RESOURCE AND PATIENT MANAGEMENT SYSTEM

Behavioral Health System

(AMH)

User Manual

Version 4.0 Patch 2
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1.0 Introduction

The Behavioral Health System (BHS) is a module of the Resource and Patient Management System (RPMS) designed specifically for recording and tracking patient care related to behavioral health. AMH v4.0 includes functionality available in the previous versions of the RPMS behavioral health software plus multiple new features and an enhanced graphical user interface (GUI).

Many behavioral health providers co-located in a primary care setting at facilities that have deployed the RPMS Electronic Health Record (EHR) have transitioned to the EHR to document their services and support integrated care. However, a large number of behavioral health clinicians are located at facilities that do not use the EHR. For these providers, AMH v4.0 can be utilized as a "stand-alone," yet integrated module within the RPMS suite of clinical and practice management software.

AMH v4.0 offers:

- Opportunities for improved continuity of care and health outcomes
- Standardized documentation
- Tools to meet regulatory and accreditation standards and reporting requirements
- Revenue enhancement
- Report generation for care management, program management, and clinical data to inform prevention activities and support local and national initiatives

While this package is integrated with other modules of RPMS, including the Patient Care Component (PCC), the package uses security keys and site-specific parameters to maintain the confidentiality of patient data. The package is divided into three major modules:

- **Behavioral Health Data Entry Menu**: Use the Behavioral Health Data Entry menu for all aspects of recording data items related to patient care, case management, treatment planning, and follow-up.
- **Reports Menu**: Use the Reports menu for tracking and managing patient, provider, and program statistics.
- **Manager Utilities Menu**: Use the Manager Utilities menu for setting site-specific parameters related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and HQE for mandated federal reporting and funding.

1.1 Primary Menu

The primary menu option for this package is (Indian Health Service) **IHS Behavioral Health System** (AMHMENU) shown in Figure 1-1:

```
                    ***********************************************
                    **       IHS Behavioral Health System       **
                    ***********************************************
                               Version 4.0 (Patch 2)

                                DEMO INDIAN HOSPITAL

   DE     Behavioral Health Data Entry Menu ...
   RPTS   Reports Menu ...
   MUTL   Manager Utilities ...

Select Behavioral Health Information System Option:
```

Figure 1-1: Options on the IHS Behavioral Health System menu

1.2 Preparations

The Behavioral Health Program Manager should meet with the site manager to set site-specific parameters related to visit sharing and the extent of data transfer to PCC.

In order for data to pass to PCC, the site manager will add Behavioral Health to the PCC Master Control file. In addition, each user of this package must have a FileMan access code of M.

The Site Manager will need to add a BHS mail group using the Mail Group Edit option. Add this mail group to the AMH Bulletins using the Bulletin Edit Option. Members of this mail group will automatically receive bulletins alerting them of any visits that failed to pass to PCC.

1.3 Security Keys

Security keys should only be assigned to personnel with privileged access to confidential behavioral health data. Program Managers should meet with the site manager when assigning these keys is shown in Table 1:

Key	Permits Access To
AMHZMENU	Top-Level menu (AMHMENU)
AMHZMGR	Supervisory-Level/Manager options
AMHZ DATA ENTRY	Data Entry module
AMHZ RESET TRANS LOG	Reset the Export log
AMHZDECT	Data Entry Forms Count Menu option
AMHZHS	BHS Health Summary Component
AMHZRPT	Reports Module
AMHZ DV REPORTS	Screening Reports
AMHZ SUICIDE FORM ENTRY	Suicide Form Data Entry Menu

Key	Permits Access To
AMHZ SUICIDE FORM REPORTS	Suicide Form Reports Menu
AMHZ DELETE RECORD	Delete unsigned records
AMHZ DELETE SIGNED NOTE	Delete records containing signed notes
AMHZ UPDATE USER/LOCATIONS	Update the locations the user is permitted to access
AMHZ CODING REVIEW	Review records to ensure accurate coding
AMHZ PROBLEM LIST	Access the PCC Problem List from AMH

Table 1: **Security Keys**

2.0 Orientation

The following provides information about using the roll-and-scroll RPMS Behavioral Health System and the RPMS Behavioral Health System GUI.

2.1 Standard Conventions (Roll and Scroll)

2.1.1 Caps Lock

Always work with the Caps Lock on.

2.1.2 Default Entries

When a possible answer is followed by double slashes (//) Figure 2-1, press Enter to default to the entry displayed. If you do not want to use the default response, enter your new response after the double slashes (//).

```
Do you want to display the health summary? N//  (No Health Summary will be
displayed.)
```

Figure 2-1: Default entry screen showing accepting the default

2.1.3 Help

Online help can be obtained at any data entry field by typing **1**, **2**, or **3** 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 the **Shift** and **6** keys to generate the caret (^) symbol. This symbol terminates the current action, and backs you up one level.

2.1.5 Exit

1. Type **HALT** at a menu prompt to exit from RPMS at any time.
2. Type **RESTART** at a menu prompt to return to the “Access Code:” prompt.
3. Type **CONTINUE** at a menu prompt to exit RPMS, and return to the previous menu.

2.1.6 Same Entries

For certain types of data fields, primarily those that use lists of possible entries (such as facilities, diagnoses, communities, patients, etc.), press the spacebar, and the Return key to repeat the last entry you used at the prompt.

2.1.7 Lookup

Be cautious of misspellings. To ensure the spelling of a name or entry, use only the first few letters. RPMS will display all choices that match those beginning letters as shown in Figure 2-2:

```
PATIENT NAME: W&&RM
1    W&&&RMAN,BARRY         M 05-05-1989 054270542 PIMC 101623
                                                     SE 101624
2    W&&&MAN,CHRIS  Y       F 06-16-1954 001290012 PIMC 100039
                                                    HID 100040
                                                     SE 100041
```

Figure 2-2: Patient lookup screen

2.1.8 Pause Indicator

The <> symbol usually displays when a multiple page report reaches the bottom of a display screen, and additional pages are in the report.

1. Press Enter to go to the next page.
2. Type the caret (^) to exit the report.

2.1.9 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)
- T+7 (a week from today)

Note: If you do not enter the year, the system defaults to the current year.

If the system prompts for time, anything between 6 AM and 6 PM will be recorded correctly by entering a number or military time. Between 6 PM and 6 AM, use military time or append the number with an A or P:

- 130 – 1:30 PM
- 130A – 1:30 AM
- If the system prompts for both date and time, the acceptable formats are:
- T@1 – Today at 1 PM
- 4/3@830 – April 3 at 8:30 AM

2.1.10 Stop

Press C-Ctrl to stop a report or to exit the application immediately.

2.1.11 Delete

Type an at sign (**@**) in a field to delete the existing data.

2.2 ListMan (Roll and Scroll)

The BHS 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.

The mouse pointer may not be used to select a menu item on the RPMS terminal.

By typing two question marks (??) at the “Select Option:” 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.

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

```
Update BH Forms            Mar 29, 2001 11:50:37      Page: 1 of  1
Date of Encounter:  Tuesday  MAR 27, 2001
---------------------------------------------------------------------------
 #  PRV PATIENT NAME         HRN      AT  ACT  PROB    NARRATIVE

  1 DKR W&&RMAN,RAE      SE100003        31     14 SEVERE DEPRESSION
  2 DKR     --            -----       60  36     95 RPMS BH TRAINING
  3 DKR     --            -----       30  32     84 EMPLOYEE COUNSELING


AV   Add Patient Visit      DE   Delete Record     AP   Appointments
AC   Add Adm/Comm Activity  PE   Print Record      MM   Send Mail Message
ED   Edit Record            HS   Health Summary       Q    Quit
```

```
OT   Other Pat Info         SO   SOAP/CC Edit
DS   Display Record         SD   Switch Dates
Select Action: AV//??

The following actions are also available:
+    Next Screen          FS   First Screen     SL   Search List
-    Previous Screen      LS   Last Screen      ADPL Auto Display(On/Off)
UP   Up a Line            GO   Go to Page       QU   Quit
DN   Down a Line          RD   Re Display Screen
>    Shift View to Right  PS   Print Screen
<    Shift View to Left   PL   Print List
```

Figure 2-3: ListMan secondary options dialog

At the “Select Action” prompt, complete the following actions:

1. Type a plus sign (+) in the display that fills more than one page to see the next full screen (when you are not on the last screen).
2. Type a minus sign (-) to display the previous screen (when you are not on the first screen). This command will only work if you have already reviewed several screens in the display.
3. Press the up arrow key on your keyboard to move the screen display back one line at a time.
4. Press the down arrow key on your keyboard to move the screen display forward one line at a time.
5. Press the right arrow key on your keyboard to move the screen display to the right.
6. Press the left arrow key on your keyboard to move the screen display to the left.
7. Type **FS** in a multipage display to return to the first screen of the display.
8. Type **LS** in a multipage display to go to the last screen in the display.
9. Type **GO** and the page number of a multiscreen display to go directly to that screen.
10. Type **RD** to redisplay the screen.
11. Type **PS** to print the current screen.
12. Type **PL** to print an entire single or multi-screen display (called a list).
13. Type **SL** to be prompted for a word that you wish to search for in the list. Press Enter after your word selection to be moved to the first occurrence of the word.

    For example, if you were many pages into a patient’s Face Sheet and wanted to know the patient’s age, you could use SL, then indicate the age, and press Enter to be moved to the Age field.

14. Type **ADPL** to either display or not display the list of menu options in the window at the bottom of the screen.

15. 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 for entering data, press Enter to accept defaulted data values or after you enter a data value into a field. The tab or arrow keys can be used for moving between fields or for bypassing data fields for which you do not want to enter a value. The system automatically fills in much of the demographic information when you enter patient, program, and course of action fields during the preliminary data entry process. In addition, if program defaults have been set, the system displays Figure 2-4:

```
* BEHAVIORAL HEALTH VISIT UPDATE *    [press <F1>E when visit entry is complete]
Encounter Date: OCT 1,2009                      User: THETA,SHIRLEY
Patient Name:  ALPHAA,CHELSEA MARIE   DOB: 2/7/75    HR#:  116431
-----------------------------------------------------------------------------
Display/Edit Visit Information  Y      Any Secondary Providers?: N

Chief Complaint/Presenting Problem:
SOAP/Progress Note <press enter>:   Comment/Next Appointment <press enter>:
PURPOSE OF VISIT (POVS) <enter>:    Any CPT Codes to enter?  Y

Activity:     Activity Time:        # Served: 1      Interpreter?

Any Patient Education Done?  N      Any Screenings to Record? N
Any Measurements?  N                Any Health Factors to enter? N
Display Current Medications? N      MEDICATIONS PRESCRIBED <enter>:
Any Treated Medical Problems?  N    Placement Disposition:
Visit Flag:      Local Service Site:
_____________________________________________________________________________


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

Figure 2-4: Using ScreenMan sample screen 1

If you make a change or new entry on the form, press Enter to record the change. A confirmation dialog might appear for further information. As an example, in the above example, typing **Y** at the "**Any Secondary Providers**" prompt indicates there was a secondary provider; but you must press Enter after typing **Y** to open the dialog and record the secondary provider information.

Type **E** and press Enter to close the screen, after all the required data has been entered. Type **Y** to save any changes.

2.3.2 Using the Pop-Up Window

Press Enter to move between fields, when inputting data in a screen. Press Tab to move to the “Command” prompt (Close option by default). Press Enter to close the screen and the original data entry screen displays as shown in Figure 2-5:

```
*******  ENTER/EDIT PROVIDERS OF SERVICE  *******

Encounter Date: MAR 27,2001            User: RHOOOO,DOROTHY K
Patient Name: MUUUUU,SALLY
-------------------------------------------------------------------

PROVIDER: SIGMA,STEPHEN A    <TAB>   PRIMARY/SECONDARY: PRIMARY   <TAB>
PROVIDER: MUUUU,GRETCHEN     <TAB>   PRIMARY/SECONDARY: SECONDARY <TAB>
PROVIDER:                    <TAB>   PRIMARY/SECONDARY:
PROVIDER:                            PRIMARY/SECONDARY:
___________________________________________________________________
Close     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: Close  [RET]                 Press <PF1>H for help    Insert
```

Figure 2-5: Using ScreenMan, sample screen 2

Press Enter to open a text editor screen as shown in Figure 2-6:

```
+-------------------------------------------------------------------+]
¦             ******  Enter/Edit Clinical Data Items  ******
¦ Encounter Date: MAR 27,2001          User: SMITH, STANLEY K.          ¦
¦ Patient Name:  JONES,ARTHUR   DOB:  8/1/84   HR#:  101813             ¦
¦  CHIEF COMPLAINT: Alcohol Dependence
¦  S/O/A/P: [RET]     ¦
```

Figure 2-6: Using ScreenMan, sample screen 3

2.4 Full Screen Text Editor (Roll and Scroll)

While many of the data entry items in the Behavioral Health System are coded entries or items selected from a table, there can be extensive text entry associated with clinical documentation, treatment plans, intake documents, etc. 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.

You have the option when entering a lengthy narrative to use the narrative in a traditional word processing application like Microsoft Word or Word Perfect and paste the text into the open RPMS window.

Table 2 lists the most commonly used 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

Table 2: RPMS text Editor Commands

Figure 2-7 is a sample of the Text Edit screen:

```
==[ WRAP ]==[ INSERT ]========< S/O/A/P >==============[ <PF1>H=Help ]====
This is a demonstration of how to type and use the full screen editor.
When all relevant information has been entered, press [F1]E

<===T=====T=====T=====T=====T=====T=====T=====T=====T>=====T
Bottom of text                PF1(F1) followed by B
```

Figure 2-7: Using Text Editor, sample screen 1

1. Press **F1** and type **H** to display all of the available commands for the RPMS Full Screen Editor (Figure 2-8). Type the caret (^) to exit the Help screens.

```
* BEHAVIORAL HEALTH VISIT UPDATE *    [press <F1>E when visit entry is
complete]
Encounter Date: OCT 1,2009                      User: THETA,SHIRLEY
Patient Name:  ALPHAA,CHELSEA MARIE   DOB: 2/7/75    HR#:  116431
-----------------------------------------------------------------------------
Display/Edit Visit Information  Y      Any Secondary Providers?: N

Chief Complaint/Presenting Problem:
SOAP/Progress Note <press enter>:  Comment/Next Appointment <press enter>:
PURPOSE OF VISIT (POVS) <enter>:   Any CPT Codes to enter?  Y

Activity:     Activity Time:        # Served: 1      Interpreter?
Any Patient Education Done?  N      Any Screenings to Record? N
Any Measurements?  N                Any Health Factors to enter? N
Display Current Medications? N      MEDICATIONS PRESCRIBED <enter>:
Any Treated Medical Problems?  N    Placement Disposition:
Visit Flag:      Local Service Site:
_____________________________________________________________________________


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

Figure 2-8: Using Text Editor, sample screen 2

2. At the “COMMAND” prompt, type **E** and **S** to save and exit the data entry screen

- If the cursor is not at the “COMMAND” prompt, press the **F1** key and type **E**. These commands will also save the data and exit the data entry screen.

2.5 Word Processing Editors (Roll and Scroll)

The word processor editors or Roll and Scroll screens

If you see Figure 2-9, when typing in a word processing field, then your default editor has been set to the RPMS line editor.

```
1>
```

Figure 2-9: RPMS line editor default

Change to the full screen editor, as follows:

1. At any menu prompt, type **TBOX**. ToolBox (Figure 2-10) is a secondary menu option that all users can access but do not normally see on their screen.

```
   DE     Behavioral Health Data Entry Menu ...
   RPTS   Reports Menu ...
   MUTL   Manager Utilities ...

Select Behavioral Health Information System Option: TBOX  User's Toolbox

          Change my Division
          Display User Characteristics
          Edit User Characteristics
          Electronic Signature code Edit
          Menu Templates ...
          Spooler Menu ...
          Switch UCI
          TaskMan User
          User Help

Select User's Toolbox Option: Edit User Characteristics
```

Figure 2-10: Change the Text Editor, Step 1

2. At the “Select User's Toolbox Option” prompt, type “Edit User Characteristics” from TBOX and a window will be displayed.

3. Press the down arrow key on your keyboard to move to the Preferred Editor field. To change your preferred editor to the Screen Editor, type **SC**. Continue to press the down arrow until the cursor reaches the “Command:” prompt.

4. At the “Command: prompt, type **S** and press Enter to save your changes. Type **E** and press Enter to exit the screen. The **Edit User Characteristics** screen and fields are shown in the Figure 2-11:

```
                          EDIT USER CHARACTERISTICS
NAME: SIGMA,SAMANTHA A                                    PAGE 1 OF 1
```

```
_____________________________________________________________________________

                   INITIAL: SAS                        PHONE:
                 NICK NAME:                     OFFICE PHONE:
                                                 VOICE PAGER:
                                               DIGITAL PAGER:

    ASK DEVICE TYPE AT SIGN-ON: DON'T ASK
                     AUTO MENU: YES, MENUS GENERATED
                   TYPE-AHEAD: ALLOWED
               TEXT TERMINATOR:
              PREFERRED EDITOR: SCREEN EDITOR - VA FILEMAN

Want to edit VERIFY CODE (Y/N):
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

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

Figure 2-11: **Edit User Characteristics** text editor, Steps 1–4

> **Note**: Refer to Section 2.4 for more information on using the Full Screen Text Editor.

2.6 Pop-Up Windows (GUI)

The application displays pop-up windows (Figure 2-12) with the same functional controls on them. Generally, these are Crystal Reports windows.

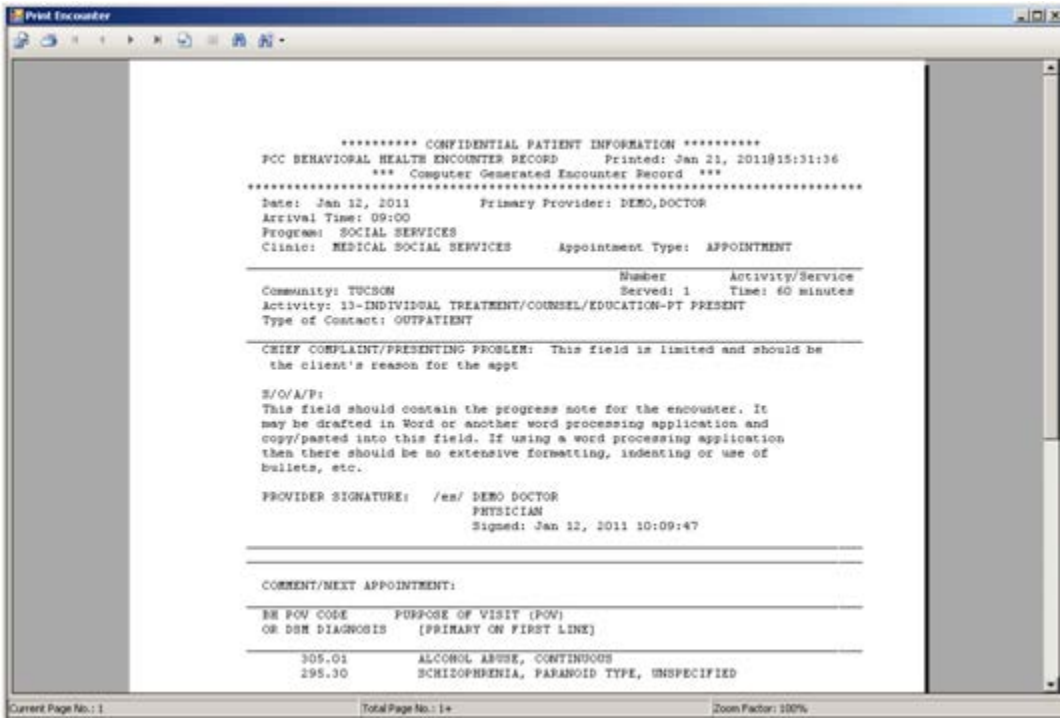


Figure 2-12: Sample pop-up dialog

Scroll through the text on the current page by doing one of the following:

- Use the scroll bar.
- Double click on any line of text. Then press the up and down arrows on the keyboard.

The information on the last line of the pop-up window displays the Current Page (being displayed), the total number of pages, and the zoom factor (of the text of the pop-up window).

The pop-up window only displays the first page (when you first access the window). If there is more than one page, you must press the Next Page and Last Page buttons to move to that page. Otherwise, you can specify the page number to move to. Refer to Section 2.6.2 for more information.

2.6.1 Buttons on Title Bar

The Minimize, Maximize, and Exit Program buttons on the upper right function as their Windows equivalents.

2.6.2 Buttons on the Toolbar

The following describes the functions of the various buttons on the toolbar.

2.6.2.1 Print Button

Click the Print button to display the Print dialog. This is the same Print dialog in the Windows equivalent. Here you select the printer, number of copies, page range, and other properties used to output the contents of the pop-up dialog.

2.6.2.2 Move To Page Buttons

The Move To Page buttons provide the means of going to adjacent pages in the text of the pop-up dialog.

From left to right, the buttons do the following: go to the first page, go to the previous page, go to the next page, go to the last page.

2.6.2.3 Go To Page

1. Press the **Go To Page** button ( ) to specify a page to move to. Figure 2-13 shows the **Go To Page** dialog:

Figure 2-13: **Go to Page** dialog

2. Type the page number and click **OK** to display the page. If a page outside the range of pages is entered, a blank page displays.

2.6.2.4 Find Text

1. Click the **Find Text** button to display the dialog shown in Figure 2-14:

Figure 2-14: **Find Text** dialog

2. Click the **Find Next** button to search for a text string. When found, the line of text is highlighted. Keep clicking the button to search for more occurrences. When the system reaches the end of the search process, the message: “information message informing you that the application has finished searching the document” displays.

3. Click **OK** to close the information message.

4. Click **Cancel** to close the dialog.

2.6.2.5 Zoom Button

Click Zoom to change the size of the text of the pop-up window (for easier reading, for example). This setting does not affect the output of the pop-up window.

2.7 Using the Calendar (GUI)

Date and time fields exist throughout the GUI (Figure 2-15):

Figure 2-15: Sample Date and Time field

There are multiple ways to set a date and time field:

- Type in the field:
  - Typing **M** in the day item sets the day to Monday.
  - Typing **09** in the month item changes the month to September.
- Place the cursor in an item (day of week, month, etc.) and press the up or down arrow keys to step through the available options.
- Click the date field’s list to display the Calendar shown in Figure 2-16:

Figure 2-16: Sample Calendar dialog

The calendar indicates today's date. Set a different date by selecting it; the selected date will display in the Date field. To manipulate the calendar further:

– To change the year, click the year label and click the up or down arrow button to step through the years (Figure 2-17).

Figure 2-17: Change **Year** dialog

– To display the previous or next month's calendar, click the left or right arrow button.
– To display a specific month, click the month label, and select from the list displayed (Figure 2-18).

Figure 2-18: List of Months dialog

– Press the up or down arrow key to step through the calendar week by week.
– Press the left or right arrow key to step through the calendar day by day.
– Right-click the month label to select "Go to Today" and return to today's date.

2.8 Using the Search Window (GUI)

Several fields in the application when clicked display a search dialog. For example, the Community field displays on the **Community** search dialog shown in Figure 2-19:

Figure 2-19: **Community** search dialog

This type of dialog has similar functionality:

1. Click **Close** to exit the dialog and return to the previous window.
2. Type a few characters in the **Search String** field and click **Search** button to retrieve records. The retrieved records will display in the Community pane.
3. Select a record and click **OK** to open the form.
4. Select a record from the **Most Recently Selected** field and click **OK**.
5. Right click the field and click **Clear** to remove the contents of the field.

2.9 Using the Search/Select Window (GUI)

Several fields in the application have fields that display a search or select window.

For example, the **Add** button on the **Axis I** pane on the **POV** tab field displays the dialog shown in Figure 2-20:

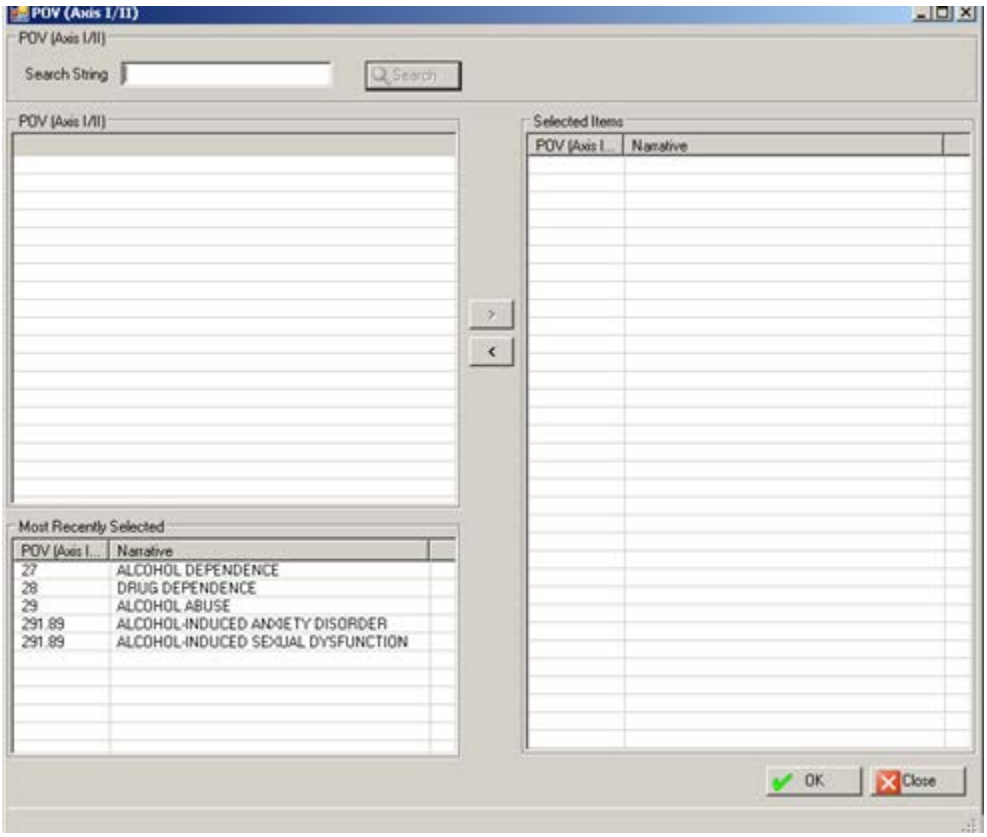


Figure 2-20: Sample search and select window

The following describes how to use the window:

1. Click the **Close** button to exit the window.
2. Type a few characters in the **Search String** field and click **Search** button to retrieve records.
3. You can add one or more records from the **Most Recently Selected** pane to the Selected Items pane by clicking the right arrow button.
4. Click the right arrow button to add one or more records from the POV **Axis I/II** pane to the **Selected Items** pane.
5. Click the left arrow button to remove one or more records from the **Selected Items** pane.
6. When you are satisfied with the information in the **Selected Item** pane, click **OK.**

7. When the field is populated on the form, you can remove its contents by right-clicking on the field and selecting the **Clear** option.

2.10 Using the Multiple Select Window (GUI)

Several fields in the application have fields that display multiple select windows such as the **AXIS IV** window, in Figure 2-21:

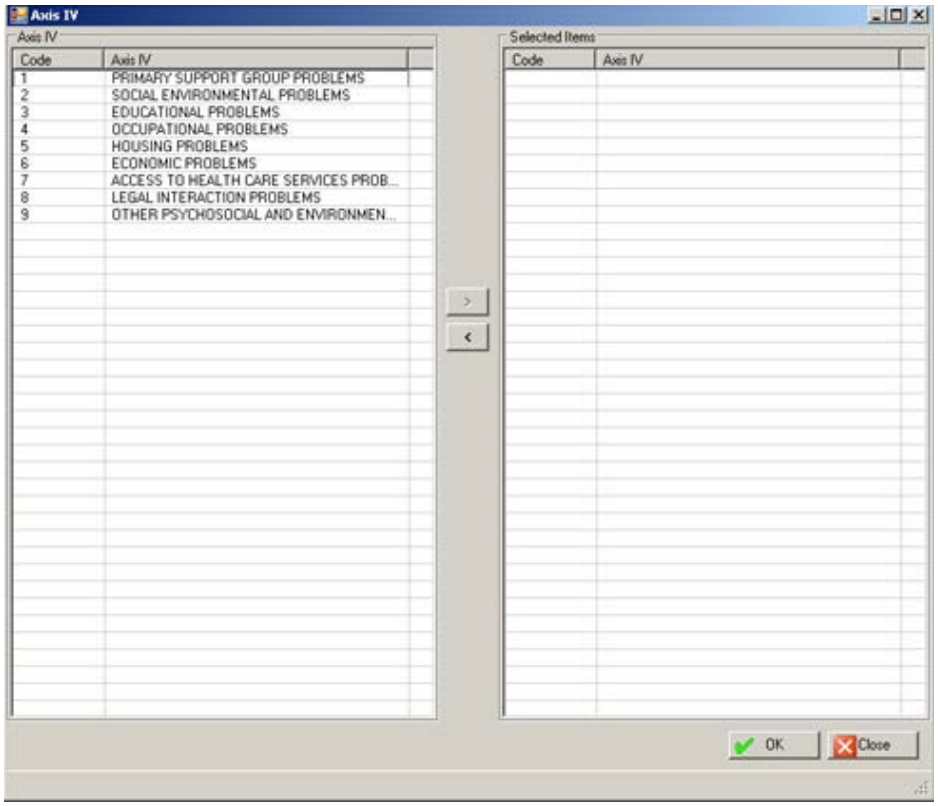


Figure 2-21: Sample **AXIS IV** multiple select window

1. Click the **Close** button to exit the window.
2. To add one or more selected codes to the **Selected Items** pane, click the right arrow button. You can select more than one by pressing Ctrl key and selecting the next code.
3. To move one or more selected records from the **Selected Items** pane to the Axis IV pane, click the left arrow button.
4. When you have the records you want in the **Selected Item** pane, click **OK**.
5. When the field is populated on the form, you can remove its contents by right-clicking on the field and selecting **Clear**.

2.11 Free Text Fields (GUI)

Free text fields are fields where you can type information.

An example of the free text field is the Axis III field on **POV** tab of the **Visit Data Entry** dialog.

To aid in editing the text, a content menu is available as shown in Figure 2-22:

Figure 2-22: Context menu to aid in editing text dialog

The following options are described below:

- **Undo**: removes the last edit action
- **Cut**: removes the selected text from its current position and places it on the clipboard
- **Copy**: copies the selected text and places it on the clipboard (the text is NOT removed)
- **Paste**: copies the contents of the clipboard and places it in the field at the current cursor position
- **Delete**: removes the selected text from its current position
- **Select All**: highlights all of the text in the current field

> **Note**: If you have a long free-text field, you could type the contents of the field in a word processing application; here you can check the spelling and view the entire text string. Then, copy the text string in the word processing application and paste it in the free text field.

2.12 Selecting a Patient

The following provides information about selecting a patient in roll and scroll as well as the RPMS Behavioral Health System GUI.

2.12.1 Patient Selection (Roll and Scroll)

Select a patient at the "Select Patient" prompt. Type the characters of the patient's last name, Social Security Number (SSN), Health Record Number (HRN), or date of birth (MM/DD/YYYY). The application accepts any form of the patient's name in the search criteria: LASTNAME,FIRSTNAME or LASTNAME, FIRSTNAME (space after the comma).

2.12.2 Patient Selection (GUI)

1. Select a patient with the following rules:

   - When no patient has been selected and you selected the **One Patient** option (such as under Visit Encounters).
   - When you want to change patients. You can change patients by selecting **Patient** and then **Select**, or by right-clicking on the menu tree.

Figure 2-23 displays the **Select Patient** dialog.

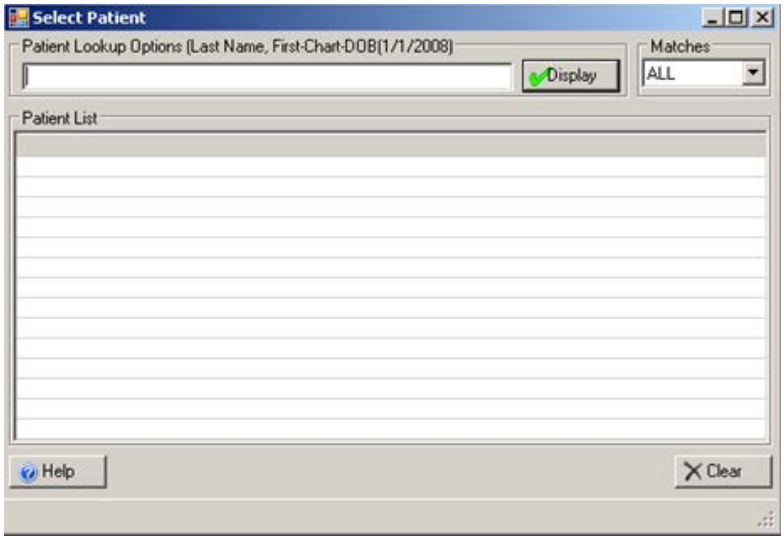
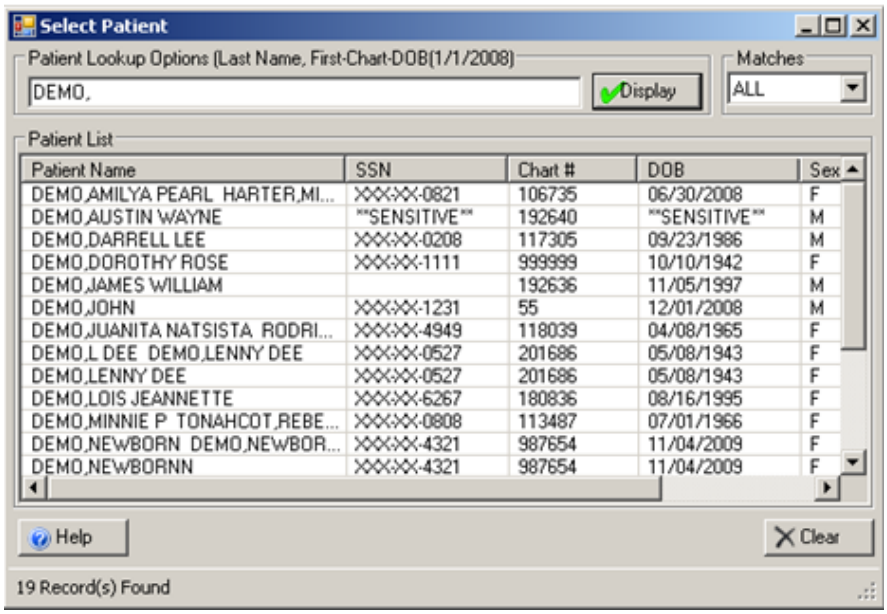


Figure 2-23: **Select Patient** dialog

2. Click **Help** to access the online help.
3. Click **Clear** to remove all data from the **Patient List** pane.
4. At the **Patient Lookup Options (Last Name, First Chart DOB (date)** field, type a few characters of the patient's last name, SSN, HRN, or date of birth (use format MM/DD/YYYY).
5. Click **Display** to enter the search criteria.

- The valid candidates are retrieved as in Figure 2-24 and displayed in the **Select Patient** window. If candidates do not match the search criteria, results will not display.



Patient Name	SSN	Chart #	DOB	Sex
DEMO,AMILYA PEARL HARTER,MI...	XXX-XX-0821	106735	06/30/2008	F
DEMO,AUSTIN WAYNE	**SENSITIVE**	192640	**SENSITIVE**	M
DEMO,DARRELL LEE	XXX-XX-0208	117305	09/23/1986	M
DEMO,DOROTHY ROSE	XXX-XX-1111	999999	10/10/1942	F
DEMO,JAMES WILLIAM		192636	11/05/1997	M
DEMO,JOHN	XXX-XX-1231	55	12/01/2008	M
DEMO,JUANITA NATSISTA RODRI...	XXX-XX-4949	118039	04/08/1965	F
DEMO,L DEE DEMO,LENNY DEE	XXX-XX-0527	201686	05/08/1943	F
DEMO,LENNY DEE	XXX-XX-0527	201686	05/08/1943	F
DEMO,LOIS JEANNETTE	XXX-XX-6267	180836	08/16/1995	F
DEMO,MINNIE P TONAHCOT,REBE...	XXX-XX-0808	113487	07/01/1966	F
DEMO,NEWBORN DEMO,NEWBOR...	XXX-XX-4321	987654	11/04/2009	F
DEMO,NEWBORNN	XXX-XX-4321	987654	11/04/2009	F

Figure 2-24: Sample **Select Patient** window

6. Drag the scroll bar to navigate through the names.

7. Double-click on a patient to view.

2.13 Sensitive Patient Tracking

As part of the effort to ensure patient privacy, additional security measures have been added to the patient access function. Any patient flagged as Sensitive will have access to the patient's record tracked. In addition, warning messages will be displayed when staff (not holding special keys) accesses these records. If the person chooses to continue accessing the record, a bulletin is sent to a designated mail group. For further information on Sensitive Patient Tracking, please see the Patient Information Management System (PIMS) Sensitive Patient Tracking User Manual.

If a patient is listed as Sensitive in the Sensitive Patient Tracking application (Figure 2-25), the word SENSITIVE will be displayed in Social Security, Date of Birth, and Age columns on the Select Patient dialog.

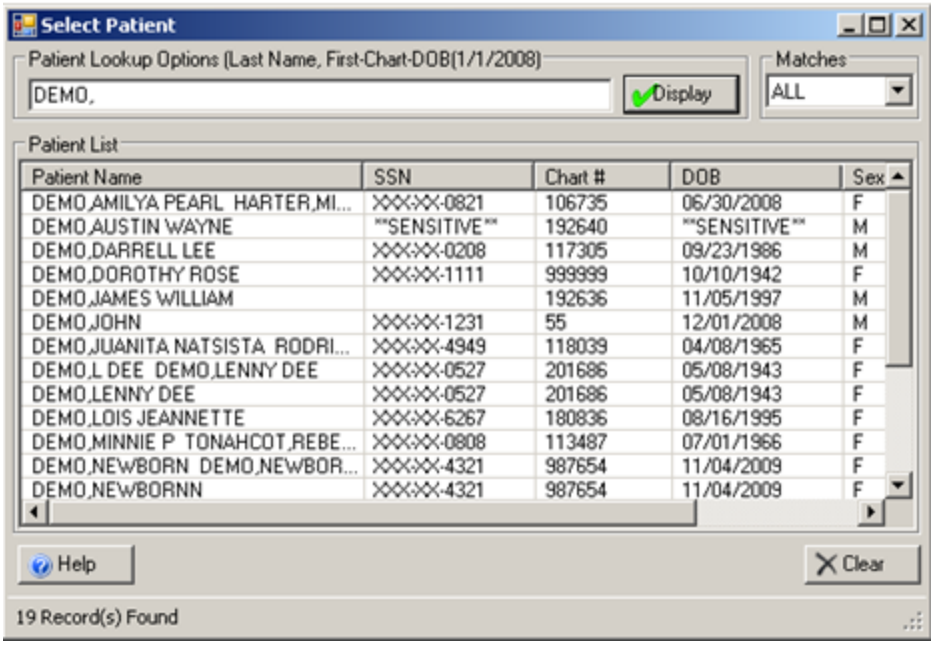


Figure 2-25: Sample **Select Patient** dialog showing sensitive patient dialog

Figure 2-26 displays the **Continue with this Record** message:

Figure 2-26: **Continue with this Record** message displayed in GUI

1. Click **Yes** to access the patient's record.
2. Click **No** to return to the **Select Patient** dialog.

   Two messages can display in the roll-and-scroll application.

The Restricted Record warning message is shown in Figure 2-27:

```
*** WARNING ***
*** RESTRICTED RECORD ***

This record is protected by the Privacy Act of 1974 & Health Insurance
Portability & Accountability Act of 1996. If you elect to proceed, you must
provide you have a need to know. Access to this patient is tracked and your
Security Officer will contact you for your justification.
```

Figure 2-27: Warning message about restricted record in the roll-and-scroll application

A simple warning message is shown here in Figure 2-28:

```
*** WARNING ***
```

```
*** RESTRICTED RECORD ***
```

Figure 2-28: Shorter warning message in the roll-and-scroll application

3. Press Enter to access the patient's record.
4. Type the caret (^) and the patient record will not display.

2.14 Electronic Signature

The following provides information about the electronic signature. This signature applies to the roll-and-scroll application as well as the GUI. Use the electronic signature to sign a SOAP/Progress note, Intake document, and Update document.

2.14.1 Creating Your Electronic Signature

The User's Toolbox in RPMS will set up the electronic signature. Use the option in bold (Electronic Signature Code Edit) shown in Figure 2-29:

```
Select TIU Maintenance Menu Option: TBOX User's Toolbox

   Change my Division
   Display User Characteristics
   Edit User Characteristics
   Electronic Signature Code Edit
   Menu Templates . . .
   Spooler Menu . . .
   Switch UCI
   Taskman User
   User Help
```

Figure 2-29: Options on the TBOX User's Toolbox

Prompts will appear for the electronic signature on SOAP/progress notes as in Figure 2-30. Do not enter credentials (such as MD) under both the block name and title to prevent the credentials from appearing twice. Ensure the printed signature block printed name contains the appropriate name and credentials.

```
INITIAL: MGH//
SIGNATURE BLOCK PRINTED NAME: MARY THETA//
SIGNATURE BLOCK TITLE//RN
OFFICE PHONE:
VOICE PAGER
DIGITIAL PAGER
```

Figure 2-30: Prompts that display at the beginning of the process

The prompt to enter the current electronic signature is shown in Figure 2-31:

```
Enter your Current Signature Code:
```

Figure 2-31: Prompt to enter your current electronic signature

Enter a new electronic signature code as in Figure 2-32:

```
Enter code:
```

Figure 2-32: Prompt for a new code

- Enter a new code (using between 6 and 20 characters) with Caps Lock ON (special characters are not permitted in the code).

  If you forget the code, it must be cleared out by your site manager and a new one must be created. You are the only one who can enter your electronic signature code.

2.14.2 Electronic Signature Usage

Each patient-related encounter can have only one SOAP/Progress Note with an electronic signature. Only the primary provider of service can electronically sign the SOAP/Progress Note, Intake document, or Update document.

- Electronically signed notes with text cannot be edited.
- Blank SOAP/Progress Notes cannot be signed.

Signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.

An encounter record containing an unsigned note can be edited or deleted.

Electronic signatures do not apply to BH encounters created in the EHR (Electronic Health Record.

Electronic signatures cannot be applied to SOAP/Progress Notes that were created before the capability of electronic signature was available in BHS. Electronic signatures do not apply to a visit that was created prior to Version 4.0 install date. In this case, you get the following message: E Sig not required for this visit, visit is prior to Version 4.0 install date.

2.14.3 Data Entry Requirements (Roll and Scroll)

The field for electronic signature is part of the MH/SS RECORD file that includes the date and time the signature was affixed.

The sample in Figure 2-33 shows the electronic signature and date/time stamp in the SOAP/Progress Note section of the printed encounter record.

```
/es/ ALPHA PROVIDER
     MA. LMSW
Signed: 05/14/2009  13:25
```

Figure 2-33: Sample date/time stamp for electronic signature

2.14.4 Assign PCC Visit

The application will apply the following check: The visit will not be passed to PCC if the SOAP/Progress Note associated with the record has not been signed.

When the provider exits the encounter the application will determine if the provider is the primary provider or not.

- If the current user is the primary provider and is trying to edit/enter the record, that person is permitted to electronically sign the SOAP/Progress Note.
- If the current user is *not* the primary provider and is trying to edit/enter the record, that person is not permitted to electronically sign the SOAP/Progress Note. In this case, the application displays the message: Only the primary provider is permitted to sign the SOAP/Progress Note. The encounter will be saved as 'unsigned.' Additionally, a message will display stating: No PCC Link. Note not signed.

2.14.5 Signing a Note (GUI)

If you have entered a SOAP/progress note, the "**Sign?**" dialog displays as shown in Figure 2-34:

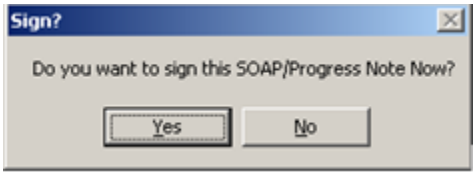


Figure 2-34: **Sign?** dialog

1. Click **Yes** to display the **Electronic Signature** dialog in Figure 2-35:
2. Click **No** to save the note without a signature.

Figure 2-35: **Electronic Signature** dialog

3. Input a valid electronic signature and click **OK**. The encounter is saved with a signed note.
4. If you enter an invalid electronic signature and click **OK**, the application displays the Invalid notice: "Invalid Signature Code".
5. Click **OK** and you return to the **Electronic Signature** dialog.

6. Click **Close** on the **Electronic Signature** dialog and the message: **Are You Sure?** "Are you sure you want to Close without Electronically Signing the Note?" displays as shown in Figure 2-36.

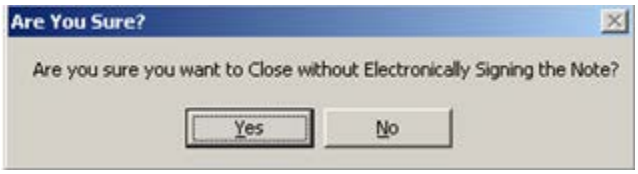


Figure 2-36: **Are you Sure?** dialog

7. Click **No** to return to the **Electronic Signature** window.

8. Click **Yes** and the **Message** dialog in Figure 2-37 displays:

Figure 2-37: Text of **Message** dialog

9. Click **OK** and the record will not have a signed note.

2.14.6 Signing a Note (Roll and Scroll)

Save and exit the encounter record, then enter a note, a prompt for a signature displays as shown in Figure 2-38:

```
Enter your Current Signature Code:
```

Figure 2-38: Prompt for current signature code dialog

- If you type **Y** with the valid electronic signature and the encounter record with a signed note is saved.
- If you use an invalid electronic signature, the encounter with a signed note will not be saved.
- If you edit a visit with a signed note and you get a message indicating that the note cannot be edited as shown in Figure 2-39:

```
The progress note has been electronically signed.  You will not be able to
edit the note.
```

Figure 2-39: Message about progress note already signed.

- If you edit the note with an unsigned note and you are not the primary provider, you will receive the message shown in Figure 2-40:

```
Only the Primary provider is permitted to sign a note.
```

Figure 2-40: Message about only primary provider can sign a note

2.15 Login to GUI

If this is the first time you have logged into the GUI, the **IHS Behavior Health System Login** dialog displays (Figure 2-41).

Figure 2-41: **Initial login** dialog

Click **Edit Connections** on the list for the RPMS Server field. The RPMS Server Connection Management dialog displays as shown in Figure 2-42:

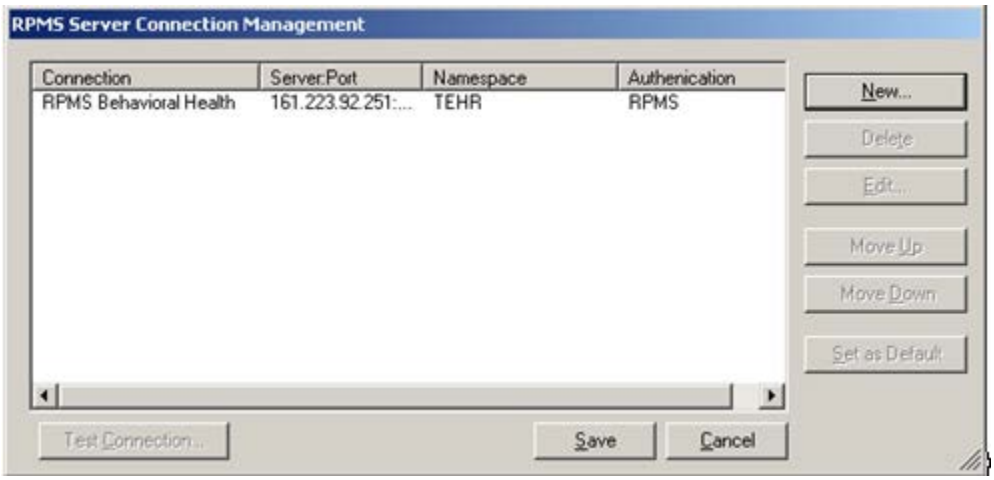


Figure 2-42: Sample **RPMS Server Connection Management** dialog

1. Click **New** to create a new connection
2. Select an existing connection and click **Edit**.

The **Edit RPMS Server Connection** dialog displays as shown in Figure 2-43:

Figure 2-43: Sample **Edit RPMS Server Connection** dialog

Do not select the Default RPMS Server Connection or Use Windows Authentication boxes.

3. At the **Edit RPMS Server Connection** dialog, type one of the following:

   - **Connection Name**: Type the name of the connection
   - **Server Address/Name**: Type server's IP address. An IP address is typically four groups of two or three numbers, separated by a period (.), e.g., 161.223.99.999.
   - **Server Port**: Type the server port number
   - **Server Namespace**: If your site has multiple databases on one server, you will need to type the namespace, such as a text string, e.g., DEVEH.
   - **Use default namespace**: Select checkbox if the Server Namespace is the default to be used.
   - **Test Connection**: The button becomes active when the fields have been populated. Click the **Test Connection** to display the Test Login dialog. Populate the Access Code and Verify Code fields and then click **OK**.

4. Click **OK**, to accept and the application displays the Connection Test message: "RPMS login was successful".

5. If an error message displays, click **OK** to return to the Test Login dialog.

6. Click **Save**, after the RPMS Server Connection Management dialog is complete.

Figure 2-44 displays the **IHS Behavioral Health System Login** dialog:

Figure 2-44: Sample login dialog

7. Type the RPMS access and verify codes. These are the same access and verify codes used to open any RPMS session.
   - Do not select the field with the checkbox.
8. Click **OK** to access the **RPMS Behavioral Health System** tree.

2.16 RPMS Behavioral Health System Tree

The default display of the RPMS Behavioral Health System tree structure is shown in Figure 2-45:

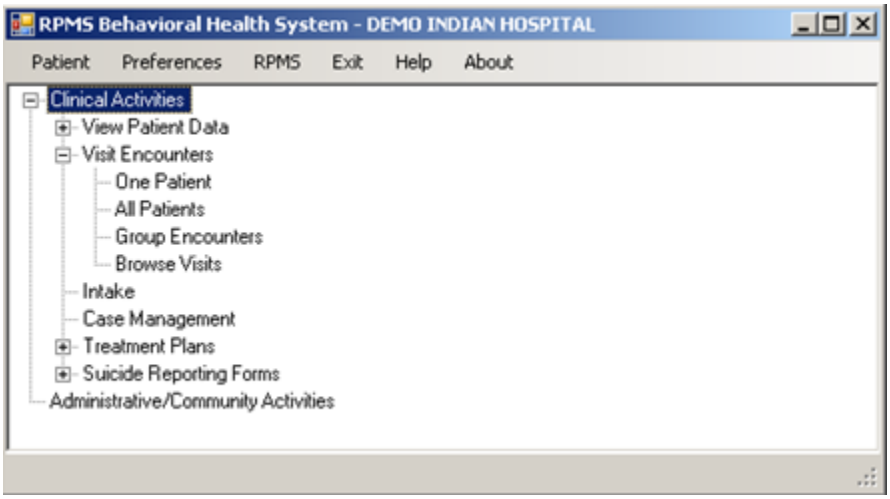


Figure 2-45: Tree structure for the **RPMS Behavioral Health System**

The tree structure is similar to any tree structure in Microsoft© Office™.

9. Click the Minimize (-) icon to collapse the list. The icon will change to the Maximize (+) icon. The **View Patient Data, Treatment Plans, and Suicide Reporting Forms** options are collapsed in Figure 2-45.

10. Click the Maximize (+) icon to expand the list. The icon will change to the Minimize (-) icon. The Visit Encounters option is expanded in the screen capture Figure 2-45.

2.16.1 Patient Menu

Select the current patient from the **Patient** menu. See Section 2.12.2 for more information.

2.16.2 Preferences Menu

1. Select a division or change the menu default from the **Preferences** menu as shown in Figure 2-46:

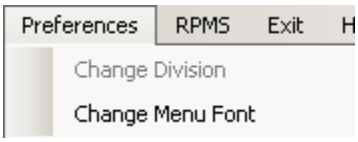


Figure 2-46: Menu options on the **Preferences** menu

2. Select **Change Division** to change the RPMS Division and apply to a site with more than one RPMS database.

3. Select **Change Menu Font** to change the font on the tree structure as shown in Figure 2-47:

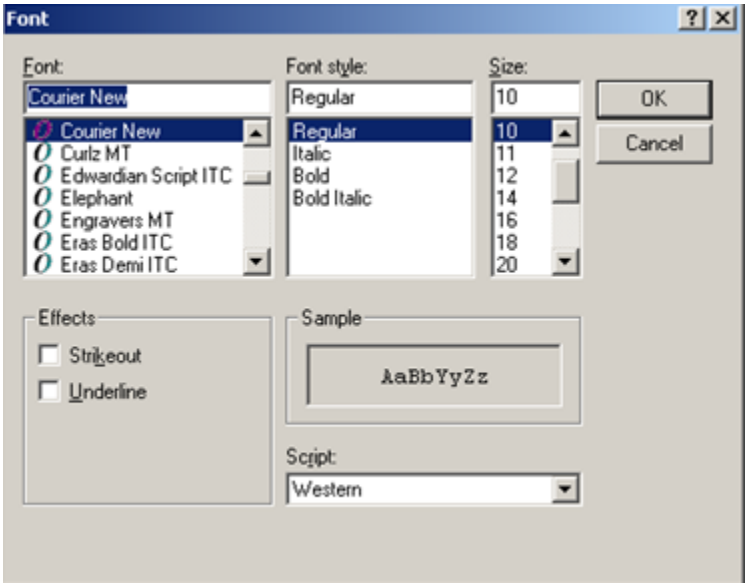


Figure 2-47: **Font** dialog

4. Select the **Font** dialog to change the font name, style, and size of the text on the tree structure.
5. Select **Script** to view how the text will be displayed in another language.
6. Click **OK** to apply the changes.
7. Click **Cancel** and the changes will not be applied

2.16.3 RPMS Menu

1. Select the **RPMS** menu to access the RPMS system (roll and scroll). After clicking the RPMS menu, the application displays the RPMS Terminal emulator window.
2. On the RPMS Terminal Emulator window, select **File | Connect** to access the Connect dialog.
3. Type the IP address in the **Host** field.
4. Click **OK** to access the RPMS system and login.
5. Select **File | Exit** to return to the GUI.

2.16.4 Exit Menu

1. Select the **Exit** menu to leave the application. The application displays the message: “Are you sure you want to Exit?”.
2. Click **Yes** to exit.

2.16.5 Help Menu

Select the **Help** menu to access the online help system.

2.16.6 About Menu

Select the **About** menu to view information about the application.

3.0 Data Entry

This section provides an overview of the data entry process for the roll-and-scroll application and for the RPMS Behavioral Health System GUI.

3.1 Roll and Scroll

Documentation of patient care and documentation of administrative and group encounters are handled through the Data Entry module of the Behavioral Health System (Figure 3-1). It is recommended that providers do their own data entry at the time of a patient encounter. However, a provider can document patient care on a BHS Encounter Form for data entry later by trained program support staff. Choosing **DE** from the Behavioral Health main menu can access the options for data entry shown in.

```
            ***********************************************
            **       IHS Behavioral Health System       **
            ***********************************************
                           Version 4.0 (Patch 2)
                           DEMO INDIAN HOSPITAL

   DE     Behavioral Health Data Entry Menu ...
   RPTS   Reports Menu ...
   MUTL   Manager Utilities ...

Select Behavioral Health Information System Option:  DE
```

Figure 3-1: Data Entry module screen

At the “Select Behavioral Health Information System Option” prompt, type **DE** to display the Data Entry menu screen shown in Figure 3-2:

```
***********************************************
                   **       IHS Behavioral Health System       **
                   **             Data Entry Menu              **
                   *********************************************
                               Version 4.0 (patch 2)
                               DEMO INDIAN HOSPITAL
   PDE    Enter/Edit Patient/Visit Data - Patient Centered
   SDE    Enter/Edit Visit Data - Full Screen Mode
   GP     Group Form Data Entry Using Group Definition
   DSP    Display Record Options ...
   TPU    Update BH Patient Treatment Plans ...
   DPL    View/Update Designated Provider List
   EHRE   Edit BH Data Elements of EHR created Visit
   EBAT   Listing of EHR Visits with No Activity Time
   SF     Suicide Forms - Update/Print

Select Behavioral Health Data Entry Menu Option:  PDE
```

Figure 3-2: Data Entry menu screen

The options on the Data Entry menu are:

- **Enter/Edit Patient/Visit –Patient Centered (PDE):** documents a patient encounter and displays the information required for a single patient on the screen.
- **Enter/Edit Visits Data–Full Screen Mode (SDE):** type the appropriate set of defaults to be used in Data entry.
- **Group Form Data Entry Using Group Definition (GP):** type the encounter data when the encounter involves a group of patients.
- **Display Record Options (DSP):** displays visit information about encounters.
- **Update BH Patient Treatment Plans (TPU):** manages treatment plans for a patient.
- **View/Update Designated Provider List (DPL)**: updates and manages a provider's patient panel.
- **Edit BH Data Elements of EHR created Visit (EHRE)**: type the BH data for a visit created in the RPMS Electronic Health Record application (EHR)
- **Listing of EHR Visits with No Activity Time (EBAT)**: lists the behavioral health EHR visits that have no activity time.
- **Suicide Forms–Update/Print (SF):** update, review, and print IHS Suicide forms that have been entered into the BHS module.

3.2 RPMS Behavioral Health System GUI

The data entry options are located under the Visit Encounters category on the tree structure for the RPMS Behavioral Health System GUI (Figure 3-3):

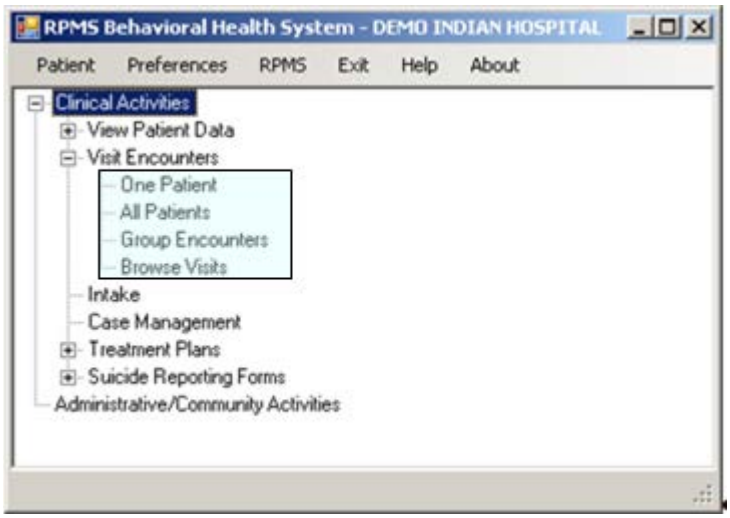


Figure 3-3: Location of **Visit Encounters** category on tree structure

- **One Patient:** manages the visits for the one patient within a date range.
- **All Patients**: manages the visits for all of the patients within a date range.
- **Group Encounters**: manages the Group Encounter data for group encounters within a date range.
- **Browse Visits**: displays visit information for the current patient within a date range.

4.0 One Patient Visit Data

This section provides information on how to manage the visit data of one patient for RPMS BHS roll-and-scroll application and the BHS GUI.

4.1 Enter or Edit Patient Visit Data (Roll and Scroll)

There are two ways to enter/edit patient visit data: type **PDE** or **SDE** on the IHS Behavioral Health System Data Entry Menu (Figure 4-1).

```
             ***********************************************
             **       IHS Behavioral Health System       **
             **             Data Entry Menu              **
             ***********************************************
                         Version 4.0 (patch 2)

                             SELLS HOSPITAL

   PDE    Enter/Edit Patient/Visit Data - Patient Centered
   SDE    Enter/Edit Visit Data - Full Screen Mode
   GP     Group Form Data Entry Using Group Definition
   DSP    Display Record Options ...
   TPU    Update BH Patient Treatment Plans ...
   DPL    View/Update Designated Provider List
   EHRE   Edit BH Data Elements of EHR created Visit
   EBAT   Listing of EHR Visits with No Activity Time
   SF     Suicide Forms - Update/Print ...

Select Behavioral Health Data Entry Menu Option:  PDE  [RET]
```

Figure 4-1: Options on the IHS Behavioral Health System Data Entry menu

Use this menu for all aspects of recording data items related to patient care, case management, treatment planning, and follow-up.

4.1.1 Enter or Edit Patient/Visit Data–Patient Centered (PDE)

Type **PDE** on the Data Entry Menu to add or edit patient visit data. This option was designed specifically for a provider to document a patient encounter and to display all the information for a single patient from a single screen. To do this process, follow these steps:

1. At the “Select Behavioral Health Data Entry Menu Option” prompt, type **PDE**. Do the following:

2. Type a patient’s name.

   - If the patient is deceased, the application displays the patient’s date of death (Figure 4-2).

```
***** PATIENT'S DATE OF DEATH IS Jan 14, 2000@20:30
```

```
                          Ok? Yes//
```

Figure 4-2: Information about patient's date of death screen

- Type **No** at the "Ok?" prompt, to return to "Enter Patient Name" prompt..
- Type **Yes** at the "Ok?" prompt, to proceed to the Patient Data Entry screen.

If the patient is living, the Patient Data Entry screen displays as in Figure 4-3:

```
PATIENT DATA ENTRY         Mar 11, 2009 17:15:55        Page:    1 of    1
Patient: DEMO,DOROTHY ROSE   HRN: 999999
         FEMALE  DOB: Oct 10, 1942   AGE: 66 YRS   SSN: XXX-XX-1111
Designated Providers:
 Mental Health:                        Social Services:
          A/SA:                                  Other:
     Other (2):                            Primary Care: SMITH,A

Last Visit (excl no shows): May 29, 2008  BETAAAA,BJ  REGULAR VISIT
            314.9  ATTENTION-DEFICIT/HYPERACTIVITY DIS. NOS
**********  LAST 6 AXIS V VALUES RECORDED.  (GAF SCORES)  **********
 04/20/2009  04/20/2009  04/22/2009  04/29/2009  05/01/2009  07/01/2009
     55          75          33          77          44          65
Pending Appointments:
                  Select the appropriate action   Q for QUIT
AV Add Visit            LD List Visit Dates      GS  GAF Scores
EV Edit Visit           TP Treatment Plan Update OI  Desg Prov/Flag/Pers Hx
DR Display Record       CD Update Case Data      EH  Edit EHR Visit
ES Edit SOAP            ID Intake Document       PPL Problem List Update
DE Delete Visit         AP Appointments          SN  Sign Note
PF Print Encounter Form HS Health Summary        TN  TIU Note Display
LV Last BH Visit        DM Display Meds          MM  Send Mail Message
BV Browse Visits        LA Interim Lab Reports   FS  Face Sheet
Select Action: Q//    Q
```

Figure 4-3: Sample Patient Data Entry screen

3. At the "Select Action" prompt, type **AV** to add a visit, or **EV** to edit a visit. Do the following:

4. At the "Which set of defaults do you want to use in Data Entry?" prompt, type the program the provider is affiliated with. The predefined defaults for clinic, location, community, and program will be automatically applied to the visit. Type one of the following:

   - **M** Mental Health Defaults
   - **S** Social Services Defaults
   - **C** Chemical Dependency or Alcohol/Substance Abuse
   - **O** Other

5. Set the date at the "Enter ENCOUNTER DATE" prompt. Refer to Section 2.1.9.

6. At the "Enter PRIMARY PROVIDER" prompt, type the primary provider name.

7. Type **EV** (Edit Visit), the application displays the Behavioral Health Record Edit window. Refer to Section 4.1.4.

8. Type **AV** (Add Visit), the application displays the Behavioral Health Visit Update screen. Refer to Section 4.1.3.

4.1.2 Add/Edit Visit Data–Full Screen Mode (SDE)

This selection specifies the program with which the provider is affiliated so that the predefined defaults for clinic, location, community, and program will be automatically applied to the visit.

1. Type **SDE** on the Data Entry Menu to enter/edit visit data for one or more patients.

2. At the "Which set of defaults do you want to use in Data Entry?" prompt, type one of the following:

   - M Mental Health Defaults
   - S Social Services Defaults
   - C Chemical Dependency or Alcohol/Substance Abuse
   - O Other

3. Set the date at the "Enter ENCOUNTER DATE" prompt.

The application displays the Update BH Forms screen (Figure 4-4).

```
Update BH Forms               Mar 19, 2009 13:50:42          Page:    1 of    1
-------------------------------------------------------------------------------

Date of Encounter:  Monday  MAR 16, 2009         * unsigned note
-------------------------------------------------------------------------------
 #  PRV PATIENT NAME         HRN      AT  ACT  PROB    NARRATIVE

   1 BJB ALPHAA,CHELSEA M WW116431    60  16 295.15 SCHIZOPHRENIA, DISORGANIZED
   2 BJB ALPHAA,CHELSEA M WW116431    30  13 305.02 ALCOHOL ABUSE, EPISODIC,
   3 BJB ALPHAA,CHELSEA M WW116431    15  19  V60.0 LACK OF HOUSING
*  4  JC ALPHAA,CHELSEA M 876543      60  13 295.15 SCHIZOPHRENIA, DISORGANIZED
*  5  JC ALPHAA,CHELSEA M 876543      60  13 295.15 SCHIZOPHRENIA, DISORGANIZED
   6  DG ALPHAA,CHELSEA M WW116431    11  22 305.62 COCAINE ABUSE, EPISODIC
   7  DG ALPHAA,CHELSEA M WW116431    20  15     79 FINANCIAL NEEDS/ASSISTANCE
   8  ST DEMO,DOROTHY ROS WW999999    1   99     97 ADMINISTRATIVE
                                          ?? for more actions
AV   Add Patient Visit      PF   Print Encounter Form SN   Sign Note
AC   Add Adm/Comm Activity  ID   Intake Document      TN   Display TIU Note
EV   Edit Record            HS   Health Summary       PPL  Patient's Problem List
OI   Desg Prov/Flag         ES   SOAP/CC Edit         AP   Appointments
DR   Display Record         SD   Switch Dates         MM   Send Mail Message
DE   Delete Record          EH   Edit EHR Record      Q    Quit
Select Action:
```

Figure 4-4: Sample Update BH Forms screen

The asterisk (*) preceding the number of the encounter record indicates that the record contains an unsigned note. Refer to Section 2.14.

The **PPL** option is fully described below. See Section 9.1.

4. Type **EV** to edit a selected record (patient visit); refer to Section 4.1.4. Type **AV** to add a patient visit, the following prompts display:.
5. At the "TYPE THE PATIENT'S HRN, NAME, SSN OR DOB" prompt, type the patient's name.
6. At the "Enter PRIMARY PROVIDER" prompt, type the primary provider name for the visit (current logon user is default). The Behavioral Health Visit Update screen displays.

4.1.3 Using the Behavioral Health Visit Update Screen

Figure 4-5 shows the Behavioral Health Visit Update screen used to enter patient visit data.

```
* BEHAVIORAL HEALTH VISIT UPDATE *    [press <F1>E when visit entry is complete]
Encounter Date: MAR 5,2009                      User: THETA,SHIRLEY
Patient Name:  DEMO,DARRELL LEE   DOB: 9/23/86    HR#:  117305
-------------------------------------------------------------------------
Arrival Time: 12:00
Display/Edit Visit Information  Y      Any Secondary Providers?: N
Chief Complaint/Presenting Problem:
SOAP/Progress Note <press enter>:   Comment/Next Appointment <press enter>:
PURPOSE OF VISIT (POVS) <enter>:    Any CPT Codes to enter?  Y

Activity:     Activity Time:        # Served: 1      Interpreter??

Any Patient Education Done?  N      Any Screenings to Record? N
Any Measurements?  N                Any Health Factors to enter? N
Display Current Medications? N      MEDICATIONS PRESCRIBED <enter>:
Any Treated Medical Problems?  N    Placement Disposition:
Visit Flag:      Local Service Site:
_____________________________________________________________________________

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

Figure 4-5: Sample Behavioral Health Visit Update screen

When saving data on the Behavioral Health Visit Update screen and you are the primary provider, you will be asked if you want to sign the (note for the) visit. Refer to Section 2.14.6 for more information.

1. At the "Arrival Time:" prompt, type a time, the default is 12:00.
2. At the "Display/Edit Visit Information" prompt, type **Y** to access the Visit Information screen shown in Figure 4-6:

```
                  *****     Visit Information     *****

 Program: MENTAL HEALTH           Location of Encounter: SELLS HOSP

 Clinic: MENTAL HEALTH            Appointment/Walk In: APPOINTMENT

 Type of Contact: OUTPATIENT

 Community of Service: TUCSON
```

Figure 4-6: Sample Visit Information screen

The application automatically populates the fields on the Visit information pop-up according to the set of defaults you selected at the “Which set of defaults do you want to use in Data Entry” prompt on the Site Parameters menu.

3. At the “Program” prompt, type one of the following:
   - **M** (Mental Health), S (Social Services)
   - **O** (Other)
   - **C** (Chemical Dependency)
4. At the “Location of Encounter” prompt, type the encounter.
5. At the “Clinic:” prompt, type the clinic context. Response must be a clinic listed in the RPMS Standard Code Book table.
6. At the “Appointment/Walk-In:” prompt, type one of the following:
   - **A** (Appointment)
   - **W** (Walk In)
   - **U** - Unspecified (non-patient or telephone contact).
7. At the “Type of Contact:” prompt, type the contact activity setting
8. At the “Community of Service:” prompt, type the response for the community included in the RPMS community code set.
9. At the “Any Secondary Providers?” prompt, type **Y** to access the **Enter/Edit Providers of Service** screen (Figure 4-7):.

```
              *******  ENTER/EDIT PROVIDERS OF SERVICE  *******

Encounter Date: MAR 5,2009@12:00       User: THETA,SHIRLEY
Patient Name: DEMO,DARRELL LEE
-----------------------------------------------------------------------------

PROVIDER: THETA,STUART                        PRIMARY/SECONDARY: PRIMARY
PROVIDER:                                     PRIMARY/SECONDARY:
PROVIDER:                                     PRIMARY/SECONDARY:
PROVIDER:                                     PRIMARY/SECONDARY:
PROVIDER:                                     PRIMARY/SECONDARY:
```

```
PROVIDER:                                        PRIMARY/SECONDARY:
```

Figure 4-7: Sample Enter/Edit Providers of Services screen

10. At the “PROVIDER:” prompt, type the secondary provider name.

11. At the “PRIMARY/SECONDARY:” prompt, type additional providers.

The following are the fields on the Behavioral Health Visit Update screen.

1. At the “Chief Complaint/Presenting Problem” prompt, type the chief complaint or problem.

2. At the “SOAP/Progress Note” prompt, press Enter, a secondary window displays. Type text in the field.

3. At the “Comment/Next Appointment” prompt, press Enter, a secondary window displays. Type text in the field.

4. At the “PURPOSE OF VISIT (POVS)” prompt, press Enter to access the Purpose of Visit (POV) Update dialog. Figure 4-8 displays the Purpose of Visit Update screen.

```
     ******* BH RECORD ENTRY -  PURPOSE OF VISIT UPDATE *******
Encounter Date: MAR 5,2009@12:00     User: THETA,SHIRLEY
Patient Name: DEMO,DARRELL LEE   DOB: 9/23/86  HR#: 117305
[press <F1>C to return to main screen]
---------------------------------------------------------------------------
DIAGNOSIS:           NARRATIVE:
DIAGNOSIS:           NARRATIVE:
DIAGNOSIS:           NARRATIVE:
DIAGNOSIS:           NARRATIVE:

AXIS III (press enter to update or TAB to bypass):
                       AXIS IV:
                       AXIS IV:
                       AXIS IV:
                       AXIS IV:

                        AXIS V:     GAF Scale Type
___________________________________________________________________________
Patient's Diagnoses from last 4 visits:
7/8/09  28  DRUG DEPENDENCE
5/15/09  39  PT HAS PROBLEM
3/10/09  29  ALCOHOL ABUSE
3/10/09  291.0  ALCOHOL WITHDRAWAL DELIRIUM

Enter RETURN to continue or '^' to exit:
```

Figure 4-8: Sample BH Record Entry - Purpose of Visit Update

5. Type the caret (^) at the last prompt to exit the Purpose of Visit Update screen.

6. When you press Enter at the last prompt, the cursor jumps to the DIAGNOSIS field.

7. At the “DIAGNOSIS:” prompt, type the POV (the one- or two-digit BHS Purpose of Visit Code or the five-digit DSM-IV-TR diagnostic code).

   - After typing the POV in the Diagnosis field, the Narrative field updates. You can accept the narrative that is displayed or edit the narrative to more clearly identify the reason for the visit. For example, if Problem Code 80 (Housing) was selected, you might want to change it to more accurately reflect the status of the patient’s housing issue – homeless, being evicted, etc. Note: the special characters, “, or ‘ cannot be the first character of the POV narrative. The POV narrative field can contain 2–80 characters.

8. At the “AXIS III:” prompt, press Enter to access another window and type the general medical conditions of the patient.

9. At the “AXIS IV:” prompt, type one of the major psychosocial or environmental problem codes.

10. At the “AXIS V:” prompt, type the patient’s functional level using the GAF scale.

11. At the “GAF Scale Type:” prompt, type the acronym for the specific GAF Scale.

The following are the fields on the Behavioral Health Visit Update screen.

12. At the “CPT Codes” prompt, Type **Y** to access the Add/Edit CPT Procedures pop-up window (Figure 4-9).

```
     **** Add/Edit CPT Procedures**** [press <F1>C to return to main
screen]

   Cpt Code:
   Cpt Code:
   Cpt Code:
   Cpt Code:
   Cpt Code:
```

Figure 4-9: Sample Add/Edit CPT Procedures dialog

1. At the “**CPT Code**:” prompt, type the CPT code for Behavioral Health services.

   - The CPT field will also accept Healthcare Procedure Coping System (HCPCS) that are commonly used by Medicare. State and Local codes might be available if the facility’s billing office has added them to the RPMS billing package. These codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient. More than one code can be used.

   - After typing the CPT, HCPCS, or other billing code, the application confirms that you want to add the code.

2. At the “Activity” prompt, type the activity code that documents the type of service or activity performed by the Behavioral Health provider.

   These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and will affect the billing process. Refer to Appendix A: .

3. At the “Activity Time” prompt, type the activity time.

4. At the “# Served” prompt, type the number served

   - Use any number between 0 and 999 (no decimal digits). The default is 1. This refers to the number of people directly served during a given activity and is always used for direct patient care as well as for administrative activities. At the “Interpreter?” prompt, type **1** (yes) or **0** (no) to indicate if an interpreter was present during the patient encounter.

5. At the “Any Patient Education Done?” prompt, type **Y** to access the **Patient Education Enter/Edit** screen (Figure 4-10).

```
*PATIENT EDUCATION ENTER/EDIT*      [press <F1>C to return to main screen]
 Patient Name: DEMO,DARRELL LEE
 ---------------------------------------------------------------------
 After entering each topic you will be prompted for additional fields

 Display Patient Education History?  N

 EDUCATION TOPIC:
 EDUCATION TOPIC:
 EDUCATION TOPIC:
 EDUCATION TOPIC:
 EDUCATION TOPIC:
```

Figure 4-10: Sample **Patient Education** enter/edit screen

6. At the “Display Patient Education History?” prompt, type **Y** or **N** to display the Behavioral Health and PCC patient education history.

7. At the “EDUCATION TOPIC:” prompt, type the education topic used for encounter.

   The application displays the following screen (Figure 4-11).

```
EDUCATION TOPIC: ABD-COMPLICATIONS

INDIVIDUAL/GROUP: INDIVIDUAL
READINESS TO LEARN:
LEVEL OF UNDERSTANDING:
PROVIDER: THETA,MARK
MINUTES:

COMMENT:
```

```
STATUS (Goal):
GOAL COMMENT:
```

Figure 4-11: Sample pop-up for education topic information

8. At the “Individual/Group” prompt, type if the education is for an individual or for a group.

9. At the “Readiness to Learn” prompt, type one of the following:

- Distraction - use when the patient has limited readiness to learn because the distractions cannot be minimized.
- Eager to Learn - use when the patient is exceedingly interested in receiving education.
- Intoxication - use when the patient has decreased cognition due to intoxication with drugs or alcohol
- Not Ready - use when the patient is not ready to learn.
- Pain - use when the patient has a level of pain that limits readiness to learn.
- Receptive - use when the patient is ready or willing to receive education.
- Severity of Illness - use when the patient has a severity of illness that limits readiness to learn.
- Unreceptive - use when the patient is *not* ready or willing to receive education.
- Level of Understanding - Specify the level of understanding. This is a required field. Type one of the following:
- **1** (Poor)
- **2** (Fair)
- **3** (Good)
- **4** (Group No Assessment)
- **5** (Refused)
- Provider - the provider for the visit (can be changed). The default is the current logon user.
- Minutes - type the number of minutes spent on education, using any integer 1–9999.
- Comment - Add comments about the education topic for the visit, if any.
- Status (Goal): type the status of the education, if any. Type one of the following:
- **GS**–goal set

- **GM**–goal met
- **GNM**–goal not met
- **GNS**–goal not set
- Goal – type the text of the stated goal of the education, if any.

10. At the "Any Screenings to Record?" prompt, type one of the following:

    - Type **N** to accept the default response
    - Type **Y** to use the displayed fields to record any Intimate Partner Violence, Alcohol Screen, or Depression Screening performed during the encounter (Figure 4-12):

```
Intimate Partner Violence (IPV/DV)  Display IPV/DV screening history?  N
      IPV Screening/Exam Result:
      IPV Screening Provider:
      IPV COMMENT:

Alcohol Screening          Display Alcohol Screening History?  N
      Alcohol Screening Result:
      Alcohol Screening Provider:
      Alcohol Screening Comment:

Depression Screening          Display Depression Screening History?  N
      Depression Screening Result:
      Depression Screening Provider:
      Dep Screening Comment:
```

Figure 4-12: Sample IPV, Alcohol Screening, and Depression Screening screen

11. At the "Display IPV/DV screening History?" prompt, type **Y** and the Intimate Partner Violence/Domestic Violence (IPV/DV) screening history displays on secondary screen.

12. At the "IPV Screening/Exam Result" prompt, type the result of the intimate partner violence/domestic violence screening. Type one of the following:

    - **N–**Negative
    - **PR–**Present
    - **PAP–**Past and Present
    - **PA–**Past
    - **REF–**Patient Refused Screening
    - **UAS–**Unable to screen

13. At the "IPV Screening Provider" prompt, type the IPV/DV provider name.

14. At the "IPV Comment" prompt, type the text of any comment related to the IPV/DV screening.

15. At the “Display Alcohol screening History?” prompt, type **Y** and the alcohol screening history displays on secondary screen.
16. At the “Alcohol Screening Result” prompt, type the result of the alcohol screening. Type one of the following:
    - **N**–Negative
    - **P**–Positive
    - **UAS**–Unable to screen
    - **REF**–Patient Refused Screening
17. At the “Alcohol Screening Provider” prompt, type the provider name
18. At the “Alcohol Screening Comment” prompt, type the text of any comment related to the alcohol screening
19. At the “Display Depression screening History?” prompt, type **Y** and the depression screening history displays on a secondary screen.
20. At the “Depression Screening Result” prompt, type one of the following:
    - **N–**Negative
    - **P–**Positive
    - **UAS–**Unable to screen
    - **REF–**Patient Refused Screening
21. At the “Depression Screening Provider” prompt, type the provider name.
22. At the “Dep Screening Comment” prompt, type the text of any comment related to the depression screening.
23. At the “Any Measurement?” prompt, type **Y** to access the Measurements pop-up in Figure 4-13:

```
     ***  Measurements  ***

Measurement Description        Value                        Provider
-----------------------------------------------------------------------
```

Figure 4-13: Sample Measurements pop-up

24. At the “Measurement” prompt, identify the type of measurement being taken on the patient. The application will populate the Description field.
25. At the “Value” prompt, type the numeric value of the measurement. If you populate this field with a value outside the valid value range, the application provides information about what valid values can be used for the field.

26. At the “Provider” prompt, type the name of the provider.

    - Measurements will print on the Full encounter form only (not on the Suppressed encounter form). Measurements can only be deleted from the encounter record where they were first recorded.

27. At the “Any Health Factors to enter?” prompt, type one of the following:

    - **N** to end the process.
    - **Y** to access the to access the Patient Health Factor Update dialog in Figure 4-14:

```
              ******* PATIENT HEALTH FACTOR UPDATE *******
Examples of health factors:  Tobacco Use, Alcohol Cage, TB Status
Patient Name: DEMO,DARRELL LEE
-------------------------------------------------------------------------
 Display Health Factor History?  N

 After entering each factor you will be prompted for additional data items

 HEALTH FACTOR
```

Figure 4-14: Sample Patient Health Factor Update dialog.

28. At the “Display Health Factor History?:” prompt, type one of the following:

    - **N** to end the process.
    - Y to display the health factor history for the patient on another screen

29. At the “HEALTH FACTOR” prompt, type patient’s health factor status at the encounter shown in Figure 4-15:

```
LEVEL/SERVERITY

QUANTITY

COMMENTS
```

Figure 4-15: Other fields for health factor data

30. At the “LEVEL/SEVERITY” prompt, type one of the following:

    - **M** (Minimal)
    - **MO** (Moderate)
    - **H** (Heavy/Severe).

31. At the “QUANTITY” prompt, type a number between 0 and 99999.

32. At the “COMMENTS” prompt, type comments regarding the health factor. Do the following:

The following are the fields on the Behavioral Health Visit Update screen.

33. At the “Display Current Medications?” prompt, type one of the following:

- **N** to display the currently dispensed medications
- **Y** to display the Output Browser screen shown in Figure 4-16:

```
OUTPUT BROWSER                Mar 11, 2009 17:59:30          Page:    1 of    1
Medication List for DEMO,DARRELL LEE

*** Medications Prescribed entries in BH Database for last 2 years ***

The last of each type of medication from the PCC Database is displayed below.
    TERBUTALINE 5MG TAB                # ?                7/17/08
     Sig: TAKE TWO (2) TABLETS BY MOUTH DAILY ON TUESDAY,THURSDAY,SATURDAY,AND S
    DEXAMETHASONE 0.5MG TAB            # ?                7/17/08
     Sig: TAKE ONE (1) TABLET BY MOUTH EVERY MORNING   [OUTSIDE MED]

          Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 4-16: Sample display of current medications

The following are the fields on the Behavioral Health Visit Update screen.

34. At the “MEDICATIONS PRESCRIBED” prompt, press Enter to access another screen and enter the medications prescribed.

35. At the “Any Treated Medical Problems?” prompt, type one of the following:

- N to end the process
- Y to access another screen as shown in Figure 4-17:

```
---------------------------------------------------------------------------
MEDICAL PROBLEM:
MEDICAL PROBLEM:
MEDICAL PROBLEM:
MEDICAL PROBLEM:
MEDICAL PROBLEM:
```

Figure 4-17: Sample medical problem dialog

36. At the “MEDICAL PROBLEM:” prompt, type the medical problems treated by the provider.

37. At the “Placement Disposition” prompt, type the active disposition such as hospitalization or placement in a treatment facility is required. A pop-up displays as shown in Figure 4-18:

```
Enter the Facility to which the patient was referred
FACILITY REFERRED TO:
```

Figure 4-18: Sample dialog for facility name

38. At the “FACILITY REFERRED TO:” prompt, type the name of the facility.

39. At the “Visit Flag” prompt, type the numeric value for the flag.

    - This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. As an example, **1** might mean any visit on which a narcotic was prescribed.

40. At the “Local Service Site” prompt, type the location.

4.1.4 Using the Behavioral Health Record Edit Window

Figure 4-19 displays the Behavioral Health Record Edit screen used to edit an existing visit.

```
* BEHAVIORIAL HEALTH RECORD EDIT *           [press <F1>E to exit]
Encounter Date: APR 3,2009                     User: THETA,SHIRLEY
Patient Name: ALPHAA,CHELSEA MARIE  DOB: 2/7/75  HRN: 116431
-------------------------------------------------------------------------
Date:    APR 3,2009@11:45         Location of Service:  CHINLE HOSP
Program: MENTAL HEALTH            Outside Location:
Clinic:  BEHAVIORAL HEAL          Appt/Walk-in: UNSPECIFIED   Visit Flag:
Type of Contact: OUTPATIENT       Community: CHINLE
Providers <press enter>:          Local Service Site:
Activity:  91         Activity Time: 20  #Served:  1  Interpreter Utilized:
Chief Complaint/Presenting Problem: none
SOAP/PROGRESS NOTE:    Comment/Next Appointment:     Medications Prescribed:
Edit Purpose of Visits?: N      Edit Treated Medical Problems?  N
Edit CPT Codes?                 Edit Health Factors?  N
Edit Patient Education?: N
Edit Any Screening Exams?  N    Edit Measurements?  N
Placement Disposition:                  Referred To:
_________________________________________________________________________

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

Figure 4-19: Sample Behavioral Health Record Edit dialog

1. At the “Date” prompt, set the date of the visit.

2. At the “Location of Service” prompt, and type the service that took place.

3. At the “Program” prompt, type, the provider name

4. At the “Outside Location” prompt, type the name of the outside location

5. At the “Clinic” prompt, type the response listed in the RPMS Standard Code Book table.

6. At the “Appt/Walk-in” prompt, type the appointment information.

7. At the “Visit Flag” prompt, type the numeric value for the flag.

- This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. As an example, **1** might mean any visit on which a narcotic was prescribed.

8. At the “Type of Contact” prompt, type the contact name..
9. At the “Community” prompt, type the name of the community.
10. Press Enter at the “Provider” prompt, to display the Enter/Edit Providers of Service screen as shown in Figure 4-20:

```
             *******  ENTER/EDIT PROVIDERS OF SERVICE  *******
[press <F1>C to return to main screen]
Encounter Date: MAR 16,2009           User: BETAAAAA,LORI
Patient Name: DEMO,DOROTHY ROSE
-----------------------------------------------------------------------------

PROVIDER: THETA,SHIRLEY                       PRIMARY/SECONDARY: PRIMARY
PROVIDER:                                     PRIMARY/SECONDARY:
PROVIDER:                                     PRIMARY/SECONDARY:
PROVIDER:                                     PRIMARY/SECONDARY:
PROVIDER:                                     PRIMARY/SECONDARY:
PROVIDER:                                     PRIMARY/SECONDARY:

_____________________________________________________________________________

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

Figure 4-20: Sample Enter/Edit Providers of Service screen

a. At the “PROVIDER:” prompt, type the name of the service provider.
b. At the “PRIMARY/SECONDARY:” prompt, type of the primary or secondary provider.
c. Type **Close** at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

11. At the “Local Service Site” prompt, type the name of the local service site.
12. At the “Activity” prompt, type the activity code that documents the type of service or activity.

- These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. Refer to Appendix A: Activity Codes and Definitions for more information.

13. At the “Activity Time” prompt, type the number of minutes spent on the activity.

Note: 0 (zero) is not allowed as a valid entry.

14. At the “# Served” prompt, type the number of the encounter.

15. At the “Interpreter Utilized” prompt, type **Y** only if an interpreter is required to communicate with the patient.

16. At the “Chief Complaint/Presenting Problem” prompt, type the reason the patient needed services.

17. At the “SOAP/PROGRESS NOTE” prompt, press Enter to access another screen that can be populated with the text of the note. The note can be edited only if it is unsigned.

18. At the “Comment/Next Appointment” prompt, type the text regarding the next appointment.

19. At the “Medications Prescribed” prompt, press Enter to display another window to input the medications prescribed.

20. Press **Y** at the “Edit Purpose of Visits?” prompt, to display the Purpose of Visit Update screen shown in Figure 4-21:

```
     ******* BH RECORD ENTRY -  PURPOSE OF VISIT UPDATE *******
Encounter Date: MAR 5,2009@12:00     User: THETA,SHIRLEY
Patient Name: DEMO,DARRELL LEE   DOB: 9/23/86  HR#: 117305
[press <F1>C to return to main screen]
---------------------------------------------------------------------------
DIAGNOSIS:           NARRATIVE:
DIAGNOSIS:           NARRATIVE:
DIAGNOSIS:           NARRATIVE:
DIAGNOSIS:           NARRATIVE:

AXIS III (press enter to update or TAB to bypass):
                       AXIS IV:
                       AXIS IV:
                       AXIS IV:
                       AXIS IV:

                       AXIS V:       GAF Scale Type:
Patient’s Diagnoses from last 5 visits:
5/6/10  312.32 KLEPTOMANIA
8/11/09  300.02 GENERALIZED ANXIETY DISORDER
9/11/09  300.3  OBSESSIVE-COMPULSIVE DISORDER

Enter RETURN to continue or ‘^’ to exit:
```

Figure 4-21: Sample BH Record Entry - **Purpose of Visit Update** screen

a. At the “Diagnosis:” prompt, type the POV (the one- or two-digit BHS Purpose of Visit Code or five-digit DSM-IV-TR diagnostic code).

b. At the “Narrative:” prompt, accept the narrative that is displayed or edit to clarify reason for visit.

- As an example, if Problem code **80** (Housing) was selected, you might want to change it to more accurately reflect the status of the patient’s housing issue - homeless, being evicted, etc.

c. At the “AXIS III:” prompt, press Enter to display another window and type general medical conditions of the patient treated during the visit.

d. At the “AXIS IV:” prompt, type one or more of the nine major psychosocial or environmental problem codes.

e. At the “AXIS V:” prompt, type the patient’s functional level using the Global Assessment of Functioning (GAF) scale.

f. At the “GAF Scale Type:” prompt, type the acronym for the GAF Scale Type.

g. Type caret (^) to close the pop-up: the Behavioral Health Record Edit screen redisplays.

21. At the “Edit Treated Medical Problems?” prompt, type **Y** to display the Enter/Edit Treated Medical Problems screen shown in Figure 4-22, where one or more medical problems can be entered.

```
****Enter/Edit Treated Medical Problems****  [press <F1>C to return to main

MEDICAL PROBLEM:
MEDICAL PROBLEM:
MEDICAL PROBLEM:
MEDICAL PROBLEM:
MEDICAL PROBLEM:
```

Figure 4-22: Sample medical problem dialog

a. At the “Medical Problem:” prompt, type the medical problems treated.

b. Press **F1-C** to close the pop-up: the Behavioral Health Record Edit screen redisplays.

22. At the “Edit CPT Codes?” prompt, type Y to display the Add/ Add/Edit CPT Procedures screen in Figure 4-23.

```
**** Add/Edit CPT Procedures**** [press <F1>C to return to main screen]

Cpt Code:
Cpt Code:
Cpt Code:
Cpt Code:
Cpt Code:
```

Figure 4-23: Sample Add/Edit CPT Procedures dialog

a. At the CPT Code: field type the code to be used.

- These Evaluation and Management (E&M) codes are based on the history, examination, complexity of the medical decision-making, counseling, coordination of care, nature of the presenting problem, and the amount of time spent with the patient.

b. Press **F1-C** to close the pop-up: the Behavioral Health Record Edit screen redisplays.

23. At the “Edit Health Factors?” prompt, type **Y** to display the Patient Health Factor Update screen (Figure 4-24):

```
              ******* PATIENT HEALTH FACTOR UPDATE *******
Examples of health factors:  Tobacco Use, Alcohol Cage, TB Status
Patient Name: DEMO,DARRELL LEE
-----------------------------------------------------------------------
 Display Health Factor History?  N

 After entering each factor you will be prompted for additional data items

 HEALTH FACTOR
```

Figure 4-24: Sample Patient Health Factor Update dialog

a. At the “Display Health Factor History?” prompt, type Y to display the Health Factor History.

b. At the “HEALTH FACTOR” prompt, type the factor to display the screen show in in Figure 4-25:

```
LEVEL/SEVERITY

QUANTITY

COMMENTS
```

Figure 4-25: Fields for health factor data

c. At the “Level/Severity” prompt, type one of the following:

- **M** (minimal)
- **MO** (moderate)
- **H** (heavy/severe)

d. At the “Quantity” prompt, type a number.

e. At the “Comment” prompt, type health factor comment.

f. Type **Close** at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

24. At the “Edit Patient Education?” prompt, Type **Y** to display the Patient Education Enter/Edit screen in Figure 4-26:

```
*PATIENT EDUCATION ENTER/EDIT*      [press <F1>C to return to main screen]
 Patient Name: DEMO,DARRELL LEE
 ---------------------------------------------------------------------
 After entering each topic you will be prompted for additional fields

 Display Patient Education History?  N

 EDUCATION TOPIC:
 EDUCATION TOPIC:
 EDUCATION TOPIC:
```

```
EDUCATION TOPIC:
EDUCATION TOPIC:
```

Figure 4-26: Sample Patient Education enter/edit screen

a. At the "Display Patient Education History?" prompt, type **Y** to display all education provided in the last two years by BH programs. This history is displayed in the **Output Browser** screen.

b. At the "EDUCATION TOPIC:" prompt, type the education topic name and Figure 4-27 displays:

```
EDUCATION TOPIC: ABD-COMPLICATIONS

INDIVIDUAL/GROUP: INDIVIDUAL
READINESS TO LEARN:
LEVEL OF UNDERSTANDING:
PROVIDER: THETA,MARK
MINUTES:

COMMENT:
STATUS (Goal):
GOAL COMMENT:
```

Figure 4-27: Sample pop-up for education topic information

c. At the "Education Topic: prompt, type the education topic.

d. At the "Individual/Group:" prompt, type the education for an individual or group.

e. At the "Readiness to Learn:" prompt, type one of the following:

- **Distraction**: use when the patient has limited readiness to learn because the distractions cannot be minimized.
- **Eager to Learn**: use when the patient is exceedingly interested in receiving education.
- **Intoxication**: use when the patient has decreased cognition due to intoxication with drugs or alcohol
- **Not Ready**: use when the patient is not ready to learn.
- **Pain**: use when the patient has a level of pain that limits readiness to learn.
- **Receptive**: use when the patient is ready or willing to receive education.
- **Severity of Illness**: use when the patient has a severity of illness that limits readiness to learn.
- **Unreceptive**: use when the patient is NOT ready or willing to receive education.

f. At the "**Level of Understanding**:" prompt, type one of the following:

- **1** (Poor)

- **2** (Fair)
- **3** (Good)
- **4** (Group No Assessment)
- **5** (Refused)

g. At the "**Provider**:" prompt, type the provider for the visit. The default is the current logon user.

h. At the "Minutes:" Prompt, type the number of minutes spent on education.

i. At the "Comment:" prompt, type any comments about the education topic.

j. At the "Status (Goal):" prompt, type one of the following:

- **GS** goal set
- **GM** goal met
- **GNM** goal not met
- **GNS** goal not set

k. Type **Close** at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

25. At the "Edit Any Screening Exams?" prompt type **Y** to display the pop-up screen in Figure 4-28:

```
Intimate Partner Violence (IPV/DV)  Display IPV/DV screening history?  N
      IPV Screening/Exam Result:
      IPV Screening Provider:
      IPV COMMENT:

Alcohol Screening          Display Alcohol Screening History?  N
      Alcohol Screening Result:
      Alcohol Screening Provider:
      Alcohol Screening Comment:

Depression Screening          Display Depression Screening History?  N
      Depression Screening Result:
      Depression Screening Provider:
      Dep Screening Comment:
```

Figure 4-28: Sample IPV, Alcohol Screening, and Depression Screening dialog

a. At the "Display IPV/DV screening History?" prompt, type **Y** and IPV/DV Exam History screen displays.

b. At the "IPV Screening/Exam Result" prompt, type one of the following:

- **N** Negative
- **PR** Present
- **PAP** Past and Present

- **PA** Past
- **UAS** Unable to screen
- **REF** Patient Refused Screening

c. At the “IPV Screening Provider” prompt, type the provider name.

d. At the “IPV Comment” prompt, type a comment related to the screening.

e. At the “Display Alcohol screening History?” prompt, type **Y** and the alcohol screening history.

f. At the “Alcohol Screening Result” type one of the following:

- **N** Negative
- **P** Positive
- **UAS** Unable to screen
- **REF** Patient Refused Screening

g. At the “Alcohol Screening Provider” prompt, type the provider name.

h. At the “Alcohol Screening Comment” prompt, type the comment related to the alcohol screening.

i. At the “Display Depression screening History?” prompt, type **Y** and the depression screening history screen displays.

j. At the “Depression Screening Result” prompt, type one of the following:

- **N** **Negative**
- **P** **Positive**
- **UAS** **Unable to screen**
- **REF** **Patient Refused Screening**

k. At the “Depression Screening Provider” prompt, type the provider name.

l. At the “Dep Screening Comment” prompt, type the text of the comment related to the depression screening.

m. Type **Close** at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

26. At the “Edit Measurements?” prompt type **Y** and the Measurements pop-up in Figure 4-29 displays:

```
     ***  Measurements  ***

Measurement Description        Value                      Provider
-----------------------------------------------------------------------
```

Figure 4-29: Sample Measurements pop-up

a. At the “Measurement” prompt, type the type of measurement being taken. The Description field will populate.

b. At the “Value” prompt, type the numeric value of the measurement.

c. At the “Provider” prompt, type the name of the provider.

d. Type **Close** at the Command prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

e. At the “Placement Disposition” prompt type when hospitalization or placement in a treatment facility is required.

f. At the “Referred to” prompt, type the name of the facility.

g. Type **Close** at the “Command” prompt and press Enter to close the pop-up: the Behavioral Health Record Edit screen redisplays.

If the SOAP/Progress Note is unsigned and you are the primary provider, the “Enter your Current Signature Code” displays at the command prompt.

- Type your signature code and the signature is applied to the SOAP/Progress Note associated with the current visit. Refer to Section 2.14 for more information.
- If you do not type your electronic signature and you leave the window, the application will display the message: No PCC Link. Note not signed. Press Enter to continue, the application displays the message: There is no electronic signature, this visit will not be passed to PCC.

Figure 4-30 shows the Other Information screen.

```
                    *******  OTHER INFORMATION  *******

Update, add or append any of the following data

     1). Update any of the following information:
          Designated Providers, Patient Flag
     2). Patient Case Open/Admit/Closed Data
     3). Personal History Information
     4). Appointments (Scheduling System)
     5). Treatment Plan Update
     6). Print an Encounter Form
     7). Add/Update/Print Intake Document
     8). Add/Update Suicide Forms
     9). Provide List Update
    10). None of the Above (Quit)
Choose one of the above:  (1-10): 10//
```

Figure 4-30: Other Information screen

27. Do one of the following:

- Type **9** to display the BH Problem List Update screen. See Section 9.1 for more information.

- Type **10** to exit and one of the following occurs:
  - If the patient was not checked in using the scheduling package, the Other Information screen closes.
  - If the patient was checked in using the scheduling package,
  - If there was an appointment the patient was checked in for using the scheduling package, the Generating PCC Visit screen displays (Figure 4-31).

Notes: If the facility is not using the scheduling package and doesn't have the Interactive PCC Link in the site parameters turned on, you will never be presented with the ability to link it to a PCC visit.

If there is no visit in PCC (patient never checked in, no appointment or walk in was created using the scheduling package and no other clinics saw the patient that day), then the option to link is never presented and the BH visit continues to create a new visit in PCC.

```
Generating PCC Visit.

PATIENT: BETAA,EMILY MAE has one or more VISITs on Mar 09, 2010@12:00.
If one of these is your visit, please select it

1  TIME: 16:00 LOC: WW   TYPE: I CAT: A CLINIC: ALCOHOL  DEC: 0
VCN:47887.1A
   Hospital Location: BJB AOD
   Primary POV:   Narrative:
2  TIME: 15:00 LOC: WW   TYPE: I CAT: A CLINIC: GENERAL  DEC: 0
VCN:47887.2A
   Hospital Location: ADULT WALKIN
   Primary POV:   Narrative:
3  TIME: 16:15 LOC: WW   TYPE: I CAT: A CLINIC: BEHAVIOR DEC: 3
VCN:47887.3A
   Hospital Location: BJB BH
   Provider on Visit: BETA,BETA
   Primary POV: 799.9  Narrative: DIAGNOSIS OR CONDITION DEFERRED ON AXIS
4  Create New Visit

Select:  (1-4): 3
```

Figure 4-31: Continuing prompts

28. At the "Select" prompt, type the number associated with the target visit and press Enter. Figure 4-32 shows the BH screen.

```
-------------------------------------------------------------------------------
Date of Encounter:  Tuesday  MAR 09, 2010      * unsigned note
-------------------------------------------------------------------------------
 #  PRV PATIENT NAME         HRN      LOC  ACT PROB    NARRATIVE
   1  BJB BETAA,EMILY MAE WW129608    WW   11   799.9 DIAGNOSIS OR CONDITION DEF
   2  BJB BETAA,EMILY MAE WW129608    WW   11      80 HOUSING
   3  BJB SIGMAAA,DAVID R WW145072    WW   12      83 MEDICAL TRANSPORTATION NEE
```

```
                                        ?? for more actions
AV   Add Patient Visit    PF   Print Encounter Form SN   Sign Note
AC   Add Adm/Comm Record  ID   Intake Document      TN   Display TIU Note
EV   Edit Record          HS   Health Summary       PPL  Patient's Problem List
OI   Desg Prov/Flag       ES   SOAP/CC Edit         AP   Appointments
DR   Display Record       SD   Switch Dates         MM   Send Mail Message
DE   Delete Record        EH   Edit EHR Record      Q    Quit
```

Figure 4-32: Prompts that continue

29. At the "Select" prompt, type **DR** and the Patient Information screen in Figure 4-33 displays.

```
Patient Name:          THETA,JIMMY JOE
Chart #:               129347
Date of Birth:         NOV 01, 1986
Sex:                   M

=============== [1mBH RECORD FILE[m ===============
DATE OF SERVICE:       FEB 15, 2012@09:07
PROGRAM:               SOCIAL SERVICES
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE:  SELLS
ACTIVITY TYPE:         13
ACTIVITY TYPE NAME:    INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT
TYPE OF CONTACT:       OUTPATIENT
PATIENT:               FAUST,JIMMY JOE
PT AGE:                25
CLINIC:                MEDICAL SOCIAL SERVICES
NUMBER SERVED:         1
APPT/WALK-IN:          WALK-IN
ACTIVITY TIME:         60
AXIS V:                65
GAF SCALE TYPE:        TEST
INTERPRETER UTILIZED:  NO
VISIT:                 FEB 15, 2012@09:07
POSTING DATE:          FEB 15, 2012
WHO ENTERED RECORD:    GAMMA,RYAN
DATE LAST MODIFIED:    FEB 15, 2012
USER LAST UPDATE:      GAMMA,RYAN
DATE/TIME LAST MODIFI: FEB 15, 2012@15:06:39
EDIT HISTORY:
  Feb 15, 2012 9:09:18 am    GAMMA,RYAN
  Feb 15, 2012 1:14 pm       GAMMA,RYAN
  Feb 15, 2012 3:06 pm       GAMMA,RYAN
EXTRACT FLAG:          ADD
CREATED BY BH?:        YES
DATE/TIME NOTE SIGNED: FEB 15, 2012@09:09:21
SIGNATURE BLOCK:       Ryan GAMMA
SIGNATURE BLOCK TITLE: TEST DOC
AXIS III:
TEST
AXIS IV:
6 - ECONOMIC PROBLEMS
SUBJECTIVE/OBJECTIVE:
THIS IS A TEST OF THE PN FIELD.
COMMENT/NEXT APPOINTMENT:
NOTE FORWARDED TO:
MEDICATIONS PRESCRIBED:
```

```
=============== MHSS RECORD PROBLEMS (POVS) ===============
PROBLEM CODE:          303.02
PROBLEM CODE NARRATIV: ALCOHOL INTOXICATION, EPISODIC
PROVIDER NARRATIVE:    ALCOHOL INTOXICATION, EPISODIC

=============== MHSS RECORD PROVIDERS ===============
PROVIDER:              GARCIA,RYAN
PROVIDER DISCIPLINE:   BEHAVIORAL HEALTH AIDE/PRACT
PRIMARY/SECONDARY:     PRIMARY

=============== MHSS RECORD UPDATED/REVIEWED ===============
CLINICAL ACTION:       PROBLEM LIST UPDATED
DATE/TIME ENTERED:     FEB 15, 2012@09:09:38
ENTERED BY:            GARCIA,RYAN
EVENT DATE AND TIME:   FEB 15, 2012
ENCOUNTER PROVIDER:    GARCIA,RYAN

Note already signed, no E Sig necessary.

Press enter to continue....:
```

Figure 4-33: Display Record information

30. At the “Press enter to continue” prompt, press Enter. Messages may display indicating that the record is or is not signed. The Other Information screen displays as shown in Figure 4-34:

```
*******  OTHER INFORMATION  *******

Update, add or append any of the following data

     1). Update any of the following information:
          Designated Providers, Patient Flag
     2). Patient Case Open/Admit/Closed Data
     3). Personal History Information
     4). Appointments (Scheduling System)
     5). Treatment Plan Update
     6). Print an Encounter Form
     7). Add/Update/Print Intake Document
     8). Add/Update Suicide Forms
     9). Problem List Update
     10). None of the Above (Quit)
Choose one of the above:  (1-10): 10
```

Figure 4-34: Other Information screen

31. At the “Choose one of the above” prompt, type **10** to exit. The Patient Visit screen displays as shown in Figure 4-35. This screen is view only.

```
-----------------------------------------------------------------------------
Date of Encounter:  Wednesday  FEB 15, 2012      * unsigned note
-----------------------------------------------------------------------------
#  PRV PATIENT NAME         HRN      LOC  ACT PROB    NARRATIVE
*  1  RJG BUBB,ROBERT JAC WW207365    WW   91  293.81 PSYCHOTIC DISORDER
DUE TO.
   2  RJG FAUST,JIMMY JOE WW129347    WW   13  303.02 ALCOHOL INTOXICATION,
EPIS
```

```
*  3  RJG WATTS,CHARLES   WW109767    WW   91  293.81 PSYCHOTIC DISORDER
DUE TO.
*  4  RJG WOODBE,ROLAND   WW258852    WW   91  293.81 PSYCHOTIC DISORDER
DUE TO.

AV   Add Patient Visit    PF   Print Encounter Form SN   Sign Note
AC   Add Adm/Comm Record  ID   Intake Document      TN   Display TIU Note
EV   Edit Record          HS   Health Summary       PPL  Patient's Problem
List
OI   Desg Prov/Flag       ES   SOAP/CC Edit         AP   Appointments
DR   Display Record       SD   Switch Dates         MM   Send Mail Message
DE   Delete Record        EH   Edit EHR Record      Q    Quit

Select Action: AV// q   Quit
```

Figure 4-35: Patient Visit View screen

32. At the “Select Action” prompt, type **Q** and press Enter to exit. The Data Entry Menu displays as shown in Figure 4-36:

```
***********************************************
                 **       IHS Behavioral Health System       **
                 **             Data Entry Menu              **
                 *********************************************
                            Version 4.0 (patch 2)

                             DEMO INDIAN HOSPITAL

   PDE    Enter/Edit Patient/Visit Data - Patient Centered
   SDE    Enter/Edit Visit Data - Full Screen Mode
   GP     Group Form Data Entry Using Group Definition
   DSP    Display Record Options ...
   TPU    Update BH Patient Treatment Plans ...
   DPL    View/Update Designated Provider List
   EHRE   Edit BH Data Elements of EHR created Visit
   EBAT   Listing of EHR Visits with No Activity Time
   SF     Suicide Reporting Forms - Update/Print ...
   CR     Coding Review

Select Behavioral Health Data Entry Menu Option: dsp Display Record Options
```

Figure 4-36: Data Entry Menu

33. At the “Select Behavioral Health Data Entry Menu Option” prompt, type **DSP**. The Data Entry Menu Display Options screen displays as shown in Figure 4-37:

```
***********************************************
                 **       IHS Behavioral Health System       **
                 **     Data Entry Menu Display Options      **
                 *********************************************
                            Version 4.0 (patch 2)
At this screen, select PCCV  prompt for patient name enter and then asks to
select patient date
                             DEMO INDIAN HOSPITAL


   RD     Display Behavioral Health Visit Record
   PCCV   Display a PCC Visit
```

```
   LV     Display Patient's Last Behavioral Health Visit
   LI     List Visit Records, STANDARD Output
   PR     Print Encounter Form for a Visit
   FC     Count Forms Processed By Data Entry
   BV     Browse a Patient's Visits
   GAF    GAF Scores for One Patient
   GAFS   GAF Scores for Multiple Patients
   PHQ    PHQ-2 and PHQ-9 Scores for One Patient
   PHQS   PHQ-2 and PHQ-9 Scores for Multiple Patients
   LD     List all Visit Dates for One Patient
   NS     List NO SHOW Visits for One Patient
   NSDR   Listing of No-Show Visits in a Date Range
   ES     Listing of Visits with Unsigned Notes

Select Display Record Options Option: pccv  Display a PCC Visit

Select PATIENT NAME: THETA,JIMMY JOE
        M 11-01-1986 XXX-XX-3033    WW 129347

Enter VISIT date: t-1  (FEB 15, 2012)
```

Figure 4-37: Data Entry Menu Display Options

34. At the Enter VISIT date: prompt, type **PCCV** Figure 4-38 shows the PCC Visit screen.

```
PCC VISIT DISPLAY                           Page:    1 of    3

Patient Name:          THETA,JIMMY JOE[m
Chart #:               129347
Date of Birth:         NOV 01, 1986
Sex:                   M
Visit IEN:             2570481
=============== VISIT FILE ===============
VISIT/ADMIT DATE&TIME: FEB 15, 2012@09:07
DATE VISIT CREATED:    FEB 15, 2012
TYPE:                  IHS
PATIENT NAME:          THETA,JIMMY JOE
LOC. OF ENCOUNTER:     DEMO INDIAN HOSPITAL
SERVICE CATEGORY:      AMBULATORY
CLINIC:                MEDICAL SOCIAL SERVICES
DEPENDENT ENTRY COUNT: 3
DATE LAST MODIFIED:    FEB 15, 2012
WALK IN/APPT:          WALK IN
CREATED BY USER:       GAMMAA,RYAN
OPTION USED TO CREATE: AMHGRPC
USER LAST UPDATE:      GAMMAA,RYAN
OLD/UNUSED UNIQUE VIS: 5059010002570481
DATE/TIME LAST MODIFI: FEB 15, 2012@14:59:58
CHART AUDIT STATUS:    INCOMPLETE
NDW UNIQUE VISIT ID (: 102320002570481
VISIT ID:              3M6T-WWX
=============== PROVIDERs ===============
PROVIDER:              GAMMAA,RYAN
AFF.DISC.CODE:         1C9AAA
PRIMARY/SECONDARY:     PRIMARY
=============== POVs ===============
POV:                   303.02
ICD NARRATIVE:         AC ALCOH DEP INTOX-EPISOD
PROVIDER NARRATIVE:    ALCOHOL INTOXICATION, EPISODIC
```

```
=============== ACTIVITY TIMEs ===============
ACTIVITY TIME:         60
TOTAL TIME:            60
+    Next Screen          -    Previous Screen      Q    Quit
Select Action: +// q   Quit
```

Figure 4-38:PCC Visit screen

35. At the “Select Action” prompt, type **Q** and press Enter to exit.

4.1.5 Edit EHR Visit (EH)

1. Type **EH** to edit a BH visit that was entered in the EHR application. (The same prompts display if you use the EHRE (Edit BH Data Elements of EHR created Visit) option on the IHS Behavioral Health System Data Entry Menu.

2. Set the date at the “Enter ENCOUNTER DATE” prompt. The application displays the Edit Behavioral Health Specific Fields for an EHR **Visit** window shown in Figure 4-39:

```
        Edit Behavioral Health Specific Fields for an EHR Visit
Patient: DELTA,EDWIN RAY   HRN: 105321
Visit Date: FEB 27, 2009@13:47    Provider: GAMMAA,RYAN
     ---------------------------------------------------------------------
          Community of Service: ALBUQUERQUE
          Activity Type: 99 INDIVIDUAL BH EHR VI
           Appt/Walk In: UNSPECIFIED
         Placement Disposition:
          Interpreter Utilized:       Comment/Next Appt (press enter)
            Local Service Site:
              Flag (Local Use):
              AXIS III (press enter to update or TAB to bypass):
                       AXIS IV:
                       AXIS IV:
                       AXIS IV:
                        AXIS V:     GAF Scale Type:
_____________________________________________________________________________

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

Figure 4-39: Sample information about editing a BH visit entered through the EHR.

3. At the “Community of Service” prompt, type the location where the encounter took place.

4. At the “Activity Type” prompt, type the activity for the visit.

5. At the “Appt/Walk In” prompt, type the visit option: appointment, walk-in, or unspecified.

6. At the “Placement Disposition” prompt, type any active disposition (such as Alcohol/Drug Rehab) and the pop-up in Figure 4-40 displays:

```
Enter the Facility to which the patient was referred   |
FACILITY REFERRED TO:
```

Figure 4-40: Pop-up window asking for facility referred to

7. At the “Facility Referred to” prompt, type the facility to which the patient was referred.
8. At the “Interpreter Utilized” prompt, indicate if an interpreter was used in the visit.
9. At the “Comment/Next Appt” prompt, press Enter to display another window and type text about the next appointment.
10. At the “Local Service Site” prompt, type the site for the visit.
11. At the “Flag (Local Use)” prompt, type a local flag for the types of visits.
    - The site will define a numeric value to indicate the definition of the flag. For example, a **1** might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of **1** which will list all visits on which narcotics were prescribed.
12. At the “AXIS III” prompt:
    a. Press Enter and another window will display, type the text for the medical condition (press Enter to update or Tab to bypass)
    b. Press Tab to bypass the field..
13. At the “AXIS IV” prompt, type one or more of the nine major psychosocial or environmental problem codes.
    - This code must be from the list of codes approved by the American Psychiatric Association and included in DMS-IV-TR.
14. At the “AXIS V” prompt, type the patient’s functional level, using the Global Assessment of Functioning (GAF) scale.
15. At the “Scale Type” prompt, type the acronym for the GAF Scale Type.

4.1.6 Edit SOAP (ES)

1. Type **ES** (Figure 4-3) at the “Select Action” prompt to edit the SOAP note for a specified patient visit as well as the text for Chief Complaint, Comment/Next Appointment, and Medications Prescribed.

Note: This applies only to records with unsigned notes.

2. At the “Edit which Record: (1-*x*)” prompt, where *x* is the number of the last record, select the record to edit and the screen refreshes.

3. At the “CHIEF COMPLAINT” prompt, type the chief complaint
4. At the “SOAP/PROGRESS NOTE” prompt, type new text if necessary. Existing text displays below the prompt and can be edited.
5. At the “Edit? NO//” prompt:
   - Type **Y** to display another window and edit the “SOAP/PROGRESS NOTE”.
   - Type **N** to continue
6. At the “COMMENT/NEXT APPOINTMENT” prompt, type new text if necessary. Existing text displays below the prompt and can be edited.
7. At the “Edit? NO//” prompt:
   - Type **Y** to edit the “COMMENT/NEXT APPOINTMENT” note.
   - Press **N** to continue
8. At the “MEDICATIONS PRESCRIBED” prompt, type new text if necessary. Existing text displays below the prompt and can be edited.
9. At the “Edit? NO//” prompt:
   - Type **Y** to edit the “MEDICATIONS PRESCRIBED” note.

   The electronic signature may be needed after you exit. Refer to Section 2.14 for more information.

   - Type **N** and the **Other Information** screen displays.

4.1.7 Delete Visit (DE)

1. Type **DE** to remove a visit for the current patient that was entered in error.

   Visit records with a signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.

   Encounter records containing unsigned, or a blank SOAP/Progress Note can be edited or deleted.

2. At the “Enter Encounter Date” prompt, set the date of the encounter to be removed.
3. At the “Are you sure you want to DELETE this record?” prompt:
   - Type **Y**: the message “Record Deleted” displays. Press Enter to continue.
   - Press **N** to end the process

4.1.8 Sign Note (SN)

Type **SN** to sign a note in a visit record (Figure 4-41). You can only sign notes where you are the primary provider.

After using SN, one or two actions happen:

- (1) if there are no notes to sign, the application displays the message: There are no records with unsigned notes that need to be signed; or
- (2) if there are notes to be signed, the application displays the Behavioral Health visits for the current patient where you are the primary provider.

> **Note**: Visits with a blank SOAP/Progress Note will not appear on the list.

```
-----------------------------------------------------------------------
             Behavioral Health visits for ALPHA,CHELSEA MARIE
-----------------------------------------------------------------------
 #     PROVIDER   LOC  DATE      ACT CONT PATIENT      PROB    NARRATIVE
-----------------------------------------------------------------------
1    THETA,SHIRLE WW   05/12/2009    OUTP WW 116431    56   MARITAL PROBLEM
```

Figure 4-41: List of records that you can change

4. At the “Which record do you want to display (1-*x*)” prompt, where *x* is the number of the last record, type the record number.
   - The application displays the BH Visit Record Display screen.
5. At the “Select Action” prompt, type Q and Enter to exit the BH Visit Record
   - Type **N** to end the sign note process.
   - Type **Y**: the **Edit SOAP** screen displays. Save the record and the signature code prompt displays.
6. At the “Enter your Current Signature Code” prompt, type your signature code.
   - This signature applies to the SOAP/Progress Note associated with the current visit. Refer to Section 2.14.6 for more information. After entering your signature code, the OTHER INFORMATION screen displays.
   - If the electronic signature is not entered or an invalid signature is entered three times, the window closes. After the screen closes, the following message displays: “There is no electronic signature, this visit will not be passed to PCC”.

4.1.9 Print Encounter Form (PF)

1. Type **PF** to print or browse the encounter form for a specified date.
2. Set the date at the “Enter ENCOUNTER DATE” prompt.

3. At the “What type of form do you want to print” prompt, type one of the following:

   - F Full Encounter Form
   - S Suppressed Encounter Form
   - B Both a Suppressed & Full
   - T 2 copies of the Suppressed
   - E 2 copies of the Full

   A full encounter form prints all data for a patient encounter including the SOAP note. The suppressed version of the encounter form will not display the following: (1) the Chief Complaint/Presenting Problem, (2) the SOAP note for confidentiality reasons, (3) the measurement data, and (4) screenings. It is important to note that the SOAP note, chief complaint/presenting problem, and measurements will be suppressed, but the comment/next appt, activity code, and POV will still appear on the printed encounter.

4. At the “Device” prompt, type the device to print or browse. Figure 4-42 shows the data for a suppressed encounter form.

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
  PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Mar 27, 2009@12:44:08
                 ***  Computer Generated Encounter Record  ***
*******************************************************************************
  Date:  Feb 23, 2009         Primary Provider: GAMMAAA,DENISE
  Arrival Time: 12:00
  Program:  MENTAL HEALTH
  Clinic:  MENTAL HEALTH                Appointment Type:  APPOINTMENT
_______________________________________________________________________________
                                                Number        Activity/Service
  Community: TUCSON                             Served:       Time:  minutes
  Activity: 13-INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT
  Type of Contact: OUTPATIENT
_______________________________________________________________________________
  Chief Complaint/Presenting Problem Suppressed for Confidentiality

  S/O/A/P:
  Behavioral Health Visit

                                                Feb 23, 2009@12:00      Page 2

  See GAMMAAA,DENISE for details.
_______________________________________________________________________________

  COMMENT/NEXT APPOINTMENT:
  Behavioral Health Visit - COMMENT Suppressed
  See GAMMAAA,DENISE for details.
_______________________________________________________________________________
  BH POV CODE      PURPOSE OF VISIT (POV)
  OR DSM DIAGNOSIS    [PRIMARY ON FIRST LINE]
_______________________________________________________________________________
       311.           DEPRESSIVE DISORDER NOS
```

```
_____________________________________________________________________________
  AXIS IV:   6 - ECONOMIC PROBLEMS
             8 - LEGAL INTERACTION PROBLEMS
  AXIS V:

Enter RETURN to continue or '^' to exit:
```

Figure 4-42: Sample Suppressed Encounter Form

4.1.10 Last BH Visit (LV)

1. Type **LV** to display the last BH Visit Record (Figure 4-43) for the current patient.
2. At the "Do you want a particular provider's last visit" prompt:
   - Type **Y** to continue

```
BH VISIT RECORD DISPLAY       Jan 18, 2012 13:26:50          Page:    1 of    3

Patient Name:          TEST,PAUL ALBERT
Chart #:               654321
Date of Birth:         NOV 08, 1934
Sex:                   M

=============== BH RECORD FILE ===============
DATE OF SERVICE:       APR 14, 2011@08:16
PROGRAM:               CHEMICAL DEPENDENCY
LOCATION OF ENCOUNTER: WHITE EARTH TRIBAL BEHAV HLTH
COMMUNITY OF SERVICE:  WHITE EARTH
ACTIVITY TYPE:         85
ACTIVITY TYPE NAME:    ART THERAPY
TYPE OF CONTACT:       OUTPATIENT
PATIENT:               TEST,PAUL ALBERT
PT AGE:                76
CLINIC:                ALCOHOL AND SUBSTANCE
NUMBER SERVED:         1
ACTIVITY TIME:         22
POSTING DATE:          APR 14, 2011
+         Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action: +//
```

Figure 4-43: Sample BH Visit Record Display screen

4.1.11 Browse Visit (BV)

1. Type **BV** to browse behavioral health visits.
2. Browse which subset of visits for [current patient name] and type one of the following:
   - **L** Patient's Last Visit
   - **N** Patient's Last N Visits

- **D** Visits in Date Range
- **A** All of this Patient's Visits
- **P** Visits to one Program
  - Type **N**, **D**, or **P** to continue

Type **A** on the Browse Patient's Visits window and the screen displays as shown in Figure 4-44:

```
BROWSE PATIENT'S VISITS      Mar 27, 2009 15:18:19       Page:   1 of   43

Patient Name: ALPHA,GLEN DALE              DOB: Nov 10, 1981
HRN: 108704


****** Suicide Forms on File ******
Date of Act: MAR 26, 2009              Suicidal Behavior: 1
Previous Attempts: 0                   Method: GUNSHOT
*****************************************************************************

Visit Date: Mar 26, 2009@09:00              Provider: GAMMAAA,DENISE
Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
Location of Encounter: SELLS HOSP
Chief Complaint/Presenting Problem: Testing AMH v4.0
POV's:
  311.   testing v4.0 provider narrative

  SUBJECTIVE/OBJECTIVE:
  Pt is making progress on his problems, real or imaged
+         Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 4-44: Sample Report screen

4.1.12 List Visit Dates (LD)

1. Type **LD** to list the current patient's visit dates.
2. Browse which subset of visits for [current patient name] and type one of the following:
   - **L** Patient's Last Visit
   - **N** Patient's Last N Visits
   - **D** Visits in Date Range
   - **A** All of this Patient's Visits
   - **P** Visits to one Program
     - Type **N**, **D**, or **P** to continue

Figure 4-45 shows the Browse Patient's Visit screen.

```
BROWSE PATIENT'S VISITS       Mar 27, 2009 15:25:54          Page:    1 of    1

Patient Name: ALPHA,GLEN DALE              DOB: Nov 10, 1981
HRN: 108704
*******************************************************************************
Date                     Provider                   DX      NARRATIVE
Mar 26, 2009@09:00       GAMMAAA,DENISE             311.    testing v4.0 provide
Mar 23, 2009@11:41       GAMMAAA,DENISE             311.    Depressive Disorder,
Jan 22, 2009@15:03       GAMMAAA,DENISE             311.    Depressive Disorder,
May 06, 2008@14:23       GAMMAAA,DENISE             311.    Depressive Disorder,
Apr 18, 2008             BETAAAA,BJ                 295.33  Paranoid Type Schizo
Apr 07, 2008@14:07       GAMMAAA,DENISE             311.    Depressive Disorder,
Apr 04, 2008@14:13       GAMMAAA,DENISE             311.    Depressive Disorder,
Feb 18, 2008@17:03       GAMMAAA,DENISE             311.    Depressive Disorder,
Feb 12, 2008@16:24       GAMMAAA,DENISE             311.    Depressive Disorder,
Jan 22, 2008@12:06       BETAAAA,BJ                 295.33  Paranoid Type Schizo
Jan 11, 2008@12:00       GAMMAAA,DENISE             296.31  MAJOR DEPRESSIVE DIS
Aug 29, 2007@08:53       BETAAAA,BJ                 295.33  Paranoid Type Schizo
Feb 02, 2006@12:00       BETAAAA,BJ                 13      SCHIZOPHRENIC DISORD

          Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 4-45: Sample list of visit dates screen

4.1.13 Display Record (DR)

1. Type **DR** to display the data about a specified visit.
2. At the Enter ENCOUNTER DATE" prompt, set the date of the visit. The BH Visit Record Display screen displays as shown in Figure 4-46:

```
BH VISIT RECORD DISPLAY       Jan 18, 2012 13:38:10          Page:    1 of    4

Patient Name:          TEST,PAUL ALBERT
Chart #:               654321
Date of Birth:         NOV 08, 1934
Sex:                   M

=============== BH RECORD FILE ===============
DATE OF SERVICE:       JAN 01, 2009@12:00
PROGRAM:               MENTAL HEALTH
LOCATION OF ENCOUNTER: SELLS HOSP
COMMUNITY OF SERVICE:  TUCSON
ACTIVITY TYPE:         11
ACTIVITY TYPE NAME:    SCREENING-PATIENT PRESENT
TYPE OF CONTACT:       INPATIENT
PATIENT:               TEST,PAUL ALBERT
PT AGE:                74
CLINIC:                MENTAL HEALTH
NUMBER SERVED:         1
APPT/WALK-IN:          UNSPECIFIED
ACTIVITY TIME:         10
+         Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
```

```
Select Action: +//
```

Figure 4-46: Sample BH Visit Record Display window for a specified visit

3. At the "Select Action" prompt, type Q and press Enter. The OTHER INFORMATION screen displays as shown in Figure 4-47:

```
                    *******  OTHER INFORMATION  *******

Update, add or append any of the following data

     1). Update any of the following information:
          Designated Providers, Patient Flag
     2). Patient Case Open/Admit/Closed Data
     3). Personal History Information
     4). Appointments (Scheduling System)
     5). Treatment Plan Update
     6). Print an Encounter Form
     7). Add/Update/Print Intake Document
     8)  Add/Update Suicide Forms
     9). Problem List Update
    10). None of the Above (Quit)
Choose one of the above:  (1-9): 9//
```

Figure 4-47: Options on the Other Information menu

4. Type **9** to display the BH Problem List Update screen. See Section 9.1 for more information.

5. Use the options to update visit information about the patient, if needed.

6. Type **10** to exit.

4.2 Visit Window (GUI)

One way to access the **Visit** window is to use the One Patient option on the **RPMS Behavioral Health System** GUI tree structure. Figure 4-48 shows the Visit window for one patient:

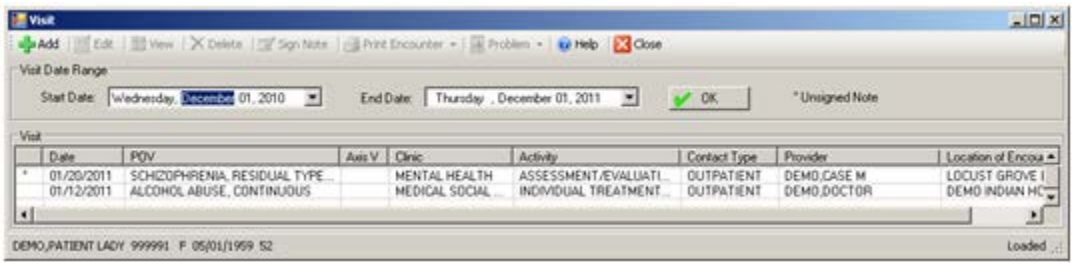


Figure 4-48: **Visit** window for one patient

Use the **Visit** for one patient window to manage the visits within a date range for the current patient (the name displays in the lower, left corner of the window). If there is no current patient, you will be asked to select one. Default range is one year.

Another way to access the **Visit** window for the patient is to use the All Patients option on the **RPMS Behavioral Health System** GUI tree structure. Figure 4-50 shows the **Visit** window for all patients:

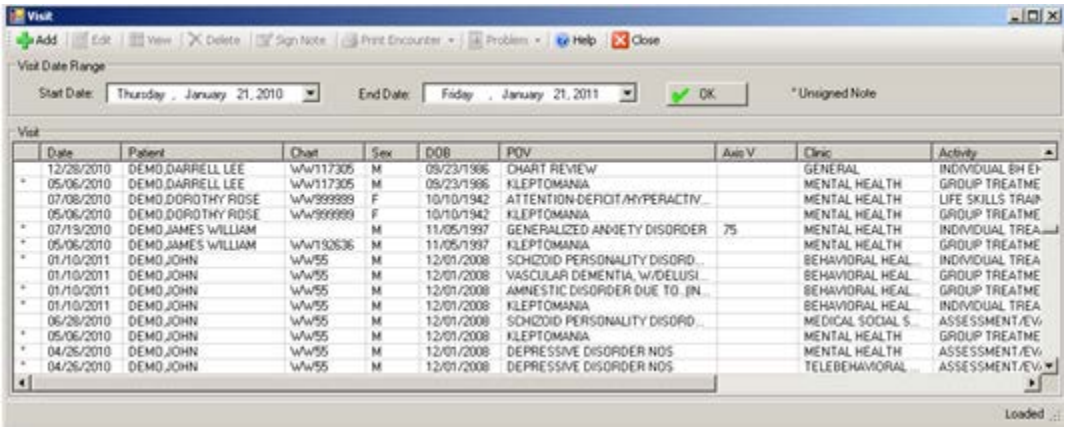


Figure 4-49: Sample **Visit** window for all patients

Use the **Visit** window for all patients to manage the visits for a selected patient. These visits are in the date range displayed in the **Visit Date Range** pane. The default is one day.

4.2.1 Visit Date Range Pane

The **Visit Date Range** pane shows the range of visits shown in Figure 4-49.

4.2.1.1 Visit Window for One Patient

The following applies to the **Visit** window for one patient:

The default start date is one year previous.

You can change the date range by clicking the drop-down list to access a calendar. After the date range is changed, click **OK** to redisplay the records in the **Visit** pane.

> **Note**: If you change the start date for the **Visit** window for one patient, this change stays in effect in future sessions of the GUI application for the **Visit** window for one patient (until you change it again).

4.2.1.2 Visit Window for All Patients

The following applies to the **Visit** window for all patients:

Default start date is today.

You can change the default start date and the application maintains that start date until you exit the application. Then, when you log in again, the start date reverts to today's date.

4.2.2 Visit Pane

The **Visit** pane shows the visit records in the visit date range.

The asterisk (*) in the first column indicates that the record contains an unsigned note. Refer to Section 2.14.5 for more information.

4.2.3 Add Button

Select the patient to use in the add process. Click **Add** to add a new visit record. You will access the **Visit Data Entry–Add Visit** dialog. Refer to Section 4.3 for more information.

4.2.4 Edit Button

Click **Edit** to edit a visit record. You will access the **Visit Data Entry–Edit Visit** dialog.

4.2.5 View Button

Click **View** (or double-click on a record) to browse a visit record. This window has the same fields as the add/edit visit dialog, except for the Intake and Suicide Form tabs.

4.2.6 Delete Button

Note:	Visit records with a signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.

- Click **Delete** to delete a visit record. The application confirms the deletion.

4.2.7 Sign Note Button

Click **Sign Note** to sign the note of an "unsigned" record (asterisk [*] in the first column). Refer to Section 2.14.5 for more information.

4.2.8 Problem Button

Select a record and click the **Problem** button to access either a BH Problem List or the PCC Problem list. Refer to Section Figure 9-2 for more information.

4.2.9 Print Encounter Button

Click **Print Encounter** to print the encounter data about a visit record. The Print Encounter button has these options: Full, Suppressed, Both Full and Suppressed.

> **Note**: The Intake document and Suicide Reporting Form must be printed elsewhere and will not appear on a printed encounter form.

The suppressed report does *not* display the following information: Chief Complaint, SOAP note, measurement data, patient education data, screenings.

After selecting one of the options, thethe first page of the **Print Encounter** windows displays as shown in Figure 4-50:

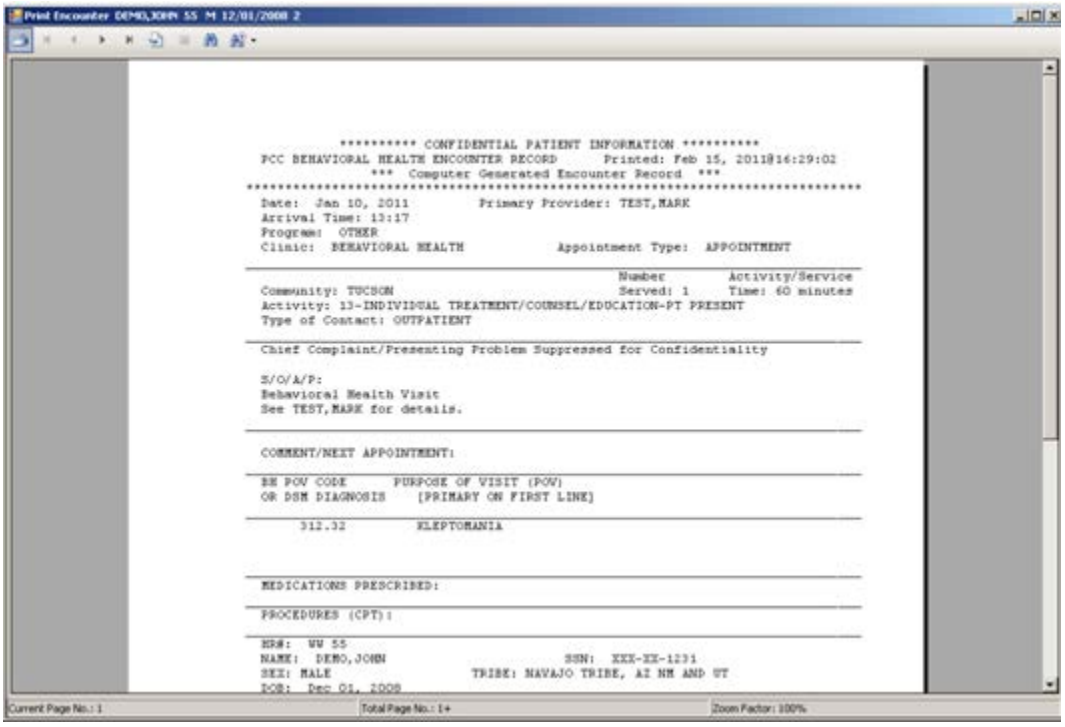


Figure 4-50: Sample **Print Encounter** window

Refer to Section 2.6 to review the features of this type of window.

4.2.10 Problem Button

Select a visit and then click the **Problem** button to manage the patient's Behavioral Health and PCC problems. See Section 9.2 for more information.

4.2.11 Help Button

Click **Help** on the **Visit** window to access the online help.

4.2.12 Close Button

Click **Close** on the **Visit** window to exit the window.

4.3 Add or Edit Visit Data Entry

1. Click **Add** on the **Visit** window to add a new record. Figure 4-51 shows the **Visit Data Entry–Add Visit** dialog.

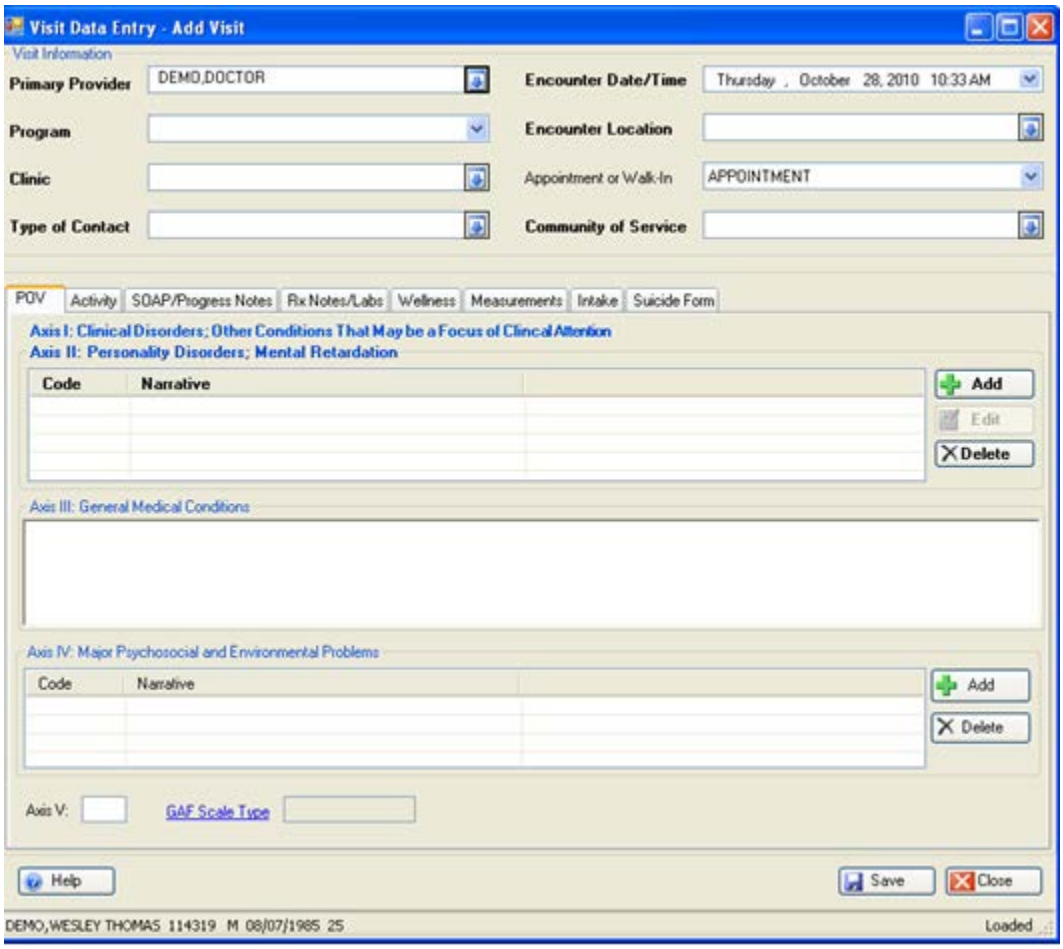


Figure 4-51: Sample **Visits Data Entry–Add Visit** window

2. Click **Edit** to edit the selected visit for the current patient. The same fields appear on the **Visit Data Entry–Edit Visit** as on the Add Visit dialog

   - The Edit button will be inactive if the patient does not have any previous visits)

3. Click **Help** to access online help about this window.

4. Click **Save**. The changes are saved and the Add or Edit window closes.

   - If a SOAP/Progress note was added, the user will be asked if they wish to sign the note. Refer to Section 2.14.5 for more information.
     - If the patient was not checked in for an appointment, the **Visit** window displays.
     - If the patient was checking in for an appointment using the scheduling package and it is set to create a visit at check-in, the **Select PCC Visit** window displays. Refer to Section 4.3.10 for more information.

Note:	If the facility is not using the scheduling package and doesn't have the Interactive PCC Link in the site parameters turned on, you will never be presented with the ability to link it to a PCC visit. If there is no visit in PCC (patient never checked in, no appointment or walk in was ever created in the scheduling package and no other clinics saw the patient that day), then the option to link is never presented and the BH visit continues to create a new visit in PCC.

The Close process displays the **Continue?** dialog: "Unsaved Data Will Be Lost, Continue?"

- Click **Yes** to close without saving; the data entry window closes.
- Click **No** to remain on the data entry window and continue to work.

4.3.1 Visit Information Pane

1. Type data in the **Visit Information** pane shown in Figure 4-52:

Figure 4-52: Sample Visit Information pane

2. Select a provider from the Primary Provider field. The default is the current provider.
3. At the “Encounter Date/Time” field, set the date from the calendar.
4. At the “Program” field, type one of the following to associate the visit:
   - Mental health
   - Social services
   - Other
   - Chemical Dependency
5. Select the encounter from the Encounter Location list.
6. Select the **Clinic** field to display the **Clinic** search window
7. At the **Appointment or Walk-In list** field, type one of the following:
   - Appointment
   - Walk In
   - Unspecified (for non-patient contact)
8. Select the activity setting from the **Type of Contact** list.
9. Select the **Community of Service** field to display the **Community** Search window.

4.3.2 POV Tab

Select the **POV** tab (Figure 4-53) to add, edit, or delete the Axis I, Axis II, and Axis IV codes, to enter the general medical conditions for Axis III, and to enter the GAF score and scale type.

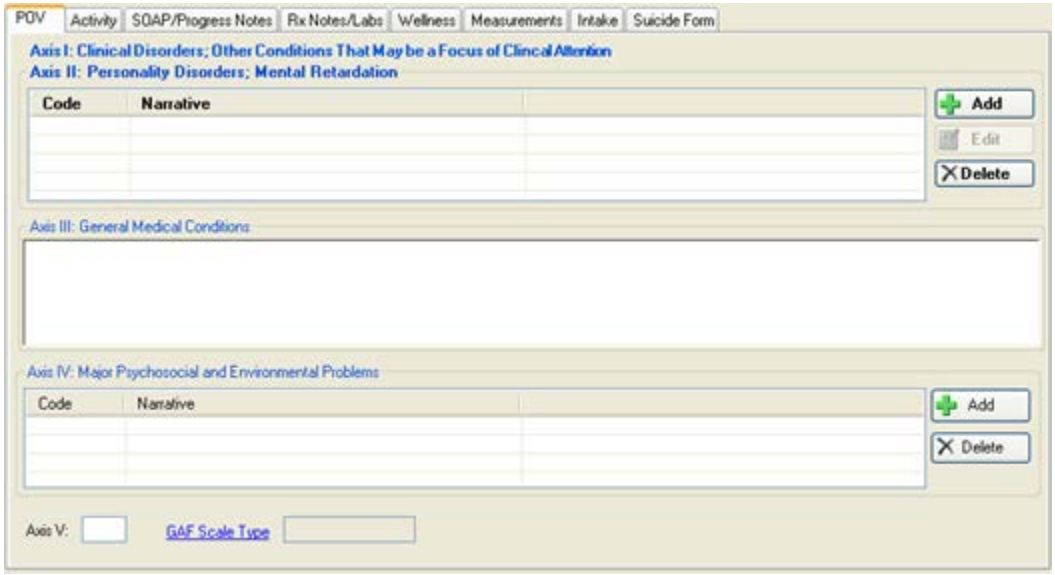


Figure 4-53: Sample **POV** Tab on **Visit Data Entry** window

4.3.2.1 Axis I/Axis II Pane

Select the **Axis I/Axis II** pane (Figure 4-54) to manage the POV codes for Axis I or Axis II issues.

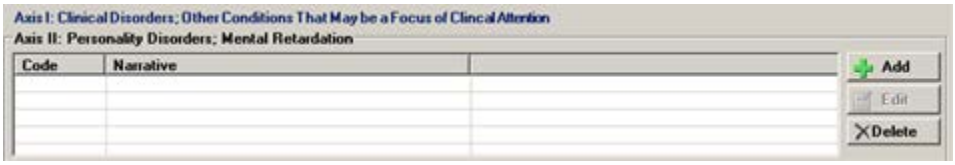


Figure 4-54: Sample **Axis I/Axis II** pane

1. Click **Delete** to remove a selected code from the pane. The **Are You Sure** confirmation displays
   - Click **Yes** to remove the selected code from the pane
   - Click **No** to cancel the request.
2. Click **Add** to access the POV (Axis I/II) search window.
   - You can add one or more POV codes associated with the visit.
   - You can search by code number or POV narrative.
3. Click **Edit** to edit the POV narrative of a selected record on the **Edit POV** dialog shown in Figure 4-55:

Figure 4-55: **Edit POV** dialog

- Click **OK** to accept the entry and the narrative is changed to the selected code.
- Click **Close** to cancel the edit.

4.3.2.2 Axis III Pane

Type the client's general medical conditions in the free text field on the **Axis III** pane. This field should only be used if the medical condition was treated during the visit.

4.3.2.3 Axis IV Pane

Figure 4-56 shows the **Axis IV: Major Physosocial and Environmental Problems** window that identify the major category of the problem in the Code field.

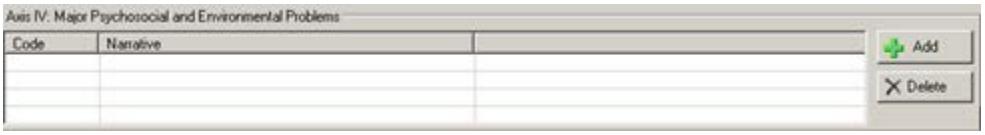


Figure 4-56: Sample Axis IV pane

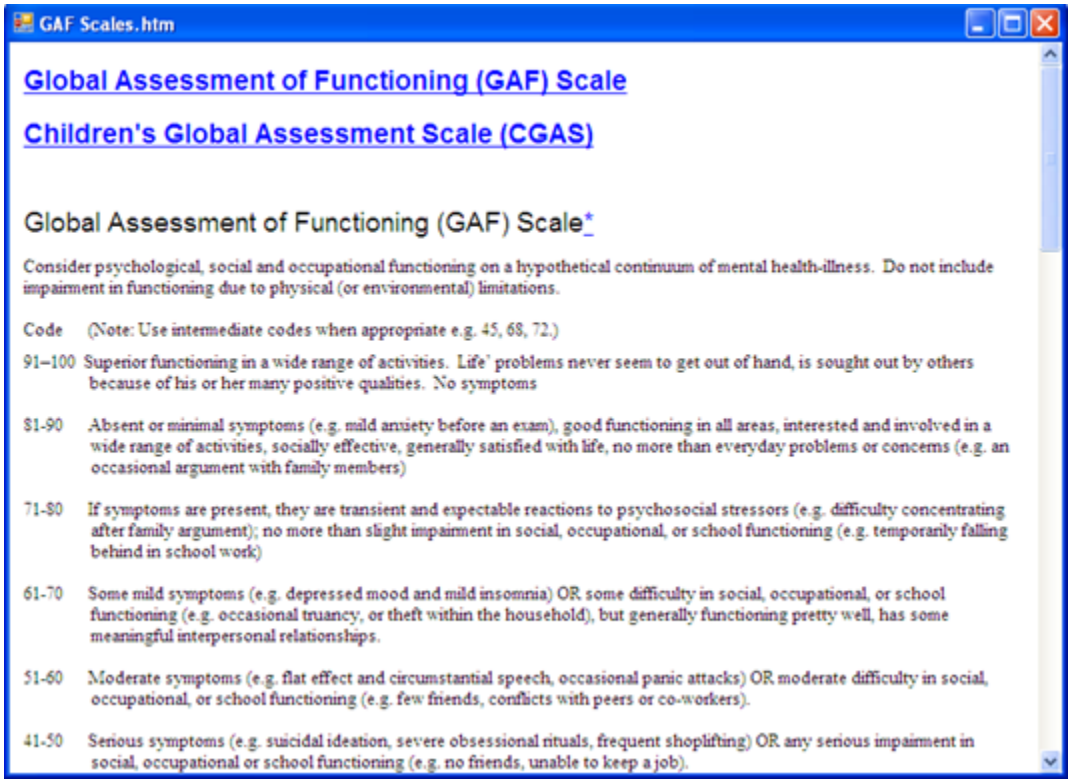
1. Click **Add** to add the codes on the **Axis IV** multiple select dialog.
2. Click **Delete** to remove a selected code. The confirmation dialog: **Are You Sure?** displays:
   - Click **Yes** to remove the selected code from the pane
   - Click **No** to cancel the deletion.

4.3.2.4 Axis V

Type the GAF scale value in the **Axis V** field shown in Figure 4-57. The field is limited to three numerical characters.

Figure 4-57: Sample Axis V area

- When the Axis V field is populated, the GAF Scale Type field becomes active. You can enter the GAF scale type - enter the acronym for the GAF Scale Type.
- If you click the link on the GAF Scale Type label, The Global Assessment of Functioning pop-up in Figure 4-58 displays. This provides information about the Global Assessment Scale of Functioning (GAF) Scale and the Children's Global Assessment Scale (CGAS).


GAF Scales.htm

Global Assessment of Functioning (GAF) Scale

Children's Global Assessment Scale (CGAS)

Global Assessment of Functioning (GAF) Scale*

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate e.g. 45, 68, 72.)

91–100 Superior functioning in a wide range of activities. Life' problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms

81-90 Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members)

71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work)

61-70 Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60 Moderate symptoms (e.g. flat effect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers).

41-50 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).

Figure 4-58: Global Assessment of Functioning (GAF) scale

4.3.3 Activity Tab

Select the **Activity** tab shown in Figure 4-59 to manage activity data about the visit for the current patient.

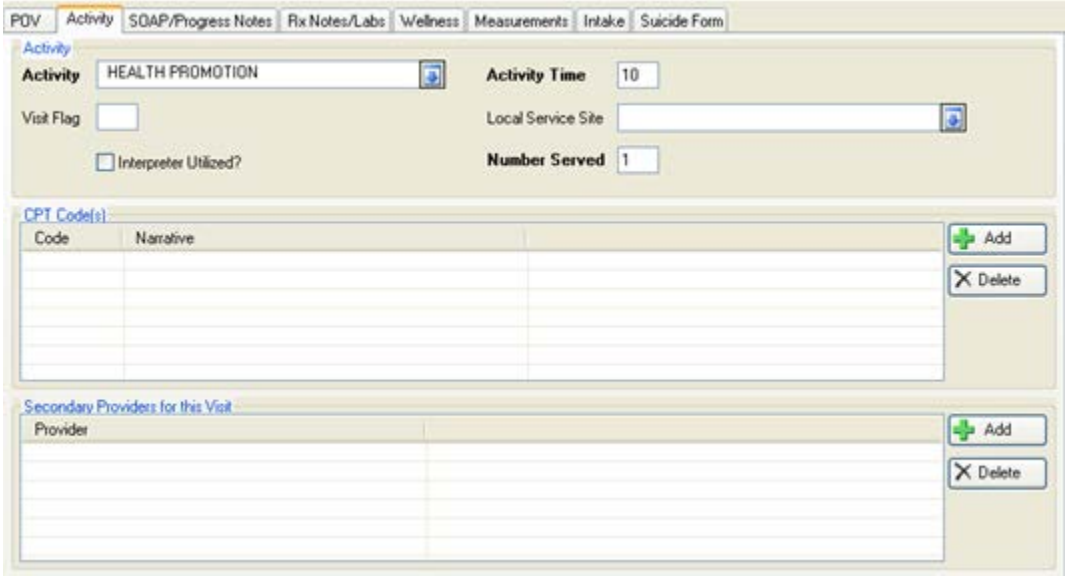


Figure 4-59: Sample **Activity** Tab on the **Visit Data Entry** window

4.3.3.1 Activity Pane

Figure 4-60 shows the **Activity** pane.

Figure 4-60: Sample **Activity** pane

The following fields in bold text are required.

1. Click the **Activity** field to select the code that documents the type of service or activity performed by the Behavioral Health provider.

   These activities might be patient-related or administrative in nature only. Use only one activity code for each record regardless of how much time is expended or how diverse the services offered. Certain Activity codes are passed to PCC, and this will affect the billing process. Click the arrow on the field to display the Activity search window. Here you search for the activity name. Refer to Appendix A: Activity Codes and Definitions for more information.

2. Type the time at the **Activity Time** field. This required field determines how much provider time was involved in providing and documenting the service or performing the activity.

3. Type the flag at the **Visit Flag** prompt. This field is for local use in flagging various types of visits.
   - The site will define a numeric value to indicate the definition of the flag. For example, a **1** might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of 1 which will list all visits on which narcotics were prescribed.
4. Click the “Local Service Site” field to select the local service site, if necessary.
5. Click the “Interpreter Utilized?” box, if an interpreter is required to communicate with the patient.
6. At the Number Served” prompt, type the number served.
   - The default is **1**. This required field refers to the number of people directly served during a given activity and always is used for direct patient care as well as for administrative activities. Group activities or family counseling are examples where other numbers might be listed.

4.3.3.2 CPT Codes Pane

Select the **CPT Code(s)** pane to manage the codes shown in Figure 4-61:

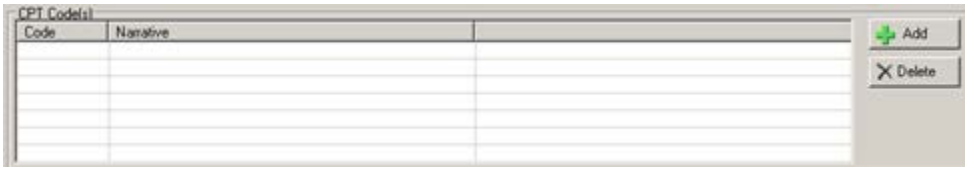


Figure 4-61: Sample CPT Codes pane

1. Click **Add** to display the CPT Code search/select window. The Narrative field is automatically populated.
2. Click **Delete** to remove a selected record. The confirmation **Are You Sure** displays: “Are you are sure you want to delete”.
   - Click **Yes**: to remove the selected code.
   - Click **No**: the code is not removed.

4.3.3.3 Secondary Providers for this Visit Pane

From the **Secondary Providers For the Visit** pane (Figure 4-62) select the providers used during the encounter.

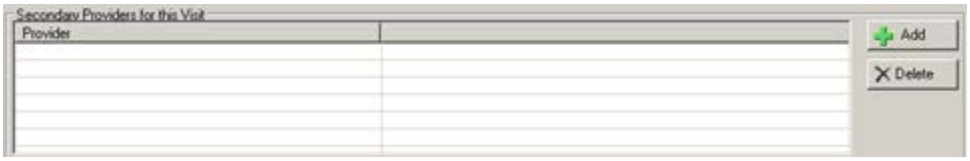


Figure 4-62: Sample secondary providers for this Visit pane

3. Click **Add** to access the Secondary Providers search/select window and search for the provider.

4. Click **Delete** to remove a selected secondary provider record. The confirmation **Are You Sure** displays: "Are you sure you want to delete?"

   - Click **Yes**: to remove the selected provider.
   - Click **No**: the provider is not removed.

4.3.4 SOAP/Progress Notes Tab

Select the **SOAP/Progress Notes** tab Figure 4-63) on the **Visit Data Entry** window to manage the SOAP/progress note associated with the current visit.

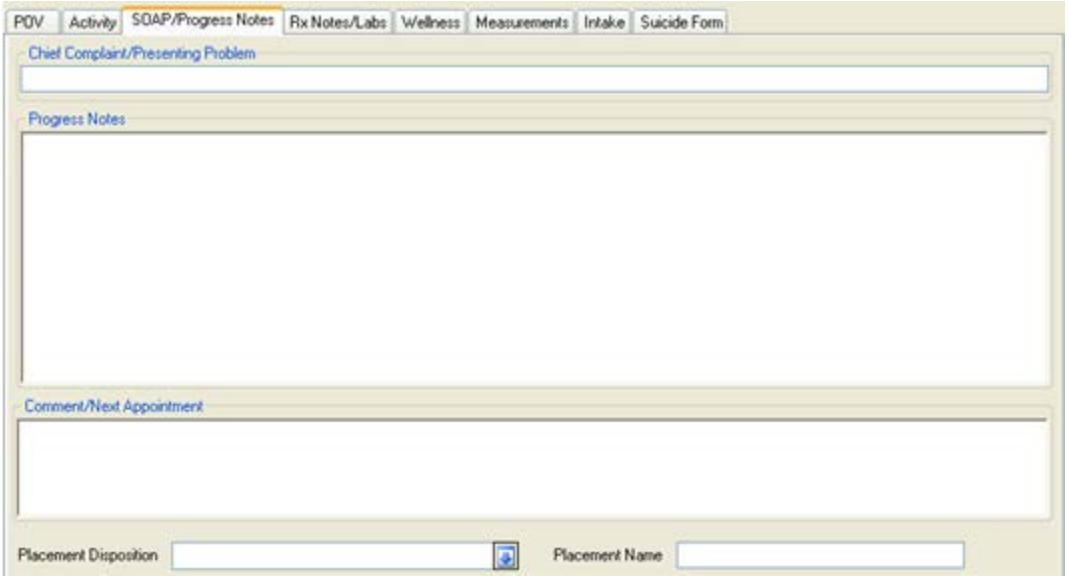


Figure 4-63: Sample **SOAP/Progress Notes** tab

- If you are editing a record and it has a signed note, the **Progress Notes** field will be inactive, all other fields will be active.

1. Type the problem in the **Chief Complaint/Presenting Problem** field.

2. Type notes in the **Progress Notes** field. A SOAP or progress note must be entered in the context of a visit.
3. Type additional comments in the **Comments/Next Appointment** field.
4. Select a placement type from the **Placement Disposition** field.
5. Type the name of the facility in the **Placement Name** field.

4.3.5 Rx Notes/Labs Tab

Select the **Rx Notes** tab to view prescription data or laboratory tests data as in Figure 4-64:

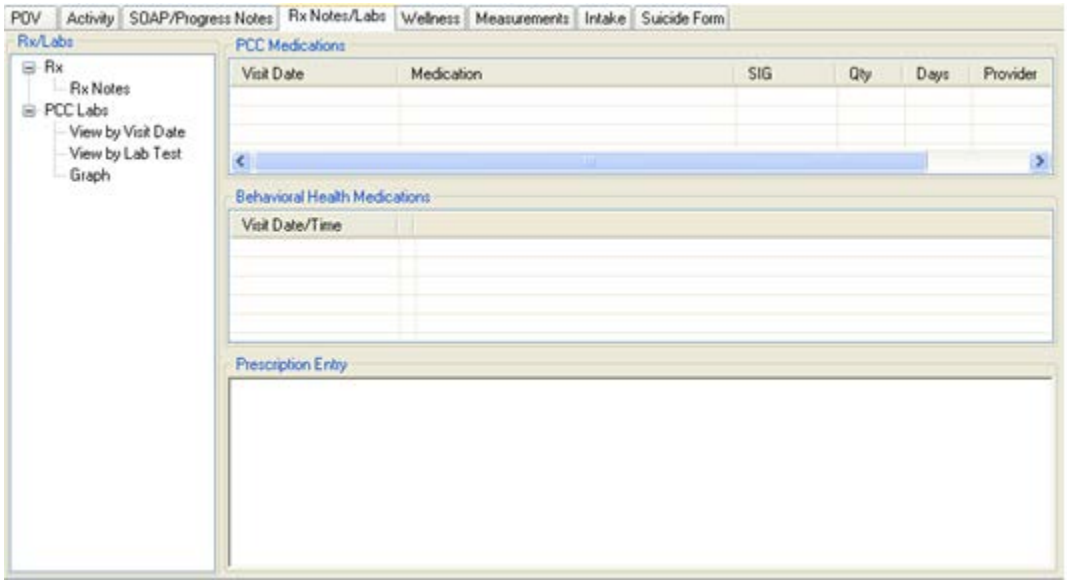


Figure 4-64: Sample **Rx Notes/Labs** tab

The Rx/Labs pane controls display on the right side of the tab.

4.3.5.1 Rx Data

When the Rx is selected in the Rx/Labs pane (default), the application displays information about PCC Medications, Behavioral Health Medications, and Prescription Entry options.

1. Select the **PCC Medications** pane to view medications prescribed for the patient.
2. Select the **Behavioral Health Medications** pane to view the visit dates when behavioral health medication was prescribed and any associated notes.
3. Select the **Prescription Entry** field to enter data about the patient's prescriptions.

– This information will be viewable in the Medications field for future visits. Items in the Medication field can be copied and pasted into the Prescription Entry field.

4.3.5.2 PCC Labs

When **PCC Labs** is selected in the **Rx/Labs** pane, you can select: View by Visit, View by Lab Test, or Graph.

4.3.5.2.1 View by Visit Date

When **View by Visit Date** is selected, (Figure 4-65) displays the **View Labs by Visit Date** dialog.

Figure 4-65: Sample View Labs by Visit Date dialog

The View Labs by Visit Date and View Labs by Lab Test dialogs display the following features:

- The default Begin Date will be one year previous.
- The application will link the default dates for these options so that if you change the date in one view, the date will be the default in both Lab views.
- When the user changes the default Begin Date, it will be maintained until the user changes it again.
- The application will save the user's default Begin Date when exiting.

You can edit the dates by clicking the field on the calendar. After setting the date, click **OK** to accept the date, or click **Close** to ignore. The **OK** function displays a pop-up that shows the first page of the PCC labs by visit date within the range.

4.3.5.2.2 View by Lab Test

When **View by Lab Test** is selected, the View Labs by Lab Test dialog displays as shown in Figure 4-66:

Figure 4-66: Sample View Labs by Lab Test dialog

The **View Labs by Visit Date** and **View Labs by Lab Test** dialog have the following features:

- If necessary, change the **Begin Date**.
- The application will link the default dates for these options so that if you change the date in one view, the date will be the default in both Lab views.
- When the user changes the default begin date, it will be maintained until the user changes it again.

See Section 2.7 for more information.

4.3.5.2.3 Graph

If you select **Graph**, the right side of the tab changes to two panels: **Lab Graph Date Range** and **Graphable Lab Tests** as in Figure 4-67:

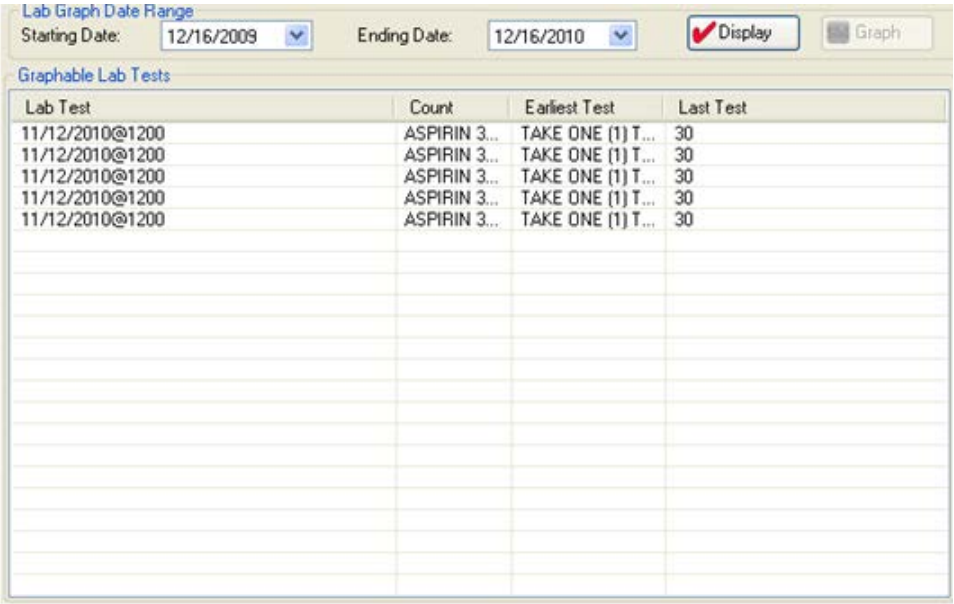


Figure 4-67: Sample panes for Graph option

Lab Graph Date Range

The default date is one year. This date range determines the data displayed in the Graphable Lab Tests pane. You can edit either or both dates. Click the drop-down list and select a date from the calendar. Click Display to refresh the data in the Graphable Lab Tests pane as shown in Figure 4-68:

Graphable Lab Tests

Lab Test	Count	Earliest Test	Last Test
BASO %	1	08/09/2001	11/13/2001
BLOOD COUNT ONLY (NO DIFF)	1	08/09/2001	11/13/2001
CBC	1	08/09/2001	11/13/2001
CLARITY	1	08/09/2001	11/13/2001
COLOR	1	08/09/2001	11/13/2001
DIFFERENTIAL	1	08/09/2001	11/13/2001
EOS %	1	08/09/2001	11/13/2001
EPITHELIAL CELLS	1	08/09/2001	11/13/2001
HCT	1	08/09/2001	08/09/2001
HCT (WIC)	1	02/20/2001	11/13/2001
HGB	1	08/09/2001	08/09/2001
LEUKOCYTE ESTERASE	1	08/09/2001	11/13/2001
LYMPH %	1	08/09/2001	11/13/2001
MCH	1	08/09/2001	08/09/2001
MCHC	1	08/09/2001	08/09/2001
MCV	1	08/09/2001	08/09/2001
MONO %	1	08/09/2001	11/13/2001
MPV	1	08/09/2001	08/09/2001
NEUT %	1	08/09/2001	11/13/2001
NITRITE	1	08/09/2001	11/13/2001
PLT	1	08/09/2001	08/09/2001
RBC	1	08/09/2001	08/09/2001

Graph

Figure 4-68: Sample Graphable Lab Tests pane

Graphable Lab Tests

To graph a laboratory test, select one laboratory test record and then click Graph. This causes the data to be entered into an Excel spreadsheet and the graph of the laboratory test is shown in Figure 4-69:

Book1

	A	B	C
1	Date	Normal Result	Abnormal Result
2	08/09/2001	0.5	0.0

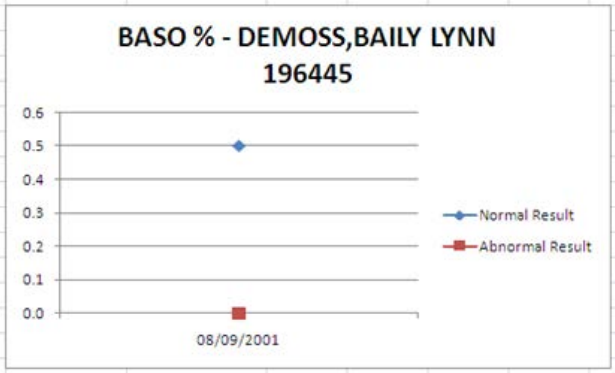


Figure 4-69: Sample graph of a particular laboratory test

4.3.6 Wellness Tab

Select the **Wellness** tab (Figure 4-70) to view the BH/PCC wellness activities, and manage the education, health factors, and screenings for the visit.

Figure 4-70: Sample **Wellness** tab

You can select any of the options on the Wellness tree structure: Patient Education, Health Factors, or Screening.

4.3.6.1 Patient Education

Select **Patient Education** on the Wellness tree structure to display the patient education panes: **Patient Education History** and **Patient Education Data Entry** panes are shown in Figure 4-71:

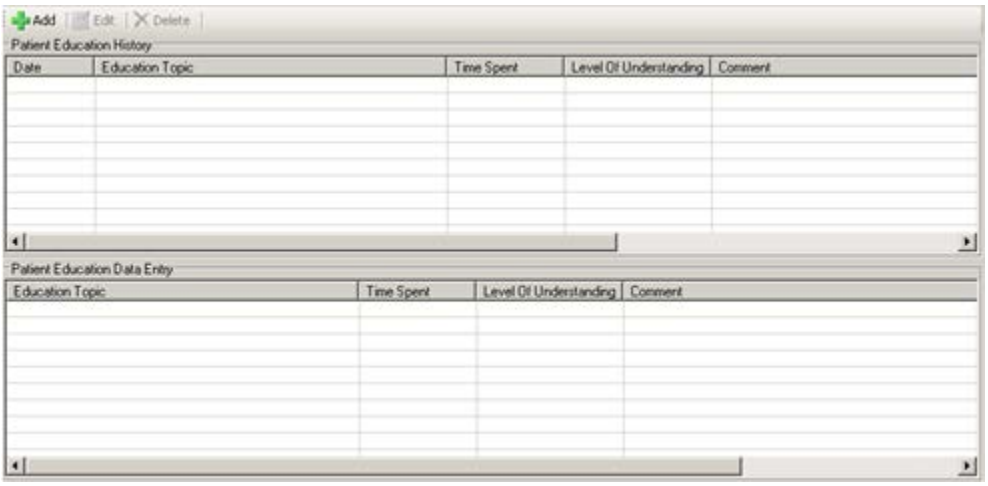


Figure 4-71: Sample **Patient Education** panes

The **Patient Education History** pane is read-only. You can scroll through the data using the scroll bar.

You can add/edit data in the **Patient Education Data Entry** pane by pressing the **Add**, **Edit**, or **Delete** button.

4.3.6.1.1 Add Patient Education Record

1. Click **Add** to display the **Education Topic** window and select a topic. . Click **OK** to accept the selection shown in Figure 4-72.
2. If you clicked **OK**, the application displays the **Patient Education** dialog, and the **Education Topic** field is populated.
3. Click **Close** and the application displays the "Continue" warning: "Canceling will lose all unsaved data, Continue?"
   - Click **Yes**: to return to the **Patient Education Data Entry** pane.
   - Click **No**: to display the **Patient Education** dialog with no data in the fields.

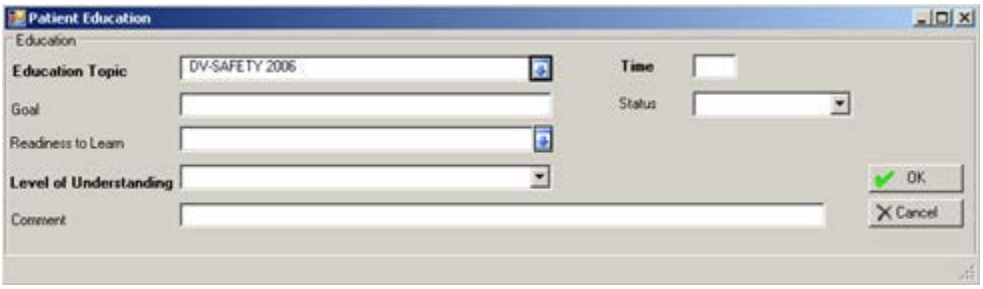


Figure 4-72: Sample **Patient Education** dialog

4. Select the topic from the "Education Topic" field.
5. At the "Time" prompt, type the number of minutes spent on the topic.
6. At the "Goal" prompt, type the goal of the education.
7. Select the "Status" field and select one of the following:
   - Goal Set (the preparation phase defined as "patient ready to change" (patient is active)
   - Goal Met (the action phase defined as "patient actively making the change" or maintenance phase defined as "patient is sustaining the behavior change")
   - Goal Not Met (the contemplation phase defined as "patient is unsure about the change" or relapse when the patient started making the change and did not succeed due to ambivalence or other reason)

- Goal Not Set (the precontemplation phase defined as “patient is not thinking about change”)

8. Select the “Readiness to Learn” field and select one of the following:

   - **Distraction**: use when the patient has limited readiness to learn because the distractions cannot be minimized.
   - **Eager to Learn**: use when the patient is exceedingly interested in receiving education.
   - **Intoxication**: use when the patient has decreased cognition due to intoxication with drugs or alcohol
   - **Not Ready**: use when the patient is not ready to learn.
   - **Pain**: use when the patient has a level of pain that limits readiness to learn.
   - **Receptive**: use when the patient is ready or willing to receive education.
   - **Severity of Illness**: use when the patient has a severity of illness that limits readiness to learn.
   - **Unreceptive**: use when the patient is *not* ready or willing to receive education.

9. Select the “Level of Understanding” field and to select one of the following:

   - **Poor** (does not verbalize understanding; unable to return demonstration or teach-back correctly)
   - **Fair** (verbalizes need for more education; incomplete return demonstration or teach-back indicates partial understanding)
   - **Good** (verbalizes understanding; able to return demonstration or teach-back correctly)
   - **Group No Assessment** (education provided in group; unable to evaluate individual response)
   - **Refused** (refuses education)

10. At the “Comment” prompt, type comments about the topic for the visit.

11. Click **OK** and the application saves the data and displays it on the **Education Topics Data Entry**.

12. Click **Cancel** and the “Continue?” warning: “Canceling will lose all unsaved data, Continue?”

    - Click **Yes**: to not save and leave the **Patient Education** dialog.
    - Click **No**: to return to the **Patient Education** dialog.

4.3.6.1.2 Edit Patient Education Record

1. Select a record in the **Patient Education Data Entry**.
2. Click **Edit**, the **Patient Education** dialog displays with the current data in the fields. Refer to Section 4.3.6.2.1 for more information about the fields.

4.3.6.1.3 Delete Patient Education Record

1. Select a record in the **Patient Education Data Entry**
2. Click **Delete**: the **Are You Sure?** confirmation displays: "Are you sure you want to delete?"
   - Click **Yes**: to delete the selected record
   - Click **No**: the record is not deleted.

4.3.6.2 Health Factors

Select the Health Factors on the **Wellness** tree structure to display the health factor panes (Figure 4-73): **Health Factors History** and **Health Factors Data Entry**.

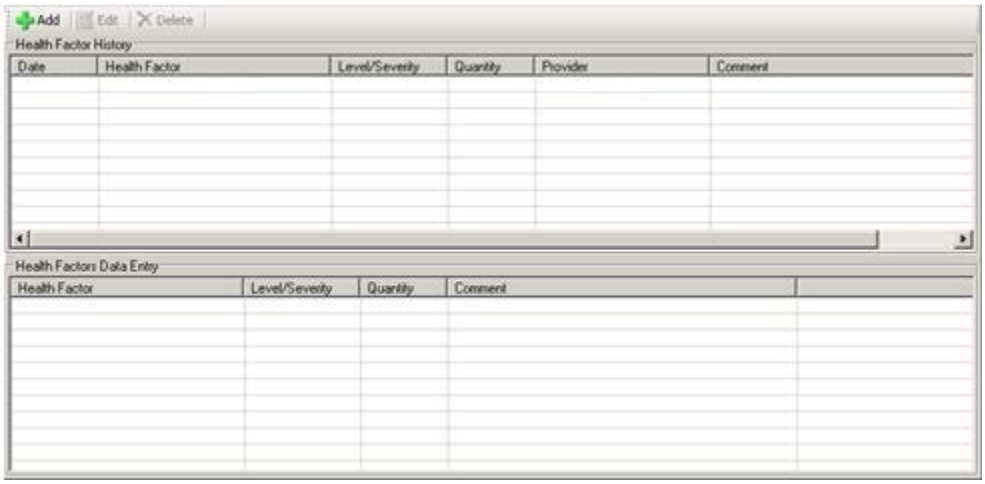


Figure 4-73: Sample **Health Factors History** dialog

Health factors describe a component of the patient's health and wellness not documented as an ICD or CPT code or elsewhere. Health factors are not visit specific and relate to the patient's overall health status. They appear on the Adult Regular and Behavioral Health summary report.

Health factors influence a person's health status and response to therapy. Some important patient education assessments can be considered health factors, such as barriers to learning, and learning preferences.

The **Health Factors History** pane is read-only. You can scroll through the data using the scroll bar.

You can add/edit data in the **Health Factors Data Entry** pane by clicking **Add**, **Edit**, or **Delete**.

4.3.6.2.1 Add Health Factor Record

1. Click **Add** to display the **Health Factors** search window.
2. Select a health factor and click **OK** and the Health Factor window displays shown in Figure 4-74:

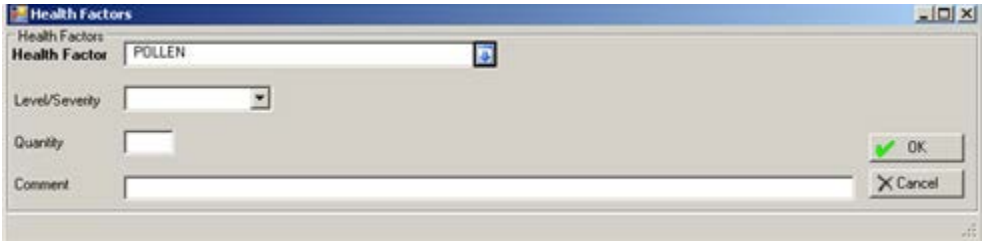


Figure 4-74: Sample Health Factors dialog

3. Select a factor from the Health Factor field.
4. Select the Level/Severity field and select one of the following:
   - Minimal
   - Moderate
   - Heavy/Severe
5. At the “Quantity” prompt, type a number, if necessary.
6. At the “Comment” prompt, type comments for the health factor.
7. Click **OK**: the data is saved and displays **Health Factors Data Entry** (Figure 4-73).
8. Click **Cancel**: the “Continue?” message displays: “Canceling will lose all unsaved data, Continue?”
   - Click **Yes**: entry is not saved and the Health Factors closes.
   - Click **No**: to return to the **Health Factors** window and data is saved.

4.3.6.2.2 Edit Health Factor Record

1. Select a record in the **Health Factors Data Entry**.
2. Click **Edit** and the **Health Factors** dialog displays with the current data. Refer to Section 4.3.6.2.1 for more information.

4.3.6.2.3 Delete Health Factor Record

1. Highlight a record in the **Health Factors Data Entry**.

2. Click **Delete**: the **Are You Sure** warning displays: “Are you sure you want to delete?”
   - Click **Yes**: to delete the selected record
   - Click **No**: the record is not deleted.

4.3.6.3 Screening

Select the Screening option on the Wellness tree structure to display the screening panes (Figure 4-75): **Screening History** and **Screening Data Entry**.

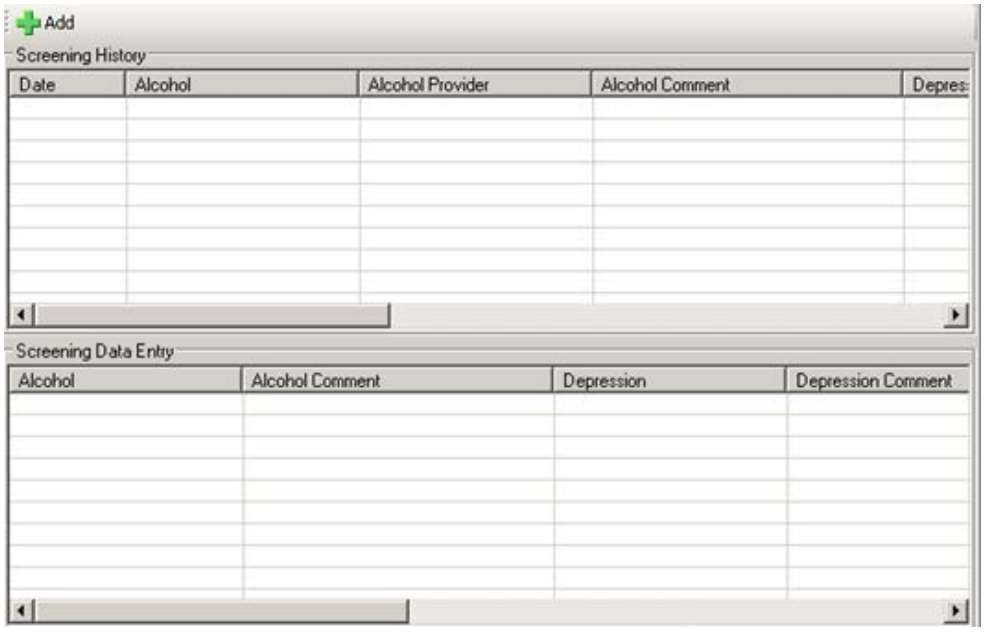


Figure 4-75: Sample **Screening History** panes

The **Screening History** dialog is read-only. Drag the scroll bar to navigate through the data.

1. **Add** displays when the **Screening Data Entry** is empty.
2. If the **Screening Data Entry** dialog is populated, **Edit** is enabled.

3. Click **Edit** and select a selected record. Figure 4-76 shows the Screening window.

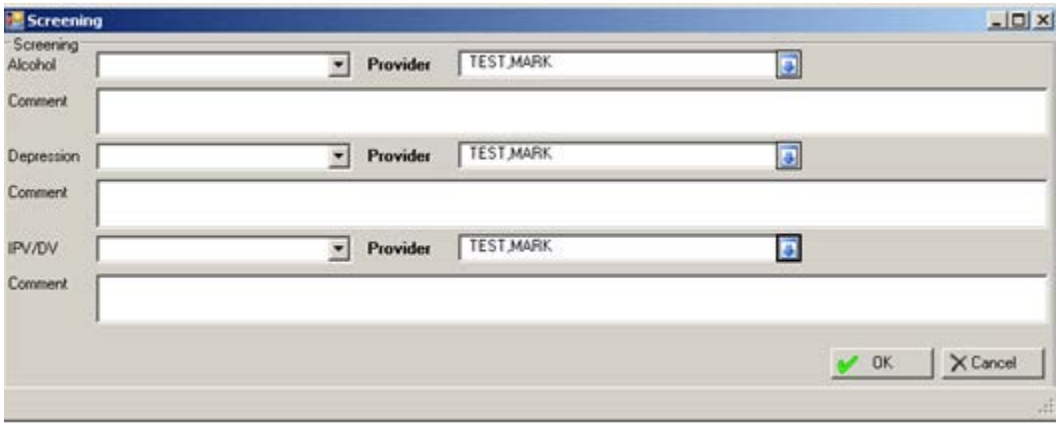


Figure 4-76: Screening dailog

4. Select the Alcohol field and select one of the following:
   - Negative (patient's screening does not indicate risky alcohol use)
   - Positive (patient's screening indicates risky alcohol use)
   - Unable to screen (provider unable to conduct the screening)
   - Patient Refused Screening (patient declined exam or screening)
5. Select a provider from the Provider field.
6. At the "Comment" prompt, type text related to the screening.
7. Select the Depression field and select one of the following:
   - Negative (denies symptoms of depression)
   - Positive (provides positive answers to depression screening; further evaluation is warranted)
   - Unable to screen (provider unable to conduct the screening)
   - Patient Refused Screening (patient declines exam or screening)
8. Select a provider from the Provider field.
9. At the "Comment" prompt, type text related to the depression screening
10. Select the IPV/DV field and select one of the following
    - : Negative (denies being a current victim of domestic violence)
    - Present (admits being a victim of domestic violence)
    - Past and Present

- Past (denies being a current victim but discloses being a past victim of domestic violence)
- Unable to screen (unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.))
- Patient Refused Screening (patient declined exam or screening)

11. Select a provider from the Provider field, if necessary.
12. At the “Comment” prompt, type comments related to the IPV/DV screening
13. Click **OK**: the data is saved and displays on the **Screening Data Entry**.
14. Click **Cancel**: the “Continue?” warning displays: “Canceling will lose all unsaved data, Continue?”
    - Click **Yes**: the **Screening** dialog closes without saving changes.
    - Click **No**: to return to the **Screening** dialog.

4.3.7 Measurements Tab

Select the **Measurements** tab to view existing measurements as well as add, edit, or delete Measurement data for the patient visit as shown in Figure 4-77:

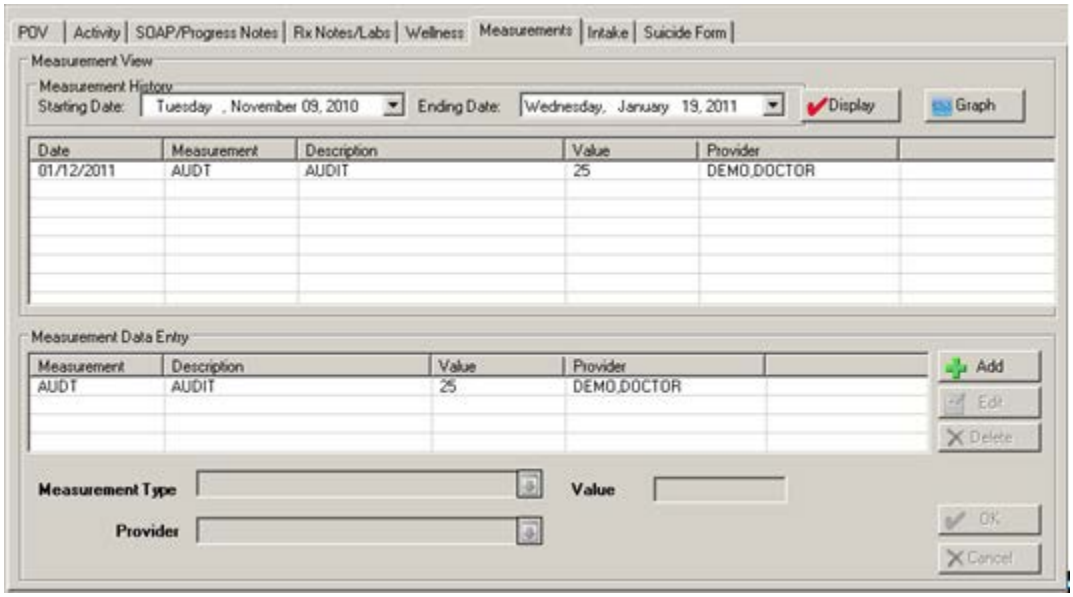


Figure 4-77: Sample **Measurements** dialog

4.3.7.1 Measurement View Pane

The pane displays the measurements for the current patient in the date range shown in the **Measurement History** pane (Figure 4-78).

1. Select the Starting Date field and set a date

2. Select the Ending Date field and set a date.

3. Click the **Display** button to refresh the data view pane.

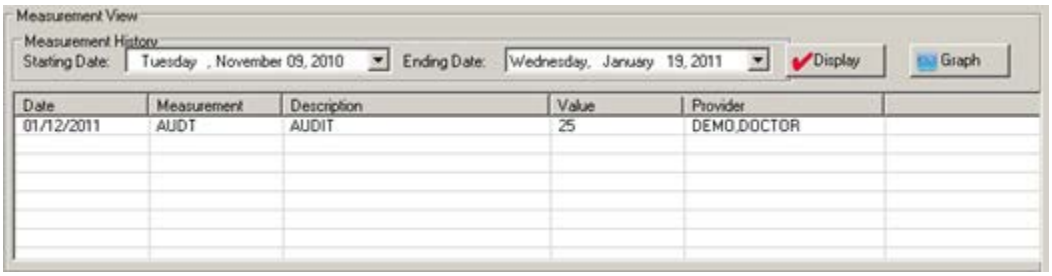


Figure 4-78: Sample **Measurement View** pane

4. To better utilize the data collected and viewed through the **Measurement View** pane, click **Graph** (Figure 4-80).

The **Measurement Type** pane displays as shown in (Figure 4-79).

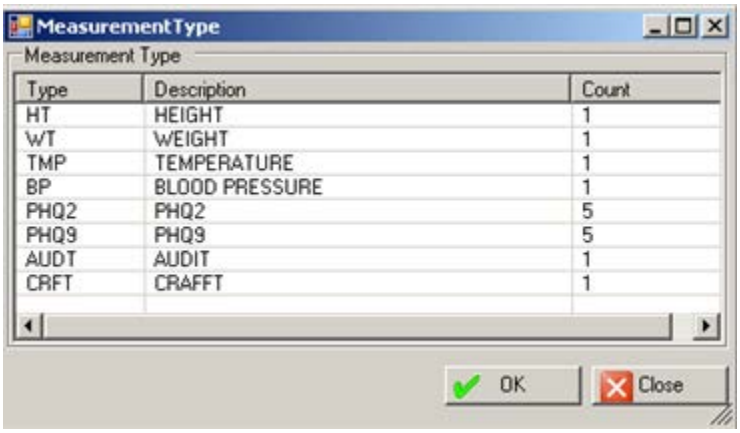


Figure 4-79: Sample **Measurement Type** pane

5. Select a measurement type to graph.

6. Click **OK** to display the MS Excel line graph in shown in Figure 4-80. A graph may be created and saved from the selected data.

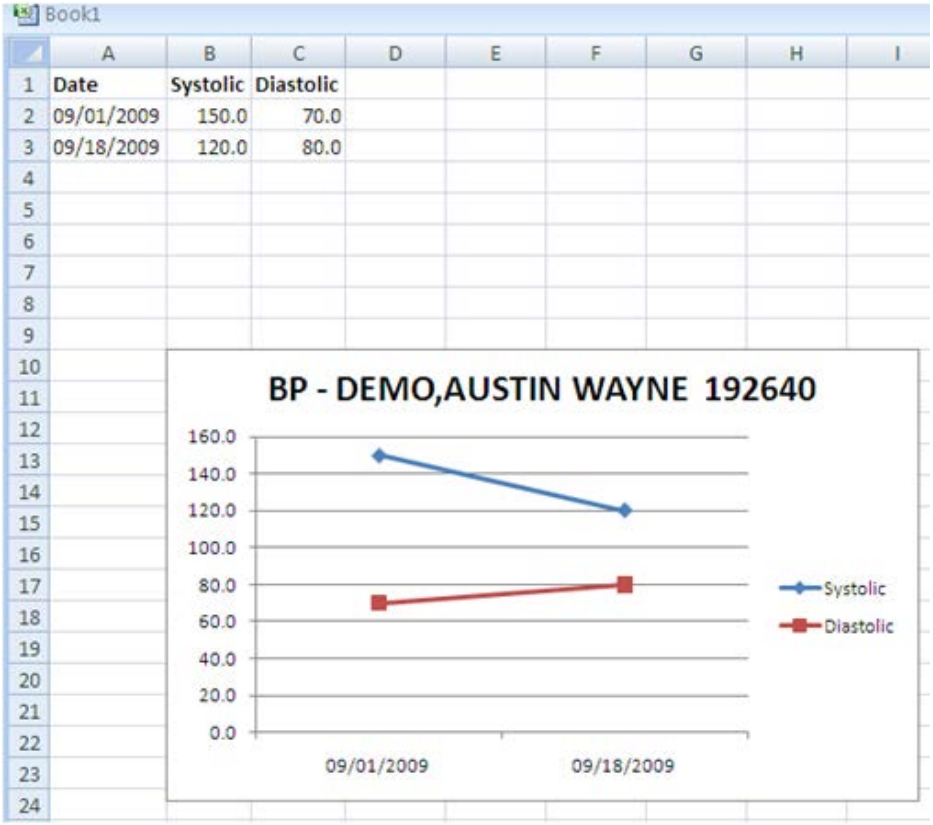


Figure 4-80: Sample line graph

4.3.7.2 Measurement Data Entry Pane

Figure 4-81 shows the **Measurement Data Entry** pane which manages the measurements during the visit.

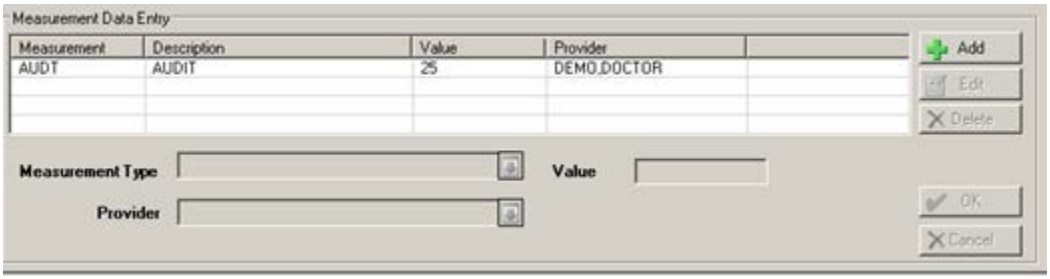


Figure 4-81: Sample **Measurement Data Entry** pane

1. Click **Add** to activate the measurement fields for data entry.

2. Select an option from the **Measurement Type** field. This field is inactive when editing a record.

3. Type the measurement number in the **Value** field. If the value is outside the accepted range, the **Warning** dialog shown in Figure 4-82 displays:

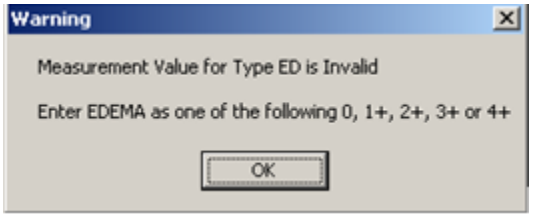


Figure 4-82: Sample value outside the acceptable range warning

4. Click **OK** to exit the warning and enter a valid number.
5. Select a provider from the Provider field.
6. Click **OK** on the **Measurement Data Entry** pane (Figure 4-81). The new record displays.
7. Click **Cancel** to end the process..
8. Click **Edit** to change a measurement or provider. The Measurement Type field is inactive when editing a record.
9. Click **OK** to change the value or provider.
10. Click **Delete** to remove a measurement record, the confirmation **Are You Sure** displays:
    - Click **Yes** to delete the record
    - Click **No** and the record will not be deleted.

4.3.8 Intake Tab (GUI)

Select the **Intake** tab and the **Intake** window displays as shown in Figure 4-83:

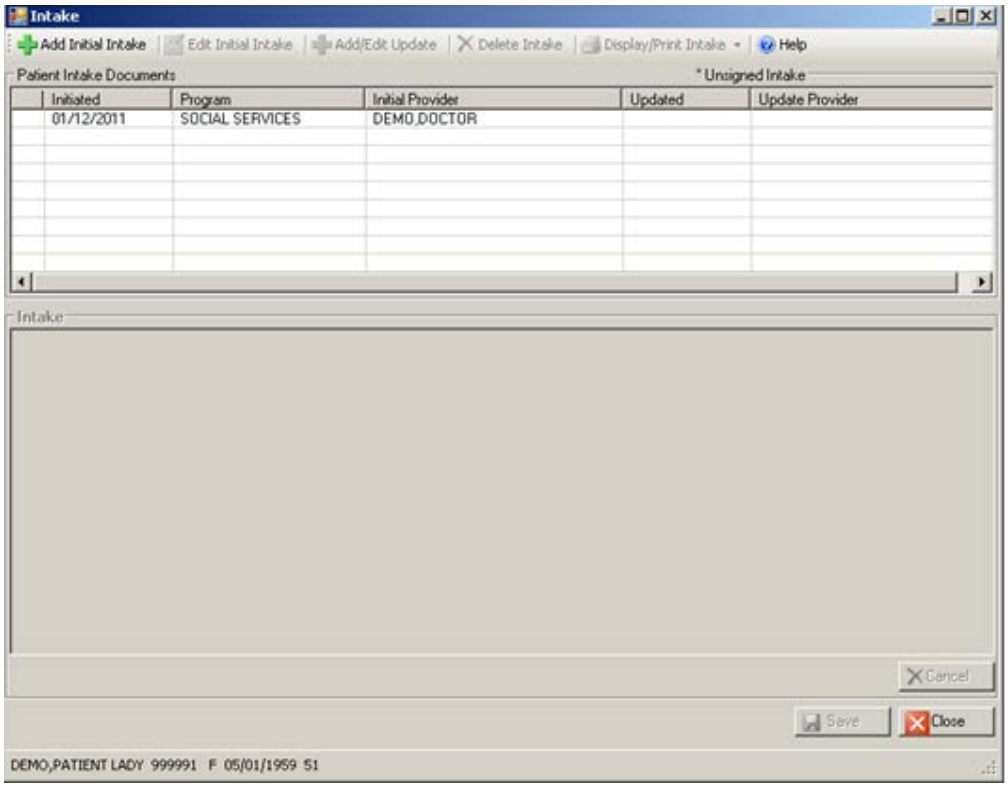


Figure 4-83: Initial **Intake** window

Refer to Section 12.2 for more information.

4.3.9 Suicide Form

Click the **Suicide Form** tab to display the **Suicide Form** window. Refer to Section Figure 11-2 for more information.

4.3.10 Select PCC Visit Window

The **PCC Visit** window (Figure 4-84) displays the visit has been saved and signed. The visit is entered in the scheduling package with the option to create a visit at check-in.

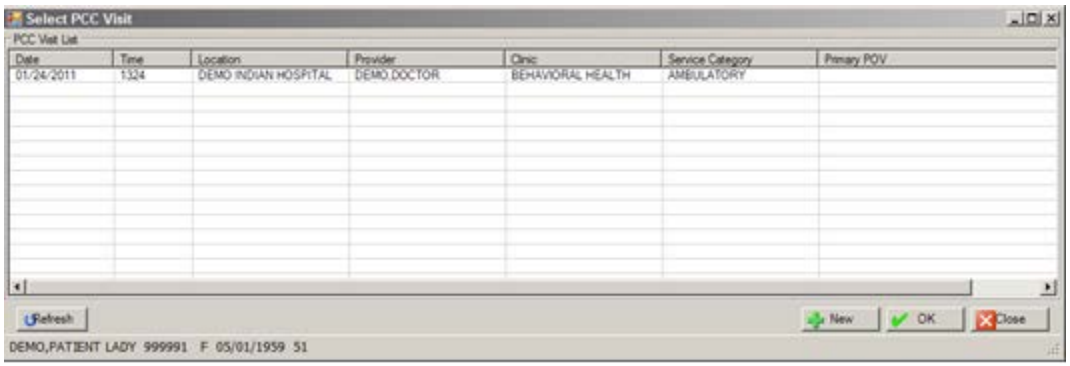


Figure 4-84: Sample **Select PCC Visit** window

1. Click **New** to create a record. The **Select PCC Visit** window closes. The Visit List View screen displays.

2. Highlight an entry and click OK to link one record to the PCC record.

3. Click **Refresh** to return to the GUI and view more visits.

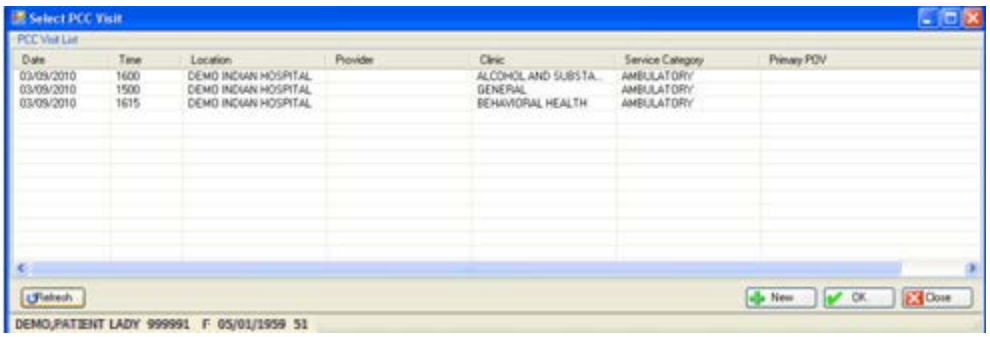


Figure 4-85: Select PCC Visit window with more visits

4. If one has been linked, it can be viewed in PCC as shown in Figure 4-86 displays.

```
Patient Name:          BETAA,EMILY MAE
Chart #:               129608
Date of Birth:         MAR 01, 1968
Sex:                   F
Visit IEN:             2565343

=============== VISIT FILE ===============
VISIT/ADMIT DATE&TIME: MAR 09, 2010@16:15
DATE VISIT CREATED:    MAR 09, 2010
TYPE:                  IHS
PATIENT NAME:          BETAA,EMILY MAE
LOC. OF ENCOUNTER:     DEMO INDIAN HOSPITAL
SERVICE CATEGORY:      AMBULATORY
```

```
CLINIC:                 BEHAVIORAL HEALTH
DEPENDENT ENTRY COUNT:  3
DATE LAST MODIFIED:     MAR 09, 2010
WALK IN/APPT:           WALK IN
HOSPITAL LOCATION:      BJB BH
CREATED BY USER:        BETA,BETAS
OPTION USED TO CREATE:  SD IHS PCC LINK  -
APPT DATE&TIME:         MAR 09, 2010@16:15
USER LAST UPDATE:       BETA,BETAA
VCN:                    47887.3A
OLD/UNUSED UNIQUE VIS:  5059010002565343
DATE/TIME LAST MODIFI:  MAR 09, 2010@16:57:35
CHART AUDIT STATUS:     REVIEWED/COMPLETE
NDW UNIQUE VISIT ID (:  102320002565343
VISIT ID:               3C5N-WWX

=============== PROVIDER ===============
PROVIDER:               BETA,BETAA
AFF.DISC.CODE:          3A513
PRIMARY/SECONDARY:      PRIMARY
V FILE IEN:             4873643

=============== POV ===============
POV:                    799.9
ICD NARRATIVE:          UNK CAUSE MORB/MORT,NEC
PROVIDER NARRATIVE:     DIAGNOSIS OR CONDITION DEFERRED ON AXIS I
V FILE IEN:             3224050

=============== ACTIVITY TIME ===============
ACTIVITY TIME:          60
TOTAL TIME:             60
V FILE IEN:             38330
```

Figure 4-86: Information from PCC

See Section 4.1.1 for more information.

4.4 Browse Visits (GUI)

Figure 4-87 shows the **Browse Visits** window.

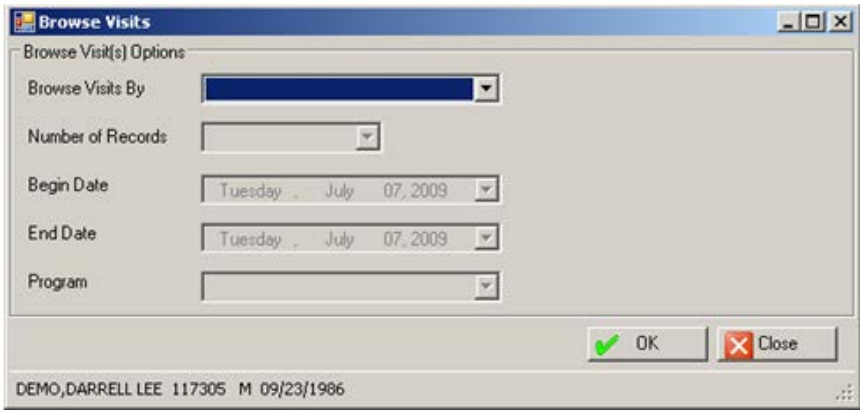


Figure 4-87: Sample **Browse Visits** dialog

1. Select the **Browse Visits By** field and type one of the following:
   - **L**: Patient's Last Visit
   - **N**: Patient's Last *N* Visits
   - **D**: visits in a Date Range
   - **A**: All of the Patient's Visits
   - **P**: Visits to One Program
   - If **L** or **A** are selected, the remaining fields will be inactive.
2. Depending on the selection in Step 1:
   - If **N** was selected, select the **Number of Records**.
   - If **D** was selected, set the **Begin Date** and **End Date**.
   - If **P** is selected, select the **Program**.
   - If **L** or **A** are selected, the remaining fields will be inactive.
3. Click **OK**: the first page of the **Browse Visits** window displays as shown in Figure 4-88:

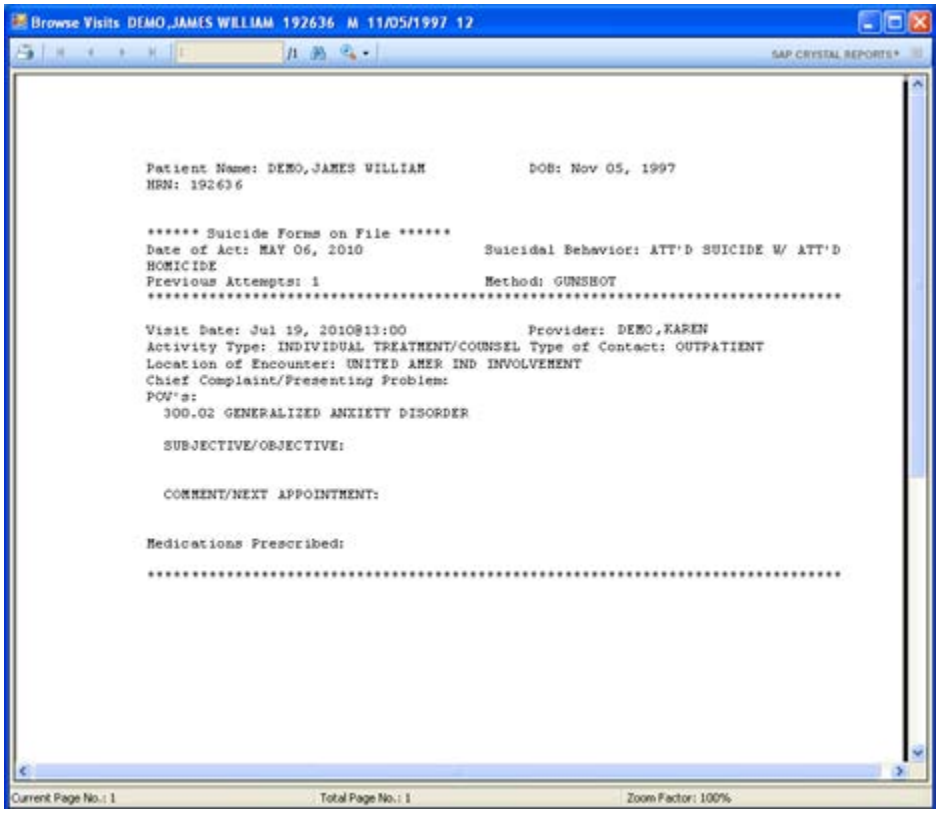


Figure 4-88: Sample of data in **Browse** window

Refer to Section 2.6 for more information.

4.5 View Patient Data

When you expand **View Patient Data** on the tree structure (Figure 4-89) for the **RPMS Behavioral Health System**, select one of the following to view patient data:

- Face Sheet, Health Summary
- PCC Medications
- PCC Labs by Visit Date
- PCC Labs by Lab Test.

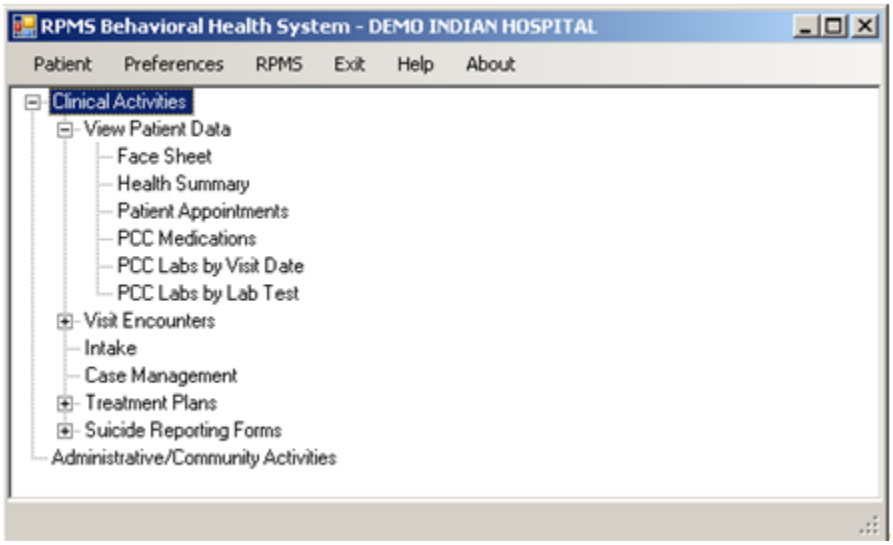


Figure 4-89: **RPMS Behavioral Health System** tree structure for View Patient Data

4.5.1 Face Sheet

The **Face Sheet** displays the first page of the **Ambulatory Care Record Brief** dialog for the current patient. Refer to Section 2.6 for more information.

- Right-click on the **Face Sheet** label to displays **Change Patient**. After selecting the option, the application displays the **Select Patient** dialog. Refer to Section 2.12.2 for more information.

4.5.2 Health Summary

The **Health Summary** displays the selected health summary type report for the current patient. Figure 4-90 shows the **Select Health Summary Type** window.

Figure 4-90: **Select Health Summary Type** window

1. Select an option from the **Select Health Summary Type** field.
2. Click **OK** to display the first page of the type of heath summary. Refer to Section 2.6 for more information.

4.5.3 Patient Appointments

The **Patient Appointments** (Figure 4-91) displays the appointments of the current patient in a date range.

Figure 4-91: Sample **Patient Appointments** dialog

The default **Begin Date** is three months previous and default **End Date** is three months in the future.

1. Select the **Begin Date** field and set the date.
2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the appointments for the patient in the date range displays. Refer to Section 2.6 for more information.

4.5.4 PCC Medications

The **PCC Medications** displays medications for the current patient in a date range. Figure 4-92 displays the **PCC Medications** window.

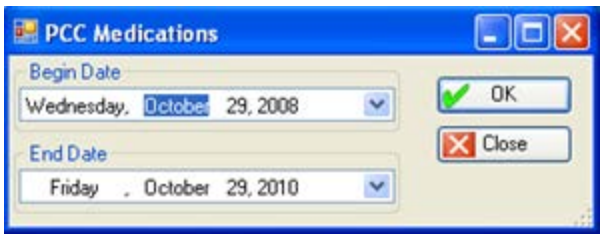


Figure 4-92: Sample **PCC Medications** dialog

The default **Begin Date** is one year previous.

1. Select the **Begin Date** field and set a date.
2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the **Medication Prescribed in the Behavioral Health** database within the date range.

4.5.5 PCC Labs by Visit Date

The **PCC Labs by Visit Date** displays the PCC Labs for the current patient in a date range. Figure 4-93 displays the **View Labs by Visit Date** window.

Figure 4-93: Sample **View Labs by Visit Date** dialog

The default **Begin Date** is one year previous.

1. Select the **Begin Date** field and set a date. The date is applied to the **View Labs by Lab Test** window as well.
2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the PCC labs by visit date in the date range.

4.5.6 PCC Labs by Lab Test

The **PCC Labs by Lab Test** option displays the PCC Labs for the current patient in a date range. Figure 4-94 displays the **View Labs by Lab Test** window:

Figure 4-94: Sample **View Labs by Lab Test** window

The default **Begin Date** is one year previous.

1. Select the **Begin Date** field and set a date. The date is applied to the **View Labs by Visit Date** window as well
2. Select the **End Date** field and set a date.
   - Click **OK** to display the first page of the **PCC labs by lab test** within the date range.

5.0 Group Encounters

This section provides information on how to enter or edit group encounter data for the roll-and scroll-application and the RPMS Behavioral Health System GUI.

5.1 Group Form Data Entry Using Group Definition (Roll and Scroll)

The Group Form Data Entry Using Group Definition (GP) option is used to input MH/SS data from a group form. Use if the encounter involves a group of patients. This process allows you to enter data into each participant's record without entering an encounter record for each patient.

1. At the "Enter Beginning Date" prompt, type the date range for displaying Group definitions.

2. At the "Enter Ending Date" prompt, type the date range for displaying Group definitions. The Group Entry dialog (Figure 5-1) displays.

```
GROUP ENTRY                    Mar 16, 2009 17:09:31          Page:    1 of   14
Group Entry                  * - Unsigned Group Note
      Date     Group Name           Activity   Prg Cln    Prov      TOC POV

1)  * 10/01/09 EDIT INTAKE          GROUP TRE  S   MEDIC  GAMMAA,R  SCH 311. – D
2)  * 10/01/09 EDIT INTAKE          GROUP TRE  S   MEDIC  GAMMAA,R  SCH 311. – D
3)  * 09/29/09 INTAKE GROUP         GROUP TRE  M   TELEB  GAMMAA,R  SCH 296.20 –
4)    09/29/09 INTAKE GROUP         GROUP TRE  M   TELEB  GAMMAA,R  SCH 296.20 –
5)    09/28/09 Mond DV              FAMILY/GR  S   MEDIC  GAMMAAA,  OUT 43.2 – P
6)    09/25/09 GOAL STATUS          GROUP TRE  S   MEDIC  GAMMAA,R  SCH 298.9 –
7)    09/25/09 Friday DV group      GROUP TRE  S   MEDIC  GAMMAAA,  SCH 80 – HOU
8)  * 09/25/09 pov test             GROUP TRE  S   MEDIC  GAMMAA,R  SCH 2 – CROS
9)    09/24/09 WW-GRIEF GROUP       LIFE SKIL  S   MEDIC  ALPHAA,W  OUT 24 – ADJ
10) * 09/24/09 WW-DEPRESSION GROUP  GROUP TRE  M   MENTA  ALPHAA,W  FIE 311. – D
11) * 09/22/09 mark edu status      GROUP TRE  M   TELEB  GAMMAAAA  SCH 2 – CROS
12) * 09/22/09 PR465 test           GROUP TRE  M   TELEB  BETAAAA,  SCH 27 – ALC
13)   09/22/09 TEST OF CC MARK      GROUP TRE  M   TELEB  BETAAAA  SCH 2 – CROS
+         Enter ?? for more actions                                          >>>
1    Add a New Group                    6    Review/Edit Group Visits
2    Display Group Entry                7    Add No Show Visit
3    Duplicate Group                    8    Edit Group Definition
4    Delete Group                       9    Sign Notes
5    Print Encounter Forms              Q    Quit
Select Action:+//
```

Figure 5-1: Sample Group Entry screen

The asterisk (*) preceding the Entry Date indicates that the record contains an unsigned group note. Refer to Section 2.14 for more information.

3. At the "Select Action" prompt, type **Q** and press Enter to close the screen.

> **Note**: You can edit group records only with the group screens, not on the individual data entry side (PDE, SDE).

5.1.1 Add a New Group

1. At the "Select Action" prompt on the Group Entry screen (Figure 5-1), type **1**.
2. At the "Enter Date of the Group Activity" prompt, type a date. The Group Encounter Documentation screen (Figure 5-2) displays:

```
*  GROUP ENCOUNTER DOCUMENTATION  *          DEMO INDIAN HOSPITAL
-----------------------------------------------------------------------------
NOTE:  Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAR 14,2009             Arrival Time: 12:00
Program:                                Community of Service:
Group Name:                             Clinic:
Activity:                               Activity Time:
Encounter Location:                     Type of Contact:
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N          CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:
_____________________________________________________________________________

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

Figure 5-2: Sample Group Encounter Documentation screen

3. Type **Y** at the "At the "Add/View/Update Providers (Primary or Secondary)" prompt and press Enter to display the Secondary Providers screen (Figure 5-3) as an overlay to the Group Encounter Documentation screen.

```
PROVIDER:                                       PRIMARY/SECONDARY:
PROVIDER:                                       PRIMARY/SECONDARY:
PROVIDER:                                       PRIMARY/SECONDARY:
```

Figure 5-3: Sample Secondary Providers screen

4. At the "PROVIDER" prompt, type a provider name.
5. At the "PRIMARY/SECONDARY" prompt, type a provider name.

> **Note**: Only one primary provider can be used, whereas, you can use multiple secondary providers.

6. At the "Command" prompt, type **Close** and press Enter to return to the Group Encounter Documentation screen (Figure 5-2).

7. At the “Encounter Date” prompt, set the date.
8. At the “Arrival Time” prompt, type the time of the encounter.
9. At the “Program” prompt, type one of the following:
   - **M** (Mental Health)
   - **S** (Social Services)
   - **C** (Chemical Dependency)
   - **O** (Other)
10. At the “Community of Service” prompt, type the name where the encounter took place
11. At the “Group Name” prompt, type the name of the group encounter.
12. At the “Clinic” prompt, type the number or name of the clinic.
13. At the “Activity” prompt, type the group encounter activity.
14. At the “Activity Time” prompt, type the number of minutes spent on the activity.

Note: 0 (zero) is not allowed as a valid entry.

15. At the “Encounter Location” prompt, type the name of the encounter location.
16. At the “Type of Contact”prompt, type the activity setting.
17. At the “POV or DSM (Primary Group Topic)” prompt, type the POV for the group topic.
18. Press Enter: to display the POV or DSM Diagnosis dialog (Figure 5-4):

```
POV or DSM Diagnosis (Primary Group Topic)

 CODE    NARRATIVE
 ------------------------------------------------------------------------


_____________________________________________________________________________
```

Figure 5-4: Sample pop-up window for POV

19. At the “Code” prompt, type the MHSS Problem/DSM IV POVcode. The Narrative for the code will display and can be edit.
20. At the “Chief Complaint/Presenting Problem” prompt, type the chief complaint.

21. At the “Any Patient Education Done?” prompt, type **Y** and the Patient Education for this Group Activity screen Figure 5-5 displays as an overaly.

```
*PATIENT EDUCATION for this Group Activity

 After entering each topic you will be prompted for more fields

 EDUCATION TOPIC:
 EDUCATION TOPIC:
 EDUCATION TOPIC:
 EDUCATION TOPIC:
 EDUCATION TOPIC:
```

Figure 5-5: Sample **Patient Education** enter/edit screen

22. At the “EDUCATION TOPIC:” prompt, type the topic code. The Education Topic screen in Figure 5-6)overlays:

```
EDUCATION TOPIC: 042.-DISEASE PROCESS

LEVEL OF UNDERSTANDING: GROUP-NO ASSESSMENT
PROVIDER: THETA,SHIRLEY
MINUTES:

COMMENT:
```

Figure 5-6: Sample screen for Education Topic

- The Individual/Group field displays GROUP and is read only.
- The Level of Understanding field displays GROUP-NO ASSESSMENT and is read only.

23. At the “Provider” prompt, accept the current user name or update.

24. At the “Minutes” prompt, type the number of minutes spent on education.

25. At the “Comment:” prompt, type a comment about the education topic.

The following fields display on the Group Encounter Documentation screen (Figure 5-2).

26. At the “CPT Code(s)” prompt, press Enter to display a secondary window.

27. At the “S/O/A/P (Standard Group Note)” prompt, press Enter to display secondary window.

28. At the “Patients” prompt, press Enter to display the Patients screen shown in Figure 5-7:

```
Please enter all patients who participated in the group.
Remove any patients who were not present

PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
PATIENT:
```

Figure 5-7: Sample pop-up for Patients

29. At the “PATIENT:” prompt, type the patient name, HRN, DOB, or SSN. Figure 5-8 displays after you save and exit the application.

```
     Select one of the following:

     Y         Yes, group definition is accurate, continue on to add visits
     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 5-8: Questions upon exit screen

30. Type **Y**: to continue editing the patient’s visit. The first patient’s record redisplays.

31. Type **N**: to edit the group definition.

32. Type **Q** and press Enter to exit. The **Group Entry** (Figure 5-1) screen displays.

    - After a provider enters the group definition, completes documentation for the individual patients, and saves, the application will display an option to sign all SOAP/Progress Notes or to leave them unsigned.

5.1.2 Edit Group Definition

1. At the “Select Action” prompt on the Group Entry screen (Figure 5-1), type **8**.

    - If the selected group already has visits created, the following message displays: “This group already has visits created. You must use the REVIEW/EDIT GROUP VISITS to modify visits within this group”.
    - The Group Entry screen redisplays.

In all other cases, the Group Encounter Documentation screen displays shown in Figure 5-9:

```
*  GROUP ENCOUNTER DOCUMENTATION  *          DEMO INDIAN HOSPITAL
-----------------------------------------------------------------------------
NOTE:  Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAY 15,2009@12:00       Arrival Time: 12:00
Program: MENTAL HEALTH                  Community of Service: ABERDEEN
Group Name: meeting on thur             Clinic: EMERGENCY MEDICINE
Activity: 25                            Activity Time: 6
Encounter Location: ABERDEEN AO         Type of Contact: CONSULTATION
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N          CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:


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

Figure 5-9: Sample Group Encounter Documentation window

Refer to Section 5.1.1 for more information.

5.1.3 Review/Edit Group Visits

1. At the “Select Action” prompt on the Group Entry screen (Figure 5-1), type **6**.
2. At the “Select GROUP ENTRY” prompt, type the group entry to review or edit.
3. If the group has a signed note, the following message displays: “The notes associated with this group entry have been signed”.
   a. You can edit other items in this entry but not the notes.
   b. Press Enter to continue.

Figure 5-10 shows the Enter/Edit Patient Group Data screen after the GROUP ENTRY field is completed.

```
Enter/Edit Patient Group Data Mar 27, 2009 17:33:04      Page:    1 of 1
Group Entry
     Patient Name                      Sex Age    DOB       HRN   Record Added
1)   PHIIII,TERRY LYNN                   F  40   05/10/1968  198794    yes
2)   THETA,LOMIE                         M  23   06/23/1985  115697    yes
         Enter ?? for more actions                                   >>>
AE   Edit Patient's Group Visit          D    Display Patient's Group Visit
X    Delete a Patient's Group Visit      Q    Quit
Select Action:+//
```

Figure 5-10: Sample Enter/Edit Patient Group Data screen

4. At the “Select Action” prompt, type **Q** and press Enter to exit.

5.1.3.1 Delete a Patient's Group Visit (X)

1. At the "Select Action" prompt, type **X** to remove a patient's group visit. The BH record displayed, followed by the prompt "Are you sure you want to delete this Patient's Visit?".
   - Type **Y** to delete the visit
   - Type **N** to cancel the deletion.

5.1.3.2 Display Patient's Group Visit (D)

- At the "Select Action" prompt, type **D** to display a patient's group visit. The application displays the BH Visits Record Display window (view only).

5.1.3.3 Edit Patient's Group Visit (AE)

1. At the "Select Action" prompt type **AE**.
2. At the "PATIENT GROUP ENTRY (1-*x*)" prompt, type the group number ("*x*" being the number of the last group data record). The BEHAVIORAL HEALTH RECORD EDIT window displays as shown in Figure 5-11:

```
* BEHAVIORIAL HEALTH RECORD EDIT *           [press <F1>E to exit]
Encounter Date: NOV 3,2006@12:00               User: THETA,SHIRLEY
Patient Name: TEST,JEREMY ISSAC  DOB: 6/15/81  HRN: 104683
-------------------------------------------------------------------------
Date:    NOV 3,2006@12:00         Location of Service:  DEMO HOSPITAL
Program: MENTAL HEALTH            Outside Location:
Clinic:  MENTAL HEALTH            Appt/Walk-in: UNSPECIFIED   Visit Flag:
Type of Contact: OUTPATIENT       Community: RED LAKE
Providers <press enter>:          Local Service Site:
Activity:  91      Activity Time: 40  #Served:  1  Interpreter Utilized:
Chief Complaint/Presenting Problem:
SOAP/PROGRESS NOTE:    Comment/Next Appointment:     Medications
Prescribed:
Edit Purpose of Visits?: N      Edit Treated Medical Problems?  N
Edit CPT Codes?     Edit Health Factors?  N
Edit Patient Education?: N
Edit Any Screening Exams?  N    Edit Measurements?  N
Placement Disposition:                  Referred To:
_____________________________________________________________________________

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

Figure 5-11: Sample Behavioral Health Record Edit window

If the message "SOAP/PROGRESS NOTE SIGNED/UNEDITABLE" displays, the fields are not editable. Refer to Section 4.1.4 for more information.

5.1.4 Display Group Entry

1. At the “Select Action” prompt on the Group Entry screen (Figure 5-11), type **2** and press Enter.

The group data is displayed in Figure 5-12 on the Output Browser screen.

```
OUTPUT BROWSER                Mar 27, 2009 17:46:48          Page:    1 of    1


DATE OF SERVICE: NOV 29, 2010@14:39     PROGRAM: MENTAL HEALTH
  GROUP NAME: TESTING LINK 1            POSTING DATE: NOV 29, 2010
  LOCATION OF ENCOUNTER: KANAKANAK HOSPITAL
  COMMUNITY OF SERVICE: KODIAK          ACTIVITY TYPE: 91
  TYPE OF CONTACT: OUTPATIENT           ACTIVITY TIME: 60
  WHO ENTERED RECORD: GARCIA,RYAN       DATE LAST MODIFIED: NOV 29, 2010
  CLINIC: MENTAL HEALTH                 USER LAST UPDATE: GARCIA,RYAN
  SIGNED?: YES                          ELECTRONIC SIGNATURE BLOCK: Ryan Garcia
  DATE/TIME ESIG APPLIED: NOV 29, 2010@14:40:50
PROVIDER: GAAMMA,RYAN                   PRIMARY/SECONDARY: PRIMARY
POV: 293.82
  NARRATIVE: PSYCHOTIC DISORDER DUE TO..(INDICATE MEDICAL CONDITION),W/HALLUCIN.
POV: 296.24
  NARRATIVE: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE W/PSYCHOTIC FEATU
RES
 SUBJECTIVE/OBJECTIVE:

+         Enter ?? for more actions                                           >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 5-12: Sample Output Browser screen

5.1.5 Print Encounter Forms

1. At the “Select Action” prompt on the Output Browser screen, type **5** and press Enter to print an encounter form for a group
2. At the “GROUP ENTRY” prompt, type the group to use.
   a. The message “Forms will be generated for the following patient visit” displays.
   b. The names of the patients in the group displays.
3. At the “Enter response” prompt, type one of the following:
   - **F**: Full Encounter Form
   - **S**: Suppressed Encounter Form
   - **B**: Both a Suppressed & Full
   - **T**: 2 copies of the Suppressed
   - **E**: 2 copies of the Full

– A full encounter form prints all data for a patient encounter including the S/O/A/P note and displays Chief Complaint, SOAP note, measurement data, screenings. The suppressed report does not display the information:

4. At the “Device” prompt, type the device to print/browse the encounter form.

Figure 5-13 shows a sample full encounter form report.

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
  PCC BEHAVIORAL HEALTH ENCOUNTER RECORD      Printed: Oct 01, 2009@17:38:44
             ***  Computer Generated Group Encounter Record  ***
                              Group Name: Mond DV
*******************************************************************************
  Date:  Sep 28, 2009         Primary Provider: GAMMA,DENISE
                                                BETAA,BJ
  Arrival Time: 10:00         Flag
  Program:  SOCIAL SERVICES
  Clinic:  MEDICAL SOCIAL SERVICES      Appointment Type:  UNSPECIFIED
_______________________________________________________________________________
                                                Number        Activity/Service
  Community: TAHLEQUAH                          Served: 1     Time: 44 minutes
  Time spent in group session: 88
  Activity: 14-FAMILY/GROUP TREATMENT-PATIENT PRESENT
  Type of Contact: OUTPATIENT
_______________________________________________________________________________
  CHIEF COMPLAINT/PRESENTING PROBLEM:  test pt ed
  S/O/A/P:
  GROUP NOTE
  This is the first meeting of the Domestic Violence group. Focus of today’s
  session was establishing group rules and discussing expectations.
  COMMENT/NEXT APPOINTMENT:
_______________________________________________________________________________
  BH POV CODE      PURPOSE OF VISIT (POV)
  OR DSM DIAGNOSIS    [PRIMARY ON FIRST LINE]
_______________________________________________________________________________
       311.           DEPRESSIVE DISORDER NOS
_______________________________________________________________________________
  MEDICATIONS PRESCRIBED:
_______________________________________________________________________________
  PROCEDURES (CPT):
_______________________________________________________________________________
              PROVIDER SIGNATURE:   /es/ DENISE GAMMA, MSW, LCSW
                                    Signed: Sep 28, 2009 15:07
_______________________________________________________________________________
  HR#:  WW 209022
  NAME:  JONES,AARON RAY                 SSN:
  SEX: MALE                  TRIBE: CHEROKEE NATION OF OKLAHOMA
  DOB:  Jul 21, 1996
  RESIDENCE:  MISSOURI UNK
  FACILITY: DEMO INDIAN HOSPITAL     LOCATION: SELLS CHS ADMIN.
  COMMENT/NEXT APPOINTMENT:
_______________________________________________________________________________
  BH POV CODE      PURPOSE OF VISIT (POV)
  OR DSM DIAGNOSIS    [PRIMARY ON FIRST LINE]
_______________________________________________________________________________
                   PROVIDER SIGNATURE:
  Jan 15, 2010                          BETTTA,LORI
Enter RETURN to continue or '^' to exit:
```

Figure 5-13: Sample encounter form output

5.1.6 Duplicate Group

1. At the “Select Action” prompt on the Group Encounter Documentation screen (Figure 5-2), type **3**. This creates a new group encounter.

   - To prevent inclusion of deceased patients in duplicated groups, the application will search the RPMS Patient Registration files for a Date of Death before displaying the patient’s name, case number, etc.
   - Duplicating a group containing signed SOAP/Progress Notes reverts the SOAP/Progress Notes associated with the new group encounter to the unsigned status.

   Note: The SOAP/Progress Note for each individual patient is actually the standard group note plus the individual entry completed on the Patient Data tab. When a group is duplicated, the standard group note is retained but the individual note added on the Patient Data tab (as well as any other changes made on that tab) is not.

2. At the “Select GROUP ENTRY” prompt, type the number corresponding to the group to duplicate

3. At the “Enter Date for the new group entry” prompt, type the date.

Figure 5-14 shows the Group Encounter Documentation screen as displayed:

```
*  GROUP ENCOUNTER DOCUMENTATION  *          DEMO INDIAN HOSPITAL
-----------------------------------------------------------------------
NOTE:  Please enter all standard information about this group activity.
After you leave this screen a record will be created for each patient.
At that time you can add additional information for each patient.

Add/View/Update Providers (Primary or Secondary) for this Group?  Y
Encounter Date: MAR 17,2009            Arrival Time: 12:00
Program: SOCIAL SERVICES               Community of Service: TAHLEQUAH
Group Name: MON DV  DG                 Clinic: MEDICAL SOCIAL SERVICES
Activity: 81                           Activity Time: 60
Encounter Location: DEMO INDIAN HOSPIT  Type of Contact: OUTPATIENT
POV or DSM (Primary Group Topic) <press enter>:
Chief Complaint/Presenting Problem:
Any Patient Education Done?  N         CPT Code(s) <press enter>:
S/O/A/P (Standard Group Note) <press enter>:
Patients <press enter>:
_____________________________________________________________________________

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

Figure 5-14: Sample Group Encounter Documentation screen

5.1.7 Add No Show Visit

1. At the "Select Action" prompt on the Group Encounter Documentation screen (Figure 5-14), type **7** and press Enter.

> **Note**: Any patient who is a no show or canceled should be removed from a duplicated group before the group documentation is completed.

2. At the "Select GROUP ENTRY (1-*x*)" prompt, type the number of the group ("*x*" being the number of the group).
3. At the "Select PATIENT NAME" prompt, type the name of the patient.
4. At the "Enter PRIMARY PROVIDER" prompt, type the primary provider name and the Behavioral Health Visit Update screen (Figure 2-4) displays. Refer to Section 4.1.3 for more information.

5.1.8 Sign Note

1. At the "Select Action" prompt on the Group Encounter Documentation screen, type **9** and press Enter to sign an unsigned SOAP/Progress note for a group encounter. Only the primary provider for the record can sign the note.
2. At the "Select Group Entry (1-*x*)" prompt, type the record number, ("*x*" being the number of the group).
3. If you are *not* the primary provider, the application displays the message in Figure 5-15:

```
You are not the primary provider for this group, no electronic
signature will be applied and no PCC link will occur.
The primary provider will need to sign these at a later time.
Press enter to continue....:
```

Figure 5-15: Message about the primary provider

4. Press Enter to return to the Group Entry window.

If there is a record but no visits were created for this group, the following message in Figure 5-16 displays:

```
There were no visits created for this group.
Press enter to continue....:
```

Figure 5-16: Message about no visits created

5. Press Enter to return to the **Group Entry** screen.

If the provider opted out of E-Signature, the message in Figure 5-17 displays:

```
No E-Sig Required. Provider opted out of E-Sig
```

Figure 5-17: Message when provider opted out of E-Signature

If you are the primary provider, the application displays the BH Visit Record Display window as shown in Figure 5-18:

```
BH VISIT RECORD DISPLAY       Aug 24, 2009 16:05:04       Page:   1 of 4

Patient Name:          ALPPHA,CHELSEA MARIE
Chart #:               116431
Date of Birth:         FEB 07, 1975
Sex:                   F
Patient Flag:          9
Flag Narrative:        99

=============== BH RECORD FILE ===============
DATE OF SERVICE:       JUL 09, 2009@09:55
PROGRAM:               MENTAL HEALTH
LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
COMMUNITY OF SERVICE:  TAHLEQUAH
ACTIVITY TYPE:         17
ACTIVITY TYPE NAME:    PSYCHOLOGICAL TESTING-PATIENT PRESENT
TYPE OF CONTACT:       OUTPATIENT
PATIENT:               ALPPHA,CHELSEA MARIE
PT AGE:                34
CLINIC:                MENTAL HEALTH
NUMBER SERVED:         1
+         Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action: +//
```

Figure 5-18: Sample BH Visit Record Display screen

6. At the “Select Action: prompt, type **Q** and press Enter. The following message displays: “Do you wish to edit this record?”

7. Type **Y**: to edit the record.

8. Type **N**: to not edit the record.

   - The application prompts: “Enter your Current Signature Code”. Refer to Section 2.14.6 for more information.

> **Note**: No Show notes are not included in this and must be signed individually.

5.1.9 Delete Group

- At the “Select Action” prompt, type **4** and press Enter to remove a group encounter record with an unsigned note. The application verifies that you want to delete the group encounter. Please note that the user must hold a specific key in order to delete group encounters with signed notes. Removing the group definition will also remove the related individual patient encounter records.

5.2 Group Entry Window (GUI)

Figure 5-19 shows the location of the **Group Encounter** function on the **RPMS Behavioral Health System** GUI tree structure.

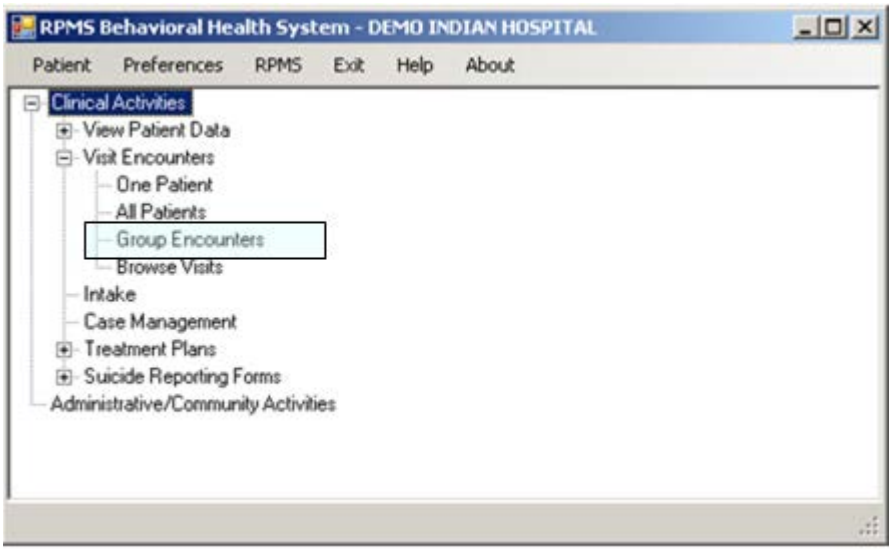


Figure 5-19: **Group Encounters** location on tree structure

- Click **Group Encounters** to access the **Group Entry** window.

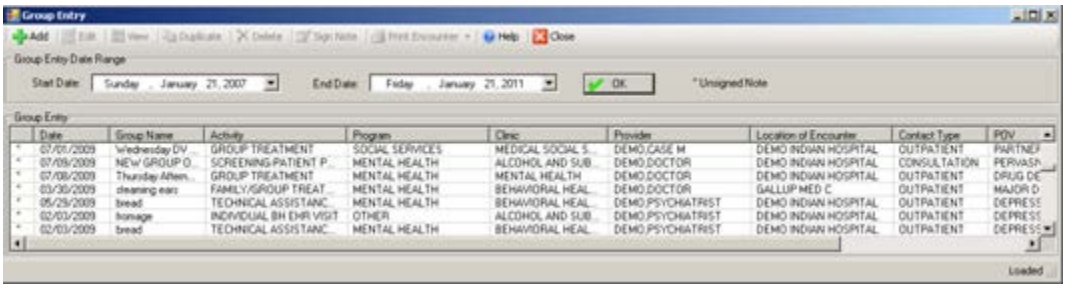


Figure 5-20: Sample **Group Entry** window

5.2.1 Group Entry Date Range Pane

The **Group Entry** window displays the group encounters in the date range shown in the Group Entry Date Range pane (default is one year). The default view is sorted by date +(from most recent).

1. Change the date range by accessing the calendar under the calendar list.
2. Click **OK**: the **Group Entry** pane updates.

5.2.2 Group Entry Pane

The Group Entry pane displays the records in the group entry date range.

The asterisk (*) in the first column indicates that the record contains an unsigned note. When you select this type of record, the **Sign Note** button becomes active. Refer to Section 2.14 for more information.

5.2.3 Add Button

- Click **Add** to add a new group encounter record and access the Group **Data Entry–Add Group Data** window. Refer to Section 5.3 for more information.

5.2.4 Edit Button

- Click **Edit** to change the highlighted group encounter record and access the **Group Data Entry–Edit Group Data** window.

5.2.5 View Button

- Click **View** (or double-click on a record) to view the highlighted group encounter record and access the **Group Data Entry–View Group Data** window.

5.2.6 Duplicate Button

You can duplicate an existing group encounter in order to create a new one. You will need to edit any information that would be different for the new encounter group.

- To prevent inclusion of deceased patients in duplicated groups, the application will search the RPMS Patient Registration files for a date of death before displaying the patient's name, case number, etc.
- Duplicating a group containing signed SOAP/Progress Notes causes the notes to revert to unsigned status (for the SOAP/Progress Notes associated with the new group encounter). The duplicated group will duplicate the standard group note only and not the individual patient group note.
- Select an existing group encounter and then click Duplicate. The application displays the Group Data Entry–Duplicate Group Data window.
- The fields are the same as those on the Group Data Entry–Add Group Data window. The duplicated group encounter will have a default date/time as the current date/time. Refer to Section 5.1.1 for more information.

5.2.7 Delete Button

> **Note**: Group Encounter records with signed SOAP/Progress Notes can only be deleted by users that have the AMHZ DELETE SIGNED NOTE security key.

1. Select a record and click **Delete**. The confirmation message: **Are You Sure** displays.
2. Click **Yes** to delete the record and remove the selected group encounter record from the pane. The group definition and all individual patient records will be removed
3. Click **No** and the record is not deleted.

5.2.8 Sign Note Button

1. Click **Sign Note** to sign a "unsigned" group encounter record (asterisk (*) in the first column). Refer to Section 2.14.5 for more information.
   - If the primary provider has opted out of E-Sig, the visit will pass to PCC, and the application displays the Message dialog displayed in Figure 5-21:

Figure 5-21: **Message** stating that the provider opted out of E Sig

   - The message indicates that an electronic signature is not required.
2. Click **OK** to leave the **Sign Note** process.

5.2.9 Print Encounter Button

Select the group encounter record you want to print and click Print Encounter. Here you will select one of the following: Full, Suppressed, Both Full and Suppressed.

The full option prints all data for the group encounter, including the SOAP note.

The suppressed report does *not* display the following information: Chief Complaint, SOAP note, measurement data, screenings.

Figure 5-22 shows the first page of the **Print Encounter Group** window.

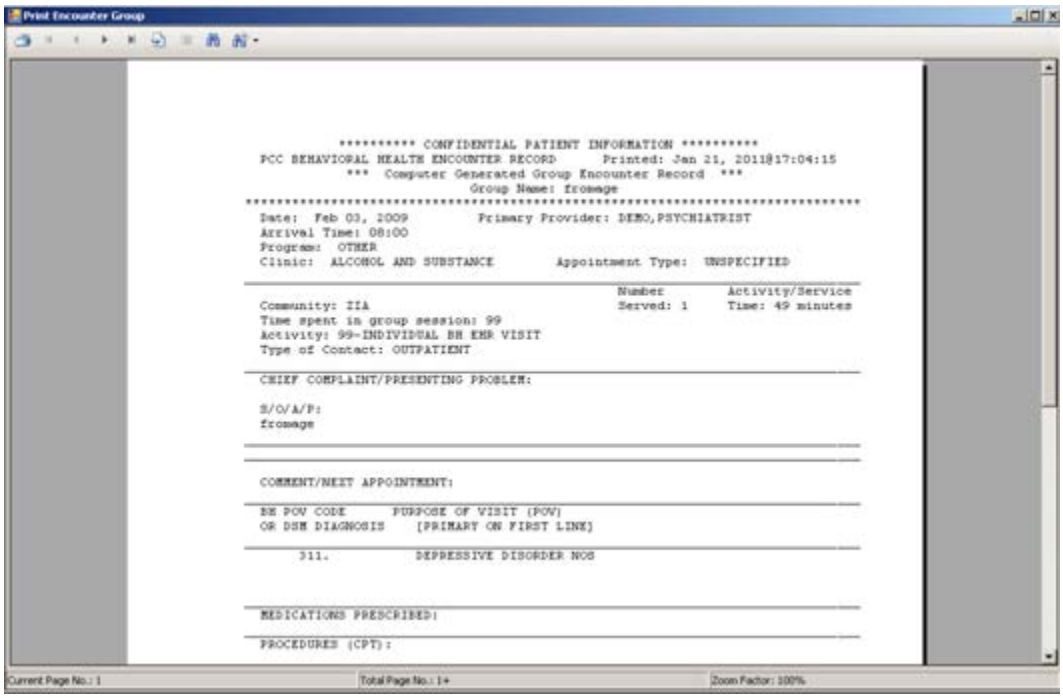


Figure 5-22: Sample **Print Encounter Group** pop-up window

Refer to Section 2.6 for more information.

5.2.10 Help Button

- Click **Help** to access the online help for the Group Entry window.

5.2.11 Close Button

- Click **Close** to exit the **Group Entry** window.

5.3 Add/Edit Group Data (GUI)

1. Do one of the following:

   - Click **Add** to add a new group data record and display the **Group Data Entry–Add Group Data** window (Figure 5-23).
   - Click **Edit** to change the group encounter record and display the **Group Data Entry–Edit Group Data** window.

Note:	All Patient Education entries created before the installation date for BHS v4.0 will continue to display the CPT field.

Figure 5-23 displays the **Group Data Entry–Add Group Data** window. (The same fields display on the **Group Data Entry–Edit Group Data** window.)

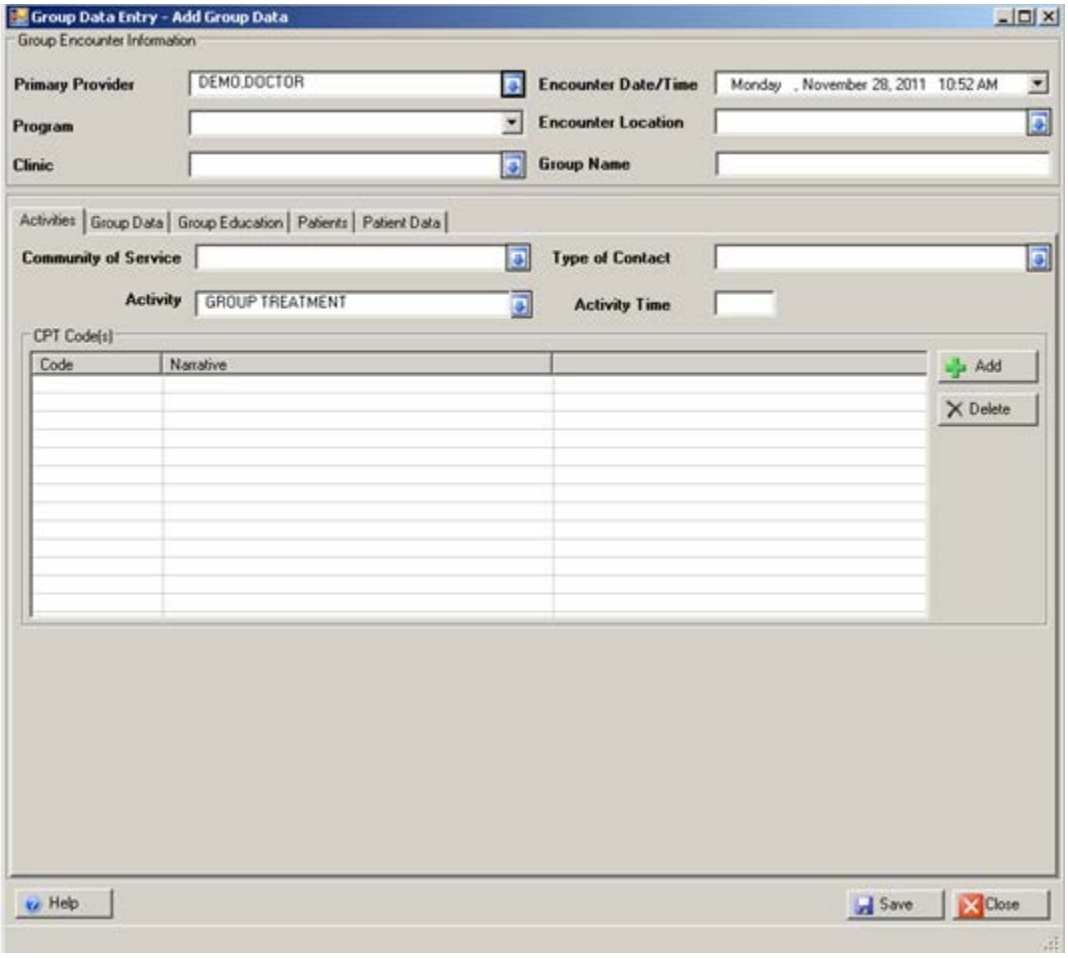


Figure 5-23: **Group Data Entry–Group Data** window

The fields in the **Group Encounter Information** pane on the **Edit Group Data** window will be active and will display the existing data (uneditable). All editing is completed in the **Group Encounter Information** pane or on the **Patient Data** tab if the group has already been saved.

- If the group has been signed the other fields, but not the note section, can still be edited.
- If you access an unsigned group data record, you can edit the note.
- Click **Help** to access online help.
- Click **Save** to save the edits and the **Add/Edit Group Data** window closes. If a SOAP/Progress note was added, the application will display the electronic signature dialog and proceed in the same manner as used for individual encounter records (**OK** or continue, etc.).

2. Click **Close** and the edits will not be saved. The **Continue?** confirmation displays: “Unsaved Data Will Be Lost, Continue?”

3. Do one of the following:

   - Click **Yes**: the record is not saved and the **Add Group Data** window closes.
   - Click **No**: to remain on the **Add Group Data** window and continue to work.

5.3.1 Group Encounter Information Pane

The add window shown in Figure 5-24 displays several active fields that can be changed on the **Edit Group Data** window.

Figure 5-24: Sample **Group Encounter Information** pane

1. Select a provider from the **Primary Provider** field.

2. Set the time and date in the **Encounter Date/Time** field.

3. Select the **Program** list and select one of the following:

   - **Mental Health**
   - **Social Services**
   - **Other**
   - **Chemical Dependency**

   After a program is selected, the application automatically populates the Clinic, Community of Service, Type of Contact, and Encounter Location fields if the defaults are set in the Site Parameters menu. These fields are read only.

4. Select the encounter from the **Encounter Location** field.

5. Select the clinic context from the **Clinic** field.

6. Select the name of the group encounter from the **Group Name** field.

5.3.2 Activities Tab

- Select the **Activities** tab shown in Figure 5-25 to identify the community of service, type of contact, activity, and activity code.
  - The information on this tab is read-only when using the **Edit Group Data** window.

5.3.2.1 Fields

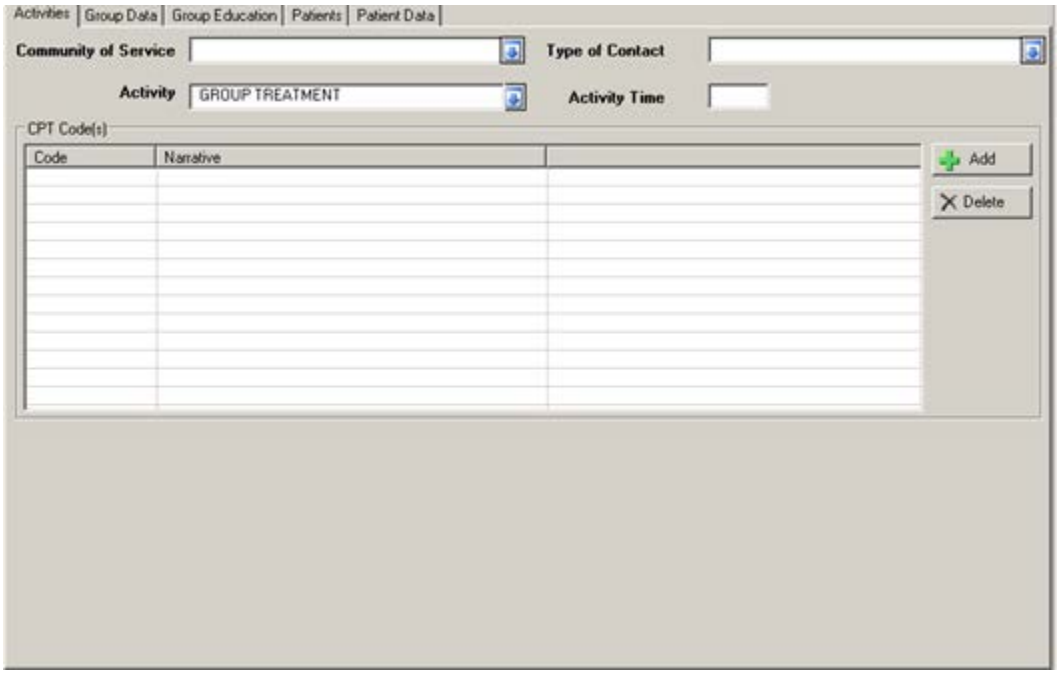


Figure 5-25: Sample **Activities** tab

1. Select a service from the **Community of Service** field.
2. Select the contact from the **Type of Contact** field.
3. Select the activity of the group encounter from the **Activity** field. Default is Group Teatment.
   - This field determines the activity for the group encounter. The default is Group Treatment. Change this field by clicking the drop-down list to access the Activity search window. Here you search for an activity name or its code.
4. Select the number of minutes from the **Activity Time** field.

5.3.2.2 CPT Codes Pane

1. Select the **CPT Code** pane to manage the CPT codes associated with the activity.
2. Click **Add** button to display the **CPT Code** search/select window.
3. Click **OK** to add to the CPT Codes pane.
4. Click **No** to cancel the process.
5. Select a code from the **CPT Codes** pane.
6. Click **Delete** button to delete a code from the **CPT Codes** pane. The confirmation **Are You Sure?** displays: “Are you sure you want to delete?”

7. Click **Yes** to remove the selected record.

8. Click **No** to cancel the process.

5.3.3 Group Data Tab

Select the **Group Data** tab (Figure 5-26) to identify a chief complaint, secondary providers, POV code, and group note.

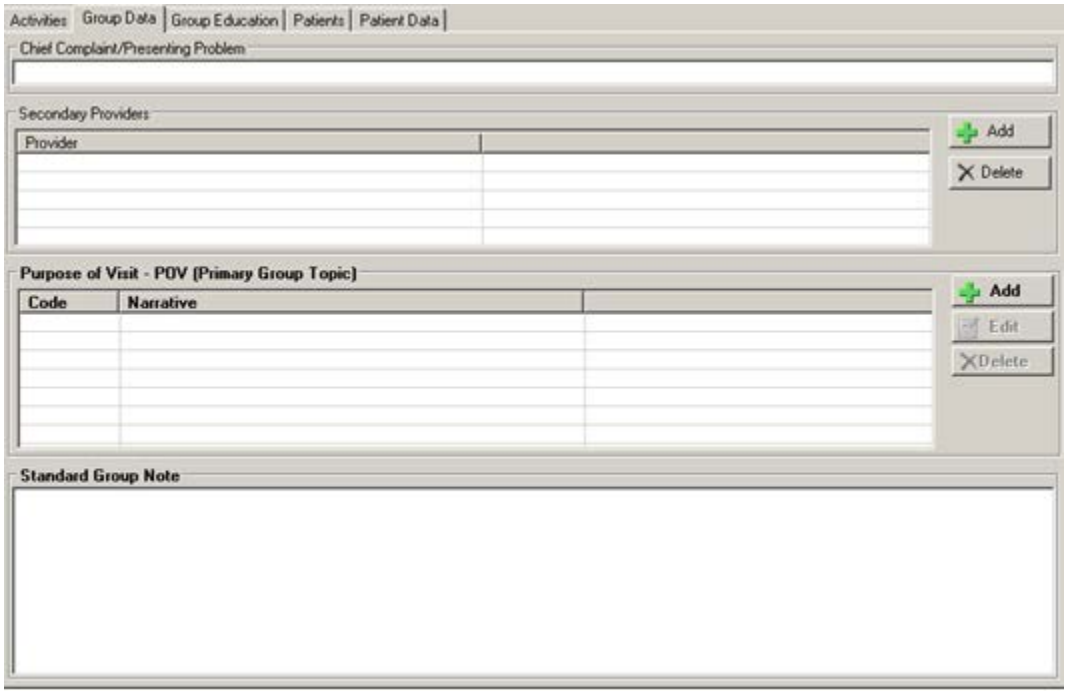


Figure 5-26: Sample **Group Data** tab

The data on the tab is read-only when using the **Edit Group Data** window.

5.3.3.1 Chief Complaint/Presenting Problem Pane

Type the chief complaint or presenting problem. This describes the major reason the patients in the group sought services.

5.3.3.2 Secondary Providers Pane

Add or delete providers on the **Secondary Providers** pane shown in Figure 5-27:

Figure 5-27: Sample **Secondary Providers** pane

1. Click **Add** access the **Secondary Provider** search/select window.

2. Click Delete to remove a secondary provider. The confirmation **Are You Sure?** displays: “Are you are sure you want to delete?”.

3. Click **Yes** to remove the selected provider

4. Click **No** to end the process..

5.3.3.3 Purpose of Visit - POV (Primary Group Topic) Pane

Select the **Purpose of Visit - POV (Primary Group Topic)** pane to manage the POV codes and narratives. These are POVs for all group members and will display as such on the **Patient Data** tab and the printed encounter record unless edited or deleted on the **Patient Data** tab.

A minimum of one POV record is required for a group encounter (Figure 5-28):

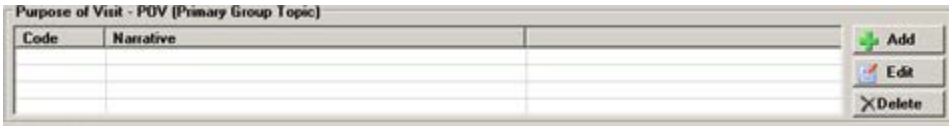


Figure 5-28: Sample **POV** pane

1. Click **Delete** to remove a POV record. The confirmation **Are You Sure?** displays: “Are sure you want to delete?”

   - Click **Yes** to remove the selected record.
   - Click **No** to end the process.

2. Click **Add** to access the **POV (Axis I/II)** search and select window. The Code and Narrative is populated for the record.

3. Select a record, click **Edit** to change the Narrative on the **Edit POV** dialog (Figure 5-29):

Figure 5-29: **Edit POV** dialog

   - Click **OK** to save the changes to the narriative.
   - Click **Close** to end the process.

> **Note**: Certain special characters (*,“,‘) cannot be the first character. In this case, none of these characters will populate the first character in the Narrative field (as you type).

5.3.3.4 Standard Group Note Pane

Select the **Standard Group Note** field to enter a group note.

- You must be on the **Patient Data** tab to do any editing after the group has been saved.

5.3.3.5 CPT Codes Pane

The information about this pane is covered in Section 5.3.2.2.

5.3.4 Group Education Tab

Select the **Group Education** tab (Figure 5-30) to add education data.

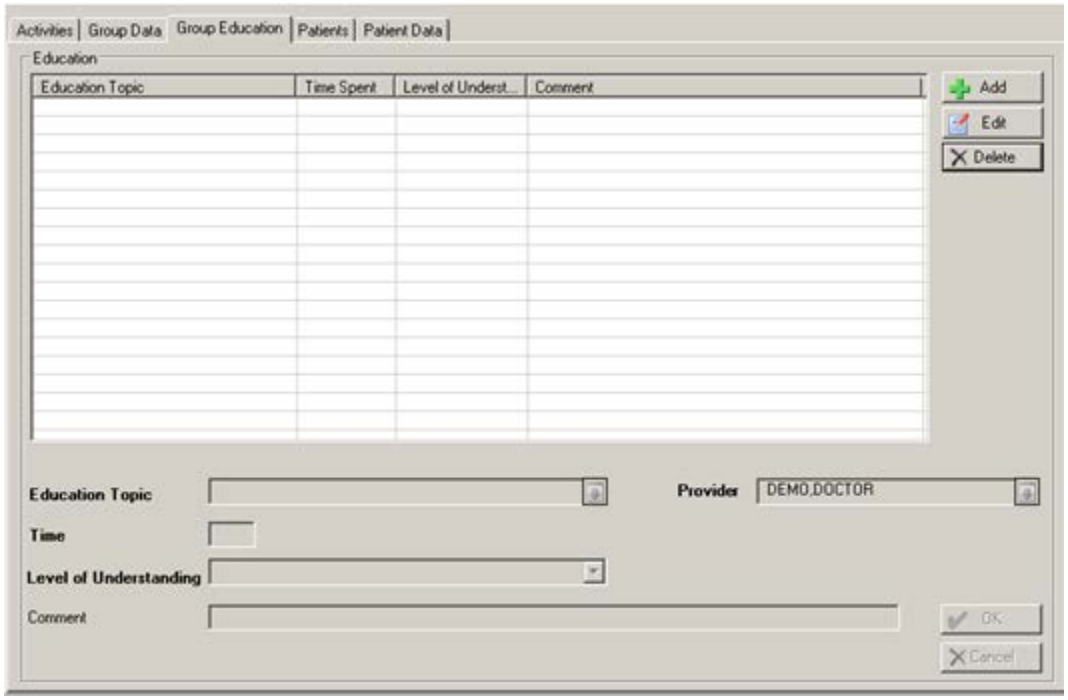


Figure 5-30: Sample **Group Education** tab

- The information on this tab is read-only when using the **Edit Group Data** window.

5.3.4.1 Add Group Education Record

1. Click **Add** on the **Group Education** tab to activate the fields on the tab (Figure 5-30).
2. Select a topic from the **Education Topic** field.
3. Select a provider from the **Provider** field.
4. Type a number in the **Time** field.
5. Select a Group-No Assessment from the **Level of Understanding** field.
6. At the **Comment** prompt, type any comments.
   - Click **Cancel** to clear the fields on the **Group Education** tab.
   - Click **OK** to add the record to the **Group Education**.

5.3.4.2 Edit Group Education Record

1. Highlight a record in the **Edit Group Education Record**.
2. Click **Edit** to display the information about the record in the fields

   Refer to Section 5.3.4.1 for more information.
3. Click **Delete** to remove a selected record. The confirmation **Are You Sure**? displays: "Are you sure you want to delete?"
4. Click **Yes** to remove the selected record
5. Click **No** to end the process.

Note:	The group education can be removed only prior to saving the group. Once the group has been saved, there is currently no way to remove it in the group format.

5.3.5 Patients Tab

The **Patients** tab (Figure 5-31) shows the patients in the group encounter.

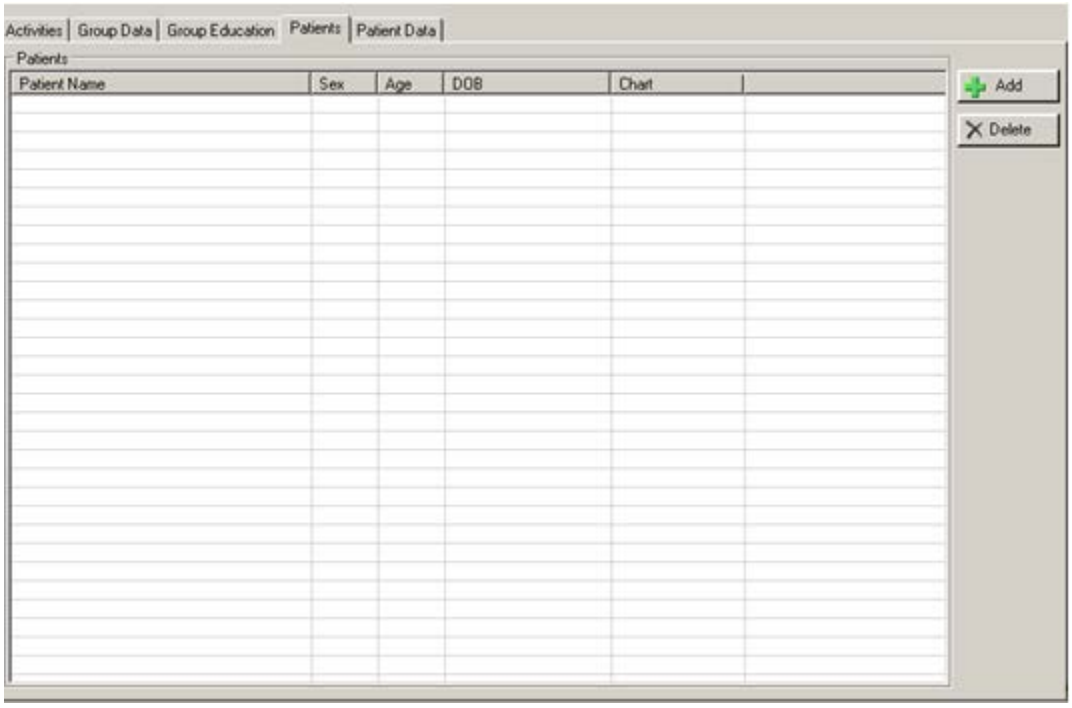


Figure 5-31: Sample **Patients** tab

- The information on this tab is read-only when using the **Edit Group Data** window.

5.3.5.1 Add Patient Record

The **Add** button requires that the **POV** pane and the **Standard Note Group Note** (on the Group Data tab) be populated.

1. Click **Add** to display the **Select Multiple Patients** dialog shown in Figure 5-32:

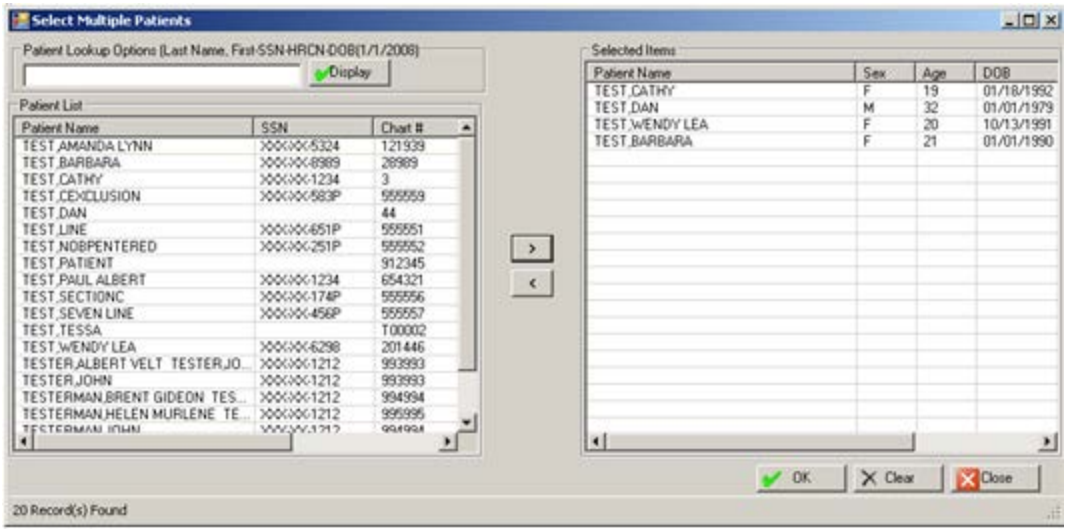


Figure 5-32: Sample **Select Multiple Patients** dialog

- You can add one or more patients to the **Patients** tab
- You can search for a patient by name, HRN, DOB, or SSN.

2. Click **OK** to add the patients names to the pane and close the dialog
3. Click **Clear** to remove the names from the pane and remain on the **Select Multiple Patients** dialog.
4. Click **Close** to end the process and close the dialog.

5.3.5.2 Delete Patient Record

1. Click **Delete** to remove a selected patient record. The confirmation **Are You Sure?** displays: “Are sure you want to delete?”
2. Click **Yes** to remove the selected patient record.
3. Click **No** to end the process.

- Leave clients who no showed or canceled in the group since it is possible to do the “no show” within the group definition on the **Patient Data** tab in the **Time In Activity** field.

5.3.6 Patient Data Tab

Select the **Patient Data** tab (Figure 5-33) to add POV, group note, comment/next appointment information, and CPT codes for a patient in the group encounter.

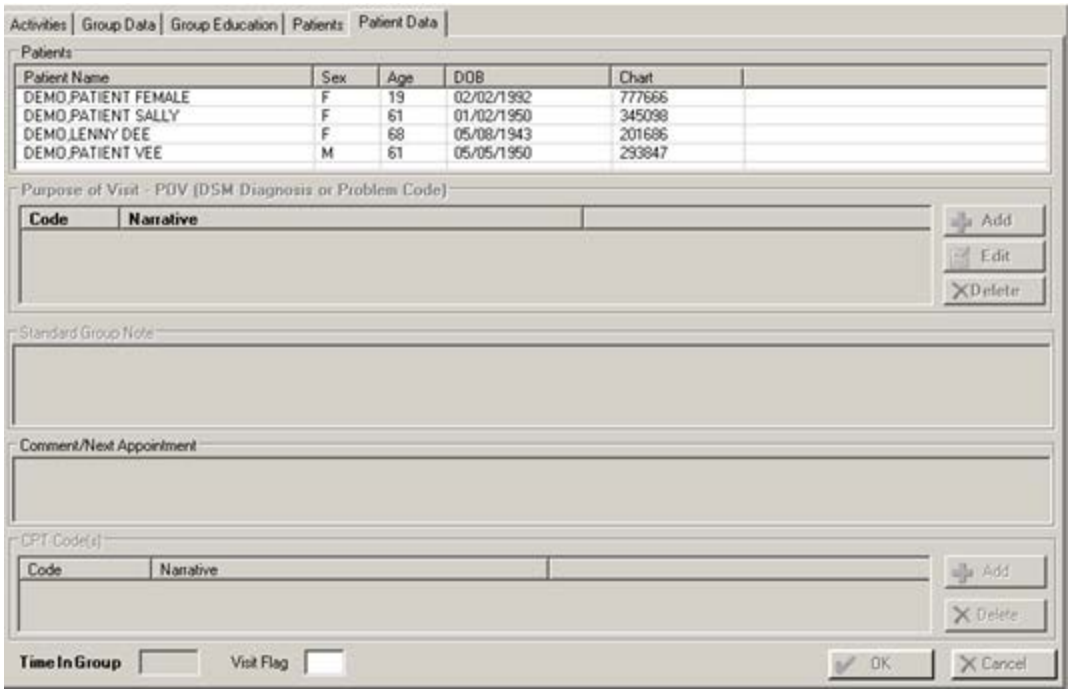


Figure 5-33: Sample **Patient Data** tab

1. Double click a patient name in the **Patients** pane.
2. Click **Save** to save the record.
3. Click **Cancel** to move to another part of the group data entry dialog.

5.3.6.1 Patients Pane

The **Patients** pane (Figure 5-34) shows the patients in the group encounter.

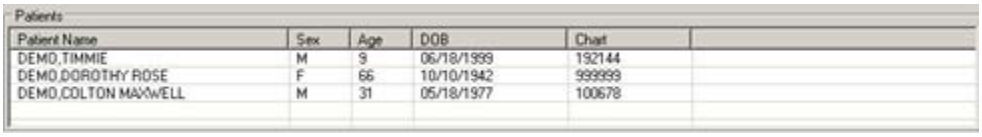


Figure 5-34: Sample **Patients** pane

1. Double click a patient name to access the othe panes.
2. Click **OK** and the cursor returns to the Patients pane. The last selected patient name is highlighted

- If you are in **ADD** mode and you click **OK** and then attempt to go to the Group Data tab, the **Continue** dialog displays (Figure 5-35):

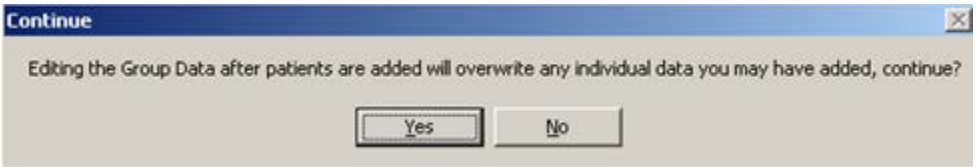


Figure 5-35: **Continue** Message

- Click **Yes** to overwrite any individual data. The **Patients Data** tab displays.
- Click **No** to end the process. The **Patients Data** tab displays.

5.3.6.2 Purpose of Visit - POV (DSM Diagnosis or Problem Code) Pane

Select the **Purpose of Visit - POV (DSM Diagnosis or Problem Code)** (Figure 5-36) pane to add, edit, or delete a POV. (You must double-click a patient name before you can add/change the data in this pane.)

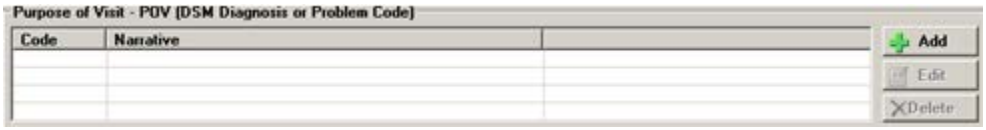


Figure 5-36: Sample **POV** pane

1. Click **Delete** to remove a selected POV. The confirmation **Are You Sure?** displays: “Are sure you want to delete?”
2. Click **Yes** to remove the selected record.
3. Click **No** to end the process.
4. Click **Add** to display the **Edit POV** (Axis I/II) search window and select POVs.
5. Click **Edit** to change the narrative text of the POV record shown in Figure 5-37:

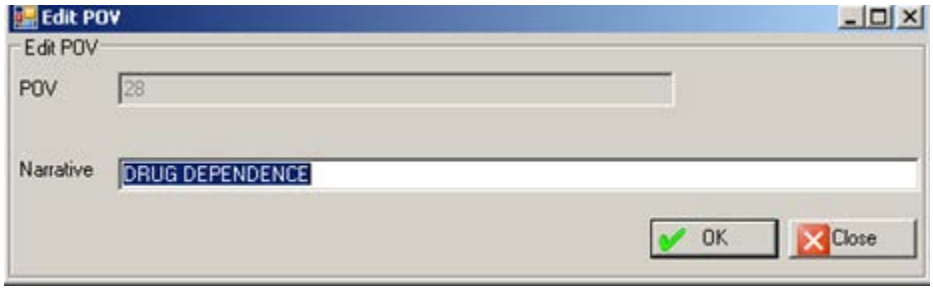


Figure 5-37: Sample **Edit POV** dialog

6. Click **OK** to accept the changes to the narrative.
7. Click **Close** to leave the narrative unchanged.

> **Note**: Certain special characters (like *,“,‘) cannot be the first character. In this case, none of these characters not populate the first character in the Narrative field (as you type).

5.3.6.3 Standard Group Note

This field will contain text of the **Standard Group Note** on the **Group Data tab**. You can add text about how the patient reacted in the group (on the Patient Data tab).

This is where the user individualizes the note for the patient in focus. The standard group note should never reference the individual patient but should have information about the individual patient’s participation in the group.

- This field is available for text entry by the primary provider of the record (only).
- This field is not available for text entry if the note for the group record is signed.

5.3.6.4 Comment/Next Appointment

Type the next appointment in the Comment/Next Appointment fieldfree text field with the text of any comments about the next appointment for the selected patient.

5.3.6.5 CPT Codes Pane

1. Select the **CPT Codes** pane to manage the codes for the selected patient.
2. Click **Add** to display the search or select window and add one or more codes.
3. Select a record and click **Delete**. The confirmation **Are You Sure?** displays: “Are sure you want to delete?”
4. Click **Yes**: to remove the selected record.
5. Click **No**: the selected record is not removed.

5.3.6.6 Time in Group

The **Time-in-Group** field (Figure 5-38) displays the number of minutes in the group encounter.

Figure 5-38: Sample **Time in Group** field

1. Do one of the following:
   - If the patient attended the whole group session, make no changes.

- If the patient was late or left early, change the field to reflect the actual time in minutes.
- Type a **0** in the field if the patient did not attend the encounter. The **No Show** message displays: “Changing Time in Group to zero removed this patient’s POV and Note entry. You will now be prompted for a No Show POV”.

2. Click **OK** to display the **POV (Axis I/II)** search or select window.
3. Select one or more “no show” POVs.
4. Click **OK** to accept the entries and the selected POVs will display in the **Purpose of Visits – POV** pane on the **Patient Data** tab
5. Click **Cancel** to end the process.

5.3.6.7 Visit Flag

Use the **Visit Flag** field to specify the visit flag by using any number between 0 and 999 (no decimal digits). This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a **1** might mean any visit on which a narcotic was prescribed. You can then, later on, retrieve all visits with a flag of **1** which will list all visits on which narcotics were prescribed.

6.0 Case Management

This section provides information about case management in the roll-and-scroll application, as well as in the RPMS Behavioral Health System GUI.

6.1 Managing Case Data (Roll and Scroll)

Manage case data on the Patient Data Entry window by selecting the Update Case Data (CD) action. The application displays the Update BH Patient Case Data screen shown in Figure 6-1:

```
Update BH Patient Case Data   Mar 23, 2009 15:27:33          Page:    0 of    0
-------------------------------------------------------------------------------
Patient Name: DEMO,DOROTHY ROSE   DOB: OCT 10, 1942   Sex: F   HRN: 99999
-------------------------------------------------------------------------------

#   PROGRAM  OPEN      ADMIT     CLOSED   DISPOSITION           PROVIDER
1   CHEMIC   10/16/09
2   OTHER    10/6/09                                            BETA,BETAA
3   MENTAL   9/30/09
4   SOCIAL   9/1/09                                             GAMMAAA,DENISE
    COMMENT: Ind case opened. Group therapy 1 x week.  **
    Primary Problem: 43.1 PARTNER ABUSE (SUSPECTED),PH  Next Review: S
5   MENTAL   8/28/09   8/28/09                                 THETAAAA,MARK
    COMMENT: TEST COMMENT AGAIN **
    Primary Problem: 300.00 ANXIETY DISORDER NOS        Next Review: 9/28/09
6   MENTAL   8/28/09   8/28/09   8/28/09  MUTUAL AGREEMENT TO   BETTTAA,LORI
    Primary Problem:                                    Next Review: 8/28/09
7   MENTAL   8/28/09             8/28/09  PATIENT DROPPED OUT
8   MENTAL   8/28/09                                            GAMMAAAAA,DENISE
         ?? for more actions  + next screen  - prev screen
OP   Open New Case        DC   Delete Case
ED   Edit Case Data       Q    Quit
Select Item(s):
```

Figure 6-1: Sample Update BH Patient Case Data screen.

- At the “Select Item” prompt, the Type **Q** and press Enter to exit the Update BH Patient Case Data screen.

6.1.1 Open New Case (OP)

1. Type **OP** and the Update Patient Case Datae screen shown in Figure 6-2 displays.
2. At the “Select Item” Enter Case Open Date” prompt, type the date to open the case. The Update Patient Case Data screen displays Figure 6-2:

```
                  **********   UPDATE PATIENT CASE DATA   *********
 Patient Name: ALPHAA,CHELSEA MARIE

***********************************************************************
                    CASE OPEN DATE: MAY 23,2009
               PROGRAM AFFILIATION: MENTAL HEALTH
```

```
                     PROVIDER NAME:
                   PRIMARY PROBLEM:

                   CASE ADMIT DATE:
              NEXT CASE REVIEW DATE:

                  DATE CASE CLOSED:
                       DISPOSITION:

COMMENT:
_____________________________________________________________________________

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

Figure 6-2: Sample Update Patient Case Data window

3. At the “Case Open Date” prompt, type the date the case was opened.
4. At the Program Affiliation, type one of the following:
   - **M** Mental Health Defaults
   - **S** Social Services Defaults
   - **C** Chemical Dependency or Alcohol/Substance Abuse
   - **O** Other
5. At the “Provider Name” prompt, type the name of the provider.
6. At the “Primary Problem” prompt, type the name or code.
7. At the “Case Admit Date” prompt, set the date.
8. At the “Next Case Review Date” prompt, type the next date for the review.
9. At the “Date Case Closed” prompt, set the date.
10. At the “Disposition” prompt, type the reason for closing the case.
11. At the “Comment” prompt, type any comments about the case.

6.1.2 Edit Case Data (ED)

- Type **Edit Case Data (ED)** to change a selected case.
  - Use this option to edit an open case where you enter the admitted date when a case is admitted or to close the case when it is closed on the Update Patient Data window. The fields on this window are the same as those when you use the Open New Case option. Refer to Section 6.1.1 for more information.

6.1.3 Delete Case (DC)

Type **DC** (Delete Case) to remove a case from the Update BH Patient Case Data window.

6.2 Designated Provider/Flag/Personal History (Roll and Scroll)

1. Type **OI** (Desg Prov/Flag/Pers Hx) at the **Patient Data Entry** screen Figure 6-3) to display the update Patient Information screen.

```
               *******  UPDATE PATIENT INFORMATION  *******
              Patient Name: DEMO,DARRELL LEE
              [press <F1>E when finished updating record]
_____________________________________________________________________


  DESIGNATED MENTAL HEALTH PROVIDER:
DESIGNATED SOCIAL SERVICES PROVIDER:
        DESIGNATED CD A/SA PROVIDER:
          DESIGNATED OTHER PROVIDER:
      OTHER PROVIDER NON-RPMS:
      OTHER PROVIDER NON-RPMS:
   ====================================================================

 PATIENT FLAG FIELD:
 PATIENT FLAG NARRATIVE:


_____________________________________________________________________


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

Figure 6-3: Sample Update Patient Information screen

2. At the “Designated Mental Health Provider” prompt, type the RPMS provider accepted to designate Mental Health provider status.
3. At the “Designated Social Services Provider” prompt, type the provider who accepted the designated Social Services provider.
4. At the “Designated CD A/SA Provider” prompt, type the provider who accepted the designated Chemical Dependency or Alcohol/Substance Abuse provider status.
5. At the “Designated Other Provider” prompt, type the provider who has accepted the designated Other provider status.
6. At the “Other Provider Non-RPMS” prompt, type another Behavioral Health provider not listed in RPMS.

7. At the “Patient Flag Field” prompt, type the number used to identify a specific group of patients.
8. At the “Patient Flag Narrative” prompt, type the narrative about the patient flag.
9. Type Save or Exit at the **Update Patient Information** window and the **Personal History** window.
   - If necessary, add a personal history factor.If the patient has an existing Personal History entry, the application displays this information (the date and the personal history factor). You can add another personal history factor, if needed.
10. At the “Enter Personal History” prompt, type the personal history factor for the current patient.
    a. If you do not want to add another personal history, type the caret (^) at the prompt. After you have completed the personal history entry, you return to the Patient Data Entry window.

    The personal history data entered here appears on the Patient List for Personal Hx Items report.

6.3 Case Management Window (GUI)

Figure 6-4 shows where the Case Management function is located on **RPMS Behavioral Health System** GUI tree structure.

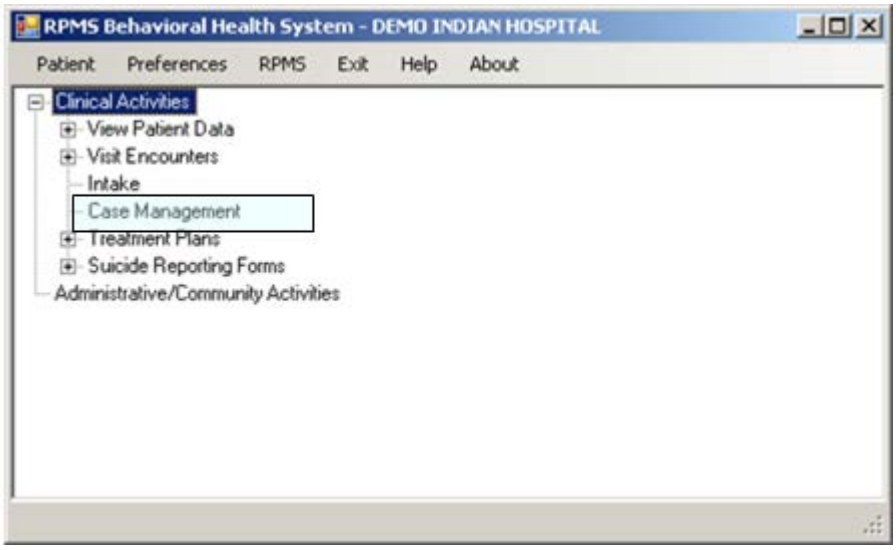


Figure 6-4: Case Management option on the **RPMS Behavioral Health System** GUI tree structure

Select Case Management to display the **Case Management** (Figure 6-5) for the current patient.

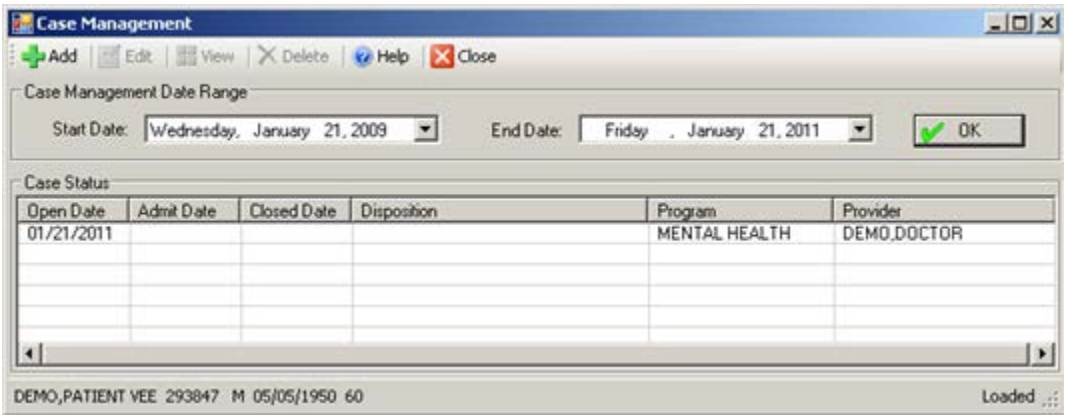


Figure 6-5: Sample **Case Management** window

6.3.1 Case Management Date Range

The **Case Status Date Range** pane displays the management records

1. Set the date at the **Start Date** field.
2. Set the date at the **End Date** field.
3. Click **OK** to update the **Case Status** pane.

6.3.2 Case Status Pane

The **Case Status** pane displays the case management records.

6.3.3 Add Button

Click **Add** to insert a new record and the **Case Management–Add Case** window displays. Refer to Section 6.4 for more information.

6.3.4 Edit Button

Click **Edit** to edit a record and the **Case Management–Edit Case** window displays.

6.3.5 View Button

Click **View** (or double-click on a record) to view the data for a record and the **Case Management–View Case** window displays. Refer to Section 6.4 for more information.

6.3.6 Delete Button

Click **Delete** to remove a selected record. The confirmation: **Are You Sure?** displays: "Are you sure you want to delete?"

- Click **Yes**: to remove the record.
- Click **No**: the record is not removed.

6.3.7 Help Button

Click **Help** to access the online help system.

6.3.8 Close Button

Click **Close** to dismiss the Case Management window.

6.4 Add or Edit Case Management Data (GUI)

1. Click **Add** to display the **Case Management–Add Case** window (Figure 6-6).
2. Select a record and click **Edit** to edit the record.

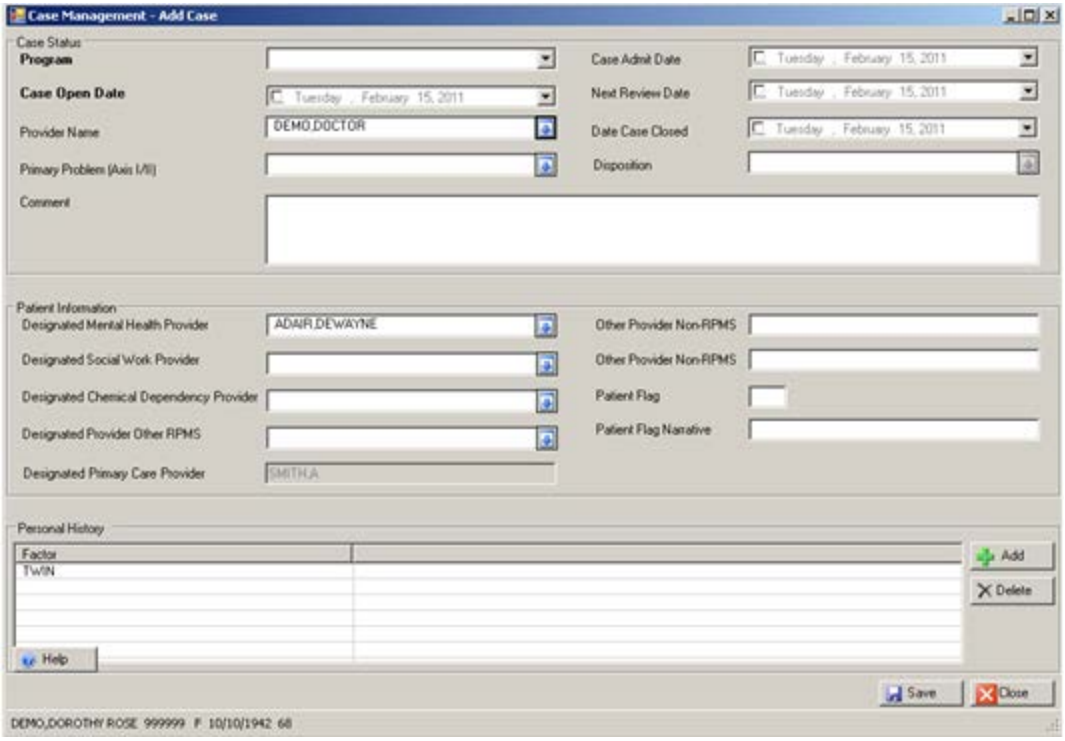


Figure 6-6: Sample **Case Management–Add Case** window

3. Complete the **Case Status** pane (Figure 6-7). The **Program** and **Case Open Date** fields are required:

Figure 6-7: Fields in Case Status pane

a. Select from the options in the **Program** field.

b. Set the date at the **Case Admit Date** field and follow the instructions Section 2.7. Accept the default by clicking the box.

c. Set the **Case Open Date**.

d. Set the **Next Review Date**.

e. Select the **Provider Name** field to display the **Primary Provider** search dialog (Section 2.8).

f. Set the **Date Case Closed**.

g. Select the **Primary Problem (Axis I/II)** field to display the **Primary Problem/POV** search dialog.

h. Select the **Disposition** field to display the **Disposition** search dialog.

i. Type a comment in the **Comment** field.

4. Complete the **Patient Information** pane (Figure 6-8) to provide information about various providers and other case management information.

Figure 6-8: Fields in the **Patient Information** pane

> **Note**: Clear the fields whenever the case is closed; otherwise, the patient will continue to show up on the provider's case list. To clear the field, right-click and select **Clear**.

a. Select the **Designated Mental Health Provider** field to display the **Designated Mental Health Provider** search dialog.

b. Type the Behavioral Health provider not listed in RPMS at the **Other Provider Non-RPMS** prompt.

c. Select the **Designated Social Work Provider** field to display **Designated Social Work Provider** search dialog.

d. Type the provider not listed in RPMS at the **Other Provider Non-RPMS** field.

e. Select the **Designated Chemical Dependency Provider** fuekdto access the **Designated Chemical Dependency Provider** search dialog.

f. Type the defined number to identify the group in the **Patient Flag** field.

- For example, **1** could designate patients with a family history of substance abuse, **2** could be used to identify patients enrolled in a special social services program, **3** could be used to identify patients enrolled in a special drug trial.
- In a program consisting of social services and mental health components, agreement must be reached on use of the flags or users might discover that the same flag has been used for multiple purposes.

g. Select the **Designated Provider Other RPMS** field to display the **Designated Provider Other RPMS** search dialog.window.

h. Type the patient narrative in the **Patient Flag Narrative** field.

i. The **Designated Primary Care Provider** field is read only and displays the name of the designated primary care provider for the patient.

5. Complete the **Personal History** pane (Figure 6-9) by adding or deleting personal history data about the current patient.

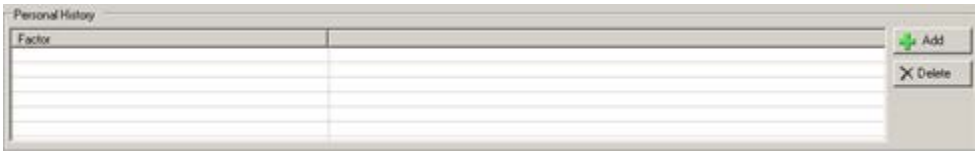


Figure 6-9: Sample **Personal History** pane

- You only need to document personal history once, as it becomes a permanent part of the patient's medical record.

a. Click **Add** to display the **Personal History Factors** window.

b. Click **Delete** to remove a selected personal history record. The confirmation **Are You Sure?** displays: "Are you are sure you want to delete?"

- Click **Yes** to remove the selected record.
- Click **No** to end the process.

6. Click **Save** to save the case management information, the **Case Management** dialog closes.

7. Click **Close**: confirmation dialog **Continue?** displays: "Unsaved Data Will Be Lost, Continue?"

- Click **Yes,** the data is not save and the **Add Case** window closes.
- Click **No**, the **Add Case** window remains open.

8. Click **Help** to access the online help.

7.0 Administrative/Community Activity

The Administrative/Community Activity option gives assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems.

7.1 Add Administrative/Community Activity Record (Roll and Scroll)

The **AC** (Add Adm/Comm Activity) is found under SDE on the BH data entry window.

1. At the "Enter Primary Provider" prompt, type the primary provider for the visit. The default is the current logon user.

The application displays the Behavioral Health Record Update screen (Figure 7-1), with the following fields automatically populated: Program, Clinic, Location of Encounter, Arrival Time, Secondary Providers, Community of Service, # Served, Type of Contact. These fields are autopopulated based on the defaults set up on the site parameters menu. If you do not have defaults set up on the site parameters menu, some of these fields might be blank.

```
                        * BEHAVIORAL HEALTH RECORD UPDATE *
Encounter Date: MAR 31,2009                      User: THETA,SHIRLEY
[press <F1>E when visit entry is complete]
-----------------------------------------------------------------------------
PROGRAM: SOCIAL SERVICES                    CLINIC:  MEDICAL SOCIAL SERVICES
              LOCATION OF ENCOUNTER: DEMO INDIAN HOSPITAL
                       ARRIVAL TIME: 12:00
                         FLAG FIELD:
            Any SECONDARY PROVIDERS? N
               COMMUNITY OF SERVICE: TAHLEQUAH
                      ACTIVITY CODE:        # SERVED: 1
                      ACTIVITY TIME:
                    TYPE OF CONTACT: SCHOOL
                  LOCAL SERVICE SITE:
Any Prevention Activities to Record? N
PURPOSE OF VISIT (POVS) <press enter>:
COMMENT (press enter):
```

Figure 7-1: Sample Behavioral Health Record Update

2. At the "Program" prompt, type the program associated with the record.
3. At the "Clinic" prompt, type the response included in the RPMS clinic code set.
4. At the "Location of Encounter" prompt, type the location of the encounter.
5. At the "Arrival Time" prompt, type the time of the encounter.
6. At the "Flag Field" prompt, type a numeric value.

- This indicates any local flag (0 to 999) used in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. For example, a **1** might mean any visit on which a narcotic was prescribed. Any Secondary Providers?

7. Type **Y** to display the **Enter/Edit Providers of Service** screen shown in Figure 7-2:

```
              *******  ENTER/EDIT PROVIDERS OF SERVICE  *******

Encounter Date: MAR 31,2009@12:00      User: THETA,SHIRLEY

-----------------------------------------------------------------------

PROVIDER: DEMO,DOCTOR                          PRIMARY/SECONDARY: PRIMARY
PROVIDER:                                      PRIMARY/SECONDARY:
PROVIDER:                                      PRIMARY/SECONDARY:
PROVIDER:                                      PRIMARY/SECONDARY:
PROVIDER:                                      PRIMARY/SECONDARY:
PROVIDER:                                      PRIMARY/SECONDARY:


_____________________________________________________________________


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

Figure 7-2: Sample Enter/Edit Providers of Service screen

8. At the “PROVIDER:” prompt, type the name of the providers..
9. At the “PRIMARY/SECONDARY: Use SECONDARY:” prompt, type any secondary providers. The BEHAVIORAL HEALTH RECORD UPDATE screen in Figure 7-1 displays.
10. At the “Community of Service” prompt, type the location of the encounter.
11. At the “Activity Code” prompt, type the activity code associated with the encounter. Refer to Appendix A: 1.1.1.1.1Appendix A: Activity Codes and Definitions for more information.
12. At the “# Served” prompt, type the number of people served in the activity.
13. At the “Activity Time” prompt, type the number of minutes spent on the activity.

Note: 0 (zero) is not allowed as a valid entry.

14. At the “Type of Contact” prompt, type the activity setting.
15. At the “Local Service Site” prompt, type the site for the encounter.

16. At the “Any Prevention Activities to Record?” prompt, type **Y** and the **Prevention Activities** screen shown in Figure 7-3 displays:

```
Please enter all Prevention Activities

PREVENTION ACTIVITY:
PREVENTION ACTIVITY:
PREVENTION ACTIVITY:


TARGET:
```

Figure 7-3: **Prevention Activities** screen

- The Target field will be disabled until a Prevention Activity is entered. In addition, the Target field will be disabled if all of the prevention activities are deleted.

17. At the “PREVENTION ACTIVITY” prompt, type the code for the prevention activity. These activities are recorded when recording non-patient activities.

18. At the “TARGET” prompt: type the population the prevention activity is designed for:

- **A** (Adult)
- **Y** (Youth)
- **F** (Family)
- **M** (Mixed Adult & Youth)
- **S** (Staff)
- **E** (Elderly Only)
- **W** (Women)

19. At the “Purpose of Visits (POVS)” prompt, press Enter. The BH Record Entry–Purpose of Visit Update screen in Figure 7-4 displays.

```
    ******* BH RECORD ENTRY -  PURPOSE OF VISIT UPDATE *******

 Encounter Date: MAR 31,2009@12:00   User: THETA,SHIRLEY
 [press <F1>C to return to main screen]
-----------------------------------------------------------------------------

 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:
 PROBLEM CODE:        NARRATIVE:

_____________________________________________________________________________
```

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

Figure 7-4: Sample BH Record Entry POV screen

20. At the “PROBLEM CODE” prompt: type the problem code defines either the Behavioral Health Purpose of Visit or the more specific DSM IV diagnostic code.

21. At the “NARRATIVE” prompt, type the narrative for the problem code.

The prompts for the Behavioral Health Record Update screen (Figure 7-1) continue.

22. At the “COMMENT (press enter) prompt, press Enter to display a secondary window and entery comments about the Administrative/Community Activity.

7.2 Administrative/Community Activity Window (GUI)

Figure 7-5 shows where the Administrative/Community Activities function is located on R**PMS Behavioral Health System** GUI tree structure.

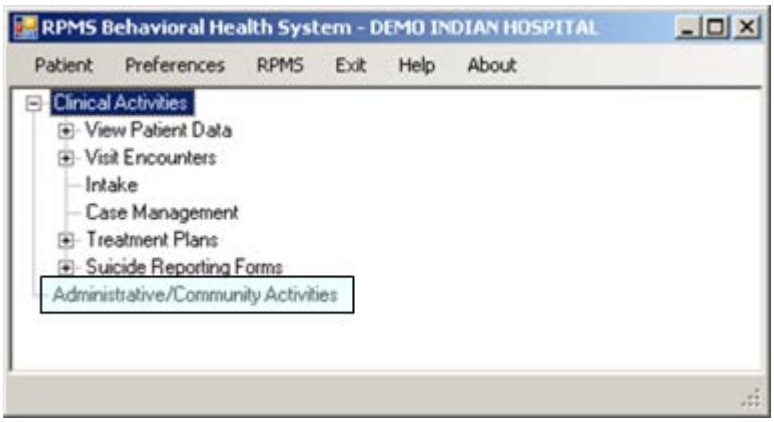


Figure 7-5: A**dministrative/Community Activities** option on the RPMS Behavioral Health System GUI tree structure

Select Administrative/Community Activities from the RPMS Behavioral Health System GUI tree structure (Figure 7-5), the **Administrative/Community Activity** in Figure 7-6 displays.

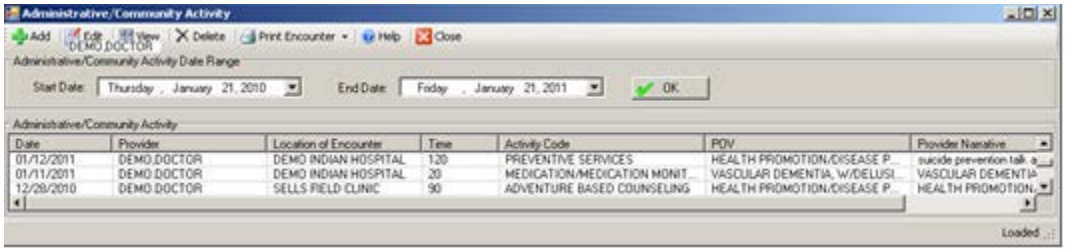


Figure 7-6: Sample Administrative/Community Activity window

The Administrative/Community Activity window shows the administrative and community activities records.

7.2.1 Administrative/Community Activity Date Range

The **Administrative/Community Activity Date Range** pane shows the date range for the records in the Administrative/Community Activity pane.

1. Select the Start Date field and set a date, if necessary.
2. Select the End Date field and set a date, if necessary.
   - Click **OK** and the records in the pane display

7.2.2 Administrative/Community Activity Pane

The records are listed in date order, within the administrative/community activity date range.

7.2.3 Add Button

Click **Add** to add a new administrative/community activity data record. You access the Administrative/Community Activity Data Entry–Add Administrative/Community Data. Refer to Section 7.3 for more information.

7.2.4 Edit Button

Click **Edit** to edit a new administrative/community activity record. This function displays the Administrative/Community Activity Data Entry–Edit Administrative/Community Data. This window has the same fields as the Administrative/Community Activity Data Entry–Add Administrative/Community Data.

7.2.5 View Button

Highlight an administrative/community activity record on the Administrative/Community Activity window and click **View** to browse the data (or double-click on a record). The Community Activity Data Entry–View Community Data window displays; this is a view-only window. The fields are the same as for the data entry (add/edit) windows. Click **Close** to exit the window.

7.2.6 Delete Button

Click **Delete** to delete a record. The deletion is confirmed.

7.2.7 Print Encounter Button

Click **Print Encounter** to print/browse an administrative/community activity record. Highlight the record and click Print Encounter. Select one of the following options: Full, Suppressed, Both Full and Suppressed. The first page of the output displays on the Print Encounter pop-up window as shown in (Figure 7-7).

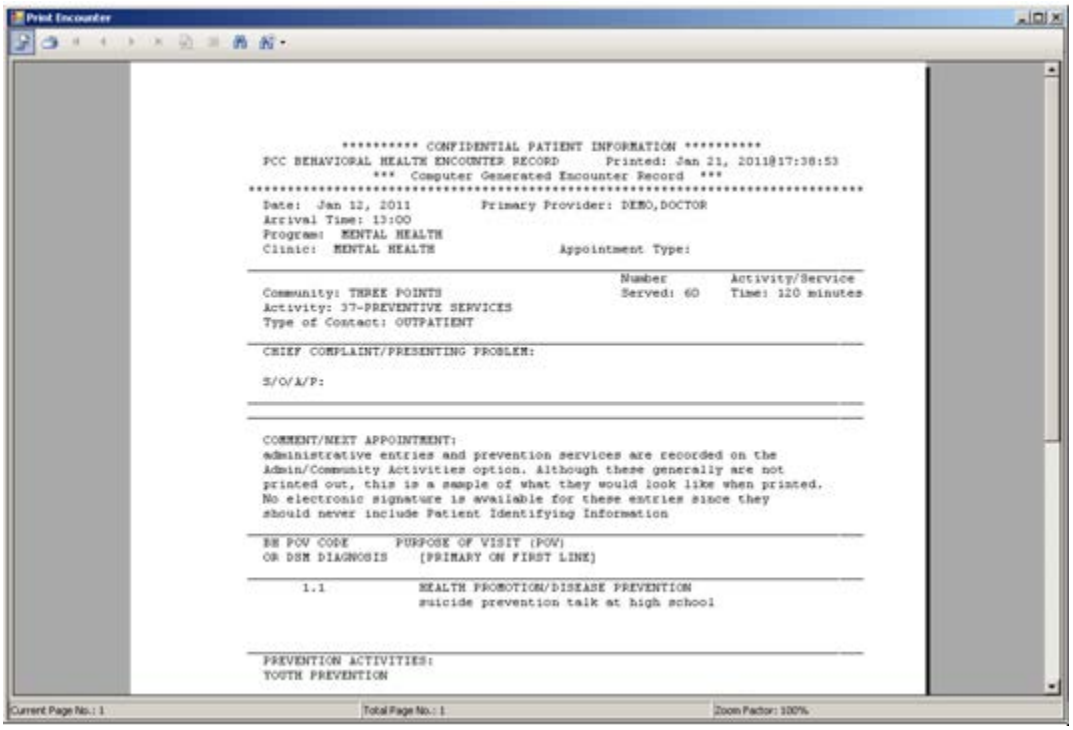


Figure 7-7: Sample output for a selected **Administrative/Community Activity** record

Refer to Section 2.6 for more information.

7.2.8 Help Button

Click **Help** to access the online help system.

7.2.9 Close Button

Click **Close** to exit the **Administrative/Community Activity** window.

7.3 Add or Edit Administrative/Community Activity (GUI)

1. Click **Add** on the Administrative/Community Activity window (Figure 7-5) to add new administrative/community activity data. This function displays the Administrative/Community Activity Data Entry–Add Administrative/Community Data window shown in Figure 7-8.

2. Highlight a record (on the Administrative/Community Activity window) and click **Edit** to change the administrative/community activity data. This function displays the Administrative/Community Activity Data Entry–Edit Administrative/Community Data window.

   - This window has the same fields as the **Administrative/Community Activity Data Entry–Add Administrative/Community Data**.

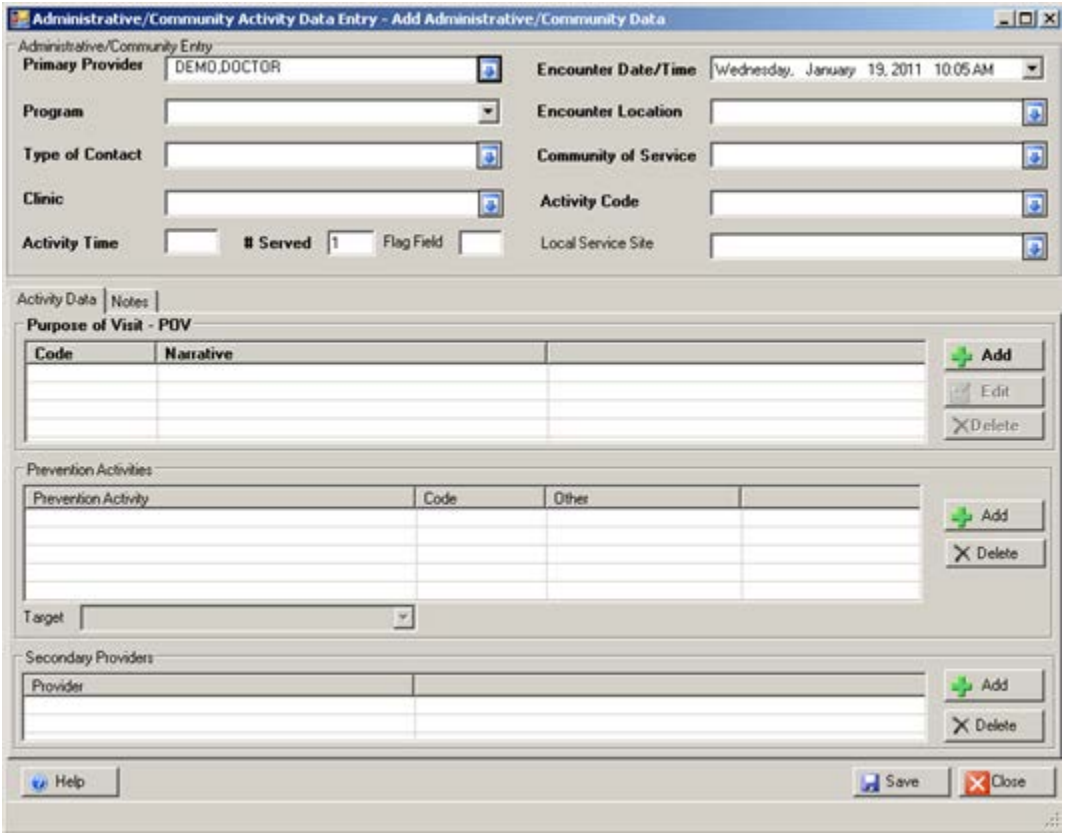


Figure 7-8: Sample **Community Activity Data Entry–Add Community Data** window

3. Click **Help** to access the online help.

4. Click **Save** to add the record.

5. Click **Cose** and the record is not saved.

7.3.1 Administrative/Community Entry Pane

Figure 7-9 shows the **Administrative/Community Entry** pane.

Figure 7-9: Sample **Community Entry** pane

1. Select a provider for the administrative/community activity from the **Primary Provider** field.
2. Set a date in the **Encounter Date/Time** field, if necessary.
3. Select the **Program** field and type one of the following:
   - **Mental Health**
   - **Social Services**
   - **Other**
   - **Chemical Dependency** to continue
4. Select a location where the administrative/community activity took place in the **Encounter Location** field.
5. Select an activity setting in the **Contact field** field.
6. Select a location from the **Community of Service** field.
7. Select a clinic from the **Clinic** field.
8. Select a code associated with the administrative/community from the **Activity Code** field.
9. Type the number of minutes in the **Activity Time** field.
10. Type the number of people served in the activity in the **# Served** field.
11. Type a numeric value in the **Flag** field.
    - This field is for local use in flagging various types of visits. The site will define a numeric value to indicate the definition of the flag. As an example, **1** might mean any visit on which a narcotic was prescribed.
12. Select the site associated with the administrative/community activity from the **Local Service Site** field.

7.3.2 Activity Data Tab

Select the **Activity Data** tab (Figure 7-10) to specify the POV, prevention activities, and secondary providers data.

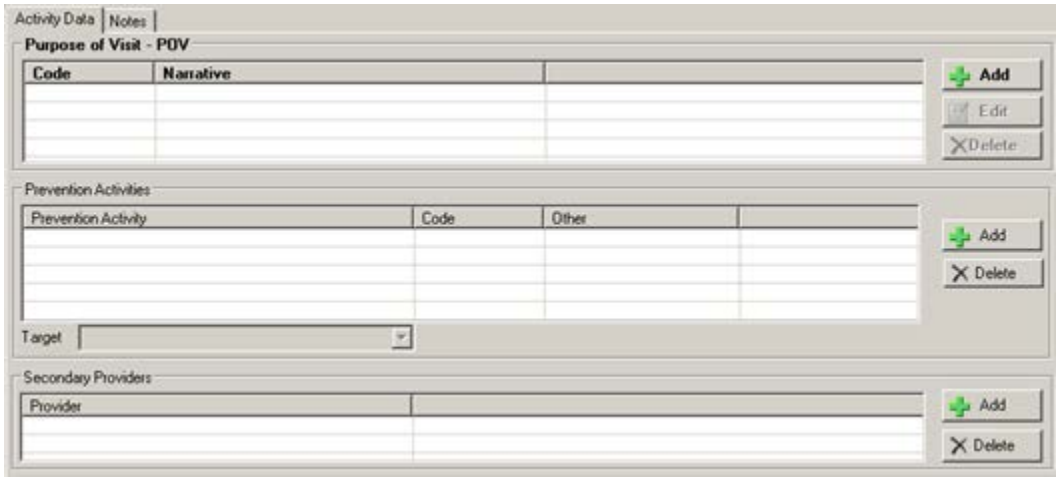


Figure 7-10: Sample **Activity Data** tab

7.3.2.1 Purpose of Visit–POV Pane

The **POV** pane in Figure 7-11 displays the POVs associated with the administrative/community activity:

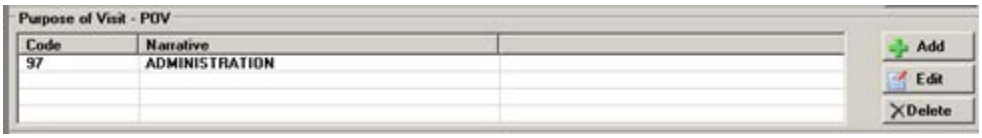


Figure 7-11: Sample **POV** pane

- At least one POV is required for an administration/community activity record. You can add, change, or delete a record.

7.3.2.1.1 Add Button

Click **Add** to add a new POV to display the search/select window. Here you select one or more POVs.

7.3.2.1.2 Edit Button

Click **Edit** Figure 7-11 to change the Narrative field of a POV record in the pane. The **Edit POV** pane shown in Figure 7-12 displays.

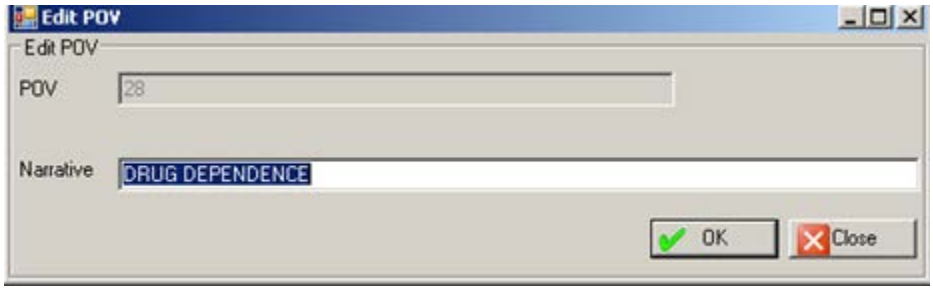


Figure 7-12: Edit POV dialog

1. Type text in the **Narrative** field.
   - Click **OK** to update the record.
   - Click **Close** to end the process and the **Edit POV** pane closes.

7.3.2.1.3 Delete Button

Select a POV record and click **Delete** to remove a record. The confirmation: **Are You Sure?** displays: "Are you are sure you want to delete?"

- Click **Yes** to remove the selected group encounter record from the pane.
- Click **No** to end the process.

7.3.2.2 Prevention Activities Pane

The **Prevention Activities** pane (Figure 7-13) lists the prevention activities associated with the administrative/community activity.

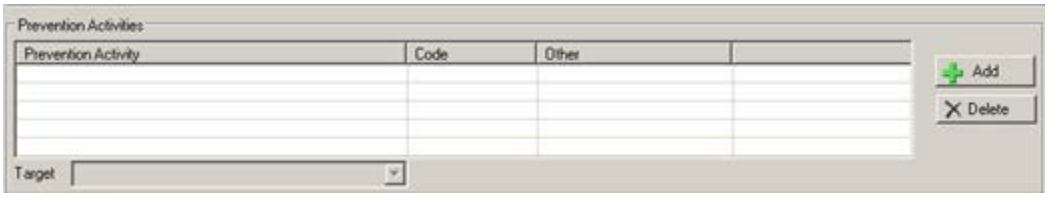


Figure 7-13: Sample **Prevention Activities** pane

- The Target field will be disabled until a **Prevention Activity** is entered. In addition, the **Target** field will be disabled if all of the prevention activities are deleted.

1. At the **Target** field, type one of the following:

- **Adult**
- **Youth**
- **Family**
- **Mixed (Adult & Youth)**
- **Staff**
- **Elderly Only**
- **Women**

7.3.2.2.1 Add Button

Click **Add** to insert a prevention activity record to the pane. Click **Add** to access the **Prevention Activity** search/select window.

- If you use **OTHER** on the Prevention Activity search window, Figure 7-14 displays

Figure 7-14: Other dialog

- Type text in the **Other** field.
  - Click **OK** to display the text in the **Other** field.
  - Click **Close** to end the operation.

7.3.2.2.2 Delete Button

1. Highlight a prevention activity record.
2. Click **Delete**. The confirmation **Are You Sure?** displays: "Are you are sure you want to delete?"
   - Click **Yes** to remove the selected record from the pane.
   - Click **No** to end the process.

7.3.2.3 Secondary Providers Pane

The **Secondary Providers** pane (Figure 7-15) lists the secondary providers associated with the administrative/community activity.

Figure 7-15: Sample **Secondary Providers** pane

7.3.2.3.1 Add

Click **Add** on the Secondary Providers pane to display the Secondary Providers search or select window.

7.3.2.3.2 Delete

1. Highlight the secondary provider record.
2. Click **Delete**. The confirmation **Are You Sure?** displays: “Are you are sure you want to delete?”
   - Click **Yes** to remove the selected record from the pane.
   - Click **No** end the process.

7.3.3 Notes Tab

Type administrative/community activity notes in the **Notes** field (Figure 7-16):

Figure 7-16: Sample **Notes** field

8.0 Encounter and Treatment Plan Sharing (Roll and Scroll)

After the entry of a Visit or a Treatment plan, you will have the option to share it with a colleague through MailMan. In order to do this, you must be properly set up through Site Parameters as a provider who can share information.

Make sure that the provider being sent the plan should actually be using this function.

After the entry of a Visit or Treatment plan, the following message displays as shown in Figure 8-1:

```
Do you want to share this visit information with other providers? N//
```

Figure 8-1: Question after entry of a visit or treatment plan

- At the "Do you want to share this visit information with other providers?" prompt, type **Y**. The process of sending the information via a MailMan message is shown in Figure 8-2:

```
Send to: NUUUU,BILL          WBM
Send to:

Message will be sent to:    THETA,BILL

Do you want to attach a note to this mail message? N// YES
Enter the text of your note.

NOTE APPENDED TO MAIL MSG:
  No existing text
  Edit? NO//Y
 - Here the provider can append a note to his/her colleague.

Ready to send mail message?? Y// ES
Send Full or Suppressed Form:  (F/S): S// f  FULL  - The answer to this
question will determine which type of encounter form will be send in the
message.

Sending Mailman message to distribution list
Message Sent
Press enter to continue....:
```

Figure 8-2: Sending a treatment plan through MailMan

9.0 Problem List

This section addresses the Problem List management for Roll and Scroll and the GUI.

9.1 Patient's Problem List (Roll and Scroll)

The PPL appears on the Patient Data Entry and Update BH Forms screens.

1. Select **PPL** to display the patient's problem list and the following message displays as shown in Figure 9-1:

```
Problem List updates must be attached to a visit. If you are updating the
Problem List in the context of a patient visit select the appropriate existing
visit and then update the Problem List. If you are updating the Problem List
outside of the context of a patient visit, first create a chart review visit
and then update the Problem List.
Select record to associate the Problem List update to:  (1-5):
```

Figure 9-1: Message displayed by the application

2. At the "Select record to associate the Problem List update to " prompt, select a visit and the following screen (Figure 9-2) displays:

```
BH Problem List Update        Aug 23, 2011 14:05:45          Page:    1 of    1
-------------------------------------------------------------------------------
Patient Name: DEMO,DUCK    DOB: FEB 05, 1975   Sex: M   HRN: 36219
-------------------------------------------------------------------------------

BH Problem List Updated On: Aug 22, 2011  By: SIGMA,DARLA

1)   DX: 301.0   Status: ACTIVE   Last Modified: 08/22/2011
     DSM Narrative: PARANOID PERSONALITY DISORDER
     Provider Narrative: PARANOID PERSONALITY DISORDER
     Date of Onset: 02/10/2009   Facility: DEMO INDIAN HOSPITAL





          Enter ?? for more actions                                        >>>
AP   Add BH Problem       NO   Add Note             FA   Face Sheet
EP   Edit BH Problem      MN   Edit Note            BP   Add BH Prob to PCC PL
DE   Delete BH Problem    RN   Remove Note          PC   PCC Problem List Update
AC   Activate BH Problem  NP   No Active BH ProblemsQ    Quit
IP   Inactivate BH Prob   LR   Problem List Reviewed
DD   Detail Display       HS   Health Summary
Select Action: +//
```

Figure 9-2: Sample BH Problem List update screen

3. At the "Select Action" prompt, type **Q** and press Enter to close the screen.

9.1.1 BH Problem Actions (Roll and Scroll)

Note: BH Problem List information ***does not*** cross to PCC.

9.1.1.1 Add BH Problem (AP)

1. Type **AP** to add a new BH problem for the current patient's visit (Figure 9-2). Figure 9-3 shows the current patient's problem list:

```
Purpose of Visit Diagnoses assigned to this patient in the past 90 days:
  1) 304.22    COCAINE DEPENDENCE, EPISODIC
  2) 304.82    POLYSUBSTANCE DEPENDENCE, EPISODIC
  3) 079.81    HANTAVIRUS INFECTION
  4) 301.0     PARANOID PERSONALITY DISORDER
  5) 301.10    AFFECTIV PERSONALITY NOS
  6) 304.00    OPIOID DEPENDENCE, UNSPECIFIED
  7) 304.30    CANNABIS DEPENDENCE, UNSPECIFIED
  8) Any Other Diagnosis
```

Figure 9-3: Example of options from which to choose screen

2. At the "Choose a Diagnosis: (1-8):" prompt, type one of the following:
   - Type 1–7 and the PROVIDER NARRATIVE prompt displays.
   - Type 8 to continue
3. At the "Enter Diagnosis to Add to the Problem List" prompt, type the diagnosis to be added to the BH Problem List.
4. At the "STATUS" prompt, type the status of the diagnosis, either **A** (active) or **I** (inactive). The default for a new problem is A.
5. At the "DATE OF ONSET" prompt, type the date of the diagnosis.
6. At the "Add TREATMENT Note?" prompt:
   - Type **N**: the focus will go to the "Enter the Date the Problem List was Updated by the Provider" prompt.
   - Type **Y** to add a treatment note.
7. At the "PROVIDER NARRATIVE" prompt, type the treatment note.
8. At the "AUTHOR" prompt, type an author name.
9. At the "LONG/SHORT TERM TREATMENT" prompt:
   - Type **1** for Short Term
   - Type **2** for Long Term. This refers to the treatment described in the Treatment note.

- After completing the last prompt, focus returns to the "Add TREATMENT Note?" prompt.

10. Set the date at the "Enter the Date the Problem List was Updated by the Provider" prompt.

11. At the "Enter the individual that updated the Problem List" prompt, type the name of the individual who updated the BH Problem List (the default will be provider listed on the visit to which the problem list item is associated).

    - If you are transcribing an update from a BHS provider, then enter the name of the provider.
    - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.2 Edit BH Problem (EP)

1. At the "Select Problem" prompt, type **EP** to edit a specified BH problem.
2. At the "Select Problem" prompt, type the number of the problem to edit.
3. At the "PROBLEM CODE" prompt, type the problem code.
4. At the "PROVIDER NARRATIVE" prompt, type the provider narrative.
5. At the "DATE OF ONSET" prompt, type the date of onset, when the problem was first diagnosed. (This can be left blank.)
6. At the "STATUS" prompt, type the status, **A** (active) or **I** (inactive), if needed.
7. Set the date at the "Enter the Date the Problem List was Updated by the Provider" prompt.
8. At the "Enter the individual that updated the Problem List" prompt, type the name of individual who updated the BH Problem List.

    - If you are transcribing an update from a BHS provider, then enter the name of the provider.
    - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.3 Delete BH Problem (DE)

1. At the "Select Problem" prompt, type **DE** to delete a specified BH problem.
2. At the "Select Action" prompt, type the action to execute, **1** (Delete BH Problem) or **2** (Detail display)

    - In this case, type **1**.

3. At the “Select Problem” prompt, type the number of the problem to delete. After specifying a valid problem number, the information about the problem displays as shown in Figure 9-4:

```
Deleting the following BH Problem from DUCK DEMO's BH Problem List.

PROBLEM CODE: 9.1                        PATIENT NAME: DEMO,DUCK
  DATE LAST MODIFIED: SEP 07, 2011@14:07:46
  PROVIDER NARRATIVE: PRE-SENILE CONDITION
  FACILITY: DEMO INDIAN HOSPITAL         NMBR: 3
  DATE ENTERED: SEP 07, 2011@13:54:16    STATUS: ACTIVE
  USER LAST UPDATE: THETA,SHIRLEY

Please Note:  You are NOT permitted to delete a BH Problem without
entering a reason for the deletion.
```

Figure 9-4: Example of information displayed about the problem code

4. At the “Are you sure you want to delete this BH Problem?” prompt, type one of the following:
   - Type **N**: the focus will return to the BH Problem List Update screen.
   - Type **Y** and the following prompts display:
5. At the “Enter the Provider who deleted the Problem” prompt, type the name of the provider who deleted the problem.
6. At the “REASON PROBLEM DELETED” prompt, type one of the following:
   - **D** (Duplicate)
   - **E** (Entered in Error)
   - **O** (Other)
     - Type O at the prompt.
7. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
8. At the “Enter the individual that updated the Problem List” prompt, type a name.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.4 Activate BH Problem (AC)

1. At the “Select Problem” prompt, type **AC** to cause the status of a inactive BH problem to be active.

2. At the “Select Problem” prompt, type the number of the problem to activate.

If the problem is already active, the following message in Figure 9-5 displays:

```
That problem is already ACTIVE!!
Press return to continue....:
```

Figure 9-5: Message displayed when the problem is already active

3. At the “Press return to continue” prompt, press Enter and the focus returns to the BH Problem List Update screen (Figure 9-2). If the problem is not active, the following prompts continue:
4. Set a date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
5. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.5 Inactivate BH Problem (IP)

1. At the “Select Problem” prompt, type **IP** to cause the status of a active BH problem to become inactive.
2. At the “Select Problem” prompt, type the number of the problem to inactivate.
   - If the problem is already inactive, the following message in Figure 9-6 displays:

```
That problem is already INACTIVE!!
Press return to continue....:
```

Figure 9-6: Message displayed when the problem is already inactive

3. At the “Press return to continue” prompt, press Enter and the focus returns to the BH Problem List Update window.
   - If the problem is not inactive, the prompts continue:
4. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
5. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the Problem List.

9.1.1.6 Detail Display (DD)

1. At the “Select Problem” prompt, type **DD** to display detail information about a selected BH problem.
2. At the “Select Problem” prompt, type the problem to use.

Behavioral Health Problem List information on the **Output Browser** screen displays as shown in Figure 9-7:

```
OUTPUT BROWSER                Dec 05, 2011 11:53:53          Page:    1 of    1
Behavioral Health Problem Display


PROBLEM CODE: 6.2                        PATIENT NAME: DEMO,DOROTHY ROSE
  DATE LAST MODIFIED: DEC 07, 2010
  PROVIDER NARRATIVE: pt has terminal illness
  FACILITY: DEMO INDIAN HOSPITAL         NMBR: 1
  DATE ENTERED: DEC 07, 2010             STATUS: ACTIVE
  ADD TO PCC PROBLEM LIST?: YES

Notes:

   1)  Date Added: 12/07/2010 Author: THETA,SHIRLEY
   Note Narrative: Treat physical illness from time to time
   SHORT TERM TREATMENT

   2)  Date Added: 12/09/2010 Author: THETA,SHIRLEY
   Note Narrative: physical ill
```

Figure 9-7: Sample Problem Detail

9.1.1.7 Add Note (NO)

1. At the “Select Problem” prompt, type **NO** to add a note to a selected BH problem.
2. At the “Select Action” prompt, type one of the following:
   - 1 Add Note
   - 2 No Active BH Problems
     - Type **1** in this case.
3. At the “Select Problem” prompt, type the problem to which to add a note.

   The application displays information about the selected problem and information about any existing notes.
4. At the “Add a new Problem Note for this Problem?” prompt, type one of the following:
   - Type **N**: to return to the BH Problem List Update window.
   - Type **Y**: and the following prompts continue:

5. At the “NARRATIVE” prompt, type the text of the narrative of the note.
6. At the “AUTHOR” prompt, type a name.
7. At the “LONG/SHORT TERM TREATMENT” prompt, type one of the following: **1** (for short) or **2** (for long).

The application will refresh with the information about the problem and information about the notes as shown in Figure 9-8:

```
Adding a Note to the following problem on DOROTHY ROSE DEMO's BH Problem List.

PROBLEM CODE: 304.22                    PATIENT NAME: DEMO,DOROTHY ROSE
  DATE LAST MODIFIED: OCT 05, 2011@11:18:18
  PROVIDER NARRATIVE: COCAINE DEPENDENCE, EPISODIC
  FACILITY: DEMO INDIAN HOSPITAL        NMBR: 2
  DATE ENTERED: OCT 05, 2011@11:18:18   STATUS: ACTIVE
  USER LAST UPDATE: DEMO,DOCTOR

Notes:

   1)  Date Added: 12/01/2011 Author: DEMO,CASE M
   Note Narrative: Pt has problems will illegaldrugs
   SHORT TERM TREATMENT

   2)  Date Added: 12/05/2011 Author: DEMO,DOCTOR
   Note Narrative: Pt has resolved some of the problems with illegal drugs
   SHORT TERM TREATMENT
```

Figure 9-8: Example of information about the problem and information about the notes

8. At the “Add a new Problem Note for this Problem?” prompt type one of the following:
   - Type **Y**: the prompts will repeat, starting with NARRATIVE.
   - Type **N** to continue
9. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
10. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
    - If you are transcribing an update from a BHS provider, then enter the name of the provider.
    - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.8 Edit Note (MN)

1. At the “Select Problem” prompt, type **MN** to edit the text of a selected note.
2. At the “Select Problem” prompt, type the problem having the note to be edited.

3. At the “Edit which one” prompt, type the note to edit.
4. At the “NARRATIVE: <text of the problem> Replace” prompt, type the replacement text for the NARRATIVE.
5. At the “LONG/SHORT TERM TREATMENT” prompt, type one of the following:
   - **1** (for short)
   - **2** (for long)
6. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.

   Use the default date or specify another one.
7. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the BH Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.9 Remove Note (RN)

1. At the “Select Problem” prompt, type **RN** to delete a selected note.
2. At the “Select Problem” prompt, type the problem having the note to be removed.
3. At the “Remove which one” prompt, type the note to remove.
4. At the “Are you sure you want to delete this NOTE?” prompt, type one of the following:
   - Type **N**: to return to the BH Problem List Updated window.
   - Type **Y**: to continue.
5. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
6. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the Problem List.
   - If you are transcribing an update from a BHS provider, then enter the name of the provider.
   - If you are a data entry/coder correcting the BH Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.1.10 No Active BH Problems (NP)

Type **NP** to specify the date when a provider indicates that the patient has no active BH problems. This action requires that there are no ACTIVE problems on the patient's BH problem list (otherwise, the application will display an error message).

1. At the "Did the Provider indicate that the patient has No Active BH Problems" prompt, type one of the following:
   - Type **N**: the focus will return to the BH Problem List Update window.
   - Type **Y** to continue
2. Set the date at the "Enter the Date the Provider documented 'No Active BH Problems: prompt.
3. At the "Enter the PROVIDER who documented 'No Active BH Problems" prompt, type the provider name who documented that there are no active BH problems.

9.1.1.11 Problem List Reviewed (LR)

1. At the "Select Problem" prompt, type **LR** to indicate who and when the current patient's BH Problem List was reviewed.
2. At the "Did the Provider indicate that he/she reviewed the Problem List?" prompt, type one of the following:
   - Type **N**: the message: 'No Action Take" displays and focus returns to the BH Problem List Update window.
   - Type **Y**: and the prompts continue.
3. Set the date at the "Enter the Date the Provider Reviewed the Problem List" prompt.
4. At the "Enter the PROVIDER who Reviewed the Problem List" prompt, type the name of the provider who reviewed the BH Problem List.

9.1.1.12 ADD BH Prob to PCC PL (BP)

1. At the "Select Problem" prompt, type **BP** to add a BH problem to the PCC problem list. This action requires security access (the security key is AMHZ PCC PROBLEM LIST).
2. At the "Select Problem" prompt, type the problem to be added to the PCC problem list.

The application displays the PCC Problem list for the patient as shown in Figure 9-9:

```
PCC Problem List for DEMO,DOROTHY ROSE.
```

```
******************  ACTIVE PROBLEMS AND NOTES  *******************

  WW1       12/26/03  995.2   ADE: PCN, SULFA
  WW2       12/28/09  493.90  Asthma, Unspecified  (ONSET: 02/00/01)
  WW3       12/07/10  V15.89  pt has terminal illness

******************  INACTIVE PROBLEMS AND NOTES  *******************

  WW4       01/12/11  998.0   Postoperative Shock, Not Elsewhere Classified
  WW5       01/12/11  999.0   Generalized Vaccinia As A Complication Of
                              Medical Care, Not Elsewhere Classified
  WW6       01/12/11  V81.5   Screening For Nephropathy
```

Figure 9-9: Example of information about the PCC Problem List

3. At the “Are you sure you want to add diagnosis XXX to PCC?” prompt type one of the following

   - Type **N**: the focus will return to the BH Problem List Update window.
   - Type **Y** and the message in Figure 9-10 displays:

```
This is the only narrative the rest of the medical community will see
on the Health Summary for this problem.  You may change it now if desired.
```

Figure 9-10: Example of message displayed by the application

4. At the “PROVIDER NARRATIVE: <words of the narrative>” prompt, edit the narrative, if necessary.

9.1.1.13 PCC Problem List Update (PC)

1. Type **PC** to update the PCC problem list. This action requires security access (the security key is AMHZ PCC PROBLEM LIST). The following message displays as shown inFigure 9-11:

```
You are now leaving the Behavioral Health Problem List and will be taken
into the PCC Problem List for updating.


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

Figure 9-11: Information displayed by the application

2. At the “Do you wish to continue?” prompt, type one of the following:

   - Type **N**: the focus will return to the BH Problem List Update window.
   - Type **Y** to continue

3. At the “Location where Problem List update occurred” prompt, type the location where the Problem List update occurred.

4. At the “Date Problem List Updated” prompt, type the date the problem list was updated. The Problem List Update screen displays as shown in Figure 9-12:

```
Problem List Update           Sep 07, 2011 15:46:04          Page:    1 of    3
-------------------------------------------------------------------------------
Patient Name: DEMO,DOROTHY ROSE   DOB: OCT 10, 1942   Sex: F   HRN: 99999
-------------------------------------------------------------------------------

   1) Problem ID:   WW1    DX: 995.2   Status: ACTIVE   Onset:
      Provider Narrative:  ADE: PCN, SULFA

   2) Problem ID:   WW2    DX: 493.90  Status: ACTIVE   Onset: 2/0/2001
      Provider Narrative:  Asthma, Unspecified
      Classification:  2-MILD PERSISTENT

   3) Problem ID:   WW7    DX: V15.89  Status: ACTIVE   Onset:
+         Enter ?? for more actions                                        >>>
AP   Add Problem          DD   Detail Display       LR   Problem List Reviewed
EP   Edit Problem         NO   Add Note             HS   Health Summary
DE   Delete Problem       MN   Edit Note            FA   Face Sheet
AC   Activate Problem     RN   Remove Note
IP   Inactivate Problem   NP   No Active Problems
Select Action: +//
```

Figure 9-12: Example of Problem List Update screen

See Section 9.1.2 for more information.

9.1.2 PCC Problem List Actions (Roll and Scroll)

Note: PCC Problem List information crosses to PCC.

The following section provides information about the various PCC Problem List actions that you can use.

9.1.2.1 Add Problem (AP)

1. At the “Select Problem” prompt, type **AP** to add a new PCC problem for the current patient’s visit.
2. At the “Enter Problem Diagnosis” prompt, type the problem diagnosis for the PCC problem.
3. At the “Provider Narrative” prompt, type the narrative for the PCC problem.
4. At the “E CODE (CAUSE OF INJURY)” prompt, type the E code for the cause of injury.
5. At the “E CODE 2” prompt, add another E Code, if necessary.
6. At the “E CODE 3” prompt, add another E Code, if necessary.

7. At the “DATE OF ONSET” prompt, type the date of when the problem was diagnosed.
8. At the “NMBR” prompt, type the number of the PCC problem.
   - This is a number which, together with the Patient (#.02) and Facility (# .06) fields, serves as a unique identifier for this problem. Up to 2 decimal places may be used to indicate that a problem is a result of, or related to, another problem.
9. At the “CLASS” prompt, indicate if this problem is documented for historical purposes. Type **P** (for PERSONAL HISTORY) or leave it blank.
10. At the “STATUS” prompt, type the status of the problem, either **A** (Active) or **I** (Inactive). The default is for a new problem is ACTIVE.
11. At the “Add a new Problem Note for this Problem?” prompt, type one of the following:
    - Type **N**: the focus will return to the “Enter the Date the Problem List was Updated by the Provider” prompt.
    - Type **Y**: the following prompts will display:
12. At the “NOTE NARRATIVE” prompt, type the text of the narrative for the note.
13. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
14. At the “Enter the INDIVIDUAL who Updated the Problem List” prompt, type the name of individual who updated the PCC Problem List.
    - If you are transcribing an update from a BHS provider, then enter the name of the provider.
    - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code) then enter your own name.

9.1.2.2 Edit Problem (EP)

1. At the “Select Problem” prompt, type **EP** to edit a specified PCC problem.
2. At the “Select Problem” prompt, type the number of the problem to edit.

The prompts are the same as adding a PCC problem. See Section 9.1.2.1 for more information.

9.1.2.3 Delete Problem (DE)

1. At the “Select Problem” prompt, type **DE** to delete a PCC problem.

2. At the “Select Action” prompt, type one of the following:
   - **1** (Delete Problem)
   - **2** (Detail Display)
     - Type **1** in this case.
3. At the “Select Problem” prompt, type the number of the problem to delete.

The screen will update as shown in Figure 9-13:

```
Deleting the following Problem from DOROTHY ROSE DEMO's Problem List.

DIAGNOSIS: 678.10                        PATIENT NAME: DEMO,DOROTHY ROSE
  DATE LAST MODIFIED: DEC 05, 2011       PROVIDER NARRATIVE: Pt has problems
  FACILITY: DEMO INDIAN HOSPITAL         NMBR: 13
  DATE ENTERED: DEC 05, 2011             STATUS: ACTIVE
  USER LAST MODIFIED: THETA,SHIRLEY      ENTERED BY: THETA,SHIRLEY


Please Note:  You are NOT permitted to delete a problem without
entering a reason for the deletion.
```

Figure 9-13: Example of information displayed about the problem code

4. At the “Are you sure you want to delete this PROBLEM?” prompt, do one of the following:
   - Type **N** to end this process and redisplay the Problem List Update screen.
   - Type **Y** to continue.
5. At the “Provider who deleted the Problem” prompt,enter the name of the provider who deleted the problem.
6. At the “REASON PROBLEM DELETED”, type one of the following reasons:
   - D – Duplicate
   - E – Entered in Error
   - O Other (Other prompts will display)
7. Set the date at the "Enter the Date the Problem List was Updated by the Provider” prompt.
8. At the “Enter the INDIVIDUAL who Updated the Problem List” prompt, type the name of the individual who updated the PCC Problem List

   Type the name of individual who updated the **PCC Problem List**.

   - If transcribing an update from a BHS provider, type the name of the provider.

- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.4 Activate Problem (AC)

1. At the “Select Problem” prompt, type **AC** to activate the status of the displayed PCC problem.
2. At the “Select Problem” prompt, type the number of the problem to activate.
   - If the problem is already active, the application displays the message in Figure 9-14:

```
That problem is already ACTIVE!!
Press return to continue....:
```

Figure 9-14: Message displayed when problem is already active

   - Press Enter, to return to the Problem List Update screen.
   - If the problem is not active, the following prompts continue:
3. Set the date at the "Enter the Date the Problem List was Updated by the Provider” prompt.
4. At the “Enter the individual that updated the Problem List” prompt, type the name of the individual who updated the PCC Problem List.
   - If transcribing an update from a BHS provider, type the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.5 Inactivate Problem (IP)

1. At the “Select Problem” prompt, type **IP** to cause the status of a active PCC problem to become inactive.
2. At the “Select Problem” prompt, type the number of the problem to inactive.
   - If the problem is already inactive, a message displays as shown in Figure 9-15:

```
That problem is already INACTIVE!!
Press return to continue....:
```

Figure 9-15: Message that displays when the problem is already inactive

   - Press Enter to return to the **Problem List Update** screen.
   - If the problem is not inactive, the prompts continue:

3. Set the date at the "Enter the Date the Problem List was Updated by the Provider" prompt.

4. At the "Enter the individual that updated the Problem List" prompt, type the name of the individual who updated the PCC Problem List.

   - If transcribing an update from a BHS provider, type the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.6 Detail Display (DD)

1. At the "Select Problem" prompt, type **DD** to display the detail information about a selected problem.

2. At the "Select Problem" prompt, type the problem to use.

   The application will display detail information about the problem on the **Output Browser** screen as shown in Figure 9-16:

```
OUTPUT BROWSER                Dec 05, 2011 12:25:37          Page:    1 of    1



DIAGNOSIS: 998.0                        PATIENT NAME: DEMO,DOROTHY ROSE
  DATE LAST MODIFIED: JAN 12, 2011      CLASS: PERSONAL HISTORY
  PROVIDER NARRATIVE: Postoperative Shock, Not Elsewhere Classified
  FACILITY: DEMO INDIAN HOSPITAL        NMBR: 4
  DATE ENTERED: JAN 12, 2011            STATUS: INACTIVE
  RECORDING PROVIDER: THETA,SHIRLEY
NOTE FACILITY: DEMO INDIAN HOSPITAL
   Note Narrative: physical ill
```

Figure 9-16: Sample Problem Detail

9.1.2.7 Add Note (NO)

1. At the "Select Problem" prompt, type **NO** to add a note to a selected problem.

2. At the "Select Action" prompt,

   - Type **1** - Add Note
   - Type **2** - No Active Problems
     - Type **1** in this case.

3. At the "Select Problem" prompt, type the problem to add a note. The application will display the information regarding the selected problem and any existing notes.

4. At the “Add a new Problem Note for this Problem?” prompt, type one of the following:
   - Type **N** to end this process and redisplay the **Problem List Update** screen.
   - Type **Y** to continue.
5. At the “NOTE NARRATIVE” prompt, type the text of the narrative of the note. The application displays the problem notes and continues.
6. At the “Add a new Problem Note for this Problem?” prompt, do one of the following:
   - Type **Y** to return to the **NOTE NARRATIVE** prompt.
   - Type **N** to continue.
7. Set the date at the "Enter the Date the Problem List was Updated by the Provider” prompt.
8. At the “Enter the INDIVIDUAL who Updated the Problem List” prompt, type the name of the person who updated the PCC problem list.
   - If transcribing an update from a BHS provider, type the name of the provider.
   - If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.8 Edit Note (MN)

1. At the “Select Problem” prompt, type **MN** to edit the text of a selected note.
   - If there are no notes, the following message displays: “No note on file for this problem”.
2. Press Enter to return to the Problem List Update window, type the problem containing the note to edit.
3. At the “Edit which one” prompt, type the note to edit.
4. At the “NOTE NMBR” prompt, type the number of the note to be edited.
5. At the “NOTE NARRATIVE: <text of the problem> Replace” prompt, type the replacement text of the note.
6. Set the date at the “Enter the Date the Problem List was Updated by the Provider” prompt.
7. At the “Enter the individual that updated the Problem List” prompt, type the name of individual who updated the PCC Problem List.
   - If transcribing an update from a BHS provider, type the name of the provider.

- If you are a data entry/coder correcting the Problem List (for instance, correcting the DSM code), type your name.

9.1.2.9 Remove Note (RN)

1. Type **RN** to delete a selected note.
2. At the Select Problem" prompt, type the problem containing the note to remove.
3. At the "Remove which one" prompt, type the note to remove.
4. At the "Are you sure you want to delete this NOTE?" prompt, type one of the following:
   - Type **N** to return to the **Problem List Updated** window.
   - Type **Y** to continue.
5. Set the date at the "Enter the Date the Problem List was Updated by the Provider" prompt.
6. At the "Enter the individual that updated the Problem List" prompt, type the name of the individual who updated the PCC Problem List.

9.1.2.10 No Active Problems (NP)

Select **NP** to specify the date when a provider indicates that the patient has no active PCC problems. This action requires that there are no ACTIVE problems on the patient's PCC problem list.

1. At the "Did the Provider indicate that the patient has No Active Problems" prompt, type one of the following:
   - Type N and the focus will return to the Problem List Update window.
   - Type Y to continue.
2. Set the date at the "Enter the Date the Provider documented 'No Active Problems".
3. At the "Enter the PROVIDER who documented 'No Active Problems" prompt, type the name of the provider name who documented the activity.

9.1.2.11 Problem List Reviewed (LR)

Select **LR** to indicate who and when the current patient's PCC Problem List was reviewed.

1. At the "Did the Provider indicate that he/she reviewed the Problem List?" prompt type one of the following:

- Type **N** and the message: 'No Action Take" displays and focus will return to the Problem List Update window.
- Type **Y** to continue.

2. Set the date at the "Enter the Date the Provider Reviewed the Problem List" prompt.
3. At the "Enter the PROVIDER who Reviewed the Problem List" prompt, type the name of the provider who reviewed the problem list.

9.2 Problem List (GUI)

This section addresses how to manage the problems for the selected patient on the Visit window.

After selecting a record and clicking the **Problem** button, select one of the following options:

- BH Problem List
- PCC Problem List

9.2.1 Behavior Health Problem List Window

1. Select the **BH Problem List** and the Behavioral Health Problem List window displays as shown in Figure 9-17. The current patient's problems displays in the Problem List including associated notes.

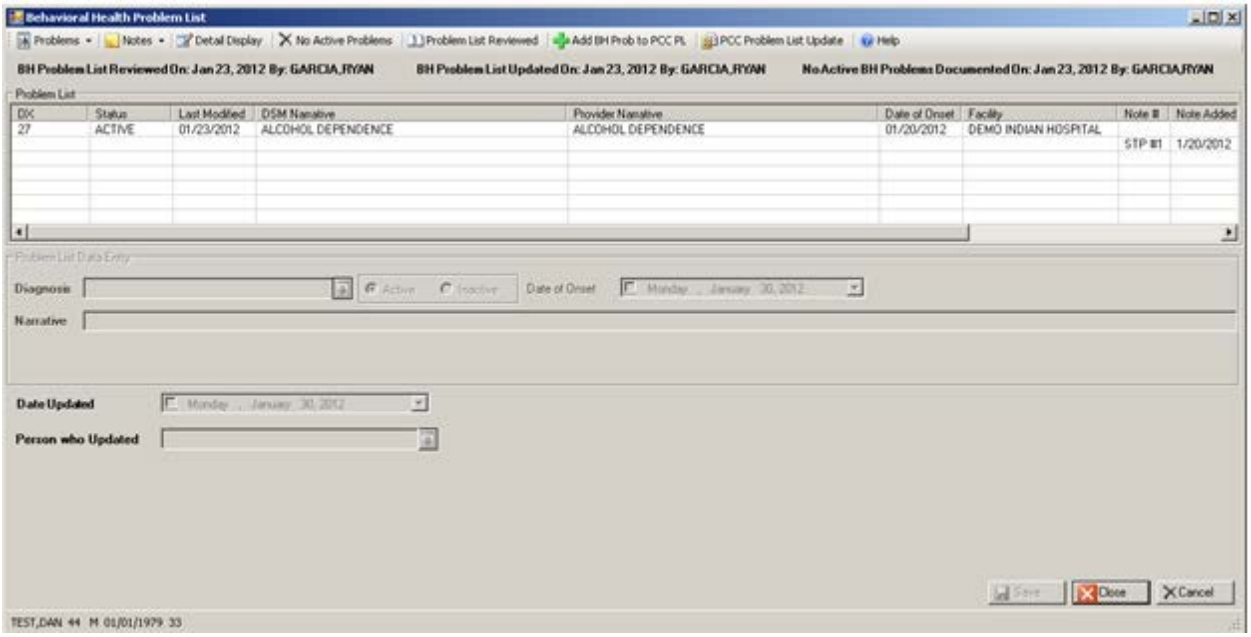


Figure 9-17: Sample **Behavioral Health Problem List** window

2. Click **Save** to execute the current action will execute and remain on the window.
3. Click **Close** to exit the window.
4. Click **Cancel** to remain on the window and no action is taken.

9.2.1.1 Add Problem

1. Select **Add Problem** from the **Problems** menu to activate the fields in the Problem List Data Entry pane shown in Figure 9-18:

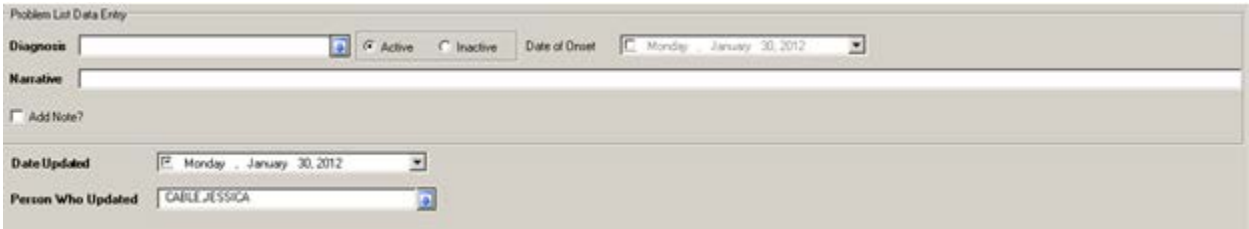


Figure 9-18: Sample **Problem List Data Entry** pane

2. Click the **Diagnosis** field to display the **POV (Axis I/II)** window and select a POV.
3. Click **Active** or **Inactive** to idenfity the diagnosis.
4. Set the **Date of Onset**.
   - To have no Date of Onset, remove the check from the box.
5. Select **Add Note?** box to display the **Note** pane shown in Figure 9-19:

Figure 9-19: **Note** pane

   - If necessary, uncheck **Note** to close the pane.
6. Type the text in the **Note** field.
7. Select a name from the **Author** field.
8. Select **Long Term or Short Term**.
9. Set **Date Updated**.
10. Select the primary provider from the **Person Who Updated** field.

11. Click **Save** to add the problem.

12. Click **Cancel** to remain on the window and no action is taken.

9.2.1.2 Edit Problem

1. Select **Edit Problem** from the **Problems** menu. The fields in the **Problem List Data Entry** pane become active.

2. Click **Save** to update the record in the **Problem List**.

3. Click **Cancel** to remain on the window and no action is taken.

9.2.1.3 Delete Problem

1. Highlight a problem in the **Problem List**.

2. Select **Delete Problem** from the **Problems** menu. The **Problem List Reason for Delete** dialog displays as shown in Figure 9-20:

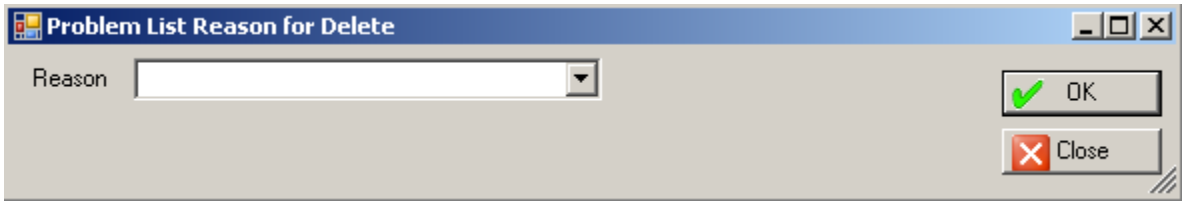


Figure 9-20: **Problem List Reason for Delete** dialog

3. Select an option from the **Reason** field as shown in Figure 9-21.

   - If you select **OTHER**, the dialog changes. Type the reason for deleting the problem in the **Other** field.

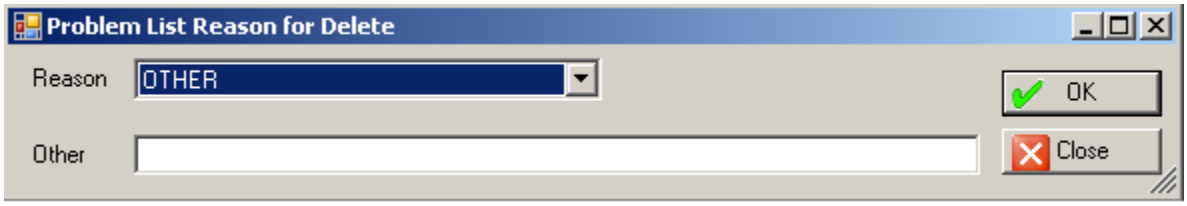


Figure 9-21: **Problem List Reason for Delete** when using **OTHER** dialog

4. Click **OK** to activate the **Date Updated** and **Person Who Updated** fields (Figure 9-22)

   - Click **Close** to close the operation.

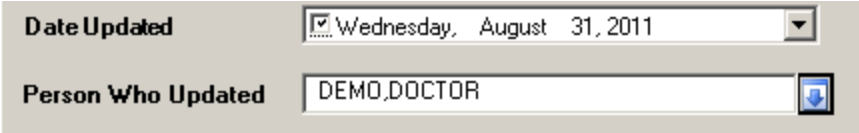


Figure 9-22: **Active Date Updated and Person Who Updated** fields

5. Set **Date Updated**.
6. Select the primary provider from the **Person Who Updated** field
7. Click **Save** to update the **Problem List**.
8. Click **Cancel** to remain on the window and no action is taken.

9.2.1.4 Activate/Inactivate Problem

1. Select an existing problem in the **Problem List**.
2. Select **Activate (or Inactive)** from the **Problems** menu. The **Date Updated** and **Person Who Updated** fields activate. See Figure 9-23:

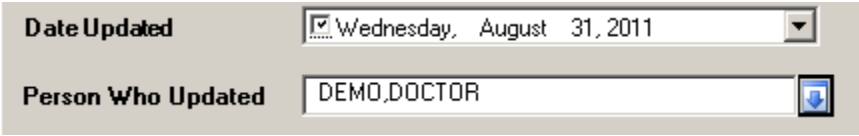


Figure 9-23: Sample active fields for **Inactivate (or Activate)** process

3. Set the **Date Updated**.
4. Select the Primary Provider from the **Person Who Updated** field.
5. Click **Save** to update the **Problem List**.
6. Click **Cancel** to remain on the window and no action is taken.

9.2.1.5 Add Note

1. Highlight a problem in the **Problem List**.
2. Select **Add Note** from the **Notes** menu to activate the fields shown in Figure 9-24:

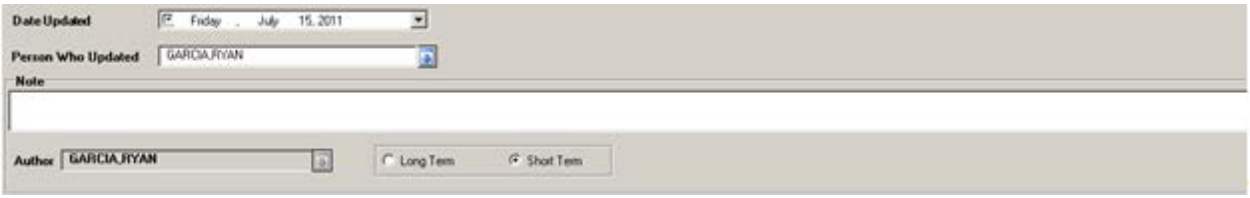


Figure 9-24: Active fields for adding a note

3. Set the **Date Updated**.

4. Select the primary provider from the **Person Who Updated** field
5. Type the text in the **Note** field.
6. Select an author from the **Author** field.
7. Select **Long Term or Short Term**.
8. Click **Save** to update the **Problem List**.
9. Click **Cancel** to remain on the window and no action is taken.

9.2.1.6 Edit Note

1. Select a note in the **Problem List**.
2. Select **Edit Note** from the **Notes** menu to activate the fields.

   See Section 9.2.1.5 for more information.
3. Click **Save** to update the **Problem List**.
4. Click **Cancel** to remain on the window and no action is taken.

9.2.1.7 Remove Note

1. Select a note in the **Problem List**.
2. Select **Remove Note** from the **Notes** menu to active the **Date Updated** and **Person Who Updated** fields (Figure 9-25)

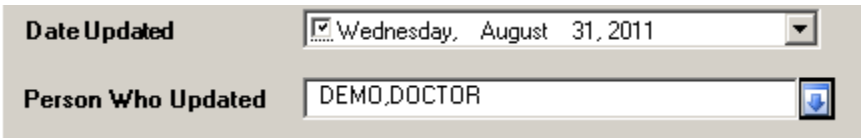


Figure 9-25: **Active Date Updated and Person Who Updated** fields

3. Set the **Date Updated**.
4. Select the primary provider from the **Person Who Updated field**.
5. Click **Save** to update the **Problem List**.
6. Click **Cancel** to remain on the window and no action is taken.

9.2.1.8 Detail Display

1. Highlight a problem in the **Problem List**.
2. Click **Detail Display**. Figure 9-26 displays the **BH Problem List Detail** pop-up for the patient.

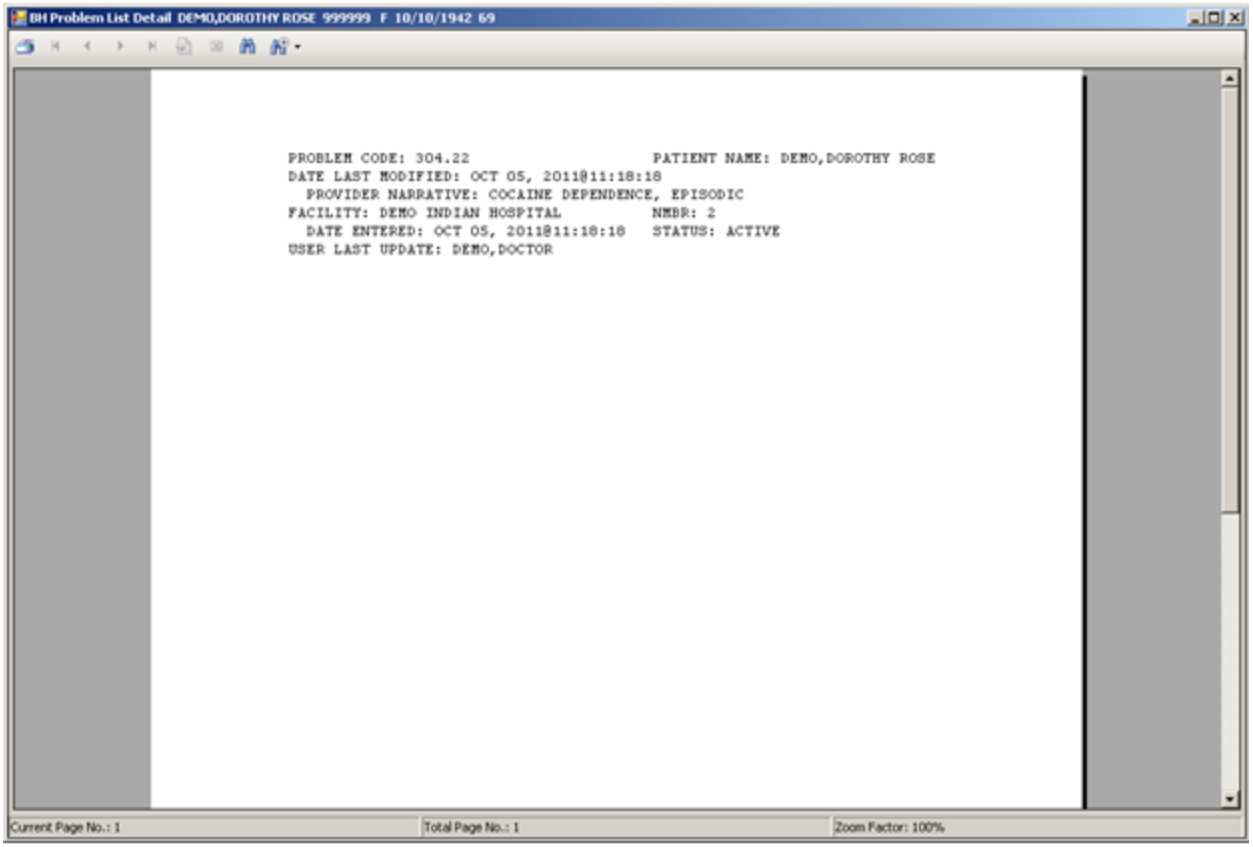


Figure 9-26: Sample **BH Problem List Detail** for a patient

9.2.1.9 No Active Problems

1. Click the **No Active Problems** button to indicate that the patient has No Active BH Problems. The application determines if the patient has active BH problems.

   - Click the button and if there are active problems, the message displays: “There are ACTIVE Problems on this patient’s BH problem list. You cannot use this action item.”

2. Click **OK** to close the message and the focus returns to the Behavioral Health Problem List window.

   - Click the button and there are no active problems, the following message displays: “Did the Provider indicate that the patient has No Active BH Problem?”

3. Click **Yes** and the **Date Documented** and **Provider Who Documented** fields become active (Figure 9-27).

4. Click **No** and the fields remain inactive.

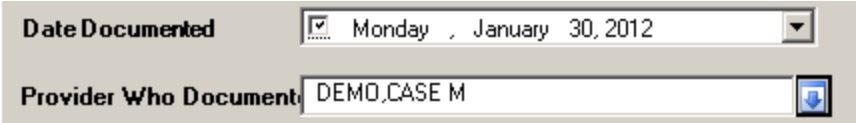


Figure 9-27: Sample Date Documented and Provider Who Documented fields

5. Set **Date Documented**
6. Select the primary provider from the **Person Who Documented** field.
7. Click **Save** to update the **Problem List**.
8. Click **Cancel** to remain on the window and no action is taken.

9.2.1.10 Problem List Reviewed

1. Click **Problem List Reviewed** to indicate that the current patient's problem list was reviewed. The **Date Reviewed** and **Provider Who Reviewed** fields become active as shown in Figure 9-28:

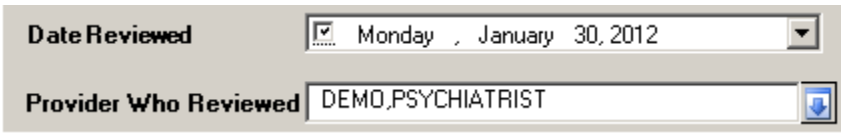


Figure 9-28: Sample **Problem List Reviewed and Provider Who Reviewed** fields

2. Set the **Date Reviewed**.
3. Select a Primary Provider from the **Person Who Reviewed** field.
4. Click **Save** to update the **Problem List**.
5. Click **Cancel** to remain on the window and no action is taken.

9.2.1.11 Add BH Problem to PCC Problem

1. Highlight a BH problem in the **Problem List** (Figure 9-17) and click **Add BH Problem to PCC Problem**.

> **Note**: This function requires the AMHZ PCC Problem List key. If you do not have this key, this button will be inactive.

- If the problem already exists on the **PCC Problem List**, the **Exists** dialog displays (Figure 9-29).
- Click **Yes** to add the problem
- Click **No** to end this process.

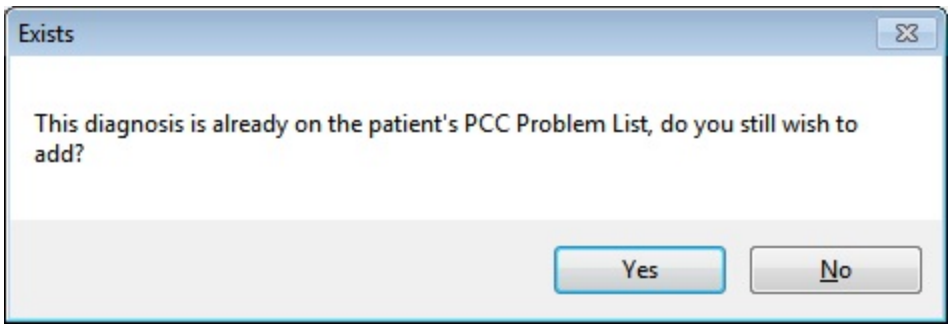


Figure 9-29: **Exists** dialog

- If the problem does not exist on the **PCC Problem List**, the **Success** dialog displays (Figure 9-30).

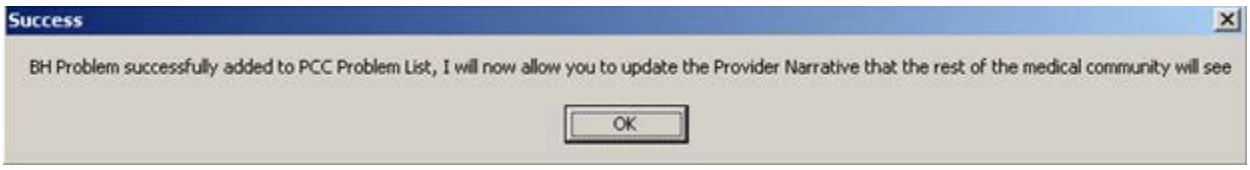


Figure 9-30: **Success** message

2. Click **OK** to display the **Problem List Data Entry** pane, with the Narrative field active. Type text in the Narrative field.

Figure 9-31: **Problem List Data Entry** pane with Narrative field active

3. Click **Save** and the problem displays on the **PCC Problem List**.
4. Click **Cancel** to end the process.
5. Diagnosis Does Exist on PCC Problem List
   - If the problem already exists on the **PCC Problem List**, the **Exists** dialog displays (Figure 9-29).
   - Click **Yes** to add the problem
   - Click **No** to end the process.

9.2.1.12 PCC Problem List Update

- Click **PCC Problem List Update** to display the **PCC Problem List** window.

9.2.2 PCC Problem List Window

1. Select **PCC Problem List** from the Problem list on the (on the **Visit** window Figure 4-48) the **PCC Problem List** window (Figure 9-32) displays.

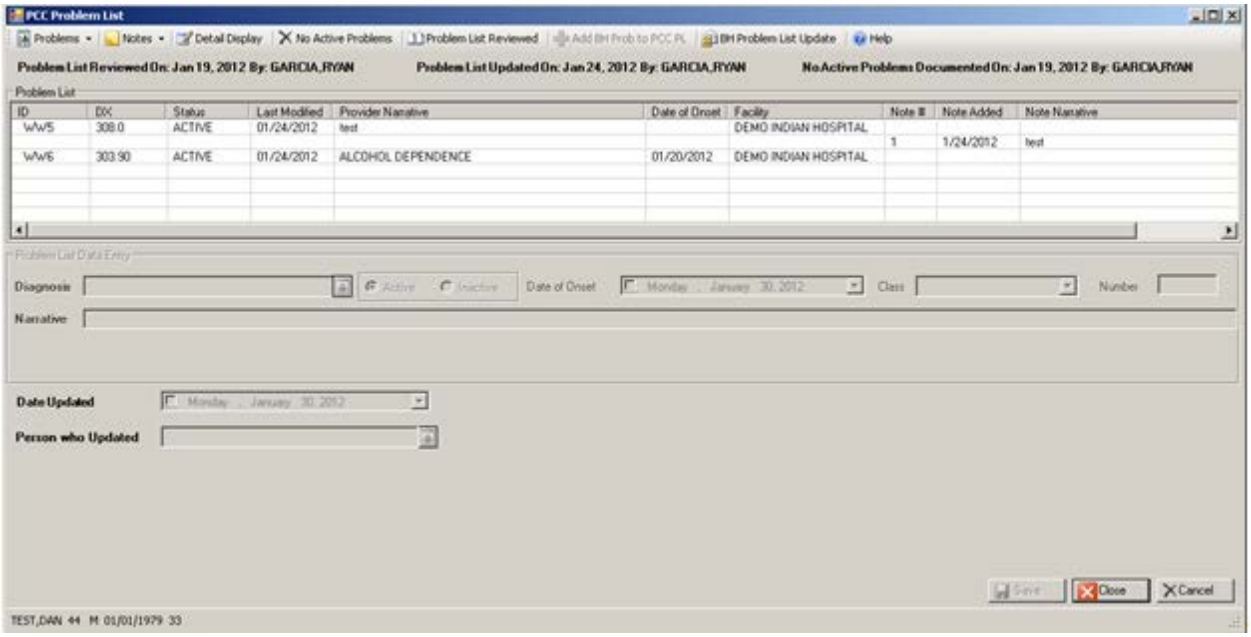


Figure 9-32: Sample **PCC Problem List** window

- The current patient's PCC problems display in the **Problem List**, including any associated notes. The notes display on the row below the problem.

2. Click **Save** to execute and remain on the window.
3. Click **Close** to exit the window.
4. Click **Cancel** to remain on the window and no action will be taken.

Refer to Section 2.0 for the instructions for these fields.

9.2.2.1 Add Problem

1. Select **Add Problem** from the **Problems** menu to display the **Problem List Data Entry** pane shown in Figure 9-33:

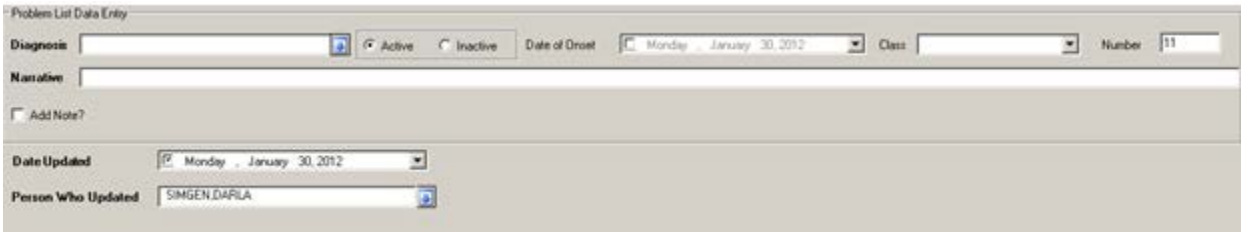


Figure 9-33: Problem List Data Entry fields for Add Problem

2. Click the **Diagnosis** field to display the **POV (Axis I/II)** window and select a POV.
3. Click **Active** or **Inactive**.
4. Set the **Date of Onset**.
   - To have no Date of Onset, remove the check mark.
5. Select PERSONAL HISTORY from the **Class** field. The **Number** field is automatically updated.
   - This is the ID number for the problem. For example, if the field is populated with 11, then the ID will be WW11.

   If the Diagnosis Code was injury related, the application will display the E Codes pane shown in Figure 9-34.

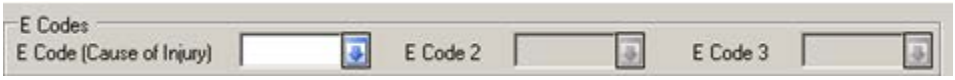


Figure 9-34: Fields in **E Codes** pane

6. Select the **E Code (Cause of Injury)** to display the **Diagnosis** search dialog.
7. Find the E Code and select it. The **E Code 2** field will become active.
8. If necessary, select the **E Code 2** to display the **Diagnosis** search dialog.
9. Find the E Code and select it. The **E Code 3** field will become active.
   - If you do not populate this field, the **E Code 3** field will remain inactive.
10. If necessary, select the **E Code 3** to display the Diagnosis search dialog.
11. Find the E-code and select it.
12. Select **Add Note?** to display the **Note** pane shown in Figure 9-35:

Figure 9-35: **Note** pane

13. Type the text in the **Note** field.
14. Select an author from the **Author** field.
15. Select **Long Term or Short Term**.

16. Set **Date Updated**.

17. Select the primary provider from the **Person Who Updated** field.

- Click **Save** to add to the **Problem List**.
- Click **Cancel** to remain on the window and no action is taken.

9.2.2.2 Edit Problem

1. Highlight a problem in the **Problem List**

2. Select **Edit Problem** from the **Problems** menu

All of the fields in the Problem List Data Entry pane become active. See Section 9.2.2.1 for more information about how to edit the fields.

- Click **Save** to update the Problem List.
- Click **Cancel** to end the process.

9.2.2.3 Delete Problem

1. Highlight a problem in the **Problem List**.

2. Select **Delete Problem** from the **Problems** menu. The **Problem List Reason for Delete** dialog (Figure 9-20) displays. Refer to Section 9.2.1.3 for more information about this dialog.

9.2.2.4 Activate/Inactivate Problem

1. Highlight a problem in the **Problem List.**

2. Select **Activate (or Inactive)** from the **Problems** menu.

See Section 9.2.1.4 for more information.

9.2.2.5 Add Note

1. Highlight a problem in the **Problem List**.

2. Select **Notes** from the **Add Note** menu.

Refer to Section 9.2.1.5 for more information.

9.2.2.6 Edit Note

1. Highlight a note in the **Problem List**.

2. Select **Notes** from the **Edit Note** menu.

Refer to Section 9.2.1.6 for more information.

9.2.2.7 Remove Note

1. Highlight a note in the **Problem List**.
2. Select **Notes** from the **Remove Note** menu.

Refer to Section 9.2.1.7 for more information.

9.2.2.8 Detail Display

1. Highlight a problem in the **Problem List**.
2. Click **Detail Display** button. The **PCC Problem List Detail** pop-up (Figure 9-36) displays:

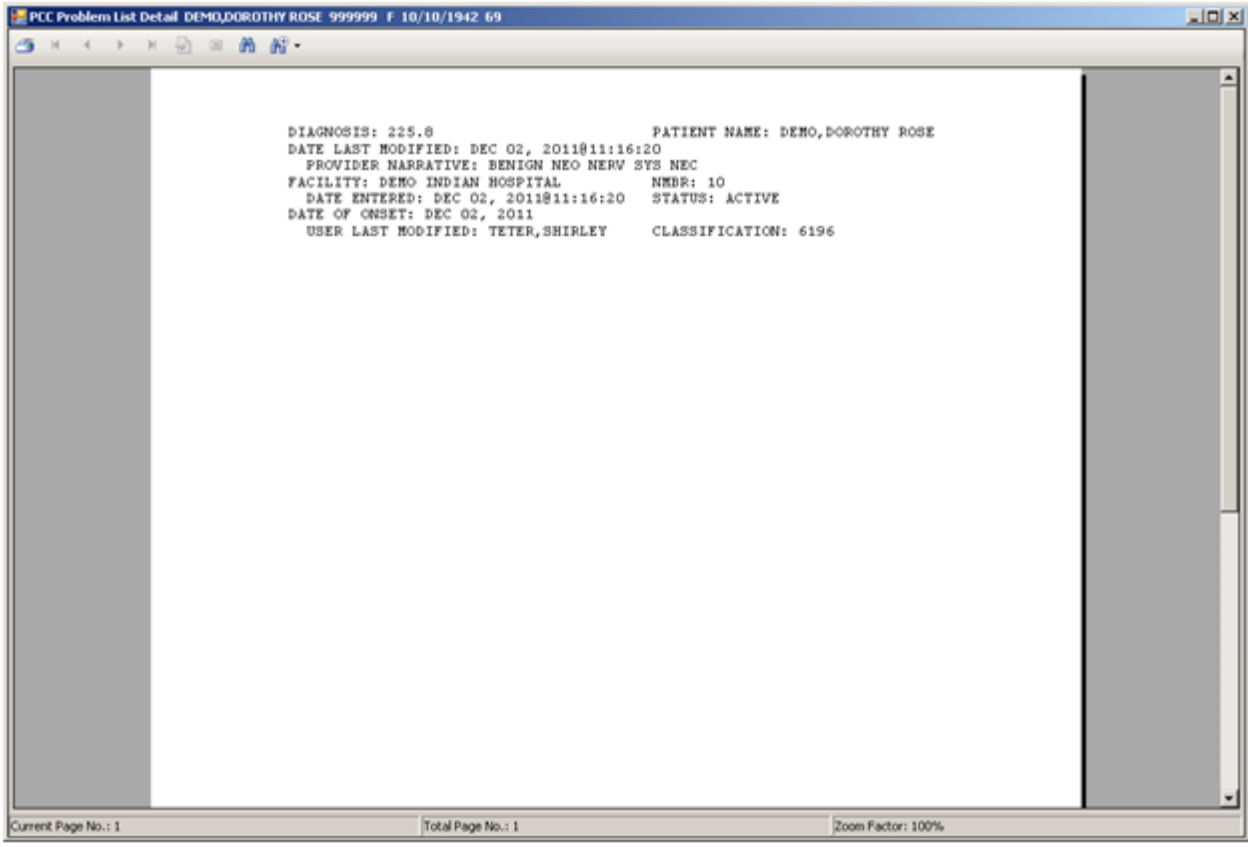


Figure 9-36: Sample **PCC Problem List Detail** pop-up window

9.2.2.9 No Active Problems

1. Click the **No Active Problems** button to indicate that the patient has No Active BH Problems. The application determines if the patient has active BH problems.

- Click the button and if there are active problems, the following message displays: “There are ACTIVE Problems on this patient’s BH problem list. You cannot use this action item.”

2. Click **OK** to close the message and the focus returns to the Behavioral Health Problem List window.

- Click the button and there are no active problems, the following message displays: “Did the Provider indicate that the patient has No Active BH Problem?”

3. Click **Yes** and the **Date Documented** and **Provider Who Documented** fields become active (Figure 9-37).

4. Click **No** and the fields remain inactive.

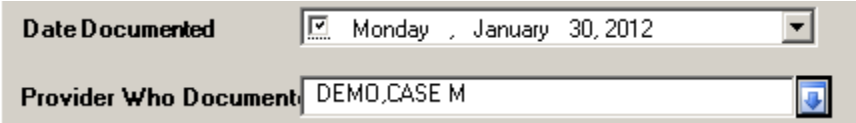


Figure 9-37: **Active fields for the No Active Problems** process

5. Set the **Date Updated**.

6. Select the Primary Provider from the **Provider Who Documented**.

7. Click **Save** to update the **Problem List**.

8. Click **Cancel** to remain on the window and no action is taken

9.2.2.10 Problem List Reviewed

This function works like the Problem List Reviewed for BH Problem list. See Section 9.2.1.10 for more information,

9.2.2.11 BH Problem List Update

- Click **BH Problem List Update** to display the **Behavioral Health Problem List** window.

10.0 Treatment Plans

You use the Treatment Plans feature to add or update treatment plans in the roll-and-scroll application and in the RPMS Behavioral Health System GUI.

10.1 Patient Treatment Plans (Roll and Scroll)

- Select **Update BH Patient Treatment Plans** (TPU) on the Data Entry Menu to display the Patient Treatment Plans menu shown on Figure 10-1:

```
                  ********************************************
                  **       IHS Behavioral Health System       **
                  **          Patient Treatment Plans         **
                  ********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL


   UP     (Add, Edit, Delete) a Treatment Plan
   DTP    Display/Print a Treatment Plan
   REV    Print List of Treatment Plans Needing Reviewed
   RES    Print List of Treatment Plans Needing Resolved
   ATP    Print List of All Treatment Plans on File
   NOTP   Patients w/Case Open but no Treatment Plan


Select Update BH Patient Treatment Plans Option:
```

Figure 10-1: Options on the Patient Treatment Plans menu

10.1.1 Add, Edit, Delete a Treatment Plan (UP)

1. At the “Select Update BH Patient Treatment Plans Option” prompt, type **UP** (Add, Edit, Delete a Treatment Plan) to display the Update Patient Treatment Plan (Figure 10-2) screen:

```
Update Patient Treatment Plan Apr 13, 2009 17:11:07          Page:    1 of    9
Patient Name:  ALPHAA,CHELSEA MARIE     DOB:  FEB 07, 1975   Sex:  F
                       TREATMENT PLANS CURRENTLY ON FILE

1)  Program:  SOCIAL SERVICES            Responsible Provider:  GAMMAA,RYAN
     Date Established:  MAR 27, 2009     Next Review Date:  APR 01, 2009
     Status:                             Date Resolved:
     Problem: eating

2)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  MAR 24, 2009     Next Review Date:  APR 15, 2009
     Status:                             Date Resolved:
     Problem: testing functionality of editing tip

3)  Program:  MENTAL HEALTH              Responsible Provider:  BETAAAA,BJ
     Date Established:  MAR 24, 2009     Next Review Date:  JUN 22, 2009
     Status:                             Date Resolved:
     Problem: TESTING BASED ON RYAN'S FINDINGS
```

```
+         Enter ?? for more actions
AD   Add Treatment Plan   RV   Enter TP Review      BV   Browse Visits
ED   Edit a Plan          DS   Disp/Print Plan      SP   Share a TP
DE   Delete Tx Plan       HS   Health Summary       Q    Quit
Select Action: AD//
```

Figure 10-2: Sample Update Patient Treatment Plan screen

2. At the "Select Action" prompt, type **Q** and press Enter to close the screen.

10.1.1.1 Add Treatment Plan (AD)

- At the "Select Update BH Patient Treatment Plans Option" prompt, type **AD** to add a new treatment plan for the current patient.

Refer to Section 10.1.1.2 for more information.

10.1.1.2 Edit a Plan (ED)

1. At the "Select Update BH Patient Treatment Plans Option" prompt, type **ED** to change a selected treatment plan for the current patient.
   - The "Enter Date Established" prompt is read only.
2. At the "Program:" prompt, type one of the following:
   - **M** (Mental Health), S (Social Services)
   - O (Other)
   - C (Chemical Dependency)
3. At the "Designated Provider prompt, type the name of the provider.
4. At the "Case Admit Date prompt, set the date.

- The "AXIS I" field is read only

5. At the "Edit?" prompt, type one of the following:
   - Type **Y** to access another window and change the AXIS I text.
   - Type **N** to cancel the operation.

- The "AXIS II" field is read only

6. At the "Edit?" prompt, type one of the following:
   - Type **Y** to access another window and change the AXIS II text.
   - Type **N** to cancel the operation.

AXIS III

- The "AXIS III" field is read only.

7. At the “Edit?” prompt, type one of the following:
   - Type **Y** to access another window and change the AXIS III text.
   - Type **N** to cancel the operation.
8. At the “Select AXIS IV” prompt, type one of the following:
   - **1** (primary support group problems)
   - **2** (social environmental problems)
   - **3** (educational problems)
   - **4** (occupational problems)
   - **5** (housing problems)
   - **6** (economic problems)
   - **7** (access to health care services problems)
   - **8** (legal interaction problems)
   - **0** (other psychosocial or environmental problem).
9. At the “AXIS V” prompt, type the functional level.
10. At the “GAF Scale Type” prompt, type the acronym GAF Scale Type.
11. At the “Problem List” prompt, type a description.
12. At the “Treatment Plan Narrative (Problems/Goals/Objectives/Methods)” prompt, type the narrative of the problem.
13. At the “Edit?” prompt, type one of the following:
    - Type **Y** to display another rwindow and change the narrative.
    - Type **N** to cancel the operation.
14. At the “Anticipated Completion Date” prompt, set the date.
    - Review Date field is read only.
15. At the “Concurring Supervisor” prompt, type the name of the supervisor.
16. At the “Date Concurred” prompt, set the date. A list of “Participants in the development of this plan” displays (Figure 10-3). If there are no participants, the “None recorded” message displays.

```
Participants in the development of this plan:
   ----------------------------------------------------------------------
  1)  Alma Beta                          cousin

     Select one of the following:
```

```
          A         Add a Participant
          E         Edit an Existing Participant
          D         Delete a Participant
          N         No Change

Which action:
```

Figure 10-3: Sample of participants in the development of this plan.

17. Do one of the following at the "Which action" prompt:

- Type **A** to add a participant.
  - At the "Enter the Participant Name" prompt, type the name of the participant.
  - At the "Enter the Relationship to the Client" prompt, type the relationship.
- Type **E** to edit an existing participant. After you indicate the participant name, the prompts are the same as the add option.
- Type **D** to delete an existing participant. The application asks to specify the one you want to delete.

No confirmation message displays.

- Type **N** to continue onto the next prompt.
- The "Date Closed" prompt is read only.

10.1.1.3 Delete Tx Plan (DE)

1. Type **DE** to delete a treatment plan, do one of the following
2. At the "Select BH Treatment Plan" prompt, type the treatment plan to be removed.
3. At the "Are you sure you want to DELETE this Treatment Plan?" prompt, do one of the following:
   - Type **Y** to remove the treatment plan from **Update Patient Treatment Plan** screen.

10.1.1.4 Enter TP Review (RV)

1. Typte **RV** to display the **Treatment Plan Update** screen for the current patient.
2. At the "Select BH Treatment Plan" prompt, type the treatment plan to review, do one of the following:
3. At the "Select REVIEW DATE" prompt, change the review date. If a date is not entered, you exit the RV process.

4. At the “Review Provider” prompt, type the name of the review provider.
5. At the “Review Supervisor” prompt, type the name of the review supervisor.
6. At the “Progress Summary”, the progress summary displays if applicable.
7. At the “Edit?” prompt, do one of the following:
   - Type **Y**: to edit the text of the progress summary, a secondary screen displays.
   - Type **N**: to continue.
8. At the “Select TX REVIEW PARTICIPANT NAME”, type a new treatment review participant name.
9. At the “Relationship to Client” prompt, type the relationship to the client.

   This prompt does not appear unless you added a name in the previous prompt.
10. At the “Next Review Date” prompt, the next review date displays

10.1.1.5 Disp/Print Plan (DS)

1. Type **DS** to display/print a specified treatment plan for the current patient, do one of the following:
2. At the “Select BH Treatment Plan” type the treatment plan to browse or print.
3. At the “What would do like to print” prompt, do one of the following:
   - Type T (Treatment Plan Only)
   - R (Treatment Plan REVIEWS Only)
   - B (both Treatment Plan and Reviews)
4. At the “Do you wish to” prompt, do one of the following:
   - Type **P** (print output on paper)
   - Type **B** (browse output on screen) shown in Figure 10-4:

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
*******************************************************************************
*                                                                             *
*  TREATMENT PLAN                            Printed: Oct 27, 2009@09:49:14   *
*  Name:  ALPHAA,CHELSEA MARIE                                   Page 1       *
*  DEMO INDIAN HOSPITAL       DOB:  2/7/75    Sex:  F   Chart #:  WW116431    *
*                                                                             *
*******************************************************************************

Date Established:          Oct 01, 2009
Admit Date:
Anticipated Completion Date:
Date Close:                Oct 01, 2009
```

```
Provider:                  GAMMA,DENISE
Supervisor:                <not recorded>
       Date Concurred:
Review Date:
Participants in Plan Creation:
   Blair                               sister

DIAGNOSIS:
AXIS I

AXIS II

AXIS III

AXIS IV
AXIS V                          GAF Scale Type

PROBLEM LIST


TREATMENT PLAN (Problems/Goals/Objectives/Methods)
******************************************************************************


  ___________________________________     ___________________________________
  Client's Signature                      Designated Provider's Signature


  ___________________________________     ___________________________________
  Supervisor's Signature                  Physician's Signature


  ___________________________________     ___________________________________
  Other                                   Other


  ___________________________________     ___________________________________
  Other                                   Other

  Date of Review:          Oct 01, 2009

  Reviewing Provider:      WILLIAMS,MARK

  Reviewing Supervisor:    <<not recorded>>

  Next Review Date:        Oct 01, 2009

  Progress Summary:

  Participants in Review:

  PARTICIPANT NAME                 RELATIONSHIP TO CLIENT
Enter RETURN to continue or '^' to exit:
```

Figure 10-4: Sample display of treatment plan

10.1.1.6 Health Summary (HS)

- Type **HS** to display/print the health summary for the patient.

10.1.1.7 Browse Visits (BV)

1. Type **BV** to browse the behavioral health visits for the current patient.
2. At the "Browse which subset of visits for [patient name]" prompt, do 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)
   - **P** (visits to one program). If you type **N**, **D**, or **P** to continue. The BROWSE PATIENT'S VISITS screen displays as shown in Figure 10-5:

```
BROWSE PATIENT'S VISITS       Jan 18, 2012 14:04:58          Page:    1 of    2

Patient Name: DEMO,DOROTHY ROSE             DOB: Oct 10, 1942
HRN: 999999


****** Suicide Forms on File ******
Date of Act: SEP 30, 2009              Suicidal Behavior: ATTEMPT
Previous Attempts: 0                   Method:
```

```
Visit Date: Jan 17, 2012                    Provider: THETA,SHIRLEY
Activity Type:                              Type of Contact: OUTPATIENT
Location of Encounter: DEMO INDIAN HOSPITAL
Chief Complaint/Presenting Problem:
POV's:

  SUBJECTIVE/OBJECTIVE:

  COMMENT/NEXT APPOINTMENT:

+         Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 10-5: Sample patient's behavioral health visits screen

10.1.1.8 Share a TP (SP)

> **Note**: You need to have shared permission in order to use this option. (Use the Site parameters on the Manager utilities (Share Records); your name would need to be added to that list.)

10.1.2 Display/Print a Treatment Plan (DTP)

1. Type **DTP** (at the Patient Treatment Plans menu) to display/print the treatment plan for a patient, do one of the following:

2. At the "Select PATIENT NAME" prompt, type the patient name to be used, do one of the following:

   If the patient does not have a treatment plan, a message displays.

   If the patient has at least one treatment plan, the **Display/Print Treatment Plan** screen will display as shown in Figure 10-6:

```
Display/Print Treatment Plan  Apr 07, 2009 17:12:08          Page:    1 of    2
Patient Name:  DUCK,DONALD R     DOB:  JUN 07, 1978   Sex:  M
                        TREATMENT PLANS CURRENTLY ON FILE


1)  Program:  SOCIAL SERVICES            Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 12, 2009
     Status:                             Date Resolved:
     Problem: testing functionality

2)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 02, 2009
     Status:                             Date Resolved:
     Problem:

3)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 02, 2009
     Status:                             Date Resolved:
     Problem:
+         Enter ?? for more actions
DS   Disp/Print Plan      PS   Previous Screen      PL   Print List
HS   Health Summary       DN   Down a Line          SL   Search List
NS   Next Screen          UP   Up a Line            Q    Quit
Select Action: DS//
```

Figure 10-6: Sample Display/Print Treatment Plan screen

- Type **Q** (Quit) to exit
- Type **NS** (Next Screen) to display the next screen of information
- Type **PS** (Previous Screen) to display the previous screen of information
- Type **DN** (Down a Line) to display the next line of information (does not work when you are on the last screen).
- Type **UP** (Up a Line) to display the line previous line of information (does not work when you are on the first screen).

10.1.2.1 Display/Print Plan (DS)

- Type **DS** to browse/print a treatment plan. Refer to Section 10.1.1.5 for more information.

10.1.2.2 Health Summary (HS)

1. Type **HS** to display a type of health summary for the current patient
2. At the "Select Health Summary Type Name" prompt, type the health summary needed. The Health Summary for the current patient on the **Output Browser** screen.

10.1.2.3 Print List (PL)

1. Type **PL** to display/print the treatment plans for the current patient.
2. At the "Device" prompt, type the device to print/browse the list of treatment plans.

   The application displays the **Display/Print Treatment Plan** for the current patient as shown in Figure 10-7:

```
Display/Print Treatment Plan  Apr 07, 2009 17:51:24       Page:  1 of    2
Patient Name:  DELTA,EDWIN RAY     DOB:  JUN 07, 1978   Sex:  M
                        TREATMENT PLANS CURRENTLY ON FILE

+-----------------------------------------------------------------------
1)  Program:  SOCIAL SERVICES            Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 12, 2009
     Status:                             Date Resolved:
     Problem: testing functionality

2)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 02, 2009
     Status:                             Date Resolved:
     Problem:

3)  Program:  MENTAL HEALTH              Responsible Provider:  GAMMAA,RYAN
     Date Established:  APR 02, 2009     Next Review Date:  APR 02, 2009
     Status:                             Date Resolved:
     Problem:


Enter RETURN to continue or '^' to exit:
```

Figure 10-7: Sample Display/Print Treatment Plan window

10.1.2.4 Search List (SL)

1. Type **SL** to search the text of the treatment plans.
2. At the "Search for" prompt, type the search text string.

If the application finds the first occurrence of the text string, the text is highlighted, do one of the following:

3. At the Stop Here?" prompt do one of the following:
   - Type **N** to leave the search sequence.
   - Type **Y** to search for the next occurrence of the text string.
     - If the text string is found, it will be highlighted.
     - If the text string is not found, the message "Text not found. Text not found. Do you want to start at the beginning of the list?" displays.

10.1.3 Print List of Treatment Plans Needing Reviewed (REV)

1. Type **REV** to print all patients who have a treatment plan which is due to be reviewed in a date range.
2. At the "Enter Beginning Date" prompt, type the beginning date of the range.
3. At the "Enter Ending Date" prompt, type the ending date of the range.
4. At the "Run the Report for which Program" prompt, type one of the following:
   - **A** (All Programs)
   - **O** (One Program) to continue
5. At the "List Treatment Plans for" prompt, type one of the following:
   - **A** (All Programs)
   - **O** (One Program) o continue
6. At the "Demo Patient Inclusion/Exclusion" prompt, do one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
7. At the "Device" prompt, type the device to print/browse the output.

Figure 10-8 shows a sample **Listing of Treatment Plans Due to be Reviewed** screen:

```
            ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                  Page 1
                            DEMO INDIAN HOSPITAL
            LISTING OF TREATMENT PLANS DUE TO BE REVIEWED
                   Date Range: APR 07, 2008 to APR 07, 2009

PATIENT NAME           DOB       CHART # DATE         REVIEW DATE   ANTICIPATED
```

```
                                          ESTABLISHED                COMPLETION
                                                                     DATE
-------------------------------------------------------------------------------

ALPHA,ALICE ROCHELLE   6/25/97   183497  Dec 01, 2005 Feb 23, 2009  Feb 23, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 21, 2006 Sep 30, 2008
   Program: CHEMICAL DEPENDENCY  Responsible Provider: GAMMAA,DENISE
ALPHAA,GLEN DALE       11/10/81  108704  Dec 10, 2007 May 06, 2008  Dec 10, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAAA,BJ

Enter RETURN to continue or '^' to exit:
```

Figure 10-8: Sample output treatment plans due to be reviewed

10.1.4 Print List of Treatment Plans Needing Resolved (RES)

- Type **RES** to print a list of all patients who have treatment plans in an anticipated completion date within a date range that need to be resolved.
  - The prompts are the same as those for the **Print List of Treatment Plans Needing Reviewed (REV)**.

Figure 10-9 shows a sample of **Listing of Treatment Plans Due to be Resolved** is displayed:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                   Page 1
                              DEMO INDIAN HOSPITAL
             LISTING OF TREATMENT PLANS DUE TO BE RESOLVED
                    Date Range: APR 07, 2008 to APR 07, 2009

PATIENT NAME           DOB       CHART # DATE         REVIEW DATE   ANTICIPATED
                                         ESTABLISHED                COMPLETION
                                                                    DATE
-------------------------------------------------------------------------------

ALPHA,ALICE ROCHELLE   6/25/97   183497  Dec 01, 2005 Feb 23, 2009  Feb 23, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Jun 27, 2007               Jul 02, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,GLEN DALE       11/10/81  108704  Dec 10, 2007 May 06, 2008  Dec 10, 2008
   Program: MENTAL HEALTH        Responsible Provider: BETAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 03, 2008 Mar 18, 2008  Apr 07, 2008
   Program: MENTAL HEALTH        Responsible Provider: GAMMAA,DENISE

Enter RETURN to continue or '^' to exit:
```

Figure 10-9: Sample output of treatment plans due to be resolved

10.1.5 Print List of All Treatment Plans on File (ATP)

1. Type **ATP** to print/browse a list of all patients who have a treatment plan on file in a specified date range.
2. At the “Enter BEGINNING Date” prompt, type the beginning date.

3. At the “Enter ENDING Date” prompt, type the ending date.
4. At the “Run the Report for which PROGRAM” prompt, type one of the following:
   - **A** (All Programs)
   - **O** (One Program), other prompts will display
5. At the “List treatment plans for” prompt, type one of the following:
   - **A** (All Programs)
   - **O** (One Program), other prompts will display
6. At the “Sort list by” prompt, type one of the following
   - **P** (Responsible Provider)
   - **N** (Patient Name)
   - **D** (Date Established)
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients).
8. At the “Device” prompt, type the device to browse/print the information. The **Listing of Treatment Plans** screen will display as shown in Figure 10-10:

```
             **********  CONFIDENTIAL PATIENT INFORMATION  **********
XX                                                                    Page 1
                              DEMO INDIAN HOSPITAL
                            LISTING OF TREATMENT PLANS
                     Date Established: JAN 13, 2009 to APR 13, 2009

PATIENT NAME           DOB       CHART # DATE         REVIEW DATE   ANTICIPATED
                                         ESTABLISHED                COMPLETION
                                                                    DATE
-------------------------------------------------------------------------------
ALPHAA,CHELSEA MARIE   2/7/75    116431  Feb 25, 2009 May 26, 2009  Feb 25, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 09, 2009 Jun 07, 2009  Mar 09, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 24, 2009 Jun 22, 2009  Mar 24, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,GLEN DALE       11/10/81  108704  Apr 06, 2009 Jul 05, 2009  Apr 06, 2010
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,BJ
ALPHAA,CHELSEA MARIE   2/7/75    116431  Mar 24, 2009
   Program: MENTAL HEALTH        Responsible Provider: BETAAAA,LORI

Enter RETURN to continue or '^' to exit:
```

Figure 10-10: Sample list of treatment plans

10.1.6 Patients w/Case Open but No Treatment Plan (NOTP)

1. Type **NOTP** to produce a report that lists all patients who have a case open date, no case closed date, and no treatment plan in place of a specified date range.
2. At the "Enter BEGINNING Date" prompt, type the beginning date.
3. At the "Enter ENDING Date" prompt, type the ending date.
4. At the "List cases opened by" prompt, type one of the following:
   - **A** (All Programs)
   - **O** (One Program)to continue

   This allows you to limit the report output to cases opened by one or all Programs.
5. At the "List cases opened by" prompt, type one of the following:
   - **A** (All Providers)
   - **O** (One Provider) to continue
6. At the "Sort list by" prompt, type one of the following
   - **P** (Responsible Provider)
   - **N** (Patient Name)
   - **C** (Case Open Date).
7. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients).
8. At the "Do you wish to" prompt, type one of the following:
   - **P** (Print output)
   - **B** (Browse output on screen).

The application displays the **LISTING OF CASES OPENED WITH NO TREATMENT PLAN IN PLACE** report shown in Figure 10-11:

```
                Case Open Dates: SEP 08, 2010 to DEC 07, 2010

PATIENT NAME           HRN     CASE OPEN PROGRAM     PROVIDER         LAST VISIT
                               DATE
-------------------------------------------------------------------------------

THETAA,ROLAND          258852  10/01/10  MENTAL HEA                     12/07/10
BETAAAA,MONTY          741147  11/03/10  MENTAL HEA                     12/07/10
DEMO,DOROTHY ROSE      999999  12/07/10  MENTAL HEA                     07/08/10
```

```
BETA,ROBERT JACOB      207365  11/22/10  CHEMICAL D  CHIII,JESSICA      12/07/10
```

Figure 10-11: Sample Listing of Cases with No Treatment Plan in Place report

10.2 Treatment Plan Window (GUI)

The **RPMS Behavioral Health System** GUI application provides ways to manage treatment plans for one patient

The treatment plan functions display as shown in Figure 10-12:

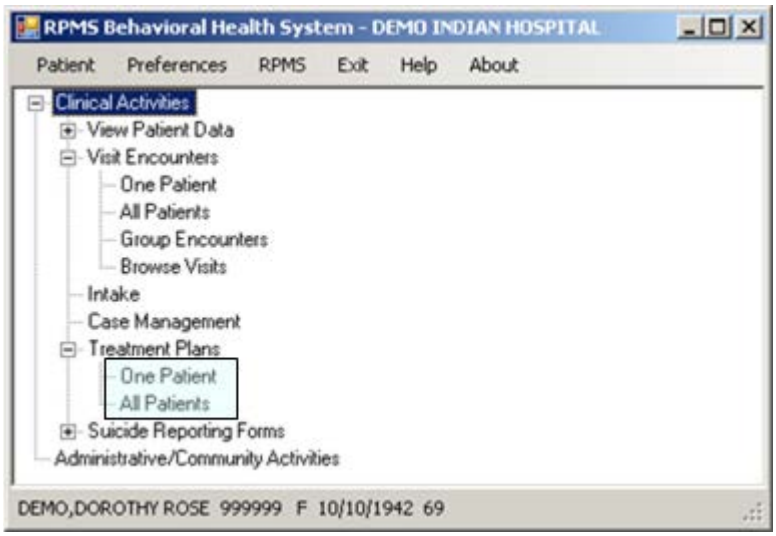


Figure 10-12: **Location of Treatment Plan** functions on tree structure

One way to access the **Treatment Plan** window is to use the One Patient selection shown in Figure 10-13:

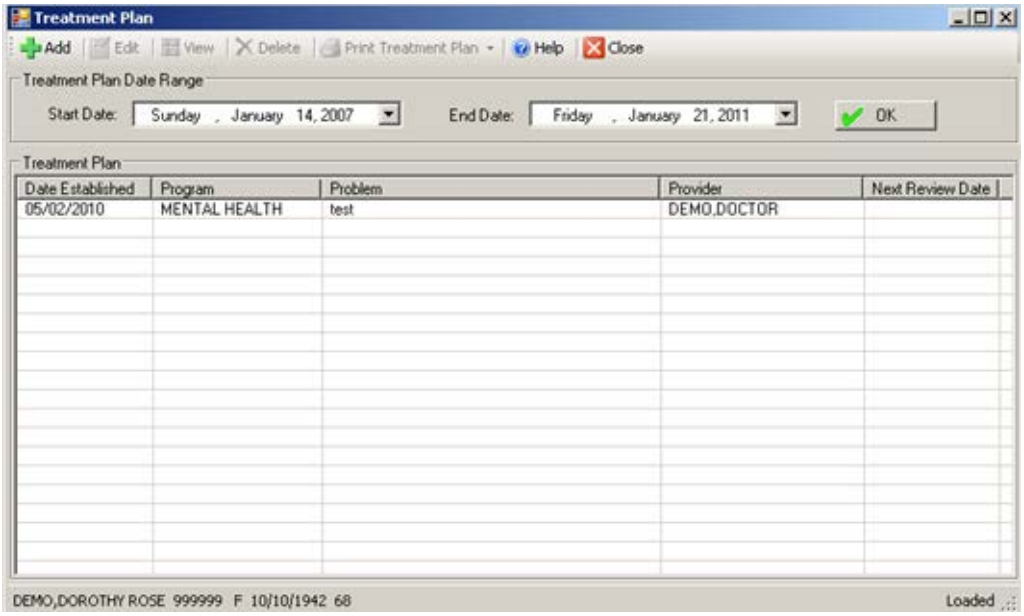


Figure 10-13: Sample **Treatment Plan** window for current patient

Another way to access the **Treatment Plan** window is to use the All Patients option shown in Figure 10-14. The features for both windows follow.

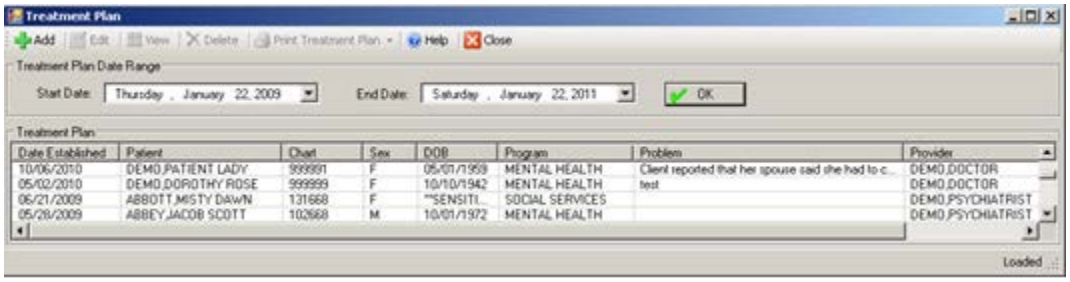


Figure 10-14: Sample **Treatment Plan** window for all patients

10.2.1 Treatment Plan Date Range

The treatment plan records are within the date range shown in the **Treatment Plan Date Range** pane.

You can change any date in the date range by clicking the drop-down list and selecting a new date from the calendar. After the date range has changed, click **OK** to display the records in the **Treatment Plan** pane.

10.2.1.1 Treatment Plan Window for One Patient

The following applies to the Treatment Plan window for one patient:

- The default Start Date is one year previous.
- If you change the Start Date for the Treatment Plan window for one patient, this change stays in effect in future sessions of the GUI application for the Treatment Plan window (until you change it again).

10.2.1.2 Treatment Plan Window for All Patients

The following applies to the Treatment Plan window for all patients:

- The default start date is one year previous.
- If you change the start date for the Treatment Plan window for all patients, this change stays in effect until you exit the application. When you login the next time, the start date reverts to one year previous.

10.2.2 Treatment Plan Pane

The Treatment Plan pane shows the records within the treatment plan date range.

10.2.3 Add Button

Click **Add** to add a new treatment record for the patient. **The Treatment Plan–Add Treatment Plan** window displays. Refer to Section 10.3 for more information.

10.2.4 Edit Button

Click **Edit** to edit a treatment plan record. Tthe Treatment Plan–Edit Treatment Plan screen displays.

10.2.5 View Button

Highlight a treatment plan record and click **View** (or double-click on the plan) to view the selected treatment plan data. The fields are the same as those on the add/edit Treatment Plan dialog. Refer to Section 10.3 for more information.

10.2.6 Delete Button

Click **Delete** to delete a treatment plan record. The deletion is confirmed.

10.2.7 Print Treatment Plan Button

1. Highlight a record and click **Print Treatment Plan** to print a Treatment Plan record. Three options will be displayed:

   - **Treatment Plan Only**
   - **Review Data Only**
   - **Treatment Plan and Review Data**

   If **Review Data Only** or **Treatment Plan and Review Data** is selected and if there are one or more reviews, the **Treatment Plan Reviews** dialog (Figure 10-15) displays.

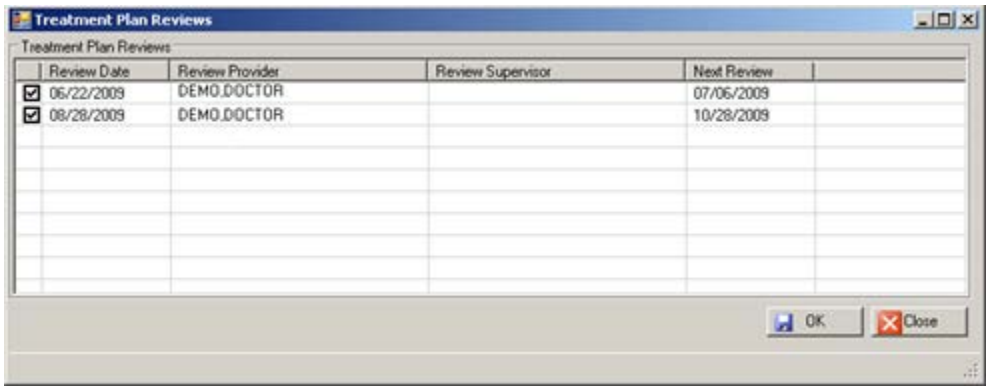


Figure 10-15: Sample **Treatment Plan Reviews** dialog

2. Select one or more **Treatment Plan Review record**s and click **OK**.

3. Click **Close** to exit the print routine.

The first page of the **Treatment Plan** pop-up window displays as shown in Figure 10-16:

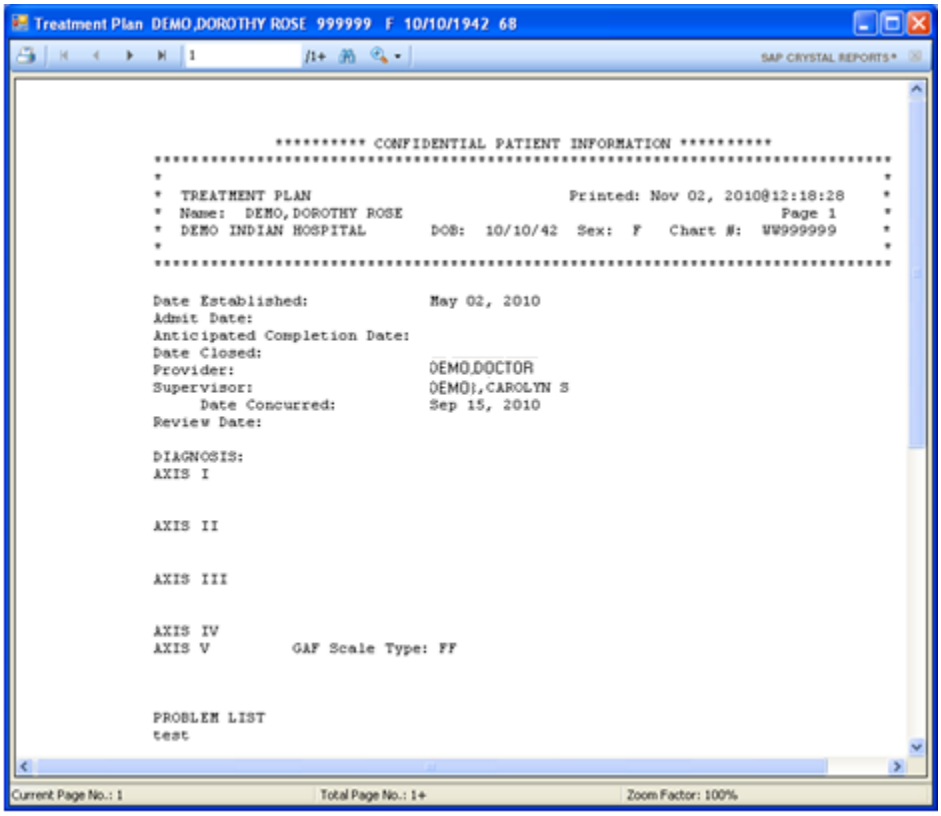


Figure 10-16: Sample **Treatment Plan** pop-up window

Refer to Section 2.6 for more information.

10.2.8 Help

Click **Help** to access the online help system.

10.2.9 Close Button

Click **Close** to close the **Treatment Plan** window.

10.3 Add/Edit Treatment Plan Record (GUI)

1. Do one of the following:

   - Click **Add** on the **Treatment Plan** window to display the **Treatment Plan–Add Treatment Plan** window.
   - Click **Edit** on the **Treatment Plan** window to display the **Treatment Plan–Edit Treatment Plan** window.

Figure 10-17 shows the **Treatment Plan - Add Treatment Plan** window:

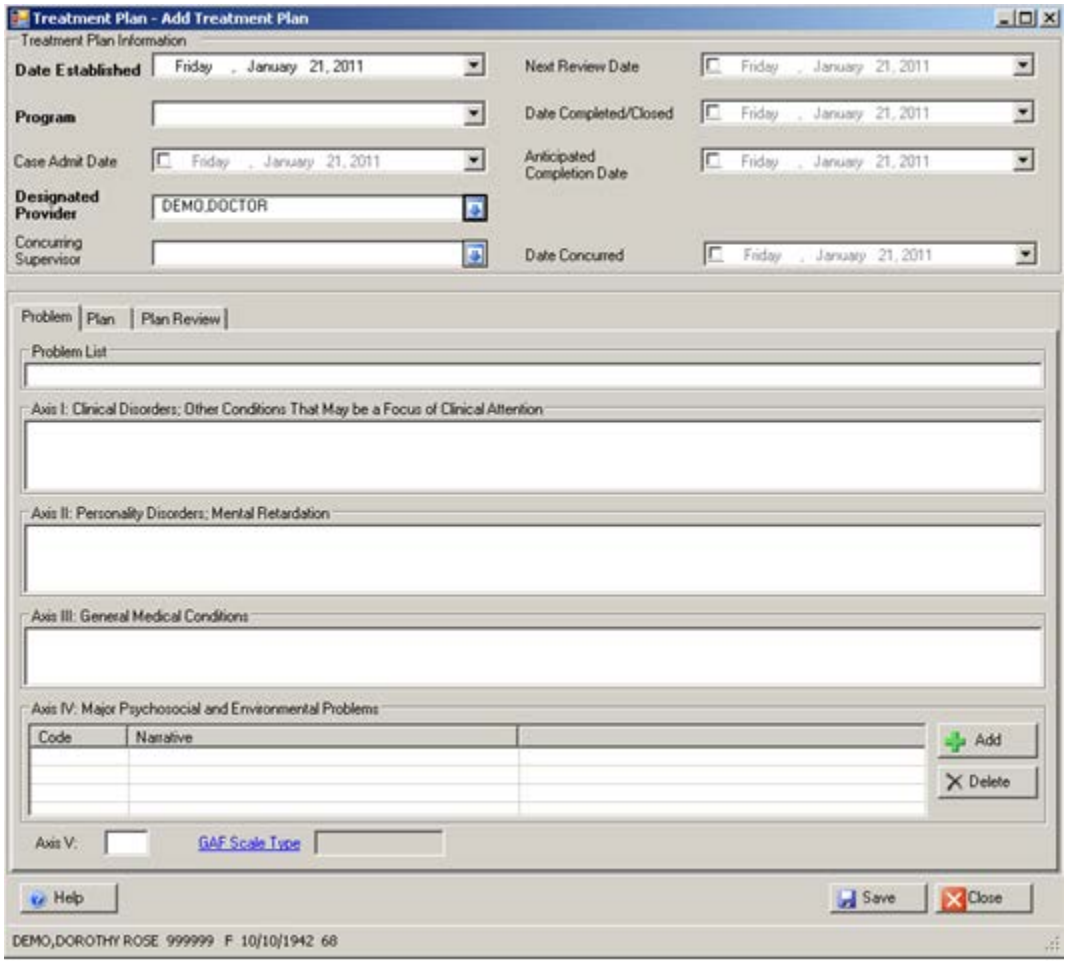


Figure 10-17: Sample **Add Treatment Plan** window

- Click **Help** to access the online help system.

2. Click **Save** to save the data or changes.

10.3.1 Treatment Plan Information Pane

Select the **Treatment Plan Information** pane (Figure 10-18) to manage the basic information about the treatment plan. Do the following:

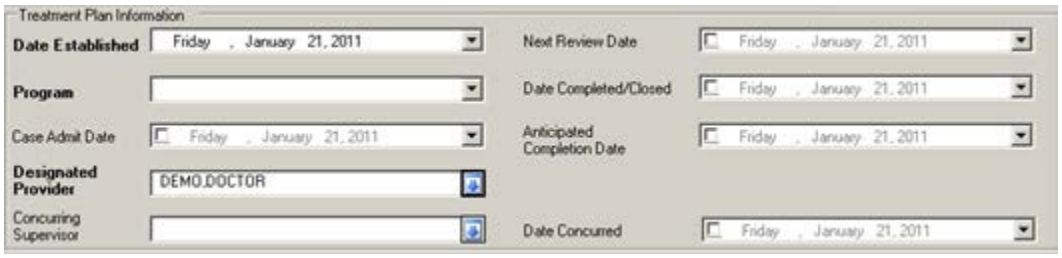


Figure 10-18: Sample **Treatment Plan Information** pane

1. Set the **Date Established**.
2. Set the **Next Review Date**.
3. Select the **Program** field and type one of the following:
   - Mental Health
   - Social Services
   - Other
   - Chemical Dependency
4. Set the **Date Completed/Closed**.
5. Set the **Case Admit Date**.
6. Set the **Anticipated Completion Date**.
7. Select a provider name from the **Designated Provider** field.
8. Select a name from the **Concurring Supervisor** field.
9. Set the **Date Concurred**.

10.3.2 Problem Tab

Select the **Problem** tab to manage the Axis I through V data and the problem list (Figure 10-19):

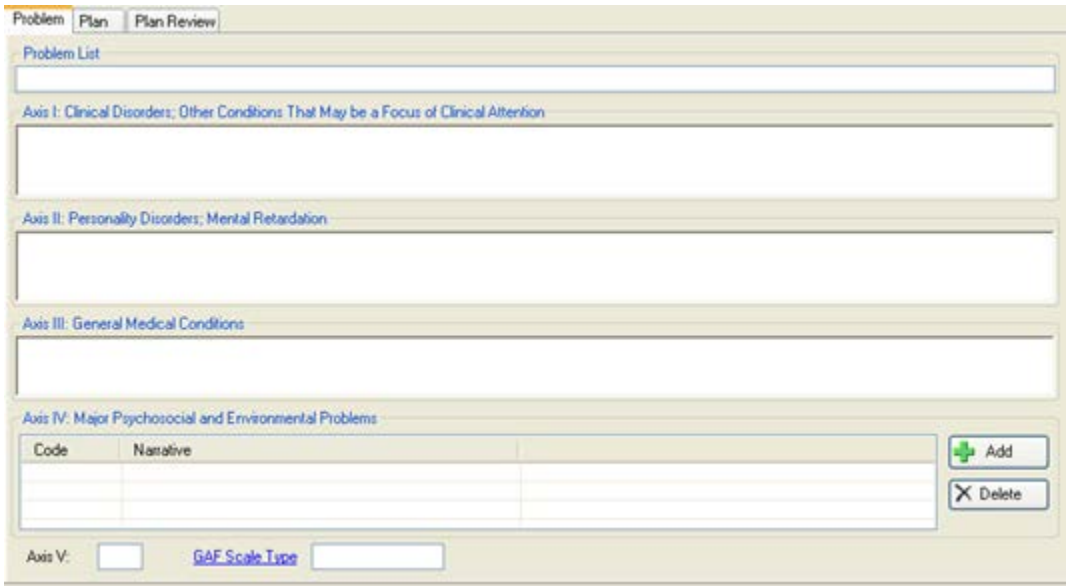


Figure 10-19: Sample **Problem** tab

10.3.2.1 Problem List Pane

Type up to 240 characters to list and briefly describe multiple problems.

10.3.2.2 Axis I Pane

Type the text of the clinical disorders or other conditions that might be a focus of clinical attention for the treatment plan.

10.3.2.3 Axis II Pane

Type the text of the personality disorders or mental retardation to be used in the treatment plan.

10.3.2.4 Axis III Pane

Type the text of a general medical condition to be used in the treatment plan.

10.3.2.5 Axis IV Pane

1. Type one or more of the psychosocial or environmental codes (Figure 10-20) that identifies the major category of the problem.

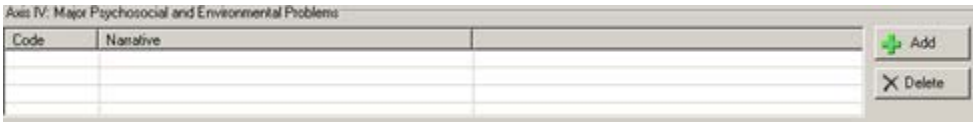


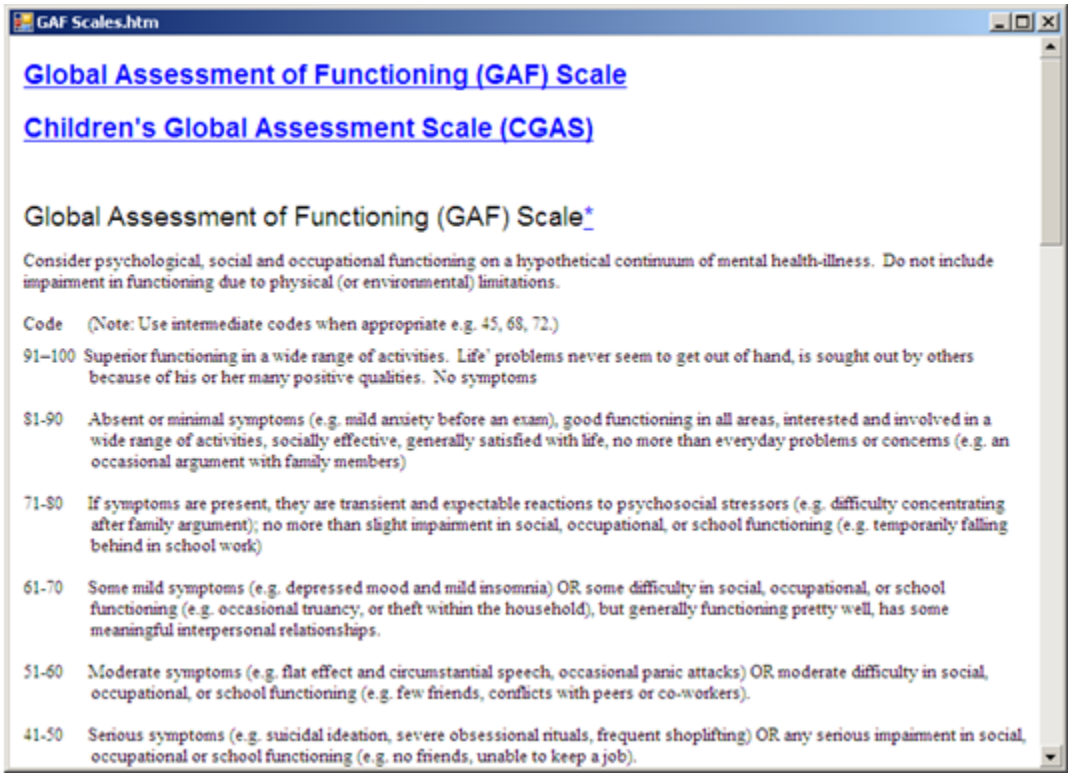
Figure 10-20: Sample Axis IV pane

2. Click **Add** to add the codes on the **Axis IV** multiple select window.
3. Click **Delete** to remove a highlighted code. The **Are You Sure?** confirmation displays: “Are you are sure you want to delete?”
   - Click **Yes** to remove the selected code from the pane.
   - Click **No** to retain the code.

10.3.2.6 Axis V

1. Type three characters in the **Axis V** field to enter the GAF scale value.
2. Type an acronym using up to 20 characters in the **GAF Scale Type** field.

If you click the link on the GAF Scale Type label, the application displays the Global Assessment of Functioning pop-up (Figure 10-21) window. T


GAF Scales.htm

Global Assessment of Functioning (GAF) Scale

Children's Global Assessment Scale (CGAS)

Global Assessment of Functioning (GAF) Scale*

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate e.g. 45, 68, 72.)

91–100 Superior functioning in a wide range of activities. Life' problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms

81-90 Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members)

71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work)

61-70 Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60 Moderate symptoms (e.g. flat effect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers).

41-50 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).

Figure 10-21: Global Assessment of Functioning (GAF) Scale

10.3.3 Plan Tab

Select the **Plan** tab to add participants to the plan as well as describing the Problems/Goals/Objectives/Methods of the plan. Figure 10-22 shows the **Plan** tab.

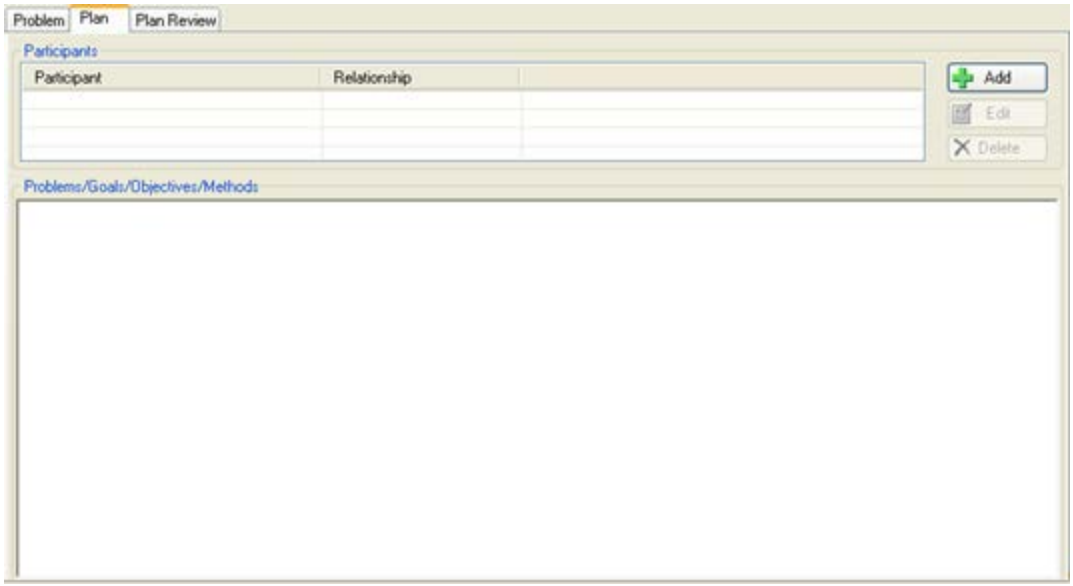


Figure 10-22: Sample **Plan** tab

To manage the participants in the treatment plan:

- Select a patient in the Patient pane and click **Edit** to change the record. **The Treatment Plan Participants** window displays (Figure 10-23).
- Select a patient in the Patient pane and click **Delete** to delete the record. A confirmation message displays.
- Click **Add** to add a new participant record. The **Treatment Plan Participants** window displays (Figure 10-23).

10.3.3.1 Treatment Plan Participants Dialog

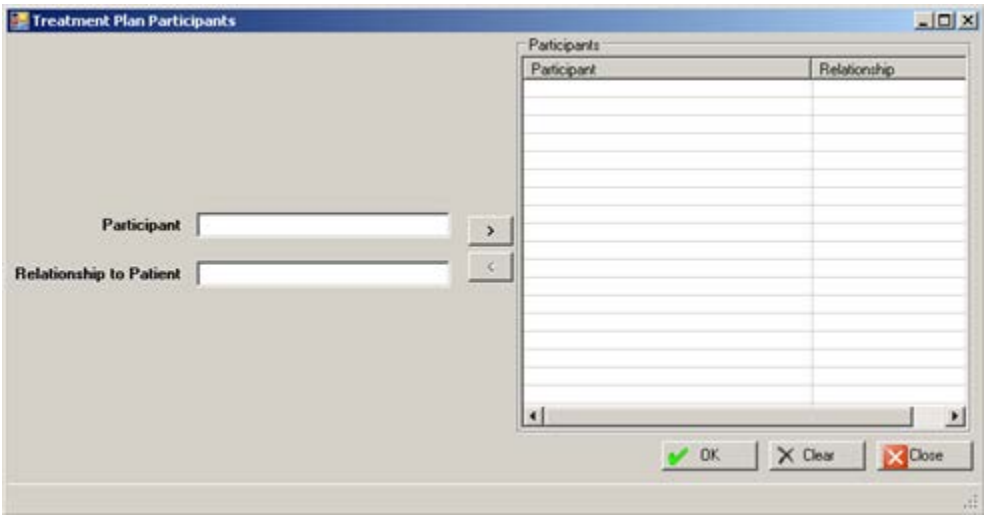


Figure 10-23: Sample Treatment Plan Participants dialog

To update the **Treatment Plan Participants** window:

1. Type the participant name in the **Participant** field.
2. Type the relationship in the **Relationship to Patient** field.
3. Click the right-pointing arrow to add the information to the **Participants** pane.
   - Click the left-pointing arrow to remove a highlighted record in the **Participants** pane.
   - Click **Clear** to remove the data in the Participant and Relationship to Patient fields.
4. Click **OK** to save the data to update the **Participants** pane of the **Plan Review** tab.
5. Click **Close** to exit the window.

10.3.3.2 Problems/Goals/Objectives/Methods

Type the text of the problems, goals, objective, or methods for the treatment plan in the **Plan** tab as shown in Figure 10-22.

10.3.4 Plan Review Tab

Select the **Plan Review** tab (Figure 10-24) to document the review of the treatment plan.

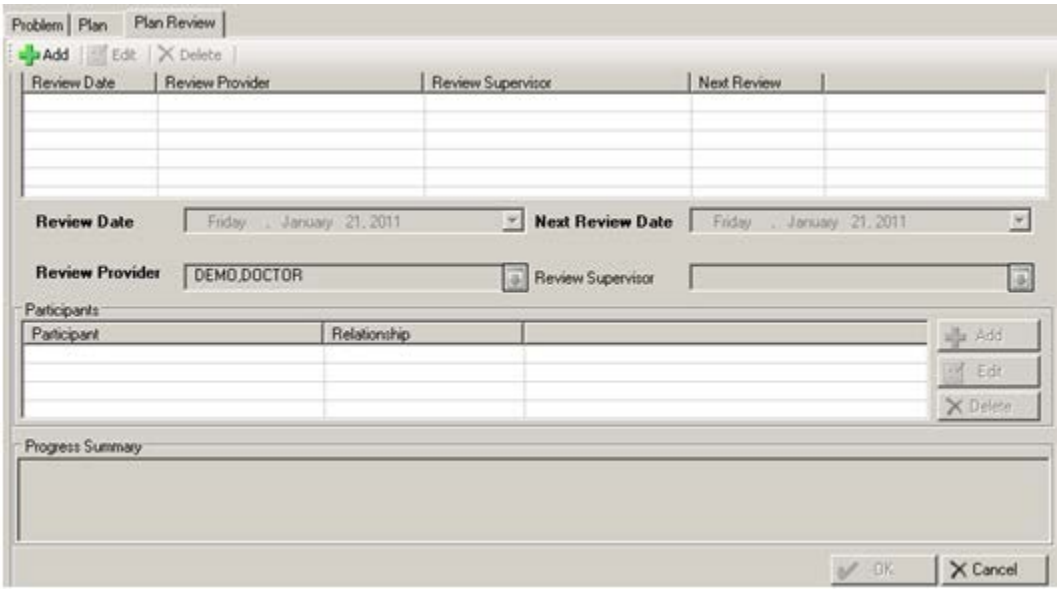


Figure 10-24: Sample **Plan Review** tab

When a record is highlighted, do the following:

1. Complete the fields for the plan review (below the grid). See Section 10.3.4.1.
2. Complete the participants in the plan review (in the Participants pane). See Section 10.3.4.2.
3. Complete the progress summary for the plan review (in the Progress Summary pane). See Section ☐.
4. Click **OK** to save the plan review record.
   - Click **Cancel** and the record is not saved.

10.3.4.1 Review Pane

Use the top pane to document the review date, the review provider, and review supervisor, and next review date for the treatment plan.

1. Do one of the following:
   - Select a record and click **Delete** to remove the record. A confirmation message displays.
     - Click **Yes** to delete the record.
     - Click **No** to end the process.
   - Select a record and click **Edit** to update the record.
   - Click **Add** to add a new review record.
2. Set the **Review Date**.
3. Set the **Next Review Date**.

Note:	Changing the next review date will also change the next review date on the **Treatment Plan Information** pane.

4. Select a provider from the Review Provider field.
5. Select a name from the Review Supervisor field.

10.3.4.2 Participants Pane (Plan Review)

Use the Participants pane (Figure 10-24) to show the participants in the plan review.

Do one of the following:

- Select a record and click **Add** to access the **Treatment Plan Participants** window. Refer to Section 10.3.3.1 for more information.

- Select a record and click **Edit** to edit a record. The **Treatment Plan Participants** window displays with the current data. Refer to Section 10.3.3.1 for more information.
- Select a record and click **Delete** to remove the record. A confirmation message displays
  - Click Yes to delete the record.
  - Click No to end the process.

10.3.4.3 Progress Summary

Type text in the Progress Summary field to add to the progress of the plan review.

11.0 Suicide Forms

You can manage suicide forms in the roll-and-scroll application, as well as in the RPMS Behavioral Health System GUI.

> **Note**: All fields are mandatory but not enforced. This means if you do not populate all of the fields, you can still save, but that suicide form will be considered incomplete. If you do complete all of the fields, the suicide form will be considered complete.

11.1 Suicide Reporting Forms (Roll and Scroll)

At the "Suicide Reporting Forms–Update/Print" prompt, type **SF** on the IHS Behavioral Health System Data Entry Menu to manage suicide forms in the roll-and-scroll application. Figure 11-1 shows the options available.

```
   SFD    Review Suicide Reporting Forms by Date
   SFP    Update Suicide Reporting Form for a Patient

Select Suicide Reporting Forms - Update/Print Option:
```

Figure 11-1: Options available for managing suicide forms

11.1.1 Update Suicide Reporting Form for a Patient (SFP)

1. Type **SFP** at the "Select Suicide Reporting Forms - Update/Print Option**"** prompt, do the following to complete:

2. At the "Select Patient Name field" prompt, type the name of the patient. The View/Update Suicide Form screen displays as shown in Figure 11-2:

```
View/Update Suicide Form      Apr 14, 2009 15:41:17          Page:    1 of    9
Suicide Forms on File for: ALPHAA,CHELSEA MARIE
HRN: 116431    FEMALE   DOB: Feb 07, 1975
Tribe: TOHONO O'ODHAM NATION OF   Community: TATRIA TOAK

1) Local Case #:                  Computer Case #: 505901090420060000034642
   Date of Act: SEP 04, 2006      Provider: GAMMAAA,DENISE
   Suicidal Behavior: ATTEMPT
   Method: HANGING  OTHER
2) Local Case #:                  Computer Case #: 505901122420060000048688
   Date of Act: DEC 24, 2006      Provider: GAMMAAAA,JAMES N
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method:
  [Incomplete Form]
3) Local Case #:                  Computer Case #: 505901013120070000048688
   Date of Act: JAN 31, 2007      Provider: BETAAA,LINZA
   Suicidal Behavior: IDEATION WITH PLAN AND INTENT
   Method: OVERDOSE
4) Local Case #:                  Computer Case #: 505901022220070000034642
+         ?? for more actions  + next screen  - prev screen
```

```
AF   Add a Suicide Form                BV   Browse Visits for this Patient
EF   Edit a Suicide Form               HS   Health Summary for this Patient
DF   Display a Suicide Form            Q    Quit
XF   Delete a Suicide Form
Select Item(s): Next Screen//
```

Figure 11-2: Sample View/Update Suicide Form screen for the current patient

- If the suicide forms are incomplete, a message displays.

3. Type **Q** and press Enter to close the window.

11.1.1.1 Add/Edit Suicide Form

The Add and Edit functions use the same update form.

11.1.1.1.1 Add a Suicide Form (AF)

1. Type **AF** at the "Select Item(s)" prompt, to add a suicide form to the patient. Do the following:
2. At the "Provider Completing the form" prompt, type the name of the provider.
3. At the "Enter the Date of the Suicide Act" prompt, set the date of the act. The Updating IHS Suicide Form screen (Figure 11-3) displays.

11.1.1.1.2 Edit a Suicide Form (EF)

1. Type **EF** at the "Select Suicide Reporting Forms - Update/Print Option**"** prompt, to change the suicide form. The Updating IHS Suicide Form screen shown in Figure 11-3 displays:

```
***  UPDATING IHS SUICIDE FORM  ***  F1 E to exit ***
Patient: ALPHAA,CHELSEA MARIE              FEMALE         HRN: 116431
DOB: Feb 07, 1975          Community Res: TATRIA TOAK
Tribe: TOHONO O'ODHAM NATION OF ARIZONA
Computer Generated Case #: 5059011224200600000486
Provider: LAMBDA,JAMES N          Initials:      Discipline:
-------------------------------------------------------------------------
 1. Local Case #:             Provider: THETAAA,JAMES
 7. Employment Status:
 8. Date of Act: DEC 24,2006  11. Community where act Occurred:
12. Relationship Status: SINGLE            13. Education: COLLEGE GRAD
14. Suicidal Behavior: IDEATION W/ PLAN AND INTENT
15. Method (press enter):                  16. Previous Attempts: 2
17. Substance Use Involved:                18. Location of Act: HOME OR VICINI
19. Contributing Factors (press enter):
20. Disposition: IN-PATIENT MENTAL HEALTH TREATMENT (VOLUNTARY)
21. Other Relevant Information:
_____________________________________________________________________


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

Figure 11-3: Sample Updating IHS Suicide Form window

2. At the “Local Case #” prompt, type the case number generated by the site (1–20 characters).
3. At the “Provider” prompt, type the provider completing the form.
4. At the “Employment Status” prompt, type one of the following:
   - **P** (part time)
   - **F** (full time)
   - **S** (self employed)
   - **UE** (unemployed)
   - **R** (retired)
   - **ST** (student)
   - **SE** (student and employed)
   - **UNK** (unknown)
5. At the “Date of Act” prompt, type the date.
6. At the “Community where Act Occurred” prompt, type the community name.
7. At the “Relationship Status” prompt, type one of the following:
   - **1** (single)
   - **2** (married)
   - **3** (divorced/separated)
   - **4** (widowed)
   - **5** (cohabiting/common law)
   - **6** (same sex partnership)
   - **9** (unknown)
8. At the “Education” prompt, type one of the following:
   - **1**–Less than 12 years
   - **2**–High School Graduate/GED
   - **3**– College/Technical School
   - **4**–Collage Graduate
   - **5**–Post Graduate
   - **6**–Unknown

9. If **1** is entered, the following prompt displays: “If less than 12 years, highest grade completed”, type between **0** and **12**.

10. At the “Suicidal Behavior” prompt, type the behavior for the suicide act.

11. At the “Method (press enter)” prompt, press Enter to display the pop-up in Figure 11-4:

```
*** If you need help type ?, not ?? ***
METHOD:
METHOD:
METHOD:
```

Figure 11-4: Sample fields on the pop-up

12. At the “Method:” prompt, type one or more suicide methods.

13. Type **Other** at the “Method” prompt, the message “Please describe the “OTHER” Method” displays. Type between 1 and 40 characters.

14. At the “Previous Attempts” prompt, type one of the following:

    - **0** 0
    - **1** 1
    - **2** 2
    - **3** 3 or more
    - **U** Unknown

15. At the “Substance Use Involved” prompt, type one of the following:

    - **1** (none)
    - **2** (alcohol and other drugs)
    - **U** (unknown)

16. At the “METHOD” prompt, type **2**. The list of drug choices type screen displays as shown in Figure 11-5:

```
For a list of drug choices type ??

SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:
SUBSTANCE DRUG USED:
```

Figure 11-5: Sample of list of drug choices used

17. At the “SUBSTANCE DRUG USED” prompt, type “**OTHER**”. The message: Drug if other. Type between 1 and 40 characters.

18. At the “Location of Act” prompt, type the location.

19. If you type **Other** in the Location of Act field, a message prompts", Location of Act If Other. Type between 1 and 80 characters.

The following fields are on the Updating IHS Suicide Form window.

20. At the "Contributing Factors (press enter) prompt, press Enter to displays the Contributing Factors pop-up in Figure 11-6:

```
Enter all Contributing Factors. To see a list of choices type ??

FACTOR:
FACTOR:
FACTOR:
```

Figure 11-6: Fields on the pop-up

21. At the "FACTOR:" prompt, type one or more contributing factors.

> **Note**: You cannot use UNKNOWN if other legitimate values have already been entered. If you want to use UNKNOWN you must first delete (type '@') all other entries and deletion confirmations will display.

22. If you type **OTHER** at the prompt, the following message prompts: "Enter a brief description of the "Other" Contributing Factor." Type between 1 and 40 characters.

23. At the "Disposition" prompt, type the disposition of the suicide act.

24. If you type **OTHER** at the prompt, the following message prompts: "Disposition If Other. Type between 1 and 80 characters.

25. At the "Other Relevant Information" prompt, press Enter to display another window and type the relevant text about the suicide act.

26. Type **Exit** or **Save** to leave the form. If there is any missing data, Figure 11-7 displays and lists the actions to take:

```
     Select one of the following:

          E         Edit and Complete the Form
          D         Delete the Incomplete Form
          L         Leave the Incomplete Form as is and Finish it Later

What do you want to do: E//
```

Figure 11-7: List of actions you can take

27. Type **E** to return to the form, edit and complete.

28. Type **D** to delete the form. There is no confirmation message.

29. Type **L** to leave the form incomplete. The form can be completed at a later time.

11.1.1.2 Display a Suicide Form (DF)

1. Type **DF** to display a specified suicide form. Do the following:
2. At the "Select Suicide Reporting Form List (1-*x*) (where *x* is the number of last form)" prompt, type the name of the suicide form to display.
3. At the "Do you wish to" prompt, type one of the following:
   - **P** (print output)
   - **B** (browse output on screen)

Figure 11-8 shows the Output Browser screen where you can browse the Suicide Reporting Form on the screen.

```
OUTPUT BROWSER            Apr 14, 2009 16:25:44       Page:    1 of    3

********** CONFIDENTIAL PATIENT INFORMATION [ST]  Apr 14, 2009 **********
Suicide Reporting Form                       Date Printed:  Apr 14, 2009

1. Case #: 5059011224200600000048688    Local Case #:

2. PROVIDER INITIALS: RWL        3. PROVIDER DISCIPLINE: NUTRITION TECHNIC
4. SEX: FEMALE          5. DOB: FEB 07, 1975        6. AGE: 31
7. EMPLOYMENT STATUS:
8. DATE OF ACT: DEC 24, 2006
9. TRIBE: TOHONO O'ODHAM NATION OF ARIZONA
10. COMMUNITY OF RESIDENCE: TATRIA TOAK
11. COMMUNITY WHERE ACT OCCURRED:
12. RELATIONSHIP STATUS: SINGLE

+    Enter ?? for more actions                                    >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 11-8: Sample Output Browser window for suicide act

11.1.1.3 Delete a Suicide Form (XF)

1. Type **XF** to remove a selected suicide form record. Do the following:
2. At the "Select Suicide Reporting Form List (1-*x*) (where *x* is the number of last form)" prompt, type the form name to be removed.
3. At the "Are you sure you want to delete this suicide form?" prompt, type one of the following:
   - Type **Y** to accept the form selection.
   - Type **N** to end the process.

11.1.1.4 Browse Visits for this Patient (BV)

Type **BV** to browse the BH visits for the current patient. Type 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)
- **P** (visits to one program).
  - Type **N**, **D**, or **P** to continue

11.1.1.5 Health Summary for this Patient (HS)

Type **HS** to display or print a health summary for the current patient. The health summary for the patient displays on the Output Browser screen (Figure 11-8).

11.1.2 Review Suicide Forms by Date (SFD)

1. Type **SFD** to review the suicide forms in a date range. Do the following:
2. At the "Enter Beginning Suicide form date" prompt, set the beginning date.
3. At the "Enter Ending Suicide form date" prompt, set the ending date. The Review Suicide Reporting Forms screen shown in Figure 11-9 displays:

```
REVIEW SUICIDE REPORTING FORMSOct 04, 2010 12:14:10          Page:    1 of    2
Suicide Form Review: Jul 06, 2010 - Oct 04, 2010
I = Incomplete Form
       Date
No.    of Act   Patient             HRN    DOB      Suicidal Behavior    PRV Loc

1)  I  09/29/10 CHI,ROBERT MITCHELL 186585 02/19/98                      MAW 123
2)     09/23/10 CHI,JIMMY RAY       146733 07/14/90 ATTEMPTED SUICIDE WI RJG 222
3)  I  09/16/10 CHI,ROBERT MITCHELL 186585 02/19/98                      RJG
4)     09/15/10 CHIY,ROBERT MITCHELL 186585 02/19/98 ATTEMPT              RJG 798
5)  I  09/15/10 THETA,CHARLES       109767 10/27/60 IDEATION WITH PLAN A RJG
6)  I  09/13/10 THETA,CYNTHIA MAE   110301 12/26/64                      LB
7)  I  09/01/10 CHI,ROBERT MITCHELL 186585 02/19/98                      RJG
8)     08/30/10 ABELL,WALTER JR     211438 01/15/04 COMPLETED SUICIDE WI BH
9)     08/27/10 CHI,ROBERT MITCHELL 186585 02/19/98 IDEATION WITH PLAN A RJG
10) I  08/11/10 SEASEAA,ALICIA MARI 169379 05/26/52 ATTEMPTED SUICIDE WI BJB
11) I  08/10/10 SEASEAA,ALICIA MARI 169379 05/26/52 ATTEMPT              BJB
12) I  08/10/10 TEST,BARBARA        28989  01/01/90                      SPR
13) I  08/09/10 SEASEAA,ALICIA MARI 169379 05/26/52 ATTEMPTED SUICIDE WI BJB
+         Enter ?? for more actions                                      >>>
AF   Add Form             DE   Delete Form          Q    Quit
EF   Edit Form            +    Next Screen
DF   Display Form         -    Previous Screen
Select Action: +//
```

Figure 11-9: Sample Review Suicide Report Forms window

- The letter I to the left of the Date of Act represents the Incomplete Suicide Reporting Forms.

Refer to Section 11.1.1 for more information.

11.2 Suicide Form Window (GUI)

The suicide form options are located under the **Suicide Reporting Forms** category on the tree structure for the **RPMS Behavioral Health System** GUI application, shown in Figure 11-10:

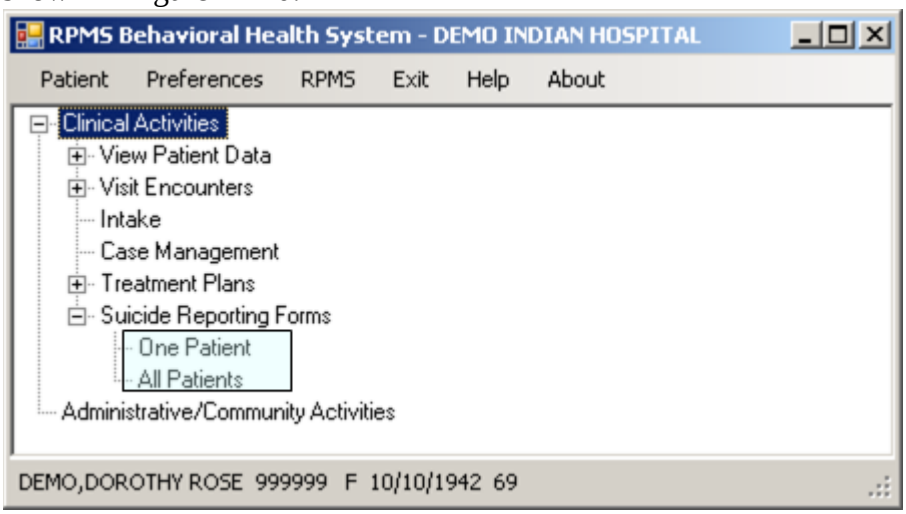


Figure 11-10: Location of **Suicide Forms** on the tree structure

One way to display the Suicide Form window is to select the One Patient option.

> **Note**: You can access this window if you click the Suicide Form tab on the **Visit Data Entry–Add/Edit** window.

The application displays the Suicide Form window for one patient (Figure 11-11). If you access the Suicide Form for one patient window and there is no current patient, you will be asked to select one.

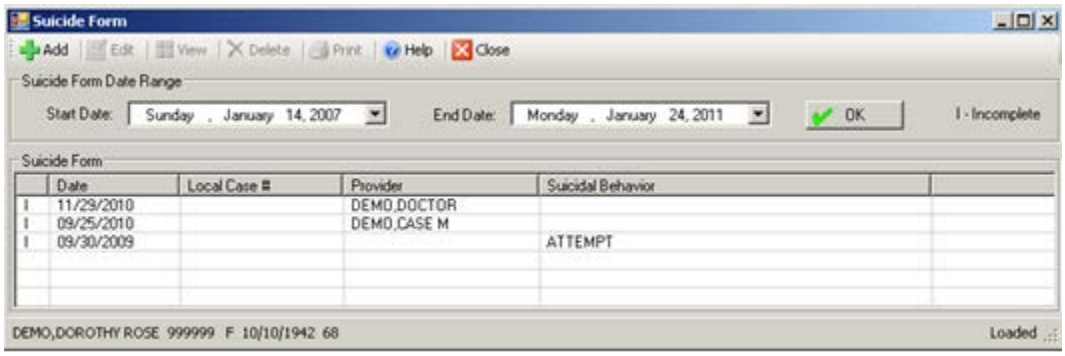


Figure 11-11: Suicide Form window for one patient

Another way to access the Suicide Form window is to select the All Patients option (Figure 11-10). The **Suicide Form** window for all patients is displayed in Figure 11-12:

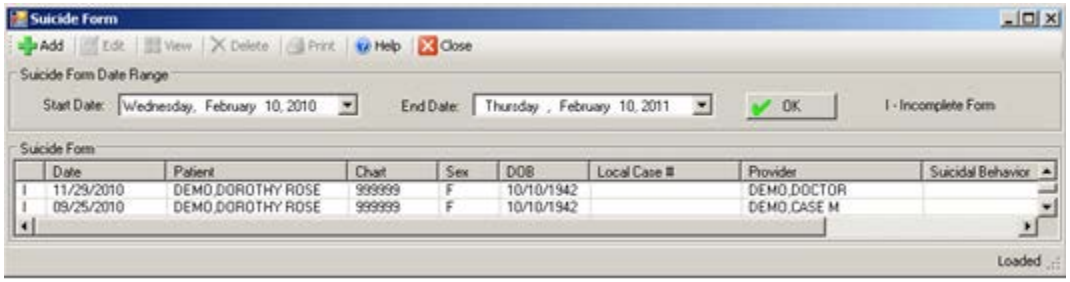


Figure 11-12: Sample Suicide Form window for all patients

11.2.1 Suicide Form Date Range

The suicide form records are in the suicide form date range. To change the date range:

1. Click the **Start Date** field and set the date.
2. Click the **End Date** field and set the date.
3. Click **OK**, the window refreshes.

11.2.1.1 Suicide Form Window for One Patient

The following applies to the **Suicide Form** window for one patient. The default start date is one year previous.

If you change the start date for the **Suicide Form** window for one patient, this change stays in effect in future sessions of the GUI application for the **Treatment Plan** window (until you change it again).

11.2.1.2 Suicide Form Window for All Patients

The following applies to the **Suicide Form** window for all patients. The default start date is one year previous.

If you change the start date for the **Suicide Form** window for all patients, this change stays in effect until you exit the application. When you login the next time, the start date reverts to one year previous.

> **Note**: If you change the start date for the Suicide Form window for one patient, this change stays in effect in future sessions of the GUI application for the **Visit** window for one patient, the Suicide Form window for one patient, and the **Treatment Plan** window for one patient.
>
> Similarly, if you change the start date for the **Suicide Form** window for all patients, this change stays in effect in future sessions of the GUI application for the **Visit** window for all patients, the **Suicide Form** window for all patients, and the **Treatment Plan** window for all patients.

11.2.2 Suicide Form Pane

The **Suicide Form** pane displays the suicide form records in the date range. The records are listed by date. The **I** in the first column of the pane indicates the suicide form is incomplete.

11.2.3 Add Button

1. Select a patient (Figure 11-12) to use in the add process
2. Click **Add** to insert a new suicide record. The **Data Entry–Add Suicide Entry** window in Figure 11-14 displays. Refer to Section 11.3 for more information.

11.2.4 Edit Button

1. Select a patient to edit in the pane.
2. Click **Edit** and the **Data Entry–Edit Suicide Entry** window displays.
   - The **Edit** button will be inactive if the patient does not have any previous visits (applies to the suicide form for the current patient). Refer to Section 11.3 for more information.

11.2.5 View Button

Click **View** (or double-click on a form) to browse the highlighted suicide form record. The **Suicide Form Data Entry–View Suicide Form** window displays.

11.2.6 Delete Button

1. Select a patient to delete in the pane.
2. Click **Delete** to remove the highlighted suicide form record. A confirmation displays.

- Click **Yes** to remove the selected suicide record.
- Click **No** to leave the record.

11.2.7 Print Button

Click **Print** on the **Suicide Form** window to output the highlighted suicide form record. The first page of the **Suicide Form** pop-up window displays as shown in Figure 11-13.

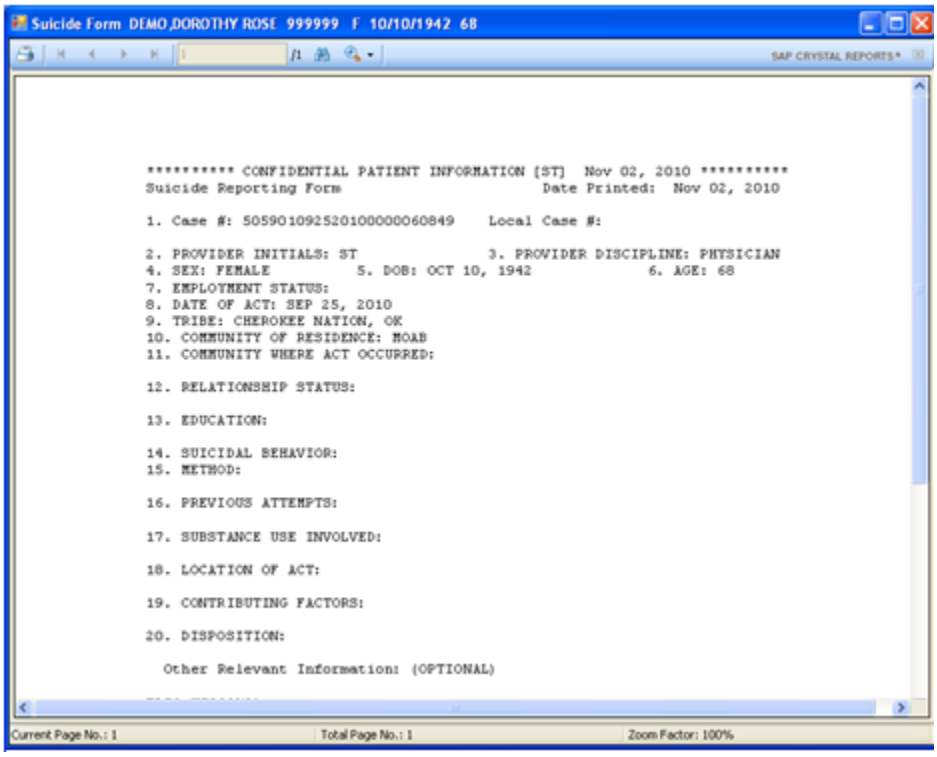


Figure 11-13: Sample **Suicide Reporting Form**

This window contains the following:

- Data from the Suicide Form
- Patient data, such as sex, DOB, Age
- Edit history, such as date last modified, user last update, and each update including date and time + person who modified

Refer to Section 2.6 for more information.

11.2.8 Help Button

Click **Help** to access the online help system.

11.2.9 Close Button

Click **Close** to close the **Suicide Form** window.

11.3 Add/Edit Suicide Form (GUI)

Figure 11-14 shows the fields on the **Suicide Form Data Entry–Add Suicide Form** window.

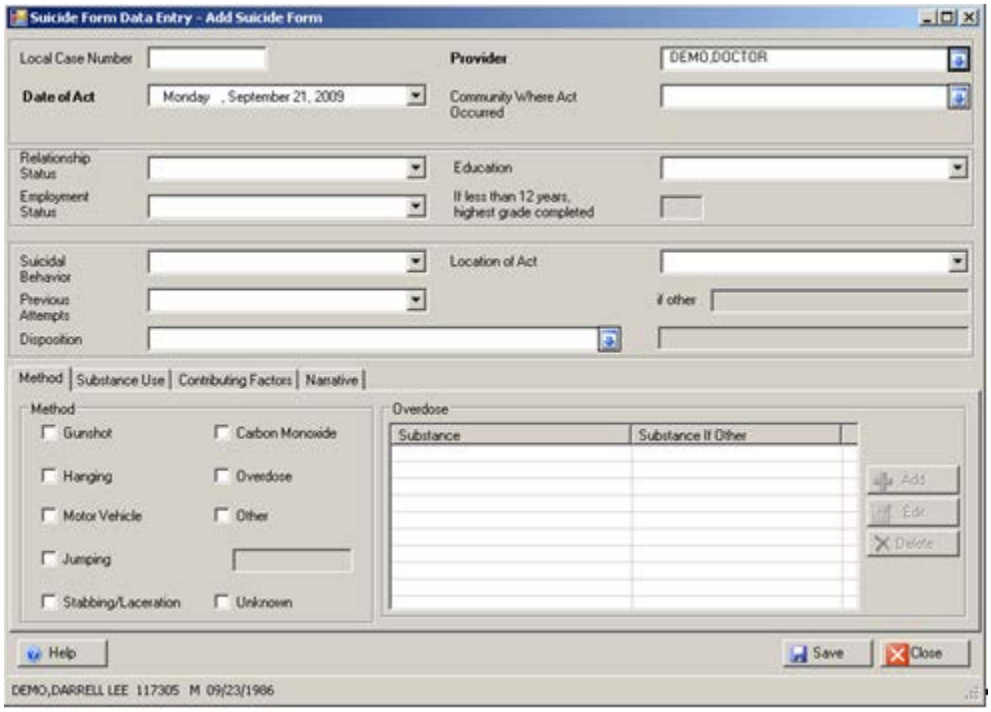


Figure 11-14: Sample **Suicide Form Data Entry–Add Suicide Form** window

1. Click Save to save the information on this window.

   - All fields except the **Local Case Number** and **Narrative** are required. If the fields are not completed, Figure 11-15 displays:

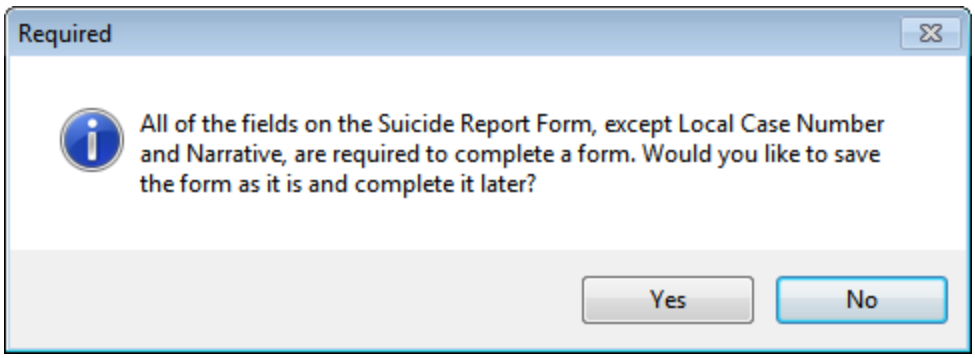


Figure 11-15: **Required** message

2. Click **Yes** to save the form and complete at a later time. You return to the **Suicide Form** window
   - Click **No**, the form is not saved and and you remain on the data entry form.
3. Click **Help** to access the online help system.
4. Click **Close**, the Continue? dialog displays:
   - Click **Yes** to not save; the **Add** window closes.
   - Click **No** to remain on the **Add** window and continue.

Refer to Section 2.11 for more information.

11.3.1 Suicide Form Fields

1. Type the case number or health record number in the **Local Case Number** field.
2. Select the provider from the **Provider** field.
3. Set the **Date of Act**
4. Select the name from the **Community Where Act Occurred** field.
5. Select the **Relationship Status** field and type one of the following:
   - **1** (single)
   - **2** (married)
   - **3** (divorced/separated)
   - **4** (widowed)
   - **5** (cohabiting/common law)
   - **6** (same sex partnership)
   - **9** (unknown)

6. Select the **Education** field and type one of the following:
   - **1**–Less than 12 years
   - **2**–High School Graduate/GED
   - **3**– College/Technical School
   - **4**–Collage Graduate
   - **5**–Post Graduate
   - **6**–Unknown
7. Select the **Employment Status** field and type one of the following:
   - **P** (part time)
   - **F** (full time)
   - **S** (self employed)
   - **UE** (unemployed)
   - **R** (retired)
   - **ST** (student)
   - **SE** (student and employed)
   - **UNK** (unknown)
8. Select the type of activity from the **Suicidal Behavior** field.
9. Select the location of the act from the **Location of Act** field.
   - If **Other** is selected in the **Location of Act** field and the **if other** field become active. Type a description.
10. Select the number of attempts from the **Previous Attempts** field.
11. Select the disposition of the suicide act in the **Disposition** field.
   - If **Other** is selected in the **Disposition** field and the field to the right becomes active. Type a description.

11.3.2 Method Tab

Figure 11-16 shows the **Method** tab used to indicate the suicide act and the substance used in overdose cases.

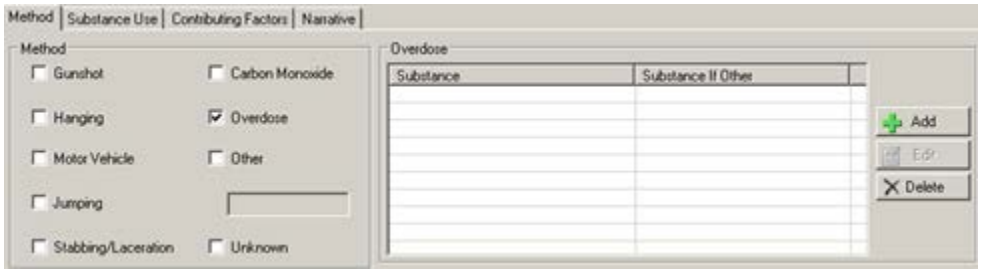


Figure 11-16: Sample **Method** tab

11.3.2.1 Method Pane

1. On the **Method** Pane, do one of the following:
2. Click one or more boxes. One box is required.
3. Select the **Overdose** box and the **Substance** window displays as shown in Figure 11-17:

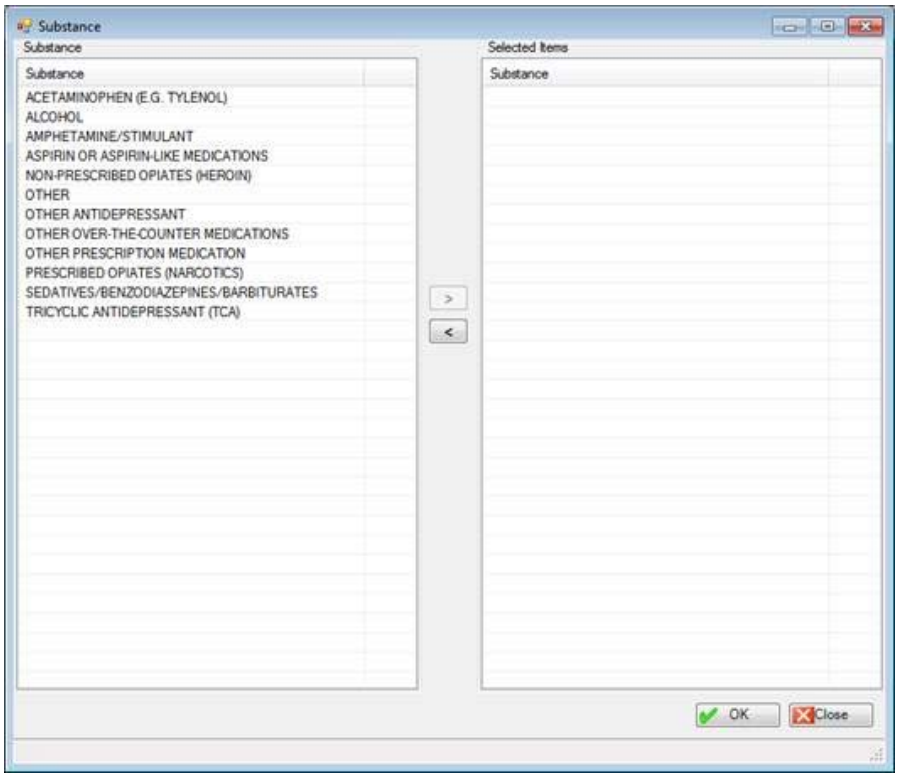


Figure 11-17: **Substance** window

4. Highlight one or more items in the **Substance** column and click the right arrow button to add to the **Selected Items** column.

5. Click **OK** to update the **Overdose** pane.

   - If you select a substance with **OTHER** in its description and click **OK**, the **OTHER ANTIDEPRESSANT** dialog displays shown in Figure 11-18:

Figure 11-18: Sample **OTHER ANTIDEPRESSANT** dialog

- Type text in the **Other** field (limited to 80 characters). You can not exit without typing text in the dialog.
- Click OK to populate the **Substance If Other** column on the Overdose pane.
- Click Close if text was not entered in the **Other** field.

6. Select the **Other** box, the field below becomes active, type text in the field.

11.3.2.2 Overdose Pane

The **Overdose** pane contains the categories of substances used in the overdose suicidal act. Once it is populated, the **Add**, **Edit**, and **Delete** buttons become active.

If you select the **Overdose** box under Method (Figure 11-16), the **Substance** window (Figure 11-17) displays.

Highlight one or more items in the **Substance** column and click the right arrow button to add to the **Selected Items** column.

Click **OK** to update the **Overdose** pane.

Click **Add** to add one or more new records. The **Substance** window displays.

Highlight one or more items in the **Substance** column and click the right arrow button to add to the **Selected Items** column.

Click **OK** to update the **Overdose** pane.

If you select a substance with **OTHER** in its description and click **OK**, the **OTHER** Figure 11-19 dialog displays:

Figure 11-19: **OTHER** dialog

Type text in the **Other** field (limited to 80 characters). You can not exit without typing text in the dialog.

Click **OK** to populate the **Substance If Other** column on the Overdose pane.

Click **Close** if text was not entered in the **Other** field.

Highlight the record in the **Substance if Other** column and click **Edit** to display the **Other** dialog (Figure 11-19). The data in the **Substance If Other** field displays in the **Other** field.

Click **OK** to exit the **Other** window.

Click **Delete** to remove a selected substance record in the Overdose pane. The deletion is confirmed.

11.3.3 Substance Use Tab

Select the **Substance Use** tab to identify the substances involved in the suicide incident and the categories of the substances involved as shown in Figure 11-20:

Figure 11-20: Sample **Substance Use** tab

11.3.3.1 Substances Involved in This Incident Pane

Select one of the boxes in this pane that describes the substance used in the suicide act. At least one is required.

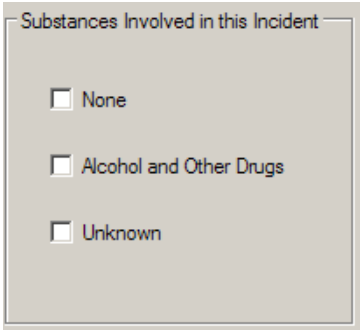


Figure 11-21: **Substances Involved This Incident** pane

If you select the **Alcohol** and **Other Drugs** box, the **Substance** window in Figure 11-22 displays.

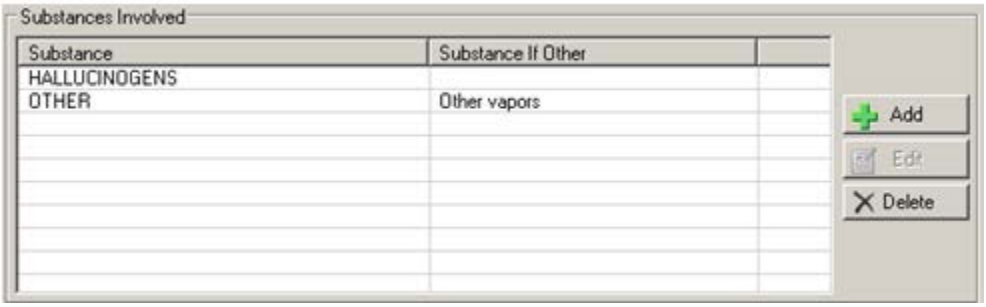


Figure 11-22: **Substance Involved** dialog

Highlight one or more items in the **Substance** column and click the right arrow button to add to the **Selected Items** column.

Click **OK** to populate the **Substance If Other** column on the **Substances Involved** pane

Select **Other** in Figure 11-22 and the **Other** dialog in Figure 11-19 displays.

Type in the **Other** field (limited to 80 characters). You can not exit without typing text in the dialog.

Click **OK** to populate the **Substance Involved** column.

Click **Close** if text was not entered in the **Other** field.

Uncheck the Alcohol and Other Drugs boxes and the **Substances Involved** pane clears.

11.3.3.2 Substances Involved Pane

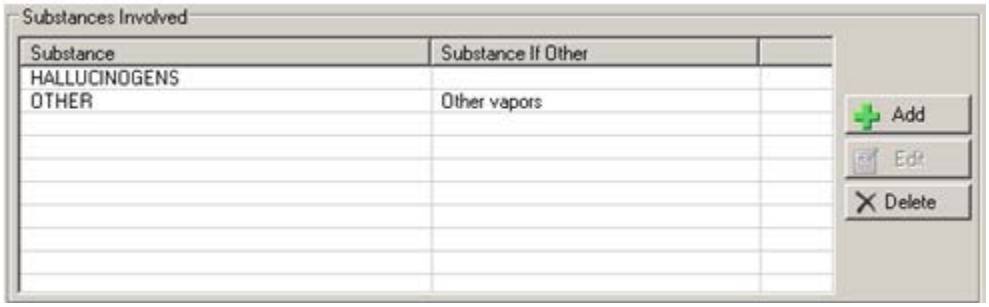


Figure 11-23: Sample **Substances Involved** pane

This pane contains the substances used immediately before or during the suicidal act. When the **Alcohol** and **Other Drugs** boxes are checked, **Add**, **Edit**, and **Delete** become active.

Click **Add** to add one or more new records. The **Substance** (Figure 11-22) window displays.

Highlight one or more items in the **Substance** column and click the right arrow button to add to the **Selected Items** column.

Click **OK** to update the **Substances Involved** pane.

If you select a substance with **OTHER** in its description and click **OK**, the **OTHER** Figure 11-19 dialog displays:

Type text in the **Other** field (limited to 80 characters). You can not exit without typing text in the dialog.

Click **OK** to populate the **Substance If Other** column on the **Substances Involved** pane.

Click **Close** if text was not entered in the **Other** field.

Highlight a record (with Other) in the **Substance If Other** column and click Edit. The Other (Figure 11-19) dialog displays.

Click **OK** to populate the **Substance If Other** column on the Overdose pane.

Click **Close** if text was not entered in the **Other** field.

Click **Delete** to remove a selected substance record in the **Substances Involved** pane.

11.3.4 Contributing Factors Tab

Select the **Contributing Factors** tab to identify the contributing factors associated with the suicide act as shown in Figure 11-24.

Figure 11-24: Sample **Contributing Factors** tab

Select one or more of the boxes that describe the contributing factors for the suicide act. At least one is required.

If you select **Other**, the field below the box becomes active. Type a description in the field.

11.3.5 Narrative Tab

Select the **Narrative** tab and type text in the **Other Relevant Information** field Figure 11-25.

Figure 11-25: Sample **Other Relevant Information** field

Note: This is *not* where you put the SOAP or progress note.

12.0 Intake

This section addresses how to manage intake/update documents in the roll-and-scroll application and the GUI.

12.1 Intake Documents (Roll and Scroll)

You can add/change/remove an intake document when you exit the visit encounter (display or add/edit) window. After you exit the last screen, the OTHER INFORMATION screen displays as shown in Figure 12-1:

```
                    *******  OTHER INFORMATION  *******


Update, add or append any of the following data

     1). Update any of the following information:
          Designated Providers, Patient Flag
     2). Patient Case Open/Admit/Closed Data
     3). Personal History Information
     4). Appointments (Scheduling System)
     5). Treatment Plan Update
     6). Print an Encounter Form
     7). Add/Update/Print Intake Document
     8). Add/Update Suicide Forms
     9). Problem List Update
    10). None of the Above (Quit)
Choose one of the above:  (1-9): 9//
```

Figure 12-1: Options on the Other Information menu

The other place you can add/change/remove an intake document is the Intake Document (**ID**) option on the Patient Data Entry (Figure 4-3) screen. You will be prompted for a Program (you are associated with). After specifying the program, the Update BH Intake Document screen displays as shown in Figure 12-2:

```
Update BH Intake Document     Jan 26, 2010 13:27:36      Page:    1 of    1
MENTAL HEALTH INTAKE DOCUMENTS        *unsigned document
Patient Name: DUCK,EDWIN RAY   DOB: JUN 07, 1978   Sex: M   HRN: 105321
                        INITIAL                        UPDATE
#  INITIATED  PROGRAM  PROVIDER            UPDATED  PROVIDER

*1  01/26/10  MENTAL H THETA,SHIRLEY
                                          *01/26/10 THETA,SHIRLEY
*2  12/29/09  MENTAL H GAMMAA,RYAN
*3  12/29/09  MENTAL H GAMMAA,RYAN
4   12/29/09  MENTAL H THETA,SHIRLEY
                                           12/29/09 THETA,SHIRLEY
                                          *12/29/09 THETA,SHIRLEY
*5  12/29/09  MENTAL H THETA,SHIRLEY
*6  12/14/09  MENTAL H GAMMAA,RYAN
*7  10/07/09           GAMMAA,RYAN
                                          *10/07/09 GAMMAA,RYAN
*8  04/21/09           GAMMAA,RYAN
          Enter ?? for more actions
```

```
I    Add Initial Intake                D    Delete Intake/Update
E    Edit Initial Intake               P    Display/Print Intake/Update
U    Add/Edit Update                   Q    Quit
Select Action: Q//
```

Figure 12-2: Sample Update BH Intake Document screen

Type **Q** and press Enter to exit the Update BH Intake Document screen.

The asterisk (*) in the first column indicates that the record contains an unsigned intake/update document.

Note: The following information about intake and update documents on the Update BH Intake Document window:

- The intake documents are listed on the left side (under the Date Initiated, Program, and Initial Provider columns).
- The update documents are listed on the right side (under the Date Updated and Update Provider columns).

12.1.1 Add Initial Intake (I)

1. Type **I** to create an initial intake document for the visit. A message displays stating the application is adding the Intake document. Do the following:
2. At the “Do you wish to continue to add the Intake Document?” prompt, type one of the following:
   - Type **N** to end the create process.
   - Type **Y** to add the Intake document and continue:
3. At the “DATE” prompt, set the date (cannot be a future date).
4. At the “PROGRAM: prompt, type the health information.
5. At the “PROVIDER” prompt, type the provider name.
6. At the “DATE LAST UPDATED” prompt, set the date (cannot be future date).
7. At the “NARRATIVE/No Existing Text/Edit?” prompt, type one of the following:
   - Type **N** to end the edit process
     - The Intake document is created.
     - The Update BH Intake Document screen displays.
   - Type **Y** to edit the narrative on another screen.
   - Click Save and complete the following:

8. At the “Enter your Current Signature Code” prompt, do one of the following:
   - Type the electronic signature to sign the document. This action marks the document as signed. It cannot be edited.
   - Press Enter and the document will not be signed and can be edited.

12.1.2 Edit Initial Intake (E)

1. Type **E** to change the selected initial intake document and do the following:

Note:	Only the original intake provider or the person who entered the intake document can edit the document; other providers can only view or print the document. Editing an initial intake that was created before the installation of BHS v4.0 will result in a prompt to enter the program associated with the intake.

2. At the “CHOOSE” prompt, type one of the following:
   - Type **2** (Quit) – to return to the Update BH Intake Document
   - Type **1** (Edit Initial Intake Document) – to continue
3. At the Select Intake (1 of *x*) where *x* is the number of the last intake document” prompt, select the intake document to edit.
   - If the intake document is signed, it cannot be edited.
   - If you are not the original author or the person who entered this document, you cannot edit it.
4. At the “DATE” prompt, set the date (cannot be a future date).
5. At the “PROGRAM: prompt, type the health information.
6. At the “PROVIDER” prompt, type the provider name.
7. At the “DATE LAST UPDATED” prompt, set the date (cannot be future date).
8. At the “NARRATIVE/No Existing Text/Edit?” prompt, type one of the following:
   - Type **N** to end the edit process
     - The applications indicates the Intake document was created
     - An intake narrative must be created before an electronic signature can be applied.
   - A message displays verifying the Intake Narrative, type one of the following:
     - Type Y to return to the Narrative prompts
     - Type N to return to the Update BH Intake Document screen.

- Type **Y** to edit the narrative on another screen.
- Click Save and complete the following:

9. At the "Enter your Current Signature Code" prompt, do one of the following:

   - Type the electronic signature to sign the document. This action marks the document as signed. It cannot be edited.
   - Press Enter and the document will not be signed and can be edited.

12.1.3 Add/Edit Update (U)

Type **U** to create a new update to a intake document or edit an existing, unsigned document where you are the provider. Do the following:

> **Note**: Only the person who originally entered the intake document or the intake document provider can edit the document.
> Other providers can only view or print the document.

1. At the "Select Intake: (1-*x*) where *x* is the document number" prompt, select the intake document. A message displays after the document is selected (Figure 12-3):

```
You can either add a new Update to this Intake document or edit an
existing, unsigned one on which you are the provider.  Please select an
Update to edit or choose 1 to add a new one or 0 to quit.

     0    Quit/Exit Update
     1    Date Updated: 01/26/10   Provider: THETA,SHIRLEY        MENTAL
HEALTH
     2    Add new Update document
Select Action:  (0-1): 0//
```

Figure 12-3: Message from the application

> **Note**: If there is no update document to edit, the second choice will *not* display. In this case, there would only be two choices: Quit or Add New Update Document.

2. At the "Select Action" prompt and do one of the following:

- Add a new update to the intake document.
- If you select the update choice, the prompts display. These are the same prompts as in Add new Update document.
- If you select the Quit option, the process ends.
- If you select the Add new Update document option (**2** in Figure 12-3), do the following:

3. At the "DATE" prompt, set the date (cannot be a future date).
4. At the "PROVIDER" prompt, type the provider name.
5. At the "DATE LAST UPDATED" prompt, set the date (cannot be future date).
   - The text of the narrative or "no existing text displays" in the "NARRATIVE"
6. At the "Edit?" prompt, type one of the following:
   - Type **N** to end the process.
   - Type **Y** to display another window and edit the text of the narrative.
   - Click **Save** and complete the following:
7. At the "Enter your Current Signature Code" prompt, do one of the following:
   - Type the electronic signature to sign the document.
   - Press Enter to do one of the following:
     - Add a new update to the intake document:
     - Edit an existing, unsigned where you are the provider or entered the document. Do one of the following:
8. At the "Select Action" prompt, type one of the following (Figure 12-4):

```
0  Quit/Exit Update
1  Date Updated: MM/DD/YY   Provider: <provider name>
2  Add new Update document
```

Figure 12-4: Prompts for the actions you can take

- Type **0** to Quit and return to the Update BH Intake Document screen.
- Type **1**, to revise the Date Updated and Provider..
- Type **2** to Add new Update Document.

Refer to Section ☐for more information

12.1.4 Delete Intake/Update (D)

Type **D** to do one of the following:

- Delete Intake/Update
- Display/Print Intake/Update

12.1.4.1 Delete Intake/Update

You can delete only unsigned Intake documents you entered or on which you are the provider, unless you possess a special key or are listed on the Delete Override list. Do one of the following:

1. At the "Select Intake" prompt, do one of the following:
   - Select the Initial Intake to delete
   - Select the Initial Intake with the Update to delete. Figure 12-5 displays the choices:

```
0  Quit/Exit
1  Date MM/DD/YY   Provider: <provider name>
```

Figure 12-5: Actions to take

2. Type **0** to return to the Update BH Intake Document screen.
3. Type **1** if you are the intake provider or the person who entered this Initial Intake document.
   - If you meet one of the criteria, a message displays indicating to select which Intake or Update document to delete.
   - Initial Intake documents that have Updates associated with them cannot be deleted.
4. Select a document to delete, the message: "Are you sure you want to delete this <name> document?"
   - Type **Y** to delete.
   - Type **N** to not delete.

12.1.4.2 Display/Print Intake/Update

This action is the same as Type **P** on the Update BH Intake Document window. Refer to Section 12.1.5 for more information.

12.1.5 Print Intake Document

1. Type **P** to print or /browse a intake document. Do the following:
2. At the "Select Intake Update (1-*x*) where *x* is the number of the last intake record" prompt, type the document to display or print.

3. At the “What would you like to print?” prompt, do one of the following
   - Type **I** (Intake document only)
   - Type **U** (Update document only) another menu is displayed listing each of the updates and an option to print all updates
   - Type **Q** (quit/exit).to return to the previous menu.
   - Type **B** (both the Intake and Update documents), do the following:
4. At the “Do you wish to” prompt, type one of the following:
   - Type **B** browse output on screen.
   - Type **P** to print output on paper as shown in Figure 12-6:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
******************************************************************************
*                                                                            *
*  INTAKE DOCUMENT                            Printed: Aug 30, 2009@16:31:52    *
*  Name:  ALPHAA,CHELSEA MARIE                                     Page 1     *
*  DEMO INDIAN HOSPITAL       DOB:  2/7/75    Sex:  F   Chart #:  WW116431     *
*                                                                            *
******************************************************************************

Date Established:   MAY 12, 2009
  Author/Provider:    THETA,SHIRLEY
  Program:            MENTAL HEALTH
  Type of Document:   INITIAL

Intake Documentation/Narrative: This is a 34-year old female requesting
antidepressant medications, stating that she ran out of her previous prescription
since moving back to the reservation.

_____________________________________________          _____________________
                                                              DATE

_____________________________________________          _____________________
                                                              DATE
```

Figure 12-6: Sample intake document report

12.2 Intake (GUI)

There are two ways to work with the Patient Intake documents in the GUI. Either method accesses the same Intake window.

- Method 1: Use the Intake option on the GUI tree structure.
- Method 2: Use the Intake tab on the Add/Edit Visit Data Entry window.

The following provides information about using the Intake option on the GUI tree structure.

The Intake option applies to the current patient. After selecting the Intake option, the application displays the **Select Program** dialog displayed in Figure 12-7:

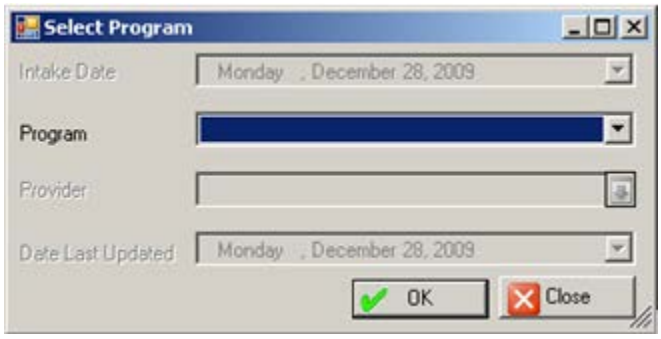


Figure 12-7: **Select Program** dialog

1. Select an option from the **Program** field.
2. Click **OK** to display **Intake** (Figure 12-8) window listing the intake documents for the program for the current patient
3. Click **Close** to end the process.

Note:	The following window is the window that displays when you click the Intake tab on the Add/Edit Visit Data Entry window.

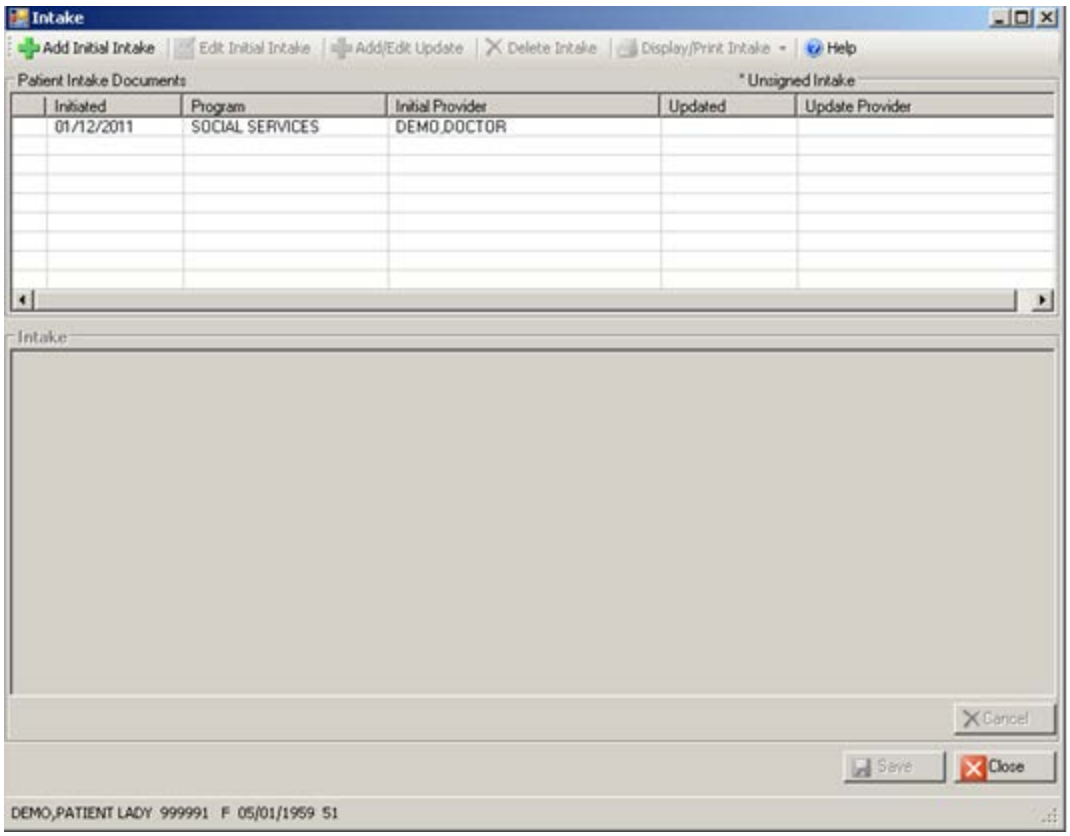


Figure 12-8: Sample **Intake** window

An asterisk (*) in the first column indicates that the record contains an unsigned intake/update document.

4. Click **Help** to access the online help.

12.2.1 Patient Intake Documents Pane

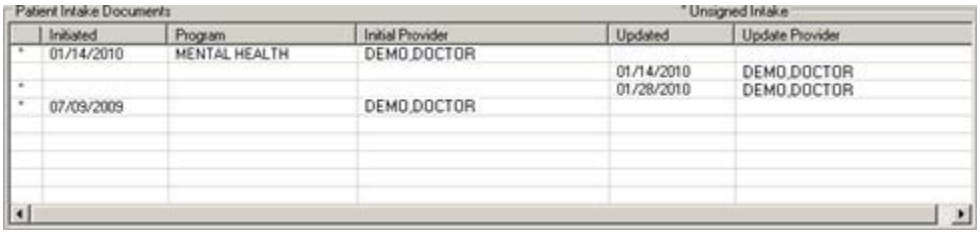


Figure 12-9: Sample **Patient Intake Documents** pane

The Patient Intake Documents (Figure 12-9) pane displays the names of the current patient's intake documents and update documents (view only). You can distinguish the documents in the following manner:

- The intake documents are listed on the left side of the pane (under the Date Initiated, Program, and Initial Provider columns).

- The update documents are listed on the right side of the pane (under the Date Updated and Update Provider columns).

When you highlight a record in the **Patient Intake Documents** pane, the text of the document displays in the Intake pane.

> **Note**: All initial documents and updates created before the BHS v4.0 installation will remain unsigned and editable. The initial provider associated with the intake will be the provider for the intake document. Any edits or updates completed after the installation date will be subject to all business rules added in BHS v4.0.

12.2.2 Add Initial Intake

1. Click Add Initial Intake (Figure 12-8) to add a new initial intake document. The **Select Intake Parameters** dialog displays as shown in Figure 12-10:

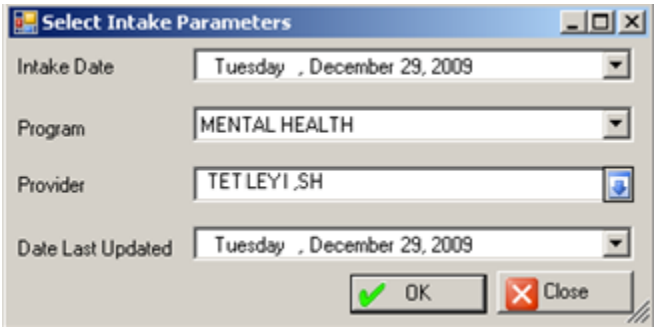


Figure 12-10: Sample **Select Intake Parameters** dialog

2. Set the **Intake Date** (cannot be a future date).
3. Select the program from the **Program** field.

> **Note**: If you change the program, it will not be visible when you return to the list view. You have to back out of the Program selection screen again and select the program associated with the document you just entered. You are strongly encouraged *not* to change the program. It is actually more efficient to back out and enter the correct program initially.

4. Select a name from the **Provider** field.
5. Set the **Date Last Updated** (cannot be a future date).
   - Click **OK** to active the Intake pane.
   - Click **Close** to end the process.

Refer to Section 12.2.3 for more information.

12.2.3 Intake Pane

Figure 12-11: Sample of active **Intake** pane

1. Type text in the **Intake** pane (Figure 12-11).
2. Click **Cancel** to cause the pane to become inactive.
3. Click **Close** and the **Continue?** dialog: "Unsaved Data Will Be Lost, Continue?"
   - Click **Yes** to cancel the input and return to the GUI tree structure.
   - Click **No** to return to the **Intake** pane.
4. Click **Save** to save the input. The **Intake Electronic Signature** dialog displays as shown in Figure 12-12:

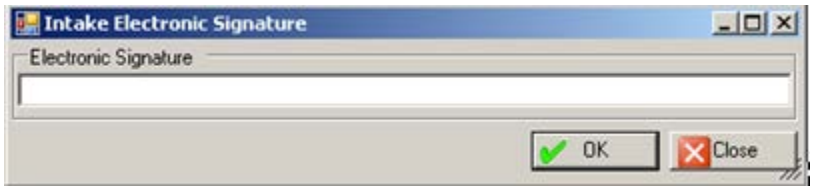


Figure 12-12: Intake Electronic Signature dialog

5. Type the signature in the **Electronic Signature** field.
6. Click **OK** to save the document and marek it as signed.
7. Click **Close** and the **Are You Sure?** dialog displays: "Are you sure you want to Close without Electronically Signing the Intake?"
8. Click **Yes** to not sign it and to save the document marked as not signed.
   - Click **OK** to exit the Message. This type of document can be edited.
   - Click **No** and you return to the Intake Electronic Signature window.

12.2.4 Edit Initial Intake

Select an existing initial intake document and click **Edit Initial Intake** to edit the initial intake document.

If the selected document has been signed, the application displays the message: This Initial Intake document has been signed. You cannot edit it.

- Click **OK** to close the message and end the process.

Only the provider or the person who entered the intake can edit it; otherwise, the application displays the message: You are not the provider or the person who entered the Intake, you cannot edit it.

- **OK** to close the message and end the process.

If you are the provider or the person who entered the intake, the application displays the **Select Intake Parameters** dialog.

After completing this dialog, the text of the initial intake document will display in the **Intake** area of the **Intake** window.

Refer to Section 12.2.2 and Section 12.2.3 for more information.

12.2.5 Add/Edit Update

This button has two different labels, depending on the action you take:

- If you select an intake document (signed or unsigned), the button reads: **Add Update**.
- If you select an unsigned update document, the button reads: **Edit Update**.

In either case, the application displays the **Select Intake Parameters** dialog.

> **Note**: If you select a signed update document, the button reads Edit Update. After you click **Edit Update**, the application displays the message: "This intake update document has been signed. You cannot edit it." Click **OK** to dismiss the message and exit the edit process.
>
> After the provider locks the document using the electronic signature, it cannot be edited or deleted unless the user possesses the appropriate security key or is listed on the delete override site parameter.

After completing this dialog, the Intake pane will become active.

12.2.6 Delete Intake

Click **Delete Intake** to delete a selected unsigned intake document (in the Patient Intake Documents pane).

- The **Are You Sure** dialog displays
- Click Yes to delete the document.
- Click No to leave the document.

- Only the intake provider or the person who entered the selected intake can use the Delete function. However, when a person is listed in the **Delete Override** section on the Site Parameters menu (in RPMS), that person can delete the document.
- If the selected intake document has an attached update document, the application displays the message: This intake document has updates associated with it. It cannot be deleted at this time.
  - Click OK on the message and you exit the Delete process.

12.2.7 Display/Print Intake

1. Click **Display/Print Intake** (Figure 12-13) to displays display/print options.

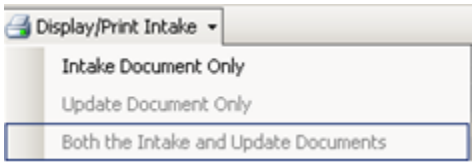


Figure 12-13: Options for the **Display/Print Intake** button

2. Highlight a record and select a highlighted option from the list.
3. Select either **Update Document Only** or **Both the Intake and Update Documents**, the **Intake Updates** window displays as shown in Figure 12-14:

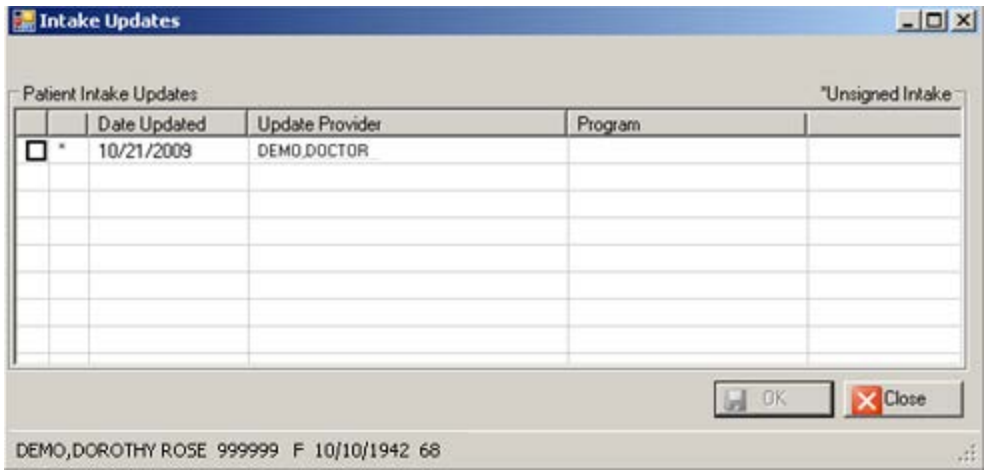


Figure 12-14: Sample **Intake Updates** dialog

4. Select the records to include in the output.

   - Click **OK** to display the first page of the Intake (for the current patient) pop-up window (Figure 12-15):

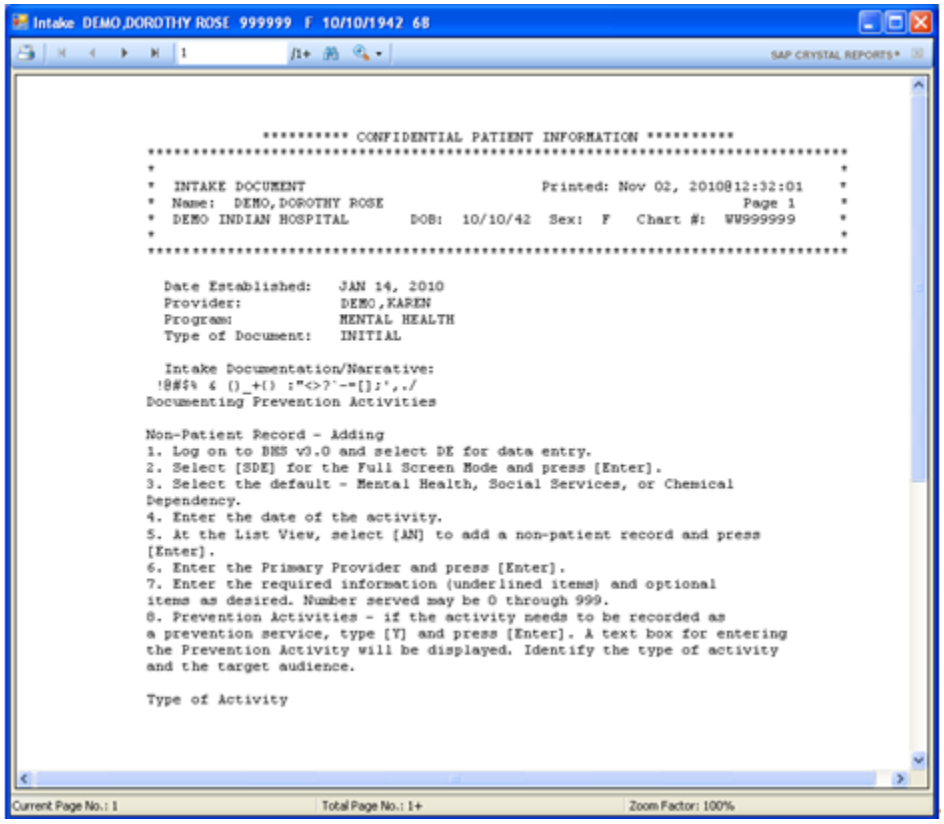


Figure 12-15: Sample **Intake** pop-up window for current patient

Refer to Section 2.6 for more information.

13.0 Reports (Roll and Scroll Only)

The Reports menu of the Behavioral Health system provides numerous options for retrieving data from the patient file. You can obtain specific patient information and tabulations of records and visits from the database. The system provides options for predefined reports and custom reports.

The Reports menu contains several different submenus that categorize the reports by type. The first four submenus contain report options specific to the Behavioral Health system. Use the last submenu to print standard tables applicable to this package. Each of these submenus and their report options (Figure 13-1) are detailed in the following sections. Use this menu for tracking and managing patient, provider, and program statistics.

```
                    ***********************************************
                    **       IHS Behavioral Health System        **
                    **                  Reports                  **
                    ***********************************************
                                Version 4.0 (patch 2)

                                DEMO INDIAN HOSPITAL

   PAT    Patient Listings ...
   REC    Behavioral Health Record/Encounter Reports ...
   WL     Workload/Activity Reports ...
   PROB   Problem Specific Reports ...
   TABL   Print Standard Behavioral Health Tables ...

Select Reports Menu Option:
```

Figure 13-1: Options on Report menu

> **Reminder**: The location screen (UU) and the list of Those Allowed to See All Visits found on the site parameters menu will impact the information displayed in the reports. For example, if your name has not been added to the list of those allowed to see all visits, the report will contain only those visits where you were a provider or completed the data entry.

13.1 Patient Listings (PAT)

shows the Patient Listings submenu that contains report options for generating lists of patients by various criteria. Also included is the Patient General Retrieval option, a custom report that allows selection of which patients to include in the report and items to print and the sort criteria.

```
                    ***********************************************
                    **       IHS Behavioral Health System        **
                    **             Patient Listings              **
                    ***********************************************
```

```
                              Version 4.0 (patch 2)
                               DEMO INDIAN HOSPITAL

   ACL    Active Client List
   PGEN   Patient General Retrieval
   DP     Designated Provider List
   GRT    Patients with AT LEAST N Visits
   AGE    Patients Seen by Age and Sex (132 column print)
   CASE   Case Status Reports ...
   GAFS   GAF Scores for Multiple Patients
   NSDR   Listing of No-Show Visits in a Date Range
   PERS   Patient List for Personal Hx Items
   PPL    Placements by Site/Patient
   PPR    Listing of Patients with Selected Problems
   SCRN   Screening Reports ...
   TPR    Treatment Plans ...
   TSG    Patients seen in groups w/Time in Group

Select Patient Listings Option:
```

Figure 13-2: Options on the Patient Listings reports

13.1.1 Active Client List (ACL)

1. At the “Select Patient Listings Option” prompt type **ACL** to review a list of patients who have been seen in a date range. To filter the report, do the following:
2. Set the date at the “Enter beginning Date” prompt.
3. Set the date at the “Enter ending Date” prompt.
4. At the “Limit the list to those patients who have seen a particular provider?” prompt, type one of the following:
   - Type N to end the process.
   - Type Y to continue.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
6. At the “Do you wish to:” prompt, type one of the following:
   - **P** (print output)
   - **B** (browse output on screen)
7. Type **B** to browse the output on the Output Browser window displayed in Figure 13-2:

```
********** CONFIDENTIAL PATIENT INFORMATION **********
```

```
XX                                                                    Page 1
                              DEMO INDIAN HOSPITAL
                               ACTIVE CLIENT LIST
                                 PROVIDER: ALL
               ENCOUNTER DATES:  NOV 17, 2010  TO  FEB 15, 2011

PATIENT NAME      CHART   SEX  DOB       LOCATION    PROVIDER    PROBLEM    #
                  NUMBER                 SEEN        SEEN        CODES   VISITS
-------------------------------------------------------------------------------
AAA,GCOX          432432   F   11/28/70  DEMO INDIA  WILLIAMS,M  293.82       1

ALPHA,JACOB SCO   102668   M   10/01/72  DEMO INDIA  BRUNING,BJ  292.12       1

ALPHAA,CHELSEA    116431   F   02/07/75  LOCUST GRO  BRUNING,BJ  293.82       2
                                         SELLS FIEL  GARCIA,RYA  296.32

ALPHAA,DIANA LE   192745   F   09/15/54  DEMO INDIA  BRUNING,BJ  80           1

ALPHAA,MISTY DA   131668   F   04/21/46  DEMO INDIA  BRUNING,BJ  314.01       3
                                         RED LAKE M  BUTCHER,LO


Enter RETURN to continue or '^' to exit:
```

Figure 13-3: Sample Output Browser data

13.1.2 Patient General Retrieval (PGEN)

1. At the “Select Patient Listings Option” prompt, type **PGEN** to produce a report showing a listing of patients based on selected criteria. Do one of the following:

2. At the “Select and Print Patient List from” prompt, Type one of the following:

   - **P** (patient file)
   - **S** to continue

3. At the “Do you want to use a PREVIOUSLY DEFINED REPORT?” prompt type one of the following:

   - **N to end the process**
   - **Y** to display the Patient Selection Menu displayed as shown in Figure 13-3:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 14:53:39          Page:    1 of 1
                        Patient Selection Menu
Patients can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Patients type Q.

1)  Sex                    14)  Medicaid Eligibility  27)  Pts seen at a Locati
2)  Race                   15)  Priv Ins Eligibility  28)  Pts Seen in a Commun
3)  Patient Age            16)  Patient Flag Field    29)  Pts w/Problem (DX)
4)  Patient DOB            17)  Case Open Date        30)  Pts w/Problem (MHSS
5)  Patient DOD            18)  Case Admit Date       31)  Pts seen by a Provid
6)  Living Patients        19)  Case Closed Date      32)  Pts w/Education Done
7)  Chart Facility         20)  Case Disposition      33)  Pts seen for an Acti
8)  Community of Residen   21)  Next Case Review Dat  34)  Pts seen w/Type of C
```

```
9)  County of Residence    22)  Designated MH Prov    35)  Pts seen w/Axis IV L
10)  Tribe of Membership   23)  Designated SS Provid  36)  Pts w/Inpatient Disp
11)  Eligibility Status    24)  Designated A/SA Prov  37)  Pts Last Health Fact
12)  Class/Beneficiary     25)  Designated Other Pro
13)  Medicare Eligibility  26)  Personal History Ite

          Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-4: Sample Patient Selection Menu options

If you do not specify any criteria, type Q and press Enter to exit the menu.

4. At the “Choose Type of Report” prompt, type one of the following:
   - **T** (total count only)
   - **S** (subcounts and total count)
   - **D** (detailed listing).
5. Select D to dispolay the Print Item Selection Menu in Figure 13-4:

```
BH GENERAL RETRIEVAL          Apr 16, 2009 14:46:31          Page:    1 of    1
                        PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1)  Patient Name           13)  Class/Beneficiary     25)  Case Disposition
2)  Sex                    14)  Medicare Eligibility  26)  Next Case Review Dat
3)  Race                   15)  Medicaid Eligibility  27)  Designated MH Prov
4)  Patient Age            16)  Priv Ins Eligibility  28)  Designated SS Provid
5)  Patient DOB            17)  Mailing Address-City  29)  Designated A/SA Prov
6)  Patient SSN            18)  Home Phone            30)  Designated Other Pro
7)  Patient DOD            19)  Mother's Name         31)  Designated Other (2)
8)  Patient Chart #        20)  Patient Flag Field    32)  Personal History Ite
9)  Community of Residen   21)  Patient Flag Narrati  33)  Pts Last Health Fact
10)  County of Residence   22)  Case Open Date
11)  Tribe of Membership   23)  Case Admit Date
12)  Eligibility Status    24)  Case Closed Date


          Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-5: Sample Print Item Selection Menu options

- This menu determins the data items on the report. Select the items in the order that you want them to appear on the output.

6. At the “Select Action” prompt, type **Q** to exit the menu. The Sort Item Selection Menu displays as shown in Figure 13-5:

```
BH GENERAL RETRIEVAL          Apr 16, 2009 14:49:47          Page:    1 of    1

                         SORT ITEM SELECTION MENU
The Patients displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by patient name.

1)  Patient Name           7)  Community of Residen   13)  Designated MH Prov
2)  Sex                    8)  County of Residence    14)  Designated SS Provid
3)  Race                   9)  Tribe of Membership    15)  Designated A/SA Prov
4)  Patient DOB            10)  Eligibility Status    16)  Designated Other Pro
5)  Patient DOD            11)  Class/Beneficiary     17)  Designated Other (2)
6)  Patient Chart #        12)  Patient Flag Field


          Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-6: Sample Sort Item Selection Menu options

- This menu determines how the data will be sorted.

7. At the “Do you want a separate page for each Patient Name?” prompt, type one of the following:

   - **Y** (create a separate page for each patient)
   - **N** (separate page is not created)

8. At the “Would you like a custom title for this report?” type one of the following:

   - **N** (custom title is not create)
   - **Y** to continue

9. At the “Do you wish to save this search/print/sort logic for future use?” prompt, type one of the following:

   - **N** (logic is not saved)
   - **Y** to continue

10. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

    - **I** (include all patients)
    - **E** (exclude demo patients)
    - **O** (include only demo patients).

11. At the “Do you wish to” prompt, type one of the following:

    - **P** (print output)
    - **B** (browse output on screen) The Patient Selection Criteria for the report displays.

12. Press Enter to display the BH Patient Listing report displayed in Figure 13-6:

```
              ********** CONFIDENTIAL PATIENT INFORMATION **********
                                BH Patient Listing
Page 1
PATIENT NAME          SSN          COMM RESIDENCE
---------------------------------------------------

A'PAT1,ALAYNA BROOKL  XXX-XX-2160  HOWE
A'PAT1,WEBB AARON     XXX-XX-4769  PORUM
ALPHA,ALICE ROCHELLE  XXX-XX-6378  COLCORD
ALPHA,GERALDINE       XXX-XX-7097  MUSKOGEE
          Enter ?? for more actions
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-7: Sample Patient Listing report

13.1.3 Designated Provider List (DP)

1. At the “Select Patient Listings Option” prompt, type **DP** to produce the designated mental health provider list report. Do the following:

2. At the “Which Designated Provider?” prompt, type one of the following:

   Type one of the following:

   - **M** Mental Health Defaults
   - **S** Social Services Defaults
   - **C** Chemical Dependency or Alcohol/Substance Abuse
   - **O** Other
   - **T** (other non-RPMS)

3. At the “Run Report for” prompt, type one of the following:

   - 2 (all providers)
   - 1 (one provider) to continue

4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

5. At the “Do you wish to” prompt, type one of the following:

   - **P** (print output)

- **B** (browse output on screen) The Designated Mental Health Provider List report displays as shown in Figure 13-7:

```
OUTPUT BROWSER                Apr 16, 2009 15:02:18          Page:    1 of    5


             ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                      Page 1
                              DEMO INDIAN HOSPITAL
                       DESIGNATED MENTAL HEALTH PROVIDER LIST
                                  PROVIDER: ALL

PATIENT NAME              CHART #    SEX   DOB      COMMUNITY   LAST VISIT
-------------------------------------------------------------------------------

PROVIDER:  GPROVIDER,D

ALPHA,ALICE ROCHELLE      183497     F   06/25/97   COLCORD      Jan 05, 2009
ALPHAA,GLEN DALE          108704     M   11/10/81   TAHLEQUAH    Apr 14, 2009
GPAT,JANE ELLEN                      F   01/01/90   TUCSON       Apr 15, 2009
MPAT11,SHERRY KEARNEY     197407     F   10/01/00   PEGGS        Sep 28, 2007
+         Enter ?? for more actions                                        >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-8: Sample Designated Mental Health Provider List report (for all providers)

13.1.4 Patients with AT LEAST N Visits (GRT)

1. At the “Select Patient Listings Option” prompt, type **GRT** to produce a report that shows a list of patients who have been seen *N* number of times in a date range. Do the following:
2. Set the date at the “Enter beginning Date” prompt.
3. Set the date at the “Enter ending Date” prompt.
4. Type a number between 2 and 100 at the “Enter the minimum number of time the patient should have been seen” prompt.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
6. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - **B** (browse output on screen) The Patient Seen N Times report displays as shown in Figure 13-8:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
```

```
XX                                                                    Page 1
                              DEMO INDIAN HOSPITAL
                       PATIENTS SEEN AT LEAST 3 TIMES
                  RECORD DATES:  JAN 16, 2009  TO  APR 16, 2009


PATIENT NAME      CHART # SEX  DOB       LOCATION    PROVIDER    PROBLEM  #
                                          SEEN        SEEN        CODES    VISITS
-------------------------------------------------------------------------------
ALPHAA,CHELSEA    116431   F   02/07/75  CEDAR CITY  BDOC111,BJ  1.1         67
                                          CHEVAK      BDOC222,LO  12
                                          CHINLE CHA  CDOC1,JESS  14
                                          CHINLE HOS  DEMO,DOCTO  15
                                          DEMO INDIA  GDOC12,RYA  22
+         Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-9: Sample Patients Seen at least 3 Times report

13.1.5 Patients Seen by Age and Sex (AGE)

1. At the “Select Patient Listings Option” prompt, type **AGE** to produce a report that tallies the number of patients, who have had an encounter. You will choose the item you want to tally, such as problems treated, or activities by age and sex. Tallies by PROBLEM ONLY includes the PRIMARY PROBLEM and group ages can be definted. You will be able to define the age groups to be used. Do the following:

2. At the “Choose an item to tally by age and sex” prompt, type one of the following:

   - **1).** Program Type
   - **2).** POV/Problem (Problem Code)
   - **3).** Problem/POV (Problem Category)
   - **4).** Problem/POV
   - **5).** Location of Service
   - **6).** Type of Contact of Visi
   - **7).** Activity Code
   - **8).** Activity Category
   - **9).** Community of Service
     - The item selected will display down the left column of the report. Age groups display across the top of the report.

3. Set the date at the “Enter beginning Visit Date for search” prompt.

4. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-9:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:01:28          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV

          Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-10: Sample Visit Selection Menu

5. At the “Do you wish to modify these age groups?” prompt, type one of the following:
   - Type **N** to have the defined age groups listed across the top of the report.
   - Type **Y** to continue.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
7. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)

- Type **B** (browse output on screen) to display the Record Search Criteria screen.

8. At the prompt, press Enter to display the Behavioral Health Record Listing report displayed in Figure 13-10:

```
OUTPUT BROWSER                Apr 16, 2009 15:20:53          Page:    1 of   23


                    BEHAVIORAL HEALTH RECORD LISTING

REPORT REQUESTED BY: THETA,SHIRLEY

The following visit listing contains BH visits selected based on the
following criteria:

                            RECORD SELECTION CRITERIA

Encounter Date range:  OCT 18, 2008 to APR 16, 2009


Report Type: RECORD COUNTS BY AGE/SEX
             ********** CONFIDENTIAL PATIENT INFORMATION **********
                                  BEHAVIORAL HEALTH RECORD/ENCOUNTER COUNTS
                                            PROBLEM DSM IV TR/CODE BY AGE AND
                                       ENCOUNTER DATES:  OCT 18, 2008  TO  A

                                                            SEX: BOTH
PROB DSM/CODE NARRATIVE                  0-0      1-4      5-14     15-19    20-
-------------------------------------------------------------------------------
ACUTE STRESS REACTION                      .        .        .        .
ADMINISTRATION                             .        .        2        .
ADULT ABUSE (SUSPECTED),UNSPEC             .        .        .        .
ALCOHOL ABUSE                              .        .        1        .
ALCOHOL ABUSE, CONTINUOUS                  .        .        .        .
ALCOHOL ABUSE, EPISODIC,                   .        .        .        1
ALCOHOL ABUSE, IN REMISSION                .        .        .        .
ALCOHOL ABUSE, UNSPECIFIED                 .        .        1        1
+         Enter ?? for more actions                                    >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-11: Sample Behavioral Health Record Listing report

13.1.6 Case Status Reports (CASE)

At the “Select Patient Listings Option” prompt, type **CASE** to display additional reports on the Case Status Reports menu shown in Figure 13-11:

```
   ACO    Active Client List Using Case Open Date
   ONS    Cases Opened But Patient Not Seen in N Days
   TCD    Tally Cases Opened/Admitted/Closed
   DOC    Duration of Care for Cases Opened and Closed
   SENO   Patients Seen x number of times w/no Case Open

Select Case Status Reports Option:
```

Figure 13-12: Options on the Case Status Reports menu

13.1.6.1 Active Client List Using Case Open Date (ACO)

1. At the “Select Case Status Reports” prompt, type **ACO** to generate a report that shows a list of patients who have a case open date without a case closed date. Do the following?
2. At the “Run the Report for which program” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
3. At the “Include cases opened by” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
5. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the CONFIDENTIAL PATIENT INFORMATION screen shown in Figure 13-12:

```
********** CONFIDENTIAL PATIENT INFORMATION **********
Page 1
WHITE EARTH HEALTH CENTER
Encounter Dates: JAN 22, 2008 to JAN 21, 2009
          ACTIVE CLIENT LIST (CASE OPEN DATE WITH NO CASE CLOSED DATE)

PATIENT NAME      CHART  SEX  DOB      CASE OPEN CASE ADMIT PROVIDER      PROBLEM
                  NUMBER               DATE      DATE       SEEN          CODES
-----------------------------------------------------------------------------
ALPHA,ALICE ROC   183497  F 06/25/97  01/23/06              BETA,BETAA    296.31
                                                            CHII,RONAL    296.32
                                                            GAMMAAAA,RYA
  Case Provider: GAMMAAA,DENISE                   Next Case Review:

ALPHA,JACOB SCO   102668  M 10/01/72  05/06/09              GAMMAAAA,RYA    39
                                                            MUUUU,KARE    93
                                                                          292.12
                                                                          V11.3
                                                                         V71.02
  Case Provider: GAMMA,RYAN                       Next Case Review: 5/6/09
```

Figure 13-13: Sample view of active client list

13.1.6.2 Cases Opened But Patient Not Seen in N Days (ONS)

1. At the “Select Case Status Reports” prompt, type **ONS** to generate a report that shows a list of patients who have a case open date, no closed date, and have not been seen in *N* days. Do the following:
2. At the “Run the Report for which program” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
3. At the “Include cases opened by” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
4. At the “Enter the number of days since the patient has been seen” prompt, type the number of days (1–99999) be included in the report.
5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
6. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) Figure 13-13 displays the Cases Opened but Patient Not Seen in *N* Days report.

```
                              DEMO INDIAN HOSPITAL
            ACTIVE CLIENT LIST (CASE OPEN & NOT SEEN IN 90 DAYS)

PATIENT NAME  CHART   SEX  DOB     CASE OPEN   PROVIDER  DATE LAST   # DAYS
              NUMBER               DATE                  SEEN         SINCE
Patient L     106299  F  11/28/85  01/01/06   GAMMAAA,DON  04/26/06   217
Patient M     102446  F  04/08/66  08/28/06   GAMMAAA,DON  03/28/06   246
Patient N     176203  M  03/04/60  10/10/05   GAMMAAA,DON  03/28/06   246
Patient O     164141  M  02/07/75  12/07/05   GAMMAAA,DON  04/25/06   218
Patient P     209591  F  04/16/62  07/25/06   ZETAAAA,MAT  07/25/06   127

 Total Number of Patients: 5
 Total Number of Cases: 5
```

Figure 13-14: Sample Cases Opened but Patient Not Seen in N Days report

13.1.6.3 Tally Cases Opened/Admitted/Closed (TCD)

1. At the “Select Case Status Reports” prompt, type **TCD** to generate a report that tallies the case open, admit, and closed dates in a specified time period. Do the following:
2. Set the date at the “Enter beginning of Time Period” prompt.
3. Set the date at the “Enter ending of Time Period” prompt.
4. At the “Run the Report for which program” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
5. At the “Include cases opened by” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
7. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Tally of Cases Opened/Admitted/Closed report shown in Figure 13-14:

```
                              DEMO INDIAN HOSPITAL
                       TALLY OF CASES OPENED/ADMITTED/CLOSED
-----------------------------------------------------------------------
          Number of Cases Opened:      6

          Number of Cases Admitted:    2

          Number of Cases Closed:      2

          Tally of Dispositions:
               PATIENT DIED                      1
               PATIENT DMOVED                    1
RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-15: Tally of Cases Opened/Admitted/Closed report

13.1.6.4 Duration of Care for Cases Opened and Closed (DOC)

1. At the "Select Case Status Reports" prompt, type **DOC** to generate a report that shows a list of all closed cases in a date range. In order to be included in this report, the case must have both a case open closed date. The duration of care is calculated by counting the number of days from the case open date to the case closed date. Cases can be selected based on Open date, Closed date, or both. Do the following:
2. Set the date at the "Enter beginning Date" prompt.
3. Set the date at the "Enter ending Date" prompt.
4. At the "Please Select which Dates should be Used" prompt, type one of the following:
   - **O** (cases opened in that date range)
   - **C** (cases closed in that date range)
   - **B** (cases either opened or closed in that date range).
5. At the "Run the Report for which program" prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
6. At the "Include cases opened by" prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
7. At the "Do you want a separate page for each Patient Name?" prompt, type one of the following:
   - **Y** (create a separate page for each patient)
   - **N** (separate page is not created)
8. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
9. At the "Do you wish to" prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Duration of Care report shown in Figure 13-15:

The application displays the Duration of Care report.

```
DURATION OF CARE REPORT
  PATIENT NAME  CHART   CASE OPEN  CASE CLOSED  DURATION  POV   PROVIDER
                NUMBER  DATE       DATE

    Patient A   148367  05/22/08   08/22/08     92 days           BETA,B
    Patient B   114077  06/27/08   08/28/08     62 days           BETA,B
    Patient B   114077  07/25/08   08/21/08     27 days           BETA,B
    Total Number of Cases for BETAA,B: 3
    Average Duration of Care: 60.33 days

    Patient C   211053  04/19/08   08/16/08    119 days  72.1  SIGMA,RO
    Total Number of Cases for SIGMA,ROBERTA: 1
    Average Duration of Care: 119.00 days

    Patient D   146565  08/01/08   08/16/08    15 days  305.62 THETA,MAUDE
    Total Number of Cases for THETA,MAUDE: 1
    Average Duration of Care: 15.00 days

    Patient E   148256  07/25/08    09/01/08   38 days         CHI,VICTOR L
    Total Number of Cases for THA,VICTOR L: 1
    Average Duration of Care: 38.00 days

    Patient F   106030  05/22/08    08/30/08   100 days      UPSILON,GEORGE
G
    Total Number of Cases for UPSILON,GEORGE G: 1
    Average Duration of Care: 100.00 days

    Total Number of Cases: 7
    Average Duration of Care: 64.71 days
```

Figure 13-16: Sample Duration of Care report

13.1.6.5 Patient Seen x Number of Times w/no Case Open (SENO)

1. At the “Select Case Status Reports” prompt, type **SENO** to generate a report that shows a list of patients, in a specified date range, who have been seen a certain number of times but do not have open cases. The user, based on the program’s standards of care, specifies when a case is to be opened. Do the following:
2. Set the date at the “Enter Beginning Visit Date” prompt.
3. Set the date at the “Enter Ending Visit Date” prompt.
4. At the “Run the Report for which program” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
5. At the “Include visits to” prompt, type one of the following:
   - **A** (all providers)
   - **O** (one program) to continue

6. At the “Enter number of visits (*X* number of visits with no case opened)” prompt, type the number of visits with no case opened.
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
8. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Patients Seen at least *N* times with no Case Open Date report shown in Figure 13-16

```
                              DEMO INDIAN HOSPITAL
              PATIENTS SEEN AT LEAST 2 TIMES WITH NO CASE OPEN DATE
                  VISIT DATE RANGE: Jun 02, 2008 to Nov 29, 2008

                       VISITS TO PROGRAM: MENTAL HEALTH
  PATIENT NAME  CHART   SEX  DOB        #     LAST VISIT    LAST      PROVIDER
                NUMBER                  VISITS              DX
-------------------------------------------------------------------------------

  Patient G     116431   F   02/07/75   3     11/14/08     43.1        BETA,B
  Patient H     142538   F   10/10/42   3     11/27/08     27          BETA,B
  Patient I     113419   M   07/18/85   3     08/16/08     296.33      BETA,KEITH N
  Patient J     201295   M   05/14/41   4     08/22/08     296.40      GAMMA, THO
  Patient K     194181   M   08/21/98   2     06/19/08     314.9       SIGMA,JOH

     Total Number of Patients: 5
```

Figure 13-17: Sample Patients Seen at least N times with no Case Open Date report

13.1.7 GAF Scores for Multiple Patients (GAFS)

1. At the “Select Patient Listings Option” prompt, **GAFS** to generate a report that lists the GAF scores for multiple patients, sorted by patient. Do the following:
2. Set the date at the “Enter Beginning Visit Date” prompt.
3. Set the date at the “Enter Ending Visit Date” prompt.
4. At the “List visits/GAF Scores for which program” prompt type one of the following
   - **A** (all programs)
   - **O** (one program) to continue
5. At the “Include visits to” prompt, type one of the following:

- **A** (all providers)
- **O** (one program) to continue

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

7. At the “Do you wish to” prompt, type one of the following:

- **P** (print output)
- Type **B** (browse output on screen) to display the GAF Scores for Multiple Patients report shown in Figure 13-17

```
   XX                              Apr 17, 2009                       Page 1

                        GAF SCORES FOR MULTIPLE PATIENTS
                    Visit Dates: Oct 19, 2008 to Apr 17, 2009
                                   Program: ALL
                                  Provider: ALL

PATIENT NAME     HRN    Date     GAF TYPE    Provider  PG Diagnosis/POV
-------------------------------------------------------------------------------

BETAAAA,MINNIE   145318 09/17/10 99  CGAS    GAMMAA,RY M  296.40-BIPOLAR I DISOR

DEMO,JAMES WILL  192636 07/19/10 75          GAAMMAA,D M  300.02-GENERALIZED ANX
+         Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-18: Sample GAF Scores for Multiple Patients report

13.1.8 Listing of No-Show Visits in a Date Range (NSDR)

1. At the “Select Patient Listings Option” prompt, **NSDR** to print a list of visits with POVs related to no shows and cancellations for multiple patients. Do the following:

2. Set the date at the “Enter beginning Date” prompt.

3. Set the date at the “Enter ending Date” prompt.

4. At the “List visits/GAF Scores for which program” prompt type one of the following

- **A** (all programs)
- **O** (one program) to continue

5. At the “Include visits to” prompt, type one of the following:

- **A** (all providers)
- **O** (one program) to continue

6. At the “How would you like the report sorted” prompt, type one of the following:
   - **P** (patient name)
   - **D** (date of visit).
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
8. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Behavioral Health No Show Appointment Listing report shown in Figure 13-18:

```
          ********** CONFIDENTIAL PATIENT INFORMATION **********
                            DEMO INDIAN HOSPITAL                      Page 1

              BEHAVIORAL HEALTH NO SHOW APPOINTMENT LISTING
            Appointment Dates:  OCT 19, 2008 and APR 17, 2009

PATIENT NAME        HRN    DATE/TIME          PROVIDER     PG  POV
-------------------------------------------------------------------------------
BPAT,ROBERT JACOB   207365 Jan 05, 2009@12:00 CBETA,JESSIC M  8-FAILED APPOI
FPAT1111,CHARLES R  112383 Dec 30, 2008       BETAAAA,BJ   M  8.1-PATIENT CANC
RPAT111,BEULAH      140325 Feb 12, 2009@12:00 GAMMAA,RYAN  S  8-FAILED APPOI
VPAT1,RACHEL MAE    201836 Jan 06, 2009@12:00 LAMBDAAA,MIC O  8.3-DID NOT WAIT

Total # of Patients: 4     Total # of No Show Visits: 4

          Enter ?? for more actions                                      >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-19: Sample Behavioral Health No Show Appointment Listing report

13.1.9 Patient List for Personal Hx Items (PERS)

1. At the “Select Patient Listings Option” prompt, type **PERS** to generate the List of Patients with Personal History Items report. Do the following:
2. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)

- **O** (include only demo patients)

3. At the “Do you wish to” prompt, type one of the following:

- **P** (print output)
- Type **B** (browse output on screen) to display the Personal History Items report Figure 13-19:

```
XX                              DEMO INDIAN HOSPITAL
PERSONAL HISTORY LIST BY PATIENT         Jul 13, 2009@09:53:05       Page 1
          PATIENT                         SEX       AGE  CHART NUMBER
-------------------------------------------------------------------------


                 ALCOHOL USE
          ALPHAA,SAUNDRA KAY              FEMALE    58   117175
          BETA,BRENNA KAY                 FEMALE    21   155215
          BETA,HEATHER LINDA PAIGE        FEMALE    73   142321
          BETAA,STEVEN                    MALE      29   188444
          GAMMA,JANE ELLEN                FEMALE    19
          GAMMA,TIMOTHY                   MALE      29
          PHIIIII,GREGORY SHANE           MALE      42   184929
          SIGMAAA,AMY LYNN                FEMALE    65   130119

    Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-20: Sample List of Patients with Personal History Items report

13.1.10 Placements by Site/Patient (PPL)

1. At the “Select Patient Listings Option” prompt, type **PPL** option to generate a report that shows a list of patients who have had a placement disposition recorded in a date range. Do the following:
2. Set the date at the “Enter beginning Date” prompt.
3. Set the date at the “Enter ending Date” prompt.
4. At the “How would you like the report sorted” prompt, type one of the following:

- **P** (alphabetically by patient name)
- **S** (alphabetically by site referred to).

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:

- **P** (print output)
- Type **B** (browse output on screen) to display the Placements report shown in Figure 13-20:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                    Page 1
                              DEMO INDIAN HOSPITAL
                                   PLACEMENTS
               PLACEMENT DATES:  OCT 19, 2008  TO  APR 17, 2009

PATIENT NAME        HRN    DATE       POV   PLACEMENT      FACILITY REFERRED TO
                           PLACED
-------------------------------------------------------------------------------
ALPHA,JACOB SCOTT   102668  05/03/09 295.15 E
APATT,CHELSEA MAR  116431  03/25/09 12     OUTPATIENT
   Placement Made by: GAMMAA,RYAN
   Designated SS Prov: BETA,BETAA
BPATT,RUSTY LYNN    207396  04/06/09 15     OUTPATIENT
   Placement Made by: GAMMAA,RYAN
BPATTTT,ADAM M      109943  04/07/09 311.   OUTPATIENT
   Placement Made by: GAMMAA,RYAN
          Enter ?? for more actions                                   >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-21: Sample Placements report

13.1.11 Listing of Patients with Selected Problems (PPR)

1. At the “Select Patient Listings Option” prompt, type **PPR** to generate a report that lists all patients who have been seen for a diagnosis/problem in a date range. Do the following:
2. At the “Which Type?” prompt, type one of the following:
   - D (individual problem or DSM codes)
   - P (Problem Code and all DSM codes grouped under it) the prompts continue:
3. At the “Enter Problem Code” prompt, type the code. The next prompt allows you to enter another problem code.
4. Set the date at the “Enter Beginning Visit Date” prompt.
5. Set the date at the “Enter Ending Visit Date” prompt.
   - At the prompt, type one of the following:
     - **P** (alphabetically by patient name)
     - **S** (alphabetically by site referred to).
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)

- **E** (exclude demo patients)
- **O** (include only demo patients)

7. At the “Do you wish to” prompt, type one of the following:

- **P** (print output)
- Type **B** (browse output on screen) to display the Patients Seen with Selected Diagnosis/Problems report shown in Figure 13-21:

```
   XX                              Apr 17, 2009                       Page 1

                 PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS
                   Visit Dates: Oct 19, 2008 to Apr 17, 2009

PATIENT NAME               HRN    DOB      SEX PROV DX DX     DATE SEEN LAST VIS
-------------------------------------------------------------------------------
APATQ,ABIGAIL              103952 02/25/32  F  BJB     41     12/08/08  12/29/08
BPAT,ROBERT JACOB          207365 02/06/55  M  JC      41     12/29/08  01/05/09
FPAT12,AMANDA ROSE         186121 01/10/98  F  DG      40     12/01/08  12/30/08
YPATB,ANNEMARIE LEE        105883 02/11/44  F  DG      40     04/06/09  04/06/09
   Designated MH Prov: GALPHA,DENISE
   Designated SS Prov: GAMMAA,RYAN
          Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-22: Sample Patients Seen with Selected Diagnosis/Problems report (P type)

- At the prompt, type the following:
  - **D** (individual problem or DSM codes) Do the following:

1. At the “Enter Problem/Diagnosis Code” prompt, type the code. The next prompt allows you to enter another problem/diagnosis code.
2. Set the date at the “Enter Beginning Visit Date” prompt.
3. Set the date at the “Enter Ending Visit Date” prompt.
4. At the “How would you like the report sorted” prompt, type one of the following:

- **P** (alphabetically by patient name)
- **S** (alphabetically by site referred to).

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:

- **P** (print output)
- Type **B** (browse output on screen) to display Patients Seen with Selected Diagnosis/Problems report shown inFigure 13-22:

```
   XX                              Apr 17, 2009                        Page 1

                 PATIENTS SEEN WITH SELECTED DIAGNOSES/PROBLEMS
                   Visit Dates: Oct 19, 2008 to Apr 17, 2009

PATIENT NAME                HRN    DOB      SEX PROV DX DX     DATE SEEN LAST VIS
-------------------------------------------------------------------------------
ALPHA,CHELSEA MARIE       116431 02/07/75  F  DG      43.3   04/06/09  04/16/09
   Designated SS Prov: BDOC11,BJ


          Enter ?? for more actions                                          >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
Select Action: +//
```

Figure 13-23: Sample Patients Seen with Selected Diagnosis/Problems report (D type)

13.1.12 Screening Reports (SCRN)

At the “Select Patient Listings Option”prompt, type **SCRN** to access the Screening Reports menu shown in Figure 13-23:

```
                  ***********************************************
                  **       IHS Behavioral Health System        **
                  **             Screening Reports             **
                  ***********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL


   IPV    IPV/DV Reports ...
   ALC    Alcohol Screening Reports ...
   DEP    Depression Screening Reports ...
   PHQ    PHQ-2 and PHQ-9 Scores for One Patient
   PHQS   PHQ-2 and PHQ-9 Scores for Multiple Patients

Select Screening Reports Option:
```

Figure 13-24: Options on the Screening Reports menu

13.1.12.1 IPV/DV Reports (IPV)

At the “Select Screening Reports Option” prompt, type **IPV** to access the IPV/DV Report menu as shown in Figure 13-24:

```
                  ***********************************************
                  **       IHS Behavioral Health System        **
                  **              IPV/DV Reports               **
                  ***********************************************
                              Version 4.0 (patch 2)
```

```
                              DEMO INDIAN HOSPITAL


   DVP    Tally/List Patients with IPV/DV Screening
   DVS    Tally/List IPV/DV Screenings
   ISSP   List all IPV/DV Screenings for Selected Patients
   IPST   Tally/List Pts in Search Template w/IPV Screening
   IVST   Tally List all IPV Screenings for Template of Pts

Select IPV/DV Reports Option:
```

Figure 13-25: Options on the IPV/DV Reports menu

13.1.12.1.1 *Tally/List Patients with IPV/DV Screening (DVP)*

This report will tally and optionally list all patients who have had IPV screening (PCC Exam Code 34) or a refusal documented. Do the following:

> **Note**: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
> This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal

1. Set the date at the "Enter Beginning Date for Screening" prompt.
2. Set the date at the "Enter Ending Date for Screening" prompt.
3. At the "Which items should be tallied: (0-11)" prompt, select the items to be tallied (Figure 13-25).

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
Provider
```

Figure 13-26: List of options from which to tally the report

   - The response must be a list or range similar to: 1,3,5 or 2-4,8.
4. At the "Would you like to include IPV/DV Screenings documented in the PCC clinical database?" prompt, type one of the following:
   - Type **Y** to include the screenings
   - Type **N** to not include the screenings
5. At the "Would you like to include a list of patients screened?" prompt type one of the following:

- Type **N** to not include the list of patients
- Type **Y** to continue

6. At the "How would you like the list to be sorted" prompt, type a selection. Figure 13-26 shows the list of options to sort. The default is **H** (Health Record Number). Do the following:

```
Select one of the following:
          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 13-27: List of options to sort the list

7. At the "Display the Patient's Designated Providers on the list?" prompt, type one of the following:
   - Type **N** to not display the list
   - Type **Y** to display the list
8. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
9. At the "DEVICE" prompt, type the device to output the report.

Figure 13-27 shows the sample report:

```
   ST                              Jan 18, 2012                        Page 1

           ***  IPV SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Nov 19, 2011 to Jan 18, 2012
            This report excludes data from the PCC Clinical database

-------------------------------------------------------------------------------
                                              #      % of patients
     Total Number of Patients screened         2

                               By Result

                               NEGATIVE         1       50.0%
                      PRESENT AND PAST          1       50.0%

                               By Gender

                                 FEMALE         1       50.0%
```

```
                                  MALE         1       50.0%

                                By Age


PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
-------------------------------------------------------------------------------

BETAAAAA,MISTY DAWN   106371 29  F 12/28/11 PRESENT AND PAST BEHAVIORAL HEALTH
   Comment: TEST3
   DXs: 296.32   MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
   Primary Provider on Visit:  GARCIA,RYAN
       Provider who screened:  GARCIA,RYAN


Enter RETURN to continue or '^' to exit:
```

Figure 13-28: Sample output of the IPV Screening Patient Tally and Patient Listing report

13.1.12.1.2 *Tally/List IPV/DV Screenings* (DVS)

The report will tally and optionally list all visits on which IPV screening (PCC Exam Code 34) or a refusal was documented in a specified time frame. Do the following:

> **Note**: This report will optionally, look at both the Behavioral Health and PCC clinical databases for evidence of screening/refusal.
> Please enter the date range during which the screening was done. To get all screenings ever put in a long date range like 01/01/1980 to the present date.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Which items should be tallied: (0-11)” prompt, select the items to be tallied (Figure 13-28).

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
 Provider
```

Figure 13-29: List of options from which to tally the report

- The response must be a list or range similar to: 1,3,5 or 2-4,8.

4. At the “Would you like to include IPV/DV Screenings documented in the PCC clinical database?” prompt, type one of the following:

- Type **Y** to include the screenings

- Type **N** to not include the screenings

5. At the "Would you like a list of visits w/screenings done?" prompt, type one of the following:

   - Type **N** to not include the list of patients
   - Type **Y** to continue

6. At the "How would you like the list to be sorted" prompt, type a selection. Figure 13-29 shows the list of options to sort. The default is **H** (Health Record Number). Do the following:

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 13-30: List of options to sort the list

7. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
   - At the "DEVICE" prompt, type the device to output the report.

Figure 13-30 shows the sample report:

```
   ST                              Jan 18, 2012                        Page 1

             ***  IPV SCREENING VISIT TALLY AND VISIT LISTING  ***
                 Screening Dates: Oct 20, 2011 to Jan 18, 2012
                        This report excludes PCC Clinics

-------------------------------------------------------------------------------
                                                #      % of patients
 Total Number of Visits with Screening           2
     Total Number of Patients screened           2

                               By Result

                               NEGATIVE          1       50.0%
                      PRESENT AND PAST           1       50.0%

                                 By Age

                                 29 yrs          1       50.0%
```

```
                                 56 yrs         1       50.0%

               By Provider who screened


Enter RETURN to continue or '^' to exit:
-------------------------------------------------------------------------------
                                                #      % of patients
                          CHIII,JESSICA         1       50.0%
                            GAMMA,RYAN          1       50.0%

           By Primary Provider of Visit

                            GAMMA,RYAN          2       100.0%

                               By Clinic

                  ALCOHOL AND SUBSTANCE          1       50.0%
                      BEHAVIORAL HEALTH          1       50.0%

                                By Date


Enter RETURN to continue or '^' to exit:
```

Figure 13-31: Sample output of the IPV Screening Visit Tally and Visit Listing report

13.1.12.1.3 List all IPV/DV Screenings for Selected Patients (ISSP)

The report lists all patients selected who have had IPV screening or a refusal documented in a specified time frame. Do the following:

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?” prompt, type one of the following:
   - **Y** to include screenings
   - **N** to not include screenings
4. At the “Include which patients in the list” prompt, tyoe one of the following:
   - **F** (FEMALES only)
   - **M** (MALES only)
   - **B** (Both MALE and FEMALES)
5. At the “Would you like to restrict the report by Patient age range?” prompt, type one of the following:
   - **N** to not restrict the age range
   - **Y** to continue

6. At the “Which result value do you want included in this list: (1-7)” prompt, type one of the selections displayed in Figure 13-31:

```
1)  Normal/Negative
2)  Present
3)  Past
4)  Present and Past
5)  Refused
6)  Unable to Screen
7)  Screenings done with no result entered
```

Figure 13-32: List of options used to be included in the list

You can limit the list by doing one of the following:

- To get only those patients who have had a result of Present enter 2.
- To get all patients who had a screening result of Past or Present, enter 2,3).

7. At the “Include visits to ALL clinics?” prompt, type one of the following:

- **Y** to include the visits
- **N** to not include the visits

Figure 13-32 shows the visits used on the report.

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 13-33: Options for visits to be used on the report

- Type **O** other prompts display:

8. At the “Would you like to limit the list to just patients who have a particular designated Mental Health provider?” prompt, type one of the following:

- **N** to not limit the list
- **Y** to continue:

9. At the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt, type one of the following:

- **N** to not limit the list
- **Y** to continue

10. At the “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?” prompt, type one of the following:

- **N** to not limit the list

- **Y** to continue

11. At the “Select Report Type” prompt, type one of the following:

    - **L** (List of Patient Screenings)
    - **S** (Create a Search Template of Patients) to continue

12. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-26 shows the list of options to sort. The default is **H** (Health Record Number). Do the following:

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 13-34: List of options to sort the list

13. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:

    - **Y** to display the provider on the list
    - **N** to display the provider on the list

14. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

    - **I** (include all patients)
    - **E** (exclude demo patients)
    - **O** (include only demo patients)

15. At the “DEVICE” prompt, type the device to output the report. Press Enter to display the IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS report displayed in Figure 13-34:

```
   XX                            Feb 15, 2011                      Page 1

           ***  IPV SCREENING VISIT LISTING FOR SELECTED PATIENTS  ***
                  Screening Dates: Nov 17, 2010 to Feb 15, 2011

                                        DATE
PATIENT NAME          HRN    AGE   SCREENED RESULT           CLINIC
---------------------------------------------------------------------------

ALPHA,WILLA BELLE     110838 44  F 01/12/11 PAST             MENTAL HEALTH
   DXs: 14       MAJOR DEPRESSIVE DISORDER
   Primary Provider on Visit:  THETA,WENDY
```

```
        Provider who screened: THETA,WENDY

ALPHA,KIMBERLY ANN    166488 59  F 12/14/10 PRESENT          MENTAL HEALTH
   DXs: 39       SUICIDE (IDEATION)
   Primary Provider on Visit:  GAMMA,RYAN
        Provider who screened: GAMMA,RYAN

Enter RETURN to continue or '^' to exit:
```

Figure 13-35: Sample IPV Screening Visit Listing for Selected Patients report

13.1.12.1.4 Tally/List Pts in Search Template w/IPV Screening (IPST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest IPV screening (PCC Exam Code 34) or a refusal documented in a specified time frame.

13.1.12.1.5 Tally/List all PIV Screenings for Template of Pts (IVST)

This report will tally and optionally list all visits on which IPV screening (PCC Exam Code 34) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. Only patients who are members of a user-defined search template are included in this report. This IPV/DV report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

13.1.12.2 Alcohol Screening Reports (ALC)

Type **ALC** to display the ALC Report menu shown in Figure 13-35:

```
                  ***********************************************
                  **       IHS Behavioral Health System       **
                  **         Alcohol Screening Reports        **
                  ***********************************************
                              Version 4.0 (patch 1)

                               DEMO INDIAN HOSPITAL

   ASP    Tally/List Patients with Alcohol Screening
   ALS    Tally/List Alcohol Screenings
   ASSP   List all IPV/DV Screenings for Selected Patients
   APST   Tally/List Pts in Search Template w/Alcohol Screening
   AVST   Tally List all Alcohol Screenings for Template of Pts

Select Alcohol Screening Reports Option:
```

Figure 13-36: Options on the ALC Reports menu

13.1.12.2.1 Tally/List Patients with Alcohol Screening (ASP)

This report will tally and optionally list all patients who have had an alcohol screening (Exam Code 35) or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

Note:	The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report. This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal. This is a tally of patients, not visits or screenings. Enter the date range during which the screening was done. To obtain all screenings entered in a long date range like 01/01/1980 to the present date.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Which items should be tallied” prompt, type the items to be displayed on the report.
   - The response must be a list or range similar to: 1,3,5 or 2-4,8.
4. At the “Would you like to include ALCOHOL Screenings documented in the PCC clinical database?” prompt, type one of the following:
   - Type **Y** to include the screenings
   - Type **N** to not include the screenings
5. At the “Would you like to include a list of patients screened?” prompt, type one of the following
   - Type **N** to not include the list
   - Type **Y** to continue
6. At the “How would you like the report sorted” prompt, type only one of the items in the list provided by the application.
7. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:

- **Y** to display the patient's Designated Providers
- **N** (No) to bypass this option.

8. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)

9. At the "Do you wish to" prompt, type one of the following:

- **P** (print output)
- Type **B** (browse output on screen) to display the Tally/List Patients with Alcohol Screenings report shown inFigure 13-36:

```
   XX                            Oct 07, 2010                        Page 1

         ***  ALCOHOL SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Sep 07, 2010 to Oct 07, 2010
            This report excludes data from the PCC Clinical database

-----------------------------------------------------------------------------
                                                #      % of patients

    Total Number of Patients screened           4
                    By Result
                    NEGATIVE                    1          25.0%
                    POSITIVE                    2          50.0%
                    REFUSED SCREENING           1          25.0%

                    By Gender
                           F                    3          75.0%
                           M                    1          25.0%

                    By Age
                    26 yrs                      1       25.0%
                    27 yrs                      1       25.0%
                    44 yrs                      1       25.0%
                    48 yrs                      1       25.0%
```

Figure 13-37: Sample Tally/List Patients with Alcohol Screenings report

13.1.12.2.2 Tally/List Alcohol Screening (ALS)

This report will tally and optionally list all visits on which an alcohol screening (Exam Code 35) or a refusal was documented in a time frame.

Alcohol Screening is defined as any of the following:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)

- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

> Note: This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
> This is a tally of visits with a screening done, if a patient had multiple screenings during the time period, all will be counted.

1. Set the date at the "Enter Beginning Date for Screening" prompt.
2. Set the date at the "Enter Ending Date for Screening" prompt.
3. At the "Which items should be tallied" prompt, type the items to be displayed on the report.
   - The response must be a list or range similar to: 1,3,5 or 2-4,8.
4. At the "Would you like to include ALCOHOL Screenings documented in the PCC clinical database?" prompt, type one of the following:
   - Type **Y** to include the screenings
   - Type **N** to not include the screenings
5. At the "Would you like to include a list of visits w/screenings done?" prompt, type one of the following:
   - Type **Y** to include the list of visits w/screenings
   - Type **N** to not include the list of visits w/screenings
6. At the "How would you like the report sorted" prompt, type only one of the items in the list.
7. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
8. At the "Do you wish to" prompt, type one of the following:
   - **P** (print output)

- Type **B** (browse output on screen) to display the Duration of Care report shown in Figure 13-37:

```
           ***  ALCOHOL SCREENING VISIT TALLY AND VISIT LISTING  ***
                  Screening Dates: Sep 10, 2010 to Dec 09, 2010
                        This report excludes PCC Clinics

-----------------------------------------------------------------------
                                          #      % of patients
Total Number of Visits with Screening    4
      Total Number of Patients screen    4
           By Result
                  NEGATIVE                1     25.0%
                  POSITIVE                2     50.0%
                  REFUSED SCREENING       1     25.0%
           By Gender
                  FEMALE                  3     75.0%
                  MALE                    1     25.0%
           By Age
                  26 yrs                 1      25.0%
                  27 yrs                 1      25.0%
                  44 yrs                 1      25.0%
                  48 yrs                 1      25.0%
         By Provider who screened
            ALPHAA, GEORGE C             1      25.0%
            BETAA, FRANK S               1      25.0%
            GAMMA, MATT                  1      25.0%
            OMICRON, STEVE N             1      25.0%
        By Primary Provider of Visit
            ALPHAA, GEORGE C             1      25.0%
            BETAA,FRANK S                1      25.0%
            WEARY, MATT                  1      25.0%
            OMICRON, STEVE N             1      25.0%
      By Designated Primary Care Provider
            UNKNOWN                      3      75.0%
            RHOOOOO,HELEN K              1      25.0%
      By Clinic
            ALCOHOL AND SUBSTANCE         1     25.0%
            MEDICAL SOCIAL SERVICES       1     25.0%
            MENTAL HEALTH                 2     50.0%
      By Date
             Jul 25, 2006                 1     25.0%
             Aug 09, 2006                 1     25.0%
             Aug 17, 2006                 1     25.0%
             Aug 23, 2006                 1     25.0%
      By Designated Mental Health Provider
             UNKNOWN                      4     100.0%
      By Designated Social Services Provider
             UNKNOWN                      4     100.0%
      By Designated A/SA Provider
             UNKNOWN                      4     100.0%
PATIENT NAME     HRN      AGE       SCREENED   RESULT        CLINIC
   Patient T11   4551     26  F     08/17/06   POSITIVE
   DXs: 29.1     SCREENING FOR ALCOHOLISM
        29.2     SCREENING FOR DRUG ABUSE
        995.81   ADULT ABUSE (SUSPECTED), PHYSICAL
Primary Provider on Visit:  BETA, FRANK S
Provider who screened: DOC22, FRANK S
```

Figure 13-38: Sample Tally/List Alcohol Screenings report

13.1.12.2.3 List All Alcohol Screenings for Selected Patients (ASSP)

This report will tally and optionally list all patients who have had an alcohol screening or a refusal documented in a specified time frame. Alcohol Screening is defined as any of the following documented:

- Alcohol Screening Exam (Exam Code 35)
- Measurements: AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- Diagnoses V79.1, 29.1
- Education Topics: AOD-SCR, CD-SCR
- CPT Codes: 99408, 99409, G0396, G0397, H0049
- Refusal of Exam Code 35

> **Note**: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
> This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- This is a tally of patients, not visits or screenings. Do the following?

Below are the prompts.

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening” prompt.
3. At the “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?” prompt, type one of the following:
   - Type **Y** to include the screenings
   - Type **N** to not include the screenings
4. At the “Include which patients in the list” prompt, tyoe one of the following:
   - **F** (FEMALES only)
   - **M** (MALES only)
   - **B** (Both MALE and FEMALES)
5. At the “Would you like to restrict the report by Patient age range?” prompt, type one of the following:
   - **N** to list visits for patients in a date range

- **Y** to continue

6. At the "Which result values do you want included on this list?" prompt, choose from the following:

   - 1) Normal/Negative
   - 2) Positive
   - 3) Refused
   - 4) Unable to Screen
   - 5) Screenings done with no result entered

   You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter 2 to get all patients who have had a screening result of Positive or Refused, enter 2,3).

7. At the "Include visits to ALL clinics" prompt, type one of the following:

   - **Y** to include visits
   - **N** to continue

8. At the "Report should include visits whose PRIMARY PROVIDER on the visit is" prompt, type one of the following:

   - **P** (Any/All Providers including Unknown)
   - **U** (Unknown Provider Only)
   - **O** (One Provider Only)

9. At the "Select which providers who performed the screening should be included" prompt, type one of the following:

   - **P** (Any/All Providers including Unknown)
   - **U** (Unknown Provider Only)
   - **O** (One Provider Only)

10. At the "Would you like to limit the list to just patients who have a particular designated Mental Health provider?" prompt, type one of the following:

    - **N** to not limit the list
    - **Y** to continue

11. At the "Would you like to limit the list to just patients who have a particular designated Social Services provider?" prompt, type one of the following:

    - **N** to not limit the list

- **Y** to continue

12. At the “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?” prompt, type one of the following:

    - **N** to not limit the list
    - **Y** to continue

13. At the “Select Report Type” prompt, type one of the following:

    - **L** (List of Patient Screenings)
    - **S** (Create a Search Template of Patients).

14. At the “How would you like the report sorted” prompt, sort by only one of the items in the list.

15. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:

    - **Y** to display the provider
    - **N** to not display the provider

16. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

    - **I** (include all patients)
    - **E** (exclude demo patients)
    - **O** (include only demo patients)

17. At the “Do you wish to” prompt, type one of the following:

    - **P** (print output)
    - Type **B** (browse output on screen) to display the Tally/List Alcohol Screenings report shown in Figure 13-16:

```
   XX                            Oct 07, 2010                       Page 1

        ***  ALCOHOL SCREENING VISIT LISTING FOR SELECTED PATIENTS  ***
                 Screening Dates: Jul 09, 2010 to Oct 07, 2010

                                     DATE
PATIENT NAME          HRN    AGE   SCREENED            CLINIC
---------------------------------------------------------------------------

SIGMAAAAA,BRITTANY LYN  129079 41  F 08/03/10            BEHAVIORAL HEALTH
   Type/Result: ALCOHOL SCREENING  NEGATIVE
   Primary Provider on Visit:  BETA,BETAA
       Provider who screened:  BETA,BETAA

SIGSIG,ALICIA MARIE  169379 58  F 09/08/10            ALCOHOL AND SUBSTANC
   Type/Result: AUDT  21
   Primary Provider on Visit:  BETA,BETAA
       Provider who screened:  UNKNOWN
```

```
Enter RETURN to continue or '^' to exit:
```

Figure 13-39: Sample Alcohol Screenings Visit Listing for Selected Patients report

13.1.12.2.4 Tally/List Pts in Search Template w/Alcohol Screenings (APST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest alcohol screening (Exam Code 35) or a refusal documented in a specified time frame. This report will tally the patients by age, gender, result, screening provider, primary provider of the visit, designated primary care provider, and date of screening/refusal.

13.1.12.2.5 Tally list all Alcohol Screenings for Template of Pts (AVST)

This report will tally and optionally list all visits on which an alcohol screening (Exam Code 35) or a refusal was documented in a specified time frame. This report will tally the visits by age, gender, result, provider (either exam provider, if available, or primary provider on the visit), and date of screening/refusal. Only patients who are members of a user-defined search template are included in this report. This alcohol screening report is intended for advanced RPMS users who are experienced in building search templates and using Q-MAN.

13.1.12.3 Depression Screening Reports (DEP)

Type **DEP** to access the Depression Screening Reports menu.

```
                  ********************************************
                  **       IHS Behavioral Health System       **
                  **       Depression Screening Reports       **
                  ********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL


   DSP    Tally/List Patients with Depression Screening
   DLS    Tally/List Depression Screenings
   DSSP   List all Depression Screenings / Selected Patients
   DPST   Tally/List Pts in Search Temp w/Depression Scrn
   DVST   Tally List all Depression Scrn for Template of Pts

Select Depression Screening Reports Option:
```

Figure 13-40: Options on the Depressing Screening Reports menu

13.1.12.3.1 Tally/List Patient with Depression Screening (DSP)

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)

- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

> Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
> This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusals.

- This is a tally of patients, not visits, or screening. Do the following:

1. Set the date at the "Enter Beginning Date for Screening" prompt.
2. Set the date at the "Enter Ending Date for Screening prompt.
3. At the "Which items should be tallied: (0-11)" prompt, select the items to be tallied (Figure 13-40).

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
Provider
```

Figure 13-41: List of options from which to tally the report

4. At the "Would you like to include DEPRESSION Screenings documented in the PCC clinic database?" prompt, type one of the following:
   - **Y** to include the screenings
   - **N** to not include the screenings
5. At the "Would you like to include a list of patients screened." prompt, type one of the following:
   - **N** to not include the list of patients

   Y the following screen will display Figure 13-41:

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
```

```
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 13-42: List of options to sort the list

- The default is H (Health Record Number).

6. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:

- **Y** to display the list
- **N** to not display the list

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

- **I** (include all patients)
- **E** (exclude demo patients)
- **O** (include only demo patients)
- At the “DEVICE” prompt, type the device to output the report.

Figure 13-42 shows the sample report:

```
   XX                              Jan 18, 2012                       Page 1

        ***  DEPRESSION SCREENING PATIENT TALLY AND PATIENT LISTING  ***
                 Screening Dates: Dec 19, 2011 to Jan 18, 2012
             This report excludes data from the PCC Clinical database

-------------------------------------------------------------------------------
                                                #      % of patients
     Total Number of Patients screened           5

                                By Result

                                 PHQ2  2        1       20.0%
                                PHQ9  13        1       20.0%
                                PHQ9  16        1       20.0%
                                PHQ9  18        1       20.0%
                                PHQ9  22        1       20.0%

                                By Gender

                                       F        3       60.0%

-------------------------------------------------------------------------------
                                                #      % of patients
                                       M        2       40.0%

                                  By Age

                                  11 yrs        1       20.0%
                                  29 yrs        1       20.0%
```

```
                                45 yrs         1       20.0%
                                62 yrs         1       20.0%
                                68 yrs         1       20.0%

              By Provider who screened

                            GARCIA,RYAN         1       20.0%


PATIENT NAME          HRN    AGE   SCREENED            CLINIC
--------------------------------------------------------------------------------

BETAAAAA,MISTY DAWN   106371 29  F 12/28/11            BEHAVIORAL HEALTH
   Type/Result: PHQ9  22
   Primary Provider on Visit:  GARCIA,RYAN
       Provider who screened:  GARCIA,RYAN


THETAAAA,REBECCA LEE  113487 45  F 12/30/11            MENTAL HEALTH
   Type/Result: PHQ9  16
   Primary Provider on Visit:  SIMGEN,DARLA
       Provider who screened:  SIMGEN,DARLA


Enter RETURN to continue or '^' to exit:
```

Figure 13-43: Sample Tally/List Patients with Depression Screening report

13.1.12.3.2 Tally/List Depression Screenings (DLS)

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

> Notes: This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.

- This is a tally of visits with a screening done. Do the following:

The application displays the following prompts:

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening prompt.

3. At the “Which items should be tallied: (0-11)” prompt, select the items to be tallied (Figure 13-43).

```
   0)  Do not include any Tallies       6)  Date of Screening
   1)  Result of Screening              7)  Primary Provider on Visit
   2)  Gender                           8)  Designated MH Provider
   3)  Age of Patient                   9)  Designated SS Provider
   4)  Provider who Screened            10) Designated ASA/CD Provider
   5)  Clinic                           11) Designated Primary Care
Provider
```

Figure 13-44: List of options from which to tally the report

4. At the “Would you like to include DEPRESSION Screenings documented in the PCC clinic database?” prompt, type one of the following:
   - **Y** to include the screenings
   - **N** to not include the screenings
5. At the “Would you like a list of visits w/screenings done?” prompt, type one of the following:
   - Type **N** to not include the list of patients
   - Type **Y** to continue
6. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-29 shows the list of options to sort. The default is **H** (Health Record Number). Do the following:

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 13-45: List of options to sort the list

7. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:
   - Type **N** to not display the list
   - Type **Y** to display the list
8. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)

- **E** (exclude demo patients)
- **O** (include only demo patients)

9. At the “DEVICE” prompt, type the device to output the report.

Figure 13-45 shows the sample report:

```
   XX                              Jan 18, 2012                        Page 1

          ***  DEPRESSION SCREENING VISIT TALLY AND VISIT LISTING  ***
                 Screening Dates: Dec 19, 2011 to Jan 18, 2012
                         This report excludes PCC Clinics

-------------------------------------------------------------------------------
                                                #      % of patients
 Total Number of Visits with Screening           7
     Total Number of Patients screened           6

                               By Result

                                PHQ2  2         1       14.3%
                               PHQ9  13         1       14.3%
                               PHQ9  15         1       14.3%
                               PHQ9  16         2       28.6%
                               PHQ9  18         1       14.3%
                               PHQ9  22         1       14.3%

                               By Gender


-------------------------------------------------------------------------------
                                                #      % of patients
                                      F         4       57.1%
                                      M         3       42.9%

                                 By Age

                                 11 yrs         1       14.3%
                                 29 yrs         1       14.3%
                                 45 yrs         2       28.6%
                                 61 yrs         1       14.3%
                                 62 yrs         1       14.3%
                                 68 yrs         1       14.3%

               By Provider who screened



PATIENT NAME          HRN    AGE   SCREENED            CLINIC
-------------------------------------------------------------------------------

BETAAAAA,MISTY DAWN   106371 29  F 12/28/11            BEHAVIORAL HEALTH
   Type/Result: PHQ9  22
   Primary Provider on Visit:  GARCIA,RYAN
       Provider who screened:  GARCIA,RYAN

THETAAAA,REBECCA LEE  113487 45  F 12/30/11            MENTAL HEALTH
   Type/Result: PHQ9  16
   Primary Provider on Visit:  SIMGEN,DARLA
       Provider who screened:  SIMGEN,DARLA
```

```
Enter RETURN to continue or '^' to exit:
```

Figure 13-46: Sample Depression Screening Visit Tally and Visit Listing report

13.1.12.3.3 List all Depression Screenings / Selected Patients (DSSP)

This report will tally and optionally list all patients who have had DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

Note: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
This report will optionally, look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
This is a tally of patients, not visits, or screenings.

You will be able to choose the patients by age, gender, clinic, primary provider, or result of the screening. Do the following:

1. Set the date at the “Enter Beginning Date for Screening” prompt.
2. Set the date at the “Enter Ending Date for Screening prompt.
3. At the “Would you like to include screenings documented in non-behavioral health clinics (those documented in PCC)?” prompt, type one of the following:
   - **Y** to include screenings
   - **N** to not include screenings
4. At the “Include which patients in the list” prompt, tyoe one of the following:
   - **F** (FEMALES only)
   - **M** (MALES only)
   - **B** (Both MALE and FEMALES)
5. A the “Would you like to restrict the report by Patient age range?” prompt, type one of the following:

- **N** to not restrict the age range
- **Y** to continue

6. At the "Which result values do you want included on this list" prompt, choose one of the following:

```
1)  Normal/Negative
2)  Positive
3)  Refused
4)  Unable to Screen
5)  Screenings done with no result entered
```

Figure 13-47: List of options from which to select

You can limit the list to only patients who have had a screening in the time period on which the result was any combination of the following: (e.g. to get only those patients who have had a result of Positive enter 2 to get all patients who have had a screening result of Positive or Refused, enter 2,3).

7. At the "Include visits to ALL clinics" prompt, type one of the following:

- **Y** to include visits
- **N** to continue

8. At the "Report should include visits whose PRIMARY PROVIDER (Figure 13-47 on the visit), type one of the following:

- **P** (Any/All Providers including Unknown)
- **U** (Unknown Provider Only)
- **O** (One Provider Only) to continue.

```
          O         One Provider Only
          P         Any/All Providers (including unknown)
          U         Unknown Provider Only
```

Figure 13-48: Options for visits to be used on the report

9. At the "Select which providers who performed the screening should be included" (Figure 13-48) prompt, type one of the following:

- **P** (Any/All Providers including Unknown)
- **U** (Unknown Provider Only)
- **O** (One Provider Only) to continue

```
Select one of the following:

          O         One Provider Only
          P         Any/All Providers (including unknown)
```

```
          U         Unknown Provider Only
```

Figure 13-49: Options for providers to be used on the report

10. At the “Would you like to limit the list to just patients who have a particular designated Mental Health provider?” prompt, type one of the following:
    - **N** to not limit the list
    - **Y** to continue:
11. At the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt, type one of the following:
    - **N** to not limit the list
    - **Y** to continue
12. At the “Would you like to limit the list to just patients who have a particular designated Social Services provider?” prompt, type one of the following:
    - **N** to not limit the list
    - **Y** to continue
13. At the “Would you like to limit the list to just patients who have a particular designated ASA/CD provider?” prompt, type one of the following:
    - **N** to not limit the list
    - **Y** to continue
14. At the “Select Report Type” prompt, type one of the following:
    - **L** (List of Patient Screenings)
    - **S** (Create a Search Template of Patients)to continue
15. At the “How would you like the list to be sorted” prompt, type a selection. Figure 13-49 shows the list of options to sort. The default is **H** (Health Record Number). Do the following:

```
Select one of the following:

          H         Health Record Number
          N         Patient Name
          P         Provider who screened
          C         Clinic
          R         Result of Exam
          D         Date Screened
          A         Age of Patient at Screening
          G         Gender of Patient
          T         Terminal Digit HRN
```

Figure 13-50: List of options to sort the list

16. At the “Display the Patient’s Designated Providers on the list?” prompt, type one of the following:
    - Type **N** to not display the list
    - Type **Y** to display the list
17. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
    - **I** (include all patients)
    - **E** (exclude demo patients)
    - **O** (include only demo patients)
    - At the “DEVICE” prompt, type the device to output the report. Press Enter.

Figure 13-50shows the sample report:

```
   XX                          Feb 15, 2011                      Page 1

       ***  DEPRESSION SCREENING VISIT LISTING FOR SELECTED PATIENTS  ***
                 Screening Dates: Nov 17, 2010 to Feb 15, 2011

                                     DATE
PATIENT NAME          HRN    AGE   SCREENED            CLINIC
---------------------------------------------------------------------------

BETA,MISTY DAWN       106371 28  F 01/07/11            BEHAVIORAL HEALTH
   Type/Result: DEPRESSION SCREENING  POSITIVE
   Comment: testing ehr
   Primary Provider on Visit:  GAMMA,RYAN
       Provider who screened:  GAMMA,RYAN

CHI,WILLA BELLE       110838 44  F 01/12/11            MENTAL HEALTH
   Type/Result: DEPRESSION SCREENING  POSITIVE
   Primary Provider on Visit:  IOTA,WENDY
       Provider who screened:  IOTA,WENDY

Enter RETURN to continue or '^' to exit:
```

Figure 13-51: Sample Depression Screening Visit Listing for Selected Patients report

13.1.12.3.4 Tally/List Pts in Search Temp w/Depression Scrn (DPST)

This report will tally and list all patients who are members of a user defined search template. It will tally and list their latest DEPRESSION screening or a refusal documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR

- Refusal of PCC Exam Code 36

> **Note**: The last screening/refusal for each patient is used. If a patient was screened more than once in the time period, only the latest is used in this report.
> This report will look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
> This is a tally of patients, not visits or screenings.

13.1.12.3.5 Tally List all Depression Scrn for Template of Pts (DVST)

This report will tally and optionally list all visits on which DEPRESSION screening or a refusal was documented in the time frame specified by the user. Depression Screening is defined as any of the following documented:

- Depression Screening Exam (PCC Exam Code 36)
- Measurements: PHQ2, PHQ9
- Diagnoses V79.0, 14.1
- Education Topics: DEP-SCR
- Refusal of PCC Exam Code 36

> **Note**: This report will look at both PCC and the Behavioral Health databases for evidence of screening/refusal.
> This is a tally of visits with a screening done; if a patient had multiple screenings during the time period, all will be counted.

13.1.12.4 PHQ-2 and PHQ-9 Scores for One Patient (PHQ)

1. Type **PHQ** option to generate a report that lists PHQ2 and PHQ9 Scores for one patient within a date range. Do the following:
2. At the “Select PATIENT NAME” prompt, type the name of the patient.
3. Browse which subset of visits for [current patient name] and type one of the following:

   L Patient’s Last Visit

   N Patient’s Last N Visits

   D Visits in Date Range

   A All of this Patient’s Visits

   P Visits to one Program

a. Type **N**, **D**, or **P**to continue

4. At the “Limit by Clinic/Provider” prompt, type one of the following:

- **C** (Visits to Selected Clinics)
- **P** (Visits to Selected Providers)
- **A** (Include All Visits regardless of Clinic/Provider)

Figure 13-51 displays the PHQ-2/PHQ-9 Scores for One Patient report.

```
PHQ-2/PHQ-9 Scores         Oct. 03,2008 18:37                     Page 1 of 1

Patient Name: Doe, Jane            DOB: Dec 11, 1976
HRN: 123942

Date          PHQ-2  PHQ-9 PROVIDER     CLINIC  Diagnosis/POV

  10/01/08    5      21    GAMMA, JOHN   MENT    311. – Depressive Disorder, Not Els

  09/30/08    1            GAMMA, JOHN   MENT    311. – Depressive Disorder, Not Els
  09/19/08    3      24    GAMMA, JOHN   MENT    311. – Depressive Disorder, Not Els
  09/19/08    0            GAMMA, JOHN   ALCO    305.02 – ALCOHOL ABUSE,
  09/12/08           14    KAPPA, ADAM   MEDSS   305.02 – ALCOHOL ABUSE,
  07/18/06    4      19    DELTA, JAMES  BH      13 – SCHIZOPHRENIC DISORDER
  06/01/05    2            GAMMA, DON    PC      311 – DEPRESSIVE DISOCER,NOS

        Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 13-52: Sample PHQ-2 and PHQ-9 Scores for One Patient report

13.1.12.5 PHQ-2 and PHQ-9 Scores for Multiple Patients (PHQS)

1. At the “Select Action” prompt, type **PHQS** option to produce a report that lists PHQ-2 and PHQ-9 Scores for multiple patients, sorted by patient. Only visits with PHQ-2/PHQ-9 scores recorded will display on this list. Do the following:

2. Set the date at the “Enter Beginning Visit Date” prompt.

3. Set the date at the “Enter Ending Visit Date” prompt.

4. At the “Clinic Selection” prompt, type one of the following:

- **A** (Visit to All Clinics)
- **C** (Visits at Selected Clinic) to continue

5. At the “Provider Selection” prompt, type one of the following:

- **A** (Visits to All Providers)
- **C** (Visits to Selected Providers) to continue

6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
7. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the PHQ-2 and PHQ-9 Scores for Multiple Patients report shown in Figure 13-52:

```
   XX                              Jul 13, 2009                        Page 1

                  PHQ-2 and PHQ-9 SCORES FOR MULTIPLE PATIENTS
                   Visit Dates: Jan 04, 2009 to Jul 13, 2009
                              Clinic: ALL Clinics
                            Providers: ALL Providers

PATIENT NAME     HRN    Date     PHQ-2 PHQ-9 Provider    CLINIC Diagnosis/POV
-------------------------------------------------------------------------------

ALPHAA,JACOB SCO  102668 02/07/09       3    GAMMA,RYA  MENTA

ALPHAB,CHELSEA   116431 07/11/09 3           BETAAAA,LO  MENTA  22-SLEEP DIS
ALPHAB,CHELSEA   116431 07/02/09       17    DEMO,PSYCH  MENTA  296.31-MAJOR DEP
ALPHAB,CHELSEA   116431 05/19/09 3           GAMMAAA,DE  MENTA  311.-DEPRESSIV
ALPHAB,CHELSEA   116431 03/17/09 4           BETA,BETAA  MEDIC  305.02-ALCOHOL A
ALPHAB,CHELSEA   116431 03/12/09       17    BETA,BETAA  BEHAV  V11.0-PERSONAL
ALPHAB,CHELSEA   116431 03/10/09       19    GAMMAAA,DE  MENTA  296.32-MAJOR DEP
ALPHAB,GLEN DAL  108704 04/11/09 4           BETA,BETAA  MENTA  296.32-DEPRESSED
ALPHAB,GLEN DAL  108704 03/27/09       21    GAMMAAA,DE  MENTA  311.-testing v
ALPHAB,GLEN DAL  108704 03/18/09 4           BETA,BETAA  MEDIC  300.6-DEPERSONA


Enter RETURN to continue or '^' to exit:
```

Figure 13-53: Sample PHQ-2 and PHQ-9 Scores for Multiple Patients report

13.1.13 Treatment Plans (TPR)

At the “Select Patient Listings Option” prompt, type **TPR** to access the Treatment Plans menu displayed in Figure 13-53

```
   ATP    Print List of All Treatment Plans on File
   REV    Print List of Treatment Plans Needing Reviewed
   RES    Print List of Treatment Plans Needing Resolved
   NOTP   Patients w/Case Open but no Treatment Plan


Select Treatment Plans Option:
```

Figure 13-54: Options on the Treatment Plans menu

Print List of All Treatment Plans on File (ATP): refer to Section 10.1.5.

Print List of Treatment Plans Needing Reviewed (REV): refer to Section 10.1.3.

Print List of Treatment Plans Needing Resolved (RES): refer to Section 10.1.4.

Patients w/Case Open but no Treatment Plan (NOTP): refer to Section 10.1.6.

13.1.14 Patients Seen in Groups w/Time in Group (TSG)

1. At the "Select Patient Listings Option" prompt, type **TSG** option to generate a report that shows a list of patients who have spent time in a group in a specified date range. It will list the patient, the primary provider, diagnosis, and time spent in the group. Do the following:
2. Set the date at the "Enter beginning Date" prompt.
3. Set the date at the "Enter ending Date" prompt.
4. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
5. At the "Do you wish to" prompt, type one of the following:
   - **P** (print output)

Type **B** (browse output on screen) to display the Patients Seen in Groups with Time Spent in Group report shown in Figure 13-54:

```
              ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                                  Page 1
                              DEMO INDIAN HOSPITAL
                        PATIENTS SEEN IN GROUPS WITH TIME SPENT IN GROUP
                      DATES:  JAN 17, 2009  TO  APR 17, 2009


PATIENT NAME      HRN    SEX  DOB       DATE     PROVIDER        PROBLEM  TIME
-------------------------------------------------------------------------------

APHAAA,CHRYSTAL   106299  F   11/28/85  04/20/09 BETA,BETAS     13       0
          Total with provider BETAAAA,BJ          0
          Total for patient ALPHAA,CHRYSTAL GAYL  0

APHAAA,DIANA LE   192745  F   09/15/54  03/05/09 GAMMAA,DENISE  92       60
                                        03/25/09 Not Recorded    307.50   15
                                        04/21/09 THETAAAA,MARK   8.3      0
                                                 THETAAAA,MARK   311.     60
        Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
```

Figure 13-55: Sample Patients Seen in Groups with Time Spent in Group report

13.2 Behavioral Health Record/Encounter Reports (REC)

Type **REC** to list various records from the Behavioral Health patient file that are available on the BHS Encounter/Record Reports menu (Figure 13-55).

```
                  ***********************************************
                  **       IHS Behavioral Health System        **
                  **         Encounter/Record Reports          **
                  ***********************************************
                               Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL

   LIST   List Visit Records, STANDARD Output
   GEN    List Behavioral Hlth Records, GENERAL RETRIEVAL
Select Behavioral Health Record/Encounter Reports Option:
```

Figure 13-56: Options on the Encounter/Record Reports menu

13.2.1 List Visit Records, Standard Output (LIST)

At the Select Behavioral Health Record/Encounter Reports Option" prompt, type **LIST** option to generate a report that shows a listing of visits in a specified date range. The visits can be selected based on any combination of selected criteria. The user will select the sort criteria for the report. Do the following:

Be sure to have a printer available that has 132-column print capability.

1. Set the date at the "Enter Beginning Date for Search" prompt.
2. Set the date at the "Enter Ending Date for Search" prompt.

Figure 13-56 displays the Visit Selection Menu.

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:14:46          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
```

```
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV


+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-57: Sample Visit Selection Menu

Use the menu in Figure 13-56 to select the visit criteria for the report.

3. At the “Type of Report to Print” prompt, type one of the following:

- **D** (detailed using 132 column print)
- **B** (brief (using 80 column print))

The Sort Item Selection Menu as shown in Figure 13-57:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:18:08          Page:    1 of    2

                         SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1)  Patient Name           16)  Program               31)  Inpatient Dispositio
2)  Patient Sex            17)  Visit Type             32)  PCC Visit Created
3)  Patient Race           18)  Location of Encounte   33)  Axis V
4)  Patient DOB            19)  Clinic                 34)  Flag (Visit Flag)
5)  Patient DOD            20)  Outside Location       35)  Primary Provider
6)  Patient Chart #        21)  SU of Encounter        36)  Primary Prov Discipl
7)  Patient Community      22)  County of Service      37)  Primary Prov Affilia
8)  Patient County Resid   23)  Community of Service   38)  Primary POV
9)  Patient Tribe          24)  Activity Type          39)  Designated MH Prov
10)  Eligibility Status    25)  Days in Residential    40)  Designated SS Provid
11)  Class/Beneficiary     26)  Days in Aftercare      41)  Designated A/SA Prov
12)  Patient Flag Field    27)  Activity Category      42)  Designated Other Pro
13)  Encounter Date        28)  Local Service Site     43)  Designated Other (2)
14)  Appointment/Walk-In   29)  Number Served
15)  Interpreter Utilized  30)  Type of Contact



+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-58: Sample Sort Item Selection Menu options

4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
5. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the criteria for the report and the Behavioral Health Record Listing report shown in Figure 13-58:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
                              DEMO INDIAN HOSPITAL                      Page 1

                        BEHAVIORAL HEALTH RECORD LISTING
                   Visit Dates:  OCT 19, 2008 and APR 17, 2009
==============================================================================
 DATE     PROV LOC  PATIENT NAME ACT CONT AT  HRN        PROB   NARRATIVE
------------------------------------------------------------------------------
10/20/08  DG   WW   ALPHA1,CHELS  12 OUTP 30  WW116431   311.   DEPRESSIVE DISO
10/22/08  DG   WW   ALPHA1,CHELS  12 OUTP 90  WW116431   311.   DEPRESSIVE DISO
10/22/08  DG   WW   ALPHA1,CHELS  12 OUTP 88  WW116431   311.   Mask Narrative
11/03/08  GHH  WW   ALPHA,ALTHEA  99 OUTP     WW123942   300.00 Situational Anx
11/06/08  GHH  WW   ALPHA,ALTHEA  99 OUTP     WW123942   311.   Depression
                                                         300.00 Anxiety
11/11/08  BJB  1202 FPAT11,AMAND  12 OUTP 120 WW186121   V71.01 OBSERVATION OF
11/12/08  DGC  WW   SIGMA,MACEY   05 OUTP 20  WW104376   V61.01 FAMILY DISRUPTI

        Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 13-59: Sample Behavioral Health Record Listing report

13.2.2 List Behavioral Hlth Records, General Retrieval (GEN)

1. At the “Select Action” prompt, type **GEN** to generate a report that shows a listing of visits selected by visit criteria. The visits printed can be selected based on any combination of selected items and the selected sort criteria. Do the following

   When the selected print data items exceed 80 characters, a 132-column capacity printer will be needed.

2. At the “Select and Print Encounter List from” prompt, type one of the following:
   - **S** (search template)
   - **D** (date range)
3. At the “Do you want to use a PREVIOUSLY DEFINED REPORT?” prompt, type one of the following:

- **N** to not use the report
- **Y** to continue

Figure 13-59 displays the Visit Selection Menu.

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:14:46          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV


+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-60: Sample Visit Selection Menu options

4. At the “Choose Type of Report” prompt, type one of the following:

- **T** (Total Count Only), S (Subcounts and Total Count)
- **D** (Detailed Listing)
- **F** (Flag ASCII file (predefined record format)).

Figure 13-60 displays the Print Item Selection Menu.

```
BH GENERAL RETRIEVAL          Sep 07, 2011 17:08          Page:    1 of    2
                        PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.
```

```
1)  Patient Name           27)  Interpreter Utilized  53)  Primary Provider
2)  Patient Sex            28)  Program               54)  Primary Prov Discipl
3)  Patient Race           29)  Visit Type            55)  Primary Prov Affilia
4)  Patient Age            30)  Location of Encounte  56)  Prim/Sec Providers
5)  Patient DOB            31)  Clinic                57)  Prim/Sec Prov Discip
6)  Patient SSN            32)  Outside Location      58)  POV (Prim or Sec)
7)  Patient DOD            33)  SU of Encounter       59)  DSM/Problem Code Nar
8)  Patient Chart #        34)  County of Service     60)  POV (Prob Code Grps)
9)  Patient Community      35)  Community of Service  61)  Primary POV
10)  Patient County Resid  36)  Chief Complaint/Pres  62)  POV Problem Code Nar
11)  Patient Tribe         37)  Activity Type         63)  POV (Problem Categor
12)  Eligibility Status    38)  Activity Type Narrat  64)  POV Diagnosis Catego
13)  Class/Beneficiary     39)  Days in Residential   65)  POV Prov Narrative
14)  Medicare Eligibility  40)  Days in Aftercare     66)  Procedures (CPT)
15)  Medicaid Eligibility  41)  Activity Category     67)  Education Topics Pro
16)  Priv Ins Eligibility  42)  Local Service Site    68)  Prevention Activity
17)  Patient Flag Field    43)  Number Served         69)  Treated Medical Prob
18)  Patient Flag Narrati  44)  Type of Contact       70)  Personal History Ite
19)  Case Open Date        45)  Activity Time         71)  Designated MH Prov
20)  Case Admit Date       46)  Inpatient Dispositio  72)  Designated SS Provid
21)  Case Closed Date      47)  Place Referred To     73)  Designated A/SA Prov
22)  Case Disposition      48)  PCC Visit Created     74)  Designated Other Pro
23)  Next Case Review Dat  49)  Axis IV               75)  Designated Other (2)
24)  Encounter Date        50)  Axis V
25)  Encounter Date&Time   51)  Comment
26)  Appointment/Walk-In   52)  Flag (Visit Flag)
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-61: Print Item Selection Menu options

5. Select the data items to be used on the report and type **Q** at the Select Actions" prompt. Use the Q option when you have completed your selections. The Sort Item Selection Menu displays as shown in Figure 13-61:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:18:08          Page:    1 of    2

                         SORT ITEM SELECTION MENU
The Visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1)  Patient Name           16)  Program               31)  Inpatient Dispositio
2)  Patient Sex            17)  Visit Type            32)  PCC Visit Created
3)  Patient Race           18)  Location of Encounte  33)  Axis V
4)  Patient DOB            19)  Clinic                34)  Flag (Visit Flag)
5)  Patient DOD            20)  Outside Location      35)  Primary Provider
6)  Patient Chart #        21)  SU of Encounter       36)  Primary Prov Discipl
7)  Patient Community      22)  County of Service     37)  Primary Prov Affilia
8)  Patient County Resid   23)  Community of Service  38)  Primary POV
9)  Patient Tribe          24)  Activity Type         39)  Designated MH Prov
10)  Eligibility Status    25)  Days in Residential   40)  Designated SS Provid
11)  Class/Beneficiary     26)  Days in Aftercare     41)  Designated A/SA Prov
12)  Patient Flag Field    27)  Activity Category     42)  Designated Other Pro
13)  Encounter Date        28)  Local Service Site    43)  Designated Other (2)
14)  Appointment/Walk-In   29)  Number Served
15)  Interpreter Utilized  30)  Type of Contact
```

```
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-62: Options on the Sort Item Selection Menu

6. At the “Do you want a separate page for each Visit Date?” prompt, type one of the following:
   - **Y** to create a separate page
   - **N** to not create a separate page
7. At the “Would you like a custom title for this report?” prompt, type one of the following:
   - **N** to not create a custom title
   - **Y** to continue
8. At the “Do you wish to save this search/print/sort logic for future use?” prompt, type one of the following:
   - **N** (logic is not saved)
   - **Y** to continue
9. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
10. At the “Do you wish to” prompt, type one of the following:
    - **P** (print output)
    - Type **B** (browse output on screen) to display the critiera for the report.
11. Press Enter to display the BH Visit Listing report shown in Figure 13-62:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
                            BH Visit Listing                        Page 1
                 Record Dates:  JAN 14, 2009 and JUL 13, 2009

PATIENT NAME          DOB           HRN         PROGRAM
---------------------------------------------------------------------------

ALPHAA,CHELSEA MARIE  02/07/1975    WW116431    MENTAL
SIGMA,ALBERT TILLMAN  02/07/1975    WW164141    OTHER
SIGMA,ALBERT TILLMAN  02/07/1975    WW164141    MENTAL
```

```
SIGMA,ALBERT TILLMAN  02/07/1975    WW164141    SOCIAL

        Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 13-63: Sample visit report

13.3 Workload/Activity Reports (WL)

Type **WL** to view the Activity Workload Reports menu displayed in Figure 13-63:

```
                  ***********************************************
                  **       IHS Behavioral Health System       **
                  **         Activity Workload Reports        **
                  ***********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL


   GRS1   Activity Report
   GRS2   Activity Report by Primary Problem
   ACT    Activity Record Counts
   PROG   Program Activity Time Reports (132 COLUMN PRINT)
   FACT   Frequency of Activities
   FCAT   Frequency of Activities by Category
   PA     Tally of Prevention Activities

Select Workload/Activity Reports Option:
```

Figure 13-64: Options on the Activity Workload Reports menu

The Workload/Activity Reports menu has options to generate reports related specifically to the activities of Behavioral Health providers. Included are options for generating reports that categorize and tabulate activity times, frequency of activities, and primary problems requiring Behavioral Health care.

13.3.1 Activity Report (GARS #1) (GRS1)

1. At the “Select Workload/Activity Reports Option” prompt, type **GRS1** option to generate a report that will tally activities by service unit, facility, and provider. The report is patterned after GARS Report #1. Do the following:

2. Set the date at the “Enter Beginning Encounter Date prompt.

3. Set the date at the “Enter Ending Encounter Date” prompt.

4. At the “Run Report for which Program” prompt, type one of the following:

   - **M**–MENTAL HEALTH
   - **S**–SOCIAL SERVICES

- **C**–CHEMICAL DEPENDENCY or ALCOHOL/SUBSTANCE ABUSE
- **O**–OTHER
- **A**–ALL

5. At the “Run Report for” prompt, type one of the following:
   - 2 (all providers)
   - 1 (one provider) to continue
6. At the “Include which providers” prompt, type one of the following:
   - **P** (Primary Provider Only)
   - **S** (Both Primary and Secondary Providers).
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
8. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Activity report shown in Figure 13-64:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
XX                                                      MAY 04, 2009Page 1
          ACTIVITY REPORT FOR ALL PROGRAMS (MH,SS,CD,OTHER) PROGRAM
                 RECORD DATES:  FEB 03, 2009  TO  MAY 04, 2009
# PATS is the total number of unique, identifiable patients when
a patient name was entered on the record.  # served is a tally of the
number served data value.

                                          # RECS    ACT TIME  # PATS   # SERVED
                                                    (hrs)
-------------------------------------------------------------------------------
AREA:  TUCSON
  SERVICE UNIT:  SELLS
     FACILITY:  SELLS HOSP
        PROVIDER:  BETAA,BJ (PSYCHIATRIST)
           13-INDIVIDUAL TREATMENT/COUNS         3       2.8        3          3
           16-MEDICATION/MEDICATION MONI         1       1.0        1          1
           91-GROUP TREATMENT                    2       1.5        2          2
                                          =======   =======  =======    =======
        PROVIDER TOTAL:                          6       5.3        6          6
Enter RETURN to continue or '^' to exit:
```

Figure 13-65: Sample Activity Report

13.3.2 Activity Report by Primary Problem (GRS2)

At the “Select Workload/Activity Reports Option” prompt, type **GRS2** to generate a report that will tally primary problems by service unit, facility, and by provider and activity.

The prompts are the same as those for the GRS1 report. Refer to Section 13.3.1 for more information.

The Activity Report by Primary Purpose report dipslays as shown in Figure 13-65:

```
             ********** CONFIDENTIAL PATIENT INFORMATION **********
xx                                                    MAY 04, 2009Page 1
                       ACTIVITY REPORT BY PRIMARY PURPOSE
          ACTIVITY REPORT FOR MENTAL HEALTH PROGRAM
                 RECORD DATES:  FEB 03, 2009 TO MAY 04, 2009
# PATS is the total number of unique, identified patients when
a patient name was entered on the record.  # served is a tally of the
number served data value.

                                            # RECS    ACT TIME # PATS    # SERVED
-------------------------------------------------------------------------------
AREA:  TUCSON
   SERVICE UNIT:  SELLS
     FACILITY:  SELLS HOSP
       PROVIDER:  BETAAAA,BJ (PSYCHIATRIST)
         ACTIVITY:  13-INDIVIDUAL TREATMENT/C
             311.-DEPRESSIVE DISORDER NOS        1       1.0        1         1
                                            =======   =======  =======   =======
         ACTIVITY TOTAL:                         1       1.0        1         1

         ACTIVITY:  16-MEDICATION/MEDICATION
             295.15-SCHIZOPHRENIA, DISORGAN      1       1.0        1         1
                                            =======   =======  =======   =======
         ACTIVITY TOTAL:                         1       1.0        1         1

                                            =======   =======  =======   =======
       PROVIDER TOTAL:                           2       2.0        2         2

        Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 13-66: Sample Activity Report by Primary Purpose report

13.3.3 Activity Record Counts (ACT)

1. At the “Select Workload/Activity Reports Option” prompt, type **ACT** to generate produce a report that will generate a count of activity records for a selected item in a specified date range. You will be given the opportunity to select which visits will be included in the tabulation. Do the following:

2. At the “Choose an item for calculating activity time and records counts” prompt, do the following:

3. Set the date at the “Enter beginning Visit Date for search” prompt.

4. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-66:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:14:46          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV


+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-67: Sample Visit Selection Menu options

5. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

6. At the “Do you wish to” prompt, type one of the following:

   - **P** (print output)
   - Type **B** (browse output on screen) to display report critera.

Figure 13-67 shows the Activity Record Counts report.

```
                                                        MAY 04, 2009  Page 1
                 RECORD DATES:  FEB 03, 2009  TO  MAY 04, 2009
               NUMBER OF ACTIVITY RECORDS BY PROBLEM DSM IV TR/CODE

PROB DSM/CODE NARRATIVE   CODE            # RECS  # PATS    ACTIVITY  # SERVED
                                                            TIME

-------------------------------------------------------------------------------
ADMINISTRATION            97                   4       4       0.1         4
ALCOHOL ABUSE             29                   4       4       1.2         4
ALCOHOL ABUSE, EPISODIC   305.02               5       2       4.1         5
ALCOHOL ABUSE, UNSPECIF   305.00               4       2       2.0         4
ALCOHOL DEPENDENCE        27                   3       3       2.0         3
ALCOHOL DEPENDENCE, IN    303.93               2       2       1.5         2
ALCOHOLISM IN FAMILY      V61.41               4       4       0.7         4
AMPHETAMINE DEPENDENCE,   304.40               1       1       0.0         1


        Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 13-68: Sample Activity Record Counts report

13.3.4 Program Activity Time Reports (PROG)

At the “Select Workload/Activity Reports Option” prompt, type **PROG** to create a report that will generate a count of activity records, total activity time, and number of patient visits by program and by a selected item within a specified date range. You will be given the opportunity to select which visits will be included on the report.

> **Note**: If you choose to report on Problems, *only the primary problem* is included.

The prompts are the same as those for the ACT report. Refer to Section 13.3.3 for more information.

The application displays the record selection criteria. Press Enter to display the Program Activity Time report shown in Figure 13-68:

```
Encounter Date range:  FEB 03, 2009 to MAY 04, 2009


                                                MENTAL HEALTH AND SOCIAL SERVI
                        ACTIVITY TIME, PATIENT AND RECORD COUNT REPORT BY PROGR
                                              RECORD DATES:  FEB 03, 2009  TO  MA

                     SOCIAL SERVICES AND MENTAL HEALTH COMB           SOCIAL SERV
                        NO. OF     NO. OF      TOTAL           NO. OF     NO. OF
PROVIDER                RECORDS    PATIENTS  ACTIV TIME        RECORDS    PATIENT
```

```
ALPHA,AAA                    15          7        3.6                2          2
BETA,BETAA                   33         18       22.6                8          4
BETAAAA,LORI                 16          6        5.0                .          .
CAAAA,JESSICA                 9          2        6.3                .          .
DEMO,CASE M                   1          1        0.0                .          .
DEMO,DOCTOR                   1          1        0.2                1          1
NUUUUUUU,AMY J                3          3        2.0                .          .
GAMMMA,RYAN                 106         30       66.3               24          5
**** Patient Count TOAL is not an unduplicated count.

        Enter ?? for more actions
+    Next Screen          -    Previous Screen      Q    Quit
Select Action:+//
```

Figure 13-69: Sample Program Activity Time report

13.3.5 Frequency of Activities (FACT)

1. At the “Select Workload/Activity Reports Option” prompt, type **FACT** option to generate a report that will generate a list of the top *N* Activity Codes for selected visits. Do the following:

Below are the prompts.

2. Set the date at the “Enter beginning Visit Date for search” prompt.

3. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-69:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:14:46          Page:    1 of    2
                         Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
```

```
22)  Case Disposition      44)  Axis IV


+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-70: Sample Visit Selection Menu options

4. At the “Select Type of Report” prompt, type one of the following:
   - **L** (list of items with counts)
   - **B** (Bar Chart, requires 132 column printer)
5. At the “How many entries do you want to list (5–100)” prompt, type the number of entries.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
7. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the criteria for the report.
8. Press Enter to display the Frequency of Activities report shown in Figure 13-70:

```
  MAY 04, 2009                                                          Page 1
                              DEMO INDIAN HOSPITAL

TOP 10 Activity Code's.
DATES:  FEB 03, 2009  TO  MAY 04, 2009

No.   ACTIVITY TYPE                    ACTIVITY CODE    # RECS   ACT TIME (HRS)
-------------------------------------------------------------------------------
1.    SCREENING-PATIENT PRESENT        11               55           34.8
2.    INFORMATION AND/ OR REFERRAL-P   15               32           12.3
3.    GROUP TREATMENT                  91               30           17.1
4.    INDIVIDUAL TREATMENT/COUNSEL/E   13               22           17.0
5.    ASSESSMENT/EVALUATION-PATIENT    12               19           15.5
6.    INDIVIDUAL BH EHR VISIT          99               19            0.6
7.    ACADEMIC SERVICES                96               16            8.1
8.    ART THERAPY                      85               15            6.7

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-71: Sample Frequency of Activities report

13.3.6 Frequency of Activities by Category (FCAT)

At the "Select Workload/Activity Reports Option" prompt, type **FCAT** to create a report that generates a list of the top *N* Activity Category for selected visits.

The prompts are the same as for the Frequency of Activities report. Refer to Section 13.3.5 for more information.

Figure 13-71 displays the Frequency of Activities by Category report.

```
  MAY 04, 2009                                                    Page 1
                              DEMO INDIAN HOSPITAL

TOP 10 Activity Category's.
DATES:  FEB 03, 2009  TO  MAY 04, 2009

No.   ACTIVITY CATEGORY           CATEGORY CODE    # RECS   ACT TIME (HRS)
-----------------------------------------------------------------------------
1.    PATIENT SERVICES                P                943       556778.2
2.    SUPPORT SERVICES                S                56           52.9
3.    ADMINISTRATION                  A                21           26.6
4.    PLACEMENTS                      PL               6             2.8
5.    COMMUNITY SERVICES              C                2             9.0
6.    EDUCATION/TRAINING              E                2             1.5
7.    CULTURALLY ORIENTED             O                1             0.5
8.    TRAVEL                          T                1             0.3

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-72: Sample Frequency of Activities by Category report

13.3.7 Tally of Prevention Activities (PA)

1. At the "Select Workload/Activity Reports Option" prompt, type **PA** option to produce a report that will show a count of all visits with a prevention activity entered. It will also produce a tally/count of those prevention activities with Target Audience subtotals. Do the following:
2. Set the date at the "Enter Beginning Visit Date" prompt.
3. Set the date at the "Enter Ending Visit Date" prompt.
4. At the "Run the Report for which Program" prompt, type one of the following:
   - **A** (All Programs)
   - **O** (One Program) to continue
5. At the "Enter a code indicating which providers are of interest" prompt, type one of the following:

   A (all providers)

O (one provider) to continue

S (Select set or Taxonomy of Providers) to continue

6. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
7. At the "DEVICE" prompt, type the device to output the report.

Figure 13-72 shows the Tally of Prevention Activities report:

```
May 04, 2009                                                          Page: 1
                              Behavioral Health
                        ************************************
                        *  TALLY OF PREVENTION ACTIVITIES  *
                        ************************************
              VISIT Date Range: FEB 03, 2009 through MAY 04, 2009
     PREVENTION ACTIVITY                     # of visits    % of visits
-----------------------------------------------------------------------------

Total # Visits w/Prevention Activity:        3
Total # of Prevention Activities recorded:   5

 AIDS/HIV                                    1               33.3
    YOUTH           1       100.0

 OTHER                                       1               33.3
    NOT RECORDED    1       100.0

 PUBLIC AWARENESS                            1               33.3
    NOT RECORDED    1       100.0

 SELF-AWARENESS/VALUES                       1               33.3
    ADULT           1       100.0

 SMOKING/TOBACCO                             1               33.3
    YOUTH           1       100.0

TARGET TOTALS

    ADULT           1        33.3
    NOT RECORDED    1        33.3
    YOUTH           1        33.3

RUN TIME (H.M.S): 0.0.0
Enter RETURN to continue or '^' to exit:
```

Figure 13-73: Sample Tally of Prevention Activities report

13.4 Problem Specific Reports (PROB)

At the "Select Workload/Activity Reports Option" prompt, type **PROB** to create a list of BH issues of concern to providers, managers, and administrators from a clinical and public health perspective. Figure 13-73 shows the Problem Specific Reports menu.

```
                  ***********************************************
                  **       IHS Behavioral Health System       **
                  **         Problem Specific Reports         **
                  ***********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL

   ABU    Abuse Report (Age&Sex)
   FDSM   Frequency of Problems
   FPRB   Frequency of Problems (Problem Code Groupings)
   FPRC   Frequency of Problems by Problem Category
   SUIC   Suicide Related Reports ...

Select Problem Specific Reports Option:
```

Figure 13-74: Options on the Problem Specific Reports menu

13.4.1 Abuse Report (ABU)

1. At the "Select Problem Specific Reports Option" prompt, type **ABU** to create a report that focuses on patients who might have been victims of abuse or neglect. The report will include: by age and sex, the number of individual patients who were seen for the following Purpose of Visit (POV)–the application displays the POVs. Do the following:

2. Set the date at the "Enter Beginning Visit Date" prompt.

3. Set the date at the "Enter Ending Visit Date" prompt to display the Age Groups prompt.

4. At the "Do you wish to modify these age groups? Prompt, type one of the following:

   - **N** to not modify the age groups
   - **Y** to continue

5. At the "Demo Patient Inclusion/Exclusion" prompt, type one of the following:

   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

6. At the "Do you wish to" prompt, type one of the following:

- **P** (print output)
- Type **B** (browse output on screen) to display the Abuse by Age and Sex report.
  - A 132-column printer is needed to print the report.

13.4.2 Frequency of Problems (FDSM)

1. At the "Select Problem Specific Reports Option" prompt, type **FDSM** to create a report that shows a list of the top *N* Problem/POV for selected visits. Do the following:
2. Set the date at the "Enter Beginning Visit Date" prompt.
3. Set the date at the "Enter Ending Visit Date" prompt.

Figure 13-74 shows the Visit Selection Menu.

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:14:46          Page:    1 of    2
                         Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV


+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-75: Sample Visit Selection Menu options

4. At the "Include which POVs" prompt, type one of the following:

- **P** (Primary POV only)
- **S** (Primary and Secondary POVs)

5. At the “Select Type of Report” prompt, type one of the following:
   - **L** (list of items with counts)
   - **B** (Bar Chart, requires 132 column printer)
6. At the “How many entries do you want to list (5–100)” prompt, type the number of entries.
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
8. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Frequency of Problems report shown in Figure 13-75:

```
  JUN 09, 2009                                                        Page 1
                              DEMO INDIAN HOSPITAL

TOP 10 Problem/POV's.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

No.   PROB DSM/CODE NARRATIVE         CODE          # RECS   ACT TIME (HRS)
-----------------------------------------------------------------------
1.    DEPRESSIVE DISORDER NOS          311.          150         114.8
2.    ANXIETY DISORDER NOS             300.00        52           28.8
3.    CROSS-CULTURAL CONFLICT          2             48           35.5
4.    SCHIZOPHRENIA, DISORGANIZED TY   295.15        33           26.1
5.    PARANOID PERSONALITY DISORDER    301.0         32           21.1
6.    PHYSICAL ILLNESS,ACUTE           5             32           22.9
7.    DEMENTIA OF THE ALZHEIMER'S TY   290.0         31           27.4
8.    MARITAL PROBLEM                  56            25            7.9
9.    HEALTH/HOMEMAKER NEEDS           1             21           17.6
10.   MAJOR DEPRESSIVE DISORDER, REC   296.32        20           32.3

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-76: Sample Frequency of Problems report

13.4.3 Frequency of Problem (Problem Code Groupings) (FPRB)

1. At the “Select Problem Specific Reports Option” prompt, type **FPRB** to create a report that shows a list of the top *N* Problem/POV for visits that you select. Do the following:

2. Set the date at the “Enter beginning Visit Date for search” prompt.

3. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-76:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:14:46          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV


+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-77: Sample Visit Selection Menu options

4. At the “Include which POVs” prompt, type one of the following:

   - **P** (Primary POV only)
   - **S** (Primary and Secondary POVs)

5. At the “Select Type of Report” prompt, type one of the following:

   - **L** (list of items with counts)

- **B** (Bar Chart, requires 132 column printer)

6. At the “How many entries do you want to list (5–100)” prompt, type the number of entries.

7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:

   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

8. At the “Do you wish to” prompt, type one of the following:

   - **P** (print output)
   - Type **B** (browse output on screen) to display the Frequency of Problems by Category report shown in Figure 13-77:

```
  JUN 09, 2009                                                    Page 1
                              DEMO INDIAN HOSPITAL

TOP 10 POV/Problem (Problem Code)'s.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

No.   PROB CODE NARRATIVE         PROBLEM (POV) CODE# RECS  ACT TIME (HRS)
-----------------------------------------------------------------------------
1.    MAJOR DEPRESSIVE DISORDERS       14               123          94.2
2.    ANXIETY DISORDER                 18               30           14.2
3.    SCHIZOPHRENIC DISORDER           13               29           25.8
4.    CROSS-CULTURAL CONFLICT          2                19           15.0
5.    MARITAL PROBLEM                  56               18            5.4
6.    ALCOHOL ABUSE                    29               16           14.1
7.    ILLNESS IN FAMILY                55               16            4.3
8.    HOUSING                          80               15            8.0
9.    SENILE OR PRE-SENILE CONDITION   9                14            9.7
10.   BIPOLAR DISORDER                 15               13            5.2

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 13-78: Sample Frequency of Problem by groupings report

13.4.4 Frequency of Problems by Problem Category (FPRC)

1. At the “Select Problem Specific Reports Option” prompt, type **FPRC** to create a report that generates a list of the top N Problem/POV (Problem Category) for selected visits. Do the following:

2. Set the date at the “Enter beginning Visit Date for search” prompt.

3. Set the date at the “Enter ending Visit Date for search” prompt. The Visit Selection Menu screen displays as shown in Figure 13-78:

```
BH GENERAL RETRIEVAL          Aug 23, 2011 15:14:46          Page:    1 of    2
                        Visit Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all Visits type Q.

1)  Patient Name           23)  Next Case Review Dat  45)  Axis V
2)  Patient Sex            24)  Appointment/Walk-In   46)  Flag (Visit Flag)
3)  Patient Race           25)  Interpreter Utilized  47)  Primary Provider
4)  Patient Age            26)  Program               48)  Primary Prov Discipl
5)  Patient DOB            27)  Visit Type            49)  Primary Prov Affilia
6)  Patient DOD            28)  Location of Encounte  50)  Prim/Sec Providers
7)  Living Patients        29)  Clinic                51)  Prim/Sec Prov Discip
8)  Chart Facility         30)  Outside Location      52)  POV (Prim or Sec)
9)  Patient Community      31)  SU of Encounter       53)  POV (Prob Code Grps)
10)  Patient County Resid  32)  County of Service     54)  Primary POV
11)  Patient Tribe         33)  Community of Service  55)  POV (Problem Categor
12)  Eligibility Status    34)  Activity Type         56)  POV Diagnosis Catego
13)  Class/Beneficiary     35)  Days in Residential   57)  Procedures (CPT)
14)  Medicare Eligibility  36)  Days in Aftercare     58)  Education Topics Pro
15)  Medicaid Eligibility  37)  Activity Category     59)  Prevention Activity
16)  Priv Ins Eligibility  38)  Local Service Site    60)  Personal History Ite
17)  Patient Encounters O  39)  Number Served         61)  Designated MH Prov
18)  Patient Flag Field    40)  Type of Contact       62)  Designated SS Provid
19)  Case Open Date        41)  Activity Time         63)  Designated A/SA Prov
20)  Case Admit Date       42)  Inpatient Dispositio  64)  Designated Other Pro
21)  Case Closed Date      43)  PCC Visit Created
22)  Case Disposition      44)  Axis IV


+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure 13-79: Sample Visit Selection Menu options

4. At the “Include which POVs” prompt, type one of the following:
   - **P** (Primary POV only)
   - **S** (Primary and Secondary POVs)
5. At the “Select Type of Report” prompt, type one of the following:
   - **L** (list of items with counts)
   - **B** (Bar Chart, requires 132 column printer)
6. At the “How many entries do you want to list (5–100)” prompt, type the number of entries.
7. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)

8. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display record selection criteria.
9. Press Enter to display the Frequency of Problems by Category report shown in Figure 13-79:

```
  JUN 09, 2009                                                        Page 1
                              DEMO INDIAN HOSPITAL

TOP 10 Problem/POV (Problem Category)'s.
PRIMARY POV Only
DATES:  MAR 11, 2009  TO  JUN 09, 2009

No.   CATEGORY NARRATIVE          CATEGORY CODE    # RECS   ACT TIME (HRS)
-----------------------------------------------------------------------------
1.    PSYCHOSOCIAL PROBLEMS           2                294         220.6
2.    MEDICAL/SOCIAL PROBLEMS         1                73          598.6
3.    FAMILY LIFE PROBLEMS            5                37           11.5
4.    SOCIOECONOMIC PROBLEMS          8                27           12.4
5.    ADMINISTRATIVE PROBLEM          11               14           11.5
6.    ABUSE                           3                10            5.1
7.    OTHER PATIENT RELATED           13               6            12.3
8.    EDUCATIONAL/LIFE PROBLEMS       10               8             5.9
9.    SCREENING                       12               7             4.9
10.   PREGNANCY/CHILDBIRTH PROBLEMS   6                6             1.8

RUN TIME (H.M.S): 0.0.1
End of report.  PRESS ENTER:
```

Figure 13-80: Sample Frequency of Problems by Problem Category report

13.4.5 Suicide Related Reports (SUIC)

Type **SUIC** to access the Suicide Reports menu shown in Figure 13-80:

```
                  ***********************************************
                  **       IHS Behavioral Health System        **
                  **              Suicide Reports              **
                  ***********************************************
                              Version 4.0 (patch 1)

                               DEMO INDIAN HOSPITAL


   SSR    Aggregate Suicide Form Data - Standard
   SAV    Aggregate Suicide Data Report - Selected Variables
   SDEL   Output Suicide Data in Delimited Format
   SGR    Listing of Suicide forms by Selected Variables
   SUIC   Suicide Report (Age&Sex)
   SPOV   Suicide Purpose of Visit Report

Select Suicide Related Reports Option:
```

Figure 13-81: Options on Suicide Report menu

13.4.5.1 Aggregate Suicide Form Data–Standard (SSR)

1. At the “Select Problem Specific Reports Option” prompt, type **SSR** to create a report that tallies the data items to the Suicide Form for a date range, community, and type of suicidal behavior (specified by the user). Do the following:
2. Set the date at the “Enter Beginning Date of Suicide Act prompt.
3. Set the date at the “Enter Ending Date of Suicide Act prompt.
4. At the “Report on Suicide Forms for Suicide Acts that occurred in” prompt, type one of the following:
   - **O** (One particular Community)
   - **A** (All Communities).
5. At the “Include which Suicidal Behaviors (0–9)” prompt, type the associated number.
6. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
7. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Aggregate Suicide Form Data–Standard report shown in Figure 13-81:

```
DEMO INDIAN HOSPITAL              Jul 13, 2009                        Page 1

               ***** AGGREGATE SUICIDE FORM DATA - STANDARD*****
                   Act Occurred: Jan 14, 2009 - Jul 13, 2009
                 Community where Act Occurred: ALL Communities
-------------------------------------------------------------------------------

Age Range: 20-24 years        Total # of Suicide Forms: 1
                                                          REPORT TOTALS
           Suicidal Behavior:  ATT SUICIDE W/ ATT HOMICIDE        1     100%
  Event logged by Discipline:  PSYCHIATRIST                       1     100%
    Event logged by Provider:  GAMMAA,RYAN                        1     100%
                         Sex:  MALE                               1     100%
                    Employed:  PART-TIME                          1     100%
         Tribe of Enrollment:  CHEROKEE NATION OF OKLAHOMA        1     100%
      Community of Residence:  WELLING                            1     100%
                Relationship:  MARRIED                            1     100%
                   Education:  COLLEGE GRADUATE                   1     100%
                      Method:  GUNSHOT                            1     100%
                              HANGING                             1     100%
           Previous Attempts:  1                                  1     100%
      Substance Use Involved:  NONE                               1     100%
```

```
             Location of Act:  WORK                                1     100%
                 Disposition:  IN-PATIENT MENTAL HEALTH TREAT      1     100%
        Contributing Factors:  DEATH OF FRIEND OR RELATIVE         1     100%
Age Range: 45-64 years        Total # of Suicide Forms: 13
                                                             REPORT TOTALS
           Suicidal Behavior:  IDEATION WITH PLAN AND INTENT      4      31%
                               ATTEMPT                            3      23%
                               ATT SUICIDE W/ ATT HOMICIDE        3      23%
                               ATT SUICIDE W/ COMP HOMICIDE       2      15%
                               COMP SUICIDE W/ ATT HOMICIDE       1       8%
  Event logged by Discipline:  ACUPUNCTURIST                      7      54%
                               PSYCHIATRIST                       6      46%
    Event logged by Provider:  GAMMAAA,DENISE                     1       8%
                               BETAAAA,BJ                         7      54%
                               THETAA,RYAN                        5      38%

Enter RETURN to continue or '^' to exit:
```

Figure 13-82: Sample Aggregate Suicide Form Data - Standard report

13.4.5.2 Aggregate Suicide Form Data - Selected Variables (SAV)

This report will tally the selected data items for Suicide Forms in a date range.

13.4.5.3 Output Suicide Data in Delimited Format (SDEL)

This report will extract all data elements on the Suicide form in a delimited form for a specified date range.

13.4.5.4 Listing of Suicide Forms by Selected Variables (SGR)

This report is a ‘general retrieval’ type report that will list the selected data items for Suicide Forms in a date range. You can also specify how to display the items in the printed report.

13.4.5.5 Suicide Report (Age & Sex) (SUIC)

This report will present, by age and sex, the number of individual patients who were seen for the following POVs: 39, 40, and 41 as well as V62.84 (Suicidal Ideation).

13.4.5.6 Suicide Purpose of Visit Report (SPOV)

This report will display the Suicide POVs (39, 40, 41) as a percentage of the total number of Behavioral Health encounter records (Encs). Any records containing the International Classification of Diseases, Ninth Revision (ICD-9) Code v62, 84, Suicidal Ideation will be included in the tallies for Problem Code 39. A display by age and gender is also included.

Below are the prompts.

1. At the “Enter Beginning Visit Date” prompt, type the beginning visit date.

2. At the “Enter Ending Visit Date” prompt, type the ending visit date.
3. At the “Run the Report for which Program” prompt, type one of the following:
   - **A** (all programs)
   - **O** (one program) to continue
4. At the “Demo Patient Inclusion/Exclusion” prompt, type one of the following:
   - **I** (include all patients)
   - **E** (exclude demo patients)
   - **O** (include only demo patients)
5. At the “Do you wish to” prompt, type one of the following:
   - **P** (print output)
   - Type **B** (browse output on screen) to display the Suicide Purpose of Visit report shown in Figure 13-82:

   The application displays the Suicide Purpose of Visit report.

```
                  *   SUICIDE PURPOSE OF VISIT REPORT  *
                VISIT Date Range: OCT 31, 2006 through NOV 30, 2006
                      BOTH MALE AND FEMALE PATIENTS' VISITS

39& v62.84 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP   # Encs     # w POV 39   w/ POV 40   w/ POV 41   w/ 39/40/41
            #     %    #       %    #      %    #      %    #      %
 1-4 yrs    0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 5-9 yrs    2  10.0    0     0.0    0    0.0    0    0.0    0    0.0
 10-14 yrs  7  35.0    0     0.0    0    0.0    0    0.0    0    0.0
 15-19 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 20-24 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 25-34 yrs  6  30.0    0     0.0    0    0.0    0    0.0    0    0.0
 35-44 yrs  2  10.0    0     0.0    0    0.0    0    0.0    0    0.0
 45-54 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 55-64 yrs  1   5.0    0     0.0    0    0.0    0    0.0    0    0.0
 65-74 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 75-84 yrs  0   0.0    0     0.0    0    0.0    0    0.0    0    0.0
 85+ yrs    2  10.0    0     0.0    0    0.0    0    0.0    0    0.0

TOTAL       20 100.0   0     0.0    0    0.0    0    0.0    0    0.0

                            MALE PATIENTS VISITS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
AGE GROUP    # Encs    # w POV 39    w/ POV 40   w/ POV 41    w/ 39/40/41
      #    %    #      %      #      %    #      %     #      %
 1-4 yrs    0   0.0   0    0.0      0     0.0   0    0.0     0    0.0
 5-9 yrs    0   0.0   0    0.0      0     0.0   0    0.0     0    0.0
 10-14 yrs  6  66.7   0    0.0      0     0.0   0    0.0     0    0.0
 15-19 yrs  0   0.0   0    0.0      0     0.0   0    0.0     0    0.0
 20-24 yrs  0   0.0   0    0.0      0     0.0   0    0.0     0    0.0
 25-34 yrs  2  22.2   0    0.0      0     0.0   0    0.0     0    0.0
 35-44 yrs  1  11.1   0    0.0      0     0.0   0    0.0     0    0.0
```

45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	9	100.0	0	0.0	0	0.0	0	0.0	0	0.0

FEMALE PATIENTS VISITS

39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	4	36.4	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	18.2	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	11	100.0	0	0.0	0	0.0	0	0.0	0	0.0

UNDUPLICATED PATIENT COUNT - BOTH MALE AND FEMALE PATIENTS

39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	5	38.5	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
85+ yrs	2	15.4	0	0.0	0	0.0	0	0.0	0	0.0
TOTAL	13	100.0	0	0.0	0	0.0	0	0.0	0	0.0

UNDUPLICATED PATIENT COUNT - MALE PATIENTS

39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed

AGE GROUP	# Encs		# w POV 39		w/ POV 40		w/ POV 41		w/ 39/40/41	
	#	%	#	%	#	%	#	%	#	%
1-4 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
5-9 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
10-14 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
15-19 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
25-34 yrs	2	50.0	0	0.0	0	0.0	0	0.0	0	0.0
35-44 yrs	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0
45-54 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
55-64 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
65-74 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
75-84 yrs	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

```
85+ yrs     0    0.0     0     0.0     0    0.0     0    0.0      0    0.0

TOTAL       4  100.0     0     0.0     0    0.0     0    0.0      0    0.0

                UNDUPLICATED PATIENT COUNT - FEMALE PATIENTS
39 - Suicide Ideation; 40 - Suicide Attempt/Gesture; 41 - Suicide Completed
AGE GROUP    # Encs      # w POV 39    w/ POV 40    w/ POV 41     w/ 39/40/41
             #     %     #      %      #      %     #      %      #      %
1-4 yrs      0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
5-9 yrs      1  11.1     0     0.0     0    0.0     0    0.0      0    0.0
10-14 yrs    1  11.1     0     0.0     0    0.0     0    0.0      0    0.0
15-19 yrs    0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
20-24 yrs    0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
25-34 yrs    3  33.3     0     0.0     0    0.0     0    0.0      0    0.0
35-44 yrs    1  11.1     0     0.0     0    0.0     0    0.0      0    0.0
45-54 yrs    0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
55-64 yrs    1  11.1     0     0.0     0    0.0     0    0.0      0    0.0
65-74 yrs    0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
75-84 yrs    0   0.0     0     0.0     0    0.0     0    0.0      0    0.0
85+ yrs      2  22.2     0     0.0     0    0.0     0    0.0      0    0.0

TOTAL        9 100.0     0     0.0     0    0.0     0    0.0      0    0.0
```

Figure 13-83: Sample Suicide Purpose of Visit report

13.5 Print Standard Behavioral Health Tables (TABL)

Type **TABL** to print the various BH tables (activity code, clinical codes, BH Problem/DSM IV, and BH Problem Codes).

The TABL (Figure 13-83) displays the Print BH Standard Tables menu.

```
                  ***********************************************
                  **       IHS Behavioral Health System        **
                  **         Print BH Standard Tables          **
                  ***********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL


   ACT    Print Activity Code Table
   CLN    Print Clinic Codes
   DSM    Print Behavioral Health Problem/DSM IV Table
   PROB   Print Behavioral Health Problem Codes

Select Print Standard Behavioral Health Tables Option:
```

Figure 13-84: Options on the Print BH Standard Tables menu

13.5.1 Print Activity Code Table (ACT)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type **ACT**. This report will print either to a printer or screen (Figure 13-84), a list of all activity codes. It will list the code, short description, the category, and whether the code passes to PCC.

```
XX                                   May 04, 2009                Page 1

             ********** BEHAVIORAL HEALTH ACTIVITY CODES **********

CODE DESCRIPTION                                            CATEGORY     PCC   MNE
-------------------------------------------------------------------------------
01   TWELVE STEP WORK - GROUP                             PATIENT SERV  YES   TSG

02   TWELVE STEP WORK - INDIVDUAL                         PATIENT SERV  YES   TSI

03   TWELVE STEP GROUP                                    PATIENT SERV  NO    TWG

04   RE-ASSESSMENT, PATIENT PRESENT                       PATIENT SERV  YES   RAS

05   RE-ASSESSMENT, PATIENT NOT PRESENT                   SUPPORT SERV  NO

11   SCREENING-PATIENT PRESENT                            PATIENT SERV  YES   SCN

12   ASSESSMENT/EVALUATION-PATIENT PRESENT                PATIENT SERV  YES   EVL

13   INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT    PATIENT SERV  YES   IND

14   FAMILY/GROUP TREATMENT-PATIENT PRESENT               PATIENT SERV  YES   FAM

15   INFORMATION AND/ OR REFERRAL-PATIENT PRESENT         PATIENT SERV  YES   REF

16   MEDICATION/MEDICATION MONITORING-PATIENT PRESENT     PATIENT SERV  YES   MED

17   PSYCHOLOGICAL TESTING-PATIENT PRESENT                PATIENT SERV  YES   TST

18   FORENSIC ACTIVITIES-PATIENT PRESENT                  PATIENT SERV  YES   FOR

19   DISCHARGE PLANNING-PATIENT PRESENT                   PATIENT SERV  YES   DSG
Enter RETURN to continue or '^' to exit:
```

Figure 13-85: Sample Behavioral Health Activity Codes report

13.5.2 Print Clinic Codes (CLN)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type **CLN** to print the activity code table displayed in Figure 13-85:

```
CLINIC STOP LIST                                  APR 16,2009  14:22    PAGE 1
NAME                              CODE
-----------------------------------------------------------------------------

ALCOHOL AND SUBSTANCE             43
AMBULANCE                         A3
ANTICOAGULATION THERAPY           D1
AUDIOLOGY                         35
```

```
BEHAVIORAL HEALTH              C4
CANCER CHEMOTHERAPY            62
CANCER SCREENING               58
CARDIOLOGY                     02
CASE MANAGEMENT SERVICES       77
CAST ROOM                      55
CHART REV/REC MOD              52
CHEST AND TB                   03
CHIROPRACTIC                   A6
CHRONIC DISEASE                50
COLPOSCOPY                     C3
COMPLEMENTARY MEDICINE         A5
```

Figure 13-86: Sample Clinic Stop List codes

13.5.3 Print Behavioral Health Problem/DSM IV Table (DSM)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type **DSM**. This report will print either to a printer or the screen, a list of all active Problem/DSM codes. It will list the code, narrative, the 2-digit problem code it is mapped to and the ICD9-Diagnosis code it is mapped to, as shown in Figure 13-86:

```
XX                                  May 04, 2009                Page 1

           ********** BEHAVIORAL HEALTH PROBLEM/DSM CODES **********

CODE     NARRATIVE                                                PROBLEM ICD-9
                                                                  CODE    CODE
-------------------------------------------------------------------------------
.9999    UNCODED DIAGNOSIS                                        99.9    .9999

010.00   PRIM TB COMPLEX-UNSPEC                                   99.9    010.00

011.41   TB LUNG FIBROSIS-NO EXAM                                 6.1     011.41

030.9    LEPROSY NOS                                              99.9    030.9

034.0    STREP SORE THROAT                                        5       034.0

054.10   GENITAL HERPES NOS                                       99.9    054.10

1        HEALTH/HOMEMAKER NEEDS                                   1       V60.4

Enter RETURN to continue or '^' to exit:
```

Figure 13-87: Sample Behavioral Health Problem/DSM Codes report

13.5.4 Print Behavioral Health Problem Codes (PROB)

At the “Select Print Standard Behavioral Health Tables Option” prompt, type **PROB**. This report will print either to a printer or the screen, a list of all active Problem codes. It will list the code, narrative, and the problem category. The report displays in Figure 13-87:

```
XX                                  May 04, 2009                Page 1
```

```
             ********** BEHAVIORAL HEALTH PROBLEM CODES **********

CODE  NARRATIVE                                          PROBLEM CATEGORY
-------------------------------------------------------------------------------
1     HEALTH/HOMEMAKER NEEDS                             MEDICAL/SOCIAL PROBL

1.1   HEALTH PROMOTION/DISEASE PREVENTION                MEDICAL/SOCIAL PROBL

2     CROSS-CULTURAL CONFLICT                            MEDICAL/SOCIAL PROBL

3     UNSPECIFIED MENTAL DISORDER(NON-PSYCHOTIC)         MEDICAL/SOCIAL PROBL

4     PHYSICAL DISABILITY/REHABILITATION                 MEDICAL/SOCIAL PROBL

5     PHYSICAL ILLNESS,ACUTE                             MEDICAL/SOCIAL PROBL

6.1   PHYSICAL ILLNESS, CHRONIC                          MEDICAL/SOCIAL PROBL

6.2   PHYSICAL ILLNESS, TERMINAL                         MEDICAL/SOCIAL PROBL


Enter RETURN to continue or '^' to exit:
```

Figure 13-88: Sample Behavioral Health Problem Codes report

14.0 Manager Utilities Module (Roll and Scroll)

The Manager Utilities module shown in Figure 14-1, provides options for Site Managers and program supervisors to customize BHS to suit their site's needs. Options are also available for administrative functions, including the export of data to the Area, resetting local flag fields, and verifying users who have edited patient records.

```
                  ***********************************************
                  **       IHS Behavioral Health System       **
                  **            Manager Utilities             **
                  ***********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL


   SITE   Update Site Parameters
   EXPT   Export Utility Menu ...
   RPFF   Re-Set Patient Flag Field Data
   DLWE   Display Log of Who Edited Record
   ELSS   Add/Edit Local Service Sites
   EPHX   Add Personal History Factors to Table
   DRD    Delete BH General Retrieval Report Definitions
   EEPC   Edit Other EHR Clinical Problem Code Crosswalk
   UU     Update Locations a User can See

Select Manager Utilities Option:
```

Figure 14-1: Options on the Manager Utilities menu

This menu might be restricted to the site manager and the program manager or the designee. Use this menu for setting site-specific options related to security and program management. In addition, options are available for exporting important program statistics to the Area Office and IHS Headquarters for mandated federal reporting and funding.

14.1 Update Site Parameters (SITE)

1. At the "Select Manager Utilities Option" prompt, type **SITE** to modify the parameters in the Behavioral Health file. Individual sites use the Site Parameters file to set BHS to suit their program needs. Do the following:

2. At the "Select MHSS SITE PARAMETERS" prompt, type the location where the program visits take place. You will be prompted if a new location is being used.

The application displays the Update BH Site Parameters screen (Figure 14-2):

```
** UPDATE BH SITE PARAMETERS **      Site Name: SITEXXX
==========================================================================
Update DEFAULT Values?  N
```

```
Default Health Summary Type: BEHAOVIRAL HEALTH

Default response on form print: FULL    Suppress Comment on Suppressed
Form? NO
# of past POVs to display: 1            Exclude No Shows on last DX
Display? N

Update PCC Link Features?  N
Turn Off EHR to BH Link?  NO
Turn on PCC Coding Queue? YES             Update Provider Exception to E
Sig? N
Update those allowed to see all records?  N
Update those allowed to override delete?  N
Update those allowed to share visits? N
Update those allowed to order Labs?  N
If you are using the RPMS Pharmacy System, enter the Division:
_____________________________________________________________________________


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

Figure 14-2: Sample Update BH Site Parameters window

3. At the “Update DEFAULT Values?” prompt, type **Y** and the application displays Figure 14-3. All default settings are moved to this separate pop-up window. Do the following:

```
           ****  Enter DEFAULT Values for each Data Item ****
 MH Location: DEMO INDIAN HOSPITAL
 MH Community: TAHLEQUAH                 MH Clinic: MENTAL HEALTH
 SS Location: DEMO INDIAN HOSPITAL
 SS Community: TAHLEQUAH                 SS Clinic: MEDICAL SOCIAL SERVI
 Chemical Dependency Location: DEMO INDIAN HOSPITAL
 Chemical Dependency Community: TAHLEQUAH
 Chemical Dependency Clinic: BEHAVIORAL H
 OTHER Location: DEMO INDIAN HOSPITAL
 OTHER Community: TAHLEQUAH              OTHER Clinic: MENTAL HEAL

 Default Type of Contact: OUTPATIENT
 Default Appt/Walk In Response: APPOINTMENT
 EHR Default Community: TAHLEQUAH
```

Figure 14-3: Pop-up for default values of BH site

4. At the “MH/SS/CD/OTHER Location” prompt, type the name of the location where the program visits take place.

5. At the “MH/SS/CD/OTHER Community” prompt, type the name of the community where the program visits occur.

6. At the “MH/SS/CD/OTHER Clinic” prompt, type the name of the clinic where the program visits occur.

7. At the “Default Type of Contact” prompt, indicate the type of contact setting or code.

8. At the “Default Appt/Walk in Response” prompt, indicate Specify the type of visit that occurred.

9. At the “EHR Default Community” prompt, type the name of the default community used in the EHR.

   - In order to pass EHR behavioral health encounter records into the BHS v4.0 files, a Default Community of Service field was created on the BHS v4.0 site parameters’ menu. If the facility has opted to pass behavioral health encounter records created in EHR to BHS v4.0, the application will populate the Community of Service field with the value entered in the site parameter EHR Default Community or, if that field is blank, with the default Mental Health community value. If the default Mental Health community value is blank, the field will be populated with the default Social Services community value; if that field is also blank, the field will be populated with the default Chemical Dependency value; and if that field is blank, the default Other Community value will be used. If none of the default community fields contains a value, no behavioral health record will be created.

10. At the “Default HEALTH Summary Type” prompt, indicate the type of health summary printed from within the BH package.

    - The default value is the Mental Health/Social Services summary type. Refer to the Health Summary System Manuals for further information.

11. At the “Default response on form print” prompt, the response applies to when to print a Mental Health/Social Services record. Type one of the following:

    - **B** (both)
    - **F** (full)
    - **S** (suppressed form)
    - **T** (Suppressed–two copies)
    - **E** (Full–two copies)
      - The suppressed report does *not* display the following information: Chief Complaint, SOAP note, measurement data, screenings.
      - A full encounter form prints all data for a patient encounter including the S/O/A/P note. The suppressed version of the encounter form will not display the S/O/A/P note for confidentiality reasons. It is important to note that the S/O/A/P and chief complaint will be suppressed, but the comment/next appt, activity code, and POV will still appear on the printed encounter.

12. At the “Suppress Comment on Suppressed Form?” prompt, type one of the following:
    - **Y** to suppress the comments
    - **N** to not suppress the comments
13. At the “# of past POVs to display” prompt, type the number of the past POVs to be displayed on the Patient Data Entry screen.
14. At the “Exclude No Shows on last DX Display?” prompt, type one of the following:
    - **Y** to exclude no shows
    - **N** to include no shows
15. At the “Update PCC Link Features?” prompt, type **Y** to display the Update PCC Link Feature Parameters pop-up window (Figure 14-4).

```
**** Update PCC Link Feature Parameters ****
=====================================================

Type of PCC Link

Type of Visit to create in PCC

Interactive PCC Link?

Allow PCC Problem List Update?

Update PCC LINK Exceptions?
```

Figure 14-4: Fields on the Update PCC Link Feature Parameters pop-up

16. At the “Type of PCC Link: prompt, determine the type of data that passes from BHS to the PCC, select one of the following:
    - **No Link Active** – Use to have the data link between the two modules turned off. No data is passed to the PCC visit file from the BHS system (including the Health Summary).
    - **Pass STND Code and Narrative** – Use type to have all patient contacts in the Behavioral Health programs passed to the PCC visit file using the same ICD-9 code and narrative, as defined by the program.
    - **Pass All Data as Entered (No Masking)** - Use to have all DSM IV and Problem Codes passed as ICD-9 codes as shown in the crosswalk along with the narrative as written by the provider.
    - **Pass Codes and Canned Narrative** - Use to have both DSM IV and Problem Codes converted to ICD-9 codes as shown in the crosswalk and passed with a single standard narrative, as defined by the program, for all contacts.

For “Pass STND Code and Narrative” and “Pass Codes and Canned Narrative” options, the application displays the Standard Code to Use pop-up shown in Figure 14-5:

```
Standard Code to Use (Option 2 ONLY): V65.40

Narrative for MH Program: MH/SS/SA COUNSELING

Narrative for SS Program: SS VISIT
```

Figure 14-5: Standard code to use screen

– With each of these link types, standard data is passed to the PCC. You can specify those standards using the Standard Code to Use screen. The standard code, shown in the first line, will be passed if using Pass STND Code and Narrative. The narrative entered will be the only narrative passed if you have selected Pass STND Code and Narrative and Pass Codes and Canned Narrative options.

17. At the “Type of Visit to create in PCC” prompt, is dependent upon type of visit created from the encounter record you enter into BHS. Depending on the classification of the BHS programs at your facility. Type one of the following

- **I** (IHS)
- **C** (Contract)
- **6** (638 Program)
- **T** (Tribal)
- **O** (Other)
- **V** (VA)
- **P** (Compacted Program)
- **U** (Urban Program)

18. At the “Interactive PCC Link?” prompt, type **Y** or **N**.

The BHS site parameters contain a question about an interactive PCC link to address an issue with the PIMS Scheduling package. Because it is possible to set up a clinic in the Scheduling package that initiates a PCC record at check in, some sites were creating two separate records for each individual patient encounter in the behavioral health clinics. If you leave the field blank, this is the same as using N (for this prompt) and the interactive link will not be turned on.

In the Scheduling package, if the clinic set-up response is YES to the question about creating an encounter at check in, then the Interactive PCC Link question in the BHS site parameters must also be answered YES. If the clinic set up in the Scheduling package has a negative response, then the Interactive Link question in BHS should be set to NO.

> **Note**: There should never be a mismatched response where one package has YES and the other NO.

19. At the "Allow PCC Problem List Update?:" prompt, type one of the following:
    - **Y** to allow the ability to update a patient's PCC problem list
    - **N** to not allow the ability to update a patient's PCC problem list
20. At the "Update PCC LINK Exceptions?:" (Figure 14-6) prompt, type one of the following:
    - **Y** to determine if you want to set data passing parameters for individuals that are different from the program default.
    - N – not to set data passing parameters for individuals that are different from the program default.

```
Provider Name                      Type of PCC Link for this Provider
SIGMA,LORRAINE          NO LINK ACTIVE
CZZ,BILL                PASS CODE AND STND NARRATIVE
DELTA,GREG              PASS STND CODE AND NARRATIVE
MBETAA,MARY             PASS ALL DATA AS ENTERED
```

Figure 14-6: Setting up PCC link exceptions

21. At the "Turn Off EHR to BH Link?" prompt, type **Y** or **N**.

    A site parameter was created to give sites the ability to "opt out" of the new behavioral health (BH) Electronic Health Record (EHR) visit functionality. This functionality allows BH providers to enter a visit into the EHR that passes first to PCC and then to the behavioral health database (AMH). These visits display in the EHR as well as the BH applications, BHS v4.0 and the RPMS Behavioral Health System v4.0 GUI.

    The name of the site parameter is Turn Off EHR to BH Link and it is accessed via the BHS v4.0 Manager Utilities module SITE menu option. The default setting on this new site parameter is NO and no action is required if sites will be deploying the BH EHR functionality. If sites will not be deploying the BH EHR visit functionality, then the site parameter should be changed to YES.

22. At the "Turn on PCC Coding Queue?" prompt, type one of the following:
    - **Y** - the visits will not be passed directly to the billing package. The visits will be marked as incomplete and must be reviewed by local data entry staff, billers, or coders.
    - **N** - all visits will continue to pass to PCC as complete.

Because the visits entered in the behavioral health system have always been marked as complete, the visits were going through PCC to the claims generator without review. With this version of the software, sites are given the option of transmission to the Coding Queue or continuing to send visits to PCC marked as complete.

In addition to establishing an option on the site parameters' menu to turn on the Coding Queue, an option that can be placed on data entry staff's RPMS menu has been created. Because the SOAP/Progress Notes related to visits created in BHS do not pass to PCC, the data entry staff, billers, and/or coders needed some method to access the notes for review. The option will allow them to review the specifics for a visit but will not give them full access to BHS. For example, they will not be able to view treatment plans, case status information, or the Suicide Reporting Forms.

Turning on the link to the Coding Queue in the Behavioral Health System should not be done if the PCC Coding Queue has not been activated. However, if the PCC Coding Queue has been activated and the site wants the BHS-generated visits to be reviewed, complete the following steps:

23. Log into BHS v4.0 and select the Manager Utilities menu.
24. Select Site Parameters and type the name of the site to update.
25. On the site parameters entry window, scroll down to the Turn on PCC Coding Queue field.
26. Type **Y** at this field.
27. Save the changes to the site parameters.

    Once the coding queue option has been turned on and the changes to the site parameters are saved, any visits documented in BHS v4.0 will be flagged as incomplete. Visits created the same day but before the site parameters were changed will still be marked as complete. The date and time the visit was entered in RPMS determines the flag to be applied, not the date and time of service.

28. At the "Update Provider Exceptions to E Sig?" prompt type one of the following:

    The electronic signature function is available on the PDE, SDE, Intake, and Group entry menus (in roll and scroll) and also available on the One Patient, All Patients, Intake, and Group entry menus (in the GUI). Only those encounter records with signed SOAP/Progress Notes will pass to PCC.

    - N to not update the provider exceptions.
    - Type **Y** the following pop-up displays as shown in Figure 14-7:

```
Electronic Signature will not be activated for providers added to
```

```
this list.

PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:
PROVIDER:
```

Figure 14-7: Place to list provider exceptions to electronic signature

29. At the “PROVIDER” prompt, type the name of the provider with exception to electronic signature.

    Some sites may still use data entry staff to enter behavioral health visits, the ability to opt out of the electronic signature for a specific provider has been added to the site parameters menu. If a site determines that a provider should be exempted from the electronic signature, those visits will pass to PCC but show up as unsigned on the visit entry display.

30. At the “Update those allowed to see all records?” prompt, type one of the following:

    - Type **N**, the user’s name is not added to this list, only those encounter records the user created or those on which the user was a provider will be visible to that user.
    - Type **Y**, (Figure 14-8) the user’s name is added to this list, the user will be able to see all records entered into the system, whether the user was the provider of the visit or not, or whether the provider created the record or not.

```
Enter only those users who should be permitted to see all Visit and Intake
records for all patients whether they were the provider of record or the
user who entered the record or not. Users not entered on this list will see
only those Visits or Intake records that they entered or for which they
were the provider of record. This parameter applies to the SDE menu option
and all other options that display Visit and Intake information.
 ---------------------------------------------------------------------
+THETA,SHIRLEY
 PHI,LISA M
 RHO,SUSAN P
 ALPHA,WENDY
```

Figure 14-8: List of names allowed to see all records

31. At the “Update those allowed to override delete?” prompt, type one of the following:

    - N to not allow override delete
    - **Y** to determine if you want to update those allowed to override delete. Figure 14-9 shows the screen.

```
Enter only those users who should be permitted to delete any Intake
document, signed or unsigned, whether they are the user who
```

```
entered the Intake document or the provider of record.
---------------------------------------------------------------------

THETA,MARK
CHI,RONALD D SR
NU,KAREN
```

Figure 14-9: List of names allowed to delete any Intake document

32. At the “Update those allowed to share visits?” prompt, type one of the following:

    - N to not update those allowed to share visit information via RPMS mail message
    - Type Y, the pop-up in Figure 14-10 displays.

    A new name can be added at the “User allowed to share visits via mail” prompt. All users permitted to share visit information via RPMS mail messages should be entered here.

```
Entering users into this field will give them access to send a copy of
 a completed encounter form (either full or suppressed) to other
 RPMS users.  Keep confidentiality issues in mind when deciding on
 who should be given this access.

 User allowed to share visits via mail: BETA,BJ
 User allowed to share visits via mail: ALPHA,WENDY
 User allowed to share visits via mail: GAMMA,RYAN
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
 User allowed to share visits via mail:
```

Figure 14-10: Sample pop-up to enter user names allowed to share visits via mail

33. At the “Update those allowed to order Labs?” prompt type one of the following:

    - N to not update those allowed to order labs.
    - Type Y to display the pop-up in Figure 14-11.

    A new name can be added at the “User Permitted to Order Labs” prompt. All users permitted to order lab tests should be entered here.

```
The users that you enter into this field will be given access to
order LAB tests through the SEND PATIENT option.
If a user is not entered here he/she will not be granted access to the
LAB SEND PATIENT option.


User Permitted to Order Labs:
User Permitted to Order Labs:
User Permitted to Order Labs:
```

Figure 14-11: Pop-up to enter user names allowed to order labs

34. At the “If you are using the RPMS Pharmacy System, enter the Division” prompt, type the name of the division for the RPMS Pharmacy System.

14.2 Export Utility Menu (EXPT)

1. At the “Select Manager Utilities Option” prompt, type **EXPT** to access the Export Utility Menu shown in Figure 14-12:

```
                  ***********************************************
                  **       IHS Behavioral Health System        **
                  **              Export Utility               **
                  ***********************************************
                              Version 4.0 (patch 2)

                               DEMO INDIAN HOSPITAL

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

Select Export Utility Menu Option:
```

Figure 14-12: Options on the Export Utility Menu

Use the options on this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes.

> **Note**: This set of utilities should only be accessed and used by the site manager, the BH program manager, or designee.

These options should be familiar to site managers and other RPMS staff who generate exports. The recommended sequence for their use follows those from PCC-CHK, clean, GEN, DISP, ERRS, transmit. RGEN, RSET, and OUTP should be reserved for expert use as required.

14.2.1 Generate BH Transactions for HQ (GEN)

1. At the “Select Export Utility Menu Option” prompt, type **GEN** to generate BH transactions to be sent to HQ.

   The transactions are for records posted since the last time you did an export up until yesterday. Both BH visit records and Suicide forms will be exported.

2. Type the caret (^) at any prompt to exit and the application will display a confirmation prior to generating transactions as shown in Figure 14-13:

```
The inclusive dates for this run are DEC 28,2008 through APR 18,2009.
The location for this run is DEMO INDIAN HOSPITAL.
Do you want to continue? N//
```

Figure 14-13: Sample information before continuing

3. At the "Do you want to continue?" prompt, type one of the following:
   - **N** to return to the Export Utility menu
   - **Y** to continue.
4. At the "Do you want to QUEUE this to run at a later time?" prompt, type **N** and the generation will be put in the queue and the generate process continues as shown in Figure 14-14:

```
Enter beginning date for this run:   SEP 1, 2008

  The inclusive dates for this run are   SEP 1, 2008   THROUGH   SEP 30,
2008
  The location for this run is the _________________HOSPITAL/CLINIC.

  Do you want to continue (Y/N)  N// Y

  Generating transactions.     Counting records    (  * 100*    )

  *100* Transactions were generated.
  Updating log entry.
  Deleting cross reference entries (100)

  RUN TIME  (H.M.S): 0.3.56
```

Figure 14-14: Sample information for generating the new log entry

14.2.2 Display a Log Entry (DISP)

1. At the "Select Manager Utilities Option" prompt, type **DISP** to display the extract log information in a date range.
2. At the "Select MHSS EXTRACT LOG BEGINNING DATE" prompt, type the extract log beginning date. (You can view the extract date by typing two question marks (**??**) at this prompt.)
3. At the "DEVICE" prompt, type the device for viewing the data.

Figure 14-15 displays the extract log information.

```
NUMBER:  2                          BEGINNING DATE:  SEP 1,  2008
      ENDING DATE:   SEP 30, 2008@10:26:49
      RUN STOP DATE/TIME:   OCT 2, 1994@10:30:51
      COUNT OF ERRORS:  2        COUNT OF TRANSACTIONS:  98
      COUNT OF RECORDS PROCESSED:  100         RUN LOCATION:  _____________
```

```
      # ADDS:  97                    # MODS:  1
      # DELETES: 0
      TRANSMISSION STATUS:  SUCCESSFULLY COMPLETED
```

Figure 14-15: Sample extract log information

14.2.3 Print Export Log (PRNT)

1. At the "Select Export Utility Menu Option" prompt, type **PRNT** to display the export extract log report. The application displays the previous selection's beginning date.
2. Set the date at the "START WITH BEGINNING DATE" prompt.
3. Set the date at the "GO TO BEGINNING DATE" prompt.
4. At the "DEVICE" prompt, type the device to print/browse the log.

Figure 14-16 displays the Mental Health/Social Service Export Extract Log.

```
                    *****MENTAL HEALTH/SOCIAL SERVICES*****
                            ***EXPORT EXTRACT LOG***          PAGE:   1
                                                   REPORT DATE:   04/20/09
                            ADDS    DEL     MODS    TRANS  ERROR   RECORD
 ==========================================================================
3    10/24/06  12/21/06                                 39     10      45
     10/24/06  12/21/06
4    12/20/06  05/14/07                                256     34     278
     12/20/06  05/14/07
5    05/13/07  08/22/07                                128     55     181
     05/13/07  08/22/07
6    08/21/07  10/03/08                                537     77     595
     08/21/07  10/03/08
7    10/02/08  11/17/08                                 21      4      17
     10/02/08  11/17/08
8    11/16/08  12/10/08                                185     12     180
     11/16/08  12/10/08
9    12/09/08  12/29/08                                 33      0      33
     12/09/08  12/29/08
                             ------  ------  ------  -----  -----  ------
TOTAL                        0       0       0        1199    192    1329
```

Figure 14-16: Sample export extract log

14.2.4 Regenerate Transactions (RGEN)

1. At the "Select Export Utility Menu Option" prompt, type **RGEN** to regenerate transactions between two dates. Do the following:

   Warning: Do not use this option if you are not an expert user.

2. Set the date at the "Select MHSS EXTRACT LOG BEGINNING DATE" prompt, Figure 14-17 displays.

```
Log entry 6  was for date range MAR 2, 2007 through JUN 16, 2007
And generated 44 transactions from 67 records.
Do you want to regenerate the transactions for this run?  N//
```

Figure 14-17: Sample information about regenerate transactions

14.2.5 Reset Data Export Log (RSET)

This routine will reset the BH Data Transmission Log. You must be absolutely sure that you have corrected the underlying problem that caused the Transmission process to fail in the first place!

The BH Data Transmission log entry you choose will be removed from the log file and all Utility and Data globals associated with that run will be killed.

You must now select the Log Entry to be reset. <Select carefully>

The BH Data Transmission log entry you choose will be *removed* from the log file and all Utility and Data globals associated with that run will be killed.

14.2.6 Check Records Before Export (CHK)

1. At the "Select Export Utility Menu Option" prompt, type **CHK** to review all records that were posted to the BH database since that last export was done. It will review all records that were posted from the day after the last date of that run up until 2 days ago.

   The application displays the two dates, such as APR 19, 2009 and APR 20, 2009 inclusive. If the entries are displaying on this list, they are not passing to PCC and the billing package. Do the following:

2. At the "Do you want to continue?" prompt, type one of the following:

   - **N** to end the process
   - **Y** to continue

3. At the "DEVICE" prompt, type the device to review the report.

Figure 14-18 displays the BH Export Record Review report.

```
                              DEMO INDIAN HOSPITAL                      Page 1
                            BH EXPORT RECORD REVIEW
                Record Posting Dates:  APR 19, 2009 and APR 20, 2009

RECORD DATE           PATIENT              HRN     PGM  TYPE            ACT TYPE
-------------------------------------------------------------------------------

APR 20, 2009@09:44    ALPHA,CHELSEA MARIE 116431    S   OUTPATIENT        16
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@09:51    DELTA,EDWIN RAY      105321   S   OUTPATIENT        85
```

```
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:46    DELTA,EDWIN RAY      105321   S   OUTPATIENT        85
E023-NO AFFILIATION FOR PROVIDER

APR 20, 2009@10:00    ALPHA,CHRYSTAL GAYL  106299   M   OUTPATIENT        94
E023-NO AFFILIATION FOR PROVIDER

RUN TIME (H.M.S): 0.0.0
End of report.  PRESS ENTER:
```

Figure 14-18: Sample report about records before export

14.2.7 Print Error List for Export (ERRS)

1. At the "Select Export Utility Menu Option" prompt, type **ERRS** to print/browse the report that shows all records that have been posted to the database and are still in error after the latest Export/Generation. Do the following:

2. Set the date at the "Select MHSS EXTRACT LOG BEGINNING DATE" prompt.

   You can view the extract date list by typing two question marks (**??**) at the prompt.

   > **Note**: The Check Records before Export option should have been used to determine all errors before running the generation. You can now correct these remaining errors before the next export/generation.

3. At the "DEVICE" prompt, type the device to print/browse the report.

Figure 14-19 displays the MHSS Extract Log Error Report.

```
MHSS EXTRACT LOG ERROR REPORT                  APR 20,2009  13:15    PAGE 1
                                                                        ACT
VISIT DATE           PATIENT              HRN     PGM  TYPE            TYPE
-------------------------------------------------------------------------------


AUG 21,2006  17:44   ALPHAAA,STEVEN ALLAN  165583  S    OUTPATIENT      31
ERROR: E021-NO PURPOSE OF VISIT

JUNE 8,2006
ERROR: E023-NO AFFILIATION FOR PROVIDER

Press ENTER to Continue:
```

Figure 14-19: Sample MHSS Extract Log Error Report

14.2.8 Create OUTPUT File (OUTP)

At the "Select Export Utility Menu Option" prompt, type **OUTP** to create an output file. Consult with the site manager on how to create an RPMS export.

14.3 Re-Set Patient Flag Field Data (RPFF)

1. At the “Select Manager Utilities Option” prompt, type **RPFF** to reset all patient flag fields to null.

   This should be done each time you want to flag patients for a different reason. You can reset one flag or all flags. You may use this reset option to reassign a flag or all flags as needed. Do the following:

2. At the “Reset which flags” prompt, type one of the following:

   - **A** (all flags)
   - **O** (one flag) to continue

3. At the “Are you sure you want to do this?” prompt, type **Y**, Figure 14-20 displays:

```
Hold on... resetting data..293:592:611:1572:1976:2694:3078:3920:4180:4411:4961:5
242:5491:5967:7660:8654:12720:12781:13108:15628:15665:16830:17196:20251:20887:22
379:22604:24527:24600:24962:26128:26397:28641:29432:30641:30713:33704:34642:3551
9:36798:37194:37299:38703:40814:41623:46087:47626:48105:48399:49948:50808:53523:
56139:56333:59916:59929:60849:61983:63387:63633:65054:65550:66154:66590:68642:68
953:69967:70792:72143:73566:75490:77236:81213:82525:83534:83972:84879:87330:8777
6:88478:89314:89451:89506:91441:93294:94577:94602:96414:97179:99617:101901:10395
3:104155:104991:105619:105741:106853:107151:111050:111155:111761:112200:112584:1
12591:113958:115379:115454:115820:117208:118421:118985:119700:120926:121147:1247
10:125785:126107:127004:128411:128474:128609:129047:129724:130782:132029:132030:
132031:132032:132187:132516:132565:132568:132573:132575:132576:132580:132581:132
592:132636:132643:
All done.
```

Figure 14-20: Sample information from the application about the reset process

14.4 Display Log of Who Edited Record (DLWE)

1. At the “Select Manager Utilities Option “ prompt, type **DLWE** to display a list of who edited BH records of a specified patient. Do the following:

2. Set the date at the “Enter ENCOUNTER DATE” prompt.

3. At the “Enter LOCATION OF ENCOUNTER” prompt, type the location.

4. At the “Enter PATIENT” prompt, type the name of the patient.

   Figure 14-21 displays the visits with no location or patient.

```
-------------------------------------------------------------------------------
             Behavioral Health visits for APR 10, 2009
-------------------------------------------------------------------------------
 #     PROVIDER   LOC  COMMUNITY ACT CONT PATIENT      PROB    NARRATIVE
-------------------------------------------------------------------------------
1    GAMMAA,RYAN  WW   TAHLEQUAH  13 OUTP WW 116431    14      MAJOR DEPRESSIV
2    BETAAAA,BJ   WW   TAHLEQUAH  99 OUTP WW 108704    296.32  DEPRESSED
3    GAMMAA,RYAN  WW   TAHLEQUAH  13 ADMI -----        14.1    SCHIZOPHRENIA
```

```
4    GAMMAA,RYAN  LC   ABIQUIU    76 INTE WW 105321    15      BIPOLAR DISORDE
5    GAMMAA,RYAN  WW   TAHLEQUAH  16 OUTP WW 116431    311.    DEPRESSIVE DISO
6    GAMMAA,RYAN  WW   TAHLEQUAH  19 OUTP WW 116431    314.9   ATTENTION-DEFIC
7    GAMMAA,RYAN  WW   TAHLEQUAH  16 OUTP WW 116431    295.15  SCHIZOPHRENIA,

Which record do you want to display:  (1-7):
```

Figure 14-21: Sample Behavioral Health Visits window

You can display the visit data for a record by responding the “Which record do you want to display?” prompt. The application displays the visit data as shown in Figure 14-22:

```
MHSS RECORD LIST                          APR 20,2009  11:31    PAGE 1
DATE
CREATED      WHO ENTERED RECORD   LAST MOD   USER LAST UPDATE
         DATE/TIME EDITED         WHO EDITED
-------------------------------------------------------------------------

04/10/09     BETAAAA,BJ           04/10/09   BETAAAA,BJ
         APR 10,2009  12:01       BETAAAA,BJ
         APR 10,2009  12:04       BETAAAA,BJ
         APR 10,2009  12:05       BETAAAA,BJ
         APR 10,2009  12:06       BETAAAA,BJ

End of report.  Press enter:
```

Figure 14-22: Sample report about visit data of a particular record

14.5 Add/Edit Local Service Sites (ELSS)

1. At the “Select Manager Utilities Option” prompt, type **ELSS** to add/edit location service sites. If a new location is added, a name and abbreviation should be provided. Counts of these visits can be recovered using the GEN option in Encounter Reports or ACT in the Workload reports. Do the following:

2. At the “Select MHSS LOCAL SERVICE SITES” prompt, type a new or existing local service site.

   - Type Y to confirm the new site
   - Type new service site and a confirmation displays.
   - Type **N** and the “Select MHSS LOCAL SERVICE SITES” prompt displays.

3. Type an existing factor, for example, HEADSTART, do the following:

4. At the “LOCAL SERVICE SITE: HEADSTART Replace” prompt, press Enter to accept the existing service site.

5. At the “ABBREVIATION: HEAD” prompt, press Enter to accept the abbreviation of the existing service site.

14.6 Add Personal History Factors to Table (EPHX)

1. At the "Select Manager Utilities Option" prompt, type **EPHX** to add personal history factors to the four-item list initially identified for use in BHS programs. Added items will be shown as items in the Personal History field any place this option exists in a Select or Print field in the GEN reports. Do the following:

2. At the "Enter a PERSONAL HISTORY FACTOR" prompt, type a personal history factor.

   - Type **Y** to confirm the factor entry.
   - Type **N** and the "Enter a PERSONAL HISTORY FACTOR" prompt repeats.

3. Type an existing factor, such as, FAS, the application displays a similar message: At the "FACTOR: FAS//" prompt, press Enter to accept the existing factor.

14.7 Delete BH General Retrieval Report Definitions (DRD)

1. At the "Select Manager Utilities Option" prompt, type **DRD** to delete a PCC Visit or Patient General Retrieval report definition. This enables the user to delete a PCC Visit or Patient General Retrieval report definition. Do the following:

2. At the "REPORT NAME" prompt, type the name of the report to be removed.

   - Type a question mark (**?**) at this prompt to view a list of existing definitions.

3. At the "Are you sure you want to delete the [report name] definition?" prompt, identify the name of the report.

   - Type **Y** to confirm the deletion
   - Type **N** to not delete

14.8 Edit Other EHR Clinical Problem Code Crosswalk (EEPC)

At the "Select Manager Utilities Option" prompt, type **EEPC** to loop through all MHSS PROBLEM/DSM IV table entries created by EHR users to change the grouping from the generic 99.9 OTHER EHR CLINICAL grouping to a more specific MHSS PROBLEM CODE grouping.

In the RPMS behavioral health applications, the POV is recorded as either a BH Problem Code or DSM-IV TR code. For the purpose of reports, these codes are grouped within larger problem code groupings and then again in overarching categories. For example, DSM-IV TR code 311 Depressive Disorder NOS is also stored as problem code grouping 14 Depressive Disorders and problem category Psychosocial Problems.

In the RPMS EHR, the POV is recorded using ICD-9 codes, not DSM-IV TR codes. Many ICD and DSM numeric codes are identical. There may be instances when a provider selects an ICD code that does not have a matching DSM code. When this occurs it will be dynamically added to the MHSS PROBLEM/DSM IV table. Once the ICD-9 code is in the MHSS PROBLEM/DSM IV table, then it is accessible to users in BHS or BH GUI as well.

These ICD-9 codes that have been added to the MHSS PROBLEM/DSM IV table will not have been automatically assigned to the appropriate BH problem code group. To ensure that these ICD-9 codes are captured in BHS reports that have the option to include problem code groupings, a site can manually assign the code to the appropriate group. The assignment of this code to a group only needs to be done one time. The following sample prompts display:

- **CODE: V72.3**
- **ICD Narrative: GYNECOLOGIC EXAMINATION**

1. At the “Enter the Problem Code Grouping” prompt, type the grouping code for the above Code and ICD Narrative.

   The application provides you with the caret (^) option so that you don’t have to go all the way through the entries.

14.9 Update Locations a User can See (UU)

1. At the “Select Manager Utilities Option” prompt, type **UU** to identify the location a user can view in this application.

   BHS v4.0 contains a new field called the **BH User** that will permit a site to screen the locations that a user may access to view or enter information.

   If a site wants to limit the visits by location that a BH user can access then they will enter that user into this file and list all the facilities/locations that that user is allowed to “see” or access. If an entry is made in this file for a user that user will only be able to “lookup” patients with a health record at those facilities, only patients with health records at those facilities will display on patient lists and reports, and will only be able to view/access visits to those locations. If a user is not entered into this file that person will be able to see visits to all locations. This file will only be updated if a site is multidivisional and there is a need to restrict the viewing of data between sites.

2. At the “Select BH USER NAME” prompt, type the user name to be added to the BH User file. A ScreenMan screen will pop-up permitting the manager to enter all of the locations that the user is able to access or “see” on the screen.

Figure 14-23 displays the Update Visit Locations a User can See screen.

```
****  Update Visit Locations a User can See ****
USER: BETA,LORI

Location: DEMO INDIAN HOSPITAL
Location: SELLS HOSP
Location:
Location:
Location:


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

Figure 14-23: Sample Update Visit Locations a User can See screen

3. At the “Location” prompt, type the location that the user can view.

   - You can specify more than one location.

   In the example, the provider will only be able to access visits to the designated Hospitals. If a patient being treated, has to visit another, the provider would not see that visit information. For example, if the user chooses “Browse Visits” they would not see any visit in the visit list that was to a location other than the two listed above.

Appendix A: Activity Codes and Definitions

BHS activity codes are presented here by category for ease in reviewing and locating particular codes. The category labels are for organizational purposes only and cannot be used alone to report activities. However, aggregate reports can be organized by these activity categories.

All the Activity Codes shown with a three letter acronym are assumed to involve services to a specific patient. During the data entry process, if you enter one of these activity codes, you must also enter the patient's name so that the data you enter can be added to the patient's visit file.

A.1 Patient Services–Patient Always Present (P)

Direct services provided to a specific person (client/patient) to diagnose and prognosticate (describe, predict, and explain) the recipient's mental health status relative to a disabling condition or problem; and where indicated to treat and/or rehabilitate the recipient to restore, maintain, or increase adaptive functioning.

- **01–Twelve Step Work – Group (TSG)**

  Twelve Step work facilitation in a group setting; grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

- **02–Twelve Step Work - Individual (TSI)**

  Twelve Step work facilitation in an individual setting grounded in the concept of the Twelve Step model of recovery and that the problem – alcoholism, drug dependence, overeating, etc. It is a disease of the mind, body, and spirit.

- **03–Twelve Step Group (TSG)**

  Participation in a Twelve Step recovery group including but not limited to AA, NA, Alateen, Al-Anon, Co-dependents Anonymous (CoDA).and Overeaters Anonymous (OA).

- **04-Re-assessment, Patient Present (RAS)**

  Formal assessment activities intended to reevaluate the patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

- **11-Screening (SCN)**

Services provided to determine in a preliminary way the nature and extent of the recipient's problem in order to link him/her to the most appropriate and available resource.

- **12-Assessment/Evaluation (EVL)**

  Formal assessment activities intended to define or delineate the client/patient's diagnosis and problem. These services are used to document the nature and status of the recipient's condition and serve as a basis for formulating a plan for subsequent services.

- **13-Individual Treatment/Counseling/Education (IND)**

  Prescribed services with specific goals based on diagnosis and designed to arrest, reverse, or ameliorate the client/patient's disease or problem. The recipient in this case is an individual.

- **15-Information and/or Referral (REF)**

  Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization.

- **16-Medication/Medication Monitoring (MED)**

  Prescription, administration, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications.

- **17-Psychological Testing (TST)**

  Examination and assessment of client/patient's status through the use of standardized psychological, educational, or other evaluative test. Care must be exercised to assure that the interpretations of results from such testing are consistent with the socio-cultural milieu of the client/patient.

- **18-Forensic Activities (FOR)**

  Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters.

- **19-Discharge Planning (DSG)**

  Collaborative service planning with other community caregivers to develop a goal-oriented follow-up plan for a specific client/patient.

- **20-Family Facilitation (FAC)**

  Collection and exchange of information with significant others in the client/patient's life as part of the clinical intervention.

- **21-Follow-through/Follow-up (FOL)**

  Periodic evaluative review of a specific client/patient's progress after discharge.

- **22-Case Management (CAS)**

  Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination.

- **23-Other Patient Services not identified here (OTH)**

  Any other patient services not identified in this list of codes.

- **47–Couples Treatment (CT)**

  Therapeutic discussions and problem-solving sessions facilitated by a therapist sometimes with the couple or sometimes with individuals.

- **48-Crisis Intervention (CIP)**

  Short-term intervention of therapy/counseling and/or other behavioral health care designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

- **85-Art Therapy (ART)**

  The application of a variety of art modalities (drawing, painting, clay, and other mediums), by a professional Art Therapist, for the treatment and assessment of behavioral health disorders; based on the belief that the creative process involved in the making of art is healing and life-enhancing.

- **86–Recreation Activities (REC)**

  Recreation and leisure activities with the purpose of improving and maintaining clients'/patients' general health and well-being.

- **88–Acupuncture (ACU)**

  The use of the Chinese practice of Acupuncture in the treatment of addiction disorders (including withdrawal symptoms and recovery) and other behavioral health disorders.

- **89–Methadone Maintenance (MET)**

  Methadone used as a substitute narcotic in the treatment of heroin addiction; administered by a federally licensed methadone maintenance agency under the supervision of a physician. Services include methadone dosing, medical care, counseling and support and disease prevention and health promotion.

- **90–Family Treatment (FAM)**

  Family-centered therapy with an emphasis on the client/patient's functioning within family systems and the recognition that addiction and behavioral health disorders have relational consequences; often brief and solution focused.

- **91–Group Treatment (GRP)**

  This form of therapy involves groups of patients/clients who have similar problems that are especially amenable to the benefits of peer interaction and support and who meet regularly with a group therapist or facilitator.

- **92–Adventure Based Counseling (ABC)**

  The use of adventure-based practice to effect a change in behaviors (both increasing function and positive action and decreasing dysfunction and negative action) as it relates to health and/or mental health.

- **93–Relapse Prevention (REL)**

  Relapse prevention approaches seek to teach patients concrete strategies for avoiding drug use episodes. These include the following:

  – Cataloging situations likely to lead to alcohol/drug use (high-risk situations)
  – Strategies for avoiding high-risk situations
  – Strategies for coping with high-risk situations when encountered
  – Strategies for coping with alcohol/drug cravings
  – Strategies for coping with lapses to drug use to prevent full-blown relapses

- **94–Life Skills Training (LST)**

  Psychosocial and interpersonal skills training designed to help a patient or patients make informed decisions, communicate effectively, and develop coping and self-management skills.

- **95–Cultural Activities - Pt. Present (CUL)**

  Participation in educational, social, or recreational activities for the purpose of supporting a client/patient's involvement, connection, and contribution to the patient's cultural background.

- **96–Academic Services (ACA)**

  Provision of alternative schooling under the guidelines of the state education program.

- **97–Health Promotion (HPR)**

Any activities that facilitate lifestyle change through a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices.

A.2 Support Services–Patient Not Present (S)

Indirect services (e.g., information gathering, service planning, and collaborative efforts) undertaken to support the effective and efficient delivery or acquisition of services for specific clients/patients. These services, by definition, do not involve direct recipient contact. Includes:

- **05-Reassessment, Patient Not Present**

  Reassessment or reevaluation activities when patient is not present at time of service delivery.

- **24-Material/Basic Support (SUP)**

  Support services required to meet the basic needs of the client/patient for food, shelter, and safety.

- **25-Information and/or Referral (INF)**

  Information services are those designed to impart information on the availability of clinical resources and how to access them. Referral services are those that direct or guide a client/patient to appropriate services provided outside of your organization

- **26-Medication/Medication Monitoring (MEA)**

  Prescription, assessment of drug effectiveness, and monitoring of potential side effects of psychotropic medications. Patient is not present at the time of service delivery.

- **27-Forensic Activities (FOA)**

  Scientific and clinical expertise applied to legal issues in legal contexts embracing civil, criminal, and correctional or legislative matters. Patient is not present at time of service delivery.

- **28-Discharge Planning (DSA)**

  Collaborative service planning with other community caregivers to develop a goal oriented follow-up plan for a specific client/patient.

- **29-Family Facilitation (FAA)**

  Collection and exchange of information with significant others in the client/patient’s life as part of the clinical intervention.

- **30-Follow-up/Follow-through (FUA)**

  Periodic evaluative review of a specific client/patient's progress after discharge.

- **31-Case Management (CAA)**

  Focus is on a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients/patients with appropriate services to address specific needs and achieve stated goals. May also be called Care Management and/or Service Coordination. Patient is not present at the time of service delivery.

- **33-Technical Assistance**

  Task-specific assistance to achieve an identified end.

- **34-Other Support Services**

  Any other ancillary, adjunctive, or collateral services not identified here.

- **44-Screening**

  Activities associated with patient/client screening where no information is added to the patient/client's file.

- **45-Assessment/Evaluation**

  Assessment or evaluation activities when patient is not present at time of service delivery.

- **49-Crisis Intervention (CIA)**

  Patient is not present. Short-term intervention of therapy/counseling and/or other behavioral healthcare designed to address the presenting symptoms of an emergency and to ameliorate the client's distress.

A.3 Community Services (C)

Assistance to community organizations, planning groups, and citizens' efforts to develop solutions for community problems. Includes:

- **35-Collaboration**

  Collaborative effort with other agency or agencies to address a community request.

- **36-Community Development**

  Planning and development efforts focused on identifying community issues and methods of addressing these needs.

- **37-Preventive Services**

  Activity, class, project, public service announcement, or other activity whose primary purpose is to prevent the use/abuse of alcohol or other substances and/or improve lifestyles, health, image, etc.

- **38-Patient Transport**

  Transportation of a client to or from an activity or placement, such as a medical appointment, program activity, or from home.

- **39-Other Community Services**

  Any other form of community services not identified here.

- **40-Referral**

  Referral of a client to another agency, counselor, or resource for services not available or provided by the referring agency/program. Referral is limited to providing the client with information and might extend to calling and setting up appointments for the client.

- **87-Outreach**

  Activities designed to locate and educate potential clients and motivate them to enter and accept treatment.

A.4 Education Training (E)

Participation in any formal program leading to a degree or certificate or any structured educational process designed to impart job related knowledge, attitudes, and skills. Includes:

- 41-Education/Training Provided
- 42-Education/Training Received
- 43-Other Education/Training

A.5 Administration (A)

Activities for the benefit of the organization and/or activities that do not fit into any of the above categories. Includes:

- **32-Clinical Supervision Provided**

  Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

- **50-Medical Rounds (General)**

  On the inpatient unit, participation in rounds designed to address active medical/psychological issues with all members of the treatment team and to develop management plans for the day.

- **51-Committee Work**

  Participation in the activities of a body of persons delegated to consider, investigate, take action on, or report on some matter.

- **52-Surveys/Research**

  Participation in activities aimed at identification and interpretation of facts, revision of accepted theories in the light of new facts, or practical application of such new or revised theories.

- **53-Program Management**

  The practice of leading, managing, and coordinating a complex set of cross-functional activities to define, develop, and deliver client services and to achieve agency/program objectives.

- **54-Quality Improvement**

  Participation in activities focused on improving the quality and appropriateness of medical or behavioral healthcare and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

- **55-Supervision**

  Participation in activities to ensure that personnel perform their duties effectively. This code does not include clinical supervision.

- **56-Records/Documentation**

  Review of clinical information in the medical record/chart or documentation of services provided to or on behalf of the client. This does not include the time spent in service delivery.

- **57-Child Protective Team Activities**

  Participation in a multi-disciplinary child protective team to evaluate alleged maltreatments of child abuse and neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance their caregiver's capacity to provide a safer environment when possible.

- **58-Special Projects**

A specifically-assigned task or activity which is completed over a period of time and intended to achieve a particular aim.

- **59-Other Administrative**

  Any other administrative activities not identified in this section.

- **60-Case Staffing (General)**

  A regular or ad-hoc forum for the exchange of clinical experience, ideas and recommendations.

- **66-Clinical Supervision Received**

  Clinical supervision is a process based upon a clinically-focused professional relationship between the practitioner engaged in professional practice and a clinical supervisor.

A.6 Consultation (L)

Problem-oriented effort designed to impart knowledge, increase understanding and insight, and/or modify attitudes to facilitate problem resolution. Includes:

- **61-Provider Consultation (PRO)**

  Focus is a specific patient and the consultation is with another service provider. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

- **62-Patient Consultation (Chart Review Only) (CHT)**

  Focus is a specific patient and the consultation is a review of the medical record only. The purpose of the consultation is of a diagnostic or therapeutic nature. Patient is never present.

- **63-Program Consultation**

  Focus is a programmatic effort to address specific needs.

- **64-Staff Consultation**

  Focus is a provider or group of providers addressing a type or class of problems.

- **65-Community Consultation**

  Focus is a community effort to address problems. Distinguished from community development in that the consultant is not assumed to be a direct part of the resultant effort.

A.7 Travel (T)

- **71-Travel Related to Patient Care**

  Staff travel to patient's home or other locations – related to provision of care. Patient is not in the vehicle.

- **72 Travel Not Related to Patient Care**

  Staff travel to meetings, community events, etc.

A.8 Placements (PL)

- **75-Placement (Patient Present) (OHP)**

  Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences.

- **76-Placement (Patient Not Present) (OHA)**

  Selection of an appropriate level of service, based on assessment of a patient's individual needs and preferences. This activity might include follow-up contacts, additional research, or completion of placement/referral paperwork when the patient is not present.

A.9 Cultural Issues (O)

- **81-Traditional Specialist Consult (Patient Not Present) (TRA)**

  Seeking recommendation or service from a recognized Indian spiritual leader or Indian doctor with the patient present. Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

- **82-Traditional Specialist Consult (Patient Not Present) (TRA)**

  Seeking evaluation, recommendations, or service from a recognized Indian spiritual healer or Indian doctor (patient not present). Such specialists can be called in either as advisors or as direct providers, when agreed upon between client and counselor.

- **83-Tribal Functions**

  Services offered during or in the context of a traditional tribal event, function, or affair—secular or religious. Community members gather to help and support individuals and families in need.

- **84-Cultural Education to Non-Tribal Agency/Personnel**

The education of non-Indian service providers concerning tribal culture, values, and practices. This service attempts to reduce the barriers members face in seeking services.

Appendix B: Activity Codes that Pass to PCC

Activity Code	Description	Pass to PCC
01	Twelve Step Work – Group (TSG)	Yes
02	Twelve Step Work – Individual (TSI)	Yes
03	Twelve Step Group (TWG)	No
04	Re-Assessment, Patient Present	Yes
05	Re-Assessment, Patient Not Present	No
11	Screening – Patient Present (SCN)	Yes
12	Assessment/Evaluation – Patient Present (EVL)	Yes
13	Individual Treatment/Counsel/Education – Pt. Present (IND)	Yes
15	Information and Referral – Patient Present (REF)	Yes
16	Medication/Medication Monitoring – Pt. Present (MED)	Yes
17	Psychological Testing – Patient Present (TST)	Yes
18	Forensic Activities – Patient Present (FOR)	Yes
19	Discharge Planning – Patient Present (DSG)	Yes
20	Family Facilitation –Patient Present (FAC)	Yes
21	Follow Through/Follow Up – Patient Present (FOL)	Yes
22	Case Management – Patient Present (CAS)	Yes
23	Other Patient Services Not Identified – Patient Present (OTH)	Yes
24	Material/Basic Support – Patient Not Present (SUP)	No
25	Information and/or Referral – Patient Not Present (INF)	No
26	Medication/Medication Monitoring – Pt. Not Present (MEA)	Yes
27	Forensic Activities – Patient Not Present (FOA)	No
28	Discharge Planning – Patient Not Present (DSA)	No
29	Family Facilitation – Patient Not Present (FAA)	No
30	Follow Through/Follow Up – Patient Not Present (FUA)	No
31	Case Management – Patient Not Present (CAA)	Yes
32	Clinical Supervision Provided	No
33	Technical Assistance – Patient Not Present	No
34	Other Support Services – Patient Not Present	No
35	Collaboration	No
36	Community Development	No
37	Preventive Services	No
38	Patient Transport	No
39	Community Services	No
40	Referral	No
41	Education/Training Provided	No
42	Education/Training Received	No
43	Other Education/Training	No
44	Screening – Patient Not Present	No
45	Assessment/Evaluation – Patient Not Present	No
47	Couples Treatment – Patient Present (CT)	Yes

Activity Code	Description	Pass to PCC
48	Crisis Intervention – Patient Present (CIP)	Yes
49	Crisis Intervention – Patient Not Present (CIA)	No
50	Medical Rounds (General)	No
51	Committee Work	No
52	Surveys/Research	No
53	Program Management	No
54	Quality Improvement	No
55	Supervision	No
56	Records/Documentation	No
57	Child Protective Team Activities	No
58	Special Projects	No
59	Other Administrative	No
60	Case Staffing (General)	No
61	Provider Consultation (PRO)	Yes
62	Patient Consultation (Chart Review) (CHT)	Yes
63	Program Consultation	No
64	Staff Consultation	No
65	Community Consultation	No
66	Clinical Supervision Received	No
71	Travel Related to Patient Care	No
72	Travel Not Related to Patient Care	No
75	Placement – Patient Present (OHP)	Yes
76	Placement – Patient Not Present (OHA)	No
81	Traditional Specialist Consult – Patient Present (TRD)	Yes
82	Traditional Specialist Consult – Patient Not Present (TRA)	No
83	Tribal Functions	No
84	Cultural Education to Non-Tribal Agency/Personnel	No
85	Art Therapy (ART)	Yes
86	Recreation Activities (REC)	No
87	Outreach	No
88	Acupuncture (ACU)	Yes
89	Methadone Maintenance (MET)	Yes
90	Family Treatment (FAM)	Yes
91	Group Treatment (GRP)	Yes
92	Adventure Based Counseling (ABC)	Yes
93	Relapse Prevention (REL)	Yes
94	Life Skills Training (LST)	Yes
95	Cultural Activities (CUL)	No
96	Academic Services (ACA)	No
97	Health Promotion (HPR)	Yes

Appendix C: ICD-9CM v Codes

ICD Code	Description
v11.0	Personal history of Schizophrenia
v11.1	Personal history of affective disorders
v11.2	Personal history of neurosis
v11.3	Personal history of alcoholism
v11.8	Personal history of other mental disorders
v11.9	Personal history of unspecified mental disorder
v13.21	Personal history of pre-term labor
v13.7	Personal history of perinatal problems
v15.41	History of physical abuse (includes rape)
v15.42	History of emotional abuse or neglect
v15.49	Psychological trauma, not elsewhere classified
v15.52	Personal History of Traumatic Brain Injury (TBI)
v15.81	History of noncompliance with medical treatment
v15.82	History of tobacco use
v15.89	Other personal history presenting hazards to health
v15.9	Unspecified personal history presenting hazards to health
v17.0	Family history of psychiatric condition
v18.4	Family history of mental retardation
v23.9	Supervision of unspecified high risk pregnancy
v25.09	General counseling and advice on contraceptive management; family planning advice
v26.33	Genetic counseling
v26.41	Procreative counseling and advice using natural family planning
v26.49	Other procreative management counseling and advice
v40.0	Mental and behavioral problems with learning
v40.1	Mental and behavioral problems with communication including speech
v40.2	Other mental problems
v40.9	Unspecified mental or behavioral problem
v57.9	Care involving unspecified rehabilitation procedure
v60.0	Lack of housing
v60.1	Inadequate housing
v60.2	Inadequate material resources
v60.3	Person living alone
v60.4	No other household member able to render care
v60.5	Holiday relief care
v60.6	Person living in a residential institution
v60.8	Other specified housing or economic circumstances
v60.81	Foster care (status)
v60.89	Unspecified housing or economic circumstances
v61.01	Family disruption due to family member on military deployment
v61.02	Family disruption due to return of family member from military deployment
v61.03	Family disruption due to divorce or legal separation

ICD Code	Description
v61.04	Family disruption due to parent-child estrangement
v61.05	Family disruption due to child in welfare custody
v61.06	Family disruption due to child in foster care or in care of non-parental family member
v61.07	Family disruption due to death of family member
v61.08	Family disruption due to other extended absence of family member
v61.09	Other family disruption
v61.10	Counseling for marital and partner problems, unspecified
v61.11	Counseling for victim of spousal and partner abuse
v61.12	Counseling for perpetrator of spousal and partner abuse
v61.20	Counseling for parent-child problem, unspecified
v61.21	Counseling for victim of child abuse
v61.22	Counseling for perpetrator of parental child abuse
v61.23	Counseling for parent-biological child problem
v61.24	Counseling for parent-adopted child problem
v61.25	Counseling for parent (guardian)-foster child problem
v61.3	Problems with aged parents or in-laws
v61.41	Alcoholism in family
v61.49	Other health problems within family
v61.5	Multiparity
v61.6	Illegitimacy or illegitimate pregnancy
v61.7	Other unwanted pregnancy
v61.8	Other specified family circumstances
v61.9	Unspecified family circumstances
v62.0	Unemployment
v62.1	Adverse effects of work environment
v62.21	Personal current military deployment status
v62.22	Personal history of return from military deployment
v62.29	Other occupational circumstances or maladjustment
v62.3	Educational circumstances
v62.4	Social maladjustment
v62.5	Legal circumstances
v62.6	Refusal of treatment for reasons of religion or conscience
v62.81	Interpersonal problems, not elsewhere classified
v62.82	Bereavement, uncomplicated
v62.83	Counseling for perpetrator of physical/sexual abuse
v62.84	Suicidal ideation
v62.89	Other psychological or physical stress, not elsewhere classified (life circumstance problems; phase of life problems, borderline intellectual functioning; religious or spiritual problem)
v62.9	Unspecified psychosocial circumstance
v63.0	Residence remote from hospital or other health care facility
v63.1	Medical services in home not available
v63.2	Person awaiting admission to adequate facility elsewhere

ICD Code	Description
v63.8	Other specified reasons for unavailability of medical facilities
v63.9	Unspecified reason for unavailability of medical facilities
v65.0	Healthy person accompanying a sick person
v65.11	Pediatric pre-birth visit for expectant mother
v65.19	Other person consulting on behalf of another person
v65.2	Person feigning illness
v65.3	Dietary surveillance and counseling
v65.40	Other unspecified counseling
v65.41	Exercise counseling
v65.42	Counseling on substance use and abuse
v65.43	Counseling on injury prevention
v65.44	HIV Counseling
v65.45	Counseling on other sexually transmitted diseases
v65.49	Other specified counseling
v65.5	Person with feared complaint in whom no diagnosis was made
v65.8	Other reasons for seeking consultation
v65.9	Unspecified reason for consultation
v66.3	Convalescence following psychotherapy and other treatment for mental disorder
v66.7	Encounter for palliative care (end of life care)
v67.3	Follow-up examination following psychotherapy and other treatment for mental disorder
v68.1	Issue of repeat prescriptions
v68.2	Request for expert evidence
v68.81	Referral of patient without examination or treatment
v68.89	Encounter for other specified administrative purpose
v68.9	Encounters for unspecified administrative purpose
v69.0	Problems related to lifestyle – lack of exercise
v69.1	Problems related to lifestyle – Inappropriate diet and eating habits
v69.2	Problems related to lifestyle – High risk sexual behavior
v69.3	Problems related to lifestyle – gambling and betting
v69.4	Problems related to lifestyle – lack of adequate sleep
v69.5	Problems related to lifestyle – behavioral insomnia of childhood
v69.8	Other problems related to lifestyle; self-damaging behavior
v69.9	Unspecified problem related to lifestyle
v70.1	General psychiatric examination, requested by the authority
v70.2	General psychiatric examination, other and unspecified
v71.01	Observation of adult antisocial behavior
v71.02	Observation of childhood or adolescent antisocial behavior
v71.09	Observation of other suspected mental condition
v71.81	Observation and evaluation for other specified suspected conditions, abuse and neglect
v71.89	Observation and evaluation for other specified suspected conditions not found
v79.0	Special screening for depression

ICD Code	Description
v79.1	Special screening for alcoholism
v79.2	Special screening for mental retardation
v79.3	Special screening for developmental handicaps in early childhood
v79.8	Special screening for other specified mental disorders and developmental handicaps
v79.9	Special screening for unspecified mental disorder and developmental handicap
v80.01	Special Screening for Traumatic Brain Injury (TBI)

Appendix D: RPMS 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. The Full Screen Text Editor works like a traditional word processor, however, with limited functionality. The lines wrap automatically. The up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.

Interface

A boundary where two systems can communicate.

Line Editor

A word-processing editor that allows editing text line-by-line.

Menu

The menu is a list of different options from which to select at a given time. To choose a specific task, select one of the items from the list by entering the established abbreviation or synonym at the appropriate prompt.

Menu Tree/Tree Structure

A tree structure is a way of representing the hierarchical nature of a structure in a graphical form. It is named a "tree structure" because the classic representation resembles a tree, even though the chart is generally upside down compared to an actual tree, with the "root" at the top and the "leaves" at the bottom.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for entry of some specific information.

Roll-and-Scroll

The roll-and-scroll data entry format captures the same information as the graphical use interface (GUI) format but uses a series of keyboard prompts and commands for entering data into RPMS. This method of data entry is sometimes referred to as CHUI – Character User Interface.

Security Keys

Tools used to grant/restrict access to certain applications, application features, and menus.

Site Manager

The person in charge of setting up and maintaining the RPMS database(s) either at the site or Area-level.

Submenu

A menu that is accessed through another menu.

Suicide

The act of causing one's own death.

Ideation with Intent and Plan–Serious thoughts of suicide or of taking action to take one's life with means and a specific plan

Attempt–A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.

Completion–Fatal self-inflicted destructive act with explicit or inferred intent to die.

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

A word processing program that entering and editing text.

Word Processing Field

This is a field that allow users to write, edit, and format text for letters, MailMan messages, etc.

Acronym List

A/SA	Alcohol and Substance Abuse
BH	Behavioral Health
BHS	Behavioral Health System
CAC	Clinical Applications Coordinator. The CAC is a person at a medical facility assigned to coordinate the installation, maintenance, and upgrading of BHS and other software programs for the end users. The CAC is sometimes referred to as the application coordinator or a "super-user."
CD	Chemical Dependency
EHR	Indian Health Service RPMS Electronic Health Record
GPRA	Government Performance and Results Act; a federal law requiring federal agencies to demonstrate through annual reporting that they are using appropriated funds effectively to meet their Agency's missions.
GUI	Graphic User Interface, a Windows-like interface with drop-down menus, text boxes icons, and other controls that supports data entry using a combination of the computer mouse and keyboard.
IHS	Indian Health Service
MH	Mental Health
RPMS	Resource and Patient Management System
TIU	Text Integration Utilities, a document management application. This application is used to create and store a wide variety of clinical note templates in the RPMS Electronic Health Record.

Contact Information

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

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

E-mail: support@ihs.gov