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PATIENT CARE DATA CAPTURE

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy requiring the capture of all outpatient encounters, inpatient appointments in outpatient clinics, and all inpatient billable encounters not captured elsewhere; it expands current policy for patient care data capture by including the capture of all inpatient mental health professional services.

2. BACKGROUND

a. Since October 1, 1996, VHA facilities have been required to electronically report data concerning the provision of care, inpatient facility, and outpatient professional services in VHA, to the National Patient Care Database (NPCD) in Austin, Texas. Effective October 1, 2006, the capture of billable inpatient appointments in outpatient clinics and billable inpatient services was added to the requirement of encounter data to be captured. This Directive extends the requirement to capture inpatient professional services for all mental health care delivered by psychiatrists, psychologists, physician assistants, nurse practitioners, clinical nurse specialists and social workers. VHA is required to utilize data definitions for clinical and administrative data promulgated by internationally and nationally-recognized standard setting organizations (e.g., American Society for Testing and Materials (ASTM), American National Standards Institute (ANSI), Centers of Medicare and Medicaid Services (CMS), Health Insurance Portability and Accountability Act of 1996 (HIPAA), etc.).

b. VHA information systems were modified in January 2005 to enable the transmission of all encounters (both inpatient and outpatient) from Patient Care Encounter (PCE) to the NPCD.

c. All coded data for professional service encounters may not be billable. Third-party payers have business rules that require health care data to be submitted in a specific format before the claim for payment can be adjudicated. As such, there will be specific circumstances where the code sequence or codes in PCE do not match one-to-one with the bill created in the Integrated Billing Package.

d. VHA facilities utilize a variety of software packages to capture inpatient and outpatient delivery of care. Regardless of the software package utilized, all data must pass, or be transferred, into PCE (if not directly entered into PCE) and ultimately to the NPCD.

e. Each clinic must be set up with appropriate Decision Support System (DSS) Identifiers. Utilized both locally and nationally, these identifiers describe DSS clinical work units. The DSS Program Office is responsible for maintaining and nationally distributing the list of DSS identifiers which are updated annually (see the current VHA policy).

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f. Use of electronic encounter forms and documentation templates were mandated in May 2003. The nationally-developed templates and encounter forms support quality documentation and coding; they are user friendly, efficient, meet compliance criteria, and incorporate instructional text to avoid omission of appropriate information. These nationally developed templates and encounter forms may be edited at the facility level. Facilities need to continue to refine local templates and encounter forms to ensure quality documentation and data capture. VHA Program Offices develop and provide guidance on program specific templates. All nationally developed templates and encounter forms can be found on the VHA Health Information Management (HIM) website at:

<http://vaww.vhaco.va.gov/him/natldoctemplates.html>. *NOTE: This is an internal VA link not available to the public.*

g. For VHA purposes, a Department of Veterans Affairs (VA) medical center, including all identified divisions and Community Based Outpatient Clinics (CBOCs), is considered to be the business entity furnishing health care at the organizational level. Sub-organizational level entities by which data needs to be retrievable include: parent and community site, specific clinic (regardless of whether the site has more than one type of station suffix, for example a CBOC), treatment team, and individual practitioner. A Person Class taxonomy code for each billable provider with the VA medical center and VA medical center division code is reported to the NPCD.

h. **Definitions.** The following definitions apply to PCE data:

(1) **Licensed Practitioner.** A licensed practitioner is an individual at any level of professional specialization who requires a public license or certification to practice the delivery of care to patients. A practitioner can also be a provider.

(2) **Non-Licensed Practitioner.** A non-licensed practitioner is an individual without a public license or certification who is supervised by a licensed or certified individual in delivering care to patients.

(3) **Provider.** A provider is a person or organization that furnishes health care to a consumer and bills or is paid for the health care in the normal course of business. This includes a professionally-licensed practitioner who is authorized to operate in a health care delivery facility.

(4) **Mental Health Inpatient Professional Services.** Mental Health Inpatient Professional Services are inclusive of daily evaluation and management, therapy sessions, consultations, etc. For purposes of patient care data capture, mental health services include inpatient professional services performed by a psychiatrist with the credentials of Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO), psychologist with the credentials of Doctor of Philosophy (PhD) or Doctor of Psychology (PsyD), master level social workers, or physician extender with the credentials of Nurse Practitioner (NP), Clinical Nurse Specialist (CNS) or Physician Assistant (PA) in an inpatient setting, location of the service notwithstanding.

(5) **Encounter.** An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting.

(a) Contact can include face-to-face interactions or those accomplished via telecommunications technology.

(b) Use of e-mail is limited and does not constitute an encounter. E-mail communications are not secure and e-mail must not contain patient specific information. *NOTE: Secure messaging communication is available through the My HealthVet (MHV) personal health record (PHR). These communications may meet the definition of an encounter, based on type of message and content.*

(c) Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc.

(d) A telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter, namely history and clinical decision-making. Telephone encounters must be associated with a clinic that is assigned one of the DSS Identifier telephone codes and are to be designated as count clinics. *NOTE: Count refers to workload that meets the definition of an encounter or an occasion of service. NOTE: The American Medical Association (AMA) changed the definition of the 2008 CPT Telephone Call codes. Many of VHA's performance monitors require follow-up care delivered by telephone, therefore, the 2008 CPT telephone codes are to be used as previously defined.*

(6) **Care Coordination.** Care Coordination (formerly referred to as Telemedicine and Telehealth) in VHA is the use of health informatics, disease management and telehealth technologies to enhance and extend care and case management to facilitate access to care and improve the health of designated individuals and populations with the specific intent of providing the right care in the right place at the right time.

(7) **Telehealth.** Telehealth Services may be described as:

(a) General Telehealth. General telehealth is the use of real-time interactive video conferencing technology, sometimes with supportive peripheral devices, to provide care and consultation between providers and patients at VA facilities and clinics and other remote sites such as Vet Centers.

(b) Home Telehealth. Is the use of in-home telehealth technologies, such as non-video messaging and monitoring devices or video technology for veteran patients with chronic diseases such as diabetes, heart failure and chronic pulmonary disease for home monitoring.

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(c) **Store and Forward.** Is the use of imaging technologies at the patient site to acquire and store clinical information (e.g., data, image, sound, video) that is then forwarded to (or retrieved by) another health care practitioner site for reading, review and clinical evaluation. For VHA purposes, a telehealth contact between a practitioner and a patient is considered to be an encounter if the specific conditions are met as outlined in DSS instructions for Telehealth. The provider's encounter does not always occur simultaneously with the patient's encounter (refer to VHA current policy and instructions on Telemedicine and Telehealth Services for more information).

(8) **Collateral Services.** The Collateral (spouse, family member, or significant other who receives services relative to the patient's care) is to be enrolled in Veterans Health Information Systems and Technology Architecture (VistA) for entry of all encounters provided directly to the Collateral (i.e., to the spouse) and reporting using the Collateral's name as the person who received the services. **NOTE:** *Services provided to persons other than the patient as a part of the patient's care (such as family therapy) are not to be reported separately.*

(9) **Occasion of Service (formerly known as ancillary service).** An "occasion of service" is a specified identifiable instance of an act of technical and administrative service involved in the care of a patient or consumer which is not an encounter and does not require independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s).

(a) Occasions of service, are the result of an encounter. Examples are: clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

(b) Occasions of service, such as clinical laboratory and radiology studies and tests are automatically loaded to the PCE database from other VistA packages.

(10) **Statistics Only (formerly known as workload only).** Situations may exist which do not meet the definition of an encounter nor an "occasion of service. "Statistics Only" clinics within the Scheduling application need to be set to non-count and non-billable and are tracked for workload only (internal use), and are not transmitted to the NPCD.

(11) **Visit.** The term "visit" is used for the purpose of reporting services provided to a veteran and patient in a 24-hour period; for example, the visit of an outpatient to one or more clinics or units within one calendar day at the facility level, including the station number and the suffix identifiers (i.e., for facilities, visits are to be reported at the three-digit station level, for visits reported; for instance, at CBOCs it must include the suffix (STA6A)).

(12) **Minimum Clinical Data Elements.** In addition to the current administrative data elements, such as: eligibility, period of service and service-related condition information, patient address, next-of-kin, etc., the minimum clinical data elements required to constitute an encounter or occasion of service are as follows:

(a) **Patient.** The person receiving health care services.

1. VistA. The full legal name, date of birth, Social Security Number (SSN) or pseudo-SSN (or other personal identifier), eligibility, etc.

2. NPCD. The full legal name, date of birth, SSN, or pseudo-SSN (or other personal identifier), eligibility, etc.

(b) Date and Time of Service. Time is a single entry indicating the time that the encounter was scheduled to occur and the data element is taken from the Appointment Scheduling software. For all scheduled appointments the date is the date services are actually provided and when unscheduled appointments are entered, the date and time that the encounter is entered into VistA is what is used as the encounter date and transmitted.

(c) Practitioner. VistA stores specific practitioner information from the New Person and Person Class files for an individual provider to allow for encounters to be transmitted. Each practitioner must be designated within the NEW PERSON FILE with a correct defined specific practitioner type from the PERSON CLASS FILE; this applies to all: physicians, nurse practitioners, physician assistants, other licensed health care providers and those non-licensed providers that provide patient care. *NOTE: Refer to the current VHA policy.*

(d) Place of Service. Information about the location where the service was provided. In both VistA and NPCD, this includes the three-digit medical center and/or station identifier, with any applicable suffixes (STA6A), as well as the DSS Identifier(s). The place of service must include the five-character medical center national VHA division value. The division value must reflect the location where care was provided.

(e) Active Problems. Problems and/or diagnosis(es) treated that relate to the encounter are required to be reported as International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes with a minimum of one required. When more than one active problem or diagnosis is designated for an encounter, the practitioner must determine which one is the primary reason the patient sought treatment at that encounter and all additional diagnoses or conditions that affected the treatment of the patient during the encounter need to be included as additional secondary codes.

(f) Classification Questions. The determination of whether or not a treatment was related to an adjudicated service-connected condition or treatment of conditions related to exposure (Agent Orange, Ionizing Radiation, Military Sexual Trauma, combat veterans, or environmental Contaminants) must be based on all conditions treated during the encounter and the entire encounter must be designated service connected, or designated as being related to the special categories. VistA maintains and stores text descriptions along with coded values. Only the coded values are transmitted to NPCD.

(g) The Service Provided. Services provided to the patient by the practitioner or provider must be fully and clearly documented and coded using nationally-accepted coding schemes, such as Current Procedural Terminology (CPT) codes and Healthcare Common Procedural Coding System (HCPCS). VistA maintains and stores text descriptions along with the coded values. Only the coded values are transmitted to NPCD. *NOTE: Guidelines published by the American*

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Medical Association (AMA) must be followed for CPT code assignment and guidelines published by the Centers for Medicare and Medicaid Services (CMS) must be followed for HCPCS code assignment

(h) **Primary Provider.** A Licensed Independent Provider is always to be listed as the primary provider for all encounters. The supervising or attending physician is to be listed as the primary provider for all encounters provided by a Medical Resident, RN, or other non-licensed independent practitioner (NLIP) under the physician's supervision. The relevant other Licensed Independent Providers, (e.g., Psychology Intern, Pharmacy Resident) or any other NLIP under their supervision. **NOTE:** *Use of evaluation and management (E & M) codes require that certain criteria be met within the coding guidelines, such as scope of practice, and may limit the use of many E & M codes.*

3. POLICY: It is VHA policy to capture and report inpatient appointments in outpatient clinics, inpatient billable professional services, inpatient professional mental health services, and outpatient care data to support the continuity of patient care, resource allocation, performance measurement, quality management, provider productivity, research, and third-party payer collections. **NOTE:** *See Attachment A, which provides answers to frequently asked questions (FAQs) about Capturing Inpatient Professional Services.*

4. ACTION

a. **Network Director.** The Network Director is responsible for ensuring:

(1) The Patient Information Management System (PIMS) and PCE software packages are maintained on all medical centers' VistA systems in accordance with nationally-distributed software and software patches.

(2) Electronic encounter forms are created, implemented and utilized to optimize health record documentation and the revenue cycle.

(3) All encounters are entered into a software application such as Computerized Patient Record System (CPRS) or Appointment Management that results in the encounter data being reported to the PCE application in order to transmit to the NPCD. **NOTE:** *If a package does not pass workload to PCE automatically, that workload must be entered manually (i.e., the Medicine Package)*

b. **Facility Director and Facility Chief of Staff.** The facility Director and Chief of Staff are responsible for ensuring that:

(1) Clinical staff document clinical information in conformance with medical center documentation policies and by-laws and, in a format that conforms to the software requirements for defining the practitioner; the patient's active problems, diagnosis(es) or reason for visit; and the services provided to the patient.

(2) Psychiatrists, Psychologists, Social Workers, Advanced and Practice Providers (Advanced Practice Registered Nurse (APRN), CNS, PA) document and enter encounter data on all mental health professional services provided in an inpatient setting. *NOTE: The entry of the data requires the same data elements as the outpatient encounters.*

(3) Staff accurately document patient demographics, the date and time of service, and the place of service in conformance with the requirements of the software.

(4) Facility staff continue to maintain, on each clinic set up in the Scheduling Package, a primary DSS identifier and credit pair (if appropriate) as the work group associated with that clinic set up. A primary DSS identifier must be assigned to encounters in both outpatient and inpatient settings. The primary DSS identifier needs to depict the primary clinical workgroup responsible for the type of services provided during the encounter. The secondary DSS identifier serves as a modifier to further define the primary workgroup or type of services provided. The costs and workload are to be mapped appropriately for inpatient care reporting via the encounter identifier number. The DSS identifier(s) for a patient setting must meet the definitions outlined in the DSS directive. *NOTE: See the current VHA DSS policy.*

(5) The encounter forms, like those from the Automated Information Collection System (AICS), are used as a tool to manage the collection of coded information manually or on data collection screens. Data validation is required to ensure that only valid codes are used on all encounter forms. Regular maintenance of these forms is required at least twice each year. The nationally-approved code sets are changed twice annually generally on October 1 and January 1, according to the releases of CPT, HCPCS, and ICD-9-CM coding changes. Trained and competent coding staff must perform data validation of the coded information in accordance with the data validation requirements of the facility. The data on the encounter forms must conform to the definitions and conventions included in the appropriate coding methodologies noted previously.

(6) Inpatient and Outpatient Encounter data is transmitted to the NPCD at the Austin Information Technology Center (AITC), Austin, Texas, and accepted (making any necessary corrections that result in a rejection from the NPCD).

(7) General monitoring of the transmission and acceptance of encounter data at the NPCD is at regular intervals through the use of the Ambulatory Care Report Program (ACRP) Transmission report, and Outpatient Activity Report (OPA) reports (the OPR includes all inpatient encounters when validating the transmission of workload data) messaging mail groups for transmission status, checking the logical link for the HL7 messages, and checking the transmission queue. *NOTE: See Attachment B, which details the monitoring and validating transmission of workload data to NPCD.*

(8) Acceptable mechanisms to capture workload are implemented; these include:

(a) Direct Encounter Form Completion;

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(b) Certain VistA Software Packages (i.e., Radiology, Surgical, and Laboratory Packages); and

(c) Event Capture System (ECS).

(9) All workload must transmit PCE to the NPCD, regardless of the mechanism utilized, and contain all required data elements detailed in subparagraph 5a(3). If PCE is not directly used for reporting encounters, the data is entered into an application that transmits data to the NPCD.

NOTE: *PCE is the transmission mechanism of all encounter data for transmission of the data to NPCD.*

(10) The workload is submitted by monthly closeout date.

c. **Vet Centers.** Vet Centers currently have patient contact information captured by the VHA Support Service Center (VSSC) using a data extract. This data reflects patient contacts including the number of contacts for outreach, Post Traumatic Stress Disorder, etc. Vet Centers will be asked to provide more detailed workload information above and beyond their current reportings once the centers have access to an electronic health record.

5. REFERENCES

a. American Medical Association. Common Procedural Terminology (CPT).

b. American Society for Testing and Materials. (1999). E1384-99: Standard Guide for Content and Structure of the Electronic Health Record (EHR). West Conshohocken, PA.

c. Centers for Medicare and Medicaid Services, Healthcare Current Procedural Coding System, Level II and Level III Codes.

d. National Committee for Vital and Health Statistics, NCVHS, Uniform Ambulatory Medical Care Minimum Data Set.

e. World Health Organization International Classification of Diseases-9th Edition –Clinical Modification (ICD-9-CM).

f. Youman, K.G. (2000). Basic Healthcare Statistics for Healthcare Information Management Professionals. Glossary. Chicago, IL: American Health Information Management Association (AHIMA).

g. DSS Identifier web site: http://vaww.dss.med.va.gov/programdocs/pd_oident.asp **NOTE:** *This is an internal VA link not available to the public.*

6. FOLLOW-UP RESPONSIBILITY: Director, Health Data and Informatics (19F), is responsible for the content of this Directive. Questions may be addressed to 760-777-1170.

7. RESCISSIONS: VHA Directive 2006-026, VHA Directive 2003-012, and VHA Directive 2004-037 are rescinded. This VHA Directive expires January 31, 2014.

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Attachments

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ATTACHMENT A

INPATIENT DATA TRANSMISSION FREQUENTLY ASKED QUESTIONS

Question 1: Is there a mandate to enter all inpatient professional information (both billable and non-billable) into Patient Care Encounter (PCE)?

Answer: Sites are currently required to record all billable inpatient professional services not captured through any other package (i.e., surgery). In addition, this directive requires the capture of defined inpatient professional mental health services regardless of the third-party billing status.

Question 2: Why was there a decision to transmit inpatient professional services encounters to Austin?

Answer: For several years, researchers, budget forecasters, and the Veterans Health Administration (VHA) Physician Productivity and Advisory Group have requested data related to inpatient professional encounters. In response to those continuous requests, a new service request was submitted and the work to remove the inpatient flag (barrier) to transmitting inpatient PCE data to Austin was begun. The patches to allow the transmission of any inpatient encounters located in the PCE were finished in early December 2004. Patches SD*5.3*387 and DG*5.3*617 were released 12/14/04 (installation compliance date was January 4, 2005).

Question 3: How does the requirement for Mental Health Inpatient Services Data transmissions affect providers and were instructions provided to them on any such changes that do affect them?

Answer: The Mental Health Workload and Analysis Workgroup with involvement of Patient Care Services Office of Mental Health Services (OMHS) recommended that all inpatient Mental Health Services be captured. This recommendation was approved by the Deputy Undersecretary for Health. The Mental Health Program Office will provide necessary guidance. The same level of encounter data for inpatient care is required as is currently required for outpatient care. .

Question 4: In order to transmit inpatient encounters to PCE, what attributes must be included?

Answer: Patches SD*5.3*398 and DG*5.3*617 require that inpatient encounters processed in PCE and appointment management must be checked out with diagnosis, procedure, provider and other checkout items like classifications or they will accumulate as local Veterans Health Information Systems and Technology Architecture (VistA) errors in the Incomplete Encounter Module. **NOTE:** If you have questions or concerns, log a Remedy ticket to Scheduling.

Question 5: We already have count clinics set up to capture this information. Can we change them to non-count clinics?

Answer: No - In clinics where there are provider-patient interactions, the clinics should be marked count, even if the patients being seen are inpatients. Valid reasons for marking a clinic non-count are instances where the credit is being passed by another application (Radiology, Surgery) and the clinic is only used to assign appointment times for the patient.

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Question 6: I have one inpatient clinic set up that is used to collect all inpatient encounters; what stop code should I use?

Answer: Sites are required to create an inpatient clinic for each specialty using the Decision Support System (DSS) Identifier that most accurately depicts the service being performed. The criteria used to create outpatient clinics can be used to create the inpatient clinics as well. This is especially important for the Mental Health services. Again, in collaboration with DSS, the OMHS will instruct sites on which DSS identifiers should be used in association with which clinics to ensure the appropriate capture of the Mental Health workload.

Question 7: What if we are using the 801 Screen to enter professional encounters?

Answer: Data entered into the 801 Screen in PTF (using encoder software) creates a PCE entry and will transmit to the Austin database.

Question 8: Is there a mandate to use either PCE or the 801 Screen to capture inpatient professional services?

Answer: No. Each site should have a business rule in place to assure all inpatient professional services are captured using the functionality that best meets the facilities business needs. Workload for the same encounter should not be entered into both systems to prevent duplicate entries.

Question 9: Do we have to do anything new or different with Fee PTF as a result of this change?

Answer: No, there are no changes to the way in which Fee cases are coded and entered into VistA.

Question 10: How does this affect Domiciliary workload?

Answer: Domiciliary workload was not part of the block previously and will continue to require associated data and will continue to be transmitted to Austin. With the associated encounters, standard edit checks will be applied and corrections must be made for any rejected encounters (inpatient or outpatient).

Question 11: How do we know if any of the encounters for inpatients seen in outpatient clinics were rejected?

Answer: There must be review and correction of any encounters rejected at the local or national level. Your facility may handle the review and correction of rejected encounters in a number of ways. Regardless of who may coordinate this process locally, Health Information Management (HIM) should be an integral part of reviewing both inpatient and outpatient encounter error rejections that pertain to HIM, i.e., diagnosis or procedure code rejections. Inpatient encounters rejected by either VistA or NPCD use the same error codes as outpatient encounters with the exception of the new error code 421 for an incomplete admission date and

time. Errors are handled in the same way as outpatient encounters using the VistA package Incomplete Encounter Management Module (IEMM).

Question 12: Will there be any reports that I can run to evaluate encounter data for inpatients seen in outpatient clinics data?

Answer: Reports that mirror the outpatient (OP) reports are being created and are available on the NPCD Web page. The NPCD homepage is <http://vaww.aac.va.gov/npcd/> and the reports page is located at <http://vaww.aac.va.gov/npcd/DailyReport.php> Select the reports that begin with IP for information about your facility's inpatient encounters transmitted to NPCD. **NOTE:** These are internal VA links not available to the public.

ATTACHMENT B

INSTRUCTIONS FOR INFORMATION RESOURCES MANAGEMENT (IRM) STAFF TRANSMITTING WORKLOAD TO THE NATIONAL PATIENT CARE DATABASE (NPCD)

1. Ambulatory Care Nightly Transmission to National Patient Care Database (NPCD)

Option. Ensure that the option Ambulatory Care Nightly Transmission (including Inpatient encounters) to NPCD [SCDX AMBCAR NIGHTLY XMIT] is scheduled to run on a daily basis, as this is the background job that generates the AmbCare HL7 messages. After each completion of this job, a summary bulletin stating the number of encounters included in the HL7 messages is sent to members of the mail group assigned to the SCDX AMBCARE TO NPCDB SUMMARY bulletin.

2. Systems Link Monitor Option. Using the option Systems Link Monitor [HL MESSAGE MONITOR] ensures the following:

- a. At least one incoming filer is running.
- b. At least one outgoing filer is running.
- c. The AMB-CARE logical link is running (STATE column lists IDLE).
- d. Values in the MESSAGES RECEIVED and MESSAGES PROCESSED columns for the AMB-CARE logical link increase on a daily basis.
- e. Values in the MESSAGES TO SEND and MESSAGES SENT columns for the AMBCARE logical link increase on a daily basis.

3. Logical Link Possibilities

- a. The HL7 outgoing filer is probably not running if the MESSAGES TO SEND for the AMB-CARE logical link does not increase and the Ambulatory Care Nightly Transmission to NPCDB job has run. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an outgoing filer.
- b. The HL7 incoming filer is probably not running if the MESSAGES RECEIVED for the AMB-CARE logical link continues to increase while the MESSAGES PROCESSED does not. If this happens, use the option Monitor, Start, Stop Filers [HL FILER MONITOR] to start an incoming filer.
- c. It is highly likely that the AMB-CARE logical link is not running if the MESSAGES TO SEND for the AMB-CARE logical link continue to increase while the MESSAGES SENT do not. If this happens, use the option Start and Stop Links [HL START] to stop and then start the AMB-CARE logical link.

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4. Using the option Transmission History Report - Full [SCDX AMBCAR XMIT HIST FULL], generate the ACRP TRANSMISSION HISTORY report for previous days. This report lists all the encounters transmitted to Austin during a given time frame and includes whether or not an acknowledgement was received. Acknowledgements are usually received within 2 days of transmission and if you are not seeing the acknowledgements, it is highly likely that something is not running and all AmbCare and HL7 background processes should be checked.

5. Monitor the OPA reports coming from Austin to ensure that they reflect receipt of data. Not seeing receipt of data in Austin via these reports indicates something is not running and all AmbCare and HL7 background processes should be checked.