



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **CHR PCC Reporting System**

(BCH)

## **User Manual**

Version 2.0

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# 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.

```

*****
**      RPMS CHR/PCC REPORTING SYSTEM      **
*****
                IHS COMMUNITY HOSPITAL
                Version 2.0

THIS SYSTEM CONTAINS CONFIDENTIAL PATIENT INFORMATION CONVERED BY THE
PRIVACY ACT.  UNAUTHORIZED USE OF THIS DATA IS ILLEGAL.

Do you wish to continue? N//
    
```

Figure 1-1: RPMS CHR/PCC Reporting System

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.

```

*****
** RPMS CHR/PCC REPORTING SYSTEM **
*****
IHS Community Hospital
Version 2.0

DE      Data Entry Menu ...
RPTS   Reports Menu ...
MUTL   Manager Utilities ...
PWH    CHR Patient Wellness Handout
    
```



Select Option:

Figure 1-2: CHR/PCC main menu

The four menu options are briefly outlined below. They are described in detail in subsequent sections of this manual.

## 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/bjpc0200.09u\\_apch.pdf](http://www.ihs.gov/RPMS/PackageDocs/BJPC/bjpc0200.09u_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

**Note:** 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*”).

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.

PATIENT NAME: PATIEN						
1	PATIENT, DEMO1		M	05-05-1989	00000542	PIMC 101623
						SE 101624
2	PATIENT, DEMO2	Y	F	06-16-1954	00000012	PIMC 100039
						HID 100040
						SE 100041

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)

**Note:** If you do not enter the year, the value defaults to the current year. In cases where the resulting date is in the future, this may result in an error.

### 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.

```

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):  PATIENT,DEMO1
-----
No records currently on file for PATIENT,DEMO1 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/??

The following actions are also available:
+  Next Screen           Shift View to Left    PS  Print Screen

```

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):

```

* * ENTER CHR RECORD DATA * *                               DATE OF SERVICE: MAR 4,2012
CHR: PROVIDER,DEMO2                                         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      Insert
    
```

Figure 2-4: Using ScreenMan sample screen 1

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          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!
    
```

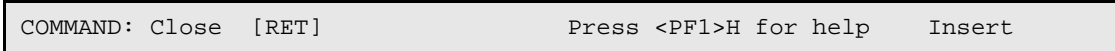


Figure 2-5: Using ScreenMan, sample screen 2

## 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

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

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

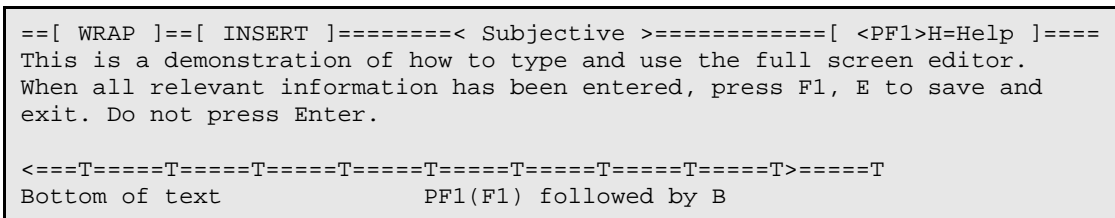


Figure 2-6: Using Text Editor, sample screen 1

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,DEM01                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 2-7: Using Text Editor, sample screen 2

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).

```

***** P A T I E N T I N F O R M A T I O N *****

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:

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):

NARRATIVE :

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

ADDITIONAL NARRATIVE :

Figure 3-8: Entering a canned (predefined) narrative

- 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.

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 3-9: Choosing a narrative

- 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.
- 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.
  - 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.

\* \* ENTER CHR RECORD DATA \* \* DATE OF SERVICE: MAR 4,2012  
CHR: PROVIDER,DEMO 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 3-10: Main Data Entry screen

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).

MEDICAL	1	MD
NURSING	2	NR
DENTAL	3	DN
EYE	4	EY
SOCIAL WORKER	5	SW
BEHAVIORAL HEALTH	6	BH
OTHER PROFESSIONALS	7	OP
TECHNICIAN	8	TN
AGENCY/PROGRAM	9	AP
FAMILY/SELF/COMMUNITY	10	FS
CHR	11	CH
NOT APPLICABLE	12	NA

Figure 3-11: Referral menu options

- **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

```

* * ENTER CHR RECORD DATA * *                DATE OF SERVICE: MAR 4,2012
CHR: PROVIDER,DEMO                            PROGRAM: TOHONO O'ODHAM
-----
Enter/Update Assessments/Purpose of Visits? YES

          ACTIVITY LOCATION:
            TRAVEL TIME:
              # SERVED:

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

Figure 3-12: All Other (Non-Patient) Entry screen

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:

```

Save changes before leaving form (Y/N)?
    
```

Figure 3-13: Save confirmation

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.

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

```

***** CONFIDENTIAL PATIENT INFORMATION *****
-----
                                CHR RECORD
-----
DATE OF SERVICE: APR 03, 2012      PROGRAM: TOHONO O'ODHAM
CHR PROVIDER: PROVIDER.DEMO1      PATIENT: PATIENT,DEMO
ACTIVITY LOCATION: HOME           TRAVEL TIME: 20
NUMBER OF CLIENTS SERVED: 1       WHO ENTERED RECORD: PROVIDER.DEMO1
DATE LAST MODIFIED: APR 03, 2012  POSTING DATE: APR 03, 2012
CHR (AFFL/DISC/CODE): 113222     PROGRAM CODE: 0001096
FORM #: 1                         SYSTEM OF ORIGIN: HOST
TOTAL SERVICE TIME: 20           PATIENT NAME: PATIENT,DEMO
DOB: FEB 3, 1940                 SEX: FEMALE
SSN: 000123456                  TRIBE: CHEROKEE NATION, OK
COMMUNITY OF RESIDENCE: BARTLESVILLE  COMMUNITY (FT): BARTLESVILLE
CHART FACILITY: CIMARRON COMMUNITY HOSPITAL
HEALTH RECORD NUMBER: 103326     BLOOD PRESSURE: 120/80
PULSE: 60
REFERRED TO CHR BY: MEDICAL
REFERRED BY CHR TO: NOT APPLICABLE
  REFERRED TO CHR BY (ALL): MEDICAL  REFERRED BY CHR TO (ALL): NOT APPLICABLE
  REFERRED TO CHR BY: 1             REFERRED BY CHR TO: NO
-----
                                CHR POV
-----
PROBLEM CODE: HYPERTENSION        PATIENT: PATIENT,DEMO
CHR RECORD: APR 03, 2012         SERVICE CODE: PATIENT CARE
SERVICE MINUTES: 20
NARRATIVE: PROVIDED EMOTIONAL SUPPORT. DELIVERED ITEM
~~~~~

```

Figure 3-14: Example of a patient record

- 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:

```

- 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.

```

          ****   Enter/Edit Assessments/Purpose of Visits   ****
<<< To edit the Provider Narrative press ENTER at the SVC MINS prompt >>>
-----
Problem Code: HYPERTENSI Service: PATIENT CA      Mins: 20
Problem Code:           Service:                Mins:
Problem Code:           Service:                Mins:
Problem Code:           Service:                Mins:
Problem Code:           Service:                Mins:
Problem Code:           Service:                Mins:
    
```

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           HC:
PULSE: 60           VU:
RESP:              VC:
BLOOD SUGAR Result:
TEMP:
HEIGHT:
WEIGHT:
BMI:                ** REPRODUCTIVE FACTORS **
WAIST CIRCUMFERENCE:  LMP:
HEMOGLOBIN A1C:      FP Method:
    
```

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.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
                CHR PCC FORM
                *** Computer Generated Encounter Record ***
*****
Date of Service:  APR 03, 2012
Temporary Residence:
                                Program Code:  0001096
                                Provider (CHR): PROVIDER,DEMO2
-----
SUBJECTIVE INFORMATION (includes patient's complaint)          TEMP
                                                                PULSE 60
                                                                RESP
                                                                BP    120/80
                                                                WT
                                                                HT
-----
OBJECTIVE DATA                                                  HEAD
                                                                BMI
                                                                WAIST
                                                                VU
                                                                VC
-----
ASSESSMENT - PCC Purpose of Visit
Hlth Prob Svc Svc      Narrative
Code   Code Mins
-----
HY     PC    20  PROVIDED EMOTIONAL SUPPORT.
                                DELIVERED ITEM
                                                                PPD
                                                                BG
                                                                Hemoglobin Alc
-----
Plans/Treatments                                               HCT
                                                                Reproductive Factors
                                                                LMP
                                                                FP
-----
Activity Location:  HOME
Referred to CHR by:
MEDICAL
Travel Time:  20
                                Referred by CHR to:
                                NOT APPLICABLE
                                Number Served:  1
    
```

HR#: 103326	SEX: FEMALE
NAME: PATIENT, DEMO1	Tribe: CHEROKEE NATION, OK
SSN: XXX-XX-1234	RESIDENCE: BARTLESVILLE
DOB: FEB 3, 1940	FACILITY: CIMARRON COMMUNITY HOSPITAL
CHR SIGNATURE:	

Figure 3-20: CHR PCC Form Format display

```

***** CONFIDENTIAL PATIENT INFORMATION *****
-----
                                CHR RECORD
-----
DATE OF SERVICE: APR 03, 2012      PROGRAM: TOHONO O'ODHAM
CHR PROVIDER: PROVIDER, DEMO2      PATIENT: PATIENT, DEMO1
ACTIVITY LOCATION: HOME            TRAVEL TIME: 20
NUMBER OF CLIENTS SERVED: 1        WHO ENTERED RECORD: PROVIDER, DEMO3
DATE LAST MODIFIED: APR 03, 2012   POSTING DATE: APR 03, 2012
CHR (AFFL/DISC/CODE): 113222       PROGRAM CODE: 0001096
FORM #: 1                           SYSTEM OF ORIGIN: HOST
TOTAL SERVICE TIME: 20              PATIENT NAME: PATIENT, DEMO1
DOB: FEB 3, 1940                    SEX: FEMALE
SSN: XXXXX1234                       TRIBE: CHEROKEE NATION, OK
COMMUNITY OF RESIDENCE: BARTLESVILLE
COMMUNITY (FT): BARTLESVILLE
CHART FACILITY: CIMARRON COMMUNITY HOSPITAL
HEALTH RECORD NUMBER: 103326        BLOOD PRESSURE: 120/80
PULSE: 60
REFERRED TO CHR BY: MEDICAL
REFERRED BY CHR TO: NOT APPLICABLE
REFERRED TO CHR BY (ALL): MEDICAL    REFERRED BY CHR TO (ALL): NOT APPLICABLE
REFERRED TO CHR BY: 1                REFERRED BY CHR TO: NO
-----
                                CHR POV
-----
PROBLEM CODE: HYPERTENSION          PATIENT: PATIENT, DEMO1
CHR RECORD: APR 03, 2012            SERVICE CODE: PATIENT CARE
SERVICE MINUTES: 20
NARRATIVE: PROVIDED EMOTIONAL SUPPORT. DELIVERED ITEM
-----

```

Figure 3-21: Standard Display

### 3.1.4 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.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
-----
                                CHR RECORD
-----
DATE OF SERVICE: APR 03, 2012      PROGRAM: TOHONO O'ODHAM
CHR PROVIDER: PROVIDER, DEMO4      PATIENT: PATIENT, DEMO1
ACTIVITY LOCATION: HOME            TRAVEL TIME: 20
NUMBER OF CLIENTS SERVED: 1        WHO ENTERED RECORD: PROVIDER, DEMO
DATE LAST MODIFIED: APR 03, 2012   POSTING DATE: APR 03, 2012

```

```

CHR (AFFL/DISC/CODE): 113222          PROGRAM CODE: 0001096
FORM #: 1                            SYSTEM OF ORIGIN: HOST
TOTAL SERVICE TIME: 20               PATIENT NAME: PATIENT, DEMO1
DOB: Feb 3, 1940                     SEX: FEMALE
SSN: 555001676                       TRIBE: CHEROKEE NATION, OK
COMMUNITY OF RESIDENCE: BARTLESVILLE COMMUNITY (FT): BARTLESVILLE
CHART FACILITY: CIMARRON COMMUNITY HOSPITAL
HEALTH RECORD NUMBER: 103326        BLOOD PRESSURE: 120/80
PULSE: 60
REFERRED TO CHR BY: MEDICAL
REFERRED BY CHR TO: NOT APPLICABLE
  REFERRED TO CHR BY (ALL): MEDICAL   REFERRED BY CHR TO (ALL): NOT APPLICABLE
  REFERRED TO CHR BY: 1              REFERRED BY CHR TO: NO
----- CHR POV -----
PROBLEM CODE: HYPERTENSION           PATIENT: PATIENT, DEMO1
CHR RECORD: APR 03, 2012             SERVICE CODE: PATIENT CARE
SERVICE MINUTES: 20
NARRATIVE: PROVIDED EMOTIONAL SUPPORT. DELIVERED ITEM
~~~~~
    
```

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:

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,DEMO2: N//

- 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.
- 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:

```

UPDATE CHR PCC FORMS           Mar 04, 2012 15:29:13           Page:      1 of      0
-----
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 3-24: 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. Afer
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.

```

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

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
-----
HLTH PROB:                SRV CODE:                SVC MINS:
HLTH PROB:                SRV CODE:                SVC MINS:
HLTH PROB:                SRV CODE:                SVC MINS:
HLTH PROB:                SRV CODE:                SVC MINS:
    
```

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
```

```

SERVICE CODE: HEALTH EDUCATION          SERVICE MINUTES: 20
NARRATIVE: PROVIDED HEALTH EDUCATION

Do you wish to continue? Y//
    
```

Figure 3-29: Data Summary screen

12. At the “Do you wish to continue?” prompt, type **Y** and press Enter.

```

***** 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.

So far you have entered 0 patient records out of a total of 2.

Enter PATIENT NAME or CHART #: PATIENT,DEMO1
                                F 02-03-1940 XXX-XX-1234 CIMD
103326

                                Ok? Yes// (Yes)

Creating new record for PATIENT,DEMO1.
    
```

Figure 3-30: Patient Information

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.

```

***** ENTER MEASUREMENTS/TESTS/REPRODUCTIVE FACTORS *****

Patient Name: PATIENT,DEMO1                CHR: 113222
Please NOTE:  If you enter a BMI, the HT and WT values are REQUIRED.
-----
***** MEASUREMENTS/TESTS *****

BP:                                HC:
PULSE:                             VU:
RESP:                              VC:
BLOOD SUGAR Result:
TEMP:
HEIGHT:
WEIGHT:
BMI:                                ** REPRODUCTIVE FACTORS **
WAIST CIRCUMFERENCE:              LMP:
HEMOGLOBIN A1C:                  FP Method:
    
```



Figure 3-31: Measurements/Tests/Reproductive Factors 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 CHRs 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:

```

***** P A T I E N T   I N F O R M A T I O N *****

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.

```
GROUP ENTRY          Apr 04, 2012 11:35:59          Page: 1 of 1
Group Entry
  Date      Group Name      CHR      # SERVED ASSESSMENTS
1)  04/04/12 WEEKLY DM SUPPORT GR PROVIDER,DEMO2  1
2)  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 3-37: New group entry

## 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).

```

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,DEMO5
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 3-39: 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.

```

OUTPUT BROWSER                Apr 04, 2012 11:50:26                Page: 1 of 1
Group Definition Display

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:                   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

                Enter ?? for more actions

>>>
+   NEXT SCREEN          -   PREVIOUS SCREEN          Q   QUIT
Select Action: +//

```

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:

```
Forms will be generated for the following patient visits:
PATIENT,DEMO6                APR 04, 2012

Do you wish to PRINT a hard copy encounter form for each patient in the
group? N//
```

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 for OCT 15, 2011   CHR (Provider): HARRIS,LAVINA
-----
#  CHR/PROVIDER  HP SC MIN NARRATIVE          LOC  PATIENT NAME
-----
1  PROVIDER,DEMO1  DM PC 35 CLEANED AND WRAP      HOME PATIENT,DEMO3
2  PROVIDER,DEMO1  DM PC 30 CLEANED AND WRAP      HOME PATIENT,DEMO4
3  PROVIDER,DEMO1  DM PC 20 DIABETES MELLITU      HOME PATIENT,DEMO4

Select record: (1-3):
```

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:

```
Please select a patient from the Non-Registered Patient Database or enter a
new Non-Registered Patient.
Select CHR NON REGISTERED PATIENTS PATIENT NAME:
```

- 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

- 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:

- At the “Select Option” prompt, type **OPV** and press Enter.
- 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.
- 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//
```

- At the “Browse which subset of visits for <patientname>” prompt, type the letter corresponding to the choice and press Enter.
- At the “Device” prompt, enter the printer name. The report (Figure 3-45) is generated.

```
***** CONFIDENTIAL PATIENT INFORMATION *****
                CIMARRON COMMUNITY HOSPITAL
```

Page 1

VISITS by CHR's						
Patient Name: PATIENT,DEMO1						
Health Record Number: 103326						
DOB: Feb 3, 1940						
DATE	CHR	LOCATION	ASSESSMENTS - POVS			
04/04/2012	PROVIDER,DEMO1	COMMUNITY	DM HE	30	PROVIDED	HEALTH EDUCATION
04/04/2012	PROVIDER,DEMO1	COMMUNITY	DM HE	10	PROVIDED	HEALTH EDUCATION
04/04/2012	PROVIDER,DEMO1	COMMUNITY	DM HE	10	PROVIDED	HEALTH EDUCATION
04/03/2012	PROVIDER,DEMO1	HOME	HY PC	20	PROVIDED	EMOTIONAL SUPPOR
04/03/2012	PROVIDER,DEMO1	HOME	DM PC	20	PROVIDED	EMOTIONAL SUPPOR
04/03/2012	PROVIDER,DEMO1	HOME	DM PC	20	DELIVERED	MEDS.
03/05/2012	PROVIDER,DEMO1	COMMUNITY	DM MP	10	WEEKLY	DM SUPPORT

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.

```

*****
**          RPMS CHR/PCC REPORTING SYSTEM          **
**          Service Workload Reports              **
*****
                2010 DEMO HOSPITAL
                Version 2.0

GEN      List CHR Records, GENERAL RETRIEVAL Output
LIST     List CHR Records, STANDARD Output

```

```

ACT1 Activity Tally by Program, CHR, and Setting
ACT2 Activity Tally by Program, CHR, Setting, Problem
ACT3 Activity Record Counts
FACT Frequency of Activities
FPRB Frequency of Problems (CHR)
FCAT Frequency of Problems by Problem Category
TBT Tally of Records and Patients by Tribe

Select Workload/Activity Reports Option:

```

Figure 4-2: Activity Workload Reports selection screen

#### 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 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 D
6) Chart Facility 20) Referred to CHR by 34) Vision Corrected Tak
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/Benefici24) Prim Hlth Prob (Code 38) Waist Circumference
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 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:

```

Figure 4-4: Report Output Type menu

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.

```

                                PRINT DATA ITEMS Menu
The following data items can be printed.  You can use up to 132 characters.
Choose the data items in the order you want them printed.
      Total Report width (including column margins - 2 spaces):    0
1) Registered Patient N      20) Date of Service          39) Service Minutes
2) Non-Registered Patie     21) Program                  40) Blood Pressure Taken
3) Patient Chart #         22) CHR (Provider)          41) Blood Pressure Value
4) Patient SSN             23) Activity Location       42) Weight Value
5) Patient Sex             24) Hospital/Clinic NAME    43) Height
6) Patient DOB            25) Specialty               44) Head Circumference
7) Patient Age            26) Referred to CHR by      45) Vision Uncorrected V
8) Mailing Address-Stre    27) Referred by CHR to     46) Vision Corrected Val
9) Mailing Address-City    28) Travel Time            47) Temperature
10) Home Phone             29) Number Served          48) Pulse
11) Mother's Name         30) Prim Hlth Prob (Code    49) Waist Circumference
12) Patient Community     31) Prim Hlth Prob (Desc   50) Respiration
13) Patient Tribe         32) Provider Narrative     51) BMI Value
14) Eligibility Status    33) Health Problem Code    52) PPD Reading
15) Class/Beneficiary     34) Health Problem (Desc   53) Blood Sugar Result
16) Medicare Eligibility  35) Primary Service Code   54) A1c Value
17) Medicaid Eligibility  36) Primary Service (Des
18) Priv Ins Eligibility  37) Service Code
19) Designated Provider   38) Service (Desc)

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

Select print item(s):  (1-54):

```

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.

```

Total Report width (including column margins - 2 spaces):  0
Enter Column width for Date of Service (suggested: 15):  (2-80): 15//

Total Report width (including column margins - 2 spaces):  17
Enter Column width for CHR (Provider) (suggested: 20):  (2-80): 20//

Total Report width (including column margins - 2 spaces):  39
Enter Column width for Patient Age (suggested: 5):  (2-80): 5//

Total Report width (including column margins - 2 spaces):  46
Enter Column width for Activity Location (suggested: 10): (2-80): 10//

```

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          19) Weight Taken
2) Patient Sex                      20) Height Taken
3) Patient Age                      21) Head Circ Taken
4) Patient Community                22) Vision Uncorrected Done
5) Patient Tribe                    23) Vision Corrected Taken
6) Patient Chart #                  24) Temperature Taken
7) Designated Provider              25) Pulse Taken
8) Classification/Beneficiary       26) Respiration Taken
9) Eligibility Status               27) Respiration
10) Patient DOB                     28) Blood Sugar Done
11) CHR (Provider)                  29) Date of Service

```

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):

Figure 4-8: Sort Criteria menu

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

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

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/Benefici24) Prim Hlth Prob (Code) 38) Waist Circumference Ta
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):
    
```

Figure 4-11: Selection Criteria menu

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 Ta
8) Patient Tribe       20) Prim Hlth Prob (Code)   32) Respiration
9) Eligibility Status  21) Primary Service Code    33) BMI Taken
10) Classification/Benefici22) 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

- 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

Include which Patients: B//
    
```

Figure 4-14: Patient Data menu

- 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
                    Page 1
    
```

```

=====
DATE          CHR PATIENT NAME          LOC   TT   ASSESSMENTS - POVS
-----
03/22/2013 PA  DEMO,PATIENT1          HOME  5    HY MP 15 F/U NO C/O. F/U MEDS
                                HY PC 30 PROVIDED EMOTIONAL S
                                HT MP 15 F/U NO C/O. F/U MEDS
                                HT PC  5 DX-HT PULSE
                                OR CF  5 SCREENED
                                DM CF  5 SCREENED
                                FE CF  5 SCREENED
                                FL HE 15 PREVENTION HEALTH ED
                                IC ES 10 CHECKED FOR HEALTH A
03/22/2013 PA  DEMO,PATIENT2          COMMU 0    HT HE  2 PREVENTION HEALTH ED
03/22/2013 PA  DEMO,PATIENT3          COMMU 5    HT HE  2 PREVENTION HEALTH ED
03/22/2013 PA  DEMO,PATIENT4          COMMU 0    HT HE  2 PREVENTION HEALTH ED
03/22/2013 PA  DEMO,PATIENT5          COMMU 0    HT HE  2 PREVENTION HEALTH ED
    
```

Figure 4-15: Example of a standard brief report

### 4.1.3 ACT1 Activity Tally by Program, Setting and CHR

This report prints a tally of activities by program, setting, and CHR. To produce the ACT1 report:

1. Type **ACT1** 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:

```

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 4-16 contains a sample ACT1 report for the service dates March 22-26, 2013.

***** CONFIDENTIAL PATIENT INFORMATION *****		
CHR/PCC ACTIVITY REPORT		
PA	2010 DEMO HOSPITAL	APR 02, 2013 Page 1
PROGRAM: CHICKASAW (5062027)		
PATIENTS: Both Registered and Non-Registered Patients		
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013		
	# Activities	ACT TIME (hrs)
-----		
PROGRAM: CHICKASAW (5062027)		
ACTIVITY LOCATION: CHR OFFICE		
PROVIDER: PROVIDER,DEMO1		
ADMINISTRATION/MANAGEMENT (AM)	3	0.8
OTHER PATIENT SERVICE (OP)	6	4.0
	=====	=====
PROVIDER TOTAL:	9	4.8
PROVIDER: PROVIDER,DEMO1		
OTHER PATIENT SERVICE (OP)	5	1.8
	=====	=====
PROVIDER TOTAL:	5	1.8
PROVIDER: PROVIDER,DEMO1		
ADMINISTRATION/MANAGEMENT (AM)	1	0.3
OTHER PATIENT SERVICE (OP)	3	1.3
	=====	=====
PROVIDER TOTAL:	4	1.6
	=====	=====
ACTIVITY LOCATION TOTAL:	18	8.1
ACTIVITY LOCATION: COMMUNITY		
PROVIDER: PROVIDER,DEMO1		
CASE MANAGEMENT (CM)	1	0.3
ENVIRONMENTAL SERVICE (ES)	1	0.3
HEALTH EDUCATION (HE)	1	0.3
	=====	=====
PROVIDER TOTAL:	3	1.0
PROVIDER: PROVIDER,DEMO2		
HEALTH EDUCATION (HE)	15	0.5
	=====	=====
PROVIDER TOTAL:	15	0.5
PROVIDER: PROVIDER,DEMO3		
CASE FINDING/SCREENING (CF)	31	4.1
HEALTH EDUCATION (HE)	7	0.5
INTERPRET/TRANSLATE (IT)	28	0.5
	=====	=====
PROVIDER TOTAL:	66	5.0
	=====	=====
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:

```

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 4-17 contains a sample ACT2 report for the service dates March 22-26, 2013.

```

PA          ***** CONFIDENTIAL PATIENT INFORMATION *****          Page 1
              APR 02, 2013
              2010 DEMO HOSPITAL
              ACTIVITY REPORT BY HEALTH PROBLEM
              PROGRAM:  CHICKASAW (5062027)
PATIENTS:    Both Registered and Non-Registered Patients
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013

                                                # Activities  ACT TIME (hrs)
-----
PROGRAM:  CHICKASAW (5062027)
ACTIVITY LOCATION:  CHR OFFICE
CHR:  ACORD,ARLIS L
ACTIVITY:  ADMINISTRATION/MANAGEMENT (A
          PROBLEM:  ADMINISTRATIVE/MANAGEMENT (AM)          3      0.8
          =====
ACTIVITY TOTAL:          3      0.8

ACTIVITY:  OTHER PATIENT SERVICE (OP)
    
```



	PROBLEM: ADMINISTRATIVE/MANAGEMENT (AM)	4	2.0
PA	***** CONFIDENTIAL PATIENT INFORMATION *****		
	APR 02, 2013		Page 2
	2010 DEMO HOSPITAL		
	ACTIVITY REPORT BY HEALTH PROBLEM		
	PROGRAM: CHICKASAW (5062027)		
	PATIENTS: Both Registered and Non-Registered Patients		
	REPORT DATES: MAR 22, 2013 TO MAR 26, 2013		
		# Activities	ACT TIME (hrs)
-----			
	PROBLEM: INJURY CONTROL (IC)	2	2.0
		=====	=====
	ACTIVITY TOTAL:	6	4.0
		=====	=====
	PROVIDER TOTAL:	9	4.8
CHR:	PATIENT, DEMO		
	ACTIVITY: OTHER PATIENT SERVICE (OP)		
	PROBLEM: ADMINISTRATIVE/MANAGEMENT (AM)	5	1.8

Figure 4-17: Activity Report by Health Problem

### 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.

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

Figure 4-18: Activity Record Counts menu

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:

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/Benefici24) Prim Hlth Prob (Code) 38) Waist Circumference Ta
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>>

Record selection criteria:
    
```

Figure 4-19: Selection Criteria menu

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.

```

CHR RECORD LISTING
    
```

```

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

                                                APR 02, 2013  Page 1
                        2010 DEMO HOSPITAL
RECORD DATES:  MAR 22, 2013 TO MAR 26, 2013
NUMBER OF ACTIVITY RECORDS BY CHR PROGRAM

CHR PROGRAM          PROGRAM CODE          # PCC      # SERVED  ACTIVITY TIME
                        FORMS                        (hrs)
-----
CHICKASAW            5062027                102        104        144.4
                        Totals:                102        104        144.4
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  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/Benefici24) Prim Hlth Prob (Code) 38) Waist Circumference Ta
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>>

Record selection criteria:

```

Figure 4-21: Selection Criteria menu

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:

```

Select one of the following:

      L          List of items with Counts
      B          Bar Chart (REQUIRES 132 COLUMN PRINTER)

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.

```

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 4-22 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)

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                                2010 DEMO HOSPITAL

TOP 10 Activity Codes.
DATES:  MAR 22, 2013  TO  MAR 26, 2013

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

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

Figure 4-22: Example of a List report

```

    APR 02, 2013                                                    Page 1
                                2010 DEMO HOSPITAL

TOP 10 Activity Codes.
DATES:  MAR 22, 2013  TO  MAR 26, 2013

ACTIVITY TYPE
-----
OTHER PATIENT SER (OP) | ***** 506
TRANSPORT PATIENT (TP) | ***** 293
ADMINISTRATION/MA (AM) | ***** 134
HEALTH EDUCATION (HE)  | ***** 117
MONITOR PATIENT (MP)   | ***** 111
CASE FINDING/SCRE (CF) | ***** 68
LEAVE TIME (LT)        | ***** 62
PATIENT CARE (PC)      | ***** 32
OBTAIN TRAINING (OT)   | ***** 31
CASE MANAGEMENT (CM)   | ** 17
    
```

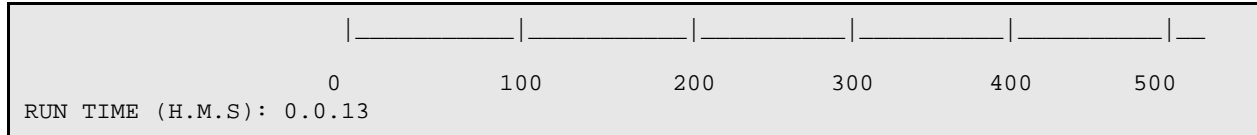


Figure 4-23: Example of a Bar Chart report

#### 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 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/Benefici24) Prim Hlth Prob (Code) 38) Waist Circumference Ta
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>>

Record selection criteria:

```

Figure 4-24: Selection Criteria menu

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:

```

Select one of the following:

      P          PRIMARY POV Only
      S          PRIMARY and SECONDARY POV's

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

```

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

```

Select one of the following:

      L          List of items with Counts
      B          Bar Chart (REQUIRES 132 COLUMN PRINTER)

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.

```

Select one of the following:

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

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.

```

                                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)

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                                     2010 DEMO HOSPITAL

TOP 10 POV/Problem (Problem Code)'s.
PRIMARY POV Only
DATES:  MAR 22, 2013  TO  MAR 26, 2013

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

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
    
```



```

9) Eligibility Status      23) Number Served      37) Respiration Taken
10) Classification/Benefici24) Prim Hlth Prob (Code) 38) Waist Circumference Ta
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>>

Record selection criteria:
    
```

Figure 4-26: Selection Criteria menu

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:

P          PRIMARY POV Only
S          PRIMARY and SECONDARY POV's

Include which POV's: P// RIMARY POV Only
    
```

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

```

Select one of the following:

L          List of items with Counts
B          Bar Chart (REQUIRES 132 COLUMN PRINTER)

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.

```

Select one of the following:
    
```

```

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

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.
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

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

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:

```

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 4-28 contains a sample TBT report for the service dates March 22-26, 2013.

	# CHR PCCs	# PATIENTS
***** CONFIDENTIAL PATIENT INFORMATION *****		
PA	Apr 02, 2013	Page 1
2010 DEMO HOSPITAL		
TALLY OF CHR PCCs AND PATIENTS BY TRIBE		
PROGRAM: CHICKASAW (5062027)		
PATIENTS: Both Registered and Non-Registered Patients		
REPORT DATES: Mar 22, 2013 TO Mar 26, 2013		
-----		
ANAKTUVUK PASS, VILLAGE OF ANAKTUVUK PASS	1	1
CADDO TRIBE INDIAN, OK	1	1
CHEROKEE NATION, OK	1	1
CHEYENNE-ARAPAHO TRIBES, OK	1	1
CHOCTAW NATION, OK	3	3
CHUGACH NATIVES, INC.	1	1
CREEK NATION, OK	2	2
EASTERN BAND OF CHEROKEE IND, NC	43	43
INDIAN - NON-TRIBAL MEMBER	1	1
NAVAJO TRIBE, AZ NM AND UT	1	1
NON-INDIAN BENEFICIARY	12	11
NON-INDIAN MEMBER OF IND. HOUSEHOLD	2	2

PYRAMID LAKE PAIUTE TRIBE, NV	1	1
SEMINOLE NATION, OK	2	2
SENECA NATION, NY	2	1
SHOSHONE-BANNOCK TRIBES FORT HALL RES, ID	1	1
ALL TRIBES/TOTAL	75	73

Figure 4-28: Example of a Tally of CHR PCCs and Patients by Tribe report

## 4.2 CHRS – CHR Reports

The following reports are available from the CHRS Reports menu:

```

*****
**          RPMS CHR/PCC REPORTING SYSTEM          **
**                CHR REPORTS                **
*****
                2010 DEMO HOSPITAL
                Version 2.0

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

Select CHR Reports Option:
    
```

Figure 4-29: CHR Reports menu

### 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.

```

***** CHR REPORT NO. 1 *****

      TIME SPENT, SERVICE ACTIVITIES, AND SERVICES by HEALTH PROBLEM

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 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.

PA	2010 DEMO HOSPITAL				APR 02, 2013	Page 1
***** CHR REPORT NO. 1 *****						
TIME SPENT, SERVICE ACTIVITIES, AND SERVICES by HEALTH PROBLEM						
PROGRAM: CHICKASAW (5062027)						
PROVIDER: ALL						
PATIENTS: Both Registered and Non-Registered Patients						
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013						
* SERVICES is equal to # of Lines of Assessment						
HEALTH PROBLEM		SERVICE HOURS	TRAVEL HOURS	SERVICE ACTIVITIES	SERVICES*	
-----		-----	-----	-----	-----	
TOTAL		144 100%	14 100%	551 100%	507 100%	
AD	ACTIVITIES OF DAILY LI	1 0%	1 5%	3 1%	3 1%	
AM	ADMINISTRATIVE/MANAGEM	7 5%	2 12%	0 0%	17 3%	
AG	ALLERGY	1 1%	0 0%	5 1%	5 1%	
RUN TIME (H.M.S): 0.0.0						

Figure 4-30: Example of Time Spent, Client Contacts, and Activities by Health Problem report

#### 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.

***** CHR REPORT NO. 2 *****						
TIME SPENT, SERVICE ACTIVITIES, AND SERVICES by SERVICE						

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.

```

PA
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                                ***** CHR REPORT NO. 2 *****
                                TIME SPENT, SERVICE ACTIVITIES, AND SERVICES by SERVICE

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

* SERVICES is equal to # of Lines of Assessment

SERVICE                SERVICE        TRAVEL        SERVICE        SERVICES*
                SERVICE        HOURS        HOURS        ACTIVITIES
                HOURS
-----
TOTAL                144 100%        14 100%        551 100%        507 100%

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

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.



```

***** CHR REPORT NO. 3 *****

TIME SPENT, # SERVED, AND SERVICES by SETTING

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 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

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

PA	2010 DEMO HOSPITAL				APR 02, 2013	Page 1
***** CHR REPORT NO. 3 *****						
TIME SPENT, # SERVED, AND SERVICES by SETTING						
PROGRAM: CHICKASAW (5062027)						
PROVIDER: ALL						
PATIENTS: Both Registered and Non-Registered Patients						
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013						
* SERVICES is equal to # of Lines of Assessment						
SETTING	SERVICE HOURS	TRAVEL HOURS	NUMBER SERVED	SERVICES*		
-----						
TOTAL	144 100%	14 100%	104 100%	507 100%		
CH CHR OFFICE	8 6%	2 15%	0 0%	18 4%		
CM COMMUNITY	6 4%	1 4%	47 45%	84 17%		
HM HOME	62 43%	10 66%	49 47%	360 71%		
HC HOSPITAL/CLINIC	12 9%	1 8%	8 8%	38 7%		
NO NONE	55 38%	1 7%	0 0%	7 1%		
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 CHR’s 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.

PA	2010 DEMO HOSPITAL		APR 02, 2013	Page 1
***** CHR REPORT NO. 4 *****				
NUMBER OF REFERRALS FROM/TO				
PROGRAM: CHICKASAW (5062027)				
PROVIDER: ALL				
PATIENTS: Both Registered and Non-Registered Patients				
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013				
REFERRALS TO CHR FROM	# REFERRALS	REFERRALS BY CHR TO	# REFERRALS	
-----				
TOTAL	56 100%	TOTAL	56 100%	

MD	MEDICAL	8	14%	MD	MEDICAL	7	13%
NR	NURSING	2	4%	NR	NURSING	0	0%
DN	DENTAL	0	0%	DN	DENTAL	0	0%
EY	EYE	1	2%	EY	EYE	1	2%
SW	SOCIAL WORKER	0	0%	SW	SOCIAL WORKER	0	0%
BH	BEHAVIORAL HEALTH	2	4%	BH	BEHAVIORAL HEALTH	0	0%
OP	OTHER PROFESSIONALS	0	0%	OP	OTHER PROFESSIONALS	0	0%
TN	TECHNICIAN	0	0%	TN	TECHNICIAN	1	2%
AP	AGENCY/PROGRAM	0	0%	AP	AGENCY/PROGRAM	11	20%
FS	FAMILY/SELF/COMMUNIT	13	23%	FS	FAMILY/SELF/COMMUNIT	0	0%
CH	CHR	0	0%	CH	CHR	0	0%
NA	NOT APPLICABLE	30	54%	NA	NOT APPLICABLE	36	64%
RUN TIME (H.M.S): 0.0.0							

Figure 4-33: Example of a Number of Referrals From/To report sample

### 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.

PA 1	DATE GENERATED: APR 02, 2013										Page	
2010 DEMO HOSPITAL												
***** CHR REPORT NO. 5 *****												
NUMBER OF SERVICES (LINES OF ASSESSMENT) BY HEALTH PROBLEM, AGE AND SEX												
PROGRAM: CHICKASAW (5062027)												
PROVIDER: ALL												
PATIENTS: Both Registered and Non-Registered Patients												
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013												
HEALTH PROBLEM	---ALL AGES---		0-9		9-19		20-39		39-59		>59	
	M	F	M	F	M	F	M	F	M	F	M	F
TOTAL	149	249	7	7	13	19	22	11	22	31	85	181
OI	0	1	.	.	.	.	.	.	.	.	.	1
CA	3	5	.	.	3	.	.	.	.	.	.	5
DM	24	45	.	.	.	6	2	3	8	3	14	33
ED	6	4	.	.	.	.	.	.	.	.	6	4
HY	28	45	3	3	4	2	6	2	4	2	11	36
HT	29	45	2	2	2	5	5	2	5	6	15	30
FL	0	0	.	.	.	.	.	.	.	.	.	.
AS	6	0	.	.	.	.	.	.	.	.	6	.
AG	5	0	.	.	.	.	.	.	.	.	5	.
OR	13	30	1	1	.	2	3	1	3	2	6	24
FE	3	7	.	.	.	1	.	.	.	1	3	5
SF	0	3	.	.	.	.	.	.	.	3	.	.
NU	6	5	.	.	.	.	.	.	.	3	6	2
IC	17	22	1	1	1	2	3	1	2	3	10	15
TH	0	2	.	.	.	1	.	.	.	.	.	1
OX	0	4	.	.	.	.	.	.	.	.	.	4
DP	0	4	.	.	.	.	.	2	.	.	.	2
OM	0	6	.	.	.	.	.	.	.	6	.	.
MB	0	0	.	.	.	.	.	.	.	.	.	.
AD	1	2	.	.	.	.	1	.	.	.	.	2
WH	0	1	.	.	.	.	.	.	.	.	.	1
CR	3	4	.	.	3	.	.	.	.	.	.	4
SO	3	3	.	.	.	.	.	.	.	.	3	3
DG	0	3	.	.	.	.	.	.	.	.	.	3
DD	0	2	.	.	.	.	.	.	.	.	.	2
OS	2	6	.	.	.	.	2	.	.	2	.	4

RUN TIME (H.M.S): 0.0.0

Figure 4-34: Example of a Client Contacts by Health Problem, Age, and Sex report

## 4.2.6 C6 CHR #6 – Provider Data

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

```

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

PA								DATE GENERATED: APR 02, 2013
Page 1								
2010 DEMO HOSPITAL								
***** CHR REPORT NO. 6 *****								
PROVIDER DATA								
PROGRAM: CHICKASAW (5062027)								
PATIENTS: Both Registered and Non-Registered Patients								
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013								
PROVIDER	SERVICE HOURS	TRAVEL HOURS	LEAVE HOURS	TOTAL HOURS	0 NUM SERV	1 NUM SERV	>1 NUM SERV	TOT # SERVED
-----								
TOTAL	96	14	48	159	23	76	3	104
PROVIDER, DEMO1	33	6	0	39	7	15	2	28
PROVIDER, DEMO2	35	5	0	40	6	38	0	38
PROVIDER, DEMO3	28	4	8	40	5	23	1	38
PROVIDER, DEMO4	0	0	40	40	5	0	0	0
-----								
RUN TIME (H.M.S): 0.0.0								

Figure 4-35: Example of a Provider Data report

#### 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 **C8** and press Enter. The following sequence displays.

\*\*\*\*\* CHR REPORT NO. 8 \*\*\*\*\*

HOURS (SERVICE+TRAVEL) BY MONTH

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.



- 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//
    
```

- At the “Which report do you wish to run?” prompt, type **PG** or **PR** and press Enter.
- At the “Include data from ALL CHR Programs?” prompt, type **YES** or **NO** and press Enter. If **NO** was selected:
  - At the “Which CHR Program” prompt, type the CHR program name.
  - 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//
    
```

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

```

PA                                     APR 02, 2013 Page 1
                                     2010 DEMO HOSPITAL
                                     ***** CHR REPORT NO. 8 *****
                                     HOURS (SERVICE+TRAVEL) BY MONTH AND PROGRAM
                                     PROGRAM: CHICKASAW (5062027)
                                     PATIENTS: Both Registered and Non-Registered Patients
                                     REPORT DATES: MAR 22, 2013 TO MAR 26, 2013
MONTH/YEAR      TOTAL HOURS      SERVICE HOURS      TRAVEL HOURS
-----
MAR 2013        159                144                14
RUN TIME (H.M.S): 0.0.0
    
```

Figure 4-36: Example of a Report Output by Program

PA	2010 DEMO HOSPITAL			APR 02, 2014 Page 1
***** CHR REPORT NO. 8.2 *****				
HOURS (SERVICE+TRAVEL) BY MONTH AND PROVIDER				
PROGRAM: CHICKASAW (5062027)				
PROVIDER: PROVIDER,DEMO1				
PATIENTS: Both Registered and Non-Registered Patients				
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013				
MONTH/YEAR	TOTAL HOURS	SERVICE HOURS	TRAVEL HOURS	
-----				
MAR 2013	39	33	6	
PA	2010 DEMO HOSPITAL			APR 02, 2014 Page 2
***** CHR REPORT NO. 8.2 *****				
HOURS (SERVICE+TRAVEL) BY MONTH AND PROVIDER				
PROGRAM: CHICKASAW (5062027)				
PROVIDER: PROVIDER,DEMO2				
PATIENTS: Both Registered and Non-Registered Patients				
REPORT DATES: MAR 22, 2013 TO MAR 26, 2013				
MONTH/YEAR	TOTAL HOURS	SERVICE HOURS	TRAVEL HOURS	
-----				
MAR 2013	40	36	4	
RUN TIME (H.M.S): 0.0.0				

Figure 4-37: Example of a Report Output by Provider

**Note:** In the by provider report one page will print for each CHR.

#### 4.2.8 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.

```

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                    ***** 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

PROVIDER          TOT NUM OF    NUMBER    S&T HRS    S&T HRS    S&T HRS
                  ACTIVITIES    SERVED    ALL SRVS   NON ADM    ADM SRV
-----
TOTAL              507          104       159        102         57

PROVIDER, DEMO1    118          28        39         30          9
PROVIDER, DEMO2    200          38        40         40          0
PROVIDER, DEMO3    184          38        40         32          8
PROVIDER, DEMO4     5            0        40         0           40

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:
      O          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:

```
Select one of the following:

      L          List of items with Counts
      B          Bar Chart (REQUIRES 132 COLUMN PRINTER)

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:

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

DATE PRINTED: APR 02, 2013	Page 1	
2010 DEMO HOSPITAL		
COMMUNITY HEALTH REPRESENTATIVE REPORT 13 -- HIGHLIGHTS		
TOP 10 HEALTH PROBLEMS AND SERVICES		
PROGRAM: CHICKASAW (5062027)		
PROVIDER: ALL		
PATIENTS: Both Registered and Non-Registered Patients		
REPORTING PERIOD: MAR 22, 2013 TO MAR 26, 2013		
HEALTH PROBLEM	SERVICE & TRAVEL HOURS	% OF TOTAL
-----		
LEAVE TIME	48.0	30.2
HYPERTENSION	19.1	12.0
DIABETES MELLITUS	16.4	10.3
HEART	16.1	10.1
INJURY CONTROL	11.7	7.3
ADMINISTRATIVE/MANAGEMENT	8.4	5.3
NUTRITION	4.6	2.9
OTHER RESPIRATORY	4.3	2.7
DIALYSIS	4.0	2.5

OTHER MENTAL HEALTH	3.0	1.9
EYE DISEASE	2.5	1.6
OSTEOPOROSIS	2.5	1.6
ALL HEALTH PROBLEMS	158.8	100%
LEAVE TIME	48.0	30.2
MONITOR PATIENT	23.1	14.5
CASE FINDING/SCREENING	13.3	8.4
PATIENT CARE	13.0	8.2
CASE MANAGEMENT	12.8	8.0
HEALTH EDUCATION	12.0	7.5
OTHER PATIENT SERVICE	9.9	6.2
OBTAIN TRAINING	8.0	5.0
ENVIRONMENTAL SERVICE	7.3	4.6
INTERPRET/TRANSLATE	4.6	2.9
TRANSPORT PATIENT	4.3	2.7
ALL SERVICES	158.8	100%
RUN TIME (H.M.S): 0.0.0		

Figure 4-39: List report example

### 4.3 Unduplicated Patient Count Reports

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

```

*****
**      RPMS CHR/PCC REPORTING SYSTEM      **
**      Unduplicated Patient Count Reports  **
*****

                2010 DEMO HOSPITAL
                Version 2.0

U1      Unduplicated Patient Counts by CHR
U2      Unduplicated Patient Counts by AGE
U3      Unduplicated Patient Counts by Gender
U4      Unduplicated Patient Counts by Tribe
U5      Unduplicated Patient Counts by Program

Select Unduplicated Patient Count Reports Option:
    
```

Figure 4-40: Unduplicated Patient Count Reports menu

#### 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.

```

PA                                     APR 02, 2013 Page 1
                                     2010 DEMO HOSPITAL

***** UNDUPLICATED PATIENT REPORT NO. 1 *****
Unduplicated Patient Count by CHR

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

CHR                # PATIENTS    # FEMALES    # MALES    SERVICE
                                     HOURS
    
```

TOTAL	73	100%	41	100%	32	100%	73	100%
PATIENT, DEMO1	15	21%	9	22%	6	19%	19	26%
PATIENT, DEMO2	37	51%	19	46%	18	56%	31	43%
PATIENT, DEMO3	22	30%	14	34%	8	25%	23	32%
RUN TIME (H.M.S): 0.0.1								

Figure 4-41: Example of an Unduplicated Patient Count by CHR report

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

PATIENT AGE	# PATIENTS	# FEMALES	# MALES	SERVICE HOURS
-----				
TOTAL	73 100%	41 100%	32 100%	73 100%
3	1 1%	0%	1 3%	2 2%
4	2 3%	1 2%	1 3%	2 3%
5	1 1%	0%	1 3%	1 1%
8	1 1%	0%	1 3%	1 2%
11	1 1%	1 2%	0%	0 0%
14	2 3%	1 2%	1 3%	1 1%
15	1 1%	0%	1 3%	2 2%
18	1 1%	1 2%	0%	2 3%
19	1 1%	1 2%	0%	0 0%
20	1 1%	0%	1 3%	0 0%
22	1 1%	0%	1 3%	1 2%
25	1 1%	1 2%	0%	1 1%
26	1 1%	1 2%	0%	2 2%
27	1 1%	1 2%	0%	0 0%
28	2 3%	0%	2 6%	2 3%
32	1 1%	0%	1 3%	0 0%
36	1 1%	0%	1 3%	2 3%
37	2 3%	2 5%	0%	2 2%
39	2 3%	0%	2 6%	0 1%
40	3 4%	2 5%	1 3%	1 2%
42	1 1%	1 2%	0%	0 0%
43	2 3%	1 2%	1 3%	1 2%
44	1 1%	0%	1 3%	1 2%
50	1 1%	1 2%	0%	1 2%
51	1 1%	1 2%	0%	2 2%
56	2 3%	2 5%	0%	3 4%
60	1 1%	1 2%	0%	1 1%
61	1 1%	0%	1 3%	0 0%
63	3 4%	2 5%	1 3%	1 2%

65	2	3%	2	5%		0%	3	5%
66	3	4%	1	2%	2	6%	6	8%
67	1	1%		0%	1	3%	1	1%
70	3	4%	1	2%	2	6%	3	4%
72	2	3%	1	2%	1	3%	2	3%
73	1	1%	1	2%		0%	2	3%
74	1	1%		0%	1	3%	2	3%

Figure 4-42: Example of an Unduplicated Patient Count by Patient Age report

### 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
    
```

```

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

```

PA                                     APR 02, 2013 Page 1
                                     2010 DEMO HOSPITAL

***** UNDUPLICATED PATIENT REPORT NO. 3 *****
Unduplicated Patient Count by GENDER

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

GENDER                                # PATIENTS    # FEMALES    # MALES      SERVICE
-----                                -            -            -            HOURS
TOTAL                                73 100%      41 100%      32 100%      73 100%
FEMALE                                41 56%       41 100%       0%           40 55%
MALE                                   32 44%       0%           32 100%      33 45%

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:

```
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 4-44 contains a sample U4 report for the service dates March 22-26, 2013.

TRIBE	# PATIENTS	# FEMALES	# MALES	SERVICE HOURS
TOTAL	73 100%	41 100%	32 100%	73 100%
ANAKTUVUK PASS, VILLAGE O	1 1%	0%	1 3%	1 1%
CADDO TRIBE INDIAN, OK	1 1%	0%	1 3%	1 1%
CHEROKEE NATION, OK	1 1%	0%	1 3%	2 2%
CHEYENNE-ARAPAHO TRIBES,	1 1%	0%	1 3%	2 3%
CHOCTAW NATION, OK	3 4%	1 2%	2 6%	4 6%
CHUGACH NATIVES, INC.	1 1%	1 2%	0%	0 0%

CREEK NATION, OK	2	3%	1	2%	1	3%	3	4%
EASTERN BAND OF CHEROKEE	43	59%	27	66%	16	50%	37	51%
INDIAN - NON-TRIBAL MEMBE	1	1%		0%	1	3%	1	2%
NAVAJO TRIBE, AZ NM AND U	1	1%	1	2%		0%	1	1%
NON-INDIAN BENEFICIARY	11	15%	7	17%	4	13%	13	18%
NON-INDIAN MEMBER OF IND.	2	3%	1	2%	1	3%	1	1%
PYRAMID LAKE PAIUTE TRIBE	1	1%		0%	1	3%	0	0%
SEMINOLE NATION, OK	2	3%		0%	2	6%	3	4%
SENECA NATION, NY	1	1%	1	2%		0%	2	3%
SHOSHONE-BANNOCK TRIBES F	1	1%	1	2%		0%	2	3%
RUN TIME (H.M.S): 0.0.0								

Figure 4-44: Example of an Unduplicated Patient Count by Tribe report

### 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.

```
PA                                     APR 02, 2013 Page 1
                                     2010 DEMO HOSPITAL
***** UNDUPLICATED PATIENT REPORT NO. 5 *****
Unduplicated Patient Count by PROGRAM

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

PROGRAM          # PATIENTS    # FEMALES    # MALES        SERVICE
-----          -
TOTAL            73 100%      41 100%      32 100%        73 100%
CHICKASAW 5062027 73 100%      41 100%      32 100%        73 100%

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:

```

LAM                                     APR 05, 2012  Page 1
                                CIMARRON COMMUNITY HOSPITAL

                                ***** LIST OF NON-REGISTERED PATIENTS *****
                                SEEN BY THE CHR PROGRAM SINCE APR 08, 2002
NAME                                DOB      SEX  TRIBE                                COMMUNITY
-----
PATIENT, DEMO2                      02/03/40  M   TOHONO O'ODHAM  SELLS
PATIENT, DEMO3                      02/03/40  F   CHOCTAW NATION,  JAY
PATIENT, DEMO4                      02/03/40  F   CHOCTAW NATION,  ADA
    
```

Figure 4-47: Example Non-Registered Patient List

## 4.5 Print CHR Standard Tables

The following report options print the CHR standard tables listed.

```

*****
**      RPMS CHR/PCC REPORTING SYSTEM      **
**      Print CHR Standard Tables          **
*****
DEMO HOSPITAL/CLINIC
Version 2.0

AL   Print Activity Location Table
FP   Print Family Planning Method Table
PG   Print CHR Programs Table
RF   Print Referrals Table
SC   Print Service Code 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.

```

CHR ACTIVITY LOCATIONS LIST                                OCT 16, 2011 08:34  PAGE 1
                                MNEMONIC
                                ( CHRIS
NAME                                II )

CHR OFFICE                          CH
COMMUNITY                           CM
HOME                                 HM
HOSPITAL/CLINIC                     HC
NONE                                 NO
RADIO/TELEPHONE                     RT
SCHOOL                               SC
    
```

CHR <b>FAMILY PLANNING</b> METHODS LIST		OCT 16,2011 08:34	PAGE 1
NAME	CODE		
BIRTH CONTROL PILLS	3		
CERVICAL CAP	5		
CONDOM	4		
DEPO PROVERA HORMONE	12		
DIAPHRAGM	10		
IUD	8		
MORNING AFTER	14		
NORPLANT	13		
NOT NEEDED	1		
NOT USED	2		
OVULATION/RHYTHM	9		
SPONGE/SPERMICIDE	6		
TUBAL LIGATION	7		
VASECTOMY	11		

CHR <b>REFERRALS</b> LIST		OCT 16,2011 08:39	PAGE 1
NAME	MNEMONIC		
AGENCY/PROGRAM	AP		
BEHAVIORAL HEALTH	BH		
CHR	CH		
DENTAL	DN		
EYE	EY		
FAMILY/SELF/COMMUNITY	FS		
MEDICAL	MD		
NOT APPLICABLE	NA		
NURSING	NR		
OTHER PROFESSIONALS	OP		
SOCIAL WORKER	SW		
TECHNICIAN	TN		

CHR <b>SERVICE CODES</b> LIST		OCT 16,2011 08:40	PAGE 1
NAME	MNEMONIC		
ADMINISTRATION/MANAGEMENT	AM		
CASE FINDING/SCREENING	CF		
CASE MANAGEMENT	CM		
COMMUNITY DEVELOPMENT	CD		
EMERGENCY CARE	EC		
ENVIRONMENTAL SERVICE	ES		
HEALTH EDUCATION	HE		
HOMEMAKER SERVICES	HS		
INTERPRET/TRANSLATE	IT		
LEAVE TIME	LT		
MONITOR PATIENT	MP		
NOT FOUND	NF		
OBTAIN TRAINING	OT		
OTHER EDUCATION	OE		
OTHER PATIENT SERVICE	OP		
PATIENT CARE	PC		
TRANSPORT PATIENT	TP		
STAFF TRAINING	ST		

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:

```

*****
**      RPMS CHR/PCC REPORTING SYSTEM      **
**              Manager Utilities          **
*****
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

GEN      Generate CHR Transactions for HQ
DISP     Display a Log Entry
RGEN     Re-generate Transactions
RSET     Re-set Data Export Log
CHK      Check Records Before Export
ERRS     Print Error List for Export
OUTP     Create OUTPUT File

```

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.

- Determine at what interval (weekly or monthly) the export should be performed.
- 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
ask 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//

```

- 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//

```

- 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.

```

List patients seen in the past how many years?: (1-100): 10//
DEVICE: HOME// VT Right Margin: 80//

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2010 DEMO HOSPITAL

***** LIST OF NON-REGISTERED PATIENTS *****
SEEN BY THE CHR PROGRAM SINCE APR 05, 2003
NAME DOB SEX TRIBE COMMUNITY
-----
CARLTON,GEORGE 01/01/19 M WASHOE TRIBE OF ADA
FILES,RICE 02/17/25 M CHICKASAW NATIO ADA
BROCK,NOAH 07/01/29 M CHOCTAW NATION, DURANT
BOW,WOW 02/14/30 M APACHE TRIBE, O BEMIDJI
BONKAR,VERNON 01/02/40 M CHICKASAW NATIO PURCELL
BRODYCK,ELVIS 01/02/40 M CHICKASAW NATIO PURCELL
BONKAR,VELMA 01/03/40 F CHICKASAW NATIO PURCELL
WEDANEH,JERRY LEE 01/04/40 F CHICKASAW NATIO PURCELL
ANGLOND,KAREN S 01/06/40 F CHICKASAW NATIO PURCELL
ANGLOND,KELLY A 01/07/40 F CHICKASAW NATIO PURCELL
BOFFNGTUN,DARLA J 01/08/40 F CHICKASAW NATIO PURCELL
PONCE,ANDREANNA 02/02/72 F KIOWA INDIAN TR SHAWNEE
ESTRELLA,JENNIFERLIN 10/12/75 F TOHONO O'ODHAM SAN LUCY VIL
CAT,TOM 02/05/76 M CHICKASAW NATIO PAULS VALLEY
ON, TOP 04/06/76 M TOHONO O'ODHAM SELLS
ROMANNOSE,L 01/01/78 F CHEYENNE-ARAPAH WATONGA
MILLER,AGNES ANN 05/05/05 F TOHONO O'ODHAM TUCSON
YARD,BYA 05/05/05 M TULALIP TRIBE, PORTLAND
DAVIS,TATIN 09/12/06 F SEMINOLE NATION MUSKOGEE
CANDY,BILLY 01/21/07 M HOPI TRIBE, AZ SANTA ROSA
SEED,POPPY 03/19/08 F TOHONO O'ODHAM SELLS
SLOWDOWN,JOE H 03/24/08 M CADDO TRIBE IND SULPHUR
ZABALA-LOPEZ,SUMO 04/14/08 M TOHONO O'ODHAM VAYA CHIN
DAVIS,WYLIE 01/04/09 M SEMINOLE NATION SEMINOLE
End of report.

```

## 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.

## 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)

Command	Shortcut	Description
EXIT	<F1>E	Exit form (asks whether changes should be saved)
CLOSE	<F1>C	Close window & return to previous level
SAVE	<F1>S	
NEXT PAGE	<F1><Down>	Go to next page
REFRESH	<F1>R	Repaint screen

### B.2 Other Shortcut Keys

Action	Shortcut
Exit form and save changes	<F1>E
Quit form without saving changes	<F1>Q
Invoke Record Selection Page	<F1>L

### B.3 Cursor Movement

Action	Shortcut
Move right one character	<Right arrow>
Move left one character	<Left arrow>
Move right one word	<Ctrl-L> or <F1><Space>
Move left one word	<Ctrl-J>
Move to right of window	<F1><Right>
Move to left of window	<F1><Left>
Move to end of field	<F1><F1><Right>
Move to beginning of field	<F1><F1><Left>

### B.4 Modes

Action	Shortcut
Insert/Replace toggle	<PF3>
Zoom (invoke multiline editor)	<F1>Z

## B.5 Deletions

Action	Shortcut
Character under cursor	<PF2> or <Delete>
Character left of cursor	<Backspace>
From cursor to end of word	<Ctrl-W>
From cursor to end of field	<F1><PF2>
Toggle null/last edit/default	<F1>D or <Ctrl-U>

## B.6 Macro Movement

Action	Shortcut
Field below	<Down>
Next page	<F1><Down> or: <PageDown>
Field above	<Up>
Previous page	<F1><Up> or: <PageUp>
Field to right	<Tab>
Next block	<F1><PF4>
Field to left	<PF4>
Jump to a field	^ <b>FieldName</b>
Pre-defined order	<Enter>
Go to Command Line	^
Go into multiple or word processing field	<Enter>

## Appendix C: Full Screen Editor – Crib Sheet

### C.1 Navigation

Action	Key Sequence
Incremental movement	Arrow keys
One word left	<Ctrl-J>
One word right	<Ctrl-L>
Next tab stop to the right	<Tab>
Jump left	<F1><Left>
Jump right	<F1><Right>
Beginning of line	<F1><F1><Left>
End of line	<F1><F1><Right>
Screen up	<F1><Up> or: <PrevScr> or: <PageUp>
Screen down	<F1><Down> or: <NextScr> or: <PageDown>
Top of document	<F1>T
Bottom of document	<F1>B
Go to a specific location	<F1>G

### C.2 Exiting/Saving

Action	Key Sequence
Exit and save text	<F1>E
Quit without saving	<F1>Q
Exit, save, and switch editors	<F1>A
Save without exiting	<F1>S

### C.3 Deleting

Action	Key Sequence
Character before cursor	<Backspace>

Action	Key Sequence
Character at cursor	<PF4> or: <Remove> or: <Delete>
From cursor to end of word	<Ctrl-W>
From cursor to end of line	<F1><PF2>
Entire line	<F1>D

## C.4 Settings/Modes

Action	Key Sequence
Wrap/nowrap mode toggle	<PF2>
Insert/replace mode toggle	<PF3>
Set/clear tab stop	<F1><Tab>
Set left margin	<F1> ,
Set right margin	<F1> .
Status line toggle	<F1> ?

## C.5 Formatting

Action	Key Sequence
Join current line to next line	<F1>J
Reformat paragraph	<F1>R

## C.6 Finding

Action	Key Sequence
Find text	<F1>F or: <Find>
Find next occurrence of text	<F1>N
Find/Replace text	<F1>P

## C.7 Cutting/Copying/Pasting

Action	Key Sequence
Select (Mark) text	<F1>M at beginning and end of text
Deselect (Unmark) text	<F1><F1>M

Action	Key Sequence
Delete selected text	<Delete> or: <Backspace> on selected text
Cut and save to buffer	<F1>X on selected text
Copy and save to buffer	<F1>C on selected text
Paste from buffer	<F1>V
Move text to another location	<F1>X at new location
Copy text to another location	<F1>C at new location

## 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 user 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

<b>Acronym</b>	<b>Term Meaning</b>
<b>CHR</b>	Community Health Representative
<b>HHS</b>	Department of Health and Human Services
<b>HP</b>	Health Problem
<b>IHS</b>	Indian Health Service
<b>RPMS</b>	Resource and Patient Management System
<b>RoB</b>	Rules of Behavior
<b>SC</b>	Service Code

## Contact Information

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

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

**Web:** <http://www.ihs.gov/helpdesk/>

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