

**INDIAN HEALTH SERVICE
RESOURCE AND PATIENT MANAGEMENT
SYSTEM**



**BEHAVIORAL HEALTH SYSTEM
BHS v3.0**

TRAINING MANUAL

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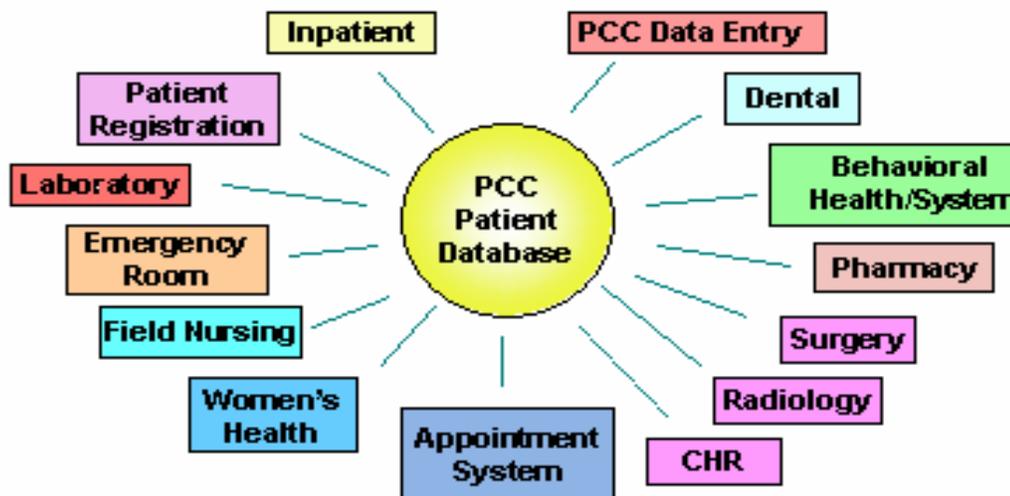
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Introduction to RPMS and BHS v3.0

Resource and Patient Management System (RPMS) is an integrated solution for management of clinical and administrative information in healthcare facilities of various sizes and orientation. Flexible hardware configurations, over 50 software applications, and network communication components combine to create a comprehensive clinical, financial, and administrative information technology solution.

The Behavioral Health System (BHS) is a discipline specific clinical sub-component of the RPMS. BHS interfaces with the registration module for patient information, the Patient Care Component (PCC) for medical information, and the pharmacy module for medications issues by IHS pharmacies. While BHS does not require that PCC be operational in a specific site, it is dependent on the registration module. It is strongly recommended that a site implement BHS and PCC in order to take advantage of the other components of RPMS that utilize PCC such as the Third Party Billing Package. BHS facilitates billing for clinical care provided.



BHS v3.0 captures and stores three basic kinds of information in a BHS data file: 1) clinical diagnoses associated with a specific patient (stored in the BHS file in DSM-IV diagnostic terms and passed to PCC in ICD-9-CM Diagnostic terms), 2) presenting problems in descriptive terms (problems which are not captured using DSM-IV diagnostic codes; these presenting problems are captured as "problem codes" and are stored in BHS and passed to the PCC in appropriate ICD-9-CM V-Codes, and 3) information about both the clinical and non-clinical activities (called administrative activities) of providers.

In addition to recording patient visits and provider activities, users can also record and print treatment plans and plan reviews, record results of an Alcohol/Substance Abuse placement tool and document incidents of suicide. Locally, BHS program staff can generate a BHS health summary, generate a very robust set of standard and ad-hoc reports and also export BHS clinical data (without patient identifiers) to Headquarters for data collection and epidemiological purposes.

Security and Confidentiality

Security and confidentiality of sensitive clinical information has always been of tremendous concern to Behavioral Health providers. Computer systems and software applications must address these concerns as well by including functionality designed to assist in protecting patient information in accordance with federal laws and professional standards. RPMS and BHS do this in several ways:

- providers can access RPMS only if they are given an Access and Verify code. It is recommended that only behavioral health providers and program staff are given access to the BHS;
- programs can control the specificity of the information passed from BHS to the PCC. Sensitive issues can be masked to preclude inadvertent disclosure without significant loss of data for continuity of care, program management and billing;
- hard copy encounter forms can be printed for the chart with the progress note, Purpose of Visit (POV) label, and Comment fields suppressed; and
- direct provider entry of clinical data limits access to patient information.

Why Would Programs Use BHS v3.0?

- Interfaces with all existing RPMS applications
- Improves quality and continuity of care
- Supports direct provider entry of clinical data
- Secure access to up-to-date clinical records
- Supports third-party billing
- Assists sites in meeting JCAHO, CARF and GPRA standards and reporting requirements
- Records and reports on both clinical and administrative activities
- Generates patient- and provider- specific reports including workload reports
- Assists with Area and National data reporting requirements

Introduction to the Application

The Behavioral Health System (BHS) v3.0 is a clinical subcomponent of the RPMS. BHS was developed by subject matter experts from the mental health, alcohol and substance abuse and social work disciplines. It combines functionality from the previously existing Mental Health/Social Services (MH/SS) and Chemical Dependency Management Information System (CDMIS) applications. BHS v3.0 also contains additional functionality including a suicide surveillance tool, new Activity codes designed to capture the unique activities of residential facilities, and updated Purpose of Visit codes which reflect current DSM-IV-TR and ICD-9 codes. BHS v3.0 consists of three main modules: Data Entry, Reports and Manager Utilities. In addition to the documentation of clinical and administrative activities BHS v3.0 offers robust reporting capabilities and an export function similar to the PCC Export. Data can be entered into BHS v3.0 by data entry staff or by the provider of service. New development, including a graphical user interface to BHS v3.0 which resides in the IHS Patient Chart, is designed primarily to facilitate provider entry of clinical data.

Purpose:

The purpose of this BHS v3.0 training is to give the user the skills and knowledge needed to use BHS v3.0 to review and record clinical data efficiently and effectively in order to improve patient care and management.

Goal:

Upon completion of this course, the user will be able to use BHS v3.0 to accurately record, edit, view, and print patient encounters for all visit types, including Mental Health, Alcohol/Substance Abuse, and Social Work. The user will be able to accurately record, edit, view and print group encounters, treatment plans, incidents of suicide and administrative activities.

Objectives:

1. **Set Up** – Access BHS v3.0 site parameters and select defaults, type of link to PCC, and SDE function.
2. **Patient Related Data Entry** – Enter patient-related data including an encounter record, Suicide Form, treatment plan, patient information and case status.
3. **Other BH Options** – Record all required elements for group encounters, non-patient activities, and administrative records.
4. **Reports** – Access the Reports menu, identify specific reports and run a sample report.
5. **Exporting** – Routinely export behavioral health data to Headquarters using the Export Utility menu.

Objective #1: Set Up

Access BHS v3.0 site parameters and select defaults, type of link to PCC, and SDE function.

Purpose:

The purpose of this lesson is to introduce you to the set-up options and security limitations that are available in both BHS v3.0 and BH GUI.

Overview:

It is important that users of the BH GUI, regardless of their discipline, recognize the purpose of the site parameters and links to PCC.

Skills You Will Acquire:

Upon completion of this objective you'll be able to:

- Identify the various fields within the BHS v3.0 site parameters
- Discuss the five types of links to PCC
- Explain the purpose of the SDE function

Log On

1. Log onto RPMS BHS v3.0
2. At the IHS Kernel Option, access Behavioral Health as instructed by your site manager.
3. At the Behavioral Health System display, select MUTL, Manager Utilities.
4. On the next screen, select Site Parameters.

Reminder: Site Parameters are controlled by security keys. If you do not have the key for this function, please contact the facility IT department or RPMS site manager to set up or edit the parameters.

Adding/Editing Default Values in Data Entry

Defaults are entered based on type of service – Mental Health, Social Service or Chemical Dependency. Location and Community are often the same for each type of service while the clinic may vary. If the server is used by only one facility providing one type of service, all defaults would be the same.

1. Enter the name of the Location. RPMS conventions apply so you may enter the first part of the name, ??? to see the entire list, etc.
2. Enter the name of the community where service is provided.
3. Enter the type of clinic (from the standard IHS list).

```
***** DEFAULT VALUES IN DATA ENTRY *****
MH Location: DULCE HEALTH CENTER      SS Location: DULCE HEALTH CENTER
MH Community: DULCE                   SS Community: DULCE
MH Clinic: MENTAL HEALTH              SS Clinic: MEDICAL SOCIAL SERVI
More Defaults (press enter):
```

4. Repeat Steps 1-3 to enter the Social Service defaults.
5. Press [Enter] to access the additional defaults.

```

Default Chemical Dependency Location: DULCE HEALTH CENTER
Default Chemical Dependency Community: DULCE
Default Chemical Dependency Clinic: ALCOHOL AND SUBSTANCE

Default Type of Contact: OUTPATIENT
Default Appt/Walk In Response: APPOINTMENT

```

6. Repeat Steps 1-3 to enter defaults for Chemical Dependency services.
7. Select the most frequently used type of contact – applies to all three sets of defaults.

09	Group Services
11	Home
14	Mental Health
22	School
25	Other
30	ER
43	Alcohol & Substance Abuse
48	Medical Social Services
51	Telephone Call
52	Chart Review
77	Case Management Services

More choices may be found by entering ??? at the prompt

8. Select the most frequently used value for Appointment, Walk In or Unspecified.
9. Press [Enter] to return to the Site Parameters view.

Adding/Editing Type of PCC Link

```

Type of Visit to Create in PCC: IHS                INTERACTIVE PCC LINK?
Type of PCC Link: PASS ALL DATA AS ENT          Allow PCC Problem List Update?
Update PCC Link Exceptions? N Update those allowed to see all visits on SDE?

```

- 1) **No Active Link**
The data link between the two modules is not turned on. No data is passed to the PCC visit file from the MH/SS system.
- 2) **The Data Link is on. All records are the same.**
Patient contacts in the Behavioral Health programs are passed to the PCC visit file. The same ICD-9 code and narrative, as defined by the program, are used for all cases.
- 3) **The Data Link is on. Some Masking of Data.**
Patient contacts in the Behavioral Health program are passed to the PCC visit file according to the manner in which the Purpose of Visit (POV) is recorded.
 - If the POV is identified using a DSM-IV diagnostic code, the equivalent ICD-9 diagnostic code along with the standard narrative, prefaced with the phrase, "Diagnostic impression" is passed to PCC.
 - If a psychosocial problem is characterized by using a MH/SS Problem Code as a POV, the ICD-9 code and the narrative as shown in the crosswalk table are passed to PCC. Potentially sensitive issues may be appended by the phrase, "See (Provider's Name) for Details of this Contact".

There are two exceptions:

- For MH/SS Problem codes 39 (Suicide Ideation) and 40 (Suicide Attempt/Gesture), the ICD-9 code and standard narrative are accompanied by the provider's actual narrative.
- For problem codes 42 (Child Abuse) and 44 (Adult Abuse) the ICD-9 codes for those problems (995.5 and 995.81) have been added as acceptable DSM codes to allow an additional option for what gets passed to PCC. When these codes are used to characterize a POV, each gets passed "as is" along with the provider's narrative.

4) The Data Link is on. No Masking of Data.

All DSM IV and Problem Codes are passed as ICD-9 codes as shown in the crosswalk along with the narrative as written by the provider.

5) The Data Link is on. Single standard narrative for all contacts.

Both DSM IV and Problem Codes are 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.

Select the type of link from the above list. Enter either the number or part of the name.

Updating Those Allowed to See All Visits in SDE

The SDE screen in BHS v3.0 and the BH Options Visit Entry list view in BH GUI are full screen mode, allowing the user to see all data entered for a specific date or time period. In order to access these list views, the user's name must be entered in this field in the site parameters.

If the facility is multi-divisional, the SDE function must be completed for each division where the user needs this level of access.

```
INTERACTIVE PCC LINK?  
Allow PCC Problem List Update?  
Update those allowed to see all visits on SDE?
```

1. At the prompt, type [Y] to access the data entry screen; press [Enter].
2. Type in the names of those individuals who need access to all patient information. Enter the name(s) using standard RPMS format – Last name,first name (no space between comma and first name).
3. Press [F1][C] to close the text box.
4. Press [F1][E] to exit site parameters and save the changes.

Objective #2: Patient Related Data Entry

Enter patient-related data including an encounter record, Suicide Form, treatment plan, patient information and case status.

Purpose:

The purpose of this exercise is to introduce you to the various types of patient-related documentation that can be entered through the BH GUI.

Overview:

It is important that users of the BH GUI, regardless of their discipline, be able to enter accurate patient-related data. Complete and accurate data is critical for many reasons including, most importantly, patient outcome but also for billing purposes and program management and planning.

Skills You Will Acquire:

Upon completion of this objective you'll be able to:

- Recognize the different types of visit documentation and identify the required fields.
- Summarize the importance of Suicide Surveillance and enter suicide data using the Suicide Tab in BH GUI.
- Complete a client-specific Treatment Plan.
- Identify the purpose of the Patient Information and Case Status Tabs.

Log On

1. Log onto BHS v3.0.
2. Select the Data Entry (DE) option from the Behavioral Health Information System menu.
3. Select PDE on the Data Entry menu.
4. Search for your patient by typing one of the following: name, Social Security #, Medical Record #, DOB (MM/DD/YY) and press [Enter]. Patients matching your search criteria will be returned. If only one match, skip to step 5. If more than one name is returned, enter the number for your client and press [Enter].
5. Select Add Visit (AV) from the Patient Data Entry Screen and press [Enter].
6. On the next screen, select the appropriate defaults based on your credentials and area of practice. After entering M, S, or C, press [Enter].
7. Type the date of the encounter and press [Enter].

Reminder: Dates may be entered in multiple formats in RPMS. If the date alone is asked, acceptable formats are: T (today); 2/18 (if no year is entered, the default is the current year); 0218; 2-18' 2.18; T-1 (yesterday); T-30 (a month ago); or T+7 (a week from today).

8. Select the visit type and accept the default or type in the one-letter value for the type and press [Enter].
9. Enter the primary provider if different from the default and press [Enter].

Encounters - Adding Visit Information

1. On the Behavioral Health Visit Update screen, all underlined categories must be completed.
2. Some values may be displayed if the defaults have been installed. To change the information, tab or use the up/down arrows to access the field and then type in the correct information. Press [Enter] to accept the change and move to the next field.

Encounters - Adding Purpose of Visit (POV, Axes I – V)

Reminder: An Axis I or II value is required; all other fields are optional.

1. Move to the Purpose of Visit field and press [Enter].
2. To enter a Problem or DSM code, type in the number or use a few letters of the diagnosis' name. If multiple choices are available, they will be displayed at the bottom of the screen. Follow the instructions to select the most appropriate diagnosis or problem code. If you do not know the code for the problem or diagnosis, it can also be located by using the POV/Problem Code List Job Aide. Due to the large number of possible diagnoses in this field, it is not recommended that ?? be used to pull up the list.
3. After the code has been accepted, the cursor moves to the narrative box. If you press [Enter], the computer will display the narrative and move to the next line. If you wish to change the narrative, type in the information and press [Enter].

Note: Anytime you see [Press Enter], another dialog box must be opened to record data. Pressing the [Enter] key displays the additional box; using either [F1][E] or [F1][C] will close the box. To bypass the field, use the [Tab] key.

4. Add additional POVs by repeating steps 2 and 3.
5. To move to the other axes, typing [Enter] on a blank space will indicate to the computer that you have completed data entry for this field.
6. Axis III is a free-text box that must be accessed by pressing the [Enter] key.
7. Axis IV is entered by selecting a number value between 1 and 9; then pressing [Enter]. Multiple entries can be made in this section by continuing to enter a number. To view a list of the numbered items, type a [??] and press [Enter].
8. Add Axis V (GAF Score) by entering a numerical value between 0 and 100 and pressing [Enter].
9. Press [Enter] to accept the default [Close] and return to the Behavioral Health Visit Update screen.

Encounters - Editing/Deleting POV

A POV or DSM diagnosis for Axes I or II cannot be edited, but the narrative attached to the numerical code can be. For example, if the clinician wants to change the narrative from Bipolar Disorder (POV 15) to Clinic Visit:

1. Return to the POV field and press [Enter].
2. Press [Enter] until the value to be edited is accessible.
3. Type in the change and press [Enter] when completed.
4. Return to the bottom of the page and press [Enter] to return to the previous screen.

If the wrong code has inadvertently been entered:

1. Follow the above steps; type in the correct code and press [Enter] to accept it.
2. Return to the previous screen.

To edit a free-text box such as Axis III on the POV Update screen, move the cursor to the end of the section to be deleted & use the backspace key to remove data.

Axis IV can only be edited by adding or deleting items.

Encounters - Adding Chief Complaint and SOAP/Progress Notes

1. Type chief complaint data directly into free-text box. Field is limited to 80 characters.
2. SOAP/Progress Note may be typed directly into the free-text box or copy/paste technique may be used. Copy and paste SOAP or progress note narrative from Word or another word processing application following the instructions below.

Copy & Paste

To copy information from a word processing application to the BHS V3.0

- Type the document in the format you want to use
- Highlight the section(s) you wish to add to the GUI free-text box
- Click on "Edit" at the top of the window and select "Copy"
- Open the BHS v3.0 and select the location where the data is to be added
- Right click your mouse and select "Paste"
- Continue with the rest of the documentation and save the visit when completed

Encounters - Adding Medications Prescribed

1. This tab is used to track prescriptions that have been ordered or for other relevant medication information. This is not a medication-ordering field.
2. If medications are prescribed, use the free-text format to enter the information.

Encounters - Editing Chief Complaint, SOAP/Progress Notes & Medications Prescribed

1. Edit the Chief Complaint by re-wording the information, staying within the 80 character limit.
2. Edit the SOAP/Progress Note by adding additional information.
3. Edit the SOAP/Progress Note by deleting one sentence from previously saved data.
4. Edit the Medications Prescribed field by adding, "Client has a history of abusing psychotropic medications".

Encounters - Adding Visit Admin

1. After completing the top portion of the data entry for this encounter, tab or use the Up/Down arrow keys to enter the Administrative Data Items.
2. Select Activity Code from the Job Aide and type in the number or first few letters of the description in the "Activity" field.
3. If a list of options is displayed, enter the number of the appropriate activity type and press [Enter].
4. Activity Time: Enter time in minutes.
5. Number served: Defaults to 1; change as needed.
6. Other fields are optional.

Reminder: CPT codes will pass to the Third Party Billing package depending upon the choice of Activity and POV codes and the Link to PCC.

Encounters - Adding Patient Education

1. Move to the Patient Education field, type a [Y] for yes and press [Enter]
2. If you wish to view historical Patient Education data, type a [Y] at the Display Patient Education History prompt. When finished viewing the information, type [Q] to return to the data entry fields.
3. On the Patient Education Enter/Edit screen, type in the code for the Education Topic as found in the Patient Education Protocols 2005. Press [Enter] to move to the Ind/Grp field.
4. Enter an [I] for individual or [G] for group education & press [Enter].
5. Enter the time (in minutes) spent providing patient education & press [Enter].
6. Select a level of understanding (Poor; Fair; Good; Group- no assessment) & press [Enter].
7. Provider may enter a comment from 2-100 characters in length.
8. Press the [F1] key and then the [C] key to return to the previous screen.

Encounters - Adding Health Factors

1. Move to the Health Factors field, type a [Y] for yes and press [Enter].
2. If you wish to view historical Health Factor data, type a [Y] at the Display Health Factor History prompt. When finished viewing the information, type [Q] to return to the data entry fields.
3. On the Patient Health Factor Update screen, type in the first few letters of the health factor or a [??] to see the list of factors specific to your facility. Follow the instructions at the bottom of the screen.
4. Level of Severity is an optional field. If appropriate, select from **M**inimum, **M**oderate, or **H**eavy/Severe, enter the information in the field and press [Enter].
5. Quantity is an optional field. When a quantity is relevant, a number greater than 0 should be entered. Additional health factors may be entered. Pressing [Enter] on a blank line will inform the computer that this section has been completed.
6. Provider may enter a comment from 2-100 characters in length.
7. On the command line, press [Enter] to accept the default [Close] and return to the previous screen.

Encounters - Adding Intimate Partner Violence/Domestic Violence Screening (IPV/DV) GPRC Clinical Performance Indicator

1. Move to the IPV/DV Screening field, type a [Y] for yes and press [Enter].
2. If you wish to view historical Intimate Partner Violence/Domestic Violence (IPV/DV) data, type a [Y] at the Display IPV/DV History prompt. When finished viewing the information, type [Q] to return to the data entry fields.
3. On the IPV/DV Screen, select a Screening/Exam Result (**N**egative, **P**resent, **P**ast, **U**AS unable to screen, or patient **REF**used screening), enter the information in the field and press [Enter].
4. The provider is defaulted to the individual logged in. If this is not the provider who conducted the screening, type in the provider's name and press [Enter].
5. Comment section may be used to enter information that is not contained in the narrative portion of the progress/SOAP note. Comment may be 2 – 245 characters in length.

Encounters - Editing/Deleting Patient Education, Health Factors and IPV/DV Screenings

Editing may be completed prior to the visit being saved or later. To edit the education or health factors while entering visit/encounter demographics:

1. Return to the field containing the code to be edited & press [Enter].
2. Change the information, return to the command line at the bottom of the screen and press [Enter].

Encounters - Saving Data

1. After reviewing and editing data as needed, move to the command line at the bottom of the screen.
 - a. Type in Save and press [Enter] and then Exit and press [Enter]; **or**
 - b. Type in Exit and press [Enter] and then select [Y] when asked if you want to save the data before leaving the form; **or**
 - c. Type [F1] and [E] keys to save and exit.

Encounters - Printing

1. After saving the encounter record, the "Other Information" screen will be displayed.
2. Type in #6, Print an Encounter and press [Enter].
3. Select the type of form you want to print (Full, Suppressed, Both or multiple copies).
4. At the prompt type the code for the selected format and press [Enter].

Encounters - Adding an Intake Document

Documentation completed on the Update Intake Document screen will print out as part of the Encounter Record. A separate Intake Document can be printed from this screen by selecting PI, Print Intake Document.

Copying and pasting an intake from another word processing application will work if the formatting within the document is simple. For example, check boxes, tables, etc. will not copy into this field. Formats can't be saved within the computer application; however, it is possible to copy from a previously entered document.

1. Select an Intake visit type.
2. Enter all required data.
3. Saving the encounter will automatically prompt for the Intake documentation.
4. Enter free text or use the copy/paste functionality to complete Intake documentation.
5. Click on [Save].

Encounters - Entering the SAN New and SAN F/U Information

1. Select a SAN New or SAN F/U visit type.
2. Enter all required data.
3. Saving the encounter will automatically take you to the SAN New or SAN F/U screen.
4. At the Select Action prompt, press [Enter]; then list the numbers of the items you wish to add, such as 1,5,7.
5. All fields are optional. If no data is available, do not select that number.
6. After the data is entered, the application will return to the Select Action prompt. Type [Q] to quit data entry.
7. At this point, the encounter information is saved and may be printed.

Encounters - Adding CD Staging

The Staging Tool results can be entered on the Intake, Regular and A/SA visit types by responding YES at the prompt:

```
ACTIVITY:      ACTIVITY TIME:      # SERVED: 1      VISIT FLAG:
LOCAL SERVICE SITE:      INTERPRETER?
Would you like to update the Staging Tool?  N
```

After the visit is saved, the fields for the Staging Tool will be displayed.

1. Days Used Alcohol & Days Used Drugs: Enter number of days client reports using alcohol and/or drugs in the past six months. Record all answers in days.

2. Enter Drug Types: Enter [Y] to access the next text box. Enter all categories of drugs used by the client; press [Enter] on a blank field to close the text box.
3. Alcohol-related Arrests: Enter number of arrests within the past six months.
4. Days Hospitalized: Enter the number of days within the past six months that the client has been hospitalized due to alcohol-or-drug-related illnesses or complications.
5. Tobacco Use: Using ??? to see the list of tobacco-related Health Factors, select the category that best describes the client's current use. Then use ^ ([shift] [6] keys) to exit the list and type in the factor.
6. Stages: Enter a score from 1 to 6 for each of the seven stages. The staging average will be calculated as the scores are entered.
7. Select a Recommended placement based on the staging average; select an actual placement and, if different than the recommended placement, enter a difference reason.

Reminder: In order to look at a complete list of options, a "?", "??", or "???" may be entered in any field that has a text box. For example, in the box labeled "Component Code"; enter a "?" and press [Enter]. Using additional question marks will give you more information.

Encounters - Adding CD Data

The A/SA Visit Type is the only visit type that includes the ability to enter the CD Data. The CD Data includes the Component Code; Type of Component; and the Type of Contact. On this visit type, these are required fields displayed in the body of the encounter record.

Enter days in residential treatment and/or days in aftercare within the past six months, if appropriate.

Follow established procedures to save the data and print an encounter record.

Suicide Form – Adding Data

1. At the Select Suicide Forms prompt, choose SFP to add a form for a specific client.
2. Select the Patient Name.
3. Choose AF to add a new report.
4. Enter the date and provider name as requested.
5. Add a local case number (if used), Provider and Date of the Act.
6. Enter the name of the community where the act occurred.

Reminder: The user will be prompted to complete a Suicide Form when entering a record (visit) that includes the Purpose of Visit codes for suicide (39, 40, or 41). The user has the option of completing the Suicide Form after saving the Visit entry or completing the form at a later time.

Suicide Form - Adding Personal Information

1. Employment status: Choices are Part-time; Full-time; Self-employed; Unemployed; Student; Student and Employed; and Unknown.
2. Relationship status: Choices are Single; married; Divorced/Separated; Widowed; Cohabiting/Common Law; Same Sex Partnership; and Unknown.
3. Highest level of education completed: Choices are Less than 12 years; High School Graduate/GED; Some College/Technical School; College Graduate; Post Graduate; and Unknown. If less than 12 years is selected, free text field will be displayed & number of years completed should be entered.

Suicide Form - Adding Self Destructive Act Information

1. Self Destructive Act: Choices are Ideation with plan and intent; Attempt; Completed Suicide; Attempted Suicide with Homicide; Completed Suicide with Homicide.
2. Location of Act (not the community): Choices are Home or Vicinity; School; Work; Jail/Prison/Detention; Treatment Facility; Medical Facility; Other; and Unknown.
3. Lethality: Choices are Low, Medium and High.
4. Disposition: Choices are Mental Health Follow-up; Alcohol/Substance Abuse Follow-up; In-patient Mental Health Treatment (Voluntary); In-patient Mental Health Treatment (Involuntary); Medical Treatment (ED or Inpatient); Outreach to Family/School/Community; Other; and Unknown. If other is selected, free text field will be displayed & description should be entered.

Suicide Form - Adding Other Statistical Data

1. Type the number of previous attempts, based on information provided by the client. Choices are 0,1,2,3 (3 or more), and Unknown.
2. Method tab: Press [Enter] to access box. Enter method(s) or view a list of choices by typing [??] and pressing [Enter]. If "Overdose" is entered, the user needs to add the categories of medications/drugs used in this attempt.
3. Substance Use tab: Refers to substances involved in this incident, even if overdose was not the primary means. For example, the client got drunk so that he could "get up enough nerve to drive his car into the bridge abutment". In this case, Alcohol would be entered on this screen. If Overdose is entered on the Method screen, then the categories of medications should also be selected here.
4. Contributing Factors: Select all that apply. If "Other" is selected, the free text box will be displayed and an explanation should be entered.
5. Describe in your own words (Narrative): Record in your own words events which you feel contributed to this suicide encounter. This is not the location for your SOAP or progress note. In addition to the textual description this field may also be used to record additional information such as the inpatient facility's contact person and phone number, etc.

Reminder: Information added to the Suicide Form will not be saved until the user returns to the command line and saves/exits the screen.

Suicide Form - Printing

1. Return to the Suicide Form List View and enter DF on the command line to display the form.
2. At the command line, enter the number of the Suicide Form to be printed, and press [Enter].
3. The next prompt will require a selection of either printing the form or viewing it on the computer screen.
4. After printing the document, type [Q] and press [Enter] to return to the List View.

Suicide Form - Editing

1. Return to the Suicide Form List View.
2. Type [EF] and press [Enter].
3. Make changes to the data as needed.
4. When finished editing the fields, return to the command line, save and exit.

Suicide Form - Deleting

1. Return to the Suicide Form List View and type [XF] and press [Enter]
2. At the command line, type the number of the entry to be deleted and press [Enter].
3. A confirmation prompt will be displayed, requiring a Yes/No answer.

4. If yes is typed at the confirmation prompt, the information has now been permanently removed from the record.

Reminder: If an encounter record (visit) has been entered, it is not deleted when the Suicide Form is deleted. To delete a visit, the user must go to the Patient Data Entry screen, select EV to edit the visit and follow the instructions on the next screen.

Treatment Plan - Log On

1. Log onto BHS v3.0 and select Data Entry (DE).
2. Select the Update BH Patient Treatment Plans (TPU) option from the Behavioral Health Information System menu.
3. At the prompt, type [UP] to add, edit or delete a treatment plan.
4. Search for your patient by typing one of the following: name, Social Security #, Medical Record #, DOB (MM/DD/YY) and press [Enter]. Patients matching your search criteria will be returned. If only one match, skip to step 5. If more than one name is returned, enter the number for your client and press [Enter].
5. Select Add Treatment Plan (AD) from the menu options on the Update Patient Treatment Plan Screen and press [Enter].

Treatment Plan - Information

1. Treatment Plan basic information will be presented in a roll & scroll mode. Each question must have a typed response before moving to the next one. The application does not allow the user to return to a previous line.
2. Program, Case Admit Date and Designated Provider are all required fields.

Treatment Plan – Adding Diagnosis/Problem Information

1. Axes I - III: a prompt will appear showing the existing text and asking if the user wants to edit it. Responding with a [Y] for yes will result in the display of a free text box where the information can be entered or edited.
2. Axis IV: Enter any numerical values for Axis IV. Axis IV fields will continue to be displayed until the user presses [Enter] on a blank field.
3. Enter the GAF (0-100) for Axis V.
4. Problem List: Enter any information that may reflect the client's current situation. Size is limited to 240 characters (includes spaces, commas, etc.)

Treatment Plan - Adding the Plan Narrative

1. Problems/Goals/Objectives/Methods: Information may be entered into the free-text boxes or pasted from a word processing program. To enter the free text box, respond with a [Y] at the prompt.
2. After completing data entry, press [F1] [E] to close the text box and return to the primary screen.

Treatment Plan - Adding the Plan Update Information

1. Resolve by Date: What is the target date for the completion of the goals outlined in the treatment plan?
2. Next Review Date: When will the team be reviewing the client's progress? This is a projected date for the next review. This date should never be the same day or before the date treatment plan established".
3. Status: Choices are Active, Inactive or Resolved.
4. Concurring Supervisor: Does your facility require a supervisor to sign treatment plans or is the Designated Provider authorized to sign treatment plans without a concurring supervisor's signature? If no signature is required, leave this field blank.

5. Concurring Date: Enter the date the supervisor signed off on the Treatment Plan, if required.
6. Date Closed/Resolved: Leave blank until client is no longer receiving services or has been transferred to another facility or program.

Treatment Plan - Printing or Viewing

1. On the Update Patient Treatment Plan screen, select [DS] to display or print a plan.
2. If multiple plans are listed, enter the number for the plan to be viewed/printed.
3. At the next prompt, select one of the following: **Treatment Plan Only**; **Treatment Plan Review Only**, or **Both the Treatment Plan and Reviews**.
4. At the next prompt, select either print or browse.

Treatment Plan - Adding Reviews

1. Return to the Treatment Plan List View and select RV to review a plan.
2. On the Treatment Plan Review Update screen, enter the date of the treatment team meeting or date the review was signed as the "Review Date".
3. Enter the name of the Reviewing Provider and Reviewing Supervisor (if required).
4. Progress Summary: Optional field. Use the free-text box to record the client's progress since the last case review.
5. To enter a list of the Review participants, type in each person's name and relationship to the client and type in the participant's name and their relationship to the client.
6. Type in a date at the Next Review Date prompt and press [Enter].

Treatment Plan - Printing or Viewing the Reviews

1. On the Treatment Plan List View screen, identify the Treatment Plan containing the Review you want to view or print.
2. At the prompt, type in [DS] to display/print the treatment plan.
3. At the next prompt, enter the number of the treatment plan or review to be printed and press [Enter].
4. At the next prompt, select one of the following: **Treatment Plan Only**; **Treatment Plan Review Only**, or **Both the Treatment Plan and Reviews**.
5. At the next prompt, select either print or browse.

Designated Provider(s), Patient Flag & Personal History

1. Log onto BHS v3.0.
2. Select the Data Entry (DE) option from the Behavioral Health Information System menu.
3. Select PDE on the Data Entry menu.
4. Search for your patient by typing one of the following: name, Social Security #, Medical Record #, DOB (MM/DD/YY) and press [Enter]. Patients matching your search criteria will be returned. If only one match, skip to step 5. If more than one name is returned, enter the number for your client and press [Enter].
5. Select the Designated Provider/Flag/Personal History (OI) option and press [Enter].
6. After the "Update Patient Information" screen is displayed, add or edit information by pressing [Enter] or [Tab] to move between fields.
7. Press the [F1] key and then [E], to save the information. The Personal History prompt will then be displayed.
8. The Personal History prompt requires a response. To exit without entering a new item, press the [shift] and [6] keys simultaneously. When the [^] is displayed, press [Enter].
9. To enter a Personal History factor, type [??] and press to see the list of factors available at your facility. Type the first three letters of the factor you wish to add for the patient and press [Enter].
10. The Personal History factor is then saved and the user is returned to the primary Data Entry menu.

Case Status - Adding

1. Enter the program (mental health, social services or chemical dependency) and the provider name.
2. Enter the Primary Problem – what is the main reason for treatment?
Enter the DSM/POV Code or the first few letters of the description.
3. If the client has not been admitted at this time, save the information and return to the List View.

Case Status - Editing

1. At the Case Status List View, select [ED] to edit information or to add information to existing Case Status.
2. Enter additional information such as the “Case Admit Date” or “Date Case Closed”.
3. At the command prompt, save and exit.
4. If “Date Case Closed” is being entered, the “Disposition” box will be activated and a reason must be entered before the information can be saved.

Reminder: Anytime a possible answer is followed by //, pressing the [ENTER] key will default to the entry displayed. If an alternative response is desired, it must be typed after the //.

Practice Scenarios

A. September 16th - An elderly female schedules an appointment with you for screening. She reports that her husband was at a Service Organization meeting, heard your community presentation on depression and is now convinced that she is depressed. She mentions coming in for the appointment to please him. The appointment lasts for 30 minutes. The client reports that she does not want to continue today and reschedules for September 23rd. Since the appointment was so brief, you are unable to complete a thorough assessment and decide to use the deferred diagnosis 799.9 for today's visit. (Brief Visit Type)

The agency you are working for uses the first contact date as the case open date. Please enter this case status information. Using your training ID, assign yourself as the Designated Provider for this client.

September 23rd - The client returns and completes the intake assessment. After reviewing the results of the interview with her, she agrees to enter treatment. She is still somewhat in denial but appears motivated to continue. You schedule another appointment to begin counseling next week. Use a diagnosis of 296.31, Major Depressive Disorder, Recurrent, Mild. (Intake Visit Type)

September 30th – the client returns for her appointment and agrees to a treatment plan that has been mutually developed, based on the assessment results. Enter a visit for individual therapy (Regular Visit Type) and a Treatment Plan.

Now that the treatment plan has been signed, enter a case status of admitted as of September 30th.

October 27th – During a regular counseling session, the client reports that she was abused physically as a child and has difficulties with relationships as a result of the abuse. She claims that she is unable to bond with other females, has few friends, and is only able to feel comfortable in social settings if she is drinking. When screened for alcohol and drug problems using the CAGE, the client replies affirmatively to two out of the four questions. Complete the visit documentation;

1. Add a Personal History of Child Abuse – Victim;
2. Add a screening for alcoholism POV;
3. Add a Health Factor of CAGE 2/4; and,
4. Record a referral to the local alcohol and drug abuse clinic.

November 3rd – The client has been making excellent progress in treatment – appears to be recognizing her symptoms and is beginning to respond to the antidepressant medication. She reports that her relationship with her husband has not improved significantly and he is refusing to enter into couple's therapy. She is feeling despondent over her husband's continued threats to leave her. During the counseling session, she admits that she has been thinking about killing herself. Further discussion reveals that she has a gun and has thought about going to her husband's camping cabin and shooting herself. She doesn't feel that she is important to anyone and believes that her family would be better off without her. After further discussion, she agrees to sign a No Harm contract and to call immediately if she feels like harming herself. She agrees to call her husband from your office to ask him to place the weapons in a safe location. Enter a Regular Visit Type using **Problem Code 39** and then complete a Suicide Surveillance Report.

November 4th – As agreed, the client calls to report her status. Her husband has given the guns to his brother temporarily and has talked to his wife about his feelings. She indicates that he is spending more time with her and that she is starting to feel hopeful. As agreed yesterday, you contacted her husband earlier in the day to verify that the guns have been safely stored. You mention to the client that her husband seems concerned about her wellbeing and has stated that he might be amenable to couple's counseling. Enter a telephone contact using the Brief Visit Type.

November 29th – Now that the client’s husband has left her, you decide to conduct a formal assessment using one of the depression assessment tools as a means of reviewing her progress. Client expresses an understanding of her progress and the need to continue her medication and individual sessions. Document an encounter for this date, changing the diagnosis to 296.32, Major Depressive Disorder, Recurrent, Moderate.

December 15th – Due to the significant changes in the client’s life, she agrees to complete a treatment plan review, adding additional information. Complete a Treatment Plan Review with the client present and yourself.

January 20th – The client reports that she would like to enter a Halfway House while she rebuilds her life. She states that she has recently lost her job because she is unable to concentrate and remains separated from her husband, so she is able to be away from the community for an extended period of time. Complete a Regular Visit Type and enter the Placement Disposition. Enter a Treatment Plan Review to record the plan as inactive. Enter a revised Case Status to indicate the client is discharged/transferred to another resource.

B. Using the scenario above, select any adult male patient. Change the diagnosis to Alcohol Dependency and complete data entry using the same dates of service. For the Intake visit, enter the following Staging Tool results:

The client reported that he has at least three drinks each day but never uses drugs. He denies any arrests or hospitalizations related to his drinking. Client reports that he used to smoke but gave it up when his first child was born five years ago.

Alcohol/Substance	2	Physical	3	Emotional	2
Social	3	Cultural/Spiritual	2	Behavioral	2
Vocational/Educ	3				
Recommended Placement	Primary Residential	Actual Placement	Intensive Outpatient	Difference Reason	Client’s Choice

Values for Staging Tool

C. The patient is a female with a diagnosis of Schizophrenia, Undifferentiated type. Patient reports that auditory hallucinations are present but not distressing, consistent with her usual baseline.

Appetite and sleep patterns are normal. Patient reports that she is doing well in her sheltered work program; continues to live at home with her parents and is getting along well with family members. Patient states she is binge drinking 1-2 times per week. Patient did not display any signs of akathisia, tremor or rigidity.

Brief Impression: Currently stable on meds

Plan: Continue current medication regimen; Olanzapine 10 mg. PO q hs. Continue participation in sheltered work program and SMI Case Management program. Refer to tribal A/SA program for further assessment of alcohol use.

Patient Education: Advised patient about weight-gain potential of Olanzapine and recommended that she decrease the amount of simple sugars in her diet.

Record as BH-M (Behavioral Health – Medication), 10 minutes, Fair

Health Factor: CAGE 2/4, Heavy, (Quantity not required)

D. A male child is referred to the Social Services Department by pediatric clinic staff. Dr. Elizabeth Johnson has evaluated the child and reports he has bruising consistent with an electrical cord being used for discipline. The alleged abuser is an uncle whose name is John B. He is the current legal guardian for the child and lives at 223 North Cliffside Road in Little Bigwater.

- The home address is the same as above.
- The natural parents have been deceased for 8 years.
- Officer Charley Smith has taken the complaint (#2334478) earlier today.
- There is a history of prior incidents reported in the medical record and by social services. The uncle apparently has a severe drinking problem.
- There is an aunt (Clarissa B., Box 23, Little Bigwater, telephone (520) 333-4333) who has taken the child in the past and is willing to do so again.
- The risk of re-injury appears high as the patient reports that the uncle threatened to “show you what a whipping is if you tell anyone about this”.

Follow Up Visit – one week later

A telephone call to Tribal Social Services reveals the uncle has been drinking heavily for several months. A criminal charge is in process of being adjudicated in court. The uncle has apparently admitted to inflicting the injuries “to keep his wildness under control – that boy don’t listen”. The boy has been placed for the foreseeable future with his aunt Clarissa B. and proceedings have been started to divest the uncle of guardianship.

The boy is also attending weekly counseling with the school counselor and appears to be adapting well into his new home.

Tribal Social Services is continuing the case until the guardianship issue is resolved and the placement with his aunt becomes permanent.

Risk of re-injury in current placement appears low.

Document the encounters using the SAN New and SAN Follow Up visits.

E. You are called to the local hospital emergency room to assist in determining if a teenager needs to go to an inpatient facility or can be treated successfully in the community. She had been transported to the ER following an overdose at school. While conducting your interview with the patient, she reveals that she was making a serious suicide attempt by trying to overdose on acetaminophen and denies any history of substance abuse. She then states that she has no prior history of substance use or abuse but does have two previous suicide attempts.. She shows you the scars on her wrists from one attempt and says that the other attempt involved jumping off a bridge into a lake.

Demographics: Use community where training is taking place as the community where the act occurred; use training ID as the provider ID; and select a date within the past 30 days as the date of occurrence.

Personal information: Not currently employed; single; and finished 10th grade in school.

F. Select any male in the 20-40 age range and record a No Show for a regularly scheduled appointment with you. The client did not call to cancel or reschedule. Since the client is on probation, you used 15 minutes of the allotted hour to prepare a report on frequent no shows for the probation officer.

G. Enter a regular visit with an IPV/DV Screening for a female client in the late teens – 40 age range.

Objective #3: Other BH Options

Record all required elements for group encounters, non-patient activities, and administrative records.

Purpose:

The purpose of this exercise is to introduce you to the other BH options and their data entry fields and to describe how these differ from the other visit types.

Overview:

It is important that all users of the BHS v3.0, regardless of their discipline, be able to key in data for a group encounter visit, for non-patient activities and for administrative records. Complete encounter data is critical for many reasons and helps to improve patient care, billing, and can be used to substantiate funding.

Skills You Will Acquire:

Upon completion of this objective, you'll be able to:

- Enter all data elements for the group including the group SOAP/progress note
- Duplicate a previously defined group and enter all required information
- Generate a No Show note for a group member
- Enter data for non-patient-related activities
- Enter data for administrative record keeping

Log On

1. Log onto BHS v3.0.
2. On the Data Entry menu, select [GP] for Group Form Data Entry Using Group Definition.
3. At the List View screen prompt, enter [1] to add a new group.

Group - Adding Visit Information

1. Enter the Encounter Date and press [Enter].
2. At the Add/View/Update Providers prompt. Enter [Y] and press [Enter].
3. Enter the Primary and Secondary Provider information and return to the command line at the bottom of the screen. Press [Enter] to close the window.
4. Modify the date and time as needed.
5. Enter the type of program – mental health, social service, chemical dependency or other.
6. Enter a unique group name.
7. Enter the community and the clinic where the service was provided.
8. Activity Code may be entered as 91, Group or another code that would further identify the group or type of activity.
9. Enter the Encounter Location and the Activity Time (total time for the group).
10. Enter the Type of Contact.

Group - Adding Group Data

1. POV or DSM – required field. Press [Enter] to open the data entry box. Enter the diagnosis or diagnoses that fit(s) all group members.
2. Enter any applicable CPT codes such as 90853, Group Psychotherapy.
3. Press [Enter] to add the standard group note. Press [F1] [E] to return to the main screen.
4. Press enter to add the patients to the group. When all patients have been added, press [F1] [C] to return to the main screen.
5. Type [S] to save the data and press [Enter]. Then type [E] and press [Enter] to leave the group data fields and begin patient data entry.

Group - Adding Patient Data

1. The next screen is a display of the group definition with a prompt asking you to indicate if you wish to edit it or continue with entering patient visits. Once data is correct, enter [Y] to continue.

2. Enter the time (in minutes) this patient spent in the group session.

Reminder: The Time in Group field is used to record the actual time a patient spends in the Group activity. A client may arrive late or leave early and is unable to fully participate. E.g., the group meets for 90 minutes but the client only attends for 45 minutes - record [45] in the Time in Group field.

3. An additional diagnosis or problem code may be entered for this individual client at the next prompt. If no additional coding is needed, press [Enter] and continue.
4. SOAP/Progress Note – the prompt will ask if the information needs to be edited. If entering new or additional information, pressing [Y] and then [Enter] will open a free text box. The group note will be displayed.
5. Type the client-specific notes in this section or use the copy/paste functionality to transfer the information from a word processing document. Press [F1] [E] to close the window.
6. Continue with the next client.
7. After information has been completed for all clients, press [Enter] to continue.
8. At the list view, type in [5] to print the group encounter records and press [Enter].
9. If there are multiple group entries displayed, type in the number for the group to be printed and press [Enter].
10. Select the type of form to be printed – Full, Suppressed, Both, 2 Full, or 2 Suppressed. Press [Enter] to accept the Device and Right Margin. Once forms have printed return to the List View.

Group – Duplicating the Group Definition

1. Log onto BHS v3.0 and select [DE] for Data Entry.
2. On the Data Entry menu, select [GP] for Group Form Data Entry Using Group Definition.
3. At the List View screen prompt, enter [3] to duplicate an existing group.
4. Select the group entry to be duplicated, enter the corresponding number at the prompt and press [Enter].
5. Enter the Encounter Date and press [Enter].
6. At the Add/View/Update Providers prompt. Enter [Y] and press [Enter].
7. Edit/Enter the Primary and Secondary Provider information and return to the command line at the bottom of the screen. Press [Enter] to close the window.
8. Modify the arrival time as needed.
9. If needed, edit the other duplicated visit information - type of program, the community and clinic where the service was provided, Activity Code, Encounter Location or type of contact.

Group – Duplicating/Editing Group Data

1. POV or DSM – required field. Press [Enter] to open the data entry box. Edit/Enter the diagnosis or diagnoses that fit(s) all group members.
2. Edit/Enter any applicable CPT codes such as 90853, Group Psychotherapy.
3. Press [Enter] to edit the standard group note. Press [F1] [E] to return to the main screen.
4. Press [Enter] to edit/add/delete the patients. Patients who were no shows should be removed at this time. The no show notes will be written as a separate function. When all patients have been edited/added/deleted, press [F1] [C] to return to the main screen.
5. Type [S] to save the data and press [Enter]. Then type [E] and press [Enter] to leave the group data fields and begin patient data entry.

Group – Duplicating/Adding Patient Data

1. The next screen is a display of the group definition with a prompt asking you to indicate if you wish to edit it or continue with entering patient visits. Once data is correct, enter [Y] to continue.
2. Enter the time (in minutes) this patient spent in the group session.

Reminder: The Time in Group field is used to record the actual time a patient spends in the Group activity. A client may arrive late or leave early and is unable to fully participate. E.g., the group meets for 90 minutes but the client only attends for 45 minutes - record [45] in the Time in Group field.

3. An additional diagnosis or problem code may be entered for this individual client at the next prompt. If no additional coding is needed, press [Enter] and continue.
4. SOAP/Progress Note – the prompt will ask if the information needs to be edited. If entering new or additional information, pressing [Y] and then [Enter] will open a free text box. The group note will be displayed.
5. Type the client-specific notes in this section or use the copy/paste functionality to transfer the information from a word processing document. Press [F1] [E] to close the window.
6. Continue with the next client.
7. After information has been completed for all clients, press [Enter] to continue.
8. At the list view, type in [5] to print the group encounter records and press [Enter].
9. If there are multiple group entries displayed, type in the number for the group to be printed and press [Enter].
10. Select the type of form to be printed – Full, Suppressed, Both, 2 Full, or 2 Suppressed. Press [Enter] to accept the Device and Right Margin. Once forms have printed return to the List View.

Group – Duplicating/Printing No Show Notes

1. Log onto BHS v3.0.
2. On the Data Entry menu, select [GP] for Group Form Data Entry Using Group Definition.
3. At the List View screen prompt, enter [7] to duplicate an existing group.
4. If there are multiple group entries displayed, type in the number for the group session the patient failed to attend and press [Enter].
5. Search for your patient by typing one of the following: name, Social Security #, Medical Record #, DOB (MM/DD/YY) and press [Enter]. Patients matching your search criteria will be returned. If only one match, skip to next step. If more than one name is returned, enter the number for your client and press [Enter].
6. Enter the Primary Provider and press [Enter].
7. Follow the standard procedures for documentation of the No Show.
8. If more than one patient was absent, repeat the procedure starting with #3 above.

Group – Review/Edit Group Visits

1. Return to the Group Entry List View.
2. At the Select Action prompt, type [6] and press [Enter].
3. Enter the display number for the group to be displayed, edited or deleted and press [Enter].
4. The next screen will display a list of all patient records associated with the group.
5. At the prompt, select one of the following: [AE] to Add/Edit a Patient's Group Visit; D to Display a Patient's Group Visit or [X] to Delete a Patient's Group Visit.
6. Follow the instructions and return to the list view.

Group – Delete the Definition from the List View

1. Return to the Group Entry List View.
2. At the Select Action prompt, type [4] and press [Enter].
3. Enter the display number for the group definition to be deleted and press [Enter].
4. The next screen will display the data entry field definitions and a list of all patients associated with the group.
5. At the prompt, if you want to remove this group from the list view, type [y] and press [Enter]. If you want to keep this group on the list view, press [Enter] to accept the default of [no].

Reminder: Removing the group definition using this action #4 will not remove the individual patient encounter records. This function simply removes the group from the display. If you want to remove the individual records, use option #6, Review/Edit Group Visits or access each individual patient's record display and delete the encounter record.

Non-Patient Record – Adding

1. Log on to BHS v3.0 and select DE for data entry.
2. Select [SDE] for the Full Screen Mode and press [Enter].
3. Select the default – **Mental Health**, **Social Services**, or **Chemical Dependency**.
4. Enter the date of the activity.
5. At the List View, select [AN] to add a non-patient record and press [Enter].
6. Enter the Primary Provider and press [Enter].
7. Enter the required information (underlined items) and optional items as desired. Number served may be 0 through 999.
8. Prevention Activities – if the activity needs to be recorded as a prevention service, type [Y] and press [Enter]. A text box for entering the Prevention Activity will be displayed. Identify the type of activity and the target audience.
9. At the POV prompt, press [Enter] to update the Purpose of Visit. When data entry is completed in the text box, press [F1] [C] to close the box.
2. After reviewing and editing data as needed, move to the command line at the bottom of the screen.
 - i. Type in **Save** and press [Enter] and then **Exit** and press [Enter]; **or**
 - ii. Type in **Exit** and press [Enter] and then select [Y] when asked if you want to save the data before leaving the form; **or**
 - iii. Type [F1] and [E] keys to save and exit.

Non-Patient Record - Editing

1. Select [SDE] on the Data Entry Menu screen and press [Enter].
2. Enter the date of the activity.
3. At the List View, select [EV] to edit a record and press [Enter].
4. Enter the number of the item to be edited and press [Enter].
5. Make the changes to the information as needed. After editing is complete, return to the prompt at the bottom of the screen and save the changes.

Non-Patient Record – Deleting

3. Select [SDE] on the Data Entry Menu screen and press [Enter].
4. Enter the date of the activity.
5. At the List View, select [DE] to delete a record and press [Enter].
6. Select #1, Delete record.

7. Enter the number of the item to be deleted and press [Enter].
8. The record will be displayed for review prior to proceeding with the delete function.
9. The next prompt will ask if the user is sure that the record should be deleted.
10. Typing [Y] will immediately remove the record.
11. Press [Enter] to continue and return to the List View.

Administrative Record - Log On

1. Log on to BHS v3.0 and select DE for data entry.
2. Select [ADM] for Admin Record Entry and press [Enter].
3. Select the default – **M**ental Health, **S**ocial Services, or **C**hemical Dependency.

Administrative Record - Adding

1. Enter the Encounter Date and the Primary Provider.
2. Enter an Activity Code that is not patient centered.
3. Enter activity time as minutes. For example, six hours = 360 minutes.
4. Number served – enter 1 for most activities. If presenting information to a group, etc., the user may enter the total number of individuals attending.
5. Enter the Primary POV for the activity.
6. Use the Provider Narrative box to enter a description of the activity such as the course name or continuing education.
7. Add any comments in the free-text field.
8. Pressing [Enter] will return the user to the Data Entry Menu.

Administrative Record - Printing

1. Select [SDE] on the Data Entry Menu screen and press [Enter].
2. Enter the date of the activity.
3. At the List View, select [PF] to print a form and press [Enter].
4. Enter the number of the item to be printed and press [Enter].
5. Select the type of form to be printed (Full, Suppressed, etc.) and press [Enter].

Administrative Record - Editing

6. Select [SDE] on the Data Entry Menu screen and press [Enter].
7. Enter the date of the activity.
8. At the List View, select [EV] to edit a record and press [Enter].
9. Enter the number of the item to be edited and press [Enter].
10. Make the changes to the information as needed. After editing is complete, return to the prompt at the bottom of the screen and save the changes.

Administrative Record – Deleting

12. Select [SDE] on the Data Entry Menu screen and press [Enter].
13. Enter the date of the activity.
14. At the List View, select [DE] to delete a record and press [Enter].
15. Select #1, Delete record.
16. Enter the number of the item to be deleted and press [Enter].
17. The record will be displayed for review prior to proceeding with the delete function.
18. The next prompt will ask if the user is sure that the record should be deleted.
19. Typing [Y] will immediately remove the record.
20. Press [Enter] to continue and return to the List View.

Practice Scenarios

A. You are the facilitator for a medication education group for clients diagnosed with Major Depressive Disorder, Single episode, in partial remission. You follow the IHS patient education protocol for Behavioral Health – Medication during this one-hour group session. Today, only three of the group members attended. Two were attentive but did not actively participate in the discussion. The third group member was quite engaged and talked frequently.

Enter the group data for this scenario. Select a date that is at least one week ago. Add both the group note and individual notes for each client.

Then duplicate the group and record information for today's session. Write a no-show note for one group member.

B. Enter a group session dated one month ago for this scenario - You are the facilitator of a Children of Alcoholics therapy group that meets at the clinic every Wednesday night for two hours. You have four clients who have attended to discuss the first two Chapters of Claudia Black's book. The group focuses on her statement that there is an Elephant in the Living Room and its implications in their own lives.

POV/Diagnosis for the group is 62, Other Family Life Problems and the Activity Code is 91, Group Treatment (please change the narrative to "Clinic Visit").

Today's date: Duplicate the group and accept POV, providers, etc, as previously defined. One of the group members was unable to attend – please complete all required documentation for a no show.

During the group tonight, one of the clients acknowledges that she has a problem with alcohol and group members spend some time discussing this and the possibility that other group members may have some dependency issues also. Add a chemical dependency POV or DSM diagnosis to one of the group members. One of the other group members became upset when the group began discussing the possibility that they may also have dependency issues. She left the group at the end of the first hour rather than staying for the whole group session.

C. You are participating in a two-hour community health fair – operating a booth to provide information on mental health services. Record this as an administrative entry.

D. You are doing a presentation on alcohol and drug prevention for the teachers at the Middle School. Please record this as a Non-Patient Record and identify the type of Prevention Activity and the Target. Record the number of participants.

E. You are the writer of a series of articles to be published in the local newspaper. The topic of the articles is Domestic Violence. Please enter this record, identifying the type of Prevention Activity and the Target.

F. You are attending RPMS BH GUI training for two days. Each day's training last six hours or 360 minutes. Record your time in this training as an administrative entry. Change the narrative to indicate that this was BH GUI training. Comments are optional.

G. You are teaching a three-hour class on updates to the DSM IV-TR and appropriate clinical documentation.

H. You are the supervisor providing clinical supervision to one of the staff for one hour.

Objective #4: Reports

Access the Reports menu, identify specific reports, and run a sample report.

Purpose:

The purpose of this exercise is to introduce you to the various types of reports that can be generated through BHS v3.0.

Overview:

It is important that all users of the BHS v3.0, regardless of their discipline, be able to generate a report showing patient contacts, a clinician's caseload, or Treatment Plans needing revision. Generating reports enables the provider to monitor encounter data for accuracy, manage resources efficiently and provide encounter data to governing bodies, funding sources, etc.

Skills You Will Acquire:

Upon completion of this objective, you'll be able to:

- Identify reports that can be generated in BHS v3.0
- Select report parameters including time frames, clinicians, types of visits, etc.
- Generate reports to display an individual clinician's caseload, treatment plans needing revised, and aggregated suicide data
- Print generated reports to a selected printer or view on your computer screen

Log On

1. Enter your access and verify codes and click [Enter].
2. Type in the Behavioral Health program title from the menu and click [Enter].
3. Type in "RPTS" and click [Enter] to access the Reports menu.

Generating an Active Client List

1. Type "PAT" to select Patient Listings Reports and click [Enter].
2. Type "ACL" for an Active Client List and click [Enter].
3. Type a Beginning Date of 30 days ago (T-30) and click [Enter].
4. Type an Ending Date of today (T) and click [Enter].
5. If you are interested in one particular provider's caseload, type in a "Y" and click [Enter] when asked "Limit the list to those patients who have seen a particular provider?" If you want to see the information for all providers at your clinic (or in this class), type "N" and click [Enter].
6. If you answered "Yes", type in the provider's name (last name, first) and click [Enter].
7. Click "Print" to generate a hard copy of the report, or click "Browse" to view the report onscreen.
8. Follow the onscreen instructions to return to the Report Menu after completing this activity.

Generating a Treatment Plans Needing Resolved Report

1. Return to the Reports menu, type "PAT" and click [Enter].
2. Type "TPR" and click [Enter].
3. Type a Beginning Date of 90 days ago (T-90) and click [Enter].
4. Type an Ending Date of 90 days in the future (T+90) and click [Enter].
5. If you are interested in one particular provider's caseload, type in a "Y" and click [Enter] when asked "Limit the list to those patients who have seen a particular provider?" If you want to see the information for all providers at your clinic (or in this class), type "N" and click [Enter].
6. If you answered "Yes", type in the provider's name (last name, first) and click [Enter].
7. Click [Print] to generate a hard copy of the report, or click [Browse] to view the report onscreen.

Generating an IPV/DV Screenings Report (controlled by a security key)

1. Return to the Reports menu, type "PAT" and click [Enter]
2. Type [DVR]– IPV/DV and click [Enter]
3. Type [DVP] – Tally/List Patients with IPV/DV Screenings and click [Enter]
4. Type a Beginning Date and an End Date
5. At the next prompt, select all the items you wish to tally.
6. Answer all the remaining categories to select the data you wish to view.
7. Select [Browse] or [Print].

Generating an Aggregate Suicide Report

8. Return to the Reports menu, type "PROB" and click "Enter".
9. Type "SSR"– aggregate Suicide data – and click "Enter".
10. Type a Beginning Date and an End Date.
11. Type an "A" for all communities or "O" for one community.
12. If one community is selected, enter the name of that community and click "Enter".
13. Type a "P" to print the report or a "B" to view it on your computer screen.

Practice Scenarios

A. *Generate a caseload report for all providers who saw patients within the past 30 days. Browse it on your computer screen.*

B. *Generate a Report of Treatment Plans Needing Review using the beginning date of 30 days ago (T-30) and the ending date of 60 days from today (T+ 60). Select all providers for the report. Browse the report on your computer.*

D. *Generate an IPV/DV Screening report for the past 90 days, include information from other clinics and the name of the mental health, social services, or substance abuse provider. Browse the report on your computer.*

C. *Generate an Aggregate Suicide Report for all communities using a beginning date of 6 months ago and an end date of the last day of the previous month. Browse the report on your computer.*

Objective # Exporting

Routinely export behavioral health data to headquarters using the Export utility menu.

Purpose:

The purpose of this exercise is to discuss and demonstrate the Exporting process.

Overview:

It is important that all users of the BH GUI, regardless of their discipline, demonstrate an understanding of the data exporting process.

Manager Utilities Menu

The Manager Utilities menu provides options for Site Managers and program supervisors to customize the Behavioral Health System to suit their site's needs. Options are also available for administrative functions, including the export of data to the Area, re-setting local flag fields, and verifying users who have edited particular patient records.

Note: Not all users of the Behavioral Health System will be given access to this menu.

Export Utility Menu

Use this menu to pass data from your facility to the IHS Headquarters office for statistical reporting purposes. (Most users will not have access to this menu option).

These options should be familiar to site managers. 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.

```
___ GEN ___ Generate__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_  
___ ERRS ___ Print_Error_List_for_Export_  
___ OUTP ___ Create_OUTPUT_File_
```

Generate Transactions for HQ

This routine will generate BHS transactions to HQ. The transactions are for records posted between a specified range of dates. If you type ^ at any prompt, you will be asked to confirm your entries before generating transactions.

To generate BHS transactions to Headquarters, type GEN at the "Select Export Utility Menu Option:" prompt.

Type information as requested at the prompts that follow to record each entry.

Print Export Log

Use this option to print an export log.

- Type PRNT at the “Select Export Utility Menu Option:” prompt.
- Type information as requested at the prompts that follow and press the Return key to record each entry.

Check Records before Export

Use this option to review all records that have been posted to the BHS database since the last export was performed.

- Type CHK at the “Select Export Utility Menu Option:” prompt.
Note: This option will review all records that were posted from the day after the last date of that run up until two days ago.
- Type the information as requested at the prompts that follow and press the Return key to record each entry.

Print Error List for Export

Use this report to review all records that have been posted to the database and are still in error AFTER the latest Export/Generation.

- Type ERRS at the “Select Export Utility Menu Option:” prompt.
Note: The Check Records before Export option should have been used to determine all errors before running the generation. You may now correct these errors before the next export/generation.
- Type information as requested at the prompts that follow and press the Return key to record each entry.

Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Service Center by:

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