



# DOCUMENTATION AND CODING GUIDELINES FOR PUBLIC HEALTH NURSES

Version 2.0  
October 2012



Office of Clinical and Preventive Services  
Indian Health Service  
U.S. Department of Health and Human Services

# ACKNOWLEDGMENTS

The IHS Office of Clinical and Preventive Services acknowledges the hard work of the following individuals who contributed, wrote, edited, designed, and distributed the various versions of the *Documentation and Coding Guidelines for Public Health Nurses*:

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# FOREWORD

This manual was written by and for public health nurses in the Indian Health Service, in Tribal health facilities, and in Urban Indian health facilities.

Users do not have to read this manual from start to finish. They can start at the beginning of any chapter and be able to understand the instructions. However, it is strongly recommended that users read at least the first two chapters before moving on to anything else.

The manual is configured in a modular format and can be printed on loose-leaf paper. When new content is produced, only the revised pages will be released. Users can simply insert the new pages. The pagination of unchanged chapters will not be affected.

The chapter on the Electronic Health Record (EHR) is based on a training version of the EHR used by the Office of Information Technology in Albuquerque. The information displayed in the graphics is not actual data. Because the EHR is customizable, the way tabs and windows appear in EHRs in various facilities will differ.

The use of acronyms is kept to a minimum.

Most of the graphics are screen shots, and the low resolution of screen shots unfortunately contributes to a grainy look.

If you have any comments, please contact Tina Tah at [tina.tah@ihs.gov](mailto:tina.tah@ihs.gov) or at (301) 443-0038.

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## 1.0 STANDARDIZED DOCUMENTATION

This manual standardizes the documentation and coding practices of public health nursing services for the Indian health system. Standardized documentation and coding improves (a) the accurate documentation of the care provided, (b) data generation and capture, and (c) comparability between programs and areas. It also helps protect the health system against liability.

### 1.1 Nursing Process as a Guide to Documentation

Public health nursing (PHN) documentation is part of a client's medical record (which is a legal document). Nurses must make a record (either electronically or on hard copy) of every significant, patient-focused service. The documentation must meet certain criteria to comply with legal and accreditation requirements, as well as local bylaws, rules, and regulations. PHN-significant, patient-focused service includes all workload encountered by the program, such as the services listed in Table 1.1.1.

Public health nurses need to be aware that the same event can have two different names in the Resource and Patient Management System (RPMS) and the Electronic Health Record (EHR). For example, a clinic name in RPMS is called a visit location in EHR. Notice the terms in the column headers in Table 1.1.1.

The RPMS clinic name and the EHR visit location are not to be confused with location of encounter. Location of encounter designates exactly where the patient services were provided and needs to be documented in the nurse's note to be entered in by data entry personnel.

Table 1.1.1 Typical Public Health Nursing Services

Clinic Name (RPMS) and Visit Location (EHR)	Definition	Clinic Code and Location Code	Service Category (RPMS) and Type of Visit (EHR)
PHN Clinic (Encounter)	A patient had an encounter with a public health nurse or a public health technician only. No other medical providers gave care. While RPMS refers to this as a PHN clinic, it does not mean that the encounter takes place only in an office or clinic setting.	45	Ambulatory



Clinic Name (RPMS) and Visit Location (EHR)	Definition	Clinic Code and Location Code	Service Category (RPMS) and Type of Visit (EHR)
<b>PHN Visit to Inpatient</b>	The nurse had an encounter with a patient while the patient was located in inpatient ward. Examples include a lactation consultation for new mother or referral from a provider.	45	Inpatient
<b>PHN Home Visit</b>	The nurse provided health care service to a patient in the patient's home.	11	Ambulatory
<b>PHN Home Not Found</b>	The nurse attempted to provide health care service at the patient's home, but the patient was not home.	11	Not Found
<b>PHN Immunization</b>	An organized clinic (such as a flu clinic) provided assessment and administration of immunizations.	12	Ambulatory
<b>PHN School</b>	An organized clinic at a school provided nursing, education, or counseling services to school-age children (kindergarten through 12th grade). Do not use this code for an immunization clinic at a school; see above.	22	Ambulatory
<b>PHN Homeless</b>	The nurse provided services to a patient living in a homeless shelter, in transitional housing, on the streets, or with friends or relatives.	D3	Ambulatory
<b>PHN Homeless Not Found</b>	The nurse attempted to provide service to a homeless patient (defined above), but the patient was not found.	D3	Not Found
<b>PHN Telephone</b>	The nurse contacted an individual via telephone for a significant, health-related intervention. This includes contact by text messaging.	51	Telecommunication
<b>PHN Phone Not Found</b>	The nurse unsuccessfully attempted to contact an individual via telephone or text message for a significant, health-related intervention.	51	Not Found
<b>PHN Chart Review</b>	The nurse's review of the medical record resulted in the documentation of medically significant information. This code does not include a patient visit.	52	Chart Review

Clinic Name (RPMS) and Visit Location (EHR)	Definition	Clinic Code and Location Code	Service Category (RPMS) and Type of Visit (EHR)
PHN Letter	The nurse or technician sent correspondence to a patient to notify for immunizations due, to reschedule an appointment, to provide test results, or to schedule a follow-up visit.	53	Chart Review
PHN Education Class	A scheduled, organized activity provided an education class to a group on health-related topics.	60	Ambulatory
PHN Case Management	The nurse made sure that the most appropriate type and level of care was provided in the most cost-effective manner to a patient in person.	77	Ambulatory
PHN Case Management	The nurse made sure that the most appropriate type and level of care was provided in the most cost-effective manner to a patient over the phone.	77	Telecommunication
PHN Case Management	The nurse made sure that the most appropriate type and level of care was provided in the most cost-effective manner in a patient's absence.	77	Chart Review
PHN Well Child	An organized clinic provided developmental screening assessment and services to well children. This code is used in the field when a public health nurse works with a pediatrician. Public Health Nurses usually do not work in well child clinics in the hospital or clinic.	24	Ambulatory
PHN Other	This code is used only when there is <b>absolutely</b> no other code to describe a nurse's intervention.	25	Ambulatory

The Indian Health Manual (in Part 3, Chapter 3) states, “Timely entries must be made on appropriate documents following examination and treatment as specified in IHS and facility policies.” (See [http://www.ihs.gov/IHM/index.cfm?module=dsp\\_ihm\\_pc\\_p3c3](http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p3c3).) Documentation must be *accurate, relevant, timely, and complete*. The scope of documentation must be organized, complete, and comprehensive enough to provide continuity of care, to reflect all treatment, to support the health care provider's reported workload, and to support services that are reimbursed by third-party payers. Each patient event must include, or refer to, the: chief complaint

or reason for visit; relevant history and examination of findings; clinical impression or diagnosis; plan of care; identification of appropriate risk factors; date; and legible identification of the health care professional.

The Manual references time frames: “Each entry in the record is completed (including authentication) within the time frames delineated by the facility’s medical staff bylaws, rules, and regulations.” Public health nurses need to be knowledgeable of, and adhere to, their local facilities’ policies regarding time frames.

Documentation has to occur in a timely fashion, usually at the end of the workday. In some cases, public health nurses deliver service in the field and do not return to the office until the next business day; in these cases, documentation must happen within 24 business hours of the service delivered. Delaying documentation leads to incomplete or inaccurate information.

In addition to incomplete reporting, delayed documentation can create a gap in service and possible harm to a patient. For example, let’s say a patient receives service on Monday from a public health nurse who does not document the service on the day it occurred. Then, on Tuesday, an emergency happens and a different provider gives service to the same patient without knowing what was provided on Monday because Monday’s service was not recorded yet in the patient’s record. This delayed documentation creates a health risk for the patient and a potential legal liability for the Indian Health Service if the patient experiences a negative outcome. Another negative scenario would be that medications or tests ordered for a patient are not delivered or performed in a timely manner because documentation was not made on the day of service. This would also create a potential health risk and legal liability.

In regards to billing for PHN services, timeliness of documentation is crucial to support the processing of collection and to seek immediate reimbursement payments. Documentation must be accurate to avoid inappropriate billing practices and the potential for negative financial legal consequences, such as a facility having to repay fees. Therefore, every effort must be made to ensure that PHN documentation is accurate and timely.

***Remember: if a service was not documented, then the overwhelming presumption is that the service was not provided.***

The American Nurses Association’s *Nursing: Scope and Standards of Practice* provides nurses, regardless of specialty, with a scientific process in providing nursing care. Using the nursing process as a tool in documenting patient care aligns with the Indian Health Service’s Health Information Management guidelines and is a best practice for managing documentation risk.

As public health nurses think about documentation using the nursing process as a guide, they must consider the subjective-objective-assessment-plan format (SOAP) outlined in Indian Health Service policy quoted below.

## **Indian Health Manual**

### **Part 3: Professional Services**

#### **Chapter 3: Health Information Management**

...

##### **3–3.2 Health Record**

...

**D. Electronic Health Records.** Electronic capture and storage of patient health information will be implemented to enhance access to patient data by health care practitioners and other authorized users. Electronically stored and/or printed health information is subject to the same medical and legal requirements as handwritten information in the health record.

...

##### **3–3.8 Health Record Documentation**

...

**AQ. Progress Notes.** IHS adopted the Problem-Oriented Record System; therefore, notes should be written in the subjective, objective, assessment, and plan (SOAP) format. The progress notes must document the patient's course and response to treatment. The frequency of the physician's or other licensed independent practitioner's progress notes is determined by the change in the patient's condition, but must be adequate to document the severity of illness and the intensity of service during the patient's hospitalization.

...

#### **Chapter 4: Nursing**

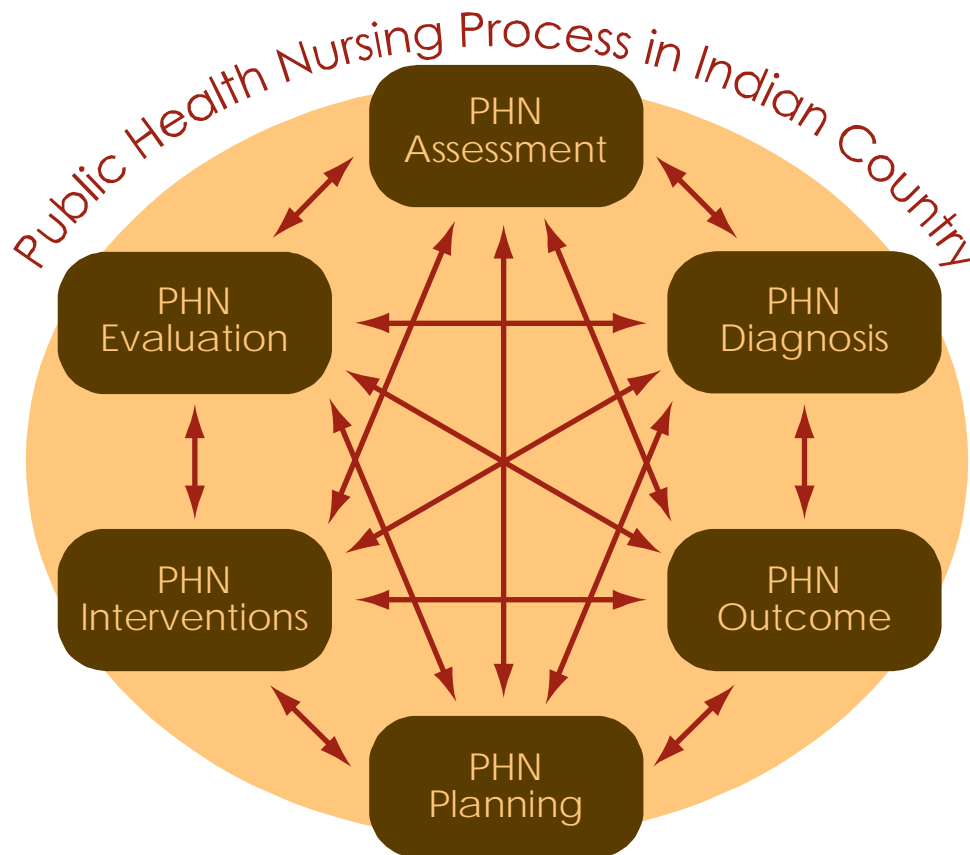
...

##### **3–4.5 Nursing Practice Management**

...

**E. Nursing Process.** The nursing process (assessment, diagnosis, planning, intervention, evaluation), the framework of nursing practice, shall be applied and documented in all three areas of nursing practice: inpatient, ambulatory and public health nursing.

Figure 1.1 Public Health Nursing Process



Nursing assessment includes subjective and objective information. Subjective data is data that the patient states significant to his or her current condition, according to Patricia A. Duclos-Miller, author of *Managing Documentation Risk: A Guide for Nurse Managers*. Duclos-Miller writes, “[I]f the patient says something that can be used to demonstrate mental, behavioral, or cognitive status at the time of the assessment, [then] documentation of the conversation can be used to measure progress or decline over the course of treatment.”

Objective data includes data that can be measured, such as vital signs and results of tests. Duclos-Miller writes, “The physical exam of the patients—which includes key

assessment techniques, such as inspection, palpation, percussion, and auscultation—provides objective data about your patients’ health status.”

The North American Nursing Diagnosis Association states:

Nursing diagnosis is a clinical judgment about actual or potential individual, family, or community experiences or responses to health problems [and] life processes. A nursing diagnosis provides the basis for selection of nursing intervention to achieve outcomes for which the nurse has accountability.  
(<http://www.nanda.org/DiagnosisDevelopment/DiagnosisSubmission/PreparingYourSubmission/GlossaryofTerms.aspx>)

In the SOAP format, nursing diagnosis is part of nursing assessment, because the diagnosis shows how a nurse made his or her clinical decisions, according to Duclos-Miller.

Nursing planning is the phase where the nurse takes the information from the assessment and formulates a plan of care that identifies and prioritizes the nursing diagnoses.

Nurses must document of all types of nursing interventions (such as, therapeutic interventions, comfort, education, and referrals) and the patients’ responses to the interventions.

Nursing evaluation includes the reassessment of the patient’s status, including all data, diagnoses, and interventions for achieving the planned outcome.

When using SOAP documentation, the final three components of the nursing process can be incorporated in the plan of care, because the plan describes why, what, and how the nurse handled the patient’s needs, according to Duclos-Miller.

Table 1.1.2 (below) is a side-by-side comparison showing the alignment of the nursing process with the requirements indicated in the Indian Health Manual. Incorporating the nursing process as a guide in public health nursing documentation will improve data quality, minimize risk, and maintain the integrity of the Indian Health Service’s documentation standards.

Table 1.1.2 Indian Health Manual Vis-à-Vis the Nursing Process

Health Information Management Requirements in the Indian Health Manual	Nursing Process
Chief complaint or reason for visit	Assessment—subjective data
Relevant history and examination of findings	Assessment—objective data
Clinical impression or diagnosis	Nursing diagnosis
Plan of care	Outcome (goals) and planning
Identification of appropriate risk factors	Implementation, nursing interventions, and evaluation of progress

### ***Refusals***

Documenting services refused is just as important as documenting services provided. If a patient refuses a service, the health care provider must document that refusal to show that the provider did his or her best to offer a service according to standards of care. This documentation is an important risk management activity, because it will help protect the provider if any legal issues arise from a negative outcome to the patient. It is also very important that these refusals are recorded in the Electronic Health Record (which is explained below). Refusals must be documented.

### **1.2 Understanding the Data Collection Process**

In the Indian health system, patient databases are managed by the Resource and Patient Management System (RPMS), which is a set of integrated computer applications designed to support clinical and administrative functions of a health care program. Most public health nurses and other health care providers use the Electronic Health Record (EHR)—a user-friendly application that interfaces with the RPMS—to enter and manage patient information. The EHR replaces paper forms that record visit information and activities. However, public health nurses at some facilities are still filling out Patient Care Component (PCC) forms.

The Indian Health Service (IHS) PHN program compiles data into the PHN data mart, which generates reports on level of activity, performance, and other measurements. (See <http://www.ihs.gov/NonMedicalPrograms/ihpes/phn/>.) The Indian Health Service's PHN budget justification for the fiscal year is based on outcome measures of performance specific to the PHN program. The performance measurement is the total number of public health nurse activities captured by the PHN data mart with an emphasis on primary, secondary, and tertiary prevention activities to individuals,

families, and community groups. Paramount to the IHS budget being a transparent performance budget that supports the goals and objectives of the US Department of Health and Human Services, the PHN data mart collects PHN data so overall assessments can be made to describe the activity of public health nurses. This automated monitoring of PHN performance measures provides stakeholders, consumers, and Congress with information to assess ongoing progress in providing and meeting the health care needs of American Indians and Alaska Natives more efficiently and effectively.

PHN data mart information summarizes activities in a number of different ways, but there are two major factors that must be present in order for the data to be captured correctly.

1. Public health nurses must be identified with the correct provider discipline code upon setup in RPMS. This is usually done by a health information manager or RPMS site manager. The RPMS provider discipline code is 13 for full-time permanent staff and 32 for contract staff.
2. The location of encounter defines where the visit occurred. Codes are numerical and based on the IHS Area, service unit, and facility. The Standard Code Book (<http://www.ihs.gov/scb>) has a complete listing of locations of encounter by facility, and your site should have at least have “Facility-Home-School-Other” designated as an active option.

PHN program directors need to make sure that data is entered into RPMS accurately so that outcomes are measured correctly. Program directors should check provider discipline codes when a new hire enters the PHN program and during quarterly assessments of staff. This is especially important when a staff person moves into PHN from another department within the same facility. Program directors must also review data to ensure that data entry personnel and coders are capturing the correct location of encounters in alignment with the clinic codes for visit services. For example, clinic code 11 should match location of encounter “Home.”

Poor documentation practices due to the lack of knowledge of the electronic health system and other such tools will result in poor data integrity. PHN performance measures, PHN program contributions, and agency performance measures are adversely affected by poor documentation.

### ***Electronic Health Record***

In regard to electronic health records, the data collection process is fairly straightforward. Fields in the EHR database are programmed with drop-down menus and other functions to ease data entry. Although the method of documentation has



changed from paper to electronic, the legal requirements have *not* changed. It is the nurse's responsibility to fill in the fields properly.

Nurses must choose the correct categories within fields; choosing the right categories ensures accurate and complete data. All fields that detail the nursing process must be completed, and information in all the fields must use the subjective-objective-assessment-plan (SOAP) format or the subjective-objective-assessment-plan-intervention-evaluation (SOAPIE) format. Records must have an electronic signature.

***Warning: there is no paper record to back up the data entered, so it is of utmost importance that patient care information is entered correctly the first time. Correcting inaccuracies is sometimes difficult.***

### ***Patient Care Component***

Regarding PCC forms, the process requires more diligence on the parts of the health care provider and the data entry staff. Information must be written legibly in the correct places and must follow the SOAP or SOAPIE format. The health care provider must describe the nursing process employed. A legal signature and title must be included. Any error must be struck out neatly with one line through and must be initialized. Don't erase or scratch out.

***Warning: a third-party, non-medical professional has to read your completed PCC and enter the information from it into a database. Therefore, legibility and plain language are essential.***

While there are literally hundreds of PCC templates (overlays) and PCC+ templates being used in public health nursing in the Indian Health Service, they all have three objectives in common.

1. They save time, because parts of the form are already filled in.
2. They prompt nurses to document according to the standards of care for the service delivered.
3. They provide standardized information in several places on the form, making it easier for data entry staff to find and enter information electronically.

After the public health nurse completes the PCC form, it is delivered to a medical record department. One copy of the form is placed in the patient's health record, and a second copy is delivered to a data entry department. Data entry staff reads the se-

cond copy and enters information into the RPMS (which is then used to generate reports).

Some PCC forms are layered, with duplicate or triplicate sheets under the top sheet. The user has to bear down when writing on the top sheet to make sure his or her handwriting is visible on the bottom layer. The nurse completing this kind of form must remember that the data entry staff will not receive the top sheet (which goes into the patient's health record). The data entry staff will see the middle or second copy of the top sheet, posing the possibility of omission or illegibility. For example, if a hand stamp is used on the top layer of the form, the impression from the stamp is not visible on the second or third layer. Consequently, the data entry personnel will not enter that information into the database.

***Note: the PCC form (and any copy of it) is subject to requirements of the Health Insurance Portability and Accountability Act. Public health nurses should familiarize themselves with these requirements. And, the PCC form must adhere to accreditation standards for physical security of patient information.***

Nurses should understand how their data entry staff gleans information from PCC forms. Data entry staffers are trained to read PCC forms in a certain sequence. Until recently, they scanned across the top of the form from the left to the right. Then, they moved down the right side of the form until they got to the purpose of visit and a valid signature. After that, they went to the next form. Now, there are more pieces of information they need to collect to meet accreditation standards and Government Performance and Results Act requirements.

***Bottom line:*** information entered into the RPMS must be *accurate, complete, and timely*. By knowing where and what to document in legible handwriting, nurses can contribute to a smoother data generation process and, in turn, improve patient care, data quality, and, where appropriate, revenue.

## 2.0 DO'S AND DON'TS OF PUBLIC HEALTH NURSING DOCUMENTATION

### 2.1 Do's

- Document that you have the correct chart number or have retrieved the correct patient in the Electronic Health Record (EHR) before you begin documentation.
- Make sure your documentation reflects the nursing process and your professional capabilities. This includes all EHR components as well as a note for every visit.
- Document legibly. Check spelling before signing a note in EHR.
- Document the time you gave a medication, the administration route, and the patient's response. Document the Five Rights, which are the:
  - right patient,
  - right medication,
  - right dose,
  - right route, and
  - right time.
- Document precautions or preventive measures used.
- Document each phone call and text message to a physician or patient, including the exact time, message, and response.
- Document patient care at the time you provide it or as soon as possible. Be sure documentation is completed at the end of each workday.
- Document the reasons for care and service refusals.
- Document why the patient, parent, or guardian refused care or service. Also document the education and intervention provided that outlined the potential risks and complications of refusal. Include the patient education codes. Good documentation protects the nurse from risks associated with adverse patient outcomes when care or services are refused.

- If you remember an important point after you've completed your documentation, chart the information with a notation that it is a late entry. Include the date and time of the late entry.
- Document often enough to tell the whole story.

## 2.2 Don'ts

- Don't document a symptom, such as "c/o pain," without also charting what you did about it.
- Don't alter a patient's record; this is a criminal offense.
- Don't use shorthand or abbreviations that aren't widely accepted. See the approved abbreviations list at your facility. They may differ from facility to facility.
- Don't document imprecise descriptions, such as "bed soaked" or "a large amount."
- Don't document what someone else said, heard, felt, or smelled unless the information is critical. In that case, use quotations and attribute the remarks appropriately.
- *Don't document care ahead of time. Something may happen to prevent you from actually giving the care you've charted. Charting care that you haven't done is considered fraud.*

## 3.0 SETTING UP PUBLIC HEALTH NURSING CLINICS IN THE RESOURCE AND PATIENT MANAGEMENT SYSTEM

The public health nurse must communicate to the site manager, clinical application coordinator, or health information manager the list of clinic codes (Tables 1.1.1 and 3.5) that describes their visits. This step is required before entering patient documentation.

### 3.1 Log onto the RPMS

To open the RPMS software, double click the RPMS icon. RPMS will prompt the user for an access code.

*Note: The RPMS software requires the use of all capital letters.*

Type in your access code. The software will display asterisks in place of what you type. Hit return or the Enter key. Type in your verify code, and type Enter again. You are now logged in.

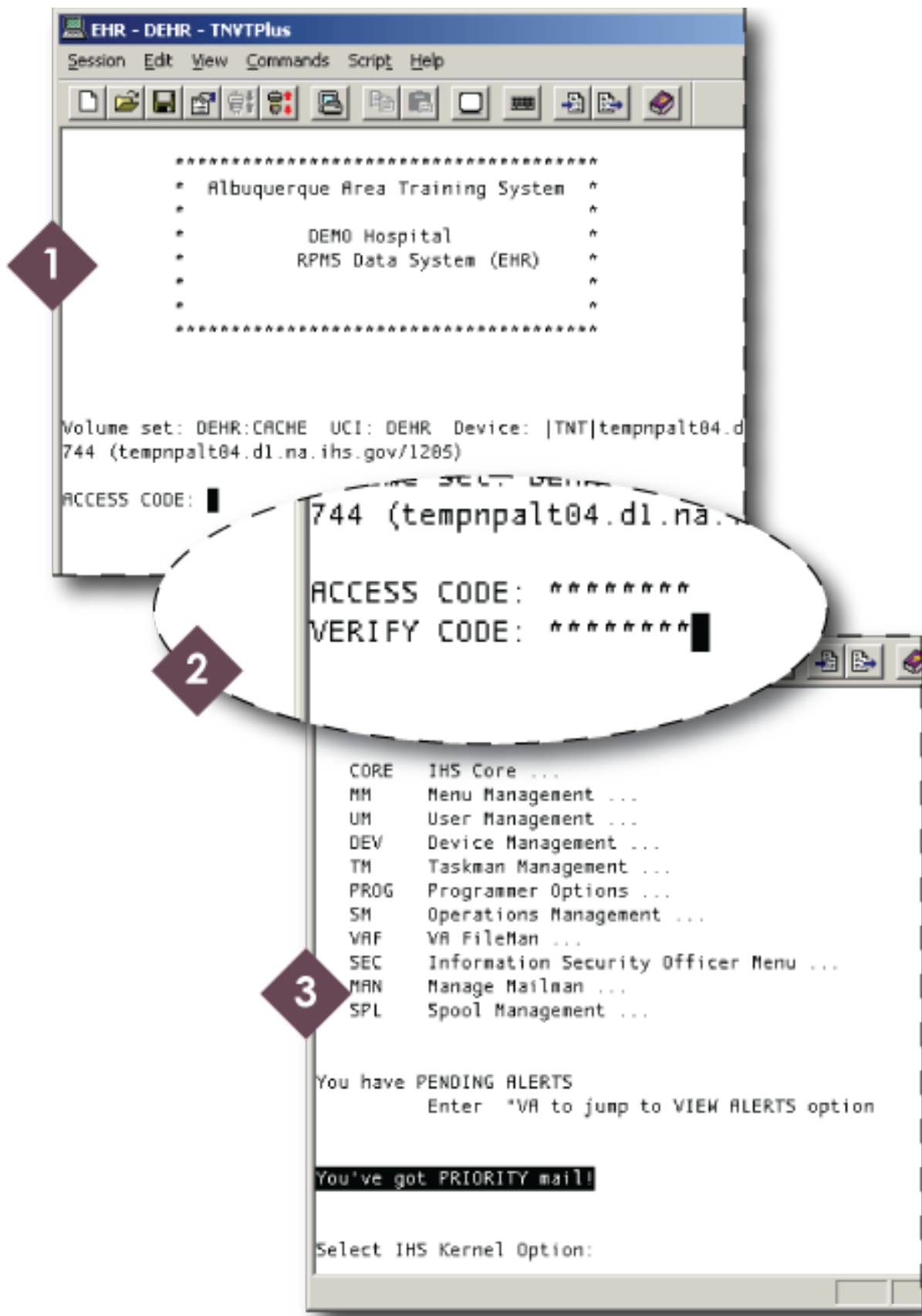
You will stay logged into RPMS until you quit the program or until one of these two instances happens:

1. you do nothing for 15 minutes, or
2. you mistype the access code or verify code during three successive attempts to login.

In the first instance, when the system automatically logs you out after a period of inactivity, simply type Enter and repeat the login process. After you log back in, the system will ask you if you want to return your previous location.

In the latter instance, you will have to shut down the program and restart the computer. After restarting, double click the RPMS icon and try to login again. Contact the information technology specialist if the problem persists.

Figure 3.1. Logging Onto RPMS



### 3.2 Navigate RPMS Menus

Public health nurses will have a menu built at their local sites with assistance from their local site managers. The directors of public health nursing (PHN) may have expanded options available. The availability of PHN menus (or the options available within the menu) may vary according to local practice. Table 3.2 lists the *minimum* menu access that every public health nurse should have available.

Table 3.2 RPMS Menus for Public Health Nurses

Menu	Technical Information	Description	Functionality
Immunization Tracking System (BI)	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• Kernel v8 or later</li> <li>• FileMan v22</li> <li>• Immunization v8.4 or later, or Immunization never before installed</li> <li>• Cache 4.1 or later</li> <li>• Cache \$ZF Heap of at least 124335</li> </ul> <p><b>Security Keys</b></p> <ul style="list-style-type: none"> <li>• BIZMENU</li> <li>• BIZ EDIT PATIENTS</li> <li>• BIZ MANAGER—only provided to a limited staff that has received training specific to parameter setup and program management.</li> <li>• BIZ LOT NON-MANAGER—only provided to limited staff that have received training to enter lots <i>only</i>. For example, if pharmacy manages the storage of vaccine, then this key can be allocated to pharmacy for lot entry and management without having full BIZ Manager keys.</li> </ul> <p><b>Note</b></p>	<p>The Immunization Module provides a means to track and recall patients for immunizations, to provide feedback to the providers and administrators about immunization rates in their patient population, and to share immunization information with authorized agencies.</p>	<p>The module is composed of a main menu with options available in three submenus. Options in the submenus are grouped by the type of function they perform. Some screens also display options at the bottom of the screen to perform operations on the information presented on the screen. Not all options and actions are available to all users. Manager keys are provided to a limited staff that has received appropriate training (typically designated an immunization coordinator). For questions or concerns regarding locked options and actions, please contact your site manager. At a minimum, the director of PHN and the PHN staff need to have view and edit capability.</p>

Menu	Technical Information	Description	Functionality
	<p>It is critically important that the screen handling codes for C-VT100 in the Terminal Type File be up to date.</p>		
<p><b>PCC Management Reports (APCL)</b></p>	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• Kernel 7.1 or higher</li> <li>• FileMan 21 or higher</li> <li>• AUPN (Patch 4) or higher</li> <li>• Taxonomy 5.1</li> <li>• Q-Man (Patch 9)</li> </ul> <p><b>Security Keys</b></p> <ul style="list-style-type: none"> <li>• APCLZ—Delete a report definition</li> <li>• APCLZMENU—PCC Management Reports main menu</li> <li>• APCLZRT—Report template retrieval tool and data fetcher</li> <li>• APCCUSER</li> </ul>	<p>The richness of the Patient Care Component (PCC) database, as well as the functional need for retrieving data in an organized manner for administrative and clinical management purposes, led to the development of the PCC Management Reports module. The options available in this module allow users to quickly and easily generate reports containing the data they need from the PCC.</p>	<p>PCC Management Reports provides numerous reports for patient and program management. This module facilitates the retrieval of data from the PCC by offering the user predefined report options as well as tools for custom report generation. Users specify the parameters for each of the reports to retrieve the data of interest. Reports are organized by category on the main menu for ease of use. Access to the PCC Management Reports menus is restricted to authorized individuals and is controlled by the facility's site manager through the use of security keys (code words assigned to the user that allow access to a menu).</p>
<p><b>Clinical Reporting System (BGP)</b></p>	<p><b>System Requirements</b></p> <p>IHS Clinical Reporting System v12.0</p> <p><b>Security Keys</b></p> <ul style="list-style-type: none"> <li>• BGPZMENU</li> <li>• BGPZPATIENT LISTS</li> </ul>	<p>The IHS Clinical Reporting System (CRS) is an RPMS software application designed for national reporting. CRS helps Area Office and local monitor clinical GPRA (Government Performance and Results Act) and developmental measures.</p>	<p>CRS produces reports on demand from local RPMS databases for both GPRA and developmental clinical performance measures that are based on RPMS data. It eliminates the need for manual chart audits for evaluating and report-</p>



Menu	Technical Information	Description	Functionality
		<p>Each year, an updated version of CRS software is released to reflect changes in the logic descriptions of the different denominators and numerators. Additional performance measures may also be added. Local facilities can run reports as often as they want and can also use CRS to transmit data to their Area offices.</p>	<p>ing clinical measures. For each measure, CRS produces a list of patients related to the specific measure. Most patient lists include patients from the denominator, with any visit dates or codes that identify them as meeting the measure. Patient lists are a good way to identify patients who need a procedure or test; for example, a list can show patients ages 50 or older who have not received influenza vaccinations.</p>
<p><b>Adverse Reaction Tracking (ART)</b></p>	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• Kernel v8.0 or later</li> <li>• FileMan v22 patch 1002</li> <li>• Cache v 4.1 or later</li> <li>• EHR v1.1 Patch 9</li> <li>• GMRA V4.0 Patch 100</li> </ul> <p><b>Security Keys</b></p> <ul style="list-style-type: none"> <li>• GMRA-ALLERGY VERIFY</li> <li>• GMRA-CLINIC</li> <li>• GMRA-USER</li> </ul>	<p>The objective of Adverse Reaction Tracking (ART) is to track and report patient allergy and adverse reaction data. It's intended for all users of the package. All users are reminded that many of the reports and mail bulletins generated by this package contain confidential patient information, which is protected by the Privacy Act.</p>	<p>ART has multiple functionality for program managers. Public health nurses don't need program manager functionality. But, they will need some keys to allow them the ability to document adverse reactions in any setting, verify allergy and adverse reactions, and receive notifications of reactions needing verification. A basic knowledge of RPMS is presumed for most users.</p>
<p><b>Patient Registration (AG)</b></p>	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• Kernel (XU) v8.0 Patch 1009 or later</li> <li>• FileMan (DI) v21 or later</li> <li>• Patient Registration (AG) v7.0 through patch 5</li> </ul>	<p>The Patient Registration application provides a means of managing patient data. It also provides a means of tracking and billing patient care. The Patient Registration ap-</p>	<p>The View Patient's Registration Data is an option that allows the viewing of patient information only. This option is useful for staff members who do not have writing access to</p>

Menu	Technical Information	Description	Functionality
	<ul style="list-style-type: none"> <li>AUT v98.1 through patch 15</li> <li>AUPN v 99.1 through Patch 15</li> </ul>	<p>plication ensures that the most accurate patient data possible is maintained. The application provides a complete, accurate, and current patient profile to assist in evaluation, tracking, and billing of care provided.</p>	<p>the patient database but need viewing access to the information contained in the patient's online record. The View Patient's Registration Data option contains and presents all pertinent information on registered patients. The screens available through this option are identical to the screens available for edit, aside from the lack of editing capabilities in the view option.</p>
<p><b>Electronic Health Record (EHR)</b></p>		<p>The EHR represents a novel approach to electronic health records. Built on the VueCentric® Framework, the EHR is a highly customizable window into a patient's health record. Because of its flexibility, the EHR can be tailored to meet the needs of a wide range of user roles: providers, nurses, pharmacists, clerks, and others. Because the exact layout and configuration of the EHR will vary among user roles and health care facilities, the components available to a given user will also vary.</p>	<p>The RPMS-EHR is comprised of multiple functional components built upon an open architecture framework known as VueCentric. The unique construction of the application from over 70 discrete components dictates a slightly different structure for technical documentation. All PHN users need access to functions that relate to documentation of patient care. Directors of PHN need an additional key to allow them to track and manage consults.</p>
<p><b>Referred Care Information System (BMC)</b></p>	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>Referred Care Info System (RCIS) v3.0</li> <li>First-time RCIS install doesn't require v3.0</li> </ul>	<p>The Referred Care Information System (RCIS) is a group of computer programs that automate the clinical and administra-</p>	<p>The RCIS provides a standard tool for automating the referral process and maintaining records on referred care services. There</p>

Menu	Technical Information	Description	Functionality
	<ul style="list-style-type: none"> <li>• VA FileMan 21 or higher</li> <li>• VA Kernel 8 or higher</li> <li>• IHS Dictionaries (Patient) (AUPN) v99.1 patch 11</li> <li>• Taxonomy Package (ATX) v5.1 patch 5</li> <li>• Patient Registration (AG) v7.1</li> </ul> <p><b>Security Keys</b></p> <ul style="list-style-type: none"> <li>• Directors of PHN: BMCZSUPERVISOR</li> <li>• Public health nurses: BMCZSPECIAL</li> </ul>	<p>tive management of all referred care, including in-house referrals, referrals to other IHS facilities, and referrals to outside contract providers. Information entered to the system provides timely and accurate referral data on individuals and groups of patients for the key clinical and administrative managers at care delivery sites, IHS Areas, and IHS Headquarters. By tracking this information, RCIS helps ensure that referred care services are appropriate, effective, high quality, and provided at fair, reasonable prices.</p>	<p>are four main modules specific to the RCIS that are accessible from the main menu of the system: data entry; print reports; RCIS management; and RCIS special print menu. All of the data entry, management, and retrieval for the RCIS are performed with these four menu options. Public health nurses need access to view the existing referrals from outside agencies.</p>
<p><b>iCare Population Management Graphical User Interface (BQI)</b></p>	<p><b>System Requirements</b> There are multiple requirements for iCare to work properly. Please go to the technical and installation manuals found at <a href="http://www.ihs.gov/RPMS/?module=Applications&amp;option=View&amp;AC_ID=0">http://www.ihs.gov/RPMS/?module=Applications&amp;option=View&amp;AC_ID=0</a>.</p>	<p>iCare is a Windows-based, client-server graphical user interface (GUI) to RPMS. iCare retrieves key patient information from various components of the RPMS database and brings it together under a single, user-friendly interface. iCare is intended to help providers manage the care of their patients. The ability to create multiple panels of patients with common characteristics (e.g., age, diagnosis, community) allows users to personalize the way they view patient data</p>	<p>IHS has developed a set of chronic condition management applications. This type of application provides a way for health care providers to manage a specific group of patients for a single disease state. Register management applications help health care providers identify high-risk patients. These applications proactively track care reminders and the health status of individuals or populations, and they provide more standardized and appropriate care by embedding evidence-based</p>

Menu	Technical Information	Description	Functionality
			<p>guidelines. The iCare GUI is intended to allow providers to see a more complete view of patients with multiple conditions, while maintaining the integrity of user-defined, disease-specific registers.</p>
<p><b>Computerized Public Health Activity Data System (BNI)</b></p>	<p>The Computerized Public Health Activity Data (CPHAD) System occupies the BNI name space. Options, security locks and keys, templates, routines, and globals are name-spaced BNI.</p> <p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• Kernel (XU) v8.0 or higher</li> <li>• FileMan (DI) v21 or higher</li> </ul> <p><b>Contents of Distribution for GUI Interface</b></p> <ul style="list-style-type: none"> <li>• bni10client.zip—GUI software for the client PC</li> <li>• bni10setup.exe</li> <li>• Indian-HealthService.bni10.msi</li> </ul> <p><b>Security Key</b></p> <ul style="list-style-type: none"> <li>• BNIZMENU</li> </ul>	<p>The CPHAD application provides for the entry of public health activity performed by clinicians or other providers of public health activities. This software application will work in conjunction with existing RPMS applications. The package requires access and verify codes to access the system. These can be obtained from your supervisor or site manager. Security keys are assigned with your access codes. They are required to perform certain options in the CPHAD application. Some options within the application are “locked”; the user is unable to access the option without the appropriate security key.</p>	<p>CPHAD is a menu-driven application designed to provide its users with an efficient, dependable way to enter each occurrence of a public health activity. The application:</p> <ul style="list-style-type: none"> <li>• enables the entry of new records;</li> <li>• enables editing of records already entered at the facility; and</li> <li>• prints several reports about various aspects of the record.</li> </ul> <p>There are three basic types of screens that you will encounter using the CPHAD application: the main menu screen, submenu screens, and help screens.</p>
<p><b>Immunization Data Exchange (BYIM)</b></p>	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• Kernel (XU) v8.0 or higher</li> <li>• FileMan (DI) v22 or higher</li> <li>• IHS/VA Utilities (XB/ZIB) v3.0 patch 11</li> <li>• IHS Patient Dictionaries (AUPN)</li> </ul>	<p>Immunization Interface Management, also known as Immunization Data Exchange, allows a two-way exchange of immunization data for children from birth to 19 years of age between facilities running RPMS and state im-</p>	<p>The HL7 Communications Bridge, a non-RPMS application, enables an automated two-way exchange of immunization data between IHS and the state. All IHS sites can download this bridge; however, it can only</p>

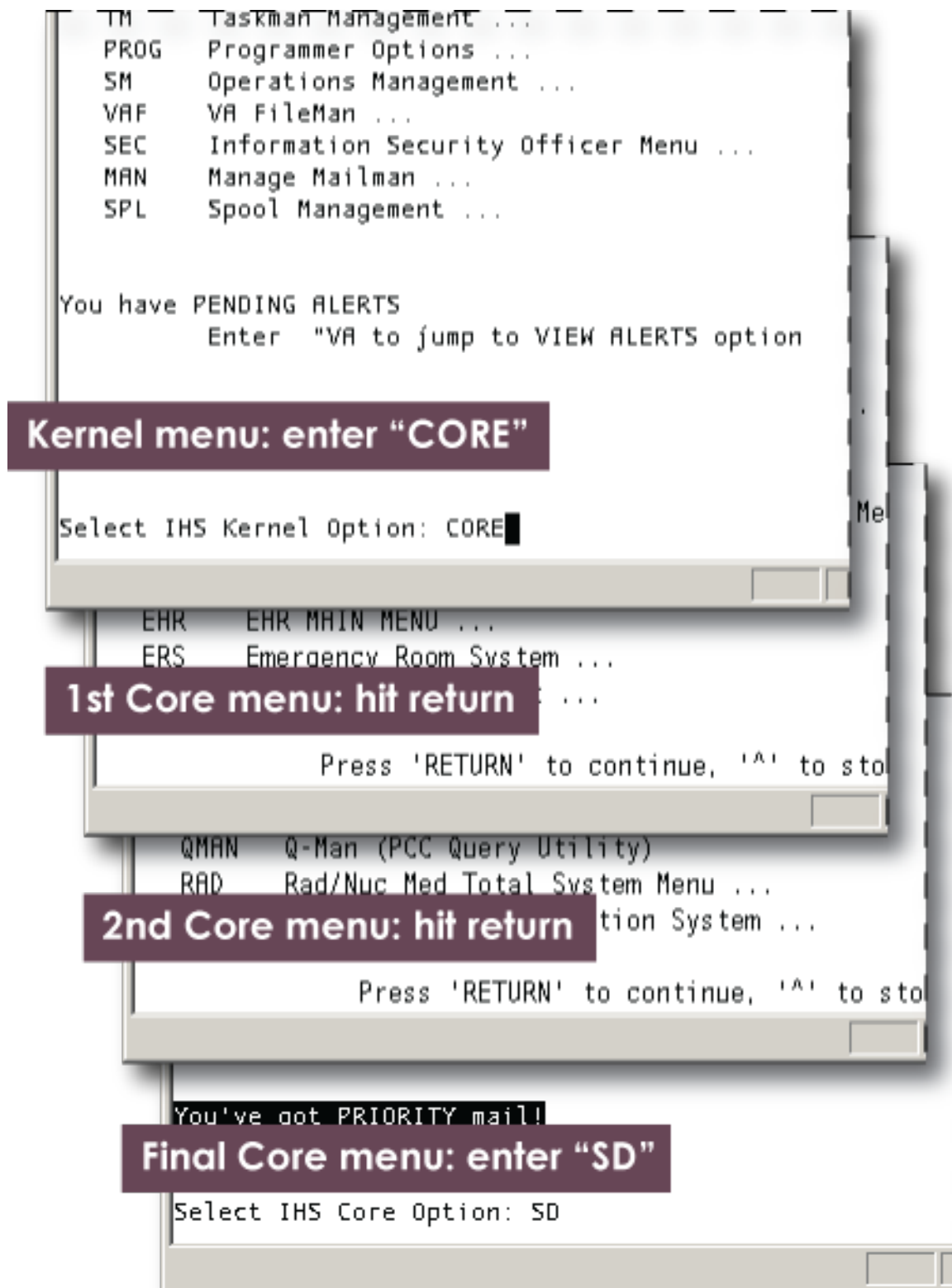
Menu	Technical Information	Description	Functionality
	<p>v99.1 patch 17</p> <ul style="list-style-type: none"> <li>• Patient Information Management (PIMS) v5.3 patch 1006 or MAS V5 (DG/SD) patch 8, if still in use</li> <li>• Generic Interface (GIS) v3.0 patch 14</li> <li>• IHS Immunization System (BI) v8.1 or higher</li> <li>• HL7 Communications Bridge for sites with the ability to transmit immunization data to or from their state immunization registry automatically</li> </ul> <p><b>Note</b> The site must have an account with its state immunization registry for HTTPS-secured transfer of the immunization data to the state.</p> <p><b>Security Keys</b></p> <ul style="list-style-type: none"> <li>• BYIMZMENU</li> <li>• BYIMZ IZ EXPORT</li> <li>• BYIMZ SET PARAMETERS</li> <li>• BYIMZ IZ AUTO IMPORT</li> <li>• BYIM IZ TEST EXPORT</li> </ul>	<p>munization registries. The Immunization Interface Management Menu uses secured data exchange via HTTPS to meet Health Insurance Portability and Accountability Act data security requirements for exchange of information between IHS and Tribal facilities and state registries.</p>	<p>be used in states whose registries support secure data exchange via an HTTPS connection. It's strongly recommended that the HL7 Communications Bridge be installed at the same time as the Immunization Data Exchange software.</p>
<p><b>Women's Health (BW)</b></p>	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• FileMan v21</li> <li>• Kernel v7.1</li> </ul> <p>There are no IHS SACC exemptions in this package. All code is ANSI M Standard.</p> <p><b>Security Keys</b></p> <ul style="list-style-type: none"> <li>• BWMENU</li> <li>• BWZ MANAGER</li> <li>• BWZ LAB PCD EDIT</li> </ul>	<p>The Women's Health software package can be used to track women receiving PAP smears and colposcopies. The software includes a full range of breast and cervical cancer screening and tracking functions.</p>	<p>The RPMS Women's Health package functions in two main areas: patient management and management reports. Patient management is the portion of the software used to manage individual patients, their procedures, due dates, and</p>

Menu	Technical Information	Description	Functionality
	<p>All users of the RPMS Women's Health software should have an "MW" as part of their Fileman Access Code.</p>		<p>correspondence. In the patient management menu, it's possible to maintain patient data, such as the patient's next PAP smear, colposcopy, or mammogram, the patient's pregnancy, her EDC, and her current PAP regimen. It's also possible to track the patient's individual procedures, including the date performed, the provider and clinic, the results or diagnosis. Notifications (letters and phone calls) can be tracked. The management reports portion of the software is used to print epidemiological reports, such as the number of women who received a mammogram for a selected time period or the number of patients having abnormal PAP results during a selected time period. In the management reports portion of the software, lists of patients who are past their due dates for follow-up procedures can be produced. It's also possible to store program statistics by date for later comparison of program trends and progress.</p>
<p><b>Clinical Scheduling for Windows (BSDX)</b></p>	<p><b>System Requirements</b></p> <ul style="list-style-type: none"> <li>• Cache v5.0</li> <li>• Kernel v8.0</li> <li>• BMXNet v2.0</li> <li>• PIMS v5.3 patch</li> </ul>	<p>The Clinical Scheduling application for Windows is the graphical user interface (GUI) for RPMS Patient Infor-</p>	<p>This application provides appointment management functions included in PIMS scheduling, with the</p>

Menu	Technical Information	Description	Functionality
	1003 <ul style="list-style-type: none"> <li>• RPC Broker v1.1</li> </ul> <b>Security Key</b> <ul style="list-style-type: none"> <li>• BSDXZMENU</li> </ul>	mation Management System (PIMS) application.	added convenience and usability of a GUI. The package should be used with PIMS scheduling. Directors of PHN need to work with their local health information management staff to ensure PHN clinics are set up in PIMS as needed to capture department services.

The applications listed above in Table 3.2 are available from the Indian Health Service website on the RPMS Clinical Applications page ([http://www.ihs.gov/RPMS/?module=Applications&option=View&AC\\_ID=0](http://www.ihs.gov/RPMS/?module=Applications&option=View&AC_ID=0)) and the RPMS Administrative Applications page ([http://www.ihs.gov/RPMS/?module=Applications&option=View&AC\\_ID=1](http://www.ihs.gov/RPMS/?module=Applications&option=View&AC_ID=1)). Technical and user manuals are also available on those pages.

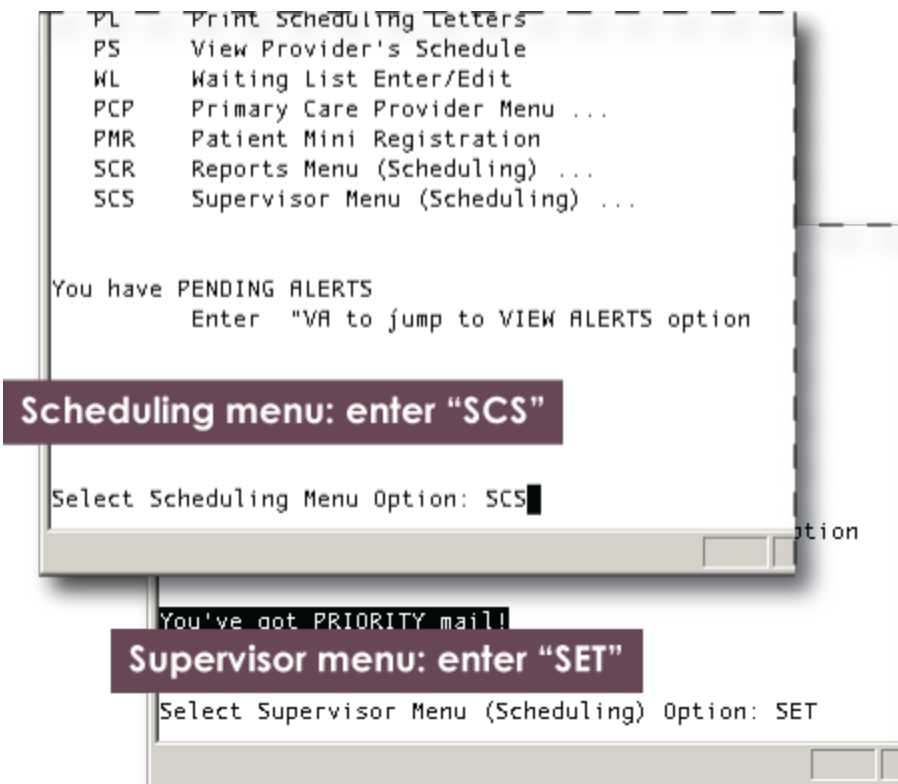
Figure 3.2a. Navigating the Core Menu





After the Core menu, there are two more menus to get through before the user starts setting up a new clinic: the Scheduling Menu and the Supervisor (Scheduling) Menu. See Figure 3.2b below.

Figure 3.2b. Navigating the Scheduling and Supervisor Menus

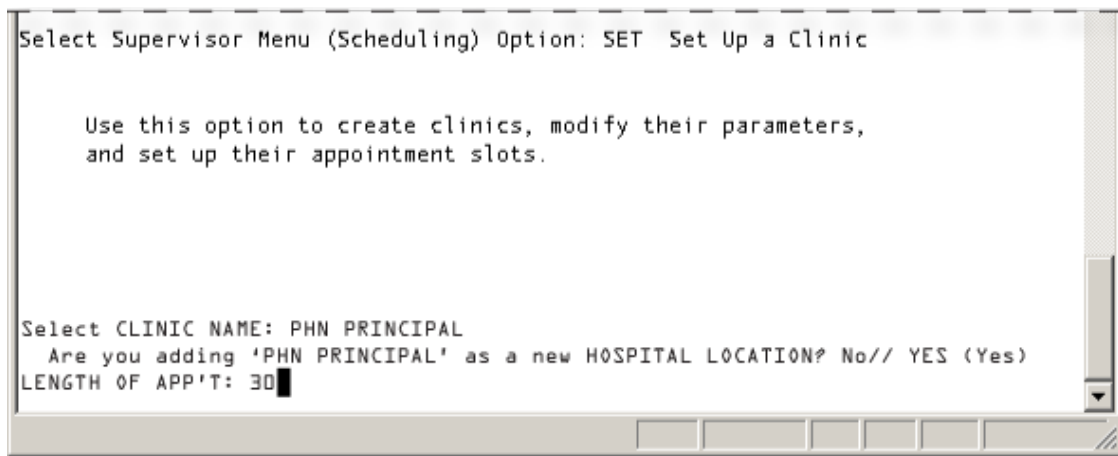


### 3.3 Setting Up a Clinic, Starting With PHN PRINCIPAL

The next step is to set up a PHN principal clinic definition. The PHN principal clinic functions as the master clinic in reporting RPMS Patient Care Component reports referencing all PHN clinics. No appointments are made to the principal clinic, nor is it used to document PHN service. The principal clinic is helpful for the scheduling package owners in the management of clinics in regards to reporting. When a report is needed for all PHN clinics, only the name of the principal clinic is needed to access all PHN information.

To improve PHN data collection, the use of the following process is recommended: After choosing the Set Up a Clinic option in the Supervisor Menu (Figure 3.2b above), the RPMS will ask the user to create a clinic name. “PHN PRINCIPAL” is entered in Figure 3.3a below. In the next prompt, the user will be asked if PHN PRINCIPAL will also serve as the hospital location. The correct answer is yes. At the next prompt, the standard appointment length should be set at 30. The user should understand that setting the appointment length here does not restrict all public health nursing visits to 30 minutes.

Figure 3.3a. Clinic Name and Length of Appointment



#### *Default options*

RPMS offers default answers at some prompts. For example, in Figure 3.3a above, the system gives “No” as a default answer to “Are you adding ‘PHN PRINCIPAL’ as a new HOSPITAL LOCATION?” The two slash marks after “No” signify a default answer. If the user simply hit return at this prompt (instead of typing “YES”) the system would automatically enter “No.”

The next four screens in RPMS will be used to set up the PHN PRINCIPAL clinic and can be used to set up other public health nursing clinics. (These screens are sometimes referred to as the Patient Information Management System scheduling application, or PIMS.) Clinics will not appear in the Electronic Health Record (EHR) until they are set up in these four screens first. The information associated with clinics set up in RPMS will automatically appear as default information for clinics in the EHR.

#### *Keyboard navigation*

- Return or Enter key—advances the cursor to the next field
- Tab key—moves the cursor to a field on the right
- Down arrow—moves the cursor to a field below

Figure 3.3b. First Clinic Setup Screen

The screenshot shows a terminal window titled "EHR - DEHR - TNVTPlus" with a menu bar (Session, Edit, View, Commands, Script, Help) and a toolbar. The main window is titled "SET UP A CLINIC" and "Page 1 of 4". The form contains the following fields and text:

- CLINIC NAME: PHN PRINCIPAL
- DIVISION:
- ABBREVIATION:
- FACILITY:
- MEETS AT THIS FACILITY?:
- NON-COUNT CLINIC? (Y OR N): NO
- INCLUDE ON FILE ROOM LISTS?:
- PRINCIPAL CLINIC:
- PHYSICAL LOCATION:
- TELEPHONE:
- CLINIC CODE:
- HOSPITAL SERVICE:
- CLINIC OWNERS (responsible for setup)
- COMMAND:
- Press <PF1>H for help
- Insert

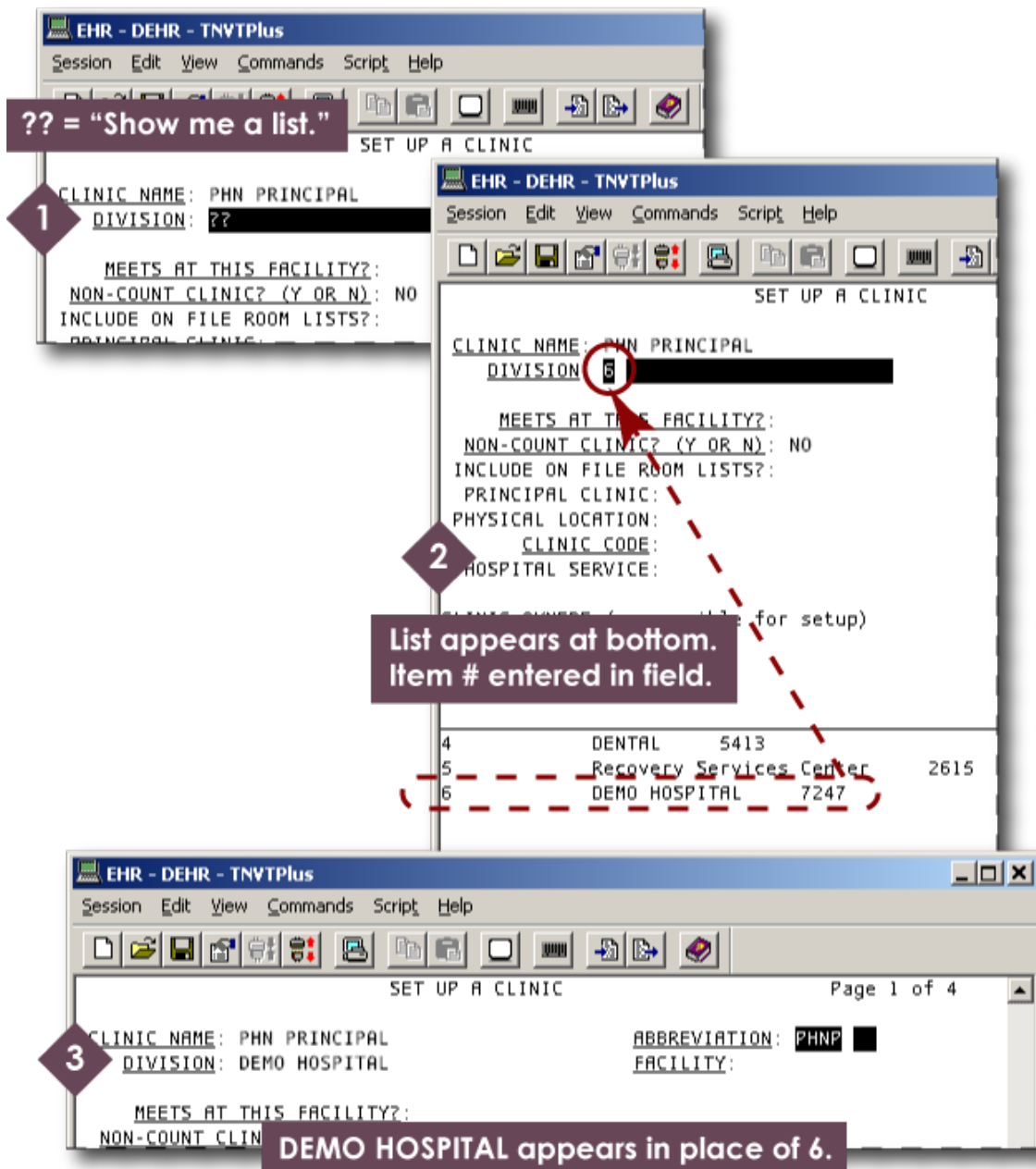
In the first Clinic Setup screen, PHN PRINCIPAL already appears in the first field. No change here is necessary. Type return or enter to advance the cursor to the next field, Division. Type in the division in all capitals and hit return to advance to the Abbreviation field.

What if the user did not know his or her division? Typing two question marks (??) in the Division field and hitting return will bring up a numbered list of divisions at the bottom of the screen. The user would enter a number in the Division field and hit

return. The selected division would appear in the Division field and the cursor would appear in the next field, Abbreviation. In Figure 3.3c below, Demo Hospital is the chosen Division, but you should choose your own division when you set up PHN PRINCIPAL in your RPMS.

RPMS offers an extensive amount of help through question marks. Typing one question mark in a field or at a prompt and hitting return will usually bring up an explanation as to what a user needs to do. Two question marks usually pull up lists of choices.

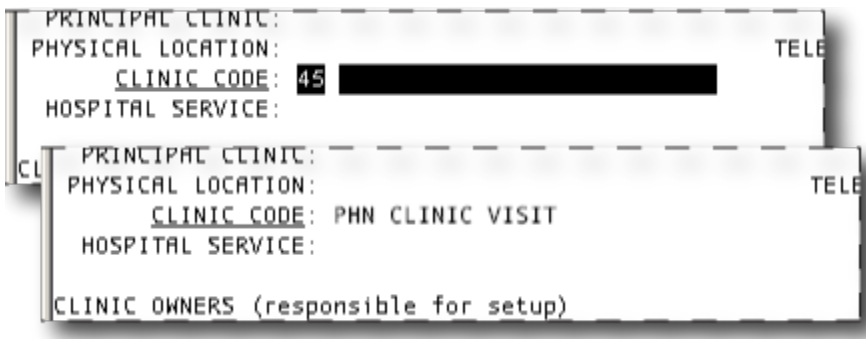
Figure 3.3c. Choosing from a List



In the Abbreviation field, type in PHNP and hit return. Enter the facility in all capital letters in the next field (Facility). Enter Y or YES for “Meets at the Facility?” The next question—“Non-count clinic?”—is already answered, no; do not change the answer to yes.

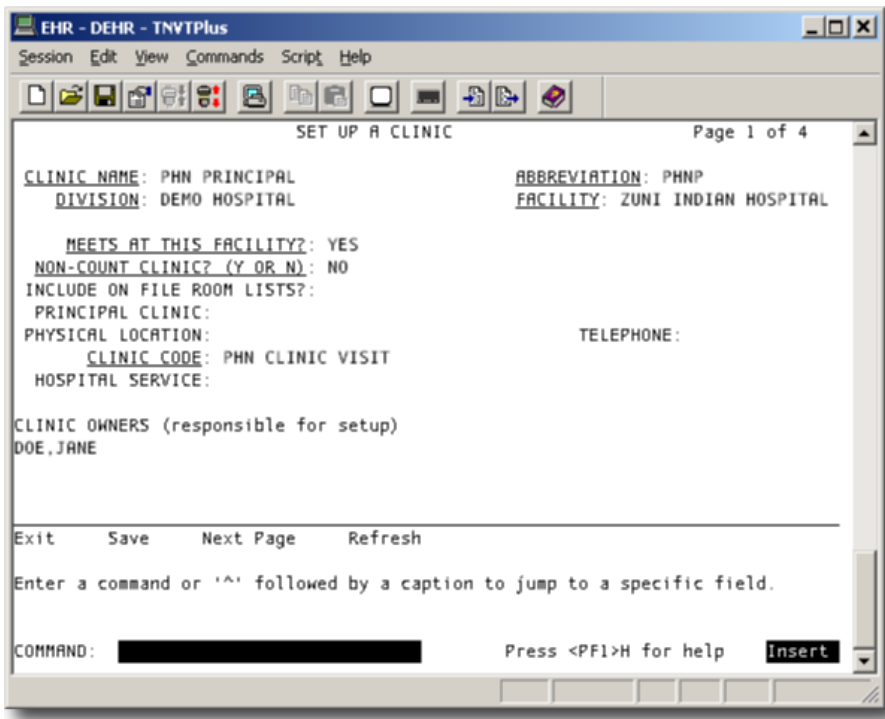
Skip down to the Clinic Code field. Enter the numeral 45 and type return. “PHN CLINIC VISIT” will replace 45. See Figure 3.3d.

Figure 3.3d. Clinic Code



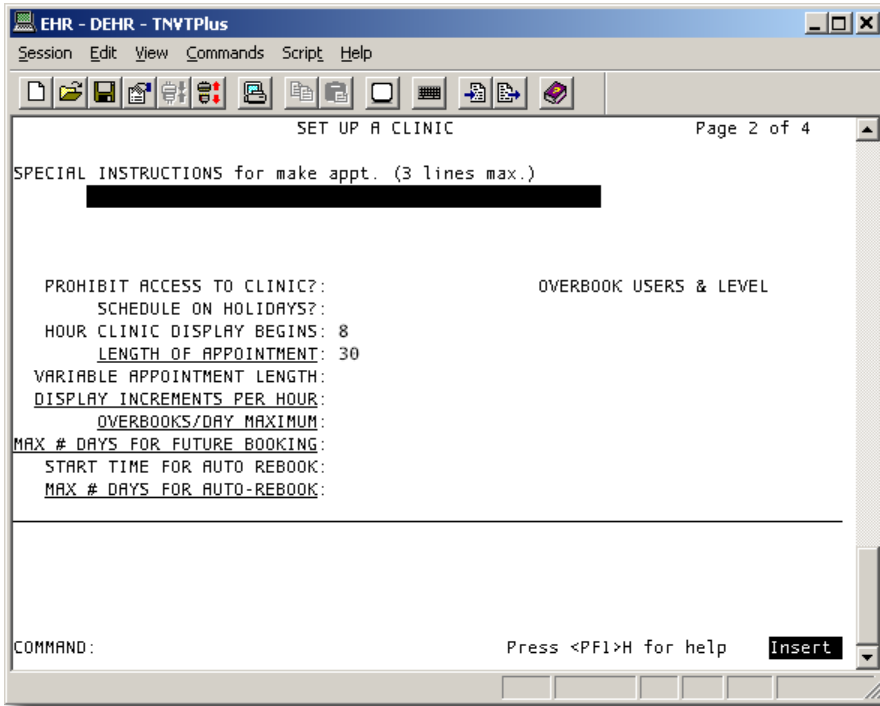
Skip down to the Clinic Owners field. In all capital letters, type in the clinic owner, last name first. Do not leave a space after the comma. Hit return. Figure 3.3e shows a completed first screen for the clinic setup.

Figure 3.3e. First Clinic Setup Screen, Completed



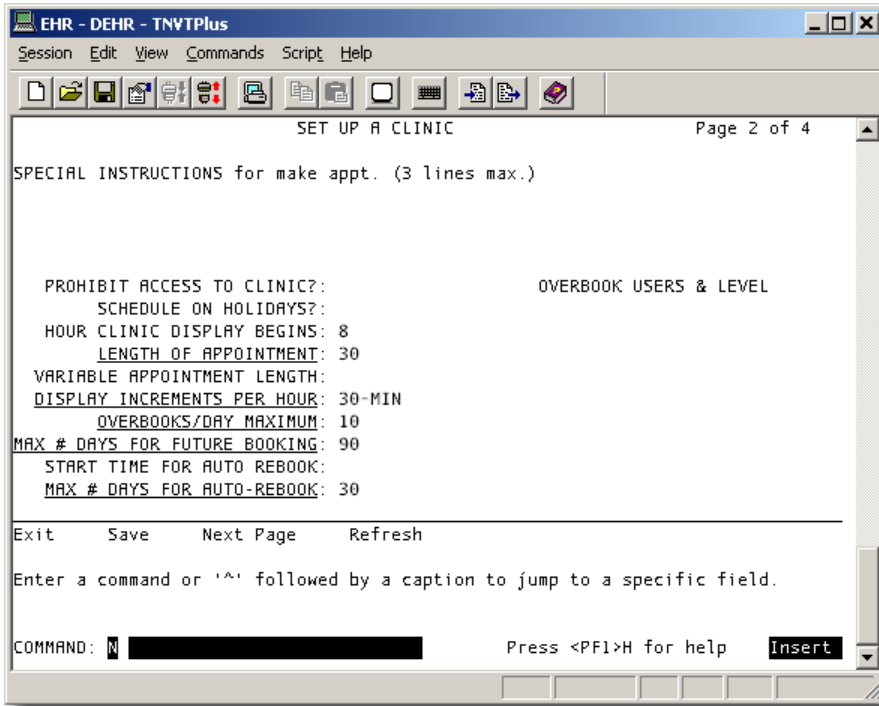
After the Clinic Owners field, the cursor should advance to the Command prompt at the bottom of the screen. See Figure 3.3e. Type capital N for “Next Page” and hit return to advance to the second clinic setup screen.

Figure 3.3f. Second Clinic Setup Screen



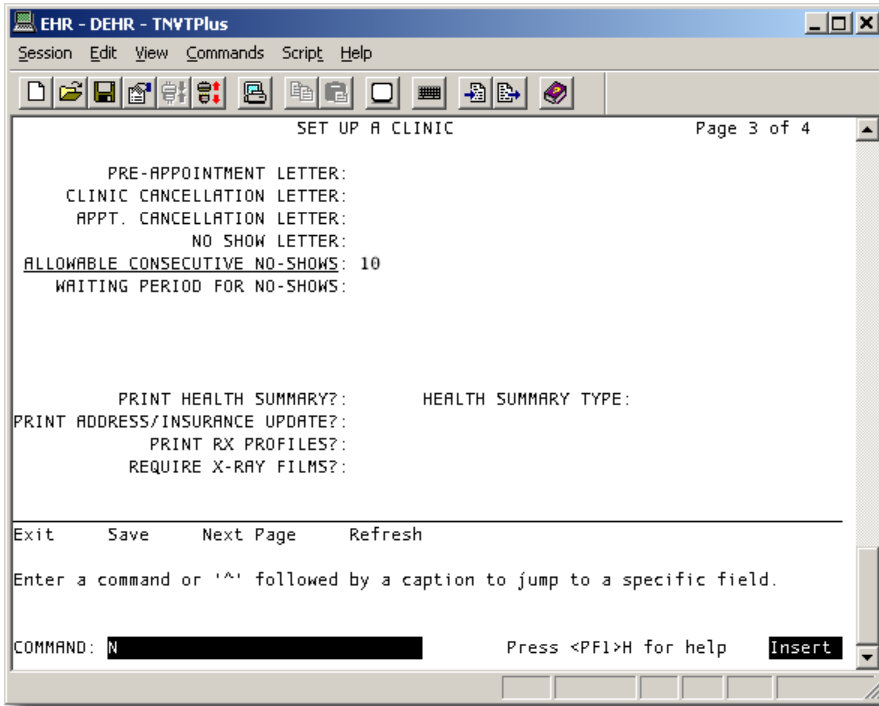
The second setup screen has two fields already filled in: Hour Clinic Display Begins (8) and Length of Appointment (30). See Figure 3.3f. Using the return or Enter key, skip down to the Display Increments per Hour field. Enter “30-MIN” (without quotation marks) and hit return. Enter 10 in the Overbooks field and 90 in the Future Booking field. Skip the next field and enter 30 in the Maximum Number of Days for Auto-rebook field. Hit return and type a capital N for “Next Page” in the Command prompt. See Figure 3.3g.

Figure 3.3g. Second Clinic Setup Screen, Completed



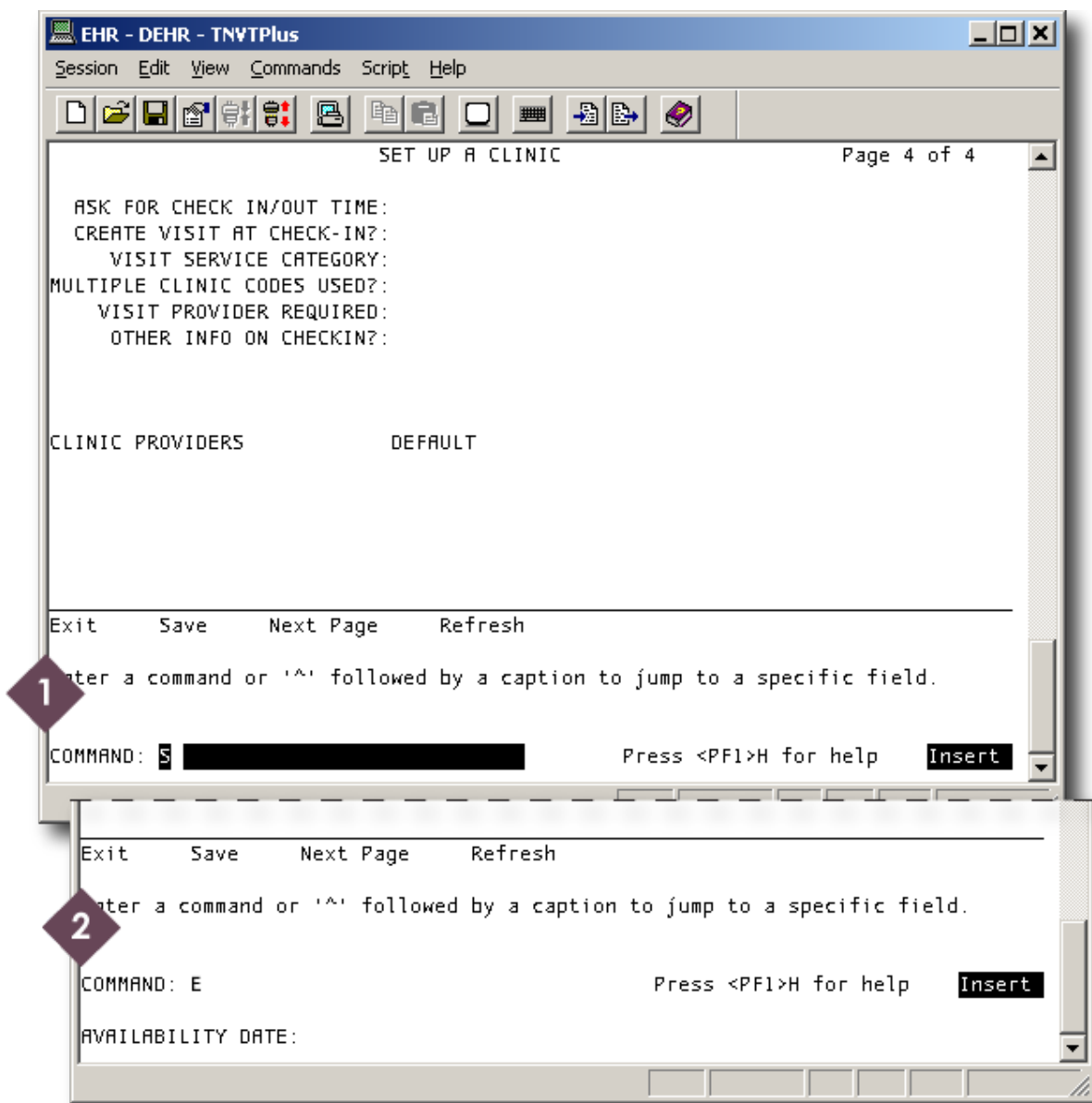
In the third setup screen, skip down to the Allowable Consecutive No-shows field and enter 10. Then, skip down to the Command prompt and type in a capital N.

Figure 3.3h. Third Clinic Setup Screen, Completed



The fourth setup screen can be left blank. Skip down to the Command prompt and type a capital S for “Save.” Hit return. The cursor will stay at the Command prompt. Type a capital E for “Exit” and hit return. A prompt for availability date will appear. Leave it blank and type return. See Figure 3.3i. Upon exiting the clinic scheduling application, the user will be returned to the Supervisor Menu (Scheduling).

Figure 3.3i. Save and Exit





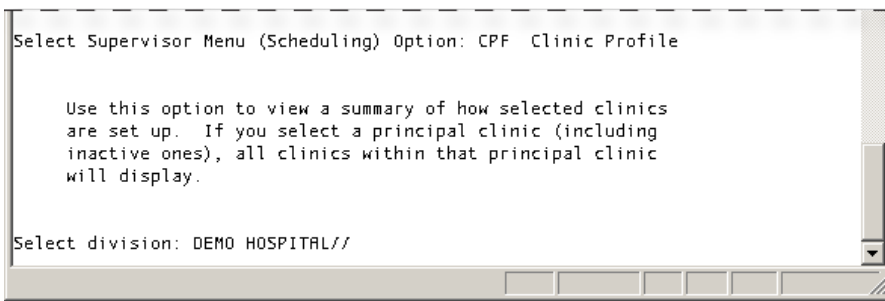
### 3.4 Review a Clinic After Setup

The RPMS user can review information about a clinic after it has been created. Getting a clinic profile is easy if the user does it right after setting up the clinic. As soon as one quits the clinic setup application, the next menu that appears is the Supervisor Menu (Scheduling), which has the clinic profile option. Otherwise, the user will need to navigate the RPMS menus the way it is described in Section 3.2 above.

At the prompt at the bottom of the Supervisor Menu, enter “CPF” (without quotation marks) and hit return.

The first prompt in the Clinic Profile menu asks the user to enter a division. In Figure 3.4a, DEMO HOSPITAL is the default choice, as indicated by the two slash marks. Demo Hospital was the division used in the PHN PRINCIPAL clinic that was just set up in Section 3.3 above. Whatever division you used in your RPMS will appear as the default at this prompt. Hit return to accept the default choice.

Figure 3.4a. Select Division, Default

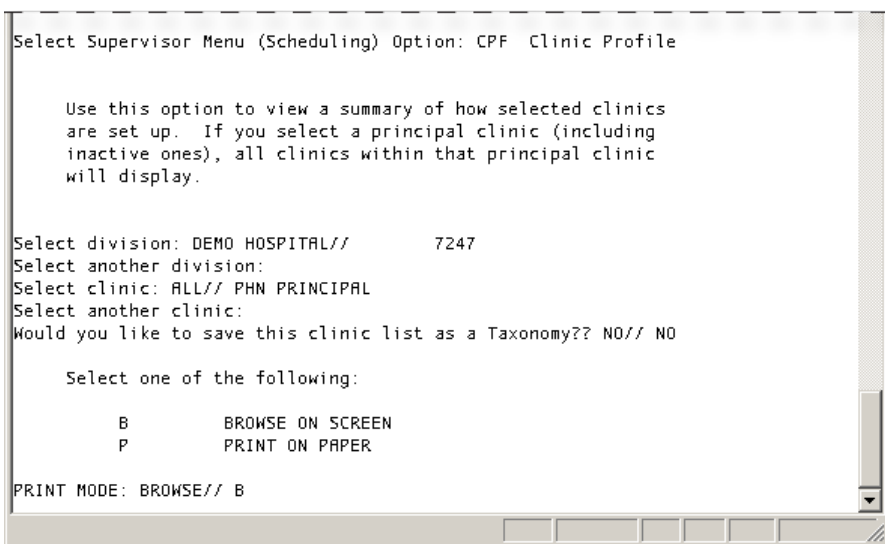


Leave the next prompt (“another division”) blank and type return.

In the next prompt (“Select clinic”), RPMS offers ALL clinics as the default option. Do not accept the default option. Type in “PHN PRINCIPAL” (in all capitals, without quotation marks) and hit return.

For the next three prompts: do not select another clinic; do not save the clinic list as a taxonomy; and select browse as the print option. See Figure 3.4b.

Figure 3.4b. Clinic Profile Menu, Completed



The Clinic Profile is split into two screens; see Figures 3.4c and 3.4d.

Figure 3.4c. Clinic Profile, First Screen

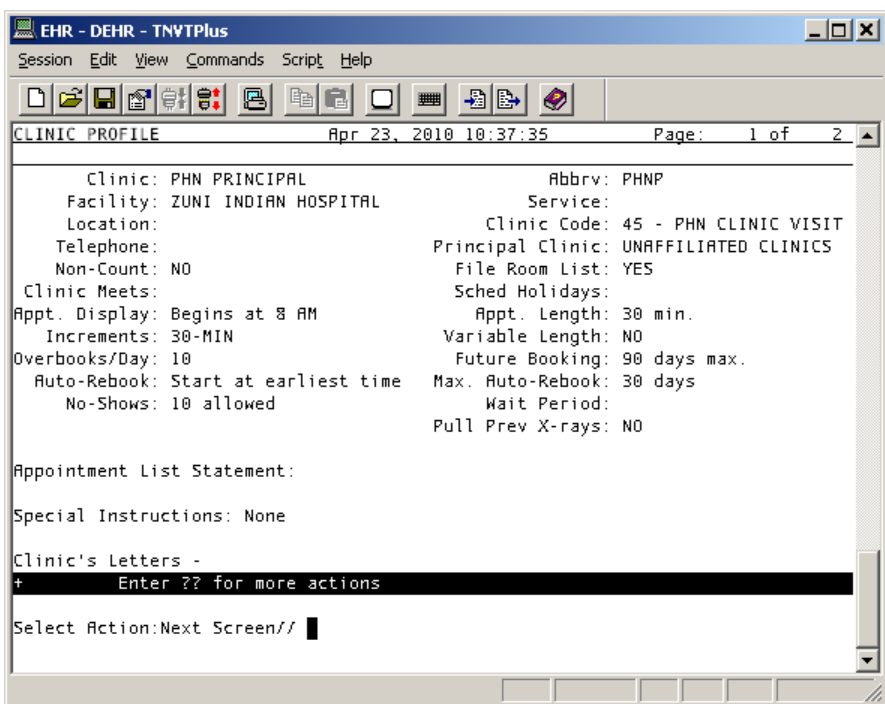
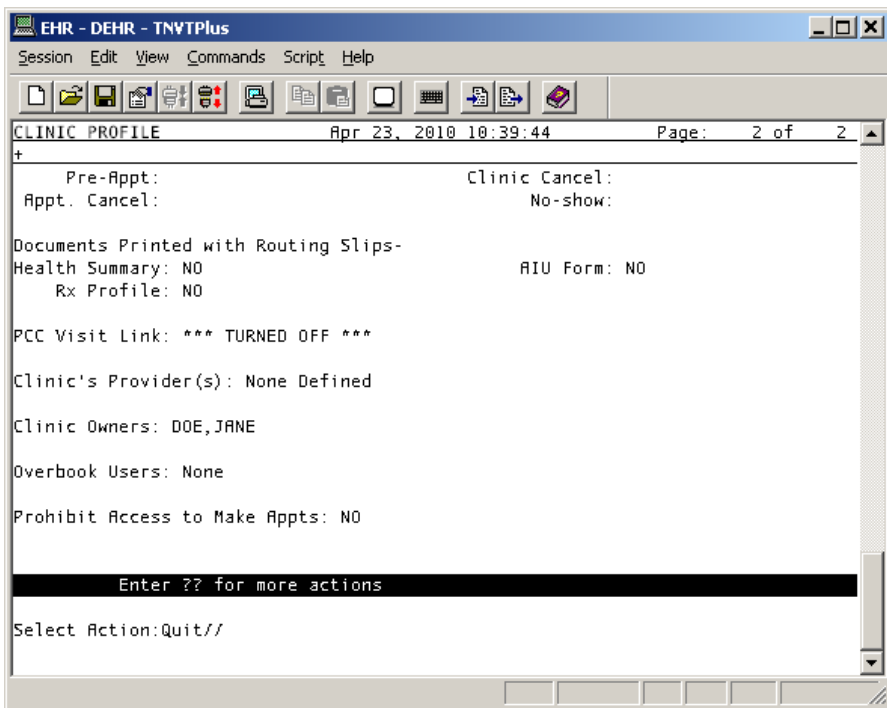


Figure 3.4d. Clinic Profile, Second Screen



### 3.5 Setting Up Public Health Nursing Clinics in the PIMS package

PHNs/DPHNs in collaboration with the assigned PIMS package coordinator (site manager/CAC/HIM) should set up all clinics listed in Table 3.5 below. The Clinic Name should include the title “PHN” prefacing the clinic name as this improves documentation efficiency and accuracy. Location of Encounter should be set up in this area when possible under “Facility” and should align with your facilities designation as outlined in the Standard Code book found on the IHS web site:

[http://www.ihs.gov/SCB/index.cfm?module=W\\_FACILITY&option=list&num=38&newquery=1](http://www.ihs.gov/SCB/index.cfm?module=W_FACILITY&option=list&num=38&newquery=1)

The Standard Code Book has a listing of tables. To review those appropriate to your facility select “Facility” from the standard code book tables:

**Standard Code Book (SCB)**

**SCB Tables**

Standard Code Book Tables		
Table Name	Records	Updated
<a href="#">Admission</a>	5	10/24/2012
<a href="#">APC Recodes</a>	214	10/24/2012
<a href="#">Area</a>	53	10/24/2012
<a href="#">Blood Quantum</a>	7	10/24/2012
<a href="#">Cause of Injury (External Cause)</a>	1291	10/24/2012
<a href="#">Classification (Beneficiary)</a>	31	10/24/2012
<a href="#">Clinic</a>	131	10/24/2012
<a href="#">Clinical Services</a>	23	10/24/2012
<a href="#">Community</a>	13983	10/24/2012
<a href="#">County</a>	2008	10/24/2012
<a href="#">Facility</a>	8098	10/24/2012
<a href="#">Facility Type</a>	20	10/24/2012
<a href="#">Patient Education Protocol (Education Topics)</a>	1107	10/24/2012
<a href="#">Place of Injury</a>	12	10/24/2012
<a href="#">Reservation</a>	329	10/24/2012
<a href="#">Service Unit</a>	570	10/24/2012
<a href="#">Services Rendered By (Provider)</a>	139	10/24/2012
<a href="#">State</a>	71	10/24/2012
<a href="#">Tribe</a>	865	10/24/2012
<a href="#">Type of Provider (Vendor)</a>	19	10/24/2012

20 Record(s)

In the search box type your facility name and click “search”:

**Standard Code Book (SCB)**

**Facility**

1-25 of 8098 items displayed

Reset  Search search tips

page 1: records 1-25 go >>

Code	Area	Service Unit	Facility	Status	Pseudo Code	APC Flag
------	------	--------------	----------	--------	-------------	----------

The facility listing will appear with a status designated as active or inactive. Only those with an active status should be utilized during clinic set up. Some facilities have robust locations to choose from while others may be limited. Most sites have the facility as well as school, home and other as active locations. DPHNs will need

to review the list of clinic codes in the table below to align with the location of encounter keeping in mind there may be instances where it may not be possible to correctly align unless additional clinics are created. An example would be PHN Immunizations as these encounters can occur at multiple locations programs need to determine what the best process is:

1. Have one clinic identified PHN immunization and staff document in note where the location of encounter occurred for data-entry to enter.
2. Align PHN Immunization clinics with several locations:
  - a. PHN Immunization School / clinic code 12 / service cat. A / loc-school
  - b. PHN Immunization Office / clinic code 12 / service cat. A / loc-facility
  - c. PHN Immunization Off Site / clinic code 12 / service cat. A / loc-other

This identification process at the beginning of set up will enhance data and eliminate user error, and needs to occur before the DPHN approaches the assigned PIMS package coordinator (site manager/CAC/HIM). This level of program set up is integral to accurate data capture in the PHN/CHN Data Mart.

Table 3.5. Public Health Nursing Clinics to Set Up

Clinic Name	Abbreviation	Clinic Code	Service Category*	Location of Encounter (ASUFAC)
<b>PHN CLINIC</b>	PHNC	45	A	
<b>PHN INPT CLINIC</b>	PHIPT	45	I	
<b>PHN HOME VISIT</b>	HV	11	A	
<b>PHN SCHOOL</b>	PHNSC	22	A	
<b>PHN HOMELESS</b>	HL	D3	A	
<b>PHN HOME NOT FOUND</b>	HNF	11	N	
<b>PHN PHONE NOT FOUND</b>	PNF	51	N	
<b>PHN HOMELESS NOT FOUND</b>	HLNF	D3	N	
<b>PHN IMMUNIZATION</b>	IMM	12	A	

Clinic Name	Abbreviation	Clinic Code	Service Category*	Location of Encounter (ASUFAC)
PHN TELEPHONE	PH	51	T	
PHN CHART REVIEW	CR	52	C	
PHN LETTER	LT	53	C	
PHN EDUC CLASS	EDUC	60	A	
PHN CASE MGMT	CM	77	A	
PHN OTHER	OT	25	A	

\* A=Ambulatory, N=Not found, T=Telecommunication, and C=Chart Review.

Public health nurses should follow the instructions in Section 3.3 for setting up the clinics in Table 3.5, except in the following places:

*First Screen (See Figure 3.5a)*

- In the Clinic Name, Abbreviation, and Clinic Code fields, enter the values as they appear in Table 1.
- In the Meets at This Facility field, enter NO.
- In the Principal Clinic field, type in PHN PRINCIPAL.

*Fourth Screen (See Figure 3.5b)*

- In the Visit Service Category field, enter the value from Table 3.5.
- Enter YES in the following fields:
  - Create Visit at Check-In.
  - Multiple Clinic Codes Used.
  - Visit Provider Required.
- Enter the Clinic Provider (last name first, no space after the comma, all caps)

Figure 3.5a. First Clinic Setup Screen, PHN Clinic

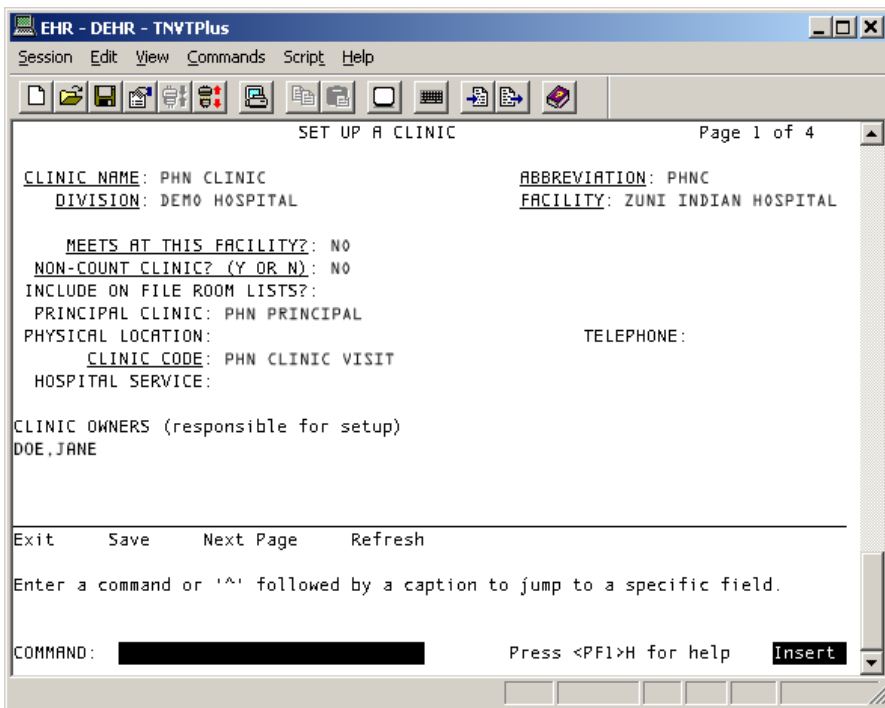
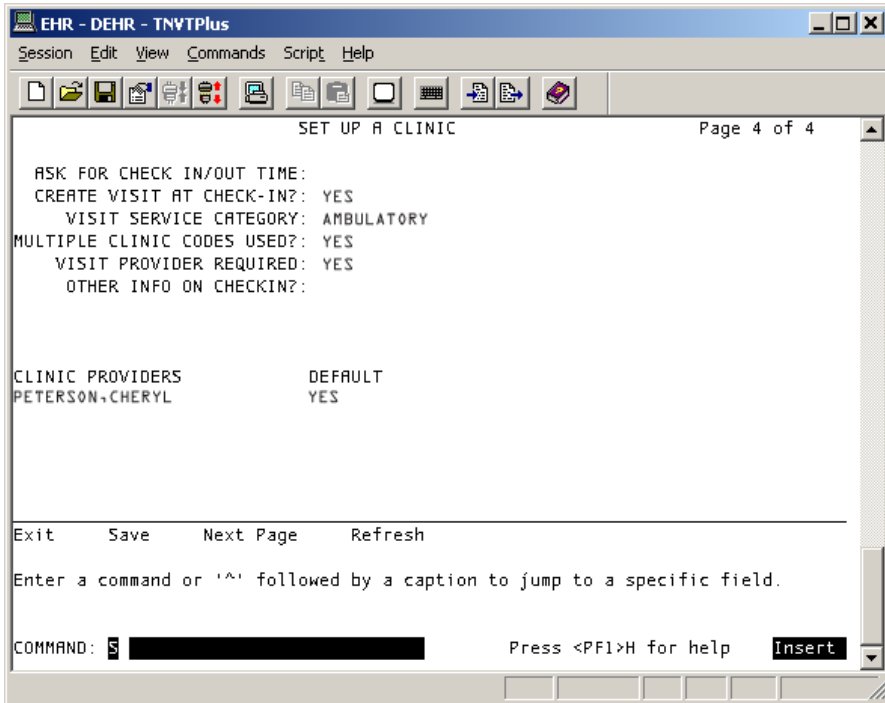


Figure 3.5b. Fourth Clinic Setup Screen, PHN Clinic



Review the clinic profiles as each clinic setup is finished. See Section 3.4 for instructions.

Log onto the EHR to make sure all clinic codes are accessible to public health nursing.



## 4.0 USING THE ELECTRONIC HEALTH RECORD

Public health nurses do most of their patient documentation in the Electronic Health Record (EHR). Unlike the Resource and Patient Management System (RPMS), the EHR software is a mouse-driven application that employs many user-friendly features that Windows users are accustomed to.

The following items must be entered into the EHR for each public health nursing (PHN) visit:

- the chief complaint;
- allergies, even no known allergy;
- reproductive history (e.g., last menstrual period);
- vital signs and other measurements, such as height and weight;
- immunizations, if given;
- education, health factors, exams, and screenings;
- the purpose of visit;
- visit services; and
- the progress note.

### 4.1 Log-In

After launching the Electronic Health Record application, public health nurses sign into the EHR using the same access and verification codes they have for the RPMS. Figure 4.1a displays the log-in screen. For security, bullets replace whatever is typed in the access code and verify code fields. Figure 4.1b. shows the first screen displayed after log-in: a blank patient chart.

Figure 4.1a. EHR Log-In

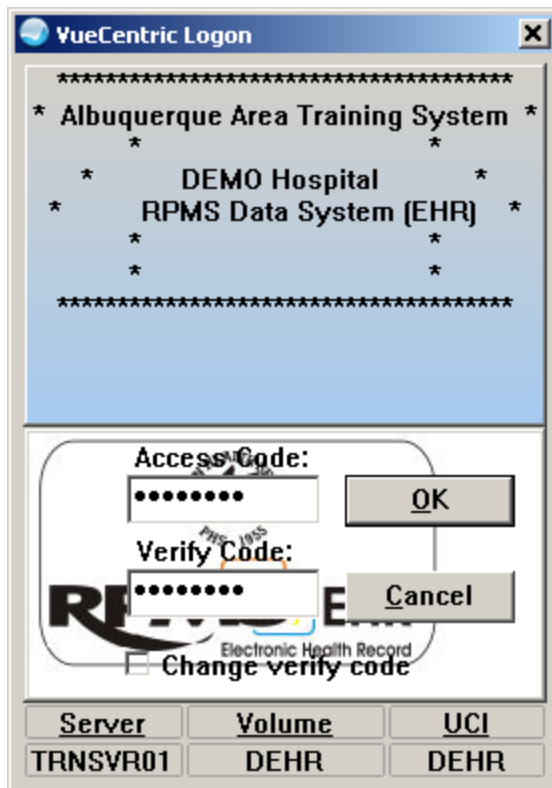
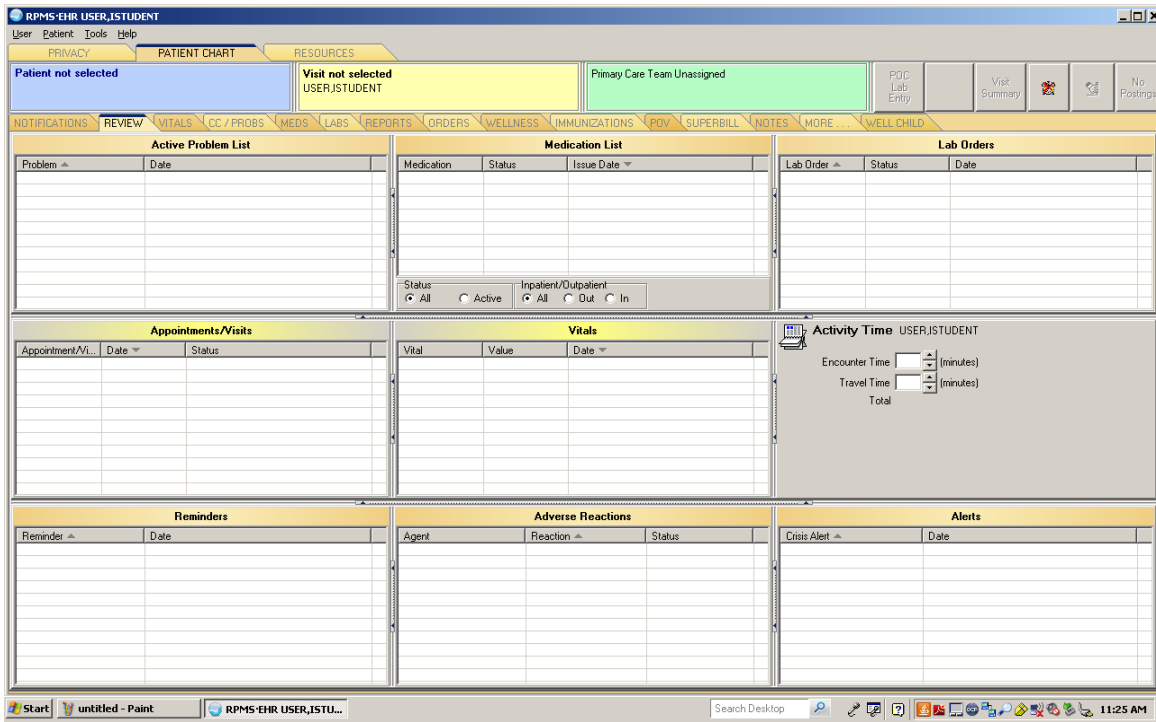
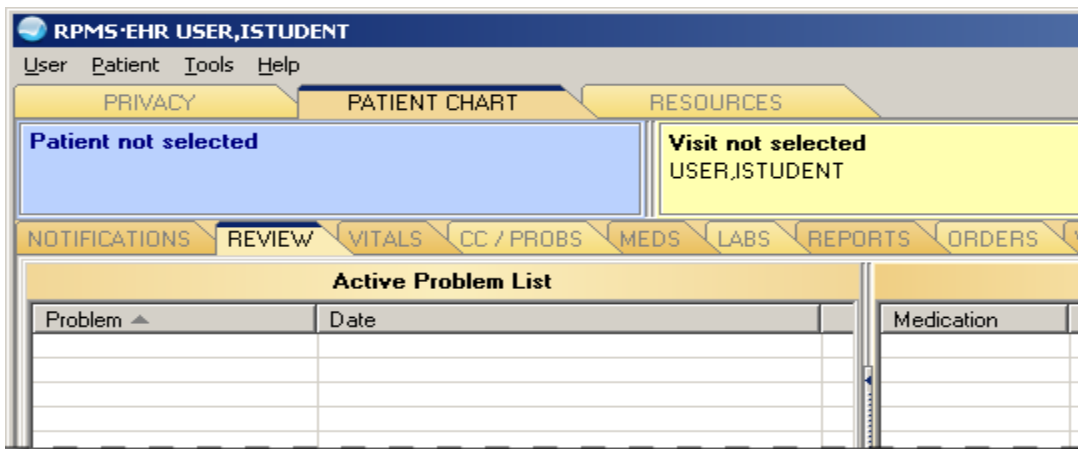


Figure 4.1b. Blank Patient Chart



The Patient Chart tab in the top row of tabs is active. See Figure 4.1c. The Privacy tab should be used when maintaining confidentiality without signing out of EHR, and the Resource tab provides a shortcut to RPMS. In Figure 4.1c, the patient and visit information in the blue and yellow areas have not yet been selected.

Figure 4.1c. Blank Patient Chart, Patient and Visit Sections



The EHR pictured in Figures 4.1b and 4.1c above is a default configuration, and the EHR you use in your local facility may appear differently. The tabs and the frames within the tab windows can be manipulated by the local clinical applications coordinator. Local EHR designs are changed to meet different providers' documentation processes. PHN programs should discuss design options with their local clinical applications coordinators. Figure 4.1d is an example of common tabs used for comprehensive PHN documentation. Most PHN documentation in this layout would take place between the Notifications tab on the left and the Notes tab in the middle right. The tabs used less often are on the right. This layout eliminates the need to jump over one or more tabs when completing documentation.

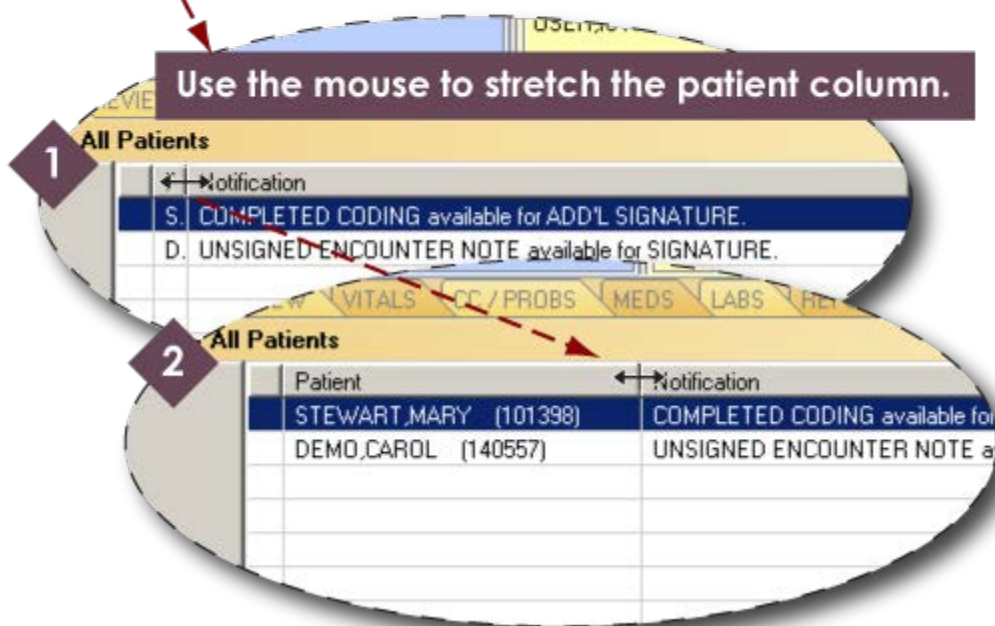
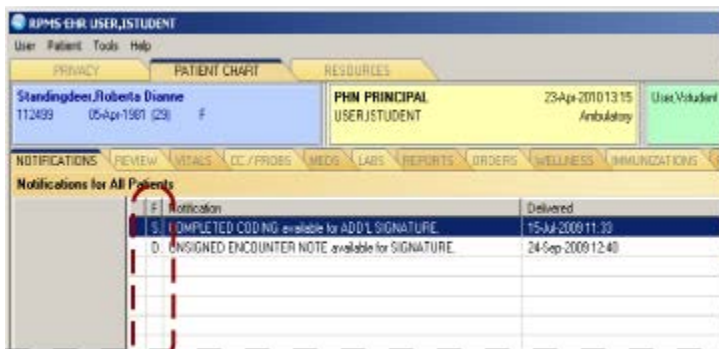
Figure 4.1d. Design Template for EHR Tab Layout



## 4.2 Notifications

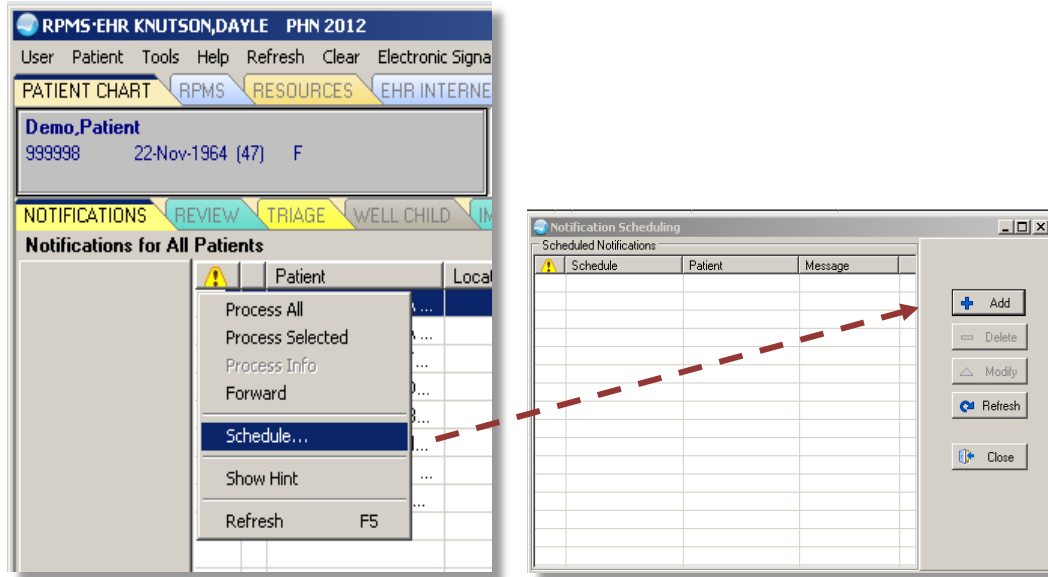
The public health nurse should check notifications at the beginning of the workday to process new consults and to review potential documentation errors. The Notifications window contains unsigned orders, notes, etc. Figure 4.2a shows a Notifications window with two items needing signature and explains how to make the patient column visible.

Figure 4.2a. Notifications



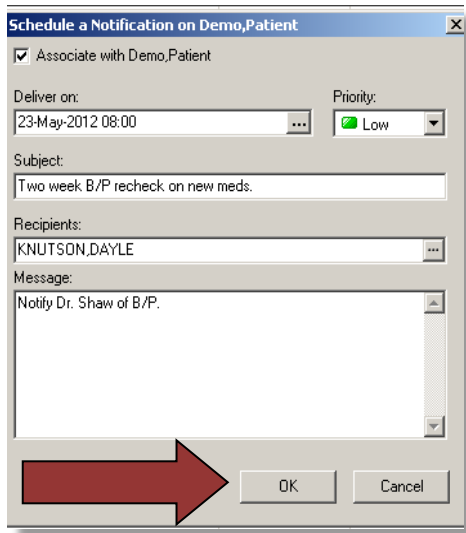
A public health nurse can use the Notifications window to create patient reminders. Figure 4.2b demonstrates how to schedule a notification. Hover the mouse pointer inside the Notification tab window and right click. Select Schedule from the drop-down menu.

Figure 4.2b. Notification Setup



In the Schedule a Notification dialog box (shown in Figure 4.2c), complete information in each field to schedule future a notification. You may also add recipients to receive the notifications (for example, if you're going to be off duty when the notification is delivered). After the fields are filled in, click OK.

Figure 4.2c. Schedule a Notification Dialog Box



### 4.3 Set Up Patient and Visit

The first order of business is to select a patient. Click on the blue area. The Patient Selection dialog box will appear. See Figure 4.3a. Either type in a patient's name (last name first) or choose the patient's name in the scroll box. The HRN number is the patient's chart number. Click the OK button when finished. The patient information will now appear in the blue area. See Figure 4.3b.

Next, click on the yellow visit area. The Encounter Settings for Current Activities dialog box will pop up. Click on the New Visits tab. The public health nursing visits set up in RPMS—see Section 3—should appear in Visit Location scroll box. Choose a visit. Select a date and time. Click the Create a Visit Now check box. When this box is

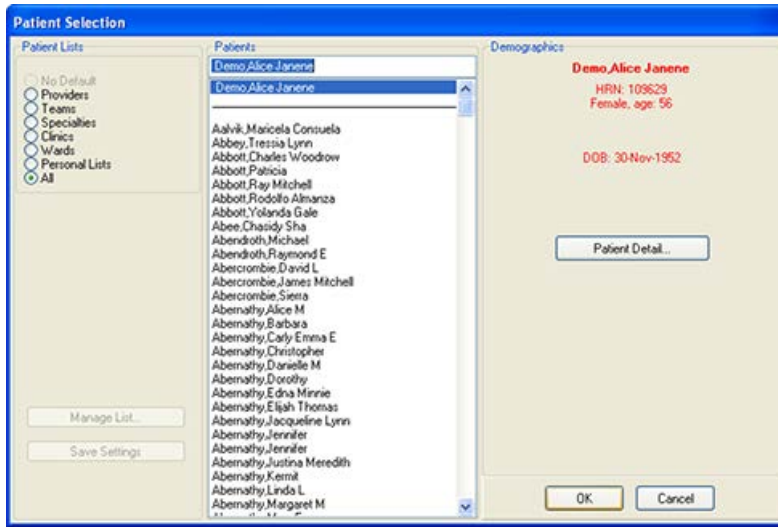
checked, a new area will appear called Providers for This Encounter. The public health nurse will need to select his or her name in the All Providers scroll box and

Figure 4.3b. Patient Chart With Patient Info; Visit Blank

The screenshot shows the RPMS-EHR interface for a patient named Roberta Dianne Standingdeer. The patient's information includes ID 112499, birth date 05-Apr-1981, and gender F. The chart is currently blank, with a message 'Visit not selected' and 'USER:JSTUDENT'. The 'Active Problem List' includes conditions like ASTHMA, Diabetes With Unspecific..., LAB TEST +HCG, POSITIVE CHLAMYDIA..., POSTPARTUM DEPRES..., REACTIVE AIRWAY DIS..., and RISKY SEXUAL BEHAVI... The 'Medication' list shows several active medications. The 'Appointments/Visits' section shows a list of visits, all currently blank.

move it to the Providers for This Encounter area by clicking on the green arrow. The nurse can also select another provider—e.g., a primary physician—and move his or her name into the Providers for This Encounter area. The nurse can designate herself or himself as the primary provider

Figure 4.3a. Patient Selection Dialog Box

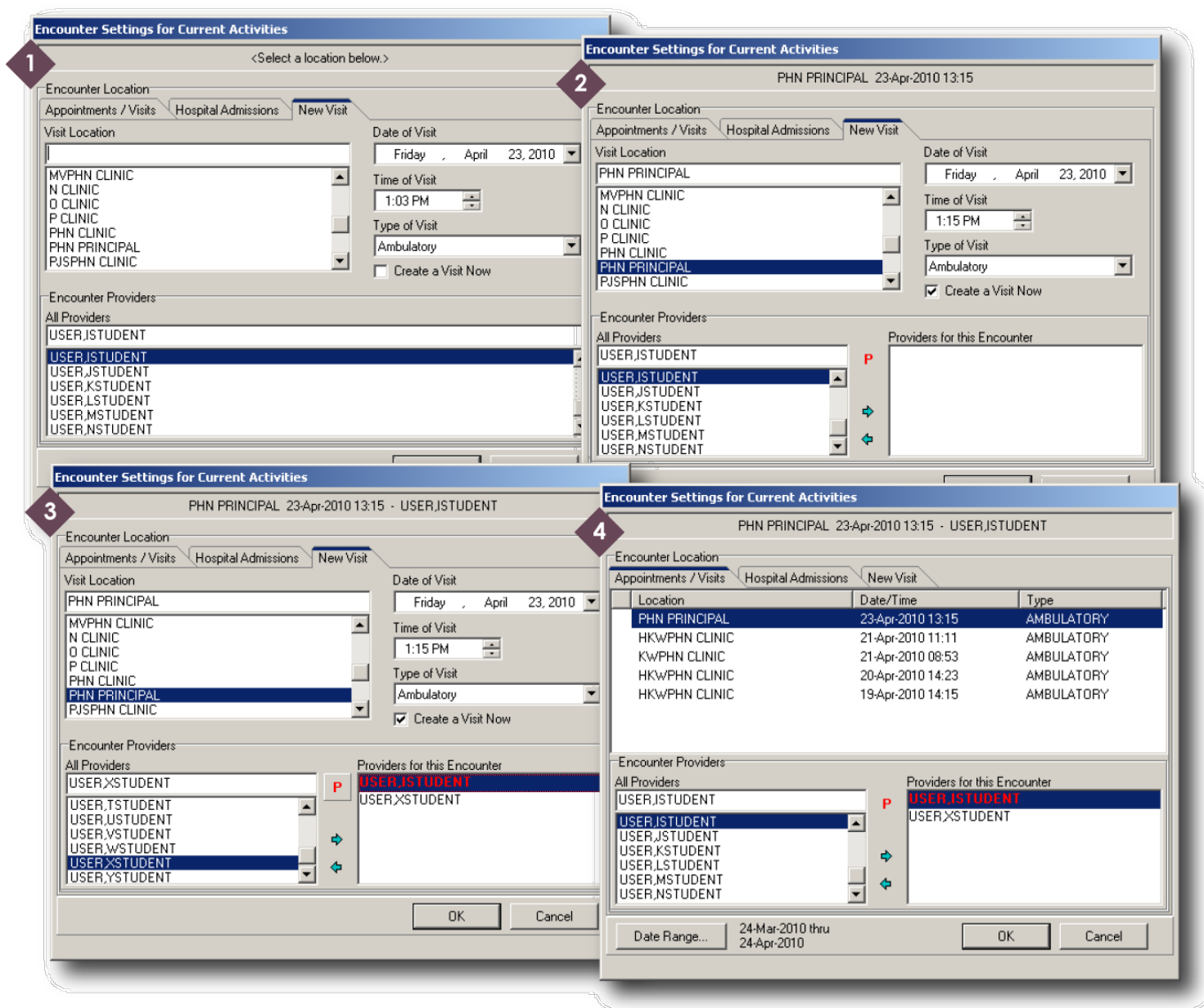


by choosing his or her name in the Providers for This Encounter area and clicking on the red “P.” In Figure 4.3c, USER,ISTUDENT is the public health nurse, and USER,XSTUDENT is the physician. Clicking on the Appointments/Visits tab reveals visits already created by public health nurse USER,ISTUDENT.

***If the public health nurse will be entering any orders, he or she must set an ORES key holder (physician, nurse practitioner, physician assistant, etc.) as the visit context provider. To do this, highlight the individual—it will be blue—and click OK. You will notice that the selected individual is the provider in the Visit box. That individual will be the “ordered by” provider on orders. The logged in user is the “entered by” on all entries.***

Click the OK button when finished. The user will be returned to the patient chart. The Visit Location will appear in the yellow area along with the date and time of the visit.

Figure 4.3c. Encounter Settings, Step by Step





#### 4.4 Review/Cover Sheet

The Review Tab offers an overview of patient information and is an excellent source of “one-stop shopping” in patient health information. Public health nurses can review the patient’s history, problem list and current medications. Public health nurses can also enter information on this tab, such as allergy information and vital signs.

Figure 4.4 Activity Time

The screenshot shows a software interface for entering activity time. The main window is titled "Activity Time USER, JSTUDENT". It features three input fields: "Encounter Time" set to 35 (minutes), "Travel Time" set to 66 (minutes), and a "Total" field showing 101 minutes. Below this is a yellow "Alerts" bar with the text "No Crisis Alerts Found".

The next step is to fill in the Activity Time. See Figure 4.4. Depending on the local design template created by your clinical applications coordinator, your Activity Time may be located in the Review Tab or may be placed in another section. The design template can be changed to meet your department’s needs.

Activity Time is divided into Travel Time and Encounter Time. Travel Time is the total time spent going to and from the patient’s site. Encounter Time is the face-to-face time with the patient, plus any chart reviews, case management, documentation, etc., completed before and after the patient visit. (In a sense, encounter time is everything but travel time.) The EHR automatically totals the activity time. All times must be in minutes, not in hours.

## 4.5 Allergies

Public health nurses are allowed to add allergies in the EHR. To enter a patient's allergies or to edit an existing one, go to the Adverse Reactions area (Figure 4.5a), which is located in the Review tab if you're using the default EHR design.

Figure 4.5a. Adverse Reactions

Adverse Reactions				
Agent	Type	Reaction	Status	InAct Date
WINE	Food, Other	AGITATION	Verified	
WALNUTS	Food	DIARRHEA	Nonv...	
PEACHES	Food	COUGHING	Nonv...	16-May-2011 15:42
RED WINE	Food	ANXIETY	Nonv...	
COTTONSEED OIL	Drug, Food	ASTHMA	Verified	
PENICILLIN	Drug	NAUSEA,VOMITING...	Verified	
SULFA	Drug		Verified	

Status  
 All  Active

Right click anywhere on the Adverse Reactions area and a pop-up menu will appear. Select New Adverse Reaction (or Edit Adverse Reaction for an existing one).

Figure 4.5b. Lookup Causative Agent Dialog Box

**Look up Causative Agent**

Enter causative agent for Adverse Reaction:  
 (Enter at least 3 characters)

chocolate

Select from one of the following items

1 matches found.

- VA Allergies File (1)
  - CHOCOLATE**
- Drug Ingredients File (1)
  -
- VA Drug Class File (no matches)
  -
- National Drug File - Generic Drug Name (no matches)
  -
- National Drug file - Trade Name (no matches)
  -

Select from the matching entries on the list, or search again.

In the Look up Causative Agent dialog box (Figure 4.5b), enter an allergy cause at the top and click the Search button. Select an item from the list that appears below the causative agent you entered. Then, click the OK button.

The Create Adverse Reaction dialog box will appear (Figure 4.5c). Be sure to select a sign or symptom on the lower left and, using the green arrow, move it to the Selected area on the lower right. When finished, click the OK button.

Figure 4.5c. Create Adverse Reaction Dialog Box

The new allergy will appear in in the Adverse Reactions area. See Figure 4.5d.

Figure 4.5d. New Adverse Reaction

Adverse Reactions				
Agent	Type	Reaction	Status	InAct Date
CHOCOLATE	Drug, Food	RASH	Verified	
GABAPENTIN	Drug	ALOPECIA	Verified	

Status:  All  Active

If a patient has “No Allergy Assessment” and has no allergies, then it is extremely important that an entry of “No Known Allergies” is entered into the Adverse Reaction frame.

To enter “No Known Allergies,” right click anywhere on the Adverse Reactions area and a pop-up menu will appear. Select New Adverse Reaction and the Look up Causative Agent window will appear. Select No Known Allergies at the bottom and “click” OK.

Figure 4.5e. No Allergy Assessment Complete to Date

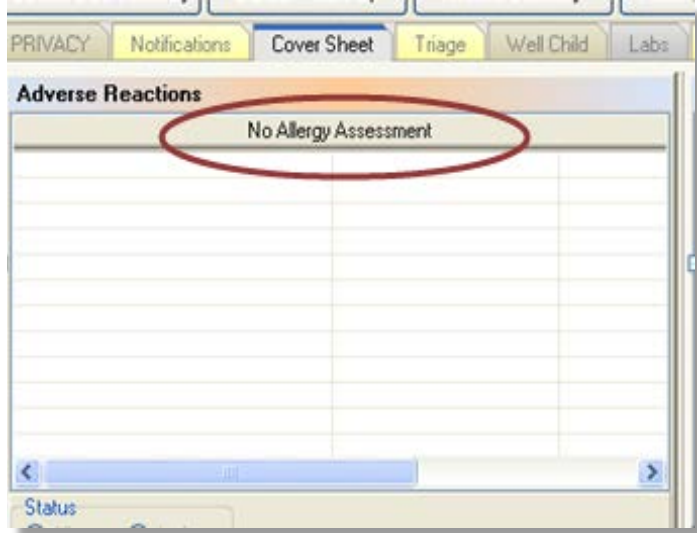
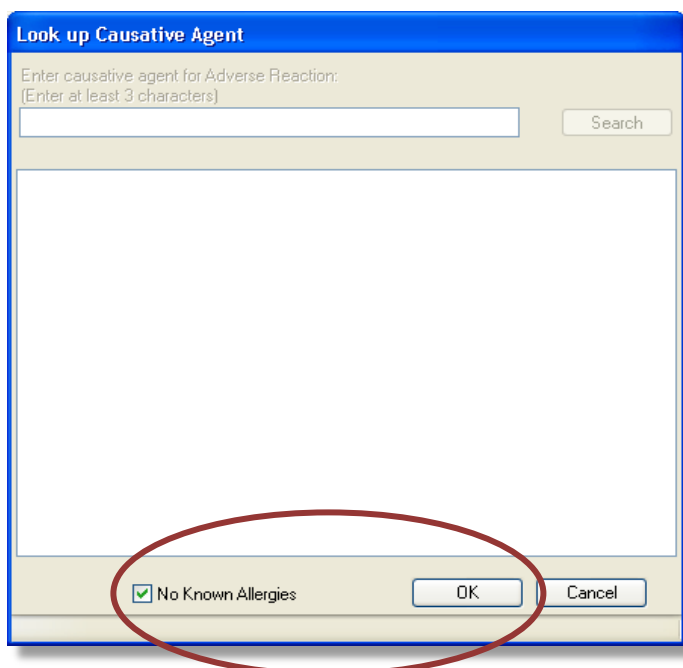
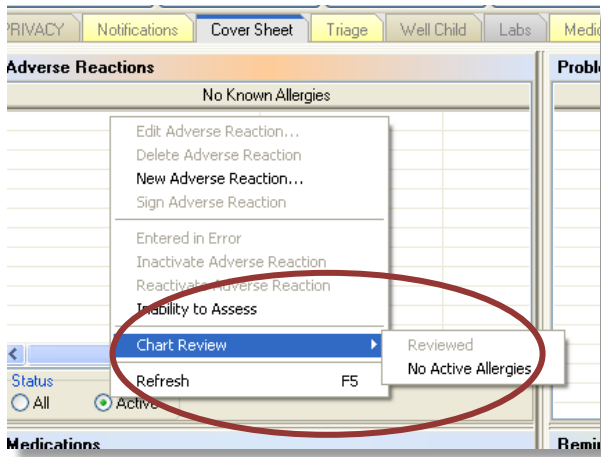


Figure 4.5f. No Known Allergies



When the patient without allergies returns at a later date, you'll need to verify in EHR that he or she still has no allergies. Right click in the Adverse area to bring up a pop-up menu, and select Chart Review. In the side menu that pops up, select No Known Allergies. See Figure 4.5g.

Figure 4.5g. Verifying No Active Allergies



### 4.6 Vitals and Other Measurements

Click on the Vitals tab. The Vitals window is split in two halves. The left half—Vital Measurement Entry—is where the public health nurse must enter data. See Figure 4.6a. As the nurse enters data on the left side, the right side—Vitals—will show the updated information. Figure 4.6b displays completed vitals documentation. The updated vitals information will also appear in the Vitals area of the Review window.

Figure 4.6a. Vital Measurement Entry

Default Units	23-Apr-2010 13:27	Range	Units
O2 Saturation			%
Height			cm
O2 Saturation			%
Temperature	98.6		F
Edema			
Ankle Blood Pressure		90 - 150	mmHg
Pulse		60 - 100	/min
Respirations			/min
Blood Pressure		90 - 150	mmHg
Weight			kg
Asq - Questionnaire (Mos)			
PHQ2			

Figure 4.6b. Vitals Entered

Vital	Value	Date
BMI	23.57	23-Apr-2010 13:27
TMP	98.6 F (37 C)	23-Apr-2010 13:27
TMP	98.6 F (37 C)	23-Apr-2010 13:27
PU	66 /min	23-Apr-2010 13:27
RS	25 /min	23-Apr-2010 13:27
O2	97 %	23-Apr-2010 13:27
BP	120/80 mmHg	23-Apr-2010 13:27
HT	68 in (172.72 cm)	23-Apr-2010 13:27
WT	155 lb (70.31 kg)	23-Apr-2010 13:27
HT	68 in (172.72 cm)	23-Apr-2010 13:27

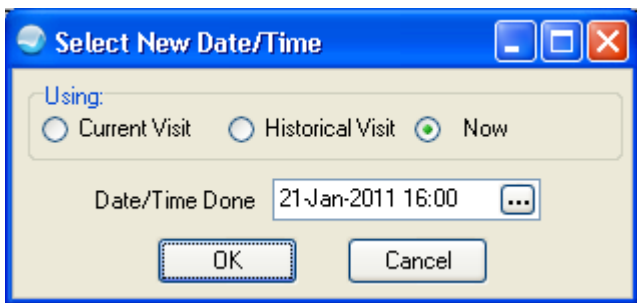
To reduce documentation errors, it's recommended that a public health nurse have a conversation with the clinical applications coordinator requesting to set the default of the vital entry component to the date and time of the current visit. This default provides improved EHR efficiency by decreasing the number of clicks, because the vitals entered will automatically default to the visit time and date.

### ***Historical Measurements***

Public health nurses experience situations where documentation of patient encounters may not happen on the same day. Historical measurements can be entered through the vital entry component and are designed to capture measurements transcribed from outside records, such as birth weight or cardiac ejection fraction from echocardiogram reports. This creates a historical event and should not be confused with a late entry.

To enter historical measurements in EHR, right click in the Vitals frame and select Enter Vitals in the pop-up menu. The Vital Measurement Entry dialog box will appear. Click on the New Date/Time button, and the Select New Date/Time dialog box, shown in Figure 4.6c, will appear.

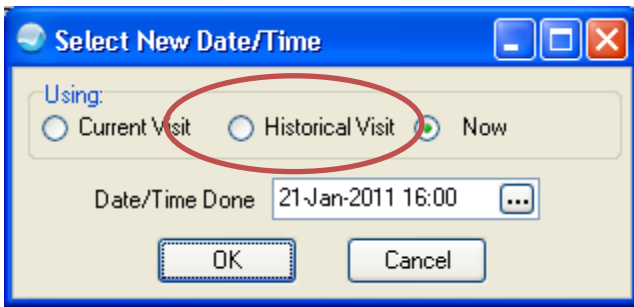
Figure 4.6c. Select New Date and Time Dialog Box



The default setting is Now. You may change to the date and time of the current visit by clicking the radio buttons labeled Current Visit and Historical Visit, which is circled in Figure 4.6d.

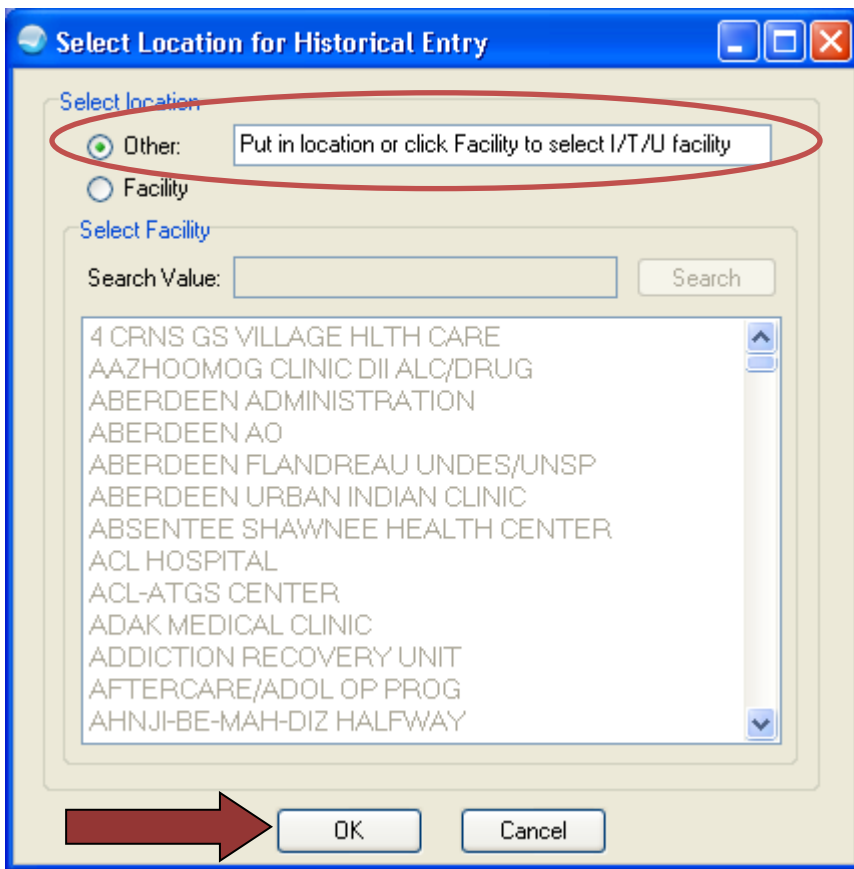


Figure 4.6d. Select New Date and Time Dialog Box



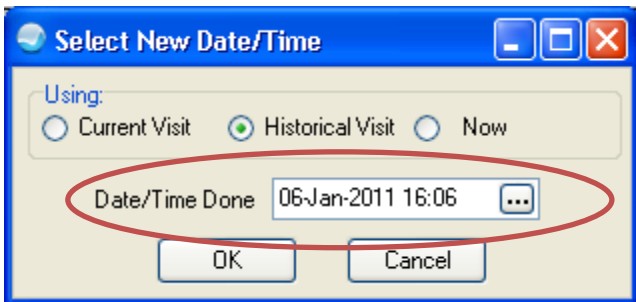
After clicking the Historical Visit button, the Select Location for Historical Entry dialog box (Figure 4.6e) opens. In the Select location area, choose the Other or Facility radio button. If you choose Other, type in the facility name in the text field. If you choose Facility, scroll or search for the facility name in the Select Facility area. Click OK when finished.

Figure 4.6e. Select Location for Historical Entry Dialog Box



After clicking OK in the Select Location for Historical Visit dialog box, you'll be returned to the Select New Date/Time dialog box. Enter the date and time of the historical measurement.

Figure 4.6f. Select New Date and Time Dialog Box With Historical Visit Entered



After clicking OK, you'll be returned to the Vital Measurement Entry dialog box (Figure 4.6g). A new column with the historical date and time in the header will appear; enter historical measurements in that column. Click OK when finished entering historical measurements.

Figure 4.6g. Vital Measurement Entry Dialog Box

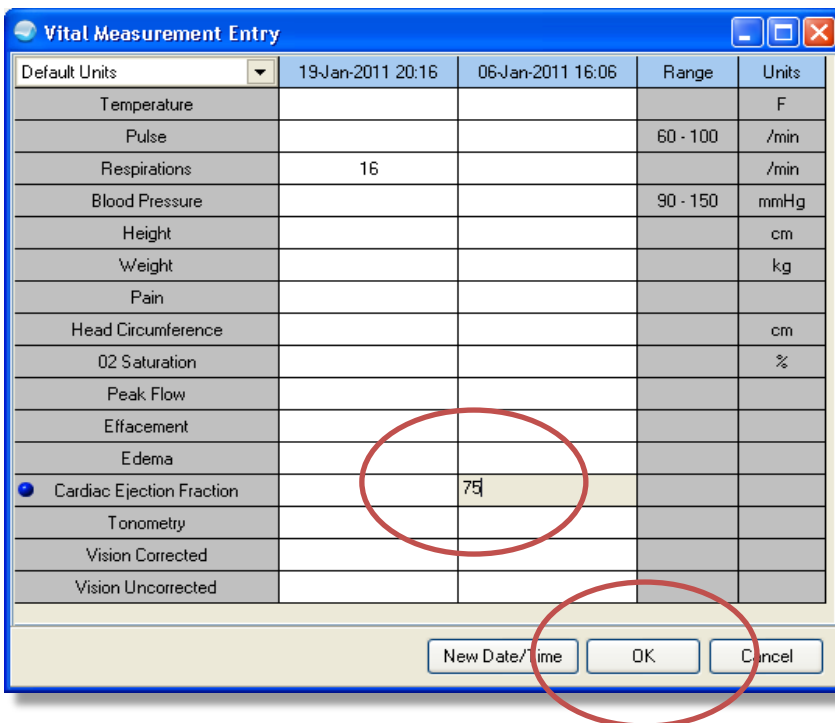
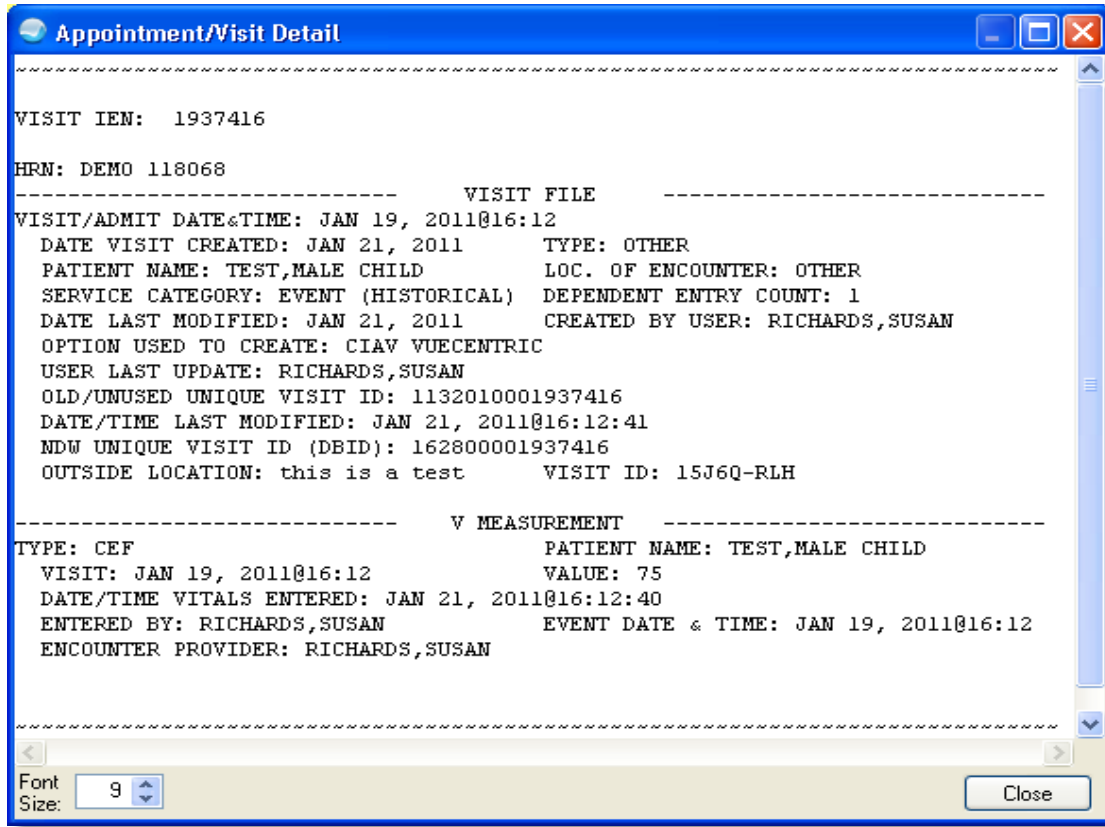


Figure 4.6h. Appointment/Visit Detail



## 4.7 Chief Complaint

Public health nurses must add a chief complaint for a patient encounter. Clicking the “CC/PROBS” tab (in the default EHR design) reveals the Chief Complaint and Problem List page. Figure 4.7a shows an example of what this page looks like before a chief complaint has been entered. Click on the Add button on the far right in the Chief Complaint area. The Chief Complaint dialog box will appear. Type in the patient’s chief complaint in the text box in the top half, as shown in Figure 4.7b. Below the text box is a list of symptoms to choose from. Because most of the symptoms refer to ambulatory patients visiting a health center, a public health nurse will probably not use this option. Click the OK button to close the Chief Complaint dialog box. The new chief complaint appears in the Chief Complaint area of the CC/PROBS window.

Information for the Problem List and the Triage Summary (in the middle of the window) is entered in other parts of the EHR.

Figure 4.7a. Chief Complaint and Problem List Window; Add Button Circled

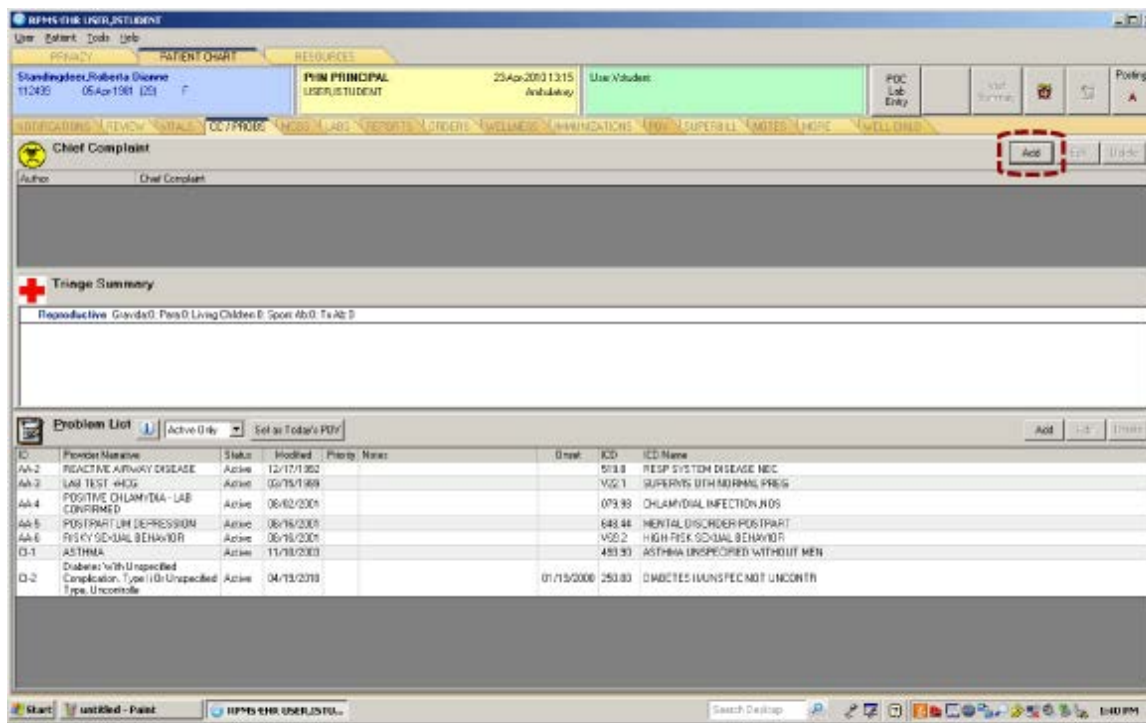


Figure 4.7b. Chief Complaint Dialog Box

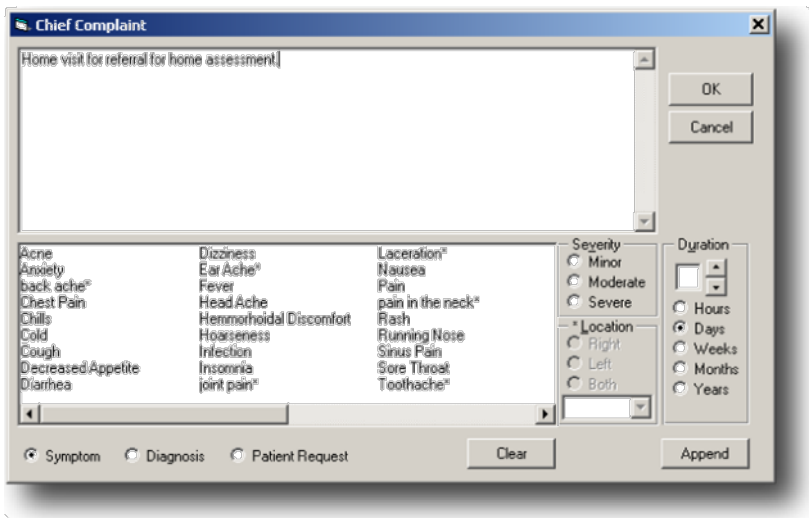
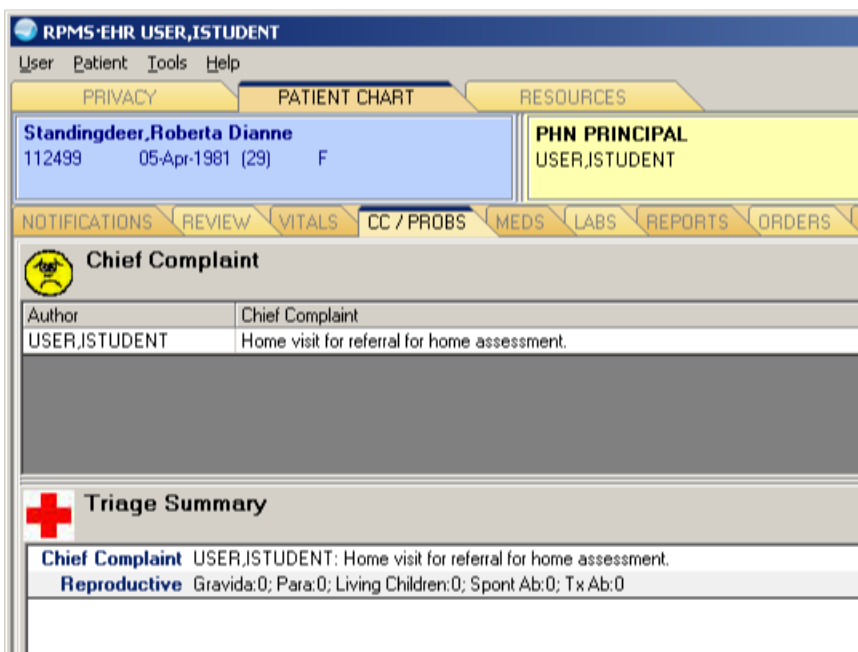


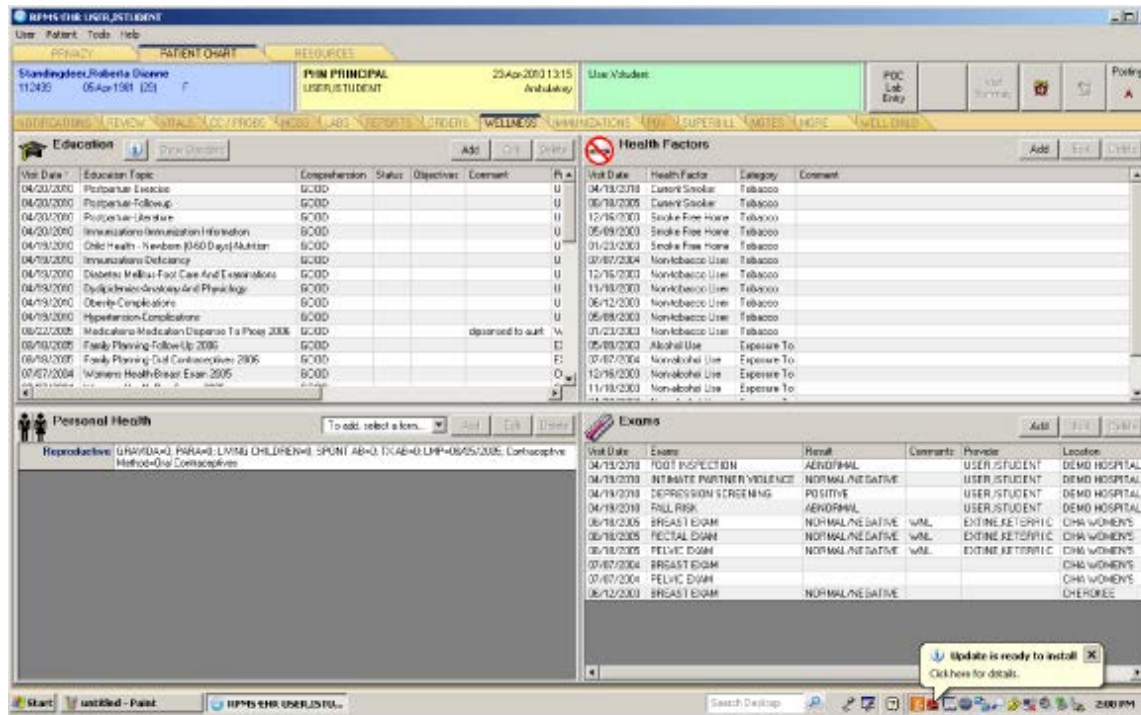
Figure 4.7c. Chief Complaint Completed



## 4.8 Patient Education, Health Factors, and Exams

The public health nurse must document the patient education delivered, the patient's health factors (such as smoking), and exams administered. These items can be found in the Wellness window (Figure 4.8).

Figure 4.8. Wellness Window



There are some things to pay attention to.

### Health Factors

The Health Factors area is where much documentation required by Government Performance and Results Act occurs, including:

- alcohol use (CAGE assessment only);
- tobacco use and exposure (smoking, smokeless, chew, and dip); and
- barriers to learning physical activity, etc.

### Personal Health

The Personal Health area is key for patient-specific information.

Complete a reproductive history for any female patient, and keep it up to date. If you are using a version of EHR other than patch 10, then this component remains under personal health. In EHR patch 10, reproductive history is its own component.

Complete a functional assessment for elderly or at-risk clients.

Complete a breastfeeding assessment on newborns through their breastfeeding duration. Note: infant feeding is found in the infant feeding section.

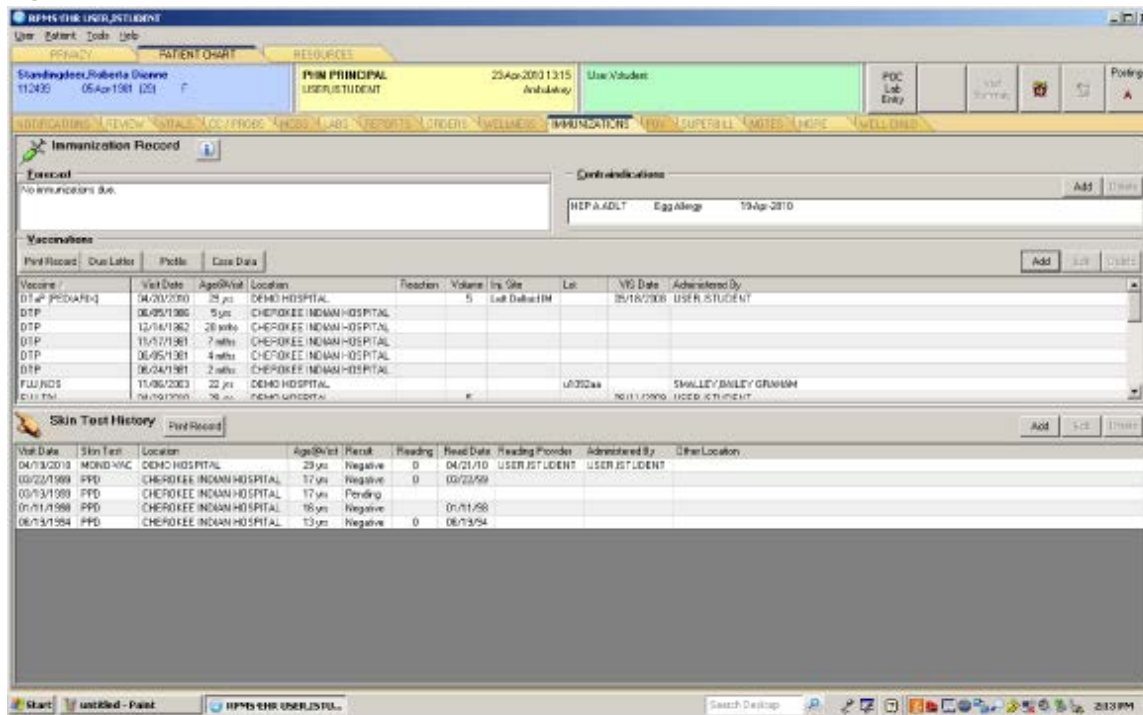
### ***Exams***

The Exams section includes screenings for intimate partner violence, depression, alcohol, foot inspection, fall risk, and newborn hearing screening.

### 4.9 Immunizations

Public health nurses must enter vaccines and skin tests administered in the Immunizations window. Use the Add buttons in the vaccine and skin test areas to add new information. Be sure the vaccine documentation includes the lot number, injection site, etc. Use the Due Letter button in the vaccines area to generate a vaccination due letter to a patient. Enter any patient allergies to a vaccine in the Contraindications area. After clicking the Add button, enter the vaccine and allergy by clicking on the plus (+) sign in the dialog box.

Figure 4.9. Immunizations Window





#### 4.10 Purpose of Visit (POV)

Click on the POV tab. In the default EHR design, the POV window has three areas: Visit Diagnosis (which is the purpose of visit); ICD-9 Pick Lists; and Problem List/Past Diagnoses/Past Procedures.

To add a purpose of visit, click on the Add button in the Visit Diagnosis area (Figure 4.10a). A dialog box titled Add POV for Current Visit will pop up. See Figure 4.10b. Click on the ellipsis (...) button.

Figure 4.10a. Visit Diagnosis, Unfilled

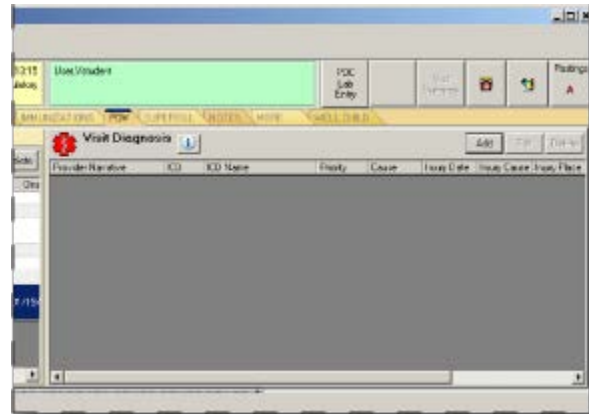
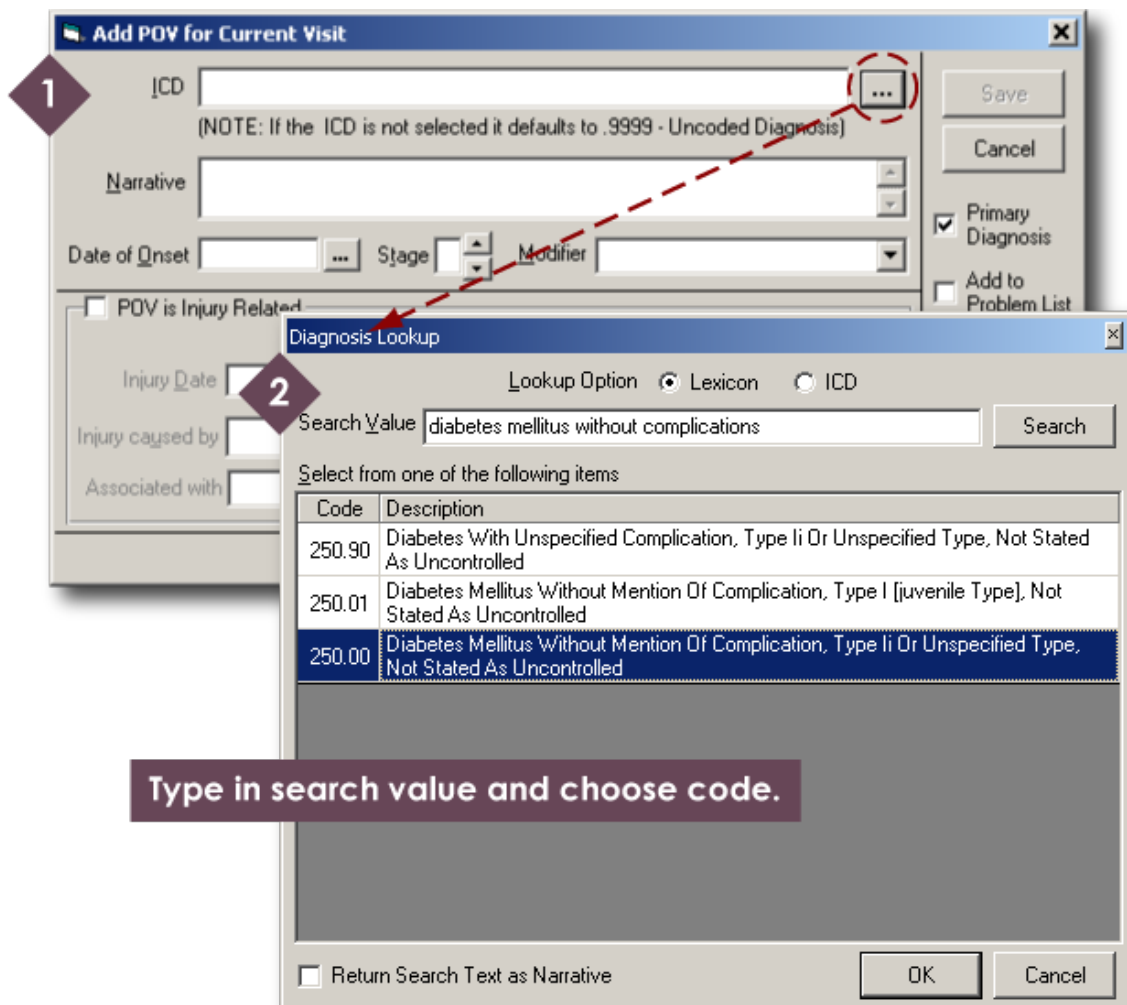
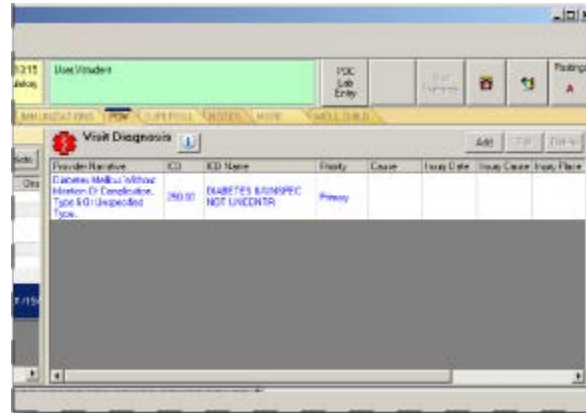


Figure 4.10b. Adding a Visit Diagnosis



The Diagnosis Lookup dialog box will open in front of the Add POV dialog box. With the Lookup Option set to “Lexicon” (text), type key words in the Search Value field and click the Search button. A list will appear below the Search Value field. Choose the most appropriate code in the list and click the OK button to save and close the Diagnosis Lookup box. In the Add POV box, select Primary Diagnosis. Add a narrative and any necessary other information and click the Save button. The new purpose of visit will be visible in the Visit Diagnosis area of the POV window.

Figure 4.10c. Visit Diagnosis Area After POV Added



An easier way to add a visit diagnosis (POV) is to use the ICD–9 Pick List. Figure 4.10d shows the ICD–9 Pick List area with a diagnosis chosen. To view pick lists, activate the Show All option in the lower left. The pick lists that appear will depend on the facility where the EHR is located. In Figure 4.10d, the “Phn” list is selected. This is a local version of a public health nursing list. The items on this list are displayed on the right. Each item has a check box. More than one item can be selected. In Figure 4.10d, V79.0–Screening for Depression is chosen. As a result of this selection, depression screening now appears in the Visit Diagnosis area. See Figure 4.10e.

Figure 4.10d. ICD–9 Pick List With Pick List Selected and Diagnosis Chosen

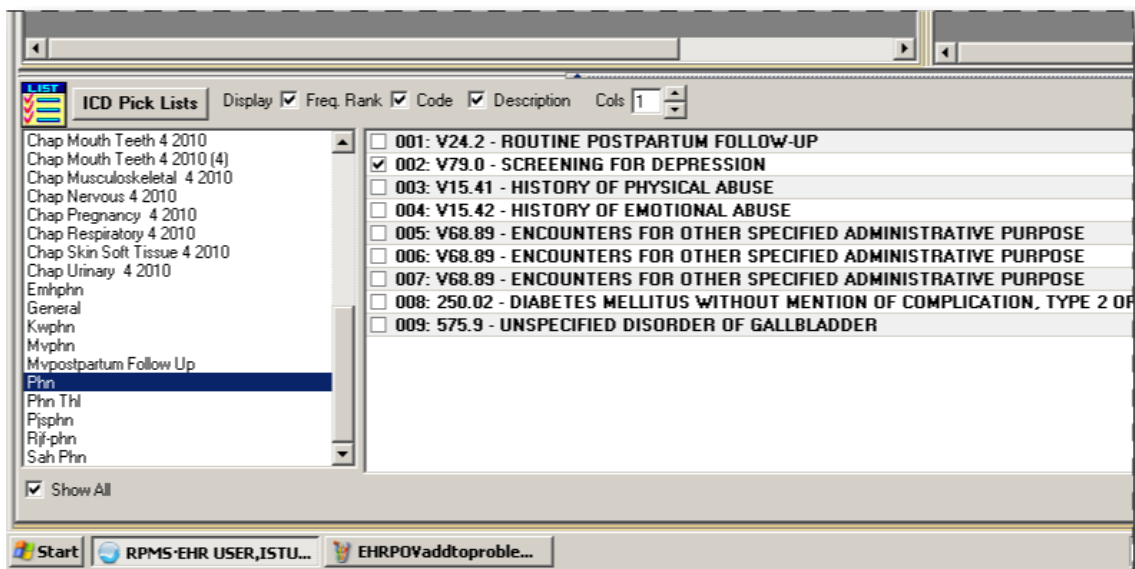
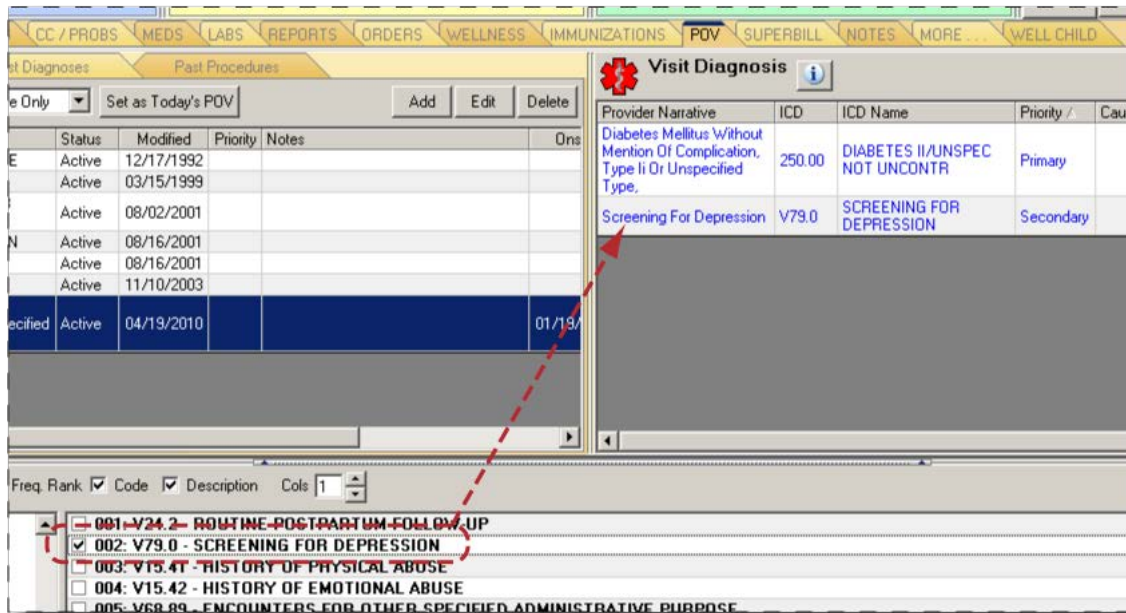
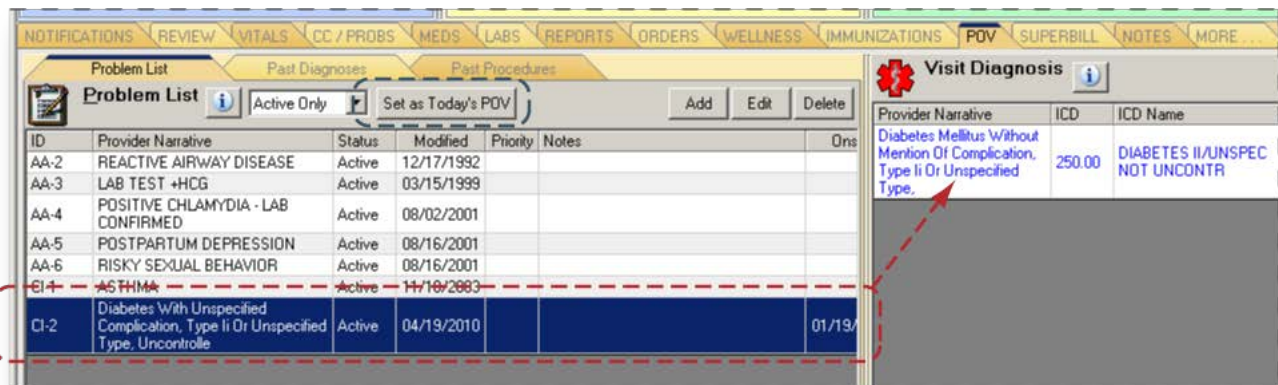


Figure 4.10e. Using the ICD-9 Pick List to Add a POV



A third way to set the purpose of visit is to use the Problem List. Simply select an item in the Problem List and click the Set as Today's POV button. The Problem List item will appear in the Visit Diagnosis area. See Figure 4.10f.

Figure 4.10f. Using the Problem List to Set the Purpose of Visit



### 4.11 Visit Services

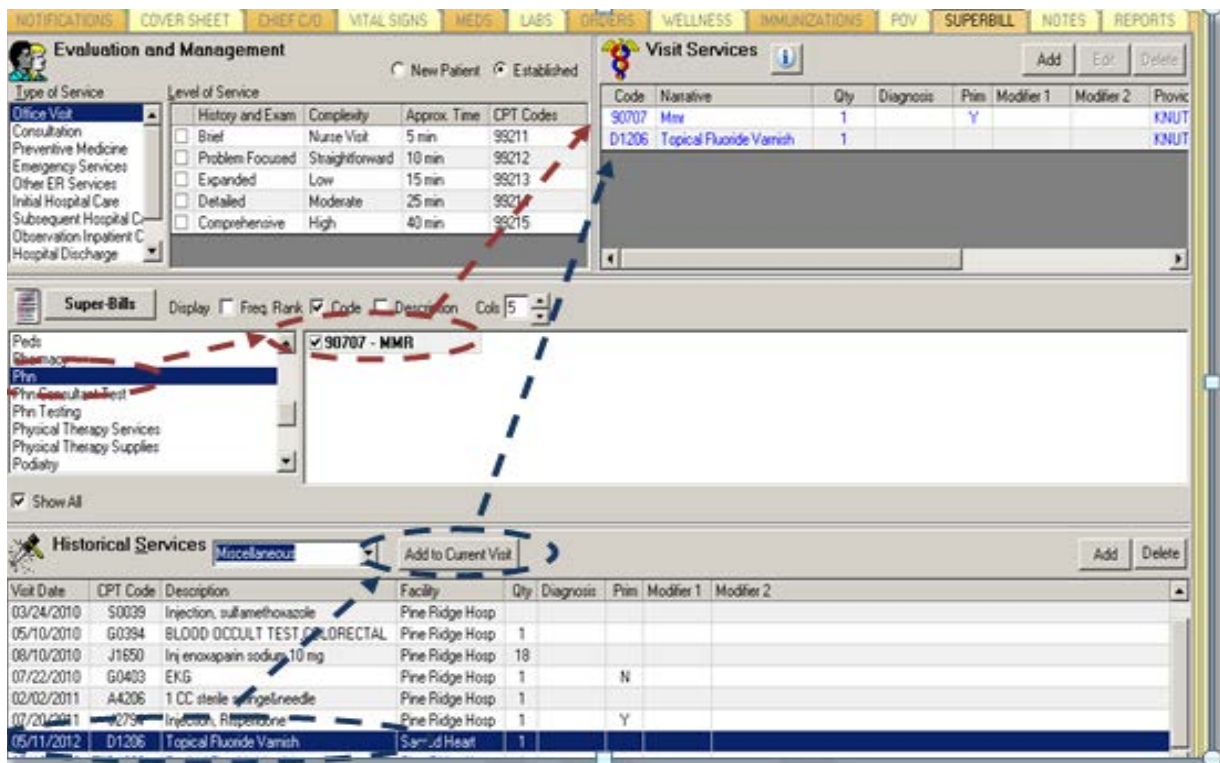
Public health nurses must enter services rendered in the Visit Services area of the Superbill window. The Visit Services area is in the upper right of the Superbill window (in the default EHR design) as shown in Figure 4.11a. There are several ways to add services.

Figure 4.11a. Visit Services, Blank



The nurse can add a service (or services) by using pick lists in the Super-Bills area across the middle of the Superbills window. In Figure 4.11b, a pick list called "Mvimmunizations" is selected. Notice the Show All function is checked. This function must be activated in the "Super-Bills" area to be able to view all the pick lists.

Figure 4.11b. Two Ways to Add Services

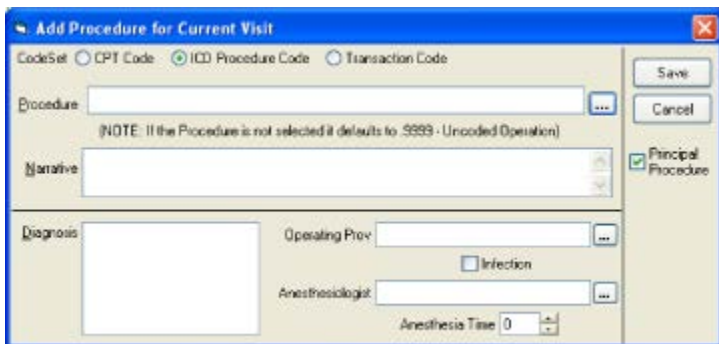


The Mvimmunizations pick list contains one item: 90707–MMR (measles, mumps, and rubella vaccine). When 90707–MMR is checked in the Super-Bills area, it appears in the Visit Services area. The dotted red line in Figure 4.11b reflects the process described here.

Another way to add a service rendered is through the Historical Services area. Follow the dotted green line in Figure 4.11b. In this process, a glucose blood test performed on August 18, 2005, is selected. Once an item in the Historical Services area is selected, all the user has to do is click the Add to Current Visit button to add the item to the Visit Services area.

If the nurse cannot find the service rendered in the pick lists or Historical Services, he or she must click the Add button in the Visit Services area and add a service using the Add Procedure for Current Visit dialog box (Figure 4.11c). In the dialog box, click on the ellipsis (...) button at the top to choose a procedure.

Figure 4.11c. Dialog Box: Add Procedure for Current Visit



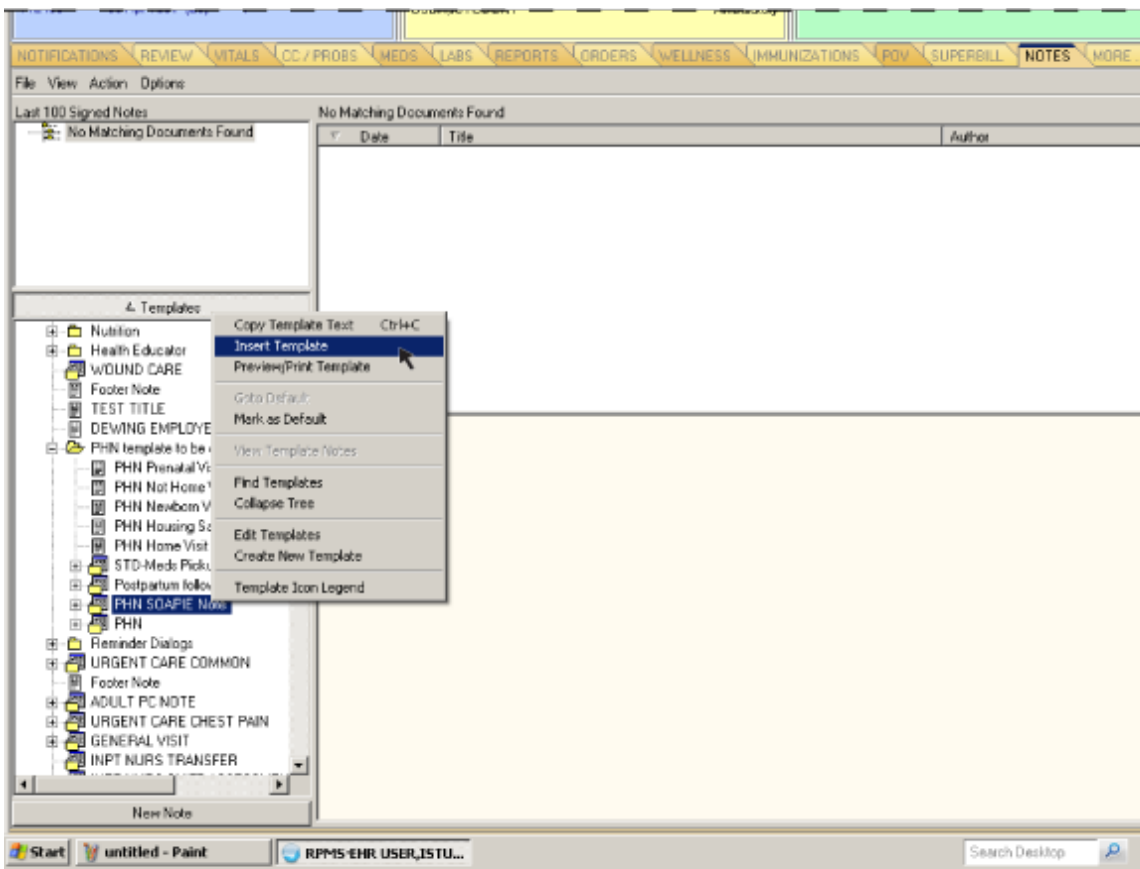
#### 4.12 Notes

Public health nurses must complete a progress note for all patient visits. The body of the progress note should contain a narrative about health factors, screenings, immunizations, and other services performed. However, it is important also to include this information in other relevant parts of the EHR. Otherwise, crucial data will not be included in reports generated by the health facility, because the body of the progress note is not included in these reports. Hence, an immunization discussed in the progress note must also be documented in the Immunizations section of the EHR.

***If your process includes medical orders (lab, consults, medications, radiology, etc.), you must ensure that the order has been entered before completing your nurse's note.***

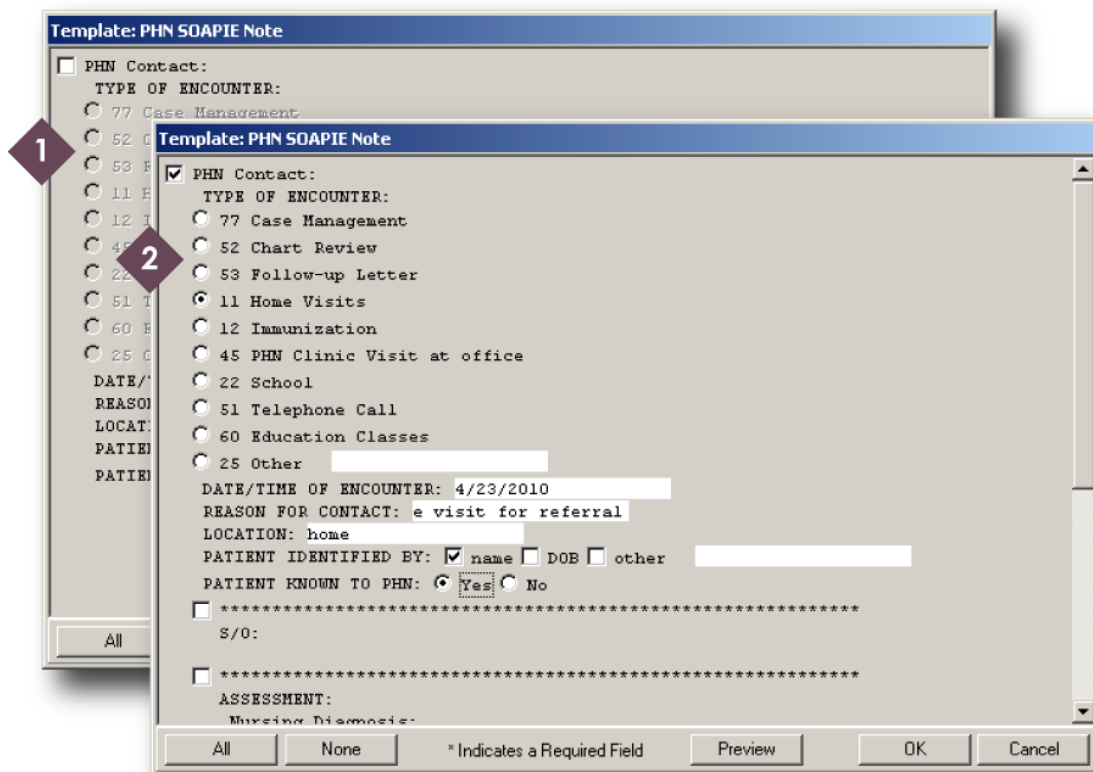
Click on the Notes tab (if you're using the default EHR design). Notice the expandable-contractible list of templates on the left. Find a template for a public health nursing SOAPIE (subjective-objective-assessment-plan-intervention-evaluation) note. Select the PHN SOAPIE template and right click on it. A pop-up menu will appear. Select Insert Template in the pop-up menu. See Figure 4.12a.

Figure 4.12a. Notes Window; PHN SOAPIE Note Template Selected



A dialog box titled Template: PHN SOAPIE Note will pop up. The PHN Contact option must be checked to be able to enter information in the SOAPIE note template. See Figure 4.12b. Fill in the date and reason for the encounter and all the other relevant fields. When finished click the OK button.

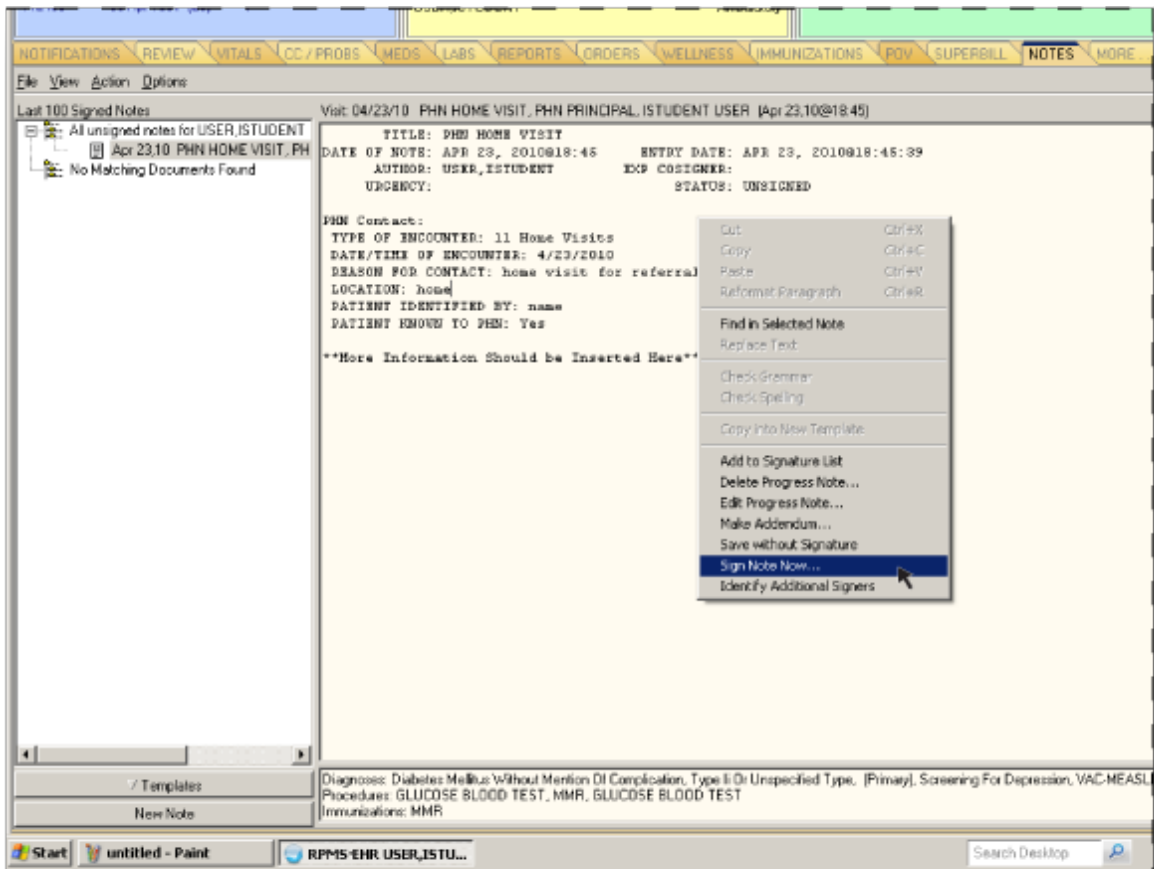
Figure 4.12b. PHN SOAPIE Note Dialog Box



The text of the unsigned progress note will appear in the body of the Notes window, where the public health nurse can add more text. See Figure 4.12c. If the location of the encounter is not already in the progress note, nurses must add it here. Documenting the visit location is a legal requirement.



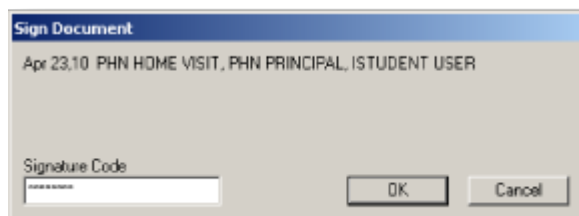
Figure 4.12c. Notes Window; Getting Ready to Sign Progress Note



Public health nurses must sign their progress notes. Position the mouse in the body of the progress note and right click. In the pop-up menu, select Sign Note Now. See Figure 4.12c.

The Sign Document dialog box will appear. Enter the Access Code (from Figure 4.12d) in the Signature Code field and click OK.

Figure 4.12d. Sign Document Dialog Box



### 4.13 Medications

Ordinarily, public health nurses do not order medications. However, if there is a standing order, a public health nurse must enter a medication order in the EHR. Please refer to Section 5.0 of this manual for the standing orders documentation process.

Public health nurses may encounter patients that receive medications from outside sources, such as Veterans Affairs or private clinics. EHR patch 10 has an option to enter outside medications into the system, allowing primary care providers the ability to review medications the patient takes that are not ordered or filled by the in-house pharmacy. This process provides reconciliation of all patient medications.

Go to the Medications tab and select “non” facility medications. Then, click New and a dialog box will appear. See Figure 4.13a. Figures 4.13a–e show how to document an unknown outside medication.

Figure 4.13a. Outside Medications, Step One

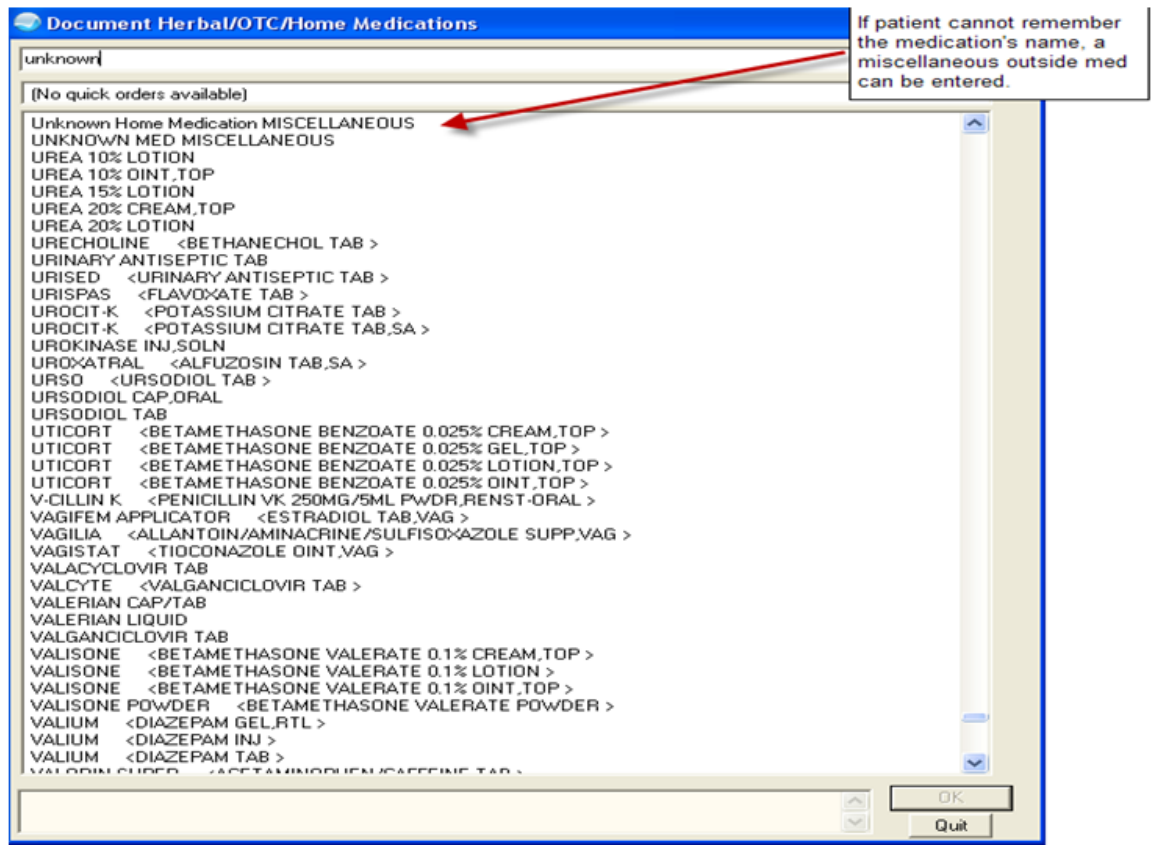


Figure 4.13b. Outside Medications, Step Two

Document Herbal/OTC/Home Medications

Unknown Home Medication MISCELLANEOUS Change

Fields not required for Miscellaneous Medication

Dosage	Route	Schedule	PRN
		BEDTIME BID BIDAC BIDPC BIDWM DAILY EVERY OTHER DAY MO-WE-FR MONTHLY NOW ON CALL ONCE	<input type="checkbox"/>

Comments:

Statement/Explanation

- Non-VA medication not recommended by VA provider.
- Non-VA medication recommended by VA provider.
- Patient wants to buy from Non-VA pharmacy.
- Medication prescribed by Non-VA provider.

Home Medication List Source

- Patient
- A list the patient may have
- Medications themselves
- Friend
- Family member
- Medical record
- Patient's pharmacy
- Patient's primary care physician
- Other

Medication Reason

Location of Medication

- Home
- Hospital
- Other

Start Date:  Last Dose Taken:

Unknown Home Medication MISCELLANEOUS Accept Order Quit

Figure 4.13c. Outside Medications, Step Three

Figure 4.13d. Outside Medications, Step Four

Action	OUTSIDE MEDS	Start Date	Status
Validate	Home-Med Unknown Home Medication MISCELLANEOUS Sep 04, 2010 HOME Blood pressure pill, large blue tablet		Active
	Home-Med FUROSEMIDE 40MG TAB (GEO. LASTX) 40MG MOUTH EVERY DAY Sep 05, 2010 HOME		Active
	Home-Med Unknown Home Medication MISCELLANEOUS Sep 04, 2010 HOME Blood pressure pill, large blue tablet		Discontinued

- Once signed, the unknown miscellaneous medication becomes active, with an action of “Validate”.
- When the correct drug information is collected from the patient or patient representative, the user would select the outside medication row, and choose the action of “Change” from the toolbar.
- The user would change the drug name and other fields captured during outside medication entry, and the system would create a new outside medication row, and discontinue the unknown miscellaneous medication.

Figure 4.13e. Outside Medications, Step Five

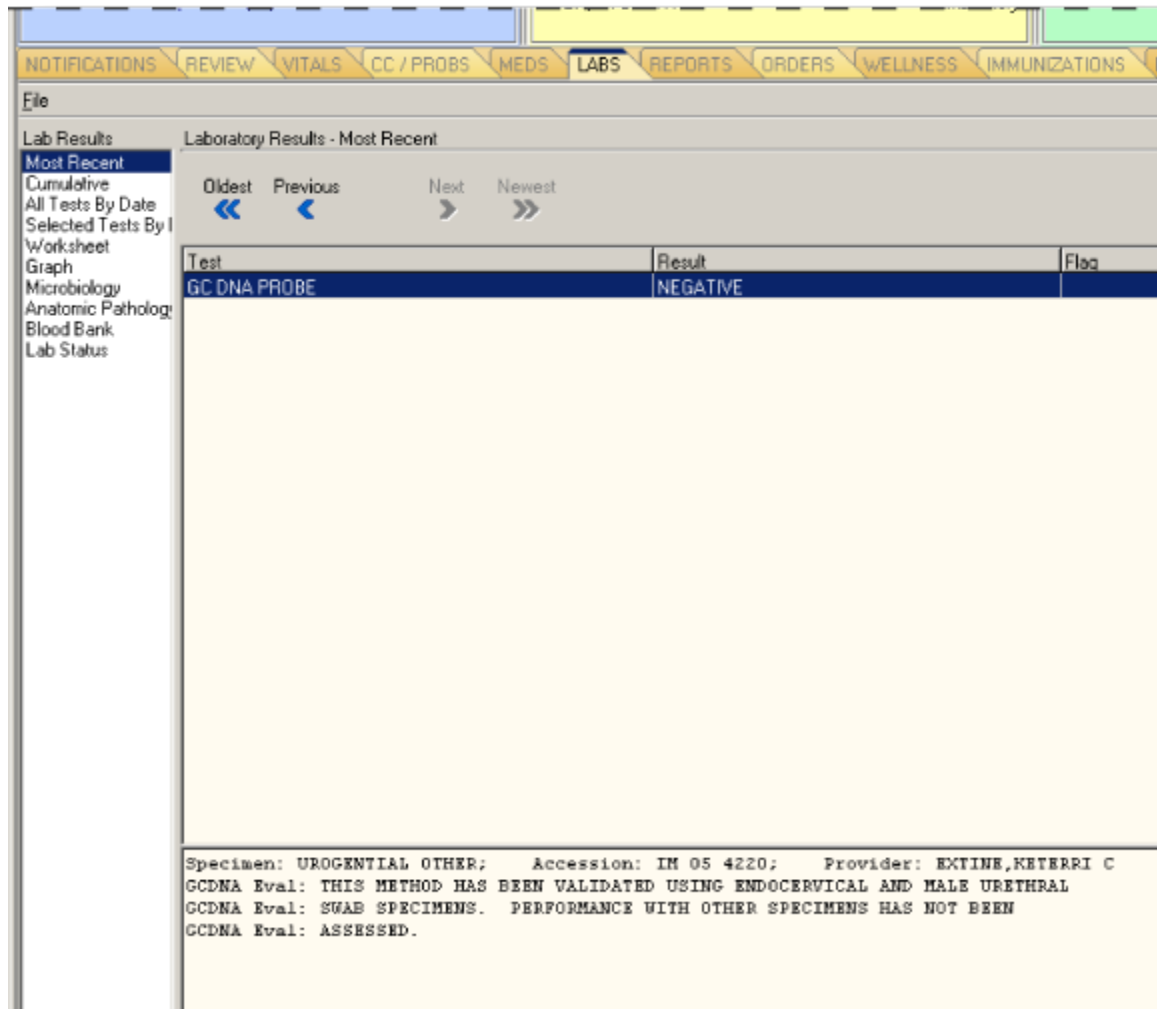
Action	OUTSIDE MEDS	Start Date	Status
	Home-Med ATORVASTATIN CALCIUM 10MG TAB [GEO: LIPITOR] 10MG MOUTH DAILY Sep 04, 2010 HOME		Hold
	Home-Med FURROSEMIDE 40MG TAB [GEO: LASIX] 40MG MOUTH EVERY DAY Sep 05, 2010 HOME		Transfer To Ip
	Home-Med Unknown Home Medication MISCELLANEOUS Sep 04, 2010 HOME Blood pressure pill, large blue tablet		Discontinued
	Home-Med ACETAMINOPHEN 80MG CHEW TAB [GEO: TYLENOL] 80MG MOUTH TWICE A DAY		Transfer To Op

1. Outside medications can now be placed on hold and/or released from hold.
2. Outside medications can be transferred to an inpatient medication, the outside medication stays active with a new status of "Transfer to IP".
3. Outside medication can be transferred to an outpatient medication, the outside medication stays active with a new status of "Transfer to OP".
4. Any outside medication can be transferred or held multiple times, to allow for reconciliation at admission, transfer, and discharge. This also allows for the medication to become a part of the patient's longitudinal record.

#### 4.14 Labs

A patient's laboratory test results are viewable in the Labs window. Selecting an option in the Lab Results area on the left allows the user to view all or some lab results or to view certain kinds of lab results. See Figure 4.14a.

Figure 4.14a. Labs Window

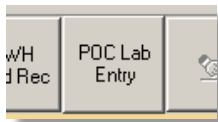


Ordinarily, public health nurses do not order laboratory tests. However, if there is a standing order, a public health nurse must enter a lab order in the EHR. Tests performed at the point of care and tests waived by the Clinical Laboratory Improvement Amendments (<http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/>) must be documented by public health nurses.

The point of care in the laboratory package uses the Fast Bypass option to order, accession, result, and sign in one process. Use the following steps to complete a nursing order for point-of-care testing.

1. With a patient and visit selected, click the POC Lab Entry button to open the Point of Care Data Entry Form dialog box.

Figure 4.14b POC Lab Entry Button



2. Select the test to be performed from the list.

Figure 4.14c Lab Point of Care Data Entry Form Dialog Box

A screenshot of a software dialog box titled "Lab Point of Care Data Entry Form". The dialog box has a yellow header bar with "Patient: ABBOTT, RAY MITCHELL" and "Hospital Location: A CLINIC". Below the header, there are several fields: "Ordering Provider" (USER, ZZSTUDENT), "Nature of Order/Change" (WRITTEN), "Test" (POC GLUCOSE), "Sample Type" (VENOUS BLOOD), "Collect" (POC GLUCOSE), and "Sign or Symptom". A dropdown menu is open under "Collect", showing a list of tests: POC A1C, POC HGB, POC RAPID STREP A, POC URINE DIPSTICK, and POC URINE PREGNANCY. There is an "Add Canned Comment" button. Below the form fields is a section titled "TEST RESULTS" with a table containing one row of data. At the bottom are "Save" and "Cancel" buttons.

Test Name	Result	Result Range	Units
POC GLUCOSE		65 to 105	MG/DL

3. Enter the test information and test results.
4. Select the nature of the lab order or change. If the test was done by policy, the nurse *must* select "Policy" as the nature of the order and follow the documentation guidelines. *Only* select "Written" if there is a prior written order in the medical chart or record for that patient for the point-of-care test.

Figure 4.14d Lab Point of Care Data Entry Form Dialog Box With Test Results

Lab Point of Care Data Entry Form

Patient: ABBOTT, RAY MITCHELL Hospital Location: A CLINIC

Ordering Provider: USER, ZZSTUDENT Nature of Order/Change: WRITTEN

Test: POC GLUCOSE Sample Type: VENOUS BLOOD

Collection Date and Time: 11/29/2010 03:16 PM Sign or Symptom: 250.00 Diabetes Mellitus Without Me

Comment/Lab Description:

Add Canned Comment

TEST RESULTS			
Test Name	Result	Result Range	Units
POC GLUCOSE	115 H	65 to 105	MG/DL

Save Cancel

5. Add any desired comments. Click Add Canned Comment to display a list of standard comments.

Figure 4.14e Choose a Lab Comment Box

Choose a Lab Comment

Code	Lab Comment Description
FBS	Fasting Specimen
SPEC	Specialty Laboratories Inc. 2211 Michigan Ave. Santa Monica CA 90404
ERRORCK	Error was made in the recheck.
VER	Verified by Repeat Analysis.
ORB	Verbal order read back to physician.

OK Cancel

6. When finished, click OK to close the Choose a Lab Comment dialog and reveal the Lab Point of Care Data Entry Form dialog.



Figure 4.14f Lab Point of Care Data Entry Form Dialog Box With Comment

Lab Point of Care Data Entry Form

Patient: ABBOTT, RAY MITCHELL Hospital Location: A CLINIC

Ordering Provider: USER, ZZSTUDENT Nature of Order/Change: WRITTEN

Test: POC GLUCOSE Sample Type: VENOUS BLOOD

Collection Date and Time: 11/29/2010 03:16 PM Sign or Symptom: 250.00 Diabetes Mellitus Without Me

Comment/Lab Description:  
Verbal order read back to physician. Add Canned Comment

TEST RESULTS			
Test Name	Result	Result Range	Units
POC GLUCOSE	115 H	65 to 105	MG/DL

Save Cancel

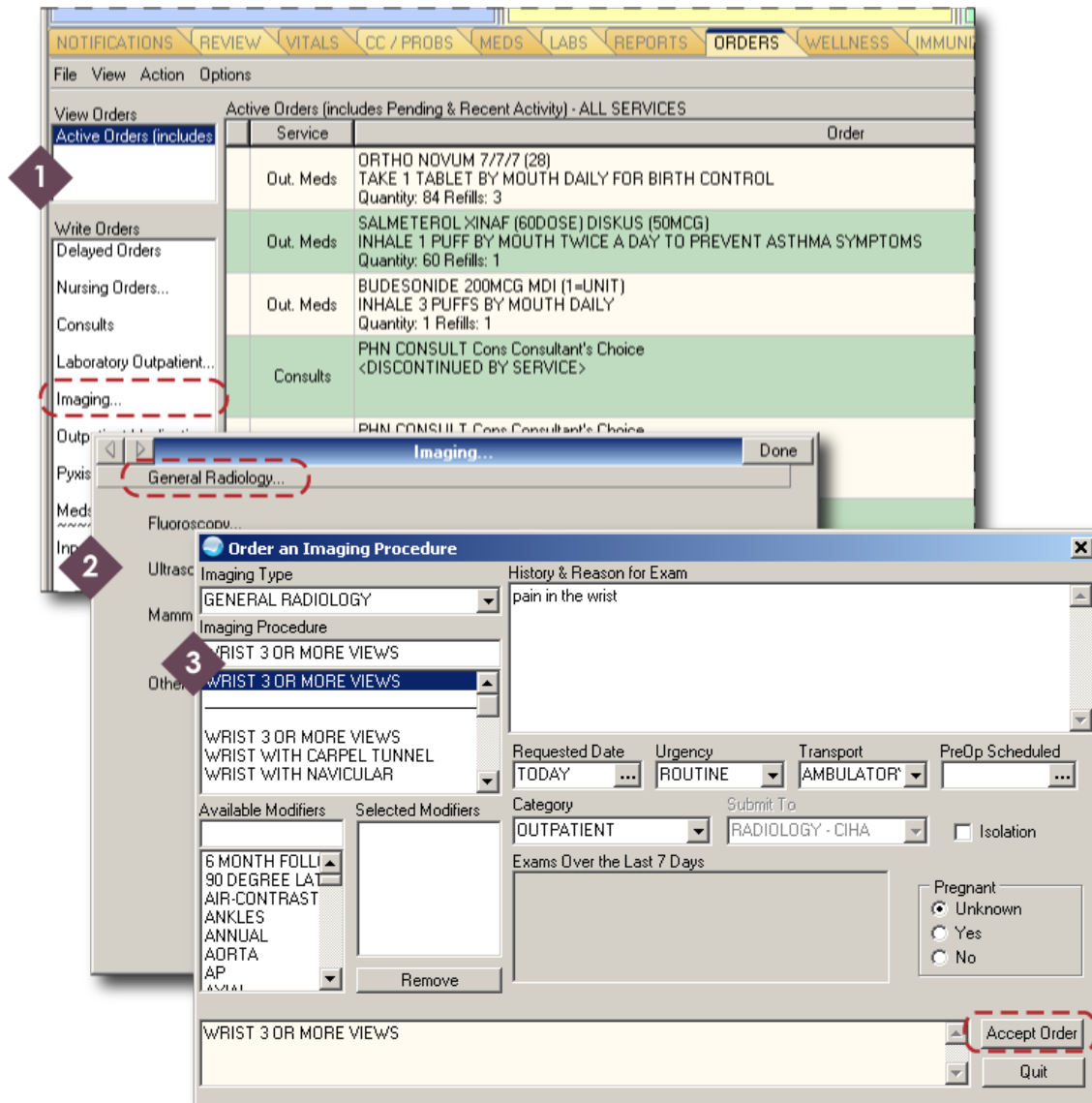
7. Click Save to save the test and close the Lab Point of Care Data Entry Form dialog.

## 4.15 Radiology

Ordinarily, public health nurses do not order imaging; but, if there is a standing order, a public health nurse must enter an imaging order in the EHR. Before doing so, a secondary provider must be entered in the patient and visit setup described in Section 4.3 above.

Imaging requests are made in the Orders window. Click on the Imaging link in the left under the Write Orders heading.

Figure 4.15a. Ordering an X-Ray



In the Imaging dialog, select General Radiology for an x-ray. The dialog box for ordering an imaging procedure will open. Select the procedure, date for the procedure,

urgency, transport, and category (outpatient in this case). The History and Reason field can hold multiple lines of text; therefore, enter as much information here as necessary. If the patient is female and in child-bearing years, the user must choose one of the options in the Pregnant field. When finished, click the Accept Order button. The new, unsigned imaging order will appear in the Orders window.

Figure 4.15b. Unsigned X-Ray Order

View Orders	Service	Order
Active Orders (includes)	Imaging	WRIST 3 OR MORE VIEWS *UNSIGNED*
Write Orders	Out. Meds	DIPHENHYDRAMINE CAP ORAL 25MG TAKE ONE (1) CAPSULE BY MOUTH AT BEDTIME MAY CAUSE DROWSINESS Quantity: 30 Refills: 0
Delayed Orders		
Nursing Orders...	Out. Meds	ORTHO NOVUM 7/7/7 (28) TAKE 1 TABLET BY MOUTH DAILY FOR BIRTH CONTROL Quantity: 84 Refills: 3
Consults		
Laboratory Outpatient...	Out. Meds	SALMETEROL XINAF (600DOSE) DISKUS (50MCG) INHALE 1 PUFF BY MOUTH TWICE A DAY TO PREVENT ASTHMA SYMPTOMS Quantity: 60 Refills: 1
Imaging...	Out. Meds	BUDESONIDE 200MCG MDI (1-UNIT) INHALE 3 PUFFS BY MOUTH DAILY Quantity: 1 Refills: 1
Outpatient Medications	Lab	PREGNANCY TEST URINE CLEAN CATCH W/C ONCE Indication: RISKY SEXUAL BEHAVIOR LB #60052
Phys Medication Menu		
Meds Given in Clinic...	Consults	PHN CONSULT Cons Consultant's Choice <DISCONTINUED BY SERVICE>
Inpatient Menus...		PHN CONSULT Cons Consultant's Choice

## 4.16 Reports

Public health nurses can generate and view a number of reports from the patient chart in the Reports window. Simply select one of the report titles on the left under the Available Reports heading. The EHR will generate a report with the latest information entered in the main area of the Reports window. The Daily Order Summary is displayed in Figure 4.16.

Figure 4.16. Reports Window; Daily Order Summary Selected

The screenshot displays the RPMS-EHR interface. At the top, the user is identified as 'RPMS-EHR\_USER,ISTUDENT'. The interface includes a menu bar with 'User', 'Patient', 'Tools', and 'Help'. Below this, there are tabs for 'PRIVACY', 'PATIENT CHART', and 'RESOURCES'. The 'PATIENT CHART' tab is active, showing patient information for 'Standingdeer,Roberta Dianne' (ID: 112499, DOB: 05-Apr-1981, Gender: F). The patient's role is 'PHN PRINCIPAL' and the user is 'USER,ISTUDENT'. The date and time are '23-Apr-2010 13:15' and the location is 'Ambulatory'. The user is logged in as 'User,Vstudent'.

The 'REPORTS' tab is selected, showing a list of 'Available Reports' on the left and the 'Daily Order Summary' report on the right. The 'Daily Order Summary' report is displayed as follows:

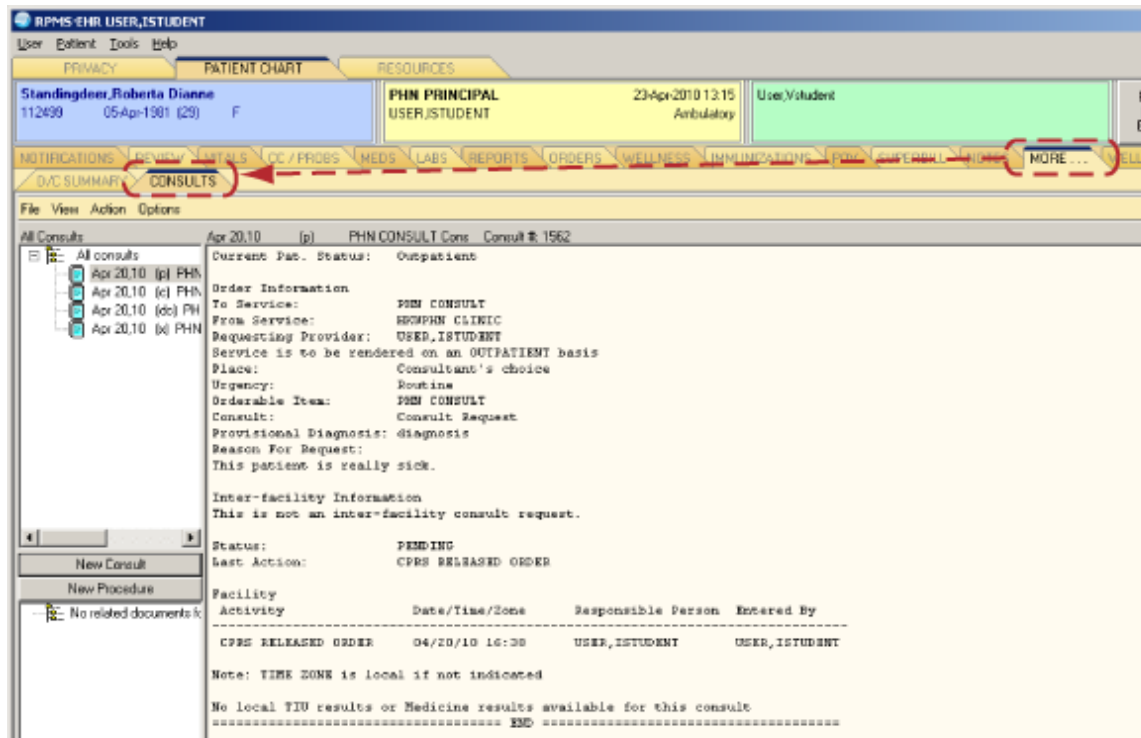
DAILY ORDER SUMMARY			Page 1
			Printed Apr 23, 2010@18:59
Ord'd	ST	Item Ordered	Requestor Start Stop
04/23/10 p		WRIST 3 OR MORE VIEWS	USER,I 04/23/10
	16:35		PHN SECRET
ISU		Typ:WRITTEN	Sgn:ON CHART w/written orders
04/23/10 p		DIPHENHYDRAMINE CAP,ORAL 25MG	"
	15:53	TAKE ONE (1) CAPSULE BY MOUTH AT BEDTIME	"
		MAY CAUSE DROWSINESS	
		Quantity: 30 Refills: 0	
ISU		Typ:POLICY	Sgn:ELECTRONIC
04/23/10 p		PREGNANCY TEST URINE CLEAN CATCH UC ONCE	USER,X 04/23/10
	15:32	Indication: RISKY SEXUAL BEHAVIOR LB	
		#60052	
ISU		Typ:POLICY	Sgn:ELECTRONIC
* END OF ORDERS *			

EHR report options are similar to health summary and predefined reports in RPMS. To capture statistical data and PHN program management, one still needs to access RPMS directly for enhanced reports, such as VGEN and others.

## 4.17 Consults

To view a patient's consults, click on the More tab (if you're using the default EHR design) first to reveal a second row of tabs, then click on the Consults tab.

Figure 4.17a. Clicking the More Tab to Reveal the Consults Tab



A list of consults (typically sorted by date) will appear on the left under the All Consults heading. Choosing one of the consults in this list will reveal the entire consult text in the main area of the Consults window (Figure 4.17a).

The ability of public health nurses to order consults in the EHR varies by facility. If a user has the need and ability to order a consult, there are two places to start a consult. One is at the New Consult button in the Consults window. The other is at the Consults link in the Orders window. See Figure 4.17b. Either option will open the consult ordering dialog box (Figure 4.17c). In the dialog box, select a service or specialty. Enter a reason for consult in the Reason for Request text field. Click the Accept Order button when finished.

Figure 4.17b. Starting a Consult in Either the Consult Window (Left) or the Orders Window

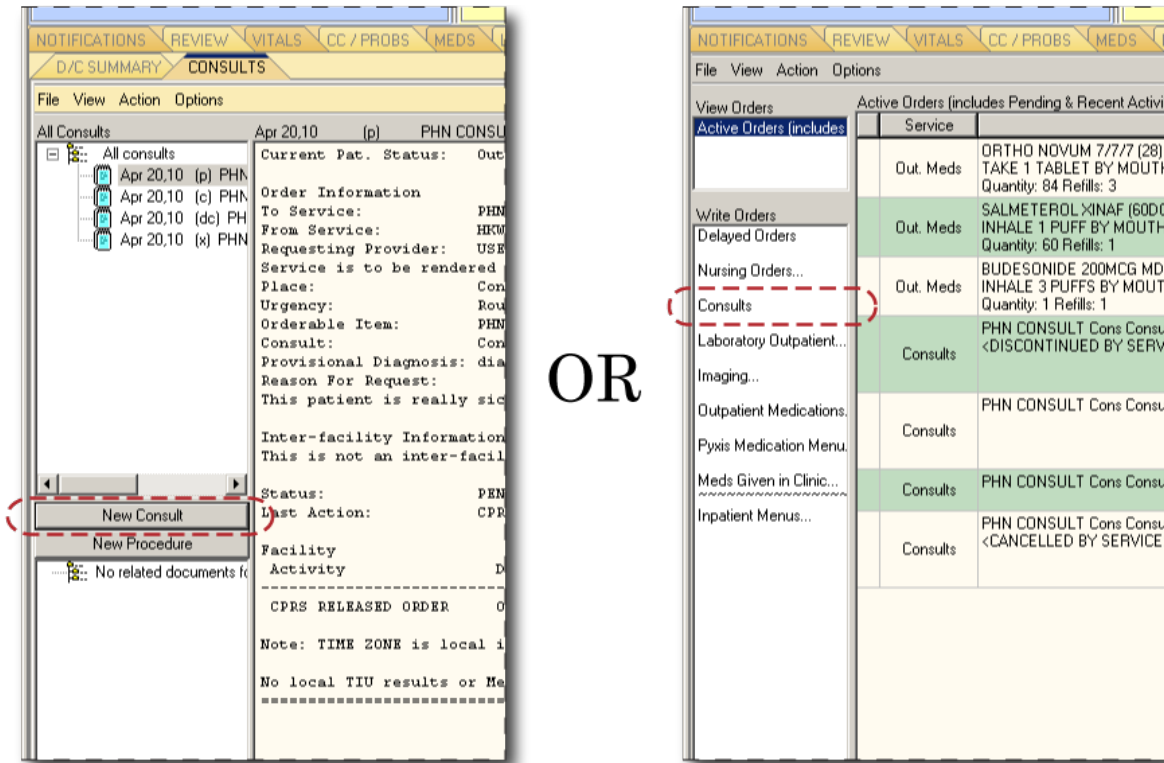
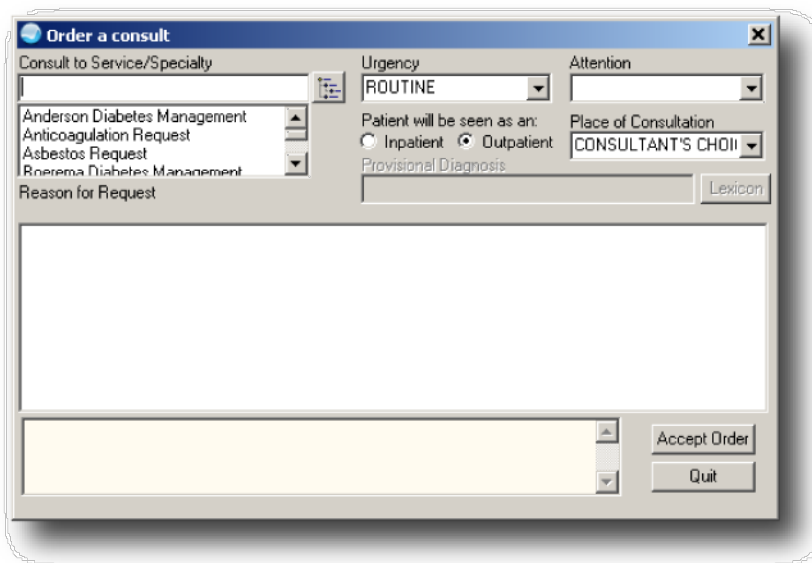


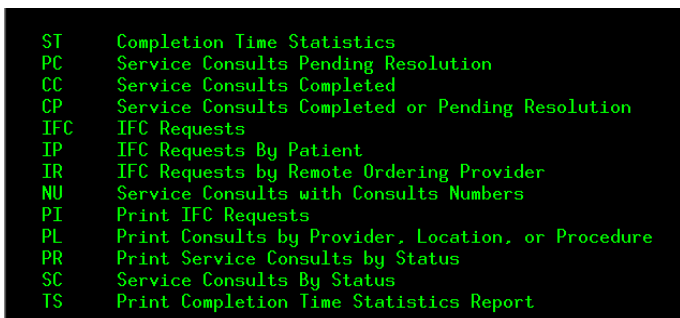
Figure 4.17c. Order a Consult Dialog Box



If you have an established PHN team with a PHN consult identified in EHR, the option to do consult management tracking is available in the Resource and Patient Management System (RPMS). Consult management allows for the evaluation of consult status, such as pending or complete. This is an essential tool for program

management, planning, and access to quality care. For example, directors of PHN can use this to review compliance with the priority, intensity, and timeliness criteria defined in Section 8 in this manual.

Figure 4.17d. Tracking Manager in RPMS

A screenshot of a terminal window showing a list of menu options for the Tracking Manager in RPMS. The text is displayed in green on a black background. The options are listed as follows:

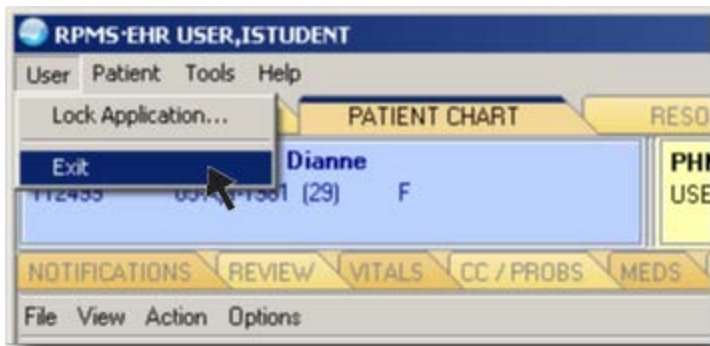
```
ST      Completion Time Statistics
PC      Service Consults Pending Resolution
CC      Service Consults Completed
CP      Service Consults Completed or Pending Resolution
IFC     IFC Requests
IP      IFC Requests By Patient
IR      IFC Requests by Remote Ordering Provider
NU      Service Consults with Consults Numbers
PI      Print IFC Requests
PL      Print Consults by Provider, Location, or Procedure
PR      Print Service Consults by Status
SC      Service Consults By Status
TS      Print Completion Time Statistics Report
```

Directors of PHN can run reports of service consults completed or pending resolution on a daily, weekly, or monthly basis to determine staff capacity and departmental efficiency. This tool assists with program management, position justifications, prioritizing vacancies, and performance appraisals.

#### 4.18 Quitting the Patient Record

After completely documenting an encounter in the patient's file, the public health nurse must quit the EHR. Quitting the EHR will save the information entered. In the upper left corner, pull down the User menu and select Quit, as shown in Figure 4.18.

Figure 4.18. Exiting the Patient Record





## 4.19 Help

Before contacting an information technology specialist, nurses should try using the EHR's extensive help application. The Help menu (Figure 4.19a) is in the Windows menu bar at the top. Figure 4.19b is an example of one of the many EHR help topics. Use the Index and Search tabs in the help application to find a topic.

Figure 4.19a. Help Menu

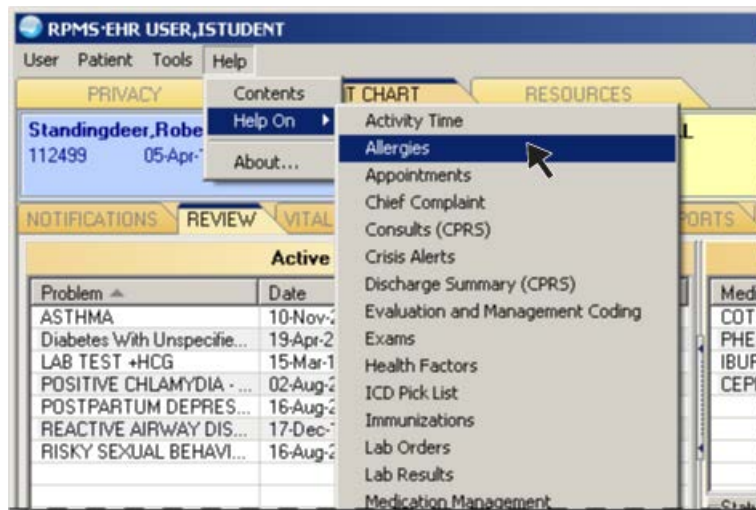
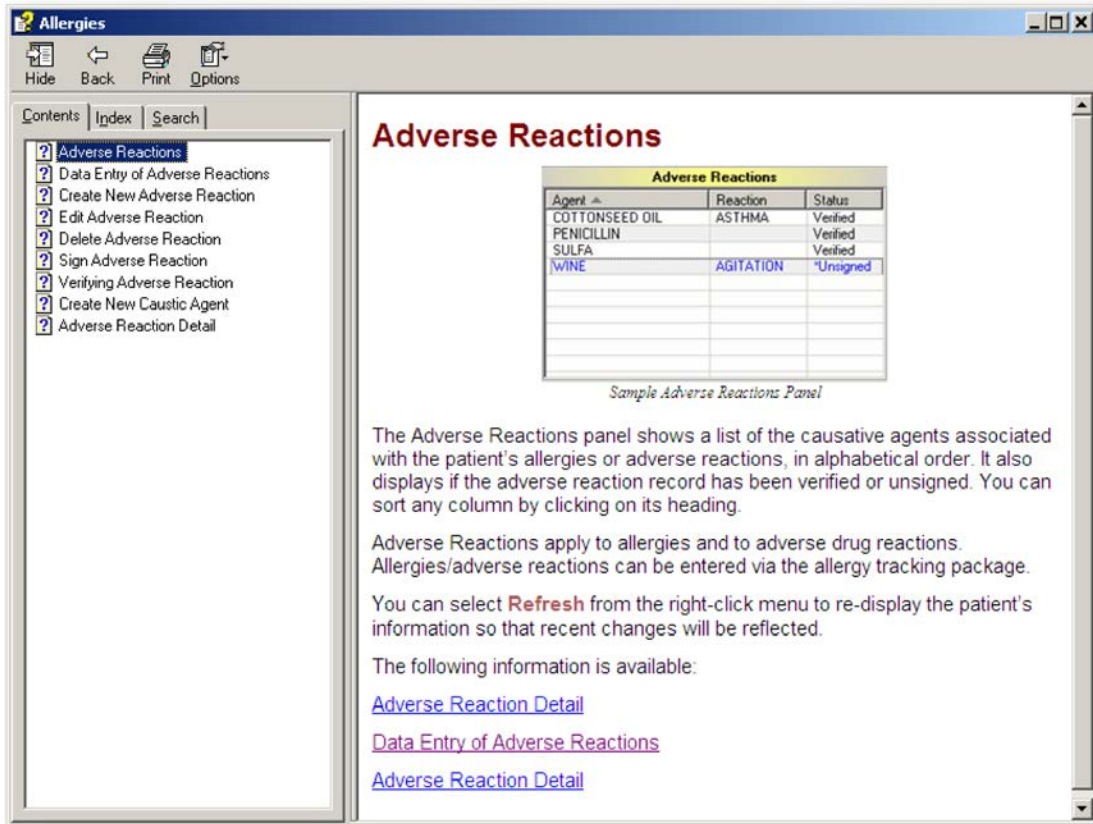


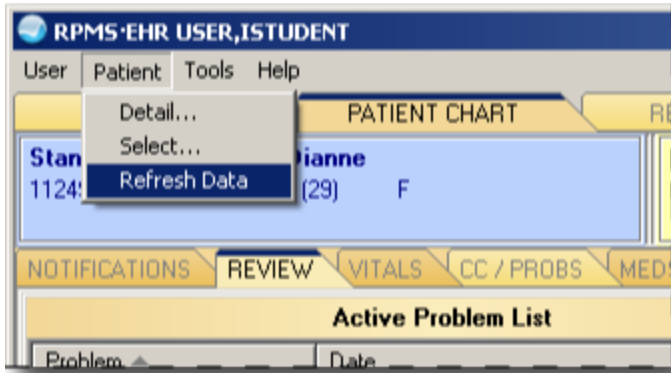
Figure 4.19b. Help Application



#### 4.20 Refreshing Data on the Screen

If the latest data entered does not appear in the patient chart, try “refreshing” the screen. In the Patient menu in the Windows menu bar at the top, select Refresh Data.

Figure 4.20. Refresh Data



## 5.0 STANDING ORDER DOCUMENTATION

Documentation of nursing care and nursing actions is a professional standard for nursing practice. Initiation of a medical standing order is an action that requires nursing documentation.

This section provides a guide to public health nursing (PHN) documentation based on best practices and professional nursing standards. This section is not comprehensive, and PHN departments should review additional requirements that may be necessary for compliance with specific accrediting bodies, state regulations, facility policy or reimbursement entities (such as a private insurer or state Medicaid) because these may vary from facility to facility.

It is important that standing order policies and protocols include acceptable means of “authenticating” (defined as linking the medical order with the patient care delivered by the public health nurse) orders. It may be acceptable to offer more than one authenticating method for users. This should be determined by each PHN department with input from Area nurse, PHN consultant, health information management, billing staff, risk manager, compliance officer, and clinical medicine staff.

***Please see Section 5.8 below for resources to assist in development of policies and procedures for standing orders. Clinics and hospitals should refer to IHS, Tribal, state, facility, and accreditation policies and regulations for additional guidance.***

### 5.1 What Is a PHN Medical Standing Order?

There are two kinds of PHN medical standing orders. One is an individual, patient-specific standing order, and the other is a non-patient-specific standing order. The former is an instruction for a patient’s care under specified circumstances. The latter is an instruction for patient care under specified circumstances, which the public health nurse is to follow for all patients unless the attending physician intervenes with different instructions.

#### ***Example of an Individual, Patient-Specific Standing Order***

The medical provider orders a PHN consult in the Electronic Health Record (EHR) and asks the public health nurse to provide three weekly weights on a premature infant. The medical provider also asks the public health nurse to assess home infant feeding, amounts and frequency, at each of the three weekly visits. This medical order only applies to a specific patient.

Nursing	>> Wet to dry dressings to wound on left hip daily x 1 week.	Start: 12/12/11 13:28 Stop: 12/19/11	Richards,S				active
Outpt. Meds	*AZITHROMYCIN TAB 250MG TAKE FOUR (4) TABLETS BY MOUTH ONCE Dispense to PHN who will administer to patient. Patient positive contact of patient with laboratory confirmed chlamydia Quantity: 4 Refills: 0 Dispense as Written: NO	Start: 12/12/11 Stop: 12/13/11	Richards,S				active

Service	Order	Duration	Provider	Nur
Consults	PHN Cons Consultant's Choice	Start: 12/12/11 14:20	Richards,S	

**Order Details - 947951;**

PHN Cons Consultant's Choice

Activity:  
12/12/2011 14:20 New Order entered by RICHARDS,SUSAN P (DATA TRANSCRIBE)  
Order Text: PHN Cons Consultant's Choice  
Nature of Order: ELECTRONICALLY ENTERED  
Elec Signature: RICHARDS,SUSAN P (DATA TRANSCRIBE) on 12/12/2011 14:20

Current Data:  
Treating Specialty:  
Ordering Location: SATURDAY CLINIC  
Start Date/Time: 12/12/2011 14:20  
Stop Date/Time:  
Current Status: PENDING  
Order #947951

Order:  
Consult to Service/Specialty: PHN  
Reason for Request:  
-----PHN: ALL OTHER REQUESTS-----  
3 weekly weights weeks on premature infant, and PHN to assess home infant feeding, amounts and frequency, at each of the 3 weekly visits

Category: OUTPATIENT  
Urgency: ROUTINE  
Place of Consultation: Consultant's Choice  
Provisional Diagnosis: Poor weight gain  
Consult No.: 36656

**Example of a Non-Patient-Specific Standing Order**

All patients should receive an annual influenza vaccine, unless they have a contra-indication to the influenza vaccine. All patients with diabetes should have a HgbA1C every three months if the previous result was seven or greater or every six months if previous result was under seven.

*The documentation for implementing a standing order may be the same no matter if it is patient specific or not patient specific. The nature of the documentation will depend on whether the PHN service was delivered in a mass community setting (flu clinic or community screening event, for example) or in an individual setting (home visit). See Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation—Proposed Rules for guidance on standing orders development, initiation, and documentation at <http://www.gpo.gov/fdsys/pkg/FR-2011-10-24/pdf/2011-27175.pdf>.*

## 5.2 Verify Order

The public health nurse should verify that there is a patient-specific standing order (EHR consult from the medical provider to the public health nurse, a medication order, or a text order) on the patient's chart and a PHN department policy to support the action. Consults are done by electronically receiving the consult and documenting the consulting provider and the date when consult was received on the Text Integration Utility (TIU) note template.

Paper referrals may be handled in one of two ways: the consult may be entered by the director of PHN (or designated representative) for tracking *or* a paper referral log can be kept for all outside providers. The paper referral should be filed in the medical record and referenced in the TIU note template when documenting care for the patient.

Another way to verify an order is for the public health nurse to verify that she or he has a non-patient-specific medical standing order or protocol and a supporting PHN department policy to support her or his performing the action.

***Medical standing orders only apply to licensed public health nurses within the PHN department, not to ancillary PHN department staff (health technicians, certified nursing assistants, drivers, interpreters, and office assistants). All PHN staff must have up-to-date competencies.***

***Directors of PHN must verify that medical standing orders have been approved by a legal, administrative entity or procedural body (for example, a governing board or a medical executive). Directors of PHN must verify that orders are reviewed or updated on an annual basis.***

### 5.3 Labs, Radiology, Consults, and Referrals Standing Order Entry

Non-patient-specific standing orders for labs, radiology, and consults will need to be entered into the EHR and released by policy so the patient may receive the service.

Point-of-care labs implemented per standing order must be entered with the nature of order set to “policy.”

#### ***Select Patient and Visit, and Set the Visit Context to Indicate the Ordering Medical Provider***

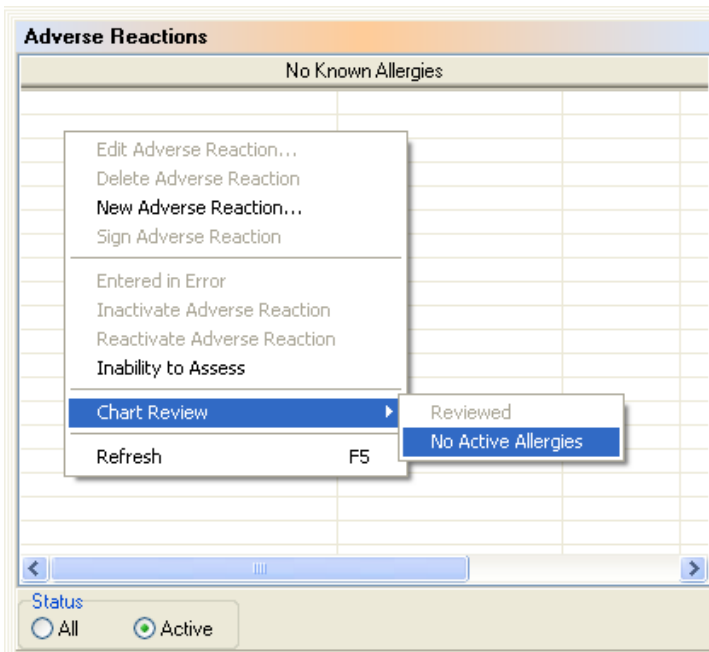
Place the medical provider (physician, physician assistant, or nurse practitioner) in the Providers for This Encounter field. The public health nurse should be highlighted in the Providers for This Encounter field. The public health nurse provider will then appear in the visit area of the patient chart, and he or she will be the ordering provider for any orders. The ordering medical provider becomes the secondary provider, and the public health nurse becomes the primary provider.

Patient	Location

#### ***Document the Review and Update of Allergies and Adverse Reactions***

Case 1: Let’s say no known allergies are previously documented, and no additional adverse reactions are reported. Move the mouse pointer over the Adverse Reactions

frame and right click. In the pop-up menu, choose Chart Review and then choose No Active Allergies in the submenu as shown in the figure below.



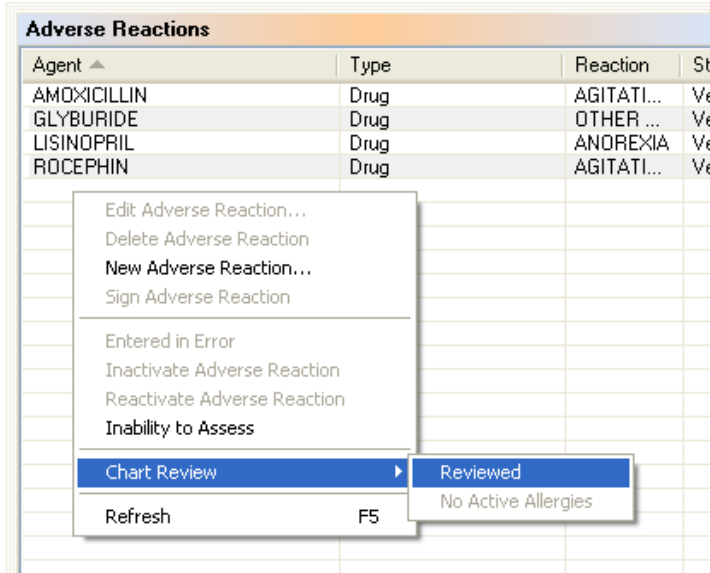
```

----- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) -----

      NO KNOWN ALLERGIES/ADVERSE DRUG REACTIONS noted on Feb 22, 2012

Allergy List Reviewed On:           Feb 22, 2012   By: RICHARDS,SUSAN
Allergy List Updated On:           Feb 22, 2012   By:
No Active Allergies Documented On: Feb 22, 2012   By: RICHARDS,SUSAN
    
```

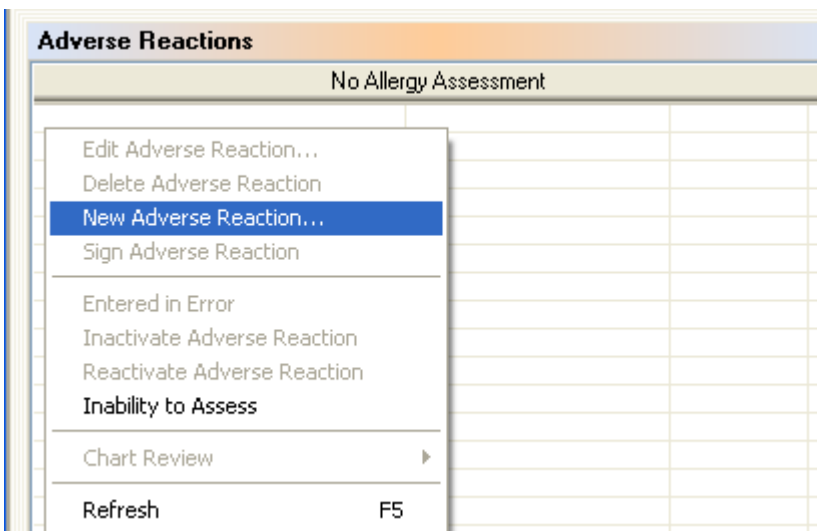
Case 2: Let's say allergies or adverse reactions were previously documented, and no additional adverse reactions are going to be reported. Right click on the Adverse Reactions frame, select Chart Review, and then select Reviewed. See figure.



```

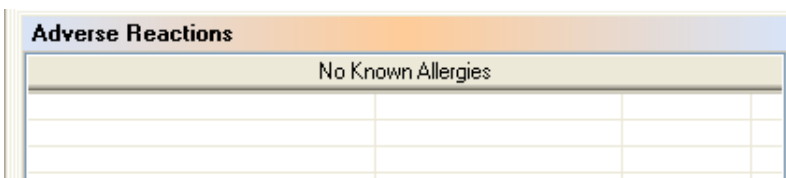
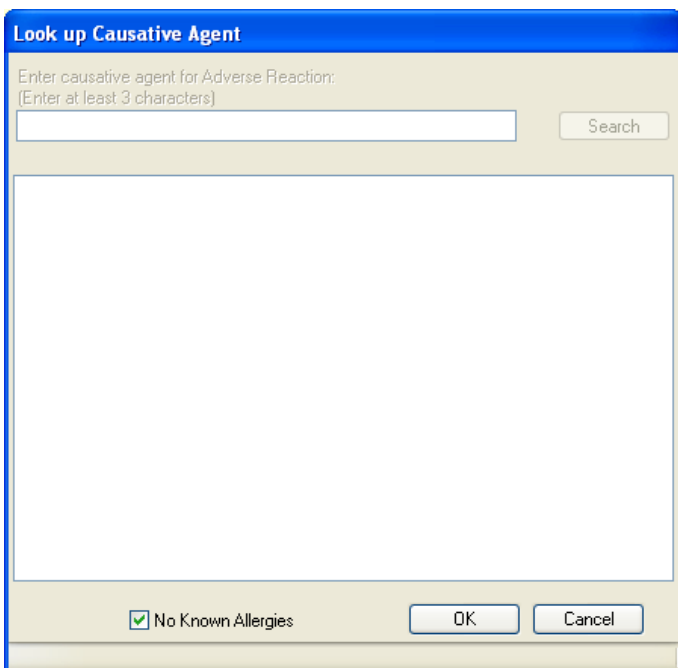
----- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) -----
Allergies: LISINOPRIL (verified) - ANOREXIA
           ROCEPHIN (verified) - AGITATION
Adverse Reactions: GLYBURIDE (verified) -
                   AMOXICILLIN (verified) - AGITATION
Allergy List Reviewed On:      Feb 22, 2012   By: RICHARDS,SUSAN
Allergy List Updated On:      Oct 18, 2011   By: RICHARDS,SUSAN
No Active Allergies Documented On:      By:
    
```

Case 3. What if no allergy assessment has been done? If no allergy assessment has been done and the patient has no allergies, then right click on the Adverse Reactions frame and select New Adverse Reaction in the pop-up menu.

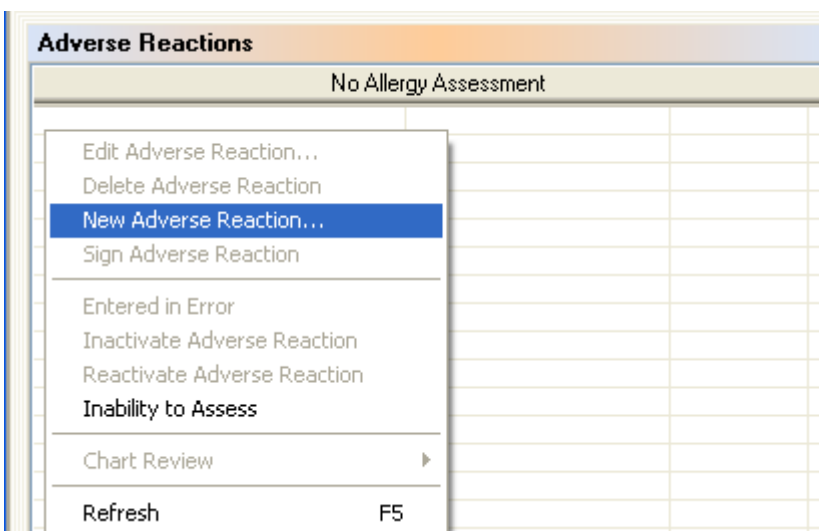


The Lookup Causative Agent dialog box will appear. Check the No Known Allergies option. Click OK. The Adverse Reactions frame will indicate no known allergies.





Case 4: New allergies or adverse reactions need to be reported. Right click on the Adverse Reactions frame and select New Adverse Reaction in the pop-up menu.



Use the search function in the dialog box to find the desired food, drug, or other causative agent. Click OK after selecting the desired agent.

**Look up Causative Agent**

Enter causative agent for Adverse Reaction:  
(Enter at least 3 characters)

lisinopril

Select from one of the following items

6 matches found.

- VA Allergies File (no matches)
- National Drug File - Generic Drug Name (1)**  
LISINOPRIL
- National Drug file - Trade Name (4)
- Local Drug File (no matches)
- Drug Ingredients File (1)
- VA Drug Class File (no matches)
- Add new free-text allergy (1)

No Known Allergies

Select from the matching entries on the list, or search again.

Fill out all the appropriate fields. The Comments and Source fields are optional. Click OK.

**Create Adverse Reaction**

Reaction

Causative agent: LISINOPRIL

Nature of Reaction: Drug

Event Code: DRUG ALLERGY

Source of Information: PATIENT

Observed

Observer: Richards, Susan

Reaction Date/Time:

Severity:

Signs/Symptoms

Available

- ANAPHYLAXIS
- AGITATION
- AGRANULOCYTOSIS
- ALOPECIA
- ANAPHYLAXIS
- ANEMIA
- ANOREXIA
- ANXIETY
- APNEA
- APPETITE, INCREASED
- ARRHYTHMIA

Selected

ANAPHYLAXIS Feb 22, 2012 @ 17:05

Date/Time: 22-Feb-2012 17:05

Source:

Comments

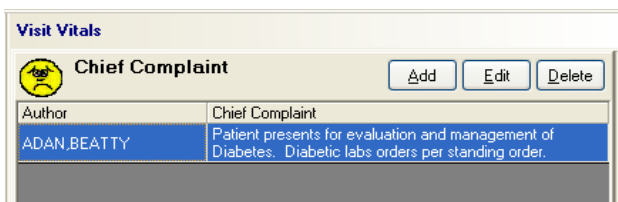
Comments and Source for Sign/Symptom are optional fields

The new data entered in the four cases illustrated above will be stored as visit data and will be displayed on the health summary.

Please use the help function in EHR for more detailed information on documenting adverse reactions.

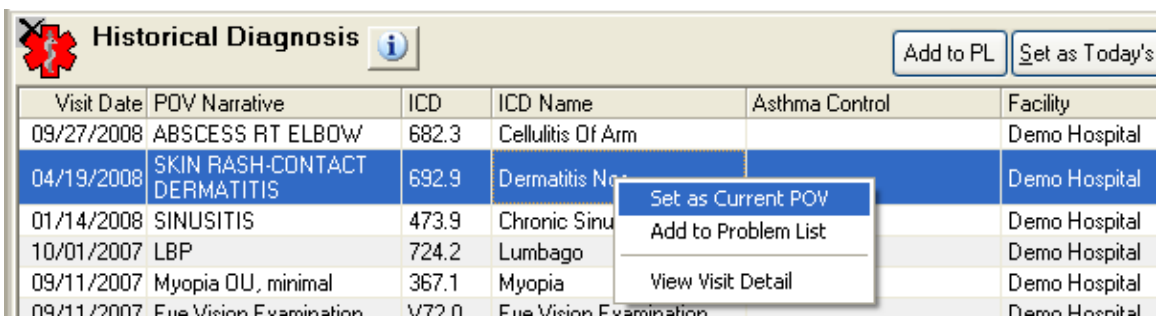
### Document the Chief Complaint

You may refer to the standing orders here as part of your justification for implementing standing orders for lab, radiology, consults, or referrals. The Chief Complaint frame is shown in the figure. See Section 4.7 above to see how to enter a chief complaint.

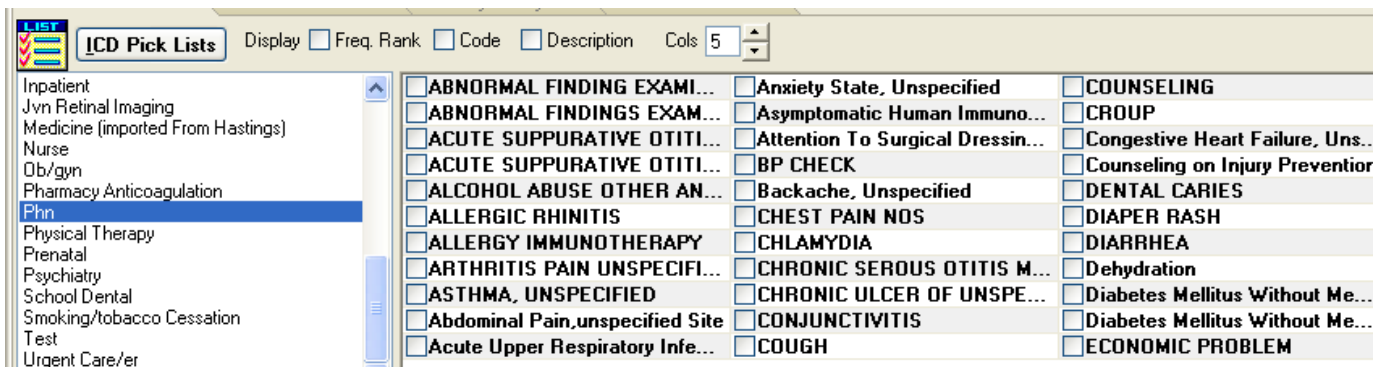


### Document the Purpose of Visit

There's more than one way to set up the purpose of visit (POV). The public health nurse can select an existing problem or a historical diagnosis and use that to establish the POV. See figure.



The nurse can also select and enter from a pick list, which is shown below.



She or he can also search for a sign, symptom, or diagnosis from the Visit Diagnosis frame, show below.

Provider Narrative	ICD	ICD Name	Priority	Asthma Control	Cause	Injury Date
--------------------	-----	----------	----------	----------------	-------	-------------

For more details about how to set up the POV, see Section 4.10 above.

### ***Document the Activity Time***

See Section 4.4 above.

**Activity Time** RICHARDS,SUSAN

Encounter Time  (minutes)

Travel Time  (minutes)

Total 60 minutes

### ***Enter the Lab Order***

Document the indication for the study using (a) the clinical indication field for lab orders, (b) the history section for radiology, (c) the reason for requests for consults, or (d) the visit diagnosis based on local policy.

The indication represents part of the specified circumstances for the standing order policy initiation. It is usually (a) a problem list item, (b) a purpose of visit entered by a provider previously, or (c) a sign or symptom identified in the chief complaint or nursing assessment.

To release nonmedication standing orders by policy, select the Policy radio button in the signature tool dialog box. This allows these orders to be processed by the receiving service, such as laboratory.

**Review/Sign Changes for Adakai, Justin Michael**

Signature will be applied to checked items

**Orders -**

- GLUCOSE BLOOD SP Indication: Type 2 diabetes \*UNSIGNED\*

For orders, select from:

Signed on Chart   
 Release to Service   
 Verbal   
 Telephone   
 Policy

OK    Cancel

The order will show that the order was entered by the nurse on behalf of the provider as a policy order.

***Point-of-Care Laboratory Testing Standing Order Documentation***

Point-of-care laboratory screening tests (waived tests) are implemented per medical standing order. The nurse entering the point-of-care lab on behalf of the provider needs to set the Nature of Order field in the Lab Point-of-Care Data Entry Form to “Policy,” as in the figure below.

**Lab Point of Care Data Entry Form**

Patient: \_\_\_\_\_ Hospital Location: ANDERSON - DM

Ordering Provider: RICHARDS, SUSAN Nature of Order/Change: POLICY

Test: PREGNANCY TEST Sample Type: URINE, RANDOM

Collection Date and Time: 12/12/2011 11:56 AM Sign or Symptom: amenorrhea

Comment/Lab Description: \_\_\_\_\_ Add Canned Comment

TEST RESULTS				
	Test Name	Result	Result Range	Units
▶	PREGNANCY TEST	NEGATIVE	N/A	

Save    Cancel

Other fields in the entry form should be handled thusly:

*Ordering Provider*

If this field is prepopulated, the provider's name will be displayed in the visit frame of the patient chart. If it is blank, the nurse must enter the ordering medical provider who will receive the notification and will authenticate the order.

#### *Test*

Select the point-of-care test you are entering the results for. Common point-of-care lab tests performed by public health nurses are glucose (HgbA1C), cholesterol, and urine nCG.

#### *Collection Date and Time*

The default setting is the current date and time. If you are entering a late documentation, change this field to the actual date and time of the lab.

#### *Sign or Symptom*

Choose from the drop-down menu (which contains a list of problems and purposes of visit) or search for a sign or symptom.

#### *Comment*

This field is optional.

At the end of the form, enter the test result, move to next field, and then click Save.

***You cannot edit your point-of-care lab entry once it has been saved. Carefully review the information before clicking Save. If you entered something in error, contact your laboratory supervisor.***

### ***Authentication of an Implemented Order***

Orders for services and delegated functions must be authenticated by the ordering medical provider. Authentication is performed by a physician, nurse practitioner, midwife, or physician assistant.

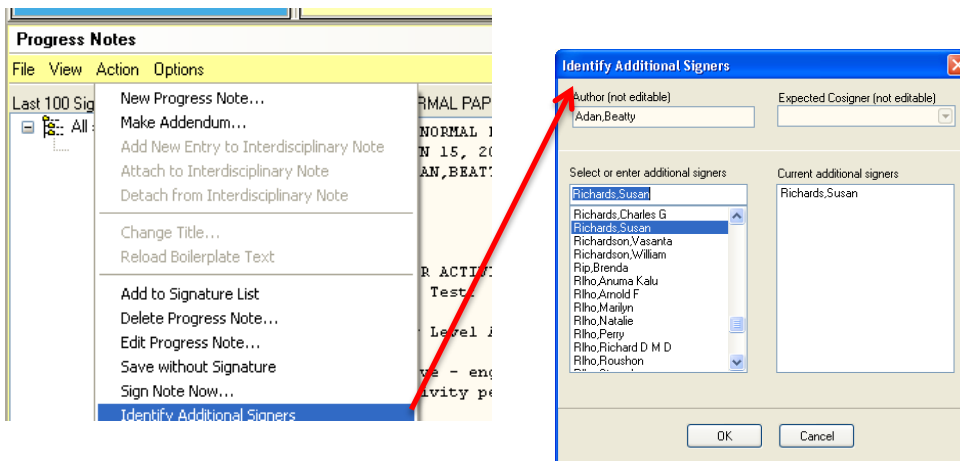
When orders are not signed by the provider—as when orders are released by policy—the nurse must enter medical documentation (for example, a progress note) of the orders initiated, the indication for the orders, and any assessment required. For standing orders, this documentation is done after the fact.

It is important to meet Centers for Medicare and Medicaid Services (CMS) conditions of participation by ensuring the provider assigned is readily available during the hours of the PHN activity. Some sites have a primary provider assigned to the

PHN department and have an established policy that this provider will review and enter all outside referrals into the EHR. Other sites have given that authority to the director of PHN and have a provider assigned each day to co-sign referrals and notes for the entire PHN department.

Your program will need to have a conversation with the clinical director to establish a local authentication process for PHN services. How sites choose to authenticate may vary, but it is recommended that nurses use the following process to ensure the necessary documentation.

The public health nurse completes a note that documents the care provided, including the delegated functions and initiation standing orders. He or she then requests an additional signature by the ordering provider.



The nurse includes the orders initiated and the justification in the PHN note. Your clinical applications coordinator can automate this by using TIU objects in the PHN note template used to create the PHN note or PHN consult note. The TIU objects automatically populate the note text with the policy orders entered for the visit. Authentication can be accomplished by the nurse's requesting an additional signature by the ordering provider.

**Example of an Encounter**

TITLE: PHN OFFICE  
 DATE OF NOTE: JUL 23, 2012@16:16      ENTRY DATE: JUL 23, 2012@16:16:51  
 AUTHOR: ADAN, BEATTY      EXP COSIGNER:  
 URGENCY:      STATUS: COMPLETED

PHN IMMUNIZATION ENCOUNTER

-----  
 07/23/12 16:11 00-00-11

30 minutes      0 minutes

DEMO,PATIENT BOSSY, DOB OCT 23,1969 presents to PHN Office for immunization update.



-----  
S: Chief Complaint: Requests annual flu shot. Denies complaints or concerns.

Flu Screen:

The following questions will help us determine if there is any reason we would not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the person to be vaccinated sick today? No
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? No
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? No
4. Has the person to be vaccinated ever had Guillain-Barr'e syndrome? No

-----  
O: Alert and Active: Yes

Did patient receive current and complete VIS Yes

BLOOD PRESSURE: 120/58 (Jul 23, 2012@16:12)  
HEIGHT: 65.00 (165.10 cm) (Jul 23, 2012@16:12)  
PULSE: 72 (Jul 23, 2012@16:12)  
RESPIRATIONS: 16 (Jul 23, 2012@16:12)  
TEMPERATURE: 98.7 (37.056 C) (Jul 23, 2012@16:12)  
WEIGHT: 146.00 (66.28 kg) (Jul 23, 2012@16:12)

Tobacco Screen :

Last TOBACCO (SMOKELESS - CHEWING/DIP) HF: NEVER USED SMOKELESS TOBACCO - Jul 23, 2012  
Last TOBACCO (EXPOSURE) HF: SMOKE FREE HOME - Jul 23, 2012  
Last TOBACCO (SMOKING) HF: CEREMONIAL USE ONLY - Jul 23, 2012

-----  
A: Consent Obtained: Informed Consent - pt 18y/o or more  
Educational activities :  
FLU-LITERATURE; FLU-PREVENTION; GBS-ANATOMY & PHYSIOLOGY; IM-SCHEDULE;

-----  
P: Immunizations given today :  
INFLUENZA [TIV], SEASONAL, INJ

Received Acetaminophen Adult strength 325mg/tablet to be administered per dosing instructions provided.  
"After the Shots" brochure provided to parent/guardian.  
<http://www.immunize.org/catg.d/p4015.pdf>

Received Incentives of Not Applicable

Follow in 1 year for annual FLU shot for next immunization update.

-----  
PRIMARY - LEVEL OF INTERVENTION

/es/ BEATTY ADAN  
BEATTY ADAN, PHN  
Signed: 07/23/2012 16:22

Receipt Acknowledged By:  
\* AWAITING SIGNATURE \* RICHARDS, SUSAN

## 5.4 Medication Standing Orders

Most medication standing orders—two examples are directly observed therapy and prophylaxis for identified close contacts for a particular communicable disease—should be placed ahead of time by the medical provider. These are orders for medications that often require an assessment before administration.

The public health nurse may also receive an EHR consult on an individual patient. For example, a medical provider asks a public health nurse to change a patient's medication or dose due to a medical error or lab result.

***Administering medications in clinic fall under “incident to” rules for Medicare billing. See section 50 of Chapter 15 of the Medicare Benefit Policy Manual at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>.***

The public health nurse must verify that he or she has a current policy or protocol to follow, such as a policy on delivery and administration of sexually-transmitted-disease prophylaxis to partners.

***The public health nurse places the order for the medication in the EHR and chooses “hold until signed.” Once the medication order is signed by the provider, the public health nurse then follows the rest of the policy to deliver and administer the medication.***

The nurse must document the required assessment and the administration of the medication, using approved format—SOAP (subjective-objective-assessment-plan) or SOAPIE (SOAP plus intervention and evaluation)—based on local policy. See Sections 1.1 and 4.12 above for discussions about SOAP and SOAPIE.

### ***Sample Note***

The following note is authenticated using the Identify Additional Signer function.

PUBLIC HEALTH NURSING STI CONTACT ENCOUNTER  
DATE OF VISIT: 07/23/12 16:11 DEMO,PATIENT BOSSY,OCT 23,1969,00-00-11  
AT/TT:30 minutes/0 minutes  
LOCATION OF ENCOUNTER: HOME

REFERRAL RECEIVED: 20-Jul-2012FROM:PR PRIMARY PROVIDER  
R/T: POSITIVE CHLAMYDIA

Not At Home attempts X 0

-----  
Priority I - PHN Level of Care  
-----

SUBJECTIVE  
-----

Chief Complaint: Requests annual flu shot. Denies complaints or concerns.

PAIN:0 = Denies pain  
EXPLANATION OF PAIN: N/A  
ALLERGIES: CIPRO, AMITRIPTYLINE, PENBUTOLOL, IBUPROFEN, NAPROXEN  
CONTACT SHEET COMPLETED BY PATIENT: Yes

Depression Screen : Date: Jul 23, 2012 Results: NORMAL/NEGATIVE  
Alcohol Screen : Date: Jul 23, 2012 Results: NORMAL/NEGATIVE LAST ETOH USE:  
USED PREVIOUSLY BUT QUIT  
Intimate Partner Screen : Date: Jul 23, 2012 Results: NORMAL/NEGATIVE

Tobacco Screen :  
Last TOBACCO (SMOKELESS - CHEWING/DIP) HF: NEVER USED SMOKELESS TOBACCO -  
Jul 23, 2012  
Last TOBACCO (EXPOSURE) HF: SMOKE FREE HOME - Jul 23, 2012  
Last TOBACCO (SMOKING) HF: CEREMONIAL USE ONLY - Jul 23, 2012

-----  
OBJECTIVE  
-----

42 yo FEMALE. COOPERATIVE WITH CARES:Yes  
PERSONAL HYGIENE: Kempt-clean grooming/clothing noted  
FAMILY PRESENT DURING HOME VISIT: Yes

Independent

HEALTH ASSESSMENT

BLOOD PRESSURE: 120/58 (Jul 23, 2012@16:12)  
HEIGHT: 65.00 (165.10 cm) (Jul 23, 2012@16:12)  
PULSE: 72 (Jul 23, 2012@16:12)  
RESPIRATIONS: 16 (Jul 23, 2012@16:12)  
TEMPERATURE: 98.7 (37.056 C) (Jul 23, 2012@16:12)  
WEIGHT: 146.00 (66.28 kg) (Jul 23, 2012@16:12)

Appetite Good  
Mucous Membranes : moist  
Skin : warm, dry, intact  
Lungs : clear to auscultation bilaterally  
Heart : Regular Rate and Rhythm  
Peripheral pulses : Positive x 4 extremities  
Edema :none noted x 4 extremities

HOME ASSESSMENT

HOME ENVIRONMENT: Safe without risk factors  
RISK FACTORS : None

MODERN CONVENIENCES IN HOME (check all that apply):  
Electricity, Plumbing, Heating, Home Phone, Airconditioning, Stove,  
Refrigerator, Microwave, Cell phone

-----  
ASSESSMENT  
-----

KNOWLEDGE DEFICIT R/T COMMUNICABLE DX PREVENTION  
SHORT TERM GOAL - COMPLIANCE W/ TREATMENT & FOLLOW-UP.  
LONG TERM GOAL - MAINTAIN OPTIMAL LEVEL OF HEALTH

- 1 COMM DX-P: 4 min.; INDIVIDUAL; Understanding-GOOD  
Comment:
- 2 MED - I: 4 min.; INDIVIDUAL; Understanding-GOOD  
Comment:
- 3 COMM DX-FU: 4 min.; INDIVIDUAL; Understanding-GOOD  
Comment:

-----  
INTERVENTION  
-----

MEDICATIONS RECEIVED TODAY:ZITHROMAX 1 GRAM PO  
REFER TO PCC 23-Jul-2012 FOR ORDERS.  
CONDOMS DISPENSED: Yes  
URINE SPECIMEN OBTAINED FOR SCREEN:Yes  
-----

PLAN

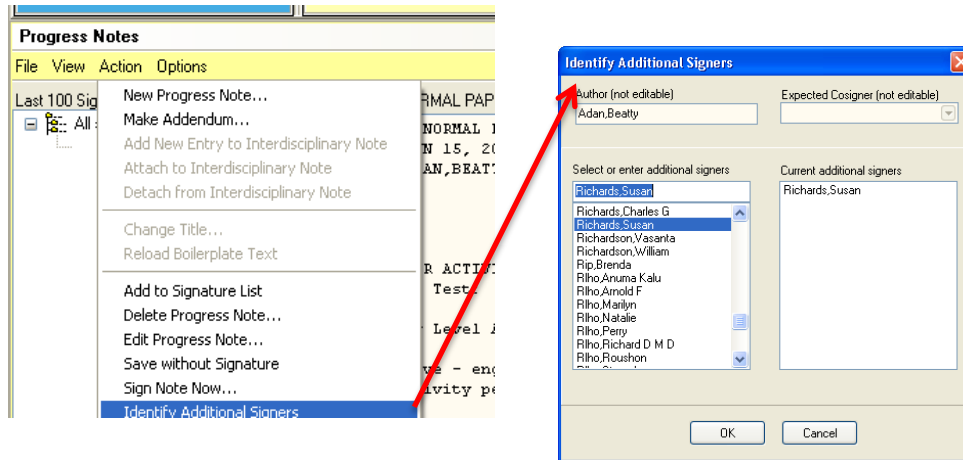
-----  
PHN Home Visit PRN  
-----

PHN Level of intervention: Primary Prevention  
/es/ Jane Smith, RN  
Registered Nurse  
Signed: 04/26/2011 08:52

Receipt Acknowledged By:  
4/26/2011 12:22 /es/ Susan Pierce-Richards, ARNP  
Nurse Practitioner

### ***Authentication of an Implemented Standing Order***

Standing orders must be “authenticated by the practitioner responsible for the care of the patient,” per CMS. This can be a physician, nurse practitioner, midwife, or physician assistant. How sites choose to authenticate may vary, but the recommended process is to ensure the necessary documentation is in the nurse’s note and requests an additional signature by the ordering provider.



CLINICAL REMINDER ACTIVITY

Activity Level Test:

-- Activity Level Assessment --

Very Active - engages in 300 min (5 hrs) or more of physical activity per week

CVD Reminder:

Ordered EKG  
per standing order

Ordered lipid profile  
per standing order

/es/ JAMES H LANGAGER

Signed: 06/15/2011 16:50

Receipt Acknowledged By:

\* AWAITING SIGNATURE \*                      RICHARDS,SUSAN

## 5.5 Immunization Standing Order

Initiation should be documented in the Immunization Record in EHR (Section 4.9 above) and in a note (Section 4.12). CMS considers immunization standing order initiation the same as a medication standing order, with the exception of influenza and Pneumovax, which do not require a medical provider authentication. (This only applies to adults. If your state doesn't have a law or position summary supporting this, nurses may be violating their state practice act.) Other non-patient-specific orders for immunizations and communicable disease outbreaks—pertussis outbreak, tuberculosis, sexually transmitted infections, hepatitis, measles, hanta virus, etc.—must be covered by medical staff-approved policies or procedures.

***If your site has deployed the clinical reminders package, using a reminder dialog box will document a note and enter immunization component data into RPMS and EHR at the same time. Ask your clinical applications coordinator about using reminder dialog boxes.***

Public health nurses must verify they have current standing orders for immunizations. They must also ensure they have the legal scope of practice and the PHN department policy to interpret and initiate standing orders.

***Standing orders need to be reviewed and updated annually. If inspectors find old standing orders or orders lacking signatures, you will be cited.***

Nurses must document the required assessment and the administration of vaccines using approved formats (SOAP, SOAPIE, or reminder dialog tool) based on IHS Area and local policies.

### ***Immunization Documentation Example #1***

The nurse documents the chief complaint and the vital signs of a child who presents with mother for an immunization update, as shown in the Chief Complaint dialog box below.

The nurse documents the vaccine given in the Immunization Record (Section 4.9 above). The nurse records the vaccine, lot, injection site, etc. The V Chief Complaint, V Measurements, and V Immunizations objects to automatically fill in the nurse's note, as shown below.

### Resulting Note

The following note is the result of Immunization Documentation Example #1. The note is authenticated using the Identify Additional Signer function.

S:  
 Chief Complaint: Patient presents with mother for immunization update.  
 Screened and no contraindication for today's immunizations which are given by per standing order.

O: TMP:98.20 (36.7 C), PU:80, RS:16, BP:100/60, WT:88.18 (40.04 kg)

A: Immunization Update

P: The following immunizations were given per standing order.  
 HEP B,ADULT  
 /es/ Jane Smith, RN  
 Registered Nurse  
 Signed: 04/26/2011 08:52

Receipt Acknowledged By:  
 4/26/2011 12:22 /es/ Susan Pierce-Richards, ARNP  
 Nurse Practitioner

### Immunization Documentation Example #2

The nurse documents the chief complaint and the vital signs of a child who presents with mother for an immunization update, as shown in the Chief Complaint dialog box below.

The nurse uses the Reminder Resolution dialog box (shown below) to document vaccine administration in the EHR note and elsewhere.

If your reminder dialog does not contain a full SOAPIE note format, you may either type in your note or use a separate template to document your assessment, then process the clinical reminder dialog immediately after that in the same note.



### ***Resulting Note***

The following note is the result of Immunization Documentation Example #2. The note is authenticated using the Identify Additional Signer function.

S:

Chief Complaint: Patient presents with mother for immunization update.  
Screened and no contraindication for today's immunizations which are given by per standing order.

O: TMP:98.20 (36.7 C), PU:80, RS:16, BP:100/60, WT:88.18 (40.04 kg)

A: Immunization Update

P: \*\*\*\*\* CLINICAL REMINDERS ACTIVITY \*\*\*\*\*

Td/Tdap:  
Tdap Immunization information.  
Patient received Tdap immunization at this visit  
per standing order  
Lot Number: AC2B054BA  
Imm Site: Left deltoid im  
Injection Volume: 0.5  
Vacc Info Sheet Date: November 18, 2008

/es/ Jane Smith, RN  
Registered Nurse  
Signed: 04/26/2011 08:52

Receipt Acknowledged By:  
4/26/2011 12:22 /es/ Susan Pierce-Richards, ARNP  
Nurse Practitioner

### ***Authentication of an Implemented Immunization Standing Order***

Immunization standing orders must be authenticated, with the exception of influenza and Pneumovax. See the Authentication of an Implemented Standing Order subsection above under Section 5.4.

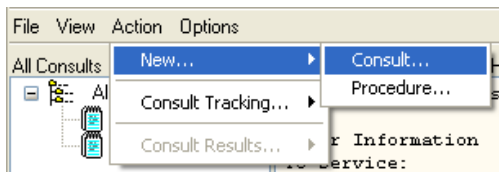
## 5.6 PHN Referrals

Many PHN visits are not initiation of standing orders; rather, they represent both delegated actions and referred care. Examples of PHN referrals are patient education, blood pressure checks, and PHN patient assessments that were requested by the supervising medical provider.

It is important to establish the link between the referring medical provider and the nonphysician provider: in this case, a public health nurse. How health care facilities choose to satisfy the documentation of the link between the public health nurse and the referring physician for “incident to” billing may vary. “See Section 5.4 above about “incident to” rules for Medicare billing.” A straightforward way would be for the nurse performing the service to add the referring provider as an additional signer who would review or sign to acknowledge the receipt and who would review of the progress. Regardless of method chosen, it would be wise to have an established process and policy at the facility.

### ***Recommended Steps for Referred Care***

First, the medical provider refers patients to the PHN department by entering a consult request in EHR using a quick order. Or, the medical provider selects Option: New from the consult drop-down menu, as shown below, and requests services to be provided by the PHN department.



Second, the PHN department electronically receives the consult, and the public health nurse provides the requested services.

Third, the public health nurse documents the encounter with the patient using the appropriate consult note title.

### ***Documentation of Referred Care***

Check with your clinical applications coordinator for the consult note title appropriate to your facility.

You will be asked to associate the consult note with the consult request.

Using a TIU template to document the PHN consult note improves the consistency of nursing documentation. Your clinical applications coordinator can help you create a TIU template if you do not have one already. This template should be developed in

the facility-required format (usually, SOAP or SOAPIE format) and include the following items.

*Referred By*

The template should include the ordering provider's name or medical service (obstetric ward for example), as well as the date when the referral or consult was received.

*Chief Complaint*

An example of a chief complaint would be a PHN home visit for blood pressure check, assessment, and teaching home management for the monitoring of end-stage renal disease per provider consult order. The chief complaint should also include the subjective assessment.

*Other Items*

Nursing diagnosis, outcome identification, planning, and initiation of interventions should be clearly documented in the nurse's note, including what orders were implemented and the evaluation of interventions.

***Authentication of Referred Care***

Authenticate the service provided by adding the referring provider as an additional signer on the PHN consult note after signing. (Refer to the end of Section 5.4 above for the authentication process.) This completes the PHN referral process and authenticates the services provided.

***Exception: Influenza and Pneumovax do not require authentication by the provider for Medicare. However, your facility or state Medicaid agency may require additional documentation. Please check with your PHN department.***

### 5.7 Other PHN Visits

If care is provided in the PHN scope of practice and the nurse is not implementing a standing order or responding to a provider referral, then documentation does not require authentication by a medical provider. It is the discretion of the PHN to include the primary care provider (or other clinician) as an additional signer as a means of communicating updates on ongoing care or relevant changes that need to be brought to the attention of the health care team. This may include communicating abnormal findings, history, screening outcomes, identified risk factors, or significant improvements in the patient's status.

### 5.8 Resources

CMS, Updated Guidance on Medication Administration, Hospital Appendix A of the State Operations Manual. November 18, 2011. Visit <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/CMS1254234.html>.

Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation. May 16, 2012. Final Rule. 77 Fed. Reg. 29033. Visit <https://federalregister.gov/a/2012-11548>.

CMS, "Chapter 15: Covered Medical and Other Health Services," *Medicare Benefit Policy Manual*. Visit <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>; go to Section 50.3, Incident-To Requirements., and Section 80.6, Requirements for Ordering and Following Orders for Diagnostic Tests.

## 6.0 USING THE PUBLIC HEALTH NURSING PCC ENCOUNTER RECORD

Use the following guidelines to complete the Patient Care Component (PCC) form for public health nursing (PHN). Special care must be taken when completing the PCC form, especially with regards to handwriting. Please read Section 1.2, Understanding the Data Collection Process.

### 6.1 Date and Time

Write the date and time in the upper left corner of the form as shown in Figure 6.1.

- Date is a mandatory field. The Resource and Patient Management System (RPMS) will not allow the data entry staff to begin a record without this information.
- If a specific time is not included on this line, the RPMS will set the visit time to 12 noon.
- Including a specific time becomes even more important if two visits to the same patient take place on the same day. RPMS will not accept records for two visits to the same patient at the same time.

Figure 6.1. Date and Time

IHS-802 (1/99)

Date 9/13/04 @ 9:35 **PUBLIC**

Location: \_\_\_\_\_ Remove

AT: \_\_\_\_\_ TT: \_\_\_\_\_

Clinic \_\_\_\_\_

WT	<input type="checkbox"/> GM	HT	<input type="checkbox"/> CM	HEAL
	<input type="checkbox"/> KG		<input type="checkbox"/> IN	
	<input type="checkbox"/> LB-OZ			

### 6.2 Location of Encounter

This is also a mandatory field. Terms such as “home,” “jail,” “school,” “office,” “grocery store parking lot,” or “nursing home” are acceptable.

Figure 6.2. Date, Time, and Location

IHS-802 (1/99)

Date 9/13/04 @ 9:35 **PUBLIC**

Location: home Remove

AT: \_\_\_\_\_ TT: \_\_\_\_\_

Clinic \_\_\_\_\_

WT	<input type="checkbox"/> GM	HT	<input type="checkbox"/> CM	HEAL
	<input type="checkbox"/> KG		<input type="checkbox"/> IN	
	<input type="checkbox"/> LB-OZ			

### 6.3 Activity and Travel Time

“AT” means activity time, which is the length of time it took to perform the service. This is also a mandatory field.

- Activity time includes planning time as well as documentation time.
- Time is documented in minutes, such as 15 or 120. Do not use fractions of minutes, such as 91.5.

Figure 6.3. Date and Time, Location, Activity Time, and Travel Time

IHS-802 (1/99)

Date 9/13/04 @ 9:35 PUBLIC

Location: home Remove

AT: 120 TT: 45

Clinic \_\_\_\_\_

WT	<input type="checkbox"/> GM	HT	<input type="checkbox"/> CM	HEAL
	<input type="checkbox"/> KG		<input type="checkbox"/> IN	
	<input type="checkbox"/> LB-OZ			

“TT” means travel time, which is the total number of minutes it took to travel to and from the location. While it is not mandatory, travel time is useful information in RPMS-generated reports. In the case of several stops at different places, travel time may be entered on one visit or divided by the total number of visits and put on each PCC.

### 6.4 Clinic

Often confused with the location field, the clinic field is a two-digit or digit-and-letter code that signifies what kind of service was provided.

***“Location” is where the service was provided;  
“clinic” is what service was provided.***

#### ***Most Common Clinic Codes for Public Health Nurses***

*11 = Home Care*

This includes all visits that take place at any site that can be defined as where the patient “lays his or her head down at night.” For example, if the contact was made at a dormitory, jail, or even an outdoor location where the patient sleeps at night, then this is his or her “home.” If the patient is not found, then the clinic code is 11. Nurses should consult the data entry staff

Figure 6.4. Date and Time, Location, Activity Time, Travel Time, and Clinic Code

IHS-802 (1/99)

Date 9/13/04 @ 9:35 PUBLIC

Location: home Remove

AT: 120 TT: 45

Clinic 11

WT	<input type="checkbox"/> GM	HT	<input type="checkbox"/> CM	HEAL
	<input type="checkbox"/> KG		<input type="checkbox"/> IN	
	<input type="checkbox"/> LB-OZ			

concerning where “not found” should be indicated on the public health nursing PCC note.

*12 = Immunization*

This clinic code includes immunizations at schools or elsewhere.

*09 = Grouped Services*

This code is not as explicit as others. Better choices include code 45 for health screenings, 53 for immunization letters, or 52 for chart reviews. More about grouped services appears later in this section.

*22 = School*

Except for immunizations, this code includes all public health nursing services performed at a school.

*25 = Other*

Code 25 is to be used only when there is *absolutely* no other code to fit a public health nursing service.

*4 5 =PHN Clinic Visit*

In addition to visits held at a PHN office, this code includes visits to designated, organized programs or screenings, such as health screenings at a chapter house. It also includes patients seen at a “delivery of service” site, like a casino or the parking lot of a grocery store, etc.

*51 = Telephone Call*

*52 = Chart Review or Record Modification*

*53 = Follow-up Letter*

Codes 51, 52, and 53 include reminder letters, follow-up to a failed appointment for an abnormal test result (e.g., follow-up to an abnormal Pap smear or mammogram), or delinquent immunization letters.

*60 = Education Classes*

Prenatal classes, diabetes education classes, etc.

*77 = Case Management Services*

This clinic may be used when public health nurses are case managing a client that has a chronic or long-term prognosis. It’s also used to document collabo-

ration in services, such as care team meetings to discuss the overall care of the client.

*D3 = Homeless*

If the patient is living in a shelter, transitional housing, on the street, or temporarily living with friends or relatives, use code D3.

Nurses should review Table 1.1.1 in Section 1.1 to learn the clinic codes for typical PHN services. To view the complete list of clinic codes, go to the Standard Code Book Tables on the IHS website at <http://www.ihs.gov/CIO/scb/>. Click on the Standard Code Book Tables link and then click on the Clinic link under the Table Name heading.

### 6.5 Provider Codes

In the upper right corner of the PCC form, the public health nurse fills out the provider codes, which consist of an affiliation code, a discipline code, and the nurse's initials or code. The primary provider is the individual responsible for the overall care of the patient. All other providers get credit as secondary providers. Provider codes *do not* take the place of legal signatures. Each nurse is responsible for using the correct provider code.

#### *Affiliation*

The affiliation code designates whether the nurse works for the Indian Health Service, a Tribal program, or another entity.

- Indian Health Service = 1*
- Contract = 2*
- Tribal = 3*
- State = 4*
- Municipal = 5*
- Volunteer = 6*
- National Health Service Corps = 7*
- Non-Indian Health Service = 8*
- Other = 9*

Figure 6.5. Affiliation Code, Discipline Code, and Provider Initials

		AFFIL.	DIS.		INITIALS/CODE	
Active	PROVIDERS	1	1	3	m	wk
	PRIMARY PROVIDER					
RESP		B/P				
		PT. F.	TOPIC	LOU	TIME	



### ***Discipline***

The PHN discipline code is 13. A contracted public health nurse is 32. The code for someone who provides driving or interpreting assistance to a public health nurse is 91.

### **6.6 Measurements**

Under the clinic and provider codes is a row of boxes dedicated to measurements. Any measurement taken must be documented in the appropriate area on the PCC. These measurements include weight, height, head circumference, temperature, pulse, respiration, blood pressure, and oxygen saturation. Legibility is crucial to ensure the accuracy of the data entered into RPMS.

### **6.7 Purpose of Visit**

Nurses must complete the purpose of visit section in the lower half of the Public Health Nurse PCC Encounter Record. The purpose of visit must be specific and reflect the highest understanding of the client's problems or needs. Specificity in the purpose of visit section of the PCC helps produce statistical reports that more accurately portray the variety of services provided (instead of grouping services into one general category) and is vital to consistent funding.

While there must be at least one purpose of visit documented, this section may contain more than one purpose. If there is more than one, list the most important purpose first followed by the others in descending importance. Only the first purpose of visit will appear on the reports generated from the PCC Management Reports—PHN Report application.

Because legibility in this section is critical, printing is required, and abbreviations are prohibited. In the past, illegible abbreviations have caused incorrect data entries, such as “DM” instead of “OM.”

The diagnostic category of care (e.g., diabetes, pregnancy, etc.) documented in this section should follow the International Classification of Diseases, Ninth Revision, (ICD–9) and be described in terms of a medical diagnosis or procedure. E- and V-codes should be used to supplement ICD–9 codes. E-codes address the source and mechanism of injury. V-codes address encounters that may be unrelated to a specific diagnosis for an individual, such as a “contact” for a preventable, communicable disease that the individual does not yet have.

Nursing providers are encouraged to look at an ICD–9 manual to get an understanding of the terminology used. There are several pages of codes related just to pregnancy, for example. The manuals are usually available in the medical records, data

entry, or patient business office. The Centers for Disease Control and Prevention has an entire Web site dedicated to the International Classification of Diseases at <http://www.cdc.gov/nchs/icd.htm>.

Nurses are sometimes reluctant to put a medical diagnosis on the PCC. However, if a medical diagnosis—for instance, diabetes—has already been made by a physician, then the nurse is not making his or her own diagnosis if he or she writes “diabetes foot care” or “diabetes—knowledge deficit related to insulin administration.” In addition, because the purpose of visit represents the highest level of knowledge, it is appropriate for the nurse to document his or her level of knowledge (e.g., “papular, diffuse, rash”) without having to make a diagnosis of specific cause.

Although primary data entry and retrieval is based on medical diagnosis, nursing diagnosis is still very appropriate and is encouraged for use in the purpose of visit section. The nursing diagnosis must include the phrase “related to” followed by the medical diagnosis. If the diagnosis is not definitely established—tuberculosis suspect, unconfirmed pregnancy, or possible strep throat—then the nurse should document symptoms rather than a diagnosis. For example, if unsure of the diagnosis, write “sore throat” instead of “possible strep throat.” The rule is to document the highest level of knowledge. So, if the client has abdominal pain and the cause is unknown, then write “abdominal pain,” not “possible gallbladder disease” or “rule out appendicitis.” The terms “rule out,” “possible,” “probable,” etc., should not be used in the purpose of visit field.

The diagnosis, assessments, and problems documented in this section are printed verbatim in the Outpatient and Field Encounters section of the patient’s Health Summary.

## 6.8 Medications/Interventions

Several rows below the purpose of visit section is the medications/interventions part of the PCC form. Nurses should enter the treatments, procedures, etc., that are considered part of the treatment (as opposed to being part of the assessment). Prescriptions and one-time doses of medications administered at the time of the visit are recorded in this section. The time, dose, route (including site of injection), and the nurse's initials or legal signature are required for medications administered by the nurse.

## 6.9 Patient Education

Nurses must complete the patient education section, labeled "PT. ED," on the far right side of the PCC form under the blood pressure field. Codes take the place of narratives in this section to facilitate data entry.

The Indian Health Service has two extensive publications that are helpful in choosing the correct patient education codes. *Documenting Patient Education, Volume 1* describes the processes for describing patient education. *Patient and Family Education Protocols and Codes, Volume 2* contains the entire list of outcomes and standards for all education topics. Copies of both are available in IHS hospitals and clinics. They are also available at <http://www.ihs.gov/HealthEd/?module=pepc>.

The patient education section of the PCC form is divided into four columns. The first column has preprinted abbreviations of the patient education services most commonly performed by public health nurses. There are a few empty boxes at the bottom of the column to fill in other patient education services. The second column, titled "TOPIC," is really a subtopic of the first column. In Figure 6.9, the letter "N" is marked in the topic column in the "Breastfeed BF" row, signifying "BF-N, Nutrition (Maternal)."

Figure 6.9. Blood Pressure and Patient Education (Topic, Level of Understanding, and Time)

B/P		TOPIC		LOU	TIME
112/0		18/0			
PT. ED	TOPIC	LOU	TIME		
LEARN PREF	LP				
LEARN BAR	BAR				
READY TO LEARN	RL				
BREASTFEED	BF	N	G	6	
CHILD HEALTH	CH				
CANCER	CA				
COMM DIS	CDC				
DIABETES	DM				
HIV	HIV				
HTN	HTN				
FAM PLAN	FP				
IMM	IM				
OBESITY	OBS				
PNEUMONIA	PNM				
MEDICATIONS	M				
POSTPARTUM	PP				
STD/STI	STI				
TUBERCULOSIS	TB				
Employ. Related	TOBACCO	TO			
	WELLNESS	HPDP			
	WOMEN'S HEALTH	WH			
		BF	EQ	G	8

The third column, “LOU,” is where the patient’s level of understanding is recorded. This space must contain one of the following codes: G for good, F for fair, P for poor, R for refuses education, and GP for group education. It is imperative to document refusal of any education in this area.

The fourth column, “TIME,” is notated in minutes (with no fractions) in the same fashion as the activity and travel times at the top left of the PCC form. Each patient education topic used must have an individual time assigned to it.

Nurses are required to initial each topic taught in the right margin (not shown in Figure 6.9). Data entry staff persons will not enter patient education information into the RPMS if it is not initialized. Initializing the topics also informs the data entry staff regarding who exactly provided the patient education.

### **6.10 Immunizations**

The nurse must document any immunizations given on the far right of the PCC form under the patient education section. The most commonly administered vaccines are listed in the “IMMUN” column, but there are a few empty spaces at the bottom of the column to write in vaccines not listed. The nurse needs to indicate the lot number of the vaccine given in the “LOT #” column and leave the number sign (#) column blank. Nurses must include their initials in the right margin of the row of each vaccine administered. Immunizations that are not initialized are not entered into the RPMS.

A vaccine information sheet must also be completed in addition to the PCC form. Site and route of administration should be documented in the narrative.

Many facilities have implemented point-of-service data entry, increasing the accuracy of the immunizations entered in the RPMS. As long as the facility maintains a paper record, it is the nurse’s responsibility to document completely the immunizations given.

## 7.0 COMMON PURPOSE-OF-VISIT CODES USED BY PUBLIC HEALTH NURSES

The following are commonly used ICD–9 (International Classification of Diseases, Ninth Revision) codes. The Indian Health Service is in the process of converting to ICD–10. See <http://www.ihs.gov/icd10>.

### **7.1 Prenatal (First, Second, or Third Trimester)**

V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2*	Pregnant state incidental
V23.0	Supervision of high-risk pregnancy
V23.3*	Pregnancy with grand multiparity
V23.7	Insufficient prenatal care
V23.8	Other high-risk pregnancy
V23.9	Unspecified high-risk pregnancy
V23.41	Supervision of pregnancy with history of preterm labor
V61.50	Counseling multiparity
V61.7	Other unwanted pregnancy

### **7.2 Postpartum**

V24.2	Routine postpartum follow-up
V24.1	Postpartum care and exam of lactating mother

### **7.3 Family Planning**

V25.02	Family planning
V25.09	Contraception management
V25.03	Emergency contraception counseling and prescription

### **7.4 Newborn**

V20.2	Routine infant or child health check
V20.0	Health supervision of foundling—abandoned newborn (unknown parents)

### **7.5 Chronic Illness and Care**

401.91	Unspecified essential hypertension
496	Chronic airway obstruction, not elsewhere classified

250	Diabetes mellitus without complication, type not specified Diabetes mellitus without complication, type II Diabetes mellitus without complication, type I
250.4	Diabetes with renal manifestations
250.10	Diabetes mellitus ketoacidosis
719.4	Pain in joint unspecified
780.9	Other general symptoms
312.23	Socialized conduct disorder
780.39	Seizure disorder
789	Abdominal pain
414.01	Coronary atherosclerosis of native coronary artery
414.9	Chronic ischemic heart disease, unspecified
428.0	Congestive heart failure, unspecified
286.9	Other and unspecified coagulation defects
295.9	Unspecified schizophrenia
295.91	Unspecified type schizophrenia, subchronic state
295.92	Unspecified type schizophrenia, chronic state
295.94	Unspecified type schizophrenia, chronic state with exacerbation
295.95	Unspecified type schizophrenia, in remission
714.0	Rheumatoid arthritis

### **7.6 Immunizations**

V07.9	Need for prophylactic measure
V05.3	Need for inoculation against viral hepatitis
V05.4	Need for inoculation against varicella
V05.8	Need for vaccination and inoculation
V04.81	Need for flu shot
V06.1	Need for inoculation with diphtheria-tetanus-pertussis combined vaccine (DTaP)
V06.5	Need for inoculation against tetanus-diphtheria
V06.4	Need for inoculation against measles-mumps-rubella
V04.89	Need for inoculation against other viral diseases. Use this code for human papillomavirus and meningitis vaccines.
V04.0	Need for inoculation against poliomyelitis
V03.81	Need for inoculation against hemophilus influenza, type B (Hib)
V03.82	Need for inoculation against streptococcus pneumoniae (pneumococcus)

- V03.5 Need for inoculation against diphtheria alone
- V03.6 Need for inoculation against pertussis alone
- V15.81 Personal history of noncompliance with medical treatment, presenting hazards to health
- V15.83 Personal history of underimmunization status

### **7.7 Adolescent**

- V20.2 Routine infant or child health check
- V20.1 Other healthy infant or child receiving care

### **7.8 Women's Health**

- 795 Abnormal papanicolaou smear

### **7.9 Screenings**

- V67.59 Purified protein derivative reading (follow-up exam necessary)—other specified follow-up exam
- V74.1 Screening examination for pulmonary tuberculosis
- V74.5 Screening examination for venereal disease
- V77.1 Screening for diabetes mellitus
- V81.1 Screening for hypertension
- V82.9 Screening for unspecified condition
- V82.89 Special screenings for other specified conditions (foot screening) no loss

### **7.10 Elder Care or Other**

- V15.41 History of physical abuse
- V15.42 History of emotional abuse
- V60.6 Person living in institution
- V60.3 Person living alone
- V60.0 Lack of housing
- V60.1 Inadequate housing
- V60.2 Inadequate material resources
- V60.4 No other household member able to render care
- V60.6 Person living in institution
- V61.3 Problems with aged parents or in-laws

### **7.11 Acute**

- 462 Acute pharyngitis (sore throat)
- 465.9 Acute upper respiratory infections of unspecified site
- 460 Acute nasopharyngitis (common cold)

- 034.0 Streptococcal sore throat
- 790.6 Other abnormal blood chemistry
- 790.22 Impaired glucose tolerance test
- V58.30 Change nonsurgical dressing
- V58.31 Encounter for change or removal of surgical wound dressing

**7.12 Follow-up**

- V67.0 Follow-up examination following surgery
- V46.2 Dependence on supplemental oxygen (long-term oxygen therapy)

**7.13 Diabetes mellitus**

- 250 Diabetes mellitus
- 250.4 Diabetes with renal manifestations
- 583.81 Nephritis and nephropathy not specified as acute or chronic in diseases classified elsewhere
- 250.60 Diabetes mellitus with neurological manifestations type ii or unspecified type not stated as controlled
- 357.2 Polyneuropathy in diabetes
- 250.80 Diabetes mellitus with other specified manifestations type ii or unspecified type not stated as uncontrolled
- 707.15 Ulcer of other part of foot
- 707 Chronic ulcer of skin

**7.14 Communicable Disease**

- V65.45 Counseling on other sexually transmitted diseases
- 079.4 Human papillomavirus
- 079.88 Other specified chlamydial infection
- 079.98 Unspecified chlamydial infection
- V01.6 Contact with or exposure to venereal diseases
- V01.89 Contact with or exposure to other communicable diseases
- V01.9 Contact with or exposure to unspecified communicable disease
- V01.5 Contact with or exposure to rabies
- V01.71 Contact/exposure to varicella
- V74.1 Screening examination for pulmonary tuberculosis
- 096 Late syphilis, latent
- 091.0 Genital syphilis primary
- 091.2 Other primary syphilis
- 092.1 Early syphilis, latent, serological relapse after treatment



- 092.9 Early syphilis, unspecified
- 097.1 Latent syphilis, unspecified
- 098.0 Gonococcal infection (acute) of lower genitourinary tract
- 004.0 Shigella dysenteriae
- 004.1 Shigella flexneri
- 004.3 Shigella sonnei
- 004.8 Other specified shigella infections
- 004.9 Shigellosis, unspecified
- 066.40 West Nile fever, unspecified
- 066.41 West Nile fever with encephalitis
- 066.42 West Nile fever with other neurologic manifestation
- 066.49 West Nile fever with other complications
- 066.1 Tick-borne fever
- 066.3 Other mosquito-borne fever
- 008.43 Intestinal infection due to campylobacter
- 008.00 Intestinal infection due to E. coli unspecified
- 008.08 Intestinal infection due to enterohemorrhagic E. coli

***7.15 History of Hazards to Health***

- V15 Other personal history presenting hazards to health
- V15.41 History of physical abuse
- V15.42 History of emotional abuse
- V15.88 History of fall

***7.16 Problems With Lifestyle***

- 305.1 Tobacco use disorder
- V15.82 History of tobacco use
- 305 Nondependent abuse of drugs
- V69.3 Gambling and betting
- 312.31 Pathological gambling
- V71.2 Observation of suspected tuberculosis
- V71.4 Observation following other accident
- V71.6 Observation following other inflicted injury
- V71.5 Observation following alleged rape or seduction

***7.17 Behavioral/Family Health***

- V61 Other family circumstances

- V15.41 History of physical abuse
- V15.42 History of emotional abuse
- V15.9 History of health hazard, unspecified
- V69.2 High-risk sexual behavior

### ***7.18 Case Management***

**Tip:** If case management services are being provided for a specific condition, the condition of service should be the POV code of choice.

### ***7.19 Administrative and Counseling***

- V61 Other family circumstances
- V68 Encounters for administrative purposes
- V68.8 Encounters for other specified administrative purposes
- V68.81 Referral of patient without examination or treatment
- V68.89 Encounters for other specified administrative purposes
- V65.40 Other specified counseling
- V65.41 Exercise counseling
- V65.43 Counseling on injury prevention
- V65.44 HIV counseling
- V65.45 Counseling on other sexually transmitted diseases
- V65.49 Other specified counseling
- V61.11 Counseling for victim or spousal and partner abuse
- V61.3 Problems with aged parents or in-laws
- V61.49 Other health problems within the family
- V61.8 Other specified family circumstances
- V61.9 Unspecified family circumstances
- V61.41 Alcoholism in family

## 8.0 PRIORITY, INTENSITY, AND TIMELINESS FOR CASELOAD MANAGEMENT

The following priority, intensity, and timeliness criteria (sometimes called PIT) provides guidance for responding to referrals to a public health nursing (PHN) program.

### 8.1 Priority One

#### *Initial Contact*

The patient arrives within 1–5 working days after the receipt of a referral or a case find.

#### *Intensity of Visits*

The patient visits every 1–10 days until client changes to another level of intensity or meets the criteria for discharge.

#### *Active Communicable or Infectious Disease*

The patient needs treatment, case contact investigation and patient education.

#### *Newly Diagnosed Acute or Chronically Ill*

The patient or the family requires PHN assessment or intervention and patient education. Examples: hospital discharge, clinic, and other referral sources.

#### *High-Risk Maternity Patients*

- Multiple gestation
- Single parent or patient without family support
- Late entry or no prenatal care
- Current or history of medical or obstetrical complication
- Current or history of alcohol or substance abuse
- Current or history of previous domestic violence
- Current or history of depression or mental health disorder
- Inappropriate weight gain or loss
- Multipara with five or more pregnancies
- Prenatal under 19 or over 35 years of age

- Multiple gestation without complications

*High-Risk Postpartum Patients*

- Premature or multiple-birth delivery
- Complications of labor, delivery, or puerperium
- Breastfeeding problems or complications
- Delivery resulting in infant death or severe congenital anomalies with need for emotional and psychological support
- Current or history of depression or mental health disorder
- Current or history of medical or obstetrical complication
- Needing additional teaching (parenting, child care, etc.)
- Under 19 or over 35 years of age
- Single parent or patient without family support
- Current or history of alcohol or substance abuse
- Current or history of previous domestic violence
- Anemic (< 9 Hgb)

*High-Risk Neonate, Infant, or Child*

- Neonates with complications of labor, delivery, or congenital anomalies
- Premature infants or low birth weight (equal to or less than 2,500 grams at birth)
- Infants of multiple-birth delivery
- Failure to thrive or lack of other normal physiological and mental development
- Evidence of poor maternal-infant bonding
- Infants born to mothers with a history of alcohol or substance abuse
- Patients in families with history of domestic violence
- Infant child of teen parent(s) in need of PHN intervention
- Patients whose parents have cognitive or learning disabilities

*Noncompliance With Medical Treatment*

- Potentially life-threatening or adverse consequences

*Neglected or Abused Individuals*

*Injury Prevention*

The nurse needs to assess the patient's home or community environment and administer patient education about poisoning, falls, suffocation, drowning, burns, etc.

*Acute Illness or Crisis of an Individual Living in a Vulnerable Family*

- Multiple-problem, crisis-prone family
- Socioeconomically stressed family with inadequate resources
- Dysfunctional families in need of referral, teaching, monitoring, or case management
- Single-parent families without a support system

*Terminally Ill Clients at End Stage*

PHN services and coordination of care with other agencies is needed.

## **8.2 Priority Two**

### ***Initial Contact***

The patient arrives within 1–2 weeks after the receipt of a referral or a case find.

### ***Intensity of Visits***

The patient visits every 3–8 weeks until the patient changes to another level of care or meets the criteria for discharge.

*Active Communicable Disease Under Treatment*

The patient receives education on how to arrest or prevent transmission to others in the household or the community.

*Newly Diagnosed Chronic or Terminal Disease*

The patient is without adequate family support and needs PHN intervention or education.

*Prenatal, Postpartum, or Newborn Without Complication*

The patient needs PHN intervention and patient education

*Noncompliance With Medical Treatment—Nonemergency*

The patient needs PHN intervention and patient education regarding hazards to the patient's health.

*Nonemergency Psychosocial Situations*

The patient needs PHN support to cope, seek appropriate intervention, and identify resources for unresolved grief, a dysfunctional family situation, etc.

*Infants, Children, and Adults With Special Needs*

The patient needs PHN intervention or patient education to access resources for mental or physical developmental deficits.

*Delinquent Immunization Status*

The nurse must monitor and track patients defined in the PHN caseload.

*Patients With a History of Recurrent Episodes of Illness or Hospitalization*

PHN intervention and patient education is needed.

*Safety Hazards*

PHN assistance is needed to identify safety hazards and resources for correction.

*Health Promotion/Disease Prevention*

- Individual, family, and community education
- Patients with knowledge deficits needing teaching regarding disease, treatment, medication, and understanding principles needed to carry out treatment

### **8.3 Priority Three**

***Initial Visit***

The patient arrives 1–2 weeks after the receipt of a referral or a case find.

***Intensity of Visits***

The patient visits every 3–12 months until the patient changes to another level of intensity or meets the criteria for discharge.

*Chronic or Debilitating Illness, Infection, or Communicable Disease Under Treatment With Family Support*

The patient needs occasional PHN monitoring, intervention, assessment, evaluation or education.

*Individuals, Families, or Groups With Health Promotion or Disease Prevention Issues not Addressed in Priority One or Two*

This priority includes screening for seniors, diabetes, schools, child find, etc.

*Individuals or Families Who Have Reached the Highest Level of Function*

The patient needs PHN intervention to prevent regression.

## 9.0 LEVELS OF INTERVENTION

Public health nursing best practice is to document the level of intervention at every encounter. There are three levels of intervention.

### 9.1 Primary Prevention: Prevention of Disease

Primary prevention includes actions to protect against disease and disability, such as getting immunizations, ensuring the supply of safe drinking water, applying dental sealants to prevent tooth decay and guarding against accidents.

### 9.2 Secondary Prevention: Prevention of Complications With Existing Disease

Secondary prevention includes actions to prevent, or minimize complications of, existing disease and to limit further disability.

### 9.3 Tertiary Prevention: Improving the Quality of Life

Tertiary prevention includes interventions that improve the quality of life for people with various diseases by (a) limiting complications and disabilities, (b) reducing the severity and progression of disease, and (c) providing rehabilitation interventions to restore functionality and self-sufficiency.