DOCUMENTATION AND CODING GUIDELINES FOR PUBLIC HEALTH NURSES

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FOREWORD

This manual is written for public health nurses in the Indian Health Service, in Tribal health facilities, and in urban Indian health facilities. A draft was reviewed by public health nurses in the field.

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

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

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

The text is written in U.S. Government Printing Office style. The use of acronyms is kept to a minimum.

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

If you have any comments, please contact Cheryl Peterson at cheryl.peterson@ihs.gov or at (301) 443–1870.

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1.0 STANDARDIZED DOCUMENTATION

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

1.1 What to Document and When to Do It

A public health nurse must make a record (either electronically or on hard copy) of every *significant, patient-focused* service. Examples of such a service may be a clinic visit, home visit, office visit, community visit, telephone call, case conference, chart review, or education class. The nurse's documentation should answer the following questions:

- Is the reason for the patient encounter documented in the medical record?
- Are all services that were provided correctly documented?
- Does the medical record clearly explain the medical necessity of the level of service, diagnostic and therapeutic procedures, support services, and supplies provided?
- Is the assessment of the patient's condition apparent in the medical record?
- Does the medical record contain information about the patient's progress, as well as the results of treatment?
- Does the medical record include the patient's plan for care?
- Does the information in the medical record describing the patient's condition provide reasonable medical rationale for the services and the choice of setting in which the services were provided?
- Does the information in the medical record support the care given, especially when another health care professional must assume care or perform medical review?
- Is the medical record legible and comprehensible to the other health care personnel?

Documentation has to occur in a timely fashion, usually at the end of the workday. Delaying documentation leads to incomplete or inaccurate information. Memory fades over time, and the nurse will likely forget some details if he or she does not document an activity on the day that it happened.

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

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

Refusals

Documenting services refused is just as important as documenting services provided. If a patient refuses a service, the health care provider must document that refusal to show that the provider did his or her best to offer a service according to standards of care. This documentation is an important risk management activity, because it will help protect the provider if any legal issues arise from a negative outcome to the patient. It is also very important that these refusals be recorded in the Electronic Health Record (which is explained below). The fact that the reporting required to comply with the Government Performance and Results Act no longer requires the recording of refusals should not be interpreted as a lessening of the need to document services refused.

1.2 Understanding the Data Collection Process

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

forms that record visit information and activities. However, public health nurses at some facilities are still filling out Patient Care Component (PCC) forms.

EHR

In regard to electronic health records, the data collection process is fairly straightforward. Fields in the EHR database are programmed with drop down menus and other functions to ease data entry. It is the nurse's responsibility to fill in the fields properly.

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

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

PCC

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

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

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

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

After the public health nurse completes by hand the PCC form, she or he delivers it to a medical records department. One copy of the form is placed in the patient's health record, and a second copy is delivered to a data entry department. Data entry staff reads the second copy and enters information into the RPMS (which is then used to generate reports).

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

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

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

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

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

2.1 Do's

- Check that you have the correct chart number or have retrieved the correct patient in the Electronic Health Record (EHR) before you begin documentation.
- Make sure your documentation reflects the nursing process and your professional capabilities.
- Write legibly.
- Chart the time you gave a medication, the administration route, and the patient's response. The Five Rights:
  - Right patient
  - Right medication
  - Right dose
  - Right route
  - Right time.
- Chart precautions or preventive measures used.
- Record each phone call to a physician or patient, including the exact time, message, and response.
- Chart patient care at the time you provide it or as soon as possible. Be sure documentation is completed at the end of each workday.
- If you remember an important point after you've completed your documentation, chart the information with a notation that it is a "late entry." Include the date and time of the late entry.
- Document often enough to tell the whole story.

2.2 Don'ts

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

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

Public health nurses must create public health nursing clinics in the Resource and Patient Management System (RPMS) before entering nursing information into patient files in the Electronic Health Record. After setting up the clinics in RPMS, nurses will do the vast majority of their documentation in the Electronic Health Record, which, fortunately, operates in a much more user-friendly environment.

Before starting, the public health nurse needs to find out who the "clinic owner" is for his or her RPMS. The clinic owner is the staff person responsible for managing the RPMS software. Many times, there are two clinic owners. They usually work in a medical records or business office.

3.1 Log onto the RPMS

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

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

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

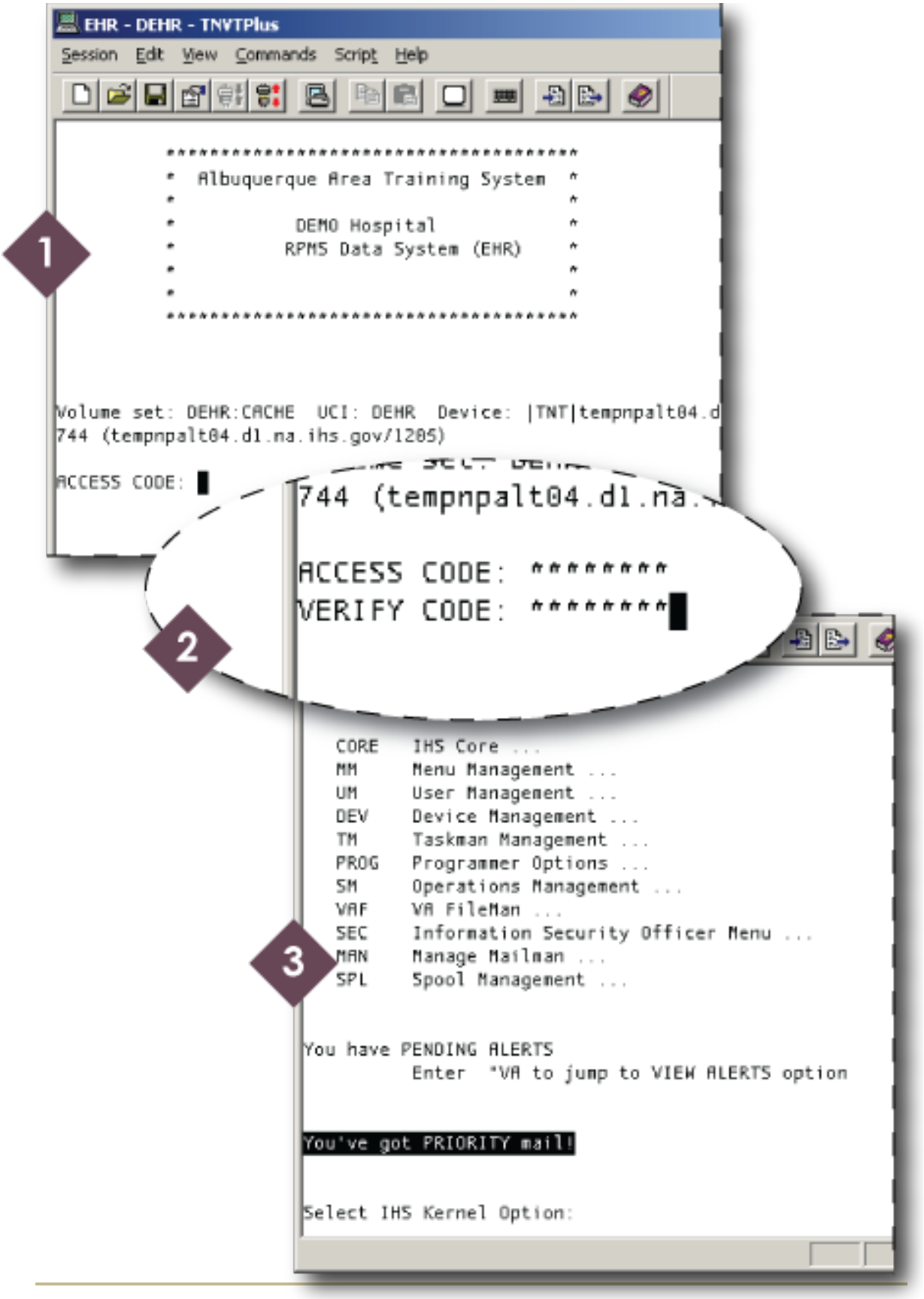
You will stay logged into RPMS until you quit the program or until one of these two instances happens:

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

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

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

Figure 3.1. Logging Onto RPMS



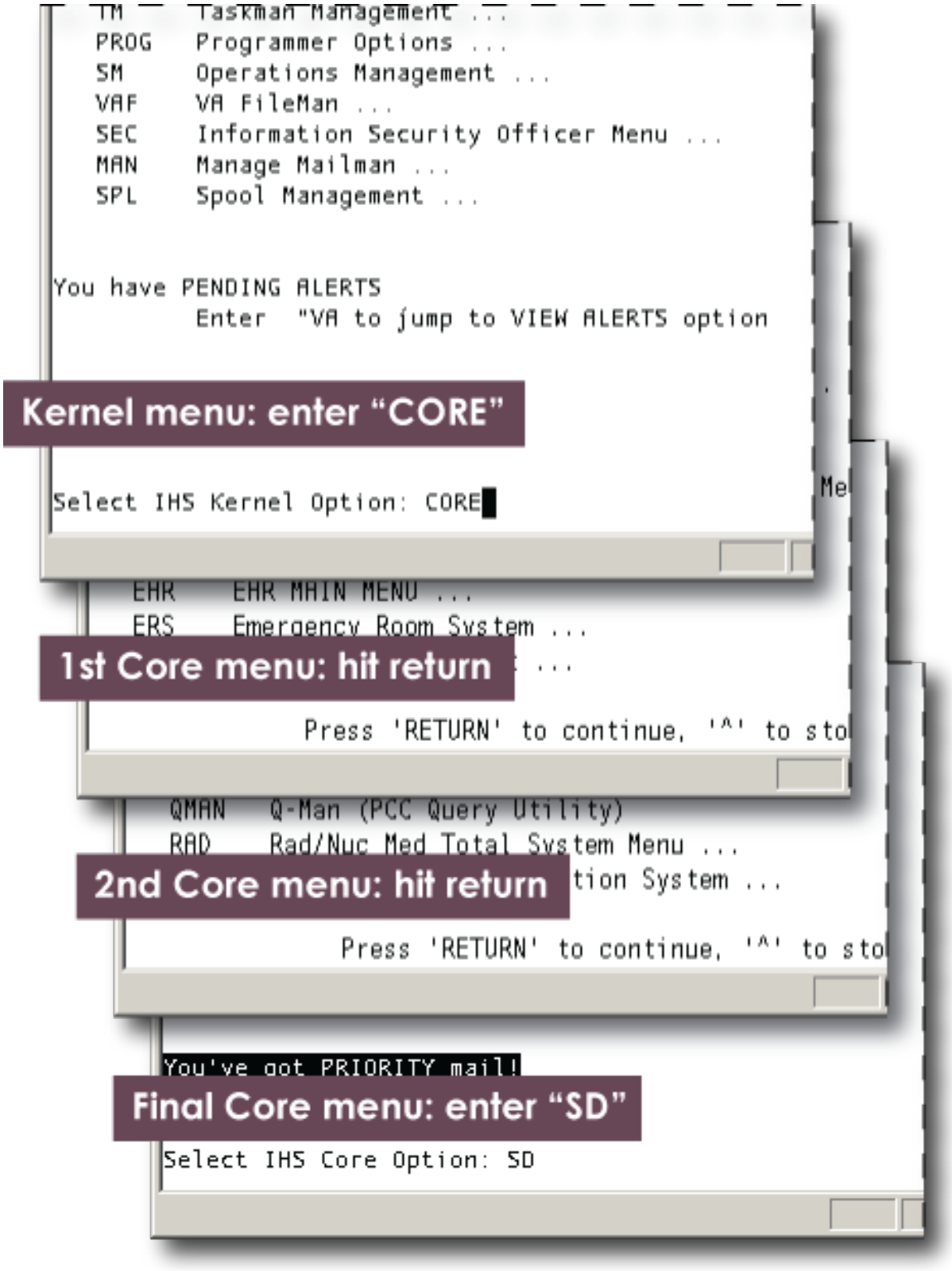
3.2 Navigate RPMS Menus

Users must navigate through several RPMS menus before arriving at the clinic setup application. After logging in, the first menu the user sees is the IHS Kernel menu. There will be a prompt at the bottom that reads "Select IHS Kernel Option." Type in "CORE" for the IHS Core menu.

> *Long menus*
>
> The Core menu is lengthy. In RPMS, when a menu has more than 22 items, the system spreads the menu out over several screens. The user has to hit return at the end of each screen until the final screen appears. RPMS will not accept a menu selection before the final screen.

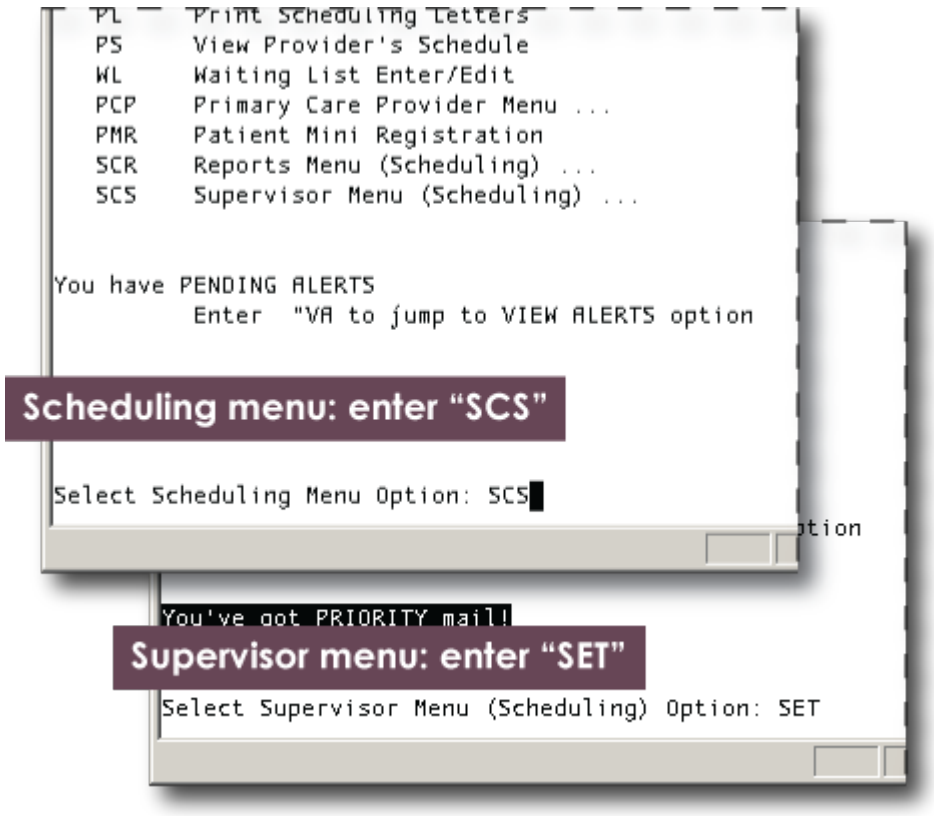
At the bottom of the final Core menu, where it reads "Select IHS CORE Option," type in "SD" (for the Scheduling Menu) and hit return. See Figure 3.2a below to see how to navigate the Core menu.

Figure 3.2a. Navigating the Core Menu



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

Figure 3.2b. Navigating the Scheduling and Supervisor Menus

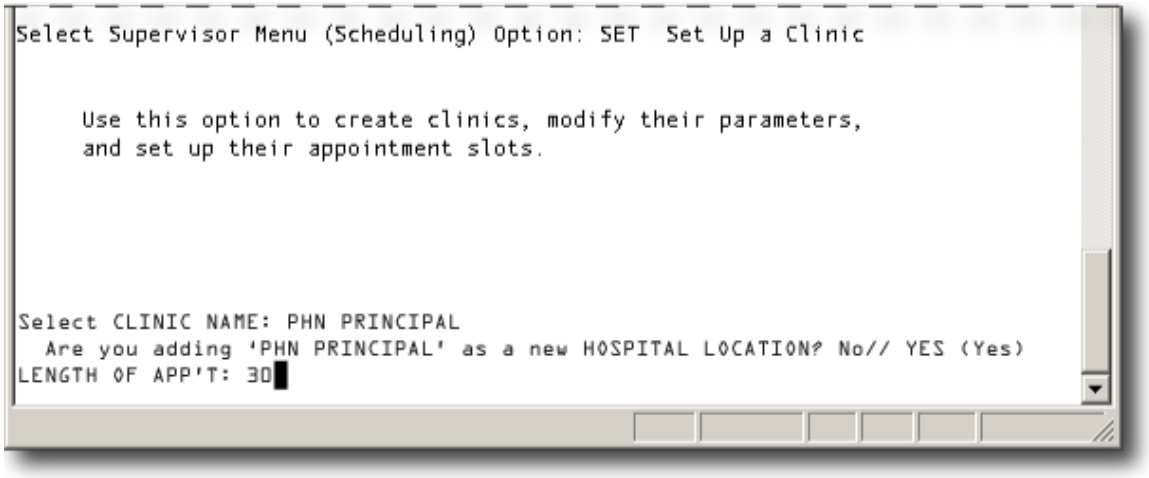


3.3 Setting Up a Clinic, Starting with PHN PRINCIPAL

The next step is to set up a principal clinic definition, which will help with reporting. When a report is needed for all public health nursing (PHN) clinics, only this principal clinic name will need to be entered to access all parameter definitions of this type of clinic.

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

Figure 3.3a. Clinic Name and Length of Appointment



Default options

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

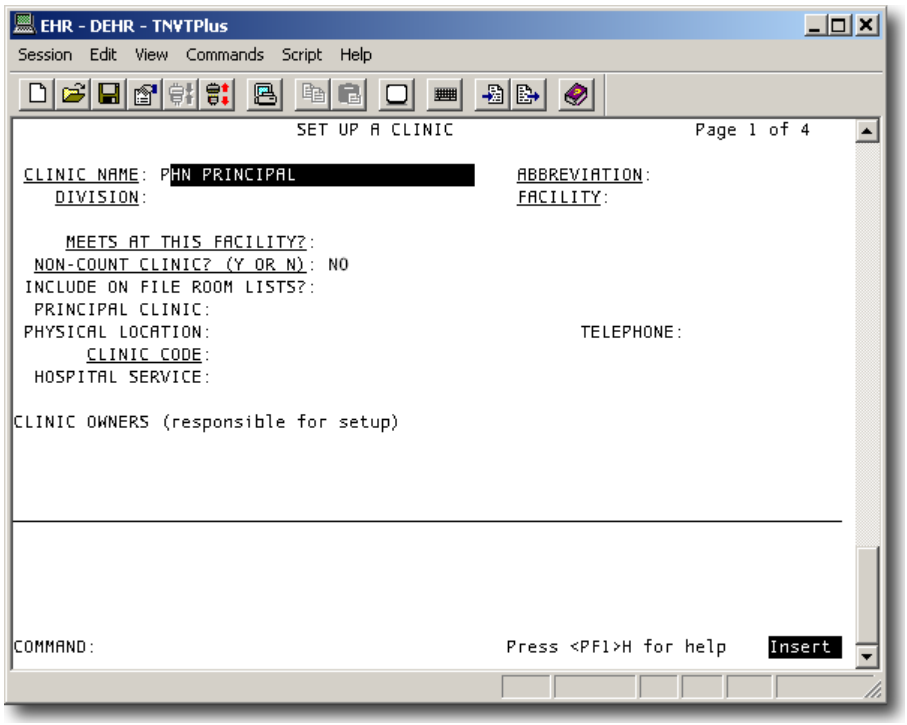
The next four screens in RPMS will be used to set up the PHN PRINCIPAL clinic and can be used to set up other public health nursing clinics. (These screens are sometimes referred to as the Patient Information Management System scheduling application, or PIMS.) Clinics will not appear in the Electronic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

clinics set up in RPMS will automatically appear as default information for clinics in the EHR.

Keyboard navigation

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

Figure 3.3b. First Clinic Setup Screen

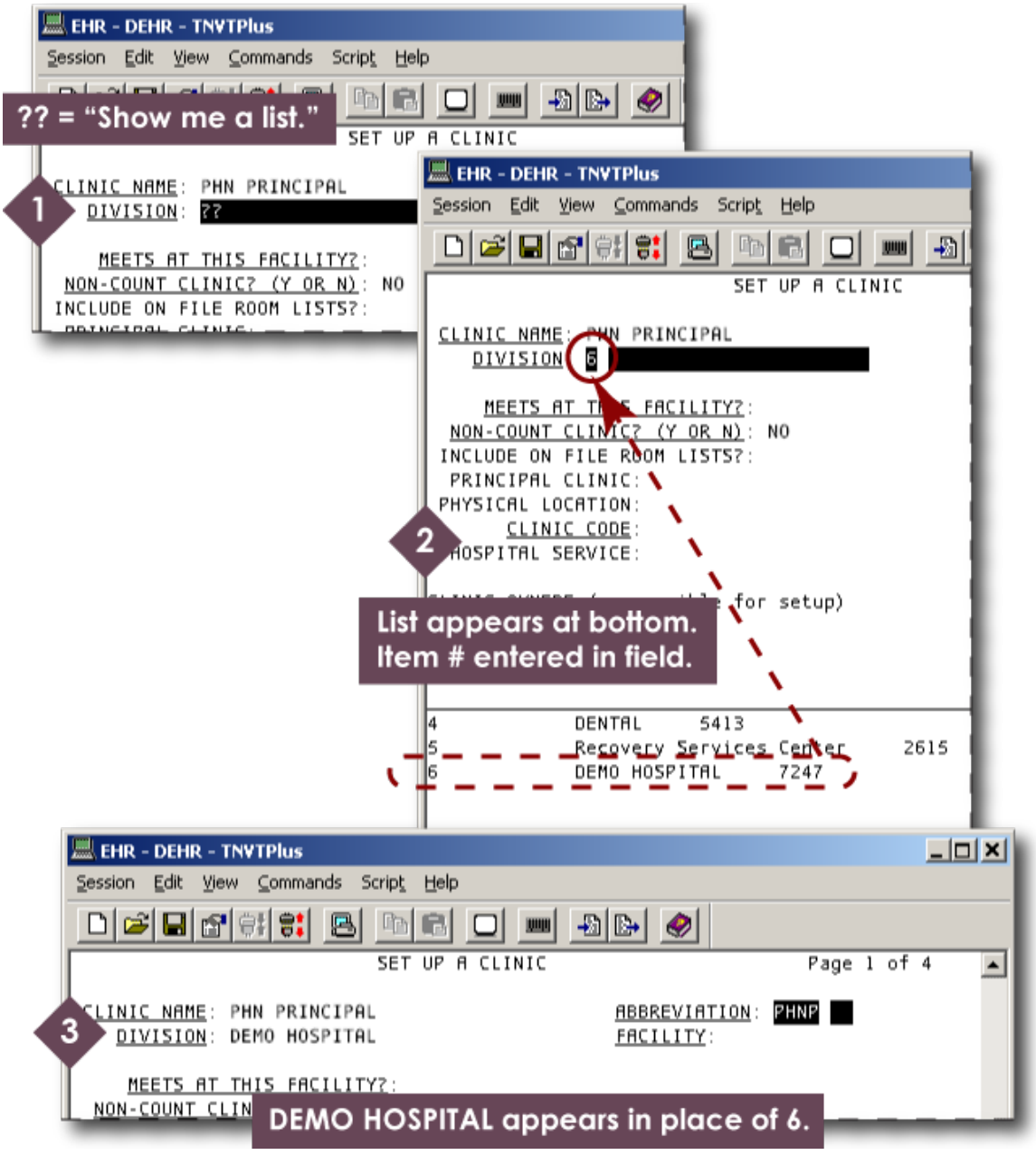


In the first Clinic Setup screen, PHN PRINCIPAL already appears in the first field. No change here is necessary. Type return or enter to advance the cursor to the next field, Division. Type in the division in all capitals and hit return to advance to the Abbreviation field.

What if the user did not know his or her division? Typing two question marks (??) in the Division field and hitting return will bring up a numbered list of divisions at the bottom of the screen. The user would enter a number in the Division field and hit return. The selected division would appear in the Division field and the cursor would appear in the next field, Abbreviation. In Figure 3.3c below, Demo Hospital is the chosen Division, but you should choose your own division when you set up PHN PRINCIPAL in your RPMS.

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

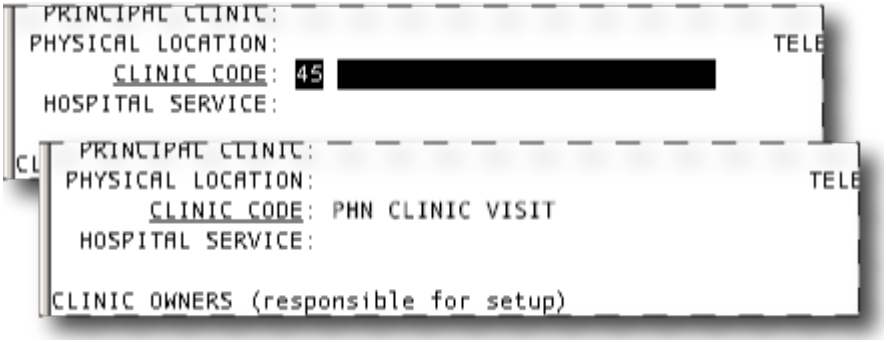
Figure 3.3c. Choosing from a List



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

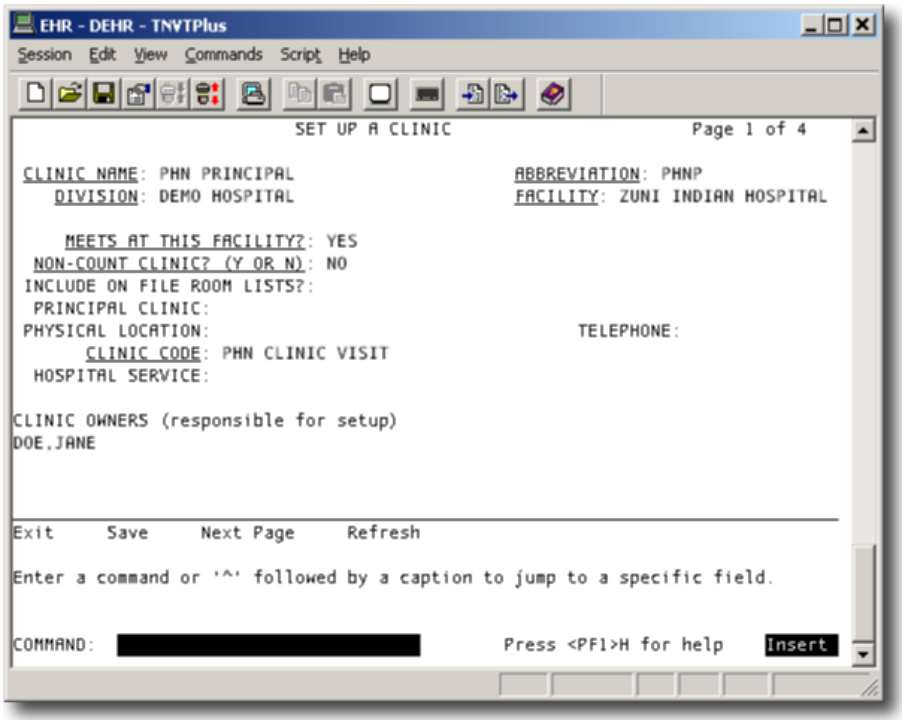
Skip down to the Clinic Code field. Enter the numeral 45 and type return. "PHN CLINIC VISIT" will replace 45. See Figure 3.3d.

Figure 3.3d. Clinic Code



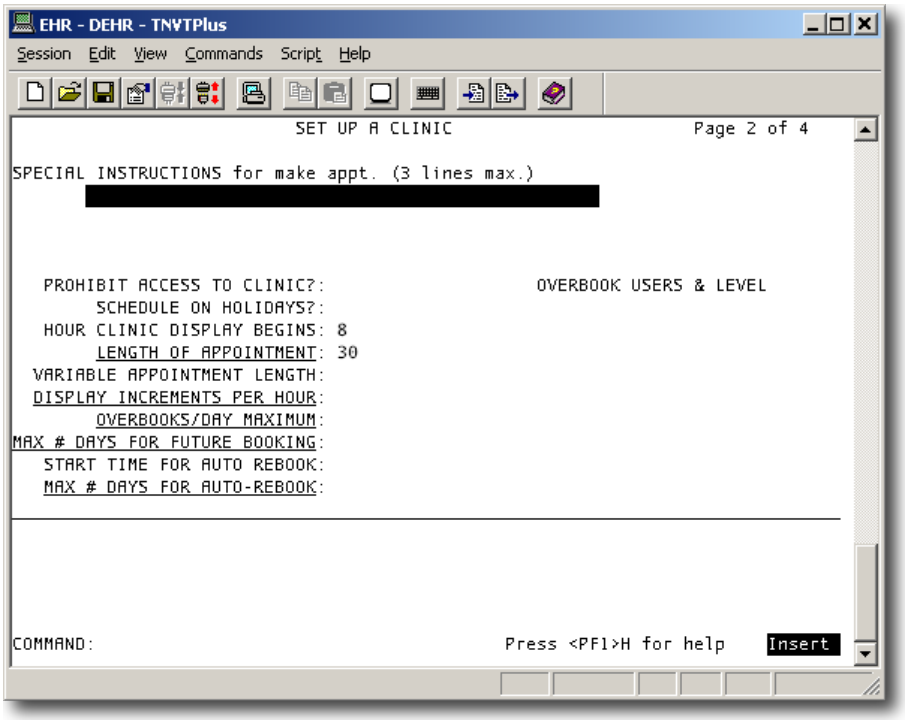
Skip down to the Clinic Owners field. In all capital letters, type in the clinic owner, last name first. Do not leave a space after the comma. Hit return. Figure 3.3e shows a completed first screen for the clinic setup.

Figure 3.3e. First Clinic Setup Screen, Completed



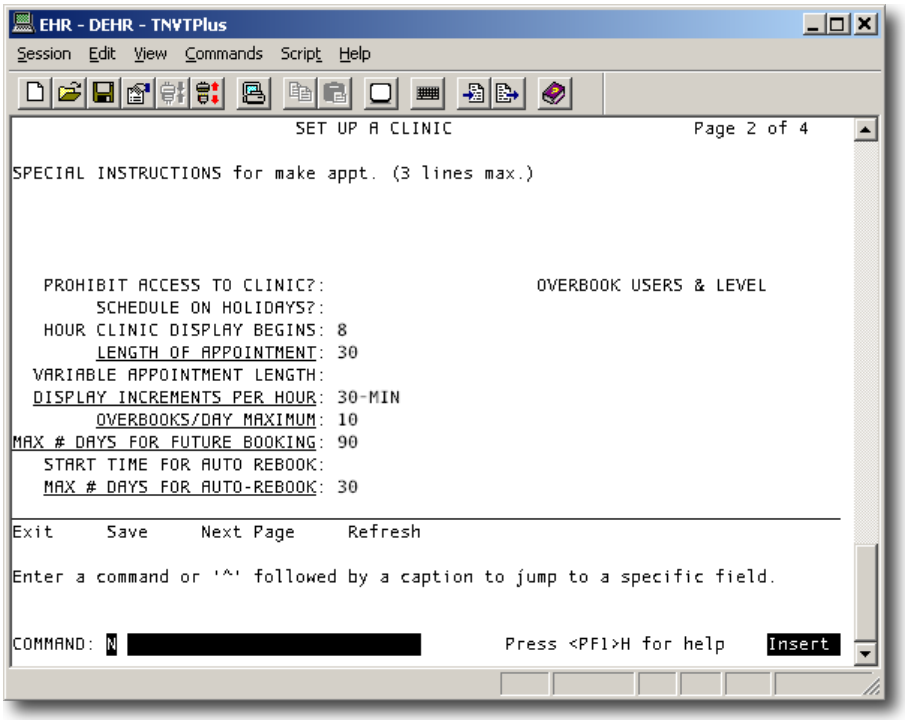
After the Clinic Owners field, the cursor should advance to the Command prompt at the bottom of the screen. See Figure 3.3e. Type capital N for "Next Page" and hit return to advance to the second clinic setup screen.

Figure 3.3f. Second Clinic Setup Screen



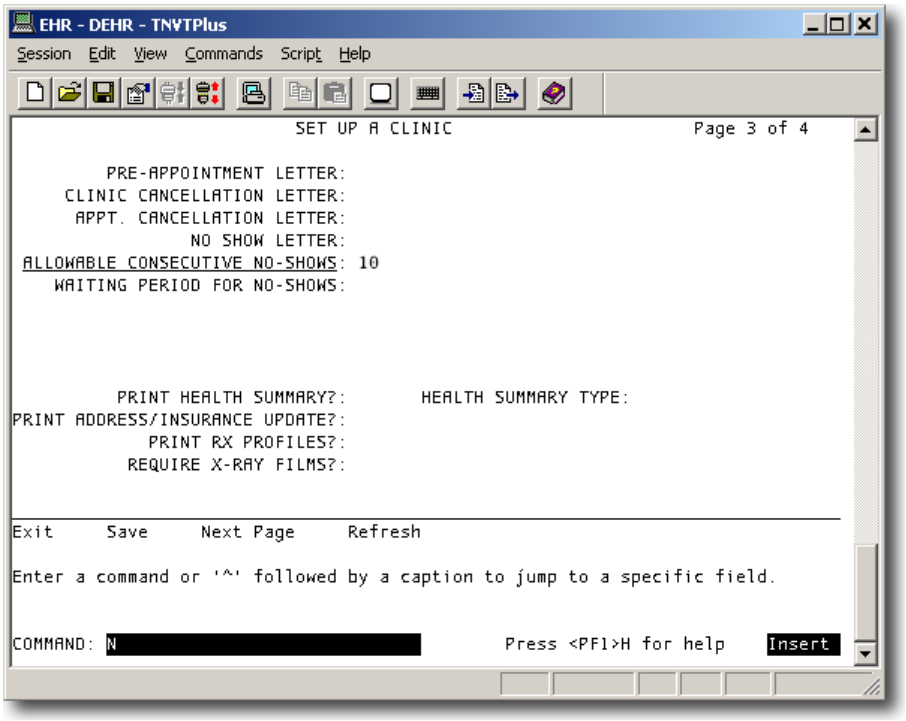
The second setup screen has two fields already filled in: Hour Clinic Display Begins (8) and Length of Appointment (30). See Figure 3.3f. Using the return or Enter key, skip down to the Display Increments per Hour field. Enter "30-MIN" (without quotation marks) and hit return. Enter 10 in the Overbooks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

Figure 3.3g. Second Clinic Setup Screen, Completed



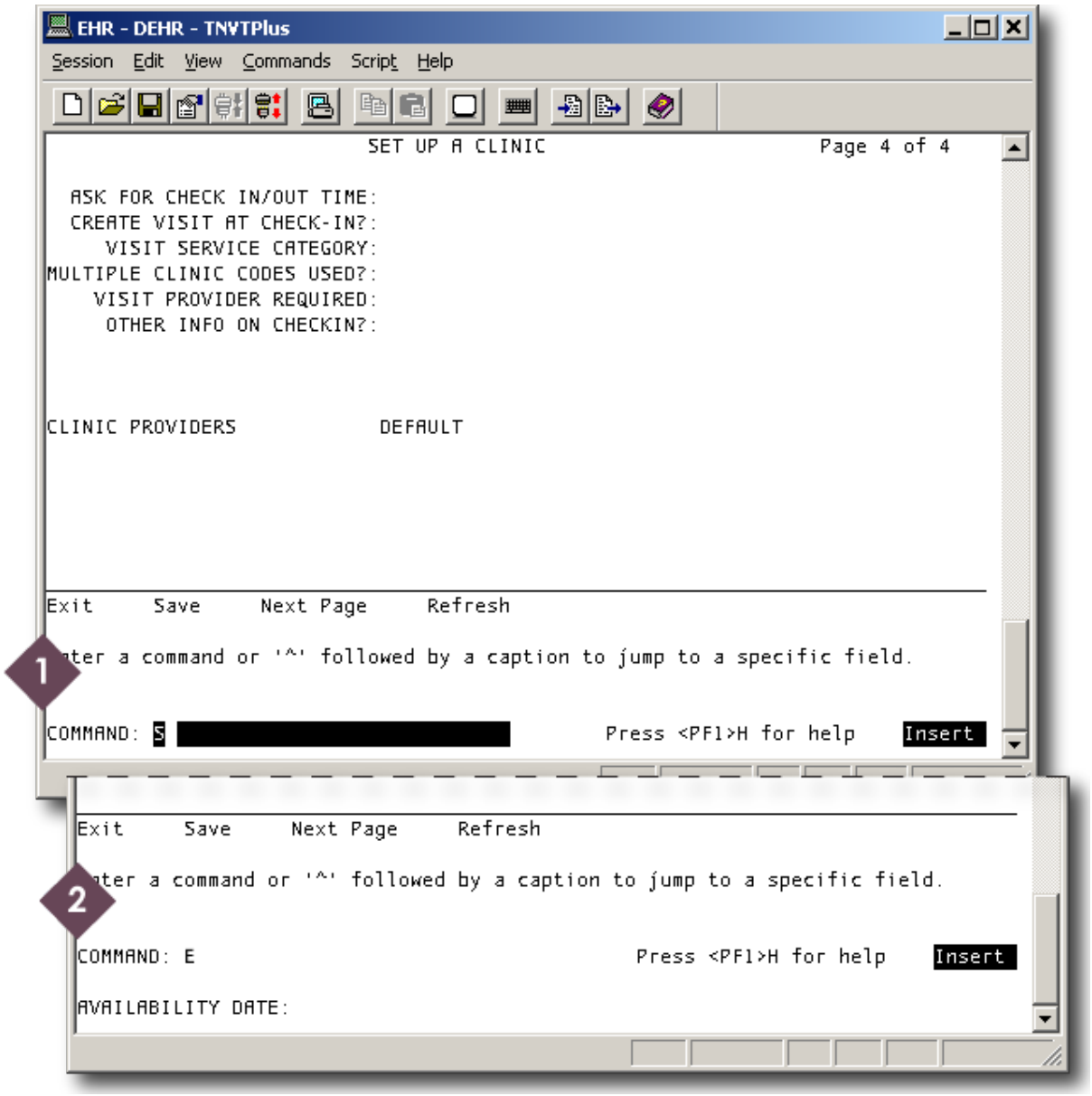
In the third setup screen, skip down to the Allowable Consecutive No-shows field and enter 10. Then, skip down to the Command prompt and type in a capital N.

Figure 3.3h. Third Clinic Setup Screen, Completed



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

Figure 3.3i. Save and Exit



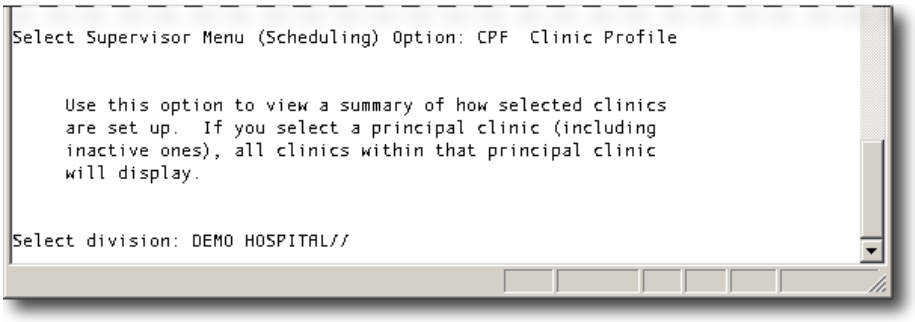
3.4 Review a Clinic After Setup

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

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

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

Figure 3.4a. Select Division, Default

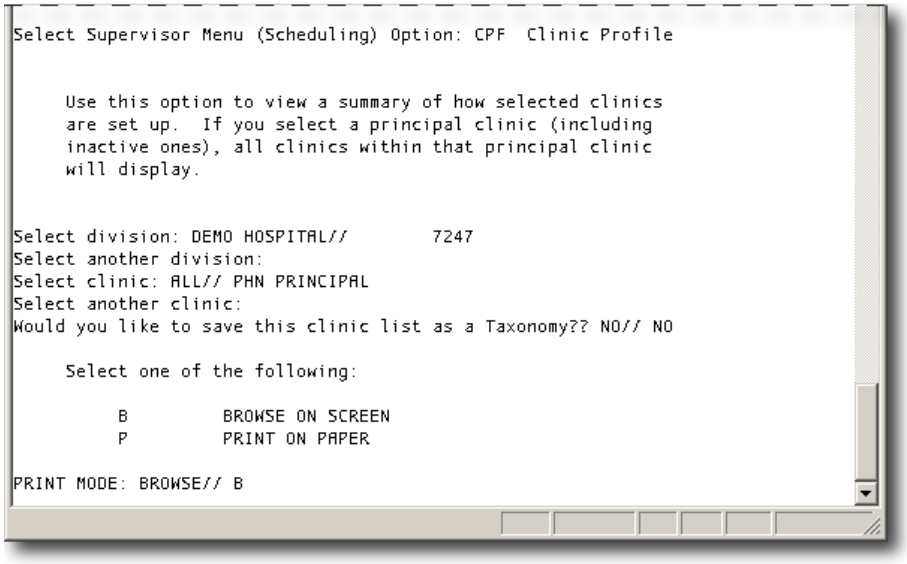


Leave the next prompt ("another division") blank and type return.

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

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

Figure 3.4b. Clinic Profile Menu, Completed



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

Figure 3.4c. Clinic Profile, First Screen

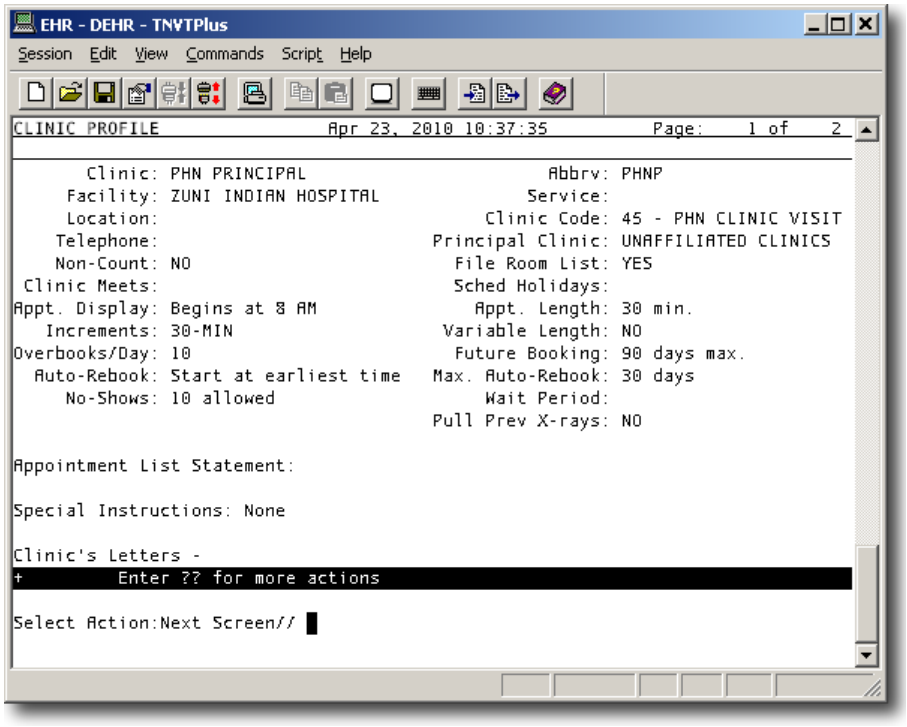
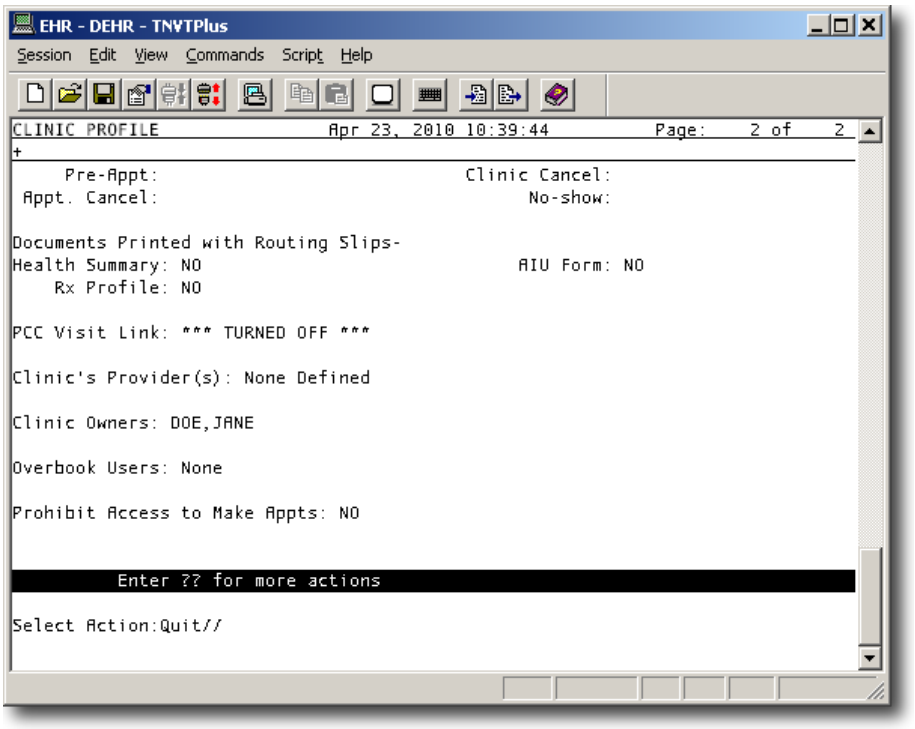


Figure 3.4d. Clinic Profile, Second Screen



3.5 Setting Up Other Public Health Nursing Clinics

Public health nurses should set up at least the first four clinics listed in Table 3.5 below. The rest of the clinics in Table 3.5 are recommended but not required.

Table 3.5. Public Health Nursing Clinics to Set Up

Clinic Name	Abbrev-iation	Clinic Code	Service Category*	Done ☑
PHN CLINIC	PHNC	45	A	☐
HOME VISIT	HV	11	A	☐
SCHOOL	PHNSC	20	A	☐
HOMELESS	HL	D3	A	☐
HOME NOT FOUND	HNF	11	N	☐
PHONE NOT FOUND	PNF	51	N	☐
HOMELESS NOT FOUND	HLNF	D3	N	☐
IMMUNIZATION	IMM	12	A	☐
TELEPHONE	PH	51	T	☐
CHART REVIEW	CR	52	C	☐
LETTER	LT	53	C	☐
EDUC CLASS	EDUC	60	A	☐
CASE MGMT	CM	77	A	☐
OTHER	OT	25	A	☐

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

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

First Screen (See Figure 3.5a)

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

Fourth Screen (See Figure 3.5b)

- In the Visit Service Category field, enter the value from Table 3.5.

- Enter YES in the following fields:
  - Create Visit at Check-in.
  - Multiple Clinic Codes Used.
  - Visit Provider Required.
- Enter the Clinic Provider (last name first, no space after the comma, all caps)

Figure 3.5a. First Clinic Setup Screen, PHN Clinic

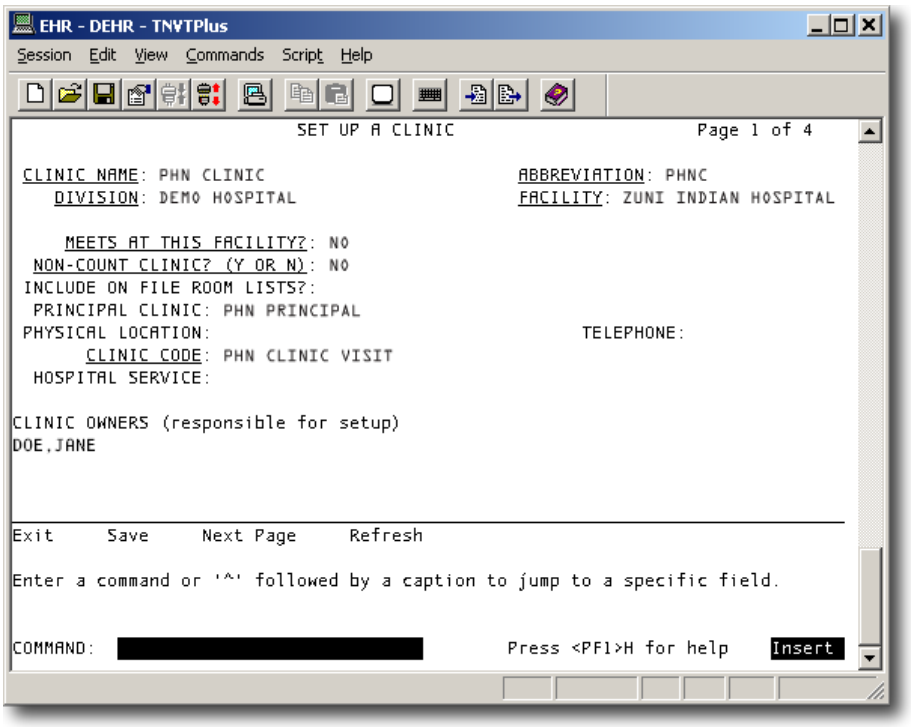
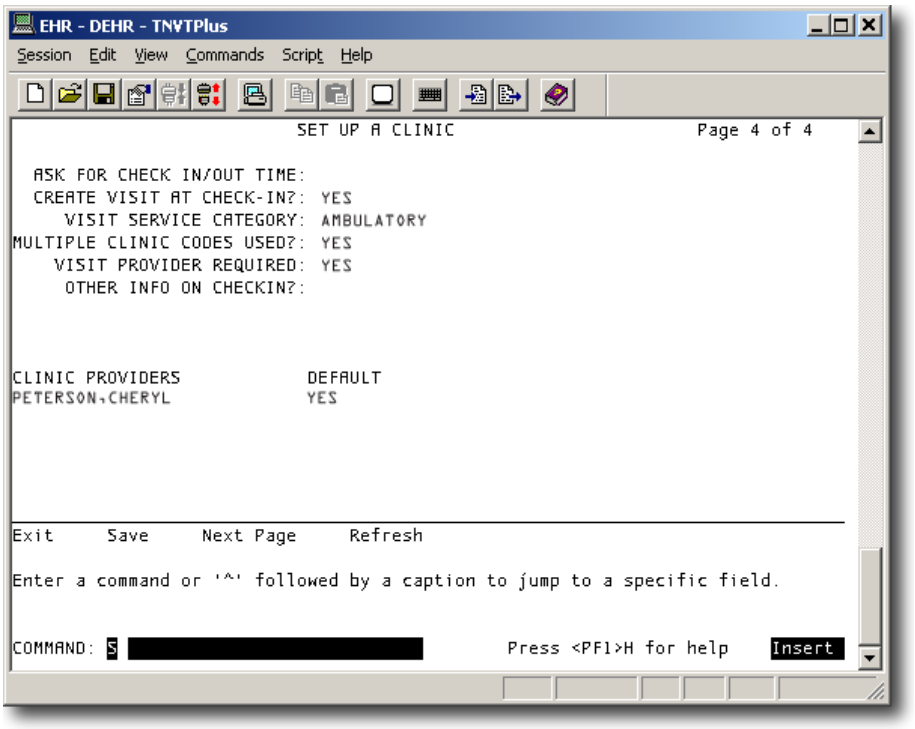


Figure 3.5b. Fourth Clinic Setup Screen, PHN Clinic



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

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

4.0 USING THE ELECTRONIC HEALTH RECORD

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

The following items must be entered into the EHR for each visit:

- Chief complaint.
- Vital signs.
- Immunizations, if given.
- Education, health factors, and exams.
- Purpose of visit.
- Progress note.
- Visit services.
- Allergies, even no known allergy.

4.1 Log In

After launching the Electronic Health Record application, public health nurses sign into the EHR using the same access and verification codes they have for the RPMS. Figure 4.1a displays the login screen. For security, bullets replace whatever is typed in the access code and verify code fields.

Figure 4.1b shows the first screen displayed after login—a blank patient chart. The Patient Chart tab in the top row of tabs is active. See Figure 4.1c. The other two tabs—Privacy and Resources—are almost never used. The Review tab in the second row of tabs is almost always

Figure 4.1a. EHR Login

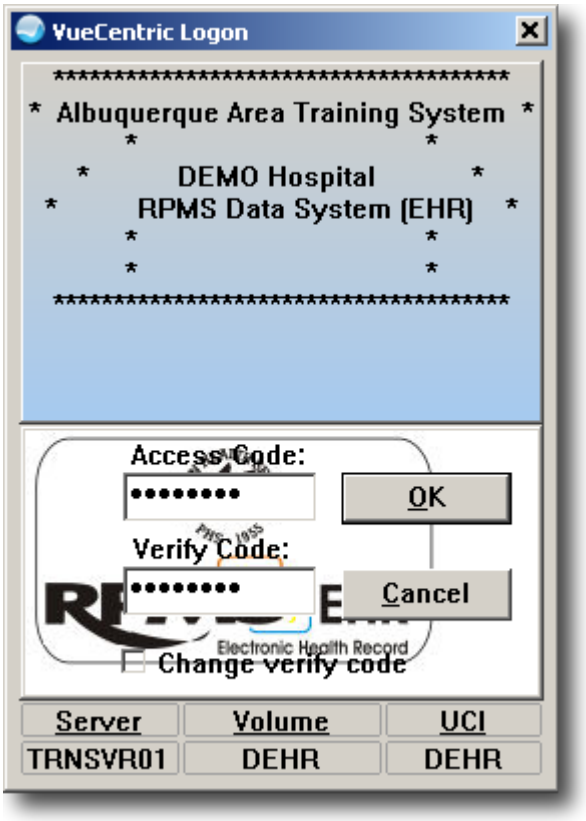
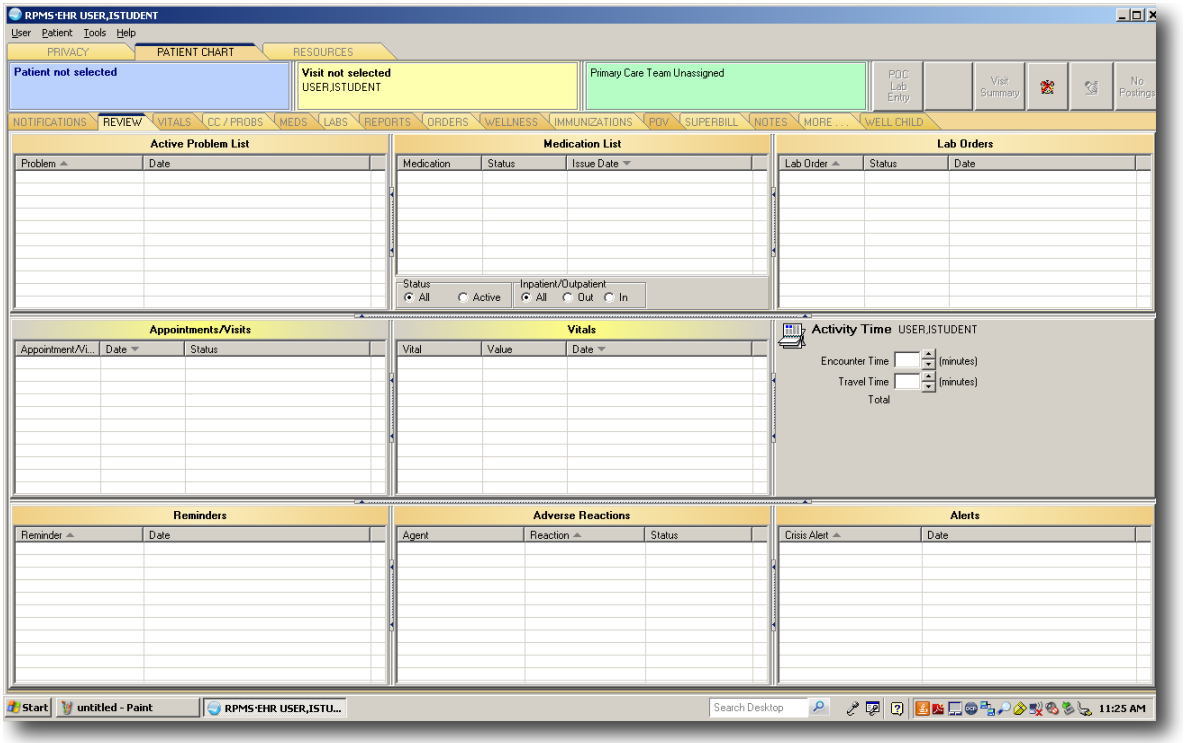
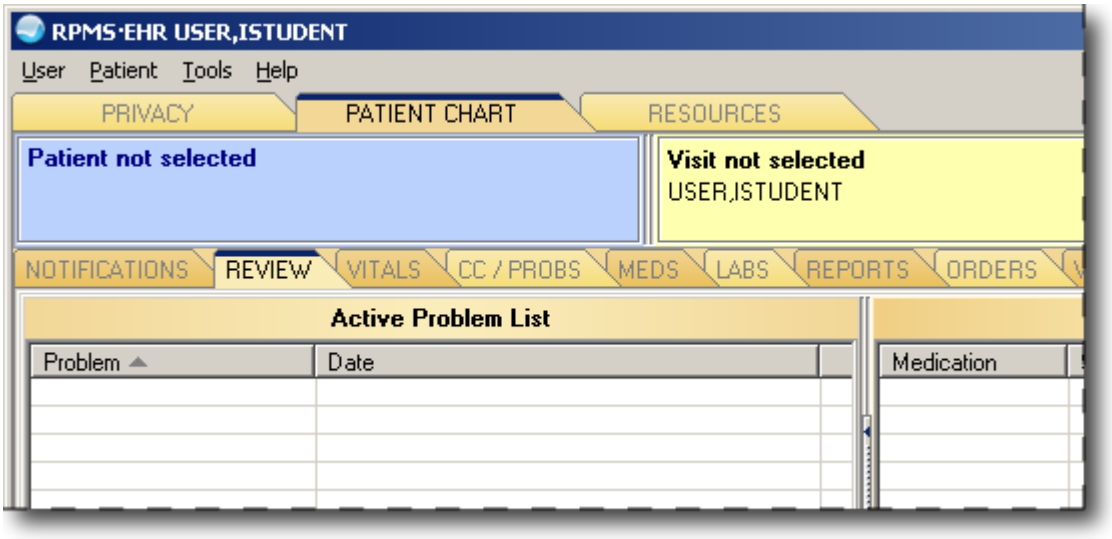


Figure 4.1b. Blank Patient Chart



the first active tab in the patient chart after logging into EHR. In Figure 4.1c, the patient and visit information in the blue and yellow areas have not yet been selected.

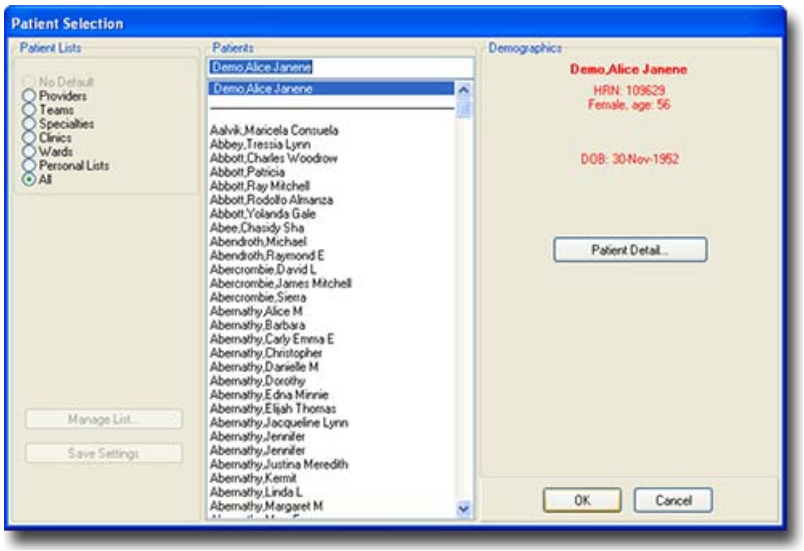
Figure 4.1c. Blank Patient Chart, Patient and Visit Sections



4.2 Set Up Patient and Visit

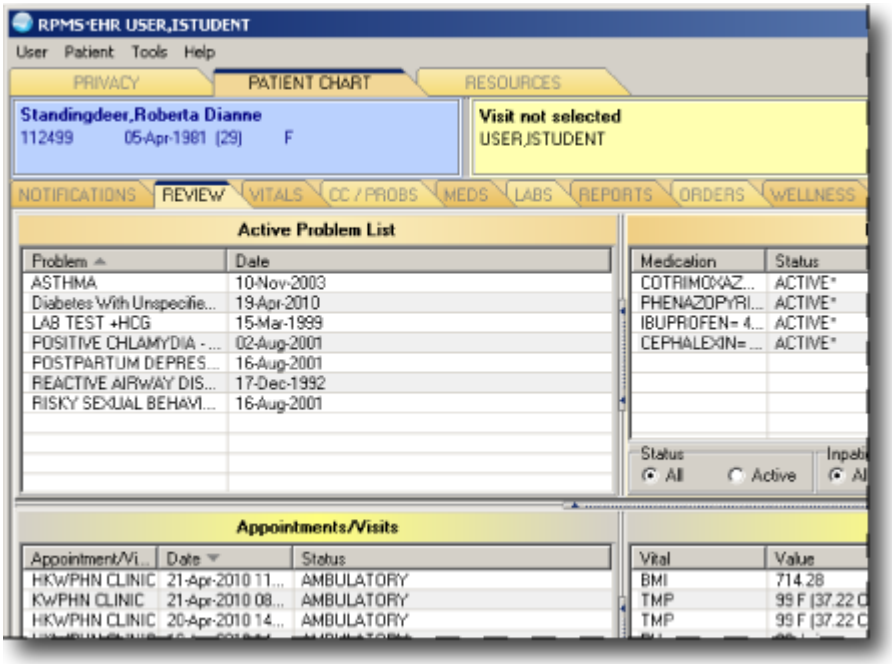
The first order of business is to select a patient. Click on the blue area. The Patient Selection dialog box will appear. See Figure 4.2a. Either type in a patient's name (last name first) or choose the patient's name in the scroll box. The HRN number is the patient's chart number. Click the OK button when finished. The patient information will now appear in the blue area. See Figure 4.2b.

Figure 4.2a. Patient Selection Dialog Box



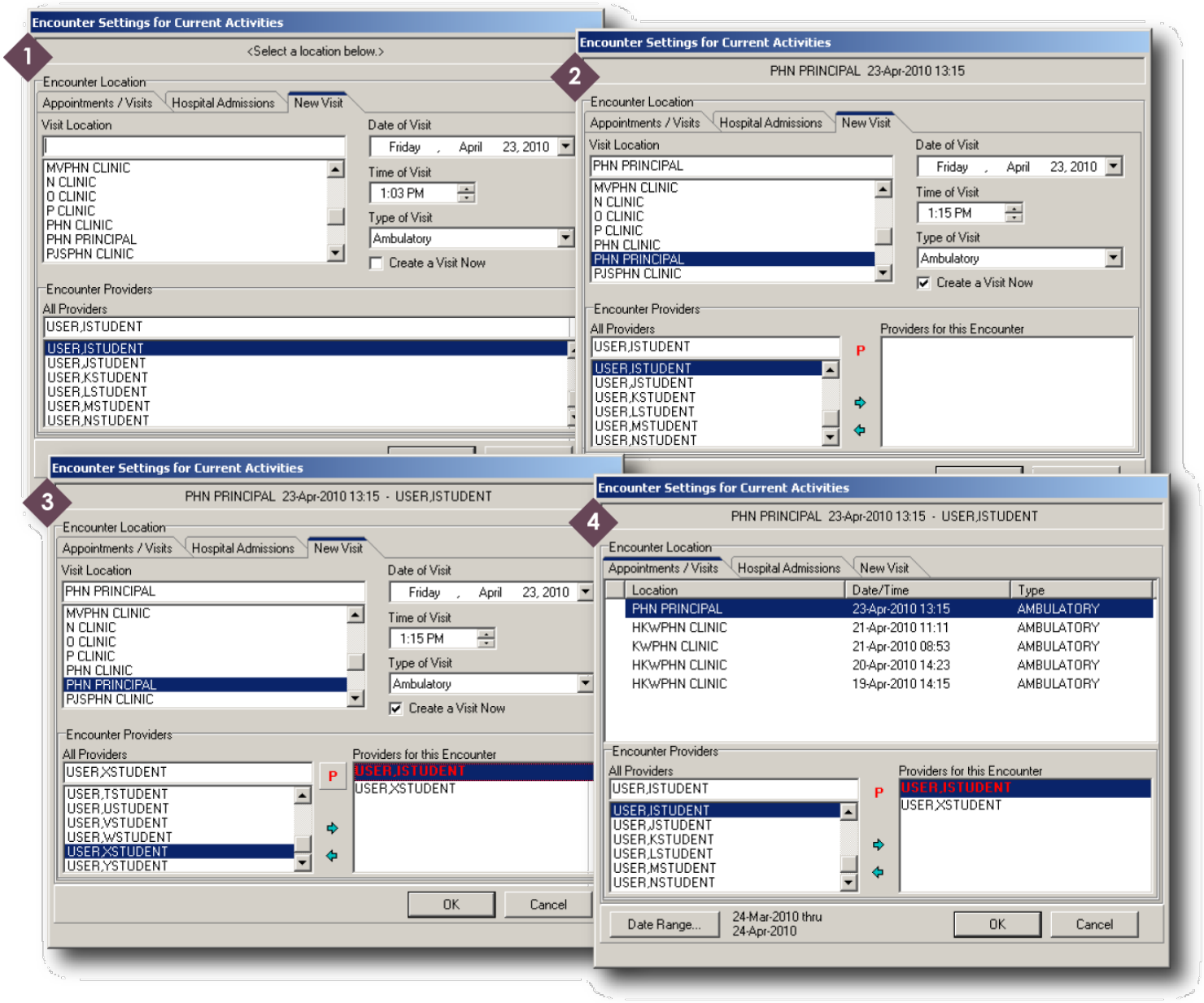
Next, click on the yellow visit area. The Encounter Settings for Current Activities dialog box will pop up. Click on the New Visits tab. The public health nursing visits set up in RPMS—see Section 3—should appear in Visit Location scroll box. Choose a visit. Select a date and time. Click the Create a Visit Now check box. When this box is checked, a new area will appear called Providers for This Encounter. The public health nurse will need to select his or her name in the All Providers scroll box and move it to the Providers for This Encounter area by clicking on the green arrow. The nurse can also select another provider—e.g., a primary physician—and move his or her name into the Providers for This Encounter area. The nurse can designate herself or himself as the primary provider by choosing his or her name in the

Figure 4.2b. Patient Chart With Patient Info; Visit Blank



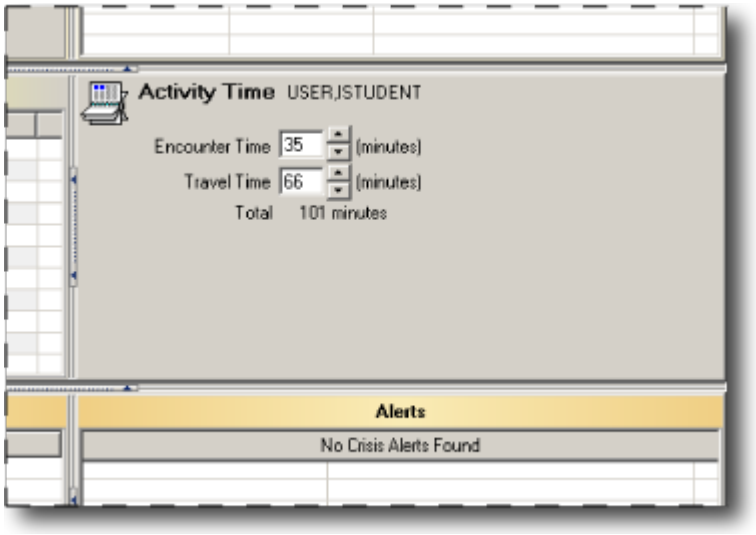
Providers for This Encounter area and clicking on the red "P." In Figure 4.2c, USER,ISTUDENT is the public health nurse, and USER,XSTUDENT is the physician. Clicking on the Appointments/Visits tab reveals visits already created by public health nurse USER,ISTUDENT. Click the OK button when finished. The user will be returned to the patient chart. The Visit Location will appear in the yellow area along with the date and time of the visit.

Figure 4.2c. Encounter Settings, Step by Step



4.3 Activity Time

Figure 4.3. Activity Time

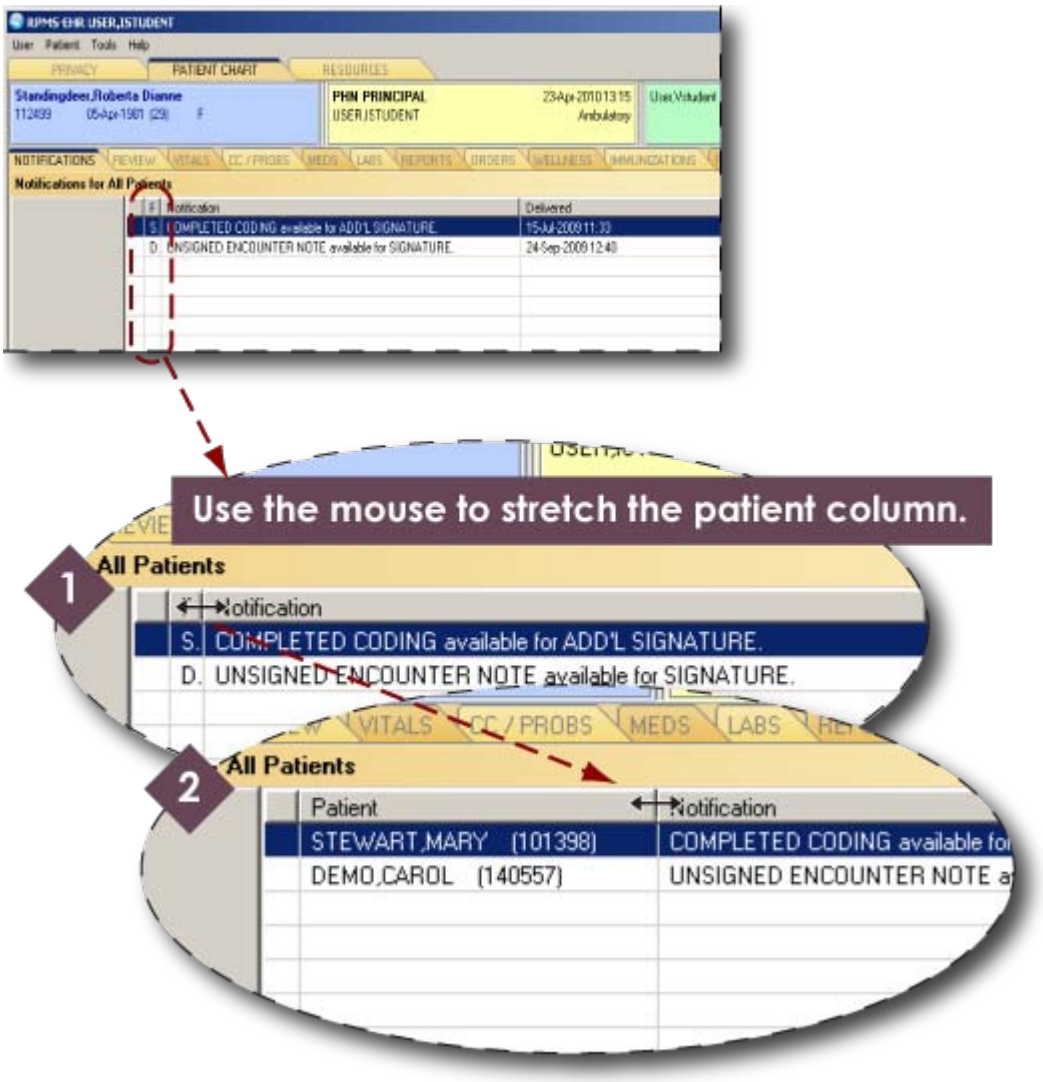


The next step is to fill in the Activity Time in the right center of the patient chart. See Figure 4.3. The Travel Time is the total time spent going to and from the patient's site. The Encounter Time is the face-to-face time with the patient, plus any chart reviews, case management, documentation, etc., completed before and after the patient visit. (In a sense, encounter time is everything but travel time.) The EHR automatically totals the activity time. All times must be in minutes, not in hours.

4.4 Notifications

The public health nurse should check notifications before moving on to the rest of the patient chart. Click on the Notifications tab to the left of the Review tab. The Notifications window contains unsigned orders, notes, etc. Figure 4.4 shows a Notifications window with two items needing signature and explains how to make the patient column visible.

Figure 4.4. Notifications



4.5 Vitals

Click on the Vitals tab. The Vitals window is split in two halves. The left half—Vital Measurement Entry—is where the public health nurse must enter data. See Figure 4.5a. As the nurse enters data on the left side, the right side—Vitals—will show the updated information. Figure 4.5b displays completed vitals documentation. The updated vitals information will also appear in the Vitals area of the Review window.

Figure 4.5a. Vital Measurement Entry

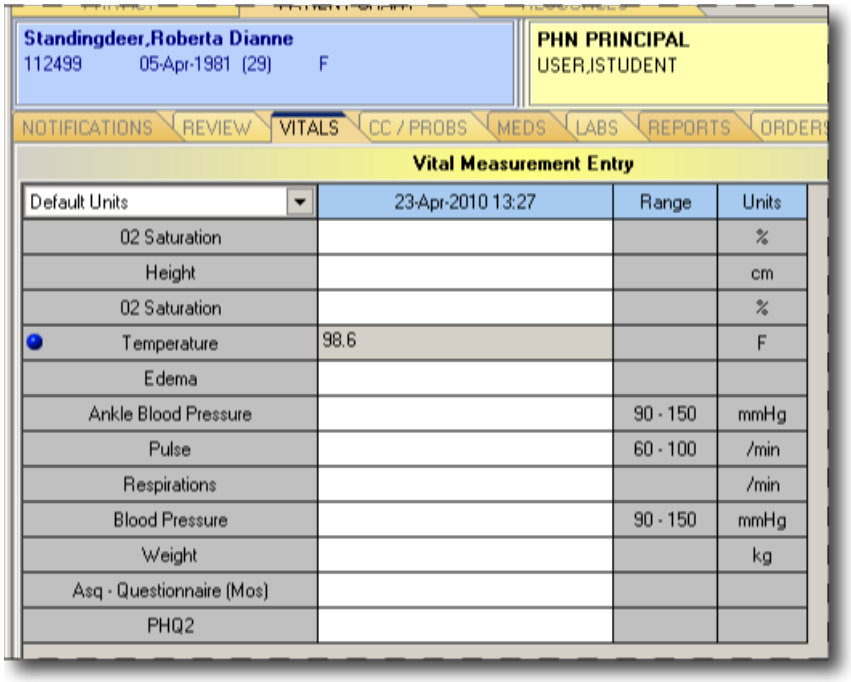
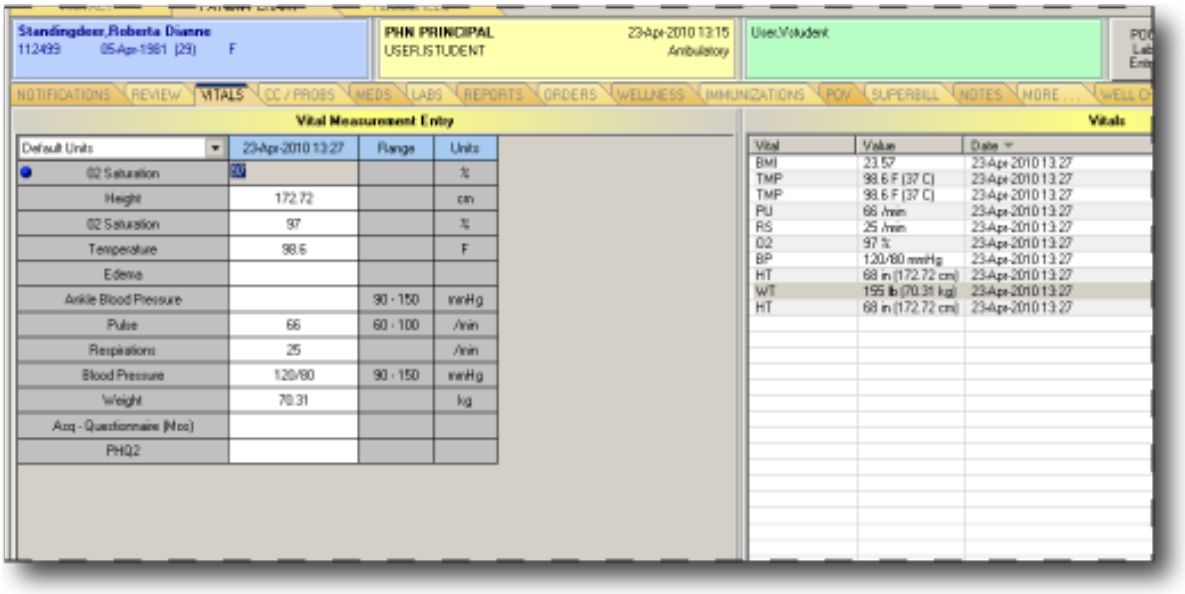


Figure 4.5b. Vitals Entered



4.6 Chief Complaint

Public health nurses must add a chief complaint for a patient encounter. Clicking the "CC/PROBS" tab reveals the Chief Complaint and Problem List page. Figure 4.6a shows an example of what this page looks like before a chief complaint has been entered. Click on the Add button on the far right in the Chief Complaint area. The Chief Complaint dialog box will appear. Type in the patient's chief complaint in the text box in the top half, as shown in Figure 4.6b. Below the text box is a list of symptoms to choose from. Because most of the symptoms refer to ambulatory patients visiting a health center, a public health nurse will probably not use this option. Click the OK button to close the Chief Complaint dialog box. The new chief complaint appears in the Chief Complaint area of the CC/PROBS window.

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

Figure 4.6a. Chief Complaint and Problem List Window; Add Button Circled

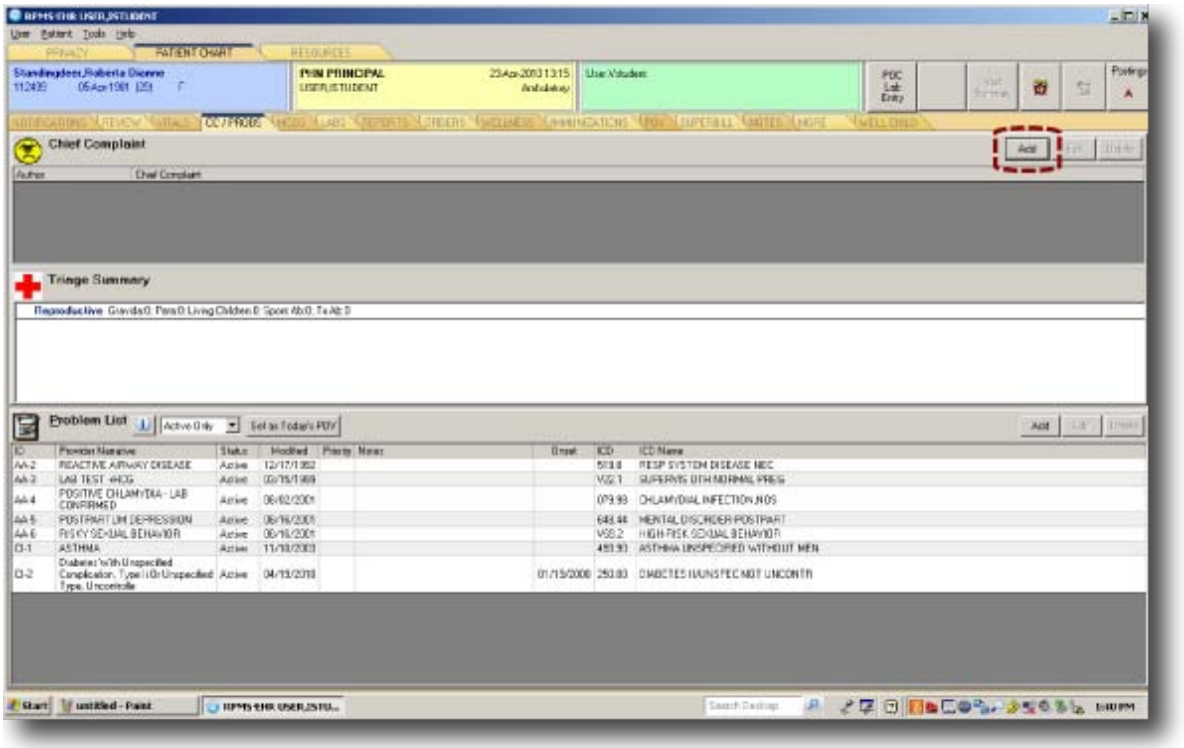


Figure 4.6b. Chief Complaint Dialog Box

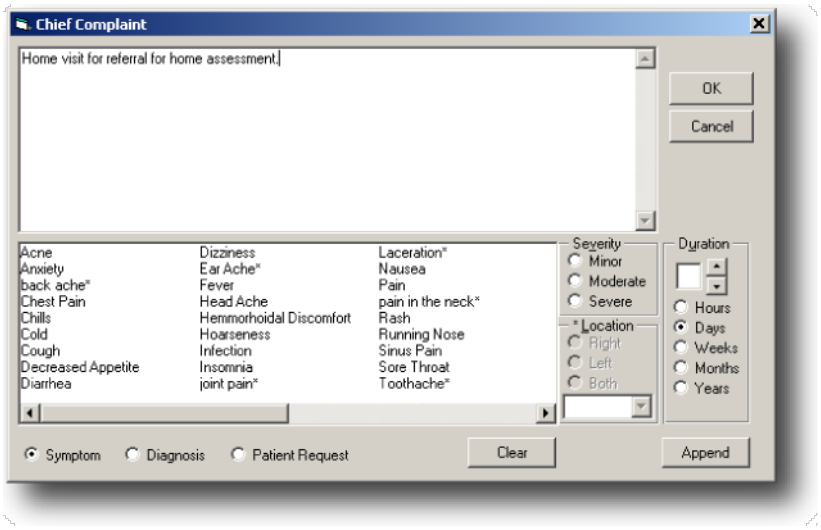
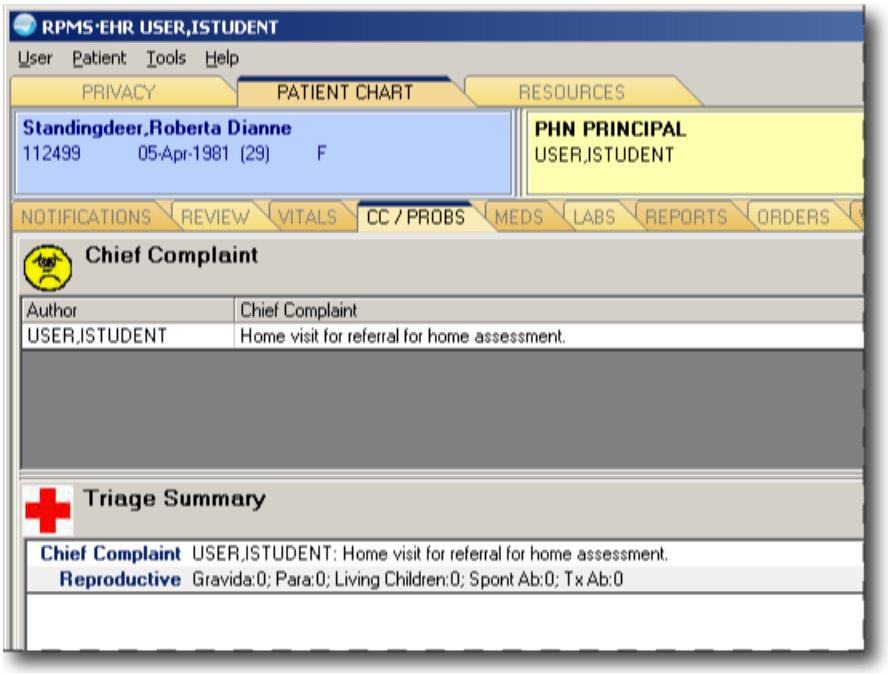
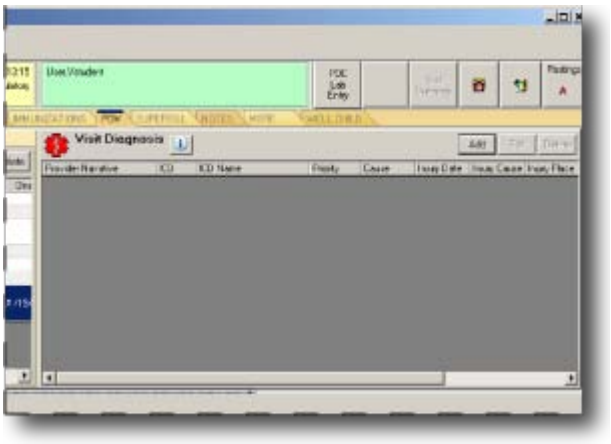


Figure 4.6c. Chief Complaint Completed



4.7 Purpose of Visit (POV)

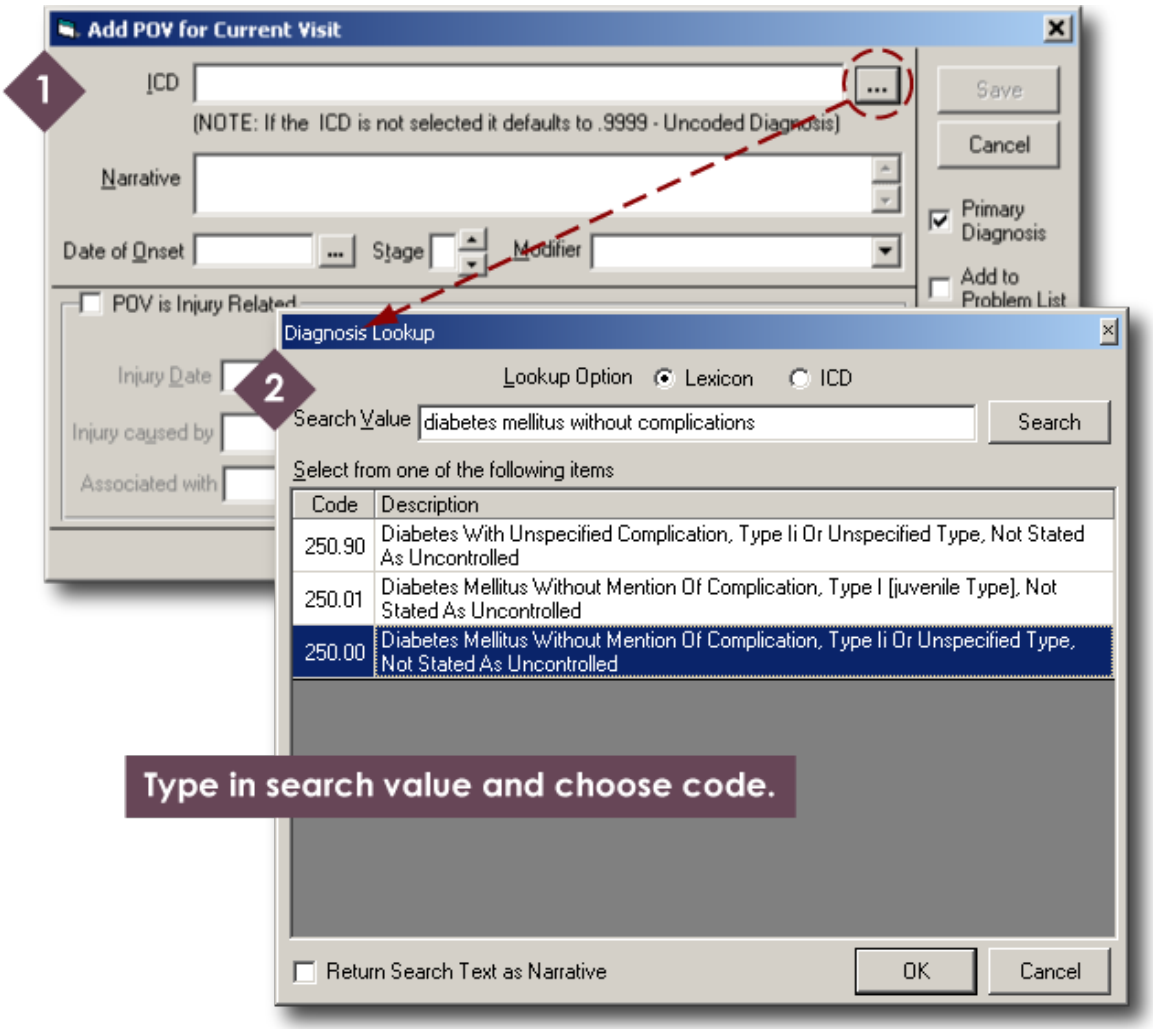
Figure 4.7a. Visit Diagnosis, Unfilled



Click on the POV tab. The POV window has three areas: Visit Diagnosis (which is the purpose of visit; ICD–9 Pick Lists; and Problem List/Past Diagnoses/Past Procedures.

To add a purpose of visit click on the Add button in the Visit Diagnosis area (Figure 4.7a). A dialog box titled Add POV for Current Visit will pop up. See Figure 4.7b. Click on the ellipsis (…) button. The Diagnosis Lookup dialog box will open in front of the Add POV dialog box. With the Lookup Option set to "Lexicon" (text), type in some keywords into the

Figure 4.7b. Adding a Visit Diagnosis

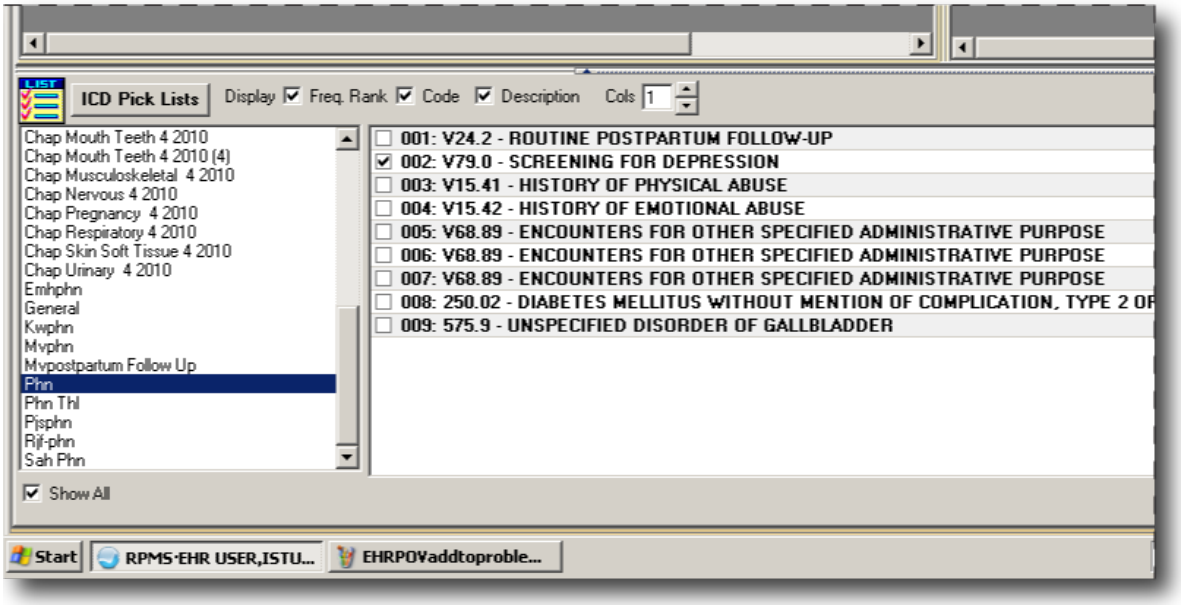


Search Value field and click the Search button. A list will appear below the Search Value field. Choose the most appropriate code in the list and click the OK button to save and close the Diagnosis Lookup box. In the Add POV box, select Primary Diagnosis. Add a narrative and any necessary other information and click the Save button. The new purpose of visit will be visible in the Visit Diagnosis area of the POV window.

Figure 4.7c. Visit Diagnosis Area After POV Added

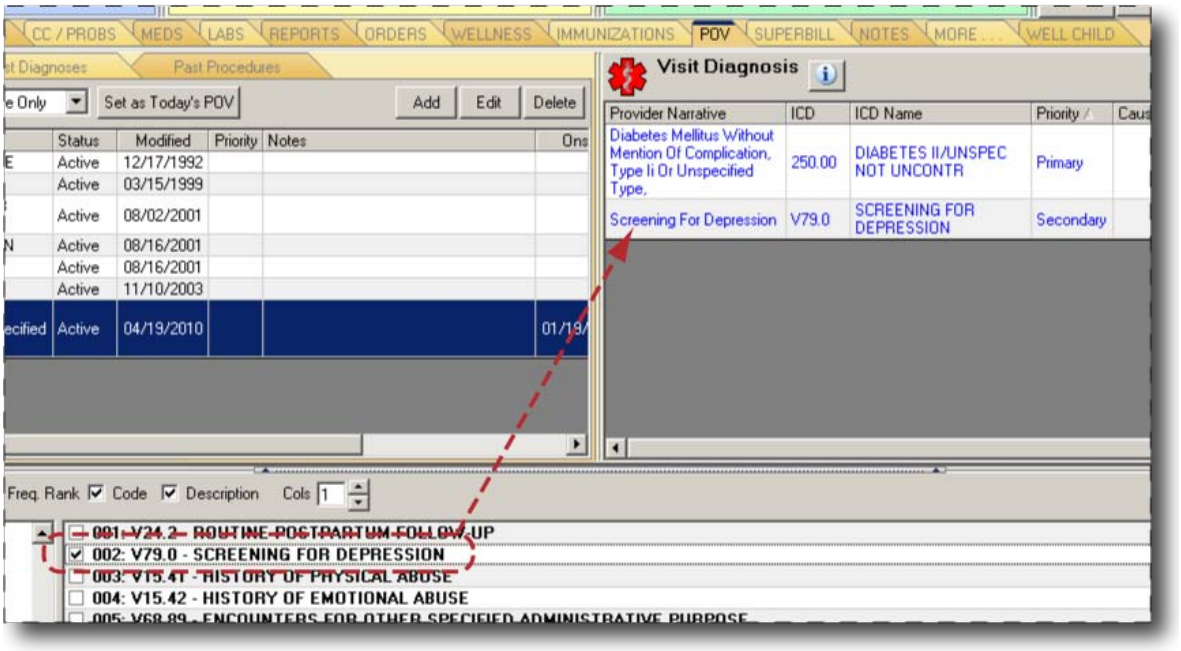
An easier way for public health nurses to add a visit diagnosis (purpose of visit) is to use the ICD–9 Pick List. Figure 4.7d shows the ICD–9 Pick List area with a diagnosis chosen. To view pick lists, activate the Show All option in the lower left.

Figure 4.7d. ICD–9 Pick List With Pick List Selected and Diagnosis Chosen



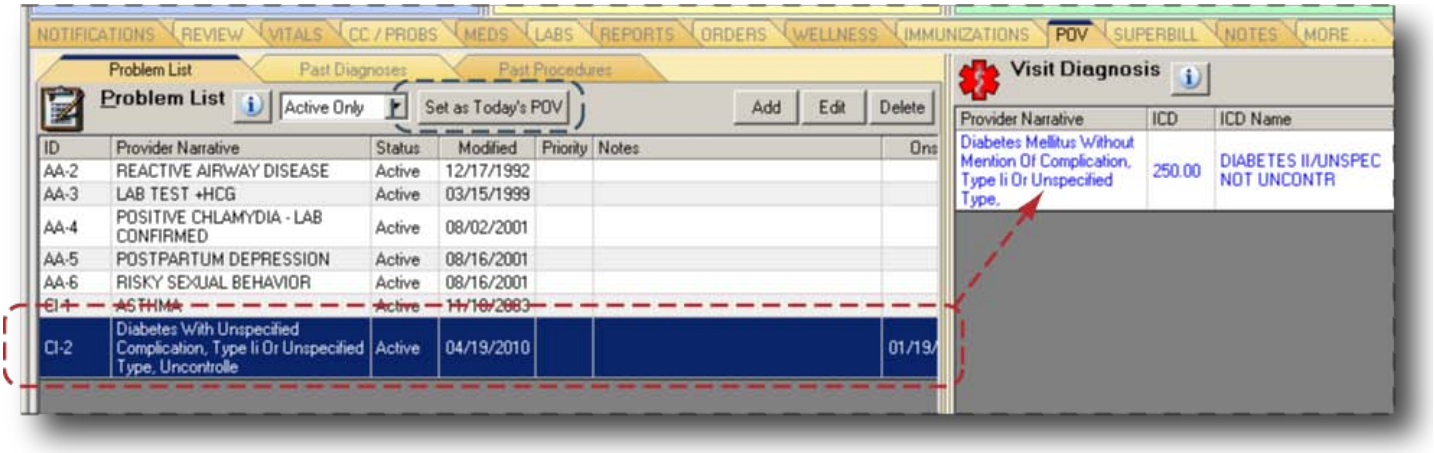
The pick lists that appear will depend on the facility where the EHR is located. In Figure 4.7d, the "Phn" list is selected. This is a local version of a public health nursing list. The items on this list are displayed on the right. Each item has a check box. More than one item can be selected. In Figure 4.7d, V79.0–Screening for Depression is chosen. As a result of this selection, depression screening now appears in the Visit Diagnosis area. See Figure 4.7e.

Figure 4.7e. Using the ICD–9 Pick List to Add a POV



A third way to set the purpose of visit is through the Problem List. Simply select an item in the Problem List and click the Set as Today's POV button. The Problem List item will appear in the Visit Diagnosis area. See Figure 4.7f.

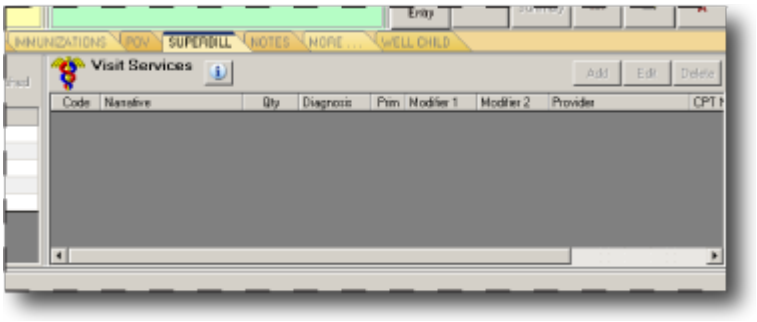
Figure 4.7f. Using the Problem List to Set the Purpose of Visit



4.8 Visit Services

Public health nurses must enter services rendered in the Visit Services area of the Superbill window. The Visit Services area is in the upper right of the Superbill window as shown in Figure 4.8a. There are several ways to add services.

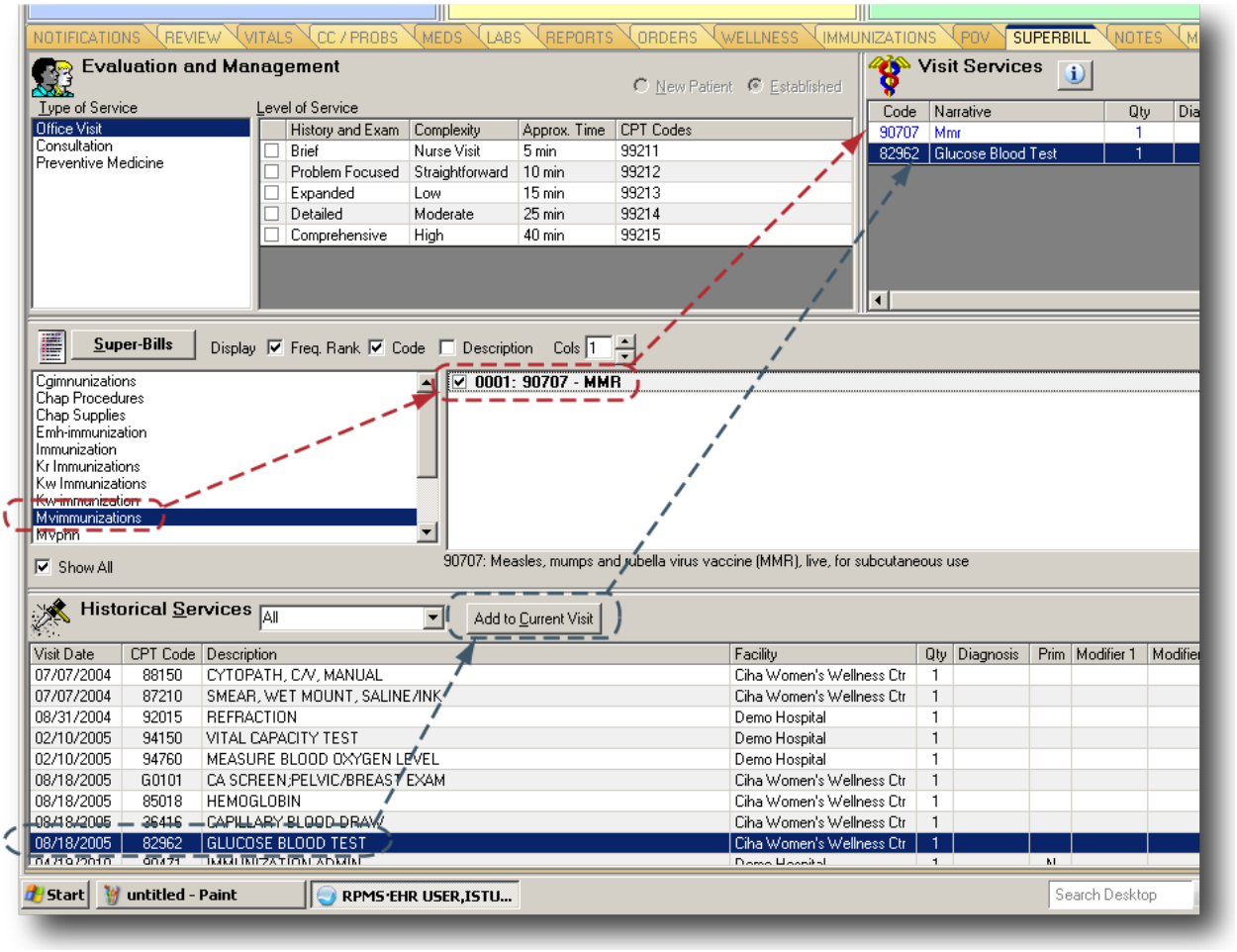
Figure 4.8a. Visit Services, Blank



The nurse can add a service (or services) by using pick lists in the Super-Bills area across the middle of the Superbills window. In Figure 4.8b, a pick list called "Mvimmunizations" is selected. Notice the Show All function is checked. This function must be activated in the Super-Bills area to be able to view all the pick lists. The Mvimmunizations pick list contains one item: 90707–MMR (measles, mumps, and rubella vaccine). When 90707–MMR is checked in the Super-Bills area, it appears in the Visit Services area. The dotted red line in Figure 42 reflects the process described here.

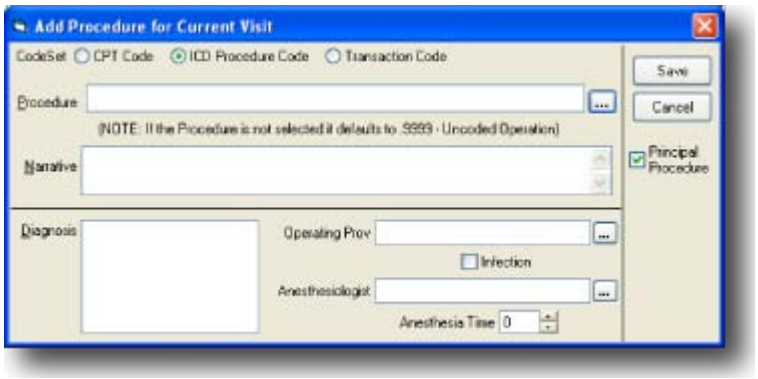
Another way to add a service rendered is through the Historical Services area. Follow the dotted green line in Figure 4.8b. In this process, a glucose blood test performed on August 18, 2005, is selected. Once a item in the Historical Services area is selected, all the user has to do is click the Add to Current Visit button to add the item to the Visit Services area.

Figure 4.8b. Two Ways to Add Services



If the nurse cannot find the service rendered in the pick lists or Historical Services, he or she must click the Add button in the Visit Services area and add a service using the Add Procedure for Current Visit dialog box (Figure 4.8c). In the dialog box, click on the ellipsis (…) button at the top to choose a procedure.

Figure 4.8c. Dialog Box: Add Procedure for Current Visit

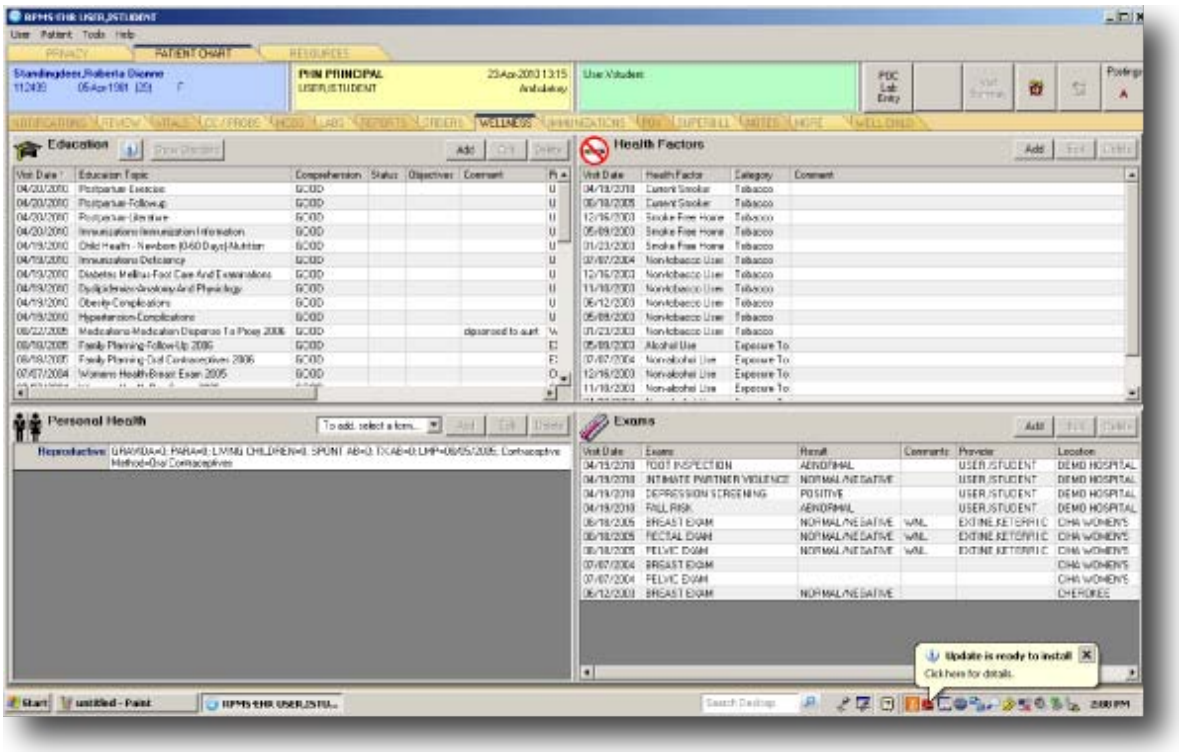


4.9 Patient Education, Health Factors, and Exams

The public health nurse must document the patient education delivered, the patient's health factors (such as smoking), and exams administered. These items can be found in the Wellness window. These are some things to pay attention to:

- The Health Factors area is where alcohol use, tobacco use, and barriers to learning, etc., are documented.
- For any female patient, complete a reproductive history and keep it up-to-date in the Personal Health area.
- The Exams section includes screenings for intimate partner violence, depression, etc.

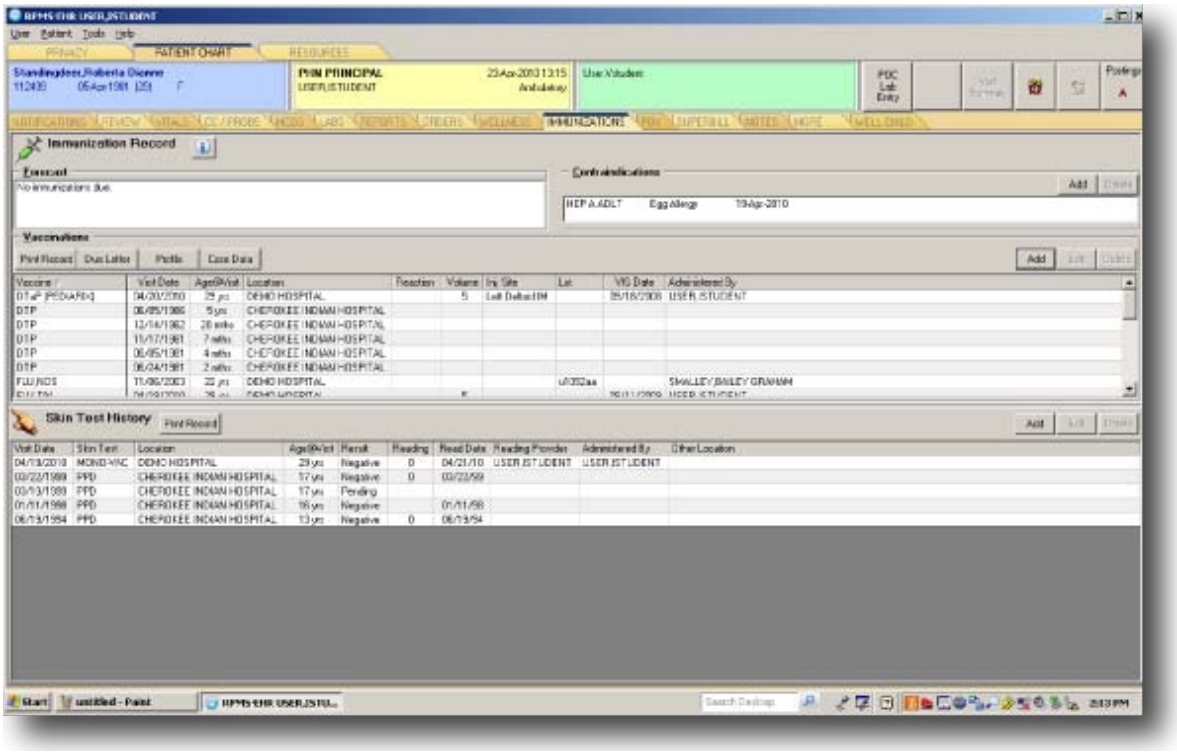
Figure 4.9. Wellness Window



4.10 Immunizations

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

Figure 4.10. Immunizations Window

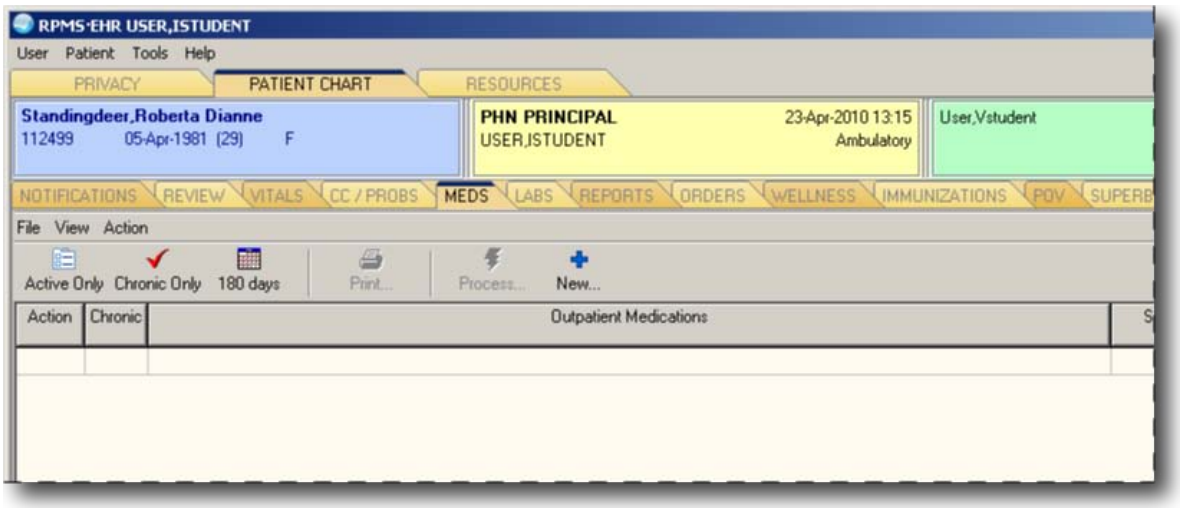


4.11 Medications

Ordinarily, public health nurses do not order medications. However, if there is a standing order, a public health nurse must enter a medication order in the EHR.

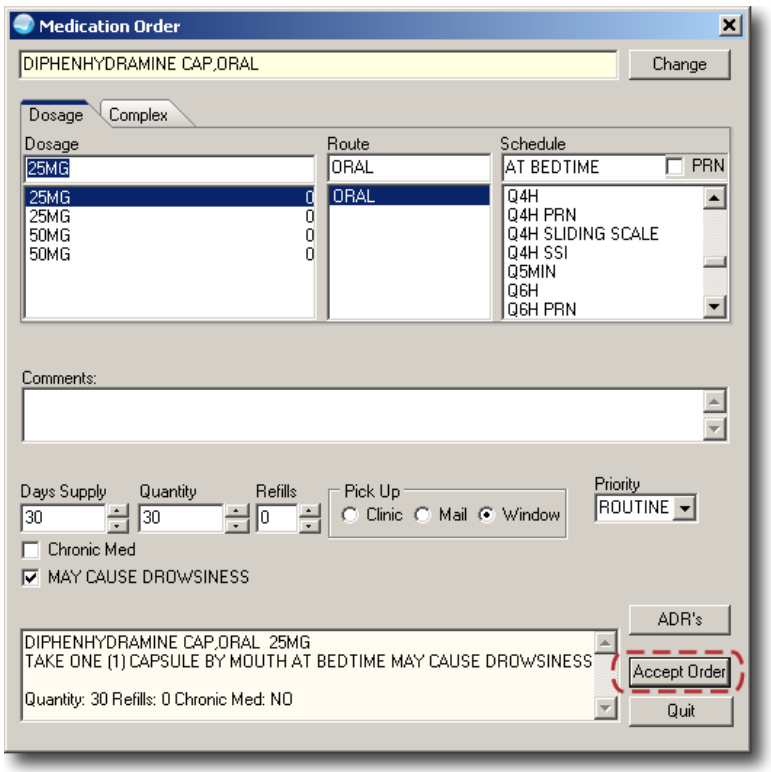
Click on the "MEDS" tab to view a patient's medications. Figure 4.11a shows a blank medications window.

Figure 4.11a. Medications Window, Blank



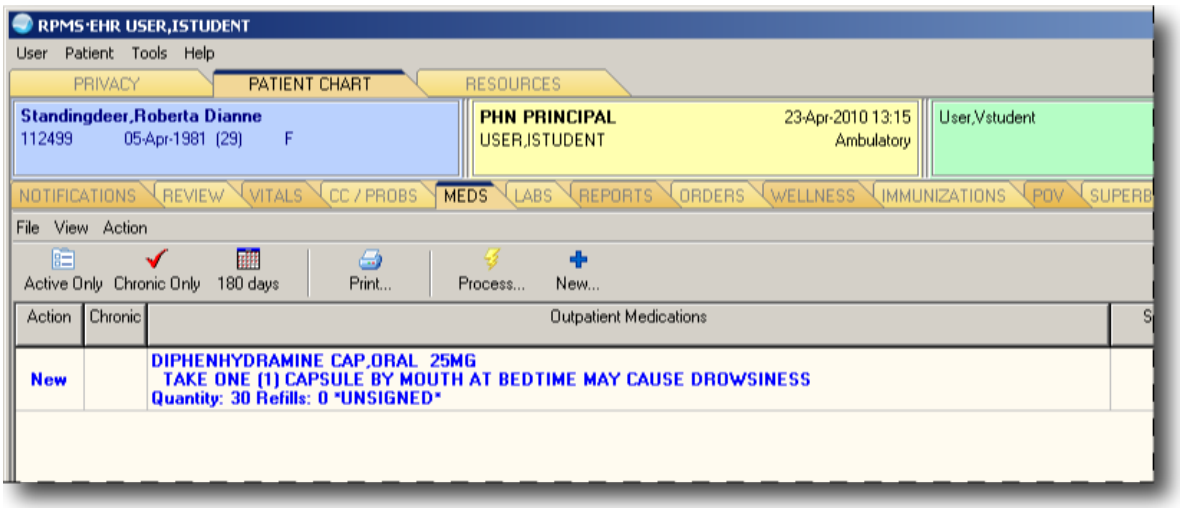
Click on the blue cross (New…) to add a medication. Fill out all relevant information in the Medication Order dialog box and click on the Accept Order button, which is circled in Figure 4.11b.

Figure 4.11b. Setting Up a Medication Order



The new medication appears in Figure 4.11c. Notice that it is an unsigned order.

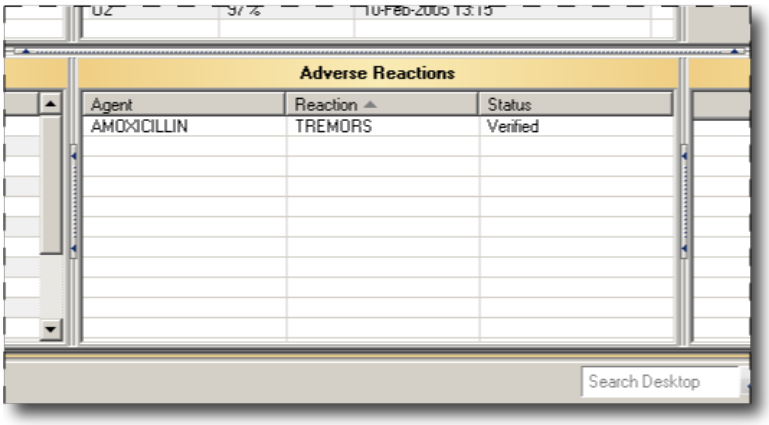
Figure 4.11c. Medications Window



4.12 Allergies

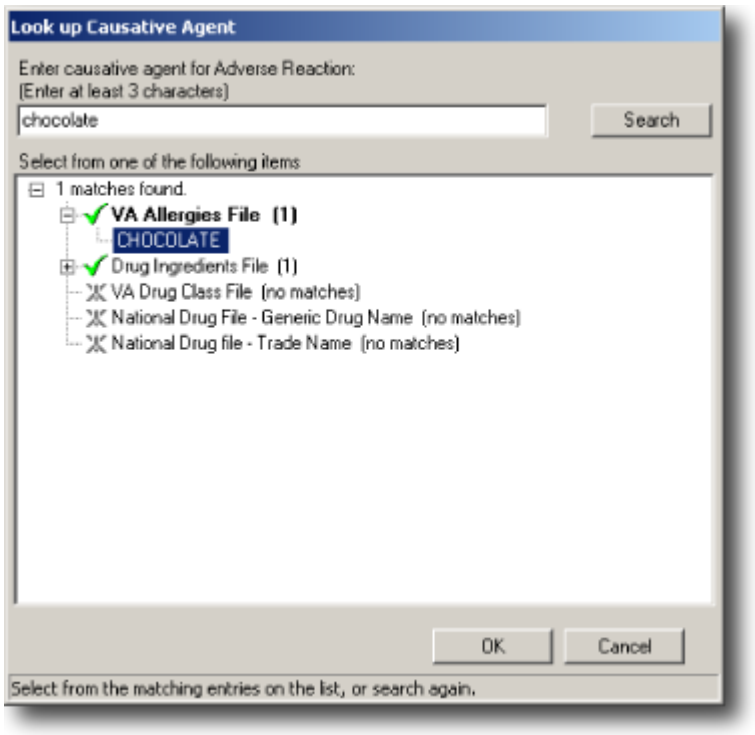
Some nurses in some facilities are allowed to add allergies in the EHR. To enter a patient's allergies or to edit an existing one, go to the Adverse Reactions area at the bottom of the of the Review window (Figure 4.12a). Right click anywhere on the Adverse Reactions area and a popup menu will appear. Select New Adverse Reaction (or Edit Adverse Reaction for an existing one).

Figure 4.12a. Adverse Reactions Area in the Review



In the Look up Causative Agent dialog box (Figure 4.12b), enter an allergy cause at the top and click the Search button. Select an item from the list that appears below the causative agent you entered. Then, click the OK button.

Figure 4.12b. Lookup Causative Agent Dialog Box



The Create Adverse Reaction dialog box will appear (Figure 4.12c). Be sure to select a sign or symptom on the lower left and, using the green arrow, move it to the Selected area on the lower right. When finished, click the OK button.

The new allergy will appear in blue type in the Adverse Reactions area. Notice that the new allergy is unsigned. To sign it, right click on the new allergy and select Sign Adverse Reaction in the popup menu. The new allergy will change to black text and will be verified. See Figure 4.12d.

Figure 4.12c. Create Adverse Reaction Dialog Box

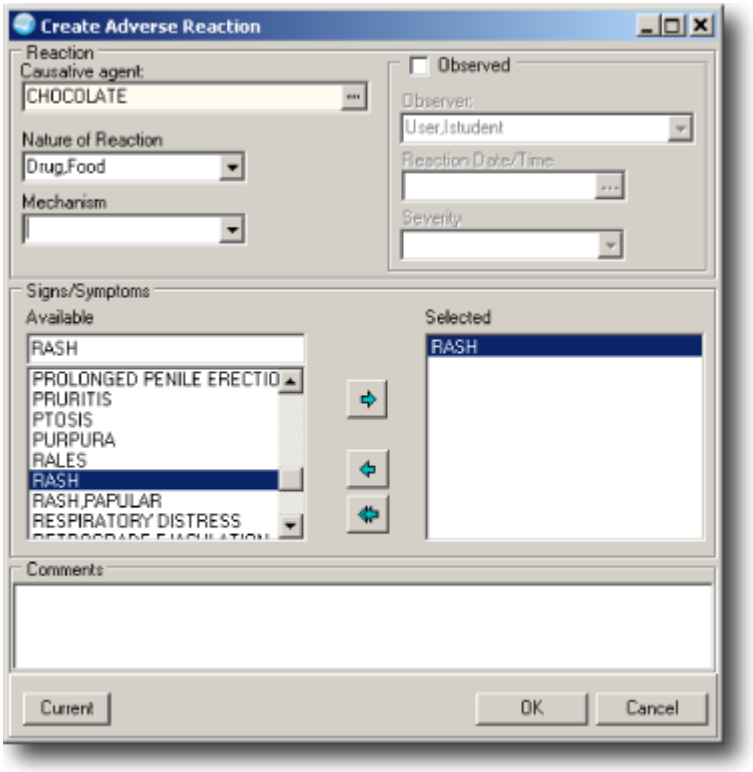
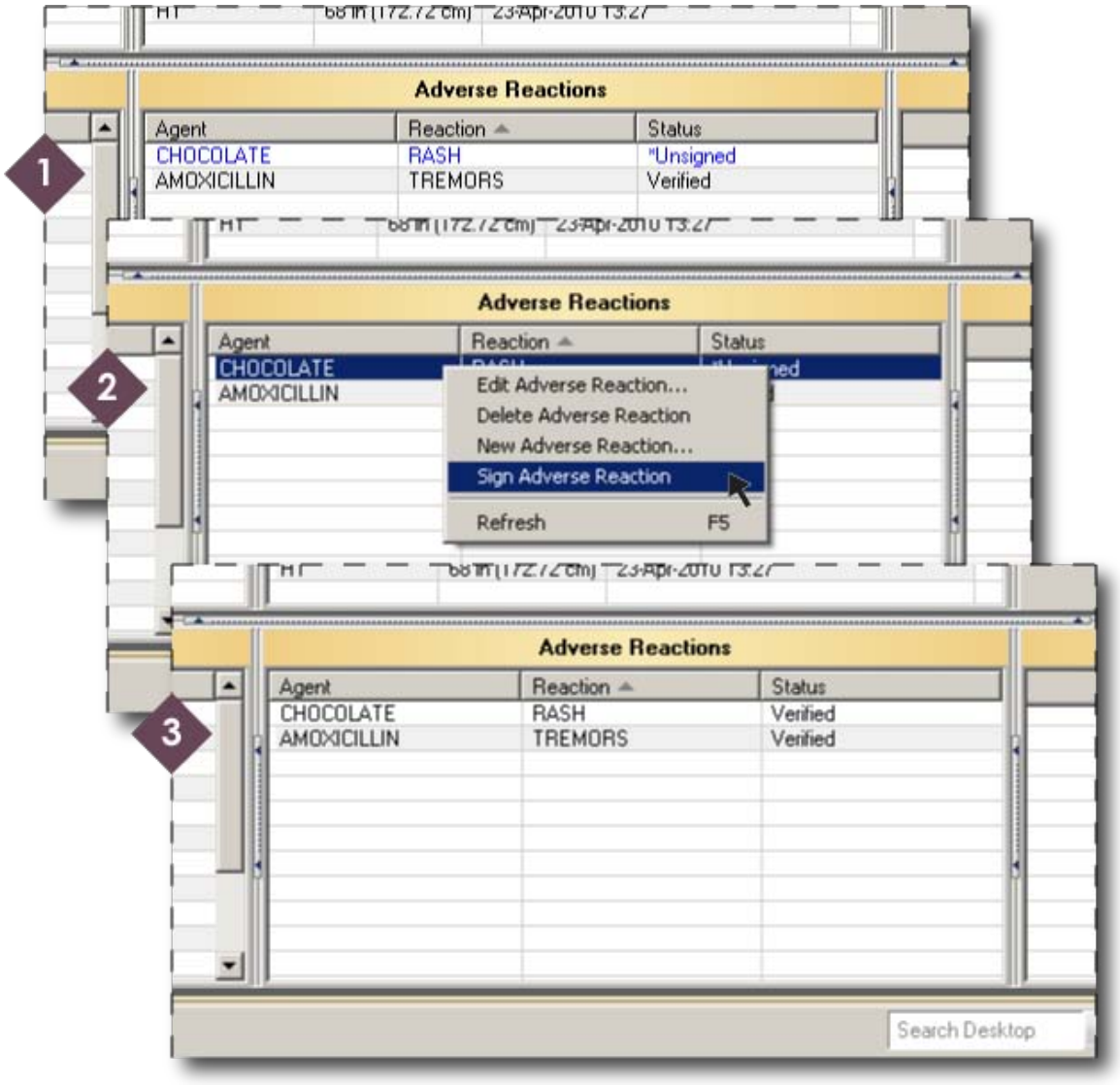


Figure 4.12d. Signing an Adverse Reaction

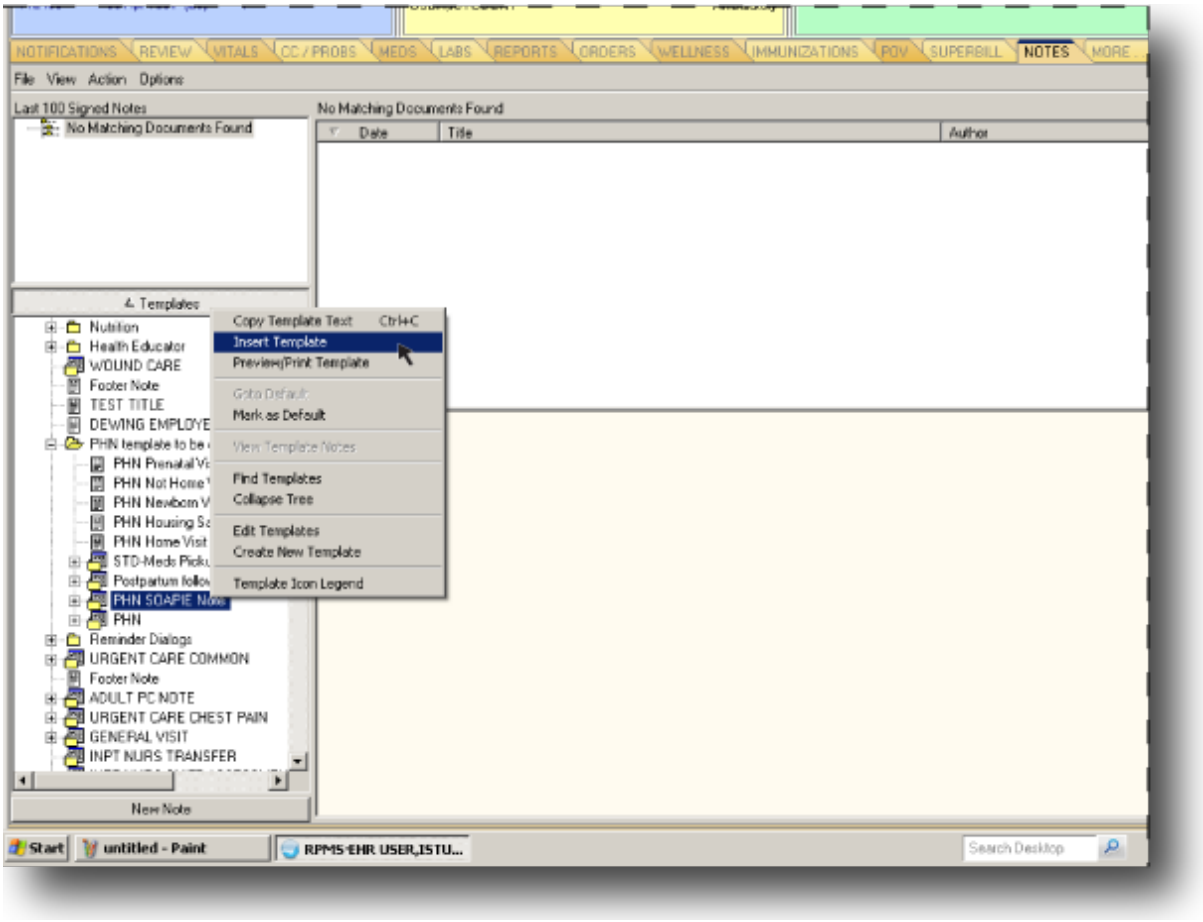


4.13 Notes

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

Click on the Notes tab. Notice the expandable/contractible list of templates on the left. Find a template for a public health nursing SOAPIE (subjective-objective-

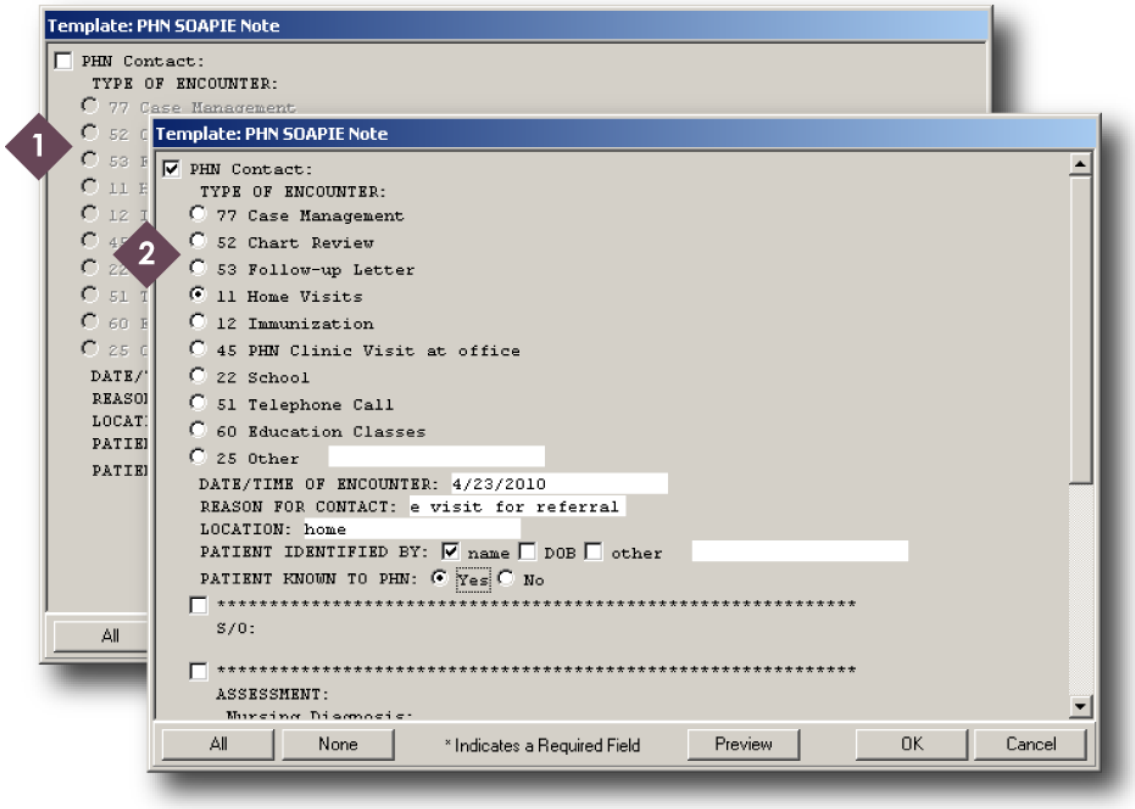
Figure 4.13a. Notes Window; PHN SOAPIE Note Template Selected



assessment-plan-intervention-evaluation) note. Select the PHN SOAPIE template and right click on it. A popup menu will appear. Select Insert Template in the popup menu. See Figure 4.13a.

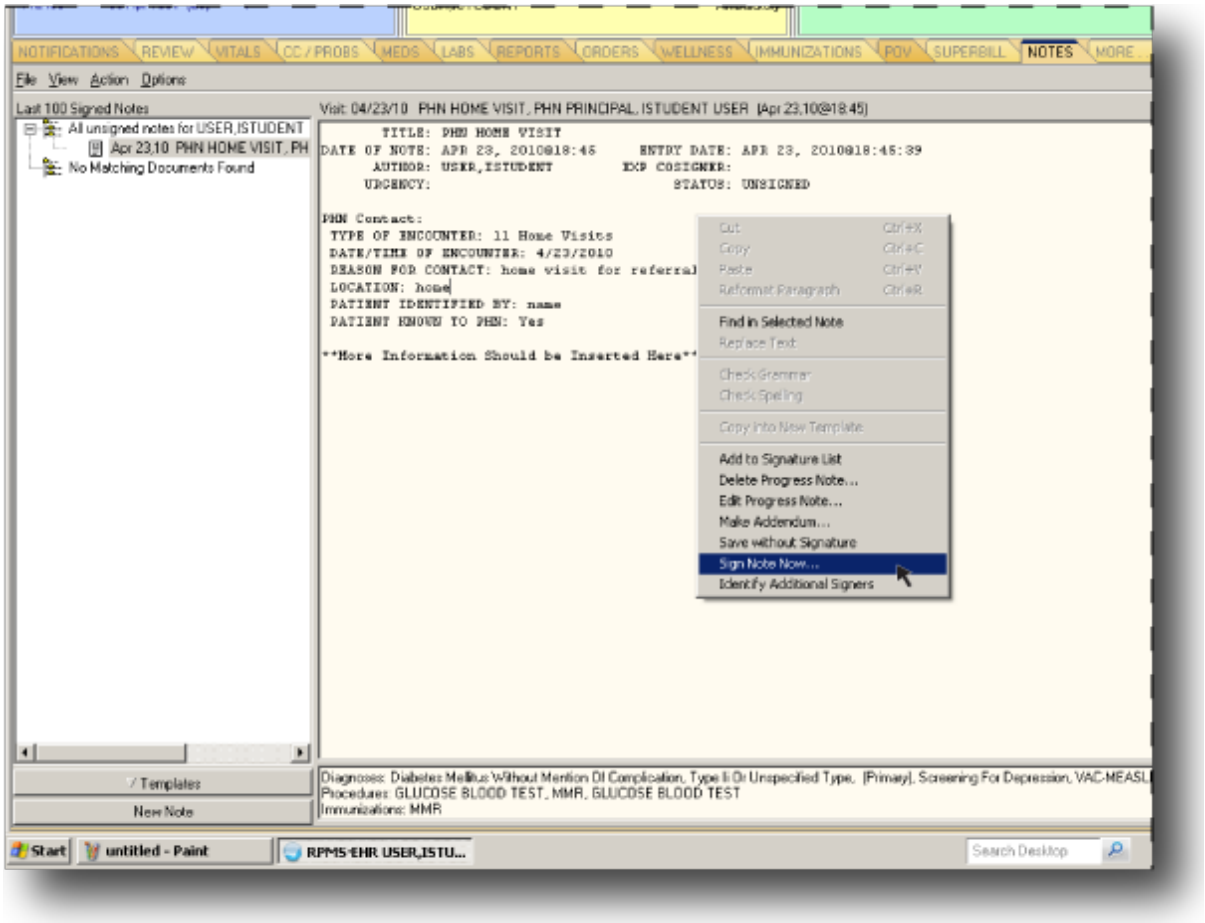
A dialog box titled Template: PHN SOAPIE Note will pop up. The PHN Contact option must be checked to be able to enter information in the SOAPIE note template. See Figure 4.13b. Fill in the date and reason for the encounter and all the other relevant fields. When finished click the OK button.

Figure 4.13b. PHN SOAPIE Note Dialog Box



The text of the unsigned progress note will appear in the body of the Notes window, where the public health nurse can add more text. See Figure 4.13c. If the location of the encounter is not already in the progress note, nurses must add it here. Documenting the visit location is a legal requirement.

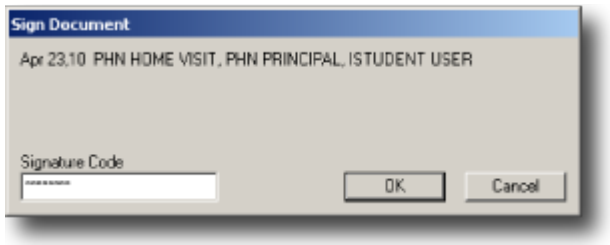
Figure 4.13c. Notes Window; Getting Ready to Sign Progress Note



Public health nurses must sign their progress notes. Position the mouse in the body of the progress note and right click. In the popup menu, select Sign Note Now. See Figure 4.13c.

The Sign Document dialog box will appear. Enter the Access Code (from Figure 4.13d) in the Signature Code field and click OK.

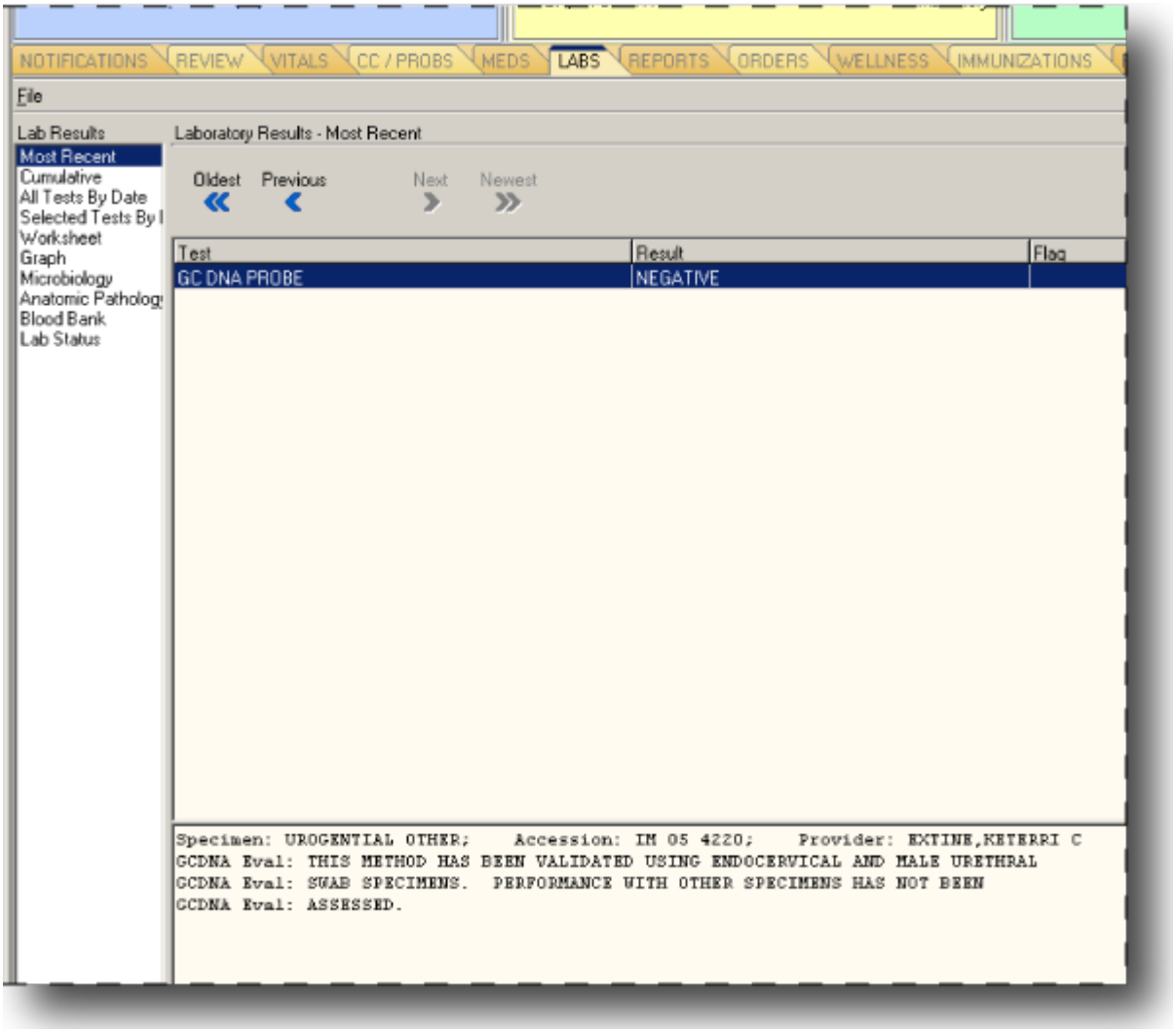
Figure 4.13d. Sign Document Dialog Box



4.14 Labs

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

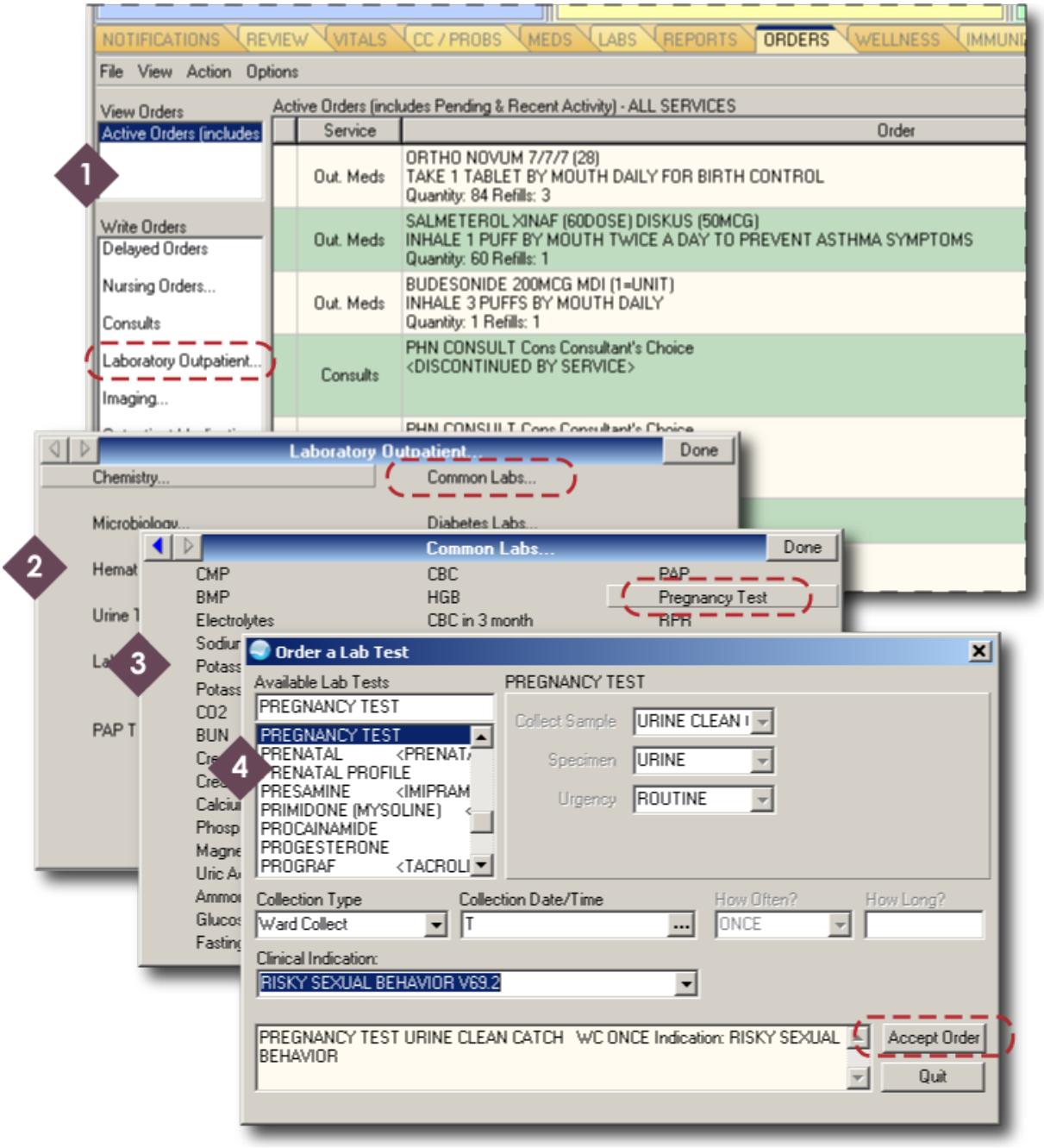
Figure 4.14a. Labs Window



Ordinarily, public health nurses do not order laboratory tests. However, if there is a standing order, a public health nurse must enter a lab order in the EHR. Tests performed at the point of care and tests waived by the Clinical Laboratory Improvement Amendments must be documented by public health nurses.

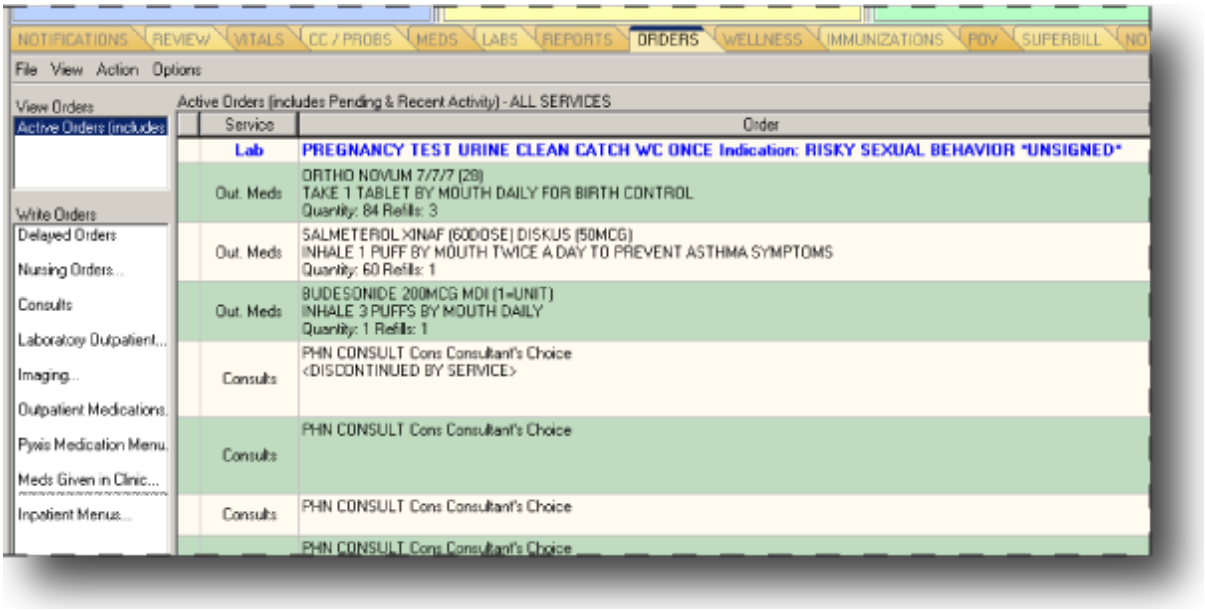
Ordering a lab test for a patient takes place in the Orders window. Figure 4.14b shows an example of an outpatient lab order—a pregnancy test in this case. In the Orders window, click on the Laboratory Outpatient link in the left column under the Write Orders heading. In the Laboratory Outpatient dialog box, click on Common Labs, and then click on Pregnancy Test in the Common Labs dialog box. The Order a Lab Test dialog box will pop up. Be sure to document the collection type, the time and date of collection, and the clinical indication. When finished, click the Accept

Figure 4.14b. Ordering a Laboratory Test in the Orders Window



Order button. The pregnancy test will appear as an unsigned order at the top of the orders list. See Figure 4.14c.

Figure 4.14c. Unsigned Laboratory Test

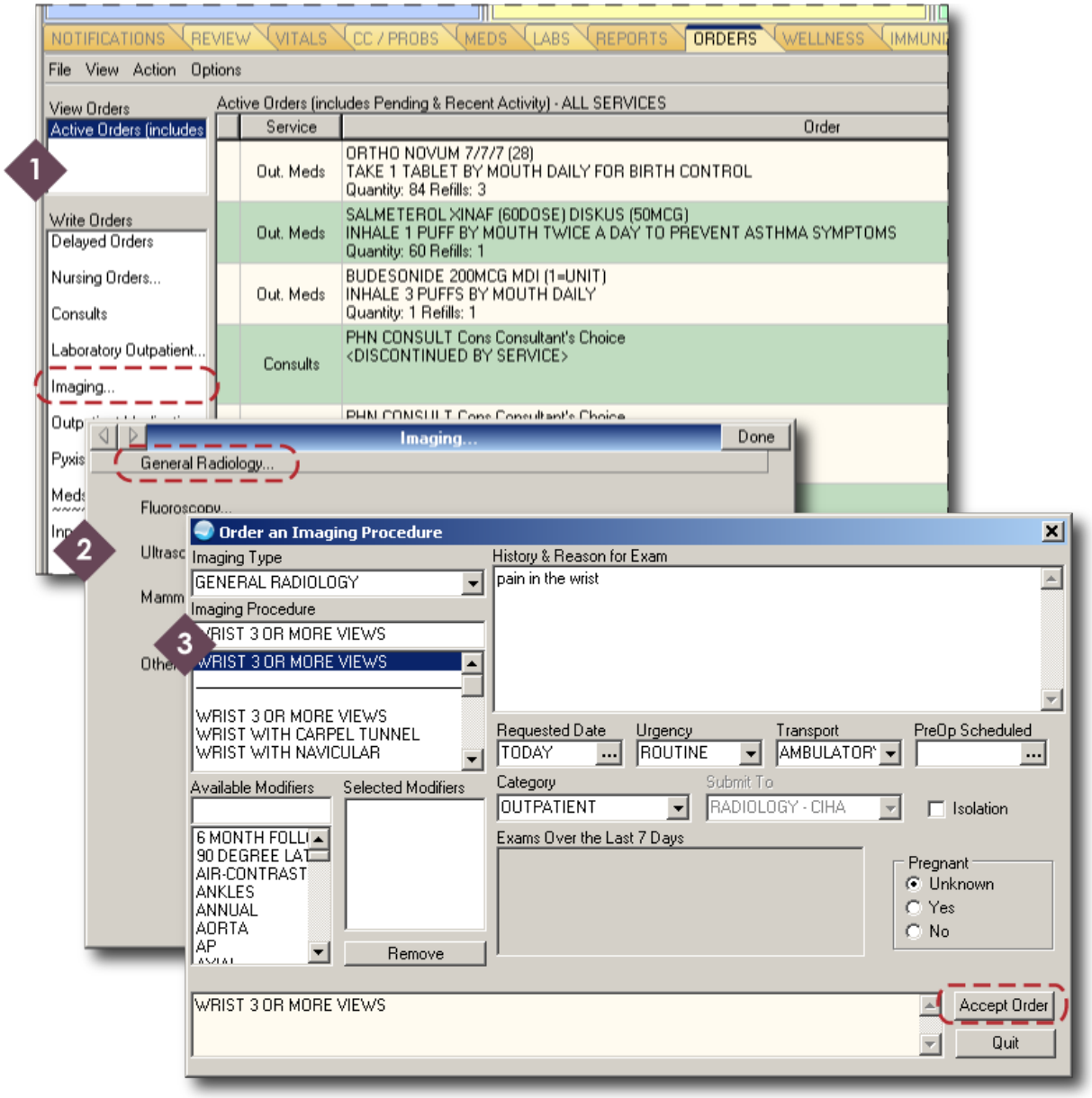


4.15 Radiology

Ordinarily, public health nurses do not order imaging; but, if there is a standing order, a public health nurse must enter an imaging order in the EHR.

Imaging requests are made in the Orders window. Click on the Imaging link in the left under the Write Orders heading. See Figure 4.15a. In the Imaging dialog, select General Radiology for an x ray. The dialog box for ordering an imaging procedure will open. Select the procedure, date for the procedure, urgency, transport, and category (outpatient in this case). The History and Reason field can hold multiple lines of text; therefore, enter as much information here as is necessary. If the patient is female and in child-bearing years, the user must choose one of the options in the

Figure 4.15a. Ordering an X Ray



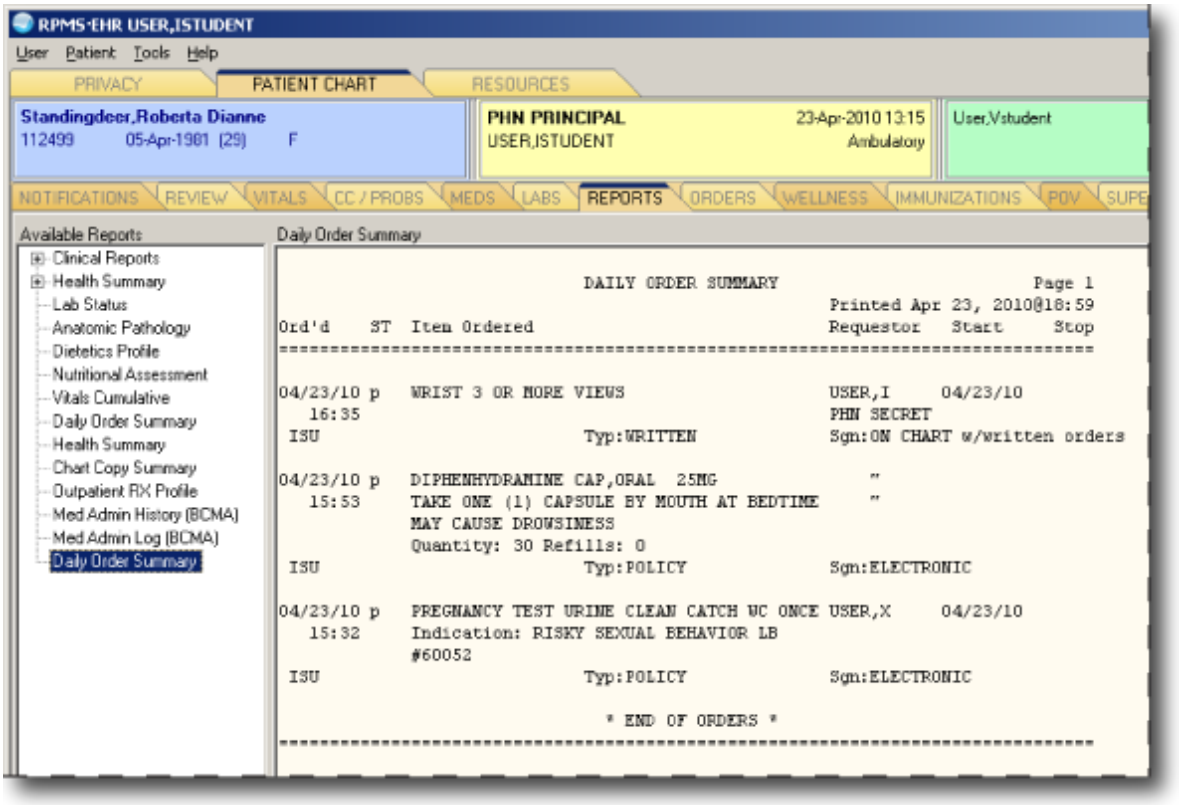
Pregnant field. When finished, click the Accept Order button. The new, unsigned imaging order will appear in the Orders window. See Figure 4.15b.

Figure 4.15b. Unsigned X Ray Order

4.16 Reports

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

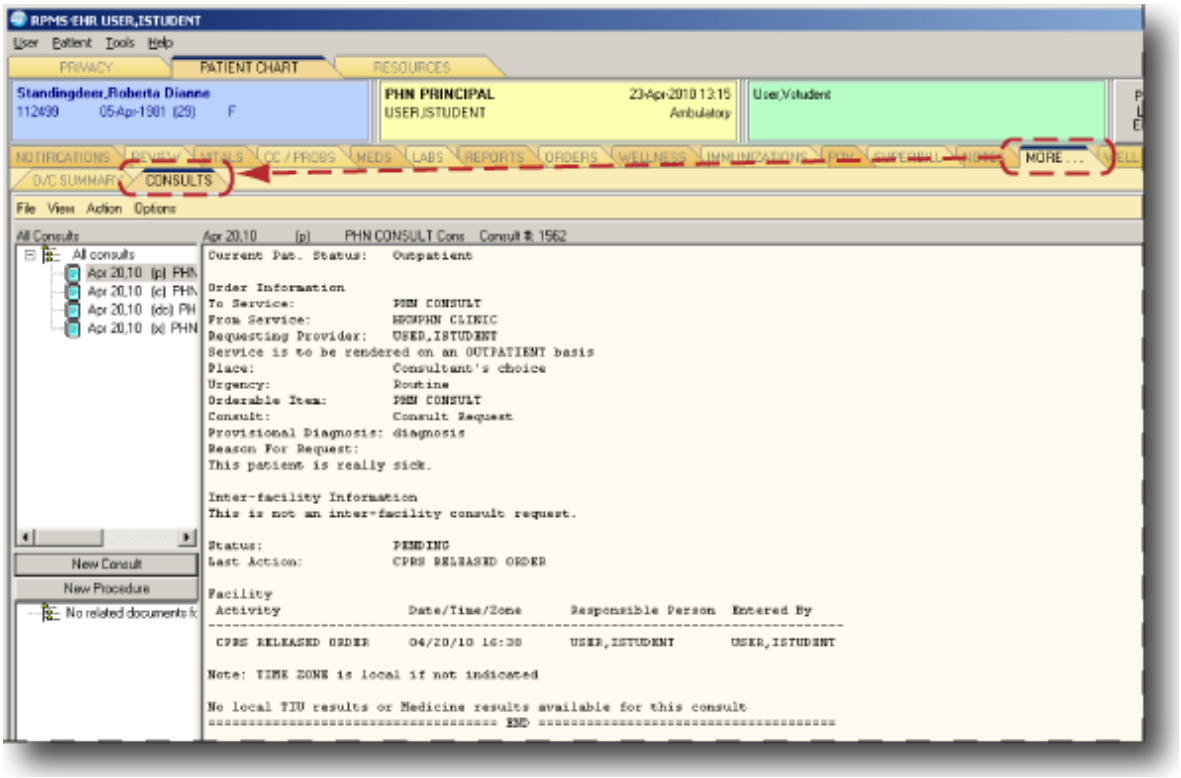
Figure 4.16. Reports Window; Daily Order Summary Selected



4.17 Consults

To view a patient's consults, click on the More tab first to reveal a second row of tabs, then click on the Consults tab (as shown in Figure 4.17a). A list of consults

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



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

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

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

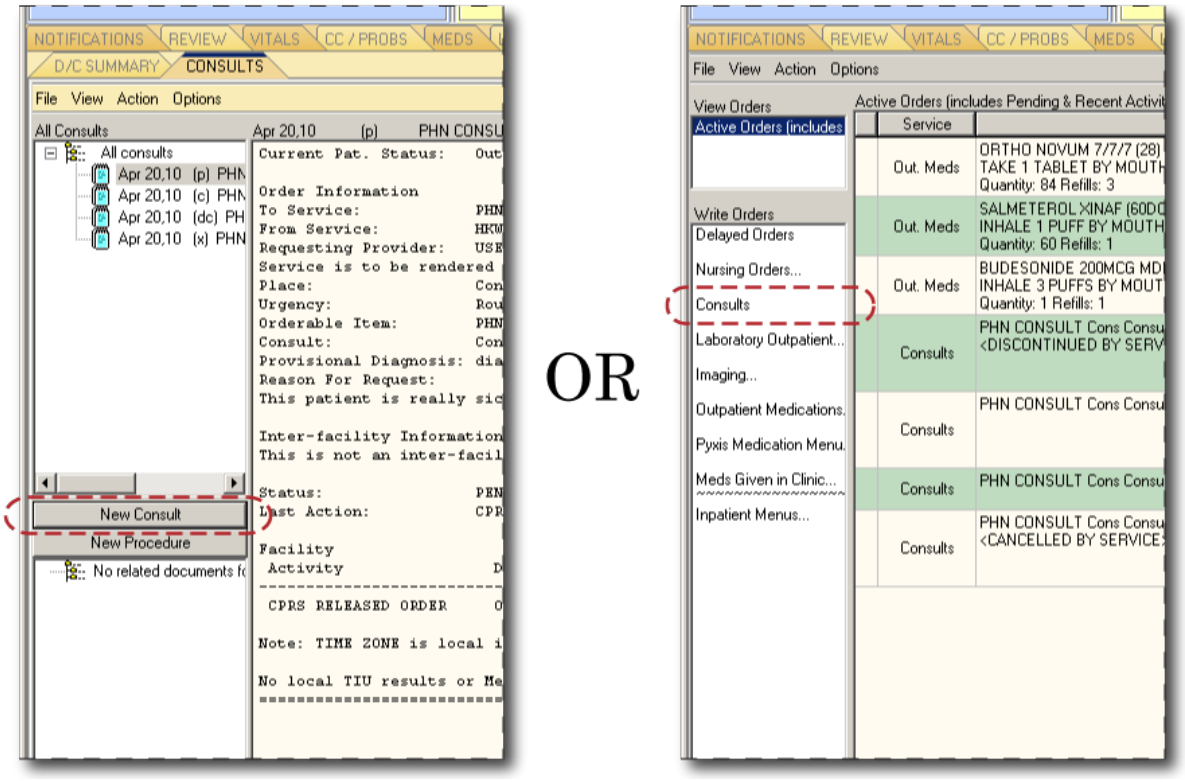
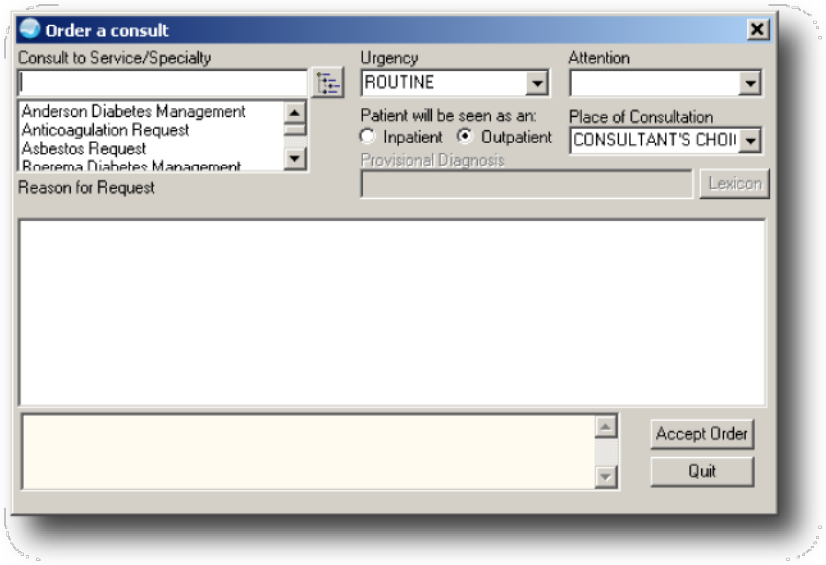


Figure 4.17c. Order a Consult Dialog Box



4.18 Quitting the Patient Record

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

Figure 4.18. Exiting the Patient Record

4.19 Help

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

Figure 4.19a. Help Menu

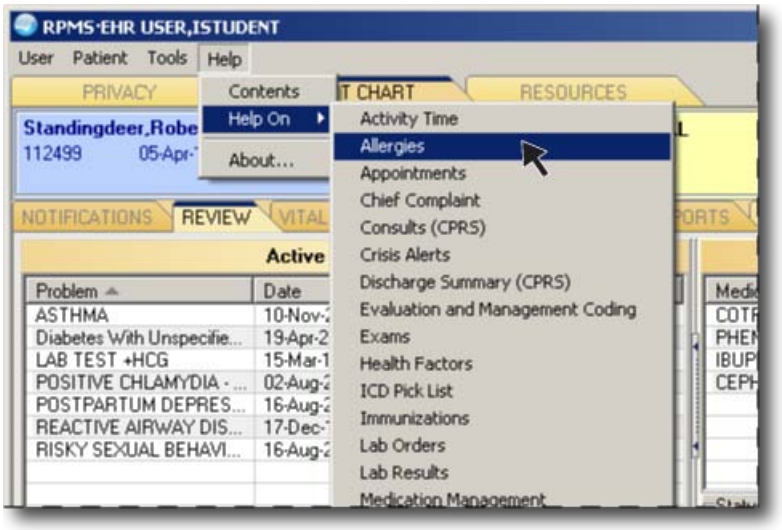
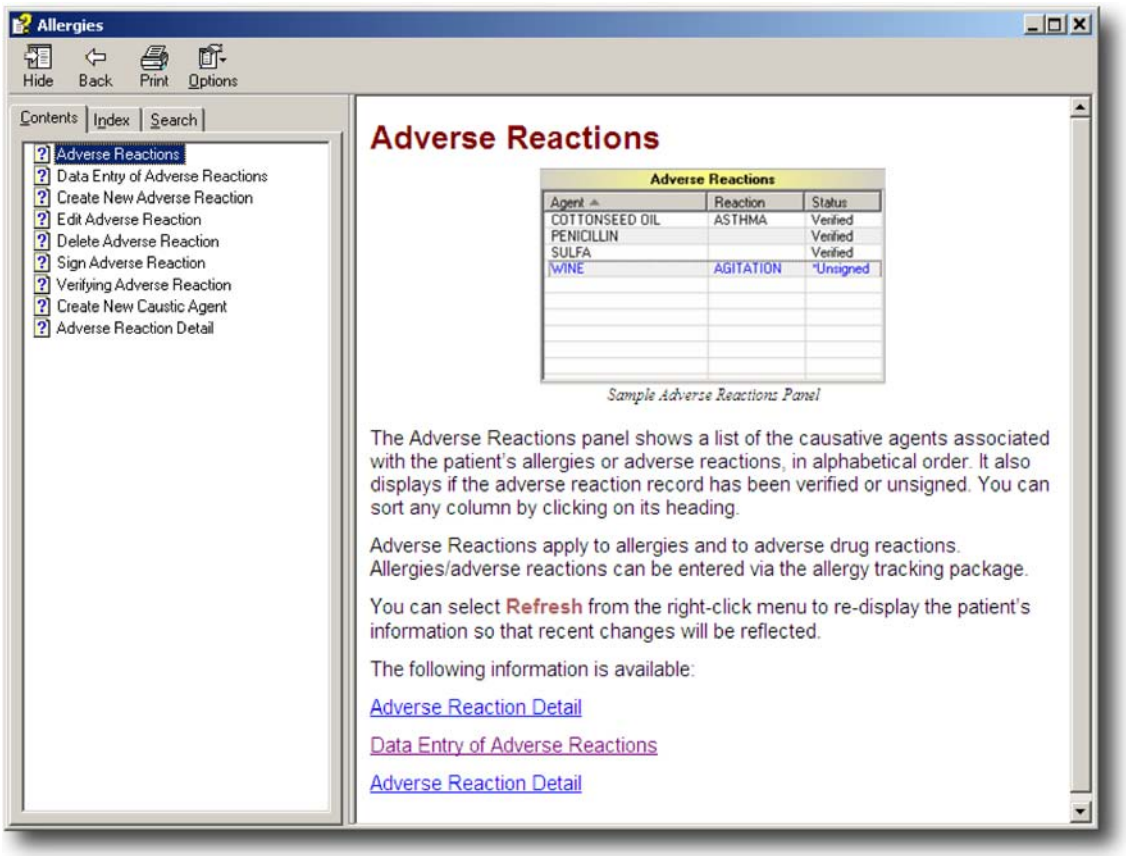


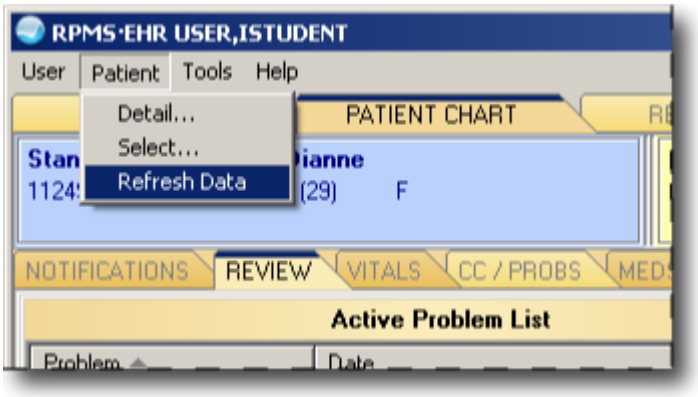
Figure 4.19b. Help Application



4.20 Refreshing Data on the Screen

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

Figure 4.20. Refresh Data



5.0 USING THE PUBLIC HEALTH NURSING PCC ENCOUNTER RECORD

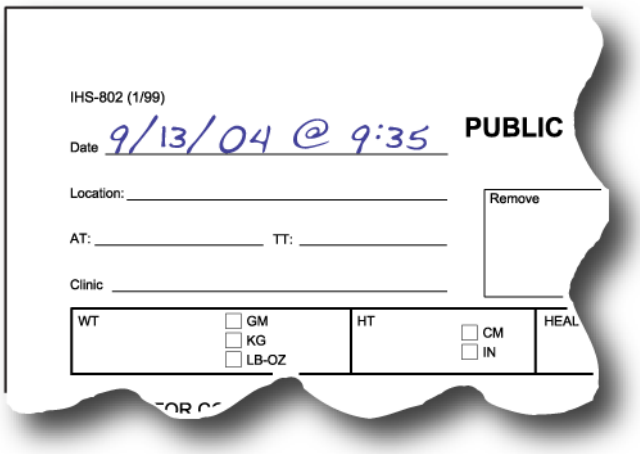
Use the following guidelines to complete the Patient Care Component (PCC) form for public health nursing. Special care must be taken when completing the PCC form, especially with regards to handwriting. Please read Section 1.2, Understanding the Data Collection Process.

5.1 Date and Time

Write the date and time in the upper left corner of the form as shown in Figure 5.1.

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

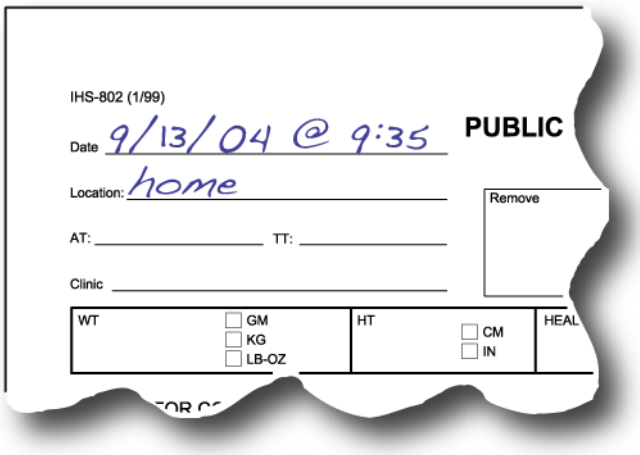
Figure 5.1. Date and Time



5.2 Location of Encounter

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

Figure 5.2. Date, Time, and Location

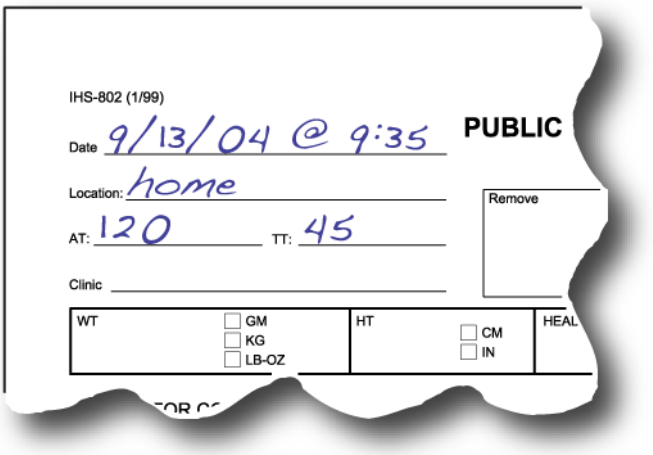


5.3 Activity and Travel Time

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

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

Figure 5.3. Date and Time, Location, Activity Time, and Travel Time



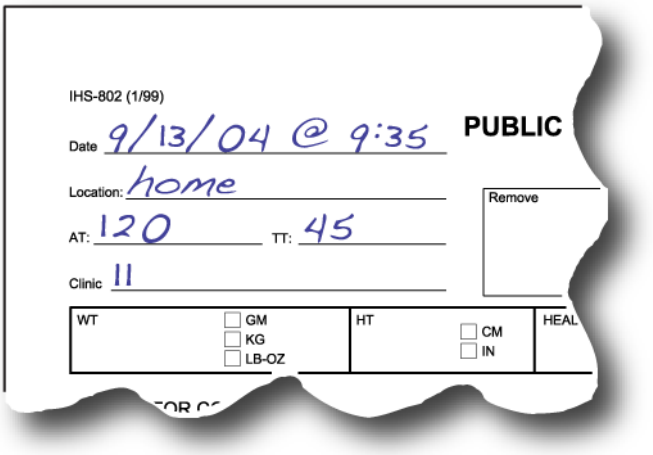
"TT" means travel time, which is the total number of minutes it took to travel to and from the location. While it is not mandatory, travel time is useful information in RPMS-generated reports. In the case of several stops at different places, travel time may be entered on one visit or divided by the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

5.4 Clinic

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

> *"Location" is* where *the service was provided; "clinic" is* what *service was provided.*

Figure 5.4. Date and Time, Location, Activity Time, Travel Time, and Clinic Code



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

  11=Home Care

  This includes all visits that take place at any site that can be defined as where the patient "lays his or her head down at night." For example, if the contact was made at a dormitory, jail, or even an outdoor location where the patient sleeps at night, then this is his or her "home." If the patient is not

found, then the clinic code is 11. Nurses should consult the data entry staff concerning where "not found" should be indicated on the public health nursing PCC note.

45=PHN Clinic Visit

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

12=Immunization

This clinic code includes immunizations at schools or elsewhere.

22=School

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

09=Grouped Services

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

51=Telephone Call

52=Chart Review or Record Modification

53=Followup Letter

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

60=Education Classes

Prenatal classes, diabetes education classes, etc.

77=Case Management Services

25=Other

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

D3=Homeless

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

To view the complete list of clinic codes, go to the Standard Code Book Tables on the IHS Web site at http://www.ihs.gov/CIO/scb/. Click on the Standard Code Book Tables link and then click on the Clinic link under the Table Name heading.

5.5 Provider Codes

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

- ***Affiliation***

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

  Indian Health Service=1

  Contract=2

  Tribal=3

  State=4

  Municipal=5

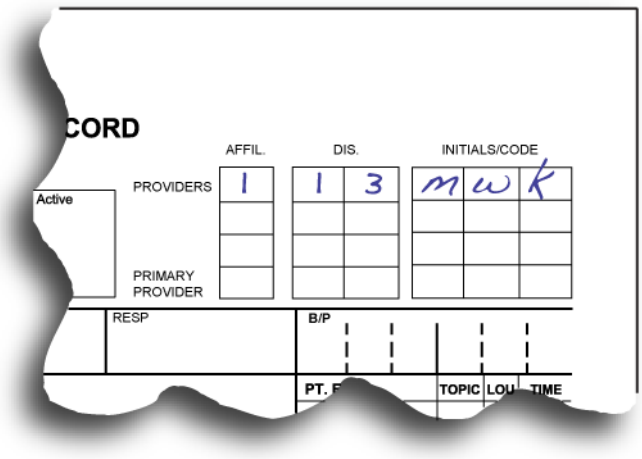
  Volunteer=6

  National Health Service Corps=7

  Non-Indian Health Service=8

  Other=9

Figure 5.5. Affiliation Code, Discipline Code, and Provider Initials



- ***Discipline***

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

5.6 Measurements

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

5.7 Purpose of Visit

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

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

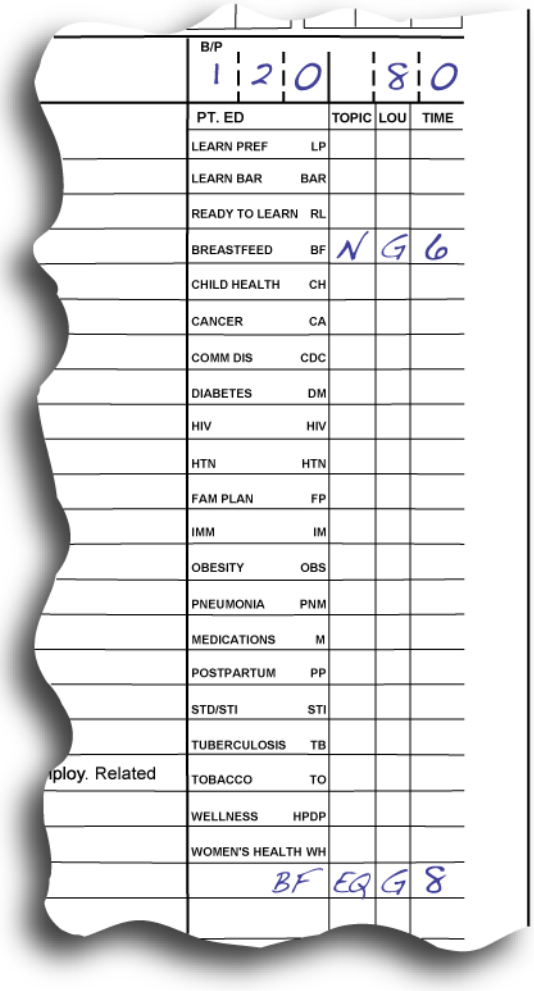
Because legibility in this section is critical, printing is required, and abbreviations are prohibited. In the past, illegible abbreviations have caused incorrect data entries, such as "DM" instead of "OM."

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

Nursing providers are encouraged to look at an ICD–9 manual to get an understanding of the terminology used. There are several pages of codes related just to pregnancy, for example. The manuals are usually available in the medical records, data entry, or patient business office. The Centers for Disease Control and Prevention has an entire Web site dedicated to the International Classification of Diseases at http://www.cdc.gov/nchs/icd.htm.

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

Figure 5.9. Blood Pressure and Patient Education (Topic, Level of Understanding, and Time)



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

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

5.8 Medications/Interventions

Several rows below the purpose of visit section is the medications/interventions part of the PCC form. Nurses should enter the treatments, procedures, etc., that are

considered part of the treatment (as opposed to being part of the assessment). Prescriptions and one-time doses of medications administered at the time of the visit are recorded in this section. The time, dose, route (including site of injection), and the nurse's initials or legal signature are required for medications administered by the nurse.

5.9 Patient Education

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

The Indian Health Service has two extensive publications that are helpful in choosing the correct patient education codes. "Documenting Patient Education, Volume 1" describes the processes for describing patient education. "Patient and Family Education Protocols and Codes, Volume 2" contains the entire list of outcomes and standards for all education topics. Copies of both are available in IHS hospitals and clinics.

Public health nurses have a fast and easy reference in the IHS "Patient and Family Education Codes for Public Health Nursing" pamphlet, which lists codes related to public health nursing (without descriptions).

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

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

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

Nurses are required to initial each topic taught in the right margin (not shown in Figure 5.9). Data entry staff persons will not enter patient education information into the RPMS if it is not initialized. Initializing the topics also informs the data entry staff regarding who exactly provided the patient education.

5.10 Immunizations

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

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

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

6.0 COMMON PURPOSE-OF-VISIT CODES USED BY PUBLIC HEALTH NURSES

6.1 Prenatal (First, Second, or Third Trimester)

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

6.2 Postpartum

V24.2	Routine post partum followup
V24.1	Post partum care and exam of lactating mother

6.3 Family Planning

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

6.4 Newborn

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

6.5 Chronic Illness and Care

401.91	Unspecified essential hypertension
496	Chronic airway obstruction, not elsewhere classified
250	Diabetes mellitus without complication, type not specified Diabetes mellitus without complication, type II Diabetes mellitus without complication, type I
250.4	Diabetes with renal manifestations
250.10	Diabetes mellitus ketoacidosis

719.4	Pain in joint unspecified
780.9	Other general symptoms
312.23	Socialized conduct disorder
780.39	Seizure disorder
789	Abdominal pain
414.01	Coronary atherosclerosis of native coronary artery
414.9	Chronic ischemic heart disease, unspecified
428.0	Congestive heart failure, unspecified
286.9	Other and unspecified coagulation defects
295.9	Unspecified schizophrenia
295.91	Unspecified type schizophrenia, subchronic state
295.92	Unspecified type schizophrenia, chronic state
295.94	Unspecified type schizophrenia, chronic state with exacerbation
295.95	Unspecified type schizophrenia, in remission
714.0	Rheumatoid arthritis

6.6 Immunizations

V07.9	Need for prophylactic measure
V05.3	Need for inoculation against viral hepatitis
V05.4	Need for inoculation against varicella
V05.8	Need for vaccination and inoculation
V04.81	Need for flu shot
V06.1	Need for inoculation with diphtheria-tetanus-pertussis combined vaccine (DTaP)
V06.5	Need for inoculation against tetanus-diphtheria
V06.4	Need for inoculation against measles-mumps-rubella
V04.89	Need for inoculation against other viral diseases. Use this code for human papillomavirus and meningitis vaccines.
V04.0	Need for inoculation against poliomyelitis
V03.81	Need for inoculation against hemophilus influenza, type B (Hib)
V03.82	Need for inoculation against streptococcus pneumoniae (pneumococcus)
V03.5	Need for inoculation against diphtheria alone
V03.6	Need for inoculation against pertussis alone

6.7 Adolescent

V20.2	Routine infant or child health check

V20.1	Other healthy infant or child receiving care

6.8 Women's Health

795	Abnormal papanicolaou smear

6.9 Screenings

V67.59	Purified protein derivative reading (followup exam necessary)—other specified followup exam
V74.1	Screening exam for pulmonary tuberculosis
V82.9	Screening for unspecified condition
V82.89	Special screenings for other specified conditions (foot screening) no loss

6.10 Elder Care or Other

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

6.11 Acute

462	Acute pharyngitis (sore throat)
465.9	Acute upper respiratory infections of unspecified site
460	Acute nasopharyngitis (common cold)
034.0	Streptococcal sore throat
790.6	Other abnormal blood chemistry
790.22	Impaired glucose tolerance test
V58.30	Change nonsurgical dressing
V58.31	Encounter for change or removal of surgical wound dressing

6.12 Followup

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

6.13 Diabetes mellitus

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

6.14 Communicable Disease

V65.45	Counseling on other sexually transmitted diseases
079.4	Human papillomavirus
079.88	Other specified chlamydial infection
079.98	Unspecified chlamydial infection
V01.6	Contact with or exposure to venereal diseases
V01.89	Contact with or exposure to other communicable diseases
V01.9	Contact with or exposure to unspecified communicable disease
V01.5	Contact with or exposure to rabies
V01.71	Contact/exposure to varicella
V74.1	Screening examination for pulmonary tuberculosis
096	Late syphilis, latent
091.0	Genital syphilis primary
091.2	Other primary syphilis
092.1	Early syphilis, latent, serological relapse after treatment
092.9	Early syphilis, unspecified
097.1	Latent syphilis, unspecified
098.0	Gonococcal infection (acute) of lower genitourinary tract
004.0	Shigella dysenteriae
004.1	Shigella flexneri
004.3	Shigella sonnei

004.8	Other specified shigella infections
004.9	Shigellosis, unspecified
066.40	West Nile fever, unspecified
066.41	West Nile fever with encephalitis
066.42	West Nile fever with other neurologic manifestation
066.49	West Nile fever with other complications
066.1	Tick-borne fever
066.3	Other mosquito-borne fever
008.43	Intestinal infection due to campylobacter
008.00	Intestinal infection due to E. coli unspecified
008.08	Intestinal infection due to enterohemorrhagic E. coli

6.15 History of Hazards to Health

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

6.16 Problems with Lifestyle

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

6.17 Behavioral/Family Health

V61	Other family circumstances
V15.41	History of physical abuse
V15.42	History of emotional abuse
V15.9	History of health hazard, unspecified
V69.2	High-risk sexual behavior

6.18 Case Management

V68.89	Encounters for other specified administrative purpose

6.19 Administrative and Counseling

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