RESOURCE AND PATIENT MANAGEMENT SYSTEM

CHR PCC Reporting System

(BCH)

User Manual Supplement

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Office of Information Technology
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Document Revision History

Revision Date	Implemented By	Approved By	Approval Date	Description of Change
4/20/2013	Pam Aguilar	Cathy Stueckemann	4/20/2013	Initial release
12/05/2014	Pam Aguilar	Ron Galloway	12/05/2014	**Sections**: • Sections: 1.0, 2.1, 2.2.2, 2.3, 2.5.1, 3.1, 3.2.2, 3.3, 3.5.1, 4.1, and 4.4.2: Various updates. • Sections 2.2.2, 3.2.2, and 4.4.2: - Deleted data entry note. - Changed to Non-registered patient database. • Old Appendix A moved to Appendix C: . • Health Problem Codes and Definitions: Added as new Appendix A: . • Appendix B: Added service codes. • Appendix D: Updated. **Figures**: • Figures: 2-5, 2-6, and 3-6: Updated.

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Preface

This manual provides supplemental information to the Community Health Representative (CHR) System v2.0 package. It is a guide for CHRs and other CHR Program staff to document services and activities performed at the local facility level. All Tribal and IHS staff members who are paid by the CHR Program, regardless of title should document their services and activities using CHR PCC.

Use of CHR PCC and exporting the data to the national data warehouse provides verifiable, documented information to ensure accountability to both:

- Congress for CHR services that are paid for through federal funding.
- Patients and other care providers on behalf of patients and which impact patient case management and care management.

At present, CHR PCC is the only mechanism that allows IHS Headquarters CHR Program to report program performance measures to Congress, Tribes, Department of Health and Human Services (HHS), and Office of Management and Budget. CHR Programs can use CHR PCC to identify and track patient services in a variety of categories and health issues, see existing and anticipated services, identify resource allocation needs, and provide data to support grant applications, among other uses.

The Health Care Facility or the CHR Program are responsible for exporting the data to the National Data Warehouse. It is vital that the CHR Program ensures their data is exported, so that it may be included in reports at the national level.

1.0 Encounter Records

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 Program, including 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. Inaccurate information could cause harm to the patient, so all measurements and documentation must be as accurate as possible.

CHRs have three forms from which they may choose to document 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 Indian Health Service's (IHS) Resource and Patient Management System (RPMS) using the CHR PCC data entry system.

Note:	CHRs may use any of the forms to document any CHR activities and services. Each form described herein contains all of the required fields for data entry and reporting.

1.1 Brief Form Descriptions

1.1.1 IHS-535: The CHR Comprehensive PCC Encounter Record

This form incorporates the SOAP (Subjective, Objective, Assessment, Plans) approach to documenting health care. This form is recommended to document more extensively for a specific patient, such as a new patient or a patient with complex health issues. However, be aware that information documented in the Subjective, Objective, and Plan is not accessible to medical providers; it can only be viewed at a CHR Program level. Therefore, all Subjective and Objective data should be documented in the narrative. Although, this form can be used to document daily activities and groups it is not the preferred form.

The CHR Comprehensive PCC Encounter Record is covered in Section 2.0.

1.1.2 IHS-535-1: The CHR Abbreviated PCC Encounter Record

This form includes the required fields, frequently used values, and only the assessments sections of SOAP charting. For most patient visits, daily activities and

groups this form will provide effective documentation. This form is preferred by many for being the most appropriate to document on a day-to-day basis and can be used to document individual patient services, activities, and groups.

The CHR Abbreviated PCC Encounter Record is covered in Section 3.0.

1.1.3 IHS-962: The CHR Group PCC Encounter Record

This form includes the required fields. Individual patient services performed in a group encounter can be collectively captured using this form or time spent providing the same service to multiple patients on the same day and location. It also provides a more efficient data entry process for encounters with measurements, tests, and family planning methods. This is not the only form for capturing group data.

The CHR Group PCC Encounter Record is covered in Section 4.0.

1.2 Blue Shaded Sections

The labels of required fields are shaded blue. These must be filled out in order for the CHR PCC to be electronically processed. If a required field is missing, it will be returned by RPMS with an error message. Run an error report prior to CHR Program export, and correct all errors.

1.3 Write Legibly

Print clearly, using block printing, this is a legal document. Writing clearly makes it is easy to read the form quickly and efficiently. In addition, documentation may need to be entered in RPMS by someone else. Writing legibly will reduce data entry errors when reviewing notes.

2.0 IHS-535 CHR Comprehensive PCC Encounter Record

An example of the IHS-535 CHR Comprehensive PCC Encounter Record appears in Appendix D: . 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 three fields in the first row. All are required fields.

CHR Provider Code:		Program Code:		Date of Service:	

Figure 2-1: Header Information section of the PCC Encounter Record

1. Record the **CHR Provider Code**. The Site Manager assigns the CHR Provider Code at the RPMS facility site:

   - 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.

   The CHR Provider Code for Demo A. Provider would be **DAP**.

Data Entry Note:	At the "CHR Provider Code" prompt, record the CHR's initials as assigned by the IT site manager, or the CHR's last name. Do not enter **353** prior to the initials.

2. Record the **Program Code**. Write one of the following:

   - The tribal CHR program name.
   - The CHR Program's unique seven-digit program code:
     - The first two digits identify the IHS Area.
     - The second two digits identify the Service Unit.
     - The last three digits identify the Tribe.

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

Data Entry Note:	Type the first three initials of the Tribe's name and press Enter; RPMS will either automatically fill it in, or a list will come up from which you may choose.

3. Record the **Date of Service**. Write the date of which this service took place. An example of a date of service is 081812, 08/18/12 or 0812 (it will assume the current year) for August 18, 2012. Dates in the future are not allowed.

Data Entry Note:	Type **T** in the date field to record the current day's date. Type **T-1** for yesterday's date or **T-2** for two days ago, etc.

2.2 Patient Information

This information is used to track the information back to the patient's medical record. If the information is in doubt, leave the field empty. While this information is not required for data entry, 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 into the correct person's medical file.

Patient Information			
Patient Chart Name (Last, First MI)	HRN	DOB	Sex
Tribe	Community of Residence		

Figure 2-2: **Patient Information** section of the PCC Encounter Record

Note:	Record all of 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 into a patient record.

2.2.1 Completing Patient Information

1. At the **Patient Chart Name** field, do one of the following:
   - Record the Patient Name in the format **Last name, First Name Middle Initial** (Example: **Patient,Demo P**).
   - If this encounter is not an individual patient record, write **N** in the **Patient Chart Name** field to indicate to data entry that it is "N-All Other Activities."
2. At the **HRN** field, do one of the following:
   - Record the patient's Health Record Number (HRN).
   - If the patient does not have a HRN, fill in **NON REG**.
3. Record the patient's Date of Birth (**DOB**) in the format **mm/dd/yyyy**.
4. Record the patient's **Sex**: **M**=Male, **F**=Female.

5. Record the name of the **Tribe** in which the patient is enrolled. This can also include Non-Indian Beneficiary and Non-Indian Member of Indian Household.
6. At the **Community of Residence** field, record the name of the community in which the patient lives.

2.2.2 Data Entry Notes Non-Registered Patient Data Base

The CHR PCC Non-registered (NON-REG) patient database does not create a "chart" at the health care facility, but it will capture services provided and save the information. Once you enter the required demographic information, this system assigns a unique number, which begins with the letters CHR.

Criteria to enter into CHR Non-registered patient data base:

- Nonregistered Tribal member.
- Nonregistered member of another Tribe.
- Non-Indian member of Indian household.
- Non-Indian Beneficiary.

Required information to save a Non-registered patient to CHR data base:

- Name.
- Tribe.
- Gender.
- DOB.
- Community.

Data entry steps to input Non-registered patient and save to CHR data base:

1. At the "Name" prompt, type the patient's name. LAST,FIRST MI.
2. A message displays indicating that the patient is not in the database and asks if you want to look up again; type NO.
3. A new screen displays to collect the name and other required patient information.
4. At the "Tribe" prompt, type the Tribe name or **non-Indian** and select one of the two options.

Benefits of the NONREG database:

- The NON-REG patient information saves to the CHR database.
- The demographic information is available for reports.
- The required fields do not have to be re-entered in the future.

2.3 Vital Signs/Measurements

Record the results of any vital signs and measurements taken; otherwise, leave this section blank. This data can be useful in tracking health and wellness of an individual. Use care to ensure accuracy on all of these measurements. Descriptions of the individual fields and recording instructions follow Figure 2-3. Record more than one reading or value the patient reports in the narrative area of the **Assessment/CHR PCC Primary Purpose of Visit** section.

Vital Signs/Measurements									
BP	P	R	BG	T	HT in	WT lb	BMI	WC in	A1C
HC	VU – L R			VC – L R			LMP FPM		

Figure 2-3: **Vital Signs/Measurements** section of the PCC Encounter Record

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

- **BP**. Record the patient's Blood Pressure reading. Write the systolic value, followed by a forward slash (/), then the diastolic value (e.g., 115/72).

> **Data Entry Note**: RPMS accepts a blood pressure reading if the systolic is within the range of 20 and 275 and the diastolic is within the range of 20 and 200.

  To record more than one reading, write the additional readings in the narrative of the **Assessment/CHR PCC Primary Purpose of Visit** section.

- **P**. Record the patient's Pulse in beats per minute (e.g., 78). Measure the heart rate at the wrist or the neck.

> **Data Entry Note**: RPMS accepts a pulse reading if it is within the range of 30 to 250.

- **R**. Record the patient's Rate of Respiration in number of breaths per minute (e.g., 18).

> **Data Entry Note**: RPMS accepts a respirations reading if it is within the range of 8 to 90 per minute.

- **BG**. Record the date and the result of a patient's Blood Glucose reading (e.g., 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).
- **T**. Record the patient's body Temperature in degrees Fahrenheit. Note the method by which the patient's temperature was taken.

Data Entry Note:	RPMS accepts a temperature if it is within the range of 94.0ºF to 109.9ºF.

- **HT**. Record the patient's Height in inches (not feet and inches).

Data Entry Note:	RPMS accepts a height reading if it is within the range of 10 to 80 inches.

- **WT**. Record the patient's Weight in pounds.

Data Entry Note:	RPMS accepts a weight reading if it is within the range of 2 to 750 pounds.

- **BMI**. Record the patient's Body Mass Index (BMI).

Data Entry Note:	RPMS accepts a BMI reading if it is within the range of 9 to 80 and both HT and WT are recorded.

- **WC**. Record the measurement in inches of the patient's Waist Circumference.

Data Entry Note:	RPMS accepts a waist circumference reading if it is within the range of 20 to 99 inches.

- **A1C.** Record the result of the patient's Hemoglobin A1c (HB A1C) blood glucose reading. HB A1c is a test that measures a person's average blood glucose levels over the previous two or three months.
- **HC**. Record the patient's Head Circumference in inches. Head circumference is generally recorded only for infants and young children.

Data Entry Note:	RPMS accepts a head circumference reading if it is within the range of 10 to 30 inches.

- **VU**. Record the patient's Uncorrected Vision:
  - Record the value for the left eye in the space following the **L**.
  - Record the value for the right eye in the space following the **R**.

  The first number 20/ (the distance for the testing) is assumed. Therefore, record only the value of the test result for the eye being tested in the corresponding field.

Data Entry Note:	RPMS accepts an uncorrected vision range reading if it is within the range of 10 to 999.

- **VC**. Record the patient's Corrected Vision (i.e., when wearing glasses or contact lenses):
  - Record the value for the left eye in the space following the "L".
  - Record the value for the right eye in the space following the "R".

The first number 20/ (the distance for the testing) is assumed. Therefore, record only the value of the test result for the eye being tested in the corresponding field.

Data Entry Note:	RPMS accepts an uncorrected vision range reading if it is within the range of 10 to 999.

- **LMP**. Record the first day of the patient's Last Menstrual Period using the format mm/dd/yyyy.
- **FPM**. Record the patient's Family Planning Method from the methods listed in Table 2-1. If the patient specifically reports using no Family Planning Method, record **Not Used**.

Table 2-1: Family Planning Methods

Method	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

2.4 Assessment/CHR PCC Primary Purpose of Visit

The **Assessment/CHR PCC Primary Purpose of Visit** section provides a place to record the **Health Problem** (Code – HPC), **Service Code** (SC), **Service Minutes** (SM), and **Narrative**. Record the Primary Purpose of Visit (POV) on the first line. An example of this section of the form is in Figure 2-4.

Assessment / CHR PCC Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative

Figure 2-4: **Assessment/CHR PCC Primary Purpose of Visit** section of the PCC Encounter Record

The blue shading of the column headings indicates that for each performed service all four entries are required.

One of the primary purposes of CHR PCC is to capture patient encounters and services. Information in the assessment section can be shared with other providers. It is essential that the proper codes and related descriptions be included for each service performed.

The form provides a limited number of lines for documenting assessment services and activities, but the computer will accept multiple lines of assessment. If more lines are needed than are provided on the form, do one of the following:

- Attach and complete an additional form.
- Attach a piece of paper containing the needed information.

In either case, make a note mentioning that there are more services to record and provide instructions as to their location.

> **Note**: The first line of assessment in this section is reported as the Primary POV.

1. **Health Problem**. Record the two-letter HPC that best describes the health area in which you are providing service, receiving training, or in leave status. Select the HPC that best fits. Some HPCs are actual diagnoses, like Diabetes, Stroke, Parkinson's, and Chronic Obstructive Pulmonary Disease (COPD). Others are simply health related topics like Nutrition, Traditional Healing, and Injury Control.

   To determine if a patient has been diagnosed with a specific health problem at the IHS, Tribal, or Urban (I/T/U) facility at which the CHR documents, contact appropriate medical staff.

   > **Note**: If the patients' diagnosis was not received at the facility where you enter data, note in the narrative where the patient received the diagnosis.

   If a diagnosis came from outside the I/T/U 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 HPCs is

on the back of the forms. The HPC descriptions are located in this manual and will assist in coding properly.

> **Note**: If a HPC is used more than once, include each subsequent appearance within quotation marks (“”).

Figure 2-5 provides an example of HPC detail information.

Assessment / CHR PCC Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative
DM	MP	20	F/U HEALTH NO C/O. F/U MEDS NO REFILLS NEEDED (1,3)
"DM"	HE	20	PROVIDED HEALTH EDUCATION - CARBS (1-CARBS)

Figure 2-5: **Assessment/CHR PCC Primary Purpose of Visit** section of the PCC Encounter Record

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

3. **Service Minutes**. Record the SMs – the approximate amount of time you spent in performing the specific service. CHR PCC is intended to capture and give you credit for all services you provide and activities you perform, you should be able to account for approximately 435-450 minutes a day. Remember if you are delivering a medication, supplies, equipment, or food to the patient your time should be documented as service minutes.

4. **Narrative**. Record a brief description regarding the specific service performed. This description should be brief, clear, and factual. Other providers can view the narrative section. 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 can be shared with other providers.

   Predefined narratives are provided to assist in standardizing narratives and to make it easier use for the CHR to fill out the form and do data entry. Once the number to the selected narrative is entered, the CHR PCC data entry system automatically enters the predefined narrative.

2.5 Referral/Activity Location/Travel Time/Number Served

This section of the form is used to report the activity location, referral, travel time, and number served. These four fields are blue shaded indicating they are required fields.

2.5.1 Referral Codes

Referral codes provide a picture of how the CHR program coordinates with other community resources and uses available resources.

- No referral is required when documenting groups or services such as administration, obtain training, or leave time.
- If no referral was received or made when documenting patient services, select the number **12** as the option for **None**.

Refer to CHR by:	1	2	3	4	5	6	7	8	9	10	11	12
1: Medical; 2: Nursing; 3: Dental; 4: Eye; 5: Social Work; 6: Behavioral Health; 7: Other Professional; 8: Technican; 9: Agency Program; 10: Family/Self/Community; 11: CHR Program; 12: None												
Refer by CHR to:	1	2	3	4	5	6	7	8	9	10	11	12

Figure 2-6: Referral Codes section of the PCC Encounter Record

- **Refer to CHR by**. Circle the number that best describes who referred the patient. You may select up to five referrals received. If there is no referral received, circle the number **12** as the option for **None**.
- **Referred by CHR to**. Circle the number that best describes to whom you referred the patient. If you made more than one referral, you may select up to five. If there is no referral made, circle the number **12** as the option for **None**.

There are twelve 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**. Podiatrist, Homoeopathist, Chiropractor, Traditional Healer, Pharmacist, Physical Therapist, Sanitarian, or any other professional category not covered elsewhere.

8. **Technician**. X Ray Technician, Lab Technician, etc.

9. **Agency or Program**. Non-medical social service programs and agencies; including but not limited to:

   - 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

10. **Family, Self, or Community**. 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:

    - **Family**. A group of persons sharing a common dwelling.
    - **Self**. An individual.
    - **Community**. A group of people with common interests living in a particular place or region.

11. **CHR**. From your own CHR program or from another CHR program.

12. **None**. No referral received.

> **Data Entry Note:** Instead of typing the entire referral category name, record the associated number.

2.5.2 Activity Location

Activity Location:	1	2	3	4	5	6	7
1: Home; 2: CHR Office; 3: Community; 4: Include Name of Hospital/Clinic, I/T/U or Specialty Facility with City and State; 5: Radio/Telephone; 6: None; 7: School							

Figure 2-7: **Activity Location** section of the PCC Encounter Record

Circle the number that best describes the setting where the service took place. This location is not always where the activity began. There are seven codes to describe the location where the service occurred:

1. **Home. Patient's** primary residence.
2. **CHR Office.** Regularly assigned office space (even if in health facility) of the CHR program or satellite office.
3. **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 includes Senior Sites, Tribal Office, state government offices, or social agencies.
4. **Hospital/Clinic.** If the hospital or clinic is an I/T/U facility include the name of the facility. If the facility is not I/T/U, document the type of specialty after the number 4 and include the City and State of facility.
    - Cancer, City, State.
    - Child Health, City, State.
    - Dialysis, City, State.
    - Eye, City, State.
    - Heart, City, State.
    - Lung, City, State.
    - Mammogram, City, State.
    - Orthopedic, City, State.
    - Other Chronic, City, State.
    - Women's Health, City, State.
5. **Radio/Telephone:** Includes activities that are taking place over the telephone, by radio transmission, or by email.
6. **None:** This setting should always be used with Leave Time and Obtain Training.
7. **School:** Includes all school settings from day care settings through college; also includes vocational schools.

Data Entry Note: To save keystrokes and time, record the number associated with the location category.

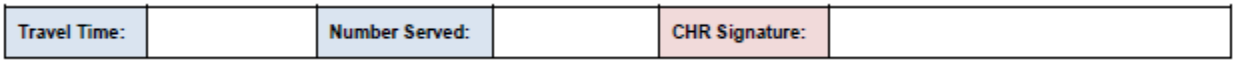

Figure 2-8: **Travel Time**, **Number Served**, and **CHR Signature** section of the PCC Encounter Record

2.5.3 Travel Time

Record the approximate amount of time (to the nearest five minutes) spent traveling to and from the setting, whether on foot, in a vehicle or in the air. Travel time is NON-SERVICE TIME. This is time travelling but spent without patients, and without medications, supplies, equipment, or food to deliver. Delivering items to a patient is NOT travel time and should be documented as SM.

This is a required field and a value is required even if zero.

When 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.

2.5.4 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 service recipient. If you provided services to the infant then you should complete another CHR PCC as a service recipient. When serving a group, record the total number of service recipients.

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 SC Case Management (CM) to reflect completing a service on behalf of a patient. CM allows you to document that a patient was served without you actually making contact with the patient during that service.

This is a required field. If no patient was served (training, administrative, or leave time), record a zero (0).

2.5.5 CHR Signature

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

2.6 Subjective/Objective/Plan

Note:	**Subjective**, **Objective**, and **Plan** are not included in information that other providers can access. Document all important information in the narrative so that other providers may view.

Figure 2-9: **Subjective/Objective/Plan** section of the PCC Encounter Record

Subjective

Record information from the patient's point of view. It is the information the patient tells you – the patient's story. 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 the narrative with "Patient states…" Report any concerns, requests, or the patient's mental state if relevant.

Objective

Record only the information that can be confirmed through your own senses - what you hear, see, touch, smell, and feel.

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.

Plan/Treatments/Education/Medication

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.

> **Note**: All of the examples listed except the list of medications can be documented in the assessment section as CM.

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 D: . 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. All are required fields.

CHR Provider Code:		Program Code:		Date of Service:	

Figure 3-1: Header Information section of the PCC Encounter Record

1. Record the **CHR Provider Code**. The Site Manager assigns the CHR Provider Code at the RPMS facility site:

   - 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.

   The CHR Provider Code for Demo A. Provider would be **DAP**.

Data Entry Note:	At the "CHR Provider Code" prompt, record the CHR's initials as assigned by the IT site manager, or the CHR's last name. Do not enter **353** prior to the initials.

2. Record the **Program Code**. Write one of the following:

   - The tribal CHR program name.
   - The CHR Program's unique seven-digit program code:
     - The first two digits identify the IHS Area.
     - The second two digits identify the Service Unit.
     - The last three digits identify the Tribe.

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

Data Entry Note:	Type the first three initials of the Tribe's name and press Enter; RPMS will either automatically fill it in, or a list will come up from which you may choose.

3. Record the **Date of Service**. Write the date of which this service took place. An example of a date of service is 081812, 08/18/12 or 0812 (it will assume the current year) for August 18, 2012. Dates in the future are not allowed.

Data Entry Note:	Type **T** in the date field to record the current day's date. Type **T-1** for yesterday's date or **T-2** for two days ago, etc.

3.2 Patient Information

This information is used to track back to the patient's medical record. If the information is in doubt, leave the field empty. While this information is not required for data entry, 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 encounter is documented in the correct patient's medical file.

Patient Information			
Patient Chart Name (Last, First MI)	HRN	DOB	Sex
Tribe	Community of Residence		

Figure 3-2: **Patient Information** section of the PCC Encounter Record

Note:	Record all of 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 into a patient record.

3.2.1 Completing Patient Information

1. At the **Patient Chart Name** field, do one of the following:
   - Record the **Patient Chart Name** in the format **Last name, First Name Middle Initial** (Example: **Patient, Demo P**).
   - If this encounter is not an individual patient record, write **N** in the **Patient Chart Name** field to indicate to data entry that it is "N-All Other Activities."
2. At the **HRN** field, do one of the following:
   - Record the patient's HRN.
   - If the patient does not have a HRN, fill in **NON REG**.
3. Record the patient's **DOB** in the format **mm/dd/yyyy**.
4. Record the patient's **Sex**: **M**=Male, **F**=Female.

5. Record the name of the **Tribe** in which the patient is enrolled. This can also include Non-Indian Beneficiary and Non-Indian Member of Indian Household.
6. At the **Community of Residence** field, record the name of the community in which the patient lives.

3.2.2 Data Entry Notes Non-Registered Patient Data Base

The CHR PCC Non-registered (NON-REG) patient database does not create a "chart" at the health care facility, but it will capture services provided and save the information. Once you enter the required demographic information, this system assigns a unique number, which begins with the letters CHR.

Criteria to enter into CHR Non-registered patient data base:

- Nonregistered Tribal member.
- Nonregistered member of another Tribe.
- Non-Indian member of Indian household.
- Non-Indian Beneficiary.

Required information to save a Non-registered patient to CHR data base:

- Name.
- Tribe.
- Gender.
- DOB.
- Community.

Data entry steps to input Non-registered patient and save to CHR data base:

1. At the "Name" prompt, type the patient's name. LAST,FIRST MI.
2. A message displays indicating that the patient is not in the database and asks if you want to look up again; type NO.
3. A new screen displays to collect the name and other required patient information.
4. At the "Tribe" prompt, type the Tribe name or non-Indian and select one of the two options.

Benefits of the NONREG database:

- The NON-REG patient information saves to the CHR database.
- The demographic information is available for reports.
- The required fields do not have to be re-entered in the future.

3.3 Vital Signs/Measurements

Record the results of any vital signs and measurements taken; otherwise, leave this section blank. This data can be useful in tracking health and wellness of an individual. Use care to ensure accuracy on all of these measurements. Descriptions of the individual fields and recording instructions follow Figure 3-3. Record more than one reading or value the patient reports in the narrative area of the **Assessment/CHR PCC Primary Purpose of Visit** section.

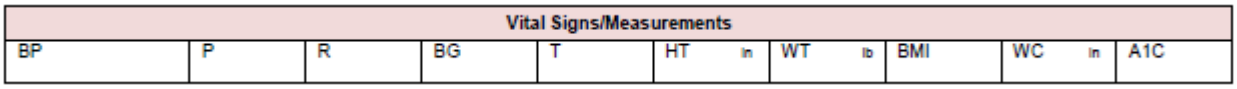

Figure 3-3: Example of **Vital Signs/Measurements** fields on form

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

- **BP**. Record the patient's Blood Pressure reading. Write the systolic value, followed by a forward slash (/), then the diastolic value (e.g., 115/72).

> **Data Entry Note**: RPMS accepts a blood pressure reading if the systolic is within the range of 20 and 275 and the diastolic is within the range of 20 and 200.

  To record more than one reading, write the additional readings in the narrative of the **Assessment/CHR PCC Primary Purpose of Visit** section.

- **P**. Record the patient's Pulse in beats per minute (e.g., 78). Measure the heart rate at the wrist or the neck.

> **Data Entry Note**: RPMS accepts a pulse reading if it is within the range of 30 to 250.

- **R**. Record the patient's Rate of Respiration in number of breaths per minute (e.g., 18).

> **Data Entry Note**: RPMS accepts a respirations reading if it is within the range of 8 to 90 per minute.

- **BG**. Record the date and the result of a patient's Blood Glucose reading (e.g., 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).
- **T**. Record the patient's body Temperature in degrees Fahrenheit. Note the method by which the patient's temperature was taken.

Data Entry Note:	RPMS accepts a temperature if it is within the range of 94.0ºF to 109.9ºF.

- **HT**. Record the patient's Height in inches (not feet and inches).

Data Entry Note:	RPMS accepts a height reading if it is within the range of 10 to 80 inches.

- **WT**. Record the patient's Weight in pounds.

Data Entry Note:	RPMS accepts a weight reading if it is within the range of 2 to 750 pounds.

- **BMI**. Record the patient's BMI.

Data Entry Note:	RPMS accepts a BMI reading if it is within the range of 9 to 80 and both HT and WT are recorded.

- **WC**. Record the measurement in inches of the patient's Waist Circumference.

Data Entry Note:	RPMS accepts a waist circumference reading if it is within the range of 20 to 99 inches.

- **A1C.** Record the result of the patient's HB A1C blood glucose reading. HB A1c is a test that measures a person's average blood glucose levels over the previous two or three months.

3.4 Assessment/CHR PCC Primary Purpose of Visit

The **Assessment/CHR PCC Primary Purpose of Visit** section provides a place to record the HPC, SC, SM, and Narrative. Record the primary POV on the first line. An example of the assessment section on the form is in Figure 3-4.

Assessment / CHR PCC Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative

Figure 3-4: **Assessment/CHR PCC Primary Purpose of Visit** section of the PCC Encounter Record

The blue shading of the column headings indicates that for each performed service all four entries are required.

One of the primary purposes of CHR PCC is to capture patient encounters and services. Information in the assessment section can be shared with other providers. It is essential that the proper codes and related descriptions be included for each service performed.

The form provides a limited number of lines for documenting assessment services and activities, but the computer will accept multiple lines of assessment. If more lines are needed than are provided on the form, do one of the following:

- Attach and complete an additional form.
- Attach a piece of paper containing the needed information.

In either case, make a note mentioning that there are more services to record and provide instructions as to their location.

> **Note**: The first line of assessment in this section is reported as the Primary POV.

1. **Health Problem**. Record the two-letter HPC that best describes the health area in which you are providing service, receiving training, or in leave status. Select the HPC that best fits. Some HPCs are actual diagnoses, like Diabetes, Stroke, Parkinson's, and COPD. Others are simply health related topics like Nutrition, Traditional Healing, and Injury Control.

   To determine if a patient has been diagnosed with a specific health problem at the I/T/U facility at which the CHR documents, contact appropriate medical staff.

   > **Note**: If the patients' diagnosis was not received at the facility where you record data, note in the narrative where the patient received the diagnosis.

   If a diagnosis came from outside the I/T/U system, use this opportunity to do an appropriate referral so the patient can be accounted for by the IHS or Tribal facility's health problem registries. An at-a-glance list of the HPCs are on the back of the forms. The HPC descriptions are located in this manual and will assist you in coding properly.

   > **Note**: If a HPC is used more than once, include each subsequent appearance within quotation marks ("").

Figure 3-5 provides an example of HPC detail information.

Assessment / CHR PCC Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative
DM	MP	20	F/U HEALTH NOC/O. F/U MEDS NO REFILLS NEEDED (1,3)
"DM"	HE	20	PROVIDED HEALTH EDUCATION - CARBS (1-CARBS)

Figure 3-5: Example of HPC detail information

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

3. **Service Minutes**. Record the SMs – the approximate amount of time you spent in performing the specific service. CHR PCC is intended to capture and give you credit for all services you provide and activities you perform, you should be able to account for approximately 435-450 minutes a day. Remember if you are delivering a medication, supplies, equipment, or food to the patient your time should be documented as service minutes.

4. **Narrative**. Record a brief description regarding the specific service performed. This description should be brief, clear, and factual. Other providers can view the narrative section. 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 can be shared with other providers.

   Predefined narratives are provided to assist in standardizing narratives and to make it easier use for the CHR to fill out the form and do data entry. Once the number to the selected narrative is recorded, the CHR PCC data entry system automatically enters the predefined narrative.

3.5 Referral/Activity Location/Travel Time/Number Served

This section of the form is used to report the activity location, referral, travel time, and number served. These fields are blue shaded indicating they are required fields.

3.5.1 Referral Codes

Referral codes provide a picture of how the CHR program coordinates with other community resources and uses available resources.

- No referral is required when documenting groups or services such as administration, obtain training, or leave time.
- If no referral was received or made when documenting patient services, circle the number **12** as the option for **None**.

Refer to CHR by:	1	2	3	4	5	6	7	8	9	10	11	12
1: Medical; 2: Nursing; 3: Dental; 4: Eye; 5: Social Work; 6: Behavioral Health; 7: Other Professional; 8: Technican; 9: Agency Program; 10: Family/Self/Community; 11: CHR Program; 12: None												
Refer by CHR to:	1	2	3	4	5	6	7	8	9	10	11	12

Figure 3-6: Referral Codes section of the PCC Encounter Record

- **Refer to CHR by**. Circle the number that best describes who referred the patient. You may select up to five referrals received. If there is no referral received, circle the number **12** as the option for **None**.
- **Referred by CHR to**. Circle the number that best describes to whom you referred the patient. If you made more than one referral, you may select up to five. If there is no referral made, circle the number **12** as the option for **None**.

There are twelve 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 RN, LPN, LVN, NP, CNS, 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**. Podiatrist, Homoeopathist, Chiropractor, Traditional Healer, Pharmacist, Physical Therapist, Sanitarian, or any other professional category not covered elsewhere.
8. **Technician**. X Ray Technician, Lab Technician, etc.
9. **Agency or Program**. Non-medical social service programs and agencies; including but not limited to:
    - 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.

10. **Family, Self, or Community**. 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:

    - **Family**. A group of persons sharing a common dwelling.
    - **Self**. An individual.
    - **Community**. A group of people with common interests living in a particular place or region.

11. **CHR**. From your own CHR program or from another CHR program.

12. **None**. No referral received.

> **Data Entry Note:** Instead of typing the entire referral category name, record the associated number.

3.5.2 Activity Location

Activity Location:	1	2	3	4	5	6	7
1: Home; 2: CHR Office; 3: Community; 4: Include Name of Hospital/Clinic, I/T/U or Specialty Facility with City and State; 5: Radio/Telephone; 6: None; 7: School							

Figure 3-7: **Activity Location** section of the PCC Encounter Record

Circle the number 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.

1. **Home**. Patient's primary residence.
2. **CHR Office**. Regularly assigned office space (even if in health facility) of the CHR program or satellite office."
3. **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 includes Senior Sites, Tribal Office, state government offices, and social agencies.
4. **Hospital/Clinic.** If the hospital or clinic is an I/T/U facility include the name of the facility. If the facility is not I/T/U, document the type of specialty after the number 4 and include the City and State of facility.

    - Cancer, City, State.
    - Child Health, City, State.
    - Dialysis, City, State.
    - Eye, City, State.
    - Heart, City, State.

- Lung, City, State.
- Mammogram, City, State.
- Orthopedic, City, State.
- Other Chronic, City, State.
- Women's Health, City, State.

5. **Radio/Telephone**. Includes activities that are taking place over the telephone, by radio transmission or by email.
6. **None**. This setting should always be used with Leave Time and Obtain Training.
7. **School**. Includes all school settings from day care settings through college; also includes vocational schools.

Figure 3-8: **Travel Time**, **Number Served**, and **CHR Signature** section of the PCC Encounter Record

3.5.3 Travel Time

Record the approximate amount of time (to the nearest five minutes) spent traveling to and from the setting, whether on foot, in a vehicle or in the air. Travel time is NON-SERVICE TIME. This is time travelling but spent without patients, and without medications, supplies, equipment, or food to deliver. Delivering items to a patient is NOT travel time and should be documented as SM.

This is a required field and a value is required even if zero.

If 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.

3.5.4 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 service recipient. If you provided services to the infant then you should complete another CHR PCC as a service recipient. When serving a group, record the total number of service recipients.

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 SC CM to reflect completing a service on behalf of a patient. CM allows you to document that a patient was served without you actually making contact with the patient during that service.

This is a required field. If no patient was served (training, administrative, or leave time), record a zero (0).

3.5.5 CHR Signature

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

The bottom of the 535-1 provides space 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 information documented in this location. Collecting additional data or information on the CHR PCC Form can eliminate additional paper work. Examples include but are not limited to:

- Beginning and ending mileage for the service/activity.
- Arrival and departure time for the service/activity.
- Adding patient signature.

4.0 IHS-962 CHR PCC Group Encounter Record

This section contains instructions for filling out the IHS-962 CHR PCC Group Encounter Record, which is designed to be used in group settings when repetitive services are being provided and those services are to be recorded in individual patient's charts. The Group Encounter form drastically cuts down the data entry time when the services provided would otherwise be recorded individually. The 535 Comprehensive and 535-1 Abbreviated forms may still be used to capture group activities particularly if there are no measurements, tests, or values to record.

> **Note**: Using a 962 Group Form to document requires the CHR to ensure that each patient's personal health information is confidential. When obtaining personal information such as DOB, you are responsible for protecting information, even a blood pressure value, from being overheard or viewed by other participants. Remember to consider confidentiality and setting location when selecting the form to use.

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

4.1 Header Information

The header consists of the three fields in the first row. All are required fields.

CHR Provider Code:		Program Code:		Date of Service:	

Figure 4-1: Header Information section of the PCC Group Encounter Record

1. Record the **CHR Provider Code**. The Site Manager assigns the CHR Provider Code at the RPMS facility site:

   - 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.

   The CHR Provider Code for Demo A. Provider would be **DAP**.

> **Data Entry Note:** At the "CHR Provider Code" prompt, record the CHR's initials as assigned by the IT site manager, or the CHR's last name. Do not enter **353** prior to the initials.

2. Record the **Program Code**. Write one of the following:

   - The tribal CHR program name.
   - The CHR Program's unique seven-digit program code:
     - The first two digits identify the IHS Area.
     - The second two digits identify the Service Unit.
     - The last three digits identify the Tribe.

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

Data Entry Note:	Type the first three initials of the Tribe's name and press Enter; RPMS will either automatically fill it in, or a list will come up from which you may choose.

3. Record the **Date of Service**. Write the date of which this service took place. An example of a date of service is 081812, 08/18/12 or 0812 (it will assume the current year) for August 18, 2012. Dates in the future are not allowed.

Data Entry Note:	Type **T** in the date field to record the current day's date. Type **T-1** for yesterday's date or **T-2** for two days ago, etc.

4.2 Assessment/Primary Purpose of Visit

The **Assessment/CHR PCC Primary Purpose of Visit** section provides a place to record the HPC, SC, SM, and Narrative. Record the primary POV on the first line. An example of the assessment section on the form is in Figure 4-2.

Assessment / Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative

Figure 4-2: **Assessment/Primary Purpose of Visit** section of the PCC Group Encounter Record

The blue shading of the column headings indicates that for each performed service all four entries are required.

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 be shared with other providers. It is essential for the proper codes and related descriptions to be included for each service performed.

The group encounter form has four lines to document activities. If more than one service is provided, it must be provided to all patients on that form. An example, 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 receive both services performed for the documentation to be accurate.

The computer will accept multiple lines of assessment activities, but it is unlikely that a wide variety of services will be provided in a group format. If more lines are needed than are provided on the form, do one of the following:

- Attach and complete an additional form.
- Attach a piece of paper containing the needed information.

In either case, make a note mentioning that there are more services to record and provide instructions as to their location.

> **Note**: The first line of assessment in this section is reported as the Primary POV.

1. **Health Problem**. Record the two-letter HPC that best describes the health area in which you are providing service, receiving training, or in leave status. Select the HPC that best fits. Some HPCs are actual diagnoses, like Diabetes, Stroke, Parkinson's, and COPD. Others are simply health related topics like Nutrition, Traditional Healing, and Injury Control.

   To determine if a patient has been diagnosed with a specific health problem at the I/T/U facility at which the CHR documents, contact appropriate medical staff.

   > **Note**: If the patients' diagnosis was not received at the facility where you enter data, note in the narrative where the patient received the diagnosis.

   If a diagnosis came from outside the I/T/U system, use this opportunity to do an appropriate referral so the patient can be accounted for by the IHS or Tribal facility's health problem registries. An at-a-glance list of the HPCs are on the back of the forms. The HPC descriptions are located in this manual and will assist you in coding properly.

   > **Note**: If a HPC is used more than once, include each subsequent appearance within quotation marks ("").

Assessment / CHR PCC Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative
DM	CF	10	SCREENED BG (1BG)
"DM"	HE	15	PREVENTION HEALTH EDUCATION CARBS (2 CARBS)

Figure 4-3: Sample of repeating HPC entries

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

3. **Service Minutes**. Record the SMs – the approximate amount of time you spent in performing the specific service. CHR PCC is intended to capture and give you credit for all services you provide and activities you perform, you should be able to account for approximately 435-450 minutes a day. Remember if you are delivering a medication, supplies, equipment, or food to the patient your time should be documented as service minutes.

4. **Narrative**. Record a brief description regarding the specific service performed. This description should be brief, clear, and factual. Other providers can view the narrative section. 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 can be shared with other providers.

   Predefined narratives are provided to assist in standardizing narratives and to make it easier use for the CHR to fill out the form and do data entry. Once the number to the selected narrative is recorded, the CHR PCC data entry system automatically records the predefined narrative.

4.3 Activity Location/Travel Time/Number Served

This section of the form is used to report the activity location, travel time, and number served. These fields are blue shaded indicating they are required fields.

4.3.1 Activity Location

Circle the number that best describes the setting where the service took place. Please see the following list of locations:

1. **Home:** Patient’s primary residence.

2. **CHR Office:** Regularly assigned office space (even if in health facility) of the CHR program or satellite office.

3. **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 includes Senior Sites, Tribal Office, state government offices, and social agencies.

4. **Hospital Clinic:** If the hospital or clinic is an I/T/U facility include the name of the facility. If the facility is not I/T/U, document the type of specialty after the number 4 and include the City and State of facility.

    - Cancer, City, State.
    - Child Health, City, State.
    - Dialysis, City, State.
    - Eye, City, State.
    - Heart, City, State.
    - Lung, City, State.
    - Mammogram, City, State.
    - Orthopedic, City, State.
    - Other Chronic, City, State.
    - Women's Health, City, State.

5. **Radio/Telephone/Email:** Includes activities that are taking place over the telephone, by radio transmission or by email.

6. **None:** This setting should always be used with Leave Time and Obtain Training.

7. **School:** Includes all school settings from day care settings through college and includes vocational schools as well.

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

4.3.2 Travel Time

Record the approximate amount of time (to the nearest five minutes) spent traveling to and from the setting, whether on foot, in a vehicle or in the air. Travel time is NON-SERVICE TIME. This is time travelling but spent without patients, and without medications, supplies, equipment, or food to deliver. Delivering items to a patient is NOT travel time and should be documented as SM.

This is a required field and a value is required even if zero.

If 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.

4.3.3 Number Served

Record the number of persons served. The 962 Group Form provides the option to input additional lines of assessment and values, but when editing you do not have the option to document a referral If you have a patient for whom you need to make a referral, create an individual CHR PCC Encounter Record (either Comprehensive or Abbreviated) on this individual so that a referral can be documented. Deduct from the total number (remove) anyone for whom you use a 535 or 535-1 form of the number served on the group encounter form.

4.4 Patient Information

This information is used to track back to the patient's medical record. On this form it is essential that you obtain each piece of information. This helps ensure that the encounter is documented in the correct patient's medical file.

Patient Name	Sex	Patient Identifier	Tests/Measurements, if any
1.			
2.			
3.			
4.			

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

4.4.1 Completing Patient Information

1. At the **Patient Name** field, record the **Patient Name** in the format **Last name, First Name Middle Initial** (Example: **Patient, Demo P**).
2. Record the patient's **Sex**: **M**=Male, **F**=Female.
3. At the **Patient Identifier** field, do one of the following:
   - Record the patient's HRN.
   - Record the patient's DOB.

   If the patient is not registered, fill in **NON REG**. The Tribe and Community can be recorded in this field; if more room is needed, Community can be included in the **Test/Measurements** section.
4. At the **Test/Measurements** field.

This information may pass to the patient's chart.

If any tests or measurements are performed, record the values. Since the **Tests/Measurements…** section does not have a listing to record these values,

abbreviate the Vital Sign or Measurement name next to the value listed. See Section 2.3. These values can be useful in tracking the health and wellness of an individual. Use care to ensure accuracy on all of these measurements.

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

4.4.2 Data Entry Notes Non-Registered Patient Data Base

The CHR PCC Non-registered (NON-REG) patient database does not create a "chart" at the health care facility, but it will capture services provided and save the information. Once you enter the required demographic information, this system assigns a unique number, which begins with the letters CHR.

Criteria to enter into CHR Non-registered patient data base:

- Nonregistered Tribal member.
- Nonregistered member of another Tribe.
- Non-Indian member of Indian household.
- Non-Indian Beneficiary.

Required information to save a Non-registered patient to CHR data base:

- Name.
- Tribe.
- Gender.
- DOB.
- Community.

Data entry steps to input Non-registered patient and save to CHR data base:

1. At the "Name" prompt, type the patient's name. LAST,FIRST MI.
2. A message displays indicating that the patient is not in the database and asks if you want to look up again; type NO.
3. A new screen displays to collect the name and other required patient information.
4. At the "Tribe" prompt, type the Tribe name or non-Indian and select one of the two options.

Benefits of the NONREG database:

- The NON-REG patient information saves to the CHR database.
- The demographic information is available for reports.

- The required fields do not have to be re-entered in the future.

RPMS will accept the same vital signs and measurements as accepted on the IHS-535 Comprehensive Form. See Section 2.4 for a complete listing and descriptions of patient Vital Signs/Measurements and Reproductive Factors that can be entered.

Appendix A: Health Problem Codes and Definitions

The HPC represent possible health areas addressed by CHRs. It is critical to be able to demonstrate that CHR Programs are having an impact in health and wellness in the CHRs communities. In order to receive data that reflects a true picture of patient centered ("hands-on" care) activities, always select the most specific health problem that best fits the services provided. The first line of assessment is considered the POV and is the main reason for the visit. HPC can reflect:

- Actual diagnoses such as Hypertension, Diabetes Mellitus.
- General health categories such as nutrition, fitness.

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

Record the two-letter HPC that best describes the health area in which service or training is being provided. Select the HPC that best fits.

Only use HPCs that are actual diagnoses with SC, such as Monitor Patient and Patient care, if you know for a fact that the patient has received this diagnosis at the facility you document your services. If the diagnosis was not received at the facility where you enter data, only use SCs such as Casefind/Screen (CF) or Health Education (HE).

If a diagnosis came from outside the I/T/U system, 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 HPCs by category are on the back of the forms. The HPC descriptions in this section will assist you in coding properly.

A.1 Communicable Diseases

It is important to educate patients and assist them and their families to control and manage communicable/infectious disease. Communicable means that something is capable of being transmitted from one body to another.

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	A disease caused by a bacterium called *Mycobacterium tuberculosis.* The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal.
HE	Hepatitis	An inflammation of the liver.
SX	Sexually Transmitted Diseases	Any contagious disease passed/contracted through sexual contact.
HI	HIV/AIDS	Human Immunodeficiency Virus destroys T-cells – lymphocytes that are essential in the protecting the body against infections. Acquired Immune Deficiency Syndrome is 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 stool.
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 elsewhere in this list. 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 elsewhere in this list. 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.

A.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 their complications.

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.

Code	Definition	Description
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 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	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.
OS	Osteoporosis	The thinning of bone tissue and loss of bone density over time and is the most common type of bone disease.
OX	Other Chronic	Any chronic disease not covered elsewhere in this list. Please be specific in the narrative when using this code.

A.3 Digestive

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

Code	Definition	Description
GA	Gallbladder	A hollow, pear shaped organ located beneath the live 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: 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 elsewhere in this list. Please be specific in the narrative if you use this code.

A.4 Ear

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

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.
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.

A.5 Behavioral Health

Participate in the care plans of patients and families who are coping with mental illnesses, undergoing treatment, or dealing with abuse.

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 or dependence on mood or behavior-altering addictive substances and results in a chronic disorder affecting physical health 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 or assistance of new daily activities that assist patients in managing a new way of living, due to physical health 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 when using this code.

A.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 or neglect and to assist in the care of patients afflicted with these problems and their complications.

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.

Code	Definition	Description
SL	Sexual Abuse (suspected)	Suspected sexual maltreatment of a child or 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.

A.7 Health Promotion/Disease Prevention

Information regarding health promotion and disease prevention is required to educate 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.

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.
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 Sudden Infant Death Syndrome, 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	Use if no other health problem applies. Activities that help support the tribe or local community.
MH	Men's Health	Services provided to male patients that ensure their overall health and wellbeing through education and other follow-up activities.
OH	Other HP/DP*	Use if no other health problem applies. Any health promotion disease prevention activity. Please be specific in the narrative when using this code.

A.8 Ill-Defined Conditions

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

Code	Definition	Description
SK	Skin Conditions	Pertaining to anything associated with a skin condition or 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.
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	Use only if patient does not have a primary diagnosis. Any service provided that involves assisting with daily routine activity, including, but not limited to personal care and homemaker services.
DD	Developmental Disabilities	A diverse group of severe chronic conditions that are due to mental or physical impairments, often leading to problem, with major life activities language, mobility, learning, self-help and independent living.

A.9 Screening

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

Code	Definition	Description
HB	A1c	Use this code when using a HB A1c test only. Use when the CHR has been trained locally, achieved competence and ensured compliance with CLIA. A test that measures a person's average blood glucose levels over the previous two or three months. If not using the HB A1c test use the HPC Diabetes “DM.”
LP	Lipids	Use this code when using a cholesterol screening test only. Screening of blood cholesterol levels to raise awareness of high blood cholesterol as a risk factor for coronary heart disease.
DG	Diagnostic Testing	Testing to help determine the cause of a patient's symptoms and medical complaints. Examples include but not limited to: MRI, CAT Scan, Lab, and X-ray.

A.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.

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	FASD	Fetal Alcohol Spectrum Disorder refers to the range of neurological impairments that can affect a child who has been exposed to alcohol in the womb.

A.11 Nervous System

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

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	Paraplegic/Quadriplegic	Paraplegic is a person with a condition in which the lower half of the body is paralyzed. Quadriplegic is a person with a condition in which upper and lower extremities are paralyzed.
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 elsewhere in this list. Please be specific in the narrative when using this code.

A.12 Respiratory

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

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.

Code	Definition	Description
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 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 elsewhere in this list. Please be specific in the narrative when using this code.

A.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 their complications.

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.

A.14 Vision

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

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.

A.15 Other

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

Code	Definition	Description
LT	Leave Time or Paid time off.	When coding LT for the HPC and the SC 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.
SO	Socio-Economic Assistance	Any service provided that improves a patient's social or economic standing, not only with tribally based programs but also with community based programs. Including, but not limited to energy assistance, general assistance, and housing.
TR	Traditional Healing	Services or activities that incorporate individual tribal traditions, beliefs, and healing techniques.

Appendix B: Service Codes and Definitions

This appendix describes the use of each SC.

B.1 Health Education (HE)

Use this code when planning, preparing, or providing education on health and wellness, whether individually, in a group, or while transporting. Examples include but are not limited to:

- Obtaining health information for a patient, or preparing materials for a presentation (such as a class, talk, or health fair exhibit).
- Conducting research by talking to experts, reading articles, or otherwise obtaining health and wellness educational information.
- Assisting with health education activities.

B.2 Case Findings/Screen (CF)

Use this code when providing a service for a HP that is a diagnosis and the patient is not diagnosed with that HP. Screening is done to find, discover or detect. If the patient has a known health problem diagnosis, another SC may be more appropriate. Examples include but are not limited to:

- Obtaining blood pressure, pulse, respirations, and blood glucose readings, 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.
- Having a first visit with a patient.

B.3 Case Management (CM)

Use this code for any activity that results in a patient obtaining services. The patient does not have to be present when this service is performed. Examples include but are not limited to:

- 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).
- Obtaining or working with documents such as patient demographic information, emergency contacts, list of medications, etc. that are related to managing the patient's 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 ensure that they are properly working.
- Documenting referrals received or made by the CHR.

B.4 Monitor Patient (MP)

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

Examples include but are not limited to making contact with a patient who has a known health problem or diagnosis, or who is at high risk of illness or disability, 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.

B.5 Emergency Care (EC)

Use this code when providing emergency care services. Examples include but are not limited to:

- Responding to emergency situations.
- 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.

B.6 Patient Care (PC)

Use this code when providing services directly to a patient for general health categories (i.e., nutrition, fitness) or with a condition diagnosed at the facility where the CHR enters data. If the CHR is unsure about the patient diagnosis, document vital signs or other patient care related services under Case Find/Screen. Examples include but are not limited to:

- Providing hands on services such as taking blood pressure or other vital signs to persons with that HPC as a diagnosis.
- Providing emotional and mental support.
- Delivering items such as medications, supplies and equipment to a patient's home.
- .Assisting with basic self-care tasks such as dressing, tying shoes, hair brushing.
- Care usually takes place in the patient's presence or the patient directly receives the service.

B.7 Homemaker Services (HS)

Use this code when assisting a patient with household duties. If the patient needs long term assistance with HS, the CHR should find a resource to meet the patient's needs. Examples include but are not limited to:

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

B.8 Transport Patient (TP)

Use this code when transportation is provided to a patient for health-related services. 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:	During the transport and at the health care facility you can reduce transportation time. To reduce overall transportation time you should document the additional services you will be providing for example: monitor patient MP, provide emotional support PC, Health education, Case

> Management, Interpret translate, etc. Then reduce your service minutes for the transportation time appropriately.

B.9 Interpret or Translate (IT)

Use this code if you interpret, translate, or clarify information for the patient. Explaining in layman's terms or the preferred language of the patient to other health care providers and vice versa Examples include but are not limited to:

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

> **Note**: The CHR should NOT provide information to patient that requires a licensed provider.

B.10 Other Patient Service (OP)

Use this code when no other patient code applies. Examples include but are not limited to:

- Completing and entering CHR PCCs, for the HPC use Administrative/Management (AM).
- Includes any patient-centered services not included in other SCs. 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, events, health fairs, or expos. 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.

B.11 Environmental Services (ES)

Use this code for a variety of environmental services that are intended to prevent injury or disease. Examples include but are not limited to:

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

B.12 Administration/Management (AM)

Use this code when performing CHR program administrative services. Examples include but are not limited to:

- Meetings not directly related to patient care or training.
- Maintaining program records.
- Reporting on program activities to Tribal or other government officials.
- Answering the program's telephone, and similar activities.

> **Note**: When using Administration/Management code, put a zero (0) in the Number Served field, because no patients are being served.

B.13 Obtain Training (OT)

Use this code when participating in all types of training. This is intended for your own instruction to further your knowledge of health care and or your job. Examples include but are not limited to:

- Basic training.
- Advanced or specialty CHR training.
- CHR PCC training and update.
- Management or administrative training.

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

> **Note**: When using Obtain Training, put a zero (0) in the Number Served field, because no patients are being served. Activity location is 6. None.

B.14 Leave Time (LT)

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

			Assessment / Primary Purpose of Visit
Health Problem	Service Code	Service Minutes	Narrative
LT	LT	480	VACATION

Figure B-1: Sample Recording of Leave Time

> **Note**: When you use this code, report minutes used as Service Time and put a zero (0) in the number served field. Activity Location 6. None. Use a new CHR PCC Form for each day of leave.

B.15 Community Development (CD)

Use this code for activities in which you participate that help support your tribe or local community and indicates another SC does not apply. Examples include but are not limited to:

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

B.16 Not Found (NF)

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

The HPC that should be documented with this SC 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 HPC and NF as the SC. Put a zero (0) in the Number Served field.

B.17 Staff Training (ST)

Planning, coordinating, and conducting the training of CHR and other health or community agency employees (including development of instructional materials and researching instructional materials) related to the CHR program.

Examples include but are not limited to:

- New CHR Orientation.

- Training new CHR to do Home Visits.
- Teaching staff CPR, FA, etc.
- Training on CHR PCC Coding or Data Entry for new staff.

> **Note**: Staff Training is not a patient service and should not be documented using their name in the patient information.

Appendix C: Predefined (Canned) Narratives

Predefined (also called "canned") narratives are optional. Predefined narratives ease documentation and data entry by allowing the coder and data entry person to record commonly used narratives with a number that corresponds to a particular narrative. It works much like using the numbers for activity location and referrals. Once the number to the narrative is entered, the CHR PCC data entry system automatically fills in the predefined narrative.

At the narrative prompt, select a predefined narrative, or enter free text. Once a predefined narrative is selected, additional information may be appended to it. It is possible to select more than one predefined narrative from the list provided. However, the field is limited to 76 characters.

Become familiar with predefined narratives because it will make documentation easier. Predefined narratives cover the majority of services provided and will ultimately reduce documentation and data entry time. **Use of predefined narratives promotes standardization of documented data.**

A predefined narrative has one or more of the following characteristics:

- **P**: Patient Centered. Use these narratives to document an individual patient encounter.
- **N**: All Other Activities. Use these narratives to document a service unrelated to an individual patient, such as Obtain Training (OT), Leave Time (LT), etc., or to document a group activity on a form other than the 962-Group form.
- **G**: Group. Use these narratives to document group services only with the 962 Group form, thereby creating an individual patient record for each patient who received services.

C.1 Functionality

The lists that follow illustrate predefined narratives organized by functionality. Each narrative includes one or more of the letters P, N, and G, indicating the category or categories to which it applies.

C.1.1 Case Find/Screen

NARRATIVE	P	N	G
1. SCREENED	P	N	G
2. CONDUCTED INTERVIEW/SURVEY	P	N	G
3. NEW PATIENT	P	N	G

C.1.2 Health Education

NARRATIVE	P	N	G
1. PROVIDED HEALTH EDUCATION	P	N	G
2. PREVENTION HEALTH EDUCATION	P	N	G
3. PREPARED FOR HEALTH EDUCATION		N	
4. PLANNED HEALTH EDUCATION		N	

C.1.3 Case Management

NARRATIVE	P	N	G
1. COORDINATED PATIENT SERVICES	P	N	
2. ADVOCATED FOR PATIENT	P	N	
3. CHECKED MEDICAL EQUIPMENT	P	N	
4. ASSIST WITH PAPER WORK/FORMS	P	N	
5. MADE REFERRAL	P	N	
6. RECEIVED REFERRAL	P	N	

C.1.4 Monitor Patient

NARRATIVE	P	N	G
1. F/U NO C/O	P		
2. F/U MEDS: NO REFILLS NEEDED	P		
3. F/U MEDS: REFILLS NEEDED	P		

C.1.5 Emergency Care

NARRATIVE	P	N	G
1. PROVIDED FIRST AID	P		
2. PROVIDED CPR	P		
3. ARRANGED EMERGENCY TP	P		
4. PROVIDED EMERGENCY CARE UNTIL EMS ARRIVES	P		

C.1.6 Patient Care

NARRATIVE	P	N	G
1. PROVIDED EMOTIONAL SUPPORT	P		
2. DELIVERED ITEM	P		

NARRATIVE	P	N	G
3. PROVIDED PERSONAL CARE	P		
4. DX-[HPC]	P		

C.1.7 Interpret/Translate

NARRATIVE	P	N	G
1. LANGUAGE	P	N	G
2. CLARIFIED MEDICAL INSTRUCTIONS	P	N	G
3. CLARIFIED OTHER DOCUMENTS	P	N	G
4. EXPLAINED NORMAL VALUES	P	N	G

C.1.8 Other Patient Centered Service

NARRATIVE	P	N	G
1. OTHER PATIENT CENTERED SERVICE	P	N	
2. ASSISTED WITH FUNERAL/ARRANGEMENTS	P		
3. PLANNED SPECIALTY CLINIC/EVENT		N	
4. PRE/POST EVENT DUTIES		N	G
5. CHR PCC DOCUMENTATION		N	
6. CHR PCC DATA ENTRY		N	
7. CHR PCC REPORTS		N	

C.1.9 Environmental Services

NARRATIVE	P	N	G
1. CHECKED FOR HEALTH AND SAFETY HAZARDS	P	N	
2. INJURY PREVENTION ACTIVITIES	P	N	
3. DISEASE PREVENTION ACTIVITIES	P	N	
4. ANIMAL IMMUNIZATION CLINIC		N	
5. COMMUNITY CLEAN UP PROJECT		N	
6. COORDINATED REPAIR/MAINTENANCE COMMUNITY		N	

C.1.10 Not Found

NARRATIVE	P	N	G
1. ATTEMPTED HOME VISIT	P		

NARRATIVE	P	N	G
2. NOTICE OF ATTEMPTED VISIT	P		
3. ATTEMPTED CONTACT BY PHONE	P		

C.1.11 Transport

NARRATIVE	P	N	G
1. TRANSPORT	P	N	
2. PATIENT REQUESTED	P	N	
3. I/T/U REQUESTED	P	N	
4. OTHER PERSON REQUESTED	P	N	
5. NO CAR	P	N	
6. NO GAS	P	N	
7. NO DRIVER'S LICENSE	P	N	
8. NO OTHER RESOURCE	P	N	

C.1.12 Administration Management

NARRATIVE	P	N	G
1. STAFF MEETING		N	
2. GENERAL OFFICE DUTIES		N	
3. NON PATIENT RELATED PAPER WORK		N	
4. NON PATIENT RELATED SERVICE		N	

C.1.13 Obtain Training

NARRATIVE	P	N	G
1. OBTAINED TRAINING		N	

C.1.14 Leave Time

NARRATIVE	P	N	G
1. VACATION		N	
2. SICK		N	
3. HOLIDAY		N	
4. PERSONAL		N	
5. ADMINISTRATION		N	

NARRATIVE	P	N	G
6. LWOP		N	

C.1.15 Community Development

NARRATIVE	P	N	G
1. ASSISTED WITH NON HEALTH RELATED TRIBAL FUNCTION		N	
2. ASSISTED ANOTHER TRIBAL DEPARTMENT WITH PROJECT		N	
3. ASSISTED COMMUNITY ORGANIZATION WITH PROJECT		N	

C.1.16 Staff Training

NARRATIVE	P	N	G
1. PROVIDED OTHER EDUCATION		N	
2. NEW CHR ORIENTATION/TRAINING		N	

C.2 Sample Exercise

Learn to use predefined narratives one-step at a time. Start with the standard protocol for home visits to practice using the numbers associated with the predefined narratives.

When providing services to a real patient, additional services most likely will be added. It may be necessary to add free text to the predefined narrative. Remember that what follows is only an example.

The six lines of assessment based on protocol for home visit are:

1. Monitor patient health and well-being. Follow up on medication.
2. Check BP.
3. Check Pulse.
4. Check Respirations.
5. Provide Health Education.
6. Monitor Environment for Safety.

Using the suggested home visit protocol to document will result in a minimum of six lines of assessment every time. Two pieces of information are required:

1. Patient diagnosis (diagnosed at facility where CHR enters data).
2. Health education topic.

The example that follows will use predefined narratives and provide a description on how to outline a home visit using the suggested method. It is based on assumption no med refills are needed.

Required information to document home visit:

- **Diagnosis**. Hypertension.
- **Health Education**. Increase activity.

HP	SC	PREDEFINED	RPMS WILL INSERT TEXT
HY	MP	1,2	FOLLOW UP NO C/O , FOLLOW UP MEDS, NOREFILLS NEEDED
HY	PC	4	DX-HY
HT	CF	1	SCREENED
OR	CF	1	SCREENED
FI	HE	2	PREVENTION HEALTH ED
IC	ES	1	MONITOR ENVIROMENT FOR SAFETY

Note: The HPC will depend on the patient diagnosis and the topic of health education. Most patients have more than one diagnosis and should be monitored for each, which will result in more than six lines of assessment.

C.3 Scenarios

In the two scenarios that follow, use the suggested standard protocol for home visit and document for a Demo Patient. Don't worry about HRN, DOB, etc. The goal of the exercise is to practice using predefined narratives. Complete all required fields, service and travel times, and referrals. There is no correct answer dividing service minutes, however they must total reported time of visit.

C.3.1 Scenario One

Demo Patient. Demographic information not required.

Diagnoses. Hypertension and Heart Disease.

Health Ed. Diabetes prevention.

Summary of patient encounter:

- The patient has no complaints and reports medication filled yesterday. During visit, vital signs are checked: BP-120/80; P- 80- R-20- educated on diabetes prevention and monitor environment for safety. No referrals are required.
- Travel Time: 15 minutes. Total visit time: 80 minutes.

See Figure C-1 for how the completed form should look.

IHS-535-1 (12/2012)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
COMMUNITY HEALTH REPRESENTATIVE (CHR) PATIENT CARE COMPONENT (PCC)
ABBREVIATED ENCOUNTER RECORD

CHR Provider Code:	PKA	Program Code:	Chickasaw	Date of Service:	8/25/12

Patient Information

Patient Chart Name (Last, First MI)		HRN	DOB	Sex
Patient, Demo A		13246	2/3/1940	F
Tribe: Seminole		Community of Residence: Konawa		

Vital Signs/Measurements

BP	P	R	BG	T	HT in	WT lb	BMI	WC in	A1C
120/80	80	20							

Assessment / CHR PCC Primary Purpose of Visit

Health Problem	Service Code	Service Minutes	Narrative
HY	MP	15	1,2
HY	PC	5	4
HT	MP	15	1,2
HT	PC	5	4
OR	CF	5	1
IC	ES	15	1
DM	HE	20	2

Refer to CHR by:	1	2	3	4	5	6	7	8	9	10	11	(12)
1: Medical; 2: Nursing; 3: Dental; 4: Eye; 5: Social Work; 6: Behavioral Health; 7: Other Professional; 8: Technician; 9: Agency Program; 10: Family/Self/Community; 11: CHR Program; 12: None												
Refer by CHR to:	1	2	3	4	5	6	7	8	9	10	11	(12)

Activity Location:	(1)	2	3	4	5	6	7
1: Home; 2: CHR Office; 3: Community; 4: Include Name of Hospital/Clinic, IT/U or Specialty Facility with City and State; 5: Radio/Telephone; 6: None; 7: School							

Travel Time:	15	Number Served:	1	CHR Signature:	Demo Provider, CHR

Figure C-1: Results of Scenario One

C.3.2 ScenarioTwo

Demo Patient. Demographic information not required.

Diagnosis. Diabetes.

Health Ed. How to read food labels (carbs).

Summary of patient encounter:

- The PHN requested follow up and insulin delivery. The patient states they feel fine. During visit, vital signs are checked: BP-140/90; P-86; R-20; BG 100 fasting. Health education on reading food labels to count carbs is provided.
- Travel time: 0. Total visit time: 100 minutes.

See Figure C-2 for how the completed form should look:

IHS-535-1 (12/2012)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
COMMUNITY HEALTH REPRESENTATIVE (CHR) PATIENT CARE COMPONENT (PCC)
ABBREVIATED ENCOUNTER RECORD

CHR Provider Code:	PKA	Program Code:	Chickasaw	Date of Service:	8/25/12

Patient Information

Patient Chart Name (Last, First MI)	HRN	DOB	Sex
Patient,Demo I	213245	02/03/1940	F
Tribe: Upper Soux	Community of Residence: Wewoka		

Vital Signs/Measurements

BP	P	R	BG	T	HT in	WT lb	BMI	WC in	A1C
140/90	86	20	100						

Assessment / CHR PCC Primary Purpose of Visit

Health Problem	Service Code	Service Minutes	Narrative
DM	CM	15	6-PHN, 5-PHN
DM	MP	10	1
DM	PC	30	2-INSULIN, 4-FBG100
DM	HE	20	1-READ FOOD LABEL
HY	CF	5	1
HT	CF	5	1
OR	CF	5	1
IC	ES	10	1

Refer to CHR by:	1	(2)	3	4	5	6	7	8	9	10	11	12

1: Medical; 2: Nursing; 3: Dental; 4: Eye; 5: Social Work; 6: Behavioral Health; 7: Other Professional; 8: Technician; 9: Agency Program; 10: Family/Self/Community; 11: CHR Program; 12: None

Refer by CHR to:	1	(2)	3	4	5	6	7	8	9	10	11	12

Activity Location:	(1)	2	3	4	5	6	7

1: Home; 2: CHR Office; 3: Community; 4: Include Name of Hospital/Clinic, IT/U or Specialty Facility with City and State; 5: Radio/Telephone; 6: None; 7: School

Travel Time:	0	Number Served:	1	CHR Signature:	Demo Provider, CHR

Figure C-2: Results of Scenario Two-Did you remember to document refer to and by?

Appendix D: CHR PCC Forms

D.1 IHS-535: CHR Comprehensive PCC Encounter Record

IHS-535 (12/2012)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
COMMUNITY HEALTH REPRESENTATIVE (CHR) PATIENT CARE COMPONENT (PCC)
COMPREHENSIVE ENCOUNTER RECORD

CHR Provider Code:		Program Code:		Date of Service:	

Patient Information			
Patient Chart Name (Last, First MI)	HRN	DOB	Sex
Tribe	Community of Residence		

Vital Signs/Measurements									
BP	P	R	BG	T	HT in	WT lb	BMI	WC in	A1C
HC	VU – L R			VC – L R			LMP FPM		

Assessment / CHR PCC Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative

Refer to CHR by:	1	2	3	4	5	6	7	8	9	10	11	12
1: Medical; 2: Nursing; 3: Dental; 4: Eye; 5: Social Work; 6: Behavioral Health; 7: Other Professional; 8: Technican; 9: Agency Program; 10: Family/Self/Community; 11: CHR Program; 12: None												
Refer by CHR to:	1	2	3	4	5	6	7	8	9	10	11	12

Activity Location:	1	2	3	4	5	6	7
1: Home; 2: CHR Office; 3: Community; 4: Include Name of Hospital/Clinic, I/T/U or Specialty Facility with City and State; 5: Radio/Telephone; 6: None; 7: School							

Travel Time:		Number Served:		CHR Signature:	

Subjective

Objective

Plan/Treatments/Education/Medication

D.2 IHS-535-1: CHR Abbreviated PCC Encounter Record

IHS-535-1 (12/2012)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
COMMUNITY HEALTH REPRESENTATIVE (CHR) PATIENT CARE COMPONENT (PCC)
ABBREVIATED ENCOUNTER RECORD

CHR Provider Code:		Program Code:		Date of Service:	

Patient Information			
Patient Chart Name (Last, First MI)	HRN	DOB	Sex
Tribe	Community of Residence		

Vital Signs/Measurements									
BP	P	R	BG	T	HT in	WT lb	BMI	WC in	A1C

Assessment / CHR PCC Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative

Refer to CHR by:	1	2	3	4	5	6	7	8	9	10	11	12
1: Medical; 2: Nursing; 3: Dental; 4: Eye; 5: Social Work; 6: Behavioral Health; 7: Other Professional; 8: Technician; 9: Agency Program; 10: Family/Self/Community; 11: CHR Program; 12: None												
Refer by CHR to:	1	2	3	4	5	6	7	8	9	10	11	12

Activity Location:	1	2	3	4	5	6	7
1: Home; 2: CHR Office; 3: Community; 4: Include Name of Hospital/Clinic, I/T/U or Specialty Facility with City and State; 5: Radio/Telephone; 6: None; 7: School							

Travel Time:		Number Served:		CHR Signature:	

IHS-535 (12/2012) (Back)

D.3 IHS-962: CHR Group PCC Encounter Record

IHS-962 (12/2012)

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

CHR Provider Code:		Program Code:		Date of Service:	

Activity Location:	1	2	3	4	5	6	7

1: Home; 2: CHR Office; 3: Community; 4: Include Name of Hospital/Clinic, I/T/U or Specialty Facility with City and State; 5: Radio/Telephone; 6: None; 7: School

Travel Time:		Number Served:		CHR Signature:	

Assessment / Primary Purpose of Visit			
Health Problem	Service Code	Service Minutes	Narrative

Patient Name	Sex	Patient Identifier	Tests/Measurements, if any
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

IHS-535-1 (12/2012) (Back)

Appendix E: 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.

E.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).

E.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.

E.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.

E.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.

E.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.

E.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.

E.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).

E.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, DOB, 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.

E.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.

E.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.

E.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.

E.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.

E.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.

E.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.

E.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.

E.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.

Acronym List

Acronym	Term Meaning
BMI	Body Mass Index
CHR	Community Health Representative
CM	Case Management
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
DOB	Date of Birth
HB A1C	Hemoglobin A1c
HHS	Department of Health and Human Services
HPC	Health Problem Code
HRN	Health Record Number
I/T/U	IHS, Tribal, or Urban
IHS	Indian Health Service
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
NP	Nurse Practitioner
PCC	Patient Care Component
PHN	Public Health Nurse
POV	Purpose of Visit
RN	Registered Nurse
RPMS	Resource and Patient Management System
SC	Service Code
SM	Service Minutes
SOAP	Subjective, Objective, Assessment, Plans

Contact Information

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

Phone: (888) 830-7280 (toll free)

Web: http://www.ihs.gov/helpdesk/

Email: support@ihs.gov