

BHS v3.0



IHS
Office of Information Technology
Albuquerque, NM

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 entry 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-direct patient activities, and administrative encounters.

Set Up



Objective #1: Access BHS v3.0 site parameters and set defaults, type of link to PCC, and SDE function.

Manager Utilities

```

SITE  Update Site Parameters
EXPT  Export Utility Menu ...
RPF  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
    
```

Select Manager Utilities Option: █

Update Site Parameters

```

** UPDATE BEHAVIORAL HEALTH SITE PARASite Name: CRON HO
***** DEFAULT VALUES IN DATA ENTRY *****
MH Location: CRON HO          SS Location: CRON HO
MH Community: CRON AGENCY    SS Community: CRON AGENCY
MH Clinic: MENTAL HEALTH     SS Clinic: MEDICAL SOCIAL SERVI
More Defaults (press enter):
-----
Default Health Summary Type: MENTAL HEALTH/SOCIAL SERVICES
Ask Interpreter Utilized? YES Universal/Site Spec. Lookup: SITE SPE
Default response on form print: BOTH Suppress Comment on Suppressed Form? YE
# of past POVs to display: 5 Exclude No Shows on Last DX Display? YS
-----
Type of Visit to Create in PCC: IHS INTERACTIVE PCC LINK? NO
Type of PCC Link: PASS ALL DATA AS ENT allow PCC Problem List Update? YE
Update PCC Link Exceptions? N Update those allowed to see all visits on SDE? N
Update those allowed to share visits? N Update those allowed to order Labs? N
    
```

For an explanation of the various categories that can be modified, please reference the BHS v3.0 Users Manual.

```

Type of Visit to Create in PCC: IHS
Type of PCC Link: PASS ALL DATA AS ENT
    
```

Update Site Parameters

Type of PCC Link –

1. No Active Link
2. All records passed with the same ICD-9 code and narrative
3. Some masking of data based on how POV is recorded
4. No masking of data – passed as written
5. Single standard narrative for all contacts

Summary

- Access to BHS v3.0 is controlled by security keys and, in some cases, by entries on the site parameters.
- Setting up defaults on the site parameter menu contributes to ease of data entry.
- Establishing a link to PCC will allow transfer of data for GPRA indicators and billing purposes.

Patient Related Data Entry

Obj. #2: Enter patient-related data including an encounter record, Suicide Form, treatment plan, patient information and case status.

Main Menu

```
PDE  Enter/Edit Patient/Visit Data - Patient Centered
SDE  Enter/Edit Visit Data - Full Screen Mode
RDE  Enter/Edit Visit Data - Roll n Scroll Mode
ADM  Enter a Brief Administrative Record
GP   Group Form Data Entry Using Group Definition
GRP  Group Form Data Entry
DSP  Display Record Options ...
TPU  Update BH Patient Treatment Plans ...
DPL  View/Update Designated Provider List
DUP  Duplicate a Previous Visit
SF   Suicide Forms - Update/Print ...
```

Select Behavioral Health Data Entry Menu Option: █

Selecting a Patient

- Type a full or partial name (last name, first name), SSN, DOB or HRN for the patient
- Press [Enter] key
- If more than one name is returned, select the number for the patient, press [Enter] to see more names or use ^ to exit

```
Select PATIENT NAME: SMALL,A
1  SMALL, AARON W           M 10-21-1988 176365771  CR 29901
2  SMALL, AMY              F 01-10-1995 537973815  CR 33786
3  SMALL, AMY CECILIA     F 04-15-1974 276269538  CR 31585
4  SMALL, ANGEL LEAH      F 11-16-1993 370390194  CR 31650
5  SMALL, ANGEL LEIGH     F 10-12-1934 309446208  CR 5949
ENTER '^' TO STOP, OR
CHOOSE 1-5:
```

Visit Types

No Show	Regular
Brief	Info/Contact
Intake	San (New)
A/SA	San (F/U)

```
Patient: SMALL, AARON W  HRN: 29901
      MALE  DOB: Oct 21, 1988  AGE: 15 YRS  SSN: 176365771
Designated Providers:
Mental Health: BRUNING, BJ          Social Services:
A/SA:                               Other:
Other (2):                            Primary Care:

Last Visit (excl no shows): Feb 20, 2004  BRUNING, BJ  REGULAR VISIT
      305.20  CANNABIS ABUSE, UNSPECIFIED
Pending Appointments:

Main Data Entry Screen
Select the appropriate action
AV Add Visit          BV Browse Visits      DM Display Meds
EV Edit Visit        LD List Visit Dates  LA Interim Lab Reports
DV Display Visit     TP Treatment Plan Update  SR Staging Report
ES Edit SOAP        CD Update Case Data  OI Desg Prov/Flag
DE Delete Visit     ID Update Intake Document  PL Problem List Update
PF Print Encounter Form  AP Appointments      MM Send Mail Message
LV Last BH Visit     HS Health Summary    Q Quit
Select Action: Q// av
```

Notes



- ❖ Medications Prescribed – *NOT* a medication-ordering field; free-text box to track medications prescribed or other useful medication info
- ❖ Chief Complaint – brief description of problem; no more than 80 characters
- ❖ SOAP/Progress Notes
 - ◆ Direct entry into the free-text box
 - ◆ Copy & paste from a word processing application
 - ◆ Copy & paste from another BHS v3.0 entry

visit Admin

- Enter Activity Time as minutes, not hours
- Select the Activity Code from the Job Aide or type ?? To see the list
- Enter a CPT Code (Optional)
- Number Served should default to 1; Type over to change

Patient Education



- Encounters using the IHS Patient Education Protocols are tracked as part of the visit documentation.
- Education may be provided individually or in group settings.
- On the visit screen at the education question, type a [Y] to access the Education screen



Health Factors

- Each Health Factor is entered once only
- Current list should be available from your site manager
- CAGE or CAGE-T scores may be entered here

IPV/DV SCREENING QUESTION

PROGRAM: MENTAL HEALTH LOCATION OF ENCOUNTER: DULCE HEALTH C
 CLINIC: MENTAL HEALTH APPOINTMENT OR WALK-IN: APPOINTMENT
 TYPE OF CONTACT: OUTPATIENT ARRIVAL TIME: 12:00
 COMMUNITY OF SERVICE: DULCE ANY SECONDARY PROVIDERS?: N

Includes new IPV/DV Screening Question

CHIEF COMPLAINT:
 SOAP/PROGRESS NOTE (press enter to update, TAB to bypass):
 COMMENT/NEXT APPOINTMENT (press ENTER to update, TAB to bypass):
 Display Currently Dispensed Meds? N MEDICATIONS PRESCRIBED:
 IPV/DV Screening Done? Y
 ANY CPT CODES? Y PURPOSE OF VISIT (POVS) <enter>:
 PLACEMENT DISPOSITION:
 ACTIVITY: ACTIVITY TIME: # SERVED: 1

N	NEGATIVE
PR	PRESENT
PA	PAST
UAS	UNABLE TO SCREEN
REF	PATIENT REFUSED SCREENING

IPV/DV Screening

Intimate Partner Violence/Domestic Violence (IPV/DV) Screen

Display IPV/DV screening history?

Screening/Exam Result:

Provider: BRUNING, BJ

COMMENT:

Printing an Encounter

After the encounter is saved, the following screen is displayed

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). None of the Above (Quit)

Choose one of the above: (1-7): 7 // 6

Type [6] at the prompt to print

Printing an Encounter

Select the type of form to print

- Full
- Suppressed
- Both
- Two Full
- Two Suppressed



When returned to previous screen, Type [7] and [Enter] to exit

SAN (New) Visit Type

- | | |
|---|-----------------------|
| 1 | Parents |
| 2 | Guardians |
| 3 | Lives With |
| 4 | Spouse/Partner Info |
| 5 | Person Referring Info |

- | | |
|----|----------------------------------|
| 12 | Risk for Recurrence |
| 13 | Services Provided/Treatment Plan |
| 14 | Examining Physician |
| 15 | Date of Examination |
| 16 | Police Contacted: Y/N |

- Used to document 1st visit in SAN case.
- Enter visit demographics and save encounter.
- Select categories to be recorded from the list.

- | | |
|----|----------------------------------|
| 6 | Relation To Victim |
| 7 | Suspected Perpetrator Info |
| 8 | History |
| 9 | Prior Incidents Noted |
| 10 | Assessment: Problems Identified |
| 11 | Assessment: Strengths Identified |

- | | |
|----|---------------------------|
| 17 | Date/Time Complaint Filed |
| 18 | Complaint # |
| 19 | Officer Name and Agency |
| 20 | Referral(s) Made to |
| 21 | Other Comments |

SAN (F/U) Visit Type

- Used to document follow up contacts in a SAN case.
- Enter visit demographics and save encounter.
- Select categories to be recorded from the list.

1 Reasons for Review
2 Outcome
3 Outcome Reasons
4 Assessment: Problems Identified
5 Assessment: Strengths Identified
6 Risk
7 Services Provided up to time of review
8 Recommendations: Treatment Plan Changes/Additions
9 Recommendations: Continue with DSS
10 Recommendations: Continue with SAN
11 Other Comments

A/SA Visit Screen

A/SA CD COMPONENT: [REDACTED] A/SA CD COMPONENT TYPE:
A/SA CD TYPE OF CONTACT: CLINIC: **ALCOHOL AND SUB**

Alcohol/Substance Stage:	Average 1.0-1.9:	DETOX, PRT
Physical Stage:	Average 2.0-3.4:	PRT, FGH, INOPT
Emotional Stage:	Average 3.5-4.3:	FGH, HWH, TLC, INOPT
Social Stage:	Average 4.4-5.4:	OPT, GH, HWH, TLC
Cultural/Spirit Stage:	Average 5.5-6.0:	HWH/TLC, OPT, AFT, GH
Behavioral Stage:		
Voc/Educ Stage:	Recommended Placement:	
	Actual Placement:	
	Difference Reason:	

The Staging Average is: 0

SUMMARY

- All visit types have some elements in common.
- Visit Admin information must be entered.
- SOAP note: This is the progress note; copy and paste from a data processing program can be utilized.
- All visit types may be edited or printed as needed. Deleting a visit is controlled by a site parameter.

SFD Review Suicide Forms by Date
SFP Update Suicide Forms for a Patient

Select Suicide Forms - Update/Print Option:

Suicide Form Data Elements

1. Local Case #: [REDACTED] Provider: BRUNING, BJ
7. Employment Status:
8. Date of Act: APR 22, 2005 11. Community where act Occurred:
12. Relationship Status: 13. Education:
14. Self Destructive Act:
15. Method (press enter): 16. Previous Attempts:
17. Substance Use Involved: 18. Location of Act:
19. Contributing Factors (press enter): 20. Lethality:
21. Disposition:
22. Other Relevant Information:

Treatment Plans



- Use this option to add, edit, print, or review a Treatment Plan
- Required fields – Program, Case Admit Date, and Designated Provider

```
Program .....:
Case Admitted Date.....:
Designated Provider.....: BRUNING, BJ//      BJB      COMPUTER, SPECIALIST
AXIS I:
  No existing text
  Edit? NO//
AXIS II.....:
  No existing text
  Edit? NO//
AXIS III:
  No existing text
  Edit? NO//
Select AXIS IV:
AXIS V.....:

There are 240 characters available to list & briefly describe multiple problems.
PROBLEM LIST:

Treatment Plan Narrative (Problems/Goals/Objectives/Methods):
  No existing text
  Edit? NO//
Resolve by Date....:
Next Review Date.....: |
```

Treatment Plans

Designated Provider



- **Designated Provider** – clinician who has primary responsibility for the client's care.
- **Designated Other Provider #2** – Used to identify external contacts such as Probation or Parole Officers, teachers, etc.



Patient Flags Personal History

- **Patient Flags** – locally-defined numeric field used to identify a specific group of patients.
- **Personal History** – Events that have impacted on the patient's life and may effect treatment. These should not be diagnoses such as Depression or temporary circumstances such as Homelessness.

Case Status

```
CASE_OPEN_DATE: DEC 4, 2003
PROGRAM_AFFILIATION: CHEMICAL DEPEND
PROVIDER_NAME: BRUNING, BJ
PRIMARY_PROBLEM: 30

CASE ADMIT DATE:
NEXT CASE REVIEW DATE:

DATE CASE CLOSED:
DISPOSITION:
```

Use this screen to open, admit and close cases

SUMMARY

- Incidents of suicide can be documented in the context of a visit or entered as an historical event.
- Treatment Plans and Case Status are optional but recommended.
- Designated Provider, Patient Flags, and Personal History are optional fields. They may be used to record and review information about a patient's status, assigned providers, etc.

Hands On

- **Walk through the data entry process as explained in the Training Manual**
- **Complete the data entry for the Practice Scenarios in the manual**

Other B H Options

Obj. # 3, Other BH Options : Record all required data elements for group encounters, non-patient activities and administrative records.

Group Entry Format



- Allows provider to enter:
- Standard group elements (group topic, SOAP note, etc.)
 - Individualized notes for each participant
 - Allows provider to duplicate the encounter records for subsequent group sessions
 - Required elements - same as for individual encounter (Provider, date, etc.)

Adding Group Data

- **Axis I/II:** Problem or Diagnosis - primary focus of group discussion
- **CPT:** Optional coding. Group psychotherapy code is **90853**
- **SOAP/Progress Note:** Add the standard group note
- **Patients:** Add all patients who attended the group session

Adding Patient Data

- Enter time patient actually attended the group
- Enter any additional DSM or Problem codes
- **SOAP/Progress Note** – Enter new or additional information for the patient, if appropriate.

Printing Group Notes



- After all client data has been entered, type "Y" at the prompt to print the Encounter Forms
- Select the type of form to print (same as for other visits)

```
1 Add a New Group          5 Print Encounter Forms
2 Display Group Entry      6 Review/Edit Group Visits
3 Duplicate Group          7 Add No Show Visit
4 Delete Group             0 Quit
Select Action:++
```

Additional Group Functions

- Duplicating a Group maintains basic data fields and allows for editing of group and individual notes.
- Deleting the Group removes the display only; it doesn't remove individual encounter records.

No Show Visits

- After duplicating the group, remove patients who no-showed from the Patient List.
- After completing group data entry, return to list view and select #7, Add No Show Visit Record.

Additional Group Functions

NON-PATIENT RECORD ENTRY



Record prevention activities, health fairs, and other non-patient activities

NON-PATIENT RECORD ENTRY

```
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GP   Group Form Data Entry Using Group Definition
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DUP  Duplicate a Previous Visit
SF   Suicide Forms - Update/Print ...

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

Return to main menu
Select SDE for Full Screen Mode

Administrative Activities

```
PDE  Enter/Edit Patient/Visit Data - Patient Centered
SDE  Enter/Edit Visit Data - Full Screen Mode
RDE  Enter/Edit Visit Data - Roll n Scroll Mode
ADM  Enter a Brief Administrative Record
GP   Group Form Data Entry Using Group Definition
GRP  Group Form Data Entry
DSP  Display Record Options ...
TPU  Update BH Patient Treatment Plans ...
DPL  View/Update Designated Provider List
DUP  Duplicate a Previous Visit
SF   Suicide Forms - Update/Print ...

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

Return to the Behavioral Health Data Entry menu to access the Admin Record Entry.



Activity Code.....: 31// 45

Activity/Service Time....: 120

Number Served.....: 1

Enter PRIMARY Problem-POV: 99//

Provider Narrative.....:

COMMENT/NEXT APPOINTMENT:

No existing text

Edit? NO//

Administrative Activities

Hands On

- Walk through the data entry process as explained in the Training Manual
- Complete the Other BH Options exercises in the Training Manual



OBJECTIVES

#4 Reports: Access the Reports menu in BHS v3.0, identify specific reports, and run a sample

#5 Exporting: Routinely export behavioral health data to headquarters using the Export utility

Report Types

- Patient Listings
- Encounter Reports
- Workload/Activity Reports
- Problem Specific Reports



Patient Listings

- Options for generating lists of patients by various criteria.
 - **ACL** = Active Client List
 - **PPL** = Placements by Site/Patient
 - **SEEN** = Cases opened but patient not seen in N days
 - **TCD** = Tally cases opened/admitted/closed
 - **DVR** = IPV/DV Reports (controlled by a security key)
 - **Etc.**

Encounter Reports



- **LIST** = List Visit Records
- **GEN** = List Behavioral Health Records (General Retrieval)
- **BILL** = Potentially billable Behavioral Health visits
- **ETC.**

Workload/Activity Reports



- **GRS1** = Activity Report (GARS#1)
- **ACT** = Activity Reports Count
- **PROG** = Program Activity Time Reports
- **FACT** = Frequency of Activities
- **FCAT** = Frequency of Activities by Category

Problem Specific Reports



- **SUI** = Suicide Report by Age and Sex
- **ABU** = Abuse Report by Age and Sex
- **SSR** = Suicide Aggregate Report - Standard

Real Life Examples



- Clinician wants to know how many clients he/she has seen this month
- Social Worker wants to identify all clients screened for IPV/DV
- Chemical Dependency counselor wants to identify all Treatment Plans needing revision within the next 30 days.
- Tribal Council wants aggregate data on suicide ideation/attempts/completions for the past year.

Hands On

DE Behavioral Health Data Entry Menu ...
RPTS Reports Menu ...
MUTL Manager Utilities ...
Select Behavioral Health Information System Option: |

- Log on to RPMS
- Select BHS v3.0
- Select RPTS option

Exporting Data

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
ERRS Print Error List for Export
OUTP Create OUTPUT File

Select Export Utility Menu Option:

Exporting data from the BH applications is similar to exporting from PCC.

CHK, Clean

Select CHK – Check Records before Export

This program will review all records that have been 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.

Application will display a prompt. User will select to proceed or to terminate this process.

Generate Transactions for HQ

This routine will 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.

Select "GEN" then type information as requested.

ERRS – Error List for Export

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

```
FEB 3, 2004 12:00 WOODWARD, TESSA LYNN 123456 M OUTPATIENT 11  
ERROR: E000-AREA SU COMM CODE INVALID  
  
MAR 31, 2004 13:00 WOODWARD, TESSA LYNN 123456 M OUTPATIENT 11  
ERROR: E000-AREA SU COMM CODE INVALID
```

Transmit



Send transactions according to your program's established routine.

Review of Objectives

#1 Set Up

Set defaults via the Site Parameters menu.

#2 Patient-Related Data Entry

Encounter Records, Treatment Plans, Suicide Forms, Patient Information and Case Status may all be entered for individual patients.

#3 Other BH Options

Recording standard group elements and individualized notes for each participant; adding non-patient or administrative contacts

Review of Objectives

#4 Reports

Ability to generate and print commonly used reports such as Workload Reports, Aggregate Suicide Reports or Treatment Plans Needing Review, etc.

#5 Exporting

Export behavioral health data to Headquarters using the Export Utility menu.

Wrap Up

- Questions?
- Training Evaluation
- Help Desk
(888) 830 – 7280
support@ihs.gov


