## Document Revision History

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Implemented By</th>
<th>Approved By</th>
<th>Approval Date</th>
<th>Description of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/20/2013</td>
<td>Pam Aguilar</td>
<td>Cathy Stueckemann</td>
<td>4/20/2013</td>
<td>Initial release</td>
</tr>
<tr>
<td>12/05/14</td>
<td>Pam Aguilar</td>
<td>Ron Galloway</td>
<td>12/05/14</td>
<td>General:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Updated report information based on 40-hour week and removed other responses that are no longer available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sections:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Sections 1.0, 2.1.8, 3.1, 3.1.1.1, 3.1.2.1, 3.1.6, 5.1.1, 5.1.2, and 5.1.6: Various minor revisions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Section 2.1.7: Clarified input format.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Section 3.1.1.1:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Step 1: Added Data Entry Note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Step 2: Edited text.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Section 3.3 Step 4: Added Data Entry Note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Section 4.1.1: Deleted note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Section 5.1.2, Step 2: Edited text.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Appendix A:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Edited last bullet text.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Added a bullet.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Figures:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Figures 3-8, 3-27, 4-15, 4-16, 4-26, 4-29, 4-39, 4-42, and 4-44: Various minor revisions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Figure 4-37: Replaced content.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Figure 4-49: Added Staff Training to CHR Service Code list.</td>
</tr>
</tbody>
</table>
# Table of Contents

## 1.0 Introduction
- 1.1 Main Menu ................................................................. 1
- 1.2 Data Entry Menu .......................................................... 2
- 1.3 Reports Menu ............................................................... 2
- 1.4 Manager Utilities .......................................................... 2
- 1.5 CHR Patient Wellness Handout ...................................... 2

## 2.0 Orientation
- 2.1 Standard Conventions (Roll and Scroll) ......................... 3
  - 2.1.1 Caps Lock ............................................................... 3
  - 2.1.2 Default Entries ....................................................... 3
  - 2.1.3 To Obtain Help ....................................................... 3
  - 2.1.4 To Back Out .......................................................... 3
  - 2.1.5 To Exit ................................................................... 3
  - 2.1.6 To Repeat the Previous Entry .................................... 4
  - 2.1.7 To Look up a Name ................................................ 4
  - 2.1.8 To Enter Dates and Times ........................................ 4
  - 2.1.9 To Delete ............................................................... 5
- 2.2 ListMan (Roll and Scroll) ............................................... 5
- 2.3 ScreenMan (Roll and Scroll) .......................................... 6
  - 2.3.1 Using the ScreenMan Window .................................. 6
  - 2.3.2 Using the Pop-Up Window ........................................ 7
- 2.4 Full Screen Text Editor ................................................ 8

## 3.0 The Data Entry Menu
- 3.1 DE – Enter/Update CHR PCC Using IHS-535 (Comprehensive) 10
  - 3.1.1 AD – Add Record ..................................................... 12
  - 3.1.2 ED – Edit Record ..................................................... 20
  - 3.1.3 DS – Display Record ............................................... 24
  - 3.1.4 DE – Delete Record ................................................ 25
  - 3.1.5 BV – Browse Patient’s Visits ..................................... 26
  - 3.1.6 HS – Health Summary ............................................ 27
  - 3.1.7 NS – Next Screen .................................................... 27
  - 3.1.8 PS – Previous Screen ............................................. 27
  - 3.1.9 CP – Change Provider ............................................. 27
  - 3.1.10 CD – Change Date ............................................... 27
  - 3.1.11 CF – Change Form ............................................... 27
  - 3.1.12 PL – Print List ...................................................... 28
  - 3.1.13 Q – Quit .............................................................. 28
  - 3.1.14 Help .................................................................... 28
- 3.2 ADE – Enter/Update CHR PCC Using IHS-535-1 (Abbreviated) 28
  - 3.2.1 AD – Add Record ................................................... 29
  - 3.2.2 ED – Edit Record ................................................... 29
3.2.3 DS – Display Record ................................................................. 29
3.2.4 DE – Delete Record ................................................................. 29
3.2.5 BV – Browse Patient’s Visits .................................................... 30
3.2.6 HS – Health Summary .............................................................. 30
3.2.7 NS – Next Screen ................................................................. 30
3.2.8 PS – Previous Screen .............................................................. 30
3.2.9 CP – Change Provider ............................................................ 30
3.2.10 CD – Change Date ................................................................. 30
3.2.11 CF – Change Form ................................................................. 30
3.2.12 PL – Print List ................................................................. 30
3.2.13 Q – Quit ........................................................................ 30
3.2.14 Help ........................................................................ 30

3.3 GP – Enter Data Using IHS-962 Group Encounter Form .......... 30
3.4 PRT – Print CHR Forms (Hard Copy) ......................................... 35
3.5 GDEF – Group Data Entry Using Group Definition ................. 35
3.5.1 Duplicate a Group ............................................................... 36
3.5.2 Add a New Group ............................................................... 39
3.5.3 Display Group Entry .......................................................... 42
3.5.4 Print Encounter Forms ....................................................... 43

3.6 RDSP – Display CHR Record .................................................. 43
3.7 LV – Display Patient’s Last CHR Visit ....................................... 44

3.8 LIST – List CHR Records, Standard Output .......................... 44
3.9 PGP – Print or Reprint Forms for a Group ............................ 44
3.10 NONR – Review and Update Non-Registered Patient Demographics ... 44
3.11 OPV – List One Patient’s CHR Visits ........................................ 45

4.0 The Reports Menu .................................................................................. 47
4.1 Workload/Activity Reports ......................................................... 47
4.1.1 GEN List CHR Records, GENERAL RETRIEVAL Output .... 48
4.1.2 List CHR Records, STANDARD Output ................................. 53
4.1.3 ACT1 Activity Tally by Program, Setting and CHR .............. 56
4.1.4 ACT2 Activity Tally by Program, CHR, Setting, and Problem ... 58
4.1.5 ACT3 Activity Record Counts ............................................ 59
4.1.6 FACT Frequency of Activities ........................................... 61
4.1.7 FPRB Frequency of Problems (CHR) .................................. 64
4.1.8 FCAT Frequency of Problems by Problem Category ........... 66
4.1.9 TBT – Tally of Records and Patients by Tribe ..................... 69

4.2 CHRS – CHR Reports ................................................................. 70
4.2.1 C1 CHR #1 – Time, Serv Acts, Services by HEALTH PROBLEM .... 70
4.2.2 C2 CHR #2 – Time, Contacts, and Activities by Service .......... 72
4.2.3 C3 CHR #3 – Time, Contacts, Activities by Setting ............... 74
4.2.4 C4 CHR #4 – Number of Referrals from/to ......................... 76
4.2.5 C5 CHR #5 – Client Contacts by Health Area, Age, Sex ......... 78
4.2.6 C6 CHR #6 – Provider Data ............................................... 81
4.2.7 C8 CHR #8 – Hours (Service + Travel) by Month ................ 82
4.2.8 C9 CHR #9 – Data Summary by Provider .......................... 84
4.2.9 CH CHR #13 – Highlights .............................................................. 86
4.3 Unduplicated Patient Count Reports .............................................. 88
  4.3.1 U1- Unduplicated Patient Counts by CHR ................................. 88
  4.3.2 U2 – Unduplicated Patient Count by Age ................................. 90
  4.3.3 U3 – Unduplicated Patient Counts by Gender .......................... 92
  4.3.4 U4 – Unduplicated Patient Count by Tribe ............................... 93
  4.3.5 U5 – Unduplicated Patient Count by Program ........................... 95
4.4 Non-Registered Patient List .............................................................. 96
4.5 Print CHR Standard Tables ............................................................. 97

5.0 Manager Utilities .............................................................................. 99
  5.1 Export Utility Menu ......................................................................... 99
    5.1.1 GEN – Generate CHR Transactions for HQ ............................. 100
    5.1.2 DISP – Display a Log Entry .................................................... 101
    5.1.3 RGEN Re-Generate Transactions .............................................. 102
    5.1.4 RSET Re-set Data Export Log ............................................... 103
    5.1.5 CHK Check Records Before Export ....................................... 103
    5.1.6 ERRS Print Error List for Export .......................................... 103
  5.2 Merge Two Non-Registered Duplicate Patients ............................... 103
  5.3 Non-Registered Patient List ............................................................ 103
  5.4 SITE Update Site Parameters ......................................................... 104

Appendix A: Helpful Tips ...................................................................... 105
Appendix B: ScreenMan Help – Crib Sheet ........................................... 107
  B.1 Command Line Options ............................................................ 107
  B.2 Other Shortcut Keys ................................................................. 107
  B.3 Cursor Movement ...................................................................... 107
  B.4 Modes ....................................................................................... 107
  B.5 Deletions .................................................................................. 108
  B.6 Macro Movement ...................................................................... 108

Appendix C: Full Screen Editor – Crib Sheet .......................................... 109
  C.1 Navigation ............................................................................... 109
  C.2 Exiting/Saving ......................................................................... 109
  C.3 Deleting .................................................................................. 109
  C.4 Settings/Modes ....................................................................... 110
  C.5 Formatting .............................................................................. 110
  C.6 Finding .................................................................................. 110
  C.7 Cutting/Copying/Pasting ......................................................... 110

Appendix D: Rules of Behavior ............................................................... 112
  D.1 All RPMS Users .................................................................. 112
  D.2 RPMS Developers ................................................................. 118
  D.3 Privileged Users ................................................................ 118

Glossary ............................................................................................... 121
Acronym List ....................................................................................... 124
Contact Information .................................................................................................. 125
1.0 **Introduction**

This manual provides user instructions for the Indian Health Service (IHS) Resource and Patient Management System (RPMS) Community Health Representative (CHR) Patient Care Component (PCC) Reporting System Version 2.0. The RPMS CHR PCC is used by CHRs to collect data about their services and activities. The CHR PCC permits CHRs to inform other health-care team members about health-related services and activities taking place in the patient's home or in the community.

This system provides a data entry option so that data can be entered directly into the RPMS Service Unit database from forms filled out by a CHR. Once data is entered, an extensive reports module is available. Extracting these service and activity records and exporting them to the national data warehouse CHR reporting system is also vital to the CHR Program.

1.1 **Main Menu**

Entering the main CHR Menu displays the screen in Figure 1-1.

![Figure 1-1: RPMS CHR/PCC Reporting System](image)

To access the CHR module, at the “Do you wish to continue?” prompt, type **Yes** and press Enter.

It is vitally important to keep patient information confidential.

The main menu for the CHR/PCC is shown in Figure 1-2. One or more of these menu options will be available depending on your level of security access.
1.2 Data Entry Menu

Use this set of options to enter data into the CHR/PCC. There are two ways to enter data into the CHR/PCC:

- Manually record data on the CHR/PCC forms and then enter the data into the computer.
- Enter data directly into the computer without completing a paper form.

Section 3.0 provides detailed instructions on how to enter data into the system with either method.

1.3 Reports Menu

The Reports Menu provides a means of generating a wide variety of reports from the data available in the system. These reports are designed to assist in managing programs, providing quality patient care, and to making available general retrieval capability. All of these report options are described in Section 4.0.

1.4 Manager Utilities

This menu provides the manager of the CHR/PCC system several utilities that allow updating the system site parameters, exporting data to the national CHR data system and merging duplicate non-registered patients. These options are described in Section 5.0.

1.5 CHR Patient Wellness Handout

This option allows the CHR to print a Patient Wellness Handout (PWH) that can be given to the Patient. For instructions on the use of the PWH, see the PCC Health Summary User Manual located on the IHS website at: http://www.ihs.gov/RPMS/PackageDocs/BJPC/bjee0200.09u_apch.pdf
2.0 Orientation
The following provides general information about using CHR for entering data.

2.1 Standard Conventions (Roll and Scroll)

2.1.1 Caps Lock
Always work with the Caps Lock on.

2.1.2 Default Entries

<table>
<thead>
<tr>
<th>Note:</th>
<th>A prompt or menu prompt is a question posed by the software in order to solicit information from the user. A prompt is usually a word or question followed by a colon (:) or double slashes (///). It is represented in this manual as text enclosed in quotation marks (“text”).</th>
</tr>
</thead>
</table>

When a possible answer is followed by two forward slashes (///) as in Figure 2-1, press Enter to accept this default response. To provide a different response, type it after the two slashes and press Enter.

Do you want to display the health summary? N//

Figure 2-1: Default entry prompt showing the default answer of “N” No.

In the example of Figure 2-1, pressing Enter accepts the default response of N (No); no Health Summary will be displayed.

2.1.3 To Obtain Help
Online help can be obtained at any data entry field by typing one, two, or three question marks (? , ?? , ?? ? ). If available, a narrative description of the expected entry or a list of choices will appear.

2.1.4 To Back Out
Press Shift-6 to type a caret (^). This symbol terminates the current action, and returns to the preceding menu or screen prompt.

2.1.5 To Exit
Type H (HALT) at any menu prompt to exit from RPMS.
2.1.5.1 Exit and Save
Press F1, E to save and exit the screen.

2.1.5.2 Exit and Quit
Press F1, Q to quit and exit a screen without saving.

2.1.6 To Repeat the Previous Entry
For certain types of data fields, primarily those that use lists of possible entries (such as program names, facilities, communities, patients, etc.), press the spacebar, and the Enter key to repeat the last entry you used at the prompt.

2.1.7 To Look up a Name
Be cautious of misspellings. To ensure the spelling of a name or entry, use only the first few letters of the last name. RPMS displays all choices that match those beginning letters as shown in Figure 2-2. When there are many patients with the same last name, scroll down to see all or press Enter to display more names.

<table>
<thead>
<tr>
<th>PATIENT NAME: PATIENT</th>
<th>NAME</th>
<th>SEX</th>
<th>BIRTHDATE</th>
<th>ID</th>
<th>PROVIDER NAME</th>
<th>SERVICE CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1          PATIENT,DEMO1</td>
<td>M 05-05-1989 00000542 PIMC 101623</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SE 101624</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2          PATIENT,DEMO2</td>
<td>F 06-16-1954 00000012 PIMC 100039</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HID 100040</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SE 100041</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2-2: Patient lookup screen

When entering the full name, enter the last name, a comma (,), and the first name; do not type a space after the comma (example: PATIENT,DEMO).

2.1.8 To Enter Dates and Times
Dates and times may be entered in a number of formats. If the system prompts for a date alone, the acceptable formats are:

- T (today)
- 3/28
- 0328
- 3-28
- 3.28
- T-1 (yesterday)
- T-30 (a month ago)
2.1.9  To Delete

Type the “at” sign (@) in a field to delete the existing data.

2.2  ListMan (Roll and Scroll)

The CHR Reporting program uses a screen display called ListMan for review and entry of data. The system displays data in a window-type screen. Menu options for editing, displaying, or reviewing the data are displayed in the bottom portion of the window.

Note: The mouse pointer does not work to select a menu item when using RPMS.

By typing two question marks (??) at the “Select Action” prompt, additional menu options are available for displaying, printing, or reviewing data. Entering the symbol or letter mnemonic for an action at the “Select Action” prompt will result in the indicated action. A mnemonic is typically characters located to the left of the descriptive text of the options on a menu. These allow for quick selection of the options by decreasing the number of keystrokes need to identify them.

In Figure 2-3, two question marks (??) were typed at the “Select Action:” prompt to see the list of secondary options available.

Figure 2-3: ListMan secondary options dialog
Secondary options at the original data entry screen are:

1. Type a plus sign (+) in the display that fills more than one page to see the next full screen (unless on the last screen).

2. Type a minus sign (-) to display the previous screen.

3. Press the up arrow key to move the screen display back one line at a time.

4. Press the down arrow key to move the screen display forward one line at a time.

5. Press the right arrow key to move the screen display to the right.

6. Press the left arrow key to move the screen display to the left.

7. Type PL to print an entire single or multi-screen display (called a list).

8. Type QU to close the screen and return to the menu.

2.3 ScreenMan (Roll and Scroll)

2.3.1 Using the ScreenMan Window

When using ScreenMan to enter data, press Enter to accept default data values or after entering a data value into a field. Use the tab or arrow keys to move between fields or to bypass data fields into which no value will be entered. The system automatically fills in much of the demographic information when you enter the patient, program, and course of action fields during the preliminary data entry process. If defaults have been set, the system displays automatic entries such as in Figure 2-4, where the prompt reads “Enter/Update Assessments/Measurements/Tests? YES” (YES is the default) and “# Served: 1” (1 is the default):
After making a change or new entry on the form, press Enter to record the change. A confirmation dialog might appear for further action. As an example, in Figure 2-4, when at the "Enter/Update Assessments/Measurements/Tests?" prompt press Enter to open the dialog and record the secondary information.

Appendix A: contains a list of ScreenMan commands.

2.3.2 Using the Pop-Up Window

The tab or arrow keys can be used for moving between fields or for skipping data fields. Press Enter to move between fields, when inputting data. After all the required data has been entered and while the cursor is above the solid line, press F1, E to exit and save but do not press Enter. Note if Enter is pressed after F1, E, a required field is skipped. If the cursor is below the solid line you will be asked to enter the letter C for CLOSE to return to the original data entry screen as shown in Figure 2-5:

```
**** Enter/Edit Assessments/Purpose of Visits ****
----------------------
*********** MEASUREMENTS/TESTS ***********
BP         P     R     BG     T       HT      WT       BMI       WC
A1C        HC    VU         VC          LMP              FPM
<< to enter/edit the provider narrative press enter at SVC MINS >>
HEALTH PROB:       SVC CODE:       SVC MINS:
HEALTH PROB:       SVC CODE:       SVC MINS:
HEALTH PROB:       SVC CODE:       SVC MINS:
HEALTH PROB:       SVC CODE:       SVC MINS:
HEALTH PROB:       SVC CODE:       SVC MINS:
HEALTH PROB:       SVC CODE:       SVC MINS:
At least ONE Assessment is Required!
```
2.4 Full Screen Text Editor

While many of the data entry items in the CHR Reporting System are coded entries or items selected from a table, there can be text entry associated with subjective, objective, and plan documentation. RPMS has two text editors: a line editor and a full screen editor. Most users find it more convenient to use the Full Screen Text Editor.

In many ways, the Full Screen Text Editor works just like a traditional word processor. The lines wrap automatically; the up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used. On the other hand, some of the conventions of a traditional word processing program do not apply to the RPMS full screen editor. For example, the Delete key does not work. Delete text by moving one space to the right of the error and backspacing to remove the erroneous entry.

A lengthy narrative may be created in a traditional word processing application like Microsoft Word or Word Perfect and the text pasted into the open RPMS window. If the words do not wrap like a traditional word processing application then speak to your IT staff for assistance in switching from a line editor to a text editor or go to Helpful Tips at the end of this manual.

Table 2-1 lists the most commonly used RPMS text editor commands:

Table 2-1: RPMS text Editor Commands

<table>
<thead>
<tr>
<th>What is Needed</th>
<th>Use These Keys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delete a line (extra blank or text)</td>
<td>PF1(F1) followed by D</td>
</tr>
<tr>
<td>Join two lines (broken or too short)</td>
<td>PF1(F1) followed by J</td>
</tr>
<tr>
<td>Save without exiting</td>
<td>PF1(F1) followed by S</td>
</tr>
<tr>
<td>Exit and save</td>
<td>PF1(F1) followed by E</td>
</tr>
<tr>
<td>Quit without saving</td>
<td>PF1(F1) followed by Q</td>
</tr>
<tr>
<td>Top of text</td>
<td>PF1(F1) followed by T</td>
</tr>
</tbody>
</table>

Figure 2-6 is a sample of the Text Edit screen:

```
==[ WRAP ]==[ INSERT ]==< Subjective >==[ <PF1>H=Help ]==
This is a demonstration of how to type and use the full screen editor. When all relevant information has been entered, press F1, E to save and exit. Do not press Enter.
<===T=====T=====T=====T=====T=====T=====T=====T=====T========T
Bottom of text PF1(F1) followed by B
```
1. Press **F1, H** to display all of the available commands for the RPMS Full Screen Editor (Figure 2-7).

   - Type a caret (^) to exit the Help screens.
   - For convenience the help text list is included in Appendix C: of this manual.

```
* * ENTER CHR RECORD DATA * *              DATE OF SERVICE: MAR 4, 2012
CHR: PROVIDER, DEMO1           PROGRAM: TOHONO O'ODHAM
--------------------------------------------------------------------
Enter/Update Assessments/Measurements/Tests? YES

Referred To CHR By:
Referred By CHR To:

ACTIVITY LOCATION:
TRAVEL TIME:
# SERVED: 1

SUBJECTIVE:          OBJECTIVE:        PLANS/TREATMENTS:
TEMP RESIDENCE:
___________________________________________________________________________

COMMAND:                                       Press <PF1>H for help
```

2. If the cursor is not at the “COMMAND” prompt, press **F1, E**, do not press Enter. If the cursor is at the “COMMAND” prompt, type **E** and **S** to save and exit the data entry screen. These commands will save the data and exit the data entry screen.
3.0 The Data Entry Menu

The options on the Data Entry menu allow patient data to be viewed, entered, and modified, and CHR forms to be printed. Access the Data Entry menu from the main CHR menu by typing DE and then pressing Enter. The menu in Figure 3-1 displays:

```
*******************************************
**     RPMS CHR/PCC REPORTING SYSTEM     **
**             Data Entry Menu           **
*******************************************
IHS COMMUNITY HOSPITAL
Version 2.0
DE     Enter/Update CHR PCC Using IHS-535 (Comprehensive)
ADE    Enter/Update CHR PCC Using IHS-535-1 (Abbreviated)
GP     Enter Data Using IHS-962 Group Encounter Form
PRT    Print CHR Forms (Hard Copy)
GDEF   Group Data Entry Using Group Definition
RDSP   Display CHR Record
LV     Display Patient's Last CHR Visit
LIST   List CHR Records, STANDARD Output
PGP    Print/Reprint Forms for a Group
NONR   Review/Update Non-Registered Patient Demographics
OPV    List One Patient's CHR Visits
```

Select Option:

Figure 3-1: CHR PCC Data Entry Menu

Instructions for using each of the Data Entry menu options follow.

3.1 DE – Enter/Update CHR PCC Using IHS-535 (Comprehensive)

Use this option to enter data from the IHS-535 (Comprehensive) form. It includes the ability to document unlimited free text in the Subjective, Objective, and Plan (SOP) fields. To avoid entering the SOP fields, follow the instructions in Section 3.2, which describe abbreviated, prompting only for required fields and does not prompt for SOP data.

The following steps are an example of entering data using the DE - Enter/Update CHR PCC Using IHS-535 (Comprehensive) option. This section describes only the process of entering data; it does not provide detailed information regarding the responses that should be entered into each field. See the CHR PCC User Manual Supplement.
1. At the “Select Option” prompt, type **DE** and press Enter. The following sequence displays:

```
CHR Data Entry Module
************************
* Update CHR Records *
************************
Enter Provider (CHR):
```

2. At the “Enter Provider (CHR)” prompt, type the appropriate CHR provider code or the provider’s name and press Enter; see Section 2.1.7 for name formatting information and search options.

3. At the “Enter CHR PROGRAM” prompt, type the name or code of the CHR program and press Enter. This information is located in the top-middle portion of the CHR/PCC form.

4. At the “Enter DATE OF SERVICE” prompt, type the date of service shown at the top right corner of the paper form; press Enter.

The date can be entered in several ways as described in Section 2.1.8.

**Note:** Until you change the CHR Program and Date of Service, the system will continue to create records for the CHR Program and Date of Service entered.

The UPDATE CHR PCC FORMS screen (Figure 3-2) displays:

```
UPDATE CHR PCC FORMS          Mar 04, 2012 15:29:13       Page:    1 of   1
---------------------------------------------------------------------------
Date of Encounter:  MAR 04, 2012      Program:  TOHONO O'ODHAM
Provider (CHR): PROVIDER,DEMO3
---------------------------------------------------------------------------
No records currently on file for PROVIDER,DEMO3 on MAR 04, 2012
Enter ?? for more actions
AD   Add Record           BV   Browse Pt's Visits   CF   Change Form
ED   Edit Record          NS   Next Screen          PL   Print List
DS   Display Record       PS   Previous Screen      Q    Quit
DE   Delete Record        CP   Change Provider
HS   Health Summary       CD   Change Date
Select Action: AD//
```

Figure 3-2: Update CHR PCC Forms

This screen displays a list of options that can be accessed from this point. Each of the 13 options is described in one of the following sections.
3.1.1 AD – Add Record

To add a new record:

1. At the “Select Action” prompt, type **AD** and press Enter. The following sequence displays.

   Select one of the following:
   
   P    Individual Patient Encounter Record
   N    All Other Activities
   Q    QUIT, GO BACK

Which Type of Record: P//

2. At the “Which Type of Record” prompt, type one of the following and press Enter:

   - **P**. An Individual Patient Encounter Record documents a service provided to one patient only.
   - **N**. This record is not an individual patient related encounter (such as administrative, leave, training, or a group).
   - **Q**. Quit this process and redisplay the UPDATE CHR PCC FORMS screen (Figure 3-2).

   If Individual Patient Encounter Record was selected, the system will ask for the patient’s name or chart number (Figure 3-3).

   ***** PATIENT INFORMATION *****

   If this encounter involved a particular patient, please enter the patient's chart # or name now. If this is not a single patient encounter, but a group encounter or an Non-Patient encounter, simply HIT the ENTER key to exit back and Enter N for All Other Activities.

   Please enter the patient information now.

   Enter PATIENT NAME or CHART #:

   Enter PATIENT NAME or CHART #: 101846 PATIENT, DEMO3 M 02-03-40
   071730717 SE 101846
   OK? YES//

   Figure 3-3: Entering a patient's name

3. At the “Enter PATIENT NAME or CHART #” prompt, type the patient’s name (see Section 2.1.7 for name formatting information and search options) or chart number. This prompt will also accept the patient’s social security number or date of birth.
To capture demographic information about a Non-Registered Patient (one who cannot be found in the Patient Registration database), type **NO** at the next lookup prompt.

4. Select a patient from the Non-Registered Patient Database or enter a new Non-Registered Patient.

   **Note:** Demographic data for patients who are already registered can be edited only within the Patient Registration system.

   Select CHR NON REGISTERED PATIENTS PATIENT NAME: PATIENT,DEMO1//
   Are you adding ' PATIENT,DEMO1' as
   a new CHR NON REGISTERED PATIENTS (the 4TH)? No// Y  (Yes)
   CHR NON REGISTERED PATIENTS DOB: 020340  (Feb 3, 1940)
   CHR NON REGISTERED PATIENTS GENDER: F  FEMALE
   CHR NON REGISTERED PATIENTS TRIBE: TOHONO O'ODHAM NATION
   CHR NON REGISTERED PATIENTS COMMUNITY OF RESIDENCE: TUCSON

   **Figure 3-4: Adding a non-registered patient**

5. Enter following information for each Non-Registered patient entered into the database:
   - Date of Birth (DOB)
   - Gender
   - Tribe
   - Community of Residence.

   **Note:** Non-Indian Beneficiary or Non-Indian Member of an Indian Household are acceptable entries for Patient’s Tribe.

6. Review and if necessary edit the data.

   Please review and update if necessary this non-registered patient’s data:
   PATIENT NAME: PATIENT,DEMO1//
   DOB: Feb 3, 1940//
   GENDER: FEMALE//
   SSN: 
   TRIBE: TOHONO O'ODHAM NATION,AZ

   **Figure 3-5: Patient information review**

7. If the data is correct, press Enter at each prompt. If a correction is needed, type the corrected information and press Enter. The screen that appears next will differ depending on the entry:
   - Individual Patient Encounter (Section 3.1.1.1)
• Non-Patient Activity (Section 3.1.1.2)

3.1.1.1 Patient Encounter Entry Screen

* * ENTER CHR RECORD DATA * *              DATE OF SERVICE: MAR 4, 2012
CHR: PROVIDER, DEMO1              PROGRAM: TOHONO O’ODHAM
--------------------------------------------------------------------
Enter/Update Assessments/Measurements/Tests? YES

Referred To CHR By:
Referred By CHR To:

ACTIVITY LOCATION:
TRAVEL TIME:
# SERVED: 1

SUBJECTIVE:          OBJECTIVE:        PLANS/TREATMENTS:
TEMP RESIDENCE:

COMMAND:                                       Press <PF1>H for help

Figure 3-6: Patient Encounter Entry Screen

1. Press Enter at the “Enter/Update Assessments/Measurements/Tests?” prompt to enter at least one assessment:
   • Assessment data is required.
   • Enter the data items as they appear on the completed CHR/PCC form.

The Enter/Edit Assessments/Purposes of Visits screen (Figure 3-7) displays.

**** Enter/Edit Assessments/Purpose of Visits ****

********** MEASUREMENTS/TESTS **********

BP         P     R     BG     T       HT      WT       BMI       WC
A1C        HC    VU         VC          LMP              FPM

<< to enter/edit the provider narrative press enter at SVC MINS >>

HEALTH PROB:                     SVC CODE:                     SVC MINS:
HEALTH PROB:                     SVC CODE:                     SVC MINS:
HEALTH PROB:                     SVC CODE:                     SVC MINS:
HEALTH PROB:                     SVC CODE:                     SVC MINS:
HEALTH PROB:                     SVC CODE:                     SVC MINS:
HEALTH PROB:                     SVC CODE:                     SVC MINS:
HEALTH PROB:                     SVC CODE:                     SVC MINS:

At least ONE Assessment is Required!

Figure 3-7: Enter/Edit Assessments/Purposes of Visits screen
Data Entry Note:  When entering data into the assessment section the enter key should be used to move from one field to another to ensure all required fields are entered. Pressing the tab key will bypass the narrative.

This screen is used to capture all Measurements/Tests and all activity information found in the middle of the CHR/PCC form. Multiple health problems can be entered for each record.

2. For the measurements/tests, fill in all available values at the corresponding prompts. To get to a prompt use the Tab key or the Enter key. If there are no measurement or test values to enter, press the down arrow twice to reach the Health Problem prompt.

- **BP: Blood Pressure.** Enter the Blood Pressure value. Enter as SYSTOLIC/DIASTOLIC (example: 120/80):
  - SYSTOLIC must be between 20 and 275.
  - DIASTOLIC must be between 20 and 200.
- **P: Pulse.** Enter the Pulse value, if taken. Enter an even whole number between 30 and 250.
- **R: Respiration.** Enter the Respiration value, if taken. Enter the respiration rate of the patient. Must be in range 8 to 90.
- **BG: Blood Glucose.** Enter the Blood Glucose value, if taken. Type a Number between 0 and 2500, 0 Decimal Digits
- **T: Temperature.** Enter the Temperature value, if taken. Enter as degrees Fahrenheit. Must be between 94 and 109.9 degrees.
- **HT: Height.** Enter the Height value, if measured.
  - To enter height in INCHES, use one of the following formats:
    - Whole inches (example: 64)
    - Inches and fractions (example: 64 3/4)
    - Inches and decimal (example: 64.75)
    Height inches must be between 10 and 80.
  - To enter height in CENTIMETERS, enter the value, followed by the letter “C” (example: 100C).
    Height in centimeters must be between 26 and 203.
- **WT: Weight.** Enter the Weight value, if measured.
  - To enter weight in pounds and ounces use one of the following formats:
    - Pounds Ounces (example: 132 12)
• Pounds Fraction (example: 132 3/4)
• Pounds Decimal (example: 132.75).

Weight must be between 2 and 750 pounds; any fractional or decimal part must be a multiple of 1/16 (.0625).

− To enter weight in Metric values, use one of the following formats:
  • Kilograms (example: 100K):
    − Value must be between 1 and 340.
    − Value is followed by K (no space).
    − Fractions and decimals are allowed.
  • Grams (example: 1200G):
    − Value must be between 1000 and 340000.
    − Value is followed by G (no space).
    − Fractions and decimals are allowed.

Fractions must be entered as in 4000 1/2 or 4 2/3

• BMI: Body Mass Index. Enter the BMI value, if calculated. Type a Number between 9 and 80, two decimal digits.

  Note: RPMS will not accept a BMI value unless the height and weight are also entered.

• WC: Waist Circumference. Enter the Waist Circumference value, if measured. Type a Number between 20 and 99, using up to two decimal digits

• A1c: Hemoglobin A1c. Enter the Hemoglobin A1c value, if measured, using up to two decimal digits.

• HC: Head Circumference. Enter the Head Circumference value, if measured.
  − To enter head circumference in INCHES, use one of the following formats:
    • Whole inches (example: 21)
    • Inches and fractions (example: 21 3/4)
    • Inches and decimal (example: 21.75)

  Head circumference in inches must be between 10 and 30.

  − To enter head circumference in CENTIMETERS, enter the value, followed by the letter “C” (example: 30.2C).

  Head circumference in centimeters must be between 26 and 76.

• VU: Vision Uncorrected. Enter the Vision Uncorrected value, if measured. Answer must be 1-9 characters in length. Enter denominators only. The 20/ is
assumed. Enter right eye / left eye using format number/number (20/20). If right
eye only enter number (20). If left eye only enter /number (/20). Must be between
10 and 999.

- **VC: Vision Corrected.** Enter the Vision Corrected value, if measured. Answer
must be 1-9 characters in length. Enter denominators only. The 20/ is assumed.
Enter right eye / left eye using format number/number (20/20). If right eye only
enter number (20). If left eye only enter /number (/20). Must be between 10 and
999.

  **LMP: Last Menstrual Period.** Enter the Last Menstrual Period date, if obtained.
Enter the date of the Patient's LMP. The date can be entered in several ways as
described in Section 2.1.8.

- **FPM: Family Planning Method.** Enter the Family Planning Method, if obtained.
Enter the Patient's Family Planning Method. Choose one from the list:
  - BIRTH CONTROL PILLS
  - CERVICAL CAP
  - CONDOM
  - DEPO-PROVERA HORMONE
  - DIAPHRAGM
  - IUD
  - MORNING AFTER
  - NORPLANT
  - NOT NEEDED
  - NOT USED
  - OVULATION/RHYTHM
  - SPONGE/SPERMICIDE
  - TUBAL LIGATION
  - VASECTOMY

- **Health Problem (HP).** Enter the 2-digit HP code (for example, DM, HY, WC) to
indicate the HP. Note that if you are entering the same problem twice, the second
and subsequent ones must be entered with quotes (“””) around it the second time it
is entered. For example, you enter DM as an HP with a service code of PC, then
you want to enter another DM as an HP with a service code of HE. You must
enter the DM on the next line with quotes around it; for example: “DM.”

- **Service Code (SC).** Enter the 2-digit service code (for example, CM, MP, EC).

- **Service Minutes.** Enter the number of service minutes. After you have entered
this value, the following sequence will display for capturing the provider narrative
associated with this problem.

  **Canned Narrative (Y/N):**
To enter a canned narrative type a Y at the Canned Narrative prompt.

Note: The narratives provided will be different depending on the Health Problem and Service codes used. Some Health Problem and Service Code combinations will not have canned narratives, but a narrative must be typed in because it is a required field.

The text in Figure 3-9 displays.

To select one of the predefined narratives type the number associated with the narrative after the “Which Narrative” prompt. If you wish to choose more than one, type the second, etc. numbers at the subsequent narrative prompts.

To skip using a canned narrative, type N and press Enter. Type the narrative you wish to enter in the NARRATIVE field.

4. **Additional Narrative.** Enter any additional narrative to the canned narrative selected. The additional narrative is not required when using a canned narrative but can be used to supplement the information in the canned narrative.

5. When done, exit this screen by pressing Enter at the HP prompt, then press Enter at the command line that displays Close. Control returns to the main Data Entry screen as shown in Figure 3-10.
The remaining data items on the screen are:

- **Referred to CHR by.** Was this patient referred to the CHR by some other professional? If so, enter the type of professional. Enter a list of referral types separated by commas and no spaces before or after the commas (for example type 1,3 or NR,MD).

- **Referred by CHR to.** Was this patient referred by the CHR to some other professional? If so, enter the type of professional. Enter a list of referral types separated by commas and no spaces before or after the commas (for example, type 1,3 or NR,MD).

  Up to five referrals can be selected for either type of referral (Figure 3-11).

- **Activity Location.** Enter the activity location.
  - If the activity location is IHS Hosp/Clinic, enter the name of the I/T/U facility.
  - If the activity location is a specialty clinic identify the type of specialty clinic (Behavioral Health, Cancer, Child Health, Dialysis, Eye, Heart, Lung, Mammo, Ortho, Other Chronic, Women's Health) and include city and state.

- **Travel Time.** Enter the number of minutes traveled to perform this activity. If none, enter zero (0). This field is required.

- **# Served.** Enter the number of people served during this activity.
• **Temp Residence.** If the patient is living in a temporary residence, enter the location of residence.

The next three prompts “SUBJECTIVE,” “OBJECTIVE” and “PLANS/TREATMENTS” are connected to word processing fields.

• To enter information into these fields, press Enter at each field to open in a word processor. In general, type the data and when done, press F1, E.

• To skip these fields, press F1, E and do not press Enter to save and exit. Another option is to use the TAB key and bypass these fields. (Press TAB three times to bypass all three fields.) At any prompt above the command line press F1, E to save and exit the forms.

### 3.1.1.2 All Other (Non-Patient) Entry Screens

![Figure 3-12: All Other (Non-Patient) Entry screen](image)

When finished, type F1, E (do not press Enter) to save and exit the screen.

If the cursor is at the command line, type E and press Enter. The prompt in Figure 3-13 displays:

![Figure 3-13: Save confirmation](image)

To save the data, type Y (yes); otherwise type N (no) to return to the Data Entry screen to edit the data.

### 3.1.2 ED – Edit Record

Use this option to correct an error or change data in a record. For example, if the travel time was entered as 30 minutes and it was supposed to be 20 minutes, use this option to correct that data. To edit a record:

1. At the “Select Action” prompt, type ED and press Enter.
2. At the “Select CHR ACTIVITY RECORDS:” prompt, type the number of the record to be edited. The entire record displays (Figure 3-14).

Figure 3-14: Example of a patient record

3. Press Enter to display the following sequence.

Select one of the following:

1. Patient Demographic Data
2. All Other Record Data

EDIT Which Data Item:

4. At the “EDIT Which Data Item:” prompt, type the number corresponding to the desired choice and press Enter:

- Option 1, Patient Demographic Data is described in Section 3.1.2.1.
- Option 2, All Other Record Data is described in Section 3.1.2.2.

3.1.2.1 Choice 1 – Edit Patient Demographic Data

This option allows a non-registered patient’s demographic data to be modified.

- If the selected patient is already registered via the RPMS Patient Registration system, the demographic data cannot be edited; however, the opportunity is presented to select another patient, as shown in Figure 3-15.
This is a REGISTERED Patient. You cannot edit any of his demographic data. You may enter a different patient if this was entered in error.

PATIENT: PATIENT,DEMO1//

Figure 3-15: Registered patient data

- If the patient was not already registered, the screen in Figure 3-16 displays.

If this is a registered patient, enter their name or chart number otherwise type an "^" to update a non-registered patient’s data.

PATIENT: ^
PATIENT (NON-REGISTERED): PATIENT,DEMO2//
PATIENT NAME: PATIENT,DEMO2//
DOB: FEB 3,1940//
GENDER: MALE//
SSN:
TRIBE: TOHONO O'ODHAM NATION,AZ (FORMERLY PAPAGO) //
COMMUNITY OF RESIDENCE: SELLS//

Figure 3-16: Non-registered patient data

To edit any piece of information, for example, Community of Residence, press Enter repeatedly until the “Community of Residence” prompt displays. Type the corrected community information following the two slashes (//) and press Enter.

3.1.2.2 Choice 2 – Edit All Other Record Data

This option allows any other piece of information on the record to be modified using the screen in Figure 3-17.

Note: When editing the Assessment portion of patient record, predefined narratives are not an option.

* * EDIT CHR RECORD DATA * *

DATE OF SERVICE: APR 3,2012               PROGRAM: TOHONO O'ODHAM
CHR PROVIDER: PROVIDER,DEMO 1
Edit Assessments/POVs? NO
Activity Location: HOME
IF Hospital/Clinic: IHS Hospital/Clinic:
Specialty:
City:
State:
Enter/Update Referred To CHR By? YES
Enter/Update Referred By CHR To? YES

# SERVED: 1               TRAVEL TIME: 20
SUBJECTIVE:               OBJECTIVE:           PLANS/TREATMENTS:
Any tests or measurements to record (Y/N)?   TEMP RESIDENCE:

Figure 3-17: Edit CHR Record Data
1. Use the Enter or Tab keys to navigate around the screen and edit any data item.

2. To edit an already existing data item, simply type the new value at the corresponding prompt.

3. To edit the subjective, objective, or plans/treatments data, press Enter at the prompt.

4. To delete a value from a field, type the at sign (@) at the field prompt.

Do not delete required field values.

5. To change the assessments or purpose of visit, type Y at the “Edit Assessments/POVs?” prompt to display the screen in Figure 3-18, where the data can be modified.

```
<table>
<thead>
<tr>
<th>Problem Code:</th>
<th>Service:</th>
<th>Mins:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HYPERTENSI</td>
<td>PATIENT CA</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Service:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service:</td>
<td></td>
</tr>
</tbody>
</table>
```

Figure 3-18: Enter/Edit Assessments/Purpose of Visits

6. To edit measurements, tests, and reproductive factors, type Y at the corresponding prompt to display the screen in Figure 3-19 where the data can be modified.

```
********** MEASUREMENTS/TESTS **********
BP: 120/80
PULSE: 60
RESP: 
BLOOD SUGAR Result: 
TEMP: 
HEIGHT: 
WEIGHT: 
BMI: 
WAIST CIRCUMFERENCE: 
HEMAGLOBIN A1C: 
** REPRODUCTIVE FACTORS **
```

Figure 3-19: Editing measurements/tests

7. When done, press F1, E to close this screen.

8. When all of the data has been edited, type F1, E to exit and save the changes.
3.1.3 DS – Display Record

Use this option to display a record. To display a record:

1. At the “Select Action” prompt, type DS and press Enter.

2. At the “Select CHR ACTIVITY RECORDS” prompt, type the record number and press Enter. The following sequence displays.

   Select one of the following:
   C   CHR PCC Form Format
   S   Standard Display

   Select Print Format: C//

3. To select the print format, type the choice at the “Select Print Format” prompt and press Enter. The result of these choices is shown in Figure 3-20 and Figure 3-21.
**DE – Delete Record**

Before deleting a record, check with Health Information Management officials to ensure compliance with facility/program requirements. To delete a record:

1. At the “Select Action” prompt, type **DE** and press Enter.
2. At the “Select CHR ACTIVITY RECORDS” prompt, type the record number and press Enter. The record (Figure 3-22) displays.
Figure 3-22: Example of a patient record

3. Verify that it is the record to delete.

Once a record has been deleted, it is erased from the system forever.

4. Press Enter at the end of the record display. A confirmation message (Figure 3-23) displays:

Are you sure you want to DELETE this record? N//

Figure 3-23: Confirmation to delete record

5. At the “Are you sure you want to DELETE this record?” prompt:
   - Type N and press Enter to stop the deletion.
   - Type Y and press Enter to proceed with the deletion.

A message displays confirming that the record was deleted.

3.1.5 BV – Browse Patient’s Visits

This action is used to browse through one patient’s visits. To browse a patient’s visits:

1. At the “Select Action” prompt, type BV and press Enter.

2. At the “Select PATIENT NAME” prompt, type the patient’s name or Health Record number and press Enter. The following sequence displays:
3. At the “Browse which subset of visits for <patientname>” prompt, type the letter corresponding with the set of visits to browse and press Enter. The resulting visits display in a browser format.

4. When done, type Q and press Enter to close the browser display.

3.1.6 HS – Health Summary

At the “Select Action” prompt, type HS and press Enter to display a PCC health summary for a registered patient.

Refer to the Health Summary User’s Guide for more detailed information.

3.1.7 NS – Next Screen

At the “Select Action” prompt, type NS and press Enter to view the next full screen of data.

3.1.8 PS – Previous Screen

At the “Select Action” prompt, type PS and press Enter to view the previous full screen of data.

3.1.9 CP – Change Provider

At the “Select Action” prompt, type CP and press Enter to change the provider for which the forms are being entered.

3.1.10 CD – Change Date

At the “Select Action” prompt, type CD and press Enter to change the date for which the forms are being entered.

3.1.11 CF – Change Form

At the “Select Action” prompt, type CF and press Enter to change between the IHS-535 Comprehensive Form and the IHS-535 -1 Abbreviated Form. To change to the IHS-962 Group Form, Quit the original data entry screen and return to the main menu.
3.1.12 PL – Print List

At the “Select Action” prompt, type PL and press Enter to print the list in the list box.

3.1.13 Q – Quit

At the “Select Action” prompt, type Q and press Enter to quit entering records for the CHR and date specified.

3.1.14 Help

Type ? or ?? at any prompt to see help screens. Additional commands are available, including:

- FS. First Screen (go to top of list)
- LS. Last Screen (go to bottom of list)
- RD. Redisplay Screen
- PS. Print Screen
- GO. Go to Page (go to the page specified)

3.2 ADE – Enter/Update CHR PCC Using IHS-535-1 (Abbreviated)

Use this option to enter data from the IHS-535-1 (Abbreviated) form. It does not include the ability to enter Subjective, Objective, and Plan narratives. To enter these narratives, follow the instructions in Section 3.1.

The following is an example of entering data using the ADE – Enter/Update CHR PCC Using IHS-535-1 (Abbreviated) option. This section describes only the process of entering data; it does not provide detailed information regarding the responses that should be entered into each field. See the CHR PCC User Manual Supplement.

1. At the “Select Option” prompt, type ADE and press Enter. The following sequence displays:

   CHR Data Entry Module
   *********************************
   * Update CHR Records  *
   *********************************
   Enter Provider (CHR):

2. At the “Enter Provider (CHR)” prompt, type the appropriate CHR provider code or the provider’s name and press Enter; see Section 2.1.7 for name formatting information and search options.
3. At the “Enter CHR PROGRAM” prompt, type the name or code of the CHR program and press Enter. This information is located in the top-middle portion of the CHR/PCC form.

4. At the “Enter DATE OF SERVICE” prompt, type the date of service shown at the top right corner of the paper form; press Enter.

   The date can be entered in several ways as described in Section 2.1.8.

   **Note:** Until you change the CHR Program and Date, the system will continue to create records for the CHR Program and Date entered.

The UPDATE CHR PCC FORMS screen displays:

<table>
<thead>
<tr>
<th>UPDATE CHR PCC FORMS</th>
<th>Mar 04, 2012 15:29:13</th>
<th>Page: 1 of 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Encounter: Mar 04, 2012</td>
<td>Program: TOHONO O'ODHAM</td>
<td></td>
</tr>
<tr>
<td>Provider (CHR): PROVIDER,DEMO3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No records currently on file for PROVIDER,DEMO3 on Mar 04, 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter ?? for more actions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AD Add Record</td>
<td>BV Browse Pt's Visits</td>
<td>CF Change Form</td>
</tr>
<tr>
<td>ED Edit Record</td>
<td>NS Next Screen</td>
<td>PL Print List</td>
</tr>
<tr>
<td>DS Display Record</td>
<td>PS Previous Screen</td>
<td>Q Quit</td>
</tr>
<tr>
<td>DE Delete Record</td>
<td>CP Change Provider</td>
<td></td>
</tr>
<tr>
<td>HS Health Summary</td>
<td>CD Change Date</td>
<td></td>
</tr>
<tr>
<td>Select Action: AD//</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-24: Update CHR PCC Forms

This screen displays a list of options that can be accessed from this point. Each of the 13 options is described in one of the following sections.

### 3.2.1 AD – Add Record
Refer to Section 3.1.1

### 3.2.2 ED – Edit Record
Refer to Section 3.1.2

### 3.2.3 DS – Display Record
Refer to Section 3.1.3

### 3.2.4 DE – Delete Record
Refer to Section 3.1.4
3.2.5 BV – Browse Patient’s Visits
Refer to Section 3.1.5

3.2.6 HS – Health Summary
Refer to Section 3.1.6

3.2.7 NS – Next Screen
Refer to Section 3.1.7

3.2.8 PS – Previous Screen
Refer to Section 3.1.8

3.2.9 CP – Change Provider
Refer to Section 3.1.9

3.2.10 CD – Change Date
Refer to Section 3.1.10

3.2.11 CF – Change Form
Refer to Section 3.1.11

3.2.12 PL – Print List
Refer to Section 3.1.12

3.2.13 Q – Quit
Refer to Section 3.1.13

3.2.14 Help
Refer to Section 3.1.14

3.3 GP – Enter Data Using IHS-962 Group Encounter Form

Once started, a group form must be completed; you cannot save and return to the document. If not completed, the document will only save the patients up to that point, and the service minutes will be recorded inaccurately creating an error that will require a fix.
Use this option to enter data from a group activity that was documented using form IHS-962. Enter the activity data once and then enter a list of patient names. To enter data:

1. At the “Select Option” prompt, type GP and press Enter. The following sequence displays:

   ![IHS/RPMS CHR REPORTING SYSTEM
   ************************************************************
   * GROUP FORM ENTER Mode *
   ************************************************************

   You will be asked to enter the data that will be included on each patient's visit. You will then be asked to enter each patient's name who attended the group session. After that you will be given the opportunity to add measurements and/or edit each patient's visit record.

   The form ID for this group form is G11. Please make a note of this. It will be needed if and when you need to re-print forms.

   **Note:** The system assigns and displays the number for the group session; in this example the number is G11. Make note of this number so as to be able to re-print the forms. The individual information will still be available by date of service in the section where the data was entered (ListMan).

2. Press Enter. The ScreenMan data entry screen (Figure 3-25) displays.

   ![Figure 3-25: ScreenMan data entry screen
   All of the following information entered on this screen will be recorded for each individual in the group. Please enter all data that will be added to each patient's record. When entering service time please enter the total time you spent for the whole group, it will be divided equally amongst the patients in the group. FORM ID: G12

   **DATE OF SERVICE:**
   **CHR PROGRAM:**
   **CHR:**
   **TRAVEL TIME:**
   **ACTIVITY LOCATION:**
   **Assessments - PCC Purpose of Visits:**
   **TOTAL NUMBER OF PATIENTS IN GROUP:**
   **COMMAND:**
   Insert
   Press <PF1>H for help

   Figure 3-25: ScreenMan data entry screen

3. Make the following entries:
a. Type the Date of Service and press Enter
b. Type the CHR Program and press Enter
c. Type the CHR and press Enter
d. Type the Travel Time and press Enter
e. Type the Activity Location and press Enter

4. At the “Assessments - PCC Purpose of Visits” prompt, press Enter to display the Assessment screen (Figure 3-26).

Please enter all assessments associated with this group encounter.
For service minutes please record the total time you spent on each activity. The minutes will be divided equally among all patients in the group.
Please press enter after entering minutes to update the narrative

<table>
<thead>
<tr>
<th>HLTH PROB:</th>
<th>SRV CODE:</th>
<th>SVC MINS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HLTH PROB:</td>
<td>SRV CODE:</td>
<td>SVC MINS:</td>
</tr>
<tr>
<td>HLTH PROB:</td>
<td>SRV CODE:</td>
<td>SVC MINS:</td>
</tr>
<tr>
<td>HLTH PROB:</td>
<td>SRV CODE:</td>
<td>SVC MINS:</td>
</tr>
</tbody>
</table>

Figure 3-26: Assessment screen

Data Entry Note: When entering data into the assessment section the enter key should be used to move from one field to another to ensure all required fields are entered. Using the tab key will allow the user to bypass the narrative.

5. Make the following entries:

a. At the “HLTH PROB” prompt, type the Health Problem Code and press Enter.
b. At the “SRV CODE” prompt, type the Service Code press and press Enter.
c. At the “SVC MINS” prompt, type the Service Minutes and press Enter.

The Entering provider narrative sequence (Figure 3-27) displays.

Canned Narrative (Y/N)

NARRATIVE:

To append additional narrative to the end of the canned narrative, enter it in the line below.

ADDITIONAL NARRATIVE:

Figure 3-27: Entering provider narrative

Canned (Predefined) Narratives are provided with the most common services used in a group setting (such as health education and case/find screen). If a Canned Narrative
is not available, enter a narrative. Another option when using Canned Narratives is to add additional text in the Additional Narrative box.

6. Type Y at the “Canned Narrative” prompt and press Enter. If narratives are available, the Select a narrative screen (Figure 3-28) displays.

```
Note: The narratives provided will be different depending on the Health Problem and Service Codes used. Please choose the narrative(s) you wish to use.

1  PROVIDED HEALTH EDUCATION: DIABETES MELLITUS
2  PREVENTION HEALTH EDUCATION: DIABETES MELLITUS

Which Narrative:
Which Narrative:
Which Narrative:
```

Figure 3-28: Select a narrative

7. Do one of the following:

- To use one of the predefined narratives, at the “Which Narrative” prompt type the number associated with the narrative. To choose more than one, type their numbers in the subsequent narrative prompts. Close the screen when done selecting the canned narratives.

- To not use a canned narrative, type the narrative in the NARRATIVE field.

8. At the “ADDITIONAL NARRATIVE” prompt, enter any additional narrative to be added to the canned narrative selected. The additional narrative is not required.

9. When done, exit this screen by pressing **F1, E** (do not press Enter) to save and exit. The main Data entry screen displays.

```
Note: Allow enough time to enter all the patients in the group before starting.
```

10. At the “TOTAL NUMBER OF PATIENTS IN GROUP” prompt, type the total number of attendees in the group.

11. Exit by pressing **F1, E** (do not press Enter). The Data Summary screen (Figure 3-29) displays.

```
I am going to ask you to enter 2 patient names. I will then create a record in the CHR file for each patient. The record will contain the following information:

FORM ID: G12                         PROGRAM: TOHONO O’ODHAM
CHR PROVIDER: PROVIDER,DEMO          DATE OF SERVICE: APR 04, 2012
ACTIVITY LOCATION: COMMUNITY         TRAVEL TIME: 20
TOTAL NUMBER OF PATIENTS: 2
PROBLEM CODE: DIABETES MELLITUS      GROUP FORM: G12
```

User Manual
Revised: December 2014
12. At the “Do you wish to continue?” prompt, type Y and press Enter.

13. Enter the names of the patients who attended the group; see Section 2.1.7 for name formatting information and search options.

14. At the “Any MEASUREMENT, TEST OR REPRODUCTIVE FACTORS?” prompt, do one of the following:
   - Type Y and press Enter to display the Measurements/Tests/Reproductive Factors screen (Figure 3-31).
   - Type N and press Enter to return to the Patient Information screen.
15. Type the values obtained into the appropriate fields, pressing Enter to advance to the next field.

16. When done, press F1, E to close the screen.

17. At the “Edit” prompt, type N to complete this record and return to the Patient Information screen. Otherwise, type Y to continue editing.

3.4 PRT – Print CHR Forms (Hard Copy)

This option allows CHR/PCC Forms to be printed. If the CHR program maintains hard copy charts, this option can be used for printing a CHR/PCC Form to file in the chart. To print CHR/PCC forms

1. At the “Select Option” prompt, type PRT and press Enter. The following sequence displays:

```
********** ENCOUNTER FORM PRINT **********
This report will produce hard copy computed generated encounter forms.
Please enter the date range for which forms should be printed.
Enter beginning Date:)
```

2. At the “Enter beginning Date” prompt, type the beginning date of the period for which to print forms.

3. At the “Enter ending Date” prompt, type the end date of the period for which to print forms. The following sequence displays:

```
Do you wish to print forms for one particular CHR? Y//
```

4. At the “Do you wish to print forms for one particular CHR?” prompt, do one of the following:

   • Type Y and press Enter to print the forms for one CHR type. At the “Enter CHR Name” prompt, type the CHR's name and press Enter.

   • Type N and press Enter to print all forms for the date range regardless of CHR type.

5. At the “Device” prompt, type the name of the target printer and press Enter.

3.5 GDEF – Group Data Entry Using Group Definition

The Group Form Data Entry Using Group Definition option is useful when the same group activity occurs repeatedly for the same group of patients. GDEF allows the group definition to be used at a future time so that data can be entered into each
participant’s record without re-entering the patient’s name. Assessment can be edited if needed. To use GDEF:

1. At the “Select Option” prompt, type GDEF and press Enter.

2. Pick a beginning date that precedes the last time that the group met.

3. At the “Enter Beginning Date” prompt, type the beginning date for displaying Group definitions.

4. At the “Enter Ending Date” prompt, type the ending date for displaying Group definitions. The Group Entry dialog (Figure 3-32) displays.

```
GROUP ENTRY               Apr 04, 2012 09:51:17          Page:    1 of    1
Group Entry
Date     Group Name           CHR              # SERVED ASSESSMENTS
1)    03/05/12 WEEKLY DM SUPPORT GR PROVIDER,DEMO2    2

Enter ?? for more actions                                    >>>
1    Duplicate Group                    4    Print Encounter Forms
2    Add a New Group                    Q    Quit
3    Display Group Entry

Select Action:+//
```

Figure 3-32: Group Entry screen

In the example there is one group already defined as a Weekly DM Support Group. The following actions may be taken at this screen:

- Duplicate Group (Section 3.5.1).
- Add a New Group (Section 3.5.2).
- Display Group Entry (Section 3.5.3).
- Print Encounter Forms (Section 3.5.4).
- Quit.

### 3.5.1 Duplicate a Group

Use this action to duplicate a group definition that has been entered and used previously. For example, the group definition listed in the previous section is for a group session held on March 5, 2012. To enter data for a group session that also was a weekly DM support group, duplicate the existing group to save data entry time:

1. At the “Select Action” prompt, type 1 and press Enter.

2. At the “Select GROUP ENTRY” prompt, type the number of the group to duplicate and press Enter.

3. At the “Enter Date for the new group entry” prompt, type the date and press Enter.
The system copies the group definition into a new group entry for the new group session being recorded. The New Group Entry screen (Figure 3-33) displays with the data filled in.

All of the following information entered on this screen will be recorded for each individual in the group. Please enter all data that will be added to each patient's record.

When entering service time please enter the total time you spent for the whole group, it will be divided equally amongst the patients in the group.

---------------------------------------------------------------------------
DATE OF SERVICE: APR 4,2012         CHR PROGRAM: TOHONO O'ODHAM
GROUP NAME: WEEKLY DM SUPPORT GROUP
CHR: PROVIDER,DEMO3                  TRAVEL TIME: 20
ACTIVITY LOCATION: COMMUNITY
Assessments - Purpose of Visits (press enter)
TOTAL NUMBER OF PATIENTS IN GROUP: 2

Figure 3-33: New group entry

4. Press Enter repeatedly to step through the data, making any needed changes.

5. When finished press F1, E to close the screen. A summary of the group definition (Figure 3-34) displays.

---------------------------------------------------------------------------
DATE OF SERVICE: APR 04, 2012           CHR PROGRAM: TOHONO O'ODHAM
GROUP NAME: WEEKLY DM SUPPORT GROUP   POSTING DATE: APR 04, 2012
ACTIVITY LOCATION: COMMUNITY          CHR PROVIDER: PROVIDER,DEMO1
TRAVEL TIME: 20                       NUMBER SERVED: 2
WHO ENTERED RECORD: PROVIDER,DEMO     DATE LAST MODIFIED: APR 04, 2012
USER LAST UPDATE: PROVIDER,DEMO      PATIENTS: PATIENT,DEMO1
PATIENTS: PATIENT,DEMO2
Assessments: PROBLEM CODE:           DIABETES MELLITUS
                     SERVICE CODE:       MONITOR PATIENT
                     SERVICE MINUTES: 20
                     NARRATIVE:         WEEKLY DM SUPPORT GROUP
                     PROBLEM CODE:       DIABETES MELLITUS
                     SERVICE CODE:       HEALTH EDUCATION
                     SERVICE MINUTES: 20
                     NARRATIVE:          PROVIDED HEALTH EDUCATION. PREVENTION
                                              HEALTH EDUCATION

Select one of the following:

Y       Yes-group definition is accurate-continue to Patient List
N       No, I wish to edit the group definition
Q       I wish to QUIT and exit

Do you wish to continue on to add patient visits for this group: Y//

Figure 3-34: Summary of the group definition
6. At the “Do you wish to continue on to add patient visits for this group” prompt, do one of the following:

- Type N and press Enter to return to the group definition process where additional edits to the group may be made.
- Type Q and press Enter to end this data collection without saving.
- Type Y and press Enter to save this patient’s data and to begin collecting data for the next patient. The following sequence displays:

You will be prompted to confirm the list of patients who were in the WEEKLY DM SUPPORT GROUP group on APR 04, 2012.

The following patients are currently assigned to this group:
1) PATIENT,DEMO1
2) PATIENT,DEMO2

Select one of the following:

| A | Add a Patient to the Group |
| D | Delete a Patient from the Group |
| F | Finished Entering Patients for this Group |

Which action: //

Figure 3-35: Group Definition completed

3.5.1.1 Add a Patient to the Group

To add a patient to the group:

1. At the “Which Action” prompt, type A and press Enter. The following sequence displays:

***** PATIENT INFORMATION *****

If this encounter involved a particular patient, please enter the patient's chart # or name now. If this is not a single patient encounter, but a group encounter, simply HIT the RETURN key to continue.

Please enter the patient information now.

Enter PATIENT NAME or CHART #:

Figure 3-36: Adding a patient

2. At the “Enter PATIENT NAME or CHART #” prompt, type the patient’s name and press Enter.
### 3.5.1.2 Delete a Patient from the Group

To remove a patient from the group:

1. At the “Which Action” prompt, type **D** and press Enter. The following sequence displays:

   ```
   Which action: // Delete a Patient from the Group
   The following patients are currently assigned to this group:
   1)  PATIENT,DEMO1
   2)  PATIENT,DEMO2
   Which one do you want delete from the group: (1-2):
   ```

2. At the “Which one do you want delete from the group:” prompt, type the number associated with the patient to be removed from the group and press Enter. The following sequence displays showing that the patient was removed:

   ```
   The following patients are currently assigned to this group:
   1)  PATIENT,DEMO2
   ```

### 3.5.1.3 Finish Editing Patients in the Group

To conclude entering patients and to move on, type **F** and press Enter. At this point the system will:

- Create a record for each patient.
- Prompt for measurements or tests.

When the entry is completed, the main entry ListMan screen (Figure 3-37) displays showing the newly entered group.

![Figure 3-37: New group entry](image)

### 3.5.2 Add a New Group

Use this action to create a new group definition:

1. At the “Select Action” prompt, type **2** and press Enter.
2. At the “Enter Date for the new group entry” prompt, type the date and press Enter. The Group Definition screen (Figure 3-38) displays.

All of the following information entered on this screen will be recorded for each individual in the group. Please enter all data that will be added to each patient's record.

When entering service time please enter the total time you spent for the whole group, it will be divided equally amongst the patients in the group.

---------------------------------------------------------------------------
DATE OF SERVICE: APR 4,2012         CHR PROGRAM:
GROUP NAME: GROUP A
CHR: PROVIDER,DEMO1                  TRAVEL TIME:
ACTIVITY LOCATION:
Assessments - Purpose of Visits (press enter)
TOTAL NUMBER OF PATIENTS IN GROUP:
---------------------------------------------------------------------------

Figure 3-38: Group Definition screen

3. Enter all data elements. Press Enter repeatedly to step through the fields, entering needed data:

   a. **Date of Service.** Enter the date the group took place.
   b. **CHR Program.** Enter the Program with which the CHR is affiliated.
   c. **GROUP Name.** Enter the descriptive name for the group.
   d. **CHR.** Enter the CHR’s name
   e. **Travel Time.** Enter the number of minutes traveled to perform this activity. If none, enter 0 (zero). This field is required.
   f. **Activity Location.** Enter the activity location.
   g. **Assessments – Purpose of Visits (press enter).** Press Enter to see the assessments entry screen. Follow the instructions found elsewhere in this manual for entering assessments and narratives.
   h. **Total Number of Patients in Group.** Enter the total number of patients who attended the group session.

4. When finished with entry press F1, E. A summary of the group definition displays (Figure 3-39).
PATIENTS: PATIENT,DEMO1
PATIENTS: PATIENT,DEMO2
Assessments: PROBLEM CODE: DIABETES MELLITUS
         SERVICE CODE: MONITOR PATIENT
         SERVICE MINUTES: 20
         NARRATIVE: WEEKLY DM SUPPORT GROUP
PROBLEM CODE: DIABETES MELLITUS
SERVICE CODE: HEALTH EDUCATION
SERVICE MINUTES: 20
NARRATIVE: PROVIDED HEALTH EDUCATION. PREVENTION
HEALTH EDUCATION

Select one of the following:

Y    Yes—group definition is accurate—continue to Patient List
N    No, I wish to edit the group definition
Q    I wish to QUIT and exit

Do you wish to continue on to add patient visits for this group: Y//

Figure 3-39: Summary of group definition

5. At the “Do you wish to continue on to add patient visits for this group” prompt, do one of the following:

   • Type N and press Enter to return to the group definition process where additional edits to the group may be made.

   • Type Q and press Enter to end this data collection without saving.

   • Type Y and press Enter to save this patient’s data and to begin collecting data for the next patient. The following sequence displays:

You will be prompted to confirm the list of patients who were in the WEEKLY DM SUPPORT GROUP group on APR 04, 2012.

The following patients are currently assigned to this group:
1)  PATIENT,DEMO1
2)  PATIENT,DEMO2

Select one of the following:

A    Add a Patient to the Group
D    Delete a Patient from the Group
F    Finished Entering Patients for this Group

Which action: //

Figure 3-40: Group Definition completed
3.5.2.1 Add a Patient to the Group
Refer to Section 3.5.1.1

3.5.2.2 Delete a Patient from the Group
Refer to Section 3.5.1.2

3.5.2.3 Finish Editing Patients in the Group
Refer to Section 3.5.1.3

3.5.3 Display Group Entry
Use this action to display and review a group definition:

1. At the “Select Action” prompt, type 3 and press Enter.

2. At the “Select GROUP ENTRY:” prompt, type the number associated with the group to display and press Enter. A summary of the group definition (Figure 3-41) displays.

```
DATE OF SERVICE: APR 04, 2012           CHR PROGRAM: TOHONO O'ODHAM
GROUP NAME: WEEKLY DM SUPPORT GROUP   POSTING DATE: APR 04, 2012
ACTIVITY LOCATION: COMMUNITY          CHR PROVIDER: PROVIDER,DEMO4
TRAVEL TIME: 20                       NUMBER SERVED: 1
WHO ENTERED RECORD: PROVIDER,DEMO     DATE LAST MODIFIED: APR 04, 2012
USER LAST UPDATE: PROVIDER,DEMO      PATIENTS: PATIENT,DEMO1
CHR RECORD: APR 04, 2012
Assessments:  PROBLEM CODE:          SERVICE CODE:         SERVICE MINUTES:     NARRATIVE:
               DIABETES MELLITUS            MONITOR PATIENT       20            WEEKLY DM SUPPORT GROUP
PROBLEM CODE:  DIABETES MELLITUS       SERVICE CODE:         SERVICE MINUTES:     NARRATIVE:
SERVICE CODE:  HEALTH EDUCATION       SERVICE MINUTES:       NARRATIVE:
              PROVIDED HEALTH EDUCATION. PREVENTION
HEALTH
```

Figure 3-41: Group definition summary

3. To step through multiple screens, type a plus (+) or minus (-) sign at the “Select Action” prompt and press Enter.

4. To exit, at the “Select Action” prompt type Q and press Enter.
### 3.5.4 Print Encounter Forms

Use this action to print a hard copy of encounter forms for the patients in the group.

1. At the “Select Action” prompt, type 4 and press Enter.
2. At the “Select GROUP ENTRY” prompt, type the group’s number and press Enter. The following sequence displays:

   ![Print encounter forms](image)

   **Figure 3-42: Print encounter forms**

3. At the “Do you wish to PRINT a hard copy encounter form for each patient in the group?” prompt, type **YES** and press Enter.
4. At the “DEVICE” prompt, type the printer name and press Enter.

### 3.6 RDSP – Display CHR Record

Use this option to display a CHR Record in detail. To use RDSP:

1. At the “Select Option” prompt, type RDSP and press Enter.
2. At the “Enter DATE OF SERVICE” prompt, type the date of service and press Enter.
3. At the “Enter CHR (if known)” prompt, type the CHR, if known, and press Enter. A list of records that match the criteria entered (Figure 3-43) displays.

   ![CHR records](image)

   **Figure 3-43: CHR records**

4. At the “Select record” prompt, type the number of the record to display.
5. At the “Select Print Format” prompt, type the number of the format in which to display the record: CHR PCC Form format or standard display and press Enter. These formats are shown in Section 3.1.3.
3.7 LV – Display Patient’s Last CHR Visit

Use this option to view a detailed display of a patient’s last CHR visit. To use LV:

1. At the “Select Option” prompt, type LV and press Enter.

2. Enter the patient’s name.

3. At the “Select Print Format” prompt, type the number of the format in which to display the record: CHR PCC Form format or standard display and press Enter. These formats are shown in Section 3.1.3.

3.8 LIST – List CHR Records, Standard Output

This option produces a list of CHR records that match the criteria that you specify. To use LIST, at the “Select Option” prompt, type LIST and press Enter.

3.9 PGP – Print or Reprint Forms for a Group

**Note:** Use the Group Data Entry Using Group Definition option (Section 3.5) to print or reprint group encounter forms created using that option.

Use this option to print or re-print group encounter forms that were created using the GP – Enter Data Using IHS-962 Group Encounter Form option (Section 3.3). To use PGP:

1. At the “Select Option” prompt, type PGP and press Enter. The following sequence displays:

   You must know the group ID form number or the date of the group visit.
   Please enter the group ID form or the date of the group session.

   Select CHR GROUP FORM TEMP FILE FORM ID: G11

2. At the “Select CHR GROUP FORM TEMP FILE FORM ID” prompt, type the group ID form number or session date and press enter.

3. At the “Device” prompt, enter the printer name.

3.10 NONR – Review and Update Non-Registered Patient Demographics

Use this option to review and update information about any patient in the Non-Registered CHR patient database. To use NONR:

1. At the “Select Option” prompt, type NONR and press Enter. The following sequence displays:
2. At the “Select CHR NON REGISTERED PATIENTS PATIENT NAME” prompt, type the patient’s name and press Enter.

Please review and update if necessary this non-registered patient’s data:
PATIENT NAME: PATIENT,DEMO1/
DOB: Feb 3, 1940/
GENDER: MALE/
SSN:
TRIBE: TOHONO O'ODHAM NATION,AZ (FORMERLY PAPAGO)
COMMUNITY OF RESIDENCE: SELLS/

Figure 3-44: Example of selecting a patient or entering a new non-registered patient

3. Review and update the patient’s demographic information field by field, updating values as necessary and pressing Enter between each.

Note: Non-Indian Beneficiary or Non-Indian Member of an Indian Household are acceptable entries for Patient’s Tribe.

3.11 OPV – List One Patient's CHR Visits

Use this option to create a list of all of one patient’s CHR visits. To use OPV:

1. At the “Select Option” prompt, type OPV and press Enter.

2. At the “Enter Patient Name” prompt, type the patient’s name. If more than one patient is matched to the name, a list is generated.

3. Select the patient and answer the “OK?” prompt. The following sequence displays.

Select one of the following:
L    Patient’s Last Visit
N    Patient’s Last N Visits
D    Visits in a Date Range
A    All of this Patient’s Visits

Browse which subset of visits for PATIENT,DEMO: N/

4. At the “Browse which subset of visits for <patientname>” prompt, type the letter corresponding to the choice and press Enter.

5. At the “Device” prompt, enter the printer name. The report (Figure 3-45) is generated.
<table>
<thead>
<tr>
<th>DATE</th>
<th>CHR</th>
<th>LOCATION</th>
<th>ASSESSMENTS - POVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/04/2012</td>
<td>PROVIDER, DEMO1</td>
<td>COMMUNITY</td>
<td>DM HE 30 PROVIDED HEALTH EDUCATION</td>
</tr>
<tr>
<td>04/04/2012</td>
<td>PROVIDER, DEMO1</td>
<td>COMMUNITY</td>
<td>DM HE 10 PROVIDED HEALTH EDUCATION</td>
</tr>
<tr>
<td>04/04/2012</td>
<td>PROVIDER, DEMO1</td>
<td>COMMUNITY</td>
<td>DM HE 10 PROVIDED HEALTH EDUCATION</td>
</tr>
<tr>
<td>04/03/2012</td>
<td>PROVIDER, DEMO1</td>
<td>HOME</td>
<td>HY PC 20 PROVIDED EMOTIONAL SUPPORT</td>
</tr>
<tr>
<td>04/03/2012</td>
<td>PROVIDER, DEMO1</td>
<td>HOME</td>
<td>DM PC 20 PROVIDED EMOTIONAL SUPPORT</td>
</tr>
<tr>
<td>04/03/2012</td>
<td>PROVIDER, DEMO1</td>
<td>HOME</td>
<td>DM PC 20 DELIVERED MEDS.</td>
</tr>
<tr>
<td>03/05/2012</td>
<td>PROVIDER, DEMO1</td>
<td>COMMUNITY</td>
<td>DM MP 10 WEEKLY DM SUPPORT</td>
</tr>
</tbody>
</table>

Figure 3-45: Example of All Visits
4.0 The Reports Menu

The Reports menu provides many options for producing a wide variety of both predefined and custom reports. These reports are designed to assist with managing CHR programs and providing quality patient care.

To access the Reports menu, type **RPTS** at the main menu prompt and press Enter key. You will then see the following menu screen:

```
*********************************************
**       RPMS CHR/PCC REPORTING SYSTEM    **
**       Reports                        **
*********************************************
DEMO HOSPITAL/CLINIC
Version 2.0
WL     Workload/Activity Reports ...  
CHRS   CHR Reports ...               
UP     Unduplicated Patient Count Reports ... 
NRL    Non-Registered Patient List    
TABL   Print Standard CHR Tables ...  
```

Figure 4-1: Report menu

The report options are divided into the four main groups that are shown above. This section contains detailed instructions on using all the report options and provides a sample of each. All reports can be generated for three groups:

- Registered Patients Only
- Non Registered Patients Only
- Both

4.1 Workload/Activity Reports

This group of reports provides information on CHR activities. Two custom report options (GEN and LIST) are available from this group that allows visits of interest to be screened. The other report options are predefined reports that print CHR data based upon parameters entered, such as date of service.

The report options available from the Workload/Activity Reports group are shown in Figure 4-2 and described in detail in the following sections.
4.1.1 GEN List CHR Records, GENERAL RETRIEVAL Output

The GEN report produces a list of records within a specified date range based on selectable criteria. Since this report output is extremely flexible and provides several options, before producing a GEN report, identify three things:

- **Selection Criteria.** Decide what data to include in the report. For example, the report could be restricted to return data for females over the age of 60. Note that if too many criteria are selected, the results could be nil.
- **Report Output Type.** Decide what data to print and in what format to print it.
- **Sort Order.** Decide the order in which to display the data.

To produce the GEN report:

1. Type G at the “Select Workload/Activity Reports Option” prompt and press Enter; the following sequence displays:

```
Select one of the following:
 S    Search Template
 D    Date Range
```

Select and Print Encounter List from:

2. Type a selection at the “Select and Print Encounter List from” prompt:

- Type S to use a search template. The system will prompt for the Template Name. The GEN report option allows report logic used during previous retrievals (Detailed Patient Listing only) to be saved for use later, eliminating the need to re-create a report many times.
- Type D to enter a date range; the following sequence displays asking for the Beginning Date and the Ending Date:

```
Enter Beginning Date of Service for search:
Enter Ending Date of Service for search:
```

   a. Type the Beginning Date at the “Enter Beginning Date of Service for search” prompt and press Enter.
b. Type the Ending Date at the “Enter Ending Date of Service for search” prompt and press Enter.

The Selection Criteria menu (Figure 4-3) displays:

The records displayed can be selected based on any of the following criteria:

1) Registered Patient Name  15) Program
2) Non-Registered Patient  16) CHR (Provider)
3) Patient Sex             17) Activity Location
4) Patient DOB             18) Hospital/Clinic NAME
5) Patient Age             19) Specialty
6) Chart Facility          20) Referred to CHR by
7) Patient Community       21) Referred by CHR to
8) Patient Tribe           22) Travel Time
9) Eligibility Status      23) Number Served
10) Classification/Benefici24) Prim Hlth Prob (Code
11) Medicare Eligibility   25) Health Problem Code
12) Medicaid Eligibility   26) Primary Service Code
13) Private Ins Elig       27) Service Code
14) Designated Provider    28) Service Minutes
29) Blood Pressure Taken   30) Weight Taken
31) Head Circ Taken        32) Vision Uncorrected D
33) Vision Corrected TAK  34) Temperature Taken
35) Respiration Taken     36) Pulse Taken
37) Waist Circumference   38) BMI Taken
39) HbA1c Done
40) Other parameters

<Enter a list or a range. E.g. 1-4,5,20 or 10,12,20,30>
<<PRESS Enter to conclude selections or bypass screens>>

Select visits based on which of the above: (1-40):

Figure 4-3: Selection Criteria menu

3. At the “Select visits based on which of the above” prompt, type one or more of the numbers corresponding to the menu choices; for example:

   a. Type individual numbers separated by commas, e.g., 2,14,27,30.
   
   b. Specify a range of numbers by typing the lowest and highest values separated by a hyphen (-), e.g., 2-4, 11-21.
   
   c. Type a combination of these two formats, e.g., 1-3,5,17,22-26,30.

4. If any of the choices includes further specific parameters of interest, an appropriate prompt displays. For example, if 5) Patient Age were selected, a prompt would display asking for the age range of interest to be entered; do one of the following:

   • Provide the required information and press Enter.
   • To include all records, leave the fields blank and press Enter.

The Report Output Type menu (Figure 4-4) displays:

Select one of the following:

T  Total Count Only
S  Sub Counts and Total Count
D  Detailed Record Listing

Choose Type of Report:
5. Select one of the following types by typing the corresponding letter at the “Choose Type of Report” prompt and pressing Enter:

- **T: Total Count Only.** This report displays the number of records that match the selection criteria. Only the total number of matching records will print. Follow the instructions in Section 0.

- **S: Sub-Counts and Total Count.** This report displays the total number of matching records with the records subtotaled by the categories within the sort variable chosen. For instance, if Sex was selected as the sort variable, subtotals for males and females would print in addition to the total number of records. Follow the instructions in Section 0.

- **D: Detailed Record Listing.** The Detailed Record Listing allows selection of the specific data items to print as well as the sort variable. Follow the instructions in Sections 4.1.1.1 and 0.

### 4.1.1.1 Specify Print Items

The Print Item menu (Figure 4-5) displays, listing the choices of data items available to print in the report. The report may be up to 132 characters wide if the printer permits, otherwise, the report is limited to 80 characters wide.

<table>
<thead>
<tr>
<th>PRINT DATA ITEMS Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following data items can be printed. You can use up to 132 characters.</td>
</tr>
<tr>
<td>Choose the data items in the order you want them printed.</td>
</tr>
<tr>
<td>Total Report width (including column margins - 2 spaces): 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Figure 4-5: Print Item menu
1. At the “Select print item(s)” prompt, type the number associated with each data item to be printed in the order it is to be printed. Make multiple selections in the same manner as described in Step 3 of Section 4.1.1. When done, press Enter. Each selected item is presented in turn, along with a suggested column width.

<table>
<thead>
<tr>
<th>Total Report width (including column margins - 2 spaces):</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Column width for Date of Service (suggested: 15):</td>
<td>(2-80): 15//</td>
</tr>
<tr>
<td>Total Report width (including column margins - 2 spaces):</td>
<td>17</td>
</tr>
<tr>
<td>Enter Column width for CHR (Provider) (suggested: 20):</td>
<td>(2-80): 20//</td>
</tr>
<tr>
<td>Total Report width (including column margins - 2 spaces):</td>
<td>39</td>
</tr>
<tr>
<td>Enter Column width for Patient Age (suggested: 5):</td>
<td>(2-80): 5//</td>
</tr>
<tr>
<td>Total Report width (including column margins - 2 spaces):</td>
<td>46</td>
</tr>
<tr>
<td>Enter Column width for Activity Location (suggested: 10):</td>
<td>(2-80): 10//</td>
</tr>
</tbody>
</table>

Figure 4-6: Example of setting column widths

2. For each selected item:
   a. If desired, at the “Enter Column width for...(suggested:...)...” prompt, type a column width other than the default value.
   b. Press Enter.

   When all selected items have been confirmed, the Report Width Confirmation sequence (Figure 4-7) displays.

```
PRINT Items Selected:
  Date of Service - column width 15
  CHR (Provider) - column width 20
  Patient Age - column width 5
  Activity Location - column width 10

Total Report width (including column margins - 2 spaces): 58
```

Figure 4-7: Example of the Report Width Confirmation sequence

3. If everything is correct, press Enter; the Sort Criteria menu (Figure 4-8) displays.

4.1.1.2 Select the Sort Criterion

The records displayed can be SORTED by any one of the following:

1) Registered Patient Name
2) Patient Sex
3) Patient Age
4) Patient Community
5) Patient Tribe
6) Patient Chart #
7) Designated Provider
8) Classification/Beneficiary
9) Eligibility Status
10) Patient DOB
11) CHR (Provider)
12) Registered Patient Sex
13) Registered Patient Age
14) Registered Patient Community
15) Registered Patient Tribe
16) Registered Patient Chart #
17) Registered Designated Provider
18) Registered Classification/Beneficiary
19) Registered Eligibility Status
20) Registered DOB
21) Sex Taken
22) Age Taken
23) Community Taken
24) Tribe Taken
25) Chart # Taken
26) Designated Provider Taken
27) Classification/Beneficiary Taken
28) Eligibility Status Taken
29) DOB Taken
30) Date of Service Taken
31) Weight Taken
32) Height Taken
33) Head Circ Taken
34) Vision Uncorrected Done
35) Vision Corrected Taken
36) Temperature Taken
37) Pulse Taken
38) Respiration Taken
39) Respiration
40) Blood Sugar Done
41) Date of Service
CHR PCC Reporting System (BCH) Version 2.0

12) Activity Location  30) Program
13) Hospital/Clinic NAME  31) HbA1c Done
14) Travel Time  32) Waist Circumference Taken
15) Number Served  33) BMI Taken
16) Prim Hlth Prob (Code)  34) Non-Registered Patient Name
17) Primary Service Code  35) Specialty
18) Blood Pressure Taken

<<If you don't select a sort criteria the report will be sorted by Date.>>

Sort visits by which of the above: (1-35):

1. Specify the Sort Criterion by typing its corresponding number at the “Sort visits by which of the above” prompt and pressing enter.

   **Note:** If Sort Criterion is not selected, the report will be sorted by date.

2. At the “Do you want a separate page for each CHR (Provider)?” prompt, type **YES** or **NO** and press Enter.

3. At the “Would you like a custom title for this report? prompt, type **YES** or **NO** and press Enter.

Each report includes a cover page (Figure 4-9) that details the selection criteria, print items, and sort criterion, as applicable. An example of the body of a report is shown in Figure 4-10.

---

**REPORT SUMMARY**

**VISIT Selection Criteria**
Date of Service range: MAR 22, 2013 to MAR 26, 2013

**PRINT Items Selected:**
- Date of Service - column width 15
- CHR (Provider) - column width 20
- Patient Age - column width 5
- Activity Location - column width 10

Total Report width (including column margins - 2 spaces): 58

**Visit SORTING Criteria**
Visits will be sorted by: CHR (Provider)

**DEVICE:** HOME// VT Right Margin: 80//

**RPMS/CHR-PCC CHR RECORD LISTING**

REPORT REQUESTED BY: PROVIDER, DEMO
2010 DEMO HOSPITAL

The following report contains a CHR Record report based on the following criteria:
VISIT Selection Criteria

Date of Service range: MAR 22, 2013 to MAR 26, 2013

PRINT Field Selection

Date of Service (15)
CHR (Provider) (20)
Patient Age (5)
Activity Location (10)

TOTAL column width: 58

Records will be sorted by: CHR (Provider)

Figure 4-9: Report Cover Page

********** CONFIDENTIAL PATIENT INFORMATION **********
CHR ENCOUNTER LISTING           Page 1
2010 DEMO HOSPITAL
Record Dates: MAR 22, 2013 and MAR 26, 2013

<table>
<thead>
<tr>
<th>DATE</th>
<th>CHR (PROVIDER)</th>
<th>AGE</th>
<th>ACTIVITY L</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAR 22, 2013</td>
<td>DEMO,PATIENT1</td>
<td>0</td>
<td>HOME</td>
</tr>
<tr>
<td>MAR 22, 2013</td>
<td>DEMO,PATIENT2</td>
<td>0</td>
<td>HOME</td>
</tr>
<tr>
<td>MAR 22, 2013</td>
<td>DEMO,PATIENT3</td>
<td>0</td>
<td>HOME</td>
</tr>
<tr>
<td>MAR 22, 2013</td>
<td>DEMO,PATIENT4</td>
<td>--</td>
<td>CHR OFFICE</td>
</tr>
<tr>
<td>MAR 22, 2013</td>
<td>DEMO,PATIENT5</td>
<td>--</td>
<td>COMMUNITY</td>
</tr>
<tr>
<td>MAR 22, 2013</td>
<td>DEMO,PATIENT6</td>
<td>0</td>
<td>HOME</td>
</tr>
<tr>
<td>MAR 22, 2013</td>
<td>DEMO,PATIENT7</td>
<td>--</td>
<td>CHR OFFICE</td>
</tr>
<tr>
<td>MAR 23, 2013</td>
<td>DEMO,PATIENT8</td>
<td>66</td>
<td>HOSPITAL/C</td>
</tr>
<tr>
<td>MAR 23, 2013</td>
<td>DEMO,PATIENT9</td>
<td>74</td>
<td>HOME</td>
</tr>
</tbody>
</table>

Total Records: 9

RUN TIME (H.M.S): 0.0.6

Figure 4-10: Example of a Detailed Record Listing

4. When complete, a prompt to save changes displays. This creates a Search Template for future use. To save the Search Template, type a name for the report at the prompt and press Enter.

4.1.2 List CHR Records, STANDARD Output

This report produces a list of records within a specified date range based on various criteria you select. The report output is either a brief or detailed list of records. To produce the LIST report:

1. Type L at the “Select Workload/Activity Reports Option” prompt and press Enter.

2. Type the Beginning Date at the “Enter BEGINNING Date of Service for Report” prompt and press Enter.

3. Type the Ending Date at the “Enter ENDING Date of Service for Report” prompt and press Enter. The Selection Criteria menu (Figure 4-11) displays:
The records displayed can be selected based on any of the following criteria:

1) Registered Patient Name 15) Program 29) Blood Pressure Taken
2) Non-Registered Patient 16) CHR (Provider) 30) Weight Taken
3) Patient Sex 17) Activity Location 31) Height Taken
4) Patient DOB 18) Hospital/Clinic NAME 32) Head Circ Taken
5) Patient Age 19) Specialty 33) Vision Uncorrected Don
6) Chart Facility 20) Referred to CHR by 34) Vision Corrected Taken
7) Patient Community 21) Referred by CHR to 35) Temperature Taken
8) Patient Tribe 22) Travel Time 36) Pulse Taken
9) Eligibility Status 23) Number Served 37) Respiration Taken
10) Classification/Beneficiary 24) Prim Hlth Prob (Code) 38) Waist Circumference Taken
11) Medicare Eligibility 25) Health Problem Code 39) BMI Taken
12) Medicaid Eligibility 26) Primary Service Code 40) HbA1c Done
13) Private Ins Elig 27) Service Code
14) Designated Provider 28) Service Minutes

<Enter a list or a range. E.g. 1-4,5,20 or 10,12,20,30>

<<PRESS Enter to conclude selections or bypass screens>>

Select print item(s):

4. At the “Select print item(s)” prompt, type the number associated with each data item to be printed in the order it is to be printed. Make multiple selections in the same manner as described in Step 3 of Section 4.1.1. When done, press Enter.

5. If any of the choices includes further specific parameters of interest, an appropriate prompt displays. For example, if 5) Patient Age were selected, a prompt would display asking for the age range of interest to be entered; do one of the following:
   - Provide the required information and press Enter.
   - To include all records, leave the fields blank and press Enter.

Select one of the following:

D  Detailed (132 column print)
B  Standard Brief (80 column print)

Figure 4-12: Report Output Type menu

6. Type the letter corresponding to the desired Record Output Type and press Enter; the Sort Criteria menu (Figure 4-13) displays.

Note: The Detailed report requires a printer capable of producing lines that are 132 characters wide.

The records displayed can be SORTED by any one of the following:

1) Registered Patient Name 13) Program 25) Head Circ Taken
2) Non-Registered Patient 14) CHR (Provider) 26) Vision Uncorrected Don
3) Patient Chart # 15) Activity Location 27) Vision Corrected Taken
4) Patient Sex             16) Hospital/Clinic NAME  28) Temperature Taken
5) Patient DOB             17) Specialty             29) Pulse Taken
6) Patient Age             18) Travel Time           30) Respiration Taken
7) Patient Community       19) Number Served         31) Waist Circumference Taken
8) Patient Tribe           20) Prim Hlth Prob (Code) 32) Respiration
9) Eligibility Status      21) Primary Service Code 33) BMI Taken
10) Classification/Beneficiary 22) Blood Pressure Taken 34) Blood Sugar Done
11) Designated Provider    23) Weight Taken          35) HbA1c Done
12) Date of Service        24) Height Taken
<<If you don't select a sort criteria the report will be sorted by Date.>>

Sort records by which of the above: (1-35):

Figure 4-13: Sort Criteria menu

7. At the “Sort records by which of the above” prompt, type the number corresponding to the desired Sort Criterion and press Enter. The Patient Data menu (Figure 4-14) displays.

Note: If an item is not selected, the report will be sorted by date.

Select one of the following:
R       Registered Patients
N       Non-Registered Patients
B       Both Registered and Non-Registered Patients

Figure 4-14: Patient Data menu

8. At the “Include which Patients” prompt, type the letter corresponding to the desired choice and press Enter. A cover page providing a summary of the selection and sort criteria will always print as the first page of the report. A sample cover page and a standard brief report are shown in Figure 4-15.

CHR RECORD LISTING
REPORT REQUESTED BY: PROVIDER, DEMO
2010 DEMO HOSPITAL

The following visit listing contains CHR records selected based on the following criteria:

RECORD SELECTION CRITERIA

PATIENTS: Both Registered and Non-Registered Patients
Date of Service range: MAR 22, 2013 to MAR 26, 2013
Report Type: STANDARD BRIEF

********** CONFIDENTIAL PATIENT INFORMATION **********
2010 DEMO HOSPITAL
CHR RECORD LISTING
Record Dates: MAR 22, 2013 and MAR 26, 2013
撤回
Figure 4-16 contains a sample ACT1 report for the service dates March 22-26, 2013.

**CONFIDENTIAL PATIENT INFORMATION**

CHR/PCC ACTIVITY REPORT

2010 DEMO HOSPITAL

PROGRAM: CHICKASAW (5062027)

PATIENTS: Both Registered and Non-Registered Patients

REPORT DATES: MAR 22, 2013 TO MAR 26, 2013

# Activities   ACT TIME (hrs)

<table>
<thead>
<tr>
<th>PROGRAM: CHICKASAW (5062027)</th>
<th>ACTIVITY LOCATION: CHR OFFICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER: PROVIDER,DEMO1</td>
<td>ADMINISTRATION/MANAGEMENT (AM) 3 0.8</td>
</tr>
<tr>
<td></td>
<td>OTHER PATIENT SERVICE (OP) 6 4.0</td>
</tr>
<tr>
<td>PROVIDER TOTAL:</td>
<td></td>
</tr>
<tr>
<td>PROVIDER: PROVIDER,DEMO1</td>
<td>OTHER PATIENT SERVICE (OP) 5 1.8</td>
</tr>
<tr>
<td>PROVIDER TOTAL:</td>
<td></td>
</tr>
<tr>
<td>PROVIDER: PROVIDER,DEMO1</td>
<td>ADMINISTRATION/MANAGEMENT (AM) 1 0.3</td>
</tr>
<tr>
<td></td>
<td>OTHER PATIENT SERVICE (OP) 3 1.3</td>
</tr>
<tr>
<td>PROVIDER TOTAL:</td>
<td></td>
</tr>
</tbody>
</table>

ACTIVITY LOCATION TOTAL: 18 8.1

<table>
<thead>
<tr>
<th>ACTIVITY LOCATION: COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER: PROVIDER,DEMO1</td>
</tr>
<tr>
<td>CASE MANAGEMENT (CM) 1 0.3</td>
</tr>
<tr>
<td>ENVIRONMENTAL SERVICE (ES) 1 0.3</td>
</tr>
<tr>
<td>HEALTH EDUCATION (HE) 1 0.3</td>
</tr>
<tr>
<td>PROVIDER TOTAL:</td>
</tr>
<tr>
<td>PROVIDER: PROVIDER,DEMO2</td>
</tr>
<tr>
<td>HEALTH EDUCATION (HE) 15 0.5</td>
</tr>
<tr>
<td>PROVIDER TOTAL:</td>
</tr>
<tr>
<td>PROVIDER: PROVIDER,DEMO3</td>
</tr>
<tr>
<td>CASE FINDING/SCREENING (CF) 31 4.1</td>
</tr>
<tr>
<td>HEALTH EDUCATION (HE) 7 0.5</td>
</tr>
<tr>
<td>INTERPRET/TRANSLATE (IT) 28 0.5</td>
</tr>
<tr>
<td>PROVIDER TOTAL:</td>
</tr>
</tbody>
</table>

ACTIVITY LOCATION TOTAL: 84 6.5

Figure 4-16: CHR/PCC Activity Report
4.1.4 ACT2 Activity Tally by Program, CHR, Setting, and Problem

This report prints a tally of activities by program, setting, CHR, and problem. To produce the ACT2 report:

1. Type **ACT2** at the “Select Workload/Activity Reports Option” prompt and press Enter.

2. Type the Beginning Date at the “Enter Beginning Date of Service” prompt and press Enter.

3. Type the Ending Date at the “Enter Ending Date of Service” prompt and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt:
   - To select a single program, accept the default (No) and press Enter; at the “Which CHR Program” prompt, type the program name and press Enter.
   - To select all programs, type **Yes**.

   The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R  Registered Patients</td>
</tr>
<tr>
<td>N  Non-Registered Patients</td>
</tr>
<tr>
<td>B  Both Registered and Non-Registered Patients</td>
</tr>
</tbody>
</table>

   Include which Patients: **B//**

5. At the “Include which Patients” prompt, type **R**, **N**, or **B** and press Enter.

6. Set the device and right margin when prompted.

Figure 4-17 contains a sample ACT2 report for the service dates March 22-26, 2013.
4.1.5 ACT3 Activity Record Counts

This report counts activity records for the item and date range specified and presents the option of selecting the records that will be included in the tabulation. For example, activity time can be tallied by problem code for only those activities that took place in the home. To produce the ACT3 report:

1. Type ACT3 at the “Select Workload/Activity Reports Option” prompt and press Enter. The Activity Record Counts menu (Figure 4-18) displays.

   1) CHR
   2) Program
   3) Date of Encounter
   4) POV/Problem (Problem Code)
   5) Problem/POV (Problem Category)
   6) Activity Location
   7) Activity Code
   8) Patient Community of Residence

   Choose an item for calculating activity time and record counts:  (1-8):

2. At the “Choose an item for calculating activity time and record counts” prompt, type the number corresponding to the desired item and press Enter.

3. Type the Beginning Date at the “Enter BEGINNING Date of Service for Report” prompt and press Enter.
4. Type the Ending Date at the “Enter ENDING Date of Service for Report” prompt and press Enter. The Selection Criteria menu (Figure 4-19) displays.

The records displayed can be selected based on any of the following criteria:

- Registered Patient Name
- Non-Registered Patient
- Patient Sex
- Patient DOB
- Patient Age
- Chart Facility
- Patient Community
- Patient Tribe
- Eligibility Status
- Classification/Beneficiary
- Medicare Eligibility
- Medicaid Eligibility
- Private Ins Elig
- Designated Provider
- CHR (Provider)
- Activity Location
- Hospital/Clinic NAME
- Head Circ Taken
- Specialty
- Hospital/Clinic NAME
- Referred to CHR by
- CHR to
- Referred by CHR to
- Travel Time
- Number Served
- Prim Hlth Prob (Code)
- Health Problem Code
- Service Code
- Service Minutes
- Waist Circumference Taken
- BMI Taken
- HbA1c Done
- Respiration Taken
- Temperature Taken
- Pulse Taken
- Vision Uncorrected Done
- Vision Corrected Taken

<Enter a list or a range. E.g. 1-4,5,20 or 10,12,20,30>

<<PRESS Enter to conclude selections or bypass screens>>

5. At the “Select print item(s)” prompt, type the number associated with each data item to be printed in the order it is to be printed. Make multiple selections in the same manner as described in Step 3 of Section 4.1.1. When done, press Enter.

6. If any of the choices includes further specific parameters of interest, an appropriate prompt displays. For example, if 5) Patient Age were selected, a prompt would display asking for the age range of interest to be entered; do one of the following:

- Provide the required information and press Enter.
- To include all records, leave the fields blank and press Enter.

The following sequence displays:

```
Select one of the following:

R         Registered Patients
N         Non-Registered Patients
B         Both Registered and Non-Registered Patients

Include which Patients: B//
```

7. At the “Include which Patients” prompt, type R, N, or B and press Enter.

8. Set the device and right margin when prompted.

Figure 4-20 contains a sample ACT3 report for the service dates March 22-26, 2013.
REPORT REQUESTED BY: AGUILAR, PAMELA
2010 DEMO HOSPITAL

The following visit listing contains CHR records selected based on the following criteria:

RECORD SELECTION CRITERIA

PATIENTS: Both Registered and Non-Registered Patients

Date of Service range: MAR 22, 2013 to MAR 26, 2013

Report Type: RECORD COUNTS/ACTIVITY TIME TOTALS

The following listing contains CHR records selected based on the following criteria:

RECORD SELECTION CRITERIA

PATIENTS: Both Registered and Non-Registered Patients

Date of Service range: MAR 22, 2013 to MAR 26, 2013

Report Type: RECORD COUNTS/ACTIVITY TIME TOTALS

<table>
<thead>
<tr>
<th>CHR PROGRAM</th>
<th>PROGRAM CODE</th>
<th># PCC FORMS</th>
<th># SERVED ACTIVITY TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHICKASAW</td>
<td>5062027</td>
<td>102</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>144.4</td>
</tr>
<tr>
<td>Totals:</td>
<td></td>
<td>102</td>
<td>104</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>144.4</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

Figure 4-20: Example of Record Counts/Activity Time Totals Report

4.1.6 FACT Frequency of Activities

The Frequency of Activities report produces a list of the top \( n \) activity codes for CHR visits. To produce the FACT report:

1. Type FA at the “Select Workload/Activity Reports Option” prompt and press Enter.

2. Type the Beginning Date at the “Enter BEGINNING Date of Service for Report” prompt and press Enter.

3. Type the Ending Date at the “Enter ENDING Date of Service for Report” prompt and press Enter. The Selection Criteria menu (Figure 4-21) displays.

The records displayed can be selected based on any of the following criteria:

1) Registered Patient Name  
2) Non-Registered Patient  
3) Patient Sex  
4) Patient DOB  
5) Patient Age  
6) Chart Facility  
7) Patient Community  
8) Patient Tribe  
9) Eligibility Status  
10) Program  
11) CHR (Provider)  
12) Activity Location  
13) Hospital/Clinic NAME  
14) Specialty  
15) Referred to CHR by  
16) Referred by CHR to  
17) Travel Time  
18) Number Served  
19) Blood Pressure Taken  
20) Weight Taken  
21) Height Taken  
22) Vision Uncorrected Don  
23) Vision Corrected Taken  
24) Temperature Taken  
25) Pulse Taken  
26) Respiration Taken

User Manual
Revised: December 2014

The Reports Menu

61
4. At the “Select print item(s)” prompt, type the number associated with each data item to be printed in the order it is to be printed. Make multiple selections in the same manner as described in Step 3 of Section 4.1.1. When done, press Enter.

5. If any of the choices includes further specific parameters of interest, an appropriate prompt displays. For example, if 5) Patient Age were selected, a prompt would display asking for the age range of interest to be entered; do one of the following:
   - Provide the required information and press Enter.
   - To include all records, leave the fields blank and press Enter.

The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>L List of items with Counts</td>
</tr>
<tr>
<td>B Bar Chart (REQUIRES 132 COLUMN PRINTER)</td>
</tr>
</tbody>
</table>

6. At the “Select Type of Report” prompt, type L or B and press Enter.

   **Note:** The bar chart requires a printer capable of producing lines that are 132 characters wide.

7. At the “How many entries do you want in the list” prompt, type a number from 5 to 100 and press Enter. The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R Registered Patients</td>
</tr>
<tr>
<td>N Non-Registered Patients</td>
</tr>
<tr>
<td>B Both Registered and Non-Registered Patients</td>
</tr>
</tbody>
</table>

8. At the “Include which Patients” prompt, type R, N, or B and press Enter.

9. Set the device and right margin when prompted.
Figure 4-22 contains a sample FACT report in List format for the service dates March 22-26, 2013. Figure 4-23 contains a sample FACT report in Bar Chart format.

**CHR RECORD LISTING**

**REPORT REQUESTED BY:** PROVIDER, DEMO  
2010 DEMO HOSPITAL

The following visit listing contains CHR records selected based on the following criteria:

**RECORD SELECTION CRITERIA**

**PATIENTS:** Both Registered and Non-Registered Patients  
**Date of Service range:** MAR 22, 2013 to MAR 26, 2013  
**Report Type:** FREQUENCY REPORT (TOP TEN)

<table>
<thead>
<tr>
<th>No.</th>
<th>ACTIVITY TYPE</th>
<th>ACTIVITY CODE</th>
<th># Activities</th>
<th>ACT TIME (hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CASE FINDING/SCREENING</td>
<td>CF</td>
<td>135</td>
<td>12.9</td>
</tr>
<tr>
<td>2.</td>
<td>MONITOR PATIENT</td>
<td>MP</td>
<td>76</td>
<td>16.8</td>
</tr>
<tr>
<td>3.</td>
<td>HEALTH EDUCATION</td>
<td>HE</td>
<td>64</td>
<td>11.9</td>
</tr>
<tr>
<td>4.</td>
<td>PATIENT CARE</td>
<td>PC</td>
<td>63</td>
<td>13.0</td>
</tr>
<tr>
<td>5.</td>
<td>INTERPRET/TRANSLATE</td>
<td>IT</td>
<td>50</td>
<td>4.6</td>
</tr>
<tr>
<td>6.</td>
<td>CASE MANAGEMENT</td>
<td>CM</td>
<td>41</td>
<td>9.8</td>
</tr>
<tr>
<td>7.</td>
<td>ENVIRONMENTAL SERVICE</td>
<td>ES</td>
<td>41</td>
<td>7.2</td>
</tr>
<tr>
<td>8.</td>
<td>OTHER PATIENT SERVICE</td>
<td>OP</td>
<td>15</td>
<td>7.6</td>
</tr>
<tr>
<td>9.</td>
<td>TRANSPORT PATIENT</td>
<td>TP</td>
<td>7</td>
<td>3.3</td>
</tr>
<tr>
<td>10.</td>
<td>LEAVE TIME</td>
<td>LT</td>
<td>6</td>
<td>48.0</td>
</tr>
</tbody>
</table>

**RUN TIME (H.M.S): 0.0.0**

Figure 4-22: Example of a List report
4.1.7 FPRB Frequency of Problems (CHR)

This report produces a list of the top \( n \) POVs/Problems for selected CHR visits. The report may be configured to include only primary POVs or all POVs. To produce the FPRB report:

1. Type FP at the “Select Workload/Activity Reports Option” prompt and press Enter.

2. Type the Beginning Date at the “Enter BEGINNING Date of Service for Report” prompt and press Enter.

3. Type the Ending Date at the “Enter ENDING Date of Service for Report” prompt and press Enter. The Selection Criteria menu (Figure 4-24) displays.

   The records displayed can be selected based on any of the following criteria:

   1) Registered Patient Name
   2) Non-Registered Patient
   3) Patient Sex
   4) Patient DOB
   5) Patient Age
   6) Chart Facility
   7) Patient Community
   8) Patient Tribe
   9) Eligibility Status
   10) Classification/Beneficiary
   11) Medicare Eligibility
   12) Medicaid Eligibility
   13) Private Ins Elig
   14) Designated Provider
   15) Program
   16) CHR (Provider)
   17) Activity Location
   18) Hospital/Clinic NAME
   19) Specialty
   20) Referred to CHR by
   21) Referred by CHR to
   22) Travel Time
   23) Number Served
   24) Prim Hlth Prob (Code)
   25) Health Problem Code
   26) Primary Service Code
   27) Service Code
   28) Service Minutes
   29) Blood Pressure Taken
   30) Weight Taken
   31) Height Taken
   32) Head Circ Taken
   33) Vision Uncorrected Don
   34) Vision Corrected Taken
   35) Temperature Taken
   36) Pulse Taken
   37) Respiration Taken
   38) Waist Circumference Ta
   39) BMI Taken
   40) HbA1c Done

   <Enter a list or a range. E.g. 1-4,5,20 or 10,12,20,30>
   <<PRESS Enter to conclude selections or bypass screens>>

4. At the “Record selection criteria” prompt, type the number associated with each data item to be printed in the order it is to be printed. Make multiple selections in the same manner as described in Step 3 of Section 4.1.1. When done, press Enter.

5. If any of the choices includes further specific parameters of interest, an appropriate prompt displays. For example, if 5) Patient Age were selected, a prompt would display asking for the age range of interest to be entered; do one of the following:
• Provide the required information and press Enter.
• To include all records, leave the fields blank and press Enter.

The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>P PRIMARY POV Only</td>
</tr>
<tr>
<td>S PRIMARY and SECONDARY POV's</td>
</tr>
</tbody>
</table>

Include which POV's: P// PRIMARY POV Only

6. At the “Include which POV’s” prompt, type P or S and press Enter.

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>L List of items with Counts</td>
</tr>
<tr>
<td>B Bar Chart (REQUIRES 132 COLUMN PRINTER)</td>
</tr>
</tbody>
</table>

Select Type of Report: L//

7. At the “Select Type of Report” prompt, type L or B and press Enter.

**Note**: The bar chart requires a printer capable of producing lines that are 132 characters wide.

8. At the “How many entries do you want in the list” prompt, type a number from 5 to 100 and press Enter. The following sequence displays.

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R Registered Patients</td>
</tr>
<tr>
<td>N Non-Registered Patients</td>
</tr>
<tr>
<td>B Both Registered and Non-Registered Patients</td>
</tr>
</tbody>
</table>

Include which Patients: B//

9. At the “Include which Patients” prompt, type R, N, or B and press Enter.

10. Set the device and right margin when prompted.

Figure 4-25 contains a sample FPRB report in List format for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>CHR RECORD LISTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPORT REQUESTED BY: PROVIDER, DEMO</td>
</tr>
<tr>
<td>2010 DEMO HOSPITAL</td>
</tr>
</tbody>
</table>

The following visit listing contains CHR records selected based on the following criteria:

<table>
<thead>
<tr>
<th>RECORD SELECTION CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENTS: Both Registered and Non-Registered Patients</td>
</tr>
</tbody>
</table>
TOP 10 POV/Problem (Problem Code)'s.

PRIMARY POV Only

DATES: MAR 22, 2013 TO MAR 26, 2013

<table>
<thead>
<tr>
<th>No.</th>
<th>PROB CODE</th>
<th>NARRATIVE</th>
<th>PROBLEM CODE</th>
<th># Activities</th>
<th>ACT TIME (hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>HY</td>
<td>HYPERTENSION</td>
<td>HY</td>
<td>87</td>
<td>13.8</td>
</tr>
<tr>
<td>2.</td>
<td>HT</td>
<td>HEART</td>
<td>HT</td>
<td>85</td>
<td>15.0</td>
</tr>
<tr>
<td>3.</td>
<td>DM</td>
<td>DIABETES MELLITUS</td>
<td>DM</td>
<td>82</td>
<td>15.0</td>
</tr>
<tr>
<td>4.</td>
<td>OR</td>
<td>OTHER RESPIRATORY</td>
<td>OR</td>
<td>52</td>
<td>4.3</td>
</tr>
<tr>
<td>5.</td>
<td>IC</td>
<td>INJURY CONTROL</td>
<td>IC</td>
<td>50</td>
<td>10.9</td>
</tr>
<tr>
<td>6.</td>
<td>AM</td>
<td>ADMINISTRATIVE/MANAGEMENT</td>
<td>AM</td>
<td>17</td>
<td>6.7</td>
</tr>
<tr>
<td>7.</td>
<td>NU</td>
<td>NUTRITION</td>
<td>NU</td>
<td>14</td>
<td>4.3</td>
</tr>
<tr>
<td>8.</td>
<td>FE</td>
<td>FEVER,UNKNOWN ORIGIN</td>
<td>FE</td>
<td>13</td>
<td>1.1</td>
</tr>
<tr>
<td>9.</td>
<td>ED</td>
<td>EYE DISEASE</td>
<td>ED</td>
<td>10</td>
<td>2.4</td>
</tr>
<tr>
<td>10.</td>
<td>OM</td>
<td>OTHER MENTAL HEALTH</td>
<td>OM</td>
<td>10</td>
<td>2.8</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

Figure 4-25: Example of a List report

4.1.8 FCAT Frequency of Problems by Problem Category

This report generates a list of the top \( n \) POVs/Problems (Problem Category) for visits selected. The report may be configured to include only primary POVs or all POVs.

To produce the FCAT report:

1. Type FC at the “Select Workload/Activity Reports Option” prompt and press Enter.

2. Type the Beginning Date at the “Enter BEGINNING Date of Service for Report” prompt and press Enter.

3. Type the Ending Date at the “Enter ENDING Date of Service for Report” prompt and press Enter. The Selection Criteria menu (Figure 4-26) displays.

The records displayed can be selected based on any of the following criteria:

1) Registered Patient Name 15) Program 29) Blood Pressure Taken
2) Non-Registered Patient 16) CHR (Provider) 30) Weight Taken
3) Patient Sex 17) Activity Location 31) Height Taken
4) Patient DOB 18) Hospital/Clinic NAME 32) Head Circ Taken
5) Patient Age 19) Specialty 33) Vision Uncorrected Don
6) Chart Facility 20) Referred to CHR by 34) Vision Corrected Taken
7) Patient Community 21) Referred by CHR to 35) Temperature Taken
8) Patient Tribe 22) Travel Time 36) Pulse Taken
4. At the “Record selection criteria” prompt, type the number associated with each data item to be printed in the order it is to be printed. Make multiple selections in the same manner as described in Step 3 of Section 4.1.1. When done, press Enter. Each selected item is presented, along with a suggested column width.

5. If any of the choices includes further specific parameters of interest, an appropriate prompt displays. For example, if 5) Patient Age were selected, a prompt would display asking for the age range of interest to be entered; do one of the following:
   - Provide the required information and press Enter.
   - To include all records, leave the fields blank and press Enter.

The following sequence displays:

![Select one of the following:](image)

6. At the “Include which POV’s” prompt, type P or S and press Enter.

7. At the “Select Type of Report” prompt, type L or B and press Enter.

![Select one of the following:](image)

8. At the “How many entries do you want in the list” prompt, type a number from 5 to 100 and press Enter. The following sequence displays.

![Select one of the following:](image)
9. At the “Include which Patients” prompt, type **R**, **N**, or **B** and press Enter.

10. Set the device and right margin when prompted.

11. Figure 4-27 contains a sample FCAT report in List format for the service dates March 22-26, 2013.

---

**CHR RECORD LISTING**

**REPORT REQUESTED BY:** PROVIDER, DEMO

2010 DEMO HOSPITAL

The following visit listing contains CHR records selected based on the following criteria:

**RECORD SELECTION CRITERIA**

**PATIENTS:** Both Registered and Non-Registered Patients

**Date of Service range:** MAR 22, 2013 to MAR 26, 2013

**Report Type:** FREQUENCY REPORT (TOP TEN)

**APR 02, 2013**                                                                 Page 1

2010 DEMO HOSPITAL

**TOP 10 Problem/POV (Problem Category).**

**PRIMARY POV Only**

**DATES:** MAR 22, 2013 TO MAR 26, 2013

<table>
<thead>
<tr>
<th>No.</th>
<th>CATEGORY NARRATIVE</th>
<th>CATEGORY CODE</th>
<th># Activities</th>
<th>ACT TIME (hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CHRONIC DISEASE</td>
<td>CHRONIC DISEASE</td>
<td>268</td>
<td>47.0</td>
</tr>
<tr>
<td>2.</td>
<td>RESPIRATORY</td>
<td>RESPIRATORY</td>
<td>71</td>
<td>7.9</td>
</tr>
<tr>
<td>3.</td>
<td>HP/DP</td>
<td>HP/DP</td>
<td>64</td>
<td>15.3</td>
</tr>
<tr>
<td>4.</td>
<td>OTHER</td>
<td>OTHER</td>
<td>42</td>
<td>58.7</td>
</tr>
<tr>
<td>5.</td>
<td>ILL-DEFINED CONDITIONS</td>
<td>ILL-DEFINED CON</td>
<td>25</td>
<td>4.1</td>
</tr>
<tr>
<td>6.</td>
<td>BEHAVIORAL HEALTH</td>
<td>BEHAVIORAL HEAL</td>
<td>14</td>
<td>4.2</td>
</tr>
<tr>
<td>7.</td>
<td>VISION</td>
<td>VISION</td>
<td>10</td>
<td>2.4</td>
</tr>
<tr>
<td>8.</td>
<td>URINARY TRACT</td>
<td>URINARY TRACT</td>
<td>8</td>
<td>3.3</td>
</tr>
<tr>
<td>9.</td>
<td>SCREENING</td>
<td>SCREENING</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td>10.</td>
<td>COMMUNICABLE DISEASES</td>
<td>COMMUNICABLE DI</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>11.</td>
<td>MATERNAL &amp; CHILD HEALTH</td>
<td>MATERNAL &amp; CHIL</td>
<td>1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

**RUN TIME (H.M.S):** 0.0.0

---

Figure 4-27: Example of a List report
### 4.1.9 TBT – Tally of Records and Patients by Tribe

This report will present a tally of all CHR PCCs (encounter records) and patients by Tribe of Membership. To produce the TBT report:

1. Type **T** at the “Select Workload/Activity Reports Option” prompt and press Enter.
2. At the “Enter beginning Date of Service” prompt, type the desired start date and press Enter.
3. At the “Enter ending Date of Service” prompt, type the desired end date and press Enter.
4. At the “Include data from ALL CHR Programs?” prompt:
   - To select a single program, accept the default (No) and press Enter; at the “Which CHR Program” prompt, type the program name and press Enter.
   - To select all programs, type **Yes**. The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R Registered Patients</td>
</tr>
<tr>
<td>N Non-Registered Patients</td>
</tr>
<tr>
<td>B Both Registered and Non-Registered Patients</td>
</tr>
</tbody>
</table>

   Include which Patients: B//

5. At the “Include which Patients” prompt, type **R**, **N**, or **B** and press Enter.
6. Set the device and right margin when prompted.

Figure 4-28 contains a sample TBT report for the service dates March 22-26, 2013.
4.2 CHRS – CHR Reports

The following reports are available from the CHRS Reports menu:

<table>
<thead>
<tr>
<th>Report</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>CHR #1-Time, Serv Acts, Services by HEALTH PROBLEM</td>
</tr>
<tr>
<td>C2</td>
<td>CHR #2-Time, Serv Acts, Services by SERVICE CODE</td>
</tr>
<tr>
<td>C3</td>
<td>CHR #3 - Time, # Served, Services by SETTING</td>
</tr>
<tr>
<td>C4</td>
<td>CHR #4 - Number of Referrals From/To</td>
</tr>
<tr>
<td>C5</td>
<td>CHR #5 - Services by Health Area/Age/Sex</td>
</tr>
<tr>
<td>C6</td>
<td>CHR #6 - Provider Data</td>
</tr>
<tr>
<td>C8</td>
<td>CHR #8 - Hours (Service+Travel) by Month</td>
</tr>
<tr>
<td>C9</td>
<td>CHR #9 - Data Summary by Provider</td>
</tr>
<tr>
<td>CH</td>
<td>CHR #13 – Highlights</td>
</tr>
</tbody>
</table>

Select CHR Reports Option:

4.2.1 C1 CHR #1 – Time, Serv Acts, Services by HEALTH PROBLEM

This report shows how CHR Program manpower resources were spent on different health areas. It provides information to help determine if program objectives and needs in priority health areas are being addressed:

- Is more time than expected being spent in certain areas?
- Less time?
- Is the proportion of time spent on high-priority areas adequate?
- Does travel time seem high?

Note that the number served is not a count of only different people served, since it may include multiple activities for the same person. Instead, it is a count of patient contacts or encounters. For individual CHR performance, managers can review Report #1 at the provider level. To generate the report:

1. At the “Select CHR Reports Option” prompt, type C1 and press Enter. The following sequence displays.
2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.
   The following sequence displays:

   Select one of the following:
   
   O         One CHR
   A         All CHRs

   Include Data for: A/

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.

6. At the “Do you wish to subtotal by SERVICE CODE?” prompt, type YES or NO and press Enter. The following sequence displays:

   Select one of the following:
   
   I         Include Leave Time in this Report
   D         DO NOT Include Leave Time in this Report

   Select: D/

7. At the “Select” prompt, type I or D and press Enter. The following sequence displays:

   Select one of the following:
   
   R         Registered Patients
   N         Non-Registered Patients
   B         Both Registered and Non-Registered Patients

   Include which Patients: B/
8. At the “Include which Patients” prompt, type R, N, or B and press Enter.
9. Set the device and right margin when prompted.

Figure 4-30 contains a sample CHR Report No. 1 for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>HEALTH PROBLEM</th>
<th>SERVICE HOURS</th>
<th>TRAVEL HOURS</th>
<th>SERVICE ACTIVITIES</th>
<th>SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>AM</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>AG</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

4.2.2 C2 CHR #2 – Time, Contacts, and Activities by Service

This report shows how time was spent on various services:
- Are certain services taking more or less time than the tribe had projected/planned?
- Is this situation okay or does the manager need to reevaluate the situation for possible change?
- Is sufficient time spent training areas that are of a high priority to the tribal program?
- Does the amount of time used for administration exceed the recommended level of 15%? If yes, Why?

To generate the report:
1. At the “Select CHR Reports Option” prompt, type C2 and press Enter. The following sequence displays.
You must enter the time frame and the program for which the report will be run.

2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.

   The following sequence displays:

   Select one of the following:
   
   O One CHR
   A All CHRs

   Include Data for: A//

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.

6. At the “Do you wish to subtotal by HEALTH PROBLEM?” prompt, type YES or NO and press Enter. The following sequence displays:

   Select one of the following:
   
   I Include Leave Time in this Report
   D DO NOT Include Leave Time in this Report

   Select: D//

7. At the “Select” prompt, type I or D and press Enter. The following sequence displays:

   Select one of the following:
   
   R Registered Patients
   N Non-Registered Patients
   B Both Registered and Non-Registered Patients

   Include which Patients: B//

8. At the “Include which Patients” prompt, type R, N, or B and press Enter.
9. Set the device and right margin when prompted.

Figure 4-31 contains a sample CHR Report No. 2 for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>SERVICE HOURS</th>
<th>TRAVEL HOURS</th>
<th>SERVICE ACTIVITIES</th>
<th>SERVICES*</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>144 100%</td>
<td>14 100%</td>
<td>551 100%</td>
<td>507 100%</td>
</tr>
<tr>
<td>AM ADMINISTRATION/MANAGEM</td>
<td>1 1%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>4 1%</td>
</tr>
<tr>
<td>CF CASE FINDING/SCREENING</td>
<td>13 9%</td>
<td>0 3%</td>
<td>177 32%</td>
<td>135 27%</td>
</tr>
<tr>
<td>CM CASE MANAGEMENT</td>
<td>10 7%</td>
<td>3 21%</td>
<td>51 9%</td>
<td>41 8%</td>
</tr>
<tr>
<td>ES ENVIRONMENTAL SERVICE</td>
<td>7 5%</td>
<td>0 1%</td>
<td>50 9%</td>
<td>41 8%</td>
</tr>
<tr>
<td>HE HEALTH EDUCATION</td>
<td>12 8%</td>
<td>0 1%</td>
<td>73 13%</td>
<td>64 13%</td>
</tr>
<tr>
<td>HS HOMEMAKER SERVICES</td>
<td>1 1%</td>
<td>0 0%</td>
<td>4 1%</td>
<td>4 1%</td>
</tr>
<tr>
<td>IT INTERPRET/TRANSLATE</td>
<td>5 3%</td>
<td>0 0%</td>
<td>49 9%</td>
<td>50 10%</td>
</tr>
<tr>
<td>LT LEAVE TIME</td>
<td>48 33%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>6 1%</td>
</tr>
<tr>
<td>MP MONITOR PATIENT</td>
<td>17 12%</td>
<td>6 44%</td>
<td>77 14%</td>
<td>76 15%</td>
</tr>
<tr>
<td>OT OBTAIN TRAINING</td>
<td>7 5%</td>
<td>1 7%</td>
<td>0 0%</td>
<td>1 0%</td>
</tr>
<tr>
<td>OP OTHER PATIENT SERVICE</td>
<td>8 5%</td>
<td>2 16%</td>
<td>0 0%</td>
<td>15 3%</td>
</tr>
<tr>
<td>PC PATIENT CARE</td>
<td>13 9%</td>
<td>0 0%</td>
<td>62 11%</td>
<td>63 12%</td>
</tr>
<tr>
<td>TP TRANSPORT PATIENT</td>
<td>3 2%</td>
<td>1 8%</td>
<td>8 1%</td>
<td>7 1%</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

Figure 4-31: Example of Time Spent, Client Contacts, and Activities by Activity (Service) report

4.2.3 C3 CHR #3 – Time, Contacts, Activities by Setting

The CHR #3 report shows where the CHRs reported spending their time and the number of patient encounters that occurred in the different settings. There is no ideal distribution of time to the different settings. However, if the data showed that CHRs were spending a high proportion of time in hospitals/clinics when the tribe planned for an emphasis in home visits, it would raise questions for the program manager. Also, if CHRs were spending too much time in the office, this could indicate that outreach services were not being emphasized enough. To generate the report:

1. At the “Select CHR Reports Option” prompt, type C3 and press Enter. The following sequence displays.
You must enter the time frame and the program for which the report will be run.

2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.
   The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
</tr>
<tr>
<td>A</td>
</tr>
</tbody>
</table>

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.

6. At the “Do you wish to subtotal by CHR?” prompt, type YES or NO and press Enter. The following sequence displays:

   Select one of the following:
   | I | Include Leave Time in this Report |
   | D | DO NOT Include Leave Time in this Report |

7. At the “Select” prompt, type I or D and press Enter. The following sequence displays:

   Select one of the following:
   | R | Registered Patients |
   | N | Non-Registered Patients |
   | B | Both Registered and Non-Registered Patients |

Include which Patients: B//
8. At the “Include which Patients” prompt, type R, N, or B and press Enter.

9. Set the device and right margin when prompted.

Figure 4-32 contains a sample CHR Report No. 3 for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>SETTING</th>
<th>SERVICE</th>
<th>TRAVEL</th>
<th>NUMBER</th>
<th>SERVICES*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HOURS</td>
<td>HOURS</td>
<td>SERVED</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>144</td>
<td>14</td>
<td>104</td>
<td>507</td>
</tr>
<tr>
<td>CH CHR OFFICE</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>CM COMMUNITY</td>
<td>6</td>
<td>1</td>
<td>47</td>
<td>84</td>
</tr>
<tr>
<td>HM HOME</td>
<td>62</td>
<td>10</td>
<td>49</td>
<td>360</td>
</tr>
<tr>
<td>HC HOSPITAL/CLINIC</td>
<td>12</td>
<td>1</td>
<td>8</td>
<td>38</td>
</tr>
<tr>
<td>NO NONE</td>
<td>55</td>
<td>1</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

Figure 4-32: Example of a Time Spent, Client Contacts, and Activities by Setting report

4.2.4 C4 CHR #4 – Number of Referrals from/to

The number and distribution of the referral data in this report show the connection between CHRs and the community health-care delivery system. The report details the number and frequency of referrals to the CHR program and the number and frequency of referrals made by the CHR program. To generate the report:

1. At the “Select CHR Reports Option” prompt, type C4 and press Enter. The following sequence displays.

```
********** CHR REPORT NO. 4 **********
NUMBER OF REFERRALS FROM/TO

You must enter the time frame and the program for which the report will be run.
```

2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.
3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.

   The following sequence displays:

   Select one of the following:
   
   O  One CHR
   A  All CHRs

   Include Data for: A/

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.

   The following sequence displays:

   Select one of the following:
   
   R  Registered Patients
   N  Non-Registered Patients
   B  Both Registered and Non-Registered Patients

   Include which Patients: B/

6. At the “Include which Patients” prompt, type R, N, or B and press Enter.

7. Set the device and right margin when prompted.

Figure 4-33 contains a sample CHR Report No. 4 for the service dates March 22-26, 2013.
4.2.5 C5 CHR #5 – Client Contacts by Health Area, Age, Sex

This report provides information on the characteristics of the individual people served. Are the program’s resources primarily directed to:

- Younger or older patients?
- Groups with the greatest health-care needs?
- Targeted ages the tribe wants addressed?

**Note:** This report requires a printer capable of producing lines that are 132 characters wide.

This report can also help to monitor reporting accuracy, since certain health areas, like Gerontological and Maternal/Child Health, should include patients from certain age and sex groups, such as older and younger people and women. Given the age distribution of the community, are CHR resources meeting the needs of the local population? The answer requires information on the age distribution and health-care needs of the local population, which can be found in certain IHS data sources. Remember that the numbers do not necessarily represent different people since the same person can receive multiple services. To generate the report:

1. At the “Select CHR Reports Option” prompt, type **C5** and press Enter. The following sequence displays.

```
********** CHR REPORT NO. 5 **********

NUMBER OF SERVICES (LINES OF ASSESSMENT) BY HEALTH PROBLEM, AGE AND SEX

You must enter the time frame and the program for which the report will be run.

You can also define your own age groups, if you so desire. If you do, Please LIMIT the # of age groups to 5
```
2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.
   The following sequence displays:

   Select one of the following:
   
   O One CHR
   A All CHRs

   Include Data for: A//

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.
   The following sequence displays:

   The Age Groups to be used are currently defined as:
   0 - 9
   10 - 19
   20 - 34
   35 - 54
   55 - 199

   Do you wish to modify these age groups? N// O

6. At the “Do you wish to modify these age groups?” prompt, type YES or NO and press Enter. If YES was selected:
   a. Follow the onscreen prompts to change the age groups.
   b. Press Enter.
   The following sequence displays:

   Select one of the following:
   
   R Registered Patients
   N Non-Registered Patients
   B Both Registered and Non-Registered Patients

   Include which Patients: B//
7. At the “Include which Patients” prompt, type R, N, or B and press Enter.

8. Set the device and right margin when prompted.

Figure 4-34 contains a sample CHR Report No. 5 for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>HEALTH PROBLEM</th>
<th>---ALL AGES---</th>
<th>0-9</th>
<th>19-19</th>
<th>20-39</th>
<th>39-59</th>
<th>&gt;59</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>TOTAL</td>
<td>149</td>
<td>249</td>
<td>7</td>
<td>7</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>OI</td>
<td>0</td>
<td>1</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>CA</td>
<td>3</td>
<td>5</td>
<td>.</td>
<td>.</td>
<td>3</td>
<td>.</td>
</tr>
<tr>
<td>DM</td>
<td>24</td>
<td>45</td>
<td>.</td>
<td>.</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>ED</td>
<td>6</td>
<td>4</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>HY</td>
<td>28</td>
<td>45</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>HT</td>
<td>29</td>
<td>45</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>FL</td>
<td>0</td>
<td>0</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>AS</td>
<td>6</td>
<td>0</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>AG</td>
<td>5</td>
<td>0</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>OR</td>
<td>13</td>
<td>30</td>
<td>1</td>
<td>1</td>
<td>.</td>
<td>2</td>
</tr>
<tr>
<td>FE</td>
<td>3</td>
<td>7</td>
<td>.</td>
<td>.</td>
<td>1</td>
<td>.</td>
</tr>
<tr>
<td>SF</td>
<td>0</td>
<td>3</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>NU</td>
<td>6</td>
<td>5</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>IC</td>
<td>17</td>
<td>22</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TH</td>
<td>0</td>
<td>2</td>
<td>.</td>
<td>.</td>
<td>1</td>
<td>.</td>
</tr>
<tr>
<td>OX</td>
<td>0</td>
<td>4</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>DP</td>
<td>0</td>
<td>4</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>OM</td>
<td>0</td>
<td>6</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>MB</td>
<td>0</td>
<td>0</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>AD</td>
<td>1</td>
<td>2</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>WH</td>
<td>0</td>
<td>1</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>CR</td>
<td>3</td>
<td>4</td>
<td>.</td>
<td>.</td>
<td>3</td>
<td>.</td>
</tr>
<tr>
<td>SO</td>
<td>3</td>
<td>3</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>DG</td>
<td>0</td>
<td>3</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>DD</td>
<td>0</td>
<td>2</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>OS</td>
<td>2</td>
<td>6</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

Figure 4-34: Example of a Client Contacts by Health Problem, Age, and Sex report
The Provider Data report gives a quick comparative overview of the performance of each CHR in the program

- How does reported time vary among CHRs and why do some CHRs report more time than others?
- If there is a significant discrepancy in the number of hours shown, be sure CHRs can account for their time so you can tell whether there is a problem with coding or with missing data.
- Why do some CHRs show more work hours than would be expected in the time period covered? Fewer hours? Review the number of people served and make sure that very high and very low numbers are accurate. Calculate time per person served by dividing total service hours by the total number served. You can do this for each CHR and for all CHRs combined.
- Are CHRs spending too little time per person served? Too much?

Note: This report requires a printer capable of producing lines that are 132 characters wide.

To generate the report:

1. At the “Select CHR Reports Option” prompt, type C6 and press Enter. The following sequence displays.

   ******************** CHR REPORT NO. 6 ********************

   PROVIDER DATA
   You must enter the time frame and the program for which the report will be run.

2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.

The following sequence displays:

   Select one of the following:
   R  Registered Patients
   N  Non-Registered Patients
5. At the “Include which Patients” prompt, type \textbf{R}, \textbf{N}, or \textbf{B} and press Enter.

6. Set the device and right margin when prompted.

Figure 4-35 contains a sample CHR Report No. 6 for the service dates March 22-26, 2013.

\begin{center}
\begin{tabular}{|c|c|c|c|c|c|c|}
\hline
& Service & Travel & Leave & Total & 0 Num & 1 Num \\
Provider & Hours & Hours & Hours & Hours & Serv & Serv \\
\hline
Total & 96 & 14 & 48 & 159 & 23 & 76 \\
Provider, Demo1 & 33 & 6 & 0 & 39 & 7 & 15 \\
Provider, Demo2 & 35 & 5 & 0 & 40 & 6 & 38 \\
Provider, Demo3 & 28 & 4 & 8 & 40 & 5 & 23 \\
Provider, Demo4 & 0 & 0 & 40 & 40 & 0 & 0 \\
\hline
\end{tabular}
\end{center}

\textbf{Figure 4-35: Example of a Provider Data report}

\subsection{4.2.7 C8 CHR #8 – Hours (Service + Travel) by Month}

This report produces a summary of the total number of hours (service, leave, and travel) spent by the CHR program staff each month on CHR activities during the reporting period. To generate the report:

1. At the “Select CHR Reports Option” prompt, type \textbf{C8} and press Enter. The following sequence displays.

\begin{center}
\begin{tabular}{|c|c|c|c|c|c|}
\hline
& Service & Travel & Leave & Total & 0 Num \\
Hours (Service+Travel) by Month & Hours & Hours & Hours & Hours & Serv \\
\hline
You must enter the time frame and the program for which the report will be run. \\
\hline
\end{tabular}
\end{center}

2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.
3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter. The following sequence displays.

```
Select one of the following:
PG     By PROGRAM (Report 8)
PR     By PROVIDER (Report 8.2)
Which report do you wish to run: PG//
```

4. At the “Which report do you wish to run?” prompt, type PG or PR and press Enter.

5. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.
   The following sequence displays:

```
Select one of the following:
R     Registered Patients
N     Non-Registered Patients
B     Both Registered and Non-Registered Patients
Include which Patients: B//
```

6. At the “Include which Patients” prompt, type R, N, or B and press Enter.

7. Set the device and right margin when prompted.

Figure 4-36 contains a sample CHR Report No. 8 Report Output by Program for the service dates March 22-26, 2013. Figure 4-37 contains a sample Report Output by Provider report for the same time period.
### C9 CHR #9 – Data Summary by Provider

The Data Summary by Provider report displays a summary of the CHR’s activities. The CHR’s time is broken down into administrative and non-administrative duties so that you can determine on which types of activities the CHRs are spending the majority of their time. To generate the report:

1. At the “Select CHR Reports Option” prompt, type C9 and press Enter. The following sequence displays.

   ******* CHR REPORT NO. 9  *******
   DATA SUMMARY BY PROVIDER

   You must enter the time frame for the report.

2. At the “Enter beginning Date of Service for report” prompt, type the desired start date and press Enter.
3. At the “Enter ending Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type **YES** or **NO** and press Enter. If **NO** was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.

The following sequence displays:

```
Select one of the following:
R     Registered Patients
N     Non-Registered Patients
B     Both Registered and Non-Registered Patients

Include which Patients: B//
```

5. At the “Include which Patients” prompt, type **R**, **N**, or **B** and press Enter.

6. Set the device and right margin when prompted.

Figure 4-38 contains a sample CHR Report No. 9 for the service dates March 22-26, 2013.

```
2010 DEMO HOSPITAL

**********  CHR REPORT NO. 9  **********

DATA SUMMARY BY PROVIDER
PROGRAM:  CHICKASAW (5062027)
PATIENTS: Both Registered and Non-Registered Patients
REPORT DATES:  MAR 22, 2013 TO MAR 26, 2013

**Note:  S&T HRS stands for Service and Travel Hours
ADM Service is defined as service codes AM, LT and OT

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>TOT NUM OF ACTIVITIES</th>
<th>NUMBER SERVED</th>
<th>S&amp;T HRS ALL SRVS</th>
<th>S&amp;T HRS NON ADM</th>
<th>S&amp;T HRS ADM SRV</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>507</td>
<td>104</td>
<td>159</td>
<td>102</td>
<td>57</td>
</tr>
<tr>
<td>PROVIDER,DEMO1</td>
<td>118</td>
<td>28</td>
<td>39</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>PROVIDER,DEMO2</td>
<td>200</td>
<td>38</td>
<td>40</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>PROVIDER,DEMO3</td>
<td>184</td>
<td>38</td>
<td>40</td>
<td>32</td>
<td>8</td>
</tr>
<tr>
<td>PROVIDER,DEMO4</td>
<td>5</td>
<td>0</td>
<td>40</td>
<td>0</td>
<td>40</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0
```

Figure 4-38: Example of a Data Summary by Provider report
4.2.9 CH CHR #13 – Highlights

The local CHR program can compare its scope of work performance over a specified time period by listing the top five reported areas or services as a portion of 100% in the following areas:

- Health areas by time
- Health areas by client contacts
- Services by time
- Patient transportation services against standard values
- Administration/management services against standard values
- Non-specific health area services against standard values
- Individual provider activities by setting, individual versus group encounters in total client contacts

To generate the report:

1. At the “Select CHR Reports Option” prompt, type CH and press Enter. The following sequence displays.

```
*********** CHR REPORT NO. 13 ***********
CHR HIGHLIGHTS REPORT
You must enter the time frame for the report.
```

2. Type the Beginning Date at the “Enter BEGINNING Date of Service for Report” prompt and press Enter.

3. Type the Ending Date at the “Enter ENDING Date of Service for Report” prompt and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter. The following sequence displays:

```
Select one of the following:
   0       One CHR
   A       All CHRs
Include Data for: A// 11 CHRs
```

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
b. Press Enter.

The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
</tr>
<tr>
<td>B</td>
</tr>
</tbody>
</table>

Select Type of Report: L/

6. At the “Select Type of Report” prompt, type L or B and press Enter.

Note: The bar chart requires a printer capable of producing lines that are 132 characters wide.

7. At the “How many entries do you want in the list” prompt, type a number from 5 to 100 and press Enter. The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>B</td>
</tr>
</tbody>
</table>

Include which Patients: B/

8. At the “Include which Patients” prompt, type R, N, or B and press Enter.

9. Set the device and right margin when prompted.

Figure 4-39 contains a sample Highlights report in List format for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>DATE PRINTED: APR 02, 2013</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY HEALTH REPRESENTATIVE REPORT 13 -- HIGHLIGHTS</td>
<td></td>
</tr>
<tr>
<td>TOP 10 HEALTH PROBLEMS AND SERVICES</td>
<td></td>
</tr>
<tr>
<td>PROGRAM: CHICKASAW (5062027)</td>
<td></td>
</tr>
<tr>
<td>PROVIDER: ALL</td>
<td></td>
</tr>
<tr>
<td>PATIENTS: Both Registered and Non-Registered Patients</td>
<td></td>
</tr>
<tr>
<td>REPORTING PERIOD: MAR 22, 2013 TO MAR 26, 2013</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH PROBLEM</th>
<th>SERVICE &amp; TRAVEL</th>
<th>% OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEAVE TIME</td>
<td>48.0</td>
<td>30.2</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>19.1</td>
<td>12.0</td>
</tr>
<tr>
<td>DIABETES MELLITUS</td>
<td>16.4</td>
<td>10.3</td>
</tr>
<tr>
<td>HEART</td>
<td>16.1</td>
<td>10.1</td>
</tr>
<tr>
<td>INJURY CONTROL</td>
<td>11.7</td>
<td>7.3</td>
</tr>
<tr>
<td>ADMINISTRATIVE/MANAGEMENT</td>
<td>8.4</td>
<td>5.3</td>
</tr>
<tr>
<td>NUTRITION</td>
<td>4.6</td>
<td>2.9</td>
</tr>
<tr>
<td>OTHER RESPIRATORY</td>
<td>4.3</td>
<td>2.7</td>
</tr>
<tr>
<td>DIALYSIS</td>
<td>4.0</td>
<td>2.5</td>
</tr>
</tbody>
</table>
4.3 Unduplicated Patient Count Reports

The following reports are available from the Unduplicated Patient Count Reports menu (Figure 4-40):

4.3.1 U1- Unduplicated Patient Counts by CHR

This report will present an unduplicated count of patients seen by provider. To generate the report:

1. At the “Select Unduplicated Patient Count Reports Option” prompt, type U1 and press Enter. The following sequence displays:

```
********** UNDUPLICATED PATIENT REPORT NO. 1 **********
This report will present an unduplicated count of patients seen by CHR.
```
2. At the “Enter BEGINNING Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ENDING Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.

   The following sequence displays:

   Select one of the following:
   
   O  One CHR
   A  All CHRs

   Include Data for: A//

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.

   The following sequence displays:

   Select one of the following:
   
   R  Registered Patients
   N  Non-Registered Patients
   B  Both Registered and Non-Registered Patients

   Include which Patients: B//

6. At the “Include which Patients” prompt, type R, N, or B and press Enter.

7. Set the device and right margin when prompted.

Figure 4-41 contains a sample U1 report for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>CHR</th>
<th># PATIENTS</th>
<th># FEMALES</th>
<th># MALES</th>
<th>SERVICE HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHICKASAW (5062027)</td>
<td>All</td>
<td>Both Registered and Non-Registered Patients</td>
<td>MAR 22, 2013 TO MAR 26, 2013</td>
<td></td>
</tr>
</tbody>
</table>
4.3.2 U2 – Unduplicated Patient Count by Age

This report will present an unduplicated count of patients seen by Age. To generate the report:

1. At the “Select Unduplicated Patient Count Reports Option” prompt, type U2 and press Enter. The following sequence displays:

```
**********  UNDUPLICATED PATIENT REPORT NO. 2  **********

This report will present an unduplicated count of patients seen by PATIENT AGE.
```

2. At the “Enter BEGINNING Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ENDING Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.

The following sequence displays:

```
Select one of the following:

0    One CHR
A    All CHRs

Include Data for: A/
```

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.

The following sequence displays:

```
Select one of the following:

```
6. At the “Include which Patients” prompt, type R, N, or B and press Enter.

7. Set the device and right margin when prompted.

Figure 4-42 contains a sample U2 report for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>PATIENT AGE</th>
<th># PATIENTS</th>
<th># FEMALES</th>
<th># MALES</th>
<th>SERVICE HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>73</td>
<td>41</td>
<td>32</td>
<td>73</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>3%</td>
<td>1 2%</td>
<td>1 3%</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>14</td>
<td>2</td>
<td>3%</td>
<td>1 2%</td>
<td>1 3%</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>26</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>27</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>28</td>
<td>2</td>
<td>3%</td>
<td>0%</td>
<td>2 6%</td>
</tr>
<tr>
<td>32</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>36</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>37</td>
<td>2</td>
<td>3%</td>
<td>2 5%</td>
<td>0%</td>
</tr>
<tr>
<td>39</td>
<td>2</td>
<td>3%</td>
<td>0%</td>
<td>2 6%</td>
</tr>
<tr>
<td>40</td>
<td>3</td>
<td>4%</td>
<td>2 5%</td>
<td>1 3%</td>
</tr>
<tr>
<td>42</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>43</td>
<td>2</td>
<td>3%</td>
<td>1 2%</td>
<td>1 3%</td>
</tr>
<tr>
<td>44</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>50</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>51</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>56</td>
<td>2</td>
<td>3%</td>
<td>2 5%</td>
<td>0%</td>
</tr>
<tr>
<td>60</td>
<td>1</td>
<td>1%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>61</td>
<td>1</td>
<td>1%</td>
<td>0%</td>
<td>1 3%</td>
</tr>
<tr>
<td>63</td>
<td>3</td>
<td>4%</td>
<td>2 5%</td>
<td>1 3%</td>
</tr>
</tbody>
</table>
4.3.3 U3 – Unduplicated Patient Counts by Gender

This report will present an unduplicated count of patients seen by Gender. To generate the report:

1. At the “Select Unduplicated Patient Count Reports Option” prompt, type U3 and press Enter. The following sequence displays:

```
********** UNDUPLICATED PATIENT REPORT NO. 3 **********
This report will present an unduplicated count of patients seen by GENDER.
```

2. At the “Enter BEGINNING Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ENDING Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.
   The following sequence displays:

```
Select one of the following:
O   One CHR
A   All CHRs
Include Data for: A/
```

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.
   The following sequence displays:

```
Select one of the following:
R   Registered Patients
```
6. At the “Include which Patients” prompt, type R, N, or B and press Enter.

7. Set the device and right margin when prompted.

Figure 4-43 contains a sample U3 report for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>GENDER</th>
<th># PATIENTS</th>
<th># FEMALES</th>
<th># MALES</th>
<th>SERVICE HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>73 100%</td>
<td>41 100%</td>
<td>32 100%</td>
<td>73 100%</td>
</tr>
<tr>
<td>FEMALE</td>
<td>41 56%</td>
<td>41 100%</td>
<td>0%</td>
<td>40 55%</td>
</tr>
<tr>
<td>MALE</td>
<td>32 44%</td>
<td>0%</td>
<td>32 100%</td>
<td>33 45%</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

Figure 4-43: Example of an Unduplicated Patient Count by Gender report

4.3.4 U4 – Unduplicated Patient Count by Tribe

This report will present an unduplicated count of patients seen by Tribe. To generate the report:

1. At the “Select Unduplicated Patient Count Reports Option” prompt, type U4 and press Enter. The following sequence displays:

   *********** UNDUPLICATED PATIENT REPORT NO. 4 ***********
   This report will present an unduplicated count of patients seen by TRIBE.

2. At the “Enter BEGINNING Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ENDING Date of Service for report” prompt, type the desired end date and press Enter.
4. At the “Include data from ALL CHR Programs?” prompt, type **YES** or **NO** and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.

   The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O  One CHR</td>
</tr>
<tr>
<td>A  All CHRs</td>
</tr>
</tbody>
</table>

   Include Data for: A/

5. At the “Include Data for” prompt, type **O** or **A** and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.

   The following sequence displays:

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R  Registered Patients</td>
</tr>
<tr>
<td>N  Non-Registered Patients</td>
</tr>
<tr>
<td>B  Both Registered and Non-Registered Patients</td>
</tr>
</tbody>
</table>

   Include which Patients: B/

6. At the “Include which Patients” prompt, type **R**, **N**, or **B** and press Enter.

7. Set the device and right margin when prompted.

Figure 4-44 contains a sample U4 report for the service dates March 22-26, 2013.
4.3.5 U5 – Unduplicated Patient Count by Program

This report will present an unduplicated count of patients seen by Program. To generate the report:

1. At the “Select Unduplicated Patient Count Reports Option” prompt, type U5 and press Enter. The following sequence displays:

   **********  UNDUPLICATED PATIENT REPORT NO. 5  **********
   This report will present an unduplicated count of patients seen by PROGRAM.

2. At the “Enter BEGINNING Date of Service for report” prompt, type the desired start date and press Enter.

3. At the “Enter ENDING Date of Service for report” prompt, type the desired end date and press Enter.

4. At the “Include data from ALL CHR Programs?” prompt, type YES or NO and press Enter. If NO was selected:
   a. At the “Which CHR Program” prompt, type the CHR program name.
   b. Press Enter.
   The following sequence displays:

   Select one of the following:
   O One CHR
   A All CHRs

   Include Data for: A/

5. At the “Include Data for” prompt, type O or A and press Enter. If O was selected:
   a. At the prompt, type the CHR’s name.
   b. Press Enter.
The following sequence displays:

Select one of the following:

R  Registered Patients
N  Non-Registered Patients
B  Both Registered and Non-Registered Patients

Include which Patients: B//

6. At the “Include which Patients” prompt, type R, N, or B and press Enter.

7. Set the device and right margin when prompted.

Figure 4-45 contains a sample U5 report for the service dates March 22-26, 2013.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th># PATIENTS</th>
<th># FEMALES</th>
<th># MALES</th>
<th>SERVICE HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>73 100%</td>
<td>41 100%</td>
<td>32 100%</td>
<td>73 100%</td>
</tr>
<tr>
<td>CHICKASAW 5062027</td>
<td>73 100%</td>
<td>41 100%</td>
<td>32 100%</td>
<td>73 100%</td>
</tr>
</tbody>
</table>

RUN TIME (H.M.S): 0.0.0

Figure 4-45: Example of an Unduplicated Patient Count by Program report

4.4 Non-Registered Patient List

This report will generate a list of Non-Registered Patients who have been provided a service by the CHRs in the past number of years defined by the user.

********** NON-REGISTERED PATIENT LIST **********

This report will list all Non-Registered Patients in the CHR Non-Registered patient file who have been seen in the last N number of years you indicate. The list will be sorted by DOB, NAME, TRIBE, COMMUNITY

Please enter the number of years to determine if the patient should be listed on the report. For example, if you want all patients who have been seen in the past 5 years enter 5.

List patients seen in the past how many years?: (1-100): 10//
Figure 4-46: Non-Registered Patient List prompt

Sample:

CIMARRON COMMUNITY HOSPITAL

**********  LIST OF NON-REGISTERED PATIENTS  **********
SEEN BY THE CHR PROGRAM SINCE APR 08, 2002

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>SEX</th>
<th>TRIBE</th>
<th>COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT,DEMO2</td>
<td>02/03/40</td>
<td>M</td>
<td>TOHONO O'ODHAM</td>
<td>SELL</td>
</tr>
<tr>
<td>PATIENT,DEMO3</td>
<td>02/03/40</td>
<td>F</td>
<td>CHOCTAW NATION</td>
<td>JAY</td>
</tr>
<tr>
<td>PATIENT,DEMO4</td>
<td>02/03/40</td>
<td>F</td>
<td>CHOCTAW NATION</td>
<td>ADA</td>
</tr>
</tbody>
</table>

Figure 4-47: Example Non-Registered Patient List

4.5 Print CHR Standard Tables

The following report options print the CHR standard tables listed.

<table>
<thead>
<tr>
<th>MNEMONIC</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>Print Activity Location Table</td>
</tr>
<tr>
<td>FP</td>
<td>Print Family Planning Method Table</td>
</tr>
<tr>
<td>PG</td>
<td>Print CHR Programs Table</td>
</tr>
<tr>
<td>RF</td>
<td>Print Referrals Table</td>
</tr>
<tr>
<td>SC</td>
<td>Print Service Code Table</td>
</tr>
</tbody>
</table>

Figure 4-48: CHR Standard Tables menu

To print any of these tables, enter the corresponding mnemonic and press Enter. You can then select how you want the table sorted. The default value for the sort prompt is Name. To see the other options available, type a question mark (?) and press Enter.

These reports are displayed in Figure 4-49.
<table>
<thead>
<tr>
<th>NAME</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIRTH CONTROL PILLS</td>
<td>3</td>
</tr>
<tr>
<td>CERVICAL CAP</td>
<td>5</td>
</tr>
<tr>
<td>CONDOM</td>
<td>4</td>
</tr>
<tr>
<td>DEPO PROVERA HORMONE</td>
<td>12</td>
</tr>
<tr>
<td>DIAPHRAGM</td>
<td>10</td>
</tr>
<tr>
<td>IUD</td>
<td>8</td>
</tr>
<tr>
<td>MORNING AFTER</td>
<td>14</td>
</tr>
<tr>
<td>NOT NEEDED</td>
<td>1</td>
</tr>
<tr>
<td>NOT USED</td>
<td>2</td>
</tr>
<tr>
<td>OVULATION/RHYTHM</td>
<td>9</td>
</tr>
<tr>
<td>SPONGE/SPERMICIDE</td>
<td>6</td>
</tr>
<tr>
<td>TUBAL LIGATION</td>
<td>7</td>
</tr>
<tr>
<td>VASECTOMY</td>
<td>11</td>
</tr>
</tbody>
</table>

**CHR REFERRALS LIST**

<table>
<thead>
<tr>
<th>NAME</th>
<th>MNEMONIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGENCY/PROGRAM</td>
<td>AP</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH</td>
<td>BH</td>
</tr>
<tr>
<td>CHR</td>
<td>CH</td>
</tr>
<tr>
<td>DENTAL</td>
<td>DN</td>
</tr>
<tr>
<td>EYE</td>
<td>EY</td>
</tr>
<tr>
<td>FAMILY/SELF/COMMUNITY</td>
<td>FS</td>
</tr>
<tr>
<td>MEDICAL</td>
<td>MD</td>
</tr>
<tr>
<td>NOT APPLICABLE</td>
<td>NA</td>
</tr>
<tr>
<td>NURSING</td>
<td>NR</td>
</tr>
<tr>
<td>OTHER PROFESSIONALS</td>
<td>OP</td>
</tr>
<tr>
<td>SOCIAL WORKER</td>
<td>SW</td>
</tr>
<tr>
<td>TECHNICIAN</td>
<td>TN</td>
</tr>
</tbody>
</table>

**CHR SERVICE CODES LIST**

<table>
<thead>
<tr>
<th>NAME</th>
<th>MNEMONIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMINISTRATION/MANAGEMENT</td>
<td>AM</td>
</tr>
<tr>
<td>CASE FINDING/SCREENING</td>
<td>CF</td>
</tr>
<tr>
<td>CASE MANAGEMENT</td>
<td>CM</td>
</tr>
<tr>
<td>COMMUNITY DEVELOPMENT</td>
<td>CD</td>
</tr>
<tr>
<td>EMERGENCY CARE</td>
<td>EC</td>
</tr>
<tr>
<td>ENVIRONMENTAL SERVICE</td>
<td>ES</td>
</tr>
<tr>
<td>HEALTH EDUCATION</td>
<td>HE</td>
</tr>
<tr>
<td>HOMEMAKER SERVICES</td>
<td>HS</td>
</tr>
<tr>
<td>INTERPRET/TRANSLATE</td>
<td>IT</td>
</tr>
<tr>
<td>LEAVE TIME</td>
<td>LT</td>
</tr>
<tr>
<td>MONITOR PATIENT</td>
<td>MP</td>
</tr>
<tr>
<td>NOT FOUND</td>
<td>NF</td>
</tr>
<tr>
<td>OBTAIN TRAINING</td>
<td>OT</td>
</tr>
<tr>
<td>OTHER EDUCATION</td>
<td>OE</td>
</tr>
<tr>
<td>OTHER PATIENT SERVICE</td>
<td>OP</td>
</tr>
<tr>
<td>PATIENT CARE</td>
<td>PC</td>
</tr>
<tr>
<td>TRANSPORT PATIENT</td>
<td>TP</td>
</tr>
<tr>
<td>STAFF TRAINING</td>
<td>ST</td>
</tr>
</tbody>
</table>

Figure 4-49: CHR Standard Tables List report
5.0 Manager Utilities

This section provides instructions on using the Manager Utilities available in the RPMS CHR/PCC system. These utilities include functions to update site parameters for the system, download patient demographics to the remote computers, and export data to the CHR system.

The following utilities are available from the Manager Utilities menu:

```
DEMO HOSPITAL/CLINIC
Version 1.0
EXP    Export Utility Menu ...
MNR    Merge Two Non-Registered Duplicate Patients
NRL    Non-Registered Patient List
SITE   Update Site Parameters
```

Figure 5-1: Manager Utilities menu

- The Export Utility Menu and its options are described in Section 5.1.
- The Merge Two Non-Registered Duplicate Patients option is described in Section 5.2.
- The Non-Registered Patient List option is described in Section 5.3.
- The Update Site Parameters option is described in Section 5.4.

5.1 Export Utility Menu

This set of options is used to export data to the National CHR Reporting system. At a specified interval, which will be defined by your Area CHR Coordinator, export the data that has been entered into the computer to the National CHR Reporting System. This interval may be weekly, monthly, or quarterly. Contact the Area CHR Coordinator for the interval to be used in your Area.

The export process can be handled one of two ways. The first, and by far the easiest, is to have the RPMS Site Manager schedule a task called “BCH EXPORT GENERATE TXS” to run automatically at the indicated interval time. The second way to perform an export is to execute the option called GEN – Generate Transactions once a week, once a month, or at whatever interval has been defined.
To access the export menu, type **EXP** and press Enter. The CHR Export Utility menu (Figure 5-2) displays.

```
********************************************
**     RPMS CHR/PCC REPORTING SYSTEM      **
**          CHR Export Utility           **
********************************************
DEMO HOSPITAL/CLINIC
Version 2.0

<table>
<thead>
<tr>
<th>Command</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GEN</td>
<td>Generate CHR Transactions for HQ</td>
</tr>
<tr>
<td>DISP</td>
<td>Display a Log Entry</td>
</tr>
<tr>
<td>RGEN</td>
<td>Re-generate Transactions</td>
</tr>
<tr>
<td>RSET</td>
<td>Re-set Data Export Log</td>
</tr>
<tr>
<td>CHK</td>
<td>Check Records Before Export</td>
</tr>
<tr>
<td>ERRS</td>
<td>Print Error List for Export</td>
</tr>
<tr>
<td>OUTP</td>
<td>Create OUTPUT File</td>
</tr>
</tbody>
</table>
```

Figure 5-2: Export Utility menu

### 5.1.1 GEN – Generate CHR Transactions for HQ

Follow these steps to export data to the National CHR Reporting system.

1. Determine at what interval (weekly or monthly) the export should be performed.

2. Choose one of the following:
   - Request that the Site Manager schedule the generation of the transactions at the appropriate interval. If done, proceed to Step 5.
   - Type **GEN** and press Enter. The following sequence displays:

   This routine will generate CHR records to be sent to HQ.
   The data transmitted will include everything entered since the last time data was exported up until yesterday.
   You may "^" out at any prompt and will be asked to confirm your entries prior to generating transactions.
   Last run was for JAN 1,2000 through SEP 1,2011.
   The inclusive dates for this run are SEP 2,2011 through APR 4,2012.
   The location for this run is DEMO HOSPITAL.
   Do you want to continue? N//

3. At the “Do you want to continue?” prompt, type **YES** and press Enter. The following sequence displays:

   Generating New Log entry..
   Do you want to QUEUE this to run at a later time? N//

4. At the “Do you want to QUEUE this to run at a later time?” prompt, type **NO** and press Enter. The following sequence displays:
Generating transactions. Counting records. (9)

12 transactions were generated.
Updating log entry.
Deleting cross-reference entries. (9)

RUN TIME (H.M.S): 0.0.4
Please Standby - Copying Data to File /usr/spool/uucppublic/BCHR000101.150

This filename is very important. You should now let the Site Manager know that the export file has been created. Give this file name to the Site Manager to send it to the Area Office. If your site is set up for auto sending the file you do not need to do this step.

-->There are more than twelve generations of CHR RECORDs stored in the LOG file.
-->Time to do a purge.

DONE -- Press RETURN to Continue:

5. Press Enter at the “Press RETURN to Continue” prompt.

6. To display this log entry, follow the instructions in Section 5.1.2.

5.1.2 DISP – Display a Log Entry

1. Display the log entry. To do this, enter DISP at the Export Utilities menu prompt and press Enter.

Select CHR EXTRACT LOG BEGINNING DATE: (press the space bar here) 10-21-2011

DEVICE: HOME://

Information for Log Entry 14 Beginning Date: OCT 21,2011

NUMBER: 14 BEGINNING DATE: OCT 21, 2011
ENDING DATE: OCT 28, 2011
RUN START DATE/TIME: OCT 29, 2011@11:19:38
RUN STOP DATE/TIME: OCT 29, 2011@11:19:41
COUNT OF ERRORS: 0 COUNT OF TRANSACTIONS: 12
COUNT OF RECORDS PROCESSED: 9 RUN LOCATION: SELLS HOSPITAL/CLINIC
UPDATES: 12 DELETES: 0
TRANSMISSION STATUS: SUCCESSFULLY COMPLETED

Figure 5-3: Example of displaying a log entry

The above log entry shows you how many records were processed, how many transactions were generated, how many errors occurred, and which dates were included in this transmission. It is recommended that you save a copy of these log entries in a folder for future reference.

2. If any errors occurred, print the list of errors and correct.
To print the error list, type **ERRS** at the Export Utilities menu prompt and press Enter. Note that there were no errors for this export.

```
Select CHR EXTRACT LOG BEGINNING DATE: hit a space bar here or enter the log number
No TX errors generated on that run.
```

Figure 5-4: Printing the error list

### 5.1.3 RGEN Re-Generate Transactions

If a file of transactions is lost or unreadable by the National CHR software, there may be a need to re-generate a set of transactions. To do this, enter **RGEN** at the Export Utility menu prompt and press Enter. The following segment displays.

At the “Select CHR EXTRACT LOG BEGINNING DATE” prompt, enter the log number of the log to be reprocessed.

```
Log entry 14 was for date range May 21, 2011 through May 28, 2011 and generated 12 transactions from 9 records.

This routine will generate CHR transactions.
Do you want to regenerate the transactions for this run? N// YES
Do you want to QUEUE this to run at a later time? N//
Generating transactions. Counting visits. (9)
12 transactions were generated.
Updating Log entry.
RUN TIME (H.M.S): 0.0.1
-->There are more than three generations of RECORDs stored in the LOG file.
-->Time to do a purge.
Resetting RECORD specific data in Log file. (9)
Resetting Record TX Flags. (9)
Please Standby – Copying Data to File /usr/spool/uucppublic/BCHR000101.150
```

Figure 5-5: Example of regenerating a set of transactions

The filename that appears at the end of the dialog is very important. Let the Site Manager know that the export file has been created. Give the file name to the Site Manager who will send the file to the Area Office.
5.1.4 RSET Re-set Data Export Log
This option will only be used by the RPMS Site Manager and will be done so only if an export did not complete successfully.

5.1.5 CHK Check Records Before Export
Before you do a GEN (Generate Transactions) you can use this option to check to see if any CHR records contain errors. If there are errors you can correct them using the Edit Record option under the Data Entry set of menu options.

5.1.6 ERRS Print Error List for Export
This option can be run to create a list of all errors encountered on an export. If there are records listed, the error should be edited and corrected using the Edit Record option under the Data Entry set of menu options.

5.2 Merge Two Non-Registered Duplicate Patients

```
Select Manager Utilities Option: M  Merge Two Non-Registered Duplicate Patients

This option is used to merge two Non-Registered Patients who are in the file as duplicates. You will be asked to select the two patients who are duplicates. If one patient has a data value such as Tribe and the other doesn't the system will use the Tribe value from the patient with Tribe recorded. If both patients have a data value and they are different you will be asked to choose which value to use. Values looked at are: DOB, Sex, SSN, Name, Tribe, Community of Residence.

Please select the first patient of the set of duplicates.

Select CHR NON REGISTERED PATIENTS PATIENT NAME: HOTHEAD,IMA
  1  HOTHEAD,IMA             05-05-1925     FEMALE     WASHOE TRIBE OF NV, CA
      WEWOKA     CHR261
  2  HOTHEAD,IMA LIL         05-05-1925     FEMALE     WASHOE TRIBE OF NV, CA
      WEWOKA     CHR262
CHOOSE 1-2: 2  HOTHEAD,IMA LIL   05-05-1925     FEMALE     WASHOE TRIBE OF NV, CA
      WEWOKA     CHR262

Please select the second patient of the set of duplicates.

Select CHR NON REGISTERED PATIENTS PATIENT NAME:
```

5.3 Non-Registered Patient List

```
*************** NON-REGISTERED PATIENT LIST ***************

This report will list all Non-Registered Patients in the CHR Non-Registered patient file who have been seen in the last N number of years you indicate. The list will be sorted by DOB, NAME, TRIBE, COMMUNITY

Please enter the number of years to determine if the patient should be listed on the report. For example, if you want all patients who have been seen in the past 5 years enter 5.
```
**5.4 SITE Update Site Parameters**

Before using the RPMS CHR/PCC Information and Reporting System, the site parameters need to be set. To set-up these parameters:

1. Type **SITE** and press Enter.

2. At the “Select CHR SITE PARAMETERS” prompt, type the site’s name. and press Enter. The word “SITE” displays followed by the site name.

3. Press Enter.

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOB</th>
<th>SEX</th>
<th>TRIBE</th>
<th>COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARLTON, GEORGE</td>
<td>01/01/19</td>
<td>M</td>
<td>WASHOE TRIBE OF ADA</td>
<td></td>
</tr>
<tr>
<td>FILES, RICE</td>
<td>02/17/25</td>
<td>M</td>
<td>CHICKASAW NATIO ADA</td>
<td></td>
</tr>
<tr>
<td>BROCK, NOAH</td>
<td>07/01/29</td>
<td>M</td>
<td>CHOCTAW NATION, DURANT</td>
<td></td>
</tr>
<tr>
<td>BOW, NOW</td>
<td>02/14/30</td>
<td>M</td>
<td>APACHE TRIBE, O BEMIDJI</td>
<td></td>
</tr>
<tr>
<td>BONKAR, VERNON</td>
<td>01/02/40</td>
<td>M</td>
<td>CHICKASAW NATIO PURCELL</td>
<td></td>
</tr>
<tr>
<td>BRODYCK, ELVIS</td>
<td>01/02/40</td>
<td>M</td>
<td>CHICKASAW NATIO PURCELL</td>
<td></td>
</tr>
<tr>
<td>BONKAR, VELMA</td>
<td>01/03/40</td>
<td>F</td>
<td>CHICKASAW NATIO PURCELL</td>
<td></td>
</tr>
<tr>
<td>WEDANEH, JERRY LEE</td>
<td>01/04/40</td>
<td>F</td>
<td>CHICKASAW NATIO PURCELL</td>
<td></td>
</tr>
<tr>
<td>ANGLOND, KAREN S</td>
<td>01/06/40</td>
<td>F</td>
<td>CHICKASAW NATIO PURCELL</td>
<td></td>
</tr>
<tr>
<td>ANGLOND, KELLY A</td>
<td>01/07/40</td>
<td>F</td>
<td>CHICKASAW NATIO PURCELL</td>
<td></td>
</tr>
<tr>
<td>BOFFNGTUN, DARLA J</td>
<td>01/08/40</td>
<td>F</td>
<td>CHICKASAW NATIO PURCELL</td>
<td></td>
</tr>
<tr>
<td>PONCE, ANDREANNA</td>
<td>02/02/72</td>
<td>F</td>
<td>KIOWA INDIAN TR SHAWNEE</td>
<td></td>
</tr>
<tr>
<td>ESTRELLA, JENNIFERLIN</td>
<td>10/12/75</td>
<td>F</td>
<td>TOHONO O'ODHAM SAN LUCY VIL</td>
<td></td>
</tr>
<tr>
<td>CAT, TOM</td>
<td>02/05/76</td>
<td>M</td>
<td>CHICKASAW NATIO PAULS VALLEY</td>
<td></td>
</tr>
<tr>
<td>ON, TOP</td>
<td>04/06/76</td>
<td>M</td>
<td>TOHONO O'ODHAM SELLS</td>
<td></td>
</tr>
<tr>
<td>ROMANNOSE, L</td>
<td>01/01/78</td>
<td>F</td>
<td>CHEYENNE-ARAPAHA WATONGA</td>
<td></td>
</tr>
<tr>
<td>MILLER, AGNES ANN</td>
<td>05/05/05</td>
<td>F</td>
<td>TOHONO O'ODHAM TUCSON</td>
<td></td>
</tr>
<tr>
<td>YARD, BYA</td>
<td>05/05/05</td>
<td>M</td>
<td>TULALIP TRIBE, PORTLAND</td>
<td></td>
</tr>
<tr>
<td>DAVIS, TATIN</td>
<td>09/12/06</td>
<td>F</td>
<td>SEMINOLE NATION MUSKOGEE</td>
<td></td>
</tr>
<tr>
<td>CANDY, BILLY</td>
<td>01/21/07</td>
<td>M</td>
<td>HOPI TRIBE, AZ SANTA ROSA</td>
<td></td>
</tr>
<tr>
<td>SEED, POOPPY</td>
<td>03/19/08</td>
<td>F</td>
<td>TOHONO O'ODHAM SELLS</td>
<td></td>
</tr>
<tr>
<td>SLOWDOWN, JOE H</td>
<td>03/24/08</td>
<td>M</td>
<td>CADDIO TRIBE IND SULPHUR</td>
<td></td>
</tr>
<tr>
<td>ZABALO-LOPEZ, SUMO</td>
<td>04/14/08</td>
<td>M</td>
<td>TOHONO O'ODHAM VAYA CHIN</td>
<td></td>
</tr>
<tr>
<td>DAVIS, WYLIE</td>
<td>01/04/09</td>
<td>M</td>
<td>SEMINOLE NATION SEMINOLE</td>
<td></td>
</tr>
</tbody>
</table>

End of report.
Appendix A: Helpful Tips

- Type two question marks (??) in the CHR PCC package and press Enter to find out more information.
- Keep CAPS lock on while doing data entry.
- The mouse does not work in the CHR PCC package.
- When entering data in the computer, use the Enter key. When not entering data use the TAB key or arrow keys to navigate around.
- When entering data on the IHS-535 COMPREHENSIVE Form, skip or jump over the word processing sections in the Subjective, Objective, and Plans/Treatments/Education/Medications using the tab key.
- To exit the word processing sections, press F1, E.
- For the IHS-535 Comprehensive Form – At the Subjective, Objective, and Plans/Treatment/Education/Medications word processing field, the Line Text Editor displays with numbered lines such as:
  
| >1 |
| >2 |
| >3 |

Change to the Full Screen Editor. Ask the IT Staff or Site Manager for help.

a. Step back through the system to the CHR PCC form selection prompt; type TBOX and press enter.

b. Choose Edit User Characteristics, and press Enter. A prompt for Terminal Type displays; press Enter.

c. Tab to the PREFERRED EDITOR field and type SCREEN EDITOR.

d. Press F1, E to exit. It may be necessary to log out and log in again for the change to take place.

- Even with Caps Lock on, it is necessary to press the Shift key to use any of the special characters above the numbers.
- Press F1, H to open ScreenMan help.
- For each form, after entering a health problem code once, enclose duplicate health problem codes in quotation marks, e.g., “DM”.
- When entering in the Subjective, Objective, or Plans/Treatments section on the Comprehensive Form the screen can look the same. Check the title on the page to determine which section is in use. For example, it will read <Subjective> when in the Subjective section.
• When entering a patient’s name, Tribe, or community, type the first few letters of each and press enter to view a list from which to choose.

| Data Entry Note: | When entering data into the assessment section (HPC-SC-SM-Narrative) the enter key should be used to move from one field to another to ensure all required fields are entered. Using the tab key will allow user to bypass the narrative. |
Appendix B: ScreenMan Help – Crib Sheet

B.1 Command Line Options

(Enter carat (^) at any field to jump to the command line)

<table>
<thead>
<tr>
<th>Command</th>
<th>Shortcut</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXIT</td>
<td>&lt;F1 E&gt;</td>
<td>Exit form (asks whether changes should be saved)</td>
</tr>
<tr>
<td>CLOSE</td>
<td>&lt;F1&gt;C</td>
<td>Close window &amp; return to previous level</td>
</tr>
<tr>
<td>SAVE</td>
<td>&lt;F1&gt;S</td>
<td></td>
</tr>
<tr>
<td>NEXT PAGE</td>
<td>&lt;F1&gt;&lt;Down&gt;</td>
<td>Go to next page</td>
</tr>
<tr>
<td>REFRESH</td>
<td>&lt;F1&gt;R</td>
<td>Repaint screen</td>
</tr>
</tbody>
</table>

B.2 Other Shortcut Keys

<table>
<thead>
<tr>
<th>Action</th>
<th>Shortcut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exit form and save changes</td>
<td>&lt;F1&gt;E</td>
</tr>
<tr>
<td>Quit form without saving changes</td>
<td>&lt;F1&gt;Q</td>
</tr>
<tr>
<td>Invoke Record Selection Page</td>
<td>&lt;F1&gt;L</td>
</tr>
</tbody>
</table>

B.3 Cursor Movement

<table>
<thead>
<tr>
<th>Action</th>
<th>Shortcut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move right one character</td>
<td>&lt;Right arrow&gt;</td>
</tr>
<tr>
<td>Move left one character</td>
<td>&lt;Left arrow&gt;</td>
</tr>
<tr>
<td>Move right one word</td>
<td>&lt;Ctrl-L&gt; or &lt;F1&gt;&lt;Space&gt;</td>
</tr>
<tr>
<td>Move left one word</td>
<td>&lt;Ctrl-J&gt;</td>
</tr>
<tr>
<td>Move to right of window</td>
<td>&lt;F1&gt;&lt;Right&gt;</td>
</tr>
<tr>
<td>Move to left of window</td>
<td>&lt;F1&gt;&lt;Left&gt;</td>
</tr>
<tr>
<td>Move to end of field</td>
<td>&lt;F1&gt;&lt;F1&gt;&lt;Right&gt;</td>
</tr>
<tr>
<td>Move to beginning of field</td>
<td>&lt;F1&gt;&lt;F1&gt;&lt;Left&gt;</td>
</tr>
</tbody>
</table>

B.4 Modes

<table>
<thead>
<tr>
<th>Action</th>
<th>Shortcut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert/Replace toggle</td>
<td>&lt;PF3&gt;</td>
</tr>
<tr>
<td>Zoom (invoke multiline editor)</td>
<td>&lt;F1&gt;Z</td>
</tr>
</tbody>
</table>
### B.5 Deletions

<table>
<thead>
<tr>
<th>Action</th>
<th>Shortcut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Character under cursor</td>
<td>&lt;PF2&gt; or &lt;Delete&gt;</td>
</tr>
<tr>
<td>Character left of cursor</td>
<td>&lt;Backspace&gt;</td>
</tr>
<tr>
<td>From cursor to end of word</td>
<td>&lt;Ctrl-W&gt;</td>
</tr>
<tr>
<td>From cursor to end of field</td>
<td>&lt;F1&gt;&lt;PF2&gt;</td>
</tr>
<tr>
<td>Toggle null/last edit/default</td>
<td>&lt;F1&gt;D or &lt;Ctrl-U&gt;</td>
</tr>
</tbody>
</table>

### B.6 Macro Movement

<table>
<thead>
<tr>
<th>Action</th>
<th>Shortcut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field below</td>
<td>&lt;Down&gt;</td>
</tr>
<tr>
<td>Next page</td>
<td>&lt;F1&gt;&lt;Down&gt; or: &lt;PageDown&gt;</td>
</tr>
<tr>
<td>Field above</td>
<td>&lt;Up&gt;</td>
</tr>
<tr>
<td>Previous page</td>
<td>&lt;F1&gt;&lt;Up&gt; or: &lt;PageUp&gt;</td>
</tr>
<tr>
<td>Field to right</td>
<td>&lt;Tab&gt;</td>
</tr>
<tr>
<td>Next block</td>
<td>&lt;F1&gt;&lt;PF4&gt;</td>
</tr>
<tr>
<td>Field to left</td>
<td>&lt;PF4&gt;</td>
</tr>
<tr>
<td>Jump to a field</td>
<td>^FieldName</td>
</tr>
<tr>
<td>Pre-defined order</td>
<td>&lt;Enter&gt;</td>
</tr>
<tr>
<td>Go to Command Line</td>
<td>^</td>
</tr>
<tr>
<td>Go into multiple or word processing field</td>
<td>&lt;Enter&gt;</td>
</tr>
</tbody>
</table>
Appendix C: Full Screen Editor – Crib Sheet

C.1 Navigation

<table>
<thead>
<tr>
<th>Action</th>
<th>Key Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incremental movement</td>
<td>Arrow keys</td>
</tr>
<tr>
<td>One word left</td>
<td>&lt;Ctrl-J&gt;</td>
</tr>
<tr>
<td>One word right</td>
<td>&lt;Ctrl-L&gt;</td>
</tr>
<tr>
<td>Next tab stop to the right</td>
<td>&lt;Tab&gt;</td>
</tr>
<tr>
<td>Jump left</td>
<td>&lt;F1&gt;&lt;Left&gt;</td>
</tr>
<tr>
<td>Jump right</td>
<td>&lt;F1&gt;&lt;Right&gt;</td>
</tr>
<tr>
<td>Beginning of line</td>
<td>&lt;F1&gt;&lt;F1&gt;&lt;Left&gt;</td>
</tr>
<tr>
<td>End of line</td>
<td>&lt;F1&gt;&lt;F1&gt;&lt;Right&gt;</td>
</tr>
<tr>
<td>Screen up</td>
<td>&lt;F1&gt;&lt;Up&gt; or: &lt;PrevScr&gt; or: &lt;PageUp&gt;</td>
</tr>
<tr>
<td>Screen down</td>
<td>&lt;F1&gt;&lt;Down&gt; or: &lt;NextScr&gt; or: &lt;PageDown&gt;</td>
</tr>
<tr>
<td>Top of document</td>
<td>&lt;F1&gt;T</td>
</tr>
<tr>
<td>Bottom of document</td>
<td>&lt;F1&gt;B</td>
</tr>
<tr>
<td>Go to a specific location</td>
<td>&lt;F1&gt;G</td>
</tr>
</tbody>
</table>

C.2 Exiting/Saving

<table>
<thead>
<tr>
<th>Action</th>
<th>Key Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exit and save text</td>
<td>&lt;F1&gt;E</td>
</tr>
<tr>
<td>Quit without saving</td>
<td>&lt;F1&gt;Q</td>
</tr>
<tr>
<td>Exit, save, and switch editors</td>
<td>&lt;F1&gt;A</td>
</tr>
<tr>
<td>Save without exiting</td>
<td>&lt;F1&gt;S</td>
</tr>
</tbody>
</table>

C.3 Deleting

<table>
<thead>
<tr>
<th>Action</th>
<th>Key Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Character before cursor</td>
<td>&lt;Backspace&gt;</td>
</tr>
</tbody>
</table>
### C.4 Settings/Modes

<table>
<thead>
<tr>
<th>Action</th>
<th>Key Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrap/narrow mode toggle</td>
<td>&lt;PF2&gt;</td>
</tr>
<tr>
<td>Insert/replace mode toggle</td>
<td>&lt;PF3&gt;</td>
</tr>
<tr>
<td>Set/clear tab stop</td>
<td>&lt;F1&gt;&lt;Tab&gt;</td>
</tr>
<tr>
<td>Set left margin</td>
<td>&lt;F1&gt;,</td>
</tr>
<tr>
<td>Set right margin</td>
<td>&lt;F1&gt;.</td>
</tr>
<tr>
<td>Status line toggle</td>
<td>&lt;F1&gt;?</td>
</tr>
</tbody>
</table>

### C.5 Formatting

<table>
<thead>
<tr>
<th>Action</th>
<th>Key Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Join current line to next line</td>
<td>&lt;F1&gt;J</td>
</tr>
<tr>
<td>Reformat paragraph</td>
<td>&lt;F1&gt;R</td>
</tr>
</tbody>
</table>

### C.6 Finding

<table>
<thead>
<tr>
<th>Action</th>
<th>Key Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find text</td>
<td>&lt;F1&gt;F</td>
</tr>
<tr>
<td>or:</td>
<td>&lt;Find&gt;</td>
</tr>
<tr>
<td>Find next occurrence of text</td>
<td>&lt;F1&gt;N</td>
</tr>
<tr>
<td>Find/Replace text</td>
<td>&lt;F1&gt;P</td>
</tr>
</tbody>
</table>

### C.7 Cutting/Copying/Pasting

<table>
<thead>
<tr>
<th>Action</th>
<th>Key Sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select (Mark) text</td>
<td>&lt;F1&gt;M at beginning and end of text</td>
</tr>
<tr>
<td>Deselect (Unmark) text</td>
<td>&lt;F1&gt;&lt;F1&gt;M</td>
</tr>
<tr>
<td>Action</td>
<td>Key Sequence</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Delete selected text</td>
<td>&lt;Delete&gt;</td>
</tr>
<tr>
<td></td>
<td>or:</td>
</tr>
<tr>
<td></td>
<td>&lt;Backspace&gt; on selected text</td>
</tr>
<tr>
<td>Cut and save to buffer</td>
<td>&lt;F1&gt;X on selected text</td>
</tr>
<tr>
<td>Copy and save to buffer</td>
<td>&lt;F1&gt;C on selected text</td>
</tr>
<tr>
<td>Paste from buffer</td>
<td>&lt;F1&gt;V</td>
</tr>
<tr>
<td>Move text to another location</td>
<td>&lt;F1&gt;X at new location</td>
</tr>
<tr>
<td>Copy text to another location</td>
<td>&lt;F1&gt;C at new location</td>
</tr>
</tbody>
</table>
Appendix D: Rules of Behavior

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

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

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

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

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

D.1 All RPMS Users

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

D.1.1 Access

RPMS users shall

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

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
• Access, research, or change any user account, file, directory, table, or record not required to perform their official duties.

• Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.

• Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

D.1.2 Information Accessibility

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

RPMS users shall

• Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.

• Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

D.1.3 Accountability

RPMS users shall

• Behave in an ethical, technically proficient, informed, and trustworthy manner.

• Log out of the system whenever they leave the vicinity of their personal computers (PCs).

• Be alert to threats and vulnerabilities in the security of the system.

• Report all security incidents to their local Information System Security Officer (ISSO)

• Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.

• Protect all sensitive data entrusted to them as part of their government employment.

• Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.
D.1.4 Confidentiality

RPMS users shall

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

RPMS users shall not

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

D.1.5 Integrity

RPMS users shall

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

RPMS users shall not

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

D.1.6 System Logon

RPMS users shall

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

D.1.7 Passwords
RPMS users shall
• Change passwords a minimum of every 90 days.
• Create passwords with a minimum of eight characters.
• If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
• Change vendor-supplied passwords immediately.
• Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
• Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
• Keep user identifications (IDs) and passwords confidential.

RPMS users shall not
• Use common words found in any dictionary as a password.
• Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user’s name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
• Share passwords/IDs with anyone or accept the use of another’s password/ID, even if offered.
• Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
• Post passwords.
• Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
• Give a password out over the phone.
D.1.8 Backups

RPMS users shall

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

D.1.9 Reporting

RPMS users shall

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

RPMS users shall not

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

D.1.10 Session Timeouts

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

RPMS users shall

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

D.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.
RPMS users shall not
• Eat or drink near system equipment.

D.1.12 Awareness
RPMS users shall
• Participate in organization-wide security training as required.
• Read and adhere to security information pertaining to system hardware and software.
• Take the annual information security awareness.
• Read all applicable RPMS manuals for the applications used in their jobs.

D.1.13 Remote Access
Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that
• Are in writing.
• Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
• Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
• Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
• Establish mechanisms to back up data created and/or stored at alternate work locations.

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

Remote RPMS users shall not
• Disable any encryption established for network, internet, and Web browser communications.
D.2 RPMS Developers

RPMS developers shall

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

RPMS developers shall not

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

D.3 Privileged Users

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

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

• Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.

• Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

• Access any files, records, systems, etc., that are not explicitly needed to perform their duties

• Grant any user or system administrator access to RPMS unless proper documentation is provided.

• Release any sensitive agency or patient information.
Glossary

Caret
The symbol ^ obtained by pressing Shift-6.

Command
The instructions you give the computer to record a certain transaction. For example, selecting “Payment” or “P” at the command prompt tells the computer you are applying a payment to a chosen bill.

Database
A database is a collection of files containing information that may be used for many purposes. Storing information in the computer helps in reducing the user’s paperwork load and enables quick access to a wealth of information. Databases are comprised of fields, records, and files.

Data Elements
Data fields that are used in filling out forms in BHS.

Default Response
Many of the prompts in the BHS program contain responses that can be activated simply by pressing Enter. For example: “Do you really want to quit? No//.” Pressing the Enter key tells the system you do not want to quit. “No//” is considered the default response.

Device
The name of the printer to use when printing information. Home means the computer screen.

Fields
Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, the application displays a prompt requesting specific types of data.

FileMan
The database management system for RPMS.

Free Text Field
This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters that are allowed.
Frequency
The number of times a particular situation occurs in a given amount of time.

Full Screen Editor
A word processing system used by RPMS to document Subjective, Objective, and Plan. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.

Interface
A boundary where two systems can communicate.

Line Editor
A word-processing editor that allows editing text line-by-line.

Menu
The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure
A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a tree structure because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the root at the top and the leaves at the bottom.

Prompt
A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll
The roll-and-scroll data entry format captures the same information as the graphical use interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

Security Keys
Tools used to grant/restrict access to certain applications, application features, and menus.
Site Manager
The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

Submenu
A menu that is accessed through another menu.

Terminal Emulator
A type of software that gives users the ability to make one computer terminal, typically a PC, appear to look like another so that a user can access programs originally written to communicate with the other terminal type. Terminal emulation is often used to give PC users the ability to log on and get direct access to legacy programs in a mainframe operating system. Examples of Terminal Emulators are Telnet, NetTerm, etc.

Text Editor
Word processing program that enters and edits text.

Word Processing Field
This is a field that allows users to write, edit, and format text for letters, MailMan messages, etc.
# Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHR</td>
<td>Community Health Representative</td>
</tr>
<tr>
<td>HHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>HP</td>
<td>Health Problem</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>RPMS</td>
<td>Resource and Patient Management System</td>
</tr>
<tr>
<td>RoB</td>
<td>Rules of Behavior</td>
</tr>
<tr>
<td>SC</td>
<td>Service Code</td>
</tr>
</tbody>
</table>
Contact Information

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

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

**Web:** [http://www.ihs.gov/helpdesk/](http://www.ihs.gov/helpdesk/)

**Email:** support@ihs.gov