



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **Community Health Representative System**

**(BCH)**

**User Manual Supplement**

Version 1.0  
July 2007

Office of Information Technology (OIT)  
Division of Information Resource Management  
Albuquerque, New Mexico

## Preface

This manual provides supplemental information to the Community Health Representative System v1.0 package.

It is a guide for Community Health Representatives (CHRs) and other individuals who need to document CHR services and activities performed. All staff – whether fulltime, part-time, and administrators, who are paid out of CHR program funds, should document their services using CHR PCC.

An appendix to this document includes documentation forms used by CHRs.

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## 1.0 Encounter Records

This document is intended help you provide correct coding of CHR services and activities, and accurate completion of the forms.

CHR PCC Encounter Forms are used for documenting *all* CHR services and activities. Although the focus is on documentation of patient services, it is to be used for *all* CHR activities. Documenting all services and activities provides a complete picture of a CHR record, such as administrative/management, community development, training and leave time.

CHRs should record *only* the services they perform. For example, do not record the patient's weight if you ask the patient what he or she weighs. Record the patient's weight only if you take the reading from a scale. All measurements that you record are part of the patient's medical record and are used to make health care decisions. Misinformation could cause harm to the patient, so all measurements and documentation must be as accurate as possible.

CHRs have three documentation forms from which they may choose to record service/activity data, as described in this section. Some of the information recorded on these forms will go into the patient's medical record through the Resource and Patient Management System (RPMS) using the CHR Patient Care Component (PCC) data entry system.

**Note:** CHRs may use any of the above forms to document any CHR activities and services. Each of the following forms contain all of the required fields for data entry and reporting.

### 1.1 IHS-535

IHS-535: The CHR Comprehensive PCC Encounter Record which incorporates the SOAP (Subjective, Objective, Assessment, Plans) approach to documenting health care.

### 1.2 IHS-535-1

IHS-535-1: The CHR Abbreviated PCC Encounter Record. It features the required fields, frequently used values, and only the assessments sections of SOAP charting. If you need to document more extensively for a specific patient (such as a new patient or a patient with complex health issues) it is recommended to use the IHS-535 Comprehensive Form.

## 1.3 IHS-962

IHS-962: The CHR Group PCC Encounter Record which features the required fields. This provides a single-form method to collectively capture repetitive individual patient services in a group setting. It also provides a more efficient data entry process for encounters of this type.

### 1.3.1 Data Entry Methods

There are two methods for entering data:

- CHR PCC Direct: Allows a straightforward “live” connection with an RPMS facility. The data entered *drops* directly into the patient’s chart.
- CHR PCC Remote: Allows the data to be entered from any location, but requires a dial up to a RPMS facility to drop the data into the patient’s chart. Both methods allow the information to be available to other health care providers who access the patient’s chart.

## 1.4 General Instructions for All Forms

### 1.4.1 Confidential Records

All patient information is confidential and is protected by law. Patient records and health information shall be stored, carried and protected to ensure the privacy of the patient and the patient’s health information. The Resource Patient Management System (RPMS), where patient data and information is accessed and entered for the CHR Program, requires individuals to meet local facility protocols and guidelines for access. Speak with your local facility/facilities Site Manager(s) to determine what training is required for you to gain access to the RPMS CHR PCC Package.

For more information on ethics, privacy act, the Health Insurance Portability and Accountability Act (HIPAA), and confidentiality of patient records, speak to your local facility’s Medical Records Director, IHS Area Office CHR Coordinator, or the person at your Area IHS who is responsible for the training regarding these topics.

### 1.4.2 Shaded Sections

Required fields are shaded sections on the form that *must* be filled out in order for the CHR PCC to be electronically processed. Please note the following example.

ASSESSMENT - PCC PURPOSE OF VISIT			
Health Problem Code (see back)	Service Code (see back)	A.1.1.1  Minutes	Narrative
		A.1.1.2	
		A.1.1.3	
		A.1.1.4	

Figure 1-1: Sample of shaded areas on a form

If you do not fill out a required field it will be returned by RPMS with an error message.

### 1.4.3 Write Legibly

Print clearly, using block printing – this is a documented record. By writing clearly, it's easier for other people, including you, to read the form quickly and efficiently. In addition, your documentation may need to be entered by another person. Writing legibly will reduce data entry errors and potentially reduce your own frustration when trying to review your notes in the future.

Detailed instructions for filling out the various forms appear in following sections of this document.

## 2.0 IHS-535 CHR Comprehensive PCC Encounter Record

An example of the IHS-535 CHR Comprehensive PCC Encounter Record appears in *Appendix B: Forms*. Printable forms are available in the supplemental document *Community Health Representative System CHR PCC Forms*.

### 2.1 Header Information

The header consists of the first four fields in the first row. Required fields are indicated by shading.

#### Residence

This space is used to document the location of a patient residence. This is helpful during the delivery of care for contacting the patient and/or his/her family; especially when a patient resides at a temporary location due to health, social or other emergent reasons. This is common when the patient is older and is being cared for by relatives or close friends. Even if the location is their permanent residence, write their address or location in the blank field. The computer will accept 3 to 30 characters.

#### Program Code

The program code is your tribal CHR program name. You may also write out your CHR Program's unique 7-digit program code. The first two digits identify the IHS Area, the second two digits identify the Service Unit, and the last three digits identify the Tribe. If you don't know your program code, write your Tribal program name. The computer can display your program code if you enter your Tribe's name.

An example of a Program Code is "5055004" (Apache Tribe of Oklahoma).

<p><b>Data Entry Note:</b> You can type the first three initials of the Tribe's name and hit enter and it will either automatically fill it in, or a list will come up from which you may choose. This tip helps eliminate key strokes.</p>
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#### Provider Code

For your CHR Provider Code you may either use your name, initials or your CHR Provider Code.

The CHR Provider Code is assigned at the RPMS facility site by the Site Manager. The first three characters represent the provider's discipline. The provider discipline code for Tribal CHRs is **353**. The last three characters usually consist of the CHR's initials.

An example of a CHR Provider Code for Jane A. Doe would be 353JAD.

**Data Entry Note:** At the CHR Provider Code prompt, you may enter the code, your initials, or last name.

The following screen shot shows the upper right corner of the form where entries for Provider Code and Date of Service can be made.

PROVIDER CODE	DATE OF SERVICE
3 5 3	
	Pulse
	Resp.
	BP

Figure 2-1: Sample of Provider Code and Date of Service boxes on form

### Date of Service

This space is to record the date of which this service took place. This is a *required data element and must always be included on the form*. An example of a date of service is 081802 for August 18, 2002.

**Data Entry Note:** Typing a T will give you the current day's date. You can also type T-1 for yesterday's date or T-2 for two days ago, etc.

## 2.2 Subjective Information

The subjective information section is designed to capture information from the patient's point of view. It is the information the patient tells you – the patient's story, if you will. It provides the foundation and direction for making an assessment during the visit. This is why it is very important to include the most serious of complaints in the subjective information section.

Subjective information consists of statements made by the patient that would not necessarily be apparent just by observing the patient. For example, the patient might report feeling pain, fever or dizziness. The CHR should begin their narrative with "Patient states..." Report any concerns, requests, or the patient's mental state if relevant.

By including the pertinent details of their complaint; you, other CHR staff and the medical staff can be more effective because:

1. You will understand and be able to describe how long the patient has had this complaint.

2. You will be able to describe how the problem is impacting the patient's life.
3. You will understand and be able to describe how severe the patient thinks the complaint is.

## 2.3 Objective Information

Objective information is meant to capture only the information that can be confirmed through what you observe (hear, see, touch, smell), such as bleeding, bruises, abrasions, burns, wounds, infections, etc.

When taking vital signs such as a pulse, this can be an excellent time to observe other physical conditions that you might not ordinarily catch just by looking at a person. For example, you can feel body tremors when holding the person's wrist, or notice patient discomfort when touching the patient's skin.

## 2.4 Assessment – PCC Purpose of Visit

All of this section is shaded, which means all of the information is required, and must be completed, in order for the form to transfer without errors. This section includes the Health Problem Code, Service Code, Service Minutes and Narrative. An example of that part of the form follows.

ASSESSMENT - PCC PURPOSE OF VISIT			
Health Problem Code (see back)	Service Code (see back)	Service Minutes	Narrative

Figure 2-2: Sample of Assessment area of form

One of the primary purposes of CHR PCC is to capture patient encounters and services. The assessment section is one of two sections where information can drop into the patient's chart. It is essential for the proper codes and related descriptions to be included for each service performed.

**Note:** The information within patient assessments will migrate to the medical record *if* a service code is used that drops into the patient's chart. See "Service Codes" to determine which codes drop into the patient's chart. Make sure your coding is accurate.

Six lines are visible for documenting assessment services and activities, but the computer will accept up to 13 lines of assessment services and activities. If you need more than six lines, you can complete an additional PCC or attach another piece of paper. If you attach them or write them elsewhere on the form, make a note for yourself or the data entry clerk mentioning that there are more services to enter and provide instructions as to their location.

**Note:** The first Health Problem Code used in this section will be viewed and reported as the Primary Purpose of Visit.

### Health Problem Code

Record the two-letter health problem code that best describes the health area in which you are providing service, receiving training, or in leave status. When selecting a health problem code, select the health problem code that best fits.

**Note:** Only use Health Problem codes combined with service codes that pass to the chart if you know for a fact that the patient has received this diagnosis.

Ways to determine whether or not a patient has been diagnosed with a specific health problem include:

- Doctor
- Public Health Nurse
- Pharmacy
- Medical Records

**Note:** If the diagnosis was not received at the facility where you enter data, only use Service Codes which will not pass to the patient's RPMS chart because using service codes that pass to the chart will create a new diagnosis and CHR's do not diagnose.

If a diagnosis came from outside the IHS, Tribal or Urban system, you can also use this opportunity to do an appropriate referral so the patient can be accounted for by the IHS/Tribal facility's health problem registries. An at-a-glance list of the health problem codes are on the back of the forms. The Health Problem Code descriptions are located in this manual and will assist you in coding properly.

**Data Entry Note:**

When the same health problem code is used more than once on a form:  
 Many times more than one service is provided for the same health problem. For example you are providing service to a patient that is a diagnosed diabetic (DM = Diabetes), you check their blood sugar, provide health education and check and repair their crutches. When entering the data the first health problem code DM will be allowed to be entered. However, once any health problem code is entered in the computer, subsequent identical health problems must be entered enclosed in double quotations for the computer to accept it for that form.

The following table provides an example of health problem code detail information.

Health Problem	Service Code	Service Minutes	Narrative
DM	PC	10	Checked Blood Sugar-121
"DM"	HE	15	Carb Control
"DM"	CM	10	Checked condition of crutches; tightened screws

Figure 2-3: Example table of health problem codes and descriptions

**Service Codes**

Record the two-letter service code. The Service Code describes what you are doing. An at-a-glance list of Service Codes is located on the back of the form. The list of service code definitions are provided in this manual.

**Service Minutes**

Use this space to record the Service Minutes – the approximate amount of time you spent in performing the specific service.

**Narrative**

In this space record a brief description regarding the specific service performed. This description should be brief, clear and factual. The narrative will appear on the health summary in the patient's medical chart. It should assist other providers in effectively extending patient care. Because of this potential scrutiny, our data needs to furnish clear collegial communication (no opinions or assumptions). This should help to assure patients that their best interests are actively safeguarded.

The narrative is limited to 80 characters per assessment on the computer, however only 76 characters are allowed in the chart. A "space" is considered as one character, use your facility accepted abbreviations to help reduce the number of characters used. The narrative section does drop into the patient's chart *if* a service code is used that drops into the patient's chart. See "Service Codes" to determine which codes drop into the patient's chart. (Reminder: All the service codes which appear in the left column of the service code section drop in to the chart.)

## 2.5 Plans/Treatments/Education/Medications Section

Immediately following the Assessment – PCC Purpose of Visit section of the form entries can be made for plans, treatments, education and/or medications. This section is designed to allow the CHR to record follow up notes that include numerous aspects of the plan of care. All information recorded in this section should focus on future activities or plans. It should not mention current patient conditions or activities as these should already be present in the Subjective and Objective Information sections. Future plans or follow up notes may include the following:

- Any necessary follow up health care status checks
- Scheduling of medical appointments
- List of medications prescribed to the patient – to be used as a future reference
- Educational lesson plans
- Description and schedule of the next CHR task
- Description and schedule of patient's task that has been requested by the CHR or other qualified health care professional
- Schedule for verifying patient task
- Any resources contact on behalf of the patient

## 2.6 Activity Location/Referral/Evaluation

The bottom third of the form is used to report the activity location, referral, evaluation, travel time and number served. The fields that are shaded are required fields. Please see the following example.

ACTIVITY / REFERRAL / EVALUATION (Check ONE)			
<b>ACTIVITY LOCATION:</b>	<b>REFERRED TO CHR BY:</b>	<b>REFERRED BY CHR BY:</b>	<b>EVALUATION:</b>
<input type="checkbox"/> Home (1)	<input type="checkbox"/> Medical (1)	<input type="checkbox"/> Medical (1)	<input type="checkbox"/> Level of understanding improved
<input type="checkbox"/> CHR Office (2)	<input type="checkbox"/> Nursing (2)	<input type="checkbox"/> Nursing (2)	<input type="checkbox"/> Level of compliance improved
<input type="checkbox"/> Community (3)	<input type="checkbox"/> Dental (3)	<input type="checkbox"/> Dental (3)	<input type="checkbox"/> Level of functioning improved
<input type="checkbox"/> Radio/Telephone (4)	<input type="checkbox"/> Eye (4)	<input type="checkbox"/> Eye (4)	<input type="checkbox"/> Problem resolved
<input type="checkbox"/> Hospital/Clinic (5) Name: _____	<input type="checkbox"/> Social Worker (5)	<input type="checkbox"/> Social Worker (5)	
	<input type="checkbox"/> Behavioral Health (6)	<input type="checkbox"/> Behavioral Health (6)	Travel Time: _____ min.
	<input type="checkbox"/> Other Professional (7)	<input type="checkbox"/> Other Professionals (7)	Number Served: _____
<input type="checkbox"/> None (6)	<input type="checkbox"/> Technician (8)	<input type="checkbox"/> Technician (8)	
<input type="checkbox"/> School (7)	<input type="checkbox"/> Agency/Program (9)	<input type="checkbox"/> Agency / Program (9)	
	<input type="checkbox"/> Family/Self/Community (10)	<input type="checkbox"/> Family / Self / Community (10)	
	<input type="checkbox"/> Other CHR Program (11)	<input type="checkbox"/> Other CHR Program (11)	

Figure 2-4: Sample of form section used to record activity, referral, and/or evaluation information

### Activity Location

Check the box that *best describes* the setting where the service took place. The location that best describes where the activity took place is not always where the activity began. There are seven codes to describe location where the service occurred.

- Home: Patient's primary residence.
- CHR Office: Regularly assigned office space of the CHR program or satellite office; when seeing a patient in a CHR's office which is located within a clinical facility code "office."
- Community: This setting includes all locations in which a service is performed other than a patient's home, school, clinic or the CHR office. This code also includes Tribal Office, state government office or social agency.
- Radio/Telephone/Email: Includes activities that are taking place over the telephone, by radio transmission or by email. Such as when a CHR phones a patient to monitor his/her conditions or calls to make an appointment for a patient.
- Hospital/Clinic: This setting includes all hospital or clinic locations. *If* the hospital or clinic is an IHS or Tribal facility include the name of the facility.
- None: This setting should *only* be used with Leave Time.
- School: Includes all school settings from day care settings through college; also includes vocational schools.

**Data Entry Note:** Instead of typing the whole location category name, you may enter the number associated for reduced key strokes.

### Referral Codes

Referral codes include data from referrals provide a picture of how the CHR program coordinates with other community resources and use other available resources.

**Referred to CHR By**

Check the box that *best describes who referred the patient to you*. If there is no referral then leave the box blank.

**Referred by CHR To**

Check the box that *best describes to whom you referred the patient*. If there is no referral, then leave the box blank.

There are eleven categories for placing a referral:

1. Medical - Medical Doctor (M.D. or D.O.) including general physician and specialists such as Ophthalmologist, Pediatrician, Obstetrician, Gynecologist or Psychiatrist.
2. Nursing – Includes Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Public Health Nurse (PHN), or other type of nursing personnel.
3. Dental – Dentist, Orthodontist, Dental Hygienist, or other dental health professional.
4. Eye – Optometrist or Optician.
5. Social Worker – Professional member of social service or other agency providing social services.
6. Behavioral Health Professional – Substance Abuse Counselor, Psychologist, or other professional specializing in Behavioral Health services.
7. Other Professional – Psychologist, Podiatrist, Homoeopathist, Chiropractor, Traditional Healer, Pharmacist, Physical Therapist, Sanitarian, or any other professional category not covered above.
8. Technician – X Ray Technician, Lab Technician, etc.
9. Agency/Program – Non-medical health and social service programs and agencies. Includes the Bureau of Indian Affairs, State and local government, social service and welfare agencies, private non-profit health and social service programs, schools, housing authorities, group homes, nursing homes, etc.
10. Family/Self/Community – Family (a group of persons sharing a common dwelling)/Self (one independent person)/ Community (a group of people with common interests living in a particular place or region). Includes “walk-in” cases where the patient seeks CHR care without recommendation from other health care personnel. This code includes cases that the CHR found as a result of community or family member’s suggestion to the CHR.

11. CHR – From your own CHR program or from other CHR program this code refers to other CHRs, not you the reporter.

**Data Entry Note:** Instead of typing the entire referral category name, you may enter the number associated for less keystrokes.

### **Evaluation**

Check the box that best describes your evaluation of the outcome of this patient service. If there was no change in the patient's status as a result of your visit/care, *do not* check a box for evaluation.

### **Travel Time**

Record the approximate amount of time (to the nearest five minutes) that you spent traveling to and from the setting, whether on foot, in a vehicle or in the air. Travel time refers to NON-SERVICE TIME, this is time you spent alone without patients, medications, supplies or equipment.

If you are traveling with one or more CHRs, each CHR should record the same travel time. For example, if CHR #1 and CHR #2 travel together leaving the same location to another location, and it takes them 120 minutes to arrive, each CHR would document 120 minutes travel time, because it took both of them 120 minutes to arrive, not 60 minutes each.

### **Number Served**

Record the number of persons served. If you counseled a mother about breast-feeding her newborn, count only the mother as one person served, as the primary service recipient. Likewise if you performed CPR on a child, count 1 as number served, even though others may have been present.

If no patient is being served (training, administrative or leave time) record a zero (0) because it is a required field. When serving a group, record the total number of people receiving the same service.

Count only the person with whom you actually made contact with during the service. An exception to this rule would be when you use the Service Code Case Management to reflect completing a service on behalf of a patient. Case Management allows you to document that a patient was served without you actually making contact with the patient during that service.

## 2.7 Measurements/Test

The Patient Vital Sign Information is not displayed with a separate category header, but is located in the column on the far right side of the form. The information within this section will migrate to the medical record. This information need only be supplied if you performed the measurements.

**Note:** Each Program should have established protocols for acceptable ranges of vital signs and tests as well as what action to follow if a client's vital signs or test results fall outside those acceptable ranges.

Be extra careful to insure accuracy on all these measurements – somebody's life depends on it.

### **Temp (Temperature)**

This space is used to record the patient's temperature (e.g. 99°F). Note the method by which the patient's temperature was taken (oral or anal) in the narrative portion. All temperatures should be taken in Fahrenheit. For the computer to accept a temperature it must be within a range of 94°F and 109.9°F.

### **Pulse**

This space is to record the patient's pulse in beats per minute (e.g., 78). Measure the heart rate at the wrist or in the neck in beats per minute. For the computer to accept a pulse it must be within a range of 30 and 250.

### **Resp (Respirations)**

This space is to record the patient's rate of respiration in number of breaths per minute (e.g., 18). For the computer to accept the respirations it must be within a range of 8 to 90 breaths per minute.

### **BP (Blood Pressure)**

This space is to record the patient's blood pressure reading. Record the systolic reading on the left, on the diastolic reading on the right of the dark solid line. For example: 115/72. In order for the computer to accept the blood pressure reading the systolic must be between 20 and 275 and diastolic must be between 20 and 200. If you want to record more than one reading, record the additional readings in the narrative of the Assessment section.

**WT (Weight)**

This space is to record the patient's weight. Be sure to check the appropriate unit of measure box, indicating whether the weight was measured in grams (GM), kilograms (KG), or pounds and ounces (LB-OZ). Example: 185 lbs. For the computer to accept the weight it must be within range of 1 to 340 kilograms, 1000 to 340000 grams or 2 to 750 pounds.

**HT (Height)**

This space is used to record the patient's height. Be sure to check the appropriate unit of measure box, indicating whether the height was measured in centimeters (CM) or inches (IN). Record height in inches: example 73 IN, do not record height in feet and inches (6'1"). For the computer to accept the height must be in the range of 10 to 80 inches and 26 to 203 centimeters.

**Head (Head Circumference)**

This space is to record the patient's head circumference. Be sure to check the appropriate measure box indicating whether the circumference is measured in centimeters (CM) or inches (IN). Head circumference will generally be recorded only for infants and young children. For the computer to accept the head circumference must be within 10 to 30 inches or 26 to 76 centimeters.

**Body Mass Index (BMI)**

This space is to record the patient's BMI. BMI is a measure of body fat based on height and weight that applies to both *adult* men and women. In order for the computer to accept BMI, you must enter height and weight. BMI provides a reliable indicator of body fat for most people and is used to screen for weight categories that may lead to chronic health problems. For the computer to accept BMI, enter a value between 9 and 80.

**Waist Circumference**

Use this space to record the measurement in inches of the patient's waist. To determine a patient's waist circumference locate the iliac crest (hip bone) by pressing on the hip bones with your fingers, place the measuring tape right above the hip bone. It is a good indicator of abdominal fat which is another predictor of risk, when combined with BMI it provides an indicator for developing heart disease and other chronic diseases. As a general rule, this risk increases with a waist measurement of over 40 inches in men and over 35 inches in women. For the computer to accept Waist Circumference enter a value between 20 and 99.

**Vision – Uncorrected**

This space is to record the patient's uncorrected vision. Record the value for the right eye in the space with the "R". Record the value for the left eye in the space with the "L". Example: 40/30. For the computer to accept the uncorrected vision range must be within 10 to 999. The first number 20/(the distance for the testing) is assumed. Therefore, only enter value of the test result for the eye being tested in the available field.

**Vision – Corrected**

This space is to record the patient's corrected vision (i.e., when wearing glasses or contact lenses). Record the value for the right eye in the space with the "R". Record the value for the left eye in the space with the "L". Example: 20/20. For the computer to accept the uncorrected vision range must be within 10 to 999. The first number 20/(the distance for the testing) is assumed. Therefore, only enter value of the test result for the eye being tested in the available field.

## 2.8 Tests

The test information section should be used to record the results of medical tests, if you collect the values. If you collected a sample for the test but did not perform it, record the results as a date (MM/DD/YYYY). Otherwise record the actual finding. The information within this assessment will migrate to the medical record. It is important that any and all values that are recorded are accurate to the best of your knowledge. This step is very important to the wellness of the patient and must be taken with care.

**PPD**

This space is to record the date or the result: (in mm) or as negative (0) of a patient's PPD (Purified Protein Derivative), or tuberculosis tests. For the computer to accept PPD enter a number between 0 and 40. Example: 2mm

**Blood Sugar**

This space is to record the date and the result of a patient's blood sugar reading. Example: 109. Only record the regular blood glucose reading here; the test that measures the levels of sugar in the blood at the time of the test.

**Hemoglobin A1c**

This space is to record the result of the patient's Hemoglobin A1c (HB A1c) blood sugar reading. HB A1c is a blood sugar test that measures a person's average blood sugar levels over the previous two or three months.

## 2.9 Reproductive Factors

Reproductive factors include the following items:

### LMP (Last Menstrual Period)

This space is to record the first day (MM-DD-YYYY) of the patient's LMP.

### FP Method

This space is to record the patient's Family Planning Method (e.g., IUD, Diaphragm, OCP – Oral Contraceptive Pill, etc.) If the patient specifically reports using no FP Method, write **none**.

FAMILY PLANNING METHODS LIST	CODE
BIRTH CONTROL PILLS	3
CERVICAL CAP	5
CONDOM	4
DEPO-PROVERA HORMONE	12
DIAPHRAGM	10
IUD	8
MORNING AFTER	14
NORPLANT	13
NOT NEEDED	1
NOT USED	2
OVULATION/RHYTHM	9
SPONGE/SPERMICIDE	6
TUBAL LIGATION	7
VASECTOMY	11

Figure 2-5: Sample of screen showing family planning methods list

## 2.10 Patient Information

The bottom left part of the form is used to record patient information.

HR#	Sex <input type="text"/>	Purpose of Referral by CHR
Name	Tribe	Insurer
SS#	Community of Residence	CHR Signature
Birthdate	Facility	

Figure 2-6: Sample of patient information section of form

This information is used to track the information back to the patient's medical record. If you are not sure about the information then it is better to leave the field empty. Try to make every effort possible to gather the correct information and take the time to complete this portion of the form. This helps ensure that the information is put in the correct person's medical file.

**Note:** Fill in all the Patient Information known for each patient visit whether or not they are registered. A service for an unregistered patient can still be reported and captured as a service provided, but will not merge in a patient record (see data entry note below).

**HR# (Health Record Number)**

This space is used to record the patient's Health Record Number.

**Name**

This space is to record the patient's name: Last Name, First Name, Middle Initial.  
Example: Roberts, Irene C.

**SS# (Social Security Number)**

This space is to record the patient's social security number.

**Birth date**

This space is to record the patient's date of birth (MM-DD-YYYY).

**Sex**

This space is to record the patient's gender, M = Male, F=Female.

**Tribe**

This space is to record the name of the tribe in which the patient is enrolled.

**Data Entry Note:** If you provide services to a Non-Indian person of an Indian household or an Indian Beneficiary, you may still capture that service.

At the Name prompt enter their name, when it says they are not in the database, do you want to look up again, type no. The new screen will allow you to type in their name and other patient identifying information. At the Tribe prompt type non-Indian, and select one of the two options.

**Community of Residence**

This space is used to record the name of the community in which the patient lives.

**Facility**

This space is used to record the name of the medical facility in which the patient's medical records are kept.

**Purpose of Referral by CHR**

If you referred the patient to another health care provider or program, use this space to give the reasons for the referral. The referral still must be made in the customary way for your program and or facility.

**Insurer**

This space is used to record the patient's insurer (e.g., Medicare, Medicaid and/or other third party payer, if private insurance, name company/plan). If the patient has no insurance, leave blank or write "none".

**CHR Signature**

When the form is completed, and checked, sign here to verify that you completed the activities described.

## 3.0 IHS-535-1 CHR Abbreviated PCC Encounter Record

This section contains instructions for filling out the IHS-535-1 CHR Abbreviated PCC Encounter Record.

An example of the IHS-535-1 CHR Abbreviated PCC Encounter Record appears in *Appendix B: Forms*. Printable forms are available in the supplemental document *Community Health Representative System CHR Forms*.

### 3.1 Header Information

The header consists of the first three fields in the first row. Each field is a required field and is indicated by shading.

#### CHR Provider Code

For your CHR Provider Code you can either use your name, initials or your CHR Provider Code.

The CHR Provider Code is assigned at the RPMS facility site by the Site Manager. The first three characters represent the provider's discipline. The provider discipline code for CHRs is "353". The last three characters usually consist of the CHR's initials. An example of a CHR Provider Code for Jane A. Doe would be **353JAD**.

**Data Entry Note:** At the CHR Provider Code prompt, you may enter the code, your initials or last name.

#### Program Code

The program code is your tribal CHR program name. Alternatively you can write out your CHR Program's unique 7-digit program code. The first two digits identify the IHS Area, the second two digits identify the Service Unit, and the last three digits identify the Tribe. If you don't know your program code, just write in your Tribal program name. The computer can display your program code by entering your Tribe's name.

An example of a Program Code is **5055004** (Apache Tribe of Oklahoma).

**Data Entry Note:** You can type the first three initials of the Tribe's name and hit enter and it will either automatically fill it in or a list will come up to choose from. This tip helps eliminate key strokes.

**Date of Service**

Write the date (MM-DD-YY) of the activity or service. An example of a date of service is **081802** for August 18, 2002.

**Data Entry Note:** Typing a T will give you the current day's date. You can also type **T-1** for yesterday's date, or **T-2** for two days ago, etc.

### 3.2 Assessment – PCC Purpose of Visit

This section is all shaded, which means it is required and must be completed in order for the form to transfer without errors. This section includes the Health Problem Code, Service Code, Service Minutes and Narrative. One of the primary purposes of CHR PCC is to capture patient encounters and services. The assessment section is also one of two sections where information can drop into the patient's chart. It is critical that the proper codes and related description is included for each service performed. The information within patient assessments will migrate to the medical record *if* a service code is used that drops into the patient's chart. See "Service Codes" to determine which codes drop into the patient's chart.

There are six lines to document assessment activities, but the computer will accept up to 13 lines of services and activities. If you need more than six lines, you can complete an additional PCC, attach another piece of paper, or write them in the additional notes section at the bottom of the form. If you attach them or write them at the bottom of the page make yourself or the data entry clerk a note that there are more activities to enter and provide instructions to their location.

<p><b>Note:</b> The first Health Problem Code used in this section will be viewed and reported as the Primary Purpose of Visit.</p>
---

3.2.1.1.1			ASSESSMENT - PCC PURPOSE OF VISIT
Health Problem Code (see back)	Service Code (see back)	Service Minutes	Narrative
		A.1.1.2	
		A.1.1.3	

Figure 3-1: Sample of assessment area of form

### Health Problem Code

Record the two-letter health problem code that best describes the health area in which you are providing service, receiving training, or in leave status. When selecting a health problem code, select the health problem code that best fits.

*Only use Health Problem codes combined with service codes that pass to the chart if you know for a fact that the patient has received this diagnosis.*

Ways to determine if a patient has been diagnosed with a specific health problem include:

- Doctor
- Public Health Nurse
- Pharmacy
- Medical Records

*If the diagnosis was not received at the facility where you enter data, only use Service Codes which will not pass to the patient's RPMS chart because using service codes that pass to the chart will create a new diagnosis and CHR's do not diagnose.*

If a diagnosis came from outside the IHS, Tribal or Urban system, you can also use this opportunity to do an appropriate referral so the patient can be accounted for by the IHS/Tribal facility's health problem registries. An at-a-glance list of the health problem codes are on the back of the forms. The Health Problem Code descriptions are located in this manual and will assist you in coding properly.

**Data Entry Note****When the same health problem code is used more than once on a form:**

Many times more than one service is provided for the same health problem. For example you are providing service to a patient that is a *diagnosed* diabetic (DM = Diabetes), you check their blood sugar, provide health education and check and repair their crutches. When entering the data the first health problem code DM will be allowed to be entered.

*However, once any health problem code is entered on a form, subsequent identical health problems must be entered enclosed in double quotations for the computer to accept it for that form.*

The following table provides an example of health problem code detail information.

Health Problem	Service Code	Service Minutes	Narrative
DM	PC	10	Checked Blood Sugar-121
"DM"	HE	15	Carb Control
"DM"	CM	10	Checked condition of crutches; tightened screws

Figure 3-2: Example table of health problem code information.

**Service Codes**

Record the two-letter service code. The Service Code describes what you are doing. An at-a-glance list of Service Codes is located on the back of the form. The list of service codes and definitions are provided in this manual.

**Service Minutes**

Use this space to record the Service Minutes – the approximate amount of time you spent in performing the specific service.

**Narrative**

In this space record a brief description regarding the specific service performed. This description should be brief, clear and factual. The narrative will appear on the health summary in the patient's medical chart. It should assist other providers in effectively extending patient care. Because of this potential scrutiny, our data needs to furnish clear collegial communication (no opinions or assumptions). This should help to assure patients that their best interests are actively safeguarded.

The narrative is limited to 80 characters per assessment on the computer, however only 76 characters are allowed in the chart. A "space" is considered as one character, use your facility accepted abbreviations to help reduce the number of characters used. The narrative section does drop into the patient's chart *if* a service code is used that drops into the patient's chart. See "Service Codes" to determine which codes drop into the patient's chart. (Reminder: All the service codes which appear in the left column of the service code section drop in to the chart.)

### 3.3 Activity/Referral/Evaluation

#### Activity Location

Check the box that *best describes* the setting where the service took place. There are seven codes to describe location where the service occurred. The location that best describes where the activity took place is not always where the activity began.

- Home: Patient's primary residence.

CHR Office: Regularly assigned office space of the CHR program or satellite office. When seeing a patient in a CHR's office which is located within a clinical facility code **office**.

- Community: This setting includes all locations in which a service is performed other than a patient's home, school, clinic or the CHR office. This code also includes Tribal Office, state government office or social agency.
- Radio/Telephone/Email: Includes activities that are taking place over the telephone, by radio transmission or by email. Such as when a CHR phones a patient to monitor his/her conditions or calls to make an appointment for a patient.
- Hospital/Clinic: Includes all hospital or clinic locations. Only if the hospital or clinic is an IHS or Tribal facility include the name of the facility.
- None: This setting should *only* be used with Leave Time.
- School: Includes all school settings from day care settings through college and includes vocational schools as well.

<p><b>Data Entry Note:</b> Instead of typing the whole location category name in, you may enter the number associated for reduced key strokes.</p>
--

#### Referral Codes

Data from referrals provide a picture of how the CHR program coordinates with other community resources and uses other available resources.

**Referred to CHR By**

Check the box that *best describes* who referred the patient to you. If there is no referral, then leave it blank.

**Referred by CHR To**

Check the box that *best describes* to whom you referred the patient. If there is no referral, then leave it blank.

There are 11 categories into which a referral may be placed:

1. Medical - Medical Doctor (M.D. or D.O.) including general physician and specialists such as Ophthalmologist, Pediatrician, Obstetrician, Gynecologist or Psychiatrist.
2. Nursing – Includes Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Public Health Nurse (PHN), or other type of nursing personnel.
3. Dental – Dentist, Orthodontist, Dental Hygienist, or other dental health professional.
4. Eye – Optometrist or Optician.
5. Social Worker – Professional member of social service or other agency providing social services.
6. Behavioral Health Professional – Substance Abuse Counselor, Psychologist, or other professional specializing in behavioral health services.
7. Other Professional – Psychologist, Podiatrist, Homoeopathist, Chiropractor, Traditional Healer, Pharmacist, Physical Therapist, Sanitarian, or any other professional category not covered above.
8. Technician – X Ray Technician, Lab Technician, etc.
9. Agency/Program – Non-medical health and social service programs and agencies. Includes the Bureau of Indian Affairs, State and local government, social service and welfare agencies, private non-profit health and social service programs, schools, housing authorities, group homes, nursing homes, etc.
10. Family/Self/Community – Family (a group of persons sharing a common dwelling)/Self (one independent person)/Community (a group of people with common interests living in a particular place or region). Includes “walk-in” cases where the patient seeks CHR care without recommendation from other health care personnel. This code includes cases that the CHR found as a result of community or family member’s suggestion to the CHR.

11. CHR – From your own CHR program or from other CHR program this code refers to other CHRs, not you the reporter.

**Data Entry Note:** Instead of typing the whole referral category name in, you may enter the number associated for less key strokes.

### **Travel Time**

Record the approximate amount of time (to the nearest five minutes) that you spent traveling to and from the setting, whether on foot, in a vehicle, or in the air. Travel time refers to NON-SERVICE TIME, this is time you spent *alone without patients, medications, supplies or equipment*.

If you are traveling with one or more CHRs, each CHR should record the same travel time. For example, if CHR #1 and CHR #2 travel together leaving the same location to another location and it takes them 120 minutes to arrive, each CHR would document 120 minutes travel time, because it took both of them 120 minutes to arrive, not 60 minutes each.

### **Number Served**

Record the number of persons served. If you counseled a mother about breast-feeding her newborn, count only the mother as one person served, as the primary service recipient. Likewise if you performed CPR on a child, count 1 as number served, even though others may have been present.

If no patient is being served (training or administrative) record a zero (0) since it is a required field. When serving a group, record the total number of people receiving the same service.

Count only the person with whom you actually made contact with during the service. An exception to this rule would be when you use the Service Code Case Management to reflect completing a service on behalf of a patient. Case Management allows you to document that a patient was served without you actually making contact with the patient during that service.

## **3.4 Patient Information**

The following example shows the next part of the form we will address. It is used for the recording of patient information.

Patient's Chart Name (Last, First, Middle Initial):			Patient Identifier:	
Measurements / Tests (this information will pass to the chart):				
BP: ____ / ____	Weight: ____ lbs.	Height: ____ in.	Temp: _____	Pulse: _____
Respirations:	Blood Sugar:	Waist Circumference:	Hemoglobin A1c:	Body Mass Index:
CHR Signature:			Patient's Signature:	

Figure 3-3: Patient information area of form

### 3.4.1 Patient's Chart Name and Patient Identifier

Use this space to record the patient's name the following information:

- Last Name
- First Name
- Middle Initial

A Patient Identifier can be customized by the program to help distinguish the patient receiving the service. For example, this space could be used for the patient's chart number, social security number, or date of birth.

### 3.4.2 Measurements/Tests

**Note:** This information will pass to the patient's chart.  
Record this information only if you collect the values.

If you perform any of these measurements or tests, then record the information, if not then leave blank. These measurements and tests can be useful in tracking the health and wellness of an individual. Be extra careful to insure accuracy on all of these measurements – somebody's life depends on it!

**Note:** Each Program should have established protocols for acceptable ranges of vital signs and tests as well as what action to follow if a client's vital signs or test results fall outside those acceptable ranges.

Measurement values are listed below, to record more than one reading use the narrative section in the assessment section:

**BP (Blood Pressure)**

This space is to record the patient's blood pressure reading. Record the systolic reading on the left, and the diastolic reading on the right of the slashed line. For example: 115/72. For the computer to accept it the systolic must be between 20 and 275 and diastolic must be between 20 and 200. If you want to record more than one reading, record the additional readings in the narrative section.

**Weight**

This space is to record the patient's weight. Be sure to indicate whether the weight was measured in grams (GM), kilograms (KG), or pounds and ounces (LB-OZ). For the computer to accept the weight must be within range of 1 to 340 kilograms, 1000 to 340000 grams or 2 to 750 pounds. Also record whether the weight was measured in grams (GM), kilograms (KG) or pounds and ounces (LB-OZ). For example: 185 Lbs.

**HT (Height)**

This space is used to record the patient's height. Be sure to check the appropriate unit of measure box, indicating whether the height was measured in centimeters (CM) or inches (IN). Record height in inches: example 73 IN, do not record height in feet and inches (6'1"). For the computer to accept the height must be in the range of 10 to 80 inches and 26 to 203 centimeters.

**Temp. (Temperature)**

This space is to record the patient's temperature (e.g., 99° F). Note the method by which the patient's temperature was taken (oral or anal) in the narrative portion of the assessment. For the computer to accept temperatures it must be within the range of 94° and 109.9° F.

**Pulse**

This space is to record patient's pulse in beats per minute (e.g., 78). For the computer to accept the range must be between 30 and 250. Measure the heart rate at the wrist or in the neck in beats per minute.

**Respirations**

This space is to record patient's rate of respiration in number of breaths per minute (e.g., 18). For the computer to accept respirations the number must be from 8 to 90 breaths per minute.

**Blood Sugar**

This space is to record the date or the result of a patient's blood sugar reading. Example: 109. Only record the regular blood glucose reading here; the test that measures the levels of sugar in the blood at the time of the test.

**Waist Circumference**

Use this space to record the measurement in inches of the patient's waist. To determine a patient's waist circumference locate the iliac crest (hip bone) by pressing on the hip bones with your fingers, place the measuring tape right above the hip bone. It is a good indicator of abdominal fat which is another predictor of risk, when combined with BMI it provides an indicator for developing heart disease and other chronic diseases. This risk increases with a waist measurement of over 40 inches in men and over 35 inches in women. For the computer to accept Waist Circumference enter a value between 20 and 99.

**Hemoglobin A1c**

This space is to record the result of the patient's Hemoglobin A1c (HB A1c) blood sugar reading. HB A1c is a blood sugar test that measures a person's average blood sugar levels over the previous two or three months.

**Body Mass Index**

Body mass index (BMI) is a measure of body fat based on height and weight that applies to both adult men and women. In order for the computer to accept BMI, you must enter height and weight. BMI provides a reliable indicator of body fat for most people and is used to screen for weight categories that may lead to chronic health problems. The computer will accept values between 9 and 80.

Other values can be collected, such as: uncorrected vision, corrected vision, head circumference, last menstrual period, etc. In order to record these values you must use the comprehensive IHS-535 form.

### 3.4.3 Signature Fields

**CHR Signature**

When the form is completed and checked, sign to verify that you completed the activities described.

**Patient's Signature**

This is a space to capture the patient's signature.

**Additional Notes**

Use the blank area at the bottom of the page to customize your record with any additional information your program may collect. However, there is not a data entry field within CHR PCC to enter or extract "customized documentation" in the computer.

## 4.0 IHS-962 CHR PCC Group Encounter Record

This section contains instructions for filling out the IHS-962 CHR PCC Group Encounter Record. It is designed to be used in group settings when repetitive services are being provided and you want to record those services in individual patient's charts. The Group Encounter form drastically cuts down the data entry time when the services provided needs to be recorded individually. The other two forms may still be used to capture group activities, by recording the number served in the number served section, but does not allow you to record individual patients.

An example of the IHS-962 CHR PCC Group Encounter Record appears in *Appendix B: Forms*. Printable forms are available in the supplemental document *Community Health Representative System CHR Forms*.

### 4.1 Header Information

The header consists of the first three fields in the first row; each field is a required field and is indicated by shading.

#### CHR Provider Code

For your CHR Provider Code you can either use your name, initials or your CHR Provider Code.

The CHR Provider Code is assigned at the RPMS facility site by the Site Manager. The first three characters represent the provider's discipline; the provider discipline code for CHRs is **353**. The last three characters usually consist of the CHR's initials.

An example of a CHR Provider Code for Jane A. Doe would be **353JAD**.

<p><b>Data Entry Note:</b> At the CHR Provider Code prompt, you may enter the code, your initials or last name.</p>
---

#### Program Code

The program code is your tribal CHR program name or you can write out your CHR Program's unique 7-digit program code. The first two digits identify the IHS Area, the second two digits identify the Service Unit, and the last three digits identify the Tribe. If you don't know your program code, write in your Tribal program name. The computer can display your program code by entering your Tribe's name.

An example of a Program Code is **5055004** (Apache Tribe of Oklahoma).

**Data Entry Note:** You can type the first three initials of the Tribe's name and hit enter and it will either automatically fill it in or a list will come up to choose from. This tip helps eliminate key strokes.

### **Date of Service**

Write the date (**MM-DD-YY**) of the activity or service. An example of a date of service is **081802** for August 18, 2002.

**Data Entry Note:** Typing a T will give you the current day's date. You can also type T-1 for yesterday's date or T-2 for two days ago, etc.

## 4.2 Assessment – PCC Purpose of Visit

All of this section shaded, which means it is required and must be completed in order for the form to transfer without errors. This section includes the Health Problem Code, Service Code, Service Minutes and Narrative. One of the primary purposes of CHR PCC is to capture patient encounters and activities. The assessment section is also one of two sections where information can drop into the patient's chart. It is critical that the proper codes and related description is included for each service. The information within patient assessments will migrate to the medical record *if* a service code is used that drops into the patient's chart. See "Service Codes" to determine which codes drop into the patient's chart. Be accurate on your coding.

The group encounter form has two lines to document activities. Please remember that if you provide more than one service, it must be provided to all patients on that form. For example, if you are taking blood pressures and blood sugars at a health fair and you code both of these activities on one group encounter form, everyone on that form must have both of these activities performed on them to be accurate.

The computer will accept up to 13 lines of assessment activities, but it is unlikely that 13 different services will be provided in a group format. If you need more than two lines, you can attach another piece of paper. Make yourself or the data entry clerk a note that there are more activities to enter and provide instructions as to their location.

**Note:** The first Health Problem Code used in this section will be viewed and reported as the primary purpose of visit.

### **Health Problem Code**

Record the two-letter health problem code that best describes the health area in which you are providing service, receiving training, or in leave status. When selecting a health problem code, select the health problem code that *best fits*.

*Only use Health Problem codes combined with service codes that pass to the chart if you know for a fact that the patient has received this diagnosis.*

Ways to determine if a patient has been diagnosed with a specific health problem include:

- Doctor
- Public Health Nurse
- Pharmacy
- Medical Records

If the diagnosis was not received at the facility where you enter data, only use Service Codes which will *not* pass to the patient's RPMS chart because using service codes that pass to the chart will create a new diagnosis and CHR's do not diagnose. If a diagnosis came from outside the IHS, Tribal or Urban system, you can also use this opportunity to do an appropriate referral so the patient can be accounted for by the IHS/Tribal facility's health problem registries. An at-a-glance list of the health problem codes are on the back of the forms. The Health Problem Code descriptions are located in this manual and will assist you in coding properly.

**Data Entry Note:**

**When the same health problem code is used more than once on a form**

Many times more than one service is provided for the same health problem. For example you are providing service to a patient that is a *diagnosed* diabetic (DM = Diabetes), you check their blood sugar, provide health education and check and repair their crutches. When entering the data, the first health problem code

Entries of DM will be allowed. *However, once any health problem code is entered on a form, subsequent identical health problems must be entered enclosed in double quotations for the computer to accept it for that form.* Please note the following table which provides examples:

Health Problem	Service Code	Service Minutes	Narrative
DM	CF	10	Checked Blood Sugar at Senior Site
"DM"	HE	15	Carb Control

Figure 4-1: Sample table of health problem codes

### Service Codes

Record the two-letter service code. The Service Code describes what you are doing. The list of Service Codes is located on the back of the form. The list of service codes and definitions are provided in this manual.

### Service Minutes

Use this space to record the Service Minutes. Regarding the approximate amount of time you spent in performing the specific service for the whole group, the computer will divide the minutes equally among the patients in the group. For example, you spend four hours (240 minutes) performing blood pressure readings as a screening service at a local event, you would enter **HY** (Hypertension) for the Health Problem Code, **CF** (Case Find/Screen) for the service, and **240** minutes in the Service Minutes. That represents the time you spend with the group. The computer will divide those minutes up among all the patients to whom you provided service. If you provide **HE** (Health Education) as a service in addition to the blood pressure screening, you would divide the 240 minutes between the two services provided. For example, you might give **CF** (Case Find/Screen) 120 minutes and **HE** (Health Education) 120 minutes, for the total of 240 minutes.

### Narrative

In this space record a brief description regarding the specific service performed. This description should be brief, clear and factual. The narrative will appear on the health summary in the patient's medical chart. It should assist other providers in effectively extending patient care. Because of this potential scrutiny, our data needs to furnish clear collegial communication (no opinions or assumptions). This should help to assure patients that their best interests are actively safeguarded.

The narrative is limited to 80 characters per assessment on the computer, however only 76 characters are allowed in the chart. A "space" is considered as one character, use your facility accepted abbreviations to help reduce the number of characters used. The narrative section does drop into the patient's chart *if* a service code is used that drops into the patient's chart. See "Service Codes" to determine which codes drop into the patient's chart. (Reminder: All the service codes which appear in the left column of the service code section drop in to the chart.)

<p><b>Reminder:</b> All the service codes which appear in the left column of the service code section drop in to the chart.</p>
---

## 4.3 Activity Section

### Activity Location

Check the box on the form that *best describes* the setting where the service took place. Please see the following list:

- Home: Patient's primary residence.
- CHR Office: Regularly assigned office space of the CHR program or satellite office. Used when seeing a patient in a CHR's office, that is located within a clinical facility, code *office*.
- Community: This setting includes all locations in which a service is performed other than a patient's home, school, clinic or the CHR office. This code also includes Tribal Office, state government office or social agency.
- Radio/Telephone/Email: Includes activities that are taking place over the telephone, by radio transmission or by email. For example, when a CHR phones a patient to monitor his/her conditions or calls to make an appointment for a patient.
- Hospital/Clinic: Includes all hospital or clinic locations. Only if the hospital or clinic is an IHS or Tribal facility include the name of the facility.
- None: This setting should *only* be used with Leave Time.
- School: Includes all school settings from day care settings through college and includes vocational schools as well.

<p><b>Data Entry Note:</b> Instead of typing the whole location category name, you may enter the number associated for reduced key strokes.</p>
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### Travel Time

Record the approximate amount of time (to the nearest five minutes) that you spent traveling to and from the setting, whether on foot, in a vehicle or in the air. Travel time refers to *NON-SERVICE TIME*, this is time you spent alone without patients, medications, supplies or equipment.

If you are traveling with one or more CHRs, each CHR should record the same travel time. For example, if CHR #1 and CHR #2 travel together leaving the same location to another location and it takes them 120 minutes to arrive, each CHR would document 120 minutes travel time, because it took both of them 120 minutes to arrive, not 60 minutes each.

### Number Served

Record the number of persons served.

If you have a patient whose test results fall outside your program protocols, it is recommended that an individual CHR PCC Encounter Record (either Comprehensive or Abbreviated) be done on those individuals so that a referral can be documented. Make sure you deduct those individuals from the total number of the number served on the group encounter form, as they will be counted through the individual CHR PCC Encounter Record you do on them.

## 4.4 Patient Information

The following example shows the next part of the form we will address. It is used for the recording of patient information.

Patient Name	Sex	Patient Identifier	Tests/Measurements, if any

Figure 4-2: Sample of patient information portion of the form

### **Patient's Name**

Use this space to record the patient's name: Last Name, First Name, and Middle Initial.

### **Sex**

Use this space to record the patient's gender: male or female.

### **Patient Identifier**

This space can be customized by the program. For example, this space could be used for the patient's chart number, social security number or date of birth. This will help identify the person during the data entry process if there is a question on the individual receiving the service.

### Measurements/Tests

This information *will* pass to the patient's chart.

Record this information *only if you collect the values*. If you perform any of these measurements or test record the information, if not, leave them blank. These measurements and tests can be useful in tracking the health and wellness of an individual. Be extra careful to insure accuracy on all of these measurements – somebody's life depends on it!

*Each Program should have established protocols for acceptable ranges of vital signs and tests as well as what action to follow if a client's vital signs or test results fall outside those acceptable ranges.*

The computer will accept the same Tests/Measurements as accepted on the IHS-535 Comprehensive Form. See these sections for a complete listing and descriptions of a Patient Vital Signs/Test/Measurements and Reproductive Factors that can be entered.

Since the Test/Measurement section does not have a listing to enter these values, abbreviate the Test/Measurement name next to the value listed. For example:  
*Value/Test Reference Guide for Group Encounter Form.*

Value/Test	Abbreviation	Value/Test	Abbreviation
Temperature	Temp	Waist Circumference	Waist
Pulse	P	Vision Uncorrected R/L	VU R- L-
Respirations	Resp	Vision Corrected R/L	VC R- L-
Blood Pressure	BP	Purified Protein Derivative	PPD
Weight	WT	Blood Sugar	BS
Height	HT	Hemoglobin A1c	HBA1c
Head Circumference	Head	Last Menstrual Period	LMP
Body Mass Index	BMI	FP Method	FPM

Figure 4-3: Table of tests and measures information

The following example shows correct entry of information onto the form.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Indian Health Service  
COMMUNITY HEALTH REPRESENTATIVE (CHR)  
GROUP ENCOUNTER RECORD

CHR Provider Code 3 5 3 J A D		Program Code Apache Tribe (OK)	Date of Service June 20, 2006
ASSESSMENT - PCC PURPOSE OF VISIT			
Health Problem Code	Service Code (see back)	Service Minutes	Narrative
HY	CF	120	Took Blood Pressure Readings at Health Fair
HY	HE	120	Instructed on lowering sodium intake to reduce BP
ACTIVITY / REFERRAL / EVALUATION (Check One)			Travel Time: 30
ACTIVITY LOCATION: <input type="checkbox"/> Home (1) <input type="checkbox"/> Hospital/Clinic (4) <input type="checkbox"/> Telephone (5) <input type="checkbox"/> CHR Office (2)      Name: _____ <input type="checkbox"/> None (6) <input type="checkbox"/> Community (3) <input type="checkbox"/> School (7)			Number Served: 45
Patient Name	Sex	Patient Identifier	Tests/Measurements, if any
		PROOF	

Figure 4-4: Sample of tests and measures information entered on a form

## 5.0 Health Problem Codes & Definitions

The Health Problem Codes represent possible health areas addressed by CHR's. It is critical to be able to demonstrate that CHR Programs are having an impact in health and wellness in their communities. In order to receive data that reflects a true picture of your patient centered ("hands-on" care) activities, always select the most specific health problem that best fits the primary purpose of the service. Most Health Problem Code sections have a generic "other" code.

**Note:** When using *any* of the "other" codes, be specific in the narrative.

Record the two-letter health problem code that best describes the health area in which you are providing service or receiving training. When selecting a health problem code select the health problem code that *best fits*.

*Only use Health Problem codes combined with service codes that pass to the chart if you know for a fact that the patient has received this diagnosis. If the diagnosis was not received at the facility where you enter data, only use Service Codes which will not pass to the patient's RPMS chart. Using service codes that pass to the chart will create a new diagnosis and CHR's do not diagnose.*

If a diagnosis came from outside the IHS, Tribal or Urban system, you can also use this opportunity to do an appropriate referral so the patient can be accounted for by the IHS/Tribal facility's health problem registries.

There are a number of ways to confirm a patient diagnosis:

- Patient Chart/Health Summary
- Primary Care Physician
- Public Health Nurse
- Pharmacy
- Medications

An at-a-glance list of the health problem codes by category are on the back of the forms. The Health Problem Code descriptions in this section will assist you in coding properly. There should be no reason to record a dash ( - ) as a Health Problem.

### 5.1 Communicable Diseases

The following refers to communicable/contagious diseases.

ME: Measles	MU: Mumps
CP: Chicken Pox	ST: Strep Throat
TB: Tuberculosis	IM: Impetigo
HE: Hepatitis	RA: Rabies
SX: Sexually Transmitted Diseases	SC: Scabies
HI: HIV/AIDS	HL: Head Lice
	OC: Other Communicable
GE: Gastroenteritis/Diarrhea	OI: Other Infections

The following table provides detailed code information.

Code	Definition	Description
ME	Measles	A highly contagious virus characterized by inflammation of the mucous membranes of the eyes, nose and throat, along with high fever and a typical spreading rash. Spots occur in the mouth and gums, and then a red rash appears on the scalp and face and behind the ears. The rash then spreads downward until it reaches the feet. It then fades in the same order as it appeared.
MU	Mumps	A highly contagious virus disease causing swelling of the parotid glands at the angles of the jaw. It sometimes also affects other glands, the testicles or ovaries, pancreas, etc.
CP	Chicken Pox	A highly contagious virus seen mostly in childhood and characterized by pock like eruptions generally beginning on the chest, back and face and continues to spread all over the body for three to five days. A highly characteristic feature of chicken pox is that all the different stages (of the lesions) may be found at the same time on the child's body. It is caused by a specific virus.
TB	Tuberculosis	Any infection caused by Mycolacterium tuberculosis. Infection of the lung is the most common type.
HE	Hepatitis	An inflammation of the liver.
SX	Sexually Transmitted Diseases	Any contagious disease passed/contracted through sexual contact.
HI	HIV/AIDS	HIV is an abbreviation for the Human Immunodeficiency Virus that destroys T-cells – lymphocytes that are essential in the protecting the body against infections. AIDS (Acquired Immune Deficiency Syndrome), a fatal condition caused by HIV.
GE	Gastroenteritis/Diarrhea	Gastroenteritis is an inflammation, usually acute, of the stomach and intestines. Cramps and diarrhea are characterized symptoms. Diarrhea is the increased frequency and liquid consistency of the stools.
ST	Strep Throat	Strep throat is a contagious disease caused by infection with streptococcal bacteria, which require antibiotics to treat.
IM	Impetigo	A skin infection caused by bacteria. It is most common in children and is contagious. Impetigo forms round, honey crusted, oozing spots that grow larger day by day. The hands and face are the favorite locations for impetigo, but it often appears on other parts of the body.

Code	Definition	Description
RA	Rabies	A virus spread through bites or saliva of infected animals that attacks nerve tissue in warm-blooded animals, including humans. Can be transmitted to humans through an infected animal's bite. If untreated, can result in paralysis and death.
SC	Scabies	A highly contagious skin disorder caused by a tiny mite that burrows into the skin and produces an intense, itchy rash. Scabies is also known as "the itch". The rash usually involves the hands, wrists, breasts, genital area, and waistline. In severe cases scabies can spread to almost the entire body, but rarely the face.
HL	Head Lice	One of many varieties of sucking lice. As the name implies, head lice are specialized to live among the hair present on the human head and are exquisitely adapted to living mainly on the scalp and neck hairs of human host.
OC	Other Communicable	Any communicable disease not covered by designation above. Communicable means that something is capable of being transmitted from one body to another. Please be specific in your narrative when using this code.
OI	Other Infections	Any infectious disease not covered by designation above. An infection is the presence and growth of bacteria, viruses or parasites within the body. Please be specific in your narrative when using this code.

Figure 5-1: Table of communicable disease information

## 5.2 Chronic and Circulatory Diseases

It is important to educate patients and assist them and their families to control and manage chronic (suffering of long duration or frequent recurrence) diseases and prevent complications; and to assist and control circulatory problems and to assist and coordinate the care of these problems and/or their complications.

CA: Cancer  
 DM: Diabetes Mellitus  
 AR: Arthritis  
 OB: Obesity  
 HY: Hypertension  
 SK: Stroke  
 HT: Heart  
 LU: Lupus  
 LD: Liver Disease  
 CH: Congestive Heart Failure  
 TH: Thyroid  
 BD: Blood Disorder  
 RF: Renal Failure  
 OX: Other Chronic

The following table provides detailed code information.

Code	Definition	Description
CA	Cancer	Any malignant growth or tumor caused by abnormal and uncontrolled cell division; it may spread to other parts of the body through the lymphatic system or the blood stream
DM	Diabetes Mellitus	A disease characterized by the inability to burn up the sugars (carbohydrates) which have been ingested. It is caused by insufficient production of insulin by the pancreas.
AR	Arthritis	Inflammation of the joint is usually accompanied by pain, swelling, and sometimes changes in structure. There are more than 100 kinds of arthritis.
OB	Obesity	Excessive fat in body tissues. A person has traditionally been considered to be obese if they are more than 20 % over their ideal weight. That ideal weight must take into account the person's height, age, sex, and build. A person is considered obese if he or she has a body mass index (BMI) of 30 or greater.
HY	Hypertension	High blood pressure.
SK	Stroke	The sudden rupture of clotting of a blood vessel to the brain and its residual effects to the body.
HT	Heart	Anything related to the hollow muscular organ in the chest which pumps blood throughout the body.
LU	Lupus	Chronic inflammatory disease of unknown cause. It affects women more often than men. Symptoms include arthritis, red rash over nose and cheeks, fatigue, weakness followed by fever, photosensitivity and lesions starting in the neck region and spreading to the mucous membranes.
LD	Liver Disease	Liver disease is a term for a collection of conditions, disease, and infections that affect the cells, tissues, structures, or functions of the liver not covered by another designated code. The most common cause of liver damage is malnutrition, especially that which occurs with alcoholism.
CH	Congestive Heart Failure	Heart failure in which the heart is unable to maintain adequate circulation of blood in the tissues of the body. The heart cannot pump enough blood to the body's other organs.
TH	Thyroid	A large endocrine gland that produces a hormone that has a profound influence on growth and development, and specifically stimulating the metabolic rate.
BD	Blood Disorder	A disease or disorder of the blood.
RF	Renal Failure	The inability of the kidneys to excrete wastes and to help maintain the electrolyte balance.
OX	Other Chronic	Any chronic disease not covered by designation above. Please be specific in the narrative when using this code.

Figure 5-2: Table of chronic and circulatory disease information

### 5.3 Digestive

It is important to detect, prevent and/or control digestive problems and to assist coordinate the care of these problems and/or their complications.

GA: Gallbladder

UL: Ulcers

DE: Dental (All)

PC: Pancreatitis

IB: Irritable Bowel

OD: Other Digestive

GD: GERD

The following table provides detailed code information.

Code	Definition	Description
GA	Gallbladder	A hollow, pear shaped organ located beneath the liver in the right upper portion of the abdomen which stores and concentrates bile.
DE	Dental (All)	Pertaining to anything associated with the teeth.
IB	Irritable Bowel	Recurrent abdominal pain and diarrhea, often alternating with periods of constipation.
GD	GERD	Gastro Esophageal Reflux Disease (GERD): A chronic condition in which the lower esophageal sphincter allows gastric acids to reflux into the esophagus, causing heartburn, acid indigestion, and possible injury to the esophageal lining.
UL	Ulcers	An ulcer in the wall of the stomach or duodenum resulting from the digestive action of the gastric juice on the mucous membrane.
PC	Pancreatitis	Inflammation of the pancreas.
OD	Other Digestive	Any condition associated with the breaking down of food for absorption by the digestive tract not covered by designation above. Please be specific in the narrative if you use this code.

Figure 5-3: Table of digestive problem information

### 5.4 Ear

It is important to assist patients and their families in coordinating care of ear problems and/or their complications.

IN: Infections

HA: Hearing Aids

HP: Hearing Problems

OE: Other Ear

The following table provides detailed code information.

Code	Definition	Description
IN	Infections	The presence and growth of organisms within the ear causing disease and pain.
HP	Hearing Problems	Anything that interferes with the process which occurs when sound waves enter the ear and hit the eardrum, middle and inner ear.

Code	Definition	Description
HA	Hearing Aids	Anything to do with the small portable electronic apparatus that amplifies sound and are worn to compensate poor hearing.
OE	Other Ear	Pertaining to anything associated with the ear. Please be specific in the narrative if you use this code.

Figure 5-4: Table of ear problem information

## 5.5 Behavioral Health

Please participate in the care plans of patients and families who are coping with mental illnesses and their treatment, and/or problems of abuses.

SU: Suicide	DP: Depression
NI: Nicotine	SS: Stress
AL: Alcohol	LA: Lifestyle Adaptation
SA: Substance Abuse	OM: Other Mental Health

The following table provides detailed code information.

Code	Definition	Description
SU	Suicide	Self-destruction; taking one's own life.
NI	Nicotine	All activities associated with tobacco use.
AL	Alcohol	Situations that involve excessive and repeated ingestion of large quantities of alcohol.
SA	Substance Abuse	Overindulgence in and/or dependence on mood or behavior-altering addictive substances and results in a chronic disorder affecting physical health and/or personal or social functioning, including alcohol and nicotine.
DP	Depression	A psychoneurotic disorder marked especially by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feeling of dejection and hopelessness and sometimes suicidal thoughts or an attempt to commit suicide.
SS	Stress	A mentally or emotionally disruptive or disquieting influence.
LA	Lifestyle Adaptation	Development and/or assistance of <i>new</i> daily activities that assist patients in managing a new way of living, due to physical health and/or personal or social functioning.
OM	Other Mental Health	Any other conditions of mental illness that result in a disruption in a person's thinking, feeling, moods, and ability to relate to others. Please be specific in the narrative if you use this code.

Figure 5-5: Table of mental health and/or abuse problem information

## 5.6 Suspected Abuse/Neglect

It is important to educate and prevent the incidence and consequences of patients and their families in matters relating to suspected abuse and/or neglect and to assist in the care of patients afflicted with these problems and/or their complications.

CS: Child Abuse/Neglect (suspected) EL: Elder Abuse/Neglect (suspected)  
DV: Domestic Violence (suspected) SL: Sexual Abuse (suspected)

The following table provides detailed code information.

Code	Definition	Description
CS	Child Abuse/Neglect (suspected)	Suspected purposeful maltreatment or neglect of a child.
DV	Domestic Violence (suspected)	Suspected acts of violence or willful neglect within a family.
EL	Elder Abuse/Neglect (suspected)	Suspected purposeful maltreatment or neglect of an elder.
SL	Sexual Abuse (suspected)	Suspected sexually maltreatment with a child or with a non consenting adult that provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities.

Figure 5-6: Table of information relating to suspected abuse and/or neglect

## 5.7 Health Promotion/Disease Prevention

Information regarding health promotion and disease prevention is required to educate and conduct or help patients in matters relating to health promotion/disease prevention, e.g., individual wellness and fitness programs, health fairs, immunization campaigns, environmental programs or health education.

NU: Nutrition  
BF: Breast Feeding  
IZ: Immunization  
SH: School Health  
IC: Injury Control  
SY: SIDS  
FI: Fitness  
CD: Community Development  
OH: Other HP/DP\*

\*Use this code sparingly and ALWAYS describe in narrative section.

The following table provides detailed code information.

Code	Definition	Description
NU	Nutrition	Any activity related to the science or practice of taking in and utilizing nourishing foods or substances for cell growth, energy and to fight infections.

Code	Definition	Description
BF	Breast Feeding	The activity of nourishing a baby through feeding mother's milk from the mother's breast.
IZ	Immunization	Any activity related to the process of protecting people against susceptibility to a contagious disease.
SH	School Health	Activities conducted within the school setting, which promote health through education, practice or procedures directed to school aged children.
IC	Injury Control	Activities that teach about or remove dangerous environmental situations to individuals and groups which could cause personal damage.
SY	SIDS	Activities associated with SIDS (Sudden Infant Death Syndrome). SIDS is a fatal syndrome that affects sleeping infants under a year old, characterized by a sudden cessation of breathing. Also called crib death.
FI	Fitness	Any activity related to improving one's fitness level.
CD	Community Development	Activities that help support your tribe or local community, if no other health problem applies to the activity.
OH	Other HP/DP*	<b>Note:</b> Use this code sparingly and <i>always</i> describe in the narrative section.

Figure 5-7: Table of health promotion/disease prevention information

## 5.8 Ill-Defined Conditions

It is important to assist patients and their families in the care and treatment of ill-defined conditions.

SN: Skin Conditions                      PA: Pain, Unknown origin  
 FA: Fainting                                PS: Poisoning  
 HD: Headaches                            MB: Mobility  
 SF: Surgery Follow-up                AC: Accidental Injury  
 FE: Fever, Unknown origin        AD: Activities of Daily Living

The following table provides detailed code information.

Code	Definition	Description
SK	Skin Conditions	Pertaining to anything associated with a skin condition/disease.
FA	Fainting	A momentary loss of consciousness.
HD	Headaches	A condition of mild to severe pain in the head.
SF	Surgery Follow-up	Directed activities that assist a patient who has recently undergone an operation.
FE	Fever, Unknown origin	Fever, also known as pyrexia, is a medical symptom which describes an increase in internal body temperature to levels which are above normal (37 degrees Celsius, 98.6 degrees Fahrenheit).
PA	Pain, Unknown origin	A hurting/unpleasant sensation, occurring in varying degrees of severity as a consequence of injury, disease or other distress.

Code	Definition	Description
PS	Poisoning	A toxic condition caused by bacteria, drugs, medications, spoiled foods, bites, contact with certain plants, etc. Almost any substance can cause poisoning if the particular person reacts unfavorably to it.
MB	Mobility	Any condition that limits the range of motion for any limb(s).
AC	Accidental Injury	An unexpected and unintentional event that causes damage to a person.
AD	Activities of Daily Living	Any service provided that involves assisting with daily routine activity, including, but not limited to personal care and homemaker services.

Figure 5-8: Table of information regarding conditions that are poorly defined

## 5.9 Screening

It is important to provide specific screening of blood glucose or lipids. *These codes are for screening purposes only.*

HB: A1c – Use this code when using the HB A1c Test only\*

LP: Lipids

The following table provides detailed code information.

Code	Definition	Description
HB	A1c	<b>Note:</b> <i>Use this code when using the HB A1c Test only.</i> A blood sugar test that measures a person's average blood sugar levels over the previous two or three months. Use this code only if using this specific lab test. <i>If not using the HBA1c test use the Health Problem Code Diabetes "DM."</i>
LP	Lipids	Screening of blood cholesterol levels to raise awareness of high blood cholesterol as a risk factor for coronary heart disease.

Figure 5-9: Table of screening information

## 5.10 Maternal and Child Health

Use the information in the following table to educate and assist patients and their families in providing maternal and child health care.

FP: Family Planning

WC: Well Child Care

PR: Prenatal Care

WH: Women's Health

PO: Postnatal Care

FF: FAE/FAS

The following table provides detailed code information.

Code	Definition	Description
FP	Family Planning	Activities associated with the practice of regulating the time for, or preventing the onset of pregnancy.
PR	Prenatal Care	Activities supporting the care of the woman during pregnancy, before childbirth.
PO	Postnatal Care	Activities associated with the period ensuing immediately after birth for both woman and infant.
WC	Well Child Care	Activities to assist/keep a child in good health.
WH	Women's Health	Activities that relate to women's health and wellness.
FF	FAE/FAS	A condition in which body deformation or facial development or mental ability of a fetus is impaired because the mother drank alcohol while pregnant.

Figure 5-10: Table of maternal and child healthcare information

## 5.11 Nervous System

It is important to assist patients and their families in coordinating care of nervous problems and/or their complications.

SD Seizure Disorder

PQ Para/Quadriplegic

DT Dementia

SE Senility

PK Parkinson's Disease

ON Other Nervous System

The following table provides detailed code information.

Code	Definition	Description
SD	Seizure Disorder	A sudden attack of a condition, such as sudden convulsion. A convulsion is a violent, uncontrolled muscle spasm, or a series of them, sometimes repeated at rapid intervals.
PQ	Para/Quadriplegic	Paraplegic, a person with lower limbs paralyzed. Quadriplegic, a person with paralysis of all four limbs.
DT	Dementia	Deterioration of intellectual faculties, such as memory, concentration, and judgment, results from an organic disease or a disorder of the brain. It is sometimes accompanied by emotional disturbance and personality changes.
SE	Senility	Mental deterioration associated with the aging process.
PK	Parkinson's Disease	A progressive nervous disease occurring most often after the age of 50, associated with the destruction of brain cells that produce dopamine and characterized by muscular tremor, slowing of movement, partial facial paralysis, peculiarity of gait and posture, and weakness.
ON	Other Nervous System	Any health or disease condition not covered by the options listed above. Please be specific in the narrative when using this code.

Figure 5-11: Table of information used for nervous problems and/or complications

## 5.12 Respiratory

It is important to assist and control respiratory problems and to assist and coordinate the care of these problems and/or their complications.

CO: Cold  
 FL: Flu  
 AS: Asthma  
 AG: Allergy  
 CG: Cough  
 PN: Pneumonia  
 CR: COPD  
 SI: Sinuses  
 OR: Other Respiratory

The following table provides detailed code information.

Code	Definition	Description
CO	Cold	The inflammation of the mucous membrane of the nose cause by a virus.
FL	Flu	A viral infection of the upper respiratory system.
AS	Asthma	An allergic condition characterized by wheezing, coughing, mucous sputum and difficulty in exhaling air.
AG	Allergy	Hypersensitivity to certain irritating substances with which one comes in contact.
CG	Cough	A sudden and noisy effort to expel air from the lungs.
PN	Pneumonia	An acute or chronic disease marked by inflammation of the lungs and caused by viruses, bacteria, or other microorganisms and sometimes by physical and chemical irritants.
CR	COPD	Chronic obstructive pulmonary disease (COPD) refers to diseases that produce obstruction of airflow and includes asthma, chronic bronchitis and pulmonary emphysema. Usually a combination of emphysema and chronic bronchitis. It is a nonreversible lung disease.
SI	Sinuses	Any problems with the sinus cavity, such as sinusitis or infections.
OR	Other Respiratory	Any breathing related condition that is not covered by the above categories. Please be specific in the narrative when using this code.

Figure 5-12: Table of information used for respiratory problems

## 5.13 Urinary Tract

Use the information in the following table when you detect and control urinary tract problems and to assist in coordination of the care of these problems and/or their complications.

DI: Dialysis  
 GU:Genito/Urinary Disease

The following table provides detailed code information.

Code	Definition	Description
DI	Dialysis	The artificial, mechanical and regular systematic removal of toxins from the body.
GU	Genito/Urinary Disease	Any disease referring to the sex organs and the urinary system, including the kidneys, ureters, bladder, prostate, etc.

Figure 5-13: Table of information when urinary tract problems are detected

## 5.14 Vision

Use information in the following table to assist patients and their families in coordinating care of vision problems and/or their complications.

ED: Eye Disease

EC: Eye Care/Glasses

The following table provides detailed code information.

Code	Definition	Description
ED	Eye Disease	All conditions related to the eye and systems that service the function of seeing.
EC	Eye Care/Glasses	All functions associated with well eye care and or the management of obtaining and maintenance of the eyeglasses.

Figure 5-14: Table of information vision problems and complications

## 5.15 Other

The following miscellaneous codes are not used for specific health problems, but they allow for complete documentation.

LT: Leave Time

SO: Socio-Economic Assistance

AM: Administrative/Management

TR: Traditional Healing

The following table provides detailed code information.

Code	Definition	Description
LT	Leave Time	Paid time off. When coding LT for the health problem code and the service code will also be LT.
AM	Administrative/Management	General office activities, CHR PCCs and CHR program administrative activities not related to a specific health problem, wellness or patient care. Use this code as a health service code when the activities are not directly related to a health problem.
SO	Socio-Economic Assistance	Any service provided that improves a patient's social or economic standing, not only with tribal based programs but also with community based programs. Including, but not limited to energy assistance, general assistance, and housing.

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<b>Code</b>	<b>Definition</b>	<b>Description</b>
TR	Traditional Healing	Services or activities that incorporate individual tribal traditional healing techniques and traditions.

Figure 5-15: Table of miscellaneous code information

## 6.0 Service Codes

The following table contains service code information. The first grouping of codes will *pass to* the patient chart.

The following table provides detailed code information.

Code	Definition	Pass to Patient Chart
HE	Health Education	Yes
CF	Case Finding/Screen	Yes
CM	Case Management	Yes
MP	Monitor Patient	Yes
EC	Emergency Care	Yes
PC	Patient Care	Yes
HS	Homemaker Services	Yes
TP	Transport	No
IT	Interpret/Translate	No
OP	Other Patient Service	No
ES	Environmental Service	No
AM	Administrative/Mgmt	No
OT	Obtain Training	No
LT	Leave Time	No
CD	Community Development	No
NF	Not Found	No

Figure 6-1: Table of service code information

### 6.1 Health Education (HE)

Use the **HE** code when planning, preparing or providing education on health and wellness, whether individually, in a group or while transporting.

Examples include but not limited to the following:

- Obtaining health information for a patient, or preparing materials for a presentation (such as a class, talk or health fair exhibit booth).
- Conducting research by talking to experts, reading articles, or otherwise obtaining health and wellness educational information.
- Planning, coordinating, and conducting the training of CHR and other health or community agency employees (including development of instructional materials and/or researching instructional materials) related to the CHR program.
- Assisting with health education activities in schools.

## 6.2 Case Findings/Screen (CF)

Use this code for *a patient who does not already have an identified health problem or diagnosis*. Screening is done to find, discover or detect. *If the patient has a known health problem diagnosis, another service code may be more appropriate.*

Examples include but are not limited to the following:

- Performing blood pressure readings, Snellen eye examinations, dipstick urinalysis, and other tests *to check apparently healthy people for the presence of abnormal findings* that may require medical attention.
- Participating in school physicals and screening clinics such as those for diabetes, excess lead in blood, high cholesterol, well baby, and immunization clinics.
- Conducting interviews/surveys to identify individual or household risk factors for disease, such as environmental health home safety surveys.
- Discovering or locating a new patient.

## 6.3 Case Management (CM)

Use this code for any service that results in a patient obtaining health care. *The patient does not have to be present when this service is performed*. This includes direct patient care that is monitored by the CHR, *but* is provided by a parent or other family member (i.e. providing patient care in-directly).

Examples include but are not limited to the following:

- Participating in case management conferences and discharge planning such as developing a care plan, such as working in conjunction with a public health nurse, physical, social worker, or substance abuse counselor and working as part of the health care team to carry out the plan.
- Establishing the responsibilities of each person involved in the patient's care.
- Serving as a *patient advocate* by arranging appointments, filing complaints for the patient, helping the patient to fill out forms or applications, planning for follow-up services. For example, therapy and otherwise helping with medical assistance benefits (Medicare/Medicaid) applications, assisting the patient in obtaining basic needs of living healthy.
- Arranging transportation by explaining bus schedules, or arranging for other means of transportation, except in cases of emergency transports (see Emergency Care).
- Charting, filing and working with records, charts and forms related to the management of patient care.
- Arranging for traditional Tribal Ceremonial Services for a sick patient.

- Checking the condition of crutches, wheelchairs, eyeglasses, hearing aids, and other health equipment to insure that they are properly working.

## 6.4 Monitor Patient (MP)

Use this code when you consistently check on the patient to ensure proper health care is maintained and/or provided as needed. Monitoring takes on the form of personal contact either by in-person or by phone. In *all* cases, the contact must be with the patient personally.

Examples include but are not limited to the following:

- Making *regular* contact with a patient who has a known *health problem or diagnosis* – or who is at high risk of illness or disablement to see if he or she is feeling well, has enough food, water and/or medicine, is obtaining regular health care, has adequate heating, etc.

## 6.5 Emergency Care (EC)

Use this code when providing emergency care services.

Examples include but are not limited to the following:

- Responding to emergency calls.
- Arranging for an ambulance to transport a seriously ill or injured person or giving care to the person when necessary.
- Providing crisis intervention for emotionally upset or suicidal patient.
- Maintaining emergency equipment/restocking supplies.

## 6.6 Patient Care (PC)

Use code **PC** when providing treatment and other services *directly to a patient with a known illness*. Care usually takes place in the patient's presence, or the patient directly receives the service. If you are unsure about the patient diagnosis you should document your vital signs or other patient care related services under Case Find/Screen.

Examples include but are not limited to the following:

- Providing proper foot care.
- Providing hands on services such as taking temperatures or other vital signs to persons with *a known illness*.

- Providing emotional and/or mental support.
- Delivering items such as medications, supplies and equipment to a patient's home.
- Personal care by bathing, toilet assistance, shampooing hair, feeding and other common personal need activities.

## 6.7 Homemaker Services to Disabled, Elderly or Bedridden Persons (HS)

Use the **HS** code when assisting disabled, elderly or bedridden persons.

Examples include but are not limited to the following:

- Providing household chores such as shopping, washing clothes, etc.
- Preparing food
- Lawn care, shoveling snow, chopping wood, etc.

## 6.8 Transport Patient (TP)

Use this code when transportation is provided to a patient for health-related services. If you provide health education on a health topic while transporting, document that time as HE (Health Education), and reduce your travel time appropriately.

Examples include but are not limited to:

- Transporting a patient to or from a local IHS/Tribal hospital, clinic, or other local health care provider when there is *no other transportation available*, or according to local tribal transportation policy.
- Waiting for a patient who has been transported to finish treatment, *if you are not involved in any other reportable service*.

**Note:** To cut your transport time down, take with you health literature and/or paperwork to finish, or call and check on patients. If you go in the treatment room at the request of your patient, that is another service you are providing.

## 6.9 Interpret/ Translate (IT)

Use this code if you interpret, translate, or clarify the preferred language of the patient to other health care providers and vice versa.

Examples include but are not limited to the following:

- Taking a statement from one language and expressing the meaning, either orally or in writing, in another language.
- Clarifying medical treatment and/or instructions, either to the patient or the patient's family/caregivers.
- Clarifying and/or reading other documents, such as mail, applications for services, for patients.

## 6.10 Other Patient Service (OP)

Use this code when no other patient code applies.

Examples include but are not limited to the following:

- Completing and entering CHR PCCs, for the health problem code use Administrative/Management (AM)
- Includes any patient-centered services not included in other Service codes. An example of such a service is making or assisting with arrangements for a person's funeral.
- Support services such as setting up for special community clinics and events, such as but not limited to health fairs or expos, etc. Support services for setting up these events may include sign in sheets for the event, making up flyers, setting up tables/chairs, packing/unpacking boxes, contacting presenters, cleaning up, etc.

## 6.11 Environmental Services (ES)

Use this code for a variety of environmental services; please refer to the full definition of services from your three-week basic manual.

Examples include but are not limited to the following:

- Identifying health or safety hazards in a patient's environment such as faulty electrical wiring, lack of adequate sanitation facilities, poor condition of wood burning stoves, or unsafe storage of medicines or cleaning products; and recommending or seeking a solution.
- Participating in animal immunization programs, water fluoridation projects, community clean-ups, and other injury or disease prevention activities.
- Maintaining or monitoring the safety of the water supply through testing, addition of chemicals equipment checks, etc.
- Maintaining and monitoring waste disposal systems (including operating and maintaining equipment at landfills or sewage treatment sites).

- Coordinating arrangement for repair and maintenance of homes and community facilities.
- Arranging for and informing the community of animal, insect or vector control programs (e.g., rabies clinics or mange dips) that prevent the spread of disease.

## 6.12 Administration/Management (AM)

Use this code when performing CHR program administrative services. This includes attending a wide variety of meetings *not directly related to patient care or training*, such as: maintaining program records, reporting on program activities to Tribal or other government officials, answering the program's telephone, and similar activities.

**Note:** When you're using Administration/Management code, put a **0** in the Number Served box, because you are not serving a patient.

## 6.13 Obtain Training (OT)

Use this code when participating in all types of training, including basic, advanced or specialty CHR training, refresher or update training, management, administrative training, or any other training intended for *your own* instruction to further your knowledge of health care and or your job.

*Code a Health Problem whenever you can.* For example, workshop on CPR would be coded HT – OT.

**Note:** When you're using Obtain Training put a 0 in the Number Served box, because you are not serving a patient.

## 6.14 Leave Time (LT)

Use this code for paid time off such as: vacations, holidays, sick hours, personal leave and administrative leave.

**Note:** When you use this code, report minutes used as "Service Time" and put a **0** in the number served box. Use a new CHR PCC Form for each day of leave.

See the following example.

**Assessment – PCC Purpose of Visit**

Health Problem Code	Service Code	Service Minutes	Narrative
LT	LT	480	Vacation

**6.15 Community Development (CD)**

Use this code for activities in which you participate that help support your tribe or local community. This code indicates that you assisted another organization with a project.

Examples include but are not limited to the following:

- Assisting the local blood bank to conduct a blood drive in your community.
- Working with community organizations such as the American Red Cross.

When using this service code if no other health problem applies, use *Community Development* for the health problem and explain in the narrative.

**6.16 Not Found (NF)**

Use the **NF** code when you are attempting to pick up, deliver items, or meet and/or speak with a patient and the patient was not home or no contact was made.

The Health Problem code that should be documented with this service code will be the primary purpose you went to see the client. For example, if you went to follow up on a diabetic patient and they were not home, you would document **DM** as the Health Problem Code and **NF** as the service code.

## 7.0 Standard Protocol for Home Visit

This section contains the suggested standard protocol for home visits.

**Note:** Each CHR Program may wish to use this as a template to establish minimum protocols to conduct Home Visits.

- Check vital signs on all patient visits, even if it is just for screening purposes.
- Inquire about health and well being.
- Check to ensure patient has a sufficient amount of medication.
- Survey the environment for health and safety issues.
- Provide Health Education on a topic appropriate for the patient or about prevention.
- Be aware of personal safety issues for you in/around the home.

## 8.0 Additional Data Entry Notes

- You can always type a double question mark (??) in the DIRECT program and hit enter to find out more information.
- Keep CAPS lock *on* while doing data entry.
- The mouse does not work in the DIRECT program.
- When entering data in the computer, use the Enter key. When not entering data use the TAB key or arrow keys to navigate around.
- When entering data on the IHS-535 COMPREHENSIVE Form, you can *skip or jump over* the word processing sections in the Subjective, Objective and Plans/Treatments/Education/Medications by using the *tab key*.
- To exit the word processing sections, press and release the **F1** key and then the **E** key.
- Always read the screen.
- For the IHS-535 Comprehensive Form – If when you get into the Subjective, Objective and Plans/Treatment/Education/Medications word processing field, and you have the Line Text Editor which will display with numbered lines such as:

>1  
>2  
>3

- You should change it to the Full Screen Editor. You can ask your IT Staff or Site Manager to help or you can do it yourself.
  - You have to back out of the system back to where you select what CHR PCC form you are going to enter. At that prompt type **TBOX** and enter.
  - Next choose **Edit User Characteristics**, and press **Enter**. A prompt for Terminal Type will display, just hit enter.
  - Then you will need to TAB down to the PREFERRED EDITOR field and type in **Screen Editor** (typing **S** is enough). Press **F1 E** to get out.
  - You have successfully changed the Line Text Editor to Full Screen Editor. Sometimes you have to log off and then log back on for the change to take place, but not always.
- Even though you have CAPS lock on, you still have to press the **Shift** key to use any of the special characters above the numbers.
  - The **F1** key used with **H** will give you the ScreenMan help sheet. You can print the help sheet.
  - Don't forget — for each form, after entering a health problem code once, you must enclose duplicate health problem codes in quotation marks, i.e., “DM”.

## 9.0 Frequently Asked Questions

### FAQ

#### **What if I can not get my name or provider code to come up on the computer?**

Try typing the first three initials of your last name and hit enter. If you still don't see your name this means that you have not been set up as a provider in the RPMS. Ask the Information Technology (IT) Site Manager at the RPMS Facility to set you up as a Tribal CHR Provider (Code 353).

#### **What is the difference between Community Development (CD) and Other Patient (OP) Services?**

Community Development indicates you assisted another organization with a project. Other Patient Services indicates your CHR Program organized the event.

#### **Can you use Administrative/Management for client services?**

No, "Administrative/ Management" refers to providing a wide variety of services that *are not* directly related to patient care. Other Service Codes that are not related to patient care are Leave Time and Obtain Training.

#### **How do I document travel and transportation time when I pick up more than one patient?**

Travel time is the time you spend alone in the vehicle without a patient's medicine, equipment, supplies or a patient. Any travel time should be documented on the first patient's PCC. Once you pick up a patient's medicine, equipment, supplies or a patient you are providing a service.

For example, if you travel 15 minutes to pick up Patient A, travel another 15 minutes with Patient A to pick up Patient B, then travel another 30 minutes to the facility, for a total of 60 minutes.

**Patient A** – Travel Time = 15 Minutes, Service Minutes = 30 Minutes (15 minutes to pick up Patient B and half of the time to the facility)

**Patient B** – Travel Time = 0 Minutes, Service Minutes = 15 Minutes (half of the time to the facility)

The service minutes may be documented as a transportation service or any other service code, such as: health education, monitor patient or patient care. It is recommended that you double-check yourself and add up service and travel time for all patients involved to ensure accurate accounting of your time.

#### **We just got hooked up to RPMS and we have a stack of PCCs to put in. Should we start with the oldest PCCs first?**

No. It is recommended that you stay current. Enter the most current PCCs as they come in. That way that critical patient information gets to the chart in a timely fashion. Next enter the backlog of PCCs as time permits.

#### **Can I use the IHS-535 Comprehensive or IHS-535-1 Abbreviated forms for group services?**

Yes – especially when providing services that are not critical elements in a patient's chart. An example would be conducting head lice checks in a school setting. However, in cases such as health screenings where medical values are being collected, the IHS-962 Group form, drastically cuts down the data entry time, and allows these important screening medical values to be placed in the patient's chart for review.

**FAQ****When might I use the IHS-962 Group form?**

When you are providing services in a screening situation, and medical values are collected, the 962 Group form will decrease data entry time and allow the important medical values to pass to each patient's chart.

However, be aware that when using an IHS-962 Group form, you should ensure that everyone listed on the form receives the same service, since the health problem and service codes are the same for everyone listed on the form. The other criteria for documenting on the 962 group form is that all the patients you provide service must be American Indian/Alaska Native, non-Indian members of an Indian household, or Indian beneficiary, and you must be familiar enough with the screening participants to be able to distinguish the differences.

**If a patient reports that the Home Health Nurse just took his blood pressure, can you document the results under measurements and test?**

No – because you did not obtain the reading. The measurements and test section is only for documenting values that you obtained yourself. You can however make a notation in the narrative section and record the value.

For example: Pt reports Home Health Nurse took BP today 140/70.

## Appendix A: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: <http://security.ihs.gov/>.

The ROB listed in the following sections are specific to RPMS.

### A.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

#### A.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual Part 8, "Information Resources Management,"* Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

### A.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

### A.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

#### A.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

#### A.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

### A.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

### A.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

### A.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

### A.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

### A.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

### A.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

### A.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

### A.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

## A.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## A.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## Appendix B: Forms

This section contains examples of the following forms:

- IHS-535: CHR Comprehensive PCC Encounter Record
- IHS-535 1: CHR Abbreviated PCC Encounter Record
- IHS-962: CHR PCC Group Encounter Record

## Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

**Phone:** (505) 248-4371 or (888) 830-7280 (toll free)

**Fax:** (505) 248-4363

**Web:** <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

**Email:** [support@ihs.gov](mailto:support@ihs.gov)