Patient Care Encounter (PCE)

Technical Manual

Version 1.0

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Department Of Veterans Affairs

Office of Information and Technology

Product Development

Revision History

Initiated on 11/19/04

Date	Description (Patch # if applic.)	Project Manager	Technical Writer
07/2014	PX*1*199 – Updates for ICD-10 Patient Care Encounter: Updated Title page Updated Revision History (p.1) ICD-10 changes (pp. 29, 38, 46, 63, 77, 79, 81, 82, 83, 85, 86, 87) Technical Edit	VA PM: Curtis Clay HP PM: Mike Klein	Ellen Phelps/Bob Thomas
03/30/2009	PX*1*168 – Enrollment VistA Changes Release 2 (EVC R2) Changed *environmental contaminants* to *SW Asia Conditions* Added Project 112/SHAD Indicator	Laura Prietula	Corinne Bailey
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02/03/2006	Technical Edit		Meena Rentachintala
02/01/2006	Manual updated to show changes with patch PX*1*164		Dennis Bricker
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08/10/2005	Manual updated to show changes with patch PX*1*153: added option PCE Delete Encounters W/O Visit	Carol Greening	Tim Dawson
03/17/2005	Manual updated to show changes with Patch PX*1*151 See section: $$CLNCK^SDUTL2(CLN,DSP	Beverly Jones	Berry Anderson
11/19/2004	Manual updated to comply with SOP 192-352 Displaying Sensitive Data	Beverly Jones	Corinne Bailey

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Introduction

Purpose of PCE

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

Patient Care Encounter (PCE) adds to current V*ISTA* (DHCP) patient information by capturing clinical data resulting from a patient encounter, including problems treated, procedures done and provider information, as well as immunizations, skin tests, treatments, and patient education.

The goal of PCE is to provide an underlying database structure which enables the collection and management of clinical data from multiple data collection sources, including scanners, user interfaces, and non-interactive ancillary interfaces. The key users of this clinical data are clinicians, management, Quality Assurance, and Scheduling personnel.

Functionality

The primary functions exported with Version 1.0 of PCE are:

- Collection and management of outpatient encounter data
- Presentation of outpatient encounter data through Health Summary components and Clinical Reports

Outpatient encounter data is captured through interactive and non-interactive interfaces.

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

Non-interactive interfaces
- PCE Device Interface, which supports the collection of encounter form data from scanners such as PANDAS, Teleform, and Automated Information Collection System (AICS), also supports workstation collection of outpatient encounter data.
- PCE application programming interfaces (API) which support the collection of outpatient encounter data from ancillary packages such as Laboratory, Radiology, Text Integration Utility (TIU), and Computerized Patient Record System (CPRS).

Impact of PCE on IRM

• Sites must evaluate functionality exported with PCE and then choose to implement the portions that will enhance current data collection practices at their facilities.

• PCE will need a clinical coordinator to help facilitate data capture implementation and health summary type modifications.

• Patient Care Encounter is used as a clinical repository for data from many data collection sources, including scanning devices such as PANDAS and TELEFORM, the Automated Information Collection System (AICS), or the Graphical User Interface (GUI) physician workstation, as well as manual data entry options in Scheduling and PCE. The table below lists estimated disk space requirements for PCE/Visit Tracking for four levels of facility complexity. Estimates are based on adding 83k to the database for every 100 encounters, where each encounter averages two procedures, one diagnosis, and one provider. Each visit averages 1.9 encounters, based on stop code reporting per visit transmitted to Austin.

Complexity Level	Average # of Ambulatory Visits/Year	Estimated Disk Space Requirements/Year
1	254,018	400mb
2	149,101	234mg
3	92,761	146mb
4	71,371	112mb

MSM SITES: Increase your Stack/Stap to 24k to avoid STKOV errors, and the size of your partitions to 85k to avoid PGMOV errors.

SAC Exemption: PCE has requested an exemption to SAC 2.2.7 which states the maximum routine size.

To avoid PGMOV errors, add an entry and exit action to dynamically increase/decrease the partition size as described below for the following options:

```
Appointment Management [SDAM APPT MGT]
Appointment Check-in/Check-out [SDAM APPT CHECK IN/OUT]
Add/Edit Stop Codes [SDADDEDIT]
Check-in/Unsched. Vsit [SDI]
Make Appointment [SDM]
Multiple Appointment Booking [SDMULTIBOOK]
Disposition an Application [DG DISPOSITION APPLICATION]
Disposition Log Edit [DG DISPOSITION EDIT]


Entry action: S %K=85 D INT^%PARTSIZ
Exit action:  S %K=40 D INT^%PARTSIZ
```

DSM SITES: Expand string length for data and global references to accommodate Standards and Conventions (SAC) 2.3.2.2 which extends the full evaluated length of a global reference to 200 characters.

Since the current default for maximum global reference length is 128 for DSM sites, do the following:

What UCI: **MGR**
YOU'RE IN UCI: MGR,DEV

```
>D ^VOLMAN
Volume Management Utilities
     1.   ADD                           (ADD^VOLMAN)
     2.   CREATE                        (CREATE^VOLMAN)
     3.   EXTEND                        (EXTEND^VOLMAN)
     4.   MAXIMUM GLOBALS               (MAXGLO^VOLMAN2)
     5.   STRING LENGTH                 (EXPSTR^VOLMAN2)
Select Option > 5.   STRING LENGTH
Volume Set to set EXPANDED STRING LENGTH flag for   > ^TMP
Expanded string length for data and global references is currently
DISALLOWED on this Volume Set:
  255 bytes is the maximum data length, and
  128 bytes is the maximum global reference length.
When you enable expanded strings and global references on a Volume Set,
then:
  512 bytes is the maximum data length, and
  249 bytes is the maximum global reference length.

*** WARNING *** Once you have enabled a Volume Set for use with expanded
strings and subscripts, that flag may NOT be reset.

Allow expanded string lengths on Volume Set ^TMP [Y OR N] ? <N> Y

Expanded string length is now ENABLED on Volume Set ^TMP.
```

NOTE: The new settings will not take effect until the DSM configuration is shut down and re-started on all nodes.

Impact of PCE on Providers

Providers will be impacted by PCE through entry and retrieval of outpatient encounter data. Below is a scenario demonstrating a possible sequence of events:

1. A provider has a patient encounter (appointment, walk-in, telephone call, Hospital Based Home Care (HBHC), etc.).

Materials available to a provider which relate to PCE:
- *Health Summary* with new components summarizing previous encounters, and a health reminders component with reminders based on clinical repository data.
- *Encounter Form* (hard copy or workstation with pre-defined terminology for the provider's clinic/service type). This is the instrument for documenting the encounter information.

2. The provider enters encounter information directly into PCE or onto an encounter form.

3. A data entry clerk scans the encounter form or manually enters the information from the encounter form into PCE. Scanned encounter data is passed to the PCE Device Interface Module, where the data is stored in PCE files. The encounter data is automatically passed from PCE to Scheduling for clinical workload reporting and billing purposes.

Types of Encounter Form data collected and stored in PCE:
> *Encounters*
> *Providers*
> *Problems/Diagnosis/symptoms treated at visit*
> *CPT procedures performed*
> *Immunizations (CPT-mappable)*
> *Skin tests (CPT-mappable)*
> *Patient education*
> *Exams (non-CPT-mappable)*
> *Treatments (non-CPT-mappable)*

4. The provider may later view information relating to these encounters on clinical reports or on health summaries. Reminders and maintenance information relating to patients can also be printed on health summaries.

Implementation & Maintenance

Implementation

1. ASSIGN PCE MENU AND OPTIONS

PCE IRM Main Menu
(This menu includes all options exported with PCE.)

```
  SP      PCE Site Parameters Menu ...
          SITE  PCE Site Parameters Edit
          RPT   PCE HS/RPT Parameter Menu ...
                PRNT   PCE HS/RPT Parameters Print
                HS     PCE HS Disclaimer Edit
                RPT    PCE Report Parameter Edit
          DISP  PCE Edit Disposition Clinics
  TBL     PCE Table Maintenance ...
          INFO   PCE Information Only ...
          ACT    Activate/Inactivate Table Items ...
          CED    Education Topic Copy
          DEWO   PCE Delete Encounters W/O Visit
          ED     Education Topic Add/Edit
          EX     Examinations Add/Edit
          HF     Health Factors Add/Edit
          IM     Immunizations Add/Edit
          SK     Skin Tests Add/Edit
          TR     Treatments Add/Edit
  INFO    PCE Information Only ...
          ACT    Activate/Inactivate Table Items ...
                 E    Exams
                 ET   Education Topics
                 H    Health Factors
                 I    Immunizations
                 S    Skin Tests
                 T    Treatments
          ED     Education Topic List
          EDI    Education Topic Inquiry
          EX     Exam List
          HF     Health Factors List
          IM     Immunizations List
          SK     Skin Tests List
          TR     Treatments List
          CM     PCE Code Mapping List
```

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


  CR      PCE Clinical Reports ...
          PA      Patient Activity by Clinic
          CP      Caseload Profile by Clinic
          WL      Workload by Clinic
          DX      Diagnoses Ranked by Frequency
          LE      Location Encounter Counts
          PE      Provider Encounter Counts
  HOME    Directions to Patient's Home Add/Edit
  CO      PCE Coordinator Menu ...
          SUP     PCE Encounter Data Entry - Supervisor
          PCE     PCE Encounter Data Entry
          DEL     PCE Encounter Data Entry and Delete
          NOD     PCE Encounter Data Entry without Delete
          TBL     PCE Table Maintenance ...
          INFO    PCE Information Only ...
          HOME    Directions to Patient's Home Add/Edit
          MDR     CIDC Missing Data Report
          PARM    PCE HS/RPT Parameters Menu ...
          DIE     PCE Device Interface Error Report
          DISP    PCE Edit Disposition Clinics
  CL       PCE Clinician Menu
                      RPT     PCE Clinical Reports ...
                      ENC     PCE Encounter Data Entry and Delete
                      INFO    PCE Information Only...
                      HOME    Directions to Patient's Home Add/Edit
```

Assign the *PCE IRM Main Menu* to the IRM person who will maintain and set up the package and who will need access to all of the PCE options.

PCE IRM Main Menu Descriptions

PX SITE PARAMETER MENU - Site Parameter Menu
This menu includes all options that deal with defining and displaying entries in the PCE PARAMETERS file (#815). The PCE Site Parameters Edit option includes all editable fields, for IRM/ADPAC use. The PCE HS/RPT Parameter Print option can be included on a Health Summary Coordinator's menu if the coordinator is involved with the definition of Clinical Reminders to be printed on the Health Summary. This option is also included on the PCE Coordinators menu and the PCE Reports option menu. The PCE HS Parameters option can be included on a Health Summary Coordinators menu, and is included on the PCE Coordinator's menu. This user should be familiar with the PCE Reminders and the use of the reminder disclaimer on the "Clinical Maintenance" and "Clinical Reminder" components. The PCE Report Parameters Setup option can be included on a PCE Coordinator's menu to setup the local file definitions to use to represent Emergency Clinics and various categories of Lab tests by the PCE Report Module.

PXTT TABLE MAINTENANCE - PCE Table Maintenance
The options on this menu are used to add or edit the types of data to be collected by PCE such as Health Factors, Patient Education, Immunizations, Skin Tests, etc. Once these tables have been defined, the table entries will be selectable for encounter data entry (PCE package) and encounter form definitions (AICS package). The patient information collected based on these table definitions is viewable on Health Summaries. This menu also includes options to edit the Clinical Reminder/Health Maintenance definitions, based on your site's clinical terminology in the tables. Once reminder criteria have been defined, they may be included in the Health Summary Type definitions for the "Clinical Reminder" and "Health Maintenance" Components. These options may be used in conjunction with the "PCE Information Only" menu options to manage the contents of the files or tables supporting PCE.
The option PCE Delete Encounters W/O Visit has been created to provide a routine utility to remove Encounters that have missing Visits. (This is described in detail in the text of patch PX*1*153.)

PXTT PCE INFORMATION ONLY - PCE Information Only
This is a menu of options that list information about the files/tables used by PCE. Some of the files/tables determine what clinical data will be collected as the sites' clinical terminology for specific categories of data such as Immunizations, Skin Tests, Patient Education, and Treatments. The PCE Code Mapping file determines whether two entries should be made from one clinical data item entered. For example, if an immunization is entered into the V Immunization file, a CPT code is generated in the V CPT file for billing and workload. The mapping definition of the CPT relationship with the Immunization type is viewable from the PCE Code Mapping list option. The reminder lists allow the user to see what the clinical reminders definitions are for use with the Health Summary package.

PXRM REMINDER MENU - PCE Reminder Maintenance Menu
This is the menu for editing reminder logic and making queries about the files involved with Clinical Reminders and Clinical Maintenance components in the Health Summary package.

PXRR CLINICAL REPORTS - PCE Clinical Reports
This is a menu of PCE clinical reports that clinicians can use for summary level information about their patients, workload activity, and encounter counts.

PX EDIT LOCATION OF HOME - Directions to Patient's Home Add/Edit
This option lets you enter directions to a patient's home; especially useful for Hospital-Based Home Care staff. The Health Summary package contains a new PCE component that displays the directions entered through this option.

PX PCE CLINICIAN MENU - PCE Clinician Menu
This menu contains PCE options which may be useful to the clinician.

PX PCE COORDINATOR MENU - PCE Coordinator Menu
This is the menu for the ADPAC for PCE. It includes all of the user interface options as well as the options for file maintenance. The data entry options may be assigned to clerk and/or clinician menus as needed. The HS and Report parameter options manage fields for site specific preferences/definitions in the Health Summary and PCE Reports.

The first four options/menus are used by IRM staff or coordinators who will be responsible for setting up PCE, maintaining the entries in the PCE tables (such as Patient Education, Immunization, Treatments, etc.), and defining the clinical reminders/maintenance system for your site. Data entry options on the PCE Coordinator and PCE Clinician Menus should be assigned as follows:

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

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

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

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

2. Set PCE Site Parameters using the PCE Site Parameters Menu on the PCE IRM Menu. This menu includes all options that deal with defining and displaying entries in the PCE PARAMETERS file (815) and all editable fields for IRM/ADPAC use.

PCE Site Parameter Menu

PX PCE SITE PARAMETERS EDIT - PCE Site Parameters Edit
This option is used to edit entries in the PCE PARAMETERS file. The parameters that are set are used as the default controls for the user interface when it starts up. You can set your default view as Appointment or Encounter and a range of dates.

PX HS DISCLAIMER EDIT - PCE HS Disclaimer Edit
This option is used to specify a Site Reminder Disclaimer to be used by the Health Summary package whenever the Health Summary "Clinical Maintenance" and "Clinical Reminder" components are displayed in a Health Summary.

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

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

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

The PCE HS/RPT Parameter Print and PCE HS Parameters options can be
included on a Health Summary Coordinator's menu if the coordinator is involved
with the definition of Clinical Reminders to be printed on the Health Summary.
These options are also included on the PCE Coordinator menu and the PCE Reports
option menu.

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

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

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

The PCE Report Parameters Edit option can be included on a PCE Coordinator's menu to set up the local file definitions to use to represent Emergency Clinics and various categories of Lab tests by the PCE Report Module. The *Caseload Profile by Clinic* and *Patient Activity by Clinic* reports track Critical Lab Values and Emergency Room Visits. The PCE Report Parameter Edit option allows your site to specify which clinics in file 44 represent "Emergency Room" clinics and what tests from the Laboratory Test file (#60) should be used for looking up patient data for Glucose, Cholesterol, LDL Cholesterol and HBA1C lab results. (This is necessary since the Laboratory Test File is not standardized and each site may have customized it differently.)

PCE HS/RPT Parameters Print Example

```
Select PCE HS/RPT Parameter Menu Option:prnt PCE HS/RPT Parameters Print
DEVICE:  VAX    RIGHT MARGIN: 80// [ENTER]


PCE HS/RPT PARAMETERS PRINT            MAY 21,1996  11:52  PAGE 1
---------------------------------------------------------------
PARAMETERS related to HEALTH SUMMARY
------------------------------------
Default Reminder Disclaimer:
    The following disease screening, immunization and patient
    education recommendations are offered as guidelines to
    assist in your practice.
    These are only recommendations, not practice standards.
    The appropriate utilization of these for your individual
    patient must be based on clinical judgment and the
    patient's current status.
Site Reminder Disclaimer (Replaces default disclaimer if defined):
PARAMETERS related to PCE REPORTS
---------------------------------
Report ER Clinic Names: EYE
Report Glucose Names: URINE GLUCOSE
Report Cholesterol Names: CHOLESTEROL
Report LDL Cholesterol Names:
Report HBA1C Names:
```

PCE Site Parameters Edit

The default Startup View may be set to Appointment or Visit/Encounter. We recommend that you set the default Startup View to Appointment, which displays all the appointments that have been made during the default date range.

The default date range is determined by values that are defined for the Date Offset fields. There are four Date Offset fields. The first two, Beginning Patient Date Offset and Ending Patient Date Offset, determine the default date range for display of patient data. The last two, Beginning Hos Loc Date Offset and Ending Hos Loc Date Offset, determine the default date range for display of patient data based on hospital location (clinic or ward). A number subtracted from today's date is the Beginning Patient Date Offset (e.g., -30) and a number added to today's date is the Ending Patient Date Offset (e.g., 1). Do not put in specific dates, but count backwards and forward from the current date.

The Multiple Primary Diagnosis prompt lets sites that use scanning devices choose whether to receive warnings or not have the encounter processed if more than one diagnosis is listed as primary.

You can also set the switch-over date from using the Scheduling interface for checkouts and dispositions, and the starting date for displaying PCE data on Health Summaries.

```
Select PCE IRM Main Menu Option: SP  PCE Site Parameter Menu
    SITE    PCE Site Parameters Edit
    RPT     PCE HS/RPT Parameter Menu ...
    DISP    PCE Edit Disposition Clinics

Select PCE Site Parameter Menu Option: SI PCE Site Parameters Edit
Select PCE PARAMETERS ONE: 1
STARTUP VIEW: ENCOUNTER
BEGINNING PATIENT DATE OFFSET: -30//[ENTER]
ENDING PATIENT DATE OFFSET: 1//[ENTER]
BEGINNING HOS LOC DATE OFFSET: -7//[ENTER]
ENDING HOS LOC DATE OFFSET: 0//[ENTER]
RETURN WARNINGS: YES//[ENTER]
MULTIPLE PRIMARY DIAGNOSES: RETURN WARNING//?    If errors are returned by
the Device Interface then the whole encounter is
not processed.
     Choose from:
        0          RETURN WARNING
        1          RETURN ERROR
MULTIPLE PRIMARY DIAGNOSES: RETURN WARNING//[ENTER]
SD/PCE SWITCH OVER DATE: JUL 1,1996
HEALTH SUMMARY START DATE: JUL 28,1996 Select PCE PARAMETERS ONE: [ENTER]
```

3. Review entries contained in PCE Supporting Files: Data is exported for Education Topics, Examinations, Health Factors, Immunizations, Skin Tests, and Treatments. With the exception of "treatments" data was exported with a status of "active." Entries in each of the supporting files should be evaluated and assigned an appropriate status. Use the *Activate/Inactivate Table Items Menu* option to review and assign a status for entries. Unless you activate current entries or create new entries for "Treatments," users will not be able to add treatments to an encounter.

Example of activating Treatment items

```
Select PCE Coordinator Menu Option: TBL  PCE Table Maintenance
Select PCE Table Maintenance Option: ACT  Activate/Inactivate Table Items
    E       Exams
    ET      Education Topics
    H       Health Factors
    I       Immunizations
    S       Skin Tests
    T       Treatments
Select Activate/Inactivate Table Items Option: T  Treatments

Select TREATMENT NAME: WOUND CARE
INACTIVE FLAG: INACTIVE// ??
     This field is used to inactivate a treatment type.  If this field
     contains a "1" then the treatment is inactive.  Inactive treatments
     cannot be selected in the manual data entry process.  Treatment
     entries should be made inactive when they are no longer used.  Do
     not delete the entry or change the meaning of the treatment entry.
     To make an inactive treatment type active, enter the "@" symbol to
     delete the "1" from the field.
     Choose from:
        1          INACTIVE
INACTIVE FLAG: INACTIVE// @
Select TREATMENT NAME: Continue to enter treatments, as needed.
```

4. **Edit the Report Parameters using the *PCE Report Parameter Edit* option.** This option is used to define parameters that will be used by the PCE Report Module. You need to identify which clinics are considered Emergency Room clinics by clinicians. You also need to identify the lab test names that are used by your site to identify the following types of Lab tests: Glucose, Cholesterol, LDL Cholesterol, and HBA1C.

To get a printout of current definitions in the PCE Parameters fields for these fields, use the PCE HS/RPT Parameters Print.

Example of editing report parameters

```
Select PCE Coordinator Menu Option: parm  PCE HS/RPT Parameter Menu
   PRNT    PCE HS/RPT Parameters Print
   HS      PCE HS Disclaimer Edit
   RPT     PCE Report Parameter Edit
Select PCE HS/RPT Parameter Menu Option: RPT  PCE Report Parameter Edit
Select PCE PARAMETERS ONE: 1
Select ER CLINIC NAME: eye
  Are you adding 'EYE' as a new REPORT ER CLINIC NAMES (the 1ST for this PCE
PARAMETERS)? y  (Yes)
Select ER CLINIC NAME: 2a
  Are you adding '2A' as a new REPORT ER CLINIC NAMES (the 2ND for this PCE
PARAMETERS)? y  (Yes)
Select ER CLINIC NAME: [ENTER]
Select GLUCOSE NAMES: ?
 Answer with REPORT EMERGENCY CLINICS GLUCOSE NAMES
     You may enter a new REPORT EMERGENCY CLINICS, if you wish
     Enter the name(s) of the BLOOD GLUCOSE lab assays as they appear in
     the Laboratory Test (60) file . DO NOT INCLUDE Glucose Tolerance or
Fluid
     Glucose test names.
     LAB TEST STORED ONLY AT THE "CH" NODE
 Answer with LABORATORY TEST NAME, or LOCATION (DATA NAME), or
     PRINT NAME
 Do you want the entire LABORATORY TEST List? n  (No)
Select GLUCOSE NAMES: glu
     1    GLUCAGON
     2    GLUCOSE
     3    GLUCOSE, OTHER
     4    GLUTAMINE
     5    GLUTETHIMIDE
TYPE '^' TO STOP, OR
CHOOSE 1-5:
     6    GLU  URINE GLUCOSE
CHOOSE 1-6: 6  URINE GLUCOSE
  Are you adding 'URINE GLUCOSE' as
    a new REPORT EMERGENCY CLINICS (the 1ST for this PCE PARAMETERS)? y
(Yes)
Select GLUCOSE NAMES:[ENTER]
Select CHOLESTEROL NAMES: ??
     This field will contain the names of any and all TOTAL CHOLESTEROL
     assays as they appear in the Laboratory Test (60) file to allow the
clinic
     reporting module of the Patient Care Encounter Package to monitor
Quality
     of Care Markers. Entries should be made either by IRM personnel or
     Clinic coordinator.
Select CHOLESTEROL NAMES: chol
     1    CHOLESTEROL
     2    CHOLESTEROL CRYSTALS
     3    CHOLINESTERASE
     4    CHOLYLGLYCINE
```

```
CHOOSE 1-4: 1
  Are you adding 'CHOLESTEROL' as
    a new REPORT CHOLESTEROL NAMES (the 1st for this PCE PARAMETERS)? Y
(Yes)
Select LDL CHOLESTEROL NAMES: ??
      This field will contain the names of any and all LDL CHOLESTEROL assays
      as they appear in the Laboratory Test (60) file to allow the clinic
      reporting module of the Patient Care Encounter Package to monitor
      Quality Assurance
Select LDL CHOLESTEROL NAMES:  CHOLYLGLYCINE
  Are you adding 'CHOLYLGLYCINE' as a new REPORT LDL CHOLESTEROL NAMES (the
1ST for this PCE PARAMETERS)? y (Yes)
Select LDL CHOLESTEROL NAMES:[ENTER]
Select HBA1C NAMES: ?
 Answer with REPORT HBA1C NAMES
      You may enter a new REPORT HBA1C NAMES, if you wish
      Enter the name(s) of the Glycosolated Hemoglobin assays as they
      appear in the Laboratory Test (60) file.
      LABS STORED ONLY AT THE "CH" NODE
 Answer with LABORATORY TEST NAME, or LOCATION (DATA NAME), or
      PRINT NAME
 Do you want the entire LABORATORY TEST List? n  (No)
Select HBA1C NAMES: glycoSYLATED HEMOGLOBIN A1C
  Are you adding 'GLYCOSYLATED HEMOGLOBIN A1C' as
    a new REPORT HBA1C NAMES (the 1ST for this PCE PARAMETERS)? y  (Yes)
Select HBA1C NAMES:[ENTER]

Select PCE PARAMETERS ONE:[ENTER]
```

5. Make sure the following EVENTS are on the appropriate ITEM protocols:

EVENT	PROTOCOL
SDAM PCE EVENT	ITEM multiple of the PXK VISIT DATA EVENT
IBDF PCE EVENTS	ITEM multiple of the PXK VISIT DATA EVENT
PXK SDAM TO V-FILES	ITEM multiple of the SDAM APPOINTMENT EVENTS
IBDF PCE EVENTS	ITEM multiple of PXCA DATA EVENT
VSIT PATIENT STATUS	ITEM multiple of DGPM MOVEMENT EVENTS.

Example of EVENT placement on PROTOCOLS.

```
[DVF,DEV]>D P^DI
VA FileMan 21.0
Select OPTION: INQUIRE TO FILE ENTRIES
OUTPUT FROM WHAT FILE: PROTOCOL        (3091 entries)
Select PROTOCOL NAME: PXK VISIT DATA EVENT          VISIT RELATED DATA
ANOTHER ONE: SDAM APPOINTMENT EVENTS          Appointment Event Driver
ANOTHER ONE: PXCA DATA EVENT        PCE Device Interface Module's Data Event
ANOTHER ONE:DGPM MOVEMENT EVENTS....
STANDARD CAPTIONED OUTPUT? Yes// [ENTER]  (Yes)
Include COMPUTED fields:  (N/Y/R/B): NO// [ENTER] - No record number (IEN),
no Computed Fields
NAME: PXK VISIT DATA EVENT               ITEM TEXT: VISIT RELATED DATA
  TYPE: extended action                  CREATOR: EATON,DENIS
 DESCRIPTION:    This is a Protocol that PIMS can hook onto to find the data
 that was collected by PCE using List Manager, Scanning etc.
 PIMS has developed a protocol, SDAM PCE EVENT, which will use the visit
 related data to do an auto-checkout.
ITEM: SDAM PCE EVENT
ITEM: IBDF PCE EVENT
  EXIT ACTION: K PXKSPX                  ENTRY ACTION: S PXKSPX=1
  TIMESTAMP: 56796,37384
NAME: SDAM APPOINTMENT EVENTS            ITEM TEXT: Appointment Event Driver
  TYPE: extended action                  CREATOR: EATON,DENIS
  PACKAGE: SCHEDULING
 DESCRIPTION:    This extended action contains all the actions that need to
 be performed when an action is taken upon an appointment, such as checking
 in.
ITEM: ORU PATIENT MOVMT
ITEM: IBACM OP LINK                      SEQUENCE: 1
ITEM: DG MEANS TEST REQUIRED
ITEM: VAFED EDR OUTPATIENT CAPTURE
ITEM: SDAM LATE ENTRY                    SEQUENCE: 2
ITEM: RMPR SCH EVENT                     SEQUENCE: 3
ITEM: DVBA C&P SCHD EVENT                SEQUENCE: 8
ITEM: PXK SDAM TO V-FILES
  ENTRY ACTION: D ANC^SDVSIT2            TIMESTAMP: 56796,37371
NAME: PXCA DATA EVENT
  ITEM TEXT: PCE Device Interface Module's Data Event
  TYPE: extended action                  CREATOR: EATON,DENIS
 DESCRIPTION:    This is the event point invoked by PCE Device Interface
Module when it has not found any errors in the data passed to it.  This
makes the data available to other users of the data including users of any
Local data that may be included.
ITEM: IBDF PCE EVENT
  TIMESTAMP: 56796,37383
NAME: DGPM MOVEMENT EVENTS               ITEM TEXT: MOVEMENT EVENTS v 5.0
  TYPE: extended action                  CREATOR: SCHLEHUBER,PAMELA
  PACKAGE: REGISTRATION
 DESCRIPTION:
  At the completion of a patient movement the following events
  take place through this option:
```

```
   1. The PTF record is updated when a patient is admitted,
      discharged or transferred.

   2. The appointment status for a patient is updated to 'inpatient'
      for admissions and 'outpatient' for discharges.  Admissions
      to the domiciliary have an 'outpatient' appointment status.

   3. When a patient is admitted, dietetics creates a dietetic
      patient file entry and creates an admission diet order.
      When a patient is discharged, all active diet
      orders are discontinued.  If a patient is absent or on
      pass, the diet orders are suspended.

   4. Inpatient Pharmacy cancels all active orders when a
      patient is admitted, discharged or on unauthorized absence.
      A patient can not be given Unit Dose meds unless s/he is
      admitted to a ward.  The patient can receive IV meds; however.
      When a patient is transferred, an inpatient system parameter
      is used to determine whether or not the orders should be
      cancelled.  When a patient goes on authorized absence, the
      inpatient system parameter is used to determine whether the
      orders should be cancelled, placed on hold or no action taken.
      When a patient returns from authorized absence any orders
      placed on hold will no longer be on hold.

   5. With ORDER ENTRY/RESULTS REPORTING v2.2,
      MAS OE/RR NOTIFICATIONS may be displayed to
      USERS defined in an OE/RR LIST for the patient. These notifications
      are displayed for admissions and death discharges.
    FILE LINK: 11754;DIC(19,
ITEM: ORU AUTOLIST
ITEM: ORU PATIENT MOVMT
ITEM: FHWMAS
ITEM: GMRVOR DGPM
ITEM: PSJ OR PAT ADT
ITEM: IB CATEGORY C BILLING              SEQUENCE: 10
ITEM: DG MEANS TEST DOM                  SEQUENCE: 8
ITEM: DGJ INCOMPLETE EVENT               SEQUENCE: 6
ITEM: DGOERR NOTE                        SEQUENCE: 7
ITEM: DGPM TREATING SPECIALTY EVENT      SEQUENCE: 1
ITEM: VAFED EDR INPATIENT CAPTURE
ITEM: SD APPT STATUS                     SEQUENCE: 2
ITEM: GMRADGPM MARK CHART
ITEM: YS PATIENT MOVEMENT
ITEM: DVB ADMISSION HINQ
ITEM: VSIT PATIENT STATUS
    TIMESTAMP: 56803,40994
Select PROTOCOL NAME: [ENTER]
```

6. **Use the Visit Tracking Parameters Edit option to ensure that the entries in the VISIT TRACKING PARAMETERS file (#150.9) are correct**. (This option is not on a menu— go through MenuMan to access it.) The post-installation routine ^VSITPOST, which is called automatically by the installation process, checks to see if the VISIT TRACKING PARAMETERS file (#150.9) has an entry. If not, it will configure it with default values.

- Answer the SITE PART OF VISIT ID prompt with TEST ACCOUNT if this is in your test or training account.
- Answer with the three-letter identifier for your facility if you are in production.

Example of editing Visit Tracking Parameters

```
>D ^XUP
Select OPTION NAME: VSIT TRACKING PARM EDIT Visit Tracking Parameters edits.
Select VISIT TRACKING PARAMETERS NAME: 1
DEFAULT TYPE: VA//[ENTER]
DEFAULT INSTITUTION: Enter your institution name here
Select PACKAGE:  PCE PATIENT CARE ENCOUNTER         PX
        ...OK? Yes// [ENTER]  (Yes)
  PACKAGE: PCE PATIENT CARE ENCOUNTER//[ENTER]
  ACTIVE FLAG: ON//[ENTER]
Select PACKAGE: SCHEDULING          SD
        ...OK? Yes// [ENTER] (Yes)
  PACKAGE: SCHEDULING//[ENTER]
  ACTIVE FLAG: OFF// ON
Select PACKAGE: ORDER ENTRY/RESULTS REPORTING        OR
        ...OK? Yes// [ENTER] (Yes)
  PACKAGE: ORDER ENTRY/RESULTS REPORTING//[ENTER]
  ACTIVE FLAG: ON//[ENTER]
Select PACKAGE:[ENTER]
SITE PART OF VISIT ID: ??
     This is a three letter identifier for this computer system that is
     unique in the VA, or "TEST" of a test account. This is appended after a
     "-" onto the sequence number to form the unique Visit Id in the VA
     system.  It is important that this is set to the correct value and not
     changed.
Choose from:
   ALBANY, NY       ALN
   ALBUQUERQUE, NM       ALB
   ALEXANDRIA, LA       ALX
   ALLEN PARK, MI       ALL     (continuing to display all sites)
Select VISIT TRACKING PARAMETERS NAME:[ENTER]
```

7. Create a PXCA PCE ERROR BULLETIN mail group in MAIL GROUP file (#3.8):

```
>D P^DI

VA FileMan 20.0

Select OPTION: ENTER OR EDIT FILE ENTRIES

INPUT TO WHAT FILE: MAIL GROUP// [ENTER]
EDIT WHICH FIELD: ALL// [ENTER]

Select MAIL GROUP NAME: PXCA PCE ERROR BULLETIN
  ARE YOU ADDING 'PXCA PCE ERROR BULLETIN' AS
    A NEW MAIL GROUP (THE 65TH)? Y  (YES)
Select MEMBER: USER,JOE
 ARE YOU ADDING 'USER,JOE' AS A NEW MEM (THE 1ST FOR THIS MAIL GROUP)?Y(YES)
Select MEMBER: [ENTER]
DESCRIPTION:
  1>A mail group to send error bulletin messages from PXCA.
  2>Used by "PXCA PCE ERROR BULLETIN" bulletin.
  3>[ENTER]
EDIT Option: [ENTER]
TYPE: PU  public
ORGANIZER:[ENTER]
COORDINATOR: USER,ANOTHER//[ENTER]
Select AUTHORIZED SENDER:[ENTER]
ALLOW SELF ENROLLMENT?: NO
REFERENCE COUNT:[ENTER]
LAST REFERENCED:[ENTER]
RESTRICTIONS: LOCAL
Select MEMBER GROUP NAME:[ENTER]
Select REMOTE MEMBERS:[ENTER]
Select DISTRIBUTION LIST:[ENTER]

Select MAIL GROUP NAME:[ENTER]

Select OPTION: ENTER OR EDIT FILE ENTRIES

INPUT TO WHAT FILE: MAIL GROUP// BULLETIN      (86 entries)
EDIT WHICH FIELD: ALL// MAIL GROUP      (multiple)
   EDIT WHICH MAIL GROUP SUB-FIELD: ALL// [ENTER]
THEN EDIT FIELD:[ENTER]

Select BULLETIN NAME: PXCA PCE ERROR BULLETIN
Select MAIL GROUP: PXCA PCE ERROR BULLETIN
  ARE YOU ADDING 'PXCA PCE ERROR BULLETIN' AS
    A NEW MAIL GROUP (THE 1ST FOR THIS BULLETIN)? Y  (YES)
Select MAIL GROUP:[ENTER]
Select BULLETIN NAME:[ENTER]
```

8. **Create VSIT CREATE ERROR as a mail group (as described above) adding appropriate members.** Visit Tracking sends a message to this mail group when it has an error that prevents it from creating a visit.

9. Activate PCE components in the Health Summary Component file.

10. Implement the PCE Reminder/Maintenance items to appear on Health Summaries.

The Clinical Reminders feature of PCE uses a combination of PCE Table Maintenance options, PCE Clinical Reminders options, PCE Taxonomy options, Health Summary Create/Modify Health Summary Type options, and AICS Encounter Form options. *The PCE User Manual Appendices document (Appendix A) provides a more detailed description of developing and customizing clinical reminders.*

Follow the steps below, as applicable, to implement Clinical Reminders.
NOTE: Most of these steps are optional, to be performed only if you want to modify items to meet site needs.

- Use the *List Reminder Definitions* option to print the nationally distributed reminder definitions (both the "VA" and "VA-*" prefixed). Determine if you want to use the distributed definitions.

Example of List Reminder Definitions (1st page)

```
Select PCE IRM Main Menu Option: rm  PCE Reminder Maintenance Menu
   RL     List Reminder Definitions
   RI     Inquire about Reminder Item
   RE     Add/Edit Reminder Item
   RC     Copy Reminder Item
   RA     Activate/Inactivate Reminders
   RT     List Reminder Types Logic
   TL     List Taxonomy Definitions
   TI     Inquire about Taxonomy Item
   TE     Edit Taxonomy Item
   TC     Copy Taxonomy Item
   TA     Activate/Inactivate Taxonomies
Select PCE Reminder Maintenance Menu Option: RL  List Reminder Definitions
DEVICE: [ENTER]   VAX    RIGHT MARGIN: 80// [ENTER]
```

```
PCE REMINDER/MAINTENANCE ITEM LIST              MAY 22,1996  08:57    PAGE 1
-----------------------------------------------------------------------------
BREAST CANCER SCREEN
-----------------------------------
Print Name:                    Breast Cancer Screen
Related VA-* Reminder:         555002
Reminder Description:
    Mammogram should be given every 2 years to female patients, ages 50-69.
    The "VA-*Breast Cancer Screen" reminder is based on the following
    "Breast Cancer Screen" guidelines specified in the "Guidelines for
     Health Promotion and Disease Prevention", M-2, Part IV, Chapter 9.
          Target Condition: Early detection of breast cancer.
          Target Group:     All women ages 50-69.
```

- Identify the reminders that your site wants to implement. Copy, as necessary, using the *Copy Reminder Item* option. After copying the reminders, you can alter the new reminders to meet your site's needs.

NOTE: The "VA-" prefix represents the nationally distributed set. When you copy items, the VA-prefix is dropped. "VA-*" represents the minimum requirements as defined by the National Center for Health Promotion (NCHP). As an alternative, you can create a local site reminder item using the *Edit Taxonomy Item* option.

- Use the Health Summary package to activate Clinical Reminders and Clinical Maintenance components. Then rebuild the Adhoc Health Summary Type.
  a. Identify which Health Summary Type is used by the implementing clinic.
  b. Add the Clinical Reminders and/or the Clinical Maintenance components to the Health Summary Type.
  c. Edit component parameters, identifying desired selection items.

- If a taxonomy definition related to a reminder needs modification, do the following steps:
  a. Copy the taxonomy using the *Copy Taxonomy Item* option.
  b. Modify the taxonomy, using the *Edit Taxonomy Item* option.
  c. Copy the related Reminder.
  d. Modify the Reminder to reflect the newly created taxonomy, using the *Add/Edit Reminder Item* option.
  e. As an alternative to copying a taxonomy, local site taxonomy items can be created, using the *Edit Taxonomy Item*.

Modify the Treatment, Immunization, Patient Ed, Skin Test, Exam, and Health Factors files, if necessary, through *PCE Table Maintenance* options. *If clinical reminders are not showing up correctly on Health Summaries, see Appendix A-7 in the PCE User Manual Appendices document for troubleshooting information which IRM staff with programmer access can use.*

- Coordinate the use of Encounter Forms (through the AICS package) with the use of Health Summary Clinical Maintenance Components. Make sure that the relevant encounter forms contain all appropriate list bubbles for PCE data: Health Factors, Exams, Immunizations, Diagnosis, Patient Education, Procedures, and Skin Tests.

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

11. (Optional) **Add Health Summary, Problem List, and Progress Notes as actions on PCE screens to allow quick access to those programs while using PCE**.

Example of adding programs to PCE screens

```
>D P^DI

VA FileMan 21.0
Select OPTION: ENTER OR EDIT FILE ENTRIES

INPUT TO WHAT FILE: 101   PROTOCOL
                                        (2978 entries)
EDIT WHICH FIELD: ALL// ITEM
   EDIT WHICH ITEM SUB-FIELD: ALL// .01   ITEM
   THEN EDIT ITEM SUB-FIELD: MNEMONIC
   THEN EDIT ITEM SUB-FIELD: [ENTER]
THEN EDIT FIELD: [ENTER]

Select PROTOCOL NAME: PXCE SDAM MENU          Appointment Menu      AV
Select ITEM: PXCE BLANK HS// [ENTER]
  ITEM: PXCE BLANK HS// PXCE GMTS HS ADHOC        Health Summary      HS
  MNEMONIC: HS
Select ITEM: PXCE BLANK PN
         ...OK? Yes//[ENTER]  (Yes)

  ITEM: PXCE BLANK PN// PXCE GMRP REVIEW SCREEN      Progress Notes      PN
  MNEMONIC: PN
Select ITEM: PXCE BLANK PL
         ...OK? Yes// [ENTER]  (Yes)

  ITEM: PXCE BLANK PL// PXCE GMPL OE DATA ENTRY    Patient Problem List   PL
  MNEMONIC: PL
Select ITEM:[ENTER]

Select PROTOCOL NAME: PXCE MAIN MENU
Select ITEM: PXCE BLANK HS// [ENTER]
  ITEM: PXCE BLANK HS// PXCE GMTS HS ADHOC        Health Summary      HS
  MNEMONIC: HS
Select ITEM: PXCE BLANK PN
         ...OK? Yes// [ENTER]  (Yes)
```

```
   ITEM: PXCE BLANK PN// PXCE GMRP REVIEW SCREEN        Progress Notes      PN
   MNEMONIC: PN
Select ITEM: PXCE BLANK PL
         ...OK? Yes// [ENTER]  (Yes)

   ITEM: PXCE BLANK PL// PXCE GMPL OE DATA ENTRY    Patient Problem List   PL
   MNEMONIC: PL
Select ITEM: [ENTER]

Select PROTOCOL NAME: [ENTER]
```

12. **Create a DISPOSITION CLINIC for each division in your facility using the "Set Up a Clinic" option on the Scheduling Supervisor Menu**. If you are a multi-divisional facility and you want to credit disposition workload for each division, you will need to set up a DISPOSITION CLINIC for each division. Make sure you define each DISPOSITION CLINIC so that it is easily associated with the division for which you want to credit workload.

- If you are a single-division facility, you should define only one DISPOSITION CLINIC.

- The DISPOSITION CLINICS will *only* be used with Dispositions.

- PCE recommends creating a clinic defined as Disposition, with a Stop Code number of 102. This clinic should be used with all dispositions.

- Use "PCE Edit Disposition Clinics" option located on the "PCE Site Parameter Menu" to enter the DISPOSITION CLINICs that were defined for use with Dispositions for your facility. The purpose of this is to restrict the Hospital Location for a Disposition to DISPOSITION CLINICs only.

- In single-division facilities, the hospital location for Dispositions will be stuffed automatically, and you will not be prompted to select a DISPOSITION HOSPITAL LOCATION.

PCE Edit Disposition Clinics Example

```
Select PCE Site Parameter Menu Option: PCE Edit Disposition Clinics
Select PCE PARAMETERS ONE: 1
Select DISPOSITION HOSPITAL LOCATIONS: ?
 Answer with DISPOSITION HOSPITAL LOCATIONS
Choose from:
   DISPOSITION 1
   DISPOSITION 2
      You may enter a new DISPOSITION HOSPITAL LOCATIONS, if you wish
Answer with HOSPITAL LOCATION NAME, or ABBREVIATION
 Do you want the entire 58-Entry HOSPITAL LOCATION List? n
Select DISPOSITION HOSPITAL LOCATIONS: DISPOSITION 1
```

Maintenance

Table Maintenance Options

The Table Maintenance options let sites add or edit the items in the tables for Health Factors, Patient Education, Immunizations, Skin Tests, etc. Once these tables have been defined, the table entries can be selected for encounter data entry (PCE package) and encounter form definitions (AICS package). Scanning encounter forms with the AICS package will provide PCE with patient information which is stored in the V files. The patient information collected based on these table definitions is viewable on Health Summaries (Health Summary package).

This menu also includes options to edit the Clinical Reminder/Health Maintenance definitions, based on your site's clinical terminology in the tables. Once reminder criteria have been defined, they may be included in the Health Summary Type definitions for the "Clinical Reminder" and "Health Maintenance" Components.

Table items that are distributed with the PCE package can be inactivated using the PCE "Activate/Inactivate Table Items" menu. Use the "Inactive Flag" field to make an item "INACTIVE" for selection in the Encounter form definition process and the PCE encounter data entry process. Enter "@" at the "Inactive Flag" field to reactivate an inactivated item.

These options may be used in conjunction with the "PCE Information Only" menu options to manage the contents of the files or tables supporting PCE. Below is a description of the options.

PXTT ACTIVATE/INACTIVATE MENU - Activate/Inactivate Table Items
This option is the main menu option to activate or inactivate the entries in the supporting tables. (e.g., Immunizations, Skin Tests, Education Topics)

PXTT COPY EDUCATION TOPICS - Education Topic Copy
This option lets you copy an existing education topic into a new education topic entry in the Education Topics file (#9999999.09). The original education topic to be copied is selected first. If the topic is prefixed with "VA-" the "VA-" will be stripped off the name automatically. The new name must be unique.

PXTT EDIT EDUCATION TOPICS - Education Topic Add/Edit
This option lets you create a new Education Topic or edit an Education Topic that was originally created at your site. Education topics distributed with the PCE package can be inactivated using "Activate/Inactivate Table Items."

PXTT EDIT EXAM - Examinations Add/Edit
This option allows you to create a new name to represent an examination type or
edit an examination type that was originally created at your site.
The examination types originally distributed by PCE are a breakdown of potential
categories of exams within a Physical Exam.

PXTT EDIT HEALTH FACTORS - Health Factors Add/Edit
This option allows the user to create a new Health Factor or edit a Health Factor
that was originally created at your site.

PXTT EDIT IMMUNIZATIONS - Immunizations Add/Edit
This option allows a user to create a new Immunization type or edit an existing
Immunization type that was originally created at your site.

PXTT EDIT SKIN TESTS - Skin Tests Add/Edit
This option allows a user to create a new Skin Test table entry or edit a Skin Test
table entry that was originally created at your site.

PXTT EDIT TREATMENT - Treatments Add/Edit
This option allows a user to create a new Treatment or edit a Treatment that was
originally created at your site.

PCE Information Only Menu

This is a menu of options that list information about the files/tables used by the
Patient Care Encounter (PCE) package. Some of the files/tables determine what
clinical data will be collected as the sites' clinical terminology for specific categories
of data such as Immunizations, Skin Tests, Patient Education, and Treatments.
Below is a description of the options.

PXTT LIST ACTIVE EDUC TOPICS - Active Educ. Topic List - Detailed
This lists the current detailed definition of the goals and standards defined for the
active education topics.

PXTT LIST ALL EDUC TOPICS - Education Topic List
This option prints a brief list of ALL Education Topics using only two fields:
Inactive Flag status and Topic Name.

PXTT INQUIRE EDUC TOPIC - Education Topic Inquiry
This option can be used to print the definition of a specific Education Topic
definition.

PXTT LIST EXAMS - Exam List
This option lists all of the exam names, with their Active Status, that are defined in the Exam file for use with PCE.

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

PXTT LIST IMMUNIZATIONS - Immunization List
This option lists all immunizations, with their Active Status, which have been defined in the Immunization file for use with PCE. Note: To see what CPT codes may be related to the immunization entries, print the PCE Code Mapping List.

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

PXTT LIST TREATMENTS - Treatment List
This option lists all treatments, with their active status, that have been defined in the Treatment file for use with PCE

PX PCE CODE MAPPING LIST - PCE Code Mapping List
This option allows the user to see the mapping between CPT codes and a related entry in a PCE supporting file. For example, the CPT code 90732 is related to the Immunization file entry PNEUMOCCOCAL. PCE uses the code mapping relationships to populate multiple files from one data entry step. For example, an entry of PNEUMOCCOCAL in the V Immunization file will also create a CPT entry, 90732 in the V CPT file which is then passed to PIMS.

PCE Reminder Maintenance Menu

This is the menu for editing reminder logic and making queries about the files involved with Clinical Reminders and Clinical Maintenance components in the Health Summary package. The taxonomy feature of PCE contains expert rules that can provide very timely and pertinent patient information to clinicians on Health Summaries. See the Implementation section of this manual and the PCE User Manual Appendices document (Appendix A) for more detailed information about developing and customizing clinical reminders. Below is a description of the options.

PXRM REMINDERS LIST - List Reminder Definitions
Lists the PCE reminder/maintenance items with their definitions. Active items may be selected for use in the Clinical Reminder and Clinical Maintenance components of the Health Summary package.

PXRM REMINDER INQUIRY - Inquire About Reminder Item
Allows a user to display the definition of how a clinical reminder/health maintenance item is used in the Health Summary "Clinical Reminder" and "Health Maintenance" components.

PXRM REMINDER EDIT - Add/Edit Reminder Item
This option is used to edit the PCE Reminder/ Maintenance Item definitions. Several predefined reminder/maintenance items are distributed with the PCE package based on the Ambulatory Care EP Preventive Health Maintenance Guidelines. Sites may define their own Age Findings, Results Findings, Taxonomy, and Health Factor findings. They may also create routines for computed findings where necessary. Result findings at each site may require modification to represent local use of clinical data named in supporting Lab test, Radiology, Education Topic, Health Factor and PCE Taxonomy data definitions. The distributed reminder item's "Technical Description" will help the coordinator ensure that the reminder definition is modified to reflect local guidelines for reminders.

PXRM REMINDER COPY - Copy Reminder Item
This option lets you copy an existing reminder item definition into a new reminder item in the PCE Reminder/ Maintenance Item file (#811.9). The original reminder item to be copied is selected first. If the original reminder item is prefixed with "VA-", the "VA-" will be stripped off the name automatically to create the name for the new reminder item. The new name must be unique. If the new name is not unique, you must enter a unique name for the new reminder item entry. If no name is provided, the new entry will not be created. Once a new name is defined for the new reminder item, the new reminder item can be edited to reflect the local reminder definition.

PXRM (IN)/ ACTIVATE REMINDERS - Activate/Inactivate Reminders
This option is used to make reminders active or inactive.

PXRM TAXONOMY COPY - Copy Taxonomy Item
This option allows you to copy an existing taxonomy definition into a new taxonomy entry in the PCE Taxonomy file (#811.2). The original taxonomy to be copied is selected first. If the original taxonomy is prefixed with "VA," the "VA-" will be stripped off the name automatically to create the name for the new taxonomy entry. The new name must be unique. If the new name is not unique, the user must enter a unique name for the new taxonomy entry. If no name is provided, the new entry will not be created. Once a new name is defined for the new taxonomy entry, the new taxonomy entry can be edited to reflect the local taxonomy definition.

PXRM TAXONOMY EDIT - Edit Taxonomy Item
This option is used to edit the PCE Taxonomy Item definitions. Several predefined taxonomy items are distributed with the PCE package based on the Ambulatory Care EP Preventative Health Maintenance Guidelines. The distributed taxonomy items all have a "VA-" prefix. To alter a VA- prefixed taxonomy item, first copy it to a different name and then edit the taxonomy to reflect your site's definition for the taxonomy.

PXRM TAXONOMY INQUIRY - Inquire about a Taxonomy Item
This option provides a detailed report of a Taxonomy item's definition, with a list of the actual ICD codes that will meet the taxonomy definition from the ICD Diagnosis and ICD Operation/Procedure files.

PXRM TAXONOMY LIST - List Taxonomy Definitions
This option lists the current definition of taxonomies defined in the PCE Taxonomy file. The PCE Taxonomy file is used to define the coded values from ICD Diagnosis, ICD Operation/ Procedures, and CPT codes that can be viewed as being part of a clinical category (taxonomy). These taxonomy low and high range definitions are used in the Clinical Maintenance and Clinical Reminders components to determine if a patient has coded values in the clinical files that indicate the patient is part of the taxonomy.

PXRM (IN)/ ACTIVATE TAXONOMIES - Activate/Inactivate Taxonomies
This option allows you to activate/inactivate taxonomies.

PCE Clinical Reports

The PCE Clinical Reports options provide clinicians and managers with data never before available. They extract data from various files in V*IST*A, including laboratory, pharmacy, and PIMS to create output reports which have been requested by physicians all over the VA. Below is a description of the options.

PXRR PATIENT ACTIVITY BY CL - Patient Activity by Clinic-
This report provides a summary of patient data for one or more clinics as a measure of continuity of care.

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

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

PXRR MOST FREQUENT DIAGNOSES - Diagnoses Ranked by Frequency
This report lists the most frequent diagnostic codes (ICD9 or ICD10) and the most frequent diagnostic categories.

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

PXRR PROVIDER ENCOUNTER COUNTS - Provider Encounter Counts
This report lists provider counts related to PCE outpatient encounters (in detailed or summary reports). The selection criteria includes facility, service category, provider, and date range.

File Descriptions

PCE Patient Care Encounter Files

File Number	File Name	Global	Data	Journaling
811.1	PCE Code Mapping	^PXD(811.1,	YES	
811.2	PCE Taxonomy	^PXD(811.2,	NO	
811.8	PCE Reminder Type	^PXD(811.8,	YES	
811.9	PCE Reminder/ Maintenance Item	^PXD(811.9,	YES	
815	PCE Parameters	^PX(815,	NO	
839.01	PXCA Device Interface Module Errors	^PX(839.01,	NO	ON
839.7	Data Source	^PX(839.7,	YES	
9000001	Patient/IHS	^AUPNPAT(	NO	ON
9000010.06	V Provider	^AUPNVPRV(	NO	ON
9000010.07	V POV	^AUPNVPOV(	NO	ON
9000010.11	V Immunization	^AUPNVIMM(	NO	ON
9000010.12	V Skin Test	^AUPNVSK(	NO	ON
9000010.13	V Exam	^AUPNVXAM(	NO	ON
9000010.15	V Treatment	^AUPNVTRT(	NO	ON
9000010.16	V Patient Ed	^AUPNVPED(	NO	ON
9000010.18	V CPT	^AUPNVCPT(	NO	ON
9000010.23	V Health Factors	^AUPNVHF(	NO	ON
9999999.06	Location	^AUTTLOC(	NO	
9999999.09	Education Topics	^AUTTEDT(	YES	ON
9999999.14	Immunization	^AUTTIMM(	YES	
9999999.15	Exam	^AUTTEXAM(	YES	
9999999.17	Treatment	^AUTTTRT(	YES	
9999999.27	Provider Narrative	^AUTNPOV(	NO	ON
9999999.28	Skin Test	^AUTTSK(	YES	
9999999.64	Health Factors	^AUTTHF(	YES	ON

811.1—PCE CODE MAPPING FILE

This file is used to map entries from two different files such as between CPT codes and a related entry in a PCE supporting file. For example, the CPT code 90732 is related to the Immunization file entry PNEUMOCCOCAL. PCE uses the code mapping relationships to populate multiple files from one data entry step. For example, an entry of PNEUMOCCOCAL in the V Immunization file will also create a CPT entry, 90732 in the V CPT file which will then be passed to PIMS.

811.2—PCE TAXONOMY FILE

This file stores the taxonomies used by the PCE/Reminders/Maintenance sub-module. A Taxonomy entry in this file allows the coded values in another file to be related as a group, identified by the taxonomy name. Once entries are defined in this file, they can be referenced in the PCE Reminders/ Maintenance Item file to define a group of codes to use for reminders/maintenance. The taxonomy entries may be defined in ranges for ICD Diagnosis, ICD Operation/Procedure, and CPT-coded values.

811.8—PCE REMINDER TYPE FILE

This file contains the names of reminder types.

811.9—PCE REMINDER/MAINTENANCE ITEM FILE

This file contains the names of reminders and their definitions which can be selected for use in the Health Summary package components:

> PCE CLINICAL REMINDERS
> This component evaluates patient findings to determine if the reminder is "DUE NOW."
> PCE CLINICAL MAINTENANCE
> This component evaluates patient findings and reports the findings or lack of findings used to determine if the reminder is due.

815—PCE PARAMETERS FILE

This file has one entry which contains parameters used by PCE. Users can set defaults for start-up views (Appointment or Encounter lists), for a range of dates that will be displayed, whether to display warnings if no diagnoses or procedures are passed, and several Health Summary/Reminders/Reports parameters.

839.01—PCE DEVICE INTERFACE MODULE ERROR FILE

This file holds the PXCA and PXKERROR variables when PXK returns error(s) to the device interface.

839.7—DATA SOURCE FILE

This file holds the names of the sources that PCE receives encounter data from — scanning devices, scheduling package, PCE User Interface, etc.

V Files – Files originally from Indian Health Service and involved in Joint Sharing

In all V-files, the patient name is a pointer to the IHS Patient file, and the visit is a pointer to the visit file. Both of these must exist before data can be entered into any V file. The .01 field may be duplicated in multiple records. Also, a V file can have multiple entries for a visit, to capture multiple procedures, etc. For example, a patient may have several performed; each one would be a separate entry in V-CPT, each pointing to the same patient and visit.

9000010 – VISIT

This file contains a record of all patient visits at health care facilities or by health care providers, including direct outpatient and clinic visits, as well as inpatient encounters with providers of care. All other visit related files, such as purpose of visit (diagnoses), operative procedures, immunizations, examinations, etc. will point to a visit in this file. The records are maintained by date/time of visit, and the patient name field is a pointer to the IHS Patient file, where the patient must exist before data can be added here.

9000010.06 – V PROVIDER

Stores providers related to a visit. There can be multiple providers for a given visit. The primary/ secondary field identifies which provider is considered the primary provider for this visit.

9000010.07 – V POV

Stores problems treated at a visit. At least one purpose of visit (POV) is required for workload and billing purposes for each patient outpatient visit, regardless of the discipline of the provider (i.e. dental, CHN, mental health, etc.). There is no limit to the number of POVs that can be entered for a patient for a given encounter.

9000010.11 – V IMMUNIZATION

This file contains immunizations specific to a particular visit for a particular patient.

9000010.12 – V SKIN TEST
Stores skin tests done at a visit. There will be one record for each type of skin test given to a patient on a given visit. The record is normally created when a skin test is given, and the results, if available, are entered at a later date and matched to the original record. If results are entered and a skin test given does not exist, a new record is created.

9000010.13 – V EXAM
Stores exams done at a visit which do not map to a CPT code. This file contains exam information specific to a particular visit for a particular patient.

9000010.15 – V TREATMENT
Stores miscellaneous clinical data not fitting into any other V-file global. This file contains a record for each treatment provided to a patient on a given patient visit. There will be multiple treatment records for the same treatment (.01) field based on the date on which it was given.

9000010.16 – V PATIENT ED
Stores patient education done at a visit.

9000010.18 – V CPT
Stores CPT-related services performed at a visit.

9000010.23 – V HEALTH FACTORS
Stores patient health factors as of the visit date.

Supporting Files (evolved from IHS/VA Joint Sharing)

9000001 – Patient/HIS
This file is IHS's primary patient data file. The NAME (.01) field of this file is a pointer to the VA's patient file (#2). Fields in common between the two dictionaries actually exist only in the VA patient file and are referenced by the IHS patient file as computed fields. All other files containing patient data have backward pointers linking them to this file. The linkage is by patient name and the internal FileMan generated number of the ancillary file is the same number used in this file.

9999999.06 – LOCATION
Dinumed to the Institution file (#4).

9999999.09 – EDUCATION TOPICS
This file contains Patient Education Topics. Patient Education topics are subjects on which a patient needs may receive additional health-related information to facilitate better health care habits. For example, a patient may have had some podiatry work done and therefore was instructed with information about "foot care." The "foot care" information is in this file. It is pointed to by the V Patient Ed file.

9999999.14 – IMMUNIZATION
This file contains a list of Immunizations and is pointed to by the V Immunization file. This file contains a full descriptive name for each Immunization, a shortened name of ten characters which is used in the Health Summary Immunization components and on other clinical reports.

9999999.15 – EXAM
This file contains a list of Physical Exams and associated codes used to document Examinations performed during an Outpatient or Inpatient Encounter. This file is pointed to by V Exam file. Some of the Exams are used in Surveillance Computations.

9999999.17 – TREATMENT
This file contains Patient Treatments which are not included in the CPT codes, but are needed for clinical documentation. This file is pointed to by the V Treatment file. These treatments generally reflect nursing activities performed during a patient encounter, such as ear irrigation, or instructions or counseling given to a patient for a medical problem.

9999999.27 – PROVIDER NARRATIVE
This file contains each unique NARRATIVE QUALIFIER.

9999999.28 – SKIN TEST
This file contains Skin Tests and their associated codes. It is pointed to by V Skin Test.

9999999.64 – HEALTH FACTORS
This file contains Health Factors terms or phrases which describe patient health characteristics (e.g., Current Smoker, Non-Tobacco User), and is pointed to by V Health Factors file. Some entries in this file are categories, used to group related health factors (e.g., Smoking).

File Descriptions

Archiving and Purging

Archiving and purging utilities are not provided in this version of PCE. Initially, PCE was developed to provide a longitudinal database which would document patient care activities.

Callable Routines

This package provides APIs as callable entry points for use by other developers, as well as those of the PCE Device Interface, which are described in Appendix A of this manual. These APIs and entry points are all by subscription only.

$$CLNCK^SDUTL2

Patient Care Encounter application was modified to check the clinic associated with an encounter to ensure that its corresponding stop pairs conform to the stop code restriction. The following components were affected:
Routines PXBAPI1, PXCEVSIT and PXCE were modified to call API, $$CLNCK^SDUTL2 which checks to ensure a clinic has valid stop code pairs in accordance with restriction type.

PCE APIs

$$INTV^PXAPI(WHAT,PKG,SOURCE,.VISIT,.HL,.DFN,APPT, LIMITDT,ALLHLOC)
This API should be used by subscribing packages to prompt for Visit and related V-file data. The parameters passed by the subscribing packages determine which prompts will be displayed. If VISIT, HL or DFN are passed by reference (.), a value will be returned for those variables.

Parameter Description:

1. WHAT

Required parameter that defines the series of prompts that will be displayed.

- INTV - Includes all prompts for the checkout interview:
1. Patient (if not defined)
2. Hospital Location (if not defined)
3. Appointment/Eligibility (Call to Scheduling API if the encounter is not associated with an appointment and is a new encounter.)
4. Check Out Date/Time
5. Service Connected/Classification Questions
    - Service Connected
    - Agent Orange Exposure
    - Ionizing Radiation Exposure
    - SW Asia Conditions
    - Military Sexual Trauma
    - Head and/or Neck Cancer
    - Combat Veteran
    - Project 112/SHAD
6. Provider (multiple)
    - Provider
    - Primary/Secondary Designation
7. Procedures (multiple)
    - CPT code
    - Quantity
8. Diagnosis (multiple)
    - ICD code
    - Primary/Secondary Designation

Enhanced API

The DATA2PCE and PXCA Application Program Interface (API) Files, which are used by other packages to exchange data with the PCE files, were updated to include the CPT associated diagnoses and the diagnosis classifications of SC, CV, AO, IR, EC, MST, HNC, and Project 12/SHAD.

$$DATA2PCE^PXAPI(INPUTROOT,PKG,SOURCE,.VISIT,USER,ERR DISP,.ERRARRAY,PPEDIT,.ERRPROB, .ACCOUNT)
This is a function which will return a value identifying the status of the call. Data that is processed by PCE will be posted on the PXK VISIT DATA EVENT protocol.

Parameter Description:

1. INPUTROOT
(Required) Where INPUTROOT is a unique variable name, either local array or global array, which identifies the defined data elements for the encounter. An example of an INPUTROOT is ^TMP(”LRPXAPI”,$J) or ^TMP(”RAPXAPI”,$J). The gross structure of the array includes four additional subscripts (ENCOUNTER, PROVIDER, DX/PL, PROCEDURE and STOP) for defining the data passed. A detailed description of this array and its structure are included below in a table format.

2. PKG
(Required) Where PKG is a pointer to the Package File (9.4).

3. SOURCE
(Required) Where SOURCE is a string of text (3-30 character) identifying the source of the data. The text is the SOURCE NAME field (.01) of the PCE Data Source file (#839.7). If the SOURCE currently does not exist in the file, it will be added. Examples of SOURCE are: "LAB DATA" or "RADIOLOGY DATA" or "PXCE DATA ENTRY" or "AICS ENCOUNTER FORM."

4. VISIT
(Optional) A dotted variable name. Where VISIT is a pointer to the Visit file (9000010) which identifies the encounter which this data should be associated with.

5. USER
(Optional) User who is responsible for add/edit/delete action on the encounter. Pointer to the New Person file (200). If USER is not defined, DUZ will be used.

6. ERRDISP
(Optional) To display errors during development, this variable may be set to
"1". If it is defined the errors will be displayed on screen when the error
occurs. If ERRDISP is not defined, errors will be posted on the defined
INPUTROOT subscripted by "DIERR". BLD^DIALOG is used to manage
errors. Review BLD^DIALOG and MSG^DIALOG descriptions included in
the FileManager v. 21.0 Programmer Manual on pages 189 - 200.

7. ERRARRAY
(Optional) A dotted variable name. When errors and warning occur, the array
will contain the PXKERROR array elements to the caller.

8. PPEDIT
(Optional) Set to 1 if you want to edit the Primary Provider. Only use if for
the moment that editing is being done.

9. ERRPROB
(Optional) A dotted variable name. When errors and warnings occur, they
will be passed back in the form of an array with the general description of the
problem.

10. ACCOUNT
(Optional) A dotted variable name, where ACCOUNT is the PFSS Account
Reference associated with the data being passed by the calling application.
Each PFSS Account Reference represents an internal entry number in the
PFSS ACCOUNT file (375).

Returned Value:

1	If no errors occurred and data was processed.
-1	An error occurred. Data may or may not have been processed. If ERR_DISPLAY is undefined; errors will be posted on the INPUT_ROOT subscripted by "DIERR".
-2	Unable to identify a valid VISIT. No data was processed.
-3	API was called incorrectly. No data was processed.

ENCOUNTER
All data must be associated with an entry in the VISIT file (9000010). Only one "ENCOUNTER" node may be passed with each call to $$DATA2PCE^PXAPI. The "ENCOUNTER" node documents encounter specific information and must be passed:

1. To create an entry in the VISIT file (#9000010). All provider, diagnosis and procedure data is related to an entry in the VISIT file.
2. To enable adding, editing or deleting existing "ENCOUNTER" node data elements. The VISIT parameter may be passed in lieu of defining an "ENCOUNTER" node.

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"ENCOUNTER",1,"ENC D/T")	This is the encounter date/ time for primary encounters or the date for occasions of service. If the encounter is related to an appointment, this is the appointment date/time. If this is an occasion of service created by an ancillary package, this is the date/time of the instance of care. Imprecise dates are allowed for historical encounters. Encounter date/time may be added, but not edited. *Deletions of encounters can occur only when nothing is pointing to the encounter.	R	FileManager Internal Format for date/time
"ENCOUNTER",1,"PATIENT")	This is the patient DFN. This cannot be edited or deleted.	R	Pointer to IHS Patient file (9000001)
"ENCOUNTER",1,"HOS LOC")	This is the hospital location where the encounter took place for primary encounters, or this is the ordering location for ancillary encounters.	R	Pointer to Hospital Location file (44)
"ENCOUNTER",1,"SC")	This encounter is related to a service connected condition.	O	[1	0	null]
"ENCOUNTER",1,"CV")	This encounter is related to Combat Veteran.	O	[1	0	null]

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"ENCOUNTER",1,"AO")	This encounter is related to Agent Orange exposure.	O	[1 | 0 | null]
"ENCOUNTER",1,"IR")	This encounter is related to Ionizing Radiation exposure.	O	[1 | 0 | null]
"ENCOUNTER",1,"EC")	This encounter is related to SW Asia Conditions.	O	[1 | 0 | null]
"ENCOUNTER",1,"SHAD")	This encounter is related to Project 112/SHAD.	O	[1 | 0 | null]
"ENCOUNTER",1,"MST")	This encounter is related to Military Sexual Trauma.	O	[1 | 0 | null]
"ENCOUNTER",1,"HNC")	This encounter is related to Head and/or Neck Cancer via Nose and/or Throat Radium treatment.	O	[1 | 0 | null]
"ENCOUNTER",1,"CHECKOUT D/T")	This is the date/time when the encounter was checked out.	O	FileManager Internal Format for date/time
"ENCOUNTER",1,"ELIGIBILITY")	This is the eligibility of the patient for this encounter.	O	Pointer to Eligibility Code file (8)

SUBSCRIPT	DESCRIPTION	REQ/OPT	DATA FORMAT
"ENCOUNTER",1,"SERVICE CATEGORY")	This denotes the type of encounter.	R	A::=Ambulatory Should be used for clinic encounters. "A" s are changed to "I"s by Visit Tracking if patient is an inpatient at the time of the encounter. H::=Hospitalization Should be used for an admission. I::=In Hospital C::=Chart Review T::=Telecommunications N::=Not Found S::=Day Surgery O::=Observation E::=Event (Historical) Documents encounters that occur outside of this facility. Not used for workload credit or 3rd party billing. R::=Nursing Home D::=Daily Hospitalization Data X::=Ancillary Package Daily Data "X" s are changed to "D"s by Visit Tracking if patient is an inpatient at the time of the encounter.
"ENCOUNTER",1,"DSS ID")	*This is required for ancillary occasions of service such as laboratory and radiology or telephone encounters	*O	Pointer to Clinic Stop file (40.7)
"ENCOUNTER",1,"APPT")	This is the appointment type of the encounter.	O	Pointer to Appointment Type file (409.1)

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"ENCOUNTER",1,"OUTSIDE LOCATION")	Free text location of service if outside the VA. If set, then the type of visit is set to "Other"	O	Free Text (1-50 characters)
"ENCOUNTER",1,"INSTITUTION")	Facility of service. If set, then the type of visit is set to "VA"	O	Pointer to the Location file (#9999999.06) This field points to the Institution file (#4) and has the same internal number as that file. The Location has the same name as the Institution file (#4). The location is also referred to as the Facility
"ENCOUNTER",1,"ENCOUNTER TYPE")	This identifies the type of encounter, e.g., primary encounter, ancillary encounter, etc. A "Primary" designation indicates that the encounter is associated with an appointment or is a standalone. Examples of ancillary encounters include Laboratory and Radiology instances of care.	R	Set of Codes. P::=Primary O::=Occasion of Service S::=Stop Code A::=Ancillary Ancillary packages such a Laboratory and Radiology should pass an "A" C::=Credit Stop
"ENCOUNTER",1,"PARENT")	This is the parent encounter for which the ENCOUNTER is a supporting encounter. For example, this would be the primary encounter for which this occasion of service supports and should be associated.	O	Pointer to Visit file (#9000010).
"ENCOUNTER",1,"COMMENT")	Comment	O	Free Text (1-245 characters)
"ENCOUNTER",1,"DELETE")	This is a flag that denotes deletion of the encounter entry. Encounter will not be deleted if other data is pointing to it.	O	[1 | null]

PROVIDER

The "PROVIDER" node may have multiple entries (i) and documents the provider, indicates whether he/she is the primary provider, and indicates whether the provider is the attending provider. Comments may also be passed. To delete the entire "PROVIDER" entry, set the "DELETE" node to 1.

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"PROVIDER",i,"NAME")	Provider's IEN.	R	Pointer to NEW PERSON file (200)
"PROVIDER",i,"PRIMARY")	Indicator that denotes this provider as the "primary" provider for the encounter.	O	[1 | 0 | null]
"PROVIDER",i,"ATTENDING")	Indicator that denotes this provider as the attending provider.	O	[1 | 0 | null]
"PROVIDER",i,"COMMENT")	Comment	O	Free text (1 - 245 characters)
"PROVIDER",i,"DELETE")	This is a flag that denotes deletion of the Provider entry.	O	[1 | null]

DX/PL

The "DX/PL" node may have multiple entries (i) and documents diagnoses and/or problems. Only active ICD-9-CM or ICD-10-CM codes will be accepted. The "DX/PL" node adds diagnoses to the PCE database as well as adding an active or inactive diagnosis or problem to the Problem List. If a diagnosis or problem already exists on the Problem List, this node may be used to update it. To delete the entire "DX/PL" entry from PCE (not Problem List), set the "DELETE" node to 1.

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"DX/PL",i,"DIAGNOSIS")	Diagnosis code	O	Pointer to ICD Diagnosis file (80)
"DX/PL",i,"PRIMARY")	Code that specifies that the diagnosis is the "primary" diagnosis for this encounter. Only one "primary" diagnosis is recorded for each encounter.	N/A	"P"::=Primary "S"::=Secondary Alternatively 1::=Primary 0::=Secondary
"DX/PL",i,"ORD/RES")	Code that specifies that the diagnosis is either an "ordering" diagnosis or is a "resulting" diagnosis or both for this encounter.	N/A	"O"::=Ordering "R"::=Resulting "OR"::=Ordering and Resulting
"DX/PL",i,"LEXICON TERM")	This is a term that is contained in the Clinical Lexicon.	O	Pointer to the Expressions file (757.01)
"DX/PL",i,"PL IEN")	This is the problem IEN that is being acted upon. *This node is required to edit an existing problem on the Problem List.	*O	Pointer to Problem List file (9000011)

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"DX/PL",i,"PL ADD")	*This is required to Add a diagnosis/problem to the Problem List. "1" indicates that the entry should be added to the Problem List.	O	[1 | 0 | null]
"DX/PL",i,"PL ACTIVE")	This documents whether a problem is active or inactive. The Default is Active if not specified.	O	A::=Active I::=Inactive
"DX/PL",i,"PL ONSET DATE")	The date that the problem began.	O	FileManager Internal Format for date.
"DX/PL",i,"PL RESOLVED DATE")	The date that the problem was resolved.	O	FileManager Internal Format for date.
"DX/PL",i,"PL SC")	This problem is related to a service connected condition.	O	[1 | 0 | null]
"DX/PL",i,"PL CV")	This problem is related to Combat Veteran.	O	[1 | 0 | null]
"DX/PL",i,"PL AO")	This problem is related to Agent Orange exposure.	O	[1 | 0 | null]
"DX/PL",i,"PL IR")	This problem is related to Ionizing Radiation exposure.	O	[1 | 0 | null]
"DX/PL",i,"PL EC")	This problem is related to SW Asia Conditions.	O	[1 | 0 | null]
"DX/PL",i,"PL SHAD")	This problem is related to Project 112/SHAD.	O	[1 | 0 | null]
"DX/PL",i,"PL MST")	This problem is related to Military Sexual Trauma.	O	[1 | 0 | null]

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"DX/PL",i,"PL HNC")	This problem is related to Head and/or Neck Cancer.	O	[1 | 0 | null]
"DX/PL",i,"NARRATIVE")	The provider's description of the diagnosis/problem. *If NARRATIVE is not passed for a diagnosis/problem, the Description from the ICD Diagnosis file (80) will be used as the default.	*O	Free text (2-245 characters)
"DX/PL",i,"CATEGORY")	A term that denotes a grouping or category for a set of related diagnosis/problem.	N/A	Free text (2-245 characters)
"DX/PL",i,"ENC PROVIDER")	Provider who documented the diagnosis/problem.	R/Add	Pointer to New Person file (200)
"DX/PL",i,"EVENT D/T")	Date/Time Diagnosis was documented.	N/A	FileManager Internal Format for date/time
"DX/PL",i,"COMMENT")	Comment	O	DX Free Text (1-245 char) PL Free Text (3-60 char)
"DX/PL",i,"DELETE")	This is a delete flag used to denote deletion of the diagnosis entry.	N/A	[1 | null]

PROCEDURE

The "PROCEDURE" node may have multiple entries (i). Only active CPT/HCPCS codes will be accepted. The "PROCEDURE" node documents the procedure(s), the number of times the procedure was performed, the diagnosis the procedure is associated with and the narrative that describes the procedure. It also enables documentation of the provider who performed the procedure, the date/time the procedure was performed and any comments that are associated with the procedure. To delete the entire "PROCEDURE" entry, set the "DELETE" node to 1.

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"PROCEDURE",i,"PROCEDURE")	Procedure code	R	Pointer to CPT file (81)
"PROCEDURE",i,"MODIFIERS", MODIFIER=""	Modifiers associated with procedure.	O	External pointer to CPT Modifier file (81.3).
"PROCEDURE",i,"QTY")	Number of times the procedure was performed.	R	Whole number > 0
"PROCEDURE",i,"DIAGNOSIS")	The first diagnosis that is associated with the identified procedure and is the primary diagnosis associated with this procedure.	O	Pointer to ICD Diagnosis file (80)
"PROCEDURE",i,"DIAGNOSIS 2")	The second diagnosis that is associated with the identified procedure.	O	Pointer to ICD Diagnosis file (80)
"PROCEDURE",i,"DIAGNOSIS 3")	The third diagnosis that is associated with the identified procedure.	O	Pointer to ICD Diagnosis file (80)
"PROCEDURE",i,"DIAGNOSIS 4")	The fourth diagnosis that is associated with the identified procedure.	O	Pointer to ICD Diagnosis file (80)
"PROCEDURE",i,"DIAGNOSIS 5")	The fifth diagnosis that is associated with the identified procedure.	O	Pointer to ICD Diagnosis file (80)
"PROCEDURE",i,"DIAGNOSIS 6")	The sixth diagnosis that is associated with the identified procedure.	O	Pointer to ICD Diagnosis file (80)

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"PROCEDURE",i,"DIAGNOSIS 7")	The seventh diagnosis that is associated with the identified procedure.	O	Pointer to ICD Diagnosis file (80)
"PROCEDURE",i,"DIAGNOSIS 8")	The eighth diagnosis that is associated with the identified procedure.	O	Pointer to ICD Diagnosis file (80)
"PROCEDURE",i,"NARRATIVE")	The provider's description of the procedure performed. *If NARRATIVE is not passed for a procedure, the Short Name from the CPT file (81) will be used as the default.	*O	Free text (2-245 characters)
"PROCEDURE",i,"CATEGORY")	A term that denotes a grouping or category for a set of related procedures.	O	Free text (2-245 characters)
"PROCEDURE",i,"ENC PROVIDER")	Provider who performed the procedure.	O	Pointer to New Person file (200)
"PROCEDURE",i,"ORD PROVIDER")	Provider who ordered the procedure.	O	Pointer to New Person file (200)
"PROCEDURE",i,"ORD REFERENCE")	Order reference for the ordered procedure.	O	Pointer to Order file (100)
"PROCEDURE",i,"EVENT D/T")	Date/Time procedure was done.	O	FileManager Internal Format for date/time

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"PROCEDURE",i,"DEPARTMENT")	A 3-digit code that defines the service area. Missing Department Codes will be assigned a Department Code. The Department Code will be the Stop Code associated (in the HOSPITAL LOCATION file, #44) with the Hospital Location of the patient visit.	O	108::=Laboratory 160::=Pharmacy 419::=Anesthesiology 423::=Prosthetics 180::=Oral Surgery 401::=General Surgery 402::=Cardiac Surgery 401::=General Surgery 402::=Cardiac Surgery 403::=Otorhinolaryngology (ENT) 404::=Gynecology 406::=Neurosurgery 407::=Ophthalmology 409::=Orthopedics 410::=Plastic Surgery (inc. H&N) 411::=Podiatry 412::=Proctology 413::=Thoracic Surgery 415::=Peripheral Vascular 457::=Transplantation 105::=General Radiology 109::=Nuclear Medicine 109::=Cardiology Studies (Nuclear Med) 115::=Ultrasound 703::=Mammography 150::=CT Scan 151::=Magnetic Resonance Imaging 152::=Angio-Neuro-Interventional 421::=Vascular Lab
"PROCEDURE",i,"COMMENT")	Comment	O	Free Text (1-245 characters)
"PROCEDURE",i,"DELETE")	This is a flag that denotes deletion of the Procedure entry.	O	[1	null]

SKIN TEST
The "SKIN TEST" node may have multiple entries (i). To delete the entire "SKIN TEST" entry, set the "DELETE" node to 1.

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"SKIN TEST",i,"TEST")	Skin Test code	R	Pointer to Skin Test file (9999999.28)
"SKIN TEST",i,"READING")	Numeric measurement of the surface area tested (in millimeters).	O	Whole number between 0 and 40 inclusive.
"SKIN TEST",i,"RESULT")	Results of the Skin Test.	O	P ::=Positive D ::=Doubtful N ::=Negative O ::=No Take
"SKIN TEST",i,"D/T READ")	Date/Time Skin Test was read	O	FileManager Internal Format for date/time
"SKIN TEST",i,"DIAGNOSIS")	The primary diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)
"SKIN TEST",i,"DIAGNOSIS 2")	The second diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)
"SKIN TEST",i,"DIAGNOSIS 3")	The third diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)
"SKIN TEST",i,"DIAGNOSIS 4")	The fourth diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)
"SKIN TEST",i,"DIAGNOSIS 5")	The fifth diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)
"SKIN TEST",i,"DIAGNOSIS 6")	The sixth diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"SKIN TEST",i,"DIAGNOSIS 7")	The seventh diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)
"SKIN TEST",i,"DIAGNOSIS 8")	The eighth diagnosis that is associated with the identified Skin Test.	O	Pointer to ICD Diagnosis file (80)
"SKIN TEST",i,"ENC PROVIDER")	Provider who performed the Skin Test.	O	Pointer to New Person file (200)
"SKIN TEST",i,"EVENT D/T")	Date/Time Skin Test was done.	O	FileManager Internal Format for date/time
"SKIN TEST",i,"COMMENT")	Comment	O	Free Text (1-245 characters)
"SKIN TEST",i,"DELETE")	This is a flag that denotes deletion of the Skin Test entry.	O	[1	null]

IMMUNIZATION

The "IMMUNIZATION" node may have multiple entries (i). To delete the entire "IMMUNIZATION" entry, set the "DELETE" node to 1.

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"IMMUNIZATION",i,"IMMUN")	Immunization code	R	Pointer to Immunization file (9999999.14)
"IMMUNIZATION",i,"SERIES")	Series specifies the sequence of the series for the immunization that was administered.	O	P ::=Partially complete C ::=Complete B ::=Booster 1 ::=Series1 thru 8::=Series8
"IMMUNIZATION",i,"REACTION")	Observed reaction to the immunization.	O	0 ::=None 1 ::=Fever 2 ::=Irritability 3 ::=Local reaction or swelling 4 ::=Vomiting 5 ::=Rash or itching 6 ::=Lethargy 7 ::=Convulsions 8 ::=Arthritis or arthralgias 9 ::=Anaphylaxis or collapse 10 ::=Respiratory distress 11 ::=Other
"IMMUNIZATION",i,"CONTRAINDI CATED")	This field may be used to indicate that this immunization should not be administered again. "1" indicates that the immunization should not be given to the patient in the future	O	[1 | 0 | null]
"IMMUNIZATION",i,"DIAGNOSIS")	The primary diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)
"IMMUNIZATION",i,"DIAGNOSIS 2")	The second diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)

SUBSCRIPT	DESCRIPTION	REQ/ OPT	DATA FORMAT
"IMMUNIZATION",i,"DIAGNOSIS 3")	The third diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)
"IMMUNIZATION",i,"DIAGNOSIS 4")	The fourth diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)
"IMMUNIZATION",i,"DIAGNOSIS 5")	The fifth diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)
"IMMUNIZATION",i,"DIAGNOSIS 6")	The sixth diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)
"IMMUNIZATION",i,"DIAGNOSIS 7")	The seventh diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)
"IMMUNIZATION",i,"DIAGNOSIS 8")	The eighth diagnosis that is associated with the identified Immunization.	O	Pointer to ICD Diagnosis file (80)
"IMMUNIZATION",i,"ENC PROVIDER")	Provider who performed the Immunization.	O	Pointer to New Person file (200)
"IMMUNIZATION",i,"EVENT D/T")	Date/Time Immunization was done.	O	FileManager Internal Format for date/time
"IMMUNIZATION",i,"COMMENT")	Comment	O	Free Text (1-245 characters)
"IMMUNIZATION",i,"DELETE")	This is a flag that denotes deletion of the Immunization entry.	O	[1	null]

EXAMPLE OF DATA PASSED USING $$DATA2PCE^PXAPI

Below is an example of data passed to $$DATA2PCE^PXAPI where
Laboratory is the ancillary package reporting the data.

```
$$DATA2PCE^PXAPI("^TMP(""LRPXAPI"",$J)",182,"LAB DATA")
```

This is an example where Laboratory passes two laboratory tests (Glucose
and CPK) which were collected on 3/27/03 at 12:00 P.m. The provider who
resulted the tests is Fred Jones. This occasion of service is defined as an
Ancillary Package Daily Data (X). There are two diagnoses to support the
tests, both of which are non–service connected, however, both are associated
with agent orange exposure.

```
^TMP("LRPXAPI",543173595,"DX/PL",1,"DIAGNOSIS")=465
^TMP("LRPXAPI",543173595,"DX/PL",1,"PRIMARY")=1
^TMP("LRPXAPI",543173595,"DX/PL",1,"PL SC")=0
^TMP("LRPXAPI",543173595,"DX/PL",1,"PL AO")=1
^TMP("LRPXAPI",543173595,"DX/PL",2,"DIAGNOSIS")=466
^TMP("LRPXAPI",543173595,"DX/PL",2,"PL SC")=0
^TMP("LRPXAPI",543173595,"DX/PL",2,"PL AO")=1
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"DSS ID") = 59
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"ENC D/T") = 3030328
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"HOS LOC") = 19
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"PATIENT") = 281
^TMP("LRPXAPI",543173595,"ENCOUNTER",1,"SERVICE CATEGORY") =
X
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"ENC PROVIDER") = 58
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"ORD PROVIDER") = 66
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"EVENT D/T") =
3030327.12
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"PROCEDURE") = 82950
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"DIAGNOSIS") = 465
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"DIAGNOSIS 2") = 466
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"MODIFIER",22)=""
^TMP("LRPXAPI",543173595,"PROCEDURE",1,"QTY") = 1
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"ENC PROVIDER") = 58
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"ORD PROVIDER") = 66
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"EVENT D/T") =
3030327.12
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"PROCEDURE") = 82552
^TMP("LRPXAPI",543173595,"PROCEDURE",2,"QTY") = 1
```

$$CLNCK^SDUTL2(CLN,DSP)

This API will be used by the subscribing package to check the clinic associated with an encounter to ensure that its corresponding stop pairs conform to the stop code restriction. Effective 10/1/2003, stop codes (also known as DSS Identifiers) are assigned a restriction type of primary, secondary, or either. Primary types can only be used in the primary stop code position; secondary types can only be used in the secondary stop code position; and those with a type of either can be used in the primary or secondary stop code position. Stop codes that have a restriction type of primary or secondary will also have a restriction date to track when the stop code is designated as a restricted stop code.

Parameter Description
    CLN   The internal entry number of the clinic from file #44.
    DSP   Interactive display of error message, 1 - Display or 0 No Display

Returned Value:
    1   If clinic has conforming stop codes.
    0^error   If clinic has non-conforming stop codes plus error message.

Enhanced API

External Relations

PCE is dependent upon the following **V***IST***A** packages:

Package	Minimum Version
Kernel	8.0
VA FileMan	21
Patient Information Management System (PIMS)	5.3
Order Entry/Results Reporting (OE/RR)	2.5
Automated Information Collection System (AICS)	2.1
PCE Patient/IHS Subset (PXPT)	1.0

Package-wide Variables

No package-wide variables have been defined for use throughout the Patient Care Encounter package.

The PX namespace is reserved for use by PCE; however, the joint sharing of files between the Department of Veterans Affairs and the Indian Health Service has necessitated use of some AU-name spaced variables established for use by the Indian Health Service and by the Department of Veterans Affairs to facilitate joint sharing.

Generating On-line Documentation

Routines

The namespace for the PCE package is PX. Some AU* routines are distributed by PCE. Use the Kernel option, List Routines [XUPRROU], to print a list of any or all of the PCE routines. This option is found on the Routine Tools [XUPR-ROUTINE-TOOLS] menu on the Programmer Options [XUPROG] menu, which is a sub-menu of the Systems Manager Menu [EVE] option.

```
Select Systems Manager Menu Option: programmer Options
Select Programmer Options Option: routine Tools
Select Routine Tools Option: list Routines
Routine Print
Want to start each routine on a new page: No// [ENTER]
routine(s) ?   > PX*
```

The first line of each routine contains a brief description of the general function of the routine. Use the Kernel option, First Line Routine Print [XU FIRST LINE PRINT] to print a list of just the first line of each Health Summary subset routine.

```
Select Systems Manager Menu Option: programmer Options
Select Programmer Options Option: routine Tools
Select Routine Tools Option: First Line Routine Print
PRINTS FIRST LINES
routine(s) ?   >PX*
```

Globals

Globals exported by PCE include ^PX, ^PXD, and ^AU*. Use the Kernel option, List Global [XUPRGL], to print a list of any of these globals. This option is found on the Programmer Options menu [XUPROG], which is a sub-menu of the Systems Manager Menu [EVE] option.

```
Select Systems Manager Menu Option: programmer Options
Select Programmer Options Option: LIST Global
Global ^^PX*
```

Files

The number-spaces assigned to PCE include 800-839.99, and 9000001, 900010.xx, and 9999999.xx. Use the VA FileMan option, List File Attributes [DILIST] to print a list of these files.

XINDEX

XINDEX is a routine that produces a report called the VA Cross-Referencer. This report is a technical and cross-reference listing of one routine or a group of routines. XINDEX provides a summary of errors and warnings for routines that do not comply with VA programming standards and conventions, a list of local and global variables and what routines they are referenced in, and a list of internal and external routine calls. XINDEX is invoked from programmer mode: D ^XINDEX. When prompted to select routines, enter PX*.

Data Dictionaries

The Data Dictionaries (DDs) are considered part of the online documentation. Use VA FileMan option #8 (DATA DICTIONARY UTILITIES) to print DDs.

```
>D P^DI
VA FileMan 21.0
Select OPTION: DATA DICTIONARY UTILITIES
Select DATA DICTIONARY UTILITY OPTION: LIST FILE ATTRIBUTES
 START WITH WHAT FILE: V MEASUREMENT// 9000010  VISIT
                                         (1 entry)
      GO TO WHAT FILE: VISIT// <RET>
Select LISTING FORMAT: STANDARD// <RET>
DEVICE: PRINTER
```

Troubleshooting & Helpful Hints

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

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

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

- If clinical reminders are not showing up correctly on Health Summaries, see the PCE User Manual Appendices document, Appendix A-7, for troubleshooting information which IRM staff with programmer access can access.

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

- *Shortcuts*

After entering a diagnosis, a prompt for Provider Narrative appears. If you don't want to enter additional descriptive information, press the [ENTER] key, and the ICD9 or ICD10 short description for the diagnosis will be stored in the Provider Narrative field. (This only works if you're entering directly into the PCE user interface.)

- *More Shortcuts*

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

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

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

Device Interface Error Report

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

```
Select PCE Coordinator Menu Option: die  PCE Device Interface Error Report

     Select one of the following:

          ERN        Error Number
          PDT        Processing Date and Time
          EDT        Encounter Date and Time
          PAT        Patient Name

Look up PCE device interface errors based on: ERN//   Error Number

Enter the beginning error number:  (1-4): 1// [ENTER]

Enter the ending error number:  (1-4): 4//  [ENTER]

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

                                        Aug 08, 1996 4:05:09 pm  Page 1

                    PCE Device Interface Error Report

Report based on Error Numbers 1 through 26.
----------------------------------------------------------------------
Error Number: 1
   Patient:  PCEPATIENT,ONE 000-45-6789
   Hospital Location:  DIABETES CLINIC
   Encounter date:  May 06, 1996@14:53:17
   Processing date: May 06, 1996@16:18:53

   File: 9000010.07 (V POV)  IEN: 0  Field .04 (PROVIDER NARRATIVE)
   Error message: Missing Required Fields
   Node: Missing
      Original: Missing
       Updated: Missing

   File: 9000010.07 (V POV)  IEN: 0  Field .04 (PROVIDER NARRATIVE)
   Error message: Missing Required Fields
   Node: Missing
      Original: Missing
       Updated: Missing       ETC.
```

Glossary

AICS
Automated Information Collection System, formerly Integrated Billing, the program that manages the definition, scanning, and tracking of Encounter Forms.

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

Ambulatory Care Data Capture project
A project assigned to coordinate the efforts of various V*ISTA* (DHCP) software packages to meet the 10/1/96 outpatient minimum data set mandate from the Under Secretary for Health.

Ancillary Service
(Occasion of Service) A specified instance of an act of service involved in the care of the patient or consumer which is not an encounter.

Appointment
A scheduled meeting with a provider at a clinic; an appointment can include several encounters involving other providers, tests, procedures, etc.

Checkout Process
Part of Medical Administration (PIMS) appointment processing. The checkout process documents administrative and clinical data related to the appointment.

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

Encounter
A contact between a patient and a provider who has responsibility for assessing and treating the patient at a given contact, exercising independent judgment. A patient can have multiple encounters per visit.

Encounter Form
A paper form used to display and collect data pertaining to an outpatient encounter, developed by the AICS package.

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

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

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

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

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

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

Minimum Data Set
Each ambulatory encounter and/or ancillary service with associated provider, procedure, and diagnosis information must be reported to the National Patient Care Data Base (NPCDB), as of 10/1/96.

NPCDB
National Patient Care Data Base, a database located in the Austin Accounting Center.

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

Outpatient Encounter
Outpatient encounters include scheduled appointments and walk-in unscheduled visits. A clinician's telephone communications with a patient may be represented by a separate visit entry.

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

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

Provider
The entity which furnishes health care to a consumer. It includes a professionally licensed practitioner who is authorized to operate a health care delivery facility—an individual or defined group of individuals who provides a defined unit of health care services (defined = codable) to one or more individuals at a single session.

Stop Code
A three-digit number corresponding to an additional stop/service a patient received in conjunction with a clinic visit. Stop code entries are used so that medical facilities may receive credit for the services rendered during a patient visit. After 10/1/96, stop codes will become DSS Identifiers.

Visit
The visit of a patient to one or more units of a facility within one calendar day.

Visit Tracking
A **V***IST***A** utility that creates and manages entries in the Visit file which links patient-related information for patient encounters.

V*IST***A**
Veterans Information System Technology Architecture, the new name for DHCP.

Appendix A - Developer Guide – PCE Device Interface Module

PCE Device Interface module local array structures exported with PCE.

Conventions

An Error Suspension file records data that fails the verification process or if there are errors in storing.

1. In listings of valid values [1 | 0 | null]
   1 denotes TRUE or YES
   0 denotes FALSE or NO
   null denotes VALUE NOT SUPPLIED BY DATA CAPTURE APPLICATION

2. The PCE Device Interface uses a locally name-spaced array (called LOCAL in this document) with the following gross structure to receive data from an external device. Developers should use an array in their namespace to represent the LOCAL array. It is possible that data from multiple providers was captured for the encounter. The ENCOUNTER node records information about the "main" provider. It is mandatory that this person be identified in the ENCOUNTER node. Data will NOT be moved to VISTA if such a provider is not identified on the ENCOUNTER node. The remaining nodes in the LOCAL(array [VITALS, DIAGNOSIS, PROCEDURE, PROBLEM...] are specific to the particular PROVIDER associated with the data on that node. If the provider is unknown, (for example, the identity of the nurse who took the vitals was not captured on a scanned encounter form) the provider subscript <PROVIDER IEN> may be set to zero except provider is required for PROBLEM. This is a concession to reality, and should not be encouraged. If a provider CAN be identified, they SHOULD be identified.

Locally name-spaced array:
  LOCAL("DIAGNOSIS/PROBLEM",<PROVIDER IEN>)
  LOCAL("PROBLEM",<PROVIDER IEN>)
  LOCAL("SOURCE")
  LOCAL("ENCOUNTER")
  LOCAL("DIAGNOSIS",<PROVIDER IEN>)
  LOCAL("PROCEDURE",<PROVIDER IEN>)
  LOCAL("PROVIDER",<PROVIDER IEN>)
  LOCAL("IMMUNIZATION",<PROVIDER IEN>)
  LOCAL("SKIN TEST",<PROVIDER IEN>)
  LOCAL("EXAM",<PROVIDER IEN>)
  LOCAL("PATIENT ED",<PROVIDER IEN>)
  LOCAL("HEALTH FACTORS",<PROVIDER IEN>)
  LOCAL("VITALS",<PROVIDER IEN>)
    Vitals are not processed by PCE but are passed to the
    Vitals/Measurement package.
  LOCAL("LOCAL",
    This data doesn PCE and will not be
    processed by PCE, but it may be used to pass local data
    to a local process (see protocol for local data
    processing).

3. The Encounter and Source nodes are required; the rest are optional.

4. All entries in the local array are resolved to internal values as defined below.

5. By convention; use a DUZ = .5 (the POSTMASTER) as a default when one cannot be determined. This is only for tasked jobs on some systems.

6. The data in the ENCOUNTER, PROCEDURE, and DIAGNOSIS/ PROBLEM or DIAGNOSIS nodes are the minimal set for capturing Workload starting 10/1/96. The data in the rest of the nodes with the associated providers build on the clinically relevant data set and are not used for workload

7. While ENCOUNTER, PROCEDURE, and DIAGNOSIS/PROBLEM or
   DIAGNOSIS values are required to capture workload and generate a \
   bill, they may not be present in every data set passed through this
   event point. For example, data on Vitals may be collected by a Nurse
   and passed through the event point for storage independent of
   other data associated with the encounter. Because of this, these
   are NOT required values in this version.

8. If there is a different (ancillary) hospital location for this
   patient encounter, you have to do a separate encounter. Separate
   calls for each hospital location are required.

Required Input

    LOCAL(LOCAL(is a local array as defined in the remainder
   of this document. Developers should use an array in
   their namespace to represent the LOCAL array; e.g.,
   IBDFPCE.

Result returned

    PXCASTAT   1 = event processing occurred and the data was
   passed to DHCP.
   0 = event processing could not occur. There is data
   in LOCAL("ERROR" explaining why.

LOCAL("ERROR" as described below. Denotes Errors. Data associated
with the error was not filed. The node does not
exist if errors do not occur.
LOCAL("ERROR",<NODE>,<PROVIDER
IEN>,<i>,<PIECE>)="Free text message^REJECTED VALUE"
Where   <NODE>   ::= "ENCOUNTER" | "VITALS" |
"DIAGNOSIS" | "PROCEDURE" |
"PROBLEM" | rest of list|
<PROVIDER IEN>   ::=   internal entry number of
provider. Is 0 (ZERO) for ENCOUNTER
and SOURCE
<i>   ::= sub-entry 'i' for that provider
Is 0 (ZERO) for ENCOUNTER, SOURCE
and PROVIDER
<PIECE>   ::= $P(selector in
LOCAL(<NODE>,<PROVIDER IEN>,<i>)
that failed.
 The value of <PIECE> may be 0
(ZERO) if a problem is found that
does not relate to a single
specific piece.

LOCAL("WARNING"   as described below. Denotes problems with the
data that did not prevent processing. Processing
continued after the warnable condition was detected.
The node does not exist if warning, conditions do
not occur. Warnings do NOT affect the value of
PXCASTAT.

LOCAL("WARNING",<NODE>,<PROVIDER
IEN>,<i>,<PIECE>)
="Free text message^QUESTIONABLE VALUE"
Where   <NODE>   ::= "ENCOUNTER" | "VITALS" |
"DIAGNOSIS" | "PROCEDURE" |
"PROBLEM"
<PROVIDER IEN>   ::=   internal entry number of
provider. Is 0 (ZERO) for ENCOUNTER
and SOURCE
<i>   ::= sub-entry 'i' for that provider
Is 0 (ZERO) for ENCOUNTER, SOURCE,
and PROVIDER

                        `<PIECE>    ::=    $P( selector in`
                                   `LOCAL(<NODE>,<PROVIDER IEN>,<i>) in`
                                   question.
                                    The value of `<PIECE>` may be 0
                                   (ZERO) if a problem is found that
                                   does not relate to a single
                                   specific piece.

Entry Point for processing the data in the foreground

FOREGND^PXCA(.LOCAL,.PXCASTAT)   All data for the event driver is
    to be stored in the local array, LOCAL(, in the proper format by the
    source prior to calling this entry point. This entry point validates and
    verifies the data and then if there are no validation errors, the data is
    processed in the foreground. Computation by the source will not
    continue until all processing is completed by any and all 'down-stream'
    protocol event points.

Entry Point for processing the data in the background on the Host

BACKGND^PXCA(.LOCAL,.PXCASTAT)   All data for the event driver is
    to be stored in the local array, LOCAL(, in the proper format by the
    source prior to calling this entry point. This entry point validates and
    verifies the data and then if there are no validation errors, the data is
    processed in the background via TASKMAN. Computation by the
    source may continue.

Entry Point for data validation

VALIDATE^PXCA(.LOCAL) The data in the local array, LOCAL(, is validated and verified, but is not processed. Use of this entry point by your application will result in the data being validated twice, since it is validated prior to processing by the FOREGND^PXCAEP and BACKGND^PXCAEP entry points. If a piece of data cannot be validated, an entry is placed in the LOCAL("ERROR" node as described above

Protocol for local data processing

PXCA DATA EVENT Other developers who wish to use any of the data in the local array, including local additions, can attach a protocol that calls their routines to the item multiple of this protocol. This protocol is activated if there are no errors in the data validation and after PCE has processed the data.

For data unique to the encounter

SOURCE data LOCAL("SOURCE") = 1^2^3^4^5, where:

Piece 1
    Data Source
    Required for PCE
    Required for SD
    Format: DATA SOURCES file (#839.7)
Piece 2
    DUZ
    Required for PCE
    Required for Scheduling

Piece 3
    Form numbers
    Not stored by PCE Piece 4
    Batch ID
    Not stored by PCE Piece 5
    Record ID
    Not stored by PCE

Encounter data LOCAL("ENCOUNTER") =
1^2^3^4^5^6^7^8^9^10^11^12^13^14^15^16^17^18, where:
LOCAL("ENCOUNTER",modifier[E;1/.01]) = ""

Piece 1
   Appointment Date/Time
   Required for PCE
   Required for Scheduling
   Format: Fileman Date/Time
Piece 2
   Patient DFN
   Required for PCE
   Required for Scheduling
   Format: Pointer to IHS PATIENT file (#9000001)
Piece 3
   Hospital Location IEN
   Each hospital location is a separate encounter P,S
   Format: Pointer to HOSPITAL LOCATION file (#44)
Piece 4
   Provider IEN
   This is the person that saw the Patient at the scheduled date and
   time.
   Required for PCE
   Format: Pointer to NEW PERSON file (#200)
Piece 5
   Visit CPT code IEN
   Format: Pointer to TYPE OF VISIT (#357.69)
Piece 6
   SC Condition
   Format: [1 | 0 | null]

Piece 7
   AO Condition
   Format: [1 | 0 | null]
Piece 8
   IR Condition
   Format: [1 | 0 | null]
Piece 9
   EC Condition
   Format: [1 | 0 | null]
Piece 10
   MST Condition

Format: [1 | 0 | null]
Piece 13
    Eligibility Code IEN
    Format: Pointer to ELIGIBILITY CODE file (#8)
Piece 14
    Check-out date and time
    Format: Fileman Date/Time
Piece 15
    Provider indicator (relates to 4)
    Required for PCE
    Format: Set of Codes
        P ::= Primary
        S ::= Secondary
Piece 16
    Attending Physician IEN
    (May or may not be the same as 4)
    Format: Pointer to NEW PERSON file (#200)
Piece 17
    HNC Condition
    Format: [1 | 0 | null]
Piece 18
    CV Condition
    Format: [1 | 0 | null]

All of the remaining entries in the LOCAL(array are specific to a particular Provider associated with the data on that node. If the provider is unknown, (for example, the identity of the nurse who took the vitals isn't recorded on a scanned encounter form), the provider subscript <PROVIDER IEN> may be set to zero.

Diagnosis and/or Problems, specific to one provider

We recommend that you use these nodes instead of the separate Diagnosis and Problem nodes.

If no Diagnosis and/or Problems, $D(LOCAL("DIAGNOSIS/PROBLEM")) is true.
LOCAL("DIAGNOSIS/PROBLEM",<PROVIDER IEN>, i) =
1^2^3^4,...17^18 where:

Piece 1
 Diagnosis Code IEN
 Required for PCE
 Required for Scheduling
 Format: Pointer to ICD DIAGNOSIS file (#80)
Piece 2
 Diagnosis Specification Code
 Required for PCE
 N/A for Problem List
 Format: Set of Codes
  P ::= Primary
  S ::= Secondary
Piece 3
 Clinical Lexicon Term IEN
 Format: Pointer to EXPRESSIONS file (#757.01)
Piece 4
 Problem IEN
 Required by Problem List for existing
 Format: Pointer to PROBLEM LIST file (#9000011)
Piece 5
 Add to Problem List
 N/A for PCE
 Required by Problem List for new problem
 Format: [1 | 0 | null]
Piece 6
 Problem Active?
 Default is Active if not specified
 N/A for PCE
 Format: Set of Codes
  A ::= Active
  I ::= Inactive
Piece 7
 Problem Onset Date
 N/A for PCE
 Format: Fileman Date/Time
Piece 8
 Problem Resolved Date
 N/A for PCE
 Format: Fileman Date/Time
Piece 9
 SC Condition
 Format: [1 | 0 | null]

Piece 10
   AO Condition
   Format: [1 | 0 | null]
Piece 11
   IR Condition
   Format: [1 | 0 | null]
Piece 12
   EC Condition
   Format: [1 | 0 | null]
Piece 13
   Provider Narrative
   Required for PCE
   Required by Problem List for new problem
   Format: free text, 2-80 Characters
Piece 14
   Category Header for Provider Narrative
   N/A for Problem List
   Format: free text, 2-80 Characters
Piece 15
   MST Condition
   Format: [1 | 0 | null]
Piece 16
   HNC Condition
   Format: [1 | 0 | null]
Piece 17
   CV Condition
   Format: [1 | 0 | null]
Piece 18
   Order/Resulting
   Format: Set of Codes
      O ::= Ordering
      R ::= Resulting
      B ::= Both Ordering and Resulting

LOCAL("DIAGNOSIS/PROBLEM",<PROVIDER IEN>,i,"NOTE") = 1,
where:

Piece 1
   Provider N/A for PCE
   Format: free text, 3-60 Characters

NOTE: If the NOTE node is not needed, it does not have to exist.

NOTE: Information is passed to Problem List if there is data for any of the positions 5-8 on the "DIAGNOSIS/PROBLEM" node or if there is "NOTE" node.

NOTE: A provider is required to add a new problem to the Problem List.

Diagnosis data list, specific to one provider, for Problems being treated at this encounter:

If no Diagnoses, then '$D(LOCAL("DIAGNOSIS",<PROVIDER IEN>))is true.
LOCAL("DIAGNOSIS",<PROVIDER IEN>,i) = 1^2^3^4^...^13^14 where:

Piece 1
   Diagnosis code IEN
   Required for PCE
   Required for Scheduling
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 2
   Diagnosis specification code
   Will default to "S" if blank
   Format: Set of Codes.
      P ::= Primary
      S ::= Secondary
Piece 3
   SC Condition
   Format: [1 | 0 | null]
Piece 4
   AO Condition
   Format: [1 | 0 | null]
Piece 5
   IR Condition
   Format: [1 | 0 | null]
Piece 6
   EC Condition
   Format: [1 | 0 | null]

Piece 7
    Associated Problem IEN
    Format: Pointer to PROBLEM LIST file 9000011
Piece 8
    Physician's term for Diagnosis
    Required for PCE
    Format: free text, 2-80 Characters
Piece 9
    Physician's term for Category Header
    May have been used as a grouping for a set of related Diagnosis
    which the provider selected from
    Format: free text, 2-80 Characters
Piece 10
    Lexicon IEN
    Format: Pointer to EXPRESSIONS File (#757.01)
Piece 11
    MST Condition
    Format: [1 | 0 | null]
Piece 12
    HNC Condition
    Format: [1 | 0 | null]
Piece 13
    CV Condition
    Format: [1 | 0 | null]
Piece 14
    Order/Resulting
    Format: Set of Codes
        O ::= Ordering
        R ::= Resulting
        B ::= Both Ordering and Resulting

NOTE: PCE recommends using the DIAGNOSIS/PROBLEM node so that the diagnosis can point to the problem that it relates to.

Procedures data list, specific to one provider

If no Procedures, then '$D(LOCAL("PROCEDURE",<PROVIDER IEN>)) is true.
LOCAL("PROCEDURE",<PROVIDER IEN>,i) = 1^2^3^4^5^6^7^8^9^10^
    11^12^13^14,(pieces defined below)

LOCAL("PROCEDURE",<PROVIDER IEN>,i,modifier[E;1/.01]) = ""

Piece 1
    CPT4 Procedure code

    Required by PCE for V CPT file (Procedures)
        if this field is blank then will be stored in V TREATMENT file
    Required for Scheduling
    Format: Pointer to CPT file (#81)
Piece 2
    Quantity Performed
    Required for PCE
    Required for Scheduling
    Format: number > 0
Piece 3
    Procedure specification code
    For CPT only.
    Format: Set of Codes
        P ::= Primary
        S ::= Secondary
Piece 4
    Date/Time Procedure performed
    Format: Fileman Date/Time
Piece 5
    Primary Associated Diagnosis IEN For this CPT only.
    Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 6
    Physician's term for Procedure
    Required for PCE
    Format: free text, 2-80 Characters
Piece 7
    Physician's term for Category Header
    May have been used as a grouping for a set of related Procedures
    which the provider selected from
    Format: free text, 2-80 Characters
Piece 8
    1st Secondary Associated Diagnosis IEN For this CPT only.
    Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 9
    2nd Secondary Associated Diagnosis IEN For this CPT only.
    Format: Pointer to ICD DIAGNOSIS File (#80)

Piece 10
  3rd Secondary Associated Diagnosis IEN For this CPT only.
  Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 11
  4th Secondary Associated Diagnosis IEN For this CPT only.
  Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 12
  5th Secondary Associated Diagnosis IEN For this CPT only.
  Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 13
  6th Secondary Associated Diagnosis IEN For this CPT only.
  Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 14
  7th Secondary Associated Diagnosis IEN For this CPT only.
  Format: Pointer to ICD DIAGNOSIS File (#80)

NOTE: If a Procedure doesn't have a
CPT code, it can be passed without one and will be stored in the
V Treatment file but will not be used for workload or billing.

Problem data list, specific to one provider

If no Problems, then '$D(LOCAL("PROBLEM",<PROVIDER IEN>)) is true.
LOCAL("PROBLEM",<PROVIDER IEN>,i) = 1^2^3^4^5^...^15 where:

Piece 1
  Problem Name
  Required for new Problem List, i.e. if Pos. 10 is null
  Format: free text
Piece 2
  Problem Onset Date
  Format: Fileman Date/Time
Piece 3
  Problem Active?
  Default is ACTIVE if not specified
  Format: [1 | 0 | null]
Piece 4
  Problem Date Resolved
  Format: Fileman Date/Time

Piece 5
   SC Condition
   Format: [1 | 0 | null]
Piece 6
   AO Condition
   Format: [1 | 0 | null]
Piece 7
   IR Condition
   Format: [1 | 0 | null]
Piece 8
   EC Condition
   Format: [1 | 0 | null]
Piece 9
   ICD Code value {optional}
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 10
   Problem IEN
   Must be null if new problem
   Required for editing existing Problem
   Format: Pointer to PROBLEM LIST file 9000011
Piece 11
   Physician's term for Problem
   Null if new problem
   Format: free text, 60 Characters Max
Piece 12
   Lexicon IEN
   Format: Pointer to EXPRESSIONS File (#757.01)
Piece 13
   MST Condition
   Format: [1 | 0 | null]
Piece 14
   HNC Condition
   Format: [1 | 0 | null]
Piece 15
   CV Condition
   Format: [1 | 0 | null]

NOTE: The data in this node is passed to Problem List. A Provider is required to add a new problem to the Problem List. When a new problem is added to the Problem List, the problem IEN is not required. If data is passed to edit existing data, the problem IEN must be passed.

NOTE: It is better to use the DIAGNOSIS/PROBLEM node so that the Diagnosis can point to the problem that it relates to.

Provider data list, specific to one provider

Use this node to pass of additional providers which do not have data associated with them.

If no additional Providers, then '$D(LOCAL("PROVIDER",< PROVIDER IEN>)) is true.

LOCAL ("PROVIDER",<PROVIDER IEN>= 1^2 where:

Piece 1
    Provider indicator
    Required for PCE
    Format: Set of Codes.
        P: = Primary
        S: = Secondary
Piece 2
    Attending
    Format: [1|0| null]

NOTE: If a provider is on the Encounter node and also on this node then the data on this node will be used for Primary/Secondary indicator.

Immunization data list, specific to one provider

If no immunization entries, then '$D(LOCAL("IMMUNIZATION",<PROVIDER IEN>)) is true.

LOCAL ("IMMUNIZATION",<PROVIDER IEN>,i)=1^2^3^4^5^6^7^8^9^10^11^12^13^14^15

Piece 1
    Immunization
    Required for PCE
    Format: Pointer to IMMUNIZATION File (9999999.14)

Piece 2

    Series

    Format: Set of Codes.

        P::=Partially complete

        C::=Complete

        B::=Booster

        1::=Series1

        ...

        8::=Series8

Piece 4

    Reaction

    REACTION Field (9000010.11,.06) SET

    Format: Set of Codes.

        '0' FOR NONE

        '1' FOR FEVER;

        '2' FOR IRRITABILITY;

        '3' FOR LOCAL REACTION OR SWELLING;

        '4' FOR VOMITING;

        '5' FOR RASH OR ITCHING;

        '6' FOR LETHARGY;

        '7' FOR CONVULSIONS;

        '8' FOR ARTHRITIS OR ARTHRALGIAS;

        '9' FOR ANAPHYLAXIS OR COLLAPSE;

        '10' FOR RESPIRATORY DISTRESS;

        '11' FOR OTHER;

Piece 5

    Contraindicated

    Format: [1|0|null]

Piece 6

    Event D/T

    Format: Fileman Date/Time

Piece 7

    Remarks

    Format: Comment

Piece 8

    Primary Associated Diagnosis IEN For this mapped CPT only.

    Format: Pointer to ICD DIAGNOSIS File (#80

Piece 9

    1st Secondary Associated Diagnosis IEN For this mapped CPT only.

    Format: Pointer to ICD DIAGNOSIS File (#80)

Piece 10

    2nd Secondary Associated Diagnosis IEN For this mapped CPT only.

    Format: Pointer to ICD DIAGNOSIS File (#80)

Piece 11

3rd Secondary Associated Diagnosis IEN For this mapped CPT only.
Format: Pointer to ICD DIAGNOSIS File (#80)

Piece 12

4th Secondary Associated Diagnosis IEN For this mapped CPT only.
Format: Pointer to ICD DIAGNOSIS File (#80)

Piece 13

5th Secondary Associated Diagnosis IEN For this mapped CPT only.
Format: Pointer to ICD DIAGNOSIS File (#80)

Piece 14

6th Secondary Associated Diagnosis IEN For this mapped CPT only.
Format: Pointer to ICD DIAGNOSIS File (#80)

Piece 15

7th Secondary Associated Diagnosis IEN For this mapped CPT only.
Format: Pointer to ICD DIAGNOSIS File (#80)

Skin Test data list, specific to one provider

If no skin test entries, then '$D(LOCAL("SKIN TEST",<PROVIDER IEN>))
is true. LOCAL ("SKIN TEST",<PROVIDER
IEN>,i)=1^2^3^4^5^6^7^8^9^10^11^12^13

Piece 1

SKIN TEST
Required for PCE
Format: Pointer to SKIN TEST File (9999999.28)

Piece 2

READING
Format: Whole number between 0 and 40 inclusive

Piece 3

RESULT
Format: Set of Codes.
P::=Positive
N::=Negative
D::=Doubtful
0::=No Take

Piece 4

Date Read
Format: Fileman Date/Time

Piece 5
   Date of Injection
   Format: Fileman Date/Time
Piece 6
   Primary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80
Piece 7
   1st Secondary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 8
   2nd Secondary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 9
   3rd Secondary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 10
   4th Secondary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 11
   5th Secondary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 12
   6th Secondary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80)
Piece 13
   7th Secondary Associated Diagnosis IEN For this mapped CPT only.
   Format: Pointer to ICD DIAGNOSIS File (#80)

Examination data list, specific to one provider

If no examination entries, then '$D(LOCAL("EXAM",<PROVIDER IEN>))
is true.
LOCAL ("EXAM",<PROVIDER.IEN>")=1^2

Piece 1
   EXAM
   Required for PCE
   Format: Pointer to EXAM File (9999999.15)
Piece 2
   RESULT
   Format: Set of Codes.
      A::=Abnormal
      N::=Normal

Patient Education data list, specific to one provider

If no Patient Education entries, then '$D(LOCAL("PATIENT ED",<PROVIDER
IEN>)) is true. LOCAL ("PATIENT ED",<PROVIDER IEN>,i)=1^2

Piece 1
    Topic
    Required for PCE
    Format: Pointer to EDUCATION TOPICS File (9999999.09)
Piece 2
    Level of Understanding
    Format: Set of Codes.
        1::=Poor
        2::=Fair
        3::=Good
        4::=Group - No Assessment
        5::=Refused

Health Factors data list, specific to one provider

If no Health Factors entries, then
 '$D(LOCAL("HEALTH FACTORS",<PROVIDER IEN>)) is true. LOCAL ("HEALTH
FACTORS",<PROVIDER IEN>,i)=1^2

Piece 1
    Health Factor
    Required for PCE
    Format: Pointer to HEALTH FACTORS File (9999999.64)
Piece 2
    Level/Severity
    Format: Set of Codes.
        M::=Minimal
        MO::=Moderate
        H::=Heavy/Severe

Vitals data list, specific to one provider

If no Vitals, then '$D(LOCAL("VITALS",<PROVIDER IEN>)) is true.
LOCAL("VITALS",<PROVIDER IEN>,i) = 1^2^3^4, where:

Piece 1
  Type
  Required for PCE
  Format: Set of Codes.
      AG::= ABDOMINAL GIRTH
      AUD::= AUDIOMETREY
      BP::= BLOOD PRESSURE
      FH::= FUNDAL HEIGHT
      FT::= FETAL HEART TONES
      HC::= HEAD CIRCUMFERENCE
      HE::= HEARING
      HT::= HEIGHT
      PU::= PULSE
      RS::= RESPIRATIONS
      TMP::=TEMPERATURE
      TON::=TONOMETRY
      VC::= VISION CORRECTED
      VU::= VISION UNCORRECTED
      WT::= WEIGHT
Piece 2
  Value
  Required for PCE
  Format: Numeric
Piece 3
  Units
  Not stored; used for conversions
  Format: Set of Codes.
      C::=Centigrade (degrees)
      CM::=Centimeter
      F::= Fahrenheit (degrees)
      IN::=Inches
      KG::=Kilograms
      LB::=Pounds
Piece 4
  Date/Time Measurement taken
  Format: Fileman Date/Time

If the TYPE is HT: If the UNIT is CM it is converted to IN so that it can be stored. If the UNIT is "" it is assumed to be IN. If the TYPE is WT   If the UNIT is KG it is converted to LB so that it can be stored. If the UNIT is "" it is assumed to be LB. If the TYPE is TMP If the UNIT is C it is converted to F so that it can be stored. If the UNIT is "" it is assumed to be F.

NOTE: This data is passed to the Vitals/Measurement package for validation and storage.

Local data list, specific to one provider

If no local entries, then '$D(LOCAL("LOCAL",<PROVIDER IEN>)) is true.
LOCAL("LOCAL",<PROVIDER IEN>,i) = Site Specific data encoding

Pieces All
    Site Specific data encoding
    Not stored in PCE
    Format: Site Specific

NOTE: LOCAL("LOCAL" where "LOCAL" is replaced by locally namespaced
  string.

Appendix B - PCE Security

PCE security is maintained through menu assignment and VA FileMan protection.

Menu Assignment
PCE exports one main menu, the PCE IRM Menu, which contains several sub-menus.

```
SP      PCE Site Parameters Menu ...
TBL     PCE Table Maintenance ...
INFO    PCE Information Only ...
RM      PCE Reminder Maintenance Menu ...
CR      PCE Clinical Reports ...
HOME    Directions to Patient's Home Add/Edit
CO      PCE Coordinator Menu ...
CL      PCE Clinician Menu
```

- Assign the *PCE IRM Main Menu* to the IRM person who will maintain and set up the package, including reminder items and will need access to all of the PCE options.

- The first four options/menus will be used by IRM staff or coordinators who are responsible for setting up PCE, maintaining the entries in the PCE tables (such as Patient Education, Immunization, Treatments, etc.), and defining the clinical reminders/maintenance system for your site.

- Assign the *PCE Coordinator Menu* to the Application Coordinator who teach and support PCE. The PCE Coordinator Menu contains all of the supporting options/menus, plus the data entry options.

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

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

- Assign *PCE Encounter Data Entry - Supervisor* to users who can document a clinical encounter and can also delete any encounter entries, even though they are not the creator of the entries. This action also allows adding and editing in fields not asked in the other PCE Encounter Data Entry options.

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

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

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

VA FileMan File Protection

The following VA FileMan file protection has been assigned to the files exported by PCE and Visit Tracking.

File Number	Name	DD	RD	WR	DEL	LAY
150.1	ANCILLARY DSS ID	@		@	@	@
150.2	VSIT SITE CODES	@		@	@	@
150.9	VISIT TRACKING PARAMETERS	@			@	@
811.1.	PCE Code Mapping	@		@	@	@
811.2	PCE Taxonomy	@			@	
811.8	PCE Reminder Type	@			@	@
811.9	PCE Reminder/ Maintenance Item	@			@	
815	PCE Parameters	@			@	@
839.01	PXCA Device Interface Module Errors	@				
839.7	PCE Data Source	@			@	
9000001	Patient/HIS	@				
9000010.06	V Provider	@				
9000010.07	V POV	@				
9000010.11	V Immunization	@				
9000010.12	V Skin Test	@				
9000010.13	V Exam	@				
9000010.15	V Treatment	@				
9000010.16	V Patient Ed	@				
9000010.18	V CPT	@				
9000010.23	V Health Factors	@				
9999999.06	Location	@				
9999999.09	Education Topics	@			@	
9999999.14	Immunization	@			@	
9999999.15	Exam	@			@	
9999999.17	Treatment	@			@	
9999999.27	Provider Narrative	@			@	
9999999.28	Skin Test	@			@	
9999999.64	Health Factors	@			@	

Access recommended for Sites using Kernel Part III.

File Number	Name	User	Coordinator
811.1.	PCE Code Mapping	R	R
811.2	PCE Taxonomy	R	RW
811.8	PCE Reminder Type	R	RW
811.9	PCE Reminder/ Maintenance Item	R	RW
815	PCE Parameters	R	RW
839.01	PXCA Device Interface Module Errors	RWDL	RWDL
839.7	PCE Data Source	RL	RL
9000001	Patient/HIS	RWL	RWL
9000010.06	V Provider	RWDL	RWDL
9000010.07	V POV	RWDL	RWDL
9000010.11	V Immunization	RWDL	RWDL
9000010.12	V Skin Test	RWDL	RWDL
9000010.13	V Exam	RWDL	RWDL
9000010.15	V Treatment	RWDL	RWDL
9000010.16	V Patient Ed	RWDL	RWDL
9000010.18	V CPT	RWDL	RWDL
9000010.23	V Health Factors	RWDL	RWDL
9999999.06	Location	R	R
9999999.09	Education Topics	R	RWL
9999999.14	Immunization	R	RWL
9999999.15	Exam	R	RWL
9999999.17	Treatment	R	RWL
9999999.27	Provider Narrative	RWL	RWL
9999999.28	Skin Test	R	RWL
9999999.64	Health Factors	R	RWL

Visit Tracking

File Number	Name	User	Coordinator
150.1	Ancillary DSS ID	R	R
150.2	Visit Site Codes	R	R
150.9	Visit Tracking Parameters	R	RW
9000010	Visit	RWDL	RWDL

Appendix B

Appendix C - Visit Tracking Technical Information

Introduction

The Visit Tracking software is designed to link patient-related information in a file structure that will allow meaningful reporting and historically accurate categorization of patient events and episodes of care.

Background

This version of Visit Tracking is a hybrid of a Visit Tracking module developed by and operating at Indian Health Service (IHS) facilities as part of their Patient Care Component (PCC) and Visit Tracking V. 1.0 developed by the Dallas Information Systems Center (ISC) for the Joint Venture Sharing (JVS) sites and operating at Albuquerque, NM. The primary data file (VISIT file #9000010) developed by IHS is used with some additional fields and modifications for VA needs. The supporting software was developed with the intent to operate without modification in either facility.

Relationship to other packages

Visit Tracking is not a stand-alone application. Other packages will normally call PCE, which will handle the calls to Visit Tracking.

Where appropriate, V*IST*A packages will be able to link an event to a patient visit entry, thereby linking that event to any number of events occurring throughout the hospital during the patient's visit or admission. By linking events to a "visit," historical information surrounding that event can be retrieved from the VISIT file (#9000010) that might ordinarily be unknown, such as the patient's eligibility at time of the event, the category of patient, or the Hospital Location.

Functions provided

The Visit Tracking system provides three primary functions:

- Creating and/or matching a visit record using input criteria and user interaction (optionally)
- Providing a list of visits matching input criteria
- Maintaining the VISIT file (#9000010) and its records

Visit Tracking is a utility that can be used by a variety of V*IST*A modules, with potential benefits for clinical, administrative, and fiscal applications. Visit Tracking will allow V*IST*A packages to link an event to a patient visit entry, thereby linking that event to any number of events occurring throughout the hospital during the patient's outpatient and/or inpatient episode.

Benefits

- The VISIT file (#9000010) will be a key file in the implementation of the clinical repository.

- The VISIT file provides a home for documenting when and where other facility events have occurred.

- Medical Care Cost Recovery (MCCR) can obtain billing information related to a clinic visit, a step towards itemized billing.

- Visit Tracking provides an environment for relating clinical information to the service visit for workload tracking or query by service views, as well as by the aggregate clinic visit view.

- Users have the potential to control the Visit level of granularity while reviewing patient information (e.g., only view visits from the primary clinic visit level: an aggregate view or only ancillary visits).

- The date and time stamp on clinic and ancillary visits could be useful for retrospective work flow analysis. It may be exploitable as a Clinical Event Summary file useful to researchers doing longitudinal patient studies.

- A breakdown of clinical care provided by primary and secondary providers could help document the clinical experience of trainees (including residents, interns, and other clinicians) who require this information for privileging and credentialing purposes.

- Visit tracking has the capability to generate patient activity reports that are based on accurate historical information.

- The category of patient receiving care can be identified based on a specific episode of care.

- Medical data can be stored for historical purposes without the requirements of specific fields, except for the patient and date.

- Visit tracking has the ability to associate ancillary services provided to a patient with a DSS ID, admission, and non-patient encounter (phone contact, pharmacy mail-out, etc.)

Dependencies

Visit Tracking depends on Patient Care Encounter (PCE). V*IST*A packages that will support and/or use Visit Tracking will require some programming modifications.

VISIT CREATION

The creation of visits is facilitated by the Visit Tracking module. In order to ensure a consistent implementation of visit creation across packages, each package needs to have an agreement with the Visit Administrator to create visits.

The key to the creation of visits will be to ensure the clinical meaningfulness of visits.

Additionally, when a package works out an agreement with Visit Tracking, it must add the triggered cross-reference ADD^AUPNVSIT, SUB^AUPNVSIT, as well as a regular (whole file) cross-reference on the Visit pointer. This ensures that the visit will not be removed by Visit Tracking utilities because the dependent entry counter has been updated.

Two approaches for creating clinical visits:

1. A team of providers can be associated with a primary clinical visit (this is the traditional view taken by IHS).

2. A primary clinic visit can represent the primary provider's care, and a separate visit can be created to reflect the secondary provider's care.

Additionally, the VISIT file will be able to provide a breakdown of other ancillary services provided during the clinically significant visit. Laboratory or Radiology occasions of service are other examples of services provided that could have a separate visit reflecting the service involvement related to a clinic appointment on the same day. DSS and Outpatient Workload will benefit from a service breakdown.

IRM Responsibility

IRM will be responsible for updating the VISIT TRACKING PARAMETERS file (#150.9). IRM will also have the capability to indicate if a package is active or inactive. No other maintenance is required by IRM.

GUIDELINES FOR DEVELOPERS

This section describes the guidelines which should be used for VA developers populating visits in the Visit file. These guidelines are based on a combination of the experience of Albuquerque's joint venture sharing, IHS' PCC pilot test at Tucson VAMC, MCCR data capture pilots, HSR&D workload reporting studies at Hines VAMC, and DMMS/DSS event data capture.

The purpose of the VISIT file in the VA:

The VISIT file has multiple purposes. The primary role is to record when and where clinical encounters related to a patient have occurred. Visits will be recorded for both Outpatient and Inpatient encounters. The initial focus of the Visit file will be for tracking outpatient encounter activity.

- Outpatient encounters include scheduled appointments and walk-in unscheduled visits.

- Inpatient encounters include the admission of a patient to a VAMC and any clinically significant change related to treatment of that patient. For example, a treating specialty change is clinically significant, whereas a bed switch is not. The clinically significant visits created throughout the inpatient stay are related to the inpatient admission visit.

- If the patient is seen in a clinic while an Inpatient, a separate visit will be created representing the appointment visit – this visit is related to the Admission visit.

- A clinician's telephone communications with a patient may be represented by a separate visit.

- The clinical visits can be viewed from two approaches: 1) a team of providers can be associated with a primary clinical visit (this is the traditional view taken by IHS); or 2) a primary clinic visit can represent the primary provider's care, and a separate visit can be created to reflect the secondary provider's care.

- Additionally, the VISIT file can provide a breakdown of other ancillary services provided during the clinically significant visit. Laboratory or Radiology services are other examples of services provided that could have a separate visit reflecting the service involvement related to a clinic appointment on the same day.

Supported Entry Points

Creating visit entries in the VISIT file is not a free-for-all. Packages wishing to create visits or call Visit Tracking must publish agreements with the DBA. The DBA office provides oversight on agreements.

Conventions

Italic formatting indicates argument names that are replaced with actual values. The notation "*.argument*" indicates a call by reference.

Note: [ ] indicates optional choices   { } indicates required choices

Please refer to the section "Description of VISIT file fields" to see which fields are required, which ones will generate default values, and which ones can be used in matching/screening when selecting preexisting visits.

Create and/or Match Visit Using Input Criteria

^VSIT
(See the Package-Wide Variables section)

INPUT:	VSIT	\<visit date [and time] in FM format\>
		(time will default to 12 noon if not specified)
	DFN	\<patient file pointer\>
	[VSIT(0]	\<a string of characters that defines how the visit processor will function, see package-wide variables\>
	[VSIT("\<xxx\>")]	\<array with mnemonic subscript\>
		(used in match logic if VSIT(0)["M")
		(for SVC, TYP, INS, CLN, ELG, LOC)
		Note: For multiple field values use [\<field value\>[^...]]
		i.e., VSIT("SVC")="H^D" (will find both)
	VSITPKG	\<package name space\>

OUTPUT: VSIT(<ien   N^S[^1]
                where: N   <internal entry number of visit>
                                 or -1 if could not get a visit
                                 or -2 if calling package is not active
                                 in Visit Package Parameters
                      S   <value of .01 field of visit>
                      1   <indicates that a new visit was added>
            VSIT(<ien>,<xxx>)   returns the data that is stored in the Visit file

Update Dependent Entry Counter

These calls are customarily done through a MUMPS cross reference on the pointer field. The input parameter X is set by FileMan.

ADD^AUPNVSIT
Increase the dependent entry count by one.
        INPUT   X   Visit IEN

SUB^AUPNVSIT
Decrease the dependent entry count by one   INPUT   X   Visit IEN

$$PKG2IEN^VSIT(PKG)
Returns a pointer to the Package file when you pass in the package namespace
        INPUT   PKG   Package namespace
        OUTPUT   Pointer to the package in the Package file #9.4

$$PKG^VSIT(PKG,VALUE)
Entry point to add or edit package to multiple in tracking param
        INPUT   PKG   Package Name Space
                    VALUE   Value on the ON/OFF flag under package
                                Multiple 1=ON 0=OFF

$$PKGON^VSIT(PKG)
Returns the active flag for the package
        INPUT   PKG   Package Name Space
        OUTPUT   1 the package can create visits
                                0 the package cannot create visits
                                -1 called wrong or could not find package in VT
                                parameters file

$$IEN2VID^VSIT(IEN)
Returns the Visit ID when you pass in a pointer to a visit
      INPUT   IEN   Visit IEN
      OUTPUT   Visit ID

$$VID2IEN^VSIT(VID)
Returns a pointer to a visit when you pass in the Visit ID
      INPUT   VID   Visit ID
      OUTPUT   Visit IEN

$$LOOKUP^VSIT(IEN,FMT,WITHIEN)
Look up a visit and return all of its information
      INPUT   IEN   Visit IEN OR the Visit's ID
                            FORMAT is the format that you want the output in, where:
                            I ::= internal format
                            E ::= external format
                            B ::= both internal and external format
                            B is the default if anything other than "I" or "E"
                            WITHIEN 0 if you do not want the ien of the visit as the first subscript
                            1 if you do. "1" is the default.
      OUTPUT   -1 if IEN was not a valid IEN or Visit ID otherwise returns IEN
                            VSIT(<ien>,<xxx>)
             or   VSIT(<xxx>)depending on the value of WITHIEN The array is all of the fields in the visit file. If both internal and external format are returned the format is: internal^external

SELECTED^VSIT(DFN,SDT,EDT,HOSLOC,ENCTYPE,NENCTYPE,SERVCAT,NSERVCAT,LASTN)

Returns selected visits depending on screens passed in.

INPUT	DFN	DFN	of Patient (only required input)
		SDT	Start Date
		EDT	End Date
		HOSLOC	Hospital Location
		ENCTYPE	Encounter types to include
		NENCTYPE	Encounter types to exclude
		SERVCAT	Service Categories to include
		NSERVCAT	Service Categories to exclude
		LASTN	How many starting with the Date and going backwards until have that many or all of them, whichever is first

ONLY THE DFN IS REQUIRED

Encounter types are a string of all the encounter types wanted. e.g. "OA" for only Ancillary and Occasion of service. Not Encounter types is a string of all the encounter types not wanted. e.g. "T" for do not include Telephone. If Encounter types and Not Encounter types are null or not passed then all encounter types will be included. Service Categories is a string of all the service categories to include. If non is passed all is assumed. e.g. "H" for just historical, "T" for just Telephone, "AIT" for ambulatory (in and out patient) and Telephone. Not Service categories is a string of all the service categories to not include.

      OUTPUT   ^TMP("VSIT",$J,vsit ien,#)

           Piece 1:: Date and Time from the Visit File Entry

           Piece 2:: Hospital Location ien (pointer to file#44)_";"_
                External Value
                If service category = "H" then this Piece becomes the following:: Location of Encounter ien (Pointer to file #9999999.06)_";"_External Value

           Piece 3:: Service Category (Value of field .07 set of codes)

           Piece 4:: Service Connected (Value of field 80001 External Value)

           Piece 5:: Patient Status in/out (Value of field 15002 set of codes)

           Piece 6:: Clinic Stop ien (Pointer to file # 40.7) ";" External value)

$$HISTORIC^VSIT(IEN)
Returns a flag indicating whether the visit is historical.

INPUT	IEN	Visit IEN
OUTPUT		1 if it is an Historical visit ("E" in #.07)
		0 if it is not an Historical visit.
		-1 if the IEN is bad

MODIFIED^VSIT(IEN)
Sets the Date Last Modified (.13) field to NOW

INPUT	IEN	Visit IEN

KILL^VSITKIL(IEN)
Deletes the visit if there is no files pointing to it. Before deleting checks all the backware pointers to see if the visit is being pointed to.

INPUT	IEN	Visit IEN

PACKAGE-WIDE VARIABLES

Visit Tracking V2.0 has no package-wide variables requiring SACC exemptions. Package developers making calls to Visit Tracking must clean up locally created variables before exiting the application option.

The following are local package-wide variables under the VSIT namespace.

VSIT(<xxx>)   Variable Names for VISIT file fields,
file: 9000010, global: ^AUPNVSIT(Where <xxx> is a general reference to the field mnemonic.

Key	Indicates
r	indicated a required field
m	matching/screening logic can/does apply
s	system generated
e	strongly encouraged

Key		Variable	Description
	.001	VSIT("IEN")	NUMBER (visit internal entry number)
rm	.01	VSIT("VDT")	VISIT/ADMIT DATE&TIME (date)
s	.02	VSIT("CDT")	DATE VISIT CREATED (date)
m	.03	VSIT("TYP")	TYPE (set)
rm	.05	VSIT("PAT")	PATIENT NAME (pointer PATIENT file #9000001) (IHS file DINUMed to PATIENT file #2)
m	.06	VSIT("INS")	LOC. OF ENCOUNTER (pointer LOCATION file #9999999.06) (IHS file DINUMed to INSTITUTION file #4)
	.07	VSIT("SVC")	SERVICE CATEGORY (set)
me	.08	VSIT("DSS")	DSS ID (pointer to CLINIC STOP file)
	.09	VSIT("CTR")	DEPENDENT ENTRY COUNTER (number)
	.11	VSIT("DEL")	DELETE FLAG (set)
	.12	VSIT("LNK")	PARENT VISIT LINK (pointer VISIT file #9000010)
	.13	VSIT("MDT")	DATE LAST MODIFIED (date)
	.18	VSIT("COD") ;	CHECK OUT DATE&TIME (date)
	.21	VSIT("ELG")	ELIGIBILITY (pointer ELIGIBILITY CODE file #8)

<u>Key</u>	<u>Variable</u>	<u>Description</u>	
mr	.22	VSIT("LOC")	HOSPITAL LOCATION (pointer HOSPITAL LOCATION file #44)
	.23	VSIT("USR")	CREATED BY USER (pointer NEW PERSON file #200)
	.24	VSIT("OPT")	OPTION USED TO CREATE (pointer OPTION file #19)
	.25	VSIT("PRO")	PROTOCOL (pointer PROTOCOL file #101)
	.26	VSIT("ACT")	PFSS ACCOUNT REFERENCE (pointer PFSS ACCOUNT file #375)
	2101	VSIT("OUT")	OUTSIDE LOCATION (free text)
	80001	VSIT("SC")	SERVICE CONNECTED (set)
	80002	VSIT("AO"	AGENT ORANGE EXPOSURE (set)
	80003	VSIT("IR")	IONIZING RADIATION EXPOSURE (set)
	80004	VSIT("EC")	SW ASIA CONDITIONS (set)
	80005	VSIT("MST")	MILITARY SEXUAL TRAUMA (set)
	80006	VSIT("HNC")	HEAD AND/OR NECK CANCER (set)
	80007	VSIT("CV")	COMBAT VETERAN
	80008	VSIT("SHAD")	PROJ 112/SHAD (set)
	15001	VSIT("VID")	VISIT ID (free text)
	15002	VSIT("IO")	PATIENT STATUS IN/OUT (set)
	15003	VSIT("PRI")	ENCOUNTER TYPE (set)
	81101	VSIT("COM")	COMMENTS
	81202	VSIT("PKG")	PACKAGE (pointer PACKAGE file #9.4)
	81203	VSIT("SOR")	DATA SOURCE (pointer PCE DATA SOURCE file #839.7)
		VSIT(0)	A string of characters that defines how the visit processor will function.
		F	Force adding a new entry.
		I	Interactive mode
		E	Use patient's primary eligibility if not defined on call with VSIT("ELG").
		N	Allow creation of new visit.
		D	Look back "n" number of days for match, defaults to one (1). D[<number of days>] i.e., VSIT(0)="D7" e.g., VSIT(0)="D5" (visit date to visit date - 4) use "D0" to require exact match on visit date and time.
		M	Impose criteria on matching/screening of visits. Uses the VSIT(<xxx>) array: Matching elements must equal their corresponding field.
		DFN	Internal entry number of the patient file.
		VSIT	The date (and time) of the visit.
		VSIT(<ien>	N^S[^1]
			where:
			N = <internal entry number of visit>
			S = <value of .01 field of visit>
			1 = <indicates that a new visit was added
		^TMP("VSITDD",$J,<xxx><visit subscript>;<field #>;<node>;<piece>;	
			<error message>
		VSITPKG	Package Name Space