Appendix B. Data Dictionary for Task list

1. **Enter room** – The doctor enters the room at the beginning of the patient visit or during the patient visit.

2. **Gather Information from Patient** – This section includes any discussions, questions, statements with the patient (except any involving medications, test results, recommendations, allergies/adverse reactions, or physical exam (PE) findings – these all have their own section since these types of conversations are typically more in-depth and detailed). Discussions can be just a doctor or patient statement (no response from the other). However, if there is a patient statement and it is clear that the doctor was not listening, then it would not get coded as this is not a physician task.

2A.**Chief complaint** – Discussions involving the main reason(s) for the patient visit. This includes stating the chief compliant/reason for visit as well as further detail or descriptions of the problem(s) (e.g. frequency, causes, symptoms, etc.) This includes any discussion of what the patient is currently doing to help alleviate symptoms (but not things that are already covered in the subcategories below like medications and diet/exercise). This is usually the first patient problem that is discussed during the visit and is determined based on what the patient states and wants to discuss, rather than problems that the physician wants to discuss. For example, a patient may want to discuss chest pain and the physician states that they also need to discuss diabetes control. Chest pain is the chief complaint and discussions about diabetes control would be coded as "2B Problem information".

2B. **Problem information** – Discussions involving other patient problems or issues that the physician wants to discuss in addition to the chief complaint/reason for visit. This includes the problem and further detail or descriptions of the problem(s) (e.g. frequency, causes, symptoms, etc.) unless it can be identified more specifically with a different subcode. This includes any discussion of what the patient is currently doing to help alleviate symptoms (but not things that are already covered in the subcategories below like medications and diet/exercise). Also includes discussions about outside medical care and past medical/surgical history. If it is uncertain whether the information being discussed is separate from the chief complaint already coded, code it as problem information.

2C. **Patient's current medications** – The doctor interviews the patient to determine the medications that the patient is currently taking. Patient involvement should only be to the extent of confirming whether or not a medication is being taken or offering a list of what they are taking. Any other conversation regarding a medication should fall into one of the "2D. Gather Information from Patient – Medications" subcodes.

2D. **Medications** – Any discussion involving old, current, or new medications (other than determining patient's current medications, which should be coded above, or medication cost, which should be coded under "2F. Gather Information from Patient – Cost/access/insurance"). Discussions can be just a doctor or patient statement (no response from the other). However, if there is a patient statement and it is clear that the doctor was not listening, then it would not get coded.

2D(1). **Side effects** – Discussions involving side effects or risks of old, current, or new mediations.

2D(2). **Medication instructions** – Discussions involving instructions for taking a medication, e.g. dosage, frequency, how to take, time of day, generic vs. brand, etc.

2D(3). **Compliance** – Discussions involving patient's compliance with taking a medication, e.g. missed dose, how often, etc.

2D(4). **Effectiveness** – Discussions involving the effectiveness of a medication.

2D(5). **Evidence regarding medication treatment** – Discussions involving the evidence regarding medication treatment, such as citing a study that endorses the benefit of a medication for treating a particular condition.

2D(6). **Reason for medication** – Discussions involving why a medication is being prescribed or why the patient is currently taking a certain medication, i.e., the indication for a medication.

2D(7). **Refills needed** – Discussions involving the need for a refill of a medication.

2D(8). **Drug interactions** – Discussions involving possible drug interactions between medications.

2D(9). **Other** – Discussions that involve medications but can't be coded by any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

2E. **Patient pharmacy** – Discussions involving the patient's pharmacy, location, which one he or she wants to use, etc.

2F. **Cost/access/insurance** – Discussions involving cost, access to healthcare, or insurance. This DOES include medications and tests.
2G. **Allergies and adverse reactions** – Discussion with patient about the patient's list of current/known allergies or adverse reactions to medications in general. Discussion of current side effects from a medication should be coded under "2C(1). Medications – Side effects" above. The doctor conducts this interview using either the EHR or paper chart as a reference, in which case either the EHR or paper chart subcodes would be used.
2H. **Drug/alcohol use** – Discussions involving the patient's drug or alcohol use.
2I. **Tobacco use** – Discussions involving the patient's tobacco use.
2J. **Exercise/diet** – Discussions involving the patient's exercising habits or diet.
2K. **Vitals or weight** – Discussions involving the patient's vital signs, e.g. blood pressure, temperature, pulse/heart rate, height, or weight.
2L. **Daily life activities** – Discussions involving the patient's daily life activities.
2M. **Support network, living situation or help in emergency situation** – Discussions on the patient's support network (family, friends, etc.), living situation, or how to get help in an emergency situation.
2N. **Advanced medical directives/end of life** – Discussions involving advanced medical directives/end of life situations or living wills.
2O. **Family history** – Discussions involving the patient's family history for a medical condition.
2P. **Patient home monitoring information** – Discussions involving measures that the patient takes at home such as blood sugars, blood pressures, etc.
2Q. **Preventive screening** – Discussions involving the patient's preventative screening, e.g. mammograms, colon cancer screening, prostate cancer screening. If it is obvious that the patient has cancer already, then this should be coded as "2A. Problem information".
2R. **Test Results** – Discussions involving a test, e.g. laboratory or radiology test, the patient has had or will have done (unless the test is being recommended).
2S. **Physical exam** – Discussions involving findings from a physical exam done on the patient, or a physical exam in general.
2T. **Diagnosis** – Discussions involving a current or previous diagnosis given by the doctor present at the current patient visit. A diagnosis given by another doctor should be coded as this as well.
2U. **Secondary Patient** – Medical questions and concerns not relating to the patient but to a friend, family member, etc., e.g. the patient asks the physician for a prescription refill for his wife who is also a patient of they physician.
2V. **Previous appointments with same doctor** – Discussions about any previous appointments with that same doctor.
2W. **Review of symptoms/systems** – The doctor interviews the patient on other symptoms or systems not associated with the patient's chief complaints/problems. For this code the doctor is the one who asks the questions about these systems.

- 2W(1). **Skin**
- 2W(2). **Neurological**
- 2W(3). **Gastrointestinal**
- 2W(4). **Constitutional (fever, weight loss)**
- 2W(5). **Eyes**
- 2W(6). **Ears, nose, mouth and throat**
- 2W(7). **Cardiovascular**
- 2W(8). **Respiratory**
- 2W(9). **Sleep**
- 2W(10). **Psychiatric**
- 2W(11). **Musculoskeletal/joints/feet**
- 2W(12). **Hematologic**
- 2W(13). **Sexual/genital/urinary**

2X. **Social Contact** – Doctor and patient make initial contact and greet. This also includes any conversation that sometimes occurs at the beginning of the visit (or at any other point – "chit-chat") between the doctor and patient that isn't related to the appointment (e.g. Doctor asks "What have your kids been up to?").
2Y. **"Anything else" question** – The doctor asks the patient if there is anything else that the patient would like to talk about or have looked at. This typically occurs towards the end of the patient visit.

2Z. **Other** – Discussions that can't be coded by any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

3. **Review patient information** – The doctor looks at or reads some type of patient information. There is no interaction with the patient. Use subcodes to identify where the information was reviewed from (a. EHR, b. paper chart, or c. scratch paper). If what the doctor is reviewing is not specified (e.g. "Doctor reviews note"), use the subcode "3BB. Other".

3A. **Chief complaint -** The doctor reviews information regarding the patient's chief complaint or reason for visit.

3B. **Problem information** –The doctor reviews information involving other patient problems or issues that the physician wants to discuss in addition to the chief complaint/reason for visit. If it is uncertain whether the information being discussed is separate from the chief complaint already coded, code it as problem information.

3C. **Patient's current medications** – The doctor reviews the medications that the patient is currently taking using either the EHR or paper chart as a reference.

3D. **Medications** – The doctor reviews information regarding the patient's old, current, or new medications.

3E. **Patient pharmacy** – The doctor reviews information regarding the patient's pharmacy, location, which one they want to use, etc.

3F. **Cost/access/insurance** – The doctor reviews information regarding cost, access to healthcare, or insurance. This DOES include medications and tests.

3G. **Allergies and adverse reactions** – The doctor reviews information regarding the patient's list of current/known allergies or adverse reactions to medications in general.

3H. **Drug/alcohol use** – The doctor reviews information regarding the patient's drug or alcohol use.

3I. **Tobacco use** – The doctor reviews information regarding the patient's tobacco use.

3J. **Exercise/diet** – The doctor reviews information regarding the patient's exercising habits or diet.

3K. **Vitals or weight** – The doctor reviews information regarding the patient's vital signs, e.g. blood pressure, temperature, pulse/heart rate, height or weight.

3L. **Daily life activities** – The doctor reviews information regarding the patient's daily life activities.

3M. **Support network, living situation or help in emergency situation** – The doctor reviews information regarding the patient's support network (family, friends, etc.), living situation, or how to get help in an emergency situation.

3N. **Advanced medical directive/end of life** – The doctor reviews information regarding the patient's advanced medical directive/end of life situations or living wills.

3O. **Family history** – The doctor reviews information regarding the patient's family history for a medical condition.

3P. **Patient home monitoring information** – The doctor reviews information regarding the measures that the patient takes at home such as blood sugars, blood pressures, etc.

3Q. **Preventive screening** – The doctor reviews information regarding the patient's preventive screening, e.g. mammograms, colon cancer screening, prostate cancer screening. If it is obvious that the patient has cancer already, then this should be coded as "3X. Past medical/surgical history" or "3B. Problem information" as appropriate.

3R. **Test results** – The doctor reviews information regarding a test, e.g. laboratory or radiology test, the patient has had or will have done.

3S. **Physical exam** – The doctor reviews results from a physical exam the patient had done.

3T. **Diagnosis** – The doctor reviews one of his/her previous diagnoses for the patient. A diagnosis reviewed from a different doctor should be coded as "Outside medical/counseling care".

3U. **Secondary patient** – The doctor reviews information regarding a different patient than the one in the current visit.

3V. **Previous appointments with the same doctor** – The doctor reviews information regarding the patient's previous appointments with that same doctor.

3W. **Nursing notes/clinic note** – The doctor reviews any notes written or typed by a nurse or other person that did the rooming before the doctor came in the room.

3X. **Past medical/surgical history/problem list** – The doctor reviews information regarding the patient's past medical, history, surgical history, or problem list (essentially a list of the past history).

3Y. **Outside medical/counseling care** – The doctor reviews information regarding any outside medical or counseling care the patient has received. Subcode what type of outside medical/counseling care the patient received if possible.

3Y(1). **ER/urgent care**

3Y(2). **Specialist/other doctors** – Includes any specialists or doctors other than the doctor the patient is currently visiting.

3Y(3). **Hospitalizations** – Includes hospitalizations and discharge summaries.

3Z. **Follow-up appointment information** – The doctor reviews information regarding the patient's follow-up appointment.

3AA. **Patient paper form** – The doctor reviews a paper form given by the patient.

3BB. **Other** – The doctor reviews any information that can't be coded with any of the above subcodes. If used in this manner, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

4. **Document Information** – The doctor writes down or types some type of patient information. Use subcodes to identify where the information was documented (a. EHR, b. paper chart, or c. scratch paper). If what the doctor is documenting is not specified (e.g. "Doctor reviews note"), use the subcode "4AA. Other".

4A.**Chief complaint** - The doctor documents information regarding the patient's chief complaint or reason for visit.

4B. **Problem information**– The doctor documents information regarding the patient's other problems.

4C. **Patient's current medications** – The doctor documents information regarding the medications that the patient is currently taking.

4D. **Medications** – The doctor documents information regarding the patient's old, current, or new medications.

4D(1). **Side effects** – The doctor documents information regarding the patient's side effects or risks of old, current or new medications.

4D(2). **Medication instructions** – The doctor documents patient's medication instructions, e.g. dosage, frequency, how to take, time of day, generic vs. brand, etc.

4D(3). **Compliance** – The doctor documents information regarding the patient's compliance with taking a medication, e.g. missed dose, how often, etc.

4D(4). **Effectiveness** – The doctor documents information regarding the patient's medication effectiveness.

4D(5). **Evidence regarding medication treatment** – The doctor documents information on evidence regarding medication treatment, such as citing a study that endorses the benefit of a medication for treating a particular condition.

4D(6). **Reason for medication** – The doctor documents information regarding why a medication is being prescribed or why the patient is currently taking a certain medication, i.e. the indication for a medication.

4D(7). **Refills needed** – The doctor documents information the patient's need for a refill of a medication.

4D(8). **Drug interactions** – The doctor documents information regarding possible drug interactions between medications.

4D(9). **Other** – Any other information the doctor documents that involves the patient's medications but can't be coded by any of the above subcodes. If used in this manner, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

4E. **Patient pharmacy** – The doctor documents information regarding the patient's pharmacy, location, which one they want to use, etc.

4F. **Cost/access/insurance** – The doctor documents information regarding cost, access to healthcare, or insurance. This DOES include medications and tests.

4G. **Allergies and adverse reactions** – The doctor documents information regarding the patient's list of current/known allergies or adverse reactions to medications in general.

4H. **Drug/alcohol use** – The doctor documents information regarding the patient's drug or alcohol use.

4I. **Tobacco use** – The doctor documents information regarding the patient's tobacco use.

4J. **Exercise/diet** – The doctor documents information regarding the patient's exercising habits or diet.

4K. **Vitals/weight** – The doctor documents information regarding the patient's vital signs, e.g. blood pressure, temperature, pulse/heart rate, height or weight.

4L. **Daily life activities** – The doctor documents information on the patient's daily life activities.

4M. **Support network, living situation or help in emergency situation** – The doctor documents information regarding the patient's support network (family, friends, etc.), living situation, or how to get help in an emergency situation.
4N. **Advanced medical directive/end of life** – The doctor documents information regarding the patient's advanced medical directive/end of life situations or living wills.
4O. **Family history** – The doctor documents information regarding the patient's family history for a medical condition.
4P. **Patient home monitoring information** – The doctor documents information regarding the measures that the patient takes at home such as blood sugars, blood pressures, etc.
4Q. **Preventive screening** – The doctor documents information regarding the patient's preventive screening, e.g. mammograms, colon cancer screening, prostate cancer screening. If it is obvious that the patient has cancer already, then this should be coded as "4X. Past medical/surgical history" or "4B. Problem information" as appropriate.
4R. **Test results** – The doctor documents information regarding a test, e.g. laboratory or radiology test, the patient has had or will have done.
4S. **Physical exam** – The doctor documents information regarding a physical exam performed on the patient.
4T. **Diagnosis** – The doctor documents information regarding the diagnosis for the patient.
4U. **Secondary patient** – The doctor documents information regarding a different patient than the one in the current visit.
4V. **Treatment plan** – The doctor documents the treatment plan for the patient.
4W. **Review of symptoms/systems (not associated with main problem)** – The doctor documents information on the patient's other symptoms or systems not associated with the patient's chief complaints.

- 4W(1). **Skin**
- 4W(2). **Neurological**
- 4W(3). **Gastrointestinal**
- 4W(4). **Constitutional (fever, weight loss)**
- 4W(5). **Eyes**
- 4W(6). **Ears, nose, mouth and throat**
- 4W(7). **Cardiovascular**
- 4W(8). **Respiratory**
- 4W(9). **Sleep**
- 4W(10). **Psychiatric**
- 4W(11). **Musculoskeletal/joints/feet**
- 4W(12). **Hematologic**
- 4W(13). **Sexual/genital/urinary**

4X. **Past medical/surgical history/problem list** – The doctor documents information regarding the patient's past medical, history, surgical history, or problem list (essentially a list of the past history).
4Y. **Outside medical/counseling care** – The doctor documents information regarding any outside medical or counseling care the patient has received. Subcode what type of outside medical/counseling care the patient received if possible.

- 4Y(1). **ER/urgent care**
- 4Y(2). **Specialist/other doctors** – Includes any specialists or doctors other than the doctor the patient is currently visiting.
- 4Y(3). **Hospitalizations** – Includes hospitalizations and the discharge summary.

4Z. **Follow-up appointment information** – The doctor documents information regarding the patient's follow-up appointment. Giving the patient follow-up appointment information has its separate code in the "Print/Give Patient" section.
4AA. **Other** – The doctor documents any information that can't be coded with any of the above subcodes. If used in this manner, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

5. **Perform**

5A. **Procedure** – The doctor performs a procedure on the patient.
5B. **Vitals** – The doctor checks the patient's vitals, e.g. blood pressure, pulse, temperature, pulse oximetry.

5C. **Physical exam** – The doctor performs a physical exam on the patient. This includes the patient getting up and sitting back down from the exam table. Includes the doctor just "looking" at something briefly while the patient is sitting in the chair.
5D. **Hand sanitization** – The doctor sanitizes his/her hands.
5E. **Immunization** – The doctor gives the patient a vaccination.
5F. **Fill out patient form** – The doctor fills out a form given by the patient.
5G. **Dictate** – The doctor dictates during the patient visit.
5H. **Telephone call/answer phone/pager** – The doctor makes/takes a telephone call or answers a page.
5I. **Calculation**
    5I(1). **BMI** – The doctor calculates the patient's body mass index.
    5I(2). **Medication dosage** – The doctor calculates the patient's medication dosage.
5J. **Login to computer/EHR** – Doctor logs onto computer, EHR, or opens the patient's electronic or paper chart.
5K. **Open template** – Doctor opens any type of electronic or paper template such as a Well Child Check form, Physical Exam form, etc.
5L. **Other** – The doctor performs some other task that can't be coded with any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

6. **Recommend/Discuss Treatment Options** – The doctor recommends or presents options to the patient as treatment for a problem. This includes discussion involving the recommendation or options given. If the recommendation or option given goes into more detail that can be coded with a different code, then the different code should be used. For example, the doctor recommends a medication and then explains to the patient what the medication does. This should be coded as "6A. Recommend Treatment – Medication" and "2D6. Gather Information from Patient – Medications – Reason for medication".
6A. **Medication** – The doctor recommends to the patient a new medication, a change in a current medication, continuing the same medication, or discontinuing a medication.
6B. **Diet/exercise** – The doctor recommends the patient a diet or exercise (a specific exercise or just to exercise in general).
6C. **Test/preventive screening** – The doctor recommends the patient has a test or preventive screening done.
6D. **Procedure** – The doctor recommends the patient has a procedure done, e.g. biopsy, surgery, colonoscopy, etc.
6E. **Follow-up appointment** – The doctor recommends that the patient come back for a follow-up appointment or doctor and patient discuss a follow-up appointment (and possibly what will be covered during it) if appointment is already scheduled.
6F. **Referral to specialist/other doctor** – The doctor refers the patient to a specialist or another doctor for evaluation and/or treatment.
6G. **Home remedy** – The doctor recommends the patient a home remedy, e.g. ice, rest, etc.
6H. **Non-traditional treatment** – The doctor recommends the patient a non-traditional treatment, e.g. acupuncture, massage, chiropractor, etc.
6I. **Observation/wait and see/do nothing** – The doctor recommends they wait and see what happens or do nothing.
6J. **Immunization** – The doctor recommends the patient gets a vaccine.
6K. **Home monitoring** – The doctor recommends the patient does home monitoring, e.g. blood pressure, blood sugar, etc.
6L. **Get additional information** – The doctor recommends that they get additional information on the problem, e.g. from literature, the patient's old record, etc.
6M. **Other** – The doctor gives the patient a recommendation that can't be coded with any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

7. **Look Up**
7A. **Treatment information** – The doctor looks up treatment information in a book, on the internet, or some other electronic/paper source.
7B. **Referral doctor** – The doctor looks up information on a referred doctor.

7C. **Drug information** – The doctor looks up drug information in a book, on the internet, or some other electronic/paper source.
7D. **Other** – The doctor looks up something else that can't be coded with any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

8. **Order** – If possible subcode what the doctor uses to make the order as either a. EHR or b. paper.
8A. **Medication** – The doctor orders a new medication for the patient.
8B. **Test** – The doctor orders a test for the patient.
8C. **Referral to specialist** – The doctor orders a referral to a specialist for the patient.
8D. **Procedure** – The doctor orders a procedure for the patient.
8E. **Immunization** – The doctor orders a vaccine for the patient.
8F. **Other** – The doctor orders something else that can't be coded with any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

9. **Communicate** – The doctor communicates in person with someone other than the patient or the patient's caregiver.
9A. **Nurse**
9B. **Other healthcare provider**

10. **Print/Give Patient**
10A. **Paper prescription** – The doctor gives the patient a paper prescription.
10B. **Medication information/instructions** – The doctor physically gives the patient medication information or instructions.
10C. **Test order form** – The doctor gives the patient a test order form.
10D. **Sample medication** – The doctor gives the patient sample medication.
10E. **Disease/problem information** – The doctor gives the patient written information on a disease or problem.
10F. **Home monitoring card/paper** – The doctor gives the patient a card or paper for home monitoring.
10G. **Medical equipment** – The doctor gives the patient medical equipment or supplies, e.g. splint, bandage, gauze, etc.
10H. **Follow-up appointment information** – The doctor gives the patient follow-up appointment information on a form or piece of paper.
10I. **Appointment summary** – The doctor gives the patient an appointment summary form or paper.
10J. **Referral information** – The doctor gives the patient referral information for a specialist or other doctor.
10K. **Other** – The doctor gives the patient something else that can't be coded with any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

11. **Appointment Wrap-up**
11A**. Walk patient**
11A(1). **Nurse station** – The doctor walks the patient to the nurse station.
11A(2). **Waiting room** – The doctor walks the patient to the waiting room.
11A(3). **Labs** – The doctor walks the patient to the lab.
11A(4). **Radiology** – The doctor walks the patient to radiology.
11A(5). **Reception** – The doctor walks the patient to the reception desk.
11B. **Go to** – The doctor goes somewhere outside the patient exam room DURING the patient visit.
11B(1). **Office** – The doctor goes to his/her office.
11B(2). **Nurse station** – The doctor goes to the nurse station.
11B(3). **Waiting room** – The doctor goes to the waiting room.
11B(4). **Labs** – The doctor goes to the lab.
11B(5). **Radiology** – The doctor goes to radiology.
11B(6). **Reception** – The doctor goes to the reception desk.
11B(7). **Sample medication cabinet** – The doctor goes to the sample medication cabinet.
11B(8). **Another Patient** – the doctor goes to see another patient during appointment and then comes back to original patient.

11B(9). **Other** – The doctor goes somewhere else that can't be coded by any of the above subcodes. If used, it should be highlighted to be brought up for discussion as to whether or not a different code could be used or a new code should be added.

11C. **Log out of computer/EHR** - The doctor logs out of the computer, EHR, or closes the patient's electronic or paper chart**.**

12. **Leave room** – The doctor leaves the room at the end of the patient visit or during the patient visit.

* Add "– C" to a code to indicate that a caregiver was involved with the task instead of the patient.
* Add "– S" to a code to indicate that a student who is following the doctor performed the task instead of/for the doctor.