

# Behavioral Health GUI

## Patient Chart v1.5

**Indian Health Service**  
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### Set Up



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




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### Manager Utilities in BHS v3.0

SITE Update Site Parameters  
 EXPT Export Utility Menu ...  
 RPFF Re-Set Patient Flag Field Data  
 DLWE Display Log of Who Edited Record  
 ELSS Add/Edit Local Service Sites  
 EPHX Add Personal History Factors to Table  
 DRD Delete BH General Retrieval Report Definitions

Select Manager Utilities Option: █




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## Update Site Parameters

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** UPDATE BEHAVIORAL HEALTH SITE PARAMETERS: CRON MO
***** DEFAULT VALUES IN DATA ENTRY *****
MH Location: CRON MO          SS Location: CRON MO
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
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For an explanation of the various categories that can be modified, please reference the BHS v3.0 Users Manual.



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## Update Site Parameters

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

### 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



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## Getting Started

Select Patient Chart from your Start Menu or double click on the shortcut you've created.



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## LOG ON

RPMS Server Login

Port

Choose Server: [dropdown] OK

Access Code: [text field] Cancel

Verify Code: [text field]

Type in your RPMS Access and Verify Codes.

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Patient Chart v1.5 Help

File Edit Bookmark Options Help

Help Topics [tree view]

**Frequently Asked Questions**

- Appointments
- Alerts/Triggers
- Behavioral Health
- Diabetes Patient Care
- Face Sheet
- General
- Getting Started
- Health Summaries
- Immunizations
- Laboratory
- Measurements
- Medications
- Patient Education
- Problem List
- Purpose of Visit
- Referral Care
- Endocrine
- Tobacco
- Women's Health

**General**

- What are security links?
- How do I log in from the Patient Chart Program?

**Getting Started**

- How do I choose a patient?
- What is the cover sheet?
- Back to top

**Face Sheet**

- How do I view a patient's face sheet?
- How do I print the patient's face sheet?
- Back to top

**Problem List**

- How do I view a patient's problem list?

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**IHS Patient Chart**

Select Patient

My Labs

I-net

BH Options

Exit

**Select Patient**

The dotted black line indicates the area of focus or the default selection.

BRUNING, BJ in CROW HO

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## Summary

- Access to tabs within Patient Chart is controlled by security keys
- Only Behavioral Health staff have access to the BH tab
- Point and click functionality – use your mouse and/or a combo on keyboard entry
- BH tab = data entry module of BHS v3.0



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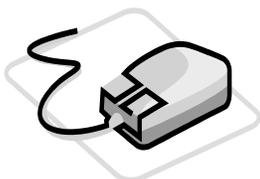
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## Hands On

Log into Patient Chart v1.5

Click on the Cover Sheet Tab

Explore each of the other tabs



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## Patient Related Data Entry

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



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# Visit Types

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



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**Add A Visit**

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## Visit Information

**Primary Provider** BRUNING,BJ      **Encounter Date** 4/21/2004  
**Program**                              **Encounter Location** CROW HO  
**Clinic**                                      **Appointment or Walk-In**  
**Type of Contact**                      **Community of Service**  
**Arrival Time** 1200

**Fields in bold print must be completed.**



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## Purpose Of Visit (POV) Tab

- **Axis I and Axis II (POV):** DSM or Problem Codes
- **Axis III:** free-text narrative box
- **Axis IV:** multi-select functionality
- **Axis V:** enter the GAF score (0-100)



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## CC/SOAP Tab



*All fields are optional.  
Some fields have limited  
space to record clinical  
notes.*



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## Visit Administration Tab

### REQUIRED FIELDS

Activity

Activity Time

Number served

### OPTIONAL FIELDS

Visit Flag

Local Service Site

Interpreter Utilized?

CPT Codes

Secondary Provider for  
this visit



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## Printing an Encounter

Use this function to print a hard copy of a patient's record. This encounter form is signed by the provider.



Print immediately after data entry or later.



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PCC Medications

Visit Date	Medication	SIG	Qty	Days	Provider
No PCC Me...					

**Rx Notes Tab**

Behavioral Health Medications

none at this time	Visit 02/03/04 1200
	Visit 01/20/04 1200

Drug/Alcohol History

These Medications Several drinking binges with blackouts

Prescription Entry

**The Rx Notes tab** allows entry of free-text notes regarding the client's prescription history.

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## Patient Education - Wellness Tab

- IHS Patient Education Protocols are tracked as part of the visit documentation.
- Education may be provided individually or in group settings.
- Patient Education Protocols are available on the Nationwide Programs and Initiatives page of the IHS website.



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## Health Factors - Wellness Tab

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



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During FY 2005 the IHS will ensure that 15% of women between the ages of 15 and 40 are screened for domestic violence.

Education	Health Factors	Screening
Intimate Partner Violence/Domestic Violence Screening		
Result	<input type="text"/>	
Comment	<b>IPV/DV Screenings – Wellness Tab</b>	

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## Intake Document

Intake Document
<p><b><u>Copy &amp; Paste</u></b></p> <ol style="list-style-type: none"><li>1. Type the document in the format you want to use</li><li>2. Highlight the section(s) to be added to the GUI free-text box</li><li>3. Click on [Edit] at the top of the window and select “Copy”</li><li>4. Open the BH GUI and select the location where the data is to be added</li><li>5. Right click on your mouse and select “Paste”</li></ol>

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Parents		Risk for Recurrence	LOW
Guardians		Services Provided	counseling for son
Lives with	Son and daughter-in-law	Examining Physician	
Spouse/Partner info		Date of Examination	
Person Referring info	Joshua T	<input checked="" type="checkbox"/> Police Contacted?	
Relation to Victim	son	Date Complaint Filed	02/03/04
Suspected Perpetrator info	Home Health provider	Complaint Number	159753
History		Officer Name and Agency	Officer Chee, Tribal Police
Prior Incidents Noted	0	Referral(s)	Home Health agency
Problems Identified	Unable to provide information o	Other comments	
Strengths Identified	supportive family		

**SAN (New) TAB**

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Reason for Review	Testing fields	Risk for Recurrence	NONE
Outcome	SUBSTANTIATED		
Outcome Reasons	Caregiver admitted striking the patient		
Problems Identified	Continued need for care & lack of additional agencies in area		
Strengths Identified	Family support		
Services Provided	counseling for patient's son and referrals		
Recommendations/Comments	None at this time. Case Closed.		

**SAN (New) TAB**

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Days Used Alcohol	<input type="checkbox"/>	Alcohol/Drug-related Arrests	<input type="checkbox"/>	Tobacco Use	
Days Used Drugs	<input type="checkbox"/>	Days Hospitalized	<input type="checkbox"/>		
Substance(s) Abused					
Narrative					<input type="button" value="Add"/> <input type="button" value="Delete"/>
may use multi-select function					

**CD STG Tab**

- Use past 180 days (6 months) as time frame
- Enter patient's response to each question

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**STAGE TAB**

- After completing assessment, enter score from 1 –6 for each stage
- Use drop down menus to select Recommended and Actual Placements

Alcohol/Substance Stage  Physical Stage  Emotional Stage   
 Social Stage  Cultural/Spiritual Stage  Behavioral Stage   
 Vocational/Educational Stage  Staging Average   
 (Suggested Placement)

Recommended Placement  Actual Placement  Difference Reason

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**C D Data Tab**

Component Code   
 Type of Component   
 Type of Contact   
 Days in Residential Treatment   
 Days in Aftercare

**Additional Chemical Dependency fields:**

- o **Component Code** - Outpatient, Inpatient, Aftercare, etc.
- o **Type of Component** - Adult, Family, Mixed, etc.
- o **Type of Contact** - Initial, Reopen, Client Service
- o **Days in Residential Treatment or Aftercare**

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**Editing or Deleting Visits**

Use these functions to:

- modify a visit entered in error
- delete a visit entered in error
- correct information
- add additional information



**Warning: Deleted visits are gone forever!**

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## 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 security key.



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## Suicide Form Data Elements

Local Case Nbr	<input type="text"/>	Provider	<input type="text" value="BRUNING, BJ"/>
Date of Act	<input type="text" value="02/18/05"/>	Community Where Act Occurred	<input type="text"/>
Relationship Status	<input type="text"/>		
Employment Status	<input type="text"/>		
Education	<input type="text"/>	If less than 12 years, highest grade completed	<input type="text"/>
Self Destructive Act	<input type="text"/>	Location of Act	<input type="text"/>
Previous Attempts	<input type="text"/>		
Lethality	<input type="text"/>		
Disposition	<input type="text"/>		

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<input type="checkbox"/> Suicide of Friend or Relative	<input type="checkbox"/> History of Substance Abuse/Dependency	<input type="checkbox"/> Legal
<input type="checkbox"/> Death of Friend or Relative	<input type="checkbox"/> Divorce/Separation/Break-up	<input type="checkbox"/> Unknown
<input type="checkbox"/> Victim of Abuse (Current)	<input type="checkbox"/> Financial Stress	<input type="checkbox"/> Other (describe)
<input type="checkbox"/> Victim of Abuse (Past)	<input type="checkbox"/> History of Mental Illness	
<input type="checkbox"/> Occupational/Educational Problem	<input type="checkbox"/> History of Physical Illness	
<b>Contributing Factors</b>		
<input type="checkbox"/> Suicidal	<input type="checkbox"/> Carbon Monoxide	
<input type="checkbox"/> Hanging	<input type="checkbox"/> Overdose	
<input type="checkbox"/> Motor Vehicle	<input type="checkbox"/> Other	
<input type="checkbox"/> Jumping		
<input type="checkbox"/> Stabbing/Laceration	<input type="checkbox"/> Unknown	
<b>Method</b>		
<b>Substance(s) involved in this incident:</b>		
<input type="checkbox"/> None		
<input type="checkbox"/> Alcohol and Other Drugs		
<input type="checkbox"/> Unknown		
<b>Substance Use</b>		



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**Case Status**

Use this screen to open, admit and close cases

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Treatment Plan

Use this option to add, edit, delete, print, or review a Treatment Plan

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**Treatment Plan Data Elements**

Items in bold are required fields.

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## Treatment Plan Diagnosis/Problem Tab

Diagnosis/Problem    Plan Narrative    Plan Review

Axis I:

Axis II:

Axis III:

Axis IV: Major Psychosocial or Environmental Problems

Code:  Narrative:  Add Delete

Axis V: IGAFI

Problem(s):

Close Save Clear

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## Treatment Plan Narrative

Problems/Goals/Objectives/Methods

**Treatment Plan Narrative is a word processing field.**

**Utilize a Treatment Plan Template or Format preferred by the facility or agency.**

**Copy and paste capability can be used here.**

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You must click the ADD button to enter the plan review.

Review Date	Rev Provider	Rev Supervisor	Next Review
01/06/04	BRUNING,BJ		02/06/04

Review Date:  Next Review:

Rvw Provider:  Rvw Supervisor:

Name	Relationship to Patient
<b>Treatment Plan Reviews</b>	

Participant:  Relationship to Patient:

Progress Summary:

Add Edit Delete

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Review Date	Rev Provider	Rev Supervisor	Next Review
01/06/04	ZIEGLER,MIKE		01/13/04
Review Date	Next Review		
1/30/2004	4/23/2004		
Rvw Provider	Rvw Supervisor		
ZIEGLER,MIKE			
Participants			
Name	Relationship to Patient	Add	
		Edit	
		Delete	
Participant			
Relationship to Patient			
Progress Summary			
A word processing field used to document progress since last review.			
		OK	Cancel




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## Summary

- **Suicide forms are for recording incidents of suicide only; they are not for recording clinical care provided**
- **Use of Case Status and Treatment Plan functions are optional**
- **Copy and Paste process can be used in any word processing field**
- **Most items are entered using drop down menus or typing directly into word processing field**




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- Designated Provider – I/T/U clinician who has primary responsibility for the client’s care.



- Designated Other Provider #2 – external providers such as Probation or Parole Officers, teachers, etc.

**Patient Information Tab**




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## Patient Information Tab

- Patient Flags – locally-defined numeric field used to identify a specific group of patients
- Personal History – document historical factors such as Alcohol Use, Suicide Attempt, Child Abuse (victim), boarding school, etc.



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## Summary

The Patient Information tab is a useful case management tool allowing the provider to document and review:

- Designated providers – I/T/U and outside agency providers
- Patient flags - specific identifiers for a group of patients
- Personal History factors that are relevant to patient care



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## Hands On



- Access the Behavioral Health Tab within Patient Chart
- Enter Practice Scenarios
- Reference Help file as needed



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# B H Options

**Obj. #3 : Access the BH Options and record all required elements for group encounters, non-direct patient activities, and an encounter record in the Visit Entry format.**



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## Group Entry Format

### Required elements –

– same as for individual encounter (Provider, date, etc.)



### Allows provider to enter-

- \* Standard group elements (group topic, SOAP note, etc.)
- \* individualized notes for each participant

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## Group Entry List View

The screenshot shows a software window titled "Group Entry" with a "Data View" section containing "Starting Date: 05/31/2004" and "Ending Date: 05/31/2005". Below this is a table with the following data:

Date	Group Name	Activity	Program	Clinic	Provider	Contact Ty...	POV
05/17/05	MEDICATION GRO...	FAMILY TR...	M	MEN...	STUDENT...	OUTPATIE...	DEPRESSIVE
05/17/05	TOBACCO CESSAT...	GROUP TR...	S	MED...	STUDENT...	OUTPATIE...	NICOTINE D...
05/16/05	FIRST STEP GROUP	GROUP TR...	C	ALC...	STUDENT...	OUTPATIE...	DRUG ABUS
05/13/05	IPV/DV EDUCATION	GROUP TR...	M	MEN...	STUDENT...	OUTPATIE...	ADULT ABUS
05/12/05	PERSONALITY DIS...	GROUP TR...	M	MEN...	STUDENT...	OUTPATIE...	PERSONALI...
05/11/05	ADD/ADHD PARE...	FAMILY TR...	M	MEN...	STUDENT...	OUTPATIE...	ATTENTION...
05/03/05	MEDICATION GRO...	FAMILY TR...	M	MEN...	STUDENT...	OUTPATIE...	DEPRESSIVE
04/26/05	TOBACCO CESSAT...	GROUP TR...	S	MED...	STUDENT...	OUTPATIE...	NICOTINE D...
04/19/05	FIRST STEP GROUP	GROUP TR...	C	ALC...	STUDENT...	OUTPATIE...	DRUG ABUS
04/17/05	MEDICATION GRO...	FAMILY TR...	M	MEN...	STUDENT...	OUTPATIE...	DEPRESSIVE
03/23/05	FIRST STEP GROUP	GROUP TR...	C	ALC...	STUDENT...	OUTPATIE...	DRUG ABUS
03/23/05	IPV/DV EDUCATION	GROUP TR...	M	MEN...	STUDENT...	OUTPATIE...	ADULT ABUS
03/22/05	PERSONALITY DIS...	GROUP TR...	M	MEN...	STUDENT...	OUTPATIE...	PERSONALI...

At the bottom of the window are buttons for "Add", "View", "Duplicate", "Delete", "Print", "Close", "Next", and "Previous".

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## Patient Data Tab

- Patient Demographics will be displayed in a List View on the Patient Data Tab.
- Double-click (or highlight and enter) on a patient name to enter patient-specific information.

Patient Name	Sex	Age	DOB	Chart #
WOODWARD, TESSA LYNN	F	102	04/19/01	123456

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## Patient Data Tab

Code	Narrative	Add
314.00	ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, PREDOM. INATT...	Edit Delete

S/O/A/P

This is the group note as recorded on the Group Data Screen.

THIS IS THE INDIVIDUAL PATIENT'S NOTE

Comment/Next Appt

RECORD ANY CHANGE IN THE CLIENT'S ATTENDANCE IN THE BOX BELOW.

Time in Group: 120

OK Cancel

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## Patient Data Tab

GREEN, ESTHER JORDAN F 7 09/29/97 37971

Code	Narrative	Add
28	DRUG DEPENDENCE	Edit Delete

**Zeroing out a patient's time in group will generate a no - show visit**

Comment/Next Appt

Time in Group: 0

OK Cancel

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**Save**

*It is advisable to print the individual patient encounters immediately after completing the group entry.*



**Print**




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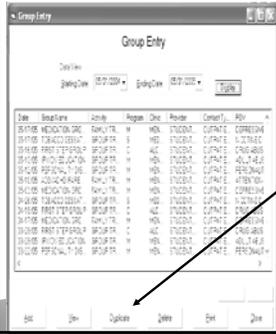
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### Duplicating a Group Entry



To duplicate a group:

1. Select the group to be copied
2. Click the Duplicate Button
3. On the Group entry screen, edit as needed.




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## SUMMARY

- Group Data Entry allows the provider to record a standard group note and an individual SOAP/progress note, as needed.
- The DSM or Problem Code for the group will be the same; additional codes may be added for a specific patient.
- Group data entry can be used for therapy or psycho-educational groups or any other group activity, including recreation.




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# Reports



**Objective #4: Use the Telnet Function to access the Reports menu in BHS v3.0, identify specific reports, and run a sample Report.**



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## Report Types



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



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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** = Domestic Violence Reports (controlled by a security key)
- **ETC.**



## Patient Listings



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## Encounter Reports



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



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## 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



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## Problem Specific Reports



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



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- Clinician wants to know how many clients he/she has seen this month.
- 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.
- Area Office wants a breakdown of activities for the past quarter.

**Real Life Examples**

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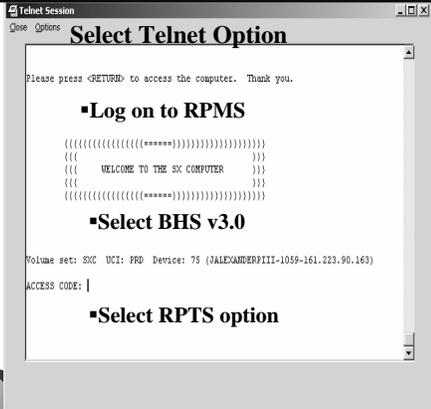
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Telnet Session
Close Options
Select Telnet Option

Please press <RETURN> to access the computer. Thank you.

    ■Log on to RPMS
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    ■Select BHS v3.0

Volume set: SX UC: PRD Device: 75 (JALEXANDERPIII-1059-161.223.90.163)
ACCESS CODE: |

    ■Select RPTS option
  
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**EXPORTING**

**Objective #5:**  
Routinely export behavioral health data to HQ using the Export Utility menu.

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## Exporting Data

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

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:

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## 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.**

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## 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.

**Transactions will be written to a file, a floppy or other method based upon selections entered in the Site Parameters.**

**Select "GEN" then type information as requested.**

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## DISP – Display a Log Entry

```
Information for Log Entry 6 Beginning Date: MAR 30, 2004  
NUMBER: 6 BEGINNING DATE: MAR 30, 2004  
ENDING DATE: APR 10, 2004  
RUN START DATE/TIME: APR 20, 2004@11:10:31  
RUN STOP DATE/TIME: APR 20, 2004@11:10:32  
COUNT OF ERRORS: 10 COUNT OF TRANSACTIONS: 160  
COUNT OF RECORDS PROCESSED: 170 RUN LOCATION: CROW HQ  
# ADDS: 160 # MODS: 0  
# DELETES: 0  
TRANSMISSION STATUS: SUCCESSFULLY COMPLETED
```

- Enter beginning date for the Transaction
- Print a copy of the log and store it according to agency guidelines



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## 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
```



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## Transmit



Send transactions according to your program's established routine.



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## Review of Objectives

### 1. Set Up

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

### 2. Patient-Related Data Entry

Clinicians can determine which documentation formats they wish to use to record encounters. Facilities will determine which optional elements of the application to use ( treatment planning, case status, etc.).

### 3. BH Options

Recording standard group elements and individualized notes; Documenting non-patient-related activities such as training or supervision; and using a view centric rather than patient centric method of data entry.



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## 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 Utilities menu.



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## Wrap Up

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



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