menu ................................................................. 52
    5.4.2. Option Descriptions ............................................................................ 52
    5.4.3. PCE HS/RPT Parameter Menu ............................................................ 53
6.0 TABLE MAINTENANCE

6.1. PCE TABLE MAINTENANCE MENU .................................................55
   6.1.1. Option Descriptions ................................................................56
6.2. EDITING THE EDUCATION TOPIC FILE .......................................57
6.3. KEY CONCEPTS ............................................................................58
6.4. ENTER/EDIT IMMUNIZATION LOT FILE .....................................58
6.5. KEY CONCEPTS ............................................................................59
6.6. DISPLAY IMMUNIZATION INVENTORY REPORT ............................59

7.0 PCE INFORMATION ONLY ...............................................................61

7.1. PCE INFORMATION ONLY MENU ................................................61
7.2. OPTION DESCRIPTIONS .................................................................61
   7.2.1. Active Educ. Topic List – Detailed ............................................61
   7.2.2. Education Topic List ...............................................................61
   7.2.3. Education Topic Inquiry ..........................................................61
   7.2.4. Exam List ................................................................................62
   7.2.5. Health Factor List .................................................................62
   7.2.6. Immunization List .................................................................62
   7.2.7. Skin Test List ..........................................................................62
   7.2.8. Treatment List .........................................................................62
   7.2.9. PCE Code Mapping List .........................................................62
7.3. PCE CODE MAPPING LIST .............................................................62
7.4. KEY CONCEPTS ............................................................................63

8.0 CLINICAL REMINDERS ..................................................................63

8.1. OVERVIEW ....................................................................................63
8.2. MANUAL DATA ENTRY ....................................................................64
8.3. AUTOMATED DATA CAPTURE ......................................................65
8.4. CLINICAL REMINDERS AND HEALTH SUMMARY PACKAGES DATA USE .........................................................65
8.5. HEALTH SUMMARY REMINDER COMPONENTS ............................65
8.6. CLINICIAN’S ROLE IN CLINICAL REMINDERS .............................66
8.7. IMPLEMENTING CLINICAL REMINDERS .......................................68
8.8. DEFINING CLINICAL TERMS WITH PCE TABLES .......................71
8.9. PCE REMINDER MAINTENANCE MENU ........................................71
8.9.1.  Option Descriptions .................................................................................................................71
8.10.  Copying and Editing a Reminder .................................................................................................73
8.11.  Health Summary Example .........................................................................................................77
8.12.  Key Concepts ...............................................................................................................................78

9.0  PCE Clinical Reports .........................................................................................................................79
9.1.   PCE Clinical Reports Menu ...........................................................................................................79
9.2.    Option Descriptions .....................................................................................................................79
  9.2.1.  Patient Activity by Clinic ...........................................................................................................79
  9.2.2.  Caseload Profile by Clinic .........................................................................................................79
  9.2.3.  Workload by Clinic ...................................................................................................................80
  9.2.4.  Diagnoses Ranked by Frequency ...............................................................................................80
  9.2.5.  Location Encounter Counts .....................................................................................................80
  9.2.6.  Provider Encounter Counts .....................................................................................................80
  9.2.7.  Patient Activity by Clinic ...........................................................................................................80
  9.2.8.  Caseload Profile by Clinic .........................................................................................................81
  9.2.9.  Technical Description ...............................................................................................................82
  9.2.10.  Workload by Clinic ..................................................................................................................84
  9.2.11.  Diagnosis Ranked by Frequency .............................................................................................85
  9.2.12.  Provider Encounter Counts ....................................................................................................88
  9.2.13.  Selected Person Classes ..........................................................................................................90
  9.2.14.  Location Encounter Counts ....................................................................................................91
  9.2.15.  Key Concepts ...........................................................................................................................93

9.3.    Missing Data Report .....................................................................................................................93

10.0  Supplementary Material ..................................................................................................................94
10.1.   Helpful Hints ..............................................................................................................................94
10.2.   Frequently Asked Questions ......................................................................................................94

11.0  Device Interface Error Reports ......................................................................................................97

12.0  Glossary ...........................................................................................................................................98

13.0  Appendix – Sample MDR Report ...................................................................................................101
1.0 Introduction

Patient Care Encounter (PCE) helps sites collect, manage, and display outpatient encounter data (including providers, procedure codes, and diagnostic codes) in compliance with the 10/1/96 Ambulatory Care Data Capture mandate from the Undersecretary of Health.

PCE also helps sites document patient education, examinations, treatments, skin tests, and immunizations, as well as collect and manage other clinically significant data, such as defining Health Factors and Health Maintenance Reminders.

PCE data may come from several sources, including external data acquisition devices (such as mark sense scanners), provider interaction (through workstations or portable computers), or clerical data entry. PCE allows new types of data (such as immunizations and purpose of visit) to be entered and stored, which can be retrieved by patient, ward, or clinic. Information entered through PCE can be viewed on Health Summaries or other reports.

1.1. Purpose and Benefits of PCE

The Veterans Health Administration has determined that it must have adequate, accurate, and timely information about each ambulatory care encounter/service provided in order to enhance patient care and to manage our health care resources into the future. Effective October 1, 1996, VHA facilities are required to report each ambulatory encounter and/or ancillary service. Provider, procedure, and diagnosis information is included in the minimum data set that will be reported to the National Patient Care Data Base (NPCDB). The Ambulatory Data Capture Project was formed to coordinate the many software packages and their developers who support this effort.

1.1.1. Goals of Ambulatory Data Capture Project

- Capture purpose of visit/problem, diagnoses, procedures, and providers
- Develop a fast, accurate method for getting ambulatory care data into VistA
- Return clinically relevant data back to the Clinician
- Make data available for workload reporting, DSS, research, MCCR, and other ongoing VHA needs

1.2. Software Necessary to Support ADCP

- Automated Information Collection System (AICS) and other capture solutions
- Patient Care Encounter
- Problem List
Patient Information
Management System
National Patient Care Data Base

Patient Care Encounter (PCE) ensures that every encounter has an associated provider(s), procedure code(s), and diagnostic code(s), in accordance with this mandate.

PCE also helps fill a gap in current VISTA patient information by capturing other clinical data such as exams, health factors, immunizations, skin tests, treatments, and patient education, which can then be viewed on Health Summaries and other clinical reports, and can be used to produce clinical reminders on Health Summaries.

1.3. Functionality of PCE

Version 1.0 of PCE provides options that allow:

- Collection and management of outpatient encounter data.
- Presentation of outpatient encounter data through Health Summary components and Clinical Reports. Outpatient encounter data is captured through interactive and non-interactive interfaces.

1.3.1. Interactive Interfaces

Online data capture using a user interface developed with List Manager tools. Online data capture in which Scheduling integrates with PCE to collect checkout information.

1.3.2. Non-interactive Interfaces

PCE Device Interface, which supports the collection of encounter form data from scanners such as PANDAS, Pen-based Teleform, and Automated Information Collection System (AICS). The interface also supports workstation collection of outpatient encounter data.

PCE application programming interface (API) which supports the collection of outpatient encounter data from ancillary packages such as Laboratory, Radiology, Text Integration Utility (TIU), and Computerized Patient Record System (CPRS).

1.4. Definitions

Outpatient Visit: The visit of an outpatient to one or more units or facilities located in or directed by the provider maintaining the outpatient health care services (clinic, physician’s office, hospital/medical center) within one calendar day.

Encounter: A contact between a patient and a provider who has primary responsibility for assessing and treating the patient at a given contact, exercising...
independent judgment. A patient may have multiple encounters per visit. Outpatient encounters include scheduled appointments and walk-in unscheduled visits. A clinician’s telephone communications with a patient may be represented by a separate visit entry. If the patient is seen in an outpatient clinic while an inpatient, this is treated as a separate encounter.

**Episode of Care:** Many encounters for the same problem can constitute an episode of care. An outpatient episode of care may be a single encounter or can encompass multiple encounters over a long period of time. The definition of an episode of care may be interpreted differently by different professional services even for the same problem. Therefore, the duration of an episode of care is dependent on the viewpoints of individuals delivering or reviewing the care provided.

**Ancillary Service/Occasion of Service:** A specified instance of an act of service involved in the care of a patient or consumer which is not an encounter. These occasions of service may be the result of an encounter; for example, tests or procedures ordered as part of an encounter. A patient may have multiple occasions of service per encounter or per visit.

**Provider:** The entity which furnishes health care to a consumer. This definition includes an individual or defined group of individuals who provide a defined unit of health care services (defined = codable) to one or more individuals at a single session.

### 1.5. Potential PCE Workflow

1. A provider has a patient encounter (appointment, walk-in, telephone call, mail conversation, etc.).

   Materials available to provider:
   - Health Summary with new components summarizing previous encounters, and a health reminders component based on clinical repository data
   - Encounter Form (hard copy or workstation) with pre-defined terminology for the provider’s clinic/service type
   - PCE Clinical Reports, Action Profile, Daily Order Summary, Lab Interim report, and other VISTA reports.

2. The provider documents the encounter (on hard copy or online).

   Types of data collected and stored in PCE:
   - Providers
   - Diagnoses
   - CPT procedures provided
   - Immunizations (CPT-mappable)
- Skin tests (CPT-mappable)
- Patient education
- Exams (non-CPT-mappable)
- Treatments (non-CPT-mappable)

3. Information from a hard copy encounter form is entered into VISTA by a data entry clerk or scanned via an interface utility.

4. Encounter form data that isn’t scanned or is scanned incorrectly can be entered or edited through the PCE data entry program described in this manual.

5. Providers can enter immunizations, patient education, or other pieces of clinical information through PCE.

6. Providers can view items entered into PCE on a Health Summary or customized report. If any of these items have been set up for clinical reminders, these reminders will appear on the patient's health summary.

1.6. Sources of Data

PCE data can be entered through many mechanisms, including:

- Scheduling (PIMS) check-out process
- AICS Encounter Forms
- PANDAS™ scanning system
- TELEFORM scanning system
- Imaging workstation
- Clinical Workstation

1.7. Designing Encounter Forms

To use AICS Encounter Forms with scanners or for direct data entry (either clinician or data entry clerk), you can design encounter forms for your hospital or clinic with the AICS Encounter Form generator. See the AICS User Manual for instructions about creating Encounter Forms.

1.8. XU*8*27 - New Person File Patch

As part of the October 1, 1996 mandate, VAMCs must collect provider information. The provider information reported is the "Person Class" defined for all providers associated with ambulatory care delivery.
To comply with this requirement, all VAMC providers must be assigned a Profession/Occupation code (Person Class) so that a Person Class can be associated with each ambulatory patient encounter by October 1.

Patch XU*8*27 has been developed to provide functionality that will enable you to assign Person Class information.

2.0 Orientation

2.1. Screen Display

PCE uses the List Manager Utility, which allows PCE to display a list of items in a screen format, with possible actions (add, edit, print) listed below. If the list is longer than one screen, the header and action portions of the screen remain stable, while the center display scrolls. So if there are too many patient encounters to fit within the scrolling portion of the screen, when you press the return key, that portion of the screen scrolls while the top and bottom stay unchanged.

```
PCE Appointment List  May 12, 1995 12:53:07  Page: 1 of 3
PCEPATIENT,ONE 000-45-6789 Clinic: All
Date range: 03/13/95 to 05/26/95
   Clinic   Appt Date/Time   Status   
1   Xyz   Mar 27, 1995 08:00   Cancelled By Patient
2   Xyz   Mar 27, 1995 09:00   No-show
3   Xyz   Mar 27, 1995 09:30   Cancelled By Patient
4   Xyz   Mar 27, 1995 10:00   No-show
5   Xyz   Mar 28, 1995 08:30   Checked Out
6   Xyz   Mar 28, 1995 08:50   No-show
+       + Next Screen  - Prev Screen  ?? More Actions
UE Update Encounter  SP Select New Patient  VC View by Clinic
LI List by Encounter  CD Change Date Range  DD Display Detail
AD Add Standalone Enc.  EP Expand Appointment
AL Appointment Lists  IN Check Out Interview  QU Quit
Select Action: Quit// AD   Add New Encounter
```

Without leaving the option, you can:
- Browse through the list
- Select items that need action
- Take action on those items
- Select other actions

You select an action by typing the name or abbreviation at the Select Action prompt.

Actions may be preselected by typing the action abbreviation, then the number of the encounter on the list. For example, UE=1 will process entry 1 for Update Encounter.
2.1.1. Other (Hidden) Actions

If you enter two question marks (??) at the Select Item(s) prompt, you will see a list of other actions that you can use with PCE.

Select Item(s): Quit// ??
The following actions are also available:
+ Next Screen  FS  First Screen  SL  Search List
- Previous Screen  LS  Last Screen  ADPL  Auto Display(On/Off)
UP  Up a Line  GO  Go to Page
DN  Down a Line  RD  Re Display Screen  SP  Leave Update and
>  Shift View to Right  PS  Print Screen  Select New Patient
<  Shift View to Left  PL  Print List
Press RETURN to continue or '^' to exit:

2.2. Review Screens

PCE provides several different perspectives for viewing encounter data. You can change to any of these views whenever you're at a Select Action: prompt.

- List by Appointment
- List by Encounter
- Select New Patient
- View by Clinic/Ward
- Change Date Range
- Display Detail
- Expand Appointment
- Appointment Lists

2.2.1. List by Appointment

Most encounters are associated with an appointment (the exceptions are Standalone Encounters, which are usually walk-ins, and Historical Encounters, which usually took place at another location). Therefore, you need to identify an appointment to associate encounter information with before you enter this information. You can change your view to List by Encounter if you wish to enter standalone or historical encounters. You can also change your default view (whether you see the Appointment List or the Encounter List when you enter PCE) through the option, PCE Parameters Add/Edit.

<p>| PCE Appointment List  Jul 26, 1996 08:07:20  Page: 1 of 1 |
| PCEPATIENT,ONE  000-45-6789  Clinic:  All |
| Date range: 07/16/96 to 07/30/96  Total Appointment Profile |</p>
<table>
<thead>
<tr>
<th>Clinic</th>
<th>Appt Date/Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diabetes Clinic</td>
<td>May 18, 1996 16:48</td>
</tr>
<tr>
<td>2</td>
<td>Cardiology</td>
<td>May 22, 1996 09:00</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes Clinic</td>
<td>Jun 22, 1996 11:00</td>
</tr>
<tr>
<td>4</td>
<td>Cardiology</td>
<td>Jun 23, 1996 09:00</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes Clinic</td>
<td>Jun 23, 1996 09:30</td>
</tr>
</tbody>
</table>
2.2.2. List by Encounter

List by Encounters includes ancillary encounters only if the process starts either through PCE Encounter Data Entry Supervisor or PXCE Encounter Viewer.

2.3. Select New Patient, View by Clinic, Change Date Range

You can change to another patient, another Clinic, or to a different date range and start all over just by selecting one of these actions at any Select Action prompt.

Display Detail
2.3.1. Expand Appointment

This action lets you see an Expanded Profile for a selected patient appointment. Note that the top line says Page: 1 of 5, indicating that you should press ENTER after each screen display to see the entire expanded profile. To scroll back, press the minus (-) key.

*** Appointment Demographics ***

Name: PCEPATIENT,ONE
ID: 000-45-6789
Clinic: DIABETES CLINIC
Date/Time: JUL 18, 1996@16:48
Status: ACTION REQ/CHECKED OUT
Purpose of Vst.: UNSCHEDULED
Length of Appt: 30
Appt Type: REGULAR
Lab: Elig of Appt: SC LESS THAN 50%
X-ray:
Overbook: NO
EKG:
Collateral Appt: NO
Other Info: Enrolled in this clinic: YES
Enrollment Date/Time: JUN 04, 1995

Select Action: Next Screen// [ENTER]

*** Appointment Event Log ***

Appt Made: JUL 18, 1996
Check In: JUL 18, 1996@16:48
Check Out: JUL 18, 1996@16:49:05
No-Show/Cancel

Checked Out:
Cancel Reason:
Cancel Remark:
Rebooked Date:
+ Enter ?? for more actions

Select Action: Next Screen// [ENTER]

Expanded Profile    Jul 26, 1996 08:52:10   Page:  3 of  5
Patient: PCEPATIENT,ONE (6789)                       Outpatient
Appointment #: 1                                      Clinic: DIABETES CLINIC

*** Patient Information ***
Date of Birth: APR 01, 1944                       ID: 000-45-6789
Sex: FEMALE                                  Marital Status: SINGLE
Religious Pref.: UNKNOWN/NO PREFERENC

Primary Elig.: SC, LESS THAN 50%              POS: VIETNAM ERA
Address:                                      Phone:
321 S 3400 E                                321 S 3400 E
SALT LAKE CITY, UTAH 84105                  SALT LAKE CITY, UTAH 84105
Radiation Exposure: YES                            Status: NO INPT./LOD. ACT.
Prisoner of War: NO                               Last Admit/Lodger Date:
AO Exposure: YES                                 Last Disch./Lodger Date:
+ Enter ?? for more actions

Select Action: Next Screen// [ENTER]

Expanded Profile    Jul 26, 1996 08:52:10   Page:  4 of  5
Patient: PCEPATIENT,ONE (6789)                       Outpatient
Appointment #: 1                                      Clinic: DIABETES CLINIC

*** Check Out ***
1 Treatment for SC Condition: NO
2 Combat Veteran: NO
3 Agent Orange Exposure: YES
4 Ionizing Radiation Exposure: NO
5 SW Asia Conditions: NO
6 Military Sexual Trauma: NO
7 Head and/or Neck Cancer: NO

PROVIDER [Required]        DIAGNOSIS [Required]
1 PCEPROVIDER,ONE+

Enter ?? for more actions

Select Action: Next Screen// [ENTER]

Expanded Profile    Jul 26, 1996 08:52:10   Page:  5 of  5
Patient: PCEPATIENT,ONE (6789)                       Outpatient
Appointment #: 1                                      Clinic: DIABETES CLINIC
+ STOP CODES

[Not Required]

Enter ?? for more actions

Select Action: Quit// [ENTER]
2.3.2. Appointment

This action gives you a list of possible appointment statuses and lets you change the appointments that will appear on the list, based on their statuses.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Appt Date/Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Clinic</td>
<td>Jul 18, 1996</td>
<td>Action Req/Checked Out</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Jul 22, 1996</td>
<td>Checked Out</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Jul 22, 1996</td>
<td>Checked Out</td>
</tr>
<tr>
<td>Diabetes Clinic</td>
<td>Jun 22, 1996</td>
<td>Checked Out</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Jun 23, 1996</td>
<td>No Action Taken</td>
</tr>
<tr>
<td>Cardiology</td>
<td>May 25, 1996</td>
<td>Checked Out</td>
</tr>
</tbody>
</table>

Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

Select List: Total Appt Profile// CO

3.0 Using PCE

Health Care Providers and data entry clerks primarily use PCE to enter or edit encounter data, to create clinical reminders to be viewed on Health Summaries, and
to view or print clinical reports summarizing various information about patients in a clinic. This section describes how to perform these functions.

3.1. PCE Data Entry Options

Patient Care Encounter lets you add information, edit information, or add a new encounter to a patient's database. When you enter the program through the PCE User Interface described in this manual, you first view a list of encounters for a patient (by appointment). Appointments are provided to the PCE program by the Checkout process of the Scheduling package.

After you select a particular view and the appointments or encounters are displayed on your screen, you can add or edit information.

PCE has four options for adding or editing encounter information.

3.1.1. PCE Encounter Data Entry - Supervisor

This option is for users who can document a clinical encounter in PCE, and can also delete any encounter entries, even though they are not the creator of the entries.

This option is intended for the Coordinator for PCE and/or supervisor of the encounter data entry staff.

3.1.2. PCE Encounter Data Entry

This option is for users who can document a clinical encounter in PCE, but can only delete entries they have created. The data entered via this option includes visit information (where and when), and clinical data related to the visit: providers of care, problems treated, procedures and treatments done, and immunizations, skin tests, and patient education given.

3.1.3. PCE Encounter Data Entry and Delete

This option is for users who can document a clinical encounter in PCE, and can also delete any encounter entries, even though they are not the creator of the entries.

This option is on the Clinician menu.

3.1.4. PCE Encounter Data Entry without Delete

This option is for users who can document a clinical encounter in the PCE, but should not be able to delete any entries, including ones that they have created.

3.2. PCE Actions

"Actions" are the choices listed at the bottom of the PCE screens (following the shaded bar) which you can select, either to edit or add to the appointments or
encounter shown in the top part of the screen, or to see a different view of that information.

<table>
<thead>
<tr>
<th>UE</th>
<th>Update Encounter</th>
<th>SP</th>
<th>Select New Patient</th>
<th>VC</th>
<th>View by Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>LI</td>
<td>List by Encounter</td>
<td>CD</td>
<td>Change Date Range</td>
<td>DD</td>
<td>Display Detail</td>
</tr>
<tr>
<td>AD</td>
<td>Add Standalone Enc.</td>
<td>EP</td>
<td>Expand Appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AL</td>
<td>Appointment Lists</td>
<td>IN</td>
<td>Check Out Interview</td>
<td>QU</td>
<td>Quit</td>
</tr>
</tbody>
</table>

The following actions can be used at the Appointment List or Encounter List screens.

**ADD STANDALONE ENC** – This action lets you add a new encounter not associated with a credit stop.

**APPOINTMENT LISTS** – This action allows you to change which appointments will be displayed based on their status. For example, you may change the display to list cancelled, checked in, checked out, future appointments, inpatient appointments, appointment where no action has been taken, non-count appointments, no show appointments, or all appointments.

**CHANGE CLINIC** – This action lets you change the display list of encounters based on hospital location. If the list includes encounters for all locations, you can select a new location and the list will be redisplayed with only encounters that relate to that location.

**CHANGE DATE RANGE** – This action allows you to change the date range used for displaying encounters or appointments. You may change the beginning and/or ending date.

**CHECKOUT INTERVIEW** – This action allows you to go through the interview questions for an encounter that is associated with an appointment. You may also edit additional information such as provider, diagnosis, and procedure. You may also edit an encounter that is associated with an appointment by entering the number associated with the item at the "Select Action" prompt or using the Update Encounter.

**DISPLAY DETAIL** – This action displays all available information related to one encounter for a selected appointment.

**EXPAND APPOINTMENT** – This action allows you to display all the patient demographics and appointment event log items that have been entered for a selected patient appointment. Expand Appointment displays information from the Scheduling package and not from PCE.

**LIST BY ENCOUNTER** – This action allows you to change the display from a list of appointments for this patient or clinic to a list of encounters for the same patient or clinic. There may be several encounters for one appointment.

**LIST BY APPOINTMENT** – This action allows you to change the display from a list of encounters for this patient or clinic to a list of appointments for the same patient or clinic. Not every appointment may have an encounter associated with it, so you can add encounters from this view.
MAKE HISTORICAL ENC – This action lets you add encounter information for an old encounter or one that took place at another hospital or clinic (VA or non-VA). Although you can't get workload credit for this kind of encounter, it can be used to help compute clinical reminders.

SELECT NEW PATIENT – This action allows you to change the display of encounters based on the patient. If you select a new patient, the display will include encounters or appointments for the selected patient.

UPDATE ENCOUNTER – This action lets you edit an encounter that is associated with an appointment. You may edit information such as provider, diagnosis, procedure, treatment, immunization, skin test, patient education, exams, and treatments, as well as date, service connection, and demographic data.

VIEW BY CLINIC – This action allows you to change the display of appointments or encounters based on a Clinic. For example, if your current list includes all appointments for a specified date range for the selected patient, and you want to display all appointments for a specific clinic, you may use this action to change the display to include appointments or encounters for the desired clinic.

QUIT – This action allows you to exit PCE and return to your menu.

Note: You can add Health Summary, Problem List, and Progress Notes as actions to the PCE screens, to enable you to go directly to these programs. See the PCE Installation Guide for instructions.

3.3. Adding and Editing Patient Care Encounters

Follow the steps in the next few pages to add, delete, or edit encounters.

3.3.1. Adding New Encounters

Use the Add Standalone Enc. action to enter a new encounter which may or may not have an appointment associated with it.

1. Select the PCE Encounter Data Entry option and a patient or clinic.

2. Select Add Standalone Enc at the Select Action prompt.
3. Enter the Encounter Date and Time and the Hospital Location where the encounter took place.

<table>
<thead>
<tr>
<th>Encounter Date and Time:</th>
<th>Hospital Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (7/1/96 - 7/26/96):</td>
<td>DIABETES CLINIC</td>
</tr>
<tr>
<td>N (JUL 26, 1996@07:47:51)</td>
<td></td>
</tr>
</tbody>
</table>

4. Respond to the following classification prompts:

--- Classification --- [Required]

- Was treatment for SC Condition? NO
- Was treatment related to Combat? NO
- Was treatment related to Agent Orange Exposure? NO
- Was treatment related to Ionizing Radiation Exposure? NO
- Was treatment related to SW Asia Conditions? NO
- Was treatment related to Military Sexual Trauma? NO
- Was treatment related to Head and/or Neck Cancer? NO

5. The screen displays the encounter data.

<table>
<thead>
<tr>
<th>PCE Update Encounter</th>
<th>Jul 26, 1996 07:56:59</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCEPATIENT,ONE</td>
<td>000-45-6789</td>
</tr>
<tr>
<td>Clinic:</td>
<td>DIABETES CLINIC</td>
</tr>
<tr>
<td>Encounter Date</td>
<td>07/26/96 07:56</td>
</tr>
<tr>
<td>Clinic Stop:</td>
<td>306 DIABETES</td>
</tr>
</tbody>
</table>

3.4. **Make a Historical Encounter**

You can create encounters for patient visits that occurred at some time in the past (exact time may be unknown) or at some other location (possibly non-VA). Although these are not used for workload credit, they can be used for setting up the reminder maintenance system.

Note: If month or day are not known, historical encounters will appear on encounter screens or reports with zeroes for the missing dates; for example, 01/00/95 or 00/00/94.

Steps to use this action:

1. Change to View by Encounters if you are in the Appointment View.
2. Select the Make Historical Enc action at the Select Action prompt.
3. Enter the date of the encounter and the time, if known.

4. Enter the location where the encounter took place. If it happened at a non-VA hospital or clinic, type that name. Otherwise enter the name or number of the VA Medical Center or other facility.

5. Enter any comments that are needed to clarify the encounter (optional).

3.5. Update Encounter

With the Update Encounter action you can add or edit encounter information, either through the Edit an Item or Delete an Item actions, or by choosing one of the following:

- CPT (Procedure) Diagnosis (ICD)
- Encounter Exam
- Health Factors Immunization
- Patient Ed Provider
- Skin test
- Treatment

Note: IRM or a Clinical Coordinator can change the items or categories available to choose from for many of these actions (Treatment, Patient Ed, Immunization, etc.) through the PCE Table Maintenance Menu. If you wish to define these items, check with your Coordinator.

Follow the steps below to use Update Encounter.
1. A screen like this appears. Type UE at the Select Action prompt.

<table>
<thead>
<tr>
<th>PCE Encounter List</th>
<th>Jul 25, 1996 07:41:25</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCEPATIENT.ONE</td>
<td>000-45-6789</td>
<td>Clinic: All</td>
</tr>
<tr>
<td>Date range:</td>
<td>07/15/96 to 07/29/96</td>
<td></td>
</tr>
<tr>
<td>Encounter Clinic</td>
<td>Clinic Stop</td>
<td></td>
</tr>
<tr>
<td>1 07/22/96 11:08 CARDIOLOGY 303 CARDIOLOGY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ Next Screen - Prev Screen ?? More Actions

UE Update Encounter SP Select New Patient VC View by Clinic
LI List by Appointment CD Change Date Range DD Display Detail
AD Add Standalone Enc. CC Change Clinic
HI Make Historical Enc. IN Check Out Interview QU Quit
Select Action: Quit// UE

2. Select the appointment you want to add items to or to edit.

3. Select the number of the item to be edited or an action that will let you add or edit encounter information.

<table>
<thead>
<tr>
<th>PCE Update Encounter</th>
<th>Jul 25, 1996 07:45:02</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCEPATIENT.ONE</td>
<td>000-45-6789</td>
<td>Clinic: CARDIOLOGY</td>
</tr>
<tr>
<td>Encounter Date</td>
<td>07/22/96 11:08</td>
<td>Clinic Stop: 303 CARDIOLOGY</td>
</tr>
<tr>
<td>1 Encounter Date and Time: JUL 22, 1996@11:08:14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Provider: PCEPROVIDER,ONE PRIMARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 ICD9 Code or Diagnosis: V70.3 MED EXAM NEC-ADMIN PURP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Narrative: OTHER GENERAL MEDICAL EXAMINATION FOR ADMINISTRATIVE PURPOSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary/Secondary Diagnosis: PRIMARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 CPT Code: 25066 BIOPSY FOREARM SOFT TISSUES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT Modifier: 22 UNUSUAL PROCEDURAL SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Education Topic: VA-TOBACCO USE SCREENING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ Next Screen - Prev Screen ?? More Actions

ED Edit an Item TR Treatment DD Display Detail
DE Delete an Item IM Immunization DB Display Brief
EN Encounter PE Patient Ed IN Check Out Interview
PR Provider ST Skin Test QU Quit
DX Diagnosis (ICD) XA Exam
CP CPT (Procedure) HF Health Factors
Select Action: Quit// 4

3.5.1. Quick Tricks

After Diagnosis has been entered, if the Provider Narrative is an exact match, you can enter = and the diagnosis will be duplicated here.

The equals sign (=) can also be used as a shortcut when selecting an action plus encounters or appointments from a list in a single response (e.g., Select Action: ED=2).

UE=1 will process entry 1 for Update Encounter
3.6. **Edit an Item**

When you choose the action **Edit an Item**, you will be prompted item-by-item to enter information about a selected encounter.

Steps to Edit an Item:

1. **Select UE from the PCE Encounter List screen.**

   ![PCE Encounter List](image)

   + Next Screen  - Prev Screen  ?? More Actions
   UE Update Encounter  SP Select New Patient  VC View by Clinic
   LI List by Appointment  CD Change Date Range  DD Display Detail
   AD Add Standalone Enc.  CC Change Clinic
   HI Make Historical Enc.  IN Check Out Interview  QU Quit
   Select Action: Quit// UE

2. **Select the encounter you want to edit.**

3. **Select ED from the PCE Update Encounter screen.**

   ![PCE Update Encounter](image)

4. **Respond to each of the following prompts, as appropriate.**

   ![Select Entry(s) (1-5): 1-5](image)

   Select Entry(s) (1-5): 1-5
   Provider:  PCEPROVIDER,ONE// PCEPROVIDER,TWO
   Is this Provider Primary:  YES// [ENTER]
   Is this Provider Attending:  NO// y YES
   ICD9 Code or Diagnosis:  V70.3// [ENTER]  V70.3  MED EXAM NEC-ADMIN PURP
   Provider Narrative:  OTHER GENERAL MEDICAL EXAMINATION FOR ADMINISTRATIVE PURPOSES
   ...OK? Yes// [ENTER]  (Yes)
   Diagnosis (ICD):  VA-TOBACCO USE SCREENING
   CPT Code:  25066  BIOPSY FOREARM SOFT TISSUES
   CPT Modifier: 22  UNUSUAL PROCEDURAL SERVICES
   Education Topic:  VA-TOBACCO USE SCREENING
   Select Action: Quit// ED
5. The edited screen is then displayed.

```
Is this Diagnosis Primary: YES// [ENTER]
Modifier: [ENTER]
Encounter Provider: PCEPROVIDER,TWO
Comments: [ENTER]

CPT Code: 25066 // [ENTER]  BIOPSY FOREARM SOFT TISSUES
Select CPT MODIFIER: 22// [ENTER]
Provider Narrative: BIOPSY FOREARM SOFT TISSUES  Replace SUSPICIOUS LUMP
Quantity: 1// [ENTER]
Diagnosis: MALIGNANT TUMOR
Principal Procedure: [ENTER]
Encounter Provider: PCEPROVIDER,ONE// PCEPROVIDER,TWO
Comments: [ENTER]

Education Topic: VA-TOBACCO USE SCREENING  Replace [ENTER]
Level of Understanding: GOOD// GOOD
Encounter Provider: PCEPROVIDER,ONE// PCEPROVIDER,TWO
Comments: [ENTER]
```

3.7. **Delete an Item**

Steps to Delete an Item:

1. Select UE from the PCE Encounter List screen.
2. Select the encounter you wish to edit.
3. Select DE from the PCE Update Encounter screen.
2 Provider: PCEPROVIDER, ONE PRIMARY ATTENDING
3 ICD9 Code or Diagnosis: V70.3 MED EXAM NEC-ADMIN PURP
   Provider Narrative: OTHER GENERAL MEDICAL EXAMINATION FOR ADMINISTRATIVE PURPOSES
   Primary/Secondary Diagnosis: PRIMARY
4 CPT Code: 25066 BIOPSY FOREARM SOFT TISSUES
   CPT Modifier: 22 UNUSUAL PROCEDURAL SERVICES
5 Education Topic: VA-TOBACCO USE SCREENING

+ Next Screen - Prev Screen ?? More Actions
ED Edit an Item TR Treatment DD Display Detail
DE Delete an Item IM Immunization DB Display Brief
EN Encounter PE Patient Ed IN Check Out Interview
PR Provider ST Skin Test QU Quit
DX Diagnosis (ICD) XA Exam
CP CPT (Procedure) HF Health Factors
Select Action: Quit// de Delete an Item
Select Entry(s) (1-5): 1-5

4. Answer the following prompts to indicate which items you will delete.

Deleting Provider PCEPROVIDER, ONE PRIMARY ATTENDING
Are you sure you want to remove this entry? NO// [ENTER]

Deleting Diagnosis V70.3 MED EXAM NEC-ADMIN PURP
Are you sure you want to remove this entry? NO// [ENTER]

Deleting CPT 25066 BIOPSY FOREARM SOFT TISSUES
Are you sure you want to remove this entry? NO// [ENTER]

Deleting Patient Education VA-TOBACCO USE SCREENING
Are you sure you want to remove this entry? NO// YES

Deleting Encounter JUL 22, 1996@11:08:14 CARDIOLOGY CARDIOLOGY
Are you sure you want to remove this entry? NO// [ENTER]

5. The edited screen is then displayed.

PCE Update Encounter Jul 25, 1996 08:16:02 Page: 1 of 1
PCEPATIENT,ONE 000-45-6789 Clinic: CARDIOLOGY
Encounter Date 07/22/96 11:08 Clinic Stop: 303 CARDIOLOGY

1 Encounter Date and Time: JUL 22, 1996@11:08:14
2 Provider: PCEPROVIDER, ONE PRIMARY ATTENDING
3 ICD9 Code or Diagnosis: V70.3 MED EXAM NEC-ADMIN PURP
   Provider Narrative: OTHER GENERAL MEDICAL EXAMINATION FOR ADMINISTRATIVE PURPOSES
   Primary/Secondary Diagnosis: PRIMARY
4 CPT Code: 25066 BIOPSY FOREARM SOFT TISSUES
   CPT Modifier: 22 UNUSUAL PROCEDURAL SERVICES

+ Next Screen - Prev Screen ?? More Actions
ED Edit an Item TR Treatment DD Display Detail
DE Delete an Item IM Immunization DB Display Brief
EN Encounter PE Patient Ed IN Check Out Interview
PR Provider ST Skin Test QU Quit
DX Diagnosis (ICD) XA Exam
CP CPT (Procedure) HF Health Factors
Select Action: Quit// [ENTER]
3.8. How to Add or Edit an Encounter

You can add an encounter for an appointment that doesn’t have an encounter associated with it, or edit an existing encounter.

Steps to edit an Encounter:

1. Select UE from the PCE Appointment List screen.

2. Select EN from the PCE Update Encounter screen.

3. Respond to the following prompts for the encounter, as appropriate.

Check out date and time: JUN 17,1996@09:00// [ENTER](JUN 17, 1996@09:00)

--- Classification --- [Required]
Was treatment for SC Condition? YES// [ENTER]

4. If you answer NO to the last prompt above, you get additional prompts as shown below.

Check out date and time: MAY 23,1996@15:17//[ENTER](MAY 23, 1996@15:17)

--- Classification --- [Required]
Was treatment for SC Condition? YES// n NO
Was treatment related to Combat? n NO
Was treatment related to Agent Orange Exposure? n NO
Was treatment related to Ionizing Radiation Exposure? n NO
Was treatment related to SW Asia Conditions? n NO
Was treatment related to Military Sexual Trauma? n NO
Was treatment related to Head and/or Neck Cancer? n NO
3.9. How to Add or Edit a Provider

When you enter or edit a provider for an encounter, you will be prompted to enter whether the provider is Primary and/or Attending. The default provider entered at checkout is the primary provider.

Steps to add or edit a Provider

1. Select UE, from the PCE Appointment List screen.
2. Select the appointment and encounter you wish to edit.
3. Select PR from the PCE Update Encounter screen.

4. Choose whether you want to edit or add and respond to the other prompts, as appropriate.

--- Provider ---

1 PCEPROVIDER,ONE PRIMARY ATTENDING
Enter 1-1 to Edit, or 'A' to Add: 1

Provider: PCEPROVIDER,ONE// [ENTER] PCEPROVIDER,ONE
Is this Provider Primary: YES// [ENTER]
Is this Provider Attending: YES// NO

5. The edited screen is then displayed.

3.10. How to Add or Edit Diagnoses (ICD9)

You can enter a diagnosis and/or an ICD-9 code for a patient’s encounter. You will be prompted to designate the diagnosis as primary or secondary. CIDC (Clinical Indicator Data Capture) has added functionality that displays patient Service Connected and Rated Disabilities for those SC patients. In addition, an optional
Ordering/Resulting Diagnosis prompt asks “Is this Diagnosis Ordering, Resulting, or Both.” See NOTE in Step 3.

With functionality put in place by the Code Set Versioning project, only ICD Codes that are active for the encounter date and time will be available.

Steps to add a Diagnosis:

1. Select UE from the PCE Appointment List screen.
2. Select DX from the PCE Update Encounter screen.

The sample below is from PCE Data Entry, also note that these prompts are seen in the Appointment Management Check-Out option.

```
Patient's Service Connection and Rated Disabilities:

   SC Percent: 100%
   Rated Disabilities: TRAUMATIC ARTHRITIS (10%-SC)
   DIABETES MELLITUS (0%-SC)

--- Diagnosis ---
1 891.0 OPEN WND KNEE/LEG/ANKLE
2 200.01 RETICULOSARCOMA HEAD
Enter 1-2 to Edit, or 'A' to Add: A [ENTER]
```

3. Respond to the following prompts for the diagnosis, as appropriate.

```
Patient's Service Connection and Rated Disabilities:

   SC Percent: 100%
   Rated Disabilities: TRAUMATIC ARTHRITIS (10%-SC)
   DIABETES MELLITUS (0%-SC)

Provider Narrative: OPEN WOUND OF KNEE, LEG (EXCEPT THIGH), AND ANKLE, WITHOUT MENTION OF COMPLICATION
   Replace [ENTER]
   OPEN WOUND OF KNEE, LEG (EXCEPT THIGH), AND ANKLE, WITHOUT MENTION OF COMPLICATION
   ON [ENTER]

Is this Diagnosis Primary for the Encounter: YES// [ENTER]
Is this Diagnosis Ordering, Resulting, or Both: RESULTING [ENTER] (See NOTE)
Injury Date and (optional) Time: [ENTER]
Modifier: FOLLOW UP [ENTER]
Encounter Provider: PCEprovider,one BM DOC [ENTER]
[ Provider Narrative Category:] [ENTER]
```

August 1996 PCE V. 1.0 User Manual 22
Comments: SEVERE HEADACHE [ENTER]

--- Classification --- [Required]

Was treatment for SC Condition? NO// [ENTER]
Was treatment related to Combat? NO// [ENTER]
Was treatment related to Agent Orange Exposure? NO// [ENTER]
Was treatment related to Ionizing Radiation Exposure? NO// [ENTER]
Was treatment related to SW Asia Conditions? NO// [ENTER]
Was treatment related to Military Sexual Trauma? NO// [ENTER]
Was treatment related to Head and/or Neck Cancer? NO// [ENTER]

Note: The Ordering/Resulting Diagnosis prompt is available for some application encounters (i.e., Surgery), that choose to distinguish between the ordering diagnosis and resulting diagnosis. This prompt is optional.

<table>
<thead>
<tr>
<th>If user chooses:</th>
<th>Integrated Billing (IB) can generate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordering</td>
<td>Institutional claim UB92.</td>
</tr>
<tr>
<td>Resulting</td>
<td>Professional claim HCFA 1500.</td>
</tr>
<tr>
<td>Both</td>
<td>Institutional and Professional claims UB92 and HCFA 1500.</td>
</tr>
</tbody>
</table>

When Ordering/Resulting Diagnosis is not entered, IB personnel must research the Provider’s documentation for Ordering and Resulting diagnosis information.

4. The edited screen is then displayed.

3.11. How to Add or Edit a CPT (Procedure)

When you choose CPT (Procedure) under Update Encounter, you will also be prompted to enter the Provider Narrative, Quantity, Diagnosis, Principal Procedure, Encounter Provider, and comments. With functionality put in place by the Code Set Versioning project, only CPT Codes that are active for the encounter date and time will be available.

One Primary diagnosis and up to seven Secondary diagnoses may be associated with a procedure as clinical indicators. The example below shows the association as it appears on the PCE Encounter Profile screen.

| CPT Code:  76003     NEEDLE LOCALIZATION BY X-RAY  |
|--------------|-----------------------------------------------|
| Order Reference:  13559999   |
| Provider Narrative:  RENAL CYST ABLATION            |
| Quantity:  1                             |
| Ordering Provider:  RNprovider,one           |
| Encounter Provider:  RNprovider,two          |
| Primary Diagnosis:  246.2     CYST OF THYROID     |
| 1st Secondary Diagnosis:  362.54     MACULAR CYST OR HOLE |
| 2nd Secondary Diagnosis:  364.63     PRIMARY CYST PARIS PLAANA |
| 3rd Secondary Diagnosis:  364.64     EXUDAT CYST PARIS PLAANA |
| 4th Secondary Diagnosis:  383.31     POSTMASTOID MUCOSAL CYST |
| 5th Secondary Diagnosis:  478.26     CYST PHARYNX/NASOPHARYNX |
Steps to edit a CPT:

1. Select UE from the PCE Appointment List screen.

2. Select CP from the PCE Update Encounter screen.

3. Respond to the following prompts for the Procedure, as appropriate.
3.12. How to Add or edit Treatments

When you choose Treatment under Update Encounter, you will also be prompted to enter the Provider Narrative, How Many, Encounter Provider, and comments.
Note: A Clinical Coordinator can change the items or categories available to choose from for Treatment through the PCE Table Maintenance Menu. If you wish to help define the Treatment list, check with your Coordinator.

Steps to edit Treatment:

1. Select UE from the PCE Appointment List screen.
2. Select TR from the PCE Update Encounter screen.
   
   PCE Update Encounter   Jul 25, 1996 08:24:21   Page: 1 of 1
   PCEPATIENT,ONE 000-45-6789   Clinic: CARDIOLOGY
   Encounter Date 07/22/96 11:08   Clinic Stop: 303 CARDIOLOGY

   1 Encounter Date and Time: JUL 22, 1996@11:08:
   2 Provider: PCEPROVIDER,ONE PRIMARY ATTENDING
   3 ICD9 Code or Diagnosis: V70.3 MED EXAM NEC-ADMIN PURP
   Provider Narrative: OTHER GENERAL MEDICAL EXAMINATION FOR
   ADMINISTRATIVE PURPOSES
   Primary/Secondary Diagnosis: PRIMARY
   4 CPT Code: 25066 BIOPSY FOREARM SOFT TISSUES
   CPT Modifier: 22 UNUSUAL PROCEDURAL SERVICES
   5 Education Topic: VA-TOBACCO USE SCREENING

   + Next Screen - Prev Screen ?? More Actions
   ED  Edit an Item  TR  Treatment  DD  Display Detail
   DE  Delete an Item  IM  Immunization  DB  Display Brief
   EN  Encounter  PE  Patient Ed  IN  Check Out Interview
   PR  Provider  ST  Skin Test  QU  Quit
   DX  Diagnosis (ICD)  XA  Exam
   CP  CPT (Procedure)  HF  Health Factors

3. Respond to the following prompts for the Treatment, as appropriate.

   Treatment: Exercise
   Provider Narrative: Circulatory Problems
   How Many: 1// [ENTER]
   Encounter Provider: PCEPROVIDER,FOUR// [ENTER] PCEPROVIDER,FOUR
   Comments:[ENTER]

   The edited screen is then displayed.

3.13. How to Add or Edit an Immunization

When you choose Immunization under Update Encounter, you will also be prompted to enter the Lot Number, Ordering Provider, Encounter Provider, Series, Reaction, Repeat Contraindicated, Administered Date and Time, Dosage, Route of Administration, Site of Administration, ordering and administered times, and Comments.

Immunizations are mapped to CPT codes. When an Immunization is entered, if the supervisor option is used, the user will be prompted for diagnoses which are associated with the mapped CPT code. If the diagnoses have not already appeared
in the encounter, the user will be prompted for additional information to qualify the diagnosis such as modifiers, comments and SC/EI classifications.

Steps to add an Immunization:

1. Select UE from the PCE Appointment List screen.
2. Select IM from the PCE Update Encounter screen.

3. Respond to the following prompts for the immunization, as appropriate.
### 3.14. How to Add or Edit a Patient Ed

When you choose Patient Ed under Update Encounter, you will be prompted to enter the Education Topic, Level of Understanding, Encounter Provider, and Comments.

**Note:** A Clinical Coordinator can change the items or categories available to choose from for Patient Ed through the PCE Table Maintenance Menu. If you wish to help define the Patient Education list, check with your Coordinator.

**Steps to add Patient Ed:**

1. Select UE from the PCE Appointment List screen.
2. Select PE from the PCE Update Encounter screen.
3. Respond to the following prompts for Patient Education.

<table>
<thead>
<tr>
<th>Action</th>
<th>Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select PE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCEPATIENT,ONE</td>
<td>000-45-6789</td>
<td>Clinic: CARDIOLOGY</td>
</tr>
<tr>
<td>Provider: PCEPROVIDER,ONE</td>
<td>PRIMARY</td>
<td>ATTENDING</td>
</tr>
<tr>
<td>Encounter Date: 07/22/96</td>
<td>11:08</td>
<td>Clinic Stop: 303 CARDIOLOGY</td>
</tr>
<tr>
<td>1 Encounter Date and Time: JUL 22, 1996@11:08:14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Provider: PCEPROVIDER,ONE</td>
<td>PRIMARY</td>
<td>ATTENDING</td>
</tr>
<tr>
<td>3 ICD9 Code or Diagnosis: V70.3</td>
<td>MED EXAM NEC-ADMIN PURP</td>
<td></td>
</tr>
<tr>
<td>Provider Narrative: OTHER GENERAL MEDICAL EXAMINATION FOR ADMINISTRATIVE PURPOSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary/Secondary Diagnosis: PRIMARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 CPT Code: 25066</td>
<td>BIOPSY FOREARM SOFT TISSUES</td>
<td></td>
</tr>
<tr>
<td>CPT Modifier: 22</td>
<td>UNUSUAL PROCEDURAL SERVICES</td>
<td></td>
</tr>
<tr>
<td>5 Education Topic: VA TOBACCO USE SCREENING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Select Action:** Quit// PE Patient Ed

4. The edited screen is then displayed.
3.15. How to Add or Edit a Skin Test

When you choose Skin Test under Update Encounter, you will also be prompted to enter Placement Date and Time, Ordering Provider, Administered By, Anatomic Location, Placement Comments, Reading Date and Time, Reader, Reading in Millimeters, Results, Reading Comments and, if the supervisor option is used, Diagnosis.

If the diagnoses have not already appeared in the encounter, the user will be prompted for additional information to qualify the diagnosis such as modifiers, comments, and SC/EI classifications.

Steps to add a Skin Test:

1. Select UE from the PCE Appointment List screen.
2. Select ST from the PCE Update Encounter screen.

--- Skin Test ---

1 CANDIDA
Enter 1-1 to Edit, or 'A' to Add: A [ENTER]

Patient's Service Connection and Rated Disabilities:

SC Percent: 100%
Rated Disabilities: TRAUMATIC ARTHRITIS (10%-SC)
DIABETES MELLITUS (0%-SC)

Skin Test: PPD [ENTER]
Placement Date and Time: 9 17@8:20A [ENTER] (SEP 17, 2004@08:20:00)
Ordering Provider: PCEprovider,one [ENTER] ST.PETE (PHYSICIAN) OP 099A
Administered By: PCEprovider,Ten [ENTER] TP PROVIDER
Anatomic Location: LA [ENTER] LEFT UPPER ARM
Placement Comments: Pre-op testing [ENTER]
Reading Date and Time: 9 19@9A [ENTER] (SEP 19, 2004@09:00:00)
Reader: PCEprovider,Ten [ENTER] TP PROVIDER
3.16. How to Add or Edit an Exam

When you choose Exam under Update Encounter, you will also be prompted to enter the Topic, Level of Understanding, and Encounter Provider.

Note: A Clinical Coordinator can change the items or categories available to choose from for Exams through the PCE Table Maintenance Menu. To help define the Exam list, check with your Coordinator.

Steps to add an Exam:

1. Select UE, from the PCE Appointment List screen.
2. Select XA from the PCE Update Encounter screen.

--- Classification --- [Required]

Was treatment for SC Condition? YES// [ENTER]
Was treatment related to Combat? YES// [ENTER]
Was treatment related to Agent Orange Exposure? NO// [ENTER]
Was treatment related to Ionizing Radiation Exposure? NO// [ENTER]
Was treatment related to SW Asia Conditions? NO// [ENTER]
Was treatment related to Military Sexual Trauma? NO// [ENTER]
Was treatment related to Head and/or Neck Cancer? YES// [ENTER]

Diagnosis 2:
3. Respond to the following prompts for Exams, as appropriate.

   Exam:  GENERAL EXAM
   Results:  ?
   Choose from:
   A  ABNORMAL
   N  NORMAL
   Results:  NORMAL

   Encounter Provider:  PCEPROVIDER,TEN//[ENTER]  PCEPROVIDER,TEN          TP
   Comments:  [ENTER]
   Exam:  [ENTER]

4. The edited screen is then displayed.

### 3.17. How to Add or Edit Health Factors

When you choose Health Factors under Update Encounter, you will also be prompted to enter the Level/Severity and comments.

Note: A Clinical Coordinator can change the items to choose from for Health Factors through the PCE Table Maintenance Menu. If you wish to help define the Health Factor list, check with your Coordinator.

Steps to add a Health Factor:

1. Select UE from the PCE Appointment List screen.
2. Select HF from the PCE Update Encounter screen.
3. Respond to the following prompts for the Health Factor, as appropriate.

Health Factor: current smoker
Level/Severity: ?
Choose from:
M MINIMAL
MO MODERATE
H HEAVY/SEVERE
Level/Severity: HEAVY/SEVERE
Comments: Trying to quit
Health Factor: [ENTER]

4. The edited screen is then displayed.

3.18. How to Add or Edit the Checkout Interview

The "Checkout Interview" which is done for all outpatients through the Scheduling package, can now also be done through PCE. You are prompted to enter Provider (and to designate if Primary Provider), Service-connection status, CPT codes, Diagnosis, etc. You may also designate if the Diagnosis should be added to the patient's Problem List.

REMEMBER: Entering one or two question marks will provide help (including lists of acceptable CPT codes, Diagnoses) on how to respond to prompts. With functionality put in place by the Code Set Versioning project, only ICD and CPT Codes that are active for the encounter date and time will be available.

Steps to add a Checkout Interview:

1. Select Checkout Interview from the Encounter or Appointment List screen or from the Update Encounter screen.
2. Confirm or edit the checkout date and service-connection status.

--- Classification --- [Required]

Was treatment for SC Condition? YES// [ENTER]

3. Enter the provider associated with the procedure performed during this encounter. (You can enter more than one provider and more than one procedure for each provider.)

PAT/APPT/CLINIC: PCEPATIENT,ONE JUL 22, 1996@11:08:14 CARDIOLOGY
No. PROVIDER

No PROVIDERS for this Encounter.

Enter PROVIDER: PCEPROVIDER,ONE
Is this the PRIMARY provider for this ENCOUNTER? YES// [ENTER]

PAT/APPT/CLINIC: PCEPATIENT,ONE JUL 22, 1996@11:08:14 CARDIOLOGY PROVIDER: ...There is 1 PROVIDER associated with this encounter.
Previous Entry: PCEPROVIDER,ONE

No. PROVIDER
1  PCEPROVIDER,ONE* PRIMARY

Enter PROVIDER: [ENTER]

4. Enter the ICD code or Diagnosis and whether you want it added to the Problem List.

PAT/APPT/CLINIC: PCEPATIENT,ONE JUL 22, 1996@11:08:14 CARDIOLOGY ICD CODE: V70.3 --MED EXAM NEC-ADMIN PURP PRIMARY

No DIAGNOSIS for this Encounter.

Enter Diagnosis: V70.3--MED EXAM NEC-ADMIN PURP

ONE primary diagnosis must be established for each encounter!
Is this the PRIMARY DIAGNOSIS for this ENCOUNTER? YES// [ENTER]

PAT/APPT/CLINIC: PCEPATIENT,ONE JUL 22, 1996@11:08:14 CARDIOLOGY ICD CODE: ...There is 1 PROVIDER associated with this encounter.
Previous Entry: V70.3

No. ICD DESCRIPTION PROBLEM LIST
1  V70.3* MED EXAM NEC-ADMIN PURP PRIMARY

Enter NEXT Diagnosis: 210

PAT/APPT/CLINIC: PCEPATIENT,ONE JUL 22, 1996@11:08:14 CARDIOLOGY ICD CODE: ...There is 1 PROVIDER associated with this encounter.
Previous Entry: V70.3

ITEM CODE DESCRIPTION 10 MATCHES
1  210.0 BENIGN NEOPLASM OF LIP
2  210.1 BENIGN NEOPLASM OF TONGUE
3  210.2 BENIGN NEOPLASM OF MAJOR SALIVARY GLANDS
5. **Enter the Procedure (CPT code or procedure name).**

   You can enter the CPT code or CPT Category or description. A "*" next to a procedure indicates that it was either added or edited during this session. You can also remove an existing CPT code for this encounter by entering 0 or @.

6. **Enter the modifiers and the number of times the procedure was administered.**
Enter NEXT PROCEDURE (CPT CODE): [ENTER]

7. The Update Encounter screen is then redisplayed with the Checkout Interview information.

3.19. Adding or Editing Directions to Patient’s Home

The Directions to Patient’s Home Add/Edit option lets you enter directions to a patient's home, which can then be displayed on a Health Summary. This feature is especially useful for Hospital-Based Home Care staff.

Steps to add directions to patient's home:

1. Choose HOME from the main PCE menu.
2. Select a patient name.
3. If no directions have already been entered, type in free text at the prompt.

Note: The screen editor you use in all your work will determine how you enter text.

Select PCE Coordinator Menu Option: home Directions to Patient’s Home Add/Edit

Select PATIENT NAME: PCEPATIENT

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date</th>
<th>Social Security Number</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCEPATIENT,ONE</td>
<td>06-04-08</td>
<td>000456789</td>
<td>NON-VETERAN (OTHER)</td>
</tr>
<tr>
<td>PCEPATIENT,TWO</td>
<td>02-16-33</td>
<td>666000000</td>
<td>NSC VETERAN</td>
</tr>
</tbody>
</table>

CHOOSE 1-2: 1 PCEPATIENT,ONE 06-04-08 000456789 NON-VETERAN (OTHER)

LOCATION OF HOME:
1>On the dock.
2>

EDIT Option:[ENTER]

Select PATIENT NAME:[ENTER]
4. To edit directions that were previously entered, select the edit option and proceed to edit according to the screen editor process you normally use.

Select PCE Coordinator Menu Option: home Directions to Patient's Home Add/Edit
Select PATIENT NAME: PCEPATIENT,EIGHT  PCEPATIENT,EIGHT  09-12-44  666777888
SC VETERAN
LOCATION OF HOME: . . .
6> WIER STREET. TURN LEFT ON WEIR STREET AND GO TO END.
7> TO THE LEFT OF THE DEADEND IS A DIRT PATH.
8> FOLLOW THIS PATH 1/4 MILES UNTIL YOU REACH A WHITE HOUSE.
EDIT Option: 8
REPLACE: WHITE WITH: GREEN REPLACE: [ENTER]
EDIT Option: [ENTER]
Select PATIENT NAME: [ENTER]

3.20. Key Concepts

- Clinicians can add individual types of data (immunizations, patient education) through the PCE user interface.
- Clerks can add encounter form data that was incorrectly scanned or was missing.
- The equals sign (=) can be used as a shortcut when selecting an action plus encounters or appointments from a list (e.g., Select Action: ED=2).
- Information added to PCE can be viewed on the Health Summary or on PCE Clinical Reports.
- Information added to PCE can be used to generate clinical reminders that will appear on a patient's Health Summary.
- Each site can modify the choices available in PCE files for health factors, patient education, etc.
- You can enter encounter information for an inexact time in the past or from another site through Make Historical Enc.
- Information entered through the Checkout Interview goes into the Scheduling package. The Checkout Interview information can also be entered directly through the Scheduling package. The dialogues, screens and resulting data are identical between the two packages.

4.0 PCE and Health Summary

Information such as Patient Education, Health Factors, and Immunizations, as well as clinical reminders about when these things are due, can be displayed on Health Summaries. Health Summary has special components designed to include these elements. See PCE Clinical Reports in this manual for setting up Clinical Reminders to appear on Health Summaries. An example of Health Summary with PCE components appears below.
4.1. PCE Clinical Reports

The PCE Clinical Reports options provide clinicians and managers with summary data about their patients, workload activity, and encounter counts. The reports extract data from various files in VISTA, including laboratory, pharmacy, and PIMS.
to create output reports which have been requested by physicians throughout the VA.

Clinical Reports Menu:

<table>
<thead>
<tr>
<th>Code</th>
<th>Report Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>Patient Activity by Clinic</td>
</tr>
<tr>
<td>CP</td>
<td>Caseload Profile by Clinic</td>
</tr>
<tr>
<td>WL</td>
<td>Workload by Clinic</td>
</tr>
<tr>
<td>DX</td>
<td>Diagnosis Ranked by Frequency</td>
</tr>
<tr>
<td>LE</td>
<td>Location Encounter Counts</td>
</tr>
<tr>
<td>PE</td>
<td>Provider Encounter Counts</td>
</tr>
</tbody>
</table>

The Caseload Profile by Clinic and Patient Activity by Clinic reports track Critical Lab Values and Emergency Room Visits (among other things). The PCE Report Parameter Edit option on the PCE HS/RPT Parameter menu allows your site to specify which clinics in the Hospital Location file (#44) represent "Emergency Room" clinics and what tests from the Laboratory Test file (#60) should be used for looking up patient data for Glucose, Cholesterol, LDL Cholesterol and HBA1C lab results. (This is necessary since the Laboratory Test File is not standardized and each site may have customized it differently.)

Note: If month or day are not known, historical encounters will appear on encounter screens or reports with zeroes for the missing dates; for example, 01/00/95 or 00/00/94.

4.2.  Caseload Profile by Clinic

This report generates a profile of the patients in a clinic's caseload for a selected date range. One or more clinics or a stop code may be selected to represent the caseload. If stop code is selected, a report is generated for each clinic within that stop code. The percentage and overall mean are calculated based on the patient data for all of the clinics selected. Where only one clinic is selected, these values are not applicable.

Note: There must be at least one PCE encounter within the selected date range for this report, even though there may be lab, radiology, and outpatient pharmacy occasions of service with the other timeframes (6 & 12 months).

This report combines PCE encounter, Lab, Radiology, Outpatient Pharmacy, and Admissions data. It provides a profile of the patients making up a clinic's caseload, over a representative period of time. Clinical staff will decide the appropriate date range. Report areas are demographics of clinic caseload, preventive medicine, quality of care markers, and utilization. Patient age, diagnosis, gender, Lab assay, RX, and procedure are all used to generate the patient profile.

Select PCE Clinical Reports Option: CP  Caseload Profile by Clinic

Caseload Profile by Clinic

The overall mean values for this report will be for the clinic(s) selected which had encounters during the selected date range.

Select clinic(s) by (H)OSPITAL LOCATION or CLINIC (S)TOP CODE: S CLINIC STOP CODE
Select the CLINIC STOP code: DIABETES

Enter ENCOUNTER BEGINNING DATE: T-30  (JUN 29, 1996)
Enter ENCOUNTER ENDING DATE: Jul 29, 1996/ [ENTER]  (JUL 29, 1996)

DEVICE: HOME/ VAX  RIGHT MARGIN: 80/ [ENTER]

Caseload Profile by Clinic

Clinic: DIABETES CLINIC
Compared to the mean of: DIABETES Clinic Stop
for 1 of 1 clinics with data

CASELOAD DEMOGRAPHICS for Encounter date range Jun 29, 1996 to Jul 29, 1996

<table>
<thead>
<tr>
<th>Clinic</th>
<th>#</th>
<th>%</th>
<th>Mean %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patient encounters</td>
<td>40</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Number of clinic sessions</td>
<td>17</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Number of patients per clinic session</td>
<td>2.4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Median patient age in years</td>
<td>46</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patients with: Coronary Artery Disease</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Diabetes and Hypertension</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

PREVENTIVE MEDICINE (12 mos. prior to Jul 29, 1996)

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who smoke.</td>
<td>0</td>
</tr>
<tr>
<td>Females &gt;50 who had a mammogram in the last year</td>
<td>0</td>
</tr>
</tbody>
</table>
(There were 1 females >50 years of age).

QUALITY OF CARE MARKERS (6 mos. prior to Jul 29, 1996)

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average HBA1C of your patients with Diabetes</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients with HBA1C&gt; 7%</td>
<td>0</td>
</tr>
<tr>
<td>Patients w/ Coronary Artery Disease who smoke</td>
<td>0</td>
</tr>
<tr>
<td>Ave. LDL for patients with Coronary Artery Disease</td>
<td>N/A</td>
</tr>
<tr>
<td>(0 of 0 pats. with CAD had no LDL results.)</td>
<td></td>
</tr>
<tr>
<td>Number of patients with: Glucose &gt;240</td>
<td>0</td>
</tr>
<tr>
<td>Cholesterol &gt;200</td>
<td>0</td>
</tr>
<tr>
<td>Either a Systolic bp &gt;160 Diastolic bp &gt; 900.0</td>
<td></td>
</tr>
<tr>
<td>Unscheduled encounters per patient.</td>
<td>0.0</td>
</tr>
<tr>
<td>Emergency Room encounters per patient.</td>
<td>0.0</td>
</tr>
<tr>
<td>Hospitalizations per patient.</td>
<td>0.2</td>
</tr>
</tbody>
</table>

UTILIZATION DATA (12 months prior to Jul 29, 1996)

<table>
<thead>
<tr>
<th>Number</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of male patients</td>
<td>9</td>
</tr>
<tr>
<td>Number of female patients</td>
<td>4</td>
</tr>
<tr>
<td>Average number of encounters per patient</td>
<td>6.8</td>
</tr>
<tr>
<td>Average number of active output. medications per patient</td>
<td>0.0</td>
</tr>
<tr>
<td>Average pharmacy cost per patient</td>
<td>5</td>
</tr>
</tbody>
</table>

Press RETURN to continue...[ENTER]
4.3. Workload by Clinic

This report provides a summary of clinic workload based on the evaluation and management codes associated with encounters occurring within a selected date range. The report will have the most complete information if it is run for a date range where clinic activities have been documented online. The representative period of time for the selected date range may be determined by clinical staff.

This report may be run for one or more clinics or for a stop code. Individual clinic totals are presented as line items on a 132 column report. For each clinic, the number of encounters reported is based on the following Patient Care Encounter (PCE) data:

- A breakdown of Evaluation and Management Codes (CPT Codes): Scheduled New Patients, Scheduled Established Patients, and Consult Patients.
- Procedures exist (CPT codes) for the encounter, which do not include Evaluation and Management code procedures.
- No Procedures (CPT codes) exist for the encounter.
- Total outpatient encounters documented in PCE.
- Scheduling encounter data:
  - No Show encounters
  - Cancelled encounters
  - Walk-In encounters
  - Total outpatient encounters documented in Scheduling
  - Overbooks and Inpatient clinic appointments

Select PCE Clinical Reports Option: W
This report requires a 132-COLUMN PRINTER.
DO YOU WISH TO CONTINUE? (Y/N)? YES// [ENTER]

Workload by Clinic

Select hospital(s) by (H)OSPITAL LOCATION or CLINIC (S)TOP CODE: HOSPITAL LOCATION

Select HOSPITAL LOCATION name: CARDIOLOGY PCEPROVIDER,ONE
Another HOSPITAL LOCATION name: DIABETES CLINIC PCEPROVIDER,ONE
Another HOSPITAL LOCATION name: [ENTER]

Enter ENCOUNTER BEGINNING DATE: T-30 (JUN 29, 1996)
DEVICE: HOME// [ENTER] VAX RIGHT MARGIN: 80// [ENTER]

Note: This report is in 132-column format.

11:30
Workload by Clinic

Encounter Date Range: Jun 29, 1996 through Jul 29, 1996
### Scheduling Data

<table>
<thead>
<tr>
<th>Scheduling Data</th>
<th>E&amp;M Patient Categories</th>
<th>Non-No</th>
<th>Total</th>
<th>Walk-Ins</th>
</tr>
</thead>
</table>

#### E&M Patient Categories

<table>
<thead>
<tr>
<th>Clinic Name</th>
<th>New</th>
<th>Established</th>
<th>Consult</th>
<th>Other</th>
<th>E&amp;M CPT Enctrs</th>
<th>APPTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>38</td>
<td>18</td>
</tr>
<tr>
<td>Diabetes Clinic</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>21</td>
</tr>
</tbody>
</table>

---

**Total Number of Clinic(s):** 2

**Average Number of PCE Encounters Per Clinic:** 50.5

This report presents a distribution of Clinic Encounters based on CPT procedures associated with encounters. CPT Evaluation and Management (E&M) procedures are categorized to provide encounters by patient type, with non E&M and no CPT procedures making up the remaining encounters.

### 4.4. Diagnoses Ranked by Frequency

This report lists the most frequent diagnostic codes (ICD) and the most frequent diagnostic categories that were entered for PCE outpatient encounters in your facility. These are presented in inverted frequency sequence (most frequent on top).

You can modify this report to show very selective views by choosing the elements to be included. These selection criteria include:

- The maximum number of diagnosis entries to be displayed (e.g., top 50). If this is blank, then all of the diagnoses satisfying the selection criteria will be ranked.
- Primary diagnosis or all diagnoses related to outpatient encounters.
- A date range when the PCE outpatient encounters occurred.
- Service Category (A-Ambulatory, H-Hospitalization, I-In Hospital, T-Telecommunications, E-Event (Historical), D-Daily Hospitalization Data, X-Ancillary Package Daily Data)
- Clinic Stop Code
- Provider
- Age of Patient
- Sex of Patient
This report will include all VA clinic encounters for all patients unless you modify the criteria. Do you want to modify the criteria?
Enter Y (YES) or N (NO) N/ y YES

Encounters may be selected by any combination of the following attributes:
1 Service Category
2 Clinic Stop Code
3 Provider
4 Age of Patient
5 Sex of Patient
6 All Encounters

Enter encounter selection attribute number(s) : (1-6): 1,2

Select SERVICE CATEGORIES: AI// AHIT
Select CLINIC STOP: CARDIOLOGY
Select another CLINIC STOP: DIABETES
Select another CLINIC STOP: [ENTER]

Enter the maximum NUMBER OF DIAGNOSES to display in the report: 10// [ENTER]

PCE Diagnosis Ranked by Frequency

10 Most Frequent ICD9 Diagnoses:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>100.0</td>
<td>LEPTOSPIROS ICTEROHEM</td>
<td>6</td>
</tr>
<tr>
<td>401.1</td>
<td>BENIGN HYPERTENSION</td>
<td>6</td>
</tr>
<tr>
<td>100.81</td>
<td>LEPTOSPIRAL MENINGITIS</td>
<td>3</td>
</tr>
<tr>
<td>342.01</td>
<td>FLAC HEMIPLEG &amp; HEMIPAR, DOM.</td>
<td>2</td>
</tr>
<tr>
<td>501.</td>
<td>ASBESTOSIS</td>
<td>2</td>
</tr>
<tr>
<td>142.0</td>
<td>MALIG NEO PAROTID</td>
<td>2</td>
</tr>
<tr>
<td>429.3</td>
<td>CARDIOMEGALY</td>
<td>2</td>
</tr>
<tr>
<td>100.89</td>
<td>LEPTOSPIRAL INFECT NEC</td>
<td>2</td>
</tr>
<tr>
<td>701.0</td>
<td>CIRCUMSCRIBE SCLERODERMA</td>
<td>1</td>
</tr>
<tr>
<td>500.</td>
<td>COAL WORKERS' PNEUMOCON</td>
<td>1</td>
</tr>
</tbody>
</table>

10 Most Frequent ICD9 Diagnostic Categories:

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>---------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>CIRCULATORY SYSTEM</td>
<td>10</td>
</tr>
<tr>
<td>INFECTIOUS &amp; PARASITIC</td>
<td>8</td>
</tr>
<tr>
<td>NERVOUS SYSTEM</td>
<td>8</td>
</tr>
<tr>
<td>MENTAL DISEASE &amp; DISORDERS</td>
<td>4</td>
</tr>
<tr>
<td>SKIN, BREAST, SUBCUTANEOUS T</td>
<td>3</td>
</tr>
<tr>
<td>RESPIRATORY SYSTEM</td>
<td>3</td>
</tr>
</tbody>
</table>
Facility: SALT LAKE CITY  660
Clinic Stop: DIABETES (146)

Total number of Encounters meeting the selection criteria:  26
Total number of Diagnoses for these Encounters:        17
Diagnoses/Encounter ratio: 0.65

PCE Diagnosis Ranked by Frequency

10 Most Frequent ICD9 Diagnoses:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 100.0</td>
<td>LEPTOSPIROS ICTEROHEM</td>
<td>2</td>
</tr>
<tr>
<td>2. 401.1</td>
<td>BENIGN HYPERTENSION</td>
<td>2</td>
</tr>
<tr>
<td>3. 309.81</td>
<td>PROLONG POSTTRAUM STRESS</td>
<td>2</td>
</tr>
<tr>
<td>4. 250.01</td>
<td>DIABETES MELLI W/0 COMP TYP I</td>
<td>2</td>
</tr>
<tr>
<td>5. 123.2</td>
<td>TAENIA SAGINATA INFECT</td>
<td>2</td>
</tr>
<tr>
<td>6. 342.01</td>
<td>FLAC HEMIPLEG &amp; HEMIPAR, DOM.</td>
<td>1</td>
</tr>
<tr>
<td>7. 345.01</td>
<td>GEN NONCNV EP W INTR EP</td>
<td>1</td>
</tr>
<tr>
<td>8. 367.0</td>
<td>HYPERMETROPIA</td>
<td>1</td>
</tr>
<tr>
<td>9. 398.99</td>
<td>RHEUMATIC HEART DIS NEC</td>
<td>1</td>
</tr>
<tr>
<td>10. 371.53</td>
<td>GRANULAR CORNEA DYSRPHY</td>
<td>1</td>
</tr>
</tbody>
</table>

10 Most Frequent ICD9 Diagnostic Categories:

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CIRCULATORY SYSTEM</td>
<td>3</td>
</tr>
<tr>
<td>2. EYE</td>
<td>3</td>
</tr>
<tr>
<td>3. NERVOUS SYSTEM</td>
<td>3</td>
</tr>
<tr>
<td>4. MENTAL DISEASES &amp; DISORDERS</td>
<td>2</td>
</tr>
<tr>
<td>5. INFECTIOUS &amp; PARASITIC</td>
<td>2</td>
</tr>
<tr>
<td>6. ENDOCRINE,NUTRIT,METABOLIC</td>
<td>2</td>
</tr>
<tr>
<td>7. DIGESTIVE SYSTEM</td>
<td>2</td>
</tr>
</tbody>
</table>

The following selected Facilities had no encounters that met the selection criteria.
SALT LAKE DOM  6001

End of the report.

8 Most Frequent ICD10 Diagnoses:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Freq.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A00.0</td>
<td>Cholera due to Vibrio cholerae 01, biovar cholerae 3</td>
<td>2</td>
</tr>
<tr>
<td>E08.649</td>
<td>Diabetes due to underlying condition w hypoglycemia w/o coma</td>
<td>2</td>
</tr>
<tr>
<td>W54.0XXA</td>
<td>Bitten by dog, initial encounter</td>
<td>1</td>
</tr>
<tr>
<td>I11.0</td>
<td>Hypertensive heart disease with heart failure</td>
<td>1</td>
</tr>
<tr>
<td>I10.</td>
<td>Essential (primary) hypertension</td>
<td>1</td>
</tr>
<tr>
<td>H21.253</td>
<td>Iridochisis, bilateral</td>
<td>1</td>
</tr>
<tr>
<td>E11.319</td>
<td>Type 2 diabetes w unsp diabetic rtnop w/o macular edema</td>
<td>1</td>
</tr>
<tr>
<td>A01.00</td>
<td>Typhoid fever, unspecified</td>
<td></td>
</tr>
</tbody>
</table>
4.5. Location Encounter Counts

This report counts PCE outpatient encounters in a date range by location. The location selection can be based on facility, hospital location(s), or clinic stop(s). The report can be run for all hospital locations or clinic stops in a facility or selected hospital locations, or clinic stops.

Select PCE Clinical Reports Option: LE Location Encounter Counts

Select FACILITY: SALT LAKE CITY     UT     660
Select another FACILITY: [ENTER]
Select SERVICE CATEGORIES: AI/[ENTER]

Enter ENCOUNTER BEGINNING DATE:  T-150 (DEC 26, 1995)
Enter ENCOUNTER ENDING DATE: May 24, 1996// [ENTER] (MAY 24, 1996)

Select one of the following:
HA All Hospital Locations
HS Selected Hospital Locations
CA All Clinic Stops
CS Selected Clinic Stops

Determine encounter counts for: HA// HS Selected Hospital Locations

Select HOSPITAL LOCATION: CARDIOLOGY          PCEPROVIDER,ONE
Select another HOSPITAL LOCATION: DIABETES CLINIC     PCEPROVIDER,ONE
Select another HOSPITAL LOCATION: ENDOCRINOLOGY       PCEPROVIDER,TEN
Select another HOSPITAL LOCATION:[ENTER]

DEVICE: HOME// [ENTER] VAX     RIGHT MARGIN: 80/[ENTER]
4.6. Provider Encounter Counts

This report lists provider counts related to PCE outpatient encounters. The selection criteria include facility, service category, encounter provided, and date range.

Person Class selection is based on the PERSON CLASS file, used to support Ambulatory Care Reporting. Person Class entries are composed of three pieces:

- Occupation (required in class definition)
- Specialty (optional)
- Sub-specialty (optional)

Once the selection criteria are chosen, the user can request a detailed or a summary report. The detailed report gives totals by date and hospital location (clinic) for each provider. The summary report lists total encounters for each provider.

Select PCE Clinical Reports Option: PE Provider Encounter Counts

Select FACILITY: SALT LAKE CITY UT 660
Select another FACILITY: [ENTER]

Enter ENCOUNTER BEGINNING DATE: T-100 (FEB 14, 1996)
Enter ENCOUNTER ENDING DATE: May 24, 1996//[ENTER] (MAY 24, 1996)

Select SERVICE CATEGORIES: AI//[ENTER]

Select one of the following:

A All Providers
P Primary Providers
S Selected Providers
C Selected Provider Classes

Select ENCOUNTER PROVIDER CRITERIA: A// Selected Providers

Select PROVIDER: WIGGIE,MARIE
Select another PROVIDER: ADELA,TOM
Select another PROVIDER:[ENTER]

Select one of the following:

S Summary
D Detail by clinic and date

Which type of report: S// [ENTER] Summary

DEVICE: HOME// [ENTER] VAX RIGHT MARGIN: 80/[ENTER]
Sorting encounters done

PCE Provider Encounter Counts

Criteria for Provider Encounter Summary Report
Provider selection criteria: Selected Providers
Report date range: Feb 14, 1996 through May 24, 1996
Service categories: AI
A - AMBULATORY
I - IN HOSPITAL
4.7. **Selected Person Classes**

This Selected Person Classes option lets you compile a report of selected Person Classes based on occupation, specialty, and/or sub-specialty. A wild card (*) may be entered as a response for any of the Person Class pieces. For example, if you want a report on every provider from a specific specialty, occupation would be "*", specialty would be the specific specialty, and sub-specialty would be "*.

The currently selected OCCUPATION is: *

The currently selected SPECIALTY is: PHYSICAL THERAPIST

The currently selected SUBSPECIALTY is: *

Your Person Class Selection was:

OCCUPATION: *
SPECIALTY: Physical Therapist
SUBSPECIALTY: *

Is this selection correct? YES
4.8. Patient Activity by Location

This report may be set up for hospital location or stop code. The report format is a summary of all selected locations. For each location, scheduling data is used to identify patients whose appointments were either scheduled, unscheduled, cancelled, or are no-shows during the patient appointment date range. VISTA data for these patients is then examined for possible patient activities for admissions/discharges, emergency room encounters, and critical lab values during the patient activity date range. If any of these activities has occurred, data specific to the activity is reported along with the patient's address, phone, and future appointments that fall in the future appointment date range.

This report was developed as a measure of continuity of care. If a provider of record has his or her care-giving interrupted through clinical rotation, leave,
reassignment, or for any other reason, this report may be used to get an update on patient activities in his/her caseload.

This report is also useful when care is not interrupted. Clinical staff may wish to review patient activity by clinic for events, which they might be unaware of.

Patient activities that are included in this report are:

4.8.1. Admission/Discharge Activities

All admissions and discharges within the selected date range are reported. If corresponding discharges exist for admissions, the discharges are shown, and vice versa; corresponding admissions are shown for discharges.

4.8.2. Emergency Room Clinic Activities

All Emergency Room stops within the selected date range are reported. Emergency Room visit date and time are displayed for all encounters with an identified Emergency Room stop. Emergency rooms are identified through the PCE PARAMETERS file. This data is entered by the clinical coordinator or IRM staff through the PCE Report Parameter Setup option.

4.8.3. Critical Lab Values

All critical lab values reported within the selected date range are presented, along with a column to identify whether the value is critically high or critically low.

Select PCE Clinical Reports Option: Patient Activity Report

Select FACILITY: SALT LAKE CITY SALT LAKE CITY UT 660
Select another FACILITY: <Enter>

Select one of the following:
HA All Hospital Locations (with encounters)
HS Selected Hospital Locations
CA All Clinic Stops (with encounters)
CS Selected Clinic Stops

Determine patient activity for: HS// HA All Hospital Locations (with encounters)

Want to start each location on a new page: Y// NO

Enter PATIENT APPOINTMENT BEGINNING DATE: 9/1/96 (SEP 01, 1996)
Enter PATIENT APPOINTMENT ENDING DATE: 9/30/96 (SEP 30, 1996)

Enter PATIENT ACTIVITY BEGINNING DATE: 9/1/96 (SEP 01, 1996)
Enter PATIENT ACTIVITY ENDING DATE: Apr 29, 1997// 9/30/96 (SEP 30, 1996)

Enter FUTURE APPOINTMENT BEGINNING DATE: Apr 29, 1997// <Enter> (APR 29, 1997)
Enter FUTURE APPOINTMENT ENDING DATE: 12/30/97 (DEC 30, 1997)

DEVICE: HOME// <Enter> ANYWHERE RIGHT MARGIN: 80// <Enter>
Criteria for Patient Activity Report

Location selection criteria: All Hospital Locations (with encounters)
Patient appointment date range: Sep 01, 1996 through Sep 30, 1996
Patient activity date range: Sep 01, 1996 through Sep 30, 1996
Future appointment date range: Apr 29, 1997 through Dec 30, 1997

Facility: SALT LAKE CITY 660
Location: ADMITTING AND SCREENING

PCEPATIENT,ONE 000-45-6789
352 SW KENTWOOD RD SALT LAKE CITY UTAH 33452
Appointment criteria met:
9/30/96 14:30 ADMITTING AND SCREENING SCHEDULED VISIT
Inpatient Stays
7/31/89 - present 4 WEST LOS: 2829
Last Tr. Specialty: PSYCHIATRY Last Prov:
Admitting Diagnosis: Disoriented

Facility: SALT LAKE CITY 660
Location: ADMITTING AND SCREENING

PCEPATIENT,TEN 666-45-6789 412 555-5555
555 ENDLESS ST. PITTSBURGH PENNSYLVANIA 15206
Appointment criteria met:
9/23/96 09:00 ADMITTING AND SCREENING SCHEDULED VISIT
Emergency Room Visits
9/25/96 11:30 DIABETES CLINIC

Facility: SALT LAKE CITY 660
Location: ADMITTING AND SCREENING

PCEPATIENT,THREE 000-00-6788
22 3RD AVENUE SALT LAKE CITY UTAH 84112
Appointment criteria met:
9/2/96 09:00 ADMITTING AND SCREENING SCHEDULED VISIT
Critical Lab Values
9/30/96 GLUCOSE 500 mg/dl
9/30/96 UREA NITROGEN 500 mg/dL

Facility: SALT LAKE CITY 660
Location: CARDIOLOGY

PCEPATIENT,FOUR 666-99-2222
2237 E 1894 S Salt Lake City UTAH 84105
Appointment criteria met:
9/30/96 10:00 CARDIOLOGY SCHEDULED VISIT
Emergency Room Visits
9/30/96 09:00 CARDIOLOGY CLINIC

Enter RETURN to continue or ‘‘’’ to exit:

Facility: SALT LAKE CITY 660
Location: DIABETES CLINIC

PCEPATIENT,SEVEN 000-88-9989
470 RANDOLPH ROAD SALT LAKE CITY UTAH 33595
Appointment criteria met:
9/24/96 09:00 DIABETES CLINIC SCHEDULED VISIT
4.9. **Key Concepts**

- You can produce reports for Caseload Profile by Clinic, Workload by Clinic, Frequency of Diagnoses, Location Encounter Counts, Provider Encounter Counts, and Patient Activity by Clinic.
- All reports can be customized to show only specified date ranges, clinics, providers, types of encounters (cancelled, walk-ins, etc.), etc.
- The reports extract data from various files in VISTA, including laboratory, pharmacy, and PIMS to create output reports which have been requested by physicians throughout the VA.
- Patient Activity by Caseload provides a measure of continuity of care. If a provider of record has his or her care-giving interrupted through clinical rotation, leave, reassignment, or for any other reason, this report may be used to get an update on patient activities in his/her caseload.
- Workload by Clinic provides a summary of clinic workload based on the evaluation and management codes associated with encounters.

5.0 **Managing PCE**

IRM staff and Clinical Coordinators manage PCE by assigning menus, setting site parameters, defining clinical reminders, setting up clinical reports, and modifying local tables containing patient education, health factors, and other items through the Table Maintenance options.

5.1. **PCE Menus and Options**

The following menus and options are exported with PCE:

PCE IRM Main Menu:

```
SF    PCE Site Parameters Menu ...
TBL   PCE Table Maintenance ...
INFO  PCE Information Only ...
RM    PCE Reminder Maintenance Menu ...
CR    PCE Clinical Reports ...
```
- Assign the IRM Main Menu or at least the first four options/menus to IRM staff or coordinators who will be responsible for setting up PCE, maintaining the entries in the PCE tables (such as Patient Education, Treatments, etc.), and defining the clinical reminders/maintenance system for your site.

- Assign the PCE Coordinator Menu to the Application Coordinator who will use all of the PCE options.

- Assign the PCE Clinician Menu to clinicians who will be entering or editing data, who will use clinical reports, who need the PCE Information Only menu to see the basis for reminders, and who might add or edit directions to a patient's home for appearance on a health summary.

- Assign Directions to Patient's Home Add/Edit to anyone who needs to enter directions to a patient's home. This is especially useful for Hospital-Based Home Care staff (directions can be viewed on Health Summaries).

### 5.2. PCE Coordinator Menu

The PCE Coordinator Menu includes all of the user interface options as well as the options for file maintenance.

<table>
<thead>
<tr>
<th>SUP</th>
<th>PCE Encounter Data Entry - Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCE</td>
<td>PCE Encounter Data Entry</td>
</tr>
<tr>
<td>DEL</td>
<td>PCE Encounter Data Entry and Delete</td>
</tr>
<tr>
<td>NOD</td>
<td>PCE Encounter Data Entry without Delete</td>
</tr>
<tr>
<td>TBL</td>
<td>PCE Table Maintenance ...</td>
</tr>
<tr>
<td>INFO</td>
<td>PCE Information Only ...</td>
</tr>
<tr>
<td>ACT</td>
<td>Activate/Inactivate Table Items ...</td>
</tr>
<tr>
<td>CED</td>
<td>Education Topic Copy</td>
</tr>
<tr>
<td>DEWO</td>
<td>PCE Delete Encounters W/O Visit</td>
</tr>
<tr>
<td>ED</td>
<td>Education Topic Add/Edit</td>
</tr>
<tr>
<td>EX</td>
<td>Examinations Add/Edit</td>
</tr>
<tr>
<td>HF</td>
<td>Health Factors Add/Edit</td>
</tr>
<tr>
<td>IM</td>
<td>Immunizations Add/Edit</td>
</tr>
<tr>
<td>LOT</td>
<td>Immunization Lot Add/Edit/Display</td>
</tr>
<tr>
<td>SK</td>
<td>Skin Tests Add/Edit</td>
</tr>
<tr>
<td>TR</td>
<td>Treatments Add/Edit</td>
</tr>
<tr>
<td>INFO</td>
<td>PCE Information Only ...</td>
</tr>
<tr>
<td>EDA</td>
<td>Active Educ. Topic List - Detailed</td>
</tr>
<tr>
<td>EDL</td>
<td>Education Topic List</td>
</tr>
<tr>
<td>EDI</td>
<td>Education Topic Inquiry</td>
</tr>
<tr>
<td>EX</td>
<td>Exam List</td>
</tr>
<tr>
<td>HF</td>
<td>Health Factor List</td>
</tr>
<tr>
<td>IM</td>
<td>Immunization List</td>
</tr>
<tr>
<td>SK</td>
<td>Skin Test List</td>
</tr>
<tr>
<td>TR</td>
<td>Treatment List</td>
</tr>
<tr>
<td>REPT</td>
<td>PCE Clinical Reports ...</td>
</tr>
<tr>
<td>HOME</td>
<td>Directions to Patient's Home Add/Edit</td>
</tr>
<tr>
<td>FARM</td>
<td>PCE HS/RPT Parameter Menu ...</td>
</tr>
<tr>
<td>DLE</td>
<td>PCE Device Interface Error Report</td>
</tr>
</tbody>
</table>
Assign PCE Encounter Data Entry - Supervisor to users who can document a clinical encounter and can also delete any encounter entries, even though they are not the creator of the entries. This option also allows, contrary to all other PXCE Encounter Data Entry, users to display, and even modify ancillary encounters so it should be assigned with caution.

Assign PCE Encounter Data Entry to data entry staff who can document a clinical encounter and who can delete their own entries.

Assign PCE Encounter Date Entry and Delete to users who can document a clinical encounter and can also delete any encounter entries, even though they are not the creator of the entries.

Assign PCE Encounter Data Entry without Delete to users who can document a clinical encounter, but should not be able to delete any entries, including ones that they have created.

5.3. Key Concepts

- PCE menus and options are designed for two main types of users: 1) end users (clinicians and clerks) and 2) managers and coordinators.

- The end user options included data entry options and clinical reports.

- The manager and coordinator options include the maintenance menus and the site parameters set-up option.

5.4. PCE Site Parameters

The PCE Site Parameters Menu on the PCE IRM Main Menu contains the PCE HS/RPT Parameter menu, PCE Edit Disposition Clinics, and PCE Site Parameters Edit.

5.4.1. PCE Site Parameters Menu

<table>
<thead>
<tr>
<th>SITE</th>
<th>PCE Site Parameters Edit</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPT</td>
<td>PCE HS/RPT Parameter Menu ...</td>
</tr>
<tr>
<td>PRNT</td>
<td>PCE HS/RPT Parameters Print</td>
</tr>
<tr>
<td>HS</td>
<td>PCE HS Disclaimer Edit</td>
</tr>
<tr>
<td>RPT</td>
<td>PCE Report Parameter Edit</td>
</tr>
<tr>
<td>DISP</td>
<td>PCE Edit Disposition Clinics</td>
</tr>
</tbody>
</table>

5.4.2. Option Descriptions

PCE Site Parameters Edit

This option is used to edit entries in the PCE PARAMETERS file. The parameters that are set are used as the default controls for the user interface when it starts up. You can set your default view as Appointment or Encounter, and a range of dates.
PCE HS Disclaimer Edit
This option is used to specify a Site Reminder Disclaimer to be used by the Health Summary package whenever the Health Summary "Clinical Maintenance" and "Clinical Reminder" components are displayed in a Health Summary.

PCE HS/RPT Parameters Print
This option prints the current PCE Parameter definitions that are used by Health Summary and some of the PCE Reports.

PCE Report Parameter Edit
This option is used to define parameters that will be used by the PCE Report Module. The report edit option allows your site to specify which clinics in file 44 represent "Emergency Room" clinics, and what Lab tests from file 60 should be used for looking up patient data for Glucose, Cholesterol, LDL Cholesterol and HBA1C lab results. These fields are used by the reports Caseload Profile by Clinic, and Patient Activity by Clinic. To get a printout of current definitions in the PCE Parameters fields for these fields, use the PCE HS/RPT Parameters Print.

PCE Edit Disposition Clinics
This option is used to define which clinics are used as Administrative Disposition Clinics.

5.4.3. PCE HS/RPT Parameter Menu
The PCE HS/RPT Parameter menu contains print and edit options for PCE fields related to the Health Summary package and PCE Reports module.

Use the print option to see what the current definition is for these fields.

PCE exports a disclaimer to appear on Health Summaries: Default Reminder Disclaimer:

The following disease screening, immunization, and patient education recommendations are offered as guidelines to assist in your practice.

These are only recommendations, not practice standards. The appropriate utilization of these for your individual patients must be based on clinical judgment and the patient's current status.

If your site prefers to use a site-defined reminder disclaimer instead of the disclaimer distributed by PCE, use the HS Disclaimer Edit option to define your site's disclaimer text. This disclaimer will appear on the top of each display of Health Summary "Clinical Maintenance" and "Clinical Reminder" components.

Two PCE Clinical Reports—Caseload Profile by Clinic and Patient Activity by Clinic—track Critical Lab Values and Emergency Room Visits. The PCE Report Parameter Edit option allows your site to specify which clinics in Hospital Location file (#44) represent "Emergency Room" clinics and what tests from the Laboratory...
Test file (#60) should be used for looking up patient data for Glucose, Cholesterol, LDL Cholesterol and HBA1C lab results. (This is necessary since the Laboratory Test File is not standardized and each site may have customized it differently.)

5.4.4. PCE Site Parameters Edit Example

The parameters that are set through this option are used as the default controls for the user interface when it starts up.

```
SITE   PCE Site Parameters Edit
RPT    PCE HS/RPT Parameter Menu ...
```

Select PCE Site Parameter Menu Option: site  PCE Site Parameters Edit

Select PCE Site Parameters Edit Option: 1

```
SITE   PCE Site Parameters Edit
RPT    PCE HS/RPT Parameter Menu ...
```

Select PCE Site Parameter Menu Option: site  PCE Site Parameters Edit

Select PCE Site Parameters Edit Option: 1

```
STARTUP VIEW: APPOINTMENT// ??
This is the default list that PCE Encounter Data Entry starts in for all users.
Choose from:
V VISIT/ENCOUNTER
A APPOINTMENT
```

```
STARTUP VIEW: APPOINTMENT// v VISIT/ENCOUNTER
BEGINNING PATIENT DATE OFFSET: -30// [ENTER]
ENDING PATIENT DATE OFFSET: 2// [ENTER]
BEGINNING HOS LOC DATE OFFSET: -14// -30
ENDING HOS LOC DATE OFFSET: 2// [ENTER]
RETURN WARNINGS: YES// ?
Enter YES if you want the Device Interface to return warnings if there are no diagnoses or procedures passed.
Choose from:
0 NO
1 YES
```

```
RETURN WARNINGS: YES// [ENTER]
```

Select PCE Site Parameters Edit Option: [ENTER]

5.4.5. PCE Edit Disposition Clinics

This option is used to define which clinics are used as Administrative Disposition Clinics.

```
Select PCE Site Parameter Menu Option: PCE Edit Disposition Clinics
Select PCE Parameters ONE: 1
```

```
Select PCE Site Parameter Menu Option: PCE Edit Disposition Clinics
Select PCE PARAMETERS ONE: 1
Select DISPOSITION HOSPITAL LOCATIONS: 3A
Are you adding '3A' as a new DISPOSITION HOSPITAL LOCATIONS (the 1ST for this PCE PARAMETERS)? Y
```

Select PCE Parameters ONE: [ENTER]

5.4.6. Key Concepts

- Coordinators can set the parameters that are used as the default controls for the user interface when it starts up. You can set your default view as Appointment or Encounter, and also a range of dates.
Coordinators can specify which clinics in file 44 represent "Emergency Room" clinics, and what Lab tests from file 60 should be used for looking up patient data for Glucose, Cholesterol, LDL Cholesterol, and HBA1C lab results.

PCE exports a disclaimer to appear on Health Summaries, stating that clinicians may use their professional discretion as to how they respond to clinical reminders. Each site may create a site-defined reminder disclaimer, using the HS Disclaimer Edit option. This disclaimer will appear on the top of each display of Health Summary Clinical Maintenance and Clinical Reminder components.

6.0 Table Maintenance

The Table Maintenance options let sites add or edit the items in the tables for Health Factors, Patient Education, Skin Tests, etc.

6.1 PCE Table Maintenance Menu

| INFO | PCE Information Only ... |
| ACT  | Activate/Inactivate Table Items ... |
| CED  | Education Topic Copy |
| DEWO | PCE Delete Encounters W/O Visit |
| ED   | Education Topic Add/Edit |
| EX   | Examinations Add/Edit |
| HF   | Health Factors Add/Edit |
| IM   | Immunizations Add/Edit |
| LOT  | Immunization Lot Add/Edit/Display |
| SK   | Skin Tests Add/Edit |
| TR   | Treatments Add/Edit |

Once these tables have been defined, the table entries will be selectable for encounter data entry (directly into PCE) or for encounter form definitions (AICS package). The patient information collected can be viewed on Health Summaries.

Use the "Inactive Flag" field to make an entry "INACTIVE" for selection in the encounter form definition process and the PCE encounter data entry process. If entries are to be included on the clinic's encounter form, the entries must first be defined in the appropriate file using this option. Canning encounter forms with the AICS package will provide PCE with information stored in the V files.

These options may be used in conjunction with the "PCE Information Only" menu options to manage the contents of the files or tables supporting the Patient Care Encounter (PCE) package.
6.1.1. Option Descriptions

PCE Information Only
This is a menu of options that lists entries in the files/tables for patient education, immunizations, skin tests, health factors and treatments.

Activate/Inactivate Table Items
This option is the main menu option that allows you to activate or inactivate the entries in the supporting tables. (e.g., Education Topics, Health Factors, Treatments).

Education Topic Copy
This option allows the user to copy an existing education topic into a new education topic entry in the Education Topics file (#9999999.09). The original education topic to be copied is selected first. If the topic is prefixed with "VA-", the "VA-" will be stripped off the name automatically. The new name must be unique. If the name is not unique, the user must enter a unique name for the new education topic.

PCE Delete Encounters W/O Visit
This option provides a tool for IRM to correct Encounters that have missing Visits. The missing Visits can cause a problem where the Encounters cannot be checked out. Under this menu option, there are 4 sub options described in detail in the text of patch PX*1*153:
- BUILD will find the missing encounters based on date range entries
- REPORT will print the problem encounters per build
- FIX ALL will fix all the encounters that are indicated by the build
- FIX INDIVIDUAL will fix encounters for one patient

Education Topic Add/Edit
This option lets you create a new Education Topic or edit an Education Topic that was originally created at your site. Education topics distributed with the PCE package can be inactivated using the PCE "Activate/Inactivate Table Items" menu. Once an education topic is defined in this table, it should not be deleted if there are any encounter form definitions which are referencing the education topic, or if there is any patient encounter data which is referencing this education topic historically.

Examinations Add/Edit
This option allows you to create a new name to represent an examination type or edit an examination type that was originally created at your site. The examination types originally distributed by PCE are a breakdown of potential categories of exams within a Physical Exam. The exams distributed with the PCE package can be inactivated using the PCE "Activate/Inactivate Table Items" menu. Once exam names are defined in this table, they should not be deleted if there are any
encounter form definitions referencing the exam name, or if there is any patient encounter data which may be referencing this exam historically.

**Health Factors Add/Edit**

This option allows the user to create a new Health Factor or edit a Health Factor that was originally created at your site. Health factors that are distributed with the PCE package can be inactivated using the PCE "Activate/Inactivate Table Items" menu. Once a health factor is defined in this table, it should not be deleted if there are any encounter form definitions which may be using the term, or if there is any patient encounter data which may be referencing this term historically.

**Immunizations Add/Edit**

This option has been placed out of order. The IMMUNIZATION file will be maintained by the Master File Server.

**Immunization Lot Add/Edit/Display**

This option allows an authorized user to add or update an immunization lot and to display or print an Immunization Inventory Report.

**Skin Tests Add/Edit**

This option has been placed out of order. The SKIN TEST file will be maintained by the Master File Server.

**Treatments Add/Edit**

This option allows a user to create a new Treatment or edit a Treatment that was originally created at your site. Treatments that are distributed with the PCE package can be inactivated using the PCE "Activate/Inactivate Table Items" menu. Once a treatment is defined in this table, it should not be deleted if there are any encounter form definitions which may be referencing the treatment, or if there is any patient encounter data which may be referencing the treatment historically.

### 6.2. Editing the Education Topic File

| Select PCE Table Maintenance Option: PE  Education Topic Add/Edit |
|--------------------|-----------------|
| Select Patient Education Option: ? |
| A    Activate or Deactivate Topics |
| E    Edit ONLY Active Topics |

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

| Select Patient Education Option: E  Edit ONLY Active Topics |
|----------------|----------------|
| Select EDUCATION TOPICS NAME: SAMPLE 1 - LIFESTYLE ADAPTATIONS |
| NAME: SAMPLE 1 - LIFESTYLE ADAPTATIONS Replace |
| MNEMONIC: ?? Replace |
| answer must be 1-9 characters in length and must contain a "-" (ie VA-DIET). |
| MNEMONIC: VA-DI |
| INACTIVE: ? |
| Choose from: |
6.3. Key Concepts

- Coordinators add or edit the items in the tables for Health Factors, Patient Education, Skin Tests, etc.
- Entries in these tables can be selected when clinicians or clerks enter encounter data such as health factors or patient education.
- When coordinators or MCCR personnel create encounter forms through the AICS package, they can use entries from these tables as items to be checked off.
- The patient information collected based on these table definitions can be seen on Health Summaries.
- This menu also includes options to edit the Clinical Reminder/ Health Maintenance definitions, based on your site's clinical terminology in the tables. Once reminder criteria have been defined, they may be included in the Health Summary Type definitions for the "Clinical Reminder" and "Health Maintenance" Components.

6.4. Enter/Edit Immunization Lot file

Select PCE Table Maintenance Option: LOT [Enter] Immunization Lot Add/Edit/Display

IMMUNIZATION INVENTORY FUNCTIONS

1. Enter/Edit Immunization Lot
2. Display/Print Immunization Inventory Report

Enter a number: (1-2): 1 [Enter]

Enter/Edit Immunization Lot

Select IMMUNIZATION LOT LOT NUMBER: EE11337 [Enter] PFIZER, INC TD (ADULT) 11-30-2017 99 DOSES UNUSED

LOT NUMBER: EE11337// ** Already assigned and cannot be edited. **
MANUFACTURER: PFIZER, INC// [Enter]
VACCINE: TD (ADULT)// [Enter]
EXPIRATION DATE: NOV 30,2017// [Enter]
STATUS: ACTIVE// [Enter]
STARTING COUNT: 100// [Enter]
DOSES UNUSED: 99// [Enter]
6.5. **Key Concepts**

- User must hold the PXV IMM INVENTORY MGR security key to access this menu option.
- Only active immunization lots may be selected when documenting an immunization.
- Entries in the IMMUNIZATION LOT file (#9999999.41) must be unique, that is, the immunization name, lot number and manufacturer combination must be unique.
- An immunization lot that has been assigned to a patient’s immunization record may not be deleted from the IMMUNIZATION LOT file (#9999999.41).
- When an immunization lot number is assigned to a patient’s immunization record, the number in the DOSES UNUSED field is decremented.

6.6. **Display Immunization Inventory Report**

Select PCE Table Maintenance Option: LOT [Enter] Immunization Lot Add/Edit/Display

**IMMUNIZATION INVENTORY FUNCTIONS**

1. Enter/Edit Immunization Lot
2. Display/Print Immunization Inventory Report

Enter a number: (1-2): 2 [Enter]

**IMMUNIZATION INVENTORY REPORTS**

Display/Print Which of the Following?

1. All or Selected Active Inventory
2. Active Inventory With Zero Doses Available

Enter a number: (1-2): 1 [Enter]

Display Inventory Information for All Immunizations? YES// NO [Enter]

Display Inventory Information for which Immunization? ANTHRAX [Enter] 24
Select an Additional Immunization: RUBELLA [Enter] 06
Select an Additional Immunization: [Enter]

Display/Print on which Device: GENERIC PRINTER [Enter] Right Margin: 80 [Enter]

**SELECTED ACTIVE IMMUNIZATION INVENTORY**

DATE PRINTED: AUG 11, 2015
Select PCE Table Maintenance Option: LOT [Enter] Immunization Lot Add/Edit/Display

IMMUNIZATION INVENTORY FUNCTIONS

1. Enter/Edit Immunization Lot
2. Display/Print Immunization Inventory Report

Enter a number: (1-2): 2 [Enter]

IMMUNIZATION INVENTORY REPORTS

Display/Print Which of the Following?

1. All or Selected Active Inventory
2. Active Inventory With Zero Doses Available

Enter a number: (1-2): 2 [Enter]

Display/Print on which Device: GENERIC PRINTER [Enter] Right Margin: 80 [Enter]
7.0 PCE Information Only

This is a menu of options that lists entries in the files/tables for patient education, immunizations, skin tests, health factors, and treatments.

7.1. PCE Information Only Menu

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDA</td>
<td>Active Educ. Topic List – Detailed</td>
</tr>
<tr>
<td>EDL</td>
<td>Education Topic List</td>
</tr>
<tr>
<td>EDI</td>
<td>Education Topic Inquiry</td>
</tr>
<tr>
<td>EX</td>
<td>Exam List</td>
</tr>
<tr>
<td>HF</td>
<td>Health Factor List</td>
</tr>
<tr>
<td>IM</td>
<td>Immunization List</td>
</tr>
<tr>
<td>SK</td>
<td>Skin Test List</td>
</tr>
<tr>
<td>TR</td>
<td>Treatment List</td>
</tr>
<tr>
<td>CM</td>
<td>PCE Code Mapping List</td>
</tr>
</tbody>
</table>

These entries determine what clinical data will be collectable for these classes of clinical data.

PCE distributes immunizations and skin test table entries that also have a related CPT code. The relationship of an immunization or skin test to a CPT code is defined in the PCE Code Mapping file. The PCE Code Mapping file determines whether two entries should be made from one clinical data item entered. For example, if an immunization is entered into the V Immunization file, a CPT code is generated in the V CPT file for billing and workload. The mapping definition of the CPT relationship with the Immunization type is viewable from the PCE Code Mapping list option.

7.2. Option Descriptions

7.2.1. Active Educ. Topic List – Detailed

This lists the current detailed definition of the goals and standards defined for the active education topics.

7.2.2. Education Topic List

This option prints a brief list of ALL Education Topics using only two fields: Inactive Flag status and Topic Name.

7.2.3. Education Topic Inquiry

This option can be used to print the definition of a specific Education Topic definition.
7.2.4. Exam List
This option lists all of the exam names, with their Active Status, that are defined in the Exam file for use with PCE.

7.2.5. Health Factor List
This option lists the Health Factors by Category, with their Active Status, that have been defined in the Health Factor file for use with PCE.

7.2.6. Immunization List
This option lists all immunizations, with their Active Status, which have been defined in the Immunization file for use with PCE.

Note: To see what CPT codes may be related to the immunization entries, print the PCE Code Mapping List.

7.2.7. Skin Test List
This option lists all skin tests, with their Active Status, that have been defined in the Skin Test file for use with PCE.

7.2.8. Treatment List
This option lists all treatments, with their active status, that have been defined in the Treatment file for use with PCE.

7.2.9. PCE Code Mapping List
This option allows the user to see the mapping between CPT codes and a related entry in a PCE supporting file. For example, the CPT code 90732 is related to the Immunization file entry PNEUMOCCOCAL. PCE uses the code mapping relationships to populate multiple files from one data entry step. For example, an entry of PNEUMO-CCOCAL in the V Immunization file will also create a CPT entry, 90732 in the V CPT file which will then be passed to PIMS for use by IB, Workload, and DSS.

7.3. PCE Code Mapping List

<table>
<thead>
<tr>
<th>PCE CODE MAPPING LIST</th>
<th>MAY 24, 1996 13:15</th>
<th>PAGE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM FILE ENTRY</td>
<td>TO RELATED SUPPORTING FILE ENTRY</td>
<td>FLAG</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------</td>
<td>--------</td>
</tr>
<tr>
<td>CPT 86485</td>
<td>SK CANDIDA</td>
<td>ON</td>
</tr>
<tr>
<td>CPT 86490</td>
<td>SK COCCI</td>
<td>ON</td>
</tr>
<tr>
<td>CPT 86510</td>
<td>SK HISTOPLAS</td>
<td>ON</td>
</tr>
<tr>
<td>CPT 86580</td>
<td>SK PPD</td>
<td>ON</td>
</tr>
<tr>
<td>CPT 86585</td>
<td>SK TINE</td>
<td>ON</td>
</tr>
<tr>
<td>CPT 90700</td>
<td>IMM DIP-TET-a/PERT</td>
<td>ON</td>
</tr>
</tbody>
</table>
7.4. Key Concepts

- Options on the Information Only menu list clinical terminology used in the PCE files/tables to represent patient education, immunizations, skin tests, health factors and treatments.

- The terminology in these tables determines what clinical data will be collectable for these classes of clinical data.

- The PCE Code Mapping List shows the mapping between CPT codes and related entries in other PCE supporting files. For example, if an immunization is entered into the V Immunization file, a CPT code is generated in the V CPT file for billing and workload.

- Options on this menu display definitions of PCE Reminders which may be selected for the PCE Clinical Reminder and PCE Clinical Maintenance components.

8.0 Clinical Reminders

This section describes how you can use clinical reminders, along with related tools and technology, to help clinicians provide better patient care. It reviews the following:

- Relationships between PCE, encounter forms, health summaries, and clinical reminders

- Encounters and encounter forms, along with the considerations you need to keep in mind when designing encounter forms

- Health summaries

- Clinical reminders set-up

- Clinical reminders benefits

8.1. Overview

Where Does the Data for Reminders Come From?

Clinical reminders depend upon patient clinical information collected from a variety of sources, using manual data entry, automated data capture tools, and/or ancillary...
service activities. The following table shows some of the sources of patient data for clinical reminders.

<table>
<thead>
<tr>
<th>User Source</th>
<th>Type of Data</th>
<th>Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checkout Clerks</td>
<td>Encounter data on encounter form or Progress Note</td>
<td>AICS, PCE, Scheduling PCE</td>
</tr>
<tr>
<td></td>
<td>Historical information noted on the encounter form</td>
<td></td>
</tr>
<tr>
<td>Practitioners</td>
<td>Encounter data on encounter form</td>
<td>AICS, PCE</td>
</tr>
<tr>
<td></td>
<td>Historical information</td>
<td>PCE</td>
</tr>
<tr>
<td></td>
<td>Vitals</td>
<td>Vitals</td>
</tr>
<tr>
<td></td>
<td>Text notes are not usable directly by the reminders, but clinical reminders can make use of coded data extracted and manually entered</td>
<td>Progress Notes, Discharge Summary or TIU</td>
</tr>
<tr>
<td>Ward Clerks</td>
<td>Encounter data from Inpatient Stay</td>
<td>PIMS - ADT summary in PTF File</td>
</tr>
<tr>
<td>MCCR personnel</td>
<td>Data entered to complete an encounter for billing and workload credit</td>
<td>Scheduling, PCE</td>
</tr>
<tr>
<td>Transcriptionists</td>
<td>Transcribed text is not usable directly by the reminders, but clinical reminders can make use of coded data extracted and manually entered</td>
<td>Progress Notes - PCE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radiology -PCE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge Summaries - PCE and ADT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cytopathology - PCE</td>
</tr>
<tr>
<td>Ancillary service practitioners</td>
<td>Record results from procedures and automatically update PCE upon verification of results.</td>
<td>Laboratory - PCE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radiology - PCE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgery - PCE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Event Capture - PCE</td>
</tr>
</tbody>
</table>

8.2. Manual Data Entry

Manual data entry is one way to record patient care encounters. The data entered provides the when, why, what, and who information related to a patient encounter:

- Encounter location and date/time
• Diagnoses treated
• Procedures performed
• Practitioner(s)

Historical information about encounters can be entered using the Encounter View action in PCE data entry options to make the patient record more complete. Data capture requirements for historical data are minimal. The historical encounter data is not used for billing and workload. No provider is required and entering only a diagnosis or procedure is okay. Immunizations, pap smears, mammograms, surgeries, etc., done elsewhere may now be recorded and used by the clinical reminders. This includes other VA Medical Centers and non-VA locations (Health Department, private office, etc.).

8.3. Automated Data Capture

Scanned encounter forms can be used to capture encounter data relevant to clinical reminders. If the reminders are to be accurate, the forms must capture the data they need.

It is a challenge to keep the forms as simple as possible while still meeting information capture requirements. This may be done by combining information such as immunizations and skin tests with other required preventive procedures and assigning appropriate CPT codes so they will be captured correctly.

There is no perfect encounter form. Everyone who uses these forms will have ideas about how to make them “perfect.” They need to be carefully designed to meet most of the users’ needs, while capturing information for workload and billing purposes. You can’t capture everything for everyone on one form.

8.4. Clinical Reminders and Health Summary Packages Data Use

Reminder items are added to health summary selection components for a given health summary type. When the health summary type is run, the Clinical Reminders software evaluates the patient’s data and returns the results to the health summary for display.

8.5. Health Summary Reminder Components

Clinical Reminder: An abbreviated component indicating only what is due now.

• Name of reminder
• Date last done
• Date next due
The clinical reminder displays on the health summary as follows:

<table>
<thead>
<tr>
<th>Reminder</th>
<th>Next</th>
<th>Last Done</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram</td>
<td>10/1/98</td>
<td>10/1/96</td>
<td></td>
</tr>
<tr>
<td>Pap Smear</td>
<td>Due Now</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>Diabetic Eye Exam</td>
<td>10/1/98</td>
<td>10/1/97</td>
<td></td>
</tr>
</tbody>
</table>

Clinical Maintenance: this component provides:

- Details about what was found from searching the VISTA clinical data.
- Text related to the findings found or not found (as defined in the reminder). This includes taxonomies (ICD or CPT codes), health factors, and test results related to the reminder and computed findings (e.g., Body Mass Index).
- Final frequency and age range used for the reminder.

The advantage of clinical maintenance over clinical reminders is that it includes related test results, health factors, and logic related to that reminder.

Example of clinical maintenance as displayed on a health summary:

<table>
<thead>
<tr>
<th>Reminder</th>
<th>Next</th>
<th>Last Done</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin A1C</td>
<td>11/1/97</td>
<td>11/1/96</td>
<td></td>
</tr>
</tbody>
</table>
11/1/96 - Problem Diagnosis: 250-Diabetes
HbA1C required yearly for diabetic patients
11/1/96 Lab procedure: HbA1C; results 9.6%
Final frequency and age range used: 1 year for diabetic patients

Health summaries and reminder definitions can be tailored to suit clinicians’ needs. Some health summaries are defined by users themselves and some are designed for generic use. Many kinds of information can be displayed on a health summary. The user can define a reminder that is very detailed so that it could be used in place of a paper chart. Most sites use the health summary to supplement the paper chart, based on the clinic and provider’s preference for health summary content.

8.6. Clinician’s Role in Clinical Reminders

The clinician plays an important role in Clinical Reminders. He/she will be asked to assist the Clinical Coordinator in selecting which reminders to implement and in defining the clinical aspects of the Clinical Reminder Definition Worksheets, including:

- Baseline Age Findings
- Reminder Frequency
- Minimum and Maximum Age
- Health Factors, Taxonomies
- Related Lab and Radiology Tests
- Computed Findings.

Clinicians may also have clinical reminders customized for their needs.
The clinician also plays a major role by appropriately marking the reminder health topics on the encounter forms. As exams, tests, immunizations, screening, and education are given, the boxes must be marked so that the information can be entered into the computer by the clinician or clerk, or picked up by scanners and passed on to PCE to satisfy the clinical reminders.

Historical encounters can be entered for patient visits that occurred sometime in the past (exact time may be unknown) or at some other location (possibly non-VA). They are used to satisfy reminders and determine next date due.

Most important, clinicians will make use of clinical reminders and clinical maintenance to enhance patient care, by assuring timely completion of appropriate tests, immunizations, exams, screenings, and education.

**How does the Clinical Reminders software helps to meet Clinical Guidelines, NCHP, performance indicators, and preventive medicine mandates?**

Make the most of your clinical reminders!

The National Center for Health Promotion (NCHP) has defined a set of 15 reminders that represent the minimum that sites must report on yearly to comply with Congressional law. The Ambulatory Care Expert Panel has defined 22 reminders that they recommend. The NCHP reminders are prefixed with VA-* and the EP reminders with VA-. Any of these reminders that meet your site's requirements may be used as is. If your site requires a reminder that is not met by one of the distributed reminders, you can create your own. It is usually easiest to start by copying the existing reminder that is closest to what you want.

You may wish to review VHA Handbook 1101.8 Health Promotion and Disease Prevention Program (RCN 10-0666), VAMC Outpatient Performance Indications, and Clinical Guidelines as resource materials when deciding what reminders you need.

Create a Preventive Medicine Health Summary or add reminder and maintenance items to existing health summaries. You can print health summaries and provide them to clinicians for all scheduled visits, or show them how to view them on their computer monitors. A clinician may use the ADHOC health summary to review individual maintenance or reminder information.

When reviewers visit your medical center, make these summaries available to them. Feedback from reviewers who have used these health summaries during their reviews has been very positive.

Note: Clinical reminders and clinical maintenance do not satisfy documentation requirements. Documentation supporting these reminders must still be made on progress notes, doctor's orders, etc.
8.7. Implementing Clinical Reminders

Tips on how to get started with clinical reminders and clinical maintenance from a Clinical Coordinator's perspective.

Clinical Reminders are created or modified by using a combination of PCE Table Maintenance options, Clinical Reminders Maintenance options, Taxonomy options, Health Summary Create/Modify Health Summary Type option, and AICS Encounter Form options.

Follow the steps below, as applicable, to implement Clinical Reminders.

1. Ask IRMS staff to assign you the PCE Table Maintenance Menu and the PCE Reminder Maintenance Menu.
   
   If you are a technical user, you may want to ask IRMS to add the PCE Reminder Test option as a secondary menu option.
   
   Refer to Appendix A of the PCE User Manual Appendices document for clinical reminders guidelines and worksheets.

2. Gather the following:
   - Appendix A-1, Start-up Process for Implementing Reminders
   - Appendix A-3, Clinical Reminder Definition Worksheet
   - Appendix A-4, PCE Clinical Integration Worksheet
   - Copy of VA Performance Indicators
   - Copy of VHA Handbook 1101.8

   Use a list of PCE Reminders/Maintenance items, health factors, and taxonomies for referral as you are working. The distributed reminders and taxonomies are listed in Appendixes A-8 and A-9. (Options to print these are located on the PCE Reminder Maintenance Menu, if you need more copies.)

3. Identify the reminders that your site wants to implement.

   a. Review reminder definitions with appropriate clinical staff and determine any reminders that will need editing.
      
      - If you are going to use the distributed reminders without making any changes, you won’t need to copy them. For example, immunizations, skin tests, and blood pressures can be used as exported. If you wish to make changes (e.g., frequency, age range, health factors), copy the exported reminder and edit it.
      
      - If no distributed reminder provides exactly what you require, you will need to create your own local reminder. It is usually easiest to start with the distributed reminder that is closest to your requirements. Copy it to a local reminder using the Copy Reminder Item option, and...
then edit the new reminder to meet your site's needs. An example of copying and editing a reminder is at the end of this chapter.

Note: The VA- prefix designates the nationally distributed set. (Sites are not allowed to use the VA- prefix in the names of locally defined reminders.) Reminders with the VA-* prefix represent the minimum requirements as defined by the National Center for Health Promotion (NCHP).

- You will always need to copy and edit the following reminders to add your specific laboratory or radiology test names:
  - VA-*: Breast Cancer Screen, *Cholesterol Screen (M) and (F)
  - VA-: Mammogram, PSA
  - VA-*: *Cervical Cancer Screen, *Colorectal Cancer Screen (FOBT), Colorectal Cancer Screen (Sig.), Hypertension Screen, Influenza, Immunization, Pneumococcal Vaccine, Tetanus Diphtheria Immunization, Weight and Nutrition Screen
  - VA-: *Pap Smear, *FOBT, Flexisigmoidoscopy, Blood Pressure check, Influenza Vaccine, Pneumovax, PPD, Weight

    * The Pap Smear and FOBT-type reminders don't look at the laboratory test names at this time. However, a future lab patch is anticipated that will require you to enter the laboratory test name as you did for PSA and cholesterol reminders.

- The following screening and education reminders work “as is,” but you must activate the topics under the PCE Reminder Maintenance Menu. The Table Maintenance item should match one or more of the Target Result Findings items as listed in each reminder definition.
  - VA-*: Fitness and Exercise Screen, Problem Drinking Screen, Seat Belt and Accident Screen and Tobacco Use Screen
  - VA-: Exercise Education, Alcohol Abuse Education, Seat Belt Education, Tobacco Education, Nutrition/Obesity Education
  - VA-: Advance Directives Education, Breast Exam, Breast Self-Exam
  - VA-: Education, Diabetic Eye Exam, Diabetic Foot Care Ed, Diabetic Foot Exam
  - VA-: Exam, Digital Rectal (Prostate) Exam

b. Run enough copies of “Clinical Reminder Definition Worksheets” (Appendix A-3 of the PCE User Manual Appendices document) for the reminders you wish to edit.
c. Complete a Clinical Definition Worksheet for each reminder you wish to change. This is where you define the reminder print name, description, type, target result finding file, timeframes, taxonomies, and health factors, etc.

d. Get approval from your Medical Staff Executive Committee for your reminder definitions.

4. (Optional) If a distributed taxonomy definition related to a reminder needs modification, do the following:
   a. Copy the taxonomy and then edit it, using the Copy Taxonomy option.
   b. Modify the reminder to reflect the newly created taxonomy, using the Reminder Edit option.

5. Use options on the PCE Table Maintenance Menu to enter any locally created education, examinations, or health factors.

6. Coordinate the use of encounter forms (through the AICS package) with the use of Health Summary Clinical Maintenance components.

7. Make sure the relevant encounter forms contain all appropriate list bubbles for PCE data: Health factors, exams, immunizations, diagnosis, patient education, procedures, and skin tests.

8. Use the Health Summary package to activate clinical reminders and clinical maintenance components.
   a. Enable components through the Health Summary Maintenance Menu (GMTS IRM/ADPAC Maintenance Menu).
   b. Inactivate reminder topics you will not be using.
   c. Create a Preventive Medicine Health Summary to display reminders and health maintenance components, or add these components to existing health summaries. You can print copies and include them with the encounter form and chart for each visit, or your providers can view health summaries on their computers.

9. Inactivate reminders which will not be used, with the Activate/Inactive Reminders option.

10. Test your reminders.
    You can do this two ways:
    a. Run health summaries on patients you know have documented health factors or taxonomies.
    b. Use the Reminder Test option, a standalone option which technical users can use to see a programmer’s view of the results of a reminder for a patient. This option doesn’t affect any data; it provides debugging information. Check with your IRMS staff for availability.
11. Meet with users and explain Clinical Reminders, the use of the Preventive Medicine Health Summary, and the need for their continued documentation of progress notes, doctor’s orders, etc.

12. Meet with appropriate staff to arrange for data validation to assure that:
   a. Encounter forms are being completed correctly.
   b. Clerks are entering information that is marked on the encounter form (if using manual entry).
   c. Scanners are picking up information accurately (if scanning).
   d. Information is being passed to health summaries correctly.
   e. Documentation in the patient’s medical record supports information displayed on the clinical reminders and clinical maintenance components.

8.8. Defining Clinical Terms with PCE Tables

The PCE package provides options for defining terminology, which your site can use to support capturing data for the reminders. The tables are categorized as follows:

- Education Topic
- Exam
- Health Factor
- Treatment

With the exception of the table of Treatments, all of the table items are supplied in an activated state. (Clinical reminders do not use Treatments). If there are choices that you don’t want your users to see and pick, you must deactivate them (with the PCE Table Maintenance Activate/Inactivate Table Items option).

8.9. PCE Reminder Maintenance Menu

8.9.1. Option Descriptions

List Reminder Definitions
Lists all of the Reminder/Maintenance item definitions.

Inquire About Reminder Item
Lists the definition of a selected reminder.

Add/Edit Reminder Item
Used to edit Reminder/Maintenance Item definitions.

Copy Reminder Item
Used to copy an existing reminder item definition into a new reminder item in the Reminder/Maintenance Item file (#811.9). Once the copy is completed, you will have the option of editing the new reminder.

**Activate/Inactivate Reminders**

Used to make reminders active or inactive with Health Summary.

**List Reminder Types Logic**

Lists the Reminder Types along with a summary of where the reminder's logic searches for data in VISTA to be used for the reminder type's target patient findings.

**List Taxonomy Definitions**

Lists the current definition of taxonomies defined in the Taxonomy file which defines the coded values from ICD Diagnosis, ICD Operation/Procedures, or CPT codes that are a part of a clinical category (taxonomy). These taxonomy low and high range definitions are used by the Clinical Reminders logic to determine if a patient has coded values in the clinical files that indicate the patient is part of the taxonomy

**Inquire about Taxonomy Item**

Lists the current definition of a single taxonomy, including the same information as the Taxonomy List option.

**Edit Taxonomy Item**

Used to edit Taxonomy Item definitions.

**Copy Taxonomy Item**

Used to copy an existing taxonomy definition into a new entry in the Taxonomy file (#811.2). Once the taxonomy has been copied, you have the option of editing it.

**Activate/Inactivate Taxonomies**

This option allows you to activate/inactivate taxonomies.

Reminder Test [PXRM REMINDER TEST], a standalone option, provides the technical user with a tool that can facilitate the creation and debugging of reminder definitions. This option lets you run a reminder directly and see all the details. It is completely safe to use, and its impact on the system is no different than running a reminder through Health Summary. The use of this option is explained in detail in Appendix A-7 of the PCE User Manual Appendices document.

Depending on a site's preferences, IRMS can add this option to the Reminder Maintenance menu or to a particular user's secondary menus.
8.10. Copying and Editing a Reminder

Note: Use one up-arrow (^) or two up-arrows (^^) to exit from the option. Two up-arrows (^^) are necessary to exit from some prompts (ones that are indented).

<table>
<thead>
<tr>
<th>RL</th>
<th>List Reminder Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>RI</td>
<td>Inquire about Reminder Item</td>
</tr>
<tr>
<td>RE</td>
<td>Add/Edit Reminder Item</td>
</tr>
<tr>
<td>RC</td>
<td>Copy Reminder Item</td>
</tr>
<tr>
<td>RA</td>
<td>Activate/Inactivate Reminders</td>
</tr>
<tr>
<td>RT</td>
<td>List Reminder Types Logic</td>
</tr>
<tr>
<td>TL</td>
<td>List Taxonomy Definitions</td>
</tr>
<tr>
<td>TI</td>
<td>Inquire about Taxonomy Item</td>
</tr>
<tr>
<td>TE</td>
<td>Edit Taxonomy Item</td>
</tr>
<tr>
<td>TC</td>
<td>Copy Taxonomy Item</td>
</tr>
<tr>
<td>TA</td>
<td>Activate/Inactivate Taxonomies</td>
</tr>
</tbody>
</table>

Select PCE Reminder Maintenance Menu Option: RC Copy Reminder Item
Select the reminder item to copy: FECAL OCCULT BLOOD TEST
PLEASE ENTER A UNIQUE NAME: LOCAL FECAL OCCULT BLOOD TEST

The original reminder FECAL OCCULT BLOOD TEST has been copied into LOCAL FECAL OCCULT BLOOD TEST.
Do you want to edit it now? YES

NAME: LOCAL FECAL OCCULT BLOOD TEST Replace <Enter>
REMINDER TYPE: LABORATORY TEST// <Enter>
PRINT NAME: Fecal Occult Blood Test Replace <Enter>
RELATED REMINDER GUIDELINE: VA-*COLORECTAL CANCER SCREEN (FOBT) // <Enter>

INACTIVE FLAG: ?
   Enter "1" to inactivate the reminder item.
   Choose from:
   1 INACTIVE
   INACTIVE FLAG: <Enter>

REMINDER DESCRIPTION:
Fecal occult blood test due every year for patients ages 50 and older with no dx of colorectal cancer.

This reminder is based on guidelines provided by the Ambulatory Care Expert Panel. It also satisfies the "Colorectal Cancer Screen - FOBT" guidelines specified in the "Guidelines for Health Promotion and Disease Prevention", M-2, Part IV, Chapter 9.
EDIT? NO// <Enter>

TECHNICAL DESCRIPTION:...
Operation/Procedure file. If this taxonomy needs modification, copy the taxonomy to a new taxonomy for your site, and make the appropriate modifications.
Copy the reminder to a new reminder for your local site's modifications.
NOTE: The Laboratory data is not available use in the reminder. When the lab package begins passing CPT codes for fecal occult blood tests to PCE, this reminder is ready to make use of the information.

EDIT? NO// <Enter>
Target Groups
DO IN ADVANCE TIME FRAME: 1M//<Enter>
SEX SPECIFIC: <Enter>
This field allows the user to stop reminders from being printed in the "Clinical Maintenance" component of Health Summary if the reminder is N/A. This is free text that can contain any combination of the following codes:

- **A**: N/A due to not meeting age criteria.
- **S**: N/A due to the wrong sex.

### Baseline frequency age range set

**Select REMINDER FREQUENCY:** 0Y//<Enter>
- **REMINDE...**
- **MINIMUM AGE:** 0//<Enter>
- **MAXIMUM AGE:** 49//40
- **AGE MATCH TEXT:**
  - Fecal Occult Blood Test (FOBT) not indicated in patients under 50.
  - EDIT? NO// YES
- **REPLACE 50 WITH 40 REPLACE <Enter>**

**EDIT Option:** <Enter>
- **AGE NO MATCH TEXT:**
  - No existing text
  - Edit? NO//<Enter>

**Select REMINDER FREQUENCY:** <Enter>

### Target Findings

**Select TARGET RESULT FINDINGS FILE:** LABORATORY TEST//<Enter>
- **TARGET RESULT FINDINGS FILE:** LABORATORY TEST//<Enter>
- **TARGET RESULT DESCRIPTION:**
  - Identify all laboratory tests which represent Fecal Occult Blood tests in the Target Result Findings Item multiple.

FOBT's may also be identified by defining a taxonomy in PCE Taxonomy that identifies coded ranges of CPT or ICD Operation/Procedure codes that represent this test.

**EDIT? NO// <Enter>**

**Select TARGET RESULT FINDINGS ITEM:** OCCULT BLOOD (STOOL)//<Enter>
- **TARGET RESULT FOUND TEXT:**
  - No existing text
  - Edit? NO//
- **TARGET RESULT NOT FOUND TEXT:**
  - No existing text
  - Edit? NO//

### Taxonomy Findings

**Select TAXONOMY:** VA-COLORECTAL CA//<Enter>
- **TAXONOMY:** VA-COLORECTAL CA//<Enter>
- **MINIMUM AGE:** 30
- **MAXIMUM AGE:** <Enter>
- **REMINDER FREQUENCY:** 0Y//1Y
- **FOUND TEXT:**
  - Patient known to have hx of colorectal cancer. Please verify appropriate tx & f/u is ongoing.

**NOT FOUND TEXT:**
- No hx of colorectal cancer on file - presumed no hx.
- Edit? NO// <Enter>

**RANK FREQUENCY:** ??
- This optional field is used to rank the frequency and age ranges that are associated with this Taxonomy Finding.

This field is used for the situation 1) where more than one match is found among Taxonomy Findings, and/or Health Factor Findings and/or Computed Findings, and 2) where more than one of the Findings definitions has its own age range and frequency. The rank is used to define a priority or ranking that tells the reminder logic which age range and
frequency should take precedence when there are multiple results found.

The value which can be entered in the Rank field should be a number from 1 to 999, or blank. The highest ranking (priority) is number 1. When there are multiple Findings found, the Finding with the highest rank will be used to set the frequency and age range which are used to determine when the reminder is due.

When the Rank field is blank (null) for this Taxonomy Finding, and also blank for the Health Factor and Computed Findings definitions, the reminder logic will use the frequency that will make the reminder occur most often. For example, a Health Factor Finding has age range 25-50 with a frequency of 6 months, and a Taxonomy Finding has age range 25-70 and a frequency of 1 year. The Health Factor age and frequency would be used for the reminder, since a 6 month interval is more frequent than 1 year interval.

**RANK FREQUENCY:** <Enter>

**USE IN DATE DUE CALC:** ??

This optional field is used by the reminder logic to determine if the date of a match on the Taxonomy Finding should be used to determine the next date the reminder will be due. If there are multiple matches among the Findings, and this Taxonomy Finding is the most recent Finding, then the reminder date due will be calculated from the encounter date of this Finding.

A blank in this field indicates the encounter date of the matched Taxonomy Finding will NOT be used to determine the next date the reminder will be due. The Taxonomy Finding encounter date and data WILL however be displayed in the clinical maintenance component as information.

This field is very useful for the situation when the Targeted Result Findings AND this Taxonomy Finding should be used as valid patient results satisfying the reminder.

Choose from:
1. YES
2. NO

**USE IN DATE DUE CALC:** <Enter>

**USE IN APPLY LOGIC:** ??

This optional field is used by the user to indicate that this Taxonomy Finding should be included as part of the "Apply Logic". The Apply Logic is used to determine whether or not a reminder should be applied (given) to a patient. This is very useful for those situations where a reminder should only be given to, or NOT given to patients with a particular Taxonomy Finding, such as diabetes.

This "Use in Apply Logic" field can be defined with one of the following coded values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>VALUE</th>
<th>OPERATOR LOGIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>----</td>
<td>-----</td>
<td>----------------</td>
</tr>
<tr>
<td>BLANK</td>
<td>not included in Apply Logic (Use @ to delete value)</td>
<td></td>
</tr>
<tr>
<td>&amp;</td>
<td>AND</td>
<td>&amp;(Finding)</td>
</tr>
<tr>
<td>!</td>
<td>OR</td>
<td>!(Finding)</td>
</tr>
<tr>
<td>&amp;'</td>
<td>AND NOT</td>
<td>&amp;'(Finding)</td>
</tr>
<tr>
<td>!'</td>
<td>OR NOT</td>
<td>!'(Finding)</td>
</tr>
</tbody>
</table>

The code selected is used to create a default Boolean "Apply Logic" string for this reminder. The Apply Logic string always initially defaults to include (SEX)&(AGE), but will add &(Finding), !(Finding), &'(Finding), or !'(Finding) to the string depending on the code in this "Use in Apply Logic" field. If a more detailed definition of the Apply Logic is required, then the "Apply Logic" field in the PCE REMINDER/MAINTENANCE FILE (811.9) can be defined via FileMan. When the Apply
Logic is defined using FileMan, the "Use in Apply Logic" field will be ignored by the reminder logic because the default "Apply Logic" is overridden by the contents of the "Apply Logic" field. To reactivate the default "Apply Logic", use FileMan to delete the contents of the "Apply Logic" field.

Choose from:
& AND
! OR
&' AND NOT
!' OR NOT

USE IN APPLY LOGIC: <Enter>
Select TAXONOMY: <Enter>

TAXON GENERAL FOUND TEXT:
No existing text
Edit? NO/

TAXON GENERAL NOT FOUND TEXT:
No existing text
Edit? NO/

Health Factor Findings
Select HEALTH FACTOR FINDINGS ITEM: ACTIVATE FOBT CANCER SCREEN// <Enter>

HEALTH FACTOR FINDINGS ITEM: ACTIVATE FOBT CANCER SCREEN// <Enter>
MINIMUM AGE: <Enter>
MAXIMUM AGE: <Enter>
REMEMBER FREQUENCY:
FOUND TEXT:
No existing text
Edit? NO/<Enter>
NOT FOUND TEXT:
No existing text
Edit? NO/<Enter>
RANK FREQUENCY:

USE IN DATE DUE CALC: <Enter>
USE IN APPLY LOGIC: <Enter>

Select HEALTH FACTOR FINDINGS ITEM:
HF GENERAL FOUND TEXT:
No existing text
Edit? NO/<Enter>

HF GENERAL NOT FOUND TEXT:
No existing text
Edit? NO/<Enter>

Computed Findings
Select ROUTINE: <Enter>

APPLY LOGIC: <Enter>
Select the reminder item to copy: <Enter>

RL List Reminder Definitions
RI Inquire about Reminder Item
RE Add/Edit Reminder Item
RC Copy Reminder Item
RA Activate/Inactivate Reminders
RT List Reminder Types Logic
TL List Taxonomy Definitions
TI Inquire about Taxonomy Item
TE Edit Taxonomy Item
TC Copy Taxonomy Item
TA Activate/Inactivate Taxonomies

Select PCE Reminder Maintenance Menu Option: <Enter>
8.11. Health Summary Example

This example shows both clinical maintenance and clinical reminders components, so you can see the differences.

The clinical reminder component is an abbreviated component indicating only what is due now.

The clinical maintenance component provides:

- Details about what was found from searching the VISTA clinical data
- Test related to the findings found or not found (as defined in the reminder)
- Final frequency and age range used for this reminder.

<table>
<thead>
<tr>
<th>Date</th>
<th>Test Description</th>
<th>Frequency and Age Range Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/13/97</td>
<td>Cholesterol Screen (Male) N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient's age (72) is greater than reminder maximum age of 65.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LAB: Date of last cholesterol test unknown.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date of last cholesterol taxonomy (CPT) unknown.</td>
<td></td>
</tr>
<tr>
<td>07/02/96</td>
<td>Fecal Occult Blood Test</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2/5/97 Health Factor: ACTIVATE FOBT CANCER SCREEN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7/2/96 Encounter Procedure: 45330-SIGMOIDOSCOPY, DIAGNOSTIC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7/2/96 Encounter Procedure: 82270-TEST FECES FOR BLOOD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FOBT due 5 years after the last sigmoidoscopy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final Frequency and Age Range used: 1 year for ages 50 and older.</td>
<td></td>
</tr>
<tr>
<td>07/02/96</td>
<td>Flexisigmoidoscopy N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2/5/97 Health Factor: INACTIVATE SIGMOIDOSCOPY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7/2/96 Encounter Procedure: 45330-SIGMOIDOSCOPY, DIAGNOSTIC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7/2/96 Encounter Procedure: 82270-TEST FECES FOR BLOOD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final Frequency and Age Range used: 0Y - Not Indicated for ages 50 and older.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exercise Education DUE NOW unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final Frequency and Age Range used: 1 year for all ages.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypertension Detection DUE NOW unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vitals: Date of last Vitals BP Measurement unknown.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date of last ICD or CPT coded hypertension screen unknown.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final Frequency and Age Range used: 2 years for all ages.</td>
<td></td>
</tr>
<tr>
<td>07/02/96</td>
<td>Influenza Immunization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7/2/96 Encounter Procedure: 90724-INFLUENZA IMMUNIZATION Influenza vaccine due yearly in patients ages 65 and older.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final Frequency and Age Range used: 1 year for ages 65 and older.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumovax</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DUE NOW</td>
<td></td>
</tr>
<tr>
<td>07/01/96</td>
<td>7/1/96 Encounter Procedure: 90732-PNEUMOCOCCAL IMMUNIZATION</td>
<td></td>
</tr>
</tbody>
</table>
Pneumovax due once for patients 65 and over.
Final Frequency and Age Range used: 99Y - Once for ages 65 and older.

Problem Drinking Screen        DUE NOW    unknown
Screen for alcohol problems yearly for all patients.
Final Frequency and Age Range used: 1 year for all ages.

Seat Belt and Accident Screen   DUE NOW    unknown
Seat belt education due yearly for all patients.
Final Frequency and Age Range used: 1 year for all ages.

Tobacco Use Screen             DUE NOW    unknown
Tobacco use screen due yearly for all ages.
No history of tobacco use screen on file. Please evaluate tobacco use and educate if currently in use.
Final Frequency and Age Range used: 1 year for all ages.

Weight and Nutrition Screen    DUE NOW    unknown
Weight and Nutrition screen due yearly for all patients.
Final Frequency and Age Range used: 1 year for all ages.

---------R - Clinical Reminders ---------------------

The following disease screening, immunization and patient education recommendations are offered as guidelines to assist in your practice. These are only recommendations, not practice standards. The appropriate utilization of these for your individual patient must be based on clinical judgment and the patient's current status.

Exercise Education             DUE NOW    unknown
Hypertension Detection         DUE NOW    unknown
Problem Drinking Screen        DUE NOW    unknown
Seat Belt and Accident Screen  DUE NOW    unknown
Tobacco Use Screen             DUE NOW    unknown
Weight and Nutrition Screen    DUE NOW    unknown

8.12. Key Concepts

- Clinical Reminders on Health Summaries furnish providers with timely information about their patients' health maintenance schedules.

- Providers can work with their local ADP coordinators to set up customized schedules based on local and national guidelines for patient education, immunizations, and other procedures.

- Options on the Clinical Reminder/Health Maintenance menu let you edit reminder and health maintenance definitions, based on your site's clinical terminology.

- A complete reminder definition includes associated components such as examinations, taxonomies, and health factors. Sites may define their own components to use in reminder definitions. A site may also create routines for computed findings where necessary. This makes reminders completely customizable by sites.
- Taxonomy entries define low and high range values from ICD Diagnosis, ICD Operation/Procedures, and CPT codes which are part of a clinical category (taxonomy).
- To alter a VA- prefixed reminder item, first copy it to a different name and then edit the reminder to reflect your site's requirements for the reminder.
- Once reminder criteria have been defined, they may be included in the Health Summary Type definitions for the Clinical Reminder and Health Maintenance components which will be displayed on Health Summaries.

9.0  PCE Clinical Reports

The PCE Clinical Reports options provide clinicians and managers with summary data about their patients, workload activity, and encounter counts. The reports extract data from various files in VISTA, including laboratory, pharmacy, and PIMS to create output reports which have been requested by physicians throughout the VA.

Note: If the month or day are not known for historical encounters, they will appear on encounter screens or reports with zeroes for the missing dates; for example, 01/00/95 or 00/00/94.

9.1.  PCE Clinical Reports Menu

<table>
<thead>
<tr>
<th>PA</th>
<th>Patient Activity by Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP</td>
<td>Caseload Profile by Clinic</td>
</tr>
<tr>
<td>WL</td>
<td>Workload by Clinic</td>
</tr>
<tr>
<td>DX</td>
<td>Diagnosis Ranked by Frequency</td>
</tr>
<tr>
<td>LE</td>
<td>Location Encounter Counts</td>
</tr>
<tr>
<td>PE</td>
<td>Provider Encounter Counts</td>
</tr>
</tbody>
</table>

9.2.  Option Descriptions

9.2.1. Patient Activity by Clinic

This report provides a summary of patient data for one or more clinics as a measure of continuity of care.

9.2.2. Caseload Profile by Clinic

This report generates a profile of the patients in a clinic's caseload, given a selected date range. One or more clinics or a stop code may be selected to represent the caseload; it combines PCE encounter, Lab, Radiology, Outpatient Pharmacy, and Admissions data, with report areas of demographics, preventive medicine, quality of care markers, and utilization.
9.2.3. Workload by Clinic

This report provides a summary of clinic workload based on the evaluation and management codes associated with encounters occurring within a selected date range. The report will have the most complete information if it is run for a date range where clinic activities have been documented online. The representative period of time for the selected date range may be determined by clinical staff.

9.2.4. Diagnoses Ranked by Frequency

This report lists the most frequent diagnostic codes (ICD9 or ICD-10) and the most frequent diagnostic categories.

9.2.5. Location Encounter Counts

This report counts PCE outpatient encounters in a date range by location. The location selection can be based on facility, hospital location(s), or clinic stop(s). The report can be run for all hospital locations or clinic stops in a facility or selected hospital locations or clinic stops.

9.2.6. Provider Encounter Counts

This report lists provider counts related to PCE outpatient encounters (in detailed or summary reports). The selection criteria includes facility, service category, provider, and date range. The facility criteria allows for selection of the facilities to be included on the report. The provider selection criteria allows for selection of all providers, primary providers, a list of individual providers, or the providers belonging to a list of provider classes. The date range specifies a time interval in which to look for encounters.

9.2.7. Patient Activity by Clinic

The Caseload Profile by Clinic and Patient Activity by Clinic reports track Critical Lab Values and Emergency Room Visits. The PCE Report Parameter Edit option on the PCE HS/RPT Parameter Menu allows your site to specify which clinics in Hospital Location file (#44) represent "Emergency Room" clinics and what tests from the Laboratory Test file (#60) should be used for looking up patient data for Glucose, Cholesterol, LDL Cholesterol and HBA1C lab results. (This is necessary since the Laboratory Test File is not standardized and each site may have customized it differently.)

Select PCE Clinical Reports Option: PA Patient Activity by Clinic

<table>
<thead>
<tr>
<th>Patient Activity by Clinic</th>
</tr>
</thead>
</table>

Select clinic(s) by (H)OSPITAL LOCATION or CLINIC (S)TOP CODE: HOSPITAL LOCATION

Select HOSPITAL LOCATION name: DIABETES CLINIC PCEPROVIDER,ONE

Another HOSPITAL LOCATION name: [ENTER]
9.2.8. Caseload Profile by Clinic

This report generates a profile of the patients in a clinic's caseload for a selected date range. One or more clinics or a stop code may be selected to represent the caseload. If stop code is selected, a report is generated for each clinic within that stop code. The percentage and overall mean are calculated based on the patient data for all of the clinics selected. Where only one clinic is selected, these values are not applicable.

Note: There must be at least one PCE encounter within the selected date range for this report, even though there may be lab, radiology, and outpatient pharmacy occasions of service with the other timeframes (6 & 12 months).

This report combines PCE encounter, Lab, Radiology, Outpatient Pharmacy, and Admissions data. It provides a profile of the patients making up a clinic's caseload, over a representative period of time. Clinical staff will decide the appropriate date range. Report areas are demographics of clinic caseload, preventive medicine, quality of care markers, and utilization. Patient age, diagnosis, gender, Lab assay, RX, and procedure are all used to generate the patient profile.

There are three separate timeframes for the report:

- SELECTED DATE RANGE
- THE SIX (6) MONTHS PREVIOUS TO BEGINNING DATE
- THE TWELVE (12) MONTHS PREVIOUS TO BEGINNING DATE
Search ranges are listed at the top of each report section.

DEMOGRAPHICS are based on the selected date range.

PREVENTIVE MEDICINE is based on 1) ICD codes recorded in PCE encounter diagnoses and 2) Radiology for the period 12 months previous to the beginning date.

QUALITY OF CARE MARKERS are based on Laboratory results, PCE encounter diagnoses, and scheduling data for the period six months previous to the beginning date.

UTILIZATION data is based on PCE encounters and outpatient pharmacy prescriptions for the period 12 months previous to the beginning date.

The six and twelve-month profiles probably won't change much month-to-month. How long the report takes to run varies according to the number of selected clinics, the number of encounters within that clinic, and the complexity of the patient data for any selected clinic.

9.2.9. Technical Description

This option executes the Scheduling Package Clinic Workload (SET^SDCWL3) routines to identify patients whose appointments were either scheduled, unscheduled, cancelled, or no-shows during the selected date range.

Admissions are found by a call to IN5^VADPT for each date within the selected date range. Temporary storage of this data, for report purposes is at the global node ^TMP($J,"ADM",DFN,ADMISSION DATE). This node is set to discharge date^room-bed^street address^address line 2^city^state^zipcode^phone number.

Emergency clinics must be defined in field 801 of the PCE PARAMETERS file, which is a multiple pointing to the HOSPITAL LOCATION file. The ER clinic names are stored permanently at the global location: ^PX(815,D0,RR1,D1,0). A call is made to SDA^VADPT for stops occurring within the selected date range for the array of clinics listed at the above global location.

Laboratory data assessed for critical values is based on the Subfile 63.04 of the Lab DATA file (63), which stores results from Chemistry, Hematology, Toxicology, RIA, Serology, and others. Critical values are identified through a pattern match of a numeric value followed by a "*". The global location read is ^LR(LRDFN,"CH",INVERSE LAB DATE, LAB TEST FIELD NUMBER). Piece one contains the result. Piece 2 indicates a critical value and if it is high or low (e.g. *H).

Select PCE Clinical Reports Option: CP Caseload Profile by Clinic

Caseload Profile by Clinic

The overall mean values for this report will be for the clinic(s) selected which had encounters during the selected date range.

Select clinic(s) by (H)OSPITAL LOCATION or CLINIC (S)TOP CODE: CLINIC STOP CODE

Select the CLINIC STOP code: DIABETES
### Caseload Profile by Clinic

**Enter ENCOUNTER BEGINNING DATE:** T-30 (JUN 29, 1996)
**Enter ENCOUNTER ENDING DATE:** Jul 29, 1996 ([ENTER]) (JUL 29, 1996)

**DEVICE:** HOME ([ENTER]) VAX [ENTER] **RIGHT MARGIN:** 80 ([ENTER])

Jul 29, 1996@11:21

#### Clinic: DIABETES CLINIC

Compared to the mean of: DIABETES Clinic Stop
for 1 of 1 clinics with data

<table>
<thead>
<tr>
<th>CASELOAD DEMOGRAPHICS for Encounter date range</th>
<th>Clinic</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun 29, 1996 to Jul 29, 1996</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Number of patient encounters</td>
<td>40</td>
<td>-</td>
</tr>
<tr>
<td>Number of clinic sessions</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>Number of patients per clinic session</td>
<td>2.4</td>
<td>-</td>
</tr>
<tr>
<td>Median patient age in years</td>
<td>46</td>
<td>-</td>
</tr>
</tbody>
</table>

- Patients with: Coronary Artery Disease      | 0 | 0.0 | 0.0 |
- Diabetes                                    | 0 | 0.0 | 0.0 |
- Hypertension                                 | 0 | 0.0 | 0.0 |
- Hyperlipidemia                               | 0 | 0.0 | 0.0 |
- Diabetes and Hypertension                    | 0 | 0.0 | 0.0 |

---

#### PREVENTIVE MEDICINE (12 mos. prior to Jul 29, 1996)

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 30, 1995 to Jul 29, 1996</td>
<td>#</td>
</tr>
<tr>
<td>Patients who smoke.</td>
<td>0</td>
</tr>
<tr>
<td>Females &gt;50 who had a mammogram in the last year</td>
<td>0</td>
</tr>
</tbody>
</table>

(There were 1 females >50 years of age).

---

#### QUALITY OF CARE MARKERS (6 mos. prior to Jul 29, 1996)

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 31, 1996 to Jul 29, 1996</td>
<td>#</td>
</tr>
<tr>
<td>Average HBA1C of your patients with Diabetes</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients with HBA1C&gt; 7%</td>
<td>0</td>
</tr>
<tr>
<td>Patients w/ Coronary Artery Disease who smoke</td>
<td>0</td>
</tr>
<tr>
<td>Ave. LDL for patients with Coronary Artery Disease</td>
<td>N/A</td>
</tr>
<tr>
<td>(0 of 0 pats. with CAD had no LDL results.)</td>
<td></td>
</tr>
<tr>
<td>Number of patients with: Glucose &gt;240</td>
<td>0</td>
</tr>
<tr>
<td>Cholesterol &gt;200</td>
<td>0</td>
</tr>
<tr>
<td>Either a Systolic bp &gt;160 or Diastolic bp &gt; 90</td>
<td>0</td>
</tr>
<tr>
<td>Unscheduled encounters per patient.</td>
<td>0.0</td>
</tr>
<tr>
<td>Emergency Room encounters per patient.</td>
<td>0.0</td>
</tr>
<tr>
<td>Hospitalizations per patient.</td>
<td>0.2</td>
</tr>
</tbody>
</table>

---

#### UTILIZATION DATA (12 months prior to Jul 29, 1996)

<table>
<thead>
<tr>
<th>Number</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 30, 1995 to Jul 29, 1996</td>
<td>#</td>
</tr>
<tr>
<td>Number of male patients</td>
<td>9</td>
</tr>
<tr>
<td>Number of female patients</td>
<td>4</td>
</tr>
<tr>
<td>Average number of encounters per patient</td>
<td>6.8</td>
</tr>
<tr>
<td>Average number of active output. medications per patient</td>
<td>0.0</td>
</tr>
<tr>
<td>Average pharmacy cost per patient</td>
<td>$ 0.0</td>
</tr>
</tbody>
</table>

Press RETURN to continue...
9.2.10. Workload by Clinic

This report provides a summary of clinic workload based on the evaluation and management CPT codes associated with encounters occurring within a selected date range. The report will have the most complete information if it is run for a date range where clinic activities have been documented online. The representative period of time for the selected date range may be determined by clinical staff.

This report may be run for one or more clinics or for a stop code. Individual clinic totals are presented as line items on a 132 column report. For each clinic, the number of encounters reported is based on categorizing encounters by the types of procedures that have been associated with the encounter in PCE. It also summarizes data from the Scheduling package, which is not available in PCE.

PCE encounter procedure categories:

- Procedures exist with an Evaluation and Management CPT code, where the Evaluation and Management codes are categorized by new patients, established patients, consult patients, and other.
- Procedures exist which do not include Evaluation and Management code procedures.
- No Procedures (CPT codes) exist for the encounter.
- Total outpatient encounters exist for PCE.

Scheduling encounter data:

- No Show encounters
- Canceled encounters
- Walk-In encounters
- Total outpatient encounters documented in Scheduling. Overbooks and Inpatient clinic appointments are included

Select PCE Clinical Reports Option: W

This report requires a 132-COLUMN PRINTER.

DO YOU WISH TO CONTINUE? (Y/N)? YES// [ENTER]

Select clinic(s) by (H)OSPITAL LOCATION or CLINIC (S)TOP CODE: H HOSPITAL LOCATION

Select HOSPITAL LOCATION name: CARDIOLOGY WELBY, DR

Another HOSPITAL LOCATION name: DIABETES CLINIC PCEPROVIDER, ONE

Another HOSPITAL LOCATION name:

Enter ENCOUNTER BEGINNING DATE: T-30 (JUN 29, 1996)

DEVICE: HOME// [ENTER] VAX RIGHT MARGIN: 80// [ENTER]

Note: This is a 132-column report.

Workload by Clinic
9.2.11. Diagnosis Ranked by Frequency

This report produces two lists: most frequent diagnoses (ICD9 or ICD10) and most frequent diagnostic categories. The list entries are ordered with the most frequent encounter diagnosis first. The most frequent diagnosis categories list is based on the ICD diagnostic category related to each diagnosis in the frequent diagnosis list.

The report can be generated using a number of different selection criteria:

- **Facility** – Select the facilities encounters to include in the report.
- **Primary Diagnoses only or All Diagnoses** – If primary is selected then only primary diagnosis associated with an encounter will be included in the report. All diagnosis will include Primary and secondary diagnoses associated with an encounter.
- **Encounter Date Range** – Only encounters that fall within the specified date range are used to generate the report.
- **Number of most frequent diagnoses** – This will determine how many diagnoses and diagnoses categories are listed on the report. For example, if 20 was input for this criteria, the report would list up to 20 of the most frequent diagnoses found associated with encounters. Diagnoses and diagnostic categories are ranked from most frequent to least frequent. If the encounters contained less than 20 different diagnoses, the report lists all the different diagnoses that were found.

The remaining criteria are optional for singling out diagnosis entries based on other encounter or patient data. You can accept the default "other" encounter/patient criteria which is all VA Clinic encounters (Service Category of "A" or "I") for all patients.

Other encounter/patient report selection criteria:
• Service Category – Only encounters with the specified service category or categories are used to generate the report. This defaults to "AI" for Ambulatory encounters and encounters at a clinic where the patient had an inpatient status.

• Clinic Stop Code – Only encounters with the specified list of clinic stop codes are used to generate the report.

• Provider criteria can specify All Providers, Primary Providers, Selected Providers, or Selected Provider Classes.

• Providers – Only encounters, where one of the encounter providers is the same as one of the providers selected, are used to generate the report.

• Primary Providers – Only encounters, where one of the encounter providers is designated as a Primary provider, are used to generate the report.

• Provider class – Only encounters, where one of the encounter providers has the same provider class as one of the providers classes selected, will be used to generate the report.

• Patient Date of Birth Range – Only encounters, where the patient's date of birth falls in the specified range, will be used to generate the report.

• Patient Sex – Only encounters, where the patient's sex matches the specified sex, are used to generate the report.

To include all encounters, ignoring all defaults for the other criteria, specify "A" for All Encounters at the Other criteria prompt.

```
Select PCE Clinical Reports Option: DX Diagnosis Ranked by Frequency
Select FACTILITY: SALT LAKE CITY/ [ENTER] UT 660
Select another FACILITY: [ENTER]
Select PRIMARY DIAGNOSIS ONLY (P) or ALL DIAGNOSES (A): P// Primary Diagnosis Only
Enter ENCOUNTER BEGINNING DATE: T-30 (JUN 29, 1996)
Enter ENCOUNTER ENDING DATE: Jul 29, 1996/ [ENTER] (JUL 29, 1996)
This report will include all VA clinic encounters for all patients unless you modify the criteria. Do you want to modify the criteria?
Enter Y (YES) or N (NO) N// YES
Encounters may be selected by any combination of the following attributes:
  1  Service Category
  2  Clinic Stop Code
  3  Provider
  4  Age of Patient
  5  Sex of Patient
  6  All Encounters
Enter encounter selection attribute number(s) : (1-6): 1-3
Select SERVICE CATEGORIES: AI// ?
A  AMBULATORY
H  HOSPITALIZATION
I  IN HOSPITAL
T  TELECOMMUNICATIONS
```
**Criteria for Frequency of Diagnoses Report**

- **Encounter diagnoses:** Primary Diagnosis Only
- **Encounter date range:** Jun 29, 1996 through Jul 29, 1996
- **Selected Providers:** Primary Providers
- **Selected clinics:** YES
- **Patient age range:** ALL
- **Patient sex:** ALL
- **Service categories:**
  - A - AMBULATORY
  - I - IN HOSPITAL

- **Maximum number of diagnoses to be displayed:** 10

**Facility:** SALT LAKE CITY 660

**Clinic Stop:** CARDIOLOGY (143)

Total number of Encounters meeting the selection criteria: 54
Total number of Primary Diagnoses for these Encounters: 43
Diagnoses/Encounter ratio: 0.80

**10 Most Frequent ICD9 Diagnoses:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>401.1</td>
<td>BENIGN HYPERTENSION</td>
<td>10</td>
</tr>
<tr>
<td>100.0</td>
<td>LEPTOSPIROS ICTEROHEM</td>
<td>6</td>
</tr>
<tr>
<td>V70.3</td>
<td>MED EXAM NEC-ADMIN PURP</td>
<td>4</td>
</tr>
<tr>
<td>440.20</td>
<td>ATHEROSCL, NAT ART EXTR, UNSP</td>
<td>3</td>
</tr>
<tr>
<td>321.0</td>
<td>CRYPTOCCAL MENINGITIS</td>
<td>3</td>
</tr>
<tr>
<td>223.0</td>
<td>BENIGN NEOPLASM KIDNEY</td>
<td>3</td>
</tr>
<tr>
<td>200.02</td>
<td>RETICULOSARCOMA THORAX</td>
<td>2</td>
</tr>
<tr>
<td>550.10</td>
<td>UNILAT ING HERNIA W OBST</td>
<td>1</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit.
10 Most Frequent ICD9 Diagnoses:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>402.00</td>
<td>MAL HYPERTEN HRT DIS NOS</td>
<td>1</td>
</tr>
<tr>
<td>224.0</td>
<td>BENIGN NEOPLASM EYEBALL</td>
<td>1</td>
</tr>
</tbody>
</table>

10 Most Frequent ICD9 Diagnostic Categories:

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIRCULATORY SYSTEM</td>
<td>14</td>
</tr>
<tr>
<td>NERVOUS SYSTEM</td>
<td>7</td>
</tr>
<tr>
<td>INFECTIOUS &amp; PARASITIC</td>
<td>6</td>
</tr>
<tr>
<td>HEALTH STATUS FACTORS</td>
<td>4</td>
</tr>
<tr>
<td>KIDNEY &amp; URINARY TRACT</td>
<td>4</td>
</tr>
<tr>
<td>MYELOPROLIFERATIVE,NEOPLASIA</td>
<td>2</td>
</tr>
<tr>
<td>DIGESTIVE SYSTEM</td>
<td>2</td>
</tr>
<tr>
<td>MENTAL DISEASES &amp; DISORDERS</td>
<td>1</td>
</tr>
<tr>
<td>FEMALE REPRODUCTIVE SYSTEM</td>
<td>1</td>
</tr>
<tr>
<td>EAR, NOSE, MOUTH &amp; THROAT</td>
<td>1</td>
</tr>
</tbody>
</table>

Facility: SALT LAKE CITY  660
Clinic Stop: DIABETES (146)

Total number of Encounters meeting the selection criteria:  21
Total number of Primary Diagnoses for these Encounters:     16
Diagnoses/Encounter ratio:                         0.76

9.2.12. Provider Encounter Counts

This report provides the number of PCE outpatient encounters within an encounter date range, by provider. The user specifies report selection criteria and then chooses either a summary report or detailed report.

The report can be generated using a number of different selection criteria:
Facility – enter the names or numbers of the facilities whose encounters will be included in the report.

Encounter Date Range – only encounters that fall within the specified date range are used to generate the report.

Service Category – only encounters with the specified service category or categories are used to generate the report. This defaults to "AI" for Ambulatory encounters and clinic encounters where the patient had an inpatient status.

Provider Criteria – Can specify All Providers with encounters, Primary Providers with encounters, Selected Providers, or Selected Person Classes.

Providers – only encounters where one of the encounter providers is the same as one of the providers selected are used to generate the report.

Primary Providers – only encounters where one of the encounter providers is designated as a Primary provider are used to generate the report.

Person class - only encounters where one of the encounter providers has the same person class as one of the person classes selected are used to generate the report.

Person Class Selection – Is based on the PERSON CLASS file, used to support Ambulatory Care Reporting. Person Class entries are composed of three pieces:

- Occupation (required in class definition)
- Specialty (optional)
- Sub-specialty (optional)

The legend for the service categories is included on the top of the report. For example, if on a particular day the provider had three ambulatory encounters and two telecommunications encounters, the string would be "AT" and the number of encounters would be five.

The summary report lists the total number of encounters for each provider.

Select PCE Clinical Reports Option:  Provider Encounter Counts
Select FACILITY: SALT LAKE CITY// [ENTER] UT 660
Select another FACILITY: [ENTER]

Enter ENCOUNTER BEGINNING DATE: T-30 (JUN 29, 1996)

Select SERVICE CATEGORIES: AI// [ENTER]
Select one of the following:
A   All Providers
P   Primary Providers
S   Selected Providers
C   Selected Provider Classes

Select ENCOUNTER PROVIDER CRITERIA: A// Primary Providers

Select PROVIDER: PCEPROVIDER,FOUR
Select another PROVIDER: PCEPROVIDER,FIVE
Select another PROVIDER:
9.2.13. Selected Person Classes

This “Selected Person Classes” option lets you compile a report of selected Person Classes based on occupation, specialty, and/or sub-specialty. A wild card (*) may be entered as a response for any of the Person Class pieces. For example, if you want a report on every provider from a specific specialty, occupation would be “*,” specialty would be the specific specialty, and sub-specialty would be “*.”
C Selected Person Classes

Select ENCOUNT PROVIDER CRITERIA: S// C Selected Person Classes
Select PERSON CLASS (OCCUPATION, SPECIALTY, SUBSPECIALTY)

Select OCCUPATION (enter * for all, return to end selection): *
The currently selected OCCUPATION is: *
Select SPECIALTY (enter * for all, return to change OCCUPATION): PHYSICAL THERAPIST
Select SUBSPECIALTY (enter * for all): *

Your Person Class Selection was:
OCCUPATION: *
SPECIALTY: Physical Therapist
SUBSPECIALTY: *
Is this selection correct? YES

The currently selected OCCUPATION is: *
Select SPECIALTY (enter * for all, return to change OCCUPATION): <Enter>

Select another PERSON CLASS OCCUPATION

Select OCCUPATION (enter * for all, return to end selection): <Enter>

Select one of the following:
S Summary
D Detail by clinic and date

Which type of report: S// <Enter> Summary
DEVICE: HOME// <Enter> VAX RIGHT MARGIN: 70//<Enter>

Sorting encounters done

Feb 07, 1997 8:21:03 am Page 1
PCE Provider Encounter Counts
Criteria for Provider Encounter Summary Report
    Provider selection criteria: Selected Person Classes
    Report date range: Apr 13, 1996 through Feb 07, 1997
    Service categories: AI
        A - AMBULATORY
        I - IN HOSPITAL
Selected Person Classes:
    Occupation: *
    Specialty: Physical Therapist
    Subspecialty: *

____________________________________________________
Facility: SALT LAKE CITY 660

Person Class
Provider (Occupation+Specialty+Subspecialty) Encounters
-----------------------------------------------
PCEPROVIDER,TEN  (Respiratory, Rehabil...+Physical 25
Therapist+Clinical Electrophys...)
PCEPROVIDER,SIX  (Respiratory, Rehabil...+Physical  5
Therapist+Clinical Electrophys...)

Total facility encounters 30
Total encounters 30

End of the report.

9.2.14. Location Encounter Counts
This report provides the number of PCE outpatient encounters within an encounter date range, by location.

The location report selection criteria can be based on facility, hospital location(s), or clinic stop(s). The selection criteria are:

**Facility** – Select the facilities whose encounters are to be included in the report.

**Service Category** – Only encounters with the specified service category or categories are used to generate the report. This defaults to "AI" for Ambulatory encounters and clinic encounters where the patient had an inpatient status.

**Encounter Date Range** – Only encounters that fall within the specified date range are used to generate the report.

**Location Criteria** – Can specify All Hospital Locations, Selected Hospital Locations, All Clinic Stops, or Selected Clinic Stops.

**Hospital Locations** – Only encounters where the encounter's hospital location is the same as one of the selected hospital locations are used to generate the report.

**Clinic Stops** – Only encounters where the encounter's clinic stop is the same as one of the selected clinic stops are used to generate the report.

The report lists the number of encounters alphabetically by the location criteria selected.

---

Select PCE Clinical Reports Option: LE  Location Encounter Counts

Select FACILITY: SALT LAKE CITY// [ENTER] UT 660
Select another FACILITY: [ENTER]

Select SERVICE CATEGORIES: AI// [ENTER]

Enter ENCOUNTER BEGINNING DATE: T-30 (JUN 29, 1996)

Select one of the following:

- HA     All Hospital Locations
- HS     Selected Hospital Locations
- CA     All Clinic Stops
- CS     Selected Clinic Stops

Determine encounter counts for: HA// CA All Clinic Stops

DEVICE: HOME// [ENTER] VAX RIGHT MARGIN: 80// [ENTER]

Jul 29, 1996 12:24:33 pm  Page 1

PCE Location Encounter Counts

Criteria for Clinic Encounter Count Report

- Location selection criteria: All Clinic Stops
- Encounter date range: Jun 29, 1996 through Jul 29, 1996
- Service categories: AI
  - A - AMBULATORY
  - I - IN HOSPITAL

Facility: SALT LAKE CITY  660
<table>
<thead>
<tr>
<th>Clinic Stop (Stop Code)</th>
<th>No. of Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMITTING/SCREENING</td>
<td>(102)</td>
</tr>
<tr>
<td>CARDIOLOGY</td>
<td>(303)</td>
</tr>
<tr>
<td>DIABETES</td>
<td>(306)</td>
</tr>
<tr>
<td>GASTROENTEROLOGY</td>
<td>(307)</td>
</tr>
<tr>
<td>GENERAL INTERNAL MEDICINE</td>
<td>(301)</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>(409)</td>
</tr>
</tbody>
</table>

Total facility encounters: 122
Total encounters: 122

End of the report

9.2.15. Key Concepts

- You can produce reports for Caseload Profile by Clinic, Workload by Clinic, Frequency of Diagnoses, Location Encounter Counts, Provider Encounter Counts, and Patient Activity by Clinic.

- All reports can be customized to show only specified date ranges, clinics, providers, types of encounters (cancelled, walk-ins, etc.), etc.

- The reports extract data from various files in VISTA, including laboratory, pharmacy, and PIMS to create output reports which have been requested by physicians throughout the VA.

- Caseload Profile by Clinic provides a measure of continuity of care. If a provider of record has his or her care-giving interrupted through clinical rotation, leave, reassignment, or for any other reason, this report may be used to get an update on patient activities in his/her caseload.

- Workload by Clinic provides a summary of clinic workload based on the evaluation and management codes associated with encounters.

9.3. Missing Data Report

The Missing Data Report (MDR) option is available from the PCE Coordinator menu. The MDR identifies CIDC data elements missing from PCE.

Who can use this report?

This report provides the HIMS (Health Information Management Systems) staff the ability to sort encounters missing CIDC data using a variety of specific data items. It allows the printing of two formats, statistics versus detail, in order to perform trending for possible follow-up with providers for education/training purposes.

Note: The MDR must be printed to a 132 column device in order to view the entire data set.

See Appendix for a sample MDR Report sorted by Data Source.
10.0 Supplementary Material

10.1. Helpful Hints

The Automated Information Collection System (AICS) package includes a Print Manager that allows sites to define reports that should print along with the encounter forms. This can save considerable time preparing and collating reports for appointments. See the Automated Information Collection System User Manual for instructions.

You can add Health Summary, Problem List, and Progress Notes as actions to PCE, to allow quick access to these programs. When you press the [RETURN] key at the quit prompts (or up-arrow out), you are automatically returned to PCE.

Since problems can occur if you delete patients (the internal entry number of the file can be reassigned, causing discrepancies in the data), we recommend that you NOT delete any patients.

If clinical reminders aren't showing up correctly on Health Summaries, see Appendix A-7 of the PCE User Manual Appendices document for troubleshooting information. (PXRMDEV is a routine that can be used to aid in the development and customization of reminders.)

If you see zeroes instead of numbers on encounter dates (e.g., 00/00/95 or 01/00/96)—on reports or encounter displays—they are for Historical Encounters where the exact date is not known.

Shortcuts

After Diagnosis has been entered, if the Provider Narrative is an exact match, you can enter = and the diagnosis is duplicated.

The equals sign (=) can also be used as a shortcut when selecting an action plus encounters or appointments from a list in a single response (e.g., Select Action: ED=2).

To quickly add or edit encounter information, select an appointment number at the first appointment screen.

10.2. Frequently Asked Questions

Q: What is the 10/1/96 mandate and how does PCE fit into it?
A: The Veterans Health Administration has determined that it must have adequate, accurate, and timely information about each ambulatory care encounter/service provided in order to enhance patient care and to manage our health care resources into the future. Effective October 1, 1996, VHA facilities are required to report each ambulatory encounter and/or ancillary service. Provider, procedure, and diagnosis information is included in the
minimum data set that will be reported to the National Patient Care Data Base (NPCDB). The Ambulatory Data Capture Project (ADCP) was formed to coordinate the various VISTA packages involved in meeting this mandate.

Patient Care Encounter (PCE) ensures that every encounter has an associated provider(s), procedure code(s), and diagnostic code(s), in accordance with this mandate.

Software necessary to support ADCP:

- Automated Information Collection System (AICS) and other capture solutions
- Patient Care Encounter (including):
  - Visit Tracking v.2.0
  - Patch SD*5.3*27
  - Patch GMT*2.7*8
- Problem List
- Patient Information Management System
- National Patient Care Data Base.

Other Patches involved in the 10/1/96 mandate:

<table>
<thead>
<tr>
<th>Patch</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XU<em>8</em>27</td>
<td>Person Class File and Utilities</td>
</tr>
<tr>
<td>IB<em>2</em>60</td>
<td>Collects Type of Insurance, Passes active Ambulatory Surgery Procedure codes to PCE Enables entry of providers and diagnoses interactively into PCE</td>
</tr>
<tr>
<td>RA<em>4.5</em>4</td>
<td>Interfaces with PCE to pass provider and procedure data for ambulatory Radiology/Nuclear Medicine encounters</td>
</tr>
<tr>
<td>LR<em>5.2</em>127</td>
<td>Interfaces with PCE to pass provider and procedure data for ambulatory Laboratory encounters</td>
</tr>
<tr>
<td>IBD<em>2.1</em>2</td>
<td>AICS Manual Data Entry functionality</td>
</tr>
<tr>
<td>GMRV<em>3</em>3</td>
<td>Measurement Data collected via AICS passed through PCE Device Interface to Vitals/Measurement Pkg</td>
</tr>
<tr>
<td>SD<em>5.3</em>44</td>
<td>Ambulatory Care Reporting Patch</td>
</tr>
</tbody>
</table>

Q. How does PCE collect and report on diagnosis and procedures that are checked off on the DIAGNOSIS and CPT PROCEDURE tool kit boxes on Encounter Forms?
A:  Items that are checked off in the above mentioned tool kit boxes are validated and stored by PCE into PCE files and then shared with other subscribing packages such as Scheduling.

Two PCE Health Summary Components, Outpatient Diagnosis and Outpatient Encounter, display diagnosis and procedure information:

- The Outpatient Diagnosis Component displays the date of the encounter, the facility, the hospital location, the encounter eligibility, the provider(s), the diagnoses, ICD9 or ICD10 code, ICD9 or ICD10 text and Provider Narrative.
- The Outpatient Encounter component displays all the information included in the Outpatient Diagnosis component plus the procedure(s), CPT code, short description and Provider Narrative.

If an immunization or skin test is collected by PCE through any of the four data collection interfaces PCE supports, data is stored in the procedure file and the Immunization or Skin Test file. Immunization or Skin Test information is included in the Outpatient Encounter component displays.

In addition, there are separate PCE Skin Test and Immunization components which only display information specific to Skin Tests and Immunizations. The Immunization component displays immunization, series, date, facility, and reaction. The Skin Test component displays skin test, reading, results, reading date, facility.

If you want to display Patient Education, treatments, examinations, and health factor information using the PCE Health Summary components, check the specific EF tool kit boxes. Otherwise that information is to be entered manually either through AICS manual data entry or PCE manual data entry.

PCE also exports six clinical reports. Two of those reports display diagnosis data related to the numbers of patients associated with the identified diagnoses: Caseload Profile by Clinic and Diagnosis Ranked by Frequency.

Q:  Explain how "Health Factors" in PCE and AICS are to be used and how this data may eventually be shared within a VISN. How are the level/severity modifiers (SEVERE, MOD and MIN) used in health factors when the health factors are not consistent with such quantification:

A:  Here's a little background. The Indian Health Service used the Health Factors originally. The HEAVY, MODERATE, MINIMUM SEVERITY modifiers can be used with a health factor if clinicians wish to define their factors in a manner that makes these modifiers useful. They do not have to be used where they do not make sense.

AICS allows encounter form designers to include health factors on their encounter forms, with or without these modifiers. The health factors that are checked off by clinicians can be captured via scanning and stored in the V Health Factor file.
The initial set of health factor entries was defined by Indian Health Service. The SLC IRMFO added additional health factors based on feedback from a supporting clinical team, and the Ambulatory Care EP.

The Health Summary package has a Health Factor component which shows the latest health factors for each health factor category. If modifiers were collected for the health factors, they would be displayed in this component. The PCE clinical reminders do not use the health factor modifier, though they do use the existence of a patient's health factor to modify the reminder criteria.

The health factor information can be viewed as risk assessment or risk factor data which could provide useful information to guide the clinician as the care giver. For example, the PCE package includes a predefined clinical reminder for determining whether tobacco education needs to be given to the patient. The Health factors distributed with PCE include the Health factor category of TOBACCO and within that category of health factors is a factor for "LIFETIME NON-SMOKER." If a clinician had a patient who never has smoked or used any form of tobacco, the reminder will not come up for the patient if the health factor for "LIFETIME NON-SMOKER" has been captured off the encounter form.

We expect to learn a lot about what clinicians really would like to do with health factors as the clinicians begin using them with the reminders.

**11.0 Device Interface Error Reports**

The PCE Device Interface Error Report lets you look up PCE device interface errors by Error Number, Error Date and Time, Encounter Date and Time, or by Patient Name.

```
Select PCE Coordinator Menu Option: die  PCE Device Interface Error Report
Select one of the following:
ERN     Error Number
PDT     Processing Date and Time
EDT     Encounter Date and Time
PAT     Patient Name

Look up PCE device interface errors based on: ERN//  Error Number
Enter the beginning error number: (1-4): 1//  [ENTER]
Enter the ending error number:   (1-4): 4//  [ENTER]

DEVICE: HOME//  [ENTER] VAX  RIGHT MARGIN: 80//  [ENTER]

May 24, 1996 4:10:05 pm  Page 1

PCE Device Interface Error Report

Report based on Error Numbers 1 through 4.

Error Number: 1
  Patient: PCEPATIENT,ONE 000-45-6789
  Encounter date: May 06, 1996@14:53:17
  Processing date: May 06, 1996@16:18:53

  File: 9000010.07 (V POV)  Field .04 (PROVIDER NARRATIVE)
```
### 12.0 Glossary

**ADCP:** Ambulatory Data Capture Project. ADCP was formed to coordinate the various VISTA packages involved in meeting this mandate. AICS Automated Information Collection System, formerly Integrated Billing, the program that makes Encounter Forms.

**Action:** A functional process that a clinician or clerk uses in the PCE computer program. For example, “Update Encounter” is an action that allows the user to pick an encounter and edit information that was previously entered (either through PCE or the PIMS Checkout process), or add new information (such as an immunization or patient education).

**Appointment:** A scheduled meeting with a provider or at a clinic; can include several encounters with other providers or clinics for tests, procedures, etc.

**Checkout Process:** Part of Medical Administration (the PIMS package), the checkout process can create appointments which are entered into the PCE component.

**Clinic:** An entry in the HOSPITAL LOCATION File #44 with a TYPE="C". Clinics must have stop codes in compliance with their restriction type. (See: Conforming Clinics; Non-conforming Clinics).

**Clinician:** A doctor or other provider in the medical center who is authorized to provide patient care.

**Conforming Clinics:** Clinics that have stop codes in compliance with their restriction types. Stop codes are used in accordance to their assigned restriction types. Stops codes with restriction type 'P' can only be used in the primary stop code position. Stop codes with restriction type 'S' can only be used in the secondary stop code position. Stop codes with restriction type 'E' can be used in either the primary or secondary stop code position.
**CPRS:** Computerized Patient Record System, a clinical record system which integrates many VISTA packages to provide a common entry and data retrieval point for clinicians and other hospital personnel.

**CPT:** Common Procedure Terminology; a method for coding procedures a performed on a patient, for billing purposes.

**CSV:** Code Set Versioning. This package is mandated under the Health Information Portability and Accountability Act (HIPAA). It contains routines, globals and data dictionary changes to recognize code sets for the International Classification of Diseases, Clinical Modification, Ninth Revision (ICD-9-CM), International Classification of Diseases, Clinical Modification, Tenth Revision (ICD-10-CM), Current Procedural Terminology (CPT) and Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). When implemented, the applications below will allow users of these three code systems to select codes based upon a date that an event occurred with the Standards Development Organization (SDO)-established specific code that existed on that event date.

**Encounter:** Each patient meeting with a provider, during an appointment, by telephone, or as a walk-in. A patient can have multiple encounters for one appointment or during a single visit to a VAMC.

**Encounter Form:** A paper form used to display data pertaining to an outpatient visit and to collect additional data pertaining to that visit. The AICS package is automating encounter forms.

**Episode of Care:** Many encounters for the same problem can constitute an episode of care. An outpatient episode of care may be a single encounter or can encompass multiple encounters over a long period of time. The definition of an episode of care may be interpreted differently by different professional services even for the same problem. Therefore, the duration of an episode of care is dependent on the viewpoints of individuals delivering or reviewing the care provided.

**Health Summary:** A Health Summary is a clinically oriented, structured report that extracts many kinds of data from VISTA and displays it in a standard format. The individual patient is the focus of health summaries, but health summaries can also be printed or displayed for groups of patients. The data displayed covers a wide range of health-related information such as demographic data, allergies, current active medical problems, laboratory results, etc.

**Indian Health Service (IHS):** IHS developed a computer program similar to VA’s VISTA, which contains Patient Care Component (PCC) from which PCE and many of its components were derived.

**Inpatient Visit:** Inpatient encounters include the admission of a patient to a VAMC and any clinically significant change related to treatment of that patient. For example, a treating specialty change is clinically significant, whereas a bed switch is not. The clinically significant visits created throughout the inpatient stay
would be related to the inpatient admission visit. If the patient is seen in an outpatient clinic while an Inpatient, this is treated as a separate encounter.

**Integrated Billing (IB):** A VISTA package responsible for identifying billable episodes of care, creating bills, and tracking the whole billing process through to the passing of charges to Accounts Receivable (AR). Includes the Encounter Form utility.

**MCCR:** Medical Care Cost Recovery, a VISTA entity which supports Integrated Billing and many data capture pilot projects related to PCE.

**Non-conforming Clinics:** Clinics with stop codes that do not comply with the assigned stop code restriction types of P=Primary, S=Secondary and E=Either.

**NPCDB:** National Patient Care Data Base, a database maintained in Austin which stores the minimum data set for all ambulatory care encounters.

**Occasion of Service:** A specified instance of an act of service involved in the care of a patient or consumer which is not an encounter. These occasions of service may be the result of an encounter; for example, tests or procedures ordered as part of an encounter. A patient may have multiple occasions of service per encounter or per visit.

**Outpatient Visit:** The visit of an outpatient to one or more units or facilities located in or directed by the provider maintaining the outpatient health care services (clinic, physician’s office, hospital/medical center) within one calendar day. Outpatient encounters include scheduled appointments and walk-in unscheduled visits. A clinician’s telephone communications with a patient may be represented by a separate visit entry.

**Person Class:** An enhancement to the New Person file, XU*8*27 NEW PERSON File Patch (8/5/96), which enables all VAMC providers to be assigned a Profession/Occupation code (Person Class) so that a Person Class can be associated with each ambulatory patient encounter by October 1, 1996.

**Procedure (CPT):** A test or action done for or to a patient that can be coded with the CPT coding process.

**Provider:** A person who furnishes health care to a consumer; such as a professionally licensed practitioner who is authorized to operate a health care delivery facility. This definition includes an individual or defined group of individuals who provides a defined unit of health care services (defined = codable) to one or more individuals at a single session.

**Stop Code:** A three-digit number corresponding to an additional stop/service a patient received in conjunction with a clinic visit. Stop code entries are used so that medical facilities may receive credit for the services rendered during a patient visit.

**Visit:** Each encounter with a provider during a patient’s appointment; can also be a telephone call or a walk-in.
**Visit Tracking:** A VISTA package which links patient-related information in a file structure that allows meaningful reporting and historically accurate categorization of patient events and episodes of care.

**VISTA:** Veterans Information System Technology Architecture.

### 13.0 Appendix – Sample MDR Report

Report example sorted by Data Source

<table>
<thead>
<tr>
<th>Patient SSN</th>
<th>Date/Time</th>
<th>Enc. ID</th>
<th>Created by</th>
<th>User</th>
<th>Defect</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTPATIENT DIAG (BAY PINES)</td>
<td>Unknown</td>
<td>NOV 03, 2004</td>
<td>----------------------------------------------------------\</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PCEpatient, One 000-00-0001 NOV 03, 2004@14:18 HMX8P-BAY PCEprovider, One Procedure: 73110 missing assoc. DXs Diagnosis: 171.6 missing Service Conn Diagnosis: 171.2 missing SC/EI

**TOTAL DEFECTS FOR HMX8P-BAY:** 1

**TOTAL DEFECTS FOR OCT 25, 2004:** 1
**TOTAL ENCOUNTERS FOR OCT 25, 2004:** 1
**TOTAL DEFECTS FOR SORT VALUE - RAD/NUC MED:** 3
**TOTAL ENCOUNTERS FOR SORT VALUE - RAD/NUC MED:** 1
**TOTAL DEFECTS FOR Unknown:** 3
**TOTAL ENCOUNTERS FOR Unknown:** 1
**TOTAL DEFECTS FOR OUTPATIENT DIAG (BAY PINES):** 3
**TOTAL ENCOUNTERS FOR OUTPATIENT DIAG (BAY PINES):** 1