

PATIENT CARE DATA CAPTURE AND CLOSEOUT

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states requirements and responsibilities for a standardized method to capture all clinical interactions as patient abstracts and establishes timelines required for closeout.

2. SUMMARY OF MAJOR CHANGES: This directive:

- a. Combines requirements for data capture and closeout into a single directive.
- b. Removes reference to the National Patient Care Database, which is no longer in use.
- c. Replaces software-specific terms (e.g., Veterans Information Systems and Technology Architecture, Computerized Patient Record System) with the general term “electronic health record” to accommodate future technology system changes.
- d. Updates terminology from “encounter” to “abstract” to better describe the focus of this directive and ensure consistent and clear uses and definitions are applied.

3. RELATED ISSUES: VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021.

4. RESPONSIBLE OFFICE: The Office of Health Information Governance (105HIG) is responsible for the content of this directive. Questions may be addressed to 971-212-0055 or VHAHIGHIMVAStaff@va.gov.

5. RESCISSIONS: VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015, and VHA Directive 1233, Closeout of Veterans Health Administration Corporate Patient Data Files Including Quarterly Patient Census, dated June 14, 2017, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of March 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

March 9, 2023

VHA DIRECTIVE 1082

**BY DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Steven Lieberman, MD, MBA
Deputy Under Secretary for Health

NOTE: *All references herein to Department of Veterans Affairs (VA) and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on March 9, 2023.

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PATIENT CARE DATA CAPTURE AND CLOSEOUT

1. PURPOSE

This Veterans Health Administration (VHA) directive states policy requiring the capture of all clinical interactions as patient abstracts (representing outpatient professional services, inpatient stays, inpatient visits in outpatient clinics, inpatient mental health services, rehabilitation treatment program services, inpatient clinical pharmacy services, surgical services and other professional services in support of revenue operations) and defines the closeout requirements for entering the abstracted data into VHA corporate data files. **AUTHORITY:** 38 U.S.C. §§ 7301(b), 7311(a).

2. BACKGROUND

a. Department of Veterans Affairs (VA) medical facilities are required to electronically report abstracted data representing the provision of care in VHA, including inpatient and outpatient VA medical facility and professional services, for inclusion in corporate data files used by VHA leadership and others for reporting, resource allocation, research and revenue.

b. This directive provides requirements and definitions to standardize methods for capture of clinical interactions by VA health care providers.

c. VHA is required to utilize data definitions for clinical and administrative data promulgated by internationally and nationally recognized standard-setting organizations and statutes (e.g., Health Insurance Portability and Accountability Act of 1996 (HIPAA)).

3. DEFINITIONS

a. **Abstract.** An abstract is a record in the electronic health record (EHR) that contains the coded data elements and additional administrative data used to represent the clinical interaction. **NOTE:** *Abstracts may refer to Veterans Information Systems and Technology Architecture (VistA) Patient Care Encounters (PCEs) in the outpatient setting, formerly referred to as “encounters”, VistA Patient Treatment Files (PTFs) in the inpatient setting or Cerner Encounters which include both inpatient and outpatient care settings.*

b. **Clinical Interaction.** A clinical interaction is an encounter between a patient and clinical professional resulting in surgical services, inpatient visits in outpatient clinics, inpatient mental health services, inpatient clinical pharmacy services, outpatient professional services, inpatient stays, rehabilitation treatment program services or other professional services. A clinical interaction also includes a clinical professional’s request for opinions or recommendations for treatment plans from another clinical professional.

c. **Closeout.** Closeout is the process of recording, completing and submitting an abstract representing a clinical interaction to the Austin Information Technology Center and receiving acceptance within the VHA corporate data file without error.

d. **Electronic Health Record.** EHR is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), VistA and Cerner platforms. ***NOTE: The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.***

e. **Health Professions Trainee.** A Health Professions Trainee (HPT) is an individual appointed under 38 U.S.C. §§ 7405 or 7406 who is participating in clinical or research training under supervision to satisfy program or degree requirements. HPT is a general term to describe undergraduate, graduate and post-graduate students, interns, residents, chief residents, fellows, VA advanced fellows and pre- and post-doctoral fellows who spend all or part of their training experiences at VA medical facilities. Some HPTs may be in non-clinical training fields but train in patient areas or use VA patient records or data in their training.

f. **Non-Count.** Non-count is a designation associated with an abstract based on the clinic location representing work performed that does not meet the definition of a reportable clinical interaction or all the requirements in paragraph 6.

g. **Occasion of Service.** An occasion of service is a specified, identifiable instance of activity provided in conjunction with an overall service which is not an independent clinical interaction and does not require independent clinical judgment in the overall diagnosis, evaluation and treatment of the patient's condition(s). Occasions of service are the result of a clinical interaction. Examples include clinical laboratory tests, radiological studies, physical medicine interventions, medication administration and vital sign monitoring.

h. **VHA Corporate Data Files.** VHA corporate data files are copies of VA medical facility-reported abstracts that have completed closeout within 7 calendar days of the last treatment date. VHA corporate data files are utilized for national reporting, funding allocation determinations, health care planning, cost accounting and performance monitoring.

4. POLICY

It is VHA policy that VA medical facilities capture, report and document complete abstracts, including representation of clinical care by coded data governed by HIPAA, for inclusion in VHA corporate data files within 7 calendar days of the last treatment date for all clinical interactions that occur at VA medical facilities or are paid for by VA, in accordance with standard HIPAA data recording and reporting requirements. For patients admitted but not yet discharged at the time of the quarterly census, it is VHA policy that a quarterly census abstract must be captured, reported and completed within 7 calendar days of the end of the quarter representing the care provided during the quarter. Occasion of service activities must not be recorded as separate abstracts.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health.** The Deputy Under Secretary for Health is responsible for supporting the VHA Health Information Management (HIM) Program Office with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, VHA Health Information Governance Program Office.** The Executive Director, VHA Health Information Governance Program Office is responsible for providing oversight of the VHA HIM Program Office to ensure compliance with this directive.

e. **Director, VHA Health Information Management Program Office.** The Director, VHA HIM Program Office is responsible for:

(1) Providing oversight for the VISN and VA medical facility compliance with this directive and ensuring corrective action is taken when non-compliance is identified through coordination with other offices and stakeholders, as appropriate.

(2) Providing clarifying guidance for VISNs and VA medical facility staff, including VA medical facility Chiefs of HIM (CHIMs), regarding all data capture and closeout processes.

(3) Providing VHA-specific HIM ad hoc training, tools and resources.

(4) Coordinating with other VHA program offices and departments to communicate and provide guidance on the data capture requirements and closeout process.

f. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Ensuring all clinical interactions represented as abstracts for an outpatient visit or inpatient stay within the VISN are recorded, complete and have supporting documentation within 7 calendar days of the last treatment date.

(3) Ensuring EHR systems are current and up to date in accordance with nationally distributed software, software patches and content as made available by VA's Office of Information Technology.

(4) Ensuring the VA medical facility Director holds staff accountable for completion of the required documentation in the patient's health record to support any abstract data recorded within 7 calendar days of the last treatment date.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring clinical staff document clinical information in the EHR in conformance with legal health records as outlined in VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021, including defining the provider of service, identification of patient, date and time of service, place of service, modality in which the service is provided, patient diagnoses or reason for the visit, services provided to the patient and treatment related to special authorities for medical care, time spent providing the care and disposition of the patient (see paragraph 6.c.(9)).

(2) Ensuring the provider of the services, in outpatient clinical settings and inpatient professional services, completes the abstract within 7 calendar days of the last treatment date. Any documentation to support the reported abstract, in the form of a progress note or equivalent in the EHR, must also be completed within 7 calendar days of the visit date.

(3) Ensuring psychiatrists, psychologists, licensed clinical social workers, pharmacists and Advanced Practice Providers (e.g., Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA) and Physician Assistant (PA)) document in the patient's health record and complete the abstract of the clinical interaction on all mental health professional services provided in an inpatient or residential rehabilitation setting. **NOTE:** *For minimum clinical data requirements for data entry, see paragraph 6.c.(9).*

(4) Ensuring a process is in place for review, acceptance and maintenance of any VISN or VA medical facility-created electronic encounter form templates or other documentation templates prior to implementation.

(5) Ensuring a process is in place to implement regular updates for any VHA HIM Program Office-provided national electronic encounter form templates provided on a quarterly basis.

(6) Ensuring a process is in place to monitor accuracy, completion and acceptance of all data abstracts and supporting documentation within 7 days of the last treatment date for inclusion in VHA corporate data files. This includes reviewing abstract completion status reports from the VA medical facility CHIM or designee.

(7) Ensuring a process is in place for auditing and providing education to VA clinicians (at least annually) to ensure abstracts are at or above the accepted minimum standard of 95% accuracy based on documentation in the patient's health record.

(a) Education must be targeted based on the result of the audit with a plan of action for any individual falling below acceptable thresholds until the acceptable level of accuracy is achieved.

(b) Audit results and any corrective action must be reported to the VA medical facility Integrity and Compliance Committee as a plan to improve abstracted data accuracy until it reaches acceptable standards consistently. Clinicians identified for review and audit are limited to Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), PAs and CNPs CNMs and CNSs. Additional staff may be included at the VA medical facility's discretion and should be outlined in VA medical facility standard operating procedures for additional disciplines and services.

(8) Ensuring a process is in place to monitor and track that all abstracts representing clinical care provided are completed within the timeframes outlined and contain supporting documentation in the patient's health record.

(9) Ensuring that all authorized community care that is provided is paid for by VA (e.g., acute inpatient and nursing home care provided to patients in the community) and is represented in VHA corporate data files, either by completion of an abstract or use of community provider claims. **NOTE:** *Community care claims may be processed and paid up to 180 days from the discharge date.*

(10) Ensuring a process is in place so all clinic locations are created and maintained with appropriate Decision Support System (DSS) identifier(s) as outlined by the VHA Managerial Cost Accounting Office (formerly the DSS Program Office).

h. **VA Medical Facility Chief, Health Information Management.** The VA medical facility CHIM is responsible for:

(1) Ensuring a quarterly census abstract is performed and completed for all bed occupants for which VA is responsible, except Contract Nursing Homes and State Veterans Homes.

(2) Ensuring VA medical facility HIM coding staff complete the coding and validate data capture for all inpatient admissions and surgical cases in the appropriate application.

(3) Ensuring a process is in place for auditing and providing education to VA health care providers and HIM coders in order to ensure that abstract coding is at or above the accepted minimum standard of 95% accuracy based on documentation in the patient's health record.

(4) Ensuring that trained and competent coding staff perform content validation of the codes included on the encounter form templates used for code picklists using the

Automated Information Collection System.

(5) Ensuring HIPAA code sets, including International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), for any locally created encounter form templates conform to the definitions and conventions included in the appropriate coding publications mandated by HIPAA and VHA coding guidelines. If VHA HIM nationally provided encounter form templates require installation and association with appropriate clinics, content updates are provided by VHA HIM Program Office.

(6) Monitoring and reporting status of abstract and health record documentation completion timeliness to the staff identified by the VA medical facility who is responsible for ensuring compliance, accountability and developing an action plan when necessary, including the VA medical facility Director.

(a) Education must be targeted based on the result of the audit with a plan of action for any individual falling below acceptable thresholds until the acceptable level of accuracy is achieved.

(b) Audit results and any corrective action must be reported to the VA medical facility Integrity and Compliance Committee as a plan to improve coding accuracy until it reaches minimum accuracy standard.

(7) Ensuring VA medical facility HIM professionals edit and update abstracts in the outpatient setting based on review and validation of documentation to ensure accuracy for all cases billed to third-party payers in accordance with the HIM and Consolidated Patient Accounting Center service-level agreement.

i. **VA Health Care Provider.** VA health care providers are responsible for:

(1) Documenting care in the EHR (e.g., using a progress note) in accordance with VHA Directive 1907.01 as evidence to support the abstract. **NOTE:** *HPTs must follow documentation requirements outlined in VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019; VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015; and VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016, based on the VA health care provider who is independently responsible for care, assessment, delivery, abstract completion and documentation in the patient's legal health record.*

(2) Completing the abstract for outpatient care, inpatient mental health and rehabilitation professional services within 7 calendar days of the last treatment date and ensuring it accurately reflects the minimum required clinical data elements (see paragraph 6.c.(9)), including but not limited to code assignment for diagnosis and services provided. **NOTE:** *Documentation to support the reported abstract in the form of a progress note or equivalent in the EHR must also be present and completed within 7 days of the visit date.*

6. PATIENT CARE DATA CAPTURE AND CLOSEOUT REQUIREMENTS

a. The abstract contains the coded data elements and additional administrative data used to represent a clinical interaction. VHA Coding Guidelines are followed to record the coded data to support the continuity of patient care, resource allocation, performance measurement, quality management, provider productivity, research and third-party payer collections and reporting accuracy. **NOTE:** For more information about VHA Coding Guidelines, see <https://dvagov.sharepoint.com/sites/vhahealth-information-management/Coding%20Resources/VHA%20Coding%20Guidelines>. This is an internal VA website that is not available to the public.

b. Accuracy of all coding must be maintained at or above the identified acceptable level of 95% accuracy by both clinical staff and coders. **NOTE:** For additional information, see VHA HIM Clinical Coding Program Guide at <https://dvagov.sharepoint.com/sites/vhahealth-information-management/Coding%20Resources/VHA%20Coding%20Guidelines>. This is an internal VA website that is not available to the public.

c. The provider is responsible for documenting the clinical interaction, including review, evaluation, assessment and plan, in a progress note or other applicable document type (e.g., diagnosis or care delivery) and additionally must record in the abstract the diagnosis or reason for visit with highest degree of specificity known represented by ICD-10-CM code for the visit and CPT/HCPCS for service(s) provided as well as location, DSS identifiers (e.g., stop code(s)) and indication of treatment related to service connected or special authority conditions when applicable. Abstracts represent care in all settings (e.g., outpatient or inpatient).

(1) Interactions can include face-to-face, video, telephone or secure messaging interactions if the definition of the abstract is met. In order for audio-only telephone services to be reportable, there must be interaction between the patient and provider with the required elements of telephone codes, evaluation and management or medicine section of CPT, performed and documented as applicable, including time spent, assessment, chief complaint or reason for visit, history and medical decision making. Telephone services not meeting this definition must be recorded as historical or associated with non-count location for tracking only.

(2) Contact can occur through secure messaging related to a visit within the last 7 days but cannot be captured as workload as it is considered part of the actual face-to-face visit.

(3) Services incidental to and supporting the clinical interaction between the patient and the primary provider are considered part of the service provided by the primary provider and do not constitute separate reportable service or abstracts separately (e.g., taking vital signs, documenting chief complaint, giving injections, pulse oximetry, administering medications, review of patient's health record, phone calls of test results).

(4) A telehealth contact between a provider and a patient is considered a clinical

interaction when synchronous video technology or store and forward asynchronous technology is utilized as the modality to provide care. Additional information on telehealth services requirements is outlined by the VHA Managerial Cost Accounting Office at http://vaww.dss.med.va.gov/programdocs/pd_oident.asp and the Office of Connected Care Telehealth Program at VHA Telehealth Intranet site at <https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/Forms/AllItems.aspx>. **NOTE:** *These are internal VA websites that are not available to the public.*

(5) All services recorded via an abstract must meet the definition of a clinical interaction and contain the supporting evaluation and medical decision making provided. The specific level of service must be recorded by applying American Medical Association guidelines for CPT/HCPCS code assigned. Additionally, the supporting documentation, in the form of a patient progress note or equivalent, must be present in the patient's health record as evidence of services provided and include these elements along with the modality and time spent performing the service.

(6) The actual services provided to the patient by the provider must be fully and clearly documented and coded using CPT/HCPCS code assignment as the nationally accepted code sets, such as current edition CPT/HCPCS codes.

(7) For purposes of patient care data capture, mental health services include inpatient and residential rehabilitation professional services performed by a psychiatrist with the credentials of MD or DO; a psychologist with the credentials of Doctor of Philosophy (PhD) or Doctor of Psychology (PsyD); licensed clinical social workers; or licensed advanced practice nurses, and PAs with the credentials of CNP, CNS, CNM, CRNA or PA.

(8) All services must be associated with a location and accurate DSS identifiers (e.g., stop codes), to ensure accurate reporting of work performed and resource consumption.

(9) **Minimum Clinical Data Elements.** In addition to the current administrative data elements (e.g., eligibility, period of service and service-related condition information, patient address, next-of-kin), the minimum required clinical data elements for capture in the patient abstract are as follows:

(a) Patient. The person receiving health care services, including the full legal name, date of birth, Social Security Number (SSN) or pseudo-SSN (or other personal identifier) and eligibility.

(b) Diagnosis. Reason for visit, diagnosis or conditions that necessitated the clinical interaction, affected the treatment or were assessed or treated during the clinical interaction, including treatment plan assessed and continued.

1. The following are required to be reported as ICD-10-CM codes: purpose of the abstract noted by the provider as the problem, reason for visit or diagnoses which necessitated the clinical interaction.

2. When more than one problem or diagnosis meets the definition of a reportable condition, the provider must determine which one is the primary reason the patient sought treatment. All additional diagnoses or conditions that affected the treatment of the patient, were assessed, were treated or where treatment was planned during the clinical interaction should be included as additional secondary codes.

(c) Classification Questions. The provider determination of whether or not a treatment was related to any adjudicated service-connected condition or treatment of special authority conditions related to exposure (e.g., Agent Orange, Ionizing Radiation, Military Sexual Trauma, combat Veterans or environmental contaminants) must be based on all conditions treated during the clinical interaction and the abstract must be designated as service-connected or designated as being related to the special authority.

(d) Date and Time of Service. Time is a single entry indicating the time that the clinical interaction was initiated. For all scheduled appointments, the date is the date services are provided. When unscheduled appointments are entered, the abstract date is the date and time the patient presented for interaction.

(e) Place of Service. Information about the location where the service was provided. This includes the three-digit VA medical facility or station identifier, with any applicable suffixes (STA6A), as well as the DSS identifier(s). The place of service must include the five-character medical center national VHA division value. The division value must reflect the location where care was provided.

(f) Primary Provider. A Licensed Independent Practitioner (LIP) or a Licensed Practitioner (LP) providing the service on behalf of the LIP, who is the attending or rendering provider. An HPT must never be listed as the primary provider in an abstracts. When the patient is seen by multiple providers during the same clinical interaction, both independent and non-independent, the provider with highest degree of licensure should be listed as primary. For example, if a nurse and physician both see the patient, the physician should be listed as primary. If the patient is being seen by a PA and a physician within the same clinic visit, the physician would be the primary provider with the PA listed as a secondary provider. If the patient is being seen by a CNP and a physician within the same clinic visit, the primary provider would be the physician. However, if the patient is being seen by a CNP or PA and is treated only by the CNP or PA, the individual who is CNP/PA should be listed as the primary provider designated on the abstract.

d. All abstracts representing inpatient and outpatient care must be complete and error free within 7 calendar days of the treatment date (e.g., date of discharge, quarterly census date, visit date of service) for inclusion in VHA corporate data files. Census abstracts must be complete and error free within 7 calendar days of the end of the quarter. **NOTE: Example of date calculation: if a patient's Discharge Date is January 31, 2016, then the abstract must be closed and accepted no later than February 7, 2016. Date of discharge to date of abstract accepted equals 7 calendar days.**

e. Abstracts containing any erroneous or inaccurate data based on the health record

documentation available at the time of coding must be corrected when it is discovered. There is no time limit on correction of abstract based on documentation available at the time of recording. Changes other than data corrections as mentioned will not be permitted in accordance with ethical coding practices. There are multiple uses for data other than workload and it is important to have the data be as accurate as possible.

f. All coded data represented in patient abstracts may not be billable to third-party payers. Thus, there will be specific circumstances where the abstract, including codes assigned and code sequence, does not match one to one with the bill created for submission to third-party payers based on business rules for payment that require submission in a specific format to support adjudication.

g. Each VA medical facility must be set up with appropriate DSS identifiers. Utilized both locally and nationally, these identifiers describe DSS clinical work units. The VHA Managerial Cost Accounting Office maintains and nationally distributes the list of DSS identifiers which are updated annually. VHA Financial Program Policy Documents and information about the VHA Managerial Cost Accounting Office can be found at http://vaww.mcao.va.gov/programdocs/pd_oident.asp. **NOTE:** *This is an internal VA website and is not available to the public.*

(1) A primary DSS identifier must be assigned to clinic locations in outpatient, residential rehabilitation and inpatient clinic settings. The primary DSS identifier must depict the primary clinical workgroup responsible for the type of service provided during the clinical interaction.

(2) The secondary DSS identifier serves as a modifier to further define the primary workgroup or type of service provided. The DSS identifier(s) for a patient setting must meet the definitions outlined by the VHA Managerial Cost Accounting Office.

h. A VA medical facility including all identified divisions and Community-Based Outpatient Clinics (CBOCs) is considered to be the business entity furnishing health care at the organizational level. Sub-organizational level entities for which data must be retrievable include parent and community site, specific clinic (regardless of whether the site has more than one type of station suffix, e.g., a CBOC), treatment team and individual provider.

7. TRAINING

The following training is **recommended** annually and for all new clinical users who are involved with or responsible for abstract completion: Talent Management System (TMS) course VA 131001971, Data Capture and Closeout.

8. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be

addressed to the appropriate Records Officer.

9. REFERENCES

- a. 38 U.S.C. §§ 7301(b), 7311(a), 7405, 7406.
- b. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.
- c. VHA Directive 1400.09(1), Education of Physicians and Dentists, dated September 9, 2016.
- d. VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021.
- e. VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.
- f. VHA Coding Guidelines: <https://dvagov.sharepoint.com/sites/vhahealth-information-management/Coding%20Resources/VHA%20Coding%20Guidelines>. **NOTE:** *This is an internal VA website that is not available to the public.*
- g. VHA HIM Clinical Coding Program Guide: <https://dvagov.sharepoint.com/sites/vhahealth-information-management/Coding%20Resources/VHA%20Coding%20Guidelines>. **NOTE:** *This is an internal VA website that is not available to the public.*
- h. VHA Managerial Cost Accounting Office: http://vaww.mcao.va.gov/programdocs/pd_oident.asp and http://vaww.dss.med.va.gov/programdocs/pd_oident.asp. **NOTE:** *These are internal VA websites that are not available to the public.*
- i. VHA Office of Connected Care Telehealth Program: <https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/Forms/AllItems.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*