

## **Clinical Reminders**

Version 2.0 Patch PXRM\*2\*4

## **CLINICIAN GUIDE**

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VistA HSD&D Department of Veterans Affairs

#### **Revision History**

Date	Page #	Description	Project Manager	r Technical Writer	
May- July 06	Throughout	Edits per development updates	Tim Landy	JoAnn Green	
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NOTE: Changes throughout the manual made for patch 4 are highlighted in blue.

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# Purpose of This Guide

# Other Sources of Information

This Clinician Guide is designed to help the clinical practitioner understand Clinical Reminders V. 2.0, and to use the functionality to improve patient care and clinical processes. This guide will also give you an overview of the following national VA reminders/dialogs and components:

VA-Ischemic Heart Disease VA-Mental Health VA-GEC Referral VA-Women's Health/CPRS Integration MyHealtheVet Reminders OEF/OIF Reminder

#### **Target Audience**

We have developed this guide for the following types of users:

- Clinicians
- Nurses
- Clinical Application Coordinators (CAC)
- Clinical Reminders Managers

#### **Related Documentation**

The following manuals are available from the VistA Documentation Library (VDL) <u>http://www.va.gov/vdl</u>.

- Clinical Reminders Patch 4 Release Notes (PXRM\_2\_4\_RN.PDF)
- Clinical Reminders Technical Manual (PXRM\_2\_4\_TM.PDF)
- Clinical Reminders Manager Manual (PXRM\_2\_4\_MM.PDF)
- Clinical Reminders V2.0 Setup Guide (PXRM\_2\_SG.PDF)

Other relevant information is also available on the Clinical Reminders website:

http://vista.med.va.gov/reminders/

### Introduction

#### Benefits of Clinical Reminders

From Harvard Innovations award:

The involvement of front-line providers, use of performance measures and universal use of electronic health records have enabled VA to set the national benchmark in quality of care. VistA's computerized system enables key decisions by checking links to automated drug distribution, leading to a significant reduction in the error rate.

VistA is innovative because of its unique linkage with standardized, consistent performance measurement. VA's electronic health records provide patientspecific, comprehensive clinical decision support that results in a performance measurement system that encourages driven evidencebased practice.

#### **Clinical Reminders Overview**

The Clinical Reminder system helps caregivers deliver higher quality care to patients for both preventive health care and management of chronic conditions, and helps ensure that timely clinical interventions are initiated.

Reminders assist clinical decision-making and also improve documentation and follow-up, by allowing providers to easily view when certain tests or evaluations were performed and to track and document when care has been delivered. They can direct providers to perform certain tests or other evaluations that will enhance the quality of care for specific conditions. The clinicians can then respond to the reminders by placing relevant orders or recording clinical activities on patients' progress notes.

Clinical Reminders may be used for both clinical and administrative purposes. However, the primary goal is to provide relevant information to providers at the point of care, for improving care for veterans. The package benefits clinicians by providing pertinent data for clinical decision-making, reducing duplicate documenting activities, assisting in targeting patients with particular diagnoses and procedures or sitedefined criteria, and assisting in compliance with VHA performance measures and with Health Promotion and Disease Prevention guidelines.

#### **Clinical Practice Guidelines**

The Veterans Health Administration (VHA), in collaboration with the Department of Defense (DoD) and other leading professional organizations, has been developing clinical practice guidelines since the early 1990s. Guidelines for the Rehabilitation of Stroke and Amputation and the Care Guide for Ischemic Heart Disease were among the first distributed throughout VHA in 1996 and 1997. Since that time, numerous other guidelines, including guidelines on Diabetes Mellitus, COPD, Major Depressive Disorder, Psychoses, Tobacco Use Cessation, Hypertension, have been developed and distributed for implementation throughout the system.

VHA defines clinical practice guidelines as recommendations for the performance or exclusion of specific procedures or services for specific disease entities. These recommendations are derived through a rigorous methodological approach that includes a systematic review of the evidence to outline recommended practice. Clinical guidelines are seen by many as a potential solution to inefficiency and inappropriate variation in care.

#### Benefits of Clinical Reminders

#### **Clinical Practice Guidelines**

#### **Purpose of Guidelines**

- Assure that the appropriate amount of care is provided (addressing both under & over-utilization)
- Reduce errors and promote patient safety
- Ensure predictable and consistent quality
- Promote learning and research
- Facilitate patient and family education

#### National Clinical Practice Guidelines Council (CPGC)

Veterans Health Administration (VHA) Directive 2002-007 established the National Clinical Practice Guideline Council (NCPGC) to coordinate the adoption, implementation, and evaluation of clinical practice guidelines throughout the system. The Council functions to:

• Prioritize clinical areas for which guidelines need to be developed or adapted/adopted

- Oversee and participate in guideline development and/or adaptation
- Assure maintenance and timely revision of existing guidelines
- Collaborate with DOD regarding the use of guideline development to improve the quality of care and health management across VHA and the Military Health System
- Facilitate implementation of guidelines by coordinating dissemination, consulting on studies, promoting education, and identifying and eliminating barriers to guideline implementation

Benefits of Clinical	Clinical Reminders, Performance Measures, and Clinical Practice Guidelines	
Reminders	Each Veterans Integrated Service Networks (VISN) must comply with performance measures that address Prevention Index/Chronic Disease Index (PI/CDI), as well as with the Health Promotion And Disease Prevention Program Handbook 1120.2, which states that each VHA facility shall have a program to educate veterans with respect to health promotion and disease prevention and to provide veterans with preventive medical care that includes screening and other clinical services.	
	The Clinical Reminders package offers tools to help clinicians comply with these performance measures and guidelines on a patient-by-patient basis. The use of these tools leads to improved patient care.	
	Providers can work with their local Clinical Application Coordinators to set up customized reminders based on local and national guidelines for patient education, immunizations, skin tests, measurements, exams, laboratory tests, mental health tests, radiology procedures, and other procedures.	
	For further information, see the PowerPoint presentation, "Implementing a Clinical Guideline Using Clinical Reminders," available on the national Clinical Reminders web page <u>http://vista.med.va.gov/reminders</u> /	
	The Office of Quality and Performance oversees the VA's performance measure plan. Each year the <u>Performance Measurement Workgroup</u> (PMWG), recommends the annual Network Performance Plan to the Under Secretary for Health. The Plan is formally signed as the Network Director's annual performance appraisal. The specific details of the plan are published annually on the OQP website. <u>http://vaww.oqp.med.va.gov/default.htm</u>	

Benefits of	Functionality in Version 2
Clinical Reminders	Clinical Reminders V. 2.0 supports Phase II of the Ischemic Heart Disease (IHD) and Mental Health QUERI projects. It adds four <i>new</i> IHD reminder definitions, two <i>modified</i> reminder definitions, modified reminder dialogs, reminder taxonomies, reminder terms, and health factors.
	It also redistributes three Mental Health (MH) reminder definitions, along with the reminder dialogs, reminder taxonomies, and reminder terms, and health factors to support Phase II of the MH project.
	Also included in version 2:
	<ul> <li>Functionality for VA-GEC Referral (Geriatric Extended Care)</li> <li>New Health Summary Reminders components and types to support MyHealtheVet</li> <li>New Reminders and dialogs to support the CPRS: Integration with</li> </ul>
	<ul> <li>Kew Kenniders and dialogs to support the CERS. Integration with Women's Health project</li> <li>Corrections for problems reported in National Online Information Sharing (NOIS) and Remedy</li> <li>Improved reminder avaluation functionality.</li> </ul>
	Most of the changes in Version 2.0 of Clinical Reminders are technical and behind-the-scenes, affecting reminder definition and set-up. For further information, see your Clinical Applications Coordinator (CAC) or the Clinical Reminders website: <u>http://vista.med.va/gov/reminders/</u>
	<ul> <li>Changes in Clinical Reminders Patch 4</li> <li>Most of the changes in Patch 4 are also technical and behind-the- scenes. Following are a few changes that clinicians might notice:</li> <li>If a frequency can't be determined for a patient, the Status and Due Date will both be CNBD and the frequency display that follows the status line will be "Frequency: Cannot be determined for this patient."</li> <li>A new option, Restore or Merge Referrals, on the GEC reports menu gives the sites the ability to open a closed referral, merge two referrals, or close an open referral.</li> <li>Normally when a patient is deceased, the status of the reminder is automatically set to "N/A." A new flag was added that can be used to override this behavior and cause the status to be determined as usual. This change was made so that if the "Include dead patients" prompt on a Reminder Due Report was answered as "yes," normal evaluation could be done.</li> </ul>

Setup of	Clinician Role in Setting up Reminders
Reminders	Clinicians play a role in the setup of reminders in the following ways:
	<ol> <li>Defining clinical reminder definitions and using them within Health Summaries, the CPRS GUI, and on encounter forms. Clinicians will be asked to assist Clinical Application Coordinators in selecting which reminders to implement and in defining the clinical aspects of the Clinical Reminder definitions, including:         <ul> <li>Defining Baseline Age Range Set(s)                 <ul> <li>Reminder Frequency</li> <li>Minimum and Maximum Age</li> <li>Defining findings that identify whether the reminder applies to the patient, resolve (satisfy) the reminder, or provide additional clinical information-only from the following finding types:</li></ul></li></ul></li></ol>
	2. Defining and using dialogs to resolve reminders. Within CPRS GUI, the clinician uses a point-and-click interface (dialog) for each reminder chosen to process. As you select check-boxed text indicating actions you performed at a given encounter, text is accumulated to add to the note in progress. When you have finished processing the reminders, encounter information is entered in PCE, orders are placed, vital signs are updated, and mental health tests are scored and stored in the Mental Health package, according to your selections. You can help your clinical coordinators define a list of possible actions related to the reminder, to create the appropriate dialog check-boxes for each reminder.
	3. The clinician plays a major role by advising when encounter forms are a clinically appropriate method of entry of health factors, education topics, immunizations and skin tests into Patient Care Encounter (PCE) to satisfy the clinical reminders. In many clinical settings reminder dialogs offer the advantage of not only passing the information to PCE but also of clinical documentation in

progress note text where it is easily available for other users.

## **II. Using Clinical Reminders**

Chapter 1: Clinical Reminders and CPRS Overview	<ul> <li>Using Clinical Reminders in CPRS</li> <li>Clinician reminders display in CPRS in four places: <ul> <li>Cover Sheet</li> <li>Clock button (upper right-hand corner of each tab in CPRS)</li> <li>Notes tab</li> <li>Reports tab (Health Summaries)</li> </ul> </li> </ul>
The cover sheet display of reminders can be customized for Site, System, Location, or User.	Cover Sheet Clinical reminders are displayed on the cover sheet of CPRS. When you left-click on a reminder, details are presented in a pop-up window. By right-clicking on a reminder on the cover sheet, you can access the reminder definition and reference information. More details about what's available from the Cover Sheet are provided

🖉 VistA CPRS in use by: Whprovider,Th	irteen (10.5.21.6	5)				_ 7 ×
<u>Eile E</u> dit <u>V</u> iew <u>T</u> ools <u>H</u> elp						
WHPATIENT, TWO H-2AS0 2	20-1	Primary Care Team Un	assigned		Remote	No Postings
666-33-1987 Jan 01,1960 (44) Current Pro	vider Not Selected	Attending: Whprovide	r,One		Flag Data	Ø
Active Problems Allergies	Adverse Reactions				Postings	
Diabetes Mellitus No Aller	rgy Assessment				No Patient Postings F	ound.
Active Medications	Clinical B	eminders	Due Date			
Non-VA Ginger Cap/Tab Active		KBAY	DUE NOW			
Non-YA         Ginger Cap/Tab         Active           Non-YA         Ginkgo Tab         Active           Non-YA         Warfanin Smg Tab         Active           Non-YA         Warfanin S25mg Tab         Active           Non-YA         Asprin 325mg Tab         Active           Non-YA         Asprosent Active         Non-YA           Non-YA         Asprosent Active         Active           Non-YA         Maprotend 00 Mg         Active           Non-YA         Metaprotennol Acrosol         Active           Non-YA         Alloprine 150mg Tab         Active           Non-YA         Alloprine 100mg Tab         Active           Non-YA         Alloprine 100mg Tab         Active           Non-YA         Alloprine 100mg Tab         Active           Non-YA         Epoetin Alla,Recombinant Inj.Soin Active         Non-YA	Mammog PAP Sm	ram Screening ear Screening	DUE NOW DUE NOW	Cover She Reminders	et s Box	
Recent Lab Results	Vitals			Appointm	nents/Visits/Admission	s
No Orders Found.	No data found			Jun 07,2	004 11:39 2as	Inpatient Appointm
Cover Sheet Problems Meds Orders Notes	Consults   Surgery   D	/C Summ   Labs   Rep	ports			
						J

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## **Using Clinical Reminders**

The Clinical Maintenance display has been expanded to include more details, such as relevant Reminder Terms and Health Factors.

🚝 Clinical Maintenance: ¥A-Mammogram Screening	×
STATUSDUE DATELAST DONE	
RESOLVED 10/30/2004 4/30/2004	
Frequency: Due every 6 months for all ages.	
Resolution: Last done 04/30/2004 Reminder Term: VA-MAMMOGRAM SCREEN IN RAD PKG Radiology Procedure: 76091 (MAMMOGRAM BILAT) - MAMMOGRAM, BOTH BREASTS 01/30/2004 Status: COMPLETE	
Reminder Term: VA-WH MAMMOGRAM SCREEN DONE Radiology Procedure(s) from taxonomy VA-MAMMOGRAM/SCREEN 01/30/2004 MAMMOGRAM BILAT-CPT: 76091 MAMMOGRAM, BOTH BREASTS Status: COMPLETE	
Reminder Term: VA-WH BREAST CARE ORDER HEALTH FACTOR Health Factor: WH ORDER MAMMOGRAM UNILAT HF 04/19/2004 WH ORDER MAMMOGRAM UNILAT HF	
Reminder Term: VA-WH MAMMOGRAM SCREEN DEFER Health Factor: WH MAMMOGRAM DEFERRED 04/19/2004 WH MAMMOGRAM DEFERRED	
Reminder Term: VA-WH MAMMOGRAM SCREEN FREQ - 4M	
Health Factor: WH MAMMOGRAM SCREEN FREQ - 4M	
04/19/2004 WH MAMMOGRAM SCREEN FREQ - 4M	
Reminder Term: VA-WH MAMMOGRAM SCREEN FREO - 6M	
Health Factor: WH MAMMOGRAM SCREEN FREQ - 6M	
04/30/2004 WH MAMMOGRAM SCREEN FREQ - 6M	
Age/Frequency:	
Reminder due every 6 months until a new mammogram is ordered,	
deferred, documented, or not clinically indicated.	
Annual screening specified for this patient.	-
Print Clos	se

#### Chapter 1: Clinical Reminders and CPRS Overview

If you right-click on a reminder, you will bring up a popup menu that looks like this:

🖉 Available Reminders			×
<u>V</u> iew <u>A</u> ction			
Available Reminders	Due Date	Last Occurrence	Priority
	DUE NOW 08/19/2000 04/05/2001 DUE NOW	08/18/2000 04/05/2000	

Clicking on Clinical Maintenance will give you the same Clinical Maintenance output you get by left-clicking.

If the reminder contains education topics, Education Topic Definition will be selectable and clicking on it will display the education topic definitions.

🚝 Education Topic: &Advanced Directives		×
	Print	Close
NAME : VA-ADVANCED DIRECTIVES		
PRINT NAME : Advanced Directives		
EDUCATIONAL OUTCOME :		
The patient and family will identify the implications of a directives.	dvanced	
EDUCATIONAL STANDARDS :		
1. Explain what an advanced directive is.		
2. Explain the difference between advanced directives and	l a living w	ill.
<ol><li>Discuss how a living will is made.</li></ol>		
<ol> <li>Explain what a durable power of attorney for health cs assign someone to have this power.</li> </ol>	re is and h	ow to
5. Identify a social worker to contact for furthur inform	ation as ap	propriate.

## **Using Clinical Reminders**

Chapter 1: CPRS and Reminders Overview Clicking on reminder inquiry will produce a display of the reminder definition. For detailed information on how reminders are defined, see the Clinical Reminders Manager's Manual.

🚝 Reminder Inquiry: Advanced Directives Education			
Print Close			
VA-ADVANCED DIRECTIVES EDUCATION No. 34			
Print Name: Advanced Directives Education			
Related VA-* Reminder:			
Reminder Dialog:			
Priority:			
Reminder Description: Advanced directives information given to all patients once.			
Technical Description: This reminder is distributed with the PCE package. The source of this reminder definition is the Ambulatory Care Expert Panel. It is based on feedback from facilities wanting to track Advanced Directive Education.			
This reminder is an education type reminder. It relies on an active education topic entry representing the Advanced Directives education in the Education Topics file.			
This reminder will be considered "DUE NOW" if there is no patient education entry for advanced directive education in the "V Patient Ed." file. The V Patient Ed. File summarizes the patient education provided			

If you click on Reference Information, you will get a list of web sites that have information related to the clinical reminder. Clicking on one of them will open your web browser at that site.

Clicking on Reminder Icon Legend will bring up a display that shows what the various reminder icons mean.

#### **Reminders Icon Legend**

Icon Legend	×
Templates Reminder	Notes Consults Surgery
<u> </u>	Reminder Category
ö	Reminder is Due
đ	Reminder is not due, but is Applicable
0	Reminder is Not Applicable
?	Reminder status has not yet been evaluated
💑 🏠 🔂 🔀	Reminder has an associated Reminder Dialog
<b>***</b>	Reminder's associated Reminder Dialog has been processed
	<u> </u>

## **Using Clinical Reminders**

Chapter 1: CPRS and Reminders Overview

You or your site can determine the folder view, and whether the folders are open or closed when you first open the reminders drawer. The next place you are likely to encounter Clinical Reminders is on the Notes tab. When you go to the Notes tab and open a new note, a Reminders tab—called a drawer—appears.



When you click on the Reminders drawer, a list of reminders is displayed.



Reminders that have an associated dialog have a special icon (see the above display of reminder icons). If you click on one of these reminders, a dialog box appears, which lists possible actions or activities that may satisfy this reminder.

The contents of the tree can be determined by the user. Details of how this is done are found in <u>Appendix C</u>.

Using a dialog to resolve a clinical reminder is discussed in Chapter 2.

#### Chapter 1: CPRS and Reminders Overview

Users have the ability to edit their own list of cover sheet reminders. (Before you do this we recommend that you check with your Reminder Manager to find out which reminders are recommended for your work area.) Click on the Tools menu then click on Options.

Clicking on Clinical Reminders will open one of two cover sheet editing forms. CPRS will automatically determine which form is appropriate for you to use. See <u>Appendix C</u>, for instructions on how to edit cover sheet reminders.

#### **Clock Button**

Another place you can interact with Clinical Reminders is by clicking on the reminders button (it looks like an alarm clock) in the upper right hand corner of the CPRS GUI.



This brings up the Available Reminders form which provides the same tree view you saw in the reminders drawer.

🖉 Available Reminders				×
<u>V</u> iew <u>A</u> ction				
Available Reminders		Due Date	Last Occurrence	Priority
Advanced Dire     Advanced Dire     Blood Pressure     Alcohol Abuse     Antrys Agetest     Applicable     Other Categories	ectives Education e Check Education	DUE NOW 08/19/2000 04/05/2001 DUE NOW	08/18/2000 04/05/2000	

Chapter 1: CPRS and Reminders Overview

#### Available Reminders form

This form has two menus: View and Action.

#### View Menu

The View menu lets you determine which categories of reminders will be displayed in the tree view. Those with a checkmark to the left of this will be displayed. You can toggle the checkmark on or off by left clicking on the icon. Note: as soon as you click on an icon the View menu will disappear and the tree will be updated to match your current selection. To make another change, left-click on View.

As was mentioned earlier, the tree you see here is identical to the one you see in the Reminders drawer, so whatever change you make here affects the tree you see in the Reminders drawer.

Zetion				×
<ul> <li>✓ Due</li> <li>✓ Applicable</li> <li>⊘ Not Applicable All Evaluated</li> <li>✓ C Other Categories</li> <li>Reminder Icon Legend</li> </ul>	ducation	Due Date DUE NOW 08/19/2000 04/05/2001 DUE NOW	Last Occurrence 08/18/2000 04/05/2000	Priority

Of primary interest to the clinician are the options on the Action menu that let you evaluate reminders.

#### Action Menu



Chapter 1: CPRS and Reminders Overview

#### Available Reminders form

#### Action Menu Evaluate Reminders

You can evaluate an individual reminder, all the reminders in a category, or a processed reminder. A processed reminder is one whose dialog has been processed. Which of these three options is selectable will depend on what has been selected on the reminders tree. If it is an individual reminder then Evaluate Reminder will be selectable, if it is a category then Evaluate Category Reminders will be selectable, and if it is a processed reminder then Evaluate Processed Reminder will be selectable.

The other two options are for Reminder Managers.

#### **CPRS Reports Tab**

Health Summaries containing Clinical Reminders can be viewed from the Reports tab in CPRS. See the Health Summary section later in this guide for more information.

The Ad hoc health summary can also be used to display selected clinical reminders using either an abbreviated display or the full clinical maintenance display. (See <u>Chapter 6: Health Summaries and Clinical Reminders</u>)

## **Using Clinical Reminders**

Chapter 2:	Summary of Steps to Process Reminders		
Resolving Clinical Reminders	These are the basic steps for processing reminders from the Notes tab in CPRS. These steps are described in more detail in Chapter 3.		
	1. Start a new progress note. To process a reminder, start a new progress note. When you begin a new progress note, the reminders drawer appears.		
NOTE: Your site can determine the folder view – which reminders and categories/folders appear in the reminders drawer.	2. Open the reminders drawer. When you click on the reminders drawer, you see several folders containing reminders for this patient. Possible folders include Due, Applicable, Not Applicable, All Evaluated, and Other Categories. These folders may contain a hierarchy of folders and reminders within folders. The view of folders is customizable by you (see <u>Appendix C</u> ). The folders and subfolders in the Reminders Drawer are sometimes called the "tree view."		
	3. Choose a reminder. Open a folder (if necessary) and click a		

**3.** Choose a reminder. Open a folder (if necessary) and click a reminder that you wish to process. At this point, you may be asked to provide the primary encounter provider, so that any PCE data entered from reminder dialog processing can be saved.

## **Using Clinical Reminders**

Chapter 2: Resolving Clinical Reminders

#### Summary of Steps to Process Reminders

4. (cont'd) If the reminder has an associated reminder dialog, a small dialog icon is shown in the bottom-right corner of the clock icon. If you click on one of these reminders, a dialog box appears, which lists possible actions or activities that may satisfy this reminder. If this is a National reminder, the dialog was created by national developers and/or members of the Office of Quality and Performance. Otherwise, the contents of this dialog were created at your site by your Clinical Application Coordinator (CAC) or a Clinical Reminders Manager. Clinicians should be involved with defining these dialogs.

If no dialog icon is displayed on a reminder, it means that your site hasn't created and/or linked a dialog to the reminder. Your CAC can provide information about this. Definitions of the reminders icons are available on the Action menu of the Available Reminders window (see page 10).



#### Chapter 2: Resolving Clinical Reminders, cont'd

#### TIP:

Use the Next or Back buttons to take you to the dialog for the next or previous reminder due in the reminders drawer.

#### Summary of Steps to Process Reminders, cont'd

- 5. Complete the dialog box. The dialog box lists possible actions or interventions that may be taken to satisfy this reminder. As you make selections from the dialog box, you can see the text of the progress note in the bottom part of the screen (below the Clear, Back, and Next buttons). Below the progress note text area is the encounter information including orders and PCE, Mental Health, and Vital Sign data. The bold text in these areas applies to the specific reminder you are processing. You can process multiple reminders.
- 6. Expanded dialog boxes. Clicking a checkbox may bring up additional choices: an area for comments, a diagnosis to choose, or other information that may satisfy the reminder.

**Dialog with orders.** Reminder dialogs can include orders. If quick orders are included in the dialog, these are placed as soon as the reminder processing is finished and the orders are signed. If the order requires more information before releasing the order, an order dialog will appear after you click Finish, allowing you to complete the order.

**Mental health tests.** Reminder dialogs can include a predefined set of mental health tests. The reminder definition can include any mental health test, but the reminder dialog is limited in the GUI resolution process to allow clinicians to enter results for the following tests: AIMS, AUDC, AUDIT, BDI, CAGE, DOM80, DOMG, MISS, and ZUNG. Progress note text can be generated based on the mental health score.

- 7. Finish processing the reminder and complete your note. Click on the Finish button when you have checked all the appropriate checkboxes for each reminder you wish to process. You then go back to the Note window, where you can review and edit the reminder dialog progress note text added, to have a completed progress note for the encounter.
- 8. (Optional) Evaluate processed reminders. You can use the Action menu to select the Evaluate Processed Reminders menu item from the Reminders Available window, to ensure that the reminders are satisfied. This action will evaluate the reminders that you processed while you wait, and update the Reminders Available window and reminders drawer lists to reflect the new statuses.

#### Chapter 3: Resolving IHD Reminders

#### Overview

#### **IHD Reminder Definitions**

The following IHD reminder definitions are distributed with Clinical Reminders Version 2.0:

#### VA-IHD LIPID PROFILE

This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code for IHD on or after 10/01/99) who have not had a serum lipid panel within the last year. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

#### VA-IHD ELEVATED LDL

This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code on or after 10/01/99) who have had a serum lipid panel within the last year, where the most recent LDL lab test (or documented outside LDL) is greater than or equal to 120 mg/dl. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

#### **VA-\*IHD LIPID PROFILE REPORTING**

This national IHD Lipid Profile Reporting reminder is used monthly to roll up LDL compliance totals for IHD patients. This reminder identifies patients with known IHD (i.e., a documented ICD-9 code for IHD) who have not had a serum lipid panel/LDL (calculated or direct lab package LDL) or documented outside LDL within the last two years. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

#### VA-\*IHD ELEVATED LDL REPORTING

This national IHD Elevated LDL Reporting reminder is used monthly to roll up compliance totals for management of IHD patients whose most recent LDL is greater than or equal to 120mg/dl. This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code) who have had a serum lipid panel within the last two years, where the most recent LDL lab test (or documented outside LDL) is greater than or equal to 120 mg/dl. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient. These compliance reminders are not for use in CPRS, so there are no related reminder dialogs.

## **Using Clinical Reminders**

Chapter 3: Resolving IHD Reminders

#### Steps to Process VA-IHD Lipid Profile

#### 1. Start a new progress note.

When you begin a new progress note, the reminders "drawer" appears below the default list of notes. You are prompted to enter Progress Note properties (Title, date, etc.) before you begin processing reminders.



#### 2. Open the reminders drawer

Click on the reminders drawer (button) to see reminders.

#### NOTE:

Due, Applicable, Not Applicable, All Evaluated, or Other Categories folders may be displayed.

You or your site can modify the contents of the "Other Categories" folder, through the option Add/Edit Reminder Categories on the CPRS Configuration Menu.

City Calls Ulaw Ashing Onkings	Taala Hala				
Ele Edic View Action Options	Toolis Teih			- (	
CRPATIENT,TWO G 666-55-4444 Oct 10,1972 (33) P	<b>M Jun 12,06 09:59</b> Provider: WHPROVIDER,TWO	Primary Care Team Unassigned	Flag	Bemote Data	No Postings
Last 100 Signed Notes	H&P GENERAL MEDICINE Vst: 06/12/06 GENERAL MED Subject:	Jun 12,2006@09:59 ICINE	Green,Joann		Change
Oct 17,04 H&P GENE					
<					~
✓ Templates					>
✓ Reminders	<no encounter="" enter<="" information="" td=""><td>ed&gt;</td><td></td><td></td><td></td></no>	ed>			
Encounter					
Cover Sheet Problems Meds Orders Notes Consults Surgery D/C Summ Labs Reports					

#### Chapter 3: Resolving IHD Clinical Reminders

#### NOTE:

To process a reminder, a "reminder dialog" must be defined and associated (linked) with the reminder. This is done by your Clinical Reminders Manager or coordinator (usually with clinician assistance). If a reminder dialog is available for a reminder, an icon representing a dialog is on the corner of the reminder icon.

#### Steps to Process VA-IHD Lipid Profile, cont'd

#### 3. Locate the IHD Lipid Profile reminder.

If necessary, open a folder (Due, Applicable, Other Categories, etc.) and click on the IHD Lipid Profile Reminder.

File Edit View Action Options	; Iools Help	
CRPATIENT,TW0 666-55-4444 Oct 10,1972 (33)	GM Jun 12,06 09:59         Primary Care Team Unassigned         Flag         Remote Data         No           Provider:         WHPROVIDER,TWO         Primary Care Team Unassigned         Flag         No         No	o Postings
Last 100 Signed Notes	H&P GENERAL MEDICINE Jun 12,2006@03:59 Green Joann C Vst: 06/12/06 GENERAL MEDICINE	Change
All unsigned notes for GRE	Subject	^
7 Templates		
SLC Diabetic Foot Care Ed     Diabetic Eye Exam     SLC Cancer Screen     Junkarija HD /Root ML Falle		
Breast Exam     Advanced Directives Educ     LTC Oversight Visit		
Weight and Nutrition Scree     HID Lipid Profile     EXCHANGE CHANGES     SUBSTANCE ABUSE     WEIGHT AND NUTRITION		>
Encounter	<no encounter="" entered="" information=""></no>	
Cover Sheet Problems Meds	Orders Notes Consults Surgery D/C Summ Labs Reports	

# Chapter 3:<br/>Resolving IHD<br/>Clinical RemindersSteps to Process VA-IHD Lipid Profile, cont'd<br/>4. Complete the dialog box.

When you select the IHD Lipid Profile reminder to process, a dialog box appears, such as the one below. It shows the possible things that may satisfy the reminder.

#### **Example: IHD Lipid Profile Dialog**

🚝 Reminder Resolution: IHD Lipid Profile	×			
The VHA/DOD Clinical Practice Guideline for Management of Dyslipidemia recommends that patients with Ischemic Heart Disease have a lipid profile/LDL every one to two years; and that patients taking lipid lowering medications have a lipid profile/LDL at least every year. Click on the 'Clinical Maint' button below to display IHD diagnosis, lab results and current lipid lowering medications. 				
No encounter information entered> * Indicates a Bequired Field	_			

#### Chapter 3: Resolving IHD Clinical Reminders

#### Steps to Process VA-IHD Lipid Profile, cont'd

4. Complete the dialog box, cont'd.

If quick orders are included in the reminder dialog, these are activated as soon as the progress note is completed and the note and order are signed. If the order requires more information before completion, an order dialog will appear after you click Finish, allowing you to complete the order.

When you click a checkbox or item, the associated text that will be placed in the progress note is shown in the area below the buttons. Data that will update PCE, orders, Vital Signs, and Mental Health packages will be shown in the area below that.

See the example on the next page.

#### Example: Expanded Dialog when "Order Lipid Profile" Checked

Reminder	Resolution: IHD Lip	id Profile				×
The VHA/DOD Clinical Practice Guideline for Management of Dyslipidemia recommends that patients with Ischemic Heart Disease have a lipid profile/LDL every one to two years; and that patients taking lipid lowering medications have a lipid profile/LDL at least every year.					ia 🔺	
Click on t results a	he 'Clinical Ma: and current lipio	int' button b d lowering me	elow to di dications.	splay IHD ·	diagnosis,	1ab
🔽 Order 1	ipid profile.					
O Order	Fasting lipid ;	profile with	calculated	LDL		
C Order	r Direct LDL					
🗖 Outside	lipid profile i	n past year :	at another	VA or non-	VA facilit	;у.
Detient	rafucae linid r	rofile testi				<u> </u>
Clear	Clinical <u>M</u> aint	<u>⊻</u> isit Info	< Back	Next >	Finish	Cancel
Health Factors: ORDER LIPID PROFILE						
* Indicates a Required Field						

#### Steps to Process VA-IHD Lipid Profile, cont'd

4. Complete the dialog box, cont'd.

When you click a checkbox or item, the associated text that will be placed in the progress note is shown in the area below the buttons. Data that will update PCE, orders, Vital Signs, and Mental Health packages is shown in the area below that.

#### **Example: Progress Note text**



Chapter 3: Resolving IHD Clinical Reminders	Steps to Process VA-IHD Lipid Profile, cont'd Next and Back processing
	Use the Next button to process the next reminder that is due in the reminders drawer. Use the Back button to take you to the reminder processed previously to the one you are currently processing.
	<b>Clinical Maintenance review</b> While processing the reminder, you can review current Clinical Maintenance patient data related to the reminder by clicking on the Clinical Maint button at the bottom of the dialog box.
	NOTE: Information in the Clinical Maintenance box has been expanded and enhanced in Version 2 of Clinical Reminders.
	<b>Clearing a single reminder</b> You will probably process several reminders for a single visit. If you have entered information on a reminder, but you need to start over on that reminder only, you can simply click Clear on the reminder from the reminders drawer, and then click the Clear button in the reminders dialog box. This removes all previous dialog selections from the reminder's dialog box and removes the related text and data from the Progress Note text box and the PCE data box for this reminder. You can now start processing again. NOTE: Clicking Clear will remove the information from only one reminder. Be careful that you are on the correct reminder before you click Clear.
Example: Cli	inical Maintenance window for IHD Lipid Profile



#### Steps to Process VA-IHD Lipid Profile, cont'd

#### **Canceling out of the Processing dialog**

If you reach the Reminders Processing dialog by mistake or you wish to delete information that you have entered and start over, click Cancel.

NOTE: If you click Cancel, you will lose all of the information for reminders that you have entered.

#### Example: Warning box when Cancel button clicked

Cancel Reminder Processing
The Following Reminder is being processed:
IHD Lipid Profile
Canceling will cause all processing information to be lost. Do you still want to cancel out of reminder processing?
Yes No

#### Steps to Process VA-IHD Lipid Profile, cont'd

#### 5. Finish processing the reminder

After you have entered all the information, you can finish processing the reminders. When you finish, the following things will happen:

- The predefined text is placed in the note you have begun writing.
- The encounter information is sent to PCE.
- If there are orders defined in the dialog, it will also create the orders. If the orders require input (if they are not predefined quick orders without prompts), the order dialogs will come up so that you can complete the orders. You will then have to sign any orders that are created.

To finish processing reminders, click Finish.

After you click Finish, you are returned to the Note screen, where you can see the text created by reminder processing. You can edit this, as necessary.

#### Example: Progress Note after reminder dialog completion

Tista CENS III use by. Gree	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
<u>File Edit View Action Options</u>	<u>T</u> ools <u>H</u> elp	
CRPATIENT,TWO         G           666-55-4444         0 ct 10,1972 (33)         F	IM Jun 12,06 09:59         Primaty Care Team Unassigned         Flag         Remote         Data         Team           rovider:         WHPROVIDER,TWO              Team         Team	No Postings
Last 100 Signed Notes	H&P GENERAL MEDICINE Jun 12,2006@09:59 Green,Joann Vst. 06/12/06 GENERAL MEDICINE	Change
E Strain Content State Strain	GREEN NOTES	~
/ Templates	IHD Lapid Profile: Ordered fasting lipid profile with calculated LDL.	
S Reminders		
SLC Diabetic Foot Care Education		
SLC Cancer Screen Ischemic HD/Post MI Follow Up		
Breast Exam Advanced Directives Education		
LTC Oversight Visit Weight and Nutrition Screen		
		<b>~</b>
WEIGHT AND NUTRITION		>
< >>	Health Factors: ORDER LIPID PROFILE	
Encounter		
Cover Sheet   Problems   Meds   O	ders Consults Surgery D/C Summ Labs Reports	

#### Steps to Process VA-IHD Lipid Profile, cont'd

#### 7. (Optional) Evaluate processed reminders

After you have processed a reminder, you can use this menu item in the Available Reminders window to see if your actions during the encounter satisfied the reminder. This action will evaluate the reminders that you processed while you wait, and update the Reminders Available window and Reminders drawer lists to reflect the new statuses.

NOTE: PCE data may take a few minutes to be correctly recorded. Please wait a few minutes after processing a reminder before evaluating it again to ensure that it was satisfied.

To evaluate processed reminders, go to the Available Reminders dialog by clicking on the Reminders button, choose Action, and then click on Evaluate Processed Reminders.

#### **Example: Evaluate Processed Reminder**

🚝 Available Reminders 📃 🔀				
View Action				
Available Reminders	Due Date Last Occurren Priority			
□       Comparison         □       □	DUE NOW 10/25/2002 10/25/2001 DUE NOW DUE NOW 05/09/2003 08/06/2004 08/06/2003			

#### VA-IHD ELEVATED LDL

This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code on or after 10/01/99) who have had a serum lipid panel within the last year, where the most recent LDL lab test (or documented outside LDL) is greater than or equal to 120 mg/dl. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

Use the same steps to process this reminder as those described above.

#### **Example: IHD Elevated LDL Dialog**

🚝 Reminder Resolution: IHD Elevated LDL	1
The VHA/DOD Clinical Practice Guideline for Management of Dyslipidemia recommends an LDL goal of <120 mg/dl for patients with Ischemic Heart Disease; and the NCEP Adult Treatment Panel II recommends a more stringent goal of <100 mg/dl. Consider initiating or adjusting lipid lowering treatment.	
Click on 'Clinical Maint' button below to display IHD Diagnosis, LDL lab results and current lipid lowering medications.	
Order initial lipid lowering medication.	
Adjust lipid lowering medication(s).	
No lipid treatment change is needed based on patient's current status.	
Lipid lowering medications are contraindicated.	
Lipid lowering management provided by another VA or non-VA facility.	
Patient reports a more recent outside LDL <120.	
C Order lipid profile or LFTs.	
Patient refuses lipid lowering therapy.	
Defer lipid lowering medications.	
Unable to confirm diagnosis of Ischemic Heart Disease. Inactivate IHD reminders.	
Clear Clinical MaintVisit Info< BackNext >FinishCancel	
<u> </u>	
* Indicates a Required Field	

#### Chapter 4: Processing Mental Health Reminders

#### **Mental Health Reminders**

The following Mental Health reminder definitions are re-distributed with Clinical Reminders Version 2.0:

#### VA-ANTIPSYCHOTIC MED SIDE EFF EVAL

The Abnormal Involuntary Movement Scale (AIMS) reminder has been designed to be due on all patients who are on any one of the antipsychotics (excluding ones like compazine). The taxonomy for Schizophrenia is included in the reminder, but will not be part of the cohort logic. By leaving the taxonomy in the reminder, data roll-up can use the Report Extracts functionality in version 2.0, either with or without information on patients with Schizophrenia.

#### **VA-DEPRESSION SCREENING**

Screening for Depression using a standard tool should be done on a yearly basis. The yearly screening is satisfied by entry of a health factor indicating positive or negative results for the 2 question MacArthur screening tool or by entry of negative or positive results in the MH package. The reminder is also resolved by entry of information indicating that the patient is already being treated/evaluated in a Mental Health clinic.

Patients are automatically excluded from the cohort if they have a recent diagnosis of depression (ICD code in the past 1 year) and have either a CPT code for psychotherapy in the past 3 months or are on antidepressant medication (current supply of medication in the past 3 months).

#### VA-POS DEPRESSION SCREEN FOLLOWUP

The reminder is applicable if the patient has positive depression screen in the past 1 year (DEPRESSION SCREEN POSITIVE). If a more recent negative depression screen is entered, then the reminder becomes not applicable (DEPRESSION SCREEN NEGATIVE).

#### Chapter 4: Processing Mental Health Reminders, cont'd

#### NOTE

Sites that use a different screening tool than the 2 question MacArthur screening tool will need to create local health factors to indicate a positive or negative result and will need to map those local health factors to the national terms: DEPRESSION SCREEN NEGATIVE, and DEPRESSION SCREEN

#### Mental Health Reminder Processing

#### **Depression Screening**

The yearly screening is satisfied by entry of a health factor indicating positive or negative results for the 2-question MacArthur screening tool or by entry of negative or positive results of any of the following in the MH package:

> Negative DOM80=0 DOMG<4 CRS<10 BDI<10 Zung<33

Positive DOM80=1 DOMG>3 CRS>9 BDI>9 Zung>32

The reminder is also resolved by entry of information indicating that the patient is already being treated/evaluated in a Mental Health clinic.

#### Example: Depression Screening dialog initial window



2-question McArthur test

#### **Depression Screening (cont'd)**

Chapter 4: Processing Mental Health Reminders, cont'd

When you click on the DOM80 or DOMG button, a window pops up that lets you perform the test. The results of the test go in the patient's record – in the progress note and in the Mental Health package.

#### Example: DOM80 test



#### Chapter 4: Processing Mental Health Reminders, *cont'd*

#### **Depression Screening (cont'd)**

The reminder is also resolved by the following:

- Unable to screen due to acute or medical illness
- Patient refuses to answer depression screening questions
- Entry of information indicating that the patient is already being evaluated/treated in a Mental Health clinic

#### Example: Other questions that resolve reminder

Reminder Resolution: Depression Screening	×
	•
▼ Unable to Screen Due to Acute Medical Illness	
Comment:	
✓ Unable to Screen Due to Chronic Medical Illness	
Comment:	
Refused to answer depression screening questions	
Patient currently followed/treated for depression	
VA Clinical Practice Guideline for Major Depressive Disorder	
http://www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm	٦
, Clear │ Clinical Maint │ Visit Info │ < Back │ Next > │ Finish │ Cancel	
	=
Depression Screening:	
The patient could not be screened for depression due to an acute medical illness	•
The patient could not be screened for depression due to an chron	ıi,
medical illness. The patient declines to anomer any of the questions for depressi	
screening.	
The patient is currently being followed for treatment of depress	ri,
	F
Health Factors: CURRENT F/U OR RX FOR DEPRESSION, REFUSED DEPRESSION	Þ
Health Factors: CURRENT F/U OR RX FOR DEPRESSION, REFUSED DEPRESSION SCREENING, UNABLE TO SCREEN-ACUTE MED CONDITION, UNABLE TO SCREEN-CHRONIC MED CONDITION	•
Health Factors: CURRENT F/U OR RX FOR DEPRESSION, REFUSED DEPRESSION SCREENING, UNABLE TO SCREEN-ACUTE MED CONDITION, UNABLE TO SCREEN-CHRONIC MED CONDITION	<u> </u>
Chapter 4: Processing Mental Health Reminders, cont'd

#### **Depression Screen Positive – Needs F/U Assessment**

This reminder is applicable if the patient has positive depression screen in the past 1 year (DEPRESSION SCREEN POSITIVE). If a more recent negative depression screen is entered, then the reminder becomes not applicable (DEPRESSION SCREEN NEGATIVE).

#### **Example: Depression Screen Positive**

🖻 Reminder Resolution: Depr Scr Pos - Needs F/U Assessment 🛛 🛛 🔀					
ASSESSMENT OF A POSITIVE SCREEN FOR DEPRESSION Patients with a positive depression screen should be assessed for Major Depressive Disorder based on DSM-IV criteria and should be assessed for the need for therapy, intervention and/or referral.					
<ol> <li>Assess if patient is at high risk (marked psychotic symptoms, suicidality, potential for violence, delirium)</li> <li>Further questions regarding current signs &amp; symptoms of depression</li> <li>Obtain careful psychiatric history of past depressive episodes</li> <li>Attention to 'red flags'.</li> </ol>					
Review history for substance abuse, other illness as a cause of depression, medication as a cause of depression and for the severity of the depression. Patients who may fit the DSM-IV criteria for Major Depressive Disorder should be considered for referral to a mental health professional for evaluation and management. Click here to view the DSM-IV criteria for Major Depressive Disorder (MDD) Click here to view the PHQ-9 Assessment Tool for Depression					
RECORD RESULTS OF ASSESSMENT OF POSITIVE DEPRESSION SCREEN					
Clear Clinical <u>M</u> aint <u>V</u> isit Info < Back Next > Finish Cancel					
<no encounter="" entered="" information=""></no>					
* Indicates a Required Field					

Chapter 4: Processing Mental Health Reminders, cont'd

#### Abnormal Involuntary Movement Scale, (AIMS) Dialog

This reminder dialog uses the AIMS Mental Health Instrument. If you click on the Perform AIMS button, the instrument pops up, so that you can answer the questions, which are scored and go into the Mental Health package and the Progress Note.

The reminder is also resolved by refusal to take the test or refusal to take antipsychotic medications.

#### **Example: Eval for Abnl Involuntary Movements**

🖉 Reminder Resolution: Eval for Abnl Involuntary Movments 🛛 🔀
Evaluation of patients on long term antipsychotic therapy for abnormal involutary movement should be performed at least yearly. AIMS (Mental Health Instrument) Perform AIMS Refuses Abnormal Involuntary Movement Evaluation Refuses to take Antipsychotic Medication
<u>Clear</u> Clinical <u>M</u> aint <u>Visit Info</u> < Back Next > Finish Cancel
<no encounter="" entered="" information=""></no>

Chapter 4: Processing Mental Health Reminders, cont'd

#### AIMS Dialog

When you click on the Perform AIMS button, the screen below pops up, so that you can answer the questions, which are scored and go into the Mental Health package and the Progress Note.

#### **Example: AIMS Mental Health Instrument**

🖉 Remip	der Br	esolution: Eval for Abol Involuntary Movements		1
Evaluat	🖉 All	MS	×	rv move
should AIMS (M	Compl severit sponta	ete Examination Procedure before making ratings. MOVEMENT RATINGS: Rate highest ty observed. Rate movements that occur upon activation one LESS than those observed neously.		-
Refu	1.	Facial and Oral Movements Muscles of facial expression, e.g., movements of forehead, eyebrows, periorbital area, cheeks. Include frowning, blinking, grimacing of upper face.		
_ Refu		<ul> <li>None</li> <li>Minimal, may be extreme normal</li> <li>✓ Mild</li> <li>✓ Moderate</li> <li>✓ Several</li> </ul>		
	2.	<ul> <li>Severe</li> <li>Facial and Oral Movements Lips and perioral area, e.g., puckering, pouting, smacking.</li> <li>None</li> <li>Minimal, may be extreme normal</li> <li>Mild</li> </ul>		
		C Moderate		
	3.	Facial and Oral Movements Jaw, e.g., biting, clenching, chewing, mouth opening, lateral movement. ✓ None Minimal, may be extreme normal ✓ Mild	-	
<no enco<="" td=""><td>, CI</td><td>lear <u>D</u>K Canc</td><td>el</td><td></td></no>	, CI	lear <u>D</u> K Canc	el	
* Indicates	a Requ	ired Field		

#### Chapter 5: Using Reminder Reports

TIP:

Clinicians should work with their site's clinical reminder coordinator or Clinical Application Coordinator to design and validate reports used at their site. Reporting can be resource-intensive and many sites have elected to centralize the access to run reports. However, limited report templates may be available to selected clinicians who work closely with clinical reminders or QM at their site.

#### **Chapter 5: Reminder Reports**

Reminder reports allow you to do large and small-scale comparisons of clinics, divisions, teams, and providers and can help in finding patients who have "slipped through the cracks."

- Ever want to know how well your team is doing with immunizations or diabetes care or pain assessments?
- Ever want to know who is coming this week who needs pneumococcal immunization, or who needs diabetic foot exam and education, or who has had a high pain score in the past and needs a pain assessment?
- Would anyone at your site ever want to look at a group of patients for a research project patients with a creatinine between 1.5 and 5 who do not have diabetes who are under the age of 80?

Reports allow you to verify diagnoses, verify that appropriate treatment was given, identify patients requiring intervention, and validate effectiveness of care.

Reminder reports are very flexible. Reports can be run on:

- Location(s)
  - -One or more inpatient hospital locations
  - -Current inpatients
  - -Patients admitted during a date range
- Alphabetical
- Sorted by ward/bed -one or more outpatient hospital locations -all hospital locations -stop code(s) -clinic group(s)
- OERR Team(s)
- PCMM team(s),
- PCMM provider(s)
- Reminder patient list(s).

Reports can be combined or kept separate for one or more facility

Report results can display:

- Summary results (numbers only)
- Detailed results (patients' names).
   -Identifier: Entire social security number or last 4 numbers of social security number only
   -Sort alphabetically or by date of the next clinic visit.

Reports can be run on either on patients with Past visits or with Future visits.

#### Chapter 5: Using Reminder Reports

TIP:

The EPI extract finding list and total options are specific to the Hepatitis C Extract project. The extracted data is based on the following reminders: VA-HEP C RISK ASSESSMENT, VA-NATIONAL EPI LAB EXTRACT, and VA-NATIONAL EPI RX EXTRACT.

#### Reminder Reports, cont'd Changes in Version 2

New reports on the Reminder Reports menu or changes to report functionality in Clinical Reminders V. 2.0 include:

- Extract Queri Totals [PXRM EXTRACT QUERI TOTALS] This option prints reminder and finding totals for extract summaries created by the automatic QUERI extracts.
- GEC Referral Report, [PXRM GEC REFERRAL REPORT] This option is used to generate GEC Reports. GEC (Geriatrics Extended Care) is used for referral of geriatric patients to receive further care.
- New type of report, Reminder Patient List, on Reminders Due option.
- Ability to show inpatient location on future appointments.

Chapter 5: Using Reminder Reports

#### **Changes in Version 2**

Version 2.0 of Reminders contains changes to the date range that can be used in searches in the Reminders Due reports. The changes include:

- Effective period and effective date are eliminated
   Replaced with beginning date and ending date
- Any of the FileMan date formats are acceptable
   May 14, 2003, T-1Y, T-2M, T-3D
- Beginning date default is beginning of data
- Ending date default is today

#### **Benefits of Date Range Finding Searches**

- The search for findings is done only in the specified date range.
- Retrospective reminder reports are now possible.

#### **Changes in Patch 4**

- A prompt was added to allow you to exclude/include Test Patients.
- A prompt was added to allow you to exclude/include deceased patients.

Chapter 5: Using Reminder Reports

TIP:

**Reminders Due Report:** 

The summary report may be run for several reminders.

The detailed report may only be run for one reminder

#### **Reminder Reports**

#### **Reminders Due Report**

For a selected reminder, the report lists any reminders that are currently due. Reports can be defined by the following criteria:

- Individual Patient
- Reminder Patient List (all patients on a patient list created through the Patient List options)
- Hospital Location (all patients with encounters)
- OE/RR Team (all patients in team)
- PCMM Provider (all practitioner patients)
- PCMM Team (all patients in team)

**Summary report**: displays totals of how many patients of those selected have reminders due.

**Detailed report:** displays patients (in alphabetical order) with reminders due. The report displays for each patient the date the reminder is due, the date the reminder was last done, and next appointment date. The detailed report can also list all future appointments, if specified. Detailed reports for Location or Provider may also be sorted by next appointment date.

Reports by Hospital Location, Provider, or Team print a separate report for each Hospital Location, Provider, or Team selected. Reports for all Hospital Locations are not separated by individual locations. The report by Hospital Location can report either current inpatients or admissions within a selected date range.

#### Chapter 5: Using Reminder Reports

#### NOTE: After scheduling a Reminder report to run, you may receive a message such as the following:

6294955: ^PXRMXPR, Reminder Due Report - print. Device NT\_SPOOL. VAH,ROU. From Yesterday at 13:14, By you. Created without being scheduled.

This doesn't mean that there's an error with the report processing. Clinical Reminders processes its reports in two tasks, one for SORT and one for PRINT. The print task will always show "created without being scheduled" until the sort task is complete.

#### **Reminder Reports**

#### **Report templates**

The selection criteria used for the Reminders Due reports may be saved into a report template file, with a user-specified identifier, as the report is being run.

When running the Reminder Due report, you may select from an existing template and run a new report using the parameters from the selected template. The prompts for date range and sort order are displayed, but all other parameters are taken from the previous report. If you select a print template, you may also edit the template and/or copy to a new template before running the report.

*Scenario*: How many patients are not receiving reminders who should be for Hepatitis C?

A report can be prepared that compares "Applicable" reminders to those that have been defined as "Due." The difference may be a missed opportunity. This can be done by individual provider or for all providers in a location or medical center, as a quality assurance measure. The example below shows a summary report where the reminders selected are all related to Hepatitis C. This illustrates how you could use the summary report as part of a larger strategy for implementing and managing a Hepatitis C guideline using reminders.

#### **Example Report**

	· r · ·r · ·		
#	Patients with	Reminder	
	Applicable	Due	
Hep C Risk Factor Screen	172	16	
Hep C Test for Risk	30	7	
Hep C Diagnosis Missed	0	0	
Hep C Diagnosis	36	36	
Hep C- Dz & Trans Ed	36	27	
Hep C - Eval for Rx	36	15	
Chr Hep - Hep A Titer	45	3	
Hepatitis A Vaccine	19	4	
Chr Hepatitis - AFP	12	4	
Chr Hepatitis - U/S	13	б	
Report run on 175 patient	s.		

Chapter 6: Health Summaries and Clinical Reminders

#### **Health Summaries**

Reminder items can be added to health summary displays. Health summaries and reminder definitions can be tailored to suit clinicians' needs.

#### Health Summary Reminder Components

- *Reminders Due:* an abbreviated component indicating only what is due now.
- *Reminders Summary*: this provides the status, the next due date, and the last done date.
- *Reminder 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.

NOTE: Statuses include "DUE SOON," to allow you to process a reminder in advance, if convenient.

#### Example of *Reminder Due* as displayed on a health summary

	STATUS	DUE DATE	LAST DONE
Advanced Directives Education	DUE NOW	DUE NOW	unknown
Alcohol Abuse Education	DUE NOW	DUE NOW	unknown

#### Example of Reminder Summary as displayed on a health summary

	STATUS	DUE DATE	LAST DONE
Mammogram	RESOLVED	05/01/2003	10/01/2002
Pap Smear	DUE NOW	06/01/2003	unknown
Diabetic Eye Exam	DUE NOW	06/01/2003	06/01/2002

#### Example of Reminder Maintenance as displayed on a health summary

CM - H	Reminder Mainten	ance	
	STATUS	-DUE DATE	LAST DONE
Fecal Occult Blood Test	DUE NOW	DUE NOW	unknown
Applicable: Due every 1 year	r for ages 50 an	d older.	
No HX of colorectal cancer of	on file - presum	ed no HX.	
Health Factor Test	DUE NOW	DUE NOW	unknown
Applicable: Due every 1 year	r for ages 40 to	60.	
Baseline set to 1Y for 40-6	0.		

# Chapter 6: Health<br/>Summaries,<br/>cont'dHealth Summary on Reports Tab in CPRSWhen you open the Reports tab, select Health Summary, and then<br/>select a Reminders Health Summary Type.

#### Example: Health Summary on CPRS Report tab

Eile Edit View Iools Help								
CRPATIENT,TWO 666-55-4444 Oct 10,1972 (33)	GM Jun 12,06 09:59 Provider: WHPROVIDER,TWO	Primary Care Team U	nassigned		Flag	Remote Data	Ø	No Postings
Available Reports	Health Summary Rem Cr For Va-							
Rem Cr For Va Clinical Reminders - N. Reminders Test (2) Remote Clinical Data ( Remote Labs All (1y) Remote Labs All (1y) Remote Meds/Labs/C Division 1 Diabetes Adhoc Report Gec Local Test Discharge Summary Future Visits Dept. of Defense Reports Dept. of Defense Reports Imaging (local only) Caraphing (local only) Lab Status Blood Bank Report Anatomic Path Reports Dietetics Profile Nutritional Assessment Vitals Cumulative Cover Sheet Problems Meds	<pre>************************************</pre>	NTIAL REM CR for 444 CR - Remine r. o account. Our DUE DUE DUE DUE DUE NUE NUE DUE DUE DUE DUE DUE DUE DUE D	ATUSDUE ATUSDUE NOW DUE NOW DUE	Y pg. DATE NOW NOW NOW NOW NOW NOW NOW NOW NOW NOW	00 1 *** I LA un un un un un un un un un un un un un	AST DON AST DON ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN ARNOWN	06 10 ***** /10/1 E	:19 *** 972 
	J				]			J

Chapter 6: Health Summaries,	My HealtheVet Health Summary
cont'd	Clinical Reminders V.2.0 contains new health summary components to support the My Health $e$ Vet project. These components will allow display of clinical reminder information to patients.
NOTE: The veteran's private health record will be securely stored and only accessible by the veteran and others they have identified.	My Health <i>e</i> Vet is a Web-based system that empowers veterans with information and tools so that they can improve their health to the maximum extent possible. Participating veterans are given copies of key portions of their electronic health records. New health summary components were devised that eliminate much of the technical text and code information that is contained in the CM component. These components will be used to display summary and detailed information on individual patient reminders to the patients from within My Health <i>e</i> Vet. They can be also used in other health summaries at a facility if it is useful for display to users at the site.

Chapter 6: Health Summaries, cont'd

#### My HealtheVet Health Summary

Two new national Health Summary types were created to include the new health summary components:

- REMOTE MHV REMINDERS DETAIL
- REMOTE MHV REMINDERS SUMMARY

These are available in health summaries on the reports tab in CPRS. Use of these health summaries will allow anyone to view the reminders and text that are being displayed to the patients, even if the patient is being seen at a different site.

#### **Example: MHVS Health Summary**

```
10/06/2004 08:55
*********** CONFIDENTIAL REMOTE MHV REMINDERS SUMMARY SUMMARY **************
CRPATIENT, ONE
               000-31-9898
                                                              DOB: 00/00/1950
                                    1A(1&2)
   ----- MHVS - Summary Display -----
                                  --STATUS-- --DUE DATE-- --LAST DONE--
Flu vaccine
                                   DUE NOW
                                              DUE NOW
                                                          unknown
     Please check these web sites for more information:
     Web Site: CDC Influenza Home Page
     URL: http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm
     Web Site: Weekly Update on Influenza Rates
     URL: http://www.cdc.gov/ncidod/diseases/flu/weekly.htm
      CDC Site for weekly updates on the current influenza activity in the
      community.
     Web Site: Dept HHS Information on Influenza Vaccination
     URL: http://odphp.osophs.dhhs.gov/pubs/guidecps/text/CH66.txt
     Web Site: California Influenza Information
     URL: http://www.dhs.ca.gov/ps/dcdc/VRDL/html/Flutable02-03.htm
     Web Site: Patient Handout for Influenza Vaccine
     URL: http://www.cdc.gov/nip/publications/VIS/vis-flu.pdf
```

Chapter 6: Health<br/>Summaries,<br/>cont'dMy HealtheVet Health Summary, cont'dThe components can also be used in other health summaries at a facility<br/>if it is useful for display to users at the site

#### Example: MHVS Health Summary, cont'd

Flu vaccine Due Now DUE NOW DUE NOW unknown This is the summary patient cohort found text. This is the summary resolution not found text. Please check these web sites for more information: Web Site: CDC Influenza Home Page URL: http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm Web Site: Weekly Update on Influenza Rates URL: http://www.cdc.gov/ncidod/diseases/flu/weekly.htm CDC Site for weekly updates on the current influenza activity in the community. Web Site: Dept HHS Information on Influenza Vaccination URL: http://odphp.osophs.dhhs.gov/pubs/guidecps/text/CH66.txt Web Site: California Influenza Information URL: http://www.dhs.ca.gov/ps/dcdc/VRDL/html/Flutable02-03.htm Web Site: Patient Handout for Influenza Vaccine URL: http://www.cdc.gov/nip/publications/VIS/vis-flu.pdf

#### Chapter 7: VA-Geriatric Extended Care (GEC) Referral

#### Important:

This GEC screening tool is for the purpose of evaluating a patient's needs for extended care and is not to be used as the document to refer or place a patient. The document should be part of a packet of information obtained when placing a patient.

Four different disciplines should complete the screening, making it less burdensome on any one individual.

## VA-Geriatric Extended Care Referral

#### Overview

Clinical Reminders V.2.0 includes a nationally standardized computer instrument called VA Geriatric Extended Care (GEC), which replaces paper forms for evaluating veterans for extended care needs. Paper forms that facilities use include VA Form 10-7108, VA Form 10064a-Patient Assessment Instrument (PAI), and VA Form 1204-Referral for Community Nursing Home Care (others sites use various instruments including Consults).

The GEC Referral is comprised of four reminder dialogs: VA-GEC SOCIAL SERVICES, VA-GEC NURSING ASSESSMENT, VA-GEC CARE RECOMMENDATIONS and VA-GEC CARE COORDINATION. These dialogs are designed for use as Text Integration Utility (TIU) templates to enter data regarding the need for extended care. Data entered via the dialogs are captured as health factors to be used for local and national reporting.

The software also includes a new report menu that may be used for local analysis.

## Chapter 7: GEC, cont'd

Updates to GEC options and GEC Reports

See <u>Appendix D</u> for a description and examples of the GEC Report changes.

### Changes made in Patch 4 (PXRM\*2.0\*4)

- The GEC Care Recommendation Dialog has been modified to allow more than one selection when a person wants to refer a patient to more than one location.
- Items 15-19 (Prognosis, Weight Bearing, Equipment, Diet, and Supplies) were moved from the "GEC Nursing" dialog to the "Care Recommendations" Dialog.
- A problem with the user being able to take some editing actions on GEC dialogs has been corrected, so the user is not able to copy or delete dialog groups from the GEC dialogs.
- An undefined error (<UNDEFINED>CALCMON+12<> PXRMG2M1) that occurred when the scheduled event fired off at the beginning of each month has been repaired.
- Several of the GEC Reports were not showing a complete list of patients or providers. This has now been corrected with this patch. The division and age of the patient has been added to some reports to help in identifying the patient.
- There is a new choice in the GEC reports menu that will give the sites the option to open a closed referral, merge two referrals, and close an open referral.

## **GEC Status Check**

There is no limit to the entry of GEC Referral data. Since there may be multiple entries of the same health factors over time, and since the data is entered via separate dialogs, extraction and viewing requires the data to be discretely identified. The GEC software depends upon the user to indicate when the data from a given referral should be concluded. The referral is finalized using a new feature called the GEC Status Indicator. This indicator is presented to the user as a dialog at the conclusion of the VA-GEC CARE COORDINATION dialog. It will prompt the user to indicate the conclusion of the Referral with a Yes or No response and will list any missing dialogs. If Yes is selected, the data for the current episode of the Referral is closed. If No is selected, the Indicator is displayed and the data entered will be included with the current episode of the Referral. The Indicator will then be displayed with each succeeding GEC dialog until Yes is selected.

To assist the ongoing management of completing GEC Referrals, the GEC Status Indicator may be added to the CPRS GUI Tools drop-down menu. It may be set at the User or Team level. If added to the drop-down menu, the Indicator may be viewed at any time and used to close the referral if needed. *See your CAC or the Clinical Reminders V. 2.0 Setup Guide for instructions on adding this to the Tools menu.* 

GEC dialogs also contain a checkbox called "CHECK TO SEE REFERRAL STATUS." This checkbox appears on all dialog boxes and lets you see a real-time view of the current Referral's dialog-completion status. It presents information similar to that found on the GEC Referral Status Display and can be used to determine if the Referral can be finalized.

## **GEC Status Check**

#### Status Indicator Instructions, cont'd

The Yes button should only be selected if the user is certain no changes are needed and they are ready to commit to the note's authentication. The Status Indicator does not update after the referral has been completed. Put another way, once a referral has been closed, it cannot be reopened. This same risk exists if a note is deleted after the Yes button has been selected and the user then reenters the dialog.

Users should *always* check the Status Indicator when a new referral is initiated on a patient. Doing so will provide the opportunity to close any previous referrals inadvertently left open.

#### Example of Status Indicator when all dialogs are complete.

GEC Referral Completion Status	×
All Dialogs are Finished.	
Is this Referral Complete?	
Yes No	

Example of Status Indicator when some dialogs are missing.

GEC Referral Completion Status
The Following Dialogs are Missing:
Social Services Nursing Assessment
Is this Referral Complete?
(If you select Yes, the current REFERRAL will be completed and any missing information cannot be added.
If you select No, the current REFERRAL will include the addition of missing information.)
Yes No

## **GEC Referral Ad hoc Health Summaries**

Two new health summary components have been created and distributed with this software:

- GEC Completed Referral Count (GECC)
- GEC Health Factor Category (GECH)

The first displays all GEC referral data according to the occurrence and time limits identified.

If a user should have access to these GEC reports, they must have access to the Ad Hoc Health Summary type. (This can be set using GMTS GUI HS LIST PARAMETERS.)

#### **GEC Referral Reports**

The software includes a new set of reports that provide a variety of GEC health factor perspectives. The reports capture data elements for reporting and tracking use of the GEC Referral Screening Tool. The reports may be generated in formatted or delimited output. The Summary (Score) report provides summary (calculated) totals from specific sections of the screening tool identified by the Office of Geriatrics Extended Care. See <u>Appendix D</u> for more details.

## **GEC Referral Reminders and Dialogs**

The GEC reminders are comprised of dialogs and health factors only. They have neither cohort nor resolution logic, and will not become due. They are intended only as TIU templates and do not need to be assigned to the CPRS Cover Sheet. Due to potential complications with reporting and duplicate entries, it is recommended that the GEC dialogs not be added to the Reminders drawer/Cover sheet.

The Referral was designed for inter-disciplinary use with dialogs created for separate services. However, a single user may perform them all. With only a few exceptions, each section of the dialogs is mandatory and is marked with an asterisk (\*). The completion of all four dialogs constitutes a discrete episode of the GEC Referral.

The VA-GEC REFERRAL SOCIAL SERVICES, VA-GEC REFERRAL NURSING ASSESSMENT, and VA-GEC REFERRAL CARE RECOMMENDATIONS dialogs comprise the clinical screening. The VA-GEC REFERRAL CARE COORDINATION dialog is used administratively to record the arrangement of and funding for extended care services. These dialogs may be performed in any order that local practices dictate. However, it is expected the screening portion will be completed prior to the coordination of services. When the screen is complete, a consult order should be placed to the service responsible for arranging services.

#### GEC Consult Order

Most sites have either an individual or a service responsible for arranging and coordinating extended care services. To accommodate local business practices and flexibility, sites may associate any consult service (or menu) they already have in place. If none exist, the sites may create a consult or establish some alternative practice to ensure that both services are arranged and that the VA-GEC REFERRAL CARE COORDINATION dialog is completed.

Sites will need to review the privileging status of those performing the GEC Referral. The staff assigned to place the consult order associated with the GEC dialogs will require the ability to place a consult order.

Chapter 7: GEC Usage, cont'd	<b>GEC Interdisciplinary Notes</b> The GEC Referral dialogs are intended for use as TIU templates. It is also expected that they will be used as part of a TIU Interdisciplinary (ID) note. The Office of Geriatrics Extended Care requests that the parent ID note title be:
NOTE:	"GEC EXTENDED CARE REFERRAL"
Refer to Appendix C in the TIU/ASU Implementation Guide for complete instructions about Interdisciplinary Notes	<ol> <li>Steps to use the GEC Dialog templates:</li> <li>In the CPRS GUI, open the NOTES tab.</li> <li>Click on New Note.</li> <li>When the Progress Note Properties box opens, type GEC in the Title box.</li> <li>The list of GEC dialog templates is displayed.</li> <li>Select the first one to process.</li> </ol>

## Example: Selecting GEC REFERRAL CARE COORDINATION

Progress Note Title:	GEC <gec care="" coordination="" referral=""></gec>	ОК
	GEC <gec consult=""> GEC <gec care="" coordination="" referral=""> GEC <gec care="" recommendations="" referral=""> GEC <gec assessment="" nursing="" referral=""> GEC <gec referral="" services="" social=""> GEC CONSULT GEC REFERRAL CARE COORDINATION</gec></gec></gec></gec></gec>	Cancel
Date/Time of Note:	May 19,2004@14:18	
Author:		

#### Chapter 7: GEC Usage, cont'd

This is first screen shot when you select GEC REFERRAL CARE COORDINATION. When you select one type of service, the screen for that service type expands. The next screen shots show each in expanded form.

#### Example: GEC REFERRAL CARE COORDINATION Opening screen

🖉 Reminder Dialog Template: GEC REFERRAL CARE COORDINATION	
CHECK TO SEE REFERRAL STATUS	-
WHERE WAS THE PATIENT REFERRED? (Use this section at time referral is being made. Both the program type and funding source are required.)	
home care services:	
DOMICILIARY REFERRALS:	
HOSPICE SERVICES:	
STRUCTURED LIVING SERVICES:	
NURSING HOME CARE REFERRALS:	
GERIATRIC SERVICES:	
HOME TELEHEALTH SERVICES:	
C OTHER REFERRAL PROGRAM:	
Patient was not referred due to:	
Date service is projected to start:	-
	el
THE PATIENT HAS BEEN REFERRED TO THE FOLLOWING SERVICES	
Date service is projected to start:	
<no encounter="" entered="" information=""></no>	
* Indicates a Required Field	

#### Chapter 7: GEC Usage, cont'd

This is the expanded screen when you select HOME CARE SERVICES in the GEC REFERRAL CARE COORDINATION dialog.

Note the checkbox "CHECK TO SEE REFERRAL STATUS." This is available on all dialog boxes and lets you see a real-time view of the current Referral's dialog-completion status. It presents information similar to that found on the GEC Referral Status Display and can be used to determine if the Referral can be finalized.

#### **Example: Expanded screen for HOME CARE SERVICES**

Reminder Dialog Template: GEC REFERRAL CARE COORDINATION	×
CHECK TO SEE REFERRAL STATUS	-
WHERE WAS THE PATIENT REFERRED? (Use this section at time referral is being made. Both the program type and funding source are required.)	
HOME CARE SERVICES:	
Select all home care services that apply:	
Community skilled home health care	
Home Based Primary Care	
Homemaker/Home Health Aide	
🗖 VA Bowel and Bladder	
🗖 Adult Day Health Care	
🗖 VA In-home Respite	
FUNDING SOURCES	
Identify the funding source for home care services:	_
Visit Info Finish Cancel	
THE PATIENT HAS BEEN REFERRED TO THE FOLLOWING SERVICES	
HOME CARE SERVICES:	
HOME CARE SERVICE FUNDING:	- 1
	=
I * Indicates a Required Field	

#### Example: Expanded screen for DOMICILIARY REFERRALS

🚝 Reminder Dialog Template: GEC REFERRAL CARE COORDINATION	×
CHECK TO SEE REFERRAL STATUS	-
WHERE WAS THE PATIENT REFERRED? (Use this section at time referral is being made. Both the program type and funding source are required.)	
HOME CARE SERVICES:	
DOMICILIARY REFERRALS:	
Select the appropriate Domiciliary:	
🔘 VA Domiciliary	
🖸 State Home Domiciliary	
FUNDING SOURCES	
Identify the funding source for Domiciliary care:	
Medicare	
Medicaid	
Other insurance	
🗖 Private pay	
Other:	•
⊻isit Info Finish Cancel	
THE PATIENT HAS BEEN REFERRED TO THE FOLLOWING SERVICES	-
<no encounter="" entered="" information=""></no>	
* Indicates a Required Field	

#### **Example: Expanded screen for HOSPICE SERVICES**

🖉 Reminder Dialog Template: GEC REFERRAL CARE COORDINATION
CHECK TO SEE REFERRAL STATUS
WHERE WAS THE PATIENT REFERRED? (Use this section at time referral is being made. Both the program type and funding source are required.)
home care services:
D DOMICILIARY REFERRALS:
HOSPICE SERVICES:
Select Hospice:
VA NHCU (respite)
🗖 VA Outpatient Hospice
Community Hospice
FUNDING SOURCES
Funding Sources for Hospice Care:
Medicare
Medicaid
🗖 Other insurance
⊻isit Info Finish Cancel
THE PATIENT HAS BEEN REFERRED TO THE FOLLOWING SERVICES
<no encounter="" entered="" information=""></no>
* Indicates a Required Field

#### Example: Expanded screen for STRUCTURED LIVING SERVICES

Reminder Dialog Template: GEC REFERRAL CARE COORDINATION	×
CHECK TO SEE REFERRAL STATUS	-
WHERE WAS THE PATIENT REFERRED? (Use this section at time referral is being made. Both the program type and funding source are required.)	
HOME CARE SERVICES:	
DOMICILIARY REFERRALS:	
HOSPICE SERVICES:	
STRUCTURED LIVING SERVICES:	
Select type of structured living:	
Personal Care Home	
Community Residential Care Program	
Assisted Living	
FUNDING SOURCES	
Funding Sources for Structured Living Situation:	
	Ŧ
	_
THE PATIENT HAS BEEN REFERRED TO THE FOLLOWING SERVICES	-
<no encounter="" entered="" information=""></no>	
* Indicates a Required Field	

#### Example: Expanded screen for NURSING HOME CARE REFERRALS

Reminder Dialog Template: GEC REFERRAL CARE COORDINATION	×
CHECK TO SEE REFERRAL STATUS	
WHERE WAS THE PATIENT REFERRED? (Use this section at time referral is being made. Both the program type and funding source are required.)	
home care services:	
Domiciliary referrals:	
HOSPICE SERVICES:	
STRUCTURED LIVING SERVICES:	
WIRSING HOME CARE REFERRALS:	
Select nursing home type:	
O VA NHCU (Rehab)	
🖸 VA NHCU (Long-term Care)	
🔘 VA NHCU (Subacute Care)	
🖸 VA NHCU (Respite)	
O Community nursing home	
🖸 State Veterans Nursing Home	
O VA NHCU (HOSPICE)	
FUNDING SOURCES	⊡
	el 🛛
THE PATIENT HAS BEEN REFERRED TO THE FOLLOWING SERVICES	•
<no encounter="" entered="" information=""></no>	
* Indicates a Required Field	

Reminder Dialog Template: GERIATRIC/EXTENDED CARE REFERRAL CARE COORDINATION	×
HOME CARE SERVICES:	
DOMICILIARY REFERRALS:	
hospice services:	
□ STRUCTURED LIVING SERVICES:	
NURSING HOME CARE REFERRALS:	
CERIATRIC SERVICES:	
Select appropriate Geriatric Care:	
🗌 Geriatric Evaluation and Management (GEM) Clinic	
🗖 Geriatric Primary Care	
Geriatric Evaluation and Management (GEM) Inpatient Unit	
FUNDING SOURCES	
Funding Sources for Geriatric Services:	
Medicare	
Medicaid	
Other insurance	
Private pay	
C Other:	<b>-</b>
⊻isit Info Finish Cancel	٦
GERIATRIC SERVICES:	
GERIATRIC SERVICES FUNDING:	
No encounter information entered	=
I vindicates a Required Field	

/	eminder Dialog Template: GERIATRIC/EXTENDED CARE REFERRAL CARE COORDINATION	x	
	HOME CARE SERVICES:		
	DOMICILIARY REFERRALS:		
	HOSPICE SERVICES:		
	STRUCTURED LIVING SERVICES:		
	NURSING HOME CARE REFERRALS:		
	GERIATRIC SERVICES:		
	OTHER REFERRAL PROGRAM:		
	Enter the alternative service program:		
	FUNDING SOURCES		
	Funding Sources for Other Referral Program:		
	Medicare		
	Medicaid		
	Other insurance		
	Private pay		
	D Other:		
		Ţ	
	Next and		
omr		<u>'</u>	
F	FUNDING SOURCES FOR OTHER REFERRAL PROGRAM:		
<no< td=""><td colspan="2"><no encounter="" entered="" information=""></no></td></no<>	<no encounter="" entered="" information=""></no>		
1 × Ind	icates a Bequired Field		

#### Example: Expanded screen for OTHER REFERRAL PROGRAM

Example: Expanded screen for "Patient was not referred due to:"

🖉 Reminder Dialog Template: GERIATRIC/EXTENDED CARE REFERRAL CARE COORDINATION 🛽	×
WHERE WAS THE PATIENT REFERRED? (Use this section at time referral is being made. Both the program type and funding source are required.)	
home care services:	
DOMICILIARY REFERRALS:	
HOSPICE SERVICES:	
STRUCTURED LIVING SERVICES:	
NURSING HOME CARE REFERRALS:	
GERIATRIC SERVICES:	
C OTHER REFERRAL PROGRAM:	
Patient was not referred due to:	
Patient does not meet criteria for referred program or service.	
Program or service has a waiting list or is unable to	
accommodate patient due to high volume of referrals.	
Patient has insufficient financial resources to access the	
program or service.	
Destint brons for ill to nonticinate in normal or consist	
Patient became too iii to participate in program or service.	
Other Comments:	-
Patient was not referred due to:	
No encounter information entered>	=
I vindicates a Required Field	

#### **Example: CARE RECOMMENDATION Dialogs**

With patch 4, the Prognosis, Weight Bearing, Diet, Equipment, and Supplies sections were moved from the Nursing Assessment dialog to the Care Recommendation dialog.

🖅 Reminder Dialog Template: GERIATRIC/EXTENDED CARE REFERRAL CARE RECOMMENDATIO 🔯			
[An * indicates the section is required.]			
*GOALS OF CARE			
Program Goals (Check as many as apply)			
Rehabilitation (Care by a licensed OT, PT, KT, or speech therapist aimed at restoring function).			
Care requiring a licensed nurse, e.g., catheter care, wound care, etc.			
Patient needs nurse to monitor parameters, e.g., blood sugars, vital signs, and medications, to avoid clinical complications.			
Patient needs assistance in setting up a structure to manage medications and treatments, e.g., medication cassettes.			
Patient/Family education.			
Respite (temporary relief for caregiver).			
Palliative/terminal care.			
Reduce hospitalizations and/or ER visits.			
A supportive, structured living situation in which the patient will have assistance with medications, IADL's, and possibly personal care.			
Care aimed at stabilizing problematic behaviors.			
*REFERRING TO WHICH PROGRAM			
Visit Info Finish Cancel			
GOALS OF CARE:			
ESTIMATED DURATION OF SERVICES:			
РROGNOSIS:			
<no encounter="" entered="" information=""></no>			
* Indicates a Required Field			

### Example: CARE RECOMMENDATION—2<sup>nd</sup> Screen

🖾 Reminder Dialog Template: GERIATRIC/EXTENDED CARE REFERRAL CARE RECOMMENDATIO	×				
Skilled care in home	^				
Home Based Primary Care (HBPC)					
ADL assistance (personal care) in home					
Chore services (homemaker) in home					
Adult Day Health Care					
Residential care (supervised living)					
Assisted Living					
Domiciliary care					
Short-term nursing home care (subacute care, rehab)					
Long-term nursing home care					
Outpatient Respite Care					
Inpatient Respite Care					
Specialized Dementia/Geropsych Care					
Inpatient Palliative/Hospice Care (NHCU)					
Outpatient Palliative/Hospice Care (Home)					
All-inclusive care or PACE program					
Home Telehealth					
D Other	~				
<u>V</u> isit Info Finish Cancel					
GOALS OF CARE:	^				
REFERRING TO WHICH PROGRAM: ESTIMATED DURATION OF SERVICES.					
PROGNOSIS:	~				
Matrix Deadthic coartic.					
Indicates a Required Field					

Reminder Dialog Template: GERIATRIC/EXTENDED CARE F	REFERRAL CARE F	RECOMMEN	DATIO 🚺				
			^				
*ESTIMATED DURATION OF SERVICES  C One week C 2-3 weeks C One month C 2-3 months C 4-6 months C 4-6 months C Indefinite  *PROCNOSIS  In the last 7 days, has the patient experienced a flare-up of a recurrent or chronic health problem? C Yes C No  Does the direct care staff (MD, RN, Rehabilitation) think the patient is capable of increased independence in ADL's, IADL's, or mobility? C Yes C No							
⊻isit Info		Finish	Cancel				
GOALS OF CARE: REFERRING TO WHICH PROGRAM: ESTIMATED DURATION OF SERVICES: PROGNOSIS: METCHT PRADIME STATUS: <no encounter="" entered="" information=""> * Indicates a Bequired Field</no>			~				

## Example: CARE RECOMMENDATION—3<sup>rd</sup> Screen

## Example: CARE RECOMMENDATION—4<sup>th</sup> Screen

🗐 Reminder Dialog Template: GERIATRIC/EXTENDED CARE REFERRAL CARE RECOMMENDATIO 🔁						
Does the patient have a limited life expectancy (likely to be less than 6						
months)?						
Q Yes						
C No						
WEIGHT BEARING STATUS						
🖸 Patient is fully weight bearing.						
🖸 Patient is partial weight-bearing.						
🖸 Patient is non-weight bearing.						
DIET						
🖸 The patient is on a regular diet.						
Patient is on a modified diet (specify):						
EQUIPMENT						
What equipment does the patient need? (Place or request Prosthetic order be placed when finished.)						
(Check all that apply.)						
Hospital bed						
⊻isit Info Finish Cancel						
GOALS OF CARE:						
REFERRING TO WHICH PROGRAM:						
ESTIMATED DURATION OF SERVICES: PROGNOSTS:						
אסטאסטבט. אסטרעייד סטאסראור כיזאיוויני.						
<no encounter="" entered="" information=""></no>						
* Indicates a Required Field						

🗧 Reminder Dialog Template: C	GERIATRIC/EXTE	NDED CARE REFERRAL	CARE RECOMMEN	IDATIO 🔀		
L Special mattress				~		
🗖 Trapeze						
🗖 Walker						
🗖 Cane						
🗖 Wheelchair						
🗖 ADL equipment						
🗖 Orthotic or splint						
D Other equipment:						
SUPPLIES						
(Please order suppl (Check all that apply.) Catheters Tubing Dressings	ies when finis	hed.)				
🗖 Wrappings						
🗖 Tape						
🗖 Glucose Strips				~		
	⊻isit Info		Finish	Cancel		
GOALS OF CARE: REFERRING TO WHICH PROGRAM: ESTIMATED DURATION OF SERVICES: PROGNOSIS: DETCUT BEADING STATUS:						
<no encounter="" entered="" information=""></no>						
* Indicates a Required Field						

## Example: CARE RECOMMENDATION—5<sup>th</sup> Screen

Chapter 8: Code Set Versioning

#### NOTE:

The Code Text Descriptors project, released in October 2004, is a follow-up project to Code Set Versioning. It ensures that the diagnostic and procedure descriptions used for billing purposes must be the descriptors that were applicable at the time the service was provided.

It doesn't affect Clinical Reminders.

#### Chapter 8: Code Set Versioning (CSV) Changes in Reminders

Several changes and enhancements are included in Clinical Reminders V.2.0 in support of Code Set Versioning, mandated under the Health Information Portability and Accountability Act (HIPAA). The changes will insure that only active, on the encounter date, ICD9, ICD0, and CPT codes are selectable in the CPRS GUI application while using Clinical Reminder Dialogs. It will also produce several email messages to Clinical Reminder Managers to help in deciding the correct usage of these codes in the Taxonomies and Dialogs.

PXRM\*1.5\*18, which contained the CSV changes, was previously released in conjunction with CSV\_UTIL v1, Code Set Versioning, which contains routines, globals, and data dictionary changes to recognize code sets for the International Classification of Diseases, Clinical Modification (ICD-9-CM), Current Procedural Terminology (CPT) and Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). When implemented, the Lexicon will allow translation 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.

Version 2.0 of Clinical Reminders includes all of the CSV changes contained in patch 18.

#### Chapter 9: My Health*e*Vet

## Chapter 9: My HealtheVet Changes in Reminders

Clinical Reminders V. 2.0 contains new health summary components to support the My HealtheVet project. These components will allow display of clinical reminder information to patients. New health summary components were devised that eliminate much of the technical text and code information that is normally displayed for clinicians. These new components will be used to display summary and detailed information on individual patient reminders to the patients from within My HealtheVet. They can be also used in other health summaries at a facility if it is useful for display to users at the site.

See the section under Chapter 5: Health Summary, for examples and descriptions of My HealtheVet HS components.

My Health Reminders are being developed for veterans to view in their My HealtheVet record. Twelve patient reminders have been created:

- Influenza Vaccine
- Pneumonia Vaccine
- Colorectal Screen
- Mammogram Screen
- Pap Smear Screen
- Three for Diabetes: Eye, Foot and HbAlc (blood glucose)
- Two for lipids: lipid measurement and LDL control
- Hypertension
- BMI

These were distributed in patch PXRM\*2\*3 in June 2005.

The veteran will be able to click on a "Details" button to see the details of a reminder – comparable to the Clinical Maintenance screens in CPRS and Health Summary.
# Chapter 10: Women's Veterans Health Reminders

# Chapter 10: CPRS: Integration with Women's Health

"It is VHA policy to provide a nationwide tracking system to ensure that consistent mammography and cervical screening follow-up is achieved and that patients have been properly notified of the test results." (VHA Directive 98-501 dated November 19, 1998)

To meet the data requirements of this policy, the Women's Health (WH) VistA package was developed. However, none of the information contained within the WH software interfaced with CPRS, so the CPRS Integration with Women's Health project was initiated.

Clinical Reminders patch PXRM\*2\*1 provides reminders and dialogs that enable CPRS GUI to interface with the Women's Health package. These reminder dialogs will update the WH package at the same time that clinical care is recorded in CPRS GUI, thus eliminating the need for dual data entry. The exchange of data will enable Clinical Reminders to capture a greater percentage of data than is currently entered into the Women's Health VistA package, but still allow continuation of Women's Health Software reporting, tracking, and notification functionality.

## **Project Goals**

- Update Pap Smear and Mammogram screening reminders
- Provide review reminders that store clinical review results in the WH package.
- Provide dialogs for the screening and review reminders that clinicians can use to document pap smear tests and mammogram procedures.
- Result in a signed progress note documenting the WH Mammogram- and Pap Smear-related care and patient notifications.

The Mammogram Screening reminder replaces the following national reminders relating to mammograms and breast cancer screening:

VA-\*BREAST CANCER SCREEN - rescinded 02/04/2005 VA-MAMMOGRAM - rescinded 02/04/2005

The Pap Screening reminder replaces the following national reminders relating to PAP smears and cervical cancer screening:

VA-\*CERVICAL CANCER SCREEN - rescinded 02/04/2005 VA-PAP SMEAR - rescinded 02/04/2005

# Using Clinical Reminders – Women's Health

# Chapter 10: Women's Veterans Health Reminders

## NOTE:

See the WH Reminders Install and Setup Guide (PXRM\_2\_1\_IG\_PDF.) for complete instructions for setting up the WH reminders application.

# Chapter 10: CPRS: Integration with Women's Health, cont'd

#### Setup and implementation by local team

Sites will need to determine if the review reminders should be used locally. If a site is not set up for automatic update of WH, these reminders will not come due, so releasing the review reminders and dialogs might be confusing.

The VA-WH PAP SMEAR REVIEW RESULTS reminder will only come due if all of the following are true:

- o PAP smear results are recorded in the VistA Lab package.
- VistA Lab package uses SNOMED codes.
- WH package has SNOMED codes mapped to the codes used by the VistA Lab package.
- WH parameters are set up to automatically receive VistA Lab results when the PAP smear procedure is verified and released.

The VA-WH MAMMOGRAM REVIEW RESULTS reminder will only come due if all of the following are true:

- Mammogram results are recorded and verified in the VistA Radiology package.
- WH parameters are set up to automatically receive VistA Radiology results when the mammogram procedure is verified and released, and status of received mammogram result is set to OPEN.

# **Using Clinical Reminders**

Chapter 10: Women's Veterans Health Reminders

#### NOTE:

You can see more information about the guidelines that the reminder is based on by clicking the top checkbox in the dialog.

#### **Steps to use dialogs:**

- 1. On the CPRS cover sheet, click on the Reminders icon.
- 2. Click on reminders in the Reminders box to see details of a reminder.
- 3. Open the Notes tab and select New Note. Enter a title.
- 4. Open the Reminders drawer and review the contents.
- 5. Locate the Mammogram or Pap reminder you wish to complete (e.g., VA-WH Mammogram Screening) and click to open it.
- 6. In the dialog box, check relevant actions.
- 7. Finish the reminder processing.
- 8. Review the text added to the note to assure its correctness.
- 9. Ensure that the reminder can be satisfied by the individual finding items that were mapped to the reminder terms.

#### **Example: Mammogram Screening Dialog**

Reminder Resolution: Mammogram Screening	×
The VHA recommends women age 40 and older have a mammogram every 1-2 years	-
Click here for more information	
Screening	-
🖸 Order mannogram	
🖸 Mammogram - screening	
🔿 Mannogram - bilateral	
🖸 Mammogram - unilateral	
C Record results of mammogram completed elsewhere	
O Order - refer to Nomen's Health Provider	
C Detient dealined nemocran	
C - /	
Defer mammogram	
9 Mammogram not indicated	
Click here to change the frequency of mammograms for this patient	
Mammogram Frequency	100
O Screen every 4 months	
C Screen every 6 months	
C Screen every year	
Clear Clinical Maint ⊻isit Info < Back Next > Finish Car	cel
No encounter information entered>	

# **Using Clinical Reminders**

### Chapter 10: Women's Veterans Health Reminders

The notification letter can be modified at your local site.

### **Review Results Dialogs**

If your site uses the Women's Health package, you can review the results of pap smear lab tests or mammogram procedures. You can then send notifications to patients to inform them of the results. The example below shows the Mammogram Review Results dialog and demonstrates sending a notification letter indicating that there is no evidence of malignancy. A follow-up mammogram can be scheduled.

#### **Review Results Dialog**

Reminde	r Resolution: Mamn	nogram Reviev	v Results			×
The VHA retter	The VHA recommends that mammogram results be reviewed and recorded in the patient's electronic record.					in
WH Mammoo	yram Clinical Re	eview				
Primary	Procedure: MAMMOGRAPHY,SCREENING (BILATERAL) Primary Diagnosis: NORMAL Modifiers: <none></none>					
Revi	ew complete rep	ort				
* Thi	s report indica	tes:				
C NEI	M (No Evidence (	of Malignanc	y) 🔿 Abnor	mal		
O Un:	satisfactory for	c Diagnosis				
Comment	»: <u> </u>					
Patient 1	Notification				101	
• Notify	patient of NEM	(No Evidenc	e of Malign	hancy) rest	ults	
O NEM	results - furth	er screenin	g not requi	red		
+ T	results - next		year D —	_		
	atient notified	.: IV Lette	rj   In-Pe	erson [	Phone Call	
Vi	ew WH Notificat	ion Letter				
O NEM	results - next	mammogram 2	years			
O NEM	results - follo	- w-up mammog:	- ram in 4 mo	nths		
C NEM	results - follo	w-up mammog	ram in 6 mo	nths		
O Notify	patient of abn	ormal result	s			
🖸 Unsati	sfactory for di	agnosis - re	cord patier	nt notific	ation	
Clear	Clinical <u>M</u> aint		< Back	Next >	Finish	Cancel
Mammogra	am Keview Kesult	<b>.s</b> :				<b></b>
	Procedure: N	AMOGRAPHY,	SCREENING (	BILATERAL )		
	rımary Diagnosı Modifier	.s: NURMAL s: <none></none>				
Notifi	led patient of m lignancy (NEM)	hammogram res	sults. The	re was no r	evidence (	of
Patient notified: Letter						
I I a a Ma E a a base			FO 1V			
Women's Hea WH Notificatio	ith Procedure: Mammodia MAM result NEM	ogram 1, next MAM 11	r			
* Indicates a F	lequired Field					

# Appendix A: FAQS, Hints, and Tips

- **Q:** Are the reminders our site has already defined compatible with the new Clinical Reminders V. 2.0 package?
- A: Yes, a conversion utility is run when the package is installed that converts your reminders to the new file structure. Some reminders may need slight adjustments to work with the new functionality so if you notice any reminders that don't seem to be working correctly notify your reminder manager.
- **Q:** If orders are included in dialogs and I check these through the Notes tab in CPRS, are the orders actually placed, or is this just recording the intention to order something?
- A: The order is actually placed, just as if you had ordered through the Orders tab. If the order is set up as a quick order, it will go through immediately (when you click the Finish button); if not a quick order, further questions will be asked to complete the order. The order will still need to be signed.
- **Q:** When I click on a reminder to process, I get a message saying "no dialog is defined for this reminder." What does this mean and what do I need to do?
- A: See your CAC or Clinical Reminders manager. They need to create and link a dialog for this reminder.
- **Q:** What do clinicians need to learn to use Clinical Reminders functionality?
- A: The most important things to learn will be related to changes in workflow. It will be important to coordinate orders that are placed through reminder dialogs with nurses and clerks. You can work with your CACs and teams to share the responsibility for reminders so that no individual is overwhelmed with reminders. Also, learning to use reports correctly to produce meaningful data will be essential.

# Appendix A: FAQS, Hints, and Tips

Q.	Is there any way to do a reminder report on an individual finding item?
	We want to add a check box that indicates depression is a new diagnosis. Is there a way to do a reminder report just on that one finding that will tell us how many of the patients that were seen this was applicable for?
<b>A</b> :	Set up a local reminder with that one finding as a resolution find Define the reminder USAGE field as Reports, and then it will no appear on the cover sheet.
	Additional trick: Make the frequency to be 1 day, and put an OR for the resolution logic and AND for the COHORT logic. That then gives you out in the CM or health summary that gives the date it was last done not only do you get a list of folks who have the finding but you can tell when it was entered.
Q:	When Clinical Maintenance is run on a reminder that is applicab due to a problem list entry, why is today's date pulled rather than date of problem list entry?
<b>A</b> :	There are two dates associated with ICD9 diagnoses found in PROBLEM LIST. There is the date entered and the date last modified. The PRIORITY field is used to determine if a problem chronic or acute. <i>If the problem is chronic, Clinical Reminders</i> <i>use today's date in its date calculations; otherwise it will use th</i> <i>date last modified.</i> Note that it only uses active problems unless field USE INACTIVE PROBLEMS is yes.
Q:	I opened the Reminders Drawer and all my reminders have disappeared, what do I do?
A:	Check your View list (Appendix D); most likely nothing will be checked. Select the reminder categories you want displayed and

# Appendix A: FAQS, Hints, and Tips

# Appendix A: FAQS, Hints, and Tips

**Q:** I tried to run a report last night, but got this message this morning when I went to look at the task number.

6294955: ^PXRMXPR, Reminder Due Report - print. Device NT\_SPOOL. VAH,ROU.

From Yesterday at 13:14, By you. Created without being scheduled.

Does this mean that there's an error with the report processing?

A: No, that message doesn't mean there's an error. Clinical Reminders processes its reports in two tasks, one for SORT and one for PRINT. The print task will always show "created without being scheduled" until the sort task is complete.

### **Tips:**

### **Clearing a Single Reminder**

You will probably process several reminders for a single visit. If you have entered information on a reminder, but you need to start over on that reminder only, you can click Clear on the reminder from the Reminders Drawer, and then click the Clear button in the Reminders dialog box. This removes all previous dialog selections from the reminder's dialog box and removes the related text and data from the Progress Note Text box and the PCE data box for this reminder. You can now start processing again.

NOTE: Clicking Clear will remove the information from only one reminder. Be careful that you are on the correct reminder before you click Clear.



### **Canceling Out of the Processing Dialog**

If you reach the Reminders processing dialog by mistake or you wish to delete information that you have entered and start over, click Cancel.



Acronyms	
AAC	Austin Automation Center
AIMS	Abnormal Involuntary Movement Scale
API	Application Programmer Interface.
CAC	Clinical Application Coordinator
CNBD	Cannot Be Determined (frequency)
CPRS	Computerized Patient Record System.
DBIA	Database Integration Agreement.
EPRP	External Peer Review Program
EVS	Enterprise VistA Service
GEC	Geriatric Extended Care
GUI	Graphical User Interface.
HSR&D	Health Services Research and Development
HL7	Health Level 7
IHD	Ischemic Heart Disease
LDL	Low-density lipo-protein
MDD	Major Depressive Disorder
MH	Mental Health
MHV	My HealtheVet
OQP	Office of Quality and Performance
PCE	Patient Care Encounter
QUERI	Quality Enhancement Research Initiative
SAS	Statistical Analysis System
SQA	Software Quality Assurance
SRS	Software Requirements Specification
TIU	Text Integration Utilities
VHA	Veterans Health Administration.
VISN	Veterans Integrated Service Networks.
VISTA	Veterans Health Information System and
	Technology Architecture.

## **National Acronym Directory**

### Definitions

### AAC SAS Files

AAC SAS files contain data that is equivalent to data stored in the Reminder Extract Summary entry in the Reminder Extract Summary file. AAC manages SAS files for use by specifically defined users.

#### Applicable

The number of patients whose findings met the patient cohort reminder evaluation.

**CNBD** Cannot Be Determined. If a frequency can't be determined for a patient, the Status and Due Date will both be CNBD and the frequency display that follows the status line will be "Frequency: Cannot be determined for this patient."

#### Due

The number of patients whose reminder evaluation status is due.

#### **National Database**

All sites running IHD and Mental Health QUERI software transmit their data to a compliance totals database at the AAC.

#### Not Applicable

The number of patients whose findings did not meet the patient cohort reminder evaluation.

#### Not Due

The number of patients whose reminder evaluation status is not due.

#### **Reminder Definitions**

Reminder Definitions comprise the predefined set of finding items used to identify patient cohorts and reminder resolutions. Reminders are used for patient care and/or report extracts.

#### **Reminder Dialog**

Reminder Dialogs comprise a predefined set of text and findings that together provide information to the CPRS GUI, which collects and updates appropriate findings while building a progress note.

#### **Reminder Patient List**

A list of patients that is created from a set of List Rules and/or as a result of report processing. Each Patient List is assigned a name and is defined in the Reminder Patient List File. Reminder Patient Lists may be used as an incremental step to completing national extract processing or for local reporting needs. Patient Lists created from the Reminders Due reporting process are based on patients that met the patient cohort, reminder resolution, or specific finding extract parameters. These patient lists are used only at local facilities.

#### **Reminder Terms**

Predefined finding items that are used to map local findings to national findings, providing a method to standardize these findings for national use.

#### **Report Reminders**

Reminders may be defined specifically for national reporting. Report Reminders do not have a related Reminder Dialog in CPRS and are not used by clinicians for patient care. However, clinical reminders that are used in CPRS may also be used for national reminder reporting. All reminders targeted for national reporting are defined in Extract Parameters.

# Appendix C: Edit Cover Sheet Reminder List

You can specify which reminders will appear on the cover sheet of CPRS. This is done by using the Edit Cover Sheet Reminder List option.

- 1. While on the CPRS Cover Sheet, click on the Tools menu.
- 2. From the drop-down menu that appears, click on Options. This screen appears:

Options	<u>?</u> ×
General Notifications	Order Checks Lists/Teams Notes
Date Range defaults	
	Change the default date ranges for displaying patient information on your cover sheet.
	Date Range Defaults
Clinical Reminders —	
1	Configure and arrange which clinical reminders are displayed on your cover sheet.
	Clinical Reminders
Other Parameters —	
	Configure other parameter settings.
	<u>O</u> ther Parameters
	OK Cancel Apply

3. Click on the Clinical Reminders button to get to the editing form.

Clinical Reminders on Cover Sheet		? ×
Reminders not being displayed: Mammography National Hepatitis Lab Extrac Nutrition/Obesity Education Pap Smear Pap Smear Pheumovax Ppd Problem Drinking Screen Psa Seat Belt Education Seatbelt and Accident Screet Tetanus Diphtheria (td-Adult) Tobacco Cessation Educatio	Reminders being displayed: Diabetic Eye Exam Diabetic Foot Care Education Hepatitis C Risk Assessment Sort by	~
	O Display Order O Alphabet	ical
	OK Can	cel

- 4. Highlight an item in the Reminders not being displayed field and then click the Add arrow ">" to add it to the Reminders being displayed field. You may hold down the Control key and select more than one reminder at a time.
- 5. When you have all of the desired reminders in the field, you may highlight a reminder and use the up and down buttons on the right side of the dialog to change the order in which the reminders will be displayed on the Cover Sheet.

## New Reminders Parameters (ORQQPX NEW REMINDER PARAMS)

If you have been assigned this parameter, you can also modify the reminders view on the coversheet.

1. Click on the reminder button next to the CWAD button in the upper right hand corner of the CPRS GUI.

Primary Care Team Unassigne Remote Data	Ø	Postings A
--	---	---------------

2. Click on Action, then click on Edit Cover Sheet Reminder List.

,,,,,,,						
🦉 Available Reminders				×		
<u>V</u> iew <u>A</u> ction						
Availa Evaluate Reminder Evaluate Category Remin Evaluate Processed Rem Refresh Reminder Dialog Edit Cover Sheet Reminder	nders ninders Is Ier <u>L</u> ist	Due 0 DUE N 08/19/ 04/05/ DUE N	Date Last Occurrence IOW /2000 08/18/2000 /2001 04/05/2000 IOW	Priority		
Cher Categories     SUBSTANCE ABUSE     HEPATITIS C     B	ORY			ti s		
Clinical Reminders and Reminde	er Cate	oories Disp	laved on Cover Sh	eet 🚿	80 C	×
	Co	ver Sheet I	Reminders (Cumula	ative List)		179117: 1
Reminder	Seq	Level		×		con Legend
Hepatitis C Risk Assessment	40	System			Ber	ander Category
+ Tobacco Use Screen (VA-*	50	System				
+ @ Seat Belt Education (VA-SE	60	System	NEDIGINE		+ Add	to Cover Sheet
+ O IHD Elevated LDL (MHDCH	. 10	Service	MEDICINE		- Rem	nove From Cover Shee
+ m Problem Drinking Screen (V	20	Service	MEDICINE		🔒 🔒 Loci	k (can not be removed
Seat Belt Education (VA-SE	40	Service	MEDICINE		Manu Ca	use Chaot Domindore
+ 22PJH TEST REMINDER [	. 50	Service	MEDICINE		VIEW CO	ver Sneet merninders
+ g Silverman Test (Local)	60	Service	MEDICINE			
+ 0	10	User Class	PROVIDER			
+ 2 Pneumovax (VA-PNEUMOV	. 20	User Class	PROVIDER			
+ 🙀 Hypertension Detection (VA	40	User	÷	-		
Location shown in Cumulative List:	2B MED		<b>•</b>	00000		F
Edi Ausilable Reminders & Categories	ting Co	over Sheet	Reminders for Use	CRPRO	IDER,ON	- <u>-</u>
Henatitis C Risk Assessment	(DT.HE	Pial -	User Level Reminder	s	Se	914 1
Henatitis C Bisk Assessment	ISLC H	FP I	+ 💇 Hypertension D	etection (VA-*H	TYPER 40	
Hupertension Detection MA	HYPER	TE	+ 🙍 Hepatitis C Risl	k Assessment	11	0
Hupertension Detection (HV)	PERTEN		+ 📆 IHD Lipid Profil	e (VA-IHD LIPID	PRO 13	Contt 1
Hupertension Screen (Huper	ancion !		+ 👸 IHD Elevated L	DL (VA-IHD EL	EVAT 14	0 260 + 1

This form provides very extensive cover sheet list management capabilities. It consists mainly of three large list areas.

+ 🗅 MH QUERI

+

+

+

F

- Cover Sheet Reminders (Cumulative List) displays selected information on the ٠ Reminders that will be displayed on the Cover Sheet.
- Available Reminders & Categories lists all available Reminders and serves as a ٠ selection list.
- User Level Reminders displays the Reminders that have been added to or removed from the cumulative list.

You may sort the Reminders in Cover Sheet Reminders (Cumulative List) by clicking on any of the column headers. Click on the Seq (Sequence) column header to view the Reminders in the order in which they will be displayed on your coversheet.

Hypertension Screen (Hypertension Sci

Hypertension Screening (UT HYPERTE

IHD Aspirin and Beta-Blocker (ZZ IHD /

IHD Elevated LDL (MRDCHECK - Loca -

🙀 Depr Scr Pos - Needs F/U Assessme... 210

220 Eval for Abnl Involuntary Movements ... 220

Depression Screening (VA-DEPRESS... 230)

0K

×

+ Add

240

Cancel

Ŧ

- Remove

# Appendix D: VA GEC Referral Reports

VA GEC Reports display the percentage of patients referred to select GEC programs who meet the eligibility criteria as outlined in the Under Secretary for Health's Information Letter IL 10-2003-005 and VHA Handbook 1140.2.

VA GEC Reports provide quarterly statistical reports on the following VA-funded programs.

- Homemaker/Home Health Aide, when Funding Source=VA
- Adult Day Health Care, when Funding Source=VA
- VA In-Home Respite, when Funding Source=VA
- Care Coordination, when Funding Source=VA

When sites submit their quarterly reports, the national office will be able to generate a report for the General Accounting Office/Office of Inspector General that demonstrates compliance with the standards for assessing patients prior to placement in VA funded programs.

These same reports can be used at the local level to evaluate how well a site is performing in meeting compliance standards for placement of patients in VA-funded GEC programs.

#### **Data Elements for Reporting**

- Source
- Living Situation
- Instrumental Activities of Daily Living
- Basic Activities of Daily Living
- Patient Behaviors and Symptoms
- Cognitive Status
- Prognosis
- Age of Patient is 75 years or greater
- Patient Identified as a High Utilizer of Medical Services

#### **Implementation Requirements**

Local sites must task the job by setting the queue to automatically generate the quarterly reports.

The Office of Geriatric and Extended Care is responsible for importing data received, via electronic email, into a GEC-created excel spreadsheet.

#### New Option

GEC Fiscal Quarterly Rollup [PXRM GEC2 QUARTERLY ROLLUP]

This is a queuable option that will gather and report to Washington DC the Fiscal Quarterly information.

This option should never be placed on an individual's menu. It should be scheduled for the 8th

day of the first month of the next calendar quarter at any time of the facility's choosing. The rescheduling frequency should be set to "3M" (every three months).

#### New Mail Group

#### GEC2 NATIONAL ROLLUP

When this mail group is installed, it will contain the email address of the two individuals in Washington DC who will receive the quarterly data. These names should not be removed. Names of local individuals (for example, CACs) may be added, if they desire to receive these reports.

#### **Important Note:**

We recommend thorough testing of GEC reminder dialogs by staff prior to implementation to avoid GEC report roll-up inaccuracies. Testing of GEC reminder dialogs and reports in a test account should mimic the actual processes and workload capture used in the site's production environment.

Informatics staff and GEC referral staff should work together to identify potential issues that arise during testing that may require modification of clinical processes and/or workload capture. Accurate capture and reporting of GEC referral health factors may require careful analysis of workload capture processes at sites that use Event Capture software. Inaccurate reporting may lead to questions from the Inspector General's office concerning funding for the patients referred to the "Home Help" type of programs.

### Potential issues if you use Event Capture

(reported by a test site):

- a) Event capture does not pass workload to PCE in real time. Data is not passed to PCE until after hours, so this needs to be taken into account when testing.
- b) There are several steps where real front-line users could make minor mistakes that would result in data entry/workload not matching up with the Care coordination note.
  - 1. Event capture date/time must be an exact match to the date/time of PCE/TIU
  - 2. Clinic location must be the same.
  - 3. Data passes after hours from EC to PCE.
  - 4. There is no drop-down menu to select from. 1 and 2 above must be manually entered.
  - 5. Patient name must be re-selected (or use spacebar return).

**NOTE:** Clinical Reminders Patch 4 (PXRM\*2.0\*4) contains a few minor changes to GEC Reports, including a new option, Restore or Merge Referrals.

#### **GEC Referral Reports Examples**

GEC Referral Reports are available on the Reminder Reports menu or on the Reminder Managers menu, depending on how your site has assigned options.

NOTE: Option 10 on the GEC Referral Report menu is new with patch PXRM\*2.0\*4.

#### **Types of reports**

- 1. Category
- 2. Patient
- 3. Provider by Patient
- 4. Referral Date
- 5. Location
- 6. Referral Count Totals
- 7. Category-Referred Service
- 8. Summary (Score)
- 9. 'Home Help' Eligibility
- 10. Restore or Merge Referrals

Options 2,3,4,5, named Patient, Provider by Patient, Referral Date, and Location, allow the user to visualize the referral for a patient by different views of the data. They all allow you to narrow the scope to a particular aspect of referral. The Patient view allows you to select a particular patient or several patients. Referral Date allow you to select a particular date range for the Referrals you wish to inquire about. Location refers to the location in the facility that the patient was at during this referral.

You can print the reports in a delimited format, if you wish to export the data to a spreadsheet.

#### **Example 1: Category**

This option first allows you to select a health factor category or several categories which correlate to different sections of the GEC dialogs. You can then select individual patients or all patients and a date range in order to view the health factors that were added to that patient's database and Note. It reports both complete and incomplete referrals.

In this example, we picked all categories.

```
Select Reminder Reports Option: ??
         Reminders Due Report
  D
  R
         Reminders Due Report (User)
  U
         User Report Templates
         Extract EPI Totals
  Т
         Extract EPI List by Finding and SSN
  L
  Q
         Extract QUERI Totals
  V
         Review Date Report
  G
         GEC Referral Report
Select Reminder Reports Option: g GEC Referral Report
All Reports will print on 80 Columns
     Select one of the following:
```

1 Category 2 Patient 3 Provider by Patient 4 Referral Date 5 Location 6 Referral Count Totals 7 Category-Referred Service 8 Summary (Score) 9 'Home Help' Eligibility 10 Restore or Merge Referrals Select Option or ^ to Exit: 7// 1 Category GEC Referral Categories 2 BASIC ADL 1 ADDITIONAL INFO COGNITIVE STATUS 4 COMMENTS 3 CONTINENCE 6 DIET 5 7 DOMICILIARY 8 EOUIPMENT/PROSTHETICS EST. DURATION OF SERVICES 10 GERIATRIC SERVICES 9 11 GOALS OF CARE 12 HOME CARE 13 HOME TELEHEALTH 14 HOMEBOUND STATUS 15 HOSPICE CARE 16 IADL 17 LANGUAGE 18 LIVING SITUATION 19 LIVING SITUATION-WITH WHO 20 NOT REFERRED TO CARE 21 NURSING HOME CARE 22 OTHER REFERRAL PROGRAM PATIENT BEHAVIORS/SYMPTOM 23 24 PRIMARY UNPAID CAREGIVER 25 26 REFERRING TO PROGNOSIS 27 SERVICES IN THE HOME 28 SKILLED CARE 30 SOURCE OF REFERRAL 29 SKIN 31 STRUCTURED LIVING SITUATION 32 WEIGHT BEARING Select Categories from the list above using Commas and/or Dashes for ranges of numbers. Select Categories or ^ to exit: (1-32): 1-32// <Enter> Select a Beginning Historical Date. BEGINNING date or ^ to exit: (1/1/1988 - 4/18/2006): T-600// (AUG 26, 2004) Select Ending Date. ENDING date or ^ to exit: (8/26/2004 - 4/18/2006): T// (APR 18, 2006) Select one of the following: А All Patients Multiple Patients М Select Patients or ^ to exit: M// ultiple Patients Select PATIENT NAME: CRPATIENT, EIGHT YES SC VETERAN Select PATIENT NAME: <Enter> Select one of the following: F Formatted D Delimited Select Report Format or ^ to exit: F// ormatted DEVICE: HOME// HOME \_\_\_\_\_ GEC Health Factor Category Detailed Report From: 08/26/2004 To: 04/18/2006 Complete and Incomplete Referrals

Category Patient Name Value Date Health Factors \_\_\_\_\_ ADDITIONAL INFO CRPATIENT, EIGHT (00000008) GEC ADVANCE DIRECTIVENO04/11/2005GEC BETTER OTHER LIVING ENVIRONMENTNO04/11/2005GEC DIFFICULT TO ENTER/LEAVE HOMENO04/11/2005GEC DPOA FINANCIAL.NO04/11/2005 04/11/2005 GEC DPOA FINANCIAL Comment: HKJHK GEC FIDUCIARY/CONSERVATOR 04/11/2005 Comment: JKLJL GEC GUARDIAN 04/11/2005 Comment: L;';L GEC LEFT ALONE LAST 7D NO 04/11/2005 GEC DEFT ALONE LAST 7DNO04/11/2005GEC OTHERS MOVED IN W/PT LAST 90DNO04/11/2005GEC PHYSICAL ACTIVITY 2HRS LAST 7DNO04/11/2005 DOMICILIARY CRPATIENT, EIGHT (00000008) 04/11/2005 GEC DOMICILIARY FUNDING-VA GEC VA DOMICILIARY (REFERRED TO) 04/11/2005 EST. DURATION OF SERVICES CRPATIENT, EIGHT (00000008) GEC ONE WEEK OR LESS 04/11/2005 GOALS OF CARE CRPATIENT, EIGHT (00000008) GEC IMPROVE COMPLIANCE MEDS/TREATMENTS 04/11/2005 GEC MONITORING TO AVOID COMPLICATIONS 04/11/2005 HOME CARE CRPATIENT, EIGHT (00000008) GEC COMMUNITY SKILLED HOME HEALTH CARE 04/11/2005 GEC HOME BASED PR. CARE (REFERRED TO) 04/11/2005 GEC HOMECARE FUNDING-VA 04/11/2005 GEC HOMECARE FUNDING-VA 07/14/2005 GEC HOMEMAKER/HOME HEALTH AIDE 04/11/2005 GEC HOMEMAKER/HOME HEALTH AIDE 07/14/2005 HOMEBOUND STATUS CRPATIENT, EIGHT (00000008) GEC HOMEBOUND NO 04/11/2005 IADL CRPATIENT, EIGHT (00000008) GEC DIFFICULT TRANSPORTATION/LAST 7D NO 04/11/2005

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GEC DIFFICULTY MANAGING MEDS/LAST 7D GEC DIFFICULTY MNG FINANCES/LAST 7D GEC DIFFICULTY PREPARE MEALS/LAST 7D GEC DIFFICULTY PREPARE MEALS/LAST 7D GEC DIFFICULTY USING PHONE/LAST 7D GEC DIFFICULTY W/ HOUSEWORK/LAST 7D GEC DIFFICULTY WITH SHOPPING/LAST 7D GEC MEALS PREPARED BY OTHERS/LAST 7D GEC MEALS PREPARED BY OTHERS/LAST 7D GEC RECENT CHANGE IN IADL RX	NO NO YES NO NO NO YES NO	04/11/2005 04/11/2005 04/11/2005 04/11/2005 04/11/2005 04/11/2005 04/11/2005 04/11/2005 04/11/2005	
LANGUAGE			
CRPATIENT,EIGHT (00000008)			
GEC ENGLISH GEC SPANISH		04/11/2005 04/11/2005	
LIVING SITUATION			
CRPATIENT,EIGHT (00000008)			
GEC BOARD AND CARE/ASSISTED LIVING GEC DOMICILIARY		04/11/2005 04/11/2005	
LIVING SITUATION-WITH WHO			
CRPATIENT,EIGHT (00000008)			
GEC ALONE		04/11/2005	
PRIMARY UNPAID CAREGIVER			
CRPATIENT,EIGHT (00000008)			
GEC NO CAREGIVER		04/11/2005	
REFERRING TO			
CRPATIENT,EIGHT (00000008)			
GEC ADL ASSISTANCE IN HOME GEC SKILLED CARE IN HOME		04/11/2005 04/11/2005	
SERVICES IN THE HOME			
CRPATIENT,EIGHT (00000008)			
GEC HOME HEALTH AIDE/LAST 14D GEC RN HOME VISIT(T+/-30D) GEC SOCIAL WORK ASSISTANCE/LAST 14D	NO NO NO	04/11/2005 04/11/2005 04/11/2005	
SOURCE OF REFERRAL			
CRPATIENT,EIGHT (00000008)			
GEC OUTPATIENT CLINIC Enter RETURN to continue or '^' to exit:		04/11/2005	

#### **Example 2: Patient**

This option lets you pick one or more patients for a specified date range. It then prints a report of all the referral information for each patient. Select Multiple Patients, if you wish to enter individual patient names. Otherwise, select All Patients.

This option reports by complete referrals only.

```
Select Reminder Reports Option: GEC Referral Report
All Reports will print on 80 Columns
    Select one of the following:
         1
                  Category
         2
                 Patient
         3
                 Provider by Patient
         4
                Referral Date
         5
                Location
         6
                Referral Count Totals
         7
                 Category-Referred Service
                Summary (Score)
         8
         9
                  'Home Help' Eligibility
         10
                  Restore or Merge Referrals
Select Option or ^ to Exit: 2 Patient
    Select one of the following:
         А
                  All Patients
                  Multiple Patients
         М
Select Patients or ^ to exit: M// <Enter> ultiple Patients
Select PATIENT NAME: CRPATIENT, EIGHT, CRPATIENT, EIGHT CRPATIENT, EIGHT
Select PATIENT NAME: <Enter>
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/18/2006): t-365// <Enter>(APR 18,
2005)
Select Ending Date.
ENDING date or ^ to exit: (4/18/2005 - 4/18/2006): T// <Enter> (APR 18, 2006)
    Select one of the following:
         F
                  Formatted
         D
                 Delimited
Select Report Format or ^ to exit: F//<Enter> ormatted
DEVICE: HOME// ;;999 HOME
_____
```

GEC Patient From: 04/18/2005 To: 04/18/2006 Patient Category Health Factor Value Date of Evaluation 1) OUTPATIENT 1) CRPATIENT, EIGHT (00000008) Total # Complete referrals: 4 Referral #1 ADDITIONAL INFO GEC GUARDIAN 04/11/2005 Comment: L;';L HOME CARE GEC HOME BASED PR. CARE (REFERRED TO) 04/11/2005 TADL GEC DIFFICULTY PREPARE MEALS/LAST 7D YES 04/11/2005 GEC MEALS PREPARED BY OTHERS/LAST 7D YES 04/11/2005 LANGUAGE GEC ENGLISH 04/11/2005 LIVING SITUATION GEC DOMICILIARY 04/11/2005 Referral #2 HOME CARE GEC COMMUNITY SKILLED HOME HEALTH CARE 04/11/2005 REFERRING TO GEC SKILLED CARE IN HOME 04/11/2005 Referral #3 ADDITIONAL INFO GEC BETTER OTHER LIVING ENVIRONMENT NO 04/11/2005 GEC DIFFICULT TO ENTER/LEAVE HOME NO 04/11/2005 NO GEC LEFT ALONE LAST 7D 04/11/2005 GEC OTHERS MOVED IN W/PT LAST 90D NO 04/11/2005 GEC PHYSICAL ACTIVITY 2HRS LAST 7D NO 04/11/2005 NO GEC ADVANCE DIRECTIVE 04/11/2005 GEC DPOA FINANCIAL 04/11/2005 Comment: HKJHK GEC FIDUCIARY/CONSERVATOR 04/11/2005 Comment: JKLJL DOMICILIARY GEC DOMICILIARY FUNDING-VA 04/11/2005 GEC VA DOMICILIARY (REFERRED TO) 04/11/2005 EST. DURATION OF SERVICES GEC ONE WEEK OR LESS 04/11/2005GOALS OF CARE GEC MONITORING TO AVOID COMPLICATIONS 04/11/2005 GEC IMPROVE COMPLIANCE MEDS/TREATMENTS 04/11/2005 HOME CARE GEC HOMECARE FUNDING-VA 04/11/2005GEC HOMEMAKER/HOME HEALTH AIDE 04/11/2005 HOMEBOUND STATUS GEC HOMEBOUND NO 04/11/2005 IADL GEC DIFFICULT TRANSPORTATION/LAST 7D 04/11/2005 NO GEC DIFFICULTY MANAGING MEDS/LAST 7D NO 04/11/2005 GEC DIFFICULTY MNG FINANCES/LAST 7D NO 04/11/2005 GEC DIFFICULTY USING PHONE/LAST 7D NO 04/11/2005 GEC DIFFICULTY W/ HOUSEWORK/LAST 7D NO 04/11/2005 NO GEC DIFFICULTY WITH SHOPPING/LAST 7D 04/11/2005 GEC RECENT CHANGE IN IADL RX NO 04/11/2005

GEC DIFFICULTY PREPARE MEALS/LAST 7D	NO	04/11/2005
GEC MEALS PREPARED BY OTHERS/LAST 7D	NO	04/11/2005
LANGUAGE		
GEC SPANISH		04/11/2005
LIVING SITUATION		
GEC BOARD AND CARE/ASSISTED LIVING		04/11/2005
LIVING SITUATION-WITH WHO		
GEC ALONE		04/11/2005
PRIMARY UNPAID CAREGIVER		
GEC NO CAREGIVER		04/11/2005
REFERRING TO		
GEC ADL ASSISTANCE IN HOME		04/11/2005
SERVICES IN THE HOME		
GEC HOME HEALTH AIDE/LAST 14D	NO	04/11/2005
GEC RN HOME VISIT(T+/-30D)	NO	04/11/2005
GEC SOCIAL WORK ASSISTANCE/LAST 14D	NO	04/11/2005
SOURCE OF REFERRAL		
GEC OUTPATIENT CLINIC		04/11/2005
Referral #4		
HOME CARE		
GEC HOMECARE FUNDING-VA		07/14/2005
GEC HOMEMAKER/HOME HEALTH AIDE		07/14/2005
Enter RETURN to continue or '^' to exit:		

#### **Example 3: Referral by Provider – All Providers**

This option lets you pick one or more providers for a specified date range. It then prints a report of all the referral information for all of the referred patients for designated providers. Select Multiple Providers, if you wish to enter individual provider names. Otherwise, select All Providers.

This report displays counts of complete referrals only

```
Select one of the following:
        1
                 Category
        2
                Patient
        3
                Provider by Patient
        4
               Referral Date
        5
                Location
               Referral Count Totals
        6
        7
                Category-Referred Service
        8
               Summary (Score)
        9
                'Home Help' Eligibility
        10
               Restore or Merge Referrals
Select Option or ^ to Exit: 1// 3 Provider by Patient
    Select one of the following:
                 All Providers
        Α
                 Multiple Providers
        м
Enter response: M// All Providers
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/19/2006): T-600// (AUG 27, 2004)
Select Ending Date.
ENDING date or ^ to exit: (8/27/2004 - 4/19/2006): T// (APR 19, 2006)
    Select one of the following:
        F
                 Formatted
        D
                 Delimited
Select Report Format or ^ to exit: F// ormatted
DEVICE: HOME// ;;999 HOME
_____
GEC Provider
From: 08/27/2004 To: 04/19/2006
Report Displays Counts of Complete Referrals Only
Provider
 Patient
              Completion Date
                                   Dialog
_____
CRPROVIDER, EIGHT (253)
 CRPATIENT, THREE (00000003) (1 Evaluation(s) )
              02/10/2005
                                   CARE COORDINATION
              02/10/2005
                                   SOCIAL SERVICES
              02/10/2005
                                   NURSING ASSESSMENT
```

CARE RECOMMENDATION 02/10/2005 CRPATIENT, FIVE (00000005) (1 Evaluation(s) ) CARE COORDINATION 01/31/2005 01/31/2005SOCIAL SERVICES 01/31/2005 NURSING ASSESSMENT 01/31/2005 CARE RECOMMENDATION CRPATIENT, FOURTEEN (000000014) (2 Evaluation(s) ) 01/27/2005 CARE COORDINATION 01/28/2005 CARE COORDINATION SOCIAL SERVICES 01/28/2005 01/28/2005 NURSING ASSESSMENT 01/28/2005 CARE RECOMMENDATION PATIENT,CHRONIC (333448888) (1 Evaluation(s) ) CARE COORDINATION 02/10/2005 02/10/2005 SOCIAL SERVICES 02/10/2005 NURSING ASSESSMENT 02/10/2005 CARE RECOMMENDATION CRPATIENT, FOUR (00000004) (1 Evaluation(s) ) 01/28/2005CARE COORDINATION 01/28/2005 SOCIAL SERVICES 01/28/2005 NURSING ASSESSMENT 01/28/2005 CARE RECOMMENDATION CRPATIENT, ONE (666112222) (1 Evaluation(s) ) 01/31/2005 CARE COORDINATION SOCIAL SERVICES 01/31/2005 01/31/2005 NURSING ASSESSMENT 01/31/2005 CARE RECOMMENDATION CRPROVIDER, ONE (1114) CRPATIENT, TWO (00000002) (1 Evaluation(s) ) CARE COORDINATION 01/27/200501/27/2005SOCIAL SERVICES CRPATIENT, EIGHT (00000008) (4 Evaluation(s)) 06/16/2005 CARE COORDINATION 06/16/2005 SOCIAL SERVICES 06/17/2005 CARE COORDINATION 06/17/2005 CARE RECOMMENDATION 06/28/2005 CARE COORDINATION 06/28/2005 SOCIAL SERVICES 06/28/2005 CARE RECOMMENDATION 07/14/2005 CARE COORDINATION CRPATIENT, FOUR (00000004) (1 Evaluation(s) ) 06/17/2005 CARE COORDINATION 06/17/2005 CARE RECOMMENDATION CRPROVIDER, THIRTEEN (123456789066) CRPATIENT, SIX (666042591P) (1 Evaluation(s) ) 03/28/2005 CARE COORDINATION 03/28/2005 SOCIAL SERVICES 03/28/2005 NURSING ASSESSMENT 03/28/2005 CARE RECOMMENDATION CRPROVIDER, TEN (123456789068) CRPATIENT, EIGHT (00000008) (1 Evaluation(s) ) 06/16/2005 SOCIAL SERVICES 06/16/2005 NURSING ASSESSMENT 06/16/2005 CARE RECOMMENDATION CRUPATIENT, TEN (123121234) (1 Evaluation(s) ) 03/28/2005 CARE COORDINATION 03/28/2005 SOCIAL SERVICES

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03/28/2005 NURSING ASSESSMENT 03/28/2005 CARE RECOMMENDATION Enter RETURN to continue or '^' to exit: Select one of the following: 1 Category 2 Patient 3 Provider by Patient 4 Referral Date 5 Location 6 Referral Count Totals 7 Category-Referred Service 8 Summary (Score) 9 'Home Help' Eligibility Restore or Merge Referrals 10 Select Option or ^ to Exit: 3// Provider by Patient Select one of the following: А All Providers М Multiple Providers Enter response: A// Multiple Providers Select NEW PERSON NAME: CRPROVIDER, ONE OC Select NEW PERSON NAME: CRPROVIDER, TEN TC Select NEW PERSON NAME: Select a Beginning Historical Date. BEGINNING date or ^ to exit: (1/1/1988 - 4/19/2006): T-600// (AUG 27, 2004) Select Ending Date. ENDING date or ^ to exit: (8/27/2004 - 4/19/2006): T// (APR 19, 2006) Select one of the following: F Formatted Delimited D Select Report Format or ^ to exit: F// ormatted DEVICE: HOME// HOME \_\_\_\_\_\_ GEC Provider From: 08/27/2004 To: 04/19/2006 Report Displays Counts of Complete Referrals Only Provider Patient Completion Date Dialog \_\_\_\_\_ CRPROVIDER, ONE (1114) CRPATIENT, TWO (00000002) (1 Evaluation(s) ) CARE COORDINATION 01/27/2005 SOCIAL SERVICES 01/27/2005 CRPATIENT, EIGHT (00000008) (4 Evaluation(s) ) 06/16/2005 CARE COORDINATION

Enter RETURN to o	continue or '^' to exit:	
	0.5 /1.5 / 0.0.5	
	06/16/2005	SUCIAL SERVICES
	06/17/2005	CARE COORDINATION
	06/17/2005	CARE RECOMMENDATION
	06/28/2005	CARE COORDINATION
	06/28/2005	SOCIAL SERVICES
	06/28/2005	CARE RECOMMENDATION
	07/14/2005	CARE COORDINATION
CRPATIENT, FOUR	(000000004) (1 Evaluati	.on(s))
	06/17/2005	CARE COORDINATION
	06/17/2005	CARE RECOMMENDATION
	00, 1, , 2000	
CRPROVIDER, TEN (1	123456789068)	
	·	
CRPATIENT, EIGH	T (000000008) (1 Evaluat	cion(s) )
	06/16/2005	SOCIAL SERVICES
	06/16/2005	NURSING ASSESSMENT
	06/16/2005	CARE RECOMMENDATION
CRPATIENT.TEN	(666121234) (1 Evaluatio	n(s))
	03/28/2005	CARE COORDINATION
	03/28/2005	SOCIAL SERVICES
	03/20/2005	NUBCINC ACCECCMENT
	03/20/2005	INTERCOMPANE TUTION
		CARE RECOMMENDATION
Enter RETURN to (	continue or '^' to exit:	

#### **Example 4: Referral Date**

The Referral Date option lets you specify a particular date range as well as incomplete referrals, completed referrals, or both.

```
Select one of the following:
        1
                 Category
                Patient
        2
                Provider by Patient
        3
        4
                Referral Date
        5
                Location
        6
                Referral Count Totals
        7
                Category-Referred Service
        8
                Summary (Score)
        9
                 'Home Help' Eligibility
        10
                 Restore or Merge Referrals
Select Option or ^ to Exit: 3// 4 Referral Date
    Select one of the following:
                 All Patients
        Α
                Multiple Patients
        М
Select Patients or ^ to exit: M// All Patients
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/19/2006): T-600// (AUG 27, 2004)
Select Ending Date.
ENDING date or ^ to exit: (8/27/2004 - 4/19/2006): T// (APR 19, 2006)
    Select one of the following:
        Τ
                 Incomplete Referrals Only
        С
                 Complete Referrals Only
                 Both Complete and Incomplete
        В
Enter response: Both Complete and Incomplete
    Select one of the following:
        F
                Formatted
                Delimited
        D
Select Report Format or ^ to exit: F// ormatted
DEVICE: HOME//
              HOME
Complete and/or Incomplete GEC Referrals by Date Range
From: 08/27/2004 To: 04/19/2006
Complete and Incomplete Referrals
Patient
                             Elapsed Time Incomplete Status
    Start Date
               Finished
CRPATIENT, EIGHT (00000008)
                                4 Referral(s)
    06/17/2005
                06/17/2005
                              1 Days
```

```
August 2006
```

0	6/28/2005	06/28/2005	1 Days	
0	6/30/2005		294 Davs	Incomplete
0	7/1//2005	07/14/2005	1 Davg	
0	//14/2005	07/14/2005	I Days	
СВБУТТ	ENT FIVE (000)	00005)	1 Referral(s	)
CICITITI			I Referrar(b	/
	1 / 21 / 22 5	01 / 01 / 0005	1 5	
0	1/31/2005	01/31/2005	I Days	
CRPATI	ENT, FOUR (000	00004)	2 Referral(s	)
0	1/28/2005	01/28/2005	1 Davs	
0	6/17/2005	06/17/2005	1 Dave	
U U	0/1/2005	00/1/2005	I Days	
0000.00T		(00000014)		<b>、</b>
CRPATI	ENT, FOURTEEN	(00000014)	4 Referral(s	)
0	1/27/2005	01/27/2005	1 Days	
0	1/27/2005		448 Davs	Incomplete
0	1/27/2005	01/27/2005	1 Davs	
0	1/20/2005	01/29/2005		
0	1/20/2005	01/28/2005	I Days	
CRPATI	ENT, THREE (00)	000003)	2 Referral(s	)
0	1/27/2005		448 Days	Incomplete
0	2/10/2005	02/10/2005	1 Davs	-
	2, 20, 2000	02,10,2000	1 2012	
CDDATT		20002	1 Defermel(a	λ.
CRPAIL	EN1,1WO (0000)	50002)	I RELEFIAL(S	)
0	1/27/2005	01/27/2005	1 Days	
CRPATI	ENT, ONE (6661)	12222)	1 Refe	erral(s)
01/31/	2005 01/2	1/2005 1 03	VC	
01/01/	2003 01/3	1/2005 I Da	YD	

#### **Example 5: Location**

This option lets you print a report on patients by locations in the facility that the patient was at during this referral.

```
Select one of the following:
          1
                     Category
          2
                    Patient
          3
                   Provider by Patient
                   Referral Date
          4
          5
                    Location
          6
                    Referral Count Totals
          7
                    Category-Referred Service
          8
                    Summary (Score)
          9
                    'Home Help' Eligibility
                    Restore or Merge Referrals
          10
Select Option or ^ to Exit: 4// 5 Location
     Select one of the following:
                    All Locations
          Δ
          S
                     Single Location
Enter response: All Locations
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/19/2006): T-600// (AUG 27, 2004)
Select Ending Date.
ENDING date or ^ to exit: (8/27/2004 - 4/19/2006): T// (APR 19, 2006)
     Select one of the following:
          F
                    Formatted
          D
                    Delimited
Select Report Format or ^ to exit: F// ormatted
DEVICE: HOME// HOME
Complete GEC Referrals by Location
From: 08/27/2004 To: 04/19/2006
Location
    Patient
                                                     Finish Date
_____
1 CRPROVIDER, ONE'S CLINIC
                                         Total # Patients Evaluated= 5
     CRPATIENT, TEN
                       (123121234)
                                                      03/28/2005

        CREATENT, IEN
        (123121234)

        CRPATIENT, EIGHT
        (00000008)

        CRPATIENT, EIGHT
        (00000008)

        CRPATIENT, EIGHT
        (00000008)

        CRPATIENT, FOUR
        (00000004)

                                                      06/16/2005
                                                      06/17/2005
                                                      06/28/2005
                                                      01/28/2005
```

1A(1&2)	Total	#	Patients Evaluated= 3
CRPATIENT,FIVE (0000) CRPATIENT,FOURTEEN (( CRPATIENT,FOURTEEN ((	00005) 000000014) 000000014)	1	01/31/2005 01/27/2005 01/28/2005
2B MED	Total	#	Patients Evaluated= 2
CRPATIENT, THREE (0000 CRPATIENT, TWO (000000	000003) 0002)		02/10/2005 01/27/2005
CARDIOLOGY	Total	#	Patients Evaluated= 1
GECPATIENT, TEN (6662)	33242)		02/08/2005
DIABETIC EDUCATION-INDIV-MO	DD BTotal	#	Patients Evaluated= 1
GECPATIENT, ONE (6662)	07282)		02/08/2005
GENERAL MEDICINE CRPATIENT,EIGHT (6662 CRPATIENT,FIVE (666189 CRPATIENT,NINE (666886 CRPATIENT,ONE (6669932 CRPATIENT,SEVEN (6662232 CRPATIENT,SIXTEEN(6662232 CRPATIENT,SIXTEEN(6662332)	Total 211234) 9600) 5636) 242) 88333) 220) 223220) 42)	#	<pre>Patients Evaluated= 4 02/09/2005 02/10/2005 02/09/2005 02/10/2005 02/16/2005 02/08/2005 02/10/2005 02/10/2005</pre>
CRPATIENT, TEN (0002332	148888)		02/10/2005

#### **Example: Referral Count Totals**

This report allows you to create a report that counts the number of Complete referrals done during a time period selected by the user. You can select the counting to be done by Patient Name, Provider, Hospital Location, or for a certain date range. This should be useful for giving reports to other users of the system.

```
Select one of the following:
         1
                 Category
         2
                Patient
         3
                Provider by Patient
         4
                Referral Date
         5
                Location
                Referral Count Totals
         6
         7
                 Category-Referred Service
         8
                 Summary (Score)
         9
                 'Home Help' Eligibility
         10 Restore or Merge Referrals
Select Option or ^ to Exit: 2// 6 Referral Count Totals
    Select one of the following:
        PA
              Patient
         PR
                Provider
         L
                Location
         D
                 Date
Select Sort Type or ^ to exit: PA Patient
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/18/2006): t-365// T-600 (AUG 26, 2004)
Select Ending Date.
ENDING date or ^ to exit: (8/26/2004 - 4/18/2006): T// <Enter> (APR 18, 2006)
    Select one of the following:
                 Formatted
        F
         D
                 Delimited
Select Report Format or ^ to exit: F// ormatted
DEVICE: HOME// ;;999 HOME
_____
Referral Count by Patient
From: 08/26/2004 To: 04/18/2006
Report Displays Counts of Complete Referrals Only
Patient
                     SSN
                           Total Count
                                                  Division
_____
1 CRPATIENT, EIGHT 00000008
                           4 OUTPATIENT
2 CRPATIENT,FIVE 00000005 1 INPATIENT SALT LAKE OEX
3 CRPATIENT,FOUR 00000004 2 OUTPATIENT
4 CRPATIENT, FOURTEEN00000014 3 INPATIENT SALT LAKE OEX
5 CRPATIENT, THREE 0000000031INPATIENTSALT LAKE OEX6 CRPATIENT, TWO0000000021INPATIENTSALT LAKE OEX
7 CRPATIENT, ONE 666112222
                                 1 OUTPATIENT
                                   7
Total Referrals
Enter RETURN to continue or '^' to exit:
```

#### **Category-Referred Service**

The Category-Referred Service is a subset of the first option. It allows you to look at the health factors based on where the patient had been referred to. So if a user would like to view all of the patients that were referred to HOME TELEHEALTH, this is one way to get that information.

```
Select one of the following:
                   Category
         1
          2
                   Patient
          3
                   Provider by Patient
          4
                   Referral Date
          5
                   Location
                   Referral Count Totals
          б
          7
                   Category-Referred Service
          8
                   Summary (Score)
                   'Home Help' Eligibility
          9
          10
                   Restore or Merge Referrals
Select Option or ^ to Exit: 7// Category-Referred Service
GEC Referral Service Categories
                                      GERIATRIC SERVICES
1
   DOMICILIARY
                                   2
3
   HOME CARE
                                       HOME TELEHEALTH
                                   4
5
   HOSPICE CARE
                                   6
                                      NOT REFERRED TO CARE
7
   NURSING HOME CARE
                                  8 OTHER REFERRAL PROGRAM
9
   STRUCTURED LIVING SITUATION
Select Categories from the list above using
Commas and/or Dashes for ranges of numbers.
Select Categories or ^ to exit: (1-9): 1-9//
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/19/2006): T-300// (JUN 23, 2005)
Select Ending Date.
ENDING date or ^ to exit: (6/23/2005 - 4/19/2006): T// ^
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/19/2006): T-300// T-600 (AUG 27,
2004)
Select Ending Date.
ENDING date or ^ to exit: (8/27/2004 - 4/19/2006): T// (APR 19, 2006)
     Select one of the following:
         Α
                   All Patients
         М
                   Multiple Patients
Select Patients or ^ to exit: A// ll Patients
     Select one of the following:
         F
                    Formatted
                   Delimited
         D
Select Report Format or ^ to exit: F// ormatted
DEVICE: HOME// ;;999 HOME
```

GEC Health Factor Category Detailed Report						
From: 08/27/2004 To: 04/19/2006						
Complete and Incomplete Referrals						
Datient Name						
Health Factors	Date					
DOMICILIARY						
CRPATIENT,EIGHT (00000008)						
GEG DOMIGILIADU EUNDING VA	01/07/0005					
GEC DOMICILIARY FUNDING-VA	01/27/2005					
GEC STATE HOME DOMICILIANT	01/2//2005					
CRPATIENT,FIVE (00000005)						
GEC DOMICILIARY FUNDING-VA	01/27/2005					
GEC DOMICILIARY FUNDING-VA	01/27/2005					
GEC DOMICILIARY FUNDING-VA	01/27/2005					
GEC DOMICILIARY FUNDING-VA	01/27/2005					
GEC VA DOMICILIARY	01/27/2005					
GEC VA DOMICILIARY	01/27/2005					
GEC VA DOMICILIARY	01/27/2005					
GEC VA DOMICILIARY	01/27/2005					
CRPATIENT,FOUR (00000004)						
CEC DOMICILIARY FUNDING VA	01 / 00 / 0005					
GEC DOMICILIARY FUNDING-VA	01/28/2005					
GEC VA DOMICILIARY	01/28/2005					
GERIATRIC SERVICES						
CRPATIENT,FIVE (00000005)						
GEC GERI SERVICES FUNDING-VA	01/31/2005					
GEC GERIATRIC EVAL/MGMT INPT UNIT	01/31/2005					
CRPATIENT, ONE (666442222)						
GEC GERI SERVICES FUNDING-VA	02/08/2005					
GEC GERIATRIC EVAL/MGMT INPT UNIT	02/08/2005					
CREATENT, TIRCE (00000000)						
GEC ADULT DAY HEALTH CARE	10/22/2001					
GEC HOMECARE FUNDING-VA	10/22/2001					
CRPATIENT, TWO (00000002)						
CEC HOMECADE FINIDING-UA	01/27/2005					
CEC VA IN-HOME RESDITE	01/27/2005					
GEC VA IN-HOME RESPICE	01/2//2005					
CRPATIENT,EIGHT (00000008)						
GEC COMMUNITY SKILLED HOME HEALTH CARE	04/11/2005					
GEC HOME BASED PR. CARE	04/11/2005					
GEC HOMECARE FUNDING-VA	04/11/2005					
GEC HOMECARE FUNDING-VA	07/14/2005					
GEC HOMEMAKER/HOME HEALTH AIDE	04/11/2005					
GEC HOMEMAKER/HOME HEALTH AIDE	07/14/2005					
WHPATIENT, FEMALEFOURTEEN (00000014)						

GEC ADULT DAY HEALTH CARE GEC HOMECARE FUNDING-VA GEC HOMECARE FUNDING-VA GEC HOMEMAKER/HOME HEALTH AIDE	01/28/2005 01/27/2005 01/28/2005 01/27/2005					
CRPATIENT, ELEVEN (333448888)						
GEC ADULT DAY HEALTH CARE GEC HOMECARE FUNDING-VA	02/10/2005 02/10/2005					
CRPATIENT, ONE (666112222)						
GEC HOMECARE FUNDING-VA GEC VA IN-HOME RESPITE	01/31/2005 01/31/2005					
HOME TELEHEALTH						
CRPATIENT, FOURTEEN (000000014)						
GEC HOME TELEHEALTH GEC HOME TELEHEALTH GEC TELEHEALTH FUNDING-VA GEC TELEHEALTH FUNDING-VA	01/27/2005 01/27/2005 01/27/2005 01/27/2005					
WHPATIENT, FEMALEFOUR (00000004)						
GEC HOME TELEHEALTH GEC TELEHEALTH FUNDING-VA	06/17/2005 06/17/2005					
HOSPICE CARE						
CRPATIENT, TEN (666121234)						
GEC HOSPICE FUNDING-MEDICARE GEC VA OUTPATIENT HOSPICE	03/28/2005 03/28/2005					
NOT REFERRED TO CARE						
CRPATIENT, FOURTEEN (000000014)						
GEC DOES NOT MEET CRITERIA	01/27/2005					
NURSING HOME CARE						
CRPATIENT, TWENTY (666211234)						
GEC NURSING HOME FUNDING-VA GEC STATE VETERANS NURSING HOME	02/03/2005 02/03/2005					
STRUCTURED LIVING SITUATION						
CRPATIENT, FIVE (000000005)						
GEC ASSISTED LIVING GEC STRUCTURED LIVING FUNDING-VA	01/31/2005 01/31/2005					
CRPATIENT, FOUR (000000004)						
GEC ASSISTED LIVING GEC STRUCTURED LIVING FUNDING-OTHER INS. Enter RETURN to continue or '^' to exit:	06/17/2005 06/17/2005					

#### **Example: Summary (Score)**

The Summary (Score) GEC option is a little different. This option is used to give some kind of a score to the patients' needs. A value of 1 or 0 has been given to certain Health Factors. These Health Factors have to be placed into different categories: IADL's, Basic ADL, Skilled Care, and Patient Behaviors. It calculates the Means and Standard Deviations for the totals. A user could watch these scores on a particular patient and see how his needs have gotten larger or smaller or a period of time.

```
Select one of the following:
              1
                           Category
              2
                            Patient
                           Provider by Patient
              3
              4
                            Referral Date
              5
                            Location
                            Referral Count Totals
              6
              7
                            Category-Referred Service
              8
                            Summary (Score)
              9
                            'Home Help' Eligibility
                          Restore or Merge Referrals
              10
Select Option or ^ to Exit: 7// 8 Summary (Score)
Select a Beginning Historical Date.
BEGINNING date or ^ to exit: (1/1/1988 - 4/19/2006): T-600// (AUG 27, 2004)
Select Ending Date.
ENDING date or ^ to exit: (8/27/2004 - 4/19/2006): T// (APR 19, 2006)
       Select one of the following:
                            All Patients
              А
              M
                            Multiple Patients
Select Patients or ^ to exit: A// ll Patients
       Select one of the following:
              F Formatted
              D
                            Delimited
Select Report Format or ^ to exit: F// ormatted
DEVICE: HOME// ;;999 HOME
_____
GEC Patient-Summary (Score)
Data on Complete Referrals Only
From: 08/27/2004 To: 04/19/2006
                                                Finished
                                                                     Basic Skilled Patient
                                                                                                          TOTAL
                              SSN
                                                             IADL ADL Care Behaviors ACROSS
                                              Date
Name
_____
CRPATIENT,EI (00000008) 06/16/2005 1 5 4
                                                                                 1
                                                                                               11

      CRPATIENT,EI
      (00000008)
      06/16/2005
      1
      5
      4
      1

      CRPATIENT,EI
      (00000008)
      06/17/2005
      0
      0
      0

      CRPATIENT,EI
      (00000008)
      06/28/2005
      0
      0
      0

      CRPATIENT,EI
      (00000008)
      06/28/2005
      0
      0
      0

      CRPATIENT,EI
      (00000008)
      07/14/2005
      0
      0
      0

      CRPATIENT,FI
      (000000005)
      01/31/2005
      7
      1
      1

      CRPATIENT,FO
      (00000004)
      01/28/2005
      2
      1
      1

      CRPATIENT,FO
      (00000004)
      06/17/2005
      0
      0
      0

      CRPATIENT,FO
      (00000004)
      06/17/2005
      0
      0
      0

                                                                                                0
                                                                                                0
                                                                                                 0
                                                                                                10
                                                                                                 4
                                                                                                  0
CRPATIENT,FO(000000014)01/27/20050CRPATIENT,FO(000000014)01/27/20050CRPATIENT,FO(000000014)01/28/20050
                                                            0
                                                                      0
                                                                                    0
                                                                                                  0
                                                               0
                                                                        0
                                                                                    0
                                                                                                   0
                                                                      0
                                                               0
                                                                                    1
                                                                                                   1
```

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```

CRPATIENT, TH (0000	00003) 02/10/2	2005 0	4	0	0	4	
CRPATIENT.TW (0000	00002) 01/27/3	2005 1	0	0	0	1	
CRPATIENT, EIGHT	(666112222)	01/31/2005	1	2	2	0	5
CRPATIENT EIGHT	(666112222)	03/28/2005	7	2	15	5	29
CRPATIENT EIGHT	(666112222)	02/09/2005	,	0	10	3	3
CRDATIENT FIGHT	(666112222)	01/27/2005	0	0	0	0	0
CREATENT, EIGHT	(666112222)	02/02/2005	1	1	1	4	0 7
CRPATIENT, EIGHT	(000112222)	02/03/2005		1 2		4	7
CRPATIENT, EIGHT	(000112222)	02/09/2005	0	2	0	1	4
CRPATIENT, FIVE	(666112223)	01/2//2005	3	1	1	1 Q	0
CRPATIENT, FIVE	(666112223)	01/31/2005	0	T	Ţ	2	4
CRPATIENT, FIVE	(666112223)	02/10/2005	0	0	0	0	0
CRPATIENT, FIVE	(666112223)	02/03/2005	0	2	1	0	3
CRPATIENT, FIVE	(666112223)	02/10/2005	0	3	0	0	3
CRPATIENT, FIVE	(666112223)	03/28/2005	1	6	8	3	18
CRPATIENT, FIVE	(666112223)	02/09/2005	0	6	0	0	6
CRPATIENT, FIVE	(666112223)	02/03/2005	0	3	0	1	4
CRPATIENT, FIVE	(666112223)	02/10/2005	0	5	0	0	5
CRPATIENT, FOUR	(666112224)	02/03/2005	1	2	0	0	3
CRPATIENT, FOUR	(666112224)	02/08/2005	7	1	0	0	8
CRPATIENT, FOUR	(666112224)	02/10/2005	3	3	0	0	6
CRPATIENT, FOUR	(666112224)	02/10/2005	0	3	0	0	3
CRPATIENT, FOUR	(666112224)	02/16/2005	5	2	0	2	9
CRPATIENT, NINE	(666112225)	02/08/2005	0	0	0	0	0
CRPATIENT, NINE	(666112225)	02/08/2005	3	0	0	0	3
CRPATIENT, NINE	(666112225)	02/09/2005	0	0	0	0	0
CRPATIENT, NINE	(666112225)	02/10/2005	0	2	0	0	2
CRPATIENT, NINE	(666112225)	02/08/2005	6	3	3	0	12
CRPATIENT, NINE	(666112225)	02/10/2005	0	2	0	0	2
CRPATIENT ONE	(666112226)	02/08/2005	Ő	0	1	0	1
CRPATIENT ONE	(666112226)	02/10/2005	0	2	0	0 0	2
CREATIENT ONE	(666112226)	02/10/2005	0	8	0	0	8
CREATIENT ONE	(666112226)	02/09/2005	0	0	0	2	2
CREATIENT ONE	(666112226)	01/31/2005	0	0	0	0	0
CREATIENT, ONE	(666112226)	01/31/2005	0	1	0	1	0
CRPATIENT, ONE	(000112220)	02/08/2005	1		0	1	2
CRPATIENT, ONE	(000112227)	02/03/2005	1	0	0	2	3
CRPATIENT, SIA	(000112227)	02/03/2005	0	0	0	0	0
CRPATIENT, SIA	(000112227)	02/08/2005	0	1	0	0	0
CRPATIENT, SEVEN	(666112228)	02/08/2005	2	1	0	0	3
CRPATIENT, SEVEN	(666112228)	02/16/2005	6	4	2	1 Q	13
CRPATIENT, TEN	(666112229)	02/09/2005	3	2	0	0	5
CRPATIENT, TEN	(666112229)	02/10/2005	3	3	0	0	6
CRPATIENT, TEN	(666112229)	02/08/2005	3	3	4	2	12
CRPATIENT, TEN	(666112229)	02/09/2005	4	3	0	0	7
CRPATIENT, TEN	(666112229)	02/03/2005	3	2	7	3	15
CRPATIENT, TEN	(666112229)	02/10/2005	0	2	0	0	2
CRPATIENT, TEN	(666112229)	02/08/2005	0	0	0	0	0
CRPATIENT, TEN	(666112229)	02/08/2005	0	0	1	0	1
CRPATIENT, TWELVE	(666112229)	02/08/2005	1	3	0	1	5
CRPATIENT, TWELVE	(666112229)	02/10/2005	0	2	0	0	2
CRPATIENT, TWELVE	(666112229)	02/08/2005	5 4	3	6	2	15
CRPATIENT, TWELVE	(666112229)	02/08/2005	0	2	7	1	10
CRPATIENT, TWELVE	(666112229)	01/28/2005	2	3	1	3	9
CRPATIENT, TWELVE	(666112229)	01/26/2005	8	13	9	10	40
CRPATIENT, TWELVE	(666112229)	02/09/2005	5 3	2	0	0	5
CRPATIENT, TWELVE	(666112229)	01/31/2005	0	0	0	0	0
CRPATIENT, TWELVE	(666112229)	01/27/2005	5 0	0	0	0	0
CRPATIENT, TWELVE	(666112229)	01/28/2005	4	0	1	1	6
· ·							
		Totals > >	96	121	78	53	348
		Means > >	1.4	1.8	1.2	0.8	5.2
	Standard Dev	iations > >	2.6	2.9	2.9	1.8	8.6
#### Example: Home Health Eligibility Report (All patients)

'Home Help' Eligibility option is a way for the local facility to view the information that is sent to VACO GEC office. A quarterly report is sent to provide statistics as to the number of patients who are eligible for care in the home that is paid for by the VA.

```
Select Reminder Reports Option: G GEC Referral Report
All Reports will print on 80 Columns
     Select one of the following:
         1
                   Category
         2
                   Patient
                   Provider by Patient
         3
          4
                   Referral Date
         5
                   Location
          6
                   Referral Count Totals
         7
                   Category-Referred Service
         8
                   Summary (Score)
         9
                   'Home Help' Eligibility
                   Restore or Merge Referrals
         10
Select Option or ^ to Exit: 8// 9 'Home Help' Eligibility
Select a year for the report (i.e.2005)
YEAR or ^ to exit: (2004-2030): 2005
Select a Fiscal QUARTER in the year 2005 (i.e.2)
    Fiscal Years start in October.
Fiscal Quarter 1 same as Calendar Quarter 4
Fiscal Quarter 2 same as Calendar Quarter 1
Fiscal Quarter 3 same as Calendar Quarter 2
Fiscal Quarter 4 same as Calendar Quarter 3
Fiscal Quarter or ^ to exit: (1-4): 2
    Select one of the following:
                   All Patients
         А
         Μ
                   Multiple Patients
Select Patients or ^ to exit: A// <Enter> 11 Patients
    Select one of the following:
         Υ
                    YES
         Ν
                    NO
Select Show Test Patients in this Report?
Y or N or ^ to exit: YES
DEVICE: HOME// ;;999 ANYWHERE Right Margin: 80//
Please wait ...
```

Referred to Homemaker/Home Health Aide(HHHA) or Adult Day Health Care(ADHC) or VA In-Home Respite(VAIHR) or Care Coordination programs(CC) From: 01/01/2005 To: 03/31/2005 Fiscal Quarter: 2 (Calendar Quarter 1) Criteria Measured SSN Prog. 0 #1 #2 #3 #4 Date Name Criteria \_\_\_\_\_ C0000 VAIHR X CRPATIENT, ONE 01/27/2005 NOT MET CRPATIENT, TWO 01/28/2005 C6667 CC Х CRPATIENT, THREE C6668 ADHC X X 02/09/2005 C6669 ADHC X CRPATIENT, FOUR 01/31/2005 NOT MET C6660 CC C6661 CC CRPATIENT, FIVE Х 01/27/2005 NOT MET X X X CRPATIENT, SIX 01/27/2005 NOT MET C6668 ADHC 01/28/2005 CRPATIENT, SEVEN C6663 VAIHR X 01/31/2005 NOT MET CRPATIENT,EIGHT C6664 ADHC Х CRPATIENT, NINE 02/09/2005 C6664 ADHC CRPATIENT, TEN X 02/09/2005 C6671 CC CRPATIENT, ELEVEN Х 01/27/2005 CRPATIENT, TWELVE C6663 ADHC X 02/09/2005 NOT MET CRPATIENT, THIRTEEN C6662 VAIHR X 02/03/2005 NOT MET CRPATIENT, THIRTEEN C6662 ADHC X X X 02/10/2005 CRPATIENT, THIRTEEN C6662 ADHC ХХ 02/09/2005 CRPATIENT, FOURTEEN C6622 HHHA ХХ 02/03/2005 Criteria 0: Not eligible under any criteria. 1: Problems with 3 or more ADL's. 2: 1 or more patient behavior or cognitive problem. 3: Expected life limit of less than 6 months. 4: Combination of the following: 2 or more ADL dependencies <AND> 2 or more of the following: Problems with 3 or more IADL's <OR> age of patients is 75 or more. <OR> living alone in the community. <OR> utilizes the clinics 12 or more time in the preceding 12 months. Enter RETURN to continue or '^' to exit:

#### Example 9b: Home Health Eligibility Report (Multiple patients)

This report lets you select specific patient names to be included in a report.

```
Select Reminder Managers Menu Option: GEC GEC Referral Report
All Reports will print on 80 Columns
    Select one of the following:
        1
                Category
        2
                Patient
        3
                Provider by Patient
        4
                Referral Date
        5
                Location
               Referral Count Totals
        6
        7
                Category-Referred Service
        8
               Summary (Score)
        9
                'Home Help' Eligibility
        10
               Restore or Merge Referrals
Select Option or ^ to Exit: 9// 9 'Home Help' Eligibility
Select a year for the report (i.e.2005)
YEAR or ^ to exit: (2004-2030): 2005
Select a Fiscal QUARTER in the year 2005 (i.e.2)
   Fiscal Years start in October.
Fiscal Quarter 1 same as Calendar Quarter 4
Fiscal Quarter 2 same as Calendar Quarter 1
Fiscal Quarter 3 same as Calendar Quarter 2
Fiscal Quarter 4 same as Calendar Quarter 3
Fiscal Quarter or ^ to exit: (1-4): 2
    Select one of the following:
        Α
                All Patients
        М
               Multiple Patients
Select Patients or ^ to exit: A// Multiple Patients
Select PATIENT NAME: CRPATIENT, TWENTY 1-4-07 666003220
                                                             YES
SC VETERAN
Select PATIENT NAME:
DEVICE: HOME// ANYWHERE Right Margin: 80//
Please wait ...
_____
Referred to Homemaker/Home Health Aide(HHHA) or Adult Day Health Care(ADHC)
or VA In-Home Respite(VAIHR) or Care Coordination programs(CC)
From: 01/01/2005 To: 03/31/2005
Fiscal Quarter: 2 (Calender Quarter 1)
                                     Criteria
                    SSN Prog. 0 #1 #2 #3 #4 Date Not Eligible
  Name
_____
  CRPATIENT, TWENTY C3220 ADHC X X 02/08/2005
Criteria
0: Not eligible under any criteria.
```

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```

1: Problems with 3 or more ADL's. 2: 1 or more patient behavior or cognitive problem. 3: Expected life limit of less than 6 months. 4: Combination of the following: 2 or more ADL dependencies <AND> 2 or more of the following: Problems with 3 or more IADL's <OR> age of patients is 75 or more. <OR> living alone in the community. <OR> utilizes the clinics 12 or more time in the preceding 12 months. Enter RETURN to continue or '^' to exit:

#### **Example: Restore or Merge Referrals**

The 'Restore or Merge Referrals' option is not a report. It is a tool that was asked for by the users. Periodically, the GEC Referrals are closed before all of the dialogs are completed. This would mean that all of the dialogs would have to be re-completed. This tool allows the users to select a Partial or Whole Referral that they would need re-opened or merged with another referral. The user has a choice of Closing an open referral, Merging 2 referrals that are either complete or not, together making one referral or viewing all the referrals for a particular patient.

```
Select Reminder Reports Option: G GEC Referral Report
All Reports will print on 80 Columns
    Select one of the following:
         1
                  Category
         2
                  Patient
         3
                 Provider by Patient
         4
                  Referral Date
         5
                  Location
         6
                  Referral Count Totals
         7
                   Category-Referred Service
         8
                  Summary (Score)
                 Summary (Score,
'Home Help' Eligibility
         9
                 Restore or Merge Referrals
         10
Select Option or ^ to Exit: 2// 10 Restore or Merge Referrals
PATIENT:
           WHPATIENT, EIGHT
      SC VETERAN
 WHPROVIDER, ONE PRIMARY
Enrollment Priority: GROUP 1 Category: IN PROCESS
                                                    End Date:
WHPATIENT, EIGHT (00000008) AGE: 57 OUTPATIENT Unknown Division
    Current Open Referral::
1
         Jul 14, 2005 11:28:28 am (start date)
              Care Coordination by: CRPROVIDER,ONE
                                                          On: Jul 14, 2005
    Historical Referral(s)::
2
         Jun 30, 2005 11:41:10 am (start date)
              Care Recommendation by: CRPROVIDER,ONE
                                                             On: Jun 30, 2005
3
         Jun 28, 2005 2:55:03 pm (start date)
              Social Servicesby:CRPROVIDER,ONECare Recommendationby:CRPROVIDER,ONECare Coordinationby:CRPROVIDER,ONE
                                                              On: Jun 28, 2005
                                                              On: Jun 28, 2005
                                                              On: Jun 28, 2005
    Select one of the following:
                   CLOSE Open Referral
         С
                   Merge 2 Referrals
         М
         V
                   View ALL Historical Referrals
```

Ρ New Patient Q Quit Enter response: View ALL Historical Referrals \_\_\_\_\_ WHPATIENT, EIGHT (00000008) AGE:57 OUTPATIENT Unknown Division Current Open Referral:: Jul 14, 2005 11:28:28 am (start date) 1 Care Coordination by: CRPROVIDER,ONE On: Jul 14, 2005 Historical Referral(s):: Jun 30, 2005 11:41:10 am (start date) 2 Care Recommendation by: CRPROVIDER, ONE On: Jun 30, 2005 3 Jun 28, 2005 2:55:03 pm (start date) Social Services by: CRPROVIDER, ONE On: Jun 28, 2005 Care Recommendation by: CRPROVIDER, ONE On: Jun 28, 2005 Care Coordination by: CRPROVIDER, ONE On: Jun 28, 2005 Select one of the following: CLOSE Open Referral С Merge 2 Referrals М D Display Last 2 Referrals Only Ρ New Patient Q Quit Enter response: Merge 2 Referrals First Referral Record: (1-3): 2 Second Referral Record: (1-3): 3 DO MERGE

### Algorithm for GEC (Next Generation) Software

The information for the "criteria" is taken from the letter # IL 10-2004-005 entitled UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER dated May 3 2004. pages B-2 and B-3

The following is the Algorithm that will be used in the software to determine if a patient meets the criteria necessary to be placed in one of the monitored programs. HEALTH FACTORS that are part of the patient record for an evaluation, are designated with capital letters (below).

#### 7D = 7 days

YES or NO = Yes or No response from the Dialog Additional explanations found to the right of health factor

#### Initial Requirement is to be referred to one of the following VA funded programs.

(Requires 1 or 6, plus one of the other Health Factors)

- 1. GEC ADULT DAY HEALTH CARE (REFERRED TO)
- 2. GEC HOMECARE FUNDING-VA
- 3. GEC HOMEMAKER/HOME HEALTH AIDE
- 4. GEC VA IN-HOME RESPITE
- 5. GEC HOME TELEHEALTH (REFERRED TO)
- 6. GEC TELEHEALTH FUNDING-VA

# Criteria #1 : "Three or more Activities of Daily Living (ADL) dependencies."

(Any 3 of the ADL's below)

- GEC BATHING HELP/SUPERVISION LAST 7D-YES
- GEC BED POSITIONING HELP LAST 7D-YES
- GEC DRESS HELP/SUPERVISION LAST 7D-YES
- GEC EATING HELP/SUPERVISION LAST 7D-YES
- GEC INDEPENDENT IN WC LAST 7D-YES
- GEC MOVING AROUND INDOORS LAST 7D-YES
- GEC TOILET HELP/SUPERVISION LAST 7D-YES
- GEC TRANSFERS HELP/SPRVISION LAST 7D-YES

#### OR

#### Criteria #2 : "Significant cognitive impairment"

(Any 1 of those indicated below)

- GEC CAN BE UNDERSTOOD LAST 7D-NO
- GEC ENDANGERED SAFETY LAST 90D-YES
- GEC MADE REASONABLE DECISIONS LAST 7D-NO
- GEC HALLUCINATIONS/DELUSIONS LAST 7D-YES
- GEC PHYSICALLY ABUSIVE LAST 7D-YES
- GEC RESISTS CARE LAST 7D-YES
- GEC VERBALLY ABUSIVE LAST 7D-YES
- GEC WANDERING LAST 7D-YES

OR

#### Criteria #3 "Prognosis of Life Expectancy of less than 6 months"

(Any 1 of these health factors )

#### • GEC LIFE EXPECTANCY < 6MO-YES

#### OR

#### Criteria #4 : "Two ADL dependencies and two or more of the following conditions:"

(Any 2 of the ADL's below and the additional requirements)

- GEC BATHING HELP/SUPERVISION LAST 7D-YES
- GEC BED POSITIONING HELP LAST 7D-YES
- GEC DRESS HELP/SUPERVISION LAST 7D-YES
- GEC EATING HELP/SUPERVISION LAST 7D-YES
- GEC INDEPENDENT IN WC LAST 7D-YES
- GEC MOVING AROUND INDOORS LAST 7D-YES
- GEC TOILET HELP/SUPERVISION LAST 7D-YES
- GEC TRANSFERS HELP/SPRVISION LAST 7D-YES

#### AND

- "(a) Dependency in three or more Instrumental ADL (IADL)" (Any 3 of the IADL)
- GEC DIFFICULT TRANSPORTATION/LAST 7D-YES
- GEC DIFFICULTY MANAGING MEDS/LAST 7D-YES
- GEC DIFFICULTY MNG FINANCES/LAST 7D-YES
- GEC DIFFICULTY PREPARE MEALS/LAST 7D-YES
- GEC DIFFICULTY USING PHONE/LAST 7D-YES
- GEC DIFFICULTY W/ HOUSEWORK/LAST 7D-YES
- GEC DIFFICULTY WITH SHOPPING/LAST 7D-YES

#### OR

"(b) Recent discharge from a nursing home, or upcoming nursing home discharge plan contingent on receipt of home and community – based care services."

- GEC COMMUNITY NRSNG HOME (REFERRED FROM)
- GEC VA DOMICILIARY (REFERRED FROM)
- GEC VA NURSING HOME

#### OR

"(c) Seventy Five Years old, or older."

(Obtained from the Patient's Records using an API call)

#### OR

"(d) High use of medical services defined as **three** or more hospitalizations in the past year and/or utilization of outpatient and/or emergency evaluation units **twelve** or more times in the past year.

(The API ....GETAPPT^SDAMA201(...) to retrieve appointments etc.)

#### OR

"(f) Living alone in the Community"

#### GEC ALONE

# Appendix E - Iraq & Afghan Post-Deployment Screen

## **Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF)**

The Clinical Reminder, *Iraq & Afghan Post-Deployment Screen*, which identified veterans of Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom, was enhanced and distributed to sites in November 2005. The OEF/OIF data will be rolled up for regional and national reporting purposes. Due to the fast track that this project has been placed on, the project will be completed in two phases.

• **Phase I** included modifications and enhancements to the current Afghan/Iraq reminder to better meet the needs of the field and provide the information needed for reporting purposes. In Phase I, the clinical reminder for post-deployment screening will be due for patients whose latest Separation date greater than 09/11/01. It is also due for active duty patients being seen at the VA.

#### Phase II Extract Reports & National Rollup of Data

Phase II is dependent on changes being made by Management Services to improve the quality and accuracy of a patient's OEF and OIF combat data. The OEF/OIF Enrollment patch will include functionality that will manage OEF/OIF Combat Veteran data. Management Systems will require OEF/OIF patients to first be a combat veteran with a combat from and to date, where the combat to date ends after 10/07/01, and secondarily have an OEF or OIF indication if the patient served in the OEF or OIF theatre during the combat service period. Patient combat data will be collected by clerks during enrollment, registration, or the first VA visit. Phase II Reminder development will be coordinated with Enrollment development to use the Combat Veteran data.

- Phase II includes re-distribution of the national OEF/OIF clinical reminder/dialog.
- In Phase II, the clinical reminder for post-deployment screening will be due for patients whose latest separation date is greater than 09/11/01, or patients whose latest combat end date was greater than 10/07/01 for service in the OEF or OIF combat theatre. The reminder will continue to also be due for active duty patients being seen at the VA.

#### Example screens

On the following pages, we show examples of the dialog screens that you'll see when you process the Iraq and Afghan Screening reminder.

# Iraq & Afghan Post-Deployment Screen Reminder Dialog Screens

1. If you answer "yes," to the first question, the rest of the dialog opens up. If the first question is answered "no," then you are done.

🖉 Reminder Resolution: Iraq&Afghan Post-Deployment Screen 🔀						
This template is designed to help identify health problems that are uniquely related to military service in Afghanistan and Iraq during recent hazardous combat operations. The questions target infectious diseases, mental health problems, and chronic symptoms, which may develop in some veterans of Operation Enduring Freedom and Operation Iraqi Freedom. A paper version of these questions is available for the Veteran to complete, and the information can then be entered into the reminder dialog.						
Operation Iraqi Freedom/Operation Enduring Freedom Questionnaire						
Did the Veteran serve in Operation Iraqi Freedom (OIF) or in Operation Enduring Freedom (OEF), either on the ground, in nearby coastal waters, or in the air above, after September 11, 2001?						
O No - No service in OBF or OIF						
Yes - Service in Operation Iraqi Freedom (OIF) (Iraq, Kuwait, Saudi Arabia, Turkey, Other)						
Yes - Service in Operation Enduring Freedom (OEF) (Afghanistan, Georgia, Kyrgyzstan, Pakistan, Tajikistan, Uzbekistan, the Philippines, Other)						
SEVERAL WEB LINKS HAVE BEEN PROVIDED FOR REFERENCE.						
Medically Unexplained Symptoms: Pain and Fatigue (VA/DOD Guideline)						
Major Depressive Disorder (VA/DOD Guideline)						
Clinical Care: Mental Health						
Outlines in Clinical Medicine						
Invironmental Agents Service						
Clear Clinical <u>M</u> aintVisit Info< BackNext >FinishCancel						
related to: Service Connected Condition						
* Indicates a Required Field						

2. When the dialog opens for a "yes" answer, the first question prompts for the location of service. OIF options are on the first screen below and OEF options are on the next screen.

🗧 Reminder Resolution: Iraq&Afghan Post-Deployment Screen	×					
This template is designed to help identify health problems that are uniquely related to military service in Afghanistan and Iraq during recent hazardous combat operations. The questions target infectious diseases, mental health problems, and chronic symptoms, which may develop in some veterans of Operation Enduring Freedom and Operation Iraqi Freedom. A paper version of these questions is available for the Veteran to complete, and the information can then be entered into the reminder dialog.						
Operation Iraqi Freedom/Operation Enduring Freedom Questionnaire						
Did the Veteran serve in Operation Iraqi Freedom (OIF) or in Operation Enduring Freedom (OEF), either on the ground, in nearby coastal waters, or in the air above, after September 11, 2001?						
C No - No service in OEF or OIF						
Yes - Service in Operation Iraqi Freedom (OIF) (Iraq, Kuwait, Saudi Arabia, Turkey, Other)						
complete all open items						
The location of the patient's most recent OIF service was						
choose one						
· Ruvait						
O Saudi Arabia						
9 Turkey						
C Other OIF Service						
1. SCREEN FOR PTSD						
C complete PTSD Screen (anster all 4 questions)						
In your life, have you ever had any experience that was so						
Clear Clinical <u>M</u> aint						
Clinical Reminders:						
Iraq&Afghan Post-Deployment Screen: The patient reports service in Operation Iraqi Freedom.	-					
related to: Service Connected Condition	_					
Health Factors: IRAQ/AFGHAN SERVICE, KUWAIT SERVICE						
× Indicates a Required Field						
maicates a mequilea mea						

🚝 Reminder Resolution: Iraq&Afghan Post-Deployment Screen 🔀
Did the Veteran serve in Operation Iraqi Freedom (OIF) or in Operation Enduring Freedom (OEF), either on the ground, in nearby coastal waters, or in the air above, after September 11, 2001?
C No - No service in OEF or OIF
C Yes - Service in Operation Iraqi Freedom (OIF) (Iraq, Kuwait, Saudi Arabia, Turkey, Other)
<ul> <li>Yes - Service in Operation Enduring Freedom (OEF)         <ul> <li>(Afghanistan, Georgia, Kyrgyzstan, Pakistan, Tajikistan, Uzbekistan, the Philippines, Other)</li> </ul> </li> </ul>
complete all open items
The location of the patient's most recent OEF service was
choose one
C Supervision
C The Philippines
C Tajikistan
C Uzbekistan
© Other OEF Service Location: *
1. SCREEN FOR PTSD
Complete PTSD Screen (answer all 4 questions)
Clear Clinical <u>M</u> aint <u>V</u> ísit Info < Back Next > Finish Cancel
Clinical Reminders:

3. If the first question has already been answered "yes," then it doesn't need to be answered again if subsequent users open the dialog to complete other sections. Note the radio button in front of the PTSD screen. This is necessary to allow the user to choose between doing the screen and entering a refusal (next screen).

Reminder	Resolution: Iraq&Afghan Post-Deplo	/ment Screen				×
This temp: and Iraq and chron & paper vo the remin <u>Iraq/Af</u> ; The record (comple	Late is designed to help identi during recent hazardous combat nic symptoms, which may develop prsion of these questions avail nder dialog. ghanistan Post-Deployment Scree indicates that the patient se stion of screening required) te all open items	fy health problems to operations. The qu in some veterans of able for the Veteran <u>ning Questionnaire</u> rved in or over Iraq	hat are uniquely estions target in Operation Endur: to complete, and or Afghanistan.	related to mili nfectious diseas ing Freedom and d the information	tary service in es, mental healt Operation Iraqi n can then be en	Afghanistan h problems, Freedom. tered into
1. SCR	<pre>BEEN FOR PTSD Complete PTSD Screen (answer In your life, have you ever ) frightening, horrible, or up;</pre>	all 4 questions) had any experience th setting that, in the	at was so past month, you:			
	Have had nightmares about it No Yes Tried hard not to think abou No Yes Were constantly on guard, was No Yes Felt numb or detached from o	or thought about it t it or went out of y tchful, or easily sta thers, activities, or	when you did not your way to avoid artled? r your surroundid	t want to? d situations that ngs?	t reminded you o	f it?
Clear	Clinical <u>M</u> aint	<u>⊻</u> isit Info	< Back	Next >	Finish	Cancel
Clinical F Iraq&Afg 1 SCR <no encounte<="" td=""><td>leminders: <b>chan Post-Deployment Screen:</b> IEEN EAD DECA rinformation entered&gt;</td><td></td><td></td><td></td><td></td><td>▲ ▼</td></no>	leminders: <b>chan Post-Deployment Screen:</b> IEEN EAD DECA rinformation entered>					▲ ▼
* Indicates a R	equired Field					

The refusal options for PTSD, depression and alcohol are now present and consistent. The alcohol section is closed because it has been completed in the past six months.

🖉 Reminder Resol	lution: Iraq&Afghan Post-Deployn	nent Screen					
Wer	e res re constantly on guard, wat • No	chful, or easily star	tled?				
	O Yes			-0			
rei	O No O Yes	ners, accivicies, or	your surrounding	51			
C Ref	used PTSD Screening						
2. SCREEN FO	DR DEPRESSION						
DEPRES	SION SCREEN (2 question so	creen)					
1. Du by 2. Du	ring the past month, have y y feeling down, depressed, o wring the past month, have y	you often been bother or hopeless? you often been bother	ed				
A "YE fo	by little interest or pleasure in doing things? A "YES" response to either question is a POSITIVE screen for depression. Further evaluation is then needed.						
0	Depression Screen Negative						
0	Depression Screen Positive						
	Refused Depression Screenin	ıg					
C 3. SCREEN	FOR ALCOHOL: DONE RECENTLY	(click here to repe	at now)				
Clear	Clinical <u>M</u> aint	<u>⊻</u> isit Info	< Back	Next >	Finish	Cancel	
Clinical Remind Iraq&Afghan P 1. SCREEN F 2. SCREEN F	lers: Post-Deployment Screen: OR PTSD OR DEPRESSION						
<no encounter="" inform<="" th=""><th>ation entered&gt;</th><th></th><th></th><th></th><th></th><th></th></no>	ation entered>						
Indicates a Required	l Field						

4. Note that questions 4B and 4D are "closed" – they have been completed in the past six months. The refusal option is available for this section.

Entering a refusal option for any one of the sections will satisfy that section for one month. However, it will not cause that section of the dialog to be "closed" – the section will remain open but the reminder would no longer be due if all four refusal options are chosen.

O Depression Screen Positive
C Refused Depression Screening
3. SCREEN FOR ALCOHOL: DONE RECENTLY (click here to repeat now)
4. SCREEN FOR INFECTIOUS DISEASES AND CHRONIC SYMPTOMS
A. Do you have any problems with chronic diarrhea or other gastrointestinal complaints since serving in the area of conflict?
O No
O Yes
(If 'YES', the patient's stool should be evaluated for ova and parasites because of the high rate of giardiasis and amoebiasis in Southwest Asia.)
B. SCREEN FOR PERSISTENT FEVER: DONE RECENTLY (click here to repeat now)
<ul> <li>No</li> <li>Yes</li> <li>(If yes and an unusual rash or lesion is verified, the patient should be evaluated for cutaneous leishmaniasis.)</li> <li>D. SCREEN FOR OTHER GENERAL SYMPTOMS: DONE RECENTLY (click here to repeat now)</li> <li>Refused to complete the 4 question screen for infectious diseases and other symptoms</li> </ul>
Clear Clinical <u>M</u> aint <u>V</u> isit Info < Back Next > Finish Cancel
ical Reminders: aq&Afghan Post-Deployment Screen: 2. SCREEN FOR DEPRESSION 4. SCREEN FOR INFECTIOUS DISERSES AND CHRONIC SYMPTOMS
encounter information entered>
cates a Benuired Field

5. The hyperlinks have been moved to the bottom of the dialog display.

Reminder Resolution: Trans/Afaban Post-Deployment Screen							
O Yes							
(If 'YES', the patient's stool should be evaluated for ova and parasites because of the high rate of giardiasis and amoebiasis in Southwest Asia.)							
B. SCREEN FOR PERSISTENT FEVER: DONE RECENTLY (click here to repeat now)							
C. Do you have a persistent papular or nodular skin rash that began after deployment to Southwest Asia?							
V Yes							
(If yes and an unusual rash or lesion is verified, the patient should be evaluated for cutaneous leishmaniasis.)							
D. SCREEN FOR OTHER GENERAL SYMPTOMS: DONE RECENTLY (click here to repeat now)							
Refused to complete the 4 question screen for infectious diseases and other symptoms							
SEVERAL WEB LINKS HAVE BEEN PROVIDED FOR REFERENCE. Office of Quality & Performance: Clinical Practice Guidelines							
Major Depressive Disorder (VA/DD Guideline)							
Clinical Care: Mental Health							
Outlines in Clinical Medicine							
Invironmental Agents Service							
(also Thinks to Peteralis heaton Interactives)							
Clinical Reminders:							
Iraq&Afghan Post-Deployment Screen:							
2. SCREEN FOR INFECTIONS DISERSES AND CHRONIC SYMPTOMS							
<no encounter="" entered="" information=""></no>							
* Indicates a Bequired Field							

6. If you would like to re-enter data on a closed section, click on the checkbox for that section – PTSD in this example

🚰 Reminder Resolution: Iraq&Afghan Post-Deployment Screen							
This template is designed to help identify health problems that are uniquely related to military service in Afghanistan and Iraq during recent hazardous combat operations. The questions target infectious diseases, mental health problems, and chronic symptoms, which may develop in some veterans of Operation Enduring Freedom and Operation Iraqi Freedom. A paper version of these questions available for the Veteran to complete, and the information can then be entered into the reminder dialog.							
Iraq/Afghanistan Post-Deployment Screening Questionnaire							
The record indicates that the patient served in or over Iraq or Afghanistan. (completion of screening required)							
complete all open items							
2. SCREEN FOR DEPRESSION          DEPRESSION SCREEN (2 question screen)         1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?         2. During the past month, have you often been bothered by little interest or pleasure in doing things?         A "YES" response to either question is a POSITIVE screen for depression. Further evaluation is then needed.							
O Depression Screen Negative							
O Depression Screen Positive							
Clear         Clinical Maint         Visit Info         < Back         Next >         Finish         Cancel							
Clinical Reminders: Iraq&Afghan Post-Deployment Screen: 2. SCREEN FOR DEPRESSION 4. SCREEN FOR INFECTIOUS DISERSES AND CHRONIC SYMPTOMS							
<no encounter="" entered="" information=""></no>							
* Indicates a Required Field							

After choosing the closed PTSD section, it opens to allow completion.

1. SC	e all open items REEN FOR PTSD: DONE RECENT	LY (click here to repeat	t now)			
-a	nswer all 4 guestions					
	Complete PTSD Screen (ans In your life, have you ev frightening, horrible, or	wer all 4 questions) er had any experience th upsetting that, in the	nat was so past month, you:			
	Have had nightmares about	it or thought about it	when you did not	want to?		
	O No					
	🖸 Yes					
	Tried hard not to think a	bout it or went out of	your way to avoid	situations that	reminded you of :	it?
	O No					
	🖸 Yes					
	Were constantly on guard,	watchful, or easily st	artled?			
	O No					
	🖸 Yes					
	Felt numb or detached fro	m others, activities, o	r your surrounding	s?		
	🖸 No					
	O Yes					
SCREI	EN FOR DEPRESSION					
DE	PRESSION SCREEN (2 questi	on screen)				
Clear	Clinical <u>M</u> aint	<u>⊻</u> isit Info	< Back	Next >	Finish	Cance
al Re g&Afgh PTSD SCRE	minders: an Post-Deployment Screen: SCREEN EN FOR DEPRESSION EN FOR INTERFICUE DICENSES	אים רונסמאדר פיזותיימונים				
counter i	nformation entered>					

This is what the dialog would look like if you did PTSD screening, Alcohol screening, and depression screening and then clicked on FINISH – and THEN opened the OEF/OIF reminder dialog – those sections would be closed.

🖉 Despis den Despisition Tox = 0.4 feb en Despis Despis Despis
ZReminder Resolution: Iraq&Afghan Post-Deployment Screen
This template is designed to help identify health problems that are uniquely related to military service in Afghanistan and Iraq during recent hazardous combat operations. The questions target infectious diseases, mental health problems, and chronic symptoms, which may develop in some veterans of Operation Enduring Freedom and Operation Iraqi Freedom. A paper version of these questions available for the Veteran to complete, and the information can then be entered into the reminder dialog.
Iraq/Afghanistan Post-Deployment Screening Questionnaire
The record indicates that the patient served in or over Iraq or Afghanistan. (completion of screening required)
complete all open items
1. SCREEN FOR PTSD: DONE RECENTLY (click here to repeat now)
C 2. SCREEN FOR DEPRESSION: DONE RECENTLY (click here to repeat now)
<ul> <li>3. SCREEN FOR ALCOHOL: DONE RECENTLY (click here to repeat now)</li> <li>4. SCREEN FOR INFECTIOUS DISEASES AND CHRONIC SYMPTOMS</li> <li>complete all open sections</li> </ul>
A. Do you have any problems with chronic diarrhea or other gastrointestinal complaints since serving in the area of conflict?
C No C Yes
(If 'YES', the patient's stool should be evaluated for ova and parasites because of the high rate of riardiasis and amoebiasis in Southwest Asia.)
Clear Clinical <u>M</u> aint <u>V</u> isit Info < Back Next > Finish Cancel
Clinical Reminders: Irag&Afghan Post-Deployment Screen: 4. SCREEN FOR INFECTIOUS DISEASES AND CHRONIC SYMPTOMS
<no encounter="" entered="" information=""></no>
* Indicates a Required Field

Clicking on clinical maintenance shows which sections are needed. The display here is based on the completion of each section AFTER the service separation date. If the dates of all seven pieces listed above 1-3 and 4A-D are later than the last service separation date, then the reminder is resolved.

🖉 Reminder Resolution: Iraq&Afghan Post-Deployment Screen						
This template is designed to help identify health problems that are uniquely related to military service in Afghanistan and Iraq during recent hazardous combat operations. The questions target infectious diseases, mental health problems, and chronic symptoms, which may develop in some veterans of Operation Enduring Freedom and Operation Iraqi Freedom. A paper version of these questions is available for the Veteran to complete, and the information can then be entered into the reminder dialog.						
Operation Iraqi Freedom/Operation Enduring Freedom Questionnaire						
Did the Veteran serve in Operation Iraqi Freedom (OIF) or in Operation Enduring Freedom (OEF), either on the ground, in nearby coastal waters, or in the air above, after September 11, 2001?						
Ves - Service in Operation Iraqi Freedom (OIF) (Iraq, Kuwait, Saudi Arabia, Turkey, Other)						
<ul> <li>G Yes - Service in Operation Enduring Freedom (OEF)</li> <li>(Afghanistan, Georgia, Kyrgyzstan, Pakistan, Tajikistan, Uzbekistan, the Philippines, Other)</li> </ul>						
SEVERAL WEB LINKS HAVE BEEN PROVIDED FOR REFERENCE. Office of Quality 4 Performance: Clinical Practice Guidelines						
Medically Unexplained Symptoms: Pain and Fatigue (VA/DOD Guideline) Major Depressive Disorder (VA/DOD Guideline)						
Clinical Care: Mental Health						
Outlines in Clinical Medicine						
(also links to Veterans Health Initiatives)						
related to: Service Connected Condition						
* Indicates a Required Field						

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